



CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Services Plan – Stroke Consultation
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning, Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Alex Martin, Principal Programme Manager, Rian Furlong, Project Manager, Nichola Couceiro, Head of Engagement, Mererid Jenkins, Head of Communications

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

In February 2026, the Board identified a preferred option for the provision of stroke services in Hywel Dda University Health Board, following the Clinical Services Plan consultation in the summer of 2025.

As this new option was the result of bringing together two alternative options that had not been tested with our communities, it was agreed that the option would need to be engaged upon before a final decision could be made.

This report sets out the recommended approach to undertake this engagement to enable Board to make a decision on stroke services.

Cefndir / Background

The Clinical Services Plan was established to address fragilities within nine services. The drivers of the work included workforce risks and our ability to meet standards and treat people in a timely way. Stroke was one of the services where it was noted that the Health Board does not have sufficient consultants or allied health professionals to meet national quality standards.

The initial phase of the programme identified the issues within the service. A series of options were produced during the second phase of the programme which the public were consulted on for 13 and a half weeks in the summer of 2025. For stroke services, two options were identified (Option A and Option B), and the public were invited to put forward alternative or new ideas.

As part of the consultation responses, an additional 30 options were put forward by those who responded. Two of these (Option 106 and Option 210) met the hurdle criteria and were considered alongside Option A and Option B at an Extraordinary Board meeting in February 2026.

During the Board discussion, it was felt that none of the options for stroke by themselves fully addressed the issues that were identified as part of the issues paper. After considering the consultation feedback, along with the petition submitted and discussed in the Senedd around changes to stroke services, it was felt that bringing parts of Option 106 and Option 210 together into a new option would best address these issues.

It was noted that, as these options came from the consultation and that our communities had not had an opportunity to discuss how this new option would impact them, a final decision could not be made until the preferred option had been through the same process as the other options, including hurdle appraisal, shortlist scoring and further engagement with our communities.

Once the preferred option had been through this process, it was anticipated that Board would be in a position to make a final decision on stroke service.

Asesiad / Assessment

Option detail development

Since February 2026, work has been undertaken to appraise and score the option, details of which can be found within the output report of a special Options Development Group session which took place virtually on 14 April 2026 (included as part of the Clinical Services Plan implementation progress report).

During the session, the preferred option was assessed by the majority of the stroke service representatives and Options Development Group to meet hurdle criteria. The session then moved into scoring, where it scored comparably more favourable than the other options previously considered in almost all criteria. It should be noted that, while there were slightly higher numbers of people scoring in this session than previously, the purpose of the scoring is to provide an indication to Board on the level of support from a clinical/operational perspective for the option.

Format of engagement

Work has also taken place at the same time to develop the materials which would be needed to engage with our public, as well as to identify the most appropriate form of engagement. Within the Welsh Government document 'How to make changes to health services: guidance for NHS organisations' (2023), there are expectations on the type of engagement to be carried out based on the nature of change, the level of potential impact and interest from communities. The guidance also sets out expectations for how to manage subsequent engagement following a consultation, where more information is needed from communities prior to a final decision being made.

The Clinical Services Plan consultation in the summer of 2025 set out the issues that needed to be addressed within the service and allowed the opportunity for people to share feedback and alternative options. Now that the options have been refined, and the issues have not changed, it is believed to be appropriate to undertake a second stage consultation to allow our communities to engage fully with the proposals. While the guidance sets out a minimum of six weeks, we believe that eight weeks would allow for more opportunity to reach as many communities as possible, both within and outside of Hywel Dda University Health Board area.

Over an eight-week engagement period we intend to use a blended approach to maximise reach and give people different ways to take part and share their views. This will include:

- Hospital site visits and walkarounds
- All-staff team meeting and staff briefings
- Public drop-in events
- Online public events
- Targeted group sessions
- Community outreach
- Health Board and third party events

A wide range of documents will be made available to staff, patients, the wider public and partners, to support their understanding of the scope of the phase 2 consultation and how they can share their views.

Formats will include: a bilingual main consultation document, Easy Read version, a bilingual audio version and a British Sign Language video. The main consultation document will also be translated into alternate languages, including into Arabic, Polish, Bengali and Kurdish Surani. Additional supporting information will also be made available online, in English only, including Teulu Jones case studies and factsheets.

Communication activity will be delivered alongside the engagement, to raise awareness and maximise participation. This will include proactive media activity (press releases, media responses and interviews, including regional and national outlets), briefings for MSs and MPs, information on hospital digital screens and posters on hospital sites, distribution via the engagement database, primary care and community venues, supported by paid radio advertising. Targeted and organic social media plus direct stakeholder emails will signpost people to the dedicated consultation website, where all materials will be hosted.

Scope of consultation

The purpose of the second phase of consultation would be to remind people of the issues that are facing our stroke services, provide the detail on the preferred option now that this has been worked up to the same level as the other options previously considered by Board and seek their views on how this option addresses issues identified and previous consultation feedback.

As part of this consultation, we will also ask if people believe that one of the other four options previously considered by Board better addresses the issues highlighted. At this stage no decision has been made, and Board may wish to reconsider one of the other options if new information comes to light.

We will also be asking people who respond regarding whether they believe there would be any Welsh language or equalities impacts not already noted within the accompanying impact assessments, so that these can be considered as part of option implementation.

During this second phase of consultation, we will not be seeking new alternative ideas for stroke services, as we captured these during the first phase of consultation. We will also not be reopening any decisions made for the other eight services included within the Clinical Services Plan or the future roles of our hospitals that were included in the first phase of consultation during summer 2025 and concluded at the extraordinary meeting of the Board in February 2026.

Resource requirements

This second phase of consultation continues to be quality assured by Hugh Irwin Company (HICO), who are using the Centre for Consultation (CfC) framework. This is a continuation of the existing contract that was approved for the summer 2025 consultation, which had contingency for multi-year consultation.

The consultation questionnaire development and analysis are being managed internally for this phase of the consultation, with support from the Engagement Team and Transformation Programme Office. While this means that additional funding is not required for this activity, the level of responses could mean that the reporting is delayed. As part of their quality assurance role, HICO will be reviewing our methodology and approach to the evaluation and reporting of consultation responses.

Detail about the resourcing required for the consultation is contained within the consultation project plan, which includes costs for the production of documents, questionnaire, advertising, etc. As this is a single service consultation with a focused scope, the costs are less than the summer 2025 consultation.

Timeline for consultation

Subject to Board approval, the consultation would run for eight weeks beginning 28 May 2026 until 26 July 2026. We would seek to analyse the responses so that they can be brought to Board in November 2026; however, as noted previously, this would be subject to the level of responses received. The position will be more clear when the consultation concludes.

Argymhelliad / Recommendation

The Board is asked to:

- Take **ASSURANCE** from the stroke output report, shared as part of the Clinical Services Plan implementation progress report, that the preferred option has been developed to the same level of detail as other options previously discussed in February 2026 Public Board.
- **ENDORSE** the format of engagement for the second phase of the Clinical Services Plan consultation for stroke services.
- **APPROVE** the scope of the phase 2 consultation, including the matters excluded from the consultation.
- Take **ASSURANCE** from the consultation project plan that there are appropriate resources in place to manage a consultation, including the analysis and evaluation of consultations, and that this continues to be quality assured by HICO.
- **APPROVE** the second phase of the Clinical Services Plan consultation for stroke services to run from 28 May 2026 until 26 July 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 233
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP:	All Strategic Objectives are applicable

UHB Strategic Objectives:	
Amcanion Cynllunio Planning Objectives	6 Clinical services plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Clinical Services Plan followed the advice and direction provided by the Consultation Institute (tCI) for Phase 1 and most of Phase 2. For Phase 3 this advice is being provided by Hugh Irwin Company (HICO) under the Centre for Consultation (CfC) quality assurance framework.
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Previous Board meetings Strategy and Planning Committee (SPC) Quality, Safety and Experience Committee (QSEC) Staff Partnership Forum Board Seminar Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	An indicative financial estimate has been included within the programme and is contained within previous Strategy and Planning Committee updates
Ansawdd / Gofal Claf: Quality / Patient Care:	The Clinical Services Plan is intended to improve Quality and Patient Care. Quality Impact Assessment screenings have been completed and have been considered at the Quality Impact Assessment Panel. These are provided in the supporting appendices.
Gweithlu: Workforce:	Indicative programme workforce assessments have been completed, and these are provided within previous Strategy and Planning Committee updates
Risg: Risk:	As outlined above.
Cyfreithiol: Legal:	The quality assurance process undertaken is designed to mitigate any risk around legal challenge directed towards decision making and consultation process.
Enw Da: Reputational:	There is political and media interest in Board decision making. A Communications and Engagement plan has been developed as part of the programme to support post decision-making communications.
Gyfrinachedd: Privacy:	Relevant privacy statements are linked and described within the consultation documents. A Data Protection Impact Assessment (DPIA) has been completed for the programme.

**Cydraddoldeb:
Equality:**

The Clinical Services Plan is intended to improve equality, and this will be further assessed as service plans are developed. Baseline Equality Impact Assessments have been undertaken based on current service provision. In addition to this Equality Impact screening templates have been completed to consider the impacts within each of the proposed options. These are provided in the supporting appendices.



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Consultation Project Plan

Clinical Services Plan Phase Two Consultation – Stroke Services

May 2026



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<p>Purpose</p>	<p>The purpose of this project plan is to set out the scope that details the issues to be included within our phase two consultation on the Clinical Services Plan (CSP) for stroke services following the identification of a preferred option by Hywel Dda University Health Board following the initial CSP consultation which took place in the summer of 2025. The Clinical Services Plan phase two consultation – stroke services (the consultation) focuses on the preferred option identified by Hywel Dda University Health Board in February 2026. This will also include whether there is a preference of another option which had also met hurdle criteria if the Board need to reconsider the option. Alternative ideas for stroke services will be out of scope for this consultation as these were gathered during the initial consultation.</p> <p>The Board has reached agreement with Llais, in accordance with the Welsh Government <i>Guidance on changes to health services, 2023</i> (the Guidance), that the issues for consideration are in line with the previous consultation and satisfy the criteria of a phase two consultation. The Board has a statutory responsibility to undertake consultation under Section 183 of the National Health Service (Wales) Act 2006.</p>
<p>Key Responsibilities</p>	<p>The Health Board’s responsibility is to involve and consult citizens about services that we provide or commission from another body, and in developing and considering proposals for changes in the way these services are provided. The Board is responsible for formally launching the consultation and using the information gathered throughout the consultation to inform its decision-making process.</p> <p>The Health Board consultation management process includes:</p> <ul style="list-style-type: none"> • The establishment of a Steering / Project Group to manage and monitor the consultation progress and monitor the responses as they are received • The development of a system to log incoming responses into a database for analysis at the end of the process • Acknowledgment of responses with a letter / email where contact details are provided • The development of a system to share our progress and findings with stakeholders • The development of a system to use feedback to inform further discussions and decision making • The development of a mid-point review process to ensure the consultation is progressing as anticipated and any emerging issues are addressed as part of the consultation process and management plan • Further development of the Equality Impact Assessment (EqIA) at the start, mid-point and end of the consultation process to help identify barriers, and any needs to be addressed to support participation from our diverse communities • The development of a system to consider impact throughout the process and adjust as necessary to eliminate or mitigate any potential or actual adverse impact at the earliest opportunity.

Equality Act 2010	<p>Our duties in relation to equality and diversity are outlined in the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011. The Act aims to ensure those carrying out a public function consider how they can positively contribute to a fairer society in our day-to-day activities through paying due regard to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations. To make this happen, the regulations place specific duties on the devolved public sector, including health boards in Wales to carry out Equality Impact Assessments (EqIA).</p> <p>In the context of this consultation project plan we are required to assess the impact of our proposals to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.</p>
Socio-Economic Duty	<p>The Wales Act 2017 enabled Welsh Ministers to enact Part 1, Section 1 of the Equality Act 2010 – the socio-economic duty. It requires specified public bodies, when making strategic decisions such as deciding priorities and setting objectives, to consider how their decisions might help to reduce the inequalities associated with socio-economic disadvantage.</p>
Mental Capacity Act 2005	<p>The Mental Capacity Act is a law designed to ensure that all people aged 16 and over are protected and empowered if they lack the capacity to make a decision about their care and treatment.</p>
Human Rights Act 1998	<p>The Human Rights Act 1998 (the Act or the HRA) sets out the fundamental rights and freedoms that everyone in the United Kingdom is entitled to. It requires all public bodies, including health boards, to respect and protect your human rights.</p>
The Health and Social Care (Quality and Engagement) (Wales) Act 2020	<p>The Health and Social Care (Quality and Engagement) (Wales) Act 2020 provides the legal framework for, among other things, the establishment of Llais and the Duty of Quality.</p>

Welsh Language (Wales) Measure 2011 & The Welsh Language Standards (Health Sector) Regulations 2016

The Welsh Language Standards are a set of statutory requirements relevant to the Health Board. They clearly identify our responsibilities to provide bilingual services.

Under the Standards, Welsh should not be treated less favourably than English.

In line with the Welsh Language Standards the organisation will be expected to consider, when formulating a new policy, or reviewing or revising an existing policy, what effects, if any (whether positive or adverse), the policy's formulation or decision would have on:

- (a) opportunities for persons to use the Welsh language, and
- (b) treating the Welsh language no less favourably than the English language.

When publishing a consultation document which relates to a decision, the document must consider, and seek views on, these effects.

National Health Service (Wales) Act 2006

Section 183 of the National Health Service (Wales) Act 2006 requires health boards to involve and consult citizens in:

- planning to provide services for which they are responsible
- developing and considering proposals for changes in the way those services are provided, and
- making decisions that affect how those services operate

The National Health Service Finance (Wales) Act 2014

The National Health Service Finance (Wales) Act 2014 makes planning the bedrock of the health system in Wales – the change from a market driven commissioning approach to a planned system – and introduced the need for the development of integrated medium-term plans.

Welsh Government Guidance on changes to health services 2023

Ministerial Guidance recommends that should service changes indicate that a consultation is likely, a two-stage process takes place:

- **Stage 1** Extensive discussion with key stakeholders to explore potential issues, refine options and determine the questions to be included within the consultation
- **Stage 2** Formal consultation for a minimum of six weeks

The guidance allows for consultation where this two-stage approach has not been met, where a consultation of up to 12 weeks follows a period of engagement.

The CSP programme has satisfied Stage 1 through the previous consultation in the summer of 2025. The recommendation would be that the consultation proceeds as a Stage 2 consultation for eight weeks instead of 6 weeks to allow sufficient time for wider stakeholders to consider the options and provide feedback.

Welsh Government The National Principles for Public Engagement in Wales (reviewed 2022)

The National Principles for Public Engagement in Wales are a set of ten principles for engaging with the public and service users. The principles aim to guide the way engagement is carried out to make sure it is good quality, open, and consistent. They offer a set of guidelines to organisations within the public and voluntary sectors in Wales:

- Design your engagement to make a difference
- Invite people to get involved, if they choose to
- Plan and deliver your engagement in a timely and appropriate way
- Work with relevant partner organisations
- Provide jargon free, appropriate, and understandable information
- Make it easy for people to take part
- Ensure people benefit from the experience
- Ensure the right resources and time are in place for your engagement to be effective
- Let people know the impact of their contribution
- Learn and share to improve your engagement

Well-being of Future Generations (Wales) Act 2015

The Well-being of Future Generations (Wales) Act 2015 is legislation which has at its heart the well-being of future generations, through the establishment of seven national well-being goals and five ways of working:

- A prosperous Wales – where everyone has jobs and there is no poverty
- A resilient Wales – where we’re prepared for things like floods
- A healthier Wales – where everyone is healthier and can see the doctor when they need to
- A more equal Wales – where everyone has an equal chance whatever their background
- A Wales of cohesive communities – where communities can live happily together
- A Wales of vibrant culture and thriving Welsh language – where we have opportunities to do different things and where people can speak Welsh
- A globally responsible Wales – where we look after the environment and think about other people around the world.

Social Services and Well-being (Wales) Act 2014

The Social Services and Well-being (Wales) Act 2014 imposes duties on local authorities, health boards, and Welsh Ministers, that require them to work to promote the well-being of those who need care and support, or carers who need support. The West Wales Care Partnership (WWCP) has been established under Part 9 of the Social Services and Well-being (Wales) Act 2014 with specific duties to promote the integration of community care and support services. The WWCP is a statutory stakeholder for the purpose of this consultation project plan.

Convention on the Rights of the Child 1989

The Welsh Government has made a commitment to promote and support children and young people’s participation, and to implementing children and young people’s rights to participate as stated in Article 12:

“Children and young people have a right to participate in the decision-making processes that are relevant to their lives and a right to influence the decisions made in their regard within the family, the school, or the community.”

2.0 Scope and mandate of the consultation

<p>Consultation Scope</p>	<p>Hywel Dda University Health Board (HDdUHB) (the consulting body) will undertake a formal consultation exercise with the public, its staff, statutory stakeholders, wider stakeholders, and targeted groups most impacted / affected by its proposals. We will ensure equality of opportunity to engage between people who share a protected characteristic and those who do not.</p> <p>The Health Board will engage all key stakeholders (the consultees) identified through stakeholder analysis on both a qualitative and quantitative basis, to understand the views on the following issue:</p> <ul style="list-style-type: none"> • Whether there is support for the preferred option and why? • If not, whether a previously considered option would work better and why? • Anything else that people think needs to be considered to make stroke services work better in the future. This includes any mitigations or improvements, and potential Welsh Language impacts if the service operates differently in the future. <p>The Board, at its public meeting in February 2026, considered the evidence provided from the previous consultation in the summer of 2025 and decided that the preferred option was the one that best met the issues identified throughout the process. However, as this was an option developed by bringing together two alternative options that had not been tested with the public, as well as affecting communities differently compared to the options that were previously consulted on, a new phase of consultation would be required to fully understand the impacts of the option before a final decision could be made.</p>
<p>Consultation Timescale</p>	<p>The consultation exercise will commence in May 2026 with the aim of presenting a consultation closing and output report at the Health Board public meeting in November 2026, subject to level of responses received which may require more time to evaluate.</p>
<p>Matters for inclusion in the consultation</p>	<p>The following matters have not yet been decided and are open to influence in the consultation, so we want to gather views on:</p> <ul style="list-style-type: none"> • Whether people agree that the preferred option, or a previously considered option, meets the issues identified within the Clinical Services Plan consultation • The positive and negative impacts associated with the preferred option, or a previously considered option

Matters excluded from the consultation

The following matters have been decided and are **not open to influence** in the consultation:

- **Options which have been previously considered and ruled out during the options development process, these are included within the consultation documentation**
- **Alternative options received in the 2025 consultation and discounted as part of the analysis undertaken**
- **The future roles of our four main hospital sites and the future service models for the other eight services included in the Clinical Services Plan consultation:**
 - **critical care,**
 - **dermatology,**
 - **emergency general surgery,**
 - **endoscopy,**
 - **ophthalmology,**
 - **orthopaedics,**
 - **radiology, and**
 - **urology**

Consultation Mandate

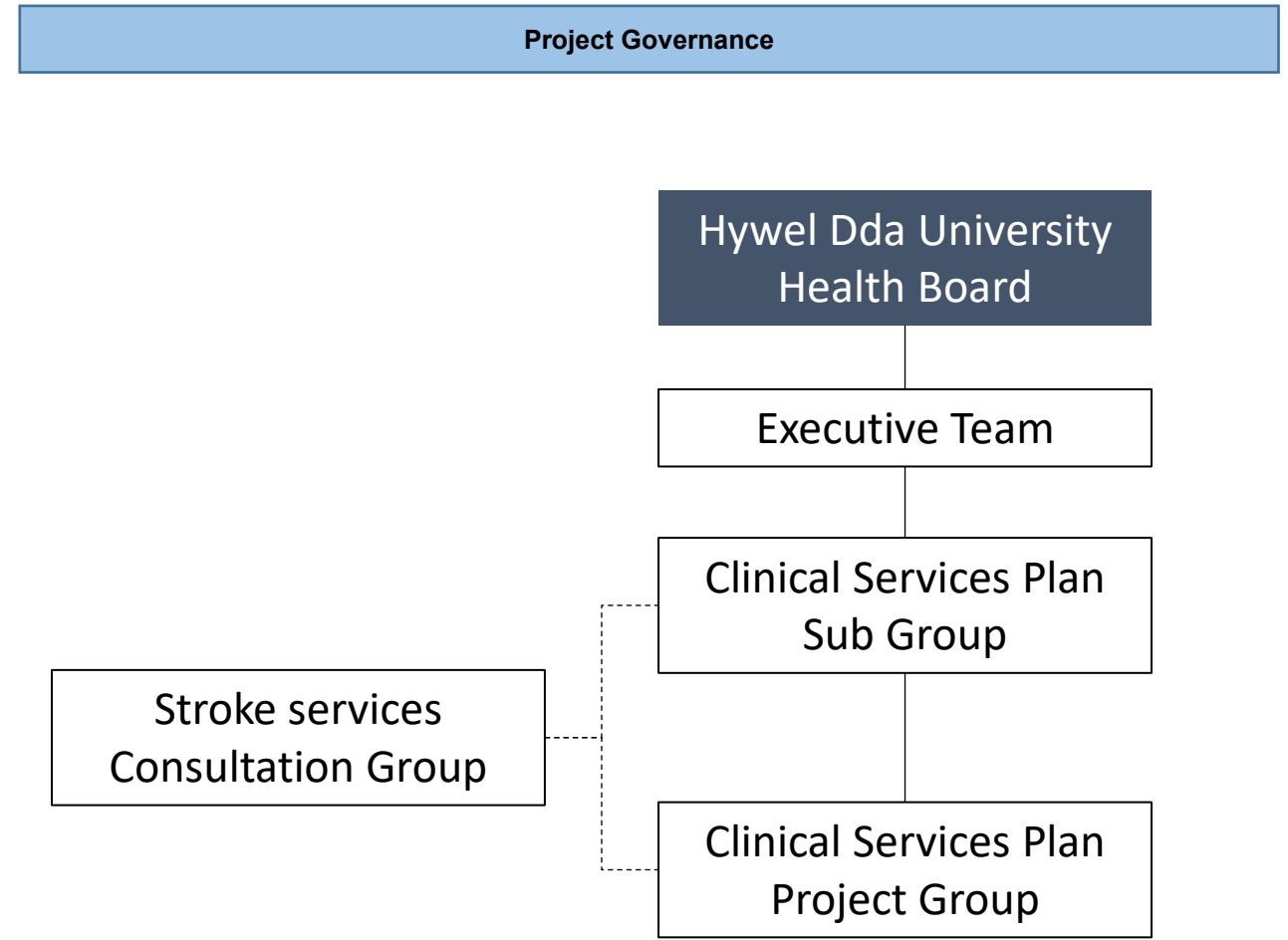
The purpose of the consultation scope defined within the consultation project plan is to enable the Board to make a formal decision on:

Clinical Services Plan, stroke services which;

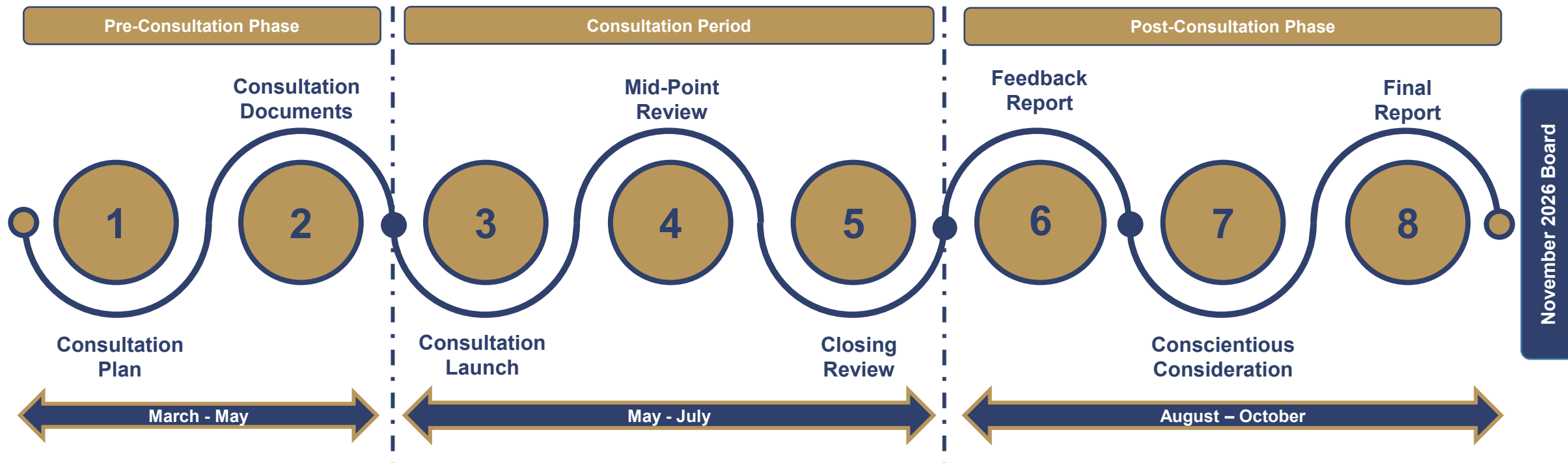
- Meets service standards,
- Responds to fragility in the service, and
- Is in line with the National Stroke Programme and the Quality statement for stroke services.

3.0 Project Governance

Consultation Group Composition	<p>The Senior Responsible Office of the Clinical Services Plan programme is Lee Davies, Executive Director of Strategy and Planning. The Chair of the Clinical Services Plan Sub Group is Mark Henwood, Executive Medical Director.</p> <p>The Chair of the Project Group is Keith Jones, Director of Operational Planning and Performance</p> <p>The consultation group carrying out the day-to-day planning and delivery will consist of:</p> <p>Head of Engagement / Engagement Manager Head of Communications / Communications Manager Principal Programme Manager/ Project Manager</p> <p>The following will be invited into the group meetings as required:</p> <p>Stroke Triumvirate Leadership Team Senior Diversity and Inclusion Manager Hugh Irwin (HICO)</p> <p>Membership of other groups can be found within their terms of reference.</p>
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4.0 Proposed timeline for the consultation



The Consultation Period will run, subject to Board decision, between the 28 May 2026 and 26 July 2026.

It is important to note that while the timeline suggests November 2026 for final consideration at Board, this will be determined by level of responses received and may need to go to the next planned Board in January 2027 unless an additional Board meeting takes place. This will not be known until August 2026 when all responses have been received.

5.0 Resource and Requirements Analysis

<p>Consultation Project Team</p>	<p>Project leadership, project management, Communications and Engagement posts identified for the project team are funded within existing team budgets. Therefore, no additional staffing costs are envisaged for the delivery of the project.</p>
<p>Supplier Costs for Quality Assurance Support and Consultation & Engagement Support</p>	<p>Quality Assurance for Consultation and Engagement (HICO) – This is a continuation of the contract to support the Clinical Services Plan, providing advice and quality assurance, including the CfC Consultation Mark QA Framework fee.</p> <p>Total = £ 34,850</p>
<p>Communications and Engagement Costs</p>	<p>The communications and engagement forecasting has been based on the consultation document development for Prince Philip Hospital Minor Injuries Unit Consultation, a recent example of a single service consultation, alongside projected costs from suppliers based on document sizes.</p> <p>Documentation (including design and printing of multiple versions of consultation documentation) - £19,581 Opportunities to engage (including events, event translators, and other engagement activity) - £4,800</p> <p>Promotion (including advertising opportunities to engage with our communities) - £10,228 Support, translation and administration (including alternative and additional languages, postage etc.) - £2,350</p> <p>Total = £36,959</p>
<p>Total Consultation Costs</p>	<p>Total Consultation Costs - £71,809</p> <p>**** Costs set out are an indicative (not inclusive of VAT) and based on current consultation project plan. Should we need to increase number of printed documents, hold and advertise more in person events, etc. as part of mid or closing point review, the final costs may change.</p>

6.0 Stakeholder identification and analysis (including equalities)

Stakeholder Identification	<p>We provide stroke services for the immediate population of Hywel Dda University Health Board, covering the communities of Carmarthenshire, Ceredigion and Pembrokeshire. We also provide stroke services for patients living in neighbouring health boards which covers Gwynedd and Powys.</p> <p>Our approach will be to create as open and accessible an opportunity for as many people as possible to be aware of the consultation and to get involved if they wish to do so, with a particular focus on the residents of Llanelli and Pembrokeshire and immediate surrounding areas. The reason for this is because in the first phase of consultation the potential impacts of changing stroke services were different and we now need to test this with these populations</p> <p>We will build on the stakeholder mapping and analysis that was carried out for the first phase of consultation. This is to make sure that any stakeholders identified throughout the process are being considered, as well as whether how and when we need to engage with people has changed.</p> <p>This detailed stakeholder mapping and analysis exercise will help us identify statutory consultees and those most affected by the potential options within the identified services so that it can inform our work. Stakeholder mapping will include a focus on disadvantaged, marginalised and minority groups and communities. Engagement will be tailored to suit their differences, circumstances and requirements.</p> <p>We will work with local community and voluntary sector groups and networks to make sure that seldom heard groups can have their say in decisions that affect them.</p> <p>Throughout the consultation process we will need to ensure due regard is given to the general and specific equality duties for public sector organisations in Wales, and the requirement to engage with representatives of protected groups in assessing the potential impact of proposals on these groups. This applies to all children and adults in the Hywel Dda area, regardless of gender, age, disability, ethnicity or sexuality. It also applies equally to people with mental health problems or a learning disability, as well as people with physical health problems.</p>
Stakeholder Analysis – Multi-level Analysis	<p>To ensure meaningful engagement of all relevant stakeholders, we will implement a comprehensive, multi-level approach that will identify and mitigate barriers to participation. Engagement will be tailored to suit people's differences, circumstances and requirements.</p>

Initial Stakeholder Analysis

These stakeholders will likely be broadly interested in our consultation:

- Patients, their carers and advocates
- Reference groups such as carers, service users, People's First, Veterans and Vulnerable groups (homeless, Syrian Refugees etc.)
- Health Board staff and contracted services, and their Union and Staff Side representatives
- Care Homes
- Residents of Carmarthenshire, Ceredigion, Gwynedd, Pembrokeshire and Powys counties will have a specific interest in the proposals
- Llais
- Local campaign groups with a specific interest on services provided at our acute hospital sites, particularly Bronglais, Prince Philip and Withybush hospitals
- NHS organisations including Betsi Cadwaladr UHB, Powys THB, Swansea Bay UHB and Welsh Ambulance Services Trust
- Statutory organisations e.g., Dyfed-Powys Police, Mid and West Wales Fire Services
- Local community organisations, community representatives, third sector, voluntary sector
- Town and Community Councils
- Local Authority (Carmarthenshire, Ceredigion, Gwynedd, Powys and Swansea) councillors and officers
- Professional Bodies

The further development of the stakeholder analysis will identify those people or groups who are likely to be potentially impacted by the potential service options and who may wish to share more in-depth views and potential impacts. This work is yet to be completed, although it may include:

- GPs and Primary Care contractors
- Patients, their families and unpaid carers with particular emphasis on those with protected characteristics
- Recent or potential patients of stroke services
- Current staff working in stroke services, as well as other staff on the acute hospital sites
- Community, interest, and campaign groups representing patients, carers and their families with particular emphasis on those with protected characteristics
- Children and young people who are children of or carers for people using stroke services
- Staff with protected characteristics and / or who may be carers

**Equality
Impact
Assessment
(EqIA)**

The impact on those with protected characteristics, together with the socio-economic impact is assessed at key stages throughout the life of this project. In the context of this consultation project plan we are required to assess the impact of our proposals to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

A baseline EqIA was undertaken during Phase 1 of the programme to understand the impacts and barriers to accessing health for the services as they are currently delivered, which supported the development of the Issues Paper. EqIA screening was undertaken during Phase 2 of the programme as options were developed to understand the impact of each option, including its staff and service users, the public, and using information that is already known to us. These were further developed following consultation in summer 2025 as part of phase 3 of the programme, with all EqIAs developed to date shared on our website.

A new EqIA has been developed for this option based on consultation feedback. By reviewing the views gathered through this consultation, and by considering the possible socio-economic impact, on identification of a final option by the Board a final EqIA will be undertaken for the selected option using this full detail.

The EqIAs have identified that certain protected characteristics (age, disability, pregnancy and maternity and socio-economic duty) are more likely to be impacted negatively due to changes in where our services will be provided, however people will still be able to access immediate care from their nearest hospital as currently provided in all options. These groups would be impacted as they would need to travel further to visit people who have had a stroke.

A Welsh language assessment has also been carried out which identifies that public would not be negatively impacted from a language perspective if they were to use services at Glangwili hospital, as the unit has a higher level of Welsh speakers.

By updating our EqIA with the consultation findings, once they are evaluated, this will ensure that decision making is fully compliant with our legal duties under the Public Sector Equality Duty (PSED), Equality Act 2010 and the National Health Service (Wales) Act 2006 and that we are taking account of people's protected characteristics.

Initial High-Level Risks

We will establish a consultation risk register which will continually evolve and be reviewed. This will include consideration of the likelihood and impact of risks, as well as defining the control measures to mitigate risks as far as possible. High-level risks identified include, but are not limited to:

- Potential of confusing the public if other Health Board consultations or engagement exercises are launched, or overlap the consultation timeline
- Lack of public involvement, due to consultation / engagement fatigue or disengagement, which may leave sections of our communities and protected characteristic groups unrepresented in the consultation process
- Reputational risk should political, community, special interest or campaign groups be opposed to the scope or options within the consultation
- Health Board will not be in a position to resource a comprehensive and compliant (statutory duties) consultation that potentially impacts all people across our communities
- There is a risk that the defined timeline will not be met as per the consultation project plan, until the project team is in place
- Receiving and responding to potential legal challenges
- Political risk of unmanaged interactions between politicians, campaign groups, staff and media channels

A more detailed risk register with risk scores, mitigations and contingencies has been included as an appendix: **Stroke Phase 2 Consultation Risk Register.xlsx**

Developing the detailed Consultation Plan

The consultation plan will set out how the consultation project plan will be delivered in detail, and will be continually reviewed, adapted and flexed to accommodate additional requirements throughout the course of the consultation, as well as formally reviewed at key stages during the consultation period. The development of the consultation plan will include:

Stakeholder identification and analysis - defining methods needed per stakeholder identified; identification of best forms of engagement to suit stakeholders identified and identification of best venues / facilities for engaging stakeholder groups

Questionnaire design - to meet the information sought from stakeholders and tailored to specific stakeholders

Building the timeline - including all activities and key milestones

Engagement planning (incl. EqIA) - considering digital vs. offline; quantitative engagement (incl. questions); qualitative engagement (incl. questions & debates); participatory (incl. questions & debates); building in contingency event space; population of spreadsheet with events and activities to meet the timeline

Communications planning - social media plan (identification of social media accounts to engage upon and frequency); developing presentations, video & apps; consultation promotion; updates and newsletters; media handling plan; social media monitoring and misinformation counter action planning; website design; agreeing narratives and dialogue handling; managing and sharing feedback and outputs of the consultation

Document planning and development - developing the main document, questionnaire, and other versions; identifying and developing the suite of consultation documents, including supporting documents (such as EqIAs, output, summary and final documents, any relevant guidance); key themes and content for Q&As

The Launch - detailed planning for the consultation launch including all activities to promote the launch

Mid-point review planning - assessment of the plan, monitoring arrangements, plan amendments and contingency

Closing review planning - assessment of the plan, contingency and decisions on extra activity requirements

Evaluation and Analysis planning - a detailed plan for how the outputs will be analysed and interpreted including by who and by when

Final Report production - this will bring all of the information together and set out the decision-making plan

Feedback planning - setting out the detail of how and when the outputs and feedback will be shared with the public, stakeholders, etc.

Influencing plan - the consultation plan will demonstrate that it has considered the Gunning principles, i.e.:

- consultation must take place when the proposal is still at a formative stage
- sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- adequate time must be given for consideration and response, and
- the product of consultation must be conscientiously considered.

Introduction	<p>The engagement plan will support the objectives of the consultation, which is intended for:</p> <ul style="list-style-type: none">• Raising awareness amongst our people of the opportunities to participate and share views to inform the Board decision on stroke services as part of the Clinical Services Plan• Facilitating ongoing engagement with public, staff, statutory stakeholders, wider stakeholders and targeted groups most impacted / affected by its proposals• Targeting those most affected by the service change options through engagement methods best suited to the key groups• Providing a range of opportunities, taking account of accessibility, for our staff and key stakeholders to give their views <p>Our approach will be underpinned by a commitment to continuous engagement, with particular reference to the seldom heard, and engage in ways that are sensitive and appropriate to their needs and in this way, we will be most likely to meet the needs of our entire population.</p> <p>Public and patient-centred tools and strategies for ensuring the methodologies used are in keeping with the needs of each stakeholder group will be prioritised. For example, questionnaires, in-person events / interviews, online digital spaces and direct communications will be targeted according to preferences and individual needs.</p>
Maximising participation	<p>All consultation documents will be available on a dedicated section of the HDdUHB website and staff intranet. The sites and associated material will be promoted via the Health Board’s corporate platforms to help reach the digital audience to maximise engagement.</p> <p>All engagement will comply with legislation in terms of the Data Protection Act 1998, the General Data Protection Regulation 2016 – effective in May 2018, the Freedom of Information Act 2000, and equality and diversity legislation.</p> <p>All promotional work will be carried out in accordance with the Department of Health’s Code of Practice for the promotion of NHS Services, published in March 2008.</p>

Quantitative and Qualitative Engagement Methods

Quantitative methods will be used to gain feedback via:

- Consultation questions
- Equality monitoring

A range of qualitative methods will be used to gain feedback from identified stakeholders using the following methods, where identified as most appropriate to those stakeholders:

- Surveys and questionnaires (electronic, hard copy, telephone) - these can be adapted to alternative formats and delivery according to need (i.e., such as Easy Read and alternative languages)
- Online digital spaces - we will consider hosting our own digital spaces, bespoke events, or using community based digital platforms to provide a space for online engagement
- Workshops / events / drop-ins / briefings / presentations for both internal and external stakeholders
- Existing key meetings / groups (particularly seldom heard)
- Use influencers and champions to help provide accurate information amongst their groups / followers / colleagues, etc.
- Capturing stories, reflections, learning from staff via a wide range of virtual and face-to-face, formal and informal methods
- Focus groups
- Interviews
- Deliberative events

Introduction

The communications plan will support the objectives of the consultation by:

- Providing clear and timely information about the purpose and scope of the consultation that helps to create understanding, build trust, and encourage engagement in the consultation
- Our communication will be proactive, open and transparent – providing enough information for individuals to feel able to participate, without overwhelming individuals and leading to confusion
- Reaching out to our diverse range of key stakeholders (inclusive of staff, service users, carers, our partners, the public, particularly those identified as potentially being disadvantaged, marginalised and minority groups) to raise awareness of the consultation and actively encouraging people to get involved and share their views
- Reduce likelihood of potential mis-information and myths by monitoring themes from events, correspondence, media and social media and responding quickly to concerns
- Demonstrating that the Health Board is listening and responding by sharing themes heard during the consultation, providing responses to concerns, and sharing the results of the consultation
- Providing consistent responses wherever possible to people’s enquiries, or concerns (including those from stakeholders such as patient and public representatives and media), and sharing feedback heard to the Health Board.

Consultation promotion

The communications plan will document key messages, audiences (which will be informed by the stakeholder analysis), products and channels necessary to support people to take part in the consultation, tactics to reach stakeholders, a schedule of promotion and activities, and how we will monitor and capture feedback. A variety of communication activities will be used to promote involvement in the consultation. More materials and activities will be prepared in advance for the first half of the consultation, allowing us the opportunity to review feedback, themes and engagement, and respond accordingly in the second half of the consultation.

To ensure consistency of approach and recognition that the consultation is part of our strategy evolution, that has been developed with our communities, we will continue to use the Teulu Jones brand. To distinguish this consultation activity from others, facilitate communication, feedback, and measurement of issues relating to the consultation, we will develop a name (and hashtag) for the consultation, akin to our previously used ‘Our Big NHS Change’.

Working with our key audiences

We will utilise existing stakeholder databases and methods of regular communication to support our cascade of information about the consultation. This includes internal staff communication platforms and newsletters, the Siarad Iechyd / Talking Health involvement scheme, partner networks, public representatives, and our local media (including hyper local media) - all of which will help us reach significant numbers in our communities. We will continue to use the appropriate channel for our audiences, to include:

Staff

- Team Brief (update following Board meetings and used as cascade brief for face-to-face team meetings)
- Townhall (open to all staff) online events
- Staff bulletins / video messages
- Staff social media – VIVA and closed staff Facebook group
- Individual directorate newsletters (such as Medical Directorate newsletter, Primary Care newsletter, etc.)
- Staff intranet – continuing to build and update the information available to staff (including FAQs, key messages, links to news stories, feedback opportunities, etc.)

Stakeholders

- Articles / snippets shared with stakeholders for use in newsletters and updates, including local authorities, Community Voluntary Councils, Town and Community Councils
- We will continue to update our political representatives through the monthly meetings held with MSs and MPs and the Chair and Chief Executive, ensuring that representatives have a forum to ask questions, are provided with the information they need to be able to answer their constituents' questions, and provide a channel for representatives to share any local feedback or issues.

Public

We will utilise the full span of available media, and purchase paid for media, to reach audiences that we may not otherwise. As a minimum, engagement will be proactive and focus on:

- Paid for newspaper adverts to guarantee space / messaging
- Regular articles / offers of interviews to the media (spanning print, digital and broadcast) prior to and throughout the span of the consultation (including mainstream media, Welsh language, and hyperlocal)
- Paid for local radio
- Paid for and 'organic' social media campaign

Accessible documents and assets	<p>Alternative versions of the consultation document and questionnaires will be developed, informed by the stakeholder mapping and Equality Impact Assessment (see Section 11).</p> <p>We will use varied forms of communication products across our digital and non-digital platforms to promote interest in the consultation and offer useful information. This will include articles in media and hyperlocal newsletters, offering stories and interviews to broadcast media, a visibility and promotional campaign in key locations, animations, graphics, storytelling and short videos on social media and other digital platforms (e.g., digital screens in physical locations). We will also utilise community venues and a wide range of healthcare and partner / community settings to ensure information (hard copy and digital) is available and accessible.</p> <p>We will support our organisational leaders and key stakeholders to encourage staff and patient / carer participation in the consultation, using briefing sessions and a suite of products (key messages, Q&As, printed and digital assets - communication products described above) to support informed sharing of messages consistently.</p> <p>We will also purchase paid for media to reach audiences that we may not otherwise, including (as a minimum), local radio advertising, adverts in regional newspapers and social media advertising targeting users from key communities.</p>
Website	<p>We will use our corporate website and online engagement platform to provide dedicated spaces for people to find out more information and to share their views. There will be significant focus and visibility for the purpose and scope of the consultation and how to get involved. Key messages for the website narrative will be reflective of the content of the main consultation document. Summary information will be provided in plain language and digitally accessible (html).</p> <p>It will also include supportive information broken down into helpful, shorter form. This will include media releases, key messages and a frequently asked questions (FAQ) section. Supportive information can evolve during the consultation so that it is responsive to the concerns, questions or ideas we are hearing.</p>

Social Media	<p>We will use our social media platforms to inform and remind people about the consultation. This will include frequent signposting to further information, events and areas where people can provide feedback. It will also include ‘themes’ in the same way as media releases to break down elements of the consultation document itself.</p> <p>We will request support for sharing our social media campaign with key stakeholders, such as local authorities, Llais, campaign groups, and Community Voluntary Councils and special interest groups that may have audiences that align with our key stakeholders. We will also commission paid for social media advertising to reach people in our locality who may not proactively visit or follow corporate pages.</p> <p>Our social media platforms are managed Monday-Friday 9am-5pm. During this time, we aim to provide a swift response to any questions and enquiries, directing individuals to further information and our FAQs, to ensure consistency of messages and information. We will keep a record of comments / questions directed to us through our social media pages on Facebook, X (formerly Twitter) and Instagram. This will form part of the social media sentiment analysis within the final consultation report, but will not be accepted as a full or part responses to the consultation.</p> <p>We will also promote use of a hashtag for the consultation, which will support us to listen and report back on themes (as opposed to individual comments) across our social media platforms. Please note we cannot ‘track’ individual’s social media and significant proportions of Facebook and Instagram are protected with privacy settings.</p>
Outputs/ Feedback Sharing	<p>We will communicate how individuals can contact us, sharing a central contact point for people who have enquiries. This will be supported by an agreed process to ensure co-ordination of response and correspondence and a system to ensure the capture of any feedback for the consultation report. As common themes are raised, these will be reflected in our communication on an ongoing basis (e.g., updating of FAQs, thematic articles, etc.).</p> <p>Any media enquiries will be handled by the Media Office, who will draft appropriate responses, including identifying appropriate spokespeople depending on the issue raised.</p> <p>Our activities will be monitored through our media monitoring service, and hashtag themes on social media. The number and nature of media enquiries will be logged. The overall activities will be summarised in a communications evaluation at the end of the consultation. Any issues raised through media enquiries will be highlighted, and if necessary, our communications will be adjusted to reflect any concerns raised (e.g., adding to our FAQs, key messaging, or developing single issue press releases / articles, and provision of spokespeople to address particular areas).</p> <p>An ongoing log of communication activities, including public affairs and correspondence, will be kept throughout the consultation period to ensure appropriate records are kept, for reflection and record maintenance.</p>

Document and Questionnaire Sharing	<p>As part of our communications planning, we will research and explore opportunities to address digital inclusion and exclusion for promotion.</p> <p>This will include ensuring the availability of both hard copy and digital documents, questionnaire and promotional materials. As a minimum this will include availability and promotion in high footfall areas or areas where there is digital exclusion.</p> <p>The Health Board will send information about the consultation to our stakeholder database (which has approximately 5,000 contacts plus approximately 3,000 who expressed an interest in being kept informed about the Clinical Services Plan work) by email, and by post directly to a wide range of stakeholders, including individuals and organisations e.g., third sector, local authorities and other interested parties.</p> <p>We will consider direct communications to targeted audiences to allow for unfiltered messaging from the Health Board direct to those we wish to influence. This could include using digital and non-digital methods (e.g., we will consider letters, flyers to households, etc.)</p>
Questions & Answers (Q&A)	<p>The website will include access to documentation including the consultation document, a summary document and associated accessible and alternative versions (more detail in Section 12), and technical documents required for formal consultation. These will be dated and stamped with their version for documentation control. The questionnaire will be available from either our corporate website or on our engagement platform, dependent on the best and most accessible user solution. This will be promoted widely through our communications plan and for the duration of the consultation.</p> <p>Building upon the resources already available on our website, a frequently asked questions section will also be available from the start of the consultation (in digital accessible html format) and will be regularly updated, and dated, as the consultation evolves, and we hear people's concerns. We will also signpost people to this resource by promoting it on all other platforms.</p>

Document versions

We will aim to be open and transparent in the provision of all our consultation materials. We acknowledge that to be involved in a consultation, some of our diverse communities will need to be provided with alternative versions, or support to participate.

Informed by the stakeholder analysis and Equality Impact Assessment, in order to make the consultation as accessible as possible we will produce:

- A bilingual consultation document in as plain writing as possible and minimum font size 12, that complies with digital accessibility guidance and best practice
- Additional languages and alternative versions that include:
 - Audio
 - Easy Read
 - British Sign Language (BSL)
 - Identified local languages (Polish, Arabic, Bengali, Kurdish Surani)
- A suite of supporting documents and impact assessments
- Animation and video promotion to attract interest from groups who may not access other versions of documents (potentially those with low literacy) and signposting to support to attend events or speak to someone

Mid-Point Review	<p>The mid-point review will be undertaken during week 5 of the consultation period, as discussed with Llais, in order to review how the consultation has met the project plan to date and any new and emerging issues, including:</p> <p>Evaluating what has been learned to date, through:</p> <ul style="list-style-type: none">• Effective monitoring of the debate and the reactions and activities of interested parties, including challenges and opposition• Considering the need for the plan to be amended as a reaction to what is being learned• Considering whether new information is needed or needs sharing• How contingency will be managed if changes to the plan are needed• Confirm sufficient media and social media awareness of the consultation or any gaps that need addressing• Evaluating stakeholder participation and identifying gaps in reach, and in particular from seldom heard voices• Review and updating of the EqIAs.
Closing Review	<p>The closing review will be undertaken around one week before the consultation period formally closes, in order to review how the consultation has met the project plan, including:</p> <ul style="list-style-type: none">• Evaluating what has been learned to date through effective monitoring of the debate and the reactions and activities of interested parties, including challenges and opposition• Considering the possible need for the consultation to be extended in response to what transpires• Considering the possible need for extra pieces of work, such as surveys and studies, in the event that what is learned leaves important questions to be answered or investigated• Reviewing what should happen post consultation and what the timeline will be for response, evaluation and analysis, sharing the outputs and feedback, and making decisions• Review and updating of the EqIAs.

Evaluation and Analysis Plan	<p>The consultation analysis, initial output report and final report will be managed internally by the Engagement Team and Transformation Programme Office. This will be overseen by the Steering Group and Project Group.</p> <p>The final report will include an overview of the consultation, along with the data analysis, feedback, and will call out how this has been used to inform the process of developing recommendations for consideration by the Health Board as part of its decision-making process.</p> <p>More information on how the information will be collected, coded, analysed and used to inform the influencing plan can be found within this document: <u>Consultation analysis methodology.docx</u></p>
Key Components	<p>The purpose of the final report is to:</p> <ul style="list-style-type: none">• provide the Board with information to enable a final decision on the future option for stroke services in Hywel Dda University Health Board as part of the Clinical Services Plan. <p>The final report is likely to include:</p> <ul style="list-style-type: none">• Executive summary• Introduction and background• Preparatory work (stakeholder mapping, EqIAs, engagement, options development and appraisal, etc.)• Methodology• Findings• Discussion of the findings (including recommendations)• Conclusions• Next steps <p>The final report will be presented and deliberated at the Public Health Board meeting in November 2026, subject to level of responses and time required to analyse and deliberate on findings, which will be livestreamed for ease of access for the public to observe.</p>

A feedback report, detailing the outcome of the consultation, will be shared with:

- Staff
- Key stakeholders
- People who have requested to be added to our circulation list

It will also be published on the Health Board website and promoted widely.



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Appendix 2 - OSG - Stroke Phasing Estimate - Proposed Option

Clinical Services Plan Stroke Proposed Option Phasing

Stroke

Idea 106/210 - Pre Provisional Decision

Appendix 2 - OSG - Stroke Phasing Estimate - Proposed Option



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	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Stroke Unit	Stroke Unit	Stroke Unit	Stroke Unit
<i>Merged Option 106/ 210</i>	Treat and Transfer Stroke rehabilitation unit TIA clinics	Stroke Unit (specialist cover 24-hours a day) TIA clinics Working regionally as part of the National Stroke Programme in the longer term	Treat and Transfer	Treat and Transfer

- A preferred option and will need further engagement within our communities and sites
- Works towards Hywel Dda having a 24hr Acute Stroke Unit longer term delivered in a phased approach.
- Maintains an Acute Stroke Rehabilitation Unit at the Bronglais site as well as Stroke Consultant and CNS.
- The following slide sets out an indicative timeline with a yellow highlight showing when the key parts of the option will be delivered at each site.

Stroke - Future State – Phasing Estimate

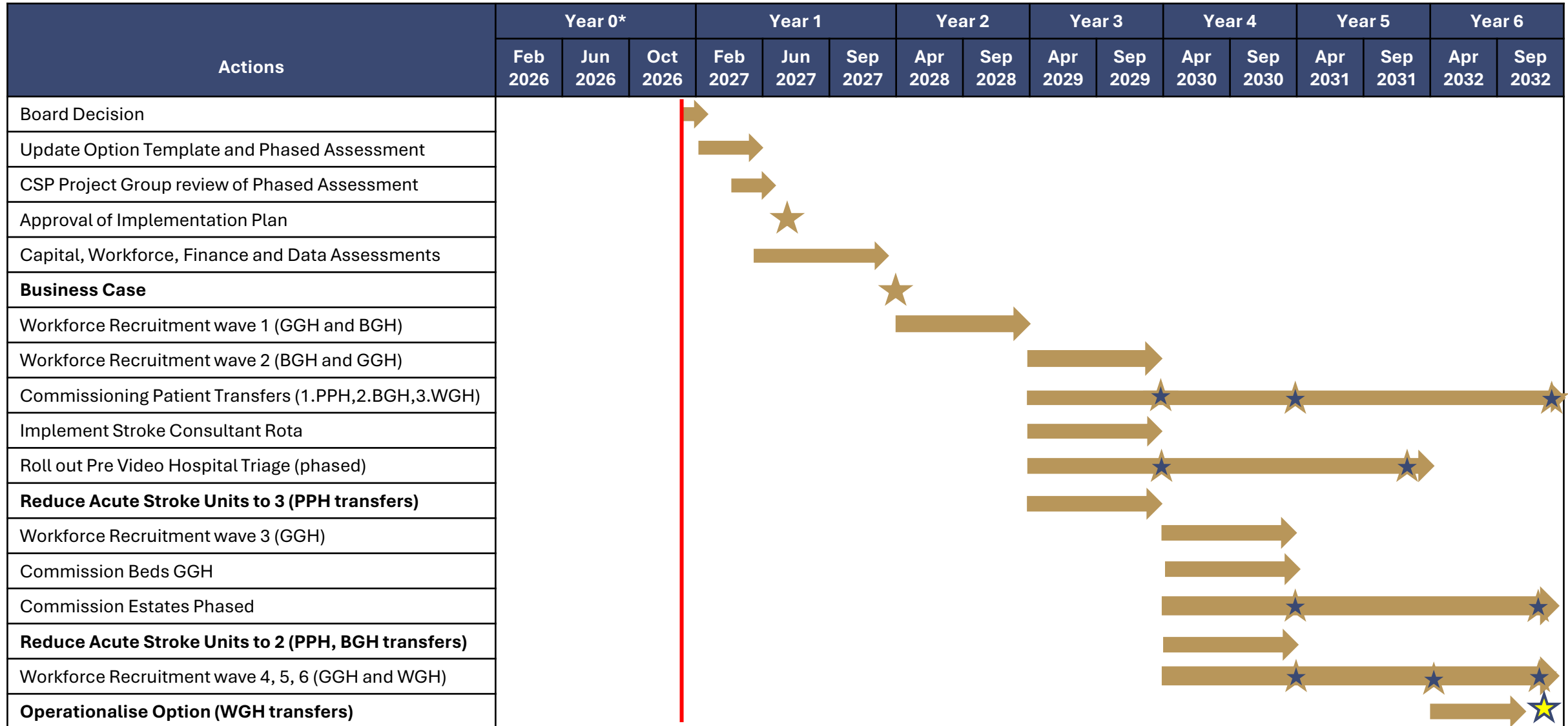


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Timeline		Bronglais	Glangwili	Prince Philip	Withybush
Phase 4 Planning	2026/27 Year 0	Board Decision SDOT Review Phased Assessment Capital Assessment Workforce Assessments Data modelling Finance Assessment			
Implementation Phase	2027/28 Year 1	<ul style="list-style-type: none"> Recruit Therapies (SaLT / Dietetics tbc.WTE) (5 Day service) 	<ul style="list-style-type: none"> Recruit ICSS (ESD-CRT tbc. WTE) (5day service) Recruit Therapies (SaLT / Dietetics tbc.WTE) Recruit 1.0 WTE consultant 1.0 WTE CNS 1.0 WTE SNM 1.0 WTE Therapy Lead 1.0WTE AHP Consultant 1.0WTE Pharmacist 		<ul style="list-style-type: none"> <i>No change</i>
	2028/29 Year 2	<ul style="list-style-type: none"> Recruit ICSS (ESD-CRT) tbc.WTE (7 day service) Recruit Therapies INPT 	<ul style="list-style-type: none"> Acute patients from PPH (5 day service) Commission – Transfers (NEPTS) Repatriate Rehab patients to PPH. Consultant rota (Stroke consultant of the week, Stroke education rotation, Stroke consultant front door.) Recruit 1.0WTE ACP Digital - Role out PVHB TIA clinic for Carmarthenshire patients at GGH 	<ul style="list-style-type: none"> Treat & Transfer starts <i>Stroke Rehabilitation Unit</i> <i>TIA clinics transfer to GGH</i> 	<ul style="list-style-type: none"> <i>No change</i>
Improvement Phase	2029/30 Year 3	<ul style="list-style-type: none"> Commission - Transfers Treat & Transfer starts Commission – Estate <i>Stroke Rehabilitation Unit</i> TIA clinic remain at BGH 	<ul style="list-style-type: none"> Recruit Therapies (inc Spasticity roles) (7-day model). Recruit 1.0WTE Consultant Commission Beds GGH Acute patients from BGH GGH Stroke Unit (7-day Service) 		<ul style="list-style-type: none"> <i>No change</i>
	2030/31 Year 4	<ul style="list-style-type: none"> Digital - PVHT roll out 	<ul style="list-style-type: none"> All PPH patients treated in GGH Recruit 1.0WTE ACP 	<ul style="list-style-type: none"> All PPH patients treated in GGH 	<ul style="list-style-type: none"> Recruit ICSS (ESD-CRT) (7 day service)
Longer Term	2030/31 Year 5		<ul style="list-style-type: none"> Commission New Stroke Unit Recruit Therapies / Nursing tbc.WTE INPT TIA clinics for Carmarthenshire and Pembrokeshire patients at GGH 		<ul style="list-style-type: none"> Commission - Transfers Treat & Transfer starts TIA clinics transfer to GGH
	2031/32 Year 6		<ul style="list-style-type: none"> Recruit 1.0 WTE ACP Recruit Therapies INPT tbc.WTE 		

Stroke Critical Path



(Key: ★denotes Pre Implementation Planning required)

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	CSP
Service Area	Stroke

Title of Procedure, Project, Proposal, Policy being screened:	Preferred option
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Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

<p>Current status:</p> <p>Withybush: A full Stroke services provided. Early Supported Discharge provided also.</p> <p>Glangwili: Full Stroke services provided.</p> <p>Prince Philip: Full Stroke services provided.</p> <p>Bronglais: Full Stroke services provided.</p> <p>Community Sites: No service provided.</p> <p>Future status:</p> <p>Withybush: Treat & Transfer</p> <p>Bronglais: Treat & Transfer Stroke Rehabilitation Unit</p> <p>Prince Philip: Treat & Transfer</p> <p>Glangwili: Acute Stroke Unit (24/7) (inc Stroke Rehab)</p> <p>Community Sites: Current Configuration – No activity at community sites</p>

Assess which protected characteristics will potentially be affected by the option in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

Group	Positive Impact	Negative Impact	No Impact	Unknown Impact
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Age	✓	✓		
Disability		✓		
Gender Reassignment				✓
Marriage / Civil Partnership			✓	
Pregnancy and Maternity		✓		
Race / Ethnicity			✓	
Religion or Belief			✓	
Sex			✓	
Sexual Orientation			✓	
Additional Determinants				
Armed Forces Community			✓	
Socio Economic Duty	✓	✓		
Welsh Language	✓			

Age			
Is it likely to affect older and younger people in different ways or affect one age group and not another?			
Positive Impact	✓	Negative Impact	✓
		No Impact	
Justification of impact identified:			
Positive impacts -			
<ul style="list-style-type: none"> It is hoped that by adopting the new option there will be better quality care and outcomes for patients as well as reducing inpatient stay. Most patients are aged 65+ (although younger personnel can have a stroke), by centralising the service there will be a greater collective of experts in an area to treat the patients. 			
Negative impacts –			
<ul style="list-style-type: none"> Due to patients' families having to travel further and financial implication. Access for relatives to support regular rehab and/or end of life care. There is no direct public transport between sites. Patient stay could increase if unable to access transport once fit for discharge. Age and frailty may have an impact on having to travel further and/or use public transport to visit patients. Older people may have mobility equipment they rely on (problematic on public transport). Some patients may struggle to adjust to the use of technology for virtual contact with family. Patients currently being seen and treated in Worthybush, Bronglais and Prince Philip will have to travel further to Glangwili. TIA clinics will be held in Glangwili and Bronglais hospitals when the option is fully implemented. This would impact older and more frail patients. 			
Mitigations			
<ul style="list-style-type: none"> Tablets available for virtual contact between patients and their families which would reduce the requirement for travel especially with some of the older families. Non-emergency transport system for patients/relatives. 			

- Potential shuttle bus operating providing direct link between sites to support travel.
- Flexibility with regards to appointment times.
- Flexible visiting times for patients to support the challenges brought with extra travel distances.
- Laundry service for patients to ease pressure on visitors bringing clean clothing etc or clothing provided for patients.
- The Health Board could work with local accommodation providers to support families and careers if required.
- For outpatients, telephone or attend anywhere follow ups could be used.
- Linking up with relatives to support patients before appointments to help preparation.
- Work closely with Stroke Association and other 3rd Sector providers to provide support pre appointments.

Disability

Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact		Negative Impact	✓	No Impact	
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Justification of impact identified:

Negative impacts

Due to patients' families having to travel further and financial implication (increased distance to travel and availability of public transport to coincide with visiting times) may result in a reduction in the number of visitors and the frequency of their visits. This will reflect as noted below:

- With the additional travel for families to visit it could impact patient physical and psychological recovery.
- Disability may have an impact on having to travel further and/or use public transport to visit patients. They may have mobility equipment they rely on (problematic on public transport)
- If there is a cognitive problem (patient), relatives may not be able to visit as frequently to help alleviate distress.
- If a relative has cognitive problems, they may not be able to negotiate travelling further afield.

Mitigation – It is anticipated by adopting the new option there will be better quality care and outcomes for patients as well as reducing inpatient stay.

- Tablets available for virtual contact between patients and their families which would reduce the requirement for travel.
- Non-emergency transport system for patients/relatives.
- Potential shuttle bus operating providing direct link between sites to support travel.
- Flexibility with regards to appointment times.
- Flexible visiting times for patients to support the challenges brought with extra travel distances.
- Laundry service for patients to ease pressure on visitors bringing clean clothing etc or clothing provided for patients.
- For outpatients, telephone or attend anywhere follow ups could be used.
- Linking up with relatives to support patients before appointments to help preparation.
- Work closely with Stroke Association and other 3rd Sector providers to provide support pre appointments.

Gender Reassignment

Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact		Negative Impact		No Impact	
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Justification of impact identified:

Unknown impact:

- Availability of gender-neutral facilities
- By use of public transport this could increase anxiety due to potential staring and name calling.

Marriage / Civil Partnership

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.

Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	✓
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Justification of impact identified:

No impacts are foreseen for this protected group.

Pregnancy and Maternity

Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact	✓	No Impact	
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Justification of impact identified:

Negative impacts

- Potential negative impact of there being a potential increase in discomfort for pregnant patients having to travel further to access care, particularly towards the end of the third trimester (increased difficulty in using public transport for longer; potentially needing to access multiple forms of transport for one journey, i.e. train and bus; needing to access toilet facilities more frequently; increase pain/discomfort if having to sit for long periods of time or walk longer distances).
- Potential need for additional childcare arrangements for those with parenting commitments with the need to travel further than they would currently.

Mitigations

- Non-emergency transport system for patients/relatives.
- Potential shuttle bus operating providing direct link between sites to support travel.
- Flexibility with regards to appointment times.
- Flexible visiting times for patients to support the challenges brought with extra travel distances.
- If a new mother had suffered a stroke, consideration would need to be given to allow for feeding.

Race / Ethnicity

Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	✓
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Justification of impact identified:

No impacts are foreseen for this protected group.

Religion or Belief

Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓
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Justification of impact identified:

No impacts are foreseen for this protected group.

Sex

Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:

No impacts are foreseen for this protected group.

Sexual Orientation

Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
-----------------	--------------------------	-----------------	--------------------------	-----------	-------------------------------------

Justification of impact identified:

No impacts are foreseen for this protected group.

Armed Forces Community

Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: [Armed-Forces-Covenant-duty-statutory-guidance](#)

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
-----------------	--------------------------	-----------------	--------------------------	-----------	-------------------------------------

Justification of impact identified:

No impacts are foreseen for this protected group.

Socio Economic Duty

Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: [more-equal-wales-socio-economic-duty](#)

Positive Impact	<input checked="" type="checkbox"/>	Negative Impact	<input checked="" type="checkbox"/>	No Impact	<input type="checkbox"/>
-----------------	-------------------------------------	-----------------	-------------------------------------	-----------	--------------------------

Justification of impact identified:

Patients

Positive impact

- It is anticipated by adopting the new option there will be better quality care and outcomes for patients as well as reducing inpatient stay, which would reduce financial burden of visiting costs.
- Tablets available for virtual contact between patients and their families which could increase contact and reduce financial costs of visiting and also reduce distress between patients and their loved ones. Not reliant on visiting times.

Negative impact

- Due to patients' families having to travel further it will have a financial implication. Timing and availability of public transport may impact visiting times.

Mitigations

- Overnight accommodation may need to be considered for families that have to travel a long distance.
- The Health Board could work with local accommodation providers to support families and careers if required.

- Non-emergency transport system for patients/relatives.
- Potential shuttle bus operating providing direct link between sites to support travel.
- Flexibility with regards to appointment times.
- Flexible visiting times for patients to support the challenges brought with extra travel distances.
- For outpatients, telephone or attend anywhere follow ups could be used.
- Linking up with relatives to support patients before appointments to help preparation.
- Work closely with Stroke Association and other 3rd Sector providers to provide support pre appointments.

Staff

Positive Impact

- Consideration will need to be given to transport services available to staff that will change their base e.g. car sharing.
- There are creche facilities available on Health Board sites.

Negative impact

- Centralising teams to a different site may mean that some staff members incur additional time and cost to travel to work. Timing and availability of public transport may impact shift times.
- Potential need for additional childcare arrangements for those with parenting commitments with the need to travel further than they would currently.
- Potential need for additional caring arrangements where staff members also have caring responsibilities with the additional travel to work time.

Mitigations

- An improved work environment for staff by locating the service on two sites as opposed to four in its current form.
- More stable and sustainable work environment by implementing a 2-site model.
- Organisational Change Process (Workforce, Trade Union, Staff) will allow staff the opportunity to be able to discuss their issues and find a resolution.
- Loan pool cars available if having to travel to alternative sites.
- Nursery on sites for staff use with staff discount.

Welsh Language

Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact		Negative Impact		No Impact	
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Justification of impact identified:

Impacts considered - unknown at this stage:

Hywel Dda University Health Board acknowledges and celebrates that in our communities in West Wales, we have a high proportion of our population – whether patients, service users, carers or volunteers - who wish to, and have a need to, communicate with the health service using their first language - Welsh.

The Health Board has always taken its statutory duties towards the Welsh language very seriously. We recognise that as an organisation we have always tried to deliver our services in the service users’ language of need; however, we have not consistently achieved this. We are committed to delivering the current Welsh Language Standards. While clear in our commitment, to deliver our statutory duties, we recognise that the commitment is not always consistent across our sites, and that culture needs to continue to change for us to deliver a seamless bilingual service to our service users. As part of this effort, we conform to the Welsh language standards 99-102, such as providing staff with employment documents, should they indicate that they prefer to receive the documents in Welsh. We work proactively with teams where there is a lack of Welsh speakers and encourage staff to learn Welsh. This is done by offering courses for all skill levels, as well as opportunities to practice the language informally. We work closely with the National Centre for Learning Welsh who tailor courses and tutors to health boards’ specific needs.

The Health Board has recorded the Welsh Language Skills Levels of 97% of our workforce. Work will continue to assess the language impact, if any, of all the options within the CSP. The Welsh Language Services team will work closely with the Workforce and Organisational Development team to assess ongoing service needs in relation to Welsh language provision.

The impact of any change can only be measured through the assessment of the availability and skills of individuals who are able to speak Welsh. Until specific options for the future of the services are confirmed, and we carry out necessary Organisational Change Policies with staff teams affected, the specific impacts on Welsh language skills amongst the workforce involved in the reconfigured services cannot be fully assessed. However, this would be monitored and any risks to Welsh language service provision will be identified with mitigations and an action plan to address and improve. The Health Board's commitment to providing information regarding services and sites bilingual will not be impacted by the service change/s.

Health Board								
Proficiency Levels (headcount)	No Skills /Dim Sgiliau	Entry / Mynediad	Foundation /Sylfaen	Intermediate / Canolradd	Higher /Uwch	Proficiency /Hyfedredd	Not yet recorded on ESR	Grand Total
Grand Total	4,891	2,676	1,075	884	922	1,355	312	12,115
%	40%	22%	9%	7%	8%	11%	3%	100%
Stroke								
Grand Total	87	42	13	13	14	21	9	199
%	44%	21%	7%	7%	7%	11%	5%	100%

Additional Comments:

Staff changing location maybe unfamiliar site and patient pathway and therefore may require further training and site map.

Positive

- Within Option this follows a more intensive 7 day service cover with 24 hour service at Glangwili which will improve outcomes for patients for the first 72 hours of Stroke Care from admission.
- This option will help align the service with the new standards
- This option will improve the sustainability through recruitment and retention by having purpose built specialist unit on one site.
- This will ensure that both patients and staff are operating safely with timely and immediate access to appropriate supervision and patient outcomes will likely improve as a result.
- Bronglais will retain the rehab element of stroke care.

Negative:

- Patients currently being seen and treated in Worthybush, Bronglais & Prince Philip will have to travel further.
- Timing and availability of public transport may impact visiting times.
- Longer work hours with travel times added to the working day.
- Some patients may struggle to adjust to the use of technology for virtual contact with family. Stroke patients can be left with cognitive and physical disabilities that may make the use of technology more difficult.

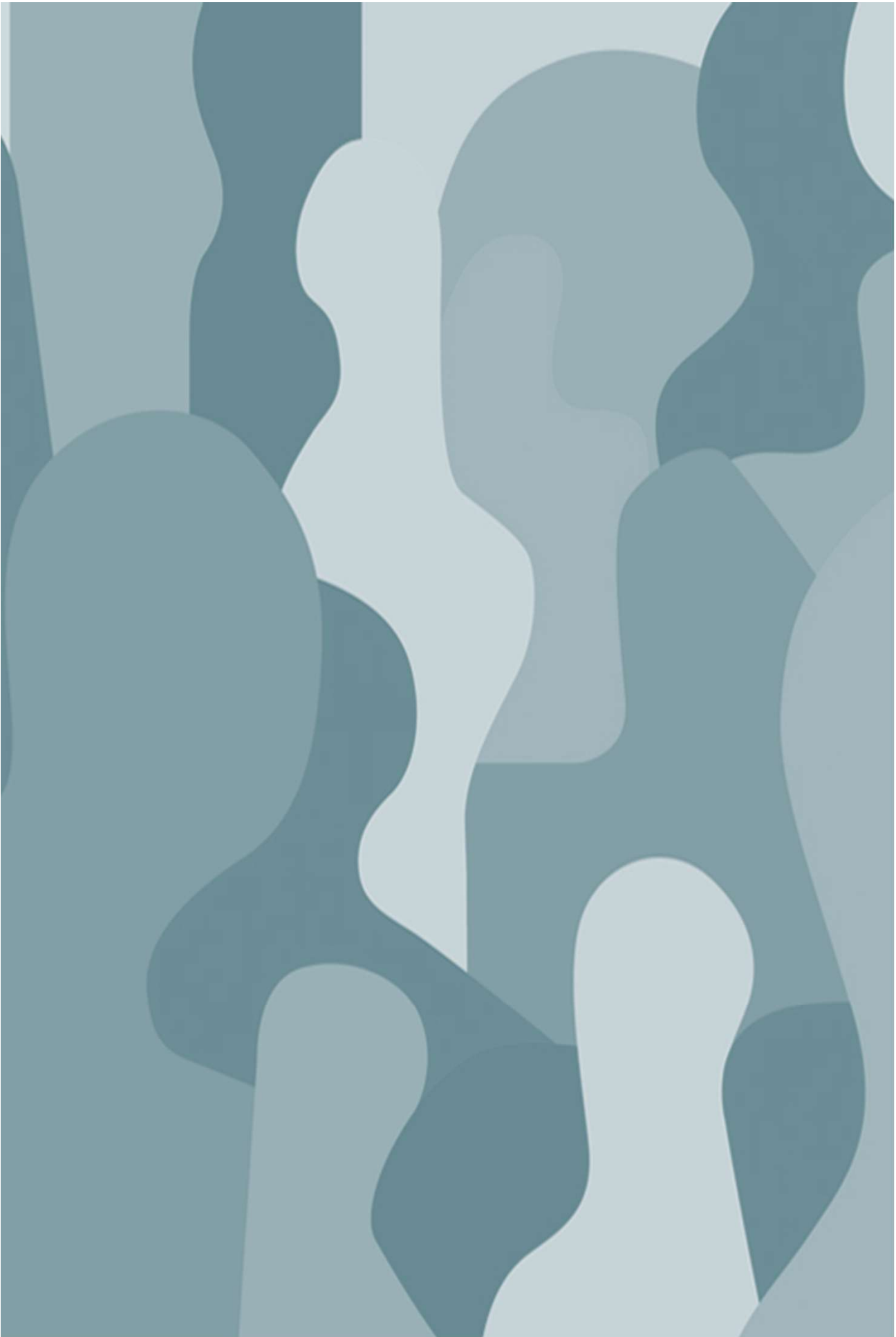
Mitigation –

- The option will also require effective commissioning of inter hospital services.
- Consideration will need to be given to transport services available to families visiting patients and supporting patient discharge.
- It is anticipated by adopting the new option there will be better quality care and outcomes for patients as well as reducing inpatient stay.

Screening Completed by:	Name	Rian furlong
	Title	Project Manager
	Contact details	transformation.mailbox@wales.nhs.uk
	Date	28/04/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Sentil Kumar, Bethan Andrews & Louise Coombe
	Title	Stroke Team
	Date	28/04/2026
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	1/5/2026
Diversity and Inclusion Team additional Comments:	EqIA updated for new Stroke option.	

**EQUITY
INFORMED -
HEALTH
IMPACT
ASSESSMENT
(EI-HIA)**





Appendix 4 - Stroke - preferred option Equity focused HIA

INTRODUCTION:

Population health and wellbeing can be influenced by wider socio-economic and environmental factors and their impact vary considerably across different population groups as defined by age, sex, geography and deprivation.

Health equity is a fundamental principle that recognises that everyone deserves the opportunity to achieve their full health potential. However, inequalities in health outcomes continue to persist, disproportionately affecting marginalised and underserved individuals and communities.

WHY DOES HEALTH EQUITY MATTER?

Everyone has the right to live a healthy life, but systemic barriers and injustices such as where you were born, level of education, adverse childhood experiences, community cohesion and access to quality education and housing often prevent certain individuals and population groups from accessing the resources and opportunities they need to achieve optimal health.

Promoting health equity can also lead to better health outcomes for all, as improving overall access to quality healthcare and services can improve population health.

Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

World Health Organisation



The route to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone justly according to their circumstances.

Race Matters Institute

HEALTH INEQUALITIES MAY BE DRIVEN BY:

- Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.
- Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.
- Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.
- Unequal access to or experience of health and other services between social groups.

Appendix 4 - Stroke - preferred option Equity focused HIA

This Equity Informed Health Impact Assessment is designed to help healthcare organisations and practitioners systematically assess inequalities when developing policy, programmes and projects.

This HIA should be used at the start of any work programme to assess potential impacts, it can also be used to analyse health equity within existing work

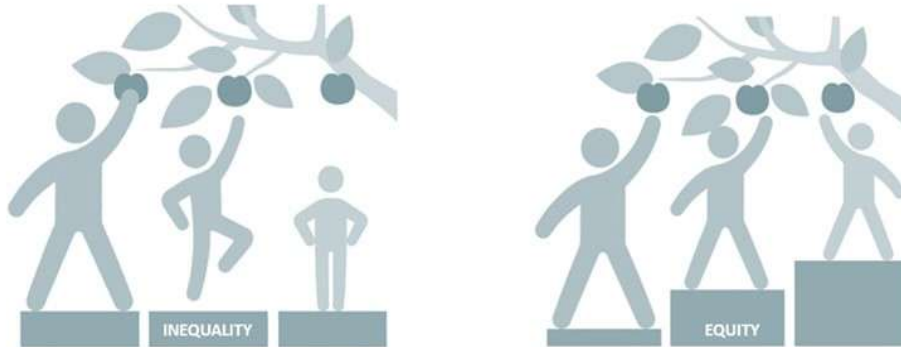
The EQUITY CHECKLIST should be used first to help practitioners/planners understand the population of interest, how needs are being assessed and addressed, and who else should be involved to identify local resources and assets as well as support co-design.

Acknowledgements:

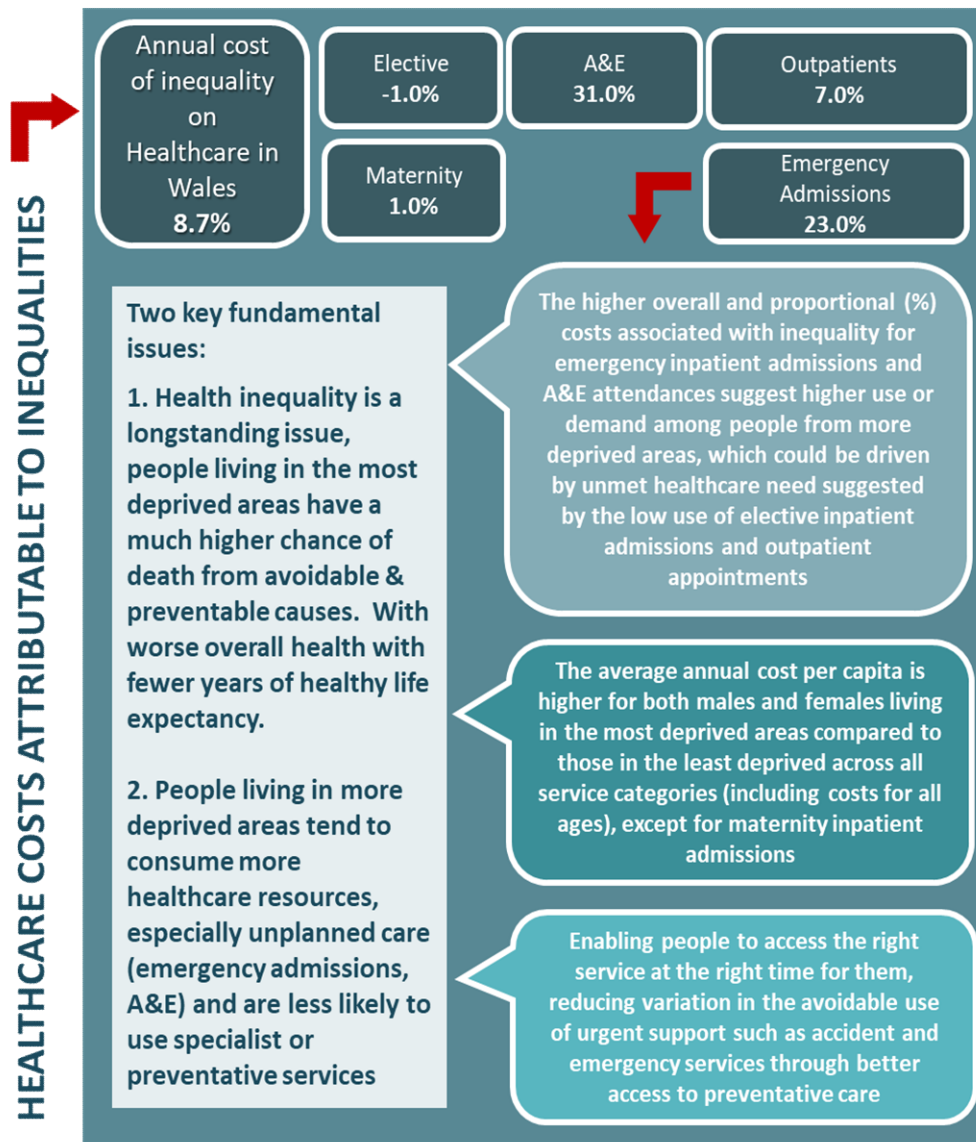
Public Health Wales Primary Care

DEFINITIONS

INEQUALITY refers to differences in outcomes between different groups of people, often due to factors such as income, education, race, gender or geographic location. These differences can lead to unequal access to healthcare, education, employment and other essential services leading to a cycle of poverty and social exclusion. Inequality can perpetuate social divisions and create barriers to social mobility. Addressing inequality requires a focus on the social determinants of health and implementing policies and interventions that aim to reduce disparities and promote equity and inclusivity.



EQUITY is the concept of fairness and justice in the distribution of resources and opportunities, with a focus on addressing the needs and circumstances of individuals to ensure everyone has an equal chance to succeed. It involves recognising and acknowledging the systematic barriers that contribute to inequality and highlights the principle of ensuring that all individuals have equal access to services and opportunities to achieve their full potential regardless of their social or economic status. It is about addressing the root causes of inequalities and working towards eliminating barriers to and improving access and quality for all populations.



Statutory Requirements and Policy

[A Healthier Wales: Long term plan for health and social care](#)

[Wellbeing of Future Generations \(Wales\) Act 2016](#)

[Socio-economic Duty](#)

[Equality Act 2010](#)

[Social Services & Wellbeing \(Wales\) Act 2014](#)

[The Primary Care Model for Wales](#)

[Welsh Language Standards](#)

[NHS Continuing Healthcare Framework](#)

[NHS Planning Framework 2022-2025](#)

[Digital Health and Care Wales: Equality & Diversity Policy](#)

[Public Health \(Wales\) Act 2017 \(legislation.gov.uk\)](#)

AIM AND OBJECTIVES:

AIM:

- To promote fairness, justice and equity in healthcare delivery to improve health outcomes for all individuals, particularly those who experience barriers to accessing quality care.

OBJECTIVES:

- Identify and understand the social determinants of health that contribute to health disparities among different population groups.
- Assess the potential impacts of health care policies, programmes and services on marginalised and vulnerable populations
- Evaluate the effectiveness of interventions in reducing health inequities and inequalities
- Engage with community members and stakeholders to ensure their perspectives and experiences are considered in the HIA process.
- Develop recommendations and strategies to address identified disparities and promote equitable access to healthcare services
- Monitor and evaluate the implementation of recommendations to track progress towards achieving health equity goals
- Promote transparency and accountability in decision-making processes to ensure that health equity considerations are integrated into healthcare planning and delivery.

Appendix 4 - Stroke - preferred option Equity focused HIA

For anyone who is involved in the planning and/or delivery of health and social care services the checklist below can be used as a reminder to keep health equity at the forefront of discussions



Does this approach consider:

- Populations living in the most deprived communities?
- Those with protected characteristics? (e.g., age sex, race, gender)
- Vulnerable and Inclusion Health Groups? (e.g., Socially excluded, Homeless, Gypsy, Roma and Travellers, Sex Workers, People in contact with the Justice System)
- Rural Populations?
- Those who miss appointments on a regular basis?
- Those who access emergency services or A&E on a regular basis for non-urgent/routine care that could be managed in the community?



Will this approach:

- Address poor health based on need and how will you know? (e.g., has a Health Needs Assessment been undertaken)
- Consider those health conditions that have the biggest impact on services and what are the trends (e.g. CVD disorders, mental health, respiratory disease)
- Integrate prevention across the healthcare continuum for example, developing models of care that consider medical care alongside the social determinants of health, mental wellbeing and behavioural factors. (See prevention framework)
- Existing services and pathways in a particular area and are these services/pathways accessible?
- Ensure service utilisation is monitored to assess healthcare service use by various characteristics? (e.g., Deprivation, Protected Characteristics, Geography)



Does this approach optimise interventions:

- Through using data to understand the factors in the local population that may contribute to poor health or high service utilisations, for example, an ageing population, areas of deprivation, high prevalence of lifestyle risk factors such as smoking or obesity or low uptake of preventative services.
- Through systematically assessing impact on inequalities and monitoring change over time (e.g., pilot testing, evaluation, research, establishing realistic benchmarks).

Appendix 4 - Stroke - preferred option Equity focused HIA



Does this approach consider:

- Strengthening and expanding partnerships to enhance health equity? (*e.g., Multi-sectoral, Multi-disciplinary, Community*)
- Ensuring that those that are likely to be affected by the outcome are engaged in the process (*Collaboration, Co-production, Engagement*)
- Making a commitment to health equity through the development and application of inclusive policy and practice that is fair and transparent
- Leadership and accountability by ensuring that organisations and teams understand their responsibilities in relation to tackling inequalities
- The resource/financial implications of this programme/intervention/option in terms of workforce demand, skills & training, programme costs?
- Patient experience (what does it tell you and how is it used?)



Could this approach widen inequalities by:

- Not tackling the full spectrum of causes? (*behavioural factors, wider determinants of health*)
- Not being co-designed? (*working in partnership with all stakeholder including those that deliver and use services*)
- Relying on professional led interventions? (*can reinforce existing systems and barriers and may not reach those in greatest need*)
- Not recognising the economic impact to service users in terms of travel cost, time off work and opportunity costs relating to immediate financial needs over a health intervention with no immediate benefits (*e.g., screening, immunisations*)
- Failing to ensure that health information is delivered in a way that empowers people to make informed decisions to meet their needs. (*e.g., where services are available, Health Literacy and Communication Strategies*)

Appendix 4 - Stroke - preferred option Equity focused HIA

Which of the following recommendations apply to your initial assessment using the equity checklist?

<p>1. There is likely to be <u>minimal</u> differential health impact following the implementation of this proposal/option.</p>	<p>Think about how this will be monitored over time and what action should be taken if differences in health outcomes occur.</p>
<p>2. There is likely to be <u>some</u> differential health impact (Use the EF-HIAF to identify any issues):</p>	<p>Think about the key areas where this difference in outcomes may occur. E.g. Not considering all sub-populations, not fully understanding the needs of all groups, a lack of engagement from partners and service users.</p>
<p>3. There is likely to be <u>substantial</u> differential health impact. Further analysis will be undertaken to address disparities in health outcomes and unmet needs. (Use the EI-HIA to identify any issues)</p>	<p>As above - Think about the key areas where this difference in outcomes may occur. E.g. Not considering all sub-populations, not fully understanding the needs of all groups, not accessing timely data, a lack of engagement from partners and service users.</p>

Appendix 4 - Stroke - preferred option Equity focused HIA

Formal process of HIA involves a range of stakeholders including community health workers, and other health equity and value integration engagement with key stakeholders (local and global)

Item	Comments
1.1	1.1.1
1.2	1.2.1
1.3	1.3.1
1.4	1.4.1
1.5	1.5.1
1.6	1.6.1
1.7	1.7.1
1.8	1.8.1
1.9	1.9.1
1.10	1.10.1
1.11	1.11.1
1.12	1.12.1
1.13	1.13.1
1.14	1.14.1
1.15	1.15.1
1.16	1.16.1
1.17	1.17.1
1.18	1.18.1
1.19	1.19.1
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1.93	1.93.1
1.94	1.94.1
1.95	1.95.1
1.96	1.96.1
1.97	1.97.1
1.98	1.98.1
1.99	1.99.1
1.100	1.100.1

Appendix 4 - Stroke - preferred option Equity focused HIA

WILL THIS PROPOSAL (Option) AFFECT THE WHOLE POPULATION, OR WILL THERE BE A DIFFERENTIAL IMPACT ACROSS SUB-GROUPS? (Link to any Equality Impact Assessments undertaken to help answer the questions in this section)	WILL THE IMPACT BE ...			Do you know how to identify your population? (Yes/ No/ Not sure)	SUPPORTING EVIDENCE: What data do you have to help you understand your population/ patient profile? What additional data do you need?	MITIGATION	MONITORING	
	NEGATIVE	NEUTRAL	POSITIVE					
Populations living in the most deprived communities. (see the WIMD tab)	✓			Reducing the number of sites will mean potential additional travel time and costs that will add further financial burden to deprived communities	Will need to work with the Informatics Team to gather this information as not currently collected and utilised	Socio economic duty monitored as part of CSP Equality Impact Assessments.	Identify ways to reduce potential negative impacts and amplify positive impacts. For example consider service design and who is currently being reached? Consider how well team members understand health inequalities.	Identify way to measure success for each mitigation strategy identified.
Rural Populations	✓			Reducing the number of sites will mean potential additional travel time and costs that will add further financial burden to deprived communities	Will need to work with the Informatics Team to gather this information as not currently collected and utilised	Travel has been identified as a negative impact for some of our population within the impact assessment work.	This has been identified within the EQIA and also includes mitigation.	Via PROMS & PREMS and monitor through themes in concerns
Those who miss appointment on a regular basis or are lost to follow-up?		✓		Not considered as part of the EQIA or CIA	Will need to work with the Informatics Team to gather this information as not currently collected and utilised	Process in place in order to follow up any missed appointments in line with referral to treatment time.	Offer virtual clinics where clinically appropriate	Through the referral to treatment time team.
Those who access emergency services or A&E on a regular basis for non-urgent care that could be managed in the community?			✓	Not considered as part of the EQIA or CIA				
Those with Protected Characteristics under the Equality Act 2010								
- Age								
- Disability								
- Sex (male/female)								
- Marriage and Civil Partnership								
- Race & Ethnicity								
- Pregnancy & Maternity								
- Sexual Orientation								
- Religion or Belief								
- Gender Reassignment								
Vulnerable and Inclusion Health Groups								
People who are experiencing or are at risk of homelessness (may also include those in temporary accommodation or care leavers)								
People with drug and alcohol dependence								
Vulnerable migrants, refugees, asylum seekers, undocumented migrants								
Gypsy, Roma, and Traveller communities								
People in contact with the justice system								
Victims of modern slavery								
Sex workers								
Other Groups (Please list below):								

Please see DATA SOURCES tab to access information on how to identify your local population and other statistics

Appendix 4 - Stroke - preferred option Equity focused HIA

HEALTH IMPACT		Expected Effect of Proposal/Option							
		No			NEUTRAL	YES			N/A
		-3	-2	-1	0	1	2	3	
ACCESS	Does this proposal/option consider the impact on rural communities and people living within those communities?					1			
	Affordability - has an assessment of the cost of the service to patients been undertaken (e.g. travel, time off work), including any potential barriers for low income individuals?			-1					
	Availability of services - Has consideration been given to patient demand to require service and availability of appointments been undertaken, ensuring these align with needs?					1			
	Does the service/option meet the cultural and linguistic needs of diverse populations?				0				
	Will there be a change in demand or access to health and social care services? e.g., Primary Care, Secondary Care, Community Services, Social Services etc.				0				
	Digital Access - Have telehealth options or digital platforms for accessing services, especially for those with mobility or transportation issues?				0				
RELEVANCE TO NEEDS	Has a review of data from any health, wellbeing or community needs assessment been undertaken to ensure the service addresses identified health challenges in the population?							3	
	Has feedback from community members, healthcare professional and local organisations been considered (Stakeholder Engagement)?							3	
	Is the programme/option aligned to local and national health priorities and strategic plans							3	
	Is the programme/option aligned to the specific demographics and health needs of the target population?						2		
	Are people's views and experiences gathered and acted upon to shape and improve services?								3
	Has a review of existing evidence been undertaken to show the effectiveness of similar programmes/options in improving health outcomes?						2		
	Have criteria for monitoring the clinical effectiveness of the programme/option been developed to measure patient outcomes e.g. admissions, recovery rates, length of stay, patient satisfaction?						2		
	Is service use (for this option) monitored to assess utilisation by various characteristics (e.g. minority groups, sex, deprivation).					1			

Appendix 4 - Stroke - preferred option Equity focused HIA

Supporting evidence / potential effect on inequity and inequalities	MITIGATION: If the effect of the proposal/option is negative identify ways to reduce the negative impacts (if possible). For example consider service design and who is currently being reached.
<p>The Options development process considered data with reference to patient drive times, LSOA access times from communities, the 2023 Staff Transport survey and Patient Transport Survey. The impact of this was assessed through EqIA and QIA process</p>	<p>Mitigations where negative aspects have been identified have been considered through the QIA and EqIA for this domain.</p>
<p>The EqIA considers where there maybe barriers to accessing services. Within this mitigations have been noted. A link to the latest EqIAs can be found within May 2026 papers. It should be noted that these are live documents as such they should only be considered up to date at the time of being published.</p>	<p>Business as usual services within the health board include access to the Non-Emergency Patient Transport Service (NEPTS). EQIA includes potential mitigations around supporting costs towards travel.</p>
<p>The objectives of the clinical services plan included ways in which activity can be increased and / waiting times reduced. Where this was the case the service conducted a SWOT assessment on whether they felt the option would be able to support in meeting demand. Some of these may be subject to funding.</p>	<p>Where service backlogs do exist current business operations can include non-recurrent waiting list initiatives.</p>
<p>Aspects covered within EqIA. EQIA references access to translation services and sites also have multi-cultural facilities (prayer rooms) to support patient/visitor needs. Hearing loops are also used across the Health Board. Where required Services can also provide material for those with visual impairments?</p>	<p>Business as usual operations include services to meet the needs of linguistic and cultural needs.</p>
<p>The option will see a change in demand over time. Community Integrated Stroke Team service should look to reduce the length of stay. Demand within an acute setting will lower and the demand within the community will increase. This will then have further impact on the demand on other health and social care services.</p>	<p>Business as usual activities within the service will remain.</p>
<p>Some options consider digital solutions as to enhance the service over time. Telemedicine will be used to improve communication and assessments between treat and transfer sites and Stroke units.</p>	
<p>The evaluation criteria within the programme and phase 3 the options development process considered the Regional Joint Committee Health Needs Assessment</p>	
<p>The CSP programme has considered this in several forms. During Phase 1 - The Issues Paper early targeted engagement asking those who had accessed our service what was good, bad and could be better. Circa 6,000 responses were received these can be seen here: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/appendix-a-clinical-services-plan-pdf/</p>	
<p>During Phase 2 Service users were asked to support the check and challenge process as well as a number of informing sessions which can be found throughout the published Output reports: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-25-july-2024/board-agenda-and-papers-25-july-2024/3-6-implementing-the-a-healthier-mid-and-west-wales-strategy-pdf/#page=28</p>	
<p>During Phase 3 - In November 2024 the Board approved the CSP Programme to progress to Phase 3 and Prepare for Public consultation to further test and assess the impact of these option of our communities, workforce and stakeholders including other healthcare professionals and local organisations.. This option has been developed as a result of an alternative option drawn from the consultation questionnaire.</p>	
<p>For Stroke the Board asked for a new preferred option to be developed further and to undertake some additional engagement with our communities before a final decision is made.</p>	
<p>A number of services within scope of the CSP programme are aligned to either Regional or National programmes and in some cases multiple. These can be seen through the Service Commonality and Variance document for the programme.</p>	
<p>The Stroke service is required to follow 2023 Royal College of physicians Stroke guidelines. There is a National Stroke Programme and also a Regional Joint Committee Regional Programme.</p>	
<p>Certain demographics and patient journey data were assessed within the programme these can be seen through the Activity data within the issues paper (March 2024 Board - Issues Paper) and also further asessed in population demand and growth to require service within the evaluation criteria (May 2025 Board)</p> <p>Population demand overlays analysed the patient access to service by age profile and community as to understand how demand may shape and change throughout Hywel Dda. This can be seen within May 2025 Board Papers.</p>	
<p>The alternative option has been developed as a result of feedback from the public consultation. It notes that outpatient appointments remaining in Carmarthen will result in a more accessible service to more people</p>	<p>Once a decision is made by Board on a service option. The service within their implementation plan should look to conduct further detailed analysis or a refresh of the current analysis as to ensure a robust foundation for business planning purposes.</p>
<p>As described above a number of approaches have been sought to seek views and understand impacts. Further analysis of this information can be seen within the issues paper and the patient experience that was generated and feedback through ORS report in survey responses: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/appendix-a-clinical-services-plan-pdf/</p>	
<p>Views of the population have been recorded as part of the public consultation. These have fed directly into the development of this alternative option.</p>	
<p>Through the Options Development Process this can be explained through the use of the Hurdle and Evaluation Criteria. As well as the use of the QIA process. Within the services options were considered by a multi disciplinary group of clinicians and operational leads along with key interdependencies as to assess what options could look like and the hurdle and evaluation criteria were used as to assess these. The Quality Impact Assessment utilises the STEEP principles to assess the impact of each option also. Which was reviewed by the QIA panel at that time.</p> <p>Quality Impact Assessments – https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/#page=85</p>	
<p>The issues paper Activity Data and the Options Development Process Evaluation Criteria contain relevant information to asses and inform and measure the services within scope of the clinical services plan. (March 2024 Board - Issues Paper).</p>	
<p>The data will be refreshed at the point of Board decision for service implementation.</p>	
<p>Protected characteristics within the programme have been considered through the EqIA process. The assessment supporting the Options development process can be found here: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/#page=233 however it should be noted that these are live documents and are in the process of being updated as to support Phase 3 - public consultation where relevant to do so.</p>	<p>This may require further assessment through the population impact and vulnerable and inclusion health groups. Services may need to further consider these aspects should option develop and progress to the next stage.</p>

Appendix 4 - Stroke - preferred option Equity focused HIA

<p>The interdependencies were developed as per the update to Board in March 2023. To date, a total of 142 service interdependencies have been identified. These continue to be tested and where the process identifies further interdependencies these are checked through the Clinical Reference Group. An assessment is made as to whether the interdependency is:</p> <ol style="list-style-type: none"> 1. Critical to the options development process (known as the 'Options Development Group') 2. Important to check and challenge the options (the 'Check and Challenge Group' includes but is not limited to 700 plus representatives from the early targeted engagement process used within the Issues Paper, Medical Leadership Forum (MLF), Healthcare Professionals Forum (HPF)), or 3. Key to be kept informed as per the process defined within the Communications and Engagement plan. <p>As a result 45 interdependencies were identified as 'critical' to the Options Development Group which is supported by a mix of circa 80 representatives across Clinical, Nursing, Therapies, and Support Services (including Liaison, service users across the Health Board, and Trade Union colleagues).</p>	
<p>Phase 2 included the development of indicative financial estimates, workforce assessments and capital and estates assessments as to understand these domains. The details and evidence of this will form a component part of the technical documents suite for Public Consultation during Phase 3 of the programme.</p> <p>Phase 3 included the development of indicative financial estimates, workforce assessments and capital and estates assessments as to understand these domains. The details and evidence of this will form a component part of the technical documents suite for Public Consultation during Phase 3 of the programme.</p>	<p>Whereas this process was effectively complete it identifies a number of service improvement domains that are subject to funding. Therefore once an option is progressed services may need to prepare and conduct further details analysis of these domains as to submit and progress appropriate business cases to deliver the option.</p>
<p>Phase 2 as described previously included a series of check and challenge sessions in addition to this the communications and engagement plan https://nhs.wales365.sharepoint.com/:b:/r/sites/HDD_ClinicalServicesPlan-CSP-CommunicationandEngagement/Shared%20Documents/CSP%20-%20Communication%20and%20Engagement/C%26E%20Plan/Clinical%20Services%20Engagement%20and%20Communications%20Plan%20October%202025%2010%201.pdf?csf=1&web=1&e=W1Bp4Vhighlitehd and tracks where the progress of the programmes has been considered by wider stakeholder both internally and externally.</p> <p>A public consultation was carried out during phase 3. This included drop in events, staff events and targeted consultation with organisations, including stroke support groups. Community attitudes and perceptions towards the initial proposal helped shape this alternative option. Furthermore, the alternative option has been presented to a wide range of stakeholders for their view and these have been played back to the options development group</p>	<p>Phase 3 of the programme a Public Consultation will look to measure and consider the wider attitudes and perception of the proposed options. This will be supported by advice of HICO and ORS survey using both closed and open ended questions</p>
<p>The EqIA considers where there may be barriers to accessing services. Within this mitigations have been noted. A link to the latest EqIAs can be found within May 2026 papers. It should be noted that these are live documents as such they should only be considered up to date at the time of being published.</p>	
<p>The communications and engagement plan tracks and monitors the number of stakeholder engagement events that have been taking place throughout the process. https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/clinical-services-plan-consultation/consultation-events/</p> <p>These have included Regional Programme Boards, Stakeholder Reference Groups, Regional meetings such as RJC and or the Mid Wales Joint Committee (which includes Powys Teaching Health Board and Betsi Cadwalder University health Board) as well as Swansea Bay university Health Board)</p>	
<p>The programme foresees that for the preferred option being considered by services may be perceived as negative to parts of our community. However the process to date as previously described has considered Patient Experience, Concerns data, Early Targeted Engagement and service user involvement during phase 2. As such where possible views have been sought to influence the process throughout the programme cycle.</p> <p>For Stroke this has caused concern for patients groups accessing the Bronglais/Withybush & Prince Philip site. Concerns have been raised on the impact this may have on the community in accessing services and onward treatment to other sites.</p> <p>Please see output of the consultation in the Consultation Report for option A, B, 106 & 210. This highlights where there has been public concern, in particular there is a concern regarding transport and travel for patients and families to receive health care further away.</p> <p>As the further engagement for Stroke will follow the same process as previous options a Engagement Report will be produced following the engagement period to capture feedback.</p>	<p>Phase 3 of the programme a Public Consultation will look to measure and consider the wider attitudes and perception of the proposed options. This will be supported by advice of HICO and ORS survey using both closed and open ended questions</p> <p>In addition to this the QIA for the stroke options consider a range of mitigations that are required as to manage and reduce the impact of change. Some of these include the retention of workforce skills at the site for the initial assessment, treatment and potential transfer. The requirement for an effective Inter Hospital Transfer as well as Access to telemedicine from Specialist Stroke Consultants within the health Board where needed.</p>
<p>Phase 2 as described previously included a series of check and challenge sessions in addition to this the communications and engagement plan https://nhs.wales365.sharepoint.com/:b:/r/sites/HDD_ClinicalServicesPlan-CSP-CommunicationandEngagement/Shared%20Documents/CSP%20-%20Communication%20and%20Engagement/C%26E%20Plan/Clinical%20Services%20Engagement%20and%20Communications%20Plan%20October%202025%2010%201.pdf?csf=1&web=1&e=W1Bp4Vhighlitehd and tracks where the progress of the programmes has been considered by wider stakeholder both internally and externally.</p> <p>Public views and experiences have been shared within the consultation, these are summarised within the consultation report. Suggestions were taken and used to develop alternative options. Any business as usual feedback was passed to the relevant service leads.</p>	<p>Phase 3 of the programme a Public Consultation will look to measure and consider the wider attitudes and perception of the proposed options. This will be supported by advice of HICO and ORS survey using both closed and open ended questions</p>
<p>The CSP Programme has followed good practice advice and guidance since inception. Which included advisors such as the Consultation Institute (tCI) at that start and currently HICO following principles of The Consultation Foundation. The process is therefore designed to be transparent, objective and well tested throughout its journey as to ensure that our communities, workforce, stakeholder and Board can make either informed decisions and or choices on the service options.</p> <p>See May 2025 Board Papers https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-29-may-2025/</p>	<p>The process of going to a formal public consultation is legal requirement as to ensure our communities are able to make informed choices on change that may impact them. To that end the public consultation in later 2025 will allow for communities to directly feedback on the concerns, impacts and options for a particular service of interest to them and in this case Stroke.</p>

DATA SOURCES

Link to PHW Public Health Outcomes Framework

[Public Health Outcomes Framework \(2022\) - Public Health Wales \(nhs.wales\)](#)

ARCH Health Needs Assessment

[ARCH Health Needs Assessment](#)

Deprivation data:

[WIMD - Explore \(gov.wales\)](#)

[WIMD - Hywel Dda University Health Board \(gov.wales\)](#)

Click on the links below to access population profile data by Unitary Authority, Community or Middle Super output Area:

[Pembrokeshire \(W06000009\) - ONS](#)

[Ceredigion \(W06000008\) - ONS](#)

[Carmarthenshire \(W06000010\) - ONS](#)

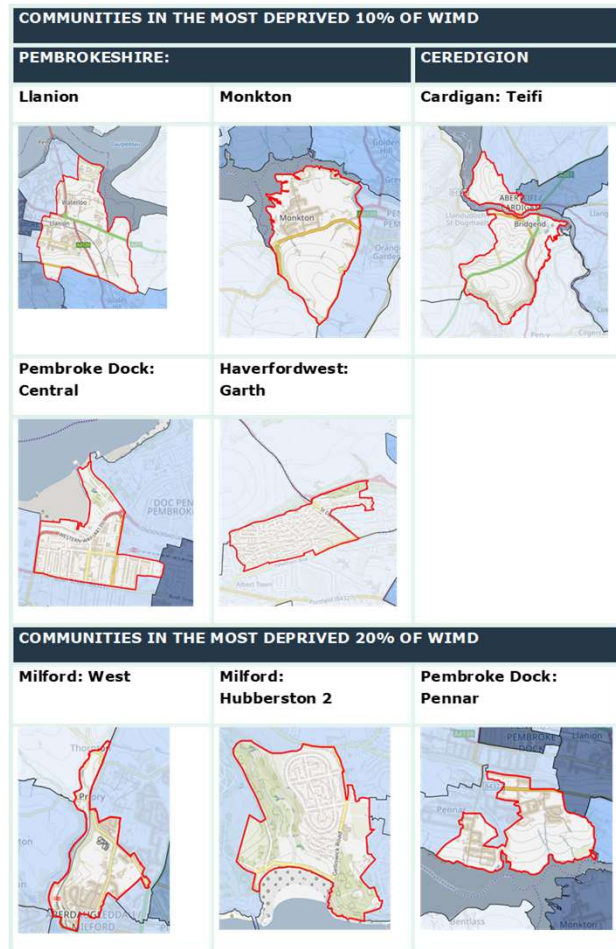
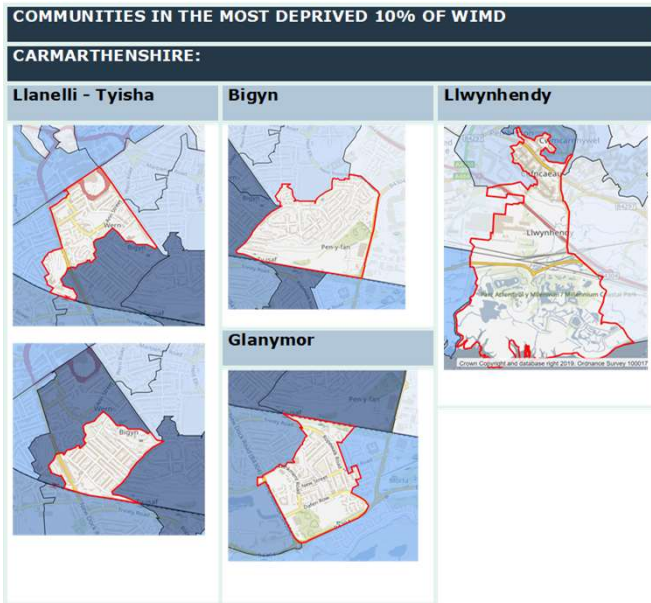
DATA ON HEALTH INCLUSION GROUPS IN HYWEL DDA BY GP CLUSTER



Appendix 4 - Stroke - preferred option Equity focused HIA

The Welsh Index of Multiple Deprivation (WIMD) is an official measure of relative deprivation for small areas in Wales. It ranks areas from 1 (most deprived) to 1909 (least deprived) and is designed to identify areas with the highest concentrations of different types of deprivation.

Communities in Hywel Dda in the most deprived 10% of WIMD (scroll down and across to view all)



Appendix 4 - Stroke - preferred option Equity focused HIA

Communities in the most deprived 10% of WIMD (RANK)

Name	Code	LHB Rank (of 229)	Wales rank (of 1909) -
Tyisha 2	W01000733	1	17
Pembroke Dock: Llanion 1	W01000601	2	62
Glanymor 4	W01001924	3	68
Haverfordwest: Garth 2	W01000570	4	71
Bigyn 4	W01000631	5	84
Pembroke: Monkton	W01000606	6	85
Aberteifi/Cardigan - Teifi	W01000511	7	125
Tyisha 3	W01000734	8	144
Pembroke Dock: Central	W01000600	9	148
Llwynhendy 3	W01000708	10	172

Communities in the most deprived 20% WIMD (RANK)

Name	Code	LHB Rank (of 229)	Wales rank (of 1909) -
Tyisha 2	W01000733	1	17
Pembroke Dock: Llanion 1	W01000601	2	62
Glanymor 4	W01001924	3	68
Haverfordwest: Garth 2	W01000570	4	71
Bigyn 4	W01000631	5	84
Pembroke: Monkton	W01000606	6	85
Aberteifi/Cardigan - Teifi	W01000511	7	125
Tyisha 3	W01000734	8	144
Pembroke Dock: Central	W01000600	9	148
Llwynhendy 3	W01000708	10	172
Glanymor 1	W01000659	11	196
Llwynhendy 2	W01000707	12	222
Glanymor 2	W01000660	13	236
Milford: Hubberston 2	W01000592	14	254
Pembroke Dock: Pennar 1	W01000604	15	294
Milford: East	W01000588	16	298
Milford: West	W01000594	17	310
Kidwelly 1	W01000670	18	318
Trimsaran 1	W01000729	19	342
Felinfoel	W01000655	20	360
Carmarthen Town North 2	W01000638	21	369
Aberteifi/Cardigan - Rhyd-y-Fuwch	W01000510	22	370

Appendix 4 - Stroke - preferred option Equity focused HIA

Use the table below to think about mitigation strategies to ensure interventions are effectively designed, at the organisational level and across sectors to ensure access to relevant groups and resources.

Intervention	Organisation	Alignment/Collaboration
Modifications that support or supplement a reduction in health inequities:	Modifications that support a reduction in health inequities:	With complementary initiatives that might help reduce inequities
Interventions and approaches that support access to programmes/services e.g. time and location	Population Health assessment (to understand needs and prioritise action)	Internal to the organisation
Stakeholder engagement & Co-design. Priority group participation in the service development, programme delivery or policy implementation	Surveillance - establish systems to monitor health outcomes by demographic groups, allowing for targeted interventions to address identified gaps.	local agencies and other services - partner with local organisations to provide support (e.g. housing issues, addressing risk factors)
Reducing barriers to those who can benefit most from the service e.g. time, location etc	Research and knowledge exchange	Local, regional and national stakeholders
Provision of additional supports e.g. Expand telehealth services to allow remote areas to consult with healthcare providers without the need for travel.	Programme evaluation	Integrated care models and pathways
Communication plan - to raise awareness of health issues or promote awareness of services. Create easy to understand resources to teach individuals how to navigate the healthcare system and manage their health.	Staff education and development - educate providers on the unique health challenges faced by specific population and strategies to reduce disparities in care.	
	Internal policies and procedures	

Appendix 4 - Stroke - preferred option Equity focused HIA

Addressing health equity in healthcare settings requires a multi-level approach that recognises the complex interplay of facilitators and barriers. By identifying and leveraging facilitators while working to mitigate the barriers, healthcare organisations could make a significant contribution toward achieving health equity

In planning your EI-HIA think about some of the barriers and facilitators that may have an impact on implementing this approach

	SYSTEM LEVEL	ORGANISATIONAL LEVEL	OPERATIONAL LEVEL
FACILITATORS	<ul style="list-style-type: none"> Mandated use of the tools (e.g. Public Health (Wales) Act, 2017) Policy frameworks – NHS long-term plans that emphasis reducing inequalities provide a framework for action. Funding/ grants aimed at addressing health inequalities. Increased political and public awareness about health equity – this can be used to pressure healthcare systems to prioritise these concerns Embed health equity into performance management incentives National/regional inequality targets 	<ul style="list-style-type: none"> Leadership commitment – a strong commitment from healthcare leaders and management to prioritise health equity and drive organisational change. Training and education for staff on health equity principles and cultural competency to enhance understanding and implementation Interdisciplinary collaboration across departments and specialties to support a more comprehensive approach to health equity, Integrate health equity metrics into performance evaluations and organisational aims. 	<ul style="list-style-type: none"> Community engagement through actively involving community members in the design and delivery of health services that can lead to more equitable outcomes Develop targeted programmes that address the specific needs of diverse populations. Use technology including telehealth and digital health solutions to improve access to care for underserved populations. Implement systems for collecting feedback from patients about their health care experiences and identify gaps and inform improvements.
BARRIERS	<ul style="list-style-type: none"> Fragmentation of services and a lack of co-ordination between health and social care or primary and secondary care can hinder comprehensive approaches to health equity. Insufficient data on health inequalities can make it difficult to identify needs and measure progress. Resource constraints and budget cuts can restrict the ability to implement programmes focussed on health equity. Policy inconsistencies including variability in health equity policies across different regions can lead to unequal implementation and outcomes. Political pressures to adopt programmes or policies without equity consideration. 	<ul style="list-style-type: none"> Lack of organisational commitment and readiness and a resistance to change Siloed decision-making which can limit sharing of best practice and collaborative approaches to addressing health inequalities Lack of training and awareness among staff regarding health equity concepts Competing priorities Lack of buy in from top management Lack of discussion on the importance of applying health equity approaches at management level. 	<ul style="list-style-type: none"> Access issues – including transportation, language and cultural differences can prevent marginalised groups from accessing healthcare services Limited workforce diversity which may result in a lack of cultural competency necessary to effectively engage with diverse populations Administrative burdens including a lack of resources (financial/human) Short-term focus especially on immediate outcomes rather than long-term equity goals Capacity of the health care sector to conduct research, access different types of information and analyse data. Lack of data to support consensus Time constraints

SOURCE:
[HTTP://WWW.HIACCONNECT.EDU.AU/EVALUATING_HIA.HTM](http://www.hiacconnect.edu.au/evaluating_hia.htm)

Appendix 5 QIA Stroke - preferred option

QUALITY IMPACT ASSESSMENT

Preferred option - Preferred option - a stroke unit at Glangwili with 24-hour specialist cover, 7 days a week. Bronglais, Prince Philip and Withybush would become treat and transfer hospitals. Stroke patients would be transferred to Glangwili from these hospitals for their acute stroke care. Bronglais would also have a stroke rehabilitation unit, meaning patients closest to this hospital, would be transferred back to Bronglais from Glangwili for their stroke specific rehabilitation.

Area	IMPACT
	Description of the impact for each area (positive/negative/neutral)
Safe	<p>This option will provide a higher quality of care for the patient with appropriate skilled staff</p> <p>This option consolidates an Acute Stroke Unit Workforce. Allowing for a higher number of qualified staff on shift covering more hours of the week.</p> <p>Within Option this follows a more intensive 7 day service cover with 24 hour service at Glangwili which will improve outcomes for patients who require the first 72 hours of Stroke Care from admission.</p> <p>Risk is still present as options would result in losing staff at other sites, (PH & WGH). A robust pathway design and effective training and development across other sites could be used to mitigate this.</p> <p>In the preferred option Bronglais will retain a stroke rehabilitation unit. There is a risk on the ability to recruit the therapy staff required at that site.</p> <p>With Prince Philip & Withybush being Treat & Transfer there will be a requirement for robust training for the medical on team and A&E & MU nursing team or at least access telemedicine.</p>
Timely	<p>Timely transfer of patients will be key to reach the KPI's e.g. 4 hours admission to a Stroke unit</p> <p>All of the Stroke Options describe the requirement of an adequately commissioned interhospital transfer service that can be designed to meet the need of transfers from the relevant sites to their most appropriate base of onward care for Stroke Admissions. WAST and ACCT's have referenced the need to ensure this is designed and appropriately commissioned, with ACCT's indicative that this is double within a timeframe for delivery of 18 months pending further detailed assessments of the requirements.</p> <p>Risk is still present as although an interhospital transfer system is in place there is no control on the demand brought upon each site. Geography and rural aspect of health board means a risk will always be present.</p> <p>In the preferred option Bronglais will retain stroke rehabilitation. There is a risk on the ability to recruit AHP's at that site.</p> <p>With Prince Philip & Withybush being Treat & Transfer there will be a requirement for robust training for the medical on team and A&E & MU nursing team or at least access telemedicine, telemedicine.</p>
Effective	<p>In accordance with National guidance, meeting the KPI's</p> <p>Enable the service to take part in multiple Stroke research</p> <p>Promote training and recruitment of staff</p> <p>All options depend on the essential interdependencies being considered as well as having refined and modelled pathways of care that will improve the Organisational SSNAP Audit (with estimated improvement score of +3 points based on the implementation of ICSS alone). There should also be realised improvements within the SSNAP audit data (with an estimated improvement of at least 5 to a grade at the receiving site).</p> <p>For the preferred option this consolidates a skilled workforce to fewer sites offering increased resilience and cover for the workforce during absences. This will ensure that both patients and staff are operating safely with timely and immediate access to appropriate supervision and patient outcomes will likely improve as a result.</p> <p>In the preferred option Bronglais will retain a stroke rehabilitation unit. There is a risk on the ability to recruit AHP's at that site.</p> <p>This option reduces the number of sites to two units and will therefore condense the workforce that would provide a dedicated team for the stroke service that could result in improved recruitment and retention.</p>
Efficient	<p>This option does centralise the service in Glangwili and could make the service more sustainable, efficient, safe and provide better outcomes for patients.</p> <p>The consolidation of the Stroke service as described within the options will optimise the health boards Stroke Bed Plan whilst also funneling the focus of Therapy Service for Specialist Stroke Support to fewer sites. This will allow for efficiency gains in workforce sustainability, attractiveness of posts, patient outcomes and improved standards whilst also aligning to the Health Boards longer term strategy and the Regional approach for Comprehensive Regional Stroke Unit.</p> <p>Virtual follow ups could be considered to make best use of time (saving travel time).</p> <p>In the preferred option Bronglais will retain a stroke rehabilitation unit There is a risk on the ability to recruit AHP's at that site.</p>
Equitable	<p>Has an EQIA screening tool been undertaken? Yes</p> <p>Has a full EQIA been undertaken? Yes on the preferred option (Please provide a summary) below.</p> <p>It is hoped that by adopting the preferred option there will be better quality care and outcomes for patients as well as reducing inpatient stay. Most patients are aged 65+ (although younger personnel can have a stroke), by centralising the service there will be a greater collective of experts in an area to treat the patients.</p> <p>In the preferred option Bronglais will retain a stroke rehabilitation unit.</p>
Person-centred	<p>The option will make the service more sustainable and a higher quality of care for patients. However due to increased travel and inpatient care further from home this will mean that families may not available to be at the centre of decisions. Virtual platforms could be used in order to mitigate this.</p> <p>In the preferred option Bronglais will retain a stroke rehabilitation unit.</p>

Opportunity / Consequence Rating*	QIA Matrix			Monitoring and Management of Impacts	
	Consequence	Likelihood	Total Score	How will these impacts be monitored? Specify the metric you will use, the current baseline, triggers for escalation	Mitigating actions of negative impacts
** positive rating	4	4	16	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	4	-4	Metric - Current Baseline (date) - Trigger for escalation -	The mitigation for this would be for Bronglais to become a T&T site and patients transferred back for rehabilitation.
** positive rating	4	4	16	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	4	-4	Metric - Current Baseline (date) - Trigger for escalation -	This option is similar to 106 however this option will require more transfers as Withybush have a higher number of Stroke patients that will need to be transferred to Glangwili. A dedicated transport service would be the mitigation and ring fenced beds would be the mitigation for patients travelling between sites
** positive rating	4	4	16	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	4	-4	Metric - Current Baseline (date) - Trigger for escalation -	The mitigation for this would be for Bronglais to become a T&T site and patients transferred back for rehabilitation.
** positive rating	5	4	20	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	4	-4	Metric - Current Baseline (date) - Trigger for escalation -	The mitigation for this would be for Bronglais to become a T&T site and patients transferred back for rehabilitation.
** positive rating	4	4	16	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	3	-3	Metric - Current Baseline (date) - Trigger for escalation -	
** positive rating	4	4	16	Metric - Current Baseline (date) - Trigger for escalation -	
** negative rating	-1	3	-3	Metric - Current Baseline (date) - Trigger for escalation -	

Appendix 5 QIA Stroke - preferred option

Considered and supported by (in line with Scheme of Delegation):	Name	Date
Clinical Service Group		
General Manager		
Head of Nursing		
Clinical Lead		
Clinical Care Group		
Service Director		
Assistant Director of Quality, Safety and Patient Experience		
Associate Medical Director		
Other Executive Function		
Director		

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Considered and supported by:	Name	Supported	Comments	Date
Deputy Director of Health Science	Jon Arthur	Yes		
Assistant Director - Business, Partnerships and Inclusion (or nominated deputy)	Helen Sullivan			14/05/2026
Associate Medical Director for Quality and Safety	Subhamey Ghosh	Yes		
	Cathie Steele		This option will provide a higher quality of care for the patient with appropriate skilled staff. It should improve stroke care and outcomes by concentrating specialist staff and 24/7 cover at Glasgow, while keeping rehabilitation at Bronglais, subject to safe transfers, training and staffing.	
Interim Assistant Director of Nursing, Assurance & Safeguarding				13/05/2026
Consultant in Public Health Medicine	Michael Thomas	Yes	This option will deliver high quality care. Strategically aligned and sustainable.	19/05/2026

Considered and approved by Clinical Executive:	Name	Supported	Comments (if applicable)	Date
Director of Nursing, Quality and Patient Experience	Sharon Daniel	Yes	I support this option as it is strategically aligned and offers a sustainable model for high-quality stroke care.	21/05/26
Medical Director	Mark Hemwood	Yes	This option is strategically aligned, will deliver the highest quality of care and will be sustainable.	14/05/26
Director of Therapies and Health Science	James Severs			

Date presented to panel	
Chair of Panel	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
Notes of panel discussion	Chair's actions approved 22/05/2026. To be ratified at the next formal QIA panel. Any further comments to be brought back to next panel.
If supported by QIA panel, what is the recommended frequency for review	

Integrated Impact Assessment – Climate Change & Environmental Sustainability

Stroke – Alternative Options

Common across all options

- The ambulance would take a suspected stroke patient to their nearest main hospital, this could be Bronglais Hospital (BGH), Glangwili (GGH), Prince Philip Hospital (PPH) and Withybush Hospital (WGH).
- The initial assessment scan (typically a CT scan), as well as initial treatment (i.e. thrombolysis or reducing a bleed in the brain) would be delivered at the receiving hospital (i.e. BGH, GGH, PPH, WGH) as is the case now.
- Care for TIAs (mini stroke) would continue at BGH and GGH, but not at PPH or WGH.
- Strokes eligible for treatment would be transferred to thrombectomy centres, such as at Bristol or Cardiff, as they are now.

Preferred option - a stroke unit at Glangwili with 24-hour specialist cover, 7 days a week. Bronglais, Prince Philip and Withybush would become treat and transfer hospitals. Stroke patients would be transferred to Glangwili from these hospitals for their acute stroke care. Bronglais would also have a stroke rehabilitation unit, meaning patients closest to this hospital, would be transferred back to Bronglais from Glangwili for their stroke specific rehabilitation.

Opportunity/Consequence Rating (RAG)	Option No.	Consequence	Likelihood
Climate & Sustainability Positive Rating	Preferred option		
Climate & Sustainability Negative Rating			

NB: While the preferred option is assessed as having a predominantly negative environmental impact across multiple domains, this reflects a structural shift towards a more transport-intensive and centralised model of care. The Health Board can partially mitigate these impacts through targeted action; however, they cannot be fully eliminated and should be considered alongside the clinical benefits of the model.

Post Evaluation Summary Table

Area / Theme	Description of Increased Risk/Impact	Mitigating Actions / Notes
<p>Transport & Travel</p>	<p>Significant increase in total journey numbers, journey length and dependency on road-based transport due to centralisation of acute stroke care at a single site. This includes:</p> <ul style="list-style-type: none"> - Additional inter-hospital transfers for acute stroke care (estimated majority of eligible patients), followed by further transfers for rehabilitation in some pathways, resulting in multiple journeys per patient episode. - Increased reliance on ambulance and patient transport services, contributing to higher vehicle mileage, fuel consumption, cost and associated emissions. - Increased travel distances for families and carers, particularly in a rural geography with limited public transport, resulting in greater dependence on private vehicles. - Increased staff commuting distances where relocation is required, contributing to ongoing transport-related emissions. - Potential cumulative system-wide emissions impact rather than simple redistribution between sites. 	<p>Develop and implement a sustainable transport strategy aligned to the service model, including:</p> <ul style="list-style-type: none"> • Demand reduction: minimise avoidable transfers through strengthened clinical triage, virtual specialist input (e.g. tele-stroke support), and clear criteria for transfer and repatriation. • Transport optimisation: coordinate patient transfers to reduce empty return journeys, improve scheduling efficiency, and reduce duplication across services. • Low emission transport: transition additional fleet requirements (e.g. patient transfer vehicles) to ultra-low emission vehicles (electric/hybrid), supported by appropriate charging infrastructure. • Staff travel reduction: support hybrid working where appropriate, review rostering to minimise cross-site travel, and promote car sharing and active travel where feasible. • Visitor travel mitigation: introduce or expand virtual visiting where clinically appropriate, and explore transport support schemes (e.g. shuttle services, subsidised travel, community transport partnerships) to reduce reliance on private vehicles. • Infrastructure planning: ensure sufficient EV charging, cycle storage and public transport connectivity are considered in site planning. <p>Monitor total travel demand (patient transfers, staff commuting, visitor travel) and associated emissions as a key performance indicator.</p>
<p>Net Zero / Emissions</p>	<p>The scheme is not neutral, it introduces: New transport activity + Centralised energy demand → This is net increase, not redistribution</p> <p>No estate + transport combined view, as emissions are:</p> <p>Travel + buildings + equipment → Currently assessed separately, not cumulatively.</p>	<p>Undertake a full carbon impact assessment of the preferred option, including transport, estate, procurement and clinical activity impacts.</p> <p>Reduce operational emissions at the acute site (GGH) through:</p> <ul style="list-style-type: none"> • energy efficiency measures (LED lighting, building fabric improvements, smart energy management systems)

	<p>Overall increase in carbon emissions is likely due to a combination of:</p> <ul style="list-style-type: none"> - Additional inter-hospital patient transfers and increased travel distances for staff, patients and visitors. - Centralisation of services leading to increased energy demand (heating, cooling, lighting, imaging and specialist equipment) at Glangwili Hospital. - Increased reliance on high-carbon transport modes in rural areas where sustainable transport options are limited. <p>The combined effect is expected to result in a net increase in the Health Board’s operational carbon footprint rather than a neutral redistribution across sites.</p>	<ul style="list-style-type: none"> • low carbon heating and cooling solutions (e.g. heat pumps where feasible) • optimisation of building use to reduce unnecessary energy demand. <p>Incorporate low-carbon design principles into all capital developments, ensuring alignment with NHS Wales decarbonisation standards.</p> <p>Embed sustainable procurement practices:</p> <ul style="list-style-type: none"> • prioritise low-carbon suppliers and products • reduce single-use items where safe and feasible • increase reuse and circular economy approaches. <p>Implement a transport decarbonisation plan (linked to Transport section) addressing fleet, staff, patient and contractor travel.</p> <p>Establish a baseline and ongoing monitoring of emissions to track the net impact of the service change over time.</p>
<p>Pollution</p>	<p>Localised increase in air and noise pollution at Glangwili Hospital due to higher concentrations of patient transfers, staff commuting and visitor activity.</p> <p>Although activity may reduce at other sites, overall pollution is unlikely to be neutral due to:</p> <ul style="list-style-type: none"> - Increased total vehicle mileage - Higher transport intensity in rural areas - Peak congestion at centralised acute site - Emissions are concentrated at one site - Increased: <ul style="list-style-type: none"> • Congestion • Idling • Parking pressure • Rural journeys → longer distances = higher emissions <p>Potential for disproportionate impact on local air quality and surrounding communities at high-activity sites</p>	<p>Introduce site-specific traffic and congestion management plans at high-activity sites (e.g. Glangwili Hospital), including:</p> <ul style="list-style-type: none"> • designated drop-off and pick-up zones to reduce idling • improved traffic flow and parking management. <p>Promote low emission transport options for staff and visitors through EV infrastructure, car sharing schemes and active travel support.</p> <p>Monitor local air quality at sites where activity is expected to increase and identify mitigation measures where thresholds are exceeded.</p> <p>Work with local authorities to align transport planning (e.g. public transport routes, infrastructure improvements) with increased activity at centralised sites.</p> <p>Reduce unnecessary vehicle movements through optimised logistics, deliveries and transfer coordination.</p>

<p>Facilities & Estates</p>	<p>Increased pressure on a single acute site (Glangwili Hospital) requiring expansion and upgrade of facilities, resulting in:</p> <ul style="list-style-type: none"> - Increased operational energy demand due to higher patient volumes and specialist equipment use. - Capital works with associated embodied carbon impacts from construction and refurbishment. - Increased reliance on a single site, creating potential vulnerability to infrastructure failure or climate-related disruption (e.g. overheating, flooding, power outages). 	<p>Ensure all estate developments and refurbishments incorporate:</p> <ul style="list-style-type: none"> • energy-efficient design and low-carbon materials • climate-resilient design (overheating mitigation, flood resilience, ventilation and cooling strategies). <p>Undertake energy modelling to understand and mitigate increased demand from centralisation.</p> <p>Invest in on-site renewable energy generation where feasible (e.g. solar PV) to offset increased electricity demand.</p> <p>Ensure infrastructure capacity (power, water, digital systems) is upgraded to support increased demand without compromising resilience.</p> <p>Consider embodied carbon in capital projects and prioritise reuse of existing estate and materials where possible.</p> <p>Maintain service redundancy where feasible to reduce reliance on a single site.</p>
<p>Climate Change / Resilience</p>	<p>The proposal clearly introduces:</p> <ul style="list-style-type: none"> • Single point of failure risk • Transport dependency • Weather vulnerability <p>From WG consultation: Delays (weather, ambulance) can affect safety Nature recovery action plan: 2026 [HTML] GOV.WALES</p> <p>Increased system vulnerability to climate-related disruption due to:</p> <ul style="list-style-type: none"> - Greater reliance on patient transfers between sites, which may be disrupted by extreme weather (flooding, storms, heat events). - Increased dependency on a single acute stroke unit, creating a potential single point of failure for critical services. 	<p>Align service design and delivery with the Health Board’s Climate Adaptation Plan, ensuring identified risks are actively mitigated.</p> <p>Undertake a climate risk assessment for the preferred option, including:</p> <ul style="list-style-type: none"> • transport disruption risks (flooding, storms) • infrastructure risks (overheating, power failure) • supply chain vulnerabilities. <p>Strengthen service resilience through:</p> <ul style="list-style-type: none"> • robust contingency plans for transfer disruption • maintaining surge capacity and flexibility across sites • avoiding critical single points of failure where possible. <p>Ensure critical infrastructure (power, ICT, clinical equipment) has appropriate redundancy and backup systems.</p>

Appendix 6 Stroke ESIA - preferred option

	<p>- Increased reliance on transport infrastructure and ambulance availability to maintain clinical pathways.</p> <p>These factors may reduce overall service resilience unless mitigated through robust adaptation planning and infrastructure resilience measures.</p>	<p>Integrate climate risks into Emergency Preparedness, Resilience and Response (EPRR) planning.</p> <p>Monitor and review climate-related incidents impacting service delivery and update plans accordingly.</p>
<p>Patient Experience</p>	<p>The current focus on virtual technology means option is missing climate-related patient risks from:</p> <ul style="list-style-type: none"> • Heat • Travel stress • Delayed discharge <p>Patients may experience indirect climate-related impacts including:</p> <ul style="list-style-type: none"> - Increased travel-related stress and fatigue, particularly for frail or older patients. - Potential delays in discharge where transport availability is limited. - Increased vulnerability to heat and environmental conditions during longer journeys or transfers. - Reduced ability for frequent family support visits due to travel burden, which may impact recovery and wellbeing. 	<p>Provide structured support for patients and families affected by increased travel requirements, including:</p> <ul style="list-style-type: none"> • clear information on travel options and financial support • access to patient transport services where eligible • consideration of additional support for vulnerable groups. <p>Expand use of virtual communication tools (e.g. video calls) to support patient-family contact where travel is not possible.</p> <p>Ensure discharge planning includes transport considerations to prevent delays in discharge.</p> <p>Incorporate environmental comfort measures in patient pathways (e.g. temperature control, hydration, rest breaks during transfers).</p> <p>Monitor patient experience specifically in relation to travel, access and environment through targeted feedback and surveys.</p>

Area (Select more than one box per area if a change has multiple impacts e.g. both positive and negative)	Option	Positive Impact	Neutral Impact	Negative Impact
<p>Transport & Travel / Fuel Consumption</p> <ul style="list-style-type: none"> • Assess to what extent the changes will result in an increase or decrease in the quantity and length of journeys made, and the subsequent impact on fuel and energy consumption. <ul style="list-style-type: none"> ○ Will this course of action result in a requirement for transport that might not otherwise have been required? ○ Will this course of actions require the development of transport or travel support services to ensure successful implementation ○ Will this course of action increase the amount of travel for staff and/or patients and/or visitors? ○ Will this course of action alter the modes of transport used by staff and/or patients and/or visitors, for example through more on-site parking or better public transport connections? ○ Will this course of action make provision for adjustments to existing transport / travel modes? e.g. the introduction of travel alternatives e.g. pool cars, or the provision of infrastructure to enable a switch to lower emission alternatives e.g. electric / hydrogen vehicles? 	<p>Preferred option</p>			<p style="text-align: center;">✓</p> <p>Clear increase in journeys, distances, and reliance on road transport</p> <p>Explicit “net increase” in emissions and demand</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p>	<p>How will these impacts be monitored?</p>			
<p>The preferred option introduces some opportunities to reduce unnecessary travel and improve efficiency in specific parts of the care pathway.</p> <ul style="list-style-type: none"> • The use of virtual communication tools (e.g. tablets for patient-family contact and virtual clinical input where appropriate) may reduce the need for some journeys, particularly for family members who would otherwise travel long distances to visit or communicate with patients. • Centralisation of specialist acute stroke care may improve clinical decision-making and coordination, potentially reducing duplication of patient movements and enabling faster, more streamlined pathways for those requiring specialist input. • Improved clinical outcomes and more timely access to specialist care in the first 72 hours may contribute to shorter overall lengths of stay for some patients, which could reduce the cumulative number of return visits and repeat journeys over the full patient pathway. • Consolidation of specialist services may create opportunities to better coordinate transport services (e.g. scheduled transfers, shared transport arrangements), improving efficiency compared to ad hoc or fragmented travel patterns. <p>While these benefits are likely to be modest in scale compared to the overall increase in travel demand, they represent opportunities to reduce avoidable journeys and improve how travel is managed within the system.</p>	<p>Not currently being monitored, could receive feedback via patient experience surveys</p>			

Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>The preferred option is expected to result in a significant increase in transport demand and associated environmental impacts due to the centralisation of acute stroke services and reliance on a treat and transfer model.</p> <p>There will be an increase in the number and length of journeys made by patients, including:</p> <ul style="list-style-type: none"> • initial travel to the nearest hospital, • inter-hospital transfer to the acute stroke unit at Glangwili, • and in some cases onward transfer for rehabilitation (e.g. to Bronglais). <p>This creates multiple journeys per patient episode rather than a single-site pathway.</p> <p>The model introduces a structural increase in inter-hospital transfers, resulting in additional use of ambulance and patient transport services, increased vehicle mileage, and increased fuel consumption.</p> <p>Patients from areas served by Bronglais, Prince Philip and Withybush will experience longer travel distances for acute care, increasing the overall transport burden across the system.</p> <p>Families and carers will be required to travel further and more frequently to visit patients, particularly during acute and rehabilitation phases of care. This is likely to result in:</p> <ul style="list-style-type: none"> • increased reliance on private vehicles due to limited public transport in rural areas, • increased financial costs, 	<p>Mitigation should focus on reducing avoidable travel, improving transport efficiency, and supporting a transition to lower-carbon travel options where possible.</p> <p>Reduce unnecessary patient transfers by:</p> <ul style="list-style-type: none"> • strengthening clinical triage and decision-making at the point of first assessment, • maximising use of remote specialist input (e.g. telemedicine) where clinically appropriate, • and establishing clear criteria for transfer and repatriation. <p>Optimise transport activity by:</p> <ul style="list-style-type: none"> • coordinating patient transfers to minimise duplication and empty return journeys, • aligning transport scheduling across services, • and improving integration between transport providers and clinical services. 	<p>Staff feedback would be captured via the organisational change process.</p> <p>Patients and family feedback maybe captured via patient experience.</p>	<p>As and when</p>	<p>SDM for the service</p> <p>Executive Lead for the service</p> <p>Executive Nursing Lead for the service</p> <p>Clinical Lead for the service</p> <p>AHP Lead</p>

<ul style="list-style-type: none"> • and increased cumulative emissions from repeated journeys. <p>Staff required to relocate or work across sites may experience increased commuting distances, contributing to ongoing transport-related emissions.</p> <p>The rural geography of the Health Board area, combined with limited public transport connectivity between hospital sites, increases dependency on high-carbon transport modes and reduces the feasibility of low-emission travel options.</p> <p>The increase in transport demand represents a net increase in emissions and travel activity, rather than a redistribution between sites, due to the introduction of new journeys (particularly inter-hospital transfers).</p> <p>Increased reliance on transport infrastructure and vehicle availability also introduces system vulnerability, where delays, weather conditions or transport constraints may impact patient flow and service delivery.</p> <p>Overall, the model shifts the service towards a more transport-intensive pathway, with associated increases in carbon emissions, operational demand, and dependence on road-based travel.</p>	<p>Support the transition to low-emission transport by:</p> <ul style="list-style-type: none"> • introducing or expanding the use of ultra-low emission vehicles (e.g. electric or hybrid) for additional transport requirements, • ensuring supporting infrastructure (e.g. charging points) is in place, • and encouraging low-emission travel options for staff where feasible. <p>Reduce travel demand for families and carers by:</p> <ul style="list-style-type: none"> • expanding the use of virtual visiting and communication tools, • providing clear information on travel options and available support, • and exploring transport support schemes (e.g. community transport, shuttle services or subsidised travel). <p>Reduce staff travel-related impacts by:</p> <ul style="list-style-type: none"> • reviewing workforce models and rostering to minimise cross-site travel, • supporting flexible or remote working where appropriate, 			
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	<ul style="list-style-type: none">• and encouraging car sharing and active travel options where feasible. <p>Ensure transport considerations are integrated into discharge planning to avoid delays caused by lack of transport availability.</p> <p>Recognise that, due to the structural nature of the service change and the rural geography, mitigation will reduce but not fully eliminate the increase in travel and associated emissions.</p>			
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<p>Facilities and Estates / Energy Consumption & Generation</p> <ul style="list-style-type: none"> • Assess the impact on our facilities and estates <ul style="list-style-type: none"> ○ Will this course of action increase or decrease the use of utilities? (e.g. electricity/heating)? ○ Will this course of action increase or decrease the use of white goods, medical and IT equipment)? ○ Will this course of action increase or decrease the Hywel Dda estate footprint? E.g. consider if you require a larger or smaller space than current and would this be via a new building, a building repurposing/refurbishment, new leased accommodation? ○ Will this course of action require future and/or ongoing maintenance / servicing needs? ○ Will this course of action increase the need for cleaning and/or catering and/or portering? 	<p>Preferred option</p>		<p>✓</p> <p>Increased energy demand, infrastructure pressure, embodied carbon</p> <p>Positives are conditional opportunities , not guaranteed outcomes</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p>	<p>How will these impacts be monitored?</p>		
<p>The preferred option provides opportunities to improve the quality, efficiency and long-term sustainability of the estate used to deliver stroke services.</p> <p>Centralisation of acute stroke services allows consolidation of specialist facilities into fewer locations, reducing duplication of equipment and enabling more efficient use of space, infrastructure and clinical resources.</p> <p>The development of a purpose-built or significantly refurbished stroke unit at Glangwili Hospital presents an opportunity to incorporate modern, energy-efficient design standards, including improved insulation, efficient lighting, and optimised building systems, which can reduce energy consumption compared to older estate areas.</p> <p>Investment in upgraded facilities and equipment can enable the introduction of more energy-efficient technologies (e.g. modern imaging equipment, digital systems), improve operational efficiency and reducing energy intensity per patient episode.</p> <p>Rationalisation of services across fewer sites may allow under-utilised space at other hospital sites to be repurposed, consolidated, or decommissioned over time, creating opportunities to reduce the overall estate footprint in the longer term.</p> <p>Concentration of activity into a smaller number of locations may enable more targeted investment in infrastructure, maintenance and energy management systems, improving performance compared to maintaining multiple smaller, less efficient service locations.</p>	<p>Budgeting</p>		

These opportunities depend on how estate changes are designed and implemented and may not be fully realised without dedicated focus on energy performance and estate optimisation.				
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>The preferred option is expected to increase demand and pressure on the estate at key sites, particularly Glangwili Hospital, resulting in increased energy use, resource consumption and potential climate-related risks.</p> <p>Centralisation of acute stroke services will lead to a significant increase in activity at a single site, driving increased demand for:</p> <ul style="list-style-type: none"> • electricity (lighting, equipment, digital systems), • heating and cooling, • water and other utilities, <p>resulting in higher overall energy consumption at that site.</p> <p>The development of new or refurbished facilities (including a purpose-built stroke unit and upgraded rehabilitation space) will generate embodied carbon impacts associated with construction, materials, and infrastructure works.</p> <p>Increased use of energy-intensive clinical equipment (e.g. imaging, monitoring and rehabilitation technologies) concentrated in one location may further increase the operational carbon footprint.</p> <p>The shift from a distributed model (across four sites) to a more centralised model increases reliance on the capacity and performance of a smaller number of estate assets, creating:</p> <ul style="list-style-type: none"> • potential bottlenecks in infrastructure (e.g. power supply, space, supporting services), 	<p>Mitigation should focus on ensuring that estate changes are delivered in a way that minimises energy demand, reduces carbon impacts and improves resilience to climate risks.</p> <p>Ensure that all new builds, refurbishments and repurposed spaces incorporate:</p> <ul style="list-style-type: none"> • high standards of energy efficiency (building fabric, insulation, lighting), • low carbon heating and cooling solutions, • and smart energy management systems to optimise performance. <p>Undertake detailed energy modelling to understand the impact of increased service concentration and identify opportunities to reduce demand through design and operational changes.</p> <p>Integrate on-site renewable energy generation where feasible (e.g. solar PV) to</p>	<p>At key points within the CSP process and via organisational change and audits.</p>	<p>Audits are reviewed monthly in some instances and 6 monthly for others (Organisational audits)</p>	<p>Executive Lead for the service</p> <p>Executive Nursing Lead for the service</p> <p>Clinical Lead for the service</p> <p>AHP Lead</p> <p>SDM for the service</p>

Appendix 6 Stroke ESIA - preferred option

<ul style="list-style-type: none"> and increased vulnerability if systems fail or become constrained. <p>Increased demand for cleaning, catering and portering services at high-activity sites will result in additional resource use (energy, water, consumables), contributing to indirect environmental impacts.</p> <p>Existing estate at receiving sites (particularly rehabilitation areas) may require significant upgrades to meet clinical standards, introducing additional energy demand and construction-related impacts.</p> <p>The concentration of services into a limited number of sites increases exposure to localised climate risks (e.g. overheating, flooding, infrastructure failure), particularly where buildings were not originally designed for higher levels of demand.</p> <p>Overall, while the model may reduce duplication of services, it is likely to result in increased intensity of estate use and associated environmental impacts at key sites, unless actively mitigated through design and operational controls.</p>	<p>offset increased electricity demand at high-activity sites.</p> <p>Prioritise the use of low-carbon and sustainable materials in construction and refurbishment and consider embodied carbon in decision-making.</p> <p>Maximise reuse of existing estate, equipment and materials where possible, reducing the need for new construction and associated carbon impacts.</p> <p>Ensure that infrastructure capacity (power supply, water systems, digital infrastructure) is upgraded to meet increased demand without compromising efficiency or resilience.</p> <p>Design facilities to be resilient to climate change impacts, including:</p> <ul style="list-style-type: none"> mitigation of overheating through passive design and ventilation strategies, flood risk management where relevant, and ensuring critical systems have appropriate backup and redundancy. 			
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	<p>Review opportunities to rationalise or repurpose underutilised estate at other sites to reduce the overall estate footprint and avoid maintaining inefficient or redundant buildings.</p> <p>Improve operational efficiency through:</p> <ul style="list-style-type: none"> • energy monitoring and management systems, • regular maintenance and optimisation of building systems, • and reduction of unnecessary resource use (e.g. water, consumables). <p>Recognise that while consolidation may improve efficiency in some areas, overall energy use may still increase due to higher activity levels, and mitigation should aim to minimise rather than eliminate this impact.</p>			
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<p>Net Zero</p> <ul style="list-style-type: none"> • Assess the potential release of carbon dioxide (and other greenhouse gases where relevant) through any related activity and deploy actions which can be taken to reduce emissions and/or offset. <ul style="list-style-type: none"> ○ Will this course of action likely increase or decrease the emissions footprint of the health board? (note – if you are increasing your accommodation/patient space/s you automatically increase the carbon footprint) ○ Will this course of action increase or decrease the opportunity for green/low carbon procurement, purchasing and supplies? ○ Will this course of action increase or decrease the emissions produced by contractors and services we procure from? ○ Will this course of action increase or decrease the use of environmentally harmful anaesthetic gases or the recycling of unused pharmaceuticals? 	<p>Preferred option</p>			<p>✓</p>
				<p>Explicitly states overall increase in emissions</p> <p>Driven by: Transport & energy concentration</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p>		<p>How will these impacts be monitored?</p>		
<p>The preferred option provides some opportunities to improve carbon efficiency and support longer-term decarbonisation, although these are dependent on how the model is implemented.</p> <p>Consolidation of specialist stroke services into fewer sites creates opportunities to reduce duplication of equipment, infrastructure and clinical activity across multiple locations, which may improve energy efficiency per patient episode.</p> <p>Investment in new or upgraded facilities at Glangwili Hospital and Bronglais Hospital provides an opportunity to incorporate low-carbon design principles, including energy-efficient building systems, improved insulation, and low-carbon technologies, supporting reductions in operational emissions compared to older estate.</p> <p>The concentration of services may enable more targeted implementation of energy management systems, monitoring, and carbon reduction initiatives, improving performance compared to a more fragmented estate.</p> <p>Opportunities exist to embed low-carbon procurement practices in the development of new facilities and service models, including the use of sustainable materials, reduced waste, and selection of lower-carbon equipment and suppliers.</p> <p>The model may support improved clinical outcomes and reduced length of stay for some patients, which could reduce the overall carbon intensity of care per patient pathway, particularly where this avoids repeated admissions or prolonged hospital stays.</p>		<p>N/A</p>		

<p>The introduction of digital solutions (e.g. virtual communication and, where appropriate, remote clinical input) may reduce some travel demand, contributing to marginal carbon savings.</p> <p>These positive impacts are conditional on active implementation of decarbonisation measures and will not be realised automatically through the service change alone.</p>				
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>The preferred option is likely to result in an overall increase in carbon emissions, primarily driven by increased transport activity and the concentration of energy demand at a smaller number of sites.</p> <p>The centralisation of acute stroke services introduces a significant increase in inter-hospital patient transfers, in addition to increased travel for staff, patients and visitors. This results in:</p> <ul style="list-style-type: none"> • increased vehicle mileage, • increased fuel consumption, • and increased greenhouse gas emissions. <p>The rural geography of the Health Board area and limited availability of public transport will increase reliance on private vehicles and road-based transport, which are typically higher carbon modes.</p> <p>While some activity is reduced at other sites, the overall level of transport demand increases due to the creation of new journeys (particularly transfers), meaning this is a net increase in emissions rather than a redistribution.</p> <p>Increased concentration of services at Glangwili Hospital will drive higher energy consumption due to:</p> <ul style="list-style-type: none"> • increased patient throughput, • increased use of clinical equipment, • increased heating, cooling and ventilation requirements, 	<p>Mitigation should focus on actively reducing emissions across transport, estate and procurement, and ensuring alignment with Welsh Government decarbonisation expectations.</p> <p>Undertake a comprehensive carbon impact assessment of the preferred option, covering:</p> <ul style="list-style-type: none"> • transport emissions (patient, staff and visitor travel), • estate energy use, • procurement and supply chain impacts, • and capital/embodied carbon from construction. <p>Develop and implement a decarbonisation plan specific to the service change, aligned with the Health Board's broader decarbonisation strategy and Welsh Government</p>	<p>As part of the contractual agreement.</p>	<p>In line with contractual requirements</p>	<p>Executive Lead for the service</p> <p>Executive Nursing Lead for the service</p> <p>Clinical Lead for the service</p> <p>AHP Lead</p> <p>SDM for the service</p>

Appendix 6 Stroke ESIA - preferred option

<p>resulting in a higher operational carbon footprint at that site.</p> <p>Capital investment required to develop or upgrade facilities will generate embodied carbon emissions associated with construction, materials and infrastructure.</p> <p>Increased demand for support services (e.g. cleaning, catering, portering) at high-activity sites will contribute to indirect emissions through resource use and supply chains.</p> <p>The combined effect of increased transport emissions, increased operational energy demand and embodied carbon from construction means that the preferred option is likely to increase the overall carbon footprint of the Health Board unless significant mitigation measures are implemented.</p> <p>This presents a potential challenge to the Health Board’s obligations as a public body in Wales to reduce emissions and contribute to national net zero targets, requiring clear justification, active mitigation, and ongoing monitoring.</p> <p>The preferred option should be considered within the context of the Welsh Government’s ambition for a net zero public sector, requiring the Health Board to demonstrate how any increase in emissions will be minimised and managed over time.</p>	<p>requirements for the public sector.</p> <p>Reduce transport-related emissions through:</p> <ul style="list-style-type: none"> • minimising avoidable inter-hospital transfers, • improving coordination and efficiency of transport services, • transitioning fleet vehicles to ultra-low emission options, • and reducing travel demand through digital solutions where appropriate. <p>Reduce estate-related emissions by:</p> <ul style="list-style-type: none"> • incorporating energy-efficient and low-carbon design into all new and refurbished facilities, • optimising building performance through energy management systems, • investing in low-carbon heating and cooling technologies, • and increasing use of on-site renewable energy generation where feasible. <p>Address embodied carbon in capital projects by:</p>			
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	<ul style="list-style-type: none"> • prioritising refurbishment and reuse over new build where possible, • using low-carbon materials and construction methods, • and embedding whole-life carbon considerations into decision-making. <p>Embed sustainable procurement practices, including:</p> <ul style="list-style-type: none"> • selecting low-carbon suppliers and products, • reducing single-use items where safe and feasible, • and supporting circular economy approaches (reuse, repair, recycling). <p>Establish clear governance and monitoring of emissions associated with the service change, ensuring that increases in emissions are identified, managed and reduced over time.</p> <p>Recognise that, due to the structural nature of the service model and the reliance on transport, mitigation measures are likely to reduce but not fully offset the increase in emissions, and this should be</p>			
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	considered in the overall balance of impacts.			
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<p>Green Spaces / Biodiversity</p> <p>Biodiversity underpins health and well-being and is in decline. Under Section 6 of the Environment (Wales) Act 2016, public authorities in Wales must seek to maintain and enhance biodiversity and, in so doing, promote the resilience of ecosystems, embedding this consideration into policies, plans, programmes, projects and day-to-day activities. Public authorities are also required to publish a report every three years on actions taken to comply with the Section 6 duty. In addition, Welsh Government’s 30by30 framework sets the direction for protecting 30% of land, freshwater and sea for people and nature by 2030, and the Nature Recovery Action Plan provides a national framework to embed and drive long-term nature recovery across public bodies and partners.</p> <ul style="list-style-type: none"> • Will this course of action/activity positively or negatively impact on biodiversity and ecosystem resilience (e.g. habitat loss, fragmentation, disturbance, pollution pressures, invasive non-native species risk), including any impacts on species and habitats of principal importance and/or designated sites where relevant? • Will this course of action increase or decrease the quality, connectivity and/or quantity of habitats (including opportunities for habitat creation, restoration or nature-based solutions), and will it avoid habitat degradation during construction, operation and maintenance? • Will this course of action increase or decrease the resilience of biodiversity to climate change (e.g. through improving ecological connectivity, water management, shading/cooling, soil health, and reducing pressures that limit nature’s ability to adapt)? • Will this course of action increase or decrease public access to, and the quality of, green and blue spaces (including for patients, staff and communities), recognising the health and well-being benefits of nature connection? • Will this course of action support or constrain the Health Board’s ability to evidence delivery of its Section 6 plan and three-yearly reporting, including any contribution to wider nature recovery priorities and the 30by30 ambition (where relevant to estate, landholdings, procurement, commissioning or partnership activity)? 	<p>Preferred</p>			<p style="text-align: center;">✓</p> <p>Impacts are indirect but credible</p> <p>Risks: development pressure, missed enhancement opportunities</p> <p>No guaranteed biodiversity gain</p> <p>Some opportunities to mitigate</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p>	<p>How will these impacts be monitored?</p>			
<p>The preferred option presents some opportunities to enhance green space use, biodiversity considerations and nature-based approaches, particularly through estate development and service design.</p> <p>The development or refurbishment of facilities at Glangwili Hospital and Bronglais Hospital provides an opportunity to incorporate biodiversity-friendly design and nature-based solutions, such as:</p> <ul style="list-style-type: none"> • creation or enhancement of green spaces, • planting for biodiversity (e.g. native species), • sustainable drainage systems (SuDS), • and green infrastructure that supports ecosystem resilience. 				

<p>Investment in upgraded rehabilitation environments creates opportunities to improve access to outdoor and therapeutic green spaces for patients, which can support recovery, mental wellbeing and connection to nature as part of the care pathway.</p> <p>Consolidation of services onto fewer sites may reduce pressure on green space at other locations if those areas are repurposed, rewilded, or managed more sustainably over time.</p> <p>There is potential to embed biodiversity considerations into estate management and grounds maintenance at key sites, contributing to wider nature recovery objectives (e.g. pollinator-friendly planting, reduced pesticide use, habitat creation).</p> <p>Improved design of healthcare environments may enhance access to green and blue spaces for patients, staff and visitors, supporting both health outcomes and wider environmental benefits.</p> <p>These positive impacts will depend on the extent to which biodiversity and green infrastructure are actively considered and embedded within estate planning and site management.</p>				
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>While the preferred option does not directly involve large-scale land use change, it may result in indirect negative impacts on green spaces, biodiversity and ecosystem resilience if not carefully managed.</p> <p>- Development or expansion of facilities (e.g. new build or refurbishment works) at Glangwili Hospital and Bronglais Hospital may result in:</p> <ul style="list-style-type: none"> • loss or disturbance of existing green space, • habitat disruption, • and potential impacts on local biodiversity, particularly during construction phases. <p>Increased concentration of activity at key sites is likely to place additional pressure on surrounding green spaces through:</p> <ul style="list-style-type: none"> • increased footfall, 	<p>Mitigation should focus on embedding biodiversity and green infrastructure considerations into estate development, site management and service planning.</p> <p>Ensure that all new developments, refurbishments and estate changes are designed to:</p> <ul style="list-style-type: none"> • avoid loss of green space where possible, • minimise habitat disturbance, 	<p>N/A at present</p>	<p>N/A at present</p>	<p>N/A at present</p>

<ul style="list-style-type: none"> • increased parking demand, • and increased infrastructure requirements. <p>Increased vehicle movements and transport activity may contribute to environmental pressures that affect biodiversity, including:</p> <ul style="list-style-type: none"> • air pollution, • noise, • and disturbance to local habitats. <p>The focus on centralised sites may reduce access to local green spaces for some patients and families, particularly where care is delivered further from home and local environments.</p> <p>Without proactive design, there is a risk that estate development prioritises clinical and operational requirements over environmental considerations, resulting in missed opportunities to enhance biodiversity and contribute to nature recovery.</p> <p>The option does not currently demonstrate a clear contribution to wider biodiversity and ecosystem resilience objectives (e.g. habitat creation, connectivity, or nature recovery), which may limit the Health Board’s ability to evidence delivery against its biodiversity duty.</p> <p>Overall, while impacts are largely indirect, failure to integrate biodiversity considerations into estate and service planning could result in negative outcomes for local green spaces and missed opportunities for environmental enhancement.</p>	<ul style="list-style-type: none"> • and incorporate biodiversity enhancements as standard practice. <p>Integrate nature-based solutions into site design, including:</p> <ul style="list-style-type: none"> • sustainable drainage systems (SuDS), • green roofs and walls where appropriate, • tree planting and native planting schemes, • and habitat creation or restoration. <p>Undertake ecological assessment where development may impact existing habitats, and implement appropriate mitigation and enhancement measures.</p> <p>Enhance existing green spaces at hospital sites to support both biodiversity and health outcomes, including:</p> <ul style="list-style-type: none"> • creating accessible therapeutic outdoor spaces for patients, • improving staff access to green space for wellbeing, • and managing grounds in a biodiversity-friendly manner. 			
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	<p>Reduce environmental pressures associated with increased site activity by:</p> <ul style="list-style-type: none"> • managing traffic and parking to limit encroachment on green space, • reducing air and noise pollution through transport mitigation measures, • and improving site design to balance operational and environmental needs. <p>Embed biodiversity considerations into estate management and procurement practices, including:</p> <ul style="list-style-type: none"> • sustainable grounds maintenance (e.g. reduced pesticide use), • supporting local biodiversity initiatives, • and aligning with wider nature recovery priorities. <p>Ensure that biodiversity and green space considerations are reflected in planning, design and decision-making processes, supporting the Health Board's wider responsibilities to maintain and enhance biodiversity</p>			
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	<p>and promote ecosystem resilience.</p> <p>Recognise that, while opportunities for enhancement exist, these will only be realised through proactive planning and integration of biodiversity objectives into estate and service delivery.</p>			
<p>Pollution</p> <ul style="list-style-type: none"> • Assess the potential release of pollution through any related activity and deploy actions which can be taken to reduce pollution: <ul style="list-style-type: none"> ○ Will this course of action affect noise, water, land, light, and air pollution in the local area, for example through increased or decreased road travel or footfall that could disturb the natural environment? ○ Will this course of action increase the risk of oil or chemical spillages? 				<p style="text-align: center;">✓</p> <p>Increased vehicle emissions + localised concentration</p> <p>Construction impacts + operational pollution risks</p>
Description of positive impacts (must include rationale and be evidence based)		How will these impacts be monitored?		
<p>The preferred option may create limited opportunities to reduce certain local pollution pressures at sites where inpatient stroke activity reduces over time, and to embed better pollution controls through planned estate upgrades.</p> <p>Consolidation of acute stroke care at fewer sites may reduce vehicle movements and localised air pollution at some sites where stroke inpatient activity decreases, particularly if this results in fewer visitor journeys and reduced onsite clinical activity.</p> <p>Planned refurbishment or development works at Glangwili Hospital and Bronglais Hospital provide an opportunity to incorporate modern pollution mitigation measures, such as improved site logistics, safer storage of chemicals, and improved waste and drainage arrangements, which can reduce risks of local land and water contamination.</p>		N/A		

<p>A more coordinated approach to patient transfers and logistics (if implemented) could reduce unnecessary vehicle idling and associated local air pollution compared to uncoordinated or ad hoc travel patterns.</p> <p>These potential benefits are dependent on effective implementation and are likely to be modest relative to the increased transport activity created by the service model.</p>				
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>The preferred option is expected to increase pollution pressures, particularly in relation to air and noise pollution, due to increased transport activity and concentration of service delivery at key sites.</p> <p>Increased inter-hospital transfers and longer travel distances for patients, staff and visitors will increase total vehicle mileage and fuel consumption, which is likely to increase air pollution (e.g. NOx and particulate matter) overall.</p> <p>Localised air pollution is likely to increase around Glangwili Hospital due to a higher concentration of:</p> <ul style="list-style-type: none"> • ambulance movements and patient transfers, • staff commuting, • and visitor travel, <p>with potential impacts on local air quality and exposure for patients, staff and neighbouring communities.</p> <p>Increased traffic intensity may also contribute to noise pollution at high-activity sites, particularly from emergency vehicle movements, delivery/logistics activity and parking congestion.</p> <p>Construction and refurbishment activity required to develop upgraded stroke facilities may generate short-term pollution impacts, including:</p> <ul style="list-style-type: none"> • dust and particulate emissions, • noise and vibration, 	<p>Mitigation should focus on reducing transport-related pollution, minimising construction impacts, and strengthening site-level controls to prevent land and water contamination.</p> <p>Reduce vehicle-related pollution by:</p> <ul style="list-style-type: none"> • minimising avoidable transfers through strengthened triage and clinical decision-making, • optimising transfer scheduling to reduce duplication and unnecessary journeys, • reducing idling through improved drop-off arrangements and transfer coordination. <p>Reduce localised pollution at high-activity sites (e.g. Glangwili Hospital) through:</p> <ul style="list-style-type: none"> • traffic flow and parking management to limit congestion, 	<p>N/A at present</p>	<p>N/A at present</p>	<p>N/A at present</p>

Appendix 6 Stroke ESIA - preferred option

<ul style="list-style-type: none"> • and increased vehicle movements from contractors and deliveries. <p>Increased activity at central sites increases the risk of incidental land and water pollution associated with:</p> <ul style="list-style-type: none"> • higher volumes of deliveries and onsite logistics, • increased use and storage of cleaning chemicals and clinical consumables, • and increased traffic-related risks such as minor fuel or oil leaks. <p>Increased reliance on road networks also increases vulnerability to pollution incidents linked to traffic disruption (e.g. congestion, collisions or vehicle breakdowns), particularly during severe weather events when risks may be heightened.</p> <p>Overall, pollution impacts are likely to be concentrated at receiving sites and along transfer routes and are unlikely to be “neutral overall” due to the net increase in transport activity created by the model.</p>	<ul style="list-style-type: none"> • designated ambulance/transfer bays to minimise idling and queuing, • encouraging low-emission staff travel options where feasible (e.g. car share, EV use supported by charging infrastructure). <p>Implement construction pollution controls for any refurbishment/new build works, including:</p> <ul style="list-style-type: none"> • dust suppression and air quality management during works, • noise management plans and restricted working hours where feasible, • routing and scheduling of contractor vehicles to reduce congestion and emissions. <p>Strengthen prevention of land and water pollution by:</p> <ul style="list-style-type: none"> • ensuring safe storage and handling of fuels, chemicals and clinical consumables, • maintaining effective drainage and spill response arrangements, • ensuring contractors follow environmental management standards for works and logistics. 			
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	<p>Reduce pollution risk associated with increased deliveries and logistics by:</p> <ul style="list-style-type: none"> • consolidating deliveries where possible, • adopting low-emission delivery requirements where feasible, • and improving onsite logistics planning to reduce vehicle movements. <p>Where feasible, introduce or strengthen local air quality considerations in estate planning and transport planning for the centralised acute site, recognising the potential for concentrated impacts on vulnerable patients and staff.</p>			
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<p>Waste</p> <ul style="list-style-type: none"> Waste in the NHS is a highly regulated industry with the risk of Not-compliance leading to fines and enforcement notices being imposed by the regulator. Wales 'Towards zero Waste' Strategy sets out long term goals for resource efficiency and waste management. To achieve this the Health Board needs to use resources efficiently by maximising reuse, recycling and recovery of resources rather than treating them as waste. <ul style="list-style-type: none"> Will the course of action increase or decrease the amount of Not-recyclable waste, clinical/Not-clinical waste, single use plastic consumption? Will this course of action increase or decrease the waste being taken to landfill? Will this course of action increase or decrease waste recovery? e.g. energy from waste? Will this course of action increase or decrease the quantity/quality of recyclable waste? Will this course of action have a positive or negative impact on circular economy principles in relation to recycling practices and sustainable waste management? Will this course of action increase or decrease the lifespan of assets and or promote recycling and reuse? e.g. Will you be promoting and maximising the repair/reuse/redistribution of products items as opposed to buying new? Will this course of action prioritise making use of existing equipment, stock and furniture surpluses as opposed to 'buying new'? Will this course of action ensure integration with existing waste mitigation processes e.g. proactively engaging with the Health Board's WARP-IT and storage management services? 	<p>Preferred option</p>		<p>✓</p> <p>↑ clinical waste intensity at Glangwili</p> <p>↑ packaging, consumables, throughput</p> <p>construction waste risk</p> <p>Redistribution acknowledged, but not impact-neutral</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p>			
<p>The preferred option creates an opportunity to improve waste performance through consolidation and standardisation, provided this is actively designed into mobilisation and estate changes.</p> <p>Consolidation at Glangwili may enable more consistent implementation of best practice in waste segregation (clinical/offensive/domestic/recycling streams), clearer ownership, and more efficient placement of waste infrastructure (bins, signage, secure storage), potentially improving recycling quality and reducing cross-contamination.</p> <p>Where services reduce at treat-and-transfer sites, there is potential to rationalise stockholding and reduce expiry-driven disposal (e.g., consumables), if surplus is proactively redistributed to higher-use areas rather than replaced.</p> <p>The required service change and any refurbishment/fit-out provides a practical point to embed circular economy practices: prioritising reuse/redistribution of furniture and equipment (e.g., via WARP-IT),</p>	<p>Site waste contractor reports (tonnage by stream), plus internal waste audit results (segregation accuracy and contamination).</p> <p>Track kg waste per occupied bed day (or per admission) at Glangwili stroke unit baseline vs post-change, and recycling rate (%) by site.</p> <p>Monitor WARP-IT reuse/redistribution metrics for any service move/refurbishment (items reused, avoided purchase value, avoided disposal).</p>		

optimising stores management, and specifying products with reusable or recyclable components and reduced packaging.				
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>While some waste may reduce at other sites, the preferred option is likely to increase waste intensity and operational waste risks at the main acute site (Glangwili) and during any estate change required to deliver the model.</p> <p>Concentration of higher-acuity activity at Glangwili is likely to increase volumes of clinical waste and disposable consumables (e.g., PPE, single-use items, absorbents), with a risk of increased high-carbon disposal routes (e.g., clinical waste treatment/incineration) compared to domestic/recycling streams.</p> <p>Increased inter-hospital transfers and throughput can drive additional packaging waste (supplies, sterile packs, transfer-related consumables) and may increase the risk of segregation errors under pressure (clinical/domestic mixing), which increases costs and reduces recycling performance.</p> <p>If the preferred option requires refurbishment/new fit-out (stroke unit / rehab areas), this will generate construction and fit-out waste and may increase replacement purchases (furniture/equipment) unless reuse is planned early.</p> <p>Higher waste volumes at a single site can increase operational dependency on waste storage capacity, collection frequency, and contractor resilience, with compliance risk if storage/collections are constrained (particularly for clinical waste.</p>	<p>Mitigation should focus on waste prevention first, followed by reuse, recycling and compliant recovery, aligning with Wales’ “Towards Zero Waste” direction referenced in the template.</p> <p>Design-out waste during mobilisation / any refurbishment:</p> <ul style="list-style-type: none"> Require a Site Waste Management Plan for any works (targets for reuse/recycling, segregation on site, take-back schemes for packaging, and evidence of compliant disposal). Prioritise refurbishment and reuse over “rip and replace” where clinically appropriate; plan early for reuse/redistribution of furniture and equipment via 	<p>Monitoring: monthly waste tonnage by stream and segregation audit findings at Glangwili post-implementation (first 6 months), then quarterly.</p>	<p>Review: at key stages in the clinical service planning / organisational change process and as part of environmental/waste governance reporting cycles</p>	<p>N/A at present</p>

	<p>WARP-IT and internal stores management.</p> <p>Reduce avoidable clinical waste and improve segregation performance:</p> <ul style="list-style-type: none"> • Ensure sufficient and correctly located segregated bins, clear signage, and safe storage capacity in the new/expanded unit to prevent inappropriate disposal routes. • Implement short, role-specific waste segregation refreshers for clinical and domestic teams at Glangwili during go-live and embed into induction for rotated staff. • Introduce periodic waste composition audits (particularly of “orange/yellow” streams) to identify avoidable clinical waste and training needs. 			
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	<p>Use procurement to prevent packaging and single-use growth:</p> <ul style="list-style-type: none"> • Build waste expectations into procurement for the stroke unit: reduced packaging, recyclable materials, supplier take-back where available, and preference for reusable products where clinically safe (aligned with IPC policy). • Strengthen stock control to reduce expiry (right-sizing par levels, rotating stock between sites, and using surplus before buying new). <p>Operational resilience and compliance:</p> <ul style="list-style-type: none"> • Confirm waste storage space and collection frequency are sufficient for increased activity at Glangwili (including contingency arrangements if collections are disrupted). 			
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<p>Climate Change Adaptation</p> <p>Climate change adaptation is the process of adjusting to the effects of climate change from both current and expected impacts. In Wales, adaptation is as urgent as decarbonisation: hotter summers, wetter winters and more frequent extreme weather are already affecting population health, inequalities, and the continuity of health and care services. The Welsh Government’s Climate Adaptation Strategy for Wales 2024 sets the national direction for strengthening resilience across sectors, including Health and Well-being, Buildings, Energy Supply, Telecoms/ICT, and Emergency Preparedness, recognising the need to protect critical services and the people who rely on them. Public Health Wales recognises climate change as one of the most significant threats to physical health, mental health and wellbeing and has made tackling the public health effects of climate change a priority within its Long-Term Strategy, working with partners to support adaptation action. As a public body in Wales, the Health Board is also required to act in accordance with the Well-being of Future Generations (Wales) Act 2015, including contributing to a “Resilient Wales” with the capacity to adapt to change. The Health Board also has a Board-approved Climate Adaptation Plan, and service changes should support delivery against its agreed priorities and actions.</p> <ul style="list-style-type: none"> • Will this course of action/activity consider current and future climate risks for the area or locality (e.g. overheating/heatwaves, flooding and surface water, storms, cold weather, drought and water scarcity, wildfire and air quality impacts, and coastal risks where relevant), including the potential for compound events? • Will this course of action have a positive or negative impact on the resilience of the Health Board’s critical dependencies and supply chains (e.g. energy/power resilience and backup arrangements, water supply and quality, digital connectivity/telecoms and cyber physical resilience, transport access and patient transfers, medicines/medical devices, food and other essential supplies, and workforce availability/skills)? • Will this course of action increase or decrease the resilience of service delivery and patient safety during climate events (e.g. ability to maintain safe internal temperatures and safe working conditions, business continuity and surge capacity, mutual aid and cross-site working, and avoidance of single points of failure where services become more dependent on fewer sites)? • Will this course of action create opportunities for adaptive measures that also deliver health and co benefits (e.g. nature-based solutions/green infrastructure for cooling and flood management, travel demand reduction through digital/virtual models where clinically appropriate, and design standards that improve long-term climate resilience)? 	<p>Preferred option</p>			<p>✓</p> <p>Introduces: single point of failure, transport vulnerability, reduced system redundancy</p> <p>Positives are conditional on investment/design</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p> <p>The preferred option presents some conditional opportunities to strengthen climate adaptation and service resilience, although these are dependent on how the model is designed, implemented and aligned to the Health Board’s Climate Adaptation Plan.</p>	<p>How will these impacts be monitored?</p> <p>Monitoring should align with existing Health Board processes and statutory requirements, rather than creating new KPIs:</p>			

<p>Consolidation of acute stroke care into a smaller number of sites (particularly Glangwili) creates an opportunity to target adaptation investment (e.g. overheating mitigation, ventilation and cooling, flood resilience, and resilient infrastructure upgrades) where clinical risk is highest, rather than spreading limited resources across multiple sites.</p> <p>Any refurbishment or development required to support the stroke unit provides an opportunity to embed climate-resilient design standards, including passive cooling, improved building fabric, and resilient drainage systems aligned to Welsh Government expectations.</p> <p>Centralisation may support stronger coordination of contingency planning and emergency response, including clearer escalation pathways and more consistent implementation of adaptation measures at key sites.</p> <p>These benefits will only be realised where adaptation is explicitly designed into estate, service and infrastructure planning, rather than assumed as a by-product of the service change.</p>		<ul style="list-style-type: none"> • Delivery against the Board-approved Climate Adaptation Plan (including relevant actions for buildings, infrastructure and service resilience). • Estates performance and risk reporting, including overheating incidents, infrastructure constraints and resilience issues. • EPRR (Emergency Preparedness, Resilience and Response) reporting on climate-related incidents and service disruption. • Business continuity and incident review processes following extreme weather events (e.g. storms, flooding, heat events). 		
Description of Negative Impacts	Mitigating actions of negative impacts	How often will this action be monitored	How often will this action be reviewed	Lead Person
<p>The preferred option introduces several clear climate adaptation risks, particularly in relation to system resilience and dependency on critical infrastructure.</p> <p>Increased reliance on a single acute stroke unit (Glangwili) creates a potential single point of failure, increasing system vulnerability if the site is affected by climate-related disruption (e.g. overheating, power outages, flooding or access issues).</p> <p>The model significantly increases dependency on transport networks and inter-hospital transfers, which are vulnerable to climate hazards such as:</p> <ul style="list-style-type: none"> • flooding and surface water affecting roads • storms disrupting transport and response times • extreme heat affecting vehicle reliability and staff capacity <p>This may impact patient flow, timeliness of care, and overall pathway resilience.</p>	<p>Mitigation should focus on aligning the service model with the Health Board’s Climate Adaptation Plan and strengthening resilience across key dependencies.</p> <p>Align fully with the Board-approved Climate Adaptation Plan, ensuring that risks introduced by the service change are explicitly reflected in priority actions and delivery plans.</p> <p>Strengthen infrastructure resilience at Glangwili and key sites by:</p> <ul style="list-style-type: none"> • ensuring sufficient backup power and 	<p>Monitoring through existing Adaptation Plan reporting cycles, EPRR governance, and Estates risk/performance reporting.</p>	<p>Review aligned to routine governance cycles and post-incident reviews following climate-related events, rather than creating new reporting structures.</p>	<p>N/A at present</p>

Appendix 6 Stroke ESIA - preferred option

<p>Increased concentration of activity at Glangwili may heighten risks associated with overheating in healthcare settings, particularly given rising summer temperatures and known impacts on patient safety, staff wellbeing and equipment performance</p> <p>Greater reliance on critical infrastructure (power supply, digital systems, water, medical equipment) at fewer sites increases the potential impact of infrastructure failure during climate events, particularly where redundancy is limited.</p> <p>The model may reduce geographic flexibility and redundancy across the system compared to a more distributed service, limiting the ability to absorb disruption or re-route patients during extreme weather events.</p> <p>Overall, the preferred option increases exposure to climate-related disruption unless adaptation and resilience measures are actively strengthened.</p>	<p>redundancy for critical systems</p> <ul style="list-style-type: none"> • improving cooling, ventilation and overheating mitigation • assessing and mitigating flood and drainage risks • ensuring resilience of digital and communications systems <p>Reduce vulnerability of transport-dependent pathways by:</p> <ul style="list-style-type: none"> • developing contingency plans for transfer disruption during extreme weather • strengthening coordination with ambulance services and transport providers • identifying alternative pathways or escalation routes where transfer delays occur 			
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	<p>Maintain system flexibility and avoid total reliance on one site by:</p> <ul style="list-style-type: none"> • maintaining contingency capacity across other hospital sites where feasible • ensuring clear business continuity plans for temporary service disruption • considering mutual aid arrangements and cross-site working <p>Integrate climate risks into EPRR and business continuity planning, ensuring that stroke pathways are explicitly considered in climate-related incident scenarios.</p> <p>Undertake a targeted climate risk assessment for the preferred option, focusing on:</p> <ul style="list-style-type: none"> • site-specific risks (e.g. overheating, flooding) • transport and access disruption • infrastructure dependencies (power, ICT, water) 			
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	<p>Recognise that mitigation will reduce but not eliminate climate-related risks, and these should be considered as part of the overall risk balance of the preferred option.</p>			
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<p>Climate Change Preparedness & Resilience</p> <ul style="list-style-type: none"> As part of NHS Wales Emergency Planning Core Guidance and our commitment to Emergency Preparedness Resilience and Response (EPRR) we must demonstrate our ability to effectively respond to the risks and impacts of climate change and climate events on our health services and the population. We must clearly document and demonstrate how services will be maintained for patients during such incidents/events as well as keeping the population safe. <ul style="list-style-type: none"> Will this course of action increase or decrease our ability to respond effectively to climate emergencies, and/or maintain our services during a climate event and/or reduce the impacts from extreme weather on our staff and population? Will this course of action increase or decrease the resilience of the Health Board's infrastructure and assets to climate change risks and impacts? 		Preferred option			<p>✓</p> <p>Increased reliance on: central site, transfers, coordinated response</p> <p>Loss of passive resilience / redundancy</p>
<p>Description of positive impacts (must include rationale and be evidence based)</p> <p>The preferred option provides some opportunities to strengthen emergency preparedness and operational coordination, although these are dependent on how the service model is implemented and integrated into existing EPRR arrangements:</p> <p>Centralisation of acute stroke care at Glangwili may support clearer command, control and coordination during incidents, with defined escalation routes and improved visibility of critical capacity (e.g. specialist beds, workforce, equipment).</p> <p>Concentration of specialist expertise and infrastructure at a single acute site may enable more consistent application of EPRR planning, training and incident response protocols, compared to a more distributed model.</p> <p>The service change provides an opportunity to review and strengthen stroke pathway inclusion within EPRR and business continuity plans, ensuring that critical patient pathways are clearly defined and prioritised during incidents.</p> <p>These benefits rely on proactive integration with EPRR planning and governance, and will not be realised without explicit consideration during service design and mobilisation.</p>		<p>How will these impacts be monitored?</p> <p>EPRR assurance processes (e.g. Core Standards for Emergency Preparedness, Resilience and Response) and internal assurance reporting.</p> <p>Outcomes from incident debriefs, exercises and simulation training involving stroke pathways.</p> <p>Routine business continuity plan testing and review cycles.</p> <p>Reporting through existing Health Board emergency planning and resilience governance structures.</p>			
<p>Description of Negative Impacts</p> <p>The preferred option introduces a number of operational resilience risks in the context of emergency preparedness and response, particularly due to increased dependency on centralised infrastructure and transport pathways.</p>	<p>Mitigating actions of negative impacts</p> <p>Mitigation should focus on strengthening preparedness, maintaining service continuity, and ensuring stroke pathways are resilient</p>	<p>How often will this action be monitored</p> <p>Through existing EPRR assurance cycles, business continuity reviews,</p>	<p>How often will this action be reviewed</p> <p>Frequency to be determined</p>	<p>Lead Person</p> <p>Service Delivery Manager</p>	

Appendix 6 Stroke ESIA - preferred option

<p>The model increases reliance on a single acute stroke unit (Glangwili), creating a potential single point of failure in emergency scenarios where site access, infrastructure, or workforce is disrupted.</p> <p>Greater dependence on inter-hospital transfers and ambulance services introduces vulnerability during major incidents or extreme weather events, where transport capacity may be constrained or prioritised elsewhere within the system.</p> <p>Increased service concentration reduces the level of inherent system redundancy, limiting flexibility to absorb surges in demand or redistribute patients quickly during incidents.</p> <p>Pressure on critical infrastructure at the central site (power, ICT, clinical equipment, bed capacity) may have wider system impacts during failure scenarios, given the reduced availability of equivalent capability elsewhere.</p> <p>Emergency response may become more complex where multiple patient movements are required across sites, particularly during simultaneous incidents affecting both transport routes and hospital capacity.</p> <p>Overall, the preferred option increases reliance on coordinated system response and reduces passive resilience, requiring stronger EPRR planning and mitigation.</p>	<p>within emergency scenarios, aligned with NHS Wales EPRR expectations.</p> <p>Embed the stroke pathway into all relevant EPRR and business continuity plans, ensuring:</p> <ul style="list-style-type: none"> • clear escalation protocols • defined roles and responsibilities • prioritisation of time-critical stroke care during incidents <p>Develop and test contingency plans for key failure scenarios, including:</p> <ul style="list-style-type: none"> • loss of access to Glangwili site (e.g. flooding, infrastructure failure) • disruption to ambulance/transfer capacity • surge scenarios affecting bed capacity and workforce availability 	<p>and post-incident debrief processes.</p>		
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	<p>Maintain system flexibility and surge capacity where feasible, including:</p> <ul style="list-style-type: none"> • identifying alternative care pathways or interim stabilisation approaches at other sites • ensuring cross-site working arrangements can be activated rapidly • exploring mutual aid arrangements where appropriate <p>Strengthen infrastructure and operational resilience at the central site, including:</p> <ul style="list-style-type: none"> • backup power and critical system redundancy • robust ICT and communications systems • clear incident management structures aligned to EPRR frameworks <p>Undertake scenario-based training and exercises that specifically include the centralised stroke model, to test:</p>			
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	<ul style="list-style-type: none"> • transfer pathways under disruption • coordination between sites • incident escalation and decision-making <p>Ensure alignment with wider system partners, including ambulance services and local resilience forums, to reflect the increased dependency on coordinated response.</p> <p>Recognise that mitigation will reduce but not eliminate risks associated with centralisation, and resilience will depend on effective implementation and ongoing testing.</p>			
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Term / Acronym	Explanation
ICT	Information and Communication Technology – digital systems used for communication, data, and clinical systems
WARP-IT	Reuse system used in NHS Wales to redistribute unwanted furniture and equipment rather than disposing of it
Net Zero	Achieving a balance between greenhouse gas emissions produced and emissions removed, resulting in no overall increase
Decarbonisation	Reducing carbon emissions from activities such as energy use, transport and procurement
Circular economy	An approach focused on reducing waste through reuse, repair, recycling and better resource use
Embodied carbon	Carbon emissions associated with materials and construction (e.g. building works), not just day-to-day energy use
Redundancy (infrastructure)	Having backup systems or spare capacity available to maintain services if the main system fails