Bundle BCU Health Board 30 July 2026

1 SUPPORTING PAPERS

1.1 26.139 Chief Executive Report and Escalation Progress Report
- 26.139.1 Escalation Board 9 July - Main Slides
- 26.139.2 Special Measures Monthly Report - June 2026

1.2 26.141 Supporting Papers for Tywyn Community Hospital - Case for Change
- Appendix 1 - Services available to meet population Health Need
- Appendix 2 - Welsh Language Impact Assessment
- Appendix 3 - Outpatient Services at Tywyn Community Hospital
- Appendix 4 - Tywyn Community Hospital Service Review Pre Consultation Engagement Report
- Appendix 5 – Balanced Room One Output Report
- Appendix 6 – Balanced Room Two Output Report
- Appendix 7 – Options Appraisal Sessions
- Appendix 8 - Tywyn Options Technical Appraisal Report
- Appendix 9 - Quality Impact Assessment
- Appendix 10 – DRAFT Integrated Equalities Impact Assessment and Socio-Economic Duty
- Appendix 11 - Tywyn Community Hospital Services Travel Impact Assessment discussion document
- Appendix 12 - References

1.3 26.153 Supporting Papers for Corporate Governance Report
- CG Appendix 1 - Corporate Policy Management Policy ENG v1.00
- CG Appendix 2 - Corporate Policy Management Procedure v3.00 ENG
- CG Appendix 3 - All Wales Approved Clinicians and Section 12-2 Doctors July 2026 Board Report
- CG Appendix 3.1 - Approved Clinicians Data - July 2026 Board report
- CG Appendix 3.2 - Section 12(2) Doctors Data - July 2026 Board Report
- CG Appendix 4 - SSPC Assurance Report 14 May and 25 June 2026

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Escalation Board: 9 July 2026

Meeting Information Pack

Agenda and Supporting Information

AGENDA

Welcome, purpose and opening remarks	CMHC
Recent correspondence 20260608 - Cabinet Minister Letter to BCU 2026.06.23 Nick Wood letter to Dyfed 20260626 - Dyfed Edwards letter to Nick	CMHC
Opening remarks	BCUHB Chair
Leadership (Well-led) • Leadership capacity, capability, and working practices • Oversight mechanisms of the Board • Organisational structure, culture and future improvement plans	BCUHB
Delivery/Performance • Progress against recovery plans and trajectories for o Planned care and diagnostics o Urgent and Emergency Care o Cancer	BCUHB
Quality • Oversight and governance arrangements for quality, safety and patient experience • Key operational quality and safety risks and mitigations	BCUHB
Finance/Planning • Progress against financial recovery plan, savings plan and opportunities pipeline • Clinical services strategy • Estates strategy and redevelopment - Royal Alexandra Hospital; North Wales Surgical Centre; Ablett Unit • Service change plans	BCUHB
Workforce • Foundations for the Future - key principles, progress to date, milestones and expected outcomes	BCUHB
Summary and next steps	CMHC

Supprting information slides

Section	Slide numbers
Leadership	2-14
Delivery/Performance	15-36
Quality	37-48
Finance/Planning	49-59
Workforce	60-61

Attendees from the Health Board

Dyfed Edwards - Chair	**Carol Shillabeer – Chief Executive**
Gareth Williams – Vice Chair; Chair: Performance, Finance and Information Governance Committee	Teresa Owen – Executive Director Allied Health Professionals and Health Scientists
Clare Budden – Chair: Planning, Population Health and Partnerships Committee	Dr Clara Day – Executive Medical Director
Sir Paul Lambert – Chair: Audit Committee	Russell Caldicott – Executive Director of Finance
Caroline Turner – Chair: Quality, Safety and Experience Committee	Tehmeena Ajmal – Chief Operating Officer
	Paolo Tardivel – Interim Executive Director of Strategy and Planning
	Pam Wenger – Director of Corporate Governance
Apologies: Angela Wood, Executive Director of Nursing	

Leadership (Well Led)

Where we were (baseline 2023)	Where we are now (current)
- Audit Wales 'Board Effectiveness' points to dysfunction; significant breakdown Board relationshsips leading to Escalation; Accounts Issue (highly contentious) - Directly appointed Independent members (x4); no governance committees in place; no CEO; 50% Executive team - Significant organisational cultural issues	- Board Effectiveness confirmed by Audit Wales and significantly improved. Structured Assessments confirm continuous improvement. - Cultural Change Programme well-established – Board-led - Exec Team turnover, presents challenge - Strengthening wider organisational leadership crucial
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Well-Led Review – monthly reporting, final report October. Establishing internal mechanism as more information becomes available. - Executive Recruitment: Exec Director Nursing; Chief Operating Officer; Exec Director of Finance - Implementation of Foundations for the Future 'People' workstream – leadership development/talent management - Cultural Change Programme Phase 2 implementation (Michael West continues to support), with over 200 Culture Change Leaders now in place - Board Development Programme agreed (12 months), to build on development already undertaken.	- Outcomes of Well-Led Review (People and Culture Committee/whole Board) - Substantive recruitment into Executive Team roles (Remuneration Committee oversight) - 'People' workstream (FftF) outcomes achieved (P & C Committee) - Cultural Dashboard results; Organisational Development Intervention approach for teams in need of additional support/intervention (P & C Committee) - Outcome tracking part of Board Development Programme (whole Board); Structured Assessment 2026 – Audit Wales (revised format)

See Supplementary Information slides

Delivery/Performance – Planned Care, Cancer & Diagnostics

Where we were (baseline 2023)

- Significant outlier on performance; with increasing referral rates outstripping capacity (worsening position particularly regarding cancer which saw a doubling of referrals over 5 year period)
- Limited Executive oversight – recovery plan of £80M unfunded - wholly reliant on outsourcing
- No Chief Operating Officer; individual Integrated Health Community working
- No Performance Committee

Where we are now (current)

- Over 104 weeks waits: Cohort **49,600** (end July 2025), down to **2,340** (end June 2026). Meeting de-escalation standard of 97% of people waiting less than 104 weeks. Tracking above IMTP trajectory
- Over 52 week waits: Cohort **155k** (August 2025), down to **32K** (end June 2026). Not yet meeting de-escalation standard of 98% of people waiting under 52 weeks for first outpatient
- Cancer: Reaching 54% against mean of 60% across Wales. Issues: skin, urology, gastroenterology, breast. Not yet meeting de-escalation standard of 55%
- Diagnostics: significantly improved. On track to meet IMTP trajectory. Risk for 2nd half of year – to be fully mitigated

Where we intend to get to next (plan)

- 104 weeks – intend to get to zero. Plan submission 19th July; Board oversight.
- Over 52 weeks – intend to meet de-escalation standard.
- Cancer – plan to meet de-escalation standard and move beyond. New plan for skin final stages.
- Diagnostics – plan to get to de-escalation standard. Risk mitigation underway
- Critical underpinning: more pan-BCU working, moving toward single PTL to improve Treat in Turn rates; internal capacity maximisation and shift of pathway.

How we will know we get there (results/assurance)

- Recovery Director bringing additional capacity and expertise; support needed to shift to single PTL for priority specialties
- Overarching Planned care, cancer and diagnostics plan – key milestones being met, plus intended impact being delivered
- Weekly oversight – Chair and Vice Chair; PFIG scrutiny; whole Board focus
- Submission of 104 week plan and wider planned care plan to WG – ensure full alignment internally to performance reporting – reset trajectory tracking (results).

Delivery/Performance - UEC

Where we were (baseline 2023)	Where we are now (current)
- Significant longstanding challenges in relation to performance at Wrexham Maelor Hospital (4 hours/12 hours); Ysbyty Glan Clwyd (HIW escalation in 2022); less so in Ysbyty Gwynedd (award winning doctor training programmes), however significant issues relating to pathway of care delays.	- Pan-BCU UEC plan in final stages (with input of external advisors and NHS P and I); underpinned by each IHC plan given differing patterns of challenge and opportunity - Single biggest area of concern for Board - approved workforce sustainability business case; Board UEC Oversight Group established - Ysbyty Glan Clwyd ED Improvement Plan (HIW) in place; assessment complete from other 2 DGHs - Handover 45 plans developed – YGC plan aligned to HIW response
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Implementation staffing business case to improve demand capacity balance/resilience/safety - Reduction number Pathway 3 patients - New Integrated Discharge Hub (YG); New Urgent Treatment Centre (YGC); Estate/special modifications – WMH and YG - Handover 45 - implementation - Shared Purpose with Local Authorities as aim 50% reduction in bed days delayed by end March 2027 - YGC specific plan – culture, leadership, clinical safety - Improved patient and staff experience feedback	- Agreed UEC plan with tracking of actions in line with agreed milestones, underpinned by each IHC 90 day delivery cycles (PFIG and QSE Committee) - Patient experience feedback (QSE) - Focus on Handover 45, including delivery of reduction in community waits – improved performance information regarding WAST access - Reduction pathways of care delays (PFIG/QSE)

Quality

Where we were (baseline 2023)	Where we are now (current)
- No Quality Committee in place - Highest number of Prevention of Future Death Notices from HM Coroner in Wales (more than other HB collectively) – key issues: investigation process, lack of Electronic Health Record, urgent and emergency care pathways. - Poor complaint management processes; no citizen experience reports at Board/Committee; lack patient experience feedback - No Quality Management System; immature approach to Clinical Audit; Service oversight	- Effective Quality Committee; Audit Wales Quality Governance Review influencing next stage of development - Citizen Experience reporting quarterly regularly at Board; good feedback rates from patient. Focus on ED patient experience (poorest rating of all services) – biggest safety and experience issue. - QMS in place, now next stage development – focusing on 'fragile' services aligned to Clinical services Plan and FftF. - Significant progress on investigations – lower number PFDs; - Mental Health Electronic Health Record secured
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Implement recommendations from Quality Governance Review - Simplify and strengthen internal quality governance approach - Implement QMS for all 'fragile' services; focus on higher risks - Implement MH EHR; engage in national digital strategy to reinstate work on wider EHR (noting community EHR not supported in DPIF review) - Implement improvement plan for Urgent and Emergency care – particular focus on ED safety and experience	- Tracking implementation of Quality Governance Review actions (Quality, Safety and Experience Committee) - All 'fragile service' have QMS assessment and a Quality Improvement/Quality Control and Quality Assurance Plan (QSE Committee) - UEC Oversight Group (Board level) – assurance on implementation of improvement plan. Regular liaison with HIW - Significant incidents/investigations oversight and learning evidenced (QSE; HM Coroner – PFDs; PSOW)

Finance/**Planning**

Where we were (baseline 2023)	**Where we are now (current)**
- No Planning, Population Health and Partnerships Committee - No Special Measures Response Plan; No Annual Plan/IMTP – hence no plan tracking/implementation oversight - Planning approach very limited across organisation. External Review commissioned – Sally Attwood	- Integrated Planning Framework approved by Board Sept 2023, recently updated; Submitted 1st balanced IMTP (2025/26) although not approved - Planning, Population Health and Partnerships Committee well established; good oversight Annual Plan/IMTP formation and implementation - Planning Maturity Matrix – mainly Level 2. Immature operational service planning needing urgent work - Strategic Intent Statements (x4) – approved by Board Nov 2025, providing clear strategic vision and direction
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Implement the improvement actions aligned to Planning Maturity Matrix (aligned to Foundations for the Future) and Integrated Planning Framework – particularly related to operational service planning - Next stage development Strategy and Clinical Services Plan, building on Board approved Strategic Intent Statements/Vision; ensuring QMS assessment of 'fragile' services forms key part; with Community by Design at its heart - Implement Annual Plan 2026/27	- Tracking implementation of improvement actions (PPHP Committee) - Clinical Services Plan being developed and agreed implementation approach - now a Major Change Programme; tracking milestone delivery, testing leadership and engagement (PPHP Committee/whole Board) - Quarterly tracking of Annual Plan deliverables; including delivery confidence and escalation/recovery where needed (all HB Committees) – reported at Board

Finance/Planning

Where we were (baseline 2023)	Where we are now (current)
- £134M deficit plan with additional £50M savings plan not underwritten. - 'No opinion' on financial accounts by Audit Wales - Forensic investigation into financial irregularities (EY report) – including significant staff impacts, political scrutiny - No Audit Committee/Performance and Finance Committee - Limited effectiveness on internal financial controls (governance)	- Delivered financial governance improvement plan actions - Improved financial performance (2nd best HB) – each year. Set balanced plan, however missed by £17M 2025/26. - 'Clean bill of health' financial accounts for 3 years running - Value and Sustainability Approach established – delivering significant cost reductions - EY matter (including HR issues) now closed – Accountable Officer Report to Board 2025. - Challenged in-year financial environment – stage 1 – underwrite savings plan; stage 2 – stretch savings to achieve break-even position. Board discussions underway.
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Financial savings – end Q1 at least 50% savings identified and classified as 'green'. End July, August and Sept key milestones for further stretch (including Board level decisions). - Strengthen further Value and Sustainability approach and pipeline, focusing on clinical variation linking to national workstream, and workforce (noting wider system working on right-sizing the workforce). Balance Grip and Control. - Alongside Clinical Service Plan development, enable the medium-long term financial approach	- Underpinned savings plan, delivering to profile (Performance, Finance and Information Governance Committee) - Significant pipeline opportunities (moving from red to amber to green), including for 2027/28 and beyond. (PFIG Committee) - Medium-long term financial approach embedded into Clinical Service Planning, particularly regarding Community by Design and resource allocation/allocative efficiency (tested by PPHP Committee)

Workforce

Where we were (baseline 2023)	Where we are now (current)
- Significant gap in Professional leadership – no Executive Director of People and OD - No People and Culture Committee - Very high levels of external agency interim staff (at all levels) - No workforce planning function/no medical staffing function - No culture/OD development plans - High levels of vacancies; high levels of bank and agency - No Staff Experience reporting to Board - Limited strategic connection with Higher and Further Education	- People and Culture Committee well established; Exec Director. - Workforce Planning Framework/(small) function now in place - Strong Partnership Forum and JLNC - Significant reduction in external agency interims (targeted only) - Vacancies reduced; retention increased; investment in staffing levels (£12M in nursing; 300+ additional doctors last 5 years) - Culture Change Programme and OD approach; Staff Engagement and Experience Team/approach in place – however staff survey results mixed (higher participation a positive) - MOUs with Education institutes (new Medical School)
Where we intend to get to next (plan)	**How we will know we get there (results/assurance)**
- Workforce planning implementation aligned to 'fragile services' work to be completed - Value and Sustainability workforce workstream phase 1 implementation (largely transactional), and Phase 2 work-up (Right-sizing the workforce) - Culture Change Programme implementation of milestones - Foundations for the Future structural change programme – consultation and 'Delivery Phase; by end of year	- Alignment of clinical service plan, QMS, and workforce planning for 'fragile' services (P & C Committee with PPHP and QSE) - Fully worked up V and S Workforce Workstream, approved Phase 2 approach (P & C/PFIG committees) - Foundation for the Future Structures workstream delivered (P & C committee) - Culture Dashboard results, including OD interventions tracking (P & C Committee)

Special Measures – Escalation Board 9th July 2026

Special Measures De-escalation Criteria Report on Progress - as at: 2nd July 2026

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
Governance 1. A vision, credible strategy and supporting plans to deliver organisational priorities which are underpinned by a culture of quality, sustainable care.	Paolo / Kamala	Whilst an extant 10-Year Strategy was in place since 2018, it was developed by the previous Board, pre-covid and did not have any supporting delivery plans. It was acknowledged that a fresh 10-Year Strategy needed to be developed.	The Health Board has agreed four statements of strategic intent at the January meeting alongside feedback on a draft vision, developed following extensive partnership work. The new 10-Year strategy is currently in the Discovery phase which will be concluded during Q2. This is a supported by a clear Annual Delivery plan set within a 3-Year context, which is now structured around the four strategic intents, representing a further evolution of the Health Board's approach.	Health Board meeting – January 2026, where the four strategic intent statements were formally agreed by the Board.	The 10-Year Strategy needs to complete the discovery phase during Q2, design phase in Q3 and delivery through key underpinning strategic plans (e.g. Clinical Services Plan) in Q4 feeding the 2027-30 IMTP.	2nd line Organisational oversight
2. Governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated	Pam	Prior to 27 Feb 23 the Structured Assessment (22/23) noted that the Health Board is taking action to	The Structured Assessment recognises progress in quality governance, internal scrutiny and the tracking of recommendations, indicating improved organisational grip. It also identifies where	Structured Assessment March 2026	Further develop the Board Assurance Framework, ensuring strategic risks are clearly articulated,	3rd line Independent Assurance

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
appropriately through clear structures and processes with effective Board oversight and a clear performance and delivery framework that drives improvement.		strengthen some systems of assurance, however there remained significant weaknesses. resulting in lack of assurance that significant and ongoing risks and performance challenges are being addressed and that necessary improvements are being delivered. After 27 Feb 23 the Health Board re-established these systems with a new Board and Committee (with a limited number of IMs)	consistency still needs to be embedded, aligning with a trajectory-based de-escalation judgement.		consistently assessed and aligned with strategic intentions.	
3. Effective oversight and scrutiny being consistently provided by the Board and/or the appropriate Committee with clear evidence, recommendations,	Pam	Prior to 27 Feb 23. Low confidence in Board/Committee oversight, scrutiny and risk management.	The Structured Assessment recognises strengthened Board effectiveness, improved flows of assurance through Committees, and clearer scrutiny and challenge. This demonstrates a materially improved ability of the Board to oversee	Structured Assessment March 2026	• Strengthening the quality and standard of papers (with a clear quality and safety lens)	3rd line Independent Assurance

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
risks and opportunities outlined in Committee and Board papers.		Structures Assessment (22/23) noted poor quality and accuracy of some Board and Committee reports. After 27 Feb 23 there was a need to re-establish a new Board, Committee and Risk Management (with a very limited number of IMs)	performance, risk and delivery in line with de-escalation expectations.		• Improving the flow of assurance from Committees to Board, including escalation reporting • Enhancing the Board Assurance Framework as the primary decision-making tool, with clearer linkage to delivery and impact • Increasing Audit Committee oversight of assurance quality and control effectiveness • Driving a more integrated view across performance, finance and transformation, particularly where funding and impact need to align.	
4. An effective risk management framework for	Pam	Pre-27 Feb 2023 A risk management	The organisation has an effective risk management framework that supports consistent identification, recording	Risk Management Framework	Strengthen risk management capability,	3rd line Independent Assurance

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
identifying, recording and managing risks across the organisation. The Board and the relevant Committee is sighted on the organisation's strategic risks and areas of concern on a regular basis.		framework was in place. Corporate Risk Management and Board Assurance Risk were overseen by two different Health Board Directorates This led to a disjointed approach and limited effectiveness for Board and Committees. Internal Audit assessment reflected this. The Structure Assessment (2022/23) noted "Despite recent changes to the Health Board's strategic and corporate risk arrangements, risk scores in some key areas are not	and management of risks, Strategic risks and emerging areas of concern are routinely reported to, and scrutinised by the Board and relevant committee, meeting core de-escalation expectations for risk oversight and assurance. Internal Audit (Reasonable Assurance 2 years consecutively)	Internal Audit on Risk Management (two consecutive years)	embedding the revised Risk Management Framework, enhancing mandatory training, and maturing pr Proactive risk identification and escalation processes across all care groups and corporate teams.	

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
		decreasing. The Health Board should review the mitigating actions on the corporate risk register and Board Assurance Framework to ensure they are having the intended impact"				
5. Processes ensure the Board and the relevant Committees are provided with regular reports on performance to maintain an appropriate level of oversight and so they can scrutinise effectively.	Pam	Pre-27 Feb 2023. The Health Board was continuing to refine performance reporting into board and committees. However, there remained concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvement. At 27 Feb 2023. New Board and Committees established with recommendations	Clear performance reporting processes ensure the Board and relevant committees receive regular and timely reports, enabling appropriate oversight and effective scrutiny. This aligns with the 2025 Structured Assessment which recognises improving Board and Committee arrangements for performance oversight while noting the need to continue embedding consistency across the organisation	Structured Assessment March 2026	Review of the way in which the committees are operating and ensure appropriate assurances and reporting to the Board	3rd line Independent Assurance

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
		from Independent Review at early stage of development. Limited number of IMs to establish Committees. PFIG Committee was prioritised.				
6. Regular self-assessment against the agreed governance framework to identify risks and opportunities and ensure continuous improvement.	Pam	The Structured Assessment noted in Feb 2023 that "While there is reasonable ongoing administration of meetings, there is an urgent need to address some long-standing concerns around assurance arrangements at board and committee meetings, including ensuring an agreed position on the level of risk the board is prepared to tolerate within the	The organisation undertakes regular self-assessment against its agreed governance framework to identify risks and opportunities and drive continuous improvement. The 2025 Structured Assessment recognises this strengthening approach to self-reflection and improvement as evidence of increasing organisational maturity. improvement plan is in place which includes the improvement actions highlighted through the self-assessment process and audit reports.	Structured Assessment March 2026 Board Papers (May 2025)	Facilitated Board Development Programme in place (currently in the contract award phase)	Third Line of Defence - Independent

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		services it delivers. There is also a need to strengthen and stabilise arrangements around the Office of the Board Secretary"				
Leadership 1. Succession and development plan in place to ensure adequate capacity and capability in all areas of the organisation.	Debbie	Succession and development plan not in place at this time. Work commenced to ensure these elements will be put in place as part of FFTF design phase.	The Foundations for the Future Programme includes a Talent and Succession Planning component, with initial focus on redesigning the PADR process. The revised PADR is aligned to organisational values and behaviours and supports delivery of the Culture, Leadership and Engagement Improvement Plan. It introduces a more structured and balanced approach, strengthening the assessment of both performance and behaviours. This provides a key foundation for succession planning, enabling the early identification of talent and a clearer assessment of workforce readiness, supporting the development of a sustainable pipeline of future leaders and critical roles across the organisation.	FFTF programme board update slide deck 3/7/26	Pilot 3 System user testing of new forms and processes. August – September 26 Refine model based on insights following pilot September 26 Prepare organisation-wide rollout October 26 Ongoing alignment with development of NHS PADR framework	1st line operational
2. A clear organisational structure	Debbie George	Succession and development plan	There have been recent resignations within the executive team. This means			

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led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.	Nia Ffion J	not in place at this time. Work commenced to ensure these elements will be put in place as part of FFTF design phase.	that recruitment plans will be progressed to fill roles substantively. Interim arrangements will also be progressed as required. Exec team development support to commence in July. Organisational structures have been reviewed and are being revised as part of the Foundations for the Future programme with structures due for consultation following recent engagement and socialisation.			
3. Effective leadership programme in place to support ongoing development of leadership and management skills at all levels/professions to strengthen management maturity.	Debbie	Succession and development plan not in place at this time. Work commenced to ensure these elements will be put in place as part of FFTF design phase.	Significant progress has been made in delivering a comprehensive, tiered leadership development offer across the organisation, delivered through the Integrated Leadership Development Framework, with strong engagement, programme growth and positive early outcomes across all pathways. As an early adopter of the NHS National Leadership and Management Framework, work is underway to align the existing integrated leadership development framework to the national model. This includes mapping current provision against the framework and strengthening data collection to better understand the scale, reach and impact of programmes.	FFTF deep dive update 11th May 26 Annual evaluation reports year 25/26. Internal Audit report January 26 People and Culture Committee paper August 26	Ongoing development, delivery and evaluation of current programmes as per BAU. Alignment with National Framework timeline set by HEIW.	1st line operational

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			This will provide greater clarity on organisational coverage, identify gaps and inform future investment, ensuring leadership development is aligned to organisational priorities and supports a sustainable pipeline of leadership capability.			
4. Continued embedding of a values and behaviours framework throughout the organisation.	Debbie	Current values were not actively embedded throughout the organisation's fabric of the 'the way we do things around here', they were out of date and in need of refreshing. There wasn't a behavioural framework in place which clearly explained the minimum behaviours required from all staff and those in people management positions	• First Culture Change Leaders Celebration event delivered demonstrating the organisation's values in action • Case studies from the impact of Culture Change Leaders collated to support the dissemination of learning across the organisation • Elements relating to the Values & Behaviours are featured in our Quality Management System (QMS) • A Culture Health Assessment tool developed based on the Values & Behaviours Framework to measure and develop local team cultures • The Ripple Effect Workshop developed to explore personal impact and further embed the Values & Behaviours Framework	Culture Change Leaders Case Studies April 2026 - ENG	The Values & Behaviours Framework is a continuously evolving piece of work which will continue as we embed into all policies, systems and ways of working across the organisation	1st line operational – within People & OD services, regular updates provided. 2nd line Organisational oversight - People & Culture committee receives updates
5. Mechanisms in place to ensure lessons learned are recorded, communicated and	Debbie Sue Brierley Hobson		The Organisational Learning Forum (OLF) and Learning Repository have been introduced to strengthen existing arrangements. OLF acts as	• Learning primarily managed through	• Increase adoption beyond early	1st Line – Operational • Learning embedded

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used to drive improvements.			an additional forum for receiving and discussing learning, complementing established governance processes, while the Repository supports the capture, validation and sharing of organisational learning to improve patient safety and clinical practice. Strong foundations are in place with early benefits evident; however, delivery remains dependent on increasing organisational buy-in for the Learning Repository and dedicated digital capacity. The Learning Repository is live but still developing, with uptake currently concentrated in early adopter areas.	existing governance processes • Learning Repository live with steady but progressive uptake, mainly in early adopter areas • OLF supports cross-organisational discussion of learning themes	adopter areas – *2026–2027* • Improve alignment between forums and Repository – *Q3–Q4 2026* • Strengthen digital capacity to support scale-up – *2026–2027* • Evidence impact on practice and outcomes – *late 2026 onwards* • Full embedding now expected – *2027/28*	locally through existing processes • Repository use remains inconsistent and focused in early adopter areas 2nd Line – Organisational Oversight • OLF and Repository support visibility and sharing but are still maturing • Phased rollout of the Learning Repository and targeted engagement in place 3rd Line – Independent Assurance • Moderate assurance (Amber)

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
						• Risks to pace and full adoption due to variable buy-in, clinical pressures and limited digital capacity
6. Improved staff engagement in NHS Wales surveys.	Debbie Katie Sargent	2024 staff survey participation rate 17.4% of workforce	BCU achieved a completion rate of 24.9% (5,203 staff) for the NHS Wales staff survey in 2025, which represents a 45% increase on the number of surveys completed in 2024 (3,577). This exceeded our target of 23%. We achieved the second highest number of completed surveys in NHS Wales following a concerted campaign to promote and encourage involvement, including prize draws, *We Said, We Did* posters and highlights of best practice via internal channels. Learning from 2025 is being incorporated into our plans for 2026.	HEIW NHS Wales staff survey dashboard Reports to People and Culture Committee and Health Board (May 2026)	Oversee further embedding of local ownership for survey participation rates via local People and Culture Committees, supported by an organisational approach.	1st line operational – within People & OD services, regular updates provided. 2nd line Organisational oversight - People & Culture committee receives updates 3rd line Independent Assurance - HEIW share our learning with other health boards.

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7. Plans are in place and being implemented to reduce the number of interim and agency staff.	Debbie	Significant spend across nursing and medical agency usage alongside significant number of interims across the organisation.	Substantial reductions made in usage of interims and agency staff and the development of the leadership framework and succession planning further solidifies this progress for future benefit. There has been significant reduction in nursing agency usage and steady reduction across all staff groups except medical staffing.	PFIG Committee papers which demonstrate the reduction in agency usage. Details within finance reports. IPEDG data packs.	More work in tightening grip and control in terms of medical and agency usage and keeping close oversight across all other staff groups. To achieved by end of Q2 / early Q3 2026/27.	1st line operational - Processes are in place to ensure sign off of agency usage as a clear escalation process and complies with current SFIs. 2nd line Organisational Oversight - Exec oversight and monitoring in place to ensure appropriate agency usage based on clinical risk. 3rd line Independent Assurance - Agency usage reported as part of IPR which is reported through PFIG and to Board as per meeting cycle.

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
8. A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including patient, user and staff feedback.	Debbie Nia Thomas	No formal evidence based programme in place to provide a comprehensive framework for culture development.	A formal evidence-based culture and leadership programme is in place. The Discovery phase of the programme has concluded and culminated in a Synthesis report presented to Board in November 2025 along with a 3 year culture, leadership and engagement improvement plan. Cohort 3 of Culture Change Leaders Induction programme will commence mid-July, taking the total number of CCLs to 329 across the organisation. Case studies have been compiled to share learning and best practice at grass roots level. a programme of Share and Learn coffee mornings are being developed to take place across DGH and Community sites to disseminate learning from CCL activity. BCU are supporting the development of a national culture and staff experience dashboard, our organisational culture dashboard has been shared with colleagues in HEIW	 2025_11_27 Health Board_Culture Synth	Ongoing delivery and monitoring progress of the Improvement Plan. Ongoing recruitment of CCL's. Ongoing development, collation and sharing of CCL's case studies for organisational learning.	1st line operational – within People & OD services, regular updates provided. 2nd line Organisational oversight - People & Culture committee receives updates
Population Health and Prevention Primary and Community Care 1. Demonstrate that primary and community care is supported by strong clinical	Tehmeena	There has not been a Director of Primary & Community Care in post Recruitment is pending FFTF. Other key vacancies across	A Primary Care Board has been established for some time with an integrated improvement plan in place, including a key focus on workforce development and Accelerated Cluster Development. This Board will now evolve into a Community by Design Board.	Executive Committee, PPHP and Board minutes evidence the discussions and agreed actions relating to Community By Design.	Need to move into development of the Community By Design plan which will be aligned to the national plan once finalised. Recruitment to the leadership roles.	2nd line organisational oversight.

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
leadership, at Board and Executive level, an effective integrated improvement plan, project management structure and effective transformation support.		Primary and Community Care also.	Discussions held at Board Committee level regarding Community By Design, objective purpose and agreed allocated funding to support this work. Programme Manager funding identified to lead the work.			
2. Evidence of improved activity within community opportunities, urgent primary care centres.	Tehmeena	There was no evidence of improved activity opportunities or increase activity within community services and urgent primary care centres.	Progress made in moving a number of services from secondary to community setting, including the Women's health hub, audiology, ophthalmology and dental. The development of Health and Well-being hubs will advance this work further. There is a developing strategy surrounding Health & well-being hubs – RAH in progress and progressing Scoping activity within Community services developed over the last 12 to 24 months to see what is scalable. This relates to the points in the criteria above regarding the Community by Design work.	Establish CBD Board, agreement through HB Board minutes for that Programme Management support	Partly contingent on Clinical Services Plan; and Strategy and ambition re community-based care. Develop the CBD plan aligned to national plan.	Line 2 – organisational oversight

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
3. A clear strategy and plans for GMS managed practices Fragile GMS practices and community dental provision	Tehmeena	There were no single clear strategic plans for GMS managed practices, GMS and community dental practice provision across North Wales	Progress has been made across the majority of GMS practices. A longer-term model will be developed via the Community by Design programme. At Primary Care Board, options and opportunities have been reviewed for strengthening managed practices. Regular reviews undertaken for fragile GMS practices.	Minutes from Primary Care Board	Clear strategy on how we will work with managed practices going forward. Need to review allocation and investment into Primary Care.	Line 1 - Operational
4. All GDS and PDS dental contracts in place with a clear plan for the commissioning of tier 2 dental services across North Wales	Tehmeena / Rachel Page	Underspend in GDS budget over the last 6 years	Approximately £4m worth of contracts were awarded in 25/6. New GDS contract reform established across all BCUHB practices. A recurrent and non-recurrent procurement plan is in place with clear timeframes for 26/7.	GDS contracts have been issued. Plans re procurement have been through governance process –OLT, Exec	Continue procurement process – timeline over the coming 6-9 months.	
Performance and Outcomes **Planned Care and Cancer** • 55% performance maintained for 4 months against the SCP target.	Olivia – Caroline Williams	Starting point was 61%	SCP target – Cancer performance was 52.5% in April and 54% in May, against the national target of 75% and is adrift of the de-escalation target (55%) • 52 weeks new appointment – Data showing improving trend from 72% in April 2025 to 92% in May 2026 for Stage 1 patients	Performance data is submitted to PFIG and Board as per the meeting schedule.	Areas of focus in Q2: Delivery of skin cancer recovery plan through additional capacity Recovery of breast cancer surgical position through increased capacity	1st line operational 2nd line organisational oversight

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
• 98% of open outpatient pathways are waiting less than 52 weeks and maintained for 4 months • Continuous improvement to ensure that 97% of open pathways are waiting less than 104 weeks and maintained/improved for 4 months. • Continuous reduction in the number of patients delayed by 100% for their follow up appointment. • 75% of patients waiting for a diagnostic test to be waiting less than 8 weeks maintained for 4 months. • 80% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 4 months.			• 104 weeks – 97% threshold achieved since June 2025. • Follow up delayed over 100% - number of patients have been increasing month on month during 25/26 and into new financial year and stands at 138,903 at May 2026. • 8 weeks diagnostic – below threshold of 75% but showing improving trend increasing to 62.6% as at end of May 2026. • % patients waiting less than 14 weeks for therapy – continue to achieve the standard with latest performance of 98.6% in May 2026.		and internal transfers Reduction in endoscopy waiting times	

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
Urgent and Emergency Care • Continuous reduction of ambulance handovers over one hour of at least 17% maintained over 4 consecutive months. • Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes. • Continuous monthly improvement towards achieving no more than 10% of patients waiting over 12 hours at each individual site and across the health board. • Continuous reduction of 5% in pathways of care delays for 3 consecutive months and then maintained for 4 months.	Olivia / Liz Wedley		This is reviewed at every QSE, PFIG, and formal Board ensuring close oversight from a Board and Executive level. • Ambulance Handovers – Current performance for June is above the target of 970, with a position of 1,754 (53%) patients waiting over 1 hour for a ambulance handover to ED. • Assessment by clinical decision maker – Current performance for June is 127 minutes, 67 minutes over the de-escalation requirement of 60. • 12 hour waits in ED. Current performance position for June is 24%, 14% over the de-escalation target. • Pathways of care delay – de-escalation criteria is 273 – monthly. Performance position for June is 317 POCD patients. Currently not meeting the de-escalation target.	Finalisation of the HB Recovery and improvement plan Shared purpose MOU with LAs re improved discharge and reduction in delayed pathways of care	Significant recovery programme required for UEC with specific focus on YGC ED. Building on progress and improvements to date to ensure sustainability.	1st line operational 2nd line organisational oversight

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
Adult Mental Health • 65% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a). • 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b). • 65% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan for 4 months (Part 2).	Teresa Owen		Achieved - All three metrics relating to Adult Mental Health - above 65% compliance since April 2025 to April 2026. Performance has ranged as follows: • Part 1A: 70.54% - 84.35% • Part 1B: 80.78% - 85.51% • Part 2: 82.17% – 86.79 %	Mental Health Measure remains compliant at BCU level for Part 1a and Part 1b, but with locality variation and waiting times in excess of 28 days in some localities. Based on April 2026 data: Part 1a (National Target: 80%) BCU – 84.35% West – 70.94% Centre – 76.88% East – 100% Part 1b (National Target: 80%) BCU – 85.51% West – 50.00% Centre - 84.40% East – 97.60% Part 2 (90%) BCU – 86.79% West – 80.17% Centre – 80.66% East – 93.87%	Although Part 1b remains compliant overall, 55% of those waiting for a first intervention have been waiting over 28 days, mainly driven by West, specifically Anglesey. Focus is on reduction of long waiters with additional sessions taking place to address backlog, waiting lists are being validated, the introduction of the enhanced silver cloud service with West staff receiving guidance on implementation. Robust local management of absences and Director level scrutiny and oversight.	

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
					Full review of systems and process for Part 2 and longer-term plans for review of CMHTs including implementation of Electronic Health Record system and development and implementation of Open Access Model	
CAMHS • 75% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a). • 60% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b). • 75% of HB residents in receipt of secondary mental health services	Olivia / Lou Bell / Fi Wright		This is a long-standing programme which has showed a significant improvement in access and performance. Part 1A and Part 2 metric compliance has been above 65% during 2025/26. An improvement plan was agreed with NHS Performance and Improvement in relation to Part 1B performance and progress against key milestones tracked via regular touchpoint meetings. Performance has ranged as follows: • Part 1A – 81% - 99% - achieved • Part 1B – improved from 41% to 85% at end of March 2026. • Part 2 – 91% - 99% - achieved	Variation in performance delivery exists across the teams Based on April 2026 data: Part 1a (National Target: 80%) BCU – 92.94% West – 100% Centre – 89.77% East – 94.62% Part 1b (National Target: 80%) BCU – 78.14% West – 100%	Challenges remain specifically in relation to the East team Part 1b target. A Getting Started group providing psychoeducation now forms part of the service offer. A SOP has been developed and is out for review with teams to ensure the offer is embedded consistently across the region. This will be completed by the end of July.	1st line operational 2nd line organisational oversight

<table>
<tr><th>De-escalation Criteria</th><th>Exec Lead / Lead Officer</th><th>Starting point (Feb 2023)</th><th>Headline Progress (Distance Travelled)</th><th>Evidence</th><th>What more is left to do, and By When?</th><th>Level of Assurance (three lines of defence)</th></tr>
<tr><td>who have a valid care and treatment plan for 4 months (Part 2).</td><td></td><td></td><td></td><td>Centre – 87.72%
East – 69.57%

<u>Part 2</u> (90%)
BCU – 91.5%
West – 100%
Centre – 86.36%
East – 92.13%</td><td>The service offer regarding group therapy is being developed further over coming months.

Reliance on agency staff remains, particularly in the East team. An agency exit plan is being produced to align with local recruitment plan. This will form part of a Recovery/Delivery plan to be completed by the end of July.</td><td></td></tr>
<tr><td><u>Finance</u>

1. The health board must demonstrate improvement and evidence of robust financial governance and a robust financial control environment.</td><td>Russell Caldicott</td><td>Qualification (accounts and regulatory opinion) significant financial challenge, fraud investigation.

Heading for c£200m deficit.</td><td>Plans for 2023/24 re-budget set following appointment of Executive Director of Finance 1st July 2023. Revised Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation. Outcomes being to attain targeted performance but not key financial duty

<table><tr><td>Description</td><td>2023/24 £m’s</td><td>2024/25 £m’s</td></tr></table></td><td>Auditors issuing unqualified opinion in relation to the Annual Accounts for 2023/24, 2024/25 and 2025/26. Clean bill of Health on reporting of financial performance.</td><td>Development of savings programmes based on a 2% efficiency ask and further work to improve productivity and efficiencies.

Headcount reduction to be progressed across all services to</td><td>Substantial Assurance, with a caveat that continuous improvement and embedding of controls remains necessary</td></tr>
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<tr><th>De-escalation Criteria</th><th>Exec Lead / Lead Officer</th><th>Starting point (Feb 2023)</th><th>Headline Progress (Distance Travelled)</th><th>Evidence</th><th>What more is left to do, and By When?</th><th>Level of Assurance (three lines of defence)</th></tr>
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<table>
<tr><td>Targeted</td><td>Movement from 34 towards 20</td><td>8.6 deficit</td></tr>
<tr><td>Actual</td><td>24 Deficit</td><td>7.6 deficit</td></tr>
<tr><td>Delivered</td><td>Achieved (but not attaining key first duty)</td><td>Achieved (but not attaining key first duty)</td></tr>
</table>

2025/26 financial plan set a balanced IMTP and targeted delivery of key financial duty. However, Health Board re-forecast in year and delivered re-forecast at a £17.3m deficit (in part driven by additional pressures associated with Employers NI and Cost Uplift Factor).

Value & Sustainability national improvement vehicle implemented in BCUHB and savings delivered as targeted in the last two financial years to 2025/26.

<table>
<tr><th>Description</th><th>2024/25 £m’s</th><th>2025/26 £m’s</th></tr>
<tr><td>Targeted savings</td><td>48.0</td><td>40.0</td></tr>
</table>
</td>
<td>Internal Audit review of budget setting process positive rating

Compliance reporting of performance developed for presentation to Audit Committee, with significant reduction in no purchase order payments and reductions in single source waivers reductions as we engage the market in procurement practice.

Additional control environments initiated for temporary workforce oversight (Medical and Nursing).</td>
<td>ensure financial balance

Underwriting of savings ask 2026/27 for plan delivery of £46m and then stretch of £17m to give a total savings delivery of £63m for the current financial year.

Further savings opportunities under V&S (CHC/Non-Pay/Medicines Mgt/Clinical Variation/workforce) to be progressed.</td>
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De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			<table><tr><td>Actual savings</td><td>58.4</td><td>45.0</td></tr><tr><td>Delivered</td><td>Achieved</td><td>Achieved</td></tr></table>			
2. Substantial progress to be made in delivering the special measures action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.	Russell Caldicott		The Special Measures financial recovery action plan has been implemented, supported by the Value and Sustainability Programme. The programme has identified significant savings opportunities and delivered savings performance exceeding target by £4.9m in 2025/26, demonstrating strengthened financial grip, improved delivery capability and sustained progress towards financial sustainability.		Underwriting of savings ask 2026/27 for plan delivery of £46m and then stretch of £17m to give a total savings delivery of £63m for the current financial year. Further savings opportunities under V&S (CHC/Non-Pay/Medicines Mgt/Clinical Variation/workforce) to be progressed	**Overall assurance: Moderate Assurance** – clear progress demonstrated, but substantial work remains before the action can be considered fully delivered and embedded.

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.	Russell Caldicott		BCUHB's IMTP 2026–2029 provides the Board's approved annual plan for 2026/27 and sets out a clear financial improvement trajectory. The plan links service transformation, productivity improvement, value-based healthcare, workforce redesign and financial sustainability. This is supported by a savings programme of circa £46m, formal financial recovery arrangements, and governance oversight through Board, Performance and Finance structures. The trajectory builds on demonstrated improvements in financial governance and reduced overspending in recent years and is underpinned by major transformation programmes including Foundations of the Future and the Clinical Services Plan .	IMTP 2026-29	Full delivery of the 2026/27 savings and efficiency programme. Clear demonstration that planned savings are recurrent and reduce the underlying structural deficit. Translation of transformation programmes into measurable financial benefits. Robust benefits realisation, accountability and performance monitoring arrangements. Continued improvement in productivity, workforce utilisation and value for money. Ongoing assurance to Welsh	**Substantial Assurance** across Lines 1 and 2, and Reasonable-to-Substantial Assurance in Line 3, giving an overall position of Substantial Assurance

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					Government, regulators and Audit Wales that financial recovery arrangements remain credible and deliverable.	
Strategy and Planning						
1. Submission of an approvable annual plan in line with the NHS Wales planning framework.	Paolo / Emma	BCU had not had an IMTP approved by Welsh Government since its formation in 2009.	The Board approved a financially balanced, 3-Year IMTP for 2025/26, although this was not approved by Welsh Government. In line with most Health Boards in Wales, the organisation will not be in a position to deliver a balanced plan for 2026-29, however an ambitious yet realistic plan was approved by the Health Board.	Health Board meetings – March 2025 and March 2026, where the 2025-28 and 2026-29 3-Year plans were approved by the Health Board.	The de-escalation criteria is to submit an approvable annual plan and whilst the Health Board felt the 2025-28 IMTP was approvable, receiving approval from Welsh Government is the ultimate aim.	Second line of defence – organisational oversight
2. Evidence of improving integrated planning across the organisation which supports the development of a coherent and	Paolo / Emma	BCU had not had an IMTP approved by Welsh Government since its	An independent review of the organisational approach to planning reported in March 2024 and the action plan associated to the recommendations has been completed. Integrated planning continues to improve across the	1) Independent review of planning and associated action plan – March 2024. 2) Welsh Government	There has been sustained improvement in the approach to planning, and whilst there are always learning and	Third Line of Defence – Independent Assurance

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
deliverable annual plan.		formation in 2009.	organisation, with a comprehensive self-assessment undertaken against the planning maturity matrix and the Board subsequently approved a revised Integrated Planning Framework in November 2025. Welsh Government feedback on both 2025-28 and 2026-29 plans point to both areas for further improvement as well as progress made.	feedback on 2025-28 and 2026-29 plans. 3) Welsh Government Planning Maturity Matrix self-assessment – November 2025. 4) BCU reflection and learning exercise outputs following 2025-28 and 2026-29 planning cycles.	improvements to be made each year, it is believed that the spirit of this de-escalation criteria has been met.	
3. Board clarity on the strategic vision for the organisation.	Paolo / Kamala	No up-to-date strategic vision for the organisation as the extant 10-Year Strategy was developed by the previous Board in 2018 prior to Covid.	The Health Board has agreed four statements of strategic intent at the January meeting alongside feedback on a draft vision, developed following extensive partnership work. The new 10-Year strategy is currently in the Discovery phase which will be concluded during Q2. This is a supported by a clear Annual Delivery plan set within a 3-Year context, which is now structured around the four strategic intents, representing a further evolution of the Health Board's approach.	Health Board meeting – January 2026, where the four strategic intent statements were formally agreed by the Board.	The 10-Year Strategy needs to complete the discovery phase during Q2, design phase in Q3 and delivery through key underpinning strategic plans (e.g. Clinical Services Plan) in Q4 feeding the 2027-30 IMTP.	Second line of defence – organisational oversight

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
4. Evidence of a clear roadmap and implementation of the health board's multi-professional clinical services plan.	Paolo & Clara / Kamala	A Clinical Services Strategy was developed in 2022, but this was under the previous Board's direction, was very high level and wasn't translated into strategic delivery plans.	Phase 1 of the Clinical Services Plan (CSP) has seen measurable improvements across the designated Challenged Services. Phase 2 is one of the Health Board's 4 major change programmes in 2026/27 with the design phase well underway, including an important Clinical Leadership engagement event held on 5th May 2026.	1) Challenged Services Progress reports to support Welsh Government oversight meetings. 2) Clinical Services Plan Programme Definition Document. 3) 5th May Clinical Leadership engagement event output QSE report.	The CSP needs to complete its preparatory work during Q2, conduct the first tranche of areas assessments during Q3 and produce the first tranche of service change proposals for approval in Q4 feeding the 2027-30 IMTP.	Second line of defence – organisational oversight
5. Deliver commitments set out within the annual plan, particularly in relation to the ministerial priorities.	Paolo / Emma	Poor delivery against the plan, particularly in respect to ministerial priorities.	Progress against commitments made within the Annual Delivery Plan are reported to Public Board and most recently in May. See that report for a detailed breakdown of delivery and elsewhere in this report for specific Special Measures de-escalation criteria. Monthly reporting has been put in place in 2026/27 in order to provide an early warning against any deliveries that are off track and allow timely intervention in quarter.	Health Board meeting – May 2026.	Continue to improve delivery against plan, particularly in relation to Special Measures de-escalation criteria, Ministerial Delivery Expectations and Enabling Actions.	Second line of defence – organisational oversight
6. Sustained improvements in delivery of the plan throughout the year.	Paolo / Emma	See previous row	See previous row	See previous row	See previous row	See previous row
7. Achieve level 2 across all aspects of the health board self-	Paolo / Emma	No assessment ratings against the Welsh	A self-assessment against the planning maturity matrix was completed, reported to Board and	Health Board Meeting – November 2025.	The Health Board is now using the planning maturity	Second line of defence –

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assessment against the planning maturity matrix.		Government planning maturity matrix.	submitted to Welsh Government by the deadline in November 2025. The Health Board scored 2s and 3s across all domains. This informed updates to the Health Board's Integrated Planning Framework which was also presented and approved by Board in November 2025		matrix proactively during its annual planning cycle reflection and learning exercise in Q1 of each year, which will inform further refinements to the Integrated Planning Framework during Q2.	organisational oversight
Quality of Care						
1. An integrated and effective quality management system operating throughout the organisation.	Angela / Chris L ? Clara / Paolo?	No QMS system in place	The implementation of the BCUHB Quality Management System (QMS) continues to progress, recognising that embedding a quality-focused culture is a long-term journey. The QMS has transitioned into business-as-usual delivery, with implementation aligned to the organisational restructure and Fit for the Future programme. Appropriate arrangements and resource are being developed to maintain momentum, support sustainability, and further advance organisational maturity.	Health Board meetings – March 2025 and March 2026, where the 2025- 28 and 2026-29 3-Year plans were approved by the Health Board	QMS still requires implementation across the Health Board and then a position of embedded practice. The resource for sustainability and development needs to be supported within current core services.	1st line operational – QMS transitioned to business as usual and usage monitored 2nd line organisation oversight – reports to QSE and Executive Committee as per reporting cycle 3rd line Independent

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						Assurance - NHS P&I oversee QMS at national level
2. Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by Quality, Safety and Experience Committee and Board.	Angela / Chris L	The improvement goals for Welsh Government (WG) trajectory cases differed significantly between 2023/24 and amended reporting periods, making direct year-on-year comparisons difficult. Despite these differences, BCUHB concluded the year with all six of the six significant reporting organisms exceeding the required trajectory levels.	Performance against the nine improvement goals for the six key healthcare-associated infection organisms at the end of May was mixed but improving. The Health Board was below trajectory for four goals, on target for two, and above trajectory for three, indicating that while further improvement is needed in some areas, targeted interventions are beginning to deliver positive results. Continued vigilance remains essential, but performance reflects stronger infection control measures, increased organisational focus, and improved operational practices. Progress is closely monitored through Local and Strategic Infection Prevention Groups, with assurance provided through the Executive Quality Delivery Group and the Quality, Safety and Experience Committee. A robust Infection Prevention Programme of Work is supporting delivery of the Health Board's improvement ambitions and is being strengthened further in response to the IPC Quality Statement gap analysis	Reported through QSE, Strategic infection prevention group and HARP team	Continuation of improvement programme as part of national c-diff collaborative. Local programme of improvement for infection prevention	1st line operational – monitoring completed through local Infection Prevention groups. 2nd line organisational oversight – reports to QSE and Executive Committee 3rd line Independent Assurance - Strong links with national collaborative and HARP team

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3. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs. • C-Diff: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 13 cases to no more than 11 per month) • E-coli: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 10 cases to no more than 8 per month)	Angela / Chris L	Revised improvement plan needed to address the issue of hospital onset HCAIs.	During April and May, the Health Board met its target of no more than 11 hospital-onset Clostridioides difficile (C. diff) infections per month, reporting 9 cases in April and 7 in May. This improvement was supported by fewer outbreaks, better case identification, and more timely patient isolation, particularly in areas involved in Quality Improvement (QI) projects. The dedicated C. diff cohort area in the East Integrated Health Community has also helped manage limited isolation capacity and reduce transmission risk. Performance for hospital-onset E. coli bacteraemia also improved, with 6 cases reported in April and 7 in May, achieving the target of no more than 8 cases per month. Ongoing work to reduce device-related infections includes task and finish groups across the Integrated Health Communities, supported by regular monitoring through local Infection Prevention Groups. In addition, PVC and CAUTI audits continue through the Tier 2 Clinical Effectiveness Audit Programme, providing assurance on compliance with infection prevention standards and supporting further reductions in device-related infections.	Reported through QSE, Strategic infection prevention group and HARP team	Continuation of improvement programme as part of national c-diff collaborative. Local programme of improvement for infection prevention	1st line operational – monitoring completed through local Infection Prevention groups. 2nd line organisational oversight – reports to QSE and Executive Committee 3rd line Independent Assurance - Strong links with national collaborative and HARP team

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4. 68% of complaints that had final reply (Reg 24)/interim reply (Reg 26) to be closed within less than 30 working days of concern received maintained for 3 months	Angela / Chris L ?Clara?	Not complying with standards or targets	The Health Bord has sustained compliance of over 68% since September 2024 bar two months (December 2025 and February 2026) this was due to special causation, Insourcing activity and increased patient contacts over a short period of time. Between 1st April 2025 and 31 March 2026, there is clear evidence of a complaints process which has become more capable in relation to responding to complainants in a timelier manner and achieving compliance with the key performance target of responding to complaints within the 30-working day target. This represents not only a statistical improvement compared to previous years, but in practical terms the complaints process has become increasingly adept at engaging with complainants, improving patient experience of the complaints process, resulting in fewer cases, being upheld by the PSOW. The BCUHB provides timelier resolutions to complaints and have the least overdue complaints of health boards of comparative size. Levels of Harm identified in complaint investigations is statistically reducing,	Target superseded by new Listening to People Legislation. Beacon dashboard holds data up to 31st March Internal figures also maintained until 31st March Report against new legislation	On track and meeting targets. Maintain current performance. Report against the Listening to People Legislation from Q3 onwards	1st line operational – monitoring completed through local groups 2nd line organisational oversight – reports to QSE and Executive Committee 3rd line Independent Assurance – compliance and reports submitted to WG

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			alongside complaints upheld by the PSOW. Forecasting in 2026 / 2027, The implementation of the new Listening to People Framework has gone well, and early indications is that the “new approach” is working.			
5. Effective response from the health board to external reports and reviews including those from Audit Wales, Public Services Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.	Angela / Chris L / Pam	Good processes in place however strengthen governance strengthen required	The Health Board has robust relationships and processes to ensure effective to external regulators and reports. Learning from regulators including HIW, PSOW and Audit Wales are shared in core forums and organisational Learning forums.	Meeting minutes and agendas for RAG, OLF, Audit Wales	Regulatory compliance remains an important area of focus through governance monitoring and Learning	1st line operational – local monitoring and reporting. 2nd line organisational oversight – reports to QSE, Board 3rd line Independent Assurance - Integrated Quality Reports to WG as per reporting cycle.
6. Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	Angela / Chris L	Good processes in place however strengthen governance strengthen required	To ensure effective governance all, the strategic People’s Experience Group (PEG) evidences the use of feedback in delivering systematic improvement. This is supplemented by quarterly ‘deep dive’ reporting of patient experience by IHC and Specialist Services, through the triangulation of data (complaints,	Reports to QSE, Board and WG	Continue to improve Patient experience – through wider improvement major change programmes on UEC and Planned Care	1st line operational – reports through Programme Boards. 2nd line organisational oversight – reports to Local

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			incidents, enquiries and feedback) to proactively highlight themes, trends, providing opportunities for learning and improvements to services. Learning from feedback is evidenced in a quarterly Citizen Report presented to Board and a bi-monthly QSE Integrated Quality Report. This is supplemented by regular, 'deep dives' of people's experience, through detailed thematic reports, to provide focus on emerging themes and trends, as part of proactive performance improvement which provide both confidence and assurance to the Board and to the public. IHC and Specialist Services, have an established system of People's Experience Groups to ensure learning is both identified and evidenced appropriately and shared across teams to inform service improvement, and to deliver sustainable changes at a local level. The health board has developed a comprehensive suite of experience led data, which is available real-time, and dynamically filterable down to ward Level utilising the Quality			Peoples Experience Group, QSE and Board 3rd line Independent Assurance – reports to WG

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			Dashboard, which is accessible by all staff. This includes quantitative metrics, but also qualitative information, to bring the data to life. The ability to visualise Data, allows us to forecast, with a view of moving from reactive to proactive, in improving People's experience. A dedicated 3-year peoples experience strategy will be launched in Quarter 3 2026/2027, and delivery of this strategy will be the responsibility, of the Head of Peoples Experience and Complaints to ensure the ambitions are delivered and the plans are being effectively implemented. As part of this wider transformational change, from the 1st April 2026, the Patient, Advice, Liaison Service (PALS) was restructured to form two new dedicated teams The Peoples Enquiry and Resolution Service (PEARS), provide a "one stop" approach, allowing the public to seek support, raise an enquiry, compliment, suggestion or Concern. This streamlined approach, based on feedback from the public, improves access and supports timelier			

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			responses, aligned to the new Listening to People Framework. The dedicated People's Experience Service (PES) has allowed greater focus and capacity to deliver “true” Peoples experience, this includes triangulation of themes and trends, identified through incidents, complaints, informal and formal feedback, to support each IHC/ Division with systematic improvement. To demonstrate our commitment to co-production, in service delivery the PES team undertake Care 2 Share Discovery interviews, which are centred around real-time experiences, to help understand what matters most to the patient/carer. Learning from lived experience is captured through storytelling, with learning and service improvements identified as a key part of this process This qualitative feedback helps informs local service-level improvements, and is reported into local IHC and Specialist Services People’s Experience Groups., such as Gynae Voices which demonstrates			

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			how feedback has been used to support improvements to services. To improve the quality-of-service delivery, Patient/Carer stories are shared at staff training sessions, service development days, and at senior meetings including Board and Quality Safety and Experience Committee meetings. The PES team also deliver training on active listening skills, compassionate communication, to a wide range of health board staff including newly qualified and student nurses. The PES team work in partnership with the Public Engagement Team to support the development and delivery of corporate consultation and engagement activity with the public, supporting a better understanding of "the things that matter", aligned to the values of the health board. The team work closely with our communities, stakeholders and partners to ensure that they have wide ranging and frequent opportunities to engage and get involved in shaping health services in North Wales - example include; the Women's Health Plan 2026, and in partnership with Llais the development of an engagement			

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			approach and toolkit on how to engage with the public when planning/changing services			
7. Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards throughout the organisation from Board to service area delivery.	Angela / Chris L	Good processes in place however strengthen governance strengthen required	The Health Board has strengthened its implementation of the statutory Duty of Quality and Duty of Candour, with progress evidenced through the national maturity matrix assessment undertaken in March 2026. These actions demonstrate the organisation's commitment to meeting Welsh Government legislative requirements and supporting a culture of openness, transparency and continuous improvement. This includes ensuring that patients, families and carers are informed appropriately when harm has occurred or where expected standards of care have not been achieved.	The national Maturity Matrix March 2026	Planning and implementation of Duty of Candour and Duty of Quality training package that would be accessible on ESR to strengthen workforce access and compliance with training and improve culture of open, honest, transparency	1st line operational – reports to Duty of Candour Group 2nd line organisational oversight – reports to QSE and Board 3rd line Independent Assurance – reports to WG
8. Oversight of safeguarding arrangements to ensure the Board has sufficient, meaningful assurance that the organisation is delivering against its safeguarding statutory responsibilities.	Angela	Oversight of safeguarding arrangements needed strengthening	There is a safeguarding governance and reporting framework which ensures robust reporting arrangements. Each meeting receives timely, accurate updates from relevant workstreams (“reporting in”), enabling informed decision-making and risk management. Outcomes, decisions and escalations are documented and communicated to stakeholders and governance bodies (“reporting out”), creating a transparent feedback loop. This dual reporting mechanism provides	Reports to BCU safeguarding group. Reports into QSE and WG.	Continuation of current practices and strong safeguarding governance reporting lines	1st line Operational – reports to Strategic Safeguarding Group. 2nd line organisational oversight – reports to QSE and Board

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			evidence of accountability, compliance and continuous assurance across all levels.			3rd line Independent Assurance – reports to WG Regional safeguarding board
9. Use of national clinical audit and outcome review programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care (including the use of patient and staff feedback to influence service design).	Clara Jo Shillingford	National clinical audit dashboards not widely used and lack of structured follow up and reporting of plans	There has been a refocus on delivering care against defined standards and the use of audit as a tool to demonstrate this. There is good participation in the national tier 1 audit programme. This is reported quarterly through SCEG and QSE. In addition, where an outlying report is received into the Health Board an immediate update is required with reporting through QSE. After criticism that Tier 2 audits did not link to organisation risk, a new approach is being taken this week to select the programmes using a risk based approach. Our enhanced follow-up processes, led by the Clinical Effectiveness Team and supported through Service Assessment of Compliance, enable drive for improvements. Audit findings are now converted into stronger, more consistent action plans that support sustainable progress in patient safety and care effectiveness. Alongside this, the use of National Clinical Audit and Outcome Review	Reports to SCEG and QSE	Continued focus on standards of care across all services as Tier 1, Tier 2 and Tier 3 audits. Ensuring pan HB standards in place wherever possible. Deeper dive into areas where partial compliance to NICE guidance taking a HB wide approach where applies to significant guidance	1st line. Local audit and adaption in real time. Tier 3 audits to be used to local prirorities 2nd line. Oversight through SCEG and QSE 3rd line. Tier 1 audits in national programme

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
			Plan (NCAORP) benchmarking data helps us identify early warning signals and ensures clinical outcomes remain central to strategic governance			
Clinical Services						
1. Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HM Coroners, Royal Colleges, HTA, MHRA, Llais etc), mortality reviews, duty of quality/candour, infection prevention and control, performance, clinical and medical leadership.	Clara / Paolo	Silo'd sources of insight on individual services that weren't triangulated in order to identify, make or monitor improvements	A comprehensive review has been undertaken of each of the 8 clinical services designated as Challenged Services. This has included root cause analysis of historical issues and identification of themes across services and these issues were agreed with Welsh Government through touchpoint meetings during the year. This is supplemented by the QMS maturity assessment where services undertake a thorough diagnostic of issues across the service. This is being supplemented by a Fragile Services Framework that is being designed but proof of concept views have been created for Ysbyty Glan Clwyd ED and Gastroenterology.	1) Challenged Services improvement plans. 2) 2) BCU QMS tool. 3) Draft Fragile 3) Services Framework.	Completion of the Fragile Services Framework during Q2 and incorporating it into BAU Quality Governance and QMS, annual service planning and Clinical Services Plan assessments.	Third Line of Defence – Independent
2. For each clinical service evidence: • Whether staff have all the information they need to deliver safe	Tehmeena		• Ask Michelle Greene, Naomi Holder, Paul Andrew, Karen Mottart – high level overview, generic headline			

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
care and treatment to people. How are people's care and treatment outcomes monitored and how do they compare with other similar services? • How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment? • How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? • How consent to care and treatment is sought in line with legislation and guidance? • Clear and effective processes for managing risks, issues and performance.			Challenged Services: The Heath Board has seen traction across all services which is now overseen by a Challenged Services Oversight group and reported through to QSE for assurance. Both Oncology and Plastics have made sufficient progress to be considered for de-escalation. Within Oncology there has been considerable strengthening of the workforce and in Plastics the waiting list position has been maintained with zero patients waiting greater than 104 weeks. All outstanding issues relating to the 2025/26 Plastics contract, along with travel funding issues have now been resolved, securing continuity of care for local patients and demonstrating cross-organisation partnership. Further partnership and commissioning work is underway with University College London and the Wirral University Trust to bring access to radical prostate cancer treatment back closer to North Wales, alongside further pathway redesign work for prostate cancer which will reduce waits to 15 days. A full tender programme for a commissioned Vasectomy service has been agreed			

De-escalation Criteria	Exec Lead / Lead Officer	Starting point (Feb 2023)	Headline Progress (Distance Travelled)	Evidence	What more is left to do, and By When?	Level of Assurance (three lines of defence)
• Strong clinical leadership, with an effective integrated improvement plan, project management structure and effective transformation support. • Effective response to recommendations from the Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan			with procurement with the tender process imminent. Regular engagement continues with regulators including recent Vascular meetings with HIW to provide assurance, and there has been a significant decrease in the number of Vascular patients waiting greater than 52, down from 1065 in February 2025 to 237 in December 2025.			
3. Evidence that the Board is sighted on clinical services and has a robust response to these issues that is being addressed by the health board.	CD / PT		Comprehensive reporting is in place via the Strategic Planning and Service Change group and through to QSE, with the outcomes of QSE reported through to Board. This oversight mechanism has strengthened significantly within the last 12 months with more assurance in place.			

Appendix 1 - Services available to meet population Health Need

Onsite Services	Community services	Visiting Services to Tywyn Community Hospital
• GP/ Health Centre • Venepuncture clinic • MIU Mon-Fri 8-8 • Treatment Room • X-Ray • Practice Nurse/ Prescribers • Outpatient Clinic • Wellbeing Hub	• Community Resource Team • Ambulance Service • District Nursing 24/7 • Community Pharmacy • Optometrist • Social Services • Social Workers • School Nursing • Community Midwifery • Heart failure nurse • Midwife • Ophthalmology • Audiology • Spirometry • Residential and Domiciliary Care • Tuag Adref	• Drug and Alcohol Services • Diabetic retinopathy • Macular degeneration group • Tuag Adref • Mental Health in reach • Occupational Therapy • Physiotherapy • Outpatient department • Podiatry • Specialist Diabetes Nurse • Palliative Team • Continence Service • Dietician Treatment Room • Speech and Language Therapy • Parkinson's Practitioner
Mental Health Services	**Third Sector and Local Authority Funded**	
• Counselling services • Well-being hub • OPMH/CPN's • Acute Mental Health services	• Voluntary Network • Meals on Wheels • Church group • Merched y Wawr • Gofal a thrwsio • coffee Mornings • Community Connectors • Dementia Go • Schools • Library • Leisure Centre	

Appendix 2 - Welsh Language Impact Assessment

1.1 Background – Welsh Language Impact Assessment	
Who is the lead Officer for this Assessment?	Eleri Hughes-Jones, Head of Welsh Language Services
What are the aims and purpose of this proposal?	The temporary closure of Dyfi Ward in 2023 highlighted longstanding challenges associated with maintaining a safe, high-quality and sustainable inpatient service within Tywyn Community Hospital. The need to close Dyfi ward was due to patient safety issues driven by workforce constraints, including difficulties recruiting and retaining appropriately skilled nursing staff, resulting in concerns regarding the immediate and long-term resilience of the service. Healthcare delivery has changed significantly in recent years, with increasing emphasis on providing care closer to home, reducing avoidable hospital admissions and supporting people to remain independent within their own communities wherever clinically appropriate. At the same time, the population served by Tywyn Community Hospital is ageing, with increasing levels of frailty, multiple long-term conditions and complex health needs requiring coordinated multidisciplinary care. In addition, community services are increasingly required to respond to a broader and more diverse range of needs across the population. This includes providing appropriate support for younger people, individuals experiencing mental health challenges, and those requiring access to a wider range of preventative, rehabilitative, and ongoing care services. As a result, community provision must be flexible and responsive, ensuring that services are inclusive, holistic, and capable of addressing wider health needs. The review, requested by the Health Board in May 2025, has identified a number of clinical challenges that need to be addressed:

	• Workforce shortages affecting the sustainability and resilience of inpatient services. • The need to ensure services are staffed by appropriately trained and experienced professionals at all times. • Maintaining clinical quality and patient safety standards within a limited-service model. • Increasing demand associated with an ageing population and growing levels of frailty and chronic disease. • The need to deliver care in line with modern clinical practice and national policy direction. • Ensuring patients receive the right care, in the right place, at the right time. • Improving integration between primary care, community services, social care and hospital services. • Making best use of available clinical resources to maximise patient benefit. • The need to balance local service provision with the wider health and care system across Meirionnydd, Gwynedd and the West Integrated Health Community. The review has therefore sought to identify the most clinically effective and sustainable model for delivering healthcare services from Tywyn Community Hospital, ensuring that services remain safe, accessible and responsive to the needs of the local population both now and in the future. The review is limited to the operating model of Dyfi Ward and directly associated community hospital services; broader issues (for example dentistry and specialist mental health) remain outside scope. **Pre consultation engagement and options development:** Following a decision by the Board in May 2025 to review the service and develop a sustainable solution for the future; since July 2025, the Health Board has undertaken a

programme of pre-consultation engagement to understand the experiences of those within the local community as well supporting the development of potentially viable options for the future of the service responding to the need to deliver safe, sustainable and value-based care to the local community, whilst acknowledging the challenges already faced.

Key Group	Date	Outcome/Evidence
Balanced Room 1	Sept 2025	Long-list and medium list of options.
Balanced Room 2	Oct 2025	Development of desirable criteria and shortlisted options.
Balanced Room 2 re-run	March 2026	A discrepancy in scoring was identified from the previous session so a second session was carried out to revisit the longlist of options resulting in group consensus to revisit the essential criteria on a number of proposed hybrid options.
Follow-up stakeholder session to Balanced Room invitees	June 2026	The options deemed most viable were presented to stakeholders for discussion and questioning before further thoughts were gathered on the consultation process and how best to reach and involve local residents.
A series of face-to-face community engagement events as well as canvassing at outpatient clinics and MIU,	Jul 2025 – February 2026	Themes including: desire for the reinstatement of the inpatient ward as well as the development of the "new" services, clarity of approach and decision-making process, desire for wide involvement, desire for local

online surveys and monitoring of correspondence		services that meet the needs of a broad range of the community – particularly younger people, children and young families, recognition of the difficulties faced by rural and older populations in accessing healthcare.
Internal clinical and operational assurance	Ongoing	Any developing model will continue to be clinically assessed against the Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) Quality Standards of services.

Pre-consultation engagement identifies strong public support for retaining and enhancing healthcare services within Tywyn and highlighted the importance of local access to care for a predominantly rural and ageing population. Stakeholders consistently emphasised the value of services being delivered as close to home as possible, particularly for older people, carers and those with limited access to transport.

Feedback from the engagement demonstrated a strong attachment to local inpatient provision and highlighted concerns regarding travel, accessibility, and the impact of service changes on patients, families and carers. The engagement identified support for exploring opportunities to expand a range of locally delivered community, outpatient, rehabilitation and preventative services.

The purpose of the proposed service change programme is therefore to identify a sustainable, high-quality model for Tywyn Community Hospital that responds to current and future population needs, makes best use of available resources, and reflects the views and priorities expressed by the local community and stakeholders. This will include ensuring that services are clinically safe, aligned with national and

	regional strategies, and integrated with wider community and primary care provision. The programme will also seek to improve patient outcomes and experience, reduce health inequalities (appendix 10), and ensure that the model is deliverable and resilient in the context of workforce capacity and financial constraints. **Proposed options for consultation** In summary, following a period of review and analysis to develop options for delivering safe and effective healthcare, presented for further consideration are: • **Option A:** A return to the inpatient model. This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times. The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care home, as well as providing an option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death. This model proposes reverting back to the original purpose for the ward of 10 beds, recognising the strength of feeling within the community and could support care closer to home and as an option to maintain flow from acute sites. **OR** • **Option B:** An expansion of community services at home and hospital-based clinics, treatments and therapies. This option proposes the closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:

	▪ Tuag Adref (Homeward Bound) ▪ Wellbeing Hub ▪ Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week) ▪ Locally delivered treatments, including a range of IV therapies ▪ Increase multi-team working across primary and community care Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services. Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would continue to provide additional options for end-of-life and step-down care where appropriate. The model aims to deliver care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required. A number of potential models and hybrid options have been considered, discussed and appraised over the last year with the above being the recommended options within scope for the consultation. It is important to highlight that a hybrid option of the two proposed models has been frequently discussed and some public feedback suggests this as a more favourable option. However, a hybrid model is not rated as sustainable due to workforce fragility, financial requirements and was further deemed out of scope due to requiring a significant shift in resources which would have an impact on wider service provision

	across the Gwynedd and the West Integrated Health Community. Further detail is available within the paper and appendices.
Who is responsible for the proposal being assessed?	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning and Tehmeena Ajmal, Chief Operating Officer
Who would be affected by the proposal – adversely or positively, directly or indirectly?	• Members of the public and patients • BCUHB staff • Partners including Wrexham County Borough Council, Community Councils, Third Sector, local community services • Independent sector
1.2 Information Gathering – Welsh Language Standards and the Welsh Language Measure (Wales) 2011 • **The Welsh Language Impact Assessment has identified that both service change options would result in broadly equivalent impacts on Welsh language provision. Regardless of the option selected, a review of current Welsh language service provision would be required, alongside comprehensive planning at service level to ensure continued compliance with Welsh language standards and the effective delivery of bilingual services. Furthermore, both options would necessitate significant input and ongoing support from the Welsh Language Team to support implementation, workforce planning, and the mitigation of potential impacts on service users.**	
Does this proposal ensure that the Welsh language is treated no less favourably than the English language, in accordance with the Welsh Language Standards?	There is a commitment to offering Welsh medium provision to all patients in accordance with the Welsh Language Standards.
Is there an opportunity to offer more opportunities for people to learn and / or use the Welsh language on a day-to-day basis?	The numbers of Welsh speakers in this particular area is slightly lower than the average across Gwynedd. In South Meirionnydd Primary Care Cluster, 53% of residents aged 3 years and over speak Welsh The data below from the 2021 census (taken from the Profile document for the Tywyn community, 12th January 2026) shows the percentage of those who can speak Welsh and

	other combinations of skills in Welsh (not including those who can understand, read or write but who cannot speak Welsh) in the Middle Super Output Area (Gwynedd 017) and the Lower Layer Output Area for Llangelynin, Tywyn 1, Tywyn 2, and Aberdyfi/Bryn-Crug/Llanfihangel: Gwynedd 017 – 40.1% Welsh speakers Llangelynin – 40.2% Welsh speakers Tywyn 1 - 36% Welsh speakers Tywyn 2 – 40.3% Welsh speakers Aberdyfi/Bryn-Crug/Llanfihangel – 43.3% Welsh speakers The percentage of Welsh speakers within the county of Gwynedd is 64.4%. In terms of current staff within the Tywyn cost centre, the current data (taken from the Health Board's ESR records) shows that of a total of 24 staff members, 8 have Welsh language skills level 3 and above, which is 33.33%, which is currently lower than the percentage of Welsh speakers in the community. Of the West IHC in total, the percentage of staff with Welsh Language Skills at level 3 and above is 60.18% and higher than the percentage of Welsh speakers in South Meirionnydd. No skills – 19.09% Lefel 1 – 9.73% Lefel 2 – 7.34% Lefel 3 – 10.35% Lefel 4 – 17.76% Lefel 5 – 32.07% Through mainstreaming the Welsh language and offering Welsh language training, there will be more opportunities for people to use the Welsh language on a day-to-day basis.

Will this project pro-actively offer services in Welsh for users?	There is an opportunity to strengthen Welsh medium provision with the implementation of Standard 110 of the Welsh Language Standards. Standard 110 states, if the Health Board is providing the service, it must: Publish a plan for each 5-year period setting out – (a) the extent to which you are able to offer to carry out a clinical consultation in Welsh; (b) the actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh; (c) a timetable for the actions that you have detailed in (b).
Is the proposal likely to protect and promote the Welsh language within communities?	It is not the role of the Health Board to protect and promote the Welsh language within communities. However, as part of our work to implement the Welsh Language Standards across the Health Board, this will be reflected in the services offered to the community.
1.5 Information Gathering – Engagement	
What has been done to date in terms of involvement and engagement about this proposal?	There has been significant local public interest and scrutiny following the decision to temporarily close Dyfi ward and a wide range of engagement and stakeholder involvement has been undertaken. Since July 2025 there has been a focused engagement exercise with residents, staff and members of the Tywyn community and surrounding area. A phased approach to engagement has been conducted to support the service review process as follows. **Phase one (July 2025 to October 2025)** This phase of communications and engagement focused on: • Listening to what matters to people — their priorities, concerns, ideas and experiences. • Recording the feedback

	• Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services. This was done via the following activity: ▪ Social media and digital awareness raising ▪ An online survey ▪ Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising. ▪ 04.08.2025: Attendance at a listening event in partnership with Hywel Dda University Health Board. ▪ 20.08.2025: Attendance at the Meirionnydd County Show. ▪ 28.08.2025: Attendance at the South Meirionnydd Older People's Forum ▪ 12.09.2025: Attendance at the Social Drop-in, Aberdyfi ▪ 09.2025: Attendance at Aberdyfi Community Council ▪ Monitoring of correspondence. To note, no specific MP or MS inquiries were received during this period directly relating to inpatient beds in Tywyn though proactive updates were provided. Feedback was published as part of the Phase One Engagement Report. **Phase Two (November 2025 to April 2026)** Phase two of the communications and engagement activity focused on raising awareness of and inviting feedback on further developed thinking, explaining the work to develop options and actively seeking feedback from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community, as well as being cognisant of the Health's Board duty under the Wellbeing of Future Generations Act. The second phase placed more of a focus on face-to-face community engagement to have more detailed conversations with members of the local community and representative groups. This included:

	▪ Continued digital awareness raising ▪ Online survey – paper copies were also available ▪ Reaching out to stakeholder groups, including local schools and colleges, for face-to-face conversations and support in awareness raising. ▪ Attendance for feedback gathering within the Minor Injuries Unit ▪ Attendance for feedback gathering within Outpatient clinics held at Tywyn Community Hospital ▪ 05.11.2025: Tywyn staff briefing onsite ▪ 12.11.2025: Attendance at Tywyn Town Council meeting ▪ 17.11.2025: Attendance at Bryncrug Council meeting ▪ 17.11.2025: Attendance at Aberdyfi Community Council meeting ▪ 18.11.2025: Attendance at Llanegryn Council meeting ▪ 21.11.2025: Tywyn staff drop-in ▪ 21.11.2025: Attendance at Friday evening youth club, Tywyn Baptist Church (c.45 young people) ▪ 24.11.2025: Attendance at Arfon Access Group meeting ▪ 25.11.2025: Attendance at morning parent and toddler group, Tywyn Baptist Church, (c.10 parents/carers) ▪ 13.01.2026: Attendance at Llanfihangel y Pennant council meeting ▪ 16.01.2026: Attendance at Tywyn Community Hub coffee morning (c.100 attendees changed the drop-in session to a "town hall" style event) ▪ 16.01.2026: Attendance at the social drop-in, Aberdyfi (8 attendees) ▪ 02.02.2026: Tywyn staff briefing. ▪ A total of 537 survey responses were also received
What other information has been used to inform this assessment?	**Clinical, political and action group engagement**

	The establishment of the Tywyn Community Hospital Action Group has resulted in several requests to the Health Board for information around the decision-making process, and questioning the Health Board's efforts to recruit staff, culminating in several submissions to the Senedd's Petition Committee, Petition P-06-1350 Re-open Dyfi Ward at Tywyn Community Hospital now. Regular meetings with local town and county councillors, local AM and MP have been held since the temporary closure of Dyfi ward at Tywyn Community Hospital. Updates on recruitment progress, feedback around patient experience, sharing information around service demand and service developments have been extremely useful and positive. Various staff engagement workshops, drop-in sessions and training sessions have been held since the temporary ward closure, ensuring staff have the support to learn and develop as well as to listen to concerns and issues related to their redeployment. All staff have been given full protection of their terms and conditions including full reimbursement of any financial costs incurred due to their temporary redeployment. The Health Board attended a public meeting arranged by the Hospital Action Group, on May 4th, 2023. The meeting was attended by the Chair, Chief Executive Officer, West Integrated Health Community Director, and the Chief Officer of Llais. During the meeting, assurances were provided that the Health Board were actively recruiting to vacant nursing posts, linking in with both Hywel Dda and Powys Health Board, Bangor and Aberystwyth Universities, local partners including Gwynedd Local Authority, third sector opportunities and private providers to maximise delivery of community services locally in the area. Llais North Wales hosted a public forum on 28th November 2024 in Tywyn to assess the impact of the Dyfi Ward closure. Llais have been actively engaged throughout the process and continue to advise, critique and their feedback has directly shaped the process followed. The Tywyn Clinical Task and Finish Group have also assessed each of the options as part of

	a Quality Impact Assessment which will continue to develop ahead of any decision being made.
Are there any gaps in the information collected to date? If so, how will these be addressed?	It is important to note that as Tywyn is an area of high tourism impacting the population during holiday periods, continued engagement will take place throughout August 2026 to listen to the views and experiences of the area's summer residents. Whilst this will not form back of the consultation feedback it will support the information that goes to the Board as part of the later decision-making process.
Is the proposal relevant to how the Health Board complies with the public sector general duty relating to people who are protected by the Equality Act 2010:	
The elimination of discrimination and harassment	✓
The advancement of equality of opportunity	✓
The fostering of good relations	✓
The protection and promotion of human rights	✓

2.0 Welsh Language Compliance.	**Positive**	**Neutral**	**Negative**	**Explanation of Decision**	**Mitigation or Opportunities**
Implementation of the Welsh Language Standards	✓			Opportunity to strengthen provision	

Is the proposal influential in terms of dealing with the Welsh speaking public? • Will activities such as corresponding by letter, communicating by telephone, public meetings and other meetings comply with the Welsh language standards?	✓			In accordance with the Service Delivery Standards, the Health Board is committed to ensuring full compliance.	
• Will any new IT development comply with the Welsh Language Standards?	✓			Digital Data and Technology requirements will need to be explored in detail. Although the IT requirements are not currently known, there is a commitment to ensure that all IT requirements comply fully with the Welsh Language Standards.	
Is the proposal likely to impact upon the public image of the organisation? • Will all internal and external signs and notices comply with the Welsh language standards? • Will publications and forms be compliant? • Will any publicity material comply? • Will staff recruitment advertisements comply?	✓			Yes, we will operate in accordance with the Welsh Language Standards.	

• Will social media and digital and technological platforms comply?					
Is the proposal likely to have an impact upon implementation of the Welsh language standards? • Internal comms – (Policy for using Welsh internally -  WP70 - Health Board Wide Procedure - Usi	✓			Welsh Language Standards will be considered from the outset as part of planning process.	Commitment to work with the Welsh Language Team to ensure compliance with Welsh Language Standards
• Will the proposal create new jobs?		✓		Whilst there won't necessarily be "new roles" staffing would need to be strengthened for Option A and Option B may offer increased staff satisfaction and development opportunities across the local health infrastructure.	
• Will the staffing arrangements facilitate implementation of the language standards? Including structure of teams/departments		✓		Teams/department structure has not yet been determined	
• Welsh Language Awareness	✓			Welsh Language Awareness is a mandatory requirement for all staff. Refresher face to face training can be arranged.	

• Will the proposal offer training through the medium of Welsh?	✓			Identify gaps in provision and align with demand to provide training as required.	
• Will any arrangements with third parties comply with the Welsh language standards?		✓		Third party involvement would be through ongoing partnership working with local care homes for example rather than any direct commissioning outside of that which already takes place under Continuing Healthcare (CHC funding.	
• Will the proposal include any targets or indicators relating to the language?	✓			We will monitor data whether percentage of Welsh speaking staff reflects percentage of Welsh speakers in the community. In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language needs for each post advertised, categorising roles as:	

Commented [AG1]: Eleri and I need to look at this on Monday – we have misinterpreted the question – this asks about training through the medium of Welsh not training for learning Welsh

				(a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside wider training opportunities.	

				Welsh Essential posts include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must then provide training support.	

				The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.	
• How will performance be measured and monitored?	✓			By comparing language skills of staff with language needs of patients and monitor to what level this is achieved.	
3.1 Effect on Welsh speaking users					
• Will the proposal offer a language choice for users?		✓		Standards relating to written correspondence will be fully achieved offering language choice to service users.	
• Will it be possible for users to receive services in Welsh?		✓		Face to face bilingual service provision will be dependent on capacity of the workforce and demand for bilingual services. This will be mapped as part of the planning process with action plan to address any gaps in provision.	
• Will there be a bilingual environment?		✓		Signage and Corporate identity will be fully bilingual in accordance with	

				the Welsh Language Standards.	
Is there a risk for the proposal to discriminate against Welsh speaking service users? • Have the needs of Welsh speakers been considered in the proposal?	✓			Welsh language will be considered as part of the development and planning process.	
• Are Welsh speakers likely to receive the same standard of service as provided in English?		✓		The needs of Welsh speakers will be fully considered – environment, written correspondence, and recording of language choice.	
• Are Welsh language arrangements likely to lead to a delay in the service?		✓		Not with written communication, but face to face service provision will be dependent on workforce and availability of Welsh speaking staff. This will be mapped as part of the planning process with action plan to address any gaps in provision.	
• Is the proposal likely to make Welsh more visible?		✓		As per policy, Welsh language signage in the local area and the hospital will continue to be bilingual.	
• Is it likely to influence others to make more use of Welsh?		✓		Welsh language signage will be visible in the locality. Visual bilingualism will raise	

				awareness and normalise the use of Welsh. The promotion of the Welsh language on site could increase the interest in the language locally but difficult to measure if it will influence others to make more use of the Welsh language.	
• Will the Welsh language service in relation to the proposal be accessible?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will be mapped as part of the planning process with action plan to address any gaps in provision.	
• Will the service be as accessible in Welsh as in English?		✓		Written documentation will be fully compliant. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will be mapped as part of the planning process with	

				action plan to address any gaps in provision.	
• Will the services be available at the same time?		✓		Written documentation will be available at the same time. Face to face provision will be dependent on structure of the services offered, as well as workforce and demand for services. This will be mapped as part of the planning process with action plan to address any gaps in provision.	
3.2 Effect on Welsh speaking communities					
• Is the proposal likely to contribute towards safeguarding Welsh in communities?		✓		Not applicable	
• Is it likely to contribute towards the local economy in Welsh speaking areas?		✓		Not applicable	
• Does the proposal take steps to promote and facilitate the Welsh language?	✓			Yes – in terms of service provision.	
• Does the proposal contribute towards Welsh medium community activities?				Not applicable	

• Does it contribute to add value to other activities relating to language?				Not applicable	
3.3 Contribution towards Welsh language standards and other relevant guidance relating to the Welsh language.					
The language policies of partners: • Is the Health Board working in partnership on the proposal?		✓		Not applicable	
• Which other organisations are likely to be affected by the development?		✓		Not yet known	
• Do those organisations have Welsh language standards or language policies?		✓		Not yet known	
• Does the proposal contribute towards these schemes?		✓		Not yet known	

• How does the proposal contribute towards the vision of the Welsh Government for one million Welsh speakers by 2050?	✓			Continue to provide training opportunities for staff to learn Welsh aligning with the Welsh Government's vision by increasing the use of Welsh in the workplace. The Health Board employs an in-house Welsh language tutor to provide Welsh lessons for staff. These are delivered via Microsoft Teams, and are open to all staff across the Health Board, therefore there are no accessibility issues in terms of location of courses, and travel. The total numbers of learners who registered on some form of Welsh language training across the Health Board in 2024-2025 was **995**, an increase of 25% from 2023-2024. There are 22 different courses including weekly on line lessons, self-studying courses, residential courses at Nant Gwrtheyrn, sessions to	

				prepare for the Language Skills Certificate, specific courses for receptionists, 1:1 raising confidence courses and more. Feedback – 96% of learners are very happy with the provision. 83% of learners stated that they have greater confidence in using the Welsh language after completing the courses.	
3.4 The impacts identified and assessed					
What impacts and effects have you identified? How do you plan to address these impacts to improve outcomes for the Welsh language? Detail mitigation measures / alternative options to reduce adverse impacts and increase positive impacts.					
Positive impacts	Opportunities to increase awareness Deliver specific training for staff. Consider Welsh language as part of service development and workforce planning.				
Adverse impacts	No adverse effects All proposals will comply with Welsh language requirements.				
Neutral	In accordance with the Welsh Language Standards (Operational Standards) which relates to workforce planning, **Standard 106** requires the Health Board to assess Welsh language				

	needs for each post advertised, categorising roles as: (a) essential, (b) to be learnt on appointment, (c) desirable, or (d) not necessary. The Health Board must also: • assess staff Welsh language skills, • provide basic lessons during work hours, • offer free advanced training for those who complete basics. To meet these standards, the **Bilingual Skills Policy and Procedure** ensures effective recruitment and workforce planning so bilingual services can be delivered according to patient choice. Posts requiring Welsh at Level 3+ on the Electronic Staff Record are advertised accordingly, alongside wider training opportunities. **Welsh Essential posts** include front-line roles such as switchboard staff, booking/call centre staff, ward clerks, and receptionists. These are automatically recorded as essential in ESR. Administrative and clerical posts may also be designated essential or "to be learnt" depending on local Welsh-speaking capacity. If recruitment fails: • internal adverts must be extended externally, • if no Welsh speaker is found, a non-Welsh speaker may be appointed if they commit to learning Welsh to the required level within a set timeframe. The Health Board must then provide training support. The **Welsh Language Training Team** has developed a pathway to support staff appointed to "Welsh to be learnt" roles, ensuring they can meet language requirements.
3.7 Engagement	
During engagement, what questions do you wish to ask about the Welsh language impacts?	Do you have a view on any impacts our proposals may have on the Welsh language?

With whom are you engaging? How are Welsh language interest groups likely to respond?	Despite materials being available in Welsh, with Welsh translation available and Welsh speakers at events, no feedback has been received thus far in the Welsh medium. For Phase Three, we will consider further targeted work to identify Welsh-first speakers in the area.
Following engagement, what changes have you made to address language issues raised?	There haven't been any thus far.
3.8 Post engagement, final proposals and on-going monitoring	
Summarise your final decisions, list the likely effects on the Welsh language and how you will promote / mitigate these. Record your compliance with the Welsh language standards (you will need to refer to this summary in the impact assessment template)	
How will you monitor the on-going effects during implementation of the policy?	

Who signed-off this Impact Assessment: *As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.*		
Approval Date:		
Review Date:		
Project Lead Sign-off I confirm that this Welsh Language Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's	**Welsh Language Team Quality Check** I confirm that I have reviewed this Welsh Language Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee.	**Committee Chair Sign-off** I confirm that this Welsh Language Impact Assessment represents evidence that we (The Health Board), in making this decision, have

WP7 Procedure for assessment work for evidencing Due Regard for: Welsh Language requirements. Signed: (Project Lead)	Signed: Eleri Hughes-Jones (Head of Welsh Language Services)	given due regard to the need to reduce the Welsh language inequality. Signed: (Committee Chair)

Appendix 3: Outpatient Services at Tywyn Community Hospital

- Audiology
- Gwynedd Autism
- Community Mental Health
- Heart Failure
- Cardiology Clinic
- Diabetic Retinopathy
- Diabetic Clinic
- Lymphoedema Clinic
- Orthopaedic Clinic
- Orthoptist
- Paediatric Clinic
- Pacemaker Clinic
- Respiratory Clinic
- Substance Misuse Counselling
- X-Ray
- CAMHS Clinics
- Continence Promotion
- Podiatry
- Physiotherapy
- Occupational Therapy
- Ophthalmology

Shaping the Future of Services at Tywyn Community Hospital

Pre-consultation report on engagement activity and feedback

1. Introduction

This report provides a summary of the pre-consultation engagement undertaken by Betsi Cadwaladr University Health Board (BCUHB) in relation to the review of services at Tywyn Community Hospital.

The report:

- Sets out the approach to engagement
- Summarises participation and methods used
- Identifies key themes arising from feedback
- Demonstrates how engagement has informed the development of options

This report is intended to support the case for change and will continue to inform the formal public consultation stage.

2. Background

In 2023, the temporary closure of Dyfi Ward at Tywyn Community Hospital highlighted longstanding issues relating to workforce sustainability and the resilience of inpatient services.

Following a decision by the Board in May 2025 to review the service and develop a sustainable solution for the future; since July 2025, the Health Board has undertaken a programme of pre-consultation engagement to understand the experiences of those within the local community as well supporting the development

of potentially viable options for the future of the service responding to the need to deliver safe, sustainable and value-based care to the local community, whilst acknowledging the challenges already faced.

3. Legal duties for communications and engagement relating to service change

As a public body, Betsi Cadwaladr University Health Board must adhere to all legislation regarding the involvement of its population in the planning, development and delivery of services.

Guidance from the Welsh Government states that:
Section 183 of the National Health Service (Wales) Act 2006 requires local health boards (LHBs), with regard to services they provide or procure, to make arrangements to involve and consult current and prospective service users, or their representatives, on:

- planning to provide services for which they are responsible
- developing and considering proposals for changes in the way those services are provided
- making decisions that affect how those services operate.

Section 242 of the National Health Service Act 2006 extends this requirement to NHS Trusts in Wales. For the purposes of this guidance, the Welsh Government considers that Llais is a body representing current and prospective service users.

Llais represents the interests of the public in relation to health and social services in Wales. The need to secure safe and sustainable services and access for all to best practice within available resources is equally of concern to the NHS and its users and something which the NHS in Wales must work with Llais to achieve. NHS bodies should therefore engage with Llais as it works to improve services.

4. Engagement approach

A wide range of engagement and stakeholder involvement has been undertaken via a focused engagement exercise with local residents, staff, and stakeholders.

A phased approach to engagement has been conducted to support the service review process as follows.

Phase one (July 2025 to October 2025)

This phase of communications and engagement focused on:

- Listening to what matters to people — their priorities, concerns, ideas and experiences.
- Recording the feedback
- Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services.

This was done via the following activity:

- Social media and digital awareness raising
- An online survey
- Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising.
- Attendance for feedback gathering within the Minor Injuries Unit
- 04.08.2025: Attendance at a listening event in partnership with Hywel Dda University Health Board.
- 20.08.2025: Attendance at the Meirionnydd County Show.
- 28.08.2025: Attendance at the South Meirionnydd Older People's Forum
- 12.09.2025: Attendance at the Social Drop-in, Aberdyfi
- 15.09.2025: Attendance at Aberdyfi Community Council
- Monitoring of correspondence was ongoing with regular updates issued to local MS and MPs via routine updates and bulletins.

Feedback was published as part of the Phase One Engagement Report.

Phase Two (November 2025 to April 2026)

Phase two of the communications and engagement activity focused on raising awareness of and inviting feedback on further developed thinking, explaining the work to develop options and actively seeking feedback from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community, as well as being cognisant of the Health's Board duty under the Wellbeing of Future Generations Act.

The second phase placed more of a focus on face-to-face community engagement to have more detailed conversations with members of the local community and representative groups. This included:

- Continued digital awareness raising
- Online survey – paper copies were also available
- Reaching out to stakeholder groups, including local schools and colleges, for face-to-face conversations and support in awareness raising.
- Attendance for feedback gathering within the Minor Injuries Unit
- Attendance for feedback gathering within Outpatient clinics held at Tywyn Community Hospital
- 05.11.2025: Tywyn staff briefing onsite
- 12.11.2025: Attendance at Tywyn Town Council meeting
- 17.11.2025: Attendance at Bryncrug Council meeting
- 17.11.2025: Attendance at Aberdyfi Community Council meeting

- 18.11.2025: Attendance at Llanegryn Council meeting
- 21.11.2025: Tywyn staff drop-in
- 21.11.2025: Attendance at Friday evening youth club, Tywyn Baptist Church (c.45 young people)
- 24.11.2025: Attendance at Arfon Access Group meeting
- 25.11.2025: Attendance at morning parent and toddler group, Tywyn Baptist Church, (c.10 parents/carers)
- 13.01.2026: Attendance at Llanfihangel y Pennant council meeting
- 16.01.2026: Attendance at Tywyn Community Hub coffee morning (c.100 attendees changed the drop-in session to a "town hall" style event)
- 16.01.2026: Attendance at the social drop-in, Aberdyfi (8 attendees)
- 02.02.2026: Tywyn staff briefing
- A total of 537 survey responses were received.

It is important to note that as Tywyn is an area of high tourism impacting the population during holiday periods, continued engagement will take place throughout August 2026 to listen to the views and experiences of the area's summer residents. Whilst this will not form back of the consultation feedback it will support the information that goes to the Board as part of the later decision-making process.

Regular communications with Llais remains ongoing with proactive updates being provided as well as their active involvement in the "Balanced Room" conversations.

5. Pre-consultation feedback

It is important to note that participation in requests for feedback is voluntary, with respondents often being self-selecting. Views collected may therefore not fully represent the broader patient or public population though efforts have been made to gather a broad range of views from the community of different ages and with differing health needs.

5.1 Findings throughout the engagement period

The programme of pre-consultation engagement has provided a detailed and consistent picture of community perspectives regarding the future of services at Tywyn Community Hospital. Across all engagement channels - including surveys, community events, stakeholder sessions and written correspondence - a number of clear and interrelated messages have emerged.

A defining feature of the feedback is the strength of feeling regarding the importance of local inpatient provision. The closure of Dyfi Ward continues to have a significant emotional impact on many in the community. Many respondents spoke of the ward not only as a clinical facility, but as a valued local asset that enabled care to be delivered close to family, community and support networks. This was particularly evident in relation to end-of-life care and rehabilitation, where proximity to home is seen as essential to maintaining dignity, independence and family involvement.

At the same time, the engagement highlights a pragmatic understanding among some stakeholders of the wider challenges facing healthcare systems, including workforce constraints and the need to deliver sustainable models of care. Whilst there is clear support for the reinstatement of inpatient beds, there is also recognition that any future model must be deliverable, safe and resilient over time. This tension between community aspiration and system sustainability underpins much of the feedback received.

A consistent theme throughout the engagement has been the importance of access to services within a rural context. Tywyn and the surrounding areas are characterised by geographical isolation, limited public transport options and an ageing population. Respondents frequently described the difficulty of travelling to larger hospitals, both for treatment and to visit relatives. These challenges were framed not only in terms of inconvenience, but as having a direct impact on health outcomes, wellbeing and the ability of families to provide support. The principle of "care closer to home" is therefore viewed as a necessity for the community.

Alongside this, there is strong support for the continuation and enhancement of community-based services, including those developed following the ward closure. Services such as the Minor Injuries Unit, Treatment Room, Wellbeing Hub and Tuag Adref are recognised as valuable and, for many, represent a positive development in the local healthcare offer. Engagement suggests that these services are seen as improving access and supporting independence, particularly for those who might otherwise need to travel. However, feedback consistently indicates that stakeholders do not view these services as a substitute for inpatient provision, but rather as complementary.

The engagement has also highlighted a strong preference for a combined or "hybrid" model, where inpatient beds and expanded community services coexist. Many respondents perceive this as representing the most balanced and equitable solution - retaining local beds while also expanding preventative and outpatient care. This preference reflects a community expectation that the hospital should operate as a fully functioning local hub, maximising the use of existing facilities. However, this expectation sits alongside the operational and workforce challenges identified through the technical appraisal and stakeholder discussions.

There has been a general polar view between different parts of the community with some expressing a deep desire for inpatient beds to provide end of life care locally, whilst generally, younger members of the community value supporting loved ones within their own home whilst supporting any solution that expanded community provision, reduced travel need and provided more long-term career opportunities for healthcare workers and their families. Some young people expressed concern at the

impact on schooling when having to travel out of Tywyn for some routine appointments or follow-ups.

Another important theme within the feedback is the issue of workforce and recruitment. While the challenges associated with staffing are acknowledged, a number of respondents expressed concern regarding perceived inconsistencies or limitations in recruitment efforts. Some participants suggested that with sufficient focus, investment or alternative approaches, staffing challenges could be addressed. This highlights a potential gap between organisational understanding of workforce constraints and public perception, reinforcing the importance of transparent communication during consultation.

The engagement process has also surfaced issues relating to trust and confidence. In some instances, participants expressed scepticism regarding the purpose of the engagement or concern that decisions may already have been made. Feedback indicates a desire for clearer information about the decision-making process, the evidence underpinning options and the extent to which community views will influence outcomes. Addressing these perceptions will be critical to ensuring that the formal consultation is seen as meaningful, open and credible.

Finally, the engagement demonstrates a wider ambition for Tywyn Community Hospital to play a broader role within the local health and care system. Stakeholders expressed interest in a wider range of services being delivered locally, including outpatient clinics, diagnostics and specialist support. This reflects both a desire to reduce reliance on distant hospitals and an aspiration to ensure that the hospital continues to contribute to the sustainability and attractiveness of the local area.

5.2 Key themes at a glance

Desire for Local Inpatient Provision

A strong and consistent theme was the desire for local inpatient beds.

Feedback highlighted:

- The importance of inpatient care within the community
- The value of Dyfi Ward for rehabilitation and end-of-life care
- Concerns about loss of local provision

Survey responses frequently expressed a preference for reopening the ward and restoring inpatient services.

Importance of Local Access to Care

Stakeholders consistently emphasised the importance of:

- Accessing care close to home
- Minimising travel to other hospitals
- Maintaining local services where possible

This was seen as particularly important for:

- Older people
- People with long-term conditions
- Those without access to transport

Rurality and Travel

Feedback highlighted challenges associated with the rural location, including:

- Long travel times to acute hospitals
- Limited public transport provision
- Difficulty for families and carers visiting patients

There were concerns that changes could disproportionately impact rural communities.

Value of Community Services

There was recognition of the benefits of:

- Community-based care models
- Services supporting independence and care at home
- Expanded outpatient and treatment services

However, feedback often indicated that these should be in addition to, rather than instead of, inpatient provision.

Workforce and Sustainability

Engagement highlighted concerns around:

- Recruitment and retention of staff
- The sustainability of different service models
- Perceived inconsistencies in recruitment activity

Some respondents suggested that improved recruitment approaches could support reopening services.

Trust and Communication

Some feedback reflected:

- A desire for greater clarity about proposals
- Concerns regarding how decisions are made

- The importance of transparent communication

This reinforces the need for a clear and accessible consultation process.

Broader Service Offer

Respondents expressed a desire for a wider range of local services, including:

- Additional outpatient clinics, particularly ones that could support the ongoing management of long-term conditions, e.g., type 2 diabetes or that could support sexual health and family planning
- Diagnostic services
- Mental health and rehabilitation provision

There is general overall support for maximising use of the hospital as a community health hub.

6. How engagement has informed option development

The findings from engagement have directly influenced the development of options by:

- Highlighting the importance of local provision and accessibility
- Informing the balance between inpatient and community-based models
- Identifying key risks and considerations for each option
- Ensuring stakeholder priorities are reflected in proposals

The options taken forward for consultation recognise both:

- Community preferences
- Clinical, workforce and operational considerations

Feedback from engagement has been regularly presented to the Service Change Oversight Group and featured throughout the Balanced Room stakeholder sessions.

During the consultation phase, communications activity will build on the feedback, particularly around clarity concerns, and will take place across multiple channels to raise awareness of any proposals and ways in which to get involved.

7. Overview of respondents

Two surveys were undertaken as part of the pre-consultation engagement process, alongside wider engagement activity. Combined, these provide an evidence base for the development of options and the next phase of engagement activity – full consultation.

Geographic Profile

The majority of respondents were resident in Gwynedd, with a strong concentration in the Tywyn (LL36) postcode area

A small number of responses were received from neighbouring areas and visitors, reflecting the wider catchment of the hospital

Overall, responses are considered to be representative of the population most directly affected by service changes within Tywyn Community Hospital.

Age Profile

Responses were predominantly from middle-aged and older adults, with particularly strong representation in:

- 55–64 years
- 65–74 years
- 75+ age groups

There were fewer responses from younger age groups, although targeted participation was sought from those aged 16–34 via specific engagement within youth clubs and local parent and toddler forums.

This profile reflects:

- The demographic composition of the local population
- The higher likelihood of older residents being frequent users of community hospital services

Gender

- The majority of respondents identified as female
- A smaller proportion identified as male, with very limited representation of other gender identities
- This pattern is consistent with typical engagement activity, where women are often more likely to participate in a call for feedback relating to health and care services**.** This was discussed as an area to address during one of the stakeholder sessions and working age men will be a target audience during the consultation phase.

Ethnicity

- The respondent group was overwhelmingly White British
- Very limited representation from other ethnic groups

This broadly reflects the demographic profile of the local area, although it is noted that engagement with more diverse communities may require targeted approaches during consultation.

Language

Respondents identified both Welsh and English as first languages, with a mix across the dataset

Feedback did not identify significant concerns regarding Welsh language provision, though some respondents highlighted the importance of ensuring services are accessible in both languages

Employment Status

Respondents included a mix of:

- Retired individuals (a significant proportion)
- People in full-time and part-time employment
- A small number of unemployed respondents and students

The high proportion of retired respondents aligns with the older age profile and reflects those most likely to access community hospital and intermediate care services though with duties under the Wellbeing of Future Generations Act in mind, further more targeted work will take place during the consultation phase to reach a broader range of feedback.

Health, Caring Responsibilities and Accessibility

A proportion of respondents identified as having a disability or long-term condition

Many respondents also identified caring responsibilities, supporting relatives or others

These perspectives are particularly relevant, as they reflect groups most directly impacted by service accessibility, travel and continuity of care.

Interpretation

Overall, the respondent profile indicates that engagement has:

- Successfully captured views from the core user group of community hospital services, particularly older residents and those with health or caring needs

- Achieved strong representation from the local population most directly affected by proposed changes
- Provided insight grounded in lived experience of rural healthcare access and service use.

However, it also highlights areas for further focus during consultation, including:

- Increasing participation from younger people and working-age adults
- Ensuring continued engagement with under-represented groups

The combined survey responses and feedback from face-to-face conversations provide a robust and locally representative evidence base, particularly reflecting the views of:

- Older residents
- People living in rural communities
- Individuals with direct experience of health and care services

These insights form an important foundation for the development and testing of proposals during formal consultation.

8. Next steps

Findings will be presented to the Health Board as part of a decision-making meeting on which options should be taken forward for formal consultation.

The information will be used to better inform the Health Board's approach to engagement, ensuring all protected characteristics are considered and heard from; particularly those as identified in the next phase of the Integrated Equalities Impact Assessment.

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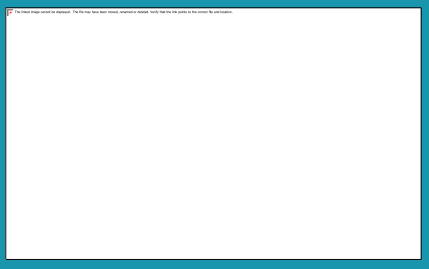

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Tywyn Community Hospital Balanced Room No. 1

Outcomes Report

October 2025

Contents

Document	2519 BCUHB_Tywyn Balanced Room 1_Report		
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1. INTRODUCTION

Background, context, and participants

Introduction

This report sets out the summary record of the deliberations and outcomes of scenario development and appraisal session held in Aberdyfi on the 5th of September 2025. The session was designed to develop a longlist of potential scenarios for potential service change at Tywyn community hospital following the temporary closure of the Dyfi ward in April 2023 and the development of mitigating services, namely:

1. **Four extra inpatient beds** were added at Dolgellau & Barmouth District Hospital to meet demand from the Tywyn area.
2. The reopening of the **Minor Injuries Unit** (MIU) in July 2023.
3. A new **Treatment Room** has opened, offering comprehensive wound care, dressing services, blood tests, and catheter management.
4. The **Tuag Adref (Homeward Bound)** service which increases community capacity by helping people stay at home, avoid unnecessary hospital admissions, leave hospital earlier, and receive support and rehabilitation after discharge.
5. In July 2023, Tywyn Hospital staff opened a **Wellbeing Hub** offering health promotion, social support, and regular community activities.

The event was held at Neuadd Dyfi; Aberdyfi; LL35 0NR, between 10:00 and 16:00.

Essential Criteria

The agreed essential criteria, against which any scenarios developed in the session were to be appraised against are shown in the table below.

Criteria	Test
Quality and Safety Services meet standards, minimise risk to patients and patients have a good experience.	Can the option provide safe, evidence-based care with sufficient registered staff, maintaining or improving outcomes and patient experience?
Efficiency and Effectiveness 1. Efficiency - Ability to do things well and without waste. 2. Effectiveness – the extent to which	Can the option deliver services efficiently, following effective clinical pathways and achieve intended outcomes?

Criteria	Test
desired outcomes or results are achieved.	
Deliverability That we can actually deliver what we say we will.	Is the option realistically achievable with available resources (e.g. finance, people) and within a reasonable timeframe?
Sustainability Ability to manage risk and adapt over time.	Can the option be maintained over time, adapting to workforce, demographic and technological changes, while supporting recruitment and retention?
Accessibility and Inclusion Services are equally available and accessible to all. **Note:** The Integrated Equality Assessment highlights the needs of older and disabled people (who are frequent users of community hospitals), as well as carers and those who are economically disadvantaged	Does this option avoid creating extra obstacles for these groups in accessing healthcare?

Participants

Participation in the event was recruited on the basis of creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising options. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

1. **Voting participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and vote in deliberations.
2. **Expert participants:** representatives of BCUHB on hand to provide expert opinion and input to deliberations.
3. **Facilitation team:** the team who enabled discussions without taking part in decision making.

Voting Participants

Table 1

1.	Geoff Ryall-Harvey	Llais
2.	Alan Jones	Bryncrug Community Council
3.	Karen Bampfield	BCUHB

Table 2

1.	Sandy Andrews,	Aberdyfi Community Council and Gwynedd Couty Council
2.	Jane Barraclough	Tywyn Hospital Action Group
3.	Janet Maher	Tywyn Hospital Action Group
4.	Andrew Bullock	BCUHB
5.	Delyth Kerr	Carers Outreach Service
6.	Bethan Lawton,	Llanegryn Community Council and Gwynedd County Council
7.	Carys Norgain	BCUHB

Table 3

1.	Tim Ryder	BCUHB
2.	Keith Jones	Hywel Dda UHB
3.	Anne Lloyd-Jones	Tywyn Town Council and Gwynedd County Council
4.	Sioned Rees	BCUHB
5.	Bethan Williams	Alexandra Nursing Home
6.	Chris Wood	Town Clerk, Tywyn Town Council

Technical experts

1.	Eleri Roberts	BCUHB
2.	Vic Peach	BCUHB

3.	Paul Andrew	BCUHB
4.	Steve Doore	BCUHB

Event Facilitation Team (non-voting)

The facilitation team supporting the event's running consisted of:

1.	Independent Facilitator	Andy Wright, ASV
2.	Senior Responsible Officer (SRO)	Paolo Tardivel (BCUHB)
3.	Table Facilitator	Helen Stevens-Jones (BCUHB)
4.	Table Facilitator	Patrick Roberts (BCUHB)
5.	Table Facilitator	Alan Morris (BCUHB)
6.	Table Scribe	Wendy Hooson (BCUHB)
7.	Table Scribe	Sophie Stevens-Jones (BCUHB)
8.	Table Scribe	Becky Jones (BCUHB)

9. DELIBERATION

Discussions and considerations

Introduction

This section details the deliberative process undertaken to developing and appraising scenarios for the future service delivery around the Dyfi ward at Tywyn Community Hospital. Discussions employed the balanced room approach to ensure a fair and inclusive assessment.

Participants with diverse viewpoints engaged in thorough discussion. Each scenario was evaluated transparently and objectively using a structured scoring system and clear criteria.

Emerging Scenarios

Table One Scenario Generation

Options developed:

1. Re-open the ward 'as was', pre-April 2023, with none of the 'new services.' Implications discussed included:
    1. Patient choice
    2. Travel impact
2. Develop the Dyfi ward as a day case treatment facility providing IV treatment including chemo/oncology, implications discussed included:
    1. Older
    2. Disabled
    3. Communities
    4. Carers
    5. Welsh Language
3. Diagnostic facility, implications discussed included:
    1. Travel
    2. Waiting times
    3. Expectations of carers
    4. Ability to deliver services in Welsh.
4. Facility focused on preparing people to go home 'well' / stay well (using the ward as a reablement facility.)
5. Using the wards as an end-of-life care facility

Table Two Scenario Generation

1. **Open all beds (16)**: a fully funded ward plus all the services. It is not clear why staffing is not resilient enough. Tywyn is a modern building with modern up-to-date facilities. Dolgellau is a crumbling building. We have the same right to decent mental health and dementia services as everyone else – develop Llys Cadfan with dementia outreach. We need a good vision. We need commitment from the Health

Board to do this. We used to have a kitchen which was funded using donations, but it is now closed and used as a clinical store. We used to have a garden, but it hasn't been maintained. The ward was used for palliative and end of life care because it is torture to have to go to Aberystwyth. It kills you as a family to have to go that far. Being local makes all the difference. At the end-of-life stage you should have a choice. Maternity and surgery used to be provided at Tywyn (it was noted however that maternity is quite specialist and that it may not be possible to re-provide this service). Improved cross-border working is needed – seamless access to the best care regardless of which Health Board is providing the service. Now cross-border services are not joined up. Computer systems are not joined up.

2. **Virtual tele-health services** linking Health Boards
3. **Eight bedded ward open.** This would mean more resources available in the community. If MIU was on the ward, then the staff could run the ward and the MIU.
4. **Increase in community services**. Tuag Adref has been a big support for District Nurses (DNs). DNs would struggle if the model reverted to a bed base.
5. **End of Life and Palliative Care beds** that offer choice in terms of care at home or care in hospital. This could be on a ward or in a nursing home. The Night Owls service in Anglesey is an example of an end-of-life scheme in the community.
6. Open the ward on an **as and when needed** basis.
7. **Learn from best practice** in other areas e.g. Bishops Castle Community Hospital and Brecon.
8. **The provision of key services such as x-ray delivered by Health Board's elsewhere**. An orthopaedic service is being provided once a week by Hywel Dda. It was noted that there could be a problem in that patients could be referred into services which are much further away.
9. **Tywyn developed as a hub for community services** rather than Dolgellau i.e. it provides what Tywyn is providing now.
10. **Dolgellau Hospital has no beds** and just delivers outpatient services.
11. **Beds in Tywyn with a reduced number of beds in Dolgellau.** Continue to provide community services in both. Transport is an issue for families and carers travelling to visit patients in Dolgellau.

Table Three Scenario Generation

1. **Ward not re-opened:** beds provided in nursing and residential homes; this would need to address the following issues:
   - What capacity are they currently running at?
   - Limited spaces?

- Build a new nursing home?

2. **Ward not re-opened:** End of care life at home; this would need to address the following issue:
   - Palliative care that can't be done at home?
3. **Ward not re-opened:** expansion of services and development, broader services provided, work with community and partners; this would need to address the following issue:
   - Understand the local demand and build on the services they need e.g. IV
4. **Ward not re-opened:** Virtual clinics provided, especially for the vulnerable, with the benefit of less requirement to travel
5. **Ward not re-opened:** Working with Powys Health Board, providing clinical expertise across a wider area
6. **Ward not re-opened:** working with Welsh Ambulance Service University NHS Trust (WAST) to establish what could they provide, e.g.:
   - Transport
   - Clinical

Combined Scenarios

Following the discussions in small groups around their individual tables their discussions were fed back to the entire group. There was a measure of overlap and duplication in the feedback and the independent facilitator amalgamated these into scenario 'family groups'. These are shown below

Key:

Removed from consideration: recognised as an enabler

Removed from consideration as a parking lot issue

1. Use as an end-of-life facility: using the ward as hospice or providing a few end-of-life beds supported by charitable provision.
2. Develop the ward as a reablement facility, to support frail/elderly people to return home and stay well.
3. Use the ward as a diagnostic facility. This scenario is based on using the Dyfi ward to expand the current provision of diagnostics beyond x-ray to provide services (currently unspecified) to prevent local people from having to travel for such services.
4. Use Dyfi ward as a day treatment centre, expanding beyond that currently provided to include services such as IV treatments and chemotherapy.

5. Telehealth. Providing virtual services to patients at home. (Removed from consideration: recognised as an enabler)

6. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)

7. Develop Tywyn as a hub for community services (without beds) building on and enhancing existing District Nursing provision (including end-of-life at home). Full detail not specified by the group.

8. "Swap with Dolgellau". It was suggested that the situation in Tywyn should be reversed with all beds open and no beds provided in Dolgellau. (Removed from consideration as a parking lot issue.)

9. Learn from best practice in other areas e.g. Bishops Castle Community Hospital and Brecon. (Removed from consideration: recognised as an enabler.)

10. Provision of services at Tywyn by partners - other health boards or trusts. (Removed from consideration as a parking lot issue.)

11. Open beds and a 'need only' basis

12. Strengthening end of life care – in patient or at home. (Removed from consideration: recognised as an enabler

13. Ten beds ward, plus 'new services'

14. Sixteen beds, fully funded with delivery of all 'new services', plus:
    1. Dementia care Mental health provision
    2. Services delivered in past at Tywyn (e.g. surgery/maternity)

15. Provision of a reduced number of beds in Dyfi ward, plus all 'new services', and delivery of increased community services (as in scenario 7.)

16. Develop the ward as a dedicated dementia facility to cater for the ageing population in Tywyn and surrounding area.

17. Maintain the current position of no beds plus 'new services.

18. Reopen the ward as it was in 2023, without 'new services.'

Enablers

The following were developed as potential scenarios by the small group (table) discussions, but after discussion in the consensus session were recognised as being underpinning actions or 'enablers' to deliver any future services at Tywyn community hospital. These were:

1. **Using staff skill mix differently**, whether to keep beds open or to deliver the alternative scenarios discussed and developed in the session deliberations.

2. **Exploring and providing telehealth options.** Providing virtual services to patients at home.

3. **Learning from best practice** in other areas where community hospitals have been successfully reconfigured e.g. Bishops Castle Community Hospital and Brecon.

4. **Strengthening end of life care**, with consideration of in patient or at home provision, with the overall aim of reducing distress caused by the need for excessive travel under very difficult circumstances.

Car Park Issues

The following were 'parked' as being outside the scope of the group discussions and purpose but recognised as important to acknowledge and provide answers to the group.

1. Scenario Eight: "swap with Dolgellau". Table 2 suggested that the situation in Tywyn should be reversed with all beds open and no beds provided in Dolgellau. This was rejected in consensus discussions based on:

    1. There was no one from the Dolgellau community present to discuss this with in the spirit of no decision about me without me.

    2. The feeling that consideration of such an option would pit community against community, which is outside the remit, authority or desire of the group to promote.

        3. It was also recognised that this would require separate public conversation and is therefore not deliverable within timescale.

    The group consensus was that this should not be considered any further but is included in the parking lot in recognition of the passion with which the minority in favour of the proposal presented their case.

2. Scenario 10: provision of services at Tywyn by partners (other health boards or trusts). It was recognised that there was no significant presence from those partners, and such discussions were outside the scope of the group discussions. Parked in recognition of the potential for future discussion and collaboration.

3. Patient informed choice to enable care closer to home (no automatic referrals to hospitals far away.) Parked as only discussed in one group and not shared in the consensus session.

Scoring

Having develop a longlist through group discussions and agreement on areas of duplication/amalgamation the group then went on to score the scenarios developed through the process.

Assessment was against the **essential criteria** which are the minimum requirements that any option must meet to be considered viable for public consultation. They act as a "pass/fail" gateway: if an option does not meet these criteria, it is ruled out before detailed scoring or weighting takes place. This ensures time and resources are focused only on options that are deliverable, lawful, and capable of meeting the service need.

The session began by defining the essential criteria to be used in appraising the longlist of scenarios to reduce it to a medium list. The following is a summary of the essential criterion for context:

1. Quality and Safety
2. Efficiency and Effectiveness
3. Deliverability
4. Sustainability
5. Accessibility and Inclusion

The groups reviewed each longlisted scenario using binary Yes/No assessment for every criterion. Only scenarios with Yes on all essential criteria move forward; any No disqualifies them. Those passing all criteria are then subject to a shortlisting process against yet to be developed desirable criteria in a separate workshop.

Overall Pass/Fail Decision

Applying this process to all the scenarios under consideration provided the following results.

NB: Where reference is made to **'new services'** this refers the mitigating services described in Section One (extra inpatient beds in Dolgellau & Barmouth, ad MIU, Treatment Room, Tuag Adref and Wellbeing Hub at Tywyn.)

Scenario	Group 1	Group 2	Group 3	Consensus
1. Use the ward as an end-of-life facility *: Ward as hospice; or charitable bed/beds	No	No	No	**No**
2. Develop the ward as a reablement facility	Yes	Yes	No	**Yes**
3. Use the ward as a diagnostic facility	No	No	No	**No**
4. Use Dyfi ward as a day treatment centre	Yes	Yes	Yes	**Yes**
5. Removed from consideration: recognised as an enabler	[redacted]			

Scenario	Group 1	Group 2	Group 3	Consensus
6. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)	Yes	No	Yes	**Yes**
7. Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)	Yes	Yes	Yes	**Yes**
8. Removed from consideration: 'car park' issue	[redacted]			
9. Removed from consideration: recognised as an enabler				
10. Removed from consideration: 'car park' issue				
11. Open beds and a 'need only' basis	Yes	No	No	**No**
12. Removed from consideration: recognised as an enabler	[redacted]			
13. Ten beds ward, plus 'new services'	No	Yes	No	**No**
14. Sixteen beds, fully funded with delivery of all 'new services', plus: 1. Dementia care Mental health provision 2. Services delivered in past at Tywyn (e.g. surgery/maternity)	No	No	No	**No**
15. Reduced number of beds, plus 'new services', and increased community services	No	Yes	No	**No**
16. Develop the ward as a dedicated dementia facility*				
17. Maintain the current position of no beds plus 'new services'*	Yes	Yes	Yes	**Yes**
18 Reopen the ward as it was in 2023, without 'new services.'	Yes	No	No	**No**

The process and consensus discussions to reach the decisions in this table, particularly where groups vary in opinion, is detailed in Section Three of this report.

3. OUTCOMES

The results of deliberations to reach consensus on selected scenarios.

Introduction

Having scored the scenarios where the groups differ, a facilitated plenary discussion was held to resolve discrepancies. In this:

1. Scenarios which received clear consensus No from were not discussed during this session.
2. In the same manner scenarios that were agreed as a YES by all groups were also not discussed in the consensus session and were put forward for the next stage of the process.

Other scenarios developed by the groups were removed from consideration in the consensus discussion for the following reasons:

1. Being an enabling mechanism for the delivery of any service change around the Dyfi ward.
2. Moved to a 'car park' issue as being outside the scope of this discussion.

Consensus Discussion

Provided below is a summary of the discussion had to reach consensus on those scenarios which were neither felt to be clearly Yes nor No.

Scenario Two

Transform the ward into a dedicated reablement facility.

1. Counter arguments to Table 3's discounted
2. Older population – doesn't suit them.
3. Home first not suitable for everyone
4. Whole system – there are people in acute hospitals who might need this care.
5. There was a difference of opinion amongst the groups,
6. **Consensus pass** with caveat that more information is needed to understand deconditioning and how the ward could function to counter this.

Scenario Three

Use the Dyfi ward as a diagnostic facility.

1. Group 2 passed, Groups 1 and 3 failed.

2. No infrastructure to support the facility.

3. Haven't got the equipment, would be unaffordable.

4. Consensus agreement as a **FAIL**

Scenario Six

Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)

1. Group 2 failed the scenario providing the rationale of concerns over sustainability moving forward. The feedback highlighted the difference between private and public provision, with members within the discussion on the table wanting to retain as 'public' rather than see it in 'private' provision.

2. Group 1, saw this as an opportunity to enhance provision/sustain workforce enabling competencies to be retained or developed, and would enhance public service for the community.

3. Group 3 took the view that the local residential/nursing home sector was well supported to deliver and have the competencies required.

4. Through consensus discussions it was agreed to **pass the scenario** with caveat that the liability of the businesses concerned was fully explored and would not expose the community to undue risk.

Scenario Eleven

Open beds and a 'need only' basis

Following discussion Group One felt this needed further consideration and asked for further information on the format and functionality of the potential scenario.

Scenario Thirteen

Ten beds ward, plus 'new services'

1. Group one felt this scenario was not deliverable, as there is a fixed financial and staff envelope where the Health Board can't use the resources twice.

2. Group two felt this makes a judgement on 'either/or' and were not happy about that.

3. Group two also made the point that Welsh Government resource allocation "…is what it is…" The point was made the even if we get ten beds and resources to deliver the 'new services', it could not be delivered, as it is unrealistic to recruit.

4. Facilitator suggested that while this scenario is agreed as not viable, further information re: funding should be explored in the spirit of openness and transparency.

Scenario Fifteen

Provision of a reduced number of beds in Dyfi ward, plus all 'new services', and delivery of increased community services (as in scenario seven detailed in section two)

1. Group two felt clarity was required re: resources, can e.g. Macmillan provide support.
2. Group three felt staffing is the same making it an unrealistic proposition.
3. Facilitator suggested that while this scenario is agreed as not viable, further information re: resources should be explored in the spirit of openness and transparency.

Scenario Eighteen

Reopen the ward as it was in 2023, without 'new services.'

This was rejected by all but group one

1. Group one felt that if there were concerns regarding a ward only opening, then logically those concerns would seem to extend to all other ward-based services. In the group's opinion it didn't make sense to reject this scenario at this point.
2. Group two rejected the scenario, however, following the broader 'all room' discussion it was acknowledged that the table's decision to fail this option was inconsistent with its decision to pass options thirteen and fifteen, which also included the reintroduction of beds'.
3. Group three rejected in on the basis that this scenario disadvantages those who have benefitted from 'new services' since 2023.
4. Overall, it was determined that scenario eighteen was not passed. However, after operational review outside the workshop and allowing for the need for consideration of operational parity with scenario two (reablement ward) this scenario is put forward to the medium list considerations as a **PASS.**

Medium List of Scenarios

Following the consensus session, and recognising the need to provide further information on rejected scenarios, a medium list of six scenarios was produced from the balanced room process. In summary these are:

	Scenario
2.	Develop the ward as a reablement facility
4.	Use Dyfi ward as a day treatment centre
6.	Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
7.	Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
17.	Maintain the current position of no beds plus new services
18	Reopen the ward as it was in 2023, without new services.

The West Integrated Health Community team concluded that scenarios four, six and seven represent overlapping service configurations and should be rationalised into a single delivery model. Taking this into account the final medium list of scenarios is as shown below.

	Scenario
A.	Reopen the ward as it was in 2023, without 'new services.'

B. Maintain the current position of no beds plus 'new services'

C.
1. Use Dyfi ward as a day treatment centre
2. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
3. Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home

D.
4. Maintain the current position of no beds plus 'new services'
5. Use Dyfi ward as a day treatment centre
6. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
7. Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)

E. Develop the ward as a reablement facility

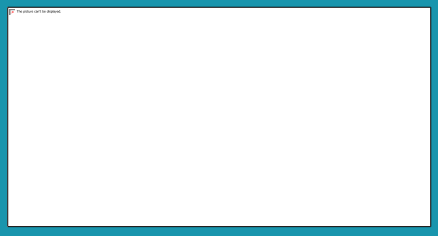
A summary of the scenarios and corresponding service delivery options is set out in the table on the following page.

Table One: Potential service change scenarios at Tywyn community hospital by service delivery options

		Four Extra Inpatient Beds (Dolgellau & Barmouth District Hospital)	Minor Injuries Unit (MIU)	Minor Injuries Unit (MIU) Extended hours and weekend opening	Treatment Room	Tuag Adref (Homeward Bound)	Wellbeing Hub	Ten Inpatient Beds – Tywyn Community Hospital
A	Reopen the ward as it was in 2023, without 'new services.'	✘	✓	✘	✘	✘	✘	✓
B	Maintain the current position of no beds plus 'new services'	✓	✓	✓	✓	✓	✓	✘
C	8. Use Dyfi ward as a day treatment centre 9. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) 10. Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)	✓	✓	✓	✓	✓	✓	✘
D	11. Maintain the current position of no beds plus 'new services' 12. Use Dyfi ward as a day treatment centre 13. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)	✓	✓	✓	✓	✓	✓	✘

	14. Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)							
E	Develop the ward as a reablement facility	✓	✓	✘	✘	✘	✘	✓

Thank You



| info@asv-online.co.uk |

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GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Tywyn Community Hospital Balanced Room No. 2

Outcomes Report

November 2025

Contents

1 INTRODUCTION

Background and Context

1.1 Introduction

This report sets out the summary record of the deliberations and outcomes of a second balanced room session, to help shape the future of inpatient services at Tywyn Community Hospital. The workshop was convened by Betsi Cadwaladr University Health Board (BCUHB) and held in Aberdyfi on the 16th of October 2025.

The purpose of the workshop was to:

- Agree a list of desirable criteria and consensus weightings for scoring the medium list of option.
- Complete scoring of the medium list of options
- Ensure balanced participation by working in diverse groups with facilitators and scribes so all voices are heard and captured.

The event was held at Neuadd Dyfi; Aberdyfi; LL35 0NR, between 09:30 and 15:30

1.1.1 Background

The series of balanced room workshops (1 and 2) was set against the potential service change at Tywyn community hospital following the temporary closure of the Dyfi ward in April 2023 and the development of mitigating services, namely:

- **Four extra inpatient beds** were added at Dolgellau & Barmouth District Hospital to meet demand from the Tywyn area.
- The reopening of the **Minor Injuries Unit** (MIU) in July 2023.
- A new **Treatment Room** has opened, offering comprehensive wound care, dressing services, blood tests, and catheter management.
- The **Tuag Adref (Homeward Bound)** service which increases community capacity by helping people stay at home, avoid unnecessary hospital admissions, leave hospital earlier, and receive support and rehabilitation after discharge.
- In July 2023, Tywyn Hospital staff opened a **Wellbeing Hub** offering health promotion, social support, and regular community activities.

The first balanced room developed a long list of potential scenarios and collectively applied the essential criteria (the minimum viable tests set by BCUHB) to this to develop a medium list, which comprised five options, as shown below.

- **Option A:**
  - Reopen the ward as it was in 2023, without ‘new services’
- **Option B:**
  - Maintain the current position of no beds plus ‘new services’
- **Option C:**
  - Use Dyfi ward as a day treatment centre.
  - Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)

- Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)

- **Option D:**
  - Maintain the current position of no beds plus ‘new services.’
  - Use Dyfi ward as a day treatment centre.
  - Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
  - Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
- **Option E:**
  - Use the ward as a reablement facility

Balanced room 2 aimed to collaboratively establish the essential criteria and scoring to create a shortlist of options for further review.

1.2 Participants

Participation in the event was recruited on the basis of creating a ‘balanced room.’ The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising options. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

- **Scoring participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and influence in deliberations and appraisal scoring.
- **Technical Advisers:** representatives of BCUHB on hand to provide expert opinion and input to deliberations as and when needed by participants.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

1.2.1 Scoring Participants

In total there were 14 participants who developed the essential criteria, their weighting and applied them to developing the short list of options, of those:

- Eight were external stakeholders.
- Six were members of BCUHB staff with specialist knowledge and experience.

The full list of those participants who took part in the scoring was:

1. Abby Smith (BCUHB)
2. Anne Lloyd-Jones (Tywyn Town Council and Gwynedd County Council)
3. Bethan Williams (Alexandra Nursing Home)
4. Carys Norgan (BCUHB);

5. Chris Wood (Town Clerk, Tywyn Town Council)
6. Dr Tim Ryder (GP)
7. Eirion Lloyd-Williams (BCUHB)
8. Emma Williams (BCUHB)
9. Geoff Ryall-Harvey (Llais - morning only)
10. Jane Barraclough (Tywyn Hospital Action Group)
11. Karen Bampfield (BCUHB)
12. Sandy Andrews (Aberdyfi Community Council and Gwynedd Couty Council)
13. Sioned Rees (BCUHB)
14. Sue Irlam (Llais)

1.2.2 Technical Advisers (non-voting)

There were a group of BCUHB staff present to provide technical advice to participants from the clinical, operational, equalities and estates perspectives, they were:

- Jane Owens BCUHB
- Sharon Jones Bullock BCUHB
- Paul Andrew BCUHB
- Steve Doore BCUHB
- Jason Dean BCUHB

1.2.3 Event Facilitation Team (non-voting)

The facilitation team supporting the event's running consisted of:

- Independent Facilitator Andy Wright, ASV
- Senior Responsible Officer (SRO) Tehmeena Ajmal (BCUHB)
- Table Facilitator Helen Stevens-Jones (BCUHB)
- Table Facilitator Patrick Roberts (BCUHB)
- Table Facilitator Sophie Stevens-Jones (BCUHB)
- Table Scribe Wendy Hooson (BCUHB)
- Table Scribe Alan Morris (BCUHB)
- Table Scribe Becky Jones (BCUHB)

2 THEMATIC DISCUSSIONS

Group conversations informing the development of desirable criteria.

2.1 Introduction

This section presents an overview of the day's discussions organised by major themes: Staffing and Workforce, Access and Transport, Community Needs, and Service Design.

It refers to specific options (A–E) and outlines areas of agreement, points of contention, and notable concerns or suggestions raised by participants.

2.2 Staffing and Workforce

Staffing emerged as a critical factor in evaluating the options. Participants emphasised the difficulty of recruiting and retaining healthcare staff in Tywyn, unless clear professional development pathways and varied work opportunities are available locally.

Safe staffing levels were a particular concern for several participants. Reopening the 10-bed inpatient ward (Option A) would likely mean only one nurse would be on duty at night. This situation was considered potentially unsafe because there would be no immediate backup in case of an emergency, and working alone in such a small, isolated ward was described as even "scarier than working in ED (the Emergency Department)" due to the lack of on-site support. Several staff members stressed that their own wellbeing and safety are as important as patient safety in such scenarios. This highlights a key workforce challenge, reopening Tywyn's ward may breach safe staffing standards. Although the Nurse Staffing Levels (Wales) Act 2016 has not yet been legally implemented in Community Hospitals, the Health Board is still responsible for maintaining safe and appropriate nurse staffing levels. Indeed, it was noted that on-site GP medical cover could be reliably provided for Options B, C, and D but not for Options A or E, underscoring that the more resource-intensive inpatient models would struggle with clinical coverage.

Another issue is recruitment and retention of staff in this rural area. Accommodation in Tywyn is limited, even when housing was sought for incoming international nurses, it was difficult to find options suitable for their whole families. Additionally, the lack of other local employment opportunities for family members can deter potential staff from settling in Tywyn. Participants pointed out that reopening the ward without addressing these support issues would be challenging.

The importance of recruiting Welsh-speaking staff (and supporting staff to learn Welsh) was also raised, both to make the hospital more welcoming culturally and because, for patients with dementia, receiving care in their native language is especially beneficial.

All these considerations fed into one of the group's agreed criteria for evaluating options: the future service model should make Tywyn an attractive and supportive place to work for staff. Options that involve a greater variety of services (such as B, C, and D) were seen as positive in this regard, since a mix of clinics and programmes on-site can enrich job roles, allow skill development, and combat professional isolation.

There was some tension between community advocates and staff on the staffing question. A representative of the Tywyn Hospital Action Group argued passionately in favour of Option A (reopening the ward), citing community sentiment and pledging to find the necessary staff, whereas many staff members voiced scepticism about the feasibility of safely staffing a standalone 24/7 ward. For instance, staff noted that a small ward would draw nurses away from other duties and still only care for up to 10 inpatients, versus the dozens of patients served weekly by existing outpatient services. The wellbeing of lone nurses and lack of immediate medical backup in Option A was a major concern for the clinical staff. This difference highlights the importance of balancing community interests with workforce challenges.

There was broad consensus that whichever option is chosen must ensure a sustainable staffing model, one that supports staff development, guarantees safe staffing levels, and addresses practical barriers like housing. In the words of one agreed criterion, staff "need to be looked after" and not overworked by any new arrangement.

2.3 Access and Transport

Geographical and transportation barriers present significant challenges to healthcare access for the Tywyn community. Consensus emerged among all participant groups that healthcare services should be restructured to better serve this remote population by bringing care closer to home. Participants provided accounts highlighting the difficulties Tywyn residents encounter when traveling to the nearest hospitals. For instance, an elderly patient hospitalised in Dolgellau (more than 30 miles from Tywyn) creates substantial obstacles for family visits. Public transport options are limited; accessing Dolgellau hospital requires taking a bus followed by traversing a steep incline, which is particularly challenging for older visitors. Additionally, taxi availability is minimal, as most local service providers have contracts dedicated to school transportation and are not available for hospital journeys. Consequently, many individuals are unable to visit relatives admitted to distant facilities on a regular basis. This situation strongly supports the case against relying on inpatient beds outside Tywyn for the care of local patients.

Additionally, Tywyn residents frequently face the necessity of travelling significant distances for outpatient and specialist healthcare services. Bronglais Hospital in Aberystwyth, located approximately 1.5 hours south by road, is generally more accessible than hospitals situated to the north or east (such as Alltwen or Bangor), owing to superior train and bus connections. Nevertheless, these journeys remain

both inconvenient and expensive. There was broad agreement that Tywyn should strive to offer as many healthcare services locally as possible to reduce the frequency with which patients must travel. All participants agreed that population-based services should be located as near Tywyn as possible.

There was considerable discussion regarding the positive impact of newly introduced services at Tywyn Hospital since the closure of the ward, particularly in terms of improved access to care. For example, the hospital's Treatment Room now accommodates procedures that previously required patients to travel considerable distances. One participant highlighted that certain urology interventions, such as catheter removals, formerly necessitated a 2.5-hour journey to Glangwili Hospital in Carmarthen, but can now be performed locally at Tywyn. This reduces travel time and centralises services within the community.

Participants expressed strong support for further enhancing these developments. For instance, the addition of a Doppler ultrasound machine at Tywyn Hospital would eliminate the need for patient referral to Shrewsbury for vascular scans, as such diagnostics could be conducted on site. Additionally, establishing a local sexual health clinic was recommended, noting that the closest clinic is presently located an hour away in Aberystwyth. These proposals (reflective of Options B, C, and D) demonstrate how expanding outpatient and diagnostic services at Tywyn Hospital has the potential to significantly improve access for the surrounding population.

Access to urgent and emergency care was also discussed. Tywyn has a Minor Injury Unit (MIU) that the community values highly. Many expressed a strong wish to keep the MIU open and expand its hours to seven days a week, instead of the current limited schedule. Locals would rather use the MIU for minor ailments than travel to A&E in Bronglais or elsewhere, especially on weekends.

By contrast, reintroducing an inpatient ward (Option A) in Tywyn would not by itself solve emergency access issues, seriously ill patients would still need transfer to district general hospitals. Consequently, it was widely believed that enhancing the MIU and outpatient services would more effectively meet routine access requirements.

Overall, there was unanimous community consensus that Tywyn's future model must prevent people from having to travel long distances for routine care. Even those who supported reopening the ward agreed that, in general, "Tywyn needs to provide care closer to home" to spare people unnecessary journeys.

2.4 Community Needs and Perspectives

The discussion underscored that any service changes must align with the needs and values of the community. Tywyn's population includes a significant proportion of older adults, including individuals who have retired to the area. One participant observed that the population is increasing, which may lead to higher local healthcare demand in the near future. A challenge specific to Tywyn's elderly residents is that they often lack

nearby family support. having moved into the area, their adult children might live far away. Staff members observed that this means some patients have no local carer to help them at home, making “wraparound care” difficult. Although, in this respect, the Tuag Adref programme has helped support patients at home, gaps in home care and respite services remain.

Social isolation was identified as a major issue in the community, with participants mentioning that some people visit their GP simply because they are lonely rather than acutely unwell. These points indicate that the community’s health needs go beyond immediate medical treatment, they also include social care, respite, and end-of-life support.

End-of-life care and the desire for people to be cared for near home was an emotionally charged topic. A Tywyn Hospital Action Group campaigner on one table strongly advocated for Option A (reopen the ward), emphasising the heartfelt wish of many residents to be able to spend their final days in a local hospital, close to family and friends. They stressed that not everyone wants to die at home, especially those who live alone might prefer the care and company available in a community hospital ward. This perspective was backed by a petition signed by over 5,000 residents calling for the inpatient ward’s reinstatement. The Action Group urged that these voices be “considered and listened to” in the decision-making. Indeed, community pride and investment in the hospital are strong: local people have historically raised funds for the hospital (even buying equipment and beds for it), reflecting a deep sense of ownership and support.

However, community opinion was not unanimous. Alongside the calls to restore the ward, other community members, and patient representatives (including members of Llais) raised critical questions. They challenged the Health Board’s portrayal of the “new services” added since the ward’s closure, one participant argued these services were not truly new, noting that many were previously provided at the GP surgery, and questioned whether the community was even aware that they are now available at the hospital. This suggests a communication gap (addressed more in Service Design below).

There was also an acknowledgment that if reopening the inpatient ward proved unviable, efforts should refocus on broader health improvements for the community. In other words, rather than endlessly debating the ward, the Health Board and community could work together to identify Tywyn’s top health priorities and co-design services to meet those needs. One participant remarked that if Option A is off the table, time would be better spent engaging locals on what other health services would most benefit the area. This pragmatic view was shared by many staff and community representatives who wanted to ensure that energy goes into solutions that help the wider population, not just a small number of patients.

Notably, all sides agreed on the fundamental goal of “care closer to home.” Regardless of differing opinions on the ward, there was unanimity that Tywyn should not lose any more services and, if possible, should expand the range of care provided locally. Even the campaigners for Option A supported retaining existing services like the MIU and clinics in Tywyn. Another point of consensus was the importance of culturally appropriate services – for example, making sure Welsh-speaking residents can be cared for in their language. Participants saw recruiting Welsh-speaking staff and offering language support as part of meeting the community’s needs, especially for vulnerable groups like dementia patients who respond better in Welsh.

In summary, the community’s needs as identified in this workshop include:

- access to care without long travel;
- support for the elderly and isolated;
- culturally sensitive care; and
- involvement in shaping local services.

The community’s sense of ownership of Tywyn Hospital is strong, and any future model must honour that, whether by reopening beds or by providing excellent alternative services. Trust will be key: as one suggestion noted, the hospital and the adjacent GP health centre should “work better together” in the future, presenting a united, community-focused front. Ensuring transparency and listening to public input (like the petition) will help maintain community trust as plans move forward.

2.5 Service Design and Future Model Ideas

When it came to designing the future service model for Tywyn, participants shared many ideas and examples. A clear theme was expanding the role of Tywyn Hospital as a community health hub. This means offering a broad spectrum of outpatient, diagnostic, therapy, and day services to serve people of all ages in the Tywyn area, rather than focusing primarily on inpatient beds. There was enthusiasm for how the hospital’s role has already evolved, the creation of the Treatment Room and introduction of new clinics have benefited patients (as described earlier, saving long journeys).

Participants want to see this trend continue, with additional clinics and services brought to Tywyn. For instance, beyond urology and wound care services already present, they suggested adding things like on-site ultrasound/Doppler scanning and a sexual health clinic, as well as more specialist outpatient clinics so that “people don’t have to travel” for routine appointments.

Each of the community hub options (B, C, D) were felt to bring in a variety of new services closer to more people. The vision is to make Tywyn a one-stop hub for as many healthcare needs as possible, within the scope of a community hospital.

- **Learning from other models:** One powerful example discussed was the transformation of Blaenau Ffestiniog’s old community hospital into a modern

"wellness hub." A participant described how Blaenau Ffestiniog, after a difficult transition, now hosts an integrated health and social care centre with GP surgery, physiotherapy, social services, mental health services (CAMHS), and specialist clinics all co-located. This was cited as "a great example of what could be achieved" in Tywyn, and some even suggested arranging a visit to Blaenau Ffestiniog to gather inspiration.

The idea of a "community hub with no beds" was favourably discussed, several felt that a hub model (like Options B, C or especially D) could deliver more value to Tywyn's population than trying to re-establish inpatient beds. In fact, there was a stated preference for a hub without beds among many participants. Such a model would focus on robust outpatient/day services, possibly partnering with local care homes for any necessary bed-based care. (It was mentioned that care delivery should not be confined to the hospital building, services might also be delivered in the community or in nursing homes, as appropriate.)

At the same time, participants recognised that certain services which used to be available in Tywyn have been lost and could be worth reintroducing in a new form. For example, respite care and a day hospital/day care facility were previously offered in Tywyn (years ago) and addressed important needs. While these were discontinued, the underlying needs (carer respite, social day activities for frail residents, etc.) still exist. In the workshop, concepts were discussed including a day centre operating 5 days a week with different themes each day (e.g., rehabilitation exercises, social activities, chronic disease management sessions). This could help combat social isolation and reduce inappropriate use of GP services by providing a place for people to go for support and companionship. If Tywyn were to implement such a facility, it should serve all age groups (not just the elderly), becoming a community wellness hub rather than an old-style day room. These ideas align most closely with Option D (the most extensive option), but elements could potentially be incorporated into Options B or C as well.

- **Communication and integration:** A recurring theme was the need for better communication about existing services. Community members admitted that many locals are not aware of all the services now available at Tywyn Hospital – there has been a "lack of advertisement around them." For the future, participants urged that the Health Board improve public awareness so that people utilise the local clinics and facilities.

  Additionally, any new service model should come with clear information for the community. For example, if inpatient or bed-based services are provided, it is important to clearly explain the type of care offered and how it operates, so individuals have an accurate understanding and realistic expectations.

Integrating the hospital's services with primary care was also mentioned: the on-site GP practice (Tywyn Health Centre) and the hospital should coordinate closely. It was felt that there's room for the hospital and health centre to work more closely together to provide seamless care – for example, ensuring GPs inform patients of hospital clinics, and hospital staff and community nurses collaborate on follow-up care.

- **Trade-offs – breadth of services vs. beds:** The discussions made clear that there is an inherent trade-off in these options. Re-opening the ward (Option A) would consume significant staffing and resources to look after up to 10 inpatients at a time, but those might not even be 10 local people, since historically Tywyn's beds often got filled by patients from other areas when local demand was low. By contrast, keeping the ward closed allows the same staff to care for dozens of people each week through outpatient clinics, day treatments, and home-visiting services.

  One staff member noted that currently over 80 patients per week receive treatment at Tywyn (in various clinics and the MIU), whereas reopening the ward would mean focusing those staff on just 10 inpatients instead. From a service design perspective, many felt that serving 80+ people's needs vs. 10 people's needs was a better use of resources, if those 10 could be cared for in alternate ways. There was also mention that keeping people in a hospital bed longer than necessary can worsen their health (increasing frailty and dependency). Thus, a modern model would aim to hospitalise people only for acute needs and for short durations, relying more on strengthened home care or intermediate care for recovery – which Options B, C, D sought to facilitate.

  Option E, which proposed introducing a small number of step-down or reablement beds in Tywyn at the cost of shutting down the new services, was met with significant scepticisms. Participants struggled to see the benefit of Option E: it was unclear what exactly it offered and how that would outweigh losing the recently established local clinics. When clarified that Option E would indeed mean closing all the new services to staff a few beds, most felt this would "turn back the clock" on progress. Essentially, Option E was viewed as the worst of both worlds – sacrificing the broad community services for very limited bed-based care. This lack of support for Option E was evident across the tables.

In summary, the preferred direction for service design (emerging from the group dialogue) was to continue building Tywyn as a community health hub, enhancing local access to a wide range of services, and addressing community-specific needs like social support and chronic care. While some still hoped for local inpatient beds, most practical ideas focused on innovative outpatient and community solutions. Any inclusion of beds (in a revised Option C, for example) would need to be done without

undermining the core outpatient services, perhaps via partnership with local nursing homes or dedicated funding (it was noted that other areas that have both community beds and home-care services obtained extra funding to do so).

Finally, participants stressed the importance of involving local people in co-designing whatever new services are developed, to ensure they are tailored to real community health needs.

2.6 Criterion

Following small group collaborative discussions, detailed above, a consensus session produced five core criteria for evaluating service options to meet Tywyn's community needs. The priorities include care closer to home, staff development and wellbeing, system-wide collaboration, reducing travel for patients and staff, and encouraging community participation in designing services. These principles guided objective assessment of each option, leading to scoring and voting to select the most promising approaches for further development and public engagement. In detail the group produced the following for subsequent appraisal of the medium list of options (A-E):

1. **CRITERION 1 Meeting Local Population Health Needs and Enabling Care Closer to Home:** Population health need met through the variety of service offer/ meets the need of the wider population/Allow care closer to home to be developed further/health promotion.
2. **CRITERION 2 Staff Development, Wellbeing, and Service Sustainability:** Allow for staff development/ staff wellbeing and service resilience/ Futureproofing – making the service form attractive as a career path/sustainability of residence of staff.
3. **CRITERION 3 Integrated Care and System-Wide Collaboration:** Viability - allow MDT (multi-disciplinary team) approach /Whole system approach and cross health board border working.
4. **CRITERION 4 Reducing Travel Burden for Patients, Staff and Carers:** Travel impact on staff and patients / potential to reduce the impact of excessive travel time and cost for patients, relatives, and carers.
5. **CRITERION 5 Community Engagement and Co-Production:** Bringing communities along /allow for co-production of services with communities / service users / residents.

Participants were then asked to provide an individual view of the relative weight of each criterion via an online system. The results of this, while close, show that meeting local population health needs is viewed as highest priority for consideration, with reducing travel burden seen as lowest priority.

Criterion	Weight (%)
Criterion 1: Meeting Local Population Health Needs and Enabling Care Closer to Home	21.8%
Criterion 2: Staff Development, Wellbeing, and Service Sustainability	19.5%
Criterion 3: Integrated Care and System-Wide Collaboration	20.8%
Criterion 4: Reducing Travel Burden for Patients, Staff and Carers	18.5%
Criterion 5: Community Engagement and Co-Production	19.5%

3 SHORTLISTED OPTIONS

Applying the Desirable Criteria to the Medium List

3.1 Shortlisting Deliberations

After reviewing the criteria, participants ranked the five options in a scored appraisal exercise. The result was a clear consensus to shortlist Options B, C, and D for further development, and to rule out Options A and E at this stage.

- Option D emerged as the highest-scoring option overall, reflecting strong support for the community hub model it represented.
- Options B and C also scored well and were deemed worth taking forward into the next phase of engagement.

These three options all align with the theme of enhancing local services (clinic-based, diagnostic, preventative, and rehabilitative care) and are considered feasible to staff with available resources (for example, GP medical cover was confirmed to be workable for B, C, D). They also best met the 'desirable criteria' the group had established, such as serving the wider community's needs and creating a positive working environment for staff.

Two options (A and E) were excluded from further consideration for the following reasons:

- **Option A** (reopening the 24/7 inpatient ward) was not shortlisted because it scored significantly lower on the agreed criteria.

  Throughout the discussions, several practical concerns about Option A arose: the difficulty of ensuring safe staffing (only one nurse on nights without guaranteed backup), the strain it could place on a small team, and the relatively limited benefit (only a handful of patients would be in the ward at a time, and they might not all be from Tywyn).

  While community sentiment for the Dyfi Ward was acknowledged (the 5,000-signature petition was noted[1]), the consensus was that simply reinstating the old model would not solve the broader access issues and could even undermine the newer services that help many more people weekly.

  In short, Option A did not perform well against criteria like sustainability, impact, and workforce, and so it was set aside despite the passionate advocacy from the Hospital Action Group.

- **Option E** fared poorly as well, ending up with a very low weighted score. The rationale for ruling out Option E was clear from participant feedback: lack of clarity and support.

[1] Signatures collected to the petition are 1,314 online and 4,214 signatures on paper. Source: Senedd Petitions Re-open Dyfi Ward at Tywyn Hospital now - Petitions

Option E would have effectively meant shutting down the successful treatment room and other new services to open a few “reablement” beds, a trade-off that few if any participants favoured. Many questioned how that would benefit Tywyn at all.

Once it was understood that all the new services would be lost under Option E, the option lost credibility in the room.

Additionally, Option E shared the same medical cover problem as Option A in that it did not have a clear plan for who would staff those beds medically (GPs had indicated they could not cover an inpatient unit under this scenario). Given these issues, Option E was eliminated from further consideration.

3.1.1 Consensus

The key areas of consensus emerging from this Balanced Room discussion (including preferences for care closer to home, the necessity for sustainable staffing, and the importance of introducing new services) will guide the engagement process.

Additionally, concerns such as transportation challenges, the need for respite care, and end-of-life preferences will be considered to further refine the available options.

3.2 Outcomes: Shortlisted Options

Balanced Room 2 worked collaboratively to address workforce, access, and community needs in planning Tywyn’s healthcare. The discussions underscored that stakeholders seek local, high-quality services delivered sustainably, and they place importance on participating in the development of these services. While there was disagreement, especially about the inpatient ward, discussions remained respectful and focused on improving services. Options B, C, and D (community hub models) received support, whereas Options A and E were excluded from further consideration at this stage.

The feedback provided by residents, stakeholders and staff who actively participated in scoring Options A-E will be incorporated for subsequent evaluation and consideration.

Each participant independently evaluated the options using an online platform, and the corresponding weighted appraisal scores are displayed in the table on the following page.

	Weighted Average Score					Total (Weighted Scores)
	Criterion 1	**Criterion 2**	**Criterion 3**	**Criterion 4**	**Criterion 5**	
Option D	**4.29**	**4.36**	**4.29**	**3.71**	**3.79**	**20.43**
Option C	**4.00**	**4.07**	**3.86**	**3.71**	**3.43**	**19.07**
Option B	**3.50**	**3.50**	**3.50**	**3.07**	**2.93**	**16.50**
Option A	1.86	2.00	2.00	3.14	2.29	11.29
Option E	1.64	1.86	2.21	2.29	2.00	10.00

Based on these outcomes, **the Health Board will prioritise Options B, C, and D,** at this stage, initiating active public engagement to collect thorough feedback on these options.

Participants agreed that from now on it is imperative to clearly articulate the strengths, limitations, and potential gaps of each shortlisted option, and to incorporate community input before reaching any decisions.

Insight | Change | Management

Tywyn Community Hospital: Options Appraisal Workshops

Report

July 2026

Contents

1 EXECUTIVE SUMMARY

Summary of the process and recommendations

1.1 Purpose

This report summarises the outcomes of the final stages of the options development and appraisal process undertaken to support decisions about the future of inpatient services at Tywyn Community Hospital.

It brings together the outputs from three linked stages of work:

1. The stakeholder options development and validation session held on 20 March 2026.
2. The technical appraisal undertaken by Betsi Cadwaladr University Health Board on 30 April 2026.
3. The final stakeholder appraisal session held on 4 June 2026.

Together these stages formed part of the Health Board's pre-consultation engagement process, with the purpose of identifying viable options for consideration before any formal public consultation.

1.2 Progression of the Process

The March stakeholder session reviewed the options previously developed through the Balanced Room process. Participants discussed the strengths and weaknesses of the options, identified additional information required and asked the Health Board to explore a number of combined or modified scenarios before returning with further evidence.

Following that session, a multidisciplinary technical panel assessed each option against the previously agreed essential criteria of:

- Quality and Safety
- Efficiency and Effectiveness
- Deliverability
- Sustainability
- Accessibility and Inclusion.

The panel concluded that only two options should be recommended for further consideration:

- Option A, reopening inpatient beds subject to a sustainable and safe staffing model; and
- Option B, incorporating the existing community service model together with the elements of Options C and D, which were considered operationally equivalent.

The technical appraisal was then presented back to stakeholders during the June workshop. Participants were given the opportunity to review the technical reasoning, challenge assumptions and consider whether any options or evidence had been overlooked before recommendations progressed through the Health Board's governance arrangements.

1.3 Principal Findings

The June session broadly endorsed the conclusions of the technical appraisal while identifying several matters that participants considered should be addressed before formal consultation.

Participants agreed that options centred on reablement should not proceed. The consensus was that reablement was viewed as falling outside the Health Board's primary role and risked confusing health services with wider social care functions. Consequently, Option E and the hybrid options incorporating reablement were not supported.

Participants broadly accepted the technical assessment that Options B, C and D should be treated as a single option. They also agreed that Option A should remain under consideration, provided its staffing requirements and associated risks were clearly explained.

Although some participants continued to express support in principle for a combined Option A+B, there was no consensus that it represented a deliverable solution. Instead, participants requested that, if this option is excluded from formal consultation, the Health Board should explain transparently why it is not considered viable.

Alongside discussion of the options themselves, participants requested clearer information on the financial context, workforce challenges, future service demand, and the evidence supporting the appraisal. They also highlighted the importance of preserving flexibility wherever possible, so that future service developments remain achievable should circumstances change.

1.4 Consultation Development

The final part of the workshop considered how any future consultation should be designed. Participants identified additional stakeholders who should be engaged, suggested locally appropriate communication channels, and proposed a range of engagement methods intended to reach people who might not normally participate in traditional public meetings.

There was consistent support for accessible, community-based engagement using a mixture of face to face and digital approaches together with clear, bilingual, and accessible information.

1.5 Overall Outcome

Taken together, the March stakeholder session, the technical appraisal and the June validation workshop demonstrate a clear progression from options generation, through technical assessment, to stakeholder review.

The process concluded with broad support for progressing two options through the Health Board's governance arrangements and into formal consultation, subject to further refinement and the provision of additional information requested by participants.

The workshops also identified a number of actions for the Health Board before consultation, including providing clearer explanations of the financial and workforce context, explaining the rationale for excluding any options not taken forward and ensuring that the consultation process is accessible, transparent, and informed by the views expressed throughout the engagement process.

2 INTRODUCTION

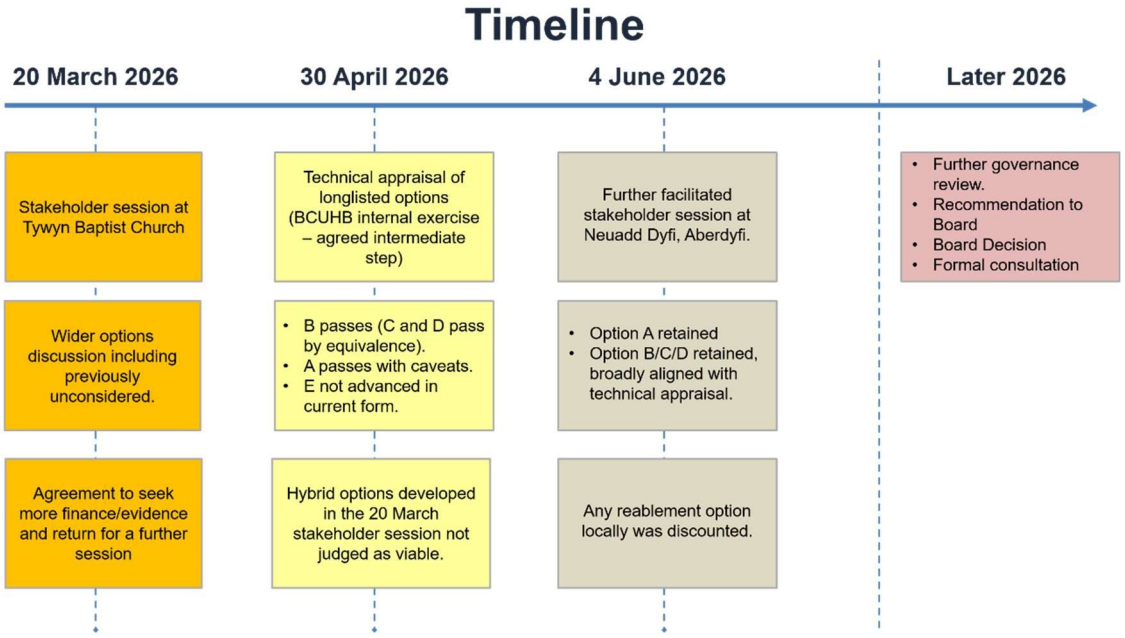
Background and Context

2.1 Introduction

This report sets out the summary record of combined results from the following options appraisal sessions to help shape the future of inpatient services at Tywyn Community Hospital.

- Options Appraisal Session 2: 20 March 2026
  Stakeholder session held at Tywyn Baptist Church, Tywyn.
- Technical Panel Appraisal: 30 April 2026
  The intermediate technical assessment by the BCUHB team that considered the outcomes of the 20th of March session and prepared recommendations before returning to stakeholders. Conducted via Teams.
- Options Appraisal Session 3: 4 June 2026
  Stakeholder session held at Neuadd Dyfi, Aberdyfi to consider the recommendations of the technical appraisal and deliberate on those options most suitable for recommendation to the Board of BCUHB for consultation.

The timeline below summarises the process, including the intermediate essential criteria appraisal.



NB: The March event repeated the October 2025 balanced room session after it became clear that BCUHB attendance had outweighed representation from other stakeholders.

2.2 Background

The sessions were set against the potential service change at Tywyn community hospital following the temporary closure of the Dyfi ward in April 2023 and the development of mitigating services, namely:

- Four extra inpatient beds were added at Dolgellau & Barmouth District Hospital to meet demand from the Tywyn area.
- The reopening of the Minor Injuries Unit (MIU) in July 2023.
- A new Treatment Room has opened, offering comprehensive wound care, dressing services, blood tests, and catheter management.
- The Tuag Adref (Homeward Bound) service which increases community capacity by helping people stay at home, avoid unnecessary hospital admissions, leave hospital earlier, and receive support and rehabilitation after discharge.
- In July 2023, Tywyn Hospital staff opened a Wellbeing Hub offering health promotion, social support, and regular community activities.

The options development session (26th of October 2025) developed a long list of potential scenarios. The assembled stakeholders collectively applied the essential criteria (the minimum viable tests set by BCUHB) to long list to develop a medium list, which comprised five options, as shown below.

- Option A: • Reopen the ward as it was in 2023, without 'new services'
- Option B: • Maintain the current position of no beds plus 'new services'
- Option C: • Use Dyfi ward as a day treatment centre
- Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
- Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
- Option D: • Maintain the current position of no beds plus 'new services'
- Use Dyfi ward as a day treatment centre
- Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds)
- Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
- Option E: • Use the ward as a reablement facility

3 ADDITIONAL OPTIONS DEVELOPMENT AND APPRAISAL

Outputs from 20 March session

3.1 Introduction

This section summarises the additional options development and appraisal work undertaken after the initial options had been identified. It records the key points from the 20 March stakeholder session, including the areas of agreement, challenge, and unresolved concern.

3.2 Options Development/Validation Session

The 20 March 2026 session was framed by facilitators as a pre-engagement stage rather than a formal consultation, with the immediate purpose being to identify viable options to take forward into a later consultation.

The overall aim of the process was to meet the need for:

- A “long term sustainable solution;”
- Broad community involvement; and
- A full consultation after the election period.

The early part of the session focused on frustration with process design, including concerns that earlier “balanced room” sessions had not been genuinely balanced and that the option set was already constraining discussion.

The clearest area of agreement was over the criteria that should be used to judge the effectiveness of the consultations in meeting the needs of Tywyn. Participants wanted any future model to:

- Support staff recruitment and retention;
- Improve patient outcomes;
- Meet the needs of the local population across age groups;
- Cover service gaps;
- Strengthen prevention; and
- Above all, remain accessible in a rural setting where travel is especially burdensome for older people and families.

Participants repeatedly emphasised that care should be provided at Tywyn Hospital, or at home, or as close to home as possible, while acknowledging that some acute or specialist care would inevitably require travel elsewhere.”

The discussion then split into two overlapping but distinct debates:

1. The first was about service content, with a substantial part of the room pressing for a model combining some form of beds with community services, often expressed as:
   - “Option B with some of Option E,”
   - “Beds plus new services,” or
   - a form of rehabilitation / reablement / intermediate care rather than a conventional ward.

   Participants repeatedly called for intermediate or step-up/step-down beds; rehabilitation after surgery; continuity with services like Tuag Adref; and more support for older people discharged “home too soon.”

   At the same time, another strand of that discussion recognised that a reablement model could be different from a nurse-led inpatient ward and might require socialcare involvement, different estate standards, and different staffing.
2. The second debate was about process legitimacy and evidence.

Multiple contributors challenged the credibility of asking the room to move between scenarios and options without access to the underlying financial modelling, funding assumptions, steering-group material, travel analysis, or equality evidence.

Participants asked for a cost-benefit analysis before being expected to indicate preferences. Additionally, some felt that they had a moral case for retaining services even if they lacked access to the financial analysis needed to produce a "well-reasoned" technical alternative.

Despite these issues, participants reached several concrete agreements, namely:

- To return for "balanced room 3" to give the Health Board time to explore additional or combined options.
- A pragmatic room consensus to explore:
- Option A;
- Option B;
- Option A&B combined;
- Option C&D combined; and
- Option B&E or A&E,

While asking the Health Board to explain more clearly why Options A/B+E and A+B may not meet the essential criteria.

- There was agreement that further information on the funding formula should be provided during consultation.
- There was also an expressed expectation from those members of Tywyn Hospital Action Group present that FoI (Freedom of Information) responses should be available before the next stakeholder session[1].

A number of matters remained unresolved at the close. These included

- Whether Tywyn is systematically disadvantaged by the underlying funding formula;
- Whether the town experiences unusually acute "health poverty;"
- How many Tywyn patients displaced to other hospitals are awaiting social-care packages;
- Establishing the realistic demand for reablement beds in Tywyn;
- What services for younger people and women are genuinely missing; and Whether the health board could or should revisit the current hurdle criteria.

4 TECHNICAL APPRAISAL

Essential criteria review of options generated

4.1 Introduction

Although the technical appraisal was not itself a balanced room, it is the decisive intermediate appraisal step around which the later discussion turns.

[1] Please note that FoI requests from the Tywyn Hospital Action Group had been reviewed and responded to before the session was convened.

The technical appraisal panel included:

- Head of Community Nursing (West),
- Head of Equality and Human Rights,
- Senior Finance Manager,
- Interim Integrated Health Community Director (West),
- Senior IHC (West) representative Strategy Programme Manager, plus an external facilitator.

The panel took the decision to test all existing and newly generated scenarios against the previously agreed minimum viability (essential) criteria. The purpose of the appraisal was to produce recommendations for the project's Senior Responsible Officers (SROs) and later governance stages.

4.2 Essential criteria

The appraisal was conducted using the following criteria, which represent the essential or hurdle criteria the options must pass to be considered viable. In this case these were:

1. Quality and Safety
2. Efficiency and Effectiveness
3. Deliverability
4. Sustainability
5. Accessibility and Inclusion

Details of the criteria and associated guidance used by the panel is shown on the next page.

Criteria	Guidance
Quality and Safety • Services meet standards, minimise risk to patients and patients have a good experience.	• Ability to provide safe, evidence-based, patient-centred care. • Required number of staff with the right level of experience, qualifications, and competencies from within existing workforce. • Maintaining or improving clinical outcomes. • Improved patient satisfaction.
Efficiency and Effectiveness • Efficiency - Ability to do things well and without waste. • Effectiveness – the extent to which desired outcomes or results are achieved.	• Clinical pathways that follow best practice. • Services delivered efficiently and effectively.
Deliverability • That we can actually deliver what we say we will.	• Can be achieved with available resources (people and finances). • Realistic and timely implementation.
Sustainability • Ability to manage risk and adapt over time.	• Responsive to current demographic and population need. • Adaptable to the latest clinical workforce and technological advances. • Supports recruitment, retention, and training.

Accessibility and Inclusion • Services are equally available and accessible to all. (Informed by the integrated impact assessment)	• Reflects the needs of patients, carers, and families. • Timely access to appropriate clinical decision makers. • Access to rehabilitation and end of life care. • Care closer to home when possible and clinically safe to do so

4.3 Appraisal

The panel used the five essential criteria to narrow down the list of options. The technical conclusions from that assessment were:

- Option A only passed quality and safety. It was, however, recommended for further consideration with the caveat and it was only approved if based on a safe-staffing establishment of two registered nurses 24/7; Option B met all five criteria.
- Options C and D were reviewed and judged equivalent to Option B; Option E should not be advanced in its current form; and Options A+E, A+B and B+E were all not viable.

The technical panel also recommended that Option A be relabelled as "Reopening on a safe-staffing basis," with the associated caveats fully visible for the consultation.

This intermediate step changed the character of the debate in three ways.

- First, it reframed A from "reopen as before" to "reopen only if safe staffing is funded and sustained."
- Secondly, it concluded that Options B, C and D were sufficiently similar to be combined into a single option, which became the technically preferred pathway in the panel's view.
- Thirdly, it indicated that Option E and the hybrid options would need stronger evidence to support their further consideration

4.4 Technical appraisal outcomes

The outcome of the technical panel's appraisal was a recommendation that two options be considered further:

- Option A: reopening the inpatient ward at Tywyn community hospital on a safestaffing basis, including sustainable MIU staffing.
- Option B (amalgamated with C and D): provide community services, including extended opening hours of the MIU, Tuag Adref services, Treatment Room, Wellbeing Hub, locally delivered services including IV therapies and catheterisation.

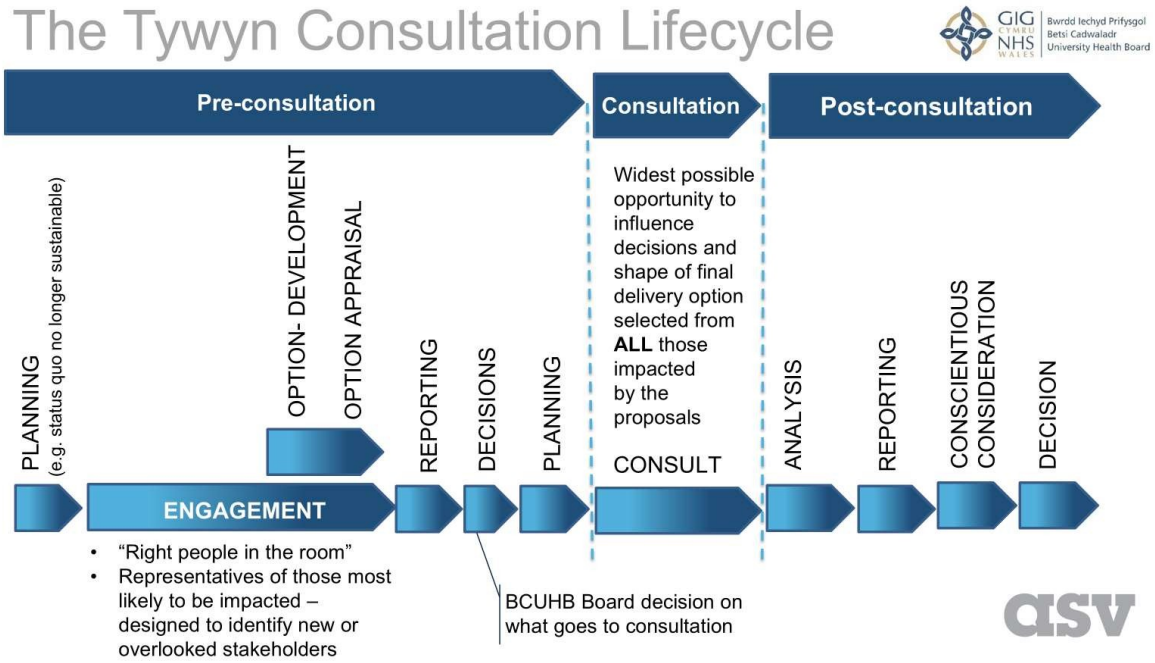
5 OPTIONS APPRAISAL

Outcomes of the 4th of June session

5.1 Introduction

The final step in the process, following the technical appraisal, was to convene the agreed third balanced room session, which took place on the 4th of June at Neuadd Dyfi in Aberdyfi. The purpose of the session was to provide the requested additional information and to validate/reject the options put forward by the technical appraisal panel, including the opportunity to reconsider any of the reasoning.

The session opened with a presentation explaining where the project sat within the overall engagement and consultation process, highlighting that this is currently the pre-consultation engagement phase of the process. Facilitators emphasised that no decisions had been made and that the purpose of the session was to test and refine the options before formal consultation.



Participants were then provided with a summary of the discussions and recommendations from the technical appraisal panel.

5.2 Framing and considerations.

Following the scene setting presentations early discussions in the session focused on the future of inpatient services at Tywyn Community Hospital in which participants challenged the current framing of the engagement, asking for:

- A clearer financial narrative comparing Tywyn with the rest of North Wales,
- A clearer staffing and workforce narrative explaining why the ward had closed, □ Better information on the hospital's former patient mix and future demand, and □ A proper explanation of what services are most needed now.

These discussions generated a number of actions, agreements, and suggestions for consideration, including retaining the hospital infrastructure so that inpatient beds could be reinstated in future if circumstances changed.

These early discussions generated several practical actions and suggestions for the Health Board before attention turned to the options themselves.

- Details of these actions, recommendations and agreements are included in section 4.7 of this report.

5.3 Review of the recommendations

The group then moved on to reviewing the recommended options from the technical appraisal and checking whether any scenarios had been missed.

In discussing the options participants felt that reablement was outside the Health Board's core role and could be seen as replacing health services with social care. In line with this reflection, participants agreed by consensus that reablement options should not proceed. This reflected a wider concern about the boundary between hospital care, primary and community health services, and broader discharge and community support. As a result, the group confirmed that Option E and the two hybrid options (A+E and B+E) be discounted from further consideration.

Participants also requested that GP surgeries should be included in the analysis, suggesting that participants favoured a broader assessment of local health services rather than one focused solely on the hospital. Although this was outside the scope and remit of this engagement this was fed back to BCUHB for further consideration.

The position on the remaining options was more nuanced in which:

- Option A was accepted for consultation with the caveat that it appeared to exclude younger people and transport to alternative community services was poor.
- Options B/C/D were said to align with the technical appraisal and should proceed to consultation as one unified option.

However, some participants saw A+B as the “ideal”, though deliberations were cautious, notably that:

- The option was reconsidered, not definitively adopted, and There was scepticism that it was realistically achievable.

The key procedural request in this respect was that, if Option A+B is excluded from consultation, BCUHB should clearly and transparently explain why it is not viable.

5.4 Outcomes of the discussions

The summary deliberation in the session on the proposed options is shown below.

Option	Summary discussion
A	Should remain under consideration despite concerns about younger people and transport
B	Broadly aligned with technical appraisal
C/D	B/C/D broadly aligned with the technical appraisal and should be considered as one option with B.
E	Reablement containing options should be discounted

A+E Discounted with other reablement-containing options

A+B Seen by some as the "ideal" in principle, but not a settled agreement; BCUHB should show why it is not viable if excluded B+E

Discounted with reablement-containing options

5.4.1 Recommended Options

Overall, participants broadly endorsed the technical appraisal while identifying a number of issues requiring further explanation before consultation.

- Option A: reopening the inpatient ward at Tywyn community hospital on a safestaffing basis, including sustainable MIU staffing.
- Option B (amalgamated with C and D): provide community services, including extended opening hours of the MIU, Tuag Adref services, Treatment Room, Wellbeing Hub, locally delivered services including IV therapies and catheterisation.

5.5 Key Actions and Suggestion Raised

A summary of the key actions and agreements from the discussions is set out in the table below.

Action	Owner	Milestone
□ Remove any option containing a reablement element from the working shortlist	BCUHB planning / option appraisal team	Before formal consultation
□ Keep Option A under consideration despite concerns about younger people and transport	BCUHB planning team	Pre-consultation refinement stage
□ Carry forward Options B/C/D in line with technical appraisal	BCUHB planning team / Board papers authors	Pre-consultation refinement stage
Action	Owner	Milestone
□ Explain clearly why Option A+B is, or is not viable, and why it is included or excluded from consultation	BCUHB Board / planning / finance leads	Before consultation documents are published
□ Publish clearer financial narrative comparing Tywyn with the wider North Wales context, including bed and care-setting cost comparisons	BCUHB finance / strategy team	Before or at start of formal consultation

□ Publish clearer staffing and workforce narrative explaining why the ward closed and what cover would be needed for future models	BCUHB workforce / operations / clinical leads	Before or at start of formal consultation
□ Bring refined options into formal consultation and then to final decision	BCUHB Board	Later in 2026

A summary of the suggestions raised from the discussions are set out in the table below.

Suggestion Raised	Owner	Milestone
□ Preserve ward facilities, if altered, in a way that will allow future reopening if population need changes	BCUHB estates / service design team	During option design
□ Plan for the safe and effective management of public events.	BCUHB engagement / communications / event leads	Before any high-profile public events

6 DEVELOPING THE CONSULTATION

The views of participants on ensuring effective wider engagement

6.1 Introduction

After reviewing the options, the discussion broadened to consider how the consultation should be carried out.

Participants favoured formats that support constructive discussion and help ensure a wider range of voices can be heard, including:

- One-to-one conversations;
- Waiting-room style engagement;
- Smaller groups; and
- An online space facilitated by Llais.

They also wanted highly local outreach in places where people already gather.

Communication format mattered just as much as venue, with participants recommending:

- Leaflets;
- paper surveys;
- social media;
- telephone/text/WhatsApp options;

- posters;
- bilingual messaging; and
- accessible formats including BSL and audio versions in English and Welsh delivered through QR codes.

Dail Dysynni, the local papur bro, was identified as a route to reach older, mainly Welsh-speaking residents.

Details of the discussions are shown below.

6.2 Additional Stakeholders

The details of the additional stakeholders participants felt needed to be included in further engagement and consultation activities is as listed below:

- Carers
- Local council – to share information
- Workplaces (e.g. Hallgates – honey factory)
- Schools
- Leisure centre
- Spar / Co-op (Co-op community room)
- Retail businesses
- Tourism / Caravan Parks
- WI Group
- Merched Y Mawr
- Magic Lantern
- Hughes Wray
- RNLI
- The Health Centre
- Headway Meirionnydd branch
- Diabetics
- Learning Disabilities
- Dementia Group
- Farmers Groups
- Library
- Farmers market every Friday
- Race the train – 15th August
- Catholic Church
- St Cadfans Church
- Tywyn weekly markets every Monday
- Hospital / health centres / community spaces

6.3 Engagement Opportunities/Best Ways to Communicate

The views expressed by participants on the most effective channels to communicate the message and encourage participation in the consultation were, in summary:

- Leaflets.
- Via the Tywyn Hospital Action Group.
- Noticeboards.
- Provide one-to-one and small-group opportunities, using waiting-room style engagement and individual conversations as an alternative to town-hall meetings, so that people who may be less comfortable speaking in larger public settings can still contribute.
- Online space for discussion facilitated by Llais.
- Video booth – or cheaper version – in busy spaces, picking up tourists and locals Hire air hockey or something like that for kids to play and talk to parents/ kids (with parental permission)
- Pint / pizza opportunity whilst engaging

Participants also suggested a proactive outreach approach, with the consultation team offering to attend local groups and venues where invited, including:

- Tywyn Baptist church, which is a hive of activity and opportunity for communications and engagement.
- Mother and baby groups.
- Spaces in pubs. Local business.

6.4 Key messages

Participants suggested the following 'straplines' as messages to convey the importance of the consultation and to encourage people to take part:

- Have your say
- Anything is possible with your involvement
- Help us decide
- Your voice, your decision
- Your voice matters – no decision has been made
- Join in. Speak out. Be heard. / Ymunwch. Lleisiwch. A cael eich clywed.

7 APPENDIX ONE: SESSION ATTENDEES

Details of participants, independent observers, and support team

7.1 Introduction

Listed below are the participants at the session in Tywyn Baptist Church on the 20th of March 2026 and Neuadd Dyfi, Aberdyfi on the 20th of June 2026.

The following categories are used:

- Participants: were those able to take part in scoring and validation discussions.
- Independent Observers: Llais North Wales were present at both sessions to ensure the process was fair and equitable.
- Support Team: those present to provide information, offer technical input when needed, facilitate discussions, and maintain a link with BCUHB governance.

7.2 Stakeholder Options Development and Validation Session (20 March 2026)

7.2.1 Participants

Name	Representing
Abby Smith	Dyfi Ward Manager
Anita Inman	South Meirionnydd Older People's Forum
Anne Lloyd Jones	Gwynedd Council
Bethan Lawton	Gwynedd Council

Carys Norgain	BCUHB Staff
Chris Wood	Tywyn Town Council
Denice Horan	BCUHB Staff
Di Drummond	South Meirionnydd Older People's Forum
Emma Williams	Deputy Head of Nursing - Community Hospitals Area West
Jane Barraclough	Tywyn Hospital Action Group
Janet Maher	Tywyn Hospital Action Group
John Pughe	Gwynedd Council
Kevin Griffiths	Gwynedd Council
Keren O'Hara	Tywyn Macular Group Leader and Sight Loss Representative
Keren O'Hara – support	Carer
Linda Frohawk	Member of the public
Mabon ap Gwynfor	Member of the Senedd
Name	Representing
Mark Kendall	Tywyn Town Council
Mary Hemming	Member of the public
Nikki Davies	BCUHB Staff
Sandy Andrews	Aberdyfi Community Council
Shui Howard	BCUHB Staff
Sioned Rees	Lead pharmacist for community services (West)
Tim Ryder	GP Tywyn (BCUHB managed practice)
Wendy Parry	Gwynedd Council

7.2.2 Independent Observers

Name	Representing
Sue Irlam	Llais North Wales

Geoff Ryall-Harvey	Llais North Wales

7.2.3 Support Team

Name	Role
Paolo Tardivel	SRO - Interim executive director of strategic planning and transformation
Victoria Peach	Interim IHC Director (West)
Sharon Jones-Bullock	Head of Nursing Area West
Helen Stevens-Jones	Director of Partnerships, Engagement and Communications
Dylan Williams	Assistant Director in the West IHC
Gwennan Griffiths	BCUHB
Kathryn Cummings	BCUHB PEC team
Andy Wright	External advisor – ASV
Patrick Roberts	BCUHB PEC team
Rebecca Jones	BCUHB PEC team
Ceri Harris	BCUHB Head of Equalities and Human Rights

7.3 Final Stakeholder Appraisal Session (4 June 2026)

7.3.1 Participants

Name	Representing
Abby Smith	Dyfi Ward Manager
Anita Inman	South Meirionnydd Older People's Forum
Anne Lloyd Jones	Gwynedd Council
Bethan Williams	Alexandra Nursing Home
Chris Wood	Tywyn Town Council
Di Drummond	South Meirionnydd Older People's Forum
Elwyn Hughes	Member of the Senedd
Emma Williams	Deputy Head of Nursing - Community Hospitals Area West
Jane Barraclough	Tywyn Hospital Action Group

Janet Maher	Tywyn Hospital Action Group
John Pughe	Gwynedd Council
Keren O'Hara	Tywyn Macular Group Leader and Sight Loss Representative
Keren O'Hara - support	Carer
Mark Kendall	Tywyn Town Council
Mary Hemming	Member of the public
Nia Hughes	Primary Care Medical Director (West)
Sandy Andrews	Aberdyfi Community Council
Sioned Rees	Lead pharmacist for community services (West)
Tim Ryder	GP Tywyn (BCUHB managed practice)

7.3.2 Independent Observers

Name	Representing
Sue Irlam	Llais North Wales
Geoff Ryall-Harvey	Llais North Wales

7.3.3 Support Team

Name	Role
Paolo Tardivel	SRO - Interim executive director of strategic planning and transformation
Victoria Peach	Interim IHC Director (West)
Sharon Jones-Bullock	Head of Nursing Area West
Dylan Williams	Assistant Director in the West IHC
Andy Wright	External advisor - ASV
Alexia Mitton	External advisor - ASV
Nicholas Duffin	External advisor - ASV
Patrick Roberts	BCUHB PEC team
Rebecca Jones	BCUHB PEC team
Sophie Stevens-Jones	BCUHB Strategy team

Ceri Harris	BCUHB Head of Equalities and Human Rights

Thank You

asv

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Technical Appraisal of Longlisted Options for the Future Operation of Tywyn Community Hospital.

EXECUTIVE SUMMARY

This report summarises the technical appraisal of longlisted options for the future operation of Tywyn Community Hospital, undertaken on 30 April 2026 following a balanced room session with internal and external stakeholders (20 March 2026). It presents Step 1 of the agreed decision process: a technical assessment against minimum "essential" criteria and recommendations for consideration by Senior Responsible Officers (SROs) ahead of subsequent governance and stakeholder steps.

- **Options assessed:**
  - A (reopen ward as in 2023);
  - B (no beds plus "new services");
  - C and D (variants using Dyfi ward as a day treatment centre and/or community hub with beds provided via nursing/residential homes),
  - E (reablement facility); and
  - three combined options (A+E, A+B, B+E).
- **Assessment method:** consensus-based pass/fail testing against five Health Board essential criteria:
  1. Quality and Safety;
  2. Efficiency and Effectiveness;
  3. Deliverability;
  4. Sustainability; and
  5. Accessibility and Inclusion.

  A five-point scale was used to capture nuance (from Fail to Pass with caveat).

Headline recommendations

- **Option A received a qualified/conditional pass only for Quality and Safety** (i.e., "pass with caveat"), contingent on a revised safe-staffing establishment (explicitly, safe staffing based on 2 registered nurses 24/7).

  Even if made safe, the panel assessed Option A as failing Efficiency and Effectiveness, Deliverability, Sustainability, and Accessibility and Inclusion, with material additional staffing and funding implications.
- **Option B passed** all five essential criteria. The panel's view is that B provides a viable community-focused model without inpatient beds, with stronger efficiency, deliverability, and sustainability than ward-based reopening.
- **Options C and D were treated as equivalent to Option B** (same outline cost, staffing model, and practical effect) and therefore also pass *by equivalence*.

  The technical recommendation is to treat **B/C/D as one option** unless governance requires the labels to remain distinct and would **pass as a combined option**

- **Option E should not be advanced in its current form.** The panel's discussions indicate it fails key criteria (including Efficiency and Effectiveness and Accessibility and Inclusion), with Sustainability not resolved positively.

  Further evidence and partner engagement (including local authority/social services and CIW leadership) would be required before any credible re-scoring.
- **Combined options A+E, A+B and B+E were assessed as not viable** against the essential criteria, driven by high financial requirements, additional staffing demands, operational/regulatory complexity, and sustainability concerns.

Implications and next steps.

- The appraisal provides technical recommendations only.
- The next stages are:
  - SRO strategic review and finalisation for governance (Step 2),
  - formal consideration/approval by the relevant governance group(s) (Step 3),
  - further balanced room review with stakeholders including costings and essential-criteria overview (Step 4), and
  - onward approvals through executive/committee/Board arrangements to determine the options to proceed to formal consultation (Steps 5–6).
- For consultation transparency, the panel recommend Option A should be taken forward for consultation but should be clearly labelled as "reopening on a safe-staffing basis" and presented with its caveats and non-passing criteria fully visible.

1. Introduction

A technical appraisal session was undertaken on the 30th of April 2026 to review the outcomes of a balanced room session with internal and external stakeholders. The balanced room session (20th March 2026) produced additional scenarios than previously considered.

In summary the full range of options considered in the session were:

Existing options:

- **Option A:** Reopen the ward as it was in 2023, without 'new services.'
- **Option B:** Maintain the current position of no beds plus 'new services'
- **Option C:** Use Dyfi ward as a day treatment centre. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
- **Option D:** Maintain the current position of no beds plus 'new services.' Use Dyfi ward as a day treatment centre. Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds). Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)

- **Option E:** Develop the ward as a reablement facility

New options:

- **Option A and E combined**
- **Option A and B combined**
- **Option B and E combined**

1.1 Participants in the Session

Technical Review Panel:

- Sharon Jones-Bullock, Head of Nursing Area West – Community Nursing
- Ceri Harris, Head of Equality and Human Rights
- Nigel McCann, Senior Finance Manager
- Vic Peach, Interim Integrated Health Community Director (West)
- Sophie Stevens-Jones, Strategy Programme Manager
- Dylan Williams, West IHC

External Facilitator:

- Andy Wright (ASV)

2. Overview

- **Step 1:** Technical assessment of options and production of ***recommendations only***, for consideration by Senior Responsible Officers (SROs) for the Tywyn Community Hospital service review.
- **Step 2:** Consideration and strategic review of technical appraisal recommendations for finalisation for governance considerations by SROs.
- **Step 3:** Consideration and approval of options following technical consideration and SRO strategic review by the Service Change Oversight Group.
- **Step 4:** Balanced Room 3 with stakeholders in Tywyn (internal and external to BCUHB) to review, moderate and identify gaps or omissions from the technical appraisal recommendations, including costings and overview of the essential criteria review.
- **Step 5:** Presentation and review of options for endorsement by the Service Change Oversight Group with recommendations for Board approval.
- **Step 6:** Presentation and review of options for endorsement by the Strategic Planning and Service Change Group with recommendations for Board approval.

- **Step 7:** Presentation to the Planning, Population Health and Partnerships Committee for review and approval of options to be considered during the formal consultation phase.
- **Step 8:** Presentation to the Board for review and approval of options to be considered during the formal consultation phase.

This report presents the outcomes of Step 1 of the process.

3. Technical Appraisal Process

It was agreed that for consistency, both the new scenarios developed from the balanced room session and those previously agreed would be considered against the five 'essential' criteria, representing minimum performance standards for viability:

1. Quality and Safety;
2. Efficiency and Effectiveness;
3. Deliverability;
4. Sustainability; and
5. Accessibility and Inclusion.

These are pass/fail assessments, and it was agreed that this would be applied to all on a consensus basis reached through moderated discussions.

However, the discussions produced a level of nuance in the pass/fail assessment which can be summarised as follows:

- 5 = Pass
- 4 = Pass with a caveat
- 3 = Unresolved/question mark
- 2 = Implied or disputed fail
- 1 = Fail

The technical review panel made the recommendations as summarised in the table below.

	OPTIONS CONSIDERED							
Criteria	**A**	**B**	**C[01]**	**D[01]**	**E**	**A+E**	**A+B**	**B+E**
Quality and Safety	4	5	5	5	5	4	5	5
Efficiency and Effectiveness	1	5	5	5	1	1	1	1
Deliverability	1	4	4	4	4	1	1	1
Sustainability	1	5	5	5	3	1	1	1
Accessibility and Inclusion	2	5	5	5	1	2	5	5
Recommendation	**Pass** (with caveat)[02]	**Pass**	**Both pass** (by equivalence to option B)		**Fail**	**Fail**	**Fail**	**Fail**

Notes on the table:

01. **Options C** and **D** were not independently rescored criterion-by-criterion. They are treated as equivalent to **B** with participants stating there is *"no significant difference,"* that *"everything that relates to B relates to C and D,"* and that all three have the *"same cost, same staffing model..."*

    An additional caution raised is a narrative issue about explicit reliance on external providers, which the panel treats as wording to explain rather than as a new score.

02. **Option A** is a pass with the caveat that without the provision of safe staffing based on 2 RNs 24/7 the technical recommendation would be that it is unsustainable based on not being viable against the essential criteria.

3.1 Summary of Option-by-Option Discussions

Presented below are the panel's recommendations for each option, accompanied by detailed criterion-by-criterion discussions.

OPTION A (Qualified Pass)

Quality and Safety: Option A received a qualified pass on Quality and Safety for several reasons:

1. Evidence-Based Care: It was noted that the standards for care delivery, which would be implemented under Option A, met the necessary quality benchmarks. The discussion implied that the care could be provided safely with the right staffing levels being in place.
2. Staffing Levels: The proposal included a staffing model that aimed to ensure sufficient numbers of registered nurses (at least two registered nurses on duty) at all times, which is crucial for maintaining quality and safety standards in a healthcare setting. It was noted strongly that two RNs would be required to avoid lone working overnight which could result in quality concerns for patient safety and personal safety for staff.
3. Historical Context: There was reference to the service having previously been delivered safely and effectively, which contributed to the belief that it could be accomplished again if appropriate staffing were ensured.
4. Regulatory Compliance: The plan was framed within the context of meeting established quality and safety regulations, suggesting that the necessary measures would be taken to comply with standards set by health authorities.

In summary, the combination of a well-defined staffing model and adherence to care standards led to the qualified pass for Quality and Safety under Option A, although this was contingent on ensuring that the required staffing levels were met consistently.

Efficiency and Effectiveness: Option A failed the efficiency and effectiveness criteria for the following reasons:

1. Resource Allocation: It was determined that maintaining a ward with inpatient beds would not lead to effective use of resources. The discussion highlighted

that focusing on inpatient services would limit the ability to provide a broader range of community services that could meet the needs of more patients.
2. Limited Patient Impact: The argument was made that the ward model would restrict access to care for a wider population and would primarily serve a small number of patients (10 inpatient beds), making it less efficient overall. In comparison, community-based services have the potential to serve a larger cohort of patients more effectively.
3. Comparison to Alternatives: The effectiveness of Option A was questioned against other existing community services that could potentially deliver better health outcomes for the population. The preference for community rehabilitation and treatment options over inpatient beds indicated inefficiencies in the proposed service model.
4. Operational Challenges: The operational challenges associated with running a hospital ward, including staff shortages and the need for coverage, added complexity that would detract from the overall effectiveness of the service.

In conclusion, due to concerns over resource utilisation, limited patient impact, and the operational challenges of managing an inpatient ward, Option A did not meet the efficiency and effectiveness criteria.

Deliverability: Option A failed the deliverability criteria for several key reasons:

1. Staffing Constraints: There was significant uncertainty about the ability to recruit and retain sufficient nursing staff. The discussion indicated that it would require an increase of around 18 additional staff members, which was viewed as a notable challenge given the recent difficulties in attracting suitable staff.
2. Financial Implications: Option A was projected to exceed the existing budget by 33%, representing a substantial increase in funding that raised doubts about its feasibility. The financial constraints were a key factor in determining that the option was not deliverable.
3. Operational Risks: The operational model proposed for the ward would require a reliable staffing structure, including two registered nurses at all times. The risk of not being able to maintain adequate staffing levels undermined the overall deliverability of the option.
4. Market Conditions: The discussion referenced the competitive nature of healthcare recruitment, indicating that attracting the additional necessary staff might not be feasible, further impacting deliverability.

Overall, the combination of staffing shortages, financial viability, and operational challenges led to the conclusion that Option A could not be reliably delivered.

Sustainability: Option A failed the sustainability criteria for the following reasons:

1. Workforce Challenges: There were significant concerns about the sustainability of the workforce needed to keep the inpatient ward operational. The requirement for consistent staffing levels, including two registered nurses at all times, raised questions about the ability to maintain such staffing in the long term, especially given ongoing recruitment difficulties.
2. Financial Viability: The expected increase in funding (33% above the current budget) posed challenges to sustainability. The financial model would need to

be viable not just initially but continuously, and it was unclear how this could be sustained over time given the constraints on available resources.
3. Operational Pressures: The operational demands associated with running an inpatient ward would necessitate significant ongoing support. If staffing shortages arose, the model would become less viable, leading to an unsustainable situation where care could be compromised.
4. Increased Dependence on Community Resources: The model may require pulling staff from other community services to fill gaps, potentially leading to resource depletion in those areas. This would create a cycle of instability, undermining the sustainability of both the ward and the broader community services.

In summary, concerns regarding the workforce availability, financial constraints, operational demands, and the impact on community resources contributed to the conclusion that Option A was not sustainable.

Accessibility and Inclusion: Option A failed the accessibility and inclusion criteria for the following reasons following discussions amongst the panel:

1. Limited-Service Scope: The focus on maintaining an inpatient ward with a small number of inpatient beds (10) meant that the service would not be able to address the broader needs of the community. This limited patient access to a wider range of services that could provide care close to home for diverse population groups.
2. Opening Hours: The specific hours of operation for the MIU within this option were also a concern, as they could restrict access for those who require care outside of regular hours. This limitation would significantly impact the ability to serve individuals with varying work schedules or other commitments.
3. Demographics of Service Users: The emphasis on providing inpatient care could disproportionately favour a limited number of people with protected characteristics, while neglecting the healthcare needs of other demographic groups, such as younger individuals or those requiring different types of services (e.g., mental health, sexual health services).
4. Potential Barriers: The model lacked the flexibility needed to provide inclusive care, often favouring patients who fit into a very specific treatment protocol while potentially disadvantaging those who might benefit from other community services that are more inclusive and accessible. There is also a potential risk on the impact of delivery of other community services (e.g., District Nursing and the MIU) in the event of short-term sickness.

Overall, the combination of a narrow focus on inpatient care, limited hours, and a lack of attention to the diverse needs of the community contributed to the conclusion that Option A failed in terms of accessibility and inclusion.

OPTION B (PASS)

Quality and Safety: Option B passed the Quality and Safety criteria for several key reasons:

1. Comprehensive Service Provision: Option B maintained a range of community services that ensured patients could receive care in a safe and controlled

environment without the pressures associated with inpatient hospital beds. It was felt that this holistic approach allows for better outcomes for patients.

2. Adequate Staffing: The option did not face the same staffing challenges as Option A. By focusing on community services rather than an inpatient ward, it was deemed that current staffing levels could be sustained effectively, thus keeping the quality of care high.
3. Evidence-Based Care: The discussions indicated that the services provided under Option B would comply with safety standards and regulations, ensuring that patients receive care based on best practices and current clinical guidelines.
4. Patient Centred Focus: The model allowed for more individualised care, catering to the specific needs of the community without being confined to a traditional hospital setting. This was seen as contributing positively to patient safety and overall health outcomes.

Overall, the combination of maintaining adequate service levels, the focus on community care, and adherence to quality standards led to Option B being assessed positively in terms of Quality and Safety.

Efficiency and Effectiveness: Option B passed the Efficiency and Effectiveness criteria for several reasons:

1. Optimal Resource Utilisation: By maintaining community services without the pressures of inpatient beds, Option B allowed for a more effective allocation of resources. The focus on outpatient and community-based care meant that resources could be directed toward a broader range of services, leading to better patient outcomes.
2. Flexibility in Service Delivery: The option provided a flexible care model that could adapt to the needs of the community. It allowed for reprioritisation of services based on demand without being restricted by the operational overheads associated with running a hospital ward. This flexibility improves efficiency.
3. Broader Reach: By offering a variety of community services, Option B could cater to a larger number of patients compared to the limited scope of inpatient care. This broader access to services enhances overall effectiveness and ensures that more patients are receiving the care they need.
4. Balanced Operational Costs: The absence of an inpatient ward reduced the costs associated with maintaining a 24/7 hospital environment, including staffing, supplies, and administration. This cost-effectiveness supports sustainability while still providing high-quality care.

In summary, the ability to utilise resources efficiently, flexibility in service provision, a broader patient reach, and reduced operational costs contributed to Option B receiving a positive assessment for Efficiency and Effectiveness.

Deliverability: Option B passed the Deliverability criteria for the following key reasons:

1. Staffing: The option represents the model that is currently being delivered with a sustainable staffing model. There would be scope to work differently as a multidisciplinary team across the community services to support services, new ways of working and strengthened support across other services, e.g., primary care.
2. Finance: the model does not present a need for significant investment and any development was assessed as not out of scope
3. Operationally: the model was deemed as deliverable operationally, building on work already taking place and increasing multi-disciplinary team working and providing an expanded number of community services for the local population than the traditional model.
4. Staff development opportunities: By working in a multi-disciplinary way, it was felt that there would be more opportunities to develop skills, attract and retain staff.

Overall, Option B was passed as deliverable, building a sustainable model that is operationally viable, financially achievable, supports enhanced multidisciplinary working and provides greater opportunities for workforce development, recruitment, and retention.

Sustainability: Option B passed the Sustainability criteria for several key reasons:

Option B passed the Sustainability criteria for several key reasons:

- Workforce resilience: The model builds on an established and sustainable workforce model, avoiding the staffing challenges associated with maintaining a 24/7 inpatient ward and supporting recruitment, retention and staff development through broader roles and multidisciplinary working.
- Alignment with population need: The model was felt to reflect changing population health needs by strengthening prevention, rehabilitation, admission avoidance and care delivered closer to home, supporting people to remain independent within their communities.
- Financial sustainability: The option makes best use of existing resources and infrastructure without requiring the workforce and recurrent funding increases associated with reopening inpatient beds.
- Service resilience: By consolidating bed-based care where required and expanding community services, the model reduces pressure on individual services, improves flexibility and supports continuity of care during periods of workforce pressure.
- System-wide sustainability: The model supports integrated working across primary care, community services, care homes and wider partners, creating a more resilient and adaptable service capable of responding to future changes in demand.

In summary, Option B was passed as sustainable as it aligns with modern models of care, supports a resilient workforce, makes effective use of available resources, and is better positioned to meet current and future population health needs.

Accessibility and Inclusion: Option B passed the Accessibility and Inclusion criteria for several key reasons:

- Broader access to services: The model would provide access to a wider range of services locally, including Treatment Room services, wellbeing support, day treatments, IV therapies and extended Minor Injuries Unit provision; benefiting a greater proportion of the population than a bed-based model.
- Care closer to home: Services would be designed to support people in their own homes and communities wherever clinically appropriate, reducing the need for unnecessary travel for more people and helping people maintain independence.
- Improved availability: Extended MIU opening hours and expanded community provision increase opportunities for people to access care at times and in ways that better meet their needs.
- Inclusive population reach: The model supports a broader range of population groups, including older people, people with long-term conditions, carers, younger people and those requiring preventative, rehabilitative and ongoing healthcare support.
- Reduced health inequalities: By increasing local access to community-based services, strengthening multidisciplinary working and improving navigation through services, the model has greater potential to reduce barriers to care and support more equitable health outcomes.

Overall, Option B was assessed as accessible and inclusive as it expands the range and availability of locally delivered services, supports diverse population needs, and improves access to care closer to home for a larger proportion of the community.

OPTIONS C AND D

The panel considered Options C and D to be essentially the same as Option B, as all provided similar frameworks for health services without inpatient beds and emphasised improving community services. The panel's main reasons for this recommendation were:

1. Service Framework: Both Options C and D maintained the emphasis on outpatient and community services rather than inpatient care. They did not introduce new significant elements that would differentiate them from Option B in terms of operational structure.
2. Financial and Operational Models: The financial implications, staffing requirements, and operational goals of Options C and D were aligned with those of Option B, reinforcing the idea that they could all be effectively evaluated under a common model.

3. Patient Centred Care: All three options expressed a commitment to providing patient centred care through community-focused models, which means they would support similar patient outcomes and experiences.

The recommendation to combine all three options into a single assessment was based on the following considerations:

1. Simplicity and Clarity: By combining the options, the evaluation process becomes clearer and simpler. It avoids redundancy in discussions and allows stakeholders to focus on a unified approach to enhancing community services.
2. Unified Strategy: The combination reflects a cohesive strategy aimed at optimising the use of community resources, enhancing the quality of care, and addressing the healthcare needs of the population more effectively together than separately.
3. Streamlined Decision Making: A combined option allows for a more efficient decision-making process, enabling stakeholders to consider a single proposal rather than multiple similar options that ultimately deliver the same or very comparable outcomes.
4. Focused Recommendations: The combination helps in providing focused recommendations to decision makers, emphasising the consistent benefits across all three options and strengthening the argument for a community-centred service model.

In summary, Options C and D were viewed as extensions of Option B and combining them facilitated a more streamlined and effective discussion around improving community healthcare services and enabling their long-term development without increasing inpatient care**.**

OPTION E (Fail - Further Consideration Required)

Quality and Safety: Option E failed the Quality and Safety criteria for the following reasons:

1. Inadequate Staffing: Option E involved transitioning to a reablement facility, which would require substantially different staffing arrangements. Concerns were raised that the staffing levels provided under this model would not be sufficient to ensure safe and effective inpatient care, particularly as it involved working in a different regulatory environment (with Care Inspectorate Wales instead of Health Inspectorate Wales).
2. Limited Clinical Oversight: The reablement model inherently differs from an inpatient model in that it focuses on aiding recovery and independence rather than providing continuous medical oversight. This lack of consistent clinical supervision could compromise the quality of care for patients who require more intensive medical attention.
3. Operational Risks: The operational challenges of managing a reablement facility as opposed to an inpatient hospital ward may pose risks concerning the safety and quality of care. If the facility could not ensure adequate support and resources, this would hinder its ability to meet the necessary quality standards.

4. Uncertain Patient Outcomes: The transition to a reablement-focused service might limit the immediate access to comprehensive healthcare services for patients, potentially leading to worse health outcomes for those who require coordinated medical care. There was also the view that reablement services in people's own homes provide better long-term outcomes.

Overall, the combination of insufficient staffing, limited clinical oversight, operational risks, and concerns regarding patient outcomes contributed to Option E failing the Quality and Safety criteria. It was also felt that reablement would be a move away from core Health Board business and purpose and an inpatient ward could not maximise a person's opportunity for independent living; significantly impacting their quality of life.

Efficiency and Effectiveness: Option E failed the Efficiency and Effectiveness criteria for several reasons:

1. Limited-Service Scope: Option E focused on establishing a reablement facility, which inherently limits the range of services and interventions available compared to a more comprehensive community healthcare model. This limitation can reduce overall effectiveness by not meeting the diverse needs of a wider patient population.
2. Reduced Access to Care: The model may not offer the same level of access to various healthcare services that are critical for effective patient management. By narrowing the focus to reablement, it risks excluding patients who may benefit from other necessary services, thus diminishing overall healthcare effectiveness.
3. Operational Inefficiencies: Transitioning to a reablement facility introduces complexities in administration and operations that might lead to inefficiencies. For instance, the need for specific regulatory compliance under Care Inspectorate Wales adds layers of complexity that could hinder effective service delivery.
4. Inadequate Support for Patients: The focus on reablement might not sufficiently address the immediate healthcare needs of patients who require medical attention in addition to rehabilitation. This gap could lead to a less effective system where patient care is fragmented, not adequately supported and a low utilisation of the service based on those who would be eligible for that kind of care.
5. Higher Dependency on External Factors: The sustainability of effectiveness in a reablement facility would heavily depend on external factors, including the capacity of local care services and support from the community. If these factors were not dependable, the model could fail to deliver the intended outcomes effectively.

In summary, the combination of a limited-service scope, reduced access, operational inefficiencies, inadequate patient support, and reliance on external factors contributed to Option E failing the Efficiency and Effectiveness criteria.

Deliverability: Option E failed the Deliverability criteria for several key reasons:

1. Staffing Challenges: The transition to a reablement facility would require a different staffing model that may not be easily achievable. The need for specific roles, such as a registered CIW manager, creates a dependency on a limited pool of qualified personnel. This raises concerns about whether sufficient staff could be recruited and retained to ensure operational effectiveness.
2. Regulatory Compliance: Operating a reablement facility would involve navigating a different regulatory framework under the Care Inspectorate Wales, adding complexity to its operation. Ensuring compliance with these regulations could present significant hurdles that might impact the feasibility of delivering services as intended.
3. Financial Viability: While Option E aimed to leverage existing resources, the associated costs (particularly if additional funding is required) could pose financial challenges. If not adequately budgeted, it may lead to complications in sustaining the service over time.
4. Competition with Existing Care Services: A reablement facility would compete with existing care homes and services in the area, which could challenge recruitment efforts and service delivery. The potential dilution of resources as a result of competing demands could further hinder deliverability.
5. Operational Risks: The shift to a reablement model introduces operational risks associated with managing patient care in a different setting. If not adequately planned and executed, these risks could compromise the ability to deliver quality services consistently.

In summary, the combination of staffing challenges, regulatory complexities, financial viability concerns, competition with existing services, and operational risks contributed to Option E failing the Deliverability criteria.

Sustainability: Option E failed the Sustainability criteria for several reasons:

1. Reliance on Limited Staffing: The transition to a reablement facility would depend on a specific type of staffing model, particularly the need for a registered CIW manager. This reliance on a limited pool of qualified staff raises concerns about the long-term sustainability of the workforce needed to operate the facility effectively.
2. Dependence on External Support: The success of a reablement model often requires collaboration with other services, including community care providers and other local agencies. If these external supports are not adequately aligned or dependable, it could jeopardise the sustainability of the reablement facility.
3. Financial Concerns: Although Option E aims to utilise existing resources, the potential need for additional funding to support operations could create sustainability issues. If funding cannot be secured or maintained, it might lead to service interruptions or quality reductions over time.
4. Operational Complexity: Managing a reablement facility introduces operational complexities that could hinder the ability to provide consistent and reliable services. This complexity can strain resources and make it challenging to sustain quality care and service delivery.

5. Changing Community Needs: If community demographics or healthcare needs shift, a rigid focus on reablement without the flexibility to adapt services could lead to a disconnect between what is being offered and the population health needs. This disconnect would threaten the long-term viability and relevance of the facility.

In conclusion, the combination of staffing dependencies, reliance on external support, financial uncertainties, operational complexities, and challenges in adapting to changing community needs contributed to Option E failing the Sustainability criteria.

Accessibility and Inclusion: Option E failed the Accessibility and Inclusion criteria for several reasons:

1. Limited Services Offered: The focus on establishing a reablement facility meant that only a narrow range of services would be available. This could limit access for patients who require a variety of healthcare options, ultimately reducing the overall inclusivity of care for different demographic groups.
2. Restricted Hours and Availability: If the reablement facility operated on limited hours, this could further restrict access for individuals who need care outside of those hours. It would likely not accommodate varied schedules of patients, particularly working individuals, which undermines inclusivity.
3. Focus on Specific Patient Needs: The reablement model typically caters to specific patient groups, such as those recovering from illness or surgery but who do not need care from registered nurses which may neglect the broader needs of the community, including those with chronic conditions, mental health needs, or other diverse healthcare requirements.
4. Barriers to Care: The focus on the reablement model could create barriers for individuals from different backgrounds or those who require different types of medical attention. If the services in this model do not meet the varied needs of the community, it could exacerbate health inequities.
5. Neglecting Younger Populations: The approach might be more tailored to older adults or those needing rehabilitation, potentially overlooking the health needs of younger populations or other protected groups who may not benefit as much from a strictly reablement-focused service.

In summary, the combination of offering limited services, restricted availability, a narrow focus on specific patient needs, potential barriers to care, and disregard for the needs of younger and diverse populations contributed to Option E failing the Accessibility and Inclusion criteria.

Further consideration required: Key factors for further consideration for Option E before it could be considered as viable (including the need to engage local authority social services), based on the panel's discussions include:

- Significant transition complexity: moving from traditional community services to a reablement facility requires careful planning, implementation, and management of impacts on existing services and patient care.

- Regulatory and compliance requirements: the model may sit within different frameworks (e.g., Care Inspectorate Wales and local authority requirements), requiring clear governance, protocols, and assurance of ongoing compliance.
- Staffing and workforce feasibility: recruitment and retention of sufficient staff (including specialist roles), workforce availability, and impacts on existing teams need assessment.
- Financial viability and sustainability: capital and ongoing operating costs, funding sources, and value-for-money considerations require detailed analysis.
- Understanding and meeting community needs: engagement with community stakeholders and local authorities is needed to ensure the service design reflects local demographics and needs.
- Integration with wider services and continuity of care: partnership working (particularly with local authority social services) is required to support seamless pathways, discharge planning, and follow-up support back in the community.
- Support for vulnerable populations: joint working helps identify and support people with higher needs (e.g., older people and people with disabilities) through appropriate care planning and access to services.
- Opportunities for alternatives: consider whether adapting existing community services could deliver similar outcomes without a full transition to a reablement focused model.
- Resource sharing and operational efficiency: collaboration with local authority social services can enable shared expertise, staffing support, and more efficient use of resources.

(NEW) OPTION A+E (Fail)

The technical recommendation is that the option fails. It's the panel's view that A and E is not a compatible combination for the Tywyn community hospital setting and population health needs.

Aside from this observation, combined option A+E failed for several reasons:

1. High Financial Requirement: Option A+E necessitated a significant increase in funding, estimated at nearly £900,000. This high financial burden made it difficult to justify or sustain, especially within the existing budget.
2. Staffing Challenges: The combined option would require a substantial increase in staffing levels—approximately 18 additional staff members compared to current resources. This raised questions about the ability to recruit and retain the necessary workforce in a competitive healthcare environment.
3. Operational Complexity: Merging the inpatient model of Option A with the reablement focus of Option E created operational complexities that could hinder effective service delivery. This combination could lead to confusion in service provision, impacting patient care quality and experience.
4. Regulatory Issues: Introducing the elements of both an inpatient ward and a reablement facility would involve navigating different regulatory environments, complicating compliance, and operational oversight.

5. Limited Effectiveness: Combining these two models may dilute the effectiveness of each approach. The focus on inpatient services may limit the ability to provide the timely, flexible care that a reablement model aims to deliver, ultimately reducing the overall effectiveness of the combined option.
6. Sustainability Concerns: The sustainability of such a complex model, which would rely on both ongoing funding and a stable workforce, was questionable. The combination of the two differed fundamentally in their operational needs and could create excessive strain on existing resources.

In summary, the combination of high financial requirements, staffing challenges, operational complexity, regulatory issues, limited effectiveness, and sustainability concerns contributed to the failure of the A+E option.

Criteria by criteria assessment from the technical panel is set out below.

Quality and Safety: Option A&E failed the Quality and Safety criteria for several reasons:

1. High Staffing Requirements: The combination of inpatient services from Option A and the reablement model of Option E would create a substantial demand for staffing. Concerns were raised about whether enough qualified staff could be recruited and retained to meet the safety standards required for both types of care.
2. Operational Complexity: Merging two distinct service models—hospital inpatient care and a reablement facility—introduces operational complexities that could compromise the quality of care. Coordinating care across these models may lead to inconsistencies in service delivery and monitoring patient safety.
3. Potential for Fragmented Care: The integration of both approaches could lead to fragmented patient experiences. Patients may face challenges in navigating between inpatient and reablement services, which could hinder their access to appropriate care and negatively impact overall health outcomes.
4. Regulatory Compliance Challenges: Operating both an inpatient ward and a reablement facility would require adherence to different regulatory standards. Ensuring compliance with varying regulations can divert focus and resources away from patient care, potentially compromising safety.
5. Quality Assurance Issues: The complexities of combining these service types could make it more challenging to implement effective quality assurance processes. This lack of robust monitoring and evaluation mechanisms could lead to gaps in care quality and safety.
6. Inadequate Clinical Oversight: The dual focus of Option A&E may limit the degree of clinical oversight necessary for effective inpatient care. The sharing of staff across both models could dilute attention to clinical protocols and patient safety measures.

In summary, the combination of high staffing demands, operational complexities, potential for fragmented care, regulatory compliance challenges, quality assurance issues, and inadequate clinical oversight contributed to Option A&E failing to meet the Quality and Safety criteria**.**

Efficiency and Effectiveness: Option A&E failed the Efficiency and Effectiveness criteria for several reasons:

1. High Financial Demand: The combined model required a substantial increase in budget, estimated to be nearly £900,000. This high financial burden made it difficult to justify the option's sustainability compared to existing resources and other viable models.
2. Inefficient Use of Resources: Combining inpatient care with the reablement model created complexities in managing resources. The setup could lead to duplication of efforts and inefficient allocation of staff, making it harder to deliver services effectively.
3. Limited Patient Impact: By trying to merge two distinct approaches, the overall effectiveness of the care model may have been diluted. Each approach could lose its specifics, resulting in suboptimal outcomes for patients who might benefit more from a focused service type.
4. Operational Challenges: The merging of inpatient services and reablement requires careful coordination and support systems, which can lead to operational inefficiencies. Delays in service delivery and communication gaps may arise as staff navigate between two distinct care models.
5. Complex Care Pathways: Patients might face confusion in navigating the combined services, leading to fragmented care. This complexity can hinder timely access to appropriate treatment plans and reduce overall patient satisfaction and effectiveness in addressing health needs.
6. Sustainability Issues: The financial and staffing demands inherent in this combined option pose challenges to long-term sustainability. The inability to consistently recruit and retain necessary staff undermines efforts to ensure optimal care delivery, further affecting efficiency and effectiveness.

In summary, the combination of high financial demands, inefficient resource utilisation, limited patient impact, operational challenges, complex care pathways, and sustainability issues contributed to Option A&E failing the Efficiency and Effectiveness criteria.

Deliverability: Option A&E failed the Deliverability criteria for several key reasons:

1. Significant Staffing Increases Required: The combination of inpatient services from Option A and the reablement facility from Option E would necessitate a substantial increase in staffing levels. This required increase would involve around 18 additional staff members, raising concerns about the feasibility of recruiting and retaining the necessary personnel to deliver both types of service effectively.
2. High Financial Burden: The estimated funding requirement for the combined option was around £900,000, which posed a challenge in finding sustainable financial resources. The difficulty in securing such a significant increase in funding made it unlikely that the option could be delivered successfully.
3. Operational Complexity: Merging two different models (hospital inpatient care and community reablement) creates complexities that can hinder efficient service delivery. The coordination needed to manage these differing

operational demands can lead to confusion and inefficiencies, jeopardising the ability to deliver quality care.

4. Regulatory Compliance Challenges: Operating both inpatient and reablement services would require adherence to different regulatory frameworks, which adds another layer of complexity to the model. This dual regulatory requirement could create obstacles in maintaining compliance, further complicating deliverability.
5. Risks of Fragmented Care: The combined approach may lead to fragmented patient experiences, making it difficult for patients to navigate between different types of care. This fragmentation can hinder the delivery of cohesive and effective services, especially if care pathways are not clearly defined and managed.
6. Potential for Resource Drain: Trying to deliver both inpatient and community services could overstretch resources, leading to inefficiencies and challenges in maintaining quality care in both realms. If required resources are continuously pulled in different directions, it can compromise the overall effectiveness of care delivery.

In summary, the combination of significant staffing increases, high financial demands, operational complexities, regulatory challenges, risks of fragmented care, and potential resource drains contributed to Option A&E failing to meet the Deliverability criteria.

Option A&E failed the Sustainability criteria for several reasons:

1. High Financial Requirement: The estimated additional funding needed for the combined option was approximately £900,000, representing a substantial financial burden. Without a clear and sustainable source of funding, the long-term viability of the services could not be assured.
2. Staffing Instability: The need for a significant increase in staffing levels (around 18 additional staff) created uncertainty about the ability to consistently recruit and retain the required workforce. Without a stable workforce, maintaining quality and continuity of care becomes challenging.
3. Operational Complexity: The integration of inpatient services and a reablement facility adds layers of operational complexity that can strain resources and hinder long-term sustainability. Managing the differing needs and demands of these two models can lead to inefficiencies that affect service delivery.
4. Regulatory Compliance Challenges: Operating within different regulatory frameworks for inpatient and reablement services introduces additional compliance burdens. Ensuring that both types of services adhere to required standards can consume significant administrative resources, impacting sustainability.
5. Risk of Resource Drain: Attempting to deliver both inpatient care and community reablement could stretch resources too thin. This might lead to reductions in service quality in both areas if there are inadequate resources to maintain standards for patient care.

6. Inability to Adapt to Changing Needs: The rigidity of merging these two models could hinder flexibility and adaptability to changing community healthcare needs over time. If circumstances shift, the combined model may not have the ability to respond effectively, jeopardising its ongoing relevance and sustainability.

In summary, the combination of high financial demands, staffing instability, operational complexities, regulatory compliance challenges, risks of resource drain, and inflexibility in adapting to community needs contributed to Option A&E failing the Sustainability criteria.

Accessibility and Inclusion: Option A&E failed the Accessibility and Inclusion criteria for several reasons:

1. Limited Range of Services: The combination of inpatient services from Option A with the reablement facility from Option E may not provide a comprehensive array of healthcare options, thereby limiting access for patients who require various types of care. This narrow focus could exclude certain demographics that would benefit from diverse services.
2. Hours of Operation: If the operational hours for the combined services did not accommodate the needs of all patients, particularly those who work or have other commitments, it would restrict access. Limited hours could disproportionately affect individuals seeking care outside of traditional working hours.
3. Risk of Bias Toward Specific Patient Groups: The focus of Option A on inpatient care might favour specific populations, such as older adults recovering from surgery, while neglecting the needs of younger individuals or those with different health requirements. This could lead to inequities in healthcare access.
4. Navigation Challenges: The complexity of navigating a combined model of inpatient and reablement services could confuse patients, making it more difficult for them to access the appropriate care. This confusion can lead to delays and potentially worsen health outcomes.
5. Potential Barriers to Access: The transitional nature of the reablement facility might create barriers for individuals who require immediate medical attention or chronic disease management. If services are not readily accessible or clearly defined, patients may struggle to obtain necessary care.
6. Inadequate Community Engagement: If the combined model does not actively engage with diverse community groups and consider their specific needs, it may not promote inclusivity effectively. Failing to tailor services to the unique needs of different populations can exacerbate health disparities.

In summary, the limitations in service range, operational hours, potential biases towards certain patient groups, navigation challenges, barriers to access, and lack of adequate community engagement contributed to Option A&E failing the Accessibility and Inclusion criteria.

(NEW) OPTION A+B (Fail)

For the following overarching reasons, option A+B was considered a high-risk option that the panel could not pass:

1. Significant Financial Increase: The combined option would require a substantial financial investment, which would be a considerable increase over the existing budget. This heightened financial demand created doubts about the feasibility of sustaining such a model given the Health Board's financial duty.
2. Staffing Requirements: Option A+B would necessitate an increase in staffing, with around 14 additional staff members needed to operate effectively. This raised concerns about the ability to recruit and retain qualified personnel, especially in a competitive job market.
3. Operational Challenges: Merging the inpatient services of Option A with the community-focused services of Option B added complexity to the operational model. This could lead to inefficiencies in service delivery, increased administrative burdens, and potential confusion regarding roles and responsibilities.
4. Quality of Care Concerns: The combination of inpatient services and community services may lead to issues regarding the quality of care, particularly if adequate staffing or resources are not maintained for both areas. This dual focus could dilute the effectiveness of care delivery.
5. Sustainability Issues: Maintaining such a complex operational model might pose long-term sustainability challenges. If the necessary funding or staffing could not be guaranteed, the viability of offering both inpatient and community services would be jeopardised.
6. Stakeholder Concerns: The combined approach may not align with the expectations or needs of the community and other stakeholders, who may prefer a more streamlined or focused service model rather than a hybrid one.

In summary, the combination of high financial demands, staffing challenges, operational complexities, quality of care concerns, sustainability risks, and stakeholder misalignment contributed to the failure of Option A+B.

Criteria by criteria assessment from the technical panel is set out below.

Quality and Safety: Option A+B failed the Quality and Safety criteria for several reasons:

1. Insufficient Staffing Levels: The combination of inpatient services from Option A and community services from Option B would still rely on staffing levels that raised concerns about the ability to consistently provide safe and effective care. The increased demand for staff without guaranteed recruitment and retention could compromise patient safety.
2. Operational Complexity: Mixing inpatient care with outpatient services creates challenges in maintaining quality standards. The need to manage two different service delivery models within the same framework could lead to inconsistencies in care quality and put patients at risk.
3. Limited Focus on Patient Safety: While Option B emphasises community care, the integration with inpatient services in Option A might shift focus away from

the requirements and protocols necessary for safe inpatient care. This dual focus could dilute the safety measures that need to be rigorously upheld in a hospital setting.

4. Risk of Fragmented Care: The combination of different service types may lead to fragmentation in care delivery, making it difficult to ensure that patients receive a coordinated and comprehensive approach to their healthcare needs. Patients may find it challenging to navigate the differing care pathways.
5. Regulatory Compliance Challenges: Offering both inpatient and community services could complicate regulatory compliance. Different standards apply to inpatient settings compared to community services, and ensuring adherence to both sets of standards may be problematic without a clear operational strategy.
6. Quality Assurance Mechanisms: The complexity introduced by combining two differing care models could make it challenging to implement effective quality assurance mechanisms. This could result in gaps in monitoring and maintaining the quality and safety of care provided to patients.

Overall, these issues related to staffing, operational complexity, focus on patient safety, risk of fragmented care, regulatory challenges, and quality assurance all contributed to Option A+B failing to meet the Quality and Safety criteria.

Efficiency and Effectiveness: Option A+B failed the Efficiency and Effectiveness criteria for several reasons:

1. High Financial Costs: The combined option required a significant financial investment of approximately £740,000, which was seen as unsustainable given the existing budget. The high cost would limit the ability to allocate funds efficiently across other necessary services.
2. Inefficient Resource Utilisation: Combining the inpatient services from Option A with the community services of Option B could lead to inefficient use of resources. The operational complexities of managing two distinct types of care could result in duplicated efforts and wasted resources.
3. Limited Impact on Patient Outcomes: Combining both models may not make patient care better. It could weaken each approach, so patient outcomes might not improve as much as if you focused on just one type of care.
4. Operational Complexity: Managing both inpatient and community services under one package introduces complexity that can lead to inefficiencies in service delivery. Coordinating between different care models may result in delays and confusion in treatment protocols, negatively affecting patient care.
5. Challenges in Provision: The conflicting needs and demands of inpatient and outpatient services could lead to difficulties in ensuring timely access to care. If resources are spread too thin across both service types, patients may experience longer wait times and diminished quality of care.
6. Adaptability Issues: The combined model may not be flexible enough to respond to changes in patient demand or community needs effectively. With a more complex structure, any adaptations or optimisations in service delivery could be hindered, reducing overall effectiveness.

In summary, the combination of high costs, inefficient resource utilisation, limited impact on patient outcomes, operational complexity, challenges in service provision, and adaptability issues contributed to Option A+B failing the Efficiency and Effectiveness criteria.

Deliverability: Option A+B failed the Deliverability criteria for several key reasons:

1. Substantial Staffing Increases Required: The combined option necessitated a significant increase in staffing levels, estimated at around 14 additional staff members. This raised concerns about the feasibility of recruiting and retaining enough qualified personnel in a competitive labour market, making it difficult to ensure that the necessary care and services could be delivered effectively.
2. High Financial Burden: The financial implications of Option A+B were considerable, requiring an estimated additional £740,000 in funding over the existing budget. Given current financial constraints, it was deemed unlikely that this funding could be sourced and sustained over time, which poses a risk to the viability of the services.
3. Complex Operational Logistics: The combination of inpatient services and community services introduces operational complexities that could hinder efficient service delivery. Managing two distinct care models within the same framework can create confusion and inefficiencies, making it difficult to ensure consistent implementation of services.
4. Dependence on Regulatory Compliance: Operating a hybrid model of both inpatient and outpatient services raises concerns regarding compliance with differing regulatory requirements. Navigating these regulations adds an additional layer of complexity, which could lead to challenges in maintaining the necessary quality of care standards.
5. Coordination Challenges: Successfully coordinating between the demands of inpatient care and community services can be difficult, particularly if there are significant differences in operational practices and patient management approaches. This can result in delays and inconsistencies in patient care.
6. Risk of Fragmentation in Service Delivery: The combined option could lead to fragmented patient experiences, where patients may struggle to navigate between the inpatient and community services. This fragmentation can complicate care pathways and diminish the overall effectiveness of service delivery.

In summary, the combination of staffing increases, high financial burdens, operational complexities, regulatory compliance challenges, coordination issues, and the potential for service fragmentation contributed to Option A+B failing to meet the Deliverability criteria.

Sustainability: Option A+B failed the Sustainability criteria for several reasons:

1. High Financial Commitment: The estimated additional funding requirement of approximately £740,000 posed significant concerns for long-term sustainability. Without an assured source of ongoing funding, maintaining the services under this combined option would be challenging.

2. Staffing Instability: The need for a substantial increase in staffing—around 14 additional staff members—was a critical concern. The ongoing ability to recruit and retain these employees in a fluctuating job market raises questions about the long-term sustainability of the workforce necessary to deliver the combined services.
3. Operational Complexity: The combination of inpatient services and community services creates operational challenges that can lead to inefficiencies. This complexity complicates resource allocation and can increase the burden on existing staff, which may result in burnout and turnover, impacting overall sustainability.
4. Regulatory Pressures: The need to meet different regulatory requirements for both inpatient and community services can strain administrative resources. Ongoing compliance efforts are necessary for sustainable operations but can divert focus and resources from patient care.
5. Inflexibility in Service Delivery: The combined model may lack the adaptability needed to respond to changing community healthcare needs effectively. If patient demographics or health trends shift, the rigid structure of combining both types of services could hinder timely adjustments and reduce sustainability.
6. Potential for Resource Drain: By attempting to deliver both inpatient and community services, resources may be overextended. This could lead to reducing the quality of care in both realms if adequate support is not maintained, jeopardising long-term sustainability.

In summary, the combination of high financial requirements, staffing instability, operational complexity, regulatory pressures, inflexibility, and potential resource drains contributed to Option A+B failing the Sustainability criteria.

Accessibility and Inclusion: Option A+B failed the Accessibility and Inclusion criteria for several reasons:

1. Limited Service Scope: By merging inpatient services with community services, the resultant offering may not adequately address the diverse healthcare needs of the entire patient population. This limitation could exclude individuals who may require specific types of care that are not addressed by the combined model.
2. Access Restrictions: The combination of these two models might lead to operational hours and availability that do not accommodate all patients' schedules, particularly those who work or have other commitments. If the service hours are not flexible, it limits access and inclusivity for those needing care.
3. Potential Bias Towards Certain Demographics: The focus on inpatient beds may favour specific groups, such as older adults requiring rehabilitation, while neglecting other populations, such as younger individuals or those with chronic conditions who may benefit more from community-based services and a reduced travel need for regular interventions.
4. Complex Care Pathways: The merging of inpatient and community services can lead to fragmented care pathways, making it more challenging for patients

to navigate the system. This complexity can create barriers for people seeking comprehensive and coordinated care.
5. Lack of Targeted Outreach: If the combined model does not actively engage with diverse community groups, including those typically underserved, it may not effectively promote inclusivity. This can exacerbate disparities in healthcare access among different demographic groups.
6. Risk of Equity Issues: The potential for inequitable access could be increased by the complications that arise from merging two different types of services. If certain populations do not use or cannot access these combined services, it could lead to wider health disparities.

In summary, the shortcomings in service scope, access restrictions, potential demographics bias, complex care pathways, lack of targeted outreach, and risks of inequity contributed to Option A+B failing the Accessibility and Inclusion criteria.

(NEW) OPTION B+E (Fail)

Overall option B+E failed the considerations of the technical panel against the hurdle criteria for the following reasons:

1. Financial Feasibility: The combined option likely required significant financial investment, which would be difficult to justify within existing budget constraints. The additional funding needed to support both the comprehensive community services of Option B and the new operational setup for the reablement facility in Option E raised sustainability concerns.
2. Staffing Challenges: Merging the community services from Option B with the reablement model of Option E would necessitate a considerable increase in staffing. The difficulty in recruiting and retaining sufficient qualified staff could impede the ability to deliver both services effectively.
3. Operational Complexity: The integration of the two different models—one focused on community services and the other on rehabilitation—would introduce operational complexities. Managing these complexities could result in inefficiencies, confusion in care delivery, and potential disruptions in patient services.
4. Quality of Care Concerns: The combination could lead to fragmented care pathways, where continuity and quality of care might be compromised. The focus on a reablement model may not adequately address the healthcare needs of all patients served by the community services.
5. Regulatory and Compliance Issues: The operational demands of a reablement facility fall under different regulatory frameworks than traditional community healthcare services. This introduces additional compliance challenges that could strain administrative resources and distract from patient care.
6. Limited Community Impact: Combining these two approaches could risk diluting the effectiveness of services offered to the community. Instead of creating a synergistic improvement in patient care, the merging of models might lead to insufficient responses to diverse community needs.

In summary, the combination of financial infeasibility, staffing challenges, operational complexity, quality of care concerns, regulatory issues, and limited community impact

contributed to Option B+E failing to meet necessary criteria for a viable service model.

Criteria by criteria assessment from the technical panel is set out below.

Quality and Safety: Option B+E failed the Quality and Safety criteria for several reasons:

1. Inadequate Staffing: The transition to a reablement facility under Option E would require specific staffing arrangements that may not be sufficient to maintain the quality of care seen in the established community services of Option B. Concerns about staffing levels and whether qualified personnel could be consistently available raised questions about patient safety.
2. Lack of Clinical Oversight: The reablement model may not provide the same level of clinical oversight as an inpatient facility. This lack of oversight can compromise the quality of care, especially for patients with complex medical needs who require continuous monitoring and intervention.
3. Operational Complexity: The integration of community services from Option B with the reablement facility introduces operational challenges that could affect the quality of care delivered. Managing two different service types can complicate workflows and increase the potential for errors, impacting overall safety.
4. Risk of Fragmented Care: Patients may experience fragmented care pathways when transitioning between community services and reablement. This fragmentation can hinder the continuity of care, increasing the likelihood of gaps in treatment and oversight that could negatively affect patient outcomes.
5. Regulatory Compliance Issues: The requirement to adhere to different regulatory standards for community services and those of a reablement facility can create additional burdens on staff and management. If compliance is not consistently met, it could jeopardise overall safety and quality of care. 6. Quality Assurance Challenges: The complexities introduced by combining these two types of services may make it more difficult to implement and maintain effective quality assurance measures. This lack of robust oversight could lead to gaps in care quality and safety protocols.

In summary, the combination of inadequate staffing, lack of clinical oversight, operational complexities, risks of fragmented care, regulatory compliance challenges, and quality assurance difficulties contributed to Option B+E failing to meet the Quality and Safety criteria.

Efficiency and Effectiveness: Option B+E failed the Efficiency and Effectiveness criteria for several reasons:

1. High Financial Requirements: The combination of Option B's community services with the reablement facility of Option E would likely necessitate a substantial financial investment. This increased funding burden could make it difficult to justify the option’s feasibility, particularly within existing budget constraints.

2. Inefficient Resource Utilisation: The merging of community services with the reablement model can lead to inefficiencies in resource allocation. Managing two distinct service models may result in overlapping efforts, increased administrative burdens, and underutilised resources that do not effectively address patient needs.
3. Limited Impact on Patient Outcomes: While both approaches aim to improve patient care, the combined model may dilute the specific benefits offered by each. Patients may not receive the comprehensive and coordinated care needed to achieve optimal health outcomes, leading to reduced overall effectiveness.
4. Operational Complexity: Integrating community services with a reablement facility can introduce operational challenges that hinder effective service delivery. Complexity in coordinating workflows between the two models may lead to delays, miscommunication, and a lack of continuity in care.
5. Fragmented Care Pathways: The merging of differing models could lead to fragmented care experiences for patients, complicating their ability to navigate the healthcare system effectively. This fragmentation can lead to inefficiencies and potentially poor health outcomes due to delays or gaps in care. 6. Inflexibility in Adaptation: The combined option may not be flexible enough to adapt to changing community healthcare needs over time. If patient demographics or health trends shift, a rigid structure could hinder timely adjustments, ultimately reducing the model's effectiveness.

In summary, the combination of high financial requirements, inefficient resource utilisation, limited patient impact, operational complexity, fragmented care pathways, and inflexibility in adaptation contributed to Option B+E failing the Efficiency and Effectiveness criteria.

Deliverability:

Option B+E failed the Deliverability criteria for several key reasons:

1. Significant Staffing Demands: The integration of community services from Option B with the reablement model of Option E would require a substantial increase in staffing levels. This need for additional qualified personnel raised concerns about the feasibility of recruiting and retaining enough staff to deliver both services effectively.
2. High Financial Burden: The combined option would involve significant financial implications, requiring additional funding that may not be feasible within existing budget constraints. This makes it challenging to ensure the option can be delivered sustainably over time.
3. Operational Complexity: Merging two distinct service models introduces complexities that can hinder efficient service delivery. The difficulties in managing these different types of care can lead to confusion, inefficiencies in workflows, and potential disruptions in patient services.
4. Regulatory Compliance Challenges: Operating both community services and a reablement facility would require adherence to different regulatory frameworks. Ensuring compliance can put additional pressure on

administrative resources, potentially diverting attention away from patient care and affecting the ability to deliver services.

5. Coordination Challenges: Successful delivery of combined services requires effective coordination between the various care pathways. The challenges in ensuring seamless transitions between community and reablement services could impede access to timely care for patients.
6. Resource Constraints: The need to allocate resources effectively while balancing the demands of both community services and the reablement facility could lead to resource strain. If resources are overly stretched, it could hamper the ability to deliver high-quality services.

In summary, the combination of significant staffing demands, high financial burdens, operational complexities, regulatory compliance challenges, coordination issues, and resource constraints contributed to Option B+E failing to meet the Deliverability criteria.

Sustainability:

Option B+E failed the Sustainability criteria for several reasons:

1. High Financial Requirements: The financial commitment associated with Option B+E was significant, requiring additional funding that could prove challenging to secure on a long-term basis. Without a reliable source of ongoing funding, the long-term viability of this combined model is questionable.
2. Staffing Instability: The integration of community services with a reablement facility would necessitate increased staffing levels. The ongoing ability to recruit and retain sufficient qualified staff in a competitive labour market raises concerns about the long-term sustainability of the workforce needed to support the option effectively.
3. Operational Complexity: Merging two different care models creates layers of operational complexity that can strain resources and hinder ongoing service delivery. The challenges of managing these complexities could lead to inefficiencies and reduced service quality over time, compromising sustainability.
4. Regulatory Compliance Burdens: Operating within distinct regulatory frameworks for both community services and a reablement facility introduces additional compliance requirements. Ensuring adherence to these standards can be resource-intensive and complicate sustainable operations.
5. Potential Resource Drain: Attempting to deliver both inpatient care and community reablement could stretch resources too thin. This could lead to a decline in service quality in both areas if adequate resources are not maintained, impacting the overall sustainability of the care model.
6. Inability to Adapt to Changing Needs: The combined model may lack the flexibility to respond effectively to changing healthcare needs within the community. If demographic shifts or health trends occur, the merged model could fail to adapt, jeopardising its ongoing relevance and sustainability.

In summary, the combination of high financial demands, staffing instability, operational complexities, regulatory compliance burdens, potential resource drains, and inflexibility in adapting to community needs contributed to Option B+E failing to meet the Sustainability criteria.

Accessibility and Inclusion: Option B+E failed the Accessibility and Inclusion criteria for several reasons:

1. Limited Scope of Services: The merger of community services from Option B with the reablement facility from Option E resulted in a narrow focus that may not adequately address the diverse healthcare needs of the entire patient population. This limitation could exclude individuals requiring a broader range of services.
2. Operational Hours Limitations: If the hours of operation for the combined services did not accommodate the needs of all patients, particularly those with jobs or other commitments, it would restrict their access to care. Limited availability could disproportionately affect individuals seeking treatment outside of traditional working hours.
3. Risk of Demographic Bias: The combined focus on inpatient care from Option B might favour particular patient groups, such as older individuals in need of rehabilitation, while overlooking the needs of younger populations or those with different health requirements. This bias can lead to inequities in healthcare access.
4. Navigation Challenges: The complexity of navigating the services offered in the combined model could confuse patients, making it difficult for them to find and access the appropriate care. Such confusion could lead to delays in treatment and negatively impact patient outcomes.
5. Inadequate Engagement with Diverse Community: If the combined model did not actively engage with various community groups and consider their specific needs, it may not effectively promote inclusivity. This lack of tailored services for different populations can exacerbate existing health disparities.
6. Barriers to Access for Vulnerable Populations: The reablement component may introduce barriers for individuals who require more immediate medical attention or chronic disease management. If services are not readily accessible or effectively integrated, patients may struggle to obtain the necessary support.

In summary, the limitations in service scope, operational hour restrictions, potential biases towards certain demographic groups, navigation challenges, lack of adequate community engagement, and barriers to access for vulnerable populations contributed to Option B+E failing the Accessibility and Inclusion criteria.

4. Recommendations

4.1 Pass

- **Option A** is recommended for consideration in consultation as an option, for transparency, and community legitimacy. However, it is further recommended that this should be presented with its caveats fully visible: it only passes Quality and Safety if recast around a revised safe-staffing establishment, and

even then, it fails Efficiency and Effectiveness, Deliverability, Sustainability and Accessibility and Inclusion.

The panel is clear in making this technical recommendation Option A requires additional staff and materially more funding to be made safe.

Option A should be labelled as reopening on a safe-staffing basis, not “as it was”

- The technical recommendation is to **PASS B/C/D as one option**. A strong case was made for rationalising them into one refined option unless governance requires the labels to remain separate.

  That is not just because B passed, it is because the panel explicitly C and D were materially the same as B in cost, staffing model, and practical effect. Keeping all three separate risks creating artificial choice where technically there is effectively only one option presented as differing shades.

  In short B/C/D should either be merged or explicitly differentiated in a way the current explanation of the option does not do. Without that cleanup, readers may misread the panel’s technical position.

  Simply put, B/C/D ought to be combined or clearly distinguished, as the current explanation fails to do so. Without clarification, consultees might misunderstand the Health Board’s position.

4.2 Further Work Needed

- **Option E** should not be advanced for consideration in its current form. The panel’s discussions show it loses on Efficiency and Effectiveness and on Accessibility and Inclusion, while Sustainability remains unresolved rather than positive.

  If Option E was revived, the technical view is it would need substantive new evidence before it could be rescored credibly on:

  - Local authority and partner discussions/support;
  - CIW leadership;
  - Recruitment;
  - Market impact; and
  - Longterm resilience.

4.3 Fail

(New) OPTION A+E

Due to significant financial demands, staffing constraints, operational complexity, regulatory challenges, limited effectiveness, and concerns regarding sustainability, the panel has concluded that Option A+E is not viable bearing in mind the caveats on both options individually.

(New) OPTION A+B

The panel recommendation to reject Option A+B was based on a mix of the following:

- significant financial requirements;
- staffing difficulties;
- operational complexities;
- concerns about care quality; sustainability risks; and
- lack of stakeholder alignment.

(New) Option B+E

Option B+E is not recommended for a pass as it did not satisfy the essential criteria for a sustainable service model due to:

- financial constraints;
- difficulties in staffing;
- operational complexities;
- concerns regarding quality of care;
- compliance with regulations; and
- minimal impact on the wider community.

Shaping the future of Tywyn Community Hospital – Service Review Quality Impact Assessment

Introduction

This Quality Impact Assessment evaluates how the potential reintroduction of inpatient services at Tywyn Community Hospital (Option A) and the continuation of a community-based model (Option B) may affect the Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) Quality Standards.

Since the temporary closure of inpatient beds in April 2023, service provision has shifted toward community-based care. Activity data shows:

- Average inpatient demand remains low at 3.7 admissions per month
- Significant growth in community services including:
  - 11,067 MIU attendances
  - 7,494 Treatment Room attendances
  - 246 Tuag Adref referrals
- Total patients supported increased from 92 (pre-change) to over 7,000 annually.

This assessment therefore considers the quality impact of both indicative models as options being suggested as the ones on which to consult.

1 QUALITY IMPACT ASSESSMENT

1.1 Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with Safe, Timely, Effective, Efficient, Equitable and Person-centered (STEEEP) Quality Standards.				
Quality Standard *Click each icon for its definition*	**Overall Impact**			**Key points and rationale**
	Positive (+1) / Neutral / Negative (-1)	**Level of impact High (3) Medium (2) or Low (1)**	**Impact score (product of previous columns)**	
	Option A: -1 Option B: +1	Option A: 2 Option B:2	Option A: -2 Option B: +2	Option A is dependent on maintaining safe staffing (minimum 2 Registered Nurses 24/7), presenting ongoing workforce risk. Option B supports MDT working and reduces reliance on fragile inpatient staffing models.

	Option A: 0 Option B: +1	Option A: 2 Option B: 2	Option A: 0 Option B: +2	Option A may improve discharge and flow from acute sites for a small number of patients. Option A would allow for reduced travel for family and loved ones to those needing inpatient care or those who choose inpatient end of life care. Option B improves access through extended MIU hours and high-volume community services, increasing local provision, potentially improving access to primary care services and reducing the need for travel to larger sites for some outpatient clinics or treatments.
	Option A: -1 Option B: +1	Option A: 3 Option B: 3	Option A: -3 Option B: +3	Option A benefits a small cohort (~3–4 patients per month on average) but allows for improved flow from acute sites and local access to step-down or rehabilitation services where family, loved ones and carers can be more actively involved. Option B supports significantly higher activity and enables prevention, early intervention and integrated care, potentially reducing the need for travel and admission to acute sites.
	Option A: -1 Option B: +1	Option A: 2 Option B: 2	Option A: -2 Option B: +2	Option A allocates resource to low utilisation inpatient beds with any variance to resource, e.g., sickness or absence potentially impacting on wider services available (MIU) as inpatient beds would be the priority for safe staffing and quality care. Option B supports thousands of contacts annually, improving efficiency and multi-disciplinary team working across local services.

	Option A: 0 Option B: +1	Option A: 2 Option B: 2	Option A: 0 Option B: +2	Option A provides local benefit for a small cohort of the elderly, rural population and their visiting family, loved ones and carers. Option B improves access for a wider population, including urgent and community care needs whilst still providing inpatient care via commissioned beds in neighbouring community hospitals.
	Option A: +1 Option B: +1	Option A: 3 Option B: 3	Option A: +3 Option B: +3	Option A supports local inpatient and end-of-life care preferences whilst acknowledging a reduced travel burden for the elderly, rural population in terms of family, carers and loved ones. Option B supports independence, care at home and broader patient choice via multi-team working across community services.

Overall impact	Option A presents a mixed quality impact overall, with benefits most clearly realised in terms of maintaining local access to inpatient and end-of-life care, which aligns closely with community expectations around care closer to home. This model supports a more traditional, bed-based service offer and may provide reassurance to those who value local hospital provision. However, these benefits may be offset by a number of challenges, particularly in relation to workforce sustainability, the ability to consistently maintain safe staffing levels and the relatively limited number of patients who would directly benefit from the service. As a result, while the model can deliver person-centred care for a small cohort, its overall impact may be constrained by lower population reach and potential risks to long-term service stability. Option B demonstrates a more consistently positive impact across the majority of quality domains; particularly in terms of access, effectiveness, and efficiency. The expansion of community-based services, including the Minor Injuries Unit, Treatment Room and Tuag Adref, enables care to be delivered to a significantly larger proportion of the population; supporting prevention, early intervention and independence. This model reflects contemporary approaches to healthcare delivery, with a strong emphasis on multidisciplinary working and care closer to home, and has already demonstrated high levels of activity and utilisation. However, it is recognised that this approach does not provide local inpatient beds, which may be perceived as a limitation for some patients and families, particularly in relation to end-of-life preferences and the need to travel for inpatient care. Taken together, both options offer strengths in different areas of quality. Option A prioritises local inpatient provision and continuity of a traditional hospital model, while Option B prioritises broader population health outcomes, accessibility and system sustainability. Both approaches can support person-centred care, albeit through different delivery mechanisms. The overall assessment therefore highlights that the distinction between the two options reflects differing approaches to how quality of care is best delivered at a population health level.

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard *Click each icon for its definition*	**Amount of activity required High (3), Medium (2) or Low (1)**	**Key points and actions to achieve the changes required**

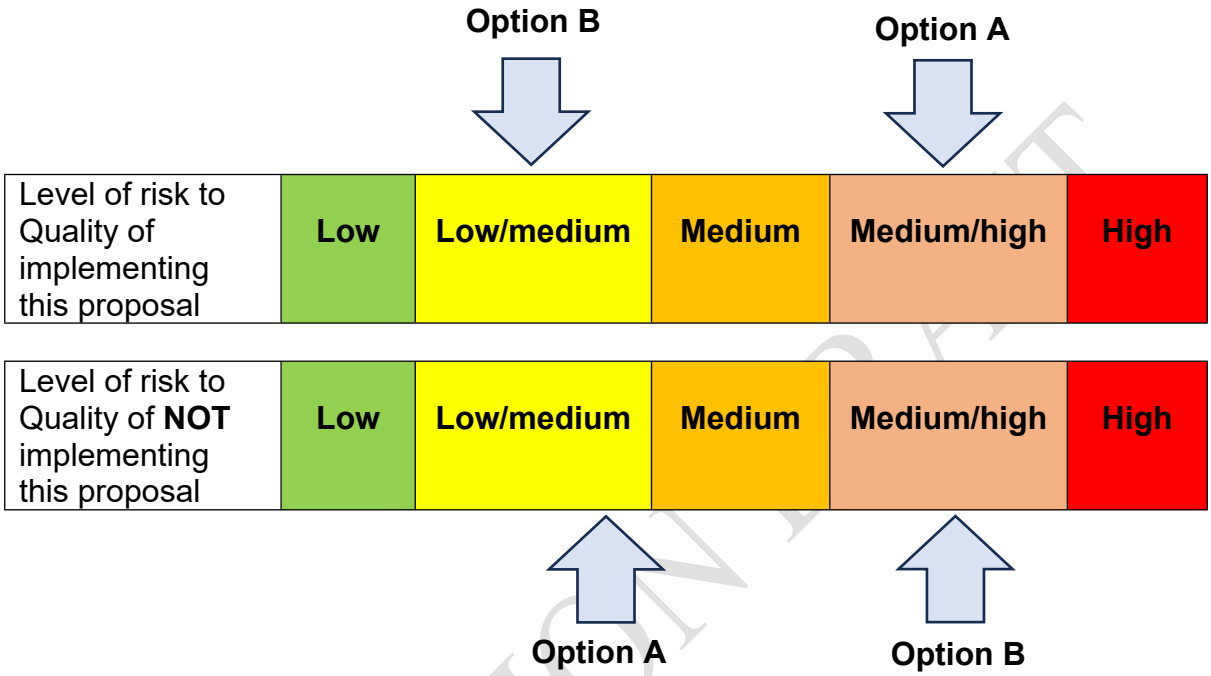
Arweinyddiaeth Leadership	2	Strategic leadership required to either safely reopen inpatient services (Option A) or coordinate integrated community delivery (Option B). Health Board leadership required in support of implementing either option safely and sustainably, ensuring links to wider strategic direction and sustainability for clinical services across North Wales.
Gweithlu Workforce	3	Option A requires additional Registered Nursing recruitment with potentially limited workforce career development. Option B requires strengthening and sustaining of multi-disciplinary community workforce, supporting new ways of working.
Diwylliant Culture	2	Cultural change is required to shift from a bed-based model to community and preventative care. Feedback from the pre-engagement phase emphasises community desire to retain inpatient beds within the Dyfi Ward. Option A reinforces bed-based care model. Option B requires shift toward prevention and care at home, with a recognised impact on some families and carers needing to travel further to visit loved ones in inpatient beds elsewhere (e.g., Dolgellau). Further work would be needed to communicate all available services as well as end-of-life care options available locally.
Gwybodaeth Information	2	Option B may require support from digital coordination and communication systems across services. As above, clear communication with the public and partners is essential around services being provided.
Gwella, dysgu ac ymchwil Learning, improvement and research	2	Routine quality monitoring and evaluation will be necessary with potential opportunities for service improvement through data collection on community outcomes.

Ymagwedd systemau cyfan Whole systems approach	3	Option A may support faster discharge from acute sites to provide inpatient step-down, rehabilitation services. Option B would involve multi-agency working across primary care, community health, care homes and social care. This enhances system integration and supports prevention and early intervention which could in turn reduce burden on secondary care.

Overall amount of activity required	Overall, the level of activity required to implement either option is assessed as **medium to high**, although the nature of that activity differs between the two models. Both options involve a degree of service redesign, workforce planning, and operational adjustment, and therefore require sustained leadership, coordination and oversight to ensure safe and effective delivery. For Option A, the primary driver of complexity is workforce-related. Reintroducing an inpatient model would require the recruitment, establishment, and ongoing maintenance of a workforce capable of delivering safe 24-hour care, including meeting the requirement for consistent registered nurse staffing. This presents a significant operational challenge in the context of existing workforce pressures and may require reallocation or redeployment of staff from other services. In addition, there would be a need to ensure appropriate clinical governance, training, and support structures are in place to sustain the model over time. As such, the activity required is concentrated around workforce mobilisation, resilience planning and maintaining safe staffing levels on an ongoing basis. Option B is characterised more by system-level complexity, rather than a single workforce challenge. While it does not require the same level of inpatient staffing, it relies on the effective coordination and integration of multiple community-based services, including multidisciplinary teams, primary care, and wider partners such as social care and third sector organisations. The activity required is therefore focused on strengthening these interfaces, ensuring clear pathways, and maintaining consistency and quality across a distributed model of care. This includes ongoing development of workforce capability across community services, as well as ensuring infrastructure, communication, and governance arrangements are robust enough to support a more integrated system. Sustainability over time will depend on maintaining this coordination and ensuring that services continue to meet demand as population needs evolve. In summary, while both options require a comparable overall level of activity to implement and sustain, Option A is more heavily weighted toward workforce establishment and maintenance within a single service model, whereas Option B requires broader system integration, coordination and sustained focus on community service development.

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?



Describe the main risks to Quality of implementing the proposals?
Main risks to implementing Option A: ▪ Workforce recruitment and retention challenges (particularly 24/7 RN staffing) ▪ Risk of service instability and need to redeploy staff from other services ▪ Limited activity and population impact (~3.7 admissions/month). ▪ Disruption to community services now in place and reliance on other parts of the system, e.g, primary and community care. **Main risks to implementing Option B:** ▪ Workforce sustainability across expanded community services ▪ Reliance on external providers for some bed-based provision ▪ Perceived loss of local inpatient provision ▪ Ongoing financial impact of commissioning beds in Dolgellau
Describe the main risks to Quality of NOT implementing the proposals?

Main risks to NOT implementing Option A:

- No local inpatient beds for patients in Tywyn
- Continued travel requirement for inpatient care – Patient Transport would be provided for patients but recognisable impact on family, carers and loved ones from within the elderly, rural population.

Main risks to NOT implementing Option B:

- Loss of high-volume community services (supporting more people in the community to receive preventative care locally and reducing travel need for some ongoing treatments)/potentially not aligning to Community by Design/national direction and principles.
- Reduced access to preventative and urgent care (extended MIU, Treatment Room)
- Reduced access to at home reablement services could increase length of stay within an inpatient setting
- Increased pressure on acute services

Part 3: Option by Option assessment summary against STEEP standards

Quality Domain	Option A: Inpatient Model	Option B: Community Model
Safe	Medium risk (staffing dependent)	Improved MDT safety
Timely	Localised access (limited reach)	Broader and faster access
Effective	Low population impact in terms of services available	High population impact in terms of services available
Efficient	Lower efficiency	Higher utilisation and efficiency
Equitable	Benefits smaller cohort	Wider population benefit
Person-centred	Strong for inpatient preference	Strong for independence and home care

Overall summary assessment

Both options demonstrate different strengths across the STEEEP domains, reflecting two distinct approaches to how care can be organised and delivered to meet the needs of the Tywyn population.

Option A provides local access to inpatient care within the community hospital setting and supports a traditional clinical model of care including step-down, rehabilitation and end-of-life care. Clinically, this offers continuity of care for a defined group of patients who may benefit from short periods of bed-based support,

particularly those who require further inpatient rehabilitation support or have palliative care needs, or where care at home is not feasible or preferred. It may also support closer involvement of family and carers due to proximity.

However, these clinical benefits must be considered alongside the challenges of maintaining consistent safe staffing, particularly registered nursing cover and the relatively low volume of patients requiring this level of care locally.

This creates a risk that clinical expertise, exposure and skill mix may be difficult to sustain and that the service may be vulnerable to fluctuations in workforce availability, with potential implications for service resilience and continuity.

Option B supports a broader, community-based model of care, focusing on early intervention, urgent care access and care delivered in patients' own homes wherever possible. Clinically, this aligns with modern models of care which prioritise prevention, rehabilitation in familiar environments and supporting independence, particularly for older populations and those with chronic conditions or frailty.

The higher activity levels seen across services such as the extended Minor Injuries Unit, Treatment Room and Tuag Adref demonstrate a shift toward managing a wider range of clinical needs within the community, potentially reducing avoidable hospital admissions and supporting earlier discharge.

However, this model requires robust coordination across multidisciplinary teams and clear clinical pathways to ensure that patients who do require inpatient care are identified promptly and transferred appropriately. It also necessitates adaptation to the absence of local inpatient beds, including managing the clinical and emotional impact of patients needing to access care at alternative sites, particularly for end-of-life care.

The assessment demonstrates that both options are viable but represent different clinical priorities and service delivery models. Option A concentrates clinical resource into a single, bed-based service for a smaller cohort of patients, while Option B distributes clinical care across a wider system, supporting larger numbers of patients with varying levels of need.

The overall quality impact is therefore determined by the balance between:

- The provision of local inpatient capacity for patients requiring bed-based care
- The ability to meet broader population health needs through prevention, early intervention, and community-based management
- The sustainability and resilience of the clinical workforce required to deliver each model safely
- The effectiveness and efficiency of the wider system in coordinating care across settings

In this context, the distinction between the options is not solely about whether care is provided within a hospital setting or the community, but about how clinical care is best organised to deliver safe, effective and person-centred outcomes across the population.

Appendix 10 - Tywyn Community Service Review Integrated Equality Assessment

EXECUTIVE SUMMARY

Purpose

This Executive Summary of the Tywyn Community Hospital Service Review Integrated Equality Assessment provides an overview of the statutory criteria in terms of equalities considerations associated with the Tywyn Community Hospital Service Review.

The assessment has been undertaken to support the Health Board's statutory duties under:

- Equality Act 2010 Public Sector Equality Duty
- Socio-economic Duty (Wales)
- Human Rights Act 1998
- Welsh Language Standards
- Armed Forces Covenant

The detailed, iterative, Integrated Equality Assessment provides the supporting evidence and ongoing considerations whilst this summary identifies the key equality issues requiring consideration to support decision-makers in moving to consultation.

Key groups most likely to be affected

Analysis indicates that impacts are most likely to be experienced by:

- Older people
- Disabled people
- Unpaid carers
- People experiencing socio-economic disadvantage
- People living in rural communities

- Welsh speakers

Evidence suggests these groups are more likely to experience barriers associated with travel, access to healthcare services, social isolation and rurality within the Tywyn area.

Key equality considerations

Discrimination

No evidence has currently been identified that any option would directly discriminate against protected groups.

However, there remains potential for indirect disadvantage if a change would increase:

- Travel requirements
- Reliance on private transport
- Distance from services

particularly for older people, disabled people and carers.

Disadvantage

The most significant equality issue identified is the potential impact of service changes on existing inequalities.

Specific concerns include:

- Rural accessibility
- Transport availability
- Travel costs
- Carer burden
- Access to inpatient care
- Access to end-of-life services

Meeting Different Needs

Different population groups have differing healthcare requirements.

Examples include:

Group	Different Needs
Older people	Rehabilitation, frailty and end-of-life care
Disabled people	Accessible transport and continuity of care
Carers	Reduced travel burden and support services
Welsh speakers	Welsh language provision
Rural populations	Local accessibility and transport solutions

Positive Action

Potential mitigations include:

- Enhanced transport support
- Improved community services
- Accessible communications
- Ongoing engagement with isolated or identified vulnerable groups
- Continued Welsh language provision
- Monitoring of equality outcomes following implementation (post decision following consultation)

Overall Conclusion

No option is currently considered to be free from equality implications.

The principal issues relate to:

- Rurality
- Accessibility
- Travel
- Carer impacts
- Health inequalities

The purpose of consultation will be to further test the extent of these impacts, identify any additional issues, and inform mitigation measures before any final decision is taken.

SECTION 1 – EQUALITY IMPACTS SUMMARY

Assessment against Public Sector Equality Duty Criteria

Based on evidence gathered and available to date:

Protected Characteristic	Discrimination /Harassment/ Victimisation	Disadvantage	Meeting Different Needs	Positive Action/ Favourable Treatment
Age	No evidence of direct discrimination identified at this stage; each proposed option	Older people may experience disproportionate impacts from increased travel requirements	Older populations have greater requirements for rehabilitation,	Enhanced community support, transport solutions and targeted engagement may be required.

	has potential advantages and disadvantages.	and transport barriers. For Option A, the greatest impact would be on the reduced availability of services locally requiring further travel or reduced access whilst for Option B, the greatest impact would be on the ability for family or loved ones to visit inpatients at other BCUHB sites.	frailty support and end-of-life care.	
Disability	No evidence of direct discrimination identified; each proposed option has potential advantages and disadvantages.	Disabled people may experience additional barriers associated with travel, transport accessibility and access to treatments.	Greater reliance on local access, continuity of care and reasonable adjustments.	Accessible transport arrangements and reasonable adjustments may be required.

Gender Reassignment	No specific issues identified to date through engagement.	No evidence currently available.	Further consultation required.	Continued engagement with seldom-heard groups.
Pregnancy and Maternity	No direct impacts identified.	Potential travel and accessibility considerations for those requiring healthcare support whilst pregnant or caring for young children.	Different support requirements may exist depending on care need.	Continued monitoring through consultation.
Race and Ethnicity	No direct impacts identified.	No evidence of disproportionate impacts currently identified.	Further engagement with minority ethnic communities required.	Targeted engagement where appropriate.
Religion and Belief	No direct impacts identified.	No specific disadvantage identified at this stage.	Ongoing engagement required.	None currently identified.
Sex	No direct impacts identified.	No evidence of disproportionate impacts by sex.	No differing needs identified at current stage.	None identified.

Sexual Orientation	No direct impacts identified.	No evidence of disproportionate impacts identified.	Additional engagement will continue during consultation.	None currently identified.
Marriage and Civil Partnership	No impacts identified.	No impacts identified.	No differing needs identified.	None identified.

SECTION 2 – INEQUALITY IMPACTS SUMMARY

Socio-Economic and Community Impacts

Community/ Group	Risk	Accessibility/Equality Considerations
Rural communities	Travel and transport barriers	Increased distance to care and treatments may disproportionately affect rural residents.
People experiencing poverty	Additional costs	Travel costs and reliance on transport may create additional burdens.
Unpaid Carers	Increased caring burden	Increased travel or reduced access to care close to or at home may affect ability to support family members.
Welsh speakers	Language accessibility	Welsh language provision must be maintained across all options.
Older and isolated People	Social isolation	Reduced access to care close to or at home may increase isolation and create barriers to support.

SECTION 3 – POSITIVE AND POTENTIALLY POSITIVE IMPACTS

Option A – reinstated local inpatient provision

Potential positive impacts include:

- Improved access to local inpatient care.

- Increased family/carer/loved one's involvement in local inpatient care with ease of access.
- Reduced travel for patients requiring admission.
- Increased options for end-of-life care and family involvement.

Option B – enhanced community services

Potential positive impacts identified include:

- Improved access to community-based care – at or close to home.
- Greater reach across the wider population and improved support for independent living.
- Increased preventative and wellbeing services.
- Reduced reliance on hospital admission where clinically appropriate.
- Stronger workforce resilience.

SECTION 4 – MITIGATION MEASURES UNDER CONSIDERATION

Issue Identified	Mitigation to consider
Travel impacts	Transport support and community transport arrangements
Access to inpatient care	Enhanced discharge and community support pathways
Impact on carers	Carer support and engagement programmes
Accessibility concerns	Equality-informed service design and reasonable adjustments
Welsh language provision	Continued bilingual services across all care settings
Seldom-heard groups	Targeted engagement and consultation activity
Rural health inequalities	Community-based service models and outreach support

This Executive Summary is intended to provide decision-makers with a high-level overview of the key equality, socio-economic and accessibility considerations identified at this stage of the Tywyn Community Hospital Service Review.

It should be read alongside the full Integrated Equality Assessment, which contains the detailed evidence base, demographic analysis, engagement findings, options appraisal and supporting rationale that have informed the conclusions within this summary.

The Integrated Equality Assessment is an iterative document and forms part of an ongoing process of assessment, engagement and review. As consultation progresses, further evidence, stakeholder feedback, lived experience and equality analysis will be gathered and considered. The assessment will continue to be updated and refined throughout the consultation period and subsequent decision-making process to ensure that the Health Board maintains due regard to its statutory duties and that any emerging impacts, risks or mitigation measures are appropriately identified and addressed.

This approach will support the development of a robust evidence base and help ensure that equality, socio-economic and human rights considerations remain central as consultation progresses ahead of a final decision being made.

WORKING DRAFT

Equality Impact Assessment form

These assessments will help to gather and record evidence of due regard to the equality duties. The key purpose to purpose is to provide evidence that the Health Board's decisions are compliant with **statutory requirements for the** Public Sector Equality Duty, Socio-economic Duty, Welsh Language Duty, Human Rights Act and Armed Forces Covenant. See the Equality Betsi net pages for support.

Step 1
Complete Part A

Section 1
- General Information

Step 2
Complete Part B – Equality Impact Assessment (EqIA)

Section 1 - Equality Impact

Step 3
Complete Part C - Socio-economic Impact Assessment (SEIA)

Version Control

Version	Date	Author	Rationale
0.1	20.8.25	Eleri Roberts	First signed off version for review by Oversight Group
0.2	18.9.25	Steve Dooré	Updated after review by working group to reflect updated Issues Paper, comments from Independent Strategic Adviser and the first Balanced Room Engagement Event.
0.3	24.9.25	Wendy Hooson	Review by Head of Health Strategy and Planning: Section 1 - General Information and Section 2a - Record of Engagement.
0.4	25.9.25	Steve Dooré	Agreement of above changes. Addition of “working draft” watermark.
V1	30.9.25	Vic Peach	Signed-off at Tywyn and Penley Oversight Group
V1.1	3.10.25	Steve Dooré	Minor changes in “Additional Information” section for consistency with updated Issues Paper. Sharon Jones-Bullock added to authors.
V1.2	16.10.25	Steve Dooré	Updated with outcomes of the balanced room 1 as per Tywyn Hospital Balanced Room No.1 Outcomes Report

V1.3	24.10.25	Steve Dooré	Further updates to reflect scribe notes from balanced room 1 and Phase One Engagement Report
V1.4	14.11.25	Steve Dooré	To reflect final reports from Balanced Rooms 1 and 2
V1.5	12.12.2025	Steve Dooré	Inclusion of results from medium list options appraisal
V1.6	5.3.26	Steve Dooré	Inclusion of final options analysis by PC and updated population profile data.
V1.7	9.6.26	Ceri Harris & Steve Dooré	Updating based on the repeat of Balanced Room 2 (20.3.26) and the Technical Assessment (30.4.26) and "Shaping the Future Stakeholder Session" (4.6.26).

Part A – Information on assessment work required

Section 1 – General information

Title: Tywyn Hospital Service Change			
Assessment Lead: Vic Peach			
Who has been involved in undertaking this equality assessment: Glesni Jordan (Community Services Operations Manager),Emma Williams (Deputy Head of Nursing, Community Services), Ceri Harris (Head of Equality & Human Rights), Steve Dooré (Equality and Inclusion Manager), Wendy Hooson(Head of Health Strategy and Planning), Sharon Jones-Bullock (Head of Nursing, West), Vic Peach (Director of Nursing, West), Andy Wright (Independent Strategic Adviser).			
Quick guide on what assessments are required: This section will help guide you to which assessments are required for your proposal.			
Types of decision being assessed:	**What is being assessed?**	**EQIA Required** [Part B]	**SEIA Required** [Part C]
Strategic policy development with strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions		✓	✓

Health Board Wide Plans. Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)		✓	✓
Business Case/Capital Involvement/Options Appraisal required		✓	✓
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)		✓	✓
Changes to and development of public services/Closure of Services	✓	✓	✓
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services		✓	✓
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities		✓	✓
Directorate Financial Planning		✓	✓
Divisional policies and procedures affecting staff		✓	
New policies, procedures or practices that affect service delivery		✓	
Large Scale Public Events		✓	
Major procurement and commissioning decisions		✓	✓
Local implementation of National Strategy/Plans/Legislation (e.g. vaccination programme)		✓	✓
Other – please state (seek advice if not sure what assessments are required)			

Equality Impact Assessment	**Socio-economic Impact Assessment**
Start date: 9/6/25 Completed date: n/a	Start date: 9/6/25 Completed date: n/a
If not undertaking EqIA state reason: N/A	**If not undertaking SEIA state reason:** N/A

Please complete the rest of this section if EQIA / SEIA is required.

Summary of the purpose and aims of the decision / service / policy / function / change being assessed:

A review is being conducted to evaluate the current challenges and opportunities to delivering safe, sustainable and high-quality care for the population of Tywyn and the surrounding area. This issues paper outlines the context and rationale for the case for change.
The review is structured around key thematic areas, including:

- Population Health Need and Service Gaps.
- Service Configuration and Activity Analysis.
- Quality and Safety Standards.
- Financial Context.

- Workforce Model.

In addition to these themes, the review will describe the deliverability, sustainability, efficiency, and overall effectiveness of current services.

This review relates to the Health Board's strategic direction using the quadruple aims to:

- Improve the health of the population (prevention, early intervention, and self-management).
- Enhance the patient/user experience including quality, access, and reliability (enabled by digital and supported by engagement).
- Have a motivated and sustainable health and social care workforce.
- Deliver value-based health care with demonstratable rapid improvement and innovation (enabled by data with a focus on outcomes).

Links to BCUHB values Indicate any values that relate to the decision / service / policy / function / change being assessed.

 Compassion	 Openness	 Respect
✓	✓	✓

Links to BCUHB Equality Objectives 2024-2028

The health board published Achieving Equity: Strategic Equality Plan (SEP) in 2024, for the period 2024-2028. Please indicate which objectives align for this decision / service / policy / function / change being assessed.

Strategic Equality Objective	Alignment
• Objective A: Achieving equity by working in partnership – 'nothing about you without you'	✓
• Objective B: Achieving equity by providing high quality inclusive services	✓
• Objective C: Achieving equity through Governance and Accountability	✓

• Objective D: Achieving equity by being a kind and compassionate organisation	✓
• Objective E: Achieving equity by innovation	✓

Well-being of Future Generations (WFG) Indicate any goals of the WFG Act that are being considered within the decision / service / policy / function / change being assessed.

A Prosperous Wales	 A Resilient Wales	 A More Equal Wales	 A Healthier Wales	 A Wales of Cohesive Communities	 A Wales of Vibrant Culture & Thriving Welsh Language	 A Globally Responsible Wales
	✓	✓	✓	✓		

Given the high profile and sensitive nature of the service change it is a recommendation of this Integrated Equality Assessment that the Well-being of Future Generations Commissioner is consulted with as part of the Engagement and Consultation Plans.

Is the decision / service / policy / function / change being assessed related to, or influenced by, other Policies or areas of work? Based on the outcome of the evidence review it is recommended that when work is commenced to generate and review options, the Integrated Equality Assessment will run concurrently with the options development and options appraisal process through the balanced room and lived experience engagement sessions. These will inform the generation and appraisal of the options with the equality impact being given a weighting in the scoring of the assessment.

Governance Route for this assessment and Executive Sponsor (usually Director level): please state which Committee / Board will scrutinise and approve this assessment:

This IEA will be signed-off by the Service Change Oversight Group. The timeline below outlines the process that has been followed.

18 June 2026	Service Change Oversight Group

24 June 2026	Strategic Planning and Service Change Group
2 July 2026	Planning, Population Health and Partnerships Committee (Private)
30 July 2026	Options suggested for approval by the Board (Public)
August 2026	Consultation documentation development and finalisation. Including easy read, bilingual, BSL, consultation survey. Continuous engagement will continue in this period to capture experience information of summer residents of which there are a high proportion in the area.
September to November 2026	Formal consultation period (extended period to take into account the summer holiday period rather than delay launch).
December 2026	Post consultation analysis and reporting
January 2026	Period of conscientious consideration
Early 2027	Decision making Board meeting (Public)

Section 2 - Evidence to support assessment

a. Record of Engagement and Consultation

The drive towards closer integration of health and social services with improved public engagement is reflected in the aims of A Healthier Wales. This sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement.

a. What steps have you taken, or planned in order to engage and consult with people who share protected characteristics and how have you done this? Include consideration for co-design. **2023-2024**

There has been significant local public interest and scrutiny following the decision to temporarily close Dyfi ward. The establishment of the Tywyn Hospital Action Group has resulted in several requests to the Health Board for information around the decision-making process, and questioning the Health Board's efforts to recruit staff, culminating in several submissions to the Senedd's Petition Committee, *Petition P-06-1350 Re-open Dyfi Ward at Tywyn Hospital now.* Regular meetings with local town and county councillors, local AM and MP have been held since the temporary closure of Dyfi ward at Tywyn Hospital. Updates on recruitment progress, feedback around patient experience, sharing information around service demand and service developments have been extremely useful and positive. Various staff engagement workshops, drop-in sessions and training sessions have been held since the temporary ward closure, ensuring staff have the support to learn and develop as well as to listen to concerns and issues related to their redeployment. All staff have been given full protection of their terms and conditions including full reimbursement of any financial costs incurred due to their temporary redeployment.

The Health Board attended a public meeting arranged by the Hospital Action Group, on May 4th, 2023. The meeting was attended by the Chair, Chief Executive Officer, West Integrated Health Community Director, and the Chief Officer of Llais. During the meeting, assurances were provided that the Health Board were actively recruiting to vacant nursing posts, linking in with both Hywel Dda University Health Board (UHB) and Powys Teaching Health Board, Bangor and Aberystwyth Universities, local partners including Gwynedd Local Authority, third sector opportunities and private providers to maximise delivery of community services locally in the area.

Llais North Wales hosted a public forum on 28th November 2023 in Tywyn to assess the impact of the Dyfi Ward closure. Two sessions were held, allowing the community to voice concerns. BCUHB staff outlined the steps taken to address healthcare needs following the closure. Further engagement is planned in collaboration with Llais, and work to develop a comprehensive engagement plan to ensure meaningful community involvement has been completed.

The Health Board has discussed local service priorities with the local community. An Engagement Workshop held in April 2024 identified several services which participants identified as lacking or could be improved upon in the area. These included in-patient bed provision, end of life care, respite care and improved mental health support. The workshop was attended by stakeholders including Cyngor Gwynedd, Tywyn Hospital Action Group, Local Town Councillors, Senedd Members, local nursing homes and Hywel Dda UHB.

Six key themes were identified from the output of the workshop, these were:

- Recruitment and Retention.
- Engagement.
- Care Closer to Home.

- Population Health and Health Promotion.
- Digital Solutions.
- Collaborative Working.

2025

Since July 2025 there has been a more focused engagement exercise with local residents, staff, and stakeholders. A phased approach to engagement is being carried out to support the service review process.

Phase one (July 2025 to October 2025)

This phase of communications and engagement focused on:

- Listening to what matters to people — their priorities, concerns, ideas and experiences.
- Recording the feedback.
- Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services.
-

This was done via the following activity:

- Social media and digital awareness raising.
  Website views: 2,401.
  Tywyn social media posts raising awareness of the survey.
  Impressions (reached people's feeds): 76,299 times.
  Social media users interacted with the posts 639 times.

A meeting took place on 5th August 2025 to review the stakeholder mapping. The group completing this work included a BCUHB Equality and Inclusion Manager who ensured that representative groups of the high-risk cohorts identified in this impact assessment were included in the mapping. The mapping will inform further engagement sessions, providing an opportunity for people with protected characteristics and high-risk cohorts to share their views with Health Board representatives.

- Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising.
- **04.08.2025:** Attendance at a listening event in partnership with Hywel Dda University Health Board.
- **20.08.205:** Attendance at the Meirionnydd County Show.
- **28.08.2025:** Attendance at the South Meirionnydd Older People's Forum.
- **12.09.2025:** Attendance at the Social Drop-in, Aberdyfi.

- **15.09.2025:** Attendance at Aberdyfi Community Council.
- Monitoring of correspondence. To note, no specific MP or MS inquiries were received during this period directly relating to inpatient beds in Tywyn though proactive updates were provided.

Survey

A total of 518 completed surveys were received by BCUHB. Every effort was made to ensure a diverse range of voices were heard as part of the survey. Equality monitoring was undertaken on the survey that showed 75% of respondents were 55 and older, with 18% over 75 years old. This has ensured that the voice of older people, a protected group identified in this assessment as potentially impacted by the decision, has been considered in the survey. 21% identified as disabled, the same proportion as the population of North Wales at large. 44% of respondents identified that they give help or support to family members, friends or neighbours due to mental or physical ill health or old age. This has ensured the views of carers are captured.

One question from the survey asked “are there any specific groups or needs in your area that you feel are not currently being met?”. A summary of the themes are below:

- **Care for the elderly is the most frequent concern** with concerns around access to health services, end of life care and social isolation.
- **Mental health services, including CAMHS** with repeated mentions of a lack of support for men and young people and those with chronic conditions.
- **Primary Care needs** with access to GP appointments repeatedly raised as a challenge.
- **Dental services** with respondents noting an absence of NHS dentists and the need to travel far for care.
- **Inpatient care** with strong calls to reopen the Dyfi Ward.
- **Access to emergency care** with concerns about ambulance delays and the distance from hospital sites.
- **Support for chronic conditions** with diabetes, respiratory issues, stroke recovery and pain management receiving specific mentions.
- **Some mentions of a lack of support for young families** with a lack of maternity and paediatric provision.
- **Many noted that poor public transport** and long travel times makes access to services more difficult.
- **Social care and home support** was mentioned as having gaps in district nursing and support for carers.

These themes informed future phases of engagement by identifying themes to explore further.

Phase two (November to December 2025)

Phase two of the communications and engagement activity aimed to raise awareness of and invite feedback on the shortlist of options; explaining the work to develop the options and actively seeking feedback from those who have been involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment).

Generally, the response to requests for feedback on the shaping of the future of inpatient services at Tywyn Community Hospital show a committed and active community with concerns around the prolonged closure of the Dyfi Ward and negative impact of perceived reduction in local provision.

The closure of Dyfi Ward is felt by the community as having led to distress for families and carers with loved ones dying away from home, families unable to visit, and increased pressure on distant hospitals. Ambulance delays and the threatened loss of the air ambulance service has compounded fears about emergency care.

Access to GP services is also cited as a challenge with respondents describe long waits, unreliable booking systems, and a lack of continuity due to reliance on locum doctors. It is suggested within the feedback that many elderly residents struggle with digital systems and report feeling dismissed or unsupported.

The Minor Injuries Unit and Treatment Room receive praise for their quality of care, but limited hours (Monday–Friday, 9–5) restrict access. The Wellbeing Hub is less well known, with mixed feedback and calls for better promotion and clearer purpose. Transport is a recurring barrier. Public services are infrequent and unreliable, especially for those without cars. Long journeys to hospitals in Aberystwyth, Bangor, or Wrexham are physically and financially burdensome, particularly for older residents and carers.

Tywyn has a higher proportion of elderly residents compared to the national average with respondents feeling that services are not tailored to their needs with delays in home care packages, lack of rehabilitation support and poor access to specialist clinics suggested as contributing to isolation and declining health.

There is a repeat call in the feedback for local clinics covering diabetes, audiology, dermatology, maternity, stroke recovery and mental health. The absence of NHS dental services is particularly noted.

Staffing shortages are well-known with respondents suggesting practical solutions, including relocation incentives, apprenticeships and better support for semi-retired professionals.

Throughout the feedback there is an apparent frustration with the Health Board with many respondents feeling a sense of distrust in decision making with a call for regular updates, transparency and meaningful engagement with the local community.

Balanced Room 1

The first "Balanced Room" stakeholder session took place on Friday 5th September at Neuadd Dyfi in Aberdyfi. During this day-long event, participants:

- generated a long list of creative options for future services.
- reduced the long list to a medium list using agreed essential criteria which included quality and safety, efficiency and effectiveness, deliverability, sustainability, accessibility and inclusion.
- reviewed and clustered ideas into clear "option families".
- validated the output with participants in the room, ensuring that all perspectives were considered.

The criteria against which the options generated were to be appraised are shown in the table below.

Criteria	Test
Quality and Safety Services meet standards, minimise risk to patients and patients have a good experience.	Can the option provide safe, evidence-based care with sufficient registered staff, maintaining or improving outcomes and patient experience?
Efficiency and Effectiveness • Efficiency - Ability to do things well and without waste. • Effectiveness – the extent to which desired outcomes or results are achieved.	Can the option deliver services efficiently, following effective clinical pathways and achieve intended outcomes?
Deliverability That we can actually deliver what we say we will.	Is the option realistically achievable with available resources (e.g. finance, people) and within a reasonable timeframe?
Sustainability Ability to manage risk and adapt over time.	Can the option be maintained over time, adapting to workforce, demographic and technological changes, while supporting recruitment and retention?
Accessibility and Inclusion Services are equally available and accessible to all.	Does this option avoid creating extra obstacles for these groups in accessing healthcare?

Participants

Participation in the event was recruited on the basis of creating a 'balanced room.' The balanced room approach ensures that a diverse mix of perspectives is represented when developing and appraising options. Rather than allowing one group or viewpoint to dominate, participants are selected to reflect different stakeholder interests, levels of influence, and lived experience. This creates a fairer, more transparent process where evidence, values, and practical considerations are weighed collectively. The aim is not consensus at all costs, but a balanced discussion that tests assumptions, highlights trade-offs, and strengthens the legitimacy of the final outcomes.

The participants were in three broad categories:

- **Voting participants:** a mix of stakeholders and representatives of BCUHB, all of whom have equal voice and vote in deliberations.
- **Expert participants:** representatives of BCUHB on hand to provide expert opinion and input to deliberations.
- **Facilitation team:** the team who enabled discussions without taking part in decision making.

During this session the main themes of the desktop analysis in this Integrated Equality Assessment were presented to the group. This included highlighting the following high-risk groups:

- Older people
- Disabled People
- Carers
- People living in low-income households
- People living in rural areas

The analysis that led to these groups being identified can be found in "Part B: Equality Impact Assessment with Human Rights".

As part of the group discussions, another risk was identified around people at risk of being digitally excluded. During the second set of group discussions each group were asked to assess the 18 potential scenarios developed in the first session against these criteria. During these discussions an Equality and Inclusion Manager was present as a "technical adviser" to answer questions on what is in scope for the accessibility and inclusion criteria. This was linked back to the high risk groups highlighted above and they were also encouraged to identify other potential barriers created in the scenario.

Outcomes from Balanced Room 1

Significant discussions took place and some scenarios were rejected on the basis of not meeting accessibility and inclusion criteria. These included:

Group One: Rejected Options on the basis of Accessibility and Inclusion

Use the ward as an end of life facility. Group one felt that this would disadvantage groups including people living with long-term conditions who needed local care but were not requiring end of life care, and would create additional barriers and create longer travel times for those people and for carers.

Use the ward as a diagnostic facility: Although the group concluded that there was some benefit to the local population, this didn't meet the complex needs of its older, disabled population, and would create additional travel barriers for high risk groups to access treatment, and continue to place additional pressure on carers.

Develop the ward as a dedicated dementia facility*: The group felt that this was too narrow an option and would mean more older and disabled people, carers, and people living in rural areas having to travel further to access a wide a range of services.

Group One: Passed with "Flag" for mitigations or further development

Develop the ward as a reablement facility. Group one felt that, there was discussion in this group that although on its own it would not meet the needs of several of the high-risk groups identified, that potentially with development mitigation could be put in place to develop this in to a viable, equitable option.

Use Dyfi ward as a day treatment centre. Group one felt that, there was discussion in this group that although on its own it would not meet the needs of several of the high-risk groups identified, that potentially with development mitigation could be put in place to develop this in to a viable, equitable option.

Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home): The group felt that there was good potential in this option for a flexible service that removed barriers and addressed inequality, but that the option needed a lot more clarity on what services would be included.

Group 2
This group felt that there wasn't enough information available for each option at this points to reach a consensus around accessibility and inclusion for may of the options.

Group Three: Rejected Options on the basis of Accessibility and Inclusion

Use the ward as an end of life facility. Group one felt that this would disadvantage groups including people living with long-term conditions who needed local care but were not requiring end of life care, and would create additional barriers and create longer travel times for those people and for carers.

Reopen the ward as it was in 2023, without "new services". The group felt that the services that had been introduced since 2023 had been of benefit to the older population of the area and reverting to the previous service model would reverse some of the positive impacts the high risks groups had seen in that time.

Group Three: Passed with "Flag" for mitigations or further development

Maintain the current position of no beds plus 'new services': These options generated a lengthy discussion around accountability and inclusion – The issue is "are older and disabled people, carers and those who are economically disadvantaged given extra obstacles through this option"? Yes and no. Some will be because the distance is greater, others will have been given greater inclusion because the new services (e.g. treatment room) has improved access. This group passed the option on accessibility and inclusion but recognised there would be other views.

Balanced Room 2

The second 'balanced room' session took place on 16th October to refine the medium list further, applying more detailed criteria to produce a short-list. Participants co-produced a list of detailed criteria against which the medium list of options were to be assessed.

Option	Option Description	Four Extra Inpatient Beds (Dolgellau & Barmouth District Hospital)	Minor Injuries Unit (MIU)	Minor Injuries Unit (MIU) Extended hours and weekend opening	Treatment Room	Tuag Adref (Homeward Bound)	Wellbeing Hub
A	Reopen the ward as it was in 2023, without 'new services'	✖	🏳	✖	✖	✖	✖
B	Maintain current position of no beds plus new services	🏳	🏳	🏳	🏳	🏳	🏳
C	• Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)	🏳	🏳	🏳	🏳	🏳	🏳
D	• Maintain the current position of no beds plus 'new services.' • Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)	🏳	🏳	🏳	🏳	🏳	🏳
E	Use the ward as a reablement facility	🏳	🏳	✖	✖	✖	✖

During the morning sessions Welsh Language was considered as a criteria. However it was discounted as the overall group came to a consensus that there was no variation between the five options being considered in the ability to deliver against the Welsh Language standards.

These options will then be subject to further engagement, with all feedback independently analysed to support informed decision-making by the Health Board. Groups that we will approach as part of the further engagement phase include representatives of Protected Characteristic Groups and identified high risk groups. At the end of each phase of engagement an engagement summary report will be produced. This will include a dedicated section on equality, protected characteristics and high risks groups identified in this impact assessment.

Following the development of a shortlist of options or preferred option for the future of inpatient services, further targeted public engagement and communications activity will be carried out across multiple channels to raise awareness of any proposals and ways in which to get involved.

Concerns Around Balanced Room 2

At this Balanced Room Meeting concerns were raised about the balance of BCUHB staff and community group representation, concerns around the process of invitation, that there was a lack of information available to support decision-making including finance information and information on how the options had been developed. It was agreed that Balanced Room 2 would be repeated to respond to the issues raised. The original outputs from this session are therefore not included in this assessment. The Outcome Report from this session can be viewed here: bcuhb.nhs.wales/get-involved/shaping-the-future-of-tywyn-community-hospital/tywyn-key-documents/bcuhbtywyn-balanced-room-2/

Balanced Room 2: Request Repeated Session (20.3.26)

The focus of the repeated Balanced Room 2 was to ensure fair representation. As a result there were 16 external, 8 internal plus Llais representatives. During the session the process was explained, the options were discussed in detail, concerns regarding the lack of financial detail – in particular around staffing – were raised, concerns around financial distribution per head of population. Discussions were held around reablement and rehabilitation. Following the meeting there was an increase in the options that were to be put forward to the Technical Assessment. These options were:

Pre-existing options (from Balanced Room One):

- Option A: Reopen the inpatient ward (as 2023 model)

- Option B: No beds + enhanced community services
- Option C/D: Community hub model + use of external beds
- Option E: Inpatient reablement facility

Newly suggested combined options:

- A + E
- A + B
- B + E

Technical Assessment (30.4.26)

A Technical Assessment was undertaken by key BCUHB staff including a finance and equality representative, with Andy Wright present to provide independent support. It was explained that the essential criteria against which an option would either pass or fail were:

All options assessed against:

- Quality and Safety.
- Efficiency and Effectiveness.
- Deliverability.
- Sustainability.
- Accessibility and Inclusion.

As a result of the assessment, an additional score of "pass with caveat" was included. The scoring approach was:

- Pass.
- Pass with caveat.
- Unresolved.
- Fail.

As part of the Technical Assessment, population demographics as well as service use was also utilised in the decision making process.

Outputs from the Technical Assessment

Feedback on Option A – reopen the ward (Minor Injuries would be available Monday-Friday only at reduced hours)

This option would reinstate the inpatient ward providing “step-down” care, rehabilitation, end-of-life care and support for those awaiting social care packages.

Criteria	Key points
✓ Quality and Safety	Would require a minimum of two registered nurses 24/7. Would only be safe if the staffing model could be fully achieved.
X Efficiency and Effectiveness	Limited reach (small inpatient cohort). Less effective than community-based (out of hospital) care.
X Deliverability	Requires additional staff and a financial increase to meet latest standards on safe staffing. Recruitment challenges.
X Sustainability	Workforce instability risk.
X Accessibility and Inclusion	Narrow service offer. Limited benefit to wider population.

The technical recommendation is to **pass the option with a caveat** that if staffing levels are not sustained, it could lead to future instability. Given the Option is the original service offer, it is felt that the option should remain with full transparency of potential risk.

Feedback on Option B/C/D (Combined) – enhanced community services , community hub, beds elsewhere (care homes/other sites)

There was an agreement that options B, C and D could all be combined into a single option.

Criteria	Key points
✓Quality and Safety	Safe, evidence-based care model No reliance on fragile inpatient staffing
✓Efficiency and Effectiveness	Supports larger population and co-dependent services (e.g., primary care) More flexible and responsive
✓Deliverability	Achievable within workforce No major recruitment required Small financial increase which could be explored within existing IHC budget budget/explored at business case stage.
✓Sustainability	Opportunities for workforce and service development
✓Accessibility and Inclusion	Broader service offer Improved access for diverse population

The recommendation is that this option is a **pass**. It is felt that this model benefits a wide range of health needs within the community. Reablement is supported in the patients' own home. Staff are developed and the services within the local area can work proactively together in new or different ways for the benefit of all, including access to primary care.

Feedback on Option E – inpatient reablement facility

This option suggests converting the ward to an inpatient reablement facility.

Criteria	Key points
X Quality and Safety	Limited clinical oversight. Not aligned to core Health Board purpose.

X Efficiency and Effectiveness	Narrow service offer. Low utilisation risk.
X Deliverability	Requires new regulatory framework (CIW). Complex staffing model. Potential financial increase but model would need to be explored.
X Sustainability	Lack of Health Board input. Dependent on partners and external system.
X Accessibility and Inclusion	Excludes wider patient needs. Only a limited number of patients would meet the criteria.

The recommendation is that the option **fails** based on significant service and estate redesign, could have a negative economic impact (on local care home partners) and would pose viability risks based on the workforce requirements. Inpatient rehabilitation could be met in Option A (in Tywyn) and B/C/D in Dolgellau.

Feedback on Option A+E – inpatient ward and reablement facility

This option suggests combining the inpatient ward model with an inpatient reablement facility (combining Health and Social Care)

Criteria	**Key points**
X Quality and Safety	Complex dual model reduces clinical oversight Risk of fragmented care pathways Challenging to maintain consistent safety standards
X Efficiency and Effectiveness	Dilutes benefits of both models Limited improvement in patient outcomes Inefficient use of resources

X Deliverability	Significant workforce recruitment challenge Complex to operationalise
X Sustainability	Workforce instability risk Not viable long-term
X Accessibility and Inclusion	Confusing service model for patients Does not improve access for wider population

The recommendation is to **fail** this option due to significant reconfiguration, staffing constraints, operational complexity, regulatory challenges, limited effectiveness, and concerns regarding sustainability. The panel did not view this as a viable option.

Feedback on Option A+B/C/D – inpatient ward and community services
This option suggests combining the inpatient ward with the currently available community services

Criteria	**Key points**
X Quality and Safety	Competing service demands risk dilution of care. Workforce pressures affect safety consistency.
X Efficiency and Effectiveness	High cost with limited additional benefit. Less effective than focused community model.
X Deliverability	Requires a high number of additional staff. Large funding increase that would impact on other services in the West. Recruitment and retention challenges.
X Sustainability	Ongoing workforce risk with significant staffing increase needed.
X Accessibility and Inclusion	Complex pathways for patients. Does not maximise access for wider population.

The recommendation is to **fail** this option - in an attempt to "do everything", neither model would be optimised meaning it would be a high-risk option that doesn't support sustainable patient need and staff satisfaction and development. The funding requirement would result in the potential need for wider service configuration and whilst it would provide more care to more people locally, the significantly enhanced staffing model required appears not to be viable.

Feedback on Option B + E – community model and reablement facility

This option suggests combining the currently in place community services with an inpatient reablement facility.

Criteria	Key points
X Quality and Safety	Reduced clinical oversight within reablement model Risk of fragmented care delivery
X Efficiency and Effectiveness	Duplication and overlap of services (reablement in the home) Reduced overall system effectiveness
X Deliverability	Increased staffing requirements Regulatory complexity (NHS + CIW models)
X Sustainability	Additional burden with limited benefit Dependent on external system partners
X Accessibility and Inclusion	Narrower service offer than Option B alone Potential exclusion of wider population needs

The recommendation is to **fail** this option – the addition of inpatient reablement adds complexity without the benefits and could impact on service quality. Having a combined inpatient and at-home reablement option could dilute both.

Shaping the Future of Services at Tywyn Community Hospital (4.6.26)
Representation at the meeting was as follows:

- 11 BCUHB staff.
- 15 independent/action group members.
- 2 Llais representatives.
- 3 ASV representatives.

To open the meeting there was an explanation of how we had arrived at this point. There was a recap of the Balanced Room approach and the ground rules. The purpose of the day was explained as:

- Review and clarify the feedback on the outcomes of the technical appraisal of additional and previously unconsidered options.
- Explore any remaining issues.
- Identify any missing groups and stakeholders along with the best ways to communicate the upcoming consultation to all.

As we went through the outcomes of the Technical Assessment (as documented above) all participants (including Llais representatives) had an opportunity to raise questions around the process and options that were agreed.

Participants were also reminded that "*Nothing is binding from today – we're working together to set a direction of travel, not to commit to anything".* An example was provided of Hywel Dda Consultation Process in February 2026 where the options identified going in to the consultation was not the final decision. . Rather than adopting the initial options, the board took two community-proposed alternative ideas and merged them into a new preferred model.

The exercise undertaken the original balanced room 1 and 2 on each option to assess impact on protected characteristics will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026.

Conclusion and next steps

The outcome of the Technical Assessment and presented to the Shaping the Future Meeting was that two options are taken forward for wider consideration before being taken to Board for discussion ahead of wider public consultation. They are:

- A – reinstating inpatient beds (albeit with the caveat).
- B/C/D – enhancing community services.

During table discussions an additional option, which had failed during the Technical Assessment, was felt should be included in the consultation documentation and taken forward.

A number of potential models and hybrid options have been considered, discussed and appraised over the last year with the above being the recommended options within scope for the consultation.

It is important to highlight that a hybrid option of the two proposed models is most favoured in public feedback however it was not rated as sustainable under current workforce constraints, recruitment challenges and was also deemed out of scope due to a significant potential impact on wider service provision across the Gwynedd and the West Integrated Health Community. Further detail is available within the paper and appendices.

The Health Board has not reached a final decision on the future configuration of services; each current option carries different risks and opportunities which will be explored further through public consultation before a final decision is sought.

The Shaping the Future meeting outcome was therefore that the following options are taken into the consultation period:

1. Option A
2. Option B/C/D (Combined)
3. Option A + Option B/C/D.

Description of Option A & Option B/C/D (awaiting confirmation that Option A & B/C/D Combined can be included in the consultation from ASV over viability concerns).

Option A: Reopen the inpatient ward.
This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times.

The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care home, as well as providing an option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death.

The ward would provide care for patients needing:

- **Step-down care** for patients transitioning from acute hospital to home or residential care.

- **Sub-acute medical care**: For patients recovering from illness who no longer need acute hospital treatment.
- **Inpatient rehabilitation and reablement:** Supporting individuals to regain independence after surgery, injury or illness.
- **End-of-life care** for patients nearing the end of life, close to family and community.
- **Support for social care delays** through providing temporary inpatient care for patients awaiting community support or placement.

This option would result in the closure of the 4 beds temporarily commissioned at Dolgellau Hospital.

Benefits:

- **Local access to inpatient care:**
  Reopening Dyfi Ward brings rehabilitation and inpatient services closer to home for the population of Tywyn and surrounding communities.
- **Care closer to home**:
  Enables delivery of care close to home, aligned with the principle of localised healthcare.
- **Reduced travel burden, increased family involvement and minimised disruption to the community:**
  Reduces travel for carers and families, making visiting easier and more frequent.
- **Increased opportunities for families to participate in rehabilitation planning and discharge preparation:**
  Patients would be within their community, reducing disruption to social support networks and daily life.
- **Access to local inpatient end-of-life-care:**
  Inpatient end-of-life care could be supported in the Dyfi Ward allowing for easier access for carers, family and loved ones.

Drawbacks:

- **Closure of newly developed community services:**
  The Treatment Room, Wellbeing Hub, and Tuag Adref service could not continue, limiting local service provision for Tywyn residents.
- **Impact on other services:**
  Patient activity currently managed by the Treatment Room would be dispersed, increasing pressure on MIU, GP practices, and District Nursing.
- **Increased pressure on patient flow:**
  The reduction of community support could increase pressure on other hospital sites.
- **Reduced MIU availability**:

Minor Injuries Unit would revert to a reduced hour, 5-day service, reducing urgent care access on weekends/out of hours.

- **Lower service reach:**
  Fewer people would be supported within the ward compared to a community-based model c.92 per year as opposed to over 7,000.
- **Risk of service disruption:**
  Staffing challenges (e.g. vacancies, sickness) may lead to suspension or closure of MIU and other services to maintain safe ward staffing.
- **Reduced integration:**
  Silo working may limit continuity and efficiency of care across services.
- **Sustainability concerns:**
  The model lacks long-term resilience due to constraints in staff development and recruitment.
- **Low demand:**
  Data shows an average of only four patients per month requiring inpatient rehabilitation and very few choosing hospital-based end-of-life care.
- **Risk of inappropriate admissions:**
  Potential for vacant beds or admissions not aligned with best care pathways.
- **Risk of patient deconditioning:**
  Evidence suggests bed-based care may hinder recovery compared to care delivered in patients' own homes.

Option B/C/D: Expand care available in the community

This option proposes the permanent closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:

- Tuag Adref (Homeward Bound).
- Wellbeing Hub.
- Treatment Room.
- Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week).
- Locally delivered treatments, including a range of IV therapies.
- Increase multi-team working across primary and community care.

Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services.

Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would provide additional options for end-of-life and step-down care where appropriate.

The model aims to deliver more care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required.

Benefits

- **Enhanced community care offer:**
  Continuation and expansion of Tuag Adref, the Wellbeing Hub, and Treatment Room preserve and strengthen services that support people to remain independent and receive care closer to home.
- **Improved access to urgent care:**
  Extended MIU opening hours (08:00–20:00, seven days a week) improve local access to urgent care and may help reduce pressure on emergency departments. This would also reduce travel for those needing urgent care out of hours or at a weekend.
- **Reduced travel for a broader range of local treatments:**
  Delivery of IV therapies, additional procedures and day treatments from Dyfi Ward reduces the need for travel and hospital transfers for many patients.
- **Repurposing of Dyfi Ward for community benefit:**
  Using Dyfi Ward as a Day Treatment Centre maximises use of the facility and supports a wider range of outpatient, ambulatory and preventative services for local people.
- **Sustainable inpatient staffing model**
  Consolidating inpatient beds at Dolgellau Hospital focuses nursing resources and reduces reliance on maintaining fragile inpatient staffing arrangements across multiple sites.
- **Improved workforce resilience and development:**
  Cross-cover arrangements, training opportunities and succession planning across the MIU, Treatment Room and Day Treatment Centre support staff retention, recruitment and career development.

- **Continued choice of end-of-life care:**
  Continued support for end-of-life care at home through Tuag Adref, alongside access to nursing home beds for those who cannot or choose not to die at home.
- **Improved patient flow and discharge pathways:**
  Access to residential home step-down and reablement beds can support earlier discharge from hospital and provide recovery closer to home.

Drawbacks

- **Increased travel for inpatient care:**
  Patients requiring community hospital inpatient care would continue to be admitted to Dolgellau Hospital, increasing travel time for some patients, families and carers. This currently affects a relatively small number of patients.
- **No inpatient beds at Tywyn:**
  Some community members may remain concerned about the loss of local inpatient beds despite the expansion of community services and alternative.
- **Reliance on external providers:**
  The model would depend more heavily on the capacity, staffing and quality of independent nursing and residential care providers.
- **Potential variation in care home provision:**
  Achieving consistent availability and standards across commissioned care home placements may require ongoing partnership working and support.

Option A + Option B/C/D Combined would maximise the benefits of both above options while minimising many of the drawbacks. Further discussion regarding **Option A + Option B/C/D Combined** on whether this would meet the consultation criteria due to viability concerns will be included in the Outcome Paper from ASV.

Revisit to the outcome of the Technical Assessment

Option	**Pass or fail?**
Option A (reopen ward)	Pass with caveat
Option B, C, D (development of new services)	Pass with suggestion to combine fully

Option E (inpatient reablement facility)	Fail
Option A+E (ward + inpatient reablement)	Fail
Option A+B (ward + new services)	Fail *
Option B+E (development of new services + inpatient reablement)	Fail

*Following Shaping Future meeting seeking confirmation if this can be included in consultation options.

Service offer at a glance

Option	Inpatient Beds (Tywyn)	External Beds (Dolgellau / Care Homes)	Extended MIU (7 days, 8–8)	Treatment Room	Wellbeing Hub	Tuag Adref	Day Treatment (Dyfi Ward)	Reablement Facility
A	✅	❌	X This option would reduce the offer to Mon-Fri)	❌	❌	❌	❌	❌
B/C/D	❌	✅ (Care homes + Dolgellau)	✅	✅	✅	✅	✅	❌
E	✅	✅ (Dolgellau rehab beds retained)	❌	❌	❌	❌	❌	✅
A + E	✅	✅	❌	❌	❌	❌	❌	✅
A + B	✅	✅	✅	✅	✅	✅	✅	❌
B + E	❌	✅	✅	✅	✅	✅	✅	✅

Financial Implications Summary of the Proposed Options

Option	Cost of indicative model (£) against budget (£1.427m) subject to final business case development
A – reinstating the inpatient ward	£1.7m* *further work needed on implications of safe staffing levels for community services
B – expansion of community services	£1.6m
A + B – hybrid model (included to highlight the scale of investment that would be required)	£2.3m (to cover significant staffing increase required and highlighting the impact on wider service provision in the area)

Both options show a marginal increase against the current spend which would have to be considered and taken into account with potential adjustments made if necessary, during final business case development in line with the Health Board's statutory requirement to deliver finance balance and sustainability.

b. Give a summary on how the decision / service / policy / function / change will be shared

With input from a range of stakeholders as part of the pre-consultation engagement process a full communications and engagement plan is in development to support the consultation and ensure as many people from Tywyn and the surrounding area are able to meaningfully contribute as possible.

When this Communications and Engagement id further developed it will be reflected in the Integrated Equality Assessment. The Communication and Engagement plan will be informed by an impact assessment.

c. Are there planned arrangements for gathering feedback during implementation of the decision / service / policy / function / change being assessed?

As above the communications and engagement plan will include a commitment to gathering feedback during implementation and will set out proposals on how this will be managed.

d. Summarise any emerging themes from the engagement work carried out:

The issues taken forward to the Protected Characteristic Assessment Workshops, based on analysis of feedback from the desktop research, the survey and the evidence from Balanced Room 1 and (original) Balanced Room 2 are summarised below.

Disability
The equality issues that we will consider as part of this Integrated Equality Assessment for the “Disability” protected characteristic are:

1. Likelihood of significant time spent away from the local area.
2. The likelihood of increased transport and travel requirements.
3. Access to end of life care and palliative care.
4. Access to mental health support.
5. Loss of community services and the impact of increased isolation.
6. Access to Point of Care testing.
7. Delays in formulation of care plans.
8. Uncertainty of local pathways.
9. Delayed discharge due to lack of step-down care.

Age

The equality issues that we will consider as part of this Integrated Equality Assessment for the "Age" protected characteristic are:

1. Access to rehabilitation services.
2. Access to GP services.
3. Access to end of life care and palliative care.
4. Access to diagnostics.
5. Access to diabetes care.
6. Access to mental health support.
7. Availability of podiatry, audiology, physiotherapy and minor surgery locally.
8. The provision of prevention and wellbeing services.
9. Likelihood of significant time spent away from the local area.
10. Overnight safety.
11. Availability of home care packages.
12. The likelihood of increased transport and travel requirements.

Carers

The equality issues that we will consider as part of this Integrated Equality Assessment for the "Carers" group:

1. Potential increase in travel required to provide care.
2. Potential increase in daily care needs if capacity is unstable in community or home care settings.
3. Increase in reliance on limited transport opportunities locally.
4. An increase in caring responsibilities can have a negative impact on the mental and physical well-being of carers.
5. May reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities.
6. Increased reliance of family members overnight.

Living Standards

The equality issues that we will consider as part of this Integrated Equality Assessment for the "Living Standards" domain:

1. Increased travel for family and friends when visiting patients in the hospital.
2. Increased reliance on limited transport opportunities locally.
3. Reduced capacity to deliver care close to home in more rural and/or isolated areas.
4. Reduced access to Point of Care Testing, particularly in rural areas.

5. Increases in costs of travel will have a greater impact on this cohort, increasing the likelihood of this group – more likely to live with poor health – being unable to access healthcare, perpetuating the Inverse Care Law.
6. The closure of inpatient services in Tywyn may reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities.

This workshop exercise will be repeated during June or July 2026 to take account of developments in the options and any additional evidence put forward and changes to legislation or Welsh Government policy direction.

e. How has the engagement work influenced / or how will the planned engagement influence your work/guide your policy/proposal? Does the engagement work highlight any opportunities to address adverse impacts?

Impacts identified from this phase of the Integrated Equality Assessment will be acknowledged and discussed throughout the forthcoming consultation. This Integrated Equality Assessment is a live process where risks to protected characteristic groups will be assessed at each stage and mitigating actions identified.

b. Additional information

Evidence to support assessment - your decisions must be based on robust evidence. What evidence base have you used in support?

Health Inequality and the Inverse Care Law

The groups who often experience the worst health include (but are not limited to) black and ethnic minority groups, people sleeping rough, people living in poverty, disabled people or those with long-term health conditions, and those who are part of the LGBTQ+ community. The 'inverse care law' describes how people who most need health care are least likely to receive it.[1] In Wales, healthy life expectancy and mental wellbeing is poorer in deprived communities. The Wellbeing of Wales 2024 report showed little change in the gap in life expectancy between the most and least deprived areas, and that inequality in life expectancy and mortality remain wide. The proportion of total deaths that were avoidable continued to be substantially larger in the most deprived areas compared with the least deprived areas. People in the most deprived areas are twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas. [2]

Local Demographic Intelligence

The area around Tywyn has a higher proportion of a number of these groups than the Welsh average including:

- **Almost 36% of the resident population of Gwynedd MSOA 017, in which Tywyn lies, is aged 65 years and over and just over 5% aged 85 years and over.[3]**
- **A higher-than-average sole occupant household**. 32.8% of households in Gwynedd are occupied by only one person; 14.2% are one person household with resident aged over 66 years. In South Meirionnydd Cluster, 37.8% of households are one person and 19.8% are one person aged 66 years and over.
- **People living in poverty.** In MSOA Gwynedd 017, LSOA Llangelynin is the most deprived area and ranked as the 725th most deprived in Wales. Tywyn 2 is ranked 747 and Tywyn 1 is ranked 1,410 indicating Tywyn 2 is the most deprived.
- 26% of children aged 0 to 15 years in South Meirionnydd Primary Care Cluster are in low-income families; the majority of which are in-work families.

[1] The King's Fund, *Tackling the Inverse Care Law,* (2024), accessed at https://www.health.org.uk/sites/default/files/upload/publications/2022/Tackling%20the%20inverse%20care%20law.pdf
[2] Welsh Government, *Wellbeing of Wales 2024,*(2024), accessed at https://www.gov.wales/wellbeing-wales-2024-healthier-wales-html
[3] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025)

- Gwynedd has three LSOAs in the most deprived 10% LSOAs in Wales. In MSOA Gwynedd 017, LSOA Llangelynin is the most deprived area and ranked as the 725th of 1909 most deprived in Wales. Tywyn 2 is ranked 747 of 1909 and Tywyn 1 is ranked 1,410 of 1909.
- **Disability:** 19.7% of population of South Meirionnydd Primary Care Cluster report to be living with a limiting long-term illness.

The population of Gwynedd UA is expected to grow by 3.8% by 2040 which is the largest increase in the North Wales region. Gwynedd is the only UA in North Wales predicted to experience an increase (2.1%) in residents aged 0 to 15 years; Gwynedd is expected to experience the smallest increase across the region, of older people aged 65 years and over (13.6%)[4].

Tywyn Demographics

The population of Tywyn, according to the most recent Census data, is 3,133 and the surrounding community is 7,485.[5]

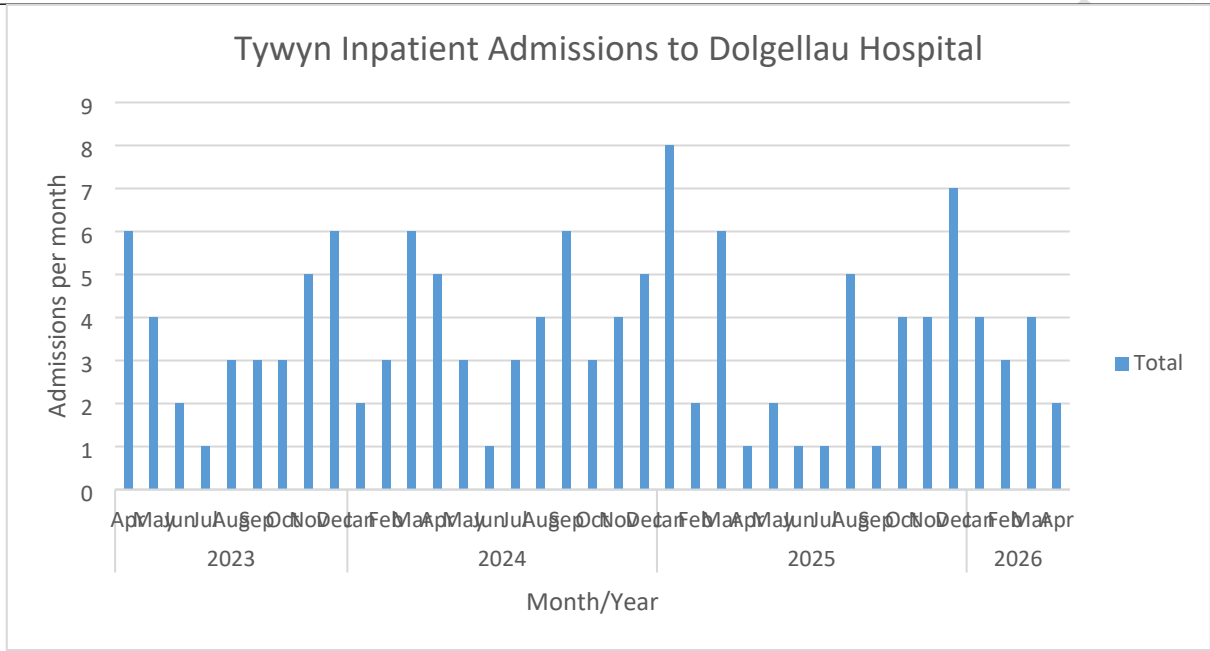
Service Use Data

As at 30/04/2026

Inpatient Activity

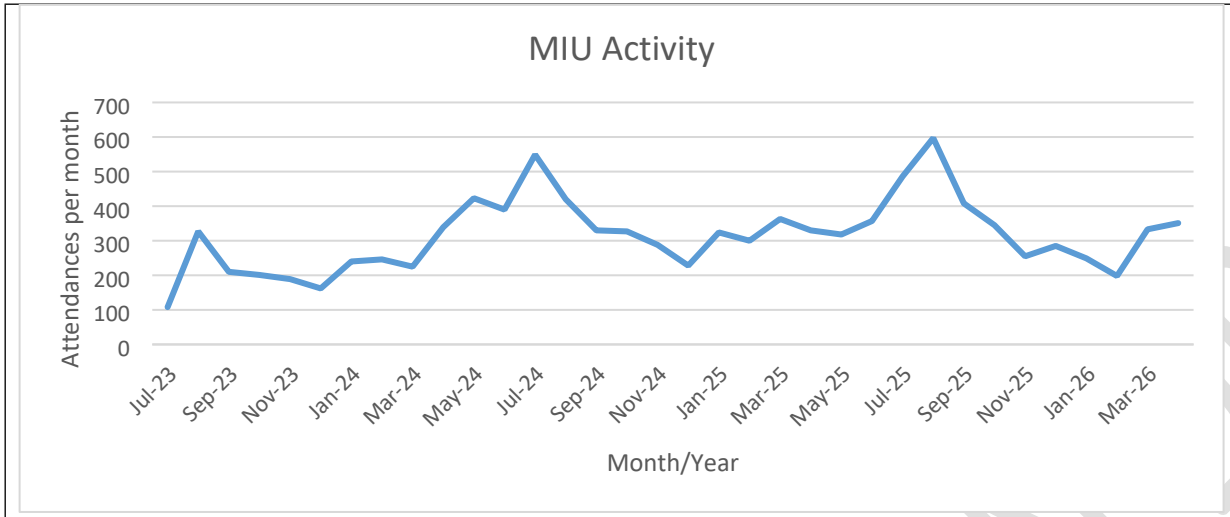
- 131 Admissions to Dolgellau Hospital for patients from Tywyn and the surrounding area since 18th April 2023.
- 3.7 Average inpatient admissions per month for this period.
- 15 of these patients have died/ received end of life care during their admission. Further work would be required to understand how many patients had been admitted specifically for end of life care.

[4] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025)
[5] https://www.llesiantgwyneddamon.org/Uploads/Pages/Documents/3-3-3-149-1-8-Tywyn-Well-being-Area.pdf



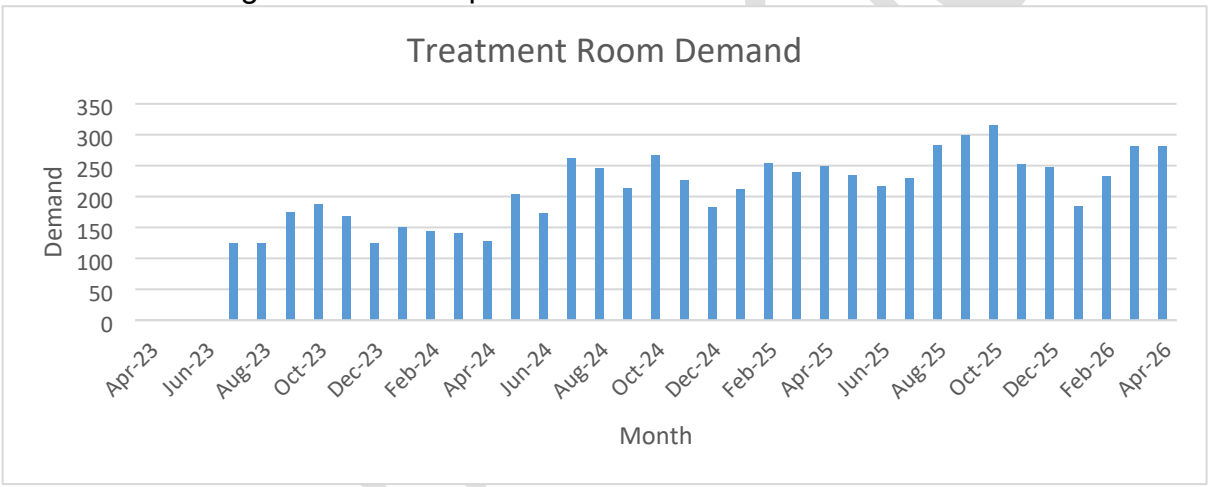
Minor Injuries Unit

- 10,953 total attendances to the MIU since July 2023.
- Average monthly attendances is 315.
- Highest number of attendances seen in August 2025 with 597 attendances.



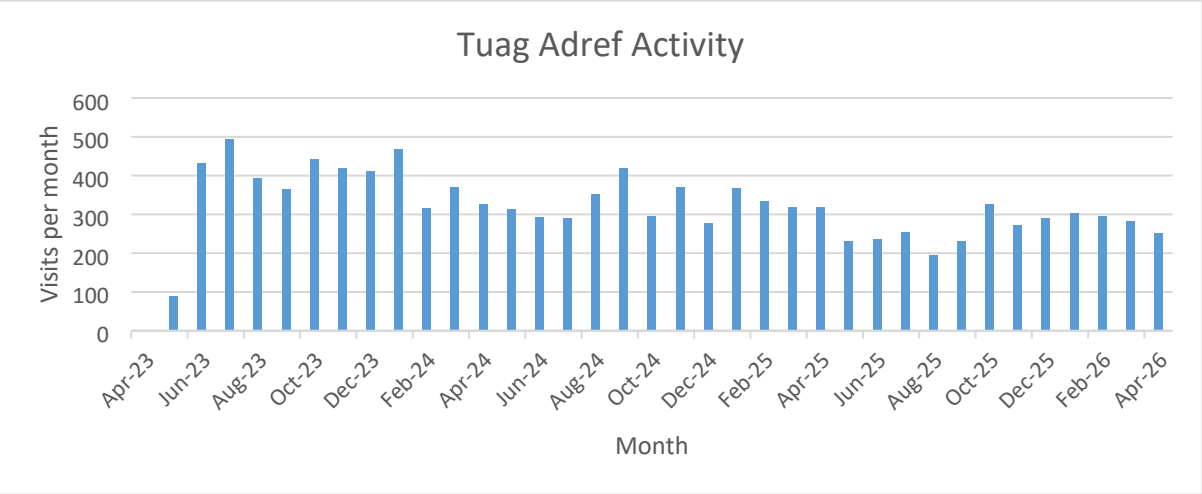
Treatment Room

- 7253 total attendances to the treatment room since July 2023.
- 213 average attendances per month.



Tuag Adref

- 238 new referrals received to the service since May 2023 (breakdown below)
- 12 patients supported per month on average
- 323 visits conducted per month on average

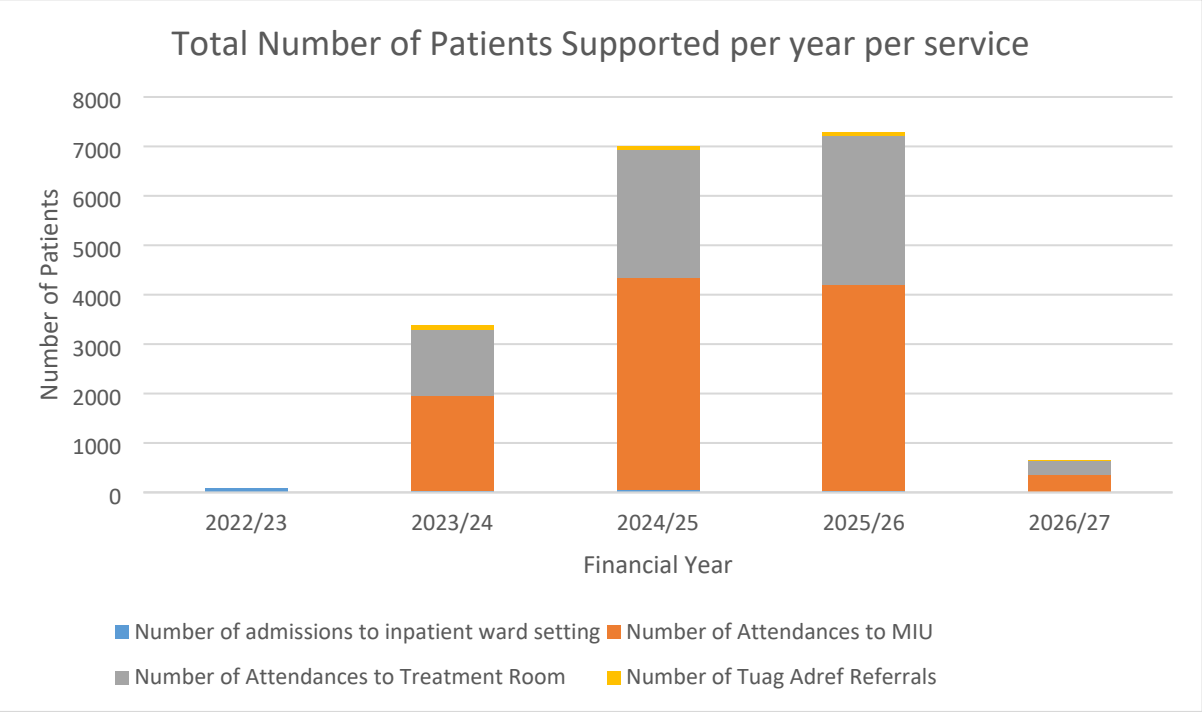


Referral Sources 30.04.2026)	
BCUHB Hospital	53
Bronglais	44
Community Services	99
Social Services	42
Total	238

Summary

Financial Year	Number of admissions to inpatient ward setting	Number of Attendances to MIU	Number of Attendances to Treatment Room	Number of Tuag Adref Referrals	Number of Tuag Adref Calls	Total Number of patients supported

2022/23	92	0	0	0	0	92
2023/24	44	1908	1340	93	4200	3385
2024/25	50	4281	2607	63	3956	7001
2025/26	37	4161	3025	75	2353	7298
2026/27	2	351	281	12	252	646



Previous Workforce Issues

Long term vacancies and sickness within the team meant staff were working excessive hours over and above their contracted hours as overtime, and often unable to take annual leave or cancelling annual leave to ensure safe levels of staffing on the ward. Agency staff were unreliable and often cancelled at short notice which presented significant risk to patient safety.

The Minor Injury service was disrupted and the service was unable to remain open , as staff employed to work in the Minor Injuries Unit were constantly required to support provision of safe inpatient staffing. Recruitment has been undertaken to the MIU since the temporary closure of the ward. Staff have been able to maintain service delivery of the MIU and develop competencies to enhance the service offer.

Progress has been made in terms of recruitment in a geographical area where it is generally difficult to attract health professionals. 4 internationally educated nurses have been successfully recruited to posts at Tywyn Hospital. These staff are now currently working in Dolgellau Hospital to complete all required competencies to practice independently.

At the time of the decision to temporarily close Dyfi ward, there were a number of vacancies within the nursing team including 4 Band 5 registered nurses, 1 Band 6 Deputy Ward Manager and 1 Band 7 Ward Manager post.

Adverts were placed via NHS jobs, with many attempts not successful in attracting any appropriately registered applicants. Further targeted recruitment drives through social media aimed at attracting health professionals to relocate from out of area were unsuccessful.

Large banners have been erected and flyers distributed around the Tywyn area to promote working in the area and for the Health Board. Local events and venues of high footfall were targeted, in particular during peak visitor season.

Opportunities to network with schools and universities have been maximised with attendance at the local school careers fair as well as forging links with Aberystwyth University and the new School of Nursing. Placements for student nurses are being offered to gain experience across our community services, both ward based and in community settings.

It is worth noting that despite being successful in recruiting to secure the minimum safe staffing level requirement for a 24/7 in patient ward, reopening Dyfi ward would undoubtedly impact on the Health Board's ability to maintain other clinical services and community provision in the long term. Namely Tuag Adref and Treatment would not be able to continue. This has the potential to impact on the attraction of the job roles as the opportunity to develop clinical skills would be limited.

National Strategy

National strategy provides a clear direction for health improvement through upstream prevention. It recognises that the burden upon acute hospitals is unsustainable and promotes the delivery of care closer to the patient's home when it is safe and appropriate to do so.

This is supported by the establishment of national targets within the Annual Quality Framework to reflect the requirements for workforce redesign, as well as meeting national guidelines and clinical policies. These aspects are all encompassed in the current assessment.

End of Part A

Part B – Equality Impact Assessment with Human Rights

Section 1 - Equality Impact Assessment

This section should record any known or potential impacts for those who share protected characteristics and other key groups. Impacts may be both negative and positive and the assessment will help to identify how different groups may be disproportionately impacted.

Age

The scores in the table opposite reflect the work undertaken in the workshops held after the original Balanced Room sessions to assess each issue identified and the impact of each option then being considered.

This exercise will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and the output table updated accordingly.

Overall Analysis Based on Below			
Option	**Positive effect**	**Negative effect**	**Neutral**
A	**5**	**4**	**7**
B	**7**	**2**	**7**
C	**8**	**1**	**7**
D	**8**	**1**	**7**
E	**2**	**7**	**7**

Evidence / supporting narrative:

Evidence shows us that the affected population are older than the average population across Wales. This means they are more likely to be living with co-existing long-term conditions, frailty and impairments, and more likely to be in need of regular health support.
The development of any future service model a disproportionate impact on older people, who make up a higher-than-average proportion of the population of the local area and are high users of local healthcare provision. This impact assessment will identify the potential positive and negative impacts of each option to inform the options appraisal.

Potential risks of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Little access to local services providing rehabilitation and end of life care, with a subsequent negative impact on patient outcomes and patient experience.
- High travel time and potential increased waiting times.
- Potential barriers for carers, family and friends being able to visit due to time and distance with a subsequent impact on recovery time.

The End-of-Life Care Workstream has analysed data from 2022 regarding end of life and palliative care. The Tywyn District Nursing Team has seen an increase in the number of patients requiring end of life and palliative care. The task and finish group reported that end-of-life care is predominately provided according to patient choice. There have been very few admissions to hospital for end-of-life care. The is strong multi-disciplinary team working between all members of the Community Resource Team which is co-located on the Tywyn hospital site and supports an integrated approach to patient care. Gaps in service provision identified by the end-of-life task and finish workstream include.[6]

[6] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025), p33

i. No availability of overnight and respite care/no availability of Marie Curie Support.
ii. Limited access to home care as packages are not readily available.
iii. Limited rapid access to specialist palliative medication.
iv. Transport issues to visit relatives whilst in hospital.

These are all risks that impact particularly on the older population who predominately access end of life.

Findings from the survey relevant to **Age**

When asked if they felt that local **healthcare services are meeting the needs of older people and those with complex health conditions, approximately 95% of respondents answered "no".** The overarching sentiment is strongly negative with widespread concern, frustration and distress expressed by respondents with a feeling that the current system is failing older people and those with complex conditions due to:

- **Travel and accessibility issues** – long distances to hospitals impacting on the wellbeing of elderly residents.
- **A lack of local services** – with specific mention of diabetes care, mental health support and palliative care.
- Limited access to diagnostics, specialist clinics and rehabilitation.
- Staff shortages impacting continuity of care.
- Difficulty getting GP appointments.
- Understaffed community nursing and allied health services.
- Isolation and mental health deterioration due to being far from home.
- Families unable to visit loved ones in distant hospitals.
- Delays in treatment and follow-up care.
- A perception that Tywyn is being neglected by the Health Board.

Respondents identified that since the **inpatient ward at Tywyn Community Hospital was temporarily closed, the following issues have been experienced that all impact on older people:**

- **Travel difficulties**: Frequent mentions of travelling long distances with poor public transport and high costs.
- **Visiting loved ones:** Emotional strain due to inability to visit family members in distant hospitals.
- **End-of-life care:** Concerns about patients dying far from home without family support.
- **Bed blocking:** Delays in discharge from larger hospitals due to lack of step-down care locally.

- **Mental health and isolation:** Impact on patients and families due to separation and lack of local support.
- **Loss of community services:** Frustration over underutilised facilities and perceived neglect of local needs.

When asked "**What additional support or services would help older residents live well in Tywyn and the surrounding area?"** the most frequently mentioned themes included:

- **Reopening the Dyfi Ward** is cited as being essential for recovery, palliative care and reducing pressure on larger hospital sites.
- **Improved access to GPs and appointments** with respondents highlighting difficulty getting timely appointments and the need for more permanent doctors.
- **Local clinics and specialist services** with a desire for services for diabetes, podiatry, audiology, physiotherapy, mental health, and minor surgery to be available locally.
- **Better transport options** with calls for community transport, hospital cars, and bus services to help residents reach appointments.
- **Improved home and community care** with requests for more district nurses, carers and home visits, especially for those with mobility issues or complex needs.
- **End-of-life and respite care** with a strong emphasis on the importance of local, dignified care for those nearing the end of life, with easier access for families.
- **Preventative and wellbeing services** with suggestions included regular health checks, wellbeing hubs, exercise classes, and social support to reduce isolation.

Bringing together the analysis from the desktop research, the survey and the evidence from Balanced Room 1 and Balanced Room 2, the equality issues that we will consider as part of this Integrated Equality Assessment for the "Age" protected characteristic are:

1. Access to rehabilitation services	7. Availability of podiatry, audiology, physiotherapy and minor surgery locally
2. Access to GP services	8. The provision of prevention and wellbeing services
3. Access to end of life care and palliative care	9. Likelihood of significant time spent away from the local area
4. Access to diagnostics	10. Overnight safety
5. Access to diabetes care	11. Availability of home care packages
6. Access to mental health support	12. The likelihood of increased transport and travel requirements

In order to make a judgment on each option, the Integrated Equality Assessment Working Group met on the 21st November and the 28th November to evaluate each shortlisted option against each of these issues using the table below. The group reached a consensus on

the impact of each option for each issues. If it was felt that the option reduces inequality on this issue it was assigned a green tick. No impact was assigned a grey dot. If there was potential negative impact it was assigned a red cross.

In order for this Integrated Impact Assessment to support the options going forward, the option must either:

- Score all green ticks.
- Score all green ticks and grey dots.
- Score few red crosses and provide complete mitigation for these (i.e. neutralise the negative impact through some other means) or provide an "objective justification" for proceeding with the identified risks.

Age: Options Appraisal Summary

A	Reopen the ward as it was in 2023, without 'new services'
B	Maintain current position of no beds plus new services
C	• Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
D	• Maintain the current position of no beds plus 'new services.' • Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home).
E	Use the ward as a reablement facility

Key	
Positive Impact	✓
Neutral Impact	●
Negative Impact	X

Issue	A	B	C	D	E
1. Access to rehabilitation services	✓	✓	✓	✓	X
2. Access to GP services	●	●	●	●	●
3. Access to end of life care and palliative care	✓	X	✓	✓	X
4. Access to diagnostics	●	●	●	●	●
5. Access to diabetes care	●	●	●	●	●
6. Access to mental health support	●	●	●	●	●
7. Availability of (a) podiatry,	●	●	●	●	●
(b) audiology,	●	●	●	●	●
(c) physiotherapy and	✓	✓	✓	✓	X
(d) minor surgery locally	●	●	●	●	●
8. The provision of prevention and wellbeing services	X	✓	✓	✓	✓
9. Likelihood of significant time spent away from the local area	X	✓	✓	✓	X
10. Overnight safety - Reality	✓	✓	✓	✓	✓
10. Overnight safety - Perception	✓	X	X	X	X
11. Availability of health care packages at home	X	✓	✓	✓	X
12. The likelihood of increased transport and travel requirements.	X	✓	✓	✓	X

Age: Rationale

Issue	Impact	Rationale
AA1	✓	Option A offers a strong rehabilitation service for a small number of inpatients but lacks the breadth of capacity that Tuag Adref offers.
AA2	●	This option has no impact on the capacity of the local GP services.
AA3	✓	This option would enable the health service to provide end of life and palliative care in the Tywyn area at the inpatient facility, improving local access for disabled people.
AA4	●	Although we recognise that access to diagnostics is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.

AA5	●	Although we recognise that access to diabetes care is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AA6	●	Although we recognise that access to mental health services is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AA7a	●	Although we recognise that access to podiatry is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AA7b	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AA7c	✓	A locally provided offer will take capacity pressures off Dolgellau as staff are having to use part of the day to travel from Dolgellau currently to offer physiotherapy.
AA7d	●	Although we recognise that access to minor surgery is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact. There was also a concern raised that the definition of “minor surgery” is unclear.
AA8	X	This option describes a model that does not focus on prevention or well-being services.
AA9	X	While there would be a positive impact for a minority of older people requiring inpatient services, there would be a far greater negative impact of this option on a wider cohort of older people who would not be able to access a wider range of community-based services locally.
AA10 Reality	✓	There is a positive impact here in terms of people’s perception of safety and the reality described by the staff. In the event of a medical emergency in the middle of the night, there is a greater likelihood of feeling safer in a ward environment staffed by nurses that at home. However, The group also felt it was worth noting that medical care is not available on the wards overnight, and emergency calls would still need to be made to out-of-hours or 999.
AA10 Perception	✓	
AA11	X	This option describes a model that does include home based health care packages.
AA12	X	While there would be a positive impact for a minority of older people requiring inpatient services, there would be a far greater negative impact of this option on a wider cohort of older people who would not be able to access a wider range of community-based services locally and therefore not facing the additional barriers posed by travel and transport. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
AB1	✓	This option provides a wider community based rehabilitation service.

AB2	●	This option has no impact on the capacity of the local GP services.
AB3	X	There would be a negative impact as currently there is little access to end of life or palliative care.
AB4	●	Although we recognise that access to diagnostics is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AB5	●	Although we recognise that access to diabetes care is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AB6	●	Although we recognise that access to mental health services is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AB7a	●	Although we recognise that access to podiatry is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AB7b	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AB7c	✓	A locally provided offer will take capacity pressures off Dolgellau as staff are having to use part of the day to travel from Dolgellau currently to offer physiotherapy.
AB7d	●	Although we recognise that access to minor surgery is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact. There was also a concern raised that the definition of “minor surgery” is unclear.
AB8	✓	This option is a model built on the provision of prevention and wellbeing services.
AB9	✓	While there would be a negative impact for a minority of older people requiring inpatient services, there would be a far greater positive impact of this option on a wider cohort of older people who would be able to access a wider range of community-based services locally. This wider range of community-based services has also shown the potential to reduce the need for inpatient services.
AB10 Reality	✓	The group felt that although people may feel safer on the ward due to the presence of nursing staff, the lack of availability of clinical and medical staff and the low capacity of nursing staff offers no tangible difference in safety.
AB10 Perception	X	
AB11	✓	This option describes a model that does home based health care packages.

AB12	✓	While there would be a negative impact for a minority of older people requiring inpatient services who would still face known barriers to travel and transport, there would be a far greater positive impact of this option on a wider cohort of older people who would be able to access a wider range of community-based services locally, reducing the need for transport and travel. This wider range of community-based services has also shown the potential to reduce the need for inpatient services. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
AC1	✓	This option provides a wider community based rehabilitation service.
AC2	●	This option has no impact on the capacity of the local GP services.
AC3	✓	This options includes the provision of end of life beds through nursing and residential homes and the development of end of life care at home services.
AC4	●	Although we recognise that access to diagnostics is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AC5	●	Although we recognise that access to diabetes care is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AC6	●	Although we recognise that access to mental health services is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AC7a	●	Although we recognise that access to podiatry is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AC7b	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AC7c	✓	A locally provided offer will take capacity pressures off Dolgellau as staff are having to use part of the day to travel from Dolgellau currently to offer physiotherapy.
AC7d	●	Although we recognise that access to minor surgery is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact. There was also a concern raised that the definition of “minor surgery” is unclear.
AC8	✓	This option is a model built on the provision of prevention and wellbeing services.
AC9	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on the people requiring inpatient services who would still need

		to access Dolgellau. The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care.
AC10 Reality	✓	The group felt that although people may feel safer on the ward due to the presence of nursing staff, the lack of availability of clinical and medical staff and the low capacity of nursing staff offers no tangible difference in safety.
AC10 Perception	X	
AC11	✓	This option describes a model that does home based health care packages.
AC12	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on the people requiring inpatient services who would still need to access Dolgellau. The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care.
AD1	✓	This option provides a wider community based rehabilitation service.
AD2	●	This option has no impact on the capacity of the local GP services.
AD3	✓	This options includes the provision of end of life beds through nursing and residential homes and the development of end of life care at home services.
AD4	●	Although we recognise that access to diagnostics is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AD5	●	Although we recognise that access to diabetes care is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AD6	●	Although we recognise that access to mental health services is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AD7a	●	Although we recognise that access to podiatry is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AD7b	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AD7c	✓	A locally provided offer will take capacity pressures off Dolgellau as staff are having to use part of the day to travel from Dolgellau currently to offer physiotherapy.
AD7d	●	Although we recognise that access to minor surgery is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of

		the scope of this program and the decision it will take. It has therefore been judged as a neutral impact. There was also a concern raised that the definition of "minor surgery" is unclear.
AD8	✓	This option is a model built on the provision of prevention and wellbeing services.
AD9	✓	More services, and a wider range of services, would be available locally. This option would further develop the new services that have been developed and the provision of day treatment, along with the use of nursing and residential homes for end of life care. There will still be a negative impact on the people requiring inpatient services who would still need to access Dolgellau. . The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care. This decreased demand would be more significant here than in C1. We have seen this decreased demand with the development of services such as Tuag Adref and an increased District Nursing offer. "From April 2022 to March 2023, Dyfi ward consistently had a midnight occupancy of full capacity, often between 10 and 12 patients. This indicates that the ward was well utilised throughout the year. The reason for a high use was predominantly due to patients who were experiencing delay pathways of care and as such at risk of deconditioning…Following the temporary closure of Dyfi Ward at Tywyn in April 2023 a total of 108 patients from Tywyn postcodes have been admitted to Dolgellau Hospital up to the 31st July 2025. This is an average of 4 patients per month."[7] For those requiring inpatient services there may be support with transport via PTS to mitigate the impact. This appears to be a stronger positive than C1.
AD10 Reality	✓	The group felt that although people may feel safer on the ward due to the presence of nursing staff, the lack of availability of clinical and medical staff and the low capacity of nursing staff offers no tangible difference in safety.
AD10 Perception	X	
AD11	✓	This option describes a model that does home based health care packages.
AD12	✓	This option would mostly reduce the likelihood of needing to access transport and travel. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
AE1	X	This option does not offer a rehabilitation service to the local population.
AE2	●	This option has no impact on the capacity of the local GP services.
AE3	X	End of life and palliative care would not be available in the local area.

[7] BCUHB, , *TYWYN COMMUNITY HOSPITAL, ISSUES PAPER : Review of the Evidence,* pp1318

AE4	●	Although we recognise that access to diagnostics is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AE5	●	Although we recognise that access to diabetes care is a concern, it is not clear that any of the options would have either a positive or negative impact on this issue.
AE6	●	Although we recognise that access to mental health services is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AE7a	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AC7b	●	Although we recognise that access to audiology is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
AC7c	X	No physiotherapy would be provided under this option.
AC7d	●	Although we recognise that access to minor surgery is of particularly concern to older people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact. There was also a concern raised that the definition of “minor surgery” is unclear.
AE8	✓	This option is a model that includes some provision of prevention and wellbeing services.
AE9	X	The group judged that from a health need perspective this would be a negative impact as there is a reduced health offer in the local area.
AE10 Reality	✓	The group felt that although people may feel safer on the ward due to the presence of nursing staff, the lack of availability of clinical and medical staff and the low capacity of nursing staff offers no tangible difference in safety.
AE10 Perception	X	
AE11	X	This option describes a model that does include home based health care packages.
AE12	X	While there would be a positive impact for some older people requiring reablement services, there would be a far greater negative impact of this option on a wider cohort of older people who would not be able to access a wider range of community-based services locally and therefore would face the additional barriers posed by travel and transport to access other services.

Mitigation action if adverse impact found:

Discussions on any residual adverse impact of the preferred option will form a part of the consultation process.

Disability
(Including long term conditions, mental health, neurodivergence and invisible impairments)
The scores in the table opposite reflect the work undertaken in the workshops held after the original Balanced Room sessions to assess each issue identified and the impact of each option then being considered.

This exercise will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and the output table updated accordingly.

Overall Analysis Based on Below			
Option	**Positive effect**	**Negative effect**	**Neutral**
A	**2**	**4**	**3**
B	**5**	**1**	**3**
C	**6**	**0**	**3**
D	**6**	**0**	**3**
E	**0**	**6**	**3**

Evidence / supporting narrative:
Evidence outlined above shows us that the affected population are older than the average population across Wales. This means they are more likely to be living with co-existing long-term conditions, frailty and impairments. They are more likely to be in need of regular health support. The development of any future service models will disproportionately impact on disabled people, who make up a higher-than-average proportion of the population of the local area and are high users of community health services. This impact assessment will identify the potential positive and negative impacts of each option to inform the options appraisal.

Potential risks of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions:

- Decreased access to local rehabilitation care may impact mostly on disabled people and people living with long-term, chronic conditions.
- Increased travel requirements present higher risks to disabled people who are more likely to use public transport as their primary mode of transport.

The Admission Avoidance and Clinical Care Pathways Workstream task and finish group identified a number of issues in the current state that may particularly impact on disabled people, with a particular risk around people living with long-term, chronic conditions.

i. No Point of Care Testing – 30 miles journey to a DGH to undergo the required diagnostic testing. This is of particular risk to disabled people who often face additional barriers to travel.
ii. Limited transport increases the need for WAST conveyances.
iii. Delays in the formulation of care plans due to the lack of PoCT, a significant risk in Tywyn due to its rural nature, particularly in urgent health situations.
iv. Same day urgent care unavailable on weekends and bank holidays.
v. Lack of clear referral pathways between services and uncertainty for patients.

Findings from the survey relevant to Disability

Respondents identified that since the **inpatient ward at Tywyn Community Hospital was temporarily closed, the following issues have been experienced that all impact on disabled people:**

- **Travel difficulties**: Frequent mentions of travelling long distances with poor public transport and high costs.
- **Visiting loved ones:** Emotional strain due to inability to visit family members in distant hospitals.
- **End-of-life care:** Concerns about patients dying far from home without family support.
- **Bed blocking:** Delays in discharge from larger hospitals due to lack of step-down care locally.
- **Mental health and isolation:** Impact on patients and families due to separation and lack of local support.
- **Loss of community services:** Frustration over underutilised facilities and perceived neglect of local needs.

EHRC draft Code of Practice

The Equality and Human Rights Commission (EHRC) updated its statutory Code of Practice for services, public functions and associations to reflect legislative changes and over a decade of case law. The revised code is currently before Parliament. The disability-related updates clarify the scope of legal definitions and strengthen the enforceability of reasonable adjustments.
Key updates to the code regarding disability include:

- **Hidden/Fluctuating Conditions:** Expanded guidance ensures that hidden impairments and fluctuating/progressive health issues are included under the Act.

- **Liability and Assessment:** Service providers must determine disability status independently. Furthermore, only knowledge of the impairment facts is required for liability, and discrimination is harder to justify if reasonable adjustments were not made.
- **Defining Discrimination:** The code clarifies that "arising from disability" requires the disability to be a "significant or more than trivial" reason for treatment, and clarifies comparisons for "substantial disadvantage".

Bringing together the analysis from the desktop research, the survey and the evidence from Balanced Room 1 and Balanced Room 2, the equality issues that we will consider as part of this Integrated Equality Assessment for the “Disability” protected characteristic are:

1. Likelihood of significant time spent away from the local area.
2. The likelihood of increased transport and travel requirements.
3. Access to end of life care and palliative care.
4. Access to mental health support.
5. Loss of community services and the impact of increased isolation
6. Access to Point of Care testing.
7. Delays in formulation of care plan.
8. Uncertainty of local pathways
9. Delayed discharge due to lack of step-down care.

In order to make a judgment on each option, the Integrated Equality Assessment Working Group met on the 21st November and the 28th November to evaluate each shortlisted option against each of these issues using the table below. The group reached a consensus on the impact of each option for each issues. If it was felt that the option reduces inequality on this issue it was assigned a green tick. No impact was assigned a grey dot. If there was potential negative impact it was assigned a red cross.

In order for this Integrated Impact Assessment to support the options going forward, the option must either:

- Score all green ticks.
- Score all green ticks and grey dots.
- Score few red crosses and provide complete mitigation for these (i.e. neutralise the negative impact through some other means) or provide an “objective justification” for proceeding with the identified risks.

Disability: Options Appraisal Summary

Key

Positive Impact	✓
Neutral Impact	●
Negative Impact	X

A	Reopen the ward as it was in 2023, without 'new services'
B	Maintain current position of no beds plus new services
C	• Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
D	• Maintain the current position of no beds plus 'new services.' • Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
E	Use the ward as a reablement facility

Issue	**A**	**B**	**C**	**D**	**E**
1. Likelihood of significant time spent away from the local area	X	✓	✓	✓	X
2. The likelihood of increased transport and travel requirements.	X	✓	✓	✓	X
3. Access to end of life care and palliative care	✓	X	✓	✓	X
4. Access to mental health support	●	●	●	●	●
5. The impact of increased isolation	X	✓	✓	✓	X
6. Access to Point of Care testing	✓	✓	✓	✓	X
7. Delays in formulation of social care plans due to patients being further afield (If patients are further afield social care professionals would have to travel to access patients to develop social care plans, potentially causing delays)	●	●	●	●	●
8. Uncertainty of local pathways	●	●	●	●	●
9. Delayed discharge due to lack of step-down care.	X	✓	✓	✓	●

Disability: Rationale

Issue	Impact	Rationale
DA1	X	While there would be a positive impact for a minority of disabled people requiring inpatient services, there would be a far greater negative impact of this option on a wider cohort of disabled people who would not be able to access a wider range of community-based services locally.
DA2	X	While there would be a positive impact for a minority of disabled people requiring inpatient services, there would be a far greater negative impact of this option on a wider cohort of disabled people who would not be able to access a wider range of community-based services locally and therefore not facing the additional barriers posed by travel and transport. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
DA3	✓	This option would enable the health service to provide end of life and palliative care in the Tywyn area at the inpatient facility, improving local access for disabled people.
DA4	●	Although we recognise that access to mental health services is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DA5	X	There would be a negative impact from this option in creating more risk of isolation in the reduction of community services, which provide regular contact to people – especially people who live alone and have mobility issues.
DA6	✓	There would be a positive impact on those disabled patients – including living with long-term, chronic and/or co-existing conditions in that Point of Care Testing would be available to inpatients.
DA7	●	Although we recognise that understanding care plans is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the formulation of care plans are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DA8	●	Although we recognise that understanding local pathways is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the communication of local pathways are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DA9	X	There would be a negative impact for those people requiring step-down support on a community basis.
DB1	✓	While there would be a negative impact for a minority of disabled people requiring inpatient services, there would be a far greater positive impact of this option on a wider cohort of disabled people who would be able to access a wider range of community-based services locally. This wider range of community-based services has also shown the potential to reduce the need for inpatient services.

DB2	✓	While there would be a negative impact for a minority of disabled people requiring inpatient services who would still face known barriers to travel and transport, there would be a far greater positive impact of this option on a wider cohort of disabled people who would be able to access a wider range of community-based services locally, reducing the need for transport and travel. This wider range of community-based services has also shown the potential to reduce the need for inpatient services. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
DB3	X	There would be a negative impact as currently there is little access to end of life or palliative care.
DB4	●	Although we recognise that access to mental health services is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DB5	✓	There would be an overall positive impact from this option in creating increasing the scope of community-based services, which provide regular contact to people – especially people who live alone and have mobility issues.
DB6	✓	There would be a positive impact in that Point of Care Testing is currently offered within the services in place, and this would continue in this option, allowing local access to Point of Care Testing.
DB7	●	Although we recognise that understanding care plans is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the formulation of care plans are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DB8	●	Although we recognise that understanding local pathways is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the communication of local pathways are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DB9	✓	Although it may seem clear that a lack of inpatient beds in the local area would increase delayed discharge, using resources to build stronger community care packages and services would allow for earlier discharge from District General Hospitals to home with a community-based package of care. This also reduced the risk of those effects that more time in a community hospital poses such as deconditioning.
DC1	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on the people requiring inpatient services who would still need to access Dolgellau. The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care.
DC2	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on the people requiring inpatient services who would still need to access Dolgellau. The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care.

DC3	✓	This options includes the provision of end of life beds through nursing and residential homes and the development of end of life care at home services.
DC4	●	Although we recognise that access to mental health services is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DC5	✓	There would be an overall positive impact from this option in creating increasing the scope of community-based services, which provide regular contact to people – especially people who live alone and have mobility issues.
DC6	✓	There would be a positive impact in that Point of Care Testing would be available through the Day Treatment Centre.
DC7	●	Although we recognise that understanding care plans is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the formulation of care plans are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DC8	●	Although we recognise that understanding local pathways is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the communication of local pathways are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DC9	✓	Although it may seem clear that a lack of inpatient beds in the local area would increase delayed discharge, using resources to build stronger community care packages and services would allow for earlier discharge from District General Hospitals to home with a community-based package of care. This also reduced the risk of those effects that more time in a community hospital poses such as deconditioning.
DD1	✓	More services, and a wider range of services, would be available locally. This option would further develop the new services that have been developed and the provision of day treatment, along with the use of nursing and residential homes for end of life care. There will still be a negative impact on the people requiring inpatient services who would still need to access Dolgellau. . The wider package of services available within the local area will, we anticipate, reduce the need for inpatient services with an increase in community based and home delivered care. This decreased demand would be more significant here than in C1. We have seen this decreased demand with the development of services such as Tuag Adref and an increased District Nursing offer. "From April 2022 to March 2023, Dyfi ward consistently had a midnight occupancy of full capacity, often between 10 and 12 patients. This indicates that the ward was well utilised throughout the year. The reason for a high use was predominantly due to patients who were experiencing delay pathways of care and as such at risk of deconditioning…Following the temporary closure of Dyfi Ward at Tywyn in April 2023 a total

		of 108 patients from Tywyn postcodes have been admitted to Dolgellau Hospital up to the 31st July 2025. This is an average of 4 patients per month."[8] For those requiring inpatient services there may be support with transport via PTS to mitigate the impact. This appears to be a stronger positive than C1.
DD2	✓	As above – this option would mostly reduce the likelihood of needing to access transport and travel. For those requiring inpatient services there may be support with transport via PTS to mitigate the impact.
DD3	✓	This options includes the provision of end of life beds through nursing and residential homes and the development of end of life care at home services.
DD4	●	Although we recognise that access to mental health services is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DD5	✓	There would be an overall positive impact from this option in creating increasing the scope of community-based services, which provide regular contact to people – especially people who live alone and have mobility issues.
DD6	✓	There would be a positive impact in that Point of Care Testing is currently offered within the services in place, and this would continue in this option, allowing local access to Point of Care Testing.
DD7	●	Although we recognise that understanding care plans is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the formulation of care plans are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DD8	●	Although we recognise that understanding local pathways is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the communication of local pathways are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DD9	✓	Although it may seem clear that a lack of inpatient beds in the local area would increase delayed discharge, using resources to build stronger community care packages and services would allow for earlier discharge from District General Hospitals to home with a community-based package of care. This also reduced the risk of those effects that more time in a community hospital poses such as deconditioning.
DE1	X	The group judged that from a health need perspective this would be a negative impact as there is a reduced health offer in the local area.
DE2	X	While there would be a positive impact for some disabled people requiring reablement services, there would be a far greater negative impact of this option on a wider cohort of disabled people who would not be able to access a

[8] BCUHB, , *TYWYN COMMUNITY HOSPITAL, ISSUES PAPER : Review of the Evidence,* pp1318

		wider range of community-based services locally and therefore would face the additional barriers posed by travel and transport to access other services.
DE3	X	End of life and palliative care would not be available in the local area.
DE4		Although we recognise that access to mental health services is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, mental health services are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DE5	X	There would be a negative impact from this option in creating more risk of isolation in the reduction of community services, which provide regular contact to people – especially people who live alone and have mobility issues.
DE6		There would be little or no access for to Point of Care Testing locally.
DE7		Although we recognise that understanding care plans is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the formulation of care plans are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DE8		Although we recognise that understanding local pathways is of particularly concern to disabled people and that this was raised as a potential issue throughout the balanced room discussion, the communication of local pathways are out of the scope of this program and the decision it will take. It has therefore been judged as a neutral impact.
DE9		Using the premises as a reablement facility would provide a similar level of step down care, so this has been judged as neutral.

Mitigation action if adverse impact found:

Discussions on any residual adverse impact of the preferred option will form a part of the consultation process.

Sexual Orientation	Positive effect	Negative effect	Neutral
			●

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to sexual orientation.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.

Discussions on any residual adverse impact of the preferred option will form a part of the consultation process.

Gender Reassignment / Gender identity (including non-binary, gender fluid and intersex) Work undertaken in the workshops held after the original Balanced Room sessions and previous versions of the Integrated Equality Assessment recognised that the repercussions of a recent Supreme Court Judgement were still to be confirmed. Since that time and as referenced below the Supreme Court gave its ruling on the meaning of sex in the application of the Equality Act 2010, and the EHRC's draft Code of Conduct is currently before Parliament. . The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the	Positive effect	Negative effect	Neutral

Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.			

On 16 April 2025, the Supreme Court gave its ruling on the meaning of sex in the application of the Equality Act 2010.
The Court clarified that the meaning of woman within the Equality Act 2010 is based on Parliament's reference to biological sex in the Sex Discrimination Act 1975.

The court was clear that it was ruling only on the definition of man, woman and sex as they are used in the provisions of the Equality Act 2010. The draft Code of Practice for the Equality Act is currently before Parliament. As a result, the facilities at both Tywyn and Dolgellau need to recognise the changes and provide appropriate facilities.

At Tywyn, the staff area is gender neutral, as are the changing rooms. In the Health Centre next to the GP Surgery, there are currently two toilets, one marked "male" and one "female".

For patients the ward was a mixed ward with gender neutral facilities. If the ward was to be reopened there would need to be a risk assessment on the previous mixed ward position going forward.

With regards Dolgellau, there is currently the provision of a mixed ward. Four beds have been allocated in Dolgellau for Tywyn population use. There is no evidence of any requests for single sex ward provision.

Sex / Gender	**Positive effect**	**Negative effect**	**Neutral**
Work undertaken in the workshops held after the original Balanced Room sessions and previous versions of the Integrated Equality Assessment recognised that the repercussions of a recent Supreme Court Judgement were still to be confirmed. Since that time and as referenced below the Supreme Court gave its ruling on the			●

meaning of sex in the application of the Equality Act 2010, and the EHRC's draft Code of Conduct is currently before Parliament. . The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.			

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The court was clear that it was ruling only on the definition of man, woman and sex as they are used in the provisions of the Equality Act 2010. The draft Code of Practice for the Equality Act is currently before Parliament. As a result, the facilities at both Tywyn and Dolgellau need to recognise the changes and provide appropriate facilities.

At Tywyn, the staff area is gender neutral, as are the changing rooms. In the Health Centre next to the GP Surgery, there are currently two toilets, one marked "male" and one "female".

For patients the ward was a mixed ward with gender neutral facilities. If the ward was to be reopened there would need to be a risk assessment on the previous mixed ward position going forward.

With regards Dolgellau, there is currently the provision of a mixed ward. Four beds have been allocated in Dolgellau for Tywyn population use. There is no evidence of any requests for single sex ward provision.

Race (including ethnicity)	**Positive effect**	**Negative effect**	**Neutral**
			●

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to race. In Gwynedd, 3.8% of residents are Black, Asian and Minority Ethnic. Data from the 2021 Census shows that almost 96% of residents in South Meirionnydd Primary Care Cluster are White-British.

We will ensure that engagement takes place with representatives of the local Black, Asian and Ethnic Minority populations.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026. ~~and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.~~

Religion and Belief (including non-belief and Philosophical belief)	**Positive effect**	**Negative effect**	**Neutral**
			●

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to religion and belief.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026. ~~and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.~~

Pregnancy and Maternity	**Positive effect**	**Negative effect**	**Neutral**
			●

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to pregnancy and maternity.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will include an analysis of each option against the draft Code of Practice and Supreme Court Ruling.

Marriage and Civil Partnership	**Positive effect**	**Negative effect**	**Neutral**
			●

The desktop analysis has not highlighted any particular issues for this group from the proposal at this stage. We are aware that issues may be raised during the engagement process and will record and respond to these here. All staff are required to undertake mandatory Treat Me Fairly Training which includes information on equality and discrimination relating to marriage and civil partnership.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026.

Unpaid Carers

Future versions of this assessment will use this section to assess the potential impact of each option on this group once the options have been developed.

Overall Analysis Based on Below			
Option	**Positive effect**	**Negative effect**	**Neutral**
A	**0**	**1**	**4**
B	**1**	**0**	**4**
C	**1**	**0**	**4**
D	**1**	**0**	**4**
E	**1**	**1**	**3**

Evidence / supporting narrative:
Potential risks of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Potential increase in travel required to provide care.
- Potential increase in daily care needs if capacity is unstable in community or home care settings.
- Increase in reliance on limited transport opportunities locally.

- An increase in caring responsibilities can have a negative impact on the mental and physical well-being of carers.
- May reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities.

The End-of-Life Care Workstream identified that overnight care provision was reported as mostly unavailable and heavily dependent on family members.[9]

Bringing together the analysis from the desktop research, the survey and the evidence from Balanced Room 1 and Balanced Room 2, the equality issues that we will consider as part of this Integrated Equality Assessment for the "Carers" group:

7. Potential increase in travel required to provide care.
8. Potential increase in daily care needs if capacity is unstable in community or home care settings.
9. Increase in reliance on limited transport opportunities locally.
10. An increase in caring responsibilities can have a negative impact on the mental and physical well-being of carers.
11. May reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities
12. Increased reliance of family members overnight.

In order to make a judgment on each option, the Integrated Equality Assessment Working Group met on the 21st November and the 28th November to evaluate each shortlisted option against each of these issues using the table below. The group reached a consensus on the impact of each option for each issues. If it was felt that the option reduces inequality on this issue it was assigned a green tick. No impact was assigned a grey dot. If there was potential negative impact it was assigned a red cross.

In order for this Integrated Impact Assessment to support the options going forward, the option must either:

- Score all green ticks.
- Score all green ticks and grey dots.
- Score few red crosses and provide complete mitigation for these (i.e. neutralise the negative impact through some other means) or provide an "objective justification" for proceeding with the identified risks.

Key	
Positive Impact	✓
Neutral Impact	●
Negative Impact	X

[9] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025), p35

A	Reopen the ward as it was in 2023, without 'new services'
B	Maintain current position of no beds plus new services
C	• Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home.
D	• Maintain the current position of no beds plus 'new services.' • Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home).
E	Use the ward as a reablement facility

Issue	**A**	**B**	**C**	**D**	**E**
1. Potential increase in travel.	X	✓	✓	✓	X
2. Potential increase in daily care needs	●	●	●	●	✓
3. Increase in reliance on limited transport opportunities locally.	●	●	●	●	●
4. An increase in caring responsibilities	●	●	●	●	●
5. May reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities	The group felt this didn't cover any ground not already covered by issue 2.				
6. Increased reliance of family members overnight.	●	●	●	●	●

Mitigation action if adverse impact found:

This will form part of the development of the options and will be completed using feedback from the balanced room engagement sessions and lived experience engagement sessions.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026

Other groups / communities of interest – Staff Future versions of this assessment will use this section to assess the potential impact of each option on this group once the options have been developed	Option	Positive effect	Negative effect	Neutral
	1			
	2			
	3			
	4			
	5			

Explanation:

Any future service models to be considered will need to take into account the diversity of the staff mix, with particular attention paid to staff who share protected characteristics. Staff representatives as well as Trade Union partners will be actively involved in all discussions on future service models and options developments and appraisals.

Mitigation action if adverse impact found:

This will form part of the development of the options and will be completed using feedback from the balanced room engagement sessions and lived experience engagement sessions.

Intersectional disadvantages

The biggest risk posed by the current state and the development of new service models is the potential to perpetuate the Inverse Care Law. Without proper considerations of the potential impacts the Health Board could potentially make care more difficult to access for older people, disabled people and people living with socio-economic disadvantage while also increasing the responsibilities of unpaid carers. The options development and appraisal will be undertaken with these issues at the heart of decision-making in order to proceed in a way that complies with the Public Sector Equality Duty. This impact assessment will provide documented evidence of how these processes show due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the act
- advance equality of opportunity between people who share and people who do not share a relevant protected characteristic
- foster good relations between people who share and people who do not share a relevant protected characteristic.

The workshop to assess each issue identified and the impact of each option then being considered will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026.

Section 2 – Human Rights Assessment

Assessment – based on human rights-based approach in health We do not envisage any compromise to Human Rights or contraventions of UN Conventions	
Here is a list of Human Rights (articles) and UN Conventions. Please tick which are relevant to the proposal?	Use a tick ✓
Article 2 - Right to life	
Article 3 - Prohibition of inhuman or degrading treatment	
Article 5 - Right to liberty and security	
Article 8 - Right to respect for family and private life	
Article 9 - Freedom of thought, conscience and religion	
Article 14 – Prohibition of discrimination	
UN Convention on the Rights of the Child	
UN Convention on the Rights of Persons with Disabilities	
UN Convention on the Elimination of All Forms of Discrimination against Women.	
UN Principles for Older Persons	
Other articles – *please state:*	

Is the proposal aligned to the FREDA principles? You can copy and paste this tick: ✓

Fairness	Respect	Equality	Dignity	Autonomy
✓	✓	✓	✓	✓

If any negative impacts are identified, how will this be reduced/addressed? N/A

Section 3 – Armed Forces Covenant

All decision makers are required under the Armed Forces Act 2022 to have due regard to the principles of the Armed Forces Covenant. WP7 contains guidance and information to help complete this section. Decision makers should recognise the unique obligations of, and sacrifices made by, the Armed Forces and ensure there are no adverse effects and where possible a positive or increased positive effect on the armed services community. Special provision for Service People may be justified by the effect on such people of membership, or former membership, of the Armed Forces.

Due regard to the Armed Forces Covenant - Factors regarding impact to the Armed Forces community have been considered. You can copy and paste this tick: ✓	Option	Positive effect	Negative effect	Neutral
We do not envisage any particular impacts on the Armed Forces Community.	**A**			●
	B			●
	C			●
	D			●
	E			●
Reasons for your decision.				

Section 4 – Welsh Language

In this section you need to consider the impact, the evidence and any action you are taking for improvement. This is to ensure that the opportunities for people who choose to live their lives and access services through the medium of Welsh are not inferior to what is afforded to those choosing to do so in English, in accordance with the requirement of the Welsh Language Measure 2011.

Welsh Language Impact Assessment You can copy and paste this tick: ✓		
Will the proposal ensure that patients and carers can choose to live and receive services through the medium of Welsh? For example - delivered bilingually in Welsh & English. e.g., Consider if the proposal increases or decrease the opportunities for people to receive information or access information in Welsh.	**Yes** ✓	**No**

Services in Tywyn are offered bilingually and patients will continue to have the opportunity to use the Welsh language should they choose to do so.

For many Welsh speakers, being able to access services in Welsh significantly improves their overall experience as health and care service users. The proportion of adults aged 16 years and over in BCUHB who can speak Welsh ranges from 12.4% in Flintshire to 64% in Gwynedd; the average for the whole of Wales in 18% (Table 10).

In South Meirionnydd Primary Care Cluster, 53% of residents aged 3 years and over speak Welsh (Table 11).

Table 10: Welsh speaking ability, persons aged 16 years and over, Wales and North Wales unitary authorities, 2022-23

	Percentage of adults (aged 16 years and over)		
	Speak Welsh	**Cannot speak Welsh**	**Some Welsh speaking ability**
Wales	18.0	66.0	15.9
Isle of Anglesey	48.0	39.7	12.3
Gwynedd	64.0	24.9	11.1
Conwy	27.6	57.5	14.9
Denbighshire	20.9	56.3	22.7
Flintshire	12.4	65.4	22.2
Wrexham	16.7	64.7	18.6

Produced by StatsWales (WG) using National Survey Welsh Language

Data source: Welsh Government, Stats Wales: Welsh Language

Table 11: Welsh speaking in persons aged 3 years and over, South Meirionnydd Primary Care Cluster, 2021

	Gwynedd UA		South Meirionnydd		North Wales	Wales
	Number	%	Number	%	%	%
Speak Welsh	73,561	64.4	9,748	53.0	29.1	17.8
No skills in Welsh	29,977	26.2	6,829	37.1	61.3	74.8

Source: Census 2021 (Office for National Statistics)

Data source: Statistical profiles for North Wales (northwalescollaborative.wales)

	Yes	No
Will the proposal have an effect on opportunities for persons to use the Welsh language? Will the proposal encourage staff to use Welsh in the workplace and to have opportunities to learn and improve their Welsh?		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: The Health Board's policy on Welsh Language provision will continue to apply.		
Will the proposal act as a catalyst for Welsh cultural awareness, understanding, activity and integration? For example, encouraging new staff and students to take up Welsh language learning opportunities and to appreciate the socio-economic and cultural context of Wales.		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: The Health Board's policy on Welsh Language provision will continue to apply		
Will the proposal increase or reduce the department/division's ability to deliver services through the medium of Welsh?		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: The Health Board's policy on Welsh Language provision will continue to apply		
Will the proposal treat the Welsh language no less favourably than the English language?		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: The Health Board's policy on Welsh Language provision will continue to apply.		

Section 5 – Summary of assurance for compliance – Public Sector Equality Duty and Human Rights

Equality Legal Duties – summary of compliance	
Has BCUHB given due regard and given consideration for this proposal with the following:	
Eliminating unlawful discrimination, harassment, and victimisation?	Yes

Unlawful discrimination takes place when people are treated 'less favourably' as a result of having a protected characteristic	
Advancing equality of opportunity between people who share a protected characteristic and those who do not? *Making sure that people are treated fairly and given equal access to opportunities and resources*	Yes
Fostering good relations between people who share a protected characteristic and those who do not? *Creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference*	Yes
Are there any potential Human Rights concerns?	No
Compliance to the Welsh Language requirements?	Yes
Compliance to giving 'due regard' to the principles of the Armed Forces Covenant?	Yes
Supporting narrative to support the above responses: At the current stage of the work this assessment has given due regard to the duties and has demonstrated a forward plan to ensure that the duties and the issues identified will inform the development of the options and the options appraisal.	
Do you consider the evidence used in this assessment to be robust? If you answer no, address this in the action plan (section 6)	Yes
Has this assessment been subject to scrutiny / been reviewed?	Yes

Section 6 – EQIA Action Plan and Recommendations

This needs to address negative impacts, which may represent a potential equality risk. All equality risks should be reviewed in line with BCUHB risk management procedures. Include any positive action.

Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
Engagement activities delivered through the "Right People in the Room" and "Balanced Room" frameworks provided by the Independent Strategic Adviser.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	March 2026	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
Lived Experience Sessions are being planned to focus specifically on the high-risk groups and the potential negative impacts identified in this impact assessment.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	Ongoing	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Ongoing
Stakeholder Mapping exercise undertaken with a protected characteristic and socio-economic duty focus	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	5.8.25	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
Produce engagement summary report at the end of each phase, to include a dedicated section on equality, protected characteristics and high risks groups identified in this impact assessment.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	November 2025	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
Agree to undertake Options Development and Options Appraisal in line with BCUHB	Inclusive engagement is ensured and the voices of people with protected	None	November 2025	Regular reporting to	Vic Peach	Complete

Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
Inclusive Decision Making Framework and agree weighting for equality scoring.	characteristics and high-risk groups identified in the assessment are included in the process.			Service Change Oversight Group		
Ensure arrangements are in place for all engagement activity to ensure all engagement opportunities are fully accessible to and inclusive of Welsh Language speakers, British Sign Language Users.	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	November 2025	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
Ensure that arrangements are agreed so that materials can be provided in other languages and/or formats upon request	Inclusive engagement is ensured and the voices of people with protected characteristics and high-risk groups identified in the assessment are included in the process.	None	November 2025	Regular reporting to Service Change Oversight Group	Vic Peach	Complete
Well-being of Future Generations Commissioner to be consulted with as part of the Engagement and Consultation Plans.	Ensure that alignment to the Well-being goals is properly addressed	None	November 2025	Regular reporting to Service Change Oversight Group	Helen Stevens-Jones	Complete
Further work to be undertaken to understand the impact of the current state on protected groups through analysis of key datasets.	Ensure all assumptions on risk and impact are evidence based.	None	December 2025	Regular reporting to Service Change Oversight Group	Vic Peach	Complete
IEA Working Group to assess each shortlisted option against	Understanding of impact of each option	None	November 2025	Regular reporting to	Steve Dooré	Complete

Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
the identified issues in the assessment				Service Change Oversight Group		
IEA Working Group to assess all issues identified in this impact assessment against the current options being put forward for consultation. This workshop will take place in and the output table updated accordingly.	Clear and objective analysis of options against the requirements of the Public Sector Equality Duty	Staff resources	June or July 2026	Regular reporting to Service Change Oversight Group	Steve Dooré	In development
IEA to be undertaken on Communications and Engagement Plan	Inclusive engagement undertaken to ensure all community voices are heard and valued	Staff resources	August 2026	Regular reporting to Service Change Oversight Group	Sophie Stevens-Jones	In development
Gap analysis to be undertaken regarding the unheard voices from the initial survey and other communication and engagement exercises up to this point. To form a key priority in the engagement plan for consultation phase.	Improved representation of whole population, and supports evidence-based decision making.	Staff resources	June 2026	Regular reporting to Service Change Oversight Group	Steve Dooré	In development

Section 7 Equality Risks

This section helps you work out the level of risk posed by any equality related risks identified above. Guidance is available **here** on completing this section, which may be helpful if you are not familiar with risk score analysis. If you have not identified any equality risks, please note this in the narrative box below.

Equality Related Risk Assessment Section

If you have identified an equality risk, please use the table below to work out the risk score. Use the table below to record the highest risk score. If you have a score of 9 and above you **should escalate to risk management procedures**.

	Level of risk				
Level of consequence	RARE: 1	UNLIKELY: 2	POSSIBLE: 3	LIKELY: 4	VERY LIKELY:5
1. Negligible	1	2	3	4	5
2. Minor	2	4	6	8	10
3. Moderate	3	6	9	12	15
4. Major	4	8	12	16	20
5. Catastrophic	5	10	15	20	25

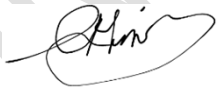
If you have identified an equality risk: What is the consequence? What is the likelihood? Risk score = consequence x likelihood	Inherent Risk Score = 4 x 4 = 16 9.6.26

Any narrative relating to risk score:

The current status shows a number of risks that the Health Board fails to provide accessible and equitable care. As the process continues this impact assessment will be updated. The impact assessment will inform the balanced room engagement sessions, and will be used to inform the options development and options appraisal to mitigate these risks and reduce the risk score.

Section 8 – EQIA Sign off

Name of persons who signed-off this Equality Impact Assessment (see below):

As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.	
Approval Date:	
Review Date: During next phase of service change programme	
Project Lead Sign-off I confirm that this Equality Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant. Signed: (IHC Project Lead)	**Equality Team Sign-off** **(Required when both EQIA and SEIA is required)** I confirm that I have reviewed this Equality Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. (Equality and Inclusion Manager) 
Committee Chair Sign-off I confirm that this Equality Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to: 1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. 2. Advance equality of opportunity between people who share a protected characteristic and those who do not. 3. Foster good relations between people who share a protected characteristic and those who do not. Signed: (Committee Chair)	

End of Part B. Only complete Part C if required.

Part C – Socio-economic Impact Assessment

The requirement for completion of Part C will have been identified in Part A and relates to complying with the Socio-economic Duty. This is a statutory duty with the aim of improving decision making to help improve outcomes for those who are socio-economically disadvantaged. The Socio-economic Duty gives us an opportunity to do things differently in Wales. It puts tackling inequality at the heart of decision-making, and will build on the good work public bodies are already doing.
This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

Section 1 - Assessment information – evidence			
Has this assessment identified Stakeholder groups? .			Yes – see part A
Has this assessment used a range of evidence?			Yes – see part A
Has this proposal engaged with those impacted by the Policy / Strategy Proposal / Policy?			Yes – see part A
Relevant communities of interest identified that may be impacted by this proposal and engagement work undertaken:	**Proposal may impact these groups**	**Engagement undertaken**	**Any supporting narrative / comments**
People experiencing poverty	✓	✓	See “Living Standards”
Carers	✓	✓	See Part B
People who share a common first language			
People experiencing homelessness			
Lone parent families	✓	✓	See “Living Standards”
Those seeking sanctuary			
Experience of local health and social care system			
Military Veterans and Armed Forces Community			
University students			
Long term caravan residents and second home visitors			
Other – please state:			
Relevant communities of place			
Urban areas			
Rural areas	✓	✓	See “Living Standards”

Areas of high levels of unemployment / deprivation	✓	✓	See "Living Standards"
Other – please state:			

Section 2 - Impacts on Socio-economic Duty Domain Areas:

The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain. These domain areas include education, work, living standards, health, justice and personal security and participation.

What are the main socio-economic impacts of the proposal?			
Domain area: Health	**Positive effect**	**Negative effect**	**Neutral**
	✓		

Supporting narrative:

When developing any potential future service models, we need to be aware of the impact on people's perceptions of their access to healthcare, and the resultant impact on their trust in their health provider and on their mental health and well-being. The BCUHB Public Health 'Health and Wellbeing Profile' for Tywyn sets out the requirements for a healthy and well population. Based on the determinants of health they include chronic condition management, healthy lifestyles and behaviours such as healthy weight, tobacco, alcohol consumption, nutrition, and physical activity. There are key services available for Tywyn residents to support chronic conditions such as diabetes management, mental health services and heart failure. These are conditions identified as being higher in Tywyn and therefore are priorities to meet population needs. Screening has been identified screening as a priority. A mobile diabetic retinopathy screening service is available for Tywyn residents and routine screening such as bowel and cervical screening is offered through the GP practice.

A range of services are provided on the Tywyn Hospital site and in the community, delivering physical wellbeing, mental health, midwifery, social care and public services such as the library and leisure centre.[10]

[10] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025), p25

Patients in Community Hospitals are expected to be discharged within 21 to 35 days to prevent negative impact on health. Addressing long stays is vital to preventing harm and disability, especially for vulnerable patients.

From April 2022 to March 2023, Dyfi Ward's average length of stay (AvLOS) consistently exceeded 30 days. There were three instances where AvLOS surpassed 50 days (September 2022 to November 2022) reinforcing the risks of extended hospitalisation.

The focus of this service change is to identify the best solution to support the Health and Well-being of the population of Tywyn and the surrounding area.

At this point the impact has been identified as positive as all parties agree that they are working to identify the best solution for the health and wellbeing of the population.

The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage?

What are the main socio economic impacts of the proposal?

Domain area: Living standards

Option	Positive effect	Negative effect	Neutral
A	0	4	1
B	5	0	0
C	5	0	0
D	5	0	0

	E	1	3	1

Supporting narrative:

Potential future service models will need to be assessed as to their impact on patients and staff affected by the rurality of the South Meirionnydd and their access to services.

Access to transport remains available in the area where required and there are good public transport links in place in most areas.

Transport has been reported as an issue when families are visiting patients in Bronglais and Dolgellau hospitals. Public transport has been reported as not readily available and there is no provision of a community car scheme in the area to support patient's families to visit their relative whilst in hospital. The Flexi bus scheme is available in some rural areas but does not cover as far as Tywyn. The Flexi bus scheme has been established through local councils in conjunction with Transport for Wales whereby members of the public ring and arrange a time to be picked up and dropped off.[11]

The current service model in Tywyn doesn't offer Point of Care Testing at present, meaning that patients are required to travel a minimum of 30 miles to a District General Hospital to undergo the required diagnostic testing. This can be challenging in a rural area where transport is limited, and as such results in the need for increased WAST conveyances to a District General Hospital site. Due to the lack of Point of Care Testing available in the area, there are delays to the formulation of care plans for patients, resulting in delays in accessing the required treatment. This is a significant risk in Tywyn due to its rural nature, particularly in urgent health situations.[12]

The development of any potential future service models will have a disproportionate impact on people living in poverty or other socio-economic disadvantage, who make up a higher-than-average proportion of the population of the local area and are high users of local services. Potential risks of the current state have been identified through desktop analysis. These will be reviewed, challenged and redrafted through the balanced room engagement sessions and lived experience sessions.

- Increased travel for family and friends when visiting patients in the hospital
- Increased reliance on limited transport opportunities locally

[11] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025), p33
[12] BCUHB, *Tywyn Community Hospital Issues Paper,* (July 2025), p33

- Reduced capacity to deliver care close to home in more rural and/or isolated areas.
- Reduced access to Point of Care Testing, particularly in rural areas
- Increases in costs of travel will have a greater impact on this cohort, increasing the likelihood of this group – more likely to live with poor health – being unable to access healthcare, perpetuating the Inverse Care Law.
- The closure of inpatient services in Tywyn may reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities.

Bringing together the analysis from the desktop research, the survey and the evidence from Balanced Room 1 and Balanced Room 2, the equality issues that we will consider as part of this Integrated Equality Assessment for the "Living Standards" domain:

7. Increased travel for family and friends when visiting patients in the hospital
8. Increased reliance on limited transport opportunities locally
9. Reduced capacity to deliver care close to home in more rural and/or isolated areas.
10. Reduced access to Point of Care Testing, particularly in rural areas
11. Increases in costs of travel will have a greater impact on this cohort, increasing the likelihood of this group – more likely to live with poor health – being unable to access healthcare, perpetuating the Inverse Care Law.
12. The closure of inpatient services in Tywyn may reduce local employment opportunities for people with less access to transport or those with increased caring responsibilities.

In order to make a judgment on each option, the Integrated Equality Assessment Working Group will evaluate each shortlisted option against each of these issues using the table below. The group will reach a consensus on the impact of each option for each issues. If it is felt that the option reduces inequality on this issue it will score a green. If there is no impact it will score a grey dot. If there is negative impact it will receive a red cross.

In order for this Integrated Impact Assessment to support the options going forward, the option must either:

- Score all green ticks.
- Score all green ticks and grey dots.
- Score few red crosses and provide complete mitigation for these (i.e. neutralise the negative impact through some other means) or provide an "objective justification" for proceeding with the identified risks.

Living Standards Assessment

Key	
Positive Impact	✓
Neutral Impact	●
Negative Impact	X

A	Reopen the ward as it was in 2023, without 'new services'
B	Maintain current position of no beds plus new services
C	• Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
D	• Maintain the current position of no beds plus 'new services.' • Use Dyfi ward as a day treatment centre. • Provision of beds for Tywyn by nursing and residential homes (including end-of-life beds) • Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
E	Use the ward as a reablement facility

Issue	A	B	C	D	E
1. Increased travel for family and friends when visiting patients in the hospital	X	✓	✓	✓	X
2. Increased reliance on limited transport opportunities locally	X	✓	✓	✓	X
3. Increased capacity to deliver care close to home in more rural and/or isolated areas.	X	✓	✓	✓	✓
4. Increases in costs of travel	X	✓	✓	✓	X
5. Local employment opportunities.	●	✓	✓	✓	●

Living Standards Rationale

Issue	Impact	Rationale

LSA1	X	While there would be a positive impact for a minority who require inpatient services, there would be a far greater negative impact of this option on a wider cohort who would not be able to access a wider range of community-based services locally.
LSA2	X	While there would be a positive impact for a minority who require inpatient services, there would be a far greater negative impact of this option on a wider cohort who would not be able to access a wider range of community-based services locally.
LSA3	X	While there would be a positive impact for a minority who require inpatient services, there would be a far greater negative impact of this option on a wider cohort who would not be able to access a wider range of community-based services locally.
LSA4	X	While there would be a positive impact for a minority who require inpatient services, there would be a far greater negative impact of this option on a wider cohort who would not be able to access a wider range of community-based services locally.
LSA5	X	This option offers a narrower range of employment opportunities.
LSB1	✓	While there would be a negative impact for a minority who require inpatient services, there would be a far greater positive impact of this option on a wider cohort who would be able to access a wider range of community-based services locally.
LSB2	✓	While there would be a negative impact for a minority who require inpatient services, there would be a far greater positive impact of this option on a wider cohort who would be able to access a wider range of community-based services locally.
LSB3	✓	Although we recognise some travel to local hubs would still be required which may present challenges to the more rural population this is still deemed a lesser demand than having to travel to Dolgellau or further afield.
LSB4	✓	While there would be a negative impact for a minority who require inpatient services, there would be a far greater positive impact of this option on a wider cohort who would be able to access a wider range of community-based services locally.
LSB5	✓	This option will offer a wider range of employment opportunities to the local population.
LSC1	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on people requiring inpatient services who would still need to access Dolgellau.
LSC2	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on people requiring inpatient services who would still need to access Dolgellau.

LSC3	✓	Although we recognise some travel to local hubs would still be required which may present challenges to the more rural population this is still deemed a lesser demand than having to travel to Dolgellau or further afield.
LSC4	✓	Day treatment services would be available locally reducing the need for travel. End of life care would be available. There will still be a negative impact on people requiring inpatient services who would still need to access Dolgellau.
LSC5	✓	This option will offer a wider range of employment opportunities to the local population.
LSD1	✓	More services, and a wider range of services, would be available locally, reducing the amount of travel required.
LSD2	✓	More services, and a wider range of services, would be available locally, reducing the amount of travel required.
LSD3	✓	Although we recognise some travel to local hubs would still be required which may present challenges to the more rural population this is still deemed a lesser demand than having to travel to Dolgellau or further afield.
LSD4	✓	More services, and a wider range of services, would be available locally, reducing the amount of travel required.
LSD5	✓	This option will offer a wider range of employment opportunities to the local population.
LSE1	X	The group judged that from a health need perspective this would be a negative impact as there is a reduced health offer in the local area increasing the need to travel to access care.
LSE2	X	The group judged that from a health need perspective this would be a negative impact as there is a reduced health offer in the local area increasing the need to travel to access care.
LSE3	✓	Although we recognise some travel to access reablement services would still be required which may present challenges to the more rural population this is still deemed a lesser demand than having to travel to Dolgellau or further afield.
LSE4	X	The group judged that from a health need perspective this would be a negative impact as there is a reduced health offer in the local area increasing the need to travel to access care.
LSE5	X	This option offers a narrower range of employment opportunities.

As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?

The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June.

This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

What are the main socio economic impacts of the proposal?			
Domain area: Education	**Positive effect**	**Negative effect**	**Neutral**
			•

Supporting narrative:
Health is crucially linked with education; good health and wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities and broader career options. The 2021 Census recorded around 106,340 (19%) adults aged 16 years and over in North Wales with no qualifications. Gwynedd has the lowest proportion with no qualifications (16.3%)[13]

The desktop analysis has not highlighted any particular issues in regards to education from the proposal at this stage. We are aware that issues may be raised during the consultation process and will record and respond to these here.

There will be opportunities to offer a variety of work and learning opportunities through each of the options. These will be explored during the consultation phase. The Communication and Engagement Plan that will inform the consultation stage will ensure the participation of education providers and people currently in education.

Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage:
The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June.

[13] Public Health Wales, *Health and Wellbeing Profile for Tywyn, Gwynedd,* (January 2026), p21

This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

What are the main socio economic impacts of the proposal?			
Domain area: Participation	**Positive effect**	**Negative effect**	**Neutral**
			•

Supporting narrative:

Rurality is an issue in the Tywyn Hospital Area. The hospital sits on the border between LSOAs Tywyn 1 and Tywyn 2 with patients also accessing services from Llangelynin and Aberdovey/Bryn-Crug/Llanfihangel. MSOA Gwynedd 017 is classified as "Rural village and dispersed in a sparse setting" according to Office for National Statistics Rural-Urban Classification for Middle Layer Super Output Areas (MSOAs), North Wales, 2011. The Welsh average number of persons per hectare is 1.5, and the BCUHB area average is 1.1. The average for the Gwynedd 017 area, the area that the hospital predominantly services, is 0.3. This presents challenges that will need to be overcome in terms of delivering care closer to home and travel times for patients, carers, family, friends and staff.

There are issues of digital exclusion that particularly impact older people and the evidence we have described shows an ageing population. None of the options describe a digital first approach to service change in Tywyn. However, all options will be assessed for any potential impacts on people's participation through digital means.

How can your proposal increase participation for people who experience socio-economic disadvantage?
The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

What are the main socio economic impacts of the proposal?			
Domain area: Work	**Positive effect**	**Negative effect**	**Neutral**

Future versions of this assessment will use this section to assess the potential impact of each option on this domain once the options have been developed			●

Supporting narrative:
The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage?

What are the main socio economic impacts of the proposal?

Domain area: Justice and personal security	**Positive impact**	**Negative impact**	**Neutral**
Future versions of this assessment will use this section to assess the potential impact of each option on this domain once the options have been developed.			●

Supporting narrative:
The exercise undertaken after the original balanced room 1 and 2 on each option to assess impact on protected characteristics and socio-economic domains will be repeated based on the three options identified following the Shaping the Future meeting on 4th June. This workshop will take place in June or July 2026 and will review the three current options against all domains of the Socio-economic Duty.

How can your proposal promote and protect people's rights and increase their access to justice and personal security?

Section 3 – Socio-economic Duty Action Plan

Socio-economic Impact Assessment Action Plan and Recommendation						
Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner	Status
Include all considerations and issues identified in this Socio-economic Impact Assessment in the Stakeholder Mapping Exercise	Representatives of all communities of place or interest are included in the stakeholder mapping exercise.	None	5.8.25	Report to Service Change Oversight Group	Steve Dooré	Complete
IEA Working Group to assess all issues identified in this impact assessment against the current options being put forward for consultation. This workshop will take place in and the output table updated accordingly.	Clear and objective analysis of options against the requirements of the Socio-economic Duty	Staff resources	June or July 2026	Regular reporting to Service Change Oversight Group	Steve Dooré	In development

Section 4 – SEIA Sign off

Approval Date: 30.9.25	
Review Date: As part of next stage of project	
Project Lead Sign-off	**Equality Team Quality Check**

I confirm that this Socio-economic Impact Assessment has been carried out in accordance with Betsi Cadwaladr University Health Board's WP7 Procedure for assessment work for evidencing Due Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant. Signed: (Project Lead)	I confirm that I have reviewed this Socio-economic Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee. **Signed:** (Equality and Inclusion Manager)
Committee Chair Sign-off I confirm that this Equality Impact Assessment represents evidence that we (The Health Board), in making this decision, have given due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Signed: (Tywyn and Penley Oversight Group Chair)	

End of SED assessment

Appendix 1

"Right People in the Room" Checklist

Use this checklist to ensure your consultation or engagement activity includes the people most relevant to the decision, those affected by it, and those with the right knowledge or perspective.

How to Use This Checklist

This checklist is designed to help you assess whether the right individuals and groups have been included in your consultation or engagement process:

- For each question, consider the current stage of your project and tick **Yes**, **No**, or **Partially** as appropriate. (Click in the check box with your cursor)
- Use the "Partially" option if some effort has been made but further action is needed.
- Where gaps are identified, make a note of any planned follow-up steps.
- This tool is best used collaboratively by the project team to support transparency, fairness, and inclusive decision-making.

Checklist Questions:

1. Who is Affected?

Have we identified all those directly or indirectly affected by the decision or proposal?

Yes ☐

No ☐

Partially ☐

2. Who Has Lived Experience or Expertise?

Are people with relevant lived experience, local insight, or frontline knowledge included?

Yes ☐

No ☐

Partially ☐

3. Who Holds Influence or Responsibility?

Are those with decision-making power, policy responsibility, or implementation roles involved?

Yes ☐

No ☐

Partially ☐

4. Are Diverse Voices Present?

Have we actively included people from seldom heard or marginalised groups, and made adjustments for them to participate?

Yes ☐

No ☐

Partially ☐

5. Have We Covered Key Perspectives?

Do we have a range of viewpoints, including those who may challenge or disagree with the proposals?

Yes ☐

No ☐

Partially ☐

6. Are Gaps Acknowledged and Addressed?

Where key groups couldn't attend, have we taken other steps to include their views (e.g. interviews, outreach, intermediaries)?

Yes ☐

No ☐

Partially ☐

7. Have We Recorded Our Reasoning?

Is there a clear record of who was included, why, and how this was judged to be fair and sufficient?

Yes ☐

No ☐

Partially ☐

Appendix 2

"Balanced Room" Checklist

Use this checklist to assess whether your consultation, co-production or engagement space includes a fair and diverse range of voices, perspectives, and stakeholder types, and whether any group is underrepresented or overly dominant.

How to Complete This Checklist

This checklist is designed to help you assess whether your engagement, consultation, or co-production session is inclusive and balanced:

- For each question, review the composition and dynamics of your group and tick **Yes**, **No**, or **Partially**. (Click in the check box with your cursor)
- Use the "Partially" option if efforts have been made but further action is needed.
- The checklist can be completed individually or as a team and should ideally be revisited at multiple stages.
- Use the Final Reflection section to determine whether your room is sufficiently balanced or if further adjustments are necessary.

Checklist Questions:

1. Representation and Diversity

1.1 Have we included a range of demographic groups (e.g. age, gender, ethnicity, disability, geography)?

Yes ☐
No ☐
Partially ☐

1.2 Does the group reflect the diversity of people affected by the issue or decision?

Yes ☐
No ☐
Partially ☐

2. Stakeholder Interests and Perspectives

2.1 Are different stakeholder types present (e.g. service users, staff, community leaders, campaigners, dissenting voices)?

Yes ☐
No ☐
Partially ☐

2.2 Is there a balance between supporters, critics, and those who are undecided?

Yes ☐
No ☐
Partially ☐

3. Power and Influence

3.1 Are less powerful or marginalised groups supported to participate fully (e.g. interpreters, access needs, digital support)?

Yes ☐
No ☐
Partially ☐

3.2 Have we prevented domination by powerful voices (e.g. senior professionals, loud stakeholders)?

Yes ☐
No ☐
Partially ☐

4. Participation and Voice

4.1 Are all participants being heard equally during the session?

Yes ☐
No ☐
Partially ☐

4.2 Are we using methods that allow quieter voices to contribute safely (e.g. breakout groups, written input)?

Yes ☐
No ☐
Partially ☐

5. Monitoring and Responsiveness

5.1 Are we actively reviewing who is in the room and who is missing?

Yes ☐
No ☐
Partially ☐

5.2 Have we taken additional steps to bring in underrepresented views (e.g. targeted outreach, focus groups)?

Yes ☐
No ☐
Partially ☐

Appendix 2

6. Final Reflection

Based on the checklist above, is this a balanced room, or are there risks of consultation capture, under-representation, or power imbalance?

- ☐ Balanced
- ☞ Some gaps identified
- ☐ Major imbalances: follow-up required

Shaping the future of Tywyn Community Hospital – Travel Impact Assessment

Executive summary

This Travel Impact Assessment evaluates how the temporary closure of inpatient beds (the Dyfi Ward) within Tywyn Community Hospital (April 2023) and any proposed future service changes may affect patient, carer, staff and community travel patterns in the Tywyn catchment area.

Tywyn has a largely ageing, rural population of approximately 3,000 residents and is located within a catchment area (MSOA Gwynedd 017) serving 6,900 residents - also with a higher proportion of older people compared with wider Gwynedd and Wales (Integrated Equalities Impact Assessment). Changes to local healthcare provision have the potential to increase travel time, costs and accessibility barriers, particularly for older adults, individuals with disabilities, lower-income households and carers making regular visits.

This assessment seeks to identify the impact on travel of potential service change, noting that since the Dyfi Ward's temporary closure, 4 beds have been commissioned in Dolgellau hospital for people from Tywyn who require the care previously provided.

1. Introduction

1.1 Purpose of the Assessment

The purpose of the Travel Impact Assessment (TIA) is to understand how changes to Tywyn Community Hospital services - the temporary closure of its inpatient ward (Dyfi Ward) in April 2023 and subsequent review to develop a sustainable solution for services - may affect patient, carer, staff and visitor travel patterns across the Tywyn catchment area.

It aims to identify potential inequalities, additional travel burdens, risks to access and potential mitigations required to ensure safe and equitable access to care. Most patients previously admitted to Tywyn Community Hospital would have been transferred from another BCUHB hospital site which means that patient transport would be available – and is still the case for any patient subsequently being transferred to another BCUHB site for similar care, primarily Dolgellau.

The impact on travel for carers, friends and family from a visitor perspective has been a repeat concern throughout pre-consultation feedback, therefore the Travel Impact Assessment takes this into account, as well as any adverse effect on staff who may be impacted.

1.2 Background and context

Dyfi Ward previously provided ten inpatient beds for patients no longer requiring acute hospital care, including those awaiting care packages or care home placement, and some end-of-life patients. The facility closed temporarily in April 2023 due to:

- Inability to deliver safe, quality care.
- Workforce and recruitment challenges affecting the sustainability and resilience of local services, including inpatient care and the Minor Injuries Unit.

Between April 2022 and March 2023, a total of 92 patients were admitted to Dyfi ward, Tywyn Hospital.

90.2% of patients were transferred from another hospital (this includes transfers from BCUHB hospitals and out of area hospitals such as Bronglais). 6.5% (6) of patients were admitted through the GP route and the remaining 3.2% were admitted as a matter of 'Emergency – Other'.

Of the 83 patients admitted from Betsi Cadwaladr University Hospital sites to Tywyn Community Hospital from April 2022 to the temporary closure in March 2023:

- 80.7% (67) were transferred from Aberystwyth (Bronglais Hospital)
- 15.7% (13) from Bangor (Ysbyty Gwynedd)
- 3.6% from Dolgellau & Barmouth Community Hospital

During this period, Dyfi ward consistently had a midnight occupancy of full capacity, between 10 and 12 patients.

Although Dyfi Ward is commissioned as a 10-bedded ward, occasions where midnight occupancy reached 10–12 patients reflect the use of short-term escalation capacity during periods of system pressure. This was only implemented in exceptional circumstances to maintain patient flow and safety across the wider system, with appropriate risk assessment and approval from senior nursing and medical staff.

Escalation capacity was not intended for sustained use but as a short-term measure, and could include measures such as using mapped additional spaces or transferring a patient slightly in advance where a discharge was anticipated within the following 24–48 hours.

- Following the temporary closure of Dyfi Ward at Tywyn in April 2023 a total of 136 patients from Tywyn postcodes have been admitted to Dolgellau Hospital up to the 31st May 2026. This is an average of less than 4 patients per month.

Since the closure of Dyfi Ward, Tywyn Community Hospital has reopened the Minor Injury Unit for 5 days a week (Mon-Fri excluding bank holidays) which has seen:

- A total of 11,067 attendances between July 2023 – May 2026.
- Highest demand of 597 patients in a month (August 2025) may be reflective of the increase in population during the summer months.

The Treatment Room also opened since the ward's closure, this service currently offers wound care, blood tests and catheter management and has further developed to include IV therapy and point of care testing which has led to:

- Activity in excess of 7,494 attendances since July 2023.
- Reduced demand on primary care and the release of District Nursing capacity.

2. Population and Equality Profile

2.1 Overview of the local population

The Tywyn catchment area (Figure 1) corresponds broadly to Middle Super Output Area (MSOA) Gwynedd 017, which includes four Lower Super Output Areas (LSOAs): Llangelynin, Tywyn 1, Tywyn 2 and Aberdovey/Bryncrug/Llanfihangel. The MSOA has approximately just under 6,900 residents.

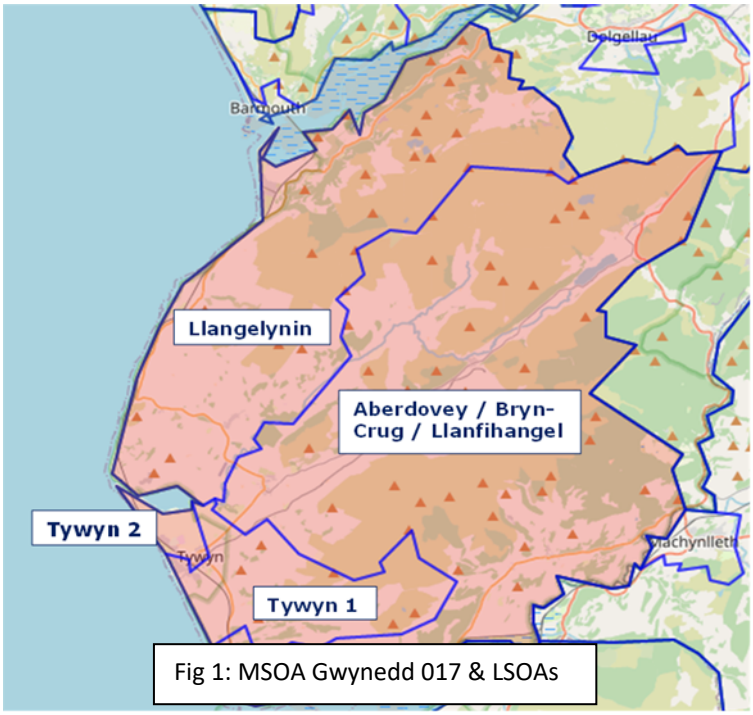


Fig 1: MSOA Gwynedd 017 & LSOAs

Key characteristics within the local population relevant to travel impact:

Older population:

- Around 36% of residents in the MSOA are aged 65+, and over 5% are aged 85+ -

Implication: Older adults are more likely to need community hospital services and may face greater travel challenges living in rural areas.

Rural geography and dispersed communities:

- The MSOA covers multiple rural villages which could imply limited public transport.

Implication: Increased travel distances and car dependency which could cause a negative impact for those with low or no income.

Health need and long-term conditions:

- Gwynedd UA has a higher proportion of those who smoke tobacco than in the rest of North Wales, at 14.9%.
- 19.7% of the population of the South Meirionnydd Primary Care Cluster report to be living with a limiting long-term illness.

Implication: Higher need for accessible, routine and urgent care.

Deprivation considerations:

- Llangelynin is the most deprived LSOA in the area, ranked 725th in Wales (moderate deprivation).
- In Gwynedd UA, 5.5% of babies are born with low birth weight. Whilst it is amongst the lowest figure in the region and lower than the Welsh figure of 6.2%, there is a strong correlation between social deprivation and low birth weight.

Implication: Some households may have reduced car ownership, making travel impacts more significant.

3. Baseline Travel Profile

3.1 Travel to and from Tywyn

Tywyn is centrally located for Llangelynin, Aberdovey, Machynlleth and surrounding villages. Access is primarily an A-road and smaller, rural routes.

Similarly, Dolgellau Hospital is accessed via the A487 and other smaller, rural routes (B-roads).

People in the Tywyn area requiring emergency care or secondary care, would predominantly access non-BCUHB services provided at the Bronglais General

Hospital site, a journey of 45-60 minutes by car – less under “blue light” (via ambulance). This is outside of the scope of the Tywyn Community Hospital service review.

3.2 Access to Local GP Surgeries

Primary care in the area is typically accessed via Tywyn Medical Centre which has a list size of around 5,500 registered patients and provides multidisciplinary primary care services.

3.3 Transport Modes

Car travel is the primary mode due to the rural location and dispersed population.

Feedback from local community members from Tywyn and the surrounding areas during the pre-engagement phase consistently emphasised the importance of accessing care close to home, minimising travel to other hospitals and maintaining local services where possible. Feedback also highlighted lived experience challenges associated with the rural location, including long travel times to acute hospitals, limited public transport provision and difficulties for families and carers visiting patients at other sites.

There is a local bus route from Tywyn and the surrounding area to Dolgellau however it is noted that there is limited transport available in the evenings and on weekends, adding potential barriers for friends, family and carers to visit inpatients at Dolgellau Hospital.

Cambrian Coast rail runs Aberdyfi ↔ Tywyn ↔ Machynlleth, whilst this is not a direct link to Dolgellau there is access via local bus routes between Machynlleth and Dolgellau. It is acknowledged that this is likely to result in increased travel times and may be more challenging for the older population however is an option available to local residents.

There is a community transport scheme – Tywyn and Area Community Transport Scheme (Taith) – supporting people in the area who don’t have access to their own vehicle or for whom public transport is difficult due to age, disability, illness and rurality. Taith is a non-profit community scheme and can support people getting to and from health appointments for a relatively low cost compared to other, private travel options. Transport schemes such as this provide support to many rural communities though are reliant on volunteers and the availability of drivers.

3.4 Staff Travel

Tywyn’s small staffing model (nurses, Healthcare Support Workers, limited medical sessions) means that staff travel is largely localised.

Staffing rotas for the region are based on travel time within an hour of staff's contracted base. This formed part of the reason as to why the Dyfi Ward was temporarily closed as staff could not be redeployed from other sites without significantly impacting on the ability to provide services in other areas, e.g., Alltwen.

There are pool cars utilised by services in Tywyn and should staff require access to support travelling to the Dolgellau site to undertake a shift, this can be arranged. Staff are rostered to work their shifts across Tywyn and Dolgellau Hospitals to mitigate impact.

4. Impact Assessment

4.1 Option A – Reinstatement of Inpatient Ward

92 patients were admitted over the year before the temporary closure and therefore the reinstatement of the inpatient ward may provide benefit to a limited number of the population. Patients would continue to receive patient transport services between hospital sites (e.g, where they have been discharged from an acute site to Tywyn) with the main benefits being on the ease of frequent visiting from friends and family that live locally – especially when loved ones are at end-of-life.

The reinstatement of an inpatient ward would mean a potential reduction in travel for staff with the ward being prioritised over other services across the area.

Reinstating the inpatient ward would mean that the recently developed wider community services would no longer be in place and could result in greater travel requirements for a larger portion of the population.

For minor injuries, with reduced opening hours in Tywyn, patients would likely present in the Emergency Department at Bronglais (c.one hour journey) or Minor Injury Units in Alltwen (c.1 hour 15 minutes) or Dolgellau (c.40 minutes).

The Tuag Adref service would no longer be available within the area. Patients could potentially face delays within community hospitals or admission to Bronglais, Ysbyty Gwynedd or the Wrexham Maelor. Carers are provided locally via Meddyg Care for those with a social care need at home, however those requiring rehabilitation would likely see an increased hospital stay which could lead to de-conditioning.

Without the Treatment Room offer, patients would be treated as an inpatient admission or receive District Nursing Care or may be required to travel to the Emergency Department at Bronglais or the Minor Injuries Units available locally.

Option B - An expansion of community services at home and hospital-based clinics, treatments and therapies.

Option B proposes an expansion of community-based services delivered both within Tywyn and directly in patients' homes, alongside enhanced outpatient, treatment and

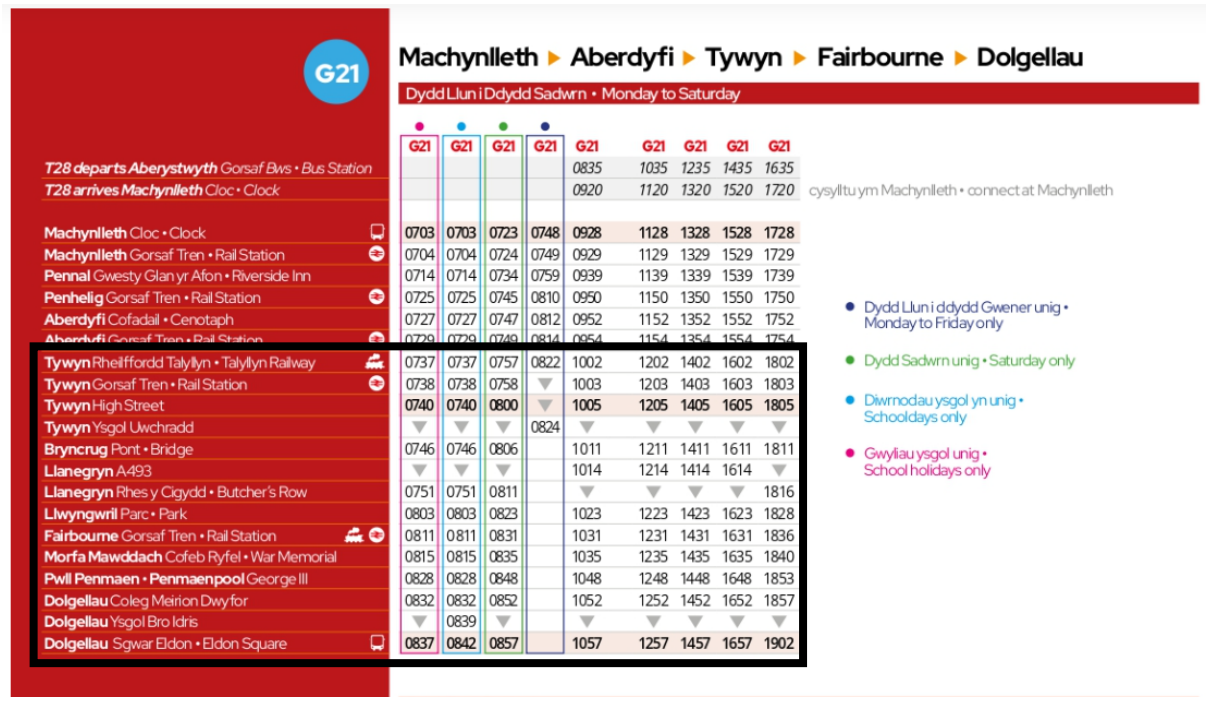
therapy provision. This model would result in a substantial increase in local access to care, with key services such as the Minor Injury Unit (MIU) moving to a seven-day service with extended hours, alongside continued development of the Treatment Room, outpatient clinics and home-based care models such as Tuag Adref.

As a result, the majority of patients would be able to access a wider range of healthcare support within their local community, reducing the need to travel for routine, preventative and ongoing care. Given the scale of activity associated with these services, this option has the potential to reduce travel requirements for thousands of attendances annually, particularly for individuals requiring frequent or repeat interventions such as wound care, IV therapy, monitoring of long-term conditions and rehabilitation support. This is of particular importance in Tywyn, where the population is older, more rural and more likely to experience transport-related barriers.

However, this model would require patients who need inpatient care to travel to alternative hospital sites, namely Dolgellau Hospital. Current activity data suggests that this would affect a relatively small cohort of patients, estimated at approximately four patients per month. While the impact on this group is limited in scale, there is a notable implication for friends, family and carers, who may need to travel greater distances to visit inpatients. This could result in increased travel time, cost and logistical challenges for those making regular visits, particularly where public transport options are limited.

4.2 Local transport offers

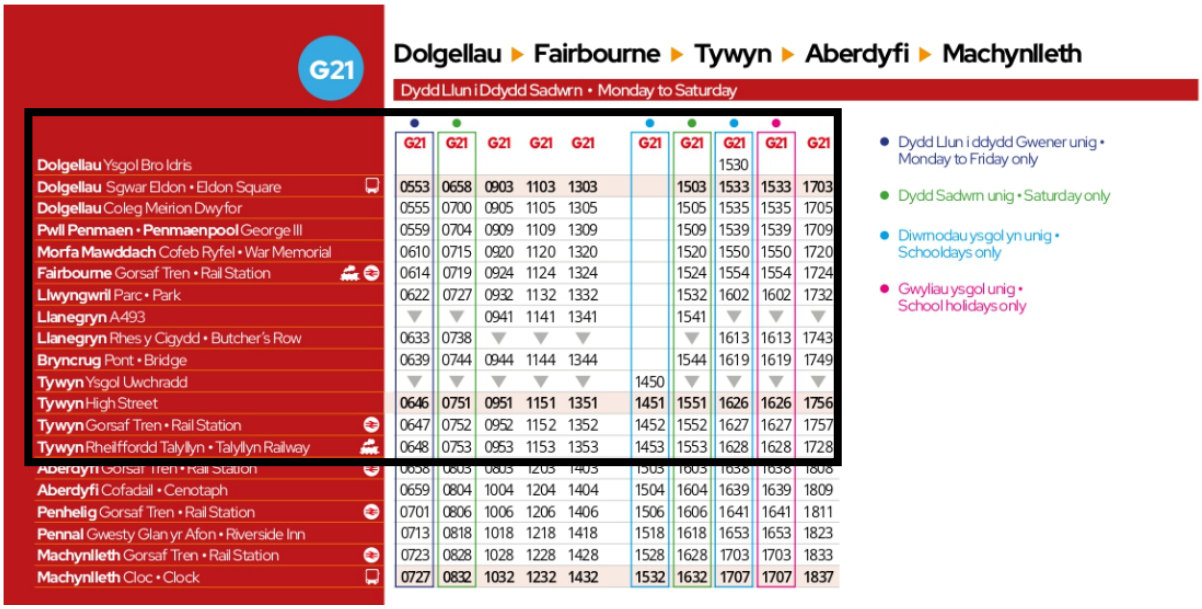
Tywyn -> Dolgellau (Bus Route) – £2.50 Adult, £1.65 Child



Reduced service on a Sunday to 3 buses – one every 4 hours from 09:28

Source information: Lloyds Coaches Wales

Dolgellau -> Tywyn (Bus Route) – £2.50 Adult, £1.65 Child



G21

Dolgellau ▸ Fairbourne ▸ Tywyn ▸ Aberdyfi ▸ Machynlleth

Dydd Llun i Ddydd Sadwrn • Monday to Saturday

	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21
Dolgellau Ysgol Bro Idris								1530		
Dolgellau Sgwar Eldon • Eldon Square	0553	0658	0903	1103	1303		1503	1533	1533	1703
Dolgellau Coleg Meirion Dwyfor	0555	0700	0905	1105	1305		1505	1535	1535	1705
Pwll Penmaen • Penmaenpool George III	0559	0704	0909	1109	1309		1509	1539	1539	1709
Morfa Mawddach Cofeb Ryfel • War Memorial	0610	0715	0920	1120	1320		1520	1550	1550	1720
Fairbourne Gorsaf Tren • Rail Station	0614	0719	0924	1124	1324		1524	1554	1554	1724
Llwyngwril Parc • Park	0622	0727	0932	1132	1332		1532	1602	1602	1732
Llanegryn A493	▼	▼	0941	1141	1341		1541	▼	▼	▼
Llanegryn Rhes y Cigydd • Butcher's Row	0633	0738	▼	▼	▼		▼	1613	1613	1743
Bryncrug Pont • Bridge	0639	0744	0944	1144	1344		1544	1619	1619	1749
Tywyn Ysgol Uwchradd	▼	▼	▼	▼	▼	1450	▼	▼	▼	▼
Tywyn High Street	0646	0751	0951	1151	1351	1451	1551	1626	1626	1756
Tywyn Gorsaf Tren • Rail Station	0647	0752	0952	1152	1352	1452	1552	1627	1627	1757
Tywyn Rheilffordd Talyllyn • Talyllyn Railway	0648	0753	0953	1153	1353	1453	1553	1628	1628	1728
Aberdyfi Gorsaf Tren • Rail Station	0658	0803	0803	1203	1403	1503	1603	1638	1638	1808
Aberdyfi Cofadail • Cenotaph	0659	0804	1004	1204	1404	1504	1604	1639	1639	1809
Penhelig Gorsaf Tren • Rail Station	0701	0806	1006	1206	1406	1506	1606	1641	1641	1811
Pennal Gwesty Glan yr Afon • Riverside Inn	0713	0818	1018	1218	1418	1518	1618	1653	1653	1823
Machynlleth Gorsaf Tren • Rail Station	0723	0828	1028	1228	1428	1528	1628	1703	1703	1833
Machynlleth Cloc • Clock	0727	0832	1032	1232	1432	1532	1632	1707	1707	1837

- Dydd Llun i ddydd Gwener unig • Monday to Friday only
- Dydd Sadwrn unig • Saturday only
- Diwrnodau ysgol yn unig • Schooldays only
- Gwyliau ysgol unig • School holidays only

Reduced service on a Sunday to 3 buses – one every 4 hours from 12:32

Source information: Lloyds Coaches Wales

Public transport connectivity between Tywyn and Dolgellau is limited and could presents a constraint for patients, visitors and carers who are reliant on non-car travel. Dolgellau does not have a railway station, meaning that bus services represent the primary and most direct form of public transport between the two locations.

On a typical weekday, there are approximately five bus services operating from Tywyn to Dolgellau, running at two-hour intervals between 10:05am and 18:05pm. Return services from Dolgellau to Tywyn operate on a similar pattern, with buses departing every two hours between approximately 09:03am and 17:03pm.

The cost of travel is approximately £2.50 per journey (each way) for adults and the limited frequency and timing of services reduce flexibility. In practice, this may result in restricted visiting windows with Option B being instated, if individuals must plan their journeys around bus times.

With Option A and fewer services available locally, the two-hourly service pattern, may act as a barrier for accessing outpatient appointments outside of Tywyn, especially for those without access to a private vehicle. This limitation is likely to disproportionately impact older residents, carers, and low-income households who are more dependent on public transport, reinforcing existing inequalities in access to care and support.

4.2 Impact on those receiving end-of-life care

In the last year, 40 patients in the Tywyn area died in their place of choice, this includes at their own home, in residential and nursing homes and in a community hospital. Of those who didn't there were 16 patients who had been admitted to an acute site due to being acutely unwell and would not have been suitable for care within Dyfi Ward had it been open and less than five patients who died whilst away from the area. The Dyfi Ward being open to support those at end of life would provide an additional choice locally.

4.3 Impact on low-income households

Two areas (Llangelynin and Tywyn 2) within the catchment area are considered of "Moderate Deprivation" which means communities within them can be expected to face slightly below to average challenges with income, housing and health.

The assumption is therefore that deprived households may experience the below when accessing healthcare or visiting loved ones:

- Reduced ability to travel by car
- Increased dependency on public transport

4.4 Environmental impact

Any increase in the duration of and need for private car journeys may increase carbon emissions, conflicting with NHS Wales sustainability objectives.

4.5 Impact rating per population group

Population Group	Option A – Reinstate Inpatient Ward	Option B – Expand Community & Home-Based Services
Older people (65+)	Moderate Positive Impact – Local inpatient care reduces travel for admissions and visiting.	Moderate Positive Impact – Greater access to local treatment, rehabilitation and community services, although inpatient travel would increase.
People with disabilities and long-term conditions	Moderate Negative Impact – Potential loss of some local community and treatment services may increase travel requirements.	High Positive Impact – More care delivered closer to home through community services, clinics and home-based support.
Patients requiring routine treatment, monitoring or therapies	High Negative Impact – Reduced local access to services may require more frequent travel to other sites.	High Positive Impact – Expanded MIU, treatment room and outpatient services significantly reduce travel.
Patients requiring inpatient admission	High Positive Impact – Care available locally.	Moderate Negative Impact – Inpatient care would continue primarily in

		Dolgellau, requiring additional travel.
Families, carers and visitors	High Positive Impact – Easier and more frequent visiting close to home.	High Negative Impact – Increased time, distance and costs associated with visiting inpatients.
End-of-life patients and families	High Positive Impact – Greater opportunity for local end-of-life care and visiting.	Moderate Negative Impact – Reduced local choice for inpatient end-of-life care.
Low-income households	Moderate Negative Impact – Potential increase in travel costs for routine healthcare access.	Moderate Positive Impact – Reduced routine healthcare travel, although inpatient visiting costs may increase.
Rural communities and people without access to a car	Moderate Negative Impact – Greater reliance on travelling outside the area for routine services.	Moderate Positive Impact – Majority of healthcare needs met closer to home, reducing transport requirements.
Staff	Low Positive Impact – Less need for cross-site working and travel.	Low Negative Impact – Some continuing requirement for travel between sites despite mitigation measures.
Welsh speakers	Low Impact – No specific travel-related impact identified.	Low Impact – No specific travel-related impact identified.
Wider population	Moderate Negative Impact – Benefits a relatively small number of inpatient admissions but may increase travel for a larger number of service users.	High Positive Impact – Delivers local access to services used by thousands of residents each year and reduces overall travel demand.

5. Mitigation measures

To mitigate these impacts, a number of measures could be explored. These include strengthening access to community and flexible transport schemes, such as community car services and demand-responsive transport (e.g. Flexi Bus), to support those without access to a private vehicle. The continued application of Healthcare Travel Cost Scheme (HTCS) reimbursement can help reduce the financial burden for eligible patients and visitors. In addition, maintaining flexible and open visiting arrangements at Dolgellau Hospital can enable families to travel at times that are most practical and cost-effective.

Digital solutions also provide an important mitigation, with the use of virtual visiting (e.g. video calls supported by ward-based devices) enabling regular contact for those unable to travel frequently. For patients requiring ongoing contact with services

post-discharge, the expansion of home-based care models such as Tuag Adref will minimise repeat travel by delivering care directly within the home environment.

Further mitigation can be achieved through care planning and scheduling, for example aligning outpatient appointments with transport availability, offering daytime appointments for those unable to travel in the evening, and clustering appointments where possible to reduce the number of journeys required. Continued investment in local outpatient and diagnostic provision within Tywyn will also reduce the need for patients to travel outside the area for non-inpatient care.

5.1 Travel cost support

Under normal circumstances, patients are expected to attend hospital appointments at their own cost with the exception of medical emergencies or where a medical condition makes travel to hospital by private or public transport unsuitable.

For some patients, however, travel to receive healthcare can present difficulties, for example where the journey is lengthy, complex, costly or there is poor access to public transport. In particular, patients with low or no income may find it difficult to meet the cost of travelling to hospital or other healthcare premises for treatments or diagnostic tests.

The Healthcare Travel Costs Scheme (HTCS), which forms part of the NHS Low Income Scheme, was set up to provide financial assistance to those patients who do not have a medical need for ambulance transport, but who may require assistance with their travel costs.

Betsi Cadwaladr University Health Board is committed to ensuring that all eligible patients and carers are reimbursed for travel costs in accordance with the HTCS.

Largely, for patients who would have previously been transferred to Tywyn Community Hospital from a District General Hospital would have received patient transport services which remains the case for those now being admitted to Dolgellau in the interim period.

5.2 Visiting times at Community Hospital sites, including for end-of-life care

Currently the Health Board operates flexible visiting hours which means that friends, relatives and carers can visit patients at any time at a time to suit them, not at a fixed or set time. Mealtimes however are usually protected so that patients are able to eat undisturbed.

Anyone wishing to visit a loved one is encouraged to liaise with the particular ward direct.

Even exceptional circumstances when a ward is closed to general visitors, e.g., for infection prevention and control measures, visits for end-of-life care are typically still permitted, provided precautions are followed BCUHB also supports:

- Letter to Loved Ones: A service is available to send messages to patients via email to the ward, which staff will deliver.
- Virtual Visits: Free hospital Wi-Fi is available for video calls. Dolgellau has 3 tablets

6. Overall assessment

Option	Overall Travel Impact
Option A – Reinstate Inpatient Ward	Moderate Positive Impact for inpatient users, families and carers; Moderate Negative Impact for the wider population who would lose access to expanded local services.
Option B – Expand Community & Home-Based Services	High Positive Impact overall, with travel benefits for the majority of residents, offset by High Negative Impact for families and carers visiting inpatients and Moderate Negative Impact for those requiring inpatient admission.

7. Conclusion

This Travel Impact Assessment aims to consider the potential effects of future service models at Tywyn Community Hospital on patients, carers, visitors, staff and the wider community. The assessment recognises the particular characteristics of the Tywyn catchment area, including its rural geography, older population profile and reliance on private and community transport for access to healthcare services.

The assessment indicates that both options have distinct travel implications. Reinstatement of the inpatient ward would provide clear benefits for the relatively small number of patients requiring inpatient care and for their families, carers and visitors by enabling care to be delivered closer to home. This would be particularly beneficial for those visiting frequently, including during end-of-life care. However, reinstatement would require the displacement of services that have subsequently developed at Tywyn Hospital, including the expansion of Minor Injury Unit opening times, Treatment Room and home-based support models, potentially increasing travel requirements for a much larger number of people accessing routine and ongoing care.

Conversely, expansion of community services, outpatient provision, treatment room activity and home-based care would enable the majority of patients to access a wider range of services within Tywyn or in their own homes. Given the volume of activity currently delivered through these services, this option has the potential to reduce

travel demand and improve accessibility for a significant proportion of the local population. However, it would continue to require those needing inpatient care, and their families and carers, to travel to alternative hospital sites such as Dolgellau, resulting in additional travel time, costs and potential challenges associated with limited public transport provision.

Overall, the assessment suggests that the travel impacts of the two options are distributed differently across the population. Option A delivers the greatest travel benefits for those requiring inpatient care and those wishing to visit them, whereas Option B delivers the greatest travel benefits for the wider population by supporting access to healthcare closer to home for a substantially larger number of service users. While adverse impacts have been identified under both options, a range of mitigation measures are available, including community transport schemes, travel cost reimbursement, flexible visiting arrangements and virtual visiting opportunities.

On balance, from a travel perspective, Option B is likely to result in a reduction in overall healthcare-related travel across the population as a whole, while Option A is likely to provide the greatest benefit for inpatient care and visiting arrangements.

Decision-makers should therefore consider both the scale of impact and the number of people affected when making any decision of the future of community healthcare provision in the area. This will be supported through further evidence gathering and feedback during the consultation phase.

Appendix 12 - References

Health Education and Improvement Wales (HEIW) (2023). *NHS Wales Workforce Trends (as at 31 March 2023)*. Available at: heiw.nhs.wales/files/nhs-workforce-trends-march-2023/ (Accessed: 27 August 2025) .

NHS Improvement (2018). Guide to reducing long hospital stays

NHS Wales (2024). Nurse Staffing Levels (Wales) Act (2016). Online. NHS Wales Performance and Improvement. Available at: Nurse Staffing Levels (Wales) Act (2016) - NHS Wales Performance and Improvement

CORPORATE POLICY MANAGEMENT POLICY

Reference Number:	DOCG04	
Version Number:	1.00	
Policy Approved/ Ratified by: If all-Wales/externally approved policy, please name approval Group/body	**Group Name:** Executive Committee Audit Committee Executive Committee Audit Committee Executive Policy Oversight Group	**Date of Meeting:** 01/10/2025 21/10/2025 26/11/2025 16/12/2025 17/04/2026
Date EQIA Completed:	12/02/2026	
Date IAST Completed:	12/02/2026	
Date of Next Review:	3 years from approval	
Date of Publication:	*Not yet published, needs Board approval*	
Link to Primary and Secondary Legislation, Ministerial Directions or Welsh Health Circulars etc:	Under legislation such as the NHS (Wales) Act 2006, Health and Safety at Work Act 1974, Equality Act 2010, and other UK-wide/Welsh regulations, NHS organisations must have documented policies in certain areas, for example: • Health and Safety Policy – required by the Health and Safety at Work Act 1974 • Equality and Diversity/Equal Opportunities Policy – required by the Equality Act 2010 • Data Protection/Information Governance Policy – required by UK GDPR and the Data Protection Act 2018 • Safeguarding Policies – required under the Social Services and Well-being (Wales) Act 2014 • Whistleblowing (Raising Concerns) Policy – statutory protection under the Public Interest Disclosure Act 1998 • Employment-related policies – some are rights (eg disciplinary, grievance, parental leave, flexible working). These are statutory policies, where NHS Wales organisations and therefore the Health Board is legally obliged to have in place.	
Group with Authority to approve Supporting Procedures:	Executive Policy Oversight Group Executive Committee Audit Committee Board	

Accountable Executive Director Team Member:	**Job Title:**
	Director of Corporate Governance
Author(s)/ Lead(s):	**Job Title:**
	Head of Statutory Compliance and Inquiries

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CORPORATE POLICY MANAGEMENT POLICY

1. POLICY STATEMENT

This Policy sets out how Betsi Cadwaladr University Health Board (BCUHB) manages corporate policies, procedures, and other written control documents to ensure compliance with legislation, national requirements, and good governance. Corporate policy-related documents apply across more than one directorate and have organisational-wide impact.

BCUHB has a statutory duty to maintain certain policies and must also adopt nationally mandated NHS Wales policies and develop local policies where required.

All policies must be evidence-based, accessible, and supported by appropriate procedures and guidance.

The completion of an Integrated Impact Assessment Screening Tool (IIAST) is mandatory for all policy-related documents and must be completed and approved prior to approval.

2. POLICY COMMITMENT

BCUHB is committed to ensuring that all corporate policy-related documents:

- reflect organisational values and behaviours
- are written clearly and accessibly
- are consulted on appropriately (including Trade Union engagement where applicable)
- have a named Executive Team Member responsible for oversight
- follow clear and proportionate approval routes
- are approved, published, reviewed, and monitored in a controlled and consistent way.

All approved corporate policy-related documents are published on BetsiNet and managed by the Corporate Governance Directorate.

3. SUPPORTING PROCEDURES AND WRITTEN CONTROL DOCUMENTS

This Policy is supported by the *Corporate Policy Management Procedure* and relevant governance documents including Standing Orders, Standing Financial Instructions, the Scheme of Delegation, Records Management arrangements, and impact assessment tools.

4. SCOPE

This Policy applies to all BCUHB staff involved in the development, approval, review, or implementation of corporate policies, procedures, and other written control documents.

5. IMPACT ASSESSMENTS

An Equality Impact Assessment and Impact Assessment Screening Tool have been completed for this Policy. No adverse impacts were identified.

6. TRAINING

No additional training is required. Awareness of this Policy will be maintained through routine Corporate Governance and Statutory Compliance activities.

7. RESOURCE IMPLICATIONS

There are no resource implications relating to the implementation of this Policy.

8. MONITORING AND ONGOING REVIEW OF POLICY

The Corporate Governance Directorate is responsible for monitoring compliance with this Policy and reviewing it to ensure ongoing legislative and regulatory compliance.

9. REVIEW PERIOD

This document will be reviewed in no more than 3 years from date of approval.

10. SUMMARY OF REVIEWS / AMENDMENTS

Version number:	Date of Review:	Date of Approval:	Date published:	Summary of Amendments / Changes:
0.01	02/04/2025	First draft	First draft	Total re-write of the DOCG01 - 'Policy for the Management of Health Board Wide Policies, Procedures & Other Written Control Documents' due to complete process change
0.02	16/04/2025	Still in draft	Still in draft	Updates following review by Compliance Team: Removal of duplication re: 'documents to be read in conjunction' Change of wording in relation to staff/employees
0.03	02/09/2025	Still in draft	Still in draft	Updated information in relation to statutory requirements around policies in the 'Policy Statement' section
0.04	27/10/2025	Still in draft	Still in draft	Updated to include comments from: Assistant Director of Compliance and Business Management Interim Executive Director of People Services and Organisational Development
0.05	02/01/2026	Still in draft	Still in draft	Final updates on draft in readiness for Health Board-wide consultation
0.06	12/02/2026	Still in draft	Still in draft	Updated following review by the Statutory Compliance Team
0.07	07/04/2026	Still in draft	Still in draft	Updated following Health Board-wide consultation feedback
1.0	17/04/2026	Approved		Approved by the Executive Policy Oversight Group – now for Board approval

11. DISCLAIMER

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by searching:

- **Policies section of BetsiNet**
- **Contacting the Document Author**
- **Or the Corporate Governance Directorate**

This is a controlled document, the master copy is retained by the Corporate Governance Directorate

We do not encourage printing as the electronic version posted on BetsiNet is the master copy. Any printed copies of this document are not controlled.

This document should **not** be saved onto local or network drives but should always be accessed from BetsiNet.

CORPORATE POLICY MANAGEMENT PROCEDURE

Reference Number:		
Version number:	1.00 (when published)	
Approved by: If all-Wales/ externally approved policy, please name approval Group/body	**Group Name:**	**Date of Meeting:**
	Executive Policy Oversight Group	8th June 2026
Date EqIA Completed:	12/02/2026	
Date IAST Completed:	12/02/2026	
Date of next Review:	3 years from date of approval	
Date of Publication:		
Link to Primary and Secondary Legislation, Ministerial Directions or Welsh Health Circulars etc:	Under legislation such as the NHS (Wales) Act 2006, Health and Safety at Work Act 1974, Equality Act 2010, and other UK-wide/Welsh regulations, NHS organisations must have documented policies in certain areas, for example: • Health and Safety Policy – required by the Health and Safety at Work Act 1974 • Equality and Diversity/Equal Opportunities Policy – required by the Equality Act 2010 • Data Protection/Information Governance Policy – required by UK GDPR and the Data Protection Act 2018 • Safeguarding Policies – required under the Social Services and Well-being (Wales) Act 2014 • Whistleblowing (Raising Concerns) Policy – statutory protection under the Public Interest Disclosure Act 1998 • Employment-related policies – some are rights (eg disciplinary, grievance, parental leave, flexible working). These are statutory policies, where NHS Wales organisations and therefore the Health Board is legally obliged to have in place.	
Accountable Executive Team Member:	**Job Title:** Director of Corporate Governance	
Author(s)/ Lead(s):	**Job Title:** Head of Statutory Compliance and Inquiries	

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CORPORATE POLICY MANAGEMENT PROCEDURE

1 INTRODUCTION AND AIM

1.1 This Procedure supports the Corporate Policy Management Policy by providing detailed instructions for developing, reviewing, approving, publishing, maintaining and the removal of corporate policy related documents within Betsi Cadwaladr University Health Board (BCUHB).

1.2 It ensures:

- A consistent and standardised approach
- Clear definitions of document types
- Clear responsibilities for authors, leads and approvers
- Compliance with legislation and national guidance
- Effective consultation and impact assessment
- Use of standard templates and formatting
- Centralised publication and version control

1.3 Corporate policy related documents include policies, procedures, guidelines and protocols that apply across more than one directorate or have organisation wide impact.

2 SCOPE

2.1 This Procedure applies to all staff involved in developing or reviewing corporate policy related documents.

2.2 It does not apply to:

- Local SOPs or departmental documents
- National clinical guidelines
- Standards
- Strategies, plans or frameworks
- Local agreements

2.3 Only corporate documents are stored on the Corporate Policies Register and published on BetsiNet.

3 DETAILS AROUND THE LINK TO POLICY, OTHER POLICIES, PROCEDURES AND/OR WRITTEN CONTROL DOCUMENTS

3.1 This Procedure must be read in conjunction with:

- Corporate Policy Management Policy
- Standing Orders, Standing Financial Instructions, Scheme of Delegation
- Records Management Policy and Procedure
- Integrated Impact Assessment Screening Tool (IIAST) Procedure
- Relevant legislation and national guidance

4 COMPLIANCE WITH LEGISLATION AND REGULATIONS

4.1 All corporate policy-related documents must follow legislative frameworks such as Consent, Deprivation of Liberties, Mental Capacity, Child and Adult Safeguarding, Data Protection, Welsh Language, Digital Accessibility, Equality and Fraud.

5 DEFINITIONS

5.1 Corporate policy-related documents

5.1.1 Corporate policy-related documents are those that apply across the whole Health Board, setting organisation-wide governance, statutory, clinical, and professional requirements, and providing the mandatory framework within which all services, professions, and staff groups must operate.

5.1.2 This includes both corporate and Health-Board-wide clinical policy-related documents where their intent, application, or assurance value extends beyond a single service, specialty, or locality.

5.1.3 Corporate policy-related documents:

- give effect to statutory, regulatory, constitutional, and professional obligations
- apply consistently across the Health Board, including across multiple clinical services or professional groups
- establish mandatory minimum standards, controls, or expectations
- include corporate clinical policies, clinical frameworks, and clinical governance documents that:
  - set Health-Board-wide clinical standards, approaches, or principles
  - address cross-cutting clinical risk, safety, or quality requirements
  - support assurance against external scrutiny, inspection, or regulation
- are approved and owned corporately (eg Board, Board Committee, Executive Committee, or delegated corporate authority)
- provide the basis for assurance, audit, inspection, and regulatory compliance.

5.1.4 Examples may include:

- corporate governance and statutory compliance policies
- information governance and records management policies
- equality, human rights, and safeguarding policies
- financial regulations and standing orders
- Health-Board-wide clinical policies (eg consent, resuscitation principles, infection prevention and control frameworks, medicines management policy, clinical risk management frameworks).

5.2 **Non-corporate/local**

5.2.1 Non-corporate policy-related documents are those that apply to a specific service, specialty, directorate, locality, or operational area, and describe how corporate (including Health-Board-wide clinical) requirements are implemented in practice within that defined context.

5.2.2 This includes local clinical policy-related documents that support the delivery of care within a particular service or pathway, provided they do not establish Health-Board-wide standards or requirements.

5.2.3 Non-corporate policy-related documents:

- operate within, and must be consistent with, corporate policies and Health-Board-wide clinical policies
- translate corporate and corporate-clinical requirements into service-specific procedures, guidance, pathways, or protocols
- address operational, technical, or clinical delivery detail relevant to a defined area of practice
- may apply to:
  - a single service or specialty
  - a specific clinical pathway or patient group
  - a particular site, team, or locality
- are owned, approved, and reviewed at service or directorate level, in line with delegated authority
- do not create new organisation-wide obligations, statutory interpretations, or Health-Board-wide clinical standards

5.3 **Definition of a Corporate Policy**

5.3.1 A corporate policy is an organisation-wide, formally approved document that sets out mandatory principles, standards, and rules required to meet statutory, regulatory, governance, clinical, and organisational obligations.

5.3.2 Corporate policies apply consistently across the whole Health Board and establish the authoritative framework within which all services, departments, staff, and local policy-related documents must operate.

5.3.3 A corporate policy:

- applies Health-Board-wide, without local variation
- gives effect to statutory, regulatory, constitutional, or professional requirements
- sets mandatory minimum standards or controls
- is used to provide corporate assurance to the Board, Authority, regulators, auditors, and inspectors
- is owned and approved at corporate level (eg Board, Board Committee, Executive Committee)
- may include corporate clinical policies where they establish organisation-wide clinical standards or governance requirements

5.4 Definition of a Corporate Procedure

5.4.1 A corporate procedure is an organisation-wide, formally approved document that sets out the mandatory steps, processes, and responsibilities required to implement a corporate policy consistently and lawfully across the Health Board.

5.4.2 Corporate procedures apply across the whole Health Board and provide the standardised method by which corporate policy requirements are carried out in practice.

5.4.3 Key defining characteristics of a corporate procedure are that it:

- applies Health Board-wide, without local variation
- supports and implements one or more corporate policies (including corporate clinical policies)
- specifies how, by whom, and in what sequence actions must be taken
- sets mandatory processes, controls, or workflows
- is used as part of the Health Board's corporate assurance framework
- is owned and approved at corporate level (or under formally delegated corporate authority)
- may include corporate clinical procedures where consistent processes are required across multiple services or professions.

5.5 Definition of a Corporate Guideline

5.5.1 A corporate guideline is a Health Board-wide, formally approved document that provides recommended approaches, good practice, or interpretive guidance to support the consistent application of corporate policies and procedures across the organisation.

5.5.2 Corporate guidelines apply across the whole Health Board but allow for professional judgement and appropriate local discretion, provided decisions remain compliant with mandatory corporate and statutory requirements.

5.5.3 Key defining characteristics of a corporate guideline is that it:

- applies Health Board-wide and is relevant across services or professional groups
- supports the implementation and understanding of corporate policies and procedures
- sets out recommended practices, principles, or options rather than mandatory steps
- provides clarity, consistency, and assurance, without creating new obligations
- may include corporate clinical guidelines where consistent advice is required to support safe and effective practice across the organisation.
- is owned and approved at corporate level (or under delegated corporate authority)
- does not override or conflict with corporate policies or procedures
- offers Health Board wide advice on best practice, helping staff apply policies and procedures consistently while allowing flexibility where justified.

5.5.4 Deviation from a corporate guideline may be appropriate where justified by professional judgement or specific circumstances, provided this does not breach corporate policy, corporate procedure, or statutory requirements and is appropriately documented.

5.6 **Definition of a Corporate Protocol**

5.6.1 A corporate protocol is a Health Board-wide, formally approved document that sets out a standardised, mandatory sequence of actions or decision rules to be followed in defined circumstances, in order to ensure consistent, safe, and lawful practice across the Health Board.

5.6.2 Corporate protocols apply across the whole Health Board where a high degree of consistency, control, or risk mitigation is required.

5.6.3 Key defining characteristics of a corporate protocol is that it:

- applies Health Board-wide or across multiple services or professional groups
- is typically used where there is:
  - higher clinical, operational, or legal risk, or
  - a need for tight standardisation of practice
- specifies clear, rule-based actions, decision thresholds, or pathways
- leaves little or no discretion outside defined parameters (except where explicitly stated)
- supports and operationalises corporate policies and procedures
- is used as part of the organisation’s corporate assurance and risk-management framework
- is owned and approved at corporate level (or under formally delegated corporate authority)

- frequently includes corporate clinical protocols where patient safety, quality, or consistency of care is critical
- sets out a standard, mandatory way of responding to specific situations, so everyone acts consistently and safely across the Health Board.

5.6.4 Deviation from a corporate protocol is permitted only where explicitly allowed, must be based on clear justification (eg clinical judgement or exceptional circumstances), and must be appropriately documented and escalated in line with governance requirements.

5.6.5 They differ from guidelines in that compliance is expected, not optional.

5.7 **Document types excluded from the corporate policy management process**

5.7.1 These are **not** covered by the Corporate Policy Management Policy and are **not** held on the Corporate Policies Register:

5.7.2 **'Non-corporate' Procedures/SOPs**
- Local, mandatory procedures.

5.7.3 **National Clinical Guidelines**
- Evidence-based guidance (eg NICE)
- Support clinical decision-making.

5.7.4 **Standards**
- Statements describing expected levels of service or care
- Not prescriptive but difficult to defend if ignored without justification.

5.7.5 **Strategies/Plans**
- Long-term organisational goals and approaches

5.7.6 **Frameworks**
- High-level structures or principles guiding a particular area

5.7.7 **Local Agreements**
- Locally approved arrangements (e.g., pay or terms and conditions)
- Apply only to the relevant service or location.

6 PROCESS

6.1 Step 1 – Review the Need

1a. New Documents – Initial Approval to Create

- Identify the need for a new document due to eg new or amended legislation, risk, or service change
- Lead Executive Team member to be informed
- Request Initial Approval Form from Statutory Compliance Team
- Complete the Initial Approval Form
- Submit the form to the Statutory Compliance Team
- If approved, templates and guides will be issued to you from the Statutory Compliance Team - proceed to Step 2.

1b. Existing Documents – Review the Need

- Request the latest approved Word version of the policy-related document from the Statutory Compliance Team
- Review the content and confirm whether revision is required
- If revision is required, proceed to Step 2
- If no revision is required, approval should be sought from the lead Executive Team member so that the review date can be updated (to no more than 3 years' time), and provided to the Statutory Compliance Team so that they can update the Corporate Policies Register.

6.2 Step 2 – Identify the Correct Template

- Ensure that the correct document type is identified:
  - use the **Policy Template** for corporate policies
  - use the **Procedure Template** for procedures, guidelines and protocols
- The Policy template or Procedure template will be provided by the Statutory Compliance Team.

6.3 Step 3 – Complete the IIAST

This work continues throughout all subsequent stages.

- Begin completing the Integrated Impact Assessment Screening Tool (IIAST) early
- Update assessments throughout drafting and consultation
- Engage relevant leads (Equality Team, Welsh Language, Information Governance etc).

6.4 Step 4 – Use Supporting Resources

- Engage the BCUHB Library Service for evidence searching, appraisal and referencing support
- Use library-provided, high-quality evidence sources to inform the document.

The Library Service can be contacted via this link.

6.5 Step 5 – Targeted Consultation During Development

- Consult relevant stakeholders, professional groups, staff groups and (where appropriate) service users
- Record all feedback received and actions taken.

6.6 Step 6 – BetsiNet Consultation

- Submit the consultation form and draft document to the Statutory Compliance Team
- The document is uploaded to BetsiNet for Health Board–wide consultation for a minimum of 14 working days
- Authors must monitor comments and respond as appropriate.

6.7 Step 7 – Revise Following Consultation

- Update the document in response to consultation feedback
- Update the IIAST following consultation
- Prepare a consultation summary.

6.8 Step 8 – Approval and Translation

- Seek committee approval, in line with the Corporate Policy-related Document Approval Process contained within this Procedure
- Corporate policies must be translated into Welsh before publication (*please consult with the Welsh Language Team)*

6.9 Step 9 – Statutory Compliance Team Review

The Statutory Compliance Team carries out a quality assurance check, including:

- Compliance with templates
- Formatting and version control
- Clarity, accuracy and legislative compliance.
- Documents may be returned for amendment.
- Please note that Policies, Procedures and Other Written Control Documents must be sent to the Statutory Compliance Team no longer than 6-months since the last approval meeting. Any received after this date will be returned.

6.10 **Step 10 – Publication and Implementation**

- The Statutory Compliance Team publishes the document on BetsiNet
- Where policies require Board approval, this is notified to the Statutory Compliance Team before publication
- Authors support implementation and communication of the document.

7 REMOVAL OF EXISTING POLICY-RELATED DOCUMENT FROM THE CORPORATE POLICIES REGISTER

7.1 Where a document is no longer required, and it needs to be removed from publication on BetsiNet, the author must obtain approval from the relevant Executive Team Member or from an individual so delegated under the local scheme of delegation.

7.2 This does not relate to documents that are being superseded by another document, or where the detail is incorporated into another document. Details around what document is being superseded or incorporate into a new document must be included within the 'Summary of Reviews/Amendments' section to ensure that the reader has clarity.

7.3 The author must provide the Statutory Compliance Team with an explanation around the reason for removal, and written confirmation of Executive Team Member approval or delegated authority. If the request is submitted by the delegated individual, a copy of the local scheme of delegation must be provided.

8 ALL-WALES OR OTHER EXTERNALLY APPROVED POLICIES, PROCEDURE OR OTHER WRITTEN CONTROL DOCUMENTS

8.1 All-Wales or external policy-related documents are developed and approved outside the Health Board.

8.2 Each all-Wales or external policy-related document must have an assigned contact from within the Health Board to assist with any queries where necessary.

8.3 **Adoption of agreed All-Wales/external documents**

8.3.1 Where an agreed national adoption process exists (eg policies developed by the Welsh Partnership Forum as part of National Pay Terms and Conditions), documents must be implemented unchanged, with no variation or amendments. No Health Board approval is required prior to publication of these types of policy-related documents, other than adding a cover sheet to identify a local contact and publication details. These documents will be made available on BetsiNet in the same way as Health Board-related documents.

8.4 **Adoption of other All-Wales/external documents**

8.4.1 The document may be submitted in any format (including PDF) and must include:

- the All-Wales/external policy-related document
- a Submission Form (Appendix 14)
- an All-Wales/NHS Wales cover sheet, in Word format only (Appendix 16)
- a completed BCUHB-specific IIAST.

8.4.2 Jointly developed or All-Wales documents may require additional local procedures to support implementation, as determined by the lead Executive Team Member. Any locally developed supporting documents must follow this Procedure.

8.4.3 Following publication on the Corporate Policies Register, All-Wales or external documents will be noted (for information only) at the Executive Policy Oversight Group.

8.4.4 Where no national agreement exists, All-Wales or external documents must follow the Health Board's approval process and be formally adopted.

8.5 **Review of All-Wales/external documents**

8.5.1 Where an All-Wales or external document is due for review and no updated version is available, The Welsh Partnership Forum Business Committee has confirmed that the All-Wales Workforce and Organisational Development policies are to remain extant until replaced by an updated version approved by the Welsh Partnership Forum.

8.5.2 To provide assurances around the continued validity of such documents, the lead Executive Team Member must:

- confirm that the document remains valid and extant, and provide assurance that no changes have been identified which would adversely affects its ongoing applicability or effectiveness within the Health Board
- approve an extension to the review date, or
- approve the development of a local replacement document until the All-Wales/external document becomes available to reduce the risk to the health Board during that intervening period.

8.5.3 Any approved review extension must be notified to the Statutory Compliance Team in writing to update the Corporate Policies Register.

9 NHS WALES JOINT COMMISSIONING COMMITTEE

9.1 Where policies relate to the functions of the NHS Wales Joint Commissioning Committee, the Board will delegate approval to the Joint Committee (JCC).

10 MEDICINES AND MEDICINES MANAGEMENT DOCUMENTS

10.1 Approval by the BCU Drugs and Therapeutics Group (DTG) is required for all medicines, medicines related and medicines management related documents to ensure that guidance is evidence-based, safe, clinically appropriate, cost-effective and aligned with the Health Board's formulary, medicines governance arrangements and medicine related legal and statutory responsibilities.

10.2 This includes, but is not limited to:

- Guidance on prescribing, administration, storage, handling, and monitoring of medicines
- Shared care agreements
- Patient Group Directions (PGDs)
- Prescribing documentation
- Other medicines-related governance arrangements.

10.3 Clinical guidance that includes advice on the use of medicines or medicines management processes also falls within this scope. This includes, for example, condition specific clinical guidelines that incorporate prescribing advice for medicines or medicine management processes.

10.4 All documents, whether developed for use across BCU or at a local level, that provide guidance on the use of controlled drugs must be approved by the Controlled Drugs Accountable Officer, in line with statutory requirements.

10.5 Pharmacy only documents will be subject to the pharmacy ratification processes under the authority of the BCU Health Board Chief Pharmacist/Controlled Drugs Accountable Officer.

11 ONGOING REVIEW

11.1 Once established, all corporate policy-related documents **must be** subject to a full review within three years of approval.

11.2 The Executive Team Member will consider the need to review existing corporate policy-related documents supported by the appropriate author.

11.3 Corporate policy-related documents may also be reviewed or amended before their review date.

12 AMENDMENTS TO DOCUMENTS FOLLOWING PUBLICATION

12.1 No changes may be made to corporate policy-related documents once approved.

12.2 Minor, non-material amendments may be made to an approved document through an interim review by the policy lead, subject to prior agreement with the Executive Team Member.

12.3 Any agreed amendment must be reported to the next appropriate Committee or Board, in line with the original approval route.

12.4 Following written approval, the Statutory Compliance Team will archive the previous version and publish the updated document upon receipt of written Executive Team Member approval.

12.5 The review date will stay the same and will not be extended.

13 APPROACH TO NAMING POLICY AUTHORS

13.1 Policy-related documents should normally identify an ownership role rather than a named individual. Where a named individual is identified as the document owner, their explicit authorisation must be obtained and evidenced by email to the Statutory Compliance Team.

14 ROLES AND RESPONSIBILITIES

14.1 Overview

This section sets out the responsibilities of the Board, Executive Team Members, Statutory Compliance Team, document authors, Approval Groups, Trade Unions, and employees.

14.2 The Board

The Board is responsible for approving policies or delegating approval to a committee or sub-committee in line with *Standing Orders and Scheme of Delegation and Reservation of Powers*. Some policies may only be approved by the Board. Procedures and other written control documents may be approved by delegated committees or groups where permitted.

14.3 Approval Groups

Approval Groups are responsible for the review and approval of Polices, Procedures and Other Written Control Documents that have been submitted in line with the Terms of Reference for that Group, and the Approval Routes contained within the Corporate Policy Management Procedure.

It is the responsibility of the Approval Group to advise the policy authors/leads of the decision from that Group (approval or not), and if not approved, the amendments/updates needed for approval to be sought.

14.4 Employees

Employees are responsible for familiarising themselves with relevant policy-related documents on BetsiNet and contributing feedback during consultation where appropriate.

14.5 Executive Team Members

Executive Team Members are responsible for ensuring their areas are supported by up-to-date policy-related documents. This includes:

- appointing and maintaining clear document ownership
- ensuring timely review, consultation, impact assessment and adoption of corporate and All-Wales documents
- confirming documents follow the required development and approval process
- managing risks associated with overdue reviews
- ensuring implementation, monitoring, and alignment with organisational values
- providing updates to the Statutory Compliance Team to maintain an accurate Corporate Policies Register.

14.6 Document Authors / Leads

Document authors or leads are responsible for drafting, reviewing, and progressing policy-related documents all through the approval process, up to and including submission to the Statutory Compliance Team for publication. This includes:

- ensuring timely review and consultation
- completing required impact and risk assessments
- engaging with relevant stakeholders
- ensuring the appropriate approvals in line with this Procedure
- supporting implementation, training, and audit where required
- arranging translation following approval
- ensuring continuity of ownership when leaving or changing roles.

For All-Wales or externally approved documents, a local lead or contact must be assigned.

14.7 **Statutory Compliance Team**

The Statutory Compliance Team is responsible for overseeing corporate policy compliance to ensure good governance practices by:

- maintaining the Corporate Policies Register and document control
- managing approvals, archiving, templates, and quality assurance
- retaining all policy-related screening documents
- providing advice, reporting, and review reminders
- recording additions, removals, and key risks
- owning and reviewing the Corporate Policy Management Policy and supporting Procedure.

14.8 **Trade Unions**

Trade Unions will be engaged as part of the consultation process for the development or review of relevant policy-related documents.

15 IMPACT ASSESSMENTS

15.1 The Equality Impact Assessment (EqIA) and Impact Assessment Screening Tool (IAST) have been completed for this Procedure and found no negative impacts.

16 IMPLEMENTATION

16.1 Implementation will be supported through:

- Publication on BetsiNet
- Communication to relevant staff groups
- Inclusion in training or induction where appropriate.

17 RESOURCE IMPLICATIONS

17.1 No additional resources are required beyond existing governance and administrative structures.

18 TRAINING

18.1 Training will be provided as required through:

- Training sessions
- Author workshops
- Self-service training material available on the Corporate Governance Hub on BetsiNet
- Support from the Statutory Compliance Team.

19 MONITORING AND ONGOING REVIEW OF PROCEDURE OR OTHER WRITTEN CONTROL DOCUMENT

19.1 Compliance with this Procedure will be monitored by the Statutory Compliance Team through:

- Review of submitted documents
- Audit of the Corporate Policies Register
- Feedback from committees.

20 REVIEW PERIOD

20.1 This document will be reviewed in no more than 3 years from date of approval.

21 SUMMARY OF REVIEWS/AMENDMENTS

Version Number	Date of Review	Date of Approval	Date Published	Summary of Amendments/Changes
0.01	02/04/2025	Still in draft	Still in draft	Total re-write of the DOCG01 - 'Policy for the Management of Health Board Wide Policies, Procedures & Other Written Control Documents' due to complete process change
0.02	08/10/2025	Still in draft	Still in draft	Updated to reflect changes made following period of interim changes to the policy management process
0.03	24/12/2025	Still in draft	Still in draft	Updated to reflect the approval of the policy-related document approval route at Executive Committee
0.04	04/02/2026	Still in draft	Still in draft	Updated to include link to Library Services
0.05	12/02/2026	Still in draft	Still in draft	Updated following review by the Statutory Compliance Team
0.06	11/03/2026	Still in draft	Still in draft	Final updates and formatting to the draft
0.07	07/04/2026	Still in draft	Still in draft	Updated to reflect changes following Health Board-wide consultation
0.08	07/04/2026	Still in draft	Still in draft	Version of Procedure submitted for Health Board-wide consultation shortened in length in line with comments received
0.09	08/04/2026	Still in draft	Still in draft	Updated following final review by the Statutory Compliance Team
0.10	27/04/2026	Still in draft	Still in draft	Updated following feedback after the Executive Policy Oversight Group meeting held on 17th April 2026: • refined the definitions of corporate policy-related documents • included delegated authority requirements for the removal of published policy-related documents • clarification around the approval route for policy-related documents that include an element of medicine management
V0.11	16/06/2026	Approved	Approved	Refinement of wording around inclusion of names of policy-related document owners

22 DISCLAIMER

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by searching the:

- **Policies section of BetsiNet,**
- **or contacting the document Author**
- **or the Corporate Governance Directorate**

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Health Board

ALL WALES APPROVED CLINICIANS AND SECTION 12(2) DOCTORS

BOARD REPORT – JULY 2026

Date of Meeting	30 July 2026
Publication Status	Open/Public Not Applicable
Report Author name and title	Meryl Roberts, All Wales Approvals Manager
Lead Executive Team Member name and title	Dr Clara Day, Executive Medical Director

Report Purpose	Endorse for Board Approval

Executive Summary

This report summarises recent approvals for **Approved Clinicians** and **Section 12(2) Doctors** across Wales, ensuring compliance with the Mental Health Act 1983 (amended 2007) and written approval processes. Betsi Cadwaladr University Health Board is the central approving board for all Health Boards and exercises this delegated function on behalf of Welsh Government.

Applications for approval under the Mental Health Act are checked and scrutinised by the Approvals Team then assessed by the All Wales Approval Panel who make recommendations for approval. The Approval Panel comprises of clinical Panel Members, a Vice-Chair and Chair drawn from all Health Boards and several Local Authorities. The Panel's recommendations for approval are then submitted in writing to the Executive Medical Director for approval using authority delegated at the March 2023 Board meeting. The Panel's recommendations are submitting in writing to the Executive Medical Director for approval, using authority delegated by the Board in March 2023. Approvals are then fully reported and ratified by the Board through this paper.

The approval process complies with Welsh Government delegated authority, Mental Health Act legislation, policies and written approval processes. It promotes transparency with details of recent approvals listed in Appendices 1 and 2.

Board Actions Requested:

- Note the contents of the report.
- Ratify the Approved Clinician and Section 12(2) approvals contained within Appendices 1 and 2.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Dates**	**Outcome, Evidence and Data**
Internal action letters submitted by the All Wales Approvals Manager to Deputy Executive Medical Director (DEMD) seeking ratification of Panel recommendations for approval, reapproval, reinstatement of approval and suspension of approval.	20 May 2026 to 7th July 2026. Details below	Please see below.
DEMD	20.05.2026	Action letter submitted via email for ratification and approval received.
DEMD	21.05.2026	As above
DEMD	26.05.2026	As above
DEMD	02.06.2026	As above
DEMD	17.06.2026	As above
DEMD	23.06.2026	As above
DEMD	30.06.2026	As above
DEMD	07.07.2026	As above
Acronyms / Glossary of Terms		
DEMD	Deputy Executive Medical Director	

All Wales Approved Clinicians and Section 12(2) Doctors – Board Assurance

1. SITUATION

1.1 This report provides Board assurance on the operation of the All Wales Approved Clinicians and Section 12(2) Doctors approval process and seeks ratification of approvals; authorised under delegated authority.

2 BACKGROUND

2.1 Betsi Cadwaladr University Health Board undertakes the All Wales approval function for all Health Boards on behalf of Welsh Government. Approvals for approved clinicians are made in accordance with the Mental Health Act 1983 (amended 2007), the Approved Clinicians (Wales) Directions 2018, the

Approval of Approved Clinicians Welsh Government Guidance Document and the All Wales Approved Clinician Procedural Arrangements Document. Approvals for Section 12(2) Doctors are made in accordance with the Mental Health Act 1983 (amended 2007) and the All Wales Section 12(2) Process and Criteria Document.

2.2 Applications for approval are scrutinised by the Approvals Team then assessed against written criteria by the All Wales Approval Panel.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 Ratification of approvals previously authorised via action letter by the Executive Medical Director or the Deputy Executive Medical Director.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 No significant risks identified.

5 RECOMMENDATIONS

5.1 The Board is asked to:

- Ratify approvals

ASSESSMENT	
Link to Strategic Priorities	 Choose an item. Improving quality, outcomes and experience
Design Principles	Consistency with Organisational Values If more than one applies, please list below:
Corporate Risks and Board Assurance Framework	
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Choose an item.	**Domains of Quality** Choose an item.
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	Choose an item.	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	A formal assessment is not required as the report relates solely to governance and assurance arrangements

		only and does not introduce changes to service delivery.
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Legal	Yes (Include further detail below)	
	The approval and ratification processes described in this report are undertaken in accordance with Welsh Minister delegation to Betsi Cadwaladr University Health Board, the Mental Health Act (1983) (as amended), Welsh Government Guidance document, Approved Clinician Directions 2018 and S12(2) Process and Criteria Document (the written approval process). There are no identified legal concerns arising from the recommendations within this report.	
Reputational	Yes (Include further detail below)	
	Robust governance of Approved Clinicians and Section 12(2) Doctor approvals is essential to maintaining public protection and public confidence in mental health services in Wales.	

	The arrangements outlined in this report provide high level assurance that approvals are subject to appropriate scrutiny, transparency and Board oversight. No reputational risks have been identified.
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	There is no direct financial or workforce impact arising from the matters outlined in this report. The activity described, represents continuation of existing All Wales approval arrangements within current resources.

APPENDIX 1

Update of Register of Approved Clinicians in Wales	
	Approved Clinicians
Approvals and Re-approvals	20
Approvals suspended	2
Approvals re-instated	1
Left Wales and Removed from Register)	3
Retired	0
No longer Registered or Licensed to Practise with Professional Body	1
Transferred from AC register (to S12 Register)	0
Removed from S12 – Became AC approved	0
Approval Ended	1
Death in Service	0
Performance Metrics Reporting period: 12th May 2026 – 7th July 2026	
Total number of AC applications processed	23
Number awaiting completion of application by the applicant	3
Pending Approvals	2
Average days to approval time per completed application.	14
Number of lapsed approvals due to missed deadlines by the applicant	1

APPENDIX 1

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 Approved Clinician (Wales) Directions 2018

Update of Register of Approved Clinicians - Wales

Ratification Period: 12th May 2026 – 7th July 2026

Approvals and Re-approvals: 20

Surname	First Name	Workplace	Date Approval Expires
Varanasi	Amrita	Aneurin Bevan University Health Board, Ysbyty Ystrad Fawr, Ystrad Mynach, Caerphilly CF82 7EP	12th May 2031
Kramer	Julia	Swansea Bay University Health Board, Liaison Psychiatry, Morriston Hospital, Swansea, SA6 6NL	19th May 2031
Collins	Ann	Aneurin Bevan University Health Board, Ty Bryn Unit, St Cadoc's Hospital, Caerleon, Newport, NP18 3XQ	20th May 2031
Elmasry	Eslam	Cwm Taf Morgannwg University Health Board, Tonteg Hospital, Church Road, Pontypridd CF38 1HG	21st May 2031
Riyadh	Mohamed	Cardiff and Vale University Health Board, Emotional Wellbeing and Mental Health Service, St David's Hospital, Cowbridge Road East, Cardiff, CF11 9XB	25th May 2031
White	Colin	Betsi Cadwaladr University Health Board, HMP Berwyn, Bridge Road, Wrexham, LL13 9QE	1st June 2031

Surname	First Name	Workplace	Date Approval Expires
Jamali	Qutub	Cygnet Healthcare, Delfryn House, Lodge and Rhyd Alyn, Alfonas, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ	15th May 2029
Pankajakshan	Rakesh	Aneurin Bevan University Health Board, Talygarn Unit, County Hospital, Coed-y-Gric Road, Pontypool, NP4 5YA	9th June 2031
Jauhari	Archana	Powys Teaching Health Board, Bryntirion Resource Centre, Salop Road, Welshpool, SY21 7EA	15th June 2031
Schmidt	Annamarie	Betsi Cadwaladr University Health Board, Perinatal Mental Health Service, Ablett Unit, Ysbyty Glan Clwyd, Bodelwyddan, Denbighshire, LL18 5UJ	16th June 2031
Ivenso	Chineze	Aneurin Bevan University Health Board, Wentwood Suite, St Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ	17th June 2031
Ohonba	Isaac	Cardiff and Vale University Health Board, Mental Health Services for Older People, Llandough Hospital, Penlan Road, Penarth CF64 2XX	17th June 2031
Kamugisha	Chris	Seren Gobaith Independent Hospital, 64 Brighton Road, Rhyl, Denbighshire, LL18 3HN	21st June 2031
Kovvuri	Suneetha	Seren Gobaith Independent Hospital, 64 Brighton Road, Rhyl, Denbighshire, LL18 3HN	21st June 2031
Rai	Ariadka	Powys Teaching Health Board, Erwood Ward, Bronllys Hospital, Bronllys, Powys LD3 0LU	21st June 2031
Mohamed	Lily	Cwm Taf Morgannwg University Health Board, Celtic Court, Tremains Road, Bridgend, CF31 1TZ	23rd June 2031
Bekhit	Sameh	Aneurin Bevan University Health Board, South Monmouthshire Older Adults CMHT, Llanfair, Chepstow Community Hospital, Tempest Way, Chepstow NP16 5YX	24th June 2031
Wagstaff	Stacey	Betsi Cadwaladr University Health Board, North Wales Adolescent Service, Llanfair Road, Abergele, LL22 8DP	30th June 2031

Surname	First Name	Workplace	Date Approval Expires
Rodriguez-Mendieta	Javier	EIP Service, Daniel Owen Centre, Office 1 & 2, Earl Road, Mold, Flintshire, CH7 1AP	2nd July 2031
Malik	Masood	Betsi Cadwaladr University Health Board, Pwll Glas Community Mental Health Team, Pwll Glas Road, Mold, Flintshire CH7 1RA	2nd July 2031

Approval Suspended: (*CCT not yet received): 2

Surname	First Name	Workplace	Date Approval Expires
*Mustafa	Saima	Betsi Cadwaladr University Health Board, Heddfan Psychiatric unit Wrexham Maelor Hospital Croesnewydd Road, Wrexham, LL13 7TD	19th February 2031
*Comeau	Catrin	Cardiff and Vale University Health Board, Hafan Y Coed, University Hospital of Llandough, Penlan Road, Penarth, Cardiff, CF64 2XX	2nd March 2031

Approvals Reinstated: 1

Surname	First Name	Workplace	Date Approval Expires
Tint	Aung	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Bangor, Gwynedd, LL57 2PW	27th April 2027

Left Wales and Removed from AC Register: 3

Surname	First Name	Workplace	Date Approval Expired/Expires
Sreenath	Narasimhamurthy Sanghalli	Betsi Cadwaladr University Health Board, Heddfan Mental Health Unit, Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	12th July 2026

Surname	First Name	Workplace	Date Approval Expired/Expires
Reagu	Shuja	Elysium Healthcare, Aberbeeg Hospital, Aberbeeg, Abertillery NP13 2DA	19th February 2029
D'Arch-Smith	Stuart	Aneurin Bevan University Health Board, Ty Cyfannol Ward, Ysbyty Ystrad Fawr, Ystrad Fawr Way, Ystrad Mynach, CP82 7GP.	8th September 2026

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered or Licensed to Practice with Professional Body: 1

Surname	First Name	Workplace	Date Approval Ended
Savage	Marie	Betsi Cadwaladr University Health Board, CMHT Noddfa, Middle Lane, Denbigh, LL16 3UR	3rd July 2026

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

Approval Expired or Ended: *1

Surname	First Name	Workplace	Date Approval Expired
*White	Colin (*later reapproved)*	Betsi Cadwaladr University Health Board, HMP Berwyn, Bridge Road, Wrexham, LL13 9QE	17th May 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	8
Approvals suspended	0
Approvals re-instated/ transferred/returned to work in Wales	0
Removed (Left Wales)	0
Retired	0
Registered without a licence to practise and retired	1
Transferred from AC register (to S12 Register)	0
Became AC approved	2
Approval Ended or Expired	2
Death in Service	0
Performance Metrics - Reporting period: 12th May 2026 – 7th July 2026	
Total number of Section 12(2) doctor applications processed	12
Pending approvals	7
Number awaiting completion of application by the applicant	1
Average days to approval per completed application	23.125
Number of lapsed approvals due to missed deadlines by the applicant.	0

APPENDIX 2

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 – All Wales Section 12(2) Process and Criteria Document

Update of Register of Section 12(2) Doctors - Wales

Ratification Period: 12th May – 7th July 2026

S12 Approvals and Re-approvals: 8

Surname	First Name	Workplace	Date Approval Expires
Ganta	Therissa	Cardiff and Vale University Health Board, Hamadryad Centre, Hamadryad Road, Bute Town, Cardiff, CF10 5UY	12th May 2031
Somoye	Edward	Cardiff and Vale University Health Board, Neuropsychiatry Unit, Hafan y Coed, University Hospital Llandough, Penlan Road, Llandough, Penarth, CF64 2XX.	21st May 2031
Qamaruddin	Shiraz	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital Ynysmaerdy, Pontyclun, CF72 8XR	21st May 2031
Ramjee	Sunita	Swansea Bay University Health Board, Orchard Centre, Trinity Place, Swansea, SA1 5DR	21st May 2031
Thomas	Tyler	Cwm Taf Morgannwg University Health Board, Celtic Court, Tremains Road, Bridgend, CF31 1TO	11th June 2031
Saville	Franklin	Cardiff and Vale University Health Board, Hafan y Coed, Llandough Hospital, Penlan Road, Cardiff, CF64 2XX.	16th June 2031
Fong	Chung Sien	Betsi Cadwaladr University Health Board, Flintshire Mental Health Services for Older People, Wepre House, Wepre Drive, Connah's Quay, Flintshire, CH5 4HA	22nd June 2031

Surname	First Name	Workplace	Date Approval Expires
Roberts	Alys	Betsi Cadwaladr University Health Board, Hergest Unit, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW	2nd July 2031

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approval Reinstated/Transferred/Returned to Wales: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Ended – Became an Approved Clinician: 2

Surname	First Name	Workplace	Date Approval Ended
Elmasry	Eslam	Aneurin Bevan University Health Board, CAMHS Team, Neath Port Talbot Hospital, Baglan Way, Port Talbot, SA12 7BX.	26th May 2031
Williams	Laura	Betsi Cadwaladr University Health Board, Ty Llywelyn MSU, Aber Road, Llanfairfechan, Conwy, LL33 0HH.	29th June 2026

Removed (Left Wales): 0

Surname	First Name	Workplace	Date Approval Expires

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 1

Surname	First Name	Workplace	Date Approval Ended
Jeal	Susan	Cwm Taf Morgannwg University Health Board, Bridgend North CMHT, Maesteg Community Hospital, Neath Road, Maesteg, CF34 9PW	1st June 2026

S12 Approval Ended or Expired: 2

Surname	First Name	Workplace	Date Approval Expired
Ulfin	Yesupalan Sheeja	Cardiff and Vale University Health Board, Cardiff and Vale 24/7, Cardiff Royal Infirmary, Glossop Terrace, Cardiff, CF24 0SZ	18th June 2026
Cartwright-Wilson	Dave	Hywel Dda University Health Board, Intermediate Care Team, Withybush Hospital, Fishguard Road, Haverfordwest, SA61 2PZ	4th July 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Ended

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee (SSPC)**
Chaired by	Huw Thomas, Executive Director of Finance at Hywel Dda University Health Board and Vice Chair of SSPC
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of Meeting	14 May 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Managing Director's Update Report - The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting, highlighting continued organisational maturity and impact as the organisation marked its 15-year anniversary, with sustained delivery of value, innovation and partnership across NHS Wales. Governance and accountability arrangements remain under development through the Implementation Group, supported by ongoing engagement, alongside positive external visibility following the Chief Executive's visit to IP5.

A balanced financial position was confirmed (subject to audit), including delivery of the £6m savings requirement to NHS Wales and Welsh Government, alongside full utilisation of capital funding to support strategic infrastructure, digital, estates, decarbonisation and resilience priorities. Ongoing focus on the Welsh Risk Pool was noted, supported by Welsh Government investment, with further work required to address emerging reimbursement pressures.

An update was provided in relation to development of key national programmes including Transforming Access to Medicines (TrAMS) and the Future Workforce Solution. While positive progress was noted in TrAMS, including advancements across regional hub developments and digital solutions, risks remain in relation to organisational approvals and Welsh Government sign-off, with potential delays linked to the formation of the new government. The Future Workforce Solution programme continues at pace but is impacted by external dependencies, including delays in documentation and outstanding clarity on system functionality.

Reasonable assurance was reported for the Single Lead Employer model following internal audit, with improvement required in specific operational areas, particularly sickness management processes, which the Committee noted as a shared responsibility. Significant risks associated with Resident Doctors' contract reform were highlighted, including operational, financial and compliance implications, with further detailed scrutiny provided to the Committee in the deep dive presentation.

The overarching report provided the Committee with updates across a broad portfolio, including Transforming Access to Medicines (TrAMS), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; Primary Care Services;

Laundry Services; decarbonisation and adaptation activity; engagement and leadership activity; and awards and recognition.

In addition, the Committee was advised of the most recent developments in relation to senior appointments, including the appointment of Dr Martin Edwards as Medical Director, following the retirement of Dr Ruth Alcolado in March 2026; ongoing recruitment to the Deputy Medical Director role; and progress in the Chair's recruitment process, with interviews scheduled for 15 June 2026. Confirmation is awaited regarding Tracy Myhill OBE remaining in post until 30 June 2026.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Update Report.

Deep Dive Presentations

Implementation of the Resident Doctor Contract Reform - The Committee received a detailed presentation on the implementation of the Resident Doctor contract reform, noting progress across a range of workstreams in line with a challenging timetable for the August 2026 go-live date. This included advancements in system development, contractual negotiations, policy development and organisational engagement. It was noted that the majority of contractual terms have been agreed with the British Medical Association (BMA), with final documentation nearing publication, and that associated policies are progressing through governance arrangements. The e-rostering system remains a key dependency, with revised timelines and interim arrangements in place to mitigate risks and support ongoing delivery. Variability in organisational readiness was recognised, alongside continued work to ensure compliance with rota requirements and to evidence workforce needs.

Key risks were highlighted in relation to workforce capacity, financial implications and the requirement for additional staffing to accommodate reduced working hours under the new contract. Mitigating actions, including enhanced workforce planning, bank usage and continued scrutiny of additionality requirements, were noted. The Committee was advised that programme governance arrangements are robust, supported by an active risk register and clear escalation processes.

Further assurance was provided through evidence of improved engagement across organisations, positive recruitment fill rates and progress in system solutions to support transition. Committee Members raised a number of queries relating to governance coverage, readiness assurance, benefits realisation, rota impact assessment and workforce additionality. It was confirmed that readiness is being monitored through structured processes and regular reporting, with post-implementation evaluation planned to assess outcomes and inform future phases.

Radiopharmacy at IP5 - The Committee received a presentation on the development of the new Radiopharmacy facility at IP5, noting significant progress and the successful completion and handover of the purpose-built facility in April. Commissioning is currently underway, with the programme progressing through a structured internal qualification phase to ensure that the facility, equipment, processes and workforce meet all required regulatory and operational standards. The specialised nature of Radiopharmacy services was acknowledged, including the complexity of manufacturing short shelf-life medicines and the requirement for robust quality assurance, safety and distribution processes. The comprehensive design of the facility, incorporating clean room environments, specialist equipment and controlled workflows aligned to stringent regulatory requirements was recognised.

The complex regulatory landscape was highlighted, with oversight from multiple bodies, and the need to ensure full compliance across environmental, staff safety and medicines regulation standards including updates to various licenses. The qualification process includes detailed testing and validation prior to progression to operational use. Plans for service implementation remain on-track for summer 2026, with a phased approach to go-live. Initial service delivery will be limited to Aneurin Bevan University Health Board to support workforce training and operational readiness, before scaling to a broader all-Wales service. Arrangements to maintain continuity of supply during transition, including collaboration with Swansea Bay University Health Board, were also noted.

Additionally, the Committee observed the virtual tour of the facility, providing assurance regarding the infrastructure, layout and technical capabilities supporting delivery.

The Committee **NOTED** the updates provided in relation to the implementation of the Resident Doctor Contract Reform and Radiopharmacy at IP5.

Items for Approval

NWSSP Performance Management Framework – The Committee **DISCUSSED** and **APPROVED** the application of the Performance Management Framework as set out in the paper and **NOTED** that elements may be subject to change pending revisions to Welsh Government accountability arrangements. The Committee was assured that arrangements are established and operating as intended, supported by regular and comprehensive performance reporting. The Framework provides clear oversight, aligned reporting and ongoing engagement with NHS Wales organisations, underpinned by defined governance principles and accountability through the Managing Director, as Accountable Officer.

NWSSP Duty of Quality Annual Report 2025–26 - The Committee **APPROVED** the NWSSP Duty of Quality Annual Report 2025–26, noting continued maturity in the organisation's approach to quality, with strengthened governance, enhanced visibility and a clear focus on delivering measurable outcomes across NHS Wales. The proportionate, system-wide approach to quality management was recognised, alongside ongoing development of an overarching quality management system to support continuous improvement.

Items for Noting

Chair's Appointment - The Committee **NOTED** the update regarding the Chair's appointment process, including progress and confirmation of interviews scheduled for 15 June 2026, with final shortlisting feedback awaited and interim arrangements in place, with the current Chair agreeing to remain in post to ensure continuity.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the draft financial position for 2025/26, subject to audit, confirming the revenue position closed broadly in line with forecast, achieving a small surplus of £9k. Savings of £6.7m were delivered, including £0.7m applied to the National Insurance funding shortfall, with the remaining £6m returned to partners. Capital expenditure of £11.7m was achieved and delivery of key capital investments was noted, including Radiopharmacy developments and estates decarbonisation schemes, such as solar panels, electric vehicle infrastructure and hot water reclamation. The Welsh Risk Pool outturn of £192m was reported in line with forecast, supported by Welsh Government funding and Risk Share Agreement contributions, with continued growth in liabilities highlighted, including a £246m increase in provisions to £1.957bn and contingent liabilities

rising to £1.2bn. Committee Members acknowledged the achievement of a balanced position while noting the scale of Welsh Risk Pool liabilities as a significant system pressure.

People and Organisational Development (POD) Report – The Committee noted the updated reporting format and the latest workforce position, with sickness absence remaining broadly stable, albeit above target in some areas, and turnover slightly above the NHS Wales average but trending downward and aligned with comparable organisations. Strong performance was noted in key areas, including PADR compliance at 85.62%, and time to hire remaining well within target, at approximately 55 days. Continued progress was reported across learning uptake, corporate induction improvements and workforce planning, supported by enhanced data and improved leavers' feedback, through increased response rates. It was confirmed that areas requiring improvement have been escalated to divisional Senior Management Teams, for action.

Performance Information Report – The Committee noted overall performance against key performance indicators for the period December 2025 to March 2026, with strong performance reported and ongoing engagement with organisations through quarterly reporting arrangements. It was highlighted that this represents the final year of reporting in the current format ahead of revised strategic objectives for 2026/27. Three indicators were reported as amber, including Audit and Assurance turnaround performance, impacted by delays in management responses, and customer satisfaction measures within Digital Workforce Solutions and Central Team e-Business Services, with contributory factors including system migration issues, staffing pressures and challenging scoring thresholds. Mitigations were noted as in place, with continued focus on partnership working and benchmarking to support improvement.

Outcome Measures Report – The Committee noted performance against outcome measures aligned to NWSSP's strategic objectives, with enhancements to reporting including increased use of statistical process control and expanded operational and customer metrics. Strong performance was reported across most service areas, with customer satisfaction targets achieved, as noted above. Increased operational activity was highlighted, including call volumes of approximately 17,000, meeting performance targets. Workforce indicators remained stable, with turnover aligned to sector benchmarks, and value measures demonstrated continued contribution to the foundational economy, with 44% of spend with Welsh suppliers. The inclusion of 'Voice of the Customer' appendix provided assurance through a summary of individual customer conversations, demonstrating that urgent matters are addressed promptly while highlighting key themes emerging from customer feedback.

Transformation Management Office (TMO) Update Report – The Committee noted the update on the TMO portfolio, including a refined approach to benefits realisation to strengthen reporting of value and impact. The portfolio currently comprises 17 projects, 2 programmes and 6 service improvement initiatives, with the majority of activity aligned to All Wales priorities. Generally positive delivery was reported, with key updates including completion of the TrAMS Radiopharmacy project and transition to post-project evaluation, improved progress within the Welsh General Ophthalmic Services (WGOS) contract reform programme, and ongoing delays to the Legal and Risk case management system, due to technical stabilisation issues. Assurance was provided that risks and mitigations are actively managed and that overall delivery remains within expected parameters.

Draft NWSSP Annual Governance Statement (AGS) 2025–26 – The Committee noted the draft publication, recognising its importance within the organisation's assurance framework and its role in providing transparency to the Committee, Velindre University

NHS Trust (as host) and wider stakeholders. The AGS reflects governance, risk management and internal control arrangements, including consideration of the Welsh Government-commissioned Independent Review of Accountability & Governance and a balanced assessment of strengths and areas for development. Committee Members were invited to provide further comments ahead of finalisation and approval, at NWSSP Audit Committee on 15 June 2026.

NWSSP Corporate Risk Register – The Committee noted the current position within a dynamic operating environment, with 17 risks for action identified including six rated red and 11 amber. Key red-rated risks relate to cyber security, pharmaceutical supply, delivery of Radiopharmacy and TrAMS developments, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that certain risks are being maintained within risk appetite where full mitigation is not achievable, with ongoing monitoring and management actions in place. Assurance was provided that Committee business is aligned to the NWSSP Corporate Risk Register, supporting focused scrutiny and forward planning, with further detailed consideration of cyber security risks scheduled for a future meeting.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Items for Information

The Committee received the following items for information:

- Finance Monitoring Returns (Month 12 of 2025-26)
- Personal Protective Equipment (PPE) Report
- Audit Wales Audit Assurance Arrangements for NWSSP 2025-26
- NWSSP Internal Audit Plan, Mandate and Charter 2026-27
- NWSSP Counter Fraud Plan 2026-27
- SSPC Forward Plan 2026-27

Part B - Private

The Committee **NOTED** and **ENDORSED** the proposed approach as set out in the Welsh Risk Pool Update.

Extraordinary (Private) Meeting of the SSPC Held on 25 June 2026

At its extraordinary meeting on 25 June 2026, the Committee (SSPC) **NOTED** that the appointment process for the new Chair had been undertaken in accordance with the SSPC Standing Orders and **APPROVED** the recommendation of the appointment panel chaired by an Independent Assessor appointed by Welsh Government.

Matters requiring Board/Committee level consideration and/or approval

The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Date of Next Meeting	Thursday 16 July 2026, 10.00am to 12.00pm