Together for Health: South Wales Programme

Matching the best in the world

Challenges facing hospital services in South Wales

September 2012
Summary

This paper sets out a range of issues that point to the need to change the way some hospital services are organised. These issues have been developed in discussion with clinical staff through the South Wales Programme. They have been prompted by the Welsh Government policy document *Together for Health*.

The policy sets the ambition that people in Wales should have access to health services that match the best in the world and are provided in ways that suit the particular circumstances of Wales. This ambition cannot be achieved if services stay as they are. Health boards need to change especially if they are to get the best outcomes for people with the most serious health needs.

This paper describes the work of the Programme and the limited range of specialist hospital services it has within its remit:

- women in pregnancy and childbirth
- newborn babies, infants and children
- people who are injured in accidents or need specialist medical help in an emergency
- people who need emergency ambulance and paramedic services

In these services there are pressures on staffing and concerns about maintaining quality and safety of care. Health boards agree that they need to work together more collaboratively to get the best pattern of services to meet people’s needs from all parts of South Wales.

This paper describes the kinds of evidence and guidance that have formed part of a series of discussions with clinical staff – doctors, nurses, midwives and therapists and senior officers of health boards. Around 300 clinical staff from across South Wales and representatives of health boards were involved in these discussions. Community Health Council (CHC) representatives contributed to these discussions and CHC leaders have continued to be involved in shaping the arrangements for the engagement process.

It reports two important themes concerning the way care is provided to the small number of patients with the most serious health needs:

- Patients who are unwell will have better care and better outcomes if health boards change the way hospitals work so that they offer consistent good care seven days a week
- Patients who are unwell will have better care and better outcomes if more of the medical care is provided by the most experienced doctors - consultants and very senior doctors coming to the end of their specialist training

It describes the conclusions that have emerged from these clinically-led discussions. The professional advice is that:
• Antenatal services (including community midwifery), paediatric assessment services and accident and emergency services should continue in all the communities that currently have them. The way these services are provided will need to change to reflect changes in medical, nursing and midwife staffing.

• For the most unwell patients inpatient services should be concentrated in four or five centres providing 24/7 consultant-led services for obstetrics, level two (high dependency) neonatal services, paediatrics and accident and emergency services.

• There should be two or three level three (intensive care) neonatal services.

• There should be one inpatient tertiary paediatric service and paediatric intensive care unit.

• There should be one trauma centre either as a single site service or as a collaborative across two sites – University Hospital of Wales (UHW) and Morriston hospital.

It describes the scenarios that might flow from concentrating some inpatient services in four or five centres. It is not yet clear what the right number of centres should be, but it is clear that these services should be concentrated in fewer centres. It is also clear that there are very important links between the services that require a common approach.

The report invites comments through local health board engagement discussions and an online questionnaire will be available on health board websites.
Introduction

In November 2011, the Minister for Health and Social Services published the policy document *Together for Health: A 5 Year Vision for the NHS in Wales*. This document set out a vision for healthcare in Wales that challenged the NHS and the communities it serves to aspire to match the standards of the best in the world and to aim at achieving excellence everywhere. The policy described the important challenges that NHS Wales faces now and in the years to come:

- Health has improved but not for everyone and our population is ageing
- Healthcare quality has improved but the NHS can do even better
- Expectations are continually rising
- Medical staffing is becoming a real limitation on our services
- Funding is limited

The policy recognises that as health boards respond to these challenges “...the status quo is not an option.”

The policy requires health boards to take action on a number of issues. One of these actions is that “Every local health board will, within a year, set out its plan for creating sustainable services for all communities”. Sustainable health services have a number of characteristics that need to be considered together. For health boards sustainability means services that:

- keep people safe
- offer care that respects everyone’s dignity
- can be used by all the community
- offer effective treatments
- follow guidance on good practice
- support recruitment, training and retention of staff
- are adaptable to changing needs
- are affordable and give good value for money

Health boards know that there have already been significant medical staffing and recruitment problems in some services across South Wales, which have been supported by interim and temporary arrangements. These arrangements allow services to continue but they are not ideal. They are vulnerable to short term changes in the availability of locum and agency medical staff; they can be disruptive to team working and continuity of care and are usually not good value for money.

**Together for Health: South Wales Programme**

The South Wales Programme was set up in January 2012 and is due to finish its work in April 2013. It has a small team of staff and draws on the knowledge and expertise of clinical staff and managers working for the health boards. The main aim of the Programme is to help health boards ensure that when they prepare their plans for the Minister for Health and
Social Services this autumn, they have a shared view about how to create a sustainable pattern of services for future generations across South Wales.

The Programme does not cover all health services; it is limited to some specialist hospital services where the health boards know that they need to share plans to get the best answers for people in South Wales as a whole.

The Programme is focused on specialist hospital services for:

- women in pregnancy and childbirth
- newborn babies, infants and children
- people who are injured in accidents or need specialist medical help in an emergency
- people who need emergency ambulance and paramedic services

The Programme involves all six health boards though it is focused on the main hospitals in four Boards; Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale and Cwm Taf. Hywel Dda has produced a plan for its community including its main hospitals, reflecting the much more rural character of its area. The Powys plan reflects on the range of services used by its residents at main hospitals in North and South Wales and neighbouring counties of England.

As part of the response to Together for Health, each health board needs to have a plan for all the services it provides to people living in its area. They will include:

- plans for developing and extending local primary and community health services such as family doctors and community nurses
- plans for community and general hospital services
- plans to ensure close working with other public services such as social services

Some health boards have already developed plans with their local populations that cover many of the challenges posed by Together for Health. Other health boards will be launching broader local service consultations. Each health board plan will include the shared plans for the services that the South Wales Programme has been considering.

The Programme is following a five stage process:

1. Review advice, guidance and evidence about how services should be organised to produce the safest and best care for patients
2. Test this advice guidance and evidence with doctors, nurses, midwives and therapists who currently provide care for people in South Wales (CHC representatives are included in this process to ensure that community views are taken into account in the clinical conversations)
3. Summarise the emerging findings for public discussion – usually known as public engagement
4. Reflect on the themes emerging from the public engagement discussion
5. Produce proposals for public consultation
Each health board will lead the public engagement activities in its own area. After they have considered what they have heard in the engagement process, the health boards will decide what proposals should be published for formal public consultation early next year. Health boards are following the Welsh Government’s guidance on public engagement and public consultation.

The Programme has gathered information about services and the needs of people who use them and looked at advice and guidance about the best ways of organising care. This has included looking at Welsh Government policies such as Setting the Direction and Together for Health. The Programme follows the policy particularly on the question of where care should be provided. Together for Health puts it like this; “The right place for care is dependent upon need. Whilst care should normally be provided as close to home as possible, specialist skills may need to be centralised and staffed accordingly”. The Programme strongly supports this approach.

It has reviewed the advice of professional bodies such as medical, nursing and midwifery Royal Colleges. It has also looked at advice from Welsh and British bodies concerned with effectiveness and efficiency of public services such as the recent National Audit Office report Healthcare across the UK: A comparison of the NHS in England Scotland Wales and Northern Ireland and the Wales Audit Office report Health Finances published in July 2012. It has considered the findings set out in the recent Welsh Institute for Health and Social Care document The Best Configuration of Hospital Services for Wales: A Review of the Evidence.

It has looked at the changing demography of South Wales using population projections produced by Welsh Government in association with the Office for National Statistics.

Hearing from Doctors, Midwives, Nurses and Therapists

The South Wales Programme called for a new approach to working with the professional staff who provide health care for patients day by day in hospitals and communities across South Wales. Health boards organised a series of conferences and summits in May and June to bring people together and discuss how the advice, guidance and evidence about what makes for safe and sustainable care matched with their direct experience of working to provide the best care for their patients.

Representatives of doctors, midwives, nurses and therapists from all the main hospitals were invited together with representatives of general practitioners. They were joined by representatives of community health councils and senior staff from health boards. Over 300 people were involved in these events, many of them in two or three events. This has never been done on this scale before and the health boards have benefitted from the professional approach that was taken and the openness and frankness of the discussions that took place.

In the conferences and summits, there was careful consideration what was needed to meet the aspiration of world class care for all in each of the services. Two very significant common themes ran through the discussions about how to improve care for the small number of patients with the most serious health needs:
• Patients who are very unwell will have better care and better outcomes if health boards change the way hospitals work so that they are able to offer consistently good care seven days a week

• Patients who are very unwell will have better care and better outcomes if more of the medical care is provided by the most experienced doctors - consultants and very senior doctors coming to the end of their specialist training

These are significant themes because they signal an important change in thinking about how hospitals can improve the safety and quality of care they offer. The traditional model of running hospitals has more experienced medical staff on duty during the ordinary working week and fewer staff with a greater reliance on doctors in training at weekends. Traditionally, the range of diagnostic and assessment services has also been more readily available during the ordinary working week than at weekends. This way of working has been acceptable in the past but there are serious questions about whether it is right for the future.

Evidence is beginning to build up that suggests this way of running hospitals is not as good for patients as it could be because they have less good care and outcomes if they are admitted to a hospital in an emergency at weekends. Outcomes include whether people recover as well as they might and, for serious conditions, whether people survive or not.

In many parts of Britain, opinions are changing within the professions about the need to improve the quality and safety of care by having more experienced staff available over the whole of the week. The discussion with clinical professionals across South Wales highlights the need to make these kinds of changes in our hospitals so health boards can serve mothers and babies, children and young people and people with serious injuries as well as they should.

As well as looking at common themes, the clinical conferences and summits looked at services in more detail and the emerging findings from those discussions are set out in the next three sections of this paper.

**Obstetric services**

Obstetrics is the branch of medicine that looks after women in pregnancy and childbirth. Most women are supported by midwives and have their babies without needing specialist medical attention. About a third of women need specialist medical attention in childbirth. The most common reason is that the baby needs to be delivered by caesarean section.

Each year in South Wales:

• University Hospital of Wales Cardiff has around 6,200 births
• Royal Gwent Hospital Newport and Singleton Hospital Swansea both have around 3,450 births
• Royal Glamorgan Hospital Llantrisant and Princess of Wales Hospital Bridgend both have around 2,400 births
• Nevill Hall Hospital Abergavenny has around 2,100 births
• Prince Charles Hospital Merthyr Tydfil has around 1,750 births

Concerns about the quality and safety of care around the time of birth, led four professional organisations to work together to publish a joint report *Safer Childbirth*. This report set out minimum standards for improving care. It was published in 2007 by the Royal Colleges of anaesthetists, midwives, obstetricians and gynaecologists and paediatrics and child health. These standards cover many aspects of care around the time of childbirth. In particular it called for:

• consultant obstetricians to be available in labour wards over more hours each week
• round the clock support from anaesthetists and paediatricians

Standards for training recommend that hospitals that train obstetricians should have at least 2500 births so that the doctors in training have a full range of experience.

Welsh Government published its document *A Strategic Vision for Maternity Services in Wales* in 2011. This looked at all aspects of care and advice for women in connection with pregnancy, childbirth and infant care and nutrition. It recognised that a great deal had been done to improve services and that as people’s needs changed so services would continue to change particularly to ensure that all women were able to benefit from good quality care and advice.

The advice from obstetricians and midwives who contributed to the clinical conferences and summits is that health boards should reshape services to follow the professional standards and guidance. This means keeping antenatal and community based services mainly as they are now, and changing some hospital services. To be specific it means:

• Keeping the current pattern of local antenatal and community midwifery services to make sure women continue to have good access to advice and support
• Continuing to offer the options of birth at home or birth in midwife led units – local units staffed by midwives
• Concentrate obstetric services in four or five units

**Paediatric and neonatal services**

Paediatrics and neonatology are the branches of medicine that look after children and newborn babies. Most children are looked after at or near home by general practitioners and their staff and by community staff including health visitors. Children with long-term health needs such as help with disability also have support from community specialist paediatricians and specialist nurses and therapists.

Hospital paediatric services specialise in assessing and treating children who have acute illness. Most of these children are seen and return home on the same day. They also support children who are admitted to hospital for surgery.
Hospital services for newborn babies concentrate on babies who are born early and on babies who have health problems that require specialist support such as help with breathing. These babies require round the clock care and often their stay in hospital is for weeks rather than days.

Neonatal care has different levels to match the needs of the babies. Babies with the most complex health needs receive level three care which is sometimes called neonatal intensive care. Often these will be very premature babies. Those with less complex needs receive level two care which is sometimes called neonatal high dependency care. Babies with less complex needs may receive level one care which is usually called special care and is often provided as part of the paediatric service.

Level three services are currently provided at Royal Gwent Hospital, Singleton Hospital and UHW. Level two services are provided at these hospitals and at Nevill Hall, Royal Glamorgan, Prince Charles and Princess of Wales. Paediatric assessment treatment and inpatient services are provided at Morriston and at all these hospitals other than Singleton.

Each year in South Wales, the number of hospital paediatric inpatient emergency admissions is as follows:

- UHW has around 4,600 admissions
- Royal Gwent has around 2,650 admissions
- Royal Glamorgan has around 2,000 admissions
- Princess of Wales has around 1,850 admissions
- Morriston and Prince Charles both have around 1,700 admissions
- Nevill Hall has around 1,350 admissions

The Royal College of Paediatrics and Child Health published a report *Facing the Future* in 2011. This sets standards recommended for paediatric departments in hospitals. It encourages health boards to ensure that children are promptly assessed and are seen by a doctor with specialist training within four hours of arrival at hospital. For those children who stay overnight, the recommendation is that they are seen at least once every 24 hours by a consultant or someone with equivalent specialist skills and training. It is recommended that all hospitals that have short stay paediatric assessment units should have access to a consultant paediatrician during all the hours they are open. It is recommended that specialist training for paediatrics should be based in hospitals that have at least 4,000 patients each year.

The British Association of Perinatal Medicine has published service standards for hospitals providing neonatal care. The third edition was published in August 2010. This sets out recommended standards for medical and nursing staff for each of the levels of neonatal care. This encourages health boards to ensure there are separate rotas of consultants for level two and level three care and that neonatal care is provided by doctors with specialist training in neonatology.
This means that consultant neonatology staffing is separate from consultant paediatric staffing and that paediatrics and neonatology need separate rotas of doctors in specialist training. In practice these recommendations will make it extremely difficult to avoid concentrating the inpatient paediatric and neonatal services in fewer hospitals. It is also highly likely to mean that choices will have to be made between the number of level three neonatal centres and the number of paediatric units as it seems very unlikely that there will be enough medical staff to support three level three neonatal centres and five paediatric inpatient units.

The advice from paediatricians and neonologists who contributed to the clinical conferences and summits is that health boards should reshape services to follow the professional standards and guidance. This means keeping local specialist assessment and treatment services for children which are the services used by the great majority of children and changing some hospital services for the small minority of children who need inpatient care. To be specific it means:

- Keeping local specialist paediatric assessment and treatment services for children in all the hospitals that currently provide these services
- Continuing to provide specialist advice and support for these local units
- Concentrating inpatient paediatric services in four or five units
- Concentrating level two neonatal services in four or five units
- Concentrating level three neonatal services in two or three units
- Maintaining a single tertiary paediatric service at UHW
- Maintaining a single paediatric intensive care unit at UHW

**Accident and Emergency Services**

Accident and emergency is the term used for a range of services provided to meet the needs of people who have been injured or who need specialist medical help in an emergency. Many people receive care and advice from general practitioners and out of hours medical services for these kinds of needs. Specialist services include assessment and treatment out of hospital by ambulance service paramedic practitioners and in hospital by specialists in emergency medicine and accident and emergency nurses and advanced nurse practitioners.

The range of specialist services available vary from hospital to hospital as does the way the services are provided. Some hospitals make more use of non-specialist doctors and some make more use of nurse practitioners. The range of supporting services also varies from hospital to hospital. As part of the engagement process, health boards are keen to work with local communities to develop a clearer way of describing the services that are provided at each hospital rather than relying only on the general label accident and emergency services.

As well as specialist accident and emergency services provided in main hospitals, there are other services such as minor injuries units in hospitals in various towns across South Wales. The Programme is focused only on the specialist services provided at main hospitals.
Trends in attendance at accident and emergency department have been rising in most hospitals in Wales by around 2% annually and this pattern is also seen in England. Currently in South Wales, hospital accident and emergency department activity is as follows;

- UHW has around 123,000 attendances
- Royal Gwent and Morriston both have around 85,000 attendances
- Royal Glamorgan and Princess of Wales both have around 61,000 attendances
- Prince Charles has around 55,000 attendances
- Nevill Hall has around 47,000 attendances

All of these attendances are significant to the individuals involved, but only a tiny proportion, typically fewer than 1 in 500 attendances are made up of people with the most serious injuries, that are usually called major trauma. The commonest causes of major trauma are road traffic accidents and falls so major trauma patients typically have head and or abdominal injuries and fractured bones.

Welsh hospitals have not collected data on the severity of trauma patients’ injuries in a standardised form so health boards have no consistent data for these services. Using estimates based on research on major trauma services in England by the National Audit Office in 2010, health boards should expect around 870 major trauma cases each year in South Wales and a further 1220 cases that are initially thought to be and treated as major trauma.

People with these most serious injuries are more likely to survive and to have better rehabilitation from their injuries if their care is provided by teams based in trauma centres that serve a region rather than being taken to the nearest hospital with an accident and emergency department.

The College of Emergency Medicine describes standards for accident and emergency departments which include 24 hour presence every day of doctors trained and experienced in emergency medicine with 24/7 access to a range of diagnostic facilities including x-ray ultrasound and CT (computerised tomography) scanning. In practice, if every department had consultant cover for say 16 hours each day this would require 10 consultants in each department. This is many more emergency medicine consultants than South Wales has currently. This is a service that has struggled to recruit and retain consultants and specialist doctors in training.

The advice from consultants in accident and emergency departments who contributed to the clinical conferences and summits is that South Wales should aim to match the Royal College of Medicine standards and that this would result in fewer consultant-led accident and emergency departments. There was a sense that health boards should avoid creating very large departments as efficiency might be difficult to maintain above 100,000 attendances. Health boards were advised that South Wales should consider carefully how to provide major trauma services and that the role of accident and emergency services that are not led by consultants should be clarified. In specific terms this means:
• Keeping a local presence for accident and emergency services and developing new ways of staffing the services that are not led by emergency medicine consultants
• Concentrating consultant-led accident and emergency services in three to six units across South Wales
• Considering whether trauma centre services should be provided in one centre or by two centres (Moorriston and UHW)

Reviewing the Professional Advice

The conclusions that had come from the clinical conferences and summits were considered on behalf of health boards by chief executives, medical directors and directors of planning. They agreed to accept all the conclusions with one variation. This concerned the advice about the number of accident and emergency departments. They decided to follow the same advice for the number of accident and emergency departments as the advice for the number of obstetric and paediatric departments.

Though there good professional arguments for concentrating services in three centres for South Wales, they were not convinced that it was necessary to consider reducing the number of accident and emergency departments to three. At the other end of the scale, there were two reasons why they did not endorse the advice that there might be six departments. From what health boards know about the current and future medical workforce, they did not believe it would be possible to staff six departments with the level of specialist trained staff that had been recommended. Also, they did not want to suggest that it would be acceptable to have an accident and emergency department in a hospital without a specialist paediatric service as this would not offer the right service to meet the needs of injured children.

The summary conclusion is that health boards should consider moving to a model where South Wales has four or five centres for specialist obstetric, neonatal, paediatric and accident and emergency services and that as soon as practicable these should be located on single hospital sites. This conclusion has been accepted by the South Wales Programme Board and commended to the South Wales health boards as the basis for public engagement.

Summary of Advice

The summary of advice for future services is that health boards should move to a model that retains good local access to outpatient and assessment services as people have it now and that specialist services should be concentrated in fewer centres so health boards can provide better staffed care round the clock, seven days a week.

The future pattern should be;

• Antenatal services, paediatric assessment services and accident and emergency services should continue in all the communities that currently have them. The way
these services are provided will need to change to reflect changes in medical, nursing and midwife staffing.

- Some inpatient services should be concentrated in four or five centres providing 24/7 consultant-led services for obstetrics, level two neonatal services, paediatrics and accident and emergency services
- There should two or three level three neonatal services
- There should one inpatient tertiary paediatric service and paediatric intensive care unit
- There should one trauma centre either as a single site service or as a collaborative across two sites – UHW and Morriston

Developing the Picture

With the advice from the clinical conferences and summits and the advice from health board leaders, the direction of change that is needed for South Wales hospitals to meet the challenges set out in Welsh Government’s Together for Health policy is clear. Health boards have not gone further yet to refine the details and turn them into precise options for consultation. That process will follow early next year as a formal part of consultation rather than this engagement stage where health boards are inviting early views. This detail will be shaped by two major streams of information and advice.

First, there is the advice that will come from engagement discussions carried out by each of the health boards over the next three months. Health boards have made no assumptions about the outcome of these discussions. Secondly, there is detailed work to be done during the engagement period to develop options that can be evaluated to see how they measure up against the sustainability criteria set out on page three of this document.

Work will be done to develop the local models of paediatric assessment services and accident and emergency services. Health boards will also look in detail at the consequences for ambulance services of these changes and of the development of a trauma centre service. Work has begun to gather data to support assessment of the potential flows and the transport consequences for the comparatively small number of patients whose care might be provided in a different hospital than at present. Work is also being done to gather data on staffing and costs of services in particular hospitals.

This preparatory work is essential though it cannot be completed until health boards have assessed the outcome of the engagement period. At this point health boards have not evaluated where the balance of advantage lies in the choice of four or five centres nor do they know whether both four and five centres meet the staffing, affordability and value for money elements of sustainability described on page one.

Possible scenarios for future hospital services

At this stage in discussions about the future pattern of hospital services, health boards are mainly interested in hearing views about the quality, safety, staffing and access factors that
are causing them to think about the need to change how services are delivered. Questions about what services will be provided at individual hospitals will be explored fully during the consultation stage early next year. Health boards thought it would be helpful at this point to describe the way thinking has developed so far, so that the possible practical consequences of change are shared openly.

It has been the pattern for some time that the main hospitals serving Cardiff and Swansea – University Hospital of Wales and University Hospital Llandough (UHW and UHL) and Morriston and Singleton have functioned as twin sites for their local communities and for wider regional services. Other than in relation to major trauma services, there has been no suggestion in the clinical discussions that the future of either of these regional centres should be reviewed. This suggests that whether four or five centres are right for the future, two of them will be Cardiff and Swansea.

In Aneurin Bevan Health Board, there has been an extensive engagement and consultation process that points to need to concentrate specialist services currently provided at Nevill Hall and Royal Gwent hospitals in a single specialist and critical care centre (SCCC). In April 2011, the then Minister for Health and Social Services gave approval for the development of a business case for a new hospital to be built at Llanfrechfa near Cwmbran. This is due to be submitted in December 2012.

It is clear that Cardiff, Llanfrechfa and Swansea are seen as fundamental parts of a sustainable hospital network for South Wales. The practical effect of these earlier decisions is that the advice about concentrating services in four or five centres has most impact on three hospitals, Prince Charles, Princess of Wales and Royal Glamorgan. It has impact also on Cardiff, Llanfrechfa and Swansea as the capacity of individual services will depend on the choices made about other centres because this will affect the flows of patients.

If at the end of the engagement process there is a clear sense that health boards should follow the advice about concentrating services, these are the likely scenarios that would need to be considered.

**Four centres**

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## Five centres

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Health boards have started to work through the implications of the choice between four or five centres. It is evident that the five centre model is likely to offer better access for some people compared to four centres. Health boards are checking whether both models are equally good at resolving the pressures they face about medical staffing and training and improving the consistency of services over the seven day week.

### Next steps

Each of the health boards will be engaging with the public, communities, stakeholders, local representatives and staff over the coming 12 weeks. In that time, Community Health Councils, consultative bodies and partner organisations will have important contributions to make. As well as hearing views and responses about the issues raised in this paper, health boards are keen to gather responses and have arranged the collection of public views through an online questionnaire which will be made available on health board websites from 26 September.