GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Workforce Land Appraisal Project

Output Report

July 2022

Final Version

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Contents

Section 1: Executive Summary – High Level - Key Points

To assess the implications on our workforce for a specific zone or site is complex and multi-faceted, however, if we simplify at this point, we are looking at two categories of workforce groups who will have different considerations:

1. Category A: our general workforce, (mostly within bands 2-4) , who could work for the Health Board, or seek local employment elsewhere.
    - Competitors would be : Local Authorities, Local Universities, Colleges, Retail & Leisure.
    - Potential advantages and disadvantages based on home base of individuals.
    - Specific groups: WGH & GGH Estates & Ancillary appear to be located closely to each site.
2. Category B: Registered Health Care Professionals, for whom they are much more restricted in the type of employment they could seek but probably more mobile.
    - Competitors would be - neighbouring Health Boards, some Local Authorities, some Universities/Private sector, and equivalents in England, Scotland etc.
    - Potential advantages and disadvantages based on home base of individuals.
    - Specific groups: Health Professionals, especially the Clinical Workforce who could potentially be commuting greater distances.

All evidence shows that there is very little difference across all acute sites in terms of recruitment. The workforce appraisal has therefore found it inconclusive to say that a site further East in the zone will have a greater positive impact as the 3 zones are so close (12 miles). The agreed view is that it is inconclusive to state that a site further east or west within the zones would be better placed to secure a sustainable workforce, or able to minimise impact on our workforce.
Population density rather than East to West difference, may be a better marker - for example, alignment to the M4 corridor i.e., Llanelli with a population base of c46,000. However if we can facilitate a "growth" of population through the new build and community infrastructure, it becomes less important. Affordable housing, access to local accommodation, amenities and a strong workforce strategy would act as significant mitigations.

By a strong workforce strategy, we mean further work on attraction, retention and development for example:

- capitalising on university partnership status: joint posts, fellowships, research activity,
- developing flexible, accessible, accommodation/work options to engage young professionals,
- brand/rebrand "rural versus urban medicine" all professions to link with research & innovation strategy,
- work with HEIW to enable our local population & workforce to access development opportunities, seeking to develop existing, and redesign new roles, based on service need.

In coming to these conclusions, this report highlights the key activities which took place, the processes and methodologies used; alongside, the data, modelling and professional standards cited; and goes further in exploring the discussions/arguments presented and the analysis undertaken.
Recommendations have been made in relation to further work that the Workforce Land Appraisal Group feel should be considered, as part of the process for gaining insights from our workforce and developing further intelligence to inform future workforce planning activity within a framework of meeting population health needs and delivering social value.

Section 1: Executive Summary – Considerations

The assessment of the Workforce Land Appraisal Group, based on the analysis of the data so far, in consideration of the 3 zones (Narberth, Whitland and St Clears) has identified that there are no clear differentiators to assess one zone as "better" or "worse" than another, in terms of the potential impact on the workforce. This has been concluded on the basis of reflection on our strategic outcomes: Accessible, Safe, Kind and Sustainable (ASKS Framework) and in review of the sources of available information accessed and analysed. This assessment, as by the summary and further questions, is considered "inconclusive" on whether one zone or one site is more favourable than another.

A summary of themes, issues and mitigations is provided below:

- Accessible –the 3 zones have similar accessibility issues; and suggest a general increase in travel for all: from east to west and west to east due to potential movement of workforce from WGH & GGH to any of the 3 zones (N.B. WGH to GGH is 33 miles & Narberth - Whitland - St Clears (Zones 1 - 3)). It is just over 12 miles between the 3 zones; Narberth option is the furthest west & St Clears option furthest east).
    - ***Question to answer: do we believe 12 miles will have an impact on the attraction of our workforce?***

- Safe – concerns have been raised around staffing of medical rotas generally in current sites and there are a number of elements necessary to address this – service & workforce redesign; medical trainee placements and mitigations such as quality accommodation for those on-call and on site, which again no single differentiator can be isolated.
    - ***Question to answer: do we believe we can successfully mitigate the impact on our clinical workforce in relation to travel?***

- Kind – the zones all have similar amenities; and based on the comments above; there are opportunities to mitigate negative impacts, create opportunities and enhance wellbeing through biophilic design and the "20-minute neighbourhood" concept by working with partners – construction, Local Authority etc.
    - ***Question to answer: do we believe we can successfully mitigate/influence developments to address the negative impacts and create positive opportunities for our workforce and population?***

- Sustainable – based on the assumption that greater population density suggests a greater local workforce: St Clears is the most densely populated of the 3 zones (2011 census), however, the differential in a 12-mile zone suggests this may be commutable (drawing on the population of all zones and equates to c.6000). The greater concern may be the gradual reduction in population density as we move from east to west, for example Llanelli has the largest/densest population base within our Health board.
    - **Question to answer: do we believe any location as far west *will have a greater negative impact on the attraction of our workforce?***

We find that in terms of our ability to work through our workforce planning assumptions, specifically the Workforce Regeneration Tool, a series of mitigations can be implemented to reduce (albeit not remove) the potential risks and negative implications on groups, whilst acknowledging that some individuals may be personally impacted.

Section 2: Introduction & Background

Hywel Dda University Health Board (HDdUHB) has submitted a Programme Business Case (PBC) as part of its *A Healthier Mid and West Wales* Strategy to Welsh Government for capital investment, which will include the development of a new Urgent and Planned Care Hospital within the zone between, and including, Narberth in Pembrokeshire and St Clears in Carmarthenshire.

As part of the Land Selection process for the new Urgent and Planned Care Hospital, an appraisal of the potential impact on the workforce took place May to June 2022; undertaken by the Workforce Land Appraisal Group, chaired by the Director of Workforce & Organisational Development to:

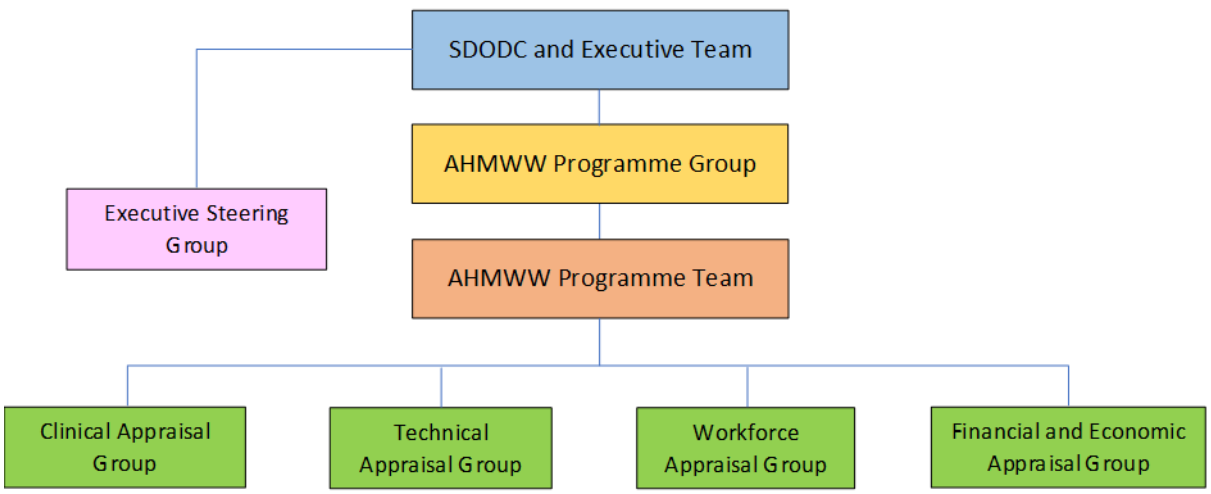
- Consider the impact on the workforce that will be required to relocate to the new Urgent and Planned Care Hospital, recognising that this will not be the case for all staff who currently work on the GGH or WGH site.

- Ensure a clear scope of work and clear timelines for the appraisal work to be completed (by end of June 2022) given due regard to the provisions of cost, quality and any limitations of the work.

- Review all relevant data sources available for assessment and value (see separate note) and determine the appropriate actions for each.

- Develop a clear plan of appraisal activities to meet the needs of the workforce assessment.

The Workforce Land Appraisal Group, forms a part of the overall governance structure to support the development of A Healthier Mid and West Wales Programme Business Case (AHMWW PBC) Programme Team on the progress of the land appraisal alongside the other three areas.



The output of this project group will be to provide insights for zonal positioning or site selection to the Board, through the AHMWW PBC Programme Team in relation to the analysis of multiple data sets.

This will be developed by sharing with wider stakeholders, so the final recommendation includes feedback from a variety of sources.

Section 3: Work Programme

This section covers the work that developed scope and context for the workforce appraisal, identified the stakeholders involved and engagement needed, as well as identifying what would or would not be appraised within the given timeframe of May to June 2022.

Scope Setting

The scope of the workforce appraisal was set by *A Healthier Mid and West Wales* Programme Board. The geographic scope was set through the *A Healthier Mid and West Wales* Strategy Consultation which identified a zone in which to build a new Urgent and Planned Care Hospital, along with the *Building A Healthier Future after COVID-19* Engagement during the summer of 2021 which asked the public for land nominations and identified 3 areas. The workforce land appraisal was only to consider the areas where there may be multiple potential sites, not the sites themselves; however, the travel analysis did enable this level of detail to be explored. The scope was to determine whether any of the areas would have an impact on future workforce viability and sustainability.

Alignment to other streams of work and defining boundaries

There was also the need to give due regard to any significant workforce issues raised throughout the appraisal of other areas, especially, the clinical appraisals where in early workshops, workforce was identified as a key risk. Workforce representatives attended the workshops with clinicians and the issues raised have been discussed through the "Discussion and Findings" section generally. The specific workforce issues have been captured in each service review.

To note, within the time of the workforce land appraisal review, exploration of new service models are being considered; in the case of Stroke services, the development of a potential Hyper Acute Stroke Unit and working with Swansea Bay University Health Boards and, similarly for Obstetrics, the design of a service model to facilitate excellent care and respond to birth numbers and respiratory days for maintaining Special Care Baby Unit and High Dependency Unit cots.

Stakeholder mapping

Stakeholders were reflected in the Workforce Land Appraisal membership in terms of the outputs and critical analysis: Data Science, Workforce – Wellbeing, Planning & Intelligence and Trade Union colleagues.

Chair	Director of Workforce & OD
Workforce representatives & focus	Head of Strategic Workforce Planning Head of Digital Workforce Solutions Head of Staff Psychological Wellbeing Service Head of Workforce Education & Development Head of People & Organisational Effectiveness
Trade Union representative	Trade Union & Partnership Forum representative
Finance representative	Asst Director Financial Planning & Statutory Reporting
Capital planning representatives	Asst Director of Strategic Planning Head of Capital Planning
Data Science & Travel Analysis	Transport & Sustainable Travel Manager Head of Data Science

Section 4: Development of Work Programme & Plan

Development of Work Plan

The work plan was developed based on the input of stakeholders through the initial discussion at project group meetings, as noted opposite. The timeline was short and required focused action and feedback.

Date	Time
9 May 2022 (Project Commenced)	11am
23rd May 2022	11am
6th June 2022	11am
13 June 2022	11am
21th June 2022 (Draft Slides for Review)	2pm
4th July 2022 (Draft Report for Review)	10.30am
July 2022	TBC

Assumptions

Critical assumptions were made: a) travel analysis data would be available, b) staff engagement would be possible, and c) clinical pathway & staff groups would remain static.

Issues

As reflected in the assumptions above, new service pathways have not yet been defined. This presents an issue in how to define “groupings” for travel analysis. The staff groupings can be considered broadly reflective and reflects why “service level” information is not included at this juncture as could be misleading.

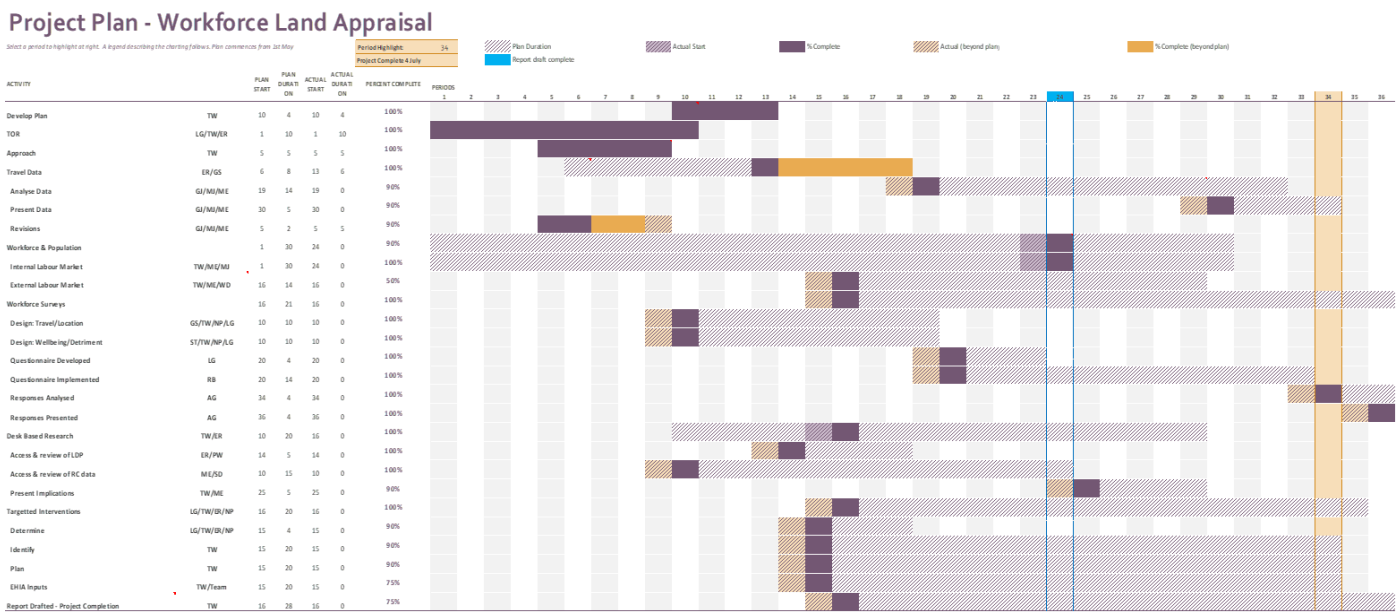
Risks

In developing the project, key risks were identified and assumed as essential to meet the project timetable or would result in implications for the project: a) critical data sets are not available or not available - on time, b) staff would not engage with project, and c) without service pathways defined our workforce would not be able assess personal impact at this stage of the process.

Constraints

Key constraints were time and resource within the project. To flag – all risks presented and impacted the project as reflected in the summary table that follows.

Work Plan



Impacts

The impacts would have resulted in a poorer quality output. Instead, the impact was on individuals and teams.

Section 5: Work Programme Methodology & Outputs

This section covers the data sources, analysis, the process for sense checking. It also includes the planning of interviews, focus groups and workshop activities including structuring and output planning.

Outputs required:

The Workforce Land Appraisal Group will:
1) Make an assessment of the impact and implications of the proposed location of the new Urgent and Planned Care Hospital, with due consideration to each of the 5 shortlisted sites and available information sources; taking account of our workforce plan and planning assumptions.
2) Identify the workforce risks that may need to be accounted for and possible mitigations. We utilise our Workforce Regeneration Framework as the basis of our assessment.
3) Inform the assessment by a review of different information sources that will reflect:

- Demographics and labour market considerations,
- Specific considerations around the implications for health & wellbeing, travel and housing considerations.

The following data/information was identified, sourced and analysed:

- Initial Census 2021 outputs,
- Review of internal workforce data,
- Workforce Survey & Workshop feedback,
- Implications for Medical Education,
- Local development plans,
- Review of local area amenities, schools, universities etc.,
- Review of key “terms and conditions” related to travel,
- Rurality & geographical considerations for transport,
- Time and distance for staff travel,
- Lessons learnt for workforce in relation to other new build developments.

This has enabled:

- Comparisons of each of the 5 shortlisted sites on travel times for staff currently based in GGH and WGH,
- Provision of information on the number of current staff and their average travel times to current base and potential new base,
- Further analysis on staff travel by staff banding/staff grouping,
- An understanding of the labour market in the east, west and centre of the zone and assess possible risks and implications,
- An understanding of wider impacts on future labour market changes e.g., availability of housing,
- An assessment on how much time staff are prepared to spend travelling to work (based on current activity).

Additionally, it was hoped that we would be able to:

- Make an assessment of current modes of travel of staff i.e. How many staff walk/cycle/use public transport to get into work currently,
- Gather data on what will be important for staff wellbeing on a new hospital site.

However, the total staff input illustrates limited engagement at this point, representing c1% of our total workforce:

- 139 responses for the survey mostly from Administrative roles based within Carmarthenshire,
- 14 attendees to the workshop in Pembrokeshire.

Section 5: Work Programme Methodology

This section covers how the data and modelling was collected and the process for sense checking along the way. It also covers the planning of interviews, focus groups and workshop activities including structuring and output planning.

Data Analysis

Transport for Wales supplied travel data and supported by further reviews by Data Science and Workforce colleagues, who aligned and assessed multiple factors: age, service and profession by locations, to understand and assess possible travel impacts. Exploration of data sources & focus groups were expanded to account for emerging themes i.e., medical rotas sustainability, medical education and travel from outside the health board geography, concept of the "20-minute neighbourhood" and affordable housing.

Sense checking

The Workforce Land Appraisal Group and wider governance framework enabled check and challenge of assumptions and exploration of conclusions. The feedback has been included within the discussion report, as well as shaping how this report is presented.

Strategic Outcomes – looking through the ASKS lens (Accessible, Safe, Kind and Sustainable)

Finally, as a method of representation, the information has been collated and reviewed through the outcomes lens designed into our future strategy – A Healthier Mid & West Wales: Our Future Generations Living Well, and reflected upon using the questions below:

- Consider whether the geographic areas could enable a Safe, Sustainable, Accessible and Kind workforce experience?
- If not, what mitigations would enable it to do so?

The table below summarises how the data informed the geographical questions to provide an overview of each area and support the strategic outcomes for workforce:

Outcomes	Accessible	Safe	Kind	Sustainable
Output 1: Data	Travel, Transport Data	T&C's & Royal Colleges Guidance	Consideration of positive & negative impacts	Labour market (Internal & external)
Output2: Intelligence	Amenities to enhance	Options to make safe & increase competence	Mitigations to address or opportunities to amplify	Ability to sustain or mitigate
Workforce Appraisal Outcome Assessment	Does the site enable good access to our workforce?	Does the site support our workforce to be safe?	Does the site support workforce health & wellbeing?	Does the site enable workforce sustainability?

A summary is presented in the section Discussion and Findings, with further detail within Appendices. However, it must be noted at this point that these questions cannot be answered fully and we will need to develop our thinking in relation to "what's important" with stakeholders and partners.

Section 6: Findings and Discussion

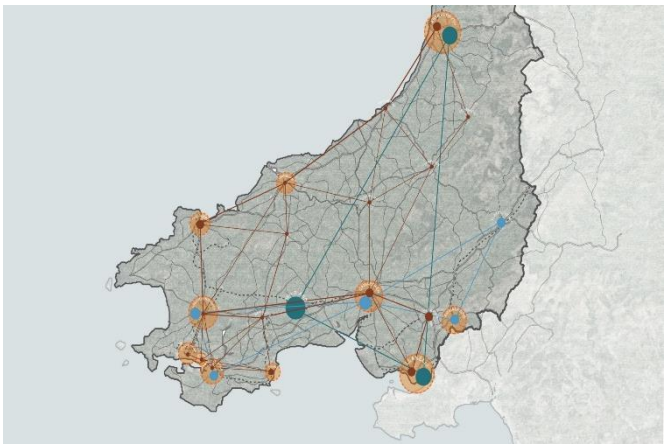
This section of the report discusses the findings of the analysis and summarises themes for consideration and review. Taking each data source and aligning to the zones where possible. Limitations of the data are noted.

Geography & population base of our workforce – alignment to our strategic direction

It is important to understand the geographical spread and scale of the population we serve and draw our workforce from: 385,000 in 3 counties of Carmarthenshire, Ceredigion and Pembrokeshire:

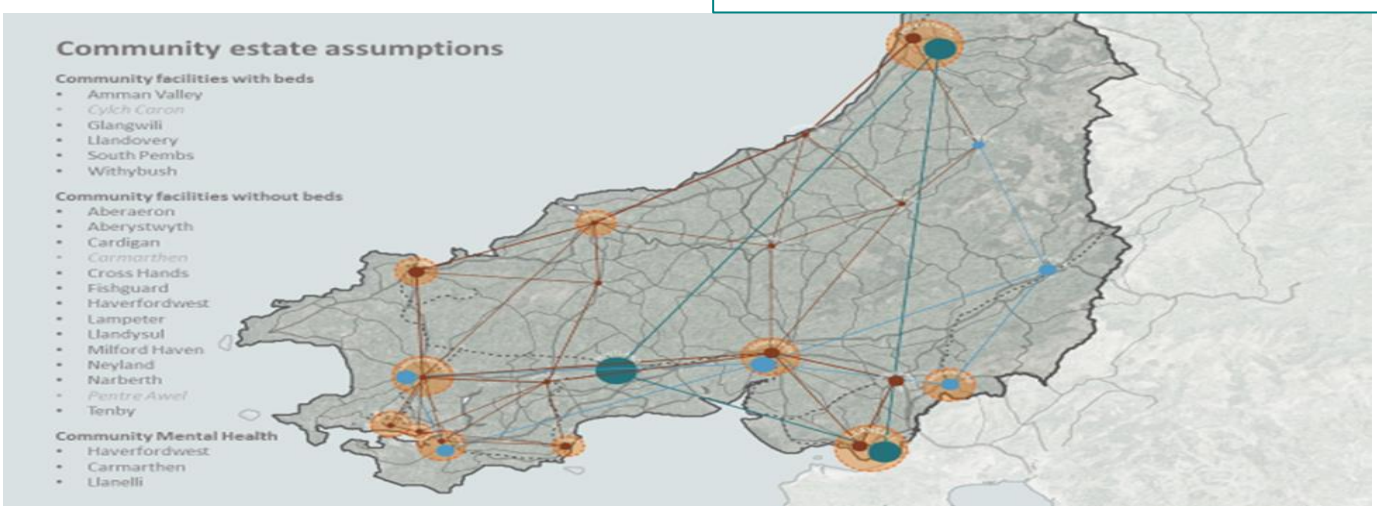
- Cover 25% of the landmass of Wales
- 2nd most sparsely populated Health Board in Wales
- 4 main conurbations have following population
  - Llanelli @46,000
  - Carmarthen @13,000
  - Haverfordwest @15,000
  - Aberystwyth @12,000
  - Compares with the population of Riverside in Cardiff @14,000
- Travel times for the population and workforce
  - @70 miles north to south is over 2 hours
  - @60 miles west to east is about 1.5 hours

A critical element of the strategy is the link to the Community Infrastructure in development and alignment to significant conurbations of population, beyond that of the proposed new build from a "work basis" for different staff groups as the strategy defines and pictured below.



A Healthier Mid and West Wales - our Future Generations Living Well (2018) – a social model of health…

A move from a reactive medical model of delivery, to one which is community-based, proactive, population focused, preventative, with person-centred care and treatment, will require realigning people, physical assets and the service offer, from a predominantly secondary care focus, to earlier, more localised, and targeted interventions.



Detailed analysis of how our community model develops will be essential to align to our current workforce capacity and capabilities to match demand/need to localised supply.

Section 6: Findings and Discussion

External Labour Market Demographics – Census 2021 (Issued June 2022 – First Issue)

National Context & Key Changes

The 2021 census identified the resident population of Wales as 3,107,500; this was the largest population ever recorded through a census in Wales, however, population growth needs to be seen in context and by comparators i.e.:

- Wales population growth across the last decade (1.4%) is lower than the rate between 2001 and 2011 (5.5%),
- England, the rate of population growth slowed to 6.6%, between 2011 and 2021 in contrast to 7.9% between 2001 and 2011,
- Cardiff, was the local authority with the largest population - 362,400 usual residents,
- Merthyr Tydfil, was the local authority with the smallest population - 58,800 usual residents,
- Newport saw the highest rate of population growth since 2011 (at 9.5%).

Perspectives on why Newport has seen such an increase is varied:

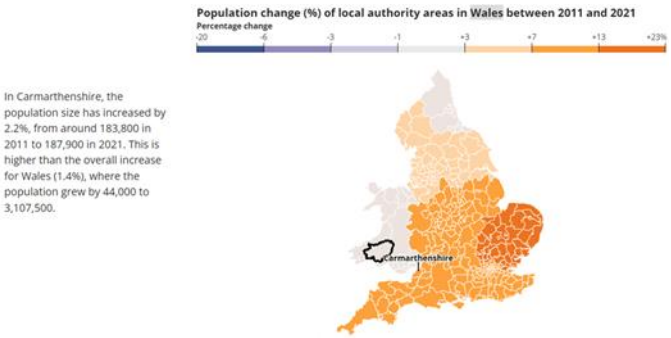
- Greater commuting between England & Wales due to lower house prices & removal of M4 Tolls,
- Forms part of the "metro-region" with Cardiff,
- Increase in University students i.e. University of South Wales.

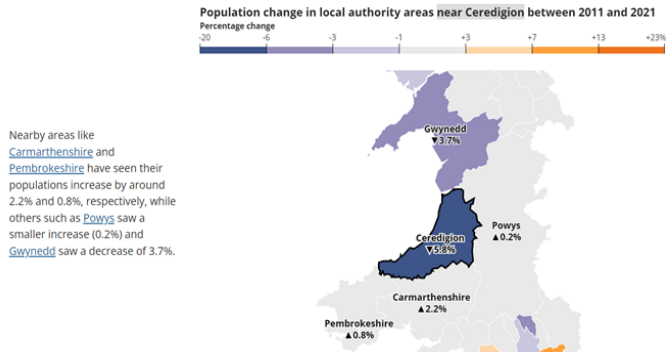
Higher than the population growth rates for both Wales (1.4%) and England (6.6%). To note, the next highest rate of population growth was in Cardiff (4.7%), followed by Bridgend (4.5%). This is referred to by some estate agents as the "M4 effect". If this is contextualised against house prices – average house prices for December 2021:

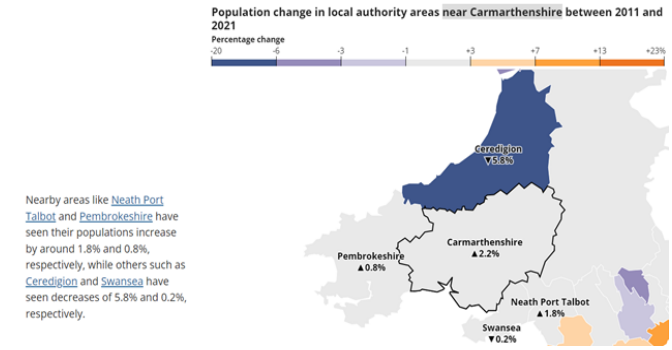
- Bristol £317,151
- Newport £195,000
- Cardiff £242,500
- Bridgend £178,000
- Swansea £175,000
- Carmarthen £169,000
- Pembrokeshire £198,000

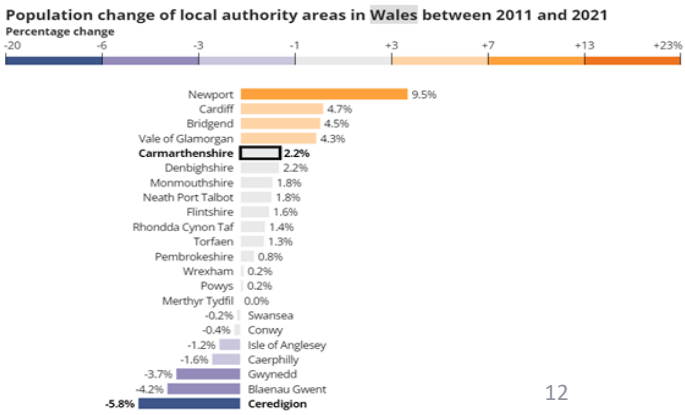
It is also useful to note that the average house price in Ceredigion is £220,000. To note, the greatest rates of population decline since 2011 were in Ceredigion (5.8%), Blaenau Gwent (4.2%/£110,000) and Gwynedd (3.7%/£175,000).

Population changes in Wales & county comparisons







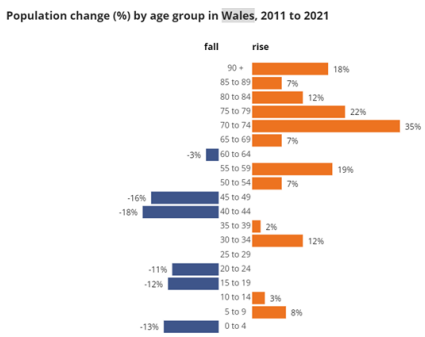


Section 6: Findings and Discussion

External Labour Market Demographics – Census 2021 (Issued June 2022)

The growth in the number of households in Wales was lower than in England, where there were 6.2% more households compared with 2011. The rate of increase in Wales was also lower than every region in England, which ranged from 4.1% in the Northeast to 8.5% in the East of England. All but three Local Authorities in Wales saw an increase in the number of households compared with 2011. The local authorities that saw the highest increases were Newport (8.1% increase), the Vale of Glamorgan (7.5% increase) and Monmouthshire (7.0% increase). Alongside this, the most densely populated Local Authority in Wales was Cardiff (2,572 residents per square kilometre), which was more than three times as densely populated as the next highest area, Newport (838 residents per square kilometre). Low population density areas included Ceredigion (40 residents per square kilometre) and Gwynedd (46 residents per square kilometre). This correlates with the decreases in the number of households i.e., Gwynedd (2.6% decrease), Ceredigion (2.1% decrease) and Blaenau Gwent (0.4% decrease).

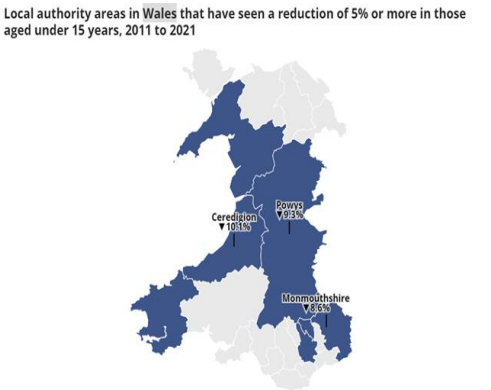
General age profiles for Wales : By gender, land & age ranges



Age and sex of the population

Wales in 2021, has a breakdown of 1,586,600 women (51.1% of the overall population) and 1,521,000 men (48.9%) little difference with England or 2011 census. Population ageing has continued, with more people than ever before in the older age groups. Over one-fifth (21.3%) of the Welsh population in 2021 (662,000) were aged 65 years and over, up from 18.4% (562,544) in 2011. The highest percentages of people aged 65 years and over were Powys (27.8%), Conwy (27.4%) and the Isle of Anglesey (26.4%).

Nearly two-thirds (62.2%) of the Welsh population (1,931,800) were aged 15 to 64 years. The size of this age group has declined slightly since 2011, when 64.7% of the overall population (1,981,784) were aged 15 to 64 years. The areas of Wales with the highest percentages of people aged 15 to 64 years were Cardiff (68.4%) and Newport (64.2%).



The remaining 16.5% of the population (513,800) in Wales were aged under 15 years. The size of this age group has also decreased since 2011, when 16.9% (519,128) were aged under 15 years. The Welsh Local Authorities with the highest percentages of the population aged under 15 years were Newport (19.0%) and Merthyr Tydfil (18.0%), whereas Ceredigion (13.1%) and Powys (14.4%) had the lowest.

Section 6: Findings and Discussion

External Labour Market Demographics – Census 2021 (Issued June 2022)

So what does this mean?

Across the three counties of Hywel Dda Health Board there are different age profiles within our population and therefore our workforce, however, does this critically have any implications for land selection?

Across all 3 counties there is a:

- decrease in working age population from 2.5%, 4.5% and 12.2% for Carmarthen, Pembrokeshire & Ceredigion respectively,
- increase in population 65 years of age and older c17-20%,
- decrease in children aged under 15 years of age of between 0.8% (Carmarthen) & 10.1% (Ceredigion) and 5.5% as the midpoint (Pembrokeshire).

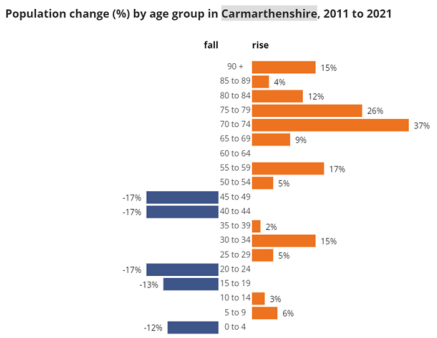
Limitations of the information - it is presented at county level and does not yet breakdown to lower areas to take account of the three zones of Narberth Whitland and St Clears, however, it is doubtful that this would give any more insight based on the general statistics which are broadly on par and previous information which suggests a collective population of c6000.

Population density has been flagged and in relation to house prices, further work may be valuable here to explore in relation to the "M4 effect". Additionally, based on the largest conurbation being Llanelli (c46,000) within the Health Board footprint, followed by Carmarthen (c12,000) and Haverfordwest (c15,000) it may be useful to look in more detail.

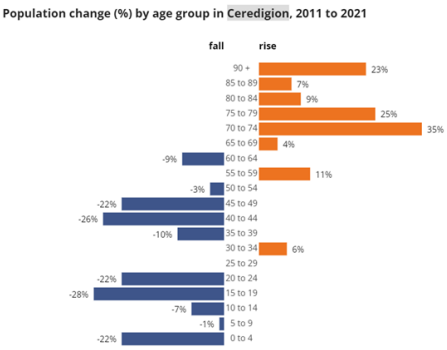
In the next section we explore our current workforce to assist in appreciating the relationship between employment and population density within our current hospital geography.

Age Range Profiles by County

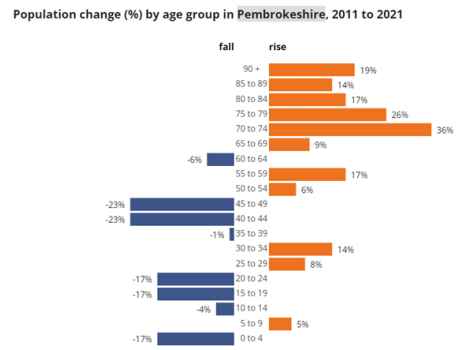
This is how Carmarthenshire compares. There has been an increase of 18.9% in people aged 65 years and over, a decrease of 2.5% in people aged 15 to 64 years, and a decrease of 0.8% in children aged under 15 years.



This is how Ceredigion compares. There has been an increase of 17.2% in people aged 65 years and over, a decrease of 12.2% in people aged 15 to 64 years, and a decrease of 10.1% in children aged under 15 years.



This is how Pembrokeshire compares. There has been an increase of 20.6% in people aged 65 years and over, a decrease of 4.9% in people aged 15 to 64 years, and a decrease of 5.5% in children aged under 15 years.



Section 6: Findings and Discussion

Internal Labour Market Demographics – Workforce Analysis 2022

The workforce profile across each staff group is noted below based on the May establishment control tool; detailed analysis is incorporated in the IMTP Workforce Technical Paper.

Health Board wide	Budget	Actual	Vacancy	Maternity	%
ADD PROF SCIENTIFIC AND TECHNICAL	361.5	351.4	10.1	8.4	2.81
ADDITIONAL CLINICAL SERVICES	2,136.2	2,185.2	(49.0)	50.6	-2.30
ADMINISTRATIVE & CLERICAL	1,990.1	2,035.5	(45.3)	23.6	-2.28
ALLIED HEALTH PROFESSIONALS	597.1	618.3	(21.2)	21.4	-3.54
ESTATES AND ANCILLIARY	876.5	852.2	24.3	6.6	2.77
HEALTHCARE SCIENTISTS	202.3	198.8	3.5	1.0	1.73
MEDICAL AND DENTAL (Excludes SLE)	*928.5*	*605.9*	*322.6*	*5.0*	*34.74*
NURSING AND MIDWIFERY REGISTERED	3,282.5	2,805.3	477.2	75.2	14.54
STUDENTS	2.2		2.2		100.00
Grand Total	10,376.8	9,652.5	724.3	191.7	6.98

As an example, Unscheduled Care (based on like for like cost centres for direct comparability) is given below to illustrate the vacancy rates against budget – very little difference is evident. For GGH & WGH vacancies are on par however PPH having the largest population base in Llanelli, is potentially experiencing equal difficulty. To add potentially competing with significantly more employers, given the commutable distance to other centres and M4 access.

USC	Budget	Actual	Vacancy	Maternity	%
BGH	427.5	327.6	99.9	14.3	23.38
GGH	823.1	637.7	185.3	18.6	22.52
PPH	590.7	476.3	114.4	12.2	19.37
WGH	607.8	490.8	117.0	11.3	19.25
	2,449.1	1,932.3	516.8	56.4	21.10

Vacancies against budget	BGH %	WGH %	GGH %	PPH %	Health Board %
ADD PROF SCIENTIFIC AND TECHNICAL	17.9%	3.7%	-8.3%	28.2%	2.8%
ADDITIONAL CLINICAL SERVICES	5.4%	10.4%	0.6%	7.2%	-2.3%
ADMINISTRATIVE & CLERICAL	-9.8%	2.8%	2.7%	3.1%	-2.3%
ALLIED HEALTH PROFESSIONALS	20.4%	13.8%	15.9%	4.9%	-3.5%
ESTATES AND ANCILLIARY	-12.7%	-3.9%	2.1%	9.2%	2.8%
HEALTHCARE SCIENTISTS	7.9%	4.6%	7.9%	7.2%	1.7%
MEDICAL AND DENTAL	31.6%	29.1%	33.9%	49.1%	34.7%
NURSING AND MIDWIFERY REGISTERED	29.0%	28.0%	13.8%	20.9%	14.5%
Grand Total	16.3%	17.2%	11.0%	14.9%	7.0%

Section 6: Findings and Discussion

Internal Labour Market Demographics – Workforce Analysis 2022

Further examples in relation to Planned Care also demonstrate our current vacancy position (as of May 2022 Establishment Control Tool). The tables below provide a snapshot of our current position, including the status of some of our specialist services, highlighting critical roles which are known to be generally more difficult to recruit in to.

Endoscopy Service comparison by site	BGH	WGH	GGH & PPH
Budget	11.4	22.3	34.0
Actual	11.2	20.3	33.9
Vacancy	0.2	2.0	0.0
Vacancy Percentage	1.8%	9.0%	0.0%

- GGH/PPH have no vacancies with both BGH and GGH slightly under establishment.
- WGH current vacancies could directly affect service delivery due to specialist area, level of training required for inexperience staff and lack of Endoscopy trained bank staff to temporarily bridge vacancy gap.

- Budget appears disproportionate across sites, with majority of services delivered in Carmarthenshire.
- Current vacancy position demonstrates impact on service delivery, and further highlights difficulty to recruit into specialist roles.

Ophthalmology Service comparison by site	BGH	WGH	GGH
Budget	16.2	6.0	53.9
Actual	13.8	6.4	47.9
Vacancy	2.4	(0.4)	6.1
Vacancy Percentage	14.8%	-6.7%	11.3%

Radiology Service comparison by site	BGH	WGH	GGH	PPH
Budget	46.6	61.5	67.8	48.0
Actual	42.1	56.9	71.7	51.0
Vacancy	4.5	4.6	(3.9)	(3)
Vacancy Percentage	9.7%	7.5%	-5.8%	-6.3%

- GGH and PPH are over establishment.
- Known recruitment challenges in WGH and BGH evident in current vacancy position.
- The impact of workforce deficits on other services must also be acknowledged e.g., Sonography/Ultrasound vacancies on Women & Childrens services.

Failure to recruit into these roles, compromises access to specialist services for our population. It is imperative that continued workforce analysis based on service design is necessary across all services, to understand impact of the new hospital and implications, to inform decision making for further workforce planning activity at a local and regional level, e.g., ARCH (A Regional Collaboration for Health) programmes.

Section 6: Findings and Discussion

Internal Labour Market Demographics – Workforce Analysis 2022

Impact on our current workforce

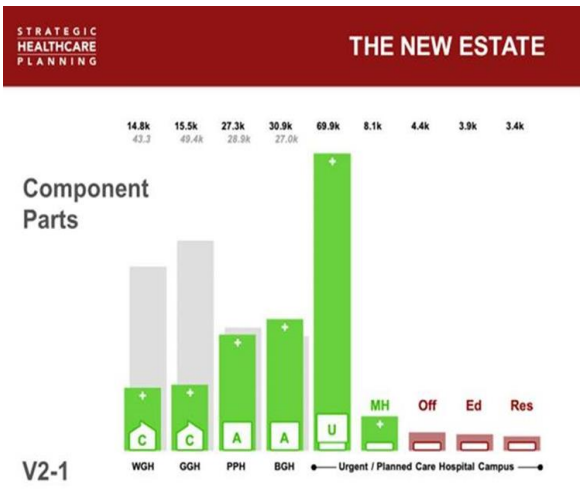
Future projections were undertaken as part of the Programme Business Case (PBC) phase for the new Urgent and Planned Care Hospital. Projections were based on the information known at that time on the functional content of the new hospital. The services within the functional content areas have been used to project the percentage of workforce who may be affected by the new site.

A proposed projected decrease in the footprint of the remaining sites (GGH and WGH) within the PBC has also been used to model the percentage of staff who may remain within their current location and therefore may not be affected by the proposed new sites.

We acknowledge the limitations of this approach to modelling the impacted workforce, however, without specific service models or pathways in place, we can only estimate the current impacted workforce.

- GGH – New community-based hospital 68% decrease in footprint.
- WGH – New community-based hospital 65% decrease in footprint.

Using these figures, the remaining workforce within GGH and WGH has been calculated purely on a percentage decrease of the estate size and using the same percentage decrease or increase to current staffing levels. This has not taken into consideration any required skills mix or changes needed to the workforce as a result of the estates changes, pathway changes or technological advances.



Based on the proposed decrease in footprint alone we can broadly state that 32% of GGH staff may not be affected and 35% of WGH staff may not be affected. According to the Staff in Post data used (March 2022) there were 6227 individual staff members or 4408.26WTE located at GGH or WGH.

Site	Staff in Post (as of March 2022) Headcount	No. of Staff potentially affected (Headcount)	No. of Staff potentially affected (Percentage)	No. Of Staff not affected (Headcount)	No. Of Staff not affected (Percentage)
GGH	3860	2625	68%	1235	32%
WGH	2367	1539	65%	828	35%
TOTAL	**6227**	**4164**		**2063**	

Section 6: Findings and Discussion

Internal Labour Market Demographics – Workforce Analysis 2022

Aging profile of our current workforce

	Headcount												
Current GGH Staff (as of May 2022)	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years	Total Headcount
Add Prof Scientific and Technic		8	15	15	16	17	10	12	3	4	1	2	103
Additional Clinical Services	30	67	91	89	71	56	63	74	56	45	4	3	649
Administrative and Clerical	6	47	43	75	66	68	83	80	97	41	15	2	623
Allied Health Professionals		13	40	30	42	33	16	12	14	9	2		211
Estates and Ancillary	16	25	19	25	34	33	32	61	53	28	10	2	338
Healthcare Scientists		5	4	12	6	11	10	9	10	6			73
Medical and Dental		2	17	33	44	33	42	29	17	17	6	2	242
Nursing and Midwifery Registered		70	92	131	130	105	130	115	100	39	6		918
Students		1											1
Grand Total	**52**	**238**	**321**	**410**	**409**	**356**	**386**	**392**	**350**	**189**	**44**	**11**	**3158**

31% (986 individuals) of GGH staff are over the age of 51

	Headcount												
Current WGH Staff (as of May 2022)	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years	Total Headcount
Add Prof Scientific and Technic		3	13	13	14	15	6	7	7	1	2		81
Additional Clinical Services	26	57	56	61	56	37	46	51	50	36	7	2	485
Administrative and Clerical	2	10	35	36	41	50	56	93	50	34	8	2	417
Allied Health Professionals		12	19	21	18	15	23	15	10	5	1		139
Estates and Ancillary	13	20	21	9	17	19	27	34	49	31	6	2	248
Healthcare Scientists		3	6	3	8	8	7	7	2	1	2		47
Medical and Dental			9	19	17	23	20	20	21	9	2	2	142
Nursing and Midwifery Registered		19	36	53	51	76	81	83	65	51	6	1	522
Grand Total	**41**	**124**	**195**	**215**	**222**	**243**	**266**	**310**	**254**	**168**	**34**	**9**	**2081**

37% (775 individuals) of WGH staff are over the age of 51.

The current staff based at GGH and WGH equate to 46% of the overall workforce at HDUHB (as of May 2022). Below is a projection of the potential number of staff we will still have in post in 2029 based on 3 retirement scenarios:

1. The current average retirement age by Professional Group across the HB,
2. The current average retirement age of the whole HB (61.4 years of age),
3. Current National Pension age of 67.

Pension changes may impact our future workforce and based on the figures below between 456 – 1131 (or up to 10% of our workforce) could decide to retire prior to the new hospital opening based on the 3 retirement scenarios above. We must mitigate against this risk and ensure succession plans are in place for our future workforce along with opportunities to retain the skills of our ageing workforce through agile working opportunities.

	Projected remaining staff currently based at GGH and WGH in 2029		
Current base	Excluding average retirement age by Professional group	Excluding All over 55 (current average retirement for HB of 61.4)	Excluding All over 60 (based on Pension age of 67 in 2029)
GGH	2512	2563	2913
WGH	1596	1616	1870
Total	4108	4179	4783
% of All HB staff	36.1%	36.7%	42.0%

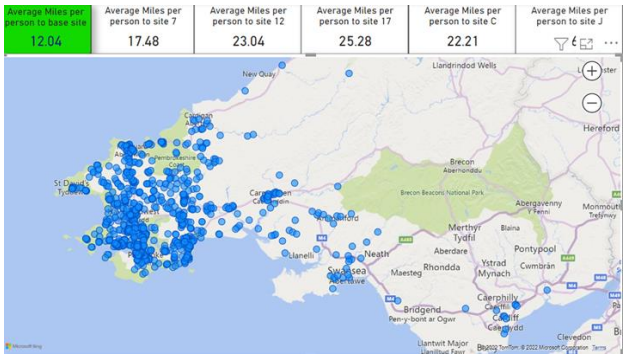
Section 6: Findings and Discussion

General implications of travel for our workforce

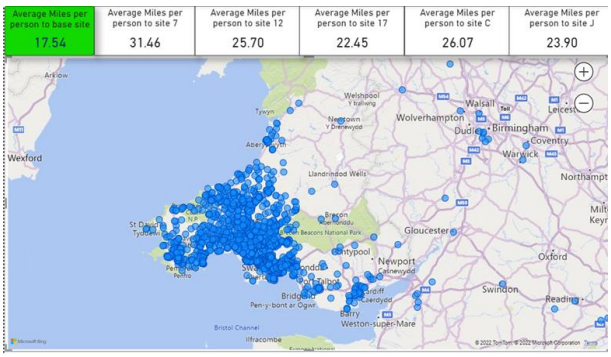
The below table shows the drive time from towns across Pembrokeshire and Carmarthenshire to their current nearest acute hospital along with the variance in drive time to the 3 proposed zones. As can be seen for the vast majority of towns there is a general increase in drive time to the 3 zones proposed with no zone showing any particular positive or negative implications for general travel.

			Drive time to				
Town/City	Postcode	Nearest Acute Hospital (excluding PPH)	Current nearest Acute Hospital	Zone 1 - Whitland	Zone 2 - Narberth	Zone 3 - St Clears	Increase / Decrease
Cardigan	SA43	WGH	41	42	39	42	↑↓
Fishguard	SA65	WGH	22	43	49	50	↑
St Davids	SA62	WGH	28	50	41	55	↑
Haverfordwest	SA61	WGH	6	29	20	35	↑
Milford Haven	SA73	WGH	22	40	32	44	↑
Pembroke	SA71	WGH	28	33	25	32	↑
Pembroke Dock	SA72	WGH	26	37	27	34	↑
Saundersfoot	SA69	WGH	32	22	17	21	↓
Tenby	SA70	WGH	35	27	21	26	↓
Narberth	SA67	WGH	19	12	1	19	↓
Kilgetty	SA68	WGH	29	17	12	16	↓
Carmarthen	SA31	GGH	8	23	34	17	↑
Ammanford	SA18	GGH	30	48	56	41	↑
Llandeilo	SA19	GGH	22	40	51	34	↑
Pembrey	SA16	GGH	27	38	48	32	↑
Newcastle Emlyn	SA38	GGH	29	35	44	33	↑
Llandysul	SA44	GGH	28	48	59	41	↑
Pencader	SA39	GGH	18	38	48	18	↑
Lampeter	SA48	GGH	38	58	68	51	↑
Llandovery	SA20	GGH	37	56	66	49	↑
Llanelli	SA14	GGH	37	49	59	42	↑
Pontyberem	SA15	GGH	21	36	45	28	↑
Whitland	SA34	GGH	24	1	13	9	↓
St Clears	SA33	GGH	16	10	20	3	↓

However, when we reflect on our current site locations against the home locations, themes begin to emerge:



Map (above left) shows the location of staff whose current base is at WGH with their current average travel times to WGH and proposed new site. The vast majority of staff currently based in WGH are situated within a 10-mile (16km) radius of WGH.

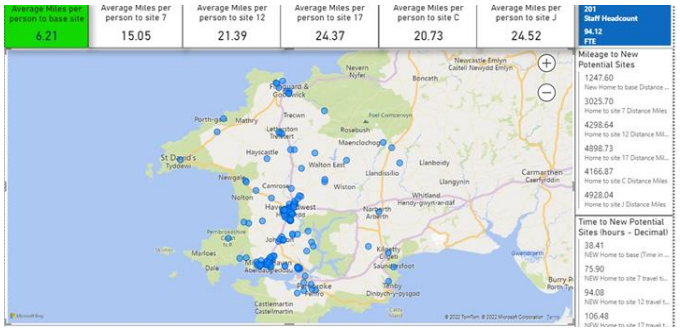


Map (above right) shows the location of staff whose current base is at GGH with their current average travel times to GGH and proposed new site. GGH based staff are located across the whole of the Health Board footprint with a number of staff located in the Swansea area and along the M4 corridor and further afield.

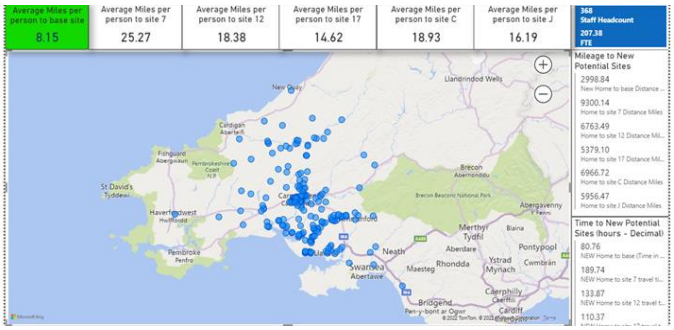
Section 6: Findings and Discussion

General implications of travel for our workforce

We can identify that specific groups could be impacted, especially the Facilities workforce located around current hospital sites of Withybush General Hospital and Glangwili General Hospital:

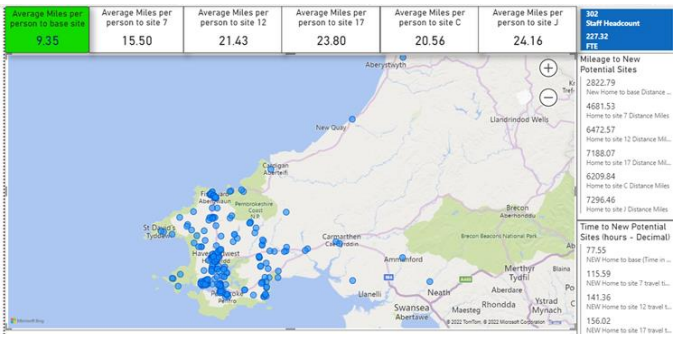


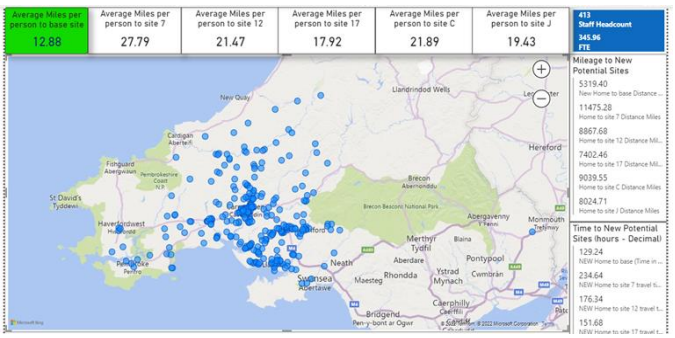
Band 2 Facilities staff currently based at Withybush General Hospital



Band 2 Facilities staff currently based at Glangwili General Hospital

We can see similar trends in Additional Clinical Services (Bands 2, 3, & 4) around Withybush General Hospital; a large proportion of staff within these roles are located fairly close to their work base of WGH (see below left image).





We see a different picture in Glangwili General Hospital as staff are more widespread across the Hywel Dda University Health Board footprint (see above right image). The rationale for this has not been explored further. i.e., it may be due to historical changes of sites and services.

Section 6: Findings and Discussion

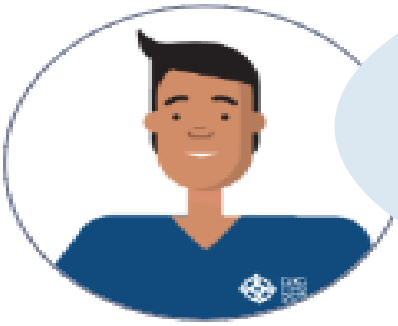
Personal implications of travel for our workforce

The travel implications – negative and positive – will be experienced throughout all professional groups. The data tells us that while a large percentage of staff working in Withybush Hospital live within a 10 miles/16 km radius of base, the staff working in Glangwili Hospital are more disperse, with a greater number living outside of the Health Board footprint. There will be a number of staff with a reduced travel time to the new site, which will bring benefits such as reduction in spend on fuel, a better work-life balance etc. However, data also shows us that the average mileage from both Withybush and Glangwili Hospitals will increase:

- The average mileage for Withybush Hospital staff will increase by 10.55 to 25.08 miles,
- The average mileage for Glangwili Hospital staff will increase by 8.5 to 23.24 miles.

The three scenarios below aim to provide examples of how travel could potentially impact on staff.
N.B The characters in the examples below are fictional, although current on-call commitments and travel times are accurate.

Ioan works as a full-time administrator in Withybush General Hospital. He lives in Milford Haven. He currently travels 10 miles to work. If the new hospital is built in zone 1, he would have to travel 25 miles; zone 2, 18 miles; zone 3, 26 miles.



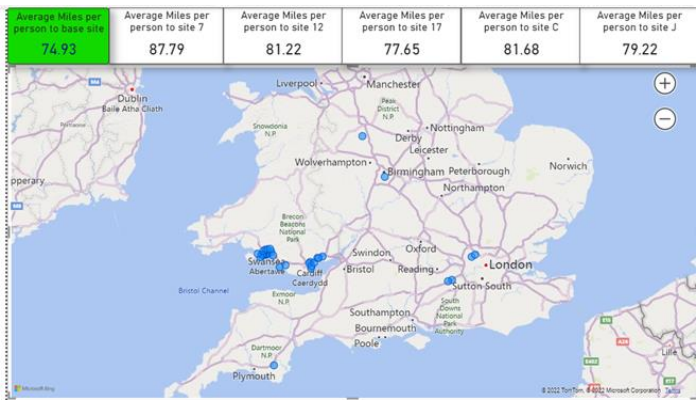
Alun works as a Medical Consultant in Glangwili General Hospital. He lives in Pontyberem. He currently travels 19 miles to work. If the new hospital is built in zone, 1 he would have to travel 29 miles; zone 2, 35 miles; zone 3, 25 miles. When working on-call, he needs to be able to get to the site within 30 minutes. If the new hospital is built in zone 1, it would take Alun 40 minutes to arrive on site; zone 2, 49 minutes; zone 3, 37 minutes.

Sarah works as a District Nurse in the Community. She lives in Newcastle Emlyn. She currently travels 20 miles to her base at Cardigan Integrated Care Centre. If the new hospital is built in zone 1, and she relocates there, she would have to travel 27 miles; zone 2, 26 miles; zone 3, 24 miles.

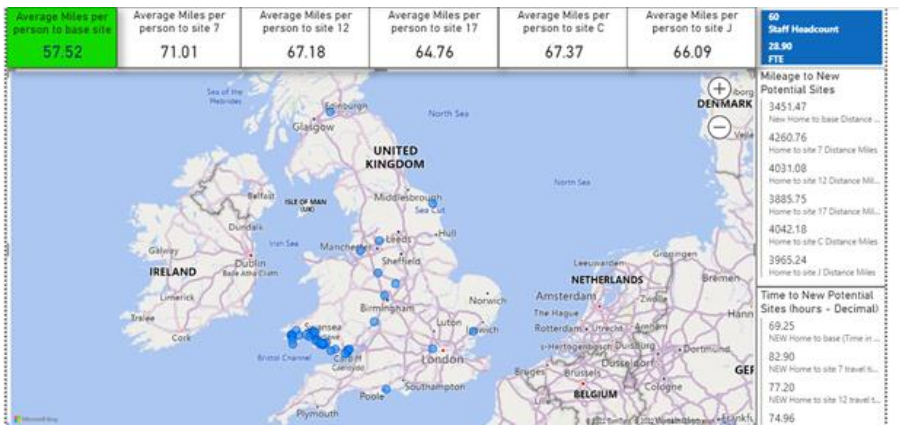
Section 6: Findings and Discussion

General implications of travel for our workforce: Medical staff

Consultant medical workforce in GGH and WGH equates to 180 individuals (157WTE). Currently 32 of these reside outside of the Health board footprint, the future location of the hospital may affect issues around retention, on call feasibility and attraction of new employees. Accommodation availability at the new site would be a key mitigation in the retention of staff.



There are 60 Medical staff in General Surgery based at GGH and WGH, almost half reside outside of the HB footprint. Location may not be an issue due to current travelling times to the HB, however access to accommodation regardless of zone may be considered important.



All Medical General Surgery staff

Currently almost half (28) of the Medical General Surgery staff reside outside of the HB footprint.

Section 6: Findings and Discussion

Implications for our workforce – contractual terms and conditions

The NHS Staff Council defines a member of staff as on call when "an established arrangement" is in place between employee and employer, enabling the employee to be "available outside of his/her normal working hours" - i.e., normal working hours are those regularly worked and/or fixed by employment contract (NHS Staff Council). Many of our staff are contractually obligated to participate in an on-call service, allowing essential service provision to be available outside or normal working hours.

The examples below, seek to illustrate the ability of our workforce to undertake current contractual obligations. It is imperative that further work to understand the impact of service relocation for all staff affected is undertaken, including assessment of capacity to maintain terms and conditions based on contractual requirements, but also including relevant clinical guidance/recommendations to ensure safe delivery of care to our local population.

N.B The characters in the examples below are fictional, although current on-call commitments and travel times are accurate.

Example 1:

Service:	Potential on call staff impacted:	Staffing Guidelines:
Theatres e.g., 30 minute on-call response time	Medical, Nursing, Allied Health Professionals & Additional Clinical Services	• Association for Perioperative Practice • Royal College of Surgeons • Royal College of Anaesthetists
Examples of other considerations/co-dependencies: Anaesthetic provision for other services, e.g., Intensive Care Unit/Obstetrics Attendance at Medical Emergencies (MET) and unscheduled admissions e.g., major trauma Inter-hospital transfers i.e., Level 3 (Critically Ill) Patients		

Evan works in Theatres at Glangwili General Hospital and works as part of the on-call rota, currently undertaking some on-call commitments from home. Due to relocation of acute services, Evan would live 40 minutes away from zone 1, 32 minutes from zone 2 and 44 minutes from zone 3.

Due to increased travel times, Evan may need to base himself on site for his on-call commitments, therefore additional provision of on-call accommodation near to the new hospital site may need to be considered.

Dave is a skilled member of the Estates Team living in St David's. He is regularly on-call on a weekly basis.

Current on-call arrangements stipulate an ideal 1-hour response time. The possible locations of the new hospital site will impact Dave's travel time and may affect his ability to reach the hospital site within 1 hour (zone 3 only), as he lives around 50 minutes from Zone 1, 41 minutes from zone 2 and 55 minutes from zone 3.

Example 2:

Service	On call staff:	Staffing Guidelines
Estates and Facilities	Skilled/Semi-Skilled Staff	N/A - although a 1-hour response time preferred
Other considerations/co-dependencies: Impact on service delivery/safety if unable to respond to call out requests, e.g., plumbing/electrical issues.		

Section 6: Findings and Discussion

Implications for our workforce – Medical Professional Standards & Contractual Arrangements

With just under half of the Medical Workforce living outside of the Health Board footprint, it is important to understand the implications this could potentially have on relocation of acute services to a new location. There are numerous guidelines and policies, both internal and external, that set out the terms and conditions of employment, including a travel or response-time requirement. In general, a consultant is required to reside at a location that is anything from a "reasonable" or "acceptable period of time" to "within 30 minutes" of the hospital – *this can be seen in the below Image*. This guidance has been developed to ensure that patient care is timely and that the staff on site have the appropriate support to meet the needs of our service users, which can be accessed 24 hours a day, 365 days of the year.

Overview and Findings of Royal College/Professional Body/Policies and Guidelines

"...a consultant would be able to choose (subject to relevant clinical governance considerations regarding being able to return to the appropriate site(s) within an acceptable period of time to respond to emergencies) an appropriate place to live. It is recognised that the old '10 mile limit' on how far away a consultant can live, is no longer appropriate – the time taken to be able to return to the relevant site(s) for emergency work purposes now being the necessary consideration"
Welsh Assembly Government NHS Wales (2005) National Consultant Contract. National Consultant Contract (wales.nhs.uk)

"the designated consultant is able to attend his/her base site within 30 minutes at all times" and that this should be governed by contractual arrangements and local policy.
The Royal College of Surgeons England. (2011) Emergency Surgery – Standards for Unscheduled Surgical Care. https://www.rcseng.ac.uk/rcs_emergency_surgery_2011_web.pdf

"Be available either within the hospital or within a reasonable distance of the hospital to give advice throughout your duty period." And "Ensure that you are able to respond promptly to a call to attend to an emergency patient."
Royal College of Surgeons. (2014) Good Surgical Practice. https://www.rcseng.ac.uk/rcs-_good-surgical-practice_guide.pdf

While the National Contract does state that "Consultants will not normally be resident on-call", it can be offered as a local service arrangement, as stated in the local Health Board principal statement of main terms and particulars of employment – "Given the particular nature of your work you are required to live in a location which is within reasonable travelling time from your place of work as agreed with your Clinical Lead/Service Manager".
Hywel Dda University Health Board Principal Statement of Main Terms and Particulars of Employment.

"Consultant or other autonomously practising anaesthetist support should be contactable at all times and have a response time for attendance on site of not more than half an hour to attend the delivery suite and maternity operating theatre".
The Royal College of Anaesthetics. (2020) Chapter 9. Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2022 | The Royal College of Anaesthetists (rcoa.ac.uk)

"The on-call EM consultant will be informed of any trauma call, and unless clearly not needed attend within 30 minute" and "Out of hours Consultant anaesthetist within 30 minutes."
Hywel Dda University Health Board Major Trauma Policy.

Section 6: Findings and Discussion

Implications for our workforce – contractual terms and conditions

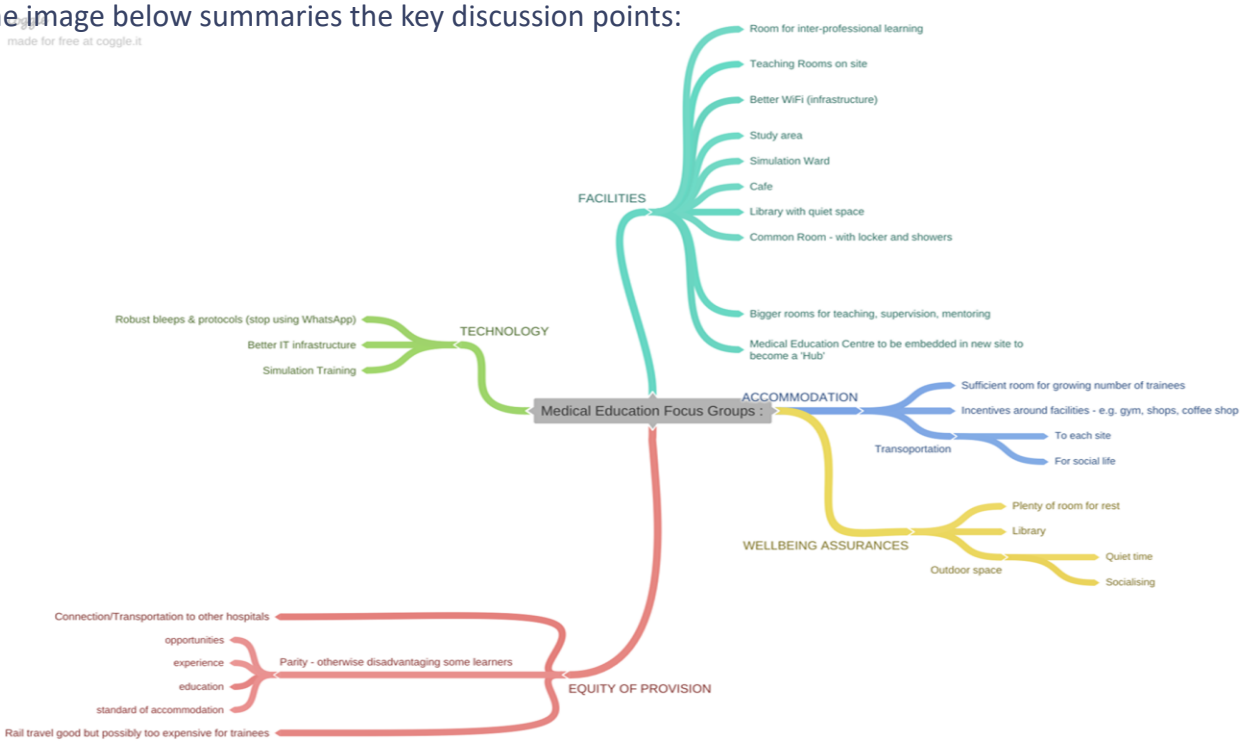
The drive times from various towns across Pembrokeshire and Carmarthenshire (page 19), demonstrates that while there are a several towns within the 30 minute on-call commitment, there are a number of towns falling outside of this timeframe. This has the potential of causing staff who are currently able to adhere to this requirements, to be unable to comply with their terms, conditions and professional guidelines. Mitigations can be developed to manage potential issues i.e., provide appropriate accommodation on site for all staff impacted/review of medical staffing rotas etc.

As development of this programme of work continues, further analysis of our workforce will enable review of current terms, conditions and guidance, which will provide opportunity to gain further understanding of the implications for the totality of our workforce impacted. This work will be based around a confirmed location and service delivery for the new hospital.

Section 6: Findings and Discussion

Consultation & Engagement Medical Education – Focus Group

During the workshops held for the Clinical Appraisal, a concern was raised around the potential implications the land selection would have on Medical Education within the University Health Board; and questions were raised around the continuity and provision for trainees. To understand the potential implications three focus groups were organised - one per county - with representatives from the Medical Education Team. The feedback from each county contained common themes around the accommodation, facilities, technology, wellbeing and equity of provision. The feeling held by each group was the location of the three zones is not what would impact the trainees, it is what is on the site that would have either a negative or positive impact. The image below summaries the key discussion points:



The provision of modern and sizeable accommodation with nearby shops, gym and coffee shops, and good transportation links to each Health Board site and local towns. It is thought that the modern and social accommodation with good transport would attract trainees not only to come to the Health Board, but to remain for the duration of their learning. The group also thought that the provision of excellent facilities, including large multi-purpose teaching rooms, simulation training, study areas, library with quiet space, café and better Wi-Fi are what trainees are looking for and will be expecting at a new site. It was brought out that under the British Medical Association's new Fatigue and Facilities Charter, the Health Board will be expected to provide adequate resources that allows the Medical Workforce access to relax and look after their Wellbeing. The potential for a new venue/facilities for the provision of Medical Education has led to concern in the provision on other sites. One representative from the team raised the concern in a risk of disadvantage to trainees on the older sites if they were not up to the same standard or with similar facilities to the new site. It was felt that there would need to be consideration given to which services would be moved to the new site and which ones would remain as this would impact on the placements authorised by the Deanery HEIW. If services are removed from certain sites, the trainees wouldn't be able to carry out the work required, and the Deanery would revoke authorisation for placements. If no trainees were then placed in the 'older' hospitals, there is a risk that the consultants currently working there would leave to work where there were trainees, as it was felt that consultants view teaching as an important aspect of their job plans.

Section 6: Findings and Discussion

Consultation & Engagement – HEIW / Deanery Feedback

Further to the focus groups held with representatives of Medical Education across the Health Board, engagement with representatives/education leads specifically for Paediatric and Neonatal Training was also facilitated to gain understanding of potential implications for Medical Students and Doctors in training posts. This allowed for views to be shared in relation to the potential zones for relocation of acute services, and the discussion provided opportunity to improve understanding of Deanery requirements, inclusive of the views shared by Students and Doctors who have been, or are currently placed/training, within Hywel Dda.

It must be stated that the opinions expressed were provided informally, and feedback was shared as a means of initial engagement *only*. It is understood that further engagement will take place, to provide clarity and appropriate detail for all services/individuals impacted, as the business case progresses.

Views shared were provided on behalf of the Training School for Paediatrics, including sharing of the view from the perspective of the relevant Senior Team(s) at Health Education Improvement Wales (HEIW). Findings are summarised below:

- Feedback on placement provision for medical students in Hywel Dda is positive and the placements are of a high quality overall.
- Historical issues around placements at more rural locations in our Health Board have been alleviated by centralising paediatric training at Glangwili General Hospital.
- Paediatric Trainees are currently informed by HEIW that all training placements will be within a reasonable commuting distance from a home base between Swansea and Cardiff.
- Paediatric recruitment to Wales as a deanery has improved since North Wales and South Wales became separate rotations, enabling trainees to live in the same place for their whole training time (minimum of 8 years).
- Historically, Doctors in training posts have been less reluctant to travel further west. In 2021 a survey of current Welsh Paediatric trainees (led by Trainee representatives) concluded that the majority of trainees should not be sent to remote units, though a smaller number of trainees, for individual reasons, may choose to work at more remote Hywel Dda units as an optional placement - partly because of reduced learning opportunities but also due to commuting distances.

Additional feedback has been researched to ensure the national views of students and trainees have been acknowledged, to provide contextual information around the opinions of individuals, placement preferences etc, as a means of summarising the main themes.

The General Medical Council's (GMC) findings from the National Training Survey 2021 suggests:

- Most trainees and trainers feel supported at work,
- Responses to overall training, experience and supervision remains high (and at pre-pandemic levels),
- Workplace pressures have caused burnout rates to increase to their highest levels (since tracking begun in 2018),
- There is a requirement for training provision to be more flexible and able to adapt to changing demands,
- 41% of responses (for secondary care trainers) suggest their wellbeing is compromised by their role to a high degree, resulting in reduction in energy to spend with family and friends during leisure time.

(GMC, 2021).

Section 6: Findings and Discussion

Consultation & Engagement – HEIW / Deanery Feedback

It is important that we, as an organisation, continue to build on this engagement/findings to provide detailed understanding and analysis of the views of our current and future workforce, ensuring collaboration with necessary workforce and representatives to:

- Prioritise the academic, clinical and personal/wellbeing needs of our current workforce,
- Gain further understanding of the possible implications of relocation of acute services,
- Continue working with necessary internal and external stakeholders to ensure a collaborative approach is adopted and maintained,
- Be transparent, open and honest in our engagement,
- Mitigate risks where possible, to reduce implications for Medical Student and Trainee Doctor placements/employment.

Section 6: Findings and Discussion

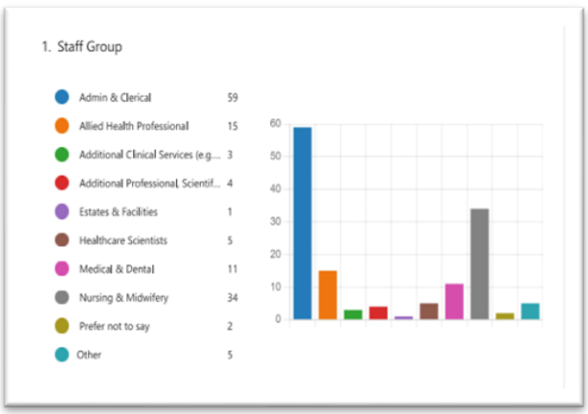
Consultation & Engagement; Staff Survey/Drop In Sessions

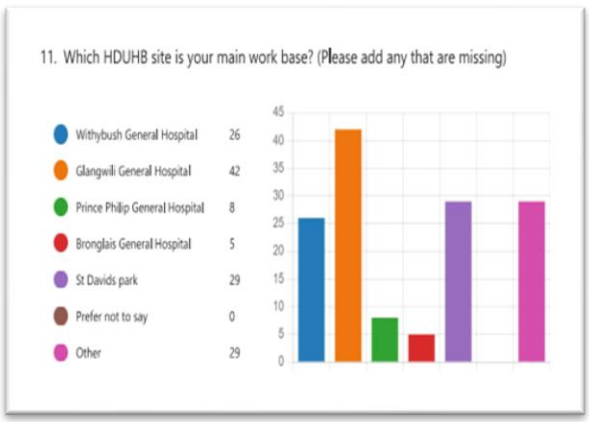
To allow the views of our staff to be considered for each of the three zones, a survey was made available for staff to complete. The survey was sent out via multiple methods, which included sharing of the survey on the intranet, global email and social media platforms, managers were also encouraged to provide staff with appropriate opportunity and facilities to undertake the survey. To promote greater accessibility to the survey, particularly for those without IT access, drop-in sessions were also facilitated, whereby staff could access and complete paper copies of the survey as well as share their views with Workforce and Organisational Design (WOD) representatives.

The number of individuals that completed the survey was c.1% of our total workforce, with the overall number of responses equating to just 139, 4 of which were from members of staff who completed the survey during drop-in sessions.

Summary of Findings

Most responses were from individuals working in Administration and Clerical roles, with very low responses from other professional groups e.g., Medical, with most responses obtained from staff >36 years of age and from staff currently based at Glangwili Hospital.





Based on responses received, survey findings indicate that:

- c.94% of individuals completing the survey currently drive their own vehicle to work, with c.55% (inc. those who selected 'Other') of respondents suggested they may consider other travel arrangements i.e.., if public transport was improved,
- Most staff are willing to commute 20-30 minutes to work,
- Most staff own, and use, their own vehicle for work related purposes,
- c.58% of respondents would consider car sharing when travelling to work,
- Some of the individuals who would be unwilling to consider car sharing, provided the following reasons:

Section 6: Findings and Discussion

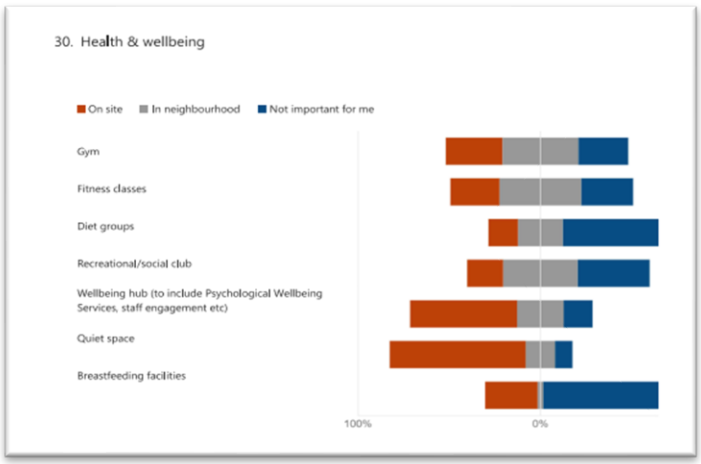
Consultation & Engagement; Staff Survey/Drop In Sessions

Staff Preferences: Neighbourhood, Amenities and Wellbeing

Staff were asked to share their views around what amenities in the neighbourhood in relation to health and wellbeing are important to them. Finding suggest the most important on-site facilities are:

- Quiet Space
- Wellbeing Hub
- Gym
- Breastfeeding Facilities
- Fitness Classes

Feedback also indicates increased preference for some amenities to be provided within the local neighbourhood e.g., Gym, Fitness Classes, Recreational/Social Club.

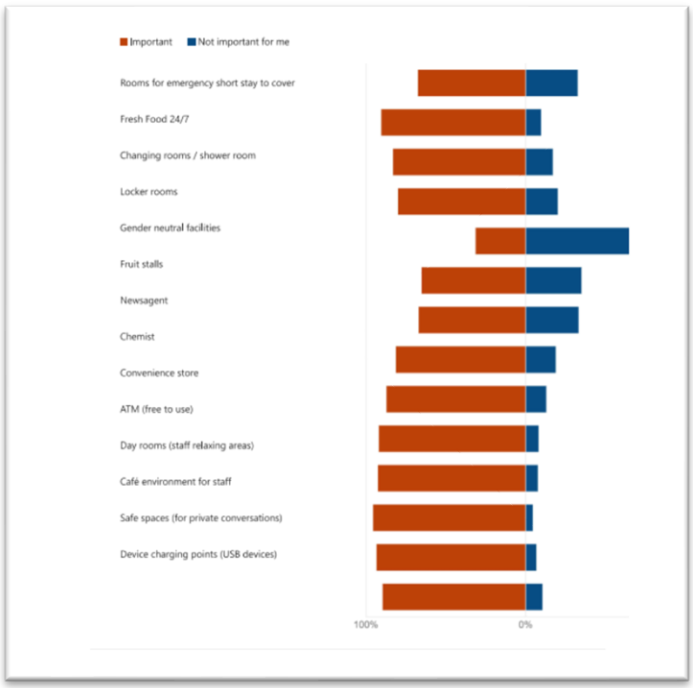


Questions in the survey also included a range of other amenities i.e., childcare facilities.

Staff Preferences: Hospital Site

A wide range of on site facilities were provided as options in the survey, to allow staff to share how important each of them were to them personally.

The graph (see right) provides a range of some of the options included in the survey. Feedback demonstrates that each of the 21 amenities listed in the survey are important to staff, and generally, most options were selected as important compared to not important.



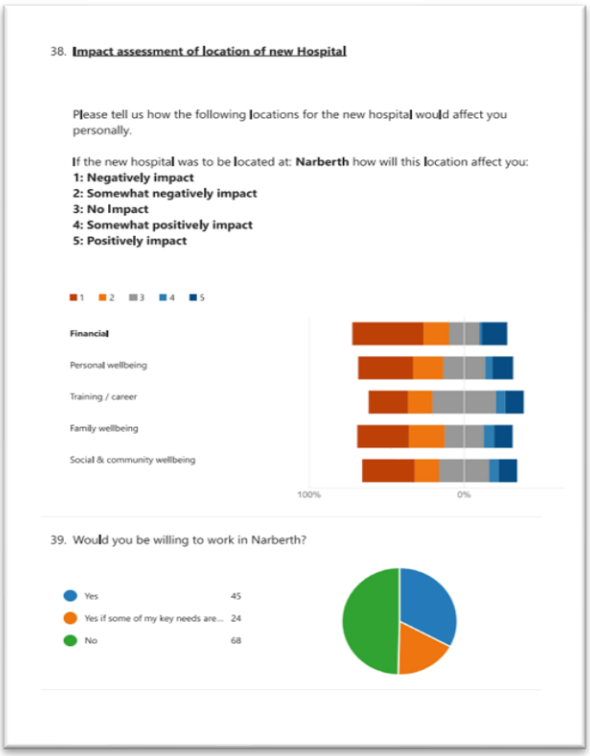
As well as the 21 options provided for selection, additional amenities were also provided by respondents, when asked to "add anything else you feel is important".
A snapshot of this feedback can be seen in the image (see bottom right).

Section 6: Findings and Discussion

Consultation & Engagement; Staff Survey/Drop In Sessions

Findings in relation to each of the zones

As part of the survey, an impact assessment to understand personal implications, was included.



Narberth

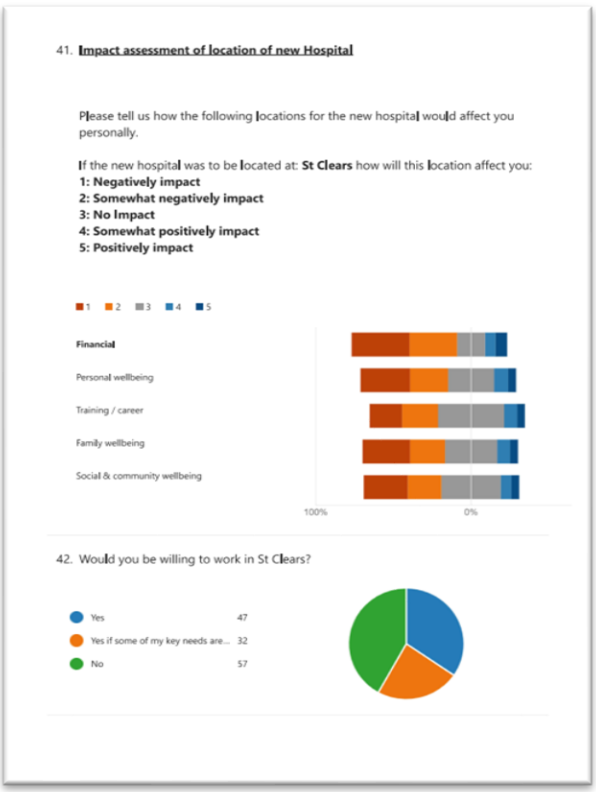
Survey findings indicate that if the new hospital was in Narberth, individuals feel the most negative impact will be financial.

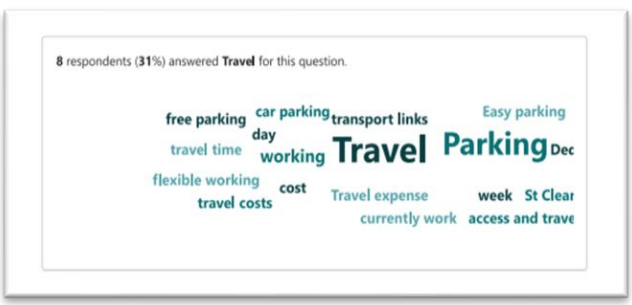
Results also demonstrate that c.49% respondents would be willing to work in Narberth (if some of key needs are met).
Responses in relation to key needs can be seen below:

St Clears

Survey findings indicate that if the new hospital was in St Clears, individuals feel the most negative impact relates to financial, closely followed by personal and family wellbeing.

Results also demonstrate that c.56% of respondents would be willing to work in St Clears (if some of key needs are met).
Responses in relation to key needs can be seen below:





Section 6: Findings and Discussion

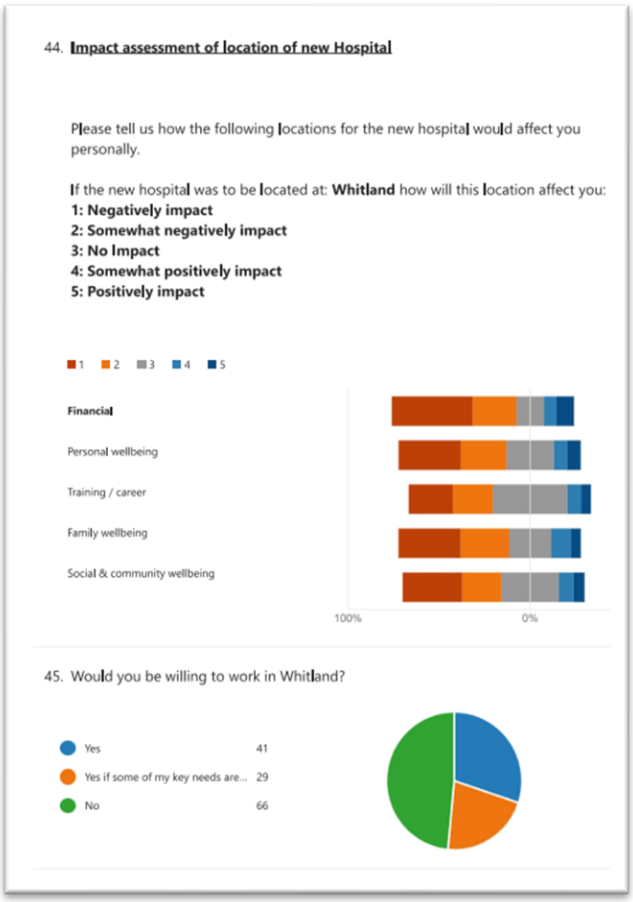
Consultation & Engagement; Staff Survey/Drop In Sessions

Findings in relation to each of the zones

Whitland

Survey findings indicate a broader range of opinion, although views shared suggest if the new hospital was in Whitland, individuals feel the most negative impact will be financial, albeit closely followed by impact on personal, family, social and community wellbeing.

Results demonstrate that c.50% respondents would be willing to work in Whitland (if some of key needs are met).
Responses in relation to key needs can be seen below:



Although those who completed the survey answered questions in detail and provided additional comments, it is not possible to draw conclusions from the survey responses due to:

- Overall response rate only represents c.1% of our total workforce,
- Inequal responses reflecting views of workforce across Carmarthenshire *and* Pembrokeshire (most respondents predominantly based at Glangwili),
- The survey does not articulate a range of views across all professional groups,
- Findings do not indicate a strong preference for a particular zone.

Therefore, we must now accept that although this exercise was beneficial, results remain inconclusive, and recommendations cannot be drawn from our findings. Further engagement is necessary, and it may be beneficial to explore a number of communication strategies e.g., targeted conversations with specific groups of staff i.e., our future workforce (apprentices etc), accompanied by informal discussions to gain further understanding of the views of all our staff.

Section 6: Findings and Discussion

Consultation & Engagement – Further Research- 20 Minute Neighbourhoods

What is a 20-minute Neighbourhood?
"Neighbourhoods are defined by the communities who live there" and "an important objective of the 20-minute neighbourhood concept is to better align spatial and urban planning (i.e., what is in an area) with transport planning (transport infrastructure), to make it easier for people to walk, cycle and use public transport" (Sustrans, 2022).

20-minute neighbourhoods seek to provide three basic amenities:

•A walkable environment,
•Destinations that support a range of daily needs (i.e., shops, jobs, parks, etc.),
•Residential density.

Features of a 20 minute Neighbourhood

Melbourne Plan 2017-2050
(Victoria State Government, 2017)

It is important that the organisation further explores this approach, as research indicates that there are interesting issues around transport/travel, workforce and local community that must be further explored for not only our workforce, but the entire current, and future, population of our Health Board.
When we consider the possible location of the new hospital, we must understand how it could contribute to provision of amenities, places and communities whereby our population can thrive, centred around delivering a high quality of life for all. Our approach to achieving this should be underpinned to ensure 20-minute neighbourhoods are designed to be equitable and that we seek to explore opportunities to adapt to benefit the local communities wherever possible.

The framework outlines the main features of a 20-minute neighbourhood. We have begun exploring some of these features through our staff engagement (survey), but it is now important that future planning for the new site considers the importance and associated benefits through a holistic lens, considering our workforce and local populations, to gain further understanding of the positive impact it could have in delivering our strategy to achieve "A Social Model of Health".

During our ongoing planning for the new hospital, we must also consider financial and environmental issues based around this concept, appreciating that many neighbourhoods are based around commuting by car. Whilst this may be considered acceptable for many, to promote greater inclusivity, equity and health benefits, further exploration and alignment to population needs is essential.

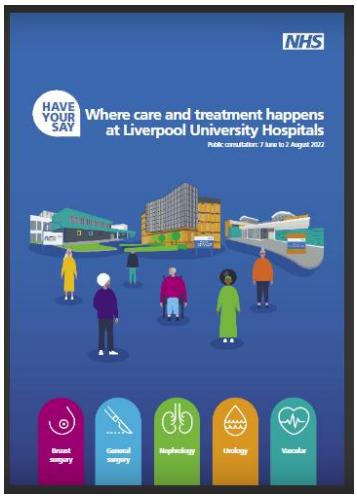
On review of the **Local Development Plans** for Pembrokeshire and Carmarthen the new build is identified. In both plans and in review of the local areas further work would be needed in consideration of the concept above and the local implications i.e., a need for affordable housing and education provision.
On review of the local amenities each zone has a similar spread i.e., 29-34 amenities in the area varying from grocery, schools, nursery and fuel stations.

Section 6: Findings and Discussion

Consultation & Engagement – Lessons from others

Liverpool University Hospitals – Royal Liverpool Experience

- Workforce planning is critical to support long terms critical clinical needs.
- Communication – especially the timing of information and consultation is critical – too soon or too late may be a value judgement, however, in terms of managing workforce expectations it is important to have clear messages potentially segmented by workforce groups i.e.
  - Careful management of on boarding of new recruits
  - Management of critical message to existing workforce.
- Useful to consider the concentration and co-location of research, industry and healthcare provision collaborating in health-related research and clinical trials, enabling Liverpool to become a centre of global excellence in biomedical sciences. This requires further exploration to truly understand lessons learned. A visit is being planned for September.



Your New Royal | Royal Liverpool Hospitals (rlbuht.nhs.uk)

Aneurin Bevan University Health Board - Grange Experience

- Staff consultation - Ensure continuous engagement with staff throughout the programme.
- Investment in OD resources to support the transformation.
- Requirements for dedicated support to aid and guide staff through the change process as they moved from one site to another.
- Ensuring clinical input to the pathway design and building design. Where services did not have much involvement issues had to be worked through.
- Ensure workforce plans developed with clearly identified risks i.e., changing workforce standards
- Ensure a detailed recruitment plan for any additional posts that are required.
- Having a planned approach to recruitment in the lead up to opening was key, selling the USPs of the new site allowed the Grange to recruit to 90% of the posts, many were hard to recruit posts.
- Ensuring that there is a robust timeline for the workforce plan to be developed and in place to manage the existing sites to avoid staff movement to the new site at the detriment of existing services.

Section 6: Findings and Discussion – Western Area (Narberth)

Accessible

Research, discussions and engagement around each of the zones in relation to our strategy: our strategy Accessible, Safe, Kind and Sustainable (ASKS) was undertaken as part of this work, a summary of main findings can be seen below.

Accessible: **Travel** **Transport Data** **Amenities** **Workforce** **Accessibility**	• **c. 94% of staff surveyed (139) currently drive to work.** • **c. 55% of respondents are willing to consider other travel arrangements. However, feedback suggests investment in improved public transport may influence willingness to use alternative modes of transport.** • **Of those surveyed, safe well-lit spaces and dedicated staff parking were the most important elements for the new site regardless of location followed by Subsidised travelling, walking paths and Electric Vehicle Charging Points.** • **Survey results revealed that the majority of staff are willing to travel a commute journey of 20-30 minutes to their work location.** • **Most important neighbourhood amenities for survey respondents in order of preference:** **1. Access to green space,** **2. Convenience stores,** **3. Cashpoint/bank,** **4. Post office and,** **5. Cafés, bars, restaurants.**

Safe

Safe: **Royal Colleges /Education Implications/ Terms and Conditions** **Safety**	• **Some of our Trainee Doctors currently residing outside of our Health Board (i.e., M4 corridor) may be impacted by relocation of acute services. Generally, their preference is to be within commutable distance (HEIW recommends home base between Cardiff and Swansea for Paediatric Trainees).** • **Sites further west may impact student placement opportunities and clinical activity. However, this may provide opportunity to review placement provision, with further emphasis on exploring placements in other settings, e.g., Primary Care, which will give students varied clinical exposure.** • **Students are already used to travelling between multiple locations, and providing adequate accommodation is available, placements further west could be managed appropriately. Feedback on current placement provision in HD is positive.**

Section 6: Findings and Discussion – Western Area (Narberth)

Kind

Kind : Positive & Negatives Workforce Health & Wellbeing	• Overall survey findings: Of the 139 responses, c.49% of staff would be willing to work within the Narberth zone (if key needs are met). • Highest number of survey responses from: Admin & Clerical Staff, Staff aged 46-50, Staff currently working in Carmarthenshire. • The majority of respondents noted a Wellbeing space, and a Quiet zone were the key on site facilities that would be important for them at the new site along with Green spaces.

Sustainable

Sustainable : Labour Market Analysis Workforce Sustainability	• Narberth has a population of 2,265. • Future workforce supply requested from Careers Wales for School Leavers Destination NHS Wales to inform further work. • A third (33.6%) of the current workforce across WGH and GGH acute sites are currently over the age of 51 with a greater proportion based at WGH (37%) therefore investment in our current workforce is imperative to ensure succession planning across all services. • Further exploration around social housing/local development plans is necessary to inform future planning.

Section 6: Findings and Discussion – Central Area (Whitland)

Accessible

Accessible: **Travel Transport** **Data** **Amenities** **Workforce** **Accessibility**	• c. 94% of staff surveyed (139) currently drive to work. • c. 55% of respondents are willing to consider other travel arrangements. However, feedback suggests investment in improved public transport may influence willingness to use alternative modes of transport. • Of those surveyed, safe well-lit spaces and dedicated staff parking where the most important elements for the new site regardless of location followed by Subsidised travelling, walking paths and Electric Vehicle Charging Points. • Survey results revealed that the majority of staff are willing to travel a commute journey of 20-30 minutes to their work location. • Most important neighbourhood amenities for survey respondents in order of preference: 1. Access to green space, 2. Convenience stores, 3. Cashpoint/bank, 4. Post office and, 5. Cafés, bars, restaurants.

Safe

Safe: **Royal Colleges /Education Implications/ Terms and Conditions** **Safety**	• Some of our Trainee Doctors currently residing outside of our Health Board (i.e., M4 corridor) may be impacted by relocation of acute services. Generally, their preference is to be within commutable distance (HEIW recommends home base between Cardiff and Swansea for Paediatric Trainees). • Sites further west may impact student placement opportunities and clinical activity. However, this may provide opportunity to review placement provision, with further emphasis on exploring placements in other settings, e.g., Primary Care, which will give students varied clinical exposure. • Students are already used to travelling between multiple locations, and providing adequate accommodation is available, placements further west could be managed appropriately. Feedback on current placement provision in HD is positive.

Section 6: Findings and Discussion – Central Area (Whitland)

Kind

Kind : Positive & Negatives Workforce Health & Wellbeing	• Overall survey findings: Of the 139 responses, c.50% of staff are willing to work within the Whitland zone. • Highest number of survey responses from: Admin & Clerical Staff, Staff aged 46-50, Staff currently working in Carmarthenshire. • The majority of respondents noted a wellbeing space, and a quiet zone were the key on site facilities that would be important for them at the new site along with Green spaces.

Sustainable

Sustainable : Labour Market Analysis Workforce Sustainability	• Future workforce supply requested from Careers Wales for School Leavers Destination NHS Wales to inform further work. • Whitland is the least densely populated site with a population of 1,792 (2011 Census) • A third (33.6%) of the current workforce across WGH and GGH acute sites are currently over the age of 51 with a greater proportion based at WGH (37%) therefore investment in our current workforce is imperative to ensure succession planning across all services. • Further exploration around social housing/local development plans is necessary to inform future planning.

Section 6: Findings and Discussion – Eastern Area (St Clears)

Accessible

Accessible : **Travel** **Transport Data** **Amenities** **Workforce** **Accessibility**	• c. 94% of staff surveyed (139) currently drive to work. • c. 55% of respondents are willing to consider other travel arrangements. However, feedback suggests investment in improved public transport may influence willingness to use alternative modes of transport. • Of those surveyed, safe well-lit spaces and dedicated staff parking where the most important elements for the new site regardless of location followed by Subsidised travelling, walking paths and Electric Vehicle Charging Points. • Located on the main A40 trunk road. • No train stop in St Clears presently however work began on 5th February 2022 to re-open St Clears Train Station. • Survey results revealed that the majority of staff are willing to travel a journey of 20-30 minutes to their work location. • Most important neighbourhood amenities for survey respondents in order of preference: 1. Access to green space, 2. Convenience stores, 3. Cashpoint/bank, 4. Post office and, 5. Cafés, bars, restaurants.

Safe

Safe: **Royal Colleges/ Education Implications/ Terms and Conditions** **Safety**	• Some of our Trainee Doctors currently residing outside of our Health Board (i.e., M4 corridor) may be impacted by relocation of acute services. Generally, their preference is to be within commutable distance (HEIW recommends home base between Cardiff and Swansea for Paediatric Trainees). • Sites further west may impact student placement opportunities and clinical activity. However, this may provide opportunity to review placement provision, with further emphasis on exploring placements in other settings, e.g., Primary Care, which will give students varied clinical exposure. • Students are already used to travelling between multiple locations, and providing adequate accommodation is available, placements further west could be managed appropriately. Feedback on current placement provision in HD is positive.

Section 6: Findings and Discussion – Eastern Area (St Clears)

Kind

Kind : Positive & Negatives Workforce Health & Wellbeing	• Overall survey findings: Of the 139 responses, c.56% of staff are willing to work within the St Clears zone. • Staff concerns for St Clears zone predominantly based around financial and wellbeing. • Highest number of survey responses from: Admin & Clerical Staff, Staff aged 46-50, Staff currently working in Carmarthenshire. • The majority of respondents noted a Wellbeing space, and a Quiet zone were the key on site facilities that would be important for them at the new site along with Green spaces.

Sustainable

Sustainable: Labour Market Analysis Workforce Sustainability	• Future workforce supply requested from Careers Wales for School Leavers Destination NHS Wales to inform further work. • St Clears is most densely populated site with 2,995 residents. (2011 census). • A third (33.6%) of the current workforce across WGH and GGH acute sites are currently over the age of 51 with a greater proportion based at WGH (37%) therefore investment in our current workforce is imperative to ensure succession planning across all services. • Further exploration around social housing/local development plans is necessary to inform future planning.

Section 6: Findings and Discussion

Summary of Impacts

Area	Zone 1 (Whitland)	Zone 2 (Narberth)	Zone 3 (St Clears)	Notes & Considerations
Workforce (Internal)	40-50 % general	40-50% general 65-68 % of WGH	40-50% general 65-68% of GGH	Risk: TRAMS/National Progs Based on estate assumptions. Retirement is not factored in
Travel Impact	Workforce Group – as per summary slide	Workforce Group – as per summary slide	Workforce Group – as per summary slide	Greatest impact: E&A as tied to largest sites/conurbations Possible mitigations.
Amenities	34 different types	32 different types	29 different types	Similar spread of amenities
Terms & Conditions	Similar	Similar	Similar	Paediatrics/On Call
Local Development Plans: Future Risks	Affordable Housing Schools/Education	Affordable Housing Schools/Education	Affordable Housing Schools/Education	Similar risks across all – will need LA view
General Risks	Mid-point	Further West	Furthest East:	The sites are placed between the largest conurbations of Carmarthen (13,000) and Haverfordwest (15,000)
Mitigations:	Accommodation Workforce Planning Community Hubs	Accommodation Workforce Planning Community Hubs	Accommodation Workforce Planning Community Hubs	Focus on employee experience, attraction, retention and development
Workforce Equality Impacts	Further work	Further work	Further work	Older workforce i.e., estates, ancillary

The summary above gives a snapshot of the zones, as reflected throughout the document; the position is “inconclusive” on any one zone or site.

Discussions have been reflective of a desire to “mitigate” implications. Llanelli as the largest and densest population base may have a more significant impact on workforce if considered, however is out of scope.

Service planning to align to workforce planning has been raised through different processes and groups. This is out of scope as information is not available at this time.

Limitations:

- Census 2021 data useful to give current assessment of population size and shape, however, further issues of the data will have greater detail on housing, employment, education,
- Staff Survey is limited as only has 139 responses and is not necessarily reflective of those who may be impacted on in WGH and GGH sites.

Section 6: Findings and Discussion

What else should the Board consider?

The following reflections are consistent with other groups discussions and are reflected here for completeness and contextualised with any specific points:

- The pathways around admission, treatment, rehabilitation and discharge are more important than the site of the new hospital: national and regional programmes of work do need to be considered in context of proposals as may impact on workforce planning, for example:
    - TRAMS programme,
    - Orthopaedics proposed programme,
    - ARCH related programmes – Pathology, Cancer, Stroke.

- The new hospital doesn't sit in isolation but is part of a hospital system with Bronglais and Prince Philip, the area selected for the new hospital will have an impact on services delivered in these three locations, therefore the workforce implications of this needs to be understood to appreciate any wider workforce considerations.

- Conversations need to take place with Swansea Bay about how models/pathways could work between the two health boards, particularly with initial admission and discharge.

- Stroke rehabilitation needs to be co-located with any centralised service or HASU as it would reduce patient outcomes if stepped down to an area without stroke consultant cover.

- Centralising of patients should also consider staffing resources to ensure that they are reflective as closely as possible to activity levels, especially if they are to increase.

- Wider planning around the new hospital site would need to be strongly managed by the Local Authority, health and wellbeing for example:

    - Capitalise on the concept of the 20-minute neighbourhood,

    - Affordable and flexible options for accommodation:
        - Site should consider accommodation for student trainees on placement and locum staff who do not live in our area,
        - To meet on-call responsibilities and other "emergency" scenarios that may happen,

    - Should look at providing gym or social facilities on the site to support existing staff, attract new staff and create a sense of community.

- Workforce planning is needed to understand the impact of all of the above on our workforce and mitigate consequences.

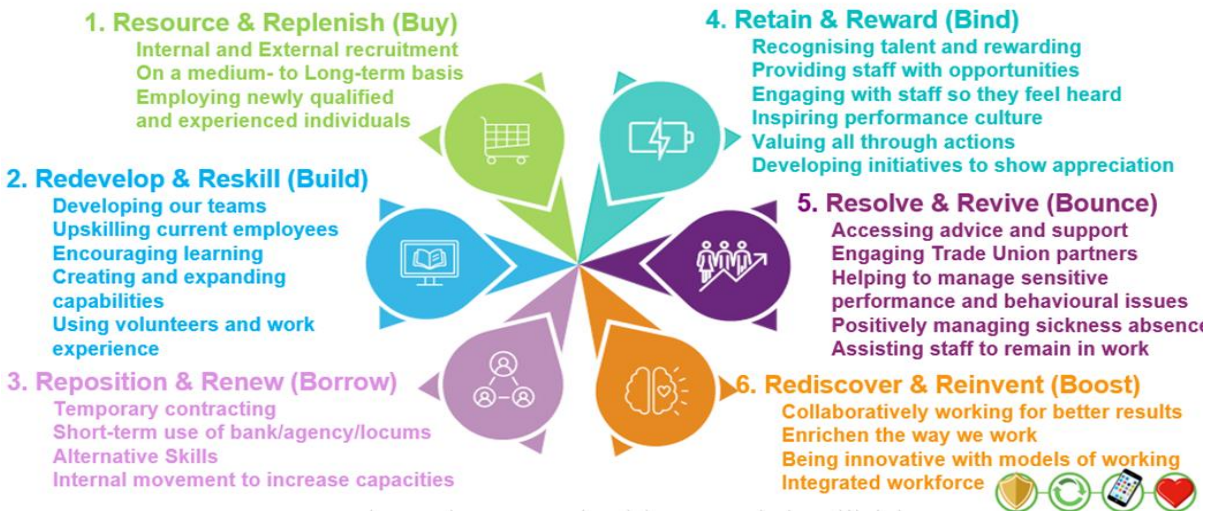
Section 7: Conclusions

In coming to these conclusion, this report highlights the key activities which took place, the processes and methodologies used; alongside, the data, modelling and professional standards cited; and goes further in exploring the discussions/arguments presented and the analysis undertaken. Detail around the themes and general discussion, interviews, focus groups and workshops have been summarised to ensure that they reflect the thoughts and feelings of attendees.

Recommendations have been made in relation to further work, that the Workforce Land Appraisal Group feel should be considered as part of the process for gaining insights from our workforce and developing further intelligence to inform future workforce planning activity within a framework of meeting population health needs and delivering social value.

This is currently being done on a "tactical" level with a view of enabling the Health Board to be in a position to carry out Strategic Workforce Planning. A framework has been developed to assist the Health Board reach this aim – the Workforce Regeneration Framework. It is a framework that sets out a broad variety of methods to be undertaken by various teams with the Workforce & Organisational Development Directorate in collaboration with other teams – such as Finance, and Operational Services. This is discussed in detail in the Workforce Technical document in the Integrated Medium Term Plan (IMTP) and a summary provided below.

Our workforce planning activity to date has allowed us to understand where our workforce risks are, providing us with opportunity to apply interventions within the Regeneration Framework.
Much of this work is based around review of service and workforce design, as well as understanding of clinical pathways now, and in the future, as development of our strategy continues. The Workforce Regeneration Framework and all associated work is a tool which will be utilised to mitigate the negative implications of workforce impacts and the opportunities that may be maximised. This will continue to develop and inform any critical skills challenges that may be identified now and into the future.



Section 7: Conclusions

The three critical areas within the Regeneration Framework which we have focused our efforts on are:

1.Retain & Reward (Bind)
2.Resource & Replenish (Buy)
3.Redevelop and reskill (Build).

Intervention around each of these elements has allowed us to review or current workforce baseline, incorporating our education plan and commissioning pipeline, as well as current and future initiatives i.e., Apprentice Academy, to project our potential workforce supply for the next ten years.
Further developments will be made as our position changes, recognising that the process is an iterative cycle which requires regular review and ongoing alignment with service and finance, in partnership with local authority and partner organisations e.g., Health Education Improvement Wales.
A summary of workforce planning interventions can be viewed (below), outlining our successes and the requirement for ongoing strategic workforce planning processes to achieve our workforce ambitions. Further activity will be undertaken in relation to all interventions in the Regeneration Framework (borrow, bounce and boost), as the programme of work for the new hospital develops.

- Aim to continue to reduce turnover rate e.g., by 1% now (this translates to approximately 100 people over 12 months), followed by 3% in an 18-month period.
- Focus will be on the Nursing workforce which would equate to approximately 25 WTE within a 12-month period.

- Align and seek greater understanding of our new graduate resourcing (via Streamlining) pipeline, to improve recruitment activity and retention e.g., to make Hywel Dda their first-choice employer.
- Increase recruitment activity, prioritising key areas, to deliver a secured supply, which includes continuation and expansion of overseas resourcing.
- Address the workforce gap we are faced with, using the education and commissioning cycle to ensure the Health Board “ask” is based on reality and delivery of strategic vision.

- Increasing our ‘Grow Our Own’ workforce. i.e., expansion of apprenticeship scheme, Band 4 Assistant Practitioners and part-time Nursing opportunities.
- Create a support system that recognises the pastoral needs of the future workforce pipeline.
- Develop our workforce in line with strategic vision, continually seeking to deliver education and commissioning requirements for current and future workforce.

Section 8: Recommendations for further work

To inform workforce planning further and to help clarify challenges and opportunities within the workforce the following suggestions have been made:

Data Analysis

- Further exploration of Census 2021 to inform workforce planning i.e. align to population health & labour market
- Further exploration of workforce aligned to service models and pathways (when available)
- Deeper analysis of critical and hard to fill roles
- Further analysis and alignment of education & commissioning to critical skill areas

Communication & Engagement

- Develop deeper understanding of issues and challenges in relation to good practice & lessons learned (Visit to Royal Liverpool planned)
- Review & implement lessons learned
- Develop communication & engagement strategy for workforce
- Further work with Swansea Bay University Health Board
- Further work with Local Authorities

Further research & scoping

- 20-minute neighbourhood
- Biophilic design

Section 9: Risk, Issues & Mitigations

Summary

A high-level summary of the issues and risks noted below. The issues that were identified are the underpinning elements of the overarching risk.

Risk	Group	Mitigations
Lack of detailed understanding of impacts on workforce groups & individuals	All staff groups, especially Estates & Ancillary may be impacted disproportionately Specific critical skilled roles	Continue to work to understand gaps in knowledge around service design and undertake targeted communications. Be clear on the message: the best medium used, the group affected and the potential impact on the group & potentially individuals

Issue	Consequence	Remedial Action/mitigations
Service pathways not yet defined	Unable to identify specific impacts on groups	Continue to work with planning & transformation teams to address gaps & clarify impacts
Lack of engagement of staff groups	Limited responses within survey & workshops	Continue to develop a communication and engagement strategy to inform all

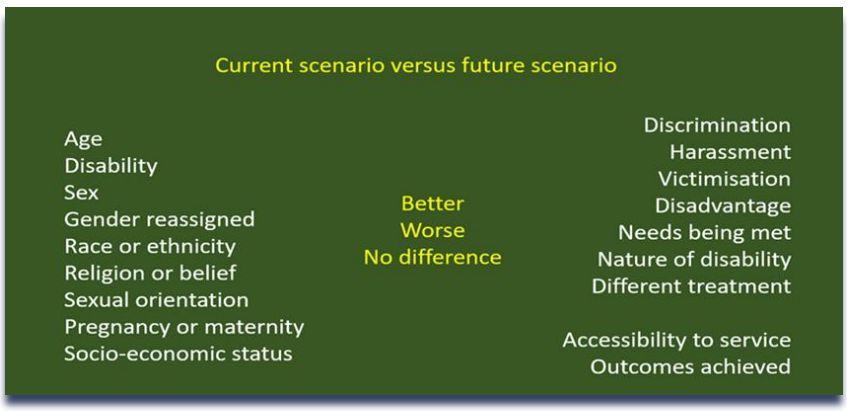
It is also important to consider wider corporate, communication and engagement risks associated with the Programme Business Case, which may impact our ability to achieve our ambition as this programme of work progresses.

Section 10: Equality Impact Assessment

Work to date:

The Equality and Health Impact Assessment (EHIA) that is being undertaken in support of 'A Healthier Mid and West Wales: Our Future Generations Living Well' Programme as a live document.
Link to EHIA undertaken for the PBC for ease is situated in the references.

Approximately 40-50% of our total workforce will be impacted in some way, positively or negatively, to a lesser or greater degree by the advent of a new hospital site in any of the 3 zones (Narberth, Whitland and St Clears).
Approximately 65-68% of our workforce based at WGH and GGH may be impacted in some way, due to the placement of a new hospital site in any of the 3 zones (Narberth, Whitland and St Clears). This figure may reduce due to retirement.
At this juncture it is difficult to be specific on individual groups, we have been able to identify themes that would need exploration as the future scenario becomes clearer.



Groups potentially impacted:

- Specific workforce groups i.e. estates and ancillary, medical and some specific healthcare professionals may be required to travel farther,
- Age related; those closer to retirement in lower salary bands may be impacted negatively,
- Possible gender and other protected characteristics in so far as it may impact on current life choices (i.e., parents with young children not able to travel farther due to childcare arrangements; and similarly, others with caring responsibilities).

This should be mitigated through workforce planning and collaboration; biophilic design is also being explored to support staff wellbeing in relation to the build itself.

Further sessions to be arranged, to review data sources based on this report.

Appendices

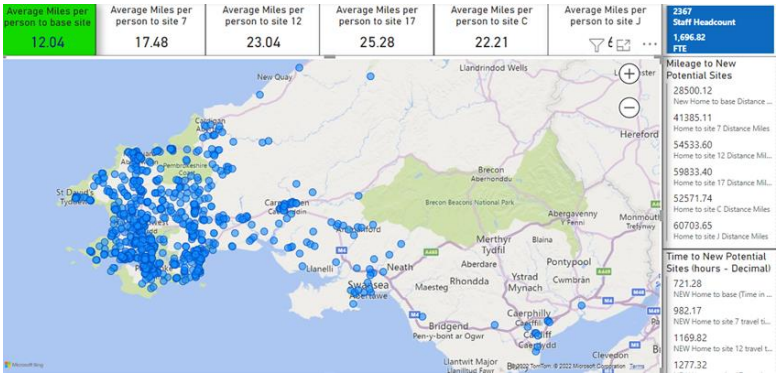
Contents

Appendix 1: Data & Modelling

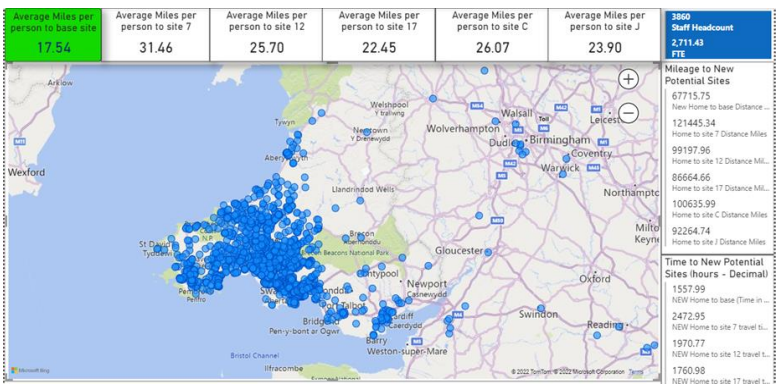
DATA

Data Sources: Extract from Hywel Dda's Electronic Staff Record (ESR) downloaded on the 10th March 2022 along with work undertaken by Transport for Wales to supply distance and travel times for staff to current base locations and proposed sites.
These data sources were input into Power BI to enable analyses and modelling scenarios for the workforce to be undertaken. Examples of the data are below. PDF of the analysis is available on request.

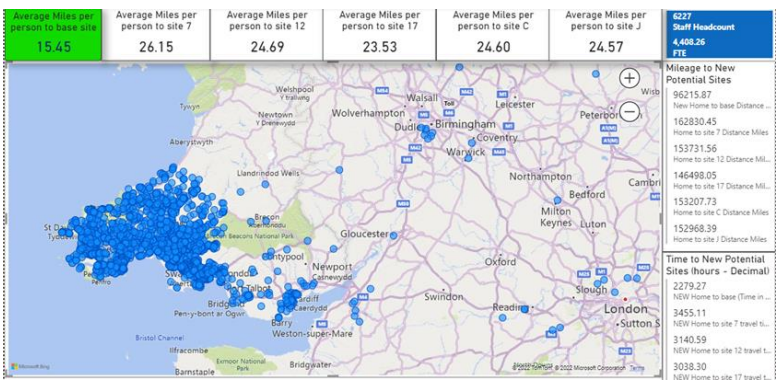
Example Image 1 – Current Staff home locations based at Withybush General hospital and average mile distance to WGH and 5 proposed sites



Example Image 2 - Current Staff home locations based at Glangwili General hospital and average mile distance to WGH and 5 proposed sites



Example Image 3 - Current Staff home locations based at Glangwili & Withybush General hospital and average mile distance to travelled to current base location and 5 proposed sites



Appendix 1: Data & Modelling

DATA

Figure 2: Population change between 2011 and 2021, local authorities in Wales

LA code	LA name	Usual resident population, 2011	Usual resident population, 2021	Percentage change
W06000001	Isle of Anglesey	69,751	68,900	-1.2
W06000002	Gwynedd	121,874	117,400	-3.7
W06000003	Conwy	115,228	114,800	-0.4
W06000004	Denbighshire	93,734	95,800	2.2
W06000005	Flintshire	152,506	155,000	1.6
W06000006	Wrexham	134,844	135,100	0.2
W06000008	Ceredigion	75,922	71,500	-5.8
W06000009	Pembrokeshire	122,439	123,400	0.8
W06000010	Carmarthenshire	183,777	187,900	2.2
W06000011	Swansea	239,023	238,500	-0.2
W06000012	Neath Port Talbot	139,812	142,300	1.8
W06000013	Bridgend	139,178	145,500	4.5
W06000014	Vale of Glamorgan	126,336	131,800	4.3
W06000015	Cardiff	346,090	362,400	4.7
W06000016	Rhondda Cynon Taf	234,410	237,700	1.4
W06000018	Caerphilly	178,806	175,900	-1.6
W06000019	Blaenau Gwent	69,814	66,900	-4.2
W06000020	Torfaen	91,075	92,300	1.3
W06000021	Monmouthshire	91,323	93,000	1.8
W06000022	Newport	145,736	159,600	9.5
W06000023	Powys	132,976	133,200	0.2
W06000024	Merthyr Tydfil	58,802	58,800	0.0

Source: Office for National Statistics – Census 2021

Census - Office for National Statistics (ons.gov.uk)

Appendix 1: Data & Modelling

DATA

Figure 3: The trend for population ageing has continued
Age and sex of the population, 2011 to 2021, Wales

Age	Males, 2011	Females, 2011	Males, 2021	Females, 2021
Aged 4 years and under	91,573	86,728	79,300	75,800
Aged 5 to 9 years	83,643	79,436	90,000	86,000
Aged 10 to 14 years	91,180	86,568	93,800	89,000
Aged 15 to 19 years	101,391	97,729	90,700	85,100
Aged 20 to 24 years	108,765	103,159	95,900	91,800
Aged 25 to 29 years	93,762	91,966	92,000	94,500
Aged 30 to 34 years	87,553	87,141	95,400	100,800
Aged 35 to 39 years	90,338	92,707	90,300	95,900
Aged 40 to 44 years	104,491	108,664	85,900	89,500
Aged 45 to 49 years	108,528	112,183	90,900	95,200
Aged 50 to 54 years	98,961	102,638	104,700	111,000
Aged 55 to 59 years	91,854	95,069	108,600	114,100
Aged 60 to 64 years	100,867	104,018	97,600	102,000
Aged 65 to 69 years	81,116	84,891	86,300	91,400
Aged 70 to 74 years	64,504	70,039	87,700	93,600
Aged 75 to 79 years	48,994	59,208	61,600	69,800
Aged 80 to 84 years	32,888	46,344	39,600	49,500
Aged 85 to 89 years	17,423	31,937	21,300	31,600
Aged 90 years and over	6,397	18,803	9,400	20,200

Source: Office for National Statistics – Census 2021

Census - Office for National Statistics (ons.gov.uk)

Appendix 3: Report

DATA

Figure 4: Age structure of the population, 2021, local authorities in Wales

Notes:
Figures are individually rounded to the nearest hundred. Figures may not add exactly due to this rounding.

LA code	LA name	All persons (number)	Aged under 15 years, 2021	Aged 15 to 64 years, 2021 (number)	Aged 65 years and over, 2021 (number)	Aged under 15 years, 2021	Aged 15 to 64 years, 2021 (percent)	Aged 65 years and over, 2021 (percent)
W06000001	Isle of Anglesey	68,900	11,100	39,600	18,200	16.1	57.5	26.4
W06000002	Gwynedd	117,400	18,000	71,900	27,300	15.3	61.2	23.3
W06000003	Conwy	114,800	17,200	66,300	31,400	15.0	57.8	27.4
W06000004	Denbighshire	95,800	15,800	56,400	23,800	16.5	58.9	24.8
W06000005	Flintshire	155,000	25,600	96,000	33,200	16.5	61.9	21.4
W06000006	Wrexham	135,100	23,300	84,400	27,300	17.2	62.5	20.2
W06000008	Ceredigion	71,500	9,400	43,700	18,400	13.1	61.1	25.7
W06000009	Pembrokeshire	123,400	19,400	71,500	32,200	15.7	57.9	26.1
W06000010	Carmarthenshire	187,900	30,400	112,100	45,400	16.2	59.7	24.2
W06000011	Swansea	238,500	38,100	151,500	48,900	16.0	63.5	20.5
W06000012	Neath Port Talbot	142,300	23,500	88,700	30,100	16.5	62.3	21.2
W06000013	Bridgend	145,500	24,300	91,100	30,200	16.7	62.6	20.8
W06000014	Vale of Glamorgan	131,800	23,100	79,900	28,800	17.5	60.6	21.9
W06000015	Cardiff	362,400	62,100	247,800	52,500	17.1	68.4	14.5
W06000016	Rhondda Cynon Taf	237,700	41,000	149,900	46,600	17.2	63.1	19.6
W06000018	Caerphilly	175,900	30,400	110,200	35,500	17.3	62.6	20.2
W06000019	Blaenau Gwent	66,900	11,000	42,300	13,600	16.4	63.2	20.3
W06000020	Torfaen	92,300	16,000	57,200	19,100	17.3	62.0	20.7
W06000021	Monmouthshire	93,000	13,800	55,200	24,000	14.8	59.4	25.8
W06000022	Newport	159,600	30,300	102,400	27,200	19.0	64.2	17.0
W06000023	Powys	133,200	19,200	76,800	37,000	14.4	57.7	27.8
W06000024	Merthyr Tydfil	58,800	10,600	37,100	11,100	18.0	63.1	18.9

Source: Office for National Statistics – Census 2021

Census - Office for National Statistics (ons.gov.uk)

Appendix 1: Data & Modelling

DATA

Figure 5: Population density, 2021 and changes since 2011, local authorities in Wales

Notes

1.Population density for 2021 has been calculated using population estimates rounded to the nearest hundred.

LA code	LA name	Population density (number of usual residents per square kilometre), 2011	Population density (number of usual residents per square kilometre), 2021	Percentage change
W06000001	Isle of Anglesey	98	97	-1.0
W06000002	Gwynedd	48	46	-4.2
W06000003	Conwy	102	102	0.0
W06000004	Denbighshire	112	114	1.8
W06000005	Flintshire	347	352	1.4
W06000006	Wrexham	268	268	0.0
W06000008	Ceredigion	43	40	-7.0
W06000009	Pembrokeshire	76	76	0.0
W06000010	Carmarthenshire	78	79	1.3
W06000011	Swansea	633	632	-0.2
W06000012	Neath Port Talbot	317	322	1.6
W06000013	Bridgend	555	580	4.5
W06000014	Vale of Glamorgan	382	398	4.2
W06000015	Cardiff	2456	2572	4.7
W06000016	Rhondda Cynon Taf	553	560	1.3
W06000018	Caerphilly	645	634	-1.7
W06000019	Blaenau Gwent	642	615	-4.2
W06000020	Torfaen	725	734	1.2
W06000021	Monmouthshire	108	110	1.9
W06000022	Newport	765	838	9.5
W06000023	Powys	26	26	0.0
W06000024	Merthyr Tydfil	528	528	0.0

Source: Office for National Statistics – Census 2021

Census - Office for National Statistics (ons.gov.uk)

Appendix 1: Data & Modelling

DATA

Figure 6: Changes in the number of households between 2011 and 2021, local authorities in Wales

LA code	LA name	Number of households with at least one usual resident, 2011	Number of households with at least one usual resident, 2021	Percentage change
W06000001	Isle of Anglesey	30,594	30,800	0.7
W06000002	Gwynedd	52,473	51,100	-2.6
W06000003	Conwy	51,177	52,200	2.0
W06000004	Denbighshire	40,546	42,400	4.6
W06000005	Flintshire	63,781	66,900	4.9
W06000006	Wrexham	57,029	57,900	1.5
W06000008	Ceredigion	31,562	30,900	-2.1
W06000009	Pembrokeshire	53,122	55,500	4.5
W06000010	Carmarthenshire	78,829	81,800	3.8
W06000011	Swansea	103,497	105,000	1.5
W06000012	Neath Port Talbot	60,393	62,400	3.3
W06000013	Bridgend	58,515	62,400	6.6
W06000014	Vale of Glamorgan	53,505	57,500	7.5
W06000015	Cardiff	142,557	147,300	3.3
W06000016	Rhondda Cynon Taf	99,663	103,300	3.6
W06000018	Caerphilly	74,479	76,300	2.4
W06000019	Blaenau Gwent	30,416	30,300	-0.4
W06000020	Torfaen	38,524	40,200	4.4
W06000021	Monmouthshire	38,233	40,900	7.0
W06000022	Newport	61,172	66,100	8.1
W06000023	Powys	58,345	60,200	3.2
W06000024	Merthyr Tydfil	24,264	25,800	6.3

Source: Office for National Statistics – Census 2021

DATA

Census - Office for National Statistics (ons.gov.uk)

Appendix 1: Data & Modelling

Data Sources: Extract from Hywel Dda's Electronic Staff Record (ESR)

USC	Budget	Actual	Vacancy	Maternity	%
BGH	427.5	327.6	99.9	14.3	23.38
GGH	823.1	637.7	185.3	18.6	22.52
PPH	590.7	476.3	114.4	12.2	19.37
WGH	607.8	490.8	117.0	11.3	19.25
	2,449.1	1,932.3	516.8	56.4	21.10

BGH USC	Values				
Row Labels	Budget	Actual	Vacancy	Maternity	Notional Cover
ADD PROF SCIENTIFIC AND TECHNICAL	3.0	3.0	0.0	0.0	0.0
ADDITIONAL CLINICAL SERVICES	116.4	115.1	1.3	5.6	1.3
ADMINISTRATIVE & CLERICAL	49.2	50.6	(1.4)	1.0	(1.4)
ALLIED HEALTH PROFESSIONALS	3.0	3.5	(0.5)	1.0	(0.5)
ESTATES AND ANCILLIARY	3.0	3.0	0.0	0.0	0.0
MEDICAL AND DENTAL	53.0	33.6	19.4	0.0	19.4
NURSING AND MIDWIFERY REGISTERED	200.0	118.8	81.1	6.7	81.1
Grand Total	427.5	327.6	99.9	14.3	99.9

GGH USC	Values				
Row Labels	Budget	Actual	Vacancy	Maternity	Notional Cover
ADD PROF SCIENTIFIC AND TECHNICAL	3.0		3.0		3.0
ADDITIONAL CLINICAL SERVICES	246.9	242.4	4.4	8.1	4.4
ADMINISTRATIVE & CLERICAL	69.6	70.9	(1.3)	1.0	(1.3)
ALLIED HEALTH PROFESSIONALS	7.2	5.8	1.3	0.0	1.3
ESTATES AND ANCILLIARY	0.0		0.0		0.0
HEALTHCARE SCIENTISTS	36.9	31.1	5.8	0.0	5.8
MEDICAL AND DENTAL	113.0	60.4	52.6	1.0	52.6
NURSING AND MIDWIFERY REGISTERED	346.5	227.0	119.4	8.5	119.4
STUDENTS	0.0		0.0		0.0
Grand Total	823.1	637.7	185.3	18.6	185.3

PPH USC	Values				
Row Labels	Budget	Actual	Vacancy	Maternity	Notional Cover
ADD PROF SCIENTIFIC AND TECHNICAL	2.0	1.0	1.0	0.0	1.0
ADDITIONAL CLINICAL SERVICES	189.4	175.4	14.0	4.6	14.0
ADMINISTRATIVE & CLERICAL	68.1	66.5	1.5	0.0	1.5
ALLIED HEALTH PROFESSIONALS	7.7	5.0	2.7	0.0	2.7
HEALTHCARE SCIENTISTS	3.0	4.4	(1.4)	0.0	(1.4)
MEDICAL AND DENTAL	69.3	30.1	39.2	0.0	39.2
NURSING AND MIDWIFERY REGISTERED	251.3	193.9	57.4	7.6	57.4
PAY BUDGET ADJUSTMENTS	0.0		0.0		0.0
Grand Total	590.7	476.3	114.4	12.2	114.4

WGH USC	Values				
Row Labels	Budget	Actual	Vacancy	Maternity	Notional Cover
ADD PROF SCIENTIFIC AND TECHNICAL	3.0	2.8	0.2	0.0	0.2
ADDITIONAL CLINICAL SERVICES	197.2	201.1	(3.9)	5.9	(3.9)
ADMINISTRATIVE & CLERICAL	50.0	54.9	(4.9)	0.0	(4.9)
ALLIED HEALTH PROFESSIONALS	3.0	3.0	0.0	0.0	0.0
MEDICAL AND DENTAL	78.7	51.1	27.6	1.0	27.6
NURSING AND MIDWIFERY REGISTERED	276.0	177.9	98.1	4.4	98.1
PAY BUDGET ADJUSTMENTS	0.0		0.0		0.0
Grand Total	607.8	490.8	117.0	11.3	117.0

Appendix 1: Data & Modelling

Data – Healthcare Apprentices

Recognising the increasing need to 'grow our own workforce', the Health Board is creating opportunities to provide additionality to the external supply of workforce. One avenue is through the Nurse Apprentice programme. The tables below demonstrate our current position.

HCA = Health Care Apprentice

Bronglais - Current Placements

2019 intake	
Leaver	No
Site	BGH
Intake	2019

Row Labels	Count of Site
HCA	3
Grand Total	**3**

2021 intake	
Leaver	No
Site	BGH
Intake	2021

Row Labels	Count of Site
Engineering (Plumbing)	1
HCA	7
Grand Total	**8**

TOTALS	
Leaver	No
Site	BGH
Intake	(All)

Row Labels	Count of Site
Engineering (Plumbing)	1
HCA	10
Grand Total	**11**

Glangwili - Current Placements

2019 intake	
Leaver	No
Site	GGH
Intake	2019

Row Labels	Count of Site
HCA	10
Physiotherapy	1
Patient Experience	1
Grand Total	**12**

2021 intake	
Leaver	No
Site	GGH
Intake	2021

Row Labels	Count of Site
Digital Services	3
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	12
Patient Experience (Customer Service)	2
Grand Total	**19**

TOTALS	
Leaver	No
Site	GGH
Intake	(All)

Row Labels	Count of Site
Digital Services	3
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	22
Patient Experience (Customer Service)	2
Physiotherapy	1
Patient Experience	1
Grand Total	**31**

Prince Phillip - Current Placements

2019 intake	
Leaver	No
Site	PPH
Intake	2019

Row Labels	Count of Site
HCA	8
Grand Total	**8**

2021 intake	
Leaver	No
Site	PPH
Intake	2021

Row Labels	Count of Site
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	10
Grand Total	**12**

TOTALS	
Leaver	No
Site	PPH
Intake	(All)

Row Labels	Count of Site
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	18
Grand Total	**20**

Withybush - Current Placements

2019 intake	
Leaver	No
Site	WGH
Intake	2019

Row Labels	Count of Site
HCA	8
Patient Experience	2
Grand Total	**10**

2021 intake	
Leaver	No
Site	WGH
Intake	2021

Row Labels	Count of Site
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	14
Patient Experience (Customer Service)	1
Patient Experience (Digital)	1
Grand Total	**18**

TOTALS	
Leaver	No
Site	WGH
Intake	(All)

Row Labels	Count of Site
Engineering (Electrical)	1
Engineering (Mechanical)	1
HCA	22
Patient Experience (Customer Service)	1
Patient Experience (Digital)	1
Patient Experience	2
Grand Total	**28**

Appendix 2: Specific Standards and Planning Guidance

Consultation & Engagement – Royal Colleges/Professional Body Research & Analysis (all groups)

"...a consultant would be able to choose (subject to relevant clinical governance considerations regarding being able to return to the appropriate site(s) within an acceptable period of time to respond to emergencies) an appropriate place to live. It is recognised that the old '10-mile limit' on how far away a consultant can live, is no longer appropriate – the time taken to be able to return to the relevant site(s)for emergency work purposes now being the necessary consideration"
Welsh Assembly Government NHS Wales (2005) National Consultant Contract. *National Consultant Contract (wales.nhs.uk)*

"the designated consultant is able to attend his/her base site within 30 minutes at all times" and that this should be governed by contractual arrangements and local policy.
The Royal College of Surgeons England. (2011) Emergency Surgery – Standards for Unscheduled Surgical
Care. *https://www.rcseng.ac.uk/rcs_emergency_surgery_2011_web.pdf*

"Be available either within the hospital or within a reasonable distance of the hospital to give advice throughout your duty period." And "Ensure that you are able to respond promptly to a call to attend to an emergency patient."
Royal College of Surgeons. (2014) Good Surgical Practice. *https://www.rcseng.ac.uk/rcs-_good-surgical-practice_guide.pdf*

While the National Contract does state that "Consultants will not normally be resident on call", it can be offered as a local service arrangement, as stated in the local Health Board principal statement of main terms and particulars of employment – "Given the particular nature of your work you are required to live in a location which is within reasonable travelling time from your place of work as agreed with your Clinical Lead/Service Manager".
Hywel Dda University Health Board Principal Statement of Main Terms and Particulars of Employment.

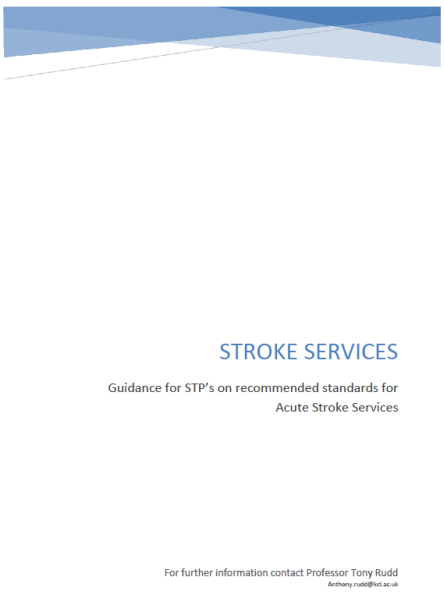
"Consultant or other autonomously practising anaesthetist support should be contactable at all times and have a response time for attendance on site of not more than half an hour to attend the delivery suite and maternity operating theatre".
The Royal College of Anaesthetics. (2020) Chapter 9. *Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2022 | The Royal College of Anaesthetists (rcoa.ac.uk)*

"The on-call EM consultant will be informed of any trauma call, and unless clearly not needed to attend within 30 minute" and "Out of hours Consultant anaesthetist within 30 minutes."
Hywel Dda University Health Board Major Trauma Policy.

Appendix 2: Specific Standards and Planning Guidance

The following documents were identified by the service as part of workshop one as being relevant and important to decision making.

Guidance for STP's on recommended standards for Acute Stroke Services

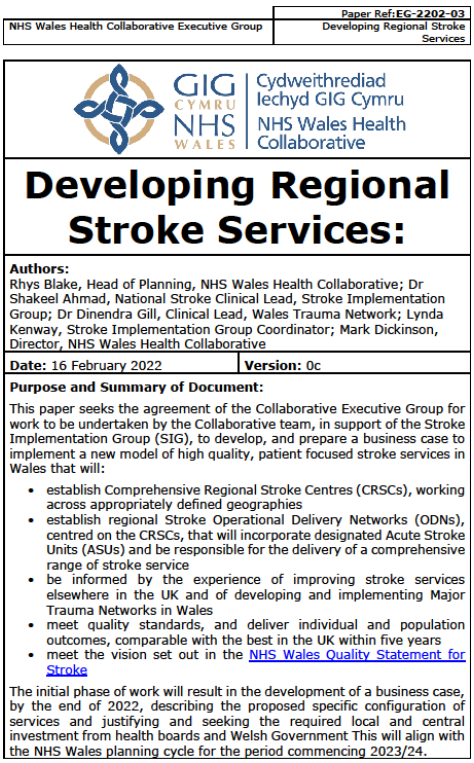


STROKE SERVICES

Guidance for STP's on recommended standards for Acute Stroke Services

For further information contact Professor Tony Rudd
Anthony.rudd@hcl.ac.uk

Developing Regional Stroke Services



NHS Wales Health Collaborative Executive Group	Paper Ref:EG-2202-03 Developing Regional Stroke Services

GIG CYMRU NHS WALES
Cydweithrediad Iechyd GIG Cymru
NHS Wales Health Collaborative

Developing Regional Stroke Services:

Authors:
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Purpose and Summary of Document:

This paper seeks the agreement of the Collaborative Executive Group for work to be undertaken by the Collaborative team, in support of the Stroke Implementation Group (SIG), to develop, and prepare a business case to implement a new model of high quality, patient focused stroke services in Wales that will:

- establish Comprehensive Regional Stroke Centres (CRSCs), working across appropriately defined geographies
- establish regional Stroke Operational Delivery Networks (ODNs), centred on the CRSCs, that will incorporate designated Acute Stroke Units (ASUs) and be responsible for the delivery of a comprehensive range of stroke service
- be informed by the experience of improving stroke services elsewhere in the UK and of developing and implementing Major Trauma Networks in Wales
- meet quality standards, and deliver individual and population outcomes, comparable with the best in the UK within five years
- meet the vision set out in the NHS Wales Quality Statement for Stroke

The initial phase of work will result in the development of a business case, by the end of 2022, describing the proposed specific configuration of services and justifying and seeking the required local and central investment from health boards and Welsh Government This will align with the NHS Wales planning cycle for the period commencing 2023/24.

Table 2.1 Recommended staffing levels for stroke units

	Physio-therapist	Occupational therapist	Speech and language therapist	Clinical neuro-psychologist/ clinical psychologist	Dietitian	Nurse	Consultant stroke physician
	Whole-time equivalent (WTE) per 5 beds					WTE per bed	
Hyperacute Stroke Unit	0.73	0.68	0.34	0.20	0.15	2.9 (80:20 registered: unregistered)	24/7 availability; minimum 6 thrombolysis trained physicians on rota
Acute Stroke Unit	0.84	0.81	0.40	0.20	0.15	1.35 (65:35 registered: unregistered)	Consultant-led ward round 5 days/week

Royal College of Physicians. (2016). National Clinical Guideline for Stroke. Accessible via: https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

Appendix 2: Specific Standards and Planning Guidance

The following documents were identified by the service as part of workshop one as being relevant and important to decision making.

Paediatrics

- A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.
- Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.
- At least two medical handovers every 24 hours are led by a consultant paediatrician.
- All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.
- Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

Royal College of Paediatrics and Children's Healthcare. (n.d.) Facing The Future – Standards for Acute Paediatric Services. *Facing the Future - standards for acute general paediatric services | RCPCH*

General - BMA

- Appropriate facilities and common room arrangements MUST be in place
- Appropriate rostering and rota design MUST be in place for sufficient rest and study.

British Medical Association. (March 2020) Wales Fatigue and Facilities Charter. *wales-fatigue-and-facilities-charter-march-2020.pdf (bma.org.uk)*

Staffing Guidelines

Consultant-led care, without an immediate consultant presence in the emergency department and acute medical unit (AMU) but with consultant-led post-take ward rounds: To assess 10 patients satisfactorily requires:

Tier 1 time – 15 hours Tier 2 time – 9.5 hours

Tier 3 time – 4.25 hours

Partly consultant-delivered care, with consultant presence and early involvement in the emergency department and AMU

To assess 10 patients satisfactorily requires:

Tier 1 time – 15 hours Tier 2 time – 7 hours

Tier 3 time – 6.5 hours.

Royal College of Physicians. (2018) Medical Safe Staffing. Available at: https://www.rcplondon.ac.uk/file/10368/download

Appendix 3: References

General Medical Council (2021) The state of medical education and practice in the UK. Accessible via: The state of medical education and practice in the UK 2021 (gmc-uk.org)

General Medical Council (2021) National Training Surveys Reports. Accessible via: National training surveys reports - GMC (gmc-uk.org)

Royal College of Surgeons. (2014, p8) Good Surgical Practice. Accessible via: https://www.rcseng.ac.uk/rcs-_good-surgical-practice_guide.pdf

The Royal College of Surgeons England. (2011) Emergency Surgery – Standards for Unscheduled Surgical Care. Accessible via: https://www.rcseng.ac.uk/rcs_emergency_surgery_2011_web.pdf

Welsh Assembly Government NHS Wales (2005) National Consultant Contract. Accessible via: National Consultant Contract (wales.nhs.uk)

British Medical Association. (2020) Wale Fatigue and Facilities Charter. Accessible via: wales-fatigue-and-facilities-charter-march-2020.pdf (bma.org.uk)

Royal College of Physicians. (2016). National Clinical Guideline for Stroke. Accessible via: https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

Royal College of Midwives. (2016) Working with Birthrate Plus. Accessible via: working-with-birthrate-plus.pdf (rcm.org.uk)

Royal College of Paediatrics and Children's Healthcare. (n.d.) Facing The Future - Standards for Acute Paediatric Services. Accessible via: Facing the Future - standards for acute general paediatric services | RCPCH

Royal College of Physicians. (2018) Medical Safe Staffing. Accessible via: https://www.rcplondon.ac.uk/file/10368/download

Appendix 3: References/weblinks

Median house prices for administrative geographies: HPSSA dataset 9 - Office for National Statistics (ons.gov.uk)

Census 2021 results - Census 2021

What is a 20-minute neighbourhood? - Sustrans.org.uk

Plan Melbourne - 20-minute neighbourhoods pilot program

20-minute neighbourhoods (planning.vic.gov.au)

Your New Royal | Royal Liverpool Hospitals (rlbuht.nhs.uk)

https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-27-january-2022/agenda-and-papers-27-january-2022/appendix-5-equalities-and-health-impact-assessment-pdf/