PTHB Board
16 September 2026
Appendices to Item 2.1 Part 2

Better Together
System Level Models of Care



Gwella Gyda'n Gilydd
Llunio dyfodol gwasanaethau iechyd diogel, o ansawdd uchel i Bowys

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

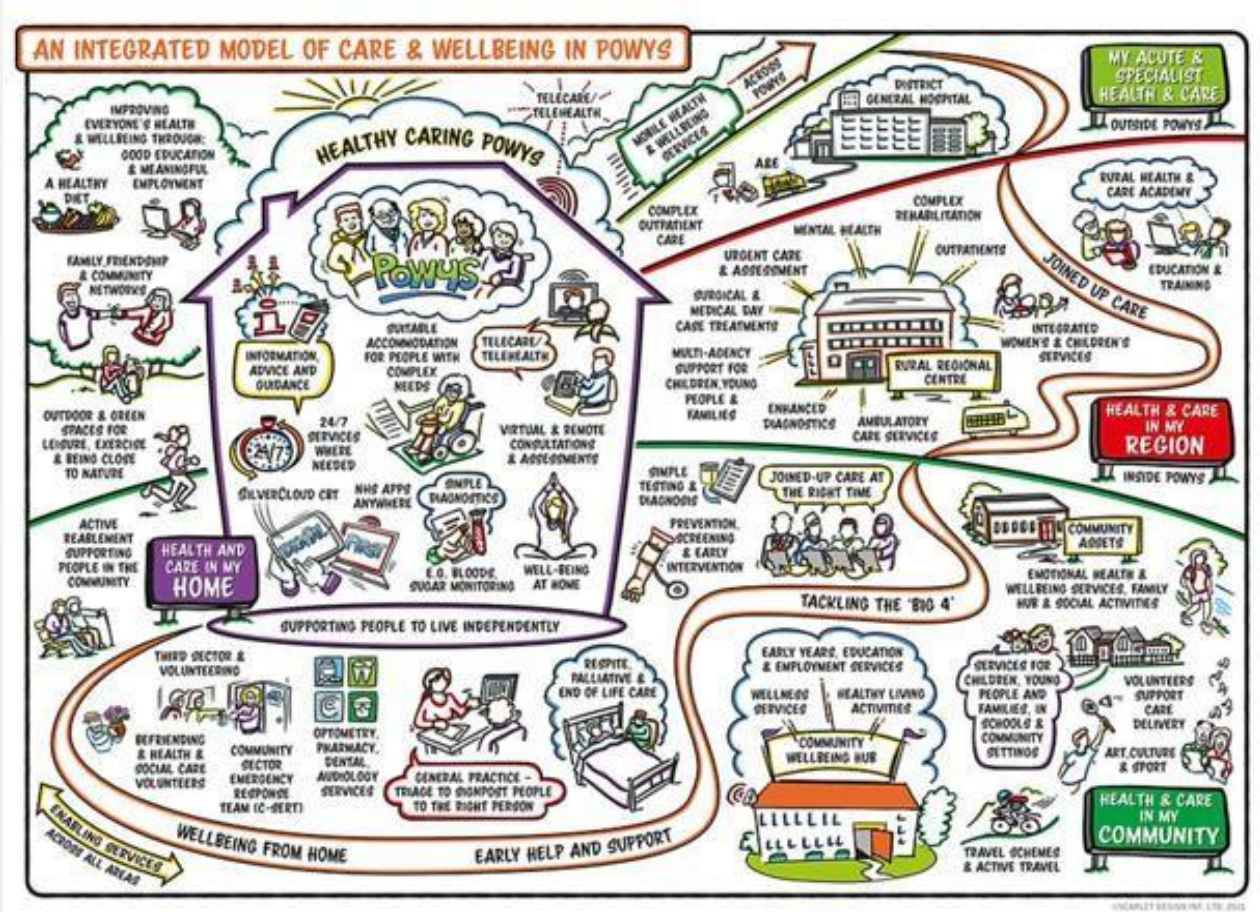
Better Together
Shaping the future of safe, quality health services for Powys

Background: Our Health & Care Strategy

Core to the model of care is:

- **Home**
- **Neighbourhood approach / community wellbeing hubs**
- **Regional Rural Centres**

- **Integrated health** and **care services** to meet holistic needs of individuals
- **Moving services (where safe and effective)** from secondary care out of county hospitals into Powys Rural Regional Centres
- **Utilising digital technology** to provide virtual clinics accessing secondary care professionals,
- **Linkage** to and provision of **adequate supported living accommodation**,
- **Community development** and **stakeholder involvement** to **deliver wider community benefits**,
- Offering **one stop services** and delivering as much of the care pathway as locally as possible within Powys,
- **Inter-generational Community Well-being Hubs** providing a means for alternative approaches to service delivery,
- Creating an opportunity to **bring communities together** to enable people to **address the well-being issues** which matter most to them.





Overarching Vision for Physical and Mental Health

Person at home

- 'Maintaining control of my life'
- Wellbeing awareness
- Information, advice & assistance
- In person services depending on need:
- Home based assessment, prevention, diagnosis and treatment
- Community development and connectors – including befriending
- Home support
- Personal care, Rehabilitation
- Respite
- Equipment and adaptations
- Virtual ward / Enhanced community care
- Same day and urgent community response
- Crisis resolution home treatment
- Emergency response
- Palliative and end of life care in the home
- Community transport

Community Solution teams & hubs

- Primary Mental Health Services
- Multi competency teams including third sector
- Virtual & actual MDT's including triage, assessment, planning (including crisis plan)
- Holistic frailty team
- Disability Teams
- Mental Health & shared care
- 111 Press 2
- Sanctuary
- Circle approaches
- Urgent community response (same day)
- Outpatients including virtual & modernised follow-up
- Shared care for frail patients with cognitive impairment
- Palliative care
- Admission avoidance & day case
- Rehab culture
- Deconditioning identified & prevented
- Inpatient optimisation through step up & step down



Rural Regional Centre

- Enhanced Urgent Care including Minor Injury & Illness
- Step up Assess /Treat including back up for virtual wards
- Primary Care OOH including Pharmacy
- Complex Rehabilitation
- Modernised Outpatient
- Diagnostics
- Specialist Community teams e.g. Respiratory, Cardiology

Rural Regional Centre for Mental Health

- In-patient assessment and treatment centre
- Section 136 suite
- Support for crisis and community teams through step up
- Shared care model for physical health needs of mental health patients

Out of County

- Specialist out of county outpatient appointments
- WAST 6-8-minute 'purple' or 'red' response and conveyance
- Emergency Admissions
- Emergency Department and Same Day Emergency Care
- Acute Clinical Unit (e.g. Medical Assessment Unit)
- Low secure, medium secure and mental health rehabilitation
- Tier 4 Eating Disorder Inpatient
- Psychiatric Intensive Care Units
- Private providers

Considerations:

- Community mental health provision needs to be more closely dovetailed into a tiered approach for enhanced community care (including rapid and crisis response in the community)
- A more joined up approach across mental health and physical health
- Sustainable care and support at home
- A tiered approach and response based on severity and urgency ranging from helping to maintain wellbeing through to people who are severely and urgently unwell who may need a crisis or emergency response.
- Travel time standards indicated in grey boxes

Social Model for Health s Wellbeing

Enable me to start well, live well & age well

- A **single hub** with several ways in to connect people to their community
- Access to **organically grown community led services** so individuals can be creative, learn new hobbies, and meet people of similar interests
- **Social connectedness** for advice, support, health promotion and signposting
- A place to **engage**, **help others** / **volunteer** and share skills & experiences
- A space to **empower individuals** to recognise their own potential
- Support to deliver **Proactive Health s Wellbeing Interventions** - transforming prevention, Early Help & support at home.
- Accessibility to **community transport**

Enable me to stay well & support myself

- **New front door** - interface between **Primary care**, **Health** and **Social Care, wellbeing activities** and **community assets**
- A place to support specific concerns "**what matters**" - housing, money worries, caring responsibilities, chronic health conditions, disabilities, bereavement.
- **Targeted intervention** - Integrated family centre, Youth club, Powys Living well service
- A place to adopt **healthy lifestyle changes** - e.g. Smoking cessation, weight management programmes
- **Drop-in services** - No eligibility or waiting lists
- Support to deliver **Targeted Support and Intervention**

Assess & Monitor me closely

- **"No wrong door"**- professionals **working together** to offer extra support when needed - helps work out what's working well
- **"Holding on"** not "referring on" principle adopting **a holistic seamless offer**
- A place for **individuals** from **stigmatised groups** to engage and **diminish negative perceptions**
- A space to focus on **trust**, **maintaining** and **strengthening relationships**
- **Coaching model** embedded within practice delivered **1:1** or **small groups**
- **Targeted interventions** - Mental & Emotional Health, Frailty, leg clubs etc. for clinicians to connect with a wider range of social issues

Step up my care

- A space for **Health champions** to work at the top of their licence - e.g. dementia navigator role, cancer champion
- A place for **individuals** suffering the **impacts** of **trauma** and **adversity** to receive holistic therapeutic **trauma informed wellness** and **healing**
- **Working together** with **Primary Care involvement**
- **Enhanced Community Care** - **multi agency** working **/ early conversations** to prevent a crisis response and support recovery
- A space to provide **specialist expertise** when needed to ensure needs are met



Goals: short term - reduce demand, long term - improved population health outcomes across the lifespan

Enablers

Digital access to advice, support and information
Digital offer to bring dispersed individuals together
Data to support assessment of current and future needs



Improved communication & common language
Collaborative working with team around the family approach
Delivery of Health & Care strategy
Listening to the community
Addressing issues together such as transport



Integrated workforce planning
Trauma informed practitioners
Investment in a skilled, competent workforce to deliver the model



Intergenerational hubs
Co-located public services and community assets
Space that adapts to people's needs
Venues free from stigma



Integrated Community Model

Enable me to start well, live well & age well

- **Place-based care** through networked **community hubs and primary care** proving care co-ordination and sign posting
- **Social prescribing &** wellbeing checks
- **Lifestyle support & behavioural activation**
- **Trauma Informed** approach
- **Health promotion** and **prevention** informed by population need
- **Vaccinations & Immunisation** programmes
- **Education** and **support** for carers and family including focus on **frailty & dementia**
- Focus on **current need and future generations**
- Use of **digital technologies** including apps and online resources to support education
- Use of community assets to support **digital inclusion**

Enable me to stay well & support myself

- **Single Point of Access**
- **Case finding & Risk stratification** including frailty indices, electronic health records, clinical insights and local intelligence
- **'What matters to me'** conversations, recognising multimorbidity
- **Personalised Care Planning** and **strengths-based assessments**
- **Future Care Planning** started closer to diagnosis to clarify what should happen when my needs escalate
- **Targeted Education** including use of **digital tools** to support **self-management** of **long-term conditions/multi-morbidity** including Living Well Services, prehabilitation and rehabilitation
- **Working together** between partners across Health including primary care, Local Authority and Third Sector to meet the **needs of the person.**

Assess & Monitor me closely

- **Multi agency Enhanced Community Care**
- Access to **diagnostic testing in the community** including **Straight to Test** pathways
- **Case Management** approach around the **needs of the person**
- **Frailty scoring** and **registers** used for monitoring
- **Comprehensive geriatric assessment**
- **Structured medication reviews**
- **Trusted Assessors**
- **Intermediate care** team including D2RA C step-down provision, falls response, rehabilitation & reablement
- **Supplementary Services** at Practice & Cluster level **based on population need**
- **Technology Enabled Care** for **remote monitoring** and **specialist input,** including focus on multimorbidity
- **Improved co-ordination** and **future care planning** for people in their last year of life and end of life

Step up my care

- **Intermediate care** team including **urgent community response** and **end of life care**
- **Enhanced support and treatment at home** including **IV antibiotics**
- Access to **one stop frailty multiagency MDT,** including dementia services
- **Same day** access to **Urgent Care assessment, diagnostic and treatment** either at home, in the community or in a health setting including **short stay inpatient admission**
- **Supplementary services** at Cluster level based on population need
- **Referral pathway optimisation** including timely access to specialist support through GPwER, Advanced Clinical Practitioners and specialist teams in and out of county

Goals – To provide integrated place-based, person-centred, digitally enabled and proactive care
Prevention of unnecessary hospital admission and supporting timely discharge
more seamless care & treatment

Enablers

Digital information sharing to support multi-agency case management and joined up care
Digital stratification, triage, referral, outcome and monitoring tools
Digital education, self-management and specialist support

Collaborative working with team around the family
Joint pathways and continuity of care
Delivery of Health C Care strategy
Listening to the community
Addressing issues together such as transport

Recruitment, Retention
Education, Training and Development
Integrated Workforce Planning
Staff Wellbeing and Support
Communication and Co-production
Empowering and supporting staff, with less aversion to managed risk

Co-located services
Age friendly environments
Intergenerational hubs
Fit for purpose, therapeutic spaces

Mental Health

Core Offer 1 - Thriving	Core Offer 2 - Getting Help	Core Offer 3 - Care and Treatment	Core offer 4 - Breaking the Cycle
Self Help and Community Based Support	**Timely Support and Intervention**	**Community based Mental Health and Social Care Services**	**Crisis Intervention and Acute Care**
• Building and Supporting inclusive communities • **Self Help/Self Care** awareness and information • **Community Based Support** including social and leisure activities that promote wellbeing • Promote **self-referral** to **Online CBT** • Promotion of **111(2)** • **Tackling Stigma** • **Joint working** and **co- location** - health, social care and third sector	• Developing the 'front door' - the **single point of open access** to direct patients to appropriate care aligned with 111p2 • Improved **pathways** and modelling care with **third sector partners** • Development of a **holistic assessment** and **navigation** service • Working with **Primary Care** to improve pathways aligned to single point of access • **Peer support** and **recovery college** approach	• **Community Teams** work seamlessly • **Primary peer support** designed by people with lived experience • **Safe space to assess, de-escalate** and **support** (Sanctuary model) • Sufficient **time to assess** mental health patients in primary care settings • Sustainable **specialist** and where appropriate, **recovery focussed multi-disciplinary** mental health support for people with higher level mental health needs • **Person Centred Care** and **Treatment**	• Strengthened pathway on admission in **commissioned providers** • **Fit for purpose Inpatient Environments** • Increased options for **enhanced care** • **Reviewed** and **improved pathways** for commissioned care • Increasing **Trauma Informed** approaches • **Agile** and **rapid response** and improved **Shared Care arrangements** with **physical health** • **Seamless support** on discharge

PEOPLE IN POWYS WILL EASILY ACCESS AND RECEIVE A TIMELY, SEAMLESS, HOLISTIC MENTAL HEALTH SERVICE CENTERED AROUND THEIR NEEDS. THE SERVICE WILL BE MODERN, SAFE SUSTAINABLE AND DELIVERED BY A SKILLED, INTEGRATED, MULTIDISCIPLINARY WORKFORCE WHO PROMOTE HOPE, CHOICE AND EMPOWER PATIENTS TO BE AT THE HEART OF THEIR CARE AND TREATMENT.

Enablers

Explore and incorporate future digital technologies
Robust case management system
Improved data, performance and outcomes system
Systems rationalised and aligned better joined up care



Collaborative working with team around the family approach
Joint pathways and continuity of care
Delivery of Health C Care strategy
Listening to the community
Addressing issues together such as transport



Recruitment, Retention
Education, Training and Development
Integrated Workforce Planning
Staff Wellbeing and Support
Communication and Co-production



Co-located services
Age friendly environments
Intergenerational hubs
Fit for purpose, therapeutic spaces



Community Health & Wellbeing Model

Enable me to start well, live well & age well

- **Support and enable people to stay healthy and maintain their health and wellbeing**
- **Community places**, where **social connections** happen, to support people to thrive
- **Public sector buildings**, **community hubs** & **community health and wellbeing hubs** contribute to delivery of the community model
- **Community groups** and **grassroots** organisations that function well
- **Volunteering opportunities** are developed & maintained across Powys
- **Information**, **advice** & **assistance**
- **Joined up** approach to area coordination and **community connection** / **social prescribing**
- Strengthening **community transport**

Enable me to stay well & support myself

- **Support and help people to manage their conditions and prevent deterioration**
- **Practical** & **personal support** in the **home** e.g. shopping; gardening; home maintenance
- **Assistive technology** (everyday aids; digital technology) to help people stay independent & manage their health, where clinically appropriate
- Support for **carers**
- **Early help** for self care including falls prevention
- **Rehabilitation / Reablement** to support and enable people to recover and maintain their independence at **home**
- Support people with **loneliness & isolation**

Assess & Monitor me closely

- **Integrated Multi-disciplinary Health and Social Care Teams to co-ordinate community input for people with rising complex conditions and needs**
- **"No wrong door"**– professionals **working together** to offer extra support when needed
- **Community Health champions** supporting and coaching people to maintain health and link to community groups
- **Targeted population interventions** – to support people to live with chronic conditions
- Support people to remain in their local community, with carer support

Step up my care

- Agreed **care plans for people with complex needs** with clear co-ordination from integrated multi-disciplinary teams
- Embed a trauma informed workforce to support **wellness** and **healing**
- **Enhanced Community Care** - **multi agency** working to prevent a crisis response and support recovery
- **Frailty teams** to support urgent escalating needs
- A space to provide **specialist expertise** when needed

Goals: short term – reduce demand, long term – improved population health outcomes across the lifespan

Enablers

Digital access to advice, support and information
Digital offer to bring dispersed individuals together
Data to support assessment of current and future needs

Improved communication & common language
Collaborative working with team around the family approach
Listening to the community
Addressing issues together

Integrated workforce planning
Investment in multi-disciplinary, skilled, competent workforce
Embed MECC that embales staff to use everyday interactions to support people to stay healthy and maintain their health & well well-being

Intergenerational hubs
Co-located services and community assets
Space that adapts to service and people's needs

ADCURIS CONSULTING

Powys Teaching Health Board

Strategic Demand and Capacity Modelling Report

Version 2.1

Updated May 2026

ADCURIS CONSULTING

Table of Contents

Table of Contents 2
Introduction and Case for Change 5
Clinical Context 5
Future Options for Powys Health Services 7
The Case for Change 7
Proposed Restructuring Options 7
Physical Health 7
Urgent Care 7
Mental Health 8
Demand and Capacity Modelling 8
Modelling Workstreams 8
Modelling Process (since 2024) 9
Modelling Components 10
Population Change 10
Non-Demographic Demand 10
Community beds and integrated community care: 11
Urgent Care: 11
Mental Health 11
Expatriation and Repatriation 11
Activity mitigation 11
Throughput and Utilisation 12
Granularity 12
Accommodating Uncertainty 12
Limitations of the Modelling and Recommendations for Follow-up Work 13
Modelling Inputs 16
Baseline Data – Data Sources 16
Demographic Change 16

Non-Demographic Demand 17
Assumptions used in Powys D&C modelling to date 17
Model Parameters 17
Expert opinion and local knowledge 17
Secondary analysis, modelling and research 18
Community Beds and Community Shift 19
Baseline Bed Capacity 19
Future Service Pathways 19
Community Beds: Summary Outputs 20
Projected Bed Capacity Requirements by Option 22
Community Shift 25
Rehabilitation and Reablement 25
Existing community rehabilitation and reablement capacity 25
Required Community Rehab capacity 25
Virtual Wards / Hospital at Home 26
Virtual Wards 26
Avoidable Admissions 27
Urgent Care 28
Optimising Urgent Care provision in Powys 28
Urgent Care: Summary Outputs 29
Projected Urgent Care Activity by Option 29
Urgent Care Room Capacity Requirements 32
Mental Health 34
Baseline Capacity 34
Mental Health: Service transformation assumptions 34
Mental Health: Summary Outputs 35
Projected Mental Health Activity and Bed Capacity Requirements by Option 35
Impact on Activity commissioned from external providers 40
Non-Elective Inpatients 40
A&E / Urgent Care 40

Mental Health..... 40
Summary and Conclusion..... 41

Introduction and Case for Change

The Powys Teaching Health Board (PTHB) Strategic Demand and Capacity Modelling Report outlines forecasted activity levels over a 10-year horizon to inform the design and scaling of future health services and infrastructure. Estimating future activity levels is a critical early step in scaling and designing new health services and infrastructure.

Operating in a uniquely rural and dispersed setting, Powys currently relies heavily on neighbouring health boards for district general hospital services and utilises a network of local community hospitals. However, escalating demand, increased patient complexity, workforce shortages, and financial pressures have rendered current service models unsustainable, creating a compelling case for systemic change.

With an emphasis on safe and sustainable high-quality care, the report focuses its modelling on three major service workstreams: Community beds and integrated community care (Physical Health), Urgent Care, and Mental Health

The analysis tests several future options—ranging from a baseline "Do Nothing" approach to realistic mid-range and highly ambitious "Do Maximum" models—to project how shifting toward integrated, community-based care pathways can alleviate current system constraints, handle demographic and non-demographic demand, and improve patient flow.

The report summarises the approach taken. It is aimed at helping to forecast the required activity levels for the various services and (using defined scenarios) giving some indication of the degree of flexibility to build into service planning to account for uncertainties and limitations in the modelling.

Any attempt to predict the future, especially as far out as 10 years, is challenging. Demand and capacity modelling is an essential component of strategic healthcare planning, but should be seen more as an "educated guess" than as a definitive crystal ball. Modelling can help health systems move away from reactive, short-term "firefighting," but it is only as good as the assumptions it uses.

Clinical Context

It is important to note that the service transformation assumptions upon which the demand and capacity modelling is based are predicated on implementation of the proposed Clinical Oversight Medical Model in Powys.

The Powys health system operates in a unique configuration characterised by a largely rural and dispersed population, a reliance on neighbouring health boards for district

general hospital services, and a network of community hospitals. Historically, services have relied on pragmatic arrangements, including GP-led inpatient care, to maintain continuity of care.

In response to existing challenges and the Health Board's level 4 de-escalation plan, Powys clinical advisors have made a strong case for change. As healthcare delivery evolves toward integrated community-based models—such as virtual wards, hospital-at-home pathways, and expanded community rehabilitation—care increasingly spans the traditional boundaries between primary care, community services, and hospital-based specialties. National evidence demonstrates that mature community pathways can significantly improve patient flow and hospital utilisation. For example, mature systems typically observe a 20–30% reduction in avoidable admissions for selected cohorts (such as frailty) and a 10–20% reduction in admissions through virtual ward programmes. However, it is critical to note that these benefits typically develop over time as systems mature.

The modelling assumptions set out later in this report regarding admission avoidance and expanded community activity depend heavily on community teams successfully managing a greater proportion of clinical complexity locally. Experience from national comparators indicates that achieving these modelled benefits relies on several critical enablers:

- Reliable multidisciplinary community teams and coordination.
- Consistent access to senior clinical advice and decision-making support for complex cases.
- Well-established and clear clinical escalation pathways.
- Appropriate governance arrangements across organisational boundaries.

Furthermore, the shift toward expanded community pathways necessitates strong clinical governance. In alignment with General Medical Council and NHS Wales frameworks, Powys's advisors recommend that redesigned pathways must ensure clear clinical accountability, safe delegation, and appropriate supervision. Maintaining clarity on referral pathways and the distinct roles of primary care (holistic, first-contact care) and secondary care (advanced, complex management and clinical leadership) remains essential for safe and sustainable multidisciplinary practice as the Powys system evolves.

Thus, the demand and capacity model Scenarios B and C transformation assumptions rely on a mature clinical operating model already being in place. In the current PTHB baseline, that senior medical model does not yet exist. Therefore, if the Clinical Oversight Medical Model is not implemented, Scenarios B and C would not be

deliverable as stated. They would need to be materially downgraded and re-assessed. As a prudent working assumption, the deliverable value might be assumed to fall below half of the stated 5% or 9% until an equivalent senior clinical governance model is in place.

Future Options for Powys Health Services

The Case for Change

Significant changes are required across Powys Teaching Health Board (PTHB) to address a multitude of systemic challenges. Growing demand and increased patient complexity are putting severe pressure on services. Currently, patients often must travel outside Powys for care that could be delivered locally, and there is limited, inequitable access to diagnostic tests such as X-rays and blood tests. Furthermore, workforce shortages, heavy reliance on temporary staffing, and escalating financial pressures are making current models unsustainable. A long-term solution is necessary to replace temporary service changes implemented in recent years and to upgrade outdated infrastructure.

Proposed Restructuring Options

To ensure safe, high-quality care, the health board has developed a spectrum of proposed options across three core service areas: Physical Health, Urgent Care, and Mental Health. The proposals range from "Do Previous" (reverting to how services operated before temporary closures) to "Do Maximum" (ambitious, large-scale structural changes).

The headline messages for each service area are:

Physical Health

The core strategy across the more ambitious options involves consolidating inpatient hospital beds from multiple community sites into two or three main hubs (such as Newtown, Brecon, and Llandrindod). This reduction in hospital sites would be offset by significantly improving community-based care, implementing a Hospital at Home model, and fostering closer joint working between physical and mental health services to help people stay and recover at home.

Urgent Care

The goal is to establish a fully integrated, community-based urgent care system to prevent unnecessary hospital admissions. The options range from completely closing Minor Injury Units (MIUs) in favour of GP-led care, to upgrading the system by

establishing advanced Minor Injury and Illness Units (MIIUs) or Urgent Care Centres (UCCs) on key sites with better access to diagnostic equipment.

Mental Health

Proposals focus on a recovery-based community model that integrates older adult mental health teams and introduces "sanctuaries" or safe spaces as an alternative to hospital admission. The mid-range to maximum options propose consolidating functional and organic mental health inpatient beds onto fewer sites—potentially centralising all beds at Bronllys, Brecon, or Newtown. A major priority of the maximum options is establishing "enhanced care" units locally to bring patients who are currently receiving out-of-county specialist care back into Powys.

The demand and capacity modelling set out in this report informs consideration of these options, and the results for each of the three service areas are summarised across the relevant options.

Demand and Capacity Modelling

The primary objectives for the D&C modelling in Powys have been agreed as:

- To understand demand and capacity requirements over a 10-year time horizon
- To inform strategic service and estate planning
- To support and inform the transformation process and feed into business cases for relevant capital and service developments

The modelling takes historical activity levels for each service and projects them forward using a set of defined parameters to produce estimates of future activity levels and capacity requirements.

Projections are made from a baseline year across a primary time horizon of 10 years. The geographical scope for modelling is defined as all Powys provider activity and commissioned activity for Powys residents and Powys-registered patients.

Modelling Workstreams

Initial work and analysis began in 2022, and this was concluded through an intensive work-up in 2025 and early 2026. A small group of clinical service leads was established for each active modelling workstream. Each group has met periodically to systematically review and agree on each aspect of the modelling and associated assumptions.

Adcuris has worked with the Powys Task and Finish Groups throughout the process (the main stakeholders for each of which are listed in Appendix 5). The evolving demand and

capacity analysis has, in turn, informed the development of the options during T&F Phase 1 work. The report consolidates the outputs shared during the option development process, and the clinical and professional teams have used them to inform workforce and financial appraisals.

The modelling for three major workstreams has been completed thus far and covered by this report:

- Community beds and integrated community care
- Urgent Care
- Mental Health

Three further modelling workstreams have been proposed, though work to update and finalise them has not yet begun.

- Planned Care: a baseline assessment has been carried out to inform recent work undertaken by the GIRFT team. No further specific modelling work is proposed at this stage.
- Imaging: this has been discussed, but modelling work has not been commissioned. It would require sourcing of up-to-date baseline diagnostic activity data from each provider organisation serving Powys residents.
- Children & Young People: again, this has not been progressed at this stage.

Modelling Process (since 2024)

Workstreams were re-established in 2024, comprising key clinical, managerial, and transformation programme leads. Each group has systematically reviewed and refined the modelling parameters relevant to its services, including:

- service scope
- baseline activity for each service
- demographic and non-demographic demand factors
- individual modelling parameters, taking account of relevant background data and information as appropriate.

Modelling Components

Change factors: The modelling accounts for the following change factors, which can impact how demand, activity and capacity requirements might evolve over time:

Population Change

The demand and capacity model includes a component which adjusts activity based on anticipated changes in the population size and age structure. The aim is to determine how service activity levels might shift due to demographic growth and structural changes.

The ONS population projections are widely regarded as the best available and are subject to ONS quality assurance.

The ONS publish national population projections for the constituent countries of the UK and separately sub-national population projections for England and Wales, which show change at the level of local authority district and Welsh Health Board.

Sub-national population projections include counts by single-year age up to age 89 and 90-plus.

Non-Demographic Demand

When considering growth in healthcare activity, it is standard practice to distinguish between demand that can be directly attributed to changes in the size and makeup of the population (demographic demand) and growth driven by other factors (typically grouped under the heading of 'non-demographic demand').

Key components of non-demographic demand include the impact of new medical technologies, changes in patient expectations, changes in clinical standards, and lifestyle and epidemiologically related factors.

Looking back, the net non-demographic demand is the residual (difference) between observed overall growth and the part explained by demographic change.

In England, the national New Hospitals Project (NHP) has carried out detailed analyses and an expert elicitation exercise to determine the NDG adjustments that have been applied within the Powys demand and capacity model as follows:

Community beds and integrated community care:

The Modelled value is based on the latest evidence base / guidance from the NHP analysis for non-elective inpatients (primary rate):

+1.16% per year

Urgent Care:

The modelled value is based on the latest evidence base / guidance from the NHP analysis for A&E (primary rate):

+1.31% per year

Mental Health

Specific drivers of non-demographic demand for mental health services include poverty and social inequality, adverse childhood experiences, trauma and abuse.

In the absence of specific national evidence and analysis, non-demographic demand rates for each service were systematically reviewed and refined with the mental health working group between 2022 and 2024. This work used local analysis to determine the difference between the observed overall demand change for each service and the element explained by demographic change, thereby producing a non-demographic demand rate for each mental health service team.

The analysis suggested that for certain mental health services, overall non-demographic demand is currently over 6% per annum, though this was impacted by COVID. COVID is considered to have had a significant impact on demand for mental health services and led to a step change in demand for certain services.

Expatriation and Repatriation

An expatriation assumption may be applied in the modelling to account for expected reductions in the current number of patients treated in Powys, who will receive care elsewhere in the future.

Repatriation assumptions, when applied in the modelling, account for an expected increase in PtHB residents being treated locally rather than outside Powys.

Activity mitigation

The modelling includes various assumptions about future service interventions, models of care and ways of working, which together mitigate the impact on required capacity

and other resources. For example, providing more proactive out-of-hospital care, making care virtual or reducing the duration of episodes of care.

Throughput and Utilisation

The projected activity requirements can be converted into required capacity requirements (beds, consulting rooms, etc.). The aim is to ensure that these are available when needed whilst minimising unnecessary downtime, and accounting for:

- Target occupancy rates
- Optimal duration of care / length of stay
- Resource availability (hours per day, days per week, weeks per year).

Granularity

Activity outputs can be broken down by patient age, activity type, point of delivery and specialty. Further breakdowns may be possible, subject to the availability of input data.

The main outputs will be projected activity levels for the horizon year, with capacity projections where appropriate. These can be used to inform work within other PtHB workstreams.

Accommodating Uncertainty

The model attempts to accommodate uncertainty by using different input scenarios.

- Scenario A: Do Nothing - keep doing what we do now
- Scenario B: Mid-Range - realistic and achievable
- Scenario C: Aspirational - more radical, “gold standard”

Using scenarios in this way allows exploration of the possible range of future activity levels, with a view to focusing on a mid-range assumption considered realistic and achievable (Scenario B).

Scenario B aims to reflect ambition to move towards significant improvements in service delivery and models of care, while being realistic about the significant challenges and constraints faced by health and care services.

Whilst this work has involved a significant amount of detailed analysis and modelling, it is acknowledged that there are modelling approaches whereby uncertainty may be characterised more formally through techniques such as confidence intervals, probability ranges, stochastic simulation, or other quantitative expressions of parameter uncertainty. Such methods are time-consuming and resource-intensive to

apply in such a comprehensive situation, as evidenced by the ongoing work to develop a demand and capacity modelling tool in the English NHS to support DHSC and its stakeholders in making robust and auditable assessments of activity that hospitals may need to accommodate in the future.

The approach adopted for the Powys demand and capacity modelling work was therefore considered more practicable, realistic, and proportionate to the stated scope and requirements.

Limitations of the Modelling and Recommendations for Follow-up Work

The model has the following overall limitations:

- It is based on estimating relative future demand for health services by undertaking a series of adjustments to baseline activity, rather than modelling demand for hospitals directly using epidemiological approaches, for example. This approach is being used given the significant challenges in modelling healthcare need directly (which requires disease-level modelling) and in translating this need into activity (where consensus on optimal approaches requires considerable debate and evolves over time). Estimating current activity and adjusting this has the advantage of an agreed starting point from which projections can be adjusted and tailored to individual schemes and scenarios.
- The modelling models future demand and capacity requirements using current observed activity as the starting point. It is acknowledged that this is not the same as the underlying population need. Further consideration will need to be given to how decisions based on the modelling outputs are aligned with population health goals.
- The report draws substantially on routine operational datasets. These are useful but have certain limitations, including issues of completeness, coding consistency, comparability across providers, changing recording practices, and pandemic-era distortion. Such limitations do not invalidate modelling, but they introduce a degree of uncertainty that is often difficult to quantify precisely.
- There are large areas of the health and care system that are beyond the scope and remit of the report, which focuses on the areas primarily concerned with transformational change. In relation to primary care, consideration has been given to assumptions that support management of demand. The impact of this on primary and community care, as well as on other aspects of the health and care system, will be assessed separately within the health board.

- The proposed health board resource for P1 will facilitate correct pathway placement for patients stepping down from acute care, thereby avoiding inappropriate community hospital placements pending social care input. This recognises the severe constraints and challenges that social care is operating under, whilst continuing to provide valuable support to P1 care. However, the report, as commissioned, focuses on demand and capacity rather than manpower planning, and so no specific modelling of the social care component has been included.
- The report strongly supports a strategic shift toward community-based, integrated care. With a primary focus on demand and capacity planning, the outputs are being used to inform more detailed local workforce and financial planning, though these aspects themselves are not covered in detail by the modelling.
- The final models themselves have now been handed over to the Health Board's informatics staff to allow ongoing local development and refinement. There are technical nuances in how modelling can approach certain calculations. In translating the models into the Databricks technical environment, Health Board staff have been able to refine some of the technical derivations. Thus, whilst an internal technical validation exercise has found that the recreated Databricks models are within 1% of the original model results in nearly all respects, the model results presented in this report may differ slightly from those of the more recently developed local models.

In relation to the **physical health modelling**, the following outstanding issues have been noted:

- Further work required to understand the possible impact of expedited discharges on D2RA Pathways 1, 2 and 3 on other provider excess beddays
- The data suggests a steep rise between 2021/2022 and 2025 in the % of patients bypassing a rehab opportunity following an acute hospital admission and being assessed for LTC in a P3 pathway. Further work is required to move to a situation where a P3 option is available only to a subset of P2 patients who are unable to move on, not as an alternative to P2.

In relation to the **urgent care modelling**, the following issue has been noted:

- Further local sensitivity analysis would help to understand the potential repatriation / expatriation impact of different options (taking account of travel times, relative population density, etc.)
- Specifically, there is a need to undertake travel time analysis. This is being picked up by the health board outside of this modelling work.

In relation to the **mental health modelling**, the following outstanding issues require attention:

- Completing the translation of demand and capacity projections into workforce and financial implications.
- Continuing to monitor progress towards realising the transformational change reflected in the modelled assumptions.
- Continue to review the proposed Powys provision in the light of the evolving model of care for inpatient mental health across Wales.

Modelling Inputs

Baseline Data – Data Sources

As far as possible, demand and capacity modelling have used NHS activity datasets (Admitted Patient Care, A&E/Urgent Care, Outpatients, Other Healthcare Professions - therapy, community, etc.). These are record/person-level data on historical NHS activity (anonymised).

Modelling baselines have recently (post-pandemic) been updated to 2024/25.

Where required, the modelling has been supplemented by local departmental activity data, for example:

Urgent Care:

- Baseline adjustment to take account of previous under-recording of activity
- Local primary care supplementary service data for urgent care
- Local analysis by clinical service leads of repatriation potential across three defined categories:
  - Category 0: unsuitable for MIU / MIIU
  - Category 1: within current scope of MIU
  - Category 2: potentially manageable with service development

Mental Health

- Memory assessment service data.

Where appropriate, other background analysis and benchmarking data have also been used to provide contextual information for users setting model parameters, rather than directly driving the modelling and outputs.

Demographic Change

The latest available projections for Powys, 2022-based sub-national projections, were published by ONS very recently

	2026	2031	2036	2041	2046
Age 0-17	23,205	22,211	21,230	20,847	20,941
Age 18-44	34,830	35,542	35,766	35,537	35,098
Age 45-64	37,667	36,237	35,668	36,886	38,894
Age 65-84	35,223	38,154	40,114	40,995	40,575
Age 85+	5,185	6,329	7,801	8,396	9,376
Total	**136,110**	**138,473**	**140,579**	**142,661**	**144,884**

Yr 0 to Yr 5	Yr 0 to Yr 10	Yr 0 to Yr 15	Yr 0 to Yr 20
4%	9%	10%	10%
2%	3%	2%	1%
4%	5%	2%	3%
8%	14%	16%	15%
22%	50%	62%	81%
2%	**3%**	**5%**	**6%**

Based on these, the projected population of Powys in 2032 is expected to be around 4.5% higher than previously projected.

The demand and capacity modelling for all workstreams has been updated to reflect the latest projections.

Non-Demographic Demand

Assumptions used in Powys D&C modelling to date:

Community beds and integrated community care:

- Modelled value is based on latest evidence base / guidance from the NHP analysis for non-elective inpatients (primary rate): +1.16% per year

Urgent Care

- Modelled value is based on the latest evidence base / guidance from the NHP analysis for A&E (primary rate): +1.31% per year

Mental Health

- In the absence of specific national evidence and analysis, non-demographic demand rates for each service were systematically reviewed and refined with the MH working group between 2022 and 2024.
- This work considered local analysis to determine the difference between observed overall demand change for each service and the element explained by demographic change.

Model Parameters

The model sets its parameters informed by:

Expert opinion and local knowledge

For example, assumptions on the impact of specific service transformation strategies and interventions, which equate to potentially mitigatable activity. These inputs have been set by working groups for each primary service area, informed by external benchmarking and evidence where appropriate.

Secondary analysis, modelling and research

Some of the inputs are drawn directly from available literature and studies, but several inputs, such as the non-demographic growth values, are the product of local and national subsidiary analysis and modelling.

The modelling uses the activity increase/decrease estimates in the parameters to transform the input data into estimates of future activity.

Details of the rationale and evidence base behind each modelling parameter, together with specific scenario assumptions are given in Appendix 1: Powys Demand and Capacity Modelling Assumptions.

Community Beds and Community Shift

Baseline Bed Capacity

The available bed capacity as of October 2024 was as follows:

South and Mid Powys

- Ystradgynlais Community Hospital: 20 beds
- Epynt Ward, Brecon: 15 beds
- Y Bannu Ward, Brecon: 14 beds
- Bronllys Community Hospital: 18 beds
- Llandrindod Community Hospital: 15 beds

North Powys

- Victoria Memorial Hospital, Welshpool: 21 beds
- Montgomeryshire County Infirmary, Newtown: 15 beds
- Bro Dyfi Hospital, Machynlleth: 14 beds
- Llanidloes War Memorial Hospital: 14 beds

The total PtHB physical health bed count is 146 beds, excluding surge provision

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 Powys County Council.

Powys also currently commissions an average of 11 community beds from external providers to deal with excess unplanned demand.

Future Service Pathways

The future service pathways defined for this model relate to patients from other providers stepping down onto Powys care pathways, or Powys residents stepping up onto Powys care pathways. Another key aspect of the modelling examines the potential to mitigate certain aspects of activity through proactive community care in Powys. Following iterative review and discussion within the physical health working group the following range of pathways was agreed for the modelling:

- Community Shift: Avoidable Admissions, Virtual Wards / Hospital at Home
- End-of-life / palliative care pathways
- Stroke step-down pathways
- Orthopaedic step-down pathways
- Step-up pathways

- Discharge to Recovery and Assess (D2RA) step-down pathways

In addition, the future service vision for mental health includes moves towards integrating physical and mental health inpatient care and holistic treatment for patients with organic mental health conditions.

Modelling parameters and assumptions for each pathway are set out in detail in Appendix 1: Powys Demand and Capacity Modelling Assumptions, together with observations from local clinical teams and references where appropriate.

Some of the pathways involve bed-based care, and some do not. The modelling derives the Future Service Pathways in sequence; so, for example, if someone is allocated to a Stroke rehab pathway, they cannot then be allocated to a D2RA pathway for the same episode of care.

The model uses a combination of frailty risk scoring, number of long-term conditions, and patient age to stream activity into the relevant future service pathways. The working assumption is that step-up or step-down patients with higher frailty will tend to require more intensive care (e.g., longer stay step-up, or D2RA pathway 2 or 3).

Target utilisation rates were set for each pathway based on local discussion informed by experience and evidence from many projects undertaken elsewhere.

Community Beds: Summary Outputs

The modelled scenarios have been defined as follows:

Scenario A: Do Nothing scenario

- Year 0: baseline + no change to current models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + no change to current models of care and ways of working

Scenario B: Realistic / Achievable scenario

- Year 0: baseline + realistic changes to models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + realistic / achievable future service pathways and throughput / utilisation

Scenario C: Radical / Aspirational scenario

- Year 0: baseline + “gold standard” / idealistic changes to models of care and ways of working

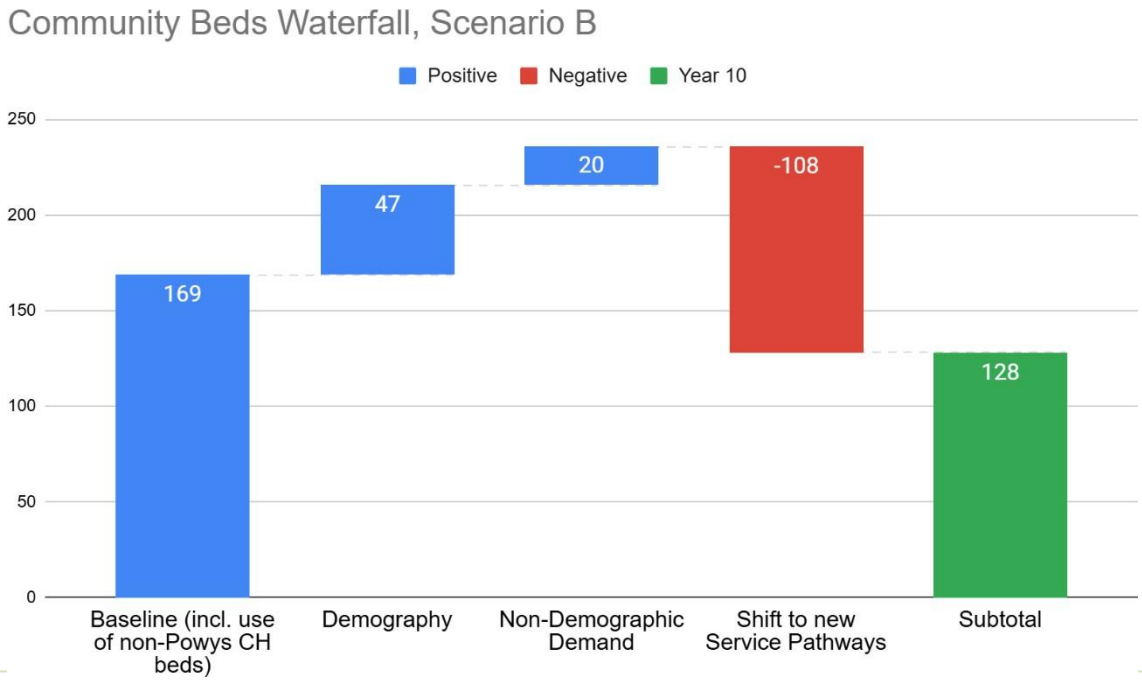
- Year 10: baseline + demographic change + non-demographic demand + "aspirational" future service pathways and throughput / utilisation

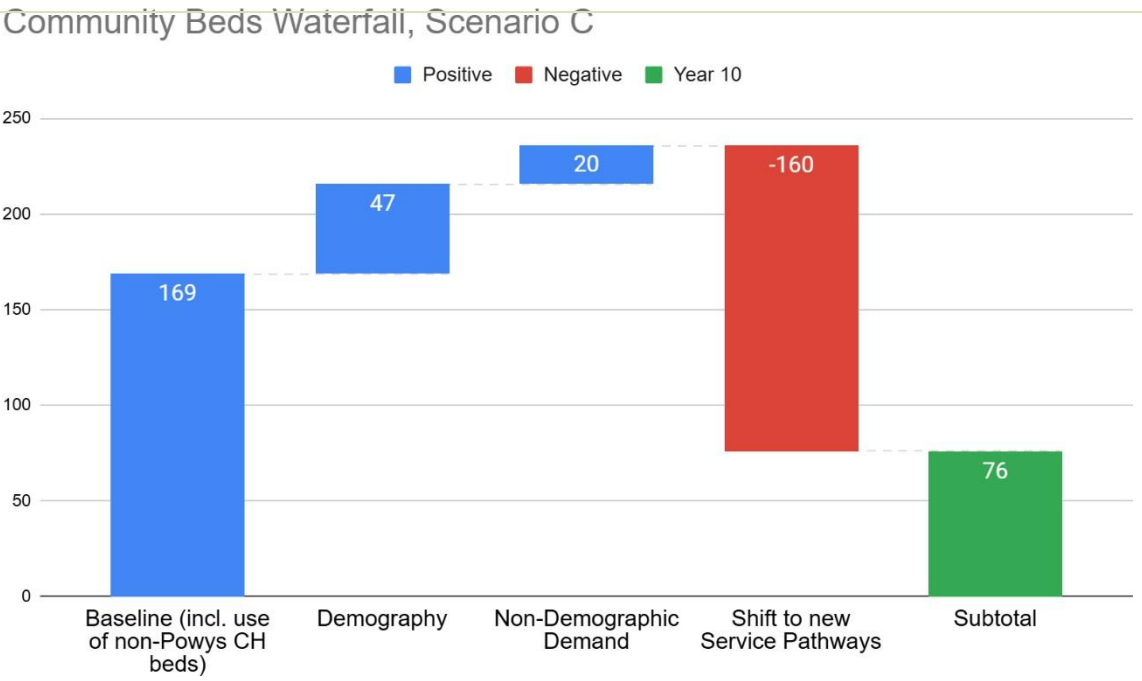
Existing and projected community bed requirements are summarised below:

	North Powys	Mid Powys	South Powys	Total
Existing / Year 0 beds				
Existing beds (October 2024)	64	27	67	158 + 11 out-of-county beds = **169**
Year 0 beds, new pathways only, Scenario B	37	24	20	**81**
Year 0 beds, new pathways only, Scenario C	22	15	14	**51**
Year 10 beds				
Year 10 beds, Scenario A (do nothing)	98	25	101	224 + 12 out-of-county beds = **236**
Year 10 beds, new pathways, Scenario B (realistic / achievable)	57	35	36	**128**
Year 10 beds, new pathways, Scenario C (aspirational / radical)	32	22	21	**76**

Based on Powys APC Model F.30

The charts below summarise the impact of the main components of change for scenarios B and C.


Community Beds Waterfall, Scenario B
Positive
Negative
Year 10
250
200
150
100
50
0
169
47
20
-108
128
Baseline (incl. use of non-Powys CH beds)
Demography
Non-Demographic Demand
Shift to new Service Pathways
Subtotal


Community Beds Waterfall, Scenario C
Positive
Negative
Year 10
250
200
150
100
50
0
169
47
20
-160
76
Baseline (incl. use of non-Powys CH beds)
Demography
Non-Demographic Demand
Shift to new Service Pathways
Subtotal

Projected Bed Capacity Requirements by Option

A series of options has been developed through structured workshops and technical analysis, progressing from a long list to a shortlist of credible and viable options

through the application of agreed Hurdle Criteria and iterative refinement. These options were subject to a comprehensive, multi-stage appraisal process, including non-financial assessment using the NHS Wales STEEP domains of quality, supported by sensitivity analysis, as well as workforce, financial, estates, demand and capacity modelling, travel time analysis, patient pathway testing, and quality and equality impact assessments.

The options were developed through a structured and iterative Options Development process, overseen by and delivered through the Option Development Group. This process brought together clinical, operational, workforce, finance, estates and planning expertise to test and refine a long list of potential options against agreed service principles, deliverability, workforce sustainability and alignment with the agreed Journey to Consultation. Options were iteratively refined through clinical working groups, technical appraisal, and non-financial options appraisal workshops, with outputs consolidated through formal Options Development Group reporting.

Demand and Capacity (D&C) modelling has been a core input to this process. As described above, the demand and capacity modelling has tested the impact of potential scenarios, i.e., do nothing, mid-range, realistic and achievable, and aspirational, ambitious, and longer-term. These have been aligned with the Powys shortlisted options to demonstrate future demand projections and have also been considered as part of the workforce and financial modelling.

Validation of the demand & capacity modelling outputs was undertaken by the information and finance teams through scrutiny of the detailed modelling outputs and a series of knowledge transfer sessions with Adcuris Ltd. This has had a twofold purpose: firstly, to assure the technical methodology, and secondly, to support the organisational delivery of modelling activity of this nature in the future. Detailed assumptions underpinning the modelling were shared with SROs and Public Health leads for review prior to its finalisation.

Based on the modelled capacity projections, capacity requirements for each option in Year 10 are as follows:

PtHB Option Description	North Powys	Mid Powys	South Powys	Total
001a: Do Previous (before any temporary service changes)	64	27	67	158
001b: Do Current (continue as now, making temporary service changes permanent)	64	27	67	158

011: Remove all inpatient beds from PTHB	0	0	0	0
002a: Do Minimum: (same number beds, on 6 sites) + better PH community	64	27	67	158
002b: Do Minimum: (same number beds, on 6 sites) + better PH community + MH join up	64	27	67	158
005a: Do Mid range: (fewer beds, on 3 sites) + better PH community	57	35	36	128
005b: Do Mid range: (fewer beds, on 3 sites) + better PH community + MH join up	57	35	36	128
008: Do Maximum: (fewer beds, on 2 sites) + better PH community + MH join up	32	22	21	76

Based on Powys APC Model F.30

Notes on option mapping:

- The bed numbers above for options 001a & b, Option 011, and options 002a & b are based on existing hospital beds, excluding beds commissioned from out-of-county providers
- Option 011: requires recommissioning of beds from out-of-county acute, community hospital and/or local nursing home providers
- Options could be implemented sequentially (e.g., if option 5 is the preferred endpoint, begin by implementing option 2)
- Projected bed requirements for Option 5 are based on D&C model Scenario B (mid-range)
- Projected bed requirements for Option 8 are based on D&C model Scenario C (aspirational)

Detailed model outputs are given in Appendix 2: Model Outputs - Community Beds and Community Shift

The bed modelling is not prescriptive about where or how the beds are to be provided in the future. It simply means these patients are 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 / care home beds, beds managed by the independent sector, etc.

Community Shift

Increasingly proactive and strengthened community services are at the heart of the service transformation necessary to achieve optimal care and improved outcomes for patients. These include, for example, D2RA Pathway 1, stroke and hip fracture rehabilitation and reablement, effective urgent community response, and a more proactive, clinically enabled urgent care model.

If these services and pathways are provided effectively and at the right scale, they can, together, help minimise undesirable consequences such as avoidable acute admissions, delayed acute discharges (and hence unnecessary excess beddays) or stepdown patients admitted to community beds due to a lack of an appropriate community care package.

Rehabilitation and Reablement

Existing community rehabilitation and reablement capacity

Between 21 and 30 patients are currently being managed in community reablement pathways in Powys. The Health Board plans to increase that by another 10 places (concurrent capacity). Reablement packages are typically provided for 4-6 weeks, with allocation to a pathway within 48 hrs of the decision to discharge.

Note that additional resources are required to manage effective Urgent Community Response services.

With a capacity of up to 40 concurrent patients and an average stay of 5 weeks, the health board can currently treat 416 community rehab cases per year.

Required Community Rehab capacity

To deliver the required activity shifts, an increase in community rehabilitation and reablement services is needed. Projected future activity levels, together with additional care hours / WTE equivalent required per week for Scenarios B and C are as follows:

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

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

So, 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).

Virtual Wards / Hospital at Home

Another important aspect of community services provision in the future relates to Virtual Wards and Hospital at Home. Whilst these are technically distinct in their clinical applications and technological focus, they share the same goal of providing 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.

Virtual Wards

The demand and capacity modelling assumes that Virtual Ward pathways will be appropriately resourced, with clearly identified protocols across Powys, leading to a reduction in excess beddays 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.

Projected future requirements for Scenario B are as follows:

- Projected Year 10 Virtual Ward expedited discharges per year: 806
- Projected Year 10 Virtual Ward excess beddays per year: -2,720

Projected future requirements for Scenario C are as follows:

- Projected Year 10 Virtual Ward expedited discharges per year: 1,274
- Projected Year 10 Virtual Ward excess beddays per year: -4,122

Avoidable Admissions

This aspect of the modelling has considered and quantified the potential to reduce avoidable acute hospital admissions to external providers (low-complexity non-elective admissions for people aged over 65).

Achieving the projected reductions will require effective hospital-at-home provision, combined with proactive in-county urgent care services with senior clinical decision-making.

Projected future requirements for Scenario B are as follows:

- Projected Year 10 Avoided Admissions activity per year: -962
- Projected Year 10 Avoided Admissions excess beddays per year: -4,531

Projected future requirements for Scenario C are as follows:

- Projected Year 10 Avoided Admissions activity per year: -1,924
- Projected Year 10 Avoided Admissions excess beddays per year: -9,062

Urgent Care

Optimising Urgent Care provision in Powys

While emergency care remains outside the scope of service delivery within PTHB, urgent care is provided locally through a range of services, including Minor Injury Units (MIUs). Additionally, PTHB Commissions a Minor Injury Supplementary Service with 11 GP Practices across Powys.

PTHB has committed to optimising its urgent care offer for several reasons: to provide the best possible care for residents, minimise unnecessary travel, and support care delivery as close to home as possible. This ambition also aligns with national strategic objectives. Reducing unnecessary attendances at Type 1 Emergency Departments helps alleviate pressure on overstretched acute services, supports improved ambulance flow, and ensures emergency resources are available for those in greatest need.

This work also supports the delivery of Goal 3, “Clinically safe alternatives to admission to hospital”, and Goal 4 “, Rapid response in a physical or mental health crisis”, of the Six Goals for Urgent and Emergency Care.

To support this, an internal review was undertaken to understand the nature of ED attendances and identify the proportion of demand that could potentially be managed within PTHB’s urgent care services, specifically through the existing Minor Injury Unit (MIU) service model and/or through a new enhanced Minor Injury and Illness Unit (MIIU) service model. This work has been used to inform the framing of the assumptions in the demand and capacity modelling.

Specifically, repatriation assumptions were based on detailed local analysis of repatriation potential across 3 defined categories:

- Category 0: unsuitable for MIU / MIIU
- Category 1: within current scope of MIU
- Category 2: potentially manageable with service development

Modelling parameters and assumptions for urgent care are set out in detail in Appendix 1: Powys Demand and Capacity Modelling Assumptions, together with observations from local clinical teams and references where appropriate.

Urgent Care: Summary Outputs

Projected Urgent Care Activity by Option

The modelled scenarios have been defined as follows:

Scenario A: Do Nothing scenario

- Year 0: baseline + no change to current models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + no change to current models of care and ways of working

Scenario B: Realistic / Achievable scenario

- Year 0: baseline + realistic / achievable future models of care and throughput / utilisation
- Year 10: baseline + demographic change + non-demographic demand + Expat Impact + Repat Impact Cat 1 + Repat Impact Cat 2 + Primary Care Minor Injury Supplementary Service (mid-range) + GMS Same-Day activity (mid-range) + realistic / achievable throughput / utilisation

Scenario C: Radical / Aspirational scenario

- Year 0: baseline + “gold standard” / idealistic changes to models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + Expat Impact + Repat Impact Cat 1 + Repat Impact Cat 2 + Primary Care Minor Injury Supplementary Service (aspirational) + GMS Same-Day activity (aspirational) + "aspirational" throughput / utilisation

Existing and projected year 10 urgent care activity levels are summarised below:

	North Powys	Mid Powys	South Powys	Total
Year 0 activity				
All scenarios	5,208	6,997	11,597	23,802
Year 10 activity				
Scenario A (do nothing)	6,026	8,317	13,812	28,155
Scenario B (mid-range)	14,519	12,642	19,418	46,579
Scenario C (aspirational)	15,377	13,605	20,716	49,698

Based on Powys UC Model C.16

Modelled scenarios have been mapped to Powys options as follows:

- Options 001a/b/dii: Do Nothing activity scenario

- Option 001cii: Do Nothing activity scenario + cat 1 repatriation
- Option 001c: Do Nothing + Cat 1 repatriation activity
- Option 010/010ii: Mid-Range activity scenario
- Option 013/013ii: Aspirational activity scenario

Based on the modelled activity projections, Year 10 activity for each 3-centre option is as follows:

PtHB Option Description Year 10 projected activity	North Powys	Mid Powys	South Powys	Total
001a: Do Previous (before any temporary service changes)	6,026	8,317	13,812	28,155
001b: Do Current (continue as now, making temporary service changes permanent)	6,026	8,317	13,812	28,155
001c: Do Minimum (make temporary service changes permanent and improve service)	10,109	10,393	17,036	37,538
005: Close Minor Injury Units and provide urgent care in other ways	0	0	0	0
010: Do Mid-Range: Better local Urgent Care (3 x MIIUs in Powys)	14,519	12,642	19,418	46,579
013: Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)	15,377	13,605	20,716	49,698

Based on Powys UC Model C.16

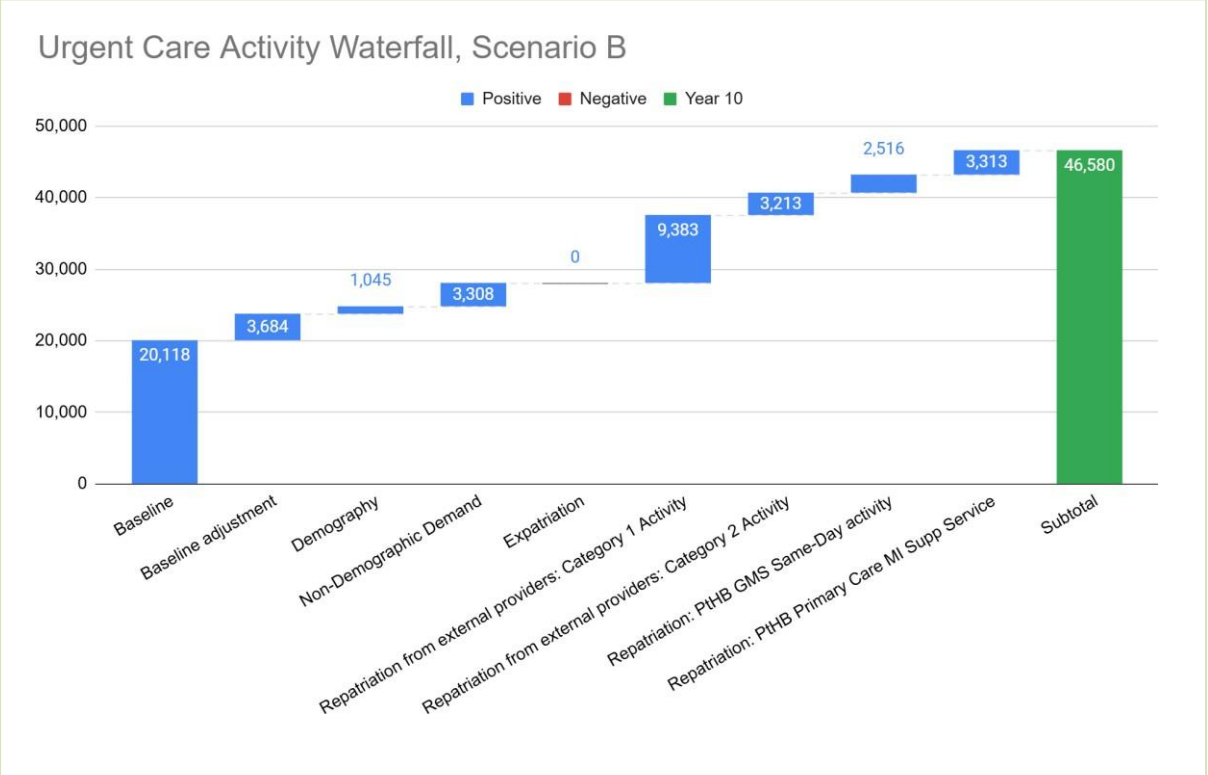
Based on the modelled activity projections, Year 10 activity for each 2-centre option is as follows:

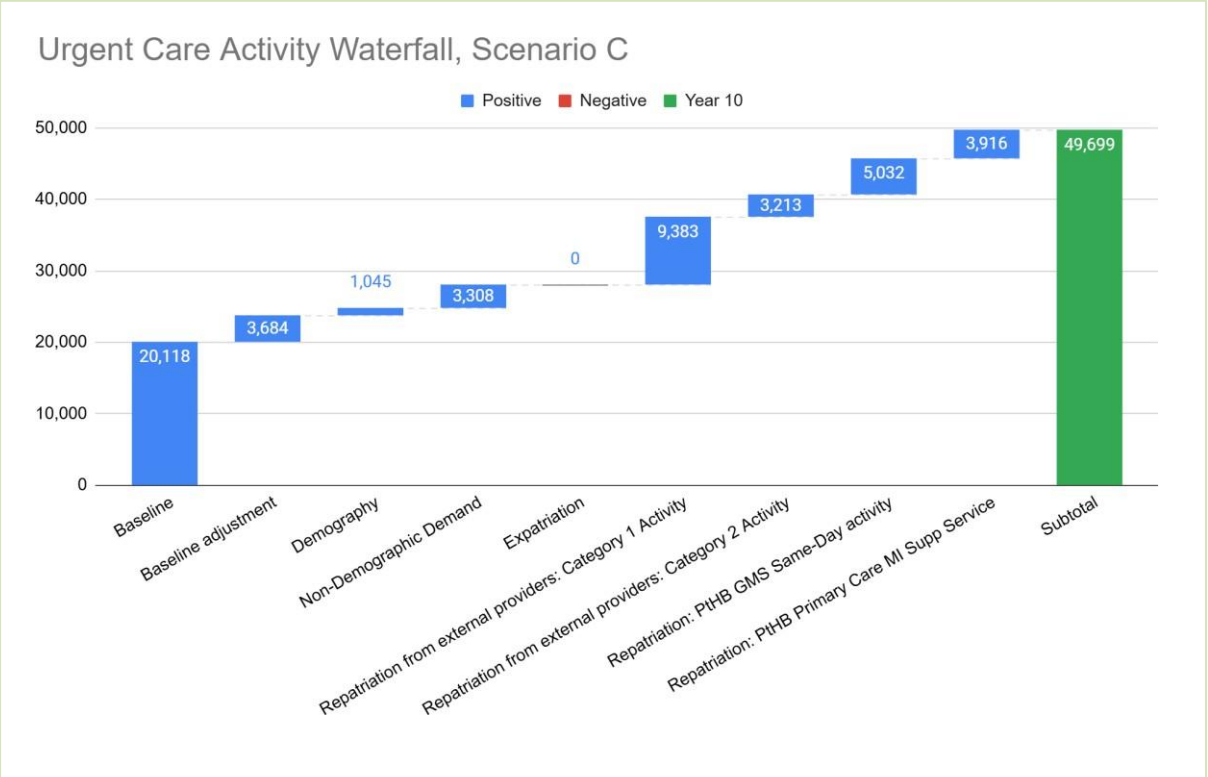
Two-centre options (Year 10)	North Powys	South Powys	Total
UCDO_001Dii – 2 MIU services: Baseline + demographic/non-demographic projection only. No projected repatriation.	10,185	17,970	28,155
UCDO_001Cii – 2 Enhanced MIU services: Baseline + demographic/non-demographic projection + Cat 1 repatriations + other previously agreed repatriations.	15,306	22,232	37,538
UCDO_010ii - 2 MIIU services: Baseline + demographic/non-demographic projection + Cat 1&2 repatriations + other previously agreed repatriations.	20,840	25,739	46,579
UCDO_013ii - 2 UCC services:	22,180	27,519	49,698

Baseline + demographic/non-demographic projection + Cat 1&2 repatriations + other previously agreed repatriations (higher threshold).			

Based on Powys UC Model C.16

The charts below summarise the impact of the main components of change for scenarios B and C *(based on Powys UC Model C.16)*.





Urgent Care Room Capacity Requirements

For activity with more unpredictable demand, the Erlang / Poisson queueing theory approach is used to determine capacity requirements.

The major consideration in converting urgent care activity is to determine an acceptable rate of room / cubicle unavailability, expressed through local consideration of acceptable levels of “turnaway rates”. Turnaway is a measure of unmet demand and reflects the consequences of insufficient capacity, such as excessive patient waiting times, patients being turned away, or patients being assessed or treated in inappropriate rooms or areas. For the urgent care capacity projections, two turnaway rates for each locality have been used. This allows the required capacity, in terms of the proportion of attendances for which a room or cubicle should be immediately available, to be expressed as a range.

Using the above approach, projected activity was used to determine the room / cubicle capacity requirements for each urgent care locality and for each option:

001c: Do Min + Cat 1 RepatriationMid Range:
keep temp. service changes and improve service (3 x MIUs in Powys)

	North	Mid	South
Cat 1 Capacity	1 to 3 rooms	1 to 3 rooms	3 to 5 rooms
Cat 2 Capacity	-	-	-

010: Do Mid Range: Better local Urgent Care (3 x MIIUs in Powys)

	North	Mid	South
Cat 1 Capacity	3 to 4 rooms	3 to 4 rooms	4 to 5 rooms
Cat 2 Capacity	0 to 1 rooms	0 to 0 rooms	0 to 0 rooms

013: Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)

	North	Mid	South
Cat 1 Capacity	3 to 4 rooms	3 to 4 rooms	4 to 5 rooms
Cat 2 Capacity	0 to 1 rooms	-	0 to 0 rooms

2-Centre Options

001Cii: 2 Enhanced MIU Services

	North	South
Cat 1 Capacity	1 to 3 rooms	1 to 3 rooms
Cat 2 Capacity	-	-

010ii: 2 MIIU Services

	North	South
Cat 1 Capacity	4 to 5 rooms	4 to 7 rooms
Cat 2 Capacity	0 to 1 rooms	0 to 0 rooms

013ii: 2 UCC Services

	North	South
Cat 1 Capacity	4 to 5 rooms	5 to 7 rooms
Cat 2 Capacity	0 to 1 rooms	0 to 0 rooms

Based on Powys UC Model C.16

Detailed model outputs are given in Appendix 3: Model Outputs – Urgent Care

Further local work is needed to understand and define the physical room requirements (room types) for the models of care related to each option, for example:

- Provision of generic clinical rooms (capable of supporting consultation, examination and treatment) is recommended depending on fluctuating demand.
- Triage room(s), if provided, should be in addition to the above.

Mental Health

Baseline Capacity

Existing bed capacity is as follows:

- Felindre Ward (Bronllys): 16 adult functional MH beds +2 crisis admission beds
- Clewedog Ward (Llandrindod Wells): 10 older adult functional & organic beds
- Tawe Ward (Ystradgynlais): 10 older adult functional & organic beds

The total baseline PtHB mental health bed count is 38 beds

In addition, 5 additional beds in Defynnog Ward (Bronllys) are planned, subject to local approval.

There are no psychiatric intensive care (PICU) beds within Powys.

Mental Health: Service transformation assumptions

A range of parameters was identified through extensive local discussions to reflect different aspects of the service-change agenda for mental health. Each parameter was informed by relevant local initiatives, external data, and, where possible, benchmarking. The aim was to determine which service areas are likely to be impacted by each initiative.

Specific impact assumptions for each parameter were agreed upon by the mental health working group to determine which service areas are likely to be affected by each initiative. In doing so, every effort was made to avoid overlapping impacts and double-counting across factors.

The parameters included in the model are as follows (reference numbers relate to internal working documents):

5.2.2 Single point of access

5.2.3 Inter-Service Collaboration

5.2.5 Reduction in intentional self-harm-related admissions

5.2.7 Reduction in A&E/ED Crisis Attendances

5.2.8 Repatriation of specialist out-of-county inpatient activity

5.2.10 Reduction in inpatient readmissions within 30 days

5.2.11 Integration of physical and mental health inpatient care and treatment for organic patients

5.2.12 Increasingly informed approach to managing psychological trauma in acute settings combined with investment in DBT

5.2.13 Bed occupancy reduction due to more proactive care: shorter LoS and reduced admissions

5.2.14 Holistic assessment (MDT approach) at front door to improve early intervention and reduce waiting times

5.2.15 Digital interface - virtual appointments increasing in line with national guidance

5.2.16 Extended working hours

5.2.17 Open access model will help to reduce the number of follow-up appointments

Mental Health: Summary Outputs

Projected Mental Health Activity and Bed Capacity Requirements by Option

Scenario A: Do Nothing scenario

- Year 0: baseline + no change to current models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + no change to current models of care and ways of working

Scenario B: Realistic / Achievable scenario

- Year 0: baseline + realistic changes to models of care and ways of working
- Year 10: baseline + demographic change + non-demographic demand + realistic / achievable future models of care and throughput / utilisation

Scenario C: Radical / Aspirational scenario

- Year 0: baseline + “gold standard” / idealistic changes to models of care and ways of working

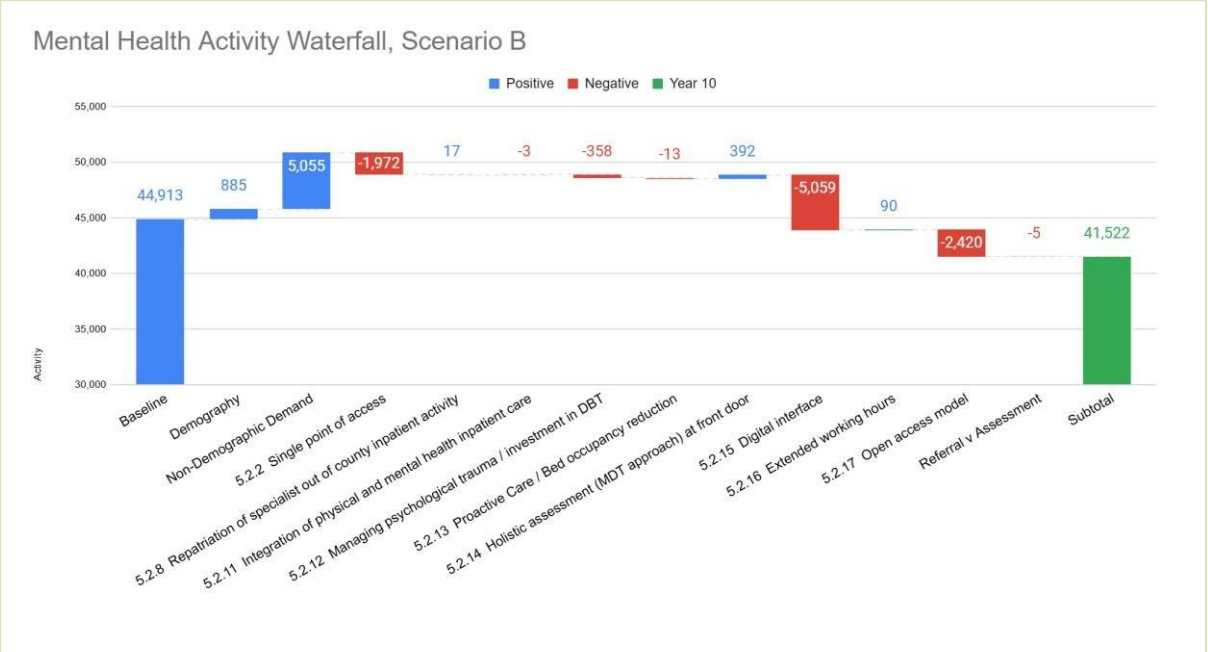
- Year 10: baseline + demographic change + non-demographic demand + "aspirational" future models of care and throughput / utilisation

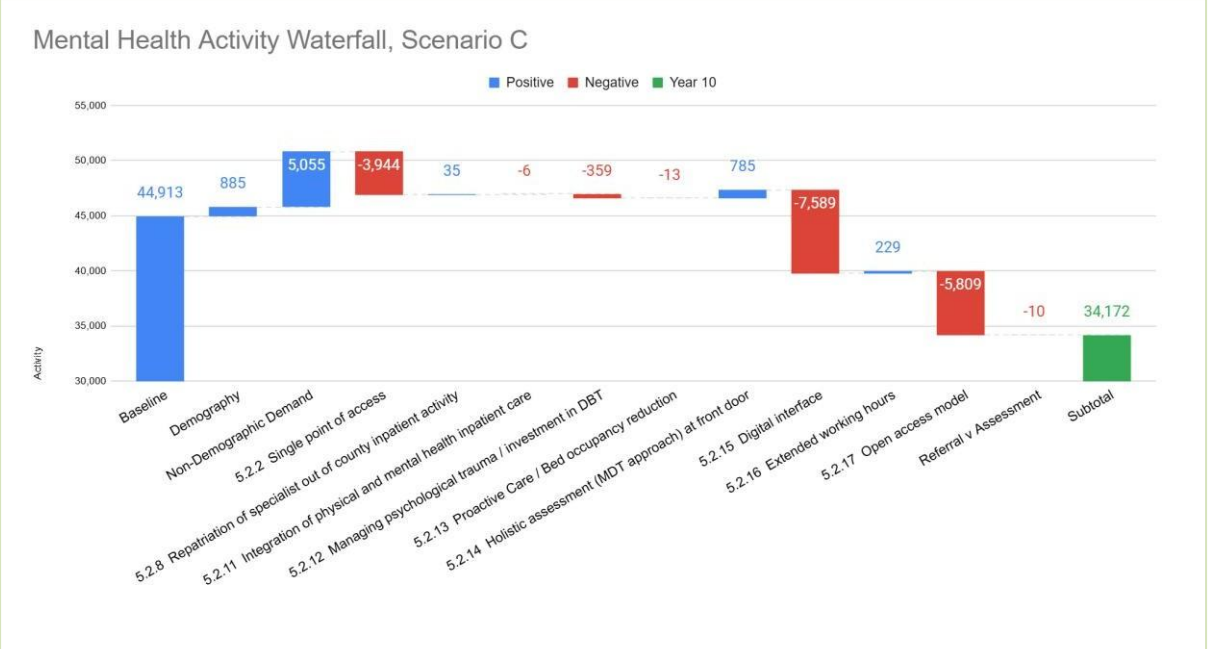
Based on the modelled activity projections, Year 10 activity and beds for each option are as follows:

Mental Health Options: Activity Year 10 (HCP and Outpatients)	North Powys	Mid Powys	South Powys	Total
001a: Do Previous (before any temporary service changes)	24,241	9,711	16,901	50,853
001b: Do Current (continue as now, making temporary service changes permanent)	24,241	9,711	16,901	50,853
003a: Do Minimum: Functional beds to Bronllys + integrated OAMH community	24,241	9,678	16,934	50,853
004a: Do Mid-Range: Functional beds to Brecon + integrated OAMH community	19,789	7,901	13,833	41,523
006a: Do Maximum: All beds to Bronllys + integrated OAMH community	16,281	6,482	11,409	34,172
007a: Do Maximum: All beds to Brecon + integrated OAMH community	16,281	6,482	11,409	34,172
008a: Do Maximum: All beds to Newtown + integrated OAMH community	16,511	6,482	11,179	34,172
010a: Do Maximum: All beds to Brecon + Newtown + integrated OAMH community	16,328	6,482	11,362	34,172

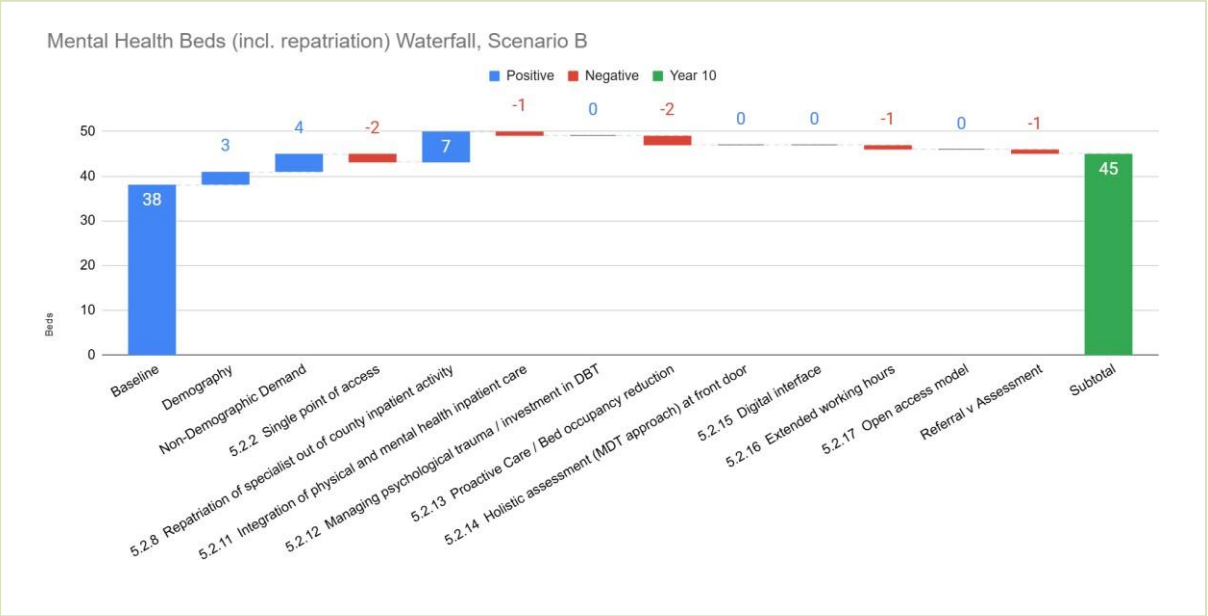
Mental Health Options: Beds Year 10	North Powys	Mid Powys	South Powys	Total
001a: Do Previous (before any temporary service changes)	0	14	31	45
001b: Do Current (continue as now, making temporary service changes permanent)	0	14	31	45
003a: Do Minimum: Functional beds to Bronllys + integrated OAMH community	0	5	39	45
004a: Do Mid-Range: Functional beds to Brecon + integrated OAMH community	0	5	40	45
006a: Do Maximum: All beds to Bronllys + integrated OAMH community	0	0	47	47
007a: Do Maximum: All beds to Brecon + integrated OAMH community	0	0	47	47
008a: Do Maximum: All beds to Newtown + integrated OAMH community	47	0	0	47
010a: Do Maximum: All beds to Brecon + Newtown + integrated OAMH community	27	0	20	47

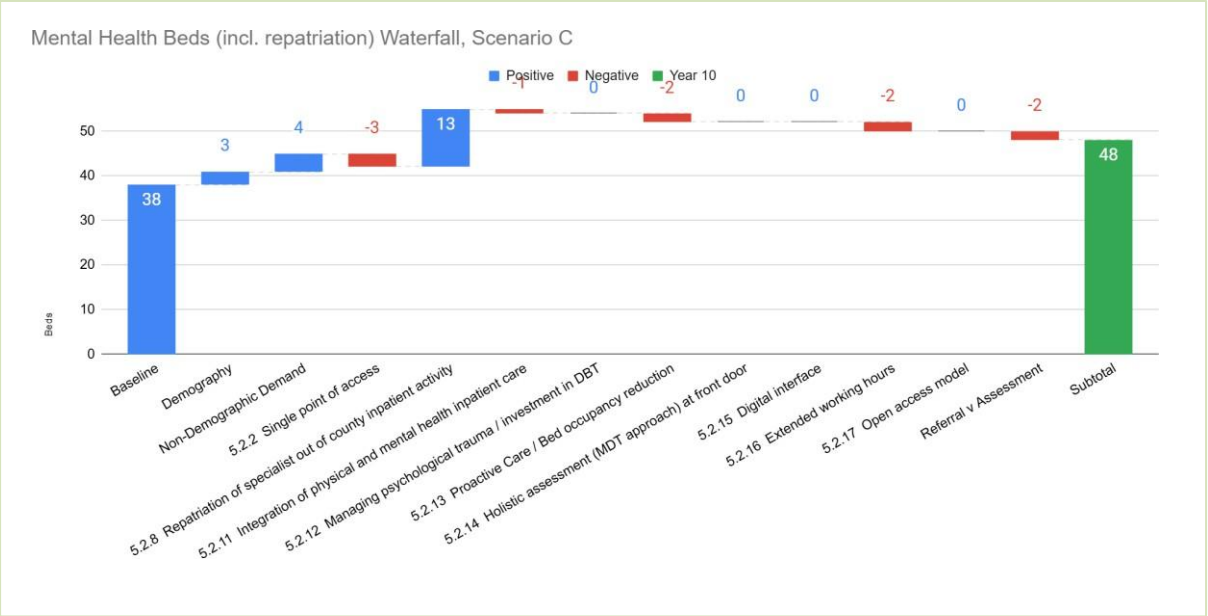
The charts below summarise the impact of the main components of change for scenarios B and C (based on Powys MH Activity Model B.25).





based on Powys MH Activity Model B.25





based on Powys MH Activity Model B.25

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.

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.

The net impact on bed requirements of the revised Powys demand and capacity modelling (excluding repatriation) is as follows:

	Bed Impact *(excl. repatriation)*	% change
Including demography & ND demand:		
Scenario B	0	0%
Scenario C	-4	-11%
Excluding demography & ND demand:		
Scenario B	-7	-17%
Scenario C	-11	-29%

Detailed model outputs are given in Appendix 4: Model Outputs – Mental Health.

Further local work is needed to:

- Complete the translation of demand and capacity projections into workforce and financial implications.
- Continue to monitor progress towards realising the transformational change reflected in the modelled assumptions.
- Continue to review the proposed Powys provision in the light of the evolving model of care for inpatient mental health across Wales.

Impact on Activity commissioned from external providers

Detailed assessment of commissioning activity and cost impact is beyond the scope of this report. Relevant modelling detail and outputs have been shared with Powys Informatics and Finance colleagues to enable them to undertake detailed analysis of the commissioning impact.

Non-Elective Inpatients

The demand and capacity modelling for non-elective admitted patient care has focused on quantifying the potential to improve stepdown care pathways within Powys, and to strengthen community services to support patient care at home. In making these improvements, the aim is to minimise the various undesirable consequences of current system inefficiencies.

Key aspects of this relate to increased investment in specific community pathways as detailed in the section on community shift above. The new service models and care pathways will help to reduce excess bedday costs with external providers and enable some low-complexity admissions to be avoided altogether.

A&E / Urgent Care

The Powys vision for urgent care implies an enhanced, proactive service that can see and treat many more patients locally, rather than having to travel to out-of-area acute A&E departments. Options to provide the new service model are still being worked up by the Health Board, with the aim of avoiding a significant amount of external A&E activity and contributing to a reduction in the number of non-elective admissions to external providers.

Mental Health

Most of the proposed improvements to mental health services concern how the service is configured and delivered within Powys. One notable exception is the opportunity to repatriate some specialist inpatient activity from external providers by providing an appropriate facility within Powys.

Summary and Conclusion

The modelling clearly indicates that the future of healthcare in Powys relies on a substantial shift from traditional inpatient care to proactive, community-based services.

For physical health, the more ambitious options propose consolidating community hospital inpatient beds into two or three main hubs, offsetting this reduction by significantly expanding "Hospital at Home" models, virtual wards, and community rehabilitation capacity.

In urgent care, establishing a fully integrated, community-based system with advanced Minor Injury and Illness Units (MIIUs) or Urgent Care Centres (UCCs) is projected to drastically increase local care capacity. This will allow Powys to handle significantly more urgent care activity locally and reduce unnecessary attendances at out-of-county emergency departments.

Similarly, mental health proposals focus on a recovery-based community model that integrates older adult mental health teams and explores consolidating inpatient beds onto fewer sites. An optional feature of these maximum options is the establishment of a local "enhanced care" unit to enable the repatriation of some specialist inpatient care currently being provided out-of-county.

The completed models have been passed over to Powys Informatics and Finance colleagues for validation, and to enable re-creation in the Databricks technical environment. This will allow the Health Board to maintain an up-to-date strategic view of need, demand, capacity, and service performance to support iterative decision-making.

In conclusion, the report demonstrates that by investing in mature community pathways, strong clinical governance, and robust local infrastructure, PTHB can successfully mitigate avoidable acute admissions to external providers, reduce excess bed days, and deliver a more sustainable and equitable healthcare system closer to home for the residents of Powys.

LONG LIST OF IDEAS		
Category		**Idea**
Empowerment and Self-Care	1	Expand **digital tools** for care and self-management (assistive tech) including information and advice
	2	Support digital literacy training in community hubs
	3	Promote **community-level prevention and wellbeing** including peer-support
	4	Create more opportunities for **self-referral and return to service by the individual**
	5	Train and support **family, informal carers** including **young carers –** shared decision making approach
	6	**Assessment of need of the whole family,** building on Team Around the Family approach
Prevention	7	Create a **proactive community baseline** for all individuals recognising their strengths and their support network including what happens when treatment needs to be escalated
	8	Place based prevention and early support, including pre-hab and support during transition, at the **"front door"** of services
Seamless Access	9	Establish **trusted assessors** to avoid duplication **across health & social care**
	10	Make **same-day urgent care** and **ambulatory services** available 7 days
	11	Develop **Single Point of Access with holistic assessment** and triage, with experienced MDT input
	12	Expand the **"one stop shop" model** for simpler access including OPAT
	13	Invest in digital technology, including text service, for communication and to access to services, supporting 'no wrong door'.

	14	Enable 'step-up admission' **requests across mental health & physical health**
	15	**Transition arrangements are needs based**, transition age increased to 25 years, with joint assessments across physical and mental health
	16	**Remote clinical consultations** from home and/or at a PTHB or partner site with digital support
Person centred care - Place-Based Working and One team approach	17	Develop neighbourhood based multi professional front door
	18	Create ambulatory care facilities for patients for diagnostics and assessment
	19	**Organise multi-agency care which is coordinated around GP practices,** "Primary Health Care" comprising Mental & Physical Health, with clear core offer and service specification
	20	**Funding GPs for additional time to see patients**
	21	Improve **collaboration between expert generalists and specialists, observing interdependencies with CAMHS and LD**
	22	Strengthen **partnerships with social care, housing and the third sector**, also providing patient point of contact
	23	**Create well organised (eg plan, actions) multi professional teams** to support people's physical and mental health needs, including named ownership, with appropriate supervision, noting what might be needed 7-days a week, and/or extending into the evening, and/or 24-hours a day

	24	Sharing public sector and using community assets to deliver care closer to home, including a 'multi-agency' building.
	25	**Align third sector commissioning to place based working**
	26	**'Open dialogue model'** – MDT approach supporting individual and their family to address needs guided by presentation/ symptoms rather than diagnosis, availability of direct payments and ensuring appropriate services are available and included in care, eg Personality Service
	27	**Fully mobile** pan -Powys **service (not linked to a building / site)** and/or utilise partners' buildings better?
	28	Focus on **repatriation of complex cases** to Powys, with potential support from a private provider for different levels of care
	29	**Strengthen use of third sector**, particularly for 'Sanctuary' and safe places, as well as respite
	30	**Consolidate physical and mental health inpatient beds to fewer sites, which are fit for purpose, therapeutic environments,** reducing transfers between sites and reduce commissioned MH beds - bringing patients back to Powys
	31	Provide **family / carer accommodation** to support an individual's treatment
	32	**Expand the use of medical day case beds**, ideally on same site as other beds
	33	**PTHB GP practice to support difficult to reach / vulnerable groups** to access primary care
Locally Responsive and Admission Avoidance-Focused	34	Create **Community Hospital Medical Assessment Unit** and Mental Health assessment ward with ring-fenced beds
	35	Be clear on how best to use community inpatient beds to support a proactive and response model (including crisis)
	36	Invest in **diagnostic centres** located in Powys with fast turnaround

	37	Design a system to proactively step down and support people back home from Emergency Departments and acute inpatient wards, with ring-fenced specialist provision
	38	Develop community-service based clinics to support people to remain at home
	39	Expand **hospice model** for End of Life care so more people can die in their place of choice
	40	Focus efforts on **care home residents** and transitions from inpatient back to home through an age related support model
	41	Expand **Hospital @ Home** models and **Flying Squad** response teams
	42	Expand **urgent & crisis responses**, including fit for purpose environments and places for people to go
	43	Exploit **opportunities with the private / commercial sector**, e.g. Wellbeing Offer delivered by private providers elsewhere
	44	Develop **enhanced care home model**, including whole care home commissioning & provider
	45	**Mixed staffing model** across physical and mental health community & inpatient services, including dual training & rotational posts
	46	**Navigation / coordination role**

	47	Provide Minor Injury Units at the Rural Regional Centres
Infrastructure and Process Improvements	48	**Remove all internal referral processes and create one team approach,** with clear clinical governance
	49	Improve **liaison mental health** and discharge processes
	50	Redesign **inpatient environments** to ensure safe high quality health services (for example to reduce observation intensity)
	51	**Invest in high-quality data** for service management, evaluation of change and population need
	52	Invest in digital technology to make better use of resource
	53	Centralise (also collocate) services to address workforce challenges
	54	**Improve non-emergency and planned clinical transport** across physical and mental health by working with WAST & others
	55	**Pooled-budgets** to reduce delays with decision making and promote integration of services
	56	Exploit the **use of digital opportunities more, e.g. artificial intelligence**, ambient AI (transribes consultations)

	57	**Directory of services** readily available to staff and patients, including how to access and what's local
	58	**Evidence-based group** to ensure we invest in tried and tested interventions ensuring quality
	59	**Single patient record** to support appropriate information sharing, including third sector
	60	**Changing culture** including around being patient centred – from "this isn't my job" to "can I help within my scope of practice?" and longer-term investment in education and joint working
	61	Visible, **on the ground, senior leadership presence** – walking the floor
	62	Over-deliver on what we're expert at so **we can be commissioned to provide for neighbouring health boards / trusts**
	63	**Develop a pathology lab** for Powys
	64	**Clear language** and agreement across health & care in Powys about definitions and terminology
	65	Increased **investment in staffing**, with a focus on clinical staff, including progression, retention and training, salary weightings for roles that are hard to recruit to
	66	Single point of access flow hub and navigation / co-ordination across the pathways
	67	Develop diagnostics pathway for pathology, biochemistry etc including POCT
	68	Improve end of life community model provision

COLOUR CODE		
		Inpatients
		Urgent Care, MIU, Step Up, admission avoidance
		Diagnostics
		End of Life
		Community model - Partnership working (Primary Care, Third sector, PCC. Commissioned providers)
		Community model - Care Homes
		Community model - Processes
		Community model - Prevention, early intervention and MDT
		Data and Evidence
		Digital
		Workforce & OD

Appendix L – Discounted Long-list Options

This document lists all long-list options that were discounted and not progressed for further development and assessment and explains the rationale for each decision. It does not include short list options that were discounted following further assessment; this information is provided in the PCBC and the Step Report.

'Do nothing' options (001) were included as baselines for comparison. In some service areas, these were subsequently separated into 'do previous' (001a) and 'do current' options (001b). Although the baseline options did not meet the hurdle criteria, they were retained for comparison so that temporary service changes could be appropriately considered within the options development process. When the do-nothing option was split the original baseline options 001 were not assessed.

Note: The total number of discounted options differs from the number recorded in the Step Report and the Pre-consultation Business Case (PCBC). This appendix includes every option that was not progressed for further development and assessment. The Step Report and PCBC reflected the position at a specific point following the lock-in week, when options were assessed against the hurdle criteria. Following lock in week some of the long list options were combined with other options and therefore discounted. For example, diagnostic options were incorporated into the urgent care options, and community mental health options were incorporated with other mental health options.

The summary table below compares the PCBC / Step Report discounted options against all long list discounted options.

Service Area	Total number of options discounted in PCBC	Total Number of options discounted	Explanation
Mental Health	15	18	Total long list discounted includes 3 community model options that were short listed and then discounted as integrated with other options
Physical Health	12	12	No change
Urgent Care	9	10	Total long list of discounted options includes 1 which was incorporated into another option.
Diagnostics	7	14	Includes 7 short listed options which were then incorporated into Urgent Care options
Total	43	54	

Inclusion of options within in this appendix does not necessarily mean an option failed the hurdle criteria, as some options were duplicated, combined, developed further or incorporated into other options rather than rejected on their merits.

Service area: Mental health

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
1	MHDO2_001	Do nothing: maintain existing inpatient mental health service provision.	Discounted: This option was included as a baseline for comparison and was not assessed against the hurdle criteria. It was agreed to separate it into 'do previous' and 'do current' options so that the position before and after the temporary service changes could be fully assessed alongside the other options.
2	MHDO2_002	Splitting organic and functional patients: Consolidate Adult and Older Adult) functional inpatient units to 1 site in Llandrindod Wells. Include enhanced care provision (beds), for complex patients (potentially accommodating out of county acute patients). Retain Tawe ward (Ystradgynlais) for organic patients. Introduce 'co-morbidity ward' with Physical Health (on 1 site TBC with Phys health). Retain commissioned provision out of county, e.g. Midlands Partnership University Foundation Trist (MPFT) to provide beds in North. Could reduce use of commissioned provision from SBUHB.	Discounted: Option MHDO2_002 is not recommended for further development as it does not address the issues within the case for change. Consolidating functional inpatients to the Llandrindod site brings challenges from an estate perspective. Staff recruitment is challenging in the Llandrindod area. Maintaining an organic inpatient setting in Ystradgynlais was considered to reduce financial efficiencies of scale and workforce efficiencies/resilience that may be achieved by consolidating workforce, allowing more efficient staff cover, thereby reducing agency spend.
3	MHDO2_002a	Llandrindod Adult & All age functional and Tawe organic unit. Move the adult functional ward (Felindre) from Bronllys to Llandrindod Wells and create a further 'all-age' (older adult and frail adults) functional unit alongside it. Maintain organic beds on Tawe. Continue commissioning of specialist beds on needs base (for example,	Discounted: Option MHDO2_002a is not recommended for further development. Although this option could strengthen operational resilience, there is insufficient assurance that it could consistently meet clinical and quality standards. Recruitment challenges, potential loss of experienced staff, increased travel, unequal access to care and ongoing out-of-county costs also raise concerns about its sustainability and deliverability.

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		PICU, learning disabilities, gender specific) and for any demand over capacity. Consider organic beds on physical wards for patients from Llandrindod and North Powys.	
4	MHDO2_003	Splitting organic and functional patients: Consolidate Adult and Older Adult functional inpatient units to 1 site at Bronllys Hospital. Include enhanced care provision (beds), for complex patients. Retain Tawe ward (Ystradgynlais) for organic patients. Introduce 'co-morbidity ward' with Physical Health (on 1 site with Physical health). Retain commissioned provision out of county, e.g. Midlands Partnership University Foundation Trist (MPFT) to provide beds in North and potentially reduce use of commissioned provision from SBUHB.	Discounted: Option MHDO2_003 is not recommended for further development. Although this option could strengthen operational resilience, there is insufficient assurance that it could consistently meet clinical and quality standards. Retaining Tawe ward in Ystradgynlais does not provide the efficiencies of workforce consolidation to create a more sustainable service offer. It would also not address the issues in the case for change in relation to the therapeutic environment. This option looked at integration of mental health organic patients with physical health wards. There is insufficient evidence that caring for people with organic mental health needs within general physical health wards would consistently provide safe, reliable and high-quality care, including meeting dementia standards.
5	MHDO2_005a	Single site hospital (functional and organic) Llandrindod Wells. Create adult / all-age functional and organic beds on single site at Llandrindod. Include repatriation with separate beds for enhanced care. Maintain commissioning of specialist beds on needs led basis. Close Tawe and Felindre.	Discounted: Option MHDO2_005a is not recommended for further development because it does not provide sufficient assurance that safe, high-quality services could be delivered and sustained. Although a single-site model could improve staff cover and operational resilience, recruitment is already challenging in Llandrindod Wells. Requiring staff to relocate could lead to workforce losses and potentially further increase temporary staffing, it does not address the workforce challenges in the case for change. . The available site capacity also

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			means that the option is not considered deliverable.
6	MHDO2_009a	Single site hospital (functional and organic) Create adult / all-age functional and organic beds on single site at Ystradgynlais. Include separate beds for enhanced care. Maintain commissioning of specialist beds on needs led basis. Close Tawe, Clywedog, and Felindre.	Discounted: Option MHDO2_009a is not recommended for further development because it does not provide sufficient assurance that safe, high-quality services could be delivered and sustained. Although a single-site model could improve staff cover and operational resilience, this option would result in significant disruption to existing service provision and current patient flows without sufficient resulting benefits. Locating all services in Ystradgynlais - is not aligned with the Rural Regional Centre model or with the proposed physical health options.
7	MHDO2_012	Place mental health acute inpatient provision at 2 sites: to facilitate 'join up' of mental and physical health care. (potential to include 'comorbidity ward' at each site). Organic patients would be managed within physical health wards. Maintain commissioning of specialist beds (for example, PICU, ND, gender specific).	Discounted: MHDO2_012 is not recommended for further development. This option looked at integration of mental health organic patients with physical health wards. There is insufficient evidence that caring for people with organic mental health needs within general physical health wards would consistently provide safe, reliable and high-quality care, including meeting dementia standards.
8	MHDO2_013	Enhance existing mental health inpatient provision, deliver all inpatient mental health in Powys, excluding PICU, LSUs, MSUs	Discounted: Option MHDO2_013 is not recommended for further development because it would not resolve the challenges associated with the current estate. The existing footprints at the Clywedog and Ystradgynlais sites could not be expanded sufficiently, and the option is not aligned with the proposed physical health model.
9	MHDO2_014	Remove all Mental Health in-patient beds in Powys and commission / re-provide outside of County	Discounted: MHDO2_014 is not recommended for further development because removing all mental health inpatient beds from Powys would conflict with the aim of providing care closer to home. Limited availability and higher costs of external beds could delay access, disrupt continuity of care and

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			increase travel for patients, families and carers. It would also reduce integration with local physical health and community services and does not provide sufficient assurance of safe, sustainable or affordable care.
10	MHDO2_015a	Provide organic mental health inpatient care within physical health units, with Dementia Home Treatment Team in-reach. Close Clywedog and Tawe units. Organic to be managed within physical health units with in-reach support from mental health services / enhanced Dementia Home Treatment Team (DHHT) service. All-age functional unit to be developed on selected site.	Discounted: MHDO2_015a is not recommended for further development because there is insufficient evidence that caring for all people with organic mental health needs within general physical health wards would consistently provide safe, reliable and high-quality care, including meeting dementia standards. The model is not known to operate elsewhere, and differing care arrangements within shared wards could create clinical and management challenges. Workforce, staff acceptance and the resources required for enhanced mental health support also remain uncertain.
11	MHDO2_016a	Commission functional step-down beds in both south and north Powys. Commissioning of 'step-down' functional beds in the periphery locations (North Powys and Ystradgynlais) to support step-down of patients from a centralised functional unit. Consider existing commissioning arrangements with Redwoods (Shrewsbury) and Ward F (Swansea Bay).	Discounted: Option MHDO2_016a is not recommended for further development as a standalone option. It was not assessed separately because it was agreed that the proposed use of commissioned step-down beds should be incorporated into other options.
12	MHDO2_017a	Provision of sanctuary services and consideration of step-down, alternatives to admission and safe place to assess. Development of sanctuary services to provide crisis intervention and support	Discounted: Option MHDO2_017a is not recommended for further development as a standalone option. Sanctuary services will be scoped within other shortlisted options, and the potential inclusion of step down provision is not within the scope of the service model
13	MHDO2_018a	Provision of gender specific functional units. Create separated male	Discounted: MHDO2_018a is not recommended for further development as a standalone option

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		and female only wards when planning functional units on relative site. This is not a stand-alone option and would be in conjunction with other development options.	because gender-specific wards would need to form part of a wider inpatient service model and site plan. Their feasibility, staffing requirements, timescale and affordability depend on that broader model.
14	MHCMDO_002	Dementia Home Treatment Team (DHTT) integrates into physical health teams, keeping the current SPOA (Single Point of Access) and crisis teams as they are meaning teams still operate from 5 sites.	Discounted: MHCMDO2_002 is not recommended for further development because integrating the DHTT into physical health teams could dilute its specialist mental health function and create complex clinical-governance arrangements. It does not address the workforce sustainability issues within the case for change.
15	MHCMDO_003	Dementia Home Treatment Team (DHTT) integrated within physical health team. Community Mental Health Teams to align with physical health geographical footprint meaning teams operate from 2 or 3 sites -	Discounted: MHCMDO2_003 is not recommended for further development for the same reason in MHCMDO_002 because integrating the DHTT into physical health teams could dilute its specialist mental health function and create complex clinical-governance arrangements. However, it does address some workforce sustainability issues within the case for change. .
16	MHCMDO_004	Incorporate Dementia Home Treatment Team (DHTT) into Community Mental Health Teams (CMHTS) over three sites aligned to physical health	Discounted: Option MHCMDO_004 met the assessment criteria for clinical sustainability, access, deliverability and financial sustainability however it was subsequently incorporated into other options and was therefore not progressed as a standalone option.
17	MHCMDO_005	Create joint team and management structure, allowing physical health and mental health teams to provide joined up care. This involves full integration across physical and mental health and will involve consideration of governance and legislation requirements.	Discounted: Option MHCMDO2_005 was considered suitable for further development, but not as a standalone option. A joint team and management structure will instead be considered as an enabler within the integrated physical and mental health model.

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		Team will deliver timely, seamless appropriate care to an individual in a time of need.	
18	MHCMDO_006	Redesign of current mental health community teams to form a Rapid Response Team that provides appropriate interventions based on patient need e.g. including short-term interventions, community liaison, wrap around support for organic inpatients, physical health assessment and monitoring, home treatment and initial diagnostics. Consideration of social care and third sector involvement.	Discounted: MHCMDO2_006 was not recommended for further development. It was agreed across both mental health and physical health community modelling that forming a single team would not operate practically across the geography of Powys and instead the principles described would be delivered through joint pathways written into the community model specifications.

Service area: Inpatient physical health services

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
1	IPDO_001	Do nothing - no change, maintain existing inpatient physical health service provision	Discounted: This option was included as a baseline option for comparison; it was not hurdled as it was agreed to split this into do previous and do current IPDO _001a and IPDO_001b to ensure full assessment prior to temporary service changes against options was available.
2	IPDO_002	Maintain existing Physical Health inpatient bed base (c145) including step up (including consideration of CATU), step down, rehabilitation, intermediate care, reablement, Ready to Go Home Units and End of Life provision and consolidate onto 3 Rural Regional Centre Sites with spoke sites in Welshpool, Machynlleth, Ystradgynlais	Discounted: This option was developed into more detailed sub-options. It was therefore not assessed as a standalone option.

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
3	IPDO_002c	Maintain existing Physical Health inpatient bed base (c145) including step up (including consideration of CATU), step down, rehabilitation, intermediate care, reablement, Ready to Go Home Units and End of Life provision and consolidate onto 3 Rural Regional Centre Sites with spoke sites spoke sites in Welshpool, Machynlleth, Ystradgynlais	Discounted: This option was not assessed because it duplicated another option.
4	IPDO_002d	Maintain existing Physical Health inpatient bed base (c145) including step up (including consideration of CATU), step down, rehabilitation, intermediate care, reablement, Ready to Go Home Units and End of Life provision and consolidate onto 3 Rural Regional Centre Sites with spoke sites spoke sites in Welshpool, Machynlleth, Ystradgynlais	Discounted: This option was not assessed because it duplicated another option.
5	IPDO_003	Maintain existing Physical Health inpatient bed base (c145) including step up (including consideration of CATU), step down, rehabilitation, reablement, Ready to Go Home intermediate care and End of Life provision and consolidate onto 3 Rural Regional Centre Sites	Discounted: Option IPDO_003 is not recommended for further development. Although it would retain approximately 145 inpatient beds and consolidate services onto three Rural Regional Centre sites, existing infrastructure could not support this model without significant investment and building works over five or more years. The option would also largely retain the current bed-based staffing model, limiting service transformation and the shift towards community-based care. It does not provide sufficient assurance that longstanding workforce, estate, governance and operational pressures would be resolved, or that the investment would deliver sustainable value. Consolidation and ward closures without investment into the community could increase travel and reduce local access for some communities.

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
6	IPDO_004	Reduce overall Physical Health inpatient bed base to 90-100 beds and consolidate onto 3 Rural Regional Centre Sites with spoke sites including step up (including consideration of CATU), step down, rehabilitation, intermediate care, Reablement and End of Life provision. Spoke sites include alternative bed bases.	Discounted: Option IPDO_004 is not recommended for further development. It would reduce the physical health inpatient bed base to approximately 90–100 beds and consolidate services onto three Rural Regional Centre sites. Although the smaller bed base may be more compatible with the existing estate, significant investment and building work would still be required over a period of five years or more. The option assumes improved patient flow but offers limited-service transformation or shift towards community-based care. It therefore does not provide sufficient assurance that longstanding workforce, estate, governance and operational pressures would be resolved, or that the investment would provide sustainable value. Consolidation and ward closures without corresponding investment in community services could also increase travel and reduce local access for some communities.
7	IPDO_006	Reduce overall Physical Health inpatient bed base to 90-100 beds and consolidate onto 3 Rural Regional Centre Sites including step up (including CATU), step down, rehabilitation, intermediate care and End of Life provision. Develop Integrated Health & Wellbeing Hubs to support delivery of community services based on population need	Discounted: Option IPDO_006 was not assessed as a standalone option. It was agreed that the development of Integrated Health and Wellbeing Hubs should be considered within the community model and linked to the wider Regional Partnership work.
8	IPDO_007	Reduce overall Physical Health inpatient bed base to less than 90 beds and consolidate onto 3 Rural Regional Centre Sites with spoke sites including step up (including CATU), step down, rehabilitation, intermediate care and End of Life provision.	Discounted: Option IPDO_007 is not recommended for further development because there is insufficient clinical evidence that fewer than 90 inpatient beds, distributed across three Rural Regional Centres and additional spoke sites, could be delivered safely or operationally without investment into the community model. Although the model could improve workforce concentration

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			and estate efficiency while retaining some local provision, spreading a substantially reduced bed base across more than three sites could leave services without sufficient capacity or resilience during periods of increased demand without alternative investment into the community model. It could increase admission delays, travel and pressure on ambulance, community, reablement and social-care services. The option therefore does not provide adequate assurance on clinical sustainability, equitable access or deliverability without alternative services being developed in the community.
9	IPDO_009	Reduce overall Physical Health inpatient bed base to 90-100 beds and consolidate onto 3 Rural Regional Centre Sites including step up (including CATU), step down, rehabilitation, intermediate care and End of Life provision. Develop Integrated Health & Wellbeing Hubs to support delivery of community services based on population need	Discounted: Option IPDO_009 duplicated option IPDO_006 and was therefore not assessed separately.
10	IPDO_010	Develop an enhanced model for intermediate care, including patients who are ready to go home, use of alternative bed base such as care homes and including a more sustainable model for Knighton Hospital	Discounted Option IPDO_010. It is not recommended for further development because its key elements enhanced intermediate care, alternative step-down beds and improved discharge pathways are already included within other options. Progressing it separately would duplicate work rather than provide a distinct service model. These elements remain important and should be developed within the wider inpatient and community-care proposals, including appropriate consultation on access, care quality, workforce capacity, and any future service model concerning Knighton Hospital.
11	IPDO_012	Enhance inpatient step-up urgent care provision CATU on 3 Rural Regional Sites	Discounted: IPDO_012 is not recommended for further development because an enhanced

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			Community Assessment and Treatment Unit (CATU) needs to be considered as part of the wider solution. Progressing it separately would duplicate work rather than provide a distinct service model. The CATU concept remains an important component of future urgent and inpatient care proposals. Its workforce, clinical governance, estate, digital, transport and 24-hour medical-cover requirements should therefore be developed and consulted upon within those wider options.
12	IPDO_014	Integration/ Co-location of physical and mental health (organic) inpatient services in 1 Rural Regional Centre - Llandrindod with an Older Adult frailty service	Discounted as a separate option: IPDO_014 is not recommended for further development A single-centre model and its proposed integration of physical and organic mental health inpatient services could have significant benefits but could also reduce access for residents in northern and southern Powys and increase travel for patients and families. Locating all services into a single site RRC is not aligned strategically with the Health and Care Strategy and would not address some of the issues in relation to the workforce. Estate feasibility for this option could also be challenging.

Service area: Urgent care

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
1	UCDO_001	Do nothing: maintain existing Minor Injury Unit service provision.	Discounted: This option was included as a baseline option for comparison; it was not hurdled as it was agreed to split this into do previous and do current UCDO_001a and UCDO_001b to ensure full assessment prior to temporary service changes against options was available.
2	UCDO_002	Keep MIU service model through consolidation onto	Discounted: Option UCDO_002 is not recommended for further

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		RRC sites and continue to maintain primary care GP minor injury supplementary services	development. Although consolidating the Minor Injury Units based on the existing service provision could improve workforce resilience and efficiency, it would not deliver the broader urgent care model required for Powys. It would not sufficiently address unequal access, population needs, integrated working or diagnostic pathways, and some patients could still need to travel between sites to complete their care pathway. Overall, it offers insufficient improvement in clinical sustainability, person-centred care and population outcomes.
3	UCDO_003	Keep MIU service model through consolidation onto RRC sites and absorb primary care GP minor injury supplementary services into MIU centres	**Discounted:** Option UCDO_003 is not recommended for further development. Although consolidating minor injury services could improve workforce resilience and provide diagnostics on the same site, it would not deliver the broader, sustainable urgent care model required for Powys. Incorporating primary care supplementary services into Minor Injury Units could reduce local access, increase travel for some patients and affect the sustainability of primary care services. The option does not sufficiently address clinical or financial sustainability, equitable access or strategic alignment.
4	UCDO_004	Consolidate the existing Minor Injury Unit service onto three sites Llandrindod Wells, Ystradgynlais and Welshpool bringing the specialist workforce together to support a more resilient staffing model.	Discounted: Option UCDO_004 is not recommended to be progressed for further development. Although consolidating Minor Injury Units could bring the specialist workforce together, it would not deliver the broader urgent care model needed for Powys. This option is not aligned with the Health and Care Strategy to develop 3 Rural Regional Centres in Newtown, Brecon and Llandrindod. Consolidating minor injury services onto these sites could reduce local access, increase travel for a significant number of patients failing to address inequalities, diagnostic

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			provision and longer-term population needs. This option does not address service issues outlined within the temporary service change
5	UCDO_006	Develop same day urgent care centres on 3 Rural Regional Centre sites that can see and treat patients with (physical / mental) minor injuries and illnesses, same day ambulatory care and outreach into the patients home - *maintain existing primary care minor injury services*	Discounted: Option UCDO_006 is not recommended for further development. Although it could improve access to integrated urgent care across Powys, there is insufficient evidence that population need and activity levels would support three urgent care centres operating to the required standards. The model would also require substantial investment and is not considered economically viable at the anticipated activity levels.
6	UCDO_007	Develop same day urgent care centres on 3 Rural Regional Centre sites that can see and treat patients with (physical / mental) minor injury and illnesses, same day ambulatory care and outreach into the patients home - *reduce and consolidate all primary care minor injury supplementary services into centres*	Discounted: Option UCDO_007 is not recommended for further development. Although it could improve access to integrated urgent care across Powys, there is insufficient evidence that population need and activity levels would support three urgent care centres operating to the required standards. The model would require substantial investment and is not considered economically viable at the anticipated activity levels. Removing supplementary minor injury services from primary care was also not supported because it could reduce local access, increase travel for some patients, destabilise primary care services and reduce relevant skills within primary care teams.
7	UCDO_008	Develop same day urgent care centres on 3 Rural Regional Centre sites that can see and treat patients with (physical / mental) minor injury and illnesses, same day ambulatory care and outreach into the patients home - *maintain, enhance or reduce primary care minor injury supplementary services in*	Discounted: Option UCDO_008 is not recommended for further development. Although it could improve access to integrated urgent care across Powys, there is insufficient evidence that population need and activity levels would support three urgent care centres operating to the required standards. The model would also require substantial investment and is not

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		some areas according to population needs	considered economically viable at the anticipated activity levels.
8	UCDO_009	Develop same-day urgent care centres across three Rural Regional Centre sites, able to see and treat patients with physical and mental health minor injuries and illnesses, provide same-day ambulatory care, and deliver outreach into patients' homes. *Remove primary care minor injury supplementary services from all practices and consolidate into centres.*	Discounted: Option UCDO_009 is not recommended for further development. Although it could improve access to integrated urgent care across Powys, there is insufficient evidence that population need and activity levels would support three urgent care centres operating to the required standards. The model would also require substantial investment and is not considered economically viable at the anticipated activity levels. Removing minor injury supplementary services from primary care was also not supported because it would reduce local access, increase travel for some patients, destabilise and deskill primary care teams.
9	UCDO_012	Develop 2 Urgent Care Centres (Newtown and Brecon) with an MIIU in Llandrindod Wells - *remove primary care minor injury supplementary services*	Discounted: Option UCDO_012 is not recommended to be progressed due to previous hurdling assessment in relation to removal of primary care minor injury supplementary services. Removing minor injury supplementary services from primary care would reduce local access, increase travel for some patients, destabilise and deskill primary care teams. Any changes to primary care services should instead be based on assessed population need, travel times and the availability of suitable alternative provision. This has been incorporated into option UCDO_013.
10	UCDO_014	Maintain existing urgent care service provision through Minor Injury Units on 2 sites aligned to RRC model (Newtown and Brecon), operating hours as per temporary changes with Minor Injury Supplementary Services aligned to geographic/population need and travel time analysis.	Discounted: Option UCDO_014 was not assessed against the hurdle criteria because it duplicated other two-site options.

Service area: Diagnostics

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
1	DDO_001	Do nothing - no change, maintain existing diagnostic provision (6 sites with plain film)	Discounted: This option was included as a baseline for comparison and was subsequently incorporated into the urgent care options. Option DDO_001 is not recommended to progress because it would not address existing challenges in timely and equitable access to diagnostics across Powys. Although it would require little immediate investment and minimise disruption, it could increase reliance on services outside Powys, place additional travel burdens on patients and limit opportunities to improve service resilience, workforce sustainability and efficiency. Assessment against the agreed criteria found that the option would not sufficiently improve access, support longer-term operational delivery or provide a financially sustainable response to future demand. It is therefore not considered a viable option for further development.
2	DDO_002	More services provided within centres of excellence and all plain film x-ray services consolidated into designated Rural Regional Centre Sites.	Discounted: This option was developed into sub-options DDO_002a–c and was therefore not assessed as a standalone option.
3	DDO_002a	Invest in diagnostic centres located in Powys with fast turnaround – Plain film consolidated from existing 6 sites to three Rural Regional Centres with opportunities for DEXA, POCT, repatriating services and seven-day working	Discounted: This option met all the assessment criteria but was then subsequently discounted and incorporated and progressed via the Urgent Care options.
4	DDO_002b	Invest in diagnostic centres located in Powys with fast turnaround - Plain film x-ray services consolidated from 6 sites into 2 Rural Regional	Discounted: This option met all the assessment criteria but was then subsequently discounted and incorporated and progressed via the Urgent Care options.

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
		Centres with a smaller central centre Centres with opportunities for DEXA, POCT, repatriating services and seven-day working	
5	DDO_002c	Invest in diagnostic centres located in Powys with fast turnaround - Plain film consolidated from 6 sites into two Rural Regional Centres with opportunities for DEXA, POCT, repatriating services and seven-day working	Discounted: This option was assessed and short listed but then subsequently discounted as it was incorporated and progressed via the Urgent Care options.
6	DDO_003	Plain film x-ray services consolidated, with mobile X-ray Machine at designated sites. The model would concentrate specialist staff and equipment while retaining access to essential on-site imaging for patients who cannot readily travel, including appropriate ward-based examinations. Final locations, operating arrangements and service capacity would require further development.	Discounted: Option DDO_003—consolidating plain-film X-ray services while providing mobile X-ray equipment at selected sites is not recommended for further development. Although it could improve the use of staff and equipment, the current proposal does not demonstrate a financially deliverable model and there are concerns about equitable access and service continuity. On the evidence currently available, the potential benefits do not provide sufficient assurance that the option would be affordable, accessible and operationally sustainable.
7	DDO_004	Plain film x-ray services consolidated from 6 to 5 sites, removing plain film x-ray at Machynlleth, this excludes expanding any diagnostic provision such as DEXA & POCT.	Discounted: This option partially met the assessment criteria and was carried forward for further assessment as a bridging option to DDo_002a-c; but was then subsequently discounted and incorporated and progressed via the Urgent Care options.
8	DDO_005	Enhanced imaging provision via development of static DEXA services to support bone health and fragility fracture management, repatriating existing demand.	Discounted: Option DDO_005—developing a static DEXA service in Powys is not recommended to progress as a standalone option. Its potential benefits, including improved access, earlier diagnosis and bringing activity back into Powys, remain relevant. It was not fully hurdled and it was recommended to be incorporated

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			into the broader diagnostic-centre proposals under DDO_002a-c options. Considering DEXA within an integrated service model allows its workforce, infrastructure, clinical oversight, digital requirements and financial viability to be assessed together. This does not mean that static DEXA provision has been ruled out.
9	DDO_006	Enhanced imaging provision via development of mobile DEXA services to support bone health and fragility fracture management, repatriating existing demand.	Discounted: Option DDO_006, providing mobile DEXA services in Powys, is not recommended for further development as a standalone option. Its potential benefits, including bringing care closer to communities and supporting earlier diagnosis, remain relevant. The option was not fully assessed against the hurdle criteria, and it was recommended that it be considered within the broader diagnostic-centre proposals under options DDO_002a–c. This does not rule out mobile DEXA provision.
10	DDO_007	Enhanced Dental Imaging provision via development of a cone beam CT service, improving patient experience and repatriation	Discounted: Option DDO_007 developing a cone-beam CT dental imaging service is not recommended to progress as a standalone option within this diagnostic programme. It was not fully hurdled and was recommended to be considered through a separate dental-services proposal. This would allow the service requirements to be assessed alongside relevant clinical pathways, priorities and wider investment requirements.
11	DDO_008	Enhanced POCT provision through expansion of testing across the health board	Discounted: Option DDO_008 expanding point-of-care testing across the Health Board is not recommended to progress as a standalone option. Point-of-care testing is an enabling part of a wider diagnostic service rather than a complete service model. It was not fully hurdled, it was recommended to be considered within the broader diagnostic-centre proposals under

	Option Reference Number	Option Description	Rationale for not progressing the option following assessment
			DDO_002 a-c due to its potential benefits. Considering point-of-care testing within the wider diagnostic model allows clinical need, locations, workforce, quality assurance, digital connectivity, affordability and effects on patient pathways to be assessed together. This does not rule out expanding point-of-care testing.
12	DDO_009	Enhanced POCT & Vascular Ultrasound for development of a deep vein thrombosis (DVT) pathway supporting earlier assessment, diagnosis and treatment closer to home, reducing avoidable hospital admissions and unnecessary travel, and improve coordination between primary care, Minor Injury Units, urgent care and diagnostic services.	Discounted: Option DDO_009 developing point-of-care testing and vascular ultrasound as a DVT pathway is not recommended to progress as a standalone option because its components are better developed within urgent care service model. It was not fully hurdled and was recommended to be considered within the broader diagnostic-centre proposals under DDO_002 a-c due to its potential benefits. The DVT pathway will be considered through the urgent-care and Minor Injury Unit options. This approach enables patient access, clinical safety, workforce, locations, affordability and links between services to be assessed as part of complete care pathways, avoiding duplicated planning or investment. This does not rule out improving DVT services.
13	DDO_010	Enhanced POCT provision for medication management of Clozapine in Mental Health Services.	Discounted: Option DDO_010—using point-of-care testing to support clozapine medication management is not recommended to progress as a standalone option. It was not hurdled and was recommended to form part of a wider clinical pathway work.
14	DDO_012	Advanced integrated community based urgent care services enabled by enhanced diagnostics	Discounted: Option DDO_012 was not hurdled as it was agreed it should form part of the Urgent Care and Physical health options.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

'Better Together'

CRG Check and Challenge Short List Options Summary Report

Friday 5th September 2025
10.00am - 1.00pm



Contents

1. Purpose of Report 2
2. Background and Context 2
3. Approach 2
3.1. Panel 2
3.2. Appraisers 3
3.3. Options 3
4. Outline Methodology 3
4.1. Hurdle Criteria 3
4.2. Supporting Information 3
4.3. Options presentation 4
5. Options Check and Challenge Outputs against Hurdle Criteria 5
6. Summary 9
Appendices 11
Appendix A – Check and Challenge Session Attendees 11
Appendix B – Delegate Pre Event Pack CRG Check and Challenge Options Session 12
Appendix C – CRG Check and Challenge Options 12

1. Purpose of Report

This report summarises the methodology, attendance, inputs, and outputs of the clinical check and challenge session held on 5th September 2025. The session focused on Phase 1 of the Better Together programme, which aims to transform adult physical and mental health community services. The scope included short listed options associated with:

Inpatient Services: Reviewing current inpatient care provision across community hospital wards and mental health inpatient units, including the delivery of palliative and end-of-life care both within hospital settings and in the community.

Urgent Care: Exploring future models for meeting urgent care needs, including the role of Minor Injury Units, GP practices, and acute hospitals funded by the Health Board.

Mental Health: Assessing the effectiveness of the single point of access for mental health services and the community-based teams supporting older adults and inpatient care.

Community-Based Services: Considering services that provide care and treatment at home or in community settings, such as District Nursing, Home First, and Falls Prevention teams. This also includes condition-specific services, therapies, and imaging—delivered either in person or virtually—and their integration with primary care and third sector partners.

2. Background and Context

The purpose of the session was to draw on clinical expertise to review, test, and challenge the shortlisted options against the agreed hurdle criteria. This forms part of a broader appraisal process.

Participants were nominated to attend by the programme Senior Responsible Officers and Clinical Leads for the current phase of delivery. They were asked to engage from the perspective of their clinical expertise, rather than their organisational role, to ensure objectivity in the review process.

The central question posed to the group was: **In your professional opinion, do you believe the options shortlisted have met the Hurdle Criteria shared within this information pack?**

3. Approach

3.1. Panel

Senior Responsible Officers, clinical and operational leads presented the scope, challenges, and proposed options for their respective service areas. All panel members remained available throughout the session to provide clarification and respond to queries.

3.2. Appraisers

A total of 21 Check and Challenge appraisers participated in the session, comprising senior clinicians and professionals from within the organisation. A full list of attendees is provided in **Appendix A**.

3.3. Options

The shortlisted options were grouped and presented in the following order:

Mental Health: Including inpatient services, Single Point of Access (SPOA), and community-based care for older adults.

Physical Health: Covering inpatient care, care at home, and intermediate/community-based services.

Urgent Care: Focused on future urgent care models.

4. Outline Methodology

4.1. Hurdle Criteria

Application of Hurdle Criteria by the Options Development Group to assess each option against agreed planning principles, including clinical assurance, financial and workforce impact, accessibility, digital inclusion, and stakeholder readiness, was carried out during a Lock-in Week (week commencing 14th July 2025). Application of the hurdle criteria was tested with the Clinical Reference Group during the check and challenge session. The hurdle criteria is outlined below.

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?
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?

4.2. Supporting Information

The following supporting information was pre-issued via a Delegate Pre-event Pack (**appendix B**) by email which included:

- Key Drivers for Change
- Our Ambitions
- Outlined Scenarios

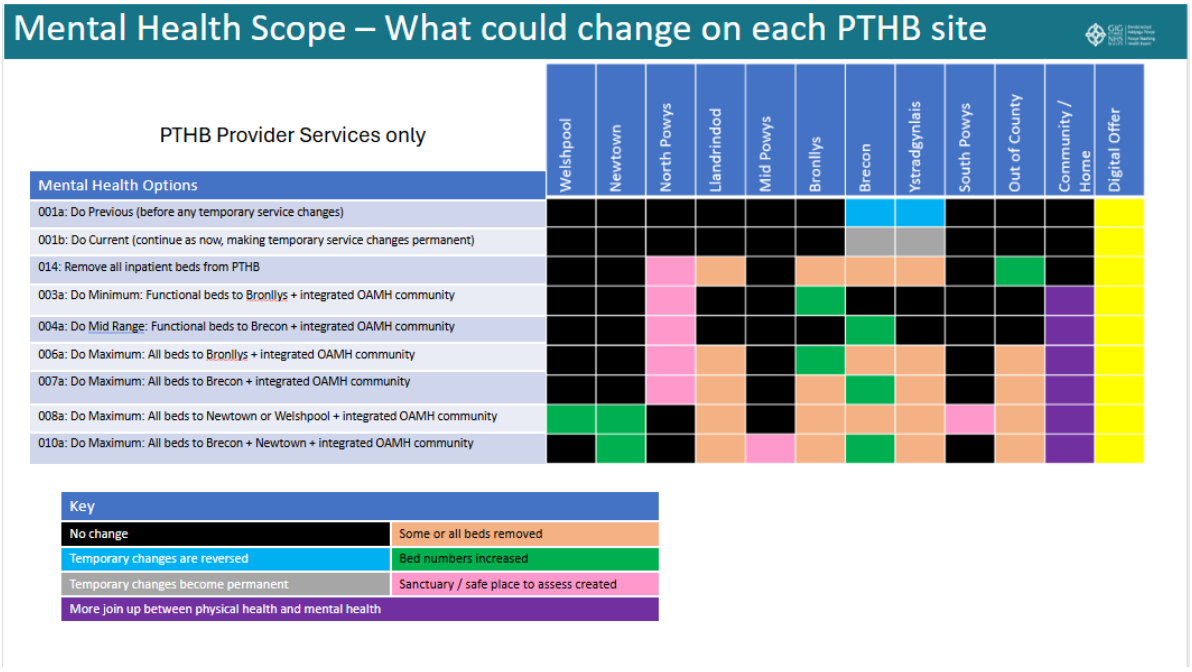
- Shaping our decisions
- Options Development Process
- Case for Change
- Emerging Options – Supporting Information
- System Models of Care
- Check and Challenge Preliminary Information

Supporting information, which included all the above, and the shortlisted options were presented during the session via a presentation pack (**appendix C**)

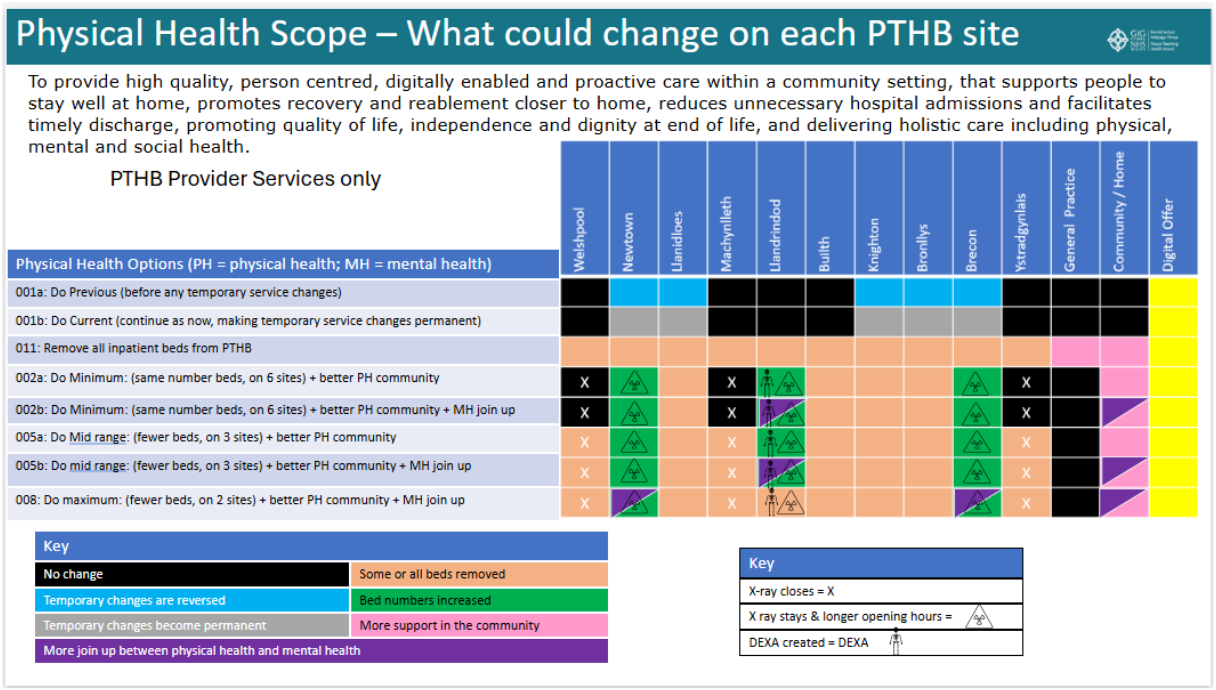
4.3. Options presentation

Options were presented by the Operational and Clinical Leads for each service area during the session. Options were presented consistently and supported by a power point presentation displaying the overview and full shortlisted options descriptions **appendix C.**

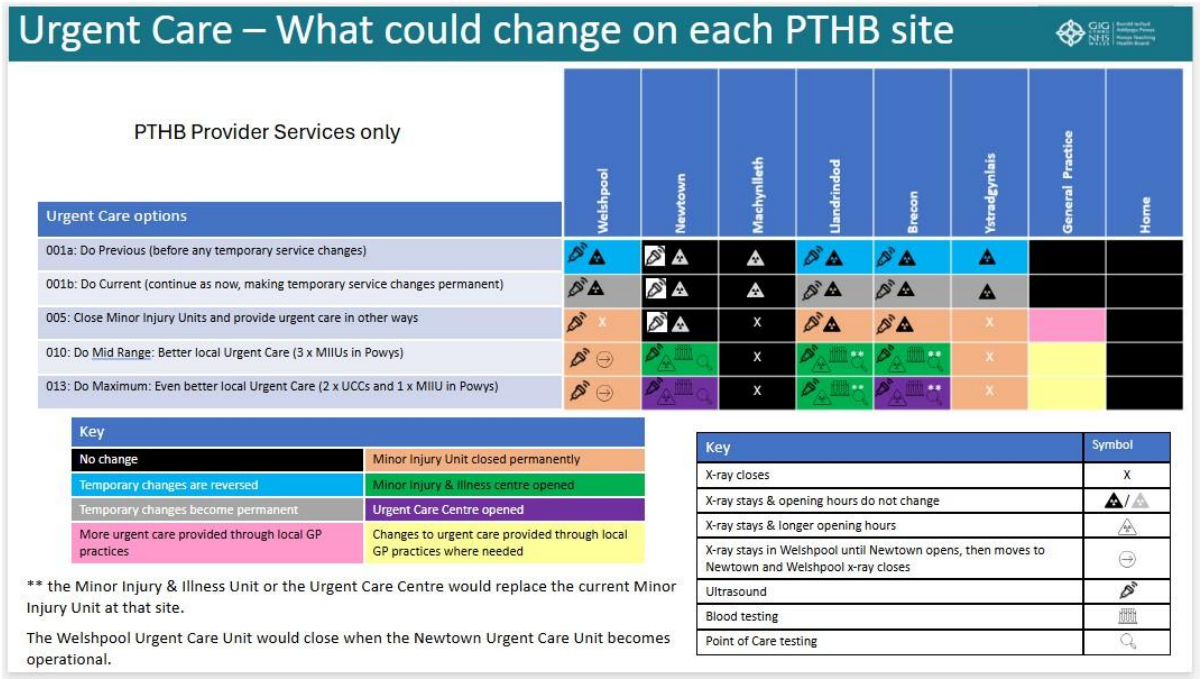
Mental Health Options Overview:



Physical Health Options Overview



Urgent Care Options Overview



5. Options Check and Challenge Outputs against Hurdle Criteria

5.1 Mental Health Services

Option	Option Descriptor	Confident Met Hurdle Criteria	Recommendations for Options Appraisal
SL MHDO02_001a	**Do previous - before temporary services change**	The group felt confident that this option **does not meet the hurdle criteria.** Not presented as slide, though discussed with 001b	Discussed by ODG. Taking forward for comparator purposes
SL MHDO02_001b	**Do current - no transformational change**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Taking forward for comparator purposes
SL MHDO02_014	**Remove mental health hospital beds in Powys**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Do not take forward to option appraisal. Following further review / services returned back to Powys as previous commissioning arrangements were too challenging to sustain
SL MHDO_003a	**Functional beds to Bronllys and integrated OAMH community**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Retain carry forward to option appraisal for further assessment. This option is included as a bridging option, it doesn't deliver fully, and although did not meet all the hurdle criteria it has been carried forward as a bridging option that moves the Health Board in the right direction.
SL MHDO_004a	**Functional beds to Brecon and integrated OAMH community**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Carry forward to Option Appraisal for further assessment
SL MHDO_006a	**All beds to Bronllys and integrated OAMH community**	The group felt confident that this **option does meet the hurdle criteria.**	Carry forward to Option Appraisal
SL MHDO_007a	**All beds to Brecon and integrated OAMH community**	The group felt confident that this **option does meet the hurdle criteria.**	Carry forward to Option Appraisal
SL MHDO_008a	**All beds to Newtown or Welshpool and**	The group felt confident that this	Carry forward to Option Appraisal with removal of Welshpool as part of the option

	integrated OAMH community	**option does meet the hurdle criteria.**	
SL MHDO_0010a	**All beds to Brecon and Newtown and integrated OAMH community**	The group felt confident that this **option does meet the hurdle criteria.**	Carry forward to Option Appraisal, potential for reduced beds to be accommodated on this site, further assessment needed

5.2 Urgent Care Services

Option	Option Descriptor	Confident Met Hurdle Criteria	Recommendations for Options Appraisal
SLUCDO 001a	**Do previous - before temporary services change**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Taking forward for comparator purposes
SLUCDO 001b	**Do current - continue as now making temporary service changes permanent**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Taking forward for comparator purposes Following CRG Check & Challenge, there was further discussion required on whether a do minimum option is required, which is to retain MIU model but only on three sites
SLUCDO 001c	**Do minimum - enhance existing MIU on fewer sites**	This is a new option and was not presented during CRG check and challenge it was added after the meeting.	New option post CRG Check and Challenge - Take forward for Option Appraisal
SL UCDO_005	**Close minor injury units and provide urgent care in other ways**	The group felt confident that this **option does meet the hurdle criteria.**	Retain carry forward to option appraisal for further assessment
SL UCDO_010	**Better local urgent care (3 x minor injury & illness units in Powys)**	The group felt confident that this **option does meet the hurdle criteria.**	Carry forward to Option Appraisal
SL UCDO_013	**Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)**	The group felt confident that this **option does meet the hurdle criteria.**	Carry forward to Option Appraisal, unless level 2 QIA information dictates it is not feasible from an estates/workforce perspective

5.3 Physical Health Inpatient and Community Care Services

Option	Option Descriptor	Confident Met Hurdle Criteria	Recommendations for Options Appraisal
SL IPDO_001a	**Put current hospital and community health services back to how they were pre temporary service changes**	The group felt confident that this option **does not meet the hurdle criteria**	Discussed by ODG. Taking forward for comparator purposes
SL IPDO_001b	**Keep current hospital and community health services as they are now**	The group felt confident that this option **does not meet the hurdle criteria**	Discussed by ODG. Taking forward for comparator purposes
SL IPDO_011	**Remove physical Health Hospital Beds**	The group felt confident that this option **does not meet the hurdle criteria**	Discussed by ODG. Retain carry forward to option appraisal for further assessment - based on lack of information to fully discount at this stage
SL IPDO_002a	**Same number beds on six sits and better Physical Health Community**	The group felt confident that this option **does not meet the hurdle criteria.**	Discussed by ODG. Retain carry forward to option appraisal for further assessment. This option is included as a bridging option, it doesn't deliver fully, and although did not meet all the hurdle criteria it has been carried forward as a bridging option that moves the Health Board in the right direction.
SL IPDO_002b	**Same number beds on six sits and better Physical Health Community and Mental Health join up.**	The group felt confident that this **option does meet the hurdle criteria**	Retain carry forward to option appraisal for further assessment. This option is included as a bridging option, it doesn't deliver fully, and although did not meet all the hurdle criteria it has been carried forward as a bridging option that moves the Health Board in the right direction.
SL IPDO_005a	**Few beds on three sites and better physical health community**	The group felt confident that this option d**oes meet the hurdle criteria**	Carry forward to Option Appraisal, unless level 2 QIA information dictates it is not feasible from an estates/workforce perspective

SL IPDO_005b	**Fewer beds on three sites and better physical health community and mental health join up**	The group felt confident that this option d**oes meet the hurdle criteria**	Carry forward to Option Appraisal
SL IPDO_008	**Even fewer beds on three sites and better physical health community and mental health join up**	The group felt confident that this **option does not meet the hurdle criteria.**	Discussed by ODG. Carry forward to Option Appraisal on basis that insufficient information was not available at the CRG check and challenge to describe the enhanced community model. It is taken forward for further assessment.

6. Summary

Mental Health

Ten options were reviewed. The group assessed whether each met the hurdle criteria and made recommendations for their inclusion in the options appraisal.

Summary of Findings

- **Comparator Options (Not meeting criteria but retained for comparison):**
  - SL MHDO02_001a – Do previous (pre-temp change)
  - SL MHDO02_001b – Do current (no transformation)
- **Options Not Meeting Criteria and Not Taken Forward:**
  - SL MHDO02_014 – Remove MH hospital beds in Powys
- **Bridging Options (Partially meeting criteria, retained for directional value):**
  - SL MHDO_003a – Functional beds to Bronllys + integrated OAMH
  - SL MHDO_004a – Functional beds to Brecon + integrated OAMH
- **Options Meeting Criteria and Taken Forward:**
  - SL MHDO_006a – All beds to Bronllys + integrated OAMH
  - SL MHDO_007a – All beds to Brecon + integrated OAMH
  - SL MHDO_008a – All beds to Newtown (Welshpool removed) + integrated OAMH
  - SL MHDO_0010a – Beds to Brecon and Newtown + integrated OAMH (further assessment needed)

Urgent Care

Six options were considered, including one new post-meeting addition. The group evaluated each against the hurdle criteria and made recommendations accordingly.

Summary of Findings

- **Comparator Options (Not meeting criteria but retained for comparison):**
  - SLUCDO 001a – Do previous (pre-temp change)
  - SLUCDO 001b – Do current (make temp changes permanent)
- **New Option (Post-meeting addition):**
  - SLUCDO 001c – Do minimum (enhanced MIU on fewer sites) – Taken forward
- **Options Meeting Criteria and Taken Forward:**
  - SL UCDO_005 – Close MIUs, provide urgent care differently
  - SL UCDO_010 – Better local urgent care (3 MIUs)
  - SL UCDO_013 – Even better urgent care (2 UCCs + 1 MIU) – Subject to QIA feasibility

<u>Physical Health Inpatients and Community Care Services</u>

Nine options were reviewed. Several were retained for comparator purposes or further assessment due to limited information.

Summary of Findings

- **Comparator Options (Not meeting criteria but retained for comparison):**
  - SL IPDO_001a – Revert to pre-temp services
  - SL IPDO_001b – Keep current services
- **Options Not Meeting Criteria but Retained for Further Assessment:**
  - SL IPDO_011 – Remove physical health beds (insufficient info to discount)
  - SL IPDO_002a – Same beds on 6 sites + better community (bridging option)
  - SL IPDO_008 – Even fewer beds on 3 sites + better community + MH join-up (insufficient info)
- **Bridging Option Meeting Criteria:**
  - SL IPDO_002b – Same beds on 6 sites + better community + MH join-up
- **Options Meeting Criteria and Taken Forward:**
  - SL IPDO_005a – Fewer beds on 3 sites + better community (subject to QIA feasibility)
  - SL IPDO_005b – Fewer beds on 3 sites + better community + MH join-up

Appendices

Appendix A – Check and Challenge Session Attendees

Service Area	Workshop role
Community Services PTHB	Check and Challenge
Community Nursing PTHB	Check and Challenge
Therapies PTHB	Check and Challenge
Therapies PTHB	Check and Challenge
Therapies PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Ward/Unit Team Lead PTHB	Check and Challenge
Medicines Management	Check and Challenge
Medicines Management	Check and Challenge
Clinical Leads Physical Health Specialist Teams PTHB	Check and Challenge
Clinical Leads Physical Health Specialist Teams PTHB	Check and Challenge
Clinical Leads Physical Health Specialist Teams PTHB	Check and Challenge
Clinical Leads Physical Health Specialist Teams PTHB	Check and Challenge
Clinical Leads Physical Health Specialist Teams PTHB	Check and Challenge
MH Clinical Lead/Service Manager PTHB	Check and Challenge
MH Clinical Lead/Service Manager PTHB	Check and Challenge
Mental Health Medical	Check and Challenge
Head of Professional Practice and Standards	CRG Member
Consultant Practitioner in Infection Prevention and Control	CRG Member

Assistant Director Quality and Safety	CRG Member
Consultant in Public Health	CRG Member
Director of Nursing	Chair
Assistant Director Community Services	SRO/AD CSG
Assistant Director Mental Health and Learning Disabilities	SRO/AD MH&LD
Head of Nursing	Clinical Lead PH
Consultant in Adult Mental Health	Clinical Lead MH
Senior Programme Manager Transformation	T&V Team
Transformation Programme Manager	T&V Team
Clinical Change Manager	T&V Team
Project Support Officer	T&V Team
Project Support Officer	T&V Team
Director of Improvement & Transformation	Supporting

Community Urgent Care Model - Issues Template

Scope: Community Urgent Care Model **including Powys Minor Injury Units and GP Minor Injuries Services**

Completing the template

1. Agree issues
2. Review metrics from C4C and agree baseline measure and definition – assign metric reference
3. Identify if source document already available (if so, embed in file)

Version control		
1.0	KP	[28/06/2025] Document created
1.1	CS/CL	[10/07/2025] Updated issues
1.2	CL/RM	[31/08/2025] UC04 updated
1.3	RM	[01/08/2025] Draft issues update UC01-05
1.4	RM/CL	[04/08/2025] UC01-05 updated, updates to baseline metrics, evidence/data and standards
1.5	RM	[14/08/2025] Additional evidence added UC05
1.6	RM	[03/09/2025] Finalisation for Programme Board approval
1.7	CL/RM	(08/09/2025) Approved at Programme Board
1.8	CL/RM	(18.08.2026) Further updated version approved at Programme Board

Issue Category	Issue Ref	Issue	Metric from C4C	Baseline Metrics *these need to link to scope for 25/2c engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years*	Standards *Identify standards that are not being met and add link to standard*
Workforce constraints impacting safe service delivery	UC01	<u>Issue:</u> Ongoing challenges with staff recruitment and lone working risks limit the ability to safely maintain 24/7 Minor Injury Unit (MIU) service provision. <u>Cause(s):</u> • Recruitment challenges • Lone working risks <u>Effect(s):</u> • TSC overnight closure (Llandrindod Wells and Brecon)	*Historic recruitment data.* *Data that informed the pre staffing model changes.*	*85 overnight MIU closures Jan-Sep 2024 (57 times at Llandrindod Wells and 28 times at Brecon)*	*No national staffing standards exist for MIUs based on demand or acuity.*

Issue Category	Issue Ref	Issue	Metric from C4C	**Baseline Metrics** *these need to link to scope for 25/2c engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years*	**Standards** *Identify standards that are not being met and add link to standard*
Inefficiency of the current MIU staffing model in relation to demand	UC02	<u>Issue:</u> The current Minor Injury Unit staffing model is inefficient, with patient demand too low to justify the level of staffing required. <u>Cause(s):</u> • Low demand (especially OOH) • High Staffing Cost <u>Effect(s):</u> • Unsustainable model • TSC overnight closure (Llandrindod Wells and Brecon) • Welshpool TSC – Previous change to 08-20 opening hours	*Overnight usage data led to service reductions in 2024.*		Delivery expectations suggestive of 12-hour service 7/7 *(see WG 10 delivery expectations of UCC)*

Issue Category	Issue Ref	Issue	Metric from C4C	**Baseline Metrics** *these need to link to scope for 25/2c engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years*	**Standards** *Identify standards that are not being met and add link to standard*
Inequity of Minor Injury Services across Powys	UC03	<u>Issue:</u> There is inequity of Minor Injury Services provision across Powys due to variability in minor injury services provided in GP practices and community services. <u>Cause(s):</u> • Variability of offer • Optional nature of Supplementary Service agreements <u>Effect(s):</u> • Inequity	10 GP practices provide minor injury services Opening hours are different across Powys MIU services.		

Issue Category	Issue Ref	Issue	Metric from C4C	Baseline Metrics *these need to link to scope for 25/2c engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years*	Standards *Identify standards that are not being met and add link to standard*
The current service model does not provide the full range of urgent care services that could be delivered in-county	UC04	Issue: The current urgent care model, including minor injury services, is unable to provide comprehensive urgent care that enables timely response to population needs such as falls, rapid response, hospital at home, and other services beyond the scope of minor injuries. Some patients are travelling to EDs out-of-county for presentations that could be seen and treated within Powys. Cause(s): • MIUs provide Minor Injury care only • Gaps in community based urgent care provision • Historic reliance on out-of-county services • Workforce and resource constraints Effect(s): • Unnecessary travel out-of-county • Increased pressure on external services • Missed opportunity for care closer to home		*Data from National Falls Dashboard*	

Issue Category	Issue Ref	Issue	Metric from C4C	Baseline Metrics *these need to link to scope for 25/2c engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years*	Standards *Identify standards that are not being met and add link to standard*
Diagnostic services are not aligned with the current service model	UC05	Issue: Diagnostic services, essentially plain film x-ray and blood testing, are not aligned with the operational hours of the urgent care current service model(s). There are currently limited timely blood testing facilities available, and this means some patients are not able to be seen and treated in Powys. Cause(s): • X-ray hours misaligned with MIU hours • Inconsistency of x-ray access across sites • Limited access to timely blood tests Effect(s): • Reduced efficiency • Delays in diagnosis/treatment • Inequity of provision/access • Impacting on some pathways of care to provide evidence-based practice.		*20-25% of MIU attendances require XR (2024/25 Baseline)*	Delivery expectations suggestive of 12-hour service 7/7 *(see WG 10 delivery expectations of UCC)*

Inpatients (Physical with inter-dependency with MH) Issues Template (when updating complete version control history below)

Scope: includes inpatients physical health

Completing the template

1. Agree issues
2. Review metrics from C4C and agree baseline measure and definition – assign metric reference
3. Identify if source document already available (if so, embed in file)

Version control		
1.0	KP	Document created
1.1	LC	Updated with PH IP group 15.07.25 – data requested 16.07.25
1.2	JM	Amendments made to put Patient Harm and Deconditioning front and centre as the root cause, with length of stay and delayed discharge as a key cause of this. Link also made to admissions due to lack of community alternative, although data to support this may not be available.
1.3	DF/CP	Approved at Programme Board – 08.09.2025
1.4	DF/CP	Further updated version approved at Programme Board – 18.08.2026

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
Deconditioning and Patient Harm	IP01	Prolonged hospital stays lead to physical and cognitive decline. This is caused by: High Length of Stay and Delayed Discharges Average length of stay is 40 days, nearly double	10 days in hospital = equivalent of 10 years' muscle ageing for over-80s Delirium triples mortality risk and doubles length of stay.	Length of stay (Digital) D2RA data (no currently operational., maybe Cottage view) Digital to source info	Query

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		the Welsh Government target of <21 days. Multiple priorities at ward level result in missed opportunities to implement active recovery. Nature of inpatient cohort – varying levels of willingness to engage in self-care. Ward acuity can result in missed opportunities for enhancing independence.	45% of inpatients were clinically ready for discharge. 36% of those had been waiting over a month. 2,906 bed days lost in 2023/24 due to discharge delays, costing £1.08 million.		

Issue Category	**Issue Ref**	**Issue (top 5)**	**Metric from C4C**	**Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years**	**Standards Identify standards that are not being met and add link to standard**
Workforce Shortages and Reliance on Temporary Staffing	IP02	High vacancy rates and reliance on agency staff. Workforce model does not enable us to deliver advanced and enhanced service model or attract/retain skilled workforce. This is also caused by the population demographics and geography of Powys, which means that we do not have an untapped workforce that we can use to fill vacancy gaps permanently or a bank-basis. The demographics	11 WTE total vacancies in at end of July 2025. One-third of inpatient beds rely on temporary staff. Without agency staff, 42 beds would be unstaffed based on previous calculation. Recent increases in whole time equivalent staffing (supported by Overseas Recruitment) has helped. However, we are aware that we have an ageing workforce and this will	Turnover – under 2 years of service Agency use/cost Sickness absence SCM Training compliance Vacancies Staff surveys Small, geographically isolated teams (single points of dependency) Service gaps – IVAB	(This is still being met, however the requirements to meet the Nurse Staffing Levels (Wales) Act in order to provide safe and effective care through the existing inpatient model creates challenges as outlined here).

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		also mean that our workforce is ageing, in a similar way to the wider Powys population.	impact on sustainability.	Datix incidents for transfers for care related to inability to deliver intervention	
Poor Estate Condition and Configuration	IP03	Outdated infrastructure limits care quality and flexibility	Estimated £70 million needed to bring estate to satisfactory condition. Small, dispersed units hinder resource sharing and staffing flexibility.	IPC incidents Datix/MEG audits for Estates issues Call bell incidents Datix Nurse staffing ratio differences due to estate configuration Estates jobs pending by site	– we are aware that many of our current inpatient wards and units do not meet the WHBN standards.

Issue Category	**Issue Ref**	**Issue (top 5)**	**Metric from C4C**	**Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years**	**Standards Identify standards that are not being met and add link to standard**
Inefficient Bed Utilisation	IP04	Mismatch between patient needs and ward configuration. People in beds who do not need to be. Admissions to DGHs and community hospitals due to lack of community-based alternative services.	28 patients in June 2024 census had no therapy or nursing needs. 32 patients required intensive rehab; 19 needed step-down care.	Bed census Day of Care audit (AH) Out of county bed waits (Digital)	Welsh Government: Pathway of Care Delays targets.

Mental Health Service Issues Template (when updating complete version control history below)

Scope: single 'front door' to access mental health services (SPOA), including "111 press 2", teams in the community that support older adults and MH inpatient care.

Completing the template

1. Agree issues.
2. Review metrics from C4C and agree baseline measure and definition – assign metric reference.
3. Identify if source document already available (if so, embed in file)

Version control		
1.0	CS	Document created
1.1	LK	Amends were made to MH3, MH4, and MH5, while additional issues were identified, including the lack of PROMS and PREMS data (MH6), the need to address co-morbidities (MH7), the limited availability of traditional models of delivery (MH8), public perception surrounding mental health (MH9), cross-border flow challenges (MH10), and transport options (MH11) as of 16/07/2025
1.2	LH/CW	31/7/25 Issue (M12) added for Inconsistencies in OOH ShropDoc cover.
1.3	LK/CW	1/8/25 LK/CW Updates to data column for MH1,3,4,5,6,7,8,9 &10.
1.4	AC	18/09/25 wording of Issue Category refined (no change to meaning) for issues MH09 and MH12.
1.5	LK/CW	Approved via Mental Health Transformation Programme Board 23.10.25
1.6	LK/CW	Further updated version approved via Mental Health Transformation Programme Board 23.07.26

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
Demand and Service Pressures	MH1	Demand for mental health services is increasing across all age groups and specialties, including early intervention, trauma therapy, and neurodivergent populations.	• *Projected 33% increase in referrals to adult and older adult mental health services by 2035.* • *14% increase in bed days* • *(LPMHSS) referrals expected to grow from 2,812 in 2023/24.*	(MH1A) Historic and projected (10 years) inpatient activity and bed days split by functional and organic. (MH1B) Historic and projected (10 years) referrals trends for older adults.	Part 1a and part 1b and Part 2 standards (care coordination) Section 117 (MH Act right to aftercare & r/v of CTP) Dementia standards (admission of OA patients) ND standard NICE guidelines for diagnostic assessments within 3 months of referral
Workforce Shortages and Reliance on Temporary Staffing	MH2	Persistent vacancies, recruitment challenges, and overreliance on agency staff are straining service delivery and continuity of care.	• *£786k spent on agency staff and £240k on bank staff in 2023/24. Wards like Clywedog and Tawe regularly exceed staffing budgets by 7.5–9 WTE.* • *Mental health nursing vacancies improved from -57.98 WTE (2022) to -40.13 WTE (2024).* • *Turnover reduced by 24%, but key roles in psychology and social work remain unfilled.*	(MH2A) Use of agency over 12-month period. (MH2B) Nursing vacancies for inpatients staff groups over 12-month period (MH2C) Staff turnover for inpatients staff groups over 12-month period	Workforce standards around staff sickness rates Recent quality audits have indicated reduced quality in CTP paperwork International nursing standards Organisational aim for staff sickness rates, duty of quality.
Long Waiting Times and	MH3	Delays in assessment and therapy access, especially for Memory	• *Only 63.1% of patients started psychological therapy within 26*	(MH3A) % of patients receiving psychological therapy within 26 weeks.	MH measure Duty of quality

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
Performance Shortfalls		Assessment Service and psychological interventions, are impacting patient outcomes. Performance dramatically improved in last year but sustaining position needs consideration. Need to focus on psychology waiting times outside of measure performance.	*weeks in Nov 2024 (target: 80%).* - *Improved to 71.4% by March 2025, but still below target.* • *LPMHSS assessments within 28 days Improved from 78.7% (Dec 2024) to 98% (March 2025).* • *Valid care and treatment plans for adults at 80.7% (target: 90%).*	(MH3B) % of patients LPMHSS assessments within 28 days (MH3C) % of patients with valid care and treatment plans (all MH services)	
Inadequate Infrastructure and Geographic Challenges	MH4	Rurality, dispersed teams, and outdated facilities are no longer fit for purpose and hinder efficient service delivery and staff flexibility. Cross cover, resilience and isolation. Challenges for digital provision of services and infrastructure. Transport challenges e.g. ECT. Inequity	• *Powys spans 5,181 km^2 with a population of ~134,000, making travel and resource allocation difficult.* • *Community mental health teams are split across five locations, amplifying the impact of absences.* • *Ward layouts require additional staffing for patient safety due to design limitations. And do not provide*	Staffing Locations and benchmark data for older adult community teams - HBN standards – evidence of additional staffing required because of ward design (service to supply?)	Dementia standards (impact of isolation, transport to appointments, dementia friendly hospital charter – environment) Standards for patient care including Royal Coll age of Psychiatry, GCU framework and CQC

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
		service access based on geography.	*therapeutic environments* • *Recent HIW inspections have raised issues with current estate which cannot be mitigated.*		
Financial Pressures and Unsustainable Commissioning	MH5	Escalating costs for specialist private provider placements and temporary staffing are straining budgets. Current contract usage. Cost of PICU, low secure, medium secure, MH acute beds.	• *Specialist placement costs rose from £189/day to £216/day in 2023/24.* • *66 adults in independent sector placements under Section 117.* • *Forecast monthly spend on complex needs rose from £9.3M to £13.9M over 2023/24.* • *Inflation for placements in 2023/24 was 12%.*	No of patients requiring specialist placements over xx years and associated costs (Finance SJ/CT) Future specialist placement projects and associated commissioned spend projected over 10 years – no change. (Finance and Service)	Health & care Strategy (achieving care close to home)
Data quality and standardisation	MH6	Data quality is generally poor, with data captured across a variety of systems, lacking standardisation and accessible reporting. In addition, an improved approach		National work is in progress to improve and streamline systems.	Dementia standards (specific stds for measurement) MH Measure (CTPs, capturing data) CTP audit Professional standards

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
		to obtaining and managing patient outcomes data is required. Current electronic system for capturing clinical notes is due to decommission in Dec 2025 without a clear timeline for a system replacement.			IG standards
Changing demand including co-morbidities	MH7	Ability to be able to care for patients presenting with multiple morbidities including LD, ND, Physical Health	•	*Data on comorbidity diagnoses is not recorded. A hand search of inpatient records is underway.*	Dementia standards (physical health reviews)
Traditional model of delivery and lack of flexibility of options to meet new demands	MH8	Lack of sanctuary style service to enable overnight de-escalation. Step down, out of hours services. Culture of managing within locality and need to consider alternative models of recovery focus and open access.	*Service to specify* *Service to specify*	**111 press 2 data would potentially show demand OOH* **Six goals data – ED attendance OOH*	MH & Well-being strategy Social Service & Wellbeing Act
A need to redefine the	MH9	Challenges expectations in	*Service to specify*		MH & Wellbeing Strategy

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
core offer of mental health & wellbeing services. To communicate this clearly and consistently to Powys communities.		relation to risk. Outcomes from receiving services and engagement with services. Lack of understanding regarding the service that MH provides and persistence of stigma around mental health. Current model is not integrated with empowering people to self-care. Core offer does not align with presenting needs.			Social services Wellbeing Act
Cross border flow from multiple sites across County complex and expensive	MH10	Patient flow across county and borders lacks efficiency due to lack of digital integration, allowing shared access to documentation and transport expenses.	*Service to specify*	*Case studies/ vignettes* *Anecdotal evidence.*	
Limited transport options	MH11	Specialist mental health patient transport options are limited and	*Service to specify*	129k for private transport, overspent 23/24 87k, 24/25 overspent 105k (minimum)	*MH Act (conveyancing – dignified and suitable for purpose)* *MH and crisis in care Concordat*

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	**Baseline Metrics,** these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	**Standards** Identify standards that are not being met and add link to standard
		expensive, usually involving private providers. St Johns Ambulance are based outside of Powys and prioritise closer HBs (perhaps PTHB need commissioned arrangement for Powys). WAST Non-Emergency Patient Transport refuse MH patients (inc. for dialysis appts).			

Community Based Services (Front Facing Services for Physical and MH) Issues Template (when updating complete version control history below)

Scope: Community services for physical and mental health services

Completing the template

1. Agree issues
2. Review metrics from C4C and agree baseline measure and definition – assign metric reference
3. Identify if source document already available (if so, embed in file)

Version control		
1.0	KP	Document created
1.1	CS	Updated to reflect comments from Day 1 – needs further review and consideration
1.2	JM	Added in proposed combined issues that reflect the root cause of the issues identified within the Case for Change for review.
1.3	LS	Reviewed by LS
1.4	JM	Updated to accept combined changes.
1.5	DF/CP	Approved at Programme Board – 08.09.2025
1.6	DF/CP	Further updated version approved at Programme Board – 18.08.2026

Issue Category	**Issue Ref**	**Issue (top 5)**	**Metric from C4C**	**Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years**	**Standards Identify standards that are not being met and add link to standard**
Inability to support a greater cohort of people in their own homes	CT01	This issue is caused by current fragmented service delivery and coordination; workforce fragility and geographic dispersion;	Specialist teams often have <5 WTE staff spread across Powys. District Nursing: 100.03 WTE, but often unable to meet supervisory standards. DHTT – fragility. Reactive approach.	Establishment report, including vacancies, agency use *Datex(?) - Digital*	National Community Nursing Specification

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		limited capacity in some teams; lack of join up between physical health and mental health and partners; current service gap for a community-based rapid response team that can respond during a crisis and enable someone to remain at home	1 in 3 people aged 65+ and 1 in 2 aged 80+ at risk of falling. Falls are a major driver of hospital admissions and deconditioning. New Community Rehabilitation Service launched April 2025. Operating 8am–8pm, 7 days/week, but coverage and impact still under evaluation.		

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		Lack of resources to deliver this model with current service configuration			
Unsustainable increase in Continuing Healthcare requirements	CT02	This is caused by: Increased CHC caseloads and costs; current service gap for a community-based team that can provide fast-track end of life care and enable people to receive	CHC cases went up 42% from 2019/20 to 2023/24. CHC costs up 128% in the same period.		

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		appropriate care and treatment at home			
Inability for current services to be sustainable		This issue is caused by: Increasing demand due to more people living longer, with multiple conditions and increasing complexity of need; current fragmented service delivery and coordination;			

Issue Category	Issue Ref	Issue (top 5)	Metric from C4C	Baseline Metrics, these need to link to scope for 25/26 engagement – baseline should be 24/25 - trend minimum 2 years suggest 3 or 5 years	Standards Identify standards that are not being met and add link to standard
		workforce fragility and geographic dispersion; limited capacity in some teams; lack of join-up between physical health and mental health and partners; current service gap for a community-based rapid response team that can respond during a crisis and enable someone to remain at home			

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Better Together

Adult Physical and Mental Health Community Services

Urgent Care

Service Model of Care

V0.6

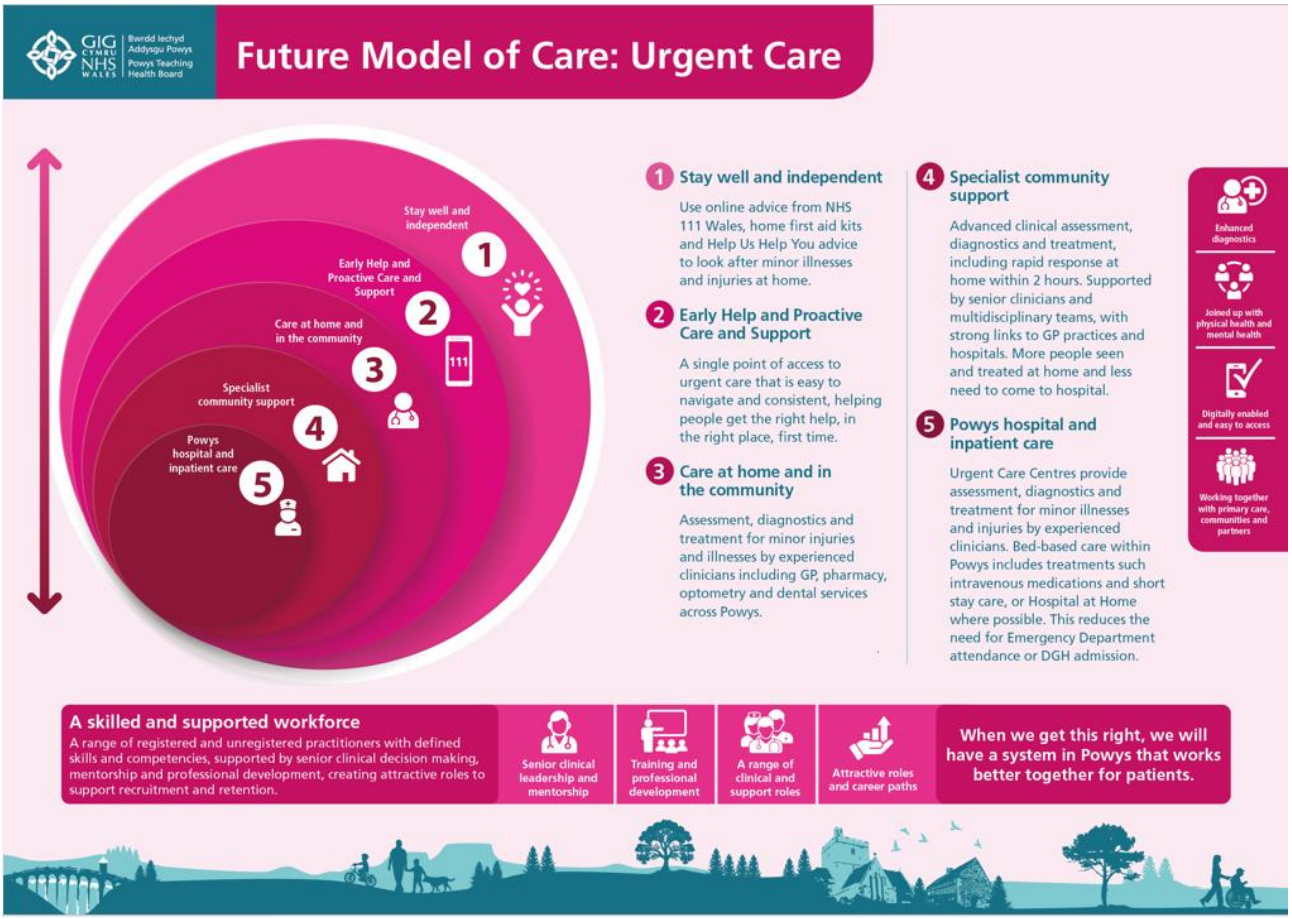
Community Urgent Care Service Model

1. Background and Context

1.1 Glossary of Terms

Abbreviation	Definition
ACP	Advanced Clinical Practitioner
AfC	Agenda for Change
AHP	Allied Health Professional(s)
ALS	Advanced Life Support
APLS	Advanced Paediatric Life Support
ATLS	Advanced Trauma Life Support
COPD	Chronic Obstructive Pulmonary Disorder
CRP	C-Reactive Protein (Blood test)
D-dimer	D-dimer (Blood test)
ECP	Emergency Clinical Practitioner
ED	Emergency Department
EHR	Electronic Health Record
ENP	Emergency Nurse Practitioner
FBC	Full Blood Count (Blood test)
GP	General Practitioner
GMS	General Medical Services
INR	International Normalised Ratio (Blood test)
LoS	Length of Stay
MIU	Minor Injury Unit
MIIU	Minor Injury and Illness Unit
MSK	Musculoskeletal
PGD	Patient Group Directive
PoCT	Point of Care Testing
PTHB	Powys Teaching Health Board
RCEM	Royal College of Emergency Medicine
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedure
SPoA	Single Point of Access
TNCC	Trauma Nursing Core Course
UCC	Urgent Care Centre
UCR	Urgent Community Response
USS	Ultrasound Scan
U+Es	Urea and Electrolytes (Blood test)
WAST	Welsh Ambulance Service Trust
WGOS	Wales General Ophthalmic Service
WPAS	Welsh Patient Administration System

Future model of urgent care services. The supporting infographic presents the future urgent care model of care, demonstrating how integrated community-based services, urgent assessment, treatment and home-based support work together to improve access, reduce unnecessary hospital attendance and deliver care closer to home.



1.2 Vision and Objectives

To deliver a fully integrated, community-based urgent care system that:

- Offers timely access to urgent care practitioners who can assess, investigate, diagnose and treat people with acute conditions that are not life-threatening emergencies such as common acute illnesses and injuries.

- Prevents unnecessary conveyance and/or admissions to hospital whilst supporting older adults and people with long-term conditions to remain at home.

- Provides person-centred health, social care, and third sector services and support according to the person's needs, across organisations, in an integrated way.

- Maximises digital solutions to facilitate a prudent model of urgent care in a rural population, with a focus on assessment, prioritising, monitoring, expert clinical support and clinical governance.

This delivers against the shared long-term Health and Care Strategy for Powys 2017 – 2027, with the aim to help people in Powys to 'Start Well', 'Live Well' and 'Age Well' through a focus on well-being, early help and support, tackling the big four health challenges, and better joined up care.

1.3 Strategic Alignment

This service model has been developed in line with:

Health and Care Strategy: The shared long-term Health and Care Strategy for Powys and the vision of 'A Healthy, Caring Powys', which forms the basis for the Regional Partnership Board Area Plan and PTHB Integrated / Annual Plan.

Powys Wellbeing Plan: The Powys Wellbeing Plan overseen by the Public Services Board, which takes an inter-generational approach to the wider social, economic and environmental determinants of wellbeing.

National Objectives: The Welsh Government long-term plan for health and social care, 'A Healthier Wales' and the emerging Integrated Community Care System for Wales, which includes the Strategic Programme for Primary Care and the Six Goals for Urgent & Emergency Care as some of the national areas that this work relates to.

1.4 Design Principles

The model embraces the Core Principles from the Powys Health and Care Strategy:

- Do What Matters
- Do What Works
- Focus on Greatest Need
- Offer Fair Access
- Be Prudent
- Work with the strengths of people & communities

- **Person-centred and timely**: Right care, right time, close to home.

- **"Home First" philosophy:** Avoid hospital admissions unless absolutely necessary.

- **Integrated and multi-agency:** Seamless working across health, social care and third sector organisations.

- **Digitally enabled:** digital solutions that support prudent models of care.

- **Evidence-based:** Align service model to up-to-date evidence base.

- **Value-based Healthcare:** Aiming to maximise health outcomes and patient experiences while minimising costs, focusing on delivering higher quality, more effective and equitable care.

- **Prudent Healthcare Principles:** Co-production, Prioritisation, Evidence-based care and reducing waste.

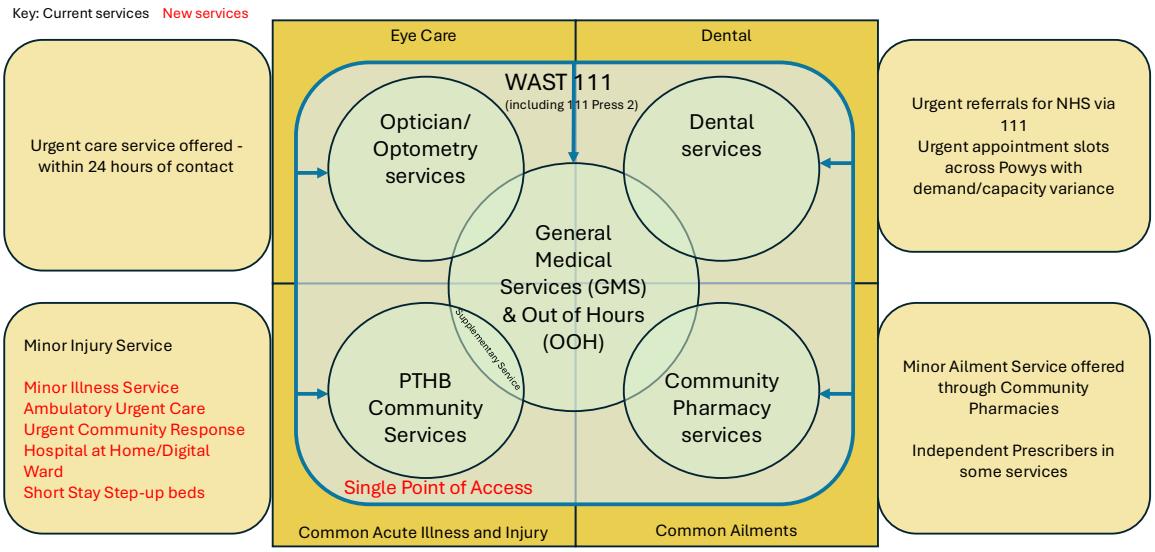
2. Community Urgent Care Service

2.1 Service Components

The following section describes the individual components of an integrated community urgent care service that builds on and enhances services that are currently available for Powys residents, either in-hours or out of hours. The various components can be viewed as modular, allowing the range of services to expand over time as practitioners broaden their scope of practice and progressively build toward a more comprehensive model of urgent care with an integrated 'front door'. This phased approach will ensure that transformation of urgent care in Powys is appropriately paced, flexible and designed to be sustainable.

Each component of the comprehensive integrated urgent care services can be adapted to the needs of the local population, geography, transport infrastructure and current operational readiness. The new network of urgent care services will be designed to deliver clinical effectiveness, value and to ensure both workforce and financial sustainability.

Urgent Care Service Components



Urgent Primary care services are delivered by dental, ophthalmic, community pharmacy and general medical services (GMS) in Powys. Urgent dental care is provided for people with an NHS dentist via their own dentist. Those without an NHS dentist can call NHS 111 for triage and urgent cases are referred to the Health Board's Urgent Dental Care pathway. Urgent eye care is provided by an optometrist for assessment under the Wales General Ophthalmic Service (WGOS). Outside normal hours NHS 111 remains the first point of contact for this service. Community pharmacies across Powys provide a number of urgent care services such as common ailment services, emergency medicines supply and emergency hormonal contraception.

For urgent medical care patients access their General Practice for General Medical Services (GMS) during core hours for advice, appointments or signposting. Temporary residents can also access General Practice in the area for urgent medical care under NHS regulations. Out-of-hours GMS is delivered by Shropdoc and Swansea Bay University Health Board, with NHS 111 handling initial triage and referrals.

Flow of referrals to the appropriate PTHB community urgent care service component will be directed by a Single Point of Access (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 will inevitably arise, we will utilise existing standard 999 and Emergency Department 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 will 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 will guide access to the appropriate follow up services e.g. fracture clinics, MSK physiotherapy services etc.

Most PTHB service components will 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 will be delivered at home. A minority of urgent care episodes will require admission escalation to an acute hospital Emergency Department outside of Powys or admission to a PTHB community hospital.

Activities that are integral to all components are:

- Triage, assessment, diagnostics, and treatment
- Signpost or redirection to appropriate services
- Referral to specialist services if required
- Referral for follow up services such as fracture clinic, physiotherapy
- Discharge / handover to appropriate services following acute episode

Key interfaces/dependencies for urgent care are:

- Single Point of Access (SPoA)
- WAST/111
- Primary care services
- Out of hours services/contract
- Integrated intermediate care team to include multi-agency availability such as social care and third sector services
- PTHB community beds
- Secondary care services e.g. Same Day Emergency Care (SDEC), Ophthalmology, Medical/Surgical assessment units
- PTHB medicines management team
- Proactive care for chronic conditions with clearly defined clinical pathways for the management of exacerbations across primary, community and secondary care services.
- PTHB mental health services
- Specialist palliative care services
- Expert clinical networks and pathways supported by telemedicine

2.1.1 Minor Injury Services

Description:

Minor Injury services provide a service for patients with injuries not necessarily requiring admission to secondary care (RCEM 2024). Listed below are examples of presentations or treatments managed by a minor injury service.

Presentations:

- 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.

Treatments:

- Dressings
- Limb immobilisation
- Minor joint manipulations
- Removal of simple foreign bodies
- Wound care (including suturing)
- Medications to take home such as antibiotics

2.1.2 Minor Illness Services

Description:

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.

Presentations:

- 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

Treatments:

- Advice
- Medications to take home
- Dressings

2.1.3 Ambulatory Urgent Care

Description:

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 will be delivered **in a healthcare facility** with on-site advanced clinical practitioners and a senior clinician capable of assessing, diagnosing and treating. The facility will have appropriate and timely diagnostic services and will 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.

Presentations:

- Range of minor injury and illness
- Falls
- Pneumonia/chest infections
- Urinary tract infections
- Cellulitis
- Deep vein thrombosis

Treatments:

- Advice
- Dressings
- Limb immobilisation
- Minor joint manipulations
- Removal of simple foreign bodies
- Wound care (including suturing)
- Medications to take home

- Medication that may need to be delivered in the urgent care setting such as intravenous antibiotics
- Physiotherapy assessment and treatment plan

2.1.4 Urgent Community Response

Description:

An urgent community response enables deployment, within 2 hours of contacting the service, of a practitioner with advanced clinical assessment skills, knowledge and competencies to assess, diagnose and initiate a treatment and support plan for an **adult in their own home.** This service is designed for adults who may be unable to independently attend a local urgent care facility. Expert clinical decision maker support, provided by out-reach from the urgent ambulatory urgent care service, will be fully integrated with Community teams and the Intermediate Care service to enable the individual to access any support, rehabilitation, palliation or step-up bed required to help them recover from the acute crisis. Listed below are examples of presentations and treatments this component may support at home, including for residents who have urgent care needs in a care home. Further details can be found in the Integrated Community Service model.

Presentations:

- Falls
- Pneumonia/chest infections
- Cellulitis
- Urinary tract infections
- Acute exacerbation of chronic conditions
- Complex care needs
- End of life care which requires urgent support beyond that of the practice team

Treatments:

- Advice
- Medications to take at home
- Subcutaneous hydration or intravenous antibiotics delivered at home
- Therapy assessments and treatment plans

2.1.5 Hospital-at-home/Digital Ward

Description:

An enhanced urgent community response that provides short term acute hospital level care for patients in their homes for the duration of their acute illness episode. Remote monitoring and treatments, including intravenous antibiotics and oxygen therapy, usually provided in hospitals are delivered to selected people in their homes or in nursing homes by clinicians with appropriate clinical skills and competences. This service provides an alternative to hospital admission or may reduce length of hospital stay and associated risks of hospital-acquired infections and deconditioning, improving patient experience.

The service will have expert clinical decision maker advice, provided by out-reach from the urgent ambulatory care service or by telemedicine decision support from specialist secondary care teams, for example frailty, heart failure, respiratory or diabetes specialists. The Hospital at Home / Digital Ward will be fully integrated with the Intermediate Care service and local point of care testing and diagnostics.

Listed below are examples of conditions or treatments that may be supported. Remote monitoring equipment may enable comprehensive clinical assessment and monitoring in the person's home.

Presentations:

- Exacerbations of COPD
- Pneumonia
- Heart failure
- Cellulitis

Treatments:

- Intravenous medications
- Oxygen therapy
- Monitoring of exacerbations of long-term conditions
- Subcutaneous hydration or intravenous antibiotics
- Therapy assessments and treatment plans

2.1.6 Short Stay Step-up beds

Description:

Short stay step-up beds are hospital based inpatient beds for up to 72 hours to undertake assessment and diagnostics, implement treatment plan and discharge with wrap around support where required. These short stay beds are for when an individual needs a higher intensity of multi-professional assessment, diagnostics and treatment than can safely be provided at

home. It avoids an emergency department attendance or an acute hospital admission. Further detail can be found in the Physical Health inpatients service mode.

3. Diagnostics

3.2 Diagnostic requirement per service component

Components	Requirement and Operating hours			
	Plain film X-ray	Point of Care testing	Lab testing	Ultrasound scan
Minor Injury Services 7 days per week 08:00 – 20:00	7 days per week 09:00 –18:00	Blood glucose and ketones 7 days per week 08:00 – 20:00	No	No
Minor Illness Services 7 days per week 08:00 – 20:00	7 days per week 09:00 –18:00	Blood glucose, blood ketones, urinalysis, COVID-19, influenza, CRP, D-Dimer. 7 days per week 08:00 – 20:00	No	No
Ambulatory Urgent Care 7 days per week 08:00 – 20:00	7 days per week 09:00 –18:00	Blood glucose, blood ketones, urinalysis, COVID-19, influenza, CRP, INR, FBC, U+Es, D-dimer, blood gases, lactate 7 days per week 08:00 – 20:00 PoCT Lab runs am and pm daily		09:00 – 17:00 Monday - Friday
Urgent Community Response 7 days per week 08:00 – 20:00	7 days per week 09:00 –18:00	Blood glucose, blood ketones, urinalysis, COVID-19, influenza, CRP, INR, FBC, U+Es, D-dimer, blood gases, lactate 7 days per week 08:00 – 20:00 PoCT Lab runs am and pm daily		09:00 – 17:00 Monday - Friday
Hospital at Home/Digital Ward 7 days per week 08:00 – 20:00	7 days per week 09:00 –18:00	Blood glucose, blood ketones, urinalysis, COVID-19, influenza, CRP, INR, FBC, U+Es, D-dimer, blood gases, lactate 7 days per week 08:00 – 20:00 PoCT Lab runs am and pm daily		09:00 – 17:00 Monday - Friday
Short Stay Step-up beds 24 hours per day 7 days per week	7 days per week 09:00 –18:00	Blood glucose, blood ketones, urinalysis, COVID-19, influenza, CRP, INR, FBC, U+Es, D-dimer, blood gases, lactate 7 days per week 08:00 – 20:00 PoCT		09:00 – 17:00 Monday - Friday

		Lab runs am and pm daily	

4. Digital and Data Support

- Shared Electronic Health Record (EHR) across sectors that enables data to be pulled to measure performance as per requirements.
- Utilise web-based patient administration system for Emergency and Urgent Care departments in Wales (WPAS) and provide infrastructure to enable efficient and effective utilisation for teams.
- Optimise interoperability with electronic systems of acute care providers outside of PTHB.
- Telemedicine to enable remote consultation and decision support by experts and specialists in various forms e.g. virtual clinics, individual case management using digital solutions already in place such as consultant connect
- Use remote diagnostics and remote reporting.
- Virtual multi-agency meeting environment that enables networking and effective communications across services, organisations and professional groups, thus reducing bureaucratic processes and barriers to integrated working.

5. Workforce Considerations

An appropriately trained multi-disciplinary clinical workforce will be essential. The staff profile and skill set must enable an equitable service across Powys and consistent operating standards across different sites or teams. The service model will require a range of unregistered and registered practitioners/clinicians with the skills, knowledge, experience and competencies to meet the needs of the urgent care services, taking into account implementation and evolution of services.

The RCEM (2018) workforce model describes senior decision makers as medical staff or credentialed Advanced Clinical Practitioners (ACPs) that are sufficiently experienced to make safe and effective decisions regarding the care of every patient. This would apply to a decision to admit or transfer the patient to the care of a specialty, or to safely discharge the patient with, or without, follow up.

The Urgent Care Practitioner framework Urgent Primary Care - Clinical Workforce Framework will be used as the basis for development of competencies for those expanding their scope of practice to manage illness. As PTHB's current urgent care workforce has elements of the required skills and competencies, the current workforce could be further developed and

supported by recruitment to current gaps in advanced practice roles. New roles such as rotational posts working across the range of service components are likely to be attractive and will support workforce recruitment and retention.

The range of roles required across the service include:

- Senior clinical decision maker role (Consultant level Doctor/Consultant Nurse with Emergency/Urgent care expertise AfC Band 8B-8C) – expert roles delivered in person, on a sessional basis, or remotely to cover several sites utilising digital technologies such as telemedicine and consultant connect/virtual support.

  The role will provide clinical oversight and leadership, mentorship of ACPs and training posts, lead on audits, research, service improvements and the delivery of high standards of evidence-based care. Maintain training and competence in Advanced Life Support (ALS), Advanced Trauma Life Support (ATLS/TNCC), Advanced Paediatric Life Support (APLS).

- Advanced Clinical Practitioner (AHP/Nursing AfC Band 8A) advanced role to provide operational, clinical and professional leadership, mentorship and drive service improvements. Maintain training and competence in Advanced Life Support (ALS), Advanced Trauma Life Support (ATLS/TNCC), Advanced Paediatric Life Support (APLS).

- Emergency Practitioners (AHP/Nursing AfC Band 6-7) – enhanced role to see, assess, diagnose, treat and discharge or refer to other services where appropriate.

- Registered practitioners (AHP/Nursing AfC Band 5-6) – a triage role but may also support treatments and additional aspects of service delivery.

- Health Care Support Workers (AfC Band 2-3) – to provide vital clinical support to the operational delivery of the service. For example, by assisting registered practitioners with performing technical and physical aspects of patient care and maintaining a clean and well stocked environment.

- Administrative staff (AfC Band 2) - to provide vital non-clinical support to the operational delivery of the service, often being the first point of contact for patients, managing patient flow, maintaining accurate records and supporting clinical staff with administrative tasks.

Implementation will require a clear workforce strategy and the expertise to support delivery. Consideration needs to be given to protecting learning time in order for staff to meet the required competencies. Headspace also needs to be created to nurture a workforce culture that enables practitioners to work at the top of their licence supported by clinical supervision, mentorship and professional development for all.

6. Clinical Governance and Safety

Having a robust and sustainable clinical leadership structure is key to the safe delivery of PTHB delivered urgent care services. Rurality creates challenges but also an opportunity to utilise technologies and workforce competencies, skills and expertise, as opposed to professional title, to work in different ways to the traditional service models we are accustomed to.

A clear and robust clinical leadership and oversight structure is essential, with a named senior clinical lead responsible for general oversight, clinical governance, audit, staff training and the strategic development of the service across a PTHB clinical network.

Implementing a networked clinical leadership approach requires innovation and flexibility and provides an alternative workforce model that may encourage recruitment and retention. Additionally, to this approach is recognition of the interdependencies within the clinical leadership structure across PTHB services to ensure that senior clinicians work collaboratively with multi-professional teams across organisational structures and services.

Underpinning requirements for effective network governance include:

- Clear and defined escalation pathways and protocols for expert clinical support and advice utilising telemedicine advice services that are already embedded into practice such as consultant connect.
- Use of nationally recognised and evidence-based clinical pathways and Service Operating Procedures (SOPs).
- Use of up-to-date evidence base and process for regular review to maintain quality and safety and best practice.
- Ensure a system is in place that enables prudent communication across the multi-agency teams that is supported with the correct IT and clinical governance structures
- Interdepartmental working with support services such as diagnostics and reception teams.
- Embed a structure and culture of mentorship and supervision to enable clinicians to develop and work to the top of their licence.
- Ensure robust and clear interdepartmental working to support advanced and enhanced practices such as non-medical prescribing.
- Use of Patient Group Directives (PGDs) for medications

- National and local audit participation
- National and local quality improvement measures and cycles.

6.1 Supporting Operational Policies

- Urgent Care Triage and Clinical Pathways Policy
- Step-Up Bed Admission and Discharge Policy
- Community Rapid Response Standard Operating Procedure
- Medicines Management and Prescribing in the Community
- Safeguarding Policy and Escalation Procedures
- Lone Working and Safety in Remote Locations
- Infection Prevention and Control in Community Settings
- Digital Records and Remote Access Policy

7. Key Performance Indicators (KPIs)

Metric	Target
% of patients seen in urgent care within 4 hours	
Time to triage	
Time to clinician	
Outcome of attendance	
2-hour urgent community response compliance	
999 calls – number of patients redirected to PTHB urgent care services	
Average LoS in step-up beds	
Reablement success rate (no readmission 30 days)	
Patient feedback/satisfaction	
Patient Reported Outcome Measures	
Patient Reported Experience Measures	
Staff feedback/satisfaction	

UCC performance measures	
Measures to evidence operational efficiencies	

Appendix 1

What is an Urgent Care Centre?

An Urgent Care Centre, or 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 Minor Injury Unit. It can support people with urgent illnesses and injuries, and it brings together urgent primary care, minor injury care and same-day urgent care in one place. The aim is to help more people be assessed, treated and supported closer to home, where it is safe to do so.

You do not need to know what is wrong with you before asking for help. 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 you, decide what investigations or treatment may be needed, and help you get the right care.

What might I go to an Urgent Care Centre for?

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 Emergency Department

What is different about an Urgent Care Centre?

A UCC provides a broader urgent care offer than a traditional Minor Injury Unit 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 Emergency Department
- 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 Emergency Department.

Is an Urgent Care Centre the same as a GP appointment?

No. A UCC does not replace your GP practice.

However, a UCC may support people who need urgent same-day assessment, and who may otherwise attend A&E because they cannot access the right help quickly enough.

Is an Urgent Care Centre the same as a Minor Injury Unit?

No. A Minor Injury Unit mainly sees people who have had a minor injury, such as a cut, sprain, strain, minor burn or suspected broken bone. People usually attend because they already know, or strongly suspect, that they have injured themselves and need help with that injury.

An Urgent Care Centre would be able to see and treat minor injuries too, but it would also offer help for a wider range of urgent same-day health problems, including some illnesses. This means you would not need to know exactly what is wrong before asking for help. If your problem is urgent but not life-threatening, the UCC team would assess you, decide what care or tests may be needed, provide treatment and if required, help direct you to the right support. It would also have a stronger link with diagnostics, community services, and wider urgent care pathways.

When should I NOT use an Urgent Care Centre?

A UCC is not an Emergency Department and should not be used for life-threatening emergencies.

You should call 999 or go to the nearest Emergency Department if you or someone else has:

- chest pain
- signs of a stroke, such as face drooping, arm weakness or speech problems
- severe breathing difficulty
- severe abdominal pain
- major trauma or serious injury
- heavy or uncontrolled bleeding
- loss of consciousness or collapse
- seizures
- a seriously ill child needing emergency treatment
- any condition that feels immediately life-threatening

What else should I not use a UCC for?

A UCC should not be used for:

- routine or non-urgent health concerns
- repeat prescriptions
- planned reviews of stable long-term conditions
- routine follow-up appointments
- pregnancy-related concerns, where maternity services, your midwife or GP should be contacted
- a mental health crisis, where dedicated mental health crisis support should be used

What if I am not sure where to go?

If you are unsure which service is right for you, you can seek advice first. This can be through NHS 111 Wales, your GP practice, or the UCC.

Better Together

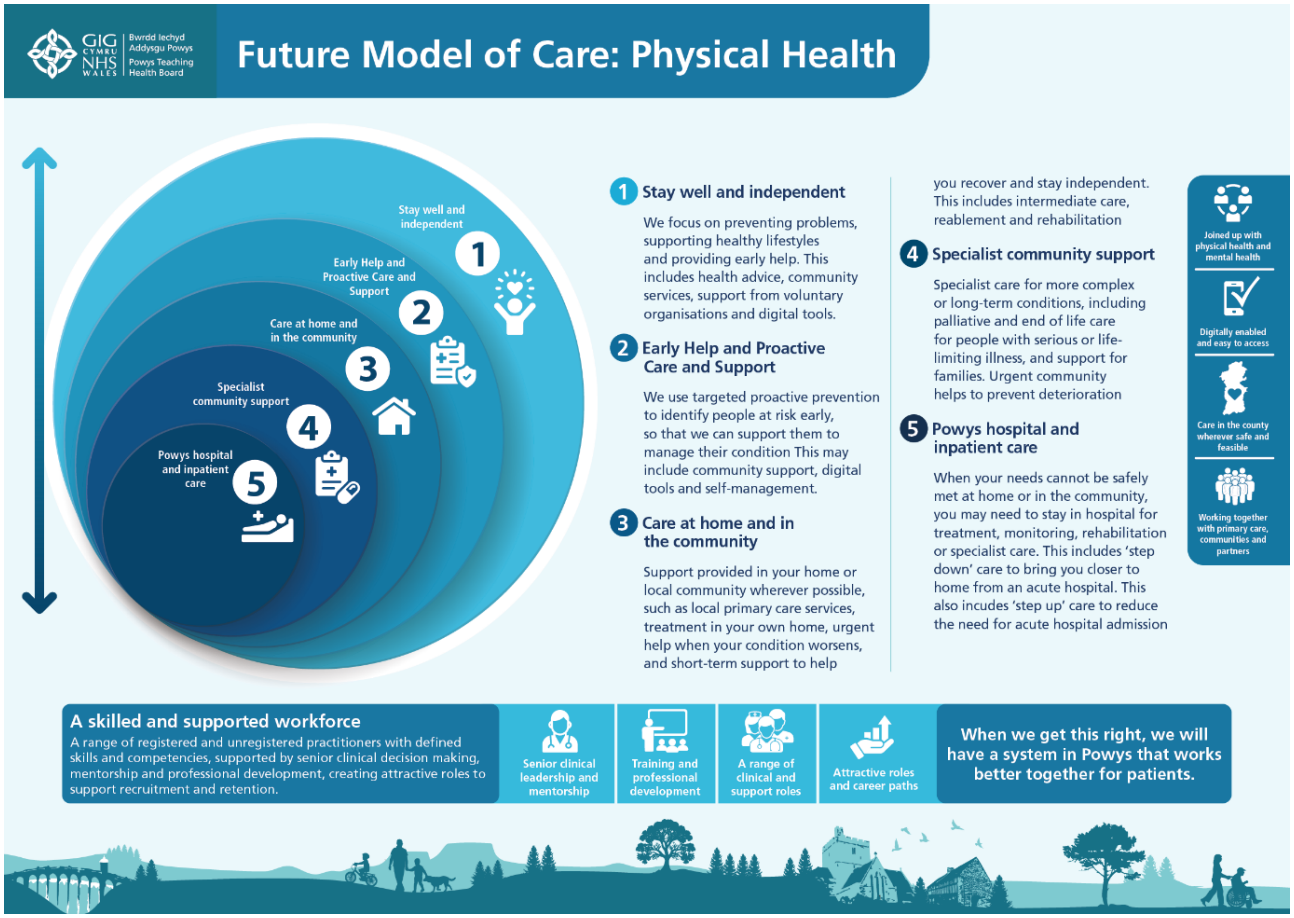
Adult Physical and Mental Health Community Services

Physical Health Bed Based Care

Service Model of Care

V0.5

Future model of adult physical health care. The supporting infographic presentation describes it as the physical health model on a page and explains that the wider model includes proactive prevention, intermediate care, multidisciplinary community support, rehabilitation and inpatient care.



Physical Health Community Bed Based Services
Service Model of Care

1. Background & Context

1.1 Vision and Purpose

To provide safe, high quality, person centred, digitally enabled, proactive and integrated care within fit-for-purpose community settings, that:

- Effectively manage patients with complex physical and mental healthcare needs
- Prevent patient harm and deconditioning
- Support recovery through rehabilitation
- Reduce unnecessary acute hospital admissions and stays
- Facilitate timely discharge and effective transitions of care
- Reduce avoidable readmissions
- The model will also support people approaching the end of life to receive timely, person-centred and dignified care closer to home, including within Powys community hospital beds where care at home or in a care home is not possible, clinically appropriate, or aligned with individual preference.

This delivers against the shared long term Health and Care Strategy for Powys 2017 – 2027 which sets out the priorities for transforming health and care in Powys, with the aim to help people in Powys to 'Start Well', 'Live Well' and 'Age Well' through a focus on well-being, early help and support, tackling the big four health challenges, and better joined up care.

1.2 Strategic Alignment

Health and Care Strategy: The shared long term Health and Care Strategy for Powys and the vision of 'A Healthy, Caring Powys', which forms the basis for the Regional Partnership Board Area Plan and PTHB Integrated / Annual Plan

Powys Wellbeing Plan: overseen by the Public Services Board, which takes an inter-generational approach to the wider social, economic and environmental determinants of wellbeing

National Objectives: The Welsh Government long term plan for health and social care, 'A Healthier Wales' and the emerging Integrated Community Care System for Wales, which includes the Strategic Programme for Primary Care and the Six Goals for Urgent & Emergency Care as some of the national areas that this work relates to.

1.3 Design Principles

The Core Principles from the Powys Health and Care Strategy:

- Do What Matters
- Do What Works
- Focus on Greatest Need
- Offer Fair Access
- Be Prudent
- Work with the strengths of people & communities

Person-Centred: Care is tailored to individual goals and preferences.

Integrated and multidisciplinary: Seamless interface with acute hospitals, primary care, community services, and social care and the voluntary sector and a collaborative approach across health and social care sector professionals.

Evidence-Based: Interventions grounded in NICE guidelines, Royal College standards, and best practice.

Value-based healthcare: Aiming to maximise health outcomes and patient experiences through operational excellence while minimising costs, focusing on delivering higher quality, more effective and equitable care. Measurable goals that support functional improvement or dignified end-of-life.

Timely: Admission and discharge pathways optimised to reduce delays and provide better outcomes and experience for individuals.

2. Service Components

2.1 Inpatient beds

2.1.1 Descriptions

Step down
Step down care will be, being discharged from hospital-based care to the intermediate care team, or the proactive prevention team, whichever is required to meet the needs of the person.

Step down care in relation to inpatient bed based care may also be used to describe a person who no longer needs nursing care in a district general hospital setting, who may require a short period of nursing care, overseen my medical and therapy colleagues in a community hospital setting.

Step up Step up will either be transfer into acute for enhanced health needs, delivered by the intermediate care team. Or. Where required, is a hospital-based bed for admission for up to 72 hours to undertake assessment and diagnostics, implement treatment plans and discharge with wrap around support where required.

Rehabilitation is a set of interventions designed to optimise functioning and reduce disability in individuals with physical and mental health conditions in interaction with their environment. Rehabilitation is generally available within the Community Hospital inpatient units for individuals who have accessed these beds via step up or step-down pathways. Complex Neurological rehabilitation will be focussed on one inpatient unit due to patient numbers and specialist Neuro Psychology support.

Palliative Care is an approach to care for individuals with life-shortening illnesses, focusing on improving quality of life, aiming to prevent and relieve suffering through early identification, assessment and treatment of physical, psycho-social or spiritual symptoms. Hospice-quality care is delivered through an integrated network of home, care home, community hospital, specialist palliative care, hospice partner and commissioned services, rather than through a single hospice building. Care will be supported through universal, targeted and specialist palliative care, with specialist input focused on people with the most complex needs and on supporting the wider workforce through advice, education and clinical leadership

End-of-life care Specifically refers to care provided in the last weeks or days of life. Community hospitals will form part of a planned, dignified and safe local pathway, supporting people to remain in Powys where clinically appropriate and helping more people to receive care closer to home in the place that best reflects their wishes, preferences and clinical needs. End of life care should be supported by Advance and Future Care Planning, clear treatment escalation planning, timely access to specialist advice where required, and coordinated support for families, unpaid carers and those important to the person.

2.2 Clinical Scope for Community Hospital Beds

Individuals who are aged 18 and over who do not require acute hospital care but are not able to be safely managed by intermediate care or palliative care at home. They may:

- Require treatment for a physical health condition (and may have a comorbid organic mental health condition)
- Require rehabilitation and wider specialist input e.g. consultant neuropsychologist, consultant stroke therapist, speech and language therapist
- Have end-of-life care, palliative care symptom management needs that cannot be met at home
- Require further clinical assessment to support discharge planning
- Require complex assessment / observation / diagnostics / intervention such as IV therapy, NIV, CPAP, NG

Individuals with cognitive impairment or a diagnosis of Dementia should not be excluded. Consideration should be based on individual need and circumstances and supported by specialist intervention if required. Assessments may need completing under the Mental Capacity Act 2005 and if required a Best Interest Meeting should be arranged.

No organic mental health condition is excluded; however, individuals will need to meet the criteria set out above and in line with the facility regulatory requirements such as the Statement of Purpose.

2.2.1 Levels of practice - Hospital Inpatient units

Assessment, treatment, rehabilitation, complex care management and discharge planning by an MDT including daily medical review and nursing interventions. The following levels of practice would be required:

- Core MDT with designated senior clinical decision makers [Medical Consultant, Consultant Therapist/Nurse and Advanced Clinical Practitioner (ACP)] (see Section 3)
- ACP / Consultant posts for Nursing and Allied Health Professions will support the development of a first-class rural regional health service through education, research, clinical and leadership methodologies, these posts would require job planning.

This level of practice will enable community assessment and treatment (CAT) beds to be embedded as part of the inpatient model through a higher level of medical support to manage higher complexity and acuity, enabling earlier repatriation and avoidance of admission to out of county DGHs.

2.2.2 Key Interfaces / Interdependencies

These include:

- Intermediate Care Team
- Specialist services

- Adult Social Care
- Flow Hub/SPOA
- Primary Care
- Third Sector
- Hospice partners
- Diagnostics
- Therapies
- Medical Devices/Community Equipment Store
- Non-Emergency patient transport services (NEPTS)
- Acute SLA Providers
- Mental Health Inpatient Model of Care

2.3 Clinical Scope - Intermediate care beds in residential facility

Individuals aged 18 and over who do not require 24-hour nursing care and who will benefit from short term Therapy-led, enabling support to improve confidence and ability to live as independently as possible:

- No longer meet the criteria for an acute hospital bed or no longer require medical treatment in a community hospital bed.
- Require care and support services which cannot yet be provided in their own homes
- Require reablement which cannot be provided at home
- Require a short stay pending housing adaptation
- Are experiencing carer and social breakdown
- Are homeless/have no right of recourse to public funds/no place to safely discharge to and will benefit from a bed in a discharge to recover facility. This should not hinder the process to resolve their ongoing housing needs.
- Planned Discharge Date must be in place.

Individuals with a cognitive impairment or diagnosis of Dementia should not be excluded. Consideration should be based on individual need and circumstances with support from specialist intervention as required to meet any individual identified need. Assessments may need completing under the Mental Capacity Act 2005 and if required a Best Interest Meeting should be arranged.

No organic Mental health condition is excluded; however, individuals will need to meet the criteria set out above and in line with the bedded facility regulatory requirements such as the Statement of Purpose.

2.3.1 Levels of Practice – Intermediate care beds in residential facility

The following levels of practice would be required:

- Supported by the registered facility with support workers and in reach from Primary care/GMS

In reach from Intermediate Care Team comprising:
- ACP / Enhanced Nursing Practitioner / OT / Physio / Nursing / Social Worker

2.3.2 Key Interfaces / Interdependencies

These include:
- Intermediate Care Team
- Specialist services
- Adult Social Care
- Flow Hub/SPOA
- Primary Care
- Third Sector
- Housing services

3. Workforce Model

3.1 Community hospital inpatient unit workforce model

Clinical site management needs to be considered in a repurposed service.

Workforce requirements (number/skill mix) will vary depending on the size of the ward / unit and the range of patient cohorts included.

Core MDT members (all wards / units) include:
- Medical oversight (Resident Doctor / GP / Consultant in charge / Specialty Doctor)
- Advanced Clinical Practitioners – 8a (ACPs)
- Consultant Practitioners
- Enhanced Nursing Practitioners
- Ward manager
- Registered Nurses (RN)
- Health Care Support Workers (HCSW)
- Physiotherapist
- Occupational Therapist
- Dietitian in-reach
- Social Worker
- Discharge Liaison
- Pharmacist

Rehabilitation specific:

- Speech and Language Therapist
- Clinical Psychologist and Neuropsychologist
- Consultant Therapist for Stroke and Neuro

Palliative Care/End of Life specific:
- Palliative Care Specialist Nurse (Pan Powys – In-Reach)

Integrated Physical & Mental Health specific:
- Registered Mental Health Nurse (RMN) on a 12-hour day shift
- Mental Health trained Health Care Support Worker on a 24-hour shift
- Integrated OT role and support worker

The Mental Health posts would be operationally managed by the Physical Health team to ensure cohesive management, leadership and integration of digital platforms (and to disable barriers).

3.1.1 Staffing Standards

Nursing: 24/7 cover
Therapy: 45 mins/day per patient minimum (NICE Stroke Quality Standard); 7-day model
Medical cover: 7-day model with on-site presence weekdays, on-call weekends

3.2 Intermediate care/reablement unit staffing model

- Commissioned beds secured through a Service Level Agreement with private providers.
- Delivering in-reach from District Nursing / General Medical Services / Community therapies and specialist services.
- ACP model would provide case management for admission and discharge.

4. Care Pathways

4.1 Admission

Overall management will align with the intermediate care service to ensure close integration and operation across a regional network receiving referrals from Single point of access.

4.2 Assessment & Goal Setting (within 48 hours)

Comprehensive Geriatric Assessment (CGA)
Multidisciplinary team (MDT) care plan and estimated date of discharge (EDD)

Use of validated tools: Barthel Index, Montreal Cognitive Assessment (MOCA), Rockwood Clinical Frailty Score

4.3 Therapy/Intervention Delivery

- 7-day therapy provision in rehabilitation units
- 5 days in reach at other sites
- Dietetic speech in-reach
- Integrated therapy plans using goal attainment scaling
- Family/carer engagement in therapy and discharge planning

4.4 Discharge Planning

- PDD initiated on admission
- Daily MDT board rounds and assertive pull back to intermediate care at home with Discharge to Recover then Assess (D2RA) model
- Twice weekly MDTs
- Integration with local social care, voluntary sector, reablement at home

5. Quality Improvement

- Regular MDT reviews, reflective practice
- Quality Improvement (QI) embedded in practice (e.g., PDSA cycles)
- Service user and carer involvement in co-design
- Annual benchmarking against national standards (e.g., SSNAP for stroke)
- Daily safety huddles (safe care)
- Monthly audits (falls, pressure ulcers, medication errors)
- Incident reporting via national systems (e.g., Datix)
- Real-time patient feedback (e.g., Friends & Family Test, patient stories)
- Quality standards framework – Quality visits/accreditation, national benchmarking.

6. Outcomes and KPIs

Metric	**Target**
Optimised Length of Stay (LOS) (in line with Step Up & Rehabilitation elements)	
Readmission rate within 7 and 30 days	
Discharges to usual place of residence	
Patient Reported Experience Measures (PREMs)	≥90% positive response rate
Bed Occupancy	90-95%
Reduction in pathway of care delays (POCD)	<3% of occupied bed days

Reduction in delays and costs associated with patients awaiting repatriation	
Patient Reported Outcome Measures (PROMs) (TBC)	
SSNAP (Sentinel Stroke National Audit Programme)	Compliance with national targets
Clinical Outcome Measures	
Mortality data including place of death	

7. Digital and Data Support

- Shared Electronic Health Record (EHR) across sectors (Gold Standard)
- Real-time bed tracking and patient flow dashboards (Powys DigiFLO)
- Integration with primary care and Proactive Prevention virtual wards
- Standardised digital outcome measurement (therapy and other)
- Data analyst support to support clinical and operational teams, and management oversight.

8. Partnership and Integration

Close working with:

- Acute hospitals (CTCs, discharge teams, stroke units, orthopaedics)
- Primary care clusters
- Community teams – Intermediate Care Team, Specialist MDTs
- Hospices and specialist palliative care
- Adult social care
- Third Sector
-
-
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Appendix Once Physical Health and Mental Health integration

This appendix to the Service Level Models of Care addresses the question; What does integration between physical health, mental health and community services actually mean in practice, and how is it different in each option?

Agreed definition

Across all shortlisted options, care would be delivered through a more integrated model that strengthens links between physical health, mental health and community services. The aim is to provide greater emphasis on early intervention and support more people to remain well at home, access coordinated care earlier,

avoid unnecessary hospital admissions and experience smoother transitions between services when hospital care is required.

Clinical Model

- The inpatient model is an integrated approach as the staffing model includes RMN within core staffing numbers, and with mental health liaison roles, the inpatient caseload would link into MH MDT on a weekly basis and provide escalation pathways where required.

Community Model

The Physical Health community model proposes to help people stay well, independent and living at home for as long as possible by bringing health, social care, voluntary sector and community services together around the individual. It combines **proactive prevention** (identifying people at risk early, supporting self-management, wellbeing, long-term conditions and frailty) with **intermediate care** (rapid response, rehabilitation, reablement and urgent support at home when people become unwell or are at risk of hospital admission). Through local multidisciplinary teams, digital technology, social prescribing and personalised care planning, the model seeks to provide the right care at the right time, reduce unnecessary hospital admissions, support timely discharge, improve quality of life, and ensure people receive coordinated care that focuses on what matters most to them

The Mental Health Community model for older adult mental health proposes enabling a holistic integrated response to work across and alongside physical and mental health services to provide a preventative offer based on patient needs, including short-term interventions, community liaison, wrap around support for organic patients, physical health assessment and monitoring, home treatment and initial diagnostics, including social care and third sector organisations.

In-reach into physical and mental health wards for older adult mental health 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 a key feature of the model. The workforce model will be enhanced with occupational therapy, mental and physical health practitioners and liaison roles to in reach into physical health 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 will improve accessibility and experience for patients, families and carers.

Joined up Community Team approach:

Whilst there will be separate SPOA's there is ambition for mutual referral to either physical or mental health services including for escalation and support pathways which will significantly impact on;

- Mental Health and Physical Health interfaces
- Reablement and social care linkage

- Shared community services
- Community-first models
- Virtual Hospital and admission avoidance
- Prevention and early intervention
- More multidisciplinary working
- Improved coordination around discharge and recovery
- Points of access that work with each other
- Joint Physical Health and Mental Health inpatient provision
- Integrated pathways

What differentiates the options?

Potential areas of variation:

Theme	**Lower Change Options**	**Higher Change Options**
Community provision	Enhanced	Significant expansion
Mental/Physical Health integration	Improved coordination	Joint inpatient provision
Inpatient configuration	Current/fewer changes	Consolidated models
Single Point of Access	Developmental	Central model feature

What does this mean?

Patient benefit:

Better Health Outcomes: Patients with long-term physical illnesses who also receive mental health support are more likely to manage their conditions effectively and engage in healthier behaviours.

Early Intervention: Healthcare providers can catch mental and physical symptoms early, preventing conditions from worsening.

Improved Experience: Patients will experience a more joined up system without needing to navigate confusing referral systems. Where there is a relationship between a person's physical and mental health condition, they will experience and enhanced support and access to the right services at the right time.

Reduced Stigma: Encouraging engagement and improving pathways to receiving mental health support alongside physical checks and health care normalizes care and will help make individuals feel less isolated.

In summary, patients may experience:

- More coordinated assessment and care planning
- Reduced need to navigate multiple services
- Improved support closer to home
- Better coordination between hospital and community-based care
- Greater focus on prevention, recovery and independence
- Improved support for people with both physical and mental health needs

The diagram below indicates the enhanced interface for joined up physical and mental health working to improve patient outcomes.

☐

Staff benefit:

Decreased Emotional Stress: Treating the "whole person" reduces the frustration of fragmented care and ensures staff don't have to carry the burden of managing complex patient conditions alone.

Improved Workplace Culture: Multidisciplinary team (MDT) working encourages collective problem-solving and shares responsibility for care delivery, which naturally breaks down traditional professional hierarchies.

Enhanced Job Satisfaction and Retention: Empowering staff to provide more effective, comprehensive care improves their day-to-day working experience, which can lower stress and mitigate burnout.

Better access to Peer Support and Strengthening Workforce Development: and other enhanced career development opportunities, with potential for roles to be rotational across mental and physical health and training opportunities across Ward settings improves knowledge, skills and location opportunities.

Core system benefits:

Cost-Effectiveness: Proactive treatment significantly reduces unnecessary emergency department visits and prevents costly hospital admission and readmissions.

Enhanced Access and Efficiency: Coordinating care and shared protocols and pathways optimises resources, prevents duplicate services, and makes care easily accessible closer to patients' homes

Quality and Safety: More holistic care is proven to identify hidden stressors, confusion, or social troubles before they turn into major medical emergencies. In inpatient settings it lowers rates of anxiety and falls by keeping patients calm, oriented, and supported in a safe environment

Better Together

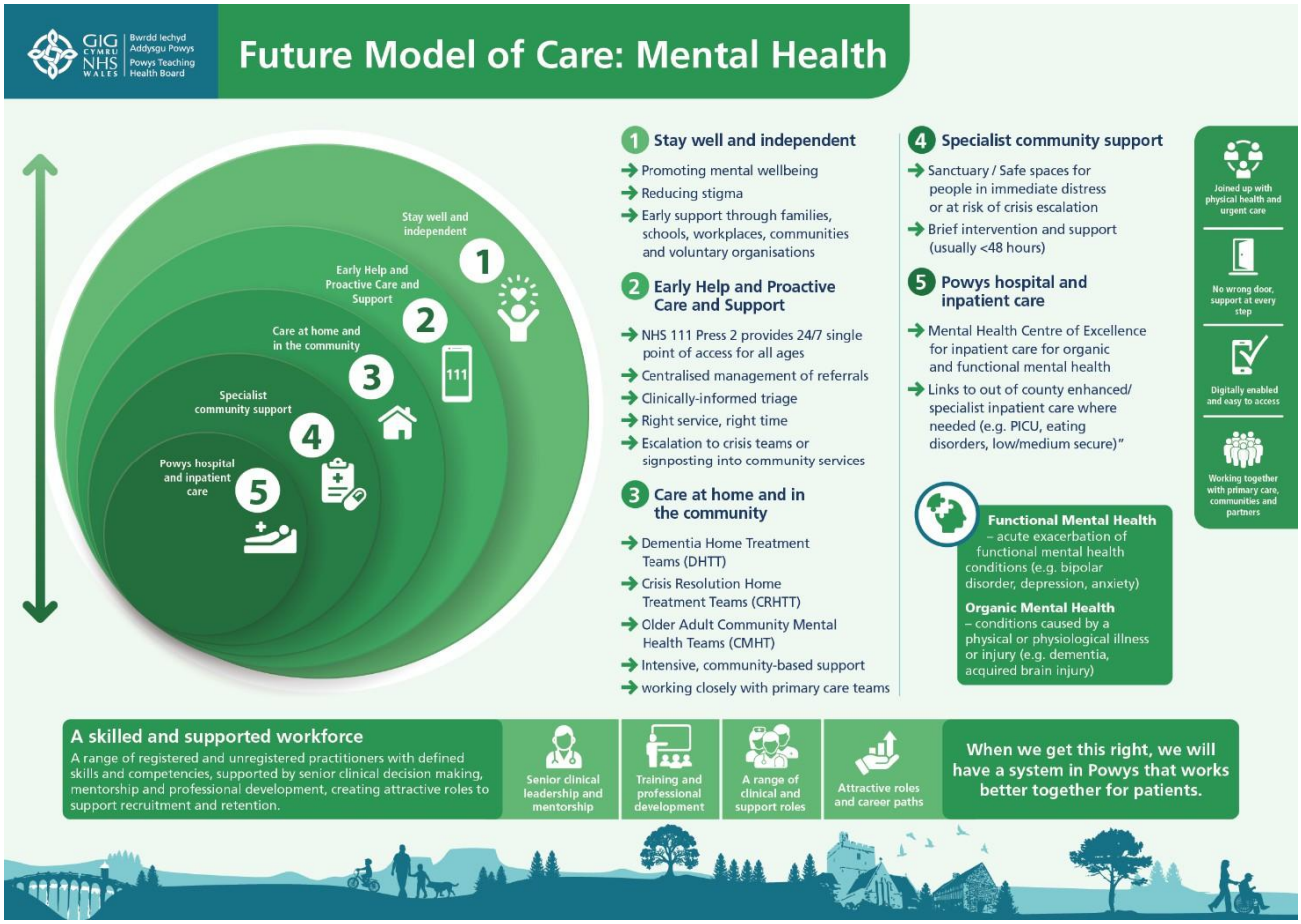
Mental Health Inpatient Services & Older Adult Community Model

Service Model of Care

V0.5

This document describes the future service models for mental health inpatient services and the mental health community service model for older adults delivered by Powys Teaching Health Board.

The supporting infographic presentation describes it as the mental health model on a page and explains that the wider model includes promoting mental wellbeing, early help and proactive care, care at home and in the community, specialist community support, and hospital and inpatient care.



Background and Context:

National Direction

The **Mental Health and Wellbeing Strategy** for Wales 2025-2035 aims to improve wellbeing for the people of Wales and improve outcomes for people accessing support for their mental health.

The strategy is underpinned by four vision Statements:

Vision Statement 1: There is action to make sure the building blocks are in place to support good mental health and wellbeing.

Vision Statement 2: Everyone has the knowledge, opportunities and confidence to protect and promote good mental health and wellbeing.

Vision Statement 3: There is a connected system where all people receive the appropriate level of support wherever they reach out for help.

Vision Statement 4: There are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay.

The Mental Health and Wellbeing strategy for Wales is underpinned by the Duty of Quality and the Health and Care Quality Standards which describe six domains of quality:

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person Centred

Physical and Mental Health – better joined up care

Research has increasingly shown that physical health and mental health are deeply interconnected. There is evidence that mental health conditions can worsen physical health resulting in increasing co-morbidity and that physical health condition can be overlooked, masked or poorly described by people with severe mental health conditions. Fostering a closer relationship between the two can result in significant benefits for individuals' overall well-being.

This includes:

- Improved overall health outcomes
- Enhanced recovery and rehabilitation
- Reduced healthcare utilisation
- Better psychological and emotional well-being

Case for Change:

An assessment of the mental health inpatient services across Powys by NHS Wales Performance and Improvement (August 2025) showed that staff dedication and good working relationships are evident on all wards.

However, issues related to workforce planning, physical infrastructure and access to specialist services, hinder the ability of these environments to fully meet the needs of patients and consistently provide a therapeutic and safe setting. Further, access to physical health services and support to the acute mental health inpatient services varies between the inpatient areas across Powys

A conclusion of the assessment was that for Powys to be able to consistently provide high-quality, responsive care that meets the complex needs of its population, processes should be standardised across the Powys footprint and resources reviewed to ensure equity and needs are met.

Vision for Mental Health Services in Powys

The vision for mental health services in Powys is for people to easily access and receive timely, seamless, holistic care centred around their needs.

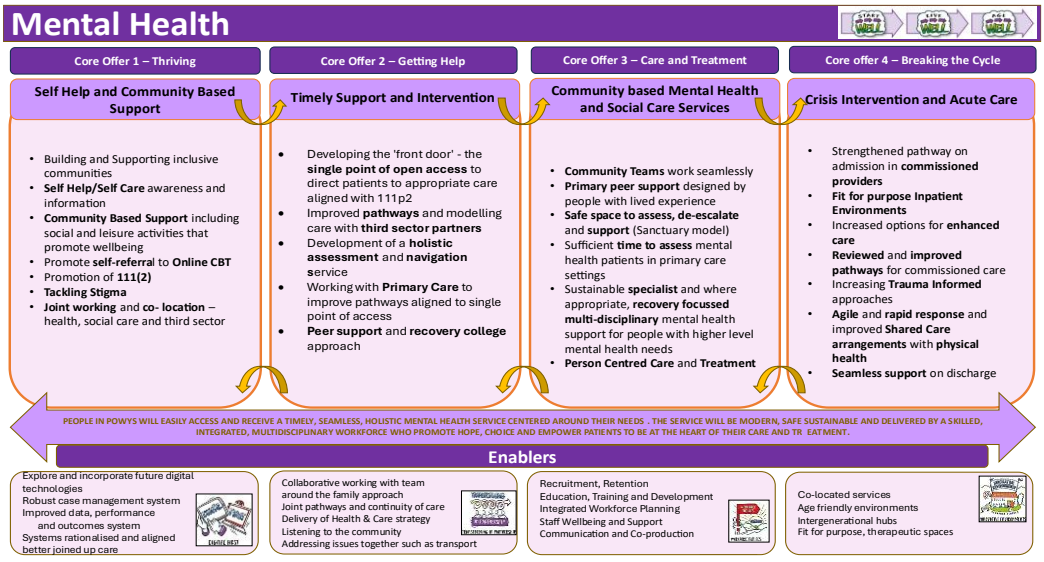
Services will be modern, safe, sustainable and delivered by a skilled multi-disciplinary workforce promoting hope, choice and empowering patients to be at the heart of their care and treatment.

Purpose:

The purpose is to deliver mental health care for all ages that:

- Is available and accessible when needed
- Is trauma informed, evidence based, therapeutic and recovery-focused
- Prevents escalation to acute or crisis services
- Supports timely recovery and reablement
- Integrates physical and mental health care
- Enable enhanced care for people with co-morbidities with mental health such as learning disabilities
- Is seamless and founded in positive partnership and multi-disciplinary practice
- Offers a sanctuary for early intervention, crisis containment, and stabilisation
- Provides dignified, specialised support for people with dementia and complex mental health needs
- When inpatient admission is necessary, care will be provided in environments that are safe, fit for purpose and have expanded options for enhanced care.

Diagram 1 – Overarching model of care for Mental Health Services in Powys



1. Mental Health Inpatient Services

Current Provision:

Mental health inpatient services in Powys are designed for adults usually aged between 18-65 or older adults usually aged over 65 and provided across three sites.

There are no dedicated mental health wards for children and young people or people with a learning disability, however if admission is required, they are accommodated on Felindre ward:

WARD	LOCATION	FUNCTION	NUMBER OF BEDS	GENDER	ADDITIONAL RESPONSIBILITY
Felindre	Bronllys Hospital, Brecon	Acute Admission (18-65)	16 admission beds plus 2 crisis beds	Mixed	Supports the management of the designated place of safety for Section 136 Suite (MHA) Out of Hours assessment unit – 00:00 to 08:00hrs weekdays and throughout weekends. There is provision for an emergency CAMHS bed (16yrs – 18yrs) as agreed.
Tawe Ward	Ystradgynlais Community Hospital	Older Adult, Functional and Organic	8 admission beds with 2 crisis beds	Mixed	
Clywedog Ward	Llandrindod Wells War Memorial Hospital	Older Adult, Functional and Organic	10 admission beds	Mixed	

Patients may be admitted to the ward informally (voluntary) or formally under the Mental Health Act. In older adult ward some patients may be under DoLS (Deprivation of Liberty Safeguards).

Each ward had a dedicated nursing and wider multi-disciplinary team and will work with community mental health teams and other agencies to support individuals from admission through to discharge.

Admissions are managed through the crisis resolution and home treatment teams between 09:00 and 21:00 operating hours or via the out of hours assessment unit based at Felindre.

Access to urgent mental health support is predominantly via the 111#2 telephone service, crisis services or out of hours assessment.

The crisis resolution and home treatment and the dementia home treatment teams will provide enhanced care, however there are currently no other services that provide an alternative to admission or sanctuary.

Future Inpatient Service Model:

Mental health inpatient services will provide a safe environment for people experiencing a mental health crisis who are unable to be managed at home or in another non-hospital environment.

Mental health inpatient services will provide a holistic assessment, person centred care planning and interventions to support recovery and discharge.

Inpatient care will be provided by a multi-disciplinary team made up of medical, nursing, social work and allied health professionals including psychology, occupational therapy, pharmacy.

Inpatient Care Pathway:

Access:

There will be 24/7 access to mental health services, referral routes will be via CMHT, CRHTT, primary care services, ambulance services and emergency department diversion.

The 111#2 Single point of access will triage referrals and provide a comprehensive assessment.

Admissions to hospital will be managed by the CRHT or the out of hours assessment unit, this is referred to as a gatekeeping assessment. The

purpose of the gatekeeping assessment is to determine whether any alternative to hospital admission would be appropriate.

Admission Criteria:

Functional Mental Health Beds

Functional mental health beds will be for short-term admission to support recovery:

- May be informal (voluntary) or formal status (detained under MHA where appropriate).
- Experiencing new onset of previously unknown or acute exacerbation of known functional MH condition.
- Not requiring intensive observation or PICU-level care, or higher level of security.
- Not able to be actively managed in the community at the time.
- May be a need for observed change in treatment, for example, medication.

Organic Mental Health Beds

Organic mental health (eg dementia) beds will be for behavioural and psychological symptoms of dementia or co-morbid conditions, temporary care:

- May be informal (voluntary) or formal status (detained under MHA or other legislative procedures, where appropriate).
- Moderate to severe cognitive dysfunction associated with challenging behaviours (BPSD).
- For the assessment or management of known dementia where appropriate.
- Requires MDT management not possible in home or care setting.

Comprehensive Inpatient Assessment:

A comprehensive holistic assessment will be undertaken to inform care and treatment during admission and to support discharge planning at the earliest opportunity. This will include an assessment of any concerns of safety or areas of risk.

The assessment will be completed on admission and reviewed and updated throughout.

Multi-Disciplinary Interventions

The new model will aim to strengthen the multi-disciplinary interventions provided including:

- Personalised recovery goals.
- Medication review.
- Access to therapies: CBT, DBT-informed practice, psychoeducation.
- Physical health monitoring and interventions.
- Comprehensive care planning in line with MH Measure.
- Daily MDT review (psychiatry, nursing, psychology, OT, pharmacy, social care).
- Enhanced and consistent access to effective group and individual psychological interventions including trauma therapy.
- Defined pathway with joint working to include physical health monitoring and interventions.

In addition, the model will aim to improve:

- In reach from physical health (see community model PH).
- Pharmacy provision in both the community and inpatient setting.
- Joint working with partner agencies, for example, Substance Misuse Services.
- Navigation through clear seamless pathways of care.
- Access to allied health professionals and non-pharmacological treatments.

Therapeutic Activities

Therapeutic engagement and activities will be person centred as much as possible, the new model will aim to increase the provision is as follows:

- Occupational therapy (providing assessment of ADLs, functional rehab).
- Creative therapies (art, drama, music).
- Peer support and community links.
- Occupational Therapy and Occupational Therapy Assistants to effectively cover all sites.
- Strengthened provision with protected time and dedicated fit for purpose space and environment for activities.
- Increased provision of green therapies and arts in health.

Standards

Mental health inpatient wards will be designed to ensure that people feel safe, have a positive experience and that admissions are meaningful.

Inpatient wards will aim to provide relational, procedural and environmental security and safety for patients and staff.

Therapeutic Environment Design

Environmental security is an important in providing safe inpatient services, in addition managing frontal environmental risks such as removing ligature points, the following will be applied to ensure risk is reduce and a therapeutic milieu is maintained.

Functional Wards: Open-plan, access to safe outdoor spaces, group rooms, gender-specific areas, activities areas

Organic Wards: Dementia-friendly design (colour-coded, signage, sensory spaces)

All environments should meet NHS Building Note 03-01: Adult Mental Health Units where applicable.

Safe Discharge from hospital:

To ensure a person-centred approach, the mental health safe discharge standards for Wales will apply including agreed monitoring and reporting against each standard

Planning discharge will begin at admission and include:

- Named discharge coordinator.
- Step-down to CMHT, reablement, or home-based care.
- Involvement of partner agencies, for example, social care, housing, and Third sector.
- Use of "discharge to assess" where appropriate
- Proactive in-reach into Inpatient settings to support and facilitate prompt discharge
- Post discharge follow up contact

Patient Safety Standards:

Specific patient safety standards for mental health inpatient ward will be aligned to the national mental health patient programme and ensuring a person-centred approach.

This will include:

- Implementing all Wales standards for assessing and managing ligatures
- Implementing safe wards as a model of care
- Implementing Person Centred Safety Planning

2. Sanctuary & Safe Place

Provision of sanctuary style services is a ministerial priority and is prominent in several key strategy and policy documents already referenced, including Welsh Government's Six Goals for Urgent and Emergency Care.

In Powys there is currently no provision for adults over the age of 18. A Crisis Hwb for children (below 18 years) based in the centre of the County, with CAMHS Crisis outreach has been delivering support since 2024 with significant positive outcomes for children and young people including avoidance of attendance at Emergency Department and mental health tier 4 hospital admission. The CAMHS Crisis Hwb funding is external and non-sustainable.

There is a ringfenced resource available to fund adult sanctuary when operational and previous scoping work has been done. Implementation has been held to ensure alignment with Better Together transformation and the development of this specification for model moving forward. Sanctuary has therefore been included in all shortlisted options. This section includes a brief overview of scoped Sanctuary provision requirements for specification with geography dependant on optimum model identified post engagement with Powys residents.

Proposed Operating Model for Adult Sanctuary / Safe Place

The Sanctuary / Safe place to assess will be a non-admission / non-bed model of care providing de-escalation form crisis and brief observation

The Sanctuary would provide a physical space that is safe and welcoming, replicating a home from home environment where people can attend outside of 9am-5pm working hours if they are feeling emotionally distressed or are experiencing social distress. With the intention of preventing presentations at ED or escalation of crisis resulting in Mental Health Act assessments. Social distress can be broadly defined as a situation that threatens a person's relationships, esteem or sense within a

group or larger social context which can have a negative impact on overall wellbeing.

Provision of Support:

- The service will provide 1:1 support for individuals for up to 2 hours, to support them to de-escalate and recover from their immediate cause of crisis.
- The service will provide onward signposting and initiate referrals in-hours with appropriate statutory and third sector services as necessary, liaising with the individual to provide any further necessary information following their visit.
- Where appropriate and as agreed with the user of the service, mental health teams will be notified that an individual has accessed the service.

Referrals:

- Referral routes into the service and onward pathways will be developed via a multi-agency group, in partnership with the Provider once a provider has been agreed.
- There will be no open access to individuals and appointments will be via referral only.
- If de-escalation is not achieved, there will be a route back into NHS via 111 Press 2 for further intervention.
- Initial triage will be carried out using the UK mental health triage scale.

Summary of Key Features

Open 24/7 or evenings/weekends
Staffed by MH nurses, peer support workers, therapists
Non-admission holding space (up to 48h)
Soft furnishings, calming environment, no locked doors
Brief psychosocial interventions (e.g., Safety Planning, DBT skills)
Option to "step up" to inpatient or CMHT referral

3. Older Adult Community Services

Delivering on strategic drivers and local vision for Mental Health Services also requires overcoming the challenges highlighted in case for change including the need to effectively manage demand and reduce need for

hospital admission. Where hospital admission is unavoidable, the joint working between community and inpatients should be enabled to be as seamless and multi-disciplinary as possible.

Transformational activity to create a specialist community service model for older adults and enhanced alignment with inpatient models of care is key. The service model for older adult mental health should enable a holistic integrated response to work across and alongside physical and mental health services to provide a preventative offer based on patient needs, including short-term interventions, community liaison, wrap around support for organic patients, physical health assessment and monitoring, home treatment and initial diagnostics, including social care and third sector organisations. It should also consider operating hours (extension to).

In-reach into physical and mental health wards for older adult mental health 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 a key feature of the model. The workforce model will be enhanced with occupational therapy, mental and physical health practitioners and liaison roles to in reach into physical health 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 will improve accessibility and experience for patients, families and carers.

The model embraces the Core Principles from the Powys Health and Care Strategy:

- Do What Matters
- Do What Works
- Focus on Greatest Need
- Offer Fair Access
- Be Prudent
- Work with the strengths of people & communities

- **Person-Centred and Strengths-Based**: Focused on what matters to the individual and tailored to individual goals and preferences
- **Digital Enablement**: Use of digital tools (e.g., remote monitoring, shared records, telehealth)
- **Team /Village around the Family Approach**: Recognising the role and needs of unpaid carers

- **Evidence-Based:** Interventions grounded in NICE guidelines, Royal College standards, and best practice.
- **Value-based healthcare:** Aiming to maximise health outcomes and individual experiences while minimising costs, focusing on delivering higher quality, more effective and equitable care. Measurable goals that support functional improvement or dignified end-of-life.
- **Home First**: Care is delivered at or close to home whenever safe and possible
- **Right Care, Right Time, Right Place**: Prevent avoidable escalation through proactive and responsive care
- **Integrated and multidisciplinary:** Seamless interface with acute hospitals, primary care, community services, and social care and the voluntary sector and a collaborative approach across health and social care sector professionals.
- **Timely:** Admission and discharge pathways optimised to reduce delays and provide better outcomes and experience for individuals.

Operating Hours

New Components

Mental and Physical health Support Workers:

It is important to note that at present, Older Adult Community Services DO NOT currently do any physical health monitoring. 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 will be changed to include physical health.

Peer Support Workers (PSWs):

Topromote recovery and self-management by sharing personal experiences, helping others navigate challenges.

Structure and Growth: As of April 2026, 1,637 peer roles were identified across 44 mental health Trusts, with numbers ranging from 1 to 147 per trust.

Senior Leadership: Senior Peer Worker roles exist in many trusts, though coverage varies, often focusing on supervision and developing the peer workforce.

Training & Integration: 95% of NHS organizations provide in-house training for these roles, and they are encouraged to be involved in co-production and care planning.

They will provide additionality to functional recovery and provide;

One-to-one support: In-person or telephone conversations, sometimes involving activities like walks.
Group support: Facilitating peer groups.
Recovery Coaching: Helping individuals build confidence and take back control of their lives. [1, 2, 3]

4. Recovery College

The Recovery College model is an established service delivered over the past 16 years with around 85 Colleges in the UK, including one Recovery College in Wales. Recovery Colleges that meet research-based fidelity criteria are shown to deliver enhanced wellbeing for students, reductions in service use, a more co-productive culture with more motivated staff which should lead to better staff retention.

Recovery Colleges deliver courses that are chosen and co-produced with the students, staff and Peer Workers. Unlike other self-management training options the courses are always co-delivered by a Peer Worker and a Professional, to a mixed group of students including people with mental health challenges (diagnosed or undiagnosed, receiving a service or not), people who support or care for people with mental health challenges, and staff or trainee staff paid to provide care and treatment. The course content is based on understanding and living with Mental Health challenges, including what does and does not help, for self-management or from support. The model of delivery is based on relationships and conversations within the group, with students supporting each other, as Peers and as supporters. As a result, learning depends on who is in the group. Everyone shares the responsibility for the group's learning. The Trainers are not the holders of all the expertise in the room. The learning is 'democratised', and as a result students have greater self-determination in their learning, which carries through into their lives. They become much more autonomous and less dependent on services.

The National Recovery College Project in Wales is led by HEIW as a part of their Mental Health Workforce Plan. They are funding a Recovery College Peer Lead in every Health Board in Wales to collect evidence to support the creation of local business cases seeking to fund the roll out of Recovery Colleges across Wales. After engaging with the local population each Recovery College Peer Lead will create a local proposal for their own area and will cost that and determine its potential impact and benefits. As part of the process in Powys a task and finish group was established to co-produce engagement, support the analysis and use the engagement results to co-produce the proposal for Powys.

81 people took part in engagement events across Powys and online, and 143 responded to an online survey. Based on a thematic analysis of the results of this engagement, the following recommendations were agreed with the task and finish group forming the following for inclusion in a proposal for transformation:

- Establish a Recovery College
- Ensure resources to set up governance arrangements
- Provide a user-friendly portal for Recovery College enrolment, course booking and statistics, with administration time to allow for access by telephone or face-to-face.
- Deliver courses in multiple locations across Powys.
- Work closely with existing services to avoid duplication, maximise mutual sign-posting, share resources, create goodwill.
- Invest in clear messaging about what the college is and is not, including use of student stories.
- Use multiple avenues for marketing.
- Provide transport/travel expenses to those on low incomes living in inaccessible areas and small communities.
- Link courses in Powys with public transport timetables and interchanges.
- Deliver some courses out of office hours.
- Provide online courses and face to face courses
- Invest in resources to support people to access online.
- Seek a budget for, or access to free training for college trainers, support workers and governance volunteers.
- Ensure staff time to connect with people one to one to support access to the College and its courses.
- Seek a budget for bank peer trainers.
- Maximise the studentship for the Powys College for viability due to the small population size.
- Ensure access to IT and workforce expertise
- Seek a budget for celebrations of achievement by students
- Recovery colleges embedded in discharge plans

5. Peer Support

Peer support in mental health has been shown to improve outcomes for both service users and peer supporters, increasing personal recovery, self-belief, and quality of life, and can also lead to reductions in service utilization for those receiving support. Peer support workers leverage their lived experiences to foster connection, provide emotional support, and offer practical knowledge, which helps to reduce isolation and stigma. This mutual process not only empowers individuals to manage their conditions but also benefits the peer supporters, who report increased self-esteem and well-being.

6. Digital Mental Health Developments

Accompanying the first cycle of Mental Health and Wellbeing Strategy Delivery Plan 2025 -2028 will be a co-produced and published Mental Health and Wellbeing Data and Digital Delivery Plan 2025 –2028, supported by Digital Health and Care Wales (DHCW). This plan will sit alongside the strategy and will align to the current Welsh Government's Digital and Data Strategy for Health and Social Care in Wales. This delivery plan will focus on six key areas.

I) Digital skills - developing workforce to have the skills and confidence they need to make the most of digital services and improve care. For Mental Health and Care services, this means:

- Train and support mental health professionals in using digital tools (e.g., virtual consultations, digital care records.)
- Embed digital confidence and literacy into mental health workforce development programmes.
- Offer specific training, for example on trauma-informed digital engagement and online therapeutic practices.

II) Digital economy - partnership with health and social care providers, academia, and the private sector to create added value, accelerate innovation and strengthen the economy of Wales. For Mental Health and Care services, this means:

- Collaborate with academia and technology partners to co-design innovative digital mental health tools (e.g., mood tracking apps, peer support platforms).
- Encourage community-led innovation by working with local groups and start-ups on culturally relevant digital solutions.
- Support pilots and evaluations to scale evidence-based tools into broader community care settings.

III) Data and collaboration - working to ensure high-quality data is available to inform every part of mental health delivery. For Mental Health and Care services, this means:

- Use integrated data to provide early identification of mental health needs, monitor trends, and personalise care plans.
- Ensure mental health data is included in shared care records and available to multidisciplinary teams across health and care providers.
- Prioritise data governance to allow safe and appropriate sharing of data,

- Allow Citizens to access their data as they following their unique pathway into mental health services.
- We will embed both Patient Reported Outcome Measures and Patient Reported Experience Measures as part of this work.
- As part of the 'data and collaboration' work we will continue to develop a mental health core dataset. This will ensure that any data collected is robust and fit for purpose, and will include prioritising demographic data, such as age, gender, preferred language, and ethnicity.

IV) Digital infrastructure and connectivity - developing a secure, stable, and sustainable foundation for seamless sharing of data in support of agile, digital services. For Mental Health and Care services, this means:

- Guarantee secure and stable digital access in community settings (e.g., at home, community centres) to enable telehealth and remote support.
- Improve digital access in rural and underserved areas to reduce health inequalities.
- Ensure digital platforms and tools used for mental health services meet standards for accessibility, confidentiality, security, and stability.
- Ensure this infrastructure allows the safe sharing of data between practitioner and organisations delivering mental health service to Welsh citizens.
- As part of the 'data infrastructure and connectivity' approach we will take action to ensure the provision of electronic patient records in all mental health services.

V) User-centred services - deliver high quality digital services designed around the needs of the citizen, professionals, and services. For Mental Health and Care, this means:

- Involve people with lived experience in the co-design of digital mental health services.
- Focus on blended care models (digital and in-person) to match user preferences and reduce barriers.
- Design tools that support self-management, crisis prevention, and personalised care.
- Provide a directory of service that helps mental health services and patient groups to quickly identify appropriate, local care options based on clinical needs and availability.

VI) Digital inclusion - equip users with the access, skills, and confidence to engage with digital health and social care services

based on their specific needs or preferences. For Mental Health and Care, this means:

- Provide targeted digital inclusion programmes for people with mental health conditions who may face additional barriers (e.g., stigma, cognitive challenges).
- Work with community partners to provide trusted spaces and digital navigation.

7. Partnership

The vision for mental health services in Powys will not be achieved without any model of care working as seamlessly as possible across partner organisations. Integrated working, alignment, co-location, pathways and commissioning all must be considered across agencies in the third sector and are bound in legislation and regulatory practice guidance with social care, police and others. These are important relationships, and it is acknowledged that joined up working that is vital to ensure mental health and wellbeing support for individuals and communities is coherent and unified.

8. Transport

It is important to note the vital part that conveyance has to play in any mental health model of care, not just in relation to care being timely and appropriate but in ensuring dignity and safety, avoiding stigma and management of complex situations. There are legal and practical considerations especially in respect of the Mental health and Mental Capacity Acts.

Conveyance must be considered in relation to both out of county placements, PICU, Medium and low secure and also to local provision. It must also be considered in terms of transport to treatments and specialist services from inpatient settings.

APPENDIX: Mental Health Clinical Standards and Quality Requirements

Category	Standard / Requirement	Key Elements
Legislative Standards	Mental Health Act 1983	Compliance with statutory requirements for detention, treatment and patient rights.
Legislative Standards	Mental Capacity Act 2005	Assessment of capacity and best interest decision-making.
Legislative Standards	Mental Health (Wales) Measure 2010	Assessment, care and treatment planning, care coordination and access to advocacy.
Legislative Standards	Deprivation of Liberty Safeguards (DoLS)	Protection of rights for individuals lacking capacity who are deprived of liberty.
National Quality Standards	Health and Care Quality Standards (Wales) 2023	National quality framework for health and care services.
Professional Standards	Relevant Professional Standards and Guidance	Compliance with standards set by professional regulatory bodies and colleges.
Policy Standards	Welsh Government Mental Health Strategy, Policy and Legislation	Alignment with national strategic direction and policy requirements.
Mental Health Quality Statement	Mental Health Quality Statement (2026)	Delivery of open access mental health care, person-centred and recovery-focused models.
Mental Health Quality Statement	9 Core Components of Mental Health Services	Co-production, trauma-informed care, flexibility, data-informed services, collaboration, person-centred care and open access support.
Self-Harm Quality Statement	Self-Harm Quality Statement (2026)	Six pillars for high-quality self-harm care.
Self-Harm Quality Statement	Immediate Treatment	Rapid access to support and intervention.

Category	Standard / Requirement	Key Elements
Self-Harm Quality Statement	Trauma-Informed Support	Care delivered using trauma-informed principles.
Self-Harm Quality Statement	Continuity of Care	Consistent care throughout the pathway.
Self-Harm Quality Statement	Safety Planning	Individualised safety planning.
Self-Harm Quality Statement	Holistic Signposting	Connection to broader support services.
Self-Harm Quality Statement	Skilled Responders	Staff trained and competent in responding to self-harm.
RCPsych / CCQI Inpatient Standards	Standards for Acute Inpatient Services for Working Age Adults (7th edition, 2019)	Quality standards for admission and assessment; care planning and treatment; referral, discharge and transfer; patient and carer experience; staffing and training; environment and facilities; and governance. Used for QNWA service review and accreditation and as a guide for developing services.
Inpatient Culture and Quality Standards	NHS England Culture of Care Standards for Mental Health Inpatient Services (2024)	Twelve core commitments covering lived experience, safety, relationships, staff support, equality, avoiding harm, needs-led care, choice, environment, activities, therapeutic support and transparency, aligned with autism-informed, culturally competent, and trauma-informed and harm-aware care. Included as a relevant best-practice benchmark for inpatient service design.

Mental Health Inpatient Patient Safety Standards

Standard Area	Requirement
Ligature Safety	Implement All-Wales standards for assessing and managing ligature risks.
Safe Wards	Implement SafeWards as the model of care.
Safety Planning	Implement Person-Centred Safety Planning.
Therapeutic Care	Admissions should be meaningful and therapeutic.
Relational Security	Provide relational security for patients and staff.
Procedural Security	Provide procedural safety and security.
Environmental Security	Ensure safe physical environments that minimise risk.
Patient Experience	People should feel safe and have a positive inpatient experience.

Mental Health Inpatient Environmental and Estate Standards

Standard	Requirement
NHS Building Note	NHS Building Note 03-01: Adult Mental Health Units.
Functional Ward Design	Open-plan layouts where appropriate.
Functional Ward Design	Safe access to external spaces.
Functional Ward Design	Group therapy/activity rooms.
Functional Ward Design	Gender-specific facilities.
Functional Ward Design	Dedicated activity spaces.
Dementia-Friendly Design	Colour-coded environments.
Dementia-Friendly Design	Clear signage and wayfinding.
Dementia-Friendly Design	Sensory-friendly spaces.
Anti-Ligature Design	Removal and management of ligature risks.
Therapeutic Milieu	Environment supports recovery and wellbeing.

Mental Health Safe Discharge Standards (Wales)

Standard	Requirement
Discharge Planning	Discharge planning begins at admission.
Discharge Coordination	Named discharge coordinator assigned.
Community Transition	Access to CMHT, reablement or home treatment support.
Multi-agency Working	Involvement of social care, housing and third sector partners.
Discharge to Assess	Use where clinically appropriate.
In-Reach Services	Proactive community and specialist in-reach to inpatient settings.
Psychology In-Reach	Access to psychological support during admission and discharge planning.
Post-Discharge Follow-up	Follow-up contact after discharge.
Monitoring and Reporting	Measurement and reporting against discharge standards.

Royal College of Psychiatrists (RCPsych) Community Mental Health Standards

Domain	Standard
Access & Equity	Annual review of demographic data and inequalities.
Referral Pathways	Clear referral criteria and waiting times.
Assessment	Timely, structured assessments of need.
DNA Management	Follow-up protocols for missed appointments.
Care Planning	Collaborative, personalised recovery-focused care plans.
Therapies	Access to evidence-based psychological therapies.
Medication Management	Safe prescribing and medicines management.
Physical Healthcare	Integration of physical health monitoring.

Domain	Standard
Risk Management	Robust risk assessment and safeguarding arrangements.
Dignity & Respect	Compassionate and respectful care.
Engagement	Active involvement of people and carers.
Information Sharing	Accessible information on rights and treatment options.
Workforce	Appropriate staffing levels.
Training	Ongoing learning, supervision and CPD.
Staff Wellbeing	Support for workforce mental health and safety.
Learning Culture	Learning from incidents, complaints and feedback.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Better Together

Adult Physical and Mental Health Community Services

Integrated Community Service Model

V0.5

Integrated Community Service Model

Please note that there are two complementary elements to this Service Model; one is Proactive Prevention and the other is Intermediate Care.

1. Background & Context

1.1 Vision and Purpose

To deliver **place-based, person-centred, digitally enabled, proactive and integrated services in the community** that:

- Supports people to remain independent
- Delivers holistic care and support for physical, mental, and social health and wellbeing
- Ensures care is provided everywhere, but at a level that is proportionate to need
- Delivers safe, coordinated, and proactive care for people with complex needs, who often are living with multiple long-term conditions and frailty
- Supports people to stay well at home for as long as possible
- Reduces unnecessary hospital admissions
- Ensures timely, safe discharge and seamless transitions
- Promotes quality of life, independence, and dignity, including at end of life

This model delivers against the shared long term Health and Care Strategy for Powys which sets out the priorities for transforming health and care: to help people in Powys to 'Start Well', 'Live Well' and 'Age Well' through a focus on well-being, early help and support, tackling the big four health challenges, and better joined up care.

1.2 Strategic Alignment

Health and Care Strategy: The shared long term Health and Care Strategy for Powys and the vision of 'A Healthy, Caring Powys', which forms the basis for the Regional Partnership Board Area Plan and PTHB Integrated / Annual Plan

Powys Wellbeing Plan: overseen by the Public Services Board, which takes an inter-generational approach to the wider social, economic and environmental determinants of wellbeing

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National Objectives: The Welsh Government long term plan for health and social care, **'A Healthier Wales'** and the emerging **Integrated Community Care System for Wales**, which includes the Strategic Programme for Primary Care, the Primary Care Model of Wales and the Six Goals for Urgent & Emergency Care as some of the national areas that this work relates to.

Integrated Quality Statement for Older People and People Living with Frailty (2024) which sets out the aim for Wales to be a place where older people and those living with frailty can live a long, healthy, and happy life.

The National Integrated Care Guidance Framework publication around **Proactive Care for Adults with Complex Needs and Older People living with Frailty in the Community** which outlines a framework for proactive management drawing from peer-reviewed evidence and the Integrated Quality Statement for Older People living with frailty.

Welsh Government Hospital Discharge Guidance (January 2025) which outlines how intermediate care teams should provide timely, recovery-focused support—such as reablement and rehabilitation—within the community to prevent hospital admissions, enable safe discharge via D2RA pathways, and reduce long-term dependency by promoting independence, especially for people living with frailty. The **Optimal Hospital Flow Framework** also supports this and outlines how community-based services can help to prevent deconditioning through early rehabilitation, and ensure continuity of care at home by integrating D2RA pathways and person-centred approaches that prioritise recovery, independence, and reduced hospital stay.

There are also further **condition-specific quality statements published by Welsh Government** which would be relevant for individuals living with these conditions:

Title	**URL**
Cancer	https://www.gov.wales/quality-statement-cancer-html
Heart Conditions	https://www.gov.wales/quality-statement-heart-conditions-html
Kidney Disease	https://www.gov.wales/quality-statement-kidney-disease-html
Liver Disease	https://www.gov.wales/written-statement-quality-statements-respiratory-kidney-liver-and-neurological-conditions
Respiratory Conditions	https://www.gov.wales/written-statement-quality-statements-respiratory-kidney-liver-and-neurological-conditions

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Neurological Conditions	https://www.gov.wales/quality-statement-neurological-conditions-html
Osteoporosis and Bone Health	https://www.gov.wales/quality-statement-osteoporosis-and-bone-health-html
Palliative and End of Life Care	https://www.gov.wales/quality-statement-palliative-and-end-life-care-wales-html
Emergency Department Care	https://www.gov.wales/quality-statement-care-emergency-departments
Diabetes	https://www.gov.wales/quality-statement-diabetes-html
Stroke	https://www.gov.wales/quality-statement-stroke
Mental Health and Wellbeing Strategy	https://www.gov.wales/mental-health-and-wellbeing-strategy-2025-2035.pdf

1.3 Design Principles

The model embraces the Core Principles from the Powys Health and Care Strategy:

- Do What Matters
- Do What Works
- Focus on Greatest Need
- Offer Fair Access
- Be Prudent
- Work with the strengths of people & communities

- **Person-Centred and Strengths-Based**: Focused on what matters to the individual and tailored to individual goals and preferences
- **Digital Enablement**: Use of digital tools (e.g., remote monitoring, shared records, telehealth)
- **Team around the Family Approach**: Recognising the role and needs of unpaid carers
- **Evidence-Based:** Interventions grounded in NICE guidelines, Royal College standards, and best practice.
- **Value-based healthcare:** Aiming to maximise health outcomes and individual experiences while minimising costs, focusing on delivering higher quality, more effective and equitable care. Measurable goals that support functional improvement or dignified end-of-life.
- **Home First**: Care is delivered at or close to home whenever safe and possible
- **Right Care, Right Time, Right Place**: Prevent avoidable escalation through proactive and responsive care
- **Integrated and multidisciplinary:** Seamless interface with acute hospitals, primary care, community services, and social care and the voluntary sector and a collaborative approach across health and social care sector professionals.

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- **Timely:** Admission and discharge pathways optimised to reduce delays and provide better outcomes and experience for individuals.

2. Proactive Prevention

2.1 Description

This element delivers proactive, preventative, and personalised focusing on independence locally through an integrated multi-disciplinary team (MDT) approach. It focuses on earlier identification of individuals who are at risk of having increased needs, coordinating care around them, and using community assets and digital tools to promote education, support self-management, build resilience, and enable wellbeing. The approach embraces the social model of health, strengthens links with voluntary and community sectors, and embeds social prescribing as a core function.

It represents a whole-system, person-centred approach to prevention and early intervention, aligned with population health principles and personalised care. It aims to:

- Improve health outcomes
- Reduce demand on crisis services
- Strengthen community resilience
- Enhance individual and carer experience
- Promote equity and inclusion in rural and deprived areas

Evidence Base: King's Fund – population health management; NHS England Proactive care: providing care and support for people living at home with moderate or severe frailty; NHS England Enhanced Health in Care Homes (EHCH) model;
Health coaching

2.2 Clinical Scope

The Proactive Prevention element of the service model supports people with existing health issues who would like to improve their health in order to prevent deterioration in their existing health and reduce the risk of developing other health problems.

Proactive Prevention will be:

- Targeted: Focused on high-risk individuals and underserved populations using robust risk stratification.
- Enhanced: Builds on core general practice with additional MDT specialist clinics, rehab programmes, and wellbeing support. The medical clinical lead/governance remains with the GP.

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- Asset-based: Strengths-based assessments leverage individual, family, and community resources.
- Multidisciplinary: The integrated team works collaboratively and flexibly to plan (including Future Care Planning), deliver, and monitor care.

2.3 Key Components of Proactive Prevention

Case Finding using frailty indices, Electronic Health Records, GP insights and local intelligence informed by public and population health data.

Personalised Care Planning for high-risk individuals, based on strengths-based assessments which are holistic and co-produced with individuals and carers. This would include **Shared Decision Making** and **Future Care Planning** to confirm what should happen when needs escalate and to record the individual's wishes. **Case Management/coordination** for some of the more complex individuals

District Nursing provide care for patients in their own homes or in community settings. Their work focuses on supporting people who are housebound, recovering from illness, living with long-term conditions, or approaching the end of life.

Community Therapies health and social care services delivered in the community with the aim of preventing illness from worsening, maintaining independence and long-term condition management (not require intensive rehabilitation)

Voluntary Sector - charities, community groups, or not-for-profits that work alongside the NHS and local authorities. Their focus is usually on prevention, wellbeing, and community support, helping people to stay healthy and independent before their needs become acute.

Social Prescribing harnessing green prescribing, arts, volunteering, peer support through the use of community hubs and social networks.

Wellbeing Checks, particularly for isolated rural individuals.

Digital Monitoring and Technology Enabled Care which allows individuals to be safely supported to remain at home where clinically appropriate. This would also include **digital inclusion support** to help individuals understand and learn how to use the technology that supports them.

Core aspects of the service and interventions:

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- Living Well Services, Prehabilitation and Rehabilitation
- Condition or symptom specific rehabilitation (pulmonary, cardiac, breathlessness), lifestyle support, and exercise programmes
- Behavioural activation, smoking cessation, and nutrition services
- Symptom management as well as specialist condition management
- Digital delivery would improve accessibility for some programmes

Escalation to intermediate care where needs increase and time-limited, intensive support is needed to help the individual remain at home.

Step up/Step down – Proactive prevention

Step up will either be transfer into acute for enhanced health needs, delivered by the intermediate care team. Or. Where required, is a hospital-based bed for admission for up to 72 hours to undertake assessment and diagnostics, implement treatment plans and discharge with wrap around support where required.

Step down care will be, being discharged from hospital-based care to the intermediate care team, or the proactive prevention team, whichever is required to meet the needs of the person.

Step down from acute or intermediate care for long term condition monitoring.

Local MDT for the team to support the more complex

2.4 MDT Function and Workforce

The multi-disciplinary team (MDT) provides local, joined-up care with coordinated wraparound support. Key roles include:

- General Practice Teams (GPs, practice nurses, practice pharmacists)
- District Nurses
- Social Workers and Care Coordinators
- Mental Health Practitioners
- Allied Health Professionals (AHPs) and support workers – Physiotherapy, Occupational Therapy, Dietetics, Podiatry
- Community Connectors and Link Workers
- Voluntary and Community Sector representatives
- Digital and Remote Support Navigators
- In reach from specialist services
- Diabetes prevention service
- Public Health schemes
- Wax management and nurse led clinics for example, ambulatory wound management
- Telecare/Telemedicine services

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- Memory Assessment Service integration into proactive care

Teams operate using a "village around the family/individual" model – working collaboratively across organisational boundaries to build trust, continuity, and community resilience.

2.5 Operating Hours / Sites

The service will be available 09:00-17:00 Monday to Friday (District Nursing will continue to work 08:00-20:00 7 days per week). Staff within the teams will spend a significant proportion of their time in the community, working directly with individuals, or liaising with other health, social care and third sector professionals. Teams will be based within the community and work flexibly from designated bases as required to respond to local needs.

Online digital resources such as Apps supports accessibility eg NHS app and e learning resources

Teams will be aligned with Powys localities or GP practice or well-being hubs (to be confirmed).

2.6 Digital Tools

Remote Monitoring: For long term conditions including COPD, diabetes, hypertension including the use of wearables.

Apps and Online Platforms: To support goal setting, condition education, and virtual group programmes e.g. multi-factorial assessment falls app. This would include the NHS Wales app.

Technology-Enabled Consultations: Telephone, video, and text-based support, as well as artificial intelligence and other innovations.

Digital Inclusion Support: Tailored help for digitally excluded populations, this could be provided, commissioned or signposted to.

2.7 Strategic Alignment

The model aligns with key Welsh Government strategies and policies:

A Healthier Wales

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- Long-term plan for health and social care
- Supports seamless, integrated care
- Emphasises prevention and wellbeing

Primary Care Model for Wales
- MDT-led care close to home
- Enhanced community care diagram
- Increased access to social prescribing and community support

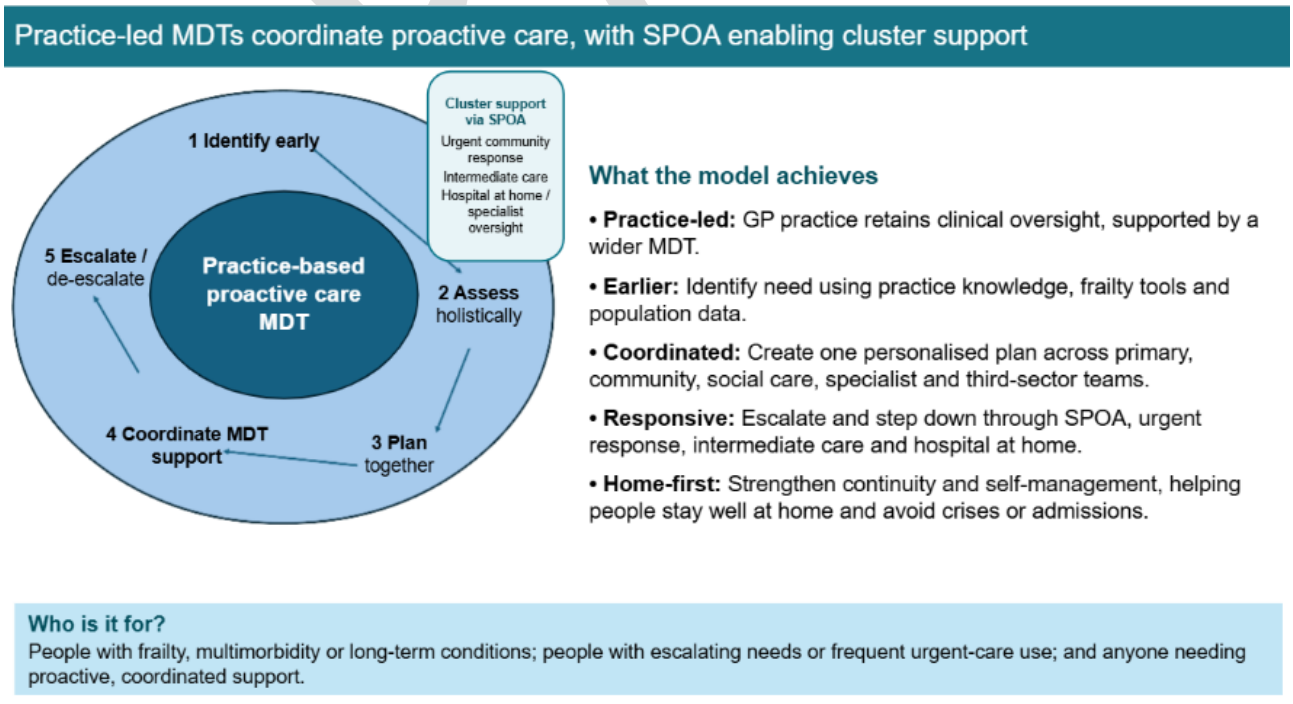
Social Services and Wellbeing (Wales) Act 2014
- Strengths-based care and co-production
- Duty to promote wellbeing and early intervention

Digital Strategy for Wales
- Harnessing technology for inclusive care
- Empowering citizens to manage their own health

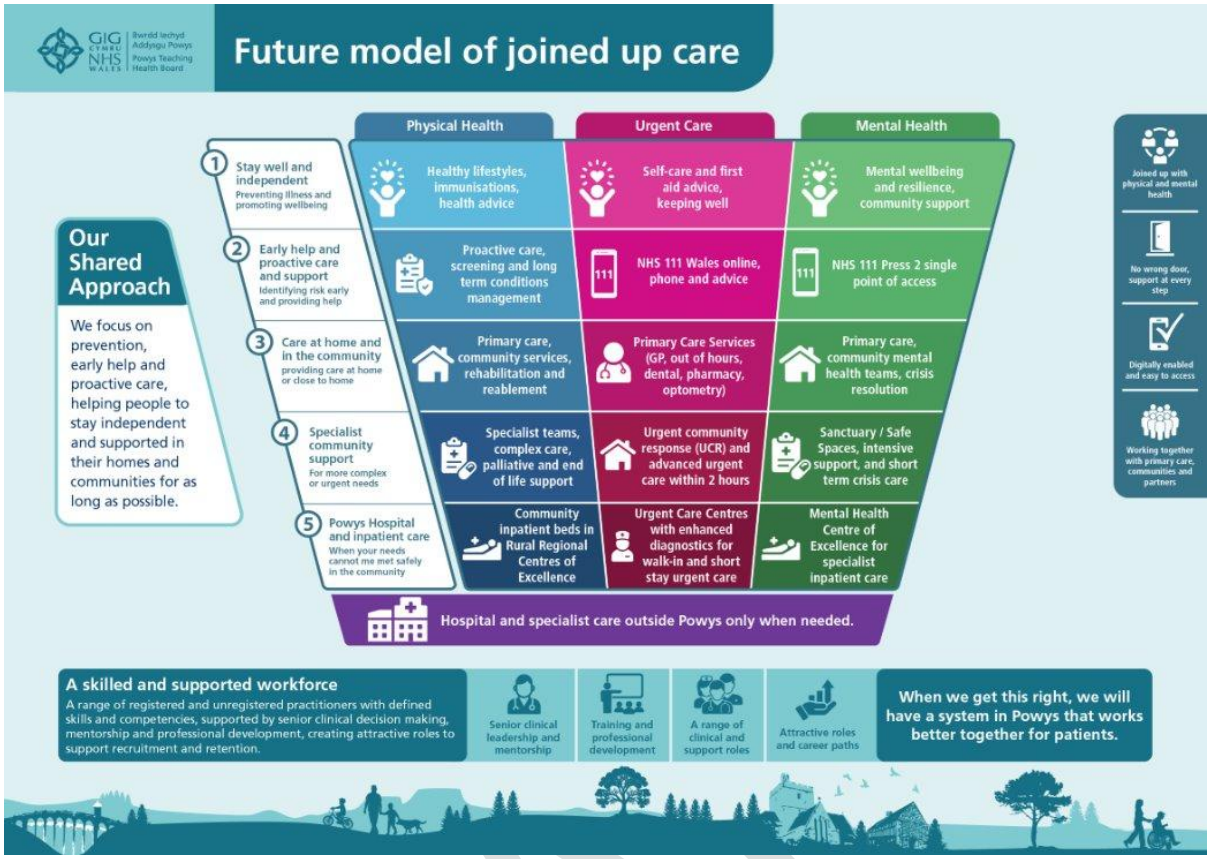
Well-being of Future Generations (Wales) Act 2015
- Promotes long-term thinking, collaboration, and community involvement

Public Health Wales' Health Impact Assessments and Population Needs Assessments
- Inform targeted interventions using local and national data

System Concept



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Pathway example: **Mrs Jones, 82, living with frailty, COPD and diabetes**

1. Frailty tool identifies increasing risk.
2. Discussed at locality MDT.
3. Holistic assessment completed.
4. Personalised care plan agreed.
5. Referred to Living Well programme and respiratory rehabilitation.
6. Given remote monitoring and future care planning.
7. Receives social prescribing support for isolation.
8. Remains stable at home.

Three months later she develops an infection:

1. Escalates to Intermediate Care.
2. Receives urgent assessment at home.
3. Recovers with treatment and rehabilitation.
4. Steps back into the Proactive Prevention pathway for ongoing support.

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3. Powys Intermediate Care Service

3.1 Description

Intermediate Care is an integrated, digitally enabled, person-centred service designed to provide urgent, rehabilitative, and palliative care at home or closer to home by empowering the health, social care, and community workforce to collaboratively deliver the right services in the right place for the individual. The enablement of this model of care delivery, will drive a reduction of inpatient bedded capacity recognising that 50% of our current patients could have care delivered at home, avoiding the risk of deconditioning and deterioration in a clinical environment.

The Intermediate Care community-based multidisciplinary (MDT) will deliver:

- urgent community response,
- rapid in-home clinical assessments and interventions which include a Hospital@Home function (enabling hospital-level care at home) that is clinically appropriate for Powys. This may include remote monitoring of Blood Pressure, oxygen saturation, blood glucose, etc.)
- rehabilitation and reablement,
- community-based palliative and end-of-life care.

The service will operate within the community to prevent unnecessary and/or unwanted hospital admissions, in line with personal preference, and facilitate timely discharge from acute settings back to the individual's usual residence or, where that is not possible, another appropriate setting in Powys.

Operating from 08:00-20:00, 7-days a week, Intermediate Care will offer assessment, support, rehab or recovery interventions for a time-limited period through a whole team approach and applying holistic goal setting combined with seamless, coordinated care across health, social care, and third-sector organisations.

Intensive support at home will be available 7 days a week from a team that has the skills to manage a level of complexity and risk with appropriate clinical oversight. The MDT will have a range of skills from support worker through to consultant medical and consultant practitioner posts, to support the intensity and complexity of the individual. Team capacity will be managed by acuity tools such as Welsh levels of care.

Pathway Examples;

Requiring IV Antibiotics

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A person who requires Intravenous antibiotics for an infection may currently need to have an inpatient stay in an acute setting – this exposes them to the risk of deconditioning. In the future model IV would be delivered at the persons home, or, where ambulatory, within a Hub or urgent care setting.

Pending a package of care

A person who is awaiting a package of care, may decondition while in an inpatient bed, pulling people out of hospital and providing care at home earlier is likely to reduce this risk.

Palliative Care/End of Life

The model places palliative and end of life 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 end of life care. To deliver this safely, the integrated model will need consistent pathways, workforce capability, education, escalation routes, governance and data across Powys. If properly resourced, this could reduce avoidable admissions and out-of-county care; if not, it risks increasing pressure on already stretched community services.

Overnight blocked catheter

In current practice, someone who experiences a blocked catheter overnight may need to travel to an emergency department, 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 nurses available overnight means that this is more likely to be treated overnight, in the person's home, and the journey and attendance at the emergency department 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 pathways around the needs of the person. This may avoid multiple appointments and assessments and bring care together in a holistic person-centred approach. This pathway would also include

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seasonal planning and rescue pathways should symptoms worsen to avoid acute admissions, a person may be stepped up for up to 72 hours if assessment and diagnostics are needed to support treatment.

3.2 Clinical Scope

Conditions supported will include:

- Falls without major injury
- Acute illness such as infections or sudden decline of uncertain cause
- Delirium
- Declining Mental health as a component of the presenting physical health issues
- End of Life care which requires support beyond that of the practice MDT
- Exacerbation of long-term conditions or management of poor symptom control (e.g. frailty, heart failure, COPD)

Acceptance criteria:

- adults in the community (18+ years)
- experiencing period of short-term decline in function
- individuals who may be at risk of hospitalisation
- adjusting to new disability following trauma/diagnosis – Stroke, Frailty, COPD, CHF, palliative stage patients
- individuals who require end of life care support
- individuals who require intensive, time-limited, multiagency / multiprofessional support, with clear outcomes identified

3.3 Key Components of Intermediate Care

3.3.1 Overview of the components of the service

Now completing baseline of existing physical health community services to inform this.

3.3.2 Urgent Community Response (UCR)

A 2-hour response to urgent care needs within the hours of 0800am to 2000pm(aligned with NHS UCR standards). This includes Triage, assessment, intervention and provision of support to enable the individual to stay at home, where triage identifies that the situation isn't manageable within service hours, the person may be stepped up into a community hospital bed or referred to emergency care, whichever is most appropriate. During this acute period the team will assess next steps enabling the individual to recover from the trauma or crisis. After 72 hours the team will

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initiate next steps e.g. rehab, palliation or step up. This would also include the Level 2 Falls response.

To deliver a Hospital@Home function will require input from ACP/ medical staff with advanced clinical assessment /clinical decision maker skills.

Digital monitoring and telemedicine will be used to support remote assessment and decision support as well as access to point of care tests.

3.3.3 End-of-Life Care at Home

Rapid deployment and coordination of a range of resources to support end-of-life care in the community.

The District Nursing Service will lead on care planning for individuals.

- Shared **Future Care Plans** visible across services
- Access to anticipatory medications at home
- Rapid hospice-at-home or nursing input
- **Integrated support for carers**, including overnight support
- Close collaboration with spiritual, psychological, and voluntary support services
- **Alignment:** With Gold Standards Framework, national End of Life Care Delivery Plan (Wales)

Collaborative work with the specialist palliative care nurse team, hospices and third-sector palliative care organisations, as needed, and with support for carers, including respite and transport options.

The model of care will initially align with district nursing service delivery of 0800-2000hrs.

Deliver 24-hour end-of-life on call nurse service care nursing support to people in their homes Delivered between 20:00 to 08:00ama dedicated telephone line for health professionals to access advice and support 24 hours. Out of hours medical cover will be available to support the out of hours District Nursing led service.

3.3.4 Discharge to Recover then Assess (D2RA)

The Discharge coordination model embedded in District General Hospitals (e.g., Bronglais, Swansea, Shrewsbury) through the current Care Transfer

Coordinators will be enhanced to have a stronger presence in Emergency Departments / Acute Medical Units / Medical Assessment / Frailty Units to support rapid return of patients to Powys. The approach will be based on:

- A 'pull' post-acute pathway and Trusted Assessors enabling swift, criteria-led discharge home or into a supported community setting.
- Home first ethos - Assessment conducted at home, not in hospital.
- Where possible, direct return home will be facilitated by early activation of community Rehabilitation & Reablement
- Post-discharge review within 48 hours.

3.3.5 Rehabilitation & Reablement at Home

Time-limited (up to 6 weeks) and goal-oriented interventions, focusing on maximising independence and functional recovery. This is delivered by integrated multi-professional, multi-agency teams who support at home as an alternative to admission or following discharge from hospital.

3.3.6 Access to Intermediate Care Beds

The Intermediate Care service will have access to beds in a community facility to enable selected individuals to avoid transfer to an acute hospital or to recover from an acute episode if this cannot be supported at home. The team will in reach to this facility to facilitate continuity of care and timely return home, applying planned date of discharge and aiming for home within 72 hours.

3.3.7 Single Point of Access (SPOA)
There will be a centralised 08:00-20:00 SPOA for management and triage of referrals from professionals to streamline access to urgent response and intermediate care as well as to wider community support.

3.3.8 Step up/Step down

Step up care – a hospital-based bed for admission for up to 72 hours to undertake assessment and diagnostics, implement treatment plans and discharge with wrap around support where required.

Step down care – when a person moves from a hospital bed to having their health needs met in a home environment.

3.4 MDT Function and Workforce

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The Multidisciplinary Team (MDT) function for the Intermediate Care Service will include:

- Daily board rounds and twice-daily virtual huddles.
- Weekly MDT meetings for proactive care planning.
- Clinical leadership –through Medical Model/ACP or consultant roles.
- Virtual clinical reviews by primary care, community, and specialist teams as required.
- Joint assessments with specialist teams e.g. Dementia Home Treatment.
- Time limited in-reach into care homes for selected residents
- Strong links with stakeholders to ensure access to diagnostics and referral pathways.

The Core Intermediate Care workforce includes:

- An identified Clinical Lead (which could be a medic or consultant nurse/therapist for each team)
- Nursing
- GP or Consultant
- Therapists (OT/PT)
- Rehab HCSW and Nursing HCSW
- Advanced Clinical Practitioners or Enhanced Nurse Practitioners – ability to prescribe, refer for diagnostics, administer IVs. Capable of advanced clinical decision making and risk management. These may be Therapy/Nurse consultants (The ACP may come from a clinical background of Therapies, Paramedic or Nursing)
- Mental Health Older Adult Liaison
- Pharmacists
- Third-sector support staff and local community assets
- Social workers
- Admin/schedulers for rotas etc

Specialist services that the Intermediate Care MDT will engage with:

- GPs
- Practice based / locality Proactive Prevention service
- Respiratory Practitioners (not physiology),
- District Nursing
- Community Therapies – e.g. falls/frailty
- Tissue Viability Nurses,
- Neuro services (including Parkinsons Nurse Practitioner)
- Dietetics
- Speech and Language therapists
- Dementia Home Treatment Team
- Cardiac practitioners (not cardiac physiology)
- Palliative care specialist nurses
- Continence
- Social workers

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- Sensory impairment workers
- Lymphoedema
- Diabetes
- Podiatry
- Complex Care nurses
- Equipment store
- Telecare

The Intermediate Care MDT will work closely with Organic Mental Health services in Powys. This will include:

- Joint working with **Community Mental Health Teams for Older Adults (CMHT-OA)** and Adult community mental health teams
- **Shared assessments and care plans**
- Joint MDTs for complex cases (dementia, delirium, those individuals identified with declining mental health)
- Crisis support and carer support in-home to prevent admission
- Dementia-friendly intermediate care and step-up beds
- **Evidence Base:** NICE NG97 (Dementia), Welsh Government's "Together for Mental Health" strategy.

Collaboration with third-sector partners eg :

- Carer support
- Community transport
- Social and emotional wellbeing services
- Social prescribing to support long term management

Collaboration with Social Care Teams

- coordinate care plans for the long term
- ensure social support is in place
- advocates, helping people access benefits, housing, and community resources,
- supporting families and carers

3.5 Operating Hours / Sites

The service will operate from 08:00-20:00, 7-days a week.

OOH
Delivery of an overnight on–call nursing service 20:00 to 08:00 to respond to urgent and end-of-life care. There will be 2 teams positioned North and South of PTHB (to be confirmed).

3.6 Equipment

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This service will need same day/next day access to community equipment 7 days a week.

3.7 Digital Tools

- Shared electronic health records (EHRs)
- Real-time dashboards & alerting systems
- Clinical documentation & remote assessment
- Digital remote dashboards for monitoring

4. System Enablers

Enabler	Description
Workforce Integration	Cross-trained staff, rotational posts, joint governance, Trusted Assessor model
Digital Infrastructure	Shared records, referral platforms, remote monitoring/technology enabled care
Community Assets and Third/Voluntary Sector	Local third-sector groups embedded in care model
Training and Development	Frailty, dementia, palliative care training for all staff
Quality and Outcomes Dashboard	Real-time tracking of key indicators (e.g., avoidable admissions, response times, satisfaction)

5. Governance and Evaluation

- **Strategic oversight** via PTHB and Powys RPB (ICCS structure)
- Locality-based MDT leadership groups
- Co-production with citizens and carers
- **Continuous Improvement Cycles** using PDSA methodology
- **Annual outcomes review** and benchmarking

6. Outcomes Expected

Outcome	Measure
Reduced emergency admissions	≥15% over 3 years
Increased care at home at EoL	>75% die in preferred place

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Reduced long-term care admissions	≥10% reduction
Improved patient/carer experience	≥90% satisfaction
Reduced falls with harm	≥20% reduction
Future Care Plan completion	100% for top 0.5%
Healthy Days at Home	Increase YoY

7. Evidence Base & Best Practice Alignment

Powys Intermediate Care Team	**Supporting Welsh Policy / Guidance**
Rapid Response & UCR (2 h, 08:00-20:00 service)	NHS Wales Falls Response Framework requiring 08:00-20:00 coverage
Discharge-to-Assess / Pull Model	"Home First" Guidance mandates community-based post-discharge assessment
Reablement & Intermediate Care (max 6 weeks)	Age Cymru factsheet under Social Services Act framework
Integrated MDT & SPOA structure	IAA Framework and Social Services Act duty for coordinated responses
Community-based step-up/step-down beds	ICF and IRCF funding guidance to RPBs for infrastructure investment
Digital Virtual Ward & hubs	IRCF supports integrated hubs and co-located services
National Community Nursing Specification	WLoC tool. Supports a larger team with enhanced skills delivering to population size. Home based care e.g. palliative and chronic disease management
All-Wales Rehabilitation Framework (2022) person-centred value-based approach	Good practice for rehabilitation—restorative, compensatory, adaptive, supportive—flexible based on individual needs

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Powys Intermediate Care Team	Supporting Welsh Policy / Guidance
The Community Rehabilitation Best Practice Standards (2023)	the rehab standards give actionable, quality-driven expectations and tools that can be used by the therapists to ensure value based health care.
Social services and well being act	
NICE Guidelines NG74 – Intermediate Care	
Silver Book II – British Geriatrics Society	
NHS UCR Best Practice	
NHS Virtual Wards Framework	
AHSN D2A Toolkit	
Royal College of Physicians National Falls Audit	
BGS Blueprint for Preventing and Managing Frailty	
BGS Reablement, Rehabilitation and Recovery	

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Appendix A - Case Study 1

Mr Jones, 89 years old

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Fall at home

↓

Ambulance assessment → No conveyance required

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Phone call to SPOA

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Intermediate Care Triage

└─> Decision: Visit within 2 hours

↓

AHP attends at 5pm

└─> Full assessment + Repeat observations

↓

Plan agreed with Reablement support

└─> 8pm visit → Assist into bed

└─> Next day → Support worker, several visits daily (48–72 hrs)

↓

Outcome: Intense support, Low complexity

↓

Discharged after 5 days

↓

Social needs identified

└─> Low mood (bereavement, reduced socialisation)

└─> Referral to Community Connectors

└─> Signposted to Village Lift Group

↓

Ongoing review and monitoring by local Proactive Prevention service

Long-term outcome: Maintained activity + Social opportunities

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Appendix One

Proactive Prevention Model

Proactive Prevention and Wellbeing Hub Service

July 2026

1. Proactive Prevention and Wellbeing Hub Service

An integrated, locality-based, multidisciplinary model delivering proactive prevention, long-term condition management, frailty support, and personalised care planning through a Wellbeing Hub approach, with escalation to Intermediate Care and Virtual Ward services when required.

2. Purpose

The Proactive Prevention and Wellbeing Hub Service aims to shift healthcare delivery from a reactive "illness" model to a proactive "wellness" model. The service focuses on prevention, early intervention, self-management, resilience, and independence to improve health outcomes and reduce avoidable demand on urgent and acute care services

The service will:

- Improve population health outcomes.
- Reduce avoidable hospital admissions and emergency attendances.
- Support people to remain independent in their own homes.
- Improve long-term condition management.
- Deliver personalised care planning and future care planning.
- Reduce health inequalities.
- Strengthen integration between primary, community, social care and specialist services.
- Future-proof services against increasing demand associated with an ageing population and rising prevalence of chronic disease

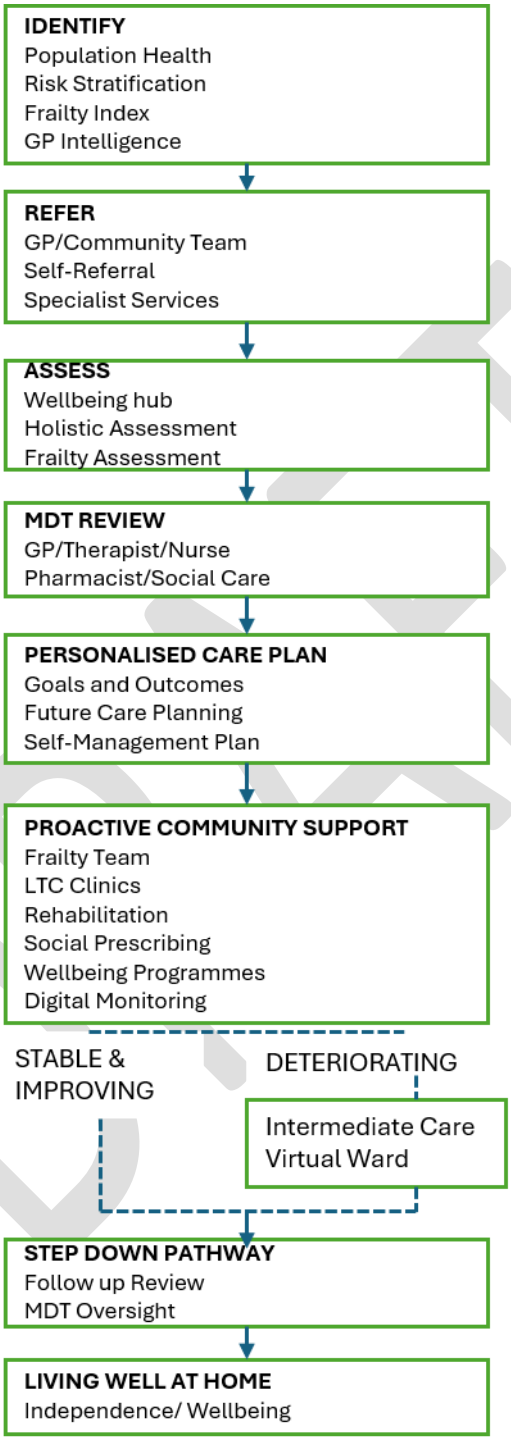
3. Service Model

The Wellbeing Hub(locally based around a GP practice) will act as the central coordinating function for proactive community-based care.

The model places:

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Primary Care Teams and Local MDTs at the centre of care delivery, supported by community, social care, voluntary sector and specialist services.



the service provides ongoing management and preventative intervention rather than episodic treatment, ensuring individuals remain supported over the long term.

4. Service Objectives

The service will:

Prevention

- Identify risk earlier.
- Prevent deterioration.
- Reduce frailty progression.
- Promote healthy lifestyles and behavioural change.

Long-Term Condition Management
Provide coordinated management of:

- COPD
- Asthma
- Diabetes
- Cardiovascular disease
- Heart failure
- Hypertension
- Obesity
- Falls risk
- Frailty syndromes
- Breathlessness
- Multi-morbidity

Personalised Care

- Develop personalised care plans.
- Complete future care planning.
- Promote shared decision making.
- Support self-management.

Integrated Care

- Improve collaboration between services.
- Deliver care closer to home.
- Reduce fragmentation.

Escalation Management
Provide seamless pathways into:

- Intermediate Care
- Virtual Wards
- Community Rapid Response Services
- Specialist services both community services and secondary care

with planned step-down back into community management.

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5. Target Population

The service will support adults who:

- Live with one or more long-term conditions.
- Are identified as moderately or severely frail.
- Frequently attend healthcare services.
- Are at risk of admission to hospital.
- Require ongoing proactive management.
- Are socially isolated or vulnerable.
- Would benefit from preventative interventions.

Population health intelligence, GP knowledge and risk stratification tools will be used for case finding

6. Core Components

Population Health and Case Finding

The service will utilise:

- Electronic health records.
- Frailty indices.
- Public health intelligence.
- Risk stratification tools.
- Practice intelligence.
- Community team intelligence

to identify individuals who would benefit from proactive intervention.

Wellbeing Local Hub Assessment

Individuals will receive:

- Holistic wellbeing assessment.
- Frailty assessment.
- Long-term condition review.
- Functional assessment.
- Social needs assessment.
- Medication review.
- Mental wellbeing review.

Assessments will adopt a strengths-based approach and identify personal goals and outcomes.

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Personalised Care Planning

Each individual will have:

- Personalised care plan.
- Self-management goals.
- Future care plan.
- Escalation plan.
- Named coordinator for complex cases.

Care plans will be reviewed by the MDT according to clinical need.

Prevention and Wellbeing Interventions

The Wellbeing Hub will coordinate:

- Lifestyle Support
- Smoking cessation.
- Weight management.
- Physical activity programmes.
- Nutritional support.
- Behaviour change coaching.

Living Well Programmes

- Falls prevention.
- Strength and balance.
- Healthy ageing programmes.
- Education and self-management courses.

Social Prescribing

- Community groups.
- Volunteering.
- Green prescribing.
- Arts programmes.
- Peer support networks.

Wellbeing Checks

Targeted support for:

- Rural communities.
- Isolated individuals.
- Vulnerable populations.

7. Frailty Management Model

Frailty management will be a key component of the service.

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The Frailty Team will:

- Undertake proactive frailty reviews.
- Deliver comprehensive geriatric assessment principles.
- Identify deterioration early.
- Coordinate support services.
- Develop future care plans.
- Support carers and families.

The focus will be maintaining function, independence and quality of life while reducing unnecessary hospital utilisation.

8. Long-Term Condition Management

The Wellbeing Hub will provide sustained management and monitoring for:

Respiratory Conditions

- COPD
- Breathlessness syndromes
- Pulmonary rehabilitation

Cardiovascular Conditions

- Heart failure
- Hypertension
- Coronary artery disease
- Cardiac rehabilitation

Diabetes
Glycaemic management
Education programmes
Lifestyle interventions

Frailty and Multi-morbidity

- Coordinated MDT reviews
- Functional monitoring
- Prevention of deterioration

The service will focus on long-term intervention, prevention of progression and maintaining independence.

****These services will be delivered by primary care and current community services but structured around communities

9. Multidisciplinary Team

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The MDT will include:

Primary Care
- General Practitioners
- Practice Nurses/AHPs
- Practice Pharmacists

Community Services
- District Nurses
- Physiotherapists
- Occupational Therapists
- Dietitians
- Podiatrists
- Rehabilitation Assistants

Care Coordination
- Social Workers
- Community Connectors

Mental Health
- Mental Health Practitioners

Third Sector
- Social Prescribing Link Workers
- Voluntary Sector Partners

Specialist In-Reach or step up
- GPwSI Cardiology
- Regional Breathlessness Services
- Diabetes Services
- Respiratory
- Community neuro services
- Memory Assessment Services
- Community Specialist Teams

The MDT will operate as a "village around the individual" model with joint decision-making and shared care planning.

10. Specialist Service Integration

Strong links will be established with regional specialist services and secondary care including:
- GPwSI Cardiology clinics.

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- Heart failure pathways.
- Breathlessness services.
- Pulmonary rehabilitation.
- Diabetes specialist teams.
- Specialist nursing services.
- Memory assessment services.
- Secondary care
- Acute specialty advice services.

Specialists will support local MDTs through in-reach, virtual consultation, education and shared care arrangements.

11. Intermediate Care and Virtual Ward Interface

The Wellbeing Hub will maintain responsibility for ongoing management.

Where patient needs escalate:

Step-Up

Referral to:
- Intermediate Care
- Virtual Ward
- Community Rapid Response

for intensive short-term intervention.

Step-Down

Upon stabilisation:
- Return to Wellbeing Hub management.
- Continue preventative interventions.
- Ongoing condition monitoring.
- MDT oversight.

This creates a seamless pathway preventing unnecessary hospital admission.

12. Digital Model

The service will utilise:
- NHS Wales App.
- Remote monitoring platforms.
- Virtual consultations.

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- Wearable technologies.
- Digital self-management tools.
- Telehealth and telecare applications.

Digital inclusion support will ensure equitable access for all populations.

13. Operating Model

Hours of Operation

Monday to Friday
09:00 – 17:00

District Nursing services will continue to operate through existing extended arrangements.

Locations

Services will be delivered through:
- Local Wellbeing Hubs.
- GP practices.
- Community settings.
- Individual homes.
- Virtual appointments.

Teams will be aligned to locality populations and primary care clusters.

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Better Togther Assessment Estates Summary
Capital / Estates Assessment against Options

Approved via Executive Committee - 29.07.26

Option No:	Option Description	Estates Assumptions: can 'hide' in final version	Cost A-D	Feasibility RAG	Narrative
Mental Health					
SL MHDO02_001a	**Do previous - before temporary services change**		A		Reinstate Crug Ward, Brecon otherwise no direct impact. Need to consider existing service challenges and 'fit for purpose' accommodation.
SL MHDO02_001b	**Do current - no transformational change**		A		No direct Capital project activity but continue Business as Usual investment. Need to consider existing service challenges and 'fit for purpose' accommodation.
SL MHDO_003a	**All functional beds to Bronllys, organic beds remain at Tawe ward, 5 bed unit created at Bronllys for frail functional patients, in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, continued use of Out Of County specialist and overflow beds.**		C		**23 beds Bronllys (new build)** **Short - Medium Term:** Current AMI / Felindre Ward (18 beds) is being extended to create 5 additional beds in Defynnog (23 beds), however, the current building configuration does not meet current NHS Health Building Note (HBN) Standards. The current unit is 1,231m2, HBN guidance assessment would indicate a compliant 23 bed Mental Health unit would be circa 1,500+/m2. **Medium - long term:** Purpose built facility on the Bronllys site. Space constraints would not be an issue, other than the overall current built environment footprint at Bronllys cannot be exceeded due the Historic Park and Garden designation of the site. Further clarification from Local Authority Planning Department is required to confirm if a new build could be constructed while AMI remains operational (decanting and demolishing AMI on completion) and would be subject to a Planning approval. The costs are likely to be circa £15M. The costs for a new build Mental Health facility have not been a specific ask to Welsh Government and this would need to be registered on the NHS 'forward look capital investment programme'. Timescale would be 5 years plus. Could this be accommodated on the existing site: **Yes** Funding: **Circa £15M+ subject to Welsh Government approval** Timescale: **5 years+**
SL MHDO_004a	**All functional beds to Brecon Hospital, organic beds remain at Tawe ward, 5 bed unit created at Brecon for frail functional patients, in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, continued use of Out Of County specialist and overflow beds.**		D		**23 beds Brecon (reconfiguration)**: Create 18 functional Beds and 5 bed frail functional unit at Brecon site (23 beds). There is limited opportunity at Brecon to extend due to significant physical site constraints. A reconfiguration within the existing footprint including current Crug Ward and Therapies Unit would provide a combined floor area of 1,235m2. NHS Health Building Note guidance assessment would indicate a compliant 23 bed Mental Health unit would be circa 1,650m2+. Subject to further feasibility testing, it may be possible to fit circa 15 beds on site for Mental Health by using Crug Ward plus Therapies Unit. This would displace a number of services and it is unlikely these could be relocated in the current hospital footprint and alternative accommodation would need to be identified (Bronllys / leased accommodation / new build on another site) and the costs for this, due to the uncertainty, have not been assessed / included. Additionally, the current configuration of Crug / Therapies areas would not be conducive to the provision of a fully compliant layout for the service and a Feasibility Study would be required to identify impact on hospital configuration, Planning constraints, etc. The costs for a new Mental Health facility at Brecon have not been a specific ask to Welsh Government and this would need to be registered on the NHS 'forward look capital investment programme'. Timescale would be 5 years plus. Could this be accommodated on the existing site: **Concerns about outcome of feasibility to accommodate (existing services would be displaced and require alternative space, with associated costs)** Funding: **Circa £16M+ excluding costs to relocate displaced services, subject to Welsh Government approval** Timescale: **5 years+**
SL MHDO_006a	**All Mental Health beds to Bronllys (functional (18 beds) and organic (12 beds)), 5 bed enhanced care unit, in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, reduced use of Out Of County specialist and overflow beds (as Out Of County patients will repatriate to 5 bed enhanced care unit).** **Further alternative option is to consider new site in the Brecon / Bronllys area.**		D		**35 beds Bronllys (new build)**: Create 18 functional beds, 12 organic beds and 5 bed enhanced care unit at Bronllys site (35 beds). Footprint would be circa 2,500m2+ with costs at circa £25M. Funding bid is not currently registered with Welsh Government. Most straightforward and deliverable option from an Estates' buildability perspective. Could this be accommodated on the existing site: **Yes** Funding: **Circa £25M+ subject to Welsh Government approval** Timescale: **5 years+**
			D		**35 beds at new site in Brecon/Bronllys area (new build)**: Create 18 functional beds, 12 organic beds and 5 bed enhanced care unit at Bronllys site (35 beds). Footprint would be circa 2,500m2+ with costs at circa £25M. Funding bid is not currently registered with Welsh Government. Some uncertainty / risk around availablity of suitable site with detailed market analysis to be undertaken as part of a feasibility study. Could this be accommodated on the existing site: **no, would require identification of a new and suitable site** Funding: **Circa £25M (plus land acquisition costs), subject to Welsh Government approval** Timescale: **5 years+**
SL MHDO_007a	**All Mental Health beds to Brecon Hospital (functional (18 beds) and organic (12 beds)), 5 bed enhanced care unit, in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, reduced use of Out Of County specialist and overflow beds (as Out Of County patients will repatriate to 5 bed enhanced care unit)**		D		**35 beds at Brecon (reconfiguration)**: Create 18 functional beds, 12 organic beds and 5 bed enhanced care unit at Brecon site (35 beds). Footprint would be circa 2,500m2+ with costs at circa £25M. Subject to feasibility testing, it may be possible to fit circa 15 beds on site for Mental Health by using Crug Ward plus Therapies Unit with the existing footprint would provide a combined floor area of 1,235m2. This would displace a number of services and it is unlikely these could be relocated in the current hospital footprint and alternative accommodation would need to be identified (Bronllys / leased accommodation / new build on another site) and the costs for this, due to the uncertainty, have not been assessed/included. Additionally, the current configuration of Crug / Therapies would not be conducive to the provision of a fully compliant layout for the service and a significant Feasibility Study to identify impact on hospital configuration, Planning constraints, etc. The costs for a new Mental Health facility at Brecon have not been a specific ask to Welsh Government and would need to be registered on the NHS 'forward look capital investment programme'. Timescale would likely be 5 years plus. **Due to the limitations of the current site configuration and footprint, subject to a more in depth feasibility study, it is not currently deemed possible to accommodate a new 35 bed Mental Health unit on site without a major reshaping and reconfiguration of the hospital.**
SL MHDO_008a	**All Mental Health beds to Newtown Hospital or Welshpool (functional (18 beds) and organic (12 beds)), 5 bed enhanced care unit, in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, reduced use of Out Of County specialist and overflow beds (as Out Of County patients will repatriate to 5 bed enhanced care unit)**		D		**35 beds at Newtown (new build)**: Design Consultant has undertaken a feasibility 'test to fit' - in principle, 35 beds could be accommodated within the Phase 2 footprint but further work would need to be undertaken to assess the impact on parking, public realm, planning and conservation constraints, proximity to the school, etc. As Phase 2 is yet to be designed, the adjacency with physical health could be built into the initial brief and all the accommodation would be modern and fit for purpose. Welsh Government are aware of the aspirations of Phase 2, but further scoping and business case development would be required. Could this be accommodated on the proposed site: **Yes, but need to assess practicality** Funding: **Circa £25M+ Mental Health element only, subject to Welsh Government approval** Timescale: 5 years+
			D		**35 beds at Welshpool (reconfiguration)**: hospital current floor area is 2,965m2 in total and it would not be feasible to provision an additional circa 2,500m2 facility at this location and the only consideration would be for a separate unit on a new site which would then need to include land purchase, additional infrastructure such as catering, etc. Could this be accommodated on the existing site: **No** Funding: **Circa £25M+ plus alternative accommodation for displaced services, subject to Welsh Government approval** Timescale: **5 years+**
	Do maximum - Two=site inpatient model with all beds (functional & organic), split between Newtown Hospital and Brecon Hospital. 42 beds in total, 21 beds at each site to include 9 functional beds, 6 organic beds, 3 all-age functional beds and 3 enhanced care beds. Will include in-reach Mental Health liasion team for physical health inpatients, specialist Older Adult Mental Health community team, reduced use of Out Of County specialist and overflow beds (as Out Of County patients will repatriate to 5 bed enhanced care unit)		D		**21 beds at Newtown (new build)**: including 9 functional beds, 6 organics beds, 3 all-age functional beds and 3 enhanced care beds. Design Consultant has undertaken a feasibility 'test to fit' - in principle 21 beds could be accommodated within the Phase 2 footprint but further work will need to be undertaken to assess the impact on parking, public realm, planning and conservation constraints, proximity to the school etc. As Phase 2 is yet to be designed, the adjacency with physical health could be built into the initial brief and all the accommodation would be modern and fit for purpose. Welsh Government are aware of the aspirations of Phase 2 - but further scoping and business case development is required. Could this be accommodated on the existing site: **Yes, but need to assess practicality** Funding: **Circa £15M+ for Mental Health element only, subject to Welsh Government approval** Timescale: **5 years+**
			D		**21 beds at Brecon (reconfiguration)**: including 9 functional beds, 6 organic beds, 3 all-age functional beds and 3 enhanced care beds. NHS Health Building Note guidance assessment would indicate a compliant 21 bed Mental Health unit would be circa 1,500m2+. A reconfiguration within the existing footprint including current Crug Ward and Therapies Unit would provide a combined floor area of 1,235m2. Subject to further feasibility testing, it may be possible to fit circa 15 beds on site for Mental Health by using Crug Ward plus Therapies Unit. This would displace a number of services and it is unlikely these could be relocated in the current hospital footprint and alternative accommodation would need to be identified (Bronllys / leased accommodation / new build on another site) and the costs for this, due to the uncertainty, have not been assessed / included. Additionally the current configuration of Crug / Therapies would not be conducive to the provision of a fully compliant layout for the service and a significant Feasibility Study would be required to identify impact on hospital configuration, Planning constraints, etc. The cost for a new Mental Health facility at Brecon has not been a specific ask to Welsh Government and so this would need to be registered on the NHS 'forward look capital investment programme'. Timescale would, therefore, likely be 5 years plus. Could this be accommodated on the existing site: **Concerns about outcome of feasibility to accommodate a compliant ward of 21 beds (existing services would be displaced and require alternative space, with associated costs)** Funding: **Circa £15M+ excluding costs to relocate displaced services, subject to Welsh Government approval** Timescale: **5 years+**
Urgent Care					
SLUCDO 001a	**Do previous - Pre=temporary service changes (4 MIUs)**	No direct Capital project activity but continue Business as Usual investment.	A		Need to consider existing service challenges and 'fit for purpose' accommodation.
SLUCDO 001b	**Do current - continue as now making temporary service changes permanent**	No direct Capital project activity but continue Business as Usual investment.	A		Need to consider existing service challenges and 'fit for purpose' accommodation.
SLUCDO 001c	**Do minimum - 3 MIUs: Newtown, Llandrindod, Brecon**	Assume minor improvements to MIU at Brecon & Llandrindod. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	B		Fairly easy to implement minor improvements to existing MIU's at all three sites with further opportunities to improve Llandrindod offer as part of Phase 3 which is on the Welsh Government 'green (approved) list' for capital investment. Further opportunities to make improvements as part of the North Powys Phase 2 scheme but the timeline for this is likely to be 5 years plus. Could this be accommodated on the existing site: **Yes** Funding: **£0.5M - £7M** Timescale: **Could be partially implemented in less than 1 yr - full implementation 5 years+**
SLUCDO 001cii	**Do minimum - 2 MIUs: Newtown & Brecon**	Assume improvement / expansion of Brecon. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	B		Fairly easy to implement minor improvements to existing MIU's at 2 three sites. Does not take advantage of potential future investment available for Llandrindod - this area would be decommissioned for alternate use. Further opportunities to make improvements as part of the North Powys Phase 2 scheme but the timeline for this is likely to be 5 years plus. Could this be accommodated on the existing site: **YES** Funding: **£0.5M - £7M** Timescale: **Could be partially implemented in less than 1 yr - full implementation 5 years+**
SLUCDO 001d	**Do current on 3 sites - MIUs at Welshpool, Llandrindod & Brecon**	No direct Capital project activity but continue Business as Usual investment. Potential mothball of other sites for future alternate use.	A		No direct Estates activity but need to consider existing service challenges and 'fit for purpose' accommodation.
SLUCDO 001dii	**Do current on 2 sites - MIUs at Welshpool, Newtown & Brecon**	No physical change at Brecon. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	B		Fairly easy to implement minor improvements to existing MIU at Brecon & Welshpool. Further opportunities to make improvements as part of the North Powys Phase 2 scheme but the timeline for this is likely to be 5 years plus. Could this be accommodated on the existing site: **Yes** Funding: **£0.5M - £7M** Timescale: **Could be partially implemented in less than 1 year - full implementation 5 years+**
SL UCDO_005	**All MIUs close; GP + community response only**	mothball spaces where services closed	A		No major investment required, current MIU's would be decommissioned for future alternate use.
SL UCDO_010	**Mid range - MIUs at Newtown, Llandrindod & Brecon**	Assume improvement / expansion of Llandrindod / Brecon. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	C		**Newtown (new build)**: Limited options to enhance / extend Welshpool service in the short term. Longer term Phase 2 of the North Powys, Newtown scheme offers the opportunity to create fit for purpose MIIU. **Llandrindod (reconfiguration / new build):** Limited options to enhance / extend current space in the short term. Medium term, Llandrindod is on the Welsh Government 'green (approved) list' of capital funding, enabling an opportunity to create fit for purpose MIIU. **Brecon (reconfiguration):** Feasibility study required to explore opportunity to enhance / extend current space without displacing services and reconfiguration. Could this be accommodated on the existing / proposed sites: **Yes, with some space challenges at Brecon** Funding: **£7M - £15M** Timescale: **full implementation 5 years+**
SL UCDO_010ii	**Mid range - MIUs at Newtown & Brecon**	Assume improvement / expansion of Newtown and Brecon. Potential mothball of other sites for future alternate use.	B		**Newtown (new build):** Limited options to enhance / extend Welshpool service in the short term. Longer term Phase 2 of the North Powys, Newtown scheme offers the opportunity to create fit for purpose MIIU. **Brecon (reconfiguration):** Feasibility study required to explore opportunity to enhance / extend current space without displacing services and reconfiguration. Could this be accommodated on the existing / proposed sites: **Yes, with some space challenges at Brecon** Funding: **£0.5M - £7M** Timescale: **full implementation 5 years+**
SL UCDO_013	**Maximum - UCCs at Newtown & Brecon; MIIU at Llandrindod**	Assume further improvement / expansion of Llandrindod / Brecon. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	C		**Newtown (new build):** Limited options to enhance / extend Welshpool service in the short term without displacing services and more extensive reconfiguration. Longer term, Phase 2 of North Powys, Newtown scheme offers the opportunity to create fit for purpose UCC. **Llandrindod (reconfiguration / new build):** Limited options to enhance / extend current space in the short term. Medium term, Llandrindod is on the Welsh Government 'green (approved) list' of capital funding, enabling opportunity to create fit for purpose MIIU. **Brecon (reconfiguration):** Feasibility study required to explore opportunity to enhance / extend current space without displacing services and reconfiguration. Could this be accommodated on the existing / proposed sites: **Yes, with some space challenges at Brecon** Funding: **£7M - £15M** Timescale: **full implementation 5 years+**
SL UCDO_013ii	**Maximum - UCCs at Newtown, Brecon & Llandrindod**	Assume further improvement / expansion of Llandrindod / Brecon. Interim position for Newtown will be Welshpool until phase 2 Newtown is complete. Potential mothball of other sites for future alternate use.	C		**Newtown (new build):** Limited options to enhance / extend Welshpool service in the short term without displacing services and more extensive reconfiguration. Longer term, Phase 2 of the North Powys, Newtown scheme offers the opportunity to create fit for purpose UCC. **Llandrindod (reconfiguration / new build):** Limited options to enhance / extend current space in the short term. Medium term, Llandrindod which is on the Welsh Government 'green (approved) list' of capital funding enabling opportunity to create fit for purpose MIIU. **Brecon (reconfiguration):** Feasibility study required to explore opportunity to enhance / extend current space without displacing services and reconfiguration. Could this be accommodated on the existing / proposed sites: **Yes, with some space challenges at Brecon** Funding: **£7M - £15M** Timescale: **full implementation 5 years+**
In Patients					
SL IPDO_001a	**Do previous - Pre=temporary service changes**	Minimal estates impact - Reinstate Knighton ward	A		Need to consider existing service challenges and 'fit for purpose' accommodation.
SL IPDO_001b	**Do current - Make temporary changes permanent**	Minimal estates impact - continue Business as Usual investment.	A		Need to consider existing service challenges and 'fit for purpose' accommodation.
SL IPDO_011	**Remove all community beds - No local community inpatient beds; rely on community team, care homes and secondary care providers**	Mothball current inpatient facilities for future alternate use	A		Decommission and hold space for reprovision to strengthen community services and / or retain for consideration of need for future strategy activity for Planned Care and Women and Childrens Services and / or consider space as part of Integrated Hub offer.
SL IPDO_002a	**Do minimum - Same Community Inpatient bed numbers across 6 sites with stronger community model**	Minimal estates impact - continue Business as Usual investment. Potential mothballing of some areas for future alternate use.	B		Some improvements to current inpatient sites. Need to consider existing service challenges and 'fit for purpose' accommodation.
SL IPDO_002b	**Do minimum + Mental Health integration - Same Community Inpatient bed numbers across 6 sites with stronger community model with integrated physical and mental health services on some sites**	Minimal estates impact - continue Business as Usual investment. Potential mothballing of some areas for future alternate use.	B		Some improvements to current inpatient sites. Need to consider existing service challenges and 'fit for purpose' accommodation.
SL IPDO_005a	**Do mid range - Fewer Community Inpatient beds reduced to 3 sites, with enhanced community model**	Assume 30 beds at Brecon, Llandrindod & Newtown	D		**30 bed wards at Brecon, Llandrindod and Newtown:** further work to identify measures related to community model. **Brecon**: Reconfigure existing ward spaces - footprint available but may be challenging to provide optimum space. The cost of development at Brecon has not been a specific ask to Welsh Government (WG) and so this would need to be registered on the forward look major capital investment programme which was an exercise WG undertook to establish their current endorsed 'green list' of projects. Timescale would, therefore, likely be 5 years plus. **Llandrindod**: Major capital funding has been ringfenced by Welsh Government. **Newtown**: Could be accommodated as part of Phase 2 hospital relocation / new build subject to Welsh Government approval of funding. Could this be accommodated on the existing site: **Some challenges with space and optimum configuration at Brecon** Funding: **£15M+** Timescale: **full implementation 5 years+**
SL IPDO_005b	**Do mid range + Mental Health integration - Fewer Community Inpatient beds reduced to 3 sites, with enhanced community model + better join up with mental health**	Assume 30 beds at Brecon, Llandrindod & Newtown	D		**30 bed wards at Brecon, Llandrindod and Newtown**: further work to identify measures related to community model. **Brecon**: Reconfigure existing ward spaces - footprint available but may be challenging to provide optimum space. The cost of development at Brecon has not been a specific ask to Welsh Government and would need to be registered on the forward look programme, which was an exercise WG undertook to establish their current endorsed 'green list' of projects. Timescale would, therefore, likely be 5 years plus. **Llandrindod**: Major capital funding has been ringfenced by Welsh Government. **Newtown**: Could be accommodated as part of Phase 2 hospital relocation / new build subject to Welsh Government approval of funding. Could this be accommodated on the existing site: **Some challenges with space and optimum configuration at Brecon** Funding: **£15M+** Timescale: **full implementation 5 years+**
SL IPDO_008	**Do maximum - Even fewer Community Inpatient beds reduced to 2 sites, with enhanced community model ++ and better join up with mental health**	Assume 30 beds at Newtown and 30 beds in Brecon	D		**30 bed wards at Brecon and Newtown**: further work to identify measures related to community model. **Brecon**: Reconfigure existing ward spaces - footprint available but may be challenging to provide optimum space. The cost of development at Brecon has not been a specific ask to Welsh Government (WG) and so this would need to be registered on the forward look major capital investment programme, which was an exercise WG undertook to establish their current endorsed 'green list' of projects. Timescale would, therefore, likely be 5 years plus. **Newtown**: Could be accommodated as part of Phase 2 hospital relocation / new build, subject to Welsh Government approval of funding. Could this be accommodated on the existing site: **Some challenges with space and optimum configuration at Brecon** Funding: **£15M+** Timescale: **full implementation 5 years+**

SWOT Analysis – Mental Health options Slide 1 of 2

Mental Health Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
001a: Do Previous (before any temporary service changes)	Familiarity and longevity of historic service provision and processes / access / interdependencies	Multiple financial and clinical risks, complex and interlinked issues as set out in Case for Change	Familiarity of previous state supports some collaboration as builds on well known systems and processes	Maintaining previous state does not allow adaption for demand growth / external changes / requirements; compounds and entrenches current issues
001b: Do Current (with temporary service changes permanent)	As above AND benefits of temporary service changes would be maintained	As above EXCEPT improvements resulting from temporary change would be maintained	As above - applies also to 'current state' AND offers additional opportunities in relation to recently improved systems/ processes and flow	As above – applies also to 'current state'
003a: Do Minimum: Functional beds to **Bronllys** + integrated OAMH community	Use of existing site builds on systems and processes / access / interdependencies; AND cohorting / integration should improve quality / performance / experience AND improves resilience of service AND moves toward stronger alignment with national / local strategy AND is heading in the direction of the overarching vision / model of care for Physical and Mental Health for Powys/ Integrated Community Model AND is a step in the direction to the Service Level Model for Mental Health And heads towards direction for the longer term Social Model /Whole System Prevention approach	Some of the multiple, complex and interlinked issues as set out in Case for Change would remain; AND does not fully improve systems /processes; AND does not fully align to national/ local strategy AND requires significant reconfiguration with associated changes for users and workforce AND difficulties in predicting demand / limitations of information to inform capacity planning	Minimum change with cohorting and integration would support some adaption to manage changes in demand/ greater use of technology AND some further collaboration /improvement e.g. pathway and service redesign AND clinical / professional practice development Potentially could support partnership development across sectors including independent / third AND as it is heading in the direction of the longer-term Vision and Models for Physical and Mental Health, has potential to also support longer term Social Model and Whole System Prevention approach	Minimum changes does not allow scale/ pace of adaption to respond to: demand growth/ external changes / requirements, nor to current issues AND does not significantly shift to a model for prevention /independence /person centred care AND assumes continuation of existing pattern of commissioned out of area care and services AND is subject to estate / capital development AND to some extent, limitations in digital AND some elements of model are untested
004a: Do Mid Range: Functional beds to **Brecon** + integrated OAMH community	As above	As above AND issues of deliverability in relation to estate	As above	As above AND greater scale of estate development and capital investment

SWOT Analysis – Mental Health options Slide 2 of 2

Mental Health Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
006a: Do Maximum: All beds to **Bronllys** + integrated OAMH community	As previous AND would deliver additional benefits in relation to single site operation as set out in full IA	As previous AND there would be some issues particular to the single site choice, notably the change in pattern of access and associated travel / distances for some	As previous AND potential to develop regional centre for MH AND greater potential to manage demand changes AND potential for greater innovation in pathway / service design and use of technology AND greater potential for clinical / professional/ partnership development across sectors including independent / third AND greater alignment to Vision /Model of Physical and Mental Health / Social Model AND greater opportunity to change pattern of commissioned services / placements	Whilst this option optimises resources in one location, it would limit collaboration with partners who predominantly operate across footprints in North (and Mid) Powys AND is subject to estate / capital investment AND more dependent on digital development
007a: Do Maximum: All beds to **Brecon** + integrated OAMH community	As above	As above AND issues of deliverability in relation to estate	As above – BUT with reduced potential to develop regional centre (as this option has lower existing base/ capacity for development)	As above AND is subject to greater capital investment / greater estate limitations
008a: Do Maximum: All beds to **Newtown** + integrated OAMH community	As above	There would be some remaining issues particular to the single site choice, due to change in the pattern of access and associated travel / distances AND issues of deliverability in relation to estate	As above	As above – but with limitations for collaboration with providers / partners from South (and Mid) Powys
010a: Do Maximum: All beds to **Brecon + Newtown** + integrated OAMH community	Development and use of existing sites would build on and improve systems and processes AND have benefits of cohorting / integration	As above AND operational viability of two sites	As above AND development of two sites would open up further opportunities for collaboration in the North and South of the County	Whilst this option provides inpatient care in two locations, it would limit collaboration with partners who predominantly operate across Mid Powys AND is subject to capital investment/ estate limitations as noted in previous options

SWOT Analysis – Physical Health options Slide 1 of 3

Physical Health Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
001a: Do Previous (before any temporary service changes)	Familiarity and longevity of historic service provision and processes / access / interdependencies	Multiple, complex and interlinked issues as set out in Case for Change Reversal of temporary changes would result in known associated decrease in patient safety/experience and outcomes (inc. deconditioning from longer los)	Familiarity of previous state could support more immediate collaboration as builds on well known systems and processes	Maintaining previous state does not allow adaption for demand/ external changes / requirements; entrenches current issues (cross reference to Strategic Change report for further detail on external developments) AND is predicated on continuation of existing pattern of commissioned services
001b: Do Current (temporary service changes permanent)	As above AND benefits of temporary service changes would be maintained	As above EXCEPT reversal of temporary changes	As above - applies also to 'current state' AND offers additional opportunities in relation to recently improved systems/ processes and flow	As above – applies also to 'current state' (cross reference to Strategic Change report for further detail on external developments)
SL IPDO_011 – Remove Physical Health Community Hospital Beds	Potential for optimisation of resources / improvement of community offer across PH and MH, Potential to radically transform, whole scale, the way that current inpatient care is delivered Potential for stronger alignment with some parts (but not all) national / local strategy Potential to become an exemplar/ experimental prototype in community healthcare.	Level of difficulty and complexity to deliver whole scale change and transition from current state to radically different future state, with multiple internal and external interdependencies AND Potential unintended / undesirable impacts in relation to changes in system utilisation and associated system flow (cross reference to full IA) AND is subject to cross-system / partner agreements and changes in contracts and financial flows AND requires major changes / reuse / reconfiguration in estate utilisation and associated workforce deployment / organisational change AND has complex interdependencies for support services and digital / information infrastructure AND Does not necessarily fully enable improvements in quality / performance / experience and outcomes	Potential for radically new and innovative ways of collaborating on a whole scale Potential to attract benefits associated with vanguard / experimental prototype approaches AND radical potential for clinical / professional development associated with wholescale change AND radical potential for innovation / use of technology as part of whole scale model change AND radical potential for partnership development across sectors including independent / third	Potential system and partner impacts given whole scale change /transition from current to future state, with complex interdependencies AND current pressure / frequent escalation statuses AND complexity of alignment between and across multiple external programmes / provider developments (cross reference to Strategic Change report) AND is subject to major estate / capital reuse/ reconfiguration / development AND changes in site locations will be sensitive, particularly where other external change applies AND potential limitations to collaboration with providers / partners (Wales and Cross Border) not aligned to radical approach AND potential impacts on contractors AND may not positively / could detrimentally impact on existing pattern of commissioned services and activity (Wales and England)

SWOT Analysis – Physical Health options Slide 2 of 3

Physical Health Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
002a: Do Minimum: (same beds, on 6 sites) + better PH community	Use of 6 existing sites builds on existing and familiar sites, systems and processes; AND offers better use of resources AND should deliver some benefits in quality / performance /experience /resilience AND enables shift to greater intermediate care and urgent community response AND strengthens alignment with national / local strategy AND heads in direction of the Vision and Models for Physical and Mental Health for Powys And heads towards direction for the longer term Social Model /Whole System Prevention approach	Some of the multiple, complex and interlinked issues and risks as set out in Case for Change would remain; AND Does not fully enable improvements in quality / performance /experience and outcomes AND does not fully improve systems and processes; AND does not fully align to national/ local strategy; AND change in site usage requires reconfiguration / change for both users and workforce AND difficulties in predicting demand / limitations of information to inform capacity planning	Minimum change would support some adaptation to manage changes in demand AND further collaboration /improvement /value in use of resources, to support further opportunities for pathway and service redesign and development AND is a 'bridging' step towards a longer term sustainable model, including greater prevention / person centred care AND potential for clinical / professional/ partnership development across sectors including independent /third AND as it is heading in the direction of the longer term Vision and Models for Physical and Mental Health, has potential to also support longer term Social Model and Whole System Prevention approach	Minimum changes does not allow scale/ pace of adaption to respond to demand / external changes /requirements, nor to current issues AND does not fully shift to a model for prevention / person centred care AND is subject to estate / capital development AND to some extent, limitations in digital AND changes in site will be sensitive, particularly where other change applies AND potential limitations to collaboration with providers / partners/ contractors including primary care deployed at sites AND may not significantly impact on existing pattern of commissioned services
002b: Do Minimum: (same beds, on 6 sites) + better PH community + MH join up	As above AND benefits of greater join up with MH services	As above	As above AND greater opportunities in relation to MH join up	As above

SWOT Analysis – Physical Health options Slide 3 of 3

Physical Health Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
005a: Do Mid range: (fewer beds, on 3 sites) + better PH community	As for option 2a, AND greater scale of optimisation of resources / AND greater scale / sustainability of improvements in quality / performance /experience and resilience	As previous AND issues particular to the single site choice, ie. pattern of access / associated travel / distances AND issues of deliverability in relation to estate	As previous AND greater opportunities in relation to demand management / improvements in PH community AND potential for greater innovation in pathway / service design and use of technology AND more potential to shift to model for prevention and person centred care longer term AND potential to support changes in pattern of commissioned services AND greater potential for clinical / professional/ partnership development across sectors including independent / third	May not fully respond to demand/ external changes / requirements / current issues May not fully or immediately enable greater shift to model of prevention and person centred care AND likely to increase sensitivity in relation to site choices AND greater dependency on estate /capital and digital development AND greater potential limitations to collaboration with providers / partners in relation to site changes/ greater risk of impacts for contractors
005b: Do mid range: (fewer beds, on 3 sites) + better PH community + MH join up	As above AND benefits of greater join up with MH services	As above	As above AND greater opportunities in relation to MH join up	As above
008: Do maximum: (fewer beds, 2 sites) + better PH community + MH join up	As for option 5a, with further optimisation of resources / improvement of community offer across PH and MH	As above but with issues particular to a 2 site choice and less alignment with current local strategy	As above	As above

SWOT Analysis – Urgent Care options Slide 1 of 3

Urgent Care Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
001a: Do Previous (before any temporary service changes)	Familiarity and longevity of historic service provision and processes / access / interdependencies	Multiple, complex and interlinked issues as set out in Case for Change Any benefits from recent temporary changes would be reversed	Familiarity of previous state could support more immediate collaboration as builds on well known systems and processes	Maintaining previous state does not allow adaption for external changes / requirements; entrenches current issues (cross reference to Strategic Change report for further detail on external developments) AND reverses recent system improvements
001b: Do Current (continue as now, temporary service changes permanent)	As above AND benefits of temporary service changes would be maintained	As above - EXCEPT and benefits from recent temporary changes would not be reversed	As above - applies also to 'current state' AND offers additional opportunities in relation to recently improved systems/ processes and flow	As above – EXCEPT recent improvements would not be reversed
005: Close Minor Injury Units and provide urgent care in other ways	Potential to radically transform, whole scale, the way that urgent care is delivered Potential for stronger alignment with some parts (but not all) national / local strategy Potential to become a vanguard / exemplar/ experimental prototype in community urgent care	Level of difficulty and complexity to deliver whole scale change and transition from current state to radically different future state, with multiple internal and external interdependencies AND Potential unintended /undesirable impacts in relation to changes in system utilisation and associated system flow (cross reference to full IA) AND is subject to cross-system /partner agreements and changes in contracts and financial flows AND requires major changes / reuse / reconfiguration in estate utilisation and associated workforce deployment / organisational change AND has complex interdependencies for support services and digital / information infrastructure AND Does not necessarily fully enable improvements in quality / performance / experience and outcomes (as model is novel and untested)	Potential for radically new and innovative ways of collaborating on a whole scale Potential to attract benefits associated with vanguard / experimental prototype approaches AND potential for clinical /professional development associated with wholescale change AND radical potential for innovation /use of technology as part of whole scale model change AND radical potential for partnership development across sectors including independent / third	Potential system and partner impacts given whole scale change /transition from current to future state, with complex interdependencies AND current pressure / frequent escalation statuses AND complexity of alignment between and across multiple external programmes / provider developments (cross reference to Strategic Change report) AND is subject to major estate / capital reuse/ reconfiguration /development AND is subject to significant digital development AND changes in site locations will be sensitive, particularly where other external change applies AND potential limitations to collaboration with providers / partners (Wales and Cross Border) not aligned to radical approach AND potential impacts on contractors AND may not positively / could detrimentally impact on existing pattern of commissioned services and activity (Wales and England)

SWOT Analysis – Urgent Care options Slide 2 of 3

Urgent Care Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
001c: Do Minimum: Refine local Urgent Care (3 x MIUs in Powys)	Potential to improve locally, the way that urgent care is delivered AND improve local systems and processes	Some of the multiple, complex and interlinked issues as set out in Case for Change would remain (particularly where these are driven by wider system issues that a local improvement cannot address); AND change in site usage/ diagnostics equipment requires change for both users and workforce AND issues particular to the site choice, ie. pattern of access /associated travel/ distances	Potential for further collaboration /improvement /value in use of resources, to support further opportunities for pathway and service redesign/ use of technology	Min range changes do not fully respond to whole system challenges relating to urgent care AND changes in site locations will be sensitive, particularly where other external change applies (cross reference to Strategic Change report)
010: Do Mid Range: Better local Urgent Care (3 x MIIUs in Powys)	As for option 001c AND stronger alignment with some parts (but not all) national /local strategy AND heads in direction of the Vision and Model for Physical and Mental Health for Powys/ and the Service Level Model for Community based urgent care AND heads towards direction for the longer-term Social Model / Whole System Prevention approach	As above AND issues of deliverability in relation to estate /equipment and associated infrastructure inc. digital	Potential for further collaboration /improvement /value in use of resources, to support further opportunities for pathway and service redesign/ use of technology AND potential for clinical /professional/ partnership development across sectors including independent /third And potential for greater alignment with national / local strategy and national / regional external change and programmes (across urgent care and diagnostics/ digital) AND as it is heading in the direction of the longer term Vision and Models for Physical and Mental Health, has potential to also support longer term Social Model and Whole System Prevention approach	As above AND Mid range changes do not fully respond to whole system challenges relating to urgent care AND potential limitations to collaboration with providers /partners who have preferences for sites that would no longer be used and/or difficulties in adapting their staff deployment to changes in sites And potential impacts on contractors

SWOT Analysis – Urgent Care options Slide 3 of 3

Urgent Care Options	Strengths INTERNAL	Weaknesses INTERNAL	Opportunities EXTERNAL	Threats EXTERNAL
013: Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU)	Potential to significantly transform the way that urgent care is delivered Potential for stronger alignment with some parts (but not all) national / local strategy Potential to become a vanguard / exemplar/experimental prototype in community based urgent care	Level of difficulty and complexity to deliver change and transition from current state, with multiple internal and external interdependencies AND Potential unintended /undesirable impacts in system utilisation and flow (cross reference to full IA) AND requires major estate changes /reuse / reconfiguration/ capital development AND associated workforce deployment / organisational change AND has complex interdependencies for support services and digital infrastructure AND Does not necessarily fully enable improvements in quality /performance / experience and outcomes (as model is novel and untested – and evidence base does not strongly support benefits realisation)	Potential for new and innovative ways of collaborating AND potential for clinical /professional development associated with change AND potential for innovation /use of technology as part of model AND potential for partnership development across sectors including independent /third	Potential system and partner impacts given complex interdependencies /system pressures / escalation statuses AND complexity of alignment across multiple external programmes /providers (cross reference to Strategic Change report) AND subject to major estate /capital reuse/ reconfiguration /development AND subject to digital development AND changes in sites will be sensitive, particularly where other change applies AND potential limitations to collaboration with providers /partners AND potential impacts on contractors AND may not positively / could detrimentally impact on existing pattern of commissioned services and activity (Wales and England)

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Better Together

Adult Physical and Mental Health NHS Community Services

Travel Time Analysis Report

Version 0.5



Contents

1. Introduction 5
1.1 How this analysis should be interpreted 5
2. Travel Time Benchmarks and Evidence Base 6
2.1 Primary Care (General Practitioners (GP's), pharmacies, routine services) 6
2.2 Community & Intermediate Care (rehabilitation, step-up/down, palliative care) 6
2.3 Specialist and Acute Hospital Services (e.g. A&E, Urgent Care) 6
2.4 Mental Health Services 7
3. Planning Principles 7
3.1 Design Principles 7
3.2 Alignment to Local Authority Place-Based Planning Principles 8
4. Travel Time Analysis 9
4.1 Methodology 9
4.1.1 Public Transport Based Travel 10
4.2 Travel Time Modelling Results 11
4.2.1 Scope, limitations and interpretation 11
4.2.2 Mental Health 12
4.2.3 Urgent Care Centres 29
4.2.4 Physical Health 35
5. Summary of Analysis 42
5.1 Mental Health 43
5.2 Urgent Care 44
5.3 Physical Health 46
6. Mitigation 49
6.1 Purpose of mitigation analysis 49
6.2 Cross-cutting community model assumptions 49
6.3 Physical Health mitigation 50
6.4 Urgent Care mitigation 51
6.5 Mental Health mitigation 52
6.6 Residual risk 53
6.7 Summary of mitigation, dependencies and residual access risk 54
7. References ..... **Error! Bookmark not defined.**
8. Appendices 55
Appendix A – Travel Time Dashboard Methodology 55

Version control

Version	Date	Lead Author	Summary of Changes	Status	Approver
v0.1	-	[LC]	Initial draft of Travel Time Analysis Report	Draft	N/A
v0.2	-	[LC]	Updated modelling outputs and narrative following internal review	Draft	N/A
v0.3	[18.09.2025]	[LC]	Revised analysis aligned to options appraisal and inclusion of additional service configurations	Draft	N/A
v0.4	[24.03.2026]	[LC, AM]	Updated following HICO feedback, including strengthened quantitative analysis, compliance with travel time standards, and enhanced mitigation narrative	Draft	N/A
v0.5	[03.07.2026]	[LC]	Final draft for PCBC submission, including updated Section 5 and Section 6 and alignment to Service Level Models of Care	Final Draft	[Insert approver]

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This report is a technical supporting analysis for the Pre consultation Business Case. It provides a consistent car-based assessment of travel time to PTHB hospital sites under a range of service configuration options. It is not intended to provide a complete assessment of future access to care, because it does not model public transport, out-of-county access, non-hospital community settings, or the reduction in hospital-based demand expected from the future community model.

The results should be interpreted alongside the Strategic Demand and Capacity Modelling Report, which sets out the assumptions for community rehabilitation, reablement, virtual wards, Hospital at Home, urgent community response, enhanced urgent care and mental health community pathways. These mitigations may reduce the number of people required to travel to hospital-based services, but they depend on workforce, clinical oversight, social care, digital infrastructure and partner delivery.

The travel time analysis therefore identifies access risk before community mitigation is applied. The Pre consultation business case should use this analysis to understand where residual access, equality and transport risks remain and where further mitigation, transport planning or community model specification is required.

1. Introduction

The travel time analysis and associated planning principles presented in this report are a core component of Better Together, which aims to transform health and care services in Powys through collaborative, evidence-based approaches. By applying national and international benchmarks for service accessibility, and moving towards place-based planning, Better Together aims to ensure that service redesign is shaped around the needs and strengths of local communities. The principles outlined here directly support the ambition to deliver equitable, sustainable, and person-centred care, enabling Powys Teaching Health Board and its partners to make informed decisions that improve outcomes for all residents and make best use of resources. It is important to note that the analysis does not include travel times for patients currently accessing services outside of the county nor does it account for the alternative offer in a future model of care (i.e. community-based services or alternatives to admission), these elements are discussed in section 6 in relation to mitigation. The purpose of this analysis and report is to support the options development process, limitations and further work to be undertaken to support a pre-consultation business case and any future decisions are recognised.

1.1 How this analysis should be interpreted

This report provides a technical assessment of travel times to PTHB hospital-based sites under a range of service configuration options. It is intended to support the Pre-Consultation Business Case by showing the relative travel impact of different options using a consistent car-based methodology. The analysis should not be interpreted as a complete assessment of future access to care, because it does not model the full effect of proposed community-based alternatives to hospital attendance or admission.

Several Better Together options are predicated on a shift from hospital-based provision towards strengthened community pathways, including urgent community response, virtual wards,

Hospital at Home, community rehabilitation and reablement, Sanctuary provision, and integrated physical and mental health pathways. These mitigations may reduce the number of people who need to travel to hospital-based services, but they are not quantified within this travel time analysis.

The analysis should therefore be read as a baseline assessment of access to site-based services for those people who continue to require hospital-based care under each option. It should be considered alongside the Strategic Demand and Capacity Modelling Report, workforce modelling, financial appraisal, Integrated Impact Assessment and service model descriptions.

2. Travel Time Benchmarks and Evidence Base

The evidence-based travel time benchmarks and planning principles guiding service configuration in Phase 1 of Better Together (comprising adult physical and mental health community services, are detailed below. These were tested through Clinical and Professional workshops held in May 2025 and Deliberative events in 2025. Further consideration was given to the Urgent Care travel time principles and evidence based in April 2026 following feedback from HICO Ltd on Integrated Impact Assessment development and ahead of a non-financial appraisal session of urgent care options. The Urgent Care Task & Finish, Options Development Group, Clinical Leads and Senior Responsible Officer agreed that both a 45-minute and 60-minute principle would be applied to analysis, recognising the urgent care offer both community and emergency care elements. This version of the report has therefore been updated to reflect this:

2.1 Primary Care (General Practitioners (GP's), pharmacies, routine services)

Standard: ≤30 minutes by car or ≤60 minutes by public transport.

Evidence: NHS England's Core20PLUS5 framework, the Inverse Care Law, and Scottish Government studies show that travel beyond 30 minutes reduces attendance and increases missed appointments, especially for older and lower-income populations (NHS England, 2022; Hart, 1971; Scottish Government, 2018)

2.2 Community & Intermediate Care (rehabilitation, step-up/down, palliative care)

Standard: ≤45 minutes by car.

Evidence: Reviews by the King's Fund, Welsh Government's Intermediate Care Fund, and RAND Europe highlight the need for local access within 30–45 minutes to support early discharge and community-based admissions (King's Fund, 2018; Welsh Government, 2019; RAND Europe, 2020).

2.3 Specialist and Acute Hospital Services (e.g. A&E, Urgent Care)

Standard: ≤ 60 minutes by car for emergency care

Evidence: NHS "Golden Hour" Principle: Best outcomes in trauma/stroke/MI within 60 minutes of onset to treatment (NCEPOD, NICE, RCP). National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Longer than 60-minute travel time for critical illness is associated with worse outcomes in rural areas. Rural Health Policy Institute (UK, 2019): Travel >60 min for urgent care linked to delayed access, higher readmission. NHS England Urgent Care Strategy and WAST standards (Wales) define 60-minute access as a key metric for equitable urgent care.

2.4 Mental Health Services

Standard: ≤45 minutes for routine care, ≤60 minutes for crisis response.

Evidence: Royal College of Psychiatrists and National Rural Mental Health Survey recommend crisis teams and Children & Adolescent Mental Health Services (CAMHS) hubs be reachable within 60 minutes to prevent escalation, with long travel times being a barrier to continuity of care in rural areas (RC Psych, 2021; National Rural Mental Health Survey, 2018)

3. Planning Principles

3.1 Design Principles

As part of our work to develop options for adult physical and mental health community services we developed a set of Design Principles. These principles recognise that when we design services, we need to consider how best to deliver them in the rural environment of Powys. This includes deciding whether they can be provided at a person's home, at a locality level, within Powys at a regional level, or need to be provided outside the county.

Service Location	Description
Home	Services delivered safely and effectively in people's homes, including staff visits, online/telephone support, and self-management tools.
Locality / Community	Services available locally within one's community.
Powys Region / Cluster (see section 3.2)	Services provided at a regional level within Powys, often requiring specialist equipment and staff in a single location serving a larger population.
Once for Powys	Specialised services delivered within the county, typically from one central location or team.
Outside the County	Some services cannot be safely delivered within Powys due to its rural and sparsely populated nature.

The principles we set as we design services for the future are that we will:

- Listen to the people of Powys about what matters to them at each level to inform our planning.
- Use data and evidence to make sure we are addressing the most important needs of people in Powys at each level.

- Use digital tools to improve access to services where appropriate. We will also work to make sure people can use them and feel comfortable.
- Design services in ways that are based on clinical need, are sustainable and use money and resources wisely.
- Aim to minimise impact on travel but need to balance this with the ability to deliver safe services.

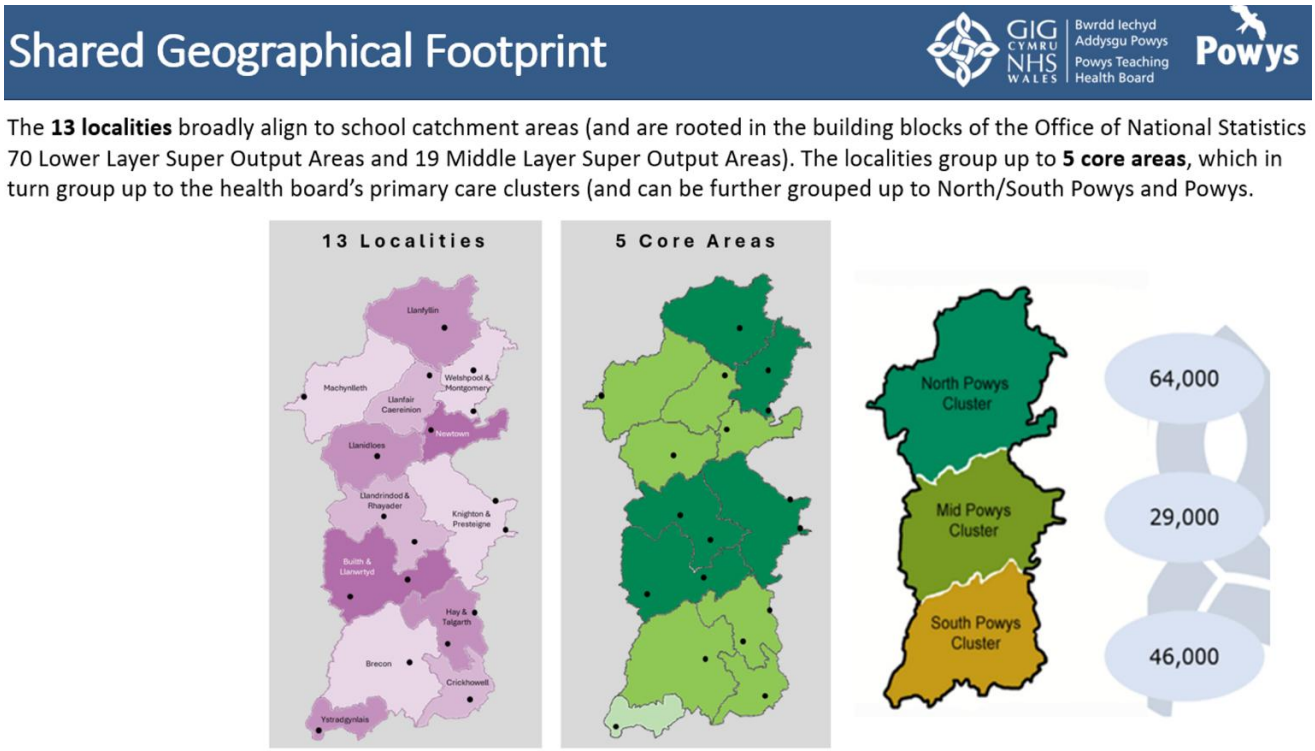
3.2 Alignment to Local Authority Place-Based Planning Principles

Powys is divided into 13 localities by Powys County Council, grouped into five core areas, each served by a hub

Public and community transport should align localities to these hubs. Powys County Council has a 7-year transport strategy in place from 2025.

Powys Teaching Health Board currently provides its services across all levels described in section 1.3. Primary Healthcare services (e.g. General Practice, Community Optometry, Community Pharmacy etc) are arranged and administered in Regions or 'Clusters'. Until 2026 this was 3 clusters (North, Mid, South) but is now in 2 clusters (North and Mid/South).

The maps below show how the locality, hub and primary care cluster footprints align to support planning. Population numbers per cluster are also outlined.



4. Travel Time Analysis

4.1 Methodology

An analysis project was completed by PTHB to understand the travel times required for the residents of Powys to access our PTHB hospitals. The project also modelled the impact of site utilisation hypotheses upon travel times.

The project's brief required:

- Travel times from domestic dwellings in Powys, to the 10 existing PTHB hospital sites in Powys
- An agreed standard set of high-level services to be considered at each site (with each service categorised as present or absent at each site), as input to service-specific scenarios
- The analysis to use the road transport network in and associated with travel around Powys, for members of the public travelling by personal car use

The key input datasets used within the analysis were:

- Domestic dwellings – this allowed modelling of over 73,000 domestic dwellings in Powys within over 69,000 domestic properties, i.e. allowing for properties featuring occupation by multiple dwellings / households. This included identifying dwellings across a range of category types (e.g. houses, flats, permanent static caravans, care homes etc.), and filtering out non-domestic properties
- PTHB Hospital sites and their high-level services – this represented the 10 main PTHB sites across Powys, listed as follows:
    - Victoria Memorial Hospital, Welshpool (Welshpool Hospital)
    - Bro Ddyfi Hospital, Machynlleth (Machynlleth Hospital)
    - Montgomeryshire County Infirmary, Newtown (Newtown Hospital)
    - Llanidloes War Memorial Hospital
    - Knighton Community Hospital
    - Llandrindod Wells Memorial Hospital
    - Glan Irfon Health and Care Centre, Builth Wells
    - Bronllys Community Hospital
    - Breconshire War Memorial Hospital, Brecon (Brecon Hospital)
    - Ystradgynlais Community Hospital
- The road transport network in Powys county and the nearby surrounding area
- Road travel navigation restrictions (e.g. one-way roads, turn restrictions etc.)
- Average travel speeds (where data coverage allowed) and speed limits on roads
- Restrictions for weight-limited weak roads (where relevant for modern-day cars)

The project used Geographic Information Systems (GIS) to calculate travel times - a standard approach in this specialism.

Travel times were calculated based upon members of the public travelling by personal car use. Travel was modelled on the basis of a 'Monday to Friday, 07:00am to 09:00am' time reference window for car travel conditions and traffic-related road speeds. This allowed for conditions representing the busiest time of day for traffic on the roads (the morning commuting 'rush hour'). This does not mean that all travel will occur within this two-hour window. The approach simply uses the travel conditions from this time window to apply within the travel modelling, for any length of journey. This therefore allows for busy road conditions as found during real-world travel.

Road speed limits and, where data coverage allowed, average recorded 'actual' travel speeds on roads (i.e. allowing for traffic – and where possible specific to the above time window conditions) were used within the analysis. Road navigation restrictions were also applied in travel routing calculations (e.g. one-way, 'No left turn', 'No right turn', 'Left turn only', 'Straight-on only', transport-mode-specific access restrictions etc.). Weak roads' weight limits were also accounted for, for the small number of roads where this may apply to modern-day cars and their navigation options.

The modelled travel times were for outbound journeys from dwellings to hospital sites. Travel time may of course be slightly different for outbound and return journeys due to e.g. one-way systems and traffic flows. Parking time, walked time from parked car to hospital door, and travel impacts from variable aspects such as roadworks, temporary road closures, higher / lower than average levels of traffic etc. are not included in travel times.

200 of the over 73,000 dwellings identified (0.27%, i.e. a very small proportion) were not able to have travel times modelled, due to different technical issues relating to their unusual contexts. As 99.73% of identified dwellings were included, this should not affect interpretation of overall presented results in any meaningful way.

The travel time analysis does not currently allow for (1) patients living outside Powys travelling into Powys, (2) travel to non-hospital healthcare sites in Powys (e.g. GP Practices), or (3) travel to hospital sites outside of Powys (which may be closer). Whilst the third point is a limitation of the current round of analysis, the analysis still offers a valuable assessment of travel times to PTHB-provided services within Powys, without reliance upon external services. Nonetheless, the aspect of travel to hospital sites outside of Powys is due to be further considered in a later round of analysis, to expand the considerations of the overall analyses.

4.1.1 Public Transport Based Travel

Additional modelling of travel times using public transport (e.g. bus) was considered. However, this would require a materially different analytical approach, including incorporation of live timetable data, interchange assumptions, walking distances, journey timing, service frequency, and evening and weekend availability. The time and resource required to restructure the modelling and re-run the analysis were not proportionate at this stage of options development. Public transport modelling has therefore not been undertaken within this version of the report, although further analysis will be undertaken for final shortlisted options to inform decision-making.

The analysis is instead based on car travel, which represents the dominant mode of transport within Powys. According to the 2021 Census, 86.9% of households had access to at least one car or van. Applying broader national travel patterns suggests that approximately 87% of households have access to a private vehicle (including cars, vans or motorcycles), indicating that private transport is the primary means of accessing healthcare across the county.

It is recognised, however, that a proportion of the population rely on public transport as their main means of travel. For these individuals, access to services may differ materially from that shown in the car-based modelling. The current analysis should therefore be interpreted as providing a comparative assessment of relative travel time between hospital sites, rather than an absolute representation of access for all transport users.

For the purposes of the PCBC, the car-based model provides a consistent and robust basis for comparing options. However, it does not constitute a full assessment of accessibility or equality impacts. Further public transport analysis will be undertaken for shortlisted options, focusing on route availability, service frequency, interchange requirements, same-day return feasibility, evening and weekend provision, and the impact on populations without access to private transport.

4.2 Travel Time Modelling Results

The results of the travel time modelling for a range of site utilisation scenarios are presented in the tables within the following sub-sections. Analysis has been undertaken across all 27 options shortlisted for non-financial and financial appraisal. Further travel time analysis will be completed on the final shortlisted options following the appraisal process to support consultation and decision-making.

How to interpret the results

- **Current**: Shows the number of households currently within a specified travel time of existing PTHB sites providing the service.
  For example, 48,274 households are currently within 0–15 minutes of a PTHB physical health inpatient ward.
- **Model**: Shows the number of households that would fall within the same travel time band under the proposed option.
- **Mean Travel Time**: Shows the average journey time (hours, minutes and seconds) for households to reach a relevant PTHB site, under both current provision and the proposed model.

4.2.1 Scope, limitations and interpretation

The modelling is based on travel by private car from Powys domestic dwellings to PTHB hospital sites, using a standardised GIS approach. This incorporates road network assumptions (including speed limits, routing restrictions and, where available, average speeds) and applies a weekday 07:00–09:00 time window to reflect busy travel conditions.

The analysis does not include:

- public transport journeys;
- community transport, ambulance, taxi or voluntary transport journeys;
- access to out-of-county sites that may be geographically closer for some residents;
- out-of-county residents travelling into Powys;
- travel to non-hospital settings (e.g. GP practices, community hubs or third sector provision);
- parking, walking distances to clinical areas, site accessibility or waiting times;
- the effect of future community-based care pathways that may reduce the need to travel.

These limitations are material to interpretation of the outputs. The analysis provides a robust and consistent comparative assessment of access to PTHB hospital-based services, but it does not represent the full patient, carer or staff experience. It does not reflect how access may change where future models reduce reliance on hospital attendance through strengthened community provision.

The results should therefore be interpreted as a comparative assessment of site-based access, rather than a complete assessment of overall accessibility under future service configurations.

4.2.2 Mental Health

For clarity, the following provides definitions of both organic and functional mental health, as these terms are used throughout the report. The travel time analysis has been undertaken to capture changes in travel time associated with these different patient cohorts as there is variability in where they would access care in the future between the shortlisted options:

Inpatient Organic Mental Health provides care and treatment within a therapeutic environment for patients with dementia with challenging behaviours, reversible delirium and complex psychosocial needs. **Organic mental health** refers to mental health conditions caused by a physical or physiological injury or illness, rather than purely psychological or functional causes. e.g. dementia and acquired brain injury.

Inpatient Functional Mental Health provides care and treatment within a therapeutic environment for patients experiencing acute exacerbation of functional mental health condition. **Functional mental health** includes conditions where cause not clearly attributable to a structural or biological brain abnormality. Conditions are often characterised by a group of symptoms which can significantly impact ability to function in daily life. E.g. bipolar disorder, anxiety disorders, depression.

Tables **1a** and **1b** below show the travel time analysis for option SL MHDO_002_001a: Do Previous. Table 1a shows travel time for older adult services for functional and organic patients, Table 1b illustrates zero change in travel time for adult functional patients.

Table 1 a - Mental Health – Do Previous			
Option	Travel Times (mins)	Current	Model
SL MHDO_002_001a: Do Previous (Llandrindod, Bronllys, Brecon (before Crug Ward temporary closure) and Ystradgynlais) (Crug Ward, Brecon was re-opened). No change to outpatients and community services. Older Adult functional and organic	0-15	18088	18088
	>15-30	15169	15169
	>30-45	13678	13678
	>45+	26601	26601
Mean current travel time	00:37:22		
Mean Model travel time	00:37:22		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	63.8%		
Change	0.0%		
Current includes: Llandrindod Wells, Brecon and Ystradgynlais. (Bronllys excluded due to being adult functional) Model includes: Llandrindod Wells, Brecon and Ystradgynlais.			

Table 1b - Mental Health – Do Previous			
Option	Travel Times (mins)	Current	Model
SL MHDO_002_001a: Do Previous (Llandrindod, Bronllys, Brecon (before Crug Ward temporary closure) and Ystradgynlais) (Crug Ward, Brecon was re-opened). No change to outpatients and community services. Adult Functional	0-15	3516	3516
	15-30	12780	12780
	30-45	8809	8809
	45+	48431	48431
Mean current travel time	01:05:21		
Mean model travel time	01:05:21		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	34.1%		
Model	34.1%		
Change	0.0%		
Current includes: Bronllys open Model includes: Bronllys open			

Tables **2a** and **2b** below show the travel time analysis for option SL MHDO_002_001b. Table 2a shows travel time for older adult services for functional and organic patients, table 2b for adult functional patients. Both tables show zero change in travel time.

Table 2a - Mental Health – Do Current			
Option	Travel Times (mins)	Current	Model
SL MHDO_002_001b: No Transformational Change: Keep current inpatient and community mental health services as they are now (Crug Ward, Brecon remains closed) Older Adult functional and organic	0-15	10877	10877
	15-30	7287	7287
	30-45	21977	21977
	45+	33395	33395
Mean current travel time	00:43:49		
Mean model travel time	00:43:49		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	54.6%		
Model	54.6%		
Change	0.0%		
Current includes Llandrindod Wells & Ystradgynlais Model includes Llandrindod Wells & Ystradgynlais			

Table 2b - Mental Health – Do Current			
Option	Travel Times (mins)	Current	Model
SL MHDO_002_001b: No Transformational Change: Keep current inpatient and community mental health services as they are now (Crug Ward, Brecon remains closed) Adult Functional	0-15	3516	3516
	15-30	12780	12780
	30-45	8809	8809
	45+	48431	48431
Mean current travel time	01:05:21		
Mean model travel time	01:05:21		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	34.1%		
Model	34.1%		
Change	0.0%		
Current includes: Bronllys open Model includes: Bronllys open			

Tables **3a, b, c, d** below show the travel time analysis for option SL MHDO_003a. These tables illustrate changes in travel time for older adult organic patients (Table 3a), adult & older adult functional patients (Table3b), adult functional patients (Table 3c) and older adult functional (Table 3d).

Table 3a - Mental Health – Do Minimum			
Option	Travel Times (mins)	Current	Model
SL MHDO_003a: Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services Older Adult organic	0-15	10877	4967
	15-30	7287	662
	30-45	21977	4344
	45+	33395	63563
Mean current travel time	00:43:49		
Mean model travel time	01:40:43		
Change	00:56:54		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	54.6%		
Model	13.6%		
Change	-41.0%		
Current includes Llandrindod Wells & Ystradgynlais Model includes: Ystradgynlais			

Table 3b - Mental Health – Do Minimum			
Option	Travel Times (mins)	Current	Model
SL MHDO_003a: Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services Adult & Older Adult Functional	0-15	14393	3516
	15-30	18185	12780
	30-45	14353	8809
	45+	26605	48431
Mean current travel time	00:38.06		
Mean model travel time	01:05:21		
Change	00:27:15		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	34.1%		
Change	-29.7%		
Current includes: Bronllys, Llandrindod Well, Ystradgynlais Model includes: Bronllys			

Table 3c - Mental Health Do Minimum			
Option	Travel Times (mins)	Current	Model
SL MHDO_003a: Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services Adult Functional	0-15	3516	3516
	15-30	12780	12780
	30-45	8809	8809
	45+	48431	48431
Mean current travel time	01:05:21		
Mean model travel time	01:05:21		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	34.1 %		
Model	34.1%		
Change	0%		
Current includes: Bronllys, Model includes: Bronllys			

Table 3d - Mental Health – Do Minimum			
Option	Travel Times (mins)	Current	Model
SL MHDO_003a: Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services Older Adult Functional	0-15	10877	3516
	15-30	7287	12780
	30-45	21977	8809
	45+	33395	48431
Mean current travel time	00:43:49		
Mean model travel time	01:05:21		
Change	00:21:32		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	54.6%		
Model	34.1%		
Change	-20.5		
Current includes: Llandrindod Well, Ystradgynlais Model includes: Bronllys			

Tables **4a, b, c, d** below show the travel time analysis for option SL MHDO_004a. These tables illustrate changes in travel time for older adult organic patients (Table 4a), adult & older adult functional patients (Table 4b), adult functional patients (Table 4c) and older adult functional (Table 4d).

Table 4a - Mental Health – Do Mid Range			
Option	Travel Times (mins)	Current	Model
SL MHDO_004a: Do Mid Range: Functional beds to Brecon + integrated OAMH community Adult & Older Adult Functional	0-15	10877	4967
	15-30	7287	662
	30-45	21977	4344
	45+	33395	63563
Mean current travel time	00:43:49		
Mean model travel time	01:40:43		
Change	00:56:54		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	54.6 %		
Model	13.6%		
Change	-41.0%		
Current includes: Llandrindod Wells & Ystradgynlais Model includes: Ystradgynlais			

Table 4b - Mental Health – Do Mid Range			
Option	Travel Times (mins)	Current	Model
SL MHDO_004a: Do Mid Range: Functional beds to Brecon + integrated OAMH community Adult & Older Adult Functional	0-15	14393	7211
	15-30	18185	8643
	30-45	14353	9707
	45+	26605	47975
Mean current travel time	00:38.06		
Mean model travel time	01:07:30		
Change	00:29:24		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8 %		
Model	34.8%		
Change	-29.0%		
Current includes: Bronllys, Llandrindod Wells, Ystradgynlais Model includes: Brecon			

Table 4c - Mental Health – Do Mid Range			
Option	Travel Times (mins)	Current	Model
SL MHDO_004a: Do Mid Range: Functional beds to Brecon + integrated OAMH community Adult Functional	0-15	3516	7211
	15-30	12780	8643
	30-45	8809	9707
	45+	48431	47975
Mean current travel time	01:05:21		
Mean model travel time	01:07:30		
Change	00:02:09		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	34.1%		
Model	34.8%		
Change	0.7%		
Current includes: Bronllys Model includes: Brecon			

Table 4d - Mental Health – Do Mid Range			
Option	Travel Times (mins)	Current	Model
SL MHDO_004a: Do Mid Range: Functional beds to Brecon + integrated OAMH community Older Adult Functional	0-15	10877	7211
	15-30	7287	8643
	30-45	21977	9707
	45+	33395	47975
Mean current travel time	00:43:49		
Mean model travel time	01:07:30		
Change	00:23:41		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	54.6%		
Model	34.8%		
Change	-19.8%		
Current includes: Llandrindod Wells, Ystradgynlais Model includes: Brecon			

Tables 5-8 each represent the change in travel time for all patients per Do Maximum option, with one table per option.

Table 5 - Mental Health – Do Maximum			
Option	Travel Times (mins)	Current	Model
SL MHDO_006a: Do Maximum: All beds to Bronllys + integrated OAMH community	0-15	14393	3516
	15-30	18185	12780
	30-45	14353	8809
	45+	26605	48431
Mean current travel time	00:38.06		
Mean model travel time	01:05:21		
Change	00:27:15		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	34.1%		
Change	-29.7%		
Current includes: Bronllys, Llandrindod Wells, Ystradgynlais Model includes: Bronllys			

Table 6 - Mental Health – Do Maximum			
Option	Travel Times (mins)	Current	Model
SL MHDO_007a: Do Maximum: All beds to Brecon + integrated OAMH community	0-15	14393	7211
	15-30	18185	8643
	30-45	14353	9707
	45+	26605	47975
Mean current travel time	00:38.06		
Mean model travel time	01:07:30		
Change	00:29:24		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	34.8%		
Change	-29.0%		
Current includes: Bronllys, Llandrindod Wells, Ystradgynlais Model includes: Brecon			

Table 7 - Mental Health – Do Maximum			
Option	Travel Times (mins)	Current	Model
SL MHDO_008a: Do Maximum: All beds to Newtown + integrated OAMH community	0-15	14393	8838
	15-30	18185	12840
	30-45	14353	14034
	45+	26605	37824
Mean current travel time	00:38.06		
Mean model travel time	00:53:58		
Change	00:15:52		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	48.6%		
Change	-15.2%		
Current includes: Bronllys, Llandrindod Wells, Ystradgynlais Model includes: Newtown			

Table 8 - Mental Health - Do Maximum			
Option	Travel Times (mins)	Current	Model
SL MHDO_0010a Do Maximum: All beds to Brecon + Newtown + integrated OAMH community	0-15	14393	16049
	15-30	18185	21483
	30-45	14353	23583
	45+	26605	12421
Mean current travel time	00:38.06		
Mean model travel time	00:29:35		
Change	-00:08:31		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	63.8%		
Model	83.1%		
Change	19.3%		

Current includes: Bronllys, Llandrindod Wells, Ystradgynlais Model includes: Brecon, Newtown

4.2.3 Urgent Care Centres

Table 9 outlines the current and previous provision. There is no difference between the Do Previous and Do Current options as there is no change in site location, just in operating hours.

Table 9:

Urgent Care			
Option	Travel Times (mins)	Current	Model
001A: Do Previous 001B: Do Current	0-15	26446	26446
	15-30	30810	30810
	30-45	12797	12797
	45+	3483	3483
Mean current travel time	00:20:43		
Mean Model travel time	00:20:43		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	95.3%		
Model	95.3%		
Change	0.0%		
Current includes: Welshpool, Llandrindod Wells, Brecon, Ystradgynlais Model includes: Welshpool, Llandrindod Wells, Brecon, Ystradgynlais			

Table 10 outlines the change in travel time with a removal of provision in Ystradgynlais but with a continuation of service in Welshpool.

Table 10:

Urgent Care			
Option	Travel Times (mins)	Current	Model
001D: Do Current (on 3 sites)	0-15	26446	21479
001C: Do Minimum	15-30	30810	30530
010: Mid-Range	30-45	12797	16460
013: Do Maximum (whilst unit remains at Welshpool, and Ystradgynlais is closed)	45+	3483	5067
Mean current travel time	00:20.43		
Mean model travel time	00:23:16		
Change	00:02:33		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	95.3%		
Model	93.1%		
Change	2.2%		
Current includes: Welshpool, Llandrindod Wells, Brecon, Ystradgynlais Model includes: Welshpool, Llandrindod Wells, Brecon			

Table 11 outlines the change in travel time with a removal of provision in Ystradgynlais and moving the service from Welshpool to Newtown.

Table 11:

Urgent Care			
Option	Travel Times (mins)	Current	Model
001D: Do Current (on 3 sites)	0-15	26446	21959
001C: Do Minimum	15-30	30810	27557
010: Mid-Range	30-45	12797	17566
013: Do Maximum (when Newtown opened and Welshpool & Ystradgynlais closed)	45+	3483	6454
Mean current travel time	00:20.43		
Mean Model travel time	00:23:50		
Change	00:03:07		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	95.3%		
Model	91.2%		
Change	4.1%		
Current includes: Welshpool, Llandrindod Wells, Brecon, Ystradgynlais Model includes: Newtown, Llandrindod Wells, Brecon,			

Table 12 outlines the change in travel time with a removal of provision in Ystradgynlais and Llandrindod Wells but with a continuation of service in Welshpool.

Table 12:

Urgent Care			
Option	Travel Times (mins)	Current (dwellings)	Model (dwellings)
001Dii: Do Current (on 2 sites)	0-15	26446	15569
001Cii: Do Minimum (on 2 sites)	15-30	30810	24284
010ii: Mid-Range (on 2 sites)	30-45	12797	16440
013ii: Do Maximum (on 2 sites) (whilst unit remains at Welshpool and Ystradgynlais & Llandrindod Wells closed)	45+	3483	17243
Mean current travel time	00:20.43		
Mean model travel time	00:30:19		
Change	00:09:36		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	95.3%		
Model	76.6%		
Change	18.7%		
Current includes: Ystradgynlais, Llandrindod Wells, Welshpool and Brecon Model includes: Welshpool and Brecon			

Table 13 outlines the change in travel time with a removal of provision in Ystradgynlais and Llandrindod Wells and moving the service from Welshpool to Newtown.

Table 13:

Urgent Care			
Option	Travel Times (mins)	Current (dwellings)	Model (dwellings)
001Dii: Do Current (on 2 sites)	0-15	26446	16049
001Cii: Do Minimum (on 2 sites)	15-30	30810	21483
010ii: Mid-Range (on 2 sites)	30-45	12797	23583
013ii: Do Maximum (on 2 sites) (when Newtown opened and Welshpool, Ystradgynlais & Llandrindod Wells closed)	45+	3483	12421
Mean current travel time	00:20:43		
Mean model travel time	00:29:35		
Change	00:08:52		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	95.3%		
Model	83.1%		
Change	12.2%		
Current includes: Ystradgynlais, Llandrindod Wells, Brecon and Welshpool Model includes: Brecon and Newtown			

Table 14 includes additional analysis to include the 60 minute standard.

Table 14:

	4-Site	3-Site		2-Site	
Sites	Welshpool Llandrindod Wells Brecon Ystradgynlais	Welshpool Llandrindod Wells Brecon	Newtown Llandrindod Wells Brecon	Welshpool Brecon	Newtown Brecon
Options included	001A 001B	001D 001C 010 013	001C 010 013	001Dii 001Cii 010ii 013ii	001Cii 010ii 013ii
Mean Travel Time	00:20:43	00:23:16	00:23:50	00:30:19	00:29:35
% within 45-minutes	95.3%	93.1%	91.2%	76.6%	83.1%
% within 60-minutes	98.7%	98.7%	98.8%	96.8%	98.5%

4.2.4 Physical Health

Table 15 below analyses the impact of putting current PTHB hospital and community health services back to how they were, which is the **Do Previous 001a option**. This would mean that there would be community hospital wards at 9 hospital sites in Powys. There is no difference between the 'Current' and 'Model' as **the Do Previous option is the baseline which all other options are being considered against.**

Table 15 - Physical Health			
Option	Travel Times (mins)	Current	Model
SL IPDO_001a - Do Previous: Put current hospital and community health services back to how they were	0-15	48,274	48,274
	15-30	22,407	22,407
	30-45	2,754	2,754
	45+	101	101
Mean current travel time	00:11:56		
Mean model travel time	00:11:56		
Change	00:00:00		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	99.9%		
Change	0%		
Community hospital wards in Machynlleth, Welshpool, Newtown, Llanidloes, Llandrindod, Knighton, Brecon, Bronllys and Ystradgynlais and Reablement continuing in beds at Glan Irfon in Builth and Knighton.			

Tables 16 a, b, c consider the implications of the **Do Current 001b option**. This would involve making the previous temporary service changes permanent.

Table 16a shows the current travel times to access the Ready to Go Home Units. Under the Do Current 001b option, the two Ready to Go Home Units would be made into permanent changes.

Table 16a - Physical Health			
Option	Travel Times (mins)	Current	Model
001b: Do Current: This is for the two Ready to Go Home Units that are currently operating	0-15	48,274	7,132
	15-30	22,407	23,947
	30-45	2,754	21,577
	45+	101	20,880
Mean current travel time	00:11:56		
Mean model travel time	00:35:01		
Change	00:23:05		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	71.6 %		
Change	-28.3%		
The current travel time assumption is that patients who are Ready to Go Home would be admitted to any community hospital. The model travel time assumption is that Llanidloes and Bronllys become permanent Ready to Go Home Units and only admit patients with this clinical presentation.			

Table 16b shows the current travel times to access the Rehabilitation Units. Under the Do Current 001b option, the two Rehabilitation Units would be made into permanent changes.

Table 16b - Physical Health			
Option	Travel Times (mins)	Current	Model
001b Do current: This is for the two Rehabilitation Units that are currently operating	0-15	48,274	16,049
	15-30	22,407	21,483
	30-45	2,754	23,583
	45+	101	12,421
Mean current travel time	00:11:56		
Mean model travel time	00:29:35		
Change	00:17:39		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	83.1%		
Change	-16.8%		
The current travel time assumption is that patients who require bedded rehabilitation would be admitted to any community hospital. The model travel time assumption is that Newtown and Brecon become permanent Rehabilitation Units and only admit patients with this clinical presentation.			

Table 16c shows the current travel times to access the Community Hospital Wards. Under the Do Current 001b option, the two Ready to Go Home Units and two Rehabilitation Units would be made into permanent changes. This would mean that Machynlleth, Welshpool, Llandrindod, Brecon and Ystradgynlais would provide community hospital wards.

Table 16c - Physical Health			
Option	Travel Times (mins)	Current	Model
001b: Do Current: This is for the current sites that have PTHB Community Hospital Wards (not Ready to Go Home Units or Rehab Units)	0-15	48,274	28,742
	15-30	22,407	31,918
	30-45	2,754	12,711
	45+	101	165
Mean current travel time	00:11:56		
Mean model travel time	00:18:31		
Change	00:06:35		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	99.8%		
Change	-0.1%		
The current travel time assumption is that patients who require a community hospital inpatient ward would be admitted to any community hospital. The model travel time assumption is that only Machynlleth, Welshpool, Llandrindod, Brecon and Ystradgynlais would provide community hospital wards.			

Table 17 analyses the impact of closing the physical health inpatients wards at Llanidloes and Bronllys permanently as part of **Options 002a and 002b**. Bedded-reablement at Glan Irfon in Builth Wells, and at Knighton, would also permanently close.

Table 17 - Physical Health			
Option	Travel Times (mins)	Current	Model
002a: Do Minimum: Six sites	0-15	48,274	37,496
	15-30	22,407	27,550
	30-45	2,754	8,376
	45+	101	114
Mean current travel time	00:11.56		
Mean model travel time	00:15.32		
Change	00:03:36		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	99.8%		
Change	-0.1%		
The current travel time assumption is community hospital wards in Machynlleth, Welshpool, Newtown, Llanidloes, Llandrindod, Knighton, Brecon, Bronllys and Ystradgynlais and Reablement continuing in beds at Glan Irfon in Builth and Knighton The model travel time assumption is only to consider 6 sites, Welshpool, Newtown, Machynlleth, Llandrindod Wells, Brecon and Ystradgynlais as inpatient units			

Table 18 analyses the impact of closing the physical health inpatients wards at Welshpool, Llanidloes, Machynlleth, Bronllys and Ystradgynlais permanently as part of **Options 005a and 005b**. Bedded-reablement at Glan Irfon in Builth Wells, and at Knighton, would also permanently close.

Table 18 - Physical Health			
Option	Travel Times (mins)	Current	Model
005a: Do Mid Range: 3 sites	0-15	48,274	21,959
	15-30	22,407	27,557
	30-45	2,754	17,566
	45+	101	6,454
Mean current travel time	00:11:56		
Mean model travel time	00:23:50		
Change	00:11:54		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	91.2%		
Change	-8.7%		
The current travel time assumption is community hospital wards in Machynlleth, Welshpool, Newtown, Llanidloes, Llandrindod, Knighton, Brecon, Bronllys and Ystradgynlais and Reablement continuing in beds at Glan Irfon in Builth and Knighton The model travel time assumption is Newtown, Llandrindod Wells and Brecon only as inpatient units.			

Table 19 analyses the impact of closing the physical health inpatients wards at Welshpool, Llanidloes, Machynlleth, Llandrindod, Bronllys and Ystradgynlais permanently as part of **Options 008**. Bedded-reablement at Glan Irfon in Builth Wells, and at Knighton, would also permanently close.

Table 19 - Physical Health			
Option	Travel Times (mins)	Current	Model
008: Do Maximum: 2 sites	0-15	48,274	16,049
	15-30	22,407	21,483
	30-45	2,754	23,583
	45+	101	12,421
Mean current travel time	00:11.56		
Mean model travel time	00:29:35		
Change	00:17:39		
Target maximum travel time achieved - to nearest hospital from selected hospitals with all selected services / facilities (% of dwellings) - using 45-minute target:			
Current	99.9%		
Model	83.1%		
Change	-16.8%		
The current travel time assumption is community hospital wards in Machynlleth, Welshpool, Newtown, Llanidloes, Llandrindod, Knighton, Brecon, Bronllys and Ystradgynlais and Reablement continuing in beds at Glan Irfon in Builth and Knighton The model travel time assumption is Newtown and Brecon only as inpatient units.			

5. Summary of Analysis

This analysis assesses how different service configuration options affect household travel times across Powys for mental health, urgent care and physical health services. For each option, the distribution of households across travel time bands (0–15, 15–30, 30–45, and 45+ minutes) is compared against the current service model. Mean travel time is also calculated to provide an overall indication of impact.

The analysis focuses on access to hospital-based services and does not account for alternative models of care, including enhanced community provision or admission avoidance pathways (e.g. Sanctuary or Urgent Community Response). These factors will be considered further as options are refined and developed within the Pre-Consultation Business Case.

Interpreting travel time and household impact

Mean travel time provides a useful high-level indicator but should not be considered in isolation. Changes in the mean can mask significant impacts on specific communities, particularly where relatively small numbers of households experience substantial increases in journey time.

The results should therefore be interpreted using three measures in combination:

1. Change in mean travel time;
2. Change in the number and proportion of households within relevant travel time thresholds;
3. Change in the number of households within the longest travel time band (particularly 45+ minutes).

The critical consideration for decision-making is not only whether average journey times increase, but how many households are adversely affected and whether impacts are concentrated within particular groups or geographies, including rural communities, areas of deprivation, older populations, Welsh-speaking communities, and households with lower access to private transport. This interpretation should be read alongside the Integrated Impact Assessment.

Assessment against travel time standards

Options have been assessed against relevant travel time benchmarks by considering both:

- the proportion of households within the benchmark; and
- the movement of households into longer travel time bands.

Options that reduce the proportion of households within the benchmark should be interpreted as increasing access risk, even where overall average travel time remains within a potentially acceptable range.

For urgent care and physical health services, the 45-minute and 60-minute thresholds are used as principal comparative benchmarks. Where options result in more households exceeding

these thresholds, the implications should be considered alongside clinical benefit, service sustainability, workforce deliverability and the proposed community model.

Specific considerations for Mental Health

Mental Health results should be interpreted with additional caution due to variation in service pathways and patient cohorts, including adult functional, older adult functional and organic mental health care. Travel impacts may differ across these pathways and should therefore be considered at a cohort level, rather than solely by overall site configuration.

5.1 Mental Health

The current distributed model provides a baseline level of accessibility, with 10,877 households within 0–15 minutes, 7,287 within 15–30 minutes, and 21,977 within 30–45 minutes, resulting in 40,141 households (approximately 54.6%) within 45 minutes of a Mental Health inpatient site. 33,395 households (45.4%) are beyond 45 minutes, with a mean travel time of 00:43:49.

These results should be considered in the context of the planning standard of ≤45 minutes for routine access and ≤60 minutes for crisis response, recognising the existing geographic constraints across Powys.

Single-site models

Under single-site configurations (e.g. consolidation at Bronllys), there is a marked redistribution of households across travel time bands:

- households within 0–15 minutes reduce from **10,877 to 4,967 (–5,910)**;
- households within 15–30 minutes reduce from **7,287 to 662 (–6,625)**;
- households within 30–45 minutes reduce from **21,977 to 4,344 (–17,633)**;
- households beyond 45 minutes increase from **33,395 to 63,563 (+30,168)**;
- mean travel time increases from **00:43:49 to 01:40:43 (+00:56:54)**.

This corresponds to a reduction in households within 45 minutes from 54.6% to approximately 13.6%.

Similar patterns are observed across other consolidated and function-specific configurations, with increases in households exceeding 45 minutes (e.g. +21,826 households in combined cohort scenarios) and mean travel time increases of approximately 27–65 minutes, depending on site configuration.

Intermediate / constrained models

Options involving partial consolidation (e.g. relocation of functional beds while retaining more than one site) show:

- increases in mean travel time to approximately **01:05–01:07**;
- an increase in the number of households exceeding the 45-minute threshold relative to the current position;

These models indicate a redistribution towards longer travel time bands while retaining some level of geographic spread.

Two-site model (Brecon and Newtown)

The two-site configuration results in a different distribution of access:

- households beyond 45 minutes reduce from **26,605 to 12,421 (–14,184)**;
- households within 30–45 minutes increase to approximately **23,583**;
- mean travel time reduces from **00:38:06 to 00:29:35 (–00:08:31)**.

This corresponds to an increase in households within 45 minutes to approximately 83%, reflecting a redistribution from the longest travel time band into intermediate travel time bands.

Summary of relative impacts

Across the range of options:

- the current model provides approximately 55% of households within 45 minutes;
- single-site configurations reduce this to approximately 13–25%, with a corresponding increase in households beyond 45 minutes;
- intermediate configurations increase overall travel times and the number of households exceeding 45 minutes;
- the two-site configuration increases the proportion of households within 45 minutes to approximately 83% and reduces the number of households in the longest travel time band relative to other consolidated options.

Interpretation

The analysis demonstrates that travel times for Mental Health inpatient services vary significantly by site configuration, with differing effects on the distribution of households across travel time bands and on compliance with the 45-minute threshold.

These findings should be considered as part of a broader decision-making framework, alongside clinical model requirements, service sustainability, workforce considerations, patient pathways (including crisis response and community provision), and the Integrated Impact Assessment.

5.2 Urgent Care

The Do Previous (baseline) configuration, reflecting the existing four-site MIU network, provides broad geographic coverage, with 26,446 households within 0–15 minutes, 30,810 within 15–30 minutes, and 12,797 within 30–45 minutes, resulting in 70,053 households (approximately 95.3%) within 45 minutes of an urgent care site. 3,483 households (4.7%) are beyond 45 minutes, with a mean travel time of 00:20:43.

Compliance with the ≤60-minute standard is higher, with approximately >99% of households within 60 minutes under the baseline configuration.

Do Current / Do Previous

The Do Previous and Do Current configurations are aligned in terms of site distribution for urgent care, and therefore show no material difference in travel time performance, maintaining:

- ~95.3% of households within 45 minutes
- mean travel time of 00:20:43

3-site configurations

Two principal three-site configurations are modelled, reflecting different combinations of retained sites:

3-site option (Ystradgynlais closed)

- mean travel time increases from **00:20:43 to 00:23:16 (+00:02:33)**
- compliance within **45 minutes reduces from 95.3% to 93.1% (–2.2%)**
- approximately **98.7% of households remain within 60 minutes**

3-site option (Newtown opened; Welshpool & Ystradgynlais closed)

- mean travel time increases to **00:23:50 (+00:03:07)**
- compliance within **45 minutes reduces from 95.3% to 91.2% (–4.1%)**
- approximately **98.8% of households remain within 60 minutes**

Across both configurations, there is a redistribution from shorter travel time bands into the 30–45 and 45+ minute categories, with a modest reduction in compliance against the 45-minute threshold, while maintaining high compliance with the 60-minute standard.

2-site configurations

Two principal two-site configurations are modelled:
2-site option (Ystradgynlais and Llandrindod Wells closed)

- mean travel time increases to **00:30:19 (+00:09:36)**
- compliance within 45 minutes reduces from **95.3% to 76.6% (-18.7%)**
- approximately **96.8% of households remain within 60 minutes**

2-site option (Newtown opened; Welshpool, Ystradgynlais and Llandrindod closed)

- mean travel time increases to **00:29:35 (+00:08:52)**
- compliance within 45 minutes reduces from **95.3% to 83.1% (-12.2%)**
- approximately **98.5% of households remain within 60 minutes**

This corresponds to a redistribution of households from the 0–30-minute bands into the 30–45 and 45+ minute bands, with households beyond 45 minutes increasing from 3,483 to 12,421 (+8,938) in the Newtown two-site configuration.

Summary of relative impacts

Across the Urgent Care options:

- Do Previous / Do Current:
  - **~95.3% within 45 minutes**
  - **99% within 60 minutes**
- 3-site configurations:
  - **91.2%–93.1% within 45 minutes**
  - **~98.7%–98.8% within 60 minutes**
- 2-site configurations:
  - **76.6%–83.1% within 45 minutes**
  - **96.8%–98.5% within 60 minutes**

These results show that reductions in site numbers are associated with a progressive decrease in compliance with the 45-minute standard, while compliance with the 60-minute standard remains comparatively high across all configurations.

Interpretation

The analysis demonstrates that Urgent Care travel times vary by site configuration, with changes affecting both mean journey time and the proportion of households within the 45-minute and 60-minute thresholds.
These findings should be considered alongside clinical model requirements, including the balance between community-based urgent response, ambulatory care, and site-based provision, as well as workforce configuration, service sustainability, and the Integrated Impact Assessment.

5.3 Physical Health

The Do Previous (baseline) configuration, representing full site availability, demonstrates a high level of accessibility, with 48,274 households within 0–15 minutes, 22,407 within 15–30 minutes, and 2,754 within 30–45 minutes, resulting in 73,435 households (approximately 99.9%) within 45 minutes of a community hospital ward. 101 households (0.1%) are beyond 45 minutes, with a mean travel time of 00:11:56.

This baseline position provides near-universal compliance with the ≤45-minute travel time standard.

Do Current configurations (existing service variations)

The Do Current configurations, reflecting existing service delivery models such as Ready to Go Home Units (RTGHU), Rehabilitation Units, and variations in operating community hospital wards, show differing impacts:

- RTGHU configuration: mean travel time 00:35:01
- Rehabilitation Unit configuration: mean travel time 00:29:35
- Community hospital ward configuration (general wards):
  - mean travel time increases to 00:18:31 (+00:06:35)
  - compliance reduces marginally from ~99.9% to ~99.8% within 45 minutes

6-site model (Do Minimum)

Under the six-site configuration, there is a limited redistribution of travel times:

- households within 0–15 minutes reduce from **48,274 to 37,496 (–10,778)**;
- households within 15–30 minutes increase from **22,407 to 27,550 (+5,143)**;
- households within 30–45 minutes increase from **2,754 to 8,376 (+5,622)**;
- households beyond 45 minutes increase from **101 to 114 (+13)**;
- mean travel time increases from **00:11:56 to 00:15:32 (+00:03:36)**.

This corresponds to compliance reducing from **~99.9% to ~99.8% within 45 minutes**, representing a small redistribution into longer travel time bands.

3-site model (Do Mid Range)

Under the three-site configuration:

- households within 0–15 minutes reduce from **48,274 to 21,959 (–26,315)**;
- households within 15-30 minutes increase from **22,407 to 27,557 (+5150):**
- households within 30–45 minutes increase from **2,754 to 17,566 (+14,812)**;
- households beyond 45 minutes increase from **101 to 6,454 (+6,353)**;
- mean travel time increases from **00:11:56 to 00:23:50 (+00:11:54)**.

This corresponds to a reduction in compliance from **~99.9% to ~91.2% within 45 minutes**, reflecting a redistribution of households from shorter travel time bands into the 30–45 and 45+ minute categories.

2-site model (Do Maximum)

Under the two-site configuration:

- households within 0–15 minutes reduce from **48,274 to 16,049 (–32,225)**;
- households within 15-30 minutes reduce from **22,407 to 21,483 (-924);**
- households within 30–45 minutes increase from **2,754 to 23,583 (+20,829)**;
- households beyond 45 minutes increase from **101 to 12,421 (+12,320)**;
- mean travel time increases from **00:11:56 to 00:29:35 (+00:17:39)**.
-

This corresponds to a reduction in compliance from **~99.9% to ~83.1% within 45 minutes**, with a larger proportion of households moving into longer travel time bands.

Summary of relative impacts

Across the Physical Health options:

- **Do Previous:** ~99.9% within 45 minutes
- **Do Current (varied configurations):** ~99.8–99.9% within 45 minutes, with increased mean travel times depending on configuration
- **6-site model:** ~99.8% within 45 minutes
- **3-site model:** ~91.2% within 45 minutes
- **2-site model:** ~83.1% within 45 minutes

These results show that both service reconfiguration (Do Current) and site consolidation (option models) influence travel time, with progressively larger redistribution into longer travel time bands as the number of sites reduces.

Interpretation

The analysis demonstrates that travel times for Physical Health services vary across both current and future configurations, reflecting differences in site distribution and service function.

These findings should be considered alongside clinical model requirements, service sustainability, workforce configuration, patient pathways (including rehabilitation and step-down care), and the Integrated Impact Assessment.

6. Mitigation

6.1 Purpose of mitigation analysis

This section sets out how the travel impacts identified in this report should be interpreted alongside the proposed future models of care. The travel time analysis provides a consistent assessment of access to hospital-based services; however, it does not quantify the extent to which future service models will reduce reliance on those sites.

Across all service areas, the approved service models of care describe a fundamental shift from hospital-based activity towards integrated, community-based, and home-first care delivery, including:

- proactive prevention and population health approaches
- urgent community response and hospital-at-home models
- rehabilitation, reablement and discharge-to-recover pathways
- strengthened mental health crisis, community and recovery pathways

These models are designed to:

- reduce avoidable admissions and attendances
- enable more care to be delivered at or closer to home
- shorten length of stay and support earlier discharge

Mitigation should therefore be understood in two complementary ways:

1. Avoided travel: reduced need for hospital attendance through community, digital and outreach models
2. Improved quality and sustainability: where hospital attendance is required, consolidated services provide safer, more consistent and clinically resilient care

However, these mitigation effects are delivery-dependent and should not be assumed as automatic offsets to increased travel time.

6.2 Cross-cutting community model assumptions

The Integrated Community Service Model establishes a “home first”, person-centred and digitally enabled system built around proactive prevention and intermediate care.

Key system features include:

- Urgent Community Response (UCR): 2-hour response, 08:00–20:00, delivering assessment, treatment and stabilisation at home
- Hospital-at-Home / Digital Ward: provision of acute-level care (e.g. IV therapy, monitoring) in the home
- Rehabilitation and Reablement at Home: time-limited, MDT-delivered interventions to restore independence
- Discharge to Recover then Assess (D2RA): “home first” discharge model with post-acute assessment in the community

- Single Point of Access (SPOA): coordinated triage and referral across services
- Integrated MDT working: cross-sector collaboration with social care and third sector partners

These services operate:

- 7 days per week, with extended hours
- with advanced clinical decision-making capability in community settings
- with digital enablement and shared care records

The Demand and Capacity Modelling confirms that these benefits scale over time and depend on:

- workforce availability and skill mix
- senior clinical oversight and governance
- integration across health, social care and third sector
- digital infrastructure and interoperability

For PCBC purposes, mitigation should therefore be treated as:

planned and deliverable where evidenced, rather than assumed in full within current travel time analysis.

6.3 Physical Health mitigation

The Physical Health Service Model sets out a networked, integrated community bed-based and home-based system, designed to reduce reliance on inpatient care and prevent deconditioning.

Key mitigation mechanisms

- Step-up / step-down pathways: enabling admission to community beds or intermediate care closer to home
- Rehabilitation-led care: recovery-focused MDT support, including stroke and neurological rehabilitation
- D2RA pathways: rapid discharge with community-based assessment and care
- Hospital-at-Home and virtual wards: enabling acute care without admission
- Integrated physical and mental health care: particularly for complex and frail patients
- Enhanced MDT workforce: including ACPs, consultant therapists, and integrated nursing models
- Digital support: real-time flow management, shared records and remote monitoring

These interventions are designed to:

- reduce unnecessary admissions
- reduce length of stay
- improve discharge flow

- support recovery closer to home

Implications for travel mitigation

- Fewer patients require hospital admission → reduced travel demand overall
- Patients return home earlier → reduced repeat journeys and visiting burden
- Community hubs and outreach reduce reliance on centralised sites

Residual risks

- Patients requiring inpatient care still experience longer travel distances under consolidated options
- Carer and family travel burden
- Delivery is dependent on:
    - community workforce capacity
    - social care availability
    - reablement and rehabilitation infrastructure

6.4 Urgent Care mitigation

The Urgent Care Service Model describes a distributed, integrated system of local access points supported by home-based care and digital triage, rather than a purely site-based model.

Key mitigation mechanisms

- Integrated urgent care network ("modular model"):
    - MIU/MIIU, ambulatory care, UCC and community services
- Urgent Community Response (2-hour standard): supports patients at home
- Hospital-at-Home / Digital Ward: acute care delivered at home
- Ambulatory Care: same-day treatment without admission
- Single Point of Access (111 / SPoA): triage and redirection to appropriate services
- Enhanced diagnostics: improving local capability
- Step-up beds: avoiding ED attendance or admission

Implications for travel mitigation

- Increased proportion of patients:
    - treated at home (UCR / Hospital-at-Home)
    - treated locally (MIU / ambulatory care)
- Reduction in:
    - out-of-county ED attendance
    - unnecessary conveyance

However:

- consolidation of urgent care sites means some patients will travel further to access enhanced services
- benefits depend on:
    - diagnostic availability
    - workforce capability
    - consistent operating hours

Residual risks

- Rural and transport-dependent populations may still experience increased travel for site-based care
- Urgent care needs remain time-sensitive and unpredictable, limiting transport mitigation
- Reliance on:
    - ambulance services
    - community transport and UCR

6.5 Mental Health mitigation

The Mental Health Service Model establishes a whole-pathway approach, shifting focus from inpatient care to community, crisis and recovery models.

Key mitigation mechanisms

- Sanctuary / Safe Space provision:
    - non-admission crisis support
    - de-escalation and short-term intervention
- Crisis Resolution and Home Treatment Teams (CRHTT):
    - gatekeeping hospital admission
    - intensive support at home
- Single Point of Access (111 press 2):
    - triage and streamlined access
- Community Mental Health and Older Adult Teams:
    - wraparound, preventative and home-based care
- Integrated MDT model:
    - physical and mental health care integration
- Recovery College and peer support:
    - reducing service dependency
    - improving self-management

- Digital mental health services:
    - remote consultations
    - self-management tools

Implications for travel mitigation

- Reduced need for inpatient admission through:
    - early intervention
    - crisis support
    - community alternatives
- Increased care delivered:
    - locally
    - at home
- Greater continuity across pathways reduces repeat travel

Residual risks

- Where inpatient care is required, travel impacts remain significant, particularly under single-site models
- Carer travel burden
- Access inequalities may arise between:
    - north and south Powys
- Delivery depends on:
    - Sanctuary implementation
    - workforce (including psychology and crisis teams)
    - integration with social care and third sector

6.6 Residual risk

Where community-based mitigation is not yet fully specified, funded or operational, the travel time analysis should be treated as a prudent assessment of access risk.

Key residual risks include:

- longer journeys for patients requiring hospital-based care
- increased burden on carers and families
- reduced access for people without private transport
- reliance on low-frequency or indirect public transport
- increased workforce travel within community models

- dependency on social care and third-sector capacity
- risk of phasing mismatch, where hospital change precedes community capacity

These risks should be explicitly carried through into:

- PCBC risk register
- Integrated Impact Assessment
- workforce and financial planning
- implementation sequencing

It is also important to distinguish between reducing the need to travel and improving the feasibility of travel for those who still need site-based care. The community model may reduce hospital attendances or admissions for some people, but it does not in itself resolve public transport limitations, long journey times, low-frequency feeder routes, same-day return issues, or the travel burden for unpaid carers and families. These issues remain residual access and equality risks and should be assessed through the Integrated Impact Assessment, public transport analysis and implementation planning.

6.7 Summary of mitigation, dependencies and residual access risk

The travel time analysis should be interpreted as a site-based access assessment, while the service models describe a system-level transformation of how care is delivered.

Across all service areas, the intended model:

- reduces demand for hospital attendance
- shifts care into community and home settings
- improves clinical quality and sustainability where hospital care is required

However:

The effectiveness of mitigation is contingent on delivery. It should not be assumed to fully offset increased travel unless supported by demonstrable service capacity, workforce readiness, and operational integration.

The table below summarises how the proposed mitigations should be interpreted. The mitigations are supported by the Service Level Models of Care and, in some areas, by the Strategic Demand and Capacity Modelling Report. However, they are not directly modelled within the travel time analysis and should therefore be treated as delivery assumptions rather than measured reductions in travel time.

Workstream	Travel impact identified	Service model mitigation	Key dependency	Residual risk
Physical Health	Longer journeys to fewer inpatient sites under	Step-up/step-down pathways, D2RA, rehabilitation and reablement,	Workforce, social care capacity, reablement capacity, senior clinical	People requiring inpatient care may still travel further; carers

	consolidated options	community hospital beds, Hospital-at-Home, virtual wards, integrated MDTs and digital flow support	oversight, community bed availability	and families may face increased travel burden
Urgent Care	Longer journeys to fewer enhanced urgent care sites	MIU/MIIU/UCC network, Urgent Community Response, Hospital-at-Home/Digital Ward, ambulatory urgent care, diagnostics, SPOA/111 interface and step-up beds	Diagnostics, staffing, 08:00–20:00 coverage, escalation protocols, WAST/111 interface, transport arrangements	Public transport remains poorly aligned to time-sensitive urgent care; some communities may still rely on ambulance or out-of-county pathways
Mental Health	Significant access impact under single-site models and north/south inequality	CRHTT, 111 press 2, Sanctuary/Safe Place, older adult community model, Recovery College, peer support, digital support and integrated physical/mental health care	Sanctuary implementation, crisis workforce, psychology, community capacity, social care, third sector and conveyance arrangements	Carer travel, crisis access, north/south equity, and inpatient conveyance remain material risks

In conclusion, the travel time analysis sets out the potential access impacts associated with changes to hospital-based service locations, while the Service Level Models of Care describe a system-wide transformation that is intended to reduce reliance on those sites and deliver more care closer to home. The extent to which these models mitigate travel impacts is dependent on the timely delivery of community capacity, workforce, clinical oversight and system integration. The analysis should therefore be interpreted as a prudent assessment of site-based access risk. For PCBC purposes, the key assurance requirement is to demonstrate that the proposed mitigation is sufficiently specified, deliverable and appropriately sequenced; where this is not yet evidenced, the associated travel impacts should be retained as residual risks within the overall programme.

7. Appendices

Appendix A – Travel Time Dashboard Methodology

‘Better Together’

Non-Financial Options Appraisal Workshop for Urgent Care Summary Report

Tuesday 21st April 2026
09.00am – 12:00 pm



Contents

1. Purpose of Report 2
2. Background and Context 2
3. Approach 3
3.1. Panel 3
3.2. Facilitators 4
3.3. Appraisers 4
3.4. Options 4
3.5. Assessment Criteria 4
4. Outline Methodology (Part 1 – non-financial appraisal) 4
4.1. Assessment Criteria Weighting and Scoring 4
4.2. Supporting Information 5
4.3. Options presentation 5
4.4. Workshop evaluation 6
5. Options Scoring Outputs 7
6. Summary 9
Appendices 11
Appendix A - Option Appraisal Scoring Summary including Sensitivity 11
Appendix B – Workshop Attendees 12
Appendix C – Assessment Criteria 14
Appendix D – Scoring Framework 15
Appendix E – Summary of Shortlisted Options 16
Appendix F – Questions of Clarification and Responses 17
Appendix G – Evaluation Form and Initial Feedback Analysis 17

1. Purpose of Report

This report provides a summary of methodology, attendance, inputs and outputs of a non-financial option appraisal process undertaken on 21st April 2026 for the assessment of the Better Together, Urgent Care (including diagnostics) shortlist options.

2. Background and Context

The purpose of the workshop was for stakeholders to appraise the urgent care (inc diagnostics) short listed options for how services could be delivered in future. This was required following the introduction of new options resulting from the workforce and finance check and challenge sessions held in October 2025.

A previous non-financial appraisal workshop was held on the 11th September 25, this workshop appraised the short-listed options for future delivery of adult physical and mental health community services in Powys, this included inpatient services, urgent care, mental health and key community-based services.

The intended outcomes of both workshops was to apply further rigour to the assessment process, using the expertise of attendees to provide a higher level of confidence in the options that will be recommended to the Executive Committee and Board for public consultation.

The comprehensive options development and appraisal process is aligned with NHS Wales planning guidance and quality standards. The process has been informed by extensive engagement (Stages 1 and 2), clinical input, and multi-agency collaboration.

The current status of engagement for phase 1, adult physical and mental health community services can be summarised as follows:

Stage	Core Aim	Timeline	Status
Stage One	Pre-engagement on case for change	January to May 2025	Complete
Stage Two	Engagement on community and mental health model	May to August 2025	Complete
Stage Three	Formal consultation on community and mental health model	September 2026 to December 2027	On Schedule

Key components of the options development process preceding the options appraisal workshop are as follows:

Development of Thematic chapters for primary care, physical health community services and mental health & learning disabilities. These chapters have been used to support the development of options and have been shared with stakeholders ahead of key engagement events. They have been published on the Better Together section of the health board website.

Development of system level models of care for a Social Model for Health & Wellbeing, Integrated Community Model and Mental Health Model. These have been tested with stakeholders through the stage 2 engagement period and updated to incorporate feedback received.

Development of service level models of care for Urgent Care, Mental Health Inpatient, Physical Health Inpatient and Community Services.

Development of a Long List of Delivery Options across five service areas: Diagnostics, Urgent Care, Mental Health Inpatient, Physical Health Inpatient, and Community Services.

Application of Hurdle Criteria by the options development group to assess each option against agreed planning principles, including clinical assurance, financial and workforce impact, accessibility, digital inclusion, and stakeholder readiness. Application of the hurdle criteria was tested with the Clinical Reference Group in a check and challenge session.

Shortlisting and appraisal of Options Using the hurdle criteria, options were shortlisted. Further assessment and appraisal has included, but not been limited to:

- Alignment to evidence & standards
- Quality Impact Assessment (Level 1 & 2)
- Travel time analysis
- Demand & Capacity Modelling
- Patient pathway testing
- Workforce and financial appraisals
- Strengths, weaknesses, opportunities & threats (SWOT) analysis

The financial and non-financial appraisal of options is now being finalised. This report contains the non-financial appraisal scoring for urgent care centres & diagnostics. The outputs from this non-financial option appraisal will be considered alongside the financial and estate assessment to enable the Health Board to put forward recommended options for public consultation that address the issues highlighted within the case for change and provides a future sustainable model of care.

3.1. Panel

A panel consisting of clinical and operational leads presented the scope, issues, benefits and options for their service area. Other panel members included the Executive Director for Primary Care, Community & Mental Health services and the Executive Director for People, Culture & Transformation, who were present for the introduction and reading period to support answering questions by appraisers. The Deputy Director of Engagement, Communication and Corporate Services was also in attendance as supporting panel member. Panel members, excluding Executive Director leads for, Primary Care, Community & Mental Health and People, Culture & Transformation, were available during the appraisal process to provide further detail and answer queries.

3.2. Facilitators

The Director of Improvement and Transformation and Assistant Director of Transformation & Value acted as room facilitators. A facilitator was allocated to each table. There were three tables in-person and one virtual table, their role was as follows:

- To verify participants' understanding of the supporting information.
- To guide appraisers through the scoring process for each option in a timely and structured manner.
- To manage queries and provide clear, accurate clarification where needed, ensuring that room facilitators were made aware so that clarifying information could be shared with the room to maintain consistency.
- Encourage concise discussion during the scoring of each option against the assessment criteria.

3.3. Appraisers

A total of 25 appraisers attended the session from a cross section of internal and external senior clinicians and professionals. The full list of appraisers is provided at **appendix B**. Efforts were made to ensure depth and breadth of appraisers including external experts. Llais were invited to attend in an observing role but declined the invitation, this was to ensure consistency from the previous session held on 11th September 2025.

Appraisers were divided into 3 in-person tables of 6-8 people per table, and one virtual table with four delegates.

3.4. Options

Shortlisted options were presented on the day for Urgent Care Centres & Diagnostics. This included information on what changed, benefits, risks and trade-offs for each option. Travel time analysis was also provided for each option based on a 45 minute and 60-minute travel time principle. All this information was contained within a delegate hand out, so they had opportunity to review whilst undertaking the scoring of the options.

3.5. Assessment Criteria

Assessment criteria were based on the NHS Wales Health and Care Quality Standards of Safe, Timely, Efficient, Effective, Equitable and Person-centred (STEEEP). These criteria were shared as part of Stage 2 public engagement and at Deliberative Events in June and August 2025 for feedback. Feedback provided was incorporated into the 'guiding' questions under each domain in the assessment criteria documentation used during the appraisal workshop. The assessment criteria are included at **appendix C.**

4. Outline Methodology (Part 1 – non-financial appraisal)

4.1. Assessment Criteria Weighting and Scoring

The assessment criteria were weighted ahead of the session by the Executive team to reflect the case for change and organisational strategic priorities. This weighting was applied to the scoring of the options.

The Weighted Assessment Criteria were: Safe 30, Timely 15, Effective 20, Efficient 15, Equitable 10 and Person Centred 10.

All appraisers reviewed all options, to ensure they understood the implications across all the options and to manage inter-dependencies across the service areas.

Each appraiser assessed each option against its ability to meet the 6 quality domains. 'Guiding' questions were provided under each domain to support people to think about the most important areas under each domain.

Scoring was completed digitally. Each appraiser brought their own technology either a phone and or a laptop to access, review and score the options via a digital form. The supporting team collected live data during the workshop and fed back to table facilitators to ensure all appraisers had completed all scoring.

Each individual appraiser scored every option based on a scoring framework with a 1-5 rating (**appendix D**).

Appraiser information was captured to enable sensitivity analysis of the scoring. Sensitivity analysis, including reverse weighting, was applied to ensure robustness.

4.2. Supporting Information

The following supporting information was pre-issued by email:

- Overview of Better Together
- Better Together Case for change and Thematic technical chapters
- System models of care and associated ambitions
- Information on the options development approach and timetable
- Hurdle criteria, design principles and assessment criteria
- Summary Feedback from Engagement
- Scope, Service Issues and Service model of care for Urgent Care
- Non-financial Options Appraisal Methodology

Delegate packs were included on tables for use during the workshop and included:

- Assessment criteria
- Scoring Framework
- Shortlisted options (including information on what changed, benefits, risks and trade-offs and travel time analysis; based on a 45 minute and 60-minute travel time principle)
- Summary information from level 2 Quality Impact Assessments, Demand projections, and workforce assumptions

4.3. Options presentation

Options were presented by the Clinical Transformation Lead and Clinical Change Manager for Urgent Care. Options were presented consistently and supported by a power point presentation displaying the shortlisted options descriptions (**appendix E**).

Questions of clarification raised from appraisers were managed via the table facilitator and sent to the panel, queries and responses were recorded by the supporting team and shared with the room (**appendix F**)

4.4. Workshop evaluation

An evaluation form was completed at the end of the session by appraisers, the form and overview of initial feedback is provided at **appendix G**.

Summary of feedback (generated via co-pilot)

The evaluation feedback confirms strong confidence in the objectives, methodology and facilitation of the Options Appraisal Workshop. Participants consistently reported that the process supported informed, evidence-based decision-making, underpinned by the quality and depth of information provided. In particular, the inclusion of benefits, risks and travel-time analysis within each option, alongside structured assessment against STEEP quality dimensions, was seen as critical to objectivity and credibility.

Access to programme expertise and cross-disciplinary colleagues enabled real-time clarification and challenge, while the structured, time-limited approach helped maintain focus and momentum. Overall, participants valued the opportunity to contribute to important system-level decisions and to see tangible progress towards firming up strategic options.

Feedback also identified clear opportunities to strengthen future workshops while retaining the core approach. Recurring themes focused on the need for more time to consider and discuss a high volume of similar options, improved clarity and consistency of materials (particularly option naming, workforce descriptions and availability of supporting documents on the day), and enhancements to the scoring approach to promote greater facilitated discussion.

Participants also highlighted the importance of inclusive and accessible design, including reviewing materials through an autism-informed lens, and offering greater digital and format flexibility, such as Teams-based participation where appropriate. Together, these findings provide a clear mandate to retain the robust methodology while making targeted refinements to further improve participant experience, inclusivity and depth of deliberation in future Options Appraisal Workshops.

Overall Assessment

The workshop was unanimously successful against its stated objectives. All respondents confirmed that:

- The workshop met its objectives.
- Objectives were clear and well defined.
- Participants were satisfied with the overall experience, and the majority would recommend this approach to others.

This confirms strong confidence in the methodology, facilitation, and purpose of the workshop.

5. Options Scoring Outputs

The tables below illustrate the outputs of the appraisers scores, against all Shortlisted options, across the service area.

Urgent Care Centre – What could change on each PTHB site

PTHB Provider Services only

Ur ent Care options		Welshpool	Newtown	Machynlleth	Llandrindod	Brecon	Ystrad ynlais	General Practice
001A	Do Previous (before any tenporary service chan es on 4 units)							
001B	Do Current (continue as now on 4 units, nakin tenporary service chan es pernanent)							
001D	Do Current on 3 units (continue as now on 3 sites, nakin tenporary service chan es pernanent, close 1 site)			×			×	
001Dii	Do Current in 2 units (continue as now in 2 units, nakin tenporary service chan es pernanent, close 2 units)			×			×	
001C	Do Mininun (nake tenporary service chan es pernanent and inprove service on 3 units, close 1 unit)			×			×	
001Cii	Do Mininun in 2 units (nake tenporary service chan es pernanent and inprove service on 2 units, close 2 units)			×			×	
005	Close Minor Injury Units and provide ur ent care in other ways (close 4 units)	×		×			×	
010	Do Mid-Ran e: Better local Ur ent Care (3 : MIIUs in Powys, close 1 unit)			×			×	
010ii	Do Mid-Ran e on less sites (2 : MIIUs in Powys, close 2 units)			×			×	
013	Do Ma:inun: Even better local Ur ent Care (2 : UCCs and 1 : MIIU in Powys, close 1 unit)			×			×	
013ii	Do Ma:inun on less sites (2 : UCCs, close 2 units)			×			×	

Key	
No chan e	
Tenporary chan es reversed	
Tenporary chan es becone pernanent	
Minor Injury Unit closed pernanently	
Minor Injury Unit opens	
Minor Injury C llness centre opened	
Ur ent Care Centre opened	
Chan es to ur ent care provided throu h local GP practices	
The new unit would replace the current unit at that site	
X-ray closes	×
X-ray stays C openin hours do not chan e	
X-ray stays C lon er openin hours	
X-ray stays until new site is developed, then noves to new site	
Ultrasound	
Blood testin	
Point of Care testin	

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For Sensitivity Analysis the averages for each metric with weightings were applied, total of each metric (grey) and rank.

The non-financial option appraisal scoring for both raw scores and raw scores with sensitivity analysis applied showed that:

UCDO_013: Do Maximum: **received the highest against the assessment criteria -** *Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys).*

SL UCDO_005, Close Minor Injury Units and provide urgent care in other ways (close 4 units), received the lowest against the assessment criteria: *Close Minor Injury Units and provide urgent care in other ways*.

The do nothing 'do current' (SL UCDO_001b)- Keep current hospital and community health services as they are now i.e. hospital based minor injury service across 4 sites scored higher than the 'do previous' (SL UCDO_001a) i.e. put current hospital and community health services back to how they were.

Figure 1 - Options Appraisal Scoring Summary – Weighted and Unweighted

	Average Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	**Rank**	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	**Rank**
SL UCDO_001a	1.9	2.3	2.2	1.6	2.3	2.4	12.78	10	0.6	0.4	0.3	0.3	0.2	0.2	2.04	11
SL UCDO_001b	2.6	2.7	2.4	2.3	2.9	2.7	15.52	7	0.8	0.4	0.4	0.5	0.3	0.3	2.55	8
SL UCDO_001d	2.9	2.7	2.6	2.7	2.6	2.6	16.09	6	0.9	0.4	0.4	0.5	0.3	0.3	2.73	6
SL UCDO_001dii	2.5	2.0	2.3	2.5	1.8	2.0	13.22	9	0.8	0.3	0.3	0.5	0.2	0.2	2.30	9
SL UCDO_001c	3.1	3.0	3.0	3.0	3.0	2.9	18.00	5	0.9	0.5	0.5	0.6	0.3	0.3	3.02	5
SL UCDO_001cii	2.7	2.3	2.7	2.7	2.2	2.4	15.13	8	0.8	0.4	0.4	0.5	0.2	0.2	2.58	7
SL UCDO_005	2.0	2.0	2.2	2.0	2.0	2.2	12.35	11	0.6	0.3	0.3	0.4	0.2	0.2	2.04	10
SL UCDO_010	3.7	3.4	3.8	3.7	3.6	3.7	21.91	2	1.1	0.5	0.6	0.7	0.4	0.4	3.65	3
SL UCDO_010ii	3.4	2.9	3.3	3.4	2.6	2.9	18.43	4	1.0	0.4	0.5	0.7	0.3	0.3	3.18	4
SL UCDO_013	4.3	4.1	4.2	4.2	3.9	4.1	24.78	1	1.3	0.6	0.6	0.8	0.4	0.4	4.17	1
SL UCDO_013ii	3.8	3.4	3.9	3.8	3.3	3.6	21.83	3	1.1	0.5	0.6	0.8	0.3	0.4	3.70	2

(Please refer to section 5 where the option number and detailed descriptions are provided).

For Sensitivity Analysis the averages for each metric with weightings were applied, total of each metric (grey) and rank.

Public Weighting (Safe 30, Timely 25, Effective 10, Efficient 10, Equitable 5 and Person Centred 20)

Figure 2 - Options Appraisal Scoring Summary – Public Weighting

	Public focus (.3,.25,.1,.1,.05,.20)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	**Rank**
SL UCDO_001a	0.6	0.6	0.2	0.2	0.1	0.5	2.13	10
SL UCDO_001b	0.8	0.7	0.2	0.2	0.1	0.5	2.59	7
SL UCDO_001d	0.9	0.7	0.3	0.3	0.1	0.5	2.72	6
SL UCDO_001dii	0.8	0.5	0.2	0.3	0.1	0.4	2.24	9
SL UCDO_001c	0.9	0.8	0.3	0.3	0.1	0.6	3.01	5
SL UCDO_001cii	0.8	0.6	0.3	0.3	0.1	0.5	2.53	8
SL UCDO_005	0.6	0.5	0.2	0.2	0.1	0.4	2.05	11
SL UCDO_010	1.1	0.9	0.4	0.4	0.2	0.7	3.63	3
SL UCDO_010ii	1.0	0.7	0.3	0.3	0.1	0.6	3.12	4
SL UCDO_013	1.3	1.0	0.4	0.4	0.2	0.8	4.17	1
SL UCDO_013ii	1.1	0.8	0.4	0.4	0.2	0.7	3.65	2

(Please refer to section 5 where the option number and detailed descriptions are provided).

Reverse Weighting (Safe 10, Timely 10, Effective 20, Efficient 15, Equitable 15 and Person Centred 30)

Figure 3 - Options Appraisal Scoring – Reverse Weighting

	Reverse(.1,.1,.2,.15,.15,.3)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	**Rank**
SL UCDO_001a	0.2	0.2	0.4	0.2	0.4	0.7	2.18	9
SL UCDO_001b	0.3	0.3	0.5	0.3	0.4	0.8	2.59	7
SL UCDO_001d	0.3	0.3	0.5	0.4	0.4	0.8	2.65	6
SL UCDO_001dii	0.3	0.2	0.5	0.4	0.3	0.6	2.17	10
SL UCDO_001c	0.3	0.3	0.6	0.5	0.4	0.9	2.98	5
SL UCDO_001cii	0.3	0.2	0.5	0.4	0.3	0.7	2.51	8
SL UCDO_005	0.2	0.2	0.4	0.3	0.3	0.7	2.09	11
SL UCDO_010	0.4	0.3	0.8	0.5	0.5	1.1	3.68	2
SL UCDO_010ii	0.3	0.3	0.7	0.5	0.4	0.9	3.04	4
SL UCDO_013	0.4	0.4	0.8	0.6	0.6	1.2	4.12	1
SL UCDO_013ii	0.4	0.3	0.8	0.6	0.5	1.1	3.65	3

(Please refer to section 5 where the option number and detailed descriptions are provided).

Other sensitivity analysis included clinically focused, patient focused and equal focused, these are provided in **appendix A**

6. Summary

The top score across all sensitivity scenarios was ranked no.1:

- Urgent Care - SL UCDO_013 - Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)

Analysis of stakeholder scoring revealed a consistent pattern of high correlation between criteria, indicating that stakeholders tended to rate options similarly across all six dimensions. Correlation and sensitivity analysis demonstrated that option rankings remained stable across different weighting scenarios, with little distinction made between criteria.

As a result, it was not possible to determine which individual criterion most influenced stakeholder preference. See Rank for each scenario in **appendix A.**

Notably, there was strong stakeholder consensus on the top-ranked option, as reflected in the low variation of scores, evidencing clear agreement on the best overall choice.

Appendices

Appendix A - Option Appraisal Scoring Summary including Sensitivity

	RANK						
	Provided	Reverse	Clinical focused	Patient focused	Public focused	Equal Weighting	Average
SL UCDO_001a	11	9	10	10	11	10	10.17
SL UCDO_001b	8	7	8	7	7	7	7.33
SL UCDO_001d	6	6	6	6	6	6	6.00
SL UCDO_001dii	9	10	9	9	9	9	G.17
SL UCDO_001c	5	5	5	5	5	5	5.00
SL UCDO_001cii	7	8	7	8	8	8	7.67
SL UCDO_005	10	11	11	11	10	11	10.67
SL UCDO_010	3	2	3	3	2	2	2.50
SL UCDO_010ii	4	4	4	4	4	4	4.00
SL UCDO_013	1	1	1	1	1	1	1.00
SL UCDO_013ii	2	3	2	2	3	3	2.50

(Please refer to section 5 where the option number and detailed descriptions are provided).

Appendix B – Attendance List

Role	Workshop role
Executive Director of Primary Care, Community Services C Mental Health	Executive Director oversight (panel)
Director of Improvement & Transformation	Presenter/Roon Facilitator (panel)
Executive Director of People, Culture and Transformation	Executive Director oversight (panel)
Assistant Director of Transformation & Value	Roon Facilitator (panel)
Deputy Director Communications, Engagement and Corporate Services	Panel member
Clinical Transformation Lead, Urgent Care	Urgent Care Clinical Lead (panel)
Clinical Change Manager	Urgent Care Lead (panel)
Head of Workforce Transformation, Planning and Resourcing	Appraiser
Trade Union representative	Appraiser
Associate Director Estates, Capital & Support Services, PTHB	Appraiser
Consultant Practitioner in Infection Prevention and Control	Appraiser
Professional Head of Nursing, Community Services Group	Appraiser
Research, Innovation and Improvement Manager	Appraiser
Transformation Programme Manager	Facilitator
Head of Operations, Mental Health	Appraiser
Head of AHPs & Health Science, Community Services Group	Appraiser
Consultant in Community Frailty Medicine	Appraiser
External Appraiser - Assistant Director Si: Goals for Urgent and Emergency Care NHS Wales Performance and Improvement	Appraiser
Professional Head of Occupational Therapy	Appraiser
GP, Llanidloes	Appraiser
Senior Practitioner Primary Care	Appraiser
Transformation Programme Manager	Facilitator
Deputy Director of Therapies and Healthcare Sciences	Appraiser
GP, Mid Cluster	Appraiser
Deputy Director of People & Culture, PTHB	Appraiser

Community Services Manag er	Appraiser
Senior Manager - Unscheduled Care	Appraiser
Integ rated Clinical Tean Manager	Appraiser
Transformation Programme Mana er	Facilitator
External Appraiser (Clinical Director Community Hospitals/SAS Advocate, Care of the Elderly)	Appraiser
External Appraiser - Geriatrician and stroke physician and honorary secretary of the British Geriatrics Society	Appraiser
Clinical Director in Community Frailty Medicine	Appraiser
GP, Hay on Wye	Appraiser
Transformation Programme Manager	Facilitator
Senior Transformation Programme Manager	Technical Support
TCV Project Manager	Technical Support
Project Support Officer	Technical Support
Project Support Officer	Technical Support
Project Support Officer	Technical Support
Administration Support Officer	Technical Support
Culture, Leadership & Succession Programme Manag er 7 Facilitator	Support

Appendix C – Assessment Criteria

Part 1 Non-Financial Appraisal Methodology Assessment Criteria

(based on NHS Wales Health and Quality Care Standards)

SAFE	TIMELY	EFFECTIVE	EFFICIENT	EQUITABLE	PERSON-CENTRED
Does this option deliver against the objective we are trying to achieve in a way that promotes 'safe' care:	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'timely' and 'accessible' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'effective' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'efficient' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'equitable' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'person-centred' care:**
Please consider as a guide for your assessment the extent to which this:	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*
• supports safe clinical practice *i.e. prevents and / or reduces harm / errors*	• delivers against required access standards / performance targets (such as reduction of delays and waits)	• is underpinned by reliable data, best practice guidance and evidence-base (e.g. NICE)	• makes best use of resources to improve patient outcomes and experience, staff satisfaction and enables us to live within our means	• delivers evidence-based care across Powys but can adapt to address differences in need; positively contributing towards reducing health inequalities	• Helps people to stay healthy, building self-reliance in patients and the population
• ensures a substantive workforce model *–i.e. the workforce is available, and a robust staffing model can deliver professional standards*	• improves access to services that support people to stay at home where possible and enables timely response when needs escalate	• supports delivery of future system models of care, national and local guidance	• uses digital technology where appropriate to aid efficient care, with consideration for those not able to use technology	• reduces inequity across Powys for example through removing unnecessary differences in the way services are delivered	• provides a responsive joined-up offer that supports people to achieve 'what matters most to them' and improves patient experience outcomes
• improves staff safety including promoting a culture of safety and speaking up safely	• enables efficient transfer and discharge pathways to prevent harm to patients	• addresses existing barriers to care in the case for change such as continuity of care and communication	• is feasible and can achieve a positive impact within the short or medium term *i.e. will improve the health of the whole population or have a very significant impact on the health of a small number*	• delivers an appropriate offer for all population groups – including those with protected characteristics (not necessarily the 'same' offer but the one that delivers the best fit between those characteristics and the care provided)	• Provides access to meet healthcare needs within acceptable travel times (in line with the evidence base)

Part 1 Non-Financial Appraisal Methodology - Scoring Framework

This scoring framework is designed to support the non-financial options appraisal process.
It uses a 1–5 scale to assess how well each option meets the defined objectives or STEEEP criteria (Safe, Timely, Effective, Efficient, Equitable, Patient-centered).

Score	Descriptor	Definition
1	Does Not Meet Needs	The option fails to address the objective or STEEEP criterion. It nay introduce risks or worsen current conditions.
2	Partially Meets Needs	The option addresses the objective or criterion in a limited or inconsistent way. Significant gaps remain.
3	Adequately Meets Needs	The option meets the minimum requirement. It is acceptable but lacks enhancement or innovation.
4	Fully Meets Needs	The option clearly meets the objective or criterion with confidence. It is robust and well-aligned with expectations.
5	Exceeds Needs / Optimal Fit	The option not only meets but enhances the objective or criterion. It offers added value, innovation, or future-proofing .



Urgent Care Centre – What could change on each PTHB site

PTHB Provider Services only

Ur ent Care options		Welshpool	Newtown	Machynlleth	Llandrindod	Brecon	Ystrad ynlais	General Practice
001A	Do Previous (before any tenporary service chan es on 4 units)							
001B	Do Current (continue as now on 4 units, nakin tenporary service chan es pernanent)							
001D	Do Current on 3 units (continue as now on 3 sites, nakin tenporary service chan es pernanent, close 1 site)							
001Dii	Do Current in 2 units (continue as now in 2 units, nakin tenporary service chan es pernanent, close 2 units)							
001C	Do Mininun (nake tenporary service chan es pernanent and inprove service on 3 units, close 1 unit)							
001Cii	Do Mininun in 2 units (nake tenporary service chan es pernanent and inprove service on 2 units, close 2 units)							
005	Close Minor Injury Units and provide ur ent care in other ways (close 4 units)							
010	Do Mid-Ran e: Better local Ur ent Care (3 : MIIUs in Powys, close 1 unit)							
010ii	Do Mid-Ran e on less sites (2 : MIIUs in Powys, close 2 units)							
013	Do Ma:inun: Even better local Ur ent Care (2 : UCCs and 1 : MIIU in Powys, close 1 unit)							
013ii	Do Ma:inun on less sites (2 : UCCs, close 2 units)							

Key	
No chan e	
Tenporary chan es reversed	
Tenporary chan es becone pernanent	
Minor Injury Unit closed pernanently	
Minor Injury Unit opens	
Minor Injury C Illness centre opened	
Ur ent Care Centre opened	
Chan es to ur ent care provided throu h local GP practices	
The new unit would replace the current unit at that site	
X-ray closes	
X-ray stays C openin hours do not chan e	
X-ray stays C lon er openin hours	
X-ray stays until new site is developed, then noves to new site	
Ultrasound	
Blood testin	
Point of Care testin	

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Appendix F – Appraiser Questions and Responses (page 1 of 4)

Non-financial Options Appraisal Ur ent Care Questions s Answers 21/04/2026

(Questions and Answers before talkin about the options):

Q: SA - None of the diagnostic options include CT or MRI, which are essential imaging modalities now in most specialties and will prevent unnecessary hospital visits. Is it possible to include this?

A (RM): It's unlikely there is sufficient denand for CT/MRI at present. CT/MRI nay be a future possibility for service developnent, but further work will be undertaken on this in the dia nostics and planned care pro ranne.

Q: SE - Are we purely scoring on the service provision of each model and completely disregarding the financial cost/value at this stage?

A: CS – Yes.

Q: SE - The problem is that the "efficient" score has to incorporate an element of VFM too.

A: RM/CS – Yes correct, nakin best use of resources and noney.

1st Option 001B:

Q: SC - Question regarding colour code for GMS/Supplementary Service. What does yellow mean? White to yellow GP's Care?

A: KP - Yellow neans chan e to supplenentary services.

Q: GP GMS and supplementary services query.

A: Supplenentary service is hi hli hted in yellow; it's about location and service bein delivered. It creates capacity within GMS.

Q: Without knowing about GP service details, it can be quite difficult to answer the questions?

A: Based on population need and site/scope, we do not have universal prinary care covera e, with only 10–11 sites coverin this, dependin on scope. There is no current plan to withdraw any of the supplenentary service. Do we need to enhance uptake of this service or provide additional services to take sane-day illness denand away fron GMS?

2nd Option 001A:

A: Why did services change in the first place?

A: There was reduced activity in MIU at ni ht, denand was very low, there were lone workin challen es, and workforce requirenent.

Appendix F – Appraiser Questions and Responses (page 2 of 4)

Q: Hospital day services 2020? What were they?

A: Traditional day centre services were closed durin the pandenic; they are better captured within connunity nodels, are relatively variable, and there was no reported adverse inpact fron those closures.

3rd Option 001D: No questions asked.

4th Option 001Dii:

Q: What happens for provision from Newtown? The potential move of services to Newtown given the development of the site there.

A: The nove is not reflected in the 'Do Previous' or 'Do Current' options but is reflected in all other options novin forward and is subject to capital investnent and developnent of the north Powys Wellbein Hub.

Q: Is there significant seasons variation in demand?

A: There does not appear to be any si nificant or naterial seasonal variation inpactin activity levels.

Q: SE - Were there any figures for previous use/overnight demand?

A: CL - Yes, fi ures were included within the Case for Chan e. Nunbers were very low, with sone places/sites seein only around 3 patients per week overni ht. Additionally, there were lone workin concerns, and those patients who did present overni ht were often not in scope for MIU.

5th Option 001C:

Clarification on POC Testing:

A: Still only bein a MIU Model – there's no additional scope. Increased leadership capacity and tria e within the workforce. Additional POC Testin would be required and enbedded into the other nodels.

Appendix F – Appraiser Questions and Responses (page 3 of 4)

6th Option 001Cii:

Q: Should the 'mean travel time' for Newtown as the north site be the same as the previous page?

A: Yes, that is a typo and should read the sane as the previous pa e. The difference in values is under one ninute.

Note: For 2-site confi urations with Newtown as the north site, the correct nean travel tine is 00:29:35, with a difference fron baseline of +00:08:52. The sane typo raphical error appeared across nultiple tables (pa es 46, 47, 48, 66, 67, 80 and 81), where it was incorrectly shown as 00:30:19 and +00:09:36. This represents a discrepancy of 44 seconds between the reported and corrected values. This clarification was provided each tine the incorrect infornation was shown durin the session.

Clarification on POC testing in terms of Option 001Cii.

A: It was confirned there is nothin additional to what they are doin currently in re ard to POC Testin .

7th Option 005:

Q: What risks are there associated with closures?

A: There is a dependency on prinary and connunity services to pick up denand and its uncertain in terns of if the denand could be safely absorbed in the services if all of then were to close.

8th Option 010:

POC Testing Question.

Q: SE - I'd need specifics to ascertain the use - CRP? D-dimer within 5 minutes or just a FBC and U&E 8 hours later because you've sent blood tubes away to a DGH?

A: CL - Increased access to tinely dia nostics, includin nore frequent blood runs to laboratories, so ur ent results are available for clinicians workin in the units. There will also be developnent of point-of-care testin to support innediate results (e. . CRP, D-Diner, Flu, Covid). This supports the ability to have sane-day access to investi ations, includin blood tests, within the nodels of care. Point-of-care testin is evolvin all the tine.

Gth Option 010ii: No questions asked.

Appendix F – Appraiser Questions and Responses (page 2 of 4)

10th Option 013:

Q: SC - Is it the case capital expense and against cost outweigh savings of keeping people in Powys and out of DGH's?

A: Option 013 represents a net investnent, notin this is a non-financial appraisal.

11th Option 013ii: No questions asked.

General Questions:

Q*: It's not that clear the differences proposed between MIIUs and UCC apart from the name? What is the proposed increase in service from former to latter?*

A: The difference between MIIU and UCC options is that in the UCC option there would be an increased advanced practice workforce to be able to nana e a broader scope of practice for nana in sane-day ur ent care presentations, and to develop further clinical pathways that could be nana ed in Powys. MIIU are predoninantly an enhanced workforce, nana in ninor injuries and ninor illness, whereas UCC have nore advanced practice workforce with additional senior clinical leadership.

Q: Is there an agreed principle of Travel Time Analysis?

A (RM): 45 ninutes for connunity care and 60 ninutes for ur ent care, applied usin professional jud enent.

Appendix G – Evaluation Form and Initial Feedback Analysis

Of the 23 appraisers that attended, 6 conpleted the evaluation forn

Evaluation questions asked and feedback iven.

1)**Did the options appraisal workshop neet the objectives?**	Yes	No	Partly	Not answered
	6	0	0	0

2)**Were the objectives clear and well defined?**	Yes	No	Partly	Not answered
	6	0	0	0

3)**Was the Pre-Event Literature of benefit, preparin you conin into the workshop?**	Yes	No	More tine	Not answered
	5	0	0	1

4)**Was the Literature shared on the day supportive to your task as an Appraiser?**	Yes 6	No 0	Partly 0	Not answered 0
How could it be inproved?	The presentation junped between slides a fair bit – it was easier for ne to view the slides online via the adnin portal. It should have been provided as a 'read only' di ital version. The QR code should have had a URL so the MS Forn could have been conpleted on a laptop. If paper is the only option then it would have been helpful to staple each option separately The codes should be nore strai ht forward – option 10 was also 13 A docunent that was shared in the pre-pack was onitted on the day – the descriptors of the scorin approach would have been helpful to have on the day Nunbered pa es			

Evaluation questions asked and feedback iven (continued).

5)**Did the Options Appraisal Workshop help you to develop new perspectives or insi hts?**	Yes 4	No 2	Partly 0	Not answered 0
Overall, how satisfied were you with the Options Appraisal Workshop Experience?	Satisfied 6	Sone satisfaction 0	Dissatisfied 0	Not answered 0
Individual connent				

6)Would you reconnend this type of approach to others?	Yes 5	No 0	Partly 0	Not answered 1
Individual connent				

7) What aspect of the Options Appraisal Workshop did you find nost valuable? **Individual connents**	The travel tine analysis was very useful as well as havin collea ues in the roon that could answer any queries. Good to have the benefits and risks analysis included in each option. I appreciated the opportunity to focus on STEEP quality dinensions for each option. Infornation Provided. The level of detail provided to nake an inforned decision. The networkin and other collea ues fron different disciplines in the roon. Ability to ask questions of the pro ranne tean.

8) What aspects of the Options Appraisal Workshop could be inproved? **Individual connents**	There were a lot of options to consider. There was quite a short anount of tine to consider and then score these. More tine could have been allocated. Nanin of options was confusin . Difference between options in terns of infrastructure (facilities and ina in etc) and hours of openin was clearer than any differences in staffin / skill ni:. Better way to score the options rather than usin a nobile phone. The appraisal reflected personal opinions, and there was very linited discussion at ny table. I would have benefited fron conpletin this e:ercise via Teans. Tine keepin – late startin resulted in a rush end of the day. Ne:t tine, please pass the literature by an autistic person as the survey response title chan ed on Q11 for e:anple.

Evaluation questions asked and feedback iven (continued).

G) What su estions do you have for inprovin future Options Appraisal Workshop? **Individual connents**	More tine to ask questions and consider scorin . Greater clarity on the differences between sone of the options as there were only ninor differences in sone. Clearer labellin of options and a clearer description of related workforce. Consider a 'table score' via the facilitator which will pronote discussion fron different professional opinions and nay influence personal scorin . I understand the need to keep info confidential ahead of the neetin but there was a lot of conple: ideas and concepts to assinilate.

10) Is there anythin else you would like to share about your experience? **Individual connents**	The innediate scorin is really useful and, in sone ways the short anount of tine did nake ne focus on ettin the scorin conpleted. The online systen worked well for ne. I found it easier to focus on the options than when I participated in person and had to switch between printed papers, the bi screen and ny nobile. This tine it was sinple to to le between the options and scorin docunents open in different windows on ny laptop. Good to seein pro ress bein nade towards firnin up strate ic options. I enjoyed it, but I'n a bit sad like that. It's such inportant work and I valued bein there.

11) What were the bi est takeaways fron the Options Appraisal Workshop? **Individual connents**	I had attended a previous appraisal workshop and I think ny scorin was pretty sinilar which was reassurin . This process has allowed a si nificant nunber of people to be included in the appraisal. I appreciate the need for objective scorin of options but feel there are linitations in lookin at options for a sin le service such as Ur ent Care when there are si nificant interdependencies with planned care, ina in and connunity services. Lots of factors to consider. Better understandin of the options and inpact of the possibilities. Positivity related to face to face en a enent. It showed how it is possible to arrive at decisions in a condensed tine frane.

END

‘Better Together’

Non-Financial Options Appraisal Workshop Summary Report

Thursday 11th September 2025
09.00am - 4.00pm



Contents

1. Purpose of Report 2
2. Background and Context 2
3. Approach 3
3.1. Panel 3
3.2. Facilitators 4
3.3. Appraisers 4
3.4. Options 4
3.5. Assessment Criteria 4
4. Outline Methodology (Part 1 – non-financial appraisal) 5
4.1. Assessment Criteria Weighting and Scoring 5
4.2. Supporting Information 5
4.3. Options presentation 6
4.4. Workshop evaluation 6
5. Options Scoring Outputs 7
6. Summary 13
Appendices 14
Appendix A - Option Appraisal Scoring Summary including Sensitivity 14
Appendix B – Workshop Attendees 15
Appendix C – Assessment Criteria 17
Appendix D – Scoring Framework 18
Appendix E – Summary of Shortlisted Options 19
Appendix F – Questions of Clarification and Responses 22
Appendix G – Evaluation Form and Initial Feedback Analysis 23

1. Purpose of Report

This report provides a summary of methodology, attendance, inputs and outputs of a non-financial option appraisal process undertaken on 11th September 2025 for phase 1 of Better Together, adult physical and mental health community services.

2. Background and Context

The purpose of the non-financial option appraisal workshop was to appraise the short-listed options for future delivery of adult physical and mental health community services in Powys. The intended outcome was to apply further rigour to the assessment process, using the expertise of attendees to provide a higher level of confidence in the options that will be recommended to the Executive Committee and Board for public consultation. The adult physical and mental health community services considered during the process were inpatient services, urgent care, mental health and key community-based services.

A comprehensive options development and appraisal process is in progress, aligned with NHS Wales planning guidance and quality standards. The process has been informed by extensive engagement (Stages 1 and 2), clinical input, and multi-agency collaboration.

The current status of engagement for phase 1, adult physical and mental health community services can be summarised as follows:

Stage	Core Aim	Timeline	Status
Stage One	Pre-engagement on case for change	January to May 2025	Complete
Stage Two	Engagement on community and mental health model	May to August 2025	Complete
Stage Three	Formal consultation on community and mental health model	September 2025 to March 2026 (formal consultation October 2025 to January 2026	On Schedule

.

Key components of the options development process preceding the options appraisal workshop are as follows:

Development of Thematic chapters for primary care, physical health community services and mental health & learning disabilities. These chapters have been used to support the development of options and have been shared with stakeholders ahead of key engagement events. They have been published on the Better Together section of the health board website.

Development of system level models of care for a Social Model for Health & Wellbeing, Integrated Community Model and Mental Health Model. These have been tested with stakeholders through the stage 2 engagement period and updated to incorporate feedback received.

Development of service level models of care for Urgent Care, Mental Health Inpatient, Physical Health Inpatient and Community Services.

Development of a Long List of Delivery Options across five service areas: Diagnostics, Urgent Care, Mental Health Inpatient, Physical Health Inpatient, and Community Services.

Application of Hurdle Criteria by the options development group to assess each option against agreed planning principles, including clinical assurance, financial and workforce impact, accessibility, digital inclusion, and stakeholder readiness. Application of the hurdle criteria was tested with the Clinical Reference Group in a check and challenge session.

Shortlisting and appraisal of Options Using the hurdle criteria, options were shortlisted. Further assessment and appraisal has included, but not been limited to:

- Alignment to evidence & standards
- Quality Impact Assessment (Level 1 & 2)
- Travel time analysis
- Demand & Capacity Modelling
- Patient pathway testing
- Strengths, weaknesses, opportunities & threats (SWOT) analysis

An options appraisal process is now underway. This report contains the non-financial appraisal scoring. The financial appraisal will be combined with the results in this report. A weighted combination of non-financial and financial scores will determine the overall score for each option, with capital costs assessed alongside.

3. Approach

3.1. Panel

A panel consisting of clinical and operational leads presented the scope, issues and options for their service area. Other panel members included Executive Director leads for Planning, Performance and Commissioning, Public Health, Primary Care, Community Services and Mental Health, and the Executive Medical Director. The Deputy Director of Engagement, Communication and Corporate Services and the Assistant Director of Quality & Safety were also in attendance as panel members. All panel members were available during the appraisal process to provide further detail and answer queries.

3.2. Facilitators

The Director of Improvement and Transformation and Assistant Director of Transformation & Value acted as room facilitators. A facilitator was allocated to each table, their role was as follows:

- To verify participants' understanding of the supporting information, including the weighted assessment criteria.
- To guide appraisers through the scoring process for each option in a timely and structured manner.
- To manage queries and provide clear, accurate clarification where needed, ensuring that room facilitators were made aware so that clarifying information could be shared with the room to maintain consistency.
- Encourage concise discussion during the scoring of each option against the assessment criteria.

3.3. Appraisers

A total of 25 appraisers attended the session from a cross section of internal and external senior clinicians and professionals. The full list of appraisers is provided at **appendix B**. Efforts were made to ensure depth and breadth of appraisers including external experts. Llais were invited to attend in an observing role but declined the invitation.

Appraisers were divided into 4 tables of 6-8 people per table.

3.4. Options

Shortlisted options were grouped and presented as follows, in order of presentation:

Mental Health

Including inpatient services, Single Point of Access (SPOA), and care at home/community services for older adult community teams.

Urgent Care

Including diagnostic and imaging services.

Physical Health

Including inpatient care, care at home, and community-based services (e.g., intermediate care).

3.5. Assessment Criteria

Assessment criteria were based on the NHS Wales Health and Care Quality Standards of Safe, Timely, Efficient, Effective, Equitable and Person-centred (STEEEP). These criteria were shared as part of Stage 2 public engagement and at Deliberative Events in June and August for feedback. Feedback provided was incorporated into the 'guiding' questions under each domain in the assessment

criteria documentation used during the appraisal workshop. The assessment criteria are included at **appendix C.**

4. Outline Methodology (Part 1 – non-financial appraisal)

4.1. Assessment Criteria Weighting and Scoring

The assessment criteria were weighted ahead of the session by the Executive team to reflect the case for change and organisational strategic priorities. This weighting was applied to the scoring of the options.

The Weighted Assessment Criteria were: Safe 30, Timely 15, Effective 20, Efficient 15, Equitable 10 and Person Centred 10.

All appraisers reviewed all options, with the exception of 1 (noted in appendix B) to ensure they understood the implications across all the options and to manage inter-dependencies across the service areas.

Each appraiser assessed each option against its ability to meet the 6 quality domains. 'Guiding' questions were provided under each domain to support people to think about the most important areas under each domain.

Scoring was completed digitally. Each appraiser brought their own technology either a phone and or a laptop to access, review and score the options via a digital form. The supporting team collected live data during the workshop and fed back to table facilitators to ensure all appraisers had completed all scoring.

Each individual appraiser scored every option based on a scoring framework with a 1-5 rating (**appendix D**).

Appraiser information was captured to enable sensitivity analysis of the scoring. Sensitivity analysis, including reverse weighting, will be applied to ensure robustness.

4.2. Supporting Information

The following supporting information was pre-issued by email:

- Better Together Case for change
- Thematic technical chapters
- Ambitions
- System models of care
- Summary service models of care

Delegate packs were included on tables for use during the workshop and included:

- System models of care
- Assessment criteria
- Scoring Framework
- Shortlisted options
- Summary information from level 2 Quality Impact Assessments
- Travel Time analysis
- SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis.

4.3. Options presentation

Options were presented by the Operational and Clinical Leads for each service area. Options were presented consistently and supported by a power point presentation displaying the approved shortlisted options descriptions (**appendix E**).

Questions of clarification raised from appraisers were managed via the table facilitator and sent to the panel, queries and responses were recorded by the supporting team and shared with the room (**appendix F**)

4.4. Workshop evaluation

An evaluation form was completed at the end of the session by appraisers, the form and overview of initial feedback is provided at **appendix G**.

Summary of feedback (generated via co-pilot)

Achievement of Objectives

- Most participants (20/22) felt the workshop met its objectives, with only one indicating it was partly met and one not answering.
- Objectives were clear and well defined for all respondents (22/22).

Pre-Event and On-the-Day Literature

- Pre-event literature was beneficial for most (14/22), but 7 wanted more time to review it.
- On-the-day literature was unanimously supportive (22/22).
- Suggestions for improvement: More contextualised information, larger print, earlier distribution, simplified examples, and ability to refer to previous scoring.

Recommendations / Areas for Improvement

- Most would recommend this approach (17/22 yes, 2 no, 1 partly, 2 not answered).
- Time: additional time required for review, discussion, and scoring.
- Content: Strengths/weaknesses of each option not always clear; more context and data requested.
- Format: Suggestions for shorter sessions, online delivery, group responses, and electronic approaches.
- Process: Desire for group discussions, seeing previous scores, and consolidating options.
- Membership: Widen to include senior managers, third sector, and PAVO.
- Options: Fewer, more distinct options; limit to three per case.
- Clarity: Maintain clarity, simplify for public involvement, and present information visually.
- Timing: Allow more time for consideration and review.

5. Options Scoring Outputs

The tables below illustrate the outputs of the appraisers scores, against all Shortlisted options, across the three service areas.

5.1 Mental Health Services

The non-financial option appraisal scoring for both raw scores, weighted scores and with sensitivity analysis applied showed that:

Option SL MHDO_0010a received the highest against the assessment criteria - *Do Maximum: Move all functional and organic mental health inpatient services to Brecon Hospital and Newtown Hospital, 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 the highest out of all*

Excluding the 'do nothing option scoring. The 'Do minimum' SL MHDO_003a: option received the lowest against the assessment criteria - Move *older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services scored the 3rd lowest against the assessment criteria*.

The do nothing 'do current' - Keep current hospital and community health services as they are now i.e. retaining temporary closure of Crug ward scored slightly higher than the 'do previous' i.e. put current hospital and community health services back to how they were.

Figure 1: Options Appraisal Scoring Summary – Weighted and Unweighted

Mental Health		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL MHDO02_001a	Do previous – before temporary services change	45.0	48.0	45.0	47.0	50.0	49.0	284.0	8	13.50	7.20	6.75	9.40	5.00	4.90	46.75	8
SL MHDO02_001b	Do current – no transformational change	45.0	47.0	49.0	45.0	48.0	52.0	286.0	7	13.50	7.05	7.35	9.00	4.80	5.20	46.90	7
SL MHDO_003a	Functional beds to Bronllys and integrated OAMH	71.0	64.0	72.0	70.0	52.0	62.0	391.0	6	21.30	9.60	10.80	14.00	5.20	6.20	67.10	6
SL MHDO_004a	Functional beds to Brecon and integrated OAMH	78.0	66.0	74.0	71.0	56.0	64.0	409.0	5	23.40	9.90	11.10	14.20	5.60	6.40	70.60	5
SL MHDO_006a	All beds to Bronllys and integrated OAMH community	98.0	87.0	95.0	95.0	73.0	77.0	525.0	3	29.40	13.05	14.25	19.00	7.30	7.70	90.70	3
SL MHDO_007a	All beds to Brecon and integrated OAMH community	100.0	86.0	98.0	90.0	74.0	87.0	535.0	2	30.00	12.90	14.70	18.00	7.40	8.70	91.70	2
SL MHDO_008a	All beds to Newtown or Welshpool and integrated	82.0	84.0	84.0	80.0	72.0	76.0	478.0	4	24.60	12.60	12.60	16.00	7.20	7.60	80.60	4
SL MHDO_0010a	All beds to Brecon and Newtown and integrated	110.0	108.0	108.0	99.0	111.0	109.0	645.0	1	33.00	16.20	16.20	19.80	11.10	10.90	107.20	1

For Sensitivity Analysis the averages for each metric with weightings were applied, total of each metric (grey) and rank.

Public Weighting (Safe 30, Timely 25, Effective 10, Efficient 10, Equitable 5 and Person Centred 20)

Figure 2: Options Appraisal Sensitivity Scoring Summary – Public Weighting

Mental Health		Public Weighting (.3,.25,.1,.1,.05,.2)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	Rank
SL MHDO02_001a	Do previous - before temporary services change	13.50	12.00	4.50	4.70	2.50	9.80	47.00	8
SL MHDO02_001b	Do current - no transformational change	13.50	11.75	4.90	4.50	2.40	10.40	47.45	7
SL MHDO_003a	Functional beds to Bronllys and integrated OAMH community	21.30	16.00	7.20	7.00	2.60	12.40	66.50	6
SL MHDO_004a	Functional beds to Brecon and integrated OAMH community	23.40	16.50	7.40	7.10	2.80	12.80	70.00	5
SL MHDO_006a	All beds to Bronllys and integrated OAMH community	29.40	21.75	9.50	9.50	3.65	15.40	89.20	3
SL MHDO_007a	All beds to Brecon and integrated OAMH community	30.00	21.50	9.80	9.00	3.70	17.40	91.40	2
SL MHDO_008a	All beds to Newtown or Welshpool and integrated OAMH community	24.60	21.00	8.40	8.00	3.60	15.20	80.80	4
SL MHDO_0010a	All beds to Brecon and Newtown and integrated OAMH community	33.00	27.00	10.80	9.90	5.55	21.80	108.05	1

Reverse Weighting (Safe 10, Timely 10, Effective 20, Efficient 15, Equitable 15 and Person Centred 30)

Figure 3: Options Appraisal Sensitivity Scoring Summary – Reverse Weighting

Mental Health		Reverse(.1,.1,.2,.15,.15,.3)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	Rank
SL MHDO02_001a	Do previous - before temporary services change	4.50	4.80	9.00	7.05	7.50	14.70	47.55	8
SL MHDO02_001b	Do current - no transformational change	4.50	4.70	9.80	6.75	7.20	15.60	48.55	7
SL MHDO_003a	Functional beds to Bronllys and integrated OAMH community	7.10	6.40	14.40	10.50	7.80	18.60	64.80	6
SL MHDO_004a	Functional beds to Brecon and integrated OAMH community	7.80	6.60	14.80	10.65	8.40	19.20	67.45	5
SL MHDO_006a	All beds to Bronllys and integrated OAMH community	9.80	8.70	19.00	14.25	10.95	23.10	85.80	3
SL MHDO_007a	All beds to Brecon and integrated OAMH community	10.00	8.60	19.60	13.50	11.10	26.10	88.90	2
SL MHDO_008a	All beds to Newtown or Welshpool and integrated OAMH community	8.20	8.40	16.80	12.00	10.80	22.80	79.00	4
SL MHDO_0010a	All beds to Brecon and Newtown and integrated OAMH community	11.00	10.80	21.60	14.85	16.65	32.70	107.60	1

Other sensitivity analysis included clinically focused, patient focused, appraiser profession (clinical and non-clinical) focused, and equal focused, these are provided in **appendix A**

5.2 Urgent Care Services

The non-financial option appraisal scoring for both raw scores and raw scores with sensitivity analysis applied showed that:

UCDO_013: Do Maximum **received the highest against the assessment criteria -** *Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)*

Excluding the 'do nothing option scoring. SL UCDO_005 received the lowest against the assessment criteria: *Close Minor Injury Units and provide urgent care in other ways*

The do nothing 'do current' - Keep current hospital and community health services as they are now i.e. hospital based minor injury service across 4 sites scored higher than the 'do previous' i.e. put current hospital and community health services back to how they were.

Figure 4: Options Appraisal Scoring Summary – Weighted and Unweighted

Urgent Care		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SLUCDO 001a	Do previous – before temporary services change	51.0	56.0	45.0	45.0	51.0	53.0	307.0	5	15.300	8.40	6.75	9.00	5.10	5.90	50.45	5
SLUCDO 001b	Do current – continue as now making temporary service	54.0	54.0	52.0	52.0	54.0	52.0	318.0	4	16.20	8.10	7.80	10.40	5.40	5.20	53.10	4
SLUCDO 001c	Do minimum – enhance existing MIU on fewer sites	67.0	67.0	63.0	63.0	62.0	64.0	386.0	3	20.10	10.05	9.45	12.60	6.20	6.40	64.80	3
SL UCDO_005	Close minor injury units and provide urgent care in other	51.0	47.0	48.0	48.0	56.0	52.0	302.0	6	15.30	7.05	7.20	9.60	5.60	5.20	49.95	6
SL UCDO_010	Better local urgent care (3 x minor injury & illness units in	85.0	81.0	81.0	76.0	80.0	80.0	483.0	2	25.50	12.15	12.15	15.20	8.00	8.00	81.00	2
SL UCDO_013	Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)	88.0	91.0	92.0	90.0	83.0	91.0	535.0	1	26.40	13.65	13.80	18.00	8.30	9.10	89.25	1

For Sensitivity Analysis the averages for each metric with weightings were applied, total of each metric (grey) and rank.

Public Weighting (Safe 30, Timely 25, Effective 10, Efficient 10, Equitable 5 and Person Centred 20)

Figure 5: Options Appraisal Sensitivity Scoring Summary – Public Weighting

Urgent Care		Public Weighting (.3,.25,.1,.1,.05,.2)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	Rank
SLUCDO 001a	Do previous - before temporary services change	15.300	14.00	4.50	4.50	2.55	11.80	52.65	5
SLUCDO 001b	Do current - continue as now making temporary service changes permanent	16.20	13.50	5.20	5.20	2.70	10.40	53.20	4
SLUCDO 001c	Do minimum - enhance existing MIU on fewer sites	20.10	16.75	6.30	6.30	3.10	12.80	65.35	3
SL UCDO_005	Close minor injury units and provide urgent care in other ways	15.30	11.75	4.80	4.80	2.80	10.40	49.85	6
SL UCDO_010	Better local urgent care (3 x minor injury & illness units in Powys)	25.50	20.25	8.10	7.60	4.00	16.00	81.45	2
SL UCDO_013	Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)	26.40	22.75	9.20	9.00	4.15	18.20	89.70	1

Reverse Weighting (Safe 10, Timely 10, Effective 20, Efficient 15, Equitable 15 and Person Centred 30)

Figure 6: Options Appraisal Sensitivity Scoring Summary – Reverse Weighting

Urgent Care		Reverse(.1,.1,.2,.15,.15,.3)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	**Rank**
SLUCDO 001a	**Do previous - before temporary services change**	5.100	5.60	9.00	6.75	7.65	17.70	51.80	
SLUCDO 001b	**Do current - continue as now making temporary service changes permanent**	5.40	5.40	10.40	7.80	8.10	15.60	52.70	
SLUCDO 001c	**Do minimum - enhance existing MIU on fewer sites**	6.70	6.70	12.60	9.45	9.30	19.20	63.95	
SL UCDO_005	**Close minor injury units and provide urgent care in other ways**	5.10	4.70	9.60	7.20	8.40	15.60	50.60	
SL UCDO_010	**Better local urgent care (3 x minor injury & illness units in Powys)**	8.50	8.10	16.20	11.40	12.00	24.00	80.20	
SL UCDO_013	**Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)**	8.80	9.10	18.40	13.50	12.45	27.30	89.55	

Other sensitivity analysis included clinically focused, patient focused and equal focused, these are provided in **appendix A**

5.3 Physical Health Inpatient and Community Care Services

The non-financial option appraisal scoring for both raw scores and raw scores with sensitivity analysis applied showed that:

Option ***SL IPDO_005b Do Mid-Range: received*** **the highest against the assessment criteria***: There would be fewer hospital beds (approx. 90-100 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.*

Excluding the 'do nothing option scoring. SL IPDO_011 – Remove all Physical Health Hospital Beds from Powys received the lowest against the assessment criteria

Both do nothing options received the lowest against the assessment criteria with the 'do current' Keep current hospital and community health services as they are now and adopt temporary service changes scoring higher than the 'do previous' i.e. put current hospital and community health services back to how they were.

Figure 7: Options Appraisal Scoring Summary – Weighted and Unweighted

Physical Health		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL IPDO_001a	Put current hospital and community health services back to how they were pre	35.0	40.0	36.0	34.0	46.0	44.0	235.0	8	10.50	6.00	5.40	6.80	4.60	4.40	37.70	8
SL IPDO_001b	Keep current hospital and community health services as	49.0	47.0	49.0	48.0	49.0	50.0	292.0	7	14.70	7.05	7.35	9.60	4.90	5.00	48.60	7
SL IPDO_011	Remove physical Health	50.0	50.0	54.0	52.0	58.0	58.0	322.0	6	15.00	7.50	8.10	10.40	5.80	5.80	52.60	6
SL IPDO_002a	Same number beds on six sits and better Physical Health	72.0	70.0	65.0	66.0	70.0	69.0	412.0	5	21.60	10.50	9.75	13.20	7.00	6.90	68.95	5
SL IPDO_002b	Same number beds on six sits and better Physical Health Community and Mental Health	73.0	72.0	73.0	70.0	72.0	77.0	437.0	4	21.90	10.80	10.95	14.00	7.20	7.70	72.55	4
SL IPDO_005a	Few beds on three sites and better physical health	89.0	86.0	86.0	85.0	81.0	87.0	514.0	2	26.70	12.90	12.90	17.00	8.10	8.70	86.30	2
SL IPDO_005b	Fewer beds on three sites and better physical health community and mental health	89.0	87.0	89.0	88.0	82.0	90.0	525.0	1	26.70	13.05	13.35	17.60	8.20	9.00	87.90	1
SL IPDO_008	Even fewer beds on three sites and better physical health community and mental health	75.0	73.0	79.0	85.0	73.0	83.0	468.0	3	22.50	10.95	11.85	17.00	7.30	8.30	77.90	3

For Sensitivity Analysis the averages for each metric with weightings were applied, total of each metric (grey) and rank.

Public Weighting (Safe 30, Timely 25, Effective 10, Efficient 10, Equitable 5 and Person Centred 20)

Figure 8: Options Appraisal Sensitivity Scoring Summary – Public Weighting

Physical Health		Public Weighting (.3,.25,.1,.1,.05,.2)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	Rank
SL IPDO_001a	Put current hospital and community health services back to how they were pre temporary service changes	10.50	10.00	3.60	3.40	2.30	8.80	38.60	8
SL IPDO_001b	Keep current hospital and community health services as they are now	14.70	11.75	4.90	4.80	2.45	10.00	48.60	7
SL IPDO_011	Remove physical Health Hospital Beds	15.00	12.50	5.40	5.20	2.90	11.60	52.60	6
SL IPDO_002a	Same number beds on six sits and better Physical Health Communtiy	21.60	17.50	6.50	6.60	3.50	13.80	69.50	5
SL IPDO_002b	Same number beds on six sits and better Physical Health Community and Mental Health join up.	21.90	18.00	7.30	7.00	3.60	15.40	73.20	4
SL IPDO_005a	Few beds on three sites and better physical health community	26.70	21.50	8.60	8.50	4.05	17.40	86.75	2
SL IPDO_005b	Fewer beds on three sites and better physical health community and mental health join up	26.70	21.75	8.90	8.80	4.10	18.00	88.25	1
SL IPDO_008	Even fewer beds on three sites and better physical health community and mental health join up	22.50	18.25	7.90	8.50	3.65	16.60	77.40	3

Reverse Weighting (Safe 10, Timely 10, Effective 20, Efficient 15, Equitable 15 and Person Centred 30)

Figure 9: Options Appraisal Sensitivity Scoring Summary – Reverse Weighting

Physical Health		Reverse(.1,.1,.2,.15,.15,.3)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Original	Rank
SL IPDO_001a	Put current hospital and community health services back to how they were pre temporary service changes	3.50	4.00	7.20	5.10	6.90	13.20	39.90	8
SL IPDO_001b	Keep current hospital and community health services as they are now	4.90	4.70	9.80	7.20	7.35	15.00	48.95	7
SL IPDO_011	Remove physical Health Hospital Beds	5.00	5.00	10.80	7.80	8.70	17.40	54.70	6
SL IPDO_002a	Same number beds on six sits and better Physical Health Communtiy	7.20	7.00	13.00	9.90	10.50	20.70	68.30	5
SL IPDO_002b	Same number beds on six sits and better Physical Health Community and Mental Health join up.	7.30	7.20	14.60	10.50	10.80	23.10	73.50	4
SL IPDO_005a	Few beds on three sites and better physical health community	8.90	8.60	17.20	12.75	12.15	26.10	85.70	2
SL IPDO_005b	Fewer beds on three sites and better physical health community and mental health join up	8.90	8.70	17.80	13.20	12.30	27.00	87.90	1
SL IPDO_008	Even fewer beds on three sites and better physical health community and mental health join up	7.50	7.30	15.80	12.75	10.95	24.90	79.20	3

Other sensitivity analysis included clinically focused, patient focused and equal focused, these are provided in **appendix A**

6. Summary

The top score across all sensitivity scenarios were ranked no.1:

- Mental Health - SL MHDO_0010a - All beds to Brecon and Newtown and integrated OAMH community
- Urgent Care - SL UCDO_013 - Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)
- Physical Health - SL IPDO_005b - Fewer beds on three sites and better physical health community and mental health join up

Analysis of stakeholder scoring revealed a consistent pattern of high correlation between criteria, indicating that stakeholders tended to rate options similarly across all six dimensions. Correlation and sensitivity analysis demonstrated that option rankings remained stable across different weighting scenarios, with little distinction made between criteria. As a result, it was not possible to determine which individual criterion most influenced stakeholder preference. See Rank for each scenario in **appendix A.**

Notably, there was strong stakeholder consensus on the top-ranked option, as reflected in the low variation of scores, evidencing clear agreement on the best overall choice.

Appendices

Appendix A - Option Appraisal Scoring Summary including Sensitivity



Option Appraisal scoring summary ap

Appendix B – Workshop Attendees

Role	Workshop Role
Executive Director of Primary Care, Community Services & Mental Health	Executive Director oversight (panel)
Director of Improvement & Transformation	Presenter/Room Facilitator (panel)
Assistant Director of Transformation & Value	Room Facilitator (panel)
Assistant Director Mental Health & LD	Senior Responsible Officer (SRO) Mental Health (panel)
Head of Psychology	Mental Health Clinical Lead (panel)
Head of Operations, Mental Health	Mental Health Operational Lead (panel)
Assistant Director Community Services Group	Senior Responsible Officer (SRO) Physical Health (panel)
Professional Head of Nursing, Community Services Group	Physical Health Clinical Lead (panel)
Head of AHPs & Health Science, Community Services Group	Physical Health Clinical Lead (panel)
Clinical Transformation Lead, Urgent Care	Urgent Care Clinical Lead (panel)
Executive Medical Director	Panel member
Executive Director Planning, Performance & Commissioning	Panel member
Executive Director of Public Health	Panel member
Deputy Director Communications, Engagement and Corporate Services	Panel member
Assistant Director Quality & Safety	Panel member
GP North Cluster (Montgomery Medical Practice)	Appraiser
PAVO	Appraiser
Associate Director Estates, Capital & Support Services, PTHB	Appraiser
External Appraiser - Geriatrician and stroke physician and honorary secretary of the British Geriatrics Society	Appraiser
GPwER Frailty, PTHB	Appraiser
Community Services Manager, PTHB	Appraiser
Head of Quality, PTHB	Appraiser
Transformation Programme Manager	Facilitator
External Appraiser - Assistant Director Six Goals for Urgent and Emergency Care NHS Wales Performance and Improvement	Appraiser
Head of Adult Social Care, PCC	Appraiser
Mental Health Inpatient Service Manager	Appraiser
GP, South Cluster (Brecon Practice)	Appraiser

Deputy Director of People & Culture, PTHB	Appraiser
PAVO	Appraiser
Transformation Programme Manager	Facilitator
External Appraiser (Clinical Director Community Hospitals/SAS Advocate, Care of the Elderly)	Appraiser
GP/Resus Lead, PTHB	Appraiser
Assistant Director of Nursing	Appraiser
External Appraiser - Assistant Director Mental Health and LD – NHS Wales Performance and Improvement	Appraiser
Trade Union representative	Appraiser
Consultant Psychiatrist, PTHB	Appraiser (NB. Did not complete Physical Health options appraisal)
Transformation Programme Manager	Facilitator
Senior Practitioner Primary Care	Appraiser
Mental Health Nurse Manager	Appraiser
Macmillan Lead Nurse for Cancer and Palliative Care	Appraiser
Professional Head of Radiography	Appraiser
Professional Head of Occupational Therapy	Appraiser
Head of Organisational Development	Appraiser
Transformation Programme Manager	Facilitator
Project Support Officer	Technical Support
Project Support Officer	Technical Support
Project Support Officer	Technical Support
Senior Transformation Programme Manager	Technical Support

Appendix C – Assessment Criteria

Part 1 Non-Financial Appraisal Methodology Assessment Criteria

(based on NHS Wales Health and Quality Care Standards)

SAFE	TIMELY	EFFECTIVE	EFFICIENT	EQUITABLE	PERSON-CENTRED
Does this option deliver against the objective we are trying to achieve in a way that promotes 'safe' care:	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'timely' and 'accessible' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'effective' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'efficient' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'equitable' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'person-centred' care:**
Please consider as a guide for your assessment the extent to which this:	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*
• supports safe clinical practice *i.e. prevents and / or reduces harm / errors*	• delivers against required access standards / performance targets (such as reduction of delays and waits)	• is underpinned by reliable data, best practice guidance and evidence-base (e.g. NICE)	• makes best use of resources to improve patient outcomes and experience, staff satisfaction and enables us to live within our means	• delivers evidence-based care across Powys but can adapt to address differences in need; positively contributing towards reducing health inequalities	• Helps people to stay healthy, building self-reliance in patients and the population
• ensures a substantive workforce model *–i.e. the workforce is available, and a robust staffing model can deliver professional standards*	• improves access to services that support people to stay at home where possible and enables timely response when needs escalate	• supports delivery of future system models of care, national and local guidance	• uses digital technology where appropriate to aid efficient care, with consideration for those not able to use technology	• reduces inequity across Powys for example through removing unnecessary differences in the way services are delivered	• provides a responsive joined-up offer that supports people to achieve 'what matters most to them' and improves patient experience outcomes
• improves staff safety including promoting a culture of safety and speaking up safely	• enables efficient transfer and discharge pathways to prevent harm to patients	• addresses existing barriers to care in the case for change such as continuity of care and communication	• is feasible and can achieve a positive impact within the short or medium term *i.e. will improve the health of the whole population or have a very significant impact on the health of a small number*	• delivers an appropriate offer for all population groups – including those with protected characteristics (not necessarily the 'same' offer but the one that delivers the best fit between those characteristics and the care provided)	• Provides access to meet healthcare needs within acceptable travel times (in line with the evidence base)

Part 1 Non-Financial Appraisal Methodology - Scoring Framework

This scoring framework is designed to support the non-financial options appraisal process.
It uses a 1–5 scale to assess how well each option meets the defined objectives or STEEEP criteria (Safe, Timely, Effective, Efficient, Equitable, Patient-centred).

Score	Descriptor	Definition
1	Does Not Meet Needs	The option fails to address the objective or STEEEP criterion. It may introduce risks or worsen current conditions.
2	Partially Meets Needs	The option addresses the objective or criterion in a limited or inconsistent way. Significant gaps remain.
3	Adequately Meets Needs	The option meets the minimum requirement. It is acceptable but lacks enhancement or innovation.
4	Fully Meets Needs	The option clearly meets the objective or criterion with confidence. It is robust and well-aligned with expectations.
5	Exceeds Needs / Optimal Fit	The option not only meets but enhances the objective or criterion. It offers added value, innovation, or future-proofing.



Appendix E – Summary of Shortlisted Options

Plain Language
Short List Options p

Physical Health Scope – What could change on each PTHB site

To provide high quality, person centred, digitally enabled and proactive care within a community setting, that supports people to stay well at home, promotes recovery and reablement closer to home, reduces unnecessary hospital admissions and facilitates timely discharge, promoting quality of life, independence and dignity at end of life, and delivering holistic care including physical, mental and social health.

PTHB Provider Services only

Physical Health Options (PH = physical health; MH = mental health)	Welshpool	Newtown	Llanidloes	Machynlleth	Llandrindod	Builth	Knighton	Bronllys	Brecon	Ystradgynlais	General Practice	Community / Home	Digital Offer
001a: Do Previous (before any temporary service changes)													
001b: Do Current (continue as now, making temporary service changes permanent)													
011: Remove all inpatient beds from PTHB													
002a: Do Minimum: (same number beds, on 6 sites) + better PH community	X			X						X			
002b: Do Minimum: (same number beds, on 6 sites) + better PH community + MH join up	X			X						X			
005a: Do Mid range: (fewer beds, on 3 sites) + better PH community	X			X						X			
005b: Do Mid range: (fewer beds, on 3 sites) + better PH community + MH join up	X			X						X			
008: Do Maximum: (fewer beds, on 2 sites) + better PH community + MH join up	X			X						X			

Key	
No change	Some or all beds removed
Temporary changes are reversed	Bed numbers increased
Temporary changes become permanent	More support in the community
More join up between physical health and mental health	

Key
X-ray closes = X
X ray stays & longer opening hours =
DEXA created = DEXA

Urgent Care – What could change on each PTHB site

PTHB Provider Services only

Urgent Care options	Welshpool	Newtown	Machynlleth	Llandrindod	Brecon	Ystradgynlais	General Practice	Home
001a: Do Previous (before any temporary service changes)								
001b: Do Current (continue as now, making temporary service changes permanent)								
001c: Do Minimum (make temporary service changes permanent and improve service)			X			X		
005: Close Minor Injury Units and provide urgent care in other ways	X		X			X		
010: Do Mid Range: Better local Urgent Care (3 x MIIUs in Powys)			X	**	**	X		
013: Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)			X	**	**	X		

Key	
No change	Minor Injury Unit closed permanently
	Minor Injury Unit opens
Temporary changes are reversed	Minor Injury & Illness centre opened
Temporary changes become permanent	Urgent Care Centre opened
More urgent care provided through local GP practices	Changes to urgent care provided through local GP practices where needed

** the Minor Injury & Illness Unit or the Urgent Care Centre would replace the current Minor Injury Unit at that site.

The Welshpool Urgent Care Unit would close when the Newtown Urgent Care Unit becomes operational.

Key	Symbol
X-ray closes	X
X-ray stays & opening hours do not change	/
X-ray stays & longer opening hours	
X-ray stays in Welshpool until Newtown opens, then moves to Newtown and Welshpool x-ray closes	
Ultrasound	
Blood testing	
Point of Care testing	

Mental Health Scope – What could change on each PTHB site

PTHB Provider Services only

Mental Health Options	Newtown	North Powys	Llandrindod	Mid Powys	Bronllys	Brecon	Ystradgynlais	South Powys	Out of County	Community / Home	Digital Offer
001a: Do Previous (before any temporary service changes)											
001b: Do Current (continue as now, making temporary service changes permanent)											
003a: Do Minimum: Functional beds to Bronllys + integrated OAMH community											
004a: Do Mid Range: Functional beds to Brecon + integrated OAMH community											
006a: Do Maximum: All beds to Bronllys + integrated OAMH community											
007a: Do Maximum: All beds to Brecon + integrated OAMH community											
008a: Do Maximum: All beds to Newtown + integrated OAMH community											
010a: Do Maximum: All beds to Brecon + Newtown + integrated OAMH community											

Key	
No change	Some or all beds removed
Temporary changes are reversed	Bed numbers increased
Temporary changes become permanent	Sanctuary / safe place to assess created
More join up between physical health and mental health	

Appendix F – Questions of Clarification and Responses

The following queries and responses were recorded during the workshop:

Area	Question	Answer	Person/Role
Mental Health	Why was Crug Ward temporarily closed in 2023?	The closure was linked to Covid-19 impacts from 2020. It helped other wards cope better. Staffing challenges were also a factor and remain a concern if the model is revisited.	Louisa Kerr, Assistant Director - Mental Health & Learning Disabilities
Mental Health	Does the option include both organic and functional beds?	Yes, it includes both types.	Louisa Kerr, Assistant Director - Mental Health & Learning Disabilities
All options	Why is 'going backwards' being considered?	Previous temporary changes must be considered and excluded as part of the consultation process.	Adrian Osborne, Deputy Director Communication, Engagement and Corporate Services
Mental Health	Is this option based on 3 sites or 4?	It is confirmed to be 3 sites. Crug Ward is not included.	Louisa Kerr, Assistant Director - Mental Health & Learning Disabilities
All options	What is meant by short to medium term?	Short term: 1-2 years; Medium term: 2-5 years; Long term: 5+ years	Lucie Cornish, Director of Improvement C Transformation
Urgent Care	What does 'minor illness' refer to?	It broadens the scope from minor injury to include minor illnesses and diagnostic provision.	Claire Lukies, Service
Physical Health	Would closing a unit create additional costs?	Individuals could access other units. Cost impact varies by system access point. Low-risk cost implications based on service modelling.	David Farnsworth, Assistant Director, Community Services Group
Physical Health	Clarification on 'direct point of care'?	The plan includes exploring recruitment to provide care directly in patients' homes.	David Farnsworth, Assistant Director, Community Services Group
Physical Health	Will beds be in patient environments?	Beds may not be in traditional patient environments but integrated across physical and mental health services, depending on demand and capacity.	David Farnsworth, Assistant Director, Community Services Group

Appendix G – Evaluation Form and Initial Feedback Analysis



Non-financial appraisal workshop

Of the 25 appraisers that attended, 22 completed the evaluation form.

Evaluation questions asked and feedback given.

1)**Did the options appraisal workshop meet the objectives?**	Yes	No	Partly	Not answered
	20	0	1	1

2)**Were the objectives clear and well defined?**	Yes	No	Partly	Not answered
	22	0	0	0

3)**Was the Pre-Event Literature of benefit, preparing you coming into the workshop?**	Yes	No	More time	Not answered
	14	0	7	0

4)**Was the Literature shared on the day supportive to your task as an Appraiser?**	Yes	No	Partly	Not answered
	22	0	0	0
How could it be improved?	Contextualised information shared on table More detail on options. More time needed Larger print on documents. The criteria printed on larger sheets Simplified examples The information given earlier to allow for time to review Variation from previous options Found my comments repetitive, alongside options. Having copies of the presentation was helpful It would be helpful to be able to refer to previous scoring L2 Summary Assessments were needed.			

Evaluation questions asked and feedback given (continued).

5)**Did the Options Appraisal Workshop help you to develop new perspectives or insights?**	No satisfaction	Some satisfaction	Satisfied	Dissatisfied
	0	4	18	0
Individual comment	Carrying out each area on a different day may help			

6)Would you recommend this type of approach to others?	Yes	No	Partly	Not answered
	17	2	1	2
Individual comment	Yes but it is tiring			

7) What aspect of the Options Appraisal Workshop did you find most valuable? **Individual comments**	Discussion and detail All options at the same time Introduction to each proposal Listening to wider perspectives Progression through options Options being explained Range of experience on the table. Ability to ask questions – but didn't exploit room discussions. Could it be hosted on Teams Focussed understanding on the options Colleague discussions on table Understanding of options considered Results on the day, top table discussing options and questions All aspects Leads talking through options Voting worked well and the system, once I understood Mix of staff on tables Getting insights from others on the table Seeing proposals in their entirety

8) What aspects of the Options Appraisal Workshop could be improved **Individual comments**	More time, wider audience to allow for more knowledge in some areas Strength and weaknesses of each option not explained, could they be. More context and data More discussions if you are out of area A lot has been achieved Time. Review of all options before scoring A lot for a day, shorter sessions, online? Prior to meeting an example. There was no time for discussions, maybe important at time of scoring Electronic approach was good Too many options Group responses instead of individual would be better informed, all have different experiences, wasn't time for group discussions Time Tick box instead of writing rational, scoring on 1 slide Time for discussion on table Seeing previous appraisal score Start with do maximum.

Evaluation questions asked and feedback given (continued).

G) What suggestions do you have for improving future Options Appraisal Workshop **Individual comments**	Widening membership to senior managers Merits of each option being highlighted Fewer options that have very limited variation to others. Data and expected outcomes. Consolidate options to a maximum of 3 for each case Keep clarity and invite 3rd sector and PAVO Time and review scores Simplify for public involvement. What does it mean for localities This focussed the understanding of options. Useful as a discussion event earlier in the process. Previous views heard, perspective not heard Lunch Not so long Introductions on the table and knowledge / background More time, less information, present in pictures 1 day per area More time to consider options Time is critical but a lot for 1 day Difficult to score without having full overview More time Do maximum first.

10) Is there anything else you would like to share about your experience? **Individual comments**	Time to score Intense day So much paper Mentally tiring could be online Very focussed in-depth discussion Lunch provision Good mediating on table Limited GP representation Very slick format from team, rapid feedback – impressive I don't feel I scored based on full range of information Huge appreciation of the amount of work currently being done by PTHB in particular the vision. Challenging as had to make decisions and score very quickly Exceptional professionalism Smaller focussed groups would be better for example, Finance, Clinicians. Important to complete robust appraisal – welcomed being invited.

11) What were the biggest takeaways from the Options Appraisal Workshop **Individual comments**	Range of options and the opportunity to be involved Useful to see what is being considered Complexity of the task ahead Blue sky thinking Complexity of task ahead and excellent work that has taken place Being part of this as a partner organisation More integrated working, primary care and LHB Good to see hard work coming together My estates limited knowledge, on fabric and feasibility impacted my scoring How important our involvement is in supporting the change process Very inclusive, challenging times ahead Professional process Need to be clear on opportunities and risks around options New approach to options appraisal Keep up the good work

END

Better Together

Strictly Confidential

Adult Physical and Mental Health Community Services

Final Recommended Options

Executive Committee

27th May 2026



Gwella Gyda'n Gilydd

Llunio dyfodol gwasanaethau iechyd diogel, o ansawdd uchel i Bowys

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

Better Together

Shaping the future of safe, quality health services for Powys

Summary of the Options Recommendations Process

A workshop of Options Development Group members was held on 5th May 2026 to consider all appraisal information to agree a set of recommended options to progress through organisational governance processes for a decision on whether to progress to public consultation. The session followed on from the Recommended Options Workshop held on 13th January 2026 and continued to focus on a structured, evidence-based appraisal of each option. Participants reviewed options against their benefits, risks and trade-offs, including workforce, financial, estates and wider non-financial impacts. The discussions were informed by a comprehensive set of inputs, including the Case for Change, system models of care, service issues, and service models. The appraisal was supported with information on travel time analysis, workforce models and assumptions, financial and non-financial appraisals, and an estates assessment. This ensured that decisions were grounded in a consistent and transparent assessment framework.

Each option and its supporting evidence base was considered against how it would address the issues in the case for change and the hurdle criteria, but mainly the group discussion focused on the non-financial and financial appraisal and estate assessment to objectively discount or recommend options to proceed to the next stage. Options that were discounted had a clear rationale to explain why they were not recommended to move forward.

The aim was to ensure robust options presented for consultation with clear rationale and evidence. This applied across Physical Health Inpatients and Community Models, Urgent Care, and Mental Health services. The “Do current” and "Do Previous" options were discounted but will progress as baseline comparator options.

In addition to option selection, the group assessed readiness to proceed and identified any further actions required before an organisational decision on proceeding to public consultation. These actions have been progressed via ODG and the outputs have informed further discussion and decision making on the recommended options in Informal Executives on 21st May 26.

This has resulted in the discounting of the mental health option 010a: Two-site inpatient model with beds split between North and South Powys with integrated community model on the basis that the option is not deliverable from a workforce perspective and is not financially viable. It is noted that whilst further internal assurances have been provided on workforce assumptions, there is limited external benchmarking information available.

Following the internal validation of the demand and capacity modelling, an update has been made to the financial appraisal for Physical Health which has resulted in a reduction in the financials savings associated with the recommended options 005 and 008. This change has not impacted on the financial ranking of the options and therefore does not change the position on the recommended options.

The Step Report will be considered by internally agreed governance arrangements and externally by HICO as part of their independent assurance, in readiness for consultation – this will include a review of the evidence base underpinning the rationale for discounting of options.

Recommended Options to be progress to next stage

Option Ref	Option Description	Recommendation Status
Mental Health		
MH006a – 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 estate assessment)**
Urgent Care & Diagnostics		
UC013 – Do Maximum (2 UCCs + 1 MI&IU)	UCCs at Newtown & Brecon; MIIU at Llandrindod	Proceed to next stage
UC013ii – Do Maximum (2 UCCs)	UCCs at Newtown & Brecon	Proceed to next stage **(subject to further estate assessment)**
Physical Health		
PH005b – Do Mid-Range + MH integration	Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model + better join up with mental health	Proceed to next stage
PH008 – 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

Do Previous (before temporary changes) and Do Current (with existing temporary changes in place) options discounted but recommended to progress as comparators for all option groups

Level 2 IIAs in progress for all recommended options with support from HICO; Quality & Equality Panel QA process agreed

Mental Health



Mental Health Short List Options

This table shows which short list options were discounted or recommended to proceed to the next stage with supporting rationale

Option Ref	Option Description	Recommendation Status	Rationale
001a – Do Previous	Pre-temporary 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- Red 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 MH community model	Discount	Ranked 1st financial and 5th non-financial appraisals. Estates rated C- Red/ 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 estate assessment)	Ranked 3rd financial and 3rd non-financial appraisals. Estates rated D-Grey 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 in 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. Its recommended this option is taken forward with the caveat that if the Bronllys site can not be re-developed 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- 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 OCP 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- Grey This option performs best on access, equity and patient experience and co-location with physical health. However, it is least favourable financially, requiring significant workforce growth and additional recurrent investment to operate inpatient services across the 2 sites. Following further review of bed requirements, workforce and commissioning assumptions this option is not deliverable due to the lack of confidence for recruitment in the North and for affordability reasons.

Mental Health inc Community Model Option Summary Information

Awaiting Estate assessment update

Options 4	001a Do previous	001b Do current	003a Functional beds to Bronllys	004a Functional beds to Brecon	006a All beds to Bronllys	007a All beds to Brecon	008a All beds to Newtown or Welshpool	010a All beds to Newtown and Brecon
Service footprint sites	4	3	2	2	1	1	1	2
Service footprint Beds	44	38	35	35	35	35	35	42
PTHB Service model adjustments	Pre-temporary	None	Minor	Moderate	Major	Major	Major	Major
PTHB Workforce (WTE) Inpatients	150.4	128.2	112.0	112.0	131.0	131.0	131.0	176.0
PTHB Workforce WTE Community	51.1	51.1	67.9	67.9	67.9	67.9	67.9	67.9
Financial costs minus savings (£m)	£12.2	£10.9	£10.4	£10.4	£10.8	£10.8	£10.8	£12.8
Financial impact vs current 001b (£m)	£+1.3	-	£-0.51	£-0.51	£-0.1	£-0.1	£-0.1	£+1.9
Non - financial appraisal score	46.8	46.9	67.1	70.6	90.7	91.7	80.6	107.2 (ranked 1st)
Ward Staff Costs per bed	£137	£124	£103	£103	£125	£125	£125	£157
Estates value	Low	Low	Significant	Significant	Major	Major	Major	Major
Estate Feasibility								

Summary

- Options 003a and 004a have the lowest financial costs (minus savings) and lowest ward staff costs per bed. But these ranked 5th and 6th in the non financial appraisal.
- Options 006a and 007a are marginally more expensive this is due to an increased staffing model on single site. These options ranked 2nd and 3rd on the non financial appraisal,
- Option 010a has the most financial costs (minus savings) and ward staff costs per bed as staffing levels significantly increase across the 2-site model however this ranked 1st in the non financial appraisal.

High Level Assumptions

- Do current baseline based on agreed ward and medical staffing (March 2026)
- All workforce options 006a – 010a based on new build.
- 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.
- All options currently modelled to year 0 for costs, activity and WTE

Mental health – Travel Time Summary across the options

Scenario / Option group	Service configuration	Mean travel time	Change vs baseline	Assessment against standards
Do Previous **SL MHDO02_001a**	*Crug Ward re-opened*	**36:50**	Improvement vs baseline	Meets **routine (≤45 min)** standard; access improves with more households within 0–15 mins
Do Current **SL MHDO02_001b**	Brecon closed; otherwise unchanged	**43:49**	No material change	Just within **routine (≤45 min)** standard
Do Minimum **SL MHDO_003a**	Functional beds consolidated at **Bronllys,** organic beds at **Ystradgynlais**	**1:05:21**	↑ significant	**Falls outside routine** standard; exceeds **crisis (≤60 min)** for many households
Do Mid Range **SL MHDO_004a**	Functional beds moved to **Brecon,** organic beds at **Ystradgynlais**	**1:07:30**	↑ significant	**Falls outside routine** and **crisis** standards
Do Maximum – single-site variants	All beds located at one site			
• Bronllys **SL MHDO_006a**	Single-site Bronllys	**1:05:21**	↑ significant	**Falls outside routine**; exceeds **crisis** standard
• Brecon **SL MHDO_007a**	Single-site Brecon	**1:07:30**	↑ significant	**Falls outside routine** and **crisis** standards
• Newtown **SL MHDO_008a**	Single-site Newtown	**53:58**	↑ moderate	**Falls outside routine**; within **crisis** standard but with many >45 mins
Do Maximum – split sites **SL MHDO_010a**	Beds split between **Brecon & Newtown**	**29:35**	↓ significant vs single-site	Meets **routine (≤45 min)** standard; reduces long journeys

Urgent Care



Urgent Care Short List Options 1 of 2

This table shows which short list options were discounted or recommended to proceed to the next stage with supporting rationale

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 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- Amber 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 A- 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 B- Amber 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.

Urgent Care Short List Options 2 of 2

This table shows which short list options were discounted or recommended to proceed to the next stage with supporting rationale

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001Dii – Current on 2 sites	MIUs at Welshpool and Newtown & Brecon	Discount	Ranked 2nd financial and 9th 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 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 appraisals. Estates rated B - 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)	MI&IUs at Newtown & Brecon	Discount	Ranked 3rd financial and 4th non-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 B- 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 appraisals. Estates rated B - 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.

Urgent Care including Diagnostics Option Summary Information

Awaiting Estate assessment update

Options	001a	001b Current	001D	001Dii	001C	001Cii	005	010	010ii	013	013ii
Service footprint:	4 sites	4 sites	3 sites	2 sites	3 sites	2 sites	None	3 sites	2 sites	3 sites	2 sites
PTHB Service model adjustments	Pre-temporary	None	None	None	Minor	Minor	N/A	Enhance Moderate	Enhance Moderate	Enhance Significant	Enhanced Significant
PTHB Workforce (WTE) UCC only	-	28.9	26.9	18.3	33.8	26.7	0	38.7	26.7	40.7	26.1
PTHB Workforce WTE Diagnostics only	-	23.4	23.4	23.4	24.4	24.4	19.2	27.1	24.4	28.4	25.4
PTHB UCC Demand assumptions	-	23,802	30,895	30,895	23,802	23,802	-	33,244	33,244	35,954	49,698
Financial costs minus savings (£m)	£3.3	£2.9	£2.8	£2.3	£2.7	£2.3	£2.3	£3.0	£2.2	£3.1	£2.1
Financial impact vs current 001b (£m)	£+0.4	-	£-0.1	£-0.6	£-0.3	£-0.6	£-0.7	£+0.1	£-0.7	£+0.1	£-0.8
Non - financial appraisal score	50.55	62.4	65.5	54.3	72.75	61.5	49.35	88.2	75.45	100.35	88.5
Direct cost per attendance	-	£124	£120	£99	£86	£76	n/a	£92	£67	£87	£60
Estates value	Low	Low	Medium	Medium	Medium	Medium	Low	Medium	Medium	Medium	Medium
Estate Feasibility	Green	Green					Green				

Summary

- Option 013ii Urgent Care Centre 2 sites, has the lowest financial costs (minus savings) and cost per attendance, but requires investment, there are associated risks with realising financial savings through reducing out of county attendances. Ranked 3rd on non-financial appraisal.
- Option 013 Urgent Care Centre 3 is marginally the second most expensive in terms of financial costs (minus savings) but is ranked the highest non-financial appraisal score.
- Option 001Dii and 001Cii which have no or minor service model adjustments across 2 sites have moderate financial savings but scored lower on the non financial appraisal

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

Urgent Care – Travel Time Principles

Urgent Care Centre Delivery Options

Travel Time Principles

	4-Site	3-Site		2-Site	
Sites	Welshpool Llandrindod Wells Brecon Ystradgynlais	Welshpool Llandrindod Wells Brecon	Newtown Llandrindod Wells Brecon	Welshpool Brecon	Newtown Brecon
Options included	001A 001B	001D 001C 010 013	001C 010 013	001Dii 001Cii 010ii 013ii	001Cii 010ii 013ii
Mean Travel Time	00:20:43	00:23:16	00:23:50	00:30:19	00:29:35
% within 45-minutes	95.3%	93.1%	91.2%	76.6%	83.1%
% within 60-minutes	98.7%	98.7%	98.8%	96.8%	98.5%

Physical Health



Physical Health Short List Options

This table shows which short list options were discounted or recommended to proceed to the next stage with supporting rationale

Option Ref	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, demand growth, 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 appraisals. 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 A/B - Amber 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 A/B - Amber 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 C/D - Red/Grey 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 with mental health	Proceed to next stage	Ranked 4th financial and 1st non-financial appraisals. Estates rated C/D - Red/Grey Ranked 1st non-financially with moderate delivery risk. Balances improved quality, MDT working, and community-based care while remaining more deliverable than two-site options. Requires workforce transformation and estate 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 C/D - Red/Grey 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.

Physical Health including Community Model Option Summary Information

Options	Option 001a Do previous	Option 001b Do current	Option 002 Same beds 6 sites	Option 002 Int' MH+P Same beds 6 sites	Option 005 Fewer beds on 3 sies	Option 005 Int' MH+P Fewer beds on 3 sies	Option 008 Int' MH+P Even fewer beds on 2 sites	Option 011 Remove all community beds
Service footprint sites	10 sites	9 sites	6 sites	6 sites	3 sites	3 sites	2 sites	None
Service footprint Beds	157	146	144	144	90	90	60	0
PTHB Service model adjustments	Pre-temporary	None	Minor shift closer home	Minor shift closer home	Moderate shift closer home	Moderate shift closer home	Enhanced care closer home	Secondary & Community only
PTHB Workforce (WTE) Inpatients	275	264	240	240	142	142	99	0
PTHB Workforce WTE Community	23.6	23.6	42.2	42.2	103.8	103.8	124.5	191.3
Financial costs minus savings (£m)	£12.8	£11.6	£11.4	£11.4	£9.7	£9.7	£7.5	£21.8
Financial impact vs current 001b (£m)	£+1.2m	-	£-1.18	£-1.18	£-2.63	£-2.63	£-3.84	£+10m
Non - financial appraisal score	37.7	48.6	69.0	72.6	86.3	87.9	77.9	52.6
Ward Staff cost per bed	£85,347	£78,149	£76,355	£76,355	£69,330	£69,330	£69,330	£0
Estates value	Low	Low	Medium	Medium	Significant / Major	Significant / Major	Significant / Major	Low
Estate Feasibility	Green	Green						Green

Summary

- Options 005 (inpatients on 3 sites) has low financial costs (minus savings), it ranked 1st in non financial appraisal, moderate risk to delivery, requiring workforce transformation and estate investment.
- Option 008 (inpatients on 2 sites) has the lowest financial costs (minus savings) and cost per bed, but requires large-scale workforce transformation. It ranked 3rd in the non financial appraisal and has high risk to delivery and major estate investment.
- Option 011 (remove all inpatient beds) demonstrates removing inpatient beds entirely is financially adverse, not beneficial. This option ranked 6th in the non financial appraisals.
- Option 002 ranked 4th and 5th in the non financial appraisal and deliver minimal financial savings but would allow some investment to support care closer to home.

High Level Assumptions

- WTE includes 26% headroom; costing uses midpoint of AfC 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, and no SLA cost reductions

Physical Health – Travel Times Summary across the options

Scenario / Option group	Service configuration	Mean travel time	Change vs "Do Previous"	Against the ≤45 min standard
Current configuration (Do Previous baseline) SLIPDO_001a	Majority of households within 30 mins of a community hospital ward	**11:56**	Baseline	Strongly within standard; most journeys short
Do Previous (All sites open) SLIPDO_001a	No change – all sites open	**11:56**	**0:00**	Strongly within standard
Do Current – RTGHU SLIPDO_001b	Ready to Go Home Units model	**35:01**	**+23:05** (vs 11:56)	Mostly within standard, but much higher average travel
Do Current – Rehab Units SLIPDO_001b	Rehab Units model	**29:35**	**+17:39** (vs 11:56)	Within standard on average; access worsens for some areas
Do Current – Community Hospital Wards (subset of sites) SLIPDO_001b	Only certain ward sites included	**18:31**	**+6:35** (vs 11:56)	Still within standard; moderate worsening vs baseline
Do Minimum (Six sites) SLIPDO_002a	Consolidate to six sites	**15:32**	**+3:36** (vs 11:56)	Within standard; small increase in average travel
Do Mid Range (Three sites) SLIPDO_005a	Consolidate to three sites	**23:50**	**+11:54** (vs 11:56)	Within standard on average; more people pushed towards longer journeys
Do Maximum (Two sites) SLIPDO_008	Consolidate to two sites	**29:35**	**+17:39** (vs 11:56)	Still within standard on average, but **more households exceed 45 mins**

*Travel Time to factor in for Public Transport – the options are a current like for like so can rule out that travel would not be adversely impacted as a result of the options

Next Steps in Readiness for Board Decision on Consultation

In preparation for readiness for a Board decision to proceed to public consultation the following next steps will be taken:

- **Further assurance checks** on the estate assessment for recommended options
- **Undertake Level 2 Integrated Impact Assessments** - the Level 2 and Integrated Impact Assessments will be progressed, this is being supported by Improvement and Quality & Safety leads.
- **Early testing of public and service user understanding and acceptability of the options, as well as gathering information to support the impact assessments** - A deliberative event will be held on 10th June 2026 to present the options proposed for consultation and their underpinning rationale, validate and sense check appraisal assumptions and scoring, and systematically stress test identified risks, impacts and potential unintended consequences. It is recognised that there are some limitations with regards to public and service user involvement since the last Deliberative event, and this event is designed to assess public and wider stakeholder acceptability of the options, as well as to strengthen confidence, transparency and consultation readiness in advance of formal public consultation.
- **Further internal and external scrutiny** - the Step Report and Recommended options workshop report will be considered by internally agreed governance arrangements and externally by HICO as part of their independent assurance, in readiness for consultation – this will include a review of the evidence base underpinning the rationale for discounting of options
- **Finalisation of the consultation plan and stakeholder and staff engagement plan**
- **Development of pre-consultation business case** – an outline pre-consultation business case will be prepared to share the outputs of the Phase 1 Adults Physical and Mental Health options development process, and this along with the supporting technical appendices will be presented to the Board in September 2026.



Better Together

What We Heard

Stakeholder Deliberative Event - 10 June 2026

A summary of discussions on the proposed changes to urgent care, physical health and mental health services in Powys.

Table of Contents

About this report 2

About the event 2

Who came 2

How the day worked 3

What we heard 3

Part 1 - Themes that came up in all three rooms 4

Part 2 - Urgent Care 6

Part 3 – Physical Health 7

Part 4 – Mental Health 8

What happens next 10

Appendix A - How the event worked 11

Appendix B - Questions we could not answer on the day 12

Appendix C - What people wrote on their postcards 14

About this report

Powys Teaching Health Board (PTHB) is looking at how to change adult urgent care, physical health and mental health services across Powys. The programme is called Better Together. Before asking the public what they think, PTHB held a special event to test the proposals with a wide range of people who know about health and care services in Powys, including clinicians, local authority staff, carers, service users and voluntary sector organisations.

This report tells you what those people said.

No decisions were made at the event, and no decisions have been made as a result of it. The next step is a formal public consultation, where everyone in Powys will have the chance to have their say.

Important
The people who came to this event are not the same as the general public. They were chosen because they have specialist knowledge or lived experience of health and care services. Their views are important, but they do not replace the views of the wider public. The public consultation is the essential next step.

About the event

The event was held on 10 June 2026. It ran from mid-morning to late afternoon. People were placed in one of three discussion rooms, one for each service area. Each room had two sessions, one in the morning and one in the afternoon.

120	3	47	2
people attended	discussion rooms Urgent Care - Physical Health - Mental Health	personal postcards completed	discussion sessions morning and afternoon

Who came

120 people came on the day. They came from a wide range of backgrounds. The aim was to bring together people who could look at the proposals from different angles, this was people who plan services, people who work in them, and people who use them or care for someone who does.

Who	This includes	Number
Independent clinical experts	Professor Anne Hendry and Naeem Aziz	2
General Practitioners	GPs attending as key community voices	4
Primary Care (PTHB)	PTHB-employed primary care staff	2
Welsh Ambulance Services	WAST representatives	2
NHS Wales and other NHS organisations	Neighbouring health boards and NHS Wales	6
PTHB staff	Clinical, operational and programme teams	29

■	**Third sector and local authority**	PAVO, LLAIS, Powys County Council, Mind, Marie Curie, St Michael's Hospice, RPB and others	**20**
■	**Carers and service users**	RPB representatives, citizen reps, mental health service users, advocates and people with lived experience	**12**
■	**PTHB executives and Board**	Executive directors and Board members	**12**
■	**Facilitators and scribes**	HICO and PTHB facilitation and scribing team	**27**
■	**Admin and support**	Event administration and support staff	**4**
	Total		**120**

People were placed at tables carefully, so that each small group had a mix of backgrounds and knowledge.

How the day worked

Three rooms ran at the same time, one for each service area. Each room had small groups of around six to eight people. Every group had a facilitator (someone to guide the discussion) and a scribe (someone to write down what was said).

Were the proposals believable?	Did the descriptions make sense? Were the assumptions realistic? Was anything important left out?
What could go wrong?	What were the risks? Who might be most affected? What would need to be in place for the proposals to work safely?
Would the public trust this?	People put themselves in the shoes of local residents and gave advice on how the consultation could be done well and be genuinely open.
Personal postcards	At the end of the day, everyone was asked to write one thing on a postcard: 'What is the one thing you would ask the Health Board to consider before it goes to public consultation?' 47 postcards were returned.

Each room also had a sheet where people could note questions that could not be answered on the day. These are in Appendix B.

What we heard

This section is in four parts. Part 1 covers the big themes that came up in all three rooms. Part 2 gives a shorter account of what was said in the Urgent Care room, Part 3 is about Physical Health and Part 4 is an account of what was said in the Mental Health room.

Where words appear in quotation marks, they came directly from the notes made by scribes during the discussions. The themes below reflect what participants said at the event: perceptions to be tested and built on through public consultation, not statements of fact or of PTHB's intent.

The main message from the day

People at the event did not oppose the idea of change. In all three rooms, there was broad agreement that the current way of delivering services is under pressure and that something needs to change. But people questioned whether the right conditions were in place to make change work - things like community services, social care, enough staff, transport, and a realistic plan. They broadly accepted the direction of travel. Their challenge was: can it actually be delivered?

Part 1 - Themes that came up in all three rooms

The community model - what does it actually mean?

The biggest single theme across the whole day was the community model, the idea that more care would be delivered closer to people's homes, with fewer patients staying in hospital.

People supported this idea. But they said they could not judge whether it would work, because it had not been described in enough detail. What services would be available in their community? Who would run them? What hours would they be open? What happens if a ward closes before the community service is up and running?

> *"The theory of doing everything in the community sounds great. But if you don't get community pathway elements in place, and you cut beds, you can end up in a right pickle."*

We heard concerns that the community model may assume a lot from charities and voluntary organisations but without saying what funding they would get or what would be expected of them. One postcard noted that charities are already in financial difficulty.

Social care - it has to be in place before anything else changes, participants said

Social care came up strongly in all three rooms, especially in Physical Health. People with direct experience of the system were clear: they felt that a big reason why people stay in community hospitals longer than they need to is that social care support is not in place when they are ready to go home. They felt that if bed numbers are reduced before social care can fill that gap, people will simply be worse off.

The home care market in north Powys was described as already stretched and unable to cope with much more demand. The divide between health funding and social care funding was described as a deep structural problem.

> *"We need to blur the boundaries of social care and health. Until you get that shared funding it is a waste of time talking about it."*

Trust - this consultation has to feel different

People in all three rooms felt there is already a real problem with trust between communities and Powys Teaching Health Board. Previous changes to services have left people feeling that decisions get made before consultation starts and that once views are collected, nothing changes as a result.

People referred back to information shared in the presentation earlier in the day and suggested that one option was the most financially attractive. They said this made the process feel like the decision had already been made.

> *"People will say it is a done deal. Will their feedback influence and inform?"*

People were clear about what they felt would rebuild trust: being honest about the financial situation as well as the quality argument; being upfront about what is genuinely still open; and showing people how their feedback made a difference, not just collecting responses and moving on.

> *"Don't avoid calling out and acknowledging the disadvantages and impacts, as this acts and creates authenticity and trust."*

Some communities are affected much more than others

People said that the proposed changes do not affect all parts of Powys equally and that a single county-wide message will not work for communities that will feel they are losing the most.

Ystradgynlais came up more than any other community, in all three rooms. It is one of the most deprived communities in Powys, out-of-hours GP services are provided by SBUHB rather than through Shropdoc, and people there tend to go to Swansea for health care rather than Brecon. At the same time, changes in all three service areas could affect it simultaneously. Llandrindod Wells was raised in relation to the risk that people may travel to Hereford rather than Brecon if the local Minor Injury Unit closed. Llanidloes came up around end-of-life care, with real emotional weight. Machynlleth was described as already feeling cut off. The central corridor of Powys, around Builth Wells, Rhayader and Presteigne, was identified as an area that could fall between two sites.

> *"Bring the areas together. Lead with geography and underpin with the service. Not lead with the service."*

The communities named here reflect those raised most frequently during the deliberative event. They should not be interpreted as the only communities affected by the proposals. The subsequent public consultation will provide an opportunity to understand how the proposals may affect communities across the whole of Powys.

Welsh language - a legal duty and a clinical need

Welsh language was raised in the Physical Health and Mental Health rooms independently and mentioned in Urgent Care too. The proposed sites for new consolidated services are in parts of Powys where fewer people speak Welsh, while some of the communities losing services are in areas where Welsh is spoken by more people.

People were clear this is not just a preference. They reported for people with dementia who speak Welsh as their first language, receiving care in Welsh is part of proper medical care because as dementia gets worse, people often revert to the language they grew up with. The assumption that a bigger site would automatically have more Welsh-speaking staff was challenged.

> *"Welsh first language with an ageing population and a high rate of dementia means people reverting to their first language - this must be taken into consideration."*

Workforce - a real problem and a real opportunity

Workforce came up in all three rooms. Concerns heard included: feeling that staff skills have declined under temporary arrangements, there is a national shortage of radiographers, and Welsh-speaking staff from places like Ystradgynlais may be unlikely to move to a site further north. But the positive case was made with genuine enthusiasm by many clinicians. A consolidated, better-resourced service could offer clearer career paths, stronger training, and the chance to build a genuinely excellent team.

> *"Being able to say I work in a centre of excellence - it allows us to have a workforce strategy. It creates more opportunity than it denies us."*

Transport - a practical problem that needs a practical answer

Transport came up in all three rooms not as a vague concern, but as a specific, practical question. How will people without cars get there? How will older people manage? What about wheelchair users and disabled people? What about unpaid carers who have to manage the journey on top of their caring responsibilities?

In the Urgent Care room, the Welsh Ambulance Service representative believed that if people cannot get to an Urgent Care Centre, will call 999 instead, potentially placing more pressure on ambulance crews, not less. In the Physical Health room, the parking and disabled access at the

proposed Brecon site were described as already unacceptable. In the Mental Health room, the concern that there is no pavement from the bus stop to the Bronllys site was raised directly.

> *"How are people getting there? Dial-a-ride, volunteer drivers - but none of this is in place for urgent care. Is this a missing gap that could be developed?"*

People, not buildings

When people filled in their postcards at the end of the day, almost none of them wrote about bed numbers, sites or NHS structures. They wrote about what the changes would mean for real people, their neighbours, their parents, themselves. Whether support would actually be there. Whether this consultation would be different from the ones before. The full postcards are in Appendix C.

> *"Focus on what we are gaining. Clarity of offer - new model versus what is on offer now."*

Part 2 - Urgent Care

The proposal: replace Minor Injury Units with two or three larger Urgent Care Centres across Powys

The Urgent Care room included doctors, nurses, ambulance service staff, local authority representatives, service users, and primary care colleagues. Many were genuinely enthusiastic about a better-resourced urgent care model. Their challenge was about what the proposals actually said, and how specific communities would be protected.

What would each site actually offer?

People in both sessions came to the same conclusion: they could not meaningfully choose between two or three sites because the proposals did not say what would actually be available at each site. What conditions could be treated? Who would staff them? What equipment would be there? How is this different from a Minor Injury Unit?

> *"We need clarity of what is a part of the options - the services offered on the sites, are they the same or varied? What are the treatment and care pathways?"*

Many clinicians were excited about what a good Urgent Care Centre could offer. This includes blood tests, imaging, IV drips, remote access to consultants, and assessment of frailty. All of these could mean people are treated locally rather than being sent to a hospital far away. However, participants also stressed that these benefits depend on enhanced diagnostics and specialist support being available whenever the Urgent Care Centre itself is open. They also noted that the language used to describe these things, like 'point-of-care testing', means nothing to most members of the public. They expressed concern that you cannot sell a benefit if people do not know what it means.

A safety question was also raised: if someone's condition gets worse while they are at an Urgent Care Centre, who is responsible for them, and how do they get to a higher level of care quickly?

Communities facing the greatest cumulative impact need specific plans

Ystradgynlais was mentioned more than any other place in the Urgent Care room. People described why it is different from other communities: out-of-hours GP cover is provided through SBUHB rather than through Shropdoc, most people travel towards Swansea rather than Brecon, significant levels of deprivation, and the potential loss of services in all three areas at once. Discussions indicated Machynlleth faces a similar sense of being left behind.

> *"Ystradgynlais already feel they get second class service because they're not covered by Shropdoc. If no MIU in Ystradgynlais, it's all Swansea Bay for us."*

Llandrindod Wells was raised as a specific risk: if the Minor Injury Unit closes under the two-site option, people may drive to Hereford rather than Brecon. A local councillor also felt that reducing healthcare in Llandrindod may affect investment and jobs in the town.

The financial ranking and the reinvestment question

People noticed that one option ranked better on quality but costs more financially, while the cheaper option ranked lower on quality. They asked how this could be explained to the public. They also asked directly: if services close and money is saved, where does that money go? This question will be asked during public consultation if it is not answered beforehand.

Transport and opening hours

The Welsh Ambulance Service raised a risk that if people cannot get to an Urgent Care Centre, they may call 999 adding pressure to ambulance services. The 8pm closing time was challenged: if people cannot be confident they will be seen before the service closes, they will not make the journey. Participants said unpaid carers face a particular burden from longer travel times and asked for this to be considered in the plans.

Seeing the whole picture

People were frustrated that the urgent care proposals were presented as if they existed separately from the physical health and mental health changes. People do not think about their town in three separate workstreams, they want to know what all the changes together mean for the place where they live.

> *"Bring the areas together - lead with geography and underpin with the service. Not lead with the service."*

Part 3 - Physical Health

The proposal: reduce inpatient beds from around 146 to 90 or 60, across two or three sites

Participants discussing physical health accepted that change is needed. Their challenge was about evidence, timing, and whether the right things would be in place before hospital beds are reduced.

Why 60 beds? Show us the evidence

People wanted to understand the evidence behind reducing from 146 beds to 90 or 60.

> *"Without justification for the lower numbers it brings into debate that you are just penny pinching."*

The strongest argument put forward by clinical representatives, that staying in hospital too long can actually harm people by making them less mobile and less independent, was described as the most persuasive case for change. This had been shared at earlier events in the deliberative series, but this was the third session and not everyone in the room had attended the previous ones. For those hearing it for the first time, it landed well. People said that where they had not encountered it before, they had been given proposals without the reasoning behind them. When the argument was made in the room, people responded positively to it. It should lead the consultation, not follow the financial argument.

Community hospitals mean more than healthcare

People said that community hospitals in Powys are not just buildings: they are part of how communities see themselves, communities have fundraised for them, people feel strongly about them. People were frank about what can happen when changes are announced.

> *"Within ten minutes of this being in the public domain you will have a Save Llanidloes Hospital Group with a flyer out in the community and social media."*

The potential change in palliative care in Llanidloes was raised with particular emotion. People have given money to support those services, and they described the idea of end-of-life care moving away as deeply upsetting.

"I think it will be incredibly bad the loss of palliative care, people collected money for it, and it will be emotional especially in Llanidloes. When they are dying people want to be close to home."

People also asked what would happen to the hospital buildings themselves. They expect communities to be told exactly what is closing, what is changing and what will replace it.

Social care has to be in place first

People said that the average stay in community hospitals, often 50 to 60 days, is substantially driven by delays in arranging home care when people are ready to leave. Continuing Healthcare (CHC) assessments, which determine whether the NHS or social care funds a person's ongoing support, were named as a specific barrier. The home care market in north Powys was described as fragile. People were emphatic: bed numbers cannot be reduced until social care is formally secured.

Transport, access, and the GP gap

Parking and disabled access at the proposed Brecon site were described as currently unacceptable. People also felt there was a gap in GP engagement: without GPs as genuine partners in the community model, the shift from hospital to community care cannot work. A GP in the room felt that GPs had not been properly involved in developing the proposals.

North Powys Programme: a credibility risk

A specific concern was raised about the relationship between Better Together and the North Powys Programme, a separate programme of health service changes in the north. People said that communities in north Powys have been told the two programmes are separate. But when Better Together goes public, Phase 2 of the North Powys Programme will now need to be informed by decisions made through the Better Together programme. Participants felt that the relationship between the Better Together Programme and the North Powys Programme would need to be explained clearly during consultation so that people understand how the two programmes relate to one another.

Planning for the future, not just for now

Several people raised the question of whether the proposed bed numbers have been calculated for the population Powys has now, or for the population it will have in 10 or 15 years. Powys has an ageing population. People are living longer, often with several conditions at once. The consultation should explain how this has been factored in.

People also raised the transition period as a specific risk, what happens to patients during the time when old services are closing and new ones are not yet fully up and running? The costs of running old and new services at the same time need to be acknowledged honestly.

Part 4 - Mental Health

The proposed direction: a single consolidated inpatient site, most likely in the Bronllys area

People broadly supported the direction of consolidating services into a better-resourced centre. But they raised serious concerns about whether the right conditions were in place and one big governance question about what it means to consult on a single option.

Is it really a consultation if there is only one option?

The biggest theme in the Mental Health consultation readiness discussions was whether presenting one option to the public is a real consultation at all. The formal assessment process looked at eight options and concluded that one was the best. But people at the event asked: if feedback cannot change the direction, will people bother to engage?

"People will say it is a done deal. Will their feedback influence and inform?"

"Credibility of only having one option means it is not an option. Need clear rationale of why only putting one option forward."

People asked for a clear, plain language explanation of how eight options became one. They also said the consultation needs to be genuinely open on the things that can still be influenced, such as the community model, transport, Sanctuary services, and what provision there will be in north Powys.

North Powys: a risk of creating two-tier care

It was felt that a single site in the south of Powys creates longer journeys and less accessible services for communities in the north that already feel underserved. People asked specifically what would be provided in north Powys to compensate and whether that provision would be clearly described, not just promised.

> *"If I lived in N. Powys, I'd feel like there is nothing for me."*

Questions were also raised about beds in north Powys that currently accept mental health patients, whether these would still be available, and about whether services over the border in Shropshire could be formally arranged to provide care closer to north Powys residents rather than requiring long journeys south. People were concerned about creating a situation where the quality of care you receive depends on which half of the county you live in.

Getting to Bronllys

The physical accessibility of the Bronllys site was raised in direct terms. It was reported that the bus goes only to the bottom of the drive, the drive is steep with no pavement and the site is not accessible for wheelchair users without a car.

> *"Bus to Bronllys goes to the bottom of the drive, it is steep, has no footpath and killer speed bumps. Amalgamation of services makes sense but make it accessible."*

People also noted that the current Bronllys ward has no visitor areas, and that patients cannot take children to any mental health location. This was something described as difficult for families. On the positive side, the current ward gives patients their own rooms, which is valued and should not be lost in any new design.

The community model for mental health needs to be specific

The Sanctuary, a safe space for people in mental health crisis, was welcomed in principle, but people said it had not been described clearly enough. Where would it be? What hours would it be open? How would people access it? Crucially, would there be one in north Powys as well as south Powys? People also pointed out that Sanctuary has been proposed before and not delivered, which makes it harder to trust the current proposals.

People said the proposals need to cover the whole journey from early community support, through to crisis care, a hospital stay if needed, and then a safe transition home or to a care home when someone is ready. The proposals as written describe the inpatient part but not the full picture around it.

Carers and families

The role of families and unpaid carers was raised as especially important in mental health, where families often provide daily support during and after a crisis. Longer travel to visit someone in hospital, and more expectation of community care without more support, could lead to carer burnout.

> *"What does it mean for unpaid carers? They will fear that more community care means more loads will fall to them."*

People also noted that in small, close-knit rural communities, some people may be reluctant to use community mental health services because they are worried about being recognised by the

professionals delivering them. This is something the community model needs to think about carefully.

Groups whose needs are not described

People flagged several groups with specific needs which they felt are not addressed in the proposals, these included people with dementia who speak Welsh as their first language and need Welsh-language care as their condition worsens; people with both learning disabilities and mental health needs; and young people. People expressed concern about no mental health inpatient beds for young people in any of the proposed options. They believed this is a significant gap.

Questions were also raised about the number of beds: are five enhanced care beds enough, and how will male and female patients be accommodated if bed numbers are limited?

Other important questions

People raised the current reliance on police in the mental health pathway in Powys, police often respond to mental health crises because there is no other option available. Any new model needs to address this directly. People also asked about patients currently treated out of county: how many are there, what does it cost, and what would the new model provide for them? Participants said these questions need answers, and PTHB will need to explain how they are being addressed as consultation develops.

What happens next

The findings from the event have been shared with the PTHB Board and the programme team. They are being used to help get ready for the public consultation not to replace it.

The public consultation is the essential next step. Everyone in Powys will have the chance to have their say on the proposed changes. Materials will be available in Welsh and English. People will be able to respond online, by post, by phone, and at events across the county.

PTHB will publish how the consultation responses influence the final proposals.

Before the public consultation starts, the Board will consider

- How to describe the community model in specific, concrete terms - what services, where, when, and who will deliver them.
- Whether reducing hospital beds should be linked to social care being formally in place first.
- How to run the Mental Health consultation in a way that is genuinely open to public influence, given that the formal assessment has produced a single recommended direction.
- How to address the combined effect of changes on communities that may face comparable cumulative impacts - especially Ystradgynlais, Llanidloes, Machynlleth and Llandrindod Wells.
- What transport plans, workforce plans and transition arrangements the programme is committed to, and how these will be explained in the consultation.
- What answers are needed to the questions raised in Appendix B.

Want to know more?

Information about the Better Together programme, the proposed options and the public consultation will be available at: https://pthb.nhs.wales//bettertogether/

You can also contact the PTHB engagement team. Contact details will be published when the consultation opens.

Appendix A - How the event worked

Why we held this event

Before the public consultation, PTHB wanted to test the proposals with people who have detailed knowledge of health and care services in Powys. The aim was to find out what questions needed answering, what risks had been missed, and what the public consultation would need to do to be credible and trustworthy.

The event was designed and run by HICO, a specialist engagement consultancy, working with PTHB.

How people were chosen

People were invited because of their professional background or lived experience. They were placed at tables to ensure each group had a mix of perspectives including clinical expertise, operational knowledge, community insight and personal experience of services.

How the discussions worked

Each room had a trained facilitator to guide the discussion and a scribe to write down what was said. Scribes captured people's actual words as closely as possible. Facilitators did not give their own views on the proposals.

Each room ran two sessions. In each session, groups started with the credibility discussion before moving to either the risks discussion or the public acceptability discussion.

Note: two groups in the Urgent Care room ran the risks discussion twice instead of the public acceptability discussion. This means there is less material from the Urgent Care room on what the public consultation should look like.

In the Mental Health room, groups were merged in the afternoon session due to fewer people being present.

How we have used what people said

This report uses quotation marks only for words that scribes recorded as someone's direct words. Where scribes summarised what a group discussed, this report describes it in plain language without quotation marks. No words attributed to participants were written by the report authors. 47 people filled in postcards at the end of the day. All 47 are set out in full in Appendix C.

What this report is and is not

This report tells you what an informed group of stakeholders said. It is not a record of what the public thinks. The people who attended were chosen for their specialist knowledge, they are not a random cross-section of Powys residents. The public consultation is the essential next step.

Appendix B - Additional Questions

Each room had a board for questions that were not answered during the discussions, for example, because there was not sufficient time for a detailed response, because they were outside the scope of the day, because participants wanted to flag these as issues to consider in the consultation document. These are not objections to the proposals. They are questions the programme needs to be ready to answer.

Urgent Care

- What other options were considered and ruled out, and why?
- If someone gets worse at an Urgent Care Centre, who is responsible for them and how do they get to higher-level care?
- Are any beds at the Minor Injury Unit included in the ward count? How does this affect safe staffing?
- If these are the only realistic options, that should be stated honestly, along with an explanation of what could not be achieved in Powys.
- Why 8pm closing time? Can the service be staffed at night, and if not, what does that mean?
- How will the Welsh Ambulance Service direct patients into Urgent Care Centres rather than hospital A&E departments?
- Do the Urgent Care Centres treat children? What happens in communities where Shropdoc does not provide out-of-hours care?
- If services close and money is saved, where is it reinvested?

Physical Health

- What will happen to hospital buildings if wards close?
- Who is responsible for commissioning, funding and delivering social care under the proposed model? What has Powys County Council formally committed to?
- What will palliative and end-of-life care look like under each option?
- What IV treatments will be available, is it just antibiotics, or others including chemotherapy?
- Has information about complaints and concerns been used to shape the proposals?
- What is the wider economic effect on communities like Llandrindod Wells if hospital services reduce?
- Does Powys need its own training and education pipeline for health staff?
- The ready-to-go-home units are not working as intended. What will change?
- How has the evidence about hospital stays causing harm through inactivity been used to determine the bed numbers?
- What diagnostic services like scans and blood tests will be available under each option and where?

Mental Health

- 111 press 2 (the mental health urgent support line) is working well but how does it connect to the proposed single site, and what happens when someone cannot or will not use it?
- The current Bronllys ward gives patients their own rooms, which is valued, this should not be lost. The ward has no visitor areas and patients cannot take children to any mental health location.
- There are no mental health inpatient services for young people in any of the proposed options. This is a significant gap.
- What community services and support will be available in north Powys?
- How did the formal assessment process go from eight options to one? This needs to be explained in plain language.
- What does a Sanctuary look like in practice? What hours? Will there be one in both north and south Powys?
- Are five enhanced care beds enough? How will male and female patients be accommodated if beds are limited?

- How many patients are currently treated out of county, what does it cost, and what will the new model provide for them?
- How will the heavy reliance on police in mental health crisis response be addressed?
- What will happen to newly qualified nursing staff based in north Powys who want to work in mental health?

Questions that came up in more than one room

- How will the consultation reach people who are unwell, do not have internet access, or are not used to formal engagement?
- What financial support will the voluntary sector receive to take on a greater role in the community model?
- How will PTHB show that this consultation is different from previous ones - and that responses genuinely change something?
- Will PTHB cover travel costs for patients and families who have to travel further to reach services?
- Will materials be available in Welsh by default, and in easy-read format, from the start of consultation?
- Will there be a single overview showing the combined effect of all three sets of changes on individual communities and towns?

Appendix C - What people wrote on their postcards

At the end of the event, 47 people responded to: 'From everything you've heard today, what is the one thing you would ask the Health Board to consider as it moves towards public consultation?'

People filled in their postcards on their own, without discussing it with others first. All 47 responses are set out below in full, grouped by theme. The number shown is the reference number from the original record. Spelling and punctuation have been lightly tidied for readability. Nothing has been changed in meaning.

Theme 1 - Tell people clearly what the community model means in practice

2	We need to focus on the positives e.g. Community Services will offer x, y and z meaning we will not require 60 beds.
8	Bold statements about 'improved' but no clarity on how this will be achieved/realised. Leaves it feeling very theory/aspirational and not necessarily realistic.
11	More details for public and clinicians about what services and conditions will be able to be managed in Urgent Care Centres and in the community - and start providing and putting these services in place as soon as possible before reducing other services/beds.
12	Ensure the public have a clear, detailed understanding of what the community care offer is to be and what it is at the moment. A united health and care system - ideal ambition! Unite health and care system to ensure health and care is free to all at the point of need.
13	1. Focus on people. More person-centred care. What do the changes mean for people? How will changes make things better? (or worse?) 2. Need to show options discarded and why. Otherwise, credibility questioned. 3. Concerned all proposals being looked at in isolation. What is cumulative impact? The 'Community Model' did not come through clearly. What it means? How would it be delivered? How would it be funded? Importance of social care and third sector referenced but not clear understanding of what is meant.
14	Suggestion for describing what any community services may look like: a) find examples of good practice already happening which demonstrate what the plan is for all of Powys; b) find examples where the community-based services are successfully working in other rural areas e.g. Scotland.
15	Confidence in the alternative community (positive) offer, clearly described - including a very clear positive offer for (and supporting) GPs.
20	The Prevention and Local Intervention services need to be defined. Describe the reduced bed required as the output of the above! Don't avoid calling out and acknowledging the disadvantages and impacts, as this acts and creates authenticity and trust.
28	Consider: investment detail and offer before what is being disinvested. Currently options are in the lens of what is reducing first.
35	Modelling of need that will be met by partners must be done soon. Essential that partner services are aware of expectations e.g. how much money will be needed to find a community offer that allows these changes to proceed without unacceptable risk/loss/liability.
42	More detail and articulation of the integrated community model vision and what this could/would look like - described from people's/person perspective in language that is understandable.

Theme 2 - Be honest and open

3	We need to demonstrate due diligence. Data driven e.g. 80% of this condition can be managed in the community by doing x, y and z. This will direct 20% of inpatient care from x hospital.
22	Be honest! Listen to the people in each community and make sure current good practice is enhanced, not changed for change's sake. Don't be solely finance driven - consider person experience.
23	Ensure we are open and honest to the public around reasons for these changes. Ensure the language we use is inclusive and appropriate, without jargon.

27	1) What financial support will the third sector have to be more involved in the preventative community offer? 2) Public consultation needs to be clear that this is the next stage of an ongoing consultation, not another (new) consultation about the same issue. It feels like there have been lots of requests for public feedback about the same thing over and over, with nothing coming of any.
34	It is important that the development/change of services keeps the person at the centre. Honesty during public consultation on the need for change and keeping the public informed as the change takes place is vital. Celebrate and share the good work but be honest about what doesn't work, and keep in mind to prepare with effective exit strategies for things that don't work.
36	Where we have more than one option taken forward to public consultation these tend to offer a choice between 'more'/'less' (e.g. physical health 2/3 sites). It feels obvious the public will choose 'more', and if the justification for option 2 is more about financial savings than patient experience, then a Health Board choice of the financial savings option could/would be a problem! Perhaps be brave re one option for all.
39	Communication appears to be key. Conversations need to happen within the workforce, between sectors and with the wider population. Consultation with the public should not be tokenistic.

Theme 3 - Focus on what this means for real people

9	Focus on what we are gaining. Clarity of offer (new model) versus what is on offer now.
17	Present the gains first to the public and why they are of benefit to them with clear, non-medical language before describing the 'losses'.
24	To really present patient pathways/stories clearly. How they are now? How they will change? The benefits of the change? The mitigations planned for downsides.
26	1) Remember - people who are complex and fit into a number of pathways. How do they get full service for each need? 2) Ambitious - very reliant on scaling community and GP services up. If that can be done - brilliant! Need to believe it still. I'm looking forward to seeing the next layers of detail for comment. Please keep each area communicating so the silos don't become too deep.
29	How will this be better for me? You are taking away services whilst not improving the ones most important to me. I feel very sceptical and jaded. Mental health community teams and psychology services need investment.
37	Please put the patient first within your decisions. Don't close hospitals but support existing ones!
38	Please consider unpaid carers and the role they play in supporting family/friends to stay well and to access services. This consultation doesn't just affect service users but their carers/supporters too.
44	Co-location of MH wards would enable significant investment in activities/alternative support for inpatients, art psychotherapy, failure-free activities etc., which can rotate across wards.

Theme 4 - Show how it all fits together

30	Join the dots between the options to give a broader overview on what these options/changes look like overall - the big picture.
31	Clear information, use partners to spread the word. Set out the now, changes (good/bad), what stays the same, reasons why.
40	More integration between the themes. E.g. Physical Health / Mental Health / Urgent Care. Produce options that include the interdependencies between the three services.
41	Integration of primary care and community services offer.
43	The third sector is referenced in most options but with little clarity. It's so important to truly engage the third sector to understand their current capacity and funding needs. Charities are in financial crisis from the dated funding allocation, engage with them early to truly understand their abilities to support these ambitious models. PS if Bronllys is to be a single site for mental health, physical accessibility of the site needs to be improved. There is no pavement up to the site; disabled individuals can't physically access the site, let alone if they are wheelchair/mobility aid dependent.

45	Even more could be achieved by joining up the mental health and physical health options and explaining how they complement each other rather than 'selling them' as very separate changes.
18	Has the health board considered the impact on services provided at neighbouring health boards and impact on the length of stay in our neighbourhood service providers?

Theme 5 - Work properly with GPs, staff and partners

6	Engagement sessions with all primary care independent contractors in respect of how they will change (not just GP).
16	Genuine engagement with primary care. We need to be heard, not just listened to, and act on our opinions/suggestions to work together. Primary care is the centre of all communities so treat us with respect as we know our communities and what they need/want. Primary care also provides cost-effective care - perhaps learn from our financial experience and not waste money on more managers/layers which do not provide face-to-face services.
32	Staff engagement really important. Digital offer both patient records and TEC.
33	Improved end of life care for patients and families in the community. More access to services, care and support to allow people to have a dignified and comfortable death at home.

Theme 6 - Make the consultation genuinely open

4	Truly make this accessible for everyone regardless of age, sex, gender, disability, finance and every other group especially when some are under threat. Will it work with how social care is planning to change? If you both change at once, who will fall through the gaps?
5	No obvious links with preventative services - culture change. More collaborative/co-produced services should be evident as part of the development of options. (Voluntary sector.) There wasn't enough time in breakout sessions. Not enough detail around community model that will support options and decisions made. A lot of info shared for people not in health.
7	Consider the number of people in each local area that are spoken to so positive or negative feedback can be weighted.
10	Please consider how the impact of removing 'local' services will have on rural communities and their access to transport.
25	Thank you for the opportunity to join a wide range of stakeholders regarding this subject. a) Future events - test information provided with a few attendees ahead of the meeting. b) Ensure the public understand the why and what this will mean for them. c) What community assets could be used to deliver your model? d) Facilitators need to allow more time to listen, not speak to us (MH session).
46	I think it's important to understand the difference between consultation and co-production and if we invest in co-production then the public will be much more willing to change especially for Mental Health.
47	Trust us - bring citizens into the process from the start and throughout. Know what co-production is - look it up.

Theme 7 - Be bold and ambitious

1	We need to make BOLD and IRREVERSIBLE decisions. This change requires a cultural change for Wales. But this can be the catalyst for the much-needed change!
19	Need to improve psychological services to inpatients and quicker access to talking therapist CBT/DBT to all in need in Powys.
21	Please ensure you get the right colleagues to facilitate engagement sessions with the public. One in particular spoke too much, didn't listen, wasn't well prepared. This wasn't helpful and certainly wouldn't go down well with the public.

PTHB Service Change Impact Assessment Mental Health 07/08/2026 Version 1.0 Approved for inclusion in PCBC

Live Document Subject to Change

Version Control (To be updated after formal final approval)

Version	Date	Author	Comments
Version 1 for PCBC	7. 8. 2026	Assistant Director of Improvement and Innovation / Quality Improvement Facilitator	Agreed for inclusion in PCBC

DOCUMENT NEEDS TO BE REFERENCED TO LATEST TECHNICAL DATA IN APPENDICES OF MASTER DOCUMENT

This Integrated Impact Assessment has drawn a number of references and documents listed and documents in the Bibliography. The significant technical documents reviewed to develop this impact assessment are held in the Step Report and Pre-Consultation Business Case. As the programme develops and new information is made available then this impact assessment will be updated.

The process used to calculate risk and copies of the risk matrix are detailed on Page 55

Section A: Overview Summary of the Proposed Changes
(See full Step Change Document and Primary Business Case for full details)

A.1. Proposal Details	
1.1 Name of Proposal	Mental Health Inpatient and Community Model
1.2 Proposal Lead	Assistant Director Mental Health & LD
1.3 Reference Number	n/a
1.4 Summary of Proposal	To create a radically enhanced community mental health model that enables more care to be delivered closer to home, reduces reliance on out-of-county placements and improves prevention, early intervention and rapid response services. To facilitate this transformation, changes to the current mental health service model have been considered through the options appraisal process. **Option SLMHDO02_001a: Do Previous** aims to return hospital and community mental health services to the previous service model, reversing recent changes and restoring services to their former configuration. **Option SLMHDO02_001b: Do Current** aims to maintain hospital and community mental health services in their current form, retaining existing inpatient and community provision without further service redesign. **And;** **Option SLMHDO02_006a: Do Maximum** aims to centralise all functional and organic mental health inpatient services in the or Brecon area., repatriate Powys patients currently receiving inpatient care outside the county and develop an enhanced community-based model integrated with physical healthcare. The model would place greater emphasis on prevention, rapid response, early intervention and holistic care closer to home. The enhanced community mental health model, supported by a consolidated inpatient service in the Bronllys or Brecon area aims to improve quality, sustainability, workforce resilience, patient experience and integration between mental and physical health services, while reducing reliance on out-of-county care and supporting more timely access to care within Powys.

1.5 Date / Version	**07.08.2026 v 1.0 Approved for inclusion in PCBC**
Interdependencies	**When reviewing this Level 2 Integrated Impact Assessment, it is important to recognise the interdependencies between the Mental Health, Physical Health and Urgent Care proposals.** Delivery of these proposals is dependent upon a range of critical interdependencies across health, social care and third sector partners. Key partners include Primary Care, Community Resource Teams, Adult Social Care, Housing Services, Welsh Ambulance Services, Acute Health Board partners, Substance Misuse Services, Psychological Therapies, Learning Disability Services, Crisis Resolution and Home Treatment Services, as well as a broad range of voluntary and community sector organisations. Together, these services will form a more integrated and responsive network of support, ensuring individuals receive the right care, at the right time, in the right place. A particular dependency of the proposed model is the strengthening of community mental health provision across the county. This includes the expansion of multidisciplinary community mental health teams, improved access to crisis intervention and intensive home treatment, enhanced psychological therapies, increased support for people with complex needs, and stronger links between physical and mental health services. The model also relies on effective care coordination, robust discharge planning arrangements, and seamless transitions between inpatient, community and wider partner services. The implementation of a county-wide community mental health model will be undertaken alongside the proposed inpatient changes through phased service redesign, workforce development, stakeholder engagement and programme governance arrangements. This approach will ensure that community capacity and capability are strengthened in advance of, and alongside, any changes to inpatient provision. Collectively, these developments will support a modern, sustainable and person-centred mental health system for Powys. By investing in enhanced community services and establishing a single inpatient centre of excellence, the model aims to improve quality, consistency and patient outcomes, whilst ensuring specialist inpatient care is available when required and community-based support remains the cornerstone of mental health care delivery. Key Interfaces/ Interdependencies These include: ▪ Community Teams ▪ Specialist Services ▪ Adult & Older Adult Social Care ▪ MH Single Point of Access (SPOA)

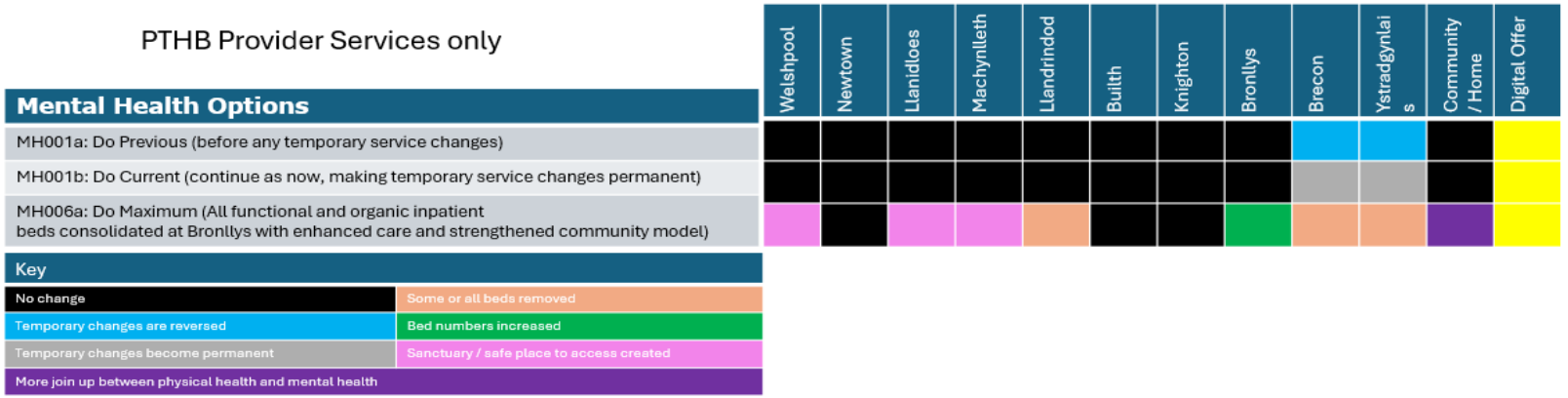
	▪ Primary Care ▪ Third Sector ▪ Out of County private providers ▪ Out of County commissioned partners ▪ Acute SLA providers ▪ Therapies ▪ Housing Services ▪ Care providers ▪ Private patient transport providers ▪ Physical Health Inpatient model of care ▪ Physical Health Community Model ▪ Police ▪ WAST ▪ Interdependencies with other services e.g. CAMHS and Learning Disabilities are mainly around Single Point of Access which is not part of public consultation
A.2. Proposal Overview	
2.1 Summary of Proposal	The proposed changes to adult mental health services are founded on the principle that care should be delivered as close to a person's home as possible, with inpatient admission reserved for those who require the most intensive levels of support. The success of the proposed centralisation of inpatient mental health beds to a single site is therefore intrinsically linked to the development and implementation of an enhanced Community Mental Health Model across all areas of Powys. This transformation requires a significant shift in the balance of care from inpatient settings to community-based services, ensuring that people experiencing mental ill health can access timely, safe and effective support within their local communities. The enhanced model aims to provide more proactive, preventative and recovery-focused care, reducing avoidable admissions, supporting earlier discharge from hospital and improving continuity of care across the whole mental health pathway.

The table below outlines the summary or proposals which are reviewed in further detail in this section.

Mental Health Scope – What could change on PTHB each site

To provide accessible, therapeutic, recovery-focused Mental Health care within a community setting that prevents escalation to acute or crisis services, supports timely recovery and reablement, integrates Physical and Mental Health care with specialist support

PTHB Provider Services only



- **SLMHDO02_001a**: Do Previous: Put current hospital and community health services back to how they were
- **SL MHDO02_001b**: Do Current: Keep current hospital and community health services as they are now
- **SL MHDO_006a**: Do Maximum: Move all functional and organic mental health inpatient services to Bronllys or Brecon area, bring back out of area

The recommended Mental Health option was identified through an integrated appraisal of financial sustainability, workforce viability, estate condition and access impacts. It moves from a fragmented ward model with limited flexibility, workforce resilience challenges, environmental constraints and financial fragility, to a consolidated inpatient site supported by strengthened community-based services. This section summarises the key implications of the recommended option to support a comprehensive Level 2 assessment.

Mental Health Proposed Future Model

The mental health model delivers a whole-system pathway spanning prevention, crisis, inpatient care and recovery, with a strong emphasis on early intervention and community-based support. It introduces a single point of access, crisis alternatives such as sanctuary provision, and integrated inpatient and community pathways.

Care is trauma-informed, recovery-focused and integrates physical health, with expanded multidisciplinary teams and digital enablement. The model aims to reduce crisis escalation and admissions while improving outcomes, experience and long-term recovery.

Proposed Option - Single Site Mental Health Model

This option would strengthen community mental health support across all communities in Powys while consolidating inpatient mental health beds together onto a single site, most likely in the Bronllys or Brecon area, subject to further estate feasibility work. The aim would be to improve service resilience, workforce sustainability and coordination of care, while providing more integrated support for people with a range of mental health conditions including older adults with dementia.

Community services would focus more strongly on prevention, early intervention, crisis support and helping people remain well at home wherever possible. The option would also include improved links between physical and mental health services and a stronger local enhanced care offer, which could reduce the need for people to travel outside Powys for specialist support and improve health outcomes through more integrated care.

During the appraisal process, this option ranked third out of eight options on quality and patient experience criteria and third on financial grounds, although further work is still required around estates, affordability and deliverability before any decisions are made. Other potential options were discounted due to lack of feasibility.

Strategic Aims

- Improve service resilience
- Enhance workforce sustainability
- Strengthen coordination of care
- Provide more integrated support across a range of mental health conditions, including older adults with dementia

Community-Based Care Approach

- Greater focus on:
    - ✓ Prevention and early intervention

- ✓ Crisis support
- ✓ Supporting people to remain well at home wherever possible

- Improved integration between physical and mental health services
- Development of a stronger local enhanced care offer

Impact on Patients and Services

- Potential to increase the need for patients and carers to travel within Powys for inpatient care
- Potential to reduce the need for patients to travel outside Powys for specialist support
- Improve health outcomes through more coordinated and integrated care

Appraisal Outcome

- Ranked 3rd (out of 8 options) for quality and patient experience
- Ranked 3rd (out of 8) for financial performance
- Requires further work on estates, affordability, and deliverability before decisions are made

The table below describes the key areas of changes identified within the proposed option.

Area	SL MHDO_006a: Do Maximum:
Overall description	▪ Move all inpatient services to the Bronllys or Brecon area, 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
What stays the same	▪ SPOA / NHS 111 Press 2 remains in place ▪ Some specialist out-of-county provision is still required ▪ Some older estate stock continues to be used
What changes	▪ All inpatient beds move to Bronllys or Brecon area ▪ Mental health inpatient services at Brecon or Bronllys, together with Llandrindod and Ystradgynlais close ▪ Some out-of-county patients are able to be brought back into Powys ▪ A single consolidated inpatient site is created in the Bronllys or Brecon area. ▪ Enhanced care provision is developed to support higher-acuity patients ▪ Community, liaison and alternatives-to-admission services are expanded ▪ A more integrated physical and mental health community offer is introduced ▪ Capital redevelopment and/or new build at Bronllys is required

	▪ Introduction of sanctuary style service into the County
Finance	▪ The option should deliver a net recurrent saving compared with the baseline, driven by fewer inpatient wards and lower support service costs. ▪ Financial sustainability is dependent on successful delivery of community substitution and reduced length of stay.
Workforce	▪ Improved workforce resilience through consolidation onto one site, reducing lone working and reliance on temporary staffing. ▪ Better opportunities for staff development, supervision and recruitment through larger multi-disciplinary teams. ▪ Workforce transition required, including redeployment into community roles and potential changes to skill mix. ▪ Offers the potential to support recruitment and retention by providing clearer career pathways, enhanced roles and a more sustainable team structure, subject to further evidence and testing.
Estates	▪ Concentration of inpatient care onto the most modern and adaptable sites. ▪ Reduced estate footprint for inpatient care, lowering ongoing maintenance and compliance risk. ▪ Capital works required for new purpose-built accommodation.
Travel time & access	▪ Increased travel times for some patients and visitors due to bed concentration on fewer sites. ▪ Access impacts are partially mitigated by fewer admissions, shorter lengths of stay and more care delivered at home.
Key benefits	▪ Enhanced Community model will offer increased support for people at home and in their communities, especially those who are disabled, socially excluded or isolated. ▪ Equity of service provision by bringing services together ▪ Improved clinical consistency and resilience ▪ Improved workforce sustainability ▪ Strategically creating a centre of excellence providing a universal approach, aligned with Royal College of Psychiatry Quality Standards

		▪ Reduced long-term reliance on out-of-county beds ▪ Simplified governance and pathways ▪ Potential for increased MDT working with physical health ▪ Improved patient outcomes and experience as follows; ▪ Improved therapeutic environment ▪ Access to therapies: CBT, DBT-informed practice, psychoeducation. ▪ Physical health monitoring and interventions. ▪ Navigation through clear seamless pathways of care. ▪ Creative therapies (art, drama, music). ▪ Peer support and community links. ▪ Creative therapies (art, drama, music). ▪ Strengthened provision with protected time and dedicated fit for purpose space and environment for activities. ▪ Improved digital offer
	Key risks	▪ High capital requirement ▪ Single-site vulnerability ▪ Risk of creating inequity of care between south and north e.g. use of alternative to admission offer in other end of county to inpatient site may promote difference in inpatient admission pathway ▪ Consolidating clinical teams may lead to reduced variability in thought, creating 'siloed thinking' ▪ Community connection – site is not well connected to the community and patient transport issues will need to be mitigated. Increased travel distances may deter patients from accessing MH services, ensure clear communication for patients to understand how to access services easily ▪ Public, staff and political acceptability challenges ▪ Complex transition period ▪ Optimal Benefits realisation dependent upon proximity to Physical Health services, a lack of co-location may impact potential benefits ▪
	Trade-offs	1. Long-term sustainability and quality **vs** short-term disruption and access impact 2. System simplification and quality **vs** access and travel distance 3. Not co-located with physical health 4. Still commissioning out of county activity in the north to meet population needs

	Level 2 view	▪ This is the sole option for Mental Health services following rigorous feasibility assessment, given the viability in improving current provision, tackling challenges highlighted in the case for change, options for purpose-built approach to provision and financial sustainability
2.2 Situation, Background, Strategic Context	**Wider Mental Health Strategic Context** This proposal has been developed with reference to the existing regulatory and statutory framework in Wales. ▪ **Well-being of Future Generations (Wales) Act 2015** Promotes long-term, preventative and integrated approaches to improving the social, economic, environmental and cultural wellbeing of Wales. The proposed model supports prevention, collaboration, integration and sustainable service delivery. ▪ **Social Services and Well-being (Wales) Act 2014** Supports person-centred care, early intervention, independence and integrated working between health, social care and third-sector organisations. ▪ **Mental Health (Wales) Measure 2010** Provides the legislative framework for improving access to mental health services, care and treatment planning, care coordination and timely access to independent mental health advocacy. The proposed model supports seamless pathways, coordinated care and improved access to support. ▪ **Mental Health Act 1983 (as amended)** Provides the legal framework for assessment, treatment and protection of individuals with severe mental illness and places responsibilities on organisations to deliver safe, appropriate and rights-based care. ▪ **Health and Social Care (Quality and Engagement) (Wales) Act 2020** Introduced the NHS Wales Duty of Quality and Duty of Candour, requiring continuous improvement in outcomes, patient safety, experience and openness when things go wrong. **Welsh Government and NHS Wales Policy** ▪ **Mental Health and Wellbeing Strategy for Wales 2025-2035** Sets the national vision for a connected system where people can access the right support at the right time, with services that are seamless, person-centred, recovery-focused and delivered closer to home.

	▪ **A Healthier Wales: Long Term Plan for Health and Social Care (2018)** Establishes the vision for integrated health and social care services, prevention, population health improvement and reducing reliance on hospital-based care. ▪ **National Clinical Framework for Wales** Promotes evidence-based, outcome-focused and value-driven healthcare, supporting consistency, quality improvement and equitable access to services across Wales. ▪ **Quality Statement for Mental Health and Wellbeing (Welsh Government)** Sets expectations for safe, effective and person-centred mental health services, with a focus on prevention, early intervention, recovery and reducing inequalities. ▪ **Integrated Community Care System (ICCS) for Wales** Supports the development of multidisciplinary community services that enable care closer to home, reduce hospital dependency and strengthen partnership working. ▪ **Home First / Discharge to Recover Then Assess (D2RA)** Promotes recovery, rehabilitation and assessment within a person's home environment wherever clinically appropriate, reducing unnecessary admissions and delays in discharge. ▪ **Value-Based Healthcare Wales** Supports investment in services that maximise outcomes, experience and population health while ensuring the best use of public resources. ▪ **Prudent Healthcare Principles** Promotes equitable access, prevention, co-production and delivery of care at the lowest appropriate level of intervention. **Mental Health Improvement and Service Transformation Drivers** ▪ **NHS Wales Mental Health Improvement Programme** Supports service redesign focused on quality, safety, outcomes, recovery, reducing variation and improving patient experience across mental health services. ▪ **All Wales Dementia Care Pathway of Standards (2021)** Provides a national framework for dementia services, promoting earlier diagnosis, coordinated support, person-centred care and improved outcomes for people living with dementia and their carers.

- **Together for Mental Health and Recovery-Focused Practice Principles**
  Promotes strengths-based, recovery-oriented approaches, empowering individuals to achieve improved wellbeing, independence and quality of life.
- **Learning Disability Strategic and Improving Lives Frameworks**
  Support the development of local, community-based services that reduce avoidable admissions, minimise out-of-county placements and improve quality of life for people with learning disabilities and complex needs.
- **Trauma-Informed Wales Framework**
  Promotes trauma-informed practice across public services, ensuring services understand, recognise and respond appropriately to the impact of trauma on individuals, families and communities.

Background

Powys Teaching Health Board serves a population of approximately 135,000 across a large rural county covering around a quarter of Wales. While many services are delivered locally, some specialist and acute services are provided through partnerships with neighbouring organisations due to geography, workforce availability and clinical sustainability.

The Health Board's vision, set out in *A Healthy, Caring Powys*, aims to help people "Start Well, Live Well and Age Well" through prevention, early intervention, improved wellbeing and integrated care.

The current mental health system faces increasing pressures from rising demand, workforce challenges, growing complexity of need and the requirement to improve integration between physical and mental healthcare. There is also a need to strengthen community-based support, reduce out-of-county placements and ensure services remain sustainable in the future.

Strategic Context

The proposed Mental Health Transformation Programme supports a broader shift towards prevention, early intervention and care closer to home.

The programme aims to:

- Improve integration between mental and physical healthcare.

	• Reduce reliance on out-of-county inpatient services. • Strengthen community-based mental health support. • Improve access to timely assessment and treatment. • Support recovery, rehabilitation and independence. • Enhance care for people with dementia and complex mental health needs. The proposals align with: • **A Healthy, Caring Powys** • Powys Regional Partnership Board Area Plan • Powys Teaching Health Board Integrated and Annual Plans • Powys Wellbeing Plan • A Healthier Wales • Mental Health and Wellbeing Strategy for Wales 2025-2035 A key principle underpinning the programme is the growing evidence that physical and mental health are closely linked. Better integration of services can improve outcomes, support recovery, enhance wellbeing and reduce unnecessary healthcare utilisation. The proposed changes are therefore not simply about the location of inpatient services. They are intended to create a more sustainable, integrated and person-centred mental health system that improves outcomes, strengthens community support and meets the future needs of the Powys population.
2.3 Assessment: Current Service Provision	Mental Health and Wellbeing Services in Powys provide a broad range of community, crisis, inpatient and specialist services that support people with varying levels of mental health need across a large and predominantly rural county. Over time, services have evolved to meet local demand and national policy requirements. However, the current model has developed across multiple sites, teams and pathways, resulting in variation, duplication and challenges in maintaining resilience. Rising demand, increasing complexity of patient need, workforce pressures and estate limitations are placing significant strain on services. Understanding the current service configuration and the challenges associated with it is essential in identifying opportunities for improvement and informing the future model of care.

	Inpatient Organic Mental Health Services Inpatient Organic Mental Health Services provide assessment, treatment and specialist care within a therapeutic environment for people experiencing mental health conditions arising from physical or neurological causes. This includes individuals living with dementia, acquired brain injury, delirium and other cognitive disorders, particularly where symptoms are impacting significantly on behaviour, wellbeing or the ability to remain safely within the community. These services support some of the most vulnerable patients within the mental health system, many of whom require specialist multidisciplinary input, comprehensive risk management and close collaboration with families, carers and partner agencies to support assessment, treatment and discharge planning. **Inpatient Functional Mental Health Services** Inpatient Functional Mental Health Services provide assessment, treatment and intensive support for adults experiencing an acute deterioration in their mental health which cannot be safely managed within the community. Functional mental health conditions are those where symptoms are not directly attributable to an identifiable structural or organic brain disorder. These conditions can significantly affect a person's psychological wellbeing, relationships, ability to maintain employment and capacity to manage everyday life. Examples include severe depression, bipolar disorder, psychosis, anxiety disorders and personality disorders. The inpatient service forms a critical component of the wider mental health pathway, providing short-term intensive treatment, stabilisation and recovery support while working closely with community services to facilitate safe and timely discharge. **NHS 111 Press 2 and Single Point of Access (SPOA)** NHS 111 Press 2 for Mental Health provides a 24-hour, seven-day-a-week access point for people of all ages who require urgent mental health advice, support or intervention. The service operates alongside the Powys Single Point of Access (SPOA), which acts as the central coordination function for referrals into Mental Health and Wellbeing Services. Through clinically informed triage and assessment, the service helps ensure individuals are directed to the most appropriate support at the earliest opportunity.

	The combined model improves consistency of access, reduces delays in referral management and enables timely escalation to crisis services where required, whilst also supporting navigation into community, voluntary sector and wellbeing services. **Dementia Home Treatment Teams (DHTT)** Dementia Home Treatment Teams provide specialist, intensive community support for people living with dementia who are experiencing complex behavioural, psychological or mental health difficulties. The service aims to provide assessment, treatment and intervention within an individual's usual place of residence wherever possible, helping people remain independent and reducing the need for hospital admission. The teams work collaboratively with families, carers, primary care, care homes and wider community services to provide coordinated care and support. Through early intervention and intensive community-based treatment, the service seeks to improve patient outcomes while reducing disruption to established support networks and familiar environments. **Crisis Resolution and Home Treatment Teams (CRHTT)** Crisis Resolution and Home Treatment Teams provide rapid assessment, intensive support and short-term intervention for individuals experiencing an acute mental health crisis. The service works primarily with adults aged 18 to 65 who may otherwise require admission to hospital without timely intervention. The team also provides support to older adults with functional mental health conditions where clinically appropriate. By delivering intensive treatment within a person's home or community setting, the service helps individuals remain connected to their family, support networks and local services whilst reducing reliance on inpatient care. The service is also a key component of the wider urgent and emergency mental health pathway, providing admission avoidance and supporting earlier discharge from hospital. **Older Adult Community Mental Health Teams (CMHs)** Older Adult Community Mental Health Teams provide specialist assessment, treatment and ongoing support for people aged 65 years and over experiencing mental health difficulties.

	The service brings together a multidisciplinary workforce to support individuals with a wide range of needs, including depression, anxiety, psychosis, dementia and other age-related mental health conditions. Care is delivered in partnership with primary care, social services, acute providers, carers and families to promote wellbeing, independence and quality of life. The focus of the service is to provide person-centred care close to home, enabling people to maintain their independence for as long as possible whilst ensuring appropriate specialist support is available when required. **Enhanced Care and Specialist Inpatient Services** A number of specialist services are commissioned from providers outside Powys to meet the needs of individuals requiring highly specialised assessment, treatment and care. These services include Psychiatric Intensive Care Units (PICU), specialist eating disorder services, learning disability inpatient services, low and medium secure services, rehabilitation placements and other highly specialised mental health provision. Whilst these arrangements ensure access to specialist expertise, they can also result in patients receiving care some distance from home, creating challenges for family involvement, continuity of care and discharge planning. Reducing reliance on out-of-county placements where safe and appropriate remains an important objective within the wider transformation programme. **Current Service Configuration and Challenges** Although the current service model provides a comprehensive range of mental health services, it has evolved over time as a collection of separate teams, pathways and locations rather than as a fully integrated system of care. Services are currently delivered from multiple community bases and inpatient sites across Powys, with separate teams often operating independently to meet specific service requirements. While this model has enabled local delivery, it can also create fragmentation, inconsistencies in access and difficulties in flexibly deploying resources across the county. The combination of increasing demand, rising patient complexity, workforce shortages, financial pressures and estate constraints is placing growing pressure on the current model. As a result:

- Patients can experience delays in accessing assessment, treatment and specialist interventions.
- Care pathways can become complex and difficult to navigate.
- Small teams may be vulnerable to staffing shortages, affecting resilience and continuity of care.
- Variations in service provision can lead to differences in patient experience depending on location.
- Resources can be spread thinly across multiple sites, limiting opportunities for service integration and innovation.
- Inpatient and community services can experience difficulties maintaining sufficient capacity to meet rising demand.

These challenges demonstrate that the current model is becoming increasingly difficult to sustain and adapt to future needs. They reinforce the need to consider a more integrated, resilient and community-focused model of mental health care that improves patient outcomes, strengthens service sustainability and makes better use of available resources across Powys.

Current Service Issues

Mental Health and Wellbeing Services in Powys provide care and treatment across primary care, community, crisis and inpatient services, supporting people with a wide range of mental health needs throughout their lives.

Despite the commitment and dedication of staff, the current model is increasingly struggling to meet the needs of a growing and changing population. Demand for mental health support continues to rise, with increasing numbers of people presenting with more complex needs, multiple long-term conditions and higher levels of psychological distress. Demand for adult and older adult mental health services is projected to increase by up to 33% over the next ten years.

While improvements have been made in access through the introduction of the Single Point of Access and NHS 111 Press 2 for Mental Health, people can still experience delays accessing assessment, treatment and ongoing support. The greatest pressures are currently seen within psychological therapies, memory assessment services and community mental health pathways.

The impact of these challenges is felt directly by patients. People may wait longer than is clinically desirable for assessment or treatment, increasing the risk that their mental health deteriorates before support is available. Delays can affect relationships, employment, housing stability and physical health, while increasing the likelihood of crisis presentations and the need for more intensive interventions.

	The current model also relies heavily on a number of small teams operating across a large geographical area. Although services work hard to respond to local needs, maintaining consistent access, resilience and equity across all areas of Powys is increasingly difficult. As demand grows, further action is required to strengthen prevention, early intervention and community-based support to ensure services remain sustainable and responsive to future population needs. **Socioeconomic Influence on Demand** Mental health outcomes are influenced by a wide range of social, economic and environmental factors. Many of the challenges experienced by individuals and communities in Powys have a direct impact on mental wellbeing and contribute to increasing demand for support services. Mental ill-health can both contribute to and result from poverty, unemployment, poor housing, social isolation and inequality. People experiencing mental health difficulties are more likely to encounter barriers to employment, housing and social participation, potentially creating a cycle of worsening wellbeing and increased dependence on services. The impacts of the COVID-19 pandemic, economic uncertainty, rising living costs and wider societal pressures have further increased levels of psychological distress across some communities. The Powys Population Needs Assessment identifies a range of factors associated with poorer mental health outcomes, including deprivation, rural isolation, homelessness, substance misuse and limited access to services. For people living in rural communities, difficulties accessing transport, social opportunities and support networks can exacerbate feelings of loneliness and isolation. In some areas, individuals may have to travel significant distances to access specialist support, creating additional barriers to early intervention and treatment. These wider determinants of health mean that growing demand cannot be addressed through healthcare services alone. Effective mental health care requires a coordinated response across health, social care, housing, education, employment and voluntary sector partners to support people's wellbeing before difficulties escalate into crisis. **Sustained Demand Pressures** Mental Health and Wellbeing Services in Powys are experiencing sustained increases in both the volume and complexity of referrals.

	Increasingly, people are presenting with multiple and interconnected needs, including mental health conditions alongside neurodevelopmental disorders, physical health conditions, learning disabilities, trauma histories, housing difficulties, substance misuse issues and social vulnerability. These needs often require coordinated support from multiple services rather than traditional single-service interventions. Whilst performance has improved across several key measures, increasing demand continues to place significant pressure on services. Workforce shortages, vacancies and sickness absence can reduce flexibility and resilience, making it difficult to consistently meet national targets and provide timely access to care. For patients, these pressures can result in longer waits between referral, assessment and treatment. During these periods people may experience worsening symptoms, increased distress, deterioration in physical health and greater risk of crisis. Families and carers may also experience additional pressures while supporting loved ones awaiting care. The increasing complexity of demand highlights the need for a more integrated and flexible model of mental health care, with stronger links between physical health, social care, primary care and community support services. **Performance and Clinical Governance Concerns** Although service performance has improved in several areas, there remain a number of challenges that affect the quality, consistency and timeliness of care provided to patients. Performance against national standards relating to Care and Treatment Plans and access to psychological therapies remains below expected levels. Whilst considerable progress has been made, many people continue to wait longer than desired to access specialist psychological interventions such as Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and other evidence-based treatments. These delays have real consequences for individuals. Patients may spend extended periods managing significant symptoms without access to the interventions most likely to support recovery. During this time they may require increased support from GPs, community teams, crisis services or emergency care settings. In some cases, delays can contribute to deterioration in mental health, increased levels of risk and avoidable hospital admissions. The profile of people accessing services is also changing. Increasing numbers of referrals are associated with: • Trauma and complex trauma.

	• Neurodevelopmental conditions, including Autism and ADHD. • Co-existing physical and mental health conditions. • Social deprivation, financial hardship and housing difficulties. • Loneliness and social isolation. • Substance misuse and dual diagnosis presentations. These factors require more personalised, multidisciplinary and long-term approaches to care than traditional service models were designed to provide. Current service arrangements can also create variation in access and resilience because specialist teams are often small, geographically dispersed and vulnerable to staffing pressures. When vacancies, sickness absence or maternity leave occur, the impact on service delivery can be significant due to limited workforce flexibility and a lack of resilience within individual teams. Key contributors to the challenges described above include: • Specialist teams spread across a large rural geography. • Small workforce numbers within some services, limiting resilience and flexibility. • Recruitment difficulties and prolonged vacancies. • Increased reliance on temporary staffing arrangements. • Rising levels of patient acuity, complexity and clinical risk. • Growing demand for specialist psychological therapies and community mental health support. • Service models that have not evolved at the same pace as changing patient needs. Taken together, these factors can result in delays, variation and fragmentation across the patient pathway. While staff continue to deliver high-quality care in challenging circumstances, the current model is increasingly stretched. Without further transformation, there is a risk that demand will continue to outpace capacity, making it more difficult to provide timely, equitable and recovery-focused care for the people of Powys. The issues described above demonstrate that the challenge is not solely one of increasing activity, but of ensuring that services are designed around the changing needs of the population. This provides a compelling case for developing a more integrated, sustainable and community-focused model of mental health care that improves access, reduces inequalities and delivers better outcomes for patients, carers and communities across Powys.

	Risks Demand and Service Pressures Demand for mental health services is increasing across all age groups and specialties, including early intervention, trauma therapy, and neurodivergent populations. ▪ Projected 33% increase in referrals to adult and older adult mental health services by 2035. ▪ 14% increase in bed days ▪ (LPMHSS) referrals expected to grow from 2,812 in 2023/24. **Long Waiting Times and Performance Shortfalls** Delays in assessment and therapy access, especially for MAS and psychological interventions, are impacting patient outcomes. Performance dramatically improved in last year but sustaining position needs consideration. There is still a need to maintain improvement and focus on psychology waiting times outside of measure performance (those not required to be captured in the data). ▪ Only 63.1% of patients started psychological therapy within 26 weeks in Nov 2024 (target: 80%). ▪ We have maintained or exceeded the 80% target since June 2025 as shown below. Currently at 87% reported May 2026. **LPMHSS assessments within 28 days Improved from 78.7% (Dec 2024) to 98% (March 2025).** This has recently dropped below target as shown below. Last MHM data, adult 1a reported to WG was 45.8% - April 2026 **Financial Pressures and Unsustainable Commissioning** Escalating costs for specialist private provider placements and temporary staffing are straining budgets. Current contract usage. Cost of Psychiatric Intensive Care Units (PICU), low secure, medium secure, MH acute beds. **Bed Utilisation** Average Bed Occupancy by site table below shows the overall bed utilisation within Powys which may change based on staffing availability and seasonal trends.

Average Bed Occupancy by site **Month**	**01/01/2025**	**01/02/2025**	**01/03/2025**	**01/04/2025**	**01/05/2025**	**01/06/2025**	**01/07/2025**	**01/08/2025**	**01/09/2025**	**01/10/2025**	**01/11/2025**	**01/12/2025**	**01/01/2026**
Average occu-pancy	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Felindre (Bronllys)	84	83	91	82	87	75	80	96	84	106	110	102	86
Tawe (Ystradgynlais)	77	95	91	75	82	75	76	76	97	99	67	57	106
Clywedog (Llandrindod)	83	86	75	95	96	88	93	95	102	100	87	96	95

Private Provider Beds

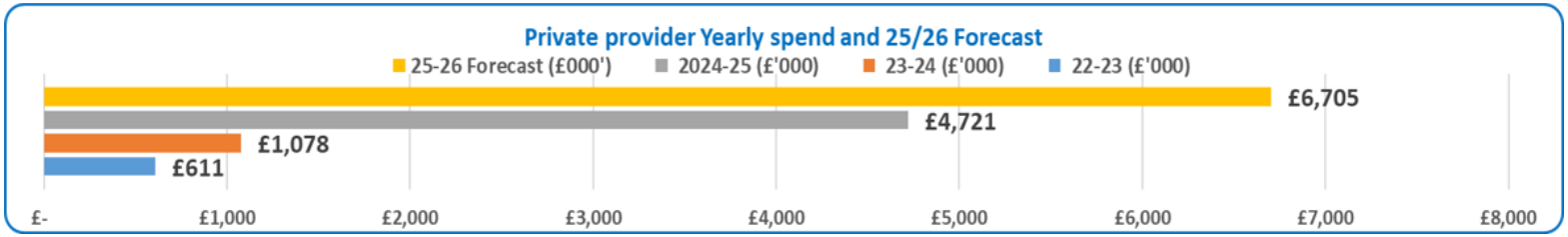
Private provider beds (out of county) Jan 2025-2026 table below shows the number of patients placed out of county which increases travel times and isolation and additional costs for the Health Board

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Total PPP beds	32	36	36	29	29	38	45	35	26	25	21	21	22
Acute	20	21	23	20	15	19	23	19	13	19	15	13	11
PICU	7	9	8	6	12	16	17	12	9	5	5	8	10
RW ward F	5	6	5	3	2	3	5	4	4	1	1	0	1

Updated below after removal of LD and duplicated patients:

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Total PPP beds	31	36	36	28	29	38	45	35	26	24	21	21	22
Acute	13	14	15	13	8	11	16	15	10	15	14	14	12
PICU	6	8	6	6	8	14	15	11	9	4	5	7	9
RW ward F	5	6	5	3	2	3	5	4	4	1	1	0	1
LD	6	6	5	5	6	6	5	4	4	4	1	1	1
	30	34	31	27	24	34	41	34	27	24	21	22	23

The 2025/2026 outturn for specialist private provider was £6.7m any increase from £4.7m in 2024/25



Breakdown of costs for 2025/26 per service areas and average active patients at end of each month.

25/26 Active patients at end of each month		
Type of Placment	Average	Total Costs
ACTIVE PATIENTS	17.00	6.70
LD	2.09	0.82
ACUTE	8.27	3.29
PICU	6.64	2.59

Per service areas

Breakdown of costs for 2025/2026 per area & service. This highlights cost associated with Placements, additional needs in Acute and PICU.

2025/26 Outturn £m		PICU or Acute		
Area	Service	Acute £'m	Med Sec £'m	PICU £'m
Learning Disability	Additional Needs	0.23		
	Placement	0.55		0.04
Learning Disability Total		0.77		0.04
Mental Health	Additional Needs	0.47		0.69
	Placement	2.12	0.27	2.34
Mental Health Total		2.59	0.27	3.03
Grand Total		3.36	0.27	3.07

- The current cost of an adult acute placement averages £800 per day (2026/27)
- The current cost of an adult PICU placement averages £1100 per day (2026/27)
- Depending upon patient acuity and additional observations required the average daily placement cost can double.
- 82 working age adults in independent sector placements under Section 117 (2026/27)

- Average inflation for national agreed packages in Commissioning Care, Assurance and Performance System (CCAPS) for PTHB placements in 2026/27 was 4%.

Staffing

The proposed Better Together model must address a number of significant workforce challenges that affect the sustainability, resilience and consistency of mental health services across Powys.

The current workforce is spread across multiple teams and locations, reflecting the historic development of services rather than the needs of a modern, integrated system. This fragmented structure can make workforce deployment more complex, reduce flexibility and create variation in service resilience between localities.

Key workforce challenges include:

- A geographically dispersed service model with multiple teams operating across a large rural county.
- A complex service configuration, including five Older Adult Community Mental Health Teams, North and South Dementia Home Treatment Teams, and North and South Crisis Resolution/Home Treatment Teams.
- Workforce fragility arising from vacancies, sickness absence, annual leave and recruitment difficulties, reducing the ability of teams to respond flexibly to changing demand.
- An ageing workforce and ongoing succession planning concerns, particularly within specialist community mental health roles.
- Challenges recruiting and retaining experienced Band 6 practitioners and specialist clinicians.
- Continued reliance on temporary staffing solutions to maintain safe service delivery.
- Difficulties maintaining specialist competencies, professional development and training compliance across geographically dispersed teams.
- Challenges in sustaining specialist skills, including Prevention and Management of Violence and Aggression (PMVA), across multiple teams and sites.

Collectively, these factors impact workforce sustainability, staff wellbeing, continuity of care, financial efficiency and the Health Board's ability to provide equitable services across Powys.

Workforce Sustainability and Variable Pay

Mental Health Services in Powys have experienced sustained workforce pressures over recent years, with recruitment and retention challenges affecting both inpatient and community-based services.

	These challenges are influenced by several factors, including the rural geography of Powys, an ageing workforce, increasing service demand, professional isolation in some roles and a limited local recruitment pool. While a range of initiatives have been introduced to strengthen recruitment pipelines, including the Aspiring Nurse Programme, overseas recruitment, career development pathways and participation in national student streamlining schemes, workforce supply continues to fall short of demand in a number of key professional groups. Alongside vacancy pressures, the increasing complexity, acuity and clinical risk of patients accessing mental health services has resulted in a need for enhanced staffing arrangements. Higher levels of nursing observation and specialist input are frequently required to maintain patient safety, often necessitating temporary staffing solutions in addition to established workforce levels. Although these arrangements have helped mitigate immediate service risks, they have increased financial pressures and highlighted the limitations of the current workforce model in responding sustainably to increasing demand. Recruitment challenges are particularly evident within medical staffing. Longstanding Consultant Psychiatrist and Specialty and Associate Specialist (SAS) vacancies continue to be difficult to fill due to factors including rurality, dispersed services, limited training pipelines and professional isolation. As a result, services remain reliant on locum medical staff to sustain safe clinical provision and meet statutory requirements. While temporary staffing plays an important role in maintaining service continuity, long-term reliance on agency, bank and locum staff is neither financially sustainable nor optimal for delivering consistent, relationship-based mental health care. Frequent changes in staffing can impact continuity of care, team cohesion, service efficiency and the overall patient experience. The proposed Better Together model provides an opportunity to develop a more resilient workforce through greater service integration, improved workforce flexibility, enhanced career pathways and a more sustainable deployment of specialist skills across the county. **Workforce Shortages and Reliance on Temporary Staffing** Workforce shortages remain a significant challenge across Mental Health Services and continue to affect operational resilience, service delivery and financial sustainability.

Key indicators include:

- Agency expenditure of £825,000 and bank expenditure of £518,000 within inpatient services during 2025/26.
- Across all Mental Health Services, total agency expenditure during 2025/26 was £2.93 million, with a further £1.0 million spent on bank staffing.
- Medical locum expenditure totalled £3.1 million during 2025/26, primarily to support longstanding Consultant and SAS vacancies.
- Mental health nursing vacancies improved from 57.98 WTE in 2022 to 40.13 WTE in 2024; however, vacancies increased again to 44.29 WTE by the end of 2025/26, demonstrating ongoing workforce instability.
- Continued vacancies across both inpatient and community services increase pressure on substantive staff and reduce organisational resilience.

Whilst there has been some reduction in agency usage and greater utilisation of bank staffing, dependency on temporary staffing remains significant. This reliance reflects the underlying workforce challenges facing mental health services and reinforces the need for a more sustainable workforce model that can support future service transformation, improve continuity of care and ensure patients receive consistently high-quality support across Powys.

Inadequate Infrastructure and Geographic Challenges

Powys covers approximately 5,181 km², around a quarter of the landmass of Wales, yet serves a relatively small and dispersed population of approximately 135,000 residents. This rural geography presents significant challenges in delivering equitable, timely and sustainable mental health services across the county.

The current model operates across multiple sites and localities, resulting in lengthy travel times for patients and staff, difficulties in workforce deployment, and variation in access to services based on where people live. Dispersed teams can experience professional isolation, reduced resilience and increased vulnerability when staff are absent due to sickness, leave or vacancies. These challenges are further compounded by limitations in digital infrastructure and transport availability, particularly in more remote communities.

Key challenges include:

- The large geographical footprint of Powys makes travel, service coordination and resource allocation complex.

- Community Mental Health Teams are currently based across multiple locations, reducing flexibility and increasing the impact of staffing pressures.
- Existing inpatient ward layouts require enhanced staffing levels to maintain patient safety due to environmental and design limitations.
- Some facilities do not provide a modern therapeutic environment that supports recovery-focused care.
- Healthcare Inspectorate Wales (HIW) inspections have highlighted estate-related concerns that cannot be fully mitigated within the current buildings. For example, the design of bathroom facilities on Clywedog Ward raises issues relating to privacy and dignity, which cannot be addressed through minor refurbishment alone.

Estate and Environment

While Mental Health and Wellbeing Services provide support throughout Powys, the estate from which many services are delivered is increasingly unable to meet the needs of modern mental health care.

A lack of appropriate therapeutic environments limits opportunities to deliver person-centred, recovery-focused services. Many teams operate from buildings that were not designed for contemporary models of care, creating challenges for both staff and service users.

In addition, the specialist nature of several mental health services means teams are often relatively small and geographically dispersed. This can impact service resilience and responsiveness, particularly during periods of staff absence or increased demand.

The current inpatient model is delivered across sites in Llandrindod Wells, Bronllys and Ystradgynlais. While this arrangement provides a local presence, it creates operational challenges, including:

- Reduced ability to share workforce resources across sites.
- Increased staffing requirements to maintain safe clinical environments.
- Difficulty providing consistent access to specialist expertise.
- Variation in the quality of patient environments and therapeutic facilities.
- Challenges in delivering a consistent model of care across all settings.

Modern, purpose-designed facilities would improve the patient experience, support recovery, enhance staff wellbeing and potentially reduce the staffing overheads associated with maintaining safety within outdated ward environments.

	Estates Maintenance The condition of the estate is a significant factor driving the need for change. Powys Teaching Health Board has one of the oldest healthcare estates in NHS Wales, with a high proportion of buildings predating modern healthcare design standards. Combined with the challenges of maintaining facilities across a large rural geography, this creates considerable operational and financial pressures. In 2024/25: • Approximately 30% of the Health Board estate pre-dated 1948, compared with an all-Wales average of 10%. • Only 10% of the estate had been built since 2005, compared with 23% across Wales. • A six-facet survey identified approximately £73 million of backlog maintenance requirements across the estate. These challenges are not simply infrastructure issues. The condition, suitability and functionality of the estate directly influence patient care, staff experience, regulatory compliance, service efficiency and long-term financial sustainability. The scale of investment required to maintain multiple inpatient sites strengthens the case for reviewing whether the current estate footprint remains sustainable and whether future inpatient services should be provided from facilities better suited to delivering modern mental health care. **Data Quality and Standardisation** Data quality and accessibility remain significant challenges across the Health Board. Information is currently captured across multiple systems with varying standards, making it difficult to produce consistent reporting, compare performance and monitor outcomes effectively. There is also a need for a more systematic approach to collecting and using patient-reported outcomes and experience measures to demonstrate service impact and support continuous improvement.

	The current electronic clinical records system is scheduled for replacement in March 2027, creating an opportunity to introduce more standardised data collection, improve interoperability and strengthen performance reporting across mental health services. **Changing Demand Including Co-Morbidities** The needs of people accessing mental health services are becoming increasingly complex. A growing proportion of individuals present with a combination of mental health, physical health, neurodevelopmental and learning disability needs, requiring more integrated and holistic models of care. Services need to be flexible and responsive to support people with multiple co-existing conditions and provide coordinated care across organisational and professional boundaries. Future service models must be capable of delivering person-centred support that recognises the interaction between mental health, physical health and wider social determinants of wellbeing. **Traditional Models of Delivery and Limited Flexibility** Current service models have evolved over time and are increasingly challenged by changing population needs and expectations. There are gaps within the pathway which can limit opportunities to provide the most appropriate support at the earliest stage. These include: • Limited access to sanctuary and safe-space alternatives. • Insufficient step-down and recovery-focused provision. • Limited out-of-hours and crisis alternatives to hospital admission. • A predominance of locality-based service delivery models that can create variation in access and capacity. There is an opportunity to develop more flexible, recovery-focused and open-access models of care that place greater emphasis on prevention, early intervention and community support.

Lack of Public Understanding of the Mental Health and Wellbeing Offer

Many people remain unclear about the role of Mental Health and Wellbeing Services, what support is available, and how to access it.

Challenges include:

- Differing expectations regarding risk management and treatment outcomes.
- Limited understanding of which services provide support for specific needs.
- Ongoing stigma associated with mental illness and seeking help.
- Insufficient emphasis on self-management, prevention and wellbeing approaches.
- A mismatch between some presenting needs and the services currently available.

Improving public awareness, strengthening preventative support and developing clearer pathways will help individuals access the right support earlier and reduce reliance on specialist services.

Cross-Border Patient Flow and System Complexity

Mental health pathways frequently cross organisational and geographical boundaries, involving multiple providers both within and outside Powys.

Current arrangements can be inefficient due to:

- Limited interoperability between digital systems.
- Difficulties accessing and sharing clinical information.
- Complex referral and transfer processes.
- Additional transport and commissioning costs associated with out-of-county placements.

Greater integration and standardisation of pathways will be required to improve patient flow, continuity of care and operational efficiency.

Limited Transport Options

Transport remains a significant challenge for many people accessing mental health services in Powys.

	The rural nature of the county, combined with limited public transport infrastructure, can make it difficult for patients, carers and families to access services. Where individuals require specialist mental health transport, arrangements are often complex and expensive, relying on commissioned or private providers. Transport barriers can contribute to delays in assessment, treatment and discharge, while also increasing inequalities in access to care across the county. **Impact on Patient Experience and Outcomes** The challenges within the current model directly affect patient experience and outcomes. People can experience delays in accessing assessment, treatment and ongoing support, increasing the risk of deterioration and crisis. Reliance on out-of-county placements may result in individuals receiving care far from their families, communities and support networks, reducing continuity of care and involvement from carers. Fragmented pathways can create duplication, communication gaps and inconsistent experiences across services. Variation in local capacity and service provision can also contribute to inequitable access, longer waits and increased pressure on wider health and care systems. Collectively, these strategic and operational challenges provide a strong case for change and highlight the need to review the current model of care. The following section outlines the assessment for change and the opportunities to develop a more sustainable, integrated and recovery-focused mental health service for the population of Powys. **Strategic Risks** The issues identified through this assessment align closely with a number of existing Health Board Strategic Risks. Evidence presented within this assessment has identified workforce fragility, variable service availability, demand and access inequity, diagnostic limitations, cost inefficiencies, and reliance on temporary service changes as factors contributing to these risks. The Mental Health options considered within this assessment have the potential to influence a number of Strategic Risks, both positively and negatively. Particular consideration is given to financial sustainability (SRR001), innovation and strategic change (SRR002), demand for commissioned services (SRR003), demand for provided services (SRR004), primary care sustainability (SRR005), workforce sustainability (SRR006), estate quality

	(SRR007) and public confidence (SRR012). The extent to which individual options mitigate, increase, or are dependent upon these risks is considered further within the options appraisal. Taken together, the current service position shows a Mental Health model that continues to provide important local access, but which is increasingly under pressure across workforce, cost, access and service reliability. This provides the foundation for the detailed Case for Change in Section 2.4. This necessitates an assessment of the Case for Change.
2.4 Assessment: Case for Change	**Assessment of the evidence supporting better alignment of Physical & Mental Health** A move towards a system of care that deals with better arrangements between physical and mental health is highly desirable and can lead to improvements in wellbeing of mental health patients across the board and help identify factor in patients with chronic condition, that leads ultimately to less utilisation of health care. In the older adult space, there are interventions in the preventative space and in primary care where this symbiosis can improve value via improved outcomes and costs. In relation to the case for Older Adult Mental Health and physical health being co-located there are some indications from systematic reviews (British Geriatrics Society) of benefit for patient outcomes, but this also has to be viewed in relation to practical, workforce and financial challenges. However, the general reading of the information herein suggests there are favourable outcomes to be harnessed from this approach – which might be considered to be best implemented in an incremental fashion – monitoring impact continuously. **Mental Health Services for People with a Learning Disability** Learning disabilities affect about 1.5 million people in the UK and are common, lifelong conditions which are neither illness nor disease. It is expected that by 2030 the number of people with a learning disability in the UK will have grown by over 10 per cent as well as a growth in the complexities of learning disabilities. The growth in complexity and comorbidity (living with more than one condition) amongst people with a learning disability is feeding through into increased pressures in mental health inpatient care, and the numbers of people requiring specialist placements funded through NHS Continuing Care. Our community and mental health services need to be reviewed to ensure that people with learning disability have their needs met within local communities and provision wherever possible; and that PTHB commissioned and provided inpatient services are able to provide suitable environments and skilled staff. **Mental Health Services for people with Complex Emotional Needs (CENs)** Following a successful application for Service Improvement Funding (SIF funding) in 2019/20, a Specialist Complex Emotional Needs (CENs) Pathway was established in Powys in 2020/21 to support clients who may attract a

	diagnosis of borderline personality disorder or emotionally unstable personality disorder. This specialist pathway comprises a small and dedicated multidisciplinary team including psychology, occupational therapy, social work, and an assistant psychologist. Together, this team offer specialist assessment and interventions (including Systems Training for Emotional Predictability and Problem Solving (STEPPS) groups, Trauma therapy, Schema Therapy, and a very limited online DBT service) in addition to offering joint assessments, consultation, and supervision to clinicians across the health board. The CENs pathway provides safe, collaborative, person-centred and structured care in order to promote recovery, reduce risk, and to enhance quality of life for clients as well as to reduce demands on other service areas such as community mental health teams (CMHTs), crisis resolution home treatment teams (CRHTTs), inpatient mental health services, A&E and blue light emergency services, amongst others. However, the CENs Pathway is currently unable to meet the needs of the most complex and vulnerable clients with complex emotional needs in the community due to insufficient capacity and resource to deliver a comprehensive Dialectical Behaviour Therapy Programme. **Government Policy** In April 2025, a new Mental Health and Wellbeing Strategy 2025-2035 was launched which places a continued and increased focus to work across the Welsh Government to tackle the wider causes of poor mental health. The primary intention of this Strategy is to set out key priorities over the next 10 years to ensure that people in Wales will live in a country which promotes, supports and empowers them to improve their mental health and wellbeing, and will be free from stigma and discrimination. There are four vision statements. 1. There is action to make sure the building blocks are in place to support good mental health and wellbeing 2. Everyone has the knowledge, opportunities and confidence to protect and promote good mental health and wellbeing 3. There is a connected system where all people receive the appropriate level of support wherever they reach out for help 4. There are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay There is a three-year delivery plan underpinning the strategy. and it will require further changes from health, social services and partners to the way in which mental health services are provided. Strategic drivers for change across Wales in older adult mental health services also include the 'All Wales Dementia Care Pathway of Standards' comprising twenty standards developed and launched in 2021.

	Government strategies are calling for change within mental health services with a national ambition to move to recovery focussed practice. There could be risk to the organisation if we do not deliver national strategy, which could cause Powys mental health services to be out of line with the rest of Wales. **Socioeconomic Influence on Demand** There remains a longstanding societal issue with stigma and discrimination relating to mental ill health, which can compound people's difficulties. Evidence confirms that people with mental health problems are among the least likely of any groups with a long-term health condition to find work (ref 2), live in good quality housing (ref 3) and be socially included in mainstream society. The COVID-19 pandemic, followed by global economic instability and geopolitical conflict have all significantly contributed to a decline in mental health amongst some of the population. Economic downturns can directly increase stress levels, which can contribute to mental ill health. Mental and emotional health services in Powys are experiencing unprecedented requests for help for mild to moderate depression, anxiety, bereavement, the psychological impact of conditions such as 'long Covid' and the lingering effects of grief, social isolation and loneliness compounded by subsequent lockdowns owing to the pandemic. This change in patient presentation needs to be reflected in the core offer of mental health service provision, underpinned by a new health model developed to meet the changing needs of the population. **Engagement Evidence** Based on the themes throughout the document, the following summary captures the feedback and expectations expressed by patients, carers, staff and stakeholders: Patients, carers and stakeholders consistently described a system that can be difficult to navigate, with services sometimes feeling fragmented and disconnected across organisational and geographical boundaries. People reported concerns about delays in accessing the right support, variation in service availability across Powys, limited access to specialist interventions for those with complex needs, and a lack of coordination between physical health, mental health, social care and third sector services. The impact of out-of-county placements was highlighted as a particular concern, with patients often being treated far from home, family, local communities and Welsh-speaking support networks. Carers described the challenges of long travel distances, reduced involvement in care and difficulties maintaining family connections during admission. Stakeholders also highlighted growing pressures arising from increasing demand, greater clinical complexity, workforce shortages and ageing estate infrastructure, raising concerns about the long-term sustainability of the current

	model. There was a strong view that services should move away from a hospital-focused approach towards earlier intervention, prevention and community-based support wherever possible. Patients and carers told us they want more care delivered closer to home, quicker access to support, better communication between services, improved crisis and out-of-hours provision, and greater continuity throughout their care journey. They supported a more joined-up model that integrates physical and mental health care, reduces the need for out-of-county placements, strengthens local specialist provision and enables people to receive the right support at the right time in the most appropriate setting. Stakeholders emphasised the importance of creating resilient multidisciplinary services, improving access to specialist expertise, supporting carers, and ensuring any future model delivers equitable access and consistent standards of care across all parts of Powys. Taken together, the evidence shows that the current model is no longer sustainable in relation to quality, workforce, finance, estate and patient flow. The case for change is not driven by one issue alone, but by the combined impact of prolonged hospital stays, delayed discharge, workforce fragility, variable bed utilisation, infrastructure constraints and financial pressure. These challenges are already affecting the Health Board's ability to provide care effectively and sustainably and will become harder to manage without service redesign. The proposed options therefore need to be assessed on how well they reduce fragmentation, strengthen community alternatives, improve workforce resilience, make better use of the estate and support safer, more coordinated care closer to home. This provides the basis for the options appraisal that follows, where the recommended options are considered against their ability to address these risks and support a more sustainable future model of care. The evidence demonstrates a clear and compelling need to transform the current mental health model to ensure services remain safe, sustainable and aligned with future population needs. Rising demand, increasing clinical complexity, workforce pressures, limited specialist capacity and growing numbers of people requiring intensive support are placing significant strain on existing services. Patients can experience fragmented pathways, inequitable access to specialist care, delays in receiving appropriate support and, in some cases, out-of-county placements that separate individuals from their families, communities and local support networks. National policy increasingly requires integrated, person-centred care that brings together physical health, mental health and social care, delivering support closer to home and at the earliest opportunity. Without change, the Health Board will face increasing challenges in meeting demand, delivering national expectations and achieving sustainable outcomes.

<table>
<tr><td></td><td>The case for change is therefore centred on creating a more integrated, community-focused and resilient model of care that improves patient experience, reduces fragmentation, strengthens local provision and makes best use of available workforce, estate and financial resources.

The next section will look to describe the Options considered.</td></tr>
<tr><td>2.5 Assessment: Options Appraisal</td><td>Options Appraisal

The purpose of the options appraisal process was to identify the most effective and sustainable model for delivering adult and older adult mental health services in Powys. The process was designed to ensure that future service provision is shaped by the needs of the population, informed by evidence, and capable of addressing the challenges identified within the current model of care.

A structured and transparent approach was adopted, involving clinicians, managers, service users, carers and partner organisations. This process considered how best to improve quality, patient outcomes, access to services, workforce sustainability, resilience and value for money, whilst supporting the strategic ambition of providing more care closer to home wherever possible.

The options appraisal was undertaken in two stages:

Long List Development

An initial wide-ranging review was undertaken to identify a broad set of potential service models. This included consideration of maintaining existing arrangements, variations in community and inpatient service configurations, different estate footprints, and opportunities for greater integration across mental health pathways.

Each option was assessed against the key challenges identified through the case for change, including increasing demand, workforce pressures, estate limitations, service resilience, quality of care and patient experience. Through this process a comprehensive long list of options was developed.

<table>
<tr><th>Option</th><th>Option description</th><th>Reason for deselection</th></tr>
<tr><td>001a</td><td>Do previous – the model that existed before the closures of day hospitals and Crug Ward</td><td>This option was rejected as it is not meeting the needs of the population is unsustainable in the longer term.</td></tr>
</table>
</td></tr>
</table>

	001b	Do Current – The model as it exists at the current time.	This option was rejected as it is not meeting the needs of the population is unsustainable in the longer term.
	003a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move functional Beds to Bronllys	This option was rejected as it did allow for the level of transformation needed to develop the enhanced community services model and inpatient services continued to be unsustainable.
	004a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move Functional Beds to Bronllys functional Beds to Brecon	This option was discounted as the Brecon Hospital site is to restricted and unable to expand to meet the needs of a new purpose built mental health inpatient beds
	006a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move Functional Beds to Bronllys all Beds to Bronllys	This option was chosen to go forwards as it has the greatest opportunity create an enhanced community model for the whole of Powys, create sustainable in patient beds on a site where there is sufficient space to rebuild new purpose built facilities.
	007a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move Functional Beds to Bronllys all Beds to Brecon	This option was discounted as the Brecon Hospital site is to restricted and unable to expand to meet the needs of a new purpose built mental health inpatient beds
	008a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move Functional Beds to Bronllys all Beds to either Newtown or Welshpool	This option was discounted as the Welshpool Hospital site is too restricted and unable to expand to meet the needs of a new purpose-built mental health inpatient beds and the new model of care facilities in Newtown have not included dedicated Mental Health inpatient beds.
	010a	Enhanced community Mental Health Services and integrate older age mental health services with physical health and move Functional Beds to Bronllys all Beds to Brecon and Newtown	This option was discounted as the Brecon Hospital site is to restricted and unable to expand to meet the needs of a new purpose-built mental health inpatient beds and the new model of care facilities in Newtown have not included dedicated Mental Health inpatient beds.

Shortlisting of Options

The long list was then systematically reviewed using agreed criteria and evaluation measures. Options that were considered undeliverable, did not adequately address the identified challenges, failed to meet future service requirements, or offered limited benefits compared to alternative approaches were discounted.

This process enabled the Health Board to reduce the long list to a smaller number of credible and feasible options that demonstrated the greatest potential to improve outcomes, enhance patient experience, strengthen community-based care, improve workforce sustainability and ensure the long-term viability of mental health services across Powys.

The shortlisted options were then developed in greater detail and subjected to further analysis and appraisal to identify a preferred way forward for consultation and decision-making.

This assessment considers a single preferred option. The rationale for selecting this option and excluding alternatives is set out in Sections below and section 2.6.

SL MHDO02_001a: Do Previous: Put current hospital and community health services back to how they were

SL MHDO_002_001b: Do Current: Keep current hospital and community health services as they are now

SL MHDO_006a: Do Maximum: Move all functional and organic mental health inpatient services to Bronllys or Brecon area, 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



- Create a holistic integrated response team to work across and alongside physical and mental health services to provide a preventative offer based on patient needs, including short-term interventions,

	community liaison, wrap around support for organic patients, physical health assessment and monitoring, home treatment and initial diagnostics, including social care and third sector organisations. • Move all mental health inpatient services (organic and functional) to the Bronllys or Brecon area, with additional development of an enhanced care unit, buildings will require redevelopment and/or new build. The single site inpatient service would have approximately 35 patient beds, (18 adult functional, 12 older adult acute, and 5 enhanced care). • Enhanced care will mean bringing patients receiving treatment and care out of county back into Powys and reduced commissioning of specialist beds out of county. • Inpatient mental health services at Llandrindod, Brecon and Ystradgynlais would be closed permanently. • Where co-located with physical health inpatient services, integrated working and shared pathways of care will be developed to strengthen whole person care. • Development of in-reach / liaison services to support physical health units to manage people admitted with physical health problems who also have mild to moderate mental health disorders, especially across sites where there are no mental health inpatient beds. • Create an alternative to hospital admission, for example, sanctuary, safe place to assess, in Powys. • 111 press 2 service and single point of access for clinicians would continue to provide patient triage, promoting prevention and correct early intervention via efficient referral management. • Timescale – 3-5 years/5+ years (dependent on capital investment and workforce) This option will improve Mental Health provision in the community. Enhance Mental Health inpatient provision. Bring together all functional and organic mental health inpatient services at one site. This model may offer improved resilience and greater workforce alignment. However, it would involve significant reconfiguration of service locations, potential estate repurposing, and will not in itself improve the provision of physical health care to mental health patients. The proposed community model represents a significant shift from the current service model, moving from a predominantly inpatient-focused approach to a more integrated, preventative and community-based model of care. It combines mental health, physical health, social care and third sector support to provide a seamless patient journey, with a stronger emphasis on early intervention, crisis prevention, recovery and care closer to home. In addition to the existing inpatient, crisis and community mental health services, the new model introduces several enhancements. These include integrated mental and physical health assessments and monitoring, specialist older adult community services, expanded multidisciplinary support, increased access to psychological therapies, en-

	hanced occupational therapy provision, peer support workers, recovery coaching and the development of a Recovery College. A new Sanctuary or Safe Place service would provide an alternative to hospital admission for people experiencing emotional distress or crisis, helping to reduce unnecessary hospital attendance and escalation. The model also strengthens links between inpatient and community services, improves discharge planning, develops liaison and in-reach services between physical and mental health settings, and supports the repatriation of some patients currently placed outside Powys. Enhanced digital services, improved partnership working and a stronger focus on carers and families are intended to reduce fragmentation and improve continuity of care. Overall, the model aims to deliver more equitable, person-centred and sustainable mental health services, ensuring people receive the right care, at the right time, in the right place, whilst promoting independence, recovery and wellbeing. **What stays the same?** • SPOA / 111 press 2 is maintained • Requirement for some specialist out-of-county provision • Continued potential use of older estate stock **What Changes?** • All functional and organic inpatient beds consolidated in the Bronllys or Brecon area. • Closure of Brecon or Bronllys together with Llandrindod and Ystradgynlais MH inpatient services • Partial repatriation of out-of-county patients • Single consolidated site -35 inpatient beds • Expanded community, liaison and alternatives to admission • Enhanced care - inpatient services will be able to support higher acuity patients enabling repatriation of some patients from out of county. • Improved integration between older people's mental health and physical health services **Finance** • The option should deliver a net recurrent saving compared with the baseline, driven by fewer inpatient wards and lower support service costs. • Financial sustainability is dependent on successful delivery of community substitution and reduced length of stay.

Workforce

Workforce sustainability is a key consideration for the Mental Health inpatient option, and the proposed model reflects the need to create a more resilient and clinically sustainable staffing arrangement for the future. By consolidating inpatient Mental Health beds at the Bronllys or Brecon area, the option has the potential to support stronger rota resilience, clearer clinical leadership, improved supervision, and more consistent multidisciplinary working. This may also provide better opportunities for staff development and stronger career pathways within a more coherent Mental Health inpatient model.

However, these benefits are dependent on the ability to recruit, redeploy, retain and develop the required mental health workforce, and to manage the transition safely. A move to a single inpatient site would require a structured programme of staff engagement, redeployment, role redesign and workforce development, with clear support for staff affected by the change.

It would also require sufficient community mental health capacity to be in place to support patient flow, timely discharge, admission avoidance and ongoing care closer to home. If redeployment into the new model does not happen at the required pace, or if recruitment to key inpatient and community mental health roles is not achieved, the option could create additional workforce and delivery risk.

- Potential to improve workforce resilience through consolidation onto a single Mental Health inpatient site, supporting more stable rotas and reducing the risks associated with dispersed staffing.
- Will support stronger clinical leadership, supervision and professional development through a larger, more coherent multidisciplinary team.
- Offers the potential to support recruitment and retention by providing clearer career pathways, enhanced roles and a more sustainable team structure, subject to further evidence and testing.
- Workforce transition will be required, including staff engagement, redeployment considerations, changes to skill mix, and support for staff affected by the proposed move to a single inpatient site.
- Delivery is dependent on the ability to staff the model safely, including sufficient registered Mental Health nursing, therapeutic, medical, psychology, occupational therapy and support worker capacity.

Change in RN/HCSW skill mix

General Wards	Cur-rent Model	New skill mix model	*Change to Cur-rent Budget*

	(Budget)		
Registered Nurse Band 5	107.4	96.9	-10.5
Registered Nurse Band 6	9.0	9.0	0.0
Registered Nurse Band 7	9.0	9.0	0.0
Nursing HCA/HCSW Band 2	128.0	125.9	-2.1
Nursing HCA/HCSW Band 3			
	253.5	**240.8**	**-12.7**
MH Wards			
Registered Nurse Band 5	19.3	19.1	-0.3
Registered Nurse Band 6	10.0	13.6	3.6
Registered Nurse Band 7	3.0	4.0	1.0
Registered Nurse Band 8A	1.0	0.0	-1.0
Nursing HCA/HCSW Band 2	31.4	40.9	9.5
Social worker Band 6	1.0	0.0	-1.0
Occupational Therapist Band 6	1.1	3.0	1.9
Occupational Therapist Band 3	1.0	1.0	0.0
Activity Coordinator Band 3	0.0	4.0	4.0
	67.8	**77.6**	**9.8**
	321.2	**318.3**	**-2.9**

Note - Does not include Admin Posts

The following assessments of impact highlight potential matters to be mitigated / addressed which have either been enhanced impact assessed as part of the Equality Impact Assessment (EQIA) or would be considered at design phase;

Estates -assessment of impact

- Concentration of inpatient care onto the most modern and adaptable sites.
- Reduced estate footprint for inpatient care, lowering ongoing maintenance and compliance risk.

- Capital works required for new purpose-built accommodation.

Travel time and access – assessment of impact

- Increased travel times for some patients and visitors due to bed concentration on fewer sites.
- Access impacts are partially mitigated by fewer admissions, shorter lengths of stay and more care delivered at home.

Identified Benefits

- Enhanced Community model will offer increased support for people at home and in their communities
- Equity of service provision by bringing services together
- Improved clinical consistency and resilience
- Improved workforce sustainability
- Strategically with creating a centre of excellence providing a universal approach, aligned with Royal College of Psychiatry Quality Standards
- Reduced long-term reliance on out-of-county beds
- Simplified governance and pathways
- Potential for increased MDT working with physical health
- Cost avoidance
- Enhanced community team benefits
- Associated reduction in bed base care

Strategic Risk Assessment

Ref	Strategic Risk	Transition	Established Model	Comments
SRR001	Financial Sustainability	Increase	Slight Increase	Supports the delivery of recurrent savings through fewer inpatient wards and lower support costs, dependent on community substitution and reduced length of stay.

	SRR002	Innovation & Strategic Change	Increase	Neutral	Successful delivery is dependent on implementation of a major service transformation programme.
	SRR003	Demand for Commissioned Services	Neutral	Mitigation	Supports enhanced care which will mean bringing patients receiving treatment and care out of county back into Powys and reduced commissioning of specialist beds out of county.
	SRR004	Demand for Provided Services	Mitigation	Mitigation	Creates a more sustainable service aligned to future demand through enhanced local service provision and clinical capability.
	SRR005	Primary Care Sustainability	Slight Mitigation	Mitigation	Promotes more effective and coordinated-ed care through closer integration of physical health, mental health, primary care and community services.
	SRR006	Workforce Sustainability	Increase	Mitigation	Requires workforce transition during implementation but improves resilience, recruitment, retention and roster sustainability once established.

SRR007	Estate Quality and Infrastructure	Increase	Slight Increase	Requires estates reconfiguration concentrating inpatient care on a modern, adaptable site, reducing the estate footprint, maintenance and compliance risk, while requiring capital investment for purpose-built accommodation.
SRR012	Public Confidence	Increase	Mitigation	Service changes may increase public concern during implementation, but improved service quality and sustainability are expected to strengthen confidence over time.

Potential 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 other end of county to inpatient site may promote difference in inpatient admission pathway
- Consolidating clinical teams may lead to reduced variability in thought, creating 'siloed thinking'
- Community connection – site is not well connected to the community and there will be patient transport issues
- Public, staff and political acceptability challenges
- Complex transition period
- Optimal Benefits realisation dependent upon proximity to Physical Health services, a lack of co-location may impact potential benefits
- Increased travel distances may deter patients from accessing MH services, ensure clear communication for patients to understand how to access services easily
- Case management system transition will be designed prior to implementation of a new model of care so risk of missing opportunities to align due to timescales.

Possible Trade-offs

- Long-term sustainability and quality **vs** short-term disruption and access impact
- System simplification and quality **vs** access and travel distance

	• Not co-located with physical health • Still commissioning out of county activity in the north to meet population needs **Welsh Language Considerations** • Consideration would be given to encourage recruitment of Welsh speaking staff enabling services to be offered in Welsh wherever possible • MH services strive to comply with Welsh Language standards • Future repatriation of Powys residents from out of county private provider beds into Powys beds will help to provide access to Welsh-speaking staff • Consolidation of staff to one site for MH services will also consolidate Welsh speaking capabilities into same site, potentially increasing access to Welsh-speaking staff for patients wishing to converse in Welsh **Justification** The preferred option has been selected because it best addresses the challenges identified within the current model, including fragmented pathways, workforce pressures, variable access to specialist services, out-of-county placements, financial sustainability concerns and an ageing estate. Unlike the 'Do Previous' and 'Do Current' options, it combines investment in a strengthened community offer with a more resilient inpatient service, supporting prevention, early intervention, crisis avoidance and care closer to home. The model improves patient flow, enhances multidisciplinary working, enables the repatriation of some out-of-county patients, strengthens workforce resilience and creates a more sustainable service aligned to future demand, national policy expectations and the long-term needs of the Powys population.
2.6 Recommendation: Preferred Option	**Selected option;** **SL MHDO_006a: Do Maximum: Move all functional and organic mental health inpatient services to the Bronllys or Brecon area. Hospital, 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** This is the sole option for Mental Health services following rigorous feasibility assessment, given the viability in improving current provision, tackling challenges highlighted in the case for change, options for purpose-built approach to provision and financial sustainability.

	From both a financial and non financial perspective option SL MHDO02_006a is clearly the expected preferred option. It is the only option that improves all the patient quality domains and also the only option that reduces cost.
2.7 Financial Summary	**Mental Health Inpatients – Non Finance and Finance Appraisal** The financial summary should be read alongside the wider quality, workforce, estates, access and deliverability assessments set out in this document. The purpose of this section is not to present cost in isolation, but to show the overall financial implications of the two recommended options and how these compare with the current baseline. A lower-cost option is not automatically the preferred option if it carries greater clinical, access, workforce or delivery risk. Equally, a higher-cost element may still be justified where it supports safer care, improved resilience or better outcomes for patients. The financial assessment should therefore be considered as one part of the wider decision-making framework, rather than as the sole basis for determining the preferred option The key message from the financial summary is that the recommended option offers potential to improve financial sustainability, but only if the wider model of care changes as intended. The financial benefits are dependent on successful community substitution, including reduced length of stay, fewer avoidable admissions, improved discharge pathways, more care delivered closer to home and reduced reliance on agency, bank and over-contract staffing. If these changes are delayed or only partly delivered, the expected recurrent savings will also be delayed or reduced. The analysis also highlights that cost does not always directly correlate with clinical priority. Some services or sites may carry a higher cost but support important clinical, access or population needs. Similarly, lower-cost configurations may carry greater quality, access, workforce or delivery risks. For this reason, the financial position should be considered alongside the quality, workforce, estates, access and equality assessments. The detailed modelling, phasing, capital requirements, investment appraisal and sensitivity analysis will be developed further through the pre-consultation business case. This should include testing the impact if community substitution delivers below the expected level, or if implementation is delayed, so that the Board can understand the affordability and risk profile of each option before consultation and future decision-making.

2.8 Governance Arrangements	Powys Teaching Health Board (PTHB) will apply a robust, transparent and proportionate approach to assessing the impacts of service change through its Integrated Impact Assessment (IIA) process. The purpose of the IIA is to identify, assess and mitigate potential impacts before decisions are made, ensuring that quality, equality, work-force, Welsh language and wider population health considerations are fully understood. The IIA framework brings together statutory and best-practice assessments into a single process. All proposals undergo a Level 1 assessment, with higher-risk or more complex proposals progressing to a detailed Level 2 assessment. Where significant adverse impacts are identified, further detailed analysis and mitigation planning are required. Alongside the IIA, dedicated assessments are undertaken where required by an independent panel, including: • Quality Impact Assessment (QIA) • Equality Impact Assessment (EQIA) • Welsh Language Impact Assessment (WLIA) • Health Impact Assessment (HIA) The Welsh Language Impact Assessment is particularly important in ensuring that the impact on Welsh speakers and Welsh-speaking communities is properly considered and that Welsh is not treated less favourably than English. Completion of the WLIA, alongside the EQIA and QIA, will form an important part of providing assurance that consultation is robust and legally defensible. The impact assessments are agreed by the Senior Responsible Officer and reviewed by a Quality and an Equality panel and final sign off is via the Programme Boards. The Equality Impact Assessments (EQIA/EIA) will remain live documents throughout the duration of the programme, supporting the ongoing identification of impacts, mitigations and associated actions. Following the engagement period, any new findings identified will be reviewed and analysed. This information will be used to update the EQIA/EIA as required, including refining existing mitigations, identifying additional impacts, and strengthening actions to address potential effects on protected groups.
2.9 Engagement and/or Consultation considerations	Stakeholder participation throughout the Better Together Phase 1 options development process was structured to ensure appropriate involvement at each stage. Early engagement focused on patients, service users, communities, staff and partners to inform the Case for Change, design principles and option development. Technical appraisal

	stages then drew on clinical, operational and professional expertise to assess quality, workforce, financial, estates and deliverability considerations. Public, patient and stakeholder feedback gathered throughout the process informed option refinement, assessment criteria, mitigations and decision-making. Stakeholder groups were established to support option development, deliberation, assurance and communication, while patient representatives remained involved through deliberative events. The engagement process remains ongoing. Importantly, information, concerns and insights received during consultation from patients, service users, carers, communities and stakeholders will be used to further develop, strengthen and refine the Quality Impact Assessment, Equality Impact Assessment, Welsh Language Impact Assessment and other supporting assessments. This will ensure that emerging evidence and lived experience continue to inform decision-making and that any additional impacts, risks or mitigation measures identified through consultation are fully considered before final decisions are made.

Quality and Equality Impact Assessment Section

Overview

This Impact assessment is based on the PTHB agreed process.

Using this template helps us to fulfil important legal duties and best practice requirements:

- The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this is through Quality Impact Assessments (QIA). A high level quality impact assessment is included in Section B.1 of the template, and a template for a deep dive assessment is included in Section C.1.
- The Equality Act 2010 and Welsh Language Act 1993 create important statutory duties for assessing the impact of key decisions for people with equality protected characteristics, in relation to Welsh Language, and for different socio-economic groups through the socio-economic duty. A high level equality impact assessment is included in Section B.2 of the template, and a template for a deep dive assessment is included in Section C.2.
- The Well-being of Future Generations Act 2015 requires public bodies to consider the wider longer term impact of their decisions on the communities they serve. Considering of the seven wellbeing goals should be considered as part of the "Whole Systems Impact" quality standard. Key issues may also be highlighted in other relevant sections (e.g. socio-economic considerations in the Equality Impact Assessment, strategic alignment and social responsibility elements of the Section A Overview).
- Good practice in evaluation and appraisal of policies and programmes is available from a range of sources including The UK Government Green Book for appraisal and evaluation, National Audit Office etc.

A Level 1 Assessment is expected for all health board proposals. This provides a high level summary of a proposal, the decision to be made, and whether there are any adverse impacts that may need to be considered in more detail before a decision can be made.

A Level 2 Assessment will be undertaken for proposals of higher value and complexity where potential adverse impacts are identified. The Level 2 Assessment requires a detailed overview of the proposal, and an integrated impact assessment covering issues such as quality, equality, compliance, strategic alignment, reputation, deliverability. Where adverse quality impacts or adverse equality impacts with a score of 9 or more are identified then a further "deep dive" will be required in order to ensure that the risks are fully understood, mitigation action is in place, monitoring measures and controls have been identified, and unintended consequences have been considered.

Approach to Scoring

The scoring tool used to inform this impact assessment utilising a standard Likelihood versus Impact assessment.
In this context the term '**Likelihood' has been used universally across this document to describe the likelihood a person would become a patient of the health services delivered or commissioned by Powys Teaching Health Board**.

For example, a person is more likely to need physical health community services or inpatient services during their entire life, whereas they may never need to use urgent care of mental health services and so it may reasonably be considered that it is possible they may need these services.

Table 1: Measures of Likelihood

Descriptor	**Rare (1)**	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost certain (5)**
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

After a person comes into contact with the Health Service then there can be a measure of the 'Impact'. In the context of the delivery of health care services the Impact is the extent of harm, loss, disruption, or adverse effect that would result if a risk from the contact with the service. The tool expresses impact using a range of domains. As the new models of care being proposed are primarily going to impact the experience people will have when using the Health Board Services the domain called 'Quality / Complaints / Audit' has been used.
For example, a person may experience a level of care where a level of treatment maybe sub optimal which would be described as negligible impact which has a score of 1. Or Overall treatment or service sub-optimal which has a score of 2.

Therefore, when the overall new model of care may demonstrate an improvement in service over existing models of care the lowest impact score would be a 1.

Table 2: Measures of Impact

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service sub-optimal Informal complaint / inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/improve-ment notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating 4 Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption / environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

The final risk score calculation used in this assessment is as follows:

Score of the likelihood of using the service x score of the impact of using the service = the overall score.

Table 3: Risk Score

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Possible 3	3	6	9	12	15
	Unlikely 2	2	4	6	8	10
	Rare 1	1	2	3	4	5
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		IMPACT				

It could be considered that a person is Likely (4) to use community services which were delivered to a satisfactory level which would have had a negligible (1). The total risk score is therefore 4.

In the assessments where a score is referred to it is listed with its colour or in brackets as above.

MHDO_006a: All beds to the Bronllys or Brecon area + integrated OAMH community which will see an enhanced Community Mental Health Team Deployed to provide more care in the community with centralising of Mental Health Inpatient Services into the inpatient provision.

- **SL MHDO_006a: All beds to Bronllys or Brecon area + integrated OAMH community will see an increase and enhancement in Community Mental Health Services, centralisation of all Inpatient Mental Health Care. Changes are: closure and transfer of Tawe – 10 beds (Ystradgynlais) and Clewedog – 10 beds (Llandrindod Wells) to a new model of 12 older adult acute beds, 5 enhanced care beds and retain the existing 18 adult functional beds on Felindre (Bronllys). The proposal will create a holistic integrated response team to work across and alongside physical and mental health services to provide a preventative offer based on patient needs, including short-term interventions, community liaison, wrap around support for organic patients, physical health assessment and monitoring, home treatment and initial diagnostics, including social care and third sector organisations.**
- **Enhanced care will mean bringing patients receiving treatment and care out of county back into Powys and reduced commissioning of specialist beds out of county.**
- **Where co-located with physical health inpatient services, joint working and shared care practices will be developed to strengthen holistic, whole person care.**
- **Development of in-reach / liaison services to support physical health units to manage people admitted with physical health problems who also have mild to moderate mental health disorders, especially across sites where there are no mental health inpatient beds.**
- **Create an alternative to hospital admission, for example, sanctuary, safe place to assess, in Powys.**
- **111 press 2 service and single point of access for clinicians would continue to provide patient triage, promoting prevention and correct early intervention via efficient referral management.**

A.3. Integrated Impact Assessment Summary			Risk of Adverse Impact		
			Likelihood	Impact	Score
3.1 Quality	**Headlines**	**Quality – Summary Headlines** Feedback identifies significant benefits and challenges. Centralising services and integrating mental and physical healthcare is expected to improve efficiency, workforce development, resource use, and care quality. Enhanced community services and purpose-built facilities, particularly at Bronllys or Brecon, are viewed positively for supporting more holistic, preventative, and person-centred care, while reducing reliance on agency staff and out-of-county placements. Key concerns focus on increased travel times and potential geographic inequalities, particularly for residents in north and mid Powys. Issues raised include access to acute physical healthcare, bed capacity, patient transport, discharge planning, and maintaining integration between mental and physical health services. While the proposed model is seen as ambitious and innovative, successful delivery depends on effective recruitment, third-sector involvement, and robust governance to ensure equitable and sustainable services across Powys. Overall, the impacts are seen as negligible but there may be some minor additional impacts during transition. **Key Quality Concerns** • Potential inequalities in access, although community provision is expected to increase in north and mid Powys. • Poor road infrastructure and transport links to Bronllys. This is reduced if Brecon was the preferred site. • Limited local activities and shopping opportunities for patients at Bronllys. This is reduced if Brecon is the chosen site.	3	2	6

		• Reduced ability to support home leave for patients from north Powys. • Risk of delayed discharges due to planning challenges in areas furthest from mental health hubs. • Potential increase in out-of-county placements for patients living furthest from the mental health hospital. • Access concerns for rural populations, particularly in mid Powys. • Reduced integration with physical health services, as plans include closing the onsite inpatient physical health ward.			
	Full QIA required?	Yes, due to the complexity of the proposal.			
3.2 Equality	**Headlines**	Equality – Summary Headlines • Key impacts from equitable increased travel times and potential impact for Welsh speakers. • Impacts to travel across Powys area, access, and rurality affecting older people, disabled people, carers, and those on lower incomes. • Risk of reduced visiting, social support, and engagement with services. • Potential for inequalities between different parts of the county to persist or worsen. • Overall impact is broader than reflected in scoring and requires ongoing monitoring. • Risks in maintaining safe staffing levels and meeting expected quality and safety standards. • Potential challenges in ensuring consistent safeguarding and appropriate care delivery.	3	2	6
	Full EQIA required	Yes, due to the complexity of the proposal.			
3.3 Legal / Statutory		The model aligns with statutory duties, including the Equality Act, Welsh Language Standards and Well-being of Future Generations Act, supporting sustainability, prevention and integrated care. Key risks relate to equitable access,	4	1	4

	travel, Welsh language provision and community cohesion. Success depends on strong community services, mitigation measures and continued compliance.			
3.4 Strategic Alignment and Health Outcomes	The model supports strategic priorities including prevention, care closer to home, integration and long-term service sustainability. Enhanced community services should improve outcomes and reduce reliance on hospital care. However, there is a risk of reduced outcomes during transition if community capacity and support services are not fully established.	4	1	4
3.5 Market and Partnerships	Delivery relies on strong partnerships with local authorities, third-sector organisations and care providers. Increased community provision strengthens integrated working but may place pressure on partner capacity. Economic impacts are broadly neutral across Powys, although communities losing inpatient services may experience reduced local spending, activity and associated economic benefits.	3	2	6
3.6 Operational Deliverability	Operational delivery presents a moderate risk due to workforce transition, reduced bed capacity and dependency on enhanced community services. Potential risks include service disruption, capacity gaps and workforce challenges. Successful implementation will require phased delivery, robust planning, clear governance and ongoing performance monitoring.	4	1	4
3.7 Ethics, Reputation and Social Responsibility	There is a reputational risk associated with perceived loss of local services and increased travel requirements, particularly in rural communities. While the model promotes sustainable, high-quality care and improved outcomes, maintaining public trust will depend on transparency, engagement, equitable access and effective communication throughout implementation.	4	1	4
3.8 Workforce	The model supports workforce sustainability through consolidation, multidisciplinary working and expanded community services. Benefits include greater resilience and development opportunities. Risks include recruitment difficulties, staff displacement and impacts on morale during transition. Effective workforce planning, engagement, training and support will be critical to successful delivery.	4	1	4
3.9 Summary of Mitigations	Mitigations focus on improving access, equity and service sustainability through expanded community care, crisis response, reablement, transport support, carer assistance and strengthened Welsh language and digital provision. Phased implementation, robust monitoring, partnership working and targeted support for vulnerable groups will be essential to reducing risks.	4	1	4

SL MHDO_006a: All beds to Bronllys or Brecon area + integrated OAMH community

Section B.1 Summary Impact Assessment - Quality

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Standard is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in Explanatory Notes. A "deep dive" assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.1).

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Summary	The proposed Mental Health Service Model represents a significant transformation in the way mental health services are delivered across Powys, with the primary focus being the substantial enhancement of community mental health services across all localities. The model seeks to shift care towards prevention, early intervention, recovery, and support closer to home, enabling more people to access timely and appropriate care within their own communities and reducing reliance on inpatient admission wherever clinically appropriate. The model also proposes greater integration between mental health and physical health services, particularly for older people, through the co-location of older adult mental health services alongside physical health inpatient services.	4	1	4

[1] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

	Inpatient mental health provision would be consolidated, with Older Adult Mental Health inpatient services centralised in the Bronllys or Brecon area and Functional Mental Health services brought together within a more resilient and sustainable inpatient model. The introduction of additional assessment beds and a Sanctuary facility will strengthen crisis response, improve patient flow and provide alternatives to inpatient admission when appropriate. The model is expected to improve consistency, quality and sustainability across the mental health system by creating stronger multidisciplinary teams, improving access to specialist expertise and providing clearer pathways between community, crisis and inpatient care. While the enhanced community model is anticipated to deliver substantial benefits for patients, carers and communities, successful implementation will require careful transition planning, investment in community capacity, workforce development and ongoing engagement with patients, families and staff. Overall, the model presents an opportunity to create a more integrated, sustainable and person-centred mental health system for Powys. **Benefits** • Significantly enhances community mental health services across all areas of Powys. • Supports prevention, early intervention and recovery-focused care. • Enables more people to receive support closer to home and reduces reliance on inpatient admission. • Strengthens integration between mental health and physical health services, particularly for older adults. • Improves crisis response through enhanced community support, additional assessment beds and the introduction of a Sanctuary service.			

	• Creates more resilient inpatient services through the consolidation of specialist expertise and staffing. • Improves access to multidisciplinary support and specialist mental health expertise. • Supports improved recruitment, retention and workforce development opportunities. • Reduces reliance on temporary staffing and out-of-county placements. • Provides a more consistent service model and patient experience across Powys. • Enhances opportunities for partnership working across health, social care, third sector and community organisations. • Supports a more sustainable long-term model of care that aligns with national policy and recovery-focused practice. **Challenges and Considerations** • Centralisation of older adult and functional mental health inpatient services may increase travel requirements for some patients, carers and visitors. • Changes to existing inpatient arrangements may create concerns within local communities and amongst service users and families. • Successful implementation is highly dependent on the timely development of enhanced community services and workforce capacity. • Workforce transition may require changes to roles, locations and ways of working. • Significant change management, engagement and communication activity will be required throughout implementation. • Short-term operational pressures may emerge while services adapt to new pathways and care models.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	• Ongoing investment will be required to ensure community services can safely support increased levels of activity. • Careful monitoring will be needed to ensure quality, safety and patient outcomes are maintained throughout the transition. • The anticipated benefits are dependent upon effective integration across services and successful delivery of the enhanced community model.			
Safe	The proposed model has the potential to significantly improve safety by strengthening community mental health services, supporting earlier intervention and providing more responsive care before individuals reach crisis point. Enhanced community teams, crisis response services, assessment capacity and the introduction of a Sanctuary facility may reduce avoidable deterioration and provide timely alternatives to inpatient admission. The integration of older adult mental health services alongside physical health inpatient services also creates opportunities for more holistic care, particularly for individuals with complex physical and mental health needs. The consolidation of specialist inpatient services is expected to strengthen workforce resilience, improve access to specialist expertise, and support greater consistency in clinical practice. However, the transition will require careful management to ensure continuity of care, maintain appropriate staffing levels, and minimise disruption for patients and carers. Particular attention will be required to manage changes associated with centralised inpatient provision and to ensure community services are fully established before activity transfers from inpatient settings.	3	2	6

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access, enhanced community model, the impact will be negligible (1) when complete, but there could be some impacts during transition which has increased to a minor impact (2), which gives an overall score of 6.			
Timely	The model is expected to improve timeliness of access through enhanced community provision, expanded crisis support, NHS 111 Press 2 access arrangements and increased assessment capacity. Earlier intervention and improved care coordination should enable individuals to access support before their needs escalate, reducing delays and improving patient flow throughout the mental health system. The Sanctuary facility and additional assessment beds may further strengthen the ability to respond rapidly to emerging mental health needs. However, these improvements will depend upon successful workforce recruitment, service mobilisation and the effective implementation of new pathways. During transition there may be temporary pressures on services as community and inpatient arrangements are adapted, requiring careful oversight to maintain timely access throughout the implementation period. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model the impact is negligible (1), which gives an overall score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Effective	The model supports a more effective mental health system by strengthening community provision, integrating physical and mental healthcare and creating clearer pathways between prevention, crisis support and inpatient care. Greater integration for older adults may improve outcomes for individuals with complex needs, while enhanced multidisciplinary working can support more holistic and coordinated care. Centralised specialist inpatient provision may improve clinical sustainability and access to expertise. However, delivering the anticipated benefits will depend on successful implementation across multiple services and ensuring that community support is sufficiently developed to meet growing demand. Ongoing monitoring and evaluation will be required to ensure improved outcomes are achieved consistently across Powys. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Efficient	The model is expected to improve efficiency through stronger community support, reduced avoidable admissions, fewer out-of-county placements, and improved use of specialist workforce resources. Consolidating inpatient services may create larger and more sustainable clinical teams, support more efficient staffing models and improve workforce utilisation across the service. Whilst the longer-term outlook is positive, efficiencies may take time to emerge and will require sustained investment in community mental health services, facilities, and workforce development. During implementation there is potential for short-term operational pressures as activity transitions across services and new models of care become embedded. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3
Equitable	The enhanced community mental health model has the potential to improve equity by providing more consistent access to assessment, treatment, recovery support and crisis services across all areas of Powys. Strengthening local services may particularly benefit rural communities by reducing barriers to accessing support and allowing more care to be delivered closer to home.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Person-Centred	However, the centralisation of inpatient services may result in longer travel distances for some patients, carers and family members. It will therefore be important to ensure that the benefits of improved local community provision are realised consistently across all localities and that any unintended impacts associated with inpatient consolidation are carefully monitored and mitigated. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model the impact is negligible (1) which gives an overall score of 3.	3	1	3
	The model places recovery, prevention and individual needs at the centre of service delivery. Enhanced community services, improved care coordination and increased opportunities for support within local communities align closely with what service users, families and carers often identify as their preferred model of care. The introduction of a Sanctuary service and strengthened crisis support pathways also provide greater choice and flexibility for individuals accessing mental health services.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	At the same time, some service users and carers may have concerns regarding changes to inpatient service locations and established care pathways. Meaningful engagement, co-production, and effective communication will therefore be essential throughout implementation to ensure the model remains focused on patient experience and individual outcomes. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3
Workforce	The model is expected to strengthen workforce sustainability through larger integrated teams, improved multidisciplinary working, and greater opportunities for specialist practice. The integration of older adult physical and mental health services may create new opportunities for collaborative working, whilst the consolidation of inpatient services may reduce professional isolation and improve workforce resilience. However, implementation will require workforce adaptation, including changes to roles, team structures and service locations. Staff may experience uncertainty during transition and will require clear communication, engagement, and development support to facilitate successful implementation and maintain morale.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.			
Leadership	The model provides a clear strategic direction focused on prevention, integration, community-based care, and sustainable inpatient services. Bringing services together within a more integrated framework may strengthen governance, improve oversight and support more consistent leadership across the mental health pathway. Successful implementation will require strong leadership at all levels to manage the complexity of service transformation, maintain stakeholder confidence and coordinate the delivery of multiple service changes simultaneously. Effective governance and programme management arrangements will be essential throughout transition. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Culture	The model supports the development of a recovery-focused, integrated and collaborative culture across Mental Health Services. Enhanced community services, closer integration of physical and mental healthcare, and stronger multidisciplinary teams may encourage innovation, shared responsibility, and a greater focus on prevention and early intervention. Cultural change of this scale will require time and sustained support. Staff and teams will need opportunities to adapt to new models of care and ways of working, making engagement, communication and organisational development important components of successful implementation. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact negligible (1) when complete but there could be some impacts during transition which has increased to a minor impact (2), which gives an overall score of 6.	3	2	6
Information	The model creates opportunities to improve information sharing, performance monitoring and service evaluation across the mental health system. Greater integration between services may support more coordinated care planning, enhanced outcome monitoring and stronger evidence-based decision making.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	As with any major service redesign, clear communication with patients, carers, staff and communities will be essential. Transparent information regarding service changes, expected benefits and transition arrangements will help maintain confidence and support a smooth implementation process. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.			
Learning, Improvement and Research	The model provides opportunities to strengthen learning, service improvement and research through larger teams, improved integration and increased workforce resilience. Enhanced community services and integrated care pathways may create additional opportunities to develop innovative approaches to mental health care and support the adoption of evidence-based practice. These benefits will depend on maintaining investment in workforce development and ensuring that opportunities for training, quality improvement and research remain priorities throughout implementation and beyond. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Whole Systems Approach	The model strongly supports a whole-system approach to mental health and wellbeing by enhancing community provision and strengthening links between mental health services, physical health services, primary care, social care, housing services, voluntary organisations and wider community partners. Greater integration of services for older adults and the emphasis on prevention, recovery and early intervention support a more coordinated and sustainable approach to care. The success of the model will depend upon ongoing collaboration across organisational boundaries and a shared commitment to delivering the enhanced community offer. Effective partnership working and careful transition planning will be essential to ensure the full benefits of the model are realised. Risk Assessment: The assessment shows that it is possible (3) that a person will contact these services and that due to the improved access through the enhanced community model, the impact is negligible (1) which gives an overall score of 3.	3	1	3

SL MHDO_006a: All beds to the Bronllys or Brecon area + integrated OAMH community

Equality Impact Assessment

This Equality Impact Assessment was undertaken to evaluate the potential effects on individuals and groups with protected characteristics under the Equality Act 2010 of the draft proposals being developed in relation to three key service areas as part of the Stage 2 Better Together programme.

The assessment drew on a range of evidence which utilised the data in the revised Full Case for Change and the feedback given from the engagement conducted to date. This is set out in the comprehensive Stage 0 – Stage 2 Better Together feedback report alongside additional feedback captured by services using patient feedback mechanisms e.g. Civica surveys, patient focus groups during the past 18 months.

Engagement for the Better Together programme was carried out with PTHB employees, residents, third sector representatives, public sector colleagues and service users including representatives from equality groups. Surveys, focus groups and targeted outreach took place in communities to ensure a broad mix of views were captured.

The views given by all stakeholders were analysed and fed back to the programme team. Further analysis then took place to identify differential impacts across protected characteristics, with particular attention to areas of potential disadvantage. Where negative impacts were identified, some mitigation actions have been included either as ideas proposed by stakeholders or as additional options to reduce or eliminate these effects.

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Characteristic is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in the Explanatory Notes. A deep dive assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.2). This should be undertaken in line with CGP009 using the template in Section C.2.

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
Summary	The proposed Mental Health Model for Powys represents a significant transformation in how mental health services are delivered, with a clear emphasis on providing more care closer to home, reducing reliance on inpatient care, and ensuring that people can access timely support within their own communities wherever possible. Central to the model is the development of a significantly enhanced Community Mental Health Service across all areas of Powys. This will increase the availability of assessment, treatment and ongoing support within local communities, helping more people remain independent and receive care in their own homes. Expanded community provision, improved crisis response, enhanced preventative services, Sanctuary and assessment facilities, and strengthened NHS 111 Press 2 and Single Point of Access arrangements will provide greater access to support and help prevent unnecessary hospital admissions. The model also promotes closer integration between mental health and physical health services. For older people with mental health needs, care will be delivered through a more integrated approach, including access to community inpatient facilities across Powys where appropriate. This will enable many patients to receive care closer to home, reduce travelling distances for patients and families, and improve coordination between physical and mental health services.	3	2	6

[2] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

For those requiring specialist inpatient mental health care, the model proposes modern, redesigned inpatient facilities located at Bronllys or Brecon. This would include centralised Older Adult Mental Health assessment beds alongside specialist Functional Mental Health inpatient services. These facilities would provide a higher-quality therapeutic environment, improved patient experience, greater clinical resilience and enhanced opportunities for multidisciplinary care than are possible within the current estate.

A key benefit of the proposed model is the opportunity to increase local capacity within Powys and reduce reliance on out-of-county placements. Enhanced community services, specialist assessment facilities, and improved inpatient provision will support the repatriation of patients currently receiving care outside the county and help prevent future placements elsewhere in Wales or across the UK. This will improve continuity of care, strengthen family involvement and enable patients to maintain stronger connections with their local communities and support networks.

Overall, the Equality Impact Assessment identifies substantial potential benefits arising from improved access to community-based care, greater service integration, enhanced crisis prevention, improved inpatient environments and increased opportunities for people to remain within Powys for treatment and recovery. The model aligns with the principles of delivering care at home where possible, providing integrated care for older adults, and ensuring that people with more complex mental health needs can access specialist care within the county.

However, the centralisation of specialist inpatient beds in the Brecon or Bronllys area may create challenges for some individuals and families, particularly those living in North Powys and more remote parts of the county. Increased travel distances may affect visiting arrangements, family involvement and access to support networks during inpatient admissions. Older people, unpaid carers, individuals experiencing socio-economic disadvantage, people with disabilities, and Welsh-speaking communities may be more affected by these challenges. These challenges will likely be less if Brecon was the preferred site.

The overall assessment concludes that the benefits of enhanced community provision, increased local service capacity, improved quality of inpatient environments, and reduced reliance on out-of-county placements have the potential to deliver significant positive outcomes for patients across Powys. To ensure these benefits are experienced equitably, implementation will need to be supported by appropriate mitigation measures, including transport solutions, flexible visiting arrangements, digital communication options, support for carers, Welsh language provision and continued investment in community-based services across all parts of the county.

Summary Table

Characteristic	Likelihood	Impact	Score
Age	3	2	6
Disability	3	2	6
Gender Reassignment	3	1	3
Marriage and Civil Partnership	3	1	3
Pregnancy and Maternity	3	1	3
Race	3	1	3
Religion or Belief	3	1	3
Gender	3	1	3
Sexual Orientation	3	1	3
Welsh Language	3	2	6
Socio-Economic Circumstances	3	2	6
Social Exclusion	3	2	6
Carers	3	2	6

Age	Powys has a significantly older population than the Wales average, with around 28% of residents aged 65 years and over. As the population continues to age, demand for both older adult mental health services and integrated physical and mental health care is expected to increase. Older people are more likely to experience dementia, depression, anxiety, frailty and multiple long-term health conditions, often requiring coordinated support from a range of health, social care and community services. The proposed model has been specifically designed to respond to these demographic changes. A key feature of the model is the significant expansion of community-based mental health services across Powys, enabling more people to receive assessment, treatment and ongoing support in their own homes, or within their local communities. Enhanced prevention, early intervention, crisis response and community treatment services will help reduce avoidable admissions, support independence and enable people to remain connected to their families, carers and local support networks for longer. The model also promotes much closer integration between mental health and physical healthcare for older people. Through stronger links with community hospitals, primary care, therapies, social care and community services, patients will benefit from more coordinated and holistic care. Older people requiring inpatient care for physical health needs alongside mental health support, may also be able to access care closer to home through community hospital facilities across Powys, reducing the need to travel and improving continuity of care. For those requiring specialist inpatient mental health treatment, the model proposes the development of modern, purpose-designed facilities in the Bronllys or Brecon area including centralised Older Adult Mental Health assessment beds. These facilities would provide a significantly improved therapeutic environment compared to the existing estate, supporting dignity, privacy, safety and recovery. The co-location of specialist inpatient services would also improve clinical resilience, multidisciplinary working and access to specialist expertise, helping to deliver more consistent and higher-quality care for older adults with complex mental health needs.	3	2	6

	In addition, the enhanced community model, specialist assessment facilities and increased local capacity create opportunities to reduce reliance on out-of-county placements and, where appropriate, repatriate Powys residents currently receiving care elsewhere. This would allow more older people to receive care closer to their homes, families and communities, improving continuity of care and supporting better recovery outcomes. However, for the smaller number of older people who require admission to a specialist mental health inpatient unit, there are potential challenges associated with the centralisation of services to the Bronllys or Brecon area. Older adults are more likely to experience mobility difficulties, frailty, sensory impairments, cognitive impairment and reduced access to private transport. For some individuals, particularly those living in North Powys, travelling to Bronllys may require longer journeys for both patients and visitors. This impact is lessened if Brecon was the preferred site. Family members and unpaid carers play a particularly important role in supporting older people during periods of illness, contributing to emotional wellbeing, recovery, care planning and discharge arrangements. Any reduction in opportunities for regular face-to-face contact may have a greater impact on older adults, especially those living with dementia or cognitive impairment, where familiarity, routine and family involvement are often important elements of care and recovery. These potential impacts must, however, be considered alongside the wider benefits of the proposed model. The overwhelming majority of older people who access mental health services do so within community settings rather than inpatient units. Under the proposed model, many more people would receive enhanced support closer to home, experience improved integration between physical and mental health services, and potentially avoid hospital admission altogether. Overall, while the centralisation of specialist inpatient mental health beds may create challenges for some older people and their carers, the proposed model delivers substantial benefits through enhanced community provision, integrated			

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	older adult care, improved inpatient environments, reduced reliance on out-of-county placements and greater access to support within local communities. The overall impact on age is therefore assessed as moderate with specific adverse impacts for those requiring inpatient admission, with mitigation focused on transport support, carer involvement, flexible visiting arrangements, digital connectivity and maintaining strong community-based services across all areas of Powys. Therefore, based on the impact to older and younger people the risk assessment score shows that the impact is possible (3) and that due to the enhanced Powys wide community service the overall impact will be minor (2) giving an overall risk rating of 6.			
Disability	The proposed model seeks to improve outcomes for people with disabilities by shifting the focus of mental health care towards earlier intervention, enhanced community support and more integrated services delivered closer to home. This approach aligns with the Health Board's commitment to reducing inequalities, improving accessibility and ensuring people receive the right care, in the right place, at the right time. A significant strength of the proposed model is the substantial expansion of community mental health services across Powys. Enhanced community teams, improved crisis response, increased home-based care and strengthened preventative support will enable more people with disabilities to receive care within their own homes and communities, reducing the need for hospital admission where this is safe and appropriate. This is particularly important for individuals whose disabilities make travel, unfamiliar environments or disruption to routines more challenging.	3	2	6

The model also strengthens integration between mental health, physical health and social care services. Many people accessing mental health services have multiple and interconnected needs, including physical disabilities, sensory impairments, learning disabilities, neurodevelopmental conditions and long-term health conditions. Greater integration between services should result in more coordinated care, improved communication between professionals and a more holistic approach to meeting individual needs.

For individuals requiring inpatient mental health treatment, the proposed development of modern inpatient facilities in the Bronllys or Brecon area would provide significant improvements over the existing estate. New facilities would be designed to support accessibility, dignity, privacy, independence and therapeutic recovery. Improved physical environments, enhanced clinical oversight and co-located specialist expertise would be expected to deliver a better experience for many patients, particularly those requiring adapted environments or specialist support.

The proposed model also creates opportunities to increase local specialist capacity within Powys. Enhanced community services, specialist assessment facilities and improved inpatient provision will help reduce reliance on out-of-county placements and support the repatriation of patients receiving care elsewhere. For many people with disabilities, receiving care closer to their local community, family and support network can significantly improve their experience of care and recovery outcomes.

However, there are also potential adverse impacts associated with the centralisation of specialist inpatient mental health beds to the Bronllys or Brecon area. People with physical disabilities, sensory impairments, learning disabilities, autism, cognitive impairments or complex mental health needs may experience additional challenges when travelling longer distances to access inpatient care. For some individuals, particularly those living in North Powys or more remote communities, longer travel times may increase stress, fatigue and practical difficulties associated with attending assessments, admissions, visits or discharge planning meetings.

Family members, carers and advocates often play a crucial role in supporting people with disabilities throughout their care journey. They contribute to communication, decision-making, emotional support, discharge planning and, in some cases, safeguarding. Increased travel distances may reduce opportunities for regular face-to-face contact and involvement, particularly where carers have their own health conditions, mobility difficulties, work commitments or limited access to transport. These challenges would likely be reduced if Brecon was the chosen site.

Individuals with learning disabilities, autism or cognitive impairment may experience particular challenges arising from admission to a specialist inpatient service further from home. Familiar routines, environments, carers and support networks can be important in reducing anxiety and promoting wellbeing. Any reduction in these protective factors may have a greater impact on these groups during periods of inpatient treatment.

Despite these concerns, it is important to recognise that only a relatively small proportion of people accessing mental health services require inpatient admission. The majority of individuals with disabilities are likely to benefit from the enhanced community model, which is specifically designed to provide earlier support, reduce barriers to access, improve continuity of care and help people remain within their local communities wherever possible.

Overall, the proposed model is expected to deliver significant benefits for people with disabilities through enhanced community provision, improved integration between physical and mental health services, more accessible and therapeutic inpatient environments, and reduced reliance on out-of-county placements. Whilst there are identifiable risks associated with increased travel distances for inpatient care, these are likely to affect a smaller number of individuals and can be mitigated through transport support, flexible visiting arrangements, digital communication, advocacy services and person-centred care planning.

The overall impact on people with disabilities is therefore assessed as Moderate with specific adverse impacts for those requiring specialist inpatient admission,

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	and those who are highly dependent on family, carers or familiar support networks. Therefore, based on the impact for people who have disabilities, the risk assessment score shows it is possible the impact will occur (3) and that due to the enhanced Powys wide community service the overall impact will be minor (2), giving an overall risk rating of 6.			
Gender Reassignment	The Strategic Equality Plan promotes inclusive services, LGBTQ+ awareness, and appropriate accommodation for all patients. The proposed model provides modern facilities, enhanced care, and more services closer to home. No disproportionate adverse impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3
Marriage and Civil Partnership	The Strategic Equality Plan includes protections for people who are married or in a civil partnership. The proposed model does not introduce any specific changes affecting this group beyond wider service improvements. No adverse impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3
Pregnancy and Maternity	The Strategic Equality Plan supports equitable access for people who are pregnant or on maternity pathways. The proposed model does not introduce any specific changes affecting this protected characteristic beyond improved service provision. No adverse impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
Race	Powys has a predominantly White population, but the Health Board remains committed to meeting its Equality Act duties for all ethnic groups. The proposed model does not create specific impacts relating to race. Workforce transition should consider any potential risks affecting internationally recruited staff. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3
Religion or Belief	The Health Board's equality framework supports individuals of all faiths and beliefs, including access to spiritual support and prayer facilities where required. The proposed model does not affect these arrangements, and no specific adverse impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3
Gender	The Strategic Equality Plan promotes inclusive healthcare and suitable environments for all patients. The proposed model improves facilities and clinical services but does not introduce any specific changes affecting people based on gender. No disproportionate impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3
Sexual Orientation	The Strategic Equality Plan supports inclusive care for lesbian, gay, bisexual and other LGBTQ+ individuals. The proposed model does not alter existing protections or service arrangements for this group and is expected to improve overall service quality. No adverse impacts have been identified. Overall risk is (3), with a possible (3) likelihood of interaction with the services and a negligible (1) impact.	3	1	3

Welsh Language	The Welsh language is a vital part of Powys' cultural identity and community life. Welsh speakers live throughout the county, with higher concentrations in areas including Machynlleth, Llanfyllin and Ystradgynlais. For many people, particularly older adults, Welsh is not simply a preferred means of communication but is closely linked to identity, relationships, emotional expression and wellbeing. The proposed model presents a number of significant opportunities for Welsh speakers. The enhanced community mental health model will increase the availability of services across local communities, enabling more people to access assessment, treatment and ongoing support closer to home. As more care is provided within community settings, individuals are more likely to remain connected to their families, local support networks and Welsh-speaking communities. This creates greater opportunities for care to be delivered in a person's language of choice and within familiar environments that support recovery and wellbeing. The proposed integration of mental health, physical health and community services also provides an opportunity to strengthen the delivery of bilingual care across pathways, improving continuity and reducing the need for repeated assessments or communication through multiple services. Enhanced community provision, prevention services, crisis support and local assessment facilities should mean that many more people can receive care without requiring admission to hospital. For those requiring specialist inpatient care, the proposed model includes the development of modern, purpose-designed facilities in the Bronllys or Brecon area. Improved facilities, enhanced therapeutic environments and increased clinical resilience have the potential to improve the overall quality of care experienced by Welsh-speaking patients. The opportunity to strengthen specialist services within Powys and reduce reliance on out-of-county placements may also benefit Welsh speakers by enabling more patients to receive care within Wales and closer to their home communities. However, language and communication are particularly important within mental health services. The ability to communicate in a person's first language can be essential for effective assessment, therapeutic engagement, risk assessment,	3	2	6

	and treatment planning. This is especially relevant for older people, individuals living with dementia, people with learning disabilities, and those experiencing severe mental illness or psychological distress. During periods of illness, many individuals naturally revert to their first language, and any inability to communicate effectively in Welsh can affect both patient experience and clinical outcomes. The centralisation of specialist inpatient services in the Bronllys or Brecon area may therefore create potential risks if sufficient Welsh-speaking workforce capacity is not maintained. Some of the current inpatient sites serve communities with relatively high proportions of Welsh speakers and have established Welsh-language capability within their workforce. Without careful workforce planning, there is a risk that some patients could experience reduced access to Welsh-medium care during inpatient admissions. This could be particularly significant for patients admitted from Welsh-speaking communities who may be separated from familiar language environments, local support networks and established relationships with Welsh-speaking staff. Any reduction in access to Welsh-language communication could impact confidence, comfort, engagement with treatment, and overall patient experience. These risks are, however, mitigated by the Health Board's statutory duties under the Welsh Language (Wales) Measure 2011 and its commitment to the principle of the Active Offer. The proposed model provides an opportunity to strengthen Welsh-language provision through targeted recruitment of Welsh-speaking staff, workforce planning, language skills development, improved identification of language preference, enhanced translation and interpretation services, and implementation of the Welsh in Healthcare Strategy. Overall, the enhanced community-based model is likely to have a positive impact for many Welsh speakers by providing more care closer to home, reducing reliance on distant placements and improving access to local services. Nevertheless, there remains a specific risk that the centralisation of specialist inpatient services			

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	could affect access to Welsh-medium care if workforce requirements are not fully addressed. The overall impact on Welsh language is therefore assessed as Moderate, subject to the successful implementation of Welsh language workforce plans and continued compliance with the Active Offer to ensure Welsh speakers can receive care in their preferred language throughout their healthcare journey. Therefore, based on the impact to the people who prefer to receive their care through the medium of Welsh then the risk assessment score shows that it is possible the impact will occur (3), and that due to the enhanced Powys wide community service where Welsh is likely to be spoken more, then the overall impact will be minor (2), giving an overall risk rating of 6.			
Socio-Economic Circumstances	The proposed Mental Health Model has been assessed against the socio-economic profile of Powys, a predominantly rural county where disadvantage is often dispersed across communities rather than concentrated within a small number of areas. Many residents experience challenges associated with lower incomes, limited employment opportunities, rural isolation, restricted access to transport and varying levels of digital exclusion. These factors can have a significant impact on both mental wellbeing and an individual's ability to access health and care services. The proposed model has the potential to deliver substantial benefits for people experiencing socio-economic disadvantage. A key objective of the redesigned service is to provide more care closer to home through significantly enhanced community mental health services across all areas of Powys. This includes strengthened prevention and early intervention services, expanded crisis response, enhanced community treatment, improved care coordination and greater integration with physical health and social care services.	3	2	6

For many individuals, particularly those facing financial hardship, the ability to receive care within their own community reduces both the practical and financial barriers associated with accessing support. Earlier intervention and locally available services can help people access support before their circumstances deteriorate, reducing the likelihood of crisis presentations, hospital admission and prolonged periods of poor mental health.

The model also aims to reduce reliance on out-of-county placements by increasing specialist mental health capacity within Powys. This will enable more people to receive care closer to their homes, families and support networks, reducing the significant emotional and financial burden often associated with travelling long distances to visit loved ones receiving treatment outside the county.

The proposed integration of mental health, physical health and community services is also expected to particularly benefit those experiencing multiple forms of disadvantage. Many people accessing mental health services face a combination of financial pressures, poor physical health, housing difficulties, social isolation or caring responsibilities. A more coordinated and community-based approach should support earlier identification of need and improve access to wider support services that contribute to wellbeing and recovery.

However, there are potential adverse impacts associated with the centralisation of specialist inpatient mental health services in the Bronllys or Brecon area. Although only a relatively small proportion of people accessing mental health services require inpatient admission, those who do may experience increased travel distances depending on where they live within Powys.

For individuals and families on lower incomes, the cost of travel can be a significant barrier to maintaining involvement in care. Longer journeys may require additional expenditure on fuel, public transport, childcare or time away from work. In rural communities where public transport options are limited, these challenges may be amplified, affecting both patients and those supporting them. These challenges would likely be reduced if Brecon was the preferred site.

Family involvement is recognised as an important component of recovery, emotional wellbeing and discharge planning. If travel costs or journey times reduce the ability of relatives and carers to visit regularly, this may affect a patient's experience of care and potentially impact recovery outcomes. The effects may be particularly significant for people who are already socially isolated or have limited support networks.

Digital exclusion also remains an important consideration. While digital communication and virtual engagement can help maintain contact between services, patients and families, not everyone has access to reliable internet connectivity, suitable devices or the confidence and skills required to use digital technology effectively. There is therefore a risk that some individuals experiencing socio-economic disadvantage may benefit less from digital solutions than others.

These risks must, however, be considered alongside the wider benefits of the proposed model. By significantly strengthening community mental health provision, increasing local access to care, reducing avoidable admissions and supporting more people within their own communities, the model is expected to have a positive impact on many of the factors that contribute to health inequalities across Powys.

Overall, the proposed model is likely to deliver significant benefits for people experiencing socio-economic disadvantage through improved access to community-based services, enhanced local support, reduced reliance on out-of-county placements and greater integration of care. Nevertheless, there remain identifiable risks for those requiring inpatient admission, particularly in relation to transport costs, travel times, social isolation and digital exclusion.

The overall impact in relation to socio-economic disadvantage is therefore assessed as Moderate with specific adverse impacts for individuals and families who experience financial hardship and are required to travel longer distances to access specialist inpatient care. Mitigation should focus on transport assistance, carer support, flexible visiting arrangements, digital inclusion initiatives and continued investment in local community services across all parts of Powys.

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	Therefore, based on the impact to the people who are experiencing social economic challenges then the risk assessment score shows that it is possible that the impact will occur (3) and that due to the enhanced Powys wide community service the overall impact will be minor (2), giving an overall risk rating of 6.			
Social Exclusion	Social exclusion can arise from a range of interconnected factors including poverty, rural isolation, limited access to services, poor transport links, digital exclusion, poor physical health, discrimination and a lack of social support. People experiencing mental health difficulties are often at greater risk of social exclusion, with mental illness both contributing to and resulting from reduced social participation, loneliness, unemployment and disengagement from community life. The proposed Mental Health Model has been designed with a strong emphasis on prevention, early intervention and community-based care, which has the potential to make a positive contribution to reducing social exclusion across Powys. By significantly enhancing community mental health services, the model aims to ensure that more people can access support within their own communities, maintain their independence and remain connected to their families, social networks and local services.	3	2	6

A key benefit of the proposed model is that more care will be delivered closer to home. Enhanced community mental health teams, improved crisis response, strengthened prevention services, Sanctuary and assessment facilities, and greater integration with physical health and social care services will enable more people to receive timely support without requiring admission to hospital. This approach supports individuals to remain active within their communities and reduces the disruption that can occur when people are removed from their local environment for treatment.

The model also provides opportunities for services to work more closely with wider partners, including social care, housing providers, community organisations and the voluntary sector. This integrated approach should help identify wider social needs earlier and enable more coordinated interventions to address issues such as isolation, housing difficulties, financial hardship and community participation. By addressing these wider determinants of wellbeing, the model has the potential to reduce the risk of people becoming socially excluded as a result of their mental health difficulties.

The proposed increase in local mental health capacity and reduction in reliance on out-of-county placements may also have a positive impact. Where individuals previously may have been admitted to services outside Powys, the enhanced model creates opportunities for more people to receive treatment within the county, helping them maintain stronger links to family, carers and local support networks throughout their recovery.

However, there are potential adverse impacts associated with the centralisation of specialist inpatient mental health services at Bronllys. For the smaller number of individuals requiring inpatient admission, longer travel distances may make it more difficult for family members, carers, friends and advocates to maintain regular contact. This may be particularly challenging for people who are already socially isolated, have limited support networks, or experience financial hardship.

Social connection and meaningful relationships are recognised as important factors in mental health recovery. Regular contact with family, carers and support

networks can help reduce anxiety, support emotional wellbeing, strengthen engagement with treatment and contribute positively to discharge planning. Any reduction in opportunities for face-to-face contact has the potential to increase feelings of loneliness, isolation and disconnection during periods of inpatient care.

These challenges may be particularly significant for people living in remote rural communities, individuals who do not have access to private transport, those experiencing poverty, and people whose support networks are themselves vulnerable due to age, disability or caring responsibilities. These challenges would likely be reduced if Brecon was the chosen site.

Digital exclusion must also be considered. Whilst digital technology offers opportunities to maintain contact with services, family members and support networks, not all individuals have access to the equipment, connectivity or skills required to engage confidently with digital alternatives. There is therefore a risk that some people experiencing social exclusion could benefit less from digital solutions and remain at greater risk of isolation.

Notwithstanding these risks, the overall direction of the proposed model is strongly aligned with reducing social exclusion. By providing more support within communities, strengthening preventative services, increasing opportunities for people to remain within Powys for treatment, and promoting greater integration across health, social care and community services, the model has the potential to improve social connectedness and reduce inequalities for many individuals who currently experience barriers to accessing support.

Overall, the impact in relation to social exclusion is assessed as Moderate. While there are identifiable risks associated with increased travel distances for individuals requiring inpatient care, the substantial expansion of community-based services, improved local access to support, enhanced prevention, and stronger integration of services are expected to reduce social exclusion for a much larger proportion of people accessing mental health services across Powys. Mitigation should focus on transport support, community outreach, carer involvement, digital inclusion, and maintaining strong links between inpatient services and local

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	communities to ensure no group experiences increased isolation as a result of the proposed changes. Therefore, based on the impact to the people who are experiencing social exclusion, the risk assessment score shows that the impact is possible to occur (3) and that due to the enhanced Powys wide community service the overall impact will be minor (2), giving an overall risk rating of 6.			
Carers	Unpaid carers play a vital role in supporting people with mental health needs across Powys. They often provide practical assistance, emotional support, advocacy, crisis management and help with daily living, enabling many individuals to remain safely within their own homes and communities. Powys has a high proportion of unpaid carers, many of whom already face challenges associated with rurality, transport limitations, financial pressures, social isolation and the impact of caring responsibilities on their own health and wellbeing. The proposed Mental Health Model has the potential to deliver significant benefits for carers by fundamentally changing the balance of care towards community-based support. A core aim of the model is to enable more people to receive care at home or within their local community, reducing the need for hospital admission wherever possible. Enhanced community mental health services, strengthened crisis response, improved preventative support, Sanctuary facilities, home treatment services, and greater integration with physical health and social care will allow more individuals to remain close to their families and support networks throughout their care journey.	3	2	6

For many carers, this represents a significant positive change. Earlier intervention and local access to support can help prevent situations from escalating into crisis, reducing stress on carers and providing support before caring responsibilities become overwhelming. Increased community capacity should also improve continuity of care and make it easier for carers to develop relationships with local mental health teams, contributing to more joined-up care planning and better communication.

The proposed model places particular emphasis on integrated care for older people, bringing mental health and physical health services closer together. This should provide a more coordinated experience for carers who often currently find themselves navigating multiple services on behalf of their loved ones. Improved partnership working between community teams, hospitals, primary care and social services has the potential to reduce duplication, simplify pathways, and provide carers with greater clarity about where to access support.

The model also seeks to reduce reliance on out-of-county placements by strengthening local services and creating additional assessment and specialist care capacity within Powys. This will allow more patients to receive treatment closer to home, reducing the burden on carers who may currently have to travel considerable distances to maintain contact and remain involved in care.

However, there are also potential adverse impacts associated with the proposed centralisation of specialist inpatient mental health services at Bronllys. While only a minority of people accessing mental health services require inpatient admission, family members and carers play a particularly important role when admission becomes necessary. Their involvement is often critical to recovery, communication, care planning, risk management and discharge arrangements.

For carers living in North Powys and more remote parts of the county, travelling to the Bronllys or Brecon area may involve significant journey times, increased costs and practical difficulties. These challenges may be particularly acute for carers who are older, have disabilities, are in employment, have childcare responsibilities or have limited access to private transport. Increased travel requirements may reduce opportunities for regular visiting and participation in care

planning meetings, potentially affecting both patient outcomes and the wellbeing of carers themselves.

Many carers already experience significant emotional, physical and financial pressures. Additional travel demands may increase stress, reduce opportunities for respite, and create barriers to maintaining the level of involvement they would wish to have in a loved one's care. Where patients are experiencing severe mental illness, dementia or cognitive impairment, regular contact with familiar carers can be especially important in supporting recovery, providing reassurance and maintaining continuity. These challenges would likely reduce if Brecon was the preferred site.

These risks are partially mitigated by the wider benefits of the proposed model. The enhanced community approach is expected to reduce overall reliance on inpatient care and increase opportunities for carers to remain actively involved in care within local settings. Additional mitigation measures, including transport assistance, flexible visiting arrangements, digital communication options, virtual participation in care planning meetings and strengthened carer support services, will be important to ensure carers can continue to contribute meaningfully to care and recovery.

Overall, the proposed model is expected to improve the experience of many carers by providing more support closer to home, reducing avoidable admissions, improving care coordination, and increasing local access to services. However, the centralisation of specialist inpatient services creates identifiable challenges for carers when admission is required, particularly in relation to travel, visiting, and ongoing involvement in care.

The overall impact on carers is therefore assessed as Moderate with significant adverse impacts for carers of patients requiring inpatient admission. While the majority of carers are likely to benefit from enhanced community provision and greater local support, targeted mitigation will be required to address travel, accessibility and involvement in care planning to ensure carers remain recognised as essential partners in recovery, discharge planning and ongoing care.

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	Therefore, based on the impact to the people who are unpaid carers, the likelihood is possible (3) and that due to the enhanced Powys wide community service, the overall impact will be minor (2) giving an overall risk rating of 6.			

Section C.2 Deep Dive Impact Assessment - Equality
Where agreed, you should copy and complete this table for every adverse equality impact score of 9 or more (yellow, amber and red impacts). This will form part of a full Equality Impact Assessment in line with Health Board policy CGP009 Equality Impact Assessment Policy. The level of detail should be proportionate to the impact and likelihood.

No impact reached the threshold for a Deep Dive Impact Assessment

PTHB Service Change Impact Assessment Physical Health 07/08/2026 Version 1.0 Approved for inclusion in PCBC

Live Document Subject to Change

Version Control (To be updated after formal final approval)

Version	Date	Author	Comments
Version 1 for PCBC	7. 8. 2026	Assistant Director of Improvement and Innovation / Quality Improvement Facilitator	Agreed for inclusion in PCBC

DOCUMENT NEEDS TO BE REFERENCED TO LATEST TECHNICAL DATA IN APPENDICES OF MASTER DOCUMENT

The significant technical documents reviewed to develop this impact assessment are held in the Step Report and Pre-Consultation Business Case. As the programme develops and new information is made available then this impact assessment will be updated.

The process used to calculate risk and copies of the risk matrix are detailed on Page 50.

Section A: Overview Summary of the Proposed Changes
(See full Step Change Document and Primary Business Case for full details)

A.1. Proposal Details	
1.1 Name of Proposal	The Future Model of Physical Health Care – Integrated Community Services
1.2 Proposal Lead	Deputy Director Primary Care, Community & Mental Health
1.3 Reference Number	n/a
1.4 Summary of Proposal	To create a radically enhanced community service model to enable more care to be delivered at home or closer to home. To facilitate this transformation, it is necessary to undertake service changes to the inpatient model, and two options have been shortlisted for consideration. Option SL IPDO_005b (Do Mid Range): which aims to centralise the inpatient bed model to three sites in Newtown, Llandrindod and Brecon, and close the inpatient beds in Welshpool, Llanidloes, Machynlleth, Bronllys and Ystradgynlais. And; Option SL IPDO_008 (Do Maximum): which aims to retain inpatient beds in Newtown and Brecon, and to close inpatient beds in Ystradgynlais, Bronllys, Llandrindod Wells, Llanidloes, Machynlleth and Welshpool. **The enhanced community service is to be delivered equally to all communities in Powys whilst the reduced inpatient bed base aims to improve quality, sustainability, environment, workforce resilience, and integration between services.**
1.5 Date / Version	**07.08.2026 v 1.0 Approved for inclusion in PCBC**
Interdependencies	The success of these proposals is dependent on strengthening and expanding community-based models of care, enabling more people to receive timely, safe and effective support closer to home. The proposed improvements

require coordinated change across the wider health and care system, with a particular focus on enhancing community services to all areas of Powys to prevent unnecessary admissions, support earlier discharge and improve patient flow across the whole pathway.

Delivering this transformation relies on several critical interdependencies across health, social care and voluntary sector partners. These services and organisations must work together to create a more integrated model of care, ensuring that patients can move seamlessly between services and receive the right support at the right time and in the right place.

Key interdependencies include primary care, community services, adult social care, acute SLA providers, mental health services, therapies, diagnostics, third sector partners and Flow Hub/Single Point of Access arrangements. Through phased pathway redesign, stakeholder engagement and programme governance, these interdependencies are being developed in parallel with the proposed changes.

In practice, this means that any future changes to inpatient beds will be supported by enhanced community capacity and capability, including Intermediate Care, Urgent Community Response, Hospital at Home, Discharge to Assess, integrated physical and mental health services, and strengthened multidisciplinary working. Together, these developments will support a more preventative, person-centred and sustainable model of care, reducing reliance on hospital-based services while improving outcomes and patient experience.

Key interdependencies and enabling services include:

- Intermediate Care Team
- Specialist Services
- Adult Social Care
- Flow Hub / Single Point of Access (SPOA)
- Primary Care
- Third Sector Organisations
- Hospice Partners
- Diagnostics
- Therapies
- Medical Devices / Community Equipment Store
- Non-Emergency Patient Transport Services (NEPTS)
- Acute SLA Providers

	• Mental Health Inpatient Model of Care

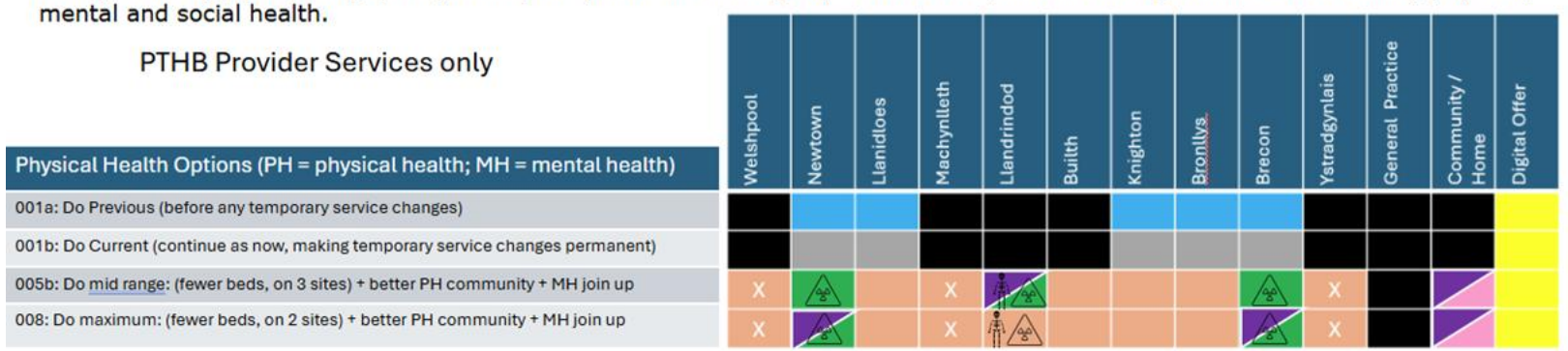
A.2. Proposal Overview	
2.1 Summary of Proposal	The proposed service changes are part of a wider transformation programme to develop an Integrated Community Services Model across Powys. The aim is to shift the balance of care from hospital-based services towards prevention, rehabilitation, urgent community response, Hospital at Home and multidisciplinary support, enabling more people to remain independent and receive care closer to or within their own homes. The case for change is driven by increasing demand from an ageing population, workforce challenges, financial pressures and the need to provide sustainable, high-quality care. The current inpatient model is becoming increasingly difficult to sustain, while investment in enhanced community services offers opportunities to deliver care in a way that is more aligned with people's preferences and clinical needs. To support this transformation, two shortlisted options for community inpatient services are proposed: • Option SL IPDO_005b (Do Mid Range): Deliver enhanced community services across Powys and retain inpatient beds on three sites at Newtown, Llandrindod Wells and Brecon, with beds closing at Welshpool, Llanidloes, Machynlleth, Bronllys and Ystradgynlais. • Option SL IPDO_008 (Do Maximum): Deliver enhanced community services across Powys and retain inpatient beds on two sites at Newtown and Brecon, with beds closing at Welshpool, Llanidloes, Machynlleth, Bronllys, Llandrindod Wells and Ystradgynlais. Both options would be accompanied by substantial investment in community-based intermediate care services to every community in Powys. These services would provide rapid assessment and treatment, urgent community response, rehabilitation and reablement, Hospital at Home, discharge support and community-based palliative and end-of-life care. Services would operate seven days a week through integrated multidisciplinary teams including nursing, therapy, medical, pharmacy, social care and third-sector staff. A central feature of the model is a strengthened Intermediate Care Service, designed to prevent avoidable hospital admissions, support timely discharge from acute hospitals, and help people recover safely at home wherever clin-

	ically appropriate. This would include a two-hour Urgent Community Response service, rehabilitation and reablement support, enhanced discharge-to-recover pathways, and coordinated care for people with frailty, long-term conditions, dementia and end-of-life care needs. The model would also introduce a Single Point of Access, improved digital systems, remote monitoring technology, stronger partnership working with social care and voluntary organisations, and improved access to community equipment. Overnight nursing support would be available for urgent and end-of-life care needs. Both shortlisted options aim to create a safer, more sustainable and integrated model of care by reducing reliance on inpatient beds while strengthening alternatives in the community. The anticipated benefits include reduced emergency admissions, fewer avoidable hospital stays, improved patient and carer experience, enhanced support for end-of-life care at home, and better outcomes for people requiring rehabilitation and ongoing support. The proposal is therefore not simply about reducing inpatient beds. It is about creating a modern, sustainable system that delivers more care at home, improves coordination between services, and ensures limited workforce and financial resources are used to provide the greatest benefit for the population of Powys.

Physical Health Scope – What could change on each PTHB site

To provide high quality, person centred, digitally enabled and proactive care within a community setting, that supports people to stay well at home, promotes recovery and reablement closer to home, reduces unnecessary hospital admissions and facilitates timely discharge, promoting quality of life, independence and dignity at end of life, and delivering holistic care including physical, mental and social health.

PTHB Provider Services only



The recommended Physical Health options were identified through an integrated appraisal of financial sustainability, workforce viability, estate condition, and access impacts. They represent a move away from the current fragmented and financially fragile inpatient model towards fewer, more sustainable inpatient sites, supported by stronger community-based services. This section brings together the assessment of the recommended options only, summarising the key implications to support a comprehensive Level 2 assessment.

These options aim to provide safe, high quality, person centred, digitally enabled, proactive and integrated care within fit-for-purpose community settings. They are designed to better support people with complex physical and mental healthcare needs:

- Effectively manage patients with complex physical and mental healthcare needs
- Prevent patient harm and deconditioning
- Support recovery through rehabilitation

- Reduce unnecessary acute hospital admissions and stays
- Facilitate timely discharge and effective transitions of care
- Reduce avoidable readmissions

The anticipated impact of this overall model of reducing the number of inpatient beds is that several patients who require inpatient care and their visiting family / carers would need to travel further to the inpatient ward than had the beds been retained within their more local area.

The anticipated impact of enhanced community services is that more patients who can have their care managed at or closer to home will receive this in a more appropriate way, and avoid an unnecessary hospital admission, travel and the potential harmful impacts of hospital admission.

This approach supports delivery of the shared long-term Health and Care Strategy for Powys 2017–2027 (extended to 2029), which sets out the ambition to transform health and care in Powys so that people can 'Start Well', 'Live Well' and 'Age Well'. It does this through a stronger focus on wellbeing, early help and support, tackling the big four health challenges, and improving joined-up care across services.

Area	SL IPDO_005b (Do Mid-Range)	SL IPDO_008 (Do Maximum)
Overall description	Approximately 90 inpatient beds consolidated onto three sites (Newtown, Llandrindod, Brecon), supported by strengthened community services and closer Physical–Mental Health integration.	Approximately 60 inpatient beds consolidated onto two sites (Newtown and Brecon), with maximum shift towards community-based care and closer Physical–Mental Health integration.
What stays the same	• Inpatient Physical Health beds remain in Powys • Inpatient rehabilitation at Newtown & Brecon • Step-up, step-down, palliative & end-of-life care retained • Community, primary care and third-sector roles continue	• Inpatient Physical Health beds remain in Powys • Inpatient rehabilitation at Newtown & Brecon • Palliative & end-of-life care retained • Community, primary care and third-sector roles continue
What changes	• Inpatient beds reduced and consolidated onto 3 sites • Closure of Physical Health beds at remaining community hospitals	• Further reduction in inpatient beds and consolidation onto 2 sites only • Closure of Physical Health beds at all other sites, including Llandrindod

		• Centralises adult functional and older adult organic inpatient care at a site in Bronllys / Brecon area• Diagnostics concentrated on fewer sites with longer hours • Expanded intermediate care and Hospital at Home • Dependency on community and Hospital at Home provision	• Centralises adult functional and older adult organic inpatient care at a site in Bronllys / Brecon area Diagnostics concentrated on fewer sites with longer hours Expanded intermediate care and Hospital at Home • Greater dependency on community and Hospital at Home provision
	Finance	• Recurrent net savings vs baseline • Savings driven by fewer wards, reduced duplication, and lower support costs • Moderate capital investment required at retained sites • Financial risk largely linked to delivery of community substitution	• Recurrent net savings vs baseline Savings driven by fewer wards, reduced duplication, and lower support costs with greatest reduction in inpatient operating costs • Higher capital requirement due to scale of consolidation • Financial benefit highly dependent on timely community investment • Higher delivery and affordability risk
	Workforce	• Improved workforce sustainability and rota resilience • Reduced reliance on agency staffing • Clearer leadership and supervision structures • Manageable workforce redeployment into community roles	• Strongest workforce concentration and sustainability • Lowest long-term dependency on temporary staffing • Larger workforce transition and change impact • Higher short-term disruption risk
	Estates	• Better use of three Rural Regional Centres • Reduced inpatient estate footprint • Capital investment needed to adapt retained sites • Decisions required on future use of closed inpatient sites	• Maximum rationalisation of inpatient estate • Concentration onto most modern sites • Significant implications for the future of closed hospitals • Greater reliance on capital funding approval

	Travel time & access	• Increased travel for some patients and visitors • Impact partially mitigated by fewer admissions and more care at home • Diagnostics on fewer sites with extended hours • Dependence on home-based alternatives	• Greatest increase in travel times for some patients and visitors although impact partially mitigated by fewer admissions and more care at home • Diagnostics on fewer sites with extended hours • Stronger dependence on home-based alternatives • Residual access and equity concerns for rural areas
	Key benefits	• Best balance of quality, access and sustainability • Strong alignment with Case for Change • Clinically safer staffing model • More deliverable within current system capacity	• Maximum efficiency and long-term sustainability • Strongest alignment with community-first ambition • Lowest long-term inpatient cost base
	Key risks	• Public, political and reputational risk • Community capacity not fully established at point of bed reduction • Transitional disruption for staff and patients • Public concern regarding loss of some local beds	• Highest public, political and reputational risk • Greater implementation complexity and dependency on capital • Transitional disruption for staff and patients • Public concern regarding loss of some local beds • Higher risk if community model under-delivers
	Trade-offs	Reduced local inpatient footprint in exchange for improved sustainability and quality, with a more balanced and deliverable change trajectory.	Maximum efficiency and consolidation in exchange for reduced accessibility and higher delivery risk.
	Level 2 view	Most balanced and deliverable recommended option for consultation and progression.	Viable but higher-risk option; benefits realised over longer term with greater implementation challenge.

	The wider strategic risk implications of the recommended options are considered further in section 2.5. This includes how each option is expected to affect the Health Board's broader risk position, particularly in relation to workforce sustainability, estates compliance, financial sustainability, and the delivery of transformation.
2.2 Situation, Background, Strategic Context	The proposed Integrated Community Services Model aligns with and supports the delivery of the following statutory and policy frameworks: **Statutory and Legislative Drivers** 1. **Well-being of Future Generations (Wales) Act 2015** Requires public bodies to improve the social, economic, environmental and cultural well-being of Wales through long-term, preventative, collaborative and integrated approaches. The urgent care proposals support sustainable service delivery, prevention, integration and prudent use of resources. [gov.wales], [legislation.gov.uk] 2. **Social Services and Well-being (Wales) Act 2014** Promotes person-centred care, prevention, wellbeing, independence and integrated working between health, social care and community services. The proposed model strengthens links between urgent care, community services and social care pathways. 3. **Health and Social Care (Quality and Engagement) (Wales) Act 2020** Introduced the NHS Wales Duty of Quality and Duty of Candour, requiring organisations to continuously improve service quality, safety, effectiveness and patient experience. The proposed urgent care model seeks to improve consistency, access and clinical capability across Powys. 4. **Equality Act 2010** Requires public bodies to eliminate discrimination, advance equality of opportunity and foster good relations. The assessment of urgent care options considers potential impacts on access, travel and health inequalities across Powys communities. 5. **The NHS (Wales) Act 2006** Places duties on NHS organisations to secure improvement in the physical and mental health of the population and the prevention, diagnosis and treatment of illness through sustainable service models. **Welsh Government and NHS Wales Policy** 1. **A Healthier Wales: Long Term Plan for Health and Social Care (2018)** Sets out the vision for a whole-system approach focused on prevention, early intervention, seamless services and care closer to home wherever possible.

2. **Six Goals for Urgent and Emergency Care (2021-2026)**
   Provides the national framework for delivering the right care, in the right place, first time. The urgent care proposals support improved access, alternatives to Emergency Departments, improved patient flow and better system integration.
3. **Integrated Community Care System (ICCS) for Wales**
   Promotes integrated models of care delivered through collaboration between primary care, community services, social care and the third sector, supporting people closer to home.
4. **NHS Wales Strategic Programme for Primary Care**
   Supports improved access to urgent and unscheduled care services through coordinated pathways, multidisciplinary teams and stronger community-based service provision.
5. **Value-Based Healthcare for Wales**
   Encourages investment in services that improve outcomes and patient experience, while making effective use of available resources. The proposed urgent care model aims to improve both clinical quality and efficiency.
6. **Prudent Healthcare Principles**
   Supports equitable access, co-production, evidence-based care and the effective use of NHS resources, ensuring patients receive the most appropriate level of intervention.

Background

Powys Teaching Health Board faces significant challenges that require a fundamental transformation of health and care services to ensure they remain safe, sustainable, and able to meet future population needs. The ambition is to develop a modern system of care that supports people to stay well, remain independent for longer, and receive care closer to home wherever possible.

The need for change is driven by a combination of demographic, workforce, financial, and estate pressures. Powys has an ageing population, with increasing numbers of people living longer with multiple long-term conditions and more complex care needs. Demand for services continues to grow, while expectations around quality, access and patient experience are increasing. The Health Board must therefore plan for the next 10 to 25 years by responding to changing patterns of illness and treatment, improving population health, developing a sustainable workforce, modernising facilities, and making best use of limited resources.

There are also growing pressures associated with fragmented service delivery, limited capacity in some teams, challenges in integrating physical and mental health services, and increasing Continuing Healthcare demand. A particular gap exists in the provision of rapid community-based responses that could prevent avoidable hospital admissions, and support people requiring urgent, complex, or end-of-life care at home.

	Evidence demonstrates that prolonged hospital stays can cause harm, particularly for older people. Deconditioning, loss of mobility, increased dependency, delirium, and hospital-acquired infections can all result from extended admissions. Delayed discharge remains a significant challenge, with many patients medically ready to leave hospital but unable to do so while awaiting social care assessments or community support arrangements. Powys' large rural geography further adds to these challenges. The county has a dispersed population and relies on a combination of community hospitals, local services, and partnerships with providers in neighbouring areas of Wales and England. While this model provides local access, it also creates challenges in workforce resilience, estate sustainability, and consistency of service provision. Although progress has been made through the joint Health and Care Strategy, the combined impact of COVID-19, inflationary pressures, and rising demand means that existing approaches are no longer sufficient. The Health Board therefore has an opportunity to redesign services, strengthen community-based care, improve quality, and make more effective use of resources. The proposed changes are intended to create a sustainable, integrated model of care that is better able to meet the needs of current and future generations in Powys. **The Strategic Context** These proposals form part of a wider strategic direction for health and care in Powys and support the long-term vision of delivering a healthier, more sustainable and more integrated model of care. They are not standalone service changes but part of a broader shift towards prevention, earlier intervention, stronger community services, and better coordination across health, social care, and the voluntary sector. The proposals align with the Powys Health and Care Strategy and its vision of "A Healthy, Caring Powys", which underpins the Regional Partnership Board Area Plan and the Powys Teaching Health Board Integrated and Annual Plans. They reflect the strategy's core principles of doing what matters, doing what works, focusing on greatest need, offering fair access, working prudently, and building on the strengths of people and communities. The proposed model is founded on several key principles: • Person-centred care, with services designed around individual needs, goals and preferences. • Integrated and multidisciplinary working across primary care, community services, acute hospitals, social care, and the third sector. • Evidence-based practice informed by national guidance, clinical standards, and recognised best practice. • Value-Based healthcare, focused on achieving the best possible outcomes and experiences while making effective use of available resources.

	• Timely access to care, with improved pathways that reduce delays, support recovery, and enhance patient experience. A key strategic consideration is that the case for change extends beyond the configuration of inpatient beds. It presents both risks and opportunities across the wider health and care system. Success therefore depends on strong alignment between organisations and services, ensuring that community, primary, secondary, social care, and voluntary sector provision work together as a coordinated system. The proposals also support the ambitions of the Powys Well-being Plan, which takes a long-term approach to improving the social, economic, and environmental factors that influence health and wellbeing. At a national level, the proposals align with Welsh Government policy, including A Healthier Wales, the Integrated Community Care System for Wales, the Strategic Programme for Primary Care, and the Six Goals for Urgent and Emergency Care. They are also consistent with the Well-being of Future Generations (Wales) Act 2015, promoting prevention, collaboration, integration, long-term sustainability, and improved outcomes for communities. Taken together, this strategic framework supports a move to assess the current service model to determine if it is fit for purpose.
2.3 Assessment: Current Service Provision	Powys Teaching Health Board currently provides a range of community-based inpatient services, including community hospital wards, inpatient rehabilitation units, reablement units, Ready to Go Home units, and mental health inpatient care. Alongside these services, community nursing and specialist teams support people with frailty, long-term conditions, and complex care needs. However, services have developed over time across multiple sites and teams, creating variation in service models, workforce resilience, and access to care. A key challenge is that demand is increasing while the current model is becoming harder to sustain. Powys has an ageing population with growing levels of frailty, multiple long-term conditions, and increasing Continuing Healthcare needs. Although community services have expanded in recent years, they do not yet provide sufficient capacity to consistently prevent hospital admissions or support timely discharge across the county. Current performance data highlights significant pressures. During 2024/25, Powys residents accounted for over 40,000 hospital admissions and more than 161,000 bed days, with most activity taking place in hospitals outside Powys. This dependence on out-of-county services can create challenges for patients and families, including longer travel times, reduced access to support networks, and delays in discharge planning.

	The evidence available indicates that workforce pressures across health services remain significant and are expected to intensify over time. Community inpatient services currently report a vacancy rate of approximately 7.58%, with agency staffing levels in 2025/26 equating to the workforce required to operate around 21 beds. In urgent care services, there are 4.5 vacancies against an establishment of 27.5 whole-time equivalent staff, while sustaining approximately 30 Ready to Go Home beds for individuals who are medically fit for discharge requires a comparatively high inpatient skill mix. Looking ahead, workforce demographics present a further challenge, with around 44% of the projected 2026 workforce aged 51 years or over and the number of staff aged 61 years and above expected to rise substantially by 2031. Taken together, these data highlight the complex interaction between workforce supply, an ageing workforce, rural geography, service configuration, and limitations in community and social care capacity, all of which have a direct impact on the resilience, sustainability, and responsiveness of services. Prolonged hospital stays can negatively affect patient outcomes, particularly for older people. Delayed discharge, deconditioning, loss of independence, and increased risk of hospital-acquired complications are all associated with longer stays. Evidence suggests that a significant proportion of patients occupying beds are clinically ready for discharge but remain in hospital awaiting community support or care arrangements. The Health Board also faces major estate challenges. Many buildings are ageing and require substantial investment, with backlog maintenance estimated at £52.9 million. A dispersed estate creates additional operational costs and limits flexibility in deploying workforce and clinical resources. Without change, demand and capacity modelling indicates that bed requirements could increase by around 37% over the next decade, placing further pressure on quality, safety, and financial sustainability. The proposed changes therefore aim to shift resources towards enhanced community-based care, including rehabilitation, reablement, urgent community response, and support at home. This would reduce reliance on prolonged inpatient stays, improve patient outcomes and enable more care to be delivered closer to home. The expected benefits include a more sustainable workforce model, improved use of beds, reduced deconditioning and delayed discharges, better integration between services and more efficient use of financial and estate resources. A continued focus on inpatient provision also ties up resources that could be used more effectively to support a larger number of people in their own homes and communities. Hospital-based care is resource intensive and can limit the ability to invest in community services, rehabilitation, discharge support, and preventative care. Shifting

	care closer to home, where clinically appropriate, would enable more people to receive timely support, improve patient experience, reduce unnecessary hospital stays, and make better use of finite workforce and financial resources. Together with the unequal distribution of beds across Powys, these pressures raise significant concerns about the model's long-term affordability, resilience, and ability to meet future population needs. **Strategic Risks** The issues identified through this assessment align closely with a number of existing Health Board Strategic Risks. Evidence presented within this assessment has identified workforce fragility, variable service availability, demand and access inequity, diagnostic limitations, cost inefficiencies, and reliance on temporary service changes as factors contributing to these risks. The Physical Health options considered within this assessment have the potential to influence a number of Strategic Risks, both positively and negatively. Particular consideration is given to financial sustainability (SRR001), innovation and strategic change (SRR002), demand for commissioned services (SRR003), demand for provided services (SRR004), primary care sustainability (SRR005), workforce sustainability (SRR006), estate quality (SRR007) and public confidence (SRR012). The extent to which individual options mitigate, increase, or are dependent upon these risks is considered further within the options appraisal. Taken together, the current service position shows a Physical Health model that continues to provide important local access, but which is increasingly under pressure across workforce, diagnostics activity, cost, access and service reliability. Temporary service changes have improved short-term operational stability, but they have not resolved the underlying issues of workforce fragility and variable service availability. The current model should therefore be understood as a risk-bearing position rather than a stable long-term comparator. This provides the foundation for the detailed Case for Change in Section 2.4.
2.4 Assessment: Case for Change	**Evidence Supporting the Case for Change** The evidence demonstrates that the current inpatient and community care model is under pressure across multiple interconnected areas: quality, workforce, patient flow, estate, finance, and growing demand. These challenges cannot be addressed independently. Together, they indicate that the current model is becoming increasingly difficult to sustain and is limiting the Health Board's ability to invest in modern, community-based alternatives. **Needs of a Changing Population**

	Here is a more strengths-based narrative that focuses on the changing needs of the Powys population and how the enhanced community model is designed to respond to those needs. **Population Need and Equality Impact Narrative** Powys has a distinctive population profile that is increasingly shaped by an ageing population, higher levels of long-term conditions, rising frailty, disability, and caring responsibilities, and the challenges associated with delivering services across a large rural county. The Powys Population Needs Assessment highlights that people increasingly require proactive, coordinated support that helps them maintain independence, manage health conditions effectively, and access services closer to home. With around 28% of residents aged 65 and over, compared with 21% across Wales, Powys has one of the oldest populations in the country. This demographic trend is expected to continue, increasing demand for services that support people to remain well, avoid unnecessary hospital admissions, and maintain independence within their own communities. The proposed model has been developed in response to these changing needs, placing greater emphasis on prevention, early intervention, rehabilitation, Hospital at Home, integrated physical and mental health care, and multidisciplinary community support. This approach will enable significantly more people to receive care closer to home, reducing the need for hospital attendance and improving access to support for most of the population. For people with disabilities, the enhanced community model represents an important opportunity to improve accessibility and personalise care. Delivering more services within homes and local communities reduces the need for travel and enables support to be provided in familiar environments that promote independence, wellbeing, and inclusion. The model is supported by improved care coordination, integrated services, and modern inpatient facilities for those who require hospital-based care. The model is also expected to benefit people experiencing socio-economic disadvantage and social exclusion. By expanding locally delivered services, improving community support, and reducing reliance on hospital attendance, the model helps address some of the practical barriers associated with rurality, transport limitations, financial pressures, and social isolation. Earlier intervention and stronger links between health, social care, and community services will improve access to support and help reduce inequalities across Powys. Unpaid carers, who play a critical role in supporting health and wellbeing across the county, are expected to benefit from a greater range of community-based services that reduce avoidable hospital admissions, support earlier

	discharge, and enable people to remain independent at home for longer. Enhanced community services will help carers remain involved in care, improve care coordination, and reduce disruption to family life. While the impact of service changes may be felt differently across local communities, particularly where traditional patterns of service use change, the overall model is designed to benefit a much larger proportion of the population through increased access to responsive, person-centred support closer to home. Overall, the assessment demonstrates that the proposed model aligns closely with the current and future needs of the Powys population. By strengthening community services, supporting independence, improving integration, and delivering more care within local communities, the model provides a positive response to the demographic, health, and wellbeing challenges facing Powys, and creates opportunities to improve outcomes for residents across the county. **Quality and Patient Outcomes** The Health Board's ambition is to support more people to receive care at home or closer to home wherever it is safe and clinically appropriate. This includes providing earlier intervention to prevent avoidable admissions, increasing access to rehabilitation and reablement at home, supporting more people with complex needs through community-based services, and enabling more people to receive end of life care in their preferred place of care. Evidence suggests that people often achieve better outcomes when care is delivered at home or in community settings, rather than through unnecessary or prolonged hospital admission. Maintaining independence, staying connected to family and carers, and recovering in familiar surroundings can improve both patient experience and outcomes. Conversely, extended hospital stays can expose patients to avoidable harm, particularly older people and those living with frailty. Continuity of care across both physical and mental health inpatient services remains challenged by workforce shortages and a continued reliance on temporary staffing arrangements. Within community inpatient services, the vacancy rate stands at 7.58%, while agency staffing utilisation during 2025/26 is reported to be equivalent to the

	workforce required to support approximately 21 beds. Mental health services are also experiencing ongoing workforce pressures, alongside rising levels of patient acuity and continued dependence on temporary staff. Collectively, these factors place additional strain on service resilience, can reduce continuity and consistency of care, and make it more difficult to sustain safe, therapeutic, and high-quality care environments for patients and staff. An independent review undertaken in August 2025 reinforced the case for change. The review concluded that reducing unnecessary admissions and prolonged hospital stays should be a priority, not simply to improve efficiency but to reduce avoidable harm and improve patient outcomes. It highlighted the need for greater investment in prevention, urgent community response, rehabilitation, reablement, virtual wards, and integrated community services that help people remain safely at home wherever possible. The review also identified opportunities to improve the experience of Powys residents receiving care outside the county. By strengthening community services and making better use of available capacity, more people could be supported to recover, rehabilitate, or receive end of life care closer to their families and communities. This is particularly relevant given that, in 2025/26, 563 Powys residents died in hospitals outside the county. Taken together, the evidence suggests that the greatest quality improvement opportunity lies in shifting care upstream through prevention, early intervention, rehabilitation, and end of life care closer to home, while reducing the harms associated with unnecessary admission and prolonged hospital stay. **Workforce Sustainability** Community inpatient services continue to face workforce challenges, with vacancies and a significant dependency on temporary staffing remaining evident across the service. Current data shows a vacancy rate of approximately 7.58%, while agency staffing usage in 2025/26 is reported to be equivalent to the workforce required to support around 21 beds. A range of measures has been implemented to strengthen workforce capacity, including overseas recruitment initiatives and locally developed workforce pipelines such as the PTHB Aspiring Nurse Programme. Although these actions have contributed to greater workforce stability, the overall position remains vulnerable and highlights the need for a more sustainable long-term staffing model. The evidence therefore suggests that workforce supply continues to be a key factor affecting both the resilience and financial sustainability of the current service configuration.

	While there are signs that workforce pressures have become more manageable, there is limited evidence of a fundamental improvement in overall workforce capacity. Service delivery remains reliant on temporary staffing arrangements, which can affect continuity of care, increase operational costs, and restrict opportunities to expand advanced clinical roles and community-based services. In addition, the maintenance of several smaller inpatient units spreads limited staffing resources across multiple sites, creating further challenges for recruitment, retention, and workforce resilience. Taken as a whole, the available evidence points to a workforce operating under ongoing and increasing pressure. Community inpatient services are currently experiencing a vacancy rate of approximately 7.58%, with agency staffing levels equivalent to the workforce needed to support around 21 beds in 2025/26. Within urgent care services, there are 4.5 vacancies against an establishment of 27.5 whole-time equivalent staff, while maintaining approximately 30 Ready to Go Home beds for patients who are medically fit for discharge, which requires a relatively high inpatient skill mix. Workforce demographics present an additional challenge, with around 44% of the projected 2026 workforce aged 51 years or over, and the proportion of staff aged 61 years and above expected to increase significantly by 2031. Collectively, these factors demonstrate how workforce availability, an ageing workforce profile, rural geography, current service configuration, and limitations within community and social care capacity interact to influence the resilience and sustainability of services. **Bed Utilisation and Patient Flow** Occupancy levels are generally high, averaging around 90%, but bed use is not always aligned to patient need. Regular monitoring census identified that there were 28 patients occupying beds despite having no ongoing therapy or nursing requirement, while other patients requiring rehabilitation or step-down care were waiting for appropriate services. For patients, this has the impact of increasing the risk of hospital acquired harm such as infection or deconditioning, which could otherwise be prevented. This demonstrates that the issue is not simply the number of beds available, but how they are being used. The current configuration often results in patients receiving care in settings that are no longer clinically necessary because community-based alternatives are insufficiently developed.

	Internal modelling suggests that redesigning pathways and reducing delays could reduce average length of stay by 25-30%, equivalent to approximately 10-12 fewer bed days per patient. This would significantly improve capacity without increasing bed numbers. **Financial and Estate Pressures** The current model is also financially inefficient. Evidence from national reviews and local analysis shows that larger wards operate at a lower cost per bed than multiple small units. For example, a consolidated 28-30 bed ward can reduce operating costs per bed by between 16% and 21% compared with smaller standalone wards. In addition, maintaining a dispersed network of inpatient sites creates duplication in staffing, facilities, catering, support services, and estate costs. The Health Board's estate backlog maintenance exceeds £73 million, with the oldest estate profile in NHS Wales. Many buildings have significant compliance, infrastructure, and maintenance challenges, while some sites have clinical limitations that restrict the level of care that can be safely delivered. **Independent Clinical Review** An independent review concluded that the current level of investment in inpatient beds is limiting the development of preventative, community-based services. The review identified opportunities to improve outcomes through shorter hospital stays, stronger intermediate care, urgent community response services, rehabilitation at home, and a more integrated model linking physical health, mental health, and social care. The review also highlighted the opportunity to repatriate more Powys residents currently receiving lengthy care outside the county, improving both patient experience and system flow. **Conclusion** The evidence consistently points to the same conclusion. The current model is not sustainable because it combines: • Long hospital stays and delayed discharge. • Workforce shortages and reliance on temporary staff. • Inefficient use of beds. • Rising demand from an ageing population. • Significant estate and infrastructure challenges.

- Financial inefficiencies associated with multiple small inpatient units.

The proposed service model addresses these issues directly by creating a smaller, more sustainable inpatient bed base supported by stronger community services, rapid response teams, rehabilitation, Hospital at Home, discharge-to-assess pathways, and integrated multidisciplinary care.

This would enable more people to receive care closer to home, reduce avoidable admissions and prolonged hospital stays, improve workforce resilience, make better use of resources, and deliver better outcomes for patients.

In summary, the case for change is not based on reducing beds alone. It is about moving from a model that increasingly manages demand in hospital settings to one that prevents avoidable admissions, promotes recovery, and provides care in the most appropriate place. Without this shift, rising demand, workforce shortages, and estate pressures will continue to increase risks to quality, safety, and sustainability.

Physical Health including Community Model Option Summary:

The summary below brings together the key appraisal information for the Physical Health including Community Model options, showing how each option compares across service footprint, bed numbers, workforce requirements, financial impact, non-financial appraisal score, ward staffing cost, and estate feasibility. Below provides some of the considerations and elements that led to deselection of these options to progress:

Option	Option description	Reason for deselection
001a	Do previous – the model of services as they appeared before the interim closures of day hospitals, smaller community services, and implementation of ready to go home units.	This option was discounted as it would fail to provide any enhanced benefit in community services and bringing the level of care closer to home that is required to make the maximum difference.
001b	Do current – the model of services as they are at the current time with existing community services and the ready to go home units.	This option was discounted as it would fail to provide the opportunity to enhance enough of the community services to provide increased community care and bring more care closer to home that is required to make the maximum difference.
002	Do minimum – the model would have a smaller enhanced community service supported by a slight reduction of 144 beds	This option was discounted as it would fail to provide any enhanced benefit in community services and

	and a small reduction in the number of inpatient wards.	bringing the level of care closer to home, which is required to make the maximum difference.
005b	Do mid range – the model would have a larger enhanced community service supported by a medium reduction in beds numbers to a bed base of approximately 90 beds.	This option was retained as it has a strong opportunity of providing an enhanced benefit in community services and bringing the level of care closer to home by redirecting staffing and resources away from an inpatient model to a community model.
008	Do maximum – the model would have a larger enhanced community service supported by a maximum reduction in beds to a bed base up to Approximately 60 beds.	This option was retained as it has the maximum opportunity of providing an enhanced benefit in community services and bringing the level of care closer to home by redirecting staffing and resources away from an inpatient model to a community model.

2.5 Assessment: Options Appraisal

The recommended Physical Health options 005b and 008 were identified through an integrated appraisal of financial sustainability, workforce viability, estate condition, and access impacts. They represent a move away from the current fragmented and financially fragile inpatient model towards fewer, more sustainable inpatient sites, supported by stronger community-based services. This section brings together the assessment of the recommended options only, summarising the key implications to support a comprehensive Level 2 assessment.

These options aim to provide safe, high quality, person centred, digitally enabled, proactive, and integrated care within fit-for-purpose community settings. They are designed to better support people with complex physical and mental healthcare needs:

- Effectively manage patients with complex physical and mental healthcare needs.
- Prevent patient harm and deconditioning.
- Support recovery through rehabilitation.
- Reduce unnecessary acute hospital admissions and stays.
- Facilitate timely discharge and effective transitions of care.
- Reduce avoidable readmissions.

Physical Health Scope – What could change on each PTHB site

To provide high quality, person centred, digitally enabled and proactive care within a community setting, that supports people to stay well at home, promotes recovery and reablement closer to home, reduces unnecessary hospital admissions and facilitates timely discharge, promoting quality of life, independence and dignity at end of life, and delivering holistic care including physical, mental and social health.

PTHB Provider Services only

Physical Health Options (PH = physical health; MH = mental health)	Welshpool	Newtown	Llanidloes	Machynlleth	Llandrindod	Builth	Knighton	Bronllys	Brecon	Ystradgynlais	General Practice	Community / Home	Digital Offer
001a: Do Previous (before any temporary service changes)													
001b: Do Current (continue as now, making temporary service changes permanent)													
005b: Do mid range: (fewer beds, on 3 sites) + better PH community + MH join up	X			X						X			
008: Do maximum: (fewer beds, on 2 sites) + better PH community + MH join up	X			X						X			

Key	
No change	Some or all beds removed
Temporary changes are reversed	Bed numbers increased
Temporary changes become permanent	More support in the community
More join up between physical health and mental health	

Key
X-ray closes = X
X ray stays & longer opening hours =
DEXA created = DEXA

The recommended options should be considered alongside the development of the Integrated Community Services Model. The future model of care assumes a significant expansion of proactive prevention, intermediate care, urgent community response, rehabilitation, Hospital at Home, and integrated multidisciplinary working. These services become the primary mechanism through which the Health Board intends to support people to remain independent and receive care closer to home.

The primary case for change is the development of a sustainable community-focused Intermediate Care model capable of meeting future population needs. Changes to inpatient provision are proposed because the current balance of investment between hospital and community services does not adequately support people to remain independent or receive care in the least restrictive and most appropriate setting.

Proposed Intermediate Care Model of Enhanced Community Care

The Intermediate Care community-based multi-disciplinary team (MDT) will deliver:

- Urgent community response.

- Rapid in-home clinical assessments and interventions, which include a Hospital at Home function (enabling hospital-level care at home) that is clinically appropriate for Powys. This may include remote monitoring of Blood Pressure, oxygen saturation, blood glucose, etc.).
- Rehabilitation and reablement.
- Community-based palliative and end-of-life care.

The service will operate within the community to prevent unnecessary and/or unwanted hospital admissions, in line with personal preference, and facilitate timely discharge from acute settings back to the individual's usual residence or, where that is not possible, another appropriate setting in Powys.

Operating from 08:00-20:00, 7-days a week, Intermediate Care will offer assessment, support, rehab, or recovery interventions for a time-limited period through a whole team approach and applying holistic goal setting combined with seamless, coordinated care across health, social care, and third-sector organisations.

Intensive support at home will be available 7 days a week from a team that has the skills to manage a level of complexity and risk with appropriate clinical oversight. The MDT will have a range of skills from support worker through to consultant medical and consultant practitioner posts, to support the intensity and complexity of the individual. Team capacity will be managed by acuity tools such as Welsh levels of care.

Clinical Scope

Conditions supported will include:
- Falls without major injury.
- Acute illness such as infections or sudden decline of uncertain cause.
- Delirium.
- Declining Mental health as a component of the presenting physical health issues.
- End of Life care which requires support beyond that of the practice MDT.
- Exacerbation of long-term conditions or management of poor symptom control (e.g. frailty, heart failure, COPD).

Acceptance criteria:
- Adults in the community (18+ years).
- Individuals experiencing a period of short-term decline in function.
- Individuals who may be at risk of hospitalisation.
- Individuals adjusting to a new disability following trauma/diagnosis – Stroke, Frailty, COPD, CHF, palliative stage patients.

- Individuals who require end of life care support.
- Individuals who require intensive, time-limited, multiagency / multiprofessional support, with clear outcomes identified.

New Service Enhancements

Urgent Community Response (UCR)

A 2-hour response to urgent care needs within the hours of 08:00-20:00 (aligned with NHS UCR standards). This includes Triage, assessment, intervention, and provision of support to enable the individual to stay at home. Where triage identifies that the situation isn't manageable within service hours, the person may be stepped up into a community hospital bed or referred to emergency care, whichever is most appropriate. During this acute period the team will assess next steps, enabling the individual to recover from the trauma or crisis. After 72 hours the team will initiate next steps, e.g. rehab, palliation, or step up. This would also include the Level 2 Falls response.

To deliver a Hospital at Home function will require input from ACP/medical staff with advanced clinical assessment/clinical decision maker skills.

Digital monitoring and telemedicine will be used to support remote assessment and decision support as well as access to point of care tests.

End-of-Life Care at Home

Rapid deployment and coordination of a range of resources to support end-of-life care in the community.

The District Nursing Service will lead on care planning for individuals.

- Shared Future Care Plans visible across services.
- Access to anticipatory medications at home.
- Rapid hospice-at-home or nursing input.
- Integrated support for carers, including overnight support.
- Close collaboration with spiritual, psychological, and voluntary support services.
- Alignment with Gold Standards Framework, National End of Life Care Delivery Plan (Wales).

	Collaborative work with the specialist palliative care nurse team, hospices, and third-sector palliative care organisations, as needed, and with support for carers, including respite and transport options. The model of care will initially align with district nursing service delivery of 08:00-20:00. Deliver 24-hour end-of-life on call nursing support to people in their homes delivered between 20:00-08:00, a dedicated telephone line for health professionals to access advice and support 24 hours. Out of hours medical cover will be available to support the out of hours District Nursing led service. <u>Discharge to Recover then Assess (D2RA)</u> The discharge coordination model embedded in District General Hospitals (e.g. Bronglais, Swansea, Shrewsbury) through the current Care Transfer Coordinators will be enhanced to have a stronger presence in Emergency Departments / Acute Medical Units / Medical Assessment / Frailty Units, to support rapid return of patients to Powys. The approach will be based on: • A 'pull' post-acute pathway and Trusted Assessors enabling swift, criteria-led discharge home or into a supported community setting. • Home first ethos – Assessment conducted at home, not in hospital. • Where possible, direct return home will be facilitated by early activation of community Rehabilitation & Reablement. • Post-discharge review within 48 hours. <u>Rehabilitation & Reablement at Home</u> Time-limited (up to 6 weeks) and goal-oriented interventions, focusing on maximising independence and functional recovery. This is delivered by integrated multi-professional, multi-agency teams who support at home as an alternative to admission or following discharge from hospital. <u>Access to Intermediate Care Beds</u> The Intermediate Care service will have access to beds in a community facility to enable selected individuals to avoid transfer to an acute hospital or to recover from an acute episode if this cannot be supported at home. The team will in reach to this facility to facilitate continuity of care and timely return home, applying planned date of discharge and aiming for home within 72 hours.

Single Point of Access (SPOA)

There will be a centralised 08:00-20:00 SPOA for management and triage of referrals from professionals to stream-line access to urgent response and intermediate care as well as to wider community support.

Multidisciplinary Approach to Care

The Multidisciplinary Team (MDT) function for the Intermediate Care Service will include:

- Daily board rounds and twice-daily virtual huddles.
- Weekly MDT meetings for proactive care planning.
- Clinical leadership – through Medical Model/ACP or consultant roles.
- Virtual clinical reviews by primary care, community, and specialist teams as required.
- Joint assessments with specialist teams, e.g. Dementia Home Treatment Team.
- Time limited in-reach into care homes for selected residents.

Core Service Offer

The Core Intermediate Care workforce includes:

- An identified Clinical Lead (which could be a medic or consultant nurse/therapist for each team).
- Nursing.
- GP or Consultant.
- Therapists (OT/PT).
- Rehab HCSW and Nursing HCSW.
- Advanced Clinical Practitioners or Enhanced Nurse Practitioners – ability to prescribe, refer for diagnostics, administer IVs. Capable of advanced clinical decision making and risk management. These may be Therapy/Nurse consultants (the ACP may come from a clinical background of Therapies, Paramedic, or Nursing).
- Mental Health Older Adult Liaison.
- Pharmacists.
- Third-sector support staff and local community assets.
- Social workers.
- Admin/schedulers for rotas, etc.

Specialist services that the Intermediate Care MDT will engage with:

- GPs.
- Practice based / locality Proactive Prevention service.

- Respiratory Practitioners (not physiology).
- District Nursing.
- Community Therapies – e.g. falls/frailty.
- Tissue Viability Nurses.
- Neuro services (including Parkinsons Nurse Practitioner).
- Dietetics.
- Speech and Language Therapists.
- Dementia Home Treatment Team.
- Cardiac practitioners (not cardiac physiology).
- Palliative care specialist nurses.
- Continence.
- Social workers.
- Sensory impairment workers.
- Lymphoedema.
- Diabetes.
- Podiatry.
- Complex Care nurses.
- Equipment store.
- Telecare.

The Intermediate Care MDT will work closely with organic Mental Health services in Powys. This will include:

- Joint working with Community Mental Health Teams for Older Adults (CMHT-OA) and Adult Community Mental Health teams.
- Shared assessments and care plans.
- Joint MDTs for complex cases (dementia, delirium, those individuals identified with declining mental health).
- Crisis support and carer support in-home to prevent admission.
- Dementia-friendly intermediate care and step-up beds.
- Evidence Base: NICE NG97 (Dementia), Welsh Government's "Together for Mental Health" strategy.

Collaboration with third-sector partners e.g.:

- Carer support.
- Community transport.
- Social and emotional wellbeing services.
- Social prescribing to support long term management.

Collaboration with Social Care Teams:

- Coordinate care plans for the long term.
- Ensure social support is in place.
- Advocates, helping people access benefits, housing, and community resources.
- Supporting families and carers.

Operating Hours

The service will operate from 08:00-20:00, 7-days a week.

Out of Hours

Delivery of an overnight on–call nursing service 20:00-08:00 to respond to urgent and end-of-life care. There will be 2 teams positioned North and South of PTHB (to be confirmed).

Quicker Access to Equipment

This service will need same day/next day access to community equipment, 7 days a week.

Digital Support

- Shared electronic health records (EHRs).
- Real-time dashboards & alerting systems.
- Clinical documentation & remote assessment.
- Digital remote dashboards for monitoring.

System Enablers

Enabler	Description
Workforce Integration	Cross-trained staff, rotational posts, joint governance, Trusted Assessor model.
Digital Infrastructure	Shared records, referral platforms, remote monitoring/technology enabled care.

Community Assets and Third/Voluntary Sector	Local third-sector groups embedded in care model.
Training and Development	Frailty, dementia, palliative care training for all staff.
Quality and Outcomes Dashboard	Real-time tracking of key indicators (e.g. avoidable admissions, response times, satisfaction).

Governance and Evaluation

- Quality and safety monitoring via the integrated patient electronic record, caseload review and measurement of quality indicators as used currently by community services.
- Strategic oversight via PTHB and Powys RPB (ICCS structure).
- Locality-based MDT leadership groups.
- Co-production with citizens and carers.
- Continuous Improvement Cycles using PDSA methodology.
- Annual outcomes review and benchmarking.

Anticipated Outcomes

Outcome	Measure
Reduced emergency admissions	≥15% over 3 years
Increased care at home at EoL	>75% die in preferred place
Reduced long-term care admissions	≥10% reduction
Improved patient/carer experience	≥90% satisfaction
Reduced falls with harm	≥20% reduction
Future Care Plan completion	100% for top 0.5%
Healthy Days at Home	Increase YoY

Strategic Risk Assessment

Ref	Strategic Risk	Transition	Established Model	Comments

	SRR001	Financial Sustainability	Increase	Slight Increase	Supports long-term service sustainability through consolidation, better workforce deployment and more efficient estate use.
	SRR002	Innovation & Strategic Change	Increase	Neutral	Successful delivery is dependent on implementation of a major service transformation programme.
	SRR003	Demand for Commissioned Services	Neutral	Mitigation	Supports community care activity being managed within Powys and reduces reliance on commissioned services where clinically appropriate.
	SRR004	Demand for Provided Services	Mitigation	Mitigation	Strengthening and expanding community-based models of care, enables more people to receive timely, safe and effective support closer to home
	SRR005	Primary Care Sustainability	Slight Mitigation	Mitigation	Promotes more effective and coordinated care through closer integration of physical health, mental health, primary care and community services.
	SRR006	Workforce Sustainability	Increase	Mitigation	Requires workforce transition during implementation but improves resilience, recruitment, retention and roster sustainability once established.

SRR007	Estate Quality and Infrastructure	Increase	Slight Increase	Requires estate reconfiguration to use inpatient and related services more efficiently, supporting clinical sustainability, patient flow and workforce deployment, with dependency on capital investment where adaptation is needed.
SRR012	Public Confidence	Increase	Mitigation	Service changes may increase public concern during implementation, but improved service quality and sustainability are expected to strengthen confidence over time.

Key Challenge to Service Improvement

The case for change is therefore focussed on radically enhancing community services with a fully integrated intermediate care model available to every community in Powys.

To meet complex health care needs of the growing older age population will necessitate a coordinated switch from a bed-based model of care to a service focussed on prevention, enablement, and care closer to home and in the home. It is not simply about reducing inpatient beds, but about creating a safer, more sustainable, and better coordinated model of care.

The challenge of providing the best model of care to meet the needs of patients and the wider community is getting the balance of provision right within the finite resources available to the Health Board such as:

- Staffing.
- Access to highly skilled staff.
- Environments to sustain training and professional standards.
- Appropriate estate.
- Financial resources.

This inevitably requires a wider assessment of the way both the community and inpatient models currently operate.

The aim of Community Inpatient Services is to deliver safe, high-quality, person-centred care within fit for purpose community inpatient settings that:

- Aim to prevent and address deconditioning and patient harm.
- Support recovery, reablement, and independence.
- Reduce unnecessary acute hospital stays.
- Facilitate timely discharge and effective transitions of care.
- Provide dignified palliative and end-of-life care, focusing on those with more complex needs.
- Reduce avoidable readmissions.

SL IPDO_005b (Do Mid Range): The total number of hospital beds in Powys will reduce to approximately 90, across fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.



- There would be more support to help people stay and recover at home with focus on proactive prevention, early intervention, intermediate care, and urgent community response service operating 08:00-20:00, 7 days a week, incorporating a clinically appropriate Hospital at Home model for Powys. There would also be closer working between physical and mental health services to support people at home.
- Hospital inpatient beds would be at the three sites of Newtown, Llandrindod, and Brecon only, and these would potentially have Urgent Care on the same three sites (depending on the outcome of the Urgent Care options).
- Llandrindod would have a centralised adult functional and older adult organic inpatient care.
- Inpatient rehabilitation would be at Brynheulog Ward (Newtown) and Epynt Ward (Brecon) for patients with significant functional impairments resulting from acute neurological, orthopaedic, or multi-system injuries and illnesses.
- Step-up, step-down, and inpatient palliative and end of life care would also be provided at Newtown, Llandrindod and Brecon.
- There would be no hospital beds at Welshpool, Llanidloes, Machynlleth, and Knighton, and no physical health hospital beds at Bronllys and Ystradgynlais.
- Reablement beds would be provided elsewhere, such as care homes.

	• There would be a single point of access for clinicians, developed in a phased approach, for all services triaged 24/7.
	• Diagnostic provision:
	  ○ Newtown, Llandrindod, and Brecon would have x-ray services, with increased opening hours to 09:00-18:00, 7 days a week.
	  ○ X-ray services at Machynlleth, Welshpool, and Ystradgynlais would close permanently.
	  ○ Point of Care Testing and blood testing facilities would be available based on the clinical model at each site.
	  ○ DEXA scanning would be introduced for the diagnosis of frailty fractures at 1 site, Llandrindod.
	• Timescales to deliver – 3-5 years (subject to capital investment and investment in community team provision).
	
	Success of this option is dependent upon full implementation of the Integrated Community Services Model, including Proactive Prevention, Intermediate Care, Urgent Community Response, Hospital at Home, rehabilitation, and community-based multidisciplinary teams.
	
	What stays the same
	
	Under Option SL IPDO_005b, several core principles of service delivery remain unchanged, providing continuity in key aspects of care while enabling targeted transformation in others. The option continues to support the delivery of safe inpatient and community-based services within the locality, retaining a model in which care is provided across a combination of hospital and out-of-hospital settings.
	
	It also maintains the strategic emphasis on delivering care as close to home as possible, with inpatient care reserved for those patients whose needs cannot be met safely through alternative pathways. These areas of continuity are important in ensuring that the option builds on existing strengths within the current model, rather than replacing them unnecessarily.
	
	• Physical Health inpatient services continue to be provided within Powys, retaining a local inpatient bed base.
	• Inpatient rehabilitation continues at Newtown (Brynheulog) and Brecon (Epynt).
	• Step-up, step-down, palliative, and end-of-life care remain available within community hospital settings.
	• Reablement continues, although delivered through alternative non-hospital settings such as care homes.

- Community health services, primary care and third-sector partnerships remain integral to the care model.

What changes

The central logic of Option SL IPDO_005b is to create a more sustainable and clinically resilient model through the consolidation of inpatient capacity, greater co-location of services, and a clearer emphasis on prevention, rehabilitation, and admission avoidance. In practice, this means a reduction in fragmentation across sites and a reshaping of bed-based provision, most notably through the concentration of activity where services can be supported more effectively by staffing, diagnostics, and multidisciplinary input. The option is therefore not simply a reduction in beds or estate, but a broader redesign of the service model intended to improve quality, support more effective pathway management, and align provision more closely with future demand and national policy direction.

- Reduction in overall inpatient bed numbers and consolidation onto three sites: Newtown, Llandrindod and Brecon.
- Closure of Physical Health inpatient beds at Welshpool, Llanidloes, Machynlleth, Knighton, Bronllys, and Ystradgynlais.
- Development of a centralised adult functional and older adult organic inpatient care at a site in Bronllys / Brecon area and a unit at Llandrindod for people with dementia and related conditions.
- Diagnostics (including x-ray) concentrated on three sites, with extended opening hours.
- Expansion of community-based services, including intermediate care, urgent community response, and Hospital at Home models.
- Bed numbers change from the current 140-170 (depending on demand) across 9 inpatient wards, to approximately 90 beds across 3 inpatient wards.

Benefits

The overall benefit of Option SL IPDO_005b lies in its ability to deliver a more clinically sustainable, integrated, and future-facing model of care than the current baseline. The option performs strongly within the non-financial appraisal because it brings together several mutually reinforcing advantages: improved quality and safety through co-location, more resilient staffing arrangements, reduced dependence on agency resource, and stronger alignment with national policy and the Case for Change.

By shifting the centre of gravity of the model towards prevention, rehabilitation, and admission avoidance, the option also supports a more appropriate use of inpatient care and a service model that is better able to respond to

	changing population need. Taken together, these changes are expected to improve patient outcomes and experience, while also supporting greater operational and financial sustainability over the medium to longer term. • Strongest performance in the non-financial appraisal. • Improved quality and safety through co-location and more sustainable staffing. • Reduced reliance on agency staffing. • Better alignment with national policy and the Case for Change through prevention, rehabilitation, and admission avoidance. • Financial and operational sustainability improved compared with current arrangements. **Finance** From a financial perspective, Option SL IPDO_005b is intended to improve the longer-term sustainability of the service model in comparison with current arrangements. The overall financial logic of the option is that a more consolidated model, supported by better workforce deployment and more efficient use of estate, should reduce avoidable inefficiencies and place the service on a more sustainable footing over time. However, this position is dependent in part on the ability to implement the proposed model as intended, including any capital investment required to enable estate changes. As such, while the option offers improved financial and operational sustainability when compared with the baseline, this benefit is linked to deliverability and should be considered alongside the associated implementation risks. • The option delivers a net recurrent saving compared with the baseline, driven by fewer inpatient wards, reduced workforce duplication, and lower support service costs. • Financial sustainability is dependent on successful delivery of community substitution and reduced length of stay. • Capital investment is required to expand and adapt inpatient capacity at retained sites and to confirm the future use of sites where beds would close. • Overall affordability is judged to be achievable with monitoring and all elements of the model in place **Workforce** Workforce sustainability is a key driver of Option SL IPDO_005b, and the option's design reflects the need to make better use of available staffing resource across the locality. By concentrating inpatient activity within a more coherent service model, the option supports more resilient rotas, improved multidisciplinary working, and more effective alignment between staffing levels and patient acuity. This is expected to strengthen continuity of care,

	improve staff experience, and reduce reliance on temporary and agency staffing, particularly in areas where recruitment has been difficult. In this sense, the workforce case for the option is not only about efficiency, but also about creating a safer and more sustainable staffing model capable of supporting consistent service delivery over time. • Improved workforce resilience through consolidation onto fewer sites, reducing lone working and reliance on temporary staffing. • Better opportunities for staff development, supervision, and recruitment through larger multi-disciplinary teams. • Workforce transition required, including redeployment into community roles and potential changes to skill mix. • Reduced vacancy pressure compared with the current highly dispersed model. **Estates** The estates implications of Option SL IPDO_005b are integral to its overall delivery logic, as the proposed service model relies on a closer alignment between physical infrastructure and future patterns of care. The option assumes a more rationalised use of estate, with inpatient and associated services configured in a way that better supports clinical sustainability, patient flow, and workforce deployment. However, this also creates a degree of dependency on capital investment, particularly where estate adaptation or reconfiguration is required to enable bed consolidation and service co-location. This is especially relevant in relation to Newtown, where the largest level of bed consolidation is proposed, and Brecon, where full Business Case visibility remains limited. Accordingly, estate requirements should be understood not simply as a background enabler, but as a significant factor in the overall deliverability of the option. • More effective use of the three Rural Regional Centres (RRC), including sites with better ventilation and piped oxygen systems. • Reduced estate footprint for inpatient care, lowering ongoing maintenance and compliance risk. • Capital works required at retained sites to accommodate increased bed numbers and integrated models of care. • Sites losing inpatient beds would require decisions on future use, disposal, or repurposing. Llandrindod Wells Hospital has Welsh Government ring-fenced funding to provide fit for purpose patient beds, with the timeline to submit business case 2027.

	Newtown Phase 2 for the new RRC is known to Welsh Government but does not currently have funding allocated with likely 3-5 year timeline, if funding is available/approved. Brecon does not currently have any business case visibility with Welsh Government and whilst a refurbishment is possible in the short term, major investment is likely to be in the 5+ year timeline. All elements are feasible subject to clarity of Brief and funding/affordability. **Travel time and access** Option SL IPDO_005b involves a degree of service concentration on fewer sites and, as a result, is associated with increased travel times for some patients, carers and visitors. This has been identified in the impact assessment as an impact across a wider range of key groups. The overall logic of the option is that these access impacts are partially offset by a reduction in the need for hospital-based care, through fewer admissions, shorter lengths of stay, and a greater emphasis on care delivered at home or closer to home wherever clinically appropriate. Public transport access is route-dependent, often connection-dependent, and may not support same-day discharge, visiting, carer responsibilities or staff travel. The impact is therefore likely to be greatest for people without access to a car, older people, carers, rural communities and communities where local hospital provision is experienced as a core community asset. The option has important equity implications, particularly for those without access to private transport, older people, and carers making frequent or repeat visits, for whom extended travel times and more complex journeys may present a greater burden. Diagnostic access is also reduced to fewer sites, although this is expected to be mitigated in part through longer opening hours. The Equality Impact Assessment should therefore be read alongside this section, as it provides the fuller assessment of the distributional and equality impacts associated with these changes. • Increased travel times for some patients and visitors due to bed concentration on fewer sites. • Access impacts are partially mitigated by fewer admissions, shorter lengths of stay and more care delivered at home. • Diagnostic access is reduced to fewer sites but offset by longer opening hours. • Impact assessment has identified that travel is a key challenge for people with disabilities, unpaid carers, socially excluded or isolated. The principal risks associated with Option SL IPDO_005b relate to deliverability, dependency and transition. In particular, successful implementation is dependent on community services being sufficiently developed before any

reduction in bed-based provision takes place, capital investment being secured to enable the required estate changes, and a clear and managed transition plan being in place for both patients and staff affected by service reconfiguration. These risks are material because they affect not only the timing of implementation, but also whether the option can be delivered safely and sustainably in practice.

It is therefore important that the option is supported by clear readiness criteria, implementation safeguards, contingency arrangements and transitional planning. This should include evidence that the required community capacity, intermediate care, urgent community response, Hospital at Home and discharge pathways are in place and operating safely; confirmation that workforce transition and redeployment plans are sufficiently developed; and assurance that the necessary estate and capital requirements are deliverable within the proposed timescales. If these conditions are not met, implementation would need to be paused, phased differently, or supported by contingency arrangements to maintain safe inpatient capacity while the wider model is strengthened.

- Risk that community capacity is not fully established before inpatient capacity is reduced.
- Transition risk for patients, staff and partners during implementation. A detailed transition plan would be required before any inpatient beds close or move. This should set out how patients currently occupying beds at affected sites would be reviewed and supported, including individual care planning, discharge arrangements, family and carer considerations, and any safe transfer requirements. A workforce transition plan would also be required for staff affected by service reconfiguration, including early engagement, individual conversations, redeployment opportunities, support to move into retained inpatient or enhanced community roles, and access to training and development where role expectations or skill mix requirements change.
- Public, political and reputational concerns regarding loss of local inpatient provision.
- Capital affordability and delivery timescales may affect pace of implementation.
- Whilst there maybe benefits experienced by a broader population due to wider access to enhanced community services and care at home there will be a smaller number if individuals who will be directly and potentially significantly impacted by inpatient services being relocated further away. Mitigating the risk and harm experienced by those individuals who maybe most effected is a key consideration in the development of this model.

Trade-offs

The central trade-off within Option SL IPDO_005b is that the anticipated gains in clinical sustainability, workforce resilience and service quality are achieved through a more concentrated model of provision, which may lead to increased travel for some patients, carers and visitors. This is an inherent feature of the option rather than a secondary consequence, and it should be clearly acknowledged as part of the overall balance of advantage and

disadvantage. While these access impacts can be mitigated to an extent through shorter lengths of stay, fewer admissions and more care delivered closer to home, they remain an important consideration in the overall assessment of the option.

- Reduced geographical access to inpatient beds in exchange for improved sustainability and quality.
- Increased travel for some balanced by fewer hospital stays and more home-based care.
- Requires significant system change and workforce transition to realise benefits.

SL IPDO_008: Do maximum: There would be fewer hospital beds (Approximately 60 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.



- Hospital inpatient beds would be at two sites at Newtown and Brecon only, and these would potentially have Urgent Care on the same two sites (depending on the outcome of the Urgent Care options).
- Inpatient rehabilitation would be at Brynheulog Ward (Newtown) and Epynt Ward (Brecon) for patients with significant functional impairments resulting from acute neurological, orthopaedic, or multi-system injuries and illnesses.
- Step-up, step-down, and inpatient palliative and end of life care would also be provided at Newtown and Brecon.
- There would be centralises adult functional and older adult organic inpatient care at a site in Bronllys / Brecon area
- There would be no hospital beds at Welshpool, Llanidloes, Machynlleth, Llandrindod and Knighton, and no physical health hospital beds at Bronllys and Ystradgynlais.
- Reablement beds would be provided elsewhere, such as care homes.
- There would be more support to help people stay and recover at home with focus on proactive prevention, early intervention, intermediate care and urgent community response service operating 8am-8pm, 7 days

a week incorporating a clinically appropriate Hospital at Home model for Powys. There would also be closer working between physical and mental health services to support people at home.
- There would be a single point of access for clinicians, developed in a phased approach, for all services triaged 24/7.
- Diagnostic provision:

    - Newtown, Llandrindod and Brecon would have x-ray services, with increased opening hours to 8am-8pm, 7 days a week.
    - X-ray services at Machynlleth, Welshpool and Ystradgynlais would close permanently.
    - Point of Care Testing and blood testing facilities would be available based on the clinical model at each site.
    - DEXA scanning would be introduced for the diagnosis of frailty fractures at 1 site, Llandrindod.

- Timescales to deliver –– 3-5/5+ years (subject to capital investment and investment in community team provision).

Success of this option is dependent upon full implementation of the Integrated Community Services Model, including Proactive Prevention, Intermediate Care, Urgent Community Response, Hospital at Home, rehabilitation and community-based multidisciplinary teams.

What stays the same

Under Option SL IPDO_008, a number of core principles of service delivery remain unchanged, providing continuity in key aspects of care while enabling a more significant level of transformation. The option continues to retain physical health inpatient provision within Powys, ensuring that the Health Board maintains a local inpatient bed base, although across fewer sites than under the current model or Option SL IPDO_005b.

It also maintains the strategic focus on supporting people at home wherever possible, with inpatient care reserved for those whose needs cannot be safely met through community or alternative pathways.

- Physical Health inpatient services remain available within Powys.
- Inpatient rehabilitation continues at Newtown (Brynheulog) and Brecon (Epynt).
- End-of-life and palliative care remain part of the inpatient offer.

	• Community services, primary care and third-sector partners remain central to service delivery. The overall ambition to provide more care closer to home remains unchanged, supported by stronger community alternatives. **What changes** The central logic of Option SL IPDO_008 is to deliver the maximum level of inpatient consolidation and the strongest shift towards a community-first model of care. In practice, this means a more significant reduction in inpatient bed numbers, concentration of physical health inpatient provision onto two sites only, and greater reliance on enhanced community services, intermediate care, urgent response and Hospital at Home to safely support fewer beds. The option is therefore not simply a further reduction in inpatient capacity, but a larger-scale redesign of the model of care, with a stronger emphasis on prevention, admission avoidance, rehabilitation, discharge flow and integration between physical and mental health services. • Further reduction in inpatient beds with consolidation onto two sites only: Newtown and Brecon. • Closure of Physical Health inpatient beds at all other community hospital sites, including Llandrindod. • Joint Physical and Mental Health inpatient provision located on the two retained sites. • Diagnostics provided on fewer sites, with extended hours. • Greater reliance on enhanced community services, intermediate care and Hospital at Home. • Bed numbers change from the current (depending on demand) across 9 inpatient wards to approximately 60 beds across 2 inpatient wards A larger workforce transition requirement, including redeployment and role change into retained inpatient sites and enhanced community services. **Finance** From a financial perspective, Option SL IPDO_008 is intended to provide the greatest reduction in inpatient operating costs through maximum consolidation. The financial logic of the option is that a more concentrated inpatient footprint, supported by a stronger community model, would reduce duplication, improve efficiency and create the lowest long-term inpatient cost base.

	This would make the option financially attractive over the longer term if the wider model is delivered as intended. However, the financial benefits are highly dependent on successful and timely community substitution. This includes reducing length of stay, avoiding unnecessary admissions, supporting timely discharge, and reducing reliance on agency, bank and over-contract staffing. If the community model is delayed, underdeveloped or unable to absorb the level of demand assumed, the expected financial benefits would also be delayed or reduced. The option also carries a higher capital dependency than the mid-range option because inpatient capacity would need to be increased and adapted on only two retained sites. • Delivers the greatest reduction in inpatient operating costs through maximum consolidation. • Financial benefits are dependent on significant and sustained community investment. • Capital investment required to increase and adapt bed capacity on two sites and address estate implications elsewhere. • Higher delivery risk than the mid-range option due to scale and pace of change. The financial case would need to be tested further through the pre-consultation business case, including sensitivity analysis where community substitution is delayed or only partially achieved. **Workforce** Workforce sustainability is one of the main drivers for Option SL IPDO_008. By concentrating inpatient provision onto two sites, the option has the potential to create larger, more resilient teams, reduce reliance on temporary staffing, strengthen supervision and leadership arrangements, and support a more consistent skill mix across retained inpatient provision. This could help address some of the workforce fragility identified in the case for change and create a more sustainable model over the longer term. At the same time, this option carries the greatest workforce transition impact. A move to two inpatient sites would require a larger programme of staff engagement, redeployment, role redesign and workforce development than the mid-range option. It would also require sufficient community workforce capacity to be in place before bed reductions proceed. If redeployment into community roles does not happen at the required pace, or if recruitment to enhanced community services is not achieved, the option could create additional delivery risk. • Strongest workforce sustainability through larger consolidated teams. • Reduced long-term reliance on temporary staffing.

	• Greater requirement for workforce redeployment and role change into community settings. Contingency arrangements will be put in place to manage any lag in workforce redeployment. This includes phased implementation aligned to workforce readiness, targeted recruitment to key community roles, and the continued use of temporary staffing where required to maintain safe service delivery during transition. Delivery will be closely monitored, with the ability to adjust the pace and sequencing of change if required. • Increased risk of workforce disruption if change is not carefully phased. **Estates** The estates implications of Option SL IPDO_008 are central to its deliverability. The option would deliver the greatest reduction in inpatient estate footprint and therefore the greatest potential to reduce long-term maintenance pressure across the current dispersed model. It would also concentrate inpatient care onto fewer sites, which may allow investment, staffing and clinical infrastructure to be focused in a more targeted way. However, the estate and capital dependency is more significant than under Option SL IPDO_005b and represents a proportionally higher deliverability risk. The capital dependency identified under Option SL IPDO_005b applies here with greater force, as this option consolidates inpatient provision onto two sites, both of which currently have unconfirmed capital positions and would need to be capable of safely accommodating the expanded role required of them. If capital funding is delayed or not approved, the option could not be delivered as intended without either delaying implementation, phasing change differently, or maintaining a greater level of interim inpatient capacity while estate solutions are developed. The option also creates significant strategic questions about the future use, repurposing or disposal of sites where inpatient beds would close. • Concentration of inpatient care onto the most modern and adaptable sites. • Create facilities that were to the latest regulations and standards to meet the needs of specific groups (e.g. people with disabilities) • Greatest reduction in estate footprint and long-term maintenance liability. • Significant strategic decisions required about the future of closed inpatient sites. • Capital investment critical to ensure retained sites are fit for expanded roles.

	Travel time and access Option SL IPDO_008 would have the greatest impact on travel time and access because inpatient beds would be concentrated onto two sites only. This would mean increased travel for some patients, carers and visitors, particularly those living further from Newtown or Brecon. Public transport access is route-dependent, often connection-dependent, and may not support same-day discharge, visiting, carer responsibilities or staff travel. The impact is therefore likely to be greatest for people without access to a car, older people, carers, rural communities and communities where local hospital provision is experienced as a core community asset. The impact may be greater for people without access to private transport, older people, carers making frequent or repeat visits, and rural communities where public transport options are limited. The overall logic of the option is that these access impacts would be mitigated by fewer admissions, shorter lengths of stay, and more care delivered at or closer to home through enhanced community services. However, because this option involves the greatest concentration of inpatient provision, residual equity and access concerns are likely to remain. These would need to be considered alongside the Equality Impact Assessment, including the specific impact on patients, carers and communities who may be disproportionately affected by longer travel times or reduced local access to inpatient and diagnostic services. • Greatest increase in travel times for patients and families compared with all other options. • Access impacts are intended to be mitigated by fewer admissions and more home-based care, but residual equity concerns remain. • Impact assessment has identified that travel is a key challenge for people with disabilities, unpaid carers, socially excluded or isolated. **Benefits** The overall benefit of Option SL IPDO_008 lies in its ability to deliver the greatest level of long-term consolidation, efficiency and workforce concentration. The option most strongly aligns with the ambition to shift care away from hospital and towards a more proactive, community-based model. By concentrating inpatient beds onto two sites, it has the potential to support stronger rota resilience, reduce duplication, lower the long-term inpatient operating cost base and create a clearer separation between care that needs to be delivered in hospital and care that can be provided at or closer to home: • Maximum efficiency and workforce resilience. • Strong alignment with long-term strategic ambition for community-based care. • Lowest long-term inpatient operating cost.

	• Improved integration of Physical and Mental Health inpatient care. Potential to reduce duplication across inpatient sites and support more focused use of staffing, diagnostics and estate. The principal risks associated with Option SL IPDO_008 relate to scale, deliverability, dependency and transition. In particular, successful implementation is dependent on a substantially strengthened community model being in place before inpatient capacity is reduced, capital investment being secured for the retained sites, and a clear transition plan being in place for patients, staff and partners affected by service reconfiguration. These risks are more significant than under Option SL IPDO_005b because the option involves a greater reduction in inpatient sites and a higher dependency on community alternatives and a reduced level of flexibility within the system once consolidation has taken place. It is therefore important that the option is supported by clear readiness criteria, implementation safeguards, contingency arrangements and transitional planning. This should include evidence that the required community capacity, intermediate care, urgent community response, Hospital at Home and discharge pathways are in place and operating safely; confirmation that workforce transition and redeployment plans are sufficiently developed; and assurance that the necessary estate and capital requirements are deliverable within the proposed timescales. If these conditions are not met, implementation would need to be paused, phased differently, or supported by contingency arrangements to maintain safe inpatient capacity while the wider model is strengthened. • Highest level of public, political and stakeholder concern due to scale of bed reduction. • Risk of service disruption if community infrastructure is not fully operational. • Greater dependency on capital funding approvals and delivery timescales. • Increased risk to equity of access for rural and remote communities. Transition risk for patients, staff and partners during implementation. A detailed transition plan would be required before any inpatient beds close or move. This should set out how patients currently occupying beds at affected sites would be reviewed and supported, including individual care planning, discharge arrangements, family and carer considerations, and any safe transfer requirements. A workforce transition plan would also be required for staff affected by service reconfiguration, including early engagement, individual conversations, redeployment opportunities, support to move into retained inpatient or enhanced community roles, and access to training and development where role expectations or skill mix requirements change.

	Public, political and reputational concerns would need to be managed through a clear engagement and communication approach, including transparent explanation of the rationale for change, the safeguards in place, and how feedback from patients, staff, communities and partners will inform next steps. **Trade-offs** The central trade-off within Option SL IPDO_008 is that the greatest potential gains in long-term sustainability, efficiency and workforce resilience are achieved through the highest level of service concentration. This means that the option offers the strongest alignment with a community-first model and the lowest long-term inpatient operating cost base, but at the expense of reduced local access to inpatient beds and a greater reliance on community services being in place and able to respond safely. This is a more significant trade-off than under Option SL IPDO_005b. While access impacts may be mitigated by fewer admissions, shorter lengths of stay and more care delivered closer to home, they remain an important issue because inpatient provision would be concentrated onto two sites only. The option also involves a delivery trade-off: its benefits depend on capital, workforce transition, estate readiness and community capacity being in place at the right time. Without these conditions, the benefits of the option may be delayed or the risks may increase. • Maximum sustainability and efficiency at the expense of local access and deliverability risk. • Larger and faster transformation required compared with the mid-range option. • Benefits realised over a longer timeframe with higher implementation risk. **Physical Health and Community Model Option Summary** The options appraisal concluded that the current model of community hospital and inpatient care is becoming increasingly difficult to sustain. Powys faces a combination of workforce shortages, estate challenges, long lengths of stay and growing demand from an ageing population with increasingly complex health and care needs. The appraisal considered a wide range of options before shortlisting four for detailed assessment: returning to previous arrangements (001a), making temporary arrangements permanent (001b), a mid-range transformation option (005b) and a maximum transformation option (008). The first two options were retained as comparators but were not considered capable of addressing the long-term workforce, financial, quality and estate challenges facing services. The appraisal therefore focused on Options 005b and 008 as the only credible options capable of delivering a sustainable future model.

	The central case for change is not simply reducing inpatient beds. It is to create a stronger community-based system that provides more care at home, prevents unnecessary admissions, supports faster recovery, enables more people to receive end-of-life care closer to home, and reduces the harms associated with prolonged hospital stays. Success depends on significant investment in an Integrated Community Services Model, including proactive prevention, urgent community response, Hospital at Home, rehabilitation and reablement, discharge-to-recover pathways, integrated physical and mental health care, and multidisciplinary community teams. Under both shortlisted options, care would increasingly be delivered through a countywide Intermediate Care Service operating seven days a week. This service would provide urgent assessment, hospital-level care at home where appropriate, rehabilitation, reablement, discharge support and end-of-life care. The aim is to support people to remain independent for longer, avoid unnecessary hospital admissions and ensure that inpatient beds are reserved for those who genuinely require bed-based care. Option 005b represents a mid-range approach. Approximately 90 beds. inpatient beds would be provided across three sites: Newtown, Llandrindod Wells and Brecon. Rehabilitation services would be centred in Newtown and Brecon, while Llandrindod would provide an integrated physical and mental health unit, including support for people living with dementia. This option delivers substantial service improvement while retaining a broader geographical spread of inpatient provision. Option 008 represents the maximum level of transformation. Approximately 60 beds would be consolidated onto two sites only, Newtown and Brecon, with a greater reliance on community services, Hospital at Home and intermediate care. This option offers the greatest potential workforce and financial efficiencies but also results in the largest reduction in local inpatient provision and the greatest impact on travel and access. Both options would improve workforce resilience, reduce fragmentation, strengthen multidisciplinary working and support a shift towards prevention, rehabilitation and care closer to home. However, both also require community services to be fully established before any inpatient capacity is reduced. They are dependent on workforce recruitment, service redesign and capital investment being delivered successfully. The appraisal concluded that Option 005b provides the strongest overall balance between quality, access, workforce sustainability, financial viability and deliverability. It achieves many of the benefits of Option 008 while maintaining greater local access and carrying lower implementation risk. Option 008 remains a viable alternative for consultation because it tests a more ambitious model with greater long-term efficiencies, but it carries higher risks relating to capital investment, workforce transition, travel and access.

	The key decision is therefore not whether change is required, but what level of change provides the best balance between improving quality and sustainability whilst maintaining access for the people of Powys. This provides a clear basis for consultation, enabling patients, communities, staff and partners to consider the relative benefits, risks and trade-offs before any preferred option is determined.
2.6 Recommendation: Preferred Option	Set out the preferred option and expected timetable for implementation **This section will remain incomplete for now, as the preferred option will only be identified following consultation.** **Including a preferred option at this stage could imply that the consultation outcome has been predetermined.**
2.7 Financial Summary	The financial assessment should be considered alongside the quality, workforce, estates, access and deliverability assessments. Its purpose is not to identify the lowest-cost option, but to understand whether the recommended options are affordable, sustainable and capable of delivering improved outcomes for patients. The 2025/26 outturn position shows that progress has been made in reducing agency spend, but it also demonstrates that the underlying workforce pressure has not been fully resolved. Agency use has continued to improve as part of dedicated grip and control measures; however, this has been accompanied by increased use of bank and over-contract working. This indicates that the service has shifted away from agency reliance, rather than removed its dependency on temporary or variable staffing altogether. **2025/26 Outturn:** • RN Agency £266k • HCSW £237k • Bank RN £479k • Bank HCSW £289k • There has been a reduction in outturn variance when inflation is factored in.

Community Service Group Inpatient Wards			
Year	Annual budget	Outturn	Variance
	£000	£000	£000
2022-2023	10,129	13,189	3,060
2023-2024	10,494	13,721	3,227
2024-2025	11,940	13,260	1,320
2025-2026	12,283	12,325	42

- Agency use continues to improve as part of dedicated measures.
- Over contracted work continues to increase.
- Bank has significantly increased.
- Changes show a shift away from Agency towards over contract and bank cover

Comparative Costs of Inpatient Beds

Comparing costs of wards with the same roster but different bed counts.

	Cost per year	Cost per bed
A 14-bed ward in Powys with the lowest staff budget	£1,031,084	£73,648
A 21-bed ward in Powys with the lowest staff budget	£1,291,337	£61,492
A 30-bed ward in Powys with the lowest staff budget	£1,912,259	£63,742

- A single 30 bed ward reducing the operating cost by £150,509.
- Conclusion: a 30-bed ward has a lower staff operating cost than 2 separate 14 bed wards.

Reducing Operating Costs by Ward Amalgamation

Configuration	Beds	Annual operating cost	Cost per bed	% reduction in cost per bed vs 14-bed baseline
Single 14- bed ward	14	£1,031,084	£73,684	Baseline
Amalgamated 28 – bed ward (3-shift)	28	£1,912,259	£68,294	7.3% lower

Amalgamated 28- bed ward (2 shift)	28	£1,735,699	£61,989	15.8% lower
30-bed footprint using 28-bed staffing	30	£1,735,680	£57,856	21.4% lower

Comparative cost analysis suggests that larger and more consolidated inpatient wards are more efficient to operate than smaller dispersed wards. A single 14-bed ward operating on a three-shift model in Powys has an annual staffing cost of £1,031,084, equivalent to £73,648 per bed. Operating two separate 14-bed wards therefore costs £2,062,168 per annum at the same unit cost. By amalgamating these into a single 28-bed ward operating on a three-shift model, the annual staffing cost reduces to £1,912,259 (£68,294 per bed). A further reduction is achieved by moving to a two-shift model, lowering annual costs to £1,735,699, equivalent to £61,989 per bed.

A larger 30-bed ward footprint would reduce the cost further to £57,856 per bed. This demonstrates a clear economy of scale, with savings generated through ward consolidation, revised staffing models and more efficient use of space.

The challenge for the Health Board is ensuring that its model of care is able to meet the changing needs of the population and be sustainable financially. The financial data suggests that smaller isolated inpatient wards are less sustainable financially in the long term.

Both shortlisted options have the potential to improve long-term financial sustainability when compared with the current model. However, the financial benefits are dependent on successful implementation of the wider service redesign, particularly the expansion of community-based services, reductions in unnecessary admissions, shorter lengths of stay, improved discharge pathways and reduced reliance on agency and temporary staffing.

Option SL IPDO_005b is expected to deliver recurrent savings through the consolidation of inpatient services onto three sites, more efficient workforce deployment, reduced duplication and better use of estate. While Option 008 offers greater long-term efficiency, it also carries significantly higher implementation, workforce, access and capital risks.

The financial case for both options is based on several key assumptions, including:

- Successful delivery of enhanced community services.
- Reduced inpatient demand through prevention and admission avoidance.
- Improved patient flow and shorter hospital stays.
- Workforce recruitment and reduced agency dependency.

	• Availability of social care and community support services. • Capital investment being secured to enable estate changes. • Benefits being delivered in line with planned implementation timescales. If these assumptions are only partially achieved, or implementation is delayed, the anticipated financial benefits will reduce and may take longer to be realised. The current assessment indicates that SL IPDO_005b offers the most balanced combination of affordability, deliverability and sustainability. It provides meaningful financial improvement while maintaining a broader geographical footprint and lower delivery risk than the two-site model. Detailed financial modelling, implementation phasing, capital requirements, benefit realisation plans and sensitivity testing will be developed through the Pre-Consultation Business Case. This will include assessment of alternative scenarios where community service expansion, workforce transformation or capital investment are delayed, enabling the Board to fully understand the affordability and financial risks associated with each option before any final decision is made.
2.8 Governance Arrangements	Powys Teaching Health Board (PTHB) will apply a robust, transparent and proportionate approach to assessing the impacts of service change through its Integrated Impact Assessment (IIA) process. The purpose of the IIA is to identify, assess and mitigate potential impacts before decisions are made, ensuring that quality, equality, workforce, Welsh language and wider population health considerations are fully understood. The IIA framework brings together statutory and best-practice assessments into a single process. All proposals undergo a Level 1 assessment, with higher-risk or more complex proposals progressing to a detailed Level 2 assessment. Where significant adverse impacts are identified, further detailed analysis and mitigation planning are required. Alongside the IIA, dedicated assessments are undertaken where required by an independent panel, including: • Quality Impact Assessment (QIA) • Equality Impact Assessment (EQIA) • Welsh Language Impact Assessment (WLIA) • Health Impact Assessment (HIA)

	The Welsh Language Impact Assessment is particularly important in ensuring that the impact on Welsh speakers and Welsh-speaking communities is properly considered and that Welsh is not treated less favourably than English. Completion of the WLIA, alongside the EQIA and QIA, will form an important part of providing assurance that consultation is robust and legally defensible. The impact assessments are agreed by the Senior Responsible Officer and reviewed by a Quality and an Equality panel and final sign off is via the Programme Boards. The Equality Impact Assessments (EQIA/EIA) will remain live documents throughout the duration of the programme, supporting the ongoing identification of impacts, mitigations and associated actions. Following the engagement period, any new findings identified will be reviewed and analysed. This information will be used to update the EQIA/EIA as required, including refining existing mitigations, identifying additional impacts, and strengthening actions to address potential effects on protected groups.
2.9 Engagement and/or Consultation considerations	Stakeholder participation throughout the Better Together Phase 1 options development process was structured to ensure appropriate involvement at each stage. Early engagement focused on patients, service users, communities, staff and partners to inform the Case for Change, design principles and option development. Technical appraisal stages then drew on clinical, operational and professional expertise to assess quality, workforce, financial, estates and deliverability considerations. Public, patient and stakeholder feedback gathered throughout the process informed option refinement, assessment criteria, mitigations and decision-making. Stakeholder groups were established to support option development, deliberation, assurance and communication, while patient representatives remained involved through deliberative events. The engagement process remains ongoing. Importantly, information, concerns and insights received during consultation from patients, service users, carers, communities and stakeholders will be used to further develop, strengthen and refine the Quality Impact Assessment, Equality Impact Assessment, Welsh Language Impact Assessment and other supporting assessments. This will ensure that emerging evidence and lived experience continue to inform decision-making and that any additional impacts, risks or mitigation measures identified through consultation are fully considered before final decisions are made.

Quality Equality Integrated Impact Assessment Section

Overview
This Impact assessment is based on the PTHB agreed process.

Using this template helps us to fulfil important legal duties and best practice requirements:

- The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this is through Quality Impact Assessments (QIA). A high level quality impact assessment is included in Section B.1 of the template, and a template for a deep dive assessment is included in Section C.1.
- The Equality Act 2010 and Welsh Language Act 1993 create important statutory duties for assessing the impact of key decisions for people with equality protected characteristics, in relation to Welsh Language, and for different socio-economic groups through the socio-economic duty. A high level equality impact assessment is included in Section B.2 of the template, and a template for a deep dive assessment is included in Section C.2.
- The Well-being of Future Generations Act 2015 requires public bodies to consider the wider longer term impact of their decisions on the communities they serve. Considering of the seven wellbeing goals should be considered as part of the "Whole Systems Impact" quality standard. Key issues may also be highlighted in other relevant sections (e.g. socio-economic considerations in the Equality Impact Assessment, strategic alignment and social responsibility elements of the Section A Overview).
- Good practice in evaluation and appraisal of policies and programmes is available from a range of sources including The UK Government Green Book for appraisal and evaluation, National Audit Office etc.

A Level 1 Assessment is expected for all health board proposals. This provides a high level summary of a proposal, the decision to be made, and whether there are any adverse impacts that may need to be considered in more detail before a decision can be made.

A Level 2 Assessment will be undertaken for proposals of higher value and complexity where potential adverse impacts are identified. The Level 2 Assessment requires a detailed overview of the proposal, and an integrated impact assessment covering issues such as quality, equality, compliance, strategic alignment, reputation, deliverability. Where adverse quality impacts or adverse equality impacts with a score of 9 or more are identified then a further "deep dive" will be required in order to ensure that the risks are fully understood, mitigation action is in place, monitoring measures and controls have been identified, and unintended consequences have been considered.

Approach to Scoring

The scoring tool used to inform this impact assessment utilising a standard Likelihood versus Impact assessment.
In this context the term '**Likelihood' has been used universally across this document to describe the likelihood a person would become a patient of the health services delivered or commissioned by Powys Teaching Health Board**.

For example, a person is more likely to need physical health community services or inpatient services during their entire life, whereas they may never need to use urgent care of mental health services and so it may reasonably be considered that it is possible they may need these services.

Table 1: Measures of Likelihood

Descriptor	**Rare (1)**	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost certain (5)**
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

After a person comes into contact with the Health Service then there can be a measure of the 'Impact'. In the context of the delivery of health care services the Impact is the extent of harm, loss, disruption, or adverse effect that would result if a risk from the contact with the service. The tool expresses impact using a range of domains. As the new models of care being proposed are primarily going to impact the experience people will have when using the Health Board Services the domain called 'Quality / Complaints / Audit' has been used.

For example, a person may experience a level of care where a level of treatment maybe sub optimal which would be described as negligible impact which has a score of 1. Or Overall treatment or service sub-optimal which has a score of 2.

Therefore, when the overall new model of care may demonstrate an improvement in service over existing models of care the lowest impact score would be a 1.

Table 2: Measures of Impact

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service sub-optimal Informal complaint / inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/improve-ment notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating 4 Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption / environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

The final risk score calculation used in this assessment is as follows:

Score of the likelihood of using the service x score of the impact of using the service = the overall score.

Table 3: Risk Score

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Possible 3	3	6	9	12	15
	Unlikely 2	2	4	6	8	10
	Rare 1	1	2	3	4	5
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		IMPACT				

It could be considered that a person is Likely (4) to use community services which were delivered to a satisfactory level which would have had a negligible (1). The total risk score is therefore 4.

In the assessments where a score is referred to it is listed with its colour or in brackets as above.

Integrated Impact Assessment

SL IPDO_005b (Do Mid Range): The total number of hospital beds in Powys will reduce to approximately 90, across fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.

Summary of Proposal:

- Community Services would be enhanced by: Key enhancements include a 2-hour Urgent Community Response service, Hospital at Home capability, enhanced end-of-life care, Discharge to Recover and Assess pathways, home-based rehabilitation and reablement, access to intermediate care beds, and a single point of access. Together, these services improve access, reduce unnecessary hospital admissions, support faster discharge, and deliver integrated, person-centred care across health, social care, and voluntary sector partners.

- Inpatient wards that would close are at: Ystradgynlais, Bronllys, Llanidloes, Machynlleth, and Welshpool.

- Inpatient wards that would stay open are located at: Newtown, Llandrindod Wells and Brecon.

- Bed numbers would reduce to approximately 90 beds.

- Current Health and Wellbeing Centres in Machynlleth and Llandrindod would remain.

A.3. Integrated Impact Assessment Summary			Risk of Adverse Impact		
			Likeli-hood	Impact	Score
3.1 Quality	Headlines	**Quality - Summary Headlines** The case for change is driven by the need to create a sustainable, community-focused model of care that better meets future population needs, rather than simply reducing bed numbers. Key features include: ▪ Greater emphasis on prevention, community-based support, and "home first" care, reducing reliance on hospital admission. ▪ Improved integration of physical and mental health services, supporting safer and more coordinated care. ▪ A better balance between access, quality, and deliverability for the majority of the population. ▪ Consolidation from eight inpatient sites to three, improving sustainability, workforce resilience, and care quality. ▪ Risks associated with reduced bed capacity and reliance on community services being fully operational. ▪ Increased travel distances for some communities, creating potential access and equity challenges. ▪ Transition and implementation risks relating to workforce capacity, service continuity, and system stability. Overall, quality improvements are achievable but depend on sustained investment, phased implementation, and strong system-wide coordination.	4	2	8
	Full QIA required?	Yes, due to the complexity of the proposal.			
3.2 Equality	Headlines	**Equality - Summary Headlines** The case for change is driven by the need to create a sustainable, community-focused model of care that better meets future population needs, rather than simply reducing bed numbers. Key findings include:	4	2	8

		▪ Expanded community services, reduced reliance on hospital admission, and improved integrated care offer significant equality benefits. ▪ Consolidation from eight inpatient sites to three improves service sustainability but reduces local provision in five communities. ▪ The greatest equality impacts relate to travel, transport, and access, particularly for rural populations. ▪ Older people, carers, disabled people, and those experiencing socio-economic disadvantage are most affected. ▪ Risks to Welsh language provision require ongoing workforce planning and compliance with Welsh Language Standards. ▪ Most of the population remains within a reasonable travel time of a retained inpatient site, compared with more centralised alternatives. ▪ Residual risks remain for remote communities, requiring mitigation through transport support, outreach services, digital inclusion, and support for carers. Overall, equality risks are manageable but require ongoing monitoring to ensure access barriers do not widen existing inequalities.			
	Full EQIA required	Yes, due to the complexity of the proposal.			
3.3 Legal / Statutory		The proposal supports statutory duties and Well-being Goals through integrated, community-based care, improving outcomes, workforce sustainability and resilience. Travel, access and Welsh language risks are identified, mitigated and considered low and manageable overall.	4	1	4
3.4 Strategic Alignment and Health Outcomes		The proposal supports NHS Wales priorities through prevention, integrated care, and care closer to home. Benefits include improved outcomes, fewer admissions, better coordination and more sustainable services, with mitigation for local impacts.	4	1	4
3.5 Market and Partnerships		The proposal strengthens partnerships across health, social care, voluntary and community sectors, improving integration and discharge pathways. Local economic impacts in areas losing inpatient services will require targeted support.	2	1	2

3.6 Operational Deliverability	The model is considered deliverable, improving workforce resilience and reducing duplication. Key risks include workforce transition, capital investment and community service capacity, requiring phased implementation and strong oversight.	4	1	4
3.7 Ethics, Reputation and Social Responsibility	The proposal supports better outcomes, independence and person-centred care. Maintaining public confidence will depend on meaningful engagement, transparent communication and demonstrating benefits from enhanced community services.	2	1	2
3.8 Workforce	The proposal supports larger multidisciplinary teams, improved recruitment, reduced agency reliance and better service integration. Workforce transition, Welsh language capability and community capacity require careful planning and management.	4	1	4
3.9 Summary of Mitigations	Mitigations include enhanced community services, Hospital at Home, transport support, digital inclusion, Welsh language planning, carer support and equality monitoring. Benefits depend on these measures being implemented before bed reductions.	4	1	4

SL IPDO_005b (Do Mid Range)
Section B.1 Summary Impact Assessment - Quality

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Standard is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in Explanatory Notes. A "deep dive" assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.1).

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likeli-hood	Impact	Score
Summary	This model delivers enhanced community services and provides a sustainable, person-centred approach to meeting the future health and care needs of Powys residents. The model prioritises care closer to home, reducing avoidable admissions and unnecessary travel to hospitals outside the county wherever clinically appropriate. Through stronger community-based services, improved prevention, rehabilitation and integrated care, more people will be able to access timely support within their own communities. To achieve this transformation, the model centralises inpatient care onto three community hospital sites. The proposed model is expected to improve consistency and equity of care across Powys by ensuring all communities benefit from enhanced community provision, closer alignment of services and improved access to specialist support. Co-location of services and larger multidisciplinary teams will strengthen patient safety, workforce resilience, collaboration and the integration of physical and mental healthcare. The proposal also supports the development of a more sustainable workforce through improved recruitment and retention opportunities, reduced professional isolation, enhanced training and development, and greater opportunities for advanced clinical and specialist practice. While implementation will require investment and careful	4	2	8

	management of change which carries a minor risk impact, the overall model is considered modern, equitable and sustainable, with significant potential to improve outcomes for patients, carers and communities across Powys. **Benefits** • Delivers more care closer to home, reducing avoidable hospital admissions and unnecessary travel outside Powys. • Improves access to preventative services, rehabilitation, early intervention and ongoing community support. • Enhances patient experience by enabling people to receive care within their own homes and communities whenever possible. • Supports more person-centred care through improved continuity, local access and care pathways tailored to individual needs. • Strengthens patient safety through larger multidisciplinary teams, improved clinical oversight and better access to specialist expertise. • Improves timeliness of care through enhanced community capacity, integrated pathways and reduced reliance on out-of-county services. • Promotes more effective and coordinated care through closer integration of physical health, mental health, primary care and community services. • Increases efficiency by reducing unnecessary admissions, supporting earlier intervention and making better use of existing workforce and facilities. • Improves equity of access by providing more consistent services across rural and geographically dispersed communities. • Creates a more sustainable workforce through improved recruitment, retention, professional development and career progression opportunities. • Reduces professional isolation and provides greater access to training, mentorship, supervision and advanced practice roles. • Strengthens leadership, workforce planning and strategic alignment around the long-term needs of the Powys population. • Encourages innovation, continuous improvement, research and the adoption of best practice through larger integrated teams.			

	• Enhances partnership working across health, social care, third sector and community organisations, supporting a more coordinated whole-system approach. • Supports long-term sustainability by shifting the focus from hospital-based care to prevention, early intervention and community-based support. **Challenges and Considerations** • Centralisation of inpatient services to three community hospital sites may result in increased travel times for some patients, visitors and staff. • Changes to local inpatient provision may generate public concern and require ongoing engagement and communication with communities. • Successful implementation will require significant organisational change and careful programme management. • Sustained investment may be needed to expand community services, infrastructure and workforce capacity before the full benefits can be realised. • Workforce transition will need to be carefully managed, including changes to roles, working practices and service delivery models. • Additional training, development and support may be required to enable staff to adapt to new ways of working. • Community services will need sufficient capacity and resilience to safely manage increased demand and activity transferred from hospital settings. • Effective integration across multiple organisations and sectors will require strong leadership, partnership working and shared accountability. • Robust monitoring and evaluation arrangements will be needed to ensure quality, safety and patient outcomes are maintained throughout implementation. • Realisation of the anticipated benefits will depend on successful delivery of the community service enhancements that underpin the proposed model.			

	Safe	The proposed model has the potential to improve safety through stronger multidisciplinary working, enhanced integration of physical and mental health services, and the development of larger and more resilient clinical teams. Delivering more care closer to home may support earlier intervention, improved continuity of care and better access to specialist expertise within community settings. However, these benefits will depend on a carefully managed transition from the current model, particularly as inpatient services become concentrated on fewer sites. During implementation, it will be important to maintain safe staffing levels, ensure effective communication between services and support staff and patients through changes to established pathways. Overall, while safety benefits are anticipated, careful planning and monitoring will be required to ensure these are realised throughout the transition period. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1). However, the impact of transition has been considered a minor (2) impact, giving an overall score of 8.	4	2	8
	Timely	The model is expected to support more timely access to care through enhanced community services, preventative approaches and better integration across health and care pathways. Increased availability of services within Powys should reduce reliance on out-of-county provision and enable more people to receive assessment, treatment and support closer to home. There is also potential for improved patient flow and reduced avoidable admissions. However, during the transition period there may be temporary pressures on services as new pathways are implemented and community capacity is expanded. Achieving the anticipated improvements in timeliness will depend upon appropriate workforce availability, effective service coordination and successful implementation of the enhanced community model. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced	4	1	4

	community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Effective	The model is anticipated to improve effectiveness through greater integration of services, enhanced multidisciplinary working and improved coordination between physical and mental health care. Providing more care closer to home could improve patient outcomes, reduce the burden associated with travelling for treatment, and support more personalised and coordinated care pathways. Opportunities for workforce development and specialist practice are also likely to strengthen clinical effectiveness over time. Nevertheless, the effectiveness of the model will rely on successful implementation, including maintaining service quality during transition and ensuring that community services are developed sufficiently to manage increased demand. Ongoing evaluation will be necessary to confirm that intended benefits are being achieved across all areas of care. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Efficient	The model has the potential to improve efficiency through greater service integration, improved utilisation of community resources, and a reduction in reliance on avoidable hospital admissions and out-of-county care. Co-location of services and larger multidisciplinary teams may support better use of workforce capacity and enable smoother patient pathways. However, efficiencies may not be realised immediately and will require investment in community services, workforce development and infrastructure during the implementation phase. There is a risk that short-term pressures could emerge while new arrangements are established, highlighting the importance of a phased and carefully managed transition to deliver sustainable longer-term benefits. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced	4	1	4

	community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Equitable	The proposed model aims to improve equity by increasing access to community-based services across Powys and reducing the need for unnecessary travel outside the county. More consistent service provision and strengthened community support could help address some of the challenges associated with serving rural and geographically dispersed populations. At the same time, the centralisation of inpatient services may result in longer journeys for some individuals, which may be perceived as having an unequal impact on particular communities. Careful attention will therefore be required to understand and mitigate any unintended consequences and to ensure that improvements in community provision are delivered consistently across all areas. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Person-Centred	The model supports a more person-centred approach by enabling more individuals to receive care and support within their homes and local communities wherever appropriate. Improved continuity of care, integrated pathways and reduced dependence on distant services have the potential to enhance patient experience, independence and wellbeing. However, some individuals and families may have concerns regarding changes to existing service locations, particularly where inpatient services become less locally available. Ensuring meaningful engagement, clear communication and responsive service design will be essential to maintaining confidence and ensuring that the transition remains focused on the needs and preferences of patients, carers and communities.	4	1	4

	It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Standard	**Potential Impacts**	**Risk of Adverse Impact[2]**		
		Likelihood	**Impact**	**Score**
Workforce	The model is expected to strengthen workforce sustainability by creating larger multidisciplinary teams, reducing professional isolation and increasing opportunities for recruitment, retention and career development. Enhanced access to training, supervision and advanced practice opportunities could improve workforce resilience and service quality over the longer term. However, implementation may require significant workforce adaptation, including changes to roles, responsibilities and ways of working. Staff may experience uncertainty during the transition period, and appropriate support, engagement and workforce planning will be essential to ensure successful delivery of the proposed model. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Leadership	The proposed model provides a clear strategic direction focused on sustainability, integration and care closer to home. It creates opportunities for stronger workforce planning, enhanced clinical leadership and better coordination of services across the health and care system. However, successful implementation will depend on strong leadership at all levels to guide organisational change, maintain stakeholder confidence and manage potential risks throughout the transition. Continued oversight and effective governance arrangements will be required to translate strategic ambition into operational success.	4	1	4

	It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Culture	The model supports the development of a collaborative culture focused on prevention, integration and person-centred care. Increased multidisciplinary working and closer alignment between community, primary, mental health and hospital services have the potential to encourage shared learning, innovation and collective accountability for outcomes. Nevertheless, cultural change can take time, and different teams may adapt to new ways of working at varying speeds. Effective engagement, communication and support will therefore be important to foster a positive culture during implementation and ensure that the intended benefits are fully realised. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), however, the impact of transition has been considered a minor (2) impact, giving an overall score of 8.	4	2	8
Information	Effective use of information, communication and data will be central to the successful implementation of the model. Improved access to performance and outcome data can support evidence-based decision-making, service planning and ongoing monitoring of equity and quality. Clear communication with patients, staff and communities will also be essential in explaining the rationale for change and maintaining confidence during implementation. There is a risk that misunderstandings or inconsistent communication could affect perceptions of the model, making robust communication and engagement plans critical to achieving a smooth transition. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Learning, Improvement and Research	The model creates opportunities for learning, innovation, research and continuous improvement through larger teams and greater service integration. Enhanced access to mentorship, supervision and specialist expertise may strengthen workforce capability and support the adoption of best practice across the organisation. However, achieving these benefits will require ongoing investment in workforce development and protected opportunities for learning during what may be a period of significant service change. Continuous evaluation will be important to ensure lessons are identified and improvements are embedded as the new model develops. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Whole Systems Approach	The proposal supports a more integrated whole-system approach by strengthening collaboration between health, social care, third sector and community organisations. This may improve coordination of care, support prevention and independence, and help reduce avoidable hospital admissions and reliance on services outside Powys. However, delivery of these benefits is dependent upon sustained partnership working, aligned priorities, and effective coordination across multiple organisations. The transition will therefore require ongoing collaboration, shared accountability and careful management to ensure system partners are able to adapt successfully to the new service model. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Section C.1 Deep Dive Impact Assessment - Quality
Copy and complete this table for every adverse quality impact score of 9 or more (amber and red impacts).

No impact reached the threshold for a Deep Dive Impact Assessment

Equality Impact Assessment SL IPDO_005b (Do Mid Range)

This Equality Impact Assessment was undertaken to evaluate the potential effects on individuals and groups with protected characteristics under the Equality Act 2010 of the draft proposals being developed in relation to three key service areas as part of the Stage 2 Better Together programme.

The assessment drew on a range of evidence which utilised the data in the revised Full Case for Change and the feedback given from the engagement conducted to date. This is set out in the comprehensive Stage 0 – Stage 2 Better Together feedback report alongside additional feedback captured by services using patient feedback mechanisms e.g. Civica surveys and patient focus groups during the past 18 months.

Engagement for the Better Together programme was carried out with PTHB employees, residents, third sector representatives, public sector colleagues and service users including representatives from equality groups. Surveys, focus groups and targeted outreach took place in communities to ensure a broad mix of views were captured.

The views given by all stakeholders were analysed and fed back to the programme team. Further analysis then took place to identify differential impacts across protected characteristics, with particular attention to areas of potential disadvantage. Where negative impacts were identified, some mitigation actions have been included either as ideas proposed by stakeholders or as additional options to reduce or eliminate these effects.

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Characteristic is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in the Explanatory Notes. A deep dive assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.2). This should be undertaken in line with CGP009 using the template in Section C.2.

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likeli-hood	Impact	Score
Summary	This Integrated Impact Assessment considers the proposed transition from eight community hospital inpatient sites to three inpatient centres, supported by a significant expansion of community-based services and more integrated physical and mental health care. The proposed model is designed to deliver a more sustainable, high-quality and person-centred health and care system for Powys. Central to the model is a substantial enhancement of community services, including Hospital at Home, intermediate care, rapid community response, rehabilitation and multidisciplinary support, enabling more people to receive timely care closer to home. This approach places greater emphasis on prevention, early intervention, recovery and independence, helping people remain well within their own communities and reducing reliance on hospital admission wherever appropriate. The assessment identifies a wide range of positive impacts across the population. Older people, carers, people with disabilities, Welsh speakers and those experiencing social or economic disadvantage are all expected to benefit from improved access to coordinated, community-based support that is delivered in familiar surroundings and tailored to individual needs. The model also provides opportunities to strengthen integration between health, social care, third-sector organisations and local communities, creating more seamless and responsive pathways of care. Enhanced community provision will support improved patient experience, better health outcomes, greater independence and stronger involvement of families and carers. The model also strengthens workforce sustainability, service resilience and the ability to provide consistent, high-quality care across Powys. Overall, the assessment concludes that the proposal offers a significant opportunity to improve health and wellbeing outcomes by delivering more care closer	4	2	8

to home, increasing access to enhanced community services and creating a more integrated, resilient and sustainable model of care for current and future generations.

Assessment Summary Table

Characteristic	Likelihood	Impact	Score
Age	4	2	8
Disability	4	2	8
Gender Reassignment	4	1	4
Marriage and Civil Partnership	4	1	4
Pregnancy and Maternity	4	1	4
Race	4	1	4
Religion or Belief	4	1	4
Gender	4	1	4
Sexual Orientation	4	1	4
Welsh Language	4	2	8
Socio-Economic Circumstances	4	1	4
Social Exclusion	4	1	4
Carers	4	2	8

Age	Powys has a significantly older population than Wales and the UK, with higher levels of frailty, long-term conditions and increasing demand for health and care services. Supporting people to maintain their independence, remain active within their communities and receive care closer to home is therefore a key priority for the future delivery of services. The proposed model has been developed to respond to these challenges by strengthening community-based care and reducing reliance on hospital admission wherever it is safe and appropriate to do so. Alongside the consolidation of inpatient care onto three sites, the model includes enhanced community provision	4	2	8

	through Hospital at Home, Intermediate Care, rapid response, reablement, discharge-to-assess and integrated multidisciplinary services. These developments will provide more proactive, preventative and responsive support, helping older people access care earlier and closer to where they live. For the majority of older residents, this represents a positive improvement in how care is provided. More people will be able to receive assessment, treatment, rehabilitation and ongoing support within their own homes or local communities, reducing the disruption often associated with hospital admission, and supporting people to maintain their independence for longer. The model also promotes greater integration across primary care, community services, social care, mental health, therapies and third-sector organisations, creating a more coordinated and seamless experience for patients and carers. While some patients requiring inpatient admission may need to travel further to access one of the retained hospital sites, the enhanced community model is expected to reduce the overall need for admissions and inpatient stays. As a result, many older people and their families may experience fewer hospital-related journeys overall. The proposal is therefore expected to have a positive impact on older people, improving access to person-centred care, supporting independence, and delivering more services closer to home while maintaining access to specialist inpatient care when required. The proposed model delivers clear improvements in service quality, integration, and sustainability. The primary residual risk relates to access, particularly travel and visiting. Therefore, based on the impact to older people, the risk assessment score shows that the impact to them is likely to occur (4), and the impact is minor (2), with an overall risk score of 8. Continued focus on transport solutions, community provision, and maintaining access to family and carer support will be essential to ensure that the benefits of the model are realised equitably across all communities.			
Disability	The proposed model supports the Health Board's commitment to improving access, inclusion and outcomes for people with disabilities by significantly enhancing the range of services available within local communities. While inpatient care will	4	2	8

	be consolidated onto three sites, this is accompanied by substantial investment in community-based care, including Hospital at Home, rapid response, reablement, intermediate care and integrated multidisciplinary support. For many people with physical, sensory, learning, cognitive or neurodiverse needs, the most significant benefit will be increased access to care closer to home. Enhanced community services will enable more assessment, treatment, rehabilitation and ongoing support to be provided in familiar environments, reducing the need for unnecessary hospital admissions and travel. This approach can promote independence, improve wellbeing, reduce anxiety associated with hospital attendance and enable greater involvement of families, carers and support networks in care planning and delivery. The model also strengthens integration between health, social care and third-sector services, supporting more coordinated, person-centred care, and helping individuals access the right support at the right time. Inpatient care will remain available when required, with retained facilities designed to modern accessibility standards that improve physical access, patient experience and support for diverse needs. Overall, the proposal is expected to have a positive impact on people with disabilities by expanding access to responsive, personalised care within local communities. By reducing reliance on hospital-based services and increasing opportunities to receive care at home, the model has the potential to improve outcomes, enhance independence and provide a more accessible and inclusive experience for the majority of disabled people across Powys. Therefore, based on the impact to the people who have a disability, the risk assessment score shows that the impact to the is likely to occur (4) and the impact is minor (2) with an overall risk score of 8.			
Gender Reassignment	People within this protected characteristic represent a very small proportion of the Powys population, with approximately 360 individuals (0.32%) identified in the 2021 Census.	4	1	4

	The proposed service model is not expected to have a direct or disproportionate impact on this group. Access to services, quality of care and health outcomes are anticipated to remain broadly unchanged. Any potential impacts would be managed through existing equality, inclusion and person-centred care arrangements. Overall, the assessment concludes that the likelihood of a significant adverse impact is low due to the small population affected and the absence of any specific barriers created by the proposal. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.			
Marriage and Civil Partnership	The proposal has been assessed against the Health Board's Strategic Equality Plan, and no specific impacts have been identified for people who are married or in a civil partnership. Access to services, patient rights and care arrangements remain unchanged. Any benefits are linked to overall improvements in clinical care and it is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Pregnancy and Maternity	The proposal has been assessed against the Health Board's Strategic Equality Plan and is not expected to have any specific impact on people who are pregnant or receiving maternity-related care. Existing pathways and protections will remain in place, with any benefits arising from overall improvements in service quality and care coordination. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Race	Powys has a relatively small ethnically diverse population compared with Wales as a whole. The proposal does not alter the Health Board's duties or arrangements for meeting the needs of people from different racial or ethnic backgrounds. No direct impacts on access, quality or outcomes have been identified for patients. Consideration will be required during implementation to ensure workforce changes continue to support an inclusive environment for internationally recruited and ethnically diverse staff.	4	1	4

	Overall, no adverse impacts have been identified, and it is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.			
Religion or Belief	The proposal does not affect the Health Board's commitment to meeting the religious and spiritual needs of patients. Existing arrangements to support prayer, worship and faith-based requirements will remain in place across services. No specific impacts have been identified for people of different religions or beliefs. Any benefits relate to wider service improvements rather than this protected characteristic directly. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Gender	The proposal has been assessed against the Health Board's equality objectives, including commitments to inclusive care and accommodation that meets the needs of all patients. No specific impacts have been identified for people whose gender identity differs from their sex registered at birth. The model does not change existing protections, policies or standards of care. Benefits are expected to arise from overall improvements in service quality and patient experience. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Sexual Orientation	The proposal does not impact the Health Board's existing arrangements for supporting lesbian, gay, bisexual and other sexual orientation groups. Equality protections, inclusive practices and patient rights will remain unchanged. No specific adverse impacts have been identified. Any benefits are linked to broader improvements in the quality, sustainability and integration of services.	4	1	4

	It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.			
Welsh Language	Welsh language and culture are an important part of community life across Powys, with particularly strong Welsh-speaking populations in areas such as Machynlleth, Ystradgynlais, Llanfyllin and Llanfair Caereinion. As demand for services continues to change, the proposed model provides an opportunity to strengthen Welsh language provision across a wider range of care settings and ensure more people can access services in their language of choice. A key feature of the model is the expansion of community-based services, including Hospital at Home, rapid response, reablement and integrated community teams. This approach will enable more care to be delivered within people's homes and local communities, where communication in a person's preferred language can have a significant impact on their experience, confidence and wellbeing. As many Welsh-speaking staff already work across community and inpatient settings, there is an opportunity to increase the number of Welsh-language interactions taking place closer to home and within everyday community environments. The Health Board is committed to meeting its obligations under the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards, ensuring that the Welsh language is treated no less favourably than the English language, and that the Active Offer is embedded throughout service delivery. With the number of Welsh speakers expected to increase in future years, the redesigned model provides a platform to further strengthen Welsh language workforce planning, recruitment, training and service provision across both community and inpatient services. Overall, the proposal is expected to have a positive impact on Welsh speakers. By expanding community-based care and embedding Welsh language considerations throughout service redesign, more people will be able to receive personalised care closer to home, within their own communities and, where appropriate, through the medium of Welsh. The model presents a significant opportunity to enhance both	4	2	8

	access to services and the visibility and use of the Welsh language across the health and care system in Powys. Therefore, the impact to Welsh speakers is likely to occur (4), and the impact is minor (2), with an overall risk score of 8.			
Socio-Economic Circumstances	Socio-economic disadvantage in Powys is influenced by rurality, lower incomes, limited public transport, digital exclusion and dispersed deprivation. Unlike many areas, deprivation is spread across communities, creating challenges in ensuring equitable access to services. The proposed model has been designed to address these challenges by shifting the focus of care from hospital-based services to enhanced support within local communities. The enhanced community model, including Hospital at Home, rapid response, reablement, integrated mental health support and improved care coordination, will enable more people to access care closer to home and reduce reliance on hospital attendance. This approach is expected to particularly benefit individuals and families who may face financial, transport or practical barriers to accessing healthcare, by reducing the need for travel and providing more timely support within familiar surroundings. For people experiencing socio-economic disadvantage, earlier intervention, improved integration between services, and greater access to community-based care can help prevent deterioration, improve outcomes, and support independence. The model also promotes closer working between health, social care and third-sector organisations, creating a more coordinated approach to meeting health and well-being needs. Additional support through transport initiatives, digital inclusion programmes, flexible visiting arrangements, carer support and ongoing monitoring of access and outcomes will help ensure services remain accessible to all communities. Overall, the proposal is expected to have a positive impact on people experiencing socio-economic disadvantage. By expanding community-based services and reducing reliance on hospital care, the model will improve access to support, reduce barriers to care and deliver more equitable, person-centred services across Powys,	4	1	4

	particularly for those who may previously have faced challenges in accessing healthcare. Overall, the impact on individuals experiencing socio-economic disadvantage is assessed as likely (4), with a negligible consequence (1) relating primarily to access and travel challenges, resulting in an overall risk score of (4).			
Social Exclusion	Social exclusion can arise through poverty, low income, rural isolation, limited access to services, digital exclusion and language barriers. In Powys, these challenges are often influenced by the county's rural geography and dispersed population, making it important that services are designed around people's needs and delivered as close to home as possible. The proposed model provides a significant opportunity to reduce many of the factors that contribute to social exclusion by expanding community-based care and reducing reliance on hospital attendance. Enhanced services such as Hospital at Home, reablement, crisis response, integrated mental health support and multidisciplinary community teams will enable more people to receive assessment, treatment and ongoing support within their own homes and local communities. For individuals who may experience barriers related to transport, income, mobility or social isolation, receiving care closer to home can improve access, reduce disruption and strengthen connections with local support networks. Earlier intervention and improved coordination between health, social care and third-sector partners will help ensure people receive timely, person-centred support while promoting independence and wellbeing. The model also creates opportunities to strengthen inclusion through community outreach, digital inclusion initiatives, transport support, flexible visiting arrangements and targeted monitoring of access and outcomes. By shifting more services into local communities, the model aims to make care more accessible and responsive for those who may previously have found it difficult to engage with services. Overall, the proposal is expected to have a positive impact on reducing social exclusion. By increasing access to integrated community services, reducing the need	4	1	4

	for hospital attendance and providing more support closer to home, the model will help create a more equitable, inclusive and accessible health and care system for communities across Powys. Therefore, based on the impact to the people who are socially excluded, the risk assessment score shows that the impact to the is likely to occur (4) and the impact is negligible (1), with an overall risk score of 4.			
Carers	Unpaid carers play a vital role in supporting wellbeing, recovery, independence and the delivery of care across Powys. With one of the highest proportions of unpaid carers in Wales, it is essential that services are designed in ways that support carers to remain involved while reducing avoidable pressures on individuals and families. The proposed model strengthens community-based care through the expansion of Hospital at Home, reablement, crisis response, intermediate care and integrated mental health support. By providing more care closer to home, the model is expected to benefit a large number of carers by reducing unnecessary hospital admissions, supporting earlier discharge and enabling people to remain independent within their own communities for longer. This can help carers stay actively involved in care, reduce disruption to family life and improve the overall experience of both carers and those they support. For many carers, enhanced community services will reduce the need for frequent hospital visits and enable care to be delivered in more familiar and accessible settings. Improved coordination across health, social care and third-sector services will also help carers navigate the system more easily and access support at the right time. It is recognised that some carers, particularly those who currently access services locally, may experience changes when inpatient care is required. However, the overall model is designed to reduce reliance on inpatient care and increase the availability of support within local communities, meaning that many carers are likely to have fewer occasions where hospital attendance is needed. This will specifically assist where care is required to be delivered when at home.	4	2	8

	Additional support through transport assistance, flexible and virtual visiting arrangements, improved care coordination and dedicated carer services will help maximise carer involvement and access to support. Overall, the proposal is expected to have a positive impact on unpaid carers by strengthening community provision, supporting independence and enabling more care to be delivered closer to home. This will help improve outcomes for carers and those they support while creating a more sustainable and person-centred model of care across Powys. Therefore, based on the impact to unpaid carers the risk assessment score shows that the impact to them is likely to occur (4) and the impact is minor (2), with an overall risk score of 8.			

Section C.2 Deep Dive Impact Assessment - Equality

Where agreed, you should copy and complete this table for every adverse equality impact score of 9 or more (yellow, amber and red impacts). This will form part of a full Equality Impact Assessment in line with Health Board policy CGP009 Equality Impact Assessment Policy. The level of detail should be proportionate to the impact and likelihood.

No impact reached the threshold for a Deep Dive Impact Assessment

Integrated Impact Assessment

SL IPDO_008 (Do maximum): There would be more support to help people stay and recover at home, and closer working between mental and physical health. The total number of hospital beds in Powys will reduce to approximately 60, across fewer places to improve the quality of care.

Summary of Proposal:

- Community Services would be boosted by an increase in: Key enhancements include a 2-hour Urgent Community Response service, Hospital at Home capability, enhanced end-of-life care, Discharge to Recover and Assess pathways, home-based rehabilitation and reablement, access to intermediate care beds, and a single point of access. Together, these services improve access, reduce unnecessary hospital admissions, support faster discharge, and deliver integrated, person-centred care across health, social care, and voluntary sector partners.
- Inpatient wards that would close are at: Ystradgynlais, Bronllys, Llandrindod Wells, Llanidloes Wells, Machynlleth, and Welshpool.
- Inpatient wards that would stay open are located at: Newtown and Brecon.
- Bed numbers reduce from between 140-170 beds, to approximately 60 beds.
- Current Health and Wellbeing Centres in Machynlleth and Llandrindod would remain.

A.3. Integrated Impact Assessment Summary			Risk of Adverse Impact		
			Likelihood	Impact	Score
3.1 Quality	**Headlines**	**Quality – Summary Headlines** • The case for change is to create a sustainable, community-focused model of care, with inpatient changes supporting a better balance between hospital and community services. • Consolidating inpatient services into fewer centres aims to improve clinical sustainability, workforce resilience and integrated care. • Enhanced community services, prevention and closer physical and mental health integration are expected to improve patient outcomes. • Key risks include reduced inpatient capacity, increased travel distances and dependency on community services being fully established. • Access and equity remain important concerns, particularly for rural communities and Mid Powys. • Implementation and workforce transition will require careful management to maintain service quality and continuity. **Overall:** The model has the potential to improve quality and sustainability but depends on successful community investment, workforce capacity and effective implementation.	4	2	8
	Full QIA required?	**Yes, due to the complexity of the proposal.**			
3.2 Equality	**Headlines**	**Equality – Summary Headlines** • The case for change is to create a sustainable, community-focused model that provides more care closer to home and supports long-term population needs. • The main equality impact is increased travel and reduced access to local inpatient services, particularly for rural communities. • Older people and carers are most affected due to potential impacts on travel, visiting and access to support. • Moderate impacts have been identified for people with disabilities, Welsh speakers, those experiencing socio-economic disadvantage and socially excluded groups.	4	2	8

		• Minimal or no adverse impacts have been identified for race, religion, sexual orientation, gender reassignment, pregnancy and maternity, or marriage and civil partnership. • The model offers positive equality benefits through expanded community services, home-based care and improved mental health integration. • Key risks relate to rurality, transport, access and digital exclusion. • Targeted mitigation, ongoing monitoring and continued investment in community services will be essential to prevent widening inequalities. **Overall:** Equality impacts are manageable with appropriate mitigation, but successful delivery depends on maintaining access, reducing travel barriers and strengthening community support.			
	Full EQIA required	**Yes, due to the complexity of the proposal.**			
3.3 Legal / Statutory		The proposal supports statutory duties, equality requirements and Welsh Language Standards. Key risks relate to access, travel and Welsh language provision, requiring ongoing mitigation and monitoring.	4	1	4
3.4 Strategic Alignment and Health Outcomes		The proposal aligns with prevention, integration, care closer to home and service sustainability. Benefits depend on community services being fully established before implementation.	4	1	4
3.5 Market and Partnerships		Successful delivery depends on strong partnerships with social care, voluntary organisations and care providers. Community and domiciliary care capacity will be critical. The model shifts activity from hospital to community services rather than removing it. Overall impact is likely to be neutral to positive across Powys, with localised impacts in affected communities.	2	1	2
3.6 Operational Deliverability		Delivery is achievable but depends on workforce transition, community capacity, careful phasing and effective programme management to maintain service continuity.	4	1	4

3.7 Ethics, Reputation and Social Responsibility	Loss of local services may affect public confidence. Maintaining trust will require transparent engagement, equitable access and evidence of improved outcomes.	2	1	2
3.8 Workforce	The model supports workforce sustainability through larger integrated teams and reduced reliance on temporary staffing. Success depends on recruitment, training and staff support.	4	1	4
3.9 Summary of Mitigations	Key mitigations include expanded community services, transport support, carer assistance, Welsh language provision, digital inclusion and phased implementation with ongoing monitoring.	4	1	4

SL IPDO_008 (Do maximum)

Section B.1 Summary Impact Assessment - Quality

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Standard is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in Explanatory Notes. A "deep dive" assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.1).

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Summary	This model delivers a significantly enhanced community-based model of care and provides a sustainable, person-centred approach to meeting the future health and care needs of Powys residents. The model prioritises prevention, early intervention, rehabilitation and integrated care, enabling more people to receive support closer to home and reducing avoidable admissions and unnecessary travel outside the county wherever clinically appropriate. To support this shift in care, inpatient services are consolidated onto two community hospital sites, with a greater emphasis placed on community capacity, outreach services and multidisciplinary care within local communities.	4	2	8

[1] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

	The proposed model is expected to improve consistency and coordination of services across Powys through stronger integration of physical and mental health services, enhanced community provision and improved access to specialist expertise. Concentrating inpatient services onto two sites may further strengthen workforce resilience, clinical sustainability and service coordination by bringing together larger teams and reducing service fragmentation. However, the reduction from three inpatient sites to two may result in increased travel requirements for some patients, carers and staff, making careful transition planning and mitigating actions particularly important. The model also supports the development of a more sustainable workforce through enhanced recruitment and retention opportunities, reduced professional isolation, greater access to training and development, and stronger opportunities for advanced clinical practice. While implementation will require significant investment in community services and careful management of change, the overall model is considered capable of delivering a more integrated, sustainable and community-focused health and care system for the population of Powys. **Benefits** • Strengthens the shift towards prevention, rehabilitation and care closer to home. • Enhances community-based services and multidisciplinary support across Powys. • Reduces reliance on hospital admissions and out-of-county provision where clinically appropriate. • Supports improved continuity of care through integrated physical and mental health services. • Creates larger and potentially more sustainable inpatient and multidisciplinary teams.			

	• Improves opportunities for workforce recruitment, retention, development and specialist practice. • Makes more effective use of available workforce, facilities and clinical expertise. • Supports better integration between health, social care, third sector and community services. • Promotes greater consistency of service delivery and clinical standards across Powys. • Improves patient experience by enabling more care to be provided within local communities. • Supports long-term organisational sustainability through a stronger community-focused care model. **Challenges and Considerations** • Consolidating inpatient services onto two sites may increase travel times for some patients, families, carers and staff. • Some communities may perceive a greater reduction in local access to inpatient services compared to models with three inpatient sites. • Successful implementation depends upon significant enhancement of community services and support systems. • Workforce transition will require careful planning to manage changes in roles, locations and ways of working. • Additional investment may be required to build community capacity before the full benefits of the model can be realised. • Maintaining public confidence will require clear communication, engagement and demonstration of community service improvements. • There may be temporary operational pressures during the transition period as services adapt to new pathways and arrangements. • Robust monitoring will be required to ensure patient experience, quality and outcomes are maintained throughout implementation.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	• The anticipated benefits are dependent upon effective partnership working and the successful delivery of the enhanced community model.			
Safe	The model has the potential to improve safety through stronger multidisciplinary working, enhanced integration of physical and mental healthcare, and the concentration of inpatient services onto two sites supported by larger clinical teams. The combination of enhanced community services and more resilient inpatient provision may improve access to specialist expertise, strengthen clinical oversight and support greater continuity of care. However, the reduction to two inpatient sites represents a more significant service change and places greater importance on ensuring safe patient transfers, effective community support and robust clinical pathways. Careful implementation, workforce planning and ongoing monitoring will be essential to ensure patient safety is maintained throughout the transition and that the benefits of the new model are fully realised. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), however the impact of transition has been considered minor (2), impact giving an overall score of 8.	4	2	8

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Timely	The model aims to improve timely access to care by investing in enhanced community services, prevention and integrated care pathways. Providing more services closer to home should reduce delays in accessing support and decrease reliance on out-of-county services. The concentration of in-patient services onto two sites may also support more efficient use of staff and resources. However, achieving these improvements will depend on ensuring sufficient community capacity is established and that any additional travel associated with fewer inpatient sites does not create barriers to access. A carefully managed transition will be required to avoid disruption and maintain service responsiveness. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Effective	The model is expected to improve effectiveness through enhanced community provision, improved integration of services and stronger multidisciplinary working. The development of larger teams across both community and inpatient settings may strengthen coordination, improve clinical decision-making and support more consistent standards of care.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Delivering more care within local communities has the potential to improve outcomes and support more personalised care pathways. However, effectiveness will depend upon successful implementation of the enhanced community model and ensuring services have sufficient capacity and capability to meet changing demand patterns. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Efficient	The model may improve efficiency through greater service integration, reduced duplication and improved use of workforce and clinical resources. Consolidating inpatient services onto two sites may create opportunities for improved staffing resilience, more effective deployment of specialist skills and better utilisation of facilities. At the same time, efficiencies will need to be balanced against the challenges associated with transitioning services and ensuring enhanced community provision is available to support the shift in care. Some efficiencies may take time to realise and will require ongoing investment and careful implementation. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Equitable	The model seeks to improve equity by increasing access to community-based services throughout Powys and reducing dependence on services outside the county. Enhanced local support may particularly benefit rural communities by bringing more services closer to where people live. However, the concentration of inpatient services onto two sites may increase travel requirements for some populations and may be perceived as creating unequal impacts across different geographical areas. Effective mitigation, transport considerations and equitable deployment of community services will be important to ensuring that benefits are experienced consistently across Powys. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4
Person-Centred	The model promotes person-centred care by supporting greater independence, earlier intervention and access to care within local communities. Enhanced community services may improve continuity of care and better align support around individual needs. However, for some patients and carers, the concentration of inpatient services onto two sites may raise concerns regarding accessibility and travel.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Ensuring ongoing engagement with patients, families and communities throughout implementation will be critical to maintaining a person-centred approach and ensuring services continue to reflect local needs and preferences. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
Workforce	The model is expected to strengthen workforce sustainability by creating larger and more resilient teams across both inpatient and community settings. Concentrating inpatient services onto two sites may reduce professional isolation, provide greater opportunities for specialist practice, and support recruitment and retention. However, the scale of change may require significant workforce adaptation, including changes to working arrangements, team structures and service locations.	4	1	4

[2] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Effective workforce engagement, support and development will be essential to successfully implement the model and maintain morale during the transition. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Leadership	The model provides a clear strategic direction focused on sustainability, community-based care and integrated service delivery. Consolidation onto two inpatient sites may support stronger operational coordination and workforce planning while enhancing opportunities for clinical leadership. However, successful implementation will require visible leadership, effective governance and consistent engagement with stakeholders to manage the increased complexity associated with delivering significant service transformation. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Culture	The model supports a collaborative culture centred on integration, prevention and person-centred care. Larger teams and stronger links between community and inpatient services may encourage innovation, shared learning and greater collective responsibility for outcomes. However, cultural change of this scale requires time and ongoing support, particularly where services, teams and locations are changing. Effective communication and staff engagement will be important in supporting the transition and embedding new ways of working. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), however the impact of transition has been considered a minor (2) impact, giving an overall score of 8.	4	2	8
Information	Clear communication, performance monitoring and effective use of information will be essential to supporting implementation of the model. Enhanced use of data can support service planning, monitor outcomes and help demonstrate the benefits of the enhanced community approach.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Given the greater concentration of inpatient services, transparent communication with communities will be particularly important to explain the rationale for change and maintain confidence. Robust engagement and communication arrangements will therefore be critical throughout implementation. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.			
Learning, Improvement and Research	The model creates opportunities for learning, research and continuous improvement through larger teams, stronger service integration and expanded multidisciplinary working. Consolidated inpatient services may support greater access to mentorship, supervision and specialist expertise, whilst enhanced community teams may broaden opportunities for innovation and service development. These benefits will depend on ongoing investment in workforce capability and ensuring that learning and development remain priorities throughout the implementation process. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Whole Systems Approach	The model supports a more integrated whole-system approach by strengthening collaboration between health, social care, third sector and community partners. The enhanced community model forms a key element of delivering sustainable care closer to home and reducing dependence on inpatient and out-of-county services. While consolidation onto two inpatient sites may create opportunities for stronger clinical sustainability and service co-ordination, the success of the model will depend upon effective partnership working and shared commitment across the system. Careful implementation and ongoing collaboration will be essential to ensure the intended benefits are achieved. It is likely that a person will be in contact with the service giving a likelihood of 4, but due to the change in the model to support care closer to home with an enhanced community offer then the impact is expected to be negligible (1), giving an overall score of 4.	4	1	4

Section C.1 Deep Dive Impact Assessment - Quality
Copy and complete this table for every adverse quality impact score of 9 or more (amber and red impacts).

No area reached the threshold requiring a deep dive impact assessment.

Equality Impact Assessment SL IPDO_008: Do maximum:

This Equality Impact Assessment was undertaken to evaluate the potential effects on individuals and groups with protected characteristics under the Equality Act 2010, of the draft proposals being developed in relation to three key service areas as part of the Stage 2 Better Together programme.

The assessment drew on a range of evidence which utilised the data in the revised Full Case for Change and the feedback given from the engagement conducted to date. This is set out in the comprehensive Stage 0 – Stage 2 Better Together feedback report alongside additional feedback captured by services using patient feedback mechanisms e.g. Civica surveys and patient focus groups, during the past 18 months.

Engagement for the Better Together programme was carried out with PTHB employees, residents, third sector representatives, public sector colleagues and service users including representatives from equality groups. Surveys, focus groups and targeted outreach took place in communities to ensure a broad mix of views were captured.

The views given by all stakeholders were analysed and fed back to the programme team. Further analysis then took place to identify differential impacts across protected characteristics, with particular attention to areas of potential disadvantage. Where negative impacts were identified, some mitigation actions have been included either as ideas proposed by stakeholders or as additional options to reduce or eliminate these effects.

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Characteristic is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in the Explanatory Notes. A deep dive assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.2). This should be undertaken in line with CGP009 using the template in Section C.2.

Characteristic	Potential Impacts	Risk of Adverse Impact[3]			
		Likelihood		Impact	Score
Summary	**Equality Impact Assessment – Summary** This assessment considers the proposed development of a new model of care that brings together enhanced community services, Hospital at Home, reablement, rehabilitation, integrated mental health support and modern inpatient care delivered from centres in Newtown and Brecon. At the heart of the proposal is a commitment to delivering more care closer to home, enabling people to access the support they need within their own communities and reducing unnecessary reliance on hospital admission. The model represents a significant investment in community-based care, creating greater opportunities for prevention, early intervention, recovery and independence. Through expanded multidisciplinary teams and stronger integration across health, social care and third-sector partners, patients will benefit from more coordinated, responsive and person-centred care. The enhanced community model is expected to deliver substantial benefits for residents across Powys. Older people, carers, people with disabilities, Welsh speakers and those experiencing social or economic challenges are all expected to benefit from improved access to support within their communities, helping people remain well, maintain independence and receive care in familiar surroundings. By increasing the availability of services such as Hospital at Home, rapid response, rehabilitation and intermediate care, more people will be able to access high-quality care without the disruption that can be associated with a hospital stay. The model also strengthens clinical sustainability by supporting workforce resilience, enhancing access to diagnostics and specialist support, improving care quality and creating a more integrated approach to physical and mental health care.	4	2	8	

[3] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

Modern facilities and closer multidisciplinary working will help ensure services remain safe, effective and sustainable for future generations.

Overall, the assessment concludes that the proposal presents a significant opportunity to improve health and wellbeing outcomes across Powys. By expanding community services, supporting independence and delivering more care closer to home, the model provides a strong foundation for a more accessible, integrated, resilient and person-centred health and care system that will benefit communities across the county for years to come.

Summary Table

Characteristic	**Likelihood**	**Impact**	**Score**
Age	4	2	8
Disability	4	2	8
Gender Reassign-ment	4	1	4
Marriage and Civil Partnership	4	1	4
Pregnancy and Ma-ternity	4	1	4
Race	4	1	4
Religion or Belief	4	1	4
Gender	4	1	4
Sexual Orientation	4	1	4
Welsh Language	4	2	8
Socio-Economic Circumstances	4	2	8
Social Exclusion	4	2	8
Carers	4	2	8

4	2	4

Age	Powys has a significantly older population than Wales and the UK, with around 28% of residents aged 65 and over. As people age, maintaining independence, managing long-term conditions effectively and accessing timely care close to home become increasingly important. For many older people living in rural communities, travelling to healthcare services can be challenging due to mobility, transport and accessibility considerations. The proposed model has been designed to respond to these demographic needs by significantly expanding community-based services, including Hospital at Home, reablement, rapid response, rehabilitation and integrated physical and mental health support. This enhanced community approach will enable substantially more care to be delivered within people's homes and local communities, reducing reliance on inpatient admission and ensuring support is available closer to where people live. The greatest benefit of the model is expected to be felt by the wider older population who use health and care services on a regular basis but do not require inpatient care. Earlier intervention, improved care coordination and stronger multidisciplinary working will help people access services more quickly, prevent deterioration, avoid unnecessary hospital admissions and support recovery within familiar surroundings. This approach aligns with the preferences of many older people, who wish to remain independent and receive care as close to home as possible. While inpatient services will be provided from centres in Newtown and Brecon, only a relatively small proportion of the older population require inpatient care at any one time. In contrast, enhanced community services have the potential to benefit thousands of older residents by reducing the need to travel for treatment, bringing services closer to communities and improving access to ongoing care and support. Overall, the proposal is expected to have a strongly positive impact on older people. By expanding community services, reducing dependence on hospital care and enabling more people to receive support locally, the model will improve access, promote independence and better meet the	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	needs of Powys' growing older population while delivering more person-centred care closer to home. The proposed model delivers clear improvements in service quality, integration, and sustainability. The primary residual risk relates to access, particularly travel and visiting. Therefore, based on the impact to older people, the risk is likely to occur (4) and the impact is minor (2), with an overall risk score of 8. Continued focus on transport solutions, community provision, and maintaining access to family and carer support will be essential to ensure that the benefits of the model are realised equitably across all communities.			

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Disability	The proposal has been assessed against the Health Board's Strategic Equality Plan and its commitment to improving access, inclusion and outcomes for people with disabilities. Central to the model is a significant expansion of community-based services, enabling more people to receive care, treatment and support closer to home and within their own communities. Enhanced services, including Hospital at Home, rapid response, reablement, rehabilitation and integrated multidisciplinary care, will help reduce reliance on hospital admission and ensure that support can be provided in the most appropriate setting for individual needs. For many people with disabilities, this represents a substantial improvement in access to care, reducing the need to travel and enabling services to be delivered in familiar environments that promote comfort, independence and wellbeing. People with physical, sensory, cognitive, learning disability and neurodiverse needs are expected to benefit from more personalised and coordinated support, improved continuity of care and stronger involvement of families and carers.	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	Receiving care closer to home can help reduce anxiety, improve communication and enable a more tailored approach that reflects individual circumstances and preferences. The model also strengthens integration across health, social care and third-sector services, helping people access the right support at the right time. When inpatient care is required, services will be delivered from modern centres designed to provide high-quality, accessible environments that better meet a wide range of physical, sensory and cognitive needs. These facilities will also support more sustainable staffing, greater access to specialist expertise and improved overall patient experience. Additional support through reasonable adjustments, transport assistance, digital inclusion initiatives, workforce development and carer involvement will further enhance accessibility across the system. Overall, the proposal is expected to have a strongly positive impact on people with disabilities. By expanding community services, reducing unnecessary hospital attendance and increasing access to coordinated care closer to home, the model will improve independence, accessibility, inclusion and health outcomes for a much larger number of people across Powys. Therefore, based on the impact to the people who have a disability the risk is likely to occur (4) and the impact is minor (2), with an overall risk score of 8.	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Gender Reassignment	The proposal has been assessed against the Health Board's Strategic Equality Plan. It supports inclusive care and modern facilities that meet the needs of all patients. No specific adverse impacts have been identified for people undergoing gender reassignment. Improved facilities and enhanced local services may provide an overall benefit through better access to care closer to home. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Marriage and Civil Partnership	The proposal does not introduce any changes that specifically affect people who are married or in a civil partnership. Existing policies, rights and support arrangements remain in place, with any benefits arising from overall improvements in service quality and delivery. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Pregnancy and Maternity	No specific impacts have been identified for people who are pregnant or receiving maternity-related care. Existing pathways and protections remain unchanged, and the proposal is expected to have a neutral or slightly positive effect through overall service improvements. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Race	The proposal does not directly affect people from different racial or ethnic backgrounds. Existing equality duties and inclusive practices will continue to apply. While workforce changes should be monitored to ensure support for internationally recruited staff, no adverse impacts on patients have been identified. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Religion or Belief	The proposal does not affect the Health Board's ability to meet religious or spiritual needs. Existing arrangements for prayer, worship and faith-based support will remain available. No specific impacts have been identified. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Gender	The proposal does not introduce any changes that disproportionately affect people based on gender. Existing equality protections and inclusive service arrangements remain in place. No specific adverse impacts have been identified. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4
Sexual Orientation	The proposal does not affect existing arrangements supporting lesbian, gay, bisexual and other sexual orientation groups. Inclusive policies and equality protections remain unchanged, and no specific adverse impacts have been identified. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, but with a negligible (1) impact and an overall score of 4.	4	1	4

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Welsh Language	The Welsh language is an important part of Powys' cultural identity and community life. According to the 2021 Census, 16% of residents speak Welsh, with particularly strong Welsh-speaking communities in areas such as Machynlleth, Ystradgynlais, Llanfyllin and Llanfair Caereinion. With Welsh language use expected to continue growing, particularly among younger generations, the proposed model provides an important opportunity to strengthen Welsh language provision across health and care services. A key feature of the model is the expansion of community-based services including Hospital at Home, rapid response services, Health and Wellbeing Hubs, reablement, and integrated multidisciplinary care. By delivering more services within people's homes and local communities, the model creates greater opportunities for patients to receive care in their preferred language and within familiar community settings. As many more people access community services than inpatient care, the potential reach of Welsh language provision is significantly increased.	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	The Health Board remains committed to its obligations under the Welsh Language (Wales) Measure 2011 and Welsh Language Standards, ensuring that the Welsh language is treated no less favourably than the English language, and that the Active Offer remains central to service delivery. Through its Welsh in Healthcare Strategy, the Health Board continues to strengthen Welsh language workforce planning, recruitment, training, bilingual communications and translation services across all care settings. The enhanced community model also supports stronger relationships between patients, staff and local communities, creating more opportunities for meaningful Welsh language interactions as part of everyday care. By embedding Welsh language considerations throughout service redesign, the model seeks to enhance both accessibility and cultural responsiveness. Overall, the proposal is expected to have a positive impact on Welsh language provision. By increasing the delivery of care within local communities, expanding community services and strengthening Welsh language capacity across the workforce, the model creates significant opportunities to increase the use of Welsh in healthcare and improve the experience of Welsh-speaking patients across Powys. It is likely (4) that this group will be in contact with the model and therefore impacted by this in some way, and the impact is minor (2) with an overall risk score of 8.	4	2	8

Socio-Economic Circumstances	People experiencing socio-economic disadvantage in Powys may face challenges associated with lower incomes, rural isolation, limited transport options and digital exclusion. Due to the dispersed nature of communities across the county, ensuring equitable access to services requires approaches that bring care closer to where people live. The proposed model has been designed with this objective at its core, creating opportunities to improve access, reduce barriers and strengthen support within local communities. A key strength of the model is the significant expansion of community-based services, including Hospital at Home, reablement, crisis intervention, integrated mental health support and multidisciplinary community care. By delivering more services within people's homes and local areas, the model will reduce reliance on hospital attendance and enable many individuals to access care more easily, without the time, cost and disruption often associated with travelling to hospital appointments or inpatient stays. For people experiencing socio-economic disadvantage, earlier intervention, improved care coordination and enhanced community support can help address barriers to accessing healthcare, improve outcomes and promote independence. The model also strengthens partnership working between health, social care and third-sector organisations, creating a more joined-up system that is better able to respond to the wider factors affecting health and wellbeing. Supporting measures including community outreach, digital inclusion initiatives, transport assistance and targeted support for vulnerable groups, will further enhance access and help ensure that services reach those who need them most. By providing more care locally, the model aims to reduce inequalities and improve opportunities for people to receive timely and appropriate support within their own communities. Overall, the proposal is expected to have a positive impact on people experiencing socio-economic disadvantage. Through enhanced community	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	services, reduced reliance on hospital-based care and improved local access to support, the model has the potential to improve health outcomes, strengthen independence and create a more equitable and accessible health and care system across Powys. Overall, the impact on individuals experiencing socio-economic disadvantage is assessed as positive and likely to be realised across a large proportion of the population, with enhanced community provision helping to reduce barriers to care and improve access to support closer to home. The overall assessment is therefore one of opportunity, reflecting the significant benefits that the model offers in improving equity, accessibility and health outcomes across communities in Powys. It is likely (4) that this group will be in contact with the model and the impact is minor (2) with an overall risk score of 8.			

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Social Exclusion	Social exclusion can arise from poverty, low income, rural isolation, limited access to services, digital exclusion and language barriers. In Powys, these challenges are often influenced by the county's rural geography and dispersed population, highlighting the importance of delivering services as close to communities as possible. A key strength of the proposed model is the significant expansion of community-based services, including Hospital at Home, reablement, crisis response and integrated mental health support. By providing more care within people's homes and local communities, the model will reduce reliance on hospital attendance and make services more accessible for many people who may previously have experienced barriers to accessing care. This approach supports earlier intervention, promotes independence and helps people remain connected to their families, support networks and local communities. The model also creates opportunities to strengthen inclusion through improved care coordination, community outreach, digital inclusion initiatives, and targeted support for vulnerable groups. By reducing the need to travel and increasing the availability of local services, although there will be two main centres, more people will be able to access timely, person-centred care in familiar surroundings. Overall, the proposal is expected to have a positive impact on social inclusion by improving access to support, strengthening community-based provision and enabling more people to receive care closer to home. This will help create a more equitable, connected and inclusive health and care system across Powys. It is likely (4) this group will be in contact with the model and the impact is minor (2), with an overall risk score of 8.	4	2	8

Carers	Unpaid carers are at the heart of health and care provision in Powys, playing a vital role in supporting wellbeing, recovery, independence and quality of life. With one of the highest proportions of unpaid carers in Wales, it is essential that services are designed to support carers as partners in care while helping to reduce the pressures they often experience. A key strength of the proposed model is the significant expansion of community-based services including Hospital at Home, reablement, crisis response, integrated mental health support, and multidisciplinary community teams. By enabling more people to receive care closer to home, the model is expected to reduce unnecessary hospital admissions and shorten hospital stays, allowing carers to remain actively involved in supporting their loved ones within familiar surroundings and established support networks. For many carers, this represents a substantial improvement in how care is delivered. Reduced reliance on inpatient services means less disruption to family life, greater involvement in decision-making and care planning, and stronger support for maintaining independence at home. This is key when considering the increase in care that is to be delivered at home. The model also recognises that carers have their own health and wellbeing needs, and enhanced community services will provide more coordinated and responsive support that benefits both carers and those they care for. Improved integration across health, social care and third-sector services, together with strengthened carer support, flexible visiting arrangements, virtual contact options, and coordinated care planning, will help ensure carers remain connected, informed and supported throughout the care journey. Overall, the proposal is expected to have a strongly positive impact on unpaid carers. By delivering more care closer to home, strengthening community support and promoting independence, the model will benefit	4	2	8

Characteristic	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	a far greater number of carers across Powys, improving wellbeing, reducing pressures on families and creating a more person-centred and sustainable approach to care. It is likely (4) this group will be in contact with the model and the impact is minor (2), with an overall risk score of 8.			

Section C.2 Deep Dive Impact Assessment - Equality

Where agreed, you should copy and complete this table for every adverse equality impact score of 9 or more (yellow, amber and red impacts). This will form part of a full Equality Impact Assessment in line with Health Board policy CGP009 Equality Impact Assessment Policy. The level of detail should be proportionate to the impact and likelihood.

No impact reached the threshold for a Deep Dive Impact Assessment

PTHB Service Change Impact Assessment Urgent Care 07/08/2026 Version 1.0 Approved for inclusion in PCBC

Live Document Subject to Change

Version Control (To be updated after formal final approval)

Version	Date	Author	Comments
Version 1 for PCBC	7. 8. 2026	Assistant Director of Improvement and Innovation / Quality Improvement Facilitator	Agreed for inclusion in PCBC

DOCUMENT NEEDS TO BE REFERENCED TO LATEST TECHNICAL DATA IN APPENDICIES OF MASTER DOCUMENT

This Integrated Impact Assessment has drawn a number of references and documents listed and documents in the Bibliography. The significant technical documents reviewed to develop this impact assessment are held in the Step Report and Pre-Consultation Business Case. As the programme develops and new information is made available then this impact assessment will be updated.

The process used to calculate risk and copies of the risk matrix are detailed on Page 57

Section A: Overview Summary of the Proposed Changes
(See full Step Change Document and Primary Business Case for full details)

A.1. Proposal Details	
1.1 Name of Proposal	Better Together: Future models for Urgent Care in Powys
1.2 Proposal Lead	Urgent & Emergency Care Clinical Transformation Lead
1.3 Reference Number	n/a
1.4 Summary of Proposal	To develop a more sustainable, resilient and clinically capable urgent care model for Powys that can respond to increasing demand, workforce challenges, and variations in service provision. To facilitate this transformation, changes to the current urgent care model are required and two options have been shortlisted for consideration. Option UCDO_013 aims to establish fewer, more capable urgent care sites with enhanced diagnostics, stronger clinical leadership, improved workforce resilience, and closer integration with primary care, ambulance services, urgent community response and wider community services, while retaining a broader geographic footprint. And; Option UCDO_013ii aims to further consolidate urgent care services into fewer sites, maximising workforce resilience, operational efficiency and clinical sustainability through a greater level of service concentration. The enhanced urgent care model with a reduced number of more capable sites aims to improve patient safety, consistency of service provision, workforce sustainability, access to diagnostics, clinical quality and integration between services across Powys.
1.5 Date / Version	**07.08.2026 v 1.0 Approved for inclusion in PCBC**

Interdependencies	These proposals extend beyond changes to PTHB inpatient beds alone and depend on coordinated change across the wider health and care system. Key links have been identified with primary care, community services, adult social care, acute SLA providers, mental health services, therapies, diagnostics, the third sector and Flow Hub / Single Point of Access (SPOA) arrangements. These interdependencies are being managed through phased pathway design, stakeholder engagement and programme governance. In practice, this means that any proposed changes to beds are being developed alongside improvements in intermediate care, urgent community response, Hospital at Home, discharge-to-assess, and more integrated physical and mental health models, so that primary, secondary, community and social care services can work together as a more coordinated pathway of care. These include: ▪ Intermediate Care Team ▪ Specialist services ▪ Adult Social Care ▪ Flow Hub/SPOA ▪ Primary Care ▪ Third Sector ▪ Hospice partners ▪ Diagnostics ▪ Therapies ▪ Medical Devices/Community Equipment Store ▪ Non-Emergency patient transport services (NEPTS) ▪ Acute SLA Providers ▪ Mental Health Inpatient Model of Care ▪ Enhanced community team

A.2. Proposal Overview

2.1 Summary of Proposal

PTHB Provider Services only

Urgent Care options		Welshpool	Newtown	Machynlleth	Llandrindod	Brecon	Ystradgynlais	General Practice
001A	Do Previous (before any temporary service changes on 4 units)							
001B	Do Current (continue as now on 4 units, making temporary service changes permanent)							
001C	Do Minimum (make temporary service changes permanent and improve service on 3 units, close 1 unit)			×			×	
001Cii	Do Minimum in 2 units (make temporary service changes permanent and improve service on 2 units, close 2 units)			×			×	
001D	Do Current on 3 units (continue as now on 3 sites, making temporary service changes permanent, close 1 site)			×			×	
001Dii	Do Current in 2 units (continue as now in 2 units, making temporary service changes permanent, close 2 units)			×			×	
005	Close Minor Injury Units and provide urgent care in other ways (close 4 units)	×		×			×	
010	Do Mid-Range: Better local Urgent Care (3 x MIIUs in Powys, close 1 unit)			×			×	
010ii	Do Mid-Range on less sites (2 x MIIUs in Powys, close 2 units)			×			×	
013	Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys, close 1 unit)			×			×	
013ii	Do Maximum on less sites (2 x UCCs, close 2 units)			×			×	

The Welshpool Urgent Care Unit would close when the Newtown Urgent Care Unit becomes operational.

Key	
No change	
Temporary changes reversed	
Temporary changes become permanent	
Minor Injury Unit closed permanently	
Minor Injury Unit opens	
Minor Injury & Illness centre opened	
Urgent Care Centre opened	
More urgent care provided through local GP practices	
Changes to urgent care provided through local GP practices	
The new unit would replace the current unit at that site	
X-ray closes	×
X-ray stays & opening hours do not change	
X-ray stays & longer opening hours	
X-ray stays until new site is developed, then moves to new site	
Ultrasound	
Blood testing	
Point of Care testing	

An options appraisal has been undertaken on all the above options to assess future models for Urgent Care in Powys, building on the Case for Change and the non-financial and financial appraisals undertaken through the Better Together programme.

The appraisal considered each shortlisted option against key domains required for a Level 2 assessment, including:

- Service quality and deliverability
- Workforce sustainability
- Financial impact and affordability
- Estates feasibility
- Travel time and population access

Following the Recommended Options Workshop on 5 May 2026, two Urgent Care options were recommended to progress. These options are assessed below.

Options Recommended for Progression

The table below provides a summary of the key features of the two recommended urgent care options, setting out the main areas of continuity and change, alongside the associated workforce, financial, estates, access, benefit, risk and trade-off considerations.

- UCDO_013 (*Do Maximum: Even Better Local Urgent Care)(2 Urgent Care Centres and 1 Minor Injury and Illness Unit)*
- UCDO_013ii (*Do Maximum on Less Sites)(2 Urgent Care Centres)*

This summary provides the basis for the detailed assessment that follows, where the benefits, risks, dependencies, and trade-offs of each recommended option are considered in full.

Area	UCDO_013 (Do Maximum: Even Better Local Urgent Care)	UCDO_013ii (Do Maximum on Less Sites)
Overall description	2 Urgent Care Centres (UCCs) and 1 Minor Injury & Illness Unit (MIIU) delivering extended urgent care and diagnostics on three sites across Powys.	2 Urgent Care Centres (UCCs) delivering extended urgent care and diagnostics on two sites across Powys.
Key features	• 7/7 service 12hrs per day • Dedicated triage nurse • Senior clinical leadership • Advanced practitioners • X-ray available 7 days per week	• 7/7 service 12hrs per day • Dedicated triage nurse • Senior clinical leadership • Advanced practitioners • X-ray available 7 days per week

		• Same day blood testing • Enhanced Point of Care Testing • Collaborative working with urgent community response service	• Same day blood testing • Enhanced Point of Care Testing • Collaborative working with urgent community response service
	What stays the same	• Urgent care services continue to be delivered within Powys. • Hybrid (appointments/walk in) access pathways to services with a phone first approach encouraged. • NHS 111 will triage and signpost to Powys urgent care services. • General Medical Services, GP Out of Hours, Pharmacy, Optometry, Community and Ambulance services continue. Range of urgent illness and injury presentations remains supported.	• Urgent care services continue to be delivered within Powys. • Hybrid (appointments /walk in) access pathways to services with a phone first approach encouraged. • NHS 111 will triage and signpost to Powys urgent care services. • General Medical Services, GP Out of Hours, Pharmacy, Optometry, Community and Ambulance services continue. • Range of urgent illness and injury presentations remains supported.
	What changes	• Establishment of two UCCs with extended diagnostics and senior clinical decision makers. • Develop and expand scope of one MIU into an MIIU, enabling treatment for minor illnesses and injuries. • Closure of remaining MIU sites following transition. • More consistent urgent care offer across Powys.	• Establishment of two UCCs with extended diagnostics and senior clinical decision makers. • Closure of two MIU sites following transition. • Full concentration of diagnostics, workforce and leadership on two sites.
	Finance	• Overall, £144K increase in cost compared with current model. • Some ongoing investment required to sustain extended diagnostics. • Additional workforce and diagnostic investment partially offset by efficiency and repatriation savings.	• Lowest overall cost of recommended options. • Greatest opportunity for revenue savings. • Savings driven by maximum consolidation and reduced estate and staffing footprint.

		• Assumptions on repatriation and repatriation savings is subject to variation from the applied financial model.	• Higher risk of offsetting costs if access pressures increase.
	Workforce	• Improved workforce resilience compared to current model, provided the required staffing can be secured. • Reduced lone working and better clinical governance. • More sustainable rotas across three sites. • Reduced reliance on temporary staffing, provided the required staffing can be secured.	• Greatest potential to support workforce sustainability, provided the required staffing can be secured. • Most resilient rotas and leadership cover. • Lowest reliance on temporary staffing, provided the required staffing can be secured. • Greater workforce concentration and efficiency.
	Estates	• Use of three sites, limiting scale of estate closures. • Moderate capital investment required to upgrade UCC sites. • Retains some geographic spread of infrastructure.	• Significant reduction in urgent care estate footprint. • Greater rationalisation of sites. • Reduced long-term estate running costs. • Clear decisions required on closed sites.
	Travel time & access	• Travel times increase for some communities compared to current model. • Majority of population remains within agreed access thresholds. • Access impact partially mitigated by diagnostic capability and local MIIU.	• Greatest increase in travel times of recommended options. • Higher proportion of population outside preferred access range. • Greater reliance on digital and community mitigation.
	Key benefits	• Best balance of quality, access and sustainability. • Strong non-financial appraisal performance. • Consistent urgent care model across Powys. • More deliverable change profile.	• Maximum efficiency and long-term sustainability. • Simplified service model. • Lowest cost base and strongest workforce resilience.

Key risks	• Some local access reduction. • Requires careful transition and public engagement. • Financial benefits dependent on reduced out-of-county activity. • Reliant on North Powys capital investment for site transition.	• Highest access and equity risk. • Reputational and consultation risk due to scale of site closures. • Risk of demand concentration at remaining sites. • Reliant on North Powys capital investment for site transition.
Trade-offs	Improved quality and workforce resilience in exchange for fewer local sites, while maintaining geographic spread.	Maximum efficiency in exchange for reduced local access and higher delivery risk.
Level 2 view	Most balanced and deliverable recommended urgent care option for consultation and progression.	Viable but higher risk option; benefits dependent on strong mitigation and engagement.

Both recommended options seek to strengthen the urgent care offer in Powys by increasing clinical capability, improving access to diagnostics, reducing workforce fragility and supporting more patients to be assessed, treated and managed closer to home where clinically appropriate.

Under UCDO_013, urgent care would be provided through two Urgent Care Centres and one Minor Injury and Illness Unit. This option retains a broader geographic footprint while still improving consistency, diagnostics and workforce resilience. It provides a more balanced approach to service sustainability, access and deliverability.

Under UCDO_013ii, urgent care would be consolidated onto two Urgent Care Centres. This option offers the strongest opportunity for workforce concentration, financial efficiency and clinical consistency, but carries greater access and equity risks because provision would be delivered from fewer sites.

A key transitional feature of both options is the dependency between Welshpool and Newtown. The existing Welshpool urgent care provision would need to remain operational until replacement facilities at Newtown are available, unless an agreed and clinically safe interim arrangement is approved. This should be treated as a programme-level delivery risk and managed through the implementation, estates and capital planning process.

	Powys presents a distinct population health context shaped by its predominantly rural geography, dispersed communities and ageing demographic profile. The county has relatively low levels of overall deprivation compared to more urban areas in Wales; however, this can mask significant pockets of rural deprivation, where factors such as transport limitations, digital exclusion, fuel poverty and reduced access to services contribute to poorer health outcomes. These factors have a direct bearing on how urgent care services need to be planned and delivered. Powys also has one of the highest proportions of older adults in Wales, with increasing levels of frailty, multi-morbidity and complex care needs, placing growing demand on community-based and urgent care services. Its large geographical area and low population density creates challenges in service accessibility, workforce deployment and timely care delivery, often resulting in longer travel times and reliance on services out of county. The current urgent care model is under sustained pressure. Minor Injury Unit provision is affected by workforce fragility, lone working risk, temporary services changes, variable access to diagnostics and inconsistency in the service offer available to different communities. At the same time, demand is expected to become more complex as the population ages and more people live with frailty, multi-morbidity and urgent care needs that require timely assessment, diagnostics and multidisciplinary unput. Additionally, current minor injury service fragility impacts on access due to unplanned closures, lone working and workforce challenges, with a high-cost service that does not align with the Value-Based principles of prudent health care. Together, these factors underline the need for a population health approach in Powys that prioritises early intervention, prevention, and locally accessible multidisciplinary urgent care services to address inequalities and sustain healthcare provision in a highly rural setting that meets the needs of the local population. The recommended options therefore seek to move away from a dispersed minor injury model towards a more consistent and clinically capable urgent care model. Both options would provide enhanced urgent care provision through Urgent Care Centres, supported by senior clinical decision-making, improved diagnostics, point-of-care testing, same-day blood testing and closer working with urgent community response and wider community services. UCDO_013 would provide two Urgent Care Centres and one Minor Injury and Illness Unit, retaining a broader geographic footprint while strengthening clinical capability and workforce resilience. UCDO_013ii would provide

two Urgent Care Centres only, offering the greatest workforce and financial efficiency but with greater access and travel implications for some communities.

The aim is to deliver a fully integrated, community-based urgent care system that:

- Offers timely access to urgent care practitioners who can assess, investigate, diagnose and treat people with acute conditions that are not life-threatening emergencies such as common acute illnesses and injuries.
- Prevents unnecessary conveyance and/or admissions to hospital whilst supporting older adults and people with long-term conditions to remain at home.
- Provides person-centred health, social care, and third sector services and support according to the person's needs, across organisations, in an integrated way.
- Maximises digital solutions to facilitate a prudent model of urgent care in a rural population, with a focus on assessment, prioritising, monitoring, expert clinical support and clinical governance.

Both options align with the shared long-term Health and Care Strategy for Powys 2017-2027 (extended to 2029), with the aim to help people in Powys to 'Start Well', 'Live Well' and 'Age Well' through a focus on well-being, early help and support, tackling the big four health challenges, and better joined up care.

The table below provides a high-level comparison of the two recommended Urgent Care options, setting out the key differences in service configuration and the main implications for finance, workforce, estates and travel time.

Option	Key Service Configuration	Finance	Workforce	Estates	Travel Time
UCDO_013	2 UCCs (Newtown, Brecon) + 1 MIIU (Llandrindod)	Highest cost of recommended options but marginal (£+0.14m vs current); improved cost per attendance.	Improved workforce resilience compared to current model, provided the required staffing can be secured.	Medium capital, feasible with phased investment.	Majority within 45 mins; some rural impacts mitigated.

UCDO_013ii	2 UCCs (New-town, Brecon)	Lowest cost and best fi-nancial efficiency (lowest attendance unit cost).	Greatest potential to support workforce resilience, provided the required staffing can be secured.	Medium capi-tal, fewer sites.	Greatest travel impact for Mid Powys.

Although the proposed three and two site options look to centralise services, which may have some impact on longer travel times, it has the key aim of enhancing the urgent care service offer to include increased diagnostics that align with opening times, an advanced and enhanced multiprofessional workforce and skill mix, and an urgent community response service that will reduce the need for onward travel out of the county.

Both proposals carry whole system interdependencies and interfaces. Key interfaces have been identified with Primary Care, Secondary care acute services, community services, social care, mental health services, therapies, diagnostics, third sector and Single Point of Access hub. Urgent care centres will have dependencies with and provide place based timely diagnostics and advanced skilled workforce, that will support the urgent community response, intermediate care, Hospital at home, and short stay assessment and treatment inpatient bed base.

In broad terms, UCDO_013 offers the stronger balance between access and geographic coverage and service resilience, whilst UCDO_013ii offers greater efficiency, affordability and workforce concentration, but with higher access and equity implications. Both options would improve the consistency and capability of urgent care provision but would also change the pattern of local access. This means that travel time, transport, equality and mitigation arrangement will need to be considered carefully as part of the detailed assessment and consultation process.

This summary provides the basis for the detailed assessment that follows, where the benefit, risks, dependencies and trade-off of each recommended option are considered in full.

2.2 Situation, Background, Strategic Context

Statutory and Legislative Drivers

1. **Well-being of Future Generations (Wales) Act 2015**
   Requires public bodies to improve the social, economic, environmental and cultural well-being of Wales through long-term, preventative, collaborative and integrated approaches. The urgent care proposals support sustainable service delivery, prevention, integration and prudent use of resources. [gov.wales], [legislation.gov.uk]
2. **Social Services and Well-being (Wales) Act 2014**
   Promotes person-centred care, prevention, wellbeing, independence and integrated working between

	health, social care and community services. The proposed model strengthens links between urgent care, community services and social care pathways. 3. **Health and Social Care (Quality and Engagement) (Wales) Act 2020** Introduced the NHS Wales Duty of Quality and Duty of Candour, requiring organisations to continuously improve service quality, safety, effectiveness and patient experience. The proposed urgent care model seeks to improve consistency, access and clinical capability across Powys. 4. **Equality Act 2010** Requires public bodies to eliminate discrimination, advance equality of opportunity and foster good relations. The assessment of urgent care options considers potential impacts on access, travel and health inequalities across Powys communities. 5. **The NHS (Wales) Act 2006** Places duties on NHS organisations to secure improvement in the physical and mental health of the population and the prevention, diagnosis and treatment of illness through sustainable service models. **Welsh Government and NHS Wales Policy** 1. **A Healthier Wales: Long Term Plan for Health and Social Care (2018)** Sets out the vision for a whole-system approach focused on prevention, early intervention, seamless services and care closer to home wherever possible. 2. **Six Goals for Urgent and Emergency Care (2021-2026)** Provides the national framework for delivering the right care, in the right place, first time. The urgent care proposals support improved access, alternatives to Emergency Departments, improved patient flow and better system integration. 3. **Integrated Community Care System (ICCS) for Wales** Promotes integrated models of care delivered through collaboration between primary care, community services, social care and the third sector, supporting people closer to home. 4. **NHS Wales Strategic Programme for Primary Care** Supports improved access to urgent and unscheduled care services through coordinated pathways, multidisciplinary teams and stronger community-based service provision. 5. **Value-Based Healthcare for Wales** Encourages investment in services that improve outcomes and patient experience, while making effective use of available resources. The proposed urgent care model aims to improve both clinical quality and efficiency.

	6. **Prudent Healthcare Principles** Supports equitable access, co-production, evidence-based care and the effective use of NHS resources, ensuring patients receive the most appropriate level of intervention. 7. **National Urgent Care Programme and Emerging Urgent Care Centre Framework** Welsh Government's Urgent Care Steering Group has identified the need for greater consistency, standardisation, diagnostic capability, clinical leadership and public understanding across urgent care services in Wales. The Powys proposals directly respond to these expectations.
	Background Powys Teaching Health Board faces significant challenges in maintaining the current urgent care model. Urgent care services are currently provided through a dispersed network of Minor Injury Units, primary care services and community-based provision across a large rural geography. While this model has provided local access for many years, it is increasingly challenged by workforce shortages, variation in service availability, limited diagnostic capability and rising demand. The current urgent care model in Powys is no longer sustainable in its present form. Demand for urgent care continues to increase as the population ages and more people live with frailty, multiple long-term conditions and complex health needs. Future population projections indicate significant growth in the older population, particularly those aged 75 years and over, creating increased demand for urgent assessment, diagnostics and treatment. Access to urgent care services currently varies across Powys. Different communities have access to different service models, opening hours and diagnostic facilities. This creates inequity in service provision and can lead to confusion for patients regarding where and when to access care. Diagnostic provision does not consistently support the current urgent care model. Access to services such as X-ray and same-day laboratory testing varies by location and time of day. Three of the four Minor Injury Units currently have no routine weekend access to X-ray services, limiting the ability to assess and manage patients locally and often resulting in onward referral or travel outside Powys. Workforce sustainability presents a significant challenge. Historically, Powys has experienced difficulty recruiting and retaining practitioners with the skills and competencies required to deliver urgent care services. Workforce shortages have contributed to temporary service changes, reduced opening hours, and challenges in maintaining resilient services across multiple sites.

	The dispersed nature of the current model also creates operational inefficiencies. Demand varies significantly between sites and across the week, making it difficult to align workforce resources with activity levels while maintaining safe and sustainable services. Maintaining multiple sites requires staffing levels that are not always proportionate to demand but are necessary for safe service operation. Many Powys residents continue to access urgent and emergency care outside the county. Patients are frequently conveyed by ambulance to Emergency Departments in neighbouring health board areas, sometimes because local urgent care services do not have the diagnostics, workforce or clinical capability required to manage their needs closer to home. This can result in longer travel times, delays in treatment, increased system costs and poorer patient experience. Temporary service changes implemented to improve operational resilience have demonstrated that the existing model is not capable of consistently providing a sustainable, equitable and clinically robust urgent care service across Powys. While these changes have helped maintain safe services, they do not provide a long-term solution. The Health Board has therefore developed options to move from a dispersed Minor Injury Unit model towards a smaller number of enhanced urgent care sites with improved diagnostics, stronger clinical leadership, greater workforce resilience and closer integration with primary care, community services, ambulance services and wider healthcare pathways. **Strategic Context** The proposed urgent care transformation forms part of the wider Better Together programme and supports the long-term vision for health and care services in Powys. It is not simply a change to Minor Injury Units, but part of a broader move towards more sustainable, integrated and clinically capable models of care. The proposals align with the Powys Health and Care Strategy and the vision of A Healthy, Caring Powys, which underpins both the Regional Partnership Board Area Plan and the Health Board's Integrated and Annual Plans. The proposed urgent care model is underpinned by several core principles: • **Person-centred care**, ensuring people receive the right care, at the right time and in the right place. • **Fair and equitable access**, reducing unwarranted variation in service availability across Powys. • **Integrated working**, strengthening links with primary care, community services, mental health, social care, ambulance services and acute providers.

	• **Evidence-based practice**, aligning services with national policy, clinical standards and emerging urgent care models. • **Enhanced diagnostics and clinical capability**, enabling more patients to be assessed and treated closer to home. • **Workforce sustainability**, creating resilient multidisciplinary teams capable of meeting future demand. • **Value-Based healthcare**, improving outcomes and patient experience while making effective use of available resources. • **Prudent healthcare**, ensuring services are designed around population need rather than historical configurations. The proposals also align with the national direction of travel for urgent care services in Wales. Through the National Urgent Care Steering Group, Welsh Government has recognised significant variation in urgent care provision across Wales and has established a set of delivery expectations for Urgent Care Centres. These include enhanced diagnostic capability, consistent opening hours, multidisciplinary staffing, senior clinical leadership, improved digital connectivity and clear public communication. Many of the challenges identified nationally are reflected within Powys, including workforce fragility, inconsistent access to diagnostics, service variation and confusion regarding urgent care pathways. The proposed options UCDO_013 and UCDO_013ii have been developed to address these issues and support a more consistent, resilient and sustainable urgent care service for current and future generations. Taken together, the local and national strategic context demonstrates why urgent care transformation is required in Powys and provides the foundation for assessing the potential impacts of the proposed service changes.
2.3 Assessment: Current Service Provision	**Current Service Position** Building on the strategic context outlined in Section 2.2, this section describes current urgent care provision in Powys and assesses whether the existing model can continue to provide a safe, consistent, resilient and sustainable service. Urgent care is currently delivered through four Minor Injury Units (MIUs) located at: • Welshpool • Llandrindod Wells • Brecon • Ystradgynlais

In addition, ten GP practices provide minor injury services under local agreements:

- Crickhowell
- Dyfi Valley
- Haygarth
- Knighton
- Llanfair Caereinion
- Llanfyllin
- Llanidloes
- Montgomery
- Newtown
- Rhayader

MIUs provide assessment and treatment for minor injuries only. Radiology is available during core weekday hours across all sites, with limited weekend provision currently available at Brecon. Outside these hours, patients requiring imaging generally attend neighbouring acute hospitals.

While the model has evolved over many years to improve local access to care, it is increasingly affected by workforce pressures, service variation and limited diagnostic capability. Temporary service changes introduced to maintain safe staffing have improved operational stability but indicate that the current model is not sustainable over the longer term.

The current position is characterised by four key challenges.

a. Workforce Constraints Affecting Service Sustainability

Recruitment and retention challenges continue to affect service resilience. Workforce shortages and lone-working risks have made it increasingly difficult to safely maintain extended opening hours across multiple sites.

Key issues

- Difficulties recruiting and retaining suitably skilled staff.
- Reliance on small teams across dispersed sites.
- Lone-working and clinical safety concerns.

Impact

- Reduced service resilience.
- Temporary overnight closures at Brecon, Llandrindod Wells and Welshpool.
- Increased pressure on remaining staff and services.

b. Staffing Model Does Not Align with Demand

Patient attendance varies considerably between sites, days and times of day. Activity levels are often low overnight and can fluctuate significantly, making it difficult to justify the staffing levels required to maintain a 24/7 service.

Key issues

- Low and variable out-of-hours demand.
- High staffing costs relative to activity.
- Lower patient throughput compared with national benchmarks.

Impact

- Inefficient use of workforce resources.
- High costs per attendance.
- Difficulty maintaining a sustainable service model.

c. Variation and Inequity Across Powys

Urgent care provision differs across Powys. In addition to the four MIUs, ten GP practices provide minor injury services under locally agreed arrangements, resulting in variation in service availability and access.

Key issues

- Different service offers across locations.
- No consistent countywide model.
- Variable opening hours and access arrangements.

Impact

- Inequitable access to care.
- Public confusion regarding where to attend.
- Inconsistent patient experience.

d. Limited Clinical Scope and Diagnostic Access

The current model is focused on minor injuries and does not provide the broader urgent care capability increasingly required by the Powys population.

Key issues

- MIUs are limited to treating minor injuries.
- Limited access to diagnostics, particularly outside weekday hours.
- Growing demand associated with frailty, long-term conditions and urgent illness.

Impact

- Patients travelling out of county for care that could potentially be provided locally.
- Increased reliance on neighbouring Emergency Departments.
- Delays, duplication and reduced opportunities for care closer to home.

Summary

Taken together, these challenges demonstrate that the current urgent care model is under increasing strain. Workforce fragility, variable service provision, limited diagnostics and an inefficient staffing model create risks to sustainability and equity. While temporary service changes have helped maintain safe services, they also highlight the need for a more resilient and clinically capable urgent care model for the future.

Sustainability and Safety Challenges

Before temporary overnight closures were introduced, the MIU model faced significant workforce, safety and sustainability challenges.

	Low and variable overnight activity meant some staff felt under-utilised, raising concerns about maintaining clinical skills and staff morale. At the same time, safe service delivery was difficult because of lone-working risks, particularly at more isolated sites. Measures such as CCTV and lone-working procedures helped reduce risk but did not eliminate the challenges associated with isolated working and unpredictable patient presentations. To support overnight services, additional bank staff were often required to reduce lone-working risks. However, demand was frequently too low to justify the staffing levels needed, creating an imbalance between activity, cost and service sustainability. Staff also experienced incidents of aggressive and threatening behaviour from members of the public. In 2024, three such incidents were recorded, including one physical assault. At Brecon, MIU staff were also required to support switchboard colleagues during some of these incidents, increasing pressure on an already stretched service. Since the introduction of temporary overnight closures, service reliability has improved, with no unplanned closures caused by staffing shortages. No further incidents associated with overnight lone working have been reported. Closing sites overnight has also improved staff safety by allowing buildings to remain secured and reducing the risk of unauthorised access. This has provided greater assurance for staff working within community hospitals and adjacent services. **MIU Activity and Utilisation** The following analysis describes MIU activity, utilisation and outcomes to provide an overview of current service performance and the effectiveness of the existing urgent care model. **Activity Trends** MIU activity has remained broadly consistent since 2021, with a notable increase in recorded attendances from June 2025. This increase is considered to be primarily attributable to improvements in data recording and governance, rather than a material change in underlying demand.

FY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2021/22	1210	1263	1748	1876	1564	1545	1353	1377	1221	1209	1098	1523	**16987**
2022/23	1571	1634	1781	1876	1851	1604	1690	1446	1300	1580	1503	1652	**19488**
2023/24	1553	1846	2167	2004	1901	1901	1855	1554	1485	1526	1428	1592	**20812**
2024/25	1729	2023	1780	1887	2008	1634	1832	1501	1537	1499	1487	1783	**20700**
2025/26	1815	2192	2189	2307	2271	2021	2042	1943	1860	1696	1704	2224	**24264**

Monthly MIU Activity 2021/22 – 2025/26

As data quality continues to improve, activity levels are expected to stabilise at a more accurate representation of service utilisation. However, it is not currently possible to determine the extent to which recorded activity includes patients who are triaged and signposted to other services. Further work is required to improve data capture to better understand patient pathways and appropriateness of attendance.

In addition to MIU provision, 10 GP practices within Powys are commissioned to deliver minor injury services, collectively treating 3,791 attendances during 2024/25.

Activity Type

ATTEND TYPE	Brecon	Llandrindod	Welshpool	Ystradgynlais	Total
⊞ NEW	4831	5068	3707	2787	**16393**
⊞ REATT	3464	2346	1369	692	**7871**
Total	**8295**	**7414**	**5076**	**3479**	**24264**

2025/26 MIU Activity by Attendance Type

Analysis of activity indicates that a significant proportion of attendances are reattendances, accounting for approximately 32.4% of total activity. Further analysis is required to fully understand the drivers of reattendance.

Initial findings from national scoping exercises and local reviews suggest that a proportion of this activity relates to wound care and dressing changes. This significant activity could be more appropriately delivered through alternative services across Powys.

Outcome following attendance

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 District General Hospitals accounted for 869 attendances (3.58%).

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

2025/26 MIU Activity – Outcome following attendance

Data on outcomes following MIU attendance provides an overview of patient pathways; however, limitations in data quality mean this cannot be used in isolation to fully understand service demand or appropriateness of attendance. For example, the 'transferred to District General Hospital' category does not differentiate between reasons for transfer or whether conveyance occurred via the Welsh Ambulance Service Trust (WAST), limiting interpretation.

Operational Reliability

Prior to the introduction of temporary service changes, including overnight closures, unplanned service closures occurred due to staffing constraints.

2023-2024					
	Total Attendance		Seasonal Average Attendance May – September		Staffing Closures
	In Hours 08:00 - 20:00	Out of Hours 20:00 - 08:00	Daily	Out of Hours 20:00 - 08:00	Jan - 09 September 2024
Brecon	7534	500	24.96	1.4	38
Llandrindod	5378	314	17.27	0.9	57
Welshpool	4055	14	13.37	0.0	N/A
Ystradgynlais	2496	0	7.39	0.0	N/A

Pre-Temporary Service Change: In/Out Hours attendance and closures

Since the implementation of overnight closures, no unplanned service closures have been recorded. This reflects an improvement in the reliability and predictability of the service offer.

Strategic Risks

The issues identified through this assessment align closely with a number of existing Health Board Strategic Risks. Evidence presented within this assessment has identified workforce fragility, variable service availability, demand and access inequity, diagnostic limitations, cost inefficiencies, and reliance on temporary service changes as factors contributing to these risks.

	The urgent care options considered within this assessment have the potential to influence a number of Strategic Risks, both positively and negatively. Particular consideration is given to financial sustainability (SRR001), innovation and strategic change (SRR002), demand for commissioned services (SRR003), demand for provided services (SRR004), primary care sustainability (SRR005), workforce sustainability (SRR006), estate quality (SRR007) and public confidence (SRR012). The extent to which individual options mitigate, increase, or are dependent upon these risks is considered further within the options appraisal. Taken together, the current service position shows an urgent care model that continues to provide important local access, but which is increasingly under pressure across workforce, diagnostics activity, cost, access and service reliability. Temporary service changes have improved short-term operational stability, but they have not resolved the underlying issues of workforce fragility, variable service availability, inconsistent diagnostic access and inequity in the service offer available to different communities. The current model should therefore be understood as a risk-bearing position rather than a stable long-term comparator. This provides the foundation for the detailed Case for Change in Section 2.4.
2.4 Assessment: Case for Change	**Evidence Supporting the Case for Change** Building on the current service position described in Section 2.3, this section sets out the evidence supporting the need to transform urgent care in Powys. The current model is under pressure from workforce fragility, variation in service availability, limited access to diagnostics, low activity across some sites, high costs, and increasing demand associated with frailty and multi-morbidity. These challenges are interconnected. Workforce shortages affect service availability, limited diagnostics restrict local treatment options, and variation in provision creates inequity and public confusion. Maintaining multiple low-volume sites also increases costs and reduces efficiency. The case for change is therefore about creating a more consistent, clinically capable and sustainable urgent care model rather than simply reducing the number of Minor Injury Units.

Urgent and Emergency Care Pathways for Frailty

An ageing population and increasing levels of frailty and long-term conditions are changing the nature of urgent care demand in Powys. More people require timely assessment, coordinated decision-making, and access to alternatives to hospital admission.

A multidisciplinary review of urgent care pathways for older Powys residents admitted to neighbouring acute hospitals examined how emergency care is currently accessed and delivered.

The findings highlighted opportunities for a more proactive and integrated urgent care model. Many patients admitted as emergencies were already known to primary care or community teams and were experiencing deterioration in existing conditions rather than a new acute illness. This suggests that earlier intervention, stronger community support, and improved coordination may help avoid some hospital admissions and conveyances.

Key Findings

The review identified several recurring themes:

- Many patients were already known to primary care or community services before admission.
- Admissions were often linked to frailty or worsening long-term conditions.
- Earlier intervention and proactive care may have prevented some admissions.
- Information sharing between organisations and clinical systems was often limited.
- Staff reported insufficient information being available at the point of admission.
- Advance care plans were not consistently referenced, even for patients with recent or repeated admissions.
- Multidisciplinary review strengthened relationships and understanding between health and care professionals.

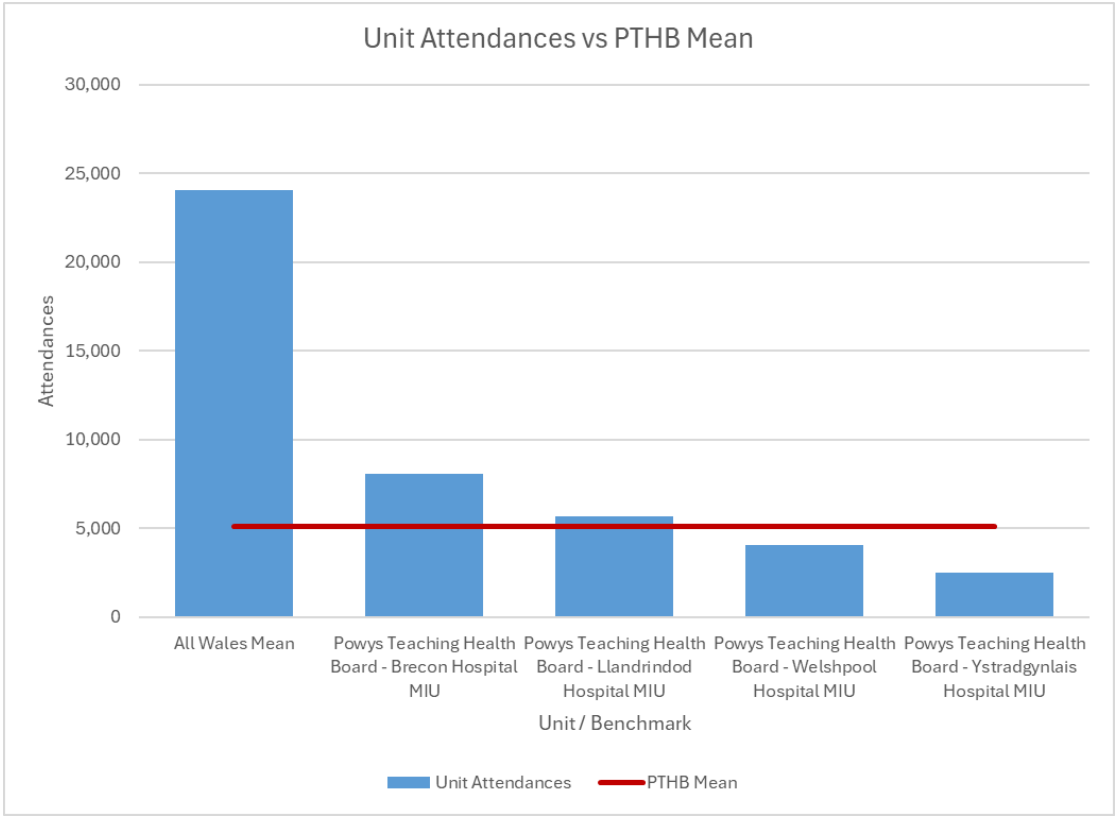
These findings reinforce the need for urgent care services that are better integrated with primary care, community teams, frailty pathways, diagnostics and shared care planning.

Financial Impact

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

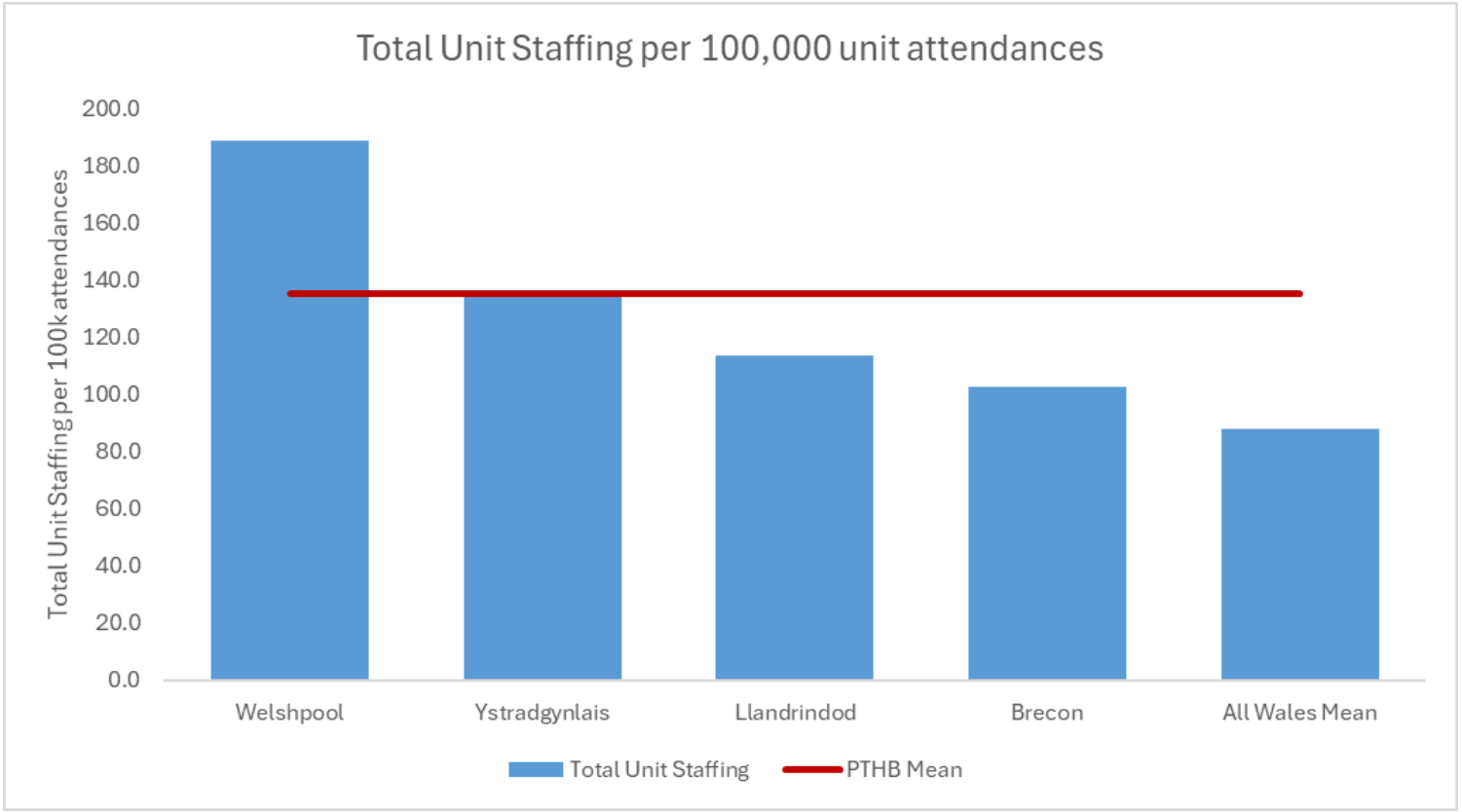
configuration and cost. In a dispersed rural model, staffing and infrastructure must be maintained across multiple locations even where activity is comparatively low or variable, resulting in higher workforce intensity and cost per attendance.

National benchmarking undertaken by the NHS Benchmarking Network in 2024 provides the most recent comparator available for assessing the relative financial position of Powys Teaching Health Board's Minor Injury Unit model. For the purposes of this assessment, that benchmarking has been used as the primary reference point for comparison (*NHS Benchmarking Network, 2024*).
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.



MIU Annual Activity per Unit: PTHB Compared to All-Wales Average (2024)

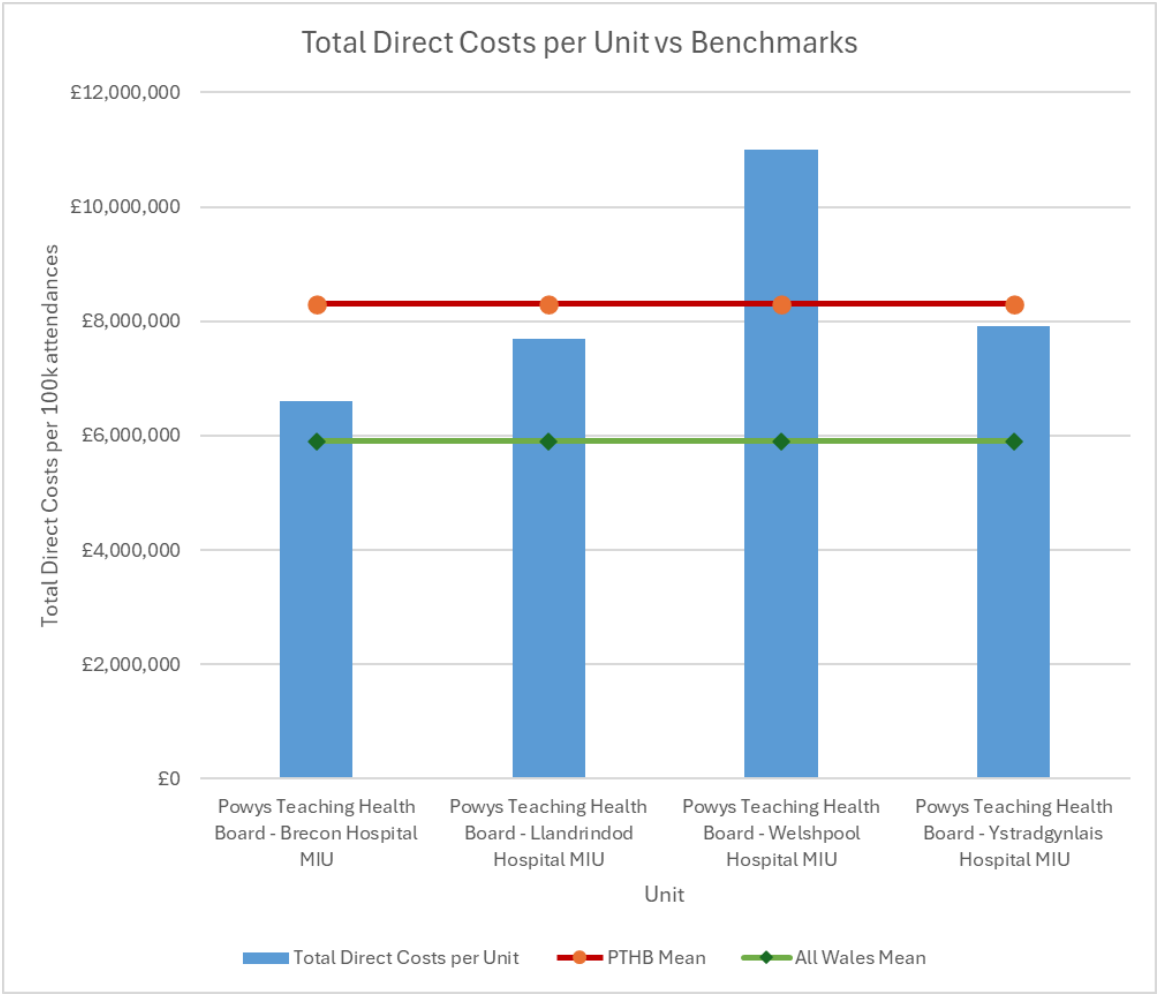
This lower level of activity has a direct effect on staffing intensity. Benchmarking shows that the PTHB mean whole-time equivalent (WTE) staffing per 100,000 attendances is approximately 1.5 times the all-Wales average, with individual units ranging from around 1.2 to 2.2 times the Welsh mean. This 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.



WTE per 100,000 Attendances: PTHB Compared to All-Wales Average (2024)

The impact of this staffing model is reflected in the cost position. Based on 2024 benchmarking data, the PTHB mean total cost per 100,000 attendances is approximately 1.4 times the all-Wales average, with individual units ranging from around 1.1 to 1.9 times the Welsh mean. Taken together, this indicates that the current model is

comparatively cost-intensive, driven by low throughput and the requirement to sustain staffing and service delivery across multiple locations.



Cost per 100,000 Attendances: PTHB Compared to All-Wales Average (2024)

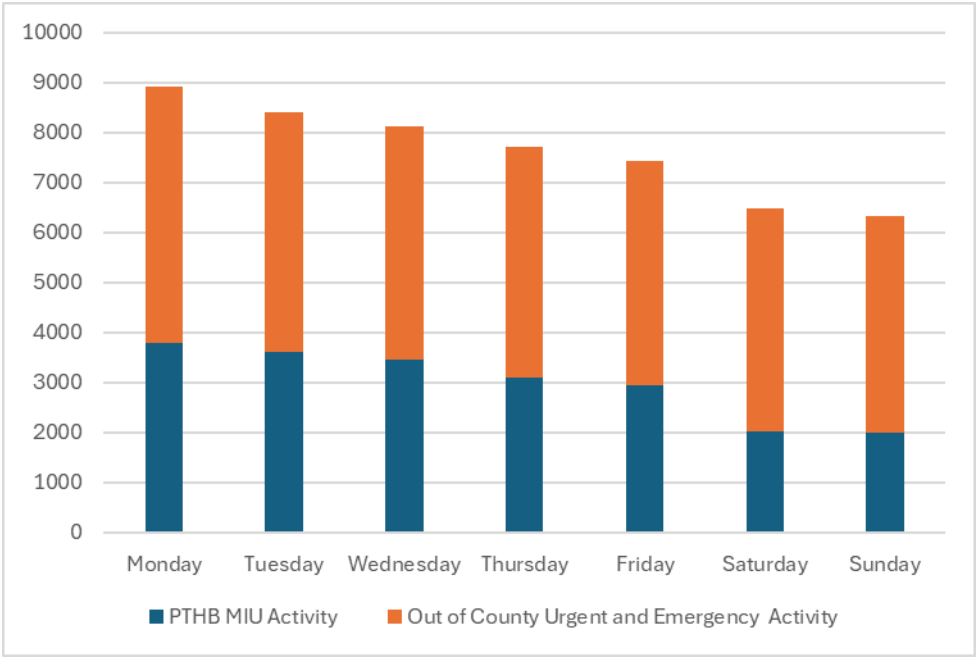
It is important to note that the majority of Emergency Department activity undertaken outside of Powys is hosted rather than directly tariffed to the Health Board and therefore does not typically represent a direct financial

pressure. As a result, the interpretation of this benchmarking is not primarily in terms of cash-releasing savings associated with repatriation of activity, but rather in terms of cost efficiency and best use of available resources.

In this context, the benchmarking highlights the relationship between activity levels, workforce requirements and cost, and indicates a requirement for a model that is able to accommodate greater levels of demand, or deliver services differently, in order to improve overall efficiency and sustainability.

Demand and Utilisation Profile

Whilst benchmarking highlights the financial implications of the current model, analysis of attendance patterns provides further insight into how urgent care demand is distributed across the service and how local utilisation relates to wider emergency care demand.

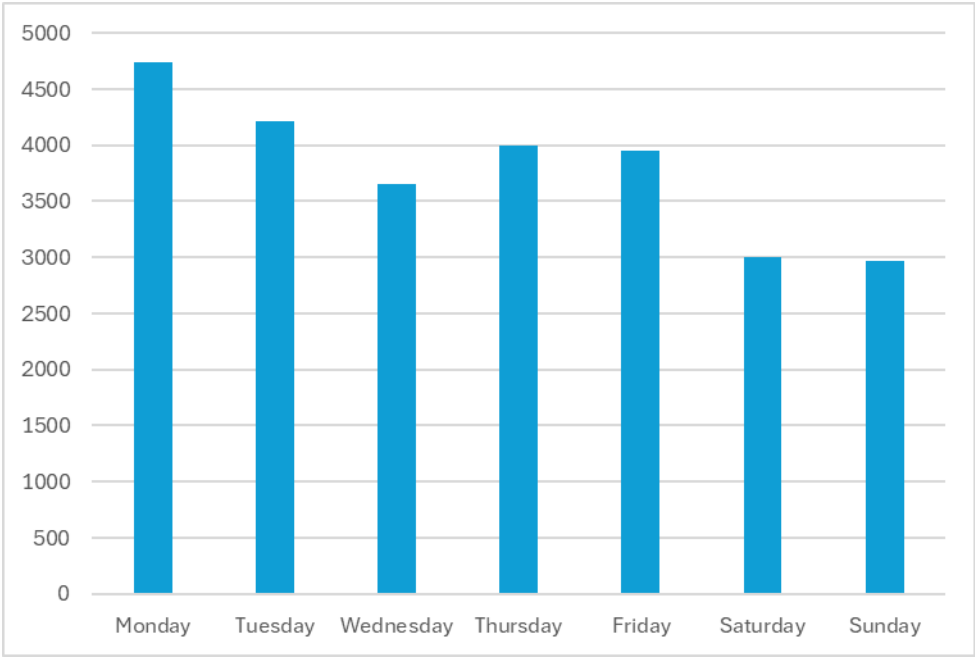


Emergency Care Activity for Powys Residents by Day of Week (2025/26)

Analysis of attendance patterns demonstrates a significant reduction in MIU activity during weekend periods when compared to weekdays. Based on 2025/26 activity data, attendances within Powys MIUs reduce by approximately 41% at weekends.

When attendances to out-of-county Emergency Departments are considered alongside MIU activity, total emergency care demand amongst Powys residents remains substantially higher, with weekend demand representing approximately 79% of weekday levels.

Whilst not all Emergency Department attendances would be appropriate for management within an MIU setting, these findings suggest that the reduction in local MIU utilisation at weekends is greater than the reduction in overall emergency care demand.



MIU-Suitable Emergency Care Activity by Day of Week (2024/25)

More detailed analysis of 2024/25 activity identified a similar pattern amongst presentations considered potentially suitable for management within an MIU setting. For this cohort, weekend activity averaged approximately 73% of weekday activity.

Whilst activity levels do reduce during weekends, the reduction is not proportional to the reduction seen within Powys MIU utilisation. This indicates that service utilisation is influenced not only by underlying demand, but also by the availability of local services and supporting diagnostics.

Out-of-Hours Activity

Out-of-hours activity provides further evidence of the mismatch between service availability, demand and staffing requirements. The purpose of this analysis is not to suggest that all out-of-hours activity is inappropriate, but to understand whether the previous overnight model represented the best use of workforce and resources.

January - March 2024	Brecon	Llandrindod
Total Out of Hours Attendance - -	79	53
Total Discharged with Reattended/Follow-Up (in hours)	21	17
Top 3 Out of Hours Attendance - Brecon & Llandrindod	-	
Laceration	28	
Thermal Burn	9	
Soft tissue/Possible Fracture	16	

Out-of-Hours MIU Attendances and Subsequent Reattendance (January–March 2024)

Prior to the introduction of temporary overnight closures, further detailed review of out-of-hours activity between January and March 2024 identified a total of 132 attendances across Powys MIUs. Of these, 38 patients (29%) subsequently reattended during standard operating hours.

This demonstrates that a proportion of activity historically undertaken overnight resulted in further activity within core service hours. A review of presenting conditions identified lacerations and thermal burns as the most common presentation categories amongst the cohort.

Workforce and Radiography Provision

The observed variation in activity and utilisation patterns must be considered alongside the workforce and radiography resource required to sustain the current service model. Whilst demand is distributed unevenly across sites, days and times of day, staffing and diagnostic provision must still be maintained to ensure safe and effective service delivery.

* Dedicated administrative role not included in this option. Admin to continue to be provided through Hospital based non-dedicated and roles that are variable across sites.

Role	Band	WTE	WTE + Headroom	Staff in Post	Deficit	Deficit £ (@ Mid point)
HCSW	3	7.72	9.26	6.08	3.18	£108,833
RN	5	0.00	0.00	1.87	-1.87	-£91,416
Emergency Practitioner	7	21.16	25.39	20.05	4.23	£276,092
Advanced Clinical Practitioner	8a	0.00	0.00		0.00	£0
Nurse Consultant	8c	0.00	0.00		0.00	£0

Current MIU Workforce Model

The current MIU model requires staffing to be maintained across multiple sites irrespective of local fluctuations in demand. As demonstrated through the activity analysis, utilisation varies significantly between sites, days of the week and times of day; however, workforce provision must be maintained to ensure safe and effective service delivery.

The current workforce model therefore reflects a balance between demand, clinical safety requirements and geographical access. Staffing levels cannot reduce in direct proportion to activity without impacting service availability, resilience and clinical governance.

This contributes to the higher staffing intensity identified through national benchmarking and reflects the challenges associated with delivering urgent care services across a dispersed rural geography.

Radiography

The current radiography model is primarily aligned to weekday demand, with more limited provision available outside of core operating hours. As a result, access to radiography varies depending on the time and location of presentation.

Role	Band	WTE	WTE + Headroom	Staff in Post	Deficit	Deficit £ (@ Mid point)
Radiographers	6	3.60	4.32	3.48	0.84	£44,403
Team Lead Radiographer Band	7	1.00	1.00	1.00	0.00	£0
Reporting Radiographer	7	1.40	1.68	1.60	0.08	£5,222
HCSW	3	5.40	6.48	5.91	0.57	£19,483
Professional Head	8a	1.00	1.00	1	0.00	£0
Lead Sonographer	8a	1.00	1.00	1.00	0.00	£0
PACS Manager	8a	1.00	1.00	1.00	0.00	£0
Radiographers	5	1.80	2.16	2.00	0.16	£7,822
Sonographers	7	2.40	2.40	2.50		£0

Current Radiography Workforce Model

Analysis of activity patterns suggests that service utilisation is influenced by the availability of supporting radiography as well as underlying demand. Whilst overall emergency care demand amongst Powys residents remains relatively consistent throughout the week, utilisation of local MIU services reduces more substantially during weekends.

Whilst multiple factors are likely to contribute to this variation, the availability of radiography represents an important consideration when assessing the ability of the current urgent care model to meet population need consistently across the county.

Taken together, the benchmarking, utilisation and workforce analysis indicate that the current model operates across a dispersed geography with comparatively low throughput, variable demand patterns and differing levels

	of access to supporting radiography. Whilst temporary service changes have improved operational stability, the assessment highlights the ongoing challenge of aligning workforce, radiography and service provision with population demand. The proposed options therefore seek to improve value by concentrating enhanced urgent care capability, diagnostics and workforce resilience on fewer sites. **Travel time analysis** The travel time analysis and associated planning principles are a core component of Better Together, which aims to transform health and care services in Powys through collaborative, evidence-based approaches. By applying national and international benchmarks for service accessibility, and embedding place-based planning, this work ensures that service redesign is shaped around the needs and strengths of local communities. The principles outlined here directly support the ambition to deliver equitable, sustainable, and person-centred care, enabling Powys Teaching Health Board and its partners to make informed decisions that improve outcomes for all residents and make best use of resources. It is important to note that the analysis does not include travel times for patients currently accessing services outside of the county, nor does it account for the alternative offer in a future model of care (i.e. community-based services or alternatives to admission). **Summary of Analysis for Urgent Care:** **Benchmark** ≤60 minutes by car for community care. **Current/Previous Models:** Most households are within 30 minutes of an MIU, with an average travel time of 20 minutes 43 seconds. **Options Analysis:** • Do Minimum/Mid-Range/Maximum (Ystradgynlais closed): Mean travel time increases slightly to 23 minutes 16 seconds, with a small rise in households facing journeys over 45 minutes but under 60 minutes. • Do Minimum/Mid-Range/Maximum (Newtown opened, Welshpool & Ystradgynlais closed): Mean travel time increases to 23 minutes 50 seconds, which is significantly under 60 minutes. **Benchmark** ≤45 minutes by car for community care **Current/Previous Models:** Most households are within 30 minutes of an MIU, with an average travel time of 20 minutes 43 seconds.

Options Analysis:

- Do Minimum/Mid-Range/Maximum (Ystradgynlais closed): Mean travel time increases slightly to 23 minutes 16 seconds, with a small rise in households facing journeys over 45 minutes.
- Do Minimum/Mid-Range/Maximum (Newtown opened, Welshpool & Ystradgynlais closed): Mean travel time increases to 23 minutes 50 seconds.

Urgent Care Centre Delivery Options

Travel Time Principles

	4-Site	3-Site		2-Site	
Sites	Welshpool Llandrindod Wells Brecon Ystradgynlais	Welshpool Llandrindod Wells Brecon	Newtown Llandrindod Wells Brecon	Welshpool Brecon	Newtown Brecon
Options included	001A 001B	001D 001C 010 013	001C 010 013	001Dii 001Cii 010ii 013ii	001Cii 010ii 013ii
Mean Travel Time	00:20:43	00:23:16	00:23:50	00:30:19	00:29:35
% within 45-minutes	95.3%	93.1%	91.2%	76.6%	83.1%
% within 60-minutes	98.7%	98.7%	98.8%	96.8%	98.5%

It is important to note that all travel time modelling has been undertaken using private car journey times and does not take account of public transport, community transport, seasonal variation or wider barriers to travel. Whilst average journey times provide a useful summary measure, they mask significant variation across Powys and therefore the impacts on individual communities should also be considered.

	Public transport access to urgent care in Powys is currently limited and cannot currently be considered as a reliable or universal access solution. Analysis of the current four-site MIU baseline and two proposed urgent care centre models found that scheduled public transport may support some daytime, planned or semi-planned journeys, but is constrained by route availability, journey times, connections, evening and weekend provision, and uncertainty about same-day return travel following assessment or treatment. Under option 013ii, the greatest travel impacts are experienced by communities within Mid Powys, where journey times to urgent care services increase more significantly than the county average. Although the majority of households remain within the agreed 45-minute access standard, the increased travel burden is not distributed evenly across the population. This is particularly relevant when considered alongside deprivation and access data. The Welsh Index of Multiple Deprivation (WIMD) includes an Access to Services domain which incorporates travel times and household access to private transport. As a result, communities experiencing greater travel impacts may also include populations less able to absorb those additional journeys. Travel time impacts should therefore be considered alongside wider issues of access, affordability and equity when assessing future service configurations. **Summary of Key Findings** The evidence shows that the current urgent care model is under increasing pressure from a combination of workforce, service, diagnostic, access and financial challenges. These issues are interconnected and together affect the sustainability of the service. **Low activity creates a high-cost service model** MIU activity in Powys is significantly lower than comparable services across Wales. Despite this, staffing and facilities must be maintained across multiple sites, resulting in higher staffing levels and costs per attendance than the Welsh average. **Demand varies significantly across sites and times of day** Activity fluctuates by location, day and time. While out-of-hours demand at MIUs is often low, wider urgent and emergency care demand from Powys residents remains substantial. Many patients who previously attended overnight reattend during daytime hours, while weekend demand remains relatively strong.

	Access to diagnostics influences service use Service utilisation is affected not only by patient demand but also by access to diagnostics. Inconsistent radiography provision across sites and times can influence where patients seek care and limit opportunities to manage patients locally. **Workforce challenges affect service resilience** Maintaining safe staffing across multiple rural sites remains difficult. Recruitment challenges, lone-working risks and previous unplanned closures highlight the fragility of the current model. Temporary service changes have improved reliability but have not resolved the underlying workforce issues. **Travel impacts vary across communities** Most households remain within the agreed 45-minute travel standard under the shortlisted options. However, some communities, particularly in Mid Powys, would experience greater increases in travel time, with impacts likely to be greater for those without access to private transport. **Demand is expected to become more complex** The ageing population and increasing levels of frailty and multi-morbidity will continue to drive demand for urgent care. Current reductions in MIU activity are not reflected in wider emergency care demand, indicating that patients continue to access services elsewhere when local provision cannot meet their needs. **The current model is not a sustainable baseline** The evidence demonstrates that the current configuration should not be regarded as a neutral comparator. While temporary service changes have improved operational stability, challenges remain around workforce sustainability, diagnostic access, service consistency, utilisation and cost. Maintaining the current model would likely lead to reduced resilience, increased inequity and continued reliance on temporary measures. The "Do Current" option should therefore be viewed as a risk-bearing position rather than a sustainable long-term solution. The case for change is not simply about reducing the number of MIUs. It is about creating a more consistent, clinically capable and resilient urgent care model that can provide timely assessment, diagnostics and treatment closer to home, while making better use of workforce, estate and financial resources.

Engagement Evidence

Further information on how the options were developed, including the influence of stakeholder and public engagement, is available in the Better Together Step Report published on the PTHB website.

Taken together, the evidence shows that the current urgent care model is no longer sustainable in relation to quality, workforce resilience, finance, access and patient flow. The proposed options therefore need to be assessed on how effectively they improve service consistency, strengthen workforce sustainability, enhance diagnostics, reduce fragmentation and support delivery of care closer to home.

This provides the basis for the options appraisal that follows, where the shortlisted options are assessed against their benefits, risks, dependencies and trade-offs.

2.5 Assessment: Options Appraisal

Following detailed financial, non-financial, workforce, estates and travel time appraisal, nine options were discarded and two Urgent Care options were recommended to progress.

Below provides some of the considerations and elements that led to deselection of these options to progress:

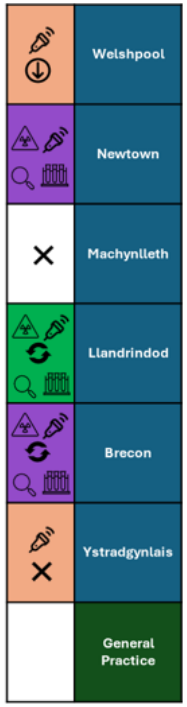
Option	Option description	Reason for deselection
001A	Do Previous (before any temporary service changes on 4 units)	This option was discounted because it would reinstate the previous service model without addressing the workforce fragility, lone working risk, diagnostic limitations, cost intensity and variation in access identified in the case for change. It is therefore retained only as a comparator.
001B	Do Current (continue as now on 4 units, making temporary service changes permanent)	This option provides limited improvement but retains too much of the current dispersed model. It does not sufficiently address the underlying issues of workforce resilience, diagnostic variation, inconsistent service offer and long-term sustainability.
001C	Do Minimum (make temporary service changes permanent and improve service on 3 units, close 1 unit)	This option provides limited improvement but retains too much of the current dispersed model. It does not sufficiently address the underlying issues of workforce resilience, diagnostic variation, inconsistent service offer and long-term sustainability.

	001Cii	Do Minimum in 2 units (make temporary service changes permanent and improve service on 2 units, close 2 units)	This option reduces the number of sites but does not deliver the full-service enhancement required to support a consistent urgent care offer. It therefore carries access impacts without providing the same level of clinical capability or diagnostic improvement as the recommended options.
	001D	Do current in 3 units (continue as now in 3 units, making temporary service changes permanent, close 1 unit)	This option represents partial consolidation, but it does not provide sufficient transformation of the current model. It would reduce some service footprint but would not fully address the need for a more clinically capable, diagnostics-enabled and sustainable urgent care model.
	001Dii	Do current in 2 units (continue as now in 2 units, making temporary service changes permanent, close 2 units)	This option concentrates provision onto fewer sites but without the enhanced urgent care model needed to mitigate access and service change impacts. It therefore creates greater access risk without delivering the full benefits of the UCC model.
	005	Close all units and provide urgent care in other ways (close 4 units)	This option was discounted because it would create significant access, equity, public confidence and deliverability risks. It would not retain a sufficiently clear urgent care offer within Powys and would be unlikely to provide an acceptable balance between sustainability and local access.
	010	Do Mid-Range: Better local Urgent Care (3 Minor Injury and Illness units, close 1 unit)	This option strengthens the minor injury model by expanding the scope of provision, but it does not deliver the same level of clinical capability, diagnostics, senior decision-making or workforce resilience as the proposed Urgent Care Centre model.
	010ii	Do Mid-Range: Better local Urgent Care (2 Minor Injury and Illness units, close 2 units)	This option offers some consolidation and service development but does not provide the same balance of enhanced diagnostics, clinical leadership and workforce sustainability as UCDO_013 or UCDO_013ii. It was therefore not recommended for progression.

	The appraisal below sets out, for each recommended option, the material differences from the current model, alongside the benefits, risks and trade-offs relevant to a Level 2 assessment. Following the appraisal process, UCDO_013 and UCDO_013ii were identified as the two options recommended for detailed Level 2 assessment. These options represent the most credible range for consultation: one retaining a broader three-site urgent care footprint and one testing a more consolidated two-site model with greater efficiency but higher access and deliverability risk. **Recommended Options:** • UCDO_013 (Do Maximum): Even Better Local Urgent Care (2 Urgent Care Centres and 1 Minor Injury and Illness Unit) • UCDO_013ii (Do Maximum on Less Sites): (2 Urgent Care Centres) **Option UCDO_013 (Do Maximum): Even Better Local Urgent Care** *(2 Urgent Care Centres + 1 Minor Injury and Illness Unit)* UCDO_013 seeks to create a more clinically capable and sustainable urgent care model that better meets the urgent care needs of the Powys population. The option achieves this through enhanced clinical capability, extended radiography including 7-day x-ray services, improved workforce resilience and greater capacity to assess, diagnose and treat patients within Powys, reducing reliance on conveyance and referral to out-of-county emergency departments. The option seeks to balance these improvements with the retention of a broader geographic service footprint through the provision of two Urgent Care Centres and one Minor Injury and Illness Unit. The existing Welshpool Unit would remain operational until replacement facilities are available in Newtown, ensuring continuity of urgent care provision during transition.

SL UCDO_013: Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)

- Create Urgent Care Centres (UCCs) on 2 sites in Newtown and Brecon
  - Operating times: 8:00 am-8:00 pm, 7 days a week, with Point of Care Testing and blood testing facilities available at each of these sites, and x-ray services 9:00 am-6:00 pm, 7 days a week.
  - Enhance delivery of urgent care treatment, access and referral pathways including Ambulatory Referral Pathway.
  - The Minor Injury Unit would stay in Welshpool until the Urgent Care Centre opens in Newtown, and then the Minor Injury Unit in Welshpool would close.
- Create a Minor Injury and Illness Unit in Llandrindod Wells:
  - Operating times: 8:00 am-8:00 pm, 7 days a week, with Point of Care Testing and blood testing facilities available at each of these sites, and x-ray services 9:00 am-6:00 pm, 7 days a week.
- The Minor Injury Unit in Ystradgynlais would close.
- X-ray services at Machynlleth and Ystradgynlais would close permanently. The x-ray service at Welshpool would stay there until the Urgent Care Centres opens in Newtown, and once this happens, the x-ray service at Welshpool would close permanently.
- Enhance inpatient bed offer to include short stay assessment and treatment beds (step up), subject to the outcome of the Physical Health options.
- Create an 'urgent community response' service which can see people in their own homes between 8:00 am-8:00 pm, 7 days a week.
- GP practices would continue to offer urgent care through their General Medical Services 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 will continue to be delivered in the community, including urgent eye care through Opticians and the Common Ailments Scheme delivered in community pharmacies.
- Hospital Day Services (which closed temporarily in March 2020) would be closed permanently across Powys.
- Timescales to deliver – 5+ years *(subject to capital investment to develop Newtown and workforce)*



What changes from the current model?

The central change under UCDO_013 is a move from a dispersed Minor Injury Unit model towards a smaller number of more capable urgent care sites. This is intended to improve consistency, clinical capability and workforce resilience while retaining a degree of geographic spread.

- Establishment of two Urgent Care Centres (UCCs) at Newtown and Brecon, operating 8am–8pm, 7 days per week.
- Conversion of Llandrindod Wells to a Minor Injury and Illness Unit (MIIU).
- Closure of Minor Injury Units at Welshpool and Ystradgynlais following transition.

	• Expansion of diagnostics including extended x-ray, point-of-care testing and blood testing at UCC sites. • Introduction of enhanced urgent care pathways including ambulatory care and urgent community response. • Option to admit to on-site step-up beds at community hospital. **What stays the same** A number of important elements of urgent care provision would remain in place, providing continuity for patients while enabling targeted service improvement. • Urgent care continues to be delivered within Powys rather than default transfer to out-of-county Emergency Departments. • GP practices, GP Out of Hours, community pharmacies (Common Ailments Scheme) and urgent eye care continue unchanged. • NHS 111 remains the primary access point for triage and advice. • Minor injury and urgent illness services remain available across the county, albeit through fewer, more capable sites. **Benefits** • Highest nonfinancial appraisal score, reflecting strong performance across safety, effectiveness and sustainability. • Improved workforce resilience through consolidation, reducing lone working and dependency on temporary staffing. • Enhanced clinical capability and governance with senior decisionmakers consistently available. • Improved diagnostic access reducing avoidable transfers out of county. • Good balance between service quality and geographic coverage. **Risks** • Requires moderate capital investment to upgrade and reconfigure existing estate. • Some communities experience increased travel times compared to the current model. • Financial benefits are partially dependent on reducing out-of-county activity, which carries delivery risk. • Requires careful transition management and public engagement around site closures. • Reliant on North Powys capital investment for site transition.

- Ability to staff the proposed model.

These risks are material because successful implementation is dependent on estates readiness, workforce availability, diagnostic capacity and clear transition arrangements. In particular, the transition from Welshpool to Newtown should be treated as a programme-level dependency. Welshpool urgent care provision should remain in place until replacement facilities are available in Newtown, unless a clinically safe and agreed interim arrangement has been approved. If capital funding or enabling works are delayed, implementation should be paused, re-phased or supported by a formal contingency plan to maintain access for North Powys patients.

Trade-offs

- Improved quality, safety and sustainability at the expense of reduced number of local sites.
- Slight increase in overall cost compared to the current model in return for improved outcomes and resilience.
- Greater clinical consistency balanced against some loss of local familiarity.

Financial Assessment

- Annual cost: approximately £3.1m, representing a marginal increase of £0.14m compared with the current model.
- Improved cost per attendance (£87) compared to the current baseline (£124).
- Financial modelling assumes that all activity considered suitable for management within the future urgent care service during proposed opening hours will be treated within Powys, reducing out-of-county activity.
- Urgent and unplanned care is by nature volatile, and the realisation of savings carries moderate financial delivery risk.

Workforce Assessment

- Requires approximately 40.7 WTE urgent care staff across the three UCC/MIIU sites.
- Supports strong clinical leadership, reduced lone working and improved roster sustainability.
- May support recruitment and retention by offering more senior roles, stronger career pathways and an enhanced skill mix.

Estates Assessment

- Medium capital requirement to reconfigure and upgrade Newtown, Brecon and Llandrindod.
- No new builds required but enabling works and refurbishment needed.
- Estates feasibility rated Amber pending detailed design and phasing.
- Reliant on North Powys capital investment for site transition.

Strategic Risk Assessment

Ref	Strategic Risk	Transition	Established Model	Comments
SRR001	Financial Sustainability	Increase	Slight Increase	Higher annual revenue costs and capital investment requirements increase affordability pressures despite improved service efficiency.
SRR002	Innovation & Strategic Change	Increase	Neutral	Successful delivery is dependent on implementation of a major service transformation programme.
SRR003	Demand for Commissioned Services	Neutral	Mitigation	Supports more urgent care activity being managed within Powys and reduces reliance on commissioned services where clinically appropriate.
SRR004	Demand for Provided Services	Mitigation	Mitigation	Improves the Health Board's ability to respond to urgent care demand through enhanced local service provision, diagnostics and clinical capability.

SRR005	Primary Care Sustainability	Slight Mitigation	Mitigation	Provides additional urgent care capacity and supports reduction of pressure on primary care for appropriate urgent presentations.
SRR006	Workforce Sustainability	Increase	Mitigation	Requires workforce transition during implementation but improves resilience, recruitment, retention and roster sustainability once established.
SRR007	Estate Quality and Infrastructure	Increase	Slight Increase	Requires estate reconfiguration and capital investment during transition; however, retention of Llandrindod Wells unit provides greater flexibility to accommodate future demand and service development.
SRR012	Public Confidence	Increase	Mitigation	Service changes may increase public concern during implementation, but improved service quality and sustainability are expected to strengthen confidence over time.

Overall Assessment

Overall, UCDO_013 offers the strongest balance between quality, access, workforce sustainability and deliverability. It provides a more clinically capable urgent care model while retaining a wider geographic footprint than the two-site option. Although it carries a marginally higher revenue cost than the current model, this is balanced by improved service capability, stronger diagnostic access, better workforce resilience and a more deliverable access profile. On that basis, it represents the most balanced recommended option for consultation.

	Option UCDO_013ii (Do Maximum on Less Sites) UCDO_013ii seeks to create a more clinically capable and sustainable urgent care model that better meets the urgent care needs of the Powys population. The option achieves this through enhanced clinical capability, extended diagnostics including 7-day x-ray services, improved workforce resilience and greater capacity to assess, diagnose and treat patients within Powys, reducing reliance on conveyance and referral to out-of-county emergency departments. The option seeks to maximise efficiency, affordability and long-term sustainability through the provision of two Urgent Care Centres operating from a more concentrated service footprint. The existing Welshpool Unit would remain operational until replacement facilities are available in Newtown, ensuring continuity of urgent care provision during transition. However, this option also carries the greatest access and equity risk, particularly for communities in Mid Powys and those currently served by Llandrindod Wells and Ystradgynlais. Its benefits are therefore more dependent on robust mitigation, including urgent community response, digital and telephone access routes, clear public communication, transport considerations and phased implementation.

SL UCDO_013ii: Do Maximum: Even better local Urgent Care on less sites (2 x UCCs)

- Create Urgent Care Centres (UCCs) on 2 sites in Newtown and Brecon
  - Operating times: 8:00 am-8:00 pm, 7 days a week, with Point of Care Testing and blood testing facilities available at each of these sites, and x-ray services 9:00 am-6:00 pm, 7 days a week.
  - Enhance delivery of urgent care treatment, access and referral pathways including Ambulatory Referral Pathway.
  - The Minor Injury Unit would stay in Welshpool until the Urgent Care Centre opens in Newtown, and then the Minor Injury Unit in Welshpool would close.
- The Minor Injury Unit in Ystradgynlais and Llandrindod Wells would close.
- X-ray services at Machynlleth and Ystradgynlais would close permanently. The x-ray service at Welshpool would stay there until the Urgent Care Centres opens in Newtown, and once this happens, the x-ray service at Welshpool would close permanently.
- Routine x-ray services would continue to be provided at Llandrindod, Monday to Friday, 9:00 am–5:00 pm.
- Enhance inpatient bed offer to include short stay assessment and treatment beds (step up), subject to the outcome of the Physical Health options.
- Create an 'urgent community response' service which can see people in their own homes between 8:00 am-8:00 pm, 7 days a week.
- GP practices would continue to offer urgent care through their General Medical Services 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 will continue to be delivered in the community, including urgent eye care through Opticians and the Common Ailments Scheme delivered in community pharmacies.
- Hospital Day Services (which closed temporarily in March 2020) would be closed permanently across Powys.
- Timescales to deliver – 5+ years *(subject to capital investment to develop Newtown and workforce)*



What changes from the current model?

- Delivery of urgent care through **two Urgent Care Centres only**, located at Newtown and Brecon.
- Closure of all other Minor Injury and Minor Injury and Illness Units following transition.
- Full concentration of diagnostics, urgent care and clinical leadership on two sites.
- Redistribution of activity and workforce to the remaining UCCs.

What stays the same?

- Urgent care remains accessible within Powys.
- GP, pharmacy, community and NHS 111 services continue unchanged.

- Range of urgent illness and injury presentations continues to be supported, with enhanced diagnostics at UCC sites.

Benefits

- Lowest overall cost and best financial efficiency of all recommended options.
- Strongest workforce concentration and roster sustainability.
- Simplified governance, leadership and clinical oversight.
- Greatest opportunity to reduce reliance on temporary staffing.

Risks

- Greatest impact on travel times, particularly for Mid Powys and areas currently served by Llandrindod.
- Larger proportion of the population falls outside the 45-minute access benchmark.
- Risk of demand pressure and congestion at remaining sites during peak periods.
- Higher reputational and engagement risk due to extent of site closures.
- Ability to staff the proposed model.

The principal risks associated with UCDO_013ii relate to access, equity, estate dependency and transition. Because this option removes more local urgent care provision than UCDO_013, it would require stronger assurance that community alternatives, travel mitigation, workforce plans, diagnostic capacity and public communication arrangements are in place before implementation. The transition plan would also need to set out how patients currently using sites that would close would be supported to access alternative provision, and how staff affected by the changes would be engaged, redeployed and supported.

Trade-offs

- Maximum efficiency and workforce resilience in exchange for reduced geographic access.
- Financial sustainability prioritised over locality-based provision.
- Increased reliance on community and digital mitigation to offset access impacts.

Financial Assessment

- Annual cost: approximately £2.1m, delivering a £0.8m saving compared to the current model.
- Lowest direct cost per attendance (£60) of all options.

	• Financial modelling assumes that all activity considered suitable for management within the future urgent care service during proposed opening hours will be treated within Powys, reducing out-of-county activity. • Urgent and unplanned care is by nature volatile, and the realisation of savings carries moderate financial delivery risk. **Workforce Assessment** • Requires approximately 26.1 WTE urgent care staff across the two UCC sites. • Resilient workforce model with minimal lone working. • Potentially increased pressure on the two remaining site teams during peak demand. **Estates Assessment** • Medium capital for two sites only. • Reduced estates footprint with opportunities for disposal or repurposing of closed sites. • Estates feasibility rated Amber. • Reliant on North Powys capital investment for site transition. The estates dependency under UCDO_013ii is more significant than under UCDO_013 because the future model relies on two sites only. This reduces flexibility during transition and places greater reliance on both the North Powys estate solution and the readiness of Brecon to support an expanded urgent care role. If capital funding, design work or enabling estates requirements are delayed, this option could not be implemented safely as planned without re-phasing, maintaining interim provision or identifying alternative temporary arrangements. **Travel Time Analysis** • Greatest impact on travel times, particularly for Mid Powys and Llandrindod catchments. • Larger proportion of households exceed the 45-minute travel benchmark. • Requires strong mitigation through community and digital services.

Strategic Risk Assessment

Ref	Strategic Risk	Transition	Established Model	Comments
SRR001	Financial Sustainability	Increase	Mitigation	Transition costs are offset by a lower forecast net cost than both the current model and Option 013, supporting improved financial sustainability once established.
SRR002	Innovation & Strategic Change	Increase	Neutral	Successful delivery is dependent on implementation of a major service transformation programme.
SRR003	Demand for Commissioned Services	Neutral	Mitigation	Supports more urgent care activity being managed within Powys and reduces reliance on commissioned services where clinically appropriate.
SRR004	Demand for Provided Services	Mitigation	Mitigation	Improves the Health Board's ability to respond to urgent care demand through enhanced clinical capability, diagnostics and service resilience, albeit through a more centralised service model.
SRR005	Primary Care Sustainability	Slight Mitigation	Mitigation	Provides additional urgent care capacity and supports reduction of pressure on primary care for appropriate urgent presentations, although access arrangements change for some communities.

SRR006	Workforce Sustainability	Increase	Mitigation	Requires workforce transition during implementation but improves resilience, recruitment, retention and rota sustainability once established.
SRR007	Estate Quality and Infrastructure	Increase	Increase	Requires significant estate dependency during transition and reduces flexibility within the future estate configuration through closure of Llandrindod Wells unit, placing greater reliance on Brecon and the North Powys estate solution.
SRR012	Public Confidence	Increase	Mitigation	Service changes may increase public concern during implementation, but improved service quality and sustainability are expected to strengthen confidence over time.

Overall Assessment

Overall, UCDO_013ii provides the strongest financial and workforce efficiency, but it also carries the highest access, equity and deliverability risk. It offers a clear long-term consolidation model and may provide the lowest cost base once fully established. However, the scale of service concentration means that its benefits are more dependent on capital delivery, workforce transition, community alternatives and effective mitigation for communities facing longer travel times. It is therefore a credible option for consultation, but with a higher risk profile than UCDO_013.

- **UCDO_013** offers the best overall balance of quality, access and sustainability.
- **UCDO_013ii** provides maximum financial and workforce efficiency with greater access risk.

All options are considered sufficiently developed to support a comprehensive Level 2 assessment and progression to recommendation and engagement activity.

Potential gaps or points to note

- Exact phasing and capital costs remain subject to further estates design work.

- Financial savings from reduced out-of-county activity are assumed, not guaranteed.
- Travel time mitigation strategies will require further development and assurance.

Urgent Care including Diagnostics Option Summary Information:

The table below summarises the urgent care options considered, including the associated diagnostic provision, and highlights the key differences in service configuration, clinical capability, workforce resilience, access, financial impact and deliverability.

Urgent Care including Diagnostics Option Summary Information

Awaiting Estate assessment update

Options	001a	001b Current	001D	001Dii	001C	001Cii	005	010	010ii	013	013ii
Service footprint:	4 sites	4 sites	3 sites	2 sites	3 sites	2 sites	None	3 sites	2 sites	3 sites	2 sites
PTHB Service model adjustments	Pre-temporary	None	None	None	Minor	Minor	N/A	Enhance Moderate	Enhance Moderate	Enhance Significant	Enhanced Significant
PTHB Workforce (WTE) UCC only	-	28.9	26.9	18.3	33.8	26.7	0	38.7	26.7	40.7	26.1
PTHB Workforce WTE Diagnostics only	-	23.4	23.4	23.4	24.4	24.4	19.2	27.1	24.4	28.4	25.4
PTHB UCC Demand assumptions	-	23,802	30,895	30,895	23,802	23,802	-	33,244	33,244	35,954	49,698
Financial costs minus savings (£m)	£3.3	£2.9	£2.8	£2.3	£2.7	£2.3	£2.3	£3.0	£2.2	£3.1	£2.1
Financial impact vs current 001b (£m)	£+0.4	-	£-0.1	£-0.6	£-0.3	£-0.6	£-0.7	£+0.1	£-0.7	£+0.1	£-0.8
Non - financial appraisal score	50.55	62.4	65.5	54.3	72.75	61.5	49.35	88.2	75.45	100.35	88.5
Direct cost per attendance	-	£124	£120	£99	£86	£76	n/a	£92	£67	£87	£60
Estates value	Low	Low	Medium	Medium	Medium	Medium	Low	Medium	Medium	Medium	Medium
Estate Feasibility	Green	Green					Green				

Summary

- Option 013ii Urgent Care Centre 2 sites, has the lowest financial costs (minus savings) and cost per attendance, but requires investment, there are associated risks with realising financial savings through reducing out of county attendances. Ranked 3rd on non-financial appraisal.
- Option 013 Urgent Care Centre 3 is marginally the second most expensive in terms of financial costs (minus savings) but is ranked the highest non-financial appraisal score.
- Option 001Dii and 001Cii which have no or minor service model adjustments across 2 sites have moderate financial savings but scored lower on the non financial appraisal

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

	Taken together, the appraisal indicates that both recommended options provide a credible response to the case for change, but they present different balances of benefit and risk. UCDO_013 offers the stronger near-term balance between service improvement, geographic access, workforce resilience and deliverability. It retains a three-site urgent care footprint while strengthening diagnostics, clinical capability and consistency of offer. UCDO_013ii offers the greatest financial and workforce efficiency, but this is achieved through a more concentrated model that carries greater access, equity, public confidence and delivery risks. Its benefits are more dependent on capital readiness, community alternatives, workforce transition and successful mitigation for affected communities. On this basis, UCDO_013 appears to provide the most balanced option for progression, while UCDO_013ii should remain in scope for consultation to test the acceptability of a more consolidated model against its potential efficiency and sustainability benefits. The next section will focus on the preferred option.
2.6 Recommendation : Preferred Option	Set out the preferred option and expected timetable for implementation **This section will remain incomplete for now, as the preferred option will only be identified following consultation.** **Including a preferred option at this stage could imply that the consultation outcome has been predetermined.**
2.7 Financial Summary	The table below summarises the financial and non-financial appraisal of the two recommended urgent care options. It should be read as an interpretation of the overall balance of benefits, risks and trade-offs, rather than as a simple comparison of cost alone. This is important because the financial and non-financial appraisals point to different strengths: UCDO_013ii provides the strongest financial efficiency. UCDO_013 provides the strongest overall balance when quality, access, workforce resilience, diagnostic capability and deliverability are considered, however, the second most expensive option. The table therefore compares the two recommended options only, as the other options have been considered and ruled out earlier in the assessment.

Urgent Care – Non Finance and Finance Appraisal

	Average Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL UCDO_001a	1.9	2.3	2.2	1.6	2.3	2.4	12.78	10	0.6	0.4	0.3	0.3	0.2	0.2	2.04	11
SL UCDO_001b	2.6	2.7	2.4	2.3	2.9	2.7	15.52	7	0.8	0.4	0.4	0.5	0.3	0.3	2.55	8
SL UCDO_001d	2.9	2.7	2.6	2.7	2.6	2.6	16.09	6	0.9	0.4	0.4	0.5	0.3	0.3	2.73	6
SL UCDO_001dii	2.5	2.0	2.3	2.5	1.8	2.0	13.22	9	0.8	0.3	0.3	0.5	0.2	0.2	2.30	9
SL UCDO_001c	3.1	3.0	3.0	3.0	3.0	2.9	18.00	5	0.9	0.5	0.5	0.6	0.3	0.3	3.02	5
SL UCDO_001cii	2.7	2.3	2.7	2.7	2.2	2.4	15.13	8	0.8	0.4	0.4	0.5	0.2	0.2	2.58	7
SL UCDO_005	2.0	2.0	2.2	2.0	2.0	2.2	12.35	11	0.6	0.3	0.3	0.4	0.2	0.2	2.04	10
SL UCDO_010	3.7	3.4	3.8	3.7	3.6	3.7	21.91	2	1.1	0.5	0.6	0.7	0.4	0.4	3.65	3
SL UCDO_010ii	3.4	2.9	3.3	3.4	2.6	2.9	18.43	4	1.0	0.4	0.5	0.7	0.3	0.3	3.18	4
SL UCDO_013	4.3	4.1	4.2	4.2	3.9	4.1	24.78	1	1.3	0.6	0.6	0.8	0.4	0.4	4.17	1
SL UCDO_013ii	3.8	3.4	3.9	3.8	3.3	3.6	21.83	3	1.1	0.5	0.6	0.8	0.3	0.4	3.70	2

Financial Appraisal		Cost implications				Net WTE
		Investment £k	Saving/ Disinvestment £k	Net Investment £k	Ranking - based on Net Investment	
SL UCDO_001a	Do Previous: Put current hospital urgent care services back to how they were	£429	£0	£429	11	7
SL UCDO_001b	Do Current: Keep current hospital and community health services as they are now	£0	£0	£0	8	0
SL UCDO_001C	Enhanced hospital and community health services model to support extended MIU hours	£225	-£518	-£293	6	6
SL UCDO_001C-2	Enhanced hospital and community health services model to support extended MIU hours - 2 sites	-£56	-£549	-£605	5	-1
SL UCDO_001D	Reduce from 4 sites to 3 sites	£93	-£207	-£115	7	-2
SL UCDO_001E	Reduce from 4 sites to 2 sites	£15	-£746	-£731	2	-12
SL UCDO_005	Close Minor Injury Units and provide urgent care in other ways	£1,212	-£1,863	-£651	4	-33
SL UCDO_010	Do Mid Range: Better local Urgent Care (3 x Minor Injury & Illness Units in Powys)	£695	-£607	£89	9	14
SL UCDO_010-2	Do Mid Range: Better local Urgent Care (2 x Minor Injury & Illness Units in Powys)	-£56	-£668	-£725	3	-1
SL UCDO_013	Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)	£994	-£850	£144	10	17
SL UCDO_013-2	Do Maximum: Even better local Urgent Care (2 x UCCs and 0 x MIIU in Powys)	£10	-£850	-£840	1	-1

Cost implication methodology

Investment £k - total investment required above current baseline cost

Saving/disinvestment £k - total savings/cost reduction deliverable from the investment

Net investment £k - total invesment less total saving/cost reduction

Net WTE change - net increase in WTE required to deliver option

Overall, the appraisal supports UCDO_013 as the most balanced option for progression. Although UCDO_013ii offers the greatest financial efficiency, it also carries higher access, equality and implementation risks. UCDO_013 is not the lowest-cost option, but it provides a more deliverable balance between financial sustainability, service quality, workforce resilience and local access. The detailed modelling, phasing, investment appraisal and sensitivity analysis should be developed further through the pre-consultation business case.

2.8 Governance Arrangements	Powys Teaching Health Board (PTHB) will apply a robust, transparent and proportionate approach to assessing the impacts of service change through its Integrated Impact Assessment (IIA) process. The purpose of the IIA is to identify, assess and mitigate potential impacts before decisions are made, ensuring that quality, equality, workforce, Welsh language and wider population health considerations are fully understood. The IIA framework brings together statutory and best-practice assessments into a single process. All proposals undergo a Level 1 assessment, with higher-risk or more complex proposals progressing to a detailed Level 2 assessment. Where significant adverse impacts are identified, further detailed analysis and mitigation planning are required. Alongside the IIA, dedicated assessments are undertaken where required by an independent panel, including: • Quality Impact Assessment (QIA) • Equality Impact Assessment (EQIA) • Welsh Language Impact Assessment (WLIA) • Health Impact Assessment (HIA) The Welsh Language Impact Assessment is particularly important in ensuring that the impact on Welsh speakers and Welsh-speaking communities is properly considered and that the Welsh language is not treated less favourably than the English language. Completion of the WLIA, alongside the EQIA and QIA, will form an important part of providing assurance that consultation is robust and legally defensible. The impact assessments are agreed by the Senior Responsible Officer and reviewed by a Quality and an Equality panel and final sign off is via the Programme Boards. The Equality Impact Assessments (EQIA/EIA) will remain live documents throughout the duration of the programme, supporting the ongoing identification of impacts, mitigations and associated actions. Following the engagement period, any new findings identified will be reviewed and analysed. This information will be used to update the EQIA/EIA as required, including refining existing mitigations, identifying additional impacts, and strengthening actions to address potential effects on protected groups.
2.9 Engagement and/or	Stakeholder participation throughout the Better Together Phase 1 options development process was structured to ensure appropriate involvement at each stage. Early engagement focused on patients, service users, communities, staff and partners to inform the Case for Change, design principles and option development. Technical appraisal

Consultation considerations	stages then drew on clinical, operational and professional expertise to assess quality, workforce, financial, estates and deliverability considerations. Public, patient and stakeholder feedback gathered throughout the process informed option refinement, assessment criteria, mitigations and decision-making. Stakeholder groups were established to support option development, deliberation, assurance and communication, while patient representatives remained involved through deliberative events. The engagement process remains ongoing. Importantly, information, concerns and insights received during consultation from patients, service users, carers, communities and stakeholders will be used to further develop, strengthen and refine the Quality Impact Assessment, Equality Impact Assessment, Welsh Language Impact Assessment and other supporting assessments. This will ensure that emerging evidence and lived experience continue to inform decision-making and that any additional impacts, risks or mitigation measures identified through consultation are fully considered before final decisions are made.

Quality and Equality Impact Assessments

Overview
This Impact assessment is based on the PTHB agreed process.

Using this template helps us to fulfil important legal duties and best practice requirements:

- The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this is through Quality Impact Assessments (QIA). A high-level quality impact assessment is included in Section B.1 of the template, and a template for a deep dive assessment is included in Section C.1.
- The Equality Act 2010 and Welsh Language Act 1993 create important statutory duties for assessing the impact of key decisions for people with equality protected characteristics, in relation to Welsh Language, and for different socio-economic groups through the socio-economic duty. A high-level equality impact assessment is included in Section B.2 of the template, and a template for a deep dive assessment is included in Section C.2.
- The Well-being of Future Generations Act 2015 requires public bodies to consider the wider longer-term impact of their decisions on the communities they serve. Considering of the seven wellbeing goals should be considered as part of the "Whole Systems Impact" quality standard. Key issues may also be highlighted in other relevant sections (e.g. socio-economic considerations in the Equality Impact Assessment, strategic alignment and social responsibility elements of the Section A Overview).
- Good practice in evaluation and appraisal of policies and programmes is available from a range of sources including The UK Government Green Book for appraisal and evaluation, National Audit Office etc.

A Level 1 Assessment is expected for all health board proposals. This provides a high-level summary of a proposal, the decision to be made, and whether there are any adverse impacts that may need to be considered in more detail before a decision can be made.

A Level 2 Assessment will be undertaken for proposals of higher value and complexity where potential adverse impacts are identified. The Level 2 Assessment requires a detailed overview of the proposal, and an integrated impact assessment covering issues such as quality, equality, compliance, strategic alignment, reputation, deliverability. Where adverse quality impacts or adverse equality impacts with a score of 9 or more are identified then a further "deep dive" will be required in order to ensure that the risks are fully understood, mitigation action is in place, monitoring measures and controls have been identified, and unintended consequences have been considered.

Approach to Scoring

The scoring tool used to inform this impact assessment utilising a standard Likelihood versus Impact assessment.
In this context the term '**Likelihood' has been used universally across this document to describe the likelihood a person would become a patient of the health services delivered or commissioned by Powys Teaching Health Board**.

For example, a person is more likely to need physical health community services or inpatient services during their entire life, whereas they may never need to use urgent care of mental health services and so it may reasonably be considered that it is possible they may need these services.

Table 1: Measures of Likelihood

Descriptor	**Rare (1)**	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost certain (5)**
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

After a person comes into contact with the Health Service then there can be a measure of the 'Impact'. In the context of the delivery of health care services the Impact is the extent of harm, loss, disruption, or adverse effect that would result if a risk from the contact with the service. The tool expresses impact using a range of domains. As the new models of care being proposed are primarily going to impact the experience people will have when using the Health Board Services the domain called 'Quality / Complaints / Audit' has been used.
For example, a person may experience a level of care where a level of treatment maybe sub optimal which would be described as negligible impact which has a score of 1. Or Overall treatment or service sub-optimal which has a score of 2.

Therefore, when the overall new model of care may demonstrate an improvement in service over existing models of care the lowest impact score would be a 1.

Table 2: Measures of Impact

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service sub-optimal Informal complaint / inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/improve-ment notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating 4 Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption / environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

The final risk score calculation used in this assessment is as follows:

Score of the likelihood of using the service x score of the impact of using the service = the overall score.

Table 3: Risk Score

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Possible 3	3	6	9	12	15
	Unlikely 2	2	4	6	8	10
	Rare 1	1	2	3	4	5
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		IMPACT				

It could be considered that a person is Likely (4) to use community services which were delivered to a satisfactory level which would have had a negligible (1). The total risk score is therefore 4.

In the assessments where a score is referred to it is listed with its colour or in brackets as above.

Quality and Equality Impact Assessments

SL UCDO_013i (Do Maximum): Even better local Urgent Care (2 x UCCs 1 MIIU in Powys)

Summary

- Development of dedicated Urgent Care Centres in Newtown and Brecon
- Closure of the Minor Injury Unit (MIU) in Welshpool Community Hospital to be transferred and enhanced to an Urgent Care Centre in Newtown Community Hospital
- Enhancement of the MIU into a Minor Injuries and Illness Unit
- Closure of the Minor Injury Units Ystradgynlais**.**

A.3. Integrated Impact Assessment Summary			Risk of Adverse Impact		
			Likelihood	Impact	Score
3.1 Quality	**Headlines**	**Quality Impact Assessment headlines** • Overall positive quality impact with improved access through a balanced model of two Urgent Care Centres and one Minor Injury and Illness Unit. • Enhanced clinical capability, diagnostics and opening hours expected to improve patient outcomes and reduce onward referrals. • Improved system integration and person-centred care, particularly for an ageing population. • Risks remain around workforce sustainability, capital investment requirements, and reliance on robust staffing models. • Some residual concerns regarding equity, variation in access, and demand pressures at larger sites.	3	2	6
	Full QIA required?	Yes, due to overall complexity of proposal			
3.2 Equality	**Headlines**	**Equality Impact Assessment headlines** • Overall reduction in travel impact for much of the population due to improved geographical distribution of services across north, mid and south Powys. • Model supports improved access and outcomes for most protected groups, particularly older people and those with disabilities. • Residual travel and access impacts remain for some communities, particularly Ystradgynlais. • Welsh language provision identified as the most significant equality risk due to potential workforce gaps across sites. • Socio-economic, social exclusion and carers groups experience moderate impacts, largely linked to transport and rurality, but mitigated through service design and existing pathways. • Most protected characteristics show low or no adverse impact, with overall equality impact assessed as moderate and requiring a full Equality Impact Assessment. • Mitigations in place, including workforce planning, Welsh language strategy, enhanced triage, and community support, reducing the overall risk over time.	3	2	6
	Full EQIA required	Yes, due to the overall complexity of the proposal			

3.3 Legal / Statutory	The proposed model remains compliant with statutory duties and delivers a strong balance between accessibility, quality, equity, and long-term sustainability. Retaining a Minor Injury and Illness Unit in Llandrindod Wells maintains local access for Mid Powys communities, while the development of two enhanced Urgent Care Centres represents a significant improvement in urgent care provision. Together, these services will provide greater clinical capability, improved diagnostics, extended opening hours and stronger workforce resilience, helping more patients receive timely and appropriate care within Powys.	4	1	4
3.4 Strategic Alignment and Health Outcomes	The model aligns strongly with national, regional and local priorities by improving access to high-quality urgent care closer to home. Enhanced diagnostics, greater clinical expertise, local step-up capacity and stronger integration with community, ambulance and emergency services will enable more patients to be assessed, diagnosed and treated within Powys. This is expected to improve patient outcomes, reduce delays in care and significantly reduce reliance on out-of-county hospitals and emergency departments.	4	1	4
3.5 Market and Partnerships	The model strengthens partnership working across primary care, community services, ambulance services, acute providers and the third sector, creating a more integrated urgent care system for Powys residents. Retaining services across Newtown, Brecon and Llandrindod Wells supports coordinated care pathways and improves opportunities for patients to access the right care in the right place. Increased local clinical capability will reduce dependence on external providers and support greater continuity of care through local services and access to local health records. The overall economic impact is expected to be positive. Enhanced Urgent Care Centres in Newtown and Brecon will attract investment, support skilled employment and increase healthcare activity within Powys, while Llandrindod Wells continues to benefit from retaining an important local healthcare service. By reducing the need for patients to travel outside the county for urgent care, the model helps retain both healthcare expenditure and wider economic benefits within Powys communities.	2	1	2
3.6 Operational Deliverability	The model provides a practical and deliverable route to a more sustainable and clinically effective urgent care system. By concentrating specialist expertise, di-	4	1	4

	agnostics and enhanced services within two Urgent Care Centres while retaining local provision in Llandrindod Wells, the model supports service standardisation, improved patient flow and greater workforce sustainability. It also provides increased flexibility to respond to future demand and changing population needs. Successful implementation will be supported through investment, workforce development and a phased approach to delivery.			
3.7 Ethics, Reputation and Social Responsibility	The model achieves a positive balance between enhanced clinical services and local accessibility. Patients will benefit from access to significantly improved urgent care services within Powys, including diagnostics, senior clinical decision-making and treatment options that are currently unavailable in many local settings. Retaining a service in Llandrindod Wells responds directly to feedback received during engagement and demonstrates a commitment to maintaining local access while improving quality. For many patients, the enhanced model is expected to reduce onward travel, lower costs and avoid lengthy waits in busy emergency departments outside Powys.	2	1	2
3.8 Workforce	The model significantly strengthens workforce resilience by bringing together specialist skills, multidisciplinary expertise and enhanced clinical leadership within two Urgent Care Centres, while maintaining local service provision through the Minor Injury and Illness Unit. This approach supports recruitment, retention, professional development and career progression, helping create a more stable and sustainable workforce. Concentrating expertise within enhanced centres also improves opportunities for training, service development and knowledge sharing, ultimately benefiting both staff and patients.	4	1	4
3.9 Summary of Mitigations	The proposed model incorporates a range of measures to minimise risks and maximise benefits for patients and communities. These include maintaining a broad geographical spread of services, enhanced urgent care pathways, improved diagnostics, local step-up capacity, community support arrangements, workforce development initiatives, Welsh language improvements and stronger integration across health and care services. Collectively, these measures create a more resilient, sustainable and clinically capable urgent care system that enables more patients to receive care closer to home, reduces reliance on out-of-county hospitals and improves overall patient experience and outcomes across Powys.	4	1	4

SL UCDO_013 (Do Maximum): Even better local Urgent Care (2 x UCCs and 1 MIIU in Powys)

Section B.1 Summary Impact Assessment - Quality

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Standard is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in Explanatory Notes. A "deep dive" assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.1).

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Summary	Feedback on the proposed urgent care model highlights significant benefits for patients, communities and the wider health and care system. The model combines two enhanced Urgent Care Centres with a Minor Injury and Illness Unit, creating a substantial improvement in the range, quality and accessibility of urgent care services available within Powys. Enhanced diagnostics extended opening hours, local step-up care capacity and improved clinical expertise will enable more people to be assessed, diagnosed and treated closer to home. The model is expected to improve patient outcomes, reduce reliance on out-of-county hospitals, support an ageing population and provide a more sustainable and resilient service. By enabling more care to be delivered within Powys, patients will benefit from reduced onward travel, lower travel costs, improved continuity of care through access to local records and fewer lengthy waits in external Emergency Departments. Successful implementation will depend on continued investment in workforce, community services and supporting infrastructure, but the overall model represents a significant step forward in urgent care provision for Powys.	3	2	6

[1] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

	Benefits • Significantly enhanced urgent care services available within Powys. • Improved access to diagnostics, assessment and treatment closer to home. • Two enhanced Urgent Care Centres providing greater clinical capability and resilience. • Retention of a Minor Injury and Illness Unit in Llandrindod Wells supporting local accessibility. • Reduced reliance on out-of-county hospitals and emergency departments. • Greater opportunities for local step-up care and admission avoidance. • Improved continuity of care through access to local records and established care pathways. • Reduced travel time, travel costs and disruption associated with onward transfers. • Stronger workforce sustainability, recruitment and retention opportunities. • Better integration with community, primary care, ambulance and emergency services. • Improved patient flow and more consistent service delivery across Powys. • A more sustainable, resilient and future-focused urgent care model. **Challenges** • Some communities may experience longer journeys to access urgent care services. • Public transport accessibility remains a challenge in parts of rural Powys. • Workforce recruitment and retention remain important factors for successful delivery. • Demand will need to be carefully managed across the enhanced Urgent Care Centres.			

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	• Continued investment will be required to maximise the benefits of the new model. • Ongoing communication and engagement will be needed to support public understanding. • Community and preventative services must continue to develop alongside urgent care provision.			
Safe	The proposed Urgent Care Model has the potential to improve patient safety by establishing two enhanced Urgent Care Centres with expanded diagnostic capability, senior clinical decision-making, advanced practitioner roles and improved access to treatment for a wider range of urgent conditions. The addition of Minor Injury and Illness Unit provision ensures local access is maintained while allowing more patients to receive safe and appropriate care within Powys. Enhanced integration with primary care, ambulance services, community services and step-up care pathways is expected to improve continuity of care and reduce unnecessary transfers to Emergency Departments. However, the model represents a significant change to existing urgent care arrangements and will require careful implementation to ensure patient safety is maintained throughout the transition. Particular attention will need to be given to staff training, clinical competency development, public understanding of the new service model, and the establishment of clear referral and escalation pathways. Successful delivery of the anticipated safety benefits will depend on ensuring the enhanced services are fully operational and supported before activity is transferred from existing arrangements.	3	2	6

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	The risk of adverse impact is considered low and it is possible (3) that members of the public may use urgent care services but any adverse impact is anticipated to be negligible (1), however the additional change of the transition has been assessed as minor (2) resulting in an overall risk score of 6.			
Timely	The model is expected to improve timely access to urgent care through enhanced clinical capability, improved diagnostics, extended service availability and stronger links with community and primary care services. More patients will be able to receive assessment, investigation and treatment locally, reducing delays associated with onward referral and avoiding unnecessary waits within busy Emergency Departments. Earlier access to diagnostics and senior clinical decision-making may also support faster treatment and better patient flow. Whilst the overall impact on timeliness is expected to be positive, some individuals may need to travel further to access the enhanced Urgent Care Centres depending on their location. During the implementation period, careful management will be required to ensure patients understand how to access the new services and that demand is managed appropriately while pathways become established. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Effective	The model supports more effective urgent care by concentrating enhanced clinical expertise, diagnostics and treatment capability within two Urgent Care Centres, whilst maintaining local access through the Minor Injury and Illness Unit. This approach enables more patients to be assessed, diagnosed and treated within Powys and provides greater access to senior decision-makers and multidisciplinary support. Enhanced clinical capability is expected to improve outcomes, reduce avoidable hospital attendances and support more appropriate use of healthcare resources. The effectiveness of the model will, however, depend upon successful workforce development, recruitment and implementation of the enhanced service offer. The transition period will require careful monitoring to ensure that service standards are maintained and that community understanding of the revised care pathways supports appropriate utilisation of services. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Efficient	The model has the potential to improve efficiency through better utilisation of workforce, diagnostics, facilities and clinical expertise. By enabling more patients to receive appropriate assessment and treatment within Powys, the model is expected to reduce unnecessary transfers to Emergency Departments, avoid duplication of assessment and improve patient flow across the wider system. Larger urgent care teams may also support more flexible staffing arrangements and improved service resilience.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	However, efficiency gains may not be immediately realised and will depend upon investment in training, infrastructure, diagnostics and workforce development. There may also be temporary operational pressures during implementation as services transition to new ways of working. A phased and carefully managed approach will be essential to achieving sustainable long-term improvements. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.			
Equitable	The model aims to improve equity of access by providing residents across Powys with access to enhanced urgent care services, improved diagnostics and a broader range of treatment options. The retention of a Minor Injury and Illness Unit supports local accessibility, while the two enhanced Urgent Care Centres provide a more consistent and comprehensive service offer across the county. This is expected to reduce variation in access to urgent care and ensure more people can receive treatment closer to home. Nevertheless, as with any service model in a large rural county, some communities may experience different travel requirements depending on their location. Careful consideration will therefore be needed to ensure that the benefits of enhanced clinical capability are experienced equitably across Powys and that any unintended impacts on specific communities are identified and mitigated. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Person-Centred	The model supports a more person-centred approach by providing greater access to diagnostics, treatment and clinical expertise within Powys. Enabling more patients to be treated locally reduces unnecessary travel, supports continuity of care and helps individuals access the right care in the most appropriate setting. This is likely to be particularly beneficial for older people, children, carers and those with complex health needs who may otherwise face longer journeys and extended waits in Emergency Departments. Some patients may need to adapt to new service locations and access arrangements, which may initially create uncertainty. Effective communication, engagement and public education will therefore be essential in ensuring patients understand the benefits of the model and how best to access urgent care services as the changes are implemented. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Workforce	The model is expected to strengthen workforce sustainability by creating larger, more resilient urgent care teams with enhanced clinical capability. Opportunities for advanced practice, diagnostics training, career development and multidisciplinary working are likely to support recruitment, retention and workforce satisfaction. Concentrating specialist expertise within the enhanced Urgent Care Centres may also reduce professional isolation and strengthen clinical support arrangements.	3	1	3
		Likelihood	**Impact**	**Score**

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Implementation will require significant workforce development to ensure staff are equipped with the skills and competencies necessary to deliver the enhanced service model. Some staff may experience changes to roles, locations or working patterns and will require appropriate support throughout the transition. Effective workforce planning and engagement will be critical to the successful delivery of the model. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.			
Leadership	The model provides a clear strategic direction for urgent care services within Powys by establishing two enhanced Urgent Care Centres supported by a wider network of community and primary care services. This creates opportunities for stronger governance, improved standardisation of care and more consistent clinical leadership across urgent care pathways. Successful implementation will require visible and sustained leadership to manage organisational change, maintain stakeholder confidence and ensure alignment across multiple services and partners. Robust governance arrangements and clear accountability structures will be important throughout the implementation period.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Culture	The model supports a culture focused on collaboration, innovation, service development and person-centred care. Enhanced Urgent Care Centres create opportunities for multidisciplinary working and stronger links between urgent care, primary care, community services and ambulance services. The model also promotes a shift towards managing more patients locally and reducing unnecessary dependence on distant hospital services. As with any significant service transformation, cultural change will take time to embed. Staff will need support to adapt to new ways of working and to fully embrace the opportunities associated with expanded clinical roles and integrated pathways. Ongoing engagement and organisational development will be important to achieving the intended cultural benefits. The risk of adverse impact is considered low and it is possible (3) that members of the public may use urgent care services but any adverse impact is anticipated to be negligible (1), however the additional change of the transition has been assessed as minor (2) resulting in an overall risk score of 6.	3	2	6
Information	The proposed model offers opportunities to improve patient navigation, information sharing and clinical decision-making through clearer pathways and greater use of local records and established systems. Delivering more care within Powys may improve continuity of information and support more effective coordination of patient care across services.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
	Clear communication with patients, staff and partner organisations will be essential throughout implementation. Without effective communication there is potential for confusion regarding access arrangements and service availability. A comprehensive communication and engagement programme will therefore be required to support successful adoption of the model. Risk Assessment: The likelihood of impact relating to information and communication is assessed as 4, with a negligible impact score of 1, giving an overall risk score of 4.			
Learning, Improvement and Research	The enhanced Urgent Care Centres provide strong opportunities for workforce development, innovation, quality improvement and adoption of best practice. Larger teams with greater clinical capability may support more consistent training opportunities, improved mentorship arrangements and greater participation in service improvement activities. Enhanced diagnostics and broader service provision may also create opportunities to evaluate new models of care and improve clinical outcomes. These benefits will depend upon ongoing commitment to professional development and ensuring sufficient time and capacity for learning activities alongside service delivery. Continued investment in training and improvement activity will be important as the model matures. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[1]		
		Likelihood	Impact	Score
Whole Systems Approach	The model supports a more integrated whole-system approach by strengthening links between urgent care, primary care, community services, ambulance services, acute hospitals and wider system partners. Enhanced local capability is expected to reduce avoidable hospital attendances, improve patient flow, and support more coordinated care pathways across the health and care system. The success of the model will depend on effective collaboration between organisations and services, alongside the successful implementation of enhanced urgent care pathways. Strong partnership working, shared accountability and careful transition management will be critical to ensuring the anticipated benefits are realised across the wider system. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Based on this assessment the threshold has not been met to proceed to a deep assessment.

Equality Impact Assessment SL UCDO_013i: Do Maximum: Even better local Urgent Care (2 x UCCs 1 MIIU in Powys)

This Equality Impact Assessment was undertaken to evaluate the potential effects on individuals and groups with protected characteristics under the Equality Act 2010 of the draft proposals being developed in relation to three key service areas as part of the Stage 2 Better Together programme.

The assessment drew on a range of evidence which utilised the data in the revised Full Case for Change and the feedback given from the engagement conducted to date. This is set out in the comprehensive Stage 0 – Stage 2 Better Together feedback report alongside additional feedback captured by services using patient feedback mechanisms e.g. Civica surveys and patient focus groups during the past 18 months.

Engagement for the Better Together programme was carried out with PTHB employees, residents, third sector representatives, public sector colleagues and service users including representatives from equality groups. Surveys, focus groups and targeted outreach took place in communities to ensure a broad mix of views were captured.

The views given by all stakeholders were analysed and fed back to the programme team. Further analysis then took place to identify differential impacts across protected characteristics, with particular attention to areas of potential disadvantage. Where negative impacts were identified, some mitigation actions have been included either as ideas proposed by stakeholders or as additional options to reduce or eliminate these effects.

Section B.2 Summary Impact Assessment – Equality Impact Assessment
Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Characteristic is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in the Explanatory Notes. A deep dive assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.2). This should be undertaken in line with CGP009 using the template in Section C.2.

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
Summary	This assessment considered the impact of the proposed urgent care model, comprising two enhanced Urgent Care Centres and a Minor Injury and Illness Unit, on protected characteristics and wider population groups across Powys. Overall, the proposed model represents a significant step change in the provision of urgent care services within Powys. The model is expected to improve access to higher quality care through enhanced diagnostics, extended opening hours, greater clinical expertise, and the introduction of more comprehensive urgent care services delivered closer to home. The development of two Urgent Care Centres, supported by local step-up bed capacity and expanded diagnostic capability, is expected to enable more patients to be assessed, diagnosed and treated locally, reducing the need for onward transfer to acute hospitals outside Powys. Retaining a Minor Injury and Illness Unit in Mid Powys helps maintain local access to urgent care while providing a more balanced geographical distribution of services across the county. For many residents, particularly those requiring diagnostics, observation, treatment or admission avoidance interventions, the model is expected to reduce unnecessary travel to out-of-county emergency departments, helping to avoid long journeys, transport costs and potentially lengthy waits in busy Accident and Emergency departments. The most significant impacts relate to older people, disabled people, carers, individuals experiencing socio-economic disadvantage, and Welsh speakers. These groups are more likely to be affected by travel times, transport availability and access to local services. While most households remain within acceptable travel thresholds, some communities, particularly Ystradgynlais, are likely to experience increased journey times and will require ongoing mitigation and monitoring.	3	2	6

[2] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

Characteristic	Potential Impacts	Risk of Adverse Impact[2]		
		Likelihood	Impact	Score
	Children and young people may also be affected by increased travel requirements, as they rely on parents and carers for transport. However, the enhanced capability of the proposed model is expected to reduce onward referrals, improve access to diagnostics and specialist assessment, and facilitate faster access to appropriate treatment closer to home. For people with learning disabilities and other disabilities, changes in familiar service locations may create challenges relating to travel, communication and continuity of care. These impacts are partly offset by improved facilities, enhanced diagnostics, greater clinical capability and opportunities to make reasonable adjustments through triage, personalised care planning and coordinated support. Across most other protected characteristics, including race, religion, sex, sexual orientation, pregnancy and gender reassignment, no significant adverse impacts were identified. The main residual risk relates to Welsh language provision, particularly in communities with higher proportions of Welsh speakers. Targeted workforce planning, training and Welsh language support measures will be required to maintain equitable access. Overall, the assessment concludes that the proposed model would deliver a more resilient, sustainable and clinically capable urgent care service for Powys. While some travel-related impacts remain for specific communities, these are considered low and manageable. The overall benefits of significantly enhanced local urgent care provision, improved access to diagnostics and clinical decision-making, increased opportunities for treatment closer to home, reduced reliance on out-of-county acute hospitals, and reduced unnecessary travel, costs and waiting times are expected to result in a positive net impact for the Powys population.			

Summary Table

Characteristic	Likelihood	Impact	Score
Age	3	2	6
Disability	3	2	6
Gender Reassignment	3	1	3
Marriage and Civil Partnership	3	1	3
Pregnancy and Maternity	3	1	3
Race	3	1	3
Religion or Belief	3	1	3
Gender	3	1	3
Sexual Orientation	3	1	3
Welsh Language	3	2	6
Socio-Economic Circumstances	3	1	3
Social Exclusion	3	1	3
Carers	3	1	3

Age	Powys has a significantly older population than Wales and the UK, with 28% of residents aged 65 and over compared with 21% across Wales and 19% across the UK. Older residents are more likely to live with frailty, long-term conditions, reduced mobility and complex health needs, resulting in greater use of urgent and unscheduled care services. Against this demographic backdrop, the proposed model represents a significant opportunity to strengthen urgent care provision for the population most likely to require it. The development of two enhanced Urgent Care Centres in Newtown and Brecon, alongside a Minor Injury and Illness Unit in Llandrindod Wells, increases the overall clinical capability available within Powys and provides access to a wider range of assessment, diagnostic and treatment services closer to home. While evidence shows that older people in rural areas can face challenges relating to travel, transport availability and digital exclusion, the proposed model has been designed to improve access to timely and appropriate care by providing enhanced local services, extended opening hours, improved diagnostics and greater clinical expertise. Importantly, the model is expected to enable more older people to be diagnosed, treated and managed within Powys, reducing the need for onward travel to out-of-county acute hospitals wherever clinically appropriate. The proposed configuration also creates a more balanced geographical distribution of services across the county. Although some communities, particularly in the Ystradgynlais area, may experience longer journeys to access urgent care services, around 91% of Powys households remain within the 45-minute travel benchmark. Average travel times increase only modestly, from 20 minutes and 43 seconds, to 23 minutes and 50 seconds. Established access routes through NHS 111 and emergency ambulance services will continue to support those who are unable to travel independently. For older people, the overall impact of the proposed model is expected to be positive. Enhanced access to diagnostics, senior clinical decision-making, urgent treatment and local step-up care capacity is likely to improve patient experience,	3	2	6

	support earlier intervention, and reduce avoidable transfers to busy emergency departments outside Powys. By providing more comprehensive urgent care services locally, the model offers the potential for faster access to appropriate care, reduced travel burden, lower associated costs and improved outcomes for an ageing population. Therefore, based on the impact to the aging population the risk assessment score shows that the impact to the older age person might happen or occur occasionally (3), and the impact would be positive for the wider population in this group with a minor impact (2), showing an overall risk score of 6.			
Disability	The Health Board's Strategic Equality Plan identifies a range of actions to improve access, experience and outcomes for people with disabilities. Many of these improvements, including the provision of reasonable adjustments, accessible communication, inclusive processes and staff training, will continue regardless of the urgent care model adopted. The proposed model provides an opportunity to further strengthen these commitments through the delivery of enhanced urgent care services across Powys. The proposed model introduces two enhanced Urgent Care Centres (UCCs) and one Minor Injury and Illness Unit (MIIU), creating a more clinically capable and sustainable service. While the number of service locations reduces from four to three, the overall offer available to patients increases significantly through enhanced diagnostics, extended opening hours, access to a wider range of clinical professionals and improved treatment options closer to home.	3	2	6

	The principal considerations for people with disabilities relate to: 1. Travel and access to services. 2. Enhanced clinical services and treatment options. 3. Accessibility and suitability of facilities. Travel impacts will vary across Powys. The retention of a service in Llandrindod Wells helps maintain local access for residents in Mid Powys and contributes to a balanced geographical distribution of services. Some individuals, particularly those living in the Ystradgynlais area, may experience longer journey times when accessing urgent care services. However, the majority of patients already access services by car or supported transport, and established access routes through NHS 111 and emergency ambulance services will remain unchanged for those unable to travel independently. Importantly, the proposed model is expected to deliver significant benefits for people with disabilities through increased access to diagnostics, senior clinical decision-making, and a broader range of urgent care interventions within Powys. The enhanced capability of the Urgent Care Centres is expected to enable more patients to be assessed, diagnosed and treated locally, reducing the need for onward transfer to acute hospitals outside the county. This has the potential to reduce travel burden, waiting times and the disruption often associated with attending larger emergency departments. A further benefit is the opportunity to develop modern facilities designed around the needs of patients. Existing facilities are constrained by the limitations of older buildings and layouts. New or enhanced facilities provide greater opportunities to meet contemporary accessibility standards, supporting people with physical disabilities, sensory impairments, learning disabilities and neurodiverse conditions. Improvements in accessibility, wayfinding, communication and the clinical environment can help create a more inclusive and positive patient experience. Overall, the proposed model is expected to have a positive impact on people with disabilities. While some individuals may experience increased travel times, these impacts are outweighed by the benefits of improved local access to diagnostics,			

	enhanced clinical expertise, expanded treatment capabilities and reduced reliance on out-of-county acute hospitals. The combination of two enhanced Urgent Care Centres and a Minor Injury and Illness Unit represents a substantial improvement in the quality and capability of urgent care services available to people with disabilities across Powys. Therefore, based on the impact for a person with a disability that their need for urgent care services might happen or occur occasionally (3) and the impact would be positive for the wider population in this group with a minor impact (2), showing an overall risk score of 6.			
Gender Reassignment	The Health Board's Strategic Equality Plan includes actions to improve inclusion, support LGBTQ+ individuals, and ensure facilities meet the needs of all patients. Census data indicates that around 0.32% of Powys residents (approximately 360 people) identify as a gender different from their sex registered at birth. The proposed model would provide enhanced clinical services in modern facilities designed to current accessibility and inclusion standards. It is expected to improve access to care within Powys and reduce the need to travel outside the county for treatment. No specific adverse impacts have been identified for this group. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Marriage and Civil Partnership	The needs of people who are married or in a civil partnership are addressed through the Health Board's wider Equality and Human Rights arrangements. The proposed urgent care model does not introduce any specific changes that would adversely affect this protected characteristic. The primary impact is the general improvement in urgent care services, including enhanced diagnostics, clinical capability and access to care. No specific equality risks have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Pregnancy and Maternity	The Health Board's Strategic Equality Plan supports the needs of people who are pregnant or on maternity pathways. The proposed urgent care model does not alter these arrangements but benefits from wider improvements in service quality and access. Enhanced diagnostics, longer opening hours and more clinically capable services may improve access to urgent assessment when required. No adverse impacts specific to pregnancy or maternity have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Race	Powys has a relatively low proportion of residents from Black, Asian and Minority Ethnic communities (2.2%), compared with the Welsh average (6.2%). The Health Board's Strategic Equality Plan sets out arrangements to ensure services are delivered fairly and in accordance with the Equality Act 2010. The proposed urgent care model does not create any specific impacts relating to race or ethnicity. Existing equality, interpretation and accessibility arrangements remain in place, while the overall quality of urgent care services is expected to improve. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Religion or Belief	The Health Board is committed to supporting the religious and spiritual needs of patients, including providing access to private spaces for prayer and facilitating faith-based support where required. The proposed model does not alter these arrangements, and no specific impacts have been identified for people with particular religions or beliefs. The changes are expected to improve overall service quality without affecting the Health Board's ability to meet religious and cultural needs. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Gender	The Strategic Equality Plan promotes inclusive services and facilities that meet the needs of all patients. The proposed urgent care model does not create any differential impact based on sex or gender. Patients of all genders will continue to access services equitably, with potential benefits arising from improved clinical services, diagnostics and access to care. No adverse impacts have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Sexual Orientation	According to the 2021 Census, approximately 2.27% of Powys residents identified as lesbian, gay, bisexual or another minority sexual orientation. The Health Board's Strategic Equality Plan includes measures to ensure services are inclusive and meet the needs of LGBTQ+ communities. The proposed urgent care model does not introduce any specific barriers or adverse impacts relating to sexual orientation and is expected to provide the same benefits of improved access and service quality for all patients. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Welsh Language	The Welsh language is an important component of cultural identity, community wellbeing and healthcare experience in Powys. Census data shows that 16% of Powys residents aged three and over speak Welsh, with substantially higher proportions in some communities, including Machynlleth, Llanfyllin and Ystradgynlais. Ensuring access to services through the medium of Welsh is therefore an important consideration in the design and delivery of urgent care services across the county. The proposed model provides an opportunity to strengthen the delivery of Welsh-language services within a more sustainable and clinically capable urgent care system. Through the development of two enhanced Urgent Care Centres and a Minor Injury and Illness Unit, patients will benefit from improved diagnostics, extended opening hours, enhanced clinical expertise and greater opportunities to receive assessment and treatment closer to home, reducing the need for onward transfer to acute hospitals outside Powys. The most significant consideration relates to communities with higher proportions of Welsh speakers, particularly Ystradgynlais, where the existing Minor Injury Unit would close and patients would access urgent care through the Urgent Care Centre in Brecon or services in Swansea where clinically appropriate. For some Welsh-speaking patients, particularly those with learning disabilities, sensory impairments, cognitive difficulties or complex communication needs, access to services in their preferred language can play an important role in supporting understanding, informed consent, dignity and overall patient experience. However, the proposed model also presents an opportunity to take a more strategic approach to Welsh-language provision across urgent care services. By concentrating resources within enhanced centres, the Health Board will be better positioned to develop a sustainable workforce capable of delivering high-quality clinical care alongside an active offer of Welsh-language services. The Welsh Language (Wales) Measure 2011 requires Health Boards to provide Welsh and English services on the basis of equality and to actively support patients who wish to receive care through the medium of Welsh. In support of this,	3	2	6

	Powys Teaching Health Board has strengthened its commitment to Welsh-language services through enhanced workforce planning, Welsh-language role assessments, recruitment initiatives, Welsh language training, translation and interpretation support, Welsh in Healthcare training, and implementation of the Welsh in Healthcare Strategy 2024-2029. Importantly, the Health Board recognises that the number of Welsh speakers is anticipated to increase over time and is committed to ensuring that Welsh-language provision develops alongside the proposed urgent care model. This creates an opportunity not only to maintain existing standards but to strengthen the consistency, visibility and availability of Welsh-language services across urgent care settings. Overall, the proposed model is expected to deliver substantial benefits through enhanced local clinical services, improved diagnostics, greater treatment capability and reduced reliance on out-of-county acute hospitals. While there is a need to carefully manage and monitor Welsh-language provision in communities with higher proportions of Welsh speakers, the Health Board's planned investment in workforce development and Welsh-language services provides a strong foundation for ensuring equitable access and positive patient experiences. Therefore, for people who would like to receive care through the medium of Welsh, the need for urgent care services might happen occasionally (3), and the health care benefits impact would be positive for the wider population in this group with a minor impact (2), showing an overall risk score of 6.			

Socio-Economic Circumstances	Powys faces a number of socio-economic challenges, including lower average wages than the Welsh and UK averages, youth unemployment, rural isolation and limited digital connectivity. These factors can affect how easily people access healthcare services, particularly in more remote communities. At the same time, the dispersed nature of deprivation across Powys means that ensuring equitable access to high-quality healthcare remains an important consideration for service planning. The proposed model provides an opportunity to improve access to urgent care for residents across Powys through two enhanced Urgent Care Centres and a Minor Injury and Illness Unit. The enhanced centres will offer improved diagnostics, extended opening hours, greater clinical expertise and a wider range of treatment options, enabling more people to receive assessment, diagnosis and treatment within Powys rather than travelling to out-of-county acute hospitals. Access to transport remains an important consideration, particularly for those without access to a private vehicle and for communities where public transport options are limited. While some people may experience longer journeys to access urgent care services, the majority of residents will continue to live within a reasonable travel distance of an urgent care facility. Established access routes through NHS 111 and emergency ambulance services will remain available for those who require additional support to access care. It is recognised that public transport access is variable, route-dependent and time-limited, particularly for people without access to a car, older people, unpaid carers, families with children, disabled people and residents in rural communities outside the main towns. This three-site option presents a lower risk than the two site option, as it retains a mid-Powys urgent care location. Option 2 presents the greatest adverse impact, creating longer and more complex journeys and a clear gap in public transport access across mid-Powys. Importantly, the proposed model is expected to reduce the need for longer onward journeys to emergency departments outside Powys by providing a higher level of urgent care capability locally. This has the potential to reduce travel	3	1	3

	costs, minimise time away from home and work, and avoid lengthy waits associated with larger emergency departments. By retaining services in Newtown, Brecon and Llandrindod Wells, the model maintains a broad geographical spread while significantly enhancing the quality and range of services available to local communities. Overall, the impact on people experiencing socio-economic disadvantage is assessed as positive to moderate. While some travel-related challenges remain for certain communities, these are substantially outweighed by the benefits of enhanced local services, improved access to diagnostics and treatment, reduced reliance on out-of-county hospitals, and a more equitable, sustainable urgent care service for the population of Powys. Therefore, based on the impact for a person with challenging social economic circumstances, their need for urgent care services might happen or occur occasionally (3) and the impact would be positive for the wider population in this group with a negligible impact (1), showing an overall risk score of 3.			
Social Exclusion	Social exclusion can arise from poverty, low income, rural isolation, limited access to services, digital exclusion and language barriers. Census and deprivation data indicate that these challenges are present across Powys, with deprivation dispersed throughout the county rather than concentrated in a single area. These factors highlight the importance of ensuring that residents can access timely, high-quality healthcare regardless of where they live or their personal circumstances. The proposed urgent care model provides an opportunity to strengthen inclusion by improving the range and quality of urgent care services available within Powys. Through two enhanced Urgent Care Centres and a Minor Injury and Illness Unit, more patients will have access to improved diagnostics, extended opening hours, increased clinical expertise and a wider range of treatment options closer to home.	3	1	3

	Access to transport and services remains an important consideration, particularly for people living in remote rural communities or those experiencing financial hardship. Retaining a service in Llandrindod Wells helps maintain a balanced geographical distribution of services and reduces the risk of a significant access gap within Mid Powys. While some residents may continue to rely on public transport or supported travel arrangements, most households remain within a reasonable travel distance of urgent care services. Existing access routes through NHS 111 and emergency ambulance services will continue to support those who are unable to travel independently. A key benefit of the proposed model is its ability to reduce the need for unnecessary travel to out-of-county hospitals. By providing greater diagnostic and treatment capability locally, more patients can receive appropriate care within Powys, reducing travel costs, travel time and the disruption often associated with accessing larger acute hospitals. Maintaining services across Newtown, Brecon and Llandrindod Wells helps preserve local access while significantly enhancing the level of care available to communities across the county. Overall, the impact on people experiencing social exclusion is assessed as positive to moderate. While some travel-related challenges remain for a small proportion of residents, these are outweighed by the benefits of improved local services, enhanced clinical capability, reduced reliance on out-of-county hospitals and more equitable access to urgent care for communities across Powys. Therefore, a person who is experiencing social exclusion may need urgent care services occasionally (3), and the impact would be positive for the wider population in this group with a negligible impact (1), showing an overall risk score of 3.			

Carers	Supporting unpaid carers is a key priority within the Powys Area Plan, which aims to improve carers' wellbeing through information, advice, respite, transport and community support. Unpaid carers play a vital role in supporting wellbeing, recovery, independence and the delivery of care across Powys particularly in Brecon and Ystradgynlais. Ensuring timely access to local healthcare services is therefore especially important for carers, whose ability to provide ongoing support can be affected by time spent travelling, attending appointments or accessing services outside the county. The proposed urgent care model provides an opportunity to strengthen support for carers through the development of two enhanced Urgent Care Centres and a Minor Injury and Illness Unit. These services will provide improved diagnostics, extended opening hours, greater clinical expertise and a wider range of treatment options within Powys, enabling more patients to receive assessment and treatment closer to home. Travel and transport remain important considerations, particularly for carers balancing healthcare needs alongside caring responsibilities. While some carers, especially in areas such as Ystradgynlais, may experience longer journeys to access urgent care services, the retention of services in Newtown, Brecon and Llandrindod Wells helps maintain a broad geographical spread across the county. Established access routes through NHS 111 and emergency ambulance services will continue to support those requiring urgent care. A significant benefit of the proposed model is the ability to provide more care locally within Powys. By treating more patients closer to home, the model is expected to reduce unnecessary onward transfers to out-of-county hospitals, helping to minimise travel time, transport costs and lengthy waits in busy emergency departments. For carers, this can reduce disruption to caring responsibilities and allow more time to be spent supporting those they care for. There are also important benefits associated with accessing care through local Powys services. Clinicians are more likely to have access to local health records	3	1	3

	and established care plans, enabling better-informed decision-making and a more joined-up patient experience. This can be particularly valuable for children, people with disabilities, individuals with complex needs and those who rely on carers to communicate important information about their health and support requirements. Having access to local records can help avoid duplication, improve continuity of care and support more timely assessment and treatment. Overall, the impact on carers is assessed as positive to moderate. While some carers may experience increased travel times, these impacts are outweighed by the benefits of enhanced local services, improved access to diagnostics and treatment, better continuity of care through access to local records, reduced reliance on out-of-county hospitals and less disruption to essential caring responsibilities. The proposed model is expected to provide a more responsive, sustainable and carer-friendly urgent care service for communities across Powys. Therefore, a carer may find their need for urgent care services might happen occasionally (3), and the impact would be positive for the wider population in this group with a negligible impact (1), showing an overall risk score of 3.			

Section C.2 Deep Dive Impact Assessment - Equality
Where agreed, you should copy and complete this table for every adverse equality impact score of 9 or more (yellow, amber and red impacts). This will form part of a full Equality Impact Assessment in line with Health Board policy CGP009 Equality Impact Assessment Policy. The level of detail should be proportionate to the impact and likelihood.

The threshold has not been met in these areas.

SL UCDO_013ii (Do Maximum) Even better local Urgent Care (2 x UCCs in Powys)

Summary

- **Development of dedicated Urgent Care Centres in Newtown and Brecon.**
- **Closure of the Minor Injury Unit (MIU) in Welshpool Community Hospital, to be transferred and enhanced to an Urgent Care Centre in Newtown Community Hospital.**
- **Closure of the Minor Injury Units in Llandrindod Wells and Ystradgynlais.**

A.3. Integrated Impact Assessment Summary			Risk of Adverse Impact		
			Likelihood	Impact	Score
3.1 Quality	**Headlines**	• Strong overall quality improvement through enhanced urgent care model with two dedicated Urgent Care Centres providing higher clinical capability, diagnostics and extended access. • Improved patient outcomes and experience, particularly for an ageing population, through more care delivered locally and reduced reliance on out-of-county services. • Positive impact on timeliness, effectiveness and person-centred care through integration with community and emergency services and seven-day provision. • Efficiency gains through service consolidation, clearer governance, and reduced reliance on temporary staffing. • Key risks relate to workforce sustainability, recruitment of senior and specialist roles, and dependency on sufficient capital investment and estate development. • Residual concerns around equitable access and increased travel times for some rural communities, with potential demand pressures at centralised sites.	3	2	6
	Full QIA required?	Yes, due to the complexity of the proposal.			
3.2 Equality	**Headlines**	• Overall moderate equality impact. • Model delivers improved clinical outcomes and service quality for most population groups, particularly older people and those with long-term conditions. • Key adverse impacts relate to increased travel times and access challenges for some rural populations, particularly those without access to private transport. • Welsh language identified as the most significant equality risk, with potential reduced access to Welsh-speaking services following consolidation at fewer sites. • Moderate impacts identified for older people, disabled individuals, carers, and those experiencing socio-economic disadvantage and social exclusion, primarily linked to transport, rurality and access. • Limited or no adverse impact identified across most other protected characteristics, with the model broadly neutral or positive in these areas.	3	2	6

		• Risk of digital exclusion and reliance on transport systems may disproportionately affect vulnerable groups. • Mitigations including NHS 111 triage, ambulance access, workforce development, Welsh language strategy and community support expected to reduce impacts over time. • Overall position reflects a balance between improved clinical capability and some reduced accessibility, with ongoing monitoring required to manage residual risks.			
	Full EQIA required	Yes, due to the complexity of the proposal.			
3.3 Legal / Statutory		The model is broadly compliant with statutory duties, including the Equality Act 2010 and Welsh Language Standards. It supports long-term sustainability, improved quality and workforce resilience through two enhanced Urgent Care Centres. Key risks relate to increased travel for some rural communities and potential impacts on Welsh language provision, particularly in Ystradgynlais. These risks can be mitigated through workforce planning, Welsh language initiatives, transport support and ongoing monitoring.	4	1	4
3.4 Strategic Alignment and Health Outcomes		The model aligns strongly with national and local strategies by improving urgent care access, supporting care closer to home and responding to the needs of an ageing population. Enhanced diagnostics, extended opening hours and better integration with community services are expected to improve outcomes, reduce hospital admissions and provide a more sustainable service.	4	1	4
3.5 Market and Partnerships		The model strengthens integration between urgent care, primary care, community services, ambulance services and the third sector. It supports more consistent care pathways and closer alignment with neighbouring health systems. Continued partnership working will be critical to address transport, community support and cross-border service use. Overall economic impact is expected to be neutral to positive across Powys. Investment, jobs and healthcare activity will be concentrated in Newtown and Brecon, creating local economic benefits. However, Welshpool, Llandrindod Wells and Ystradgynlais may experience reduced local activity following service changes. The model redistributes rather than removes healthcare spending, and offers stronger long-term financial sustainability.	2	1	2

3.6 Operational Deliverability	The model provides a simpler and more standardised urgent care system, supporting clearer governance and more resilient service delivery. Successful implementation depends on capital investment, workforce availability, robust planning and phased implementation to manage risks associated with consolidating services onto fewer sites.	4	1	4
3.7 Ethics, Reputation and Social Responsibility	The model aims to improve quality, safety and sustainability while providing enhanced urgent care services within Powys. Reputational risks remain due to changes in local access and increased travel for some communities. Clear communication, ongoing engagement and effective mitigation will be essential to maintain public confidence.	2	1	2
3.8 Workforce	Workforce sustainability is one of the key benefits of the model. Service consolidation supports stronger rotas, reduced reliance on temporary staffing and concentration of specialist skills. However, recruitment, retention and development of skilled staff, including Welsh-speaking practitioners and advanced clinical roles, remain critical to long-term success.	4	1	4
3.9 Summary of Mitigations	Key mitigations include strengthened NHS 111 and ambulance pathways, community-based support, improved transport arrangements, investment in modern facilities, workforce development and Welsh language initiatives. Phased implementation, ongoing stakeholder engagement and improved performance monitoring will help minimise risks and support equitable access across Powys.	4	1	4

Section B.1 Summary Impact Assessment – Quality

SL UCDO_013ii: Do Maximum: Even better local Urgent Care (2 x UCCs in Powys)

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Standard is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in Explanatory Notes. A "deep dive" assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.1).

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Summary	The proposed urgent care model represents a significant step change in the delivery of urgent care services in Powys. By establishing two dedicated enhanced Urgent Care Centres, the model creates a more clinically capable, resilient and sustainable service that can provide a substantially broader range of assessment, diagnostics and treatment than is currently available. Patients will benefit from seven-day services, improved access to diagnostics, greater clinical expertise and stronger integration with community, ambulance and emergency care services. The enhanced centres are expected to enable more patients to be assessed, diagnosed and treated within Powys, reducing reliance on out-of-county hospitals and emergency departments. This will help reduce unnecessary onward travel, associated costs and lengthy waits, while improving continuity of care through access to local records and integrated local services.	3	2	6

[3] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

	The model also provides the strongest workforce and financial sustainability, supporting recruitment, retention, service consistency, and long-term resilience. While travel times may increase for some communities, the overall patient journey is expected to improve through access to more comprehensive care at the point of first attendance and a reduced need for subsequent transfers to external hospitals. **Key Benefits** • Two enhanced Urgent Care Centres providing significantly improved clinical capability. • Improved access to diagnostics, assessment and treatment within Powys. • Greater opportunities to manage patients locally and avoid hospital admission. • Reduced reliance on out-of-county hospitals and Emergency Departments. • Improved patient experience through more comprehensive urgent care services. • Strongest workforce resilience, recruitment and retention opportunities. • Reduced reliance on temporary and agency staffing. • Clearer governance, leadership and service consistency. • More efficient use of specialist skills, estates and diagnostic resources. • Improved continuity of care through access to local records and local care pathways. • Greater long-term financial and operational sustainability. • Stronger integration with primary care, community services, ambulance services and emergency care. **Key Considerations** • Some communities may experience longer travel times to access urgent care services. • Public transport accessibility remains a challenge in some rural areas. • Continued workforce recruitment and retention will remain important for long-term success. • Capital investment will be required to maximise the benefits of the enhanced model.			

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	• Ongoing public engagement and communication will be required during implementation. • Community and preventative services must continue to develop alongside urgent care services.			
Safe	The proposed Urgent Care Model has the potential to improve patient safety through the development of two enhanced Urgent Care Centres with expanded diagnostic capability, increased access to senior clinical decision-makers, advanced practitioner roles, and a broader range of assessment and treatment options. This enhanced capability should enable more patients to be assessed, investigated and treated safely within Powys, reducing unnecessary transfers and supporting earlier clinical decision-making. Stronger integration with community services, primary care, ambulance services and step-up care pathways is also expected to improve continuity of care and reduce fragmentation across the urgent care system. However, the concentration of urgent care services into two enhanced centres represents a significant change for some communities and may require some patients to travel further than they do currently. Successful implementation will depend upon ensuring the enhanced centres are fully established, appropriately staffed, and operational before changes are introduced. Careful transition planning, workforce development and public communication will be essential to ensure patients continue to access care safely and confidently throughout the implementation period. The risk of adverse impact is considered low and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), however the additional change of the transition has been assessed as minor (2), resulting in an overall risk score of 6.	3	2	6

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Timely	The model is expected to improve timely access to urgent care through enhanced diagnostics, improved clinical capability, strengthened triage arrangements and greater availability of locally delivered urgent treatment. The ability to access diagnostics and senior clinical review at the point of presentation should reduce delays in decision-making and enable a greater proportion of patients to receive definitive care within Powys, avoiding unnecessary waits in Emergency Departments. While many patients are likely to benefit from faster assessment and treatment, some individuals may need to travel further to access an enhanced Urgent Care Centre. During implementation, clear communication regarding access arrangements and appropriate use of services will be important to avoid confusion and ensure patients continue to receive timely care. The anticipated improvements will be dependent upon successful workforce mobilisation and effective management of demand as new service pathways become established. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Effective	The model supports more effective urgent care by concentrating expertise, diagnostics and treatment capability within two enhanced Urgent Care Centres. This creates opportunities for a wider range of conditions to be managed locally, improving access to specialist assessment and reducing reliance on external providers. Enhanced clinical capability, improved diagnostics and strengthened multidisciplinary working are expected to support better patient outcomes and more consistent delivery of care.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	The effectiveness of the model will depend upon successful implementation of the enhanced service offer and ensuring workforce capacity keeps pace with expanded clinical responsibilities. The transition period will require careful monitoring to ensure service quality and patient outcomes are maintained while new pathways become embedded and communities adapt to revised arrangements. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Efficient	The model has the potential to improve efficiency through better utilisation of workforce, diagnostics, clinical expertise and urgent care facilities. By increasing local capability within Powys, more patients can receive assessment, investigation and treatment closer to home, reducing avoidable transfers, duplication of assessment and unnecessary attendance at Emergency Departments. Larger urgent care teams may also support more sustainable staffing arrangements and improved operational resilience. However, efficiencies may take time to emerge and will require investment in workforce training, infrastructure, diagnostics and service development. Temporary operational pressures may arise during implementation as activity transfers into the enhanced centres and new ways of working are established. A phased and carefully managed transition will therefore be essential to deliver sustainable long-term benefits. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Equitable	The model seeks to improve equity by ensuring residents across Powys have access to enhanced urgent care services with improved diagnostics, broader treatment options and higher levels of clinical expertise. Establishing two enhanced Urgent Care Centres provides greater consistency in service provision and reduces variation in the urgent care offer available across the county. This should help ensure more patients receive high-quality urgent care within Powys regardless of where they enter the system. Nevertheless, the absence of a separate Minor Injury and Illness Unit means some communities may experience increased travel requirements compared with current arrangements. Given Powys' rural geography, careful consideration will be needed to ensure the benefits of improved service capability are balanced against accessibility challenges. Ongoing monitoring of service utilisation and patient experience will be important to identify and mitigate any unintended impacts. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Person Centred	The model supports a person-centred approach by enabling more patients to access comprehensive urgent care services closer to home than would otherwise be available through attendance at Emergency Departments o,utside Powys. Improved diagnostics, senior clinical input and a broader range of treatment options should allow more patients to receive appropriate care at the first point of contact, improving continuity of care and reducing disruption associated with multiple referrals or hospital transfers.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	Some individuals may need to adjust to revised access arrangements and travel to one of the two enhanced centres rather than their previous local service. Maintaining a strong focus on communication, engagement and patient experience will therefore be essential. Effective implementation will help ensure that changes are understood, confidence is maintained, and patient needs remain central to service delivery. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.			
Workforce	The model is expected to strengthen workforce sustainability by creating larger urgent care teams with enhanced clinical capability and greater opportunities for multidisciplinary working. Concentrating urgent care expertise within two enhanced centres is likely to support recruitment, retention, advanced practice development and improved access to diagnostics training. Larger teams may also reduce professional isolation and provide greater clinical resilience. Implementation will require significant workforce development to support expanded clinical roles and ensure staff have the necessary competencies to deliver the enhanced service model. Some staff may experience changes to working locations or responsibilities and will require appropriate support throughout the transition. Careful workforce planning and engagement will be critical to ensuring successful implementation. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Leadership	The model provides a clear strategic direction for urgent care services in Powys through the establishment of two enhanced Urgent Care Centres acting as focal points for urgent care delivery. This creates opportunities for stronger governance, more consistent clinical standards and improved oversight of quality, safety and performance. The scale of transformation will require strong and visible leadership to manage service change, support staff and maintain stakeholder confidence. Effective governance arrangements and clear accountability structures will be necessary to support implementation and ensure the intended benefits are realised. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3
Culture	The model promotes a culture of collaboration, continuous improvement and person-centred care. Enhanced Urgent Care Centres will bring together multidisciplinary teams and create stronger links across primary care, community services, ambulance services and secondary care. The model supports a shift towards delivering more care within Powys and creating greater confidence in local urgent care provision.	3	2	6

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
	As with any significant service transformation, cultural change will require time and sustained support. Staff will need opportunities to adapt to expanded roles, new pathways and different ways of working. Ongoing engagement and organisational development activities will be important in embedding the desired culture throughout the service. The risk of adverse impact is considered low and it is possible (3) that members of the public may use urgent care services but any adverse impact is anticipated to be negligible (1), however the additional change of the transition has been assessed as minor (2) resulting in an overall risk score of 6.			
Information	The model provides opportunities to improve information sharing, patient navigation and clinical decision-making through clearer urgent care pathways and greater use of integrated records and systems. Delivering a greater proportion of urgent care activity within Powys may enhance continuity of information and improve coordination between services. Given the changes to service access arrangements, clear communication with patients, staff and partner organisations will be essential. Without effective engagement there is potential for confusion regarding where and how services should be accessed. A comprehensive communication strategy will therefore be required to support a smooth transition. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Learning, Improvement and Research	The enhanced Urgent Care Centres provide a strong platform for workforce development, quality improvement, innovation and the adoption of best practice. Larger teams and increased clinical capability are likely to support expanded training opportunities, stronger mentorship arrangements and greater participation in service improvement activities. Enhanced diagnostic services may also create opportunities for learning and evaluation of new models of care. Realisation of these benefits will depend upon continued investment in workforce development and ensuring that learning and improvement remain priorities alongside day-to-day service delivery. Ongoing evaluation will be important to identify opportunities for further development and refinement of the model. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Standard	Potential Impacts	Risk of Adverse Impact[3]		
		Likelihood	Impact	Score
Whole Systems Approach	The model supports a more integrated whole-system approach by strengthening connections between urgent care, primary care, community services, ambulance services, acute hospitals and wider health and care partners. Enhanced local capability is expected to reduce avoidable hospital attendances, support more coordinated patient pathways, and help ensure care is delivered in the most appropriate setting. The success of the model will depend upon effective collaboration between organisations, services and professional groups, alongside successful implementation of revised urgent care pathways. Strong partnership working, shared accountability and robust transition planning will be essential to ensure the longer-term benefits of the model are realised across the health and care system. The risk of adverse impact is considered low, and it is possible (3) that members of the public may use urgent care services, but any adverse impact is anticipated to be negligible (1), resulting in an overall risk score of 3.	3	1	3

Based on this assessment the threshold has not been met to proceed to a deep assessment.

Equality Impact Assessment

This Equality Impact Assessment was undertaken to evaluate the potential effects on individuals and groups with protected characteristics under the Equality Act 2010 of the draft proposals being developed in relation to three key service areas as part of the Stage 2 Better Together programme.

The assessment drew on a range of evidence which utilised the data in the revised Full Case for Change and the feedback given from the engagement conducted to date. This is set out in the comprehensive Stage 0 – Stage 2 Better Together feedback report alongside additional feedback captured by services using patient feedback mechanisms e.g. Civica surveys and patient focus groups during the past 18 months.

Engagement for the Better Together programme was carried out with PTHB employees, residents, third sector representatives, public sector colleagues and service users including representatives from equality groups. Surveys, focus groups and targeted outreach took place in communities to ensure a broad mix of views were captured.

The views given by all stakeholders were analysed and fed back to the programme team. Further analysis then took place to identify differential impacts across protected characteristics, with particular attention to areas of potential disadvantage. Where negative impacts were identified, some mitigation actions have been included either as ideas proposed by stakeholders or as additional options to reduce or eliminate these effects.

Section B.2 Summary Impact Assessment – Equality Impact Assessment
SL UCDO_013ii: Do Maximum: Even better local Urgent Care (2 x UCCs in Powys)

Your commentary should outline positive and negative impacts. Further information about definitions and considerations for each Characteristic is available in the Explanatory Notes. Adverse impact scoring should focus on adverse impacts only. Further information about impact and likelihood scoring is available in the Explanatory Notes. A deep dive assessment will be required if the risk of adverse impact scores of 9 or more (see Section C.2). This should be undertaken in line with CGP009 using the template in Section C.2.

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
Summary	This assessment considered the impact of the proposed urgent care model, comprising two enhanced Urgent Care Centres, on protected characteristics and wider population groups across Powys. Overall, the proposed model represents a significant step change in the delivery of urgent care services within Powys. The development of two enhanced Urgent Care Centres will provide substantially greater clinical capability than is currently available, including enhanced diagnostics, access to a wider range of healthcare professionals, extended opening hours and local step-up capacity. This will enable more patients to be assessed, diagnosed, treated and managed within Powys, reducing reliance on out-of-county acute hospitals and emergency departments. The model is expected to improve patient experience by providing access to a broader range of urgent care services closer to home, supporting earlier intervention, more timely clinical decision-making, and improved continuity of care through access to local records and established care pathways. For many residents, this will reduce unnecessary onward travel, associated travel costs, and the potential for lengthy waits in busy emergency departments outside Powys.	3	2	6

[4] Impact scoring should focus on the impact/likelihood of adverse impacts. If there are no adverse impacts the score will be 1 x 1 = 1.

	The most significant considerations relate to older people, disabled people, carers, people experiencing socio-economic disadvantage, and Welsh speakers. These groups may be more sensitive to changes in travel patterns, transport availability and access to local services. While some communities may experience longer journeys to access urgent care, the enhanced capability of the proposed centres is expected to reduce the need for subsequent travel to acute hospitals and provide more comprehensive care locally. For children, people with disabilities and those with complex health needs, access to integrated local services and local health records is expected to support safer, more coordinated care and reduce duplication, delays and unnecessary transfers. Older people and carers are also expected to benefit from greater local access to diagnostics, assessment and treatment, helping reduce disruption, travel burden and time spent accessing healthcare. Across most protected characteristics, no significant adverse impacts have been identified. The principal residual consideration relates to maintaining equitable Welsh-language provision, particularly for communities with higher proportions of Welsh speakers. This will require ongoing workforce planning, monitoring and continued implementation of the Health Board's Welsh Language Standards and Welsh in Healthcare Strategy. Overall, the assessment concludes that the proposed model delivers a more resilient, sustainable and clinically capable urgent care service for Powys. While some travel-related impacts remain, these are considered manageable and are outweighed by the substantial benefits associated with enhanced local services, improved access to diagnostics, local step-up care, reduced reliance on out-of-county hospitals, shorter patient pathways, and reduced unnecessary travel costs and waiting times for the Powys population. **Summary Table**			

Characteristic	Potential Impacts				Risk of Adverse Impact[4]		
					Likelihood	Impact	Score
	Characteristic	**Likelihood**	**Impact**	**Score**			
	Age	3	2	6			
	Disability	3	2	6			
	Gender Reassignment	3	1	3			
	Marriage and Civil Partnership	3	1	3			
	Pregnancy and Maternity	3	1	3			
	Race	3	1	3			
	Religion or Belief	3	1	3			
	Gender	3	1	3			
	Sexual Orientation	3	1	3			
	Welsh Language	3	2	6			
	Socio-Economic Circumstances	3	2	6			
	Social Exclusion	3	2	6			
	Carers	3	2	6			

Age	Powys has a significantly older population than both the Welsh and UK averages. People aged 65 and over account for 28% of the population, compared with 21% in Wales and 19% across the UK. At the same time, the number of children and young people has declined, and the working-age population is proportionately smaller. This demographic profile means Powys has a greater proportion of residents living with frailty, long-term conditions, reduced mobility and increasing reliance on health and care services. Evidence shows that ageing in rural areas can present particular challenges. Older people are more likely to experience disability, long-term illness and reduced independence, increasing reliance on healthcare and transport services. Rurality can also contribute to social isolation and create barriers to accessing timely care. While digital services can provide additional support, many older residents, particularly those aged over 75, may have limited access to technology or lower levels of digital confidence. The proposed model responds directly to these demographic pressures by establishing two enhanced Urgent Care Centres in Newtown and Brecon. Together, these centres will provide a significantly higher level of urgent care capability than is currently available, including enhanced diagnostics, access to a broader range of clinicians, extended opening hours and local step-up care. This will enable more older people to be assessed, diagnosed, treated and managed within Powys, reducing reliance on out-of-county acute hospitals and emergency departments. Analysis shows that most older residents remain within reasonable reach of the proposed centres, with approximately 91% of households remaining within the 45-minute travel benchmark. While residents in parts of Mid Powys will experience increased journey times, average travel times increase only modestly, from 20 minutes 43 seconds to 23 minutes 50 seconds. The greatest challenges are likely to be experienced by those reliant on public transport, particularly in more remote communities where journeys may be longer and require multiple connections.	3	2	6

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
	However, for many older people, the overall patient journey may become shorter and more effective. Access to improved diagnostics, senior clinical decision-making and local treatment options is expected to reduce the need for onward transfers to distant hospitals, avoiding additional travel, lengthy waits in busy emergency departments and disruption associated with receiving care outside Powys. Continued access through NHS 111 and ambulance services will remain available for those unable to travel independently. Overall, the impact on older people is assessed as moderate. While some individuals will face longer journeys to access urgent care, these impacts are outweighed by the benefits of a substantially enhanced local service, improved access to diagnostics and treatment, local step-up care capacity, reduced need for onward travel and a more sustainable urgent care system designed to meet the needs of Powys' ageing population. Therefore, based on the impact to the aging population the risk assessment score shows that the impact to the older age person might happen or occur occasionally (3), and the impact would be positive for the wider population in this group with a minor impact (2), showing an overall risk score of 6.			
Disability	The Health Board's Strategic Equality Plan includes a range of actions to improve access, experience and outcomes for people with disabilities. The proposed model supports these commitments through a "phone first" approach, enabling triage staff to identify disability-related needs, make reasonable adjustments and direct patients to the most appropriate service. These principles would continue to apply under both current and future service arrangements, helping to ensure equitable access to urgent care.	3	2	6

	The assessment identifies three key considerations for people with disabilities: 1. Travel and access 2. Quality of the service offer 3. Quality of facilities and environment Travel and access are important considerations. The move from four sites to two enhanced Urgent Care Centres may increase journey times for some patients, particularly those living in parts of Mid Powys. Public transport impacts may be more significant for some disabled people, with journeys from some communities becoming longer and potentially requiring multiple connections. For those unable to travel independently, access through NHS 111 and emergency ambulance services will remain unchanged. However, the proposed model also delivers significant benefits for people with disabilities through the creation of two enhanced Urgent Care Centres with substantially greater clinical capability than is currently available. Improved diagnostics, extended opening hours, access to a wider range of healthcare professionals and local step-up care capacity will enable more patients to be assessed, diagnosed and treated within Powys. This is expected to reduce the need for onward transfers to acute hospitals outside the county, helping to minimise additional travel, transport costs and lengthy waits in often busy emergency departments. The model also offers important benefits in terms of continuity and coordination of care. Receiving treatment within Powys increases opportunities for clinicians to access local health records, care plans and relevant background information, supporting more informed clinical decision-making. This can be particularly valuable for people with disabilities, learning disabilities, communication needs or complex health conditions, where a detailed understanding of individual needs can significantly improve patient experience and outcomes. Further benefits arise from the opportunity to provide care within modern, purpose-designed facilities. Existing facilities are constrained by older building layouts and infrastructure. New or upgraded Urgent Care Centres can be designed			

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
	to meet contemporary accessibility standards, providing improved support for people with physical disabilities, sensory impairments, communication needs, learning disabilities and neurodiverse conditions. Enhanced accessibility, improved wayfinding and more inclusive environments have the potential to improve both independence and patient experience. Overall, the impact on people with disabilities is assessed as **moderate positive**. While some individuals may experience longer journeys to access urgent care services, these impacts are outweighed by the benefits of enhanced local clinical services, improved diagnostics, greater access to specialist expertise, better continuity of care through local records, reduced reliance on out-of-county hospitals and modern accessible facilities. The proposed model is expected to provide a more sustainable, inclusive and clinically effective urgent care service for people with disabilities across Powys. Therefore, based on the impact for a person with a disability that their need for urgent care services might happen or occur occasionally (3), and the impact would be positive for the wider population in this group with a minor impact (2), showing an overall risk score of 6.			
Gender Reassignment	The Health Board's Strategic Equality Plan promotes inclusive services, LGBTQ+ awareness and facilities that meet the needs of all patients. Census data indicates around 0.32% of Powys residents (360 people) identify as a gender different from their sex registered at birth. The proposed model provides improved facilities and enhanced clinical services closer to home. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
Marriage and Civil Partnership	The needs of people who are married or in a civil partnership are addressed through the Health Board's existing equality arrangements. The proposed urgent care model does not introduce any specific changes affecting this protected characteristic. Individuals will benefit from the same improvements in service quality, access and clinical capability as the wider population. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Pregnancy and Maternity	The Strategic Equality Plan includes provisions to support people who are pregnant or accessing maternity-related care. The proposed model does not change these arrangements but provides wider improvements through enhanced diagnostics, clinical expertise and access to urgent care. No adverse impacts specific to pregnancy or maternity have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Race	Powys has a relatively small minority ethnic population, with 2.2% of residents identifying as Black, Asian or other ethnic groups, compared with 6.2% across Wales. The proposed model does not alter existing equality protections, interpretation services or accessibility arrangements. No specific impacts relating to race or ethnicity have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
Religion or Belief	The Health Board is committed to supporting the religious and spiritual needs of patients, including access to prayer facilities and faith-based support where required. The proposed model does not affect these arrangements, and no adverse impacts have been identified for people of any religion or belief. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Gender	The proposed model does not create any differential impacts based on sex or gender. Existing equality arrangements remain in place, and all patients will have equitable access to enhanced urgent care services, including improved diagnostics and clinical support. No adverse impacts have been identified. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3
Sexual Orientation	According to the 2021 Census, 2.27% of Powys residents identified as lesbian, gay, bisexual or another minority sexual orientation. The Strategic Equality Plan promotes inclusive services and equal access for LGBTQ+ communities. The proposed model does not introduce any barriers relating to sexual orientation and is expected to improve service access and quality for all patients. It is possible (3) that people in this group would use urgent care services and due to the new and enhanced model the impact would be negligible (1), giving an overall risk rating of 3.	3	1	3

Welsh Language	The Welsh language is an important part of Powys' cultural identity and community wellbeing. Census data shows that 16% of Powys residents aged three and over (21,090 people) can speak Welsh, compared with 18% across Wales. Welsh is spoken throughout the county, although usage varies significantly between localities. The highest proportions of Welsh speakers are found in Machynlleth (49%), Llanfyllin (35%) and Ystradgynlais (32%). Ensuring access to services through the medium of Welsh remains an important consideration in the design and delivery of urgent care services across Powys. The proposed model would establish two enhanced Urgent Care Centres in Brecon and Newtown, providing a significantly higher level of urgent care capability than is currently available. These centres would offer enhanced diagnostics, extended opening hours, access to a broader range of healthcare professionals and improved treatment options, enabling more patients to be assessed, diagnosed and treated within Powys. As a result, many patients who currently require onward referral to acute hospitals outside the county may be able to receive more of their care locally. The most significant consideration relates to communities with higher proportions of Welsh speakers, particularly Ystradgynlais, where local urgent care provision would no longer be available. Patients from Ystradgynlais would typically access urgent care services in Brecon or, where clinically appropriate, through services in Swansea. This creates a potential risk that some Welsh-speaking patients could experience reduced access to Welsh-medium services if Welsh-speaking workforce capacity is not maintained across receiving sites. This is particularly important for Welsh-speaking individuals with learning disabilities, communication difficulties, cognitive impairment or complex care needs, where receiving care in Welsh can significantly influence understanding, consent, confidence and overall patient experience. However, the proposed model also presents an opportunity to strengthen Welsh-language provision by concentrating services within larger, enhanced centres that are better positioned to support sustainable workforce planning, recruitment and development of Welsh-speaking clinical staff.	3	2	6

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
	The move to two enhanced Urgent Care Centres also brings wider benefits for Welsh-speaking residents. Improved diagnostics, senior clinical decision-making and greater treatment capability are expected to reduce the need for onward transfers to acute hospitals outside Powys, helping more patients receive care closer to home and within local health services. Access to local records and established care pathways can further support continuity of care and improve communication for Welsh-speaking patients and their families. Powys Teaching Health Board has already implemented a range of initiatives to strengthen Welsh-language provision, including enhanced workforce planning, Welsh-language recruitment tools, staff training, strengthened translation and interpretation services, Welsh in Healthcare training, and delivery of the Welsh in Healthcare Strategy 2024-2029. These measures provide a strong foundation for maintaining and expanding bilingual service provision within the enhanced urgent care model. Overall, the impact on Welsh language is assessed as moderate positive. While there is a potential risk of reduced access to Welsh-speaking services for some communities, particularly Ystradgynlais, this can be mitigated through targeted workforce planning, active compliance with Welsh Language Standards and continued investment in bilingual service delivery. These considerations are balanced by the substantial benefits of a significantly enhanced urgent care service, improved access to diagnostics and treatment, reduced reliance on out-of-county hospitals and greater opportunities for Powys residents to receive high-quality care closer to home. Therefore, for people who wish to receive care through the medium of Welsh, for the likelihood of requiring urgent care services is assessed as occasional (3). The anticipated health care benefits for the wider population within this group is positive, with a minor impact (2), resulting in an overall risk score of 6.			

Socio-Economic Circumstances	The impact of the proposed model on people experiencing socio-economic disadvantage has been assessed using census and deprivation data. Powys faces a range of socio-economic challenges, including lower average wages and employment levels than the Welsh and UK averages, youth unemployment and significant levels of digital exclusion. These factors can affect how easily people access healthcare services and may increase reliance on local, accessible and affordable healthcare provision. It is recognised that public transport access is variable, route-dependent and time-limited, particularly for people without access to a car, older people, unpaid carers, families with children, disabled people and residents in rural communities outside the main towns. This two-site option presents the greatest adverse impact, creating longer and more complex journeys and a clear gap in public transport access across mid-Powys. The Welsh Index of Multiple Deprivation shows that deprivation is dispersed across Powys rather than concentrated in a single location, making equitable access to healthcare an important consideration across the whole county. Transport can be a particular challenge for those on lower incomes, especially in rural areas where public transport services may be infrequent, time consuming or require multiple connections. Areas such as Ystradgynlais and Llandrindod Wells have relatively lower levels of vehicle availability, meaning some residents may be more sensitive to changes in travel requirements. The proposed model responds to these challenges by creating two enhanced Urgent Care Centres with significantly greater clinical capability than is currently available. These centres will provide improved diagnostics, extended opening hours, access to a broader range of clinical professionals, and local step-up care capacity. This will enable more patients to be assessed, diagnosed and treated within Powys, reducing reliance on acute hospitals outside the county and improving access to higher-quality urgent care services closer to home. While some individuals may experience increased journey times when accessing urgent care services, the overall patient pathway is expected to become more efficient. Rather than requiring assessment locally followed by transfer to an out-	3	2	6

	of-county hospital, many patients will be able to receive investigations, treatment and ongoing care within Powys. This has the potential to reduce overall travel distances, minimise transport costs and avoid lengthy waits in often busy emergency departments outside the county. For people on lower incomes, reducing the need for additional journeys, repeat visits and expensive return travel arrangements can provide a significant benefit. The enhanced model also supports greater continuity of care by enabling more treatment to be delivered within local health services. Access to local records, established care pathways and knowledge of local support services can help ensure patients receive more coordinated and timely care, particularly those with complex social, health or financial circumstances. Access through NHS 111 and emergency ambulance services will remain unchanged for those who are unable to travel independently or require urgent assistance. These arrangements continue to provide an important safety net for vulnerable individuals and communities. Overall, the impact on people experiencing socio-economic disadvantage is assessed as moderate positive. While some residents may face additional travel challenges, these impacts are outweighed by the substantial benefits of enhanced local urgent care services, improved access to diagnostics and treatment, local step-up care capacity, reduced reliance on out-of-county hospitals and fewer unnecessary journeys. The model is expected to improve both the quality and accessibility of urgent care services for communities across Powys while helping to reduce the financial and practical burdens often associated with accessing healthcare. Overall, the impact on people experiencing socio-economic disadvantage is assessed as low to moderate, with some travel-related challenges offset by improved service quality, reduced onward travel and more equitable access to urgent care across Powys. Therefore, for people experiencing socio-economic disadvantage, the likelihood of requiring urgent care services is assessed as occasional (3). The anticipated			

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
	is positive for the wider population within this group, with a minor impact (2), resulting in an overall risk score of 6.			

Social Exclusion	Social exclusion can arise from poverty, low income, rural isolation, digital exclusion, language barriers and limited access to services. Census and deprivation data indicate that these challenges are experienced across Powys rather than being concentrated within a single locality. The county also faces ongoing challenges relating to digital connectivity, child poverty and access to essential services, all of which can influence how individuals access healthcare and engage with support networks. The Welsh Index of Multiple Deprivation highlights that areas experiencing disadvantage are distributed throughout Powys, making equitable access to healthcare services particularly important. People experiencing social exclusion may be more likely to face barriers relating to transport, confidence, communication or access to information. For some individuals, particularly those living in more remote communities, travel to urgent care services may become more challenging following the move to two enhanced Urgent Care Centres. Those reliant on public transport may continue to experience longer journeys, multiple connections or limited-service availability. However, the proposed model also delivers significant opportunities to reduce other forms of exclusion by improving access to a much broader range of urgent care services within Powys. The two enhanced Urgent Care Centres will provide substantially greater clinical capability than is currently available, including improved diagnostics, extended opening hours, access to a wider range of healthcare professionals and local step-up care capacity. This will enable more patients to receive assessment, diagnosis and treatment within Powys, reducing reliance on acute hospitals outside the county. For many individuals who experience social exclusion, the overall patient journey is expected to improve. Rather than travelling initially to a local service and then being transferred onwards to an out-of-county hospital, more people will be able to access comprehensive assessment and treatment closer to home. This is expected to reduce overall travel requirements, minimise associated costs, and avoid lengthy waits in busy emergency departments. Improved local treatment	3	2	6

Characteristic	Potential Impacts	Risk of Adverse Impact[4]		
		Likelihood	Impact	Score
	capability may also enable more patients arriving by ambulance to receive appropriate care within Powys, reducing disruption and helping patients remain closer to their families, carers and support networks. The enhanced model also strengthens continuity of care through greater use of local services and access to local health records. This can be particularly beneficial for individuals who may already feel isolated or disconnected from services, helping to ensure more coordinated care, better communication and a smoother patient experience. Existing access routes through NHS 111 and emergency ambulance services will remain unchanged for those who cannot travel independently. Overall, the impact on people experiencing social exclusion is assessed as moderate positive. While some individuals may experience increased travel challenges, these impacts are outweighed by the benefits of significantly enhanced local urgent care services, improved access to diagnostics and treatment, reduced reliance on out-of-county hospitals, lower overall travel burden, and a stronger, more sustainable urgent care system for communities across Powys. Therefore, for people experiencing social exclusion, the likelihood of requiring urgent care services is assessed as occasional (3). The anticipated healthcare impact for the wider population within this group is positive, with a minor impact (2), resulting in an overall risk score of 6.			

Carers	Supporting unpaid carers is a key priority within the Powys Area Plan, which aims to improve carers' wellbeing through information, advice, respite, transport and community support, while reducing avoidable emergency admissions and improving urgent care outcomes. Powys has one of the highest proportions of unpaid carers in Wales, with many individuals providing substantial levels of care each week. Ensuring timely access to effective healthcare services is therefore particularly important, as carers often balance complex caring responsibilities alongside employment, family commitments and their own health needs. The proposed model recognises the vital contribution carers make to the health and wellbeing of Powys communities and seeks to strengthen urgent care services through the development of two enhanced Urgent Care Centres. These centres will provide significantly greater clinical capability than is currently available, including enhanced diagnostics, access to a wider range of healthcare professionals, extended opening hours and local step-up care capacity. This will enable more patients to receive assessment, diagnosis and treatment within Powys, reducing reliance on acute hospitals outside the county. Travel and transport remain important considerations for carers. Some carers may experience longer journeys when supporting someone to access urgent care services, particularly those living in more rural communities. Public transport journeys can be time consuming and may require multiple connections, which can place additional pressure on carers and affect other responsibilities such as work, childcare or supporting other dependants. However, these travel considerations need to be considered alongside the overall patient pathway and the benefits arising from accessing more comprehensive urgent care services within Powys. A significant advantage of the proposed model is that more patients are expected to receive the care they need locally, reducing unnecessary onward transfers to out-of-county hospitals. This has the potential to significantly reduce overall travel time; transport costs and the disruption associated with lengthy waits in	3	2	6

	external emergency departments. For carers, avoiding additional journeys to distant hospitals can reduce stress and allow more time to be spent supporting the person they care for and maintaining other caring responsibilities. The model also offers important benefits through improved continuity and coordination of care. Local Urgent Care Centres are more likely to have access to local health records, existing care plans and relevant clinical information, supporting more informed and timely decision-making. This can be particularly beneficial when caring for children, older people, individuals with disabilities or those with complex health needs, helping clinicians better understand individual circumstances and reducing delays associated with obtaining information from other organisations. The "phone first" approach further supports carers by enabling clinical teams to identify caring responsibilities at an early stage, direct patients to the most appropriate service, and reduce unnecessary attendance or delays within the urgent care system. Additional support from organisations such as PAVO Community Connectors will continue to help carers access practical assistance and contingency planning when unexpected healthcare needs arise. Overall, the impact on carers is assessed as moderate positive. While some carers may experience longer journeys to access urgent care services, these impacts are outweighed by the benefits of significantly enhanced local services, improved diagnostics and treatment capability, access to local records, reduced reliance on out-of-county hospitals and fewer unnecessary journeys. The proposed model is expected to provide a more responsive, coordinated and sustainable urgent care service that better supports both carers and the people they care for across Powys. Therefore, for carers, the likelihood of requiring urgent care services is assessed as occasional (3). The anticipated healthcare impact for the wider population within this group is positive, with a minor impact (2), resulting in an overall risk score of 6.			

Section C.2 Deep Dive Impact Assessment - Equality
Where agreed, you should copy and complete this table for every adverse equality impact score of 9 or more (yellow, amber and red impacts). This will form part of a full Equality Impact Assessment in line with Health Board policy CGP009 Equality Impact Assessment Policy. The level of detail should be proportionate to the impact and likelihood.

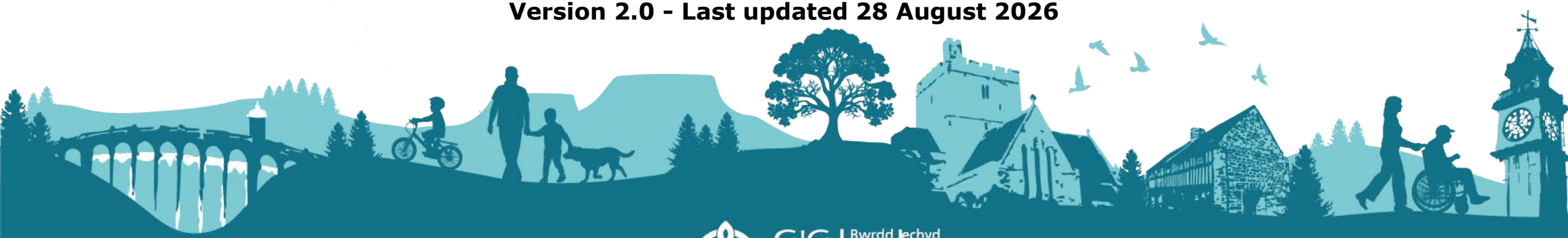
The threshold has not been met in these areas to require a deep dive assessment

Better Together

Stage 3 Formal Service Change Consultation Plan for Phase 1 (adult physical and mental health community services, some all-age diagnostic services, MIU services for people aged one and over)

5 October 2026 to 10 January 2027

Version 2.0 - Last updated 28 August 2026



Gwella Gyda'n Gilydd

Llunio dyfodol gwasanaethau iechyd diogel, o ansawdd uchel i Bowys

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

Better Together

Shaping the future of safe, quality health services for Powys

Document Version Control

Version	Date	Reason for update	Updated by	Approved by	Approval Date
V0.1	24 March 2026	This document remains substantially similar to the previous Consultation Plan approved by Portfolio Board on 16 September 2025 and has been updated to reflect key changes including the updated timetable for consultation. It was shared with tacODEC for initial feedback.	AO	Not applicable (previous Consultation Plan was approved by PB on 16/09/25)	Not applicable
V0.2	31 March 2026	Updated to reflect feedback from tacODEC	AO	Not applicable	Not applicable
V0.3	30 April 2026	Updated dates to match timetable discussed at Portfolio Board and other minor amendments reflecting comments from Portfolio Board members	AO	Not applicable	Not applicable
V0.4	8 May 2026	Endorsed by ODEC on 8 May 2026	AO	ODEC	8 May 2026
V0.5	14 May 2026	Updated to include independent assurance feedback from HICO	AO	Not applicable	Not applicable
V1.0	27 May 2026	Approved by Executive Committee with no amendments	AO	Executive Committee	27 May 2026
V1.1	29 July 2026	Approved by Board with no amendments	AO	PTHB Board	29 July 2026
V1.2	7 August 2026	Updated to reflect decisions by ODEC on 6 August per consultation assurance update	AO	ODEC	6 August 2026
V2.0	28 August 2026	Updated timeline, updated risk register, stakeholder map with summary of channels	AO	Draft for consideration by Executive Committee	

Where content is highlighted in yellow this remains under active consideration as a potential activity/channel/publication with final decisions subject to assessment of resource, capacity, risk and assurance.

This Plan will continue to be an evolving document reflecting emerging issues and needs.

Contents

Section	Contents	Page
1.0	Service Change Consultation Plan Requirements *The key requirements this plan needs to address*	4
2.0	Service Change Consultation Scope and Mandate *What is included in the consultation, and what is not*	9
3.0	Programme Governance and Resources *How is the programme governed and led*	10
4.0	Proposed Timeline for Service Change Consultation *When it will take place*	14
5.0	Stakeholders *Who we need to engage with*	15
6.0	Service Change Consultation Risks *What are the principal risks and how will we manage them*	20
7.0	Engagement and Insight Plan *How we will engage and gather insights*	21
8.0	Communication Plan *How we will communicate*	23
9.0	Document Plan *The documents we will produce*	25
10.0	Consultation Review *How we will keep the consultation process under review*	27
11.0	Consultation Findings Report *What we will include in the report following consultation*	28
12.0	Decision Reporting *How decisions will be reported to stakeholders*	29
	A series of annexes provide operational detail relating to the delivery of the plan relating to matters such as event management, media relations etc. These are not formal parts of the plan, and will continue to be updated on an ongoing basis as a "live document" under the direction the engagement and communication tactical group.	

1.0 Service Change Consultation Plan Requirements

The purpose of this project plan is to set out the scope of the issues to be included a period of formal service change consultation from October 2025, on service changes proposed in relation to the Better Together options development process, and to set out the service change consultation process that will be followed. Services included within the scope of this consultation relate to adult physical and mental health NHS community services provided or commissioned by Powys Teaching Health Board.

This plan assumes that the proposals are substantial in nature (as defined by Welsh Government *Guidance on changes to health services*, 2023).

The Health Board is therefore responsible in accordance with Section 183 of the National Health Service (Wales) Act 2006 to involve and consult citizens about services that we provide or commission from another body, and in developing and considering proposals for changes in the way these services are provided. The Board has responsibility in accordance with its Standing Orders for formally launching the consultation and using the information gathered throughout the consultation to inform its decision-making process.

Accountability for the consultation management process is delegated to Executive Directors (in line with their delegated authority) and to the Better Together Portfolio Board and its sub-groups (in line with the Better Together Portfolio Governance Framework), including:

- Developing the draft service change consultation project plan
- Reviewing associated consultation documents for presentation to the Health Board
- Identification of risks and proposing mitigation relating to the consultation
- The establishment of a working group to manage and monitor the consultation progress and monitor the responses as they are received
- The development of a system to log incoming responses into a database for analysis at the end of the process
- Acknowledgment of responses with a letter / email where contact details are provided
- The development of a system to share our progress and findings with stakeholders
- The development of a system to use feedback to inform further discussions and decision making
- The development of a mid-point review process to ensure the consultation is progressing as anticipated and any emerging issues are addressed as part of the consultation process and management plan
- Gathering insights to support the further development of the Equality Impact Assessment (EqIA) at the start, mid-point and end of the consultation process to help identify barriers, and any needs to be addressed to support participation from our diverse communities
- The development of a system to consider impact throughout the process and adjust as necessary to eliminate or mitigate any potential or actual adverse impact at the earliest opportunity.

1.1 Key Requirements in relation to this Plan

Legislation / Guidance	Overview
Equality Act 2010	Our duties in relation to equality and diversity are outlined in The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011. The Act aims to ensure those carrying out a public function consider how they can positively contribute to a fairer society in our day-to-day activities through paying due regard to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations. To make this happen, the regulations place specific duties on the devolved public sector, including health boards in Wales to carry out Equality Impact Assessments (EqIA). In the context of this consultation project plan we are required to assess the impact of our proposals to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.
Socio-Economic Duty	The Wales Act 2017 enabled Welsh Ministers to enact Part 1, Section 1 of the Equality Act 2010 – the socio-economic duty. It requires specified public bodies, when making strategic decisions such as deciding priorities and setting objectives, to consider how their decisions might help to reduce the inequalities associated with socio-economic disadvantage.
Mental Capacity Act 2005	The Mental Capacity Act 2005 is a law designed to ensure that all people aged 16 and over are protected and empowered if they lack the capacity to make a decision about their care and treatment.
Human Rights Act 1998	The Human Rights Act 1998 (the HRA) sets out the fundamental rights and freedoms that everyone in the United Kingdom is entitled to. It requires all public bodies, including health boards, to respect and protect your human rights.
The Health and Social Care (Quality and Engagement) (Wales) Act 2020	The Health and Social Care (Quality and Engagement) (Wales) Act 2020 provides the legal framework for, among other things, the establishment of Llais as the statutory Citizen Voice Body for health and social care and the statutory Duty of Quality.
Welsh Language (Wales) Measure 2011 and The Welsh Language Standards (Health Sector) Regulations 2016	The Welsh Language Standards are a set of statutory requirements relevant to the Health Board. They clearly identify our responsibilities to provide bilingual services. Under the Standards, Welsh should not be treated less favourably than English. In line with the Welsh Language Standards, the organisation will be expected to consider, when formulating a new policy, or reviewing or revising an existing policy, what effects, if any (whether positive or adverse), the policy's formulation or decision would have on: (a) opportunities for persons to use the Welsh language, and (b) treating the Welsh language no less favourably than the English language. When publishing a consultation document which relates to a decision, the document must consider, and seek views on, these effects.

Legislation / Guidance	Overview
National Health Service (Wales) Act 2006	Section 183 of the National Health Service (Wales) Act 2006 requires health boards to involve and consult citizens in: • planning to provide services for which they are responsible • developing and considering proposals for changes in the way those services are provided, and • making decisions that affect how those services operate
The National Health Service Finance (Wales) Act 2014	The National Health Service Finance (Wales) Act 2014 makes planning the bedrock of the health system in Wales – the change from a market driven commissioning approach to a planned system – and introduced the need for the development of integrated medium-term plans.
Welsh Government Guidance on changes to health services 2023	Ministerial Guidance recommends that should a two change process should take place if substantial changes are proposed that are likely to require formal consultation: • Phase 1 Extensive discussion with key stakeholders to explore potential issues, refine options and determine the questions to be included within the consultation • Phase 2 Formal consultation for a minimum of six weeks The Better Together programme has satisfied Phase 1 through Stage 1 Pre-Engagement on the case for change and Stage 2 Engagement on the issues. It is now recommended that a period of formal consultation takes place for 12 weeks, significantly exceeding Welsh Government guidance, to allow sufficient time for wider stakeholders to consider options and provide feedback. The guidance also references key requirements and expectations including the Gunning Principles
National Principles for Public Engagement in Wales (reviewed 2022	The National Principles for Public Engagement in Wales are a set of ten principles for engaging with the public and service users. The principles aim to guide the way engagement is carried out to make sure it is good quality, open, and consistent. They offer a set of guidelines to organisations within the public and voluntary sectors in Wales: • Design your engagement to make a difference • Invite people to get involved, if they choose to • Plan and deliver your engagement in a timely and appropriate way • Work with relevant partner organisations • Provide jargon free, appropriate, and understandable information • Make it easy for people to take part • Ensure people benefit from the experience • Ensure the right resources and time are in place for your engagement to be effective • Let people know the impact of their contribution • Learn and share to improve your engagement

Legislation / Guidance	Overview
The Well-being of Future Generations (Wales) Act 2015	The Well-being of Future Generations (Wales) Act 2015 is legislation which has at its heart the well-being of future generations, through the establishment of seven national well-being goals and five ways of working: • A prosperous Wales – where everyone has jobs and there is no poverty • A resilient Wales – where we're prepared for things like floods • A healthier Wales – where everyone is healthier and can see the doctor when they need to • A more equal Wales – where everyone has an equal chance whatever their background • A Wales of cohesive communities – where communities can live happily together • A Wales of vibrant culture and thriving Welsh language – where we have opportunities to do different things and where people can speak Welsh • A globally responsible Wales – where we look after the environment and think about other people around the world.
The Social Services and Well-being (Wales) Act 2014	The Social Services and Well-being (Wales) Act 2014 imposes duties on local authorities, health boards, and Welsh Ministers, that require them to work to promote the well-being of those who need care and support, or carers who need support. The Powys Regional Partnership Board (PRPB) has been established under Part 9 of the Social Services and Well-being (Wales) Act 2014 with specific duties to promote the integration of community care and support services. The PRPB is a statutory stakeholder for the purpose of this consultation project plan.
Social Partnership and Public Procurement (Wales) Act 2023	This Act places a statutory duty on public bodies to involve recognised Trade Unions in a formal, timely, and collaborative consultation process on proposed policy or service changes. This includes engagement with the PTHB Local Partnership Forum as part of our overall approach to service change consultation.
Convention on the Rights of the Child	The Welsh Government has made a commitment to promote and support children and young people's participation, and to implementing children and young people's rights to participate as stated in Article 12: "Children and young people have a right to participate in the decision-making processes that are relevant to their lives and a right to influence the decisions made in their regard within the family, the school, or the community." Whilst the majority of services for children and young people are outside the scope of this consultation, their interests will relate to issues such as use of Minor Injury Services, their role as young carers, and as future users of the services under consideration.
Health Impact Assessment (Wales) Regulations 2025	New Health Impact Assessment requirements will come into effect from April 2027 and consideration is being given to how these future requirements can be incorporated in planning and decision-making for Better Together, particularly in relation to post-consultation decision making.

1.2 Health Board Policies and Guidelines

The health board will adhere to its own policies, procedures and guidelines during the consultation. Some areas which may be pertinent during the consultation include:	
Freedom of Information Policy	Freedom of Information requests – members of the public are entitled to request information from public authorities and we have a process in place to manage these requests. See more information and contact details here: Freedom of information - Powys Teaching Health Board
Data Protection and Confidentiality Policy and related policies and procedures	There will be some requirements for the sharing of person-identifiable information including in relation to the receipt, processing and analysis of consultation responses by ORS, engagement with Llais, operation of online and in-person events etc. The health board as a framework of policies and procedures in place in order to ensure compliance with data protection and confidentiality requirements and appropriate agreements will be in place with key partners to support the effective and compliant delivery of consultation activity.
Listening To People framework	Complaints and concerns may arise that fall within the jurisdiction of concerns, complaints and redress arrangements. The new Listening To People framework came into effect from April 2026: Feedback and Concerns - Powys Teaching Health Board
Social Media Policy and guidance	PTHB has adopted the all-Wales social media policy and has in place guidelines for social media and comment moderation: Our approach to social media and comment moderation - Powys Teaching Health Board Social media comments will not be gathered and recorded as part of this consultation, and users of our social channels will be signposted to the routes available to them for submitting comments and feedback.
Petitions	PTHB has a petitions protocol in place for the consideration of petitions either directly to the health board or via third party systems. Should the health board receive a petition as part of the consultation, it will be handled by acknowledging receipt, and a copy forwarded to ORS as part of the consultation analysis process, where it will be reported under a separate section of the feedback report. The feedback report will outline the background and scope of the petition, including the statement that signatories have signed, and the number of signatures received.
Media Relations	Media relations will be managed in accordance with the health board's media policy and procedures. All media enquiries should be directed to the press office for response in accordance with agreed delegated authorities.
Other	Where additional policy requirements are identified through ongoing development and review of this Plan they will be included here.

2.0 Consultation Scope and Mandate

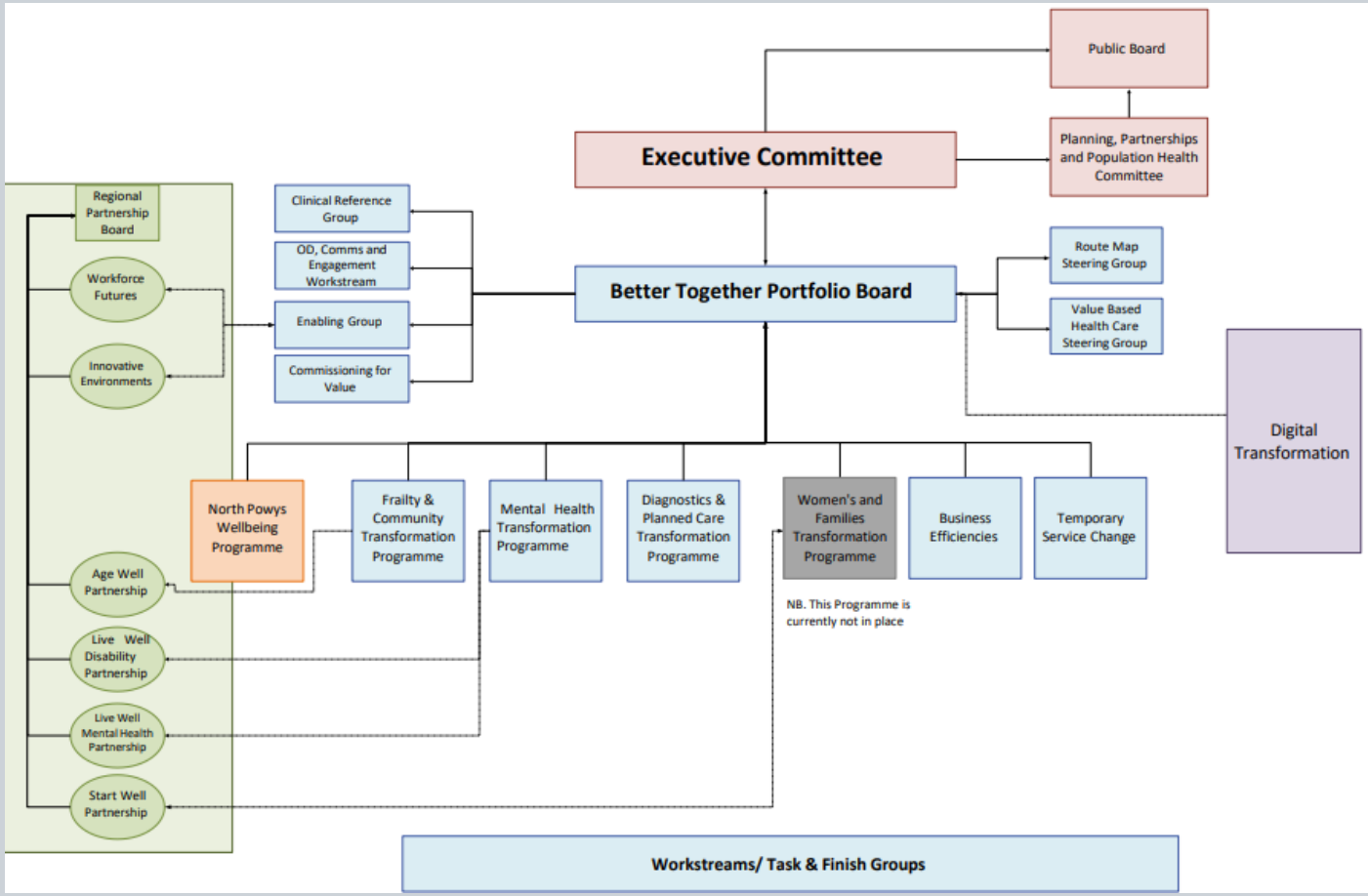
Consultation Scope	Powys Teaching Health Board (PTHB) (the consulting body) will undertake a formal consultation exercise with the public, its staff, statutory stakeholders, wider stakeholders, and targeted groups most impacted / affected by its proposals. We will ensure equality of opportunity to engage between people who share a protected characteristic and those who do not. The Health Board will engage all key stakeholders (the consultees) identified through stakeholder analysis on both a qualitative and quantitative basis, to understand the views on the following issue: • **Service change options for adult physical and mental health NHS community services in addition to some options affecting some all-age diagnostic services and PTHB minor injury unit services for people age one and over** The health board will be asked at a meeting in September 2026 to undertake a consultation to determine the options that should be taken forward on a phased implementation basis, recognising that some interim changes may also be required in order to achieve the overall implementation journey.
Consultation Timescale	The consultation period will commence in October 2026 and end in January 2027 with the aim of presenting a consultation closing and output report at a Health Board public meeting later in Spring 2027 (date TBC): • July-September: Consultation planning and document development • October-January: Consultation period • January-TBC: Analysis, conscientious consideration with decision making
Matters for inclusion in the consultation	The following matters have not yet been decided and are open to influence in the consultation, so we want to gather views on: • The suitability of each of the service change options • The positive and negative impacts associated with each of the service change options • Alternative options not yet considered within the scope of the consultation The development of the consultation programme and supporting materials has been informed by ongoing equality, Welsh language and socio-economic considerations. The impact assessment process is iterative and will continue throughout the consultation period to ensure emerging impacts, barriers and mitigations are identified and considered as part of decision-making.
Matters excluded from the consultation	The following matters have been decided on and are not open to influence in the consultation: • The scope of the consultation • The overall Health and Care Strategy agreed by the Board in 2017, which has been re-adopted and extended to 2029. • Matters relating to services outside the scope of the consultation This consultation focuses on **service change consultation** and is not formal HR consultation with staff in relation to terms and conditions through an Organisational Change Process. OCP consultation would normally follow at a later date once service change consultation and decisions have taken place.
Consultation Mandate	The purpose of the consultation scope defined within the consultation project plan is to enable the Board to make a formal decision on: **Better Together adult physical and mental health NHS community service change options in addition to options relating to some all-age diagnostic services and PTHB Minor Injury Unit services for people aged one and over**

3.0 Programme Governance and Resources

Better Together Portfolio Governance

The overall governance arrangements are set out in the Portfolio Execution Plan. This describes the agreed strategy and portfolio procedures to be adopted by the Better Together Portfolio Board, related programmes and workstreams for the successful control and implementation of the Portfolio. The portfolio of work is overseen by the Better Together Portfolio Board which oversees a portfolio of improvement and transformation programmes across PTHB to ensure delivery of impact and benefits in line with the Powys Health and Care Strategy. It acts as the strategic decision-making group with oversight of the portfolio to ensure that it delivers against intended outcomes and benefits, within time, cost and quality.

The Portfolio Board has constituted several Programmes and Groups within the portfolio structure, which are summarised below:



Organisational Development, Engagement and Communication (ODEC) Workstream	The Portfolio Board has established an Organisational Development, Engagement and Communication workstream (ODEC) to provide effective and efficient OD, engagement and communications across the portfolio. The group is also be responsible for providing support and advice on OD, engagement and consultation in line with best practice guidance and legislation. This includes oversight of development and delivery of the engagement, communication and consultation plans for Stages 1, 2 and 3 of the current phase of Better Together.

Tactical ODEC	The Tactical Group has responsibility for day-today delivery of the communication and engagement activity that supports the consultation. Each member of the group brings their delegated authorities and responsibilities, and their professional and operational accountabilities to their respective Executive Director, and will operationalise these authorities through their participation in the Tactical Group to support agile and dynamic delivery of the Consultation Plan in line with the framework agreed through Programme and wider organisational governance.
	The work of this group can be summarised as:
	• Planning and managing a range of consultation events and opportunities for both staff and public, both in person and on-line. This includes targeted engagement to ensure that people from groups with protected characteristics are fully engaged in a way that is accessible to ensure there are opportunities to participate.
	• Providing consultation materials, in a mix of digital and hard-copy formats, and in alternative versions and languages to enable participation
	• Promoting the consultation and encouraging our communities and staff to get involved.
	• Monitoring the following, and giving ongoing consideration if any changes in approach (e.g. additional communication messages or materials, or additional engagement activities) need to be put in place:
	  • dialogue across communications and engagement channels (e.g. addressing myths and misperceptions)
	  • responding to new interested participants to the consultation (e.g. responding to requests for more information from new campaign or interest groups; responding to requests through communication channels including corporate correspondence, political party or representative correspondence, or complaints; and receiving petitions)
	  • monitoring the effectiveness of communications and engagement activities
	  • reviewing targeted engagement and on-going analysis and identification of under-represented stakeholder groups.
	• Providing updates to the Workstream Group, Portfolio Board and the lead Executive Directors (Director of Corporate Governance as lead Exec for engagement and communication; Executive Director of Planning, Performance and Commissioning and lead Exec for service change engagement; Executive Director of People and Culture as Senior Responsible Owner) on progress and issues / mitigations for delivery of the consultation, or to endorse actions.

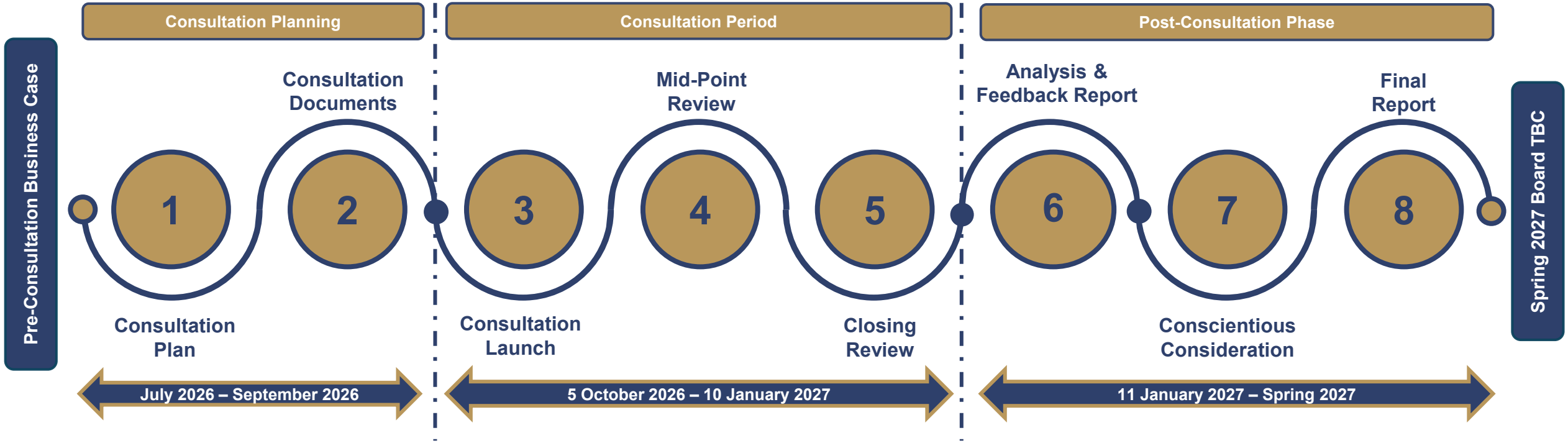
3.1 Programme Resources

Consultation Tactical Team	Project leadership, project management, and Communications and Engagement posts identified for the programme are funded within existing team budgets, or from additional requirements already agreed through Programme Business Case development and previously approved. Therefore, no further additional staffing costs are currently envisaged for the delivery of the project. However, this will be kept under review subject to the changing needs and requirements of the programme.
Supplier Costs for Quality Assurance Support and Consultation Delivery and Analysis	A contract for consultation delivery and analysis has been awarded to ORS. The contract value in 2026/27 is estimated at £80k. There is scope within the award to extend the contract for up to a further two years for the next two phases of Better Together. Final costs and scope for 2026/27 are currently being determined. A contract for consultation assurance has been awarded to HICO. The initial contract value in 2026/27 is estimated at £100k. There is scope within the award to extend the contract for up to a further two years for the next two phases of Better Together. Final costs and scope for 2026/27 are currently being determined.
Communications and Engagement Costs	Documentation (including design and printing of multiple versions of consultation documentation, household leaflet drop): £40,000 Opportunities to engage (including events and other engagement activity): £15,000 Promotion (including advertising opportunities to engage with our communities): £15,000 Support, translation and administration (including alternative and additional languages, postage etc.): £30,000 Van Hire (conveyance of event resources between venues): £3,250
Other Programme Costs	Costs associated with Stage 3 Deliberative and Clinical Design events for Adult Physical and Mental Health Community Services, as well as for pre-engagement / engagement on planned care: £15,000
Total Costs	Estimated non-pay costs during 2026/27 are £300,000. *** These costs are an estimate only, with final costs based on stakeholder analysis and EQIA.

3.2 Programme Quality Assurance

Better Together Quality Assurance	The consultation process is being supported through a combination of operational delivery support, quality assurance and external assessment arrangements. HICO is providing quality assurance support and advice on consultation good practice through associates recognised by the Centre for Consultation. Any Consultation Mark award decision will be considered independently through the Centre for Consultation. These arrangements are intended to support transparency, continuous improvement and confidence in the consultation process. This quality assurance process will include testing and review of the project plan, consultation documentation, the mid-point review, closing date review and a final report. These arrangements complement and assure, rather than replace, the statutory responsibilities of the health board. Consultation feedback will be analysed externally by Opinion Research Services via a public questionnaire, analysis of written submissions, and independent facilitation of public focus groups. Key documents in advance of the consultation launch will also be presented to a meeting in public of Powys Teaching Health Board in September 2026.

4.0 Proposed Timeline for Consultation



5.0 Stakeholders

Stakeholder Identification	These proposals have the potential to affect all adults in Powys. In addition, there are potential impacts on children including in relation to access to urgent care (Minor Injury Units can treat people aged 2 and above), as young carers of people using adult physical and mental health NHS community services, and as future users of adult services. Our approach will be to create as open and accessible an opportunity for as many people as possible to be aware of the consultation and to get involved if they wish to do so. We will build on the stakeholder mapping and analysis that was undertake as part of Stage 1 and Stage 2 Engagement. This is to make sure that any stakeholders identified during the options development process are being considered. This stakeholder mapping and analysis exercise will help us identify statutory consultees and those most affected by the potential options within the identified services so that it can inform our work. Stakeholder mapping will include a focus on disadvantaged, marginalised and minority groups and communities. Engagement will be tailored to suit different circumstances and requirements. We will work with local community and voluntary sector groups and networks to make sure that seldom heard groups can have their say in decisions that affect them. Throughout the consultation process we will need to ensure due regard is given to the general and specific equality duties for public sector organisations in Wales, and the requirement to engage with representatives of protected groups in assessing the potential impact of proposals on these groups. This applies to all adults in the Powys area, regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Stakeholder Analysis	These stakeholders are likely to be broadly interested in this consultation: • Patients, carers, advocates and proxies including Leagues of Friends • Public including town and community councils • NHS staff, and unions and professional bodies that represent them • Primary care providers including general medical practitioners, dentists, pharmacists, optometrists • Local partner organisations including Powys County Council, Powys Association of Voluntary Organisations, Dyfed Powys Police, Mid and West Wales Fire and Rescue Service, Powys Regional Partnership Board and its members and working groups, Powys Public Service Board and its members and working groups • Community and third sector organisations across Powys • National partner organisations including Welsh Government, NHS Performance & Improvement, Welsh Ambulance Service University NHS Trust, Health Education and Improvement Wales, Public Health Wales • Neighbouring NHS organisations and commissioned health services in England and Wales including all health boards in Wales, Robert Jones and Agnes Hunt NHS Foundation Trust, The Shrewsbury and Telford Hospital NHS Trust, Wye Valley NHS Trust • Political representatives including MSs, MPs and county councillors • Powys Llais Specifically we will need to ensure engagement as part of this Plan with: • Current and potential future users of adult physical and mental health NHS community services, and organisations that represent them and/or campaign on their behalf • Current NHS staff and primary care contractors working in or with adult physical and mental health NHS community services • Whilst the services under consideration are primarily used by adults, there will be specific areas of potential impact for children and young people including as users of minor injury services, as young carers of adults using adult physical and mental health community services, and as future users of adult services.

Key stakeholder are summarised in the diagram on the right



Stakeholder Group	Examples of activities/channels during Consultation
Patients, Service Users and Public	Household leaflet drop, public drop-in events, focus groups, website, social media, community outreach, govDelivery newsletter subscriptions
PTHB staff	Staff briefings, outreach visits to PTHB sites, management cascade, intranet, all staff emails
Primary Care	Cluster and collaborative meetings, individual meetings with GP practices
Provider Organisations	Information shared via care sector and community provider networks
Local System and Partner Organisations	Distribution of information to partner organisations, offer of briefings to key partnership meetings (e.g. Regional Partnership Board, Public Service Board)
Third Sector, Voluntary and Advocacy	Distribution of information to partner organisations, offer of briefings to key partnership meetings (e.g. Third Sector forums), outreach to third sector organisations to gather user and stakeholder insights
National Bodies and NHS organisations	Existing partnership arrangements, accountability arrange,ents
Political and elected representatives	Briefing sessions,
Business and wider community	Information shared via public channels
Media and communication channels	Media briefings, information on public website and social media
Trade Unions and Professional Bodies	Existing staff side representative routes within PTHB, staff-side representation in programme governance
Regulation, Scrutiny and Assurance Bodies	Llais observer role at PTHB Board and committees, regular touchpoint meetings with Llais, Llais representation in programme governance (ODEC observer), Llais representations. Existing liaison mechanisms with HIW, CIW and other regulators.
Core governance and programme stakeholders	Programme governance arrangements

Equality Considerations of this Consultation Plan	In the context of this consultation project plan we are required to assess the impact of our proposals to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised. The baseline EqIA will be shared as part of the consultation technical documents to gather additional impacts and views on issues or potential mitigations which may not have already been considered. By reviewing the views gathered through the consultation, and by considering the possible socio-economic impact, on identification of an option by the Board a final EqIA will be undertaken for the selected option using this full detail. This will ensure that decision making is fully compliant with our legal duties under the Public Sector Equality Duty (PSED), Equality Act 2010 and the National Health Service (Wales) Act 2006 and that we are taking account of people's protected characteristics. Key considerations in the delivery of the plan include: • Activities to enable people to participate who may not have digital access (e.g. information available at drop-in events, information in local press, printed information available in local libraries, route to request a copy of printed materials, targeted engagement to seldom heard groups). • Consideration of different communication needs (e.g. Easy Read, BSL, audio/video) • Consideration of different languages: previous engagement and consultation activities have seen negligible uptake of documents translated into other community languages and therefore it is proposed that (a) key documentation is published in html format on the health board website so that users can use language translation and other assistive technologies to access information in their language or medium of choice (b) a statement will be included in the consultation document in the main languages identified in the census and through use of HB translation services (Ukrainian, Arabic, Polish, Nepalese) (c) publicity materials for public events will indicate that LanguageLine facilities are available and these will be pre-installed on team devices linked to the PTHB account. • Access by geographies across a large rural geography (public events to be organised across the county - one in each of the 13 Powys localities; consideration to further events in satellite locations; consideration of outreach programme to community groups aligned with EQIA). • Activities to enable participation by other groups who may face exclusion e.g. traveller communities, socio-economic deprivation.

6.0 Service Change Consultation Risks

Risk Description	Cause of Risk	Inherent L	Inherent I	Proposed Mitigations	Residual L	Residual I
Consultation materials are insufficiently developed, assured or consistent at launch	PCBC, consultation document, questionnaire and impact assessments are being developed in parallel and changes in one document may not be reflected elsewhere.	3	5	Single approval process; document control; HICO assurance; final cross-document review; readiness review before launch.	2	4
	Insufficient time available for translation, accessible formats and final quality assurance.	3	4	Production schedule; prioritisation of critical outputs; supplier management; escalation route through Programme governance.	2	3
The public do not receive sufficient information to respond meaningfully	Consultation materials are too complex, technical or lengthy for a general audience.	4	5	Summary consultation document; infographics; plain English review; accessible formats; clear signposting.	2	4
	Key trade-offs, benefits and disadvantages of options are not clearly explained.	4	5	Option comparison tables; FAQs; independent review; use of case studies and visual material.	2	4
Consultation feedback is not representative of affected communities	Consultation fatigue following previous stages of engagement and consultation activity.	3	5	Clear explanation of how previous feedback has shaped proposals; targeted promotion; broad programme of public events.	2	4
	Consultation methods do not sufficiently reach seldom-heard groups or people with protected characteristics.	4	5	Stakeholder mapping; EQIA-led outreach; ORS focus groups; community partnerships; midpoint review.	2	4
	Rurality, transport barriers and digital exclusion prevent participation.	4	4	County-wide events; paper questionnaires; outreach activity; online and face-to-face opportunities.	2	3
Significant equality, Welsh language or socio-economic impacts are not fully understood before decisions are taken	Insufficient engagement with affected groups during consultation.	3	5	Targeted engagement activity; impact assessment reviews; consultation questions focused on impacts and mitigations.	2	4
	New impacts emerge during consultation which were not identified during options development.	3	5	Ongoing impact assessment process; midpoint and closing reviews; supplementary targeted engagement where required.	2	4
Consultation is perceived as a decision already having been made	Stakeholders view publication of preferred options as evidence that outcomes have already been determined.	4	5	Explicit explanation of Board decision-making process; publication of options appraisal work; emphasis on conscientious consideration.	3	4
	Historic temporary service changes or previous decisions create perceptions of predetermined outcomes.	4	5	Consistent communication messaging; publication of supporting evidence; Board commitment to consider consultation feedback before decisions.	3	4
Public confidence in the consultation process is undermined	Misinformation or inaccurate information circulates through media, social media or campaign groups.	4	4	Media strategy; myth-busting FAQs; monitoring and response arrangements; stakeholder briefings.	3	3
	Political or campaign group opposition challenges the legitimacy of the consultation process.	4	4	Transparent process; independent assurance; open publication of evidence and consultation findings.	3	3
Staff wellbeing, confidence or safety is adversely affected	Staff uncertainty regarding possible future changes impacts morale and wellbeing.	4	4	Staff engagement programme; manager briefings; wellbeing support; change management support.	2	3
	Staff experience hostility or inappropriate behaviour at consultation events or online.	3	4	Personal safety guidance; event risk assessments; security arrangements; incident reporting procedures.	2	3
The consultation does not generate sufficiently robust evidence to support Board decisions	Consultation questions do not adequately explore reasons for stakeholder views.	3	5	Independent review of questionnaire; qualitative follow-up questions; ORS support.	2	4
	Analysis and reporting arrangements are insufficiently robust or transparent.	2	5	Independent analysis by ORS; agreed methodology; assurance reviews; publication of findings.	1	4
Consultation delivery is adversely affected by programme capacity or supplier dependencies	Internal staff capacity is insufficient to deliver consultation activities.	3	4	Defined consultation team; additional support resources; escalation through governance arrangements.	2	3
	External suppliers are unable to deliver required outputs to timetable.	2	4	Contract management; milestone monitoring; contingency planning; regular review meetings.	1	3
Stakeholders become confused by multiple concurrent engagement or consultation activities	Other PTHB consultations or service changes are taking place at the same time.	3	4	Co-ordination through Executive Committee and Portfolio Board; integrated communications planning.	2	3
	Neighbouring or national health organisations are undertaking related consultations affecting Powys residents.	4	4	Liaison with neighbouring NHS organisations; contextual briefing and communication materials.	3	3
Information governance or confidentiality issues arise during consultation	Personal information is collected, processed or shared incorrectly.	2	5	GDPR compliance; supplier agreements; privacy notices; information governance oversight.	1	4
Material new evidence emerges during consultation that affects the basis of consultation	Further technical, clinical, workforce or estate information becomes available after launch.	3	5	Midpoint review; supplementary information process; legal and assurance advice; change control arrangements.	2	4
	Urgent operational pressures require unplanned service changes during the consultation period.	3	5	Executive oversight; issue escalation process; transparent communication; assessment of implications for consultation fairness.	2	4

The programme risk register will continue to evolve throughout the programme and will include operational, strategic, reputational, equality, clinical and legal considerations associated with major service change consultation. This will include ongoing review of consultation reach, representativeness, emerging themes, misinformation, public confidence, accessibility, and compliance with statutory duties.

7.0 Engagement and Insight Plan

Introduction	The engagement plan will support the objectives of the consultation, and specifically: • Raising awareness amongst our people of the opportunities to participate and share views to inform the Board decision on service change options for adult physical and mental health NHS community services • Facilitating ongoing engagement with public, staff, statutory stakeholders, wider stakeholders and targeted groups most impacted / affected by its proposals • Targeting those most affected by the service change options through engagement methods best suited to the key groups • Providing a range of opportunities, taking account of accessibility, for our staff and key stakeholders to give their views Our approach will be underpinned by a commitment to continuous engagement, with particular reference to the seldom heard, and engage in ways that are sensitive and appropriate to their needs and in this way, we will be most likely to meet the needs of our entire population.
Insight Methods	Tools and strategies for ensuring the methodologies used are in keeping with the needs of each stakeholder group will be prioritised. A contract is in place with ORS to support consultation analysis and delivery. The methodology for gathering insights is currently expected to include: • Online questionnaire (EN and CY) with equality monitoring • Printed questionnaire (EN and CY) with equality monitoring • Easy Read printed questionnaire (EN and CY) with equality monitoring • Receipt of correspondence via email and in writing • Receipt of petitions • Targeted public focus groups facilitated by ORS • Records from public, staff and stakeholder engagement events (currently to be gathered and analysed by PTHB) – *wherever possible, attendees at public, staff and stakeholder engagement events will be encouraged to complete the consultation questionnaire* As part of this consultation, the health board will not be logging and analysing: • Social media comments • Comments on external or third party websites (e.g. newspapers) • Other comments and feedback not received via the channels listed above

Maximising participation	All consultation documents will be available on a dedicated section of the PTHB website and staff intranet. The sites and associated material will be promoted via the Health Board's corporate platforms to help reach the digital audience to maximise engagement. A range of events will be organised including: • A public drop-in event in each of the 13 Powys localities • A staff roadshow programme reaching out to the main PTHB sites and satellite locations • A programme of outreach events and/or pop-up events that reach out to community groups aligned with key issues identified in EQIA and/or to reach the main population centres where drop-in events are not taking place • Independently facilitated public focus groups by ORS • At least two online public event(s) for people not able to attend drop-ins • Stakeholder events for (a) Town and Community Council representatives (b) County Councillors (c) MSs and MPs (d) Leagues of Friends (e) third sector providers • Offer of presentations to key forums including Local Partnership Forum, Public Service Board, and Regional Partnership Board Opportunistic engagement will include: • Sharing information at pre-existing staff events including Wellbeing Roadshows, online and in-person training events, staff meetings, CEO staff briefings • Sharing information at pre-existing public and stakeholder events such as PAVO Locality Forums All engagement will comply with legislation in terms of the Data Protection Act 1998, the UK General Data Protection Regulations, the Freedom of Information Act 2000, and equality and diversity legislation.

8.0 Communication Plan

Introduction	The communications plan will support the objectives of the consultation by: • Providing clear and timely information about the purpose and scope of the consultation that helps to create understanding, build trust, and encourage engagement in the consultation • Ensuring our communication is proactive, open and transparent – providing enough information for individuals to feel able to participate, without overwhelming individuals and leading to confusion • Reaching out to our diverse range of key stakeholders (inclusive of staff, service users, carers, our partners, the public, particularly those identified as potentially being disadvantaged, marginalised and minority groups) to raise awareness of the consultation and actively encouraging people to get involved and share their views • Reduce likelihood of potential mis-information and myths by monitoring themes from events, correspondence, media and social media and responding to escalating concerns through proactive communication messaging • Demonstrating that the Health Board is listening and responding by sharing themes heard during the consultation, providing responses to concerns, and sharing the results of the consultation • Providing consistent responses wherever possible to people's enquiries, or concerns (including those from stakeholders such as patient and public representatives and media), and sharing feedback heard to the Health Board.
Marketing and Awareness	The communications plan will document key messages, audiences (which will be informed by the stakeholder analysis), products and channels necessary to support people to take part in the consultation, tactics to reach stakeholders, a schedule of promotion and activities, and how we will monitor and capture feedback. A variety of communication activities will be used to promote involvement in the consultation. More materials and activities will be prepared in advance for the first half of the consultation, allowing us the opportunity to review feedback, themes and engagement, and respond accordingly in the second half of the consultation. In addition, consideration is being given to use of Personas to illustrate how proposals may affect access and experience of health care services, subject to capacity to develop and utilise these.

Public Channels	Key channels for public communication will include: • PTHB website pthb.nhs.wales/bettertogether and biap.gig.cymru/gwellagydangilydd – *NB as the survey is externally hosted, we suggest that consultation materials are hosted on the PTHB website rather than Engagement HQ* • PTHB social media channels (Facebook, LinkedIn, Instagram, Nextdoor) • Media releases and regular news articles through the consultation period • A household leaflet drop to households in Powys • Public Drop-in Events • govDelivery subscription service • Reach out to local community channels, particularly those that may help us reach voices seldom heard or who may face barriers to participation
Stakeholder Channels	Key channels for stakeholder communication will include: • Syndicated articles for publication via stakeholder channels (e.g. PAVO, RPB, PSB) including co-ordination via Powys Engagement and Insight Network • Use existing stakeholder mechanisms and meetings
Staff Channels	Key channels for staff communication will include: • PTHB management cascade • PTHB Team Focus • PTHB CEO Online Briefings • PTHB Intranet - continuing to build and update the information available to staff (including FAQs, key messages, links to news stories, feedback opportunities, etc.) • Staff Roadshows • Staff Closed Facebook Group

9.0 Document Plan

Document Content	The main consultation document will attend to the specific requirements set out in Welsh Government guidance on NHS Service Change that consultation documents should: • Explain the case for change, why change is necessary and provide clear evidence. • Include a clear vision of the future service. • Explain the consequences of change or of maintaining the status quo, on quality, safety, accessibility and proximity of services. • Include information on outcomes for patients and service users. • In the case of changes relating to hospitals, demonstrate how services will in future be provided within an integrated service model including working with local authorities. • Set out clearly the evidence for any proposal to concentrate services on a single site. • Include the evidence of support from clinicians for any proposed change. • In the case of changes prompted by clinical governance issues, show how these have been tested through independent review. • Show which options were considered during the engagement phase - the NHS needs to ensure that, if a preferred option is specified, this will not be seen as a 'fait accompli'. • Explain any risks and how they will be managed. • Give a clear picture of the financial implications of the different proposals. • Spell out who will be affected by the proposed changes and how their interests are being protected. • Explain how any change and benefit will be evaluated after implementation. • Be bilingual and in a range of formats, appropriate for the needs of the affected patients and communities including British Sign Language. For example, materials in Welsh could be particularly important for a patient with dementia, as their ability to use a second language may be diminished or lost. • Be agreed by the Board of the NHS body. [source: How to make changes to health services: guidance for NHS organisations | GOV.WALES]

Document Versions	We will aim to be open and transparent in the provision of all our consultation materials. We acknowledge that to be involved in a consultation, some of our diverse communities will need to be provided with alternative versions, or support to participate.
	
	Informed by the stakeholder analysis and EQIAs, in order to make the consultation as accessible as possible we will produce:
	
	• A bilingual consultation document in as plain writing as possible and minimum font size 12, that complies with digital accessibility guidance and best practice
	
	• A bilingual summary version:
	
	• Alternative formats:
	  • Audio (C)
	  • Easy Read (M)
	  • Consideration of a youth-friendly version subject to capacity and recognising that the majority of proposals have an indirect or future impact on young people (C)
	  • British Sign Language summary video (M)
	
	• html publication on the health board's digital channels so that readers can use assistive technologies, screen readers, language translation
	
	• Information within the consultation document in the four main language identified through census data and use of PTHB interpretation services (Ukrainian, Arabic, Polish, Nepalese) to indicate how information can be requested in their language of choice. A bespoke and reactive approach to translation will therefore be taken.
	
	• A suite of supporting technical/support documents to be identified by the Programme Team as part of the pre-consultation business case. This will include the current version of the Integrated Impact Assessments.
	
	• In addition, subject to capacity, consideration will be given to video promotion or animation (C)

10.0 Consultation Review

Pre-launch readiness review	A pre-launch readiness review will be undertaken during August 2026: • Sufficiency of consultation plan to meet key requirements • Sufficiency of readiness of consultation materials • Capacity and capability to deliver the agreed plan
Mid Point Review	The mid-point review will be undertaken between week 4 and week 6 of the consultation period (indicatively, w/b 16 November 2026), in order to review how the consultation has met the project plan to date and any new and emerging issues, including: • Evaluating what has been learned to date, through: • Effective monitoring of the debate and the reactions and activities of interested parties, including challenges and opposition • Considering the need for the plan to be amended as a reaction to what is being learned • Considering whether new information is needed or needs sharing • Discussing how contingency will be managed if changes to the plan are needed • Confirming sufficient media and social media awareness of the consultation or any gaps that need addressing • Evaluating stakeholder participation and identifying gaps in reach, and in particular from seldom heard voices. • Identifying any significant equalities and impact issues arising that have a material impact on the plan
Closing Review	The closing review will be undertaken approximately two weeks before the consultation period formally closes (indicatively w/b 21 December), in order to review how the consultation has met the project plan, including: • Evaluating what has been learned to date through effective monitoring of the debate and the reactions and activities of interested parties, including challenges and opposition • Considering any further essential actions to support the effectiveness and appropriateness of the consultation • Reviewing what should happen post consultation and what the timeline will be for response, evaluation and analysis, sharing the outputs and feedback, and making decisions • Review and updating of the EqIAs.
Post Decision Learning and Reflection	Learning and reflection will take place to learn lessons from the consultation period to support continuous improvement.

11.0 Consultation Findings Report

Evaluation and Analysis Plan	The consultation analysis, initial output report and final report will be undertaken independent to the Health Board via Opinion Research Services (ORS) who have been procured in advance of consultation. The consultation findings report will provide an accurate and balanced overview of the feedback received through the consultation process. The report will support, but remain distinct from, the subsequent Board decision-making and conscientious consideration process.
Key Components	The purpose of the final consultation report is to: • provide the Board with an accurate and balanced overview of the feedback received through the consultation process to support a decision on the service change options taking the impacts into consideration The final report is likely to include: • Summary of key themes • Overview of findings • Key issues raised through consultation The final consultation report will be presented and deliberated at a meeting in public of the Health Board on a date to be determined. Review and reflection of the findings from the consultation as set out in the consultation report will inform the post consultation decision case for decision by the Board. This will include updated Integrated Impact Assessments to ensure emerging impacts, barriers and mitigations are identified and considered as part of decision-making. The date and time of the meeting will be publicised through the health board channels, and the agenda and papers will be published in advance. The meeting will be livestreamed for the public to observe. There will be an opportunity for questions from the public in line with normal health board procedures and Standing Orders, recognising that this is a “meeting in public” and not a public meeting.

12.0 Decision Reporting

Following Board Decision	A feedback report summarising the outcome of the consultation, the decision of the Board and the next steps will be published and shared: • PTHB staff (intranet, PTHB News Update, staff briefings, PTHB Team Focus) • Stakeholders (email distribution) • Public (govDelivery subscribers, PTHB website, social media channels) It is currently anticipated that Wales will enter the pre-election period for the Local Authority elections 2027 shortly after a decision is taken, so it will be important that due regard is given to the specific requirements and sensitivities of the pre-election period to ensure political fairness and impartiality.

Better Together
Adult Physical and Mental Health Community Services

Step Report: Options Development

FINAL DOCUMENT V6



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Executive Summary

This report evidences the process undertaken to provide assurance to the Board on the integrity, transparency and robustness of the process undertaken by Powys Teaching Health Board (PTHB) in developing, refining and appraising options for the future delivery of adult physical and mental health community services as Phase 1 of Better Together.

The Health Board agreed a structured five-step methodology underpinned by the NHS Wales service change guidance to strive to maintain safe and sustainable services; this has been applied through engagement on the case for change, development of options and assessment of the impact of potential changes, in readiness for consultation. The HM Treasury Green Book has been adopted as best practice specifically to support the non-financial appraisal of the options – noting this is typically applied to capital investment appraisal rather than service transformation. A consistent and proportionate approach has been applied throughout, ensuring that options have been systematically tested for strategic alignment, clinical sustainability, deliverability, and impact.

The Case for Change provided a robust, evidence-based foundation and was tested through Stage 1 engagement with staff, stakeholders and the public. Feedback demonstrated strong alignment with the challenges identified, including the need to improve access, address workforce fragility, reduce inequity, and deliver more care closer to home within a rural context. These themes were embedded throughout the options development process, informing design principles, assessment criteria and appraisal.

A comprehensive programme of engagement has been undertaken across Stages 0–2, including public, patient, partner and staff involvement, supported by three deliberative events. This ensured that stakeholder perspectives informed the development, refinement and assessment of options. Engagement has been proportionate to each stage of the process, with technical appraisal activities appropriately undertaken by clinical and professional stakeholders, while earlier and planned future engagement ensures continued public involvement in shaping outcomes.

Options were developed through structured workshops and technical analysis, progressing from a long list to a shortlisted set of credible and viable options through application of agreed Hurdle Criteria and iterative refinement. These options were subject to a comprehensive, multi-stage appraisal process, including non-financial assessment using the NHS Wales STEEEP (Safe, Timely, Effective, Efficient, Equitable, Person-Centred Care) domains of quality, supported by sensitivity analysis, as well as workforce, financial, estates, demand and capacity modelling, travel time analysis, patient pathway testing, and quality and equality impact assessments.

The report identifies a small number of recommended options proposed for to be progressed through organisational governance arrangements to a decision on future public consultation. No final decisions have been made. These options represent a range of credible approaches that require further testing with the public, patients, staff and stakeholders during formal consultation.

Overall, the process provides a robust and transparent evidence base, supported by clear governance, clinical and professional assurance, and a comprehensive audit trail to support decision making necessary to proceed to Stage 3: formal public consultation for adult physical and mental health community services.

Contents

Executive Summary 3
1. PURPOSE OF THIS REPORT 6
2. WHAT IS BETTER TOGETHER? 6
2.1 Phasing of Better Together 7
2.2 Phase 1 Adult Physical and Mental Health Community Services 7
3. OPTION DEVELOPMENT APPROACH AND METHODOLOGY 8
3.1 Steps to Consultation 8
3.2 Stages of Engagement and Consultation 10
3.3 How the Stages of Engagement Supported the Steps 10
3.3.1 Stakeholder participation and public involvement 11
3.3.2 Application of the Gunning Principles 12
3.4 Hurdle Criteria, Scoring and Assessment Framework 13
3.4.1 Hurdle Criteria 13
3.4.2 STEEEP Six Domains of Quality 14
3.4.3 STEEEP Weighting and Sensitivity Analysis 15
3.4.5 Design Principles 16
3.4.6 Impact Assessments 16
3.5 Governance and Assurance 17
3.5.1 Key Groups and Responsibilities 18
3.5.2 Independent Advice and Guidance 19
3.5.3 Check and Challenge and Assurance 20
4. STEPS TO CONSULTATION 21
4.1 Step 1 – Case for Change and Models of Care (Including Stage 1 Engagement) 21
4.1.1 Case for Change and Stage 1 Engagement 21
4.1.2 Vision, Models of Care Concepts and Travel Time Principles 23
4.1.3 Progression to Step 2 25
4.2 Step 2 – Develop Initial Options 25
4.2.1 Deliberative Event 1 25
4.2.2 Stage 2 Engagement 26
4.2.3 Primary Care Workshop (GMS Focus) 28
4.2.4 Long List Ideas Review 28
4.2.5 Progression to Step 3 29
4.3 Step 3 and 4 – Review and Refinement of Options and Development of Short List Options 29
4.3.1 Short List Options Development Week 29
4.3.2 Refinement of short list options 34
4.3.3 Second Deliberative Event 35
4.3.4 Short List - Further Check and Challenge 38
4.3.5 Progression to Step 5 39
4.4 Step 5 – Score Short List of Options 39
4.4.1 Non-Financial Options Appraisal – Physical Health, Mental Health and Urgent Care 39
4.4.2 Further Technical Development of Options 43
4.4.3 Workforce & Finance Check and Challenge 44
4.4.4 Clinical Executive 'Check and Challenge' 45
4.4.5 Non-Financial Appraisal on Urgent Care Centre, including Diagnostics Options 46
5.FINALISATION OF OPTIONS 48
5.1 Recommendations Workshop Sessions 48

5.2 Outputs from the Recommended Options Workshop 49
5.3 Deliberative Event 3 57
6. CONCLUSIONS & RECOMMENDED OPTIONS FOR CONSULTATION 59
7. Readiness for Board Decision on Consultation 60
8. TECHNICAL APPENDICES 61

Figures Table

Figure 1: Social Model for Health 7
Figure 2: Description of Option Development Steps (Inputs and Outputs) 9
Figure 3: Engagement & Consultation Process 10
Figure 4: Adults Physical and Mental Health Community Services Options Develop Process 11
Figure 5: Lists the Hurdle Criteria agreed and applied during the options development process 13
Figure 6: STEEEP Assessment Criteria 14
Figure 7: Option Scoring Mechanism 15
Figure 8: Design Principles 16
Figure 9: Better together Portfolio Governance Structure 17
Figure 10: Clinical & Professional Workshop Overview 24
Figure 11: Long list to short list hurdling 31
Figure 12: Adult Physical Health, including community – Five short listed options 36
Figure 13: Urgent Care Centres including Diagnostics – Four short listed options 36
Figure 14: Adult Mental Health, including older adult community - 8 short listed options 37
Figure 15: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 41
Figure 16: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 41
Figure 17: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 42
Figure 18: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 47
Figure 19: Estate Assessment coding 50
Figure 20: PHYSICAL HEALTH Outputs from Recommended Options Workshop & Rationale 50
Figure 21: URGENT CARE Outputs from Recommended Options Workshop & Rationale 52
Figure 22: MENTAL HEALTH Outputs from Recommended Options Workshop & Rationale 54
Figure 23: Recommended Options Summary Table 59

1. PURPOSE OF THIS REPORT

This report evidences the process undertaken to provide assurance to the Board on the integrity, transparency and robustness of the process undertaken by Powys Teaching Health Board (PTHB) in developing, refining and appraising options for the future delivery of adult physical and mental health community services as Phase 1 of Better Together.

It provides transparency in the activities and decision making undertaken as part of the development of options for Adult Physical and Mental Health Community services, in relation to how future services could be provided in Powys to address the issues identified within the Case for Change. It articulates the engagement activity and how this informed the development and refinement of options, how the options were then assessed and appraised, who was involved in these activities, how appropriate assurances were provided along through drawing on expertise or evidence base to ensure a robust and transparent process has been achieved to prepare the Health Board for external scrutiny and consultation in their progression to Stage 3: Formal Public Consultation.

The Steps included within this report include the development of Cases for Change, service issues papers development of system and service models of care, development of a long list of options through stakeholder engagement and how these were reviewed against the hurdle criteria to shortlisted options. Finally, how the short-listed options were appraisal through a non-financial options appraisal, workforce and financial appraisals and estate assessment and how these were tested with stakeholders throughout the process. The outputs of this stage are intended to inform Stage 3: Formal Public Consultation

It provides a description of the work undertaken under each step, who was involved and how options were formed following engagement activities and refined or discounted following assessment and appraisal of the options.

It does not attempt to repeat detailed information provided in other reports but where required summarises key points and references the relevant source documents.

2. WHAT IS BETTER TOGETHER?

Better Together is Powys Teaching Health Board's (PTHB) big conversation to shape the future of safe, quality health services for Powys and ensure delivery of our Health and Care Strategy. It builds on previous discovery work for a sustainable model for healthcare in Powys and was established in its current format in December 2024. It responds to the requirement for the Health Board to develop a Clinical Services Plan as part of its de-escalation arrangements for its status in Level 4 Escalation (Targeted Intervention) for Finance, Strategy and Planning.

Better Together will achieve this by harnessing the skills and talents of the people of Powys, by making best use of the resources and assets in the NHS and across local organisations and communities, and by responding to the challenges and the opportunities we all face, to improve quality and outcomes. It seeks to address issues around fragility of services, meeting standards in delivery and the improvement in access and reduction in the number of patients being treated outside of Powys by bringing services closer to home, where possible and appropriate. We have a duty of care to ensure that we provide high-quality services to our population. We also have a duty to live within our means. To achieve this, we need to consider options for how and where we could

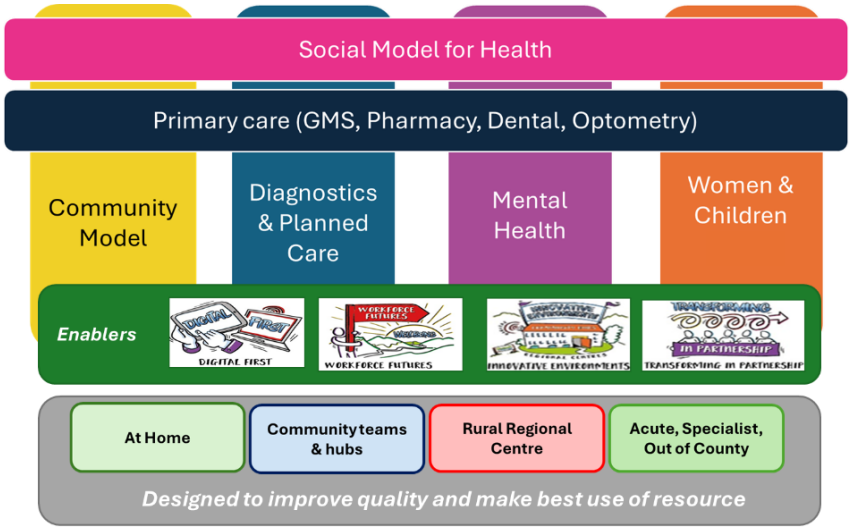
provide services in the future. This might mean patients need to access services in a different way or in a different place.

Initial planning was based on the development of the Case for Change and options for a sustainable model across all clinical service areas in the Health Board, this includes inpatient, community and urgent care services for physical and mental health, planned care, diagnostics, and women, children and family services.

2.1 Phasing of Better Together

In response to the position of both the health board and timeline for Senedd elections in May 2026, a decision was taken by the Executive Committee in March 2025 to phase delivery of Better Together into three distinct clinical delivery areas in a phased approach – adult physical and mental health community services, diagnostics and planned care, and women and children's services. This is illustrated in the diagram below.

Figure 1: Social Model for Health



The first phase of this work has been adult physical and mental health community services. More detail is provided on the Case for Change in **section 4.1.1**.

2.2 Phase 1 Adult Physical and Mental Health Community Services

The scope of Phase 1 Adult Physical and Mental Health Community Services includes the following:

Inpatient services, including our community hospital inpatient wards for both physical and mental health. This includes how we are providing palliative and end of life care both in and out of hospital.

Urgent Care, including the Minor Injury Units that the health board provides and how we work with the GP practices and acute hospitals that the health board funds.

Mental Health, including our single 'front door' to access adult mental health services and our teams in the community that support older adults and inpatient care.

Other important community-based services, including 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 condition specific teams, therapies and imaging.

3. OPTION DEVELOPMENT APPROACH AND METHODOLOGY

3.1 Steps to Consultation

This section describes how Phase 1 of Better Together was delivered, including the structured steps followed, engagement approach, appraisal methodology and assurance processes applied. The process was managed under the Frailty and Community Programme and Adults Mental Health Programme via the Options Development Group (ODG) and supporting clinically led task and finish groups. This enabled a more joined up approach to meeting patient needs from both a physical and mental health perspective and ensured as well as appropriate governance arrangements which are further detailed in **section 3.4**.

The Health Board agreed and followed a five-step process to deliver Phase 1 Adult Physical and Mental Health service options ready for consultation. This five-step methodology is underpinned by the NHS Wales service change guidance to strive to maintain safe and sustainable services; this has been applied through engagement on the case for change, development of options and assessment of the impact of potential changes, in readiness for consultation. The HM Treasury Green Book has been adopted as best practice specifically to support the non-financial appraisal of the options – noting this is typically applied to capital investment appraisal rather than service transformation.

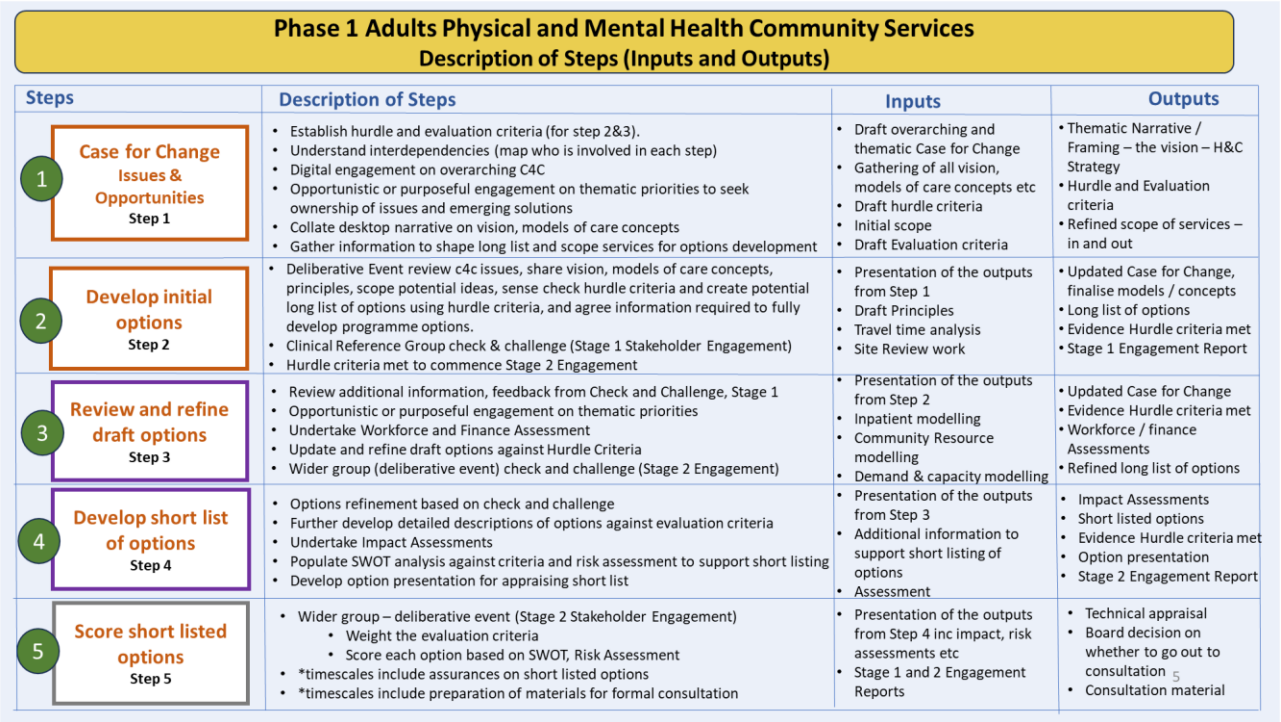
A consistent, proportionate and transparent approach has been applied across all services areas to ensure rigour, comparability and fairness in option development and appraisal. All options have been systematically tested for strategic alignment, clinical sustainability, deliverability.

The approach taken included, using in-person and virtual sessions to explore the issues, create ideas and work from a longlist of proposed options to a set of shortlisted options. Alongside this process, the Communications and Engagement team set up internet and intranet sites to support continuous engagement, allowing staff, patients, and other stakeholders the opportunity to feed into the process as it developed, including in-person sessions throughout the county for staff and the public.

The five-steps are outlined below; these are further detailed in *figure 2*:

- **Step 1:** Case for Change, Issues and Opportunities
- **Step 2:** Development of Initial Options and Engagement Events
- **Step 3:** Review and Refinement of Draft Options
- **Step 4:** Development of Shortlisted Options
- **Step 5:** Appraisal, Assurance and Preparation for Consultation

Figure 2: Description of Option Development Steps (Inputs and Outputs)



Phase 1 Adults Physical and Mental Health Community Services
Description of Steps (Inputs and Outputs)

Steps	Description of Steps	Inputs	Outputs
1 Case for Change Issues & Opportunities Step 1	• Establish hurdle and evaluation criteria (for step 2&3). • Understand interdependencies (map who is involved in each step) • Digital engagement on overarching C4C • Opportunistic or purposeful engagement on thematic priorities to seek ownership of issues and emerging solutions • Collate desktop narrative on vision, models of care concepts • Gather information to shape long list and scope services for options development	• Draft overarching and thematic Case for Change • Gathering of all vision, models of care concepts etc • Draft hurdle criteria • Initial scope • Draft Evaluation criteria	• Thematic Narrative / Framing – the vision – H&C Strategy • Hurdle and Evaluation criteria • Refined scope of services – in and out
2 Develop initial options Step 2	• Deliberative Event review c4c issues, share vision, models of care concepts, principles, scope potential ideas, sense check hurdle criteria and create potential long list of options using hurdle criteria, and agree information required to fully develop programme options. • Clinical Reference Group check & challenge (Stage 1 Stakeholder Engagement) • Hurdle criteria met to commence Stage 2 Engagement	• Presentation of the outputs from Step 1 • Draft Principles • Travel time analysis • Site Review work	• Updated Case for Change, finalise models / concepts • Long list of options • Evidence Hurdle criteria met • Stage 1 Engagement Report
3 Review and refine draft options Step 3	• Review additional information, feedback from Check and Challenge, Stage 1 • Opportunistic or purposeful engagement on thematic priorities • Undertake Workforce and Finance Assessment • Update and refine draft options against Hurdle Criteria • Wider group (deliberative event) check and challenge (Stage 2 Engagement)	• Presentation of the outputs from Step 2 • Inpatient modelling • Community Resource modelling • Demand & capacity modelling	• Updated Case for Change • Evidence Hurdle criteria met • Workforce / finance Assessments • Refined long list of options
4 Develop short list of options Step 4	• Options refinement based on check and challenge • Further develop detailed descriptions of options against evaluation criteria • Undertake Impact Assessments • Populate SWOT analysis against criteria and risk assessment to support short listing • Develop option presentation for appraising short list	• Presentation of the outputs from Step 3 • Additional information to support short listing of options • Assessment	• Impact Assessments • Short listed options • Evidence Hurdle criteria met • Option presentation • Stage 2 Engagement Report
5 Score short listed options Step 5	• Wider group – deliberative event (Stage 2 Stakeholder Engagement) ◦ Weight the evaluation criteria ◦ Score each option based on SWOT, Risk Assessment • *timescales include assurances on short listed options • *timescales include preparation of materials for formal consultation	• Presentation of the outputs from Step 4 inc impact, risk assessments etc • Stage 1 and 2 Engagement Reports	• Technical appraisal • Board decision on whether to go out to consultation • Consultation material

The five-step methodology is based on learning from other Health Board's across Wales and best practice outlined in The HM Treasury Green Book - the official UK government guidance for appraising and evaluating policies, programmes and projects. The Green Book is typically applied to capital investment appraisal rather than service transformation; however, it has been adopted as best practice specifically to support the non-financial appraisal of the options.

In summary the

- **Steps 1 and 2** focused on problem definition, exploration of possibilities and broad option generation, informed by early engagement and deliberative input;
- **Steps 3 and 4** applied structured screening, refinement and triangulation to ensure options were clinically viable, deliverable and strategically aligned; and
- **Step 5** applied a structured nonfinancial appraisal to support comparative discussion and assurance, rather than to determine a preferred option.

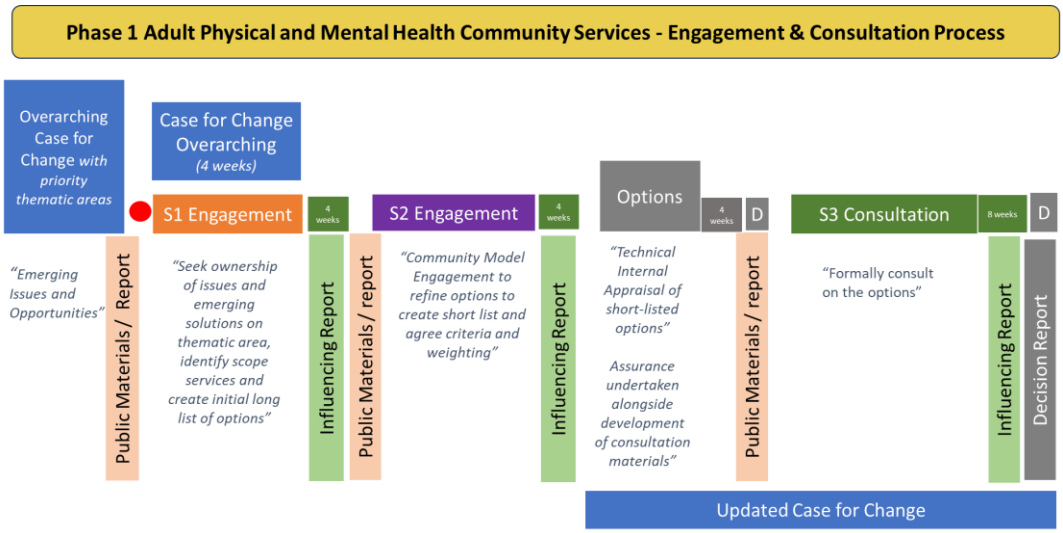
This approach ensured that progression decisions were based on a combination of evidence, engagement, professional judgement and structured assessment, providing both rigour and transparency ahead of consultation.

It should be noted that some tasks fell outside of the intended step, due to internal constraints of available resources, however all tasks within the steps have been carried out. Detailed description of each step is provided in **section 4**.

3.2 Stages of Engagement and Consultation

The engagement and consultation arrangements were based on national and legislative requirements and good practice. e.g. Welsh Government's Guidance for Engagement and Consultation on Changes to Health Services 2022, The Gunning Principles, and National Principles of Public Engagement in Wales. The Health Board agreed and followed three key stages of engagement (stages 0-2) to support and inform future consultation (stage 3). This is depicted below in figure 3.

Figure 3: Engagement & Consultation Process



Stage 0: Discovery activity – took place prior to the case for change being developed. It is therefore not depicted above as part of the above engagement and consultation process. The insights highlighted significant pressures related to access, workforce sustainability, ageing demographics and increased comorbidity, rural travel and transport – all of which were incorporated into the case for change and formed part of the Stage 1 engagement materials as a basis for continuous engagement.

Stage 1: The purpose of this stage was to share the Case for Change, seek views on how the narrative compares to resident/stakeholder understanding, confirm the issues and capture ideas to identify potential solutions through early engagement with stakeholders.

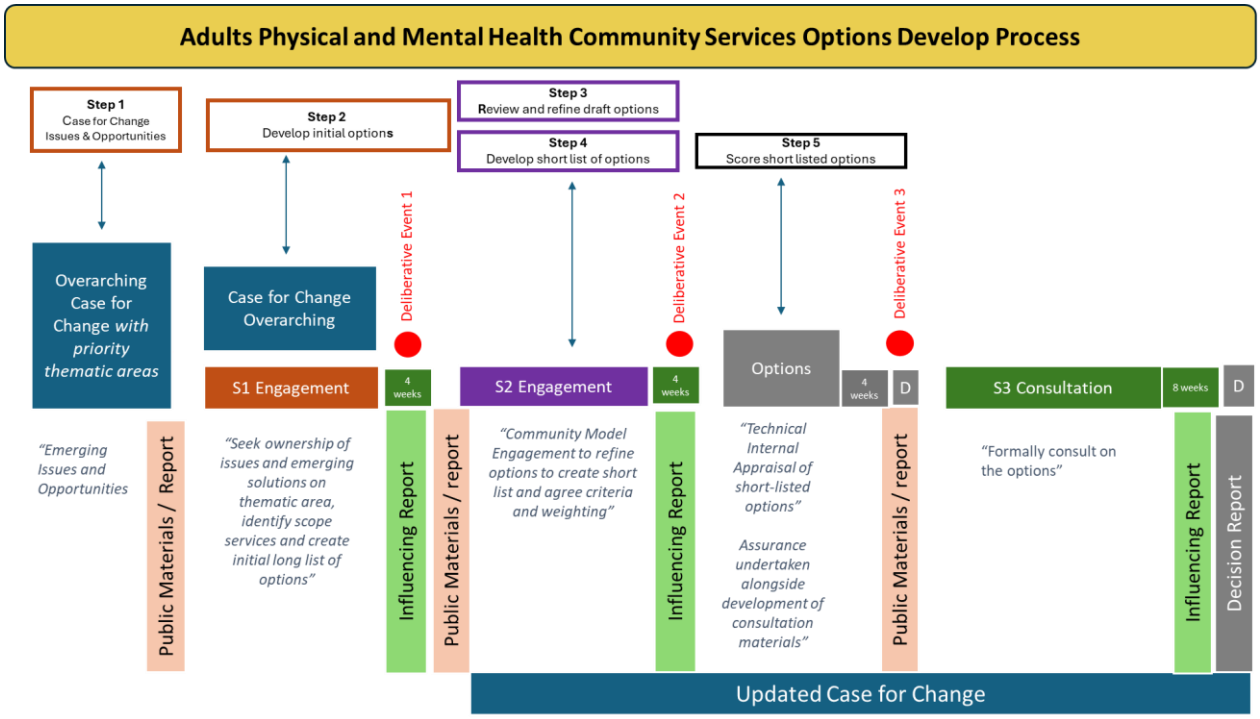
Stage 2: Engagement with stakeholders on six scenarios, draft hurdle criteria, development of the long list of ideas to create the short list of options, and options appraisal against agreed criteria and weightings.

Stage 3: Formal consultation to follow Autumn 2026.

3.3 How the Stages of Engagement Supported the Steps

Stage 1 engagement activities were aligned with Step 1, the draft outputs from Stage 1 fed into Step 2. Stage 2 engagement activities spanned Steps 2-4, and the draft outputs were reviewed and fed into Step 4. The outputs from all engagement activities were appropriately considered during the options development process and were further tested and shared at the first two Deliberative events.

Figure 4: Adults Physical and Mental Health Community Services Options Develop Process



3.3.1 Stakeholder participation and public involvement

A structured stakeholder mapping exercise was undertaken to identify the appropriate involvement required across Phase 1: options development. Working with Senior Responsible Officers, Transformation Programme Managers and Executive leads. Stakeholder groups were clearly defined to support distinct stages of the process, including Case for Change development, option development (Options Development Group), deliberation and option refinement, formal scrutiny and assurance, and stakeholders to be kept informed throughout. In parallel, patient representatives who had participated in early targeted engagement as part of the discovery phase and expressed a wish to remain involved were invited to contribute through attendance at deliberative events. This approach ensured proportionate, transparent and inclusive involvement, with clear lines of assurance across the options development process.

Stakeholder participation throughout Phase 1 of Better Together was deliberately structured to be proportionate to the purpose, technical complexity, and decision-making requirements for each step in the options development process. Different steps required different forms of involvement, and the programme of work distinguished between internal technical development, stakeholder challenge and sense checking, and public and service user engagement to inform direction and priorities. A stakeholder participation and public involvement overview is included at **appendix E**. Where public and patient representation was necessarily limited during technical appraisal stages, the Health Board remains open to conscientiously considering what emerges through consultation. This risk has been proactively managed through early, iterative engagement, multiple deliberative events, independent assurance, and the planned pre-consultation deliberative engagement in June 2026. These measures ensure that consultation remains formative, that no option is presented as predetermined, and that final decisions will be made following full consideration of consultation responses.

In preparation for Stage 0-2 Engagement there was prioritised broad engagement with patients, communities, staff, partners and representative bodies, ensuring diverse perspectives informed the Case for Change, design principles and early option development. These Engagement stages incorporated public surveys, workshops, drop-in events, targeted engagement with seldom heard groups, and deliberative events with direct service user representation.

Option development (steps 3–5) involved more technical appraisal and assurance activity, including detailed workforce, financial, estates, demand and capacity analysis, and nonfinancial options appraisal. Participation at these stages was therefore focused primarily on clinical, professional and partner stakeholders with relevant expertise. This ensured options were tested rigorously for clinical safety, deliverability and sustainability prior to public consultation.

Importantly, outputs from public and stakeholder engagement undertaken earlier in the process were actively used as inputs to inform option refinement, assessment criteria, weighting, mitigations and appraisal logic, rather than relying solely on views expressed during technical sessions.

Patient, service user and public representation was embedded throughout engagement activities, particularly during discovery, Stage 1, and Stage 2 engagement, and through both deliberative events. In addition, representative bodies including Llais (the independent statutory body in Wales, to represent the public's voice in health and social care services) were routinely invited to participate in relevant governance and engagement forums.

Llais was specifically invited to attend both of the non-financial options appraisal stages in an observer capacity. This opportunity was declined. This decision was respected and recorded, and assurance was provided through alternative mechanisms including independent engagement assurance, clinical reference group challenge, and subsequent deliberative engagement.

The programme has remained transparent regarding where direct public participation was not proportionate due to technical complexity, and where earlier or parallel engagement activity provided the necessary input and challenge to inform decision making.

3.3.2 Application of the Gunning Principles

Whilst the Gunning Principles are more appropriately associated with the formal consultation process itself, they were considered as part of engagement process to ensure meaningful engagement, and that decision making remains open prior to formal consultation.

Principle 1 – Consultation at a formative stage
Engagement commenced at the earliest stages of the programme (discovery and Case for Change), before any preferred option was identified. Public, patient and stakeholder input directly informed the identification of issues, priorities, scenarios and the long list of options.

Principle 2 – Sufficient information to give intelligent consideration
Engagement materials, scenarios and deliberative events were designed to present information in an accessible, balanced and nontechnical way, supported by independent facilitation where appropriate. Technical analysis undertaken later in the process has been clearly framed as preparatory work to enable informed consultation, rather than decision making.

Principle 3 – Adequate time to consider and respond
Engagement was delivered over multiple stages and time periods, including extended Stage 2

engagement and two deliberative events, ensuring stakeholders had sufficient opportunity to understand proposals, reflect and provide feedback.

Principle 4 – Conscientious consideration of responses
Feedback from engagement has been systematically analysed, triangulated and explicitly referenced in option refinement, assessment criteria, weighting, mitigation development and appraisal logic. There is a documented audit trail demonstrating how engagement informed decision making throughout the process.

Application of this approach provides assurance that the Phase 1 process does not predetermine outcomes, and that formal consultation (Stage 3) represents a genuine opportunity for public and stakeholder views to influence final decisions.

3.4 Hurdle Criteria, Scoring and Assessment Framework

3.4.1 Hurdle Criteria

"Hurdle Criteria" are key tests ("hurdles") that options must pass before they are given further consideration. This helps to ensure that time and public money is not spent testing options that would not work. 'Hurdle Criteria' for Better Together Phase 1 were identified following an assessment of best practice and learning across NHS Wales and NHS England organisations and their experience of the use of Hurdle Criteria when undertaking service change.
The proposed Hurdle Criteria were developed by the Options Development Group and tested through the Enabling Group and Clinical Reference Group (described in **section 3.4**). Stakeholder feedback was requested on the criteria at the first Deliberative event and during Stage 1 engagement. The hurdle criteria were approved by the portfolio board prior to application during the options development process.

Figure 5: Lists the Hurdle Criteria agreed and 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?
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?

The Hurdle Criteria formed the first formal screening mechanism within the appraisal process. Their purpose was to identify options that were not clinically sustainable, deliverable, financially viable or aligned with strategic direction, and therefore should not progress to more detailed consideration.

Shortlisting was not based on a separate or additional set of criteria, but rather on a triangulated application of:

- the Hurdle Criteria outcomes;
- refinement and consolidation of overlapping or derivative options;
- analysis of interdependencies across service areas; and
- feedback from engagement, deliberative events and clinical/professional challenge.

Only those options that passed the Hurdle Criteria and remained materially distinct and credible following this triangulation progressed to nonfinancial appraisal.

3.4.2 STEEEP Six Domains of Quality

The Six Domains of Quality were used as assessment criteria (*figure 4*) for non-financial appraisal of shortlisted options. Each appraiser was asked to score each option against the STEEP criteria according to the scoring system (Figure 6) based on 1-5. 1 being does not meet the assessment objective or criterion and 5 being exceeds the objective or criterion.

Figure 6: STEEEP Assessment Criteria

Assessment Criteria (based on NHS Wales Health and Care Quality Standards)					
SAFE	**TIMELY**	**EFFECTIVE**	**EFFICIENT**	**EQUITABLE**	**PERSON-CENTRED**
Does this option deliver against the objective we are trying to achieve in a way that promotes 'safe' care:	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'timely' and 'accessible' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'effective' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'efficient' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'equitable' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'person-centred' care:**
Please consider as a guide for your assessment the extent to which this:	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*
• supports safe clinical practice *i.e. prevents and / or reduces harm / errors*	• delivers against required access standards / performance targets (such as reduction of delays and waits)	• is underpinned by reliable data, best practice guidance and evidence-base (e.g. NICE)	• makes best use of resources to improve patient outcomes and experience, staff satisfaction and enables us to live within our means	• delivers evidence-based care across Powys but can adapt to address differences in need; positively contributing towards reducing health inequalities	• Helps people to stay healthy, building self-reliance in patients and the population
• ensures a substantive workforce model *–i.e. the workforce is available, and a robust staffing model can deliver professional standards*	• improves access to services that support people to stay at home where possible and enables timely response when needs escalate	• supports delivery of future system models of care, national and local guidance	• uses digital technology where appropriate to aid efficient care, with consideration for those not able to use technology	• reduces inequity across Powys for example through removing unnecessary differences in the way services are delivered	• provides a responsive joined-up offer that supports people to achieve 'what matters most to them' and improves patient experience outcomes
• improves staff safety including promoting a culture of safety and speaking up safely	• enables efficient transfer and discharge pathways to prevent harm to patients	• addresses existing barriers to care in the case for change such as continuity of care and communication	• is feasible and can achieve a positive impact within the short or medium term *i.e. will improve the health of the whole population or have a very significant impact on the health of a small number*	• delivers an appropriate offer for all population groups – including those with protected characteristics (not necessarily the 'same' offer but the one that delivers the best fit between those characteristics and the care provided)	• Provides access to meet healthcare needs within acceptable travel times (in line with the evidence base)

Figure 7: Option Scoring Mechanism

Score	Descriptor	Definition
1	Does Not Meet Needs	The option fails to address the objective or STEEEP criterion. It may introduce risks or worsen current conditions.
2	Partially Meets Needs	The option addresses the objective or criterion in a limited or inconsistent way. Significant gaps remain.
3	Adequately Meets Needs	The option meets the minimum requirement. It is acceptable but lacks enhancement or innovation.
4	Fully Meets Needs	The option clearly meets the objective or criteria with confidence. It is robust and well-aligned with expectations.
5	Exceeds Needs / Optimal Fit	The option not only meets but enhances the objective or criteria. It offers added value, innovation, or futureproofing.

3.4.3 STEEEP Weighting and Sensitivity Analysis

The STEEEP assessment criteria were weighted by the Executive team, out of a total score of 100, to reflect the case for change and organisational strategic priorities. This weighting was applied to the scoring of the options for non-financial appraisal.
The Executive team weighted the criteria as follows:

Safe 30, Timely 15, Effective 20, Efficient 15, Equitable 10 and Person Centred 10.

Sensitivity analysis was applied to the scoring during non-financial appraisal to add further rigour, this included Reverse, Clinical and Public Weighting.

This allowed appraisal to also reflect themes emerging consistently from stakeholder, staff and public engagement, particularly the importance of care closer to home, equitable access in a rural context, and prevention of avoidable hospital admissions.

In addition to the sensitivity analysis undertaken, engagement themes were reflected through:

- increased emphasis on *Timely*, *Equitable* and *Person-Centred* domains through alternative weighting in the sensitivity analysis;
- application of travel time analysis as a core supporting assessment; and
- interpretation of scoring through the lens of engagement feedback during deliberative and appraisal discussions.

This ensured that engagement findings were materially embedded within the appraisal framework rather than considered in parallel.

3.4.5 Design Principles

Design principles were developed and shared during Stage 2 engagement. These are described in *figure 8*.

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, GP primary care services are provided in all 13 localities in Powys. · The 13 localities in Powys 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. · Our "regions" are North, Mid and South Powys.
Once for Powys	Some services can safely be delivered within the county, but because they are much more specialised in nature they may been to be provided from one location or by one centralised team. · 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. For example, we access District General Hospital services in neighbouring counties.

3.4.6 Impact Assessments

The Health Board requires proportionate impact assessment to be undertaken for all service change proposals that are subject to public consultation or stakeholder engagement. This is to ensure compliance with statutory duties, Welsh Government policy, NHS Wales standards, and PTHB's own governance and equality framework.

A **Level 1 Impact Assessment** provides an early, proportionate screening of a proposal to identify any potential equality, access, or service impacts that may arise from the proposed change. It ensures

statutory duties are considered at the outset and determines whether a more detailed Level 2 Impact Assessment is required before engagement or consultation proceeds.

A **Level 2 Impact Assessment** provides a comprehensive, evidence-based analysis of identified impacts where proposals may result in significant, differential, or disproportionate effects on individuals, groups, or communities. It ensures statutory compliance and informs meaningful mitigation, engagement, and decision making prior to and following public consultation.

Impact assessments were not undertaken solely as a statutory compliance exercise, but as an active tool to shape option design, identify risks and inform mitigation planning throughout Phase 1 of Better Together. Equality, Welsh language, access and quality impacts were considered iteratively as options were developed, refined and appraised, rather than assessed only at the end of the process.

Outputs from Level 1 Impact Assessments were used to:

- identify potential differential impacts at an early stage;
- inform refinement or consolidation of options during shortlisting; and
- determine where a more detailed Level 2 Integrated Impact Assessment would be required prior to consultation.

Level 2 Integrated Impact Assessments have been developed in parallel with detailed option refinement and will be finalised to support the pre-consultation business case, they will be used to inform:

- mitigation measures;
- identification of residual risks to be explored with the public and stakeholders during Stage 3 consultation.

This approach ensures that equality, Welsh language, quality and access considerations are embedded within decision making and are central to consultation readiness, reflecting their statutory, legal and reputational significance.

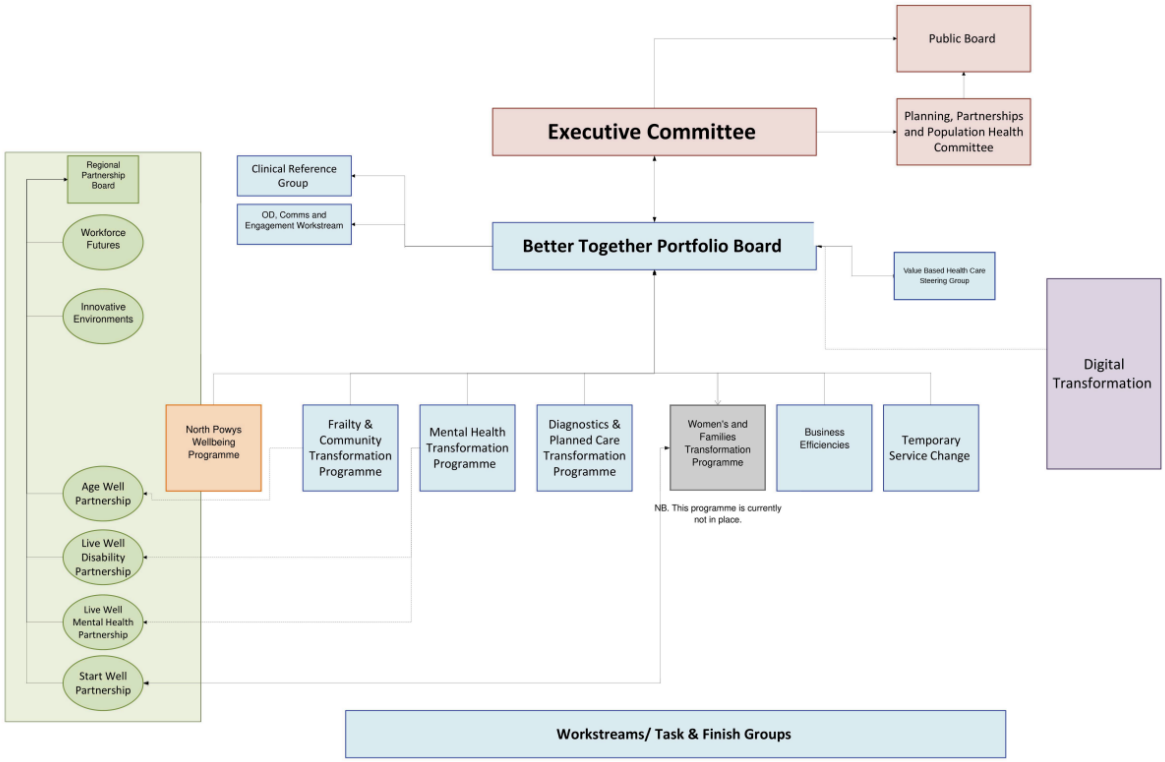
3.5 Governance and Assurance

Delivery of Phase 1 was overseen through established Better Together Portfolio governance arrangements, aligned to the Powys Health & Care Strategy and Integrated Medium-Term Plan (IMTP). This section outlines the governance arrangements, roles and responsibilities throughout the steps and the clinical and non-clinical assurance mechanisms that were in place to ensure appropriate scrutiny and assurance.

The options development process was managed through the Frailty and Community Programme and Mental Health Programme under Better Together. The responsibility for the development of options was delegated to the Senior Responsible Officers to manage via the Options Development Group (ODG). This group therefore reports directly into both programmes.

The diagram below describes the Better Together Portfolio governance structure.

Figure 9: Better together Portfolio Governance Structure



3.5.1 Key Groups and Responsibilities

The following governance arrangements are in place to ensure delivery of Better Together portfolio and have played a key role in providing oversight and delivery of the phase 1 options development.

- **Better Together Portfolio Board** - Oversees the portfolio, ensuring delivery of benefits aligned with the Health & Care Strategy, managing escalation of risks and issues, approval of key outputs and ensuring strategic alignment and assurance to the Executive Committee and Board.
- **Clinical Programme Boards** (Mental Health, Frailty & Community Model, Diagnostics and Planned Care) -Provides oversight of workstreams and task and finish groups delivering transformation projects and actions specific to a clinical area. Membership includes PAVO and Powys County Council.
- **Clinical Reference Group (CRG)** -Provision of clinical advice, challenge and assurance, for example, review of hurdle criteria and shortlisted options.
- **ODEC – Organisational Development, Engagement and Consultation** – Provision of strategic guidance and planning of organisational development, engagement, and communication activities, enabling stakeholders to transition smoothly and contribute to the change process. It is important to note that Llais Regional Director /their nominated representative is invited to attend and contribute to the group in an observer capacity.
- **Options Development Group (ODG) -** Responsible for development, refinement and testing of options across the service areas. Membership included clinical and operational lead(s) for each service, along with other clinical colleagues and representatives from enabling corporate services such as workforce, finance, estates, digital, organisational development and communications and engagement.

- **Task and Finish Groups** – Service specific groups supporting detailed option development, modelling, impact assessment and assurance. Membership included clinical, operational, workforce and finance representation.

The Improvement & Transformation team members provided facilitation and programme management support to the above groups.

3.5.2 Independent Advice and Guidance

INDEPENDENT CLINICAL EXPERTISE

Independent Clinical Expertise supported the process. This input is listed below:

- 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.

Throughout the process an evidence-based approach was applied, drawing from local, national and international sources. Alignment to national evidence-based programmes was tested with representatives from national programmes invited to participate in deliberative and options appraisal events (e.g. Six Goals programme, National Programme for Mental Health; ICCS)

INDEPENDENT ENGAGEMENT AND CONSULTATION SUPPORT

During Stage 0-2 engagement, external support was provided by Practice Solutions who undertook a range of insight work initially focused on strengthening our understanding of needs and expectations across protected equality characteristics groups (Stage 0-1) and subsequently to build deep insights in relation to the scenarios and criteria being tested during Stage 2 engagement.

Following an external procurement process, PTHB secured two sources of independent advice and consultancy:

- HICO Ltd providing independent consultation assurance
- ORS providing independent survey and insight design, delivery and analysis

INDEPENDENT DEMAND AND CAPACITY MODELLING EXPERTISE – Adcuris Consulting LTD

The contract with external provider, Adcuris Consulting Limited, provided PTHB with demand and capacity modelling, to support service change. This contract included transfer of knowledge from the contractor to Health Board technical teams to support future internal modelling capability.

3.5.3 Check and Challenge and Assurance

The following assurance mechanisms were put in place to support delivery of Phase 1:

CLINICAL REFERENCE GROUP

The Clinical Reference Group (CRG) provided review and assurance throughout the process and was chaired by a Clinical Executive Director. The CRG met monthly, or as required and was tasked by the Portfolio Board to provide clinical scrutiny.

WORKFORCE & FINANCE CHECK AND CHALLENGE

This was a 2-stage process:

Stage 1: To review, test, and challenge the shortlisted options from a workforce and financial perspective, to ensure value and evidence-based service transformation options. This included a confidence assessment that the:

1. baseline was correct on workforce, commissioning and other factors included in the costing
2. workforce model is based on evidence, demand and capacity projections and assessed against benchmark practices
3. underlying assumptions will deliver the expected changes and outcomes particularly where investment is required

First line validation and quality assurance of the workforce and financial appraisal was undertaken by finance, workforce and Transformation & Value senior team to provide professional challenge on workforce, financial and deliverability assumptions.

Stage 2: To review the confidence assessment report from Stage 1 and identify any further actions, required to ensure robust options are put forward to Executive Committee and Board for decision for consultation.

This included Clinical Executives, finance, workforce, Transformation and Value Senior team.

Providing further assurance and professional assessment that the options proposed for consultation will deliver the expected changes and outcomes particularly where investment is required.

DEMAND AND CAPACITY KNOWLEDGE TRANSFER AND VALDATION

An internal knowledge transfer and validation process took place to ensure technical validation of the external demand and capacity modelling. This involved senior Finance, Information and Public Health colleagues.

ENGAGEMENT AND CONSULTATION ASSURANCE - 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.

4. STEPS TO CONSULTATION

The steps to consultation are outlined in **section 3.1**. Each step is described in more detail below.

Discovery activity was undertaken throughout 2024 through engagement with patients, communities, partners and stakeholders. Nationally, work with the Bevan Commission identified seven consistent themes across Wales, including prevention, workforce, access, communications and changing demographics, alongside a strong desire for radical change while retaining NHS core principles. Locally, the Better Together portfolio worked with Powys County Council, community and third sector organisations, town and community councillors, young people, Llais and voluntary sector partners across all 13 localities. This engagement highlighted key Powys specific challenges, notably access to and coordination of services, travel and transport in a rural county, workforce sustainability, ageing population, mental health, reliance on the voluntary sector, prevention and the importance of joined up working.

Dedicated engagement with young people emphasised mental health, healthy lifestyles, substance use, digital behaviour and transport barriers. Feedback from the third sector, Llais and consultation on temporary service changes reinforced these themes, particularly around access to care closer to home, equity of provision, support for carers, transport, delayed discharge and workforce constraints. Collectively, this comprehensive discovery activity provided a robust, triangulated evidence base to underpin the Case for Change and shape the long list and subsequent development of service options. A detailed description of Stage 0 discovery activity is provided in the Stage 0-2 Engagement Report at **appendix D.**

4.1 Step 1 – Case for Change and Models of Care (Including Stage 1 Engagement)

Step 1 focused on seeking feedback on the Case for Change through Stage 1 public and stakeholder engagement. It also included gathering and testing existing work on the future vision, models and care, and the development of hurdle and evaluation criteria, design and travel time principles.

4.1.1 Case for Change and Stage 1 Engagement

The Case for Change (**appendix B**) was developed by professionals across the organisation to provide a transparent, evidence-based rationale for change and a shared understanding of the challenges and opportunities facing health and care services in Powys. It established the baseline for options

development and was strengthened through targeted engagement during spring 2025 with groups representing equality protected characteristics and voices less heard.

The Case for Change was tested through Stage 1 engagement between March and April 2025 with staff, stakeholders and the public to validate its completeness and accuracy, ensuring it reflected "what matters" to patients, communities and partners. This approach supports NHS Wales service change requirements by evidencing proportionate and inclusive engagement (including engagement with representative bodies such as Llais) and by providing a clear audit trail demonstrating how feedback informed proposals.

Across engagement activity, there was clear support for change that brings care closer to home, improves equity of access, strengthens prevention, and supports more coordinated and sustainable models of care in Powys. Most stakeholders considered the Case for Change to provide a fair and accurate summary of the challenges facing local services, while noting some gaps, which are set out in the Stage 0–2 Engagement Report (**appendix D).** Feedback highlighted an urgent need to strengthen primary care and mental health provision, concern about the absence of a district general hospital (DGH), and the importance of delivering services closer to home in recognition of Powys' rurality.

Key recurring themes included strong civic pride in local hospitals and community services; concerns about distance and access to DGHs; inequitable access to care; the impact of an ageing population; the need for improved partnership working; challenges with patient communication and record sharing; opportunities for greater use of digital tools; links between rurality, isolation and health outcomes; workforce recruitment and sustainability; and ongoing pressures on NHS funding in Powys.

The Case for Change acted as a golden thread throughout the five-step process, with all options developed and assessed against their ability to address the issues identified. The options development process highlighted the need to balance trade-off's, particularly between addressing workforce fragility in a geographically dispersed population and ensuring sustainable, financially viable models of care. This led to consideration of options that enhance services, consolidate provision, or combine both approaches to best meet population needs.

To underpin option development with a robust evidence base, detailed technical chapters were produced for Primary Care, Community Services, Mental Health and Learning Disabilities, and Diagnostics. These technical documents were published following Stage 1 engagement and reviewed by the Options Development Group to distil key service specific issues. The accompanying data and evidence were central to ensuring options were developed and assessed consistently and objectively against priorities agreed through stakeholder engagement.

Evidence from Stage 1 engagement demonstrated a clear case for prioritising Adult Physical and Mental Health Community Services, with a focus on care closer to home, prevention and early intervention. This influenced decision making in relation to the phasing of Better Together with Adult Physical and Mental Health Community Services, including Urgent Care, Diagnostics, and Physical and Mental Health Community Inpatient services taken forwards as Phase 1.

Throughout the options development process, the Case for Change was repeatedly tested to ensure emerging options addressed the identified issues and supported improvement against the Duty of Quality and the Health and Care Quality Standards, particularly in relation to effectiveness, safety and experience.

4.1.2 Vision, Models of Care Concepts and Travel Time Principles

This step represented a key milestone in stakeholder mobilisation, engagement and alignment, delivered through multiple workshops facilitated by the Transformation & Value Team, with support from Organisational Development and Communications and Engagement colleagues. The Stage 1 engagement process enabled a wide range of stakeholders to contribute feedback on the key issues and potential opportunities associated with the development of future services in Powys. The feedback was triangulated and demonstrated strong consistency with the Case for Change, providing assurance that the programme was focused on the most significant and material issues ahead of options development. Engagement also generated a broad range of ideas, which were consolidated into a single evidence-set for further analysis and interrogation by internal professional staff, ensuring that a breadth of clinical, operational and corporate perspectives informed subsequent work.

The evaluation criteria and design principles were reviewed and tested against Stage 1 feedback, resulting in the strengthening of the person-centred element within the STEEEP assessment framework. In response to stakeholder concerns about travelling to services in a rural county, the travel time principles were also developed. An evidence base was assembled by the Transformation and Value Team and tested with clinical and professional colleagues, drawing on best practice guidance and comparable clinical models across the UK. Establishing these principles early in the process ensured a consistent and objective framework for option development and appraisal, enabling the impact of potential changes on patient travel times to be assessed against agreed and transparent standards. Further detail is included in the travel time analysis report (**appendix W)**. The hurdle criteria, evaluation criteria, design principles and travel time principles were all agreed and approved internally prior to options development, reinforcing objectivity and transparency throughout the process.

Alongside Stage 1 engagement, a series of internal clinical and professional workshops were delivered between March and May 2025. These sessions revisited the vision set out in the Health & Care Strategy and supported the development of system level models of care and underpinning principles, including design and travel time considerations, to inform options development. The Phase 1 scope of services, together with the hurdle and assessment criteria, were shared, tested and refined through these discussions to ensure appropriate rigour was applied throughout the five-step process. The workshops generated a long list of service ideas, with outputs captured in the relevant end-of-workshop reports (**Appendix D).**

This step represented a key milestone in stakeholder mobilisation, engagement and alignment, delivered through multiple workshops facilitated by the Transformation and Value Team, with support from Organisational Development and Communications and Engagement colleagues. The Clinical Reference Group met regularly to provide clinical input, challenge and assurance on the Case for Change, vision, design principles and assessment criteria. System Models of Care were updated in response to Stage 1 engagement feedback and retested through clinical and professional workshops and the Clinical Reference Group, enabling the development of a cohesive and shared ambition for systemwide transformation in collaboration with internal and partner stakeholders.

The table below provides an overview of the clinical and professional sessions delivered during this step:

Figure 10: Clinical & Professional Workshop Overview

Date	Event / Session	Delegates (no.)	Attendees / Representation	Purpose / Focus
13 March 2025	Primary Care (GMS focused) Session	43	Primary Care colleagues	Introduce Better Together and the Route Map to Sustainability; set out the design approach and Case for Change; explore option development to improve quality and resource use; capture priorities across Frailty & Community, Diagnostics & Planned Care and Mental Health; and agree ongoing Primary Care involvement.
1 May 2025	Physical Health Community Model Workshop (1 of 3)	23	PTHB, Local Authority, Primary Care	Confirm shared vision and guiding principles; outline the emerging community model; align stakeholders around the vision and confirm its value; outline the path forward; explore a broad range of future ideas/options; agree how these will be assessed and refined.
3 May 2025	Mental Health Community Model Workshop (1 of 3)	24	PTHB: operational services, planning, transformation, medicines management, Psychiatry, therapies	Confirm shared vision and guiding principles; outline the emerging community model; align stakeholders around the vision and confirm its value; outline the path forward; explore future ideas/options; agree how these will be assessed and refined.
12 May 2025	Physical Health Community Model Workshop (2 of 3)	38	PTHB, Local Authority, Primary Care, Pavo, British Red Cross	Outline the scope and overarching vision with a wider stakeholder group; use fictional case studies/personas to generate ideas for future support models; capture more detail to inform the 'long list' for options development.
15 May 2025	Mental Health Community Model Workshop (2 of 3)	28	PTHB, Local Authority, Primary Care, Pavo	Outline the scope and overarching vision with a wider stakeholder group; use fictional case studies/personas to generate ideas for future support models; capture more detail to inform the 'long list' for options development.
21 May 2025	Accelerated Community Model Psychiatry Workshop	14	PTHB, Primary Care	Additional workshop due to clash with commitments for mental health medical teams; outline scope of transformation work; begin developing ideas for the 'long list;' use fictional case studies/personas to generate and capture ideas for options development.

Date	Event / Session	Delegates (no.)	Attendees / Representation	Purpose / Focus
28 May 2025	Physical & Mental Health Community Model Workshop (3 of 3)	45	PTHB, Primary Care, PAVO, Local Authority	Final combined workshop to support accelerated development of physical and mental health community model (Better Together portfolio); bring together outputs from previous workshops; enable physical health, mental health and partners to review existing work and develop ideas further.

4.1.3 Progression to Step 2

The following outputs from Step 1 enabled progression to step 2:

- Stage 1 engagement outputs on the Case for Change were shared and discussed with ODG members to provide insights on what internal and external stakeholders felt were strengths, weaknesses, opportunities and threats.
- Hurdle Criteria, Evaluation Criteria, Design and Travel Time principles developed ready for testing with Public and stakeholders as part of Stage 2 Engagement.
- Agreed scope of services across the clinical service areas.
- Long List of Ideas generated through collaborative workshops with staff and partner organisations.

4.2 Step 2 – Develop Initial Options

Step 2 largely focused on analysing the feedback from the stage 1 engagement and developing a long list of options based on the ideas and solutions shared through Step 1. It was fundamental to developing six scenarios for how services could be provided in future, as a basis for Stage 2 Engagement.

4.2.1 Deliberative Event 1

A Deliberative Event took place in person on 3rd June 2025, full details of the session, outputs and delegates can be found in the report at **appendix D**.

71 delegates were in attendance from the following stakeholder groups:

- Representatives from Llais
- Service User Representatives
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations

Delegates listened to a series of presentations to set the context and prepare them for the deliberative discussions through focused table-based activities. This included feedback from internal and external stakeholders on the Case for Change and provided an opportunity for discussion and for people to add to the feedback on the Case for Change as a further check and challenge. The table groups were also asked to:

- Review the list of ideas or solutions for adults physical and mental health community services that were developed through the clinical and professional workshops and share their thoughts on what was missing to meet future population needs.
- Review and provide feedback on Stage 2 engagement content including six scenarios for how services could be delivered in the future (see **section 4.2.2**), design principles and proposed hurdle and assessment criteria that would be used to objectively assess and discount options.

The event was well attended and achieved positive feedback from independent observers (Practice Solutions) in its achievement of the intended objectives. The range of participants was felt to be broad and inclusive providing opportunity for further check and challenge on the case for change but also to gather insights from a variety of stakeholder perspectives to help shape future solutions ahead of the launch of Stage 2 engagement.
The Stage 2 Engagement Briefing was updated following the Deliberative Event and the outputs were collated into a report to be shared with ODG members to help shape the next step.

4.2.2 Stage 2 Engagement

The Stage 2 engagement on Adult Physical and Mental Health Community Services commenced during Step 2, it ran from 9 June until 27 July (throughout step 3-4) The Stage 2 Engagement Document "Better Together: Seeking Your Views on Adult Physical and Mental Health Community Services in Powys" (appendix C) set out why change is needed, our level of ambition to transform healthcare services, and how stakeholders could have their say. The Stage 2 Briefing was approved by the Better Together Portfolio Board on 16th September 2025 and Executive Committee on 26th September 2025.

The objective of the engagement period was to gather views on six scenarios for how future services could be provided for adult physical and mental health community services and to seek feedback from stakeholders on the draft design principles and assessment criteria used to develop and appraise options. Full details are provided in the Stage 0-2 Engagement report (**appendix D)**.
The Scenarios:

~~1. No change~~
2. Minor change and developments to the way we provide physical and mental health community services
3. More services in Powys are provided within "centres of excellence" including in Rural Regional Centres
4. Developing and expanding the range of services available in Wellbeing Hubs across Powys and strengthen Community Teams
5. Inpatient care, including community beds, is provided outside the county in neighbouring health boards

~~6. Provide a District General Hospital in Powys~~

These scenarios do not have to happen separately, and some could occur together.
Scenarios 1 and 6 must be ruled out. Change is needed to respond to the challenges we face. Because of the very rural nature of Powys, it is not feasible to have a DGH in the county.

The six scenarios developed during Step 2 were not intended to represent discrete implementable options. Instead, they acted as a structured device to explore the range of plausible futures, enabling stakeholders and clinicians to consider different balances of local provision, centralisation, integration and community-based care.

The scenarios set out with the intention to seek views about the advantages, disadvantages and how the scenarios could or would affect different people based on a range of factors. These factors were age, carer responsibilities, deprivation, disability, gender reassignment, marriage and civil partnership, race, religion & belief, sex, sexual orientation, and Welsh language. People were also asked if there were any other scenarios we needed to consider, as part of this work. It was emphasised that the scenarios do not all have to happen separately and that some could occur together.

Feedback on these scenarios was used to:

- identify common "desirable characteristics" of future services;
- test appetite for degrees of change and consolidation; and
- inform refinement, consolidation and removal of ideas during progression from the long list to the shortlist.

Section 4.3.2 describes how the insights and evidence base gathered in Stage 2 engagement were considered and reflected on by the ODG members and service area task and finish groups throughout the development of the options.

A summary of the Stage 2 Engagement approach is provided below:

- A public survey received 164 responses via online, paper and Easy Read formats, with feedback from Powys residents, health professionals and local organisations, and responses mapped by Primary Care Cluster locality.
- Public focus groups were delivered through five face-to-face community workshops (38 participants) and one online workshop (6 participants), alongside three staff focus groups (two face-to-face with 37 participants and one online with 60 participants), independently facilitated by Practice Solutions Ltd.
- Public drop-in sessions were held in five towns (Brecon, Welshpool, Ystradgynlais, Llandrindod Wells and Newtown), supplemented by attendance at a joint event in Machynlleth, capturing views from approximately 60 residents in total.
- Additional community outreach activity was undertaken by the Engagement Team to capture views from residents less likely to attend formal workshops or drop-ins.
- Targeted specialist and clinical engagement took place with clinical, medical and service management staff, Primary Care, Powys County Council and PAVO to explore emerging adult physical and mental health community models.
- Staff engagement reached 375 staff in person across multiple sites, with further information shared with 518 staff, ensuring broad representation across clinical and nonclinical roles and staff bands.

4.2.3 Primary Care Workshop (GMS Focus)

A Primary Care-focused workshop event was held on 17th June 2025. Participants' views were sought to gain a Primary Care perspective with a specific focus on General Medical Services (GMS). The event was facilitated by PTHB Directors and staff. It included 29 participants from within PTHB, Primary Care representatives from General Practice, Pharmacy and Dentistry and other partners. The aim of this session was to share and discuss the system models of care and the six scenarios for how future services could be provided for adult physical and mental health community services and to seek feedback from stakeholders as part of the Stage 2 engagement process. The outputs of this session reinforced the need for integrated, proactive, and locally responsive models of care in Powys. Attendees consistently called for better communication, smarter use of resources, and more equitable service delivery. The suggestions — ranging from virtual wards to place-based teams — were used for the refinement and further development of options.

4.2.4 Long List Ideas Review

Following the assimilation of ideas from Stage 1 engagement including clinical and professional workshops and the deliberative event, a long list of ideas was shared and reviewed by ODG members during a workshop on the 24th of June 2025. All the information was considered and debated in relation how the proposed ideas would best respond to the Case for Change and service issues. There were 68 ideas developed from the stakeholder events held in May 2025 and June 2025 (described in **section 4.1.2**). The purpose of the workshop was to review and refine the long list of ideas to create a series of potential options. Each idea was evaluated and categorised into a group of similar nature, value and outcome – enabling, service improvement or system transformation. These ideas were then further assessed and a decision made as to whether they would be taken forward onto the long list along with any supporting rationale. During these discussions there was a strong shift in conversation between ODG members to focus more on 'how' and 'where' services could be delivered in future. There was recognition that whilst the enabling and service improvement actions would help to deliver benefits to patients and staff, they did not go far enough in relation to the scale of change needed to address the current issues and to improve quality of care and make better use of resources.

This discussion led to the generation of the long list of options for 'how' and 'where' services could be provided in future. It included options which would enhance services and alleviate system pressure, for example the development of urgent care centres. As well as opportunities to consolidate services to improve standards and address workforce fragilities, for example the consolidation of mental health inpatient services on to fewer sites. Focused discussions took place about how people could be supported to remain at home and return home from hospital more quickly through the strengthening of community-based services, and how inpatient services could be consolidated onto fewer sites to improve workforce resilience, patient flow and reduce extended length of stay and patient deconditioning. The potential to consolidate inpatient services onto fewer sites also led to discussions about re-investment of financial savings into the adult community model.

Of the 68 ideas, 54 were agreed to progress to the Long List of Options, and they were grouped under the following service areas:

- 9 for Urgent Care Services
- 11 for Adult Community Model

- 10 for Adult Mental Health Services
- 10 for Diagnostics
- 14 for Adult Physical Health Inpatient Services

The options development methodology was agreed by ODG members on the 24th of June 2025. - This enabled a consistent and objective approach and outlined detailed requirements for each service area to produce an issues template with underpinning evidence base and to complete a long list option template detailing information on the option. This would provide sufficient information on the long list option for it to be reviewed and considered against the hurdle criteria by ODG members during Step 3 and 4. It was also agreed that service level models of care would be developed to provide detailed and evidenced based service requirements as a blueprint for the future model and basis on which to assess future options. The service models of care were developed with internal and external professional and clinical input and oversight and were approved through the relevant Programme Boards (Mental Health Service Model of Care was approved on 31st December 2025 and the Physical Health Inpatients, Community Model and Urgent Care Service Models of Care were approved on 8th October 2025).

The Clinical Reference Group were asked to review and provide feedback on the long list of options which was considered and incorporated into the development process.

4.2.5 Progression to Step 3

The following outputs from Step 2 enabled progression to step 3:

- System Models of Care reviewed and tested
- 54 Long List of options
- Service issues templates
- Service models of care
- Long list option templates completed
- Published Stage 0-2 Engagement Briefing

4.3 Step 3 and 4 – Review and Refinement of Options and Development of Short List Options

Step 3 and 4 focused on gathering additional information and refining the options. Stage 2 Engagement finished during this step. Each of the long list of options were assessed against the agreed hurdle criteria and either discounted or carried forward onto the short list. The short list options were then further developed including the development of workforce, financial and estate assessments.

4.3.1 Short List Options Development Week

The refinement of the long list of options into short list of options was facilitated through a collaborative, cross system working group during options development week referred to as the 'lock-in week,' which took place from 14th – 18th July 2025. This approach brought clinical and professional stakeholders together in a single location for the duration of the week to enable a structured, in-depth consideration and development of the shortlisted options. Participants included corporate operational and professional representatives, operational management and clinical leads, and colleagues from Planning, Workforce, Finance, Digital supported by the Improvement and

Transformation Team. The week concluded with formal feedback to Clinical and Operational Executive Directors, alongside an update session with Powys County Council and PAVO strategic leads to share the outputs from the week and to identify areas of alignment and joint opportunity.

The purpose of the week was to:

1. To assess the long list of delivery options against hurdle criteria to identify short listed options.
2. To develop short listed options into detailed options gathering information to confirm workforce and finance implications - responding to queries / actions to support updating of demand and capacity modelling.
3. In line with above, further gather information to support options development.
4. Agree priority areas for integration of physical and mental health, and agree common language / definitions for service areas to support understanding and wider communication.
5. To ensure inter-dependencies between options were understood and aligned, and identify wider inter-dependencies with partners.
6. Agree plan and deliverables for the following 8 weeks via Task and Finish groups.
7. Agree updates to master messaging and engagement with adult physical and mental health services.
8. Completion of Level 1 Impact Assessments for all short-listed options.
9. Development of workforce requirements for each option, with financial rigour applied.

During the week, the long-listed options for mental health, physical health, urgent care, community care and diagnostics were further developed, refined and then assessed against the agreed Hurdle Criteria by clinical, operational and professional colleagues to test strategic alignment with the Health and Care Strategy and Case for Change, clinical viability, deliverability and sustainability. It was agreed, at this stage, the Community Model options were not viable stand-alone options and therefore would be integrated with and hurdled through the Physical Health Options.

Options were refined and where appropriate discounted if they did not meet the agreed hurdle criteria. A clear rationale was required to support options being taken forward or discounted to ensure objectivity and consistency in approach. This process was facilitated and designed to maintain openness and transparency of decision-making. Each option was discussed and reviewed systematically with clinical and professional teams, who had the opportunity to validate and test their understanding of each of the options, and to challenge each other's views during the facilitated discussion before a conclusion and rationale was recorded.

The 'do previous' and 'do nothing' options did not meet the essential hurdle criteria but were taken forward as baseline comparisons so that people would be able to understand how the various options being proposed would differ from the current situation and pre-temporary service changes. It was also agreed that some of the do minimum options should be taken forward and further developed as transition options, whilst these options did not fully meet the hurdle criteria but were assessed as a potential shorter-term step warranting further exploration and testing to understand deliverability and impact.

Across all programmes, a total of 81 options were subject to Hurdle Criteria assessment. Those assessed as sufficiently viable progressed to further scrutiny, including consideration of clinical safety and quality, workforce sustainability, financial affordability and estates feasibility. Options representing minor variations or duplicative models were rationalised through this triangulated review. **Appendix L** provides the long list of options which were discounted.

The table below provides a summary of all the options

Figure 11: Long list to short list hurdling

Programme	Long list options assessed (Hurdle Criteria)	Options short-listed after hurdling	Long List Options discounted (see appendix
All programmes (total)	**81**	**38**	**43**
Mental Health	26	11	15
Physical Health	21	9	12
Urgent Care *	20	11	9
Diagnostics * *	14	7	7

* This includes three additional options that were developed in January 2026 following Executive's Check and Challenge session on 10th November 2025. There were 17 urgent care options taken through Hurdle Criteria during Lock-in Week, with 8 short-listed after hurdling and 9 options discounted.

* * Diagnostics and imaging were aligned within the original eight agreed urgent care shortlisted options to support configuration and alignment of services.

Further information was gathered during options development week to ensure robust evidenced based short-listed options. Demand and capacity modelling, activity, performance and finance data was gathered and analysed to inform workforce models for each option. Level 1 Impact Assessments were undertaken on all options that passed the Hurdle Criteria (**appendix M**).

At the end of each day each service group provided an update on their progress, and the wider ODG plus other participants provided feedback. At the end of the options development week there was a presentation to the Clinical Executives as part of the check and challenge, the group shared which options had been 'hurdled out' and discounted and which options were being carried forward as short-listed options for further development.

A breakdown of how the options were hurdled is provided below for each service area:

Mental Health

In total, 26 options were assessed and 11 options were agreed to be progressedas sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical viability, workforce sustainability, financial affordability and 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.

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:

- **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 were 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 assessed 9 options were progressed as sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical feasibility, workforce sustainability, financial affordability and estates implications, and the removal of options representing minor variations, resulted in eight distinct, credible and deliverable options being agreed for the final shortlist.

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 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 assessed5 options were progressed 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 5 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.

(Note: Following Portfolio Board on 10th September 2025 an additional Urgent Care option was explored, meaning 6 options would be taken through non-financial options appraisal workshop on 11th September 2025. Following Executive's Check and Challenge session on 10th November 2025, additional options for urgent care were requested to be explored, bringing the total of options hurdled to 20, with 11 being taken through a further non-financial options appraisal workshop in April 2026 - reference **section 4.3.2**).

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:

- **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 assessed, 7 options were progressedas sufficiently viable to warrant further consideration. Subsequent triangulation of clinical appropriateness, workforce sustainability, financial affordability and estates feasibility, and the identification of options that represented minor variations, led to the discussion about to align diagnostics and imaging within the 5 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).

4.3.2 Refinement of short list options

After the options development week, the short-listed options were further refined iteratively following:

- Analysis of the draft stage 2 engagement outputs
- Sharing and testing of the options internally with some key stakeholders including partners.

A summary of the analysis of the draft stage 2 engagement outputs is as follows:

- Engagement feedback consistently indicated that “no change” or minor change options were not viable, reinforcing the need for substantial service transformation.
- Strong support emerged for strengthening care closer to home, influencing the prioritisation of community-based models linked to the inpatient bed base options
- Mental health services, transport and accessibility, primary care capacity, workforce sustainability, and social care and isolation emerged as dominant themes and were used to shape option design and mitigation considerations.
- Scenario testing showed support for more ambitious options (Scenarios 3 and 4), cautious interest in centres of excellence (with location concerns) and limited support for a shift to complete out-of-county provision of community inpatient beds.
- Targeted clinical engagement provided assurance that emerging options were clinically credible, deliverable and aligned to emerging models of care, while staff engagement

highlighted workforce and operational implications to be addressed through options refinement.

To address some of the stakeholder feedback and ensure better management of the inter-dependencies between the service options, it was proposed to combine some of service area options. The following was agreed with ODG (23rd July 2025)

- **Community Model options** would be aligned within Adult Physical and Mental Health Inpatient options to ensure integrated physical and mental health pathways.
- **Diagnostics options** would be aligned to Urgent Care, recognising that a full diagnostics review would be undertaken in Phase 2 under Diagnostics and Planned Care.

Technical work during lock, as well as testing and feedback, was led by clinical and professional teams in the Health Board and supported by independent experts. To ensure appropriate and robust stakeholder input and testing of the acceptability of the short-listed options, a second deliberative event was arranged. The stakeholder feedback from Stage 2 and the emerging short-listed options were then approved for sharing at a wider Deliberative event for further input and refinement.

4.3.3 Second Deliberative Event

A second Deliberative Event took place in person on 13th August 2025, full details of the session and outputs can be found in the report at **appendix D**

77 delegates were in attendance from the following stakeholder groups

- Llais
- Service Users
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations

The objectives for Deliberative Event 2 were to:

1. Provide the headline feedback on Stage 2 public, staff and stakeholder engagement activity
2. Inform and confirm, through delegate feedback, the revision of the long list of options to support the development of a short list of options
3. Invite further discussion and feedback on the identified shortlisted options
4. Share updates to the design, planning and assessment criteria, which we are using to inform how we make decisions.

Workshop exercises enabled delegates to review the draft models of care, test emerging short list options for adult physical and mental health community services and provide feedback on the assessment and evaluation criteria through facilitated table- and room-based discussions. Outputs were synthesised and reported back in plenary by Executive Directors acting as Room Chairs, with quality assurance checks undertaken by the Engagement Team on the day and final thematic verification completed by the Transformation & Value Team. Feedback was cross-referenced against

the shortlisted options to confirm completeness and alignment, with no material gaps identified and no requirement for additional options or fundamental changes to the shortlist.

Engagement consistently reinforced the Case for Change, highlighting challenges around fragmented service delivery, access and equity in a rural context, workforce sustainability, data maturity and integration of physical and mental health services, alongside strong support for integrated, person-centred, place-based models, care closer to home, improved digital enablement and strengthened partnership working. Overall, the event provided assurance that the shortlisted options remained robust, reflected stakeholder priorities, and aligned with recurring themes from earlier engagement, including a clear preference for transformational change consistent with the more integrated, community focused scenarios emerging from Stage 2 engagement.

The short-listed options were 'approved for progression' to the next step at the Frailty and Community Programme Board on 15th August 2025 and Mental Health Programme Board on 21st August 2025. This included the reduction to the 3 service areas and amalgamation of options (described above) results in 17 short listed options across the three service areas which ensured coherence across service areas and avoided duplication:

Figure 12: Adult Physical Health, including community – Five short listed options

Option number	Description
SL IPDO_001a	Do Previous: Put current hospital and community health services back to how they were
SL IPDO_001b	Do Current: Keep current hospital and community health services as they are now
SL IPDO_002b	Do Minimum: hospital bed numbers in Powys would remain the same (approx. 144 beds) but they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.
SL IPDO_005b	Do Mid-Range: There would be fewer hospital beds (approx. 90-100 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health. This option is the same as the previous one, but with closer working between mental health & physical health services
SL IPDO_008	Do maximum: There would be fewer hospital beds (fewer than 90 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.

Figure 13: Urgent Care Centres including Diagnostics – Four short listed options

Option number	Description
SL UCDO_001A	Do Previous: Put current hospital urgent care services back to how they were
SL UCDO_001B	Do Current: Keep current hospital and community health services as they are now
SL UCDO_013	Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)
SL UCDO_013ii	Do Maximum: Even better local Urgent Care on less sites (2 x UCCs)

Figure 14: Adult Mental Health, including older adult community - 8 short listed options

Option number	Description
SL MHDO02_001a	Do Previous: Put current hospital and community health services back to how they were
SL MHDO02_001b	Do Current: Keep current hospital and community health services as they are now
SL MHDO_003a	Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services
SL MHDO_004a	Do Mid-Range: Move mental health functional inpatient services to Brecon, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services
SL MHDO_006a	Do Maximum: Move all functional and organic mental health inpatient services to Bronllys Hospital, 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
SL MHDO_007a	Do Maximum: Move all functional and organic mental health inpatient services to Brecon Hospital, 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
SL MHDO_008a	Do Maximum: Move all functional and organic mental health inpatient services to Newtown Hospital, 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
SL MHDO_010a	Do Maximum: Move all functional and organic mental health inpatient services to Brecon Hospital and Newtown Hospital, 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

Task and Finish Groups were established for each service group to progress the actions required to refine the short-listed options. These groups were chaired by the Senior Responsible Officers or Clinical Leads for the relevant programme or service area with support from clinical and operational leads, senior leads from corporate functions (WOD, Finance) and Improvement & Transformation team support. The work undertaken in the Task and Finish groups included

- Gathering of evidence base to underpin service level issues and models of care
- Detailed workforce modelling on the short-listed options
- Detailed financial modelling on the short-listed options
- Refinement and finalisation of Demand & Capacity Modelling for each service area
- SWOT analysis (**appendix V**)
- Completion of Level 2 Impact Assessments (**appendix Z.2**)
- Patient Pathway testing (**appendix T**)
- Travel Time analysis (**appendix W**)

4.3.4 Short List - Further Check and Challenge

Primary Care (GMS-Focused) Engagement Session – 4th September 2025

A Primary Care (GMS-focused) engagement session was held on 4 September 2025, attended by 34 delegates from PTHB, Primary Care and PAVO. This session formed part of the programme's ongoing engagement and assurance approach, providing a mechanism to validate progress, test emerging proposals, and ensure continuing alignment with the Case for Change. The session:

- provided a structured recap of feedback captured at the June workshop and set out progress on the development of adult physical and mental health community services, including the planned next steps;
- presented the emerging models of care, including how these were being tested through patient pathway work to assess feasibility and intended outcomes; and
- enabled discussion of the short-listed options identified for this phase, supporting transparency and early challenge from Primary Care and partners.

Clinical Reference Group (CRG) Check and Challenge – 5th September 2025

To strengthen clinical assurance and provide independent clinical scrutiny, the Clinical Reference Group (CRG) and wider senior organisational clinical representation was invited to a virtual Check and Challenge session on 5 September 2025, facilitated with participation from Senior Responsible Officers (SROs), Clinical Service Leads, and the Transformation and Value Team. In advance, CRG members were briefed that the purpose of the session was to apply their clinical expertise and experience to review, test and challenge whether the draft shortlisted options met the agreed Hurdle Criteria, ahead of the appraisal process and prior to public consultation.

To support objectivity, invitees were asked to undertake the review from the perspective of clinical professional judgement, rather than their current organisational role, and were advised that participation was voluntary, with the option to decline via line management if required.

The session sought a clear assurance judgement against the question:

"In your professional opinion, do the shortlisted options meet the Hurdle Criteria as set out in the information pack?"

The outputs, including key points of challenge and resulting actions/considerations, are captured in the session report (**appendix N**), providing an auditable record of clinical scrutiny undertaken as part of the options development and assurance process. As a result of this check and challenge option SL_MHDO 02_014 Remove all Mental Health Hospital beds was removed as the group felt confident this option did not meet the hurdle criteria and was not financially sustainable and would be detrimental to delivery of high-quality patient care.

4.3.5 Progression to Step 5

The following outputs from Step 4 enabled progression to Step 5:

- Documented long list of options and short list process, approved by ODG and assured via Clinical Reference Group
- Hurdling of the long list of options with clear rationale
- Development of short-listed options
- Demand and capacity modelling interim reports
- Outline Workforce, finance and estate assessments
- Service Issue templates and Service Level Models
- SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis
- Travel time analysis
- Level 1 Impact Assessments
- Final sign off Stage 0-2 Engagement Report

4.4 Step 5 – Score Short List of Options

Step 5 included a non-financial appraisal of the shortlisted options and further technical work including more detailed workforce, finance and estate assessments. There was additional scrutiny arrangements put in place to ensure validation and assurance for the demand and capacity modelling, workforce and financial appraisals.

4.4.1 Non-Financial Options Appraisal – Physical Health, Mental Health and Urgent Care

A non-financial options appraisal workshop was held on 11th September 2025, with membership made up of stakeholders across PTHB professionals and external stakeholders from clinical and professional backgrounds. The purpose of the workshop was to appraise the short-listed options for Phase 1. The intended outcome was to apply further rigour to the assessment process, using the expertise of attendees to provide a higher level of confidence in the options in forming recommendations to the Executive Committee and Board for public consultation.

Stakeholders included Clinical and Operational Executive Directors, Corporate operational and professional representatives, operational management and clinical leads, colleagues from Planning, Workforce, Finance, Digital, Performance, Primary Care, Powys County Council, PAVO, and external professionals to provide a level of independence. A comprehensive list of attendees is available in the full report (**appendix Y**). It did not include the public, community groups or service user representation due to the complexity of the technical information being shared and stakeholder engagement undertaken earlier in the process. Llais was invited to attend in an observer capacity but

declined. The event was supported by the Improvement and Transformation, Organisational Development, Information and Communication and Engagement teams.

Appraisers (25 in total) were asked to draw upon their clinical and/or professional expertise and experience to appraise the short-listed options, and informed this was an essential part of preparing for **Stage 3**, Public Consultation.

Supporting information was issued to appraisers in advance of the workshop, including:

- Better Together Case for Change
- Thematic technical chapters
- Programme ambitions
- System and service models of care

Delegate packs provided on the day included:

- System models of care
- Shortlisted options
- Assessment criteria and scoring framework
- Summary information from Level 2 Integrated Impact Assessments
- Travel Time Analysis
- SWOT analysis

A panel consisting of clinical and operational leads presented the scope, issues and options for their service area. Other panel members included Executive Director leads for Planning, Performance and Commissioning, Public Health, Primary Care, Community Services and Mental Health, and the Executive Medical Director. The Deputy Director of Engagement, Communication and Corporate Services and the Assistant Director of Quality & Safety were also in attendance as panel members. All panel members were available during the appraisal process to provide further detail and answer queries.

All scores were obtained digitally and updated into a spreadsheet, aligned to each appraiser, for every option, with high-level feedback given at the end of the session. The Transformation & Value Team managed the inputting of scores. Scoring was undertaken using an agreed scoring framework and the NHS Wales STEEEP six domains of quality as assessment criteria (see **section 3.3**). Sensitivity analysis was applied to test the scoring of each option through equal weighting, reverse weighting, clinical focus, patient focus weighting.

A summary of the non-financial appraisal scoring is provided below, full details are provided in the full report.

MENTAL HEALTH

Figure 15: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL MHDO02_001a	Do previous – before temporary services change	45.0	48.0	45.0	47.0	50.0	49.0	284.0	8	13.50	7.20	6.75	9.40	5.00	4.90	46.75	8
SL MHDO02_001b	Do current – no transformational change	45.0	47.0	49.0	45.0	48.0	52.0	286.0	7	13.50	7.05	7.35	9.00	4.80	5.20	46.90	7
SL MHDO_003a	Functional beds to Bronllys and integrated OAMH	71.0	64.0	72.0	70.0	52.0	62.0	391.0	6	21.30	9.60	10.80	14.00	5.20	6.20	67.10	6
SL MHDO_004a	Functional beds to Brecon and integrated OAMH	78.0	66.0	74.0	71.0	56.0	64.0	409.0	5	23.40	9.90	11.10	14.20	5.60	6.40	70.60	5
SL MHDO_006a	All beds to Bronllys and integrated OAMH community	98.0	87.0	95.0	95.0	73.0	77.0	525.0	3	29.40	13.05	14.25	19.00	7.30	7.70	90.70	3
SL MHDO_007a	All beds to Brecon and integrated OAMH community	100.0	86.0	98.0	90.0	74.0	87.0	535.0	2	30.00	12.90	14.70	18.00	7.40	8.70	91.70	2
SL MHDO_008a	All beds to Newtown or Welshpool and integrated	82.0	84.0	84.0	80.0	72.0	76.0	478.0	4	24.60	12.60	12.60	16.00	7.20	7.60	80.60	4
SL MHDO_0010a	All beds to Brecon and Newtown and integrated	110.0	108.0	108.0	99.0	111.0	109.0	645.0	1	33.00	16.20	16.20	19.80	11.10	10.90	107.20	1

In Summary:

- The highest scoring option was “Do Maximum” (SL MHDO_0010a).
- Excluding “do nothing,” “Do Minimum” (SL MHDO_003a) scored lowest.
- The “do current” option scored marginally higher than “do previous.”

URGENT CARE CENTRE (inc. DIAGNOSTICS)

Figure 16: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SLUCDO 001a	Do previous – before temporary services change	51.0	56.0	45.0	45.0	51.0	59.0	307.0	5	15.300	8.40	6.75	9.00	5.10	5.90	50.45	5
SLUCDO 001b	Do current – continue as now making temporary service	54.0	54.0	52.0	52.0	54.0	52.0	318.0	4	16.20	8.10	7.80	10.40	5.40	5.20	53.10	4
SLUCDO 001c	Do minimum – enhance existing MIU on fewer sites	67.0	67.0	63.0	63.0	62.0	64.0	386.0	3	20.10	10.05	9.45	12.60	6.20	6.40	64.80	3
SL UCDO_005	Close minor injury units and provide urgent care in other	51.0	47.0	48.0	48.0	56.0	52.0	302.0	6	15.30	7.05	7.20	9.60	5.60	5.20	49.95	6
SL UCDO_010	Better local urgent care (3 x minor injury & illness units in	85.0	81.0	81.0	76.0	80.0	80.0	483.0	2	25.50	12.15	12.15	15.20	8.00	8.00	81.00	2
SL UCDO_013	Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)	88.0	91.0	92.0	90.0	83.0	91.0	535.0	1	26.40	13.65	13.80	18.00	8.30	9.10	89.25	1

Note further non-financial appraisal workshop for urgent care options detailed in **section 4.4.6**).

In Summary:

- “Do Maximum” – enhanced local urgent care model (SL UCDO_013) scored highest.
- Excluding “do nothing,” SL UCDO_005 scored lowest.
- “Do current” scored higher than “do previous.”

PHYSICAL HEALTH INPATIENTS AND COMMUNITY SERVICES

Figure 17: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL IPDO_001a	Put current hospital and community health services back to how they were pre	35.0	40.0	36.0	34.0	46.0	44.0	235.0	8	10.50	6.00	5.40	6.80	4.60	4.40	37.70	8
SL IPDO_001b	Keep current hospital and community health services as	49.0	47.0	49.0	48.0	49.0	50.0	292.0	7	14.70	7.05	7.35	9.60	4.90	5.00	48.60	7
SL IPDO_011	Remove physical Health	50.0	50.0	54.0	52.0	58.0	58.0	322.0	6	15.00	7.50	8.10	10.40	5.80	5.80	52.60	6
SL IPDO_002a	Same number beds on six sits and better Physical Health	72.0	70.0	65.0	66.0	70.0	69.0	412.0	5	21.60	10.50	9.75	13.20	7.00	6.90	68.95	5
SL IPDO_002b	Same number beds on six sits and better Physical Health Community and Mental Health	73.0	72.0	73.0	70.0	72.0	77.0	437.0	4	21.90	10.80	10.95	14.00	7.20	7.70	72.55	4
SL IPDO_005a	Few beds on three sites and better physical health	89.0	86.0	86.0	85.0	81.0	87.0	514.0	2	26.70	12.90	12.90	17.00	8.10	8.70	86.30	2
SL IPDO_005b	Fewer beds on three sites and better physical health community and mental health	89.0	87.0	89.0	88.0	82.0	90.0	525.0	1	26.70	13.05	13.35	17.60	8.20	9.00	87.90	1
SL IPDO_008	Even fewer beds on three sites and better physical health community and mental health	75.0	73.0	79.0	85.0	73.0	83.0	468.0	3	22.50	10.95	11.85	17.00	7.30	8.30	77.90	3

In Summary:

- "Do Mid-Range" (SL IPDO_005b) ranked highest.
- Excluding "do nothing," remove all physical health beds from Powys (SL IPDO_011) ranked lowest.
- Both "do nothing" options ranked lowest overall, with "do current" scoring higher than "do previous."

To conclude the analysis of stakeholder scoring demonstrated a high degree of correlation across the six STEEEP domains, indicating that stakeholders tended to assess options consistently across criteria. Correlation and sensitivity analysis confirmed that option rankings remained stable under different weighting scenarios, with no single criterion disproportionately influencing outcomes and the relative positioning of options remaining robust to changes in weighting assumptions. As the appraisal reflected the professional judgement of those present, the results are intended to be indicative and to inform further appraisal, engagement and consultation, rather than to constitute a final decision- making tool.

Across all service areas, scoring showed limited differentiation between shortlisted options. This reflects the similarities between models that had already progressed through multiple stages of screening, refinement and assurance, and which shared common enabling components and system interdependencies. The absence of significant separation between options should therefore not be interpreted as a weakness in the appraisal process.

The nonfinancial appraisal forms part of a wider, staged options development and assurance framework aligned with NHS Wales planning guidance and quality standards, and informed by engagement, clinical scrutiny and multiagency collaboration. Within this context, scoring was used to structure discussion, illuminate trade-offs and support professional judgement, rather than to produce a definitive or mechanistic ranking of options.

To support with evaluation and future event planning an optional anonymous survey was given to appraisers at the end of the workshop. Of 25 appraisers, 22 responses were received.

An Options Appraisal Workshop Summary Report was produced and received by the Better Together Portfolio Board on 16th September 2025 and Executive Committee on 17th September 2025. This included event evaluation feedback from participants. Additional sensitivity analysis was requested

which was incorporated into the final version of the report (**appendix Y**) strengthening assurance in the appraisal process.

4.4.2 Further Technical Development of Options

As described in **Section 5.4**, the Task and Finish Groups ran concurrently from the end of Step 3 and 4 through to Step 5, and the groups continued to report to the ODG and onwards into the relevant programme board. The following technical work was overseen and finalised by these groups during this period:

Detailed workforce modelling
Workforce models were developed and agreed for each shortlisted option with documented assumptions. These are based on Year 0 demand and have been reviewed by Senior Workforce leads who have provided additional support to strengthen the evidence base, benchmarking and assumptions where required.

Agreement of the baseline establishment for mental health medical and ward staffing was a key requirement which was not concluded until after later in Step 5 resulting in a delay to the mental health options recommendation workshop being conducted as described in Step 6.

Detailed financial appraisals
Financial modelling was developed iteratively and refined as the workforce models, demand and capacity analysis, and associated assumptions, were progressed and finalised, ensuring alignment with the refinement of options. Financial appraisals were developed and agreed for each shortlisted option with documented assumptions. This included financial modelling which was based on demand & capacity modelling assumptions, workforce models and commissioning assumptions. Finance leads worked collaboratively with SROs to update and finalise the financial modelling and to strengthen financial assumptions in line with the demand & capacity modelling outputs. The financial appraisal methodology is set out in **Section 3**. All options have been based on Year 0 costs for simplicity. However, each of the option short list options have been assessed by ODG members in their ability to meet future demand and population needs. A full economic and financial appraisal of all the options will be undertaken as part of the final Programme Business Case.

Estates Assessment
Estates assessments were undertaken for each shortlisted option lead by the Estates team in collaboration with SROs, clinical and operational leads. This provided an outline assessment of the estate implications for each of the short-listed options assessing and RAG rating the funding value banding i.e. less than £5m and the feasibility with supporting narrative (ADD link). Feasibility and capital assessments have not been undertaken for the purposes of consultation; these will be conducted following the consultation process when a final decision is reached as part of the final Programme Business Case – this will include a full economic and financial appraisal of the options.

Refinement and finalisation of Demand & Capacity Modelling
Further refinement and finalisation of demand & capacity modelling was overseen across the 3 service areas via the Task & Finish Groups working directly with the external consultant (Adcuris Ltd) to strengthen assumptions in line with the evidence base, local and independent clinical opinion, patient pathway testing outputs and feedback following review by Professor Anne Hendry and Dr Naeem Aziz as external clinical scrutiny.

The demand and capacity modelling has tested the impact of potential scenarios i.e. do nothing, mid-range realistic and achievable and aspirational ambitious and longer term. This have been aligned to the short-listed options to show future demand projections and have been considered as part of the workforce and financial modelling.

Validation of the demand & capacity modelling outputs was undertaken by the information and finance teams through scrutiny of the detailed modelling outputs and a series of knowledge transfer sessions with Adcuris Ltd. This had a twofold purpose, firstly in assuring the technical methodology and secondly in supporting organisational delivery of modelling activity of this nature in the future. Detailed assumptions underpinning the modelling were shared with SRO's and Public Health leads for review prior to finalisation of the modelling.

Patient Pathway Testing
Patient pathway testing was undertaken through two phases with the intention of testing and validating proposed models of care underpinning the shortlisted options with real patient scenarios.

Phase 1 was delivered through a day of care survey across all PTHB Community Hospital wards undertaken by Professor Anne Hendry and a series of retrospective patient case reviews undertaken by a PTHB GP with Extended Role in Frailty and a GP working in North Powys delivering primary care GMS services. Additional patient pathway testing for Mental Health was undertaken within the service area. Reports for Phase 1 Patient Pathway testing are at **appendix T**.

Phase 2 was delivered through a prospective week of care survey of Emergency Admissions for people aged 65+ to Wye Valley Trust in November 2025. Key stakeholders including Wye Valley Trust, Adult Social Care and Third Sector clinical and operational leads supported this survey and subsequent workshop session to explore the survey results and develop an action plan which was led by Professor Anne Hendry and the PTHB Urgent Care Transformation Lead. Using these outputs, an accelerated learning event was delivered in the North of the county with stakeholders including Shrewsbury and Telford Hospital NHS Trust (SATH) and Shropshire Community Trust (Shropcom) clinical and operational leads in March 2026. Reports for Phase 2 Patient Pathway testing are at **appendix R.**

Travel Time Analysis
A travel time analysis tool was commissioned by the Better Together portfolio for use in options development and impact assessment. The tool was used to assess all options ahead of the non-financial appraisal workshop in September 2025 and a report was produced; **appendix W**.
The tool has been actively utilised to further assess options during refinement, check, and challenge, and a second non-financial appraisal event in April 2026. Associated supporting analysis used in the second event is also provided at **appendix X**. The travel time analysis report has been reviewed by HICO Ltd as part of their assurance activity and the feedback will inform the final version which is produced as part of pre-consultation business case development.

4.4.3 Workforce & Finance Check and Challenge

The introduction of the workforce and finance check challenge resulted in an extension of the original timetable.

An initial validation of the workforce and financial appraisals was undertaken by the Director of Improvement and Transformation, Deputy Director of People and Culture, Deputy Director of Finance, Assistant Director Transformation &Value, Assistant Director of Finance and senior workforce and finance leads. Agreed next steps and further actions were captured in a decision and action log, which was assigned to relevant Task and Finish Groups to progress, ensuring continued rigour and governance as part of the options development process.

Workforce and Finance 'Check and Challenge' sessions were held on 22 October 2025 (Urgent Care options) and 24 October 2025 (Physical and Mental Health options) to provide targeted scrutiny of the shortlisted service transformation options.

The sessions brought together senior representatives from across PTHB People & Workforce and Finance functions, alongside Senior Responsible Officers, Clinical Leads, and members of the Improvement & Transformation teams. Attendance included the Director of Improvement and Transformation, Assistant Directors for Transformation and Value, and Improvement and Innovation, Deputy Directors of Finance and People & Culture, and relevant workforce and finance specialists.

The purpose of the sessions was to undertake a structured confidence assessment to:

- test the robustness and accuracy of baseline assumptions relating to workforce, commissioning and costings.
- assure that workforce models were evidence based, informed by demand and capacity projections, and appropriately benchmarked.
- assess whether underlying assumptions were sufficiently robust to deliver the expected outcomes, particularly where investment was required.
- review the Stage 1 confidence assessment and identify any further actions required to strengthen assurance prior to submission to the Executive Committee and Board for decision making ahead of consultation.

The sessions provided additional professional assurance that the refined options were credible, deliverable and affordable. Agreed next steps and further actions were captured in a decision and action log, which was assigned to relevant Task and Finish Groups to progress, ensuring continued rigour and governance as part of the options development process.

4.4.4 Clinical Executive 'Check and Challenge'

The Clinical Executive 'Check and Challenge' session took place virtually on 10th November 2025, attended by Clinical members of PTHB Executive Committee, with Senior Responsible Officers, senior operational and clinical representatives, and attendees from Improvement & Transformation teams. The aim of the session was to present shortlisted options, workforce and financial information to validate and test workforce and finance models and assumptions. The session provided assurances of the shortlisted options, patient pathway testing of the options and draft demand & capacity modelling outputs.
This resulted in some additional options being put forward for Urgent Care based on a 2-site configuration – this was driven by levels of demand and the affordability of the 3-site options with an enhanced service offering. The 2-sites configurations included the same 3 variants of service

offerings but across 2 sites. The sites included Newtown and Brecon and removing the unit in Llandrindod Wells or Newtown and Llandrindod Wells and removing the unit in Brecon.

A financial analysis was undertaken on the 2-site variants. The option for Newtown and Llandrindod Wells with removal of the Brecon unit was confirmed as not financially viable. The option for Newtown and Brecon and removal of the Llandrindod Wells unit was confirmed as financially viable. This highlighted the need to further stress test the 45-minute travel time principle and an assessment of 60-minute travel time principle was applied to all the options. Further workforce, financial and travel time information was gathered for the 2 site variants, and this information was shared at ODG on 7th January 2026. It was agreed to only take forward the 2-site variant which included Newtown and Brecon. These options are shared below:

The following options were agreed to be further appraised by ODG on 7th January 2026:

- 001Cii - Do Minimum in 2 units (make temporary service changes permanent and improve service on 2 units, close 2 units)
- 001D - Do Current on 3 units (continue as now on 3 sites, making temporary service changes permanent, close 1 site)
- 001Dii Do Current in 2 units (continue as now in 2 units, making temporary service changes permanent, close 2 units)
- 010ii - Do Mid-Range on less sites (2 x MIIUs in Powys, close 2 units)
- 013ii - Do Maximum on less sites (2 x UCCs, close 2 units)

This decision was ratified at the Community and Frailty Programme Board on 20th January 2026 and further demand and capacity modelling, travel time analysis, financial and estate assessment were undertaken.

Subsequently the 2-site variant data was presented to ODG and Executive Leads (Executive Medical Director and Executive Director of Primary Care, Community and Mental Health) and it was agreed these should be added to the shortlisted options and progressed through the full appraisal process. This decision was ratified through the Frailty & Community Programme Board on 10th March 2026. A second non-financial options appraisal took place on 21st April 26 – see section below **4.4.6**

4.4.5 Non-Financial Appraisal on Urgent Care Centre, including Diagnostics Options

Due to additional Urgent Care Centre options being requested, further work was undertaken to test the travel time principles for the 2-site options for patients to access urgent care services either within Powys or outside of Powys. These travel time principles were based on evidence from elsewhere and are contained in the travel time analysis report. Further work was undertaken to ensure benefits, risks and trade-offs of the 2-site options was available for comparison to the 3-site options during the non-financial appraisal process.

An additional non-financial options appraisal workshop took place on 21 April 2026 to consider all Urgent Care Centre and Diagnostics options following the addition of the 2-site variations. The same methodology was applied to the running of this session as for the previous session on 11th

September 2025 (detailed in **section 4.4.1**) but the approach was strengthened to reflect the evaluation feedback. Changes included dedicated time for delegates to read time information on the options and a single delegate pack with all information contained, along with a description of the options, what stays the same, what changes, risks and trade-offs, this pack did not include the updated SWOT analysis, this was subsequently updated after the workshop. Additional sensitivity analysis was also applied to reflect feedback previously received. Travel time analysis was completed for the additional options and included in delegate information packs. A summary of this additional analysis is included at **appendix W**.

Stakeholders included Executive Directors, Corporate operational and professional representatives, operational management and clinical leads, colleagues from Workforce, Finance, Primary Care, PAVO, and external professionals to provide a level of independence. A comprehensive list of attendees is available in the full report (**appendix X**). It did not include the public, community groups or service user representation due to the complexity of the technical information being shared and stakeholder engagement undertaken earlier in the process. Llais was invited to attend in an observer capacity but declined. Powys County Council, PAVO and WAST were invited but unable to attend. The event was supported by the Improvement and Transformation, Organisational Development, Information and Communication and Engagement teams.

A second non-financial options appraisal report was produced **(appendix X)** and contains full details of the methodology, attendees and scoring outputs. A summary is provided for the purpose of this report below.

URGENT CARE CENTRE (inc. DIAGNOSTICS)

Figure 18: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

	Average Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL UCDO_001a	1.9	2.3	2.2	1.6	2.3	2.4	12.78	10	0.6	0.4	0.3	0.3	0.2	0.2	2.04	11
SL UCDO_001b	2.6	2.7	2.4	2.3	2.9	2.7	15.52	7	0.8	0.4	0.4	0.5	0.3	0.3	2.55	8
SL UCDO_001d	2.9	2.7	2.6	2.7	2.6	2.6	16.09	6	0.9	0.4	0.4	0.5	0.3	0.3	2.73	6
SL UCDO_001dii	2.5	2.0	2.3	2.5	1.8	2.0	13.22	9	0.8	0.3	0.3	0.5	0.2	0.2	2.30	9
SL UCDO_001c	3.1	3.0	3.0	3.0	3.0	2.9	18.00	5	0.9	0.5	0.5	0.6	0.3	0.3	3.02	5
SL UCDO_001cii	2.7	2.3	2.7	2.7	2.2	2.4	15.13	8	0.8	0.4	0.4	0.5	0.2	0.2	2.58	7
SL UCDO_005	2.0	2.0	2.2	2.0	2.0	2.2	12.35	11	0.6	0.3	0.3	0.4	0.2	0.2	2.04	10
SL UCDO_010	3.7	3.4	3.8	3.7	3.6	3.7	21.91	2	1.1	0.5	0.6	0.7	0.4	0.4	3.65	3
SL UCDO_010ii	3.4	2.9	3.3	3.4	2.6	2.9	18.43	4	1.0	0.4	0.5	0.7	0.3	0.3	3.18	4
SL UCDO_013	4.3	4.1	4.2	4.2	3.9	4.1	24.78	1	1.3	0.6	0.6	0.8	0.4	0.4	4.17	1
SL UCDO_013ii	3.8	3.4	3.9	3.8	3.3	3.6	21.83	3	1.1	0.5	0.6	0.8	0.3	0.4	3.70	2

In Summary:

- "Do Maximum" – enhanced local urgent care model on 3 sites (SL UCDO_013) scored highest.
- "Do Maximum" – enhanced local urgent care model on 2 sites (SL UCDO_013) scored 2nd highest.
- "Do current" scored higher than "do previous."

The appraisal outputs demonstrated a high degree of consistency across the STEEEP domains, with correlation and sensitivity analysis confirming that relative option rankings remained stable under multiple weighting scenarios. This indicates that no single criterion disproportionately influenced outcomes and that the results are robust to changes in weighting assumptions. As expected at this stage of the process, scoring showed limited differentiation between several shortlisted options, reflecting their shared design principles, common enabling components and interdependencies across urgent care services.

Across all sensitivity scenarios, one option (SL UCDO_013 – Do Maximum: Even Better Local Urgent Care, comprising two Urgent Care Centres and one Minor Injury and Illness Unit) consistently ranked highest. There was strong stakeholder consensus on this option, evidenced by low variation in scores across appraisers. Options associated with greater service withdrawal or reliance on alternative models scored lowest, particularly where concerns were raised regarding access, equity, safety, and system resilience.

The appraisal outputs are intended to be indicative and to inform the next stage of the decision-making process. They will be considered alongside financial, workforce and estates assessments, as well as engagement feedback and impact assessments, to support the identification of options proposed for public consultation. The workshop outputs therefore provide an important component of the wider, staged assurance framework, supporting informed consideration of trade-off's, risks and benefits rather than serving as a definitive decision-making tool in isolation.

5.FINALISATION OF OPTIONS

This section marks the transition from the short-listed options appraisal process to a proposed set of recommended options for formal public consultation.

5.1 Recommendations Workshop Sessions

Two recommended options workshop sessions were held to consider each of the options against the issues, service models, non-financial appraisal, financial appraisal and estate assessment to objectively discuss and consider which options should be recommended for public consultation.

The objectives of the sessions were:

- To review and assess Non-financial, Financial and Estates appraisals against the shortlisted options.
- To agree options recommended for consultation for each service area to be taken forward to the pre consultation business case for Executive Committee and Board consideration.

The inputs for the sessions included:

- Service models
- Demand & capacity modelling
- Estates assessments
- Non-financial appraisal outputs
- Financial appraisal outputs
- Summary of assumptions
- Scoring frameworks

During the workshop each option and its supporting evidence base was re-considered against how it would address the issues in the case for change and the hurdle criteria, but mainly the group discussion focused on the non-financial and financial appraisal and estate assessment to objectively discount or recommend options to proceed to the next stage. Options that were discounted had a clear rationale to explain why they were not recommended to move forward.

This process ensured robust options would be taken forward to the next stage for consultation with clear rationale. This applied across Physical Health Inpatients and Community Models, Urgent Care, and Mental Health services. The “Do current” and "Do Previous" options were discounted but will progress as baseline comparator options.

In addition to option selection, the group assessed readiness to proceed and identified any further actions required before an organisational decision on proceeding to public consultation. This provided clarity on next steps and any additional work needed to support assurance and decision-making.

The first workshop was held on 13th January 2026 and considered physical health and urgent care options. The mental health options were unable to be considered at this time due to decisions pending on the baseline establishment delaying finalisation of workforce and financial appraisal. 22 internal delegates were in attendance including clinical leads, senior responsible officers, medical and nursing professionals, workforce, finance, organisational development, estates and planning. The session was facilitated and documented by the Transformation and Value team.

During the session Physical Health options were progressed to a set of options recommended for consultation pending finalisation of demand & capacity modelling. Urgent Care (inc. Diagnostics) options were recommended for consultation subject to further work to be delivered through the Task & Finish group on additional 2-site variants (detailed in sections **4.4.5 – 4.4.6**).

The second recommended options workshop was held on 5th May 2026 and considered Mental Health options, revisited the Urgent Care options including the additional 2-site variants and ratified the previously agreed Physical Health recommendations. 20 internal delegates were in attendance including clinical leads, senior responsible officers, medical and nursing professionals, workforce, finance and organisational development. Estates and Planning representatives were invited to attend but unable to do so. It was noted in the session that some supporting information for the workshop was either in draft or requiring further update/ assurance, this was acknowledged and will be addressed as part of the next steps. The session was facilitated and documented by the Transformation and Value team. Final outputs are detailed in **section 5.2**.

5.2 Outputs from the Recommended Options Workshop

The Options Development Group has not selected a single preferred option at this stage. The options recommended to be progressed to the next stage represent credible and viable options that remain subject to further engagement, consultation and decision making. This is underpinned with a clear and transparent process that shows how short-listed options were appraised and discounted. Formal public consultation is intended to meaningfully inform any final decision on the agreed future option, including how identified risks, trade-offs and mitigations should be addressed. No final decisions have been taken, and outcomes remain open to change based on consultation feedback.

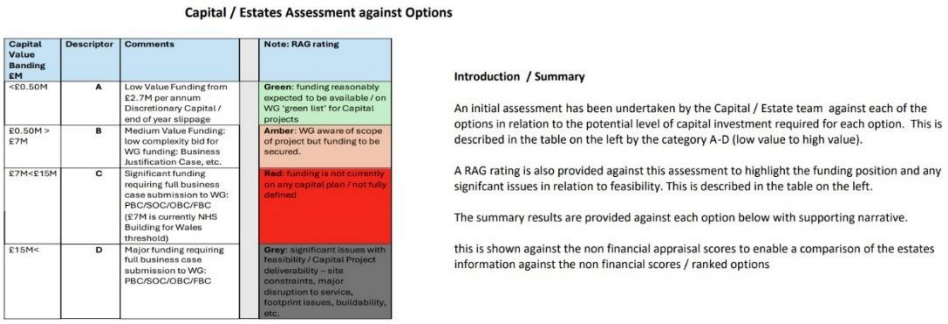
During the Recommended Options Workshop:

- 8 Physical Health options were reviewed which included different inpatient configurations dependent on the community model, distribution of inpatient sites, reablement model, diagnostics, and integration with mental health.
- 11 Urgent Care options ranged from restoring all Minor Injury Units (MIUs) to creating two fully integrated Urgent Care Centres (UCCs) across 3 or 2 sites. The appraisal considered travel times, workforce, diagnostics access, integration with physical health options, and financial sustainability.
- 8 Mental Health Options were reviewed which included different inpatient configurations, single and 2 site options, the majority of options included strengthening the Older Adults Community Mental Health services and reducing out of area placements.

The table below provides a summary of the combined outputs from each of the Recommended Options workshops held on the 13th January 2026 and 5th May 26 for each of the service areas.

Those options colour coded in green will be taken forward to the next stage, the options in blue are proposed to be discounted. In the tables below, the codes for the Estates Ratings are provided below:

Figure 19: Estate Assessment coding



Capital / Estates Assessment against Options

Capital Value Banding £M	Descriptor	Comments	Note: RAG rating
<£0.50M	A	Low Value Funding from £2.7M per annum Discretionary Capital / end of year slippage	**Green**: funding reasonably expected to be available / on WG 'green list' for Capital projects
£0.50M > £7M	B	Medium Value Funding: low complexity bid for WG funding: Business Justification Case, etc.	**Amber**: WG aware of scope of project but funding to be secured.
£7M<£15M	C	Significant funding requiring full business case submission to WG: PBC/SOC/OBC/FBC (£7M is currently NHS Building for Wales threshold)	**Red**: funding is not currently on any capital plan / not fully defined
£15M<	D	Major funding requiring full business case submission to WG: PBC/SOC/OBC/FBC	**Grey**: significant issues with feasibility / Capital Project deliverability – site constraints, major disruption to service, footprint issues, buildability, etc.

Introduction / Summary

An initial assessment has been undertaken by the Capital / Estate team against each of the options in relation to the potential level of capital investment required for each option. This is described in the table on the left by the category A-D (low value to high value).

A RAG rating is also provided against this assessment to highlight the funding position and any signifcant issues in relation to feasibility. This is described in the table on the left.

The summary results are provided against each option below with supporting narrative.

this is shown against the non financial appraisal scores to enable a comparison of the estates information against the non financial scores / ranked options

Figure 20: PHYSICAL HEALTH Outputs from Recommended Options Workshop & Rationale

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, demand growth, or workforce issues within the case for change. Retained as baseline/comparator only.

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
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 +	Proceed to next stage	Ranked 4th financial and 1st non-financial appraisals. Estates rated D – Amber. • Moderate delivery risk. Balances improved quality, MDT working, and community-based care while remaining more deliverable

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
	better join up with mental health		than two-site options. Requires workforce transformation and estate 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 21: URGENT CARE Outputs from Recommended Options Workshop & Rationale

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.

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
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 respons e 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.

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
010ii – Mid-Range (2 MI&IUs)	MI&IUs 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 22: MENTAL HEALTH Outputs from Recommended Options Workshop & Rationale

Option Ref	Option Description	Recommendation Status	Rationale
001a – Do Previous	Pre-temporary 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

Option Ref	Option Description	Recommendation Status	Rationale
			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 MH 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 o nto 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 in 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's recommended this option is taken forward with the caveat that if the Bronllys site cannot be re-developed, 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

Option Ref	Option Description	Recommendation Status	Rationale
			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 OCP 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	Proceed to next stage (subject to further actions)	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. However, it is least favourable financially, requiring significant workforce growth and additional recurrent investment. Proceeding only based on further work being undertaken to test affordability, workforce assumptions and confirm bed requirements.

The limitations of estate knowledge in the room were acknowledged along with further actions required to finalise the estate assessment. To be able to conclude the recommended options process the following actions were agreed:

Mental Health

- Further discussions with Estates team to investigate feasibility of single site in Brecon/ Bronllys area and further test the feasibility of two site option, with one site in Newtown and one site in Brecon/ Bronllys area
- Further work on option 10a do maximum to assess the workforce requirements and associated benefits to determine whether this option could be affordable.
- Completion of the workforce assumptions to provide further assurance around the workforce and financial appraisal.

Urgent Care

- Estate assessment of the 2 site options to ensure there are no estate issues which would impact on deliverability.

These actions have been progressed via ODG and the outputs have informed further discussion and decision making on the recommended options in Informal Executives on 21st May 26.

This has resulted in the discounting of the mental health option 010a: 2-site inpatient model with beds split between North and South Powys with integrated community model. Following further

review of the bed requirements, workforce model and underpinning staffing and commissioning assumptions, the model across the 2 sites is not deliverable and financially it is not affordable.

The workforce model and underpinning assumptions and updated financial appraisal were approved by the Mental Health Programme Board on 19th May 26, it is recognised that whilst internal assurances have been provided on these assumptions, this is limited due to insufficient external benchmarking information being available to test robustness of the assumptions applied.

A further review of the rationale and supporting evidence for why options have been discounted or taken forward will be undertaken by HICO as part of their independent assurance, in readiness for consultation.

5.3 Deliberative Event 3

It was recognised that there were some limitations with regards to public and service user involvement since the last Deliberative event in August 2025 so following the technical work undertaken during Autumn - spring, an additional event was agreed. This was designed to assess public and wider stakeholder acceptability of the options, as well as to strengthen confidence, transparency and consultation readiness in advance of formal public consultation.

The Deliberative Event took place in person on 10th June 2026, full details of the session, outputs and delegates can be found in the report at **appendix Z.1**. The purpose of the event was to present the options proposed for consultation and their underpinning rationale, validate and sense check appraisal assumptions and scoring, and systematically stress test identified risks, impacts and potential unintended consequences in readiness for consultation. The event was facilitated by independent consultants HICO Ltd.

120 delegates were in attendance from the following stakeholder groups:

- Representatives from Llais
- Service User Representatives
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations, including service users and carers
- Independent Clinical Experts

Delegates were asked to test the proposals of Better Together in changing adult urgent care, physical health and mental health services across Powys. No decisions were made at the event, and no decisions have been made as a result of it. The next step is a formal public consultation, where everyone in Powys will have the chance to have their say.

Delegate were assigned to discussion rooms across each service area, with two sessions in each. The table groups were asked:

Deliberative Event 3: Questions Used to Test the Proposals

1. Were the proposals believable?	2. What could go wrong?	3. Would the public trust this?	4. Personal postcards
Test whether the proposed changes felt realistic, understandable and supported by the evidence.	Identify delivery risks, unintended consequences and practical concerns.	Explore whether the public would see the proposals as credible, fair and transparent.	Capture individual reflections, concerns and key messages for the programme team.

The event was well attended and achieved positive feedback facilitated by independent observers (HICO Ltd) in its achievement of the intended objectives. The range of participants was felt to be broad and inclusive providing opportunity for further understanding of the proposals shared with delegates with the outputs of the day being collated into a report shared with ODG members to help shape the next steps.

The main message from the day "People at the event did not oppose the idea of change. In all three rooms, there was broad agreement that the current way of delivering services under pressure and that something needs to change. But people questioned whether the right conditions were in place to make change work – things like community services, social care, enough staff, transport, and a realistic plan. They broadly accepted the direction of travel. Their challenge was "can it be delivered?". During the Deliberative event there were some discussions on the single site mental health option, and a further action was agreed to look at the potential to commission inpatient services in the north of the County as part of the 2-site options.

The ODG met and agreed several actions because of the feedback during the event. This included further work on the mental health options as well as strengthening of the narrative around the community model, development of indicative phasing timetables to help people understand the potential sequence of activities for each recommended option and further work on understanding both the positive and negative impact of the proposed changes at a locality level. The findings from the event have been shared with the PTHB Board and discussed further with partners such as Primary Care and Social Care.

Further work on the mental health sub option was undertaken and the findings of this further exercise confirmed that the costs associated with a sub option of commissioned provision (3 beds) in the north would be maximum £11,778m, the costs of the Powys 2-site provider option 010a (two sites North and South) was £12.823m. Comparing these to the cost of recommended option 006a at £10.831m, means this option still remains the most affordable option. Whilst the North commissioned sub option supports the principle of care closer to home, this is marginally improved for some localities in the north, but the cost of the model significantly increases and the challenges of aligning community and inpatient provision prevail. On this basis Executive Committee confirmed on the 22nd July 26 that this sub option was not viable and agreed to continue to proceed with the recommended single site option to public consultation.

HICO have provided a briefing note on the single site option which has also been considered by Executive Committee ahead of the submission of the Pre-consultation Business Case.

6. CONCLUSIONS & RECOMMENDED OPTIONS FOR CONSULTATION

In summary, this Step Report marks the completion of Phase 1 of the Better Together Journey to Consultation, setting out a robust foundation for formal public consultation. Through a transparent and methodical appraisal process, a small number of credible and viable options for each service area have been identified, reflecting the complexities and interdependencies across the health system. This approach, in line with best practice for significant service change, ensures that future service models are both sustainable and responsive to the needs of patients, staff, and communities. The rigour and inclusivity of the process provide confidence to move forward to Stage 3, where the shortlisted options will be explored in greater depth with the public and stakeholders to inform the Final Business Case and subsequent decisions.

It is proposed the following options are progressed through the Health Board governance arrangements for decision on further testing through public consultation, ensuring that any final decisions are shaped by wider stakeholder input and local perspectives.

Figure 23: Recommended Options Summary Table

Option Ref	Option Description	Recommendation Status
Mental Health		
MH006a – Do Maximum	All functional and organic inpatient beds consolidated at Bronllys with enhanced care and strengthened community model	Proceed to next stage
Urgent Care & Diagnostics		
UC013 – Do Maximum (2 UCCs + 1 MI&IU)	UCCs at Newtown & Brecon; MIIU at Llandrindod	Proceed to next stage
UC013ii – Do Maximum (2 UCCs)	UCCs at Newtown & Brecon	Proceed to next stage
Physical Health		
PH005b – Do Mid-Range + MH integration	Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model + better join up with mental health	Proceed to next stage
PH008 – 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

7. Readiness for Board Decision on Consultation

In further preparation for readiness for a Board decision to proceed to public consultation the following next steps will be taken:

- **Finalise the Level 2 and Integrated Impact Assessments** - the Level 2 and Integrated Impact Assessments (see section 3 for description) will be finalised by Improvement and Quality & Safety leads, this will address feedback from HICO, and insights gathered at the Deliberative event.
- **Incorporating feedback from the Deliberative event -** further work is being undertaken to address the feedback from the Deliberative event, this will be reflected in the Pre-consultation Business Case and relevant technical appendices.
- **Finalisation of the consultation plan and stakeholder and staff engagement plan –** the ODEC group have finalised plans to ensure appropriate and effective stakeholder engagement in preparation for public consultation. The consultation plan will go to Public Board in July 26 for approval subject the approval of PCBC in September 26.
- **Development of pre-consultation business case** – the pre-consultation business case is being prepared and will be presented to the Board in September 2026 for decision to proceed to consultation.

8. TECHNICAL APPENDICES

Documents were available in working draft form throughout the options development process, with approval dates reflecting formal submission sign-off rather than first availability. Documents that are highlighted with target approval dates is because they are being refreshed or reviewed for sharing publicly.

The table below includes all technical documents for Phase 1 Option Development Process.

Appendices	Approval Date	Approved Via	Status
A - Portfolio Executive Plan	05.03.25	Executive Committee	Complete Include Old version
B - Overarching Case for Change	Due 20.08.26	Portfolio Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.1 - Mental Health Technical Chapter	Due 20.08.26	Mental Health Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.2 - Physical Health Technical Chapter	Due 18.08.26	Frailty & Community Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.3 - Primary Care Technical Chapter	Due 18.08.26	Frailty & Community Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
C - Stage 2 Engagement Briefing	June 2025	Portfolio Board	Complete
D - Stage 0 and 2 Engagement Report	16.09.25	Portfolio Board	Complete
E - Stakeholder Engagement Oversight	09/06/26	ODEC	Review In progress To be included within PCBC submission to Board
G - System Model of Care – Mental Health	09.09.25	MH Programme Board	Complete
G - System Model of Care – Urgent Care	08.09.25	Frailty & Community Programme Board	Complete
G - System Model of Care – Physical Health	08.09.25	Frailty & Community Programme Board	Complete – Update required on social model for health to be included with PCBC submission in Public in Sept 26
J - Strategic Demand & Capacity Final Report	21.05.26	Portfolio Board	Complete

Appendices	Approval Date	Approved Via	Status
K - Long List of Ideas	18.06.25	ODG	Complete
L - Long List of options	Q1	Programme Boards	To be included within PCBC submission to Board in September 26.
M - Level 1 Impact Assessments on short list options	19.05.26 26.05.26	Programme Boards	Complete
N - CRG Check & Challenge Report	23.09.25	Programme Boards	Complete
O - Urgent Care Service Issues template	08.09.25 Due 18.08.26	Frailty & Community Programme Board	Previously approved but update required. To be included with PCBC submission in Public in Sept 26
P - Urgent Care Service Model of Care	03.12.25	Frailty & Community Programme Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
Q - Urgent Care Workforce Summary, assumptions and financial appraisal	26.05.26	Frailty & Community Programme Board	Complete. Approved via Chairs action 01/05/26, to be ratified at Programme Board
R - Urgent Care Phase 2 Patient Testing Pathway Report	10.02.26	Programme Board	Complete
O.1 - Physical Health Service Issues template	08.09.25 Due 18.08.26	Frailty & Community Programme Board	Previously approved but updated required. To be included with PCBC submission in Public in Sept 26
P.1 - Physical Health Service Model of Care	03.12.25	Frailty Programme Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
S - Physical Health Patient Pathway Testing inc Day of Care Survey	26.09.25	Executive Committee	Complete
Q.1 - Physical Health Workforce Summary, assumptions and financial appraisal	26.05.26	Frailty & Community Programme Board	Complete Approved via Chairs action 01/05/26, to be ratified at Programme Board
O.2 - Mental Health Service Issues template	23.10.25 Due 20.08.26	Mental Health Programme Board	Previously approved but updated required. To be included with PCBC submission in Public in Sept 26

Appendices	Approval Date	Approved Via	Status
P.2 - Mental Health Service Model of Care	14.01.26	Portfolio Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
Q.2 - Mental Health Workforce Summary, assumptions and financial appraisal	19.05.26	Mental Health Programme Board	Complete Approved via Chairs action 01/05/26 and ratified at Programme Board 19/05/26
T - Mental Health Patient Testing Pathway Report	19.05.26	Mental Health Programme Board	Approved at Programme Board 19/05/26 subject to additional information provided in relation to the options. To be included within PCBC submission to Board In Committee 29th July 26.
U - Estate Assessments	26.09.25	Executive Committee	Updated estate assessment completed and enclosed.
V - SWOT Analysis	23.09.25 Due 20.08.26 / 18.08.26	Programme Boards	Review in progress. To be included with PCBC submission in Public in Sept 26
W - Travel Time Analysis Report	22.09.25	Chairs Action	Complete. Updated travel times analysis report approved at portfolio board 14/7.
X - non-financial option appraisal report – Urgent Care 21.4.26	26.05.26	Frailty & Community Programme	Complete
Y - non-financial option appraisal report – All services 11.09.25	16.09.25 17.09.25	Portfolio Board Executive Committee	Complete
Z - Recommended Options Workshop Report	13.05.26 19.05.26 26.05.06	ODG Programme Boards	To be included with PCBC submission in Public in Sept 26
Z.1 - Deliberative Event 10.6.26 Report	n/a	n/a	Complete report approved at portfolio board 14/7.
Z.2 - Level 2 Impact Assessments (Quality, EQIA, Health Impact)	13.05.26 16.06.26 18.06.26	ODG Programme Boards	To be included within PCBC submission to Board in Public in Sept 26