Insight | Change | Management

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Penley Community Hospital Balanced Room No. 2

Outcomes Report

November 2025

Contents

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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 Penley Community Hospital. The workshop was convened by Betsi Cadwaladr University Health Board (BCUHB) and held at Ruabon Village Hall, on the 29th of October 2025.

This workshop was part of the options development and appraisal process, which follows the process outlined below.

- **Balanced Room 1** was convened and independently moderated to develop a long list of options for consideration, which were then appraised using BCUHB's essential criteria to develop a medium list of options. Use of the essential criteria ensured that each option was operationally viable for further consideration.
- **Balanced Room 2** was convened with broadly the same audience to develop a set of desirable criteria reflecting the views of wider stakeholders not just the health board. Weightings were applied to each criterion and then the medium list of options was appraised using the co-developed and agreed essential criteria to develop a shortlist.

1.1.1 Background

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 develop a medium list, which comprised four options, as shown below.

A. **Health and Wellbeing Hub (Integrated)**: repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

B. **Rehab / Step-down Facility with Beds**: restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.

C. **Third Sector Led Health and Wellbeing Hub**: combining the integrated hub model with an explicit leadership and delivery role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing, and social support alongside NHS-led services.

D. **Services in the Community (No Physical Building)**: redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.

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 15 participants who developed the essential criteria, their weighting and applied them to developing the short list of options, of those:

- 10 were external stakeholders.
- 5 were members of BCUHB staff with specialist knowledge and experience.

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

Victoria Bishop	BCUHB
Paulina Dymnicka	Helping Hands CIC
Jacqui Grice	Bangor on Dee Community Council
Phil Jones	Hanmer Surgery Patient Action Group
John Pritchard	Local councillor
Lucy Reid	BCUHB
Christine Roberts/Barbara Weeks	Hanmer Community Council
Victoria Sheffield	BCUHB
Faye Sheldon	BCUHB
Claire Sullivan	North East Wales Carers Information Service
Sarah Thomas	North Wales Access Panel
Caroline Tudor-James	Rainbow Foundation
Stuart Tunnicliffe	BCUHB

John Griffiths	Wrexham Council
Dr Kieran Redman (attended for a while but didn't score)	Local GP

1.2.2 Technical Advisers (non-voting)

A group of BCUHB staff attended to provide technical advice on clinical, operational, equalities, and estates matters as required:

- Andrea Hughes Director of Nursing – East IHC BCUHB
- Ryan Welch, Lead Manager, Community Services – East, BCUHB
- Dr Sara Gerrie, Consultant Geriatrician, BCUHB
- Jade Parry Assistant Project Manager, Capital Development Team East, BCUHB
- Jenifer Dowell-Mulloy, Equality and Inclusion Manager, 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) — Paolo Tardivel (BCUHB)
- Table Facilitator/Scribe — Helen Stevens-Jones (BCUHB)
- Table Facilitator — Andy Roberts (BCUHB)
- Table Facilitator — Vicky Freeman (BCUHB)
- Table Scribe — Marie Lewis-Smith (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 in relation to options A to D outlining areas of agreement, points of contention, and notable concerns or suggestions raised by participants.

The discussion involved local community representatives, healthcare staff, and officials, focusing on future options for the Penley facility and services in South Wrexham. All participants emphasised the need for any solution to address wider system challenges, meet the needs of a largely rural and ageing population, and be sustainable for the future.

2.2 Estate and Infrastructure Suitability

Participants examined the suitability of the existing Penley healthcare facility and other local infrastructure.

2.2.1 Penley Hospital Building

Participants noted that the Penley building is relatively modern *"…the building [was] erected in 2004"* with were no known structural limitations that would preclude new service options. While some community members initially perceived the building as aging or inadequate (*"people might think the building is old and needs bulldozing"),* it was clarified that the facility was rebuilt in 2004 and remains fundamentally sound.

Routine maintenance issues (e.g. minor drainage problems) have been identified, but a significant maintenance backlog is not expected. Participants requested confirmation of any legal covenants on the property in case the site's use changes, though no specific covenants were known at the time.

2.2.2 Adaptability

There was a call to assess *"what the building is fit for – [and] could be adapted to"* in the context of each option. In other words, any proposed service model must align with the physical layout and capabilities of the Penley site. Participants felt it important to avoid retrofitting services that the building cannot appropriately accommodate. For example, if clinical inpatient beds were not feasible at scale, the building might be better purposed as a community hub for outpatient and wellbeing services. This emphasis on matching the estate to service models ties into the broader criterion of ensuring any solution is *"fit for the future"* and has longevity. The Penley facility should be utilised in a way that remains relevant 10–20 years from now, rather than implementing a short-term fix.

2.2.3 Local GP Practice

In addition to the Penley site, participants highlighted the condition of the local GP surgery. The current GP practice building in the area was *"declared unfit in 2016 and nothing has been done about it".* This was raised as a significant infrastructure gap. Any plans for Penley's healthcare provision should consider primary care facilities: improving or relocating the GP practice could be part of the solution, or else the

Penley site might supplement some primary care functions. Participants stressed that infrastructure upgrades are needed at the primary care level, as this is crucial for preventive care and keeping people out of hospital.

Use of Existing Assets

Participants expressed a strong interest in utilising existing community assets and facilities. For instance, Penley is already used for some services like physiotherapy, and *"this could be built on"* with additional clinics.

There was also discussion about utilising other local venues (e.g. *"they could go into the GP practice, not just into Penley"* for certain services). A specific example was given that something as simple as ear syringing currently requires patients to travel to Llangollen; participants saw an opportunity to provide such basic services closer to home, either at Penley or local GP surgeries.

The principle expressed was that even small or rural communities deserve a standard level of provision; *"a school still has to provide the curriculum even if [there are] small numbers. The same should apply to health services; they are still needed even if the population is low".*

In summary, the estate (Penley and other local facilities) is seen as a viable foundation for expanded local services, if planning is done thoughtfully to match building capabilities with community needs.

2.3 Care Delivery Challenges in the System

Participants underscored that any Penley solution must tackle broader care delivery challenges, not just create an isolated service.

2.3.1 Emergency Care Delays

Participants discussed stark examples of system stress, recounting recent incidents illustrating long waits for emergency care. In one case, an elderly patient with a broken hip waited outside A&E for an extended time; in another, a person with a burst appendix sat for 20 hours awaiting treatment and developed sepsis.

It was noted that Betsi Cadwaladr UHB has some of the *"worst ambulance conveyance times in Wales",* with patients facing extreme delays for transport to hospital.

These anecdotes reinforced a shared view: *"Whatever happens here [in Penley], [we] need to address this context"* of strained emergency and acute care.

Simply reopening a small inpatient unit at Penley would not solve the systemic issues of A&E backlogs, ambulance queues, and delayed admissions.

2.3.2 Delayed Discharges and Bed Blocking

Another critical challenge discussed was the difficulty in discharging hospital patients due to insufficient support in the community. Data was shared indicating there have been over *"8,000 delayed discharges in the South Wrexham area"* recently. Participants linked this to a shortage of home care packages and community-based intermediate care. They cautioned against solutions that only *"paper over the cracks".* For example, while adding step-down (rehabilitation) beds was considered (as in

Option B), many felt this addresses a symptom (hospital bed shortages) rather than the root cause. One participant argued that providing step-up/step-down beds alone *"does not address the lack of rapid access for domiciliary care",* which is a primary cause of discharge delays. In other words, if patients cannot get timely home care or residential care, they will remain stuck in any system, whether at the district general hospital or a step-down unit.

At the same time, some attendees pointed out the value of step-down beds when integrated properly. A local caregiver shared a personal story: her elderly mother had used a community hospital bed after an acute stay, and these step-down facilities *"were a major part of her recovery".* This was *"very important in rural areas,"* she emphasised, noting that *"we are not Wrexham town centre out here in Penley".* The rural context – where traveling to the main hospital (Wrexham Maelor) is difficult for patients and families – means local recuperation beds can greatly aid recovery and family involvement.

Step-down beds are not a complete solution, but participants agreed they have value in a wider model (such as Option A) particularly for elderly rural patients who would otherwise face extended hospital stays far from home.

2.3.3 Patient Suitability and Level of Care

NHS staff in the discussion noted that many inpatients today are too acutely unwell to be transferred quickly to a traditional community hospital. As one clinician observed, *"patients aren't fit for community hospital discharge"* in a lot of cases. By the time they are medically stable enough, they often can go straight home if support is available. This raises the question of what role an inpatient unit at Penley should play. Participants generally leaned away from trying to recreate a classic community hospital with long-stay beds (Option B). Indeed, Option B was seen by the group as essentially *"where we've come from"* (referring to the old Penley Hospital model) and not adequately working last time. The consensus was that simply reviving the previous service would serve *"only a few"* patients and fail to meet the wider community's needs. Instead, the focus should be on community-based care delivery that reduces admissions in the first place and speeds discharges by providing robust home and step-down support.

2.3.4 Social Care and Carer Support

A recurring theme was the interface between health services and social care. Many older patients ready for discharge cannot leave hospital because appropriate home care isn't immediately available. The group discussed ongoing efforts like a Pathways of Care Transformation grant, which is examining how to improve rapid access to domiciliary care (for example, expediting *"rapid access to domiciliary care, and moving with dignity"*).

The requirement for two carers to assist one patient, known as *"over-prescription of double handling",* worsens home care staffing shortages and delays arranging care packages. This points to workforce and policy challenges in social care that directly impact hospital flow. In addition, participants talked about carers' needs for support. For instance, caring for someone with dementia versus someone with purely physical

needs requires different services, and currently it is *"difficult to get care packages"* tailored to those needs.

Practical support for carers was also mentioned such as:

- *"…food boxes if a carer can't get out of the house,"* or
- help with *"removing furniture so a hospital bed can fit in the house"* when setting up home care.

These kinds of non-medical interventions can determine whether a patient can be safely discharged home.

Moreover, carers often feel adrift; they *"*, as having a single point of contact could prevent unnecessary re-admissions.

Carers often feel lost and want a single point of contact for questions, which could help avoid unnecessary re-admissions. They *"…need to know who their key contact is, who to phone with a question".*

The overarching message was that any new model in Penley must be part of an integrated care pathway that smooths transitions from hospital to home and supports carers, effectively reducing *"bed blocking"* by addressing why patients become stuck in the first place.

2.3.5 Population Health Needs

The demographic profile of the Penley catchment is skewed older compared to Wrexham town. Data noted in the session showed *"the Penley area has a proportionately greater number of over-50s than Wrexham town centre"*. This ageing population brings higher prevalence of chronic conditions, mobility issues, and dementia – and thus requires more healthcare and support services. Participants argued that the model should be tailored to these needs, for example by providing local wellbeing and preventive services that help keep seniors healthy and independent. They stressed a dual goal…

"…we need to prevent re-admission but also first admission".

Put simply, focus should be on both reducing hospital readmissions by improving post-discharge care and prioritising preventive measures and early intervention to minimise initial hospitalisations. This preventive approach was linked to ideas like enhanced primary care (hence the calls for a better GP practice) and community wellbeing programs at a hub.

Another community insight was acknowledging past utilisation of Penley. It was noted that…

"…the local population didn't use Penley [Hospital] before, so what do the locals need?".

This rhetorical question implies that, in the past, the services provided at Penley may not have fully reflected the needs of the community, potentially due to limited utilisation resulting from the availability of only a small number of inpatient beds. Any solution must be guided by local needs and demand, making community engagement and data analysis essential.

In summary, participants painted a picture of significant care delivery challenges: overloaded hospitals, slow discharges due to inadequate community care, an ageing rural population with limited alternatives, and caregivers under strain. They urged that whatever model is chosen for Penley, it must alleviate these challenges by boosting local capacity for care (both medical and social) and by focusing on keeping people well and cared for in the community.

2.4 Service Integration and Holistic Care

The discussions consistently highlighted the importance of integrating services across healthcare levels, as well as among health, social, and voluntary sectors, to deliver more comprehensive and holistic care. Participants believe Penley's future should be as a hub or catalyst for coordinated services rather than a standalone offer.

2.4.1 Wider System Approach

Participants repeatedly stated that the Penley solution must be part of *a "wider system approach".* They envisioned better integration between the hospital, community health services, GPs, social care, and third sector (voluntary) organisations. One participant put it clearly as...

> *"…the model/solution needs to address the wider system and meet local needs e.g. bed blocking".*

This implies designing services that actively fill gaps in the current system – for example, offering intermediate care, rehabilitation, or respite that eases pressure on acute hospitals, while also connecting to GP referrals and social services.

2.4.2 Co-location and Holistic Services:

The concept of a "community hub" at Penley (broadly corresponding to Option A) was popular, but attendees stressed it must be well-defined. They suggested a hub could host a range of services:

- Outpatient clinics,
- Therapy services,
- Preventative health programs,
- Perhaps some step-down care, and
- Even social support resources.

By *"co-locating services"* under one roof, people could more easily be *"signposted between services"* for holistic support. For example, an elderly patient visiting for a physiotherapy appointment might also be able to get a falls-risk assessment, speak with a social prescriber about community activities, or consult a benefits advisor – all in one trip. Participants saw this as an ideal to strive for:

> *"Well-being delivered locally and co-located with ... non-medical services should be considered."*

Bringing health and wellbeing services together would help address not just medical needs but social determinants of health.

2.4.3 Role of the Voluntary Sector

Option C referred to collaborating with the voluntary or community sector. Participants largely felt this was not an *"either-or"* alternative but a necessary component of any successful model.

In fact, it was noted that.

"Option A couldn't be done without the support of the voluntary sector, which is option C."

There was consensus that local charities, community groups, and volunteer networks should be involved in delivering services, whether:

- Running community activities in the hub;
- Providing volunteer drivers (for patient transport); or
- Supporting carers at home.

The voluntary sector can extend the reach of formal services and provide elements of care that the NHS struggles to, particularly in wellbeing and social support. Participants wanted to:

"…take advantage of the assets in the area".

Meaning both physical assets (like the community hall or school facilities that could host clinics) and human assets (community volunteers, support groups, etc.). Effective integration would improve sustainability, as leveraging these resources could help *"improve the sustainability"* of services and fill in gaps.

2.4.4 Avoiding Duplication and Strengthening Links

A warning was issued to make sure that services are not needlessly repeated or in conflict with each other. If Penley becomes a hub, it should complement existing services, not compete with, or replicate them unnecessarily:

"We need to avoid duplication of services…"

For example, if certain clinics are already available at the Wrexham Maelor or nearby community facilities, the hub should either coordinate to host those clinics on an outreach basis or focus on services not currently accessible locally.

Participants felt a mapping of current services was crucial:

"We should have reviewed the current services available now, and how realistically these could be built upon. Mapping should have been done."

For future planning, it is advisable to carry out a thorough service mapping and gap analysis in South Wrexham. This would identify which needs are unmet and ensure the Penley plan is targeted. Moreover, making the *population aware of all current services* was mentioned as important; integration is not just about providers talking to each other, but also about the public having a clear, navigable system.

Improved coordination between organisations is necessary, regardless of the outcome of this consideration of Penley's future service delivery. Participants asked:

"How are current services working together, what are the gaps and how can we address that?"

Existing health, social, and community services in the area are not felt to communicate or coordinate as effectively as they could. Implementing a hub model at Penley has the potential to enhance coordination efforts; however, its success would depend on the establishment of effective governance structures and robust inter-agency collaboration.

One practical idea was to establish a single *"key contact"* or care coordinator for carers (and presumably patients) to turn to with questions, to help navigate the system. This kind of integration (essentially case management) could prevent people from falling through the cracks or cycling back into hospital.

2.4.5 Preventative and Community Health

Integration also means refocusing on prevention and early intervention as part of the service mix. Participants were keen that any new facility prioritise wellbeing services, health education, and preventive clinics. The "prevention agenda" was highlighted as a must-have element. For instance, regular screening programs, exercise classes for older adults, or chronic disease management workshops could run out of a community hub. As one comment suggested:

> *"What can we do with a community hub to help keep people healthy?"*

There was acknowledgment that a strong primary care base (including a better GP practice locally) is key to prevention; hence integrating the hub's activities with local GPs is vital. This could mean GPs hold sessions at the hub or refer patients to hub programs (dieticians, smoking cessation, etc.), and conversely that hub staff coordinate with GP surgeries about patient care plans.

2.4.6 Specific Community Needs

The range of services suggested spanned all ages and needs, reflecting a holistic vision. Besides elder care, participants mentioned needs such as sexual health, family planning, mental health support, and respite care for families.

Youth services were mentioned too: e.g., a local high school (Madras School) already offers some community facilities for young people. This indicates potential for partnerships, the hub doesn't have to house every service itself if some needs are met in other community venues. Instead, the hub could act as a signposting centre or coordination point linking people to those resources.

End-of-life care, typically central to similar discussions, was not raised in this session. One participant noted its absence, suggesting palliative care deserves greater focus in future engagement. The need for hospice support or coordination with palliative care teams was identified as a follow-up item.

2.5 Transport and Access

Given the rural setting of Penley and its surrounding villages, transportation and access emerged as major considerations. Poor transport can negate the benefits of local healthcare facilities if patients, especially the elderly, cannot get there (or if staff cannot be recruited from farther afield due to commute issues).

2.5.1 Limited Public Transport

Participants described the local public transport as woefully inadequate. Penley village itself has only *"3 buses a day",* and *"surrounding villages have no buses"* at all. For those who cannot drive, this is a significant barrier to accessing any centralised service, whether it's in Wrexham town or in Penley. A community member asked whether there are any community transport schemes or local taxi services that could help, but it appears options are very limited. Transport poverty contributes to health inequality: people without cars in these rural areas struggle to attend appointments or visit relatives in hospital.

One consequence noted was the isolation of patients who end up in Wrexham Maelor Hospital, family and friends from villages like Penley often find it hard to visit due to distance and lack of transport.

"Isolation, of not having visitors when in the Maelor due to lack of transport, can affect outcomes,"

In other words, patients from rural areas may have worse recovery and wellbeing simply because they are cut off from their support networks during hospitalisation.

2.5.2 Impact of Driving Rules and Ageing:

The discussion also mentioned upcoming changes in driving regulations. *"New DVLA rules for the over-65s"* will require more frequent license renewals or health checks for older drivers, which participants fear will *"decrease the number of drivers in the rural area."*. In an area already heavily car-dependent, a significant portion of the population (seniors over 65) may soon face restrictions or challenges in driving themselves. This trend could further isolate older residents or make them reliant on family and community networks for transport. It underscores the importance of either bringing services closer to these residents or organising transportation solutions.

2.5.3 Travel Burden on Staff and Patients:

The current centralised model means not only patients, but also healthcare staff, have to travel long distances. Participants noted:

"We need to decrease the burden of travel for staff and for patients, and their families."

If more services (e.g., specialist clinics or therapy sessions) could be delivered locally at Penley or via outreach, it would save considerable time and expense for patients who currently travel to Wrexham, Llangollen or farther.

Similarly, health workers like community nurses or therapists spend a lot of time on the road covering a large rural patch; a hub might allow them to see more patients in one place or coordinate visits more efficiently. Reducing travel time is not just a convenience issue, it can improve access (more patients will use services if they are nearby) and potentially improve staff retention (jobs that don't require constant long drives might be more attractive).

2.5.4 Possible Solutions – Community and Digital:

While the fundamental lack of public transit is a challenge, participants brainstormed mitigating strategies. One idea was to create a “hub-and-spoke” model for services. In this concept, Penley might serve as the central hub, but certain services could be taken out to surrounding communities (the “spokes”) on a scheduled basis – for example, mobile clinics or regular visits by a district nurse to village halls. This would acknowledge that not everyone can come to Penley easily, so the service would occasionally go to them. Another suggestion was leveraging digital technology and telehealth to reach people at home. However, this was met with some scepticism: given the demographic, many felt that *“ageing population and dementia”* means high-tech solutions are not a complete answer. Some older residents may struggle with telemedicine or lack broadband access, and those with cognitive impairments benefit more from face-to-face contact. In short, digital interventions could *assist* (for instance, remote monitoring for certain patients or virtual consultations for those comfortable with them), but the consensus was that digital alone *“says no”* as a substitute for in-person services in this context.

Participants did emphasise exploring any existing community transport schemes, volunteer driver programs, or partnerships with local taxi firms as part of the solution. If a community hub is established, funding might be needed for a dedicated shuttle service or to reimburse volunteer drivers to get frail patients to and from the hub or hospital.

Accessibility was explicitly listed as a key criterion in evaluating options, meaning the physical location and design of services must be accessible (for disabled users, etc.) and realistically reachable for the target population. This may influence decisions such as offering multiple smaller hubs versus one central hub, or co-locating services in existing community centres to shorten travel distances.

In summary, transport is a critical concern for Penley’s future services. The participants made clear that without addressing access – either by bringing services closer to home, aiding with transportation, or supplementing with digital outreach – even the best-planned service models could fail the rural communities. Any chosen option will need an accompanying transport and access plan to ensure equity for those living in outlying areas.

2.6 Workforce Considerations

Any service change will depend on having the right workforce. Participants were keenly aware of workforce constraints and the need to make roles attractive and sustainable in a rural setting. In fact, “Recruitment and retention” of staff topped the list of essential criteria identified for evaluating options. Participants recognised that if Penley is to host new or expanded services, those services must be staffed appropriately – which has historically been challenging.

Workforce issues are central to Penley’s future. The community expects the Health Board to select an option that can be reliably staffed within current resources and provides a safe environment for staff, maximising patient benefit. Proposals needing significant new hires should consider recruitment challenges, while investing in

workforce development and innovative roles may offer strategic advantages. The focus remains on practical and sustainable staffing.

2.6.1 Staffing Challenges in Rural Areas:

Rural healthcare facilities often struggle to recruit clinicians, nurses, therapists, and care workers. Attendees highlighted this, making it clear that proposed options must be realistic about staffing. For example, if an option required 24/7 nurses for inpatient beds or a rotation of specialist doctors for clinics, is that feasible given the workforce supply? The criteria of *"maximum number of patients (scale)"* was mentioned alongside workforce and value-for-money considerations, suggesting participants want to maximise impact with the staff available – serving as many people as possible without compromising quality. Option B (inpatient beds) might score poorly on this, since running even a small ward is staff-intensive yet benefits relatively few patients at a time, whereas a hub with outpatient clinics could potentially reach more people with fewer staff.

2.6.2 Development and Support of Staff

"Development of staff" was listed as an important criterion. This suggests that participants, including health board staff, prefer models with training, career development, and professional support for employees. A community hub could, for instance, be a place where nurses or allied health professionals work in extended roles (gaining new skills) or where rotational programs bring in staff periodically (preventing professional isolation).

There was also mention of staff safety and security: any facility must ensure a safe working environment for staff (and of course patients). This is both a physical concern (e.g. adequate security measures if staff work alone or overnight) and a professional one (having sufficient colleagues or supervision so staff do not feel vulnerable or stressed).

2.6.3 Resource and Financial Considerations

While not strictly a workforce concern, participants associated staffing with the availability of resources and overall financial sustainability. They repeatedly brought up budget and value for money. There was a call for clarity on the budget envelope – *"need to understand [the] budget available",* before committing to an option.

This reflects that some options might be desirable but unrealistic if funding is insufficient for the required workforce or facilities. *"Value for money"* and *"best use of resources"* were explicitly flagged as decision criteria as well.

The community expects prudent use of funds, investing in solutions that yield the greatest benefit for the population served. A few participants were essentially analysing cost-effectiveness:

- If option A (community hub) can serve more people with a given staff and budget than option B (inpatient unit), then A was favoured.
- Similarly, a combined option might share resources across services for efficiency.

Ensuring any plan is financially and operationally sustainable (beyond the initial setup) is critical – tying back to the idea of being *"fit for the future / longevity of [the] option".*

2.6.4 Integration of Health and Care Workforce

The discussions also recognised that workforce extends beyond just NHS staff. Collaboration with social care and voluntary sector workers will be needed. For instance, to tackle home-care shortages, the health board might coordinate with the council on joint recruitment or new roles (like hybrid health-social care support workers). If volunteers are to play a role (Option C), they too need managing and supporting – effectively expanding the workforce with community assets but requiring coordination.

An additional consideration related to workforce concerns was raised in connection with domiciliary care staffing. The practice of requiring two individuals to complete specific home care activities (double-handling) was identified as an area that could be reassessed to enhance operational efficiency. Innovative workforce models or equipment that allow single-handed care could ease staffing pressures.

Additionally, having a local hub might improve staff efficiency by reducing travel (as mentioned earlier), allowing a given number of district nurses or therapists to see more patients instead of driving long distances between calls.

Participants emphasised that any option chosen should ensure or enhance care quality and outcomes, requiring a skilled and adequate workforce. "Outcomes of patients / quality of service" was a criterion on par with financial and workforce considerations.

Participants want assurance that the chosen model will deliver good results for patients (better recovery, health improvements, satisfaction) and that these outcomes will be measured and monitored. This is indirectly a workforce matter because good outcomes depend on having capable, well-supported staff in the right numbers.

2.7 Desirable Criteria

Following small group collaborative discussions, detailed above, a consensus session produced six 'desirable' criteria for evaluating service options to meet Penley's community needs.

These principles guided objective assessment of each option, leading to scoring and to select the most promising approaches for further development and public engagement.

The desirable criteria developed in the consensus discussions in the session were as follows:

1. **Sustainability and System Resilience:**
    a. Reduce pressures on the system.
    b. Future proof (avoid commissioning failure, not papering over the cracks.)
    c. Ensure there is a demand for the proposed services (including forecast demand.)
    d. Workforce recruitment, retention, development (applies to all.)
    e. Incorporates existing service delivery in the area.

f. Improve access to outpatient services e.g. physiotherapy (as much as possible)

2. **Prevention and Community Support:**
    a. Support prevention agenda.
    b. Support carers
    c. Help keep people at home / get home as soon as possible.
    d. Support local GP services – do not forget sustainability of local GP services in development / take account of GP referrals.
    e. Build on coordinate with existing service – avoid duplication.
    f. Take advantage of/work with existing assets in the area (thinking about their sustainability)
    g. Enable co-location of wellbeing services.
    h. Provides a community resource.
3. **Accessibility and Travel:**
    a. Accessibility of the site
    b. Reduce burden on people having to travel (patients/staff/carers/family)
4. **Safety and Security:**
    - Safety and security of staff/patients/visitors
5. **Clinical Outcomes:**
    - Improved patient outcomes
6. **Patient Experience:**
    - Improve patient experience.

NB: These criterion were developed by grouping the individual ideas and thoughts provided by each of the small groups into thematic clusters. The individual ideas are shown in the bulletpoints below the main criteria.

2.8 Criteria Weighting

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 Prevention and Community Support and Clinical Outcomes are viewed as highest priority for consideration, with Safety and Security seen as lowest priority.

Criterion	Weight (%)
Criterion 1 Sustainability and System Resilience	16.7%
Criterion 2 Prevention and Community Support	17.2%
Criterion 3 Accessibility and Travel	16.3%
Criterion 4 Safety and Security	16.0%
Criterion 5 Clinical Outcomes	17.2%
Criterion 6 Patient Experience	16.4%

3 SHORTLISTED OPTIONS

Applying the Desirable Criteria to the Medium List

3.1 Emerging Consensus on Future Service Options

After extensive discussion, stakeholders reached a broad consensus on which service options should be taken forward for further development and public engagement. In the scenario appraisal exercise, four options (A, B, C, D) were considered. While the details of each option were not exhaustively discussed in the notes, the general outlines were:

A. **Health and Wellbeing Hub (Integrated)**: repurposing the hospital as a multi-professional hub where health, social care and potentially voluntary sector teams co-locate. The aim is to improve access to outpatient and preventative services closer to home, reducing travel and creating a focal point for care in Penley.

B. **Rehab / Step-down Facility with Beds**: restoring a bed-based function at Penley, focused on rehabilitation, step-down care from acute hospitals and end-of-life support. This reflects community concerns about travel distances and the need for local recovery and respite beds.

C. **Third Sector Led Health and Wellbeing Hub**: combining the integrated hub model with an explicit leadership and delivery role for third-sector partners. The proposal builds on existing strengths in the local voluntary sector to deliver health, wellbeing, and social support alongside NHS-led services.

D. **Services in the Community (No Physical Building)**: redirecting resources away from maintaining a fixed site and investing instead in outreach and home-based services. This model prioritises flexibility and a "care closer to home" approach but carries risks if funding and workforce are not secured locally.

The sentiment in the room was clear:

- Options A, C, and D were favoured to move forward.
- Option B was overwhelmingly rejected.

In discussions, the group eliminated Option B from further consideration, noting that it represented…

> *"…what* [had] *already [been] done" before and was akin to "going back to what we had before, and it didn't work last time".*

- There was recognition that Option B (pure inpatient reopening) would serve few people, as only a limited number of beds could be staffed, and it would not address root causes like community care gaps.
- Some also pointed out that Option B was not a single concept but *"actually two distinct options"* – rehabilitation vs. step-down care – which *"made it hard to score"* in the appraisal. This further eroded confidence in B due to its lack of clarity and focus.

By contrast, Option A and Option C were seen as complementary and even intertwined. In discussion, stakeholders noted A and C are *"very similar"* or would naturally integrate. Option A proposes making the Penley facility a community hub,

while Option C includes voluntary and community sector leadership of service delivery in its offerings.

The consensus was to *"put our efforts now into A & C (and include D in there too)."* In other words, the preferred path is a blended approach: develop a hub at Penley that delivers a range of health and wellbeing services (Option A), build strong partnerships with the voluntary sector and community-based providers to augment these services (Option C), and incorporate any promising innovative approaches (Option D) to enhance access and efficiency. Indeed, many felt that **Option A could not succeed without Option C** (voluntary sector support) as noted earlier, and that some elements of D (like digital support or mobile outreach) could make the A/C model more effective.

It was acknowledged that options A and C open the facility to the community rather than "[just] *inpatient beds – which is only for a few".* This reflects a desire to use Penley in a way that benefits a broader cross-section of the population (e.g. through clinics, classes, and drop-in services) as opposed to a small number of inpatients at any given time. Stakeholders felt this would yield more health impact per resource invested, aligning with their criteria of scale and value.

Need for Clarity and Focus: Although the hub concept (A) is attractive, participants were cautious that it must be well-defined. *"Hub needs greater clarity – it means different things to different people,"* one comment noted. Before moving to the next engagement phase, they suggested doing a piece of work to **define the specific "offer" of the hub**. What exact services would it include? Which population groups would it target primarily? How would it operate alongside GP practices and Maelor Hospital? Without this clarity, there's a risk of over-promising. There was a *"danger of trying to deliver too much in a small space"*, so the hub needs a clear focus and prioritisation of services. Executives will need to consider capacity (both physical space and workforce) when deciding which services are core for the Penley hub. Stakeholders suggested focusing on areas of greatest need and impact for the community – which, based on the discussions, likely include intermediate care (rehab/respite), chronic disease management, preventive health, and co-located social support.

3.1.1 Unresolved Questions:

While dropping Option B was straightforward, combining A, C, and D raises some questions that stakeholders want addressed:

- **What mix of services?**
  There were calls for further definition of the range and mix of services under consideration:

  "What could we have in there [the hub]?"

  "…what is "doable / sustainable" on-site versus what should be delivered elsewhere."

  For example…

  "…could the hub include a small number of step-down beds for rehabilitation?"

Some felt a hybrid model could be possible:

"Could we have a little bit of all 4 options?"

One attendee suggested including a couple of beds, clinic space, and community outreach. This idea of a mixed model indicates the final option might not be a pure single option but a tailored blend. Clarity is needed on this point.

- **Scope of "digital" solutions:**
  Participants wanted to know…

  "…if incorporating Option D, to what extent will digital interventions be used?"

  There was scepticism about relying on telehealth for older patients, but digital could still play a role in supporting staff (e.g., sharing care records between agencies) or providing some remote services for more tech-savvy groups.

  Stakeholders didn't reject digital solutions but emphasise it must fit the needs of the demographic served.

- **Transport and accessibility plan:**
  Many participants asked how people will get to the hub from remote villages. Should a hub be established in Penley, future planning must address the needs of individuals residing outside of the immediate Penley area.

  "Will there be satellite clinics, transport assistance, or other accommodations?"

  This remains an open question.

- **Resource and staffing realism:**
  Participants want to see the budget and staffing analysis for the preferred option. Before final decisions, they expect transparency on costs (capital and revenue) and confirmation that the workforce can be secured. This was implicit in the criteria discussion: value for money, budget awareness, and sustainability must underpin the final proposal.

- **Outcome measurement:**
  Participants wanted to know how to measure outcomes to determine if the solution improves patient care.

  Decision-makers will need to build in an evaluation framework (e.g., track readmission rates, patient satisfaction, health outcomes in the area) for whichever option is implemented.

- **Public engagement on details:**
  It was agreed that once a more concrete model is sketched out, it should be tested with the wider public regarding the specific services and proposals.

  "It would be useful to hear what the public think".

  Participants acknowledged that the group in the room was relatively small and felt broader community engagement will validate whether the consensus aligns with public preferences.

For instance:

- If a hub is proposed, what services do residents most want to see in it?
- Are there concerns about any aspect?

Proactive engagement can help identify these issues.

- **Best practices from elsewhere:**
  Stakeholders were keen to understand…

  "…how these options have worked in other areas."

  There may be lessons from similar rural community hospital transformations elsewhere in Wales or the UK. This suggests researching case studies or inviting input from regions that have implemented community hubs, virtual wards, etc., to inform the Penley plans.

Despite these questions, there was a positive feeling about the consensus reached. As one person noted,

"Consensus in the room is good; people want to use a wider range of services."

This shows a collective interest in shifting from the old inpatient only model to a wider range of services, represented by Options A, C, and D.

3.2 Outcomes: Shortlisted Options

The scoring using these criteria, with the agreed weightings applied, produced the following results, with Options A, C and D forming the shortlist for further consideration. In summary the shortlist is:

- **Option A**: reopen Penley as a health and wellbeing community hub (with a range of outpatient, preventive, and some intermediate care services).
- **Option C**: invest in community/voluntary sector services (potentially without heavy use of the building, focusing on outreach and support in homes and communities.)
- **Option D**: other innovative solutions such as digital health, telemedicine, or distributed "hub & spoke" services, although the discussions suggest D involved some new element that could complement A and C.

These were scored using the following desirable criteria developed by participants in the session:

Criterion 1.	Sustainability and System Resilience
Criterion 2.	Prevention and Community Support
Criterion 3.	Accessibility and Travel
Criterion 4.	Safety and Security
Criterion 5.	Clinical Outcomes
Criterion 6.	Patient Experience

The table on the next page shows the individual criteria and total weighted scores.

	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Criterion 5	Criterion 6	Total (Weighted Scores)
Option A	**11.22**	**11.71**	**7.97**	**9.94**	**10.68**	**10.99**	**62.51**
Option C	**9.38**	**10.51**	**9.11**	**9.30**	**10.51**	**10.00**	**58.81**
Option D	**8.88**	**9.47**	**9.44**	**8.82**	**9.82**	**10.17**	**56.59**
Option B	8.37	7.23	8.46	8.34	8.96	8.86	50.22

Thank You

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