Trawsnewid ein gwasanaeth iechyd

Hywel Dda

Our big NHS change

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

English version (Welsh version available)

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Trawsnewid ein gwasanaeth iechyd

Hywel Dda

Our big NHS change

We have an ambition for our local NHS and a once in a lifetime opportunity to work with you to make it better for everyone. We want to provide the highest quality care, with excellent outcomes that improve your health and well-being and provide you with a good experience wherever you live and receive your care. We want to help you maintain your health, well-being and independence, recognising that good health is much more than living longer; it is living healthier lives, from before birth through to older age.

Last year we started a conversation with you – our population, our staff and with people we work with to provide care – to explore what is important to us and to jointly think about how to best run services. We did this because we think it is the right thing to do to design our services together. We explored the opportunities we think are offered to us through modern medicine and advancements in technology and the expectations you have for us to improve. We also set out the significant challenges faced by the NHS which we must deal with to ensure it thrives and delivers for you and your family now and in the future. This means that we will have to make decisions about where we can provide services and we know that there are going to be compromises to make, so that we make best use of our resources. We describe all of this in more detail in this document.

We now have three proposals that we think are safe, viable and offer an improvement on what we currently have. That is why we are launching a formal 12 week consultation to present these to you, to listen and talk to you further and take on board your views and ideas. This document describes our proposals for the whole of the health system and its connections with partners, including our proposed approach to community care, planned care and unplanned care. We have used our Hywel Dda family 'Teulu Jones' to demonstrate what the different proposals could mean for a typical family living in our area. They won't reflect everybody's circumstances and that is why it is really important that you and your family have your say and share your experiences and ideas.

Your feedback will be independently assessed and considered before any formal proposal is put before our Health Board for decision on how to proceed later in 2018 and we will continue to keep you updated on how we have used your feedback.

Through all of our work and as we move forward, our principles are that everything we do needs to be 'safe, sustainable, accessible and kind'. This is also what we have heard from you – you want safe services now and in the future, which you are able to access when you need them, and which treat you kindly with dignity and respect. It will involve moving towards a 'social model for health', where maintaining your own health and well-being, independence and purpose in life become the priority, recognising that people want more than just living longer. This is what we should all expect from our NHS service and what our staff aim to deliver every day.

We all have a shared passion for the NHS, our services, our history and our staff and we want to harness this to design, together with you, the best health service for our population. We are so grateful to those of you who have already been involved in this as patients, staff and members of our communities.

Thank you for helping us to change health services for the better

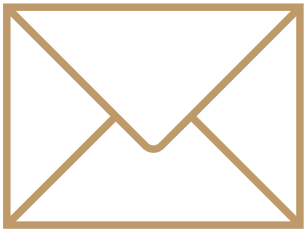
Steve Moore
Chief Executive

Bernardine Rees OBE
Chair

Dr Phil Kloer
Executive Medical Director & Director of Clinical Strategy

Libby Ryan-Davies
Transformation Director

HOW TO GET IN TOUCH



Please read the consultation document all the way through before completing the questionnaire.

You can tell us what you think in a number of ways:

- By completing the questionnaire accompanying this document and posting it to: **OPINION RESEARCH SERVICES, FREEPOST (SS1018), PO Box 530, Swansea, SA1 1ZL** (you will not need a stamp);
- Online at: **www.hywelddahb.wales.nhs.uk/Hddchange**;
- By emailing us: **hyweldda.engagement@wales.nhs.uk**;
- Talk to us on Twitter or Facebook **#Hddchange;**
- Over the phone by calling us **01554 899 056** (we will call you back so you do not have to pay for the call). You can leave a message on the answerphone if you need to call before 9am or after 5pm;
- Face-to-face at one of our public drop in events (please see below).

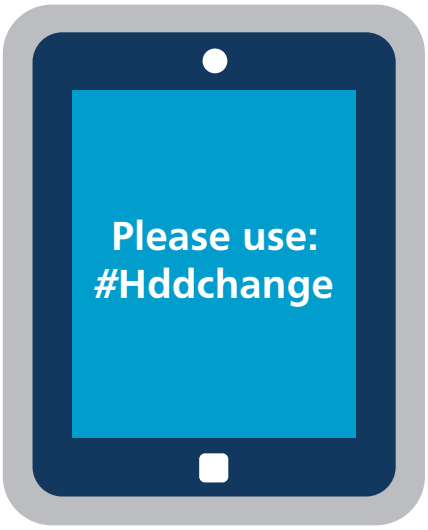
Events

Amser / Time	Dyddiad / Date	Lleoliad / Venue	Cod Post / Postcode
2pm – 7pm	4 Mai 2018 4 May 2018	Y Neuadd Fawr, Neuadd y Dref, Aberteifi The Great Hall, Guildhall, Cardigan	SA43 1JL
2pm – 7pm	8 Mai 2018 8 May 2018	Neuadd Ddinesig San Pedr, Caerfyrddin St Peter's Civic Hall, Carmarthen	SA31 1PG
2pm – 7pm	11 Mai 2018 11 May 2018	Neuadd Regency, Saundersfoot Regency Hall, Saundersfoot	SA69 9NG
2pm – 7pm	15 Mai 2018 15 May 2018	Neuadd Goffa Treletert, Treletert Letterston Memorial Hall, Letterston	SA62 5RY
2pm – 7pm	18 Mai 2018 18 May 2018	Canolfan Morlan, Aberystwyth Morlan Centre, Aberystwyth	SY23 2HH
2pm – 7pm	22 Mai 2018 22 May 2018	Canolfan Selwyn Samuel, Llanelli Selwyn Samuel Centre, Llanelli	SA15 3AE
2pm – 7pm	24 Mai 2018 24 May 2018	Neuadd Goffa Llandybie, Llandybie Llandybie Memorial Hall, Llandybie	SA18 3UR

In addition to our public drop in events we will be engaging through a range of other sessions for staff and interested parties including our neighbours in Powys, Swansea and south Gwynedd.

For more information about our events please visit our website:
www.hywelddahb.wales.nhs.uk/hddchange

Alternative versions of our documents are available by calling **01554 899 056** or visiting our website. This includes a summary version in the form of an animation; available in Welsh, English, Polish, British Sign Language, and audio; as well as Easy Read and large print versions.



Social media

Social media is going to be a really important place for us to raise awareness of our consultation, speak to you, answer questions and direct you to resources and more information.

We will mainly use Facebook and Twitter, but also YouTube for videos. We will also listen to public conversations about our consultation on Facebook and Twitter. Analysis of the themes and concerns raised and the emotion attached to them (happy, angry, sad etc) will be included in the overall analysis of the consultation, so it can be considered. To make it easier, please use the hashtag **#Hddchange**, 'tag' us, or comment on our pages.

We would always encourage formal responses to the consultation to be through the questionnaire, which asks you specific questions and provides space to give your views, but if you have difficulties with this, please contact us for help using the details provided above.

Your information

We're collecting your information as part of this consultation so we can use your views to help us with our decision making about improving health services. Please refer to page 80 for our full privacy statement.

1. WELCOME

Who are Hywel Dda University Health Board?

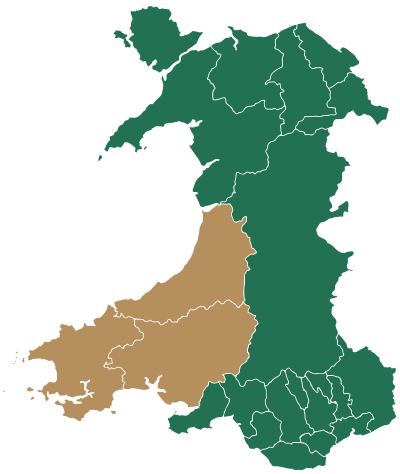
We are your local NHS organisation. We plan, organise and provide health services for 384,000 people in mid and west Wales. We manage and pay for the care and treatment that people receive in hospitals, health centres and surgeries, GPs, dentists, pharmacists, opticians and other places, including within the community. Every time you use an NHS service in Carmarthenshire, Ceredigion and Pembrokeshire, you are using a service which we are responsible for.

Hywel Dda University Health Board (the Health Board) covers the three local authority areas of Carmarthenshire, Ceredigion and Pembrokeshire and covers a quarter of the landmass of Wales. Hywel Dda is the second most sparsely populated health board area in Wales. 47.9% of the population in the region live in Carmarthenshire, 20.7% in Ceredigion and 31.4% in Pembrokeshire.

Because we have a very large border with other counties, communities in south Gwynedd, north Powys and west Glamorgan also rely on our health services.

25%

WE COVER A **QUARTER** OF THE LANDMASS OF WALES.



Who do we want to talk to?

Our proposals for change could affect everyone in our area, from bumps and babies to older people and everyone in between, so we are asking you all to tell us what you think. Whether you are a patient, a carer, a family member, or one of the thousands of people who work for the Health Board, we want to hear from you.

What this document is about

This consultation document sets out our proposals to improve health and care services across the Hywel Dda area as part of the Transforming Clinical Services Programme. We are consulting with all members of the public in mid and west Wales about these proposals because, as the people who are affected by any changes we might make, we want to not only hear your views, but to use them to help produce what our future services will look like. We will also be seeking views from people in Powys and south Gwynedd as they are also potentially affected by any proposed changes.

Who will make the decision on how future services are provided?

We are responsible for making important decisions about your health services, but when we consider big changes we will always ask you for your views and take them into consideration. The Health Board will make the decision on the final proposal, however, all of our proposals may need large investment in buildings and infrastructure and so we will need to work closely with the Welsh Government to apply for funding to make our changes. Further details are available on page 79.

What is Transforming Clinical Services?

Transforming Clinical Services is a programme led by our doctors, nurses and other healthcare professionals who have worked together to consider how we ensure our health and care services are safe, sustainable, accessible and kind for our generation, the next generation to come and beyond.

We want to provide healthcare that is of the highest quality, with excellent outcomes for patients. This applies to all children and adults in the Hywel Dda area, regardless of gender, age, disability, ethnicity or sexuality. It also applies equally to people with mental health problems or a learning disability, as well as people with physical health problems. Please read more in our Equality Impact Assessment on **http://bit.ly/2HYrznM** .

The difference we want to make for people is to:

- prevent people becoming ill where we can, and help people as soon as possible when they become ill – this is key for us to provide the best healthcare for our population;
- be proactive in our support for local people, particularly those living with health issues and the carers who support them;
- provide quick diagnosis so that you can get the treatment you need, if you need it, or move on with your life;
- be as efficient as we can be so that we don't expect you to travel unnecessarily or wait too long;
- look after you in your own bed as much as possible, reducing the need for a hospital stay;
- provide care that we would expect for ourselves, our friends and family that is safe and of a high quality;
- be open and honest and learn from what we do well, and when things go wrong;
- make best use of the money we have to get the best value from it for our patients;
- look after our staff so that they are more able to look after our patients, fully utilising their skills.

We want everything we do to be 'safe, sustainable, accessible and kind' as this is what you told us was important to you when you receive healthcare. The programme is considering the opportunities and challenges for the modern NHS, specific to us here in the Hywel Dda area.

We started the first phase of our work in June 2017 by looking at how well our current services work and how they might be reorganised and improved (to read the findings of this work please go to our Phase 1 Output Report Technical Document **http://bit.ly/2DNUtoj**).

Since then we have worked closely with our staff, patients, public and a wide range of partners. This has included a 12 week listening and engagement exercise, The Big Conversation, to listen to people's views before we started to think about any changes that may be recommended. Our proposals are ambitious. They include big changes to health and care services in community and hospital settings.

At this stage, the proposals we set out in this document are just that. We have not made any decisions yet.

What is informing this work?

The Welsh Government has undertaken a Parliamentary Review of Health and Social Care in Wales, which calls for us to revolutionise healthcare (to read the full document please follow this **https://bit.ly/2mBHQWw**). The four goals set out in the review are very similar to those that we have based our work on:

- improving the health of our population, through prevention, focusing on well-being and by intervening as early as possible;
- supporting people to live active, happy and healthy lives;
- improving the quality of services by working together with others in our communities;
- developing staff able to deliver our services now and in the future;
- getting the best value from every pound we spend on health and social care.

We also have a duty in law (The Well-being of Future Generations [Wales] Act, 2015 and Social Services and Well-being [Wales] Act, 2014) and want to join up the way different teams in our organisation work, as well as with other organisations and people who provide care. This is to ensure you receive care and support in the simplest way. We need to play our part in the social, economic, environmental and cultural well-being of our communities.

We work closely with the county councils in Carmarthenshire, Ceredigion and Pembrokeshire to agree how we will meet these goals together to improve the health and well-being of our communities. We also work with a number of partners across our region including Swansea, Powys and north Wales to set out plans of how we will work together to care for and support our whole population.

Working with other health boards across the region provides huge opportunities to consider how we can best provide planned care and urgent and emergency care in our hospitals. We will be closely considering with our neighbouring health boards the potential impacts and opportunities of our proposals.

We recognise that, although out of our direct control, we need to play a greater role in issues that affect health from poverty to environmental factors. We have millions of interactions and conversations with members of the public each year and it is often our staff who learn the real reasons for people's difficulties and poor health and well-being. We want to make it easier for people to find the advice, support or services they need to allow them to take control of their own health and well-being, and maintain or regain their independence and sense of purpose. We therefore need to play our part in developing more resilient communities.

Any proposals that we make to how health and care is delivered within mid and west Wales will need to take account of the duties and obligations on us and our partners that we have outlined.

We want everyone to have a good experience of our services and we also want to make sure that we spend your money wisely. We believe the best way to do this is to connect with local people, our staff and with partner organisations in order to jointly think about how best to run services.

To read more about what is informing this work please see our Technical Documents for What is informing this work – Regional Working; and What is informing this work – Local and National Priorities **http://bit.ly/2IJGIui** .

We need your help

We want to make things better in our communities and our hospitals. We believe the best way to do this is to ask everyone who uses, works for, or is involved with these services, what they think. Your ideas on how we can make things work better for you by providing safe, high quality care in mid and west Wales now and the future, are really important to us.

We will listen to your views and take them into account before making any decisions.

The consultation will run for 12 weeks from Thursday 19 April until Thursday 12 July 2018. We will ask you what you think about our proposals for change. We will provide key information on each of our proposals, including:

- how it will work;
- potential challenges;
- key things to think about.

We will then ask you to tell us, for each proposal:

- what it will mean for you;
- anything else that we need to consider.

How to use this document

The document aims to give you the information you need to answer the questions we are asking about our proposals for change. We want to take account of your views, and use them in our design, before making any final decisions.

We want to ask you some questions and we have tried to make it easy for you to respond, so that we can gather views from as many people as possible.

We really appreciate you taking the time to give us your thoughts – every person's input matters.

We look forward to hearing more of your views on our ideas, or your own ideas.

Information on how to get involved will be available at a range of places including hospitals, community venues, council buildings and voluntary sector organisations. We will hold drop-in events and workshops. We will share regular updates on our website **www.hywelddahb.wales.nhs.uk/Hddchange**, our social media pages on Facebook, Twitter, and our YouTube channel and we will also work closely with local media including local radio and newspapers.

Teulu Jones/The Jones Family

We have a family – Teulu Jones – who are helping test and show how our different proposals could affect someone like you. They aren't a real family, but they have been designed to be typical of the patients we care for in the Hywel Dda area. We will never capture all the different types of people we care for – that is why the consultation is seeking everybody's views – but they do help us to think about our proposals and what they could mean through the eyes of our patients and communities. You will read in this document what changes to health and care members of Teulu Jones would see in our proposals and we hope these help you think about what these changes could feel like for you.

Meet the family…

The Jones family are from Newcastle Emlyn on the border of Carmarthenshire and Ceredigion. Alun Jones, 80 years old, is a retired electrician who smokes a pipe and enjoys his daily walk for the newspaper. He has a cataract (an eye condition which can stop you seeing so well), a history of heart disease and takes tablets every day to control his diabetes. His wife is Mari Jones, 78 years old, who has recently learned she has mild dementia, which is affecting her memory and thinking. She is also finding it harder to move about and all this is putting strain on the family relationships.

Their daughter Sioned, is 47 years old, and lives in Tumble, near Llanelli. She is juggling her part-time job as a health care support worker, in Prince Philip Hospital and having to help care for her mother's needs. She also helps out with childcare for her grandson Ben. Her husband Rhys is 52 years old and is a long distance lorry driver, who is overweight and a heavy smoker. He works long hours and lives on junk food. His knees are giving him a lot of pain following his rugby days and this is the reason he can't lose weight – or so he tells Sioned.

Sioned and Rhys' daughter, Lianne, is 19 years old and lives with them. She is mam to three year old Ben and is 24 weeks pregnant. Lianne is doing a part-time course at a local college to become a childcare assistant. She isn't attending at the moment as she is sick with pregnancy related issues. Ben was born prematurely and has been recently diagnosed with a rare genetic condition.

Alun and Mari also have a son, Gareth, who is 38 years old. Gareth is the finance director of an engineering company in Birmingham. He is married to Aysha and they have two boys. He lives in Talybont, Ceredigion, but also stays in Birmingham during the week. He is a social smoker and trying to give up. He is otherwise quite active and cycles regularly with a local club. His two sons are keen swimmers, taking after their mum. Gareth tries to visit his parents as much as he can and stays in contact with Sioned.

We'll be revisiting Teulu Jones later on in the document (from page 40) to help show what impact our proposed changes could have on a typical family living in our area.

2. THE NEED TO CHANGE

We want as many people as possible to live healthier lives for longer.

Doing nothing is not an option if we want to ensure people receive excellent care in the future in the Hywel Dda area.

Transforming Clinical Services (TCS) is not only about providing health services that help people to get well, but about joining up our services around the needs of each person. This should mean giving children the best start in life, prevention of illnesses and ensuring all of us make healthier choices as well as quicker recovery if you suffer an illness.

We need a long term plan to support our communities where people are living longer and surviving serious illnesses, both of which are good news but can result in more physical and mental health needs. Modern lifestyles are also leading to longer term health conditions such as diabetes, cancer, respiratory and cardiovascular disease.

What do we have at present?

The main hospitals currently provide a lot of the same services and are struggling to meet increasing pressures from all year round demand. It is also a big challenge to continue fully staffing all four hospitals.

WE HAVE **FOUR** MAIN HOSPITALS:

BRONGLAIS IN ABERYSTWYTH;
GLANGWILI IN CARMARTHEN;
PRINCE PHILIP IN LLANELLI;
WITHYBUSH IN HAVERFORDWEST.

WE HAVE **SEVEN** COMMUNITY HOSPITALS:

AMMAN VALLEY AND **LLANDOVERY** IN CARMARTHENSHIRE;
TREGARON, ABERAERON AND **CARDIGAN** IN CEREDIGION;
TENBY AND **SOUTH PEMBROKESHIRE HOSPITAL HEALTH AND SOCIAL CARE RESOURCE CENTRE** IN PEMBROKESHIRE.

WE HAVE:

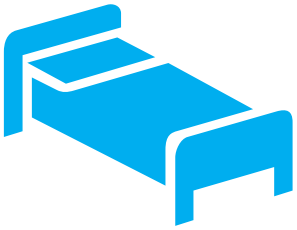
51 GENERAL PRACTICES;
46 DENTAL PRACTICES (INCLUDING ONE ORTHODONTIC);
99 COMMUNITY PHARMACIES;
64 GENERAL OPHTHALMIC PRACTICES;
11 HEALTH CENTRES;
NUMEROUS LOCATIONS PROVIDING MENTAL HEALTH AND LEARNING DISABILITIES SERVICES.

Health staff, such as GPs, district nurses and therapists, pharmacists, optometrists, dentists and support staff also provide care in people's homes within the community.

A&E

LAST YEAR WE:

HELPED **145,315** PEOPLE THROUGH OUR EMERGENCY DEPARTMENTS.



CARED FOR **61,313** INPATIENTS IN OUR HOSPITALS.

SAW **150,000** PATIENTS ACROSS ALL OF OUR SERVICES EACH AND EVERY WEEK.

Additionally, some specialist care is provided outside of the Hywel Dda area in regional centres by other health boards via the Welsh Health Specialised Services Committee (WHSCC) and other independent providers. This includes hospitals such as Morriston Hospital in Swansea and the University of Wales Hospital in Cardiff.

You can read more about our current services by referring to the What we have at present Technical Document **http://bit.ly/2ILozMP** .

The first phase of our work, including what we heard in the Big Conversation, told us that our key challenges are as follows:

- **Ageing population:** demand on our health and care services is increasing all the time and is expected to rise dramatically as more people will be living longer. Many of them will have long term conditions requiring care and treatment.
- **Geography:** providing services which people can get to and which are fair, regardless of where they live, is difficult in such a wide geographic area.
- **Rurality:** large areas are extremely rural and isolated, which means that providing services to people in their own homes can involve significant travel time.
- **Health expectations:** people want and expect to be supported to manage their health in their own homes.
- **Variation:** there are differences in the services provided and in the way in which they are managed and delivered across our three counties. We also have a 10 year gap in healthy life expectancy.

To read more about the first phase of our work please read the Phase 1: 'Discover' Output Report – The Case for Change **http://bit.ly/2DNUtoj** .

In addition, there are some key factors affecting our performance as a Health Board which, if we got right, could provide better health and care services. We have called these 'enablers' and have worked closely with experts within the organisation to identify what we need to improve:

Transport	• We are a largely rural area which means that patients need to travel sometimes long distances to access care, and staff need to travel to get to their workplace. This also means that community based staff often have long distances to travel between patients. • In lots of areas, we have relatively poor road networks, especially in rural areas, and our public transport can be limited. Both of these make our access problems worse. • We don't always take opportunities to reduce the impact of travelling, often asking you to travel for appointments and follow-ups that could be undertaken closer to home. • Parking at some of our hospital sites, particularly main hospitals, can be challenging. • Managing and co-ordinating services across such a large number of sites often needs lots of travel between these sites. This can be costly and isn't the most productive use of time. • We have worked closely with Welsh Ambulance Service NHS Trust (WAST) on the development of our proposals to ensure that their staff are able to transport them safely to a hospital if required in the event an emergency. • The Emergency Medical Retrieval & Transport Service (EMRTS) is currently only operating 12 hours per day in Wales.
Our workforce	• We have too many staff vacancies and it is difficult to recruit to some roles. We have difficulties staffing some services because there are national and local shortages of medical staff with key specialist skills. • We need to maintain the stability of our current workforce as recruitment and retention challenges mean that there is a lot of change and variability. A large number of staff from key roles are expected to retire in the next five years. • We struggle to provide creative job opportunities for example modern rota and role arrangements. • In certain areas, temporary staffing is used to ensure safe staffing levels, and we know it leads to poorer quality care – we can't continue to use this option. • Some specialist staff do not have the opportunity to see enough patients to maintain and build their expertise in certain areas.

How we use technology	• We don't currently fully use the digital opportunities to best meet the needs of our population, especially for those who have to travel to access services. • There are examples where we are deploying elements of telehealth and telecare, but this is not consistent or widespread. • There are digital solutions to support future ways of working, but we need to reorganise ourselves to better take advantage of them. • Technology itself won't deliver the changes we need to see, but if used correctly can help to make the change happen. • We need to embrace the latest medical technological advances, which require modern facilities, so our population can benefit from them and we attract the best clinical workforce.
Our buildings and facilities	• A lot of our hospital buildings are old and need lots of maintenance to keep them operating effectively and efficiently. Over 51% of the estate is over 32 years old. • Properties range from 19th century to modern day buildings in varying degrees of functionality, condition and performance. • The standard of some of our buildings is not as we would expect to deliver the modern healthcare that we strive for and leads to a poorer experience. • We have delivered targeted investment in improving specific parts of our estate.

Our changing health needs

3,500

3,500 BABIES ARE BORN IN OUR AREA EVERY YEAR.

WE HAVE FEWER PEOPLE AGED **25-44** AND MORE PEOPLE AGED **55-79** THAN OTHER PLACES IN WALES.

WE HAVE POCKETS OF **DEPRIVATION** AND **POVERTY** IN URBAN AND RURAL AREAS.

9,871

WE EMPLOY **9,871** MEMBERS OF STAFF.

The needs of people across mid and west Wales have changed a great deal since 1948 when the NHS was established. Back then life expectancy was lower and the most common conditions people faced were infectious diseases, injuries, heart attacks and strokes. During the first 40-50 years of the NHS, hospitals were caring for younger patients, with single conditions, without chronic disease, without regular medication, with good social support. It was generally less complicated to treat patients and easier to get patients home quickly. At this time society thought that people over the age of 65 were old.

Health needs in the Hywel Dda area are changing in a number of ways:

- **We are a growing population.** The population of the Hywel Dda area is expected to grow from an estimated 384,000 residents in 2016 to approximately 410,000 in 2036. Carmarthenshire's population will grow by 11%, Ceredigion by 5% and Pembrokeshire by 3%.
- **People are living longer** but will experience more years of illness and disability and so will require more support to stay well and independent. Many of the people living in the Hywel Dda area have one or more long term medical conditions (or 'co-morbidities'). The chance of having a long term condition increases with age, as does the chance of having multiple conditions, which need many different medications.
- **Some of our lifestyle choices are expected to get worse.** We think more people will come to us for help if they are overweight or obese. What we eat, drink and if we smoke contributes to the main causes of premature death in the Hywel Dda area. The effects of poor lifestyle choices, including how active we are, take time to emerge so we expect to see increasing demands on our health and care services in the future.
- **We have pockets of poverty and deprivation** which can disadvantage some of our most vulnerable people, including our youngest and oldest people and those who have fewer money or resources. Many health outcomes are worse in our areas of high deprivation and there is a 10 year difference in healthy life expectancy between the most and least well off. 75% more people attend our accident and emergency departments in our most deprived areas compared with our least deprived.

For a fuller description of our changing health needs please read more in the Understanding the needs of our local population Technical Document **http://bit.ly/2ILozMP** .

Developments in diagnosis and treatments are helping us to live longer but also mean the public have expectations that cannot always be managed. Advances in surgery and anaesthetics mean people no longer need to spend weeks in hospital and can return home sooner. However, despite new developments in technology, we have not yet been able to make best use of the advantages that they can bring – for example, holding virtual clinics over Skype to reduce the need to travel for appointments and follow-ups.

The opportunity is to move from an 'illness' service to a 'wellness' service, with a focus on quality of life and not just length of life. This would involve promoting health and well-being in our local communities, and only diagnosis and hospital treatment when necessary.

Tackling prevention will reduce or delay the results of complications of avoidable illness, and importantly avoid altogether the development of disease, disability and early death.

For this to work, we need to share the responsibility for staying well or for managing existing conditions and tackle the health inequalities in our communities. In short, the opportunity is to transform our health and care system into one that is 'safe, sustainable, accessible and kind'.

The following section describes what we heard during the first phase of our work.

Safe services

Safety and quality of care is an absolute priority; the standards we meet should go above and beyond the basic minimum care, striving for clinical excellence.

We put safety and quality at the centre of everything we do, knowing that these aspects of care are key to achieving the best possible experiences and outcomes for our patients. However, we know the safety and quality of our services can vary significantly depending on where and when our patients receive their care and treatment. When we get things wrong, patients have a negative experience with poorer outcomes of care. This is not acceptable.

Addressing this means improving how we use our resources – including our staff, money, buildings and facilities, information and procurement – to make them work in the best way for patients and their families.

We always work hard to ensure the safety of our patients, but the way services are currently organised prevents us from making the scale of improvements that we want to see.

We must use all of our resources to best effect, concentrating on providing, high quality evidence-based healthcare, to ensure our patients get the best possible support and treatment at the right time, in the right place.

This is often a balancing act and we know we will have to make some compromises, but critical to it all is to ensure patient safety is never at risk.

We can improve how successful your care and treatment is if we can identify what is wrong early and in the right place.

Sustainable services

Staffing

Our staff are at the very heart of our organisation. Getting the right mix of skilled staff to provide our services is one of our biggest challenges.

We have between 350 and 500 total staff vacancies every month. A third of our staff are also 51 years old or older, close to retirement age (which can be as early as 55 years old in the NHS). We are also using too many temporary staff to meet unexpected staff shortages and to fill gaps where we cannot recruit permanent staff. This limits our ability to invest in other services, activities and better technology – all of which could significantly improve our services. More importantly, it also means that our care and treatment costs more, and is less joined up, which means we aren't offering reliable outcomes for patients, or good value for the resource investment. This also impacts on the safety and quality of the healthcare services we provide and negatively impacts on our current staff.

Our doctors, nurses and healthcare professionals have traditionally been trained and developed to work in a hospital-based care system. The majority of current and future demands for health and social care will come from an increasingly older population with a number of different health conditions. They will require care and support from staff with a wide range of skills, working with different staff and professionals in a joined up system across different organisations within our communities.

As we seek different ways to provide healthcare to our population, this will offer a range of exciting opportunities for our staff. We will continue to develop a range of new, extended and expanded roles for example for nurses, therapists and paramedics, and other extended roles such as audiology assistant practitioners and physician associates.

In order to respond to changing needs and expectations placed on our doctors over the last 20 years, our doctor on-call rotas have had to change. To improve training opportunities and performance, doctors both in training and at consultant level are expected to be on-call less frequently and work less hours than in the past. Standards and expectations of care have increased, with early access to senior decision-makers required to assess patients in our hospitals throughout the week and weekend. At the same time, other health organisations in Wales and across the UK are able to offer less frequent more attractive on-call rotas. This has all resulted in a challenge for the Health Board in providing enough doctors in all of our hospitals to continue to provide services.

With advances in medicine and treatments, the sort of advice and care that some patients require has needed increased levels of specialism, but at the same time people need to be able to access more generalised care. On top of this the supply of doctors, nurses, and health professionals has not been at the levels we need to fill all of the jobs required. This has resulted in the use of large numbers of temporary and agency staff, which affects the training experience of junior doctors, nursing students and other healthcare professional students. Despite some success in nursing recruitment, we still rely on significant numbers of agency staff and have similar challenges in therapy staff recruitment.

Our health education facilities are outdated, without the latest technology, and our research facilities are not developed enough to meet our ambitions as a University Health Board. Our students and trainees expect excellent training, experience and facilities to attract them to the area, and they are the workforce of the future. Ambitious academic departments and facilities attract the best staff available, and drive clinical excellence.

We also recognise that our formal workforce is supported by around 47,000 carers, who support their loved ones to both overcome short term illnesses and manage longer term conditions. In all of our plans we need to make sure that we take account of the support and training needed by our carers so they maintain their own health and well-being. This will support them to be the best carers possible for their loved ones or friends, and for the longest time possible.

Our current staffing problems have a big impact on the amount of money we spend and prevent us investing in the types of services we want to develop. They also have a direct impact on the safety and quality of the care we provide. Any changes we make must help us to address these challenges.

Affordability

A key challenge for the NHS in Wales is to achieve financial stability. Almost half of the total Welsh Government budget is spent on the NHS and this is set to rise if everything stays the same. This means that difficult decisions have to be taken about how we spend our money.

Hywel Dda has a budget of around £800 million, but last year spent around £50 million more than our budget.

This was the largest overspend in NHS Wales in 2016/17 and it is growing year on year as we try to manage the rising demand for healthcare services and the increasing costs to provide those services.

It is clear that we are not using our money in the best possible way. We are overly reliant on temporary and agency staff and some of our medical rotas are extremely fragile which means that we often have to use expensive agency doctors to maintain safe services.

We also know that we have not been able to use our money wisely to support services in the community and primary care, or to support patients to live well at home, with their family or carers.

In addition, some of our facilities are outdated and expensive to maintain. This makes it difficult to provide care as, without a modern environment to meet the expectations of the public, visitors and staff, improvements are difficult.

We know that our investment in prevention measures in the community is the best value possible for conditions such as cardiovascular disease (strokes and heart attacks), respiratory disease (COPD) and cancers. We are committed to making the best use of the resources we are provided with and will be following the principles of Value-Based Healthcare (VBHc), where the best outcomes that matter for the population are provided for the least resource. At the moment our ability to invest in high value evidence-based treatments has been hampered by the increasing amount we are spending in our hospitals, due to the wide geographical spread of our hospitals and the reliance on expensive temporary and agency staff.

We are working very closely with Welsh Government on plans to stabilise our current financial position; however, this still means that we will spend more money than we have available because of how our services are currently organised. Our focus now is to organise our services so that they are safe and sustainable, and to make the best use of the money available to us. In doing so we aim to deal with our overspend (the money that we spend over our budget), whilst providing better, modern healthcare.

Managing the fact that we are spending more than our budget while embarking on a large and wide-ranging transformation programme is no easy task. Particularly as we need to invest money into the programme to make sure it delivers the outcomes we need. However, this investment will help ensure we can plan and deliver better care which over time will enable us to spend less, but spend in a more targeted way on the services which have greater positive impact.

This has to mean doing things differently from how we currently deliver health and care services. We are completely committed to improving the safety and quality of our services, which will ultimately improve the experience and outcomes of care for everyone in the Hywel Dda area, yet we need to ensure our finances are in order.

Money is not the overriding factor in why we need to change, but it plays a significant part in us being able to provide better healthcare.

So there is an urgent need to change the way we do things.

Accessible services

People often feel they have difficulties getting timely access to a GP and our community services are limited (mainly weekday services). These difficulties can lead to people ending up in hospital due to a lack of appropriate community support rather than a clinical need for hospital care.

Services supporting people and family members in the community at a time of crisis are not consistently available 24/7, or across the whole of the Hywel Dda area and therefore people and professionals often have few options other than to access A&E services. In the future we want a community and primary care service with a range of health and social care staff that is available 24/7 throughout the week to avoid having to go into hospital unless in circumstances when it is appropriate to do so. This would allow more people to either stay in their own home or have care provided as close to home as possible.

Pressures on emergency care mean that too many planned operations and procedures are delayed or cancelled. Our processes and the way our services are set up mean that people can get 'stuck' in the system and often stay in hospital longer than they need to.

Cancelling operations and procedures is upsetting and stressful for everyone. We also know that staying longer than necessary in hospital is a risk to health, especially for older people. A lack of primary and community care services can mean people are admitted to hospital when not medically necessary. This is not what we want for our patients.

Due to our rural locations, patients often need to travel considerable distances to access our services. We recognise the need to closely examine this when considering planning appointments and also in designing our urgent and emergency care services, working closely with both non-emergency and emergency transport providers including WAST.

Kind services

We recognise that whilst our hospitals are very important buildings in our communities, the experience of those using our services is not good enough, with people facing delays or cancellations and sometimes poorer quality of care than we would all expect. This is not the way we would wish to treat people.

We know we need to improve our customer service, with a relentless focus on listening to your experience and improving on it. When people become ill we know it is a particularly stressful time for the individual and that small things become important, and we will aim for our staff and partners to provide the most compassionate care possible. When people come to the end of their lives we, and our partners, will provide the support they and their loved ones require so that as many people as possible can die in the place of their choosing, with dignity. This will mean reducing futile interventions and unnecessary trips to hospital.

We will need to do everything we can to help the public avoid illness and anticipate when health conditions get worse, to reduce the pressure on our health services. To do this we also need to work with our other organisations, such as social care and the voluntary sector, to reduce delays in leaving hospital back to the home or community. This will mean that hospital beds are only used when they are really needed or where people really need the attention of a specialist.

Considering the challenges of our rural area and poor roads and public transport, we recognise the need to be kinder by making sure that the amount you have to travel to access your health services is as short as possible. Travelling for treatments that are cancelled, or for appointments and follow-ups that don't necessarily need to be undertaken in the hospital, can be very frustrating, particularly if you are feeling unwell.

Our staff are at the heart of everything we do and so we need to ensure that we look after and value every contribution from our doctors, nurses and therapists to our support staff who make it all happen.

We recognise that these challenges present us with a huge opportunity to improve – to provide 'safe, sustainable, accessible and kind' services that will meet the changing needs of our local population both now and in the future – Transforming Clinical Services is our vehicle to realise that opportunity.

What will happen if we don't change?

The way we currently do things is not efficient, does not represent good value for money and will not meet the changing health needs of our population. We have to find ways to use our resources differently to make better use of the money available to us and improve services for patients. We need to organise our services to make the most of technology, employ skilled people to work in the right settings and locations, and make the best possible use of every pound we spend.

Doing nothing is not an option because by staying the same our health and care services will not be able to deal with the growing demand and expectations. Staff shortages and pressure on the money available to us are likely to lead to a situation where local people would face:

- longer waiting times at A&E and other urgent and emergency services;
- more operations in hospitals being cancelled;
- insufficient hospital beds;
- missed opportunities to prevent illness or avoid deterioration;
- worsening infrastructure and technological capability;
- greater problems being able to see the most highly qualified doctors and nurses in hospitals;
- unplanned service change or cuts with the stopping of some services and medical procedures.

Most importantly, doing nothing would likely mean:

- lower safety standards;
- worsening impact on health;
- reduced survival rates.

We do not want to see this happen in the Hywel Dda area and we don't want to miss the opportunity to transform services to meet the needs of future generations to come.

This means we have to make important decisions about how to do things differently across our community services and hospitals, so that we can save more lives and improve the care that people receive. The need to change applies just as strongly to community services as it does to hospital services.

You can read more about why we need to change and the findings from the first phase of our work here **http://bit.ly/2DNUtoj** .

3. HOW WE'VE WORKED TOGETHER TO DEVELOP OUR PROPOSALS

How we have involved local people and our staff in developing our vision and proposals

The starting points for our Transforming Clinical Services programme were:

- listening to the views of local people and patients who have used our healthcare services, through our engagement exercise The Big Conversation;
- examining our current services in detail with our doctors, nurses and healthcare professionals to understand:
    - what currently works well;
    - the key challenges we face;
    - what can we learn from successful healthcare systems across the UK and internationally.

These two parts of our programme, known as Phase 1, were run at the same time and the messages we were hearing in The Big Conversation were being continuously considered by the groups of staff working on the programme groups to help their thinking as the work progressed.

The Big Conversation took place from 20 June 2017 to 15 September 2017. It involved sharing information about our services and challenges widely to approximately 4,000 interested people and groups. During this time we discussed our work on the Transforming Clinical Services programme in over 80 different meetings, drop-in sessions, workshops and other events and activities across Carmarthenshire, Ceredigion and Pembrokeshire. This was not a consultation on specific proposals but rather an exercise where we asked broad questions about what matters to people and what good healthcare and support would look like in their view.

The proposals set out in this document have been informed by members of the public in the following ways:

- **409** questionnaire responses (including 19 'easy read' responses);
- **80+** meetings and events;
- **3** Big Conversation engagement events in Carmarthenshire, Ceredigion and Pembrokeshire that were open to patients, the public, carers, staff, community health councils, local authorities and the third sector;
- **3** drop-in events for members of the public – one in each county;
- **14** meetings and drop-in sessions for staff;
- meetings with the Heath Board's Stakeholder Reference Group, a group made up of organisations and interested individuals who work closely with us; the Health Board's senior managers; and the Hywel Dda Community Health Council (CHC);
- meetings with various organisations within and outside of the local NHS, including staff groups, county councils, university partners and the CHC;
- a Facebook question and answer session;
- **8** community meetings organised and run by the Mid Wales Health Collaborative; **21** written responses.

The key things we heard during The Big Conversation: what you told us you want:

There were a number of themes that came through clearly in the engagement responses during The Big Conversation:

Travel and access

- People told us that they were prepared to consider travelling further if it meant they would get quicker access to specialist care and their treatment quicker.
- You also supported the idea of more services being provided locally to avoid having to travel long distances, which you are sometimes required to do at the moment.
- Some people accepted that there is a need for travel given their geographical location. However, others felt travelling long distances for healthcare services was unacceptable, with concern over the inadequate public transport networks in rural areas.
- We heard that you would welcome easier access to primary care through longer GP opening hours and shorter waiting times for appointments.

Quality of care

- This covered a variety of areas, but in particular, good communication and timeliness, especially when waiting for appointments or results.
- Care closer to home and having the same people support you through all of your care was important to many people.
- Fair and equal access to healthcare was also seen as an indicator of quality.

Where to receive healthcare

- We heard a lot of support for care in the community rather than in hospital at nearly every event we held, with a lot of enthusiasm for hubs in the community or 'one stop shops', where different health and care needs can be dealt with under one roof in the local community.

Resources

- Some people felt that money is wasted on management, paperwork and changing services. Some also felt that there are too many managers and not enough staff.
- There was a lot of support for more services in the community and having a more flexible, multi-skilled workforce working in a joined up way with other organisations like social services or voluntary services.
- There was also a willingness to be treated by nurses and non-medical staff (rather than doctors) for some conditions, although some people raised concerns about staff not being sufficiently trained.
- The people we spoke to recognise that the public would need to be educated and informed in order to understand new roles such as physician associates and advanced nurses.
- Some of the general hospital environments (Glangwili Hospital in particular) were considered not fit for purpose now, let alone for the future.
- People also highlighted that unpaid carers are a vital resource and more should be done to support them.

Joined-up services

- A large number of people felt that services would be much more joined up if there was one electronic patient record to allow different healthcare professionals to access notes quickly to understand what had happened with a patient. However, people wanted reassurance that this would be secure with a good back-up system.

You can read more about our pre-consultation public engagement and how it has been used to help shape our proposals in the documents available on our consultation website: **http://bit.ly/2GjOQDG** and **http://bit.ly/2DNUtoj** .

How our doctors, nurses and other healthcare professionals developed the vision that supports our proposals

We have developed our vision for change by working closely with local health professionals and staff, and importantly, the public, our patients, organisations and groups that work with us. This is because we are committed as a Health Board to continuously engaging with our public, staff and organisations that work closely with us, to design our future services together.

From the outset the work on our proposals has been led by doctors, nurses, therapists and other frontline workers and has been informed by what we heard in The Big Conversation.

We have brought together the views of over 600 healthcare staff and professionals, to consider how healthcare should be changed in the Hywel Dda area.

We have also sought the views of a wider range of organisations, groups and individuals including community health councils (CHCs), public services boards (PSBs), county councillors, the Stakeholder Reference Group (SRG), the Mid Wales Healthcare Collaborative, equality groups, People First, deaf clubs, sheltered accommodation, the veterans network, youth forums, gypsy traveller community and 50+ forums to ensure we have had a broad range of views to inform our work.

You said, we did

We listened to what you told us and so our starting point for the proposals was to focus on:

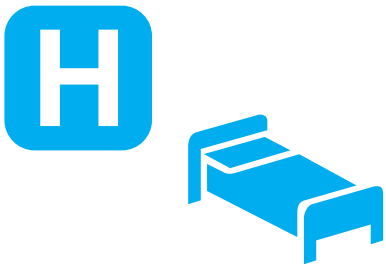
- looking at what the future holds for our local population and examining our current services to understand the impact from the challenges we face;
- engaging with the people who live in the Hywel Dda area, our staff and wider partners to better understand how we can improve health and care and design our future services together;
- learning from the experiences of other health systems to help us to develop possible models of care for the Hywel Dda area.

The first task was to establish a good understanding of the existing situation and how services are currently working. We did this for three areas – community care; planned care and urgent and emergency care, and we have set out below what we found.

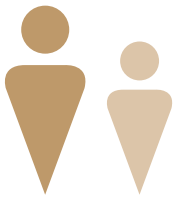
Community care

Community care covers primary care and a range of different community services, including local authority and third sector care provision.

Key facts

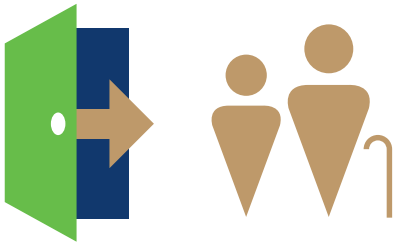


AROUND **40%** OF OUR HOSPITAL BED DAYS ARE OCCUPIED BY PEOPLE WITH CONDITIONS THAT COULD BE MANAGED IN THE COMMUNITY.

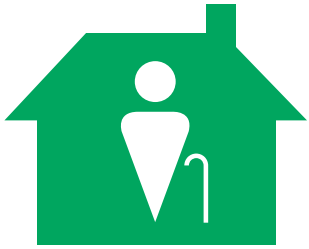


BUT THE NUMBER OF FAMILIES AND FRIENDS ABLE TO PROVIDE CARE WILL NOT INCREASE AS MUCH AS THE NUMBER OF PEOPLE NEEDING CARE.

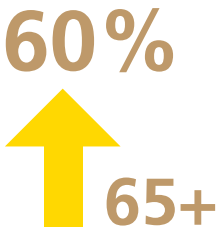
THE POPULATION WITH A LIMITING LONG TERM CONDITION (LTC) WILL INCREASE BY **10%** EVERY 5 YEARS.



PEOPLE OVER 65 RECEIVING LOCAL AUTHORITY COMMUNITY SERVICES WILL RISE BY **70%** IN 2035.



THE NUMBER OF ELDERLY PEOPLE LIVING ALONE WILL INCREASE BY **33%** OVER THE NEXT 20 YEARS.

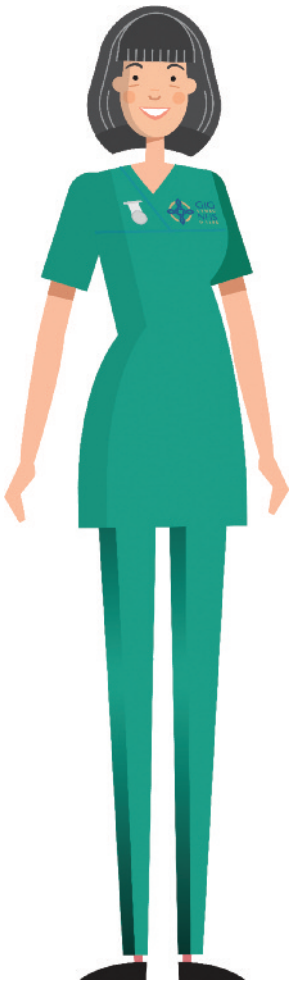


THE NUMBER OF PEOPLE OVER 65 WILL RISE BY **60%** BETWEEN 2015 AND 2035.

Our community care group told us that there are major **challenges** around:

- **Prevention:** the Health Board does not have a well-developed model for preventing ill health and long term conditions. Although there is a lot of good practice, we are not making the best use of community resources and social prescribing.
- **Complexity:** community services have often developed in response to a specific local issue or as more funding has become available. This has led to services being provided differently in different areas and, as a result, services are often very complex and difficult to navigate for patients, carers and staff. People often don't know how or where to access the advice and care they need. This can lead to people attending A&E or their GP when these are not always the best services to meet their needs.
- **Variation:** although many of the services provided across the Hywel Dda area are the same, not all services are provided in the same way or in every area. Sometimes this is responding to a specific local need but we need to make sure that people can expect the same level and quality of care wherever they access care and support.

- **Sustainability:** many of our primary care services are under great pressure and at risk of not being able to be provided in the future. Finding the right staff to employ is very challenging and we have large numbers of GPs approaching retirement. We also struggle to always staff our GP out of hours service as it is currently run.
- **Our staff:** it is really difficult to find some of the staff we need for some roles within the community. We know that we need to look at new roles that use staff and skills differently, but before our Transforming Clinical Services work we didn't have an agreed approach to do this across the whole of our organisation.
- **Managing illness:** our current system is based on a medical model where services are provided for particular illnesses, rather than for the person as a whole. Most specialist services and staff are hospital-based, rather than in the community alongside the people living with long term conditions. We need to move to a more social model of health, to move our focus from being largely on treatment rather than prevention and we are not very good at understanding that what matters to our patients is just as important as what is the matter with them.
- **Weekday services:** many of our community services only operate during weekdays and those that do run over weekends often provide a reduced service at those times. There are very few services available in our communities at night and we know this can lead to hospital attendances or admissions because there is not an alternative option – whether that person should be in hospital or not.



With more people living with numerous long term illnesses and conditions, combined with fewer people able to provide unpaid carer support, there will be increasing pressure on already stretched community health and care services. We cannot continue as we are.

Around 11,000 hospital admissions and 125,000 hospital stay days (approximately 40% of all hospital stay days in the Hywel Dda area) are due to emergency admissions for conditions that should not usually require a stay in hospital. We know that spending time in a hospital bed when it is not necessary is damaging to health and well-being, especially for older and frail people.

Good care and support available in our communities can help prevent the need for a hospital stay. Where an individual has been admitted to hospital, successful management of long term conditions like asthma, diabetes, epilepsy and dementia in a community setting can have a positive impact of how long the person stays in hospital and how quickly they return to their usual activities.

Planned care

Planned care covers routine services with planned appointments or treatments in hospitals, community settings and GP practices. The patient journey usually begins with your GP, often with a diagnostic test, before being seen in the hospital setting following a referral for an opinion, further tests or treatment.

Planned care involves any treatment that doesn't happen as an emergency and usually involves a pre-arranged appointment. Planned care is more commonly described within a hospital setting as 'scheduled' or 'elective' care.

Key facts

IN 2016/17:

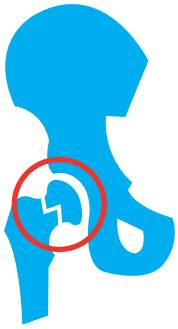
300,000

PEOPLE ATTENDED AN OUTPATIENT APPOINTMENT WITH A DOCTOR AT ONE OF OUR HOSPITALS.

18% OF PATIENTS HAD TO WAIT FOR TREATMENT FOR OVER 26 WEEKS AFTER THEIR GP REFERRED THEM.

THE HIGHEST NUMBER OF APPOINTMENTS WERE IN:

TRAUMA AND ORTHOPAEDICS **(54,886)**
OPHTHALMOLOGY **(48,145)**
GENERAL MEDICINE **(30,507)**
GENERAL SURGERY **(27,933)**



DAY CASE SURGERY RATES WERE **54%** AGAINST A TARGET OF **85%.**

9% OF ALL PLANNED OPERATIONS AND PROCEDURES WERE CANCELLED.

Our planned care group told us that there are major **challenges** around:

- **Increasing demand:** we struggle to make planned services work effectively day-in and day-out to meet our growing demand. This is not unique to the Health Board but is a shared challenge across the NHS.
- **Cancellations and missed appointments:** outpatient services are very stretched and too many operations and treatments are cancelled, often due to emergencies happening elsewhere. A lot of people either cannot, or do not, attend their appointments, and missed appointments lead to delays in when people are seen.
- **Length of hospital stay:** people who have had an operation or procedure and need a stay in hospital, either overnight or for a short period, often stay in hospital longer than expected when it is not safe to return home to recover as care arrangements are not in place. This is often because the community care and support is not in place. Many of these patients are admitted in an emergency and we have to use the beds we put aside for planned operations and procedures because of the pressure on the whole system. This means that people wait longer for their operations as beds are not available in our hospitals.

Urgent and emergency care

Urgent care is the treatment of an illness or injury that does not appear to be life threatening, but can't wait until the next day. Emergency care means providing timely treatment of life threatening / changing conditions or injuries.

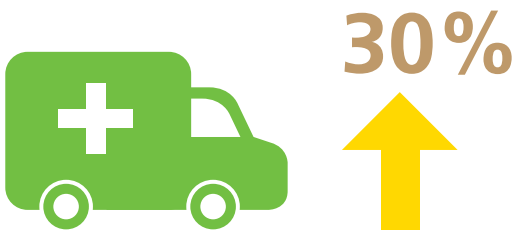
Urgent and emergency care includes not only hospital care, but also primary and community care, ambulance calls, and the more traditionally recognised hospital accident and emergency (A&E) departments, walk-in centres, minor injuries units and urgent care centres.

Key facts

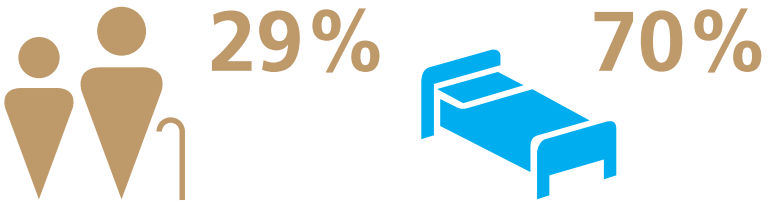
We looked closely at the services we provided in 2016 and 2017 and found that:

18% OF PEOPLE ATTENDING A&E HAD TO WAIT LONGER THAN FOUR HOURS TO BE SEEN.

IT IS ESTIMATED THAT **11,000** PEOPLE ADMITTED THROUGH A&E COULD HAVE BEEN SEEN IN A COMMUNITY SETTING, FREEING UP **40%** OF ALL AVAILABLE BED DAYS.



THE AMBULANCE SERVICE ATTENDS AROUND **49,000** INCIDENTS PER YEAR IN HYWEL DDA AND DEMAND IS ESTIMATED TO INCREASE BY **30%** IN THE NEXT 5 YEARS.



29% OF ATTENDEES AT A&E ARE OVER 65, HOWEVER THEY OCCUPY **70%** OF HOSPITAL BED DAYS.

Our urgent and emergency care group told us that there are major **challenges** around:

- **Workforce:** all A&E departments rely on a range of hospital speciality services (e.g. medicine, surgery, trauma, critical care) which have similar staffing challenges, including high use of temporary staff. We know there is a shortage of A&E doctors to meet the demand, with only five of 19 posts across our hospitals filled with permanent staff. There has been a widely reported shortage of nursing staff, which is causing pressures on our A&E departments.
- **Emergency transport:** currently our population benefits from a national Emergency Medical Retrieval and Transfer Service (EMRTS) which includes the national emergency retrieval services for babies and children, and provides transport and services for trauma and emergency medical problems. However, this service is only available currently for 12 hours a day. This does not meet the needs of our patients throughout the 24 hour period, particularly in rural and remote communities.

Too many people are seen in A&E and admitted to hospital when there are potentially other ways of looking after people in our communities that would be more appropriate and prevent a stay in hospital. Our A&Es are struggling to deal with the large numbers of people using them.

The work that we have done to look at how urgent and emergency care can be provided differently fitted with what you told us about the difficulties with our current services and how you would like them to be in the future. Many of the suggestions and ideas we heard from you about how things could and should change were in line with what we learned from successful health and care systems across the world.

You can read more about the findings from the work we've done so far by reading our Phase 1: 'Discover' Output Report The Case for Change **http://bit.ly/2DNUtoj** .

4. CO-DESIGN AND DEVELOPMENT OF OPTIONS

We have taken an open and engaging approach to the development of our proposals, inviting a wide range of people – staff, partners and groups that work alongside us – to challenge our thinking and be involved in designing our proposals. This is fairly unusual but we've taken this approach to develop this consultation together at every stage possible because we believe that this is how we will design services for the future that will be better for everyone.

We understand this will cause a lot of discussion and speculation in the community as people want to know right now, in detail, what this might mean for their community-based healthcare or their local hospital. We have been through a thorough process to narrow down and develop the options so that we can confidently say to the public 'these are the proposals we believe to be viable, safe and offer an improvement to what we already have'.

The proposals we have come up with will:

- focus on what more can be done to keep people well and improve the health of our population;
- make a commitment to better resource our primary and community care services, where most patient contact is made;
- make the best use of all the available resources in our communities by working together across organisations and putting more healthcare in the community – from telemedicine and virtual wards to supporting voluntary sector provision;
- change or even replace some of our hospitals and their services;
- access services in a timely manner.

How we developed the options

We took everything we learned from our listening and engagement exercises and we worked with a group of people, including doctors, nurses, therapists and staff, and a wide range of local interested people and groups including local councils, the CHC, WAST, and the voluntary sector to develop a range of options to redesign our services.

This process was led by our doctors, nurses and other healthcare professionals. What we mean by this is that a group of health professionals were brought together to discuss and propose a wide number of options. In total, 25 options have been developed and considered during this process. This large number of options was tested across several workshops and group sessions in December 2017 and January 2018 with staff and interested people and groups outside of the NHS, involving over 150 people. During the sessions people were asked to look at the strengths, weaknesses, opportunities and threats for each of the 25 options. This allowed us to start ruling out many of the options from what we heard.

How we narrowed down the options

We took on board all of the feedback and points of view that we heard and, as a result, we were able to narrow down our options from 25 to nine options to be discussed in greater detail with our staff and a range of groups and individuals outside of the NHS. In all, we held 21 sessions to test all of the options, speaking to more than 430 staff and other groups, organisations and individuals.

After we had held all of the sessions we again reviewed the options based on what we had heard and were able to further reduce the list of options to six.

If you would like to see more information on all of the options that were discounted and why they were discounted you can find it here **http://bit.ly/2ulwUDV** .

How we scored the options

In order to consider the remaining options in more detail, a set of eight criteria were developed by a group of staff and members of local groups and organisations who were completely independent of those tasked with developing and narrowing down the options.

The starting point for developing the criteria was what we heard during the first phase of our work, and in particular findings from The Big Conversation. For example, we heard a lot of support for more joined-up care in the community so we knew that integration, and accessibility of services, would be important criteria for you. You also told us that fair and equal access to healthcare is an important indicator of quality, so we have included quality and safety as one of our criteria. Please refer back to page 24 for more about what you told us in The Big Conversation.

The criteria in ranked order are:

Proposals have to:	
Quality and safety	Be **safe** and **effective,** and you have to have a **positive patient experience.**
Relevance to need	Be in line with the **health and well-being needs** of the population.
Integration	Support **bringing together** wider services, not just health, to provide a more joined up experience. This covers social care, housing, education, leisure and the voluntary sector.
Deliverability	Be **deliverable, realistic and achievable** in the long term.
Sustainability	Be **future proof** and meet the **next generation's** health needs as well as ours.
Accessibility	Be **reachable** and **open.**
Equity	Be **equitable, fair** and **not discriminate.** This includes access to services and access to information.
Acceptability	Be **acceptable** to the population and partners. This includes the public, staff and wider partners.

The criteria were ranked in order of importance based on what we heard as part of our ongoing engagement and following consideration at a number of workshops. Having a range of people involved with this meant that we were able to consider a variety of views around what is important.

We then asked a wide group of staff and interested people and groups to apply a score of one to ten for each of the criteria, against all six remaining options. A total of 126 people took part in the scoring exercise including doctors, nurses, midwives, therapists, county council colleagues and voluntary sector representatives.

Once the total scores had been added up we applied a weighting and then we were able to order the options from highest to lowest based on the total scores given. We used a scoring tool to do this. Finally, the order of the scoring of the remaining options from highest to lowest was identified.

The final part of the process was to look at the potential affordability of the options in order to inform the final decision on which proposals to take forward to this consultation. To read more about affordability please refer to page 72.

How we made our decision on the final proposals

The criteria setting, scoring and weighting were used as decision-making tools to help to refine the options, in conjunction with feedback from The Big Conversation, discussions around option development, what we heard during the challenge sessions and finally the financial information about affordability. Whilst doctors, nurses, other healthcare professionals, the voluntary sector, county councils, WAST and a range of other partners provided input into the development of the options, the Health Board's team of senior leaders was the group responsible for making the decision about which options were to become proposals.

To read the full details, including how we developed the options, the full long list of options and how we decided on options to discount, please refer to How we developed our options and decided on our shortlist, and How we developed the criteria to score our options: **http://bit.ly/2ulwUDV** and **http://bit.ly/2DOWmRm** . You will also see some useful background information in the Phase 1: 'Discover' Output Report The Case for Change **http://bit.ly/2DNUtoj** .

5. PROPOSALS FOR CHANGE: WE NEED YOUR VIEWS

Building on everything we have learned so far, from the first phase of our work and The Big Conversation, we only have one proposal for delivering our community services in the future (as opposed to three for hospitals). We believe that this improved and extended community service is essential to delivering our proposed changes to hospital services. But we will want to hear your feedback on things like locations, services and facilities, and the range of professionals and organisations that should be involved in providing health and care (see page 44 for more information). Once we have considered your views on these details we can get started on developing our community services, but we will continue to involve you in the design over the coming years.

We are asking you to think about three different proposals for our hospitals. They will be similar in some ways, but different in others. At this stage they are ideas that we are presenting to get your views. They are not fully detailed as this is the opportunity to shape them or provide us with new ideas. No decisions will be taken until public consultation is complete and the responses are taken into account. For this reason, please remember that information in the proposals could change based on the ongoing feedback we receive from you. When a proposed model for the future is identified, there will be more work needed to agree the detailed service design.

In all our proposals, we:

- want to focus on the health and well-being of our population in everything we do in the future;
- are aiming to not just meet health needs, but also other care and support services to help people take control of their own health;
- want to increase the number of people supported in their own homes and communities instead of our general hospitals. This will require advice, support and treatment in the community. It will mean you only stay in general hospitals when it is absolutely necessary;
- want to meet people's needs in the best way so you get care and treatment from the right person at the right time, in the right place. This means all the different organisations providing health and care, including voluntary support services, GPs, nurses, therapists, social workers and community mental health staff, working as one team around the patient.

If you need to stay in hospital, we want to make sure you can return home as soon as you have recovered, by providing more support for you at home and in your communities seven days of the week.

Our approach to community services

Our proposed community model – how we think we can provide better community care – is already decided for all the proposals we describe in this consultation document.

We are lucky in mid and west Wales to have some really strong communities where people support each other, with many playing a part in community life day-to-day.

However, our communities, like our health services, are changing and meeting new challenges and demands. Those who have lived long enough in our rural communities will remember that many villages had a cinema, a school, a pub, all kinds of shops, a railway stop as well as the hall and the chapel. Many of these buildings have diminished and there has also been a general drift of younger people to more urban centres. Our population is also ageing, with many older people living with one or more chronic conditions, which has resulted in more family members being involved in unpaid caring. We have 47,000 carers in the Hywel Dda area out of a population of 384,000. We want our

communities to be strong and if change is to happen, we must offer something which is better.

Our ambition is to build community resilience. By this we mean using the strengths and assets of a community to protect the health and well-being of those who live within it, especially in times of trouble. If people and communities have more ability to care for themselves, we could prevent ill health, improve well-being, promote independence and maintain a sense of purpose. What helps keep you healthy is much more than access to services and treatments; it can include housing, education and employment, as well as social connections. This is called a 'social model for health', which recognises that people want more than to live longer, they also want to live better and with a priority on staying fit, healthy and independent. It is also really important for us to be proactive, and provide help as soon as we can when people need it and not at the point of crisis.

We have seen in other areas across the world that early warning signs of ill health can be picked up by members of a community not traditionally involved in healthcare. For example, the 'call and check' service in Jersey (UK) sees postal workers on their usual rounds check on the well-being of vulnerable members of the community and then connect them with supportive community services. In north America, having your blood pressure checked in the barbers has been shown to reduce high blood pressure in African-American men. There are many people in our communities (from teachers to ministers) who would be well placed to help people think about their health and well-being.

There is a great deal of work that has already been put in place in our communities to strengthen care and resilience within them, but sometimes these are available in some areas and not in others, or they are projects we have started with partners that need to be further developed. For example, some GP practices use 'social prescribing' which means they refer you to services which are non-medical and often provided by the voluntary or community sector, such as an exercise class.

There is already work by the University of Wales, Trinity St David's Centre for Health and Ageing in Carmarthen to help improve the health of our older population where people can sign themselves up to an exercise programme. This could see local halls and community centres being used as a drop-in for individuals who would otherwise shy away from exercise. We want to do more of this across our whole area.

Loneliness is one of our biggest public health concerns and we are working with Swansea University to look at what more could be done to tackle it. Lots of organisations need to work together to help people who are lonely and isolated.

We are also working with Aberystwyth University's Centre for Rural Health and bringing together different kinds of knowledge and expertise across different disciplines to design together potential solutions to our rural health challenges.

Often very simple interventions could be put in place to avoid deterioration or to support people or their carers to cope with their situation at home. For our carers it will be important that we provide specific support and education for them to help maintain their own health and well-being, so that they can provide the best and longest support possible for their family and friends.

When people reach the end of their lives, we will provide the support for them and their families so that as many people as possible die in the place of their choosing, with dignity. We need to keep travel for appointments, or admissions to hospital to a minimum, and avoid futile treatments, much of this can be achieved by careful advanced care planning. We know that we need to work with our partners to achieve this and that our voluntary sector partners have a strong role to play.

Community Model

To build strong communities,
keeping people supported closer to home
and only admitting to hospital when necessary.

We know that improving the health and well-being of the population and reducing demand on the health service are not the responsibilities of one organisation alone. Consistent with the principles outlined in 'The Parliamentary Review of Health and Social Care in Wales', we will continue to work alongside our public and voluntary sector partners to provide well-run, co-ordinated services that are fit for the future and are designed around the needs of local communities.

You have already told us that you want to receive your care closer to home whenever possible. Most of your care is already provided in the community, but we would like to do more of what works to improve your health and well-being outcomes, give you choice when we can and make your experience of care better.

We are already working closely with our partners to support the integration of health and social care to provide services that are built around the person. We are working on ways to join our funding together with social care to make the best use of it, for example, to jointly pay for care home arrangements. We are also working jointly on learning disability services to develop a range of supported living projects and alternative housing options that will appropriately meet the needs of people with a learning disability and reduce the number of people needing residential care.

Care will be 'seamless' in our community model, meaning there will be no artificial separation between primary care (e.g. general practice) and secondary care (our hospitals). This will help us to better plan for the needs of our vulnerable people, especially our dementia, chronic conditions and end of life care patients, so that we can be more proactive with their care. In many cases this will help us to intervene earlier and prevent people from entering a crisis, including the need for a hospital stay. Our community model will also support people with learning disabilities, providing care and support centred around the person where the focus is on making small changes to help people access routine services, with more specialist support provided only when it's needed.

We plan to understand in detail the needs of our population using the GP list and identify those at risk of getting ill or more unwell, so that we can intervene earlier. It would change us from a service that treats people who are sick, to one which supports people to keep healthy and well. This is similar to what is planned across Wales. It involves giving more money and staff to community-based services, aimed at preventing ill health and providing more health and social support in the community and primary care services, like your local GP practice, pharmacies, dentists and opticians.

For care that is unplanned, our community model proposes to keep patients at home and only admit them to hospital when absolutely necessary. This approach will be supported by community care that is available all day and all night, seven days of the week so people do not feel they have to go to our accident and emergency departments in times of need.

Our community model is based on a network of community staff from health, social care, the voluntary sector and other agencies, who will be working in the local community providing care as close to home as possible.

Community hubs

A key part of our community model involves the development of what we are calling 'community hubs' to join up and improve health and care services in our communities.

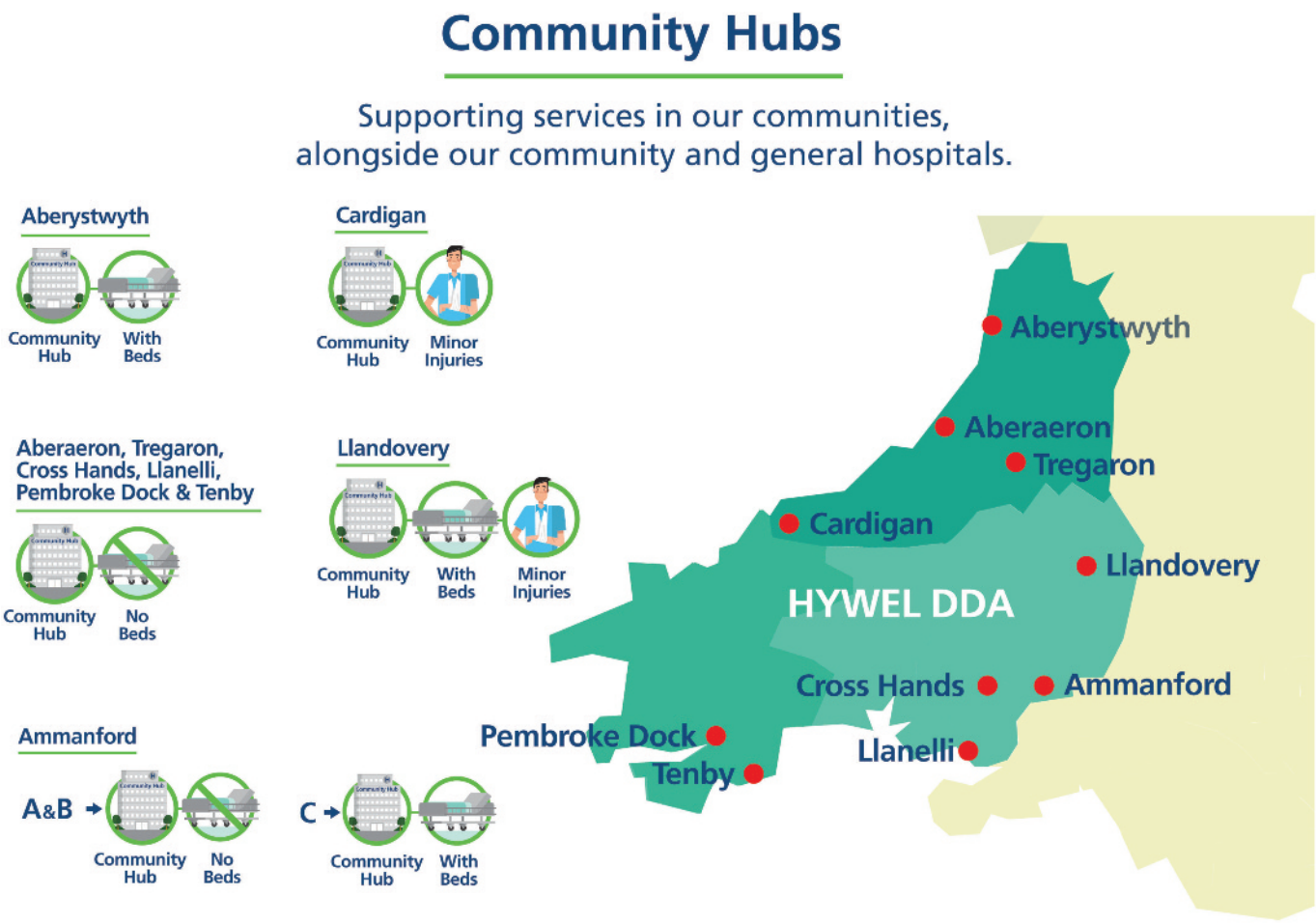
What is a community hub?

Community hubs are buildings located close to you providing a range of health and care services – particularly for older, frail and vulnerable people. They will enable you to receive advice and support across the range of issues that matter to you and your family, and also to attend some outpatient appointments outside of hospitals and closer to home.

What care and support could I expect to receive at a community hub?

This will differ in each individual hub, but could include:

- care and support from a range of health and care professionals;
- local access to tests and scans, including x-rays;
- outpatients appointments and clinics;
- care before and after your operations;
- treatment for a minor injury or illness;
- planned and preventative care for people living with long term conditions;
- rehabilitation after a stay in hospital (step-down);
- an overnight stay in a bed if you can't be cared for at home but don't need to go into hospital (step-up);
- an assisted living bed where you can be supported to live in the community;
- advice and support around your mental health;
- access to advice and support on a range of health needs, including information on how to avoid getting ill in the first place, as well as how to get better if you to become ill.



For more detail on what services are in the hubs, see page 49. Please note Tenby would have a seasonal Minor Injuries Unit.

Community hospitals

Our proposed community network also includes community hospitals. The community hospitals in our proposals will be developed by using some of our current hospitals differently. The hospitals that could change to become community hospitals in the proposals are Glangwili General Hospital, Prince Philip Hospital and Withybush General Hospital.

The community hospitals will provide all of the care and support available in a community hub (see above). They will also have 'step-up' and 'step-down' beds (intermediate care) to provide an alternative to a hospital stay for people who need more care and treatment than can be provided to them at home, or to enable them to be discharged from hospital following an acute illness or operation if they need a period of rehabilitation. The community hospitals will also have midwife-led units, where they currently exist (Glangwili and Withybush hospitals), and a minor injuries unit.

Community hospitals will have facilities for undertaking tests such as CT scans and endoscopy. They may also provide day services such as renal dialysis and chemotherapy.

The key difference between a community hospital and a hub is that the community hospitals will be located on our current main hospital sites and will provide a wide range of services, whereas the community hubs will be provided from existing community hospital sites and planned community developments, providing a smaller range of services which will vary across hubs.

The community hubs and hospitals will be supported by wider community connections or networks of care. This will not only include GPs, pharmacies and other healthcare staff, but also wider community facilities such as schools, community halls and centres, shops, chapels and sports

centres. They will provide care and support that runs smoothly from the patient's point of view, without barriers between different professionals, teams or organisations.

Hubs will help prevent illness and provide early help and treatment. The aim is to maintain health, well-being and independence and avoid the need for specialist support or a hospital visit. They will also provide easy access to high quality, community-based care for the rising numbers of people with complex care in our population.

In each proposal we suggest changing some of our existing facilities (such as our existing community hospitals) into community hubs. Where there isn't an existing building suitable for this, we would look to develop or build a new hub.

To provide more care closer to home, we will have fewer beds in hospitals and more beds within the community. So some hubs would need to have beds to account for this shift. 'Step-down' beds are provided when you need rehabilitation after an operation in hospital. 'Step-up' beds help provide care for people who need more than they can receive at home, but do not need a hospital stay. These beds may not need a doctor's direct support but could be led by nurses or therapists.

We also know that community hubs will need to be different in each community depending on community needs, existing community facilities and care, and how close they are to other services. For example, some hubs may provide a minor injuries service and others might not, with different hours that they are available including some seasonal differences. We will be listening to you through the consultation and further design and development to meet the specific needs of each local population will be needed.

Please read Mari's story to understand how things could be different in our new community services.

Mari's story

Mari Jones has lived in Newcastle Emlyn all her life. She lives with her husband Alun in an old two storey house.

Mari is a retired teacher and is President of the local Merched y Wawr. She loves cooking, especially baking cakes. She is an avid reader and has usually got a Danielle Steel novel on the go.

She has recently developed mild dementia and has become increasingly frail. She can still get around the house but needs a stick when she goes outdoors.

Now	How we believe things could look
Mari has recently been diagnosed with mild dementia and has become increasingly frail. Her forgetfulness presents itself in her wandering and ending up getting lost, fortunately staying local. It is causing great concern for her husband Alun and their daughter Sioned who have had to call the emergency services on more than one occasion, causing much anxiety to all the family, Mari included. Mari also gets flustered when she goes to her local shop and cannot remember why she is there.	Newcastle Emlyn is a dementia friendly community and most of the shopkeepers and community leaders share a responsibility to ensure people like Mari feel an active and valued member of the community. Thanks to this, Mari now helps teaching reading in her local primary school. Her local supermarket has dementia friendly staff who understand that Mari on times forgets to pay or may need extra time with her change. Mari regularly joins the chapel walk. Alun and Mari get support from the local 'Memory Café' where they meet with other carers and people with memory or mental health issues.
Mari's increasing frailty is a concern for Sioned who visits her mother several times a week and has noticed more bruises and cuts from her accidental 'trips'. Mari brushes them off but Sioned is constantly concerned that Mari will do herself more damage. They have had hand rails and aids put in place at their old house which has helped a little.	Mari visits her hairdresser once a week for her set and blow dry. As part of Mari's 'stay well' plan which she developed with her family and community care co-ordinator, her hairdresser takes her blood pressure once a month and lets the care co-ordinator know the result. The hairdresser recently contacted Mari's community hub as she noticed Mari takes much longer to get up from her chair. The care co-ordinator arranged for her to be assessed and for a care and treatment plan to be put in place to reduce the risk of falls. This includes attendance at a 'strength and balance' class run in the local community hall by exercise professionals employed by the council and who are overseen by physiotherapists.
Mari falls out of bed during the middle of night and is unable to get back on her feet. Alun is anxious that she has hurt herself and calls for an ambulance. This results in a hospital admission where Mari lies on a trolley in the A&E department for several hours. By the time she is transferred to the ward her confusion has worsened. She stays in hospital for several days whilst she awaits an assessment for potential care package. Meanwhile she gets increasingly physically frail.	Alun calls the single point of access call centre which is open 24/7 and a paramedic and occupational therapist attend to Mari in the first instance. She is helped to get mobile again and a follow-up visit for further assessments and investigations is arranged for the next day. They will consider if Mari would benefit from home adaptation or technology enabled care such as falls sensors to alert if Mari falls again. This all helps give Alun more peace of mind if he needs to leave Mari alone.

Now	How we believe things could look
Mari gets increasingly confused and frail resulting in frequent falls. She is off her food and doesn't seem at all well. Alun calls her GP who is unable to visit until later that afternoon and advises Alun to call for an ambulance if there is any deterioration. An ambulance is called as Mari is unable to tolerate fluids. Mari is admitted into a hospital bed after a long stay in the A&E department and develops hospital acquired pneumonia, complicating her admission and resulting in a long stay with questions being raised about whether she will be able to return home.	Alun calls the GP who instructs a paramedic working in the community hub to visit. She checks Mari's vital signs and diagnoses a water infection. The paramedic takes advice from the GP and, in discussion with Mari and her husband, they agree to place her temporarily in a bed at the local care home so she can have a short course of intravenous antibiotics (through a needle) and a drip. An occupational therapist and physiotherapist visit to ensure Mari keeps as active as possible to make sure she doesn't lose any more strength while she is so unwell. After her discharge, the occupational therapist arranges for Mari to receive some home care on a temporary basis to help regain her independence as quickly as possible.

You can read further details about how our community model will work in our Community and hospital models for change Technical Document **http://bit.ly/2udWwCn** .

Now that you've heard how things could be different for Mari we need you to give us your views on our formal proposal for change.

Our proposals and what we are asking you to comment on

What are we asking you to comment on?

Community:

We think our proposal to do more in our communities is the right thing to do, delivering services that are safe, sustainable, accessible and kind. This is in line with what you have told us so far. We have been developing our community services over a number of years, so we are clear on how we want these to be delivered. We are therefore not formally consulting on our community model but really value your views and comments on our approach. Please consider things like:

- the location of community hubs;
- the types of services to be delivered at community hubs;
- the range of professionals and organisations that should be involved in providing health and care.

Hospitals:

We are asking for your views on our proposals for our hospitals because we want to understand the possible effect of any changes on you and your family. It is important for you to tell us if we've missed anything or if there is something that you feel strongly needs our consideration.

Mental health services:

Although mental health services have recently been considered as part of another public consultation, we want to ensure it works alongside changes proposed here and that none of our proposals undo the good work we have already done to transform mental health services. Our mental health changes will therefore be closely aligned with any changes we make, for example we will bring together mental health and physical health services where appropriate, so that all the needs of the local population are as joined up as they can be.

You can read more about our proposed mental health changes here:
www.hywelddahb.wales.nhs.uk/mentalhealth .

Our proposals for our hospitals

We have developed a number of different proposals for our hospital services. These proposals impact on our community services in different ways and therefore we have provided some more information below to help you understand what services are provided where.

We have included here a summary of how each of our proposals would work and what services would be in different facilities (full descriptions can be found from page 50). The table below shows you the main changes for our hospitals:

	Proposal A	Proposal B	Proposal C
How many hospitals?	2	3	4
How many community hospitals?	3	2	1
How many community hubs?	10	10	10
Where will the hospitals be?	Bronglais District General Hospital in Aberystwyth	Bronglais District General Hospital in Aberystwyth	Bronglais District General Hospital in Aberystwyth
	New Major Urgent and Planned Care Hospital, between Narberth and St Clears	New Major Urgent and Planned Care Hospital, between Narberth and St Clears	New Major Urgent Care Hospital, between Narberth and St Clears
			Glangwili Planned Care Hospital, in Carmarthen
		Prince Philip Local General Hospital, in Llanelli	Prince Philip Local General Hospital, in Llanelli

In all proposals, Bronglais District General Hospital will continue to provide services for mid Wales.

All proposals see a new hospital somewhere between Narberth and St Clears.

- In proposals A and B, this would be a new major urgent and planned care hospital.
- In proposal C, urgent care would be on the new site with planned care being at Glangwili.

In all proposals:

- Withybush Hospital would have a new role as a community hospital.

In proposal A:

- Prince Philip and Glangwili hospitals would also become community hospitals.

In proposal B:

- Glangwili Hospital would be a community hospital.

And in proposals B and C, Prince Philip Hospital would remain a general hospital.

What is a general hospital?

General hospitals deliver acute care, ambulatory 'walk-in' care, day case and short stay care, as well as overnight care and treatment for patients with chronic conditions, or those who need rehabilitation and end of life care.

In all three of our proposals, Bronglais District General Hospital continues to have an important role in providing services within the hospital setting and also as an outreach into Ceredigion, south Gwynedd and Powys. Our ambition for Bronglais District General Hospital is to strengthen current services and, where clinically appropriate, expand or develop services to provide a greater range for the people of mid Wales. Bronglais District General Hospital will provide 24/7 accident and emergency (A&E) services, supported by intensive care, general surgery, general medicine, trauma and orthopaedics, obstetrics and gynaecology, paediatric, anaesthetic and diagnostic services. Our plans for the A&E department include patients being directed to the most appropriate clinician and the development of a medical assessment unit for patients requiring a number of tests or a period of observation in order for the staff to decide the best course of action. Patients would stay here for up to 12 hours and then either be discharged, admitted to the hospital or transferred to another hospital or community facility. The GP out of hours service will also be based in the A&E department. We know that patients with some conditions will need to be transferred to another hospital for more specialist care, and in these exceptional instances Bronglais District General Hospital will be able to stabilise the patient's condition prior to transfer.

Our relationship with Aberystwyth University and other university partners is key to developing unique opportunities to 'grow our own' rural workforce for Bronglais District General Hospital and its communities.

Bronglais District General Hospital will have close links with GPs and community teams which will help us to improve the way we care for patients and families. This will be achieved by providing opportunities for staff to rotate between roles and gain experience in other settings. We will provide outreach services from the hospital, either in person or using telehealth facilities to give specialist support to GPs and community teams. Some of our GPs have areas of special interest and expertise and we will seek ways to make the best use of these skills both in the hospital and in the community.

In our proposals where Prince Philip Hospital remains a main hospital, it will continue to provide a GP and nurse-led minor injuries and illness unit, supported by a 24 hour a day, seven days a week medical services. This is the new model that we have designed with you and has been working well during the past two years for the population of Llanelli and surrounding areas. It provides quick access to senior medical opinion when required and care led by the patient's needs, with many able to go home on the same day. GP out of hours services will be provided at the hospital and end of life care with beds will continue to be available at Ty Bryngwyn Hospital. The focus is on enabling and rehabilitating patients to get them back to good health and be as independent as possible. Doctors, nurses and other healthcare professionals work with other colleagues across the Health Board and beyond to ensure support from each other and the ability to develop keep their expertise.

The hospital also provides a range of tests and screening for patients and day case surgery. Outpatients will continue to be provided for the local community at the hospital, with a move to one stop clinics (already in place for lung cancer and breast cancer) and reducing the need for follow-up appointments.

Prince Philip Hospital is a thriving training hospital for clinical students and also for trainee doctors, nurses and therapists; it has excellent feedback and will continue to provide and build on this in the future. Enhanced roles for nurses, therapists, paramedics and also new roles such as physician

associates, will become increasingly important in supporting services. The hospital benefits from a close relationship with academic institutions and has an ambition to develop a centre of excellence for both education and research.

Prince Philip Hospital is already developing productive links with GPs and community teams which will help us to improve the way we care for patients and families. This will be achieved by providing opportunities for staff to rotate and get experience in other settings. We will provide outreach services from the hospital either in person or using telehealth facilities to give specialist support to GPs and community teams. Some of our GPs have areas of special interest and expertise and we will seek ways to make the best use of these skills both in the hospital and in the community.

What is a planned care hospital?

Planned care hospitals can provide quick and more reliable treatment for planned care without the disruption and delay that can be caused by emergency cases taking priority. In our proposals a planned care hospital will provide a full range of tests, such as x-rays and CT head scans, as well as planned (elective) surgery, day cases and when you need to stay overnight. There will be a high dependency unit on site, which provides more intensive observations, treatment and nursing than a general ward can provide. This unit would also be able to provide intensive care whilst patients await a transfer to a dedicated intensive care unit.

Some highly specialised procedures, such as some heart or lung surgery, would be undertaken in a regional specialist centre in Swansea or Cardiff.

When we spoke to you in the summer during The Big Conversation you told us that you would like us to separate planned care from urgent care as a way of reducing the number of cancellations of your operations and treatment.

What is an urgent care hospital?

An urgent care hospital is for emergencies or unplanned urgent medical care. This is where we would investigate what is wrong with you in an emergency and provide treatment (acute care), with high dependency and intensive care on site.

The hospital would include an accident and emergency department and would be designated the Trauma Unit for the Health Board. Other acute services would include acute medical care and specialist medical care (respiratory, cardiology, gastroenterology, endocrinology, care for older people), surgery, trauma, children's care and special care and neonates for babies, consultant led care for women when they have their babies, and ear nose and throat, ophthalmology and urology. This would be supported by a lot of testing (diagnostic) facilities including head scans, MRI, ultrasound, radiography, biochemistry, haematology and microbiology. It would also include a cardiac catheter laboratory and pacing suite for heart procedures, many of which are currently provided in Morriston Hospital. Mental health assessment and treatment units would be provided on site, along with electro convulsive therapy. There would be a fully functioning intensive care unit on site. High risk planned surgery would also be undertaken in this hospital due to having the intensive care unit available.

Patients needing emergency care would benefit by being taken to a specialist hospital with a seven day a week consultant-led service.

An urgent care centre would also have health education and research facilities on site, such as a teaching centre for healthcare professionals, where we would undertake research and clinical trials.

What is a major planned and urgent care hospital?

A major planned and urgent care hospital is a larger hospital, able to do planned, unplanned and emergency care that we have described above. The hospital would provide as many of its services as possible seven days a week, 24 hours a day.

The elements of planned and emergency care, which you told us you wanted us to separate, would be designed carefully to be clearly separated and benefit from the advantages of splitting, such as ensuring planned treatment is not interrupted by emergencies. At the same time, they would be closer in distance than having two separate hospitals, some support facilities, such as tests and high dependency back-up, could be shared and we could keep specialist staff on fewer sites.

A major planned and urgent care hospital would also have health education facilities on site, such as a teaching centre for healthcare professionals, where we would undertake research and clinical trials.

You can read more detail about our proposals for our hospitals by reading the Community and hospital models for change Technical Document **http://bit.ly/2udWwCn** .

Where does our community model fit?

Our community model is the same across all three of our proposals and you can read more about our community hubs on page 38. However, different proposals for our main hospitals have different effects on our community hospitals and hubs, so we have included an image and tick list to show where the hubs would be located and the type of services you could expect to receive there in each proposal. If the community hub or hospital appears within the proposal, it will be marked in green, and if it doesn't appear it will be marked in red. If it is marked in red please refer to the following section, 'Our proposals in more detail', for more information on how we propose to change it.

	Which proposal is it in?			What services would be in it?						
Name of Site	**A**	**B**	**C**	**Minor Injuries**	**Beds**	**Tests**	**Treatments**	**Outpatients**	**Mental Health Unit**	**Advice & Support**
Glangwili Community Hospital				✓	✓	✓	✓	✓	✓	✓
Prince Philip Community Hospital				✓	✓	✓	✓	✓	✓	✓
Withybush Community Hospital				✓	✓	✓	✓	✓	✓	✓
South Pembrokeshire Community Hub				✗	✗	✓	✓	✓	✗	✓
Tenby Community Hub				✓	✗	✓	✗	✓	✗	✓
Llandovery Community Hub				✓	✓	✓	✓	✓	✗	✓
Amman Valley Community Hub (with Beds)				✗	✓	✓	✓	✓	✗	✓
Amman Valley Community Hub (without beds)				✗	✗	✓	✓	✓	✗	✓
Delta Lakes Community Hub				✗	✗	✓	✓	✓	✗	✓
Aberystwyth Community Hub				✗	✓	✓	✓	✓	✓	✓
Cylch Caron Community Hub				✗	✗	✓	✓	✓	✗	✓
Minaeron Community Hub				✗	✗	✓	✓	✓	✗	✓
Cross Hands Community Hub				✗	✗	✓	✓	✗	✗	✓
Cardigan Community Hub				✓	✗	✓	✓	✓	✗	✓

Our proposals in more detail

Proposal A

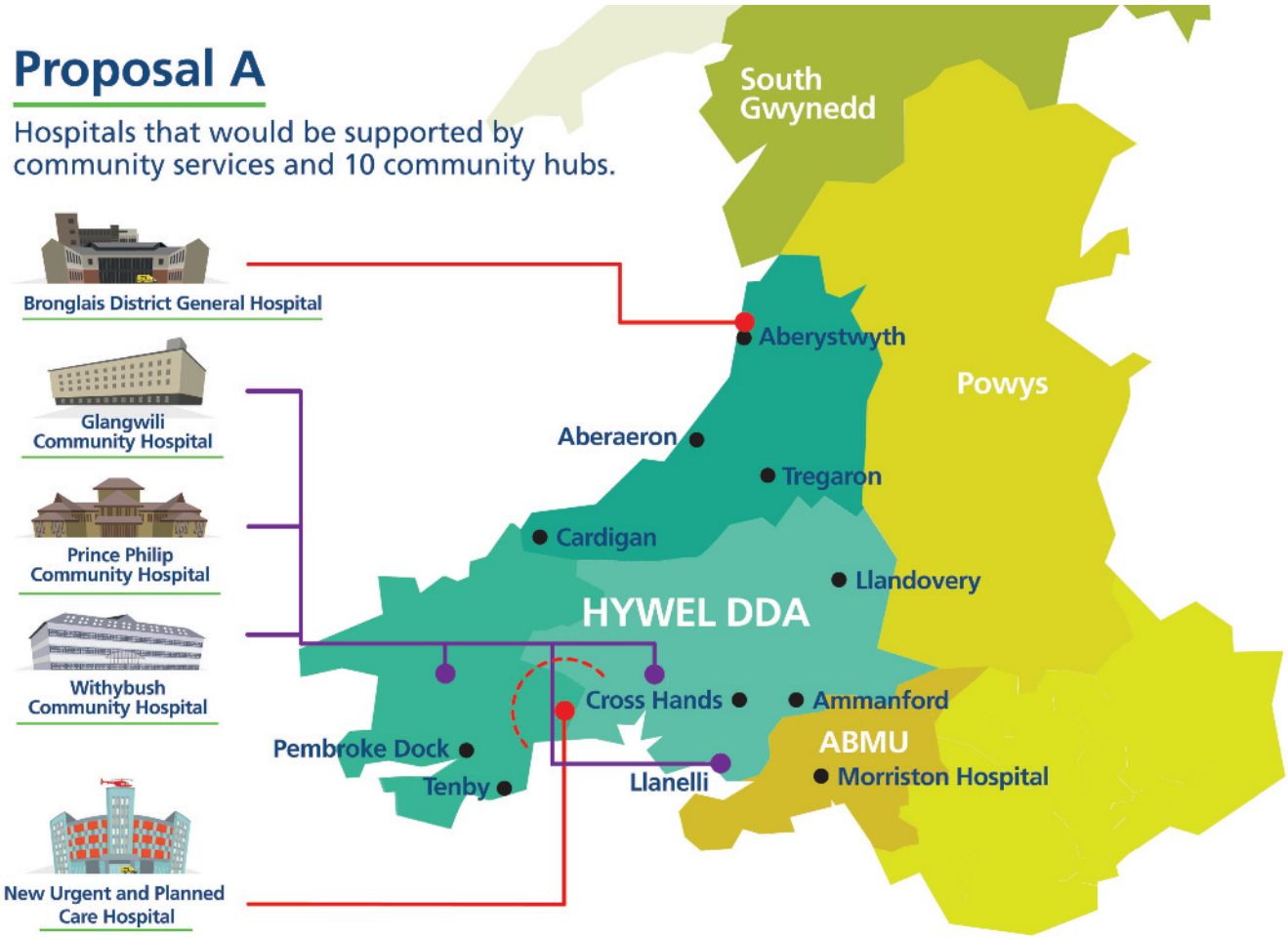
Two main hospitals

1. A major new urgent and planned care hospital centrally located somewhere between Narberth and St Clears, with all planned and specialist care centralised on a single site.
2. Bronglais District General Hospital would continue to provide services for mid Wales.

Three community hospitals

1. Glangwili in Carmarthen
2. Prince Philip in Llanelli
3. Withybush in Haverfordwest

Ten community hubs (refer to table on page 49. Please note Amman Valley does not have beds in this proposal due to availability of community beds in Glangwili and Prince Philip)



What does this mean for local people?

Potential advantages of this proposal

- ✓ Community hubs will provide more care closer to home and strengthen community support (resilience). This means less time travelling to access care, which is beneficial if you live in a rural area or are reliant on public transport.
- ✓ A newly built major hospital is likely to attract and maintain staff, which means you are more likely to be seen by the right person in the right place.
- ✓ Planned and urgent/emergency care is split on site by careful design of our buildings and services. This avoids the risks of providing planned care away from urgent care. This will provide for modern healthcare facilities to support both planned and urgent care.
- ✓ Expert medical care is focused on fewer sites, and is therefore more resilient, and also makes access to our specialists more equal for all, regardless of where you live.
- ✓ There are only two hospitals which would be easier to staff than trying to staff lots of sites. This means that you are less likely to have to wait and less likely to have your appointments or procedures cancelled.
- ✓ When on the same site, facilities can be shared across urgent and planner care e.g. tests and support services, including things like public canteens, which makes better use of our available money and buildings.
- ✓ By looking at the affordability of this proposal against the current costs of the way our services are provided, we are confident that our hospital services will cost less. This will provide an opportunity to invest in our community services.

Potential disadvantages of this proposal

- ✗ There is only one hospital for the south of the Health Board area, so some patients and staff will have to travel further to access planned and emergency care in a hospital (although almost all communities will still be within one hour of a main hospital).
- ✗ The location of the new major hospital may increase pressure on hospitals outside of the area. This means that those usually accessing Prince Philip Hospital may travel to Morriston Hospital in Swansea instead.
- ✗ It will take time to plan and build a new hospital, so it could be some time before we see the benefits.
- ✗ It might be difficult to manage demand if planned and urgent/emergency care share a site, which means that there is a risk that planned care beds will be used for emergencies if the site is not carefully designed.

Our impact assessment has suggested that:

- Having to travel further to access hospital care could impact more on older and frail patients (and their families) in rural and isolated areas in west Pembrokeshire, east and north Carmarthenshire and south Ceredigion where public transport links are not so frequent. This could increase the cost and inconvenience for these groups, however this could be mitigated by providing more care in the community.
- Access and travel for people with disabilities may become more challenging through the relocation of facilities and this might be felt hardest in some of our more deprived areas, as well as rural areas where there is less public transport.
- If patients will have to travel to Morriston Hospital instead of Prince Philip Hospital there could be a negative impact on women with high risk pregnancies living in east Carmarthenshire, and older people living in urban towns in the east (such as Llanelli and Ammanford) as they are less likely to have their own transport. The increase in cost of travelling will impact more on low income families.
- Moving paediatric services further west may disadvantage children by increasing distance away from the tertiary specialist centre. Parents in lower income groups without access to transport may find this more challenging.
- By providing a new modern hospital in the south we could risk disadvantaging patients in the north unless we invest in improving the standard of their healthcare facilities. This could have an impact on communities in the north such as ethnic minority and Lesbian, Gay, Bisexual and Transgender (LGBT) groups concentrated in Aberystwyth and surrounding areas; and students.
- There are potential positive impacts of building a new hospital to provide health facilities that recognise individual characteristics and promote dignity, respect and privacy. For example, providing accessible, gender neutral and multi-faith facilities provided through language of choice. This will improve the experience of patients with ethnic minorities, and our faith and LGBT communities.

We will understand more about the impacts when we have heard your views as part of the consultation, but to read more about our initial impact assessment go to page 70.

Proposal B

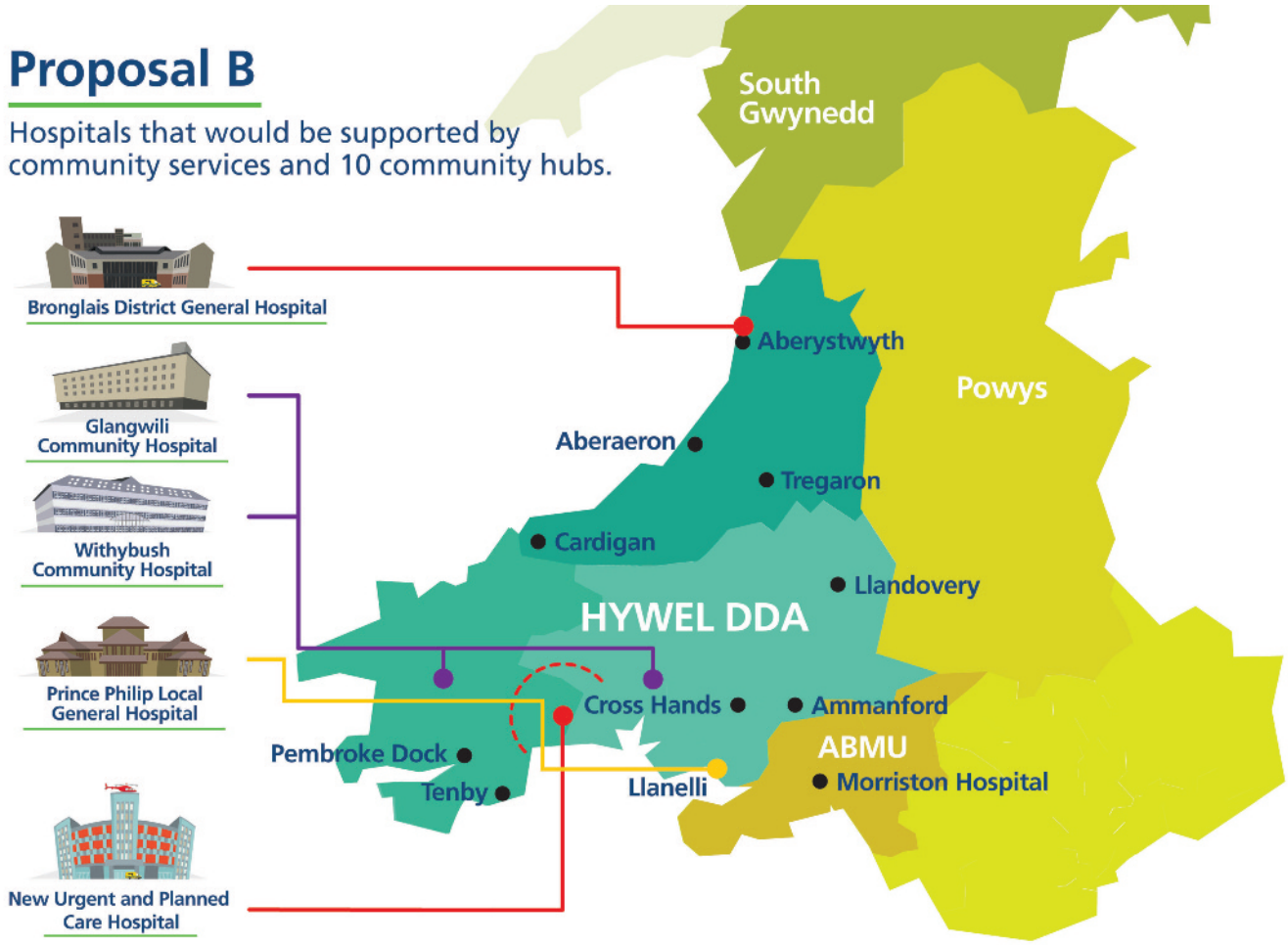
Three main hospitals

1. A major new urgent and planned care hospital centrally located somewhere between Narberth and St Clears, with all planned and specialist care centralised on a single site.
2. Bronglais District General Hospital would continue to provide services for mid Wales.
3. A general hospital on the existing site at Prince Philip, Llanelli.

Two community hospitals

1. Glangwili in Carmarthen
2. Withybush in Haverfordwest

Ten community hubs (refer to table on page 49. Please note Amman Valley does not have beds in this proposal due to availability of community beds in Glangwili)



What does this mean for local people?

Potential advantages of this proposal

- ✓ Community hubs will provide more care closer to home and strengthen community support (resilience). This means less time travelling to access care, which is beneficial if you live in a rural area or are reliant on public transport.
- ✓ The provision of two hospitals for the south of the Health Board area will provide more equal access to care and will have less impact on travel times. It will also reduce demand on hospitals outside of the area as patients in the east will still access most of their urgent care in Llanelli.
- ✓ A new major hospital is likely to attract and maintain staff, which means that you are more likely to be seen by the right person in the right place.
- ✓ Planned and urgent/emergency care is split on site by careful design of our buildings and services. This avoids the risks of providing planned care away from urgent care. This will provide for modern healthcare facilities to support both planned and urgent care.
- ✓ Expert medical care is focused on fewer sites, and is therefore more resilient, and also makes access to our specialists more equal for all, regardless of where you live.
- ✓ When on the same site, facilities can be shared across urgent and planner care e.g. tests and support services, including things like public canteens, which makes better use of our available money and buildings.
- ✓ We are confident that our hospital services will cost less than at present. Although this proposal has three main hospital sites, it will require more resources than proposal A. Therefore, this proposal will not enable the same level of investment in community services as Option A.

Potential disadvantages of this proposal

- ✗ There are three hospitals which could be difficult to staff and maintain. This increases the risk that patients will have to wait for appointments and procedures and there may be more cancellations. It also means that there may be more differences in the care you receive at one place to another.
- ✗ Patients and staff will have to travel further to access planned and emergency care in a hospital (although almost all communities will still be within one hour of a main hospital). It will take some time to plan and build a new hospital, so it could be some time before we see the benefits.
- ✗ It might be difficult to manage demand if planned and urgent/emergency care share a site, which means that there is a risk that planned care beds will be used for emergencies if the site is not carefully designed.

Our impact assessment has suggested that:

- Maintaining a main hospital in Llanelli will mitigate against the negative impact on older people living in east Carmarthenshire of locating the new build hospital further west; and any potential negative impacts on ethnic minority populations (such as Polish residents) who are more concentrated in the Llanelli area.
- Having to travel further to access hospital care could impact more on patients in rural and isolated areas in west Pembrokeshire, north Carmarthenshire and south Ceredigion where public transport links are not so frequent. This will impact negatively on older people in these areas, who are less likely to have access to their own transport; disabled people; and men living in rural areas as evidence suggests they are less likely to access services. This could increase the cost and inconvenience for these groups, however this will be mitigated by providing more care in the community.
- Women with high risk pregnancies living in east Carmarthenshire may have to travel further for consultant-led care in a new build hospital and moving paediatrics further west may disadvantage children by increasing distance away from the tertiary specialist centre. Families living in areas with more deprivation may find this challenging as the cost and availability of public transport may be problematic.
- By providing a new modern hospital in the south we could risk disadvantaging patients in the north unless we invest in improving the standard of their healthcare facilities. This could have an impact on communities in the north such as ethnic minority and Lesbian, Gay, Bisexual and Transgender (LGBT) groups concentrated in Aberystwyth and surrounding areas; and students.
- There are potential positive impacts of building a new hospital to provide health facilities that recognise individual characteristics and promote dignity, respect and privacy. For example, providing accessible, gender neutral and multi-faith facilities provided through language of choice. This will improve the experience of patients with ethnic minorities, and our faith and LGBT communities.

We will understand more about the impacts when we have heard your views as part of the consultation, but to read more about our initial impact assessment go to page 70.

Proposal C

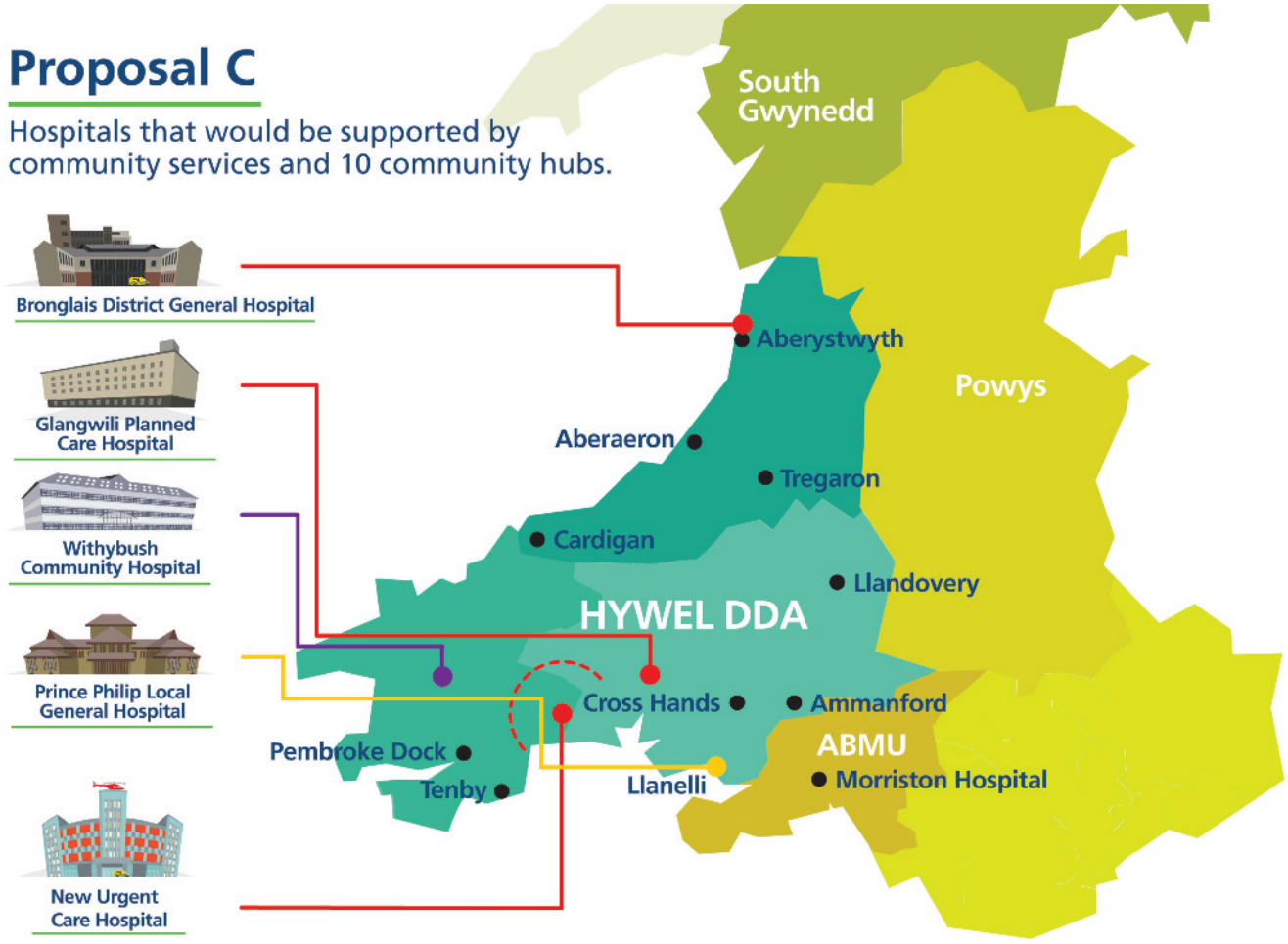
Four main hospitals

1. A new urgent care hospital centrally located somewhere between Narberth and St Clears.
2. Bronglais District General Hospital would continue to provide services for mid Wales.
3. A general hospital on the existing site at Prince Philip, Llanelli.
4. A planned care hospital at the existing Glangwili Site, Carmarthen.

One community hospital

1. Withybush in Haverfordwest

Ten community hubs (refer to table on page 49. Please note Amman Valley has beds in this proposal as there are no community beds in Glangwili and Prince Philip)



What does this mean for local people?

Potential advantages of this proposal

- ✓ Community hubs will provide more care closer to home and strengthen community support (resilience). This means less time travelling to access care, which is beneficial if you live in a rural area or are reliant on public transport.
- ✓ Planned care is separated from urgent care across two sites, so there is less likelihood of planned care beds being used for emergencies, as well as fewer cancellations or delays in treatment.
- ✓ A new build urgent care hospital will be modern and fit for purpose which could attract more specialist staff. This means that you will receive the best possible care and will have to wait less time.

Potential disadvantages of this proposal

- ✗ There are still four hospitals, which means the challenges of staffing all our services remain. This means that you could still experience the delays and cancellations that you do at present. We would also need to staff more rotas for the separate planned care site, which will risk worsening our staffing situation and also leave less resource for us to spend on community and primary care services.
- ✗ There could be some challenges from splitting planned and urgent/emergency care across two sites. For example, if something goes wrong during your planned operation, you would need to be transferred from the planned care hospital in Carmarthen to the new urgent care hospital between Narberth and St Clears.
- ✗ Some patients and staff will have to travel further to access emergency care in a hospital (although almost all communities will still be within one hour of a main hospital).
- ✗ Patients in west Pembrokeshire will also have to travel further to access planned care procedures, as the planned care hospital is located in Carmarthen.
- ✗ Refurbishing Glangwili Hospital into a planned care hospital and building a new urgent care hospital will be a very expensive option, particularly because of the current challenges at Glangwili Hospital (age, parking etc) and we will need to secure considerable capital investment for this.
- ✗ By looking at the affordability of this proposal against the current costs of the way our services are provided, our hospital services are likely to remain high given that we will be maintaining four main hospital sites. However by providing planned care only from one site this will require less medical cover. We will therefore invest less in our community services.

Our impact assessment has suggested that:

- Having to travel further to access urgent care is likely to impact more on patients in rural and isolated areas in west Pembrokeshire, east and north Carmarthenshire and south Ceredigion where public transport links are not so frequent. However by keeping a main hospital in Llanelli we can reduce the impact for people in particular groups concentrated in these areas, such as older people and ethnic minorities. We will also mitigate this by delivering more care in the community.
- The potential impact on quality and safety of maintaining four hospitals might have a more negative impact on people in vulnerable groups, such as those with disabilities and older people.
- Patients in west Pembrokeshire will also have to travel further to access planned care procedures, as the planned care hospital is located in Carmarthen, meaning that it might cost more for patients to travel for planned care, and also for their families and friends to visit. This could impact negatively on the disproportionate numbers older people living in Pembrokeshire.
- Women with high risk pregnancies living in east Carmarthenshire may have to travel further for consultant-led care in a new build hospital and moving paediatrics further west may disadvantage children by increasing distance away from the tertiary specialist centre. Families living in areas with more deprivation may find this challenging as the cost and availability of public transport may be problematic.
- By providing a new modern hospital in the south we could risk disadvantaging patients in the north unless we invest in improving the standard of their healthcare facilities. This could have an impact on communities in the north such as ethnic minority and Lesbian, Gay, Bisexual and Transgender (LGBT) groups concentrated in Aberystwyth and surrounding areas; and students.
- There are potential positive impacts of building a new hospital to provide health facilities that recognise individual characteristics and promote dignity, respect and privacy. For example, providing accessible, gender neutral and multi-faith facilities provided through language of choice. This will improve the experience of patients with ethnic minorities, and our faith and LGBT communities.

We will understand more about the impacts when we have heard your views as part of the consultation, but to read more about our initial impact assessment go to page 70.

What won't change as a result of our proposals?

We have outlined in the table below what won't be affected by our proposals, along with some information about what this means for you:

	This means that
We will still work by the principles that underpin the NHS.	– We remain committed to delivering the principles of prudent healthcare: o Public and professionals are equal partners through co-production. o Care for those with the greatest health needs first. o Do only what is needed and do no harm. o Reduce inappropriate variation through evidence-based approaches.
Bronglais will still be a general hospital. (please look at pages 46 for a description of Bronglais Hospital)	– People in north Ceredigion, as well as south Gwynedd and Powys, will continue to receive most of their hospital care in Bronglais District General Hospital. – We will focus on developing and improving Bronglais District General Hospital in line with the ambition set out in the Mid Wales Healthcare Study.
Specialist care will still be provided in tertiary specialist centres outside of the Health Board.	– If you are seriously ill, for example if you have a major heart attack or a car accident, you will still go to Morriston Hospital in Swansea or University of Wales Hospital in Cardiff, for your treatment.
GPs will remain within the community.	– You can still go to your GP. – However there will be more support around them, including other professionals that may be able to help with your health needs.
We will still implement the mental health model that was approved by the Health Board in January 2018.	– Community mental health centres will be developed in Aberystwyth, Carmarthen, Haverfordwest and Llanelli. But listening to what you told us as part of the mental health consultation we will look at co-locating the Assessment Unit, which was proposed to be in Carmarthen and the Treatment Unit, which was proposed to be in Llanelli, at the proposed new hospital between Narberth and St Clears. – You will be able to access a single point of contact for advice and support. – If you need inpatient assessment or treatment these will be provided in two separate units.

Some examples of how the proposals could change the care you receive

Ben's story

Ben Thomas is three years old. He lives in Tumble with his mum, Lianne, and mamgu and tadcu.

Ben is a happy little chap and always puts a smile on everyone's face. He loves Peppa Pig and trucks like his tadcu drives. He also likes going swimming with mamgu and seeing his friends at nursery twice a week.

Ben was born prematurely and has respiratory problems and mild developmental delay. He has recently been diagnosed with a rare genetic condition.

In all our proposals Ben will receive most of his care in the community:

Ben will be seen regularly throughout his early years and is up-to-date with all his immunisations which has protected him from vaccine preventable infections.

His asthma is reasonably well controlled and is managed by the community team who assess his inhaler use regularly.

The nursery is educated about Ben's genetic condition and asthma by our public health nurses. Our health visiting service, and then the school nursing service, provide care around the family for Ben and Lianne. The community team bring together education and voluntary groups to help build a strong (resilient) community to help families like Teulu Jones and providing opportunities for vulnerable children like Ben to thrive.

There may be occasions when Ben would require hospital admission and we have outlined below what would happen now and under each proposal, for two different circumstances. The first, involves a family holiday in Goodwick when Ben slips on the steps while crabbing. He has a little bump to his head and sustains a cut above his eye.

The second, is when early in the morning Ben suddenly found it very difficult to breathe in his sleep. Lianne correctly takes Ben into a steamy bathroom and gives him his inhaler. His symptoms don't ease and she calls an ambulance.

What would happen to Ben:			
Now	**In Proposal A**	**In Proposal B**	**In Proposal C**
When Ben has a little bump to his head: He is quickly taken to Withybush Hospital by Sioned and treated and stabilised. He needs an overnight stay in hospital and as such is transferred to Glangwili Hospital in case of deterioration. He stays in hospital for a further 24 hours and is discharged home once stable. He has an outpatient appointment in Glangwili Hospital to further assess his allergy.	Ben is taken to the minor injuries unit in Withybush Community Hospital for treatment. He needs to stay overnight for observation so is taken to the Urgent Care Hospital and is discharged home the following day. He has to have his wound checked the following week as it wasn't healing and so attends the local community hub in Cross Hands to see the practice nurse. The hub is close to home meaning that his mum or mamgu can easily make repeated visits back to the hub, saving them on time, travel and cost.		
When Ben has breathing difficulties in his sleep: He is admitted to Glangwili Hospital for treatment and a short stay in hospital. He is discharged home after two days and is seen in outpatients in Glangwili Hospital a month later.	Ben is admitted to the urgent care hospital for a short stay on the paediatric assessment unit and is discharged home. His outpatient follow-up and care is delivered locally in the community hub, which is easier for his mum Lianne, or mamgu Sioned, to get to. This is more convenient and saves time and costs of travel.		

Rhys' story

Rhys Thomas is 52 years old. He lives in Tumble with his wife Sioned, their daughter Lianne and her son Ben.

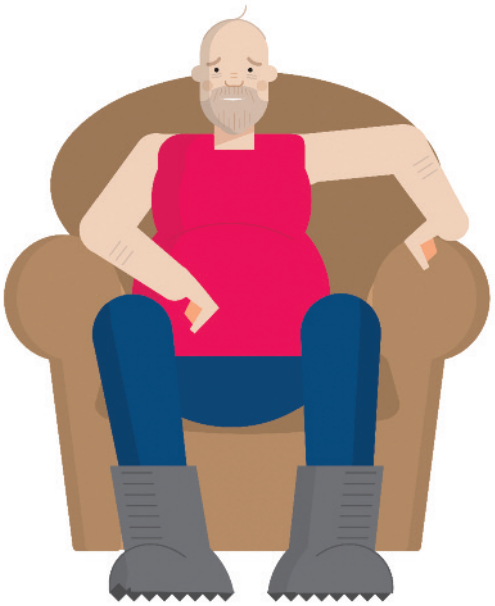
Rhys is a long distance lorry driver and is away from home a couple of nights a week.

He is originally from Cardiff and is a staunch supporter of Cardiff City. He likes to watch the match on Sky Sports, ideally with a couple of pints in the pub with his mates.

Rhys is a heavy smoker and very overweight (BMI 36).

Sioned is trying to improve his diet at home but he often resorts to fast food when he is on the road. Rhys doesn't really do any exercise and he says this is because his knee is painful.

He rarely visits his GP but did go recently about his bad knee.



In all our proposals Rhys will receive most of his care in the community:

Rhys' GP refers him to his local community hub for a knee x-ray which shows a lot of wear and tear in the joint. Rhys is also referred to the knee pain clinic – a multi-professional team including a dietician, physiotherapist, someone to help with exercise and psychologist who help him tackle his weight and diet and start him on a guided exercise course. He also has advice regarding his smoking and starts to feel as if he has more in understanding of his own health. His knee pain improves significantly and he finds he needs to use painkillers a lot less than he did.

Over the next five years, Rhys' knee gets sore again despite his healthy living and, following discussion with his team, he is referred to see a specialist. The orthopaedic surgeon sees Rhys at his local hub in an outreach clinic and advises him that surgery may benefit him and he has a better chance of a good outcome now that he has lost weight and no longer smokes. Rhys decides to go ahead with the surgery as he is no longer able to exercise without pain and the pain also wakens him at night.

<table>
<tr><th colspan="4">What would happen to Rhys:</th></tr>
<tr><th>Now</th><th>In Proposal A</th><th>In Proposal B</th><th>In Proposal C</th></tr>
<tr><td rowspan="2">Rhys has a few pre-operation assessments at Prince Philip Hospital because his operation is cancelled a couple of times.

Eighteen months later, Rhys has his operation in Prince Philip Hospital. The operation is a success but Rhys finds it difficult to attend physiotherapy sessions in the hospital, which is not good for his knee. This means he has longer sickness from work and gains more weight.

Rhys has regular follow-up clinics at his local general hospital, which means he has to take further time off work.</td><td>Rhys has his pre-operation assessment at his local hub.

He has his operation at the new urgent and planned care site.

His bed is protected from emergency admissions, reducing the chances of his operation being cancelled.</td><td>Rhys has his pre-operation assessment his local hub.

Rhys has his operation at the new urgent and planned care site.

His bed is protected from emergency admissions, reducing the chances of his operation being cancelled.</td><td>Rhys has his pre-operation assessment at his local hub.

Rhys has his planned knee surgery at the planned care hospital on the repurposed Glangwili site. As it is separate from the urgent care hospital, his bed is safe and the operation goes ahead without cancellation.</td></tr>
<tr><td colspan="3">Following surgery, Rhys has therapy on the ward and is transferred to a bed in his local hub for therapy and when he is discharged home, his therapy continues in the community. His follow-up is done via 'virtual' clinics by telephone call and email, and he is only seen by the surgeon if he feels there is a concern.</td></tr>
</table>

Lianne's story

Lianne Thomas is 19 years old and lives in Tumble with her mum and dad, and her three year old son Ben.

Lianne is 24 weeks pregnant. Her son Ben was born prematurely.

After Ben's birth she has managed to cut down her smoking to 1-2 a day.

Lianne is doing a full-time childcare course at the local college but has recently had to take some time off for pregnancy related problems.

She is a dedicated mum and enjoys shopping with her friends.

In all our proposals Lianne will receive most of her care in the community:

Lianne attends antenatal clinic in her local hub and is supported to give up smoking and take up regular and exercise at Tumble Hall to help her stay healthy throughout the remainder of her pregnancy.

Her local sexual health drop in clinic at the hub helps with advice and appropriate treatment.

The midwife who cares for Lianne is aware of her challenges with Ben and the high risk of her developing postnatal depression. She puts her in touch with a mental health facility in Llanelli who provide her with a lot of support and advice.

During her pregnancy, Lianne develops vaginal discharge and is diagnosed with Chlamydia after a visit to the hospital. Her pregnancy is classed high risk because of her previous history.

What would happen to Lianne:			
Now	**In Proposal A**	**In Proposal B**	**In Proposal C**
Lianne is booked into Glangwili Hospital under consultant-led care to have her baby delivered. If all goes well she is discharged home in a timely manner and is seen regularly by the health visitor.	Lianne would travel a little further to the new urgent care centre to deliver her baby. If all goes well she is discharged home in a timely manner, and is seen regularly by the health visitor.		

Alun's story

Alun Jones is 80 years old. He lives in an old two storey house in Newcastle Emlyn with his wife.

Alun is a retired electrician and is still quite a handyman, although it's not so easy now his sight is failing due to a cataract.

Aside from his wife Mari, Alun's passion is rugby and he follows the Carmarthen Quins. He loves to watch the home games and is able to drive to the match.

Alun enjoys his daily walk to the local shop to get the newspaper and always does the crossword. He smokes a pipe, although Mari wishes he didn't.

Alun is non-insulin dependent diabetic and takes medication to control it. He has a history of heart disease and had a heart attack when he was 70 years old.

Alun and Mari visit their daughter Sioned in Tumble regularly, sometimes overnight so they can spend time with their granddaughter and great-grandson.

In all our proposals Alun will receive most of his care in the community:

Both Alun and Mari have a 'stay well' plan which has been developed between them and the GP practice so that what matters to them is taken account of. This helps them better understand their health conditions, aiming to provide them with the care they need in the community to support them to live independently, avoiding hospital admissions. By doing this, we use information we have to build care, rather than waiting for the demand, when needs might be greater and people are more unwell. Alun is due to have his cataract surgery in his community hub in Cardigan.

One weekend over the Easter break, Alun who has been coughing for several days feels increasingly unwell. He calls 111 and a paramedic attends who discusses is case with the GP out of hours service on the telephone. They agree that Alun needs to be admitted to hospital with suspected pneumonia.

What would happen to Alun:			
Now	**In Proposal A**	**In Proposal B**	**In Proposal C**
An ambulance is called to take him to Prince Philip Hospital Medical Admissions Unit. His diagnosis is confirmed and he needs antibiotics through a needle as well as oxygen therapy for a few days.	Alun is taken by ambulance to the urgent care hospital, and admitted under the medical team. After a 72 hour period, he is discharged to a 'step down' care bed in Glangwili Community Hospital in Carmarthen to continue his treatment and to get better with some support. Alun is closer to home and able to have visitors.	Alun is taken to Prince Philip Local Hospital and admitted under the care of the medical team. After a 72 hour period, he is discharged to a short stay bed in Carmarthen to continue his treatment and to get better with some support. Alun is closer to home and able to have visitors.	

Gareth's story

Gareth is the 38-year-old younger brother of Sioned. Gareth is the finance director of an engineering company in Talybont, where he lives. He is married to Aysha and they have two boys. During the week, he lives in Birmingham for work reasons. He is a social smoker and trying to give up. He is otherwise quite active and cycles regularly with a local club. Gareth tries to visit his older parents as much as he can, and stays in contact with Sioned.

In all our proposals Gareth will be able to access community-based support to give up smoking:

Gareth is able to work flexibly from home. His local community hall has WiFi and also runs smoking cessation support weekly, as well as other healthy living sessions. Gareth decides to try give up smoking for the benefit of his overall health. This locally based support also means he can pick up his children from school.

On his Saturday cycle ride with Talybont Wheelers, Gareth has a serious fall, hitting his head and, despite wearing a helmet, the first responders are concerned.

What would happen to Gareth:			
Now	**In Proposal A**	**In Proposal B**	**In Proposal C**
EMRTS, the flying emergency medical retrieval team, stabilise Gareth at the scene and, given the seriousness of his accident, they fly him to the University Hospital of Wales in Cardiff for his treatment. Gareth would require treatment in hospital, but also rehabilitation closer to home afterwards, so he is closer to home for visitors.			
Gareth would attend follow-ups in hospital.	Gareth's follow-ups would also be done virtually whenever possible, reducing unnecessary travel times and the impact on the family until he was back to health and work.		

How we have determined where our services might be located

Community hospitals and hubs

All our proposals include the development of community hospitals and hubs. To identify what services are located at which hubs, we considered:

- the population density;
- the drive time analysis;
- the future number and location of beds needed;
- population changes over the next five years;
- existing community facilities and planned community developments.

We wanted to ensure more equitable access to a range of services, not requiring a hospital admission, as close to home as possible, building on existing plans for integrated care centres at Aberaeron, Cardigan, Cross Hands and Tregaron.

The make-up of each community hospital and hub will ensure local access to:

- minor injuries unit;
- step-up, step-down and rehabilitation beds;
- diagnostic tests (e.g. x-ray and point of care testing);
- a base for multi-professional teams.

New urgent care hospital and new major planned and urgent care hospital

Our proposals include either a new urgent care hospital or a new major planned and urgent care hospital and we have determined an area where this could be located by considering the driving times and distance away from other health services.

Maintaining safety has been the most significant consideration, so we have based the sites on locations within an hour's reach for the clear majority of the population, where they are not able to access another hospital.

At this stage of the process we would be unable to specify an exact location because we are still in consultation and no decisions have been made, but instead we have indicated an area where the hospital could be located. This area will be between Narberth and St Clears.

In Proposal A and B there are no beds at Amman Valley Hub because community beds would be provided in Community Hospitals at Prince Philip or Glangwili. In Proposal C, neither Glangwili nor Prince Philip would be Community Hospitals and therefore there would be a need for community beds in Amman Valley Hub.

The benefits we all want to see

The table below shows what you have told us you want, how our proposals respond to this and what benefits we expect to see for local people. We have indicated whether you will see this in proposal A, B, or C, or all three:

	This will mean					
You said	**We have proposed**	**A**	**B**	**C**	**More +**	**Less -**
You wanted more care closer to home and supported the idea of hubs or one stop shops that address a range of needs closer to home. Services should be co-located to be provided in one place.	A number of community hubs and a network of care to offer more care and support in the community.	✓	✓	✓	– Access to timely and reliable services, delivered by highly skilled staff. – Proactive approach, where illnesses are prevented and deteriorations avoided where possible. – Communication and joined up working between services and organisations. – Information and support available in the community so that you can take better control of your own health.	– Need to travel to a hospital for care because more services would be provided in a community setting. – Time to wait for appointments, tests and treatments because they will be available locally at hubs. – Need for you to have multiple appointments with multiple professionals.
Emergencies and planned care could be dealt with separately.	To split urgent and planned care hospitals on the same but very carefully separated site (Proposals A&B). Or on different sites (Proposal C).	✓	✓	✓	– Timely operations and procedures with reduced waiting times and 'ring-fenced' protected beds. – Access to specialist care and senior decision-making at the front door.	– Cancelled operations and procedures because planned care is delivered separately. – Waiting as you will be seen sooner. – Variation in experience. – Reduced risk of infections.

This will mean						
You said	**We have proposed**	**A**	**B**	**C**	**More +**	**Less -**
A&E waiting times are not acceptable.	Centralising A&E services in a new, modern urgent care hospital. More access to minor injuries units in the community.	✓	✓	✓	– Timely access to treatment by streamlining emergencies and urgent cases to a new urgent care facility. – Care closer to home with more patients being seen in the minor injuries unit.	– Waiting time as you will be seen sooner.
You wanted better discharge processes including access to social care, physiotherapy and occupational therapy.	Including beds in some community hubs to support more rehabilitation and 'step down' support in the community.	✓	✓	✓	– Access to 'step up' or 'step down' (intermediary beds) enabling quicker discharge from hospital, better access to therapies and return to home and back to work.	– Delay in you leaving hospital because the right support is available closer to home to help you get home.
Some of the general hospital sites are not fit for purpose now, let alone for the future.	A new urgent, or urgent and planned care hospital, which will be fit for purpose to provide modern healthcare for us and future generations.	✓	✓	✓	– State-of–the-art facilities and a better experience for patients needing admission. – Latest technology. – Parking available. – Compliance with modern healthcare standards. – Opportunity to invest and improve our facilities. – Improved recruitment.	– Ongoing repair and refurbishment costs.
More permanent staff are needed with senior specialist staff closer to the front door of A&E to speed up access.	A new hospital is likely to attract and maintain staff, meaning less reliance on temporary staff.	✓	✓	✗	– Safer services. – Sustainable rotas. – Being seen by the right person at the right time.	– Variation in the service you will receive. – Lengthy hospital stays due to continuity in care with the same staff.
Better integration of health and social care is essential.	Our proposed community model aims to develop further integration with partners moving to a more social model of health.	✓	✓	✓	– Co-ordinated approaches to your care by health and social care workers, and other partners including third sector. – Opportunities to look at developing a shared workforce.	– Silo working. – Delay in getting you home and back to work. – Need for you to tell your story multiple times to multiple people.

This will mean						
You said	**We have proposed**	**A**	**B**	**C**	**More +**	**Less -**
Joined up and innovative IT solutions (information technology).	To explore how a range of digital and technological solutions can be used to improve your access to health and social care.	✓	✓	✓	– Increasingly paperless system should allow better information sharing within the Health Board and also with partners so better decisions can be made by staff more rapidly. – Increasing access for patients to information about their care to allow people to take more responsibility for their health. – More automated digital access health information and also for appointments. – Access to tests to diagnose your health problems. – Opportunity to receive health and care support remotely in the community (telehealth). – Remote and virtual clinics.	– Need to travel to hospital for tests and appointments.
You are prepared to consider travelling further if it means you would get quicker access to specialist care.	Centralising some services so that we can make them more sustainable.	✓	✓	✗	– Being seen by the right person at the right time. – Clinicians are able to develop areas of expertise because they work in a larger network or group therefore more specialist expertise available within the Hywel Dda area.	– Cancelled operations and procedures. – Less need to travel to tertiary centres.

This will mean						
You said	**We have proposed**	**A**	**B**	**C**	**More +**	**Less -**
We should make the public aware of the community services that are available so that they don't always automatically go to their GP. You need better information and education about when and how to access various urgent and emergency care services.	To develop networks of care as well as community hubs, so that people can access advice and support to help them manage their own health better.	✓	✓	✓	– Information available for the public in more local places. – Support and empowerment to make the right decisions about your care. – Higher profile of the range of skills of non-medical community staff who will increasingly take on enhanced roles. – Care closer to home. – Education and advice readily available.	– Uncertainty over how and when to access services. – Inappropriate use of services.

Understanding the impact of our proposals

Our proposals are designed to change health for the better for everyone, making things fairer for all. Here are some ways we think our proposals will help:

- Moving more care into the community will improve how quickly you can access care and reduce travel times for things like outpatients appointments, tests and ongoing treatment.
- Providing opportunities for vulnerable people (such as those with learning disabilities) to be supported to live in the community will improve independence.
- Bringing some hospital services together will reduce the differences in care we currently see between sites and will reduce waiting times and the number of cancellations, and release resource to allow expansion of primary and community care services.
- Using technology to its fullest potential will help reduce travel and improve access for our rural communities.

Transforming Clinical Services will affect all of us living in the Hywel Dda area regardless of age, sex, disability (physical, mental health and learning disabilities), race, religion, sexual orientation, gender reassignment, marriage or civil partnership, or pregnancy and maternity.

We must ensure that our proposals are fair to people and take particular care to consider people who are vulnerable. We have already spoken to groups representing vulnerable people and will continue to ensure they are involved in our consultation.

Indeed, one of the criteria we scored our longer list of options against was equity. We asked people to consider whether the options were equitable, fair and non-discriminatory by rating them on a scale of one to 10. Proposals A, B and C were the three that scored the highest out of the six shortlisted.

We have also completed what is called an integrated impact assessment and an equalities impact assessment to consider the impacts of proposals on people. We're publishing an initial assessment now and will take on board your views and publish an update following consultation. This flags up potential negative impacts and when we implement any changes that the full Health Board may approve, we monitor any actual impact and take action to remove or reduce that impact at the earliest opportunity. As part of this process, we are also looking for areas where there is potential to bring about positive impact. We will keep a record of this as part of our equalities impact assessment documentation. If it is not possible to remove or reduce any potential negative impacts, the reasons will be given within that document to justify why we have continued to include it in our proposals.

Our impact assessment has identified that there may be negative impacts from the proposals which would affect some vulnerable groups more than others. In particular, moving services and changing our current hospital arrangements could impact more on older people and the disabled, especially as these groups are less likely to have their own transport. Coupled with challenges around access to public transport, this can increase the cost and inconvenience of accessing healthcare, and impact on family life. However, we do have the potential to mitigate the negative impacts of our proposals through positive changes offered in a new build hospital (for example, purpose built facilities which are gender neutral, age and disability friendly, and which better support dignity, privacy and social connections). This is likely to improve the experience for patients in some minority groups, including our LGBT and faith communities, and ethnic minorities.

Our assessment also found that people in the east may perceive that the proposed new build hospital is further west than existing facilities and might either require them to travel further or prompt them to travel to Morriston Hospital for their care. This will impact adversely on some groups, such as women and children having to travel further for paediatrics and high risk consultant-led maternity. Again, this could be mitigated by providing fully staffed and modern healthcare facilities in a new hospital, improving the whole patient experience. Through our assessment we also identified that any proposals where Prince Philip Hospital is retained (Proposals B and C) would reduce negative impacts, especially for older and frail residents living in the east.

Our full Integrated Impact Assessment and Equalities Impact Assessment can be read here **http://bit.ly/2HYrznM** .

Potential challenges

Any proposals agreed for implementation by the Health Board will need to be carefully managed whilst continuing to run services for our local population. We recognise this may be difficult and changes would need to be gradual, whilst continually explained to the public.

The delivery of services from our main hospitals is a particular challenge as we have problems with staffing and funding. Proposals with fewer hospitals will allow for more investment in our community and social based health and care:

Proposal A includes two main hospitals
Proposal B includes three main hospitals
Proposal C includes four main hospitals

The location of our main hospitals is also challenging as this could significantly change where some patients access care and treatment. This is particularly an issue in the east of Carmarthenshire where patients who would currently be admitted to Prince Philip Hospital for medical care would potentially go to Morriston Hospital in the future due to travel times. This increases travel for individual patients and families and also impacts on the demand for services in neighbouring Abertawe Bro Morgannwg University (ABMU) Health Board. By splitting planned and urgent care on different sites, as in proposal C, we are also potentially increasing travel between sites for our doctors, nurses and other healthcare professionals.

All of our proposals involve asking you to think differently about your health, care and support needs, from how you interact with specialists (such as virtually on the phone or conference calls) to where you receive treatment. Changing behaviour is a big change and we know from previous efforts that this takes time.

We will keep you informed about the details of change, for example, helping you to understand new roles. We will also continue our education campaigns to give you the information you need to better maintain your own health and care.

Building new hospitals and refurbishing buildings is expensive, and we will need to carry on discussions with the Welsh Government about the investment needed to improve our facilities. We will do this once we have more detail about what the changes will look like and how much they will cost.

Further things to consider

We know that there are some key factors critical to making sure that we will be able to deliver the changes required within our proposals. We have identified these as enablers and have been working with groups of experts throughout our work to make sure that we are considering these fully. This includes both where there are new opportunities presented through the proposals and where these enablers could help to overcome some of the associated challenges.

Whilst we have included some key points in the section below to show you what could be possible, until we've understood the feedback from our consultation and what you have told us, we won't understand the full impact of the opportunities and challenges, or have a detailed plan for how we address them.

You can read further details about the enablers that follow in our Affordability Transport/ Workforce/Estates/Digital/ Technical Documents **http://bit.ly/2G6ouBs** .

Affordability

One of the considerations informing the final decision on which proposals to take forward to this consultation is the potential affordability of proposals. Ensuring that the proposals help us stabilise our financial position will allow us to make best use of the money we have available to provide healthcare that is the highest quality with excellent outcomes for patients.

To test this, we have calculated the likely cost of delivering each of the proposals and compared this against our current costs. This involved modelling the impact of providing more services within our local communities on the need for patients to go to and be admitted into hospital and the amount of time they might spend there. It also involved considering the costs of running the hospital and community facilities included within each of the proposals.

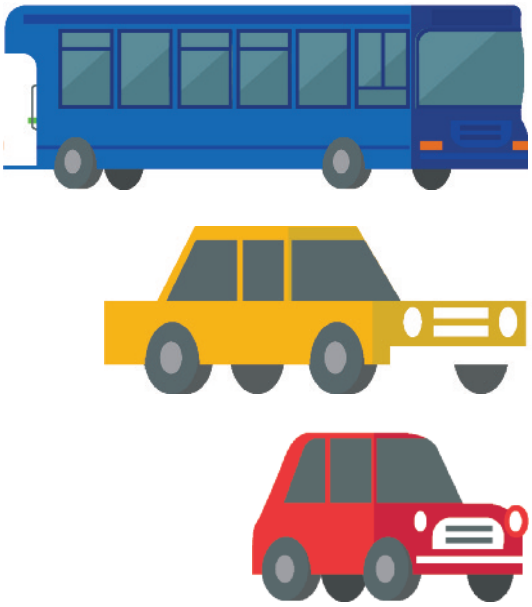
Our initial analysis suggests that by investing in community services we can reduce pressure on our hospitals and support more patients to live well at home. This will allow us to reduce costs, for instance by reducing our reliance on temporary and agency staff and the expensive maintenance of

outdated facilities. The proposals set out in this consultation provide options that will allow us to achieve this.

Following the outcome of this consultation, we will undertake a more detailed costing analysis as well as working closely with Welsh Government to apply for any funding that we might need to implement the proposals.

To read more about the work we have done so far around affordability you can get more information here **http://bit.ly/2G6ouBs** .

Transport



Local people and our staff have told us that transport is a major consideration in deciding where our health services might be located. Transport and access is of great importance to the Health Board, particularly due to the rural nature of the region we serve. Patients must often travel considerable distances to access healthcare services. In addition, many healthcare professionals must deliver services across a wide geographical area. These constraints often lead to considerable time being spent in transit by NHS staff, patients and relatives. Proposals for the centralisation of specific services within individual facilities will reduce the need for staff travel to provide cross cover and managerial oversight between sites. They will also reduce the need for the transportation of items between facilities, assuming each site has the required support services in place to fully meet their needs.

Proposals involving a new hospital between Narberth and St Clears will potentially increase the access challenges faced by some members of the public because of the existing lack of public transport services and transport infrastructure in this area. This could impact on vulnerable patient groups the most and would potentially increase non-emergency patient transport costs. However, we will work closely with partners on finding ways to develop more transport options.

To assess the impact of transport on the proposals, we looked in-depth at travel times.

We found that by locating our community hubs where we have proposed:

- more than 99% of the population would be within one hour of a planned day care facility or minor injuries unit by car.

We found that by placing a new hospital in the identified location:

- 93% of the population would be within one hour of an A&E, by car;
- 91% of the population would be within one hour of a planned inpatient care hospital by car.

Fast and responsive local 24/7 services, including intermediate care, ambulance and other rapid response services with the right skills and technology, will also help to address the challenges of our geographical area. Progress towards the Emergency Medical Retrieval and Transfer Service (EMRTS), which is the doctor-led service providing critical care in conjunction with the Wales Air Ambulance, becoming a 24/7 service will provide extra reassurance that critically ill patients will rapidly get to the right place. In some cases this will be at the proposed urgent care hospital in the Hywel Dda area, but in others it will be in a specialist centre in Swansea or Cardiff. This is something we will have to plan very carefully when we are developing our proposals further.

We know that in some areas there are significant proportions of the population that do not have access to a car and therefore access to public transport such as buses or trains become important. Also, some rely more on non-emergency patient transport.

Further detail on the work we have done around transport and travel can be seen here: **http://bit.ly/2G6ouBs** .

Current and future workforce

In all of our proposals there are changes to the services provided at our hospital sites and community hospital sites, and the way we provide care and treatment in the community. This will mean changes for some of our staff in terms of where they work and potentially the way they work. For some this will be an exciting opportunity and for others it may feel unsettling and may present problems for some staff due to increase in travel time to work.

As we have explained, our aim is to focus on prevention and early intervention in the community which will mean new and different roles are required to deliver services in our communities. Examples of these new roles include: advanced and extended scope paramedics, nurses, therapists and health science practitioners, physician associates and new types of health care support worker.

We are already seeing the benefits of advanced nursing, advanced therapist and advanced paramedic roles both in our hospitals and working in community settings and we envisage developing more of these roles in the future.

The new community model will mean close working with our colleagues in social care and the voluntary sector, and we will explore opportunities around new roles that will make working together easier and better for patients.

Whilst we are already working with university partners to increase numbers of clinical students able to take advantage of the millions of healthcare interactions in Hywel Dda, when we get to the point of deciding on the future model we will work with our university partners to design and commission training to develop the roles required.

Some of our proposals reduce the number of main hospital sites and this will have some benefits as we currently struggle to staff all our sites and are heavily reliant on temporary and agency staff.

In the proposals that have a major new hospital, we believe there will be significant opportunities to improve recruitment. The purpose built, new facility will have modern clinical facilities, latest technology, and education, research and training facilities which will be attractive for staff.

We understand that changes to their place of work may mean an increase in travel times for some staff. We will be working to understand this impact and considering how we can help (e.g. park and ride schemes). Of course, the changes will also mean that some staff have less travel.

Existing facilities – our estate

Other factors that we need to take into consideration include the current facilities on all of our sites and our current planned development to see what would impact on the proposals.

Our three main considerations are:

- the age profile of our current hospitals and facilities;
- how well we comply with modern healthcare space standards to support clinical delivery;
- the high level of backlog of maintenance work on our current hospitals and facilities.

As part of The Big Conversation you told us that some of the general hospital sites are not fit for purpose now, let alone for the future. Parts of our hospitals are old, with some areas built over 60 years ago. Over 51% of our current estate is over 32 years old. This presents considerable challenges in terms of running costs and maintenance, meaning that it costs us more to keep our hospitals open and up-to-date.

We have delivered a number of improvements and know that these have had a positive effect in many areas (including a new Accident and Emergency Department and Renal Dialysis Unit at Withybush Hospital; an upgraded Clinical Decisions Unit in Glangwili Hospital; improvement of the front of house in Bronglais District General Hospital; and a new acute Medical Assessment Unit in Prince Philip Hospital). Despite our ongoing investment, we are not seeing a reduction in the maintenance backlog. This is because, despite some major developments in some cases, there are still large parts of our operational estate that require major upgrading to meet modern day standards.

Opportunities to develop and modernise some of our existing sites is very limited. For example, to build or extend our current hospitals any further would be challenging because of limitations to the space available. Making any improvements on a working hospital site is also problematic as noise and vibration can impact on clinical services.

Something that we have heard time and time again, from the public and staff, is the issue of parking on some of our sites and we have heard many stories about the impact on appointments from patients not being able to park. We know this also causes frustrations for family and friends visiting patients in hospital.

The opportunities presented by building a new and purpose-built hospital for urgent care (in proposal C), or for urgent and planned care (in proposals A and B), would therefore go some considerable distance towards addressing these challenges. By designing a new hospital which is modern and delivers the highest standards of healthcare, we can improve the experience for patients and staff, whilst also improving efficiencies in the overall running of our estate, and improving sustainability.

Adapting some of our existing facilities into community hubs will also provide us with the opportunity to modernise our existing estate. Keeping the best features and rationalising what is no longer fit for purpose will also help to minimise the impact of some of our current constraints.

However, the proposals do also present some challenges.

All proposals are dependent on the ability to secure additional investment for new buildings. We will work closely with the Welsh Government on how we could translate any emerging proposals into deliverable plans that they are willing to fund.

In all proposals a new site would need to be identified, either for a major urgent and planned care hospital in proposals A and B, or a new urgent care hospital in proposal C. This is a time consuming and detailed process, which may extend the amount of time it takes for a new hospital to be built.

Repurposing or refurbishing facilities will also require significant investment to ensure that we are able to upgrade the sites to provide the standards we would expect to deliver modern healthcare and to deal with any maintenance backlog.

In some cases we may need to demolish parts of the facilities which will cause significant disruption and have a big impact on keeping the facility in use whilst we are developing it.

Whatever developments we need to make to our buildings, we will do so in a planned way that has the least impact on patients and staff.

You can read more information about our estate and buildings here **http://bit.ly/2G6ouBs** .

Technology

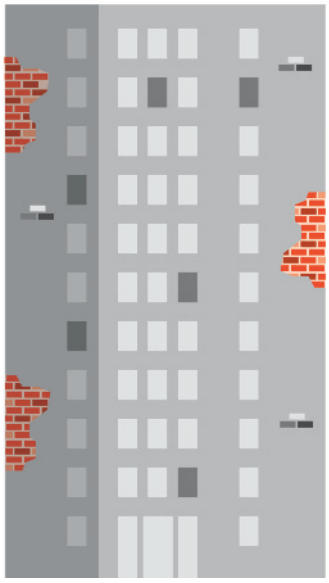
Throughout the engagement process we have heard that technology and digital solutions will be a key enabler to support the delivery of the proposals outlined within the document.

When we talk about technology, we are talking about a range of different technologies to enable care closer to home. This includes being able to monitor and check your own results at home or within a community facility; having appointments with a specialist over the internet, via Skype; using a suite of diagnostic tools currently available via smartphone applications; improved access to online resources to enhanced health promotion and make you in charge of your own healthcare. Technology that monitors your health remotely via appropriate medical devices and linked technology; and using systems to better share information between health and care professionals will ensure that you get the best care available when required.

Making the most of technology can:

- improve access to services and minimise the impact of unnecessary travel;
- support more care closer to or in your own home;
- reduce the amount of time you have to spend in hospital;
- expand the range of ways in which professionals can spot problems and initiate early and appropriate intervention;
- help you better manage your own care;
- improve the way information is shared between health and social care;
- help staff work flexibly from more locations, based on service user need;
- create a 'partnership' between patient and clinician.

The opportunities offered by building new hospitals, such as a major urgent and planned care hospital in proposals A and B, or a new urgent care hospital in proposal C, means that we would be able to factor modern, technologically advanced services into the design to improve the experience for the patient as well as the staff. In many cases this



will be easier than refurbishing what we currently have, as many of our existing facilities will not have the infrastructure to support such advances.

However, in all the proposals we also have an opportunity to adapt what we have and make the best use of resources. Simply providing our existing workforce with improved technology can go a long way towards addressing some of the challenges we currently face.

It is also important to consider that, due to our geography, some areas do not currently have adequate information and communication technology (ICT) infrastructure to fully support remote healthcare. We will have to explore opportunities for future investment to address this.

You told us that joined up information systems would support better integration of health and social care. We are already investigating the possibility of introducing a single electronic patient record for community health and social care called the Welsh Community Care Information System (WCCIS). This will deliver benefits for staff working within the community and will fundamentally underpin our approach to delivering more care within the community and closer to home. The opportunity to co-locate services within the community hubs as part of proposals A, B and C will also enable us to further support existing advances in shared IT systems.

Further detail on the work we have been doing regarding technology can be seen here: **http://bit.ly/2G6ouBs** .

6. PLEASE TELL US WHAT YOU THINK

Now we have given you some information about our proposals for change, we would like you to tell us what you think.

Please respond to the questionnaire attached to this document or by following this link to **www.hywelddahb.wales.nhs.uk/Hddchange** .

- Completed questionnaires should be returned to: **OPINION RESEARCH SERVICES, FREEPOST (SS1018), PO Box 530, Swansea, SA1 1ZL** (you will not need a stamp).

You can also tell us what you think:

- Over the phone by calling us **01554 899 056** (we will call you back so you do not have to pay for the call). You can leave a message on the answerphone if you need to call before 9am or after 5pm;
- By emailing us: **hyweldda.engagement@wales.nhs.uk;**
- Face-to-face at one of our public drop-in events (see page 6).

7. NEXT STEPS

We will not take any further steps until this consultation has closed on 12 July 2018. All responses will then be analysed by a team of independent experts.

It is important for us to hear your views and suggestions. We will consider them and test the impacts and consequences of them, together with what our doctors and other health professionals say, and the standards we have to meet. We will detail all this in a consultation closing report which will explain how feedback has influenced our thinking around the proposals. The programme will put forward a recommendation to the Health Board's Directors and Independent Members on the way forward so they can decide what they want us to do.

We plan to have these discussions in a meeting of the Health Board in public in the Autumn of 2018. Depending on the level of change needed, and the possibility we may need to approach the Welsh Government to apply for funding for any new buildings, and so it could take several years to fully put in place some of the changes agreed.

You will be able to read any of our reports and decisions on our website as part of the Board papers or at the dedicated web resource **(www.hywelddahb.wales.nhs.uk/Hddchange),** or you can request a printed copy by getting in touch with us. We will also share this information widely to those who have asked to keep up-to-date on developments and by issuing updates on our social media channels and through the local media.

PRIVACY STATEMENT

The Health Board has contracted Opinion Research Services (ORS) in Swansea to help manage aspects of the consultation including reporting feedback. We're collecting your information as part of this consultation so we can use your views to help us with our decision making about improving health services. The Health Board is using consent as a legal basis for using your personal data.

By completing the consultation questionnaire and/or by writing, e-mailing or sending in any consultation responses to the Health Board or ORS where you provide us with your personal information, you are giving the Health Board and ORS consent to use the personal information you provide for the purposes laid out above. You are able to withdraw your consent at any time and details are provided below about how to do this.

As part of the consultation the Health Board and ORS will be collecting the following information about you when you complete the consultation form:

- Your full postcode.
- Your views about health services.
- Equalities monitoring information: the Health Board and ORS are collecting this information to ensure we have a good representation of views and responses from different individuals across the Health Board area.

No identifiable personal information will be shared in any consultation reports or public forums.

For written consultation responses received from individuals via post or email, we will collect the name and postal or email address provided.

We will not share your personal data with any other individuals or organisations outside of the Health Board and ORS. An anonymised copy of the results of this consultation will be shared with the Community Health Council but no individuals will be identifiable from the information provided.

The health board and ORS will hold any personal information provided until any outcomes of the consultation are implemented, or for a maximum of 7 years. Your information will then be securely deleted by the Health Board or ORS.

You have the following rights in relation to your personal information being collected for the purposes of this consultation:

- Right to access – you can request a copy of the personal information being held about you by the Health Board or by ORS.
- Right to rectification – you have a right to request the Health Board or ORS to amend any inaccuracies in the personal information being held about you.
- Right to erasure – you have the right to request that your personal information is deleted by the Health Board or by ORS.
- Right to restrict use – you have the right to ask the Health Board or ORS to restrict how it is using the personal information held about you.

There is no obligation to participate in any part this consultation, but by participating you can help to shape the future of health services in the area.

If you would like to carry out any of the rights above then please contact the Information Governance Team by emailing

Information.Governance.HDD@wales.nhs.uk or writing to **Information Governance Team, IT Building, Withybush General Hospital, Haverfordwest, SA61 2PZ.**

The Data Protection Officer for ORS can be contacted at **dpo@ors.org.uk**

You have the right to complain to the Information Commissioner's Office if you are unhappy with the way in which your personal information has been used or held by the Health Board. The Information Commissioner's Office can be contacted by phone: **0303 123 1113** (local rate call charges apply) or by e-mail: **casework@ico.org.uk**

For any further enquires please contact: Hywel Dda University Health Board, Corporate Offices, Ystwyth Building, Hafan Derwen, St Davids Park, Jobswell Road, Carmarthen, SA31 3BB or Opinion Research Services, Strand, SWANSEA, SA1 1AF.

GLOSSARY

24/7: 7 day services, 24 hours a day.

A&E: Accident & Emergency department.

ABMU Health Board: Abertawe Bro Morgannwg University Health Board.

Acute hospital care: Short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

AMAU: Acute Medical Assessment Unit, where patients attend for assessment of acute medical illnesses.

Ambulatory care: Ambulatory care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital. You will receive the same medical treatment you would previously have received as an inpatient. The aim of this service is to provide you with the care required to treat your condition during scheduled ambulatory care opening hours. You will be able to return home and if further treatment is required you will be asked to return to the unit to receive this.

ARCH: A Regional Collaborative for Health between Swansea University, Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board.

BCUHB: Betsi Cadwaladr University Health Board.

BMI: Body Mass Index.

Care co-ordinator: A role to supervise interdisciplinary care by bringing together the different specialists whose help the patient may need, the coordinator is also responsible for monitoring and evaluating the care delivered.

CHC: Community Health Council.

Commissioning: The process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

Community health services: Community health services cover 'cradle-to-grave' services that many of us take for granted. They provide a wide range of care, from supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions. Most community healthcare takes place in people's homes. Teams of nurses and therapists co-ordinate care, working with professions including GPs and social care. Additionally community health provides preventative and health improvement services, often with partners from local government and the third sector. Although less visible than hospitals, they deliver an extensive and varied range of services.

Community hospital: A non-specialised hospital serving a local area. (Also see general hospital.)

Community hub: A site which delivers community services.

COPD: Chronic obstructive pulmonary disease.

CT: A CT (computerised tomography) scanner is a special kind of X-ray machine.

Day case surgery: A patient who is admitted to hospital or day patient unit because they need a period of medically supervised recovery, but does not occupy a bed overnight.

Diagnostics: Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

ECT: Electroconvulsive therapy.

Elective operations: Any planned surgery occurring in a non-emergency situation. This includes day surgery and short stay procedures as well as outpatient appointments at hospital.

Emergency care: Hospital-based service available 24 hours, seven days a week for urgent medical care and medical and surgical emergencies that are likely to need admission to hospital.

EMRTS: Emergency Medical Retrieval and Transfer Service. EMRTS Cymru is also referred to as the Welsh Flying Medics.

ENT: Ear, nose and throat.

General hospital: A non-specialised hospital, treating patients suffering from all types of medical conditions. (Also see community hospital.)

GP locality: A smaller group of GP practices within the Hywel Dda area. There are 8 localities in Hywel Dda.

GP: General practitioner. A doctor who is on the GP register (a register of doctors who are able to work in general practice in the health service in the UK) of the General Medical Council and who has a current licence to practise.

HDUHB: Hywel Dda University Health Board.

High dependency unit: The place in a hospital where critically ill patients are treated, and need more monitoring and treatment than can be provided on a general ward.

ICT: Information and communication technology.

ICU: Intensive care unit: Intensive care units (ICUs) are specialist hospital wards that provide treatment and monitoring for people who are very ill. They're staffed with specially-trained healthcare professionals and contain sophisticated monitoring equipment. ICUs are also sometimes called critical care units (CCUs) or intensive therapy units (ITUs).

IMTP: Integrated medium term plan: Planning document based on a three year planning cycle that is required by the Welsh Government by each Health Board within Wales.

Informatics: The science of processing data for storage and retrieval.

Integrated care: Care which is co-ordinated around the patient, making sure all parts of the NHS and social care work more closely and effectively together.

IT: Information technology.

Junior doctors: Qualified medical practitioners working whilst engaged in postgraduate training.

Lifestyle behaviours: People's lifestyles – whether they smoke, how much they drink, what they eat, whether they take regular exercise – affect their health and mortality. It is known that each of these lifestyle risk factors is unequally distributed in the population, and can co-occur or cluster in the population.

Locum and agency staff: A medical professional who temporarily fulfils the duties of another.

Long term conditions (LTC): A medical condition that cannot be cured, but can be managed by treatment such as medication and other therapies. Examples include diabetes, heart disease and dementia.

MIU: Minor injuries unit, for assessment of injuries that are not serious.

MRI: Magnetic resonance imaging, a diagnostic tool that uses magnets and radio frequency waves to take cross sectional images of body structures.

Multi-agency provision: Services that are provided by more than one organisation, for example health, social services, education, housing and the voluntary sector, to help improve the experience patients/clients have, and to reduce duplication.

Multi-morbidities: Multiple long-term conditions.

Multi-professional team: Teams made up of people from different professions.

Network of care: Organisations working more closely together in the community, including primary, community and social care, and the voluntary sector, to offer more care and support closer to home. This can involve the provision of services in a building, such as a community hub or hospital, within a patients home, or even virtually.

NHS: National Health Service. First started in 1948, it was designed to provide free healthcare to all in the United Kingdom. It has expanded rapidly, funding research and providing care for people in all medical fields.

Out of Hours (OOH): The period of time outside of normal working hours, usually meant to be before 9am and after 5pm and on weekends.

Outpatient: A patient who attends an appointment to receive treatment without needing to be admitted to hospital (unlike an inpatient).

Phase 1: The first phase of our Transforming Clinical Services Programme. This involved listening to the views of local people and patients who have used our healthcare services, through our engagement exercise The Big Conversation; and examining our current services in detail with our doctors, nurses and healthcare professionals.

Phase 1 output report: The report we wrote at the end of Phase 1, to summarise what we found out.

Pathology: A branch of medicine looking at the causes of disease and illness. This includes examining biopsies, blood tests and post mortems.

Physician associates: Medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of a multidisciplinary team. Physician associates are dependent practitioners working with a dedicated medical supervisor, in the diagnosis and management of patients, but are able to work autonomously with appropriate support.

Planned care: (also known as elective care or elective surgery) – a planned operation or medical care.

Point of care testing: Tests that doctors, nurses and other healthcare professionals can do quickly and simply which return results straight away, so that appropriate treatment can be given. Point of care tests do not need sophisticated laboratory equipment.

Population health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

Poverty and deprivation: Poverty is the lack of a certain amount of material possessions or money. Poverty is a multifaceted concept, which may include social, economic, and political elements. Absolute poverty, extreme poverty, or destitution refers to the complete lack of the means necessary to meet basic personal needs such as food, clothing and shelter. Relative poverty occurs when a person who lives in a given country does not enjoy a certain minimum level of 'living standards' as compared to the rest of the population of that country. Deprivation is the lack of access to opportunities and resources which we might expect in our society. This can relate to both material and social aspects of deprivation. Material deprivation is having insufficient physical resources – food, shelter, and clothing – necessary to sustain a certain standard of life. Social deprivation refers to the ability of an individual to participate in the normal social life of the community.

Primary care: Primary care is the day-to-day healthcare given by a healthcare provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and co-ordinates other specialist care that the patient may need. Patients can access primary care services through their local general practice, community pharmacy, optometrist, dental surgery and community hearing care providers.

Proactive case management: Identification of people at risk of unnecessary hospital admissions and an approach to address their individual needs across health and social care to prevent crises from occurring.

Procurement: The process of finding, agreeing terms and acquiring goods, services or works from an external source, often via a tendering or competitive bidding process. The process is used to ensure the buyer receives goods, services or works at the best possible price, when aspects such as quality, quantity, time, and location are compared.

Provider: An individual or an organisation that gives a service in return for payment.

Prudent healthcare: The four principles that guide the NHS in Wales. These are: Public and professionals are equal partners through co-production; care for those with the greatest health needs first; do only what is needed and do no harm; and reduce inappropriate variation through evidence-based approaches

PSBs: Public service boards.

Risk stratification: A tool for identifying and predicting which patients are at high risk or likely to be at high risk.

Secondary care: Secondary care includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services. The term 'secondary care' is sometimes used synonymously with 'hospital care'. However, many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists, most dental specialties or physiotherapists (physiotherapists are also primary care providers, and a referral is not required to see a physiotherapist), and some primary care services are delivered within hospitals.

Silo working: A system, process, department, etc, that operates in isolation from others.

Social determinants of health: The broad social and economic circumstances that together influence health throughout the life course.

Social media: Computer-mediated technologies that facilitate the creation and sharing of information, ideas, career interests and other forms of expression via virtual communities and networks.

Social model for health: The social model of health considers a broader range of factors that influence health and wellbeing, for example, environmental, economic, social and cultural.

Social prescribing: Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Social Services and Well-being (Wales) Act (2014): The Social Services and Well-being (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Step-down beds: An alternative to early supported discharge when the patient cannot be supported at home but no longer needs to be in an acute hospital.

Step-up beds: An alternative to hospital admission when the patient cannot be supported at home but does not need to be in an acute hospital.

Targeted intervention: The 'NHS Wales Escalation and Intervention Arrangements' level at which the Health Board is placed. This is noted as an action to deal with a serious issue within the Health Board – there are three types of intervention, each an escalation from the previous namely:

- Enhanced Monitoring
- Targeted Intervention
- Special Measures

Transforming Clinical Services programme (TCS): Transformation programme to deliver a healthcare system of the highest quality, with excellent outcomes for patients.

Telemedicine/Telehealth: Use of telecommunication and information technology to provide clinical healthcare from a distance.

Tertiary care: Tertiary care is specialised consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

Third sector: 'Third sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

Unscheduled care services: Accident and emergency care services.

Virtual clinics: A planned contact by the healthcare professional responsible for care, with a patient for the purposes of clinical consultation, advice and treatment planning.

Wales Ambulance Service NHS Trust (WAST): Provides high quality pre-hospital emergency care and treatment throughout Wales.

WCCIS: Welsh Community Care Information System.

Well-being of Future Generations Act 2014: The Well-being of Future Generations (Wales) Act 2015 is about improving the economic, social, environmental and cultural well-being of Wales through sustainable development.

West Wales Area Plan: The West Wales Regional Partnership Board's plan for how partners will work together over the next five years to continue the transformation and integration of care and support in West Wales, in line with the aims and values that underpin the Social Services and Well-being (Wales) Act.

West Wales Regional Partnership Board: A Board established to drive the strategic regional delivery of social services in close collaboration with health.

Whole system: An approach that recognises the contribution that all partners, including patients, make to the delivery of high quality care.

WHSCC: Welsh Health Specialised Services Committee.

Trawsnewid ein gwasanaeth iechyd

Hywel Dda

Our big NHS change

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board