Better Together

Pre-Consultation Business Case

Adults Physical and Mental Health Community Services

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List of Acronyms and Abbreviations

Abbreviation	Full term / meaning
AHP	Allied Health Professionals
CHC	Continuing HealthCare
CCQI	College Centre for Quality Improvement
CMDS	Commissioning Minimum Data Set, subject to confirmation of the exact PTHB meaning
CMHT	Community Mental Health Team
COPD	Chronic obstructive pulmonary disease
COVID-19	Coronavirus Disease 2019
CRG	Clinical Reference Group
CSP	Clinical Service Plan
D&C	Demand and capacity
D2RA	Discharge to Recover and Assess
DBT	Dialectical Behaviour Therapy
DEXA	Dual-energy X-ray absorptiometry
DGH	District General Hospital
DHCW	Digital Health and Care Wales
ED	Emergency Department
EOL	End of Life
ePMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
GMS	General Medical Services
GP	General Practitioner
HAD	Hospital-associated Deconditioning
HCP	Healthcare professional
HEIW	Health Education and Improvement Wales
HLE	Healthy Life Expectancy
HTML	Hypertext markup Language
ICCS	Integrated Community Care System
IRCF	Integrated and Rebalancing Capital Fund
IV	Intravenous
JCC	Joint Commissioning Committee
LE	Life Expectancy

Abbreviation	Full term / meaning
LGBTQ	Lesbian, gay, bisexual, transgender, queer and other diverse sexual orientations and gender identities
LMC	Local Medical Committee
LOS	Length of stay
MDT	Multidisciplinary Team
MI&IU	Minor Injury and Illness Unit
MIU	Minor Injury Unit
MSK	Musculoskeletal
MWJC	Mid Wales Joint Committee
NHS	National Health Service
NHS Wales	National Health Service Wales
NICE	National Institute for Health and Care Excellence
OAMH	Older Adult Mental Health
OD	Organisational Development
ODEC	Organisational Development, Engagement & Communications group
ODG	Options Development Group
ONS	Office for National Statistics
PAVO	Powys Association of Voluntary Organisations
PCBC	Pre-Consultation Business Case
PCC	Powys County Council
PEP	Programme Engagement Plan
PICU	Psychiatric Intensive Care Unit
POCT	Point of Care Testing
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
RCEM	Royal College of Emergency Medicine
RIS	Radiology Information System
RPB	Regional Partnership Board
RTT	Referral to Treatment
PCIP	Primary Care Information Portal
PSB	Powys Public Services Board
PTHB	Powys Teaching Health Board
RJC	Regional Joint Committees
RCPSych	Royal College of Psychiatrists
SAS	Specialty and Specialist Doctor

Abbreviation	Full term / meaning
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SPOA	Single Point of Access
SRO	Senior Responsible Owner
STEEEP	Safe, Timely, Effective, Efficient, Equitable, Person-centred care
UCC	Urgent Care Centre
UEC	Urgent and Emergency Care
UHB	University Health Board
UK	United Kingdom
WAST	Welsh Ambulance Service NHS Trust
WHBN	Welsh Health Building Note
WIMD	Welsh Index of Multiple Deprivation
WTE	Whole-time equivalent
WVT	Wye Valley Trust

Glossary of Terms

Term	Definition / description
Major Acute Hospital	Provide a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions and which usually has an Accident and Emergency department.
Allied Health Professionals	Clinical professionals who provide assessment, diagnosis, treatment, rehabilitation and support to help people maintain or regain independence.
Backlog Maintenance	Building repairs and maintenance needed to bring an estate up to an appropriate condition and standard.
Better Together	Powys Teaching Health Board's programme for developing safe, sustainable and integrated future health and care services in Powys.
Business Case	A structured document setting out the rationale, options, costs, benefits, risks and evidence supporting a proposed change or investment.
Case for Change	The evidence and rationale explaining why change is required and why maintaining the current position is not sustainable.
Chronic Obstructive Pulmonary Disease	A group of long-term lung conditions that cause breathing difficulties and restricted airflow.
Clinical Oversight	Senior clinical leadership, supervision, decision-making and governance supporting safe care across services and pathways.
Commissioning	The process of assessing need and planning, arranging, funding and monitoring services, including services delivered by other providers.
Community Hospital	In-patient care provided does not require the highly technical specialist support of an acute hospital. In-patient care provided under the supervision of GP's, specialist doctors or nurses, may include a minor injury service and elderly mentally ill beds
Community Hospital Ward	A ward providing inpatient medical, nursing, rehabilitation or end of life care within a community hospital setting.
Community Wellbeing Hub	Locality-based network of health, care, wellbeing and community support services designed to support prevention, wellbeing and care closer to home.
Continuing Healthcare	A package of ongoing care arranged and funded by the NHS for a person assessed as having a primary health need.
Consultation Mark	A quality mark for the consultation process, with any award decision considered independently through the Centre for Consultation.
Coronavirus Disease 2019	An infectious disease caused by the SARS-CoV-2 virus, first identified in 2019. Also sometimes known as COVID 19.

Term	Definition / description
Crisis Resolution and Home Treatment Team	A specialist mental health team providing rapid assessment and intensive short-term support in the community during a mental health crisis.
Deliberative Event	A structured event where participants consider evidence, discuss different perspectives and provide informed feedback.
Delirium	A sudden state of confusion caused by an underlying physical illness or medical condition. Symptoms can include disorientation, difficulty concentrating, memory problems, agitation, drowsiness or changes in behaviour. Delirium is usually temporary but requires urgent medical assessment and treatment.
Demand and Capacity Modelling	Analysis comparing current and projected demand for services with the workforce, beds, facilities and other resources available to meet that demand.
Dementia Home Treatment Team	A community-based specialist team supporting people with dementia who have complex mental health needs, with the aim of avoiding admission where possible.
Diagnostics	Tests used to identify or monitor a disease, illness or health problem, including imaging, blood tests and point-of-care testing.
Discharge to Recover and Assess	A home-first approach supporting timely discharge once a person is medically optimised, with recovery and assessment of longer-term needs undertaken at home or in a community setting.
Discharge to Recover and Assess Pathway 1	A pathway for a person who can return to their usual place of residence with short-term health or care support and assessment at home.
Discharge to Recover and Assess Pathways 1B and 1C	Categories used in the demand and capacity modelling for people discharged home with rehabilitation or reablement support. Detailed eligibility and activity assumptions are set out in the supporting modelling.
Emergency Care	Immediate assessment and treatment for serious or life-threatening illness or injury.
Emergency Department	A hospital department providing assessment and treatment for serious injuries and medical emergencies.
Enhanced or Specialist Inpatient Mental Health Services	Specialist inpatient services for people whose needs cannot be safely met in a general mental health ward, including psychiatric intensive care and secure or specialist placements.
Excess Bed Day	An inpatient day beyond the applicable expected length-of-stay threshold, for which an additional charge may apply.
Financial Year	A 12-month accounting period used for budgeting and reporting. In the NHS and UK public sector this usually runs from 1 April to 31 March.

Term	Definition / description
Functional Mental Health Condition	A mental health condition not primarily attributable to an identified organic brain disorder, such as depression, anxiety disorder, bipolar disorder or psychosis.
Functional Mental Health Ward	An inpatient ward providing assessment and treatment for people experiencing an acute episode of functional mental illness.
General Medical Services	The contractual framework through which GP practices provide core primary medical services.
General Practitioner	A medical doctor working in primary care who provides first-contact care, diagnosis, treatment, prevention and referral to specialist services where required.
Healthy Life Expectancy	The average number of years a person can expect to live in good or very good health.
HICO Ltd	The independent consultancy commissioned to provide advice, challenge and assurance on the design and delivery of engagement and public consultation.
HM Treasury Green Book	HM Treasury guidance on the appraisal of policies, programmes and projects, including options, costs, benefits, risks and value for money.
Home First	An approach that prioritises helping a person return to, or remain in, their usual place of residence wherever this can be achieved safely.
Hospital at Home	Time-limited hospital-level assessment and treatment delivered in a person's usual place of residence as an alternative to admission or to support earlier discharge.
Hospital-Associated Deconditioning	A decline in physical, cognitive or functional ability associated with a hospital stay.
Hurdle Criteria	Minimum requirements that an option must meet before it proceeds to more detailed appraisal.
Inpatient Care	Care requiring a person to stay in a hospital or other healthcare facility for assessment or treatment.
Inpatient Rehabilitation Unit	A bedded service providing specialist rehabilitation following serious illness, injury or loss of function.
Integrated Care	Care planned and delivered collaboratively across services and organisations to provide coordinated, person-centred support.
Integrated Community Care System	A coordinated system of community-based health, care and wellbeing services designed around local population needs.
Integrated Health and Wellbeing Hub	A physical facility bringing together health, care, wellbeing and community services within a single building or campus.

Term	Definition / description
Integrated Impact Assessment	A structured assessment used to identify and consider the potential effects of a proposal or decision on people, communities, equality, quality and other relevant areas.
Intermediate Care	Time-limited integrated services that promote recovery, prevent avoidable admission, support timely discharge and maximise independent living.
Length of Stay	The duration of a person's admission to a hospital or other care setting, normally measured from admission to discharge.
Life Expectancy	A statistical estimate of the average number of years a person is expected to live.
Minor Injury Unit	A service providing assessment and treatment for injuries requiring urgent attention, but which are not life or limb threatening.
Minor Injury and Illness Unit	A service providing assessment and treatment for minor injuries and illnesses requiring urgent attention, but which are not life or limb threatening.
Multidisciplinary Team	Professionals from different disciplines working together to assess needs, agree care and coordinate support.
Musculoskeletal	Relating to muscles, bones, joints, ligaments, tendons and associated tissues.
NHS 111 Wales	A telephone and online health advice and triage service that helps people access appropriate care and support.
NHS 111 Wales, Press 2	A 24-hour route through NHS 111 Wales providing access to urgent mental health support.
Organic Mental Health Condition	A mental health condition associated with an identified physical or physiological cause affecting the brain, such as dementia or acquired brain injury.
Organic Mental Health Ward	An inpatient ward providing assessment and treatment for people whose mental health needs are associated with an organic brain condition, such as dementia or delirium.
Palliative and End of Life Care	Care that aims to improve quality of life, manage symptoms and support physical, psychological, social and spiritual needs for people with life-shortening illness, including care in the last phase of life.
Patient-Reported Experience Measures	Standardised tools that capture a person's experience of receiving care.
Patient-Reported Outcome Measures	Standardised tools through which patients report changes in health, function or quality of life following care or treatment.
Point of Care Testing	Diagnostic testing undertaken near the person receiving care to provide rapid results and support clinical decisions.

Term	Definition / description
Pre-Consultation Business Case	A planning document setting out the case for change, appraisal process and proposed options before formal public consultation.
Primary Care	First-contact health services, including general practice, community pharmacy, dentistry and optometry.
Primary Care Information Portal	A Digital Health and Care Wales (DHCW) information system that provides primary care reports and performance information for NHS Wales at practice, cluster, Health Board and national levels.
Proactive Prevention	Action taken early to improve health and wellbeing, reduce risk and prevent or delay illness, deterioration or avoidable use of urgent and hospital care.
Proactive Prevention and Wellbeing Hub	A multidisciplinary team providing proactive, preventative and coordinated care within local communities.
Ready to Go Home Unit	A short-term bedded service for a person who is medically ready to leave hospital but cannot yet return home safely.
Reablement	Short-term support helping a person regain skills, confidence and independence following illness, injury or a change in circumstances.
Rehabilitation	Interventions designed to optimise functioning, independence and participation and to reduce disability.
Rural Regional Centre	A location intended to provide a broader range of health and care services for a larger geographical area within Powys.
Same Day Emergency Care	Assessment, diagnosis and treatment delivered on the same day for people who might otherwise require hospital admission.
Sanctuary or Safe Place	A non-admission service providing a safe and welcoming space for de-escalation, brief support and onward referral for people experiencing emotional or social distress.
Scenario A	The modelled do-nothing position used as a baseline comparison.
Scenario B	The modelled realistic and achievable scenario used in demand and capacity modelling.
Scenario C	The modelled more aspirational and radical scenario used in demand and capacity modelling.
Service Level Agreement	A formal agreement describing the service to be provided and the standards, costs or responsibilities that apply.
Single Point of Access	A central route for receiving, triaging and coordinating referrals so people are directed to the most appropriate service.
Step Down	Movement to a lower-intensity care setting or service when a person no longer requires the current level of support.

Term	Definition / description
Step Up	Movement to a higher level of care or support because a person's needs have increased.
Targeted Proactive Prevention	Coordinated early support for people with established conditions or rising risk, intended to prevent deterioration, crisis, admission or increased care needs.
Temporary Service Change	A non-permanent change to the way a health service is configured or delivered.
Therapeutic Environment	A care setting designed to support safety, dignity, wellbeing, engagement and recovery.
Transport Hub	A key transport interchange or service centre within the Powys transport network.
Trim Point	The expected length-of-stay threshold used for a hospital spell. Bed days beyond this threshold are excess bed days and may attract an additional charge.
Urgent Care	Healthcare services provided for illnesses, injuries, or conditions that require prompt assessment and treatment but are not immediately life-threatening.
Urgent Care Centre	A service that provides timely, same day assessment and treatment for urgent illnesses and injuries that are not life-threatening, helping patients access the right care without attending an Emergency Department when appropriate.
Urgent Community Response	A service that provides rapid assessment and care for people with urgent health needs in their own home, helping to avoid unnecessary hospital attendance or admission.
Virtual Ward	A service model supporting people outside a hospital ward through multidisciplinary oversight, planned review and, where appropriate, remote monitoring.
Welsh Index of Multiple Deprivation	The official measure of relative deprivation for small areas in Wales.
Whole-Time Equivalent	A standard measure expressing total working hours as the equivalent number of full-time posts.
Years lived with Disability	A measure of time lived in less than full health due to disease, injury or disability.

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Executive Summary

Powys Teaching Health Board's Better Together programme is a long-term programme of service transformation designed to ensure local health and care services remain safe, sustainable and able to meet the needs of future generations. This Pre-Consultation Business Case (PCBC) sets out the Case for Change and the proposed options for the future delivery of adult physical health, urgent care and mental health services across Powys. It seeks approval to proceed to formal public consultation before any final decisions are made.

In considering the proposed changes, it is important to recognise that they would not happen all at once; subject to the outcome of consultation and subsequent decision-making, implementation would be phased over several years, with some options extending beyond 5 years. This Pre-Consultation Business Case describes a strengthening of community services; the pace and sequencing of change reflect the scale and complexity of the proposals and would depend on the necessary workforce, community capacity, infrastructure and other enabling arrangements being in place. Indicative phasing for each option is provided within the relevant service sections of Section 6.

Why Change is Needed

Powys has one of the oldest populations in Wales and demand for health and care services is increasing. More people are living with multiple long-term conditions, frailty and complex physical and mental health needs. At the same time, health services face difficulties with sustaining services, significant workforce challenges, ageing estate infrastructure, increasing financial pressures, and growing difficulties sustaining services and meeting clinical standards across multiple sites. Avoidable long lengths of stay for inpatients is causing harm.

Analysis undertaken through the Better Together programme demonstrates that while current services continue to provide high-quality care, maintaining the current model unchanged will not be sustainable in the future or meet population health needs. The evidence demonstrates a need to strengthen community-based services, improve workforce resilience, reduce avoidable hospital use and ensure inpatient services remain safe and sustainable.

What Would Stay the Same

A significant proportion of services would continue to be delivered locally across Powys.

Under all options:

- Community hospitals would continue to play an important role in care delivery.
- Community nursing, therapies, rehabilitation, primary care and social care services would continue to be provided throughout the county.
- Planned care services would continue to be delivered through a network of local facilities.
- More care would be delivered in people's homes through enhanced community and Hospital at Home services.
- Services would continue to be organised around the health needs of local communities and localities.

What Would Change

The proposals would move Powys towards a community-first model of care.

This would include:

- Expanded prevention, early intervention and proactive care.
- Greater use of Hospital at Home and intermediate care services.
- Enhanced urgent care services closer to home.
- Improved discharge and rehabilitation pathways.
- Earlier access to mental health support and crisis intervention services.
- Stronger integration between physical health, mental health and community services.

The intention is to enable more people to remain independent for longer, receive care closer to home and avoid unnecessary admission to hospital where this is clinically appropriate. The anticipated benefits from these proposals are shown below:

Figure 1: Summary of expected benefits from the proposals

Benefit theme	Benefit expected from the proposals
Patient Quality, safety and outcomes	Care is more person-centred, coordinated and trauma-informed, supporting better outcomes, improved safety and an improved experience for patients, carers and families.
	Earlier intervention, rehabilitation and reablement reduce deconditioning, support independence and help people avoid escalation to long-term care where possible.
Access to services	More people are supported safely in or near their own home, reducing avoidable conveyance, hospital attendance, admission and out-of-county care.
	People receive a clearer, faster and more equitable response through simplified access routes, consistent pathways and timely assessment and treatment.
Joined up Care	Physical health, mental health, social care, third sector and partner services work together around the person, improving continuity across prevention, urgent response, rehabilitation and end of life care.
End of life choice	People on end of life or palliative care pathways have better support and greater opportunity to receive care and die in their preferred place where this can be achieved safely.
Financial sustainability	Prudent and sustainable use of limited financial resources.
Sustainable workforce	Prudent and resilient services by making better use of skills, advanced practice roles, available capacity and digital opportunities, while reducing fragility associated with small, dispersed teams and reliance on temporary staffing.

The Options Being Considered

Following extensive engagement, option development and appraisal and assurance, as detailed in the Step Report at Appendix Z.5, a small number of credible options have been shortlisted for public consultation. These differ primarily in how inpatient beds, urgent care services and specialist functions are organised across Powys.

Figure 2: Summary of proposed options for consultation

Option Reference	Option Description
Physical Health	
PH005b	Fewer community inpatient beds reduced to 3 sites, with enhanced community model and better join up with mental health
PH008	Even fewer community inpatient beds reduced to 2 sites, with enhanced community model and better join up with mental health
Urgent Care & Diagnostics	
UC013	Local Urgent Care Centres at 2 sites and Minor Illness and Injury Unit at 1 site
UC013ii	Local Urgent Care Centres at 2 sites
Mental Health	
MH006a	All functional and organic inpatient beds at 1 site with enhanced care and strengthened community model

The options proposed for consultation are not presented in order of preference and should not be interpreted as preferred options. Approval of this PCBC would constitute approval to undertake consultation on the options rather than approval to implement any specific option. Formal consultation will provide an opportunity for patients, service users, staff, partners, stakeholders and the wider public to consider the proposed options, their benefits, disadvantages and impacts, the assumptions underpinning them, and any alternative approaches that should be considered before a final decision is made. Consultation responses, alternative proposals, updated impact assessments and any additional evidence gathered through the consultation process will be conscientiously considered before any future recommendation is developed through a subsequent Final Programme Business Case.

Community Hospital and Physical Health Services

All shortlisted options include significant investment in community services, proactive care and intermediate care, including urgent community response, reablement, rehabilitation and Hospital at Home models. The principal difference between the options relates to the number and configuration of community hospital inpatient sites and beds. The options seek to balance local access with the need to maintain safe, sustainable and resilient services that can attract and retain staff and consistently meet standards of care.

Urgent Care

All options include the development of enhanced Urgent Care Centres (UCCs) capable of assessing and treating a broader range of non-life-threatening urgent conditions closer to home and reducing the need to travel to services outside of Powys. The key distinction between options is whether these services are concentrated across two or three locations. The options therefore present different balances between local accessibility and the concentration of workforce, diagnostics and specialist expertise.

Mental Health

All options include significant investment in community mental health support, crisis response, open access models, 111 press 2, virtual services and alternatives to admission such as sanctuary services. The options propose the consolidation of adult and older adult mental health (OAMH) inpatient care onto a single inpatient site, alongside strengthened community provision across all parts of Powys. The objective is to improve quality, patient experience, workforce sustainability and clinical resilience while reducing avoidable admissions and out-of-county placements.

What the Proposals Could Achieve

The future proposals could:

- Support significantly more people to receive care at home or closer to home.
- Reduce avoidable hospital admissions.
- Enable earlier discharge from acute hospitals.
- Reduce patient deconditioning associated with long hospital stays.
- Improve access to urgent care within Powys.
- Strengthen mental health crisis and community support.
- Improve workforce resilience and service sustainability.
- Reduce reliance on temporary staffing and support more consistent care delivery.
- Improve the longer-term financial sustainability of services.

Understanding the Impacts

The Health Board recognises that some of the options may result in changes to how people access services and may increase travel requirements for some patients, visitors and staff. Detailed assessments have therefore been undertaken covering travel and transport, equality, Welsh language, socio-economic impacts, community impacts, workforce considerations and environmental effects. These impacts, together with proposed mitigations, will form an important part of the public consultation.

No Decisions Have Been Made

The purpose of this PCBC is to present the evidence, explain the available options and seek approval to consult. No final decisions have been made. Following consultation, the Health Board will carefully consider all feedback alongside updated evidence and impact assessments before reaching any decision on the future configuration of services.

1. Introduction

1.1 Purpose of the Pre-Consultation Business Case

The purpose of the Pre-Consultation Business Case (PCBC) is to support the Board in determining whether the proposed options are sufficiently developed and evidenced to proceed to formal public consultation. It does not seek approval to implement any option. No final decision on the future configuration of services will be made until consultation responses, alternative proposals, updated impact assessments and any further evidence have been conscientiously considered.

The PCBC has been structured to enable readers to follow the route from the need for change to the proposed consultation options. It describes the strategic, population and operating context within which the proposals have been developed;

- **Section 2** describes the strategic, operating and population context.
- **Section 3** summarises the evidence-based Case for Change.
- **Section 4** explains how options were generated, refined, assessed and assured.
- **Section 5** describes the overarching future model and summarises the options proposed for consultation.
- **Sections 6 to 8** provide the detailed service-specific evidence, models, options, appraisal findings and potential impacts for physical health, urgent care and mental health.
- **Section 9** identifies the principal dependencies and enablers for delivery.
- **Section 10** sets out the proposed approach to formal public consultation.
- **Section 11** presents the recommendations to the Board.

The PCBC is part of a wider evidence base and does not include full details of the options development and appraisal process. It should be read alongside the Step Report, Integrated Impact Assessments, other technical reports including engagement evidence and service-specific supporting documents listed in the appendices.

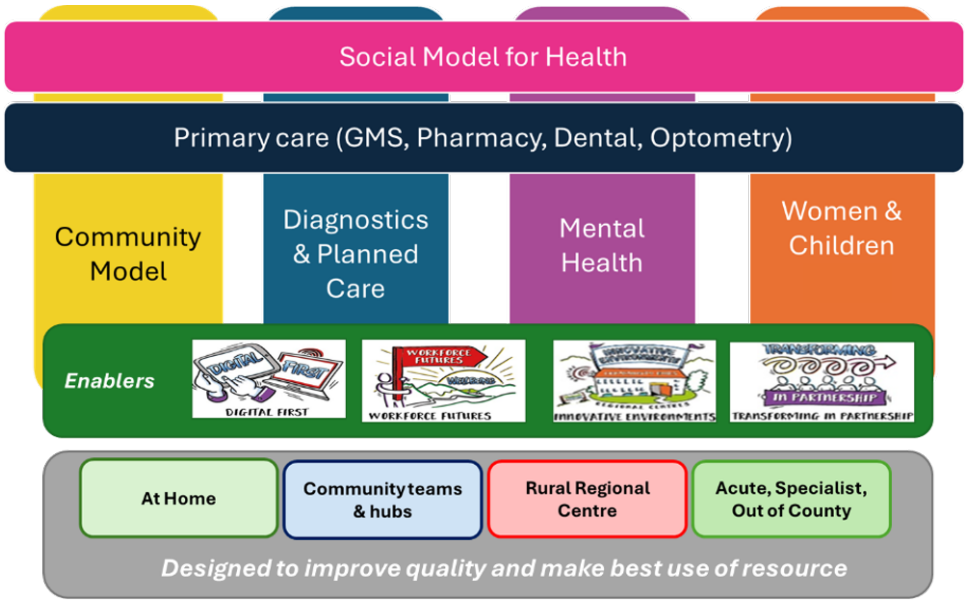
1.2 What is Better Together

Better Together is the Health Board's transformation programme for delivering the ambitions of A Healthy Caring Powys and the Integrated Model of Care and Wellbeing. It provides the framework for developing safe, sustainable and high-quality health and care services across Powys, while making better use of available resources to improve outcomes, reduce variation and ensure services remain sustainable for future generations.

Better Together seeks to address the challenges identified in the Case for Change, including workforce fragility, service sustainability, access to care and reliance on services outside Powys. It supports delivery of the Health Board's Clinical Services Plan, financial recovery objectives and wider organisational priorities.

The programme is guided by the principles of the Health and Care Strategy: Do What Matters, Do What Works, Offer Fair Access, Focus on Greatest Need, Be Prudent and Work with the Strengths of People and Communities.

Figure 3: Better Together



In 2024, the Health Board refreshed and strengthened its clinically led transformation programmes covering frailty and community services, diagnostics and planned care and mental health. These programmes provide the broader strategic framework within which Better Together is being delivered and support future planning across the full range of health and care services.

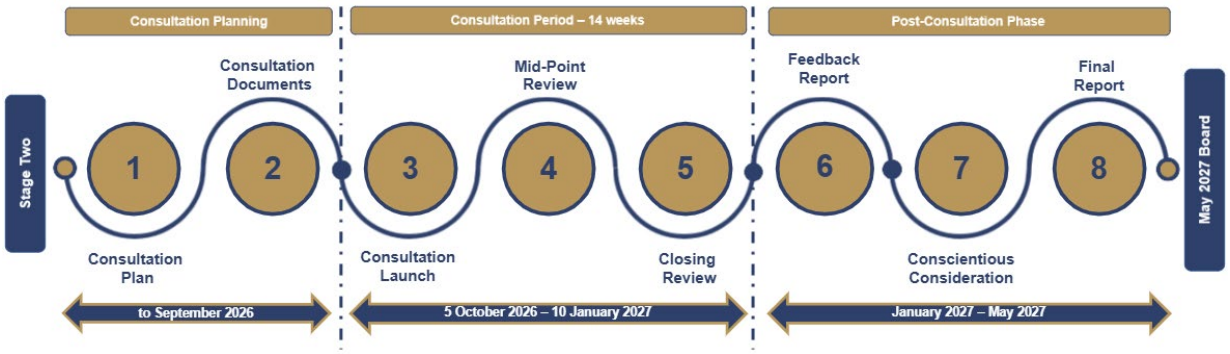
A clinically led transformation programme for Women and Children's Services will support future phases of Better Together. While this programme is not yet established, the service continues to deliver improvement and transformation objectives through the Annual Plan.

Given the scale of transformation required, and the timetable associated with the Senedd elections in May 2026, the Health Board adopted a phased approach to Better Together. In March 2025, Adult Physical and Mental Health Community Services were confirmed as Phase 1. This reflected the urgency of addressing known quality, workforce, sustainability and access challenges. It also reflected feedback from patients, carers, communities, staff, partners and stakeholders who consistently raised concerns about service sustainability, access to care, workforce pressures and temporary service changes.

1.2.1 Phasing Timeline

Better Together has been structured to enable phased transformation across the wider health and care system. The timeline for Phase 1 consultation is shown below

Figure 4: Phase 1 Adults Physical and Mental Health Consultation Timeline



Future phases will include Planned Care and Women and Children's Services. These services are not subject to options development, appraisal or consultation as part of this PCBC.

Future options development for these services will be undertaken through separate programme governance, engagement and business case processes at the appropriate stage under Better Together. Although formal options engagement for future phases is not expected to commence until Phase 1 consultation and decision-making are complete, service improvement activity and informal engagement will continue as part of ongoing programme development and annual plan delivery.

1.3 Scope of Proposals

This PCBC relates only to Phase 1, covering:

- adult physical health community and inpatient services;
- adult inpatient and older OAMH community services;
- urgent care services; and
- the diagnostic provision directly associated with the urgent care options.

The proposals include service pathways, workforce and operating models, community provision, inpatient capacity and the potential location of specified services. Some urgent care activity for children falls within the scope. However, the broader transformation of women's and children's services is outside the scope of this PCBC. Further detail on the scope is provided in Figure 5.

Figure 5: Adult Physical and Mental Health Community Services Scope

Adult Physical Health Inpatient and Community Based services	Inpatient care, which includes our community hospital inpatient wards including stroke rehabilitation, ready to go home units, palliative and end-of-life care Our teams in the community include those teams which may visit someone at home to provide support and treatment and work closely with primary care and third sector partners. These include District Nursing, Home First and Falls Prevention teams, as well as services where you might have an appointment either in person or online, for example condition specific teams, therapies.
Urgent Care and Diagnostics	This includes looking at how we meet urgent care needs in the future, including the Minor Injury Units and diagnostics (i.e. imaging, blood tests), urgent care community response, and step up care. This includes services that the health board directly provides and some services that we commission with GP practices and acute hospitals.
Adult Mental Health Inpatient and Community Based services	Single 'front door' to access mental health services Our teams in the community that support older adults and inpatient care. Adult inpatients (functional and organic)

The following areas are not being determined through this Phase 1 PCBC:

- Planned care (including outpatients, surgical day case and endoscopy).
- The comprehensive future model for diagnostic services.
- Women and Children's services (including early years interventions that directly relate to adult physical and mental health such as Healthy Schools Programme, vaccination, the Whole School Approach to Physical and Mental Wellbeing, and Integrated Family Centres).
- The commissioning configuration of acute emergency and elective hospital services outside Powys; but does include opportunities to improve patient pathways including potential repatriation.
- Directly contracted primary care services, including out-of-hours services.
- Social care.
- Third sector services, including community and voluntary organisations.

These services nonetheless have important interfaces and interdependencies with the Phase 1 proposals. Primary care, social care, third sector and externally commissioned services, including Welsh Ambulance Service NHS Trust (WAST), and the Joint Commissioning Committee (JCC) have informed option development. They will remain important partners in any future implementation.

1.3.1 Temporary Service Changes

Several services currently operate under temporary arrangements. These arrangements have been incorporated into the baseline assessment and considered during the option development. Their inclusion within the baseline does not imply that the temporary arrangements are considered permanent.

Figure 6: Temporary Service Changes

Temporary Service Changes	Description
Hospital day services	March 2020. Hospital day services closed due to impact of pandemic leading to change of pathways and re-purposing of the units in Newtown, Machynlleth, Llanidloes, Bronllys, Ystradgynlais and Brecon.
Minor Injury services	Temporary service changes have been driven by low demand at night and being unable to maintain safe staffing resulting in ad hoc minor injury unit (MIU) closures and an unpredictable service offer for the population. Prior to 2017, Welshpool, Llandrindod Wells and Brecon MIU operated a 24/7 model. In 2017, Llandrindod Wells hours reduced to 07:00-00:00 In 2020, Welshpool hours reduced to 08:00-20:00 In 2024, Llandrindod Wells and Brecon hours reduced to 08:00-20:00
Crug Ward, Brecon	Closed March 2020 to act as a surge ward to help manage the impact of the pandemic. During this period, staff who had been redeployed secured permanent roles in other teams, retired, or left the organisation, which meant the ward was unable to reopen. Alternative arrangements and pathways to the two remaining Older Adult Wards were put in place.
Panpwnton Ward, Knighton	Closed March 2020, unable to maintain safe staffing during the pandemic.
Graham Davies Ward, Llanidloes	December 2024, admission criteria changed to Ready To Go Home Unit.
Llewellyn Ward, Bronllys	December 2024, admission criteria changed to Ready To Go Home Unit.
Brynheulog Ward, Newtown **Epynt Ward, Brecon**	December 2024, admission criteria changed to Rehabilitation Unit.

The appraisal included both “do current” and, where relevant, “do previous” baselines so that the proposed options could be compared with current temporary arrangements and with the position before those arrangements were introduced. Although these baseline options did not meet all essential hurdle criteria, they were retained as comparators to support transparency and informed consultation.

1.3.2 The Types of Changes We Are Exploring

The work considers how pathways and services could be strengthened, integrated or organised differently to improve quality and outcomes and respond to the challenges identified in the Case for Change.

The table below summarises the main questions we are considering through Phase 1. These questions supported the generation of a broad range of ideas and options. They do not represent decisions about the future configuration of services.

Figure 7: Adult Physical and Mental Health Community Services changes

Service area	Description

Adult Physical Health Inpatients and Community-Based Services	• How services in the community can be strengthened to better support people at home, reduce admissions and prevent harm. • What community inpatient services are required in the future to best meet the population needs, the size of these units and where they are located.
Urgent Care and Diagnostic	• How urgent care services could be enhanced and organised differently to provide a more resilient local service offer and reduce the need for people to travel outside Powys, where safe and appropriate. • How many UCCs are required in Powys and where they should be located. • How access to diagnostics could be improved and organised in future
Adult Mental Health Inpatient and Adults Community Based Services	• How services in the community can be strengthened to better support people at home and prevent needs from escalating. • What mental health inpatient services are required in the future to best meet population needs, the size and therapeutic environments of these units and where they are located.

The proposed future models and consultation options arising from this work are summarised in Section 5 and described in detail in Sections 6 to 8.

1.3.3 Principles for Future Service Design

Due to the rurality of Powys, when we design services to meet future population health needs, we must consider how best to deliver them in our rural environment to ensure we have the right levels of patient activity to maintain staff skills and capabilities. The following design principles were therefore agreed at the beginning of Phase 1 to support clinical teams and stakeholders in considering whether services should be provided at home, in a locality or community or at a regional level within Powys, whether they are best provided out of county to ensure a clinically safe service.

Figure 8: Design Principles

Level	Description
Home	Some services can be delivered safely and effectively in people's homes. This includes health and care staff who visit you to provide services at home. It also includes online and telephone services, as well as tools to help you manage your own care at home.
Locality /Community	Some services can be provided locally within the community you live in. For example, General Practitioner (GP) primary care services are provided in all 13 localities in Powys. The 13 localities are Brecon, Builth & Llanwrtyd, Crickhowell, Hay & Talgarth, Knighton & Presteigne, Llandrindod & Rhayader, Llanfair Caereinion, Llanfyllin, Llanidloes, Machynlleth, Newtown, Welshpool & Montgomery, Ystradgynlais.
Cluster	Some services need to be provided at a "regional" level within Powys. They may need specialist equipment and staff that is best provided in a single location serving a larger population. For example, we currently provide day surgery and endoscopy in Brecon and Llandrindod Wells. We also have an ambition to provide these services in Newtown in future as part of the North Powys Wellbeing programme. Cluster Regions are North, Mid and South.
Once for Powys	Some services can safely be delivered within the county, however, because they are much more specialised in nature, they may need to be provided from a single location or by a centralised team serving all Powys residents. For example, Felindre Ward in Bronllys is currently our adult (18-64) mental health admissions unit.

Outside the county	The rural and sparsely populated nature of Powys means that some services cannot be safely delivered within the county, due to their highly specialised nature. For example, we access District General Hospital (DGH) services in neighbouring counties in both England and Wales.

Note: Since agreeing the design principles, the primary care clusters are now operating as two clusters in the north and south/mid of the county.

These principles describe the levels at which different services could appropriately be delivered in the future. They informed the development of service models, options and appraisal criteria.

1.3.4 What this PCBC Does, and Does Not, Seek to Decide

This PCBC concerns potential future models, pathways and configurations for services within Phase 1. It does not claim that changes to service configuration alone will resolve all of the wider challenges facing health and care in Powys.

The proposed options form part of a broader strategic response that includes:

- preventing ill health and reducing inequalities.
- strengthening primary and community care.
- improving the way services are commissioned.
- developing the workforce.
- improving productivity, coordination and patient pathways.
- strengthening digital and data capability.
- investing in appropriate buildings and infrastructure.
- working with local authority, primary care, third sector, ambulance and neighbouring National Health Service (NHS) partners.

The contribution of the Phase 1 proposals will depend on whether the associated service pathways, workforce, investment, digital capability, partner capacity and implementation arrangements can be delivered in practice. These dependencies and the further work required are described in Section 9.

The options should not therefore be interpreted as a fixed long-term configuration that could not change in response to future evidence. Any future implementation would require continuing review of demand, outcomes, workforce, technology, clinical standards, affordability and population health needs.

1.4 How the Consultation Options Emerged

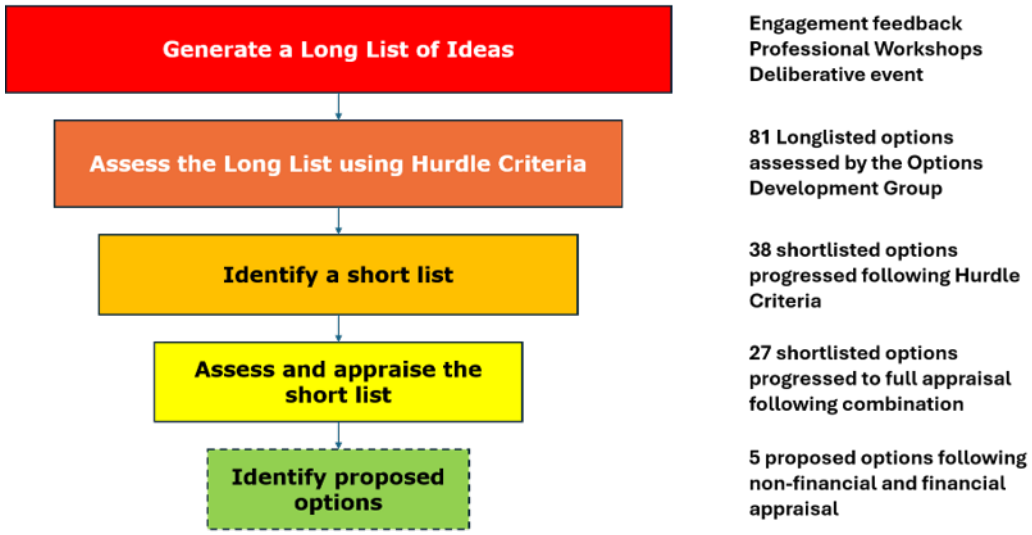
The options proposed for consultation were not developed from a predetermined configuration or preferred solution. Instead, they emerged through a structured and evidence-based process informed by the Case for Change, stakeholder engagement, clinical and professional input, technical analysis, appraisal and assurance. The process was designed to ensure that options reflected population health needs, addressed the challenges identified through the Better Together programme and could be assessed consistently against agreed criteria.

The development process included the generation of a long list of ideas and options, application of hurdle criteria, option refinement, appraisal and assurance. Evidence from engagement, modelling, impact assessments and clinical review informed progression through each stage. Options that did not meet the

agreed criteria or were shown to be less effective in addressing the identified challenges, were discounted through the process.

Figure 9 provides a summary of the process. Full details of option development, appraisal, assurance arrangements, progression decisions and discounted options are provided in Section 4 and the supporting Options Development Step Report.

Figure 9: Options development and appraisal process



1.5 Governance and Assurance Overview

Phase 1 of Better Together was developed through established programme governance arrangements, including the Better Together Portfolio Board, Programme Boards, Clinical Reference Group (CRG) and supporting clinical, professional and technical groups. These arrangements provided oversight, challenge, assurance and decision-making throughout the development of the proposals.

Independent review and assurance activities were used to support the robustness of the process and the evidence informing the proposed consultation options.

Full governance structures, group responsibilities, progression decisions and assurance activities are described in Section 4 and the supporting Step Report.

1.6 Relationship between the PCBC, Step Report and Consultation Materials

The PCBC, Step Report and consultation materials have different but complementary purposes.

The PCBC presents the Case for Change, future service models, consultation options, potential impacts and key dependencies. It provides the information required to support a decision on whether formal consultation should proceed.

The Step Report provides the detailed audit trail underpinning option development, appraisal, engagement, governance and assurance activities.

The consultation materials provide the proposals and are intended to support patients, carers, staff, stakeholders and the wider public to consider the options and provide feedback through the consultation process.

Approval of this PCBC would authorise consultation only and would not approve implementation of any option. Consultation responses, alternative proposals, updated impact assessments and any additional evidence gathered through the consultation process will be conscientiously considered before any future decision is made.

2. Strategic Context & Powys Population

2.1 National Policy and Legislative Context

Healthcare services in Wales operate within a national legislative, policy and planning framework established by the Senedd and Welsh Government. The future models of care described in this PCBC have been developed within this framework and seek to support delivery of national priorities for health and care.

2.1.1 National Vision for Health Care

National policy in Wales promotes a whole-system approach to health and care that focuses on improving wellbeing, preventing ill health and supporting people to live independently for as long as possible.

A Healthier Wales[1] sets out the long-term vision for health and social care in Wales. It promotes seamless services organised around people's needs rather than organisational boundaries and seeks to shift the balance of care towards prevention, early intervention, community-based support and improved population health.

This direction is reinforced through Welsh Government's emerging *Community by Design*[2] approach, which supports proactive, integrated and community-based models of care, supported self-management and services planned around people and communities. It promotes hospital care being reserved for people with more complex or escalating needs and supports stronger links between prevention, primary care, community services, social care and specialist services.

The *Well-being of Future Generations (Wales) Act 2015*[3] complements this approach by requiring public bodies to take a longer-term view, work collaboratively, prevent problems occurring or worsening, reduce inequalities and improve the economic, social, environmental and cultural wellbeing of Wales.

Together, these policies establish the strategic direction for health and care services in Wales, emphasising prevention, population health improvement and care delivered as close to home as possible.

2.1.2 Quality, Sustainability and Service Planning

National planning and quality frameworks require health boards to ensure services are safe, effective, sustainable and capable of delivering high-quality outcomes for patients.

[1] A healthier Wales: long-term plan for health and social care | GOV.WALES
[2] https://phw.nhs.wales/app/uploads/sites/2/2025/11/Community-By-Design.docx
[3] Well-being of Future Generations (Wales) Act 2015

The *NHS Wales National Clinical Framework*[4] provides the strategic basis for developing clinically sustainable services and improving health outcomes through evidence-based service planning, consistent standards and collaboration across clinical networks. A National Clinical Plan is currently being developed and will ultimately replace the Framework.

The annual *NHS Wales Planning Framework*[5] and associated *Performance Framework*[6] establish the priorities, expectations and performance requirements for NHS organisations in Wales. These include improving quality, addressing inequalities, strengthening community-based services, improving access to care and ensuring financial sustainability.

The *Health and Social Care (Quality and Engagement) (Wales) Act 2020*[7] places a statutory Duty of Quality on NHS bodies, requiring quality to be embedded throughout decision-making and the continuous improvement of services and outcomes for the population. The Act also establishes the Duty of Candour, requiring NHS bodies to be open and transparent when a person experiences harm arising from the care they receive.

Together, these frameworks require health boards to maintain clinically sustainable, financially viable and high-quality services.

2.1.3 Partnership, Population Health and Integrated Care

National policy also places increasing emphasis on partnership working, strengthening primary and community care, improving population health and delivering more integrated services.

The *Social Services and Well-being (Wales) Act 2014*[8] promotes wellbeing, independence, prevention and person-centred care. It requires health and social care organisations to assess population needs, work through Regional Partnership Boards (RPB) and deliver integrated services that support people to live well and remain independent.

The *Social Partnership and Public Procurement (Wales) Act 2023*[9] reinforces the importance of social partnership, workforce engagement and collaborative decision-making in the planning and delivery of public services.

The *Primary Care Model for Wales*[10] and the *Integrated Community Care System*[11] *(ICCS) for Wales* support a greater emphasis on prevention, proactive care, integrated community services and primary care as the front door to health and care services.

For urgent and emergency care (UEC), national policy is informed by the *Six Goals for Urgent and Emergency Care*[12] and associated improvement programmes, which promote a whole-system approach to ensuring people receive the right care, in the right place, first time.

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[4] National Clinical Framework 8.0
[5] NHS Wales planning framework 2025 to 2028 | GOV.WALES
[6] NHS Wales performance framework 2026 to 2027 | GOV.WALES
[7] health and social care quality and engagement wales act summary
[8] Social Services and Well-being (Wales) Act 2014
[9] Social Partnership and Public Procurement (Wales) Act | GOV.WALES
[10] Primary Care Model for Wales - Public Health Wales
[11] Towards an integrated community care system
[12] NHS Wales - six goals uec

For mental health services, the *Mental Health and Wellbeing Strategy 2025-2035*[13] the *Strategic Framework for Mental Health* and *Understanding: A Suicide Prevention and Self-Harm Strategy*[14] *for Wales* promote prevention, early intervention, trauma-informed care, integrated pathways and timely access to support.

2.1.4 Relevance to Better Together

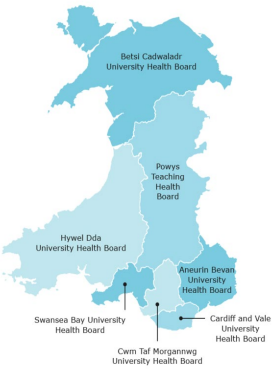


Figure 10: Map of the Health Boards in Wales

These national policies and legislative duties establish the strategic direction for health and care services in Wales and provide an important framework for the development of Better Together. They reinforce the need for prevention, reducing health inequalities, community-based care, partnership working and clinically sustainable service models.

2.2 Local Strategic Context

The Health Board has a statutory duty to continuously improve the quality of health services and outcomes for the population under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. It must also discharge its responsibilities under the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014, which together emphasise long-term planning, prevention, integration, collaboration, person-centred care and sustainable services. These duties align with the vision set out in *A Healthier Wales,* which promotes a whole-system approach focused on prevention, early intervention, seamless health and social care services and delivering more care closer to home. These duties align with the vision set out in *A Healthier Wales*, which promotes prevention, early intervention, integrated health and social care services and delivering more care closer to home.

2.2.1 Health and Care Strategy

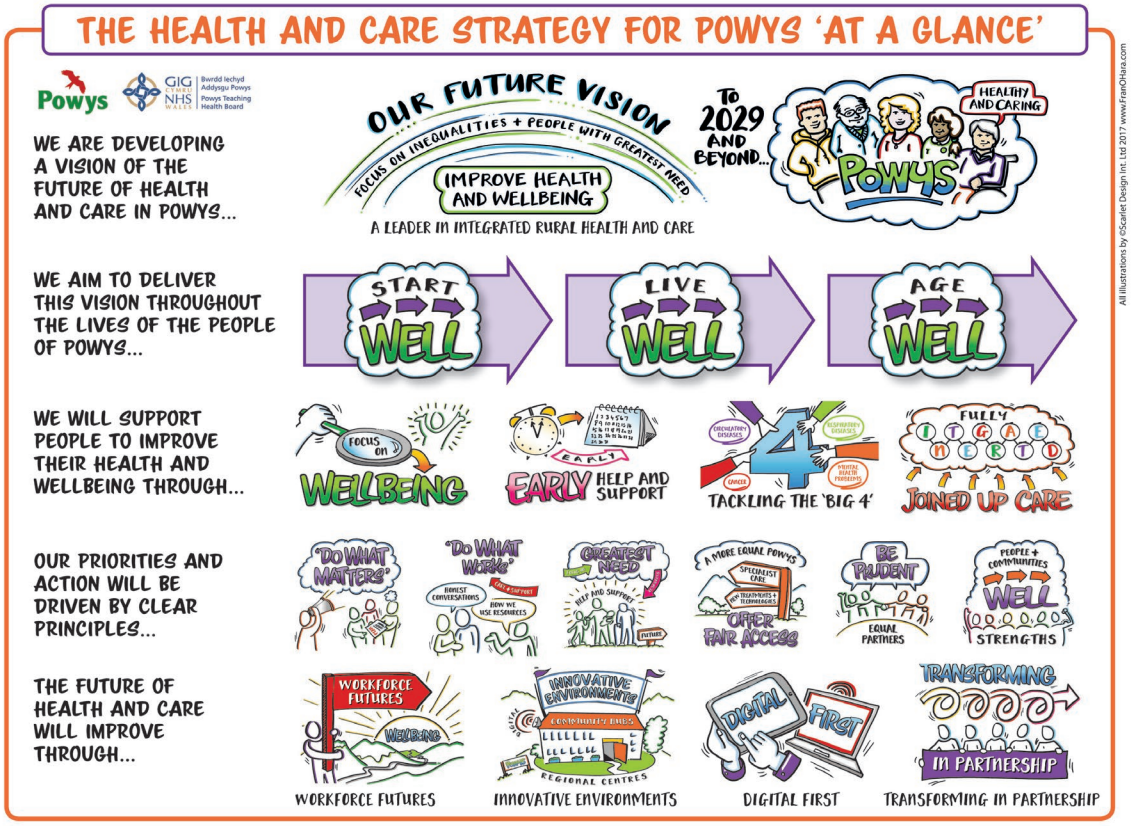
In 2017, partners across Powys agreed *A Healthy Caring Powys*[15] Strategy, a long-term vision for health and care developed with local people, third sector organisations and system partners. The Strategy adopts a life-course approach that aims to help people Start Well, Live Well and Age Well through prevention, early intervention, wellbeing, joined-up care and action to address the wider determinants of health.

The Strategy aligns with the Well-being of Future Generations (Wales) Act, the Powys Public Services Board Well-being Plan[16], the Health Board's Population Health Strategic Framework and wider regional partnership arrangements. It continues to provide the overarching strategic direction for health and care transformation in Powys.

Informed by more than 10,000 pieces of engagement feedback, the strategy established a clear ambition to strengthen prevention, community wellbeing and integrated care. It identified the development of Rural Regional Centres and a network of Community Wellbeing Hubs as key components of the future model of care, enabling more services to be delivered within Powys and closer to people's homes, where appropriate.

[13] The mental health and wellbeing strategy 2025 to 2035
[14] Understanding suicide prevention and self harm strategy
[15] Our Strategy - Powys Teaching Health Board
[16] Powys PSB Well Being Plan

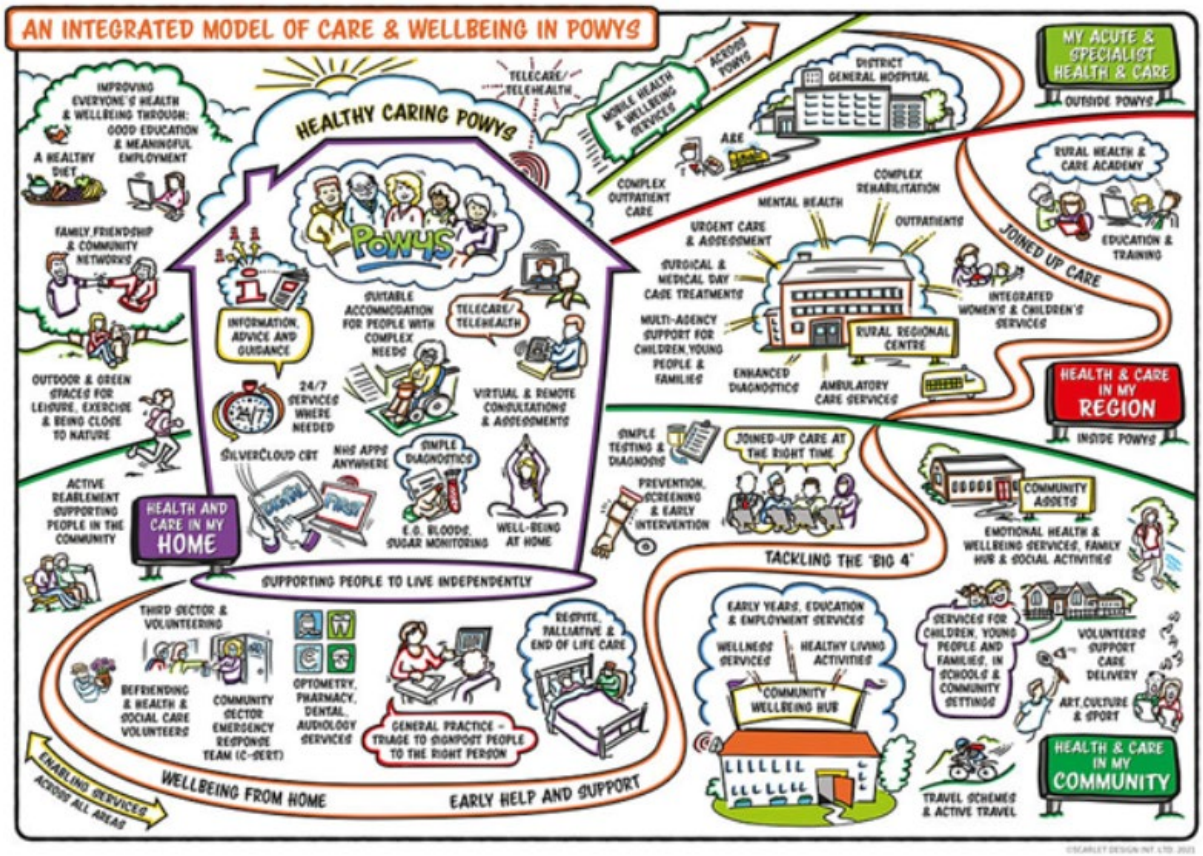
Figure 11: Health and Care Strategy 'At a glance'



The Strategy has recently been refreshed and extended to 2029 and remains the foundation for service transformation in Powys. It continues to promote improved population health and wellbeing, reduced inequalities, stronger community-based services and more integrated approaches to care.

The Integrated Model of Care and Wellbeing for Powys, translates the Health and Care Strategy into a practical framework for service delivery. It describes how health and care services should be organised and delivered at home, within communities through Community Wellbeing Hubs, at a Powys-wide level through Rural Regional Centres and, where necessary, through specialist and acute services provided outside the county.

Figure 12: An Integrated Model of Care & Wellbeing in Powys



2.2.2 Regional Partnership Working in Powys

Health and care services in Powys are planned and delivered through long-established partnership arrangements that bring organisations together to improve outcomes for the population. These arrangements support shared planning, resource coordination, and the development of integrated services that reflect the needs of local communities.

A key mechanism is the Powys Regional Partnership Board[17](RPB), which brings together the Health Board, Powys County Council (PCC), third sector organisations and other partners including Powys Association of Voluntary Organisations (PAVO), to support integrated approaches to health, care and wellbeing. Alongside the RPB, the Powys Public Services Board (PSB) provides a wider framework for collaboration between public bodies and partners through delivery of the Powys Well-being Plan.

These arrangements support a shared focus on prevention, population health improvement, reducing inequalities and delivering more coordinated services. Through strategic planning, processes, including the Joint Area Plan[18] , partners work together to identify local needs, align prioritises and improve outcomes for people across Powys.

Partnership working also extends beyond Powys through Primary Care clusters, the Mid Wales Joint Committee (MWJC), Regional Joint Committees (RJCs) and cross-border arrangements with NHS partners

[17] Health And Wellbeing | Powys Regional Partnership Board | Wales
[18] Powys Joint Area Plan

in England. These partnerships support collaborative approaches to addressing shared challenges including rurality, workforce sustainability, service resilience, and access to care.

2.2.3 Population Health Strategic Framework for Powys 2025-2035

The Health Board's 2025 Director of Public Health Annual Report, *Preventing the Preventable: Population Health Strategic Framework for Powys 2025-2035,* establishes population health improvement and prevention as central to achieving sustainable health and care services. The Framework recognises that rising demand, health inequalities and increasing levels of long-term conditions cannot be addressed through healthcare services alone and require a whole-system approach focused on improving health and wellbeing across the life course.

The Framework promotes coordinated action across health, social care, local government, communities and wider partners to address the wider determinants of health and reduce exposure to preventable risk factors. It is intended to inform future planning and investment decisions and supports a shift towards more preventative, person-centred and sustainable models of care.

2.2.4 Relevance to Better Together

Better Together provides the delivery mechanism for the strategic ambitions set out in *A Healthy Caring Powys* and associated partnership frameworks. Through a structured approach to service transformation, it translates the Health and Care Strategy, regional partnership priorities and the Population Health Strategic Framework into integrated models of care that are more preventative, community-based and sustainable. In doing so, it supports the life-course approach of helping people to Start Well, Live Well and Age Well.

The programme is aligned with wider partnership priorities and supports collective action on shared challenges, including rurality, access barriers, health inequalities, workforce sustainability, rising demand and the need to make better use of estate, financial and clinical resources. Through the development and appraisal of future service options, Better Together provides a practical route for delivering the long-term strategic vision for health and care in Powys.

2.3 Delivering Health and Care for the Population

This section describes how health and care services are currently organised and delivered to meet the health needs of the population.

PTHB operates within a complex health and care system that spans organisational boundaries across Wales and England. The Health Board is responsible for improving health outcomes, promoting wellbeing, reducing health inequalities, and planning, commissioning, and providing services for approximately 135,000 [19] residents. The geographical size of Powys, dispersed population and long travel distances have a significant influence on how services are organised and delivered.

Unlike most health boards in Wales, Powys does not have a DGH within its boundaries. As a result, many acute, specialist and highly specialised services are provided through partner NHS organisations in Wales and England. Powys residents therefore access care through a network of providers that includes primary care, community services, mental health services, social care, and hospital services both within and outside

[19] Wellbeing Information Bank: View information about Powys' population - Powys County Council

the County. The table below provides an overview of the organisations and services that collectively contribute to the delivery of care for Powys residents.

Figure 13: NHS Organisations that support delivery of healthcare in Powys

Service Area	Description
Primary Care	16 General Practices 23 Community Pharmacies 7 (Independent) Dental contractors & 7 clinics that provide dental treatment to vulnerable groups of adults and children, whose additional needs may not be accommodated in NHS general dental services. 14 Optometry & 4 mobile practices
Community Services (directly provided by PTHB)	Community Nursing Teams
	Children & Family Services
	Therapies (Allied Health Professionals, (AHPs)
	Community Hospitals & Inpatient Care
	Mental Health Community Services
	Rehabilitation & Intermediate Care
	Specialist Community Services
	Urgent & Community Response
	Minor Injuries
Acute Services	PTHB Mental Health Adult and Older Adult Acute Inpatient Care
	The Shrewsbury and Telford Hospital NHS Trust (SaTH)
	Wye Valley NHS Trust
	Aneurin Bevan University Health Board
	Swansea Bay University Health Board
	Hywel Dda University Health Board
	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
	Cwm Taf Morgannwg University Health Board
	Betsi Cadwaladr University Health Board
	Gloucestershire Hospitals NHS Foundation Trust
	Cardiff & Vale University Health Board
Specialist Services	Other services commissioned via Joint Commissioning Committee (JCC) including Velindre University NHS Trust and WAST
Social Care	Provided via one Local Authority – PCC/Independent sector
Third Sector	Powys Association of Voluntary Organisations (PAVO) and associated 920 members. However, it is estimated that there are up to 4,080 community & voluntary groups active in Powys.

2.3.1 The Health Board Operating Model

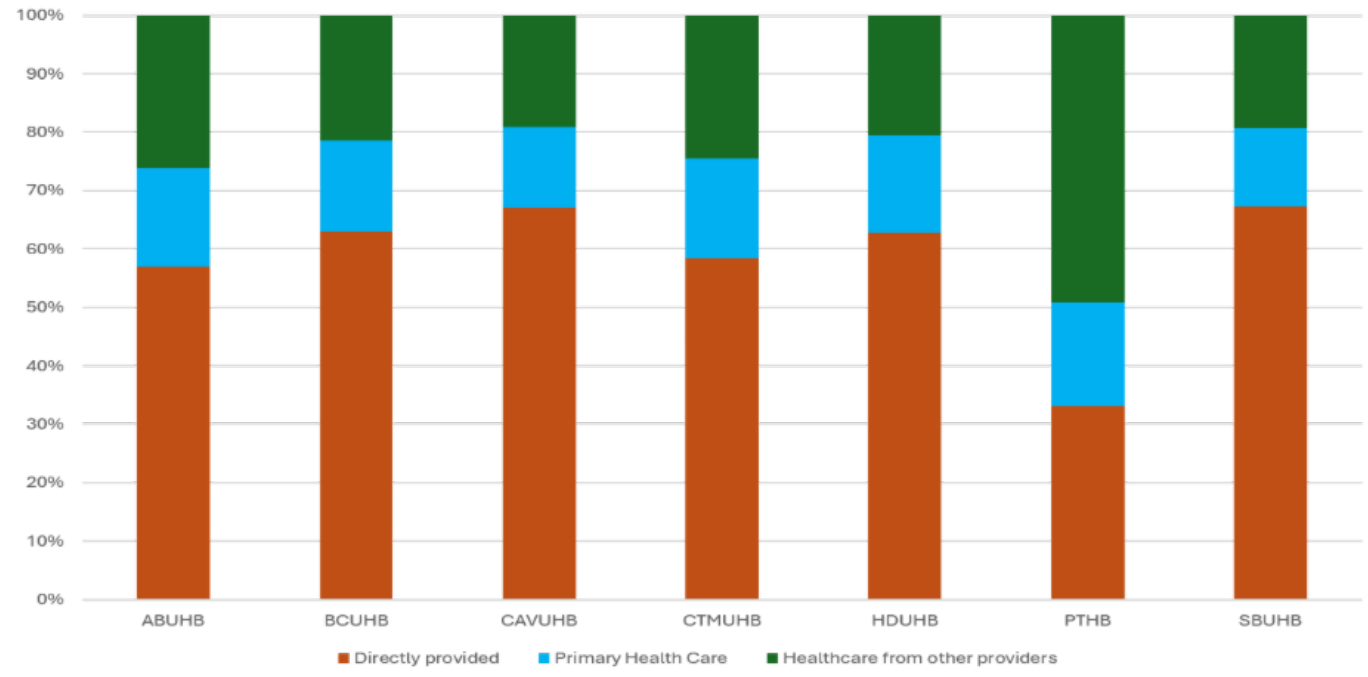
A substantial proportion of healthcare for Powys residents is commissioned from neighbouring NHS organisations in Wales and England. This enables access to acute, specialist and highly specialised services that could not be sustainably delivered within the county because of population size, geography or workforce availability. As a result, many residents travel outside Powys to access acute and specialist care.

Whilst this commissioning model provides access to a comprehensive range of services, it also means that Powys operates differently from most other health boards in Wales. A significant proportion of services accessed by Powys residents are delivered by partner organisations outside the county, reflecting the absence of a District General Hospital and the dispersed nature of the population.

Powys does not have a District General Hospital (DGH) within its boundaries. The size and dispersed distribution of the Powys population do not provide the critical mass required to sustain a DGH safely and resiliently. DGH services require sufficient activity to maintain 24-hour clinical rotas, diagnostics, theatres, critical care and specialist support services. Powys is also surrounded by established DGHs and specialist centres in neighbouring health systems, which will continue to provide acute and specialist care for Powys residents when this level of care is required.

Figure 14 illustrates how PTHB's operating model differs from other health boards in Wales and highlights the extent to which the Health Board relies on commissioned services to meet the health needs of the Powys population.

Figure 14: PTHB commissioning compared with other Welsh Health Boards



This reliance on commissioned services provides access to a broad range of hospital, specialist and ambulance services but also creates significant dependencies on external providers. Approximately 40% of the Health Board's expenditure is associated with services commissioned from other organisations, representing around £198 million during 2025/26. This reflects the unique operating model required to meet the health needs of the Powys population.

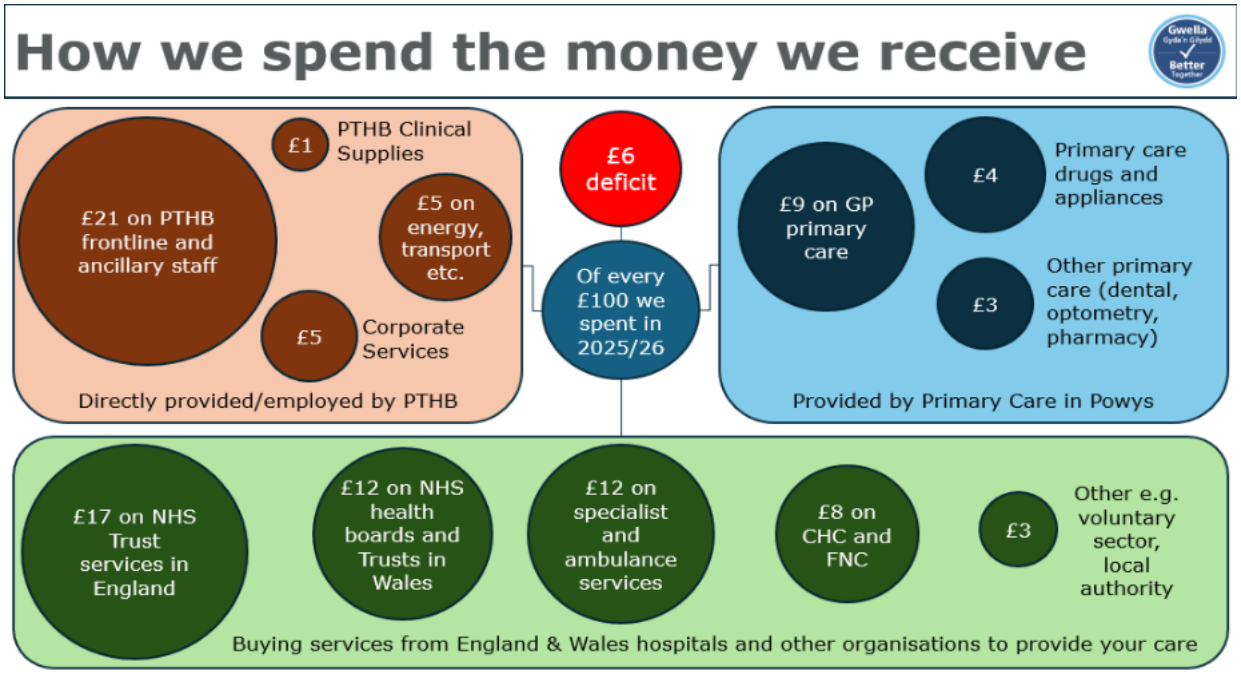
In line with the Health Board's Strategic Commissioning Framework, commissioning arrangements are used to manage the quality, performance and value of services provided for Powys residents. This includes working collaboratively with partner organisations, strengthening prevention, primary and community care, developing alternative patient pathways and supporting the delivery of more care within Powys, at home or closer to home where clinically appropriate, safe, and sustainable.

The aim is not to eliminate the need for specialist care outside the county, but to ensure that care is delivered in the most appropriate setting and that resources are used effectively to improve outcomes for the population.

The financial, workforce, activity and service sustainability challenges associated with the current operating model are explored further in Section 3.

Figure 15 shows how the Health Board utilised its resources during 2025/26.

Figure 15: Health Board expenditure 2025/26



2.3.2 Organisation Snapshot

The table below provides a high-level overview of activity delivered through commissioned and directly provided services during 2024/25 and 2025/26. It illustrates the scale and range of services accessed by Powys residents across the health and care system and highlights the breadth of activity delivered through both commissioned and directly provided services.

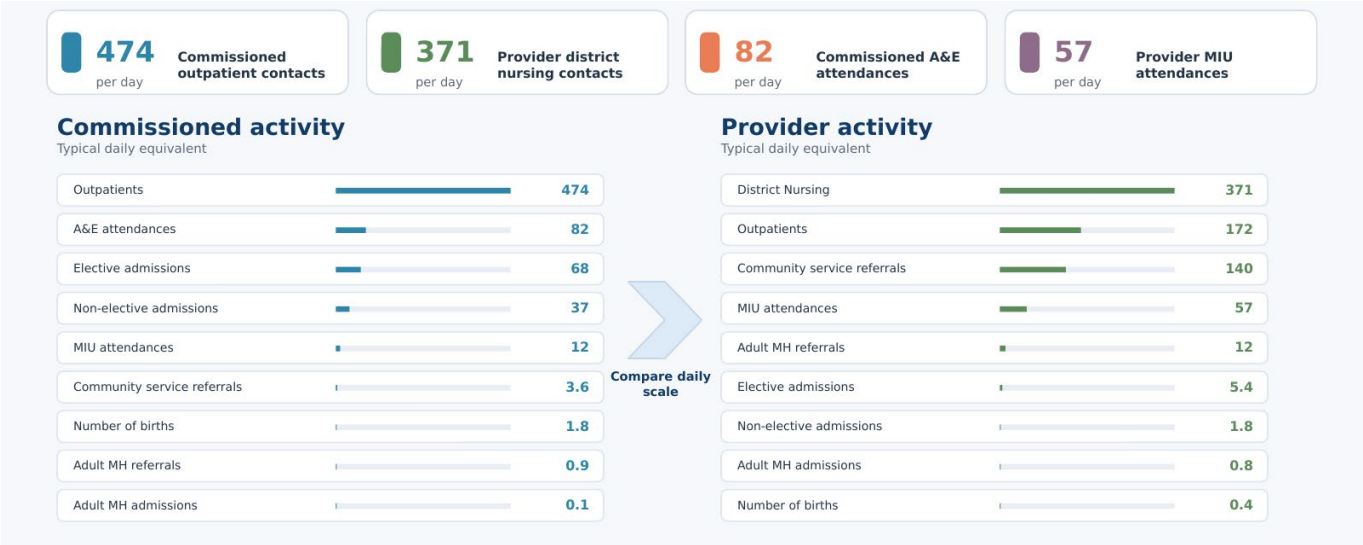
Figure 16: Commissioned and directly provided activity, 2024/25 to 2025/26

Organisation Snapshot Comparison (2024/25 - 2025/26)				
	Commissioned		Directly Provided	
Indicator	(2024/25)	(2025/26)	(2024/25)	(2025/26)

Organisation Snapshot Comparison (2024/25 - 2025/26)				
Staff (Whole-Time Equivalent, WTE)	n/a	n/a	2,087	2,137 [20]
Emergency Department (ED) attendances	27,984	29,889	n/a	n/a
Non elective admissions	13,359	13,599	516	654
Minor Injury Unit (MIU) attendances	4,218	4,308	18,105	20,852
Elective admissions	23,579	24,701	2,162	1,979
Outpatients	169,465	173,185	64,116	63,077
Number of births	733	650	172	159
Adult Mental Health admissions	33	21	219	309
Adult Mental Health referrals	306	321	2,266	4,357
Community service referrals	1,994	1,297	49,555	51,202
District Nursing	n/a	n/a	118,595	135,440
General Medical Services (GMS) patient interactions	7118616	7522310	n/a	n/a

During 2025/26, Powys residents accessed almost 30,000 emergency department attendances, more than 24,000 elective admissions and over 173,000 outpatient appointments through commissioned services. Within directly provided services, over 20,000 minor injury attendances, 135,000 district nursing contacts and more than 51,000 community service referrals were recorded. Figure 17 provides an illustrative snapshot of the scale of activity delivered each day across commissioned and directly provided services for Powys residents.

Figure 17: Daily PTHB commissioned activity



2.4 Powys Population Needs

Understanding the characteristics of the Powys population is essential to informing future service planning and ensuring that health and care services are designed around the needs of local communities. Population

[20] PTHB annual accounts 2024/25

demographics, health rurality, access to services and changing patterns of disease all influence demand for services and the way care needs to be organised and delivered.

Powys has a distinctive population profile compared with Wales and the wider UK. The county has an older and ageing population, a dispersed settlement pattern, low population density and significant challenges relating to access, transport, and digital connectivity. Whilst many health outcomes compare favourably with Wales as a whole, inequalities persist between communities and population groups, and demand for health and care services is expected to become increasingly complex over time.

Key characteristics of the Powys population include:

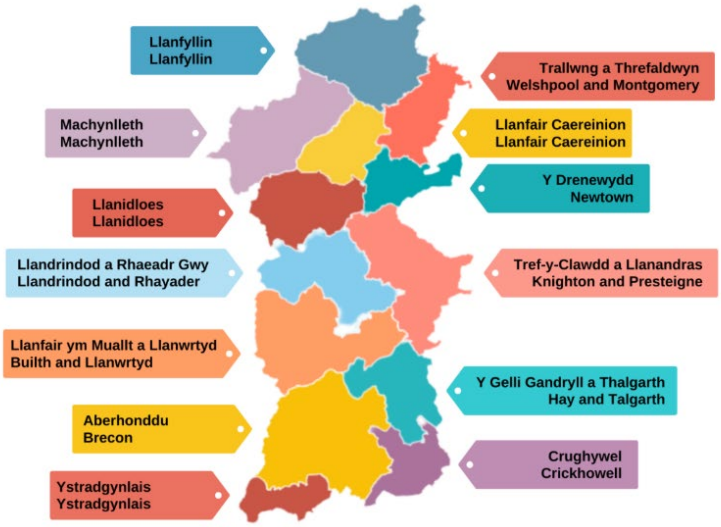
- The average age of the Powys population (50 years) is higher than both the Wales (42.5 years) and the UK (40.8 years).
- The population is predicted to grow and continue to age between 2021 and 2043.
- The rural nature of Powys, combined with low population density and dispersed communities, has important implications for how services are planned and delivered.
- Powys has approximately 61,455[21] households, with an average household size of 2.2[22] people.
- Access to services remains a significant challenge, with the Welsh Index of Multiple Deprivation (WIMD) category Access to Services show overall that 75% (59) of Lower Super Output Areas (LSOAs) falling within 30% most deprived areas in Wales for access to services.
- Population change and its potential impact on future workforce supply and service demand will be important considerations in long-term service planning.[23]

The following sections explore these characteristics in more detail and consider their implications for the future delivery of health and care services in Powys.

Figure 18 shows the 13 localities across Powys.

[21] Powys Mid-Year 2024 official statistics
[22] Powys mid-year 2024 average household size
[23] Population Needs Assessment

Figure 18: Powys localities

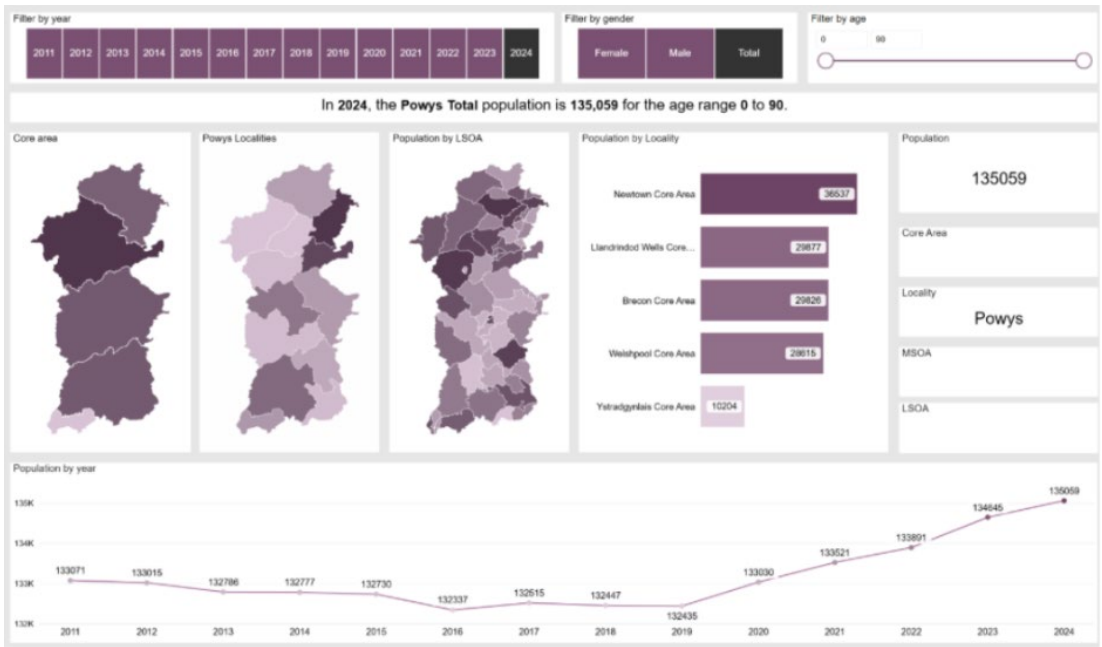


2.4.1 Population Growth

Powys has experienced only modest overall population growth over the past decade, and the total population is projected to remain broadly stable or grow only slightly.[24]

The most recent population estimates indicate that approximately 135,059 people live in Powys[25]. Figure 19 below shows population distribution across core area, localities and LSOA., with Newtown, Llandrindod Wells and Brecon representing the largest population centres.

Figure 19: Powys population density by core area



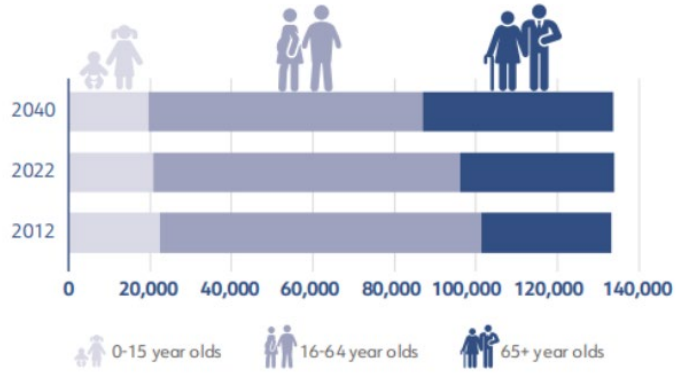
[24] Wellbeing Information Bank: View information about Powys' population - Powys County Council
[25] Office For National Statistics Census 2021 Powys population change

2.4.2 Age Profile

Whilst the total population of Powys has remained broadly stable over the past decade, this masks a significant change in its age structure: the number and proportion of older residents are increasing substantially, while the number and working-age adults is declining.

Powys has one of the oldest population profiles in Wales. It has the highest proportion of older adults, with almost three in ten people aged 65 years and over[26], 28% of the population is aged 65 years and over, compared with 21% across Wales and 19% across the UK. This demographic profile has important implications for health and care planning to meet health needs of the population, particularly in relation to maintaining good health, managing multiple chronic conditions, primary and community services and end-of-life care.

Powys currently has approximately 39,500 people aged 65 years and older, but by 2035 it is projected that there will be more than 47,000, representing over a third of the total population (see Figure 20). The number of children, young people and working adults are predicted to reduce by 2040. Around a third of households in Powys have just one person in them, with over half of those being someone older than 65 years. The population age profile is shown below and how this is predicted to change.



Source: Mid-year population estimates and Population projections, Office for National Statistics

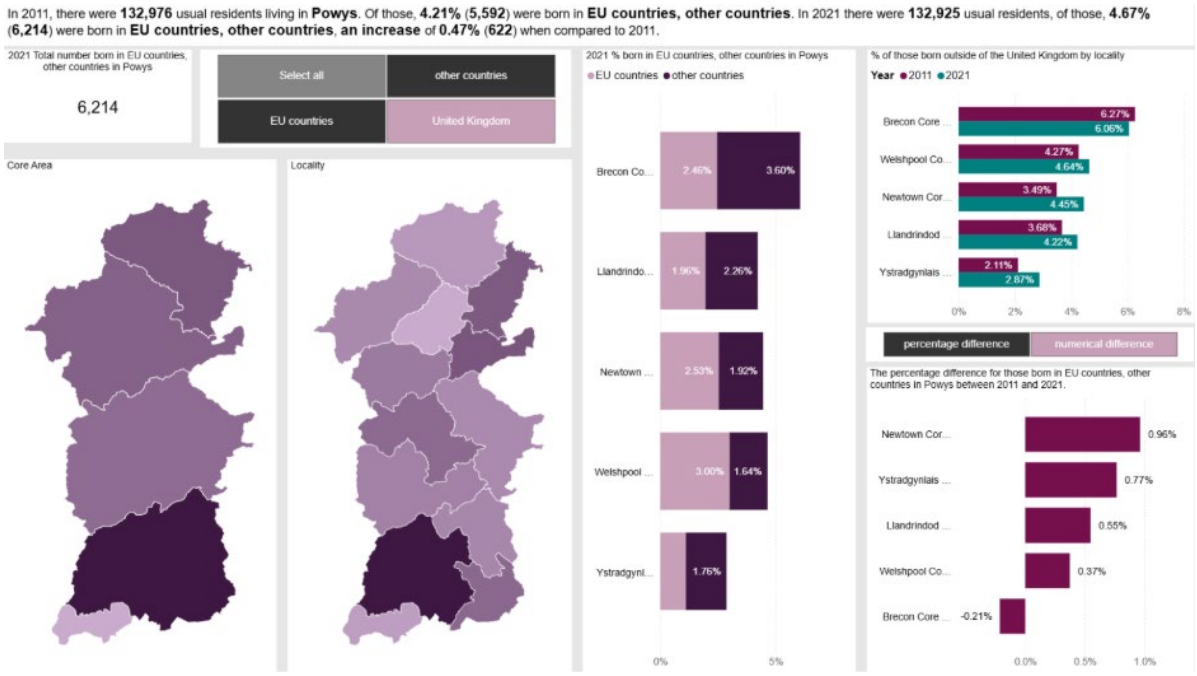
Figure 20: Mid-year population estimates and population projections

2.4.3 Ethnicity

Powys has a relatively low level of ethnic diversity compared with Wales as a whole. In 2021, 97.7% of people in Powys identified their ethnic group within the “White” category (compared with 98.4% in 2011), while 0.9% within the "Mixed or Multiple" category [27]. The percentage of people who identified their ethnic group within the “Other” category (“Arab” or “Any other ethnic group”) was 0.3% in 2021.

[26] Wellbeing Information Bank: View information about Census population - Powys County Council
[27] How life has changed in Powys: Census 2021

Figure 21: Ethnicity in Powys, 2011 to 2021



(Source: Powys Wellbeing Bank – Demographic – Place of birth and ethnicity)[28]

There are many factors that contribute to changes in ethnic composition of England and Wales, such as differing patterns of ageing, fertility, mortality, and migration. Changes may also be caused by differences in the way individuals chose to self-identify between censuses.

2.4.4 Deprivation, Life Expectancy and Health inequalities

Our health status is shaped by a combination of socioeconomic factors, rurality, housing, transport, employment, education and access to services, as shown in figure 22. This highlights the socioeconomic factors that have the largest impact on health, along with health behaviours; with access to healthcare being important but a lesser factor. This highlights the importance of wider national legislation and initiatives described in section 2.1 as well as the need to focus on health risk factors / healthy behaviours described further in section 2.4.5

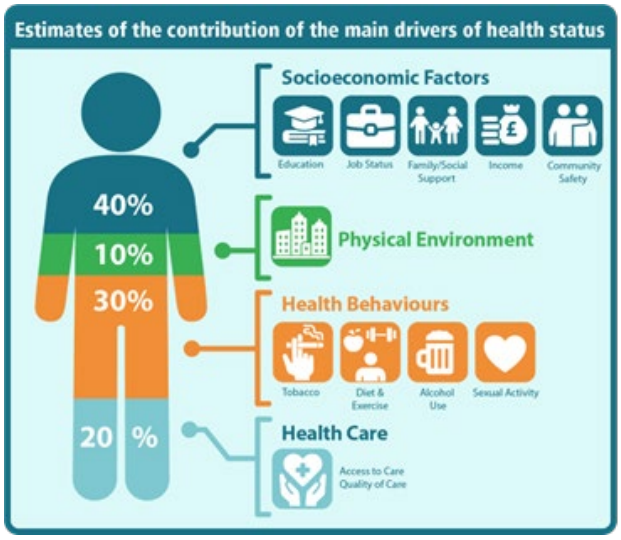


Figure 22: Visual of estimates of the contribution of the main drivers

The population of Powys is living for longer than the population of Wales as a whole, but not all these years are necessarily spent in good health. The latest figures showing life expectancy of 83.4 years for women and 79.5 years for men. County-wide averages can mask significant differences between communities and population groups. Health inequalities exist not only between the most and least deprived areas, but also among people who experience cumulative disadvantage,

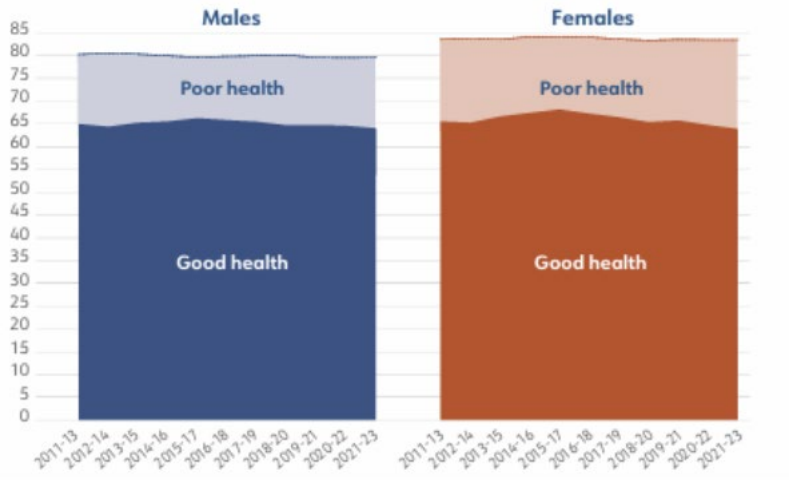
[28] Wellbeing Information Bank: View information about place of birth and ethnicity statistics - Powys County Council

including older people living alone, unpaid carers, people with disabilities, people on low incomes, homeless households and those who are digitally excluded.

HLE is an important indicator of health inequality in Powys.

HLE is 64 years for both women and men, meaning that many people live a significant number of later years in poorer health. Women tend to live longer than men, but more of this additional time is spent in poorer health. The downward trend in Powys shown below in HLE, particularly for women, is therefore a concern.

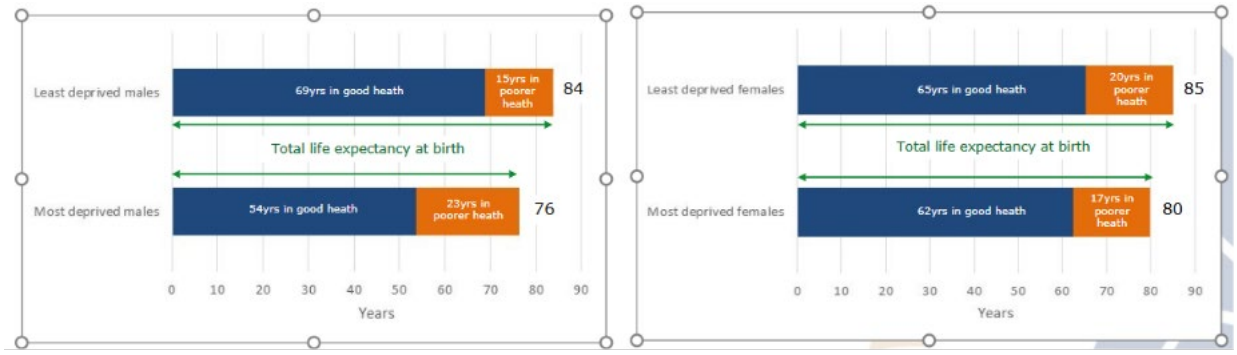
Figure 23: Life expectancy and healthy life expectancy in Powys, 2011-13 to 2021-23



Source: data produced by Public Health Wales using APS, 2011 Census, PHM, MYE (ONS)

These patterns are not equally distributed across the county. People born in the most deprived areas of Powys spend fewer years in good health than those born in the least deprived areas.

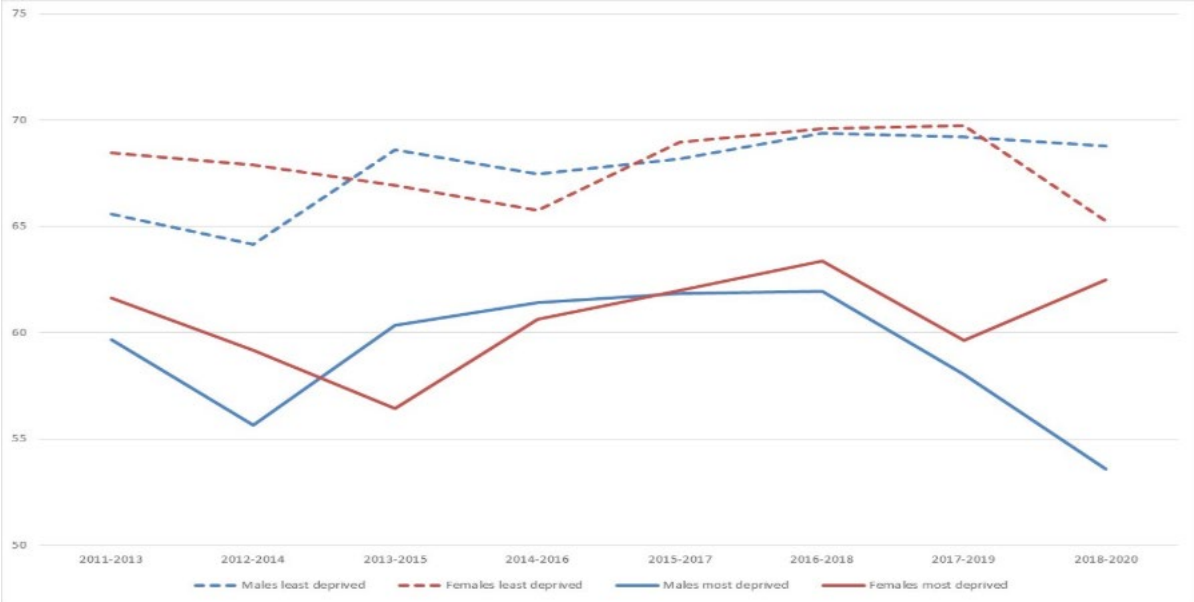
Figure 24: Life expectancy by deprivation - infographic



A population that lives longer but spends more years in poor health is likely to generate increasing demand for health and care services, including primary care, community services, hospital care, therapies, social care and support for independent living. This reinforces the importance of prevention, early intervention and equitable access to services throughout the life course.

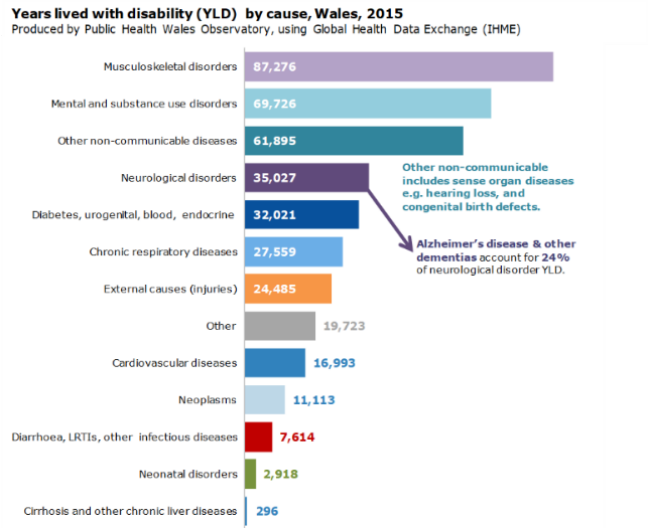
The figure below shows trends in HLE for males and females in the most and least deprived areas of Powys between 2011-2013 and 2018-2020.

Figure 25: Life expectancy by deprivation - Graph[29]



Whilst the gap in life expectancy has increased for males it has narrowed for females, but mainly due to a fall in the life expectancy of women in the more well-off areas. The main conditions reducing Healthy Life Expectancy are shown in the figure below. This highlights the significant impact of musculoskeletal (MSK) conditions, mental health needs and substance misuse on population health. Supporting people to remain active, mobile and mentally well is therefore central to improving Healthy Life Expectancy.

Figure 26: Total years lived with disability by cause, Wales 2015



The WIMD provides a relative measure of deprivation across Wales. Multiple deprivation in rural areas is less visible in WIMD ranks because it is often more dispersed, but this is not true for all individual domains of

[29] Health Expectancies Wales Profile

deprivation. For the domain of Access, nine areas are in the most deprived 30% in Wales. Local patterns of need within rural areas can be masked by county-level averages.

Figure 27 below provides a summary of relative deprivation per area in Powys. Figure 28 provides a further breakdown on deprivation based on access to services, demonstrating that access is a challenging factor for Powys population. This is due to the geography, transport availability and travel times which can affect people's ability to access healthcare, employment, education and wider support services. The dark purple represents high levels of deprivation in relation to access to services domain. The lighter colour purple is for the least deprived areas.

Figure 27: Summary of relative deprivation by area

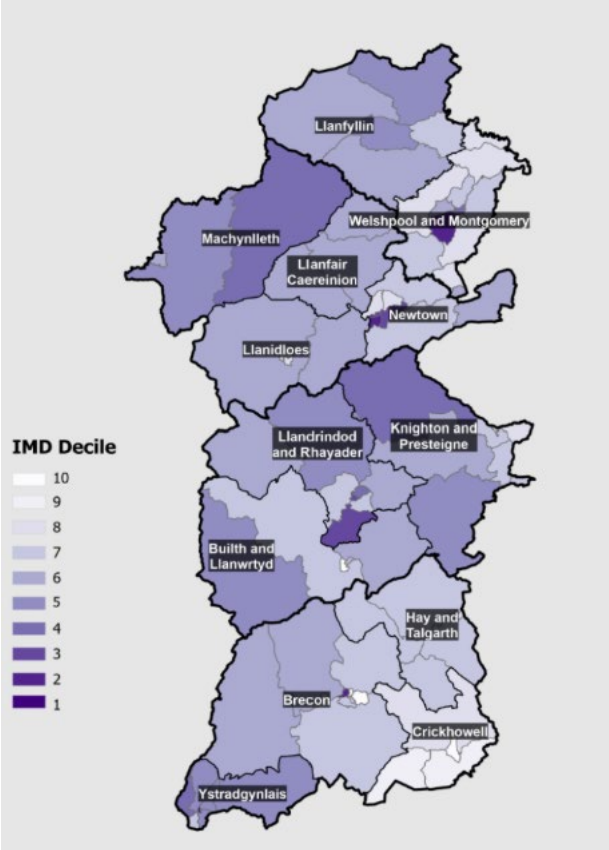
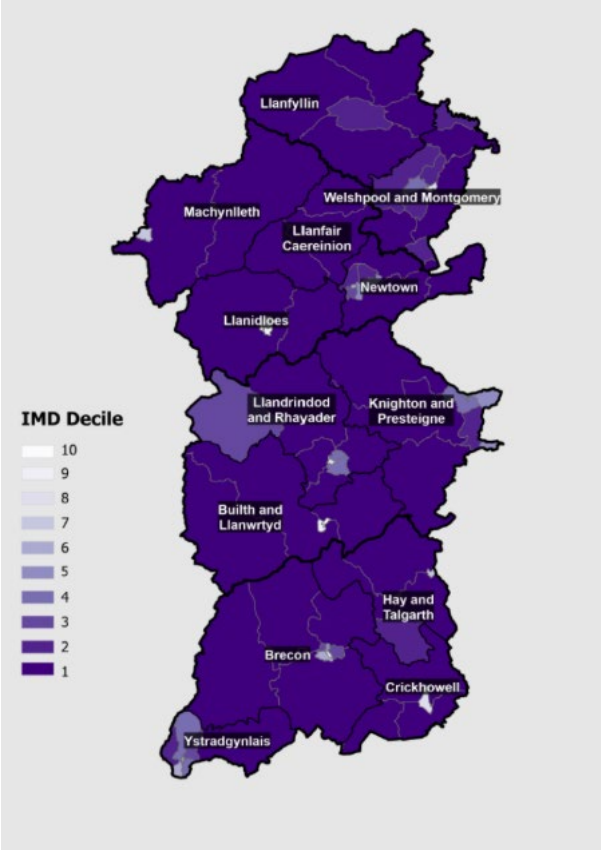


Figure 28: Access to Services deprivation per area

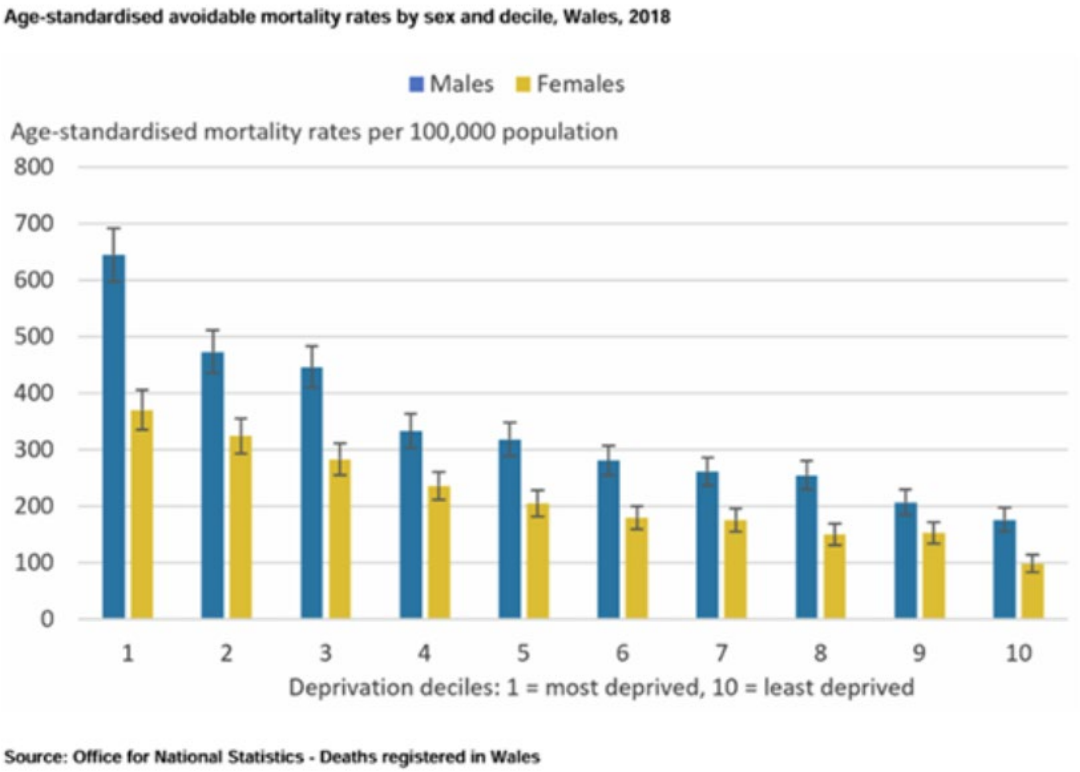


(Source: GBP Consult)

Evidence consistently demonstrates a strong relationship between deprivation and poorer health outcomes. While deprivation can be hidden in rural areas with dispersed population, its consequences for health and wellbeing are well established. Figure 29 shows age-standardised avoidable mortality rates by deprivation decile in Wales[30], demonstrating that people living in the most deprived communities experience significantly higher rates of avoidable mortality than those living in the least deprived communities. This highlights the strong association between socioeconomic disadvantage and poorer health outcomes and reinforces the overall importance of focus on wellbeing and health behaviours.

[30] Mortality rates by deprivation

Figure 29: Age-standardised avoidable mortality rates by sex and decile



Similar patterns are seen across other measures of health and wellbeing. Public Health Wales analysis found that children under 15 living in households receiving income support experienced substantially higher levels of ill health than those not eligible for income support[31]. More recent indicators also suggest increasing financial hardship for some residents. The proportion of households experiencing material deprivation in Powys increased from 9% to 14% between 2021/22 and the latest reporting period[32], while 19.5% of children were living in absolute poverty in 2023[33]. Together, these measures demonstrate the continuing impact of deprivation on health and wellbeing and the importance of targeting support towards communities experiencing the greatest disadvantage.

For PTHB, reducing health inequalities requires action both within and beyond healthcare services. This includes improving equitable access to services, strengthening prevention and early intervention, targeting support towards groups with poorer outcomes, and working with local authority, third sector and community partners to address the wider determinants of health. These considerations are important in assessing future service models and ensuring that any changes support improved outcomes for the whole population, particularly those communities most at risk of poorer health.

2.4.5 Rurality, Access and Transport Inequality

As described above, access to services is one of the most significant dimensions of deprivation affecting communities in Powys, with nine areas being in the most deprived 30% across Wales. This measure

[31] Health and income support eligibility
[32] Wellbeing Information Bank: View information about Material Deprivation - Powys County Council
[33] Wellbeing Information Bank: View information about Material Deprivation - Powys County Council

considers travel times to key services by public transport, private transport and walking, together with access to fixed-line broadband connectivity of at least 30MB/s[34].

Transport is a fundamental determinant of health and wellbeing in Powys. Evidence from stakeholder engagement, community feedback, community transport providers and national research consistently identifies transport and connectivity as significant factors influencing access to healthcare, employment, education, social participation and wider community life. In a large, predominantly rural county with an ageing population, transport can influence people's ability to live independently, maintain social connections and access essential services.

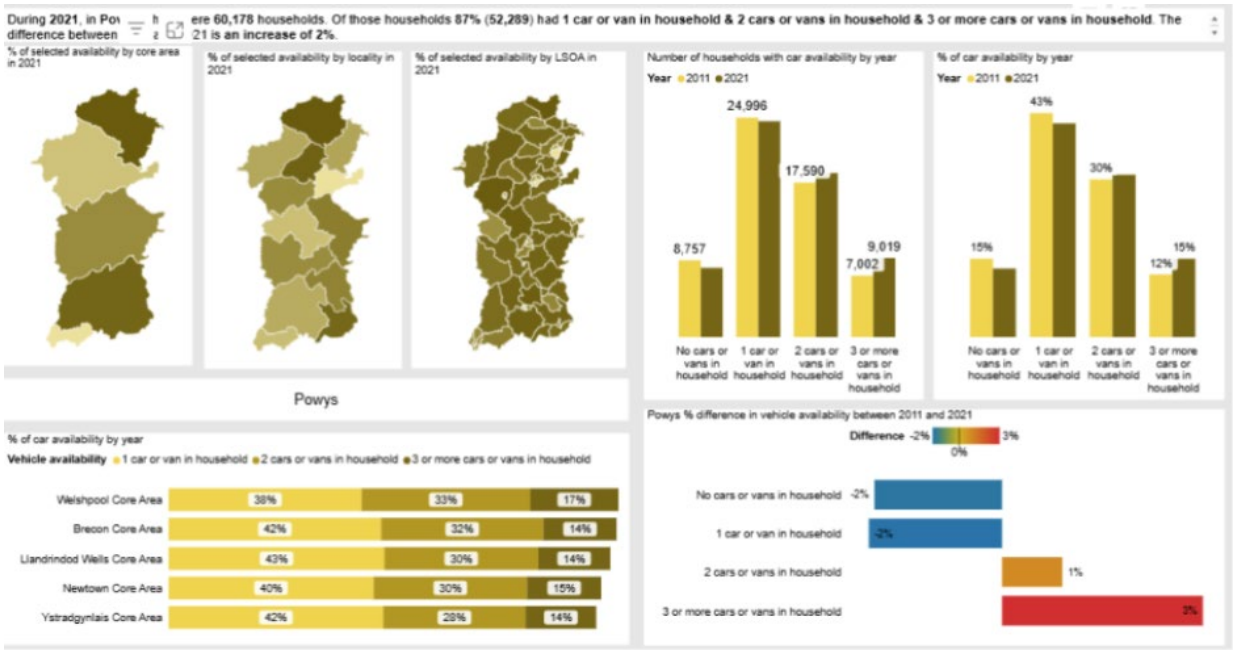
Powys faces challenges because of its dispersed settlement pattern, long travel distances and limited public transport network. Access is influenced by a combination of factors including transport availability, affordability, physical accessibility, digital connectivity and the distribution of services across the county. These factors can disproportionately affect older people, disabled people, unpaid carers, people on low incomes and those living in more remote communities.

The challenge is not solely one of distance. The availability and reliability of public and community transport, limited evening and weekend services, difficulties navigating fragmented transport networks, digital exclusion and confidence in accessing information can all influence an individual's ability to reach services when they need them. As a result, accessibility is determined not only by where services are located, but also by people's practical ability to access them.

Although many Powys residents rely on private transport to access services, car ownership and access are not universal. Figure 30 shows the distribution of vehicle availability across Powys households. Access to a vehicle can have an important influence on an individual's ability to access healthcare and other essential services, particularly in areas where alternative transport options are limited. For an ageing population, maintaining access to transport can become increasingly challenging at the same time as health and care needs increase[35].

[34] Welsh Index of Multiple Deprivation (WIMD) 2025 - Access to services
[35] Accessing Health Services in Wales - Transport Issues and Barriers

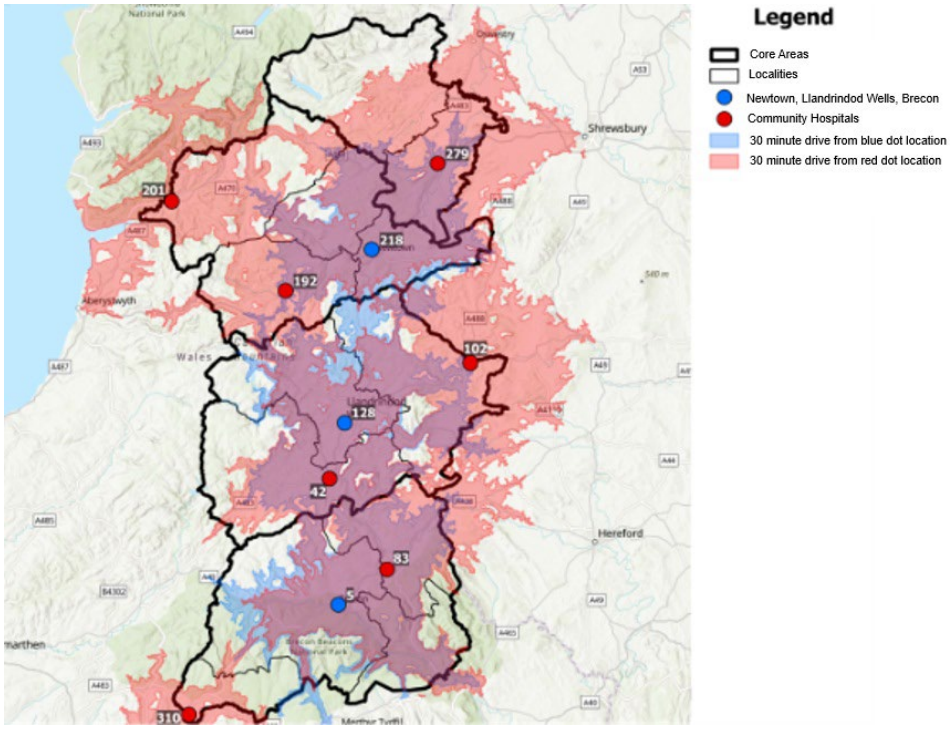
Figure 30: Household vehicle distribution across Powys



(Source: Powys Wellbeing Information Bank[36])

The map below shows travel time by car to the Rural Regional Centres outlined in the Health & Care Strategy (Newtown, Llandrindod and Brecon) and other Community Hospitals for Powys residents. *(Source: GBP Consult)*

Figure 31: Current travel time by car to the Rural Regional Centres/Community Hospitals.



[36] Wellbeing Information Bank: View information about car availability - Powys County Council

The shading on the above map represents a 30-minute travel time by car from the nearest respective colour location. The table below provides the place name references for the above map. Blue dots are Newtown, Llandrindod and Brecon hospitals representing Rural Regional Centres in the Health and Care Strategy. Red dots are the Community Hospital sites in the County.

Community Hospital Site	Code
Montgomery County Infirmary (Newtown)	218
Llandrindod Wells War Memorial Hospital	128
Breconshire War Memorial Hospital	5
Bronllys Hospital	83
Llanidloes War Memorial Hospital	192
Knighton Hospital	102
Glan Irfon Health and Care Centre	42
Bro Ddyfi Community Hospital (Machynlleth)	201
Victoria Memorial Hospital (Welshpool)	279
Ystradgynlais Community Hospital	310

The map below shows travel time by car to acute hospitals outside of Powys for Powys residents. As the county is so large there are many hospitals that Powys residents attend out of area. The map indicates travel in 60 and 90 minute intervals to acute hospital sites.

Figure 32: 60-minute car travel to acute hospitals outside of Powys for Powys residents

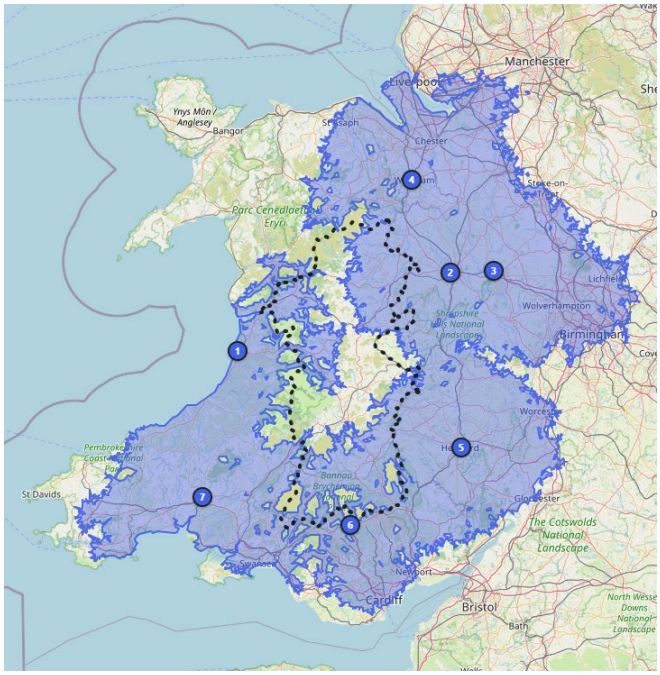


Figure 33: 90-minute car travel to acute hospitals outside of Powys for Powys residents

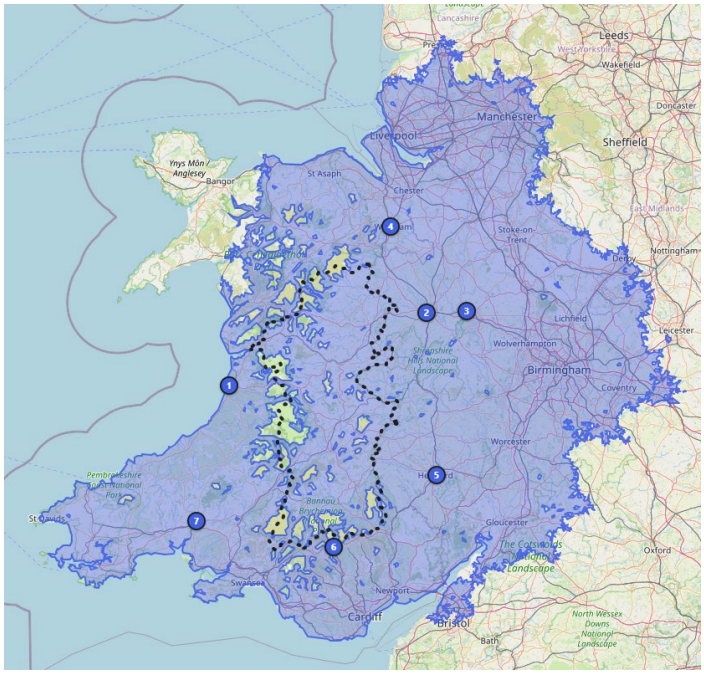
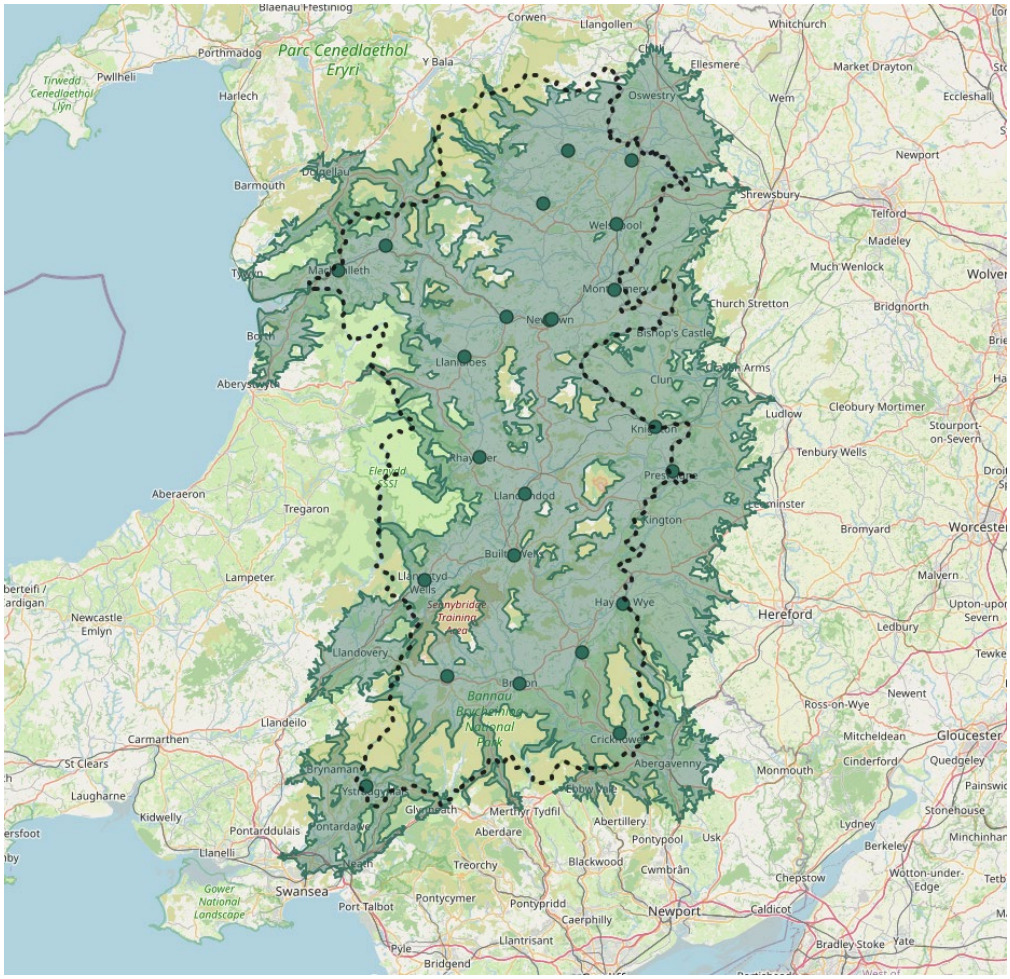


Figure 34: Location reference codes for map of travel time by car (figures 33, 34)

Acute Hospital Site	Code
Bronglais General Hospital, Aberystwyth	1
Royal Shrewsbury Hospital, Shrewsbury	2
Princess Royal Hospital, Telford	3
Wrexham Maelor Hospital, Wrexham	4
Hereford County Hospital, Hereford	5
Prince Charles Hospital, Merthyr Tydfil	6
Glangwili General Hospital, Carmarthen	7

The map below shows travel time by car to their nearest GP practice for Powys residents. It identifies a 30-minute drive for Powys residents to their nearest GP practice, illustrating that the whole of Powys is very well served by the location of its GP practices.

Figure 35: 30-minute car travel time to their nearest GP practice for Powys residents



Digital inclusion is also an important consideration. Whilst digital technology can improve access to information, support virtual consultations and reduce the need for some journeys, digital access and confidence are not consistent across the population. People living in areas with poor connectivity, older people, some disabled people and those experiencing financial hardship may face barriers to accessing digitally enabled services. Digital solutions therefore have the potential to improve access for some groups whilst creating additional barriers for others if not implemented carefully.

The cumulative impact of rurality, transport limitations, digital exclusion and wider socioeconomic disadvantage can affect how and when people access health and care services. These factors are important considerations in service planning because they influence both health outcomes and people's ability to access support in a timely way. Future service models therefore need to consider accessibility alongside quality, safety, workforce sustainability, clinical resilience and the effective use of resources.

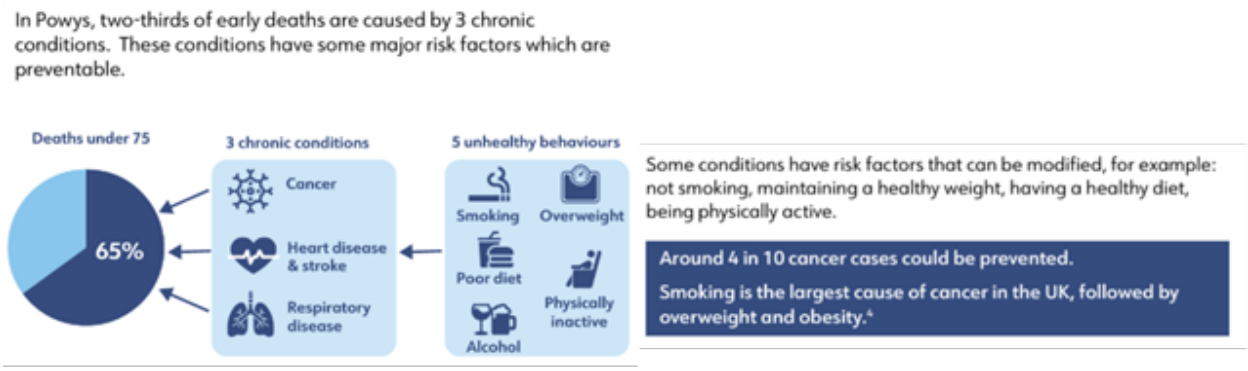
The detailed travel and transport assessment undertaken for the shortlisted options, including private vehicle travel-time modelling, public transport accessibility assessments and wider accessibility considerations, is presented in Section 9.5 and the supporting technical appendices.

2.4.6 Public Health Risk Factors and Rising Chronic Conditions

Public health risk factors also influence future demand for health and care services. In Powys we compare favourably with the rest of Wales for adults being of healthy weight, and smoking, with alcohol consumption above guidelines. The proportion of adolescents who use alcohol or smoke in Powys is significantly higher than Wales generally, which is a concern[37]. Nearly six in ten adults in Powys are overweight or obese, increasing the risk of cardiovascular disease, diabetes and some cancers.

Links have been suggested between life satisfaction and good health[38] but while generally decreasing in Powys, this measure is not markedly different for adolescents here than the Wales average.

Figure 36: Early deaths and associated risk factors [39] (pg 6)

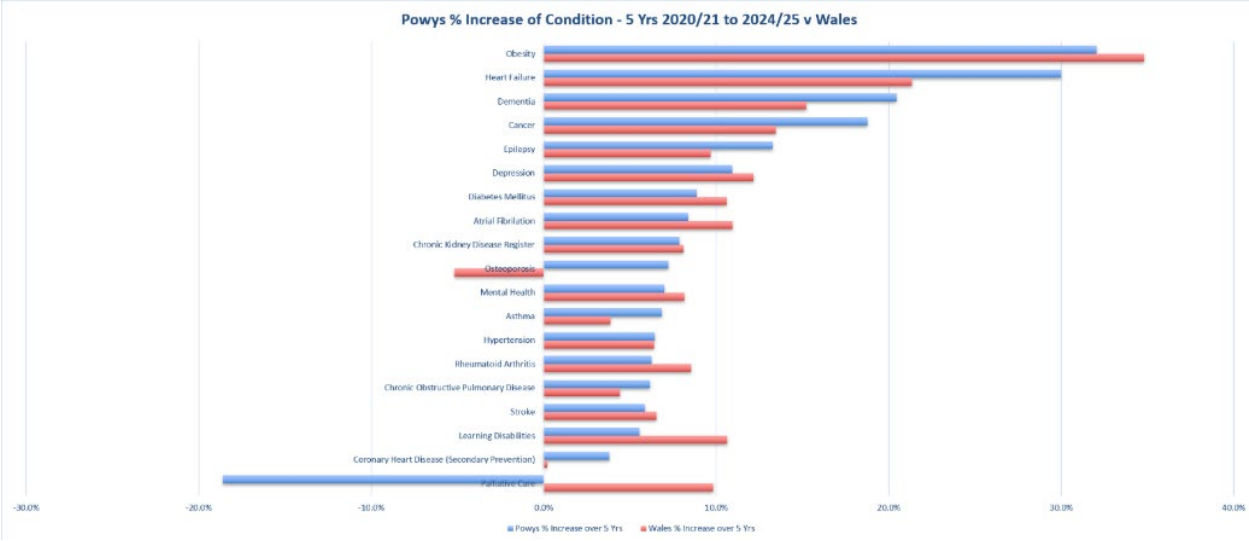


Understanding these risk factors is important because avoidable illness and increasing levels of long-term conditions can drive demand for higher-intensity services unless addressed through prevention, early intervention and targeted support.

In Powys, several long-term conditions have increased at a faster rate than the Wales average over the last five years, including heart failure, dementia, cancer and epilepsy, as shown in the chart below. Age is a key risk factor for some conditions, including certain cancers and dementia, meaning prevalence is expected to rise as the population ages[40]. However, some conditions are increasing faster than would be expected from ageing alone. For example, the number of adults in Powys living with diabetes increased by 40%, from 6,600 in 2009/10 to 9,200 in 2023/24[41]. This is shown in the chart below of the last 5 years. The example chart below (from 2018) shows how the percentage of the population that has one or more long-term condition in England increases with age.

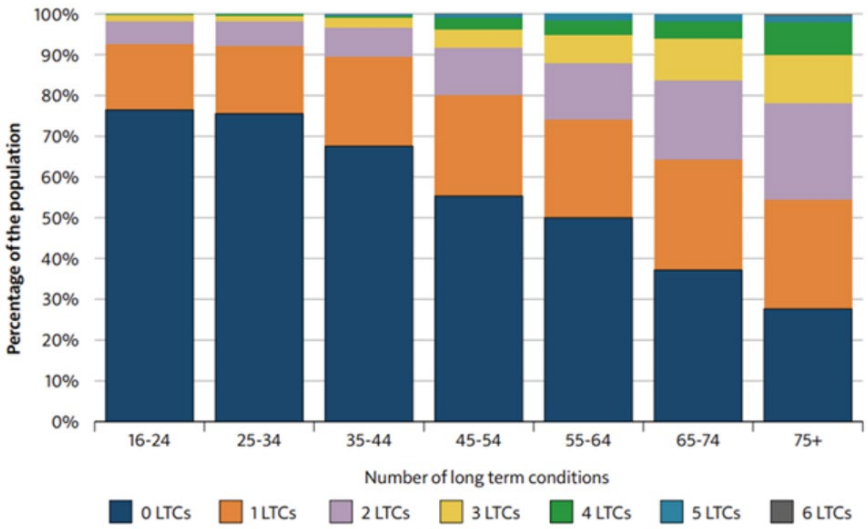
[37] PHOF Reporting Tool
[38] Personal and economic well-being - Office for National Statistics
[39] The Greatest Wealth is Health
[40] Science Evidence Advice (SEA)
[41] The Greatest Wealth is Health

Figure 37: Increase in conditions: Powys vs Wales, 2020/21 to 2024/25



These trends indicate that demand for health and care services is likely to continue increasing. Alongside this, emergency admissions continue to increase rising steadily from 15,598 in 2022/23 to 17,154 in 2025/26, representing an increase of 10% over three years.

Figure 38: Population with one or more long-term conditions by age, England 2018



Source data: Department of Health and Social Care, analysis of data from Health Survey for England 2018[8]
Image source: Redrawn from image in Chief Medical Officer's Annual Report 2020, Health trends and variation in England[9]

This sustained increase in demand has significant implications for future service planning and capacity requirements across health and care services. Increasing prevalence and complexity, including combined physical and mental health needs, reinforce the need for more integrated and preventative models of care.

2.4.7 Relevance to Better Together

Powys has a distinctive population profile which creates significant implications for future health and care services. The county has an older and ageing population, low population density, dispersed communities and

marked rural access challenges. These factors affect how people access services, how services can be safely and sustainably delivered, and the future availability of the health and care workforce.

The section also shows that population need is becoming more complex. Although Powys performs comparatively well against some health indicators, inequalities persist between communities and population groups. Deprivation, rurality, transport barriers, digital exclusion and lower healthy life expectancy all contribute to differences in outcomes and access. At the same time, rising levels of long-term conditions, frailty and age-related need are likely to increase demand for primary care, community services, planned care, urgent care, mental health services, social care, and support for independent living.

Collectively, this evidence demonstrates the need for more preventative, integrated and sustainable models of care that can support residents to stay healthy, better manage health conditions and prevent deterioration to improve health outcomes for the Powys population.

3. Challenges and the Case for Change

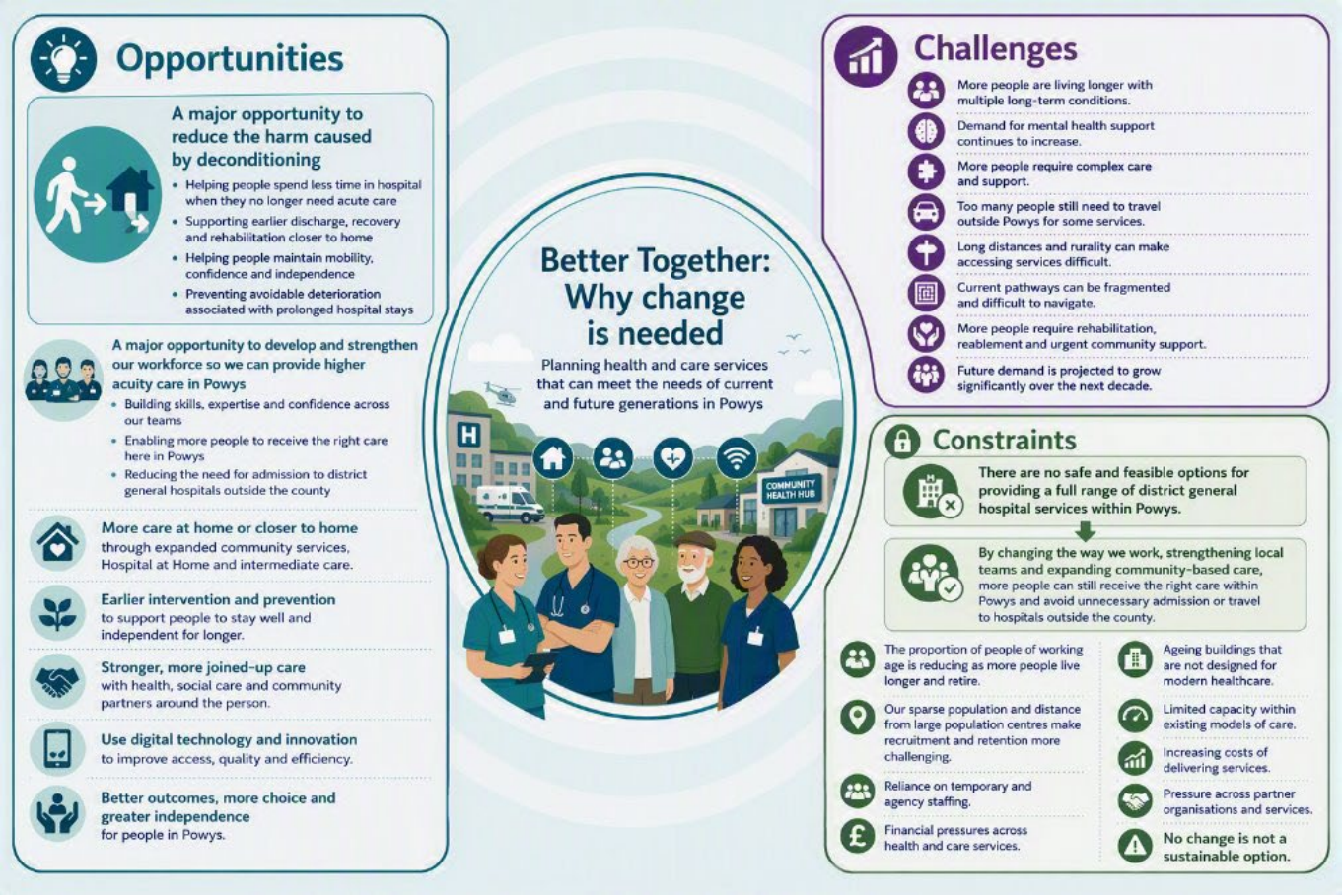
The Better Together Case for Change was shared with public, staff, partners and other stakeholders in spring 2025 to test whether it accurately reflected the challenges facing health and care services in Powys. The Case for Change was subsequently updated to reflect the feedback received through this engagement and is provided in Appendices B. The associated engagement findings are summarised within the Stage 0-2 Engagement report.

This section summarises the principal challenges affecting adult physical health, urgent care and mental health services within the scope of Phase 1. These challenges relate to:

- Quality, safety and patient outcomes
- Access to services and gaps in the current model
- Workforce sustainability
- Increasing demand and complexity
- Financial sustainability
- Estate, infrastructure and digital capability
- Strategic organisational risks.

The follow image provides an overarching summary of the Case for Change.

Figure 39: Summary of the Case for Change



The evidence presented in Sections 2.3 and 2.4 demonstrates that Powys faces a distinctive combination of challenges, including increasing demand and complexity, an ageing population, health inequalities, rurality and access issues. Whilst these factors are shaping future need, the current service model is also experiencing workforce, financial, infrastructure and capacity pressures that affect its long-term sustainability.

Taken together, these challenges demonstrate why maintaining the current configuration is unlikely to provide the most sustainable response to meet future population needs and why alternative models of care have been developed and assessed through the Better Together programme.

3.1 Patient Quality and Outcomes

The Health Board faces challenging in delivering consistently high-quality care and outcomes across adult physical health, urgent care and mental health services. Increasing demand, rising complexity, delays within care pathways and workforce pressures can all affect patient experience, quality of care and outcomes. Whilst life expectancy in Powys compares favourably with many parts of Wales, healthy life expectancy has declined, meaning many people spend a substantial proportion of later life living in poor health having developed long-term conditions.

- More needs to be done to prevent ill health and support people to manage long term conditions. Whilst underlying population needs are described in Section 2, the consequence for services is increasing need for prevention, earlier intervention and community-based care.

- Delays within care pathways continue to affect patient outcomes. Average length of stay across physical health inpatient wards is approximately 40 days, almost double the Welsh Government ambition of fewer than 21 days[42]. Prolonged hospital stays increase the risk of hospital-acquired deconditioning, loss of independence, slower recovery and poorer outcomes particularly significant for older adults and those living with frailty.[43] Reducing unnecessary time spent in hospital is therefore important both for better patient outcomes and for effective use of healthcare resources.

- Workforce instability and reliance on temporary staffing can affect continuity of care, therapeutic relationships and consistency of service delivery, with implications for patient experience and outcomes. The underlying workforce challenges are considered further in Section 3.3.

- Although the introduction of the Mental Health Single Point of Access (SPOA) aims to improve access to mental health services, some people continue to experience delays in assessment and treatment. Delays can affect patient outcomes, increase risk and place additional pressure on already stretched services.

Collectively, these challenges demonstrate opportunities to improve quality, safety and patient outcomes through earlier intervention, stronger community provision, reduced delays within care pathways and more effective support for people to remain independent at home wherever appropriate.

3.2 Access to Services

Section 2.4.5 describes the rural geography, transport challenges and wider access factors that influence access to healthcare across Powys. Within this context, variation and gaps in the current service model can make it difficult to provide timely and equitable access to the right care, in the right place and at the right time. These challenges affect patient experience, contribute to avoidable demand on hospital services and limit opportunities for prevention, early intervention and recovery closer to home.

- Demand for primary care services in Powys is increasing, placing growing pressure on GP and multidisciplinary teams (MDTs). Almost one million appointments are now delivered each year, representing the highest level of activity per head of population in Wales. This constrains GPs' capacity to focus on prevention, proactive management of frailty and long-term conditions, and earlier intervention. Although multidisciplinary working and digital solutions are helping to manage demand, primary care capacity remains a significant challenge.

- The current physical and mental health community service offer is not consistently developed or resilient across Powys. Gaps and fragility affect services including rehabilitation, reablement, community nursing, specialist practitioner support, community mental health services, learning disability services and Dementia Home Treatment. These services are essential to prevent deterioration, avoid admission, support timely discharge, and enable people to remain independent

[42] Welsh Government six goals for urgent and emergency care
[43] British Geriatric Society - deconditioning awareness

at home. However, under the current model they remain fragmented and are often unable to operate at the scale required to meet future need.

- Community transport services also rely heavily on volunteers and a limited workforce; recruitment, retention, mileage costs and administrative capacity present ongoing challenges to sustaining transport provision that enables people to access health and care services. Although not a clinical workforce issue in isolation, transport capacity is an important enabler of the service model and affects whether geographically dispersed services are accessible in practice.

- Access to preventative and protective services, including healthy lifestyle support, mental wellbeing interventions, vaccination and screening programmes, remains variable. Although not all these services are directly within the scope of Phase 1, their availability influences population health, future demand and the sustainability of health and care services.

- Powys residents continue to rely heavily on hospitals outside the county for urgent, emergency, planned and specialist care. During 2024/25 there were more than 37,000 out-of-county admissions, generating almost 100,000 bed days. Receiving care further from home can result in longer journeys, more complex pathways and additional challenges for patients, families and carers. Stakeholder feedback highlighted concerns regarding travel time, appointment scheduling, public transport availability and the cumulative impact of repeated journeys.

- Urgent care provision in Powys is currently centred on four hospital-based Minor Injury Units (MIUs), supported by participating GP practices and community-based urgent primary care services. The range of services, diagnostics and opening hours varies across locations, and weekend access is limited. Access to radiology and same-day diagnostics remains inconsistent and can result in patients travelling outside Powys or returning on another day for assessment.

- Continuing Healthcare (CHC) caseloads and costs continue to increase. This reflects growing complexity of need, the availability of care to support people at home and gaps in intermediate care services, including integrated urgent community response and fast-track home care support. There is also inconsistency in access to proactive multidisciplinary support for care home residents. Strengthening community provision could improve patient choice and reduce reliance on more intensive models of care where clinically appropriate.

- Many people with a palliative and end of life care needs express a preference, where possible and appropriate, to die at home or in a place that feels like home, close to those important to them. Preferences vary between individuals and may change according to clinical need, personal circumstances and the availability of support. Furthermore, not all deaths occur within patients with a palliative diagnosis and hospital may be the most appropriate place of care and death for some individuals. In 2025/26, there were 1,578 deaths of Powys residents. 752 were hospital deaths, of which 564 were out of county, with 188 being in hospitals in Powys and 437 of deaths occurred at home. This highlights the need to ensure that high-quality end of life care is available across a range of settings so people are supported to receive care in the setting that best meets their needs and preferences.

Collectively, these challenges demonstrate that access issues in Powys are influenced not only by geography and travel, but also by the configuration and resilience of services themselves. Gaps in prevention, early intervention, community provision, intermediate care, urgent care, diagnostics and discharge pathways contribute to avoidable admissions, delays in discharge and increased reliance on hospital-based care. Addressing these challenges will be essential to improving patient experience, supporting care closer to home and ensuring people can access the right care, in the right place, at the right time.

3.3 Workforce Challenges

Workforce sustainability is a significant challenge across adult physical health, urgent care and mental health services. Workforce pressures affect operational resilience, continuity of care and the ability to respond consistently to increasing demand. The challenges extend beyond recruitment alone and reflect the cumulative effects of vacancies, workforce distribution, retention, retirement risk, reliance on temporary staffing and the sustainability of small teams operating across a large rural county. This is reported and managed via the strategic and corporate risk register see section 3.7 for further information (SRR006 workforce sustainability).

- Within the current configuration, staff and specialist expertise are distributed across multiple sites and localities. This limits the ability to provide cross-cover, response to peaks in service demand or manage staff absence without affecting another service. This creates operational fragility, particularly where services rely on a small team, specialist roles or where there is challenges in recruiting to job post. The loss or unavailability of even a small number of staff can therefore have a disproportionate effect on service capacity and continuity.

- The Health Board's workforce age profile adds a further dimension to this challenge. In 2026, approximately 1,190 employees, around 44% of the workforce, are aged 51 or over. Around 815 employees, approximately 30%, are aged 56 or over, including about 410 aged 61 or over. Although age does not determine an individual's retirement intentions or capacity to continue working, this concentration means that retirement eligibility and potential workforce turnover are likely to become increasingly significant considerations for workforce planning. The age profile means that succession planning, knowledge transfer, and leadership development must form part of workforce sustainability planning. The potential departure of experienced staff may affect not only substantive capacity but also the Health Board's ability to supervise students and newly qualified staff, support advanced practice development and maintain professional and clinical leadership. These functions must be explicitly identified in future workforce models rather than assumed to remain available.

- The projected 2031 workforce profile indicates a marked movement into the oldest age groups. On the assumptions underpinning the projection, approximately 890 employees, around one-third of the workforce, could be aged 61 or over by 2031, including approximately 300 aged 66-70. The 61-65 age group alone is projected to increase from around 300 employees in 2026 to approximately 480 in 2031. This creates a foreseeable risk of losing substantial experience, specialist knowledge, professional leadership, and supervisory capacity over a relatively concentrated period.

- Conversely, the projected profile shows comparatively fewer employees in the younger age groups, particularly those aged 21–30 years. This suggests that natural workforce replacement cannot be assumed. Without sustained recruitment, training and retention of people at earlier career stages, the Health Board may not be able to attract suitably qualified staff to replace future retirements or meet changing demand. This is particularly important for professions requiring lengthy education, specialist training, and supervised practice before staff can operate autonomously.

- Recruitment and retention challenges are affecting several key service areas, including community inpatient wards, mental health services, imaging and specialist community roles. In a rural county, these challenges are compounded by travel time, a limited labour market, professional isolation and the difficulty of maintaining resilient staff rotas across multiple sites. This can affect continuity of care, flexibility of deployment, and the ability to consistently provide the right skill mix in the right place. It can also increase pressure on the existing workforce and reinforce reliance on temporary staffing, creating a cycle that is difficult to resolve through recruitment activity alone.

- Community inpatient services continue to experience vacancies and reliance on temporary staffing. Current information indicates a vacancy rate of around 7.58%. Agency staffing is utilised to fill vacancy posts, and for inpatient beds, agency staff are required to support approximately 21 beds in 2025/26. Whilst action has been taken to reduce staff vacancies and strengthen the workforce, including overseas recruitment and grow-your-own approaches such as the PTHB Aspiring Nurse Programme, the current position remains fragile and requires a more sustainable long-term workforce model. This suggests that workforce availability is a material constraint on the resilience and affordability of the current service configuration, notwithstanding the positive effect of actions already taken.

- Two of the Health Board's existing community hospitals have temporarily been established as Ready to Go Home units, providing around 30 beds for patients who are medically fit for discharge, but whose ongoing needs cannot currently be met through available community or social care provision. Although these patients no longer require active inpatient treatment, the units continue to need staffing level and skill mix, including registered nurses, healthcare support workers, clinical oversight and resilient rota cover. This means scarce clinical workforce capacity remains committed to an inpatient model until suitable alternatives are available; at that point, the staffing requirement could be reviewed and capacity reconfigured, where appropriate, to support admission avoidance, timely discharge and, reablement and intermediate care at home.

- Urgent care services operate from a constrained workforce baseline that is focused on maintaining existing services and safe operational cover. As a result, the workforce required to deliver future urgent care centres and community urgent response cannot be assumed to be available from within current resources and should be considered additional capacity and capability, particularly in relation to diagnostics, clinical leadership and senior decision-making.

- Mental health services are also experiencing workforce pressures, including vacancies, reliance on temporary staffing and increased staffing requirements linked to patient acuity and clinical risk; where enhanced observations are required, this can place additional pressure on already stretched rotas

and increase the need for bank or agency cover. More than £7 million was spent in 2025/26 on mental health nurse agency staffing, bank staffing and medical locums, illustrating the scale and cost of this dependency. These pressures affect service resilience, staff experience and the ability to consistently maintain safe and therapeutic care environments. They also demonstrate the importance of ensuring that future workforce models are sufficiently flexible to respond to changes in acuity, rather than being based solely on average staffing requirements.

- Primary care also faces workforce and workload pressures. Alongside increasing demand, these pressures can reduce the capacity available for prevention, proactive management of frailty and long-term conditions and early intervention. This has wider implications for system sustainability because constrained primary care and community service capacity may limit opportunity to prevent deterioration and avoid escalation of need.

Workforce sustainability is a critical factor in the long-term viability of health and care services in Powys. The combined impact of workforce fragility, recruitment and retention challenges, reliance on temporary staffing, and an ageing workforce creates significant risks to service resilience and the ability to respond to increasing demand. Maintaining the current configuration is unlikely to provide a sustainable workforce model for the future. Future service models will therefore need to be supported by a workforce that can realistically be recruited, trained, deployed, retained and sustained. The workforce implications, requirements and implementation considerations associated with the preferred model are described in Section 9.

3.4 Changing Population Needs and Continued Expansion of Healthcare Capability

The population needs described in Section 2 are translating into increasing demand, acuity and complexity across physical health, urgent care and mental health services. If services continue to operate in their current form, future need and demand is projected to exceed the capacity of the existing model with poorer health outcomes for residents. Demographic change, increasing prevalence of long-term conditions and rising complexity of need are therefore key drivers of the Case for Change.

- Continued advances in healthcare capability create significant opportunities for improving health outcomes. Modern healthcare can diagnose more conditions, intervene earlier, offer more treatments, and support people to live longer with increasingly complex needs. Whilst this represents a major achievement, it also increases the range, intensity and complexity of care provided, with associated workforce, capacity and financial implications. As healthcare knowledge, technology, clinical standards and available interventions advance, the NHS is able to do substantially more for any given patient presentation than was previously possible.

- Independent demand and capacity modelling indicates that, without a shift to new models of care, targeted prevention, stronger community services and improved patient flow, future community inpatient bed requirements in Powys could increase to approximately 235 beds within ten years. This represents an additional requirement of 66 beds compared with the current position. Continuing to meet future demand through the existing model would expose a greater number of patients to prolonged hospital stays and the associated risk of hospital-acquired deconditioning. Importantly, the modelling also demonstrates that this growth is not inevitable. Several evidence-based interventions

were identified that could mitigate future demand, including the application of Professor John Bolton's Discharge to Assess model and the development of intermediate care pathways for frailty, stroke and hip fracture.

- This is a similar picture for specialist mental health and learning disability services in Powys where demand continues to grow; with rising referrals across early intervention, prevention and a wider range of psychiatric sub-specialties. Adult and older adult referrals are projected to increase by up to 33% by 2035, alongside a projected 14% increase in bed days [44]. Independent demand and capacity modelling outlined several interventions that could mitigate against demand through new ways of working such as an 'open access' model, increased use of digital and alternatives to admissions through strengthening of the community model.

These projections demonstrate that future demand cannot be met sustainably through the continued expansion of existing services alone. Population change, increasing complexity and advances in healthcare capability will require different models of care that focus on prevention, earlier intervention, community-based support and more effective management of demand across the health and care system.

3.5 Financial Sustainability

Financial sustainability is a key driver of transformation across PTHB. Rising demand, increasing service complexity, workforce pressures, delayed discharge and growing expenditure on commissioned care continue to place significant pressure on available resources. This is reported and managed via the strategic and corporate risk register see section 3.7 for further information (SRR001 financial sustainability).

As described in Section 2.3, Powys operates a mixed model of directly provided and externally commissioned services. Approximately 40% of Health Board expenditure is associated with hospital, specialist and ambulance services commissioned from partner organisations, representing around £198 million during 2025/26. Whilst these services remain essential to meeting the needs of Powys residents, associated expenditure has increased and is influenced by demand and cost pressures over which the Health Board has more limited direct control.

The Health Board's financial position has become increasingly challenging in recent years. Despite ongoing financial recovery measures, including reductions in non-clinical expenditure, actions to reduce agency staffing and service redesign initiatives, underlying cost pressures continue to exceed available resources. The current model requires the Health Board to respond to increasing demand whilst simultaneously managing significant workforce, estate, and infrastructure challenges.

Maintaining the current configuration without addressing its underlying demand, workforce and patient flow pressures is unlikely to provide a sustainable financial response to future need. Financial sustainability is therefore not solely a question of reducing expenditure; it is also about ensuring that resources are used effectively to improve outcomes, reduce avoidable demand and provide care in the most appropriate setting.

The table below identifies the increasing financial challenge, and further detail is available within the published Annual Report and Accounts[45]. It demonstrates the increasing financial challenge facing the Health Board

[44]' Appendix B.1 Mental Health Technical Chapter

[45] PTHB annual accounts and quality statements

over recent years. The continuing gap between available resources and expenditure reinforces the need to consider how future services can be delivered in a way that is clinically effective, operationally sustainable and financially affordable

Figure 40: PTHB Financial position over past 3 years

The financial implications of the shortlisted options and the affordability of the preferred model are considered in greater detail within the Economic and Financial Cases.

3.6 Digital, Buildings and Infrastructure

2.1 Revenue Resource Performance

	Annual financial performance			
	2023-24 £000	2024-25 £000	2025-26 £000	Total £000
Net operating costs for the year	429,823	464,384	504,121	**1,398,328**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,859	1,833	1,227	**4,919**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Less any non funded revenue consequences of IFRS 16	0	0	0	**0**
Total operating expenses	431,682	466,217	505,348	**1,403,247**
Revenue Resource Allocation	419,699	450,464	472,073	**1,342,236**
Under /(over) spend against Allocation	**(11,983)**	**(15,753)**	**(33,275)**	**(61,011)**

Despite significant investment in recent years, parts of the Health Board's estate and digital infrastructure remain unsuitable for modern models of care. These limitations affect service quality, patient experience, workforce recruitment and retention, operational resilience and the ability to transform services. This is reported and managed via the strategic and corporate risk register see section 3.7 for further information (SRR002 Innovation and Strategic Change and SRR007 Estate and Quality Infrastructure).

The quality and condition of the current estate remain significant barriers to future service development in Powys, affecting patient experience, workforce recruitment and retention, and the ability to modernise services. Current backlog maintenance is estimated at £63.6 million[46] .

- Many buildings pre-date the NHS and were designed for historic models of care rather than modern service delivery; over a third of buildings date from before 1948 and only a small proportion have been built since 2005. Some of these constraints increase the cost of transformation and modernisation.

- Estate pressures have direct implications for quality, safety and sustainability; current estate compliance risks include fire safety, ventilation, medical gases, infrastructure, health and safety and other compliance issues.

- Existing facilities do not consistently provide an appropriate therapeutic environment for people with mental health needs. The layout of some inpatient wards requires additional staffing to maintain patient safety and limits the ability to provide care in environments designed around modern mental health service standards.

[46] Appendix U – Better Together Assessment of Estates

- Feedback gathered through the development of this business case has reinforced that digital is a core enabler of future service models, but only where the infrastructure is reliable, accessible and designed around the needs of patients, staff and communities. Robust connectivity across sites, improved access to shared information at the point of care, better interoperability between systems and partner organisations, and greater use of digital tools are all required to support care closer to home and more joined up working.

- Stakeholder feedback has also highlighted that digital solutions alone will not meet the needs of all communities. Concerns regarding connectivity, digital confidence, access to devices and digital exclusion reinforce the need for future models of care to remain inclusive and provide appropriate non-digital routes to access support, where required.

These challenges demonstrate that estate and digital infrastructure are not simply supporting assets but critical enablers of future service models. Ageing buildings, compliance pressures, limitations in therapeutic environments and digital infrastructure constraints all affect the ability to provide sustainable, high-quality services. Addressing these issues will be essential if future models of care are to be delivered successfully. The detailed estate, infrastructure and digital requirements associated with the preferred model are described in Section 9.

3.7 Strategic Risks

The challenges described throughout Section 3 are reflected in the Health Board's existing Strategic Risk Register. The risks summarised below are actively managed through established strategic and corporate risk management arrangements; however, the Strategic Risk Register ratings reported to the Board on 29 July 2026 demonstrate that significant residual exposure remains despite existing controls and mitigating actions.

The purpose of the Case for Change is not to identify entirely new organisational risks, but to demonstrate how the current model contributes to the persistence of existing financial, service, workforce, estate and public-confidence risks, and why transformation is required to address their underlying causes. The current service configuration should therefore be regarded as a risk-bearing baseline rather than a low-risk comparator. The information and supporting evidence presented in this section are also informed by the relevant Level 2 Impact Assessments.

Figure 41: Strategic Risks relevant to the Case for Change

Risk Ref	Risk Title	Current Risk Rating	Key Relevance to Case for Change	Current Mitigation
SRR001	Financial Sustainability	20	Rising demand, fragmented services, temporary staffing, increasing commissioned care expenditure and delayed discharges create ongoing cost pressures and affect the Health Board's ability to achieve financial sustainability.	Financial recovery programme, demand management initiatives, productivity improvements and continuing pathway redesign.
SRR002	Innovation and Strategic Change	16	The existing service, workforce, estate and digital configuration constrain the Health Board's ability to deliver transformation and realise	Better Together programme governance, portfolio management arrangements, clinical and

			the intended benefits of new models of care.	professional assurance, and transformation support structures.
SRR003	Demand for Commissioned Services	20	Reliance on commissioned and out-of-county provision exposes the Health Board to increasing activity, expenditure and pathways over which it has more limited direct control.	Contract management, commissioning oversight, pathway redesign and development of safe and sustainable local alternatives where clinically appropriate.
SRR004	Demand for Provided Services	16	Increasing demand for urgent care, community services, rehabilitation, physical health inpatient care and mental health services continues to place pressure on available capacity.	Operational D&C management, service improvement programmes, escalation processes and development of strengthened community pathways.
SRR005	Primary Care Sustainability	16	Rising demand, increasing complexity and workforce pressures constrain the capacity of primary care to support prevention, proactive care, early intervention and management of long-term conditions.	Primary care sustainability programmes, cluster working, workforce initiatives and closer integration with community services.
SRR006	Workforce Sustainability	16	Small and geographically dispersed teams, recruitment and retention challenges, an ageing workforce and reliance on temporary staffing reduce service resilience and continuity.	Workforce planning, recruitment and retention activity, skill-mix development, succession planning, new and enhanced roles, and temporary staffing arrangements.
SRR007	Estate Quality and Infrastructure	16	Ageing and, in some areas, unsuitable estate limits service redesign, modern therapeutic environments, digital integration and flexibility in the deployment of services and staff.	Estate maintenance programmes, infrastructure and capital investment planning, compliance monitoring and development of the Estates Strategy.
SRR012	Reputation and Public Confidence	15	Service fragility, temporary changes, variation in service availability and uncertainty about future models may affect confidence among patients, staff, stakeholders and communities.	Transparent engagement and communication, formal consultation, publication of supporting evidence and clear explanation of how feedback will inform decision-making.
SRR008	Unable to shift to primary prevention focussed health care system	16	The NHS historically has prioritised acute and reactive care and has not invested in prevention by allocating resources to keep people healthy and prevent ill-health.	Produced Population Health Strategic Framework. Action focussed on health needs priorities.

Taken together, the strategic risks demonstrate that the challenges facing the Health Board are interconnected. These challenges also affect the Health Board's capacity to deliver sustainable change and maintain confidence amongst patients, staff, partners and communities. Existing controls and mitigation actions help manage these risks but have not removed their underlying causes. The Case for Change and residual risk profile demonstrate maintaining the current configuration is not an option. Significant transformation of services is needed.

4. Development, Appraisal and Assurance of Options

4.1 Purpose and Overview

As summarised in Section 1.4, the options proposed for consultation emerged through a structured, transparent and evidence-based process. The process was compliant with NHS Wales service change guidance. This section describes how the Case for Change informed the development, appraisal, refinement and assurance of options, and how this process resulted in the recommended consultation options described in Sections 5 to 8.

The detailed chronology, workshop records, progression decisions, appraisal outputs and rationale for options discounted or combined are provided in the Options Development Step Report and its supporting documents at appendix Z 1-5. This section therefore provides a summary of the options development process and the route to the proposed recommended options for consultation.

4.2 Options Development Process - From the Case for Change to Consultation Options

The programme adopted a five-step methodology underpinned by NHS Wales service-change guidance. HM Treasury Green Book principles were applied proportionately to support the non-financial appraisal, recognising that the Green Book is more commonly used for investment appraisal than service transformation. The process was designed to provide a consistent and transparent framework for considering strategic alignment, clinical sustainability, accessibility, deliverability, financial sustainability and potential impact. Progression decisions were based on the totality of the evidence, professional judgement and structured assessment, rather than on any single score or exercise. Impact assessments were undertaken iteratively throughout the process rather than only at the end. Level 1 assessments supported early identification of differential impacts and informed option refinement and consolidation. Level 2 assessments were developed alongside detailed option refinement to support mitigation planning and identify residual risks and issues requiring exploration through consultation.

The five steps did not operate as isolated stages. Findings from engagement, clinical and professional workshops, modelling, impact assessment and assurance were considered iteratively as options were developed and refined. Stage 1 engagement supported and validated the Case for Change. Stage 2 engagement informed option generation, screening and refinement. Formal consultation represents the next stage of the process and forms no part of the appraisal work already completed.

The table below provides a summary of the five-step process from the Case for Change to the recommended options for consultation, the activities that took place and how evidence and engagement informed the process.

Figure 42: Summary of the five-step process Options Development Process

Stage	Principal activity	How evidence and engagement informed the process	Main output
Step 1: Case for Change, issues and opportunities	The evidence bases and service issues were developed and tested through stage 1 engagement with staff, patients, the public and partners. Future models, design	Engagement broadly supported the Case for Change. It also identified several areas requiring particular attention, including rural access,	Tested Case for Change, agreed scope, design and travel principles, assessment criteria and initial ideas on proposed solutions generated.

Stage	Principal activity	How evidence and engagement informed the process	Main output
	principles and assessment criteria began to be established.	workforce sustainability, primary care, mental health provision, service coordination, prevention, communication and care closer to home where safe and appropriate. The Case for Change subsequently acted as a continuing reference point against which emerging models and options were considered with consideration as to how the options would best address the issues in the case for change. Engagement findings also informed the design principles and assessment criteria. The person-centred element of the appraisal criteria was strengthened, while concerns about rural travel contributed to the development of travel-time principles and a travel analysis dashboard. Design principles, assessment criteria and travel principles were therefore established prior to the detailed appraisal of options and informed initial development.	
Step 2: Development of initial options	Ideas from engagement and clinical and professional workshops were reviewed, grouped and developed into potential long list options. Six broad scenarios were used to explore different balances of local, community, consolidated and out-of-county provision (this can be	Engagement feedback, clinical and professional workshops, deliberative events and technical work generated a broad range of ideas about how pathways and services could be improved or organised differently. These included a range from enabling	Long list of potential options supported by service-issues and model-of-care evidence.

Stage	Principal activity	How evidence and engagement informed the process	Main output
	found in the Stage 2 Engagement Report). Sixty-eight ideas were initially considered. These were reviewed according to their nature, intended outcome and relationship to the Case for Change. Fifty-four ideas progressed into the initial long-list development process. The distinction between an idea and an option is important. Some ideas described individual service components or enabling actions rather than alternative proposals. As development progressed, ideas were grouped, divided into service-specific variants or incorporated into wider pathway and configuration options. The resulting number of options were not therefore a simple linear reduction from 68 ideas to a final set of proposals.	actions and service improvements to more substantial changes to how and where care could be provided. The first deliberative event, Stage 2 engagement and primary care engagement tested the scenarios, criteria and emerging ideas and outputs informed in the next step.	
Steps 3 and 4: Screening, refinement and shortlisting	Long-list options were tested against hurdle criteria in section 4.4.1. The process involved clinical, operational and professional colleagues. A recorded rationale was required where an option was progressed, combined or discounted. Options were refined, combined or discounted, and further workforce, financial, estate, demand, capacity and impact evidence was developed. Only options that passed the relevant hurdle criteria and remained materially distinct and credible following this triangulation progressed to detailed non-financial appraisal. Community-model options were subsequently aligned with the physical and mental health inpatient options so that whole pathways could be considered rather than community and inpatient services	Shortlisting involved the triangulation of the hurdle-criteria assessment, clinical and professional evidence, refinement and consolidation of overlapping or derivative options, interdependencies across service areas, engagement and deliberative-event findings, workforce, financial, estate, D&C evidence; and emerging impact-assessment findings. Stage 2 findings, the second deliberative event, partner input and clinical and professional challenge informed refinement and shortlisting.	A materially distinct shortlist supported by recorded rationale. Options that did not meet essential requirements were discounted Options that did not meet the essential hurdle criteria were not progressed to detailed appraisal. However, "do current" and "do previous" positions were retained as baseline comparators to enable the proposed options to be compared transparently with current and pre-temporary arrangements. Some "do minimum" approaches were also retained where they warranted further examination as potential transitional options.

Stage	Principal activity	How evidence and engagement informed the process	Main output
	being appraised in isolation. Diagnostic components relevant to urgent care were similarly incorporated into the urgent care options, while a wider review of diagnostics will be considered in a later phase of work. This reduced duplication and allowed the appraisal to consider coherent service models rather than disconnected components.		
Step 5: Appraisal and assurance	The short list options underwent non-financial and financial appraisal using the six NHS Wales quality domains (STEEEP). Assessment and appraisal included evidence on workforce, financial, D&C, estate, travel-time, patient-pathway and impact-assessment. Further clinical, professional, executive, partner and independent challenge was then applied before the proposed consultation options were identified.	Earlier engagement findings were reflected in the criteria, weighting, sensitivity analysis, travel assessment, impact assessment and deliberative challenge. Appraisal scores informed, but did not determine progression decisions. Progression decisions took account of the totality of the evidence, including hurdle-criteria outcomes, non-financial appraisal, sensitivity analysis, clinical and professional judgement, engagement findings, deliverability, impact assessment and assurance. The appraisal process and recommended options for consultation were shared and tested at a third Deliberative Event. There was broad agreement that the current way of delivering services was not sustainable and that something needs to change, however people questioned whether the right conditions were in place to make change work – such as community services, social care, enough staff, transport,	Short list options robustly appraised and set of credible recommended options proposed for formal consultation following testing with stakeholders.

Stage	Principal activity	How evidence and engagement informed the process	Main output
		and a realistic plan. They broadly accepted the direction of travel but there was challenge around whether the community services shift could be delivered. Further work took place to address feedback on the material presented ahead of consultation and this is reflected in the technical and consultation documents.	
Stage 3: Formal consultation	The proposed, options, potential impacts, assumptions and material alternatives will be subject to public consultation.	Consultation responses and any alternative proposals will be conscientiously considered before a final decision.	Consultation report, updated supporting evidence and subsequent decision through the Final Programme Business Case process.

4.3 How the Options were Assessed

4.3.1 Hurdle Criteria

The hurdle criteria provided the first formal screening mechanism. Their purpose was to identify potential options that were not sufficiently clinically sustainable, accessible, deliverable, financially sustainable or aligned with the strategic direction and should therefore not proceed to more detailed appraisal. The criteria were developed through the Options Development Group, tested through clinical and enabling groups and stakeholder engagement, and approved before its formal application.

Figure 43: Hurdle Criteria applied during the options development process

Criteria	Explanation
Is the potential solution clinically sustainable?	Does it deliver progress towards safe and reliable services that meet quality standards? Does it consider any co-dependencies (the way in which different services need to work together)? Is it informed by evidence ensuring people receive the right care and optimal outcomes?
Does the potential solution improve access?	Does it enable people to access advice, guidance, and care quickly and easily? Does it address equity of access? Does it provide access within an appropriate timeframe?
Is the potential solution deliverable?	Is the workforce or an alternative workforce model available to deliver it? Has digital technology been considered in the development of the solution? Will it be clinically deliverable in a short (1-2 years), medium (2-4 years) or long (5-10 years) timeframe? Will it be operationally deliverable in a short (1-2 years), medium (2-4 years) or long (5-10 years) timeframe?

Criteria	Explanation
Does the potential solution support (or at least not contradict) …	A person-centred care system that meets people's needs Integrated working with partners Improvement of population health The strategic direction for Powys (e.g. Health and Care Strategy, PTHB strategic priorities) and for NHS Wales (e.g. A Healthier Wales)
Is the potential solution financially sustainable?	Does it make best use of financial resources in the short and long-term? Does it support a value-based approach to improve outcomes? Does it improve efficiency and productivity and reduce waste?

4.3.2 Non-Financial Appraisal

Figure 44: NHS Wales Health and Care 12 Quality Standards



Shortlisted options were assessed against the six NHS Wales domains of quality (figure 43). A structured five-point scoring mechanism was used to support comparative assessment. The criteria were weighted to reflect the Case for Change and organisational priorities, and sensitivity analysis was used to test how the results changed when alternative weightings were applied. Engagement themes were also reflected through the criteria, alternative weighting, travel analysis, and interpretation of appraisal results.

The appraisal provided a structured method for examining relative strengths, weaknesses and trade-offs. A higher score did not automatically determine that an option should progress. Equally, a lower score did not remove the need to consider the evidence, risks, impacts and rationale behind the result. The complete assessment criteria, scoring descriptors, weighting, sensitivity analysis, and appraisal outputs are provided in the Step Report and appendices X and Y. The service-specific implications and appraisal findings are described in Sections 6 to 8.

4.3.3 Technical and Service-Specific Assessment

Non-financial appraisal represented one part of the overall assessment. The shortlisted options were also informed by various technical processes and outputs set out in the table below:

Figure 45: Technical outputs informing overall assessment

Service issues and models of care	D&C modelling	Workforce modelling and sustainability assessment
Financial appraisal and affordability	Estate and infrastructure assessment	Travel-time analysis
Patient-pathway testing	SWOT analysis	Level 1 and Level 2 Integrated Impact Assessments
Clinical and professional scrutiny	Engagement and deliberative-event findings	Partner and independent input

Further information on these can be found in the following sections in this document and within the appendices:

- service-specific demand, capacity, workforce, finance, estate and appraisal findings are described in Sections 6 to 8

- cross-cutting workforce, digital, estate and partnership dependencies are discussed in Section 9
- travel assessment methodology and cross-cutting accessibility considerations are described in Section 9.5
- the detailed Integrated Impact Assessments are provided at appendices Z.2
- the full non-financial appraisal results are contained in the Step Report (appendices Z.5)
- detailed patient-pathway, modelling and technical reports are included within the appendices.

4.3.4 Long List of Options to Recommended Options

The Step Report describes how the long list of options was developed, assessed and reduced to a shortlist, and then to a refined set of credible recommended options, all informed by the available evidence and stakeholder feedback throughout the process. There were 81 service-specific options subjected to hurdle assessment, of which 38 were initially shortlisted and 43 discounted. There was an increase in the urgent care options following check and challenge to consider two site options. The process concluded with five recommended options for consultation which are detailed in sections 5-8 of this document.

Figure 46: Option progression from long list to shortlist to recommended options

Programme	Long list options assessed (Hurdle Criteria)	Long List Options discounted	Options short-listed after hurdling	Options being recommended for consultation following appraisal
All programmes (total)	**81**	**43**	**38**	**5**
Mental Health	26	15	11	1
Physical Health	21	12	9	2
Urgent Care	20	9	11	2
Diagnostics (subsequently combined with Urgent Care)	14	7	7	n/a

4.4 Long List Options

A full list of the long list of options and rationale for progressing or discounting is provided in appendices L. A summary of how the options were hurdled is provided below for each service area with key themes as to why options were not progressed.

Mental Health

In total, 26 options were subject to the Hurdle Criteria, with 11 options progressing as sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical viability, workforce sustainability, financial affordability, estates feasibility, and the removal of duplicative or marginally different variants, resulted in eight

distinct, credible and deliverable options being agreed for the final shortlist. The themes on why some options were not progressed to the short list due to not meeting the essential hurdle criteria is provided below:

- **Patient safety and quality standards:** Options were discounted where they could not reliably meet clinical/quality standards (for example, having the right environment, staffing levels and specialist input to deliver safe care).
- **Workforce sustainability** and ability to recruit/retain: Options were not progressed where there were significant staffing challenges or where service models would be difficult to staff safely now and into the future.
- **Strategic fit and alignment with national future models of care**: Options were discounted where they did not align with the Health and Care Strategy development of Rural Regional Centres or national direction of for modern mental health services.
- **Integration with community services and prevention/earlier intervention**: Options were not progressed where they did not create opportunities to strengthen community-based support, improve prevention and early help, or work more closely with physical health services.
- **Equity of access and travel impact across Powys**: Options were discounted where location or travel distance would disadvantage a larger proportion of the population, particularly where this could increase inequality of access.
- **Financial viability and value for money**: Options were not progressed where they were judged not to be financially viable or would not provide sufficient benefit relative to cost and risk.
- **Duplication or being better handled as a component within other options**: Some ideas for example, sanctuary and step-down approaches or gender-specific provision was not progressed as stand-alone options because they needed to be designed into other options to meet standards and deliver a coherent service model.

Physical Health

In total, 21 options were subject to the Hurdle Criteria assessment, with nine options progressing as sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical feasibility, workforce sustainability, financial affordability, estates implications, and the removal of options representing minor variations, resulted in eight distinct, credible and deliverable options being agreed for the final shortlist. The themes on why some options were not progressed to the short list due to not meeting the essential hurdle criteria is provided below:

- **Affordability and value for money –** options were not progressed where there was confidence there would be an increase in costs; they would worsen existing overspends or not represent an efficient use of available funding.
- **Workforce and resource efficiency –** options were not progressed where they did not make best use of staff capacity or would be difficult to staff sustainably.
- **Estate and infrastructure sustainability –** options were not progressed where the underlying model relies on an ageing or unsuitable estate.
- **Clinical safety, quality and standards –** options were not progressed where they would not meet expected clinical standards, or where quality and safety benefits could not be demonstrated.
- **Operational deliverability and evidence base –** options were not progressed where they were judged not to be practically deliverable (for example, spreading a smaller bed base across too many sites) or not supported by evidence.

- **Duplication or being better handled as a component within other options**: Some ideas were not progressed where they were absorbed into another option, duplicated another proposal (e.g., a bed type within a wider model).
- **Strategic fit and alignment with national future models of care**: Options were not progressed where they did not align with the Health and Care Strategy development of Rural Regional Centres or national direction, this included discounting of options where moving provision outside the area reduced local control over service quality, performance and expenditure.

Urgent Care

In total, 17 options were subject to the Hurdle Criteria, with five options progressing as sufficiently viable to warrant further consideration, during the Lock-in Week. Subsequent triangulation of clinical appropriateness, workforce sustainability, financial affordability and estates feasibility, and the identification of options that represented minor variations, led to discussions about aligning diagnostics and imaging within the five agreed urgent care shortlisted options, with diagnostics embedded as enabling components of those models. This approach reflects that the scope of this work considered only a limited element of diagnostics, with the comprehensive review of diagnostics planned as part of Phase 2 (Diagnostics and Planned Care) within the Better Together Portfolio. Following the check and challenge process and subsequent decision at Portfolio Board on 10th September 2025, additional Urgent Care options were agreed to be further explored. These were hurdled bringing the total options hurdled to 20, with 11 options taken through a further non-financial options appraisal workshop in April 2026, see appendices x).

The themes on why some options were not progressed to the short list due to not meeting the essential hurdle criteria is provided below:

- **Does not address the Case for Change or meet future population needs:** options that largely maintained the existing model were not progressed because they would not resolve the key issues identified (e.g. future demand and service sustainability).
- **Insufficient activity/need to justify the number of centres:** options proposing provision across multiple sites were discounted where population needs, activity levels and travel-time considerations suggested that the service might not be sustainable and or would dilute clinical experience.
- **Ability to meet standards and provide safe, high-quality care:** options were not progressed where it was uncertain if they would consistently meet expected clinical standards, provide timely care, or maintain safe staffing/skill mix across all sites.
- **Workforce deliverability constraints:** some options were discounted because they would be difficult to staff sustainably (recruitment/retention, rota resilience, and reliance on scarce roles) or because they did not sufficiently reduce known workforce pressures.
- **Affordability and financial viability:** options were not progressed where costs, savings or overall financial viability needed further testing, or where there was insufficient evidence that the option would be affordable and sustainable.
- **Duplication / not a distinct option:** options were removed where they duplicated another option, or were later recognised as not independent (i.e. they described a variation or component of another option).

Diagnostics

In total, 14 options were subject to the Hurdle Criteria, with seven options progressing as sufficiently viable to warrant further consideration. Subsequent triangulation of clinical appropriateness, workforce sustainability, financial affordability, estates feasibility, and the identification of options that represented minor variations, led to agreement to align diagnostics and imaging within the five agreed urgent care shortlisted options, with diagnostics embedded as enabling components of those models. Below is a list of themes on why some options were not progressed to the short list, due to not meeting the essential hurdle criteria:

- **Affordability and financial deliverability**: options were not progressed where the costs could not be supported or did not represent value for money within the agreed financial envelope (e.g., proposals requiring additional equipment and supporting ongoing staffing that were not financially viable).
- **Not a standalone option (best delivered as part of another option)**: options were not progressed where they were components, enablers, or variants of a broader model already being taken forward (e.g. DEXA and point-of-care testing developments incorporated within a wider diagnostic option).

4.4.1 Short List Options

Following the appraisal and technical development, two workshops considered the shortlisted options against the case for change, service models, non-financial appraisal, financial appraisal, estate assessment, demand and capacity evidence and the assumptions supporting each option. The purpose was to consider the evidence collectively and record which options should be recommended for progression to consultation, and which should be discounted. Options not recommended for progression were required to have a clear rationale. This process was applied across physical health, urgent care and mental health. “Do current” and “do previous” options were not recommended but were retained as baseline comparators.

The outputs were subsequently subject to clinical, executive, programme, portfolio assurance and further deliberative challenge. The tables below include all the short-listed options that were fully appraised both non financially and financially along with the rationale for discounting or proceeding to consultation as recommended options. The recommended options are further outlined in Section 5 and described in more detail in Sections 6 to 8 of this document. Approval to consult on these options would not constitute approval to implement them.

Figure 47: Physical Health Short Listed Options

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001a – Do Previous	Pre-temporary service changes	Discount (include as comparator only)	Ranked 8th financial and 8th non-financial appraisals. Estates rated A-Green. • Ranked lowest in both financial and non-financial appraisals. Does not meet future demand or address the case for change, for example reducing patient deconditioning and agency spend. Retained as baseline/comparator only.
001b – Do Current	Make temporary changes permanent	Discount (include as comparator only)	Ranked 7th financial and 7th non- financial appraisals. Estates rated A-Green. • Operationally stable short-term but does not address sustainability, future population need, demand growth,

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
			or workforce issues within the case for change. Retained as baseline/comparator only.
011 - Remove all Community beds	No local community inpatient beds; rely on community team, care homes and secondary care providers	Discount	Ranked 9th financial and 6th non-financial. Estates rated A-Green. • Higher cost associated from financial perspective i.e. commissioning costs) therefore unaffordable due to increased use of private sector and secondary care providers. Will have negative impact on Stroke Rehabilitation. Frailty recognised as syndrome – impact on community offer due to complexities. Does not improve access, does not address the issues within the case for change. Independent demand and capacity modelling indicates PTHB requires Community inpatient bed base to meet population needs. Option does not support with integration of physical and mental health services.
002a – Do Minimum	Same Community Inpatient bed numbers across 6 sites with stronger community model	Discount	Ranked 6th financial and 5th non-financial appraisals. Estates rated B – Green. • Option does not support with integration of physical and mental health services. Provides some efficiency required to operate within current funding envelope, but this is not enough in the longer term. In the short term would deliver benefits financially and non-financially and allow some investment into the community model to support people at home.
002b – Do Minimum + MH integration	Same Community Inpatient bed numbers across 6 sites with stronger community model with integrated physical and mental health services on some sites	Discount	Ranked 6th financial and 4th non-financial appraisals. Estates rated B – Green. • Option does support integration with physical and mental health. Provides some efficiency required to operate within current funding envelope, but this is not enough in the longer term. In the short term would deliver benefits financially and non-financially and allow some investment into the community model to support people at home. Could be considered as a transition option.
005a – Do Mid-Range	Fewer community inpatient beds reduced to 3 sites, with enhanced community model	Discount	Ranked 4th financial and 2nd non-financial appraisals Estates rated D – Amber. • Option does not support with integration of physical and mental health services.
005b – Do Mid-Range + MH integration	Fewer community inpatient beds reduced to 3 sites, with enhanced community model + better join up	Proceed to next stage	Ranked 4th financial and 1st non-financial appraisals. Estates rated D – Amber. • Moderate delivery risk. Balances improved quality, multi disciplinary team working, and community-based care while remaining more deliverable than two site options. Requires workforce transformation and estate

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
	with mental health		investment but agreed as a credible and balanced option.
008 – Do Maximum	Even fewer community inpatient beds reduced to 2 sites, with enhanced community model ++ and better join up with mental health	Proceed to next stage	Ranked 2nd financial and 3rd non-financial appraisals. Estates rated D – Amber. • Offers lowest net cost and strongest shift to care closer to home. Ranked 3rd non-financial but carries higher delivery and workforce risk and major estate dependence. Proceeding to consultation to test acceptability of scale of change versus benefits.

Figure 48: Urgent Care Short Listed Options

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001A – Do Previous	Pre-temporary service changes (4 MIUs)	Discount (include as comparator only)	Ranked 11th financial and 11th non-financial financial appraisals. Estates rated A- Green • Does not meet current or future demand and does not address the Case for Change. Ranked lowest in both financial and non-financial appraisals. Retained as baseline/comparator only.
001B – Do Current	Make temporary changes permanent	Discount (include as comparator only)	Ranked 8th financial and 8th non-financial appraisals. Estates rated A- Green • Fails to meet future demand and does not deliver required service improvement or resilience. Continued workforce fragility and variation in offer. Retained as baseline/comparator only.
001C – Do Minimum (3 MIUs)	3 MIUs: Newtown, Llandrindod, Brecon	Discount	Rank 6th financial and 5th non-financial appraisal. Estates rated B- Green. • Does not meet needs of population, does not extend scope – only supports some repatriation of patients from out of area. Requires investment but does not allow system integrations or allow integration with urgent care. Does not enhance the service to a level of impact that's sufficient to justify the level of negative impact.

001Cii – Do Minimum (2 MIUs)	2 MIUs: Newtown & Brecon	Discount	Ranked 5th financial and 7th non-financial appraisals. Estates rated B – Green. • Does not meet needs of population, does not extend scope – only supports some repatriation of patients from out of area. Requires investment but does not allow system integrations or allow integration with urgent care. Does not enhance the service to a level of impact that's sufficient to justify the significant level of negative impact to 2 site reduction.
001D – Current on 3 sites	MIUs at Welshpool, Llandrindod, Brecon	Discount	Ranked 7th financial and 6th non-financial appraisals Estates rated A – Green. • Does not manage needs and future patient demand for urgent care. It would reduce imaging offer provided locally. Doesn't alleviate demand on primary care services, potential to increase in some areas.
001Dii – Current on 2 sites	MIUs at Welshpool and Newtown & Brecon	Discount	Ranked 2nd financial and 9th non-financial financial appraisals. Estates rated B - Green. • Does not manage needs and future patient demand for urgent Care. It would reduce imaging offer provided locally. Doesn't alleviate demand on primary care services, potential to increase in some areas where MIU services are removed.
005 – Close all MIUs	All MIUs close; GP + community response only	Discount	Ranked 4th financial and 10th non-financial appraisals. Estates rated A - Green • Not aligned with strategic direction, capacity over cost/obligation to pull demand from A&E units. Non-financial ranked worst option. Alternative provision via GP supplementary services would only support some population needs, therefore significantly more people would travel out of county and there would potentially be gaps in meeting patient needs in some areas.
010 – Mid-Range (3 MI&IUs)	MIIUs at Newtown, Llandrindod, Brecon	Discount	Ranked 9th financial and 3rd non-financial financial appraisals. Estates rated C - Amber • Small investment required for this enhanced model which doesn't fully maximise benefits. Service offer does not enable integrated step-up provision through the interdependency with physical health options.
010ii – Mid-Range (2 MI&IUs)	Minor Injuries and Illness Units at Newtown & Brecon	Discount	Ranked 3rd financial and 4th non-financial financial appraisals. Estates rated B - Amber • Small investment required for this enhanced model which doesn't fully maximise benefits. Financially more viable through reduced sites. Service offer does not enable integrated step-up provision through the interdependency with physical health options.

013 – Maximum (2 UCCs +1 MI&IU)	UCCs at Newtown & Brecon; MI&IU at Llandrindod	Proceed to next stage	Ranked 10th financial and 1st non-financial appraisals. Estates rated C - Amber • Offers the strongest clinical capability, governance, and integration with urgent pathways. Improves diagnostics provision, avoids unnecessary conveyance, and aligns with strategic direction for community-based urgent care.
013ii – Maximum (2 UCCs)	UCCs at Newtown & Brecon	Proceed to next stage	Ranked 1st financial and 2nd non-financial appraisal. Estates rated C – Amber • Delivers strong workforce sustainability and cost efficiency, but with greater access risks (notably Llandrindod) and impact on primary care. Agreed to proceed alongside Option 013 to enable a clear consultation comparison on access vs efficiency trade-offs.

Figure 49: Mental Health Short Listed Options

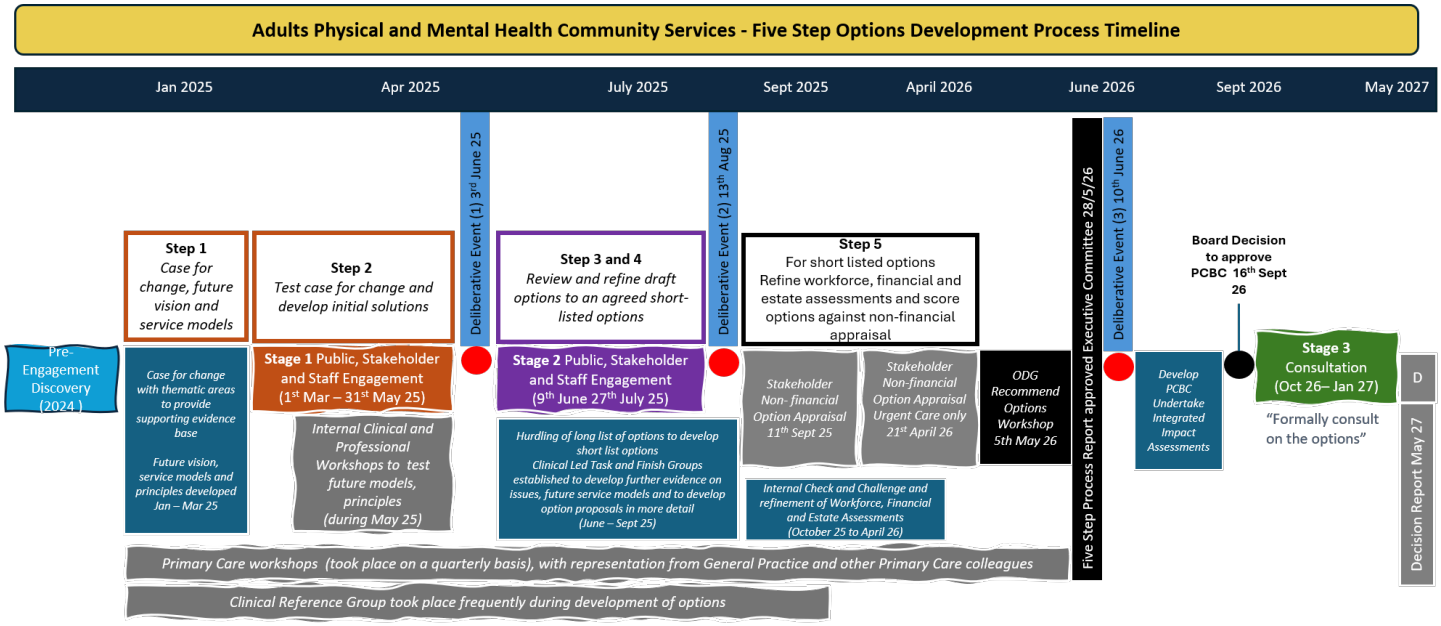
Option Ref	Option Description	Recommended Status	Rationale
001a – Do Previous	Pre-temp changes service changes	Discount (Include as comparator only)	Ranked 7th financial and 8th non-financial appraisals. Estates rated A- Green • Does not meet future demand and fails to address the case for change, including workforce fragility and reliance on out-of-county care. Ranked low in both non-financial and financial appraisals. Retained as baseline/comparator only.
001b – Do Current	Maintain current model with temporary service changes made permanent	Discount (include as comparator only)	Ranked 6th financial and 7th non-financial appraisals. Estates rated A- Green • Provides short-term stability but does not address sustainability, capacity issues, or meet future population needs and demand. Continues reliance on fragmented inpatient provision and external placements. Ranked low in option appraisal. Retained as baseline/comparator only.
003a – Do Minimum	Do Minimum: Functional beds to Bronllys + integrated OAMH community	Discount	Ranked 1st financial and 6th non-financial appraisals. Estates rated C- Amber • Non-financial appraisal ranked in bottom of half of options, financial appraisal ranked 1st. Estates rag is red as development is required. Travel distance consideration for all organic patients being accommodated in Ystradgynlais.
004a – Do Mid-Range	Functional inpatient beds at Brecon Powys site with integrated Older Adult Mental Health community model	Discount	Ranked 1st financial and 5th non-financial appraisals. Estates rated D - Grey • This option improves quality and workforce efficiency through consolidation and strengthens integration with physical health and community services. The Estate assessment output is Red due to initial site

			feasibility prohibiting services being relocated onto Brecon hospital site.
006a – Do Maximum	All functional and organic inpatient beds consolidated at Bronllys with enhanced care and strengthened community model	Proceed to next stage (subject to further actions)	Ranked 3rd financial and 3rd non-financial appraisals. Estates rated D - Red • This option offers a balance across quality, workforce sustainability and affordability, but has some limitations from a co-location with physical health perspectives, with community links and being geographically focused on the south. The option would improve clinical standards and provide a sustainable offer, reducing some reliance on out-of-county placements, as well as strengthening pathways. Requires estate investment and further testing on site feasibility to determine deliverability on Bronllys site. It is recommended this option is taken forward with the caveat that if the Bronllys site cannot be re-developing an alternative site nearby could be explored as a mitigator.
007a – Do Maximum	All functional and organic inpatient beds consolidated at a single Brecon site	Discount	Ranked 3rd financial and 2nd non-financial appraisals. Estates rated D - Grey • Strong clinical and workforce case for consolidation, and brings benefits of co-location with physical health, but significant estate constraints on the Brecon site following initial feasibility means this option cannot be progressed on the Brecon site.
008a – Do Maximum	All beds to Newtown or Welshpool	Discount	Non-financial appraisal ranked 4th, finance appraisal ranked 2nd (with small net saving). Estates rated D - Red/Grey but risk of significant cost. • This option would have challenges with deliverability; there is a lack of confidence for recruitment in North with all services relocating and it would require significant staff changes as existing staff based in the south would require relocating to the north.
010a – Do Maximum	Two site inpatient model with beds split between North and South Powys with integrated community model	Discount	Ranked 8 financial and 1st non-financial appraisals. Estates rated D – Red/Grey • This option performs best on access, equity and patient experience and co-location with physical health. Following review of the bed requirements, workforce model and underpinning staffing and commissioning assumptions, the model across the two sites is not deliverable and financially it is not affordable.

4.4.2 High Level Timeline

The diagram below provides an overview of the timeline of activities.

Figure 50: Five Step Options Development Process Timeline

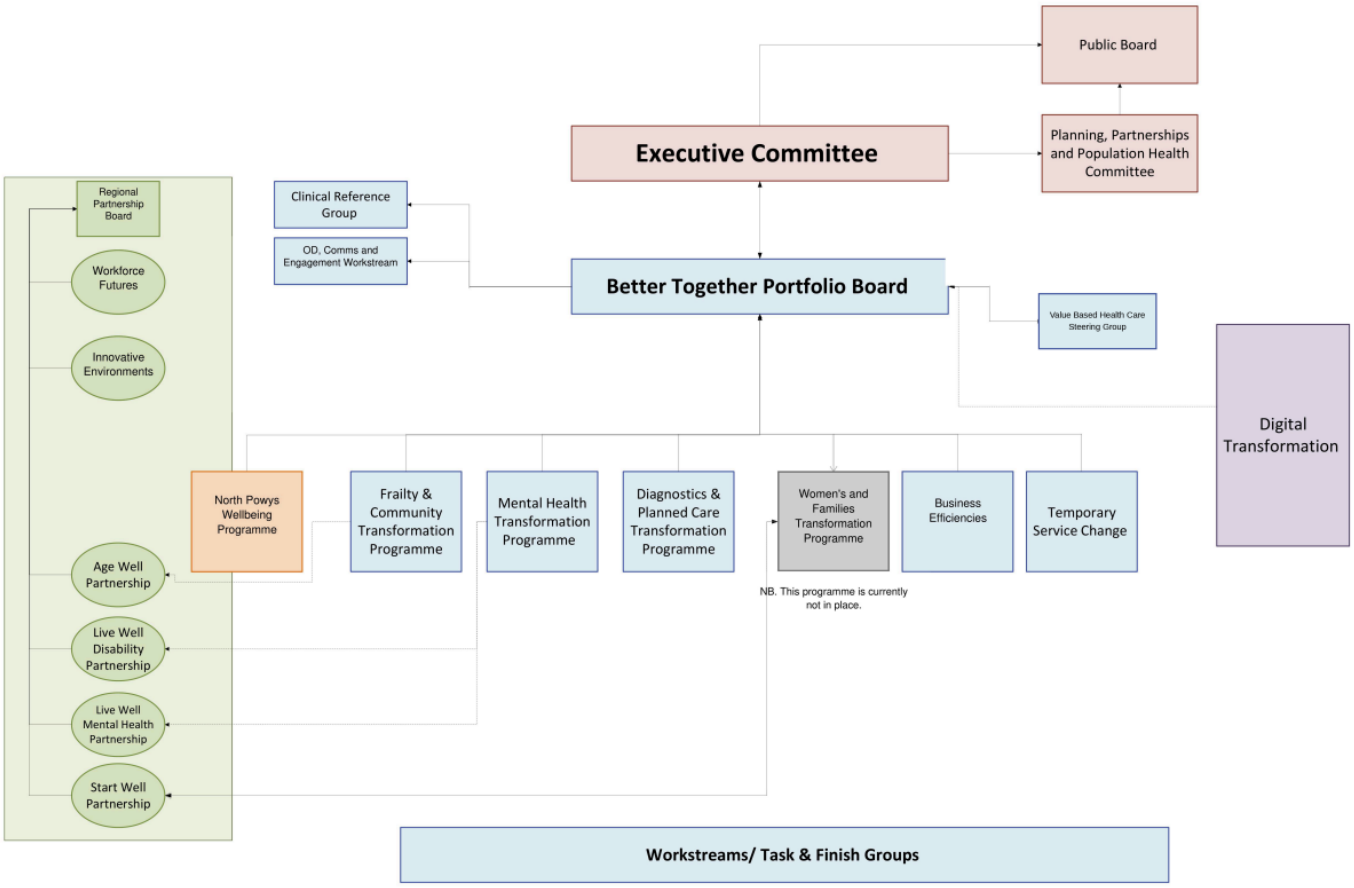


4.5 Governance, Decision Making and Assurance

The governance arrangements through which Phase 1 was managed are summarised in Section 1.5. This subsection explains how those arrangements supported oversight, progression and assurance during the options-development.

The Frailty and Community Transformation Programme and Mental Health Transformation Programme are responsible for Phase 1. Option development was coordinated through the Options Development Group and service-specific task and finish groups, with oversight through Programme Boards and Portfolio Board. Risks, issues and dependencies were escalated through established executive, Board and risk-management arrangements. Section 3.7 summarises the strategic risks most relevant to the Case for Change.

Figure 51: Better Together Portfolio Governance Structure



The primary responsibilities are:

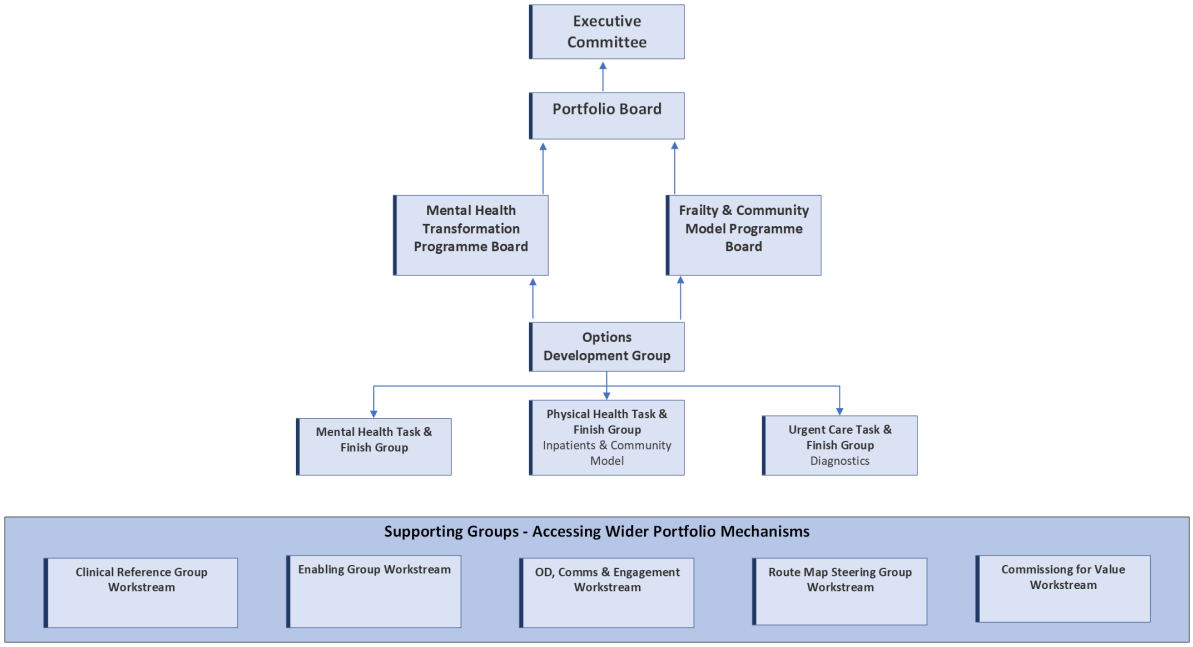
- Better Together Portfolio Board: strategic oversight, approval of key outputs, management of escalated risks and assurance to Executive Committee and Board.
- Clinical Programme Boards: oversight of service-specific workstreams, task and finish groups and progression of outputs.
- Options Development Group: coordination of the development, refinement and testing of options across the relevant service areas.
- Clinical Reference Group: clinical scrutiny, advice and challenge, including review of the criteria and emerging options.

- Organisational Development, Engagement and Communications Group: strategic coordination of organisational development, engagement and communication activity.
- Task and finish groups: detailed service-specific option development, modelling, workforce and financial assessment, pathway testing, and impact assessment.

These responsibilities are described in greater detail in the Step Report.

Progression was not determined by appraisal scores or by any individual group in isolation. Options and supporting evidence were subject to clinical, professional, financial, workforce, technical, partner, executive and independent review at different stages. This provided several opportunities to identify evidence gaps, challenge assumptions, and require further development.

Figure 52: Phase 1 Governance Structure



Both Programme Boards include third sector and social care membership.

4.5.1 Independent Expertise and Support

The programme of work has drawn on a range of independent expertise and assurance.

Independent Clinical Expertise

The Health Board sought external expertise from:

- A Senior Associate with the International Foundation for Integrated Care (IFIC), who is a Professor and Consultant in Frailty, and also the Director of IFICs Country Hub in Scotland – An expert in policy and improvement programmes in Scotland on Long-Term Conditions, Healthcare Quality, Reshaping Care for Older People, and Integrated health and social care who provided subject matter expert advice in support of service redesign and patient pathway testing. They presented as keynote speaker at the second and third deliberative event, facilitated patient pathway testing, and associated workshops. Provided external clinical review of Demand & Capacity Modelling and acted as an appraiser for non-financial options appraisal sessions.

- The Clinical Director for Community Hospitals at Aneurin Bevan University Health Board (ABUHB) with a focus on Care of the Elderly. This individual provided subject matter expert advice in support of service redesign and clinical oversight requirements. Attended deliberative events and provided external clinical review of Demand & Capacity Modelling. Acted as an appraiser for non-financial option appraisal sessions. Since supporting this work, he has been appointed as Assistant Medical Director for community hospitals and teams, this includes leading on work to strengthen the clinical oversight model.
- Representatives from Mental Health and Urgent and Emergency Care NHS Wales Performance & Improvement who supported reviewing and development of Service Level Model of Care documents and acted as independent clinical appraisers for the Non-financial Options Appraisal events in September 2025 and April 2026.

More broadly, the programme adopted an evidence-based approach informed by local, national, and international sources. Input was also provided by representatives from relevant national programmes.

Independent Expertise and Support

Practice Solutions - supported Stage 0–2 engagement, including work with protected characteristic groups and scenario testing.

HICO Ltd - HICO is providing quality assurance support and advice on consultation good practice. However, any Consultation Mark award decision will be considered independently through the Centre for Consultation." A Consultation Mark is a quality standard and accreditation awarded to certify that public consultation processes meet high standards of compliance, rigour, and best practice.

Opinion Research Service (ORS) – appointed to support survey and insight design, delivery and analysis. In addition

Adcuris Consulting Ltd - provided independent Demand and Capacity Modelling expertise, alongside knowledge transfer to build internal modelling capability within the health board.

4.5.2 Check, Challenge and Validation

The Clinical Reference Group provided ongoing clinical scrutiny throughout the process. A two-stage workforce and finance check-and-challenge process tested baselines, workforce models, financial assumptions, investment requirements, deliverability, and confidence that proposed changes could produce the intended outcomes. Demand and Capacity Modelling was also subject to internal knowledge transfer involving senior Finance, Information, and Public Health colleagues.

The arrangements were designed to ensure that options reaching consultation were sufficiently developed and evidenced to support informed consideration. They did not remove uncertainty, guarantee implementation, or replace the requirement for formal consultation and subsequent decision-making.

4.6 Stakeholder Engagement

4.6.1 Our Approach

A structured stakeholder mapping exercise was undertaken to identify the level and nature of involvement required across Phase 1 options development. This was undertaken in collaboration with Senior Responsible Officers, Transformation Programme Managers, and Executive leads to ensure that stakeholder participation was aligned to the purpose and requirements of each stage of the process. Stakeholder groups were clearly defined to support case for change development, option development through the Options Development

Group deliberation and option refinement, formal scrutiny and assurance, and wider communication with those to be kept informed throughout.

Figure 53: Stakeholder Engagement Map



In parallel, patient representatives who had participated in targeted engagement during the discovery phase and expressed a wish to remain involved were invited to contribute through deliberative events. This approach supported a proportionate, transparent, and inclusive process, with clear lines of assurance and appropriate stakeholder involvement throughout options development.

Stakeholder participation throughout Phase 1 of Better Together was designed to be proportionate to the purpose, technical complexity, and decision-making requirements of each stage. Different stages required different forms of involvement. The programme distinguished clearly between internal technical development, stakeholder challenge and sense-checking, and public and service user engagement.

A stakeholder participation and public involvement overview is provided as a supporting document to the Step Report. Whilst some technical appraisal activities necessarily relied on clinical, professional, and subject matter expertise; the programme recognised the importance of ensuring that public, patient, carer, and stakeholder perspectives informed option development throughout the process. To reduce the risk of gaps in the evidence base arising from limited direct public participation during technical appraisal stages, the programme incorporated early and iterative engagement, stakeholder workshops, multiple deliberative events, independent assurance and pre-consultation engagement activity. These approaches helped ensure that stakeholder feedback informed the development and refinement of options, assessment criteria, and associated mitigations.

Formal consultation represents a further and essential stage of engagement. The Health Board expects that consultation may identify additional issues, perspectives, alternative suggestions, and potential impacts that

have not previously emerged through the option development process. This is an intended and valuable outcome of consultation and will provide further evidence to inform decision-making. No option is presented as predetermined, and final decisions will only be taken following full consideration of consultation responses and the evidence gathered through the consultation process.

4.6.2 Engagement Methodology

A mixed-methods approach was used to collect both qualitative and quantitative evidence, drawing on anonymous internal and external surveys, focus groups, facilitated conversations, staff roadshows, drop-in events, workshops, community outreach, and written or recorded responses. Engagement was designed to be balanced and non-leading. The Case for Change and a supporting information were presented in a neutral way to enable participants to provide verbal and written feedback.

To support inclusion and accessibility, all public-facing materials were made available bilingually, with public events facilitated bilingually. Key documents were also produced in Easy Read, accessible and print formats. Additional formats such as audio-described, Braille, and community language versions were available on request through dedicated telephone, email, and postal contact routes. Stage 1 and Stage 2 engagement materials were also distributed to all public libraries across Powys.

Analysis arrangements reflected available capacity and the source of the evidence. Within PTHB, anonymous feedback from focus groups, facilitated conversations, and staff drop-in activity during Stage 0 and Stage 1 was analysed using a combination of Microsoft Copilot with consistent prompts, supplemented by human review and quality checking. Stage 1 survey responses were coded and analysed manually. Feedback gathered independently by Practice Solutions, including focus groups, facilitated conversations and the Stage 2 engagement survey, was analysed manually, with limited use of AI tools supported by human quality assurance. Further information is provided in the Stage 0-2 Engagement Report[47].

Engagement was used to:

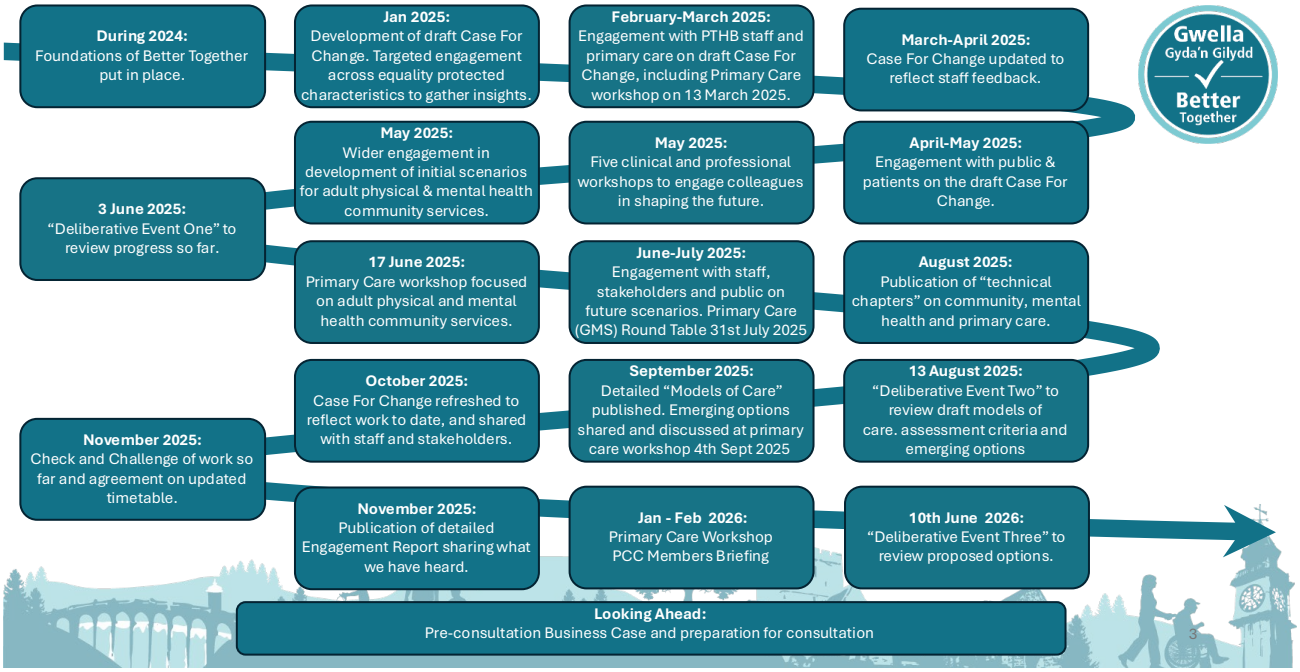
- generate ideas about potential future models of care
- test whether the Case for Change reflected people's experience
- challenge assumptions and emerging proposals
- identify potential benefits, disadvantages, trade-offs and unintended consequences
- understand how impacts may differ between communities and population groups
- inform design principles and assessment criteria and
- support the refinement and interpretation of options.

Detailed engagement activity, participation information, and thematic findings are provided in the Stage 0 to 2 Engagement Report. This section focuses on how engagement influenced the route to the consultation options rather than repeating the full record.

4.6.3 Our Engagement Journey so Far

[47] Appendix D - Stage 0-2 Engagement Report

Figure 54: Summary of engagement activities and timeline



In preparation for Stages 0 to 2, broad engagement was prioritised with patients, carers, communities, staff, partners, and representative bodies to ensure that diverse perspectives informed the Case for Change, design principles, and early option development.

These stages incorporated a range of engagement methods, including public surveys, workshops, drop-in events, targeted engagement with seldom heard groups, and deliberative events with direct service user representation.

Figure 55: Stage 1 – Case for Change Pre-engagement Survey

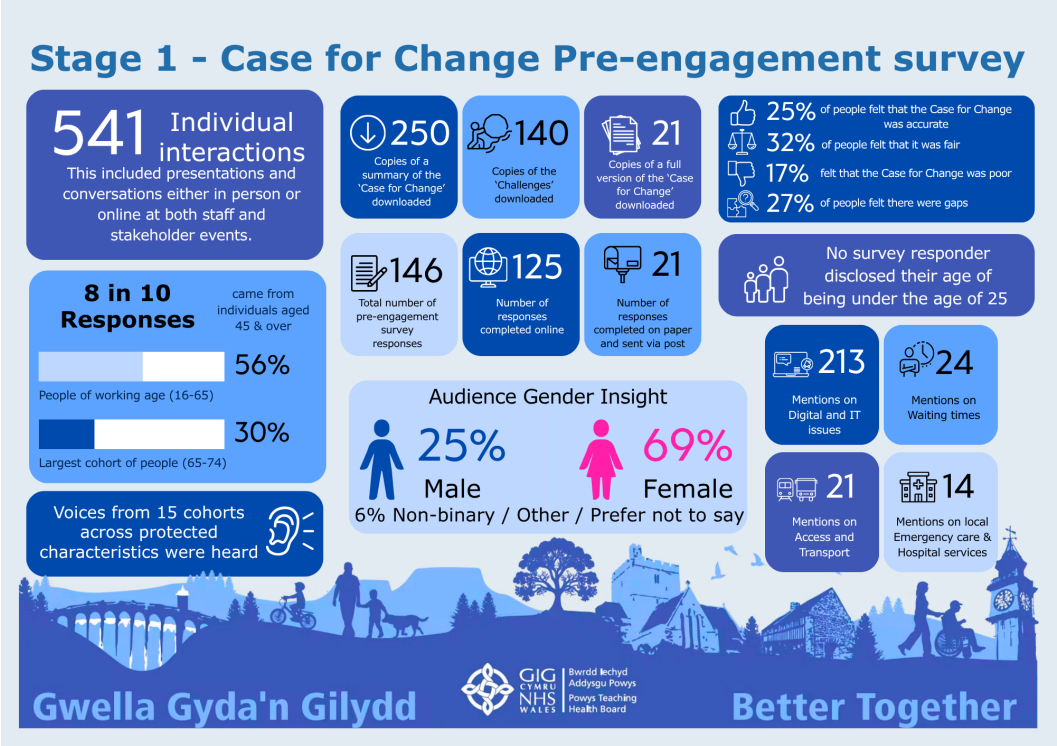
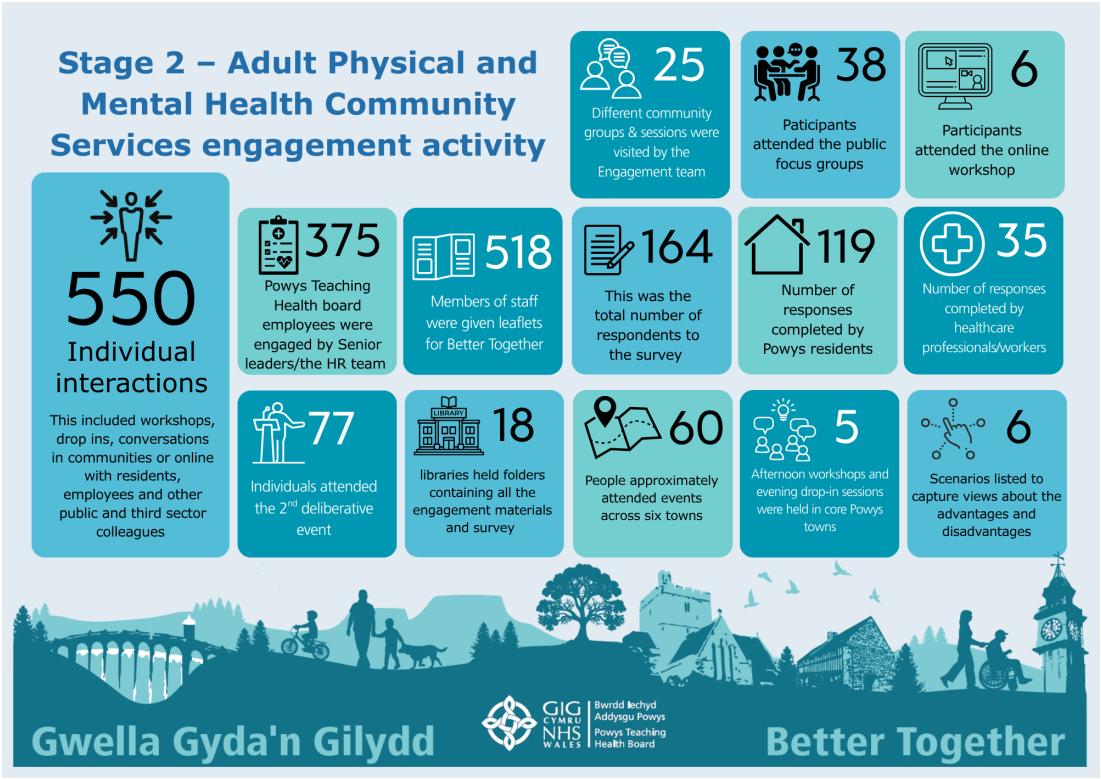


Figure 56: Stage 2 – Adult Physical and Mental Health engagement activity



Options development during Steps 3 to 5 involved a greater degree of technical appraisal and assurance activity, including detailed workforce, financial, estates, demand and capacity analysis, together with non-

financial options appraisal. Participation at these stages was therefore focused primarily on clinical, professional, and partner stakeholders with relevant expertise. This approach ensured that options were subject to rigorous testing for clinical safety, deliverability, and sustainability prior to public consultation.

Importantly, the outputs of public and stakeholder engagement undertaken earlier in the process were actively used to inform option refinement, the development of assessment criteria and weightings, and the identification of mitigations. This ensured that technical appraisal was informed by earlier engagement evidence and was not reliant solely on views expressed during technical sessions.

Patient, carer, and public representation was embedded throughout engagement activity, particularly during discovery, Stage 1, Stage 2, and deliberative events. In addition, representative bodies, including Llais, the independent statutory body in Wales representing the public's voice in health and social care, were routinely invited to participate in relevant governance and engagement forums. Llais was also specifically invited to observe both non-financial options appraisal sessions, but this opportunity was declined. The decision was respected and recorded, with assurance maintained through alternative mechanisms including independent engagement assurance, and separately challenge through the Clinical Reference Group, and subsequent deliberative engagement.

Throughout the process, the programme has remained transparent about where direct public participation was not proportionate because of technical complexity, and where earlier or parallel engagement activity provided the necessary input and challenge to inform decision-making.

4.6.4 Public, Patient, Carer and Wider Stakeholder Engagement

Public, patient, carer, and wider stakeholder engagement has been carried out using a range of methods, managed via the Organisational Development, Engagement and Communications Group with support from the Communications and Engagement Team within the Health Board.

Public, patient, carer, and wider engagement activities:

- Public and stakeholder survey
- Conversations across the five PCC designated service localities 'Hub' areas held in conjunction with PCC and the Health Board in May 2025. These workshops were with County Councillor and Town and Community Council representatives
- Interviews and focus groups with approximately 15 different cohorts of people conducted in early 2025 on a range of protected characteristics
- Community outreach activities with members of the public and third sector colleagues
- Deliberative events with service user representatives

In addition to the more formal focus group, survey and deliberative event activity, the Health Board also undertook direct engagement with elected representatives within Powys. Activity included briefings for all MSs, MPs, County and Town and Community Councillors; the offer of face-to-face briefings and group engagement activities, including workshops with County, Town and Community Councillors as the Stage 1 pre-engagement period progressed.

Their feedback has been summarised into the following core themes:

Figure 57: Summary of engagement feedback

Access to services	People repeatedly described difficulty getting the right care at the right time, including: • getting GP and dental appointments • delays for referrals, tests and treatment • uneven access across different parts of Powys • concerns about local emergency and hospital provision.
Travel and transport	This is one of the strongest recurring themes, especially in a rural county. Feedback highlights: • long travel distances to appointments and inpatient care • limited or poorly connected public transport • challenges attending short-notice appointments • concern about greater centralisation increasing inequalities.
Communication and information	Patients and service users want clearer, more timely and more compassionate communication, including: • better information about what services exist and how to access them • better communication during care journeys • clearer explanations for change proposals • less duplication and fewer situations where people have to repeat their story.
Better coordination and joined-up care	A consistent message is that the system feels fragmented. People want: • better coordination between primary, community, hospital, social care and third sector services • smoother transitions between services • continuity of care and stronger professional relationships • shared records and joined-up pathways.
Local / closer-to-home care	There is strong support for services being provided as locally as possible. This includes: • bringing care and support closer to home • strengthening community-based provision • protecting local access where possible • developing Community Wellbeing Hubs or one-stop models that reduce the need to travel.
Mental health support	Mental health is repeatedly raised as a priority, including: • gaps in access to services • desire for more integrated physical and mental health care • earlier support and intervention • more trauma-informed, holistic and person-centred approaches.
Workforce sustainability	People recognise that staffing challenges affect service quality and access. Themes include: • recruitment and retention difficulties • pressure on existing staff • concern about whether new models can be staffed safely • importance of stable, skilled local teams.
Digital access and digital exclusion	Digital was raised in two ways:

	• support for better digital systems, shared records and technology that can improve care • concern that digital-first approaches exclude some people, especially older people or those without confidence, equipment or connectivity.
Equity and fairness	People want services to be fair regardless of where they live or their circumstances. This includes: • concern about rural inequality • concern about cross-border disadvantages • need for equitable access across Powys • recognition of cultural, language and accessibility needs.

4.6.5 Addressing Health Inequalities

In developing the approach to engagement, early analysis of potentially impacted populations was undertaken with particular attention to the protected characteristics under the Equality Act. Engagement took place during March and April 2025 to ensure a wider range of lived experiences informed the Better Together programme and the Stage 1 pre-engagement process. This work sought to understand the needs of different communities across Powys, including where no established groups existed and bespoke arrangements were needed to reach participants. A mixed-method approach was used to reduce unconscious bias and improve the breadth of feedback, including nine independently facilitated focus groups delivered by Practice Solutions Ltd and a further seven focus groups or interviews undertaken by PTHB with specific groups, advocates and representatives.

Across the feedback, participants described a health and care system under pressure from rurality, an ageing population, workforce challenges and fragmented pathways. Common themes included difficulty accessing GP appointments, concerns about communication and delays, discomfort with telephone triage, barriers created by digital-first approaches, and the importance of continuity of care and trusted relationships with professionals. Participants valued frontline staff highly but called for more integrated, person-centred and preventative care, with better coordination between health, social care and third sector services and stronger support closer to home.

Some issues were specific to particular groups. For example, older people raised concerns about transport and access; veterans highlighted gaps in GP awareness, mental health support and implementation of the Armed Forces Covenant; refugees and travellers raised issues of translation, cultural sensitivity, stigma and wider social exclusion; Lesbian, gay, bisexual, transgender, queer and other diverse sexual orientations and gender identities (LGBTQ+) young people described barriers to inclusive and respectful care; and neurodivergent participants highlighted delays in diagnosis, lack of support while waiting and the need for greater understanding. Overall, the feedback reinforced the importance of designing future services that are accessible, inclusive, joined up, and responsive to the different needs of Powys residents.

These findings informed the development of the Level 1 and Level 2 Integrated Impact Assessments and continue to shape the development of mitigations designed to minimise adverse impacts and reduce the risk of widening existing inequalities.

4.6.6 Clinical, staff and partner engagement

Clinical engagement has been critical to the success of the programme; this has included a wide range of health and care professionals including Consultants, GP's, nurses, Allied Health Professionals, social care professionals and third sector colleagues.

Staff engagement activities

- Staff survey on the draft Case for Change
- Staff roadshows and site visits by the Organisational Development team
- Focused workshops with clinical and service experts
- Staff survey on the scenarios
- Staff focus groups/workshops (including independent facilitation)
- Staff roadshows reaching staff across multiple sites.

Targeted specialist / clinical and partner engagement

- Quarterly Primary Care workshops - Included representatives from all 16 GP Practices in Powys and Dental, Allied Health Professionals, General Medical Service (GMS) collaborators, Dyfed Powys Local Medical Committee (DF LMC), Medicines Management and PCC Adult Social Care
- Physical Health Community Model workshops
- Mental Health Community Model workshops
- Combined Physical and Mental Health Community Model workshop
- Mental Health Medical Psychiatry workshop
- Primary Care round table / GMS-focused events.

Figure 58: Summary of themes from clinical, staff and partner engagement

Workforce sustainability	This is one of the strongest recurring themes across staff, clinical and partner discussions: • recruitment and retention challenges • difficulty staffing services safely in rural areas • reliance on agency and bank staff • need for better career development, training and progression • desire for rotational roles, local training and clearer workforce planning.
More Joined -up care	A major consistent theme is fragmentation across the system. Staff and partners want: • better integration between physical health, mental health, primary care, community services, social care and third sector • more joined-up pathways and continuity of care • clearer discharge processes and smoother transitions • multidisciplinary and place-based working • stronger case coordination / case management.
Access, geography and rurality	Staff, clinical teams and partners repeatedly describe geography as a major constraint: • long travel distances for patients and staff • variation in service access across Powys • transport barriers affecting attendance, equity and workforce deployment • concern that some service models could disadvantage rural communities if not carefully designed.
Digital infrastructure and information sharing	A strong operational theme is that current digital systems are not good enough: • poor digital infrastructure across services

	• lack of shared records / unified systems • weak information sharing between teams and organisations • need for digital transformation to support coordination, planning and efficiency • concern that digital solutions must not worsen exclusion.
Prevention and early intervention	Across staff, primary care and partner engagement there is clear support for shifting the model: • from reactive to proactive care • more prevention, early help and community support • stronger focus on population health and self-management • greater support for proactive identification of need before crisis point.
Stronger local and community-based models	There is broad support for more care closer to home: • regional or locality-based Community hubs • one-stop / integrated health and wellbeing hubs • Hospital at Home / virtual ward approaches • stronger local provision rather than over-centralisation • better use of community assets and local facilities.
Communication and engagement	A consistent internal and partner theme is that communication needs to improve: • better communication between management and frontline staff • clearer communication about the Better Together programme and what it means in practice • better communication between services and organisations • desire from staff and partners to be involved earlier and more meaningfully in shaping options.
Partnership working is essential	Partners repeatedly emphasise that change cannot be delivered by the health board alone: • co-dependency of health, social care and third sector • importance of PCC, Primary Care and PAVO / voluntary sector • need to treat the third sector as an equal delivery partner, not an add-on • recognition that many models depend on social care capacity and community support.
Equity and consistency of service	Staff, clinicians and partners want services to be fair and consistent: • concern about variation in service offer across the county • need to ensure equal access regardless of locality • concern that some groups and places are disadvantaged • desire for more standardised, transparent and equitable provision.
Person-centred and holistic care	Particularly in clinical model workshops, there is a strong emphasis on: • treating the whole person, not just the condition • integrating physical and mental health • family and carer support • coordinated, holistic assessment • person-centred pathways rather than organisational silos.

4.6.7 Conclusion

The engagement activities reached a substantial and diverse stakeholder base across Stage 0 to Stage 2. The strongest volume of activity is evidenced in Stage 2, which combined public surveys, focus groups, drop-in sessions, outreach, staff roadshows and specialist workshops. While public and workforce survey response rates were modest, the wider programme demonstrates extensive direct engagement through in-person and

facilitated methods, suggesting a broad overall reach across residents, staff, partners and service-user groups.

Over the course of the Better Together Stage 0–2 engagement, over 600 people took part directly in engagement activities, including 310 survey responses, over 140 participants in focus groups and workshops, and approximately 226 attendees at deliberative events. In addition, over 1,200 people were reached through wider engagement activity, including community outreach, staff engagement and drop-in events and digital engagement mechanisms, including over 500 downloads of key documents.

Engagement has informed the Better Together programme at every stage of development. Feedback has influenced the Case for Change, design principles, service models, appraisal criteria, options refinement and mitigation planning. Whilst consultation may identify additional issues, perspectives and alternative proposals, the evidence gathered to date demonstrates broad support for the need for change, alongside a consistent request for assurance regarding workforce, community capacity, access arrangements, implementation planning and the ability to deliver sustainable services closer to home. These considerations have informed the recommended consultation options presented in this PCBC.

Across all engagement activity, several themes were consistently raised by members of the public, staff, partners and representative organisations. The table below summarises the principal themes and how they have influenced the development of the proposed consultation options.

Figure 59: Summary of themed responses from stakeholder feedback

What we've heard	How we have responded
Travel, transport and access are significant concerns due to Powys's rural geography and dispersed communities.	We have undertaken travel time analysis [48] by post code (based on private transport) to understand travel impact of any potential changes and have included public transport assessment in Level 2 Impact Assessment of the options. Future service proposals have focused on strengthening community-based services to support people at home where safe and appropriate, the aim is to prevent needs from escalating and prevent people being admitted to hospital. We recognise the challenges with travel in the rural area and are aligning this work with schemes under the RPB and PCC and have a joint commitment to strengthen the approach to the provision of sustainable community transport and transport solutions in Powys. Future service proposals are based on provision of services across the spine of Powys in line with the Rural Regional Centres in the Health and Care Strategy [49]. These are sited within the 3 major population centres in Powys. Further work will be undertaken to fully test the impact of proposals on different communities to avoid widening inequalities gaps.
Prevention, early help and community-based support should be increased	Future service proposals support a shift away from reactive, crisis-led care towards earlier intervention, prevention, self-management and stronger community support closer to home. The proposed future service models are fully aligned with the wider Regional Partnership work to strengthen community wellbeing and delivery of preventative services in Powys.

[48] Appendix W - Better Together Travel Time Analysis Report v0.5-FINAL

[49] Health and Care Strategy for Powys 2017 - 2027

There should be more joined-up, coordinated and person-centred care	Future service proposals will provide better coordination through integrated pathways that bring physical health, mental health, third sector and social care together through co-location of staff and strengthening of the existing virtual wards. Patient pathway testing has been undertaken by clinical teams on service options to ensure proposed service models, digital requirements and configuration of future services support joined up care.
Key workforce concerns relate to recruitment and retention, safe staffing, and the pressures associated with delivering services in a rural setting.	Extensive work has been undertaken through the clinical task and finish groups with input from the Health Board's Workforce team to undertake benchmarking and learning from elsewhere in the development of future workforce models. This has considered extending skills of existing staff, creating new roles required to provide safe and sustainable services and to attract and retain people to work in Powys.
Digital, information sharing and communication	Digital feedback received through the development of this business case has reinforced that technology is seen as an important enabler of future care, but only where it is reliable, accessible and designed around the needs of patients, staff and communities. In response, the digital contribution to the business case has been strengthened to reflect the need for better connectivity, more consistent digital infrastructure across sites, improved information sharing between teams and partner organisations, and greater use of digital tools to support care closer to home. This includes recognising the role of shared records, virtual consultations, remote monitoring, digital clinical pathways and better access to information at the point of care in reducing duplication, improving coordination and supporting more efficient ways of working.

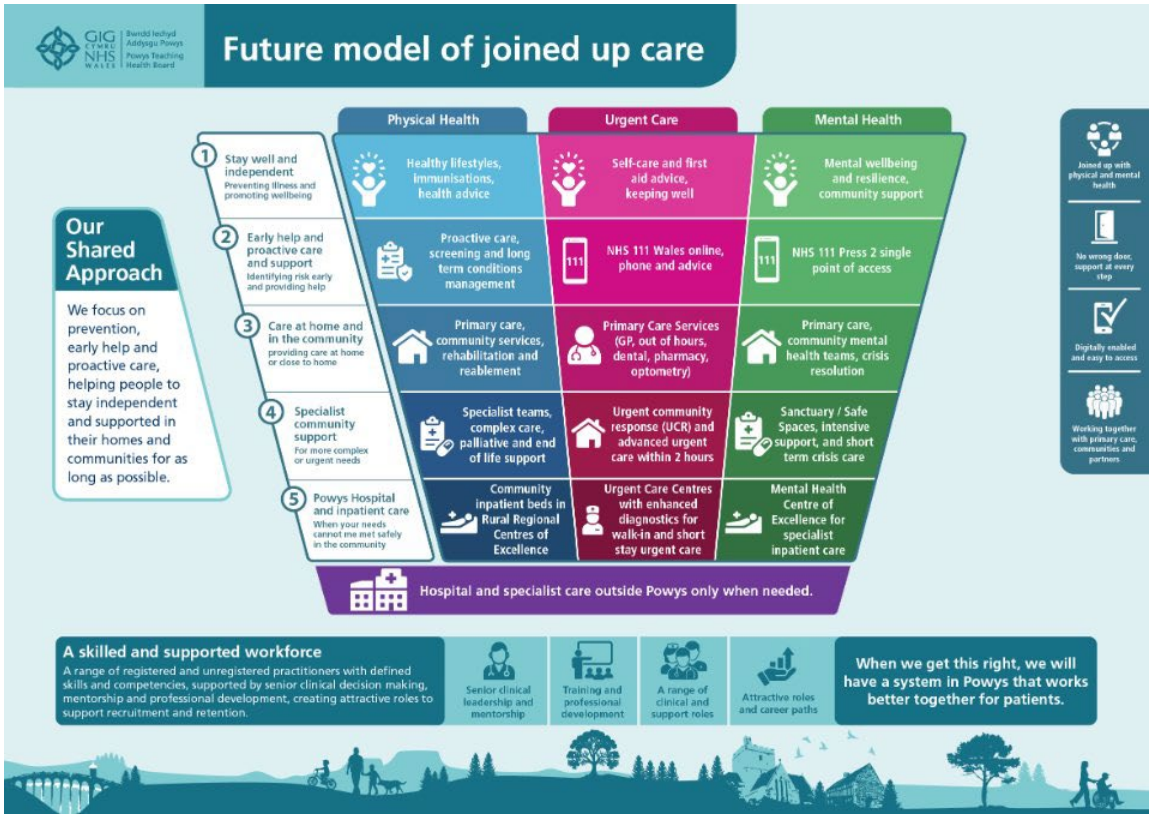
5. Proposals for the future

5.1 Proposed Future Model and Ambitions

The proposed future model is aligned with the Powys Health and Care Strategy and national policy direction. It supports the ambition to improve wellbeing, strengthen community services, promote independence and provide more care at or closer to home where it is safe and appropriate to do so. It is also aligned with the service design principles, set out in Section 1. While the consultation options differ in the configuration of specific services, they have been developed within a consistent strategic framework and are intended to address the challenges identified in the Case for Change and meet future population needs.

The proposed future model represents an integrated system of care in which community services, urgent care, mental health services and inpatient services work together to support people throughout their care journey and this is illustrated in diagram below.

Figure 60: A proposed Future Model of Joined Up Care



Our ambition is to deliver a transformed model of care in Powys that:

- Improves health outcomes for people with long-term conditions or associated risk factors and contributes to targeted prevention by supporting people to stay well and to access early help through proactive community-based support.

- Enhances access to local services at home or close to home, reducing unnecessary hospitalisation so resources can be better spent on supporting people to stay well, recover, and remain in, or return to, their preferred place of care wherever clinically appropriate. This includes strengthening community-based intermediate care, home-first and palliative and end of life care options so that more people can receive person-centred, dignified and effective care closer to home.

- Recognises that some specialist care would continue to need to be provided on a Powys wide basis or out of county to make best use of resources and achieve the best outcomes for people.
- Integrates care around the person, with joined-up services delivered by teams working together across primary care, community services, acute and community hospitals, social care, and the third sector, supported by shared information, care planning, continuity and care coordination.
- Strengthens community hospital inpatient care, ensuring high-quality, fit for purpose facilities support step-up care from home and step-down repatriation for symptom stabilisation, rehabilitation and discharge planning or planned, dignified end of life care where home or care home support is not possible or clinically appropriate.
- Has the right staff and skills in the right place to deliver safe, effective and person-centred care for people with physical health, mental health, rehabilitation, frailty, or palliative and end of life care needs.
- Expands same-day ambulatory and community-based care, enabling timely assessment, diagnostics, treatment and intervention as near to home as possible.
- Leverages digital solutions to improve access, connectivity and efficiency of care - We want to use tools like online clinics, remote check-ups, and shared health records to make care easier to get and make it more connected.
- Makes PTHB a great place to work – We want our staff to feel motivated, supported and valued. We recognise that some staff work in environments that are not conducive to delivering modern healthcare and are often required to manage gaps in staffing. These issues affect staff wellbeing and can make it more difficult to attract and retain colleagues. Whilst we recognise that service change may create uncertainty, engagement feedback suggests that many staff also see opportunities for career development, stronger team resilience and reduced reliance on agency staffing. We would continue to work with our Trade Union partners to help reassure and support our staff through any changes that might be made in the future.
- Delivers effective palliative and end of life care as an explicit ambition within the future model, supporting earlier identification, advance and future care planning, urgent response, hospice at home, care home liaison support, community hospital pathways, repatriation and coordinated support for families, unpaid carers and those important to the person.
- Enables us to live within our means - We want to plan and commission our physical and mental health community services for the future to ensure they are affordable, sustainable, deliver value for money, are of the highest quality and deliver the best health outcomes for the population of Powys.

5.2 Strengthened Community Based Offer

The future integrated community-based offer is designed to shift care away from reactive, hospital-based responses towards earlier, proactive, person-centred support delivered at home and closer to home. This reflects Welsh Government policy, which describes prevention as spanning a continuum from primary prevention at individual and population level through to more targeted proactive care to prevent or delay deterioration in patients with established health conditions or risk factors.

A key feature of the future offer is its focus on earlier identification of people at risk of deterioration, particularly those living with frailty, multiple long-term conditions, dementia, mental health needs, falls risk, recent functional decline, social isolation or increasing reliance on unpaid care. It is consistent with the Welsh Government framing of proactive care as interventions focused on keeping people well through prevention, including activities that improve health and wellbeing by increasing self-reliance, capacity and resilience for individuals, unpaid carers and local communities. Through multidisciplinary, place-based working, the model aims to coordinate personalised support, promote self-management, connect people with community and voluntary sector assets, and use digital tools to support monitoring, access and decision-making.

People who may benefit from targeted proactive prevention would be identified through local intelligence, professional judgement, multidisciplinary review, population health information, service-use data and risk-based approaches. This would help direct support to those most likely to benefit in the short to medium term. It would also help build the evidence base for future investment in broader preventative approaches.

Delivery would be through integrated community teams working with primary care, mental health, social care, therapies, the third sector, unpaid carers and community assets. Interventions would include proactive reviews for identified cohorts, personalised care and support planning, medicines and falls-related risk review, rehabilitation and reablement, carer support, action to reduce isolation, signposting to community wellbeing support, and clear escalation routes when a person's condition or circumstances change.

The intended outcomes are to improve individual wellbeing, independence, dignity and autonomy; support people to remain connected to their communities; increase self-reliance, capacity and resilience; prevent or delay further functional deterioration or crisis; and reduce or delay the need for urgent, hospital, social care or other formal care and support services. The use of targeted proactive prevention in this section therefore relates primarily to preventing escalation of need, crisis, admission or service utilisation for people with established conditions or rising risk, while recognising that broader primary prevention and population health activity remains essential to keeping the population of Powys healthier for longer.

The model strengthens home-first pathways by expanding rapid, time-limited support in the community. This includes a continuum of intermediate care services spanning urgent community response, hospital-at-home functions where clinically appropriate, rehabilitation and reablement at home, palliative and end of life care at home, and discharge-to-assess

pathways. These services are intended to reduce avoidable hospital attendance and admission, support safe discharge, and help people recover and regain independence and confidence in familiar surroundings.

For patients with mental health needs, it would be recovery-focused based on open access, “no wrong door” principles, early intervention and crisis prevention. There would be stronger links between physical health, mental health, social care and third sector, expanded peer support, recovery education, and community step-down pathways. A proposed sanctuary / safe place model would provide a non-admission alternative for people in crisis, helping to de-escalate need and avoid the emergency department (ED) attendance or inpatient admission where possible.

Overall, the strengthened community offer is intended to support people earlier, prevent avoidable deterioration, reduce unnecessary hospital use and improve recovery following illness. By bringing together prevention, proactive care, urgent community response, rehabilitation, mental health support and palliative care within a coordinated model, the programme aims to improve outcomes whilst supporting a more sustainable health and care system.

5.3 Improving Patient Flow Through Community-Based Care

The future patient pathways represent a significant shift in how adult physical health, urgent care and mental health services would operate across Powys. The focus is largely about moving from a predominantly bed-based and reactive model towards a more proactive, community-first offer.

More people would be supported at home or closer to home through strengthened prevention, proactive primary care and improved access to enhanced UCCs, intermediate care and integrated community services. Patient flow from acute hospitals would also improve discharge to recover and assess (D2RA) pathways. These pathways would support rehabilitation at home or within community hospitals for patients with frailty, stroke and hip fracture, alongside improved end of life care pathways.

Patients would be able to step-up into community hospital inpatient care from home through a Single Point Of Access (SPOA) for urgent care when their clinical care needs cannot be met at home, but they do not need to be managed in an acute hospital out of Powys. The greatest impact on patient flow is expected to come from enabling earlier discharge home, in turn preventing patient deconditioning resulting from prolonged hospital stays.

The development of Intermediate Care alternatives to hospital admission and reduction in length of hospital stay are projected to support between 806 - 1,274[50] more patients per year. Avoidable admissions modelling also indicates that strengthened in-county urgent care and enhanced specialist support for intermediate care to enable Hospital at Home for selected older patients could reduce low-complexity, non-elective admissions for older people by

[50] Appendix J - Powys Demand and Capacity Planning_ Final Report v2.1 (1)

between 962 and 1,924[51] admissions per year, in turn increasing the number of days older people are supported to stay in their own home.

For urgent care, the proposed pathways shift activity away from out-of-county Emergency Departments, increasing the urgent care offer locally for patients in Powys through the Urgent Care Centres. This would enable some of the patients who currently attend General Practice to be seen in the Urgent Care Centre if there is not enough capacity in General Practice to see and treat those patients on that particular day.

For mental health, the future pathways focus on earlier access, holistic assessment and community-based support through 111 press 2, the mental health Single Point Of Access, open access models, crisis response, sanctuary or safe space provision, virtual appointments and strengthened community teams. The intended impact is to reduce avoidable crisis presentations, minimise the need for inpatient admission, reduce readmissions and repatriate appropriate out-of-county activity where clinically safe to do so.

Overall, the pathway changes would materially alter patient flows across the Powys system. More patients would be supported at home or in the community; fewer patients would need to travel out of county for avoidable emergency care; and community bed based inpatient care would be used for those with clinical needs that cannot be seen and treated in the community.

5.4 Options Proposed for Consultation

The following options are recommended for consultation; these represent alternative approaches to delivering a future sustainable model and addressing the challenges identified in the Case for Change.

Figure 61: Summary of proposed options for consultation

Option Reference	Option Description
Physical Health	
PH005b	Fewer community inpatient beds reduced to 3 sites, with enhanced community model and better join up with mental health
PH008	Even fewer community inpatient beds reduced to 2 sites, with enhanced community model and better join up with mental health
Urgent Care & Diagnostics	
UC013	Local Urgent Care Centres at 2 sites and Minor Illness and Injury Unit at 1 site

[51] Appendix J - Powys Demand and Capacity Planning_ Final Report v2.1 (1)

UC013ii	Local Urgent Care Centres at 2 sites
Mental Health	
MH006a	All functional and organic inpatient beds at 1 site with enhanced care and strengthened community model

Across all consultation options there is a common emphasis on:

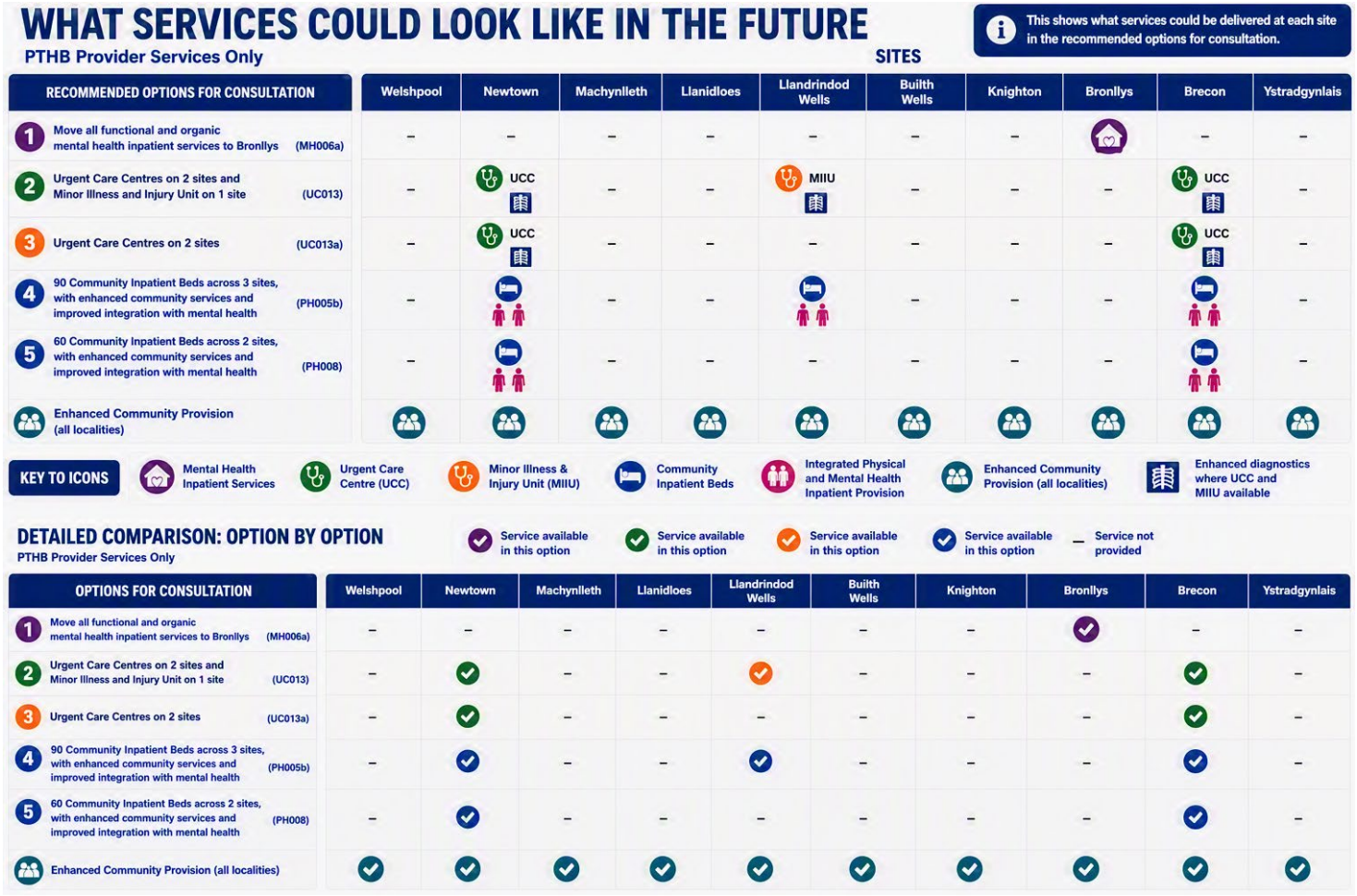
- prevention, proactive care, early intervention and reducing avoidable deterioration in health and wellbeing
- strengthening community-based services and multidisciplinary working
- supporting more people to remain independent and receive care closer to home
- improving integration between physical health, mental health and urgent care services
- improving the consistency and equity of services across Powys
- making best use of available workforce, estate and financial resources
- improving workforce resilience and reducing reliance on fragile service models; and
- ensuring services remain sustainable and able to meet future population needs.

The detailed service-specific consultation options are set out in Sections 6, 7 and 8.

5.5 Potential changes to PTHB site-based services

The diagram below shows how the future configuration of services could change on PTHB sites because of the strengthened integrated community-based offer.

Figure 62: Potential changes to services on PTHB sites



5.6 What the Proposals Could Mean for Local Communities

5.6.1 Overview

Across all localities, the proposed options would strengthen proactive, preventative and community-based physical and mental health services, enabling more people to receive assessment, treatment, rehabilitation and ongoing support at home or closer to home where safe and appropriate. Under the proposed model, adult and older adult mental health inpatient services would be consolidated within a single Mental Health Centre of Excellence on the Bronllys site or within the Bronllys and Brecon area. Enhanced community mental health services, crisis support, sanctuary provision and alternatives to admission would be available across Powys. Highly specialised services, including PICU and secure care, would continue to be commissioned outside Powys where required.

Existing arrangements for accessing primary care, planned care, social care, maternity services, children's services, emergency care and specialist services provided by neighbouring health boards and NHS Trusts would continue and are not directly affected by these proposals.

Across all options, diagnostic services would continue to play an important role in supporting care closer to home. The proposals include strengthening access to diagnostics within UCCs and community settings, helping to improve assessment, diagnosis and treatment closer to home. In some locations, access to diagnostics would increase through enhanced seven-day provision and a broader range of diagnostic services. In a small number of locations, existing limited diagnostic provision would transfer to sites offering more comprehensive and sustainable diagnostic services.

The summaries below focus on the principal implications of the shortlisted options for each locality.

5.6.2 Brecon Locality

Under both Physical Health options, community inpatient services would continue to be provided in Brecon and would support an expanded range of inpatient, rehabilitation and recovery services compared with the current position.

Under both Urgent Care options, Brecon would host an enhanced UCC supported by seven-day X-ray provision and an expanded range of diagnostic, assessment and treatment services.

Brecon could potentially host the adult and older adult mental health inpatient services consolidated within a single Mental Health Centre of Excellence with enhanced community mental health services accessible within the locality as described 5.6.1.

5.6.3 Builth Wells and Llanwrtyd Wells Locality

Glan Irfon Integrated Health and Care Centre would continue to provide residential care. Its role in supporting reablement may evolve as more people are supported through strengthened community-based services and care at home.

Under Physical Health Option 1, residents requiring community inpatient care would access services in Brecon or Llandrindod Wells.

Under Physical Health Option 2, residents requiring community inpatient care would access services in Brecon.

Under Urgent Care Option 1, a Minor Illness and Injury Unit would be retained in Llandrindod Wells, supported by seven-day X-ray provision and enhanced diagnostic services.

Under Urgent Care Option 2, the MIU would not be retained. Diagnostic services would continue to be provided from Llandrindod Wells, including five-day X-ray provision and access to an expanded range of diagnostic tests. The Health Board would work with local partners to develop strengthened local urgent care arrangements, including primary care and community-based solutions where appropriate, helping to ensure that people continue to have access to urgent care closer to home where this can be delivered safely and sustainably.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.4 Crickhowell Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Brecon.

Under both Urgent Care options, residents would access enhanced UCC services in Brecon, supported by seven-day X-ray provision and an expanded range of diagnostic, assessment and treatment services.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.5 Hay and Talgarth Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Brecon. Physical Health inpatient services currently delivered from Bronllys would transfer to community provision or to Brecon.

Under both Urgent Care options, residents would access enhanced UCC services in Brecon, supported by seven-day X-ray provision and an expanded range of diagnostic, assessment and treatment services.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.6 Knighton and Presteigne Locality

Panpwnton Ward at Knighton Hospital would not re-open and the current reablement beds would become fully integrated within Cottage View Residential Home. More people requiring reablement support would receive this within their own homes and communities.

Under Physical Health Option 1, residents requiring community inpatient care would access services in Llandrindod Wells.

Under Physical Health Option 2, residents requiring community inpatient care would access services in Newtown or Brecon.

Under Urgent Care Option 1, residents would continue to have access to a Minor Illness and Injury Unit in Llandrindod Wells, supported by seven-day X-ray provision and enhanced diagnostic services.

Under Urgent Care Option 2, the MIU would not be retained. Diagnostic services would continue to be available in Llandrindod Wells, including five-day X-ray provision and access to an expanded range of diagnostic services. The Health Board would work with local partners to develop strengthened local urgent care arrangements, including primary care and community-based solutions where appropriate.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.7 Llandrindod Wells and Rhayader Locality

Under Physical Health Option 1, community inpatient services would continue to be provided in Llandrindod Wells, offering an expanded range of inpatient, rehabilitation and recovery services compared with the current position.

Under Physical Health Option 2, community inpatient services would no longer be provided in Llandrindod Wells and residents requiring community inpatient care would access services in Newtown or Brecon.

Under Urgent Care Option 1, a Minor Illness and Injury Unit would be retained in Llandrindod Wells alongside seven-day X-ray provision and enhanced diagnostic services.

Under Urgent Care Option 2, the MIU would not be retained. Diagnostic services would continue to be provided from Llandrindod Wells, including five-day X-ray provision and access to an expanded range of diagnostic tests. The Health Board would work with local partners to develop strengthened local urgent care arrangements, including primary care and community-based solutions where appropriate, helping to ensure that people continue to have access to urgent care closer to home where this can be delivered safely and sustainably.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.8 Llanfair Caereinion Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Newtown.

Under both Urgent Care options, an enhanced UCC would be provided in Newtown, supported by seven-day X-ray provision and an expanded range of diagnostic services. This would improve local access to urgent assessment, diagnosis and treatment and reduce the need for some residents to travel outside Powys for care.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.9 Llanfyllin Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Newtown.

Under both Urgent Care options, an enhanced UCC would be provided in Newtown, supported by seven-day X-ray provision and an expanded range of diagnostic services. This would improve local access to urgent assessment, diagnosis and treatment and reduce the need for some residents to travel outside Powys for care.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.10 Llanidloes Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Newtown.

Under both Urgent Care options, an enhanced UCC would be provided in Newtown, supported by seven-day X-ray provision and an expanded range of diagnostic services. This would improve local access to urgent assessment, diagnosis and treatment and reduce the need for some residents to travel outside Powys for care.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.11 Machynlleth Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Newtown.

Under both Urgent Care options, an enhanced UCC would be provided in Newtown, supported by seven-day X-ray provision and an expanded range of diagnostic services. This would improve local access to urgent assessment, diagnosis and treatment and reduce the need for some residents to travel outside Powys for care.

Existing primary care delivered urgent care arrangements would continue.

The existing limited local X-ray provision in Machynlleth would transfer to Newtown, where residents would have access to seven-day X-ray services and a broader range of diagnostic tests as part of the enhanced UCC model.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.12 Newtown Locality

Under both Physical Health options, community inpatient services would continue to be provided in Newtown and would support an expanded range of inpatient, rehabilitation and recovery services.

Under both Urgent Care options, an enhanced UCC would be provided in Newtown, supported by seven-day X-ray provision and an expanded range of diagnostic services. This would improve local access to urgent assessment, diagnosis and treatment and reduce the need for some residents to travel outside Powys for care.

Existing primary care delivered urgent care arrangements would continue.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.13 Welshpool and Montgomery Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Newtown.

Under both Urgent Care options, services currently provided through the MIU in Welshpool would transfer to the proposed UCC in Newtown. Residents would have access to seven-day X-ray provision and an expanded range of diagnostic services in Newtown. Existing X-ray facilities in Welshpool would transfer as part of the wider consolidation of urgent care diagnostics into the enhanced UCC model.

The Health Board would work with local partners to develop strengthened local urgent care arrangements, including primary care and community-based solutions where appropriate, helping to ensure that people continue to have access to urgent care closer to home where this can be delivered safely and sustainably.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.6.14 Ystradgynlais Locality

Under both Physical Health options, residents requiring community inpatient care would access services in Brecon.

Under both Urgent Care options, services currently provided through the MIU in Ystradgynlais would transfer to the enhanced UCC in Brecon. Existing X-ray provision in Ystradgynlais would transfer to Brecon, where residents would have access to seven-day X-ray services and a broader range of diagnostic facilities as part of the enhanced UCC.

The Health Board would work with local partners to develop strengthened local urgent care arrangements, including primary care and community-based solutions where appropriate, helping to ensure that people continue to have access to urgent care closer to home where this can be delivered safely and sustainably.

Residents requiring inpatient mental health care would access the Mental Health Centre of Excellence on the Bronllys site or Bronllys and Brecon area and enhanced community mental health services within the locality as described 5.6.1.

5.7 Summary of benefits

The table below provides a summary of the benefits from the proposals. Further detail on benefits associated with each of the services is provided in sections 6, 7 and 8.

Figure 63: Summary of benefits from the proposals

Benefit theme	Benefit expected from the proposals	Indicative measures for benefits realisation
Patient Quality, safety and outcomes	Care is more person-centred, coordinated and trauma-informed, supporting better outcomes, improved safety and an improved experience for patients, carers and families.	• Patient and carer experience, satisfaction and outcome measures. • Clinical outcomes, national audit compliance and safety measures, including falls with harm. • 7-day and 30-day readmissions, repeat crisis attendance and relapse proxy measures.
	Earlier intervention, rehabilitation and reablement reduce deconditioning, support independence and help people avoid escalation to long-term care where possible.	• Community hospital LOS, bed occupancy and pathway delays. • Healthy days at home and reablement success rates. • Long-term care admissions and future care planning for people at highest risk.
Access to services	More people are supported safely in or near their own home, reducing avoidable conveyance, hospital attendance, admission and out-of-county care.	• Avoidable conveyances, ED attendances, acute admissions and out-of-county placements. • Patients' activity rapid response, ambulatory care, step-up, short-stay

Benefit theme	Benefit expected from the proposals	Indicative measures for benefits realisation
		intervention or home-based acute treatment. • Emergency admissions and bed days avoided.
	People receive a clearer, faster and more equitable response through simplified access routes, consistent pathways and timely assessment and treatment.	• Compliance with urgent community response, four-hour and two-hour response standards. • Time from referral or presentation to assessment, diagnostics and treatment. • Compliance with Mental Health Measure and relevant access standards.
Joined up Care	Physical health, mental health, social care, third sector and partner services work together around the person, improving continuity across prevention, urgent response, rehabilitation and EOL care.	• Completion of care plans, discharge plans and agreed pathway documentation. • Physical health checks for people receiving mental health support, where relevant. • Evidence of reduced duplication and improved coordination across services.
EOL **choice**	People on EOL or palliative care pathways have better support and greater opportunity to receive care and die in their preferred place where this can be achieved safely.	• People dying in their preferred place of choice. • Patient, carer and family experience for EOL and palliative care pathways.
Financial sustainability	Prudent and sustainable use of limited financial resources	• Increased provision of in-county services reducing out of county patient activity and therefore reducing commissioning costs.
Sustainable workforce	Prudent and resilient services by making better use of skills, advanced practice roles, available capacity and digital opportunities, while reducing fragility associated with small, dispersed teams and reliance on temporary staffing.	• Vacancy rate, turnover, recruitment activity and time taken to fill key roles. • Rota fill, unfilled shifts, sickness absence and the ability to maintain minimum staffing and skill mix. • Bank and agency WTE, shifts and expenditure, with substantive establishment changes shown separately. • Staff engagement and experience information, including feedback on leadership, workload, development and involvement in change. • WTE and skill mix deployed across inpatient and community services, training completion, supervision capacity, succession plans for critical roles and readiness against implementation milestones.

5.8 Summary of Revenue and Capital Implications

The revenue impact, investment and disinvestment associated with all shortlisted options has been calculated using FY25-26 service budgets as the baseline. All modelled pay costs are based on FY25-26 pay rates. Non-pay modelling assumptions, with the majority of non-pay costs assumed to follow the patient.

The following table shows the revenue implications of each option.

Figure 64: Summary of revenue implications for the proposals

Option	Baseline £k	Investment/ Disinvestment £k	Commissioning Savings £k	Net Investment £k
Physical Health				
PH005b	13,303	-1,221	-1,954	-3,175
PH008	13,303	-1,916	-3,518	-5,434
Urgent Care & Diagnostics				
UC013	2,837	994	-850	144
UC013ii	2,837	10	-850	-840
Mental Health				
MH006a	37,835	1,518	-1,595	-77

Further information is provided in options sections in sections 6, 7 and 8 including the baseline financial quantum against which the options are being modelled, and phasing estimates based on current implementation assumptions. Whilst the net investments have been phased in line with best estimates, the actual financial implications would depend on how options are implemented.

An initial assessment of the capital implications of the proposed options has been undertaken and informed part of the appraisal process for the options in relation to their potential capital costs and feasibility. Following consultation there would need to be further work to undertake more detailed capital assessment and feasibility studies associated with the preferred options ahead of any final decision. The revenue and capital implications of the proposed options can be found in Sections 6,7 and 8.

5.9 Summary of Workforce Implications

The proposed future models are intended to support a more sustainable workforce position by consolidating some services where this improves rota resilience, strengthening multidisciplinary working, developing new and enhanced roles, and shifting capacity towards prevention, proactive care and early intervention, intermediate care services which strengthen urgent community response, rehabilitation, reablement and palliative and EOL care closer to home. In doing so, the proposals aim to make better use of the skills available

within Powys, reduce avoidable duplication across small teams, and support staff to work in more resilient, integrated and professionally supported models.

However, the workforce benefits of the proposals are not automatic and would need to be actively delivered and managed. Delivery of the future models depends on the Health Board's ability to recruit, retain, train, redeploy and support the right workforce in the right places. This includes registered nurses, mental health nurses, AHPs, advanced and enhanced practitioners, medical staff, clinical leaders, healthcare support workers, community-based roles, administrative support, specialist roles across physical health, mental health, urgent care and diagnostics. Workforce planning must also address succession risks, protect supervision and training capacity, and ensure specialist knowledge and leadership are retained as experienced staff leave the organisation.

Delivery would require a planned and funded transition. Community, urgent care and mental health capacity, together with the necessary competencies, diagnostics, clinical leadership, supervision and infrastructure, must be established before corresponding inpatient capacity is reduced. Existing services, including the Ready to Go Home units, would need to remain safely staffed during transition, and implementation plans must recognise the potential for temporary workforce overlap and additional cost. Workforce benefits should therefore be treated as delivery-dependent and tested through quantified workforce plans, service-specific readiness criteria and ongoing monitoring.

Given the extensive impact of the proposed changes on the workforce, it is proposed that further work continues to assess the workforce implications alongside consultation to ensure these are robust when reflected in the final Programme business case for decision on the preferred options, currently planned for late spring 2027. This work would include engagement with staff and trade union partners, further testing of recruitment deliverability, assessment of workforce affordability and productivity assumptions, and identification of mitigations where workforce risks could affect delivery. Workforce planning would therefore remain a core part of determining whether the proposals can be implemented safely, sustainably and at the pace required.

5.10 Summary of Delivery Risks

A summary of the risks associated with the delivery of the proposals is provided below. Further detail on risks associated with each of the options is provided in Sections 6,7 and 8.

These risks will be further updated following consultation and are included to provide an outline risk assessment for the purpose of supporting a decision to consult on the proposals. It will therefore be updated to incorporate feedback from consultation.

Figure 65: Summary of risks associated with the proposals

Risk	Potential consequence	Proposed mitigating action
Whole-system pathway shift is not sufficiently specified, phased or tested	Service changes may be implemented before the alternative model is fully deliverable, potentially affecting	Develop a detailed implementation plan with clear phasing, readiness criteria, agreed monitoring and further testing before any change to service provision.

Risk	Potential consequence	Proposed mitigating action
before service provision is changed.	safety, patient flow and benefits realisation.	
Benefits from community and home-based pathways depend on capacity and capability that may not be in place.	The intended shift to care closer to home may not be achieved, with continued reliance on existing bed-based or out-of-county provision.	Confirm enabling requirements, including clinical oversight, diagnostics, digital infrastructure, estates readiness, clinical, social care and third sector capacity and capability and identify any funding opportunities to expedite this to provide confidence in the provision of a strengthened community model before service reduction is initiated.
The availability of suitably skilled staff, the ability to recruit to new or expanded roles, training and development, requirements, and the need for clinical leadership may delay the development of community-based capacity. This could affect pace at which intended benefits are realised.	The enhanced community model may not be sufficiently staffed, supervised or supported to deliver safe services, which could delay implementation and reduce confidence that intended benefits can be realised.	Each service proposal will require a detailed workforce plan before implementation. This will need to set out the future workforce model, skill mix, staffing numbers, roles and responsibilities, recruitment and retention assumptions, training requirements, supervision arrangements, succession and knowledge transfer for critical roles, staff engagement, workforce transition arrangements and any phasing required to maintain safe services during change. It will also need to identify the workforce dependencies between the different proposals, particularly where the same workforce groups are needed across inpatient, community, urgent care, diagnostics and mental health pathways. Ensure staff engagement and phased implementation plans are progressed and fully tested before service changes are progressed.
Workforce modelling assumptions may not reflect operational demand, productivity or clinical requirements	Planned establishments may be insufficient or excessive, affecting service quality, affordability and benefits realisation,	Further validate workforce assumptions through implementation planning, benchmarking, sensitivity testing and ongoing monitoring of activity, productivity and outcomes.
Insufficient clinical, operational or managerial capacity to lead implementation	Delays to implementation, reduced staff engagement and inconsistency in delivery of the future model.	Identify implementation leadership requirements and establish any further dedicated programme and clinical leadership arrangements.
Partnership dependencies are not aligned across pathways.	Patient flows and pathways are reported as being fragmented and the required level of change across Powys to support these changes may not be delivered consistently across organisations.	Strengthen partnership governance via RPB. Confirm dependencies between Better Together Phase 1 and other partner programmes and manage these. Ensure programme management, OD and ongoing stakeholder management is strengthened to support complexity of change.
Enhanced community workforce is not available at the required pace.	Changes to bed-based services could not be implemented safely or intended pathway benefits may not be realised.	Phase implementation against quantified workforce plans and agreed readiness criteria.

Risk	Potential consequence	Proposed mitigating action
Employee relations and or existing staff leave during a period of uncertainty.	Vacancies, temporary staffing reliance and pressure on remaining staff could increase.	Provide early engagement, retention support and clear, phased transition arrangements.
Internal recruitment moves pressure to another service.	The change may redistribute rather than increase workforce capacity across Powys.	Identify the expected source of each workforce group and assess impacts on neighbouring services.
Training or role development takes longer than planned.	Advanced, enhanced or specialist capacity may not be available when required.	Use realistic education, supervised practice and recruitment lead times and provide safe transitional cover.
Social care, primary care or other partner capacity is unavailable.	Patients may not be supported safely outside hospital and Ready to Go Home capacity may need to remain.	Jointly test capacity, timing and dependencies and retain contingency arrangements.
Revenue funding will not be available	The Health Board may face a financial gap and be unable to support double running to secure delivery of the proposed community model	Separate recurrent establishment changes from temporary overlap and double-running requirements. Phased implementation planning. Explore other funding opportunities.
Alternative provider pathways and realisation of associated financial savings are not deliverable.	Repatriation and pathway redesign may not deliver the expected efficiency, cost effectiveness or activity changes.	The Health Board will need to ensure that alternative provider pathways and services are more efficient and cost effective than those provided out of county prior to any decision to repatriate activity. Develop commissioning plans alongside strategic partnership arrangements and test demand, capacity, activity and financial assumptions.
Capital funding will not be available	It will not be possible to support the reconfiguration of services required to address the issues in the Case for Change and ensure sustainable service models for the future.	Undertake feasibility studies to confirm the capital impact following decision on preferred option. Progress the Phase 2 business case for north Powys and explore other funding opportunities with Welsh Government.
Digital System Capability and Implementation Capacity cannot meet delivery expectations	If digital system capability fails to deliver required changes this may cause implementation delays and inefficient use of resources.	Several options for achieving the described operating model have been considered. The worst-case scenario with a heavy administrative burden has been considered and included in the case.

6. Physical Health (Inpatients and Community Model)

6.1 Background and context

Physical health community and inpatient services are a core part of the Powys health and care system. They provide community hospital assessment, treatment, rehabilitation and nursing care, alongside reablement, community rehabilitation, urgent response, long-term condition management and care at home. Services are delivered directly and through primary care, social care, commissioning providers and third sector partners. In a large rural county, this local provision supports people whose needs do not require acute hospital care, but who still need coordinated clinical, therapeutic, nursing or social care support.

The current model includes General Medical services (GMS), community hospital beds, district nursing, specialist community teams, rehabilitation, reablement, Home First services, commissioned services and voluntary sector support. The main pressures are avoidable inpatient utilisation, prolonged lengths of stay, delayed discharge, rising CHC demand, workforce fragility, estate constraints and gaps in rapid community response. These pressures are interconnected: limited community capacity can contribute to avoidable admission or delayed discharge, increasing the risk of, deconditioning and the level of support required after hospital care.

The current model provides valued local services, but its dispersed configuration makes it increasingly difficult to meet needs consistently. The central issue is whether people can access the right support at the right point in their care journey. This should help maintain independence, supports recovery, avoid unnecessary admission and enable timely discharge.

6.2 Current Configuration of Services

6.2.1 Community Inpatient Services

Figure 66: Current PTHB Community Inpatient beds

Site	Provision
Machynlleth	14 beds
Welshpool	21 beds
Newtown	15 beds
Llanidloes	14 beds
Llandrindod Wells	15 beds
Bronllys	18 beds
Brecon	29 beds
Ystradgynlais	20 beds
Total beds	146

The current physical health inpatient model includes 146 beds across Eight community sites. Occupancy usually around 85-90%, recognising admissions and discharges do not always align.

Following temporary services changes that were put in place from 2nd December 2024, PTHB provides overnight care for adults in four settings:

- Our Ready To Go Home Units support people who are well enough to go home but not yet able to do so. These are located in Bronllys and Llanidloes.
- Our Inpatient Rehabilitation Units provide specialist rehabilitation for patients recovering from a serious illness or injury – for example, following a stroke. These are located in Brecon and Newtown.
- Our community hospital wards focus on patients who require ongoing medical or nursing assessment and treatment in a community hospital setting.

There are a further 12 short stay reablement beds at Glan Irfon Health and Care Centre in Builth Wells, which is jointly run by PTHB and PCC and 5 interim beds in Cottage View residential home, located on the Knighton Community Hospital site. These are reablement beds that support people who are ready to leave a DGH but need additional short-term support to regain confidence, independence and daily living skills before returning home. This provision forms part of the wider intermediate care service options in Powys that include intermediate care at home and bed-based provision.

In addition to the above, in 2025/26 Powys commissioned an average of 11 community beds per day[52] from external providers to manage excess unplanned demand and support patient flow out of acute hospitals.

The operational bed base across these sites may vary to reflect seasonal demand and temporary service changes and is used for a range of functions, including general community hospital care, Ready-to Go Home provision, rehabilitation, step-down reablement and intermediate care and D2RA.

This mixed configuration is important because the function of the bed base differs across the pathway. Some people require ongoing nursing care, some require intensive rehabilitation, some require step-down support and some are clinically ready to return home but are awaiting the right onward support arrangements.

Day hospital provision has also changed over time, with day hospitals on PTHB sites temporarily closed at the start of the COVID-19 pandemic, remaining temporarily closed. The current physical health service offer is therefore different from the historic model, with some previously available local provision no longer operating in the same way.

6.2.2 Community Based Nursing, Rehabilitation and Reablement

Community services are delivered through locality-based services and specialist teams. District Nursing operates across 12 localities, seven days a week, from 8am to 8pm, and provide both planned care and urgent response functions. The service predominantly

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supports people who are housebound and require care for chronic health needs, including diabetes, wound care, support with medical devices such as catheters and specialist infusion lines, and EOL care. District Nursing also operates to a two-hour response standard for urgent referrals.

Specialist community teams include cardiology, continence, diabetes, lymphoedema, Parkinson's disease, respiratory, tissue viability, specialist palliative care and continuing health care commissioning. These teams work alongside district nursing, therapies, primary care, secondary care, community pharmacy and voluntary sector partners.

Home First services form part of the current physical health pathway, working with social care and third sector partners to support people to remain at home where possible and to return home as soon as safely possible following hospital admission. From April 2025, some services were brought together to form the Community Rehabilitation Service, which supports people with rehabilitation goals, people requiring wraparound support on discharge from hospital and people in the community who are at risk of hospital admission. The service operates 8am to 8pm, seven days a week. Alongside this, PCC operates an enablement pathway for people who require an ongoing package of care and have no ongoing rehabilitation goals. This service operates 7am to 10pm, seven days a week and supports people who require a new or increased package of domiciliary care. Together, these services form an important part of the Intermediate Care service pathway between hospital, home and long-term support.

The current model also includes frailty support roles and falls prevention activity, supported through the Health Board and primary care clusters. These services aim to support people living with frailty to remain independent for longer and at home where possible, including through review of chronic conditions, clinical management of falls risk and other vulnerabilities associated with risk of admission to hospital or to long-term care. Current service information records that one in three people aged 65 and over and one in two people aged 80 and over are at risk of falling, with falls identified as a major driver of emergency hospital admission and subsequent deconditioning.

6.3 Current Activity, Performance and Clinical Standards

6.3.1 Inpatient Activity and System Flow

In 2025/26, there were 44,082 hospital admissions for Powys residents (all admissions including elective/planned), with 156,383 bed days used at a cost of over £121m. On average, 120 Powys residents were admitted to hospital each day and 428 beds were occupied daily by Powys residents, including beds within Powys and in neighbouring DGHs (*financial information from PTHB Acute* Commissioning Minimum Data Set *(CMDS) July 2026*). The current activity position includes both in-county provision and out-of-county acute hospital pathways, reflecting the way Powys residents move across local community services, Powys bed-based provision, neighbouring acute hospitals, commissioned care and onward support pathways.

The physical health pathway cannot be understood solely through the number of community hospital beds located within Powys. Activity and performance must be considered across the

whole pathway because pressure in one part of the system affects capacity and flow elsewhere. Out-of-county acute care, community hospital, social care, intermediate care, rehabilitation, reablement, mental health services, CHC, palliative care and care at home support all influence how quickly people move through the system and whether they receive the right support at the right time.

The table below shows emergency admissions only by provider over the past 4 years.

Figure 67: Emergency admissions only by provider, 2022 to 2026

Provider C	Provider	2025-2026	2024-2025	2023-2024	2022-2023
England	GLOU	41	40	33	26
	OTHER	325	357	306	353
	RJAH	27	20	23	20
	SATH	5,126	4,919	4,767	4,451
	WORC	69	54	66	57
	WVT	2,636	2,472	3,290	2,604
England Total		**8,224**	**7,862**	**8,485**	**7,511**
Wales	AB	3,390	3,227	1,218	1,017
	BC	311	289	290	211
	CTM	1,522	1,661	1,446	1,262
	CV	60	74	80	71
	HD	1,296	1,286	1,180	1,174
	POW	653	585	594	589
	SB	1,369	1,124	1,049	1,039
Wales Total		**8,601**	**8,246**	**5,857**	**5,363**
Grand Total		**16,825**	**16,108**	**14,342**	**12,874**

(*2022/23–2025/26 from PTHB Acute CMDS July 2026*)

6.3.2 Length of stay (LOS), Discharge and Bed Utilisation

The average LOS across PTHB community hospital general wards is 40 days, compared with the Welsh Government target of less than 21 days. Longer hospital stays are associated with increased risk of deconditioning, delirium, falls, loss of confidence and reduced independence, particularly for older people and those living with frailty. LOS is therefore relevant to both service flow and patient outcomes.

The June 2024 bed census found that 60 of 132 patients, equivalent to 45%, were clinically optimised and ready to return home. Of those patients, 22 of 60, equivalent to 36%, had been waiting over a month since being ready for discharge. This reflects a gap between clinical readiness for discharge and the availability of onward support, including discharge pathways, community capacity, reablement, rehabilitation, care at home and social care. The same census recorded that 28 patients had no therapy or nursing needs, 32 patients required intensive rehabilitation and 19 patients required step-down care. Patients in community hospital beds therefore do not all require the same type or level of support, and the current pattern of use reflects demand across rehabilitation, reablement, discharge support and onward care. Information gathered on pathway of care delays in 2025/26 identified 43,179 delayed bed days at an estimated cost of £15.8m. This represents a slight reduction compared with FY2024-25. These delays reflect time spent in hospital while people wait for appropriate onward care or support. They are relevant to bed availability, cost, patient

experience and wider system flow, particularly where people remain in bed-based care longer than clinically required.

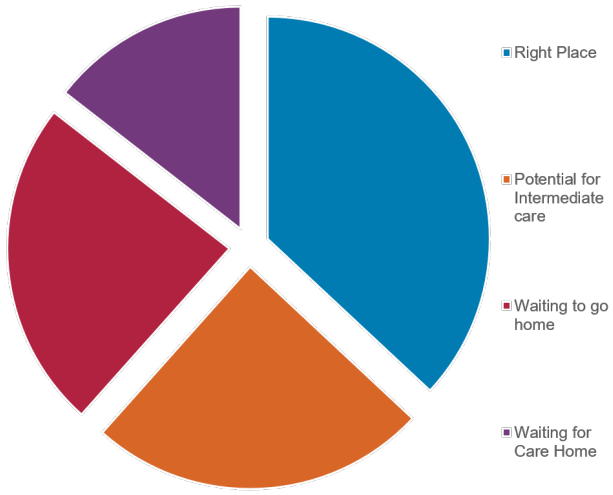
The chart below from August 2025 shows the outcome of a day of care survey that identified a cohort of community hospital inpatients with potential for Intermediate Care at home as well as patients waiting for onward social care support for discharge to home or to a care home. This demonstrated a patient LOS of 38 days –

Figure 68: Day of care survey outcome (Community Hospitals)

The current average length of stay in PTHB community hospital beds is approximately:

- **38 days** for **physical health wards & units**
- **55 days** for **older adult mental health wards**
- **37 days** for **acute adult mental health ward**

Welsh Government recommendations to minimise length of stay, particularly for patients over 65, set targets of **less than 21 days** and shorter milestones at 48 hours and 7 days.



6.3.3 Complexity and Continuing Healthcare (CHC)

CHC demand increased by 43% between 2021/22 and 2025/26, from 285 to 407, while costs increased by 89% from £20m to £37m (*figures from PTHB M12 finance performance report*). This represents a substantial increase in long-term care demand and expenditure. Demand and costs are influenced by factors, including eligibility, complexity of need, market conditions and pricing.

National and local improvement work is underway to strengthen CHC delivery and performance, including improvements in digital systems, workforce training, competency frameworks and pricing consistency across Wales.

6.3.4 Community Based Teams - Data and Reporting

Current service information identifies limitations in data quality and reporting. Information is held across different systems and there are limitations in consistent reporting, service comparison and demand and capacity analysis. The available material provides a clear basis for describing the current service position, although some areas will require continued validation where figures are used for modelling, financial analysis or evaluation. This is particularly relevant to workforce, activity, demand and capacity, finance and outcomes data.

6.3.5 Clinical Standards

A number of clinical standards are not consistently being met through existing service provision.

For example, blood transfusions have had to be reduced to delivery from two sites due to recent review demonstrating that clinical standards were not being met across all sites. Consolidation of services with focused training of staff along with a strengthened clinical oversight model and more robust ward staffing model would support more patients to receive treatment closer to home, while enabling staff to maintain and develop their skills through increased local activity.

There is also some evidence of delays in managing deteriorating patients, including people with suspected sepsis, with some community hospital patients waiting up to three hours for ambulance transfer. Limited senior clinical support, particularly out of hours, can delay interventions such as cannulation, fluids and antibiotics. A strengthened clinical oversight and ward staffing model would support earlier treatment before transfer and where clinically safe, reduce avoidable deterioration and unnecessary acute admission.

6.4 Why No Change is Not an Option (current issues)

6.4.1 Rising Number of Patients Being Admitted to Secondary Care.

Both financial and activity analysis demonstrates the Health Board is experiencing a significant and sustained increase in externally commissioned acute care expenditure. Emergency inpatient costs have risen from £29.5 million in 2022/23 to £36.1 million in 2024/25, an increase of over 22% in two years (*figures from PTHB Acute CMDS July 2026)*. Key indicators of system pressure include rising emergency admissions, increasing average cost per admission prolonged acute lengths of stay, significant levels of 7-day and 30-day readmissions, and a concentration of expenditure in general medicine and frailty-related specialties. These patterns suggest that more patients could benefit from enhanced local clinical oversight, proactive discharge planning, stronger community services and improved step-up and step-down alternatives

Current service information identifies frailty and falls as a major driver of hospital admission, deconditioning and loss of independence. Falls prevention work has been developed to identify why a person may have fallen, or feels at risk of falling, and to put actions in place to reduce risk factors and support confidence. However, there is further work required to strengthen falls and frailty community-based services to develop an integrated model to connect falls prevention, community-based rapid response, fracture support, bone health, proactive care for chronic conditions and medicines optimisation more consistently across Powys.

Service change is required in Powys to improve clinical safety, quality, patient experience clinical and financial sustainability. The Health Board has invested in strengthened clinical oversight to provide clearer accountability, more consistent senior decision-making and improved coordination with external acute providers. Recruitment to medical roles is underway. The options proposed for consultation have been developed from the current

service baseline and set out the service, workforce and investment requirements with each model.

6.4.2 Patient Deconditioning and Avoidable Patient Harm

Powys's ageing population means there are increasing levels of frailty, dementia, cardiovascular disease, respiratory disease, cancer, diabetes and multimorbidity. Complex multimorbidity, defined as four or more co-existing conditions, is projected to increase significantly, with mental health concerns present in the majority of these cases.

Prolonged hospital stays can cause avoidable harm. Deconditioning can begin soon after admission and can reduce a person's ability to return to their previous level of independence. Evidence suggests that, for people aged over 80, 10 days in hospital can result in muscle loss equivalent to 10 years of aging, while delirium can triple mortality and double the LOS[53]. These impacts will be directly contributing to the current prolonged LOS for Powys patients.

Hospital-associated deconditioning (HAD) is one of the most important and most underappreciated sources of avoidable patient harm in acute hospitals. Welch et al. [54] published the most comprehensive current international review, describing the mechanisms by which immobility, undernutrition and inadequate cognitive engagement produce acute sarcopenia and cognitive deconditioning during hospital stays. The effects can be long-lasting and are not always reversible.[55]

The "Day of Care" survey conducted in 2025, reviewed 138 patients across community hospital sites in Powys, the key finding was that only around one-third of patients were receiving care at the most appropriate level on the day of review, while nearly two-thirds could potentially have been supported through alternative pathways such as intermediate care rehabilitation at home, discharge support, or long-term residential care arrangements. The review argued that investment should shift from prolonged inpatient care toward proactive integrated home-based and community-based services, supported by stronger health, social care, and housing partnerships. In summary the review outlined:

- One-quarter of patients in community inpatient beds could potentially have been cared for at home if robust intermediate care were available, supported by the appropriate specialist clinical oversight.
- Almost one-quarter of patients were clinically ready to leave hospital but were waiting for care packages, equipment, housing solutions or carer respite arrangements. These delays contributed substantially to unnecessarily long hospital stays.
- Staff reported that many patients experience several moves between acute hospitals, community hospitals, and other facilities.
- Staff described a lack of continuity and case management throughout the patient's journey with limited integration across services with gaps between community

[53] New horizons in hospital-associated deconditioning: a global condition of body and mind
[54] Age and Ageing, November 2024
[55] Three-Pillar Model, Six Goals for Urgent and Emergency Care, May 2026

hospitals, district nursing teams, community rehabilitation and primary care teams. It is anticipated that the recently formed SPOA Service will help to improve this.

In November 2025, a multidisciplinary group from PTHB, social care and Wye Valley Trust (WVT) also reviewed emergency admissions of Powys residents aged 65+ over a one-week period. The survey focused on patients admitted to WVT via Same Day Emergency Care (SDEC), medical assessment or specialty beds, excluding those discharged directly from ED. The group collected clinical information through virtual huddles within 24–48 hours of admission. They reviewed the reasons for admission, initial clinical management, and whether additional community, primary care, social care or specialist support might have enabled a different response. The report concluded that while some emergency admissions for older people with frailty are unavoidable, many of the admissions reflected gaps in proactive care, information sharing, advance care planning, community response, and coordinated MDT, support. It identified that of 20 admitted patients (aged 65+):

- 25% were assessed as acute and not readily preventable;
- 20% were assessed as acute but earlier proactive care might have reduced risk;
- 55% were assessed as potentially avoidable through strengthened community-based services with increased focus on supporting people with frailty.

Recommendations for action following a multidisciplinary workshop include better information sharing, polypharmacy & medicines reconciliation, enhanced community hospital workforce and clinical oversight, and further strengthen falls response and proactive prevention.

The evidence provides a strong case for shifting resources from inpatient settings to support a more integrated community-based service. A reconfigured workforce could strengthen proactive prevention, earlier intervention and care planning within communities

6.4.3 Workforce Shortages and Service Capacity Issues

The current community inpatient model is experiencing significant workforce pressures. Analysis of agency usage across community inpatient wards during 2025/26, based on roster data and a minimum staffing ratio of 1:4 WTE per bed, indicates that a substantial proportion of the inpatient bed base is dependent on agency staffing to maintain safe levels of care.

Workforce pressures also exist in the community-based services. Several specialist teams are small, operating with fewer than 5 WTE staff across Powys. Specialist support is therefore being delivered across a large geography by small teams, with different operating hours and service models depending on specialty. There are workforce and service fragilities resulting from limited capacity in some teams and geographic dispersion. For example, District Nursing is recorded as having 100.03 WTE staff[56], but the service is often unable to meet the supervisory and case management expectations set out in the NHS Wales Community Nursing Specification, indicating a gap between the expected community nursing model and the current operational position. The future service model needs to increase capacity and skills in the community. Consolidation of teams would be a key enabler for this.

[56] Appendix B.2 - 20250804-Physical Health Community Services Technical

6.4.4 Lack of Community Response and Alternatives to Bed-Based Care

UK guidelines and review of evidence support the provision of rapid community response for people at risk of deterioration or avoidable admission, especially older adults and those with complex needs. Admission-avoidance models can safely substitute for hospital admission in selected groups. National Institute for Health and Care Excellence (NICE NG94) [57] gives the guideline basis. Furthermore, the evidence and policy base for D2RA, Home First, is a strong supporting person-centred recovery and reduced deconditioning risk. The 2024 Cochrane admission avoidance review found equivalent safety to inpatient care. National discharge guidance strongly supports early transfer to the least restrictive appropriate setting.[58]

The current traditional community service model has gaps in the spectrum of intermediate care service options across rapid community response, Home First support and alternatives to admission - all of which enable people to remain at home during a crisis. People who are clinically ready to leave hospital need more timely access to the right onward support.

Rurality and geography make delivery of an efficient Home First model more challenging across Powys. There remains a gap between the ambition to support more people at home and the capacity currently available. EOL care is also a key component of community care, but current workforce capacity does not consistently allow rapid support to be provided at home. In 2025/26, 1,578 Powys residents died, with a substantial proportion dying in hospital and out of county, while community-based care supported dying at home, hospice at home provision, specialist palliative care activity, community hospital activity and Fast Track CHC. We know that the majority of Powys patients express a wish to die at home when death is anticipated and inevitable. To address these gaps, there needs to be a shift in resource from inpatient services.

6.4.5 Poor Bed Configuration and Estate Condition

The current configuration of inpatient beds is both clinically and financially inefficient. There is a mismatch between patient needs and current ward provision, with the current distribution of beds not consistently aligned to patient acuity, rehabilitation and step-down needs. This is further demonstrated by variation in bed occupancy and cost across sites. Smaller inpatient units are unable to maximise bed utilisation or workforce efficiency, with a 14-bed ward staffing cost of around £89,126 per bed compared with a modelled £68,284 per bed in a 30-bed footprint.[59]

In addition to this, parts of the community hospital estate are ageing and do not consistently meet the standards required for modern models of care. This limits flexibility, care quality and efficient workforce deployment. For example, many current inpatient wards and units do not meet the national Welsh Health Building Note (WHBN) standards [60].

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[57] Overview | Emergency and acute medical care in over 16s: service delivery and organisation | Guidance | NICE
[58] Three-Pillar Model, Six Goals for Urgent and Emergency Care, May 2026
[59] Level 2 IIA Physical Health 2026
[60] Welsh Health Building Notes (WHBNs) & Health Building Notes (HBNs) - NHS Wales Shared Services Partnership

Community Inpatient units need to be staffed more efficiently to improve quality standards, resilience, patient flow and patient outcomes.

6.5 What we Have Heard Specifically About this Service Area

In addition to the engagement feedback shared in section 4, there are specific engagement insights for physical health inpatient and community services which have been considered as part of future proposals.

6.5.1 Value of Local Services

Engagement feedback shows that local services, community hospitals and the contribution of communities, volunteers and unpaid carers are highly valued in Powys. Community hospitals are a source of civic pride and local access matters to residents, particularly in a rural county. Feedback also reflects an expectation that services should be safe, sustainable and able to respond to changing needs. Local access is important to residents, alongside confidence that services can meet people's needs safely and consistently.

People have emphasised the need for prevention, early intervention and proactive frailty support. Stakeholders supported earlier frailty assessment, timely intervention and high-quality care in the last year of life. Residents also expressed a desire for more accessible preventative health and support to promote healthy lifestyles. This aligns with the current findings in relation to patient deconditioning, falls, delayed discharge and community service fragility.

6.5.2 Access, Travel, Equity and Coordination

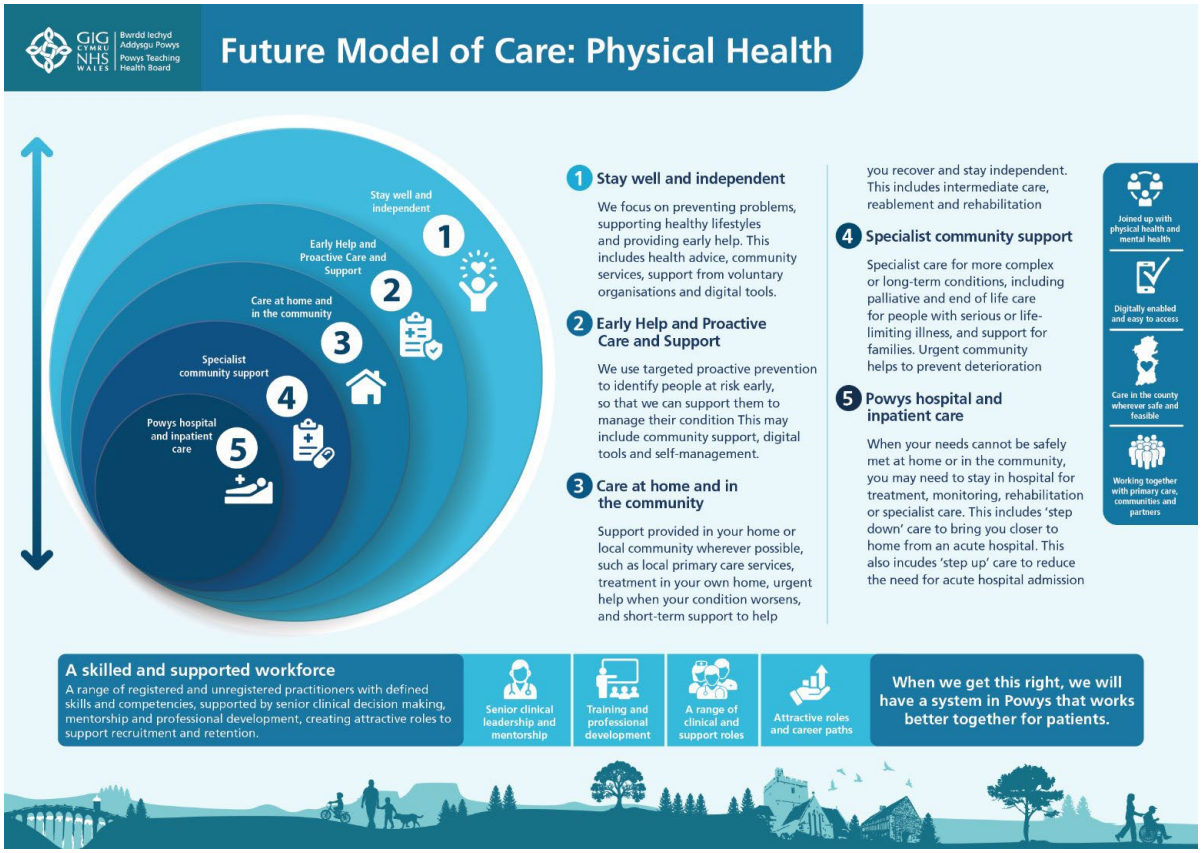
EOL and palliative care have also been identified as areas for improvement. Stakeholders highlighted the need for better access to hospice and palliative care within Powys, alongside support for people to make choices about where they receive care at the EOL. This aligns with the wider need to provide more care close to home where this is clinically safe and in line with patient preference.

Access, travel and equity are recurring themes. People have raised concerns about travel and transport, waiting times, rural access and variation in service availability across Powys. These concerns are particularly relevant because Powys residents rely on both local community services and out-of-county acute provision. Feedback also identifies the need for better coordination, communication and joined-up pathways. People describe fragmented care, poor coordination between services and the need for clearer information sharing.

6.6 Proposals for the Future

6.6.1 Integrated Community Model (Wider System Changes)

Figure 69: A Future Model of Care: Physical Health



The integrated community-based service model would support a home-first system by bringing together, prevention and early intervention, targeted proactive care, intermediate care, mental health support, and a strengthened palliative and EOL care offer. It is intended to provide more coordinated, person-centred and digitally enabled care closer to home, reduce avoidable escalation of clinical needs, and improve outcomes for patients, carers and communities.

The model responds to rising demand, increasing complexity and the challenge of equitable access across a large rural county. It aligns with the PTHB Population Health Strategic Framework and recognises that proactive prevention begins with the whole population, while targeted proactive support is directed to people with established risk.

The proposed service model is based on a prevention and early intervention approach, spanning the continuum from whole population prevention and wellbeing through to proactive support for people at risk of deterioration, crisis, hospital admission or loss of independence. The model focuses on providing coordinated community-based care for people with frailty, long-term conditions, mental health needs, dementia, palliative care needs and other complex care requirements.

The future service model supports delivery of the Powys Health and Care Strategy and the Powys Wellbeing Plan. It reflects the national legislative and policy framework described in

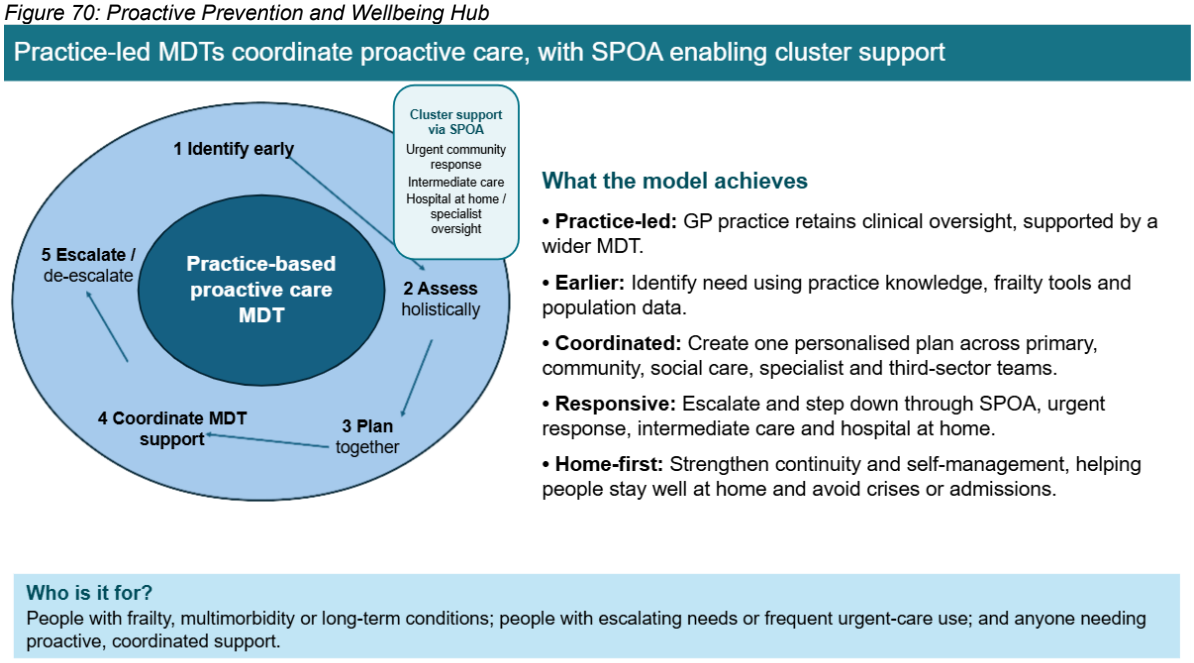
section 2, together with relevant Welsh Government guidance on proactive care, frailty, discharge, rehabilitation and urgent community response. Within this model, proactive prevention is best described as targeted proactive prevention. This sits within the wider population health approach. It provides a place-based, multidisciplinary model for people already showing signs of increased need or risk. The approach focuses on earlier identification, personalised support, self-management, chronic disease management, stronger community connections and appropriate use of digital tools. This targeted element should not be presented as the whole of prevention, but as one part of a wider population health and prevention framework[61].

Practice-based MDT would coordinate proactive care planning and long-term condition management, supported by wider community, mental health, social care and third sector services. A SPOA would coordinate escalation to urgent and intermediate care where required.

Integration is central to the model. Physical health, mental health, primary care, social care, therapies, community services, third sector partners, unpaid carers and community assets would work together through shared assessments, care planning, information and escalation arrangements around the person. This would support earlier identification of need, more joined up care and consistent support for people with complex physical, mental health and social care needs.

The diagram below illustrates how the Practice-Based Proactive Care MDT model would operate and the benefits it delivers through coordinated, proactive support.

Figure 70: Proactive Prevention and Wellbeing Hub



[61] What is targeted proactive prevention?

Mental health support would be embedded throughout the community model, with earlier intervention, recovery-focused planning, crisis prevention, open access and “no wrong door” principles, with stronger links between community mental health, primary care, physical health teams, social care, the third sector and community wellbeing assets. This would help ensure that people with mental health needs, dementia-related complexity, distress, loneliness or social vulnerability can access timely support alongside physical health, frailty, rehabilitation, reablement and long-term condition pathways.

Intermediate care would provide rapid, time-limited support through urgent community response, Hospital at home, rehabilitation and reablement at home, palliative and EOL care, discharge- to- recovery and assess pathways, and access to intermediate care beds where required. Referrals would be coordinated through a SPOA.

Subject to sufficient workforce capacity, clinical oversight and partner support, expanding this model of care is expected to reduce demand for inpatient beds by enabling more people to receive appropriate care at home or closer to home. Evidence suggests that up to 50% of current community hospital inpatients could potentially be supported through alternative community-based pathways, reducing the risk of deconditioning associated with prolonged hospital stays.

Whilst the majority of EOL and palliative care is delivered through core community teams, the new community model would include strengthened specialist assessment, advice and intervention for people with the most complex palliative and EOL care needs. The specialist palliative care team would provide complex symptom assessment and management, support for psychological, social and spiritual need, advice to universal and targeted teams, proactive case identification and review, contribution to MDTs and virtual wards, support to community hospitals, education and capability building, clinical leadership and governance across the wider system. The palliative and EOL service model would form part of the intermediate care, virtual ward and frailty pathways so that people approaching the EOL are identified early and supported through planned, coordinated care rather than crisis escalation.

The target population and pathways are described below. This should be read as the targeted proactive care element of the wider population health and prevention continuum, not as the full starting point for prevention across Powys:

- Adults living in the community, including people with physical and mental health needs who would benefit from proactive support to maintain independence and prevent deterioration.
- Priority cohorts include people living with frailty, multiple long-term conditions, those at rising risk of hospital admission, people experiencing falls or recent sudden functional decline, individuals requiring rehabilitation or reablement following illness or discharge, people with exacerbations of chronic conditions such as Chronic Obstructive Pulmonary disease (COPD) or heart failure, those needing EOL care support at home, and people whose physical health needs are accompanied by declining mental health or dementia-related complexity.
- The proactive prevention component supports a broader population health approach by identifying people at rising risk and linking them with early help, wellbeing

interventions and community support, while recognising that whole-population prevention must also address the wider risk factors for disease, illness and poor wellbeing before people reach this level of need.

Figure 71: Physical Health Proposed Pathway Changes

A person requiring Intravenous antibiotics
A person who requires Intravenous (IV) antibiotics for an infection may currently need to have an inpatient stay in an acute setting out of county – this exposes them to the risk of deconditioning. In the future model, IV antibiotics could be delivered at the person's home, or, were ambulatory, within a Hub or urgent care setting.
A pending a package of care
A person who is awaiting a package of care, may decondition while in an inpatient bed, and strengthening of community teams would enable people to return home in a timely manner by providing care and support at home earlier and is likely to reduce this risk.
Palliative Care/End of Life (EOL)
The model places palliative and EOL care at the heart of the integrated community offer. It requires a stronger home-first approach, with reliable district nursing, urgent response, CHC Fast Track, care packages, medicines, equipment, pharmacy, hospice at home and specialist advice to support more people to remain at home or in care homes where safe and appropriate. It also means embedding palliative care within intermediate care, urgent response, frailty, virtual wards and non-cancer pathways so people are identified earlier and crises are managed without defaulting to hospital admission. Community hospitals would become a planned part of the pathway for people who cannot be supported at home, providing step-up, step-down, symptom stabilisation, repatriation and dignified EOL care. To deliver this safely, the integrated model would require consistent pathways, workforce capability, education, escalation routes, clinical oversight and governance, and effective information sharing across Powys. Subject to appropriate workforce and resource capacity, the model has the potential to reduce avoidable admissions and out-of-county care. Insufficient capacity or recruitment challenges may impact delivery and place additional pressure on community services.
Overnight blocked catheter
In current practice, someone who experiences a blocked catheter overnight may need to travel to an ED, experiencing long waiting times with the potential for deconditioning. This journey may be an hour away from their home. In the future model, having a team of qualified practitioners available overnight means that this is more likely to be treated overnight, in the person's home, and the journey and attendance at the ED avoided.
Multiple chronic conditions
Currently, a person with multiple chronic conditions has several points of duplication for their care delivery. Under the new model, the MDT focus would wrap care and support around the needs of the person. This may avoid multiple appointments and assessments and bring care together in a holistic person-centred approach. The care plan would also include seasonal planning and future care planning to consider treatment escalation goals

and preferred place of care should symptoms worsen; a person may be stepped up for up to 72 hours if assessment and diagnostics are needed to support treatment.

Workforce and Digital requirements:

The service model depends on integrated MDTs working across health, social care, primary care, mental health, therapies, third sector, and community services.

- Core roles include general practice teams, district nurses, social workers, care coordinators, mental health practitioners, AHPs, support workers, pharmacists, community connectors, and specialist in-reach from services such as dementia, respiratory, cardiac, palliative care, and diabetes.
- For intermediate care, the workforce would also require advanced clinical decision-making capacity through roles such as advanced clinical practitioners, enhanced nurse practitioners, and medical oversight and leadership, supported by coordinators and administrative functions.
- Additional capacity in specialist palliative care teams to provide timely equitable specialist input.

Digital capability is an essential enabler of the future model. Requirements include shared electronic records, referral and triage systems, remote monitoring, technology-enabled consultations, operational dashboards, telecare and digital inclusion support.

To realise these benefits, the case defines a reasonable investment in digital systems and system integration, cyber security, data quality, reporting capability, devices and the supporting infrastructure needed to make these tools work effectively in practice. This would need to be supported by dedicated digital, information, clinical informatics, training, project management and change capacity to configure systems, redesign pathways, support adoption and embed new ways of working. With the right resources in place, digital capability would help teams share information more effectively, support patients and staff, reduce duplication and enable safer, more joined-up and more accessible care across Powys.

6.6.2 Community Inpatient Services

The future service model is positioned as a key delivery mechanism for the Powys Health and Care Strategy and the Powys Wellbeing Plan and reflects the national legislative and policy framework described in section 2.2. The proposed service model brings together community hospital inpatient beds and intermediate care or reablement beds into an integrated bed-based offer with four core functions:

- step-down care from acute or specialist settings for complex nursing or medical needs.
- step-up care from home for up to 72 hours to undertake assessment and diagnostics, implement treatment plans and discharge with wrap around support where required.
- inpatient rehabilitation that cannot be provided at home.
- palliative and EOL care where community hospital is the preferred place of care.

A key design feature is the integration of clinical assessment and treatment beds within the wider community inpatient bed base rather than as a separate unit. This is intended to increase flexibility, support earlier repatriation from acute hospitals and strengthen admission avoidance pathways. The model also supports a more joined up approach to managing patients with both physical and mental health needs.

This bed base would also form a core part of the Powys community hospice model, providing planned, dignified and safe palliative and EOL care for people who do not require acute hospital care, but whose needs cannot be met at home or in a care home at that point in time. This may include step-down or step-up care, repatriation from out of county hospitals, symptom stabilisation and treatment of reversible causes of deterioration where this can be safely managed in a community hospital, and care for people who wish to die in Powys when home is not possible or preferred.

The target patient cohorts and pathways are:

- Adults aged 18 and over who meet the following criteria:
  - Step-down patients who no longer need acute hospital care but are not yet able to return home as they require a further period of 24-hour nursing support, daily clinical oversight, rehabilitation, reablement or complex discharge planning
  - Step-up patients principally people with frailty, chronic condition deterioration, complex rehabilitation needs, palliative and EOL care needs, and people with dementia whose needs have escalated and are at risk of admission to the acute hospital if not assessed and supported promptly and where that support cannot safely be managed at home but can safely be managed in a Powys community bed.

Pathways are based on referral to a SPOA for early multidisciplinary assessment, goal-based care planning, proactive discharge planning, use of planned date of discharge and discharge to recover then assess principles, with strong links to primary care, Powys social services, the third sector and specialist community teams.

Workforce and Digital requirements:

- Delivery depends on a multidisciplinary workforce with appropriate medical, nursing, therapy, pharmacy, social care and specialist input.
- Core requirements include medical oversight, advanced and consultant-level practitioners, registered nurses, pharmacists, support workers, physiotherapy, occupational therapy, dietetics, discharge liaison and, where required, speech and language therapy, psychology, neuropsychology and specialist palliative care.
- To support integrated physical and mental health care, the staffing model requires dedicated mental health nursing and support worker capacity.
- Additional capacity in specialist palliative care teams to provide timely equitable specialist input and deliver increased proactive care, community hospital support, urgent response, non-cancer pathway development, education and any future seven-day face to face provision.
- Seven-day therapy and clinical oversight models are a critical enabler.

- A shared electronic health record, real-time bed and flow management, integration with virtual hospital arrangements, and robust data support for operational and clinical oversight.

The proposed options are designed to address the clinical standards and areas for improvement identified in Section 6.3 through strengthened clinical oversight, more resilient multidisciplinary working and improved access to appropriate care and support. The future service model would provide a stronger basis for meeting these standards consistently, subject to the necessary workforce, infrastructure and other enabling arrangements being in place.

6.7 Future Service Model Benefits and Evaluation

Figure 72: Physical Health Future service model benefits and evaluation

Benefit	Potential evaluation metrics to assess impact of change
Reduce patient de-conditioning	• Patient community hospital LOS • Patient re-admission rates • Bed occupancy and pathway of care delays • Patient experience and outcomes
Patients can be treated at home, reducing travel to out-of-county or community hospitals	• Number of pathways implemented • Emergency admissions and bed days avoided • Greater clinical oversight in community hospitals would support the increased use of Treatment Escalation Guides reducing the number of inappropriate transfers. • Patient discharge to usual place of residence • Increase in step-up short stay care • Reductions in falls with harm
Improved proactive prevention keeping people healthy at home	• Healthy days at home
More equitable access to community-based support	• Better patient and carer experience
Safe and timelier discharge reducing long-term dependency on care system.	• Reductions in long-term care admissions • Improved completion of future care plans for people at highest risk, and year-on-year improvement in healthy days at home.
More patient choice for those on the EOL of palliative care pathway.	• Increase in people dying in their preferred place of choice. • Improved patient and carer satisfaction.
Safe, good quality care with continuity and join up care across prevention, urgent response, rehabilitation, and EOL care.	• Clinical outcomes, including national audit compliance, where relevant • Patient-reported experience

6.8 Future Service Pathways

Demand and Capacity Modelling has been undertaken with clinical teams, drawing on an extensive national evidence base to help inform future pathways flows, examining potential to mitigate certain patient pathways into acute settings through more proactive community care in Powys. The modelling has been based on two scenarios a mid-range realistic and achievable (scenario B) and more aspirational and radical (scenario C). The 'do nothing' position has also been modelled (scenario A), which gives a picture of how well the existing model could meet demand if we do not change. This modelling work has informed the future models of care and development of options, and it has been used to translate future workforce requirements, potential changes in commissioning and the financial modelling, using year 0 as a baseline.

6.8.1 Rehabilitation and Reablement

Projected future activity levels, together with additional care hours and WTE equivalent required per week for Scenarios B and C are as follows:

Figure 73: Modelling Scenario B: Rehabilitation and Reablement

Scenario B: Rehabilitation and Reablement	Year 0	Year 10
Pathway 1B and Pathway 1C patient discharges per year	1,650	2,262
Stroke - specialist rehab at home patient discharges per year	134	181
Hip fracture - specialist rehab at home patient discharges per year	54	76
Total community rehab patient discharges per year	1,838	2,519
Additional patient care hours required per week	310	647
Additional patient care worker WTE requirement	10.5	21.9

Figure 74: Modelling Scenario C: Rehabilitation and Reablement

Scenario C: Rehabilitation and Reablement	Year 0	Year 10
Pathway 1B and Pathway 1C patient discharges per year	1,650	2,675
Stroke - specialist rehab at home patient discharges per year	134	181
Hip fracture - specialist rehab at home patient discharges per year	54	76
Total community rehab patient discharges per year	1,838	2,932
Additional patient care hours required per week	310	851
Additional patient care worker WTE requirement	10.5	28.8

To deliver the required scale of change in community reablement capacity, under Scenario B, an increase from current levels of care provision is required. This equates to an additional 10.5 WTE care workers at Year 0 activity levels and 21.9 WTE care workers at Year 10 activity levels (Scenario B).

6.8.2 Proactive Prevention (Virtual Ward) and Intermediate Care (Hospital at Home)

Virtual Wards and Hospital at Home are related but distinct components of the future community model. These both would provide hospital-level care in a patient's own residence. Virtual wards are characterised by an emphasis on data and remote monitoring for stabilised early-discharge patients requiring monitoring and recovery. Hospital at Home is more about hands-on clinical care and intervention at home for acutely unwell patients needing acute treatment, and as such, can help with admission avoidance.

The modelling assumes that the above pathways would be appropriately resourced, with clearly identified protocols across Powys, leading to a reduction in excess bed days for patients treated in external providers due to expedited discharge. Modelling has been targeted at patients aged over 65 with frailty, respiratory and cardiac pathways. Patients requiring IV antibiotics have also been considered.

Figure 75: Modelling Scenario B: Virtual Ward, Hospital at Home

Scenario B: Virtual Ward, Hospital at Home	Year 10
Projected Virtual Ward expedited patient discharges per year	806
Projected Virtual Ward excess patient bed days per year	-2,720

Figure 76: Modelling Scenario C: Virtual Ward, Hospital at Home

Scenario C: Virtual Ward, Hospital at Home	Year 10
Projected Virtual Ward expedited patient discharges per year	1,274
Projected Virtual Ward excess patient bed days per year	-4,122

6.8.3 Hospital at Home – Admission Avoidance

Achieving the projected reductions in admissions would require effective Hospital at Home provision, combined with proactive in-county urgent care services with senior clinical decision making.

The potential to reduce avoidable acute hospital admissions to external providers of patients with low-complexity non-elective admissions for people aged over 65 is modelled below.

Figure 77: Modelling Scenario B: Avoidable admissions

Scenario B: Avoidable admissions	Year 10
Projected Avoided patient admissions activity per year	-962
Projected Avoided patient excess bed days per year	-4,531

Figure 78: Modelling Scenario C: Avoidable admissions

Scenario C: Avoidable admissions	Year 10

Projected Avoided patient admissions activity per year	-1,924
Projected Avoided patient excess bed days per year	-9,062

Other modelled pathway changes included:

EOL / palliative care pathway - changes to support patients staying at home and dying in a place of their choice – 40 – 60% target for patients who currently die in hospital outside Powys who would in future receive bed-based EOL care in community hospital or in-reach hospice:

The expected patient flows and rehabilitation assumptions for the stroke and orthopaedic pathways are set out in Figure 78, below.

Figure 79: Assumed Rehabilitation Pathways Following Acute Discharge

Pathway	Direct Home	Community Rehabilitation	Rehabilitation Beds	Average Length of Stay (Days)
Stroke	30%	55% specialist stroke rehabilitation at home	15%	Scenario B: 35 Scenario C: 28
Hip Fracture	40%	20% Orthopaedic Supportive Discharge (therapy at home)	20%	Scenario B: 10 Scenario C: 14

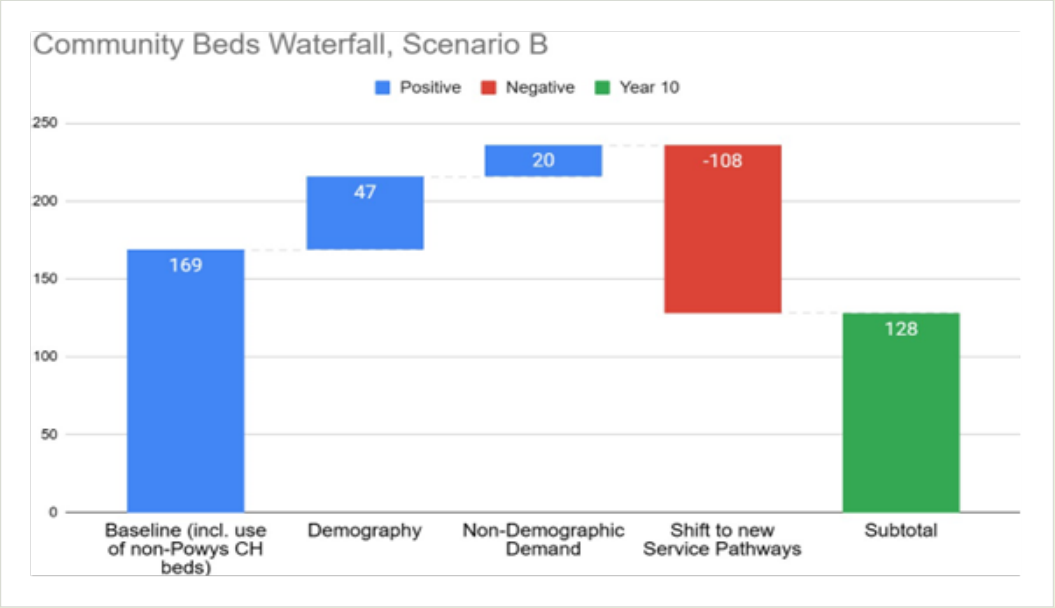
Step up community pathways - Patients proactively streamed onto step up pathway based on frailty score / long-term condition and age.

Step down community pathways – patients are proactively discharged from acute hospital providers onto the appropriate discharge to assess pathway with increased focus on supporting patients to go home with support where needed (links to reablement and rehabilitation P1 and 2 earlier).

6.8.4 Impact of Pathway Changes and Flows on Future Community Hospital Beds

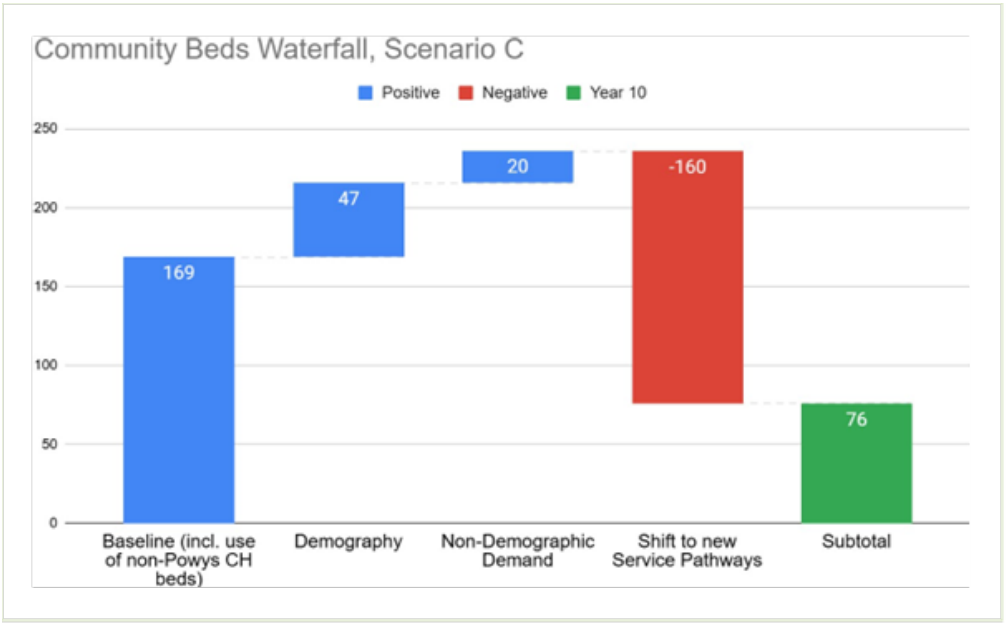
The chart below shows the potential impact of the above pathway changes based on a realistic and achievable scenario projected at Year 10.

Figure 80: Potential impact of pathway changes based on scenario projected at Year 10



The chart below shows the potential impact of the above pathway changes based on a more ambitious scenario projected at Year 10.

Figure 81: Potential impact of pathway changes based on scenario projected at Year 10



The above two charts illustrate the impact of the potential changes in patient pathways described in the tables above, demonstrating an anticipated overall reduction in requirement for community inpatient beds based on modelling informed by the evidence base and clinical opinions.

The bed modelling is not prescriptive about where or how the beds are to be provided in the future. It simply means this is the anticipated bed capacity for the caseload likely to require a period of bed-based care, including 24/7 care, daily clinical oversight and input, and a package of proactive rehabilitation/reablement. Options for provision of such care may include, for example, community hospital beds, nursing or care home beds, beds managed by the independent sector or scaling up our ambitions for delivering a Hospital at Home model.

Both existing and projected community inpatient activity is summarised below:

Figure 82:Existing and projected community inpatient activity

Community Hospital Inpatient Activity	Patient Admissions	Beds
Baseline – Powys	1,133	158
Baseline – Out of County Community Beds	231	11
Year 10 Inpatients do nothing - with growth*	1,839	235
Year 0 inpatients, with new patient pathways Scenario B**	1,719	81
Year 0 beds, with new patient pathways Scenario C**	1,189	51
Year 10 beds New pathways, with growth* Scenario B**	3,542	128
Year 10 beds, New pathways, with growth* Scenario C**	3,371	76

*Growth: includes demographic and non-demographic growth
** Scenario B: Realistic and achievable. Scenario C: Aspirational / radical

The do-nothing option models a requirement of an additional 66 beds over and above our current bed base – modelled 235 beds less current 169 beds (inclusive of out of county beds). At FY25-26 provider bed day costs this would cost an additional £11.1m if we do not make a change to our model in line with the evidence base.

6.9 Recommended Options

To deliver the future models of care described above, the current configuration of physical health services would need to change. This is necessary to address long standing challenges, including workforce shortages vacancy rates, agency expenditure, infrastructure limitations and estate quality. The Health Board has followed a robust open and transparent five-step options development process; the outcome is that two credible and robust options are now being put forward for public consultation. Alongside these two options, information is also included on the existing service arrangements and how services operated before the temporary service changes were enacted. These are included as a baseline comparator.

6.9.1 Service Configuration Before Temporary Service Changes (Do Previous)

Before a series of temporary service changes, physical health inpatient and community services operated across ten community hospital sites across Powys, providing 158 beds for people needing rehabilitation or care closer to home.

Figure 83: Physical Health Service Configuration Before Temporary Changes (Do Previous)

What changes from the current model?	What stays the same as the current model?
• Graham Davies Ward (Llanidloes) and Llewellyn Ward (Bronllys) which have been temporarily changed to Ready to Go Home Units go back to being community hospital inpatient wards • Brynheulog Ward (Newtown) and Epynt (Brecon) which have been temporarily changed to inpatient Rehabilitation Units go back to being community hospital inpatient wards • Panpwnton Ward in Knighton which has been temporarily closed reopens • This retains the same number of beds but removes the ready to go home element, meaning those patients would be placed in general wards without the options for RTGHU being available.	• Reablement continuing in beds at Glan Irfon in Builth and in Knighton. • Keeping community health services as they are now.

Benefits	• Restores a greater number of community hospital inpatient wards across Powys • Responds to public and staff preference for traditional community hospital provision. • Reduces some travel distance and disruption for patients and families • Provides short-term operational familiarity, reverting to previously established models of care
Risks	• Introduces risk of deconditioning • Does not clinically support patients requiring continuous oxygen • Re-opening wards increases workforce risk, with known challenges in recruitment, retention and sustaining safe staffing • Reversal of Ready to Go Home and Rehabilitation models may reduce flow efficiency and impact timely discharge. • Increased bed footprint risks lower average occupancy and productivity, with higher running costs. • Does not address longer-term sustainability challenges (workforce, estates condition, and increasing demand).
Trade-off(s)	• Improved local access to inpatient beds at the expense of efficiency, sustainability and affordability • Maintains a hospital-centric model rather than strengthening community-based alternatives. • Delivers reassurance in the short term but limits ability to modernise services in line with future needs.

This option would return services to those previous arrangements. While this model maintains a broad local footprint and may feel familiar to patients and staff, the appraisal process identified concerns that it would not adequately address workforce fragility, estate challenges, financial pressures or the increasing need to provide more care in people's homes and communities.

The appraisal process also identified concerns that maintaining the previous model would be increasingly difficult over time due to workforce availability, variation in service provision across the county and rising demand for care closer to home. Reverting to pre-temporary service changes does not address the issues identified in relation to clinical risk and improving patient outcomes. It also identified that the capital and revenue costs associated with returning to this model have been assessed as unaffordable, and that doing so would not deliver the financial efficiencies that the health board needs to achieve in the longer term.

6.9.2 Service Configuration Currently (Do Current)

This option would make the current temporary physical health arrangements permanent. Nine sites providing 146 beds would continue operating broadly as they do now. While this approach retains some improvements already made to patient flow and operational stability, it was not considered to fully address longer-term sustainability challenges, including workforce pressures, estate suitability and the evidence based need to expand prevention, rehabilitation and community-based care.

Figure 84: Service Configuration Currently (Do Current)

What changes from the current model?	What stays the same as the current model?
• There are no material changes from the current arrangements. • Temporary service changes are formalised, providing stability and certainty but without reconfiguration, expansion of community services or consolidation of inpatient provision	• This option maintains the current configuration of hospital and community health services, making temporary service changes permanent. • Community hospital inpatient wards continue to operate at Machynlleth, Welshpool, Newtown, Llandrindod, Brecon and Ystradgynlais. • Ready to Go Home units remain in place at Llanidloes and Bronllys. • inpatient rehabilitation continues at Brynheulog (Newtown) and Epynt (Brecon). • Reablement beds continue at Glan Irfon in Builth and in Knighton. • Community health services, models of care and pathways remain as they are now

Benefits	• Maintains the current, operationally stable model, avoiding further disruption to patients and staff. • Makes temporary service changes permanent, providing clarity and certainty for staff and services. • Retains Ready to Go Home and Rehabilitation models that support patient flow and discharge. • Does not require significant capital investment or major system redesign in the short term.
Risks	• Does not clinically support patients requiring continuous oxygen • Known workforce pressures and sustainability challenges remain unresolved. • Uneven distribution of beds and services across the county continues to create inequity of access. • Limited ability to meet future demand growth, changing acuity and complexity of patients. • Does not materially strengthen community services, diagnostics, or integration with mental health.
Trade-off(s)	• Provides short-term stability at the expense of long-term transformation. • Avoids difficult decisions now, but defers risk into the future, potentially narrowing future options. • Maintains affordability in the short term while not optimising outcomes or quality improvement.

The current model also continues to rely on temporary mitigations and varying service arrangements across Powys, which the appraisal process identified as unsustainable consistently over the longer term.

There are two recommended options for how services could be configured in the future. Both proposed options include a significantly strengthened community model, with expanded district nursing, rehabilitation, reablement, falls prevention and Hospital at Home support, and improved integration between physical and mental health services. The key difference between them is the number of inpatient sites and beds, and the associated scale of change and delivery risk.

6.9.3 SL IPDO_005b: Improve quality of care, with moderate investment into the community model and better join up with mental health, resulting in fewer Community Hospital Inpatient Beds across 3 sites

This option would strengthen community-based physical health services so that more people remain well, recover at home and avoid unnecessary admission. Subject to agreed readiness's criteria, community inpatient capacity would reduce to around 90 beds across Llandrindod Wells, Newtown, and Brecon supporting larger teams and more consistent clinical cover. to improve service quality and workforce sustainability.

Over time, more care would be delivered through new pathways (described in section 6.8) as community provision develops through re-alignment of existing resources – supporting more patient activity at home, more effectively.

Figure 85: Moderate Community Model, 90 beds across 3 sites (Option SL IPDO_005b)

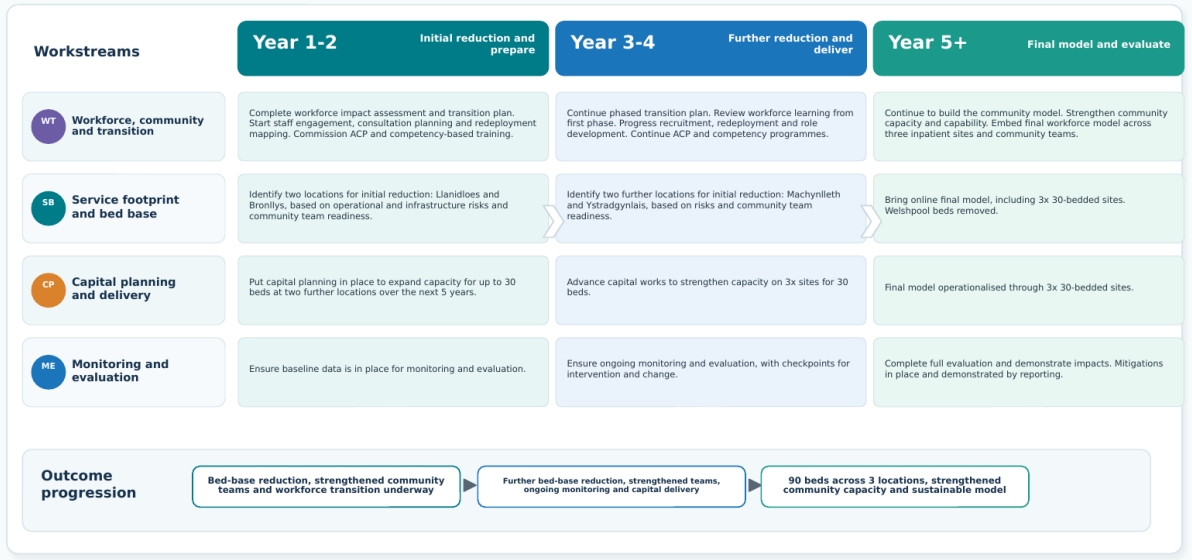
What changes from the current model?	What stays the same as the current model?
• Inpatient physical health beds are consolidated on three sites: Newtown, Llandrindod and Brecon. • Inpatient beds are removed from Welshpool, Llanidloes, Machynlleth and Knighton, and physical health inpatient beds are no longer provided at Bronllys and Ystradgynlais. • Inpatient rehabilitation is concentrated at Brynheulog Ward (Newtown) and Epynt Ward (Brecon). • Step-up, step-down, and inpatient palliative and end of life care are provided at the three core sites. • Reablement beds move away from community hospitals and are provided through alternative settings, such as care homes. • Community provision is strengthened, including proactive prevention, early intervention, enhanced intermediate care, urgent community response services and a phased Hospital@Home model. • A single point of access for services is developed, and diagnostic provision is rationalised, with extended x-ray services concentrated at core sites.	• Inpatient physical health services continue to be provided within Powys, with Newtown and Brecon remaining key inpatient sites as they are now (with Llandrindod added). • The focus on person-centred care, recovery and supporting people to remain at home wherever possible continues. • Community services remain a core component of the model, although delivered at greater scale and intensity than under the current arrangement.

Benefits	• Concentrating inpatient beds on three sites improves clinical sustainability, safety and continuity of care • Enables robust workforce models, improving resilience through critical mass, skill mix and rota sustainability. • Improves patient flow and reduces risk of patients deconditioning. • Strengthens joined up working between physical health, mental health and community services. • Shifts care closer to home through enhanced community provision, urgent community response and Hospital@Home, reducing avoidable admissions into acute settings. • Improves access to diagnostics at core sites, supporting timely assessment and decision-making.
Risks	• Loss of inpatient beds at some sites may impact travel distance and accessibility for patients, families and carers. • Delivery is dependent on successful investment in community services; delays could increase system pressure. • Workforce transition and service reconfiguration present significant change management and engagement risks. • Requires capital investment and estate readiness, introducing delivery and timing risk. • Potential short-term instability during transition as services are consolidated. • Social care and care home capacity to support whole system model
Trade-off(s)	• Reduced local inpatient access at some sites in return for higher quality, more sustainable services overall. • Moves away from a familiar hospital-led model to enable longer-term system resilience. • Balances ambition and deliverability, but does not maximise consolidation benefits

6.9.3.1 Indicative Phasing for this Option

The below timeline shows the indicative phasing for this option

Figure 86: Indicative phasing Moderate Community Model, 90 beds across 3 sites (Option SL IPDO_005b)



6.9.3.2 Commissioning Assumptions

The proposal would see a reduction in acute emergency admissions, shorter LOS and reduced associated excess bed day costs (trim point) saving approximately £1.1m per year in commissioning costs and would result in no Powys patients staying in out of area community hospitals. Modelling assumes:

- D&C Modelling of 5% and 9% reduction in emergency admission for Scenario B & C respectively are predicated on the Clinical Oversight Model investment approved and in recruitment process (not additional to it).
- Any transitional costs for Care Home provision in advance of Community Model being fully operational are not included.

6.9.3.3 Workforce Assumptions

The physical health workforce assumptions have been developed to support the proposed shift from bed-based care towards a stronger community model. The future model assumes that more people would be supported safely at home

The inpatient workforce assumptions are based on the proposed bed base, ward configuration and safe staffing principles. While consolidation of inpatient beds may reduce duplication across some ward and site-based staffing requirements, safe staffing, ward leadership, clinical supervision and overnight registered nurse cover would remain essential.

The community workforce assumptions are based on the need to increase multidisciplinary capacity across Powys. This includes district nursing, therapies, pharmacy, reablement, healthcare support workers, frailty practitioners, rapid response roles and advanced or enhanced practice roles. The model would require senior clinical decision-making, consultant-led frailty oversight, senior nursing and AHP leadership, and clear governance across inpatient and community pathways. The availability of district nursing, therapy, frailty and advanced or enhanced practice capacity would need to be tested against the proposed phasing, including the time needed to develop staff into new or expanded roles.

Workforce capacity would need to reflect the rural geography of Powys, including travel time, dispersed demand and appropriate headroom for annual leave, sickness, training and supervision. The enhanced community workforce and supporting infrastructure would need to be developed alongside any changes to inpatient capacity, so that the model can be implemented safely and sustainably.

Indicative workforce impact

This option could affect staff working in community inpatient wards and in the community, reablement, urgent response, therapy, healthcare support, frailty, medical and advanced or enhanced practice roles described in the proposed model. Potential impacts may include changes to team structure, work location, role, duties, skill mix, supervision arrangements, working patterns, travel and development requirements. The extent and distribution of these impacts have not yet been determined. No assumptions are made at this stage about individual staff outcomes; these would be assessed following consultation through staff engagement, equality assessment and the applicable organisational change and consultation arrangements.

Following consultation and subject to the option taken forward, a detailed workforce plan would be developed before implementation. For this option, it would show separately the inpatient and community establishments, substantive, bank and agency staffing, skill mix, staff who may be retained or redeployed, roles that would need to be developed, and any

additional recruitment required. It would also identify training and supervision requirements, quantify transitional overlap and confirm phasing, costs, clinical leadership, workforce readiness and dependencies with urgent care, mental health and wider community pathways.

6.9.3.4 Revenue Impact of Option

Figure 87: Moderate Community Model, 90 beds across 3 sites: Revenue impact of option SL IPDO_005b

Proposed WTE	Baseline £k	Investment/ Disinvestment £k	Commissioning Savings £k	Net Investment £k
252	£13,303	£-1,221	-£1,954	-£3,175

- Baseline WTE – 292.
- Baseline includes staffing costs for wards, SPoA and reablement team at FY25-26 pay rates.
- Investment includes an increased Clinical Oversight Model, for which the decision to invest has already been made and can be seen below in the phased analysis driving investment of £339k and commissioned savings of £880k in Year 1.
- Financial implications include investment in community teams offset by reductions to the bed base and associated teams. There are also reductions in commissioning spend of £1.954m driven by more effective PTHB provider services.
- Community specialist palliative care costs are not included.

Figure 88: Moderate Community Model, 90 beds across 3 sites: Phasing of Summary revenue implications option SL IPDO_005b

Option net investment phasing (rounding to £k) – Incremental							
	Y1	Y2	Y3	Y4	Y5	Y6-10	**Recurrent**
Gross investment	2,773	2,374	0	0	0	0	**5,148**
Gross disinvestment	-329	-986	-1,685	-1,685	-1,685	0	**-6,369**
Gross commissioning savings	-1,221	-734	0	0	0	0	**-1,954**
Net investment	**1,224**	**655**	**-1,685**	**-1,685**	**-1,685**	**-0**	**-3,175**

- The current phased model does not yet fully reflect the workforce risks, operational overlap and associated cost implications that would inevitably arise during the transition from one model to the other

- Sensitivity analysis highlights recruitment challenges and the availability of social care capacity as key delivery risk. Should these risks materialise, additional upfront investment may be required, and the realisation of planned disinvestment and savings could be delayed. The precise impact cannot currently be quantified and would be subject to ongoing workforce and implementation planning.

The phasing assumptions are:

- Clinical Oversight Model investment in Year 1 decision to invest has already occurred - June2026.
- Community Model investment phased equally across Year 1 and Year 2.
- POCT Hospital at Home investment in Year 1.
- Disinvest in hospital beds in 2 sites (move to 6 sites with hospital beds) in Year 1 and Year 2 but maintain similar bed base, phased 25% & 75% disinvestment respectively.
- Disinvest down to 3 sites with hospital beds in Years 3 to 5.
- 3% reduction in Emergency admissions from Year 1 in line with Clinical Oversight model investment.
- Reduced out of county community beds from Year 1 in line with the Clinical Oversight model investment.
- Additional 2% reduced Emergency admissions from Year 2 in line with full investment in Community Model.

6.9.3.5 Capital Impact of Option

The capital investment in the rural regional centre model has been established with Welsh Government as part of the dialogue around a forward look capital programme, which has helped outline future NHS spending needs. This programme would be further informed by the outputs from the Better Together Service Strategy and enable a more defined Estates Strategy to be developed for PTHB to underpin the much-needed modernisation of the estate. Future business case submissions would be able to draw a more distinct and confident association between the long-term service Strategy and the investment needed for a fit for purpose built environment.

Investment for the completion of the modernisation of the remaining section of the Llandrindod Wells hospital has been ringfenced by Welsh Government, subject to the approval of the business case. This funding would align well with the requirement to create a fit for purpose physical health inpatient ward at the back of the hospital.

The first phase of the North Powys, Newtown, Health and Wellbeing Campus has progressed to Final Programme Business Case level for the Integrated Health and Wellbeing Hub. The intent for Phase 2 would be to replace and relocate the current hospital into the centre of Newtown and the planning for this would incorporate the required physical health ward. Welsh Government are aware of the scope and scale of Phase 2 which is included in an ‘endorsed’ Programme Business Case for the campus, but no capital funding is currently secured.

The proposal for Breconshire War Memorial Hospital would require a reconfiguration of the existing physical health wards. No funding has been secured.

6.9.3.6. Estate Implications

The consolidation of the physical health wards onto three rural regional centres, in a fit for purpose and modern patient environment, would enable more focussed technical Estates and Facilities support in fewer locations, resulting in an improved experience for both patients and staff. The capital investment in new build or major refurbishments would reduce backlog maintenance in an existing, aging estate and allow for the complete modernisation of plant, equipment and associated infrastructure in a manner compliant with the NHS Health Technical Memorandum and Health Building Note guidance.

New build or major reconfiguration activity would enhance environmental, decarbonisation and energy efficient measures, to support the long-term sustainability of the estate. The recent heatwaves and ever rising temperatures would require significant adaptation and reconsideration of traditional cooling in our healthcare settings, in addition to the impacts of flooding, storms and climate related change.

Where wards are removed from existing hospital locations alternative use would be considered for the vacated space, which could potentially support future Service Strategy decisions for Women and Children's services, increased outpatient care and diagnostic opportunities. There are also opportunities to be explored around the RPB development of Integrated Health and Wellbeing Hubs serving Health, Care and the Third Sector.

Where all ward activity (physical and mental health) is removed from a community hospital, consideration would be given to the need for a continuation of the associated catering service at those locations.

6.9.3.7 Potential Impact of this Proposed Option

For patients, this option could:

- Reduce avoidable patient admissions
- Provide shorter hospital stays; earlier rehabilitation; reduced risk of deconditioning, hospital-acquired harm and loss of independence
- Improve care and recovery at home or within their own communities.
- Improve continuity of care reducing duplication.
- Collectively, these changes are expected to improve patient outcomes by supporting more people to remain independent for longer and receive care in the most appropriate setting, at home or closer to home where clinically appropriate.

This option could:

- Improve sustainability and resilience by consolidating the current nine inpatient wards across eight hospital sites into three strategically located wards, resulting in better staffing models with reduced reliance on agency and temporary staff.
- Improve patient safety through stronger MDTs and more consistent clinical cover.
- Enhance integration between physical and mental health services, supporting more holistic care.

- Support creation of specialist and purpose-built facilities that are better suited to modern healthcare delivery.
- Improve patient flow, clearer pathways and reduce duplication of services.
- Reduce unwarranted variation in service delivery and enabling patients to move more seamlessly between community, hospital and rehabilitation services as their needs change.

However, the changes proposed would result in some patients, service users, carers, visitors and staff travelling to a different hospital site when accessing community inpatient care, than the one they currently use, which in many cases would increase journey times.

- Travel time modelling shows that under the three-site model, mean travel time would increase from 11 minutes 56 seconds to 23 minutes 50 seconds, with 91.2% of households remaining within the 45-minute benchmark (based on private transport) compared with 99.9% currently.
- The access impact includes longer journeys to inpatient care; increased travel costs for patients, carers and visitors; reduced ease of visiting for families and unpaid carers; and greater reliance on private transport, community transport, public transport or support from others.
- These impacts are likely to be greater for older people, disabled people, Welsh language speakers, rural communities and people experiencing socio-economic disadvantage, particularly where public transport is limited, car access is restricted or digital alternatives do not fully replace face-to-face contact.
- Strengthening of community-based care is a key mitigating factor, enabling more people to receive care closer to home where clinically appropriate and reducing reliance on hospital-based care where admission is not required.

A public transport accessibility summary is provided in the below table:

Figure 89: Public transport accessibility summary, Physical Health options[62]

Option	Service Configuration	Public Transport Position	Same-Day Return & Equity Considerations
Do Current	Existing inpatient configuration including current temporary arrangements	Retains multiple inpatient locations with relatively local access for most communities	Strongest same day return potential due to larger number of inpatient sites.
PH005b	Three site model (Newtown, Llandrindod Wells, Brecon)	Retains mid-Powys inpatient provision at Llandrindod Wells and continues to benefit from the T4 corridor.	Increased travel burden for communities including Llanfyllin, Llanfair Caereinion, Knighton/Presteigne and Ystradgynlais.
PH008	Two site model (Newtown and Brecon)	Removes the mid-Powys inpatient provision and increases dependency on longer corridor journeys.	Highest public transport and equity risk, particularly for Llandrindod/Rhayader, Builth/Llanwrtyd and Radnorshire communities.

[62] https://www.traveline.cymru/timetables

Realisation of benefits would depend on enhanced community services, including Hospital at Home, rehabilitation, reablement and wider health and care support, being sufficiently developed before inpatient capacity is reduced. The transition would need to be carefully phased and monitored to manage risks relating to bed capacity, workforce change, service continuity and the availability of community and partner capacity. A full Integrated Impact Assessment for this option is found in appendix Z.2.

6.9.4 SL IPDO_008: Improve quality of care with significantly enhanced community model and better join up with mental health, resulting in even fewer Community Inpatient beds across 2 sites

There would be more support to help people stay and recover at home, and closer working between mental and physical health services. There would be fewer community hospital beds (60 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care.

This option is the most significant transformation of services, reducing inpatient provision from eight community hospital sites to two inpatient centres supported by a major expansion of community-based, home-first and integrated physical and mental health services. The model offers the greatest potential efficiencies and longest-term sustainability but also presents the greatest risks relating to access, travel, equality and implementation.

This option provides approximately 60 inpatient beds consolidated onto two sites, most likely Newtown and Brecon. The significantly expanded and enhanced community offer would mean that more people could be supported to remain well and recover at home, with fewer needing to travel to a hospital bed at all.

Figure 90: Enhanced Community Model, 60 beds across 2 sites (Option SL IPDO_008)

What changes from the current model?	What stays the same as the current model?
• Inpatient physical health beds are consolidated onto two sites only: Newtown and Brecon. • There are no inpatient beds at Welshpool, Llanidloes, Machynlleth, Llandrindod or Knighton, and no physical health inpatient beds at Bronllys or Ystradgynlais. • Inpatient rehabilitation is delivered at Newtown and Brecon, alongside step-up, step-down, palliative and end of life care. • Reablement beds are no longer provided within community hospitals and are delivered through alternative settings such as care homes. • The community model is significantly expanded, with a strong emphasis on prevention, early intervention, urgent community response, Hospital@Home and closer integration between physical and mental health services to support people at home. • A single point of access operates for triage and coordination, and diagnostic services are fully rationalised, with extended access concentrated at core sites.	• Powys continues to provide inpatient physical health services locally, albeit on fewer sites. • The overarching aim of supporting people to stay well at home, reducing unnecessary hospital admissions, and delivering high-quality, person-centred care remains unchanged. • Community services continue to play a central role, but as part of a much more community-first system.

Benefits	• Concentrates inpatient beds on two sites (Newtown and Brecon), maximising clinical safety, workforce sustainability and service standardisation. • Enables the strongest and most resilient workforce model, with improved recruitment, retention and reduced reliance on temporary staffing. • Improves patient flow and reduces risk of patients deconditioning. • Strengthens joined up working between physical health, mental health and community services. • Releases greatest opportunity to reinvest in enhanced community-based care, prevention, Hospital@Home and early intervention. • Simplifies the inpatient estate, supporting long-term financial sustainability and capital prioritisation.
Risks	• Loss of inpatient beds at some sites may impact travel distance and accessibility for patients, families and carers. • Highest level of public, political and staff concern, requiring significant engagement and mitigation. • Most reliant on successful and timely delivery of community services to avoid increased pressure elsewhere in the system. • Significant capital investment and delivery dependencies, with longer timescales and higher implementation risk. • Potential for disruption during transition if enabling services are not fully in place • Impact assessment needs to recognise higher risk in variance for workforce • Social care and care home capacity to support whole system model
Trade-off(s)	• Maximises quality, sustainability and efficiency at the expense of locality-based inpatient provision. • Moves away from a familiar hospital-led model to enable longer-term system benefits and resilience, requires strong leadership, assurance and sequencing to manage risk.

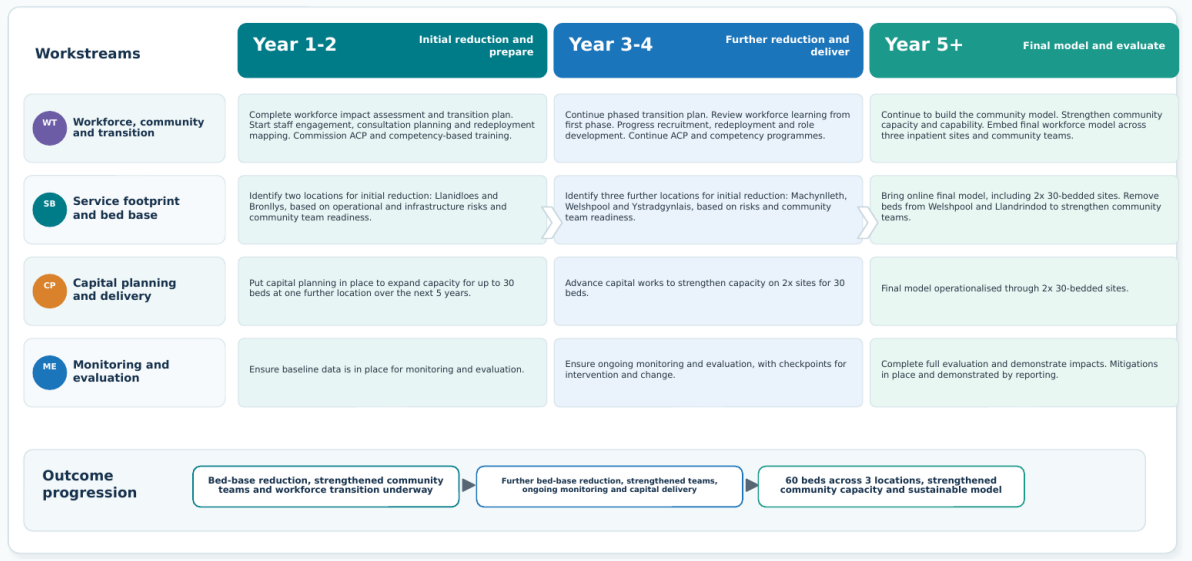
As with option 1, over time, more care would be delivered through community-based support and integrated pathways as community provision develops, keeping people supported at home more effectively. The approach aims to improve coordination of care for people with complex needs while supporting more joined-up physical and mental health services across

Powys. It is being considered alongside Option 1 to allow the trade-off between scale of change and potential benefit to be explored further with stakeholders as part of public consultation.

6.9.4.1 Indicative Phasing for this Option

The below timeline shows the indicative phasing for this option

Figure 91: Enhanced Community Model, 60 beds across 2 sites: Indicative phasing for Option SL IPDO_008



6.9.4.2 Workforce Assumptions

The workforce assumptions for the 60-bed model are based on a greater shift from bed-based care towards a strengthened community model. This option assumes that more people would be supported safely at home or in community settings through prevention, proactive care and Intermediate Care - urgent community response, rehabilitation, reablement, virtual ward and Hospital at Home pathways.

The inpatient workforce assumptions are based on approximately 60 beds across two sites. Staffing has been modelled using the proposed ward configuration and safe staffing principles, with Registered Nurse and Healthcare Support Worker levels informed by professional judgement and national standards of safe care. Safe staffing, ward leadership, clinical supervision and minimum overnight registered nurse cover would remain essential.

As more people with lower-level needs are supported at home, the remaining inpatient beds are likely to support people with greater complexity. This would require the right skill mix, leadership and clinical oversight across the inpatient model.

The community workforce requirements are more significant than in the 90-bed model. This option depends on increased multidisciplinary capacity across district nursing, therapies, pharmacy, reablement, healthcare support workers, frailty practitioners, rapid response roles and advanced or enhanced practice roles. It also assumes a stronger Hospital at Home and virtual ward offer.

To proceed safely, the enhanced community workforce and supporting infrastructure would need to be in place before any significant reduction in inpatient capacity is implemented. This includes staffing, leadership, clinical oversight, training, supervision, digital capability, travel capacity and operational readiness.

Indicative workforce impact

As this option involves a greater consolidation of inpatient provision and a more significant expansion of community-based care, it could have a wider effect on staff working in the inpatient and community services described in the model. Potential impacts may include changes to team structure, work location, role, duties, working patterns, travel and development requirements. The extent and distribution of these impacts have not yet been determined. No assumptions are made at this stage about individual staff outcomes; these would be assessed following consultation through staff engagement, equality assessment and the applicable organisational change and consultation arrangements.

Implementation would need to be phased, with clear workforce, quality and safety checkpoints. Following consultation and subject to the option taken forward, a detailed workforce plan would show separately the inpatient and community establishments, substantive, bank and agency staffing, skill mix, staff who may be retained or redeployed, roles that would need to be developed, and any additional recruitment required. It would also quantify transitional overlap and confirm phasing, costs, leadership, supervision and dependencies with urgent care, mental health and wider community pathways before implementation.

6.9.4.3 Commissioning Assumptions

The proposal would see a reduction in acute emergency admissions, shorter LOS and reduced associated excess bed day (Trim Point) costs saving approximately £2.6m per year in commissioning costs and would result in no Powys patients staying in out of area community hospitals. Modelling assumes:

- D&C Modelling of 5% and 9% reduction in emergency admission for Scenario B & C respectively are predicated on the Clinical Oversight Model investment (not additional to it).
- Any transitional Costs for Care Home provision in advance of Community Model being fully operational are not included.

The changes also have a positive impact on neighbouring hospitals, patient experience and outcomes – reducing activity and LOS and would also impact ambulance service providers because of the new patient pathways – this would be managed via the SPoA.

6.9.4.4 Revenue Impact of Option

Following consultation, further feasibility work will be undertaken.

Figure 92: Enhanced Community Model, 60 beds across 2 sites: Revenue impact for Option SL IPDO_008

WTE	Baseline £k	Investment/ Disinvestment £k	Commissioned savings £k	Net Investment £k
230	13,303	-1,916	-3,518	-5,434

- Baseline WTE - 292
- Baseline includes staffing costs for wards, SPoA and reablement team at FY25-26 pay rates.
- Investment includes an increased Clinical Oversight Model, for which the decision to invest has already been made and can be seen below in the phased analysis driving investment of £339k and commissioned savings of £880k in Year 1.
- Financial implications include investment in community teams offset by reductions to the bed base and associated teams. There are also reductions in commissioning spend of £3.518m driven by more effective PTHB provider services.
- Community specialist palliative care costs are not included.

Figure 93: Enhanced Community Model, 60 beds across 2 sites: Summary of phased revenue implications for Option SL IPDO_008

Option net investment phasing (rounded to £k) - Incremental							
	Y1	**Y2**	**Y3**	**Y4**	**Y5**	**Y6-10**	**Recurrent**
Gross investment	3,446	3,067	0	0	0	0	**6,533**
Gross disinvestment	-329	-986	-1,685	-1,685	-1,685	-2,080	**-8,448**
Commissioning savings	-1,221	-2,297	0	0	0	0	**-3,518**
Net investment	**1,916**	**-216**	**-1,685**	**-1,685**	**-1,685**	**-2,080**	**-5,434**

- The current phased model does not yet fully reflect the workforce risks, operational overlap and associated cost implications that would inevitably arise during the transition from one model to the other
- Sensitivity analysis, largely driven by recruitment risk and the ability of social care to deliver additional capacity in the models, would identify higher levels of upfront net investment, with a longer timescale for delivery of disinvestment and delivery of savings

The phasing assumptions are:

- Clinical Oversight Model investment in Year 1 decision to invest has already occurred – June2026.
- Community Model investment phased equally across Year 1 and Year 2.

- Point Of Care Testing (POCT) Hospital at Home investment in Year 1.
- Disinvest in the hospital beds on 2 sites in Year 1 and Year 2 but maintain similar bed base, phased disinvestment 25% & 75% respectively.
- Disinvest in hospital beds down to 3 sites in Years 3 to 5.
- Option 008 disinvests in hospital beds in 1 further site in Years 6 to 10.
- 3% reduction in Emergency admissions from Year 1 in line with Clinical Oversight model investment
- Reduced out of county community beds from Year 1 in line with the Clinical Oversight model investment
- Additional 6% reduced Emergency admissions for Options 8 from Year 2 in line with full investment in Community Model

6.9.4.5 Capital Impact of Option

The capital investment in the rural regional centre model has been established with Welsh Government as part of the dialogue around a forward look capital programme, which has helped outline future NHS spending needs. This programme would be further informed by the outputs from the Better Together Service Strategy and enable a more defined Estates Strategy to be developed for PTHB to underpin the much-needed modernisation of the estate. Future business case submissions would be able to draw a more distinct and confident association between the long-term service Strategy and the investment needed for a fit for purpose built environment.

The first phase of the North Powys, Newtown, Health and Wellbeing Campus has progressed to Final Programme Business Case level for the Integrated Health and Wellbeing Hub. The intent for Phase 2 would be to replace and relocate the current hospital into the centre of Newtown and the planning for this would incorporate the required physical health ward. Welsh Government are aware of the scope and scale of Phase 2 which is included in an 'endorsed' Programme Business Case for the campus, but no capital funding is currently secured.

The proposal for Breconshire War Memorial Hospital would require a reconfiguration of the existing physical health wards. No funding has been secured.

6.9.4.6. Estate Implications

The consolidation of the physical health wards onto two rural regional centres, in a fit for purpose and modern patient environment, would enable more focussed technical Estates and Facilities support in fewer locations, resulting in an improved experience for both patients and staff. The capital investment in new build or major refurbishments would reduce backlog maintenance in an existing, ageing estate and allow for the complete modernisation of plant, equipment and associated infrastructure in a manner compliant with the NHS Health Technical Memorandum and Health Building Note guidance.

New build or major reconfiguration activity would enhance environmental, decarbonisation and energy efficient measures, to support the long-term sustainability of the estate. The recent heatwaves and ever rising temperatures would require significant adaptation and reconsideration of traditional cooling in our healthcare settings, in addition to the impacts of flooding, storms and climate related change.

Where wards are removed from existing hospital locations alternative use would be considered for the vacated space, which could potentially support future Service Strategy decisions for Women and Children's services, increased outpatient capacity and diagnostic capability. There are also opportunities to be explored around the RPB development of Integrated Health and Wellbeing Hubs serving Health, Care and the Third Sector.

Where all ward activity (physical and mental health) is removed from a community hospital, consideration would be given to the need for a continuation of the associated catering service at those locations.

6.9.4.7. Summary Impact of this Option

For patients this option could:

- The greater shift towards community-based care would support Proactive care, earlier intervention, Intermediate Care – crisis response, rehabilitation and reablement, Hospital at Home, and integrated physical and mental health support; enabling more people to receive care at home where clinically appropriate.
- Older people and those with long-term conditions would receive even more care and support in their own homes and communities, resulting in fewer avoidable admissions.
- Even greater continuity of care and more coordinated support across primary care, community services, rehabilitation, mental health and inpatient services.
- More coordinated support across primary care, community services, rehabilitation, mental health and inpatient pathways.
- Shorter hospital stays; earlier rehabilitation; reduced risk of deconditioning, hospital-acquired harm and loss of independence.
- Collectively, these changes are expected to improve patient outcomes by supporting even more people to remain independent for longer and receive care in the most appropriate setting, closer to home where clinically appropriate.

This option could:

- Improve sustainability and resilience by consolidating the current nine inpatient wards across eight hospital sites into two larger, strategically located wards, resulting in better staffing models with reduced reliance on agency and temporary staff.
- Create larger teams in the community to support more consistent staffing, reduced reliance on agency staff and stronger clinical governance.
- Improved integration between physical and mental health services supports more coordinated and holistic care.
- Support creation of specialist and purpose-built facilities that are better suited to modern healthcare delivery.
- Improved patient flow, clearer pathways and reduced duplication of services.
- Reduce unwarranted variation in service delivery and enabling patients to move more seamlessly between community, hospital and rehabilitation services as their needs change.
- Release additional financial savings for reinvestment into community services, making best use of resource.

However, the changes proposed would result in a significant number of patients, service users, carers, visitors and staff travelling to a different hospital than the one they currently use, which in many cases would increase journey times.

- Travel time modelling shows that under the two site model, mean travel time would increase from 11 minutes 56 seconds to 29 minutes 35 seconds, with households within the 45-minute benchmark reducing from 99.9% to 83.1% (based on private transport).
- The access impacts include longer journeys to inpatient care; increased travel costs; reduced ease of visiting for families and unpaid carers; greater reliance on private transport, community transport, public transport or support from others; and a higher risk of inequity for people who already experience barriers to care.
- These impacts are likely to be even greater for older people, disabled people, Welsh speakers, rural communities and people experiencing socio-economic disadvantage, particularly in central Powys and where public transport is limited, car access is restricted or digital alternatives do not fully replace face-to-face support.
- Strengthening of community-based care is a key mitigating factor, enabling more people to receive care at home or closer to home where clinically appropriate and reducing reliance on hospital-based care where admission is not required.

A public transport accessibility summary is provided in section 6.9.3.7 (figure 88).

Consolidating inpatient provision onto two sites would support larger MDTs, more sustainable workforce deployment, improved utilisation of specialist skills, reduced duplication across smaller wards and more effective use of the estate; however, patients who continue to require bed-based care, alongside their families and carers, would experience a greater travel impact.

This option is particularly dependent on the enhanced community model, social care and wider partner capacity being established before the more significant reduction in inpatient beds. Without sufficient alternative capacity, there is a risk of additional pressure on the remaining beds, disruption to patient pathways and poorer outcomes during the transition. A full Integrated Impact Assessment for this option is found in appendix Z.2.

6.9.5 Patient Perspective

From a patient perspective using our services, many of the pathway changes described would mean fewer patients need to be admitted into hospital beds, and if they do require hospital admission, they are more likely to have a safe and timely discharge back home. More patients would be managed at home or in the community through a more proactive prevention model and with a range of intermediate care options including an urgent care response within 2 hours, rehabilitation and reablement at home, and a digitally enabled Hospital at Home with enhanced clinical oversight.

Introducing Iolo Field

Iolo is 55 years old and works as a farmer on the family farm with his wife Meinir and their two children Megan (23) and Geraint (17).

His days are focused on the demands of farm work. He has been spending long hours on the tractor cutting and baling silage over the past few weeks. He has struggled with cellulitis on and off for several years but is reluctant to seek medical help when farming life is so busy.

When he does see someone, he generally sees the nurse at his local GP practice to manage his condition and is prescribed oral antibiotics. He has noticed his right leg has become swollen and red over the past few days, and he is starting to feel unwell with a high temperature and is shivering.

He also knocked his right leg about a week ago causing a wound on his shin which is painful and is also feeling concerned as he was previously treated for a blood clot in his left leg about five years ago.

Under our current physical health services in Powys…

Meinir, worried about Iolo's temperature, calls the local GP practice for an appointment/advice. Based on the conversation the practice thinks that his cellulitis has got worse and he needs to seek urgent medical advice and treatment.

Iolo would need to travel to his nearest ED for urgent assessment, which is approximately a 40-minute drive from his home. Following triage, he is assessed within the hour and then after a moderate wait sees a clinician who diagnoses cellulitis and commences IV antibiotics via cannulation to treat the severe infection. If ongoing IV antibiotic treatment is required, Iolo would remain an inpatient in the DGH until it is clinically appropriate to discontinue IV therapy and consider discharge. If Iolo needs more than one cycle of IV antibiotics, he may be referred back to the same hospital to have more antibiotics and further tests, meaning he will have to take more time away from the farm.

Under the options we are proposing for future physical health services in Powys…

Meinir, who is worried about Iolo's temperature, would call the local GP practice for an appointment/advice. Based on the conversation the practice thinks that his cellulitis has got worse and he needs to seek urgent medical advice and treatment.

The surgery would suggest Meinir takes Iolo to his nearest UCC which is a 25-minute journey. Here Iolo would be triaged on arrival and wait briefly to see a clinician.

He would receive IV antibiotics and cannulation to treat the severe infection within the hour.

If Iolo's infection requires more than one cycle of IV antibiotics, he may be referred to the intermediate care team to support the delivery of these antibiotics and any further tests at home to reduce time away from the farm.

6.9.6 Summary Option Comparison

The table below provides a summary comparison of the recommended options against baseline comparators.

Figure 94: Physical Health Summary comparison of recommended options against baseline comparators

Physical Health Options	Do previous – service configuration before temporary service changes (SLPH Option 001a)	Do current – service configuration currently (Option 001b)	Fewer Community Inpatient Beds reduced to 3 sites, with moderate community model and better join up with mental health (Option 005b)	Even fewer Community Inpatient beds reduced to 2 sites with enhanced community model and better join up with mental health (Option 008)
Service footprint sites	10 sites	9 sites	3 sites	2 sites
Service footprint Beds	157	146	90	60
PTHB Service model adjustments	Pre-temporary	No change	Moderate shift closer home 30 bed inpatient units	Enhanced care closer home 30 bed inpatient units
PTHB Workforce (WTE) Inpatients	279.0	268.1	147.8	105.3
PTHB Workforce WTE Community	23.6	23.6	103.8	124.5
Financial costs minus savings (£m)	£14.5	£13.3	£10.1	£7.9
Financial impact vs current 001b (£m)	£+1.2m	-	£-3.2	£-5.4
Non - financial appraisal score	37.7	48.6	87.9	77.9
Ward Staff cost per bed	£85,347	£78,149	£69,330	£69,330
Estates value	A - Low	A -Low	D - Major	D - Major
Estate Feasibility	Green	Green		

High Level Assumptions

- WTE includes 26% headroom; costing uses midpoint of Agenda for Change pay scales.
- Facilities costs included. Non pay costs excluded.
- Commissioning assumptions across options include reduction in out of county secondary care admissions and community hospital bed days and TRIM point savings.
- All options currently modelled to Year 0 for costs, activity and WTE
- Costs for alternative bed provision in advance of community model being fully operational excluded.
- Assumes investment into clinical oversight model

Category for Initial Estate Assessment Feasibility and Value	Funding reasonably expected to be available	Welsh Government aware of project, but funding not secured	Funding is not currently on any capital plan / not fully defined	Significant issues with feasibility, deliverability, major disruption
	A - Low <£0.50M	B - Medium £0.50>£7M	C - Significant £7M<£15M	D - Major >£15M

6.9.7 Physical Health Options Assessed and Discounted

The Step Report in appendices Z.5 provides further detail on the options development process, and decisions taken in relation to the discounting of options. Below is a summary of the range of options that were assessed and discounted.

A range of different physical health service models were assessed during the appraisal process. These included options that retained a larger number of inpatient sites, options with different levels of bed reduction, and options with varying levels of integration between physical health, mental health and community services.

An option to remove all community inpatient beds raised concerns around overall cost, with increased reliance on the private sector and services outside Powys, was assessed as financially unsustainable in the longer term, adversely impacted on stroke rehabilitation and on meeting population need identified through independent D&C modelling.

Options retaining the same number of beds across six sites, with or without some mental health integration, were assessed as delivering insufficient shift towards community-based care and outcome improvement and not meeting the longer-term financial and workforce sustainability requirements.

A mid-range option of fewer beds on three sites, without the mental health integration element, was assessed as offering less opportunity to improve integration between physical and mental health services that the Case for Change identifies as important.

Overall, the options taken forward were considered more able to support integrated, preventative and community-focused care, helping more people receive support at home or closer to home while improving long-term sustainability and resilience across services.

7. Urgent Care Centres and Diagnostics

7.1 Background and context

Urgent care services in Powys are delivered through General Practice, NHS 111 Wales, GP Out of Hours, community pharmacy, optometry, dentistry, participating GP minor injury services and four PTHB MIUs. People whose needs cannot be met locally may be referred or travel to EDs outside Powys.

Community Urgent Care and Diagnostics services support people who need timely assessment, investigation and treatment for conditions that are urgent but not immediately life-threatening. Together, these services help people access care closer to home, reduce unnecessary attendance at ED and make better use of local, regional and out-of-county services. Urgent care and diagnostics are closely linked because many patients require diagnostic tests as part of their assessment and treatment. The ability to provide safe and timely care within Powys often depends not only on access to a clinician, but also on whether the required diagnostic test is available at the right site and at the right time.

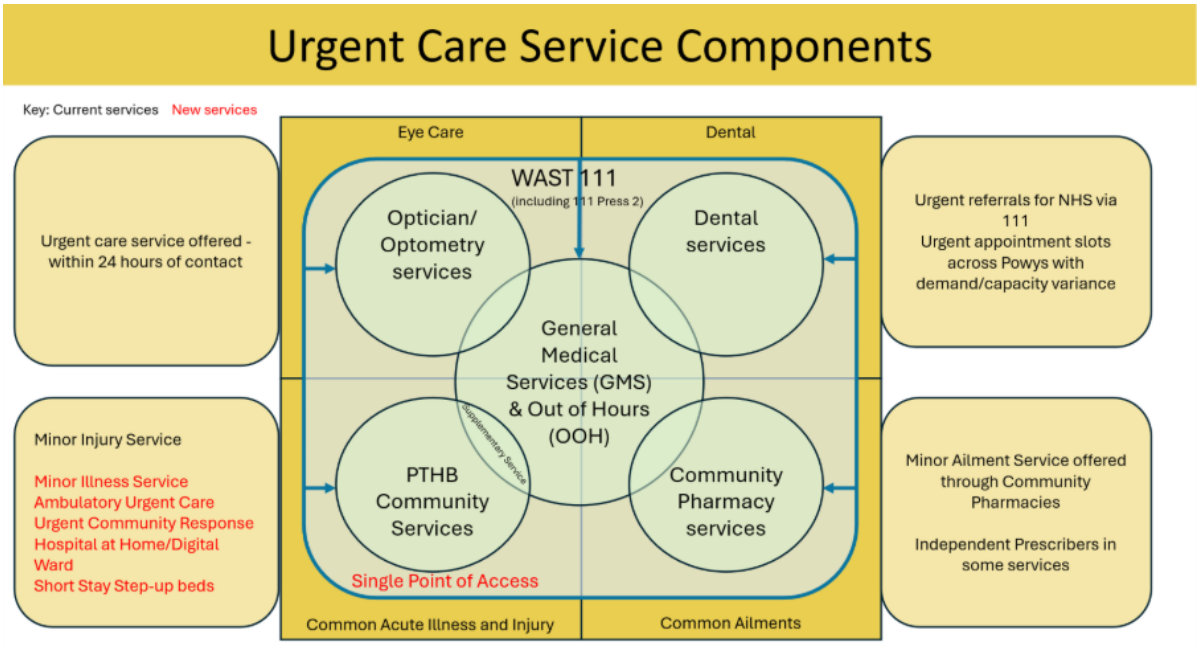
The geography of Powys strongly influences how urgent care and diagnostic services are delivered. As a large rural county, with dispersed communities and long travel distances, many residents access UEC across organisational and geographical boundaries. Some people use their general practice, primary care or community services; others access MIUs either within or outside Powys; and some travel to ED or urgent care services provided by neighbouring organisations in Wales and England. The current service offer remains variable across the county and is still largely centred on community-based minor injury provision, while the need for broader community urgent care, faster assessment, better diagnostic access and care closer to home continues to increase and requires better join up with wider physical and mental health community services.

7.2 Current configuration of services

7.2.1 Urgent care services

The diagram below shows the current services and gaps in services (in red)

Figure 95: Urgent Care Service Components, with gaps/new services highlighted in red



General Practice remains the main route for urgent medical advice, assessment and signposting during core hours. This is supported by NHS 111 Wales, GP Out of Hours, community pharmacy, urgent dental care and urgent eye care services. All GP practices in Powys support patients with urgent care needs, with ten practices also providing supplementary minor injury services.

All GP practices in Powys support patients with urgent care needs with additional minor injury supplementary services provided by ten practices. These ten practices provide minor injury services through local arrangements, and where this service is offered, practices work to a consistent specification, including agreed opening hours. However, variations to these services include access to diagnostics depending on locality and workforce skill mix.

For urgent medical care, patients can access their General Practice during core hours for advice, appointments or signposting. Temporary residents can also access urgent primary care under the NHS regulations. Out-of-hours GMS are commissioned from Shropdoc and Swansea Bay University Health Board (SBUHB). NHS 111 provides the initial triage and referral function. PTHB MIUs operate at Welshpool, Llandrindod Wells, Brecon and Ystradgynlais and provide assessment and treatment for minor injuries in adults and children aged one year and older. Services operate through a hybrid model, combining walk-in access and telephone-first assessment. Opening hours vary across sites: Welshpool, Brecon and Llandrindod Wells currently operate between 08:00 to 20:00, 7 days a week, while Ystradgynlais operates between 08:30 and 16:30 on weekdays. These arrangements have changed over time in response to workforce availability, local demand and temporary service changes

In the community, whilst there are responsive services such as district nurses and community therapy teams, there is currently no dedicated intermediate care service providing a 2-hour

urgent care response. Urgent care needs at home are largely met by the GP and community teams but there are gaps in service provision. Step-up beds are available within Community Hospitals to support people closer to home and help avoid admission to an acute hospital, but their use is limited by the level of acuity that can be safely managed with the current model.

7.2.2 Diagnostics Services

Diagnostic services are a core part of the urgent care pathway. Current provision includes plain film X-ray, blood testing and POCT, although availability varies by site and does not consistently align with urgent care operating hours. This variation directly influences what can be safely assessed and treated locally. Current service information indicates that approximately, 20% to 25% of MIU attendances require access to X-ray services meaning that diagnostic access is not a marginal issue but a key determinant of whether an urgent care attendance can be fully managed within Powys. Where X-ray, blood testing or other diagnostics are not available at the same time as urgent care services, patients may need to travel to another site, return at another time or be referred to an out-of-county provider. Only one existing MIU has X-ray access at weekends and daily access to laboratory testing is limited across sites, which means the ability to deliver timely urgent care is not determined by clinical staffing alone. It also depends on the alignment of diagnostics, workforce, equipment, digital systems and supporting infrastructure. Diagnostics therefore need to be understood as part of the urgent care model, rather than as a separate supporting service.

7.3 Current Activity, Performance and Clinical standards

7.3.1 Emergency Department (ED) Attendances

An analysis of Powys residents attending ED was undertaken in May 2025 to assess patients who could potentially have been managed within PTHB services, either through the existing MIU model or an enhanced Minor Injury and Illness Unit (MIIU) model. As Powys does not operate a Type 1 ED, residents often travel outside the county for UEC. The review therefore provides an evidence base for considering how some activity might be repatriated into local services, reducing travel for residents and supporting wider system objectives to reduce avoidable ED demand.

The analysis focused on Powys resident attendances at Type 1 ED in January and July 2024, selected to provide winter and summer comparison points. After excluding non-routine out-of-area attendances and planned follow-ups, 4,099 records were reviewed. Attendances were categorised according to whether they were likely to be outside the scope of Powys urgent care services, suitable for the current MIU model, or potentially suitable for an enhanced MIIU model.

The review found that a meaningful proportion of ED activity could potentially be managed closer to home. Following reconciliation of incomplete records, the analysis projected that presentations suitable for the current MIU model could account for around 7,721 attendances annually, including 4,510 in-hours attendances. If the service model were expanded to include selected minor illness presentations, the wider local urgent care opportunity could increase to around 10,498 attendances annually, including 5,969 in-hours attendances. This

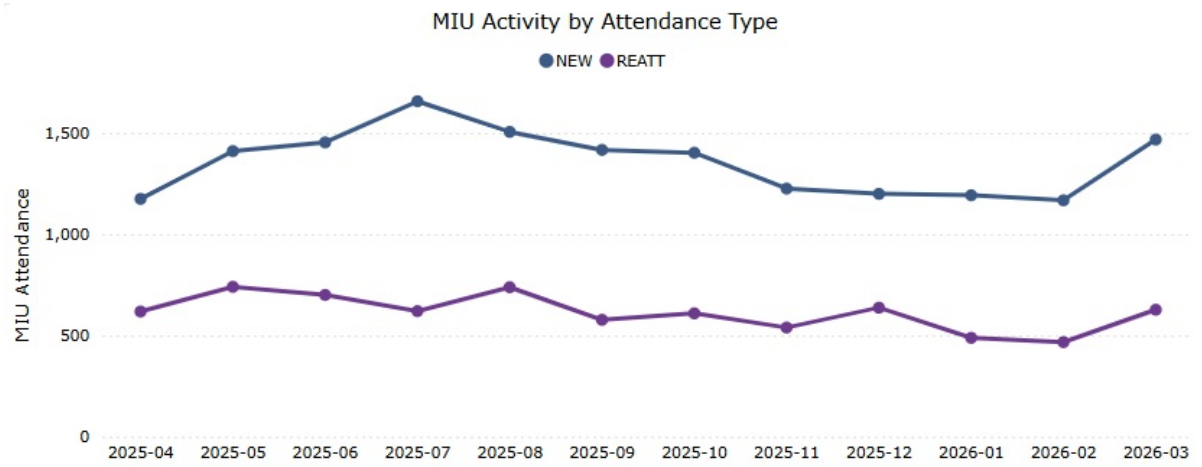
equates to approximately 497 in-hours attendances per month, or 115 per week, that may be relevant to an expanded local urgent care model.

This analysis demonstrates there are opportunities to strengthen MIU services now to reduce some out of county attendances at ED, but this does have some dependency with alignment of radiology access with MIU opening hours. It also shows further opportunity to reduce out of county attendances, if Powys develops an enhanced MIIU model capable of managing selected minor illness presentations, such as mild abdominal pain, urinary tract infection, respiratory symptoms, eye complaints, non-traumatic limb or joint pain, back pain, fever, rash, coughs and colds. Overall, the analysis provided a good evidence base to support credible pathway changes which repatriate a proportion of urgent care activity into Powys, particularly where presentations fall within the current MIU scope or could be accommodated through an enhanced MIIU model. Emergency admissions activity is also relevant to urgent care; however, this is covered in section 6.3.1 as part of the physical health inpatient and community model. This section provides patient activity and system flow activity for emergency admissions by provider over the past 4 years.

7.3.2 Minor Injury Department Activity and Performance

The following chart shows the MIU patient attendance and re-attendance rates in Powys over the past year.

Figure 96: Minor injury unit patient attendance and re-attendance rates in Powys over the past year



The below table shows the MIU activity breakdown for 2024/25, per site and the associated costs. This shows significant variation in patient activity by site. The cost per attendance is much higher in sites where the patient activity is low. Brecon as the busiest MIU has the lowest cost per attendance.

Figure 97: MIU activity breakdown by site and associated costs, 2023/24 to 2025/26

	FY23-24	FY24-25	FY25-26	FY25-26	
MIU Site	Patient activity	Patient activity	Patient activity	Full cost	Cost per patient attendance
Brecon	8,053	7,449	8,114	£807,505	£100
Llandridod Wells	5,695	6,192	7,186	£781,693	£109
Welshpool	4,069	4,133	4,937	£799,152	£162
Ystradgynlais	2,497	2,357	3,413	£630,006	£185
Totals	**20,314**	**20,131**	**23,650**	**£3,018,356**	

The table below shows the performance of the 4 hour waiting times for the MIU's in Powys, with an extremely low breach rate for the 4 hour wait during 2025/26.

Figure 98: Performance of 4 hour waiting times for the MIU's in Powys

Breach Report

Location	Breaches (Treat time over 4 hours)	Breaches (Treat time over 12 hours - includes over 4)	Non Breaches - Other long waits (treat time less than 4 hours, discharge over)
Llandrindod	3	0	6
Brecon	0	0	1
Welshpool	0	0	0
Ystradgynlais	0	0	0
Total	**3**	**0**	**7**

The majority of MIU attendances result in patients being discharged home, accounting for 20,808 attendances (85.76%), indicating that most patients are managed within the unit.

A further 1,508 attendances (6.21%) were referred to fracture clinic, reflecting established minor injury pathways within the service. Transfers to DGH accounted for 869 attendances (3.58%).

Figure 99: 2025/26 MIU Activity – Outcome following attendance

PATIENT_DISPOSAL_TYPE	Count of PATIENT_DISPOSAL_TYPE
Discharged Home	20808
Fracture Clinic	1508
Transferred to DGH	869
Did Not Attend	575
GP Surgery	258
Shropdoc	124
Community Nursing Team	59
Did Not Wait	32
Admitted	18
Unknown	10
A&E Waiting List for Minor OP	3

7.3.3 Current Imaging Activity and Performance

Radiography services in Powys currently support MIU and Urgent Care activity through a network of community hospital-based plain film X-ray facilities. Services are generally available Monday to Friday between 9am and 5pm, with limited weekend provision currently available at Brecon. Recent capital investment has modernised equipment across the service and increased theoretical capacity from approximately 10 to 15 appointments per day at each site to around 20 to 25 appointments per day. This represents additional capacity of up to 50 appointments per week per site, or approximately 250 appointments per week across Powys.

Performance against planned care access standards is currently strong. Referral to Treatment (RTT) waiting times for plain film imaging are typically between two and four weeks across Powys, significantly below the national target of eight weeks, and urgent same-day imaging appointments are routinely provided for MIU and General Practice referrals within existing operating hours.

The implementation of the Radiology Information System (RIS) has improved visibility of activity, Demand and Capacity across locations and has highlighted opportunities to optimise utilisation of imaging resources. Whilst overall imaging capacity has increased, demand for plain film imaging has remained relatively static and utilisation varies significantly between sites. Some locations are currently operating below available capacity, and activity levels are insufficient to fully utilise the equipment and staffing resource available. This is particularly evident at Machynlleth, where activity is currently concentrated into a single weekly session and is supported by older non-digital equipment. The current distribution of services therefore presents ongoing challenges in achieving the most efficient use of diagnostic resources across the county.

Diagnostic provision currently remains constrained outside core hours. There is no routine access to plain film imaging after 5pm and weekend provision is limited, creating variation in access across Powys and limiting the diagnostic capability available to urgent care pathways. Although patients requiring urgent imaging can be accommodated during existing operating hours, reduced access during evenings and weekends may contribute to avoidable travel to ED outside Powys and can affect public confidence in local urgent care services.

Ultrasound capacity associated with the Deep Vein Thrombosis (DVT) pathway is also limited. There is currently no same-day or next-day ultrasound provision within Powys, urgent scans are normally delivered within ten working days, and the service is operating at or close to existing workforce capacity. Only two of the four available sonographers are currently trained to undertake the DVT pathway. This constrains the Health Board's ability to provide a fully local urgent DVT service and results in continued dependence on external providers for some elements of care.

7.3.4 Clinical Standards

There are currently no nationally agreed clinical standards for Minor Injury Services which the Health Board can assess their services against; these are in development nationally by the Urgent & Emergency Care (UEC), NHS Wales Performance and Improvement team. However, there are 10 NHS delivery expectations for UCCs Wales which we have assessed

our current ability to meet, this is shown in the table below. Those areas where we are not meeting delivery expectations require investment, workforce, leadership, resource, estate etc to implement. The current model is hindering our ambition to provide more urgent care in county as a critical mass of patients sufficient to maintain staff skills and expertise is lacking.

Figure 100: Existing service provision against 10 NHS delivery expectations for Urgent Care Centres Wales

Meeting delivery expectations	Not meeting delivery expectations
2. UCC will be able to see patients who are directed, booked and walk-in.	1. A UCC will be Open 7 days a week, 12 hours a day as a minimum, linked to local population needs.
6. Accept ambulance conveyance (non-emergency) in accordance with the defined scope of practice.	3. UCC will see both injuries and illness in accordance with defined scope of practice (streamed).
8a. Report as type 3 ED for injury cases.	4. The UCC will have a named senior clinical leader on shift supported by an appropriate multidisciplinary workforce.
9. Have an up-to-date directory of service (DoS) profile.	5. A UCC should have a basic and consistent investigative and diagnostic (including radiology) offering on site (with clear protocols if not on site).
	7. Have access to patient records and the ability to send a post event message (PEM).
	8b. Report illness in accordance with defined metrics for urgent care.
	10. Clearly communicate to the public the service specification via a consistent UCC nomenclature, to ensure the service provision is understandable and accessible to all.

7.4 Why No Change is Not an Option (current issues)

7.4.1 Demand, Access and Equity

Demand for urgent care is increasing, with more Powys residents attending ED and being admitted to acute hospitals.

The current model does not provide consistent or equitable access across the county. Services have developed incrementally through a combination of GP minor injury provision, PTHB MIUs, temporary service changes and out-of-county pathways. Service availability and scope vary between sites, resulting in different levels of access depending on where people live.

A systematic review by Alaqil et al [63] of 12 peer-reviewed studies (2015–2024) found that urgent care coordination models significantly reduce ED visits, particularly for non-urgent

[63] The Role of Urgent Care Clinics in Alleviating Emergency Department Congestion: A Systematic Review of Patient Outcomes and Resource Utilization | Cureus

cases, with shorter wait times, improved resource allocation and higher patient satisfaction. NHS England's SPoA guidance [64] documents that implementation improves alternative pathway utilisation, appropriate ambulance dispatch, and urgent community response referral rates [65].

An alternative enhanced community urgent care model is required to meet future patient demand. It would improve outcomes, alleviate pressures on primary and secondary care services, and provide a more equitable service offer across Powys.

7.4.2 Current Activity Levels are Significantly Lower than Comparable Services, resulting in a Workforce and Cost-Intensive Model.

MIU activity within Powys is comparatively low when benchmarked against all-Wales services, with individual sites operating at substantially lower levels of throughput. Despite this, staffing and supporting infrastructure must be maintained across multiple locations to ensure safe service delivery, resulting in higher workforce intensity and cost per attendance than the Welsh average.

The current urgent care model in Powys is no longer sustainable in its present form. It is under pressure from workforce fragility, variation in service availability, limited access to diagnostics, high relative cost, and increasing demand linked to frailty, multi-morbidity and rurality. Temporary service changes have improved operational stability and whilst services are ‘clinically capable’ within the care they provide, they are not clinically capable of meeting as many of the urgent care needs of the population as could be managed with service reconfiguration.

Financial benchmarking provides further evidence that the current model is difficult to sustain. The issue is not simply the total cost of urgent care provision, but the relationship between activity, staffing requirements, site configuration and cost. In a dispersed rural model, staffing and infrastructure must be maintained across multiple locations even where activity is comparatively low or variable, resulting in higher workforce intensity and cost per attendance.

National benchmarking undertaken by the NHS Benchmarking Network in 2024 provides the most recent comparator available for assessing the relative financial position of PTHB MIU model. For the purposes of this assessment, that benchmarking has been used as the primary reference point for comparison [66]

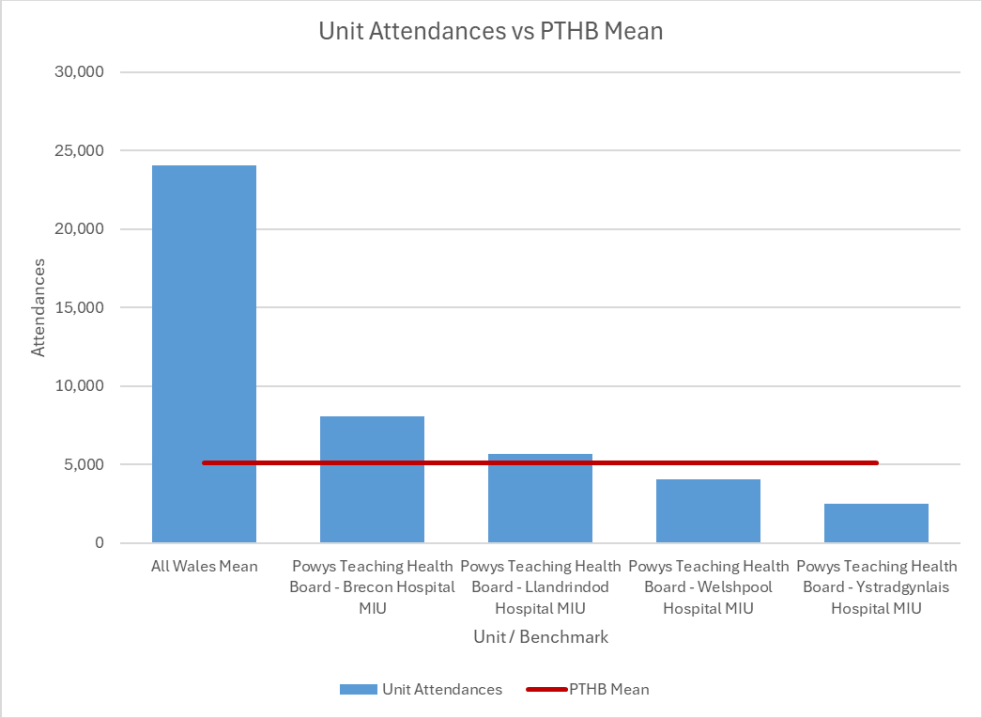
Benchmarking indicates that MIU activity in Powys is substantially lower than comparable services across Wales. On average, annual attendances per PTHB unit are around 21% of the all-Wales average, with individual units ranging from approximately 10% to 33% of the Welsh average annual activity.

This lower level of activity has a direct effect on staffing intensity. Benchmarking shows that the PTHB mean WTE staffing per 100,000 attendances is approximately 1.5 times the all-

[64] NHS England » Single point of access (SPoA)
[65] Three-Pillar Model, Six Goals for Urgent and Emergency Care, May 2026.
[66] NHS Benchmarking Network, 2024.

Wales average, with individual units ranging from around 1.2 to 2.2 times the Welsh mean. This reflects the requirement to maintain safe staffing levels across a dispersed rural geography, where services must operate across multiple sites despite comparatively low and variable demand.

Figure 101: MIU Attendances across Wales vs PTHB



Workforce sustainability continues to present challenges across PTHB urgent care and diagnostic services. While demand for urgent care is typically lower overnight, safe service delivery still requires an appropriate number and skill mix of staff. Recruitment difficulties, lone-working considerations and challenges maintaining safe staffing levels have therefore affected the ability to sustain the existing model, particularly for overnight MIU provision, resulting in phased temporary service changes over several years. These factors formed part of the Case for Change supporting the Treatment and Stabilisation Centre model and the overnight closure of MIU services.

7.4.3 Lack of Alternative Offer and Urgent Care Community Response Closer to Home

The current PTHB offer is primarily focused on site based minor injury services and does not provide the full range of urgent care services that could potentially be delivered within Powys to meet the population demographics. There are gaps in community-based urgent care provision required to meet the needs of an ageing population; this includes services beyond the scope of minor injuries such as falls response, rapid response, Hospital at Home and broader urgent assessment and treatment. This limits the ability to provide care closer to home for some people and means residents may attend ED or be admitted outside Powys

for presentations that could potentially be assessed and treated locally if the right clinical, diagnostic and community response capacity were available.

7.4.4 Diagnostics, Digital Integration and Sustainability

The current variability in availability of diagnostics across sites impacts the range and effectiveness of the service. Digital integration is also part of the sustainability challenge. Urgent care and diagnostics operate across several services and organisational boundaries, including PTHB, GP practices, NHS 111 Wales, ambulance services and neighbouring acute providers. Shared information, digital communication, remote advice, clinical pathways and robust governance arrangements would be needed to support safe, coordinated urgent care and diagnostics across the county. This is particularly important where patients move between local and out-of-county services, and where urgent care, diagnostics and community response need to operate as part of one pathway rather than separate service offers.

7.5 What We Have Heard about this Service Area

7.5.1 Travel, Local and Equitable Access to Community Provision

Engagement feedback shows that people place significant value on local urgent care services, particularly in rural communities where travel times can be substantial and public transport options are limited. Residents strongly support retaining local access wherever it is safe and sustainable to do so, and want timely assessment, treatment and diagnostics to be available as close to home as possible. Feedback emphasised that future arrangements should avoid widening inequity and should consider the practical realities of rural travel, public transport, car availability and access for people with additional needs. Any future model would need to demonstrate how travel impacts have been assessed and how mitigations would be put in place for communities and groups most likely to be affected.

At the same time, feedback reflects concern about reduced opening hours, temporary service changes and the potential loss of local provision. While attendance levels have not reduced following recent changes to opening hours, and have shown a slight overall increase, these concerns highlight the importance communities place on having local services available when needed. Future models would therefore need to balance community access with clinical safety, workforce sustainability and equity.

7.5.2 Clear Pathways, Coordination and Public Understanding

People want urgent care pathways to be simple, consistent and easy to understand. Feedback highlighted the importance of clear information about where to go, what services are available, when services are open, and whether local urgent care can meet particular needs. Where pathways are unclear or services appear inconsistent, people may default to ED or other known access routes.

The feedback also points to the need for stronger coordination between urgent care, primary care, diagnostics, community services, ambulance pathways, NHS 111 Wales and out-of-county providers. A future model would need to be clinically appropriate, but also straightforward for patients, families, carers and referrers to navigate.

7.5.3 Prevention, Early Intervention and Care Closer to Home

Stakeholders supported earlier intervention, targeted prevention and care closer to home where clinically appropriate. Feedback identified opportunities to strengthen community-based urgent care, improve access to diagnostics and reduce unnecessary attendance at ED or travel outside Powys. There was also support for developing services around patient need rather than organisational boundaries.

This aligns with the wider need to move from a model focused mainly on minor injuries towards a broader community urgent care and diagnostics offer. Such a model would support timely assessment, treatment and investigation, while recognising that prevention, early intervention and urgent response are connected parts of the same pathway, providing more joined up care, particularly for people with frailty, falls risk, long-term conditions or escalating needs.

7.5.4 Digital Access and Digitally Enabled Care

Feedback identified opportunities to use digital technology to improve access, communication and coordination across services. Participants recognised the potential benefits of digitally enabled care, including better advice, triage, communication, information sharing and support for clinical decision-making.

However, concerns were also raised about digital exclusion, connectivity and confidence in using technology, particularly for some rural communities and groups who may find digital access more difficult. Future service models would need to ensure that digital tools complement, rather than replace, accessible local care and are implemented in a way that maintains choice, equity and confidence.

7.6 Proposals for the Future

The future service model aims to provide more timely access to community-based urgent care assessment, diagnostics and treatment for people with non-life-threatening urgent care needs within Powys, while reducing avoidable attendance at ED, unnecessary hospital admissions and fragmentation between services.

The model aligns with the national and local policy and strategic context outlined in section 2.2, including the Powys Health and Care Strategy and its vision of A Healthy, Caring Powys, the Powys Wellbeing Plan, A Healthier Wales and Community by Design. The proposed approach reflects key strategic principles of prudent healthcare, value-based care, care closer to home, prevention of unnecessary escalation, and stronger integration between health, social care and third sector services.

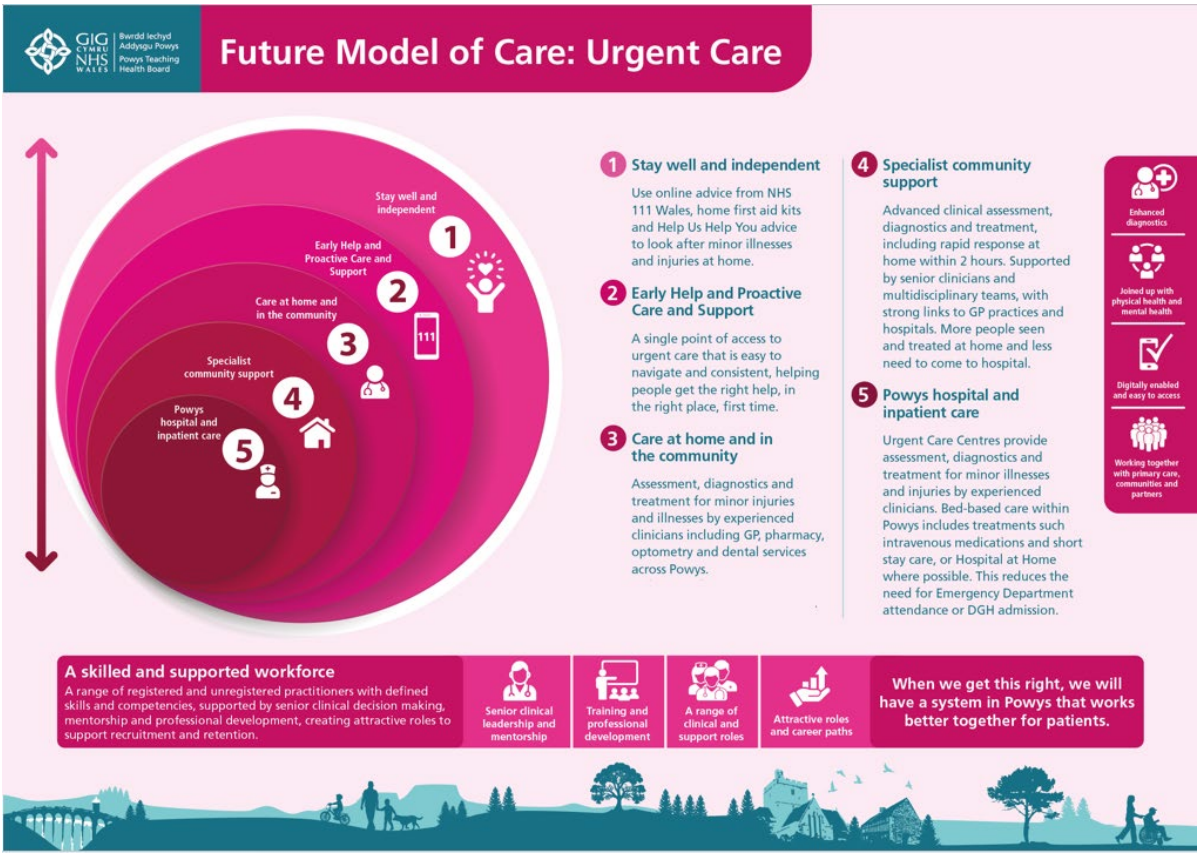
In Powys, the rurality, access to services and workforce sustainability require models of care that are more flexible, digitally enabled and better coordinated across organisational boundaries.

The proposed service model describes the components of an integrated community urgent care service that builds on existing provision. These components can be introduced incrementally, allowing the service to expand as workforce capacity develops and service

readiness improves. This phased approach would ensure that urgent care transformation in Powys is appropriately paced, flexible and sustainable.

Each component of the integrated urgent care model can be adapted to local population need, geography, transport infrastructure and operational readiness. The future network would be designed to deliver clinically effective care, while supporting workforce and financial sustainability. The diagram below illustrates the five components of the future urgent care model, which build on existing provision and can be developed incrementally as workforce capacity and service readiness improve.

Figure 102: Future Urgent Care Model



Urgent primary care would continue through General Practice, NHS 111 Wales, GP Out of Hours, community pharmacy, urgent dental and urgent eye care. A SPOA would support referral to the appropriate PTHB urgent or community pathway, with defined escalation to ED and specialist services where required.

Flow of referrals to the appropriate PTHB community urgent care service component would be directed by a SPoA, linking with WAST/111 and supported by clinical pathways and access to diagnostics in a timely manner according to evidence base.

Recognising that emergency clinical circumstances would inevitably arise, we would utilise existing standard 999 and ED pathways to ensure the immediate, safe transfer of the patients to the appropriate level of definitive care.

Defined escalation protocols and pathways with partner organisations and services would enable access to expert advice, treatment and transfer in a prudent and timely manner for people who have greater needs than the local urgent care service can manage. Robust and simple referral processes and pathways would guide access to the appropriate follow up services e.g. fracture clinics, MSK physiotherapy services etc.

Most PTHB service components would be delivered within a community healthcare facility, on an outpatient or ambulatory basis, either in a regional centre or within existing local facilities. Where appropriate, urgent care services would be delivered at home. Ultimately a minority of urgent care episodes would require admission escalation to an acute hospital ED outside of Powys or admission to a PTHB community hospital.

The current MIU model provides a foundation for the future service, with additional components introduced as workforce readiness, clinical feasibility, diagnostic capacity, governance and affordability allow.

There are three broad service offers in the future model: supported by urgent primary care, including the GMS minor illness / urgent medical care offer, as an essential part of the wider integrated urgent care system.

MIU – Minor Injury services would provide a service for patients with injuries not necessarily requiring admission to secondary care. Listed below are examples of presentations or treatments managed by a minor injury service.

- Minor back, neck, chest, facial injuries caused by low impact mechanism of injury, that do not require X-ray or imaging.
- Human, animal or insect bites and stings, without severe reaction.
- Minor burns and scalds.
- Non-penetrating ear and eye injuries
- Foreign bodies in eyes, ears and nose
- Simple slips and falls with low impact mechanism of injury.
- Cuts, abrasions and wounds
- Limb injuries and fractures, except hip injuries.
- Minor head injuries with no loss of consciousness and not on blood thinning medications.

GMS minor illness / urgent medical care offer – GMS would remain a key interface and dependency within the future urgent care model, rather than a separate service offer. The GMS minor injury offer would continue to provide local assessment and treatment of recent minor injuries such as cuts requiring closure, bruises, burns, eye injuries and foreign bodies.

MIIU – would extend the MIU model to a service that provides assessment, diagnostics and treatments for urgent care clinical presentations that could be defined as ‘Minor Illness’. Listed below are examples of minor illness presentations or treatments.

- Mild abdominal pain with associated urinary symptoms
- Coughs, colds, sore throats, fever
- Rashes, new onset skin conditions or possible infections
- Red, itching or weeping eye conditions
- Non-traumatic limb pain

Ambulatory Urgent Care – a broader urgent care model including minor injury, minor illness, advanced urgent care assessment and treatment. Ambulatory urgent care is for adults 18 years and over with non-life-threatening presentations that are more complex than minor injury or illness, but where it is expected they can return home same day**.** The service would be delivered in a healthcare facility with on-site advanced clinical practitioners and a senior clinician capable of assessing, diagnosing and treating. The facility would have appropriate and timely diagnostic services and would offer, for patients who can independently attend the facility on a daily basis, short term ambulatory care treatments such as intravenous medications that require on-site clinical oversight. Listed below are examples of presentations or treatments that may be managed by this service.

- Range of minor injury and illness
- Falls
- Pneumonia/chest infections
- Urinary tract infections
- Cellulitis
- Deep vein thrombosis

We would deliver this future model through a UCC, is for people who need help with an urgent health problem on the same day, but whose condition is not life-threatening.

A UCC is more than a traditional MIU. It can support people with urgent illnesses and injuries, and it brings together urgent primary care, including the GMS minor illness / urgent medical care offer, minor injury care and same-day urgent care in one place or through a connected pathway. The aim is to help more people be assessed, treated and supported closer to home, where it is safe to do so.

Many people attend urgent care because they feel unwell, have pain, have had a fall, have an injury, or are worried that their symptoms are getting worse. The role of the UCC team is to assess patients, decide what investigations or treatment may be needed, and help people to get the right care.

Some examples of why people might need to go to a UCC are provided below:

A UCC may be able to help if you need same-day advice, assessment or treatment for an urgent health problem.

- feel generally unwell and are not sure where to go

- have a high temperature, cough, sore throat, rash or symptoms of infection
- feel short of breath, but it is not severe or life-threatening
- have symptoms of a urine infection
- have a flare-up of a long-term condition and need urgent advice or assessment
- have had a fall and need to be checked
- have a sprain, strain, new pain, or difficulty walking or moving
- think you may have a broken bone
- have a cut, wound, minor burn, bite or skin infection
- need urgent care on the same day but do not think you need an ED

What is different about a UCC?

A UCC provides a broader urgent care offer than a traditional MIU or a short GP urgent appointment. The difference is not just about the type of problem people attend with. It is also about what the service can do once you arrive.

- clinicians with advanced or enhanced urgent care skills
- more time to assess urgent health problems
- same-day tests or investigations, where appropriate
- access to imaging, depending on the site and service model
- treatments that may reduce the need to travel to an ED
- links with community teams, rehabilitation, virtual wards and other local services.

This means that, where it is safe and appropriate, more people could be assessed and treated closer to home rather than being sent out of county or attending an ED.

This future service model has interdependencies with GMS, the wider urgent primary care offer and the Physical Health Community team. GMS would provide urgent medical advice, assessment, appointments and signposting during core hours, with out-of-hours GMS supported through commissioned arrangements and NHS 111 triage. The Physical Health Community team would deliver an enhanced community-based urgent care response service and hospital at home/digital ward functions, while the inpatient unit would support short-stay assessment and treatment beds. These components are fundamental parts of the system and must work together to meet urgent care patient needs.

Taken together, these components describe a future system in which urgent care is not limited to a physical front-door service but extends across primary care, community settings and people's homes through GMS urgent medical care, rapid response, ambulatory care, short-stay intervention and home-based acute treatment. This is intended to improve patient flow, reduce reliance on acute hospitals and strengthen the system's capacity to meet urgent need within Powys.

The target patient cohorts and pathways are:

- adults aged 18 and over;
- Children and young people
- people with long-term conditions;
- people with frailty or complex care needs;
- patients who could be safely treated at home or in community settings rather than admitted to hospital;
- patients requiring rapid intervention to avoid deterioration or unnecessary transfer.

Workforce and Digital requirements:

- Delivery depends on senior clinical decision-makers, advanced clinical practitioners, urgent care practitioners, registered staff, healthcare support workers and administrative roles.
- The new model would be dependent on sufficient staffing numbers, but also the right mix of advanced practice capability, senior oversight, professional development infrastructure and leadership accountability to ensure safe and sustainable delivery
- A networked clinical leadership model would be important in a rural setting where it may not be feasible to sustain traditional on-site medical leadership in every location. This would require virtual clinical support, telemedicine and flexible deployment of senior expertise across sites and service components.

7.7 Future Service Model Benefits and Evaluation

The proposed options are designed to meet all 10 NHS Wales UCC delivery expectations set out in Section 7.3.4. Anticipated benefits include earlier assessment and treatment, improved access to diagnostics, clearer pathways and reduced avoidable reliance on EDs outside Powys.

Benefits depend on sufficient workforce, clinical space, diagnostics, senior decision-making, digital capability and coordinated pathways with NHS 111 Wales, WAST, primary care, community teams and neighbouring providers.

Figure 103: Urgent Care Future service model benefits and evaluation metrics

Benefit	Potential evaluation metrics to assess impact of change
Improved access to urgent care in people's homes and community settings through rapid response, ambulatory care, short-stay intervention and home-based acute treatment.	• Percentage of patients seen in urgent care within four hours. • Compliance with the two-hour urgent community response standard. • Number of patients supported through rapid response, ambulatory care, short-stay intervention or home-based acute treatment.
Earlier assessment, diagnostics and treatment for non-life-threatening presentations.	• Time from referral or presentation to assessment, diagnostics and treatment. • Percentage of patients receiving same-day urgent care assessment and treatment where clinically appropriate.

	• Patient-reported outcome and experience measures.
Reduced reliance on acute hospitals by strengthening capacity and capability to meet urgent need within Powys.	• Number of patients redirected from 999 to PTHB urgent care services. • Reduction in avoidable conveyances, ED attendances and acute admissions. • Number of patients on step up care pathway • Average LOS in step-up beds.
Better use of workforce skills and advanced practice roles, supporting a more prudent, value-based and resilient service model.	• Staff feedback and satisfaction. • Use of advanced practice roles and skill-mix indicators. • Measures demonstrating operational efficiencies, including productivity, reduced duplication and improved use of local capacity.
Improved patient experience through person-centred, coordinated care.	• Patient feedback and satisfaction. • Patient-reported outcome and experience measures. • Reablement success rate and no readmission within 30 days.

7.8 Future Service Pathways

Demand and Capacity modelling has been undertaken with clinical teams to assess the potential impact of future urgent care pathways and changes to the configuration of services in Powys. The modelling draws on local activity data, evidence from comparable services and clinically informed assumptions regarding future pathway flows, particularly the opportunity to support more people within Powys through strengthened urgent care, diagnostic and community-based alternatives to hospital attendance. The clinical review undertaken in 2025 (see Section 6.4.1) explored two future-state scenarios**:** Scenario B, representing a realistic and achievable level of pathway transformation, and Scenario C, representing a more ambitious and aspirational level of change. These scenarios have informed the development of future models of care and service options and have been used to estimate workforce requirements, changes in commissioned activity, estate implications and the associated financial modelling, using Year 0 as the baseline position.

The future pathways described in Section 7.6 are intended to ensure that more patients are assessed and treated in the most appropriate setting, reducing avoidable attendance at Type 1 ED and improving access to urgent care services closer to home. The modelling suggests that strengthening urgent care pathways could reduce demand on other parts of the health and care system, including ED and, where clinically appropriate, some elements of GMS activity. However, assumptions regarding changes in primary care demand would require further testing through consultation, detailed service design and implementation planning.

These pathways align with the National UEC Improvement Plan 2026/27, particularly Pillar 1 (Pre-Hospital and Community) and Pillar 2 (Front Door and First 72 Hours), by supporting timely access to care, strengthening community-based alternatives and improving access to appropriate urgent care services.

The modelling also considers the potential repatriation of some activity currently delivered by secondary care providers outside Powys, where clinically appropriate and supported by the necessary workforce, infrastructure and service capability. The future service pathways modelled therefore focus on patients who do not require escalation to acute hospital provision and who may instead be supported through an enhanced urgent care and diagnostics offer within Powys.

7.8.1 Projected Urgent Care Activity

Existing Powys minor injury activity is 23,802 attendances across North, Mid and South Powys. In 25/26 4,308 patients attended minor injury departments outside of Powys (see section 3.1).

Repatriation assumptions have been applied in line with the analysis on ED patient activity in 2025 (referenced in section 7.3.1) and estimates for patients who would potentially attend an UCC as an alternative to other primary care services such as visiting a GP. This future demand has been triangulated with the Cardigan UCC model for sensitivity testing purposes against a similar population base and broadly this aligns.

Under the realistic and achievable D&C modelling scenario, this shows Year 10 forecast activity is projected to increase to 46,579 attendances, reflecting the broader urgent care offer, repatriation of MIU activity and increased local capacity. Under the aspirational scenario, Year 10 activity is projected to increase to 49,698 attendances.

Projected activity has been applied to the two consultation options: two UCCs with an MIIU in Llandrindod Wells, or two UCCs only.

Figure 104: Repatriation assumptions for 2 Site Urgent Care Centres, plus MIIU in Llandrindod

2 Site Urgent Care Centres, plus MIIU in Llandrindod	North Powys	Mid Powys	South Powys	Total
Year 0 activity (Baseline 24/25)	5,208	6,997	11,597	23,802
Year 10 Scenario B: realistic / achievable	14,519	12,642	19,418	46,579
Year 10 Scenario C: aspirational	15,377	13,605	20,716	49,699

Figure 105: Repatriation assumptions for 2 Urgent Care Centres only

2 Urgent Care Centres	North Powys	South Powys	Total
Year 10 Scenario B: realistic / achievable	20,840	25,739	46,579
Year 10 Scenario C: aspirational	22,180	27,519	49,699

The 2 UCCs activity modelling aligns more closely with the national benchmarking undertaken by the NHS Benchmarking Network in 2024, which highlighted the average attendances by unit across Wales to be just under 25,000 patients per annum.

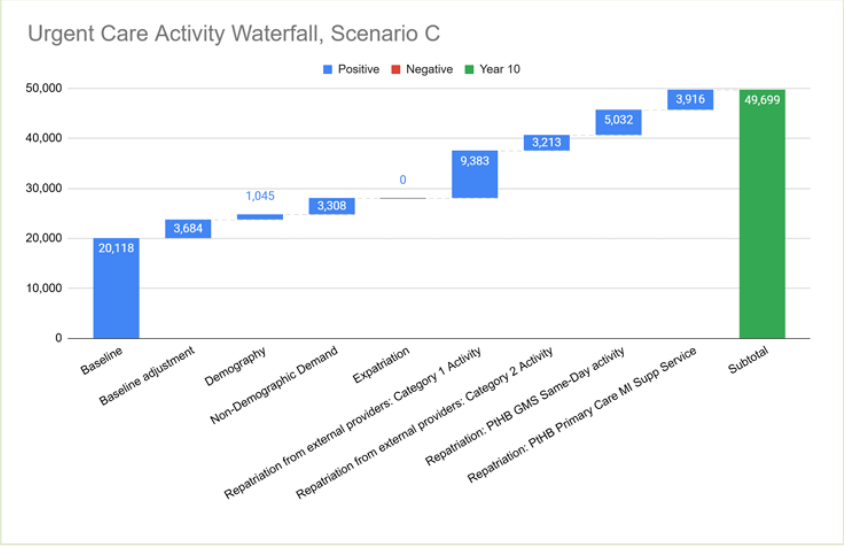
7.8.2 Impact of Pathway Changes on Urgent Care

Applying these future pathway changes would mean more patients are seen and treated in the most appropriate setting, helping to avoid unnecessary travel out of county to ED. It would also extend access to urgent care services within Powys and reduce demand on General Practice. To achieve this scale of change, there needs to be increased capacity in the community-based teams to enable future population health needs to be managed in a preventative way, with as much care being delivered as close to home where safe and effective to address challenges associated with access and travel. The chart below shows the potential impact of pathway changes in Year 10, based on the mid-range realistic and achievable scenario.

Figure 106: Urgent Care Activity Modelling Scenario B



Figure 107: Urgent Care Activity Waterfall, Scenario C



The two charts illustrate the potential scale of change that could be achieved through enhanced urgent care pathways in Powys. Under the realistic and achievable scenario, the modelling indicates a substantial increase in activity that could be managed locally through UCCs, with total projected activity rising to 46,579 attendances by Year 10. Under the aspirational scenario, this increases further to 49,699 attendances, reflecting a greater shift of activity from out-of-county emergency departments, GP urgent care and other pathways into a strengthened Powys urgent care model.

The modelling also shows that the overall level of projected activity is the same under both the two site and three site configurations, but the distribution of that activity differs significantly. A three site model spreads activity across North, Mid and South Powys, supporting a more geographically distributed offer.

The modelling indicates that enhanced urgent care pathways could materially change how urgent care activity is managed across Powys by shifting a greater proportion of activity into local services and reducing reliance on out-of-county emergency departments and General Practice urgent care. However, the benefits are dependent on having the right workforce, diagnostics, estates, digital infrastructure and community response capacity in place.

7.8.3 Future Pathways – Imaging and Diagnostics

Diagnostic imaging is a critical enabler of the future UCC model and is fundamental to supporting same-day assessment, treatment and clinical decision making closer to home. The future service model assumes that plain film imaging and DVT diagnostic pathways develop in parallel with urgent care services and that access to diagnostics is aligned, wherever practical and affordable, to the hours of operation of UCCs. The modelling undertaken has therefore examined the relationship between projected urgent care demand, diagnostic utilisation, workforce capacity and service configuration options.

Current operational analysis demonstrates that activity levels within existing MIUs generate relatively modest demand for urgent imaging. Based on current activity patterns, approximately one in three urgent care attendees may require a plain film examination. While future UCC proposals are expected to increase local activity through repatriation of patients currently attending ED outside Powys, modelling indicates that demand for imaging outside traditional operating hours remains uncertain and is likely to be relatively low, particularly after 5pm.

The diagnostic modelling suggests that utilisation and affordability improve where activity is consolidated across fewer sites. Under a three site model operating from 8am to 8pm seven days per week, imaging access would be maximised and most closely aligned with the operational model of an UCC. However, the financial analysis indicates that activity levels after 5pm would remain comparatively low, increasing the cost per examination during evening periods.

A two site configuration was therefore explored as part of the appraisal process. Modelling indicates that concentrating out-of-hours activity across fewer sites could increase utilisation rates, improve workforce efficiency and reduce the cost per appointment compared with providing extended-hour services across three locations. This approach would retain local

planned imaging provision through core operating hours while creating a more sustainable model for evening and weekend urgent care diagnostics.

The modelling also considered the future development of the DVT pathway. Clinical evidence supports the delivery of DVT assessment and treatment through ambulatory urgent care pathways, reducing unnecessary ED attendances and enabling patients to be diagnosed and treated closer to home. To support a same-day or 24-hour diagnostic pathway within Powys would require additional investment to expand sonography capacity and develop workforce capability. While this investment would increase costs, the pathway has potential to support repatriation of activity currently delivered outside the county and may contribute to reductions in ED attendances and associated patient travel.

Overall, the imaging and diagnostics modelling indicates that extending access to imaging services would improve patient experience, support timely diagnosis and strengthen the credibility of the future urgent care model. However, the scale and timing of any extension would need to be balanced against workforce availability, reporting capacity, affordability and demonstrated demand. The preferred service option would therefore require further refinement through detailed design, workforce planning and implementation planning to ensure that diagnostic provision is clinically effective, operationally sustainable and aligned with actual patterns of urgent care demand.

7.9 Recommended Options

To deliver the new models of care, pathways and associated benefits described above, and tackle long-standing challenges related to sustainability of services, the current offer and configuration of minor injury services need to change.

The Health Board has followed a robust open and transparent five-step options development process; the outcome is that two credible and robust options are now being proposed for public consultation. Alongside these, information is also included on the existing service arrangements and how services operated before the temporary service changes were enacted. These are included as a baseline comparator.

7.9.1 Service Configuration before Temporary Service Change

Before temporary service changes, hospital-based MIUs operated at four PTHB sites. The pre-temporary urgent care and diagnostic configuration is summarised in Figure 107.

Figure 108: Summary of pre-temporary urgent care and diagnostic configuration

Service	Locations	Operating Model
Minor Injury Units (MIUs)	Welshpool, Llandrindod Wells, Brecon	Open 24 hours per day, 7 days per week
	Ystradgynlais	Open 08:30-16:30, Monday-Friday
X-ray Services	Welshpool, Newtown, Llandrindod Wells, Brecon, Ystradgynlais	Weekday provision across all sites

Weekend X-ray	Brecon	Weekend morning provision
Additional X-ray Provision	Machynlleth	One day per week
Ultrasound	Main diagnostic sites	Part-week provision
Point of Care Testing (POCT)	Selected sites	Limited provision

Urgent care was also delivered through participating GP providing minor injury services, alongside PTHB MIU provision across the four sites, including daytime provision at Ystradgynlais. GP out-of-hours urgent care was available from the four PTHB Minor Injury Sites, with home visiting for patients unable to travel. Other urgent primary care services were delivered in the community, including urgent dental care, urgent eye care through optometry, and the Common Ailments Scheme delivered through community pharmacies.

The below table illustrates the changes that would be required to return to the pre-temporary configuration.

Figure 109: Urgent Care Configuration before Temporary Service Change

What changes from the current model?	What stays the same as the current model?
• Reinstatement of 24/7 Minor Injury Unit provision at Welshpool • Reinstatement of 24/7 Minor Injury Unit provision at Llandrindod Wells • Reinstatement of 24/7 Minor Injury Unit provision at Brecon • Reopening of Hospital Day Services across Powys	• Welshpool Unit continues to operate • Llandrindod Wells Unit continues to operate • Brecon Unit continues to operate • Ystradgynlais Unit continues to operate • Diagnostic services continue across existing sites and schedules • GP practices continue to deliver urgent care through GMS • Minor injury supplementary services continue in GP practices currently delivering this service • GP Out of Hours continues to operate from MIU sites • Urgent Eye Care through Opticians continues to operate • Common Ailment Scheme through Pharmacies continues to operate • Limited Point of Care Testing provision remains in place

Benefits	• Maintains geographic access to urgent care services • Maintains travel times for most populations to urgent care services • Retains local access to Minor Injury Units across 4 sites • Increases availability of urgent care through 24/7 provision • Reintroduces Hospital Day Services
Risks	• Increased workforce requirement to support 24/7 provision • Lone working challenges at night • Limited resilience across multiple sites remains • Variation in service offer across sites continues • Inability to standardise service model across sites • Limited clinical governance and leadership capacity • Increased cost of service delivery associated with extended opening hours
Trade-off(s)	• Maintains local access at the expense of workforce sustainability • Increases service availability at the expense of workforce requirements • Retains current model at the expense of service standardisation • Increases service availability at the expense of cost efficiency

The previous arrangements do not meet current or future demand and do not address the challenges within the Case for Change. It is presented as a baseline comparator only.

7.9.2 Service Configuration Currently

The following figure summarises the current urgent care and diagnostic configuration.

Figure 110: Summary of the current urgent care and diagnostic configuration

Service	Locations	Current Provision
Minor Injury Units (MIUs)	Welshpool, Llandrindod Wells, Brecon	Open 08:00-20:00, 7 days per week
	Ystradgynlais	Open 08:30-16:30, Monday-Friday
X-ray Services	Welshpool, Newtown, Llandrindod Wells, Brecon, Ystradgynlais	Weekday provision
Weekend X-ray	Brecon	Weekend morning provision
Additional X-ray Provision	Machynlleth	One day per week
Ultrasound Services	Main diagnostic sites	Part-week provision
Point of Care Testing (POCT)	Selected sites	Limited provision

Urgent care continues to be delivered through participating GP providing minor injury services, alongside PTHB MIU provision across the four sites, including daytime provision at Ystradgynlais. GP out-of-hours urgent care remains available from the four PTHB Minor Injury Sites, with home visiting for patients unable to travel. Other urgent primary care services continue to be delivered in the community, including urgent dental care, urgent eye care through optometry, and the Common Ailments Scheme delivered through community pharmacies.

Figure 111: Urgent Care Service Configuration Currently

What changes from the current model?	What stays the same as the current model?
• No change to current minor injury service configuration	• Welshpool Unit continues to operate • Llandrindod Wells Unit continues to operate • Brecon Unit continues to operate • Ystradgynlais Unit continues to operate • Existing MIU opening hours remain unchanged • Diagnostic services continue across existing sites and schedules • GP practices continue to deliver urgent care through GMS • Minor injury supplementary services continue in GP practices currently delivering this service • GP Out of Hours continues to operate from MIU sites • Urgent Eye Care through Opticians continues to operate • Common Ailment Scheme through Pharmacies continues to operate • Limited Point of Care Testing provision remains in place

Benefits	• Maintains geographic access to urgent care services • Maintains travel times for most populations accessing urgent care • Maintains established service delivery model and patient pathways • Retains local access to Minor Injury Units across 4 sites
Risks	• Limited resilience across multiple sites remains • Variation in service offer across sites continues • Inability to standardise service model across sites • Limited clinical governance and leadership capacity • High cost per patients associated with current service model remains
Trade-off(s)	• Maintains local access at the expense of service development and leadership capacity • Retains current model at the expense of service standardisation • Maintains local access at the expense of cost efficiency

This configuration does not meet future demand or provide the required improvement and resilience. It is retained as a baseline comparator only.

7.9.3 Local Urgent Care Services on 3 Sites (UC013)

This proposal establishes UCCs in Newtown and Brecon, and a MIIU in Llandrindod Wells, operating from 08:00- 20:00, seven days a week. POCT and blood testing facilities would be available at all three sites throughout operating hours, with X-ray services available from 9:00 am to 6:00 pm, seven days a week.

The proposal allows the expansion of scope of practice to include both injury and illness across all 3 units and enables the UCCs to deliver same day enhanced urgent care assessment, diagnostics and treatments, with ambulatory referral pathways into the service. The MIU would stay in Welshpool until the UCC opens in Newtown, and then the MIU in Welshpool would close (see section 7.7.3.5).

The following figure summarises the proposed urgent care and diagnostic configuration across three sites.

Figure 112: Summary of the proposed urgent care and diagnostic configuration on 3 sites

Service	Locations	Operating Model
Urgent Care Centres (UCC)	Newtown and Brecon	Open 08:00-20:00, 7 days per week
Minor Injury and Illness Unit (MIIU)	Llandrindod Wells	Open 08:00-20:00, 7 days per week
X-ray Services	Newtown, Llandrindod Wells and Brecon	Open 08:30-18:30, 7 days per week
Weekend X-ray		
Additional X-ray Provision		
Ultrasound Services	Main diagnostic sites	Part-week provision
Point of Care Testing (POCT)	Selected sites	Enhanced provision

This proposal fully supports the enhanced inpatient bed offer to include short stay assessment and treatment beds (step up) in the physical health proposal and is aligned with the creation of an ‘urgent community response’ service which can see people in their own homes between 8:00-20:00 pm, 7 days a week (as part of the community model).

GP practices would continue to offer urgent care through their GMS contract. GP practices (where there are not PTHB MIUs nearby) would provide minor injuries services. GP out of hours urgent care would continue to be offered. Other urgent primary care services would continue to be delivered in the community, including urgent dental care, urgent eye care through Opticians and the Common Ailments Scheme delivered in community pharmacies.

Figure 113: Local Urgent Care Centres on 2 sites and MIIU on 1 site (UC013)

What changes from the current model?	What stays the same as the current model?
• Reduction in number of Units from four to three • Welshpool Unit relocates to Newtown (following development of the Rural Regional Centre) • Ystradgynlais Minor Injury Unit closes • Brecon Unit becomes an Urgent Care Centre • Newtown Unit established as an Urgent Care Centre • Llandrindod Wells Unit becomes a Minor Injury and Illness Unit • X-ray provision at Ystradgynlais closes • X-ray provision at Machynlleth closes • X-ray provision at Welshpool closes (following relocation to Newtown) • X-ray provision expands to a 7-day service with extended hours • Additional Point of Care Testing introduced across all sites • Additional Blood testing introduced across all sites • Urgent care pathways expanded, including ambulatory referral pathways • Short stay assessment and treatment beds introduced (step-up capacity) • A refinement of Minor Injury Supplementary Services to reflect local population need • Addition of Triage Nurse per site • Addition of dedicated Professional and Clinical Leadership roles • Addition of Advanced Practice roles	• Welshpool Unit continues to operate until relocation to Newtown • Brecon Unit continues to operate • Llandrindod Wells Unit continues to operate • X-ray provision continues at Newtown (with extended hours) • X-ray provision continues at Brecon (with extended hours) • X-ray provision continues at Llandrindod Wells (with extended hours) • GP practices continue to deliver urgent care through GMS • GP Out of Hours continues to operate • Urgent Eye Care through Opticians continues to operate • Common Ailment Scheme through Pharmacies continues to operate • Minor Injury Supplementary Service continues as part of the overall model

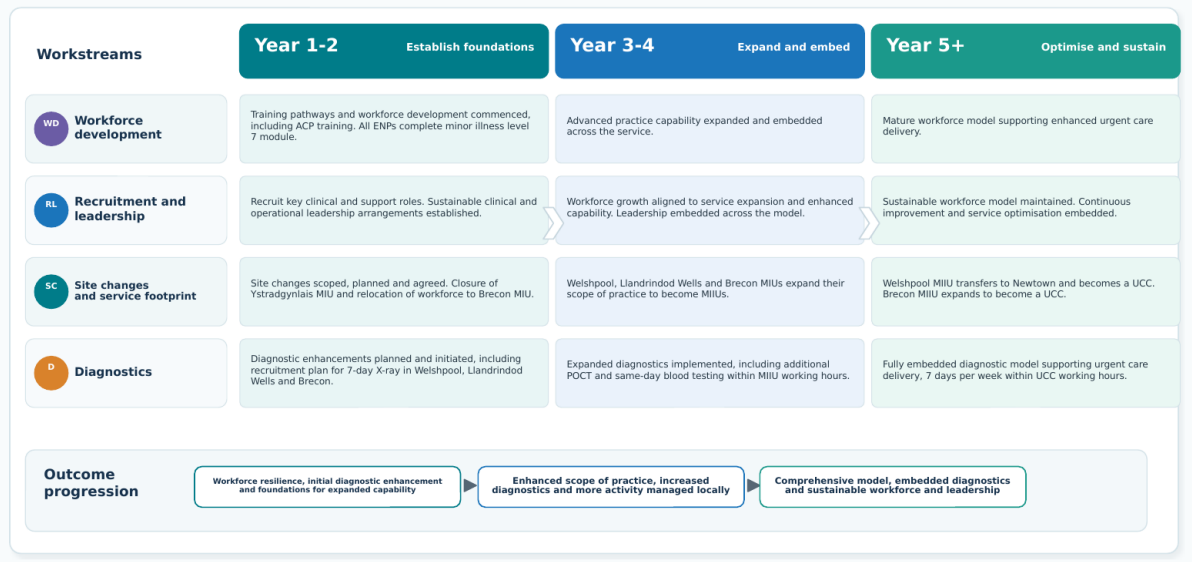
Benefits	• Concentrates workforce to support service delivery • Improves ability to staff rotas safely • Increases consistency of service offer across sites • Improved clinical governance and leadership capacity • Reduces reliance on external providers by increasing local capability • Improves clinical capability through expanded diagnostics and treatment • Increases the clinical scope of the service offer • Improves integration of urgent care pathways and patient flow • Supports the strategic direction of more urgent care delivered in the community • Increase in diagnostic access and availability reducing out of county travel
Risks	• Increased travel time for some populations accessing urgent care • Reduced access to PTHB urgent care services within 45-minute travel • Increased reliance on external providers for some populations • Variation in service offer across sites during transition • Dependency on recruitment to new roles • Dependency on workforce training, development and recruitment to deliver expanded service model • Dependency on capital investment to deliver proposed changes
Trade-off(s)	• Improves service quality at the expense of increased overall cost • Improves leadership capacity and service capability at the expense of increased investment

This option provides a significantly improved urgent care service offer compared with the current model and meets all ten NHS Wales delivery expectations for UCCs in Wales (see figure 114). It would strengthen governance, improve pathways integration and provide broader geographic coverage. It would also improve diagnostic provision, reduce unnecessary conveyances and align with the strategic direction for community-based urgent care. However, delivery across three sites would be more expensive than the 2-site option.

7.9.3.1 Indicative Phasing for this Option

The below timeline shows the indicative phasing for this option

Figure 114: Local Urgent Care Centres on 2 sites and MIIU on 1 site: Indicative phasing (UC013)



7.9.3.2 Commissioning Assumptions

- Whilst PTHB does not pay for most ED attendances (ED activity is funded by host commissioners in the main), both Urgent Care options would see the Health Board benefit by c.£535k from those providers where there are financial charges in place. Furthermore, a reduction in ED attendances would benefit the system by reducing unnecessary A&E attendances across our provider partner organisations.
- Minor injury and illness attendances only have been used to model the potential repatriation of activity from ED providers.
- A&E out of hours attendance has not been included in the modelling.
- SDEC out of county admissions have also not been included in the modelling.
- Clinical input from other providers (GP Service Level Agreements (SLA) and Supplementary Services) reduces as PTHB clinical team is recruited.

7.9.3.3 Workforce Assumptions

The workforce assumptions for this option are based on the development of two UCC and one MIIU, operating across three sites. The model assumes a broader urgent care offer than the current MIU model, with enhanced clinical assessment, treatment, diagnostics and referral pathways.

The workforce model is demand-led, with practitioner staffing scaled to projected activity by site. Clinical contact time has been modelled using projected annual demand converted into average daily demand, with assumptions applied for clinical assessment time per patient and maximum clinical contact time within each shift. The resulting establishment would also need to allow for annual leave, sickness, training, supervision and non-clinical duties; direct clinical contact time alone is not sufficient to determine a safe rota.

The model includes fixed site-based staffing requirements to support safe and consistent delivery. This includes a triage nurse and Healthcare Support Worker per site per shift, alongside site and service leadership. In addition to the fixed site-based staffing, for the UCC sites, a minimum safe staffing assumption of one Advanced Clinical Practitioner and one Enhanced Clinical Practitioner or Enhanced Nurse Practitioner per site per shift has been applied. This approach is aligned to the Professional Framework for Enhanced, Advanced and Consultant Clinical Practice in Wales, published by Health Education and Improvement Wales (HEIW), and the All-Wales Urgent Primary Care Practitioner Competency Framework, which supports development of the urgent primary care workforce.

The model also assumes increased radiography capacity to support extended hours and seven-day diagnostic provision with increased POCT capability and capacity. While some imaging workforce requirements may reduce where activity is delivered from fewer sites, the model assumes that existing diagnostic demand would need to be delivered safely from the future configuration.

Clinical oversight and governance would be essential to support the enhanced model. A clinical lead role has been identified separately within the financial appraisal and would need

to support clinical standards, pathway development, supervision, escalation and professional leadership across the urgent care model.

Indicative workforce impact

This option could affect staff working across MIUs, urgent care, diagnostics, radiography, point-of-care testing, urgent community response, administration, healthcare support and advanced or enhanced practice roles described in the proposed model. Potential impacts may include changes to team structure, work location, role, duties, skill mix, supervision arrangements, working patterns, travel and development requirements.

The extent and distribution of these impacts have not yet been determined. No assumptions are made at this stage about individual staff outcomes; these would be assessed following consultation through staff engagement, equality assessment and the applicable organisational change and consultation arrangements.

To proceed safely, implementation would need to be phased and supported by clear workforce, quality and safety checkpoints. Following consultation and subject to the preferred option, a detailed workforce plan would confirm baseline and future establishments, including substantive, bank and agency staffing, skill mix, clinical leadership, training, supervision, workforce development needs and any additional recruitment requirements. The plan would also set out implementation phasing, transitional arrangements, workforce readiness and key dependencies across diagnostics, urgent community response, primary care, mental health and wider community services.

7.9.3.4 Financial Appraisal (Revenue and Capital Implications)

Figure 115: Local Urgent Care Centres on 2 sites and MIIU on 1 site: revenue Implications (UC013)

Proposed WTE	Baseline £k	Investment /Disinvestment £k	Commissioning Savings £k	Net Investment £k
69	2,837	994	-850	144

- Baseline WTE - 52
- Baseline WTE & £k includes current staffing costs for MIU and Radiology services.
- Baseline does not include current commissioning spend, reductions in which would drive an element of the savings.

Figure 116: Local Urgent Care Centres on 2 sites and MIIU on 1 site: phased revenue implications (UC013)

Option net investment phasing (rounded £k) - Incremental						
	Y1	Y2	Y3	Y4	Y5	**Recurrent**
Gross investment	598	598	179	179	179	**1,734**
Gross disinvestment	-740	0	0	0	0	**-740**

Option net investment phasing (rounded £k) - Incremental						
Gross commissioned savings	-29	-121	-233	-233	-233	**-850**
Net Investment	**-171**	**475**	**-53**	**-53**	**-53**	**144**

- The current phased model does not yet fully reflect the workforce risks, operational overlap and associated cost implications that would inevitably arise during the transition from one model to the other

The phasing assumptions are:

- Fourth site closes in Year 1.
- Three remaining sites build to MIIU over Years 1 to 2 - phased equally
- Two sites build to UCC over Years 3 to 5.
- Closure of fourth site in Yr 1 results in increased commissioning spend.
- Category 1 ED attendances repatriated in line with MIIU development over Years 1 and 2.
- Category 2 ED attendances repatriated, and all other commissioning savings phased in line with UCC investment over Years 3 to 5.

7.9.3.5 Capital Impact of Option

The capital investment in the rural regional centre model has been established with Welsh Government as part of the dialogue around a forward look capital programme, which has helped outline future NHS spending needs. This programme would be further informed by the outputs from the Better Together Service Strategy and enable a more defined Estates Strategy to be developed for PTHB to underpin the much-needed modernisation of the estate. Future business case submissions would be able to draw a more distinct and confident association between the long-term service Strategy and the investment needed for a fit for purpose-built environment.

Investment for the completion of the modernisation of the remaining section of the approval of the business case. This funding would align well with the requirement to create a fit for purpose Minor Injuries and Illness Unit at the hospital.

The first phase of the North Powys, Newtown, Health and Wellbeing Campus has progressed to Final Programme Business Case level for the Integrated Health and Wellbeing Hub. The intent for Phase 2 would be to replace and relocate the current hospital into the centre of Newtown and the planning for this would incorporate the required UCC. Welsh Government are aware of the scope and scale of Phase 2 which is included in an ‘endorsed’ Programme Business Case for the campus, but no capital funding is currently secured.

The proposal for Breconshire War Memorial Hospital would require a reconfiguration of the existing Minor Injuries Unit to create an UCC. No funding has been secured.

7.9.3.6 Estate Implications

The creation and consolidation of the two UCC and one Minor Injuries and Illness Unit onto three rural regional centres, in a fit for purpose and modern patient environment, would enable more focussed technical Estates and Facilities support in fewer locations, resulting in an improved experience for both patients and staff. The capital investment in new build or major refurbishments would reduce backlog maintenance in an existing, ageing estate and allow for the complete modernisation of plant, equipment and associated infrastructure in a manner compliant with the NHS Health Technical Memorandum and Health Building Note guidance.

New build or major reconfiguration activity would enhance environmental, decarbonisation and energy efficient measures, to support the long-term sustainability of the estate. The recent heatwaves and ever rising temperatures would require significant adaptation and reconsideration of traditional cooling in our healthcare settings, in addition to the impacts of flooding, storms and climate related change.

Where MIUs and associated services are removed from existing community hospital locations alternative use would be considered for the vacated space, which could potentially support future Service Strategy decisions for Women and Children's services, etc. There are also opportunities to be explored around the RPB development of Integrated Health and Wellbeing Hubs serving Health, Care and the Third Sector.

7.9.3.7 Impact of this Option

For patients this option could mean:

- Improved access to a broader urgent care offer within Powys, including both minor injury and minor illness provision and urgent ambulatory care – reducing the need to travel out of county to ED for some urgent care pathways.
- More consistent service availability across the county, with UCCs operating 7 days a week, 12 hours per day.
- Better access to diagnostics, including 7-day X-ray, same-day blood testing and enhanced point-of-care testing at UCC sites, resulting in more timely assessment, diagnosis and treatment, reducing delays caused by limited diagnostic availability.
- Support a clearer and more understandable urgent care offer, supported by NHS 111 triage and signposting.

This option could mean:

- Improved clinical decision-making, with senior clinical leadership and advanced practitioners available.
- Safer care through reduced lone working and stronger clinical governance.
- Better support for people with frailty, multi-morbidity and urgent illness needs, through closer working with urgent community response and wider community services.
- Retention of a broader geographic footprint than the 2-site option, helping to mitigate access impacts for some communities.
- Enhanced diagnostics, seven-day radiography, same-day blood testing, point-of-care testing, senior clinical decision-makers and advanced practitioners would support more timely assessment, diagnosis and treatment within Powys.

- Closer integration with NHS 111, primary care, ambulance services, urgent community response, frailty pathways and wider community services would improve continuity across the urgent care pathway and support patients to receive the right care, in the right place, at the right time.
- Stronger sustainable service model which is more clinically effective but less cost effective than the 2 site model.

However, the changes proposed would result in some patients, service users, carers, visitors and staff travelling further to access urgent care and diagnostic services, following changes to the MIU and X-ray service footprint. The MIU at Ystradgynlais would close; X-ray services at Machynlleth and Ystradgynlais would close permanently; and X-ray services at Welshpool would remain until the new UCC in Newtown becomes operational, after which the Welshpool X-ray service would also close.

Travel modelling shows that under the three site urgent care model, mean travel time would increase from 20 minutes 43 seconds to 23 minutes 50 seconds, with 91.2% of households remaining within the 45-minute benchmark and around 98.8% within 60 minutes (based on private transport).

The access impacts include longer journeys for urgent care and diagnostics; increased travel costs; greater reliance on private transport, ambulance services, public transport or family support; and potential delays in seeking same-day care where travel is more difficult. These impacts are likely to be greater for older people, disabled people, carers, Welsh language speakers, rural communities and people experiencing socio-economic disadvantage, particularly where public transport is limited or where people do not have immediate access to a car.

A public transport accessibility assessment summary is provided below:

Figure 117: Public transport accessibility: Urgent Care options[67]

Option	Service Configuration	Public Transport Position	Same-Day Return & Equity Considerations
Do Current	MIUs at Welshpool, Llandrindod Wells, Brecon and Ystradgynlais	Widest geographical spread and shortest public transport journeys overall.	Strongest same day return profile due to four access points.
UC013	UCCs at Newtown and Brecon with MIIU at Llandrindod Wells	Retains north, mid and south Powys access points and preserves Llandrindod Wells as a transport hub.	Better public transport position for Builth/Llanwrtyd, Llandrindod/Rhayader and Knighton/Presteigne than UC013ii.
UC013ii	UCCs at Newtown and Brecon	Good access along the T4, X75, X76 and X85 corridors but removes Llandrindod Wells as an urgent care destination.	Increased journey complexity and reduced same day return feasibility for Llandrindod/Rhayader, Knighton/Presteigne and Builth/Llanwrtyd.

[67] https://www.traveline.cymru/timetables

Delivery of the anticipated benefits would depend on workforce availability, diagnostic capacity, estates readiness and the safe transition of services from Welshpool to Newtown; Welsh-language provision would also require continued workforce planning and monitoring to ensure that the changes do not reduce access to services through the medium of Welsh.

A full Integrated Impact Assessment for this option is found in appendix Z.2.

7.9.4 Local Urgent Care Centres (UCC) on 2 sites

Under this proposal, two UCC would be developed in Newtown and Brecon, operating from 8:00- 20:00, seven days a week. The centres would provide better access to same-day diagnostics, including seven-day, blood testing and enhanced point-of-care testing, supporting more timely assessment, diagnosis and treatment within Powys, as well as appropriate access and referral pathways, including ambulatory care.

Figure 118: Summary of proposed 2-site urgent care and diagnostics configuration

Service	Locations	Operating Model
Urgent Care Centres (UCC)	Newtown and Brecon	Open 08:00-20:00, 7 days per week
X-ray Services	Newtown, Llandrindod Wells and Brecon	Llandrindod Wells open 09:00-17:00, 5 days per week Newtown and Brecon open 08:30-18:30, 7 days per week
Weekend X-ray	Newtown and Brecon	
Additional X-ray Provision		
Ultrasound Services	Main diagnostic sites	Part-week provision
Point of Care Testing (POCT)	Selected sites	Enhanced provision

The model would also strengthen care closer to home through an urgent community response service operating from 8:00-20:00, seven days a week, alongside potential short-stay assessment and treatment beds, subject to the outcome of the physical health options. GP practices would continue to provide urgent care through their GMS contract, with minor injury services offered by practices where there is no nearby PTHB MIU. GP out-of-hours urgent care, urgent dental care, urgent eye care through optometry and the Common Ailments Scheme through community pharmacies would also continue.

Figure 119: Local Urgent Care Centres on 2 sites (option 13ii)

What changes from the current model?	What stays the same as the current model?
• Reduction in number of Units from four to two • Welshpool Unit relocates to Newtown (following development of the Rural Regional Centre) • Ystradgynlais Minor Injury Unit closes • Llandrindod Wells Minor Injury Unit closes • Brecon Unit becomes an Urgent Care Centre • Newtown Unit established as an Urgent Care Centre • X-ray provision at Ystradgynlais closes • X-ray provision at Machynlleth closes • X-ray provision at Welshpool closes (following relocation to Newtown) • X-ray provision expands to a 7-day service with extended hours at operational sites • Additional Point of Care Testing introduced across operational sites • Additional Blood testing introduced across operational sites • Urgent care pathways expanded, including ambulatory referral pathways • Short stay assessment and treatment beds introduced (step-up capacity) • Redistribution of activity to remaining sites • A refinement of Minor Injury Supplementary Services to reflect local population need • Addition of Triage Nurse per site • Addition of dedicated Professional and Clinical Leadership roles • Addition of Advanced Practice Roles	• Welshpool Unit continues to operate until relocation to Newtown • Brecon Unit continues to operate • X-ray provision continues at Newtown (extended hours) • X-ray provision continues at Brecon (extended hours) • X-ray provision continues at Llandrindod Wells • GP practices continue to deliver urgent care through GMS • GP Out of Hours continues to operate • Urgent Eye Care through Opticians continues to operate • Common Ailment Scheme through Pharmacies continues to operate • Minor Injury Supplementary Service continues as part of the overall model

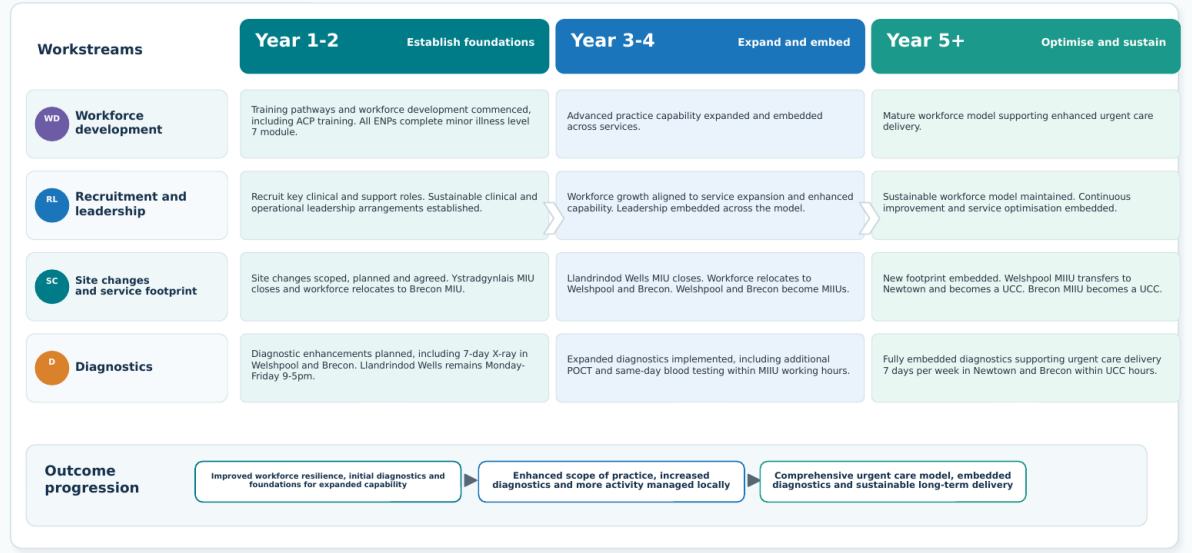
Benefits	• Concentrates workforce to support service delivery • Improves ability to staff rotas safely • Increases consistency of service offer across sites • Improved clinical governance and leadership capacity • Reduces reliance on external providers by increasing local capability • Improves clinical capability through increasing access to diagnostics and treatment, reducing out of county travel • Increased the clinical scope of the service offer • Improves integration of urgent care pathways and patient flow • Supports the strategic direction of more urgent care delivered in the community
Risks	• Increased travel time for some populations accessing urgent care • Reduced access to PTHB urgent care services within 45-minute travel • Increased reliance on external providers for some populations • Increased demand on remaining sites • Disproportionate impact on access for populations in Mid Powys • Variation in service offer across sites during transition • Dependency on recruitment to new roles • Dependency on workforce training, development and recruitment to deliver expanded service model • Dependency on capital investment to deliver proposed changes
Trade-off(s)	• Improves workforce resilience at the expense of local access • Reduces number of sites in exchange for service sustainability • Improves cost efficiency at the expense of geographic access • Improves service quality at the expense of increased overall cost • Improves leadership capacity and service capability at the expense of increased investment

This option provides a significantly improved urgent care service offer than is currently available and it meets all 10 of the NHS delivery expectations for UCCs in Wales (see figure 120). This proposal delivers even stronger workforce sustainability and cost efficiency, but with greater challenges with access to services particularly in the Mid Powys area.

7.9.4.1 Indicative Phasing for this Option

The below timeline shows the indicative phasing for this option

Figure 120: Local Urgent Care Centres on 2 sites: Indicative phasing (Option 13ii)



7.9.4.2 Commissioning Assumptions

- Whilst PTHB does not pay for most ED attendances (ED activity is funded by host commissioners in the main), both Urgent Care options would see the Health Board benefit by c.£535k from those providers where there are financial charges in place. Furthermore, a reduction in ED attendances would benefit the system by reducing

unnecessary A&E attendances and risk of admission across our provider partner organisations.

- Minor injury and minor illness attendances only have been used to model the potential repatriation of activity from ED providers.
- ED out of hours attendance has not been included in the modelling.
- SDEC out of county admissions have also not been included in the modelling.
- Clinical input from other providers (GP SLAs and Supplementary Services) reduces as PTHB clinical team is recruited.

7.9.4.3 Workforce Assumptions

The workforce assumptions for this option are based on the development of two UCC operating across two sites. The model assumes a broader urgent care offer than the current MIU model, with enhanced clinical assessment, treatment, diagnostics and referral pathways.

The workforce model is demand-led, with practitioner staffing scaled to projected activity across the two sites. Clinical contact time has been modelled using projected annual demand converted into average daily demand, with assumptions applied for clinical assessment time per patient and maximum clinical contact time within each shift.

The model includes fixed site-based staffing requirements to support safe and consistent delivery. This includes a triage nurse and Healthcare Support Worker per site per shift, alongside site and service leadership. A minimum safe staffing assumption of one Advanced Clinical Practitioner and one Enhanced Clinical Practitioner or Enhanced Nurse Practitioner per UCC site per shift has been applied.

By consolidating the enhanced urgent care model onto two sites, this option supports greater workforce resilience, clearer clinical leadership and more consistent use of advanced practice skills. It also reduces duplication across site-based staffing when compared with a three site model, while maintaining the staffing required to safely deliver an enhanced urgent care offer.

The model also assumes increased radiography capacity to support extended hours and seven-day diagnostic provision with increased POCT capability and capacity. Existing diagnostic demand would need to be delivered safely from the future configuration, with clear alignment between urgent care opening hours, X-ray, point-of-care testing and blood testing.

Indicative workforce impact

This option could affect staff working across MIUs, urgent care, diagnostics, radiography, point-of-care testing, urgent community response, administration, healthcare support and advanced or enhanced practice roles described in the proposed model. Potential impacts may include changes to team structure, work location, role, duties, skill mix, supervision arrangements, working patterns, travel and development requirements.

The extent and distribution of these impacts have not yet been determined. No assumptions are made at this stage about individual staff outcomes; these would be assessed following consultation through staff engagement, equality assessment and the applicable organisational change and consultation arrangements.

Given the greater consolidation of urgent care and diagnostic provision under this option, staff impacts may be more significant for those currently working from sites where MIU or X-ray provision would change or cease, particularly where future roles are based on a different location or require different competencies

To proceed safely, implementation would need to be phased and supported by clear workforce, quality and safety checkpoints. Following consultation and subject to the preferred option, a detailed workforce plan would confirm baseline and future establishments, including substantive, bank and agency staffing, skill mix, clinical leadership, training, supervision, workforce development needs and any additional recruitment requirements. The plan would also set out implementation phasing, transitional arrangements, workforce readiness and key dependencies across diagnostics, urgent community response, primary care, mental health and wider community services.

7.9.4.4 Financial Appraisal (Revenue and Estate Implications)

Figure 121: Local Urgent Care Centres on 2 sites: revenue implications (Option 13ii)

Proposed WTE	Baseline £k	Investment/ Disinvestment £k	Commissioning savings £k	Net Investment £k
52	2,837	10	-850	-840

- Baseline WTE - 52
- Baseline WTE & £k includes current staffing costs for MIU and Radiology services.
- Baseline does not include current commissioning spend, reductions in which would drive an element of the savings.

Figure 122: Local Urgent Care Centres on 2 sites: phased revenue implications (Option 13ii)

Option net investment phasing (rounding to £k) - Incremental						
	Y1	Y2	Y3	Y4	Y5	**Recurrent**
Gross investment	543	543	134	134	134	**1,490**
Gross disinvestment	-740	0	-740	0	0	**-1,480**
Gross commissioned savings	-29	-121	-233	-233	-233	**-850**
Net Investment	**-225**	**422**	**-839**	**-98**	**-98**	**-840**

- The current phased model does not yet fully reflect the workforce risks, operational overlap and associated cost implications that would inevitably arise during the transition from one model to the other

The phasing assumptions are:

- Fourth site closes in Year 1.
- Two sites build to MIIU over yrs 1 to 2 - phased equally.
- Third MIU remains open until Year 3 when it closes.
- Two sites build to UCC over Years 3 to 5.
- Closure of fourth site in Yr 1 results in increased commissioning spend.
- Category 1 (minor injuries) ED attendances repatriated in line with MIIU development over Years 1 and 2.
- Category 2 (minor illness) ED attendances repatriated, and all other commissioning savings phased in line with UCC investment over Years 3 to 5.

7.9.4.5 Capital Impact of Option

The capital investment in the rural regional centre model has been established with Welsh Government as part of the dialogue around a forward look capital programme, which has helped outline future NHS spending needs. This programme would be further informed by the outputs from the Better Together Service Strategy and enable a more defined Estates Strategy to be developed for PTHB to underpin the much-needed modernisation of the estate. Future business case submissions would be able to draw a more distinct and confident association between the long-term service strategy and the investment needed for a fit for purpose built environment.

The first phase of the North Powys, Newtown, Health and Wellbeing Campus has progressed to Final Programme Business Case level for the Integrated Health and Wellbeing Hub. The intent for Phase 2 would be to replace and relocate the current hospital into the centre of Newtown and the planning for this would incorporate the required UCC. Welsh Government are aware of the scope and scale of Phase 2 which is included in an 'endorsed' Programme Business Case for the campus, but no capital funding is currently secured.

The proposal for Breconshire War Memorial Hospital would require a reconfiguration of the existing Minor Injuries Unit to create an UCC. No funding has been secured.

7.9.4.6 Estate Implications

The creation of two UCCs on two rural regional centres, in a fit for purpose and modern patient environment, would enable more focussed technical Estates and Facilities support in fewer locations, resulting in an improved experience for both patients and staff. The capital investment in new build or major refurbishments would reduce backlog maintenance in an existing, ageing estate and allow for the complete modernisation of plant, equipment and associated infrastructure in a manner compliant with the NHS Health Technical Memorandum and Health Building Note guidance.

New build or major reconfiguration activity would enhance environmental, decarbonisation and energy efficient measures, to support the long-term sustainability of the estate. The recent heatwaves and ever rising temperatures would require significant adaptation and reconsideration of traditional cooling in our healthcare settings, in addition to the impacts of flooding, storms and climate related change.

Where MIUs and associated services are removed from existing community hospital locations alternative use would be considered for the vacated space, which could potentially support future Service Strategy decisions for Women and Children's services, etc. There are also opportunities to be explored around the RPB development of Integrated Health and Wellbeing Hubs serving Health, Care and the Third Sector.

7.9.4.7 Impact of this Option

For patients this option could mean:

- Improved access to a broader urgent care offer within Powys, including both minor injury and minor illness provision and urgent ambulatory care – reducing the need to travel out of county to ED for some urgent care pathways.
- More consistent service availability across the county, with UCCs operating 7 days a week, 12 hours per day.
- Better access to diagnostics, including 7-day X-ray, same-day blood testing and enhanced point-of-care testing at UCC sites, resulting in more timely assessment, diagnosis and treatment, reducing delays caused by limited diagnostic availability.
- Support a clearer and more understandable urgent care offer, supported by NHS 111 triage and signposting.

This option could mean:

- Consolidating urgent care onto two sites would further strengthen clinical governance, reduce unwarranted variation and improve workforce resilience providing an even stronger sustainable service model which is more clinically effective and cost effective.
- Provide safer care through reduced lone working and stronger clinical governance.
- Better support for people with frailty, multi-morbidity and urgent illness needs, through closer working with urgent community response and wider community services.
- Enhanced diagnostics, seven-day radiography, same-day blood testing, point-of-care testing, senior clinical decision-makers and advanced practitioners would support more timely assessment, diagnosis and treatment within Powys.
- Closer integration with NHS 111, primary care, ambulance services, urgent community response, frailty pathways and wider community services would improve continuity across the urgent care pathway and support patients to receive the right care, in the right place, at the right time.

However, the changes proposed would result in some patients, service users, carers, visitors and staff travelling further particularly in the mid Powys region to access urgent care and diagnostic services, following consolidation onto two enhanced UCC. The Welshpool MIU and X-ray service would remain until the Newtown UCC becomes operational, after which

both would close. The move to Newtown would part mitigates against the removal of service from the mid region and additional activity has been modelled into the north and south UCC to reflect this.

This option would result in the closure of MIUs at Ystradgynlais and Llandrindod Wells. Routine weekday X-ray services would continue at Llandrindod Wells, whilst X-ray services at Machynlleth and Ystradgynlais would cease permanently. The impact would be a reduction in locally accessible urgent care and diagnostic services, requiring some patients to travel further to access equivalent services. Alternative primary care and secondary care pathways may help mitigate some of these impacts, although may not fully replace local service provision.

Travel modelling shows that under the two site urgent care model, mean travel time would increase from 20 minutes 43 seconds to 29 minutes 35 seconds, with households within the 45-minute benchmark reducing from 95.3% to 83.1%. Households over 45 minutes would increase from 3,483 to 12,421, although around 98.5% remain within 60 minutes (based on private transport).

The access impacts include longer journeys for urgent care and diagnostics; increased travel costs; greater reliance on private transport, ambulance services, public transport or family support; and a greater risk that some people may delay seeking same-day care where travel is more difficult.

These impacts are likely to be greater for older people, disabled people, carers, Welsh speakers, rural communities and people experiencing socio-economic disadvantage, particularly where access to a car is limited or public transport is not a realistic option for urgent care.

A public transport accessibility assessment summary is provided in section 7.9.3.7 (figure 118).

Concentrating activity onto two sites may create additional pressure at the retained centres, particularly during periods of high demand. The option is also dependent on sufficient workforce and diagnostic capacity, capital and estates readiness, and effective community, telephone and digital alternatives; these would need to be developed without disadvantaging people who are digitally excluded.

A full Integrated Impact Assessment for this option is found in appendix Z.2

7.9.5 Patient Perspective

From a patient perspective using our services, many of the pathway changes described would mean fewer patients need to be admitted into hospital beds, and if they do require hospital admission, they are more likely to have a safe and timely discharge back home. More patients would be seen at home or in the community through a more proactive prevention model and intermediate care service providing urgent care response within two hours.

Introducing Delyth Field

Delyth is 75 years old and lives on the farm in her own bungalow close to her son Iolo and his partner Meinir. Her daughter Rose also lives close by. Delyth remains independent at home, although she has found helping on the farm increasingly difficult and exhausting, with her mobility slowing down and her memory not as good as it used to be.

Delyth is heading out for a walk on Sunday lunchtime and trips on the mat as she is leaving the house. She falls onto the ground and injures her left wrist. She is unable to stand up on her own and pushes her call help alarm that she wears as a pendant around her neck. Rose is contacted and attends the house within 30 minutes. She safely helps Delyth up onto a chair and recognises that she needs to be assessed and will likely need an X-ray of her wrist. Rose did notice that Delyth has been a bit more forgetful in the last few days and going to the toilet more frequently.

Under our current urgent care services in Powys…

Rose takes Delyth to the nearest ED where her wrist injury can be assessed and treated. This is a 45-minute drive. Delyth also has some additional investigations completed in relation to her increased urinary frequency and reduced cognitive function.

Delyth is assessed and triaged but will likely have to wait in the reception area on a chair before being seen and treated. Delyth will require support with some activities of daily living to go home safely. She is told she is both dehydrated and has a urinary tract infection alongside having broken her wrist.

Delyth is advised she can go home to live with Rose if the family are able to support with her needs. Rose works full time and does not have a safe environment for Delyth to move in with her. Delyth is advised that she will need to be admitted onto the frailty assessment unit in the hospital until support at home can be sourced.

Rose gets home in the early hours of Monday morning and sends an email to her manager explaining the situation and asking for the morning off so she can catch on her sleep.

Under the options we are proposing for future urgent care services in Powys…

Rose would check the PTHB website and find a contact number for the nearest UCC and then drive Delyth there. Her injuries would be assessed and treated, and additional investigations completed in relation to her increased urinary frequency and reduced cognitive function.

It would be confirmed that she is both dehydrated and has a urinary tract infection alongside having broken her wrist.

Treatments and follow up visits would be arranged within Powys, with additional support from the Intermediate Care service on discharge to support Delyth to return home with reablement and support to maintain independence.

Reviews and additional blood tests, if required, would be arranged and Delyth would then be discharged back to her GP practice where she would be reviewed through the Proactive Care

MDT to reduce her future risk of falls and connect her with community supports to promote strength and balance.

Alternatively, if it is felt that Delyth needed further clinical assessment or some inpatient rehabilitation, she may be admitted to a step-up bed in a Powys community hospital for up to 72 hrs depending on her needs and then discharged home with support as required from the Intermediate Care team.

7.9.6 Summary Option Comparison

The table below provides a summary comparison of the recommended options against baseline comparators.

Figure 123: Urgent Care summary comparison of recommended options against baseline comparators

Urgent Care Options	Do previous – service configuration before temporary service changes (UC Option 001a)	Do current – service configuration currently (UC Option 001b)	Local Urgent Care Centres on 2 sites and Minor Injury and Illness Unit on 1 Site (UC Option 013)	Local Urgent Care Centres on 2 sites (UC Option 013ii)
Service footprint:	4 sites	4 sites	3 sites	2 sites
PTHB Service model adjustments	Pre-temporary	None	Enhance Significant	Enhanced Significant
PTHB Workforce (WTE) UCC only	-	28.9	40.7	26.1
PTHB Workforce WTE Diagnostics only	-	23.4	28.4	25.4
PTHB UCC Demand assumptions	-	23,802	35,954	49,698
Financial costs minus savings (£m)	£3.3	£2.9	£3.1	£2.1
Financial impact vs current 001b (£m)	£+0.4	-	£+0.1	£-0.8
Non - financial appraisal score	50.55	62.4	100.35	88.5
Direct cost per attendance	-	£124	£87	£60
Estates value	A - Low	A - Low	C - Significant	C – Significant
Estate Feasibility	Green	Green		

High Level Assumptions

- WTE includes 26% headroom; costing uses midpoint of AfC scales.
- Facilities and other overhead costs are excluded.
- Commissioning assumptions across options include reduction in ED attendances and cost savings for some providers, adjustments to Local Supplementary Services.
- Option 013 excludes increased pathology / blood-run costs; SDEC out-of-county admissions impact
- All options currently modelled to year 0 for costs, activity and WTE
- 005 No Urgent Care Centre Sites, but includes 3 sites for Diagnostics

Category for Initial Estate Assessment Feasibility and Value	Funding reasonably expected to be available	Welsh Government aware of project, but funding not secured	Funding is not currently on any capital plan / not fully defined	Significant issues with feasibility, deliverability, major disruption
	A - Low <£0.50M	B - Medium £0.50>£7M	C - Significant £7M<£15M	D - Major >£15M

7.9.7 Urgent Care Options Assessed and Discounted

The Step report in appendices Z.5 provides further detail on the options development process, and decisions taken in relation to the discounting of options. Below is a summary of the range of options that were assessed and discounted.

A number of different urgent care approaches were assessed during the appraisal process. These included options that retained existing arrangements with limited change, options that reduced the number of local units, options that close all MIUs, and options that relied more heavily on community and GP-based care.

Options that kept or only modestly improved the existing MIUs, across two, three, or four sites, raised concerns that they did not sufficiently improve integration with diagnostics and wider urgent care, did not adequately address growing demand, and did not deliver enough overall change to address the issues in the Case for Change.

An enhanced model of MIIUs, without the full UCC offer, was assessed as a significant improvement in scope of provision in county but does not fully enable the service integration with other physical health inpatient and community services that the shortlisted options make possible.

An option to close all MIU s and rely entirely on GPs and community services raised significant concerns around gaps in urgent care coverage, increased travel for patients, and impact on neighbouring services; it assessed poorly against patient impact criteria.

Overall, the options taken forward were considered more able to support improved integration between urgent care, diagnostics and wider community services, while balancing local access, workforce resilience and future sustainability.

8. Mental Health (Inpatients and Community Model)

8.1 Background and context

Mental health inpatient and community services in Powys provide assessment, care and treatment across a broad pathway, from Local Primary Mental Health Support Services and the SPOA aligned to NHS 111 Press 2, through community, including psychological therapies, early intervention, specialist community provision, memory assessment, community mental health teams (CMHTs), crisis and inpatient care, to commissioned out-of-county specialist provision.

For this phase, scope includes older adult community services, sanctuary provision, inpatient services and repatriation of selected out-of-county activity.

The geography of Powys impacts how services can be delivered. Powys has a dispersed rural population, and some communities are a considerable distance from inpatient, community and specialist services. Travel can be difficult for patients, families and staff, while some specialist care cannot be delivered locally because of the scale, acuity or nature of need. Mental health care in Powys is therefore delivered through a combination of local community and inpatient services, telephone and digital access routes, partnership working and commissioned pathways outside the county. The model must balance accessible local provision with safe and appropriate specialist care for people with needs that cannot be met locally.

Demand is increasing across adult and OAMH services. Growth is particularly evident in early intervention services, trauma therapy, neurodivergent support and care for people with multiple or co-occurring needs. Mental health services are also responding to presentations associated with poverty, social disadvantage, isolation, housing issues, stigma, chronic physical health conditions, learning disability and neurodivergence. Together, these factors create pressure across access, workforce, performance, estates, clinical governance, data quality and out-of-county pathways. A coordinated partnership response is therefore required.

8.2 Current configuration of services

8.2.1 Inpatient and specialist provision

The current inpatient configuration supports adults and older adults with functional and organic mental health needs. Inpatient services are provided at Llandrindod Wells (10 beds), Bronllys (18 beds) and Ystradgynlais (10 beds), giving 38 beds across mid and south Powys. There is no inpatient provision in north Powys, so patients travel south or out of county. Crug Ward in Brecon and the hospital day services at Brecon and Ystradgynlais have been temporarily closed since March 2020.

Alongside local inpatient care, the current model relies on specialist provision outside Powys when a person's needs cannot be met within the county. This includes specialist, secure, low secure, medium secure, Psychiatric Intensive Care Unit and other commissioned placements for people with complex and persistent mental illness, mental disorder, learning disability or higher acuity needs.

Safe and effective care depends on availability of local ward capacity and the quality of robust commissioned pathways, transport, provider communication, digital information sharing and timely step-down or repatriation planning.

8.2.2 Community services and access

The mental health SPOA aligned to NHS 111 Press 2, provides a central route for triage, referral management, advice and assessment. It supports the open-access model by helping people reach the right service and reducing hand-offs between services.

Community mental health services in Powys include CMHTs, Local Primary Mental Health Support Services, psychological therapies, crisis response, dementia support and specialist community provision. These teams provide assessment, care and treatment for people with secondary mental health needs and support people to maintain wellbeing and independence in the community. For the purposes of Better Together, the Older Adult CMHTs currently comprises 51.08 WTE staff across five teams. These teams operate across a large geographical area. As a result, travel time, staff availability and local service coverage are significant operational considerations. Vacancies and absences can therefore have a greater operational impact than would be expected within a larger co-located service.

Crisis and dementia home treatment functions also form part of the current community model. Crisis Resolution and Home Treatment support people experiencing mental health crisis at home or in the community, while Dementia Home Treatment provides intensive community support for people with dementia and complex mental health needs.

Memory Assessment Services support assessment, diagnosis and onward planning for people with suspected dementia. However, the current pathway remains fragile, particularly in dementia home treatment, with gaps in alternatives to admission, step-down support and out-of-hours provision. The current community model therefore includes important access and treatment functions but does not yet provide a comprehensive range of responsive community alternatives across all parts of the county.

8.2.3 Data, Reporting and Outcomes

Mental health services use a range of systems for clinical records, activity, workforce and performance reporting. Across Wales limitations persist in data quality, standardisation, functionality and accessible outcomes information making it difficult to describe demand, activity, quality, experience and outcomes consistently across the pathway. National work is ongoing to improve and streamline systems, also the current electronic clinical records system is due to be replaced.

Outcome measurement is underdeveloped, including the consistent use of patient-reported outcome and experience measures. Stronger reporting is needed to assess changes in access, quality, recovery and experience over time.

8.3 Current Activity, Performance and Clinical Standards

8.3.1 Demand, Access and Waiting Times

Current modelling projects that referrals into adult and OAMH services may increase by up to 33% over the next 10 years without service redesign equating to a 14% increase in bed days [68]. This reflects increasing demand across age groups and specialties, including early intervention, preventative services, trauma therapy and support for neurodivergent people. This demand is already visible across access routes, assessment services, psychological therapies, community teams and crisis pathways.

Performance has improved in some areas. Adult Local Primary Mental Health Support Service assessments completed within 28 days increased to 78.7% in December 2024, close to the 80% national target. By March 2025, performance had exceeded the target, with 98% of people offered an assessment within four weeks of referral. Whilst this demonstrates progress in a timely access, pressures remain within the psychological therapies, secondary care coordination and wider community pathways. There were 626 clients on the autism assessment waiting list at the end of July 2026 with even more neurodivergent people experiencing mental health difficulties. There is also growing demand for specialist trauma therapies and more people with a learning disability being cared for in acute adult mental health settings; reinforcing the need for more integrated and flexible models of care.

Psychological therapy waiting times remain an area of challenge. In November 2024, 63.1% of patients waited less than 26 weeks to start psychological therapy against a national target of 80%. Performance improved to 87% by May 2026. Demand is also increasing for evidence-based psychological interventions, including trauma-focused therapies, Eye Movement Desensitisation and Reprocessing and Cognitive Behavioural Therapy Care. Care and Treatment Plan compliance also remains below the national target. PTHB-provided services achieving around 80.6% to 80.7% for adult patients with valid Care and Treatment Plans, compared with the 90% national target. These measures describe a current position where initial assessment performance has improved, but access to therapy and coordinated secondary care planning remain under pressure.

[68] PTHB, *Better Together:* *Mental Health Technical Chapter*- Better Together Case for Change

Out-of-county commissioned activity is projected to increase by 13% over the next 10 years, equating to a 19% increase in commissioned bed days for adults and older adults. These projections point to pressure on both local provider services and commissioned out-of-county pathways, particularly where people require specialist inpatient, secure or high-acuity provision not available locally.

Specialist placements are a significant part of the current mental health pathway. In 2025/26 there were 66 adults in independent sector specialist or low secure placements under Section 117 aftercare arrangements[69], with a total cost of £820k in 2025/26. Specialist placement use reflects the needs of a small but high-complexity cohort and has implications for care coordination, quality oversight, finance, transport and long-term pathway planning. Some out-of-county specialist provision will continue to be required, but the scale and cost of commissioned placements forms part of the current pressure across the mental health pathway.

The suicide rates in Powys (5-year rolling average age standardised rates per 100,000 population) have remained relatively stable over the past 10 years or so. The rates in Powys were similar to the average rates for Wales, with overlapping confidence intervals indicating no statistically significant difference between Powys and Wales [70]. Incidents of suicide remain an area of focus and concern, with SPOA, rapid response and postvention services forming part of the current response. Self-harm and mental health presentations through emergency pathways are also relevant to crisis, urgent care and cross-border flow.

8.3.2 Workforce, Specialist Placements and Financial Pressure

Mental health services are experiencing workforce and temporary staffing pressures. Nurse agency expenditure reached £2.93m in 2025/26, with a further £1m spent on bank staff.[71] The current position records persistent vacancies, recruitment challenges and reliance on temporary staffing. Mental health nursing vacancies improved from -57.98 WTE in 2022 to -40.13 WTE in 2024 [72], but a staffing gap remains and in 2025/26 there were 44.29 vacancies[73]. Some key roles in psychology and social work also remain unfilled and in 2025/6 [74]£3.1m was spent on medical locums to cover long-standing vacancies. [75]

The service model and rural geography compound workforce pressures. Mental health wards are currently dispersed across Llandrindod Wells, Bronllys and Ystradgynlais, whilst community teams are spread across a large rural county. This makes it more difficult to move resources between locations, and time spent travelling between clinics or domiciliary visits is greater than would be the case in an urban area. Workforce availability, skill mix, vacancies, absence and reliance on temporary staffing are therefore central to the current service position.

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[69] PTHB, Better Together: Mental Health Technical Chapter
[70] PTHB, Better Together: Mental Health Technical Chapter
[71] PTHB, IIA Level 2 Assessment Mental Health 2026
[72] PTHB, *Better Together: Mental Health Technical Chapter*
[73] PTHB, *Level 2 IIA Mental Health 2026*
[74] PTHB, *Mental Health Service Area Issues*
[75] PTHB, *Level 2 IIA Mental Health 2026*

Financial pressure is also linked to specialist placements, temporary staffing and commissioned pathways. Escalating costs from £4.7m in 2024/25 to £6.7m in 2025/26 are recorded for specialist private provider placements, Psychiatric Intensive Care Unit, low secure, medium secure and mental health acute beds. These pressures sit alongside wider service pressures in community and inpatient care, where demand, acuity and workforce capacity shape the ability to provide timely and sustainable support.

8.3.3 Assessment of Improvement Requirements against Clinical Standards and areas to be Improved by Proposed Future Model

It is important to note that Powys inpatient settings have achieved positive Health Inspectorate Wales reports in recent years. However, in terms of the ability to fully meet standards both now and in the future requires both transformation and improvement work to take place as described in the following table, with further detail on the underpinning standards provided in the service model Appendix P.2.

Figure 124: Assessment of improvement requirements to meet clinical standards for mental health

Standard / Requirement	Issue	Improvement impact
All-Wales Mental Health Patient Safety Standards	Current inpatient ward configuration does not fully support recommended therapeutic and safe ward environments.	Decreased patient safety risk, poorer patient experience, reduced therapeutic effectiveness.
SafeWards Model of Care	Whilst significant improvements have been achieved, existing ward environments limit full implementation of SafeWards principles.	Increased ability to prevent conflict, containment and restrictive practice.
Person-Centred Safety Planning	Need to fully deliver person-centred safety planning within current service configuration.	Increased effectiveness of risk management and crisis prevention.
Therapeutic Environment Standards	Current adult and older adult inpatient wards environments could improve to achieve optimum therapeutic environment.	Improved patient recovery outcomes and patient experience.
Functional Ward Standards	Ward layouts do not fully provide environments with sufficient activity areas, group rooms, safe outdoor space and could improve provision of gender-sensitive facilities.	Increased therapeutic activity, privacy and recovery-focused care.
Dementia-Friendly Design Standards	Older adult environments need to align with dementia-friendly design principles such as signage, colour coding and sensory spaces.	Decreased confusion, distress and environmental risk for patients with cognitive impairment.
NHS Building Note 03-01: Adult Mental Health Units	Existing estate may not fully comply with contemporary mental health design standards.	Environmental and safety standards meet best practice expectations.

Standard / Requirement	Issue	Improvement impact
Environmental Security Standards	Current environment does not fully support the required balance of relational, procedural and environmental security.	Decreased operational and patient safety risks.
Mental Health Safe Discharge Standards for Wales	Deficit in proactive in-reach support to inpatient settings.	Reduced delayed discharge and reduced lengths of stay.
Mental Health Safe Discharge Standards for Wales	Specific deficit in psychological in-reach support during admission and discharge pathways.	Improved discharge readiness and continuity of care.
Mental Health Quality Statement (2026)	Full implementation of open-access, trauma-informed and flexible care models requires significant transformational change.	Achieving national quality expectations and strategic objectives.
Self-Harm Quality Statement (2026)	Current system requires transformation to consistently deliver all six pillars of high-quality self-harm care.	Continuity in care quality and patient outcomes.
RCPsych Community Mental Health Standards	Current model requires redesign to fully meet standards relating to access, integrated care, physical health, patient experience and workforce requirements.	No variation in quality, equity and service user experience.
RCPsych CCQI Standards for Acute Inpatient Services for Working Age Adults (7th edition)	Covers assessment; care planning and treatment; referral, discharge and transfer; patient and carer experience; staffing and training; environment and facilities; and governance.	Assured compliance.
NHS England Culture of Care Standards for Mental Health Inpatient Services (2024)	Challenges in meeting therapeutic environment, safety, relational care, activity, staffing support and person-centred practice, but does not evidence a systematic assessment against all 12 Culture of Care commitments.	Create modernised therapeutic environments for all inpatient settings improved therapeutic relationships, staff support, equality, avoiding harm, needs-led care, choice, environment, activities, therapeutic support and transparency.

The most significant areas where current services are challenged to meet contemporary standards are:

1. Inpatient therapeutic environment and estate standards (including NHS Building Note 03-01 and dementia-friendly design standards).
2. Patient safety standards, including SafeWards, therapeutic environments, environmental security, person-centred safety planning, the RCPsych CCQI acute inpatient standards (7th edition), and the NHS England Culture of Care Standards for Mental Health Inpatient Services (2024).

3. Safe discharge standards, particularly the lack of adequate psychology and community in-reach support.
4. Mental Health Quality Statement requirements for open access, trauma-informed and flexible models of care.
5. RCPsych community mental health standards relating to modern integrated, recovery-focused mental health services.

8.4 Why no Change is not an Option

8.4.1 Demand, Complexity and Health Inequalities

Mental health services in Powys are experiencing increasing demand, acuity and complexity with costs escalating and workforce challenges, increasing. As mentioned previously, more people are presenting with needs linked to trauma, neurodivergence, poverty, isolation, housing insecurity, discrimination, stigma and chronic physical health conditions. The current model therefore needs to support people whose needs often extend beyond a single mental health diagnosis and require a coordinated response across mental health, physical health, social care, housing, primary care, voluntary sector support and specialist provision.

People living with severe mental illness experience significant health inequalities. Current evidence indicates that people living with severe mental health issues, including complex emotional needs, live up to 20 years less than the general population and are less likely to have their physical health needs met.[76] This reinforces the need for stronger integration between mental and physical health services, particularly for people with multiple conditions, dementia, learning disability, neurodivergence or other complex needs.

The Complex Emotional Needs pathway provides specialist assessment and interventions, but current service information records that it is unable to meet the needs of the most complex and vulnerable clients due to insufficient capacity and resource to deliver a comprehensive Dialectical Behaviour Therapy (DBT) programme. This sits within a wider pattern of increasing trauma-related need, neurodivergence, comorbidity and demand for psychological interventions. Without sufficient community-based capacity, people may wait longer for therapeutic support, require crisis intervention or move into more intensive parts of the pathway.

8.4.2 Workforce, Quality and Safety

Workforce sustainability is a central concern. Dispersed wards and teams, persistent vacancies, sickness absence, recruitment difficulties and reliance on temporary staff increase cost and reduce resilience, particularly in nursing, psychology and social work. These areas are directly relevant to quality, safety, consistency of practice and confidence in the current model.

The workforce position is closely linked to clinical quality and service governance. A clinical audit undertaken in early 2024 identified clinical governance shortfalls, resulting in Mental

[76] Better Together Case for Change

Health services being placed in internal escalated monitoring in March 2024[77]. Improvement work focused on areas including serious incidents, clinical policies, multidisciplinary reviews, training and Care and Treatment Plans which resulted in de-escalation in October 2024.

8.4.3 Community Alternatives, Crisis Response and Out-of-County Pathways

The current model lacks consistent alternatives to admission, sanctuary-style provision, step-down support and out-of-hours services. These functions are important for people experiencing mental health crisis, people who require short-term support to avoid admission and people who are ready to leave inpatient care but need further support before returning fully to the community. Without sufficient community-based alternatives, patient needs may escalate into crisis response, inpatient care and specialist placements. Without these options, needs may escalate into crisis response, inpatient admission or specialist placement.

This also creates pressures for partner agencies such as police and social care who also discharge powers under the Mental Health Act. Following assessments for acutely unwell individuals in the community where admission is urgently required delays in transfer to an appropriate bed if one is not available in County can be a challenge.

Cross-border flow and patient transport are also key challenges within the current model. Some specialist services are provided outside Powys, and the current position identifies inefficient cross-border patient flow linked to limited digital integration. Specialist mental health patient transport is also described as limited and expensive, usually involving private providers with escalating costs. In a rural county, distance, transport and communication between providers can have a significant impact on patient experience, family involvement and continuity of care.

The escalation of costs, patient acuity, staffing fragility and out-of-county placements make the current service model unsustainable. Without changes to pathways which deliver an increased focus on prevention, crisis response, step-down support and community alternatives, combined with consolidated inpatient services, the service pressures and associated costs are likely to continue to increase across both local and commissioned services.

8.4.4 Estate and Sustainability

Estates and geography significantly affect delivery. Current inpatient settings are unable to provide an appropriate therapeutic environment due to the estate, and small teams are dispersed across the county. This limits operational flexibility and contributes to variation in service quality and access.

Digital infrastructure, data quality and outcome measurement also need improvement. Multiple systems, limited standardisation and inaccessible reporting constrain service planning, evaluation and comparison. Improved digital capability could facilitate further understanding of demand, quality, patient experience, recovery and impact of service changes.

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[77] Powys Teaching Health Board, *Better Together: Case for Change*

8.5 What we have Heard Specifically about this Service Area

In addition to the feedback summarised in section 4, the following themes relate specifically to mental health inpatient and community services and have informed the future proposals.

8.5.1 Access, Navigation and Public Understanding

Engagement feedback identifies the need for easier access, clearer routes into support, better navigation and simpler pathways across mental health services. People described the importance of trust, involvement, demystifying the system, training and local champions. Feedback also highlights the need to clarify the mental health and wellbeing core offer, reduce stigma and communicate clearly with Powys communities.

The SPOA and NHS 111 Press 2 are important parts of the current access model, but feedback indicates that people still want pathways that are easier to understand and navigate. People need to understand where to go, what support is available and how to access help before needs escalate.

8.5.2 Integrated, Whole-Person Care and Coordination

Stakeholders support stronger integration between mental health, physical health, social care and third sector partners. Feedback identifies the need for whole-person care, integrated assessment, better communication and improved coordination across services. This is particularly relevant for people with severe mental illness, complex emotional needs, learning disability, neurodivergence, dementia, physical health needs or wider social needs.

Feedback also highlights fragmentation across services and poor integration of patient records and data systems. These themes align with the current service position, where mental health pathways rely on multiple teams, inpatient sites, community services, out-of-county providers, transport arrangements and digital systems. Improved integration is therefore central to improving experience, access and continuity of care.

8.5.3 Prevention, Crisis Support and Community-Based Care

Engagement feedback identifies the need for better community-based crisis support, alternatives to admission, sanctuary or safe place provision and stronger step-up or step-down pathways. Feedback also describes limited 24-hour community support and crisis response, with suggestions for crisis houses, sanctuary services and more home-based crisis care.

People also emphasised prevention, early intervention and recovery-focused support based on community models with home treatment options, local support and earlier access to help. This aligns with the wider need to respond before people reach crisis, reduce unnecessary admission and support recovery in the community where this is safe and appropriate.

8.5.4 Workforce, Travel and Equity

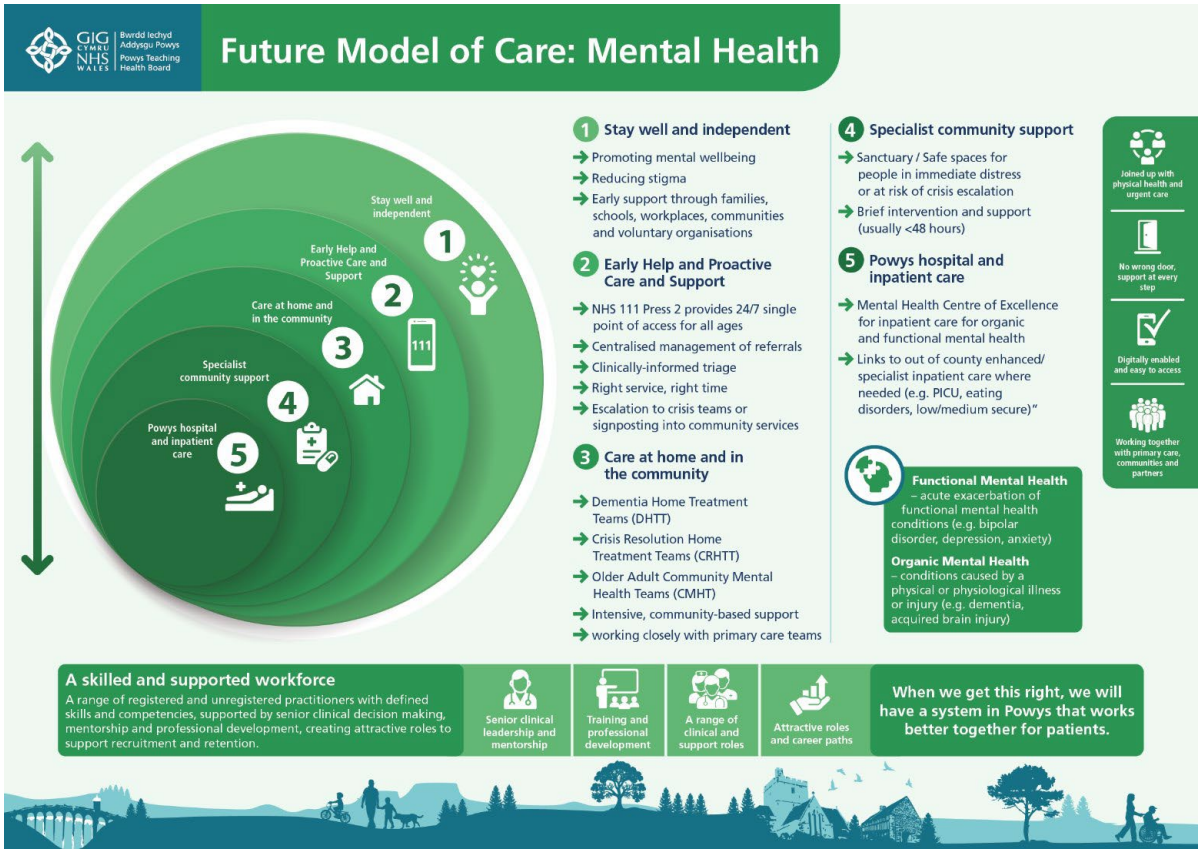
Engagement feedback identifies workforce sustainability, recruitment, retention, training and specialist workforce gaps as key issues. This reflects the current workforce position across inpatient and community mental health services, including vacancies, reliance on temporary staffing and the challenge of sustaining services across a rural geography.

Travel, transport and equity are also recurring themes. People raised concerns about geographic access, transport for patients and families, rural equity and the impact of centralisation on local service availability. In addition, there has been a rapid increasing in need form out of county placements with residents travelling as far as 320 miles away in Northumberland.

The current mental health model provides important local and specialist support, but is operating under pressure from increasing demand, rising complexity, workforce constraints, performance gaps, estate limitations, data challenges and reliance on out-of-county provision. Services need to support people earlier, provide clearer access, strengthen community alternatives, improve integration between mental and physical health and ensure people can access safe, coordinated care as close to home as clinically appropriate.

8.6 Service Model Proposals for the Future

Figure 125: A Future Model of Care: Mental Health



The future service model aims to deliver a modern, integrated, person-centred system providing timely, seamless, recovery-focused and sustainable mental health care in Powys. It would:

- Improve access to timely mental health support through open-access and “no wrong door” principles

- Prevent escalation to crisis and inpatient admission through early intervention and community-based support
- Deliver trauma-informed, recovery-focused care that empowers individuals and promotes choice
- Integrate mental and physical health care, improving outcomes for people with comorbidities
- Provide safe, fit for purpose inpatient environments when admission is necessary
- Support older adults and people with dementia with specialist care pathways.

The new model should enable a shift from reactive, hospital-based care to proactive, integrated and preventative support.

The future model supports delivery of the Powys Health and Care Strategy, the Powys Wellbeing Plan and the national legislative and policy framework described in section 2.2. The whole-system pathway spans access, assessment, community support, inpatient care and recovery, with integration and early intervention at its core.

Figure 126: Mental health future service model

Front door / access model	• SPoA aligned to 111 press 2 • 24/7 triage, assessment, brief intervention and navigation • "No wrong door" – all contacts receive support and direction
Inpatient model	• Functional and organic mental health inpatient beds • Enhanced MDT approach with integrated physical health support • Focus on shorter stays, recovery and structured discharge planning
Sanctuary / Safe Place (new)	• Non-admission model for crisis de-escalation (up to 48 hours) • Provides psychosocial interventions, calming environment and onward referral • Aims to avoid ED attendance and inpatient admission.
Community and prevention model	• Enhanced older adult community mental health services • Integrated support across health, social care and third sector • Wraparound, home-based and preventative interventions • Improved joint working to improve physical health
Recovery model	• Development of a Recovery College delivering co-produced education and self-management • Expanded peer support embedded across pathways

Care pathway design	• Access → triage → holistic assessment → MDT treatment → therapeutic activity → discharge & recovery
	• Strengthened with:
	  ○ Integrated biopsychosocial assessments
	  ○ Increased access to psychological therapies
	  ○ Stronger discharge planning and community step-down pathways
	• Improved joint working with physical health, social care and third sector

The target patient cohorts and pathways are:

Inpatient cohorts

The model supports closer integration between physical health, mental health and community services. People with dementia, cognitive impairment or organic mental health conditions should receive coordinated care based on need rather than service boundaries, supported by multidisciplinary working, mental health liaison, shared escalation pathways and closer alignment with social care and the voluntary sector, helping people receive earlier support, avoid unnecessary hospital admissions and experience smoother transitions between hospital and home.

- Functional Mental Health – these are patients requiring a short–medium stay recovery (e.g. up to 6 months)
- Organic Mental Health (e.g. dementia) – these are patients with behavioural/psychological symptoms and co-morbidities
- Sanctuary / Safe Place – these are for people presenting with a crisis requiring brief non-admitted intervention.

The criteria for admission includes:

- Acute deterioration or new onset mental health condition
- Not manageable safely in the community
- No requirement for higher acuity (e.g. Psychiatric Intensive Care Unit (PICU).

Community cohorts

This involves supporting people with:

- Mild–moderate mental health conditions (via primary care support)
- Severe and enduring mental illness
- Dementia and frailty (older adult pathways)
- Crisis or emotional/social distress
- Individuals requiring integrated physical and mental health care.

A specialist community model for older adults, aligned with inpatient and sanctuary services, is central to the proposal. It would provide a holistic, preventative offer across mental and physical health, primary care, social care and the third sector, based on patient needs, including short-term interventions, community liaison, support for people with organic conditions, physical health assessment and monitoring, home treatment and initial diagnostics.

The Sanctuary or Safe Place would provide a welcoming, non-admission setting for crisis de-escalation and brief observation outside normal working hours. It is intended to reduce ED attendance, crisis escalation and the need for Mental Health Act assessment where safe and appropriate.

In-reach into physical and mental health wards for OAMH care and core membership for Inpatient Mental Health MDTs for adults and older adults should have culturally sensitive practice, enhanced psychology input with trauma-informed care, and psychological formulation as a key feature of the model. The workforce model would be enhanced with occupational therapy, mental and physical health practitioners and liaison roles to in reach

into physical health settings and provide support to patients in residential settings, with a consolidation of older adult community mental health, memory assessment, Dementia Home Treatment and Crisis Home Treatment Teams into a holistic co-located service improving accessibility and experience for patients, families and carers.

Workforce and Digital requirements

The workforce model supports holistic, team-based care and reduced reliance on inpatient settings. It strengthens multidisciplinary working, psychological and trauma-informed capability, physical health expertise, peer and lived-experience roles, and skills aligned to recovery and community care.
At present the Older Adult Community Services do not provide any physical health monitoring to patients. This would be a fundamental change in the new model and appropriate skills would need to be introduced to training matrix for existing support workers where roles would be changed to include physical health.

Core components include:

- Medical leadership - Consultant psychiatrists and non-consultant medical staff
- Nursing workforce - Registered mental health nurses providing 24/7 care
- Psychology workforce -Consultant psychologists, senior psychologists, therapists
- CHC- Occupational therapists and assistants
- Support roles Healthcare support workers, peer support workers
- Wider system roles social workers, pharmacists, primary care/community teams
- Emerging roles Physician associates, advanced nurse prescriber.

Digital capability is a key enabler of access, integration and quality. Priorities include an interoperable Electronic Patient Record (EPR) across service, organisational and national boundaries; consistent use of patient-reported outcome and experience measures; telecare and virtual consultation; and digital tools for self-management and crisis prevention.

8.7 Future Service Model Benefits and Evaluation

The proposed option is designed to address the clinical standards and areas for improvement identified in Section 8.3, including requirements for safe and therapeutic inpatient environments, strengthened community-based care and safe, effective pathways. The future service model would provide a stronger basis for meeting these standards consistently, subject to the necessary workforce, estate, infrastructure and other enabling arrangements being in place.

Figure 127: Future service model benefits and evaluation metric

Expected Benefits	Potential evaluation metrics to assess impact of change
Improved access and navigation. Faster, easier access to the right support through a SPOA, NHS 111 press 2, clearer pathways and stronger links with community services.	• Compliance with Mental Health Measure, including waiting times and access; NR • Reduced ED attendances; patient satisfaction • Number of connections with 111p2 and SPoA activity
Better person-centred experience and outcomes More trauma-informed, person-centred care that supports recovery, reduces relapse and improves outcomes through earlier intervention and more joined-up support.	• Patient satisfaction; Patient Reported Outcome Measures (PROMs) • Improved recovery/reduced relapse proxy through 30-day readmission rates • Sanctuary repeats attendance within 30 days • Number of staff trained in trauma informed practice
More care closer to home Greater access to community, recovery-based, psychological and multidisciplinary support, including physical health monitoring for older adults, reducing the need for inpatient admission, hospital attendance and out-of-county care where safe and appropriate.	• Reduced ED attendances and inpatient admissions • Reduced average LOS for functional and organic admissions • Sanctuary attendances • Increase in community mental health service activity
More integrated physical and mental health care Better coordination between physical health, mental health, primary care, social care, third sector and wider partners, supporting more holistic and continuous care.	• Percentage of patients receiving physical health checks; • percentage of discharges with completed care plans; NR • PROMs; patient satisfaction NR • Inpatient admission intelligence
More sustainable workforce and service model including a more resilient multidisciplinary model with enhanced roles, improved skill mix, modernised working environments and stronger recruitment and retention.	• Average LOS for functional and organic admissions; • 30-day readmission rates; percentage of discharges with completed care plans; • Compliance with Mental Health Measure waiting times and access NR • Workforce business intelligence

Please note nationally reportable metrics are marked with NR

8.8 Future Service Pathways

Future service pathways are centred on NHS 111 Press 2 and the mental health SPOA, with holistic multidisciplinary assessment at the front door. This should support earlier intervention, shorter waits and more community-based treatment, reducing avoidable use of inpatient services, ED and out-of-county care.

Demand and Capacity modelling has been undertaken with clinical teams, who have considered alternative patient pathways and changes to patient flows to reflect different aspects of the service-change related to the future mental health service model described above. This work was informed by relevant local initiatives, external data, and, where possible, benchmarking is included. Demand and Capacity modelling assessed the impact of a stronger, proactive community offer and pathway efficiencies intended to prevent escalation, reduce avoidable secondary care admissions and improve effectiveness, aligned with Welsh Government policy and include:

- SPOA and associated reductions into secondary care as patient needs are met through alternative pathways.
- Open access model would help to reduce the number of follow-up appointments
- Virtual appointments increasing in line with national guidance
- Reduction in intentional self-harm-related admissions
- Reduction in ED and crisis attendances as a result of the SPOA, improved first response and new sanctuary model.
- Repatriation of specialist out-of-county inpatient activity through the development of an enhanced unit alongside the mental health inpatient services.
- Inter-service collaboration and integration of physical and mental health inpatient care and treatment for organic patients
- Increasingly informed approach to managing psychological trauma in acute settings combined with investment in DBT to reduce LOS and re-admission rates.
- Reduction in inpatient readmissions within 30 days and bed occupancy reduction due to more proactive care and shorter LoS.
- Reduced secondary care admission resulting from a strengthened community team with extended working hours.

The modelling uses two scenarios: Scenario B, which is realistic and achievable, and Scenario C, which is more aspirational. Using Year 0 as the baseline, it informed the future model, workforce requirements, commissioning assumptions and financial modelling. The summary focuses on outpatients, healthcare professional (HCP) contacts and inpatient activity.

8.8.1 Projected Mental Health Activity

In 2024/25 there were 50,853 outpatients and mental HCP professional contacts. The table below show how demand projections could change when the assumptions are applied in relation to service change or interventions and how this activity is distributed across Powys. It is anticipated 'open access' and increased digital offer would significantly support a potential reduction in referrals.

Figure 128: Mental Health HCP and Outpatients – Projected Activity

Mental Health HCP and Outpatients	North Powys	Mid Powys	South Powys	Total
Year 0 activity (Baseline 24/25)	24,241	9,711	16,901	50,853

Year 10 Scenario B: realistic / achievable	19,789	7,901	13,833	41,523
Year 10 Scenario C: aspirational	16,281	6,482	11,409	34,172

In 2024/25 there were 225 hospital admissions in Powys, with evidence indicating through the demand and capacity modelling that there are potential increases in the need for inpatient beds. However, there are international case studies (e.g. Trieste, Lille) suggesting a potential 30% shift from acute beds to the community in a national model for Wales which could potentially result in fewer patients needing to be admitted. In constructing the Powys Demand and Capacity models, the aim has been to identify the individual specific model of care and service change components (evidence-based) which, taken together, result in a shift of activity from inpatient care to community-based care.

Demand data highlights the projected need for an additional 10 beds in 10 years for mental health acute provision if the model of care does not change to prevent this. This does not include specialist private provision or PICU, medium and low secure which will always be required as cannot be provided within county. Adult acute private provision that is currently required due to demand outweighing capacity should be eradicated by the ability to enhance the Community Model, the environmental design of a consolidated site and enhanced care setting enabling more flexibility for Mental Health inpatient service provision within Powys.

The modelling has considered this intelligence and the existing evidence base in how investing in community mental health services, extending operating hours and improved joint physical and mental health care, intervening at earliest opportunity can support admission avoidance. The redesign of hospital environment and introduction of beds that can provide enhanced care based on individual needs of patients would mitigate the growing need for beds as well as an inpatient model that can better support mental health needs of patients in physical health settings.

Scenario B is described as realistic and achievable and scenario C is aspirational.

Figure 129: Mental Health Inpatient: Projected Activity

Mental Health Inpatient Activity	North Powys	Mid Powys	South Powys	Total
Year 0 activity (Baseline 24/25)	0	42	183	225
Year 10 Do Nothing	0	55	206	261
Year 10 Scenario B: realistic / achievable	2	47	182	231
Year 10 Scenario C: aspirational	3	42	168	213

Figure 130: Mental Health: Projected inpatient beds

Mental Health Inpatient Beds	North Powys	Mid Powys	South Powys	Total
Year 0 activity (Baseline 24/25)	0	10	28	38
Year 10 Do Nothing	0	14	31	45

Year 10 Scenario B: realistic / achievable	0	0	45	45
Year 10 Scenario C: aspirational	0	0	47	47

The inpatient bed requirement for scenario C is higher because it assumes all commissioned nonspecialist placements and some specialist placements are no longer required and reflects the bed requirements over two sites with enhanced care.

The recommended option retains some commissioned private provider.

Out-of-county beds are not included in the modelling baseline because recent admission caps and ward closures have prevented a sufficiently reliable dataset from being established.

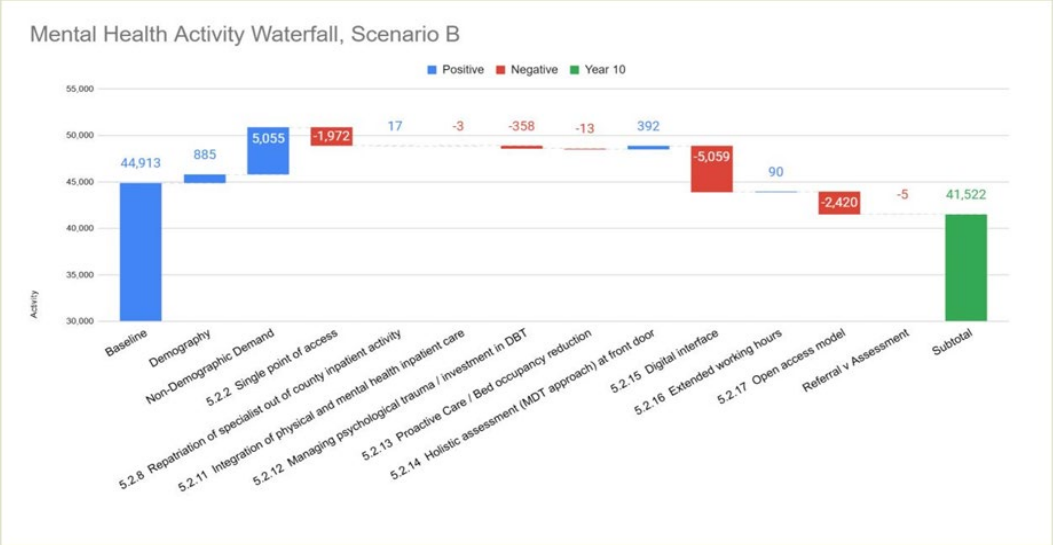
Assumptions made to support modelling of bed numbers relate to LOS and readmission, including : Integration of physical and mental health inpatient care and treatment for organic patients would improve patient outcomes, reducing organic inpatient activity and bed days (scenario B -5%, scenario C -10%); Increasingly Informed approach to managing psychological trauma in acute settings combined with investment in DBT would reduce adult inpatient admissions and bed days (scenario B -1%, scenario C -2%); Reduction in functional inpatient activity due to in-reach support and integrated community teams, (scenario B -2.5%, scenario C-5%); Extended working hours (reduce crisis admissions, scenario B -2.5%, scenario C -5%); Open Access allowing same day access and one at a time model of care would reduce functional inpatient activity (scenario B -2.5%, scenario C -5%); Reduction in LOS and reduced admissions would reduce bed occupancy, (scenarios B & C -5%).

8.8.2 Impact of Pathway Changes on Future Mental Health Service Demand

The proposed pathway changes would enable more people to be assessed and treated in the community through early intervention, crisis response and the sanctuary model. This is intended to reduce avoidable admissions. Enhanced inpatient provision, including five additional inpatient beds, would also support the repatriation of selected out-of-county activity. Delivery of these benefits depends on sufficient community capacity being available to meet future demand safely and provide care as close to home as appropriate.

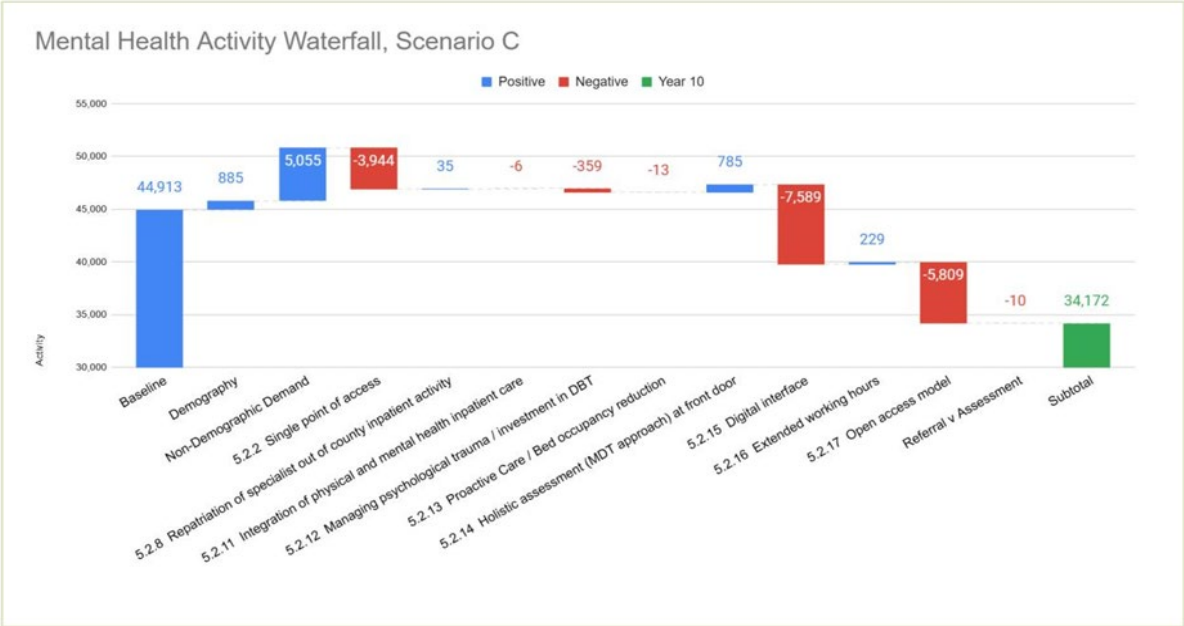
The chart shows the potential impact of pathway and efficiency changes in Year 10 based on the mid-range realistic and achievable scenario.

Figure 131: Mental Health Modelling Activity Waterfall, Scenario B



The chart below shows the potential impact of pathway and efficiency changes in Year 10 based on a more aspirational scenario.

Figure 132: Mental Health Modelling Activity Waterfall, Scenario C



The charts illustrate the potential effect of strengthened older adult community and inpatient services, the sanctuary model, the SPOA, repatriation, trauma-informed care, reduced LOS, improved digital capability and the open access model. Together, these changes could reduce referrals and release capacity while improving experience and outcomes.

8.9 Recommended Option

To deliver the new models of care described above and meet future needs, the long-standing challenges related to workforce fragility, reliance on out of county activity and associated escalation of costs, plus poor infrastructure and build environment must be addressed. The recommended Mental Health option has emerged from a structured, evidence-based options development and appraisal process described earlier in this document.

A wide range of service configurations were considered during options development. Following application of agreed hurdle criteria and subsequent refinement and challenge processes, options were progressively reduced and assessed through detailed workforce, financial, estates, accessibility, Integrated Impact Assessment and non-financial appraisal processes. The detailed methodology, appraisal outcomes and reasons options did not progress are set out within the Better Together Phase 1 Step Report and supporting appendices.

Throughout the process, options were discounted where they did not provide sufficient confidence in relation to workforce sustainability, clinical quality and safety, affordability, estate feasibility, deliverability, alignment with future models of care, or their ability to address the identified case for change. Common reasons for options not progressing included failure to address future population needs, workforce deliverability constraints, estate limitations and concerns regarding long-term sustainability.

Following completion of the appraisal process and assurance reviews, one Mental Health option was identified as capable of achieving the programme objectives. It provides the most balanced response across quality, workforce sustainability, affordability, deliverability and accessibility considerations. This option has therefore been recommended for consultation.

The existing service configuration and the arrangements in place before the temporary changes are included as baseline comparators.

8.9.1 Service Configuration before Temporary Service Change

Before temporary service changes, mental health inpatient services operated from four locations, providing 24-hour, seven-day services. This included Felindre Ward at Bronllys Hospital for adults aged 18–64, Tawe Ward at Ystradgynlais Hospital, Clywedog Ward at Llandrindod Hospital and Crug Ward at Brecon Hospital for adults aged 65 and over. Mental health hospital day services were provided at Brecon Hospital and Ystradgynlais Hospital, these have been temporarily closed since March 2020.

Figure 133: Mental Health Service Configuration before Temporary Service Change

What changes from the current model?	What stays the same as the current model?
• Reopen Crug Ward at Brecon Hospital • Reopens mental health day services at Brecon and Ystradgynlais • Reverts inpatient and community services to pre-temporary configurations • Increases number of active inpatient sites	• Multi-site inpatient model • Community teams based on existing geographies • Continued use of out-of-county beds • SPOA / 111 press 2

Benefits	• Restores local access to inpatient beds and day services • Familiar model for some patients, communities and staff • May relieve short-term pressure on inpatient capacity
Risks	• Workforce spread thinly across more sites • Increased operational and staffing costs • Reinstates models already shown to be fragile and found to be unsustainable for retaining workforce • Increased short term agency costs whilst staff models rationalised
Trade-off(s)	• Local access and familiarity **vs** sustainability, efficiency and resilience

This option would return services to those previous arrangements. While this model maintains a broad local footprint and may feel familiar to patients and staff, the stakeholder option appraisal process identified concerns that this reverting back to pre-temporary service changes would not address the issues in meeting future demand, it would fail to address workforce fragility and not reduce reliance on out-of-county care. It is presented as a baseline comparator only.

8.9.2 Service Configuration Currently (Do Current)

This comparator option would make the temporary changes permanent: inpatient services would remain across three sites, with continued reliance on out-of-county beds and a fragmented community model.

Figure 134: Mental Health Service Configuration Currently (Do Current)

What changes from the current model?	What stays the same as the current model?
• Nothing— temporary changes become permanent • Service Improvement includes improving community offer of joint working with 3rd sector and partners	• Fragmented inpatient provision across three operational sites – 38 inpatient beds • Reliance on out-of-county beds • SPOA aligned to 111 (press 2) remains with additional work to implement Open Access model. • Ongoing reliance on agency staff

Benefits	• Lowest immediate delivery and transition risk • No significant capital investment required in the short term • Familiarity for staff and partners, reduced change
Risks	• Ongoing lack of resilience for inpatient services across multiple units • Continued use of older estate stock (add impact from HSE perspective) • Workforce fragility across small units may increase variable pay (add reference to safer staffing) • Continued reliance on out-of-county provision • Ability to address predictions of ageing population needs and future demand (inc cost avoidance)
Trade-off(s)	• Mitigation of risk of change **vs** ability to meet future demand and provide long-term sustainability

Whilst this option provides some short-term stability it does not address the issues in meeting future demand, providing sustainable services. There remains continued reliance on

fragmented inpatient provision and out of county placements. It is presented as a baseline comparator only.

8.9.3 MH006a: Strengthen community mental health support for older adults and consolidate all inpatient mental health services onto a single site in Bronllys or Brecon area

The option supports holistic assessment, closer multidisciplinary working and reduced reliance on inpatient admission. It includes a sanctuary or safe assessment space as an alternative to admission, while NHS 111 Press 2 and the SPOA continue to support triage, prevention, early intervention and referral management.

This proposal consolidates all mental health inpatient services (organic and functional) to Bronllys Hospital site or new site in the Bronllys and Brecon area, with additional development of an enhanced care unit at the same site. This would provide approximately 35 patient beds, (18 adult functional, 12 organic, and 5 enhanced care).

Demand and capacity modelling undertaken has suggested that if the current model for mental health does not change, an additional 10 acute inpatient beds would be required, e.g. 45 beds. This would be particularly impactful for older adults given the demand evidence has included projected growth in the ageing population. The modelling has been undertaken with this in mind and seeking an alternative model to enable people to be cared for at home for as long as possible. Therefore, the model proposes an enhanced community team with active physical health monitoring, increased OT, Peer and social work, psychological provision in both community and inpatient settings. In addition, there would be mental health registered nurses in physical health inpatient settings which increases the service provision for patients with physical and mental health co-morbidities meaning that a cohort of patients currently cared for in mental health settings would be able to be cared for in physical health settings instead. In the adult acute pathway, the introduction of sanctuary would also reduce unnecessary admissions where at present the only option for de-escalation from crisis is to admit to the adult acute ward. In the proposed model, the consolidation of inpatient settings to one site would see greater resilience for service provision, providing a more sustainable workforce model that can cross cover, improve seamlessness of pathways across community and inpatient site, improve MDT practice and patient flow. The improved therapeutic enhanced and diverse environment would be more conducive to recovery and discharge. Finally, the proposed model retains the opportunity to seek beds externally based on individual needs. All these factors, plus the introduction of the Open Access approach to mental health service provision should fully mitigate the need to have an additional 10 beds as predicted by demand and capacity information.

Enhanced care would mean bringing patients receiving treatment and care out of county back into Powys and reducing commissioning of some specialist beds out of county. The creation of a single, consolidated mental health inpatient centre designed to improve consistency, resilience and quality of care, presents the opportunity to develop a "centre of excellence" aligned to Royal College of Psychiatrists' quality standards. It would improve integration of physical and mental health services, supporting more holistic care and better management of co-morbidities, enabling greater use of MDTs and closer working between community,

inpatient and physical health services. It would enhance ability to support people with dementia, complex mental health needs, learning disabilities and complex emotional needs.

The future proposal would strengthen mental health support across physical and mental health pathways by developing in-reach and liaison services for physical health units. A specialist OAMH Team would work alongside physical and mental health services and with primary care colleagues to provide proactive, preventative, recovery-focused support based on individual need, including secondary mental health care evidence-based interventions, short-term home treatment and extended operational hours.

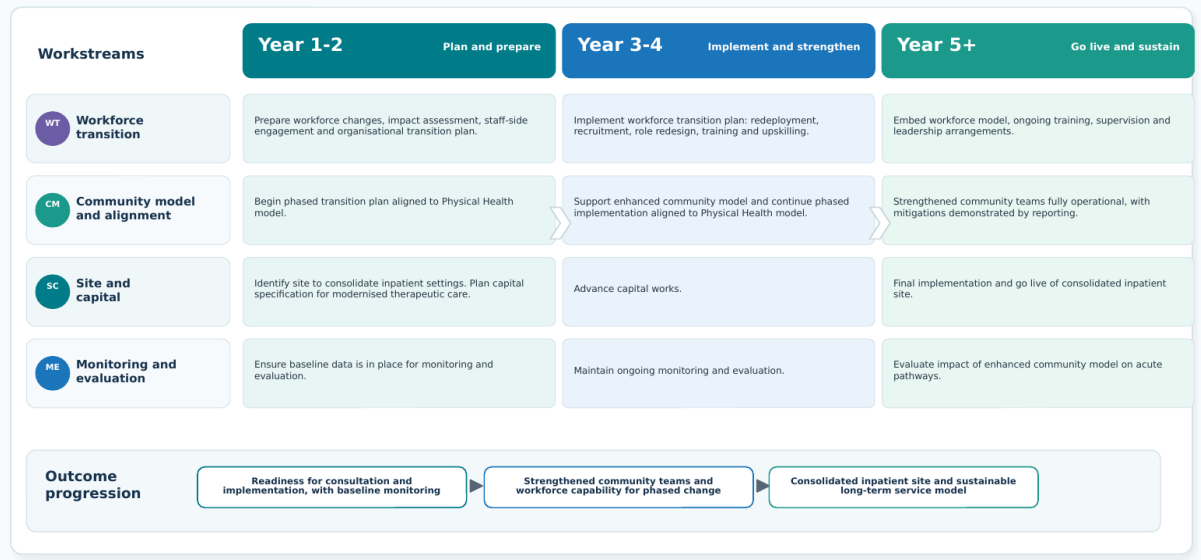
Figure 135: Mental Health functional and organic inpatient beds at 1 site with strengthened community model (Option MH006a)

What changes from the current model?	What stays the same as the current model?		
• All functional and organic inpatient beds consolidated at Bronllys • Closure of Brecon, Llandrindod and Ystradgynlais MH inpatient services • Single consolidated site -35 inpatient beds • Expanded community, liaison and alternatives to admission (add to mitigate in the north) • Enhanced care - inpatient services will be able to support higher acuity patients enabling repatriation of some patients from out of county	• SPOA / 111 press 2 • Requirement for some specialist out-of-county provision • Continued use of older estate stock	**Benefits**	• Improved clinical consistency and resilience • Improved workforce sustainability • Aligned strategically with creating a centre of excellence • Reduced long-term reliance on out-of-county beds • Simplified governance and pathways • Potential for increased MDT working with physical health • Cost avoidance, community team benefits and associated reduction in bed base care
		Risks	• High capital requirement • Single-site vulnerability • Risk of creating inequity of care between south and north eg use of alternative to admission offer in North may promote difference in inpatient admission pathway • Community connection – site is not well connected to the community, also potential patient transport issues • Public, staff and political acceptability challenges • Complex transition period • Not co-located with physical health
		Trade-off(s)	• Long-term sustainability and quality **vs** short-term disruption and access impact • System simplification and quality **vs** access and travel distance • Still commissioning out of county activity in the north to meet population needs

8.9.3.1 Indicative Phasing for this Option

The below timeline shows the indicative phasing for this option.

Figure 136: Mental Health 1-site model with strengthened community model: indicative phasing (MH006a)



8.9.3.2 Commissioning Assumptions

Currently mental health inpatient provision is commissioned from several out of county providers, both NHS and private.

The model assumes that enhanced care capacity at the Bronllys Hospital site or new site in the Bronllys and Brecon area would support the repatriation of some people currently receiving care out of county, where this can be safely and appropriately provided within Powys. This would require the right skill mix, therapeutic model, clinical oversight and environmental standards to support people with higher levels of need, while recognising that some specialist pathways, including PICU, low secure and medium secure care, would continue to be commissioned outside Powys where required.

- The main impact of this option would be a reduction in private provider out of county adult acute placements, which is modelled to reduce by 75% in line with investment in the community and clinical models. This investment would increase community-based care ensuring more efficient use of the PTHB bed base.
- Further opportunity is assumed in the financial modelling around reduced requirement for NHS Wales out of county provision, historically delivered by SBUHB.
- There may be further repatriation and savings from out of county provision of adult acute beds in Shropshire, which would be aligned to further option appraisal.

8.9.3.3 Workforce Assumptions

The workforce assumptions for this option are based on consolidating all adult functional and older adult organic mental health inpatient beds onto the Bronllys site, alongside a strengthened community mental health model. The option assumes approximately 35 inpatient beds, including functional, organic and enhanced care capacity.

The inpatient workforce model has been developed around a single-site configuration, with adult and OAMH inpatient services co-located. This supports more resilient 24-hour staffing, clearer clinical leadership, improved multidisciplinary working, greater opportunities for cross-cover, and reduced duplication across ward and site-based roles. Registered Nurse and Healthcare Support Worker staffing has been modelled using locally defined safe staffing principles, taking account of the proposed ward configuration, acuity and enhanced care requirements. The establishment would allow for changes in acuity and enhanced observation requirements, as well as annual leave, sickness, training and supervision, so that safe staffing is not based on average demand alone.

The community workforce assumptions are based on strengthening prevention, early intervention, recovery, dementia support, physical health monitoring, crisis response, discharge flow and alternatives to admission. The model assumes a broader multidisciplinary community offer, including mental health practitioners, occupational therapy, psychology, support workers, care navigation, peer or social support roles, and senior clinical roles. This is intended to support people earlier, reduce avoidable admission, improve discharge planning and strengthen the interface between inpatient and community services. Community establishments would reflect travel time and dispersed demand across Powys, together with the supervision and development capacity needed for specialist and advanced roles.

The medical workforce assumptions are based on a more consolidated and sustainable model of senior clinical oversight. The single-site inpatient model supports clearer job planning, reduced fragmentation, improved peer support and a more defined split between inpatient and community responsibilities. The model assumes consultant psychiatrist input, supported by Specialty and Specialist Doctors (SAS), specialist and senior non-medical roles, with strengthened clinical leadership across inpatient, community and specialist pathways.

Indicative workforce impact

This option could affect staff working across adult and OAMH inpatient services, CMHTs, crisis and urgent mental health services, psychological therapies, specialist mental health services, administration, healthcare support, nursing, medical, AHP and advanced practice roles described in the proposed model. Potential impacts may include changes to team structure, work location, role, duties, skill mix, supervision arrangements, working patterns, travel and development requirements.

The extent and distribution of these impacts have not yet been determined. No assumptions are made at this stage about individual staff outcomes; these would be assessed following consultation through staff engagement, equality assessment and the applicable organisational change and consultation arrangements.

To proceed safely, implementation would need to be phased and supported by clear workforce, quality and safety checkpoints. Following consultation and subject to the preferred option, a detailed workforce plan would confirm baseline and future establishments, including substantive, bank and agency staffing, skill mix, clinical leadership, training, supervision, workforce development needs and any additional recruitment requirements. The plan would also set out implementation phasing, transitional arrangements, workforce readiness and key dependencies across community mental health services, crisis and urgent mental health services, primary care, social care, housing, third sector partners and wider community support services.

8.9.3.4 Financial Appraisal (Revenue and Capital Implications)

Figure 137: Mental Health 1-site model with strengthened community model: revenue implications (MH006a)

Proposed WTE	Baseline £k	Investment £k	Savings / Disinvestment £k	Net Investment £k
176	37,835	1,518	-1,595	-77

- Baseline WTE - 159
- Baseline £k is FY26-27 Mental Health full budgets including commissioning of out of county non-specialised placements.

Figure 138: Mental Health 1-site model with strengthened community model: phased revenue implications (MH006a)

Option net investment phasing (rounding to £k) – Incremental						
	Y1	Y2	Y3	Y4	Y5	**Recurrent**

Option net investment phasing (rounding to £k) – Incremental						
Gross investment	0	0	759	759	0	**1,518**
Gross disinvestment	0	0	-181	-181	0	**-363**
Gross commissioned savings	0	0	-616	-616	0	**-1,232**
Net Investment	**0**	**0**	**-39**	**-39**	**0**	**-77**

- The current phased model does not yet fully reflect the workforce risks, operational overlap and associated cost implications that would inevitably arise during the transition from one model to the other

The phasing assumptions are:

- Investment from Year 3, in line with Physical Health second phase of inpatient development. Investment phased equally over Year 3 and Year 4.
- Disinvestment in wards following investment in communities in Year 3 and Year 4.
- Commissioning and repatriation savings in line with investment from Year 3, matching investment across Year 3 and Year 4.

8.9.3.5 Capital impact of Option

The capital investment programme has been established with Welsh Government as part of the dialogue around a forward look capital programme, which has helped outline future NHS spending needs. This programme would be further informed by the outputs from the Better Together Service Strategy and enable a more defined Estates Strategy to be developed for PTHB to underpin the much-needed modernisation of the estate. Future business case submissions would be able to draw a more distinct and confident association between the long-term service strategy and the investment needed for a fit for purpose built environment.

A single Mental Health unit at Bronllys hospital would be a new build and would need to accommodate the requirements of Planning in addition to the constraints already in place by virtue of the Historic Park and Garden status of the site. A new build would minimise disruption to existing services. A business case to secure capital investment would need to be developed and submitted to Welsh Government – there is no funding currently secured.

8.9.3.6 Estate Implications

The creation and consolidation of Mental Health services into a single site, new build option would create a fit for purpose and modern patient environment. This would enable more focussed technical Estates and Facilities support in one location, resulting in an improved experience for both patients and staff. The capital investment in a new build would reduce backlog maintenance in an existing, ageing estate and allow for the complete modernisation

of plant, equipment and associated infrastructure in a manner compliant with the NHS Health Technical Memorandum and Health Building Note guidance.

New build activity would enhance environmental, decarbonisation and energy efficient measures, to support the long-term sustainability of the estate. The recent heatwaves and ever rising temperatures would require significant adaptation and reconsideration of traditional cooling in our healthcare settings, in addition to the impacts of flooding, storms and climate related change.

Where Mental Health wards and associated services are removed from existing community hospital locations alternative use would be considered for the vacated space, which could potentially support future Service Strategy decisions for planned care or Women and Children's services, etc. There are also opportunities to be explored around the RPB development of Integrated Health and Wellbeing Hubs serving Health, Care and the Third Sector.

8.9.3.7 Impact of this Option

For patients this option could:

- Improve patient outcomes, experience.
- Reduce avoidable admissions into secondary care and reduce emergency attendances, supporting independence, recovery and wellbeing while minimising disruption to family life and social network.
- Reduce out of county travel for some patients.
- Increase local access to community teams with earlier intervention, prevention and community-based support for people at times of crisis including alternatives to admission through the new sanctuary model.
- Patients would have more consistent access to specialist inpatient mental health care, earlier intervention during periods of deterioration, improved management of more complex needs through enhanced care provision, and better continuity between community, crisis, inpatient and discharge services.

This option could:

- Support larger MDT, improved access to specialist expertise, enhanced care provision and a more sustainable medical and nursing workforce through single site working.
- Reduce variation in inpatient care, improving clinical standards and resilience across the service.
- Balances quality, workforce sustainability and affordability, providing a more cost-effective service which improves quality and makes better use of existing resource.

However, this option has some limitations from a co-location with physical health perspective; with community links and geographical location in the south of the County, there is a risk that without sufficient investment into the community services, it would widen inequalities.

Centralising all adult functional and older adult organic inpatient mental health services on a single inpatient site at Bronllys would result in the permanent closure of inpatient mental health services at Llandrindod Wells, Brecon and Ystradgynlais. Patients requiring inpatient mental health care, together with carers, visitors and staff, would therefore need to travel to a single location for inpatient services.

Travel times modelling shows that mean travel time would increase from 38 minutes 06 seconds to 1 hour 05 minutes 21 seconds, with households within the 45-minute benchmark reducing from 63.8% to 34.1% (based on private transport).

The access impacts include longer journeys; increased travel costs; reduced opportunities for family and carer involvement during admission; and greater reliance on private, community or voluntary transport, particularly for people living in rural communities or without reliable access to a car. However, this would be offset by increased investment and support in the community and safe alternatives to admission – focusing on prevention, early intervention and crisis resolution to prevent admissions and reduce out of county placements resulting in less people needing to travel for hospital-based care.

A public transport accessibility assessment summary is provided below:

Figure 139: Public transport accessibility summary: Mental Health options[78]

Option	Service Configuration	Public Transport Position	Same-Day Return & Equity Considerations
Do Current	Existing dispersed inpatient configuration	Existing access varies by pathway and cohort.	More geographically distributed but still presents challenges for some communities with regular out-of-country admissions.
MH006a	Functional and organic inpatient services consolidated at Bronllys	Supported by T4 and X44 corridors but creates significant north/south travel challenges.	Engagement feedback identified concerns regarding carers, visitors, public transport users and physical site accessibility from bus stops. Reduces need for longer out of county travel.

The following table illustrates examples of current travel times to out of county placements. The number of out of county placements should reduce following investment into enhanced inpatient care and support in the community.

Figure 140: Examples of travel times to out-of-county Mental Health placements

Out of County Location	Average Travel Time from North (Newtown)	Average Travel Time from Mid (Llandrindod Wells)	Average Travel Time from South (Brecon)
Potters bar	3hrs 40mins	4hrs 3mins	3hrs 35mins

[78] https://www.traveline.cymru/timetables

Out of County Location	Average Travel Time from North (Newtown)	Average Travel Time from Mid (Llandrindod Wells)	Average Travel Time from South (Brecon)
Stevenage	3hrs 36mins	3hrs 57mins	3hrs 51mins
Bury St Edmunds	4hrs	4hrs 34mins	4hrs 39mins
Norfolk	4hrs 40mins	4hrs 56mins	4hrs 58mins
Newcastle	4hrs 30mins	5hrs	5hrs 40mins
Northampton	2hrs 30mins	3hrs	3hrs

Strengthened community mental health services, crisis support, the mental health SPOA NHS 111 Press 2 and alternatives to admission would also support more people to remain at home where clinically appropriate, whilst repatriation of appropriate out-of-county placements would enable more Powys residents to receive inpatient care closer to family and support networks, improving continuity of care and opportunities for family involvement throughout admission and discharge.

The adverse access impacts are likely to be greater for older people, disabled people, unpaid carers, Welsh-speaking communities, people living in remote rural areas and those experiencing socio-economic disadvantage. Realisation of the anticipated benefits would depend on the timely development of enhanced community services and workforce capacity; these would need to be strengthened in advance of, and alongside, the inpatient changes, with the transition carefully managed to maintain continuity of care.

A full Integrated Impact Assessment for this option is found in appendix Z.2.

8.9.4 Patient Perspective

From a patient perspective using our services, many of the pathway changes described above would mean fewer patients need to be admitted into mental health beds. More patients would be seen at home or in the community through a more proactive integrated community-based model for Older Adults.

Introducing Delyth Field

Delyth (75) lives alone in a farmhouse on the family farm in Powys. Although she has her own home, she lives close to her son Iolo (55), his wife Meinir (52) and their family, who see her regularly and enjoy good relationships. Welsh is Delyth's first language, and she has spoken it throughout her life.

Delyth is fiercely independent and is proud of continuing to manage in her own home. She is determined to maintain her independence for as long as possible. Over the past couple of years, her family and her partner, Aled Wyn, have noticed changes.

Delyth is increasingly forgetful and sometimes struggles to remember recent conversations or events. Her mood has also changed. Usually known for her patience and warmth, Delyth has become irritable and short tempered, particularly when concerns about her wellbeing are

raised. Although these changes have developed gradually, they are becoming harder to ignore.

After a fall at home, Delyth spent a short period in hospital before returning home. While in hospital, staff noted her problems with memory and commissioned a Memory Assessment. After further tests, she has been diagnosed with Vascular Dementia.

Under our current mental health services in Powys…

In the weeks following her return home from hospital, Delyth's family became increasingly concerned that she was struggling more than she was willing to admit. She is less steady on her feet, is eating and drinking less regularly, and more forgetful and withdrawn. When she becomes increasingly confused, tired and irritable, Delyth's family seek advice from her GP.

Following a further medical assessment, Delyth is diagnosed with a urinary tract infection (UTI), which has caused her to experience the symptoms of delirium. The infection is serious enough to require a brief stay in hospital in a large acute hospital in England.

While the infection can be treated, the episode has raised wider concerns about her physical health, her mental health, memory, confidence, independence and the support she may need in the future. Her family are increasingly worried about how best to support her while respecting her wish to remain in her own home.

Clinicians, in consultation with Delyth, her family and partner, are also considering the progression of her dementia, with support from the Dementia Home Treatment Team, and the potential for future inpatient care in Llandrindod Wells. Access to these services is via 111 Press 2 – the mental health SPOA.

Under future mental health services in Powys…

In the weeks following her return home from hospital, Delyth's family became increasingly concerned that she was struggling more than she was willing to admit. She is less steady on her feet, is eating and drinking less regularly, and more forgetful and withdrawn. When she becomes increasingly confused, tired and irritable, Delyth's family seek advice from her GP.

Following a further medical assessment, Delyth is diagnosed with a urinary tract infection (UTI), which has caused her to experience the symptoms of delirium. The infection is serious enough to require a brief stay in hospital in a large acute hospital in England.

While the infection can be treated, the episode has raised wider concerns about her physical health, her mental health, memory, confidence, independence and the support she may need in the future. Her family are increasingly worried about how best to support her while respecting her wish to remain in her own home.

Clinicians, in consultation with Delyth, her family and partner, are also considering the progression of her dementia. She is supported to remain at home with an improved local service from the specialist Older Adult Community Team. This team will monitor Delyth's physical and mental health needs and work closely with other community physical health services. Access to these services is via '111 press 2' – the mental health SPOA.

Delyth's potential LOS for future inpatient care may be shorter because this option concentrates staffing and expertise in a single site in Bronllys, with a lower reliance on agency staff. Combined with improved hospital buildings and therapeutic spaces, the quality of her care in Powys improves overall. Enhanced community 'in-reach' care will make the transition from hospital to community care services work better. The single site for inpatient services will lead to longer travel times for some.

8.9.5 Summary Option Comparison

The table below provides a summary comparison of the recommended option against baseline comparators.

Figure 141: Mental Health Summary comparison of recommended option against baseline comparators

Mental Health Option	Do previous – service configuration before temporary service changes (MH Option 001a)	Do current – service configuration currently (MH Option 001b)	Move all functional and organic mental health inpatient services to Bronllys, bring back out of area patients to Powys, create community offer with physical health to meet holistic needs and provide focus on prevention, rapid response and early intervention (MH Option 006a)
Service footprint sites	4	3	1
Service footprint Beds	44	38	35
PTHB Service model adjustments	Pre-temporary	None	Major
PTHB Workforce (WTE) Inpatients	130.0	107.8	108.2
PTHB Workforce WTE Community	51.1	51.1	67.9
Financial costs minus savings (£m)	£12.2	£10.9	£10.8
Financial impact vs current 001b (£m)	£+1.3	-	£-0.1
Non - financial appraisal score	46.8	46.9	90.7
Ward Staff Costs per bed	£137,017	£124,412	£124,709
Estates value	A - Low	A - Low	D - Major
Estate Feasibility			

High Level Assumptions

- Do current baseline based on agreed ward and medical staffing (March 2026)
- Workforce options based on new build environment.
- WTE includes 26.9% headroom; costing uses midpoint of AfC scales.
- Main impact in commissioning is related to private providers. No impact on CHC included at this stage.
- Pay costs only. Non pay and facilities and other overhead costs are not included.
- Options currently modelled to year 0 for costs, activity and WTE

Category for Initial Estate Assessment Feasibility and Value	Funding reasonably expected to be available	Welsh Government aware of project, but funding not secured	Funding is not currently on any capital plan / not fully defined	Significant issues with feasibility, deliverability, major disruption
	A - Low <£0.50M	B - Medium £0.50>£7M	C - Significant £7M<£15M	D - Major >£15M

8.9.6 Mental Health Options Assessed and Discounted

The Step report in appendices Z.5 provides further detail on the options development process, and decisions taken in relation to the discounting of options. Below is a summary of the range of options that were assessed and discounted.

A range of alternative mental health service models were assessed during the appraisal process. These included different combinations of inpatient locations, varying levels of consolidation across sites, and different approaches to community integration.

Some models considered moving only part of the inpatient service, for example, beds for people with functional conditions, to a new location while keeping older adult and dementia services at Ystradgynlais. These raised concerns around travel times and accessibility for some patients and families, as well as estate assessments indicating that proposed sites would need substantial redevelopment.

Consolidating all beds onto a single site at Brecon was assessed but early feasibility work raised significant concerns about whether the site could accommodate a unit of the required size. Consolidating all beds at a single site in north Powys, at Newtown or Welshpool, was also assessed. This would have improved access for people in the north of the County but raised concerns about longer journeys for people in the south, workforce risks, and significant estate and operational questions; Welshpool in particular presented feasibility concerns.

A two site model, splitting beds between south and north Powys, initially performed strongly against quality and access criteria. However, additional work undertaken following the recommendations workshop identified significant financial, estates and workforce feasibility challenges, and it was not identified as a preferred way forward on that basis. Additional work also raised concerns about whether the model would provide a sufficiently consistent experience for patients across the county, including differences in access to specialist support and longer journeys for some patients, families and carers.

Overall, the options not shortlisted through the appraisal process were assessed as less able to deliver consistent, joined up and sustainable care for patients across Powys, while also supporting long-term service resilience

The recommendation to consult on a single Mental Health option does not mean that a final decision has been made.

Consultation will test the proposed model, supporting evidence, assumptions, potential impacts and required mitigations.

People will be able to support or challenge the proposal, identify overlooked impacts, suggest refinements and propose alternatives that may better meet the programme objectives.

Any substantive alternatives or material modifications emerging through consultation will be considered transparently against the same objectives, evidence base and appraisal criteria used during the options development process. Consultation findings will be reported formally to the Board and will be considered before any final decision is taken.

9. Dependencies and Enablers

9.1 Transforming in Partnership

As part of our planning approach, we have included key partners including Adult Social Care, Third Sector, commissioned providers, primary care and others. We have also worked to align with important partnership frameworks.

9.1.1 NHS Partners

A key feature of the programme is collaboration with NHS partners, this includes NHS Trusts, Health Boards and supporting functions.

As a rural health board without a DGH, Powys is inherently dependent on partnership working with neighbouring NHS organisations. Better Together has been developed in the context of regional service planning and seeks to strengthen Powys' ability to provide more services within Wales through:

- Increased capability within community services.
- Higher-acuity community inpatient provision within Powys.
- More rapid repatriation of patients from acute hospitals.
- Reduced reliance on out-of-county placements for mental health care.
- Closer alignment with regional and national service strategies.

This includes opportunities to support more people receiving care within Wales where clinically appropriate, consistent with wider NHS Wales ambitions around service integration and sustainability.

Powys will continue to rely on cross-border partnerships for services that cannot be safely or sustainably provided within the county. Specific work has been undertaken with WWT and Shrewsbury and Telford Hospitals NHS Trust as the two predominant out of county cross border unscheduled care flows for Powys residents to support strengthening of the proposed model, this has been described in previous sections.

9.1.2 Primary Care

Primary care is a critical partner in delivering the Better Together future model and supports the wider ambition to strengthen prevention, early intervention, supported self-management and care closer to home through integrated community-based services. Feedback from engagement activities and deliberative events consistently highlighted the importance of accessible local services, continuity of care and stronger integration between general practice, community services, mental health, social care and the third sector. Participants identified primary care as fundamental to both the credibility and successful delivery of the future community model.

The proposed model seeks to strengthen integration between primary care and community services through locality-based MDTs. These teams would operate from cluster-based Wellbeing Hubs and work closely with the pan-Powys SPOA to urgent and intermediate care. The model would be supported by enhanced clinical oversight and digitally enabled Hospital at Home capability. This would help ensure people can access the right care, from the right professional, at the right time, reducing avoidable escalation of need and supporting greater independence.

Partners recognise, however, that further work is required to develop and embed these arrangements, this would be facilitated by a range of mechanisms including practice/contractor level collaboration and Cluster planning arrangements. Feedback has highlighted the importance of continued engagement with general practice, community pharmacy and other primary care providers to refine pathways, clarify roles and responsibilities, and ensure that workforce, capacity and implementation assumptions are realistic. Better Together would continue to work with primary care partners to co-design and test elements of the future model. Successful implementation depends on primary care being an active and valued partner in both service design and delivery.

9.1.3 Adult Social Care Services

The Health Board and PCC recognise that sustainable improvement depends on a whole-system approach rather than organisational change in isolation. Both organisations share a common ambition to enable people to live independently for longer, improve wellbeing, strengthen prevention and early intervention, and reduce reliance on hospital and long-term care services through integrated community-based support.

Joint work has identified several shared transformation priorities, including proactive prevention, locality-based access arrangements, enablement, early intervention, therapy-led reablement, intermediate care and integrated discharge support. These priorities align closely with the emerging Community Wellbeing Model, RPB ambitions, and the development of integrated health and social care pathways. Work is already underway to strengthen joint working through MDTs, proactive care, SPOA developments, reablement services and community-based alternatives to hospital admission.

The Health Board acknowledges that further work is required with partners to develop some aspects of the future model, including community wellbeing pathways, market development, support for people with learning disabilities and complex needs, transport solutions and longer-term care capacity. Significant progress has already been made in areas such as domiciliary care provision. Both organisations remain committed to developing a shared narrative, common outcomes and coordinated implementation plans. This collaborative approach will continue through consultation and implementation and it will help ensure that future service changes are delivered in partnership with local authority, third sector and community stakeholders.

9.1.4 Third Sector Alignment

The proposed future model recognises the third sector as a key partner in delivering prevention, early intervention, wellbeing and independence. This aligns with the broader ambitions of Better Together, the RPB Community Wellbeing Model and the ICCS, which promote more integrated, community-based care through collaboration between health, social care, voluntary organisations and local communities.

Feedback from engagement activities consistently highlighted the importance of community support, social prescribing, advocacy, carers' services, peer support and local voluntary organisations in helping people access support earlier and remain independent for longer. Stakeholders emphasised the need for health, social care and third sector services to operate as a coordinated system around the individual.

The future model therefore seeks to strengthen the role of voluntary and community organisations within integrated locality teams, working alongside statutory services to support wellbeing, self-management, recovery and independence, helping to reduce avoidable escalation of need and demand for hospital-based care. Fragility in the sector is recognised, and clear partnership arrangements and sustainable support would be required to ensure Third Sector organisations can contribute effectively, there is commitment to the further planning that would be required to achieve this.

9.1.5 Community Wellbeing and Integrated Community Care System (ICCS)

The proposed future model aligns with the Regional PRB's emerging Community Wellbeing Model and ICCS framework, which aim to strengthen prevention, wellbeing, independence and care closer to home through coordinated action across health, social care, the third sector and local communities. The Community Wellbeing Model promotes a social model of health, recognising the importance of community assets, social connections, local support networks and early intervention in improving outcomes and reducing demand for formal services.

The proposed model for adult physical and mental health community services is complementary to this wider partnership agenda, particularly in relation to locality-based proactive care and support, SPOA arrangements, social prescribing, reablement, intermediate care, community wellbeing and preventative approaches. Through the RPB, PTHB, PCC, PAVO and wider partners are continuing to develop integrated pathways and community-based support that will help enable more people to remain independent, reduce reliance on health and care services and support delivery of a more joined-up, person-centred system of care.

9.2 Workforce Futures

Workforce is a critical enabler of the Better Together proposals. In practical terms, the future models can only operate safely if the required staff, skills, leadership and supervision are available in the right places and at the right times. This includes sufficient cover for leave, sickness, training, travel and variations in demand, not only the number of posts shown in an establishment.

The proposes are intended to reduce the fragility associated with small, dispersed teams and strengthen multidisciplinary working, clinical oversight and integrated community pathways. The case for change is supported by several workforce indicators. These include a vacancy rate of approximately 7.58% within community inpatient services, agency staffing equivalent to around 21 beds; 4.5 wte urgent care vacancies from an establishment of 27.5 WTEs; and more than £7 million spent in 2025/26 on mental health nurse agency, bank staffing and medical locums; and an age profile in which around 44% of the 2026 workforce shown is aged 51 or over. The proposals must be assessed against whether they can improve this position in practice, not simply whether a new organisational structure appears more efficient.

The future workforce model must reflect the two Ready to Go Home units, which provide around 30 beds for patients who are medically fit for discharge, but whose needs cannot currently be met through available community or social care provision. These units continue to require registered nursing, healthcare support, clinical oversight and resilient rota cover.

Scarce clinical workforce capacity therefore remains committed to an inpatient model. Once sufficient community and social care provision is established, this requirement could be reviewed and capacity reconfigured, where appropriate, to strengthen admission avoidance, timely discharge, reablement and care at home.

Changing the configuration of services would not, by itself, resolve workforce shortages. Delivery would depend on whether the required staff can realistically be retained, recruited,

developed and deployed within the proposed timescales. Workforce feasibility must therefore be tested alongside service design, including the effect of moving staff between services, the time needed to develop advanced, or specialist roles and the capacity required to operate current and future models safely during transition.

Future workforce planning would need to consider more than the overall number of posts. It should identify the required roles, competencies, skill mix, locations, working patterns, clinical leadership, supervision arrangements and training capacity. It would also need to account for staff travel time, leave and absence, service operating hours and the minimum staffing required to maintain safe and resilient rotas. Given the age profile, plans would also need to identify succession risks in small or specialist teams, how knowledge would be transferred, and where supervision or leadership capacity could be lost before replacement staff are ready.

9.2.1 Recruitment and Retention

Recruitment and retention are critical dependencies for the Better Together proposals. The Health Board would need to secure the right workforce, roles and locations when new capacity is required, while maintaining safe staffing in existing services during transition. This would require a combination of retaining current staff, redeployment, retraining, workforce development and external recruitment; recruitment alone would not provide the full solution.

The proposals are intended to support a more sustainable workforce model by creating stronger MDT, reducing service fragility and improving career development opportunities. Larger and more integrated teams may provide greater resilience, better access to professional support and supervision, and more opportunities for flexible deployment. However, these benefits would depend on the detailed design and location of services and should not be assumed solely from organisational consolidation.

The two Ready to Go Home units currently provide around 30 beds for patients who are medically fit for discharge, but whose complex ongoing needs cannot be met through the community or social care support presently available. Although these patients no longer require active inpatient treatment, the units continue to require a relatively high staffing level and skill mix, including registered nursing, healthcare support, clinical oversight and resilient rota cover. Scarce clinical workforce capacity therefore remains committed to an inpatient model while these beds remain operational and cannot readily be released or redirected to strengthen community-based services.

Any future workforce assessment should therefore identify the staffing establishment and skill mix associated with these units, the workforce required to provide alternative support outside hospital and the extent to which existing staff could be retrained, reconfigured or redeployed into community-based services.

The sequence of any change would be critical. The necessary community and social care capacity, including the appropriate workforce, skills, clinical oversight and supporting infrastructure, would need to be established before the corresponding inpatient workforce requirement can safely change. Workforce capacity should therefore be considered across

the whole pathway, recognising that a reduction in inpatient staffing would be dependent on sufficient alternative provision being available to meet patients' needs outside hospital.

The future model would require the development or expansion of roles across nursing, mental health nursing, allied health professions, pharmacy, medical staffing, advanced and enhanced practice, healthcare support, reablement, diagnostics, care navigation, peer support and wider community-based provision**.** The future model should make the best use of the whole workforce, with roles designed around patient need and staff supported to work to their full professional competence and scope of practice. This should not be interpreted simply as substituting one professional group for another; changes to skill mix would require clear role design, appropriate governance, education, supervision and evidence that quality and safety can be maintained.

Different parts of the workforce would take different lengths of time to secure. Some capacity may be available through retention or redeployment, while advanced, specialist and senior clinical roles may require postgraduate education, supervised practice or external recruitment from an already limited labour market. Implementation plans must therefore distinguish between capacity that is available now, capacity that can be developed and genuinely additional staff who must be recruited.

Recruiting into new or expanded services may simply move staff from one part of the system to another rather than create additional capacity. Workforce planning must therefore identify the expected source of each staff group and assess the impact on other services. This assessment should include staff currently working in the Ready to Go Home units. However, it should not assume that all staff can transfer directly or that inpatient skill set would align fully with the requirements of a community-based role.

Recruitment and workforce supply assumptions would therefore need to be tested in detail before implementation. This should include assessment of:

- the current workforce baseline, including substantive, bank and agency staffing;
- the establishments, staffing levels and skill mix associated with the services affected, including the Ready to Go Home units;
- the local labour market and realistic supply of appropriately qualified staff;
- hard-to-fill roles and historical recruitment and turnover patterns;
- training and development requirements and the availability of education, supervision and placement capacity;
- lead in times for new roles;
- opportunities for redeployment and retraining together with the support needed to retain existing staff through change;
- the extent to which the skills and working arrangements of the existing workforce align with the requirements of the future model;
- the affordability and sustainability of proposed establishments;
- the workforce implications of delivering services across different locations and operating hours; and
- further potential effects of changes on neighbouring services and partner organisations.

Following consultation and once the preferred service option has been determined, it should be supported by a quantified workforce plan. This should set out the current baseline, the potential future establishment and skill mix, and how any identified gaps could be addressed. It should consider the extent to which staff could be retained or redeployed, the skills and roles that may need to be developed, and any additional recruitment that may be required. The plan should also identify the workforce needed to maintain existing services during any transition, including the Ready to Go Home units until alternative provision is operational, and set out realistic timescales, costs, dependencies and contingency arrangements.

For the physical health options, this should include a transparent reconciliation of the 292 WTE baseline against the modelled 252 WTE and 230 WTE positions. The reconciliation should show where capacity is expected to reduce, increase or move between inpatient and community services; distinguish recurrent establishment changes from temporary transition requirements; and align workforce phasing and costs with the financial appraisal. These figures remain planning assumptions to be tested and do not determine the outcome of consultation.

9.2.2 Transitional Workforce Requirements

Detailed planning should distinguish the recurrent future establishment from the time-limited workforce needed to maintain safe services during transition. On the evidence currently available, the following requirements should be explicitly tested.

Figure 142: Workforce transition requirements to be tested

Transition requirement	Existing evidence or dependency	Planning treatment
Maintain current inpatient services	Existing services must continue safely until the relevant phase of an alternative model is operational.	Identify the minimum establishment, skill mix, rota cover and temporary staffing requirement for each phase.
Maintain Ready to Go Home capacity	Around 30 beds remain in operation because suitable community or social care alternatives are not yet available.	Retain the required workforce until alternative capacity is operational and patient need can be met safely outside hospital.
Build community capacity	Both options depend on strengthened multidisciplinary, Hospital at Home, virtual ward, reablement and urgent response capacity.	Set out recruitment, redeployment, training, supervision and infrastructure lead times before corresponding inpatient changes.
Support staff movement and development	An inpatient skill mix will not automatically match the requirements of a community model.	Identify affected staff, transferable skills, development requirements, lead times and any backfill needed.
Manage delay or shortfall	Recruitment, training or partner capacity may take longer than planned.	Define contingency arrangements, decision points and the financial and service consequences of delayed implementation.

9.2.3 Proposed Workforce Readiness Criteria

Subject to the outcome of consultation, implementation plans should define measurable workforce readiness criteria for each phase. These should include:

Figure 143: Proposed workforce readiness criteria

Readiness area	Proposed evidence before implementation
Establishment and affordability	The funded establishment, skill mix, locations, operating hours and recurrent and transitional costs have been agreed.
Staffing availability	The required substantive, bank and temporary staffing is available to operate the relevant phase safely without creating an unacceptable gap elsewhere.
Competence and development	Required competencies, education, supervised practice and role development have been completed or are supported by a safe, time-limited arrangement.
Clinical leadership and supervision	Leadership, professional accountability, escalation, supervision and out-of-hours arrangements are operational.
Community and partner capacity	The community, social care and other supporting capacity on which the phase depends is operational at the required scale.
Staff transition	Engagement and any required organisational change, redeployment, work-base and working-arrangement processes have been completed for the phase, with arrangements in place to support relationship building, trust and effective collaborative working within new teams.
Contingency	A documented response is available if recruitment, training, infrastructure or partner capacity is delayed or falls below the required level.

Staff engagement would be central to this work. The Health Board would need to work closely with staff, managers, professional leads and trade union partners to understand the impact of proposed changes, support workforce transition, and ensure that future roles are attractive, sustainable and deliverable in practice. This engagement should begin during detailed design and continue throughout implementation, with appropriate consultation undertaken where proposals affect roles, work bases, duties, working arrangements or organisational structures.

Retention of the existing workforce would be as important as recruitment. The way in which change is managed, including communication, involvement in service design, leadership visibility, development opportunities and support for staff whose roles may be affected, would influence workforce stability during the transition. Particular attention should be given to avoiding uncertainty or loss of experienced staff before replacement capacity is established. For changes affecting inpatient services, this would require evidence that the community and social care workforce and associated service capacity are available to meet the needs of the patients who would otherwise remain in hospital.

Implementation should be phased against defined workforce readiness criteria. Service changes should proceed only when the required staffing, competencies, leadership, supervision and supporting infrastructure are in place, or when a safe, time-limited transitional arrangement has been agreed. Progress should be monitored through measures including vacancies, turnover, absence, temporary staffing, recruitment, training completion, staff experience and the deployment of staff across inpatient and community services. Measures should be reported separately for physical health, mental health and urgent care where appropriate, and should include succession and workforce-supply indicators arising from the age profile. This would show whether workforce capacity is changing in step with the patient pathways on which the proposals depend.

9.2.4 Clinical Oversight

Strong clinical oversight would be essential to the safe delivery of the proposed future models. As more care is provided through community-based pathways, urgent response, Hospital at Home, virtual wards, enhanced mental health community services and consolidated inpatient models, there would need to be clear arrangements for senior clinical decision-making, escalation, supervision and governance.

The future models would require clinical oversight across both inpatient and community pathways. This includes medical leadership, consultant-led frailty oversight, mental health medical leadership, advanced clinical practice, senior nursing and AHP leadership, and clear professional accountability across MDTs.

Clinical oversight arrangements would need to support safe assessment, treatment planning, prescribing, medicines management, risk management and discharge planning. They must also support urgent escalation decisions and determine whether a person can be managed safely at home, within a community setting, in a Powys inpatient bed or through an out-of-county pathway.

This would be particularly important where the models rely on advanced and enhanced practitioners, MDTs, urgent and Intermediate care, Hospital at Home, enhanced care mental health beds and stronger integration between physical health and mental health services.

As the clinical oversight model is a critical enabler for in year improvement in inpatient flow and community model development, it has been progressed through a separate business case which has been approved and is being implemented. This would provide essential senior clinical roles, supervision arrangements, escalation routes, clinical governance forums, professional leadership, out-of-hours arrangements and set out how clinical standards would be monitored across the future service model.

9.2.5 Further Workforce Planning and Assessment

Further workforce assessment will be undertaken after consultation to test the deliverability of the preferred option. This would cover recruitment and retention, workforce supply and skill mix, education and development, staff transition, community capacity, clinical leadership, rural deployment, service interdependencies, affordability and implementation readiness.

Figure 144: Further workforce considerations

Area	Consideration
Recruitment and retention	The availability of the workforce required to deliver the future model, including hard-to-fill and specialist roles, and the actions required to support recruitment and retention.
Workforce model and skill mix	The workforce composition, roles, skills and competencies required to deliver the future model safely and effectively.
Education, training and development	The development, education and training requirements associated with new or changing roles and ways of working.
Staff transition and career pathways	The workforce implications of any changes and the opportunities to support staff through transition, development, redeployment and new career pathways.
Community workforce capacity	The workforce capacity and capability required to support any proposed strengthening or expansion of community-based services.
Clinical leadership and supervision	The leadership, professional governance, supervision and support required to maintain safe and effective practice.
Rurality and workforce deployment	The implications of geography, travel and dispersed service delivery for workforce capacity, deployment and resilience.
Workforce dependencies	Dependencies between services and workforce groups, including where specialist or scarce workforce capacity supports multiple pathways.
Implementation and readiness	The workforce conditions and assurance required to support implementation, including appropriate staffing, skills, leadership and operational readiness.

9.2.6 Workforce Matters for Further Planning

The workforce implications of the preferred option would continue to be developed through the next stages of business case development and implementation planning.

This work would draw on workforce data, service modelling, professional advice and ongoing engagement with staff, Trade Union partners and other relevant stakeholders. It would help to refine assumptions relating to workforce availability, skills and competencies, workforce deployment, working arrangements, staff transition and the dependencies between services.

This further work would inform the detailed workforce plan and implementation approach for the preferred option, including the actions, sequencing and workforce assurance required before any service changes are implemented.

9.2.7 Workforce Governance and Assurance

The detailed workforce plans should have clear executive and operational ownership. Establishment, skill mix, safe staffing, clinical leadership and supervision should be validated through the relevant professional and quality governance arrangements; workforce costs, savings and transitional requirements should be reconciled with the financial model; and staff and trade union partners should be engaged through the established partnership

arrangements. Approval to proceed with each implementation phase should include explicit assurance that the workforce readiness criteria and material partner dependencies have been met, or that a safe, time-limited contingency has been agreed.

9.3 Digital First

Adult physical and mental health community services transformation is increasingly dependent upon the successful delivery of a range of digital programmes and initiatives that provide both the technical foundations and operational capabilities required to support new models of care. These programmes are critical enablers of service improvement, helping to deliver safer, more integrated and community-focused services whilst supporting the strategic ambition to move care closer to home wherever clinically appropriate.

The business case aligns with the Digital First Strategic Framework by positioning digital as a key enabler of safe and sustainable care for a rural population. The emphasis on strengthening community-based services, reducing unnecessary travel, improving access to diagnostics and urgent care, and delivering more care closer to home is consistent with the framework's ambitions. It also reflects the wider Welsh Government focus on placing digital capability and data at the centre of modern health and care services.

Despite the focus on digital transformation, Digital Inclusion is critical to ensuring everyone is able to engage with the health board in a way that suits them. Digital-first has never meant digital-only. The objective of digital service design is not to replace human interaction, but to ensure that services are delivered through the most appropriate channel for each individual. Digital services provide convenience and accessibility for those who wish to use them, whilst preserving alternative routes for patients who prefer face-to-face, telephone or other forms of personal engagement. For many individuals' receiving physical and mental health community services, human interaction may be a vital component of their care experience and, in some cases, one of the few opportunities for meaningful social contact. Effective digital transformation therefore seeks to remove unnecessary barriers and administrative processes without removing the personal relationships and compassionate interactions that remain central to high-quality care. The focus is on creating inclusive services that use technology to enhance, rather than replace, human-centred care.

This case directly aligns with the five key themes detailed in the Digital First strategic framework.

9.3.1 Citizen-Centred Care & Support

Central to this transformation is the implementation of the Connecting Care Programme and the wider modernisation of clinical systems through the RiO EPR platform. This programme provides a single, integrated digital record for adult physical and mental health community services, enabling clinicians to access timely and accurate patient information across care settings. With a medium-long-term strategy that this replaces fragmented legacy systems and reduces reliance on paper-based processes, Connecting Care supports improved care coordination, more informed clinical decision-making, and enhanced multidisciplinary working. It also establishes the digital foundation required to support future service redesign,

integrated pathways and more effective use of data to improve outcomes and operational performance.

The continued expansion of the NHS Wales App also represents an important enabler for future service transformation. Increasing information flows between commissioned Health Boards, NHS Trusts and partner organisations would enable more services, appointments, communications and patient information to be made available digitally through a single access point. This would improve patient engagement and communication, increase transparency and provide citizens with greater access to information relating to their care. As interoperability improves across organisational boundaries, the NHS Wales App has the potential to become an increasingly important component of how patients interact with both adults physical and mental health community services, supporting self-management and improving access to care without the need for unnecessary administration.

Digital programmes are also supporting the successful expansion of remote monitoring solutions, which are becoming increasingly important tools for delivering care beyond traditional hospital settings. These services enable clinicians to monitor patients remotely, identify deterioration at an earlier stage and provide timely intervention whilst allowing individuals to remain safely in their homes and communities. The continued growth of virtual care models supports the strategic objective of moving care further into the community, reducing avoidable admissions and supporting more proactive, preventative approaches to care. This is particularly relevant within community and mental health pathways, where maintaining independence, supporting wellbeing and reducing the need for hospital-based intervention can significantly improve patient outcomes and experience.

9.3.2 Infrastructure & Security

The proposed service model is dependent on the availability, resilience and reliability of underlying infrastructure and connectivity, as digital systems would be essential to support joined-up care, timely access to information, virtual or remote models of care, shared records, clinical communication and effective coordination across organisations. In a rural county such as Powys, inconsistent connectivity or limitations in digital infrastructure could affect the ability of staff, patients and partner organisations to access services safely and efficiently, particularly where care is being delivered closer to home, across multiple sites or through digitally enabled pathways. The successful implementation of the case would therefore require reliable networks, appropriate devices, interoperable systems, robust support arrangements and contingency plans to maintain service continuity. Cyber security and information governance would also remain critical dependencies, with each contracted organisation required to provide appropriate assurances that patient data is protected, access is controlled, and information is handled securely in line with contractual, legal and NHS requirements.

9.3.3 Enabling Efficiency & Effectiveness

The implementation of electronic Prescribing and Medicines Administration (ePMA) further strengthens service delivery by improving medication safety, reducing prescribing errors and providing clinicians with real-time access to prescribing information. As mental health and community services increasingly adopt mobile and community-based models of care, digital

prescribing solutions support safer medicines management and contribute to more efficient multidisciplinary working.

Linked to this is the ongoing development of digital referral pathways into NHS England providers, helping to streamline access to specialist services and reduce administrative burden. Digital referrals improve the quality, completeness and timeliness of information shared between organisations, enabling faster triage, improved communication between referring and receiving clinicians and a more seamless experience for patients. As these pathways mature, they support more effective management of waiting lists and improve visibility of patient progress across organisational boundaries.

9.3.4 Data, Intelligence & Decision Making

A significant dependency on service transformation is the continued improvement of cross-border information sharing and interoperability with NHS England providers, neighbouring Health Boards and Primary Care services. Given the large volume of residents who receive elements of their care outside Powys, effective digital information flows are essential to maintaining continuity of care. Ongoing work to improve interoperability, establish secure data exchange mechanisms and support access to relevant clinical information from partner organisations would help ensure practitioners have a more complete view of a patient's health and care journey regardless of where treatment is delivered. These capabilities are particularly important within adult physical and mental health community services, where patients often receive care from multiple teams, organisations and geographical locations.

These technological developments are underpinned by investment in digital skills, workforce readiness, infrastructure resilience and cyber security. Each one is anticipated to drive and support the increasing need to ensure decisions are backed by robust digital insight and business intelligence. The benefits of modern clinical systems, digital referrals, interoperability, virtual care and patient-facing services can only be fully realised when staff are equipped with the skills, training and confidence required to utilise them effectively. Collectively, these programmes are not standalone technology initiatives; they are fundamental enablers of service transformation that support the delivery of integrated, sustainable and patient-centred services for adults with physical and mental health needs and the wider health and care system.

9.4 Innovative Environments

The physical healthcare estate in Powys is ageing and requires considerable capital investment to bring it up to a standard where it can provide a compliant and modern environment from which to deliver the best levels of service. The Better Together work to develop a forward-looking Service Strategy enables the underpinning Estates Strategy to be formed to respond to the core needs and ambition of the organisation.

Significant capital investment would be required to support the programme of works to reshape the estate and this would be subject to the need to seek approval from Welsh Government via the established formal business case process. Capital funding is held centrally and is acknowledged to be under pressure to support the competing demands for NHS schemes across Wales. A positive and ongoing dialogue exists between Powys and

Welsh Government, which has secured ring-fenced funding to support the completion of a programme of significant capital investment in Llandrindod Wells War Memorial Hospital, which is one of the three rural regional centres identified in the Health & Care Strategy. Further business case submissions will be made in early 2027 to seek to secure funding for the Integrated Health and Wellbeing Hub in Newtown, North Powys, and this would lead into the discussion in relation to the Phase 2 relocation and new build replacement for the existing hospital at Newtown as the rural regional centre situated in the North.

The outputs from Better Together will enable a clear and definable association to be established between healthcare service needs and the underpinning business case submissions for capital investment.

The consolidation of some services into the three rural regional centres offers opportunities for the space vacated at community hospitals. These opportunities can be defined in several ways; able to meet the needs for future service redesign related to women and children's services and planned care, used for the development and strengthening of community facing services or be developed as Integrated Health, Care and Wellbeing in conjunction with PCC and Third Sector.

The RPB is overseeing a feasibility study which takes a place-based approach to identify health, care and wellbeing needs on a locality basis, identify gaps in services, and suggest how these could be addressed by an Integrated Health and Wellbeing Hub model. The principle has been established with the current North Powys Integrated Health and Wellbeing Hub scheme along with the development of a further hub model in Spa Road, Llandrindod. Welsh Government have created a £70M per annum Health and Social Care Integrated and Rebalancing Capital Fund (IRCF) to support the development of integrated health and wellbeing hubs and the ambition for Powys is captured in a Strategic Capital Plan document which defines a capital programme of work. The outcome of the feasibility work and alignment of this with Better Together and the shaping of the future Service and Estate Strategy will be important to ensure we meet future population health and wellbeing needs across Powys.

9.5 Travel and Transport

Travel and transport have been considered throughout the Better Together programme as part of option development, appraisal, stakeholder engagement and Level 2 Integrated Impact Assessments. Accessibility is an important consideration within a large rural county such as Powys, where residents already travel significant distances to access some health, care and specialist services.

Better Together seeks to increase the amount of care delivered at or closer to home through strengthened community, mental health, rehabilitation, intermediate care, reablement and urgent care services. However, some shortlisted options involve the consolidation of site-based services and may therefore change travel patterns for patients, carers, visitors and staff.

Travel and transport should be considered alongside the wider benefits and challenges of each option. This includes quality and safety of care, workforce sustainability, service

resilience, equity of access, deliverability and the ability to provide more integrated community-based services. The Travel Time Analysis Report, public transport assessments and Level 2 Integrated Impact Assessments have informed the appraisal process and should be considered as part of the wider evidence base and are included in appendices W and Z2.

9.5.1 Travel Time Benchmarks and Planning Context

The Better Together programme has adopted service-specific travel time benchmarks to support accessibility analysis and option appraisal. These benchmarks were informed by available evidence, professional engagement and service planning considerations and were refined through the options development process. For urgent care services, both 45-minute and 60-minute thresholds were considered during option development following stakeholder feedback and further review of accessibility assumptions. The evidence based underpinning the travel time benchmarks are referenced in the Travel Time Analysis Report in appendices W and are summarised below.

Figure 145: Travel time benchmarks

Service Type	Benchmark
Primary Care	≤30 minutes by car or ≤60 minutes by public transport
Community and Intermediate Care	≤45 minutes by car*
Mental Health Services	≤45 minutes for routine care and ≤60 minutes for crisis response*
Urgent Care Services	≤60 minutes by car, with additional testing against a 45-minute threshold*

*Within the evidence sources used to inform the travel time benchmarks, there was not always a differential by car or public transport

These benchmarks were used to inform comparative assessment of accessibility between options and should not be interpreted as absolute decision thresholds but as a guide. The appraisal process considered accessibility alongside a wider range of factors including quality, safety, workforce sustainability, affordability, strategic fit, deliverability and equality impacts.

The programme has also considered the wider transport planning context, including PCCs hub-and-spoke transport strategy. PCCs transport strategy adopts a place-based hub-and-spoke model centred on five core towns: Welshpool, Newtown, Llandrindod Wells, Brecon and Ystradgynlais. These towns act as key centres for transport connectivity and wider public service delivery, with surrounding communities linked through a combination of scheduled

bus services, community transport and more flexible demand-responsive provision. The overall ambition for the council is to enable residents to access their nearest service hub within approximately 60 minutes, while also supporting onward and cross-border connections to larger population centres where residents access healthcare, education, employment and other services not available locally. The PCC place-based hub-and-spoke model centred on five core towns aligns with the proposed options to consolidate services onto 2 or 3 sites; Newtown, Brecon, Llandrindod Wells. For the mental health recommended option, a further transport assessment would be required subject to whether the potential consolidation of services is on the existing Bronllys site or on a new site in the Brecon and Bronllys area.

The transport network has been subject to significant review and investment in recent years. In 2025, PPC approved proposals to strengthen the public transport network through revised routes and timetables, increased service frequencies and improved evening and weekend provision. The network is supported through longer-term operating arrangements with transport providers, providing a more stable platform for future service planning and development. Existing contractual mechanisms allow routes and timetables to be reviewed where supported by evidence of need, creating opportunities for future health and care service developments to be considered as part of wider transport planning. However, any changes remain dependent on affordability, operational viability, passenger demand and agreement between relevant partners. Public transport provision should therefore be viewed as an important enabling factor that may support accessibility, rather than an assumed mitigation for healthcare service change. The Health Board are keen to work with the Council in relation to alignment of Phase 1 recommended options with their transport hub-and-spoke strategy and future plans.

9.5.2 Travel Time Analysis

The Travel Time Analysis Report[79] assessed private vehicle journey times from more than 73,000 households across Powys to proposed service locations and configurations. The analysis provides a consistent comparative assessment of access between options and forms part of the evidence base used throughout option appraisal and impact assessment work.

The analysis demonstrates that travel impacts vary between service areas and options. In general, greater consolidation of site-based services results in a larger proportion of households experiencing longer travel times, although the scale and distribution of those impacts differ between option sets. The analysis also demonstrates that travel impacts are influenced by the geography of Powys, the location of proposed sites and the distribution of the population served.

The Travel Time Analysis Report is intended to provide a comparative assessment of private vehicle access to site-based services. As such, the analysis does not model public transport journeys, community transport provision, patient transport services, appointment scheduling, transport affordability, workforce travel requirements or the impact of future community-based

[79] Appendix W - Better Together Travel Time Analysis Report v0.5-FINAL

pathways that may reduce demand for hospital attendance. These limitations should be considered when interpreting the findings.

9.5.3 Public Transport Accessibility Assessment

Recognising the limitations of car-based modelling alone, supplementary public transport accessibility assessments have been undertaken for the shortlisted Mental Health, Urgent Care and Physical Health options using public source information through the Traveline Cymru timetable and journey planning service. These assessments draw on available public transport information and local accessibility evidence to consider how proposed service locations may be accessed by public transport users.

The assessments considered:

- principal public transport routes serving proposed locations
- indicative journey times
- service frequency and availability
- interchange requirements
- feasibility of same day returns journeys
- evening and weekend accessibility; and
- potential impacts on groups who may be disproportionately affected by changes in accessibility.

The analysis demonstrates that public transport accessibility varies significantly across Powys. Strategic corridors, particularly the T4 corridor, provide comparatively strong north-south connectivity. However, many communities remain dependent on lower-frequency feeder routes, connection-based journeys or alternative transport arrangements. Public transport should therefore be considered as an important component of overall accessibility rather than a complete mitigation for increased travel distances associated with some options.

Option-specific public transport summaries are included within the relevant Mental Health, Urgent Care and Physical Health sections of this PCBC and should be considered alongside the Travel Time Analysis Report and Integrated Impact Assessments.

Across all option groups, accessibility impacts are likely to be greatest for:

- people without access to a private vehicle
- older people
- disabled people and people with mobility impairments
- unpaid carers
- people travelling with children; and
- residents of rural communities reliant on lower-frequency transport services.

These considerations are reflected within the Level 2 Integrated Impact Assessments and will continue to inform consultation, decision-making and future implementation planning.

9.5.4 Transport Dependencies and Implementation Considerations

A key objective of Better Together is to reduce avoidable travel through strengthened community-based care. Proposed developments including Hospital at Home, Urgent

Community Response, virtual wards, rehabilitation and reablement services, mental health community support and enhanced locality-based provision are intended to support more care at home or closer to home and reduce reliance on hospital attendance where clinically appropriate.

These developments have the potential to reduce travel demand for some individuals. However, the extent to which this occurs would depend on successful implementation of the wider community model and has not been assumed within the travel time analysis. People who require inpatient, urgent care or specialist services may still experience longer journeys under some options and these impacts remain relevant to decision-making.

Transport should therefore be viewed both as an enabling factor and as a delivery dependency. Accessibility considerations have informed option appraisal and would continue to be considered alongside quality, workforce, sustainability and equality objectives throughout consultation, decision-making and implementation planning.

9.5.5 Future Considerations

Travel and transport will continue to be considered through consultation and, subject to future decisions, during any detailed Final Programme Business Case development and implementation planning.

Further work would focus on understanding the practical experience of accessing services, including public transport availability, community transport provision, workforce travel requirements, patient, carer and visitor journeys, and the needs of communities most affected by potential changes. This work would support ongoing refinement of implementation plans, Integrated Impact Assessments and accessibility mitigations where appropriate.

The Better Together programme has been developed through engagement with stakeholders and recognises that transport planning and service planning are closely linked. The programme therefore provides an opportunity to work jointly with PCC, Transport for Wales, public transport operators, PAVO, community transport providers and other regional partners to better understand how future transport provision could support access to services over time.

Importantly, transport networks are not static. Bus routes, service frequencies, demand-responsive transport arrangements and community transport services will continue to evolve over the implementation period of the programme. This creates an opportunity for future transport planning to be informed by emerging healthcare delivery models and for healthcare planning to take account of planned transport developments. While no specific transport changes are assumed within the appraisal process, the programme provides a platform for continued partnership working to identify opportunities to strengthen accessibility and reduce barriers to accessing care.

Consultation feedback, further engagement with transport partners and ongoing implementation planning will help inform future discussions regarding route development, service connectivity, community transport solutions and accessibility improvements, particularly for communities identified as experiencing the greatest travel and transport challenge.

10. Approach to Consultation

The Better Together Phase 1 consultation period will be a formal 12-week, plus 2 week service change consultation (to allow for the Christmas period) on options for adult physical and mental health NHS community services. It is proposed to run from 5 October 2026 to 10 January 2027, with analysis, conscientious consideration and Board decision-making planned from early 2027.

The approach set out below is designed to meet statutory duties, Welsh Government guidance on NHS service change, equality and Welsh language requirements, and the Gunning Principles, while giving patients, staff, partners, stakeholders and the wider public a clear opportunity to influence the options before a Board decision is made.

A final version of the Consultation Plan will be considered by Board on 16th September 26 alongside this document.

Figure 146: Outline consultation plan



Formal consultation will provide an opportunity for patients, service users, staff, partners, stakeholders and the wider public to consider the proposed options, their benefits, disadvantages and impacts, the assumptions underpinning them, and any alternative approaches that should be considered before a final decision is made.

The consultation will seek views on the suitability, impacts, and potential alternatives to the proposed service change options. It will make clear which matters are open to influence and

which are outside scope, including that this is a service change consultation rather than formal Organisational Change Process consultation with health board staff, which may follow at a future date subject to the decisions made following consultation.

Any substantive alternatives or material modifications identified through consultation will be reviewed transparently against the same programme objectives, evidence base and appraisal framework applied during the options development process. The outcomes of this assessment, alongside the consultation findings, will be reported to the Board as part of the conscientious consideration process prior to any final decision being taken.

Delivery will be governed through the Better Together Portfolio arrangements, with Executive Director accountability, ODEC oversight, and a Tactical ODEC group responsible for day-to-day engagement and communications. Independent support will be provided by HICO and ORS for consultation delivery, analysis and reporting.

The approach places strong emphasis on accessibility, inclusion and representative participation. Stakeholder mapping will build on previous engagement and will focus on those most affected, including people with protected characteristics, seldom-heard groups, rural communities, staff, carers, children and young people where relevant, statutory partners, local authorities, third sector organisations, Llais, neighbouring NHS bodies and political representatives.

Engagement will use multiple routes, including online and printed questionnaires, Easy Read materials, written and email submissions, petitions, public drop-in events across the 13 Powys localities, staff roadshows, outreach and pop-up activity, targeted focus groups, stakeholder events and presentations to key forums. Social media and third-party website comments will not be analysed as consultation responses; people using those channels will be signposted to the formal response routes.

Consultation documents will be bilingual, accessible and available in a range of formats, including summary, Easy Read and HTML versions, with support for other languages and formats where required. Supporting technical documents, including impact assessments, will be published alongside the consultation materials.

The process will be actively reviewed before launch, at mid-point and near closure to assess reach, accessibility, emerging themes, misinformation, risks, equality impacts and any need to adapt the plan. Consultation feedback will be independently analysed and reported, with findings used to inform updated impact assessments, conscientious consideration and the subsequent Board decision. The outcome and next steps will then be communicated to staff, stakeholders and the public.

Consultation findings, updated impact assessments, further technical work and any additional evidence arising through consultation will be considered before the Board determines whether proposals should proceed, be modified, require further work or not proceed. This ensures that consultation remains a formative stage within the overall decision-making process. The final Programme business case will support a decision by the Board on the preferred option along with approval to proceed to implementation. This is expected in late spring 2027.