Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Helen Morgan-Howard, Sarah Isaac, Alex Martin, Ben Rogers, Yvette Pellegrotti, Transformation Programme Office

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board has an agreed and recently refreshed strategy, 'A Healthier Mid and West Wales' (AHMWW), which sets out our vision for health and care across Hywel Dda, including the future configuration of services. The fragility and unsustainability of our services was a key driver for the strategy and remains a risk that has been further exposed through the COVID-19 pandemic and in the period since. The long-term vision, set out in AHMWW, for the future hospital network remains our direction of travel; however, the Board has recognised that, in light of capital availability and the time elapsed since 2018, it is necessary to review clinical service configurations within the existing estate.

The Clinical Services Plan (CSP) programme was established to develop a set of plans for the provision of key services over the medium-term. The purpose of this report is to provide assurance on the steps being taken in Phase 4; the pre implementation planning phase.

Cefndir / Background

The long-term plans for services remain as set out in our strategy; however, there is a need to consider service provision over the medium-term, particularly with the delays in the 'A Healthier Mid and West Wales' infrastructure programme. Prior to the pandemic, and in our strategy, it was recognised that many of our services are fragile, predominantly because our clinical teams are spread across multiple sites leading to an over-reliance on a small number of individuals. This remains the case and, in certain areas, that risk has materialised. Similarly, there are many services that have not returned to pre-pandemic waiting times, which is limiting access for patients, e.g. for those patients awaiting elective surgery.

At the Board meeting held in March 2023, it was agreed that the following services required focused support and would form a programme of work to deliver a Clinical Services Plan (note: the table below has been updated to indicate services in scope and changes of roles):

Table 1: Drivers for pathways within scope of the Clinical Services Plan programme updated to reflect services in scope and change in roles:

Service	Driver	Executive Lead
Critical Care	Response to service fragility, in particular at Prince Philip Hospital (PPH)	Chief Operating Officer
Planned Care (Dermatology, Elective Orthopaedics, Ophthalmology, and Urology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients	Chief Operating Officer
Emergency General Surgery	To respond to service fragility, particularly at Withybush Hospital (WGH), as referenced in the March 2023 operational update	Chief Operating Officer
Stroke	To meet standards and respond to service fragility	Executive Director of Allied Health Professions and Health Science
Diagnostics (Endoscopy and Radiology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients	Chief Operating Officer

At the Extraordinary Board meeting in February 2026 decisions were made in relation to the above services. These are described in the extract below from the CEO Report in March 2026 and are set out in the Clinical Services Plan update to the Strategy and Planning Committee papers in April 2026.

Final decisions were confirmed for all services except Stroke.

- For Stroke, a new merged idea was explored, combining elements from two alternative options generated during the consultation to progress towards a 24-hour specialist Acute Stroke Unit in Glangwili Hospital (GGH) and an Acute Stroke Rehabilitation Unit in Bronglais Hospital (BGH). A detailed update is provided under the next agenda item on progress to date and next steps.
- Emergency General Surgery – centralising the emergency on-call rota at GGH and strengthening Surgical Same Day Emergency Care starting at GGH and Withybush Hospital (WGH);
- Critical Care – developing an Enhanced Care Unit at Prince Philip Hospital (PPH), supported by additional recruitment;
- Ophthalmology – consolidating some services at GGH while increasing activity at community sites;
- Orthopaedics – making temporary changes permanent, supporting regional working and increasing activity at sites including BGH;
- Dermatology – making temporary changes permanent, bringing services together at PPH supporting site reconfiguration;
- Urology – making temporary changes permanent, bringing together services at PPH to support a Urological Investigations Unit;
- Endoscopy – increasing activity at PPH through an additional procedure room;
- Radiology – developing seven-day routine diagnostics, with a cancer focus, at PPH and WGH, and responding to urgent needs in the service.

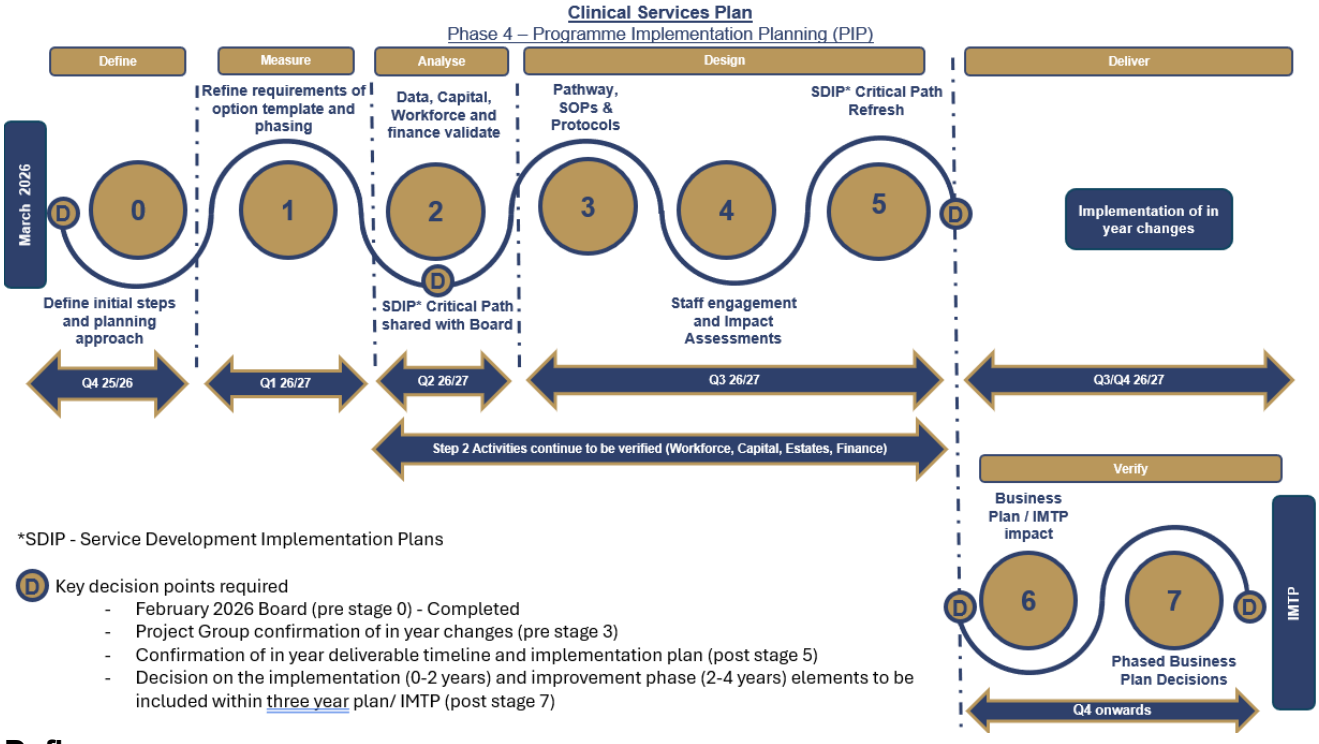
Asesiad / Assessment

Programme Approach

The Clinical Services Plan has now commenced Phase 4 – the pre implementation planning phase. The scope of the Clinical Services Plan Programme at Phase 4 is to:

- Refresh and take forward the Capital, Workforce, Data and Finance assessments
- Develop a benefits map for each service
- Identify quick wins through completion of phased assessments for each service
- Establish a process for checking, challenging and agreeing the prioritisation of services
- Produce an Implementation Plan for each service (except Stroke), which will also inform the three-year planning process

The graphic and timeline below illustrates these steps being taken during this phase.



Define

Programme governance continues according to the same template as earlier phases, although its finer details are currently under review. This phase gate review aims to ensure that the programme receives support from the appropriate roles and departments for successful delivery. As part of these developments, Trade Union colleagues are becoming actively involved within the Task and Finish Group structure and remain members of the programme's decision-making group.

Measure

Following the Board's decision in February 2026, the Clinical Services Plan began an in-depth review of option templates, moving from initial estimates to detailed requirements and refinements. Additionally, a comprehensive phased assessment is underway to map out the critical path for service change and deliver outcomes based on previous decisions. These assessments will be reviewed in May 2026 by the Clinical Services Plan Project Group, which includes Clinical Care Group Leads across the Health Board. The results will inform critical path for the service development implementation plans, help identify potential quick wins, and will be reported to Board in July 2026.

Analyse
This stage requires Clinical Services Plan programme estimates used to support Board decision making in February 2026 to transition into detailed assessments of Capital, Workforce, Data, and Finance for each service. These components are crucial for developing a robust implementation plan and informing the Health Board's three-year planning cycle.

Design
The design phase marks the beginning of more detailed work needed to implement the plans. It serves as a prerequisite for guiding the Business Case process and contributing to the three-year planning cycle.

Verify and Deliver
Quick wins identified through phased assessments are expected to begin delivery before the end of the 2026/27 reporting year. More complex requirements will need verification via the three-year planning cycle and Business Case processes. During this step, the service development Implementation plans will be refreshed with additional details.

Communications and Engagement
As the programme moves into the phase of pre-implementation and potential in year changes, the communications and engagement plan is being refreshed to support with future communications in relation to changes in activity. This will be important to keep our public informed of what is changing, but more importantly what is still remaining the same at this time, so they are able to access safe and timely care.

Stroke Services
A virtual session of the Options Development Group for stroke services was held on 14 April 2026 to evaluate and score the option previously identified at the February 2026 Board meeting (Appendix 1). The findings will support the documentation and questionnaire, which is already being developed using materials from prior consultations.

An eight-week phase 2 consultation is planned from June 2026, with the intention being to present findings to the Board by the end of the calendar year. However, the timing may depend on the volume of responses received; consequently, the Board may not make a final decision on stroke services until early 2027.

A more detailed update on stroke is provided under the next agenda item, along with materials to support the consultation.

Argymhelliad / Recommendation

The Board is asked to **TAKE ASSURANCE** that work is progressing to develop a detailed implementation plan for the eight services upon which final decision were made at the February 2026 Public Board meeting.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1082 – (T&O) Lack of Major Trauma Weekend Theatre Sessions GGH (current score 10) 1383 (Endoscopy) Nursing Staffing Issues/recruitment (current score 9) 1254 - (Endoscopy) Prince Philip Reconfiguration (current score 12)

	1531 - (General Surgery) Inability to safely support on call rota at WGH and GGH (current score 15) 1488 - (Endoscopy) Decontamination BGH (current score 20)
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: UHB Strategic Objectives:	All Strategic Objectives are applicable
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
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 Termau: 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.

CLINICAL SERVICES PLAN (CSP)
Stroke Proposed Option
Hurdle and Scoring Appraisal Session
(Report date: 15 April 2026)

SUMMARY REPORT

Workshop date: 14 April 2026

Table of Contents

1 Executive Summary

1.1 Introduction

Hywel Dda University Health Board (HDdUHB) is advancing its Clinical Services Plan to align with its vision of "A Healthier Mid and West Wales". The plan aims to enhance local care and sustain specialist services.

The aim and objective of the Stroke Proposed Option appraisal session was to assess the idea of merging options 106 and 210 generated during the decision-making process by HDdUHB, described as the preferred option in this document, along with additional information to date, against the Hurdle Criteria and to score the option against the evaluation criteria so it could be compared against other options previously considered by Board.

The session was attended by clinicians, operational leads, staff members and stakeholders representing interdependent services and the services within the Clinical Services Plan. The invitees were broadly the same as Sprint 2 from Phase 2 of the programme as well as the Alternative Option process that took place in Quarter 3 of 2025/2026, with additional people invited to reflect organisational changes to operational structures.

1.2 Methodology

The session focused on evaluating the preferred option against the Hurdle Criteria, requiring a two-thirds majority approval from both room and service representatives for progression. Subsequently, a scoring appraisal of the preferred option was conducted.

At the conclusion of the meeting, the results were presented to participants, accompanied by a reminder regarding subsequent steps in the process, including the integration of relevant elements into future engagements related to this preferred option.

The methodology employed reflected that of Phase 2, necessitating a two-thirds majority from both groups for approval.

On 14 April, the session was divided into two segments. During the first segment, the Options Development Group (ODG) undertook a Hurdle Appraisal, incorporating feedback as presented during the Alternative Options Process. In the second segment, the ODG reviewed and scored feedback pertaining to the strengths, weaknesses, opportunities and threats (SWOT) analysis of the Evaluation Criteria.

1.3 Summary of Discussions

Lee Davies, Executive Director of Strategy and Planning outlined the programme's purpose, reviewed progress, and summarised the Board’s stroke services decision to

merge two options into a preferred option and opened to questions on the purpose of the day.

The session focused on appraising this preferred option for stroke using established Hurdle Criteria. Representatives reviewed Options 106, 210 and the preferred option and the process was explained. Once the hurdle appraisal was complete and people had an opportunity to ask questions about the preferred option and assessment, the scoring began.

In the second half, participants scored 16 evaluation criteria using weighted methods following a presentation of the preferred option, feedback received previously and recent site visits, and a further opportunity to ask questions. Results were presented, and Lee Davies concluded with next steps for stroke services.

1.4 Next Steps

- Finalisation of Impact Assessments
- Phased assessment of Finance and Workforce
- Further engagement on this preferred option
- Final decision targeted for the end of the year dependent on the level of responses during the engagement period

2 Introduction

Hywel Dda University Health Board's Clinical Services Plan seeks to deliver services in the medium term in line with Hywel Dda's longer term vision contained in the "A Healthier Mid and West Wales" strategy.

The Clinical Services Plan programme has an opportunity to look at how and where the Health Board provides services, in line with the strategy's goal to deliver care closer to home, while also seeking to make specialist services more sustainable.

A clinically led process representing the nine clinical service areas has been implemented to develop options which would meet the aim and objectives of the programme:

Aim:

- Develop a series of options for delivery of the Clinical Services Plan programme in response to service fragilities or unsustainability based on the principles of care that is safe, sustainable, accessible, and kind. The development of a Clinical Services Plan is also an action within the Targeted Intervention requirements of Welsh Government.

Objectives (specifically for stroke services):

- Improve standards and respond to service fragility within the stroke service.

The session had two objectives:

1. **Hurdle appraisal of the stroke preferred option**
2. **Scoring of the stroke preferred option against each of the 16 Evaluation criteria**

Tuesday 14 April 2026, 15.30 hours to 17.00 hours:

- 56 staff members joined the event including service, interdependent services and support services as well as representatives from:
- Welsh Ambulance Service Trust (WAST)
- Betsi Cadwaladr University Health Board (BCUHB)
- Powys Teaching Health Board (PTHB)
- Llais
- Public Health Wales
- Trade Union Representatives
- Hywel Dda University Health Board (HDdUHB) Executives
- Transformation Programme Office/Engagement team members

3 Methodology

3.1 Welcome and Background

The virtual session commenced at 15.34 hours with Lee Davies, Executive Director of Strategy and Planning, welcoming attendees, and reminding them of the purpose of the day.

Lee Davies introduced the session focusing on finalising the Clinical Services Plan, specifically addressing stroke care. Lee Davies highlighted that the Board have made decisions on eight of nine services; stroke requires further analysis. The Board requested assessment of a merged idea combining elements of previous proposals (106 and 210) to overcome challenges in stroke service delivery. This became the preferred option for stroke.

Lee Davies reflected on the process to date including detailed issues across all services, developed potential solutions, and conducted public consultations, gathering substantial feedback including new suggestions. Highlighting our aim is to ensure sustainable standards, efficiency, and improved outcomes.

For stroke, bringing together services into fewer units enhances care standards but raises geographic and rehabilitation concerns. The Board favoured a single acute stroke unit at Glangwili, with a rehabilitation facility at Bronglais, subject to further appraisal and public engagement. Implementation would be gradual due to complexity, but bringing services together should improve quality, timeliness, therapy provision, and resource allocation.

3.1.1 Questions and Answers

Question (Trade Union Representative): So, with stroke are options 106 and 210 still being looked at as well as the 106/210 merger

Summarised response: The Board has reviewed several stroke options and had concerns about each one. To address these issues, they decided that combining options 106 and 210 might offer the safest and most sustainable solution. This combined approach is currently being tested and will be presented for public feedback, as that stage hasn't occurred yet. The other options have already been evaluated and set aside for now. However, nothing has been finalised; if the preferred option doesn't give the Board enough confidence after further review, they'll reconsider the previous options to find the best possible fit, despite earlier reservations.

Question (Trade Union Representative): One reservation that I do have going forward as well, notwithstanding one stroke unit, because I think from the very beginning that was the option that I said that potentially we should be looking at, where was another one, but within that one stroke unit, I think what members of the public would want as a reassurance is that thrombectomy could be carried out at that one stroke unit, because

why would you have one stroke unit, for example, based in Glangwili, when potentially you might have a super stroke unit in Swansea within the same time frame? That has a thrombectomy, so which is where everybody would go. So, we need to be very careful that we're not going to be planning to do something which could be taken over by a stroke unit, which is where everybody from South Wales will be going to, is my concern.

Summarised response: Currently, we're seeing some progress with thrombectomy services now available in Cardiff, which is a positive development since we didn't have this before. However, it's still not a 24-hour service, and more work is needed to ensure consistent round-the-clock provision. Achieving a fully reliable 24-hour thrombectomy service seems quite distant at this point, and Swansea Bay faces the same challenges regarding providing thrombectomy at Morriston. If and when these services become possible, we'll need further discussions about the most suitable stroke care model. For now, though, such comprehensive coverage appears to be many years away.

Question (PTHB): Two questions, one about Powys, one about process. So in terms of the merged option, just checking if it's assumed in those planning, the planning assumptions for that, that the patients from Powys to currently go to Bronglais will flow to Carmarthen, either via Bronglais or directly. And just to note that actually stroke services are planned to come back to Shrewsbury. And Shrewsbury's closer to Machynlleth, for example. So, my understanding of the WAST protocols at the moment, is that WAST will take to the nearest Acute Stroke unit where that's required. So, on that basis, that current SOP. We just need to all be clear what the planning assumptions around Powys patients are. And I am meeting with WAST to check that because we've got a similar issue in the southeast corner of Powys where stroke services are moving from Hereford to Worcester and for example, the Grange might be closer.
So just to check those planning assumptions on the patient flows. And then on the process, I think the slide says that there'd be this further engagement but will there also be further consultation if the merged option is taken forward after that?
Engagement, because I presume the merged option wasn't consulted upon in the previous process, which led to board decisions in February. So just to check that, is it engagement then possible consultation or is it engagement and then stop? Thank you.

Summarised response: To address your first point, we have not made any assumptions regarding the allocation of Powys or the pathways for self-presenting patients. These outcomes will be influenced by WAST protocols and the location of the nearest relevant unit, with further considerations possibly arising from commissioning discussions. There may be instances where Bronglais for thrombolysis is accessible as the closest facility, while Glangwili is not necessarily the nearest stroke unit for those patients. This creates a nuanced scenario, and at this stage, no definitive assumptions have been established. It is recognised that patient flows may vary depending on individual circumstances, such as place of residence and location of stroke, which could influence service direction in multiple ways.

Regarding the second point, our current position is that engagement is planned rather than a full consultation, although the distinction between the two is minimal. We have previously conducted a comprehensive consultation and do not intend to repeat it in its

entirety. Nevertheless, the forthcoming engagement will follow a similar process and provide comparable information. Approval to proceed will be sought from our Board in May, after which a determination will be made on whether the activity is best described as engagement or consultation. In practice, the process and substance will remain largely consistent.

To expand upon this, we envisage this next step as a continuation—a second phase—of the original clinical service plan consultation rather than a new consultation from the beginning. Insights gathered during the initial consultation have guided us towards exploring this distinct option, for which additional information is now being sought. The upcoming engagement period is expected to last eight weeks and will build directly upon the previous consultation framework, incorporating main documents, questionnaires, easy-read materials, and more. Planned activities include both online and in-person public drop-in sessions across Health Board counties, with consideration given to hosting an event in Powys, consistent with the original approach. Overall, the engagement activities will closely mirror those conducted previously, with the primary difference being a shorter engagement period rather than a full twelve-week consultation.

Question (Primary Care & Community): Now, correct me if I'm wrong, but if I recall correctly, the public was given a consultation that involved option A and B, and then we went to 106 becoming a variant of option A and 210 becoming a variant of option B and now we're at a point where they're being combined. Is that right?

Summarised response: Yes, both option 106 and option 210 originated from alternative proposals during public consultation. They met the criteria last October and November, were scored, and presented to the board. Specifically, option 106 refers to a stroke rehabilitation unit in Bronglais, while option 210 involves a 24-hour standalone stroke unit at Glangwili; these elements have since been combined into a single preferred option.

Question (Primary Care & Community): So, I guess as the rehabilitation centre in one of these, in this option is mentioning Bronglais, with regards to therapies being a unit in one place supporting stroke, and then a rehab unit supporting stroke. I'm just wondering if the staffing is such that they can deliver that. And I guess the other question obviously is on the site of Glangwili, if there's a plan for a stroke unit, actually a separate stroke unit to be built or I don't know what the background to that is, but I think it's those questions are worth asking, because I know presently that site is really quite full, it would seem.

Summarised response: The option process includes stage zero capital estimates, supported by the capital team. They assess the best approach from a capital perspective. Previously, option 210 was to build a standalone unit, which was presented to the Board and informed decisions. This information will be updated before being returned to the Board later this year.

Question (CIMCCG[1]): Has thought been given to balancing of services for the UEC centres where stroke may be T&T, i.e. employment of specialist stroke nurse/ ACP to review presentations suitable for transfer (as ~50% of stroke calls are stroke mimics) or is T&T just for those that are thrombolysed?

Summarised response: Dr Kumar the clinical lead for stroke responded to confirm that there is work in progress in relation to this.

Question (AHP[2]): It was probably just to pick up some of the assumptions impacting deliverability. So, it makes some sense to centralise and hopefully improve quality because you take some of the fragility out of the acute stroke care. But I think from a therapy's perspective, we're really concerned about the assumptions that have been made around the rehab element of it. And it doesn't feel in the way the options framed that there's sufficient focus on the early supported discharge or the community resource team infrastructure to enable this to work. And I know when we did the other options previously and we worked out that, you know, the potential bed savings on length of stay in the ESD, it only actually released enough resource to uplift workforce by 15 to 25 percent over the first four years. And that was in the acute unit only, not considering the community. So, I think probably where I'm going with this is just to check and challenge that understanding of what community infrastructure is required in order to deliver this, especially in the areas that won't have dedicated rehab units.

Summarised response: To address this, in line with other programme options, we will be conducting an updated phased assessment from a Workforce perspective to inform decision-making. We acknowledge previous feedback from you and your colleagues regarding the importance of representing community rehabilitation teams (CRT) and the early support discharge function within our considerations. Workforce colleagues are aware of this need, and we will ensure that these elements are incorporated into our work. Additionally, all engagement and input from today's session will contribute to this ongoing process.

Question : Clinically, would there be any benefit for acute PPH stroke patients to travel to Carmarthen to a Stroke Unit, if they required intervention, in the first instance, presently on offer outside our Health Board (i.e. Eastward)? Would an equivalent query be relevant to some patients in North Ceredigion patients? And would that be 24/7?

Question (CIMCCG): If there is a change in Pathways for Powys and Gwynedd to other centres, what does this mean to the sustainability of a stroke rehab unit at BGH? (And Gwynedd was added by BCUHB colleagues)

Summarised response: Lee Davies addressed several points, noting the need for clear definitions of terms like "acute stroke unit," "stroke rehabilitation unit," "early discharge," and possible "extended rehabilitation" for those unable to return home. Clarifying these should improve discussion, as there are standards for stroke rehab units, and not every

[1] Community & Integrated Medicine Clinical Care Group
[2] Allied Health Professionals

location has one in this option. The role of early discharge also requires explanation. Referring to Peter's point, he emphasized that determining the size and scope of each service will affect the scale of required rehab units, depending on patient numbers and delivery methods. He acknowledged Matthew's observation that patients follow different recovery paths, so the model must accommodate varied needs. More detail will be provided as the model is developed.

Question (Trade Union): I just want to clarify that what we're looking at is that there'll be 1 unit which would be based in Carmarthen. So, Haverfordwest would be treat and transfer. Bronglais would see and treat and transfer. What happens with Prince Phillip? Will that that be a see and treat and transfer as well? Because I am aware that currently stroke go there. So will there be a rehabilitation unit In Withybush to go back to, and there are the queries around. But we also need to be mindful that our, and coming back to John Davies point, that we have people who are employed in the Ceredigion particularly area in Withybush, they're not going to all want to transfer to rehabilitation units in, for example, Carmarthen. So we might find staffing could still be a problem. Because attracting staff to this area is still an issue.
I just wanted to clarify, is that what we're looking at?

Summarised response: The preferred option designates the acute stroke unit solely at Glangwili, with rehabilitation units at Glangwili and Bronglais. Transfers from other sites will occur as needed, and impacts will be assessed throughout this process.

Comments

Comment (CIMCCG): Will be important to describe the pathway - so 1 day at BGH - 2 days at GGH (or Shrewsbury) - then 14 days in rehab (assuming if closer to home); that will be essential information to inform an appropriate engagement.

Comment (PTHB): Apologies, I also forgot to say that we have a 'Powys First' approach to stroke rehab for our population and will feed this in again through the engagement.

Comment (Trade Union Representative): Potentially this should not fail the hurdle criteria because it passed as 106 and 210

Comment (Primary Care & Community): just to comment on the fact that obviously I've been present in most of these meetings, and whereas we've had some doctors who have been clinical leads, etc, present, I don't see as many doctors on this call. So I would hope that when we're talking about further engagement that we'll actually have meetings with doctors too.

3.2 Hurdle Appraisal of the Stroke Preferred Option

Ben Rogers, Principal Programme Manager, presented the Hurdle Criteria as applied during Phase 2 and through the Alternative Options Process after public consultation in Phase 3 of the Programme.

Attendees were provided with an overview of the Hurdle Criteria process and informed that expert opinion guided its application to the preferred stroke option. The steps involved in considering the Hurdle Criteria were reiterated, beginning with the stroke Task and Finish Group—which includes representatives from stroke services across Hywel Dda—and subsequently reviewed by stroke representatives within the ODG.

The Hurdle Appraisal slide highlighted assessments of option 106 and option 210, establishing context before detailing how service representatives within the ODG appraised the preferred option.

Since the preferred option combines elements of options 106 and 210, feedback regarding these options, previously shared during the "check and challenge" phase of the Hurdle process in October 2026, was re-presented for informational purposes.

Prior to distributing the QR code and link for form completion, a question-and-answer session was held. The questions and comments discussed are documented below:

3.2.1 Questions and Answers

Question (BCUHB): Excuse my ignorance on this one. I note that it talks specifically about hospitals in the original options, but it just says Carmarthen in the combined option, which I want, you know, the sceptic in me wonders if that's we haven't made a decision where it will be or if it is actually going to be Glangwili for the centre, central. Hospital where the patients get treated and transferred to. So just note a note from me that I've noticed as I've gone through, it says Carmarthen, and that's a big area, not a specific place.

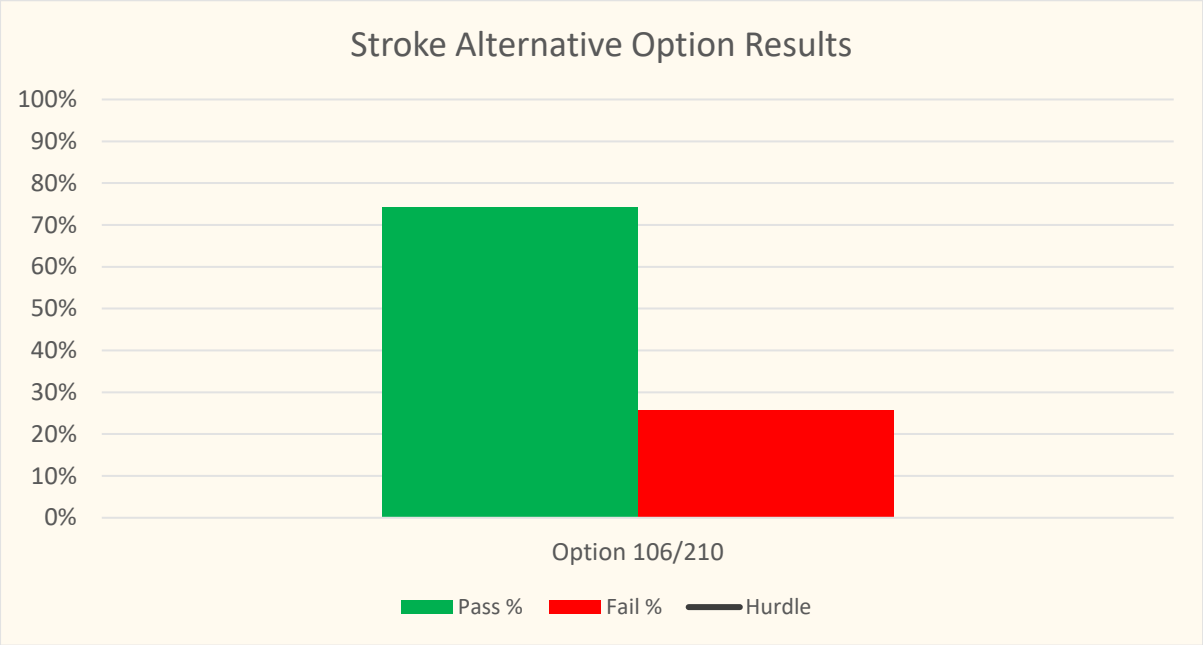
Summarised response: Apologies, Clare. Option 210 refers to Glangwili Hospital, which is in Carmarthen. The mention of Carmarthen was simply language used in the presentation slide, not for any specific reason—sorry if that caused confusion.

Question (Primary Care & Community): I think for Dr. Kumar, probably, it's just I'm thinking that if you've got a patient with an acute stroke who actually would be referred, say, on to Bristol or whatever presently, would it be more sensible to keep them, send them onwards, and then maybe send them back, but not send them to Carmarthen in the wrong direction, only to be sending them up the motorway. Sorry, I hope that made sense.

Summarised response: That's a good question. Within the option for our centres treats and transfer patients as needed: walk-in patients receive treatment, but if they require thrombectomy, they're sent to Bristol; Patient transfer often depends on location, with those nearer to Ammanford typically taken directly to Morriston. We operate 24/7 and stroke patients are managed at the main entrance, with Prince Philip Hospital providing initial care before transferring to appropriate units.

3.2.2 Hurdle Appraisal Output

3.2.2.1 Table 1: The table shows that out of 35 attendees, 26 passed and 9 failed the hurdle appraisal. The overall pass rate was 74%, exceeding the required 66%.



3.3 Scoring the Stroke Preferred Option

Alexander Martin, Principal Programme Manager, introduced the evaluation criteria. Highlighting that the preferred option had passed initial criteria, and we're moving to evaluation criteria to distinguish between them.

A brief recap was given for the evaluation criteria and the assigned weightings. The criteria were developed to cover all nine services and include both quantitative measures (like travel times, patient numbers) and qualitative assessments (such as impact from standards). Scoring would use pre-established weightings, with compliance standards, clinical sustainability, and workforce sustainability rated highest, followed by financial sustainability, reduced waiting lists, treatment times, and population health outcomes. Attendees were informed that when scoring, high-weighted criteria will influence results more.

To support the evaluation scoring process an example matrix was shared for how the preferred option would be presented, red would indicate poor alignment with a criterion, amber means uncertainty or potential future impact, and green shows strong alignment.

The group were informed they could score each criterion from 1 to 10, and that there would no adjustments to scores for extreme scoring or room balancing, with the scores from the day being compared with previous sessions at the end of the session.

The group were invited to scan the QR code to start scoring, which could be completed during or after the presentation. Alexander Martin then handed over to Dr Kumar, Clinical Lead for Stroke to present a summary of the SWOT analysis back to the room.

Dr Kumar started by highlighting that this preferred option was selected following a comprehensive review of approximately 30 to 40 alternatives by the board. From a clinical perspective, a forward-looking approach aiming to achieve high standards of care and improved outcomes is considered essential. However, it is crucial that this preferred option is supported by sufficient space and resources, including financial backing and external support such as travel guarantees.

Dr Kumar presented the evaluation criteria and that these were thoroughly considered by a robust clinical group representing all disciplines—doctors, nurses, therapists, and the wider AHP and therapy teams. The amber and red scores were highlighted. Areas rated red pertain to sustainability, particularly financial sustainability and the cost variance between current service delivery and this preferred option. It is anticipated that operating a 24/7 unit will increase costs for the Health Board; this is not a cost-reduction initiative. Accessibility also received a red score, specifically regarding patient travel times to various sites. These issues, while challenging, may be mitigated with appropriate assurances and resources.

Amber scores relate to patient safety, including the number of patients who may require transport between sites when unwell. While this is already managed in existing pathways, specialised services may require additional considerations. Further amber ratings involve the impact on staff and patients needing to travel for regional care, which is an understandable concern.

There are evident barriers to equality; for example, patients living near Carmarthen would have faster access than those from more distant locations. Acute care will continue to be provided and transferred to the nearest emergency department to ensure timely treatment.

In summary, the discussion concerns a proposed futuristic 24/7 unit based in Carmarthen, with other facilities serving as treat-and-transfer centres and post-acute units. Some patients may be ready for transfer within 24 hours, yet these units must be appropriately staffed by clinicians, therapists, and support personnel to meet rehabilitation standards.

The discussion was then handed over to Alexander Martin to present the feedback previously received and new feedback gathered from site visits before opening out to attendees for questions and further comment.

3.3.1 Question and Answer

Question (Trade Union): Another one for clarity. So, see and treat, if it is Bronglais, Prince Phillip and Withybush, so they've been seen and they've been treated, so they would go directly to the stroke unit. Is that correct? If it's somebody from Carmarthen, because it was just picking up on what something that Senthil said or I didn't hear it properly, would they go to directly to the stroke unit to be seen and treated, or would they have to go to A&E first to be seen and treated and then transferred into that stroke unit, because we all know that A&E departments, without exception, are pressurized. And I can't see at this moment in time, unless there's a huge turnaround, that that is going to decrease. So, I'm presuming that the ones seen and treated in Prince Philip, Withybush and Bronglais, would go direct to the stroke unit because they've been seen and treated. But what happens to anybody within the Carmarthenshire area? Do they go directly to that unit and they're seen and treated within that unit?

Summarised response: I'll be brief. We have a guiding principle for pathways that patients will enter through the front door at each site for treatment and possible transfer. Acute cases receive urgent care, while mild strokes or mimics may be discharged immediately. The clinician at each site communicates to determine transfers based on severity and other factors. Detailed processes are still being developed, and this is an ongoing engagement across the Health Board. Our aim is to streamline care for genuine strokes and avoid unnecessary A&E visits. Further details will be worked out as the work progresses.

Question (CIMCCG): Are we assuming that in our creation of our pathways in this, that we are going scan 1st and then to wherever we're going?

Response: Yes, Thrombectomy, off they go, mimics, they don't go anywhere near to these units. I hope that answers it.

Question (CIMCCG): The follow one from that is, if we are expecting scan first, have we taken, have we got a radiological feedback that they can cope with that scan first? Because that isn't happening on all sites at the moment, is it?

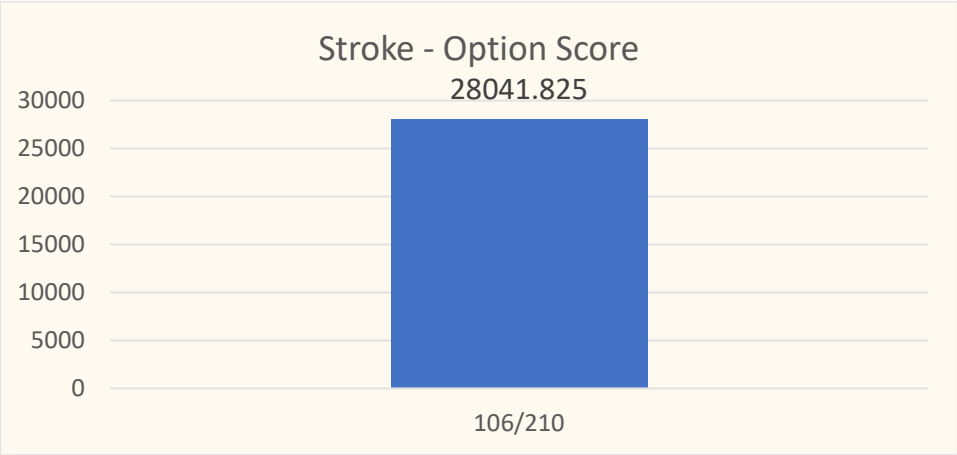
Response: this process has been well represented by Radiology. The scan in all the units is part of this process, and that will include future scans, including CT as well.

Question: What happens if a patient refuses to be transferred? Is that something that you've looked at in the option or is that something that would be looked at later in the pathway?

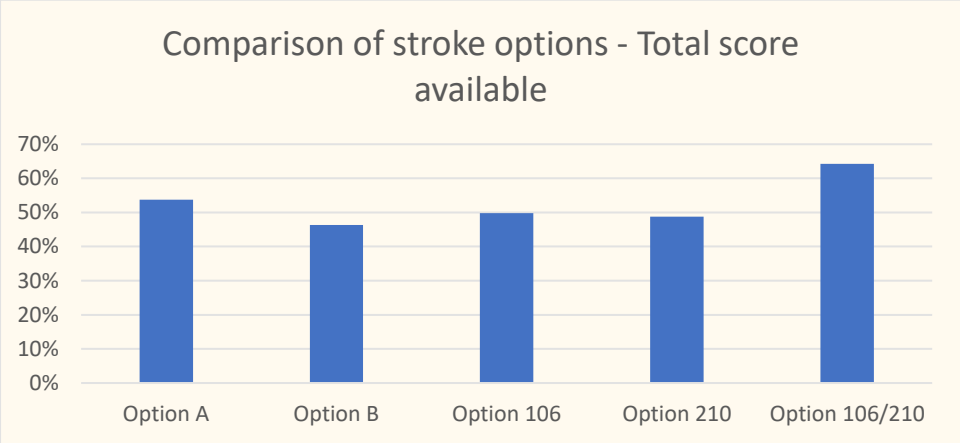
Response: They will have to be treated locally, and they take the risk of being treated in the local centre, which may not have the same level of expertise in the main area.

3.3.2 Option Scoring Outputs

3.3.2.1 Table 2: Evaluation Criteria Scoring output



3.3.2.2 Table 3: Comparison of Preferred stroke option versus previous scored options



Alexander Martin discussed the result of the scores and the group were asked to provide any further comments or queries that the Options Development Group felt might be beneficial for Board to understand as part of decision making, noting points that were made earlier had already been captured.

Comment (Primary Care): just for transparency in the meeting yesterday, something I mentioned, which was just the group here is different than the group who voted on the previous one. So, I think it's important just to flag that.

Comment (AHP): It was probably just to reiterate part of the point I was making earlier. I mean, I've got one vote today, but what we've done in physio is we've, with the support of the Transformation team, we've run workshops with all of the clinical leads in physio across the Health Board, and the consensus for you at this point is everyone's behind the strategic principle of this, but they don't think it's deliverable unless we get the community infrastructure and workforce right. So it was just to labour that point, really, because, you know, we absolutely can, you know, shift our acute staffing, but without the community infrastructure, we're not going to get discharge and flow out of the system, to put that into context in Pembrokeshire, that's one physio at the moment,

that's two registrants, that's the resource that we've got. It's just a really important piece of work and just want to make sure that it's out there and it's clear in supporting of the decisions that are ahead.

Comment (BCUHB): Concerns in Betsi with therapy staffing, trying to recruit and retain is really difficult. And I'm not trying to say it's any worse for you guys, but you're even more rural in some respects, more difficult to get to. So, I think that strategic element with the national programme about long term therapy, recruit, education and recruitment is going to be really key for both your inpatient acute, inpatient rehab and your ESD. And I think ESD is going to be vital for some of your more rural areas. So, I just wanted to support what you're saying. We have real issues up here, so I think it's going to be possibly compounded with yourselves.

Lee Davies responded to a comment with two brief points. First, we acknowledge that our current stroke service does not meet desired standards, especially in therapies, and that changes are needed rather than simply reallocating existing resources. Second, while today's session is valuable and will contribute to board decision-making, it is only one part of the overall information considered. Contributions from today will help inform decisions but are not the sole determining factor.

4 Next Steps

Lee Davies closed the session and clarified the next steps for everyone and thanked everyone for their feedback and that this will help further engagement with stakeholders regarding the preferred option. The plan is to return to May Board meeting to request permission to consult on this preferred option. We're still refining whether we'll describe this as a consultation or engagement; after all, consultation is a form of engagement. Staff and other stakeholders will have opportunities to contribute to the process. Lee Davies updated the group on the next steps in terms of decision being made through bringing the results back to the Board before year-end for a final decision about stroke services.

Lee Davies also referenced the wider Clinical Services Plan and how the programme is transitioning into the design and delivery phase for implementation plans. That there's considerable work ahead to finalise the details of how we'll implement each of the nine services. The main deliverables will be incorporated into our annual plans or IMTPs, mainly from 2027-28 onwards, when there is an expectation that we will focus on implementation.

Each service starts from a unique point, and since the proposals differ, their progress and timelines will vary across the board. Our aim is to establish solid foundations to consistently deliver the standards of care we strive for in all these services. Implementation will be a phased approach—beginning with initial rollout, continued improvement, and eventually reaching long-term plans for each.

The session closed at 17.12 hours.

5 Appendices

5.1 Appendix – Stroke ODG Presentation

Contents

Item	Presenter
Welcome & Objectives	Lee Davies, Executive Director Strategy & Planning
CSP Programme Background	Lee Davies, Executive Director Strategy & Planning
Hurdle Appraisal Proposed Stroke Option	Ben Rogers, Principal Programme Manager
Scoring Proposed Stroke Option	Alex Martin, Principal Programme Manager
Next Steps	Lee Davies, Executive Director Strategy & Planning

Welcome
Lee Davies, Executive Director Strategy & Planning

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Aim:

To Hurdle Appraise then score the merged idea for Stroke options 210 and 106

Objectives:

- CSP programme refresh & rationale (including Hurdle Criteria refresh)
- Check & challenge feedback from stakeholder session on the 6th and 7th October, CSP Clinical Reference Group, Project Group and Project Support Group.
- Hurdle Appraisal
- Score Option

Working together

- House keeping
- Time keeping
- Participation responsibilities
- Diversity of views
- Focus on the task
- Use of tech
- Support services in the room

CSP Refresh
Lee Davies, Executive Director Strategy & Planning

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Drivers for change

In March 2023, Board approved the establishment of a programme approach to develop a **Clinical Services Plan** in response to service fragilities, based on the principles of care that is safe, sustainable, accessible, and kind.

The development of a Clinical Services Plan is also an action within the Targeted Intervention requirements of Welsh Government.

Service	Driver
Critical Care	Response to service fragility, in particular at Prince Philip Hospital (PPH)
Planned Care (Dermatology, Elective Orthopaedics, Ophthalmology, and Urology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients
Emergency General Surgery	To respond to service fragility, particularly at Withybush Hospital (WGH), as referenced in the March 2023 operational update
Stroke	To meet standards and respond to service fragility
Diagnostics (Endoscopy and Radiology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients

Three phases
Lee Davies, Executive Director Strategy & Planning

- **Phase 1 – Issues Paper**
  Included a clinically led assessment of the nine service areas included within the Clinical Services Plan programme across all sites within the Health Board. This concluded with the Board endorsing the programme to move into phase 2.
- **Phase 2 – Options Development Process**
  Options Development stage focused on the development of a series of deliverable options. This stage also brought in interdependencies such as Therapies, WAST, Trade Union representatives and Swansea Bay UHB to name but a few.
- **Phase 3 – Public Consultation**
  To seek views on the service options and potential alternatives noting any impacts. Within this also consider the thematic findings with the role of the four main acute hospital sites.

Process between the consultation closing and today:

- Over **4,000** responses received during the consultation, as well as staff, public and stakeholder engagement events.
- **287** unique alternative options received
- **190** alternative options that are within the scope of the programme have been reviewed and assessed by the Task and Finish Groups.
- **4** options were presented for stroke to Board, a pre-provisional decision was made to explore a merged idea from options 106/ 210
- **Today we will be considering Stroke merged option 106/210**

Rationale
Lee Davies, Executive Director Strategy & Planning

- At the Board meeting held in January 2026 both the strategic refresh and Programme Business case Addendum reinforced the direction of travel in relation to AHMWW strategy which is to fewer acute sites within the Health Board. This directly affected the options in place for Stroke services.

- At the CSP Decision Making day on 19FEB2026 it was agreed by Board that for Stroke services a merged idea of combining elements of Option 210 (working towards a 24hr Acute Stroke Unit at a single site (which includes Acute Stroke Rehabilitation in Carmarthen) and elements of 106 (retaining Acute Stroke Rehabilitation at Aberystwyth) be tested further as a preferred option.

- Although both Option 106 and 210 have previously passed the hurdle appraisal and have been evaluated. The combined elements have not been assessed in the same way as a standalone merged option.

- This merged Option will also need to be retested through further engagement considering those impacted by this option. This is planned to begin in June, lasting for 8 weeks.

Stroke - Preferred Option 106/ 210
Lee Davies, Executive Director Strategy & Planning

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

Phase	Outcome	Delivery, benefits and risks	
IMPLEMENTATION (0-2 years) | IMPROVEMENT (2-4 years*) | LONGER TERM (4 years+)	A Stroke unit with 24 hours specialist stroke support and stroke rehabilitation. Separate Stroke rehabilitation unit.	**Delivery** • This option would be phased in delivery, taking between 2-10 years to implement. • Would be delivered by gradually bringing services together. **Benefits** • Bringing services together strengthens the quality and timeliness of care and will improve standards. • Provides dedicated therapy space at Bronglais Hospital and more efficient use of resources. • Better alignment with the National Stroke programme. **Risks** • Has not been through the same process as other alternative options, so assessments are based on other option assessments, and not this merged option. • Accessibility for patients impact is likely higher than the two individual options and would need to be better understood to support final decision making. • Option presents greater diagnostic demand at Glangwili Hospital than other options. • Staff may be reluctant to relocate where this is identified as being a requirement of the change.	**Option 106/ 210**

Hurdle Criteria
Ben Rogers, Principal Programme Manager

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CLINICALLY SUSTAINABLE

Is the potential option Clinically Sustainable?
- Does it allow progress towards delivering quality standards?
- Does it consider any co-dependencies?
- Will workforce be available to deliver it?

DELIVERABLE

Can this option be implemented?
- Will it be clinically deliverable within a medium-term timeframe of 2-4 years?
- Is it operationally deliverable within a medium-term timeframe of 2-4 years (e.g. any capital or estate requirements can be secured and implemented within that timeframe)

ACCESSIBLE

Is the potential option accessible?
- Does the option provide access within an appropriate timeframe?
- Will it support a reduction in waiting times?
- Is equity of access addressed?

STRATEGICALLY ALIGNED

Is the potential option a strategic fit?
- Does the option support the strategic direction or at least not contradict it?
- Does the option support integrated prevention to improve population health or at least not contradict it?

FINANCIALLY SUSTAINABLE

Is the potential option Financially Sustainable?
- Does the potential configuration support the effective use of our financial resources?

Service Assessments – EXAMPLE
Ben Rogers, Principal Programme Manager

GIG CYMRU NHS WALES
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- The table below demonstrates how the options will be presented today.
- RED (R) indicates 'does not meet', AMBER (A) suggests 'may meet', and GREEN (G) signifies 'does meet'. An 'S' within any coloured box represents a SPLIT DECISION.
- We have carried over feedback from the previous hurdle appraisal session where relevant to the option being appraised today.

Reference	Alternative Ideas - Option A's, B's and New ideas	Clinical	Deliverable	Accessible	Strategic	Financial
1	Option A – but with something else.	A	S	A	R	A
2	Option B – but with the addition of this service	R	A	S	A	A
3	New idea – new option – which is not always similar as what went to public consultation	A	A	R	A	S

Stroke – Option 106 and 210
Ben Rogers, Principal Programme Manager

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Reference	Alternative Ideas – Option A's and B's	Clinical	Deliverable	Accessible	Strategic	Financial
106	Options A - with an acute stroke rehabilitation unit at Bronglais gives a robust option for a Treat and Transfer option	A	A	G	S	A
210	Option B - In this option Bronglais would take the place of Withybush providing a 12 hour specialist unit, while Glangwili would take the place of Prince Philip for the 24 hour specialist unit. In the longer term (4+ years) Glangwili site would merge with staff from Swansea Bay to provide a regional stroke unit, with Bronglais remaining as a local stroke unit. At this point Bronglais would no longer provide treat and transfer to Glangwili would be a self sufficient stroke unit with patients given the opportunity to be transferred to the regional stroke unit.	A	S	S	A	S

106/ 210	A specialist Stroke Unit in Carmarthen (specialist cover 24-hours a day) Working regionally as part of the National Stroke programme in the longer term. With a Specialist Stroke Rehabilitation Unit in Bronglais. With this option patients furthest away from the Acute Stroke Unit may be treated at their nearest Emergency Department or Acute Medical Assessment Unit where direct access is not an option. Once Assessed and treated a patient may be moved to their nearest Acute Stroke unit for specialist assessment and treatment.	G	A	G	G	A

Stroke Check & Challenge Feedback
Ben Rogers, Principal Programme Manager

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Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria
210	Unsure why this option fails, as it meets the longer-term aim. Perhaps it can be worded differently to meet short term and long term.
210	Concerns about the distance to travel to a regional stroke centre, and transport links from communities to Swansea. (Stakeholders)
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. We would be happy to consider the options of stroke centre in Bronglais or a single centre for Mid Wales more carefully if those get through the hurdle criteria stage, as we know that they would be attractive to our population, although also understand there may be feasibility issues. (PTHB)
106	Need to consider alignment with longer term. WGH future role with no medical take? (CRG)
106	Workforce requirement for Bronglais will be challenging in the short term, alignments needed through education pipelines and internal grow your own pathways to facilitate the workforce requirements needed. Likely to be medium term solution 5+ years. Workforce requirements needed to assess financial sustainability. (PSG)

Stroke Check & Challenge Feedback
Ben Rogers, Principal Programme Manager

Reference	Check & Challenge feedback
RJC	The regional Stroke programme advocates alignment with regional/national stroke models and standards. The draft national standards set out ambitions and expectations for stroke services. Final standards should be available shortly (current expectations are December 2025). The CSP highlights sustainability issues with the current four-unit setup, stresses need for pragmatic treat-and-transfer solutions, and expectations that a consistent level and quality of service is available. The regional programme's ambitions would be that Hywel Dda sets out a model of care that would lay the foundation a future regional model. Our review of the options presented in the Hywel Dda CSP suggest that: • Option 210 would seem most in line with ambitions for regional working and future national models, showing strong alignment with SBUHB's ambitions for a Comprehensive Regional Stroke Centre in Morriston. • All other options to a varying extent would need greater or lesser levels of future adjustment to accommodate regional workin g

Setting the scene for the remainder of the day
Alex Martin, Principal Programme Manager

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We are going to spend the remainder of the session scoring the option against the evaluation criteria.

We will begin with a brief recap of the criteria, and the weightings that were previously applied, before giving an overview of how each of the options will be presented to the room.

We will also share feedback that has been gathered during the process which may not have been considered by the task and finish groups or the Options Development Group due to late arrival.

The rest of the session will then follow a similar format of options presentation, questions and scoring. There will be an opportunity at the end of the session to provide any further reflections which you want Board to consider.

Presenting the Criteria
Alex Martin, Principal Programme Manager

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Safe

- Number of patients likely to need transport between sites when unwell
- Compliance/ attainment of standards
- Impact on internal services (e.g. Accident & Emergency, Theatres, Paediatrics, Respiratory)
- Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust, Adult Critical Care Transfer Service)

Sustainable

- Clinically sustainable– Patient demand to require service
- Workforce sustainability– Substantive workforce available to meet solution in 2-4 years
- Financial sustainability– Cost difference between current delivery and option
- Reduction in waiting lists across diagnostics, treatments, and surgery

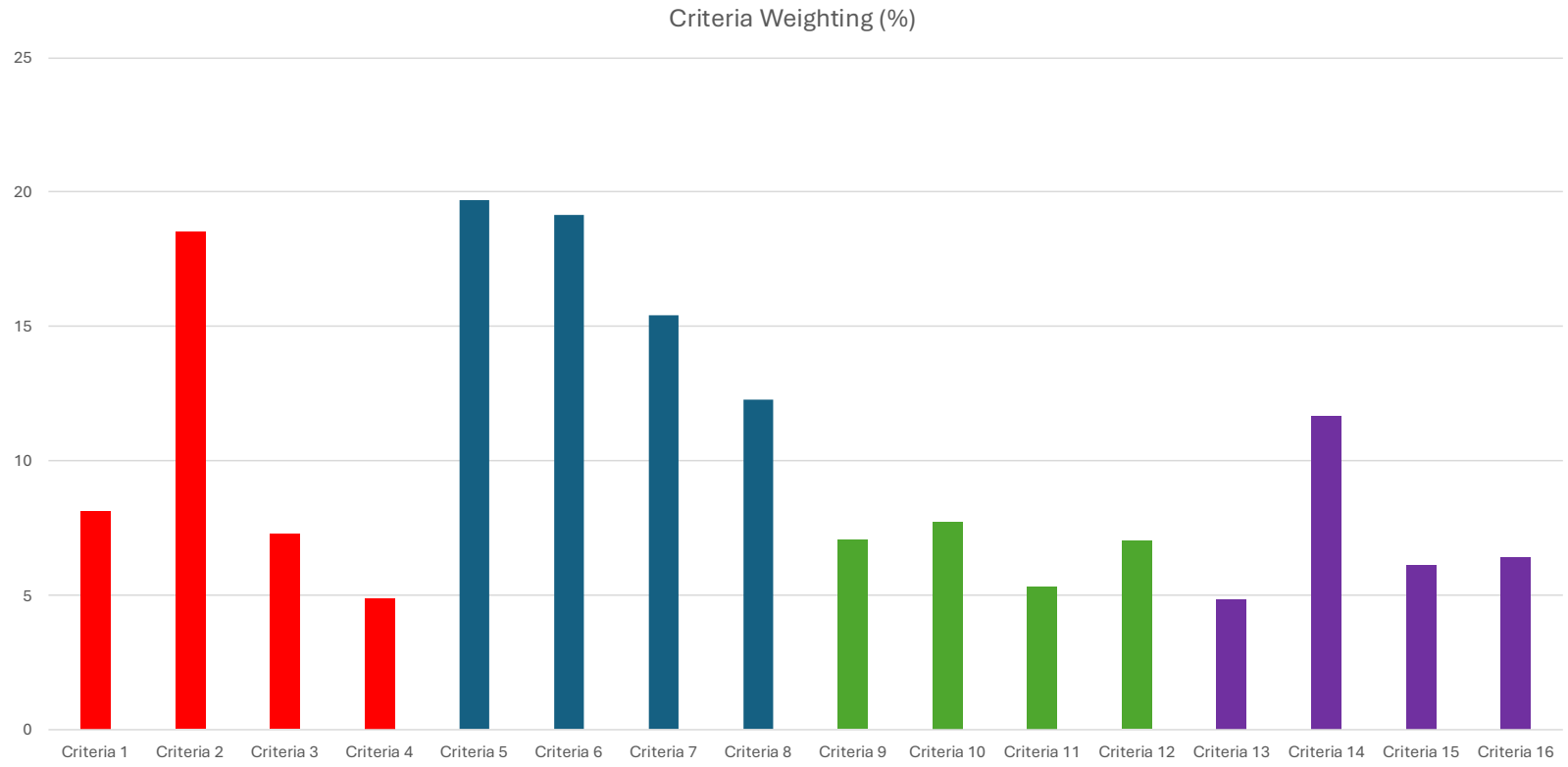
Accessible

- Patient travel time to sites
- Transfer travel time impact on options
- Impact on local communities/ infrastructure when developing community sites
- Impact on staff and patients needing to travel to access regional care pathways

Kind

- Amount of activity taking place in a community setting
- Impact on population health outcomes
- Addressing barriers to care (telemedicine, transport enablers, patient support)
- Addressing barriers to equality

Weighting the Criteria
Alex Martin, Principal Programme Manager



Introducing the options and scoring
Alex Martin, Principal Programme Manager

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- To support you with your scoring you will hear a presentation from the service
- The presentation will cover what the option does, as well as how it meets the criteria
- This will be supported by a colour block which considers mostly how the service considers the option to perform against the criteria
- There are also copies of the Strengths, Weaknesses, Opportunities and Threats assessment carried out for the option against these criteria.
- We will also share a slide with you with additional feedback received that may not have been considered by the service due to late arrival, but may inform your scoring as an ODG representative
- Please score as you perceive the option to perform against the criteria and the information that you have available.

Ref	Option Overview
A	In Option A GGH and BGH would maintain ICUs. ECUs would be provided at PPH and WGH to support stabilisation and transfer of assessed patients to GGH ICU. GGH would also have an ECU so that its ICU can focus on patients with the highest clinical need.

SAFE				SUSTAIN				ACCESS				KIND			
A	G	R	R	A	G	A	A	R	A	A	R	A	A	A	R

R	Mostly negative Impacts (Weaknesses)
A	Unknown (Opportunities/Threats)
G	Mostly positive Impacts (Strengths)
*	Asterix indicates that CSP programme have added something or completed a RAG due to missing information or unknown impact

Introducing the options and scoring
Alex Martin, Principal Programme Manager

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- During the presentation you will be able to score how well the option meets the criteria. This will be based on how you perceive the option scores against the evaluation criteria
- You will be able to score between 1 (doesn't meet the criteria) and 10 (does meet) for each criterion, and this will be multiplied by the weighting that we have just set
- There is no pass or fail in your scoring assessment. This should be how you objectively feel the option performs against the criteria
- The scores that you decide as an individual will be anonymous
- There will be no removal of 'extreme' scores and there is no vote weighting in use.

Criteria	Option 1	Option 2	Option 3	Option 4
Number of patients requiring transfers	1-10	1-10	1-10	1-10
Compliance/ attainment of standards	1-10	1-10	1-10	1-10
Impact on internal services	1-10	1-10	1-10	1-10
Impact on external services	1-10	1-10	1-10	1-10
Clinically sustainable	1-10	1-10	1-10	1-10
Workforce sustainability	1-10	1-10	1-10	1-10
Financial sustainability	1-10	1-10	1-10	1-10
Reduction in waiting lists and treatment times	1-10	1-10	1-10	1-10
Patient travel time to sites	1-10	1-10	1-10	1-10
Transfer travel time	1-10	1-10	1-10	1-10
Impact on local communities	1-10	1-10	1-10	1-10
Impact on staff and patients needing to travel regionally for care and treatment	1-10	1-10	1-10	1-10
Amount of activity taking place in the community	1-10	1-10	1-10	1-10
Impact on population health outcomes	1-10	1-10	1-10	1-10
Addressing barriers to care	1-10	1-10	1-10	1-10
Addressing barriers to equality	1-10	1-10	1-10	1-10

Stroke
Dr Senthil Kumar, Clinical Lead Stroke
Bethan Andrews, Asst General Manager Glangwili

GIG CYMRU NHS WALES
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Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
Stroke Option 106/210	A specialist Stroke Unit in Carmarthen (specialist cover 24-hours a day) Working regionally as part of the National Stroke programme in the longer term. With a Specialist Stroke Rehabilitation Unit in Bronglais. Within this option patients furthest away from the Acute Stroke Unit may be treated at their nearest Emergency Department or Acute Medical Assessment Unit where direct access is not an option. Once Assessed and treated a patient may be moved to their nearest Acute Stroke unit for specialist assessment and treatment.	A	G	G	G	G	G	R	G	R	G	G	A	G	G	G	A

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

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Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Positive (Option 106):** Support for a stroke rehab unit in Bronglais. **Negative (Option 106):** concerns about "treat and transfer" models—safety of long ambulance journeys post-thrombolysis, family travel burdens. **Negative (Options 210):** "Treat and transfer" not sufficient for Withybush. **Negative:** Need for local, high-quality rehab in line with NICE and Welsh Government guidelines; concerns about equity of access, rurality, and travel times. Calls for integrated, survivor-led rehab and better transport planning

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

GIG CYMRU NHS WALES
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Response From	Evaluation Criteria	Summary of feedback
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing
Programme team for RJC	1.4	**Regional alignment:** Stroke programme aims to align with national standards (final expected Dec 2025) and ensure consistent, sustainable services across the region. **Preferred option:** Option 210 best supports regional ambitions and future national models, aligning strongly with SBUHB's plan for a Comprehensive Regional Stroke Centre at Morriston. **Other options:** Would require varying levels of adjustment to fit regional working and future standards. **General Feedback from Meeting held on 6 November'25:** • Multiple options for stroke services were discussed, including option 106A (acute stroke rehab in Bronglais, 24-hour unit in PPH, 12-hour unit in Withybush). Cheryl supported this option for its regional benefits but noted concerns about CT scan capacity. • raised the issue of tension between regional and organisational planning, highlighting the need for alignment and clear communication. • There is uncertainty and lack of clarity regarding the national stroke programme, with participants noting limited engagement and unclear timelines from the national team. This complicates local and regional planning. • It was agreed that the RJC would provide a general statement for stroke, emphasizing the need for alignment with evolving national and regional programmes, rather than specific comments on each option.

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Response From	Evaluation Criteria	Summary of feedback
WAST	1.4	From a WAST perspective it is highly likely that there will be a resource impact from any option agreed upon resulting in additional emergency ambulance conveyances and ambulance care transport for repatriations etc This will be evident across transfer and discharge pathways, as well as outpatient and day-case activity, in addition to the repatriation impacts. While WAST will support the agreed option, prompt detailed demand data analysis relating to all proposed patient transportation and skills mix requirements to undertake these transfers and the potential funding implication, from Health Board modelling, is vital to allow WAST to determine the extent of additional transportation impacts because that cannot be naturally absorbed.
Stroke Unit – Staff Visits	1.3	**WGH Stroke Unit:** Staff were opposed to the removal of stroke services and were keen to understand patient benefit. Rehabilitation, therapies sustainability, workforce deskilling, travel impacts and retention of local skills were dominant concerns. **PPH Stroke Unit:** Discussion focused on the potential loss of a purpose-built stroke environment, locally based skilled staff, and transport and access impacts. Staff emphasised the need for funded rehabilitation, Early Supported Discharge, and realistic workforce planning. **GGH Stroke Unit:** Staff broadly supported the vision for a dedicated stroke unit but highlighted constraints around space, estates and staffing. Workforce wellbeing, therapy facilities, recruitment to standards and managing interim arrangements were key issues. **BGH Stroke Unit:** Staff raised detailed questions about pathway operation, rehabilitation capacity and catchment, and maintaining specialist skills. There was interest in digital consultant support and clarity on how the model would integrate with community services.

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

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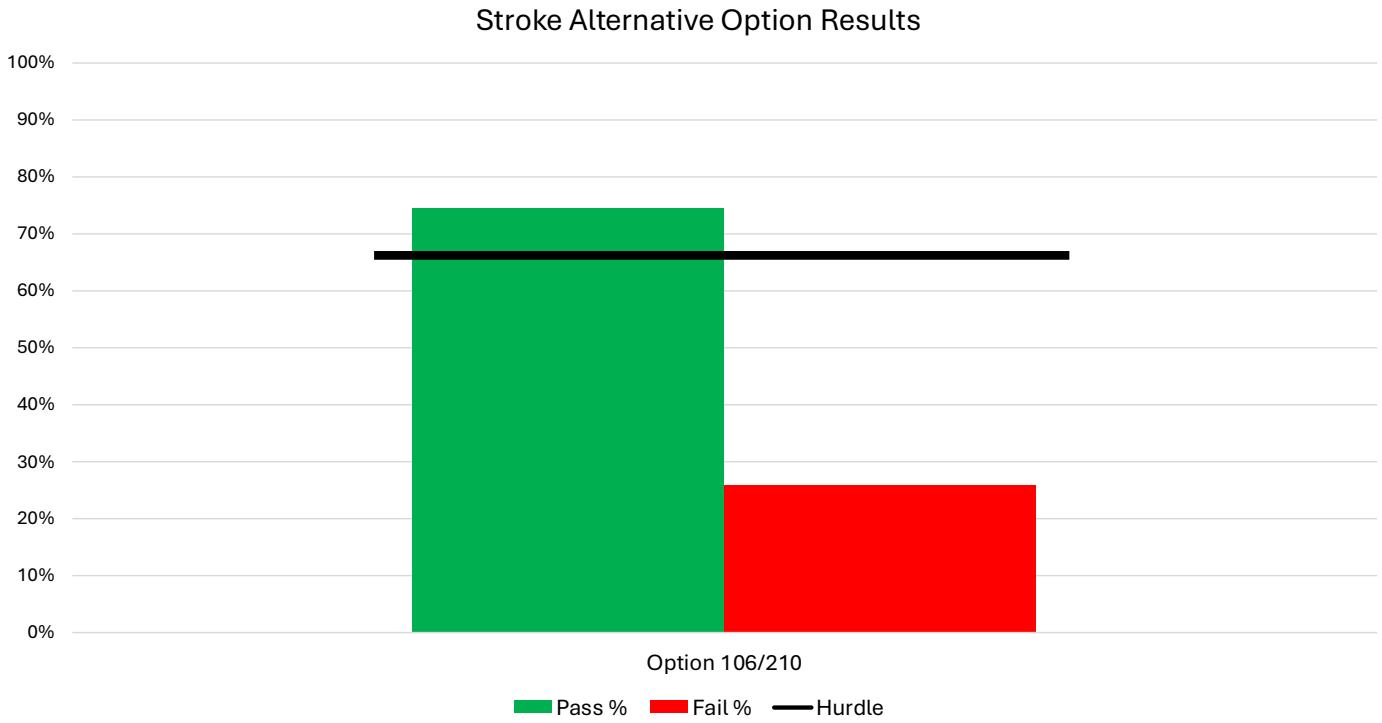
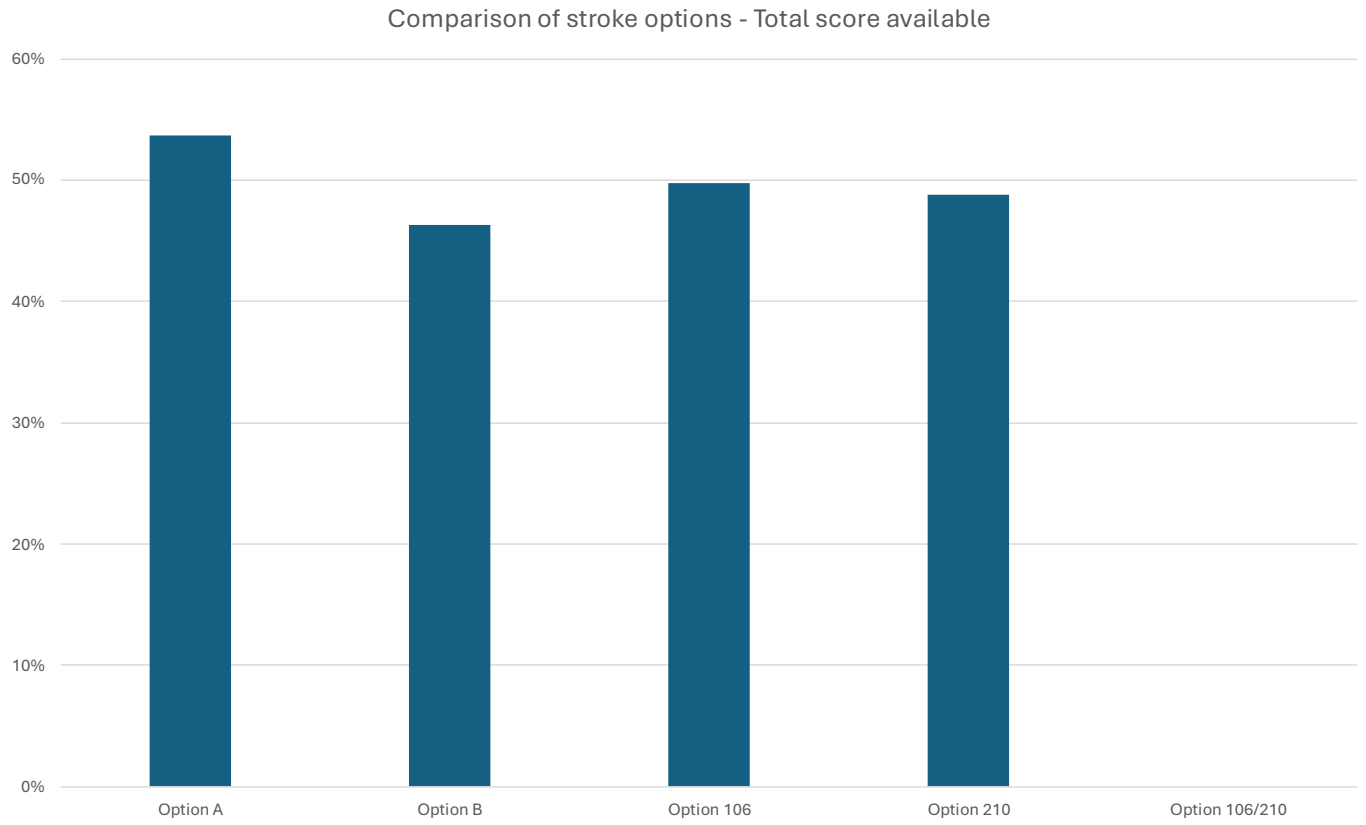
Stroke – Hurdle Appraisal Output
Ben Rogers, Principal Programme Manager



Scoring the options – Comparison with previous options
Alex Martin, Principal Programme Manager



Next Steps

Lee Davies, Executive Director of Strategy & Planning

GIG CYMRU NHS WALES
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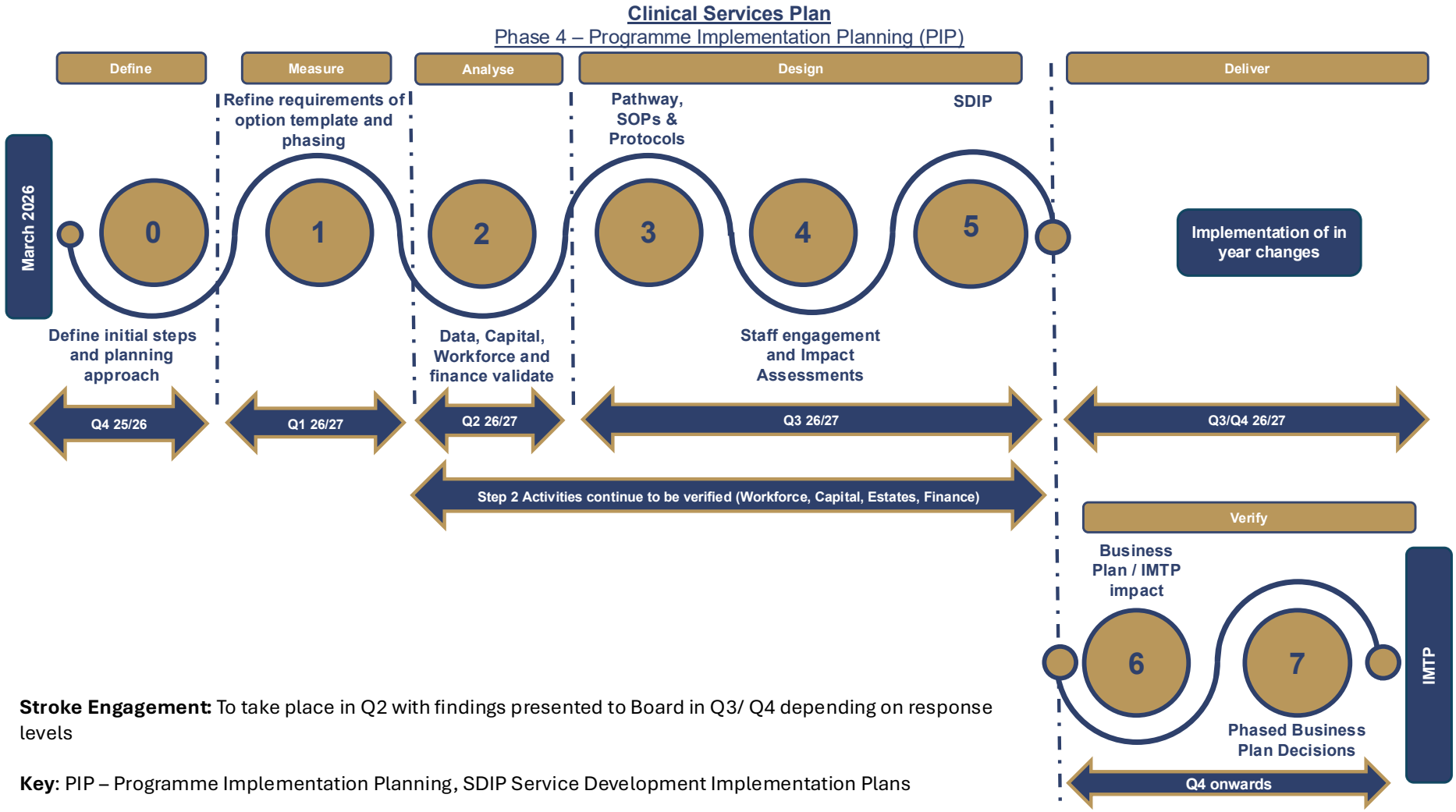
Decisions & Timelines for Stroke

- Feedback from today's session will inform further engagement on this proposed option.
- In May 2026, Board will be asked for permission to consult on this option for 8 weeks from June.
- Staff will have the opportunity to feed into this engagement process during site walkarounds, through existing meetings and individual or group submissions.
- Subject to the level of responses received, we plan to bring the engagement findings back to Board before the end of the year for a final decision on stroke services.

Decisions & Timelines for other services in CSP

- The next slide sets out the process that is being taken for the remaining8 services within CSP.
- Once a final decision is reached for stroke, the service will follow the same process as highlighted on the next slide.



Stroke Engagement: To take place in Q2 with findings presented to Board in Q3/ Q4 depending on response levels

Key: PIP – Programme Implementation Planning, SDIP Service Development Implementation Plans

5.2 Appendix – Evaluation Criteria comparison

The scoring session had more people scoring the preferred option than Option A/ B/ 106/ 210. This means that we cannot directly compare option scores as the preferred option would automatically score higher.

The percentages below show the percentage of weighted score awarded compared to the maximum weighted score that could have been awarded. For example, the preferred option scored the same as Option A for financially sustainable as more people took part in this scoring exercise, but the percentage of maximum score available was lower than Option A.

Criteria	Preferred Option	Option A	Option B	Option 106	Option 210
Number of patients likely to need transport between sites when unwell	55%	52%	46%	54%	50%
Compliance/ attainment of standards	80%	62%	60%	51%	46%
Impact on internal services (e.g. Accident & Emergency, Theatres)	61%	56%	45%	52%	51%
Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust)	65%	44%	39%	53%	52%
Clinically sustainable – Patient demand to require service	72%	60%	53%	48%	49%
Workforce sustainability – Workforce available to meet solution in 2-4 years	61%	48%	37%	46%	39%
Financial sustainability – Cost difference between current delivery and option	49%	52%	44%	50%	49%
Reduction in waiting lists across diagnostics, treatments, and surgery	65%	56%	52%	55%	57%
Patient travel time to sites	59%	40%	38%	50%	51%
Transfer travel time impact on options	59%	50%	41%	50%	52%
Impact on local communities/ infrastructure when developing community sites	65%	47%	40%	48%	48%
Impact on staff and patients needing to travel to access regional care pathways	66%	42%	36%	49%	43%
Amount of activity taking place in a community setting	60%	49%	40%	46%	48%
Impact on population health outcomes	70%	61%	50%	48%	51%
Addressing barriers to care (telemedicine, transport enablers, patient support)	61%	61%	52%	52%	59%
Addressing barriers to equality	62%	52%	45%	50%	50%

5.3 Appendix – Feedback received post event

Comment (Support service): I want to be positive and constructive but speaking openly I struggled with the approach.

I wasn't involved in the autumn scoring sessions, Richard supported these for Finance but wasn't available to join this afternoon. The lack of continuity may be the issue and perhaps being online, but I felt I was scoring blind today in the absence of information on the various points. I also wondered whether the reality of only discussing a single option, limited the info/discussions as you weren't making any direct comparisons. The best information was the scoring that Dr Kumar presented, though I don't think it's appropriate to simply be copying this. I also think the information which was shared was a rushed and a challenge to process – perhaps because I'm cold to the process and stroke services. Whilst I wasn't part of the autumn process I was involved some time ago at in person events at the Halliwell Centre, where options were discussed in groups with data fed in – a different stage in the process I realise, but I was expecting more info to be shared today on the back of that. On that basis I hadn't sought any information out independently in preparation. I did score, but I don't feel this was based on insight or knowledge.
N.B. Whilst I couldn't attend the drop-in session yesterday, I did listen back to it earlier today to try and ensure I was up to speed. And checked my emails looking for papers – if I missed anything, apologies.
Something to consider going forward, could a pack of info be shared in advance to help inform the votes, that included data and indications of the impacts the options may generate? I believe more background information could greatly enhance the scoring process.

No doubt others on the call do have the continuity from the previous scoring rounds, and insight to the service to be able to make an informed judgement. Happy to support.

Response (Programme Team): Feedback was acknowledged and will feed into the lessons learned review taking place.