Better Together
Adult Physical and Mental Health Community Services

Step Report: Options Development

FINAL DOCUMENT V6



This page is intentionally left blank.

Executive Summary

This report evidences the process undertaken to provide assurance to the Board on the integrity, transparency and robustness of the process undertaken by Powys Teaching Health Board (PTHB) in developing, refining and appraising options for the future delivery of adult physical and mental health community services as Phase 1 of Better Together.

The Health Board agreed a structured five-step methodology underpinned by the NHS Wales service change guidance to strive to maintain safe and sustainable services; this has been applied through engagement on the case for change, development of options and assessment of the impact of potential changes, in readiness for consultation. The HM Treasury Green Book has been adopted as best practice specifically to support the non-financial appraisal of the options – noting this is typically applied to capital investment appraisal rather than service transformation. A consistent and proportionate approach has been applied throughout, ensuring that options have been systematically tested for strategic alignment, clinical sustainability, deliverability, and impact.

The Case for Change provided a robust, evidence-based foundation and was tested through Stage 1 engagement with staff, stakeholders and the public. Feedback demonstrated strong alignment with the challenges identified, including the need to improve access, address workforce fragility, reduce inequity, and deliver more care closer to home within a rural context. These themes were embedded throughout the options development process, informing design principles, assessment criteria and appraisal.

A comprehensive programme of engagement has been undertaken across Stages 0–2, including public, patient, partner and staff involvement, supported by three deliberative events. This ensured that stakeholder perspectives informed the development, refinement and assessment of options. Engagement has been proportionate to each stage of the process, with technical appraisal activities appropriately undertaken by clinical and professional stakeholders, while earlier and planned future engagement ensures continued public involvement in shaping outcomes.

Options were developed through structured workshops and technical analysis, progressing from a long list to a shortlisted set of credible and viable options through application of agreed Hurdle Criteria and iterative refinement. These options were subject to a comprehensive, multi-stage appraisal process, including non-financial assessment using the NHS Wales STEEEP (Safe, Timely, Effective, Efficient, Equitable, Person-Centred Care) domains of quality, supported by sensitivity analysis, as well as workforce, financial, estates, demand and capacity modelling, travel time analysis, patient pathway testing, and quality and equality impact assessments.

The report identifies a small number of recommended options proposed for to be progressed through organisational governance arrangements to a decision on future public consultation. No final decisions have been made. These options represent a range of credible approaches that require further testing with the public, patients, staff and stakeholders during formal consultation.

Overall, the process provides a robust and transparent evidence base, supported by clear governance, clinical and professional assurance, and a comprehensive audit trail to support decision making necessary to proceed to Stage 3: formal public consultation for adult physical and mental health community services.

Contents

Executive Summary 3
1. PURPOSE OF THIS REPORT 6
2. WHAT IS BETTER TOGETHER? 6
2.1 Phasing of Better Together 7
2.2 Phase 1 Adult Physical and Mental Health Community Services 7
3. OPTION DEVELOPMENT APPROACH AND METHODOLOGY 8
3.1 Steps to Consultation 8
3.2 Stages of Engagement and Consultation 10
3.3 How the Stages of Engagement Supported the Steps 10
3.3.1 Stakeholder participation and public involvement 11
3.3.2 Application of the Gunning Principles 12
3.4 Hurdle Criteria, Scoring and Assessment Framework 13
3.4.1 Hurdle Criteria 13
3.4.2 STEEEP Six Domains of Quality 14
3.4.3 STEEEP Weighting and Sensitivity Analysis 15
3.4.5 Design Principles 16
3.4.6 Impact Assessments 16
3.5 Governance and Assurance 17
3.5.1 Key Groups and Responsibilities 18
3.5.2 Independent Advice and Guidance 19
3.5.3 Check and Challenge and Assurance 20
4. STEPS TO CONSULTATION 21
4.1 Step 1 – Case for Change and Models of Care (Including Stage 1 Engagement) 21
4.1.1 Case for Change and Stage 1 Engagement 21
4.1.2 Vision, Models of Care Concepts and Travel Time Principles 23
4.1.3 Progression to Step 2 25
4.2 Step 2 – Develop Initial Options 25
4.2.1 Deliberative Event 1 25
4.2.2 Stage 2 Engagement 26
4.2.3 Primary Care Workshop (GMS Focus) 28
4.2.4 Long List Ideas Review 28
4.2.5 Progression to Step 3 29
4.3 Step 3 and 4 – Review and Refinement of Options and Development of Short List Options 29
4.3.1 Short List Options Development Week 29
4.3.2 Refinement of short list options 34
4.3.3 Second Deliberative Event 35
4.3.4 Short List - Further Check and Challenge 38
4.3.5 Progression to Step 5 39
4.4 Step 5 – Score Short List of Options 39
4.4.1 Non-Financial Options Appraisal – Physical Health, Mental Health and Urgent Care 39
4.4.2 Further Technical Development of Options 43
4.4.3 Workforce & Finance Check and Challenge 44
4.4.4 Clinical Executive 'Check and Challenge' 45
4.4.5 Non-Financial Appraisal on Urgent Care Centre, including Diagnostics Options 46
5.FINALISATION OF OPTIONS 48
5.1 Recommendations Workshop Sessions 48

5.2 Outputs from the Recommended Options Workshop 49
5.3 Deliberative Event 3 57
6. CONCLUSIONS & RECOMMENDED OPTIONS FOR CONSULTATION 59
7. Readiness for Board Decision on Consultation 60
8. TECHNICAL APPENDICES 61

Figures Table

Figure 1: Social Model for Health 7
Figure 2: Description of Option Development Steps (Inputs and Outputs) 9
Figure 3: Engagement & Consultation Process 10
Figure 4: Adults Physical and Mental Health Community Services Options Develop Process 11
Figure 5: Lists the Hurdle Criteria agreed and applied during the options development process 13
Figure 6: STEEEP Assessment Criteria 14
Figure 7: Option Scoring Mechanism 15
Figure 8: Design Principles 16
Figure 9: Better together Portfolio Governance Structure 17
Figure 10: Clinical & Professional Workshop Overview 24
Figure 11: Long list to short list hurdling 31
Figure 12: Adult Physical Health, including community – Five short listed options 36
Figure 13: Urgent Care Centres including Diagnostics – Four short listed options 36
Figure 14: Adult Mental Health, including older adult community - 8 short listed options 37
Figure 15: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 41
Figure 16: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 41
Figure 17: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 42
Figure 18: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted 47
Figure 19: Estate Assessment coding 50
Figure 20: PHYSICAL HEALTH Outputs from Recommended Options Workshop & Rationale 50
Figure 21: URGENT CARE Outputs from Recommended Options Workshop & Rationale 52
Figure 22: MENTAL HEALTH Outputs from Recommended Options Workshop & Rationale 54
Figure 23: Recommended Options Summary Table 59

1. PURPOSE OF THIS REPORT

This report evidences the process undertaken to provide assurance to the Board on the integrity, transparency and robustness of the process undertaken by Powys Teaching Health Board (PTHB) in developing, refining and appraising options for the future delivery of adult physical and mental health community services as Phase 1 of Better Together.

It provides transparency in the activities and decision making undertaken as part of the development of options for Adult Physical and Mental Health Community services, in relation to how future services could be provided in Powys to address the issues identified within the Case for Change. It articulates the engagement activity and how this informed the development and refinement of options, how the options were then assessed and appraised, who was involved in these activities, how appropriate assurances were provided along through drawing on expertise or evidence base to ensure a robust and transparent process has been achieved to prepare the Health Board for external scrutiny and consultation in their progression to Stage 3: Formal Public Consultation.

The Steps included within this report include the development of Cases for Change, service issues papers development of system and service models of care, development of a long list of options through stakeholder engagement and how these were reviewed against the hurdle criteria to shortlisted options. Finally, how the short-listed options were appraisal through a non-financial options appraisal, workforce and financial appraisals and estate assessment and how these were tested with stakeholders throughout the process. The outputs of this stage are intended to inform Stage 3: Formal Public Consultation

It provides a description of the work undertaken under each step, who was involved and how options were formed following engagement activities and refined or discounted following assessment and appraisal of the options.

It does not attempt to repeat detailed information provided in other reports but where required summarises key points and references the relevant source documents.

2. WHAT IS BETTER TOGETHER?

Better Together is Powys Teaching Health Board's (PTHB) big conversation to shape the future of safe, quality health services for Powys and ensure delivery of our Health and Care Strategy. It builds on previous discovery work for a sustainable model for healthcare in Powys and was established in its current format in December 2024. It responds to the requirement for the Health Board to develop a Clinical Services Plan as part of its de-escalation arrangements for its status in Level 4 Escalation (Targeted Intervention) for Finance, Strategy and Planning.

Better Together will achieve this by harnessing the skills and talents of the people of Powys, by making best use of the resources and assets in the NHS and across local organisations and communities, and by responding to the challenges and the opportunities we all face, to improve quality and outcomes. It seeks to address issues around fragility of services, meeting standards in delivery and the improvement in access and reduction in the number of patients being treated outside of Powys by bringing services closer to home, where possible and appropriate. We have a duty of care to ensure that we provide high-quality services to our population. We also have a duty to live within our means. To achieve this, we need to consider options for how and where we could

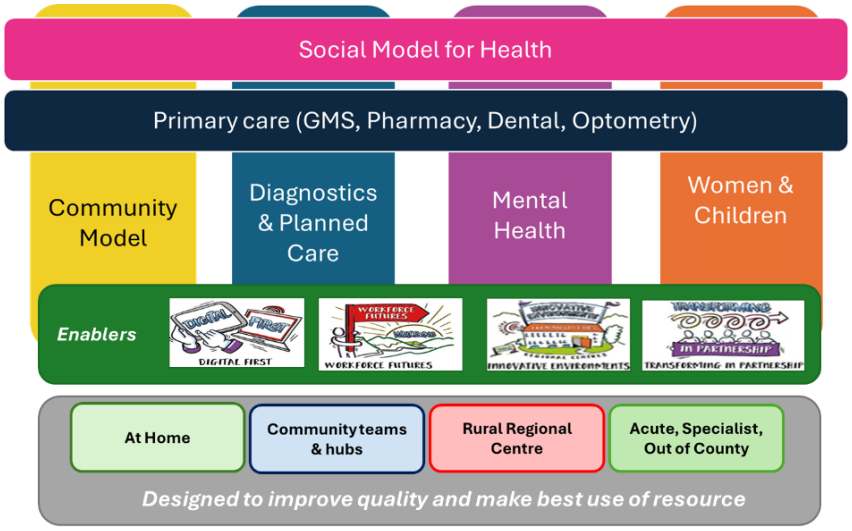
provide services in the future. This might mean patients need to access services in a different way or in a different place.

Initial planning was based on the development of the Case for Change and options for a sustainable model across all clinical service areas in the Health Board, this includes inpatient, community and urgent care services for physical and mental health, planned care, diagnostics, and women, children and family services.

2.1 Phasing of Better Together

In response to the position of both the health board and timeline for Senedd elections in May 2026, a decision was taken by the Executive Committee in March 2025 to phase delivery of Better Together into three distinct clinical delivery areas in a phased approach – adult physical and mental health community services, diagnostics and planned care, and women and children's services. This is illustrated in the diagram below.

Figure 1: Social Model for Health



The first phase of this work has been adult physical and mental health community services. More detail is provided on the Case for Change in **section 4.1.1**.

2.2 Phase 1 Adult Physical and Mental Health Community Services

The scope of Phase 1 Adult Physical and Mental Health Community Services includes the following:

Inpatient services, including our community hospital inpatient wards for both physical and mental health. This includes how we are providing palliative and end of life care both in and out of hospital.

Urgent Care, including the Minor Injury Units that the health board provides and how we work with the GP practices and acute hospitals that the health board funds.

Mental Health, including our single 'front door' to access adult mental health services and our teams in the community that support older adults and inpatient care.

Other important community-based services, including those teams which may visit someone at home to provide support and treatment and work closely with primary care and third sector

partners. These include District Nursing, Home First and Falls Prevention teams, as well as condition specific teams, therapies and imaging.

3. OPTION DEVELOPMENT APPROACH AND METHODOLOGY

3.1 Steps to Consultation

This section describes how Phase 1 of Better Together was delivered, including the structured steps followed, engagement approach, appraisal methodology and assurance processes applied. The process was managed under the Frailty and Community Programme and Adults Mental Health Programme via the Options Development Group (ODG) and supporting clinically led task and finish groups. This enabled a more joined up approach to meeting patient needs from both a physical and mental health perspective and ensured as well as appropriate governance arrangements which are further detailed in **section 3.4**.

The Health Board agreed and followed a five-step process to deliver Phase 1 Adult Physical and Mental Health service options ready for consultation. This five-step methodology is underpinned by the NHS Wales service change guidance to strive to maintain safe and sustainable services; this has been applied through engagement on the case for change, development of options and assessment of the impact of potential changes, in readiness for consultation. The HM Treasury Green Book has been adopted as best practice specifically to support the non-financial appraisal of the options – noting this is typically applied to capital investment appraisal rather than service transformation.

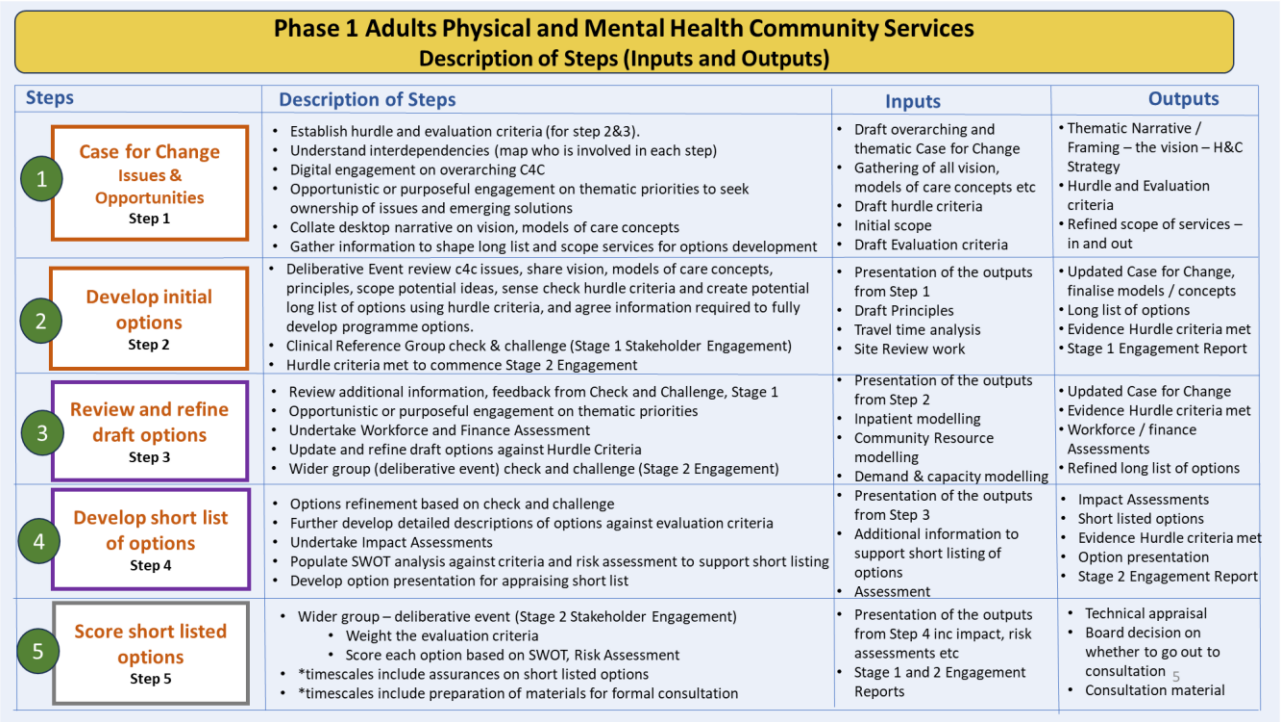
A consistent, proportionate and transparent approach has been applied across all services areas to ensure rigour, comparability and fairness in option development and appraisal. All options have been systematically tested for strategic alignment, clinical sustainability, deliverability.

The approach taken included, using in-person and virtual sessions to explore the issues, create ideas and work from a longlist of proposed options to a set of shortlisted options. Alongside this process, the Communications and Engagement team set up internet and intranet sites to support continuous engagement, allowing staff, patients, and other stakeholders the opportunity to feed into the process as it developed, including in-person sessions throughout the county for staff and the public.

The five-steps are outlined below; these are further detailed in *figure 2*:

- **Step 1:** Case for Change, Issues and Opportunities
- **Step 2:** Development of Initial Options and Engagement Events
- **Step 3:** Review and Refinement of Draft Options
- **Step 4:** Development of Shortlisted Options
- **Step 5:** Appraisal, Assurance and Preparation for Consultation

Figure 2: Description of Option Development Steps (Inputs and Outputs)



Phase 1 Adults Physical and Mental Health Community Services
Description of Steps (Inputs and Outputs)

Steps	Description of Steps	Inputs	Outputs
1 Case for Change Issues & Opportunities Step 1	• Establish hurdle and evaluation criteria (for step 2&3). • Understand interdependencies (map who is involved in each step) • Digital engagement on overarching C4C • Opportunistic or purposeful engagement on thematic priorities to seek ownership of issues and emerging solutions • Collate desktop narrative on vision, models of care concepts • Gather information to shape long list and scope services for options development	• Draft overarching and thematic Case for Change • Gathering of all vision, models of care concepts etc • Draft hurdle criteria • Initial scope • Draft Evaluation criteria	• Thematic Narrative / Framing – the vision – H&C Strategy • Hurdle and Evaluation criteria • Refined scope of services – in and out
2 Develop initial options Step 2	• Deliberative Event review c4c issues, share vision, models of care concepts, principles, scope potential ideas, sense check hurdle criteria and create potential long list of options using hurdle criteria, and agree information required to fully develop programme options. • Clinical Reference Group check & challenge (Stage 1 Stakeholder Engagement) • Hurdle criteria met to commence Stage 2 Engagement	• Presentation of the outputs from Step 1 • Draft Principles • Travel time analysis • Site Review work	• Updated Case for Change, finalise models / concepts • Long list of options • Evidence Hurdle criteria met • Stage 1 Engagement Report
3 Review and refine draft options Step 3	• Review additional information, feedback from Check and Challenge, Stage 1 • Opportunistic or purposeful engagement on thematic priorities • Undertake Workforce and Finance Assessment • Update and refine draft options against Hurdle Criteria • Wider group (deliberative event) check and challenge (Stage 2 Engagement)	• Presentation of the outputs from Step 2 • Inpatient modelling • Community Resource modelling • Demand & capacity modelling	• Updated Case for Change • Evidence Hurdle criteria met • Workforce / finance Assessments • Refined long list of options
4 Develop short list of options Step 4	• Options refinement based on check and challenge • Further develop detailed descriptions of options against evaluation criteria • Undertake Impact Assessments • Populate SWOT analysis against criteria and risk assessment to support short listing • Develop option presentation for appraising short list	• Presentation of the outputs from Step 3 • Additional information to support short listing of options • Assessment	• Impact Assessments • Short listed options • Evidence Hurdle criteria met • Option presentation • Stage 2 Engagement Report
5 Score short listed options Step 5	• Wider group – deliberative event (Stage 2 Stakeholder Engagement) ◦ Weight the evaluation criteria ◦ Score each option based on SWOT, Risk Assessment • *timescales include assurances on short listed options • *timescales include preparation of materials for formal consultation	• Presentation of the outputs from Step 4 inc impact, risk assessments etc • Stage 1 and 2 Engagement Reports	• Technical appraisal • Board decision on whether to go out to consultation • Consultation material

The five-step methodology is based on learning from other Health Board's across Wales and best practice outlined in The HM Treasury Green Book - the official UK government guidance for appraising and evaluating policies, programmes and projects. The Green Book is typically applied to capital investment appraisal rather than service transformation; however, it has been adopted as best practice specifically to support the non-financial appraisal of the options.

In summary the

- **Steps 1 and 2** focused on problem definition, exploration of possibilities and broad option generation, informed by early engagement and deliberative input;
- **Steps 3 and 4** applied structured screening, refinement and triangulation to ensure options were clinically viable, deliverable and strategically aligned; and
- **Step 5** applied a structured nonfinancial appraisal to support comparative discussion and assurance, rather than to determine a preferred option.

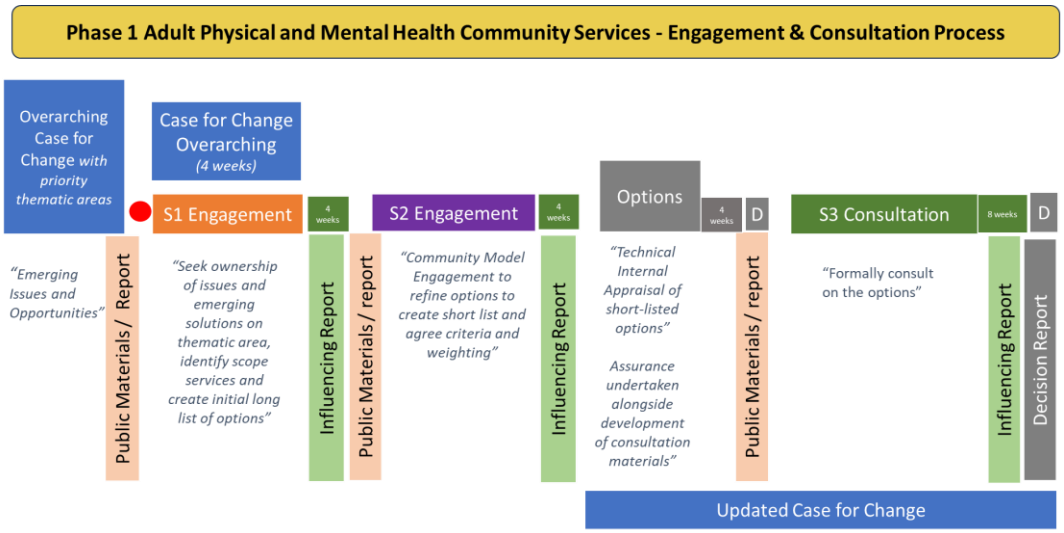
This approach ensured that progression decisions were based on a combination of evidence, engagement, professional judgement and structured assessment, providing both rigour and transparency ahead of consultation.

It should be noted that some tasks fell outside of the intended step, due to internal constraints of available resources, however all tasks within the steps have been carried out. Detailed description of each step is provided in **section 4**.

3.2 Stages of Engagement and Consultation

The engagement and consultation arrangements were based on national and legislative requirements and good practice. e.g. Welsh Government's Guidance for Engagement and Consultation on Changes to Health Services 2022, The Gunning Principles, and National Principles of Public Engagement in Wales. The Health Board agreed and followed three key stages of engagement (stages 0-2) to support and inform future consultation (stage 3). This is depicted below in figure 3.

Figure 3: Engagement & Consultation Process



Stage 0: Discovery activity – took place prior to the case for change being developed. It is therefore not depicted above as part of the above engagement and consultation process. The insights highlighted significant pressures related to access, workforce sustainability, ageing demographics and increased comorbidity, rural travel and transport – all of which were incorporated into the case for change and formed part of the Stage 1 engagement materials as a basis for continuous engagement.

Stage 1: The purpose of this stage was to share the Case for Change, seek views on how the narrative compares to resident/stakeholder understanding, confirm the issues and capture ideas to identify potential solutions through early engagement with stakeholders.

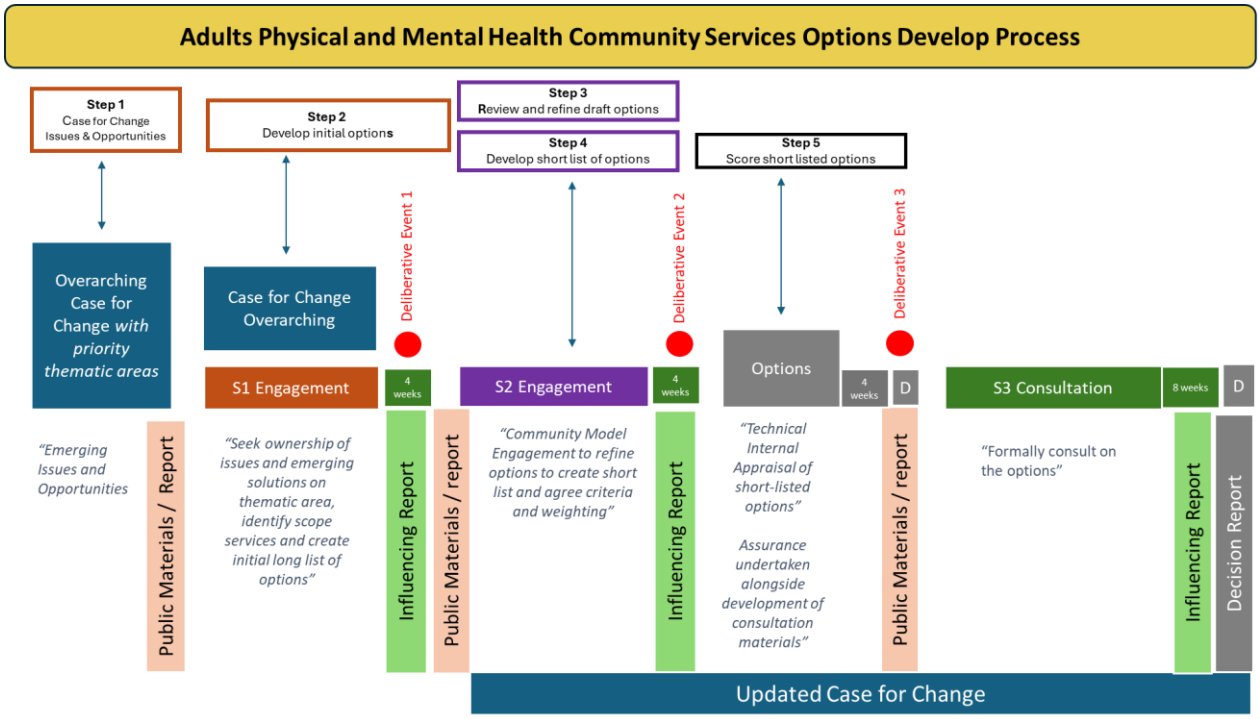
Stage 2: Engagement with stakeholders on six scenarios, draft hurdle criteria, development of the long list of ideas to create the short list of options, and options appraisal against agreed criteria and weightings.

Stage 3: Formal consultation to follow Autumn 2026.

3.3 How the Stages of Engagement Supported the Steps

Stage 1 engagement activities were aligned with Step 1, the draft outputs from Stage 1 fed into Step 2. Stage 2 engagement activities spanned Steps 2-4, and the draft outputs were reviewed and fed into Step 4. The outputs from all engagement activities were appropriately considered during the options development process and were further tested and shared at the first two Deliberative events.

Figure 4: Adults Physical and Mental Health Community Services Options Develop Process



3.3.1 Stakeholder participation and public involvement

A structured stakeholder mapping exercise was undertaken to identify the appropriate involvement required across Phase 1: options development. Working with Senior Responsible Officers, Transformation Programme Managers and Executive leads. Stakeholder groups were clearly defined to support distinct stages of the process, including Case for Change development, option development (Options Development Group), deliberation and option refinement, formal scrutiny and assurance, and stakeholders to be kept informed throughout. In parallel, patient representatives who had participated in early targeted engagement as part of the discovery phase and expressed a wish to remain involved were invited to contribute through attendance at deliberative events. This approach ensured proportionate, transparent and inclusive involvement, with clear lines of assurance across the options development process.

Stakeholder participation throughout Phase 1 of Better Together was deliberately structured to be proportionate to the purpose, technical complexity, and decision-making requirements for each step in the options development process. Different steps required different forms of involvement, and the programme of work distinguished between internal technical development, stakeholder challenge and sense checking, and public and service user engagement to inform direction and priorities. A stakeholder participation and public involvement overview is included at **appendix E**. Where public and patient representation was necessarily limited during technical appraisal stages, the Health Board remains open to conscientiously considering what emerges through consultation. This risk has been proactively managed through early, iterative engagement, multiple deliberative events, independent assurance, and the planned pre-consultation deliberative engagement in June 2026. These measures ensure that consultation remains formative, that no option is presented as predetermined, and that final decisions will be made following full consideration of consultation responses.

In preparation for Stage 0-2 Engagement there was prioritised broad engagement with patients, communities, staff, partners and representative bodies, ensuring diverse perspectives informed the Case for Change, design principles and early option development. These Engagement stages incorporated public surveys, workshops, drop-in events, targeted engagement with seldom heard groups, and deliberative events with direct service user representation.

Option development (steps 3–5) involved more technical appraisal and assurance activity, including detailed workforce, financial, estates, demand and capacity analysis, and nonfinancial options appraisal. Participation at these stages was therefore focused primarily on clinical, professional and partner stakeholders with relevant expertise. This ensured options were tested rigorously for clinical safety, deliverability and sustainability prior to public consultation.

Importantly, outputs from public and stakeholder engagement undertaken earlier in the process were actively used as inputs to inform option refinement, assessment criteria, weighting, mitigations and appraisal logic, rather than relying solely on views expressed during technical sessions.

Patient, service user and public representation was embedded throughout engagement activities, particularly during discovery, Stage 1, and Stage 2 engagement, and through both deliberative events. In addition, representative bodies including Llais (the independent statutory body in Wales, to represent the public's voice in health and social care services) were routinely invited to participate in relevant governance and engagement forums.

Llais was specifically invited to attend both of the non-financial options appraisal stages in an observer capacity. This opportunity was declined. This decision was respected and recorded, and assurance was provided through alternative mechanisms including independent engagement assurance, clinical reference group challenge, and subsequent deliberative engagement.

The programme has remained transparent regarding where direct public participation was not proportionate due to technical complexity, and where earlier or parallel engagement activity provided the necessary input and challenge to inform decision making.

3.3.2 Application of the Gunning Principles

Whilst the Gunning Principles are more appropriately associated with the formal consultation process itself, they were considered as part of engagement process to ensure meaningful engagement, and that decision making remains open prior to formal consultation.

Principle 1 – Consultation at a formative stage
Engagement commenced at the earliest stages of the programme (discovery and Case for Change), before any preferred option was identified. Public, patient and stakeholder input directly informed the identification of issues, priorities, scenarios and the long list of options.

Principle 2 – Sufficient information to give intelligent consideration
Engagement materials, scenarios and deliberative events were designed to present information in an accessible, balanced and nontechnical way, supported by independent facilitation where appropriate. Technical analysis undertaken later in the process has been clearly framed as preparatory work to enable informed consultation, rather than decision making.

Principle 3 – Adequate time to consider and respond
Engagement was delivered over multiple stages and time periods, including extended Stage 2

engagement and two deliberative events, ensuring stakeholders had sufficient opportunity to understand proposals, reflect and provide feedback.

Principle 4 – Conscientious consideration of responses
Feedback from engagement has been systematically analysed, triangulated and explicitly referenced in option refinement, assessment criteria, weighting, mitigation development and appraisal logic. There is a documented audit trail demonstrating how engagement informed decision making throughout the process.

Application of this approach provides assurance that the Phase 1 process does not predetermine outcomes, and that formal consultation (Stage 3) represents a genuine opportunity for public and stakeholder views to influence final decisions.

3.4 Hurdle Criteria, Scoring and Assessment Framework

3.4.1 Hurdle Criteria

"Hurdle Criteria" are key tests ("hurdles") that options must pass before they are given further consideration. This helps to ensure that time and public money is not spent testing options that would not work. 'Hurdle Criteria' for Better Together Phase 1 were identified following an assessment of best practice and learning across NHS Wales and NHS England organisations and their experience of the use of Hurdle Criteria when undertaking service change.
The proposed Hurdle Criteria were developed by the Options Development Group and tested through the Enabling Group and Clinical Reference Group (described in **section 3.4**). Stakeholder feedback was requested on the criteria at the first Deliberative event and during Stage 1 engagement. The hurdle criteria were approved by the portfolio board prior to application during the options development process.

Figure 5: Lists the Hurdle Criteria agreed and applied during the options development process

Criteria	Explanation
Is the potential solution clinically sustainable?	• Does it deliver progress towards safe and reliable services that meet quality standards? • Does it consider any co-dependencies (the way in which different services need to work together)? • Is it informed by evidence ensuring people receive the right care and optimal outcomes?
Does the potential solution improve access?	• Does it enable people to access advice, guidance, and care quickly and easily? • Does it address equity of access? • Does it provide access within an appropriate timeframe?
Is the potential solution deliverable?	• Is the workforce or an alternative workforce model available to deliver it? • Has digital technology been considered in the development of the solution? • Will it be clinically deliverable in a short (1-2 years), medium (2-4 years) or long (5-10 years) timeframe? • Will it be operationally deliverable in a short (1-2 years), medium (2-4 years) or long (5-10 years) timeframe?
Does the potential solution support (or at least not contradict) …	• A person-centred care system that meets people's needs • Integrated working with partners • Improvement of population health • The strategic direction for Powys (e.g. Health and Care Strategy, PTHB strategic priorities) and for NHS Wales (e.g. A Healthier Wales)
Is the potential solution financially sustainable?	• Does it make best use of financial resources in the short and long term? • Does it support a value-based approach to improve outcomes? • Does it improve efficiency and productivity and reduce waste?

The Hurdle Criteria formed the first formal screening mechanism within the appraisal process. Their purpose was to identify options that were not clinically sustainable, deliverable, financially viable or aligned with strategic direction, and therefore should not progress to more detailed consideration.

Shortlisting was not based on a separate or additional set of criteria, but rather on a triangulated application of:

- the Hurdle Criteria outcomes;
- refinement and consolidation of overlapping or derivative options;
- analysis of interdependencies across service areas; and
- feedback from engagement, deliberative events and clinical/professional challenge.

Only those options that passed the Hurdle Criteria and remained materially distinct and credible following this triangulation progressed to nonfinancial appraisal.

3.4.2 STEEEP Six Domains of Quality

The Six Domains of Quality were used as assessment criteria (*figure 4*) for non-financial appraisal of shortlisted options. Each appraiser was asked to score each option against the STEEP criteria according to the scoring system (Figure 6) based on 1-5. 1 being does not meet the assessment objective or criterion and 5 being exceeds the objective or criterion.

Figure 6: STEEEP Assessment Criteria

Assessment Criteria (based on NHS Wales Health and Care Quality Standards)					
SAFE	**TIMELY**	**EFFECTIVE**	**EFFICIENT**	**EQUITABLE**	**PERSON-CENTRED**
Does this option deliver against the objective we are trying to achieve in a way that promotes 'safe' care:	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'timely' and 'accessible' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'effective' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'efficient' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'equitable' care:**	**Does this option deliver against the objective we are trying to achieve in a way that promotes 'person-centred' care:**
Please consider as a guide for your assessment the extent to which this:	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*	*Please consider as a guide for your assessment the extent to which this:*
• supports safe clinical practice *i.e. prevents and / or reduces harm / errors*	• delivers against required access standards / performance targets (such as reduction of delays and waits)	• is underpinned by reliable data, best practice guidance and evidence-base (e.g. NICE)	• makes best use of resources to improve patient outcomes and experience, staff satisfaction and enables us to live within our means	• delivers evidence-based care across Powys but can adapt to address differences in need; positively contributing towards reducing health inequalities	• Helps people to stay healthy, building self-reliance in patients and the population
• ensures a substantive workforce model *–i.e. the workforce is available, and a robust staffing model can deliver professional standards*	• improves access to services that support people to stay at home where possible and enables timely response when needs escalate	• supports delivery of future system models of care, national and local guidance	• uses digital technology where appropriate to aid efficient care, with consideration for those not able to use technology	• reduces inequity across Powys for example through removing unnecessary differences in the way services are delivered	• provides a responsive joined-up offer that supports people to achieve 'what matters most to them' and improves patient experience outcomes
• improves staff safety including promoting a culture of safety and speaking up safely	• enables efficient transfer and discharge pathways to prevent harm to patients	• addresses existing barriers to care in the case for change such as continuity of care and communication	• is feasible and can achieve a positive impact within the short or medium term *i.e. will improve the health of the whole population or have a very significant impact on the health of a small number*	• delivers an appropriate offer for all population groups – including those with protected characteristics (not necessarily the 'same' offer but the one that delivers the best fit between those characteristics and the care provided)	• Provides access to meet healthcare needs within acceptable travel times (in line with the evidence base)

Figure 7: Option Scoring Mechanism

Score	Descriptor	Definition
1	Does Not Meet Needs	The option fails to address the objective or STEEEP criterion. It may introduce risks or worsen current conditions.
2	Partially Meets Needs	The option addresses the objective or criterion in a limited or inconsistent way. Significant gaps remain.
3	Adequately Meets Needs	The option meets the minimum requirement. It is acceptable but lacks enhancement or innovation.
4	Fully Meets Needs	The option clearly meets the objective or criteria with confidence. It is robust and well-aligned with expectations.
5	Exceeds Needs / Optimal Fit	The option not only meets but enhances the objective or criteria. It offers added value, innovation, or futureproofing.

3.4.3 STEEEP Weighting and Sensitivity Analysis

The STEEEP assessment criteria were weighted by the Executive team, out of a total score of 100, to reflect the case for change and organisational strategic priorities. This weighting was applied to the scoring of the options for non-financial appraisal.
The Executive team weighted the criteria as follows:

Safe 30, Timely 15, Effective 20, Efficient 15, Equitable 10 and Person Centred 10.

Sensitivity analysis was applied to the scoring during non-financial appraisal to add further rigour, this included Reverse, Clinical and Public Weighting.

This allowed appraisal to also reflect themes emerging consistently from stakeholder, staff and public engagement, particularly the importance of care closer to home, equitable access in a rural context, and prevention of avoidable hospital admissions.

In addition to the sensitivity analysis undertaken, engagement themes were reflected through:

- increased emphasis on *Timely*, *Equitable* and *Person-Centred* domains through alternative weighting in the sensitivity analysis;
- application of travel time analysis as a core supporting assessment; and
- interpretation of scoring through the lens of engagement feedback during deliberative and appraisal discussions.

This ensured that engagement findings were materially embedded within the appraisal framework rather than considered in parallel.

3.4.5 Design Principles

Design principles were developed and shared during Stage 2 engagement. These are described in *figure 8*.

Figure 8: Design Principles

Level	Description
Home	Some services can be delivered safely and effectively in people's homes. This includes health and care staff who visit you to provide services at home. It also includes online and telephone services, as well as tools to help you manage your own care at home.
Locality / Community	Some services can be provided locally within the community you live in. For example, GP primary care services are provided in all 13 localities in Powys. · The 13 localities in Powys are Brecon, Builth & Llanwrtyd, Crickhowell, Hay & Talgarth, Knighton & Presteigne, Llandrindod & Rhayader, Llanfair Caereinion, Llanfyllin, Llanidloes, Machynlleth, Newtown, Welshpool & Montgomery, Ystradgynlais.
Cluster	Some services need to be provided at a "regional" level within Powys. They may need specialist equipment and staff that is best provided in a single location serving a larger population. · For example, we currently provide day surgery and endoscopy in Brecon and Llandrindod Wells. We also have an ambition to provide these services in Newtown in future as part of the North Powys Wellbeing programme. · Our "regions" are North, Mid and South Powys.
Once for Powys	Some services can safely be delivered within the county, but because they are much more specialised in nature they may been to be provided from one location or by one centralised team. · For example, Felindre Ward in Bronllys is currently our adult (18-64) mental health admissions unit.
Outside the county	The rural and sparsely populated nature of Powys means that some services cannot be safely delivered within the county. For example, we access District General Hospital services in neighbouring counties.

3.4.6 Impact Assessments

The Health Board requires proportionate impact assessment to be undertaken for all service change proposals that are subject to public consultation or stakeholder engagement. This is to ensure compliance with statutory duties, Welsh Government policy, NHS Wales standards, and PTHB's own governance and equality framework.

A **Level 1 Impact Assessment** provides an early, proportionate screening of a proposal to identify any potential equality, access, or service impacts that may arise from the proposed change. It ensures

statutory duties are considered at the outset and determines whether a more detailed Level 2 Impact Assessment is required before engagement or consultation proceeds.

A **Level 2 Impact Assessment** provides a comprehensive, evidence-based analysis of identified impacts where proposals may result in significant, differential, or disproportionate effects on individuals, groups, or communities. It ensures statutory compliance and informs meaningful mitigation, engagement, and decision making prior to and following public consultation.

Impact assessments were not undertaken solely as a statutory compliance exercise, but as an active tool to shape option design, identify risks and inform mitigation planning throughout Phase 1 of Better Together. Equality, Welsh language, access and quality impacts were considered iteratively as options were developed, refined and appraised, rather than assessed only at the end of the process.

Outputs from Level 1 Impact Assessments were used to:

- identify potential differential impacts at an early stage;
- inform refinement or consolidation of options during shortlisting; and
- determine where a more detailed Level 2 Integrated Impact Assessment would be required prior to consultation.

Level 2 Integrated Impact Assessments have been developed in parallel with detailed option refinement and will be finalised to support the pre-consultation business case, they will be used to inform:

- mitigation measures;
- identification of residual risks to be explored with the public and stakeholders during Stage 3 consultation.

This approach ensures that equality, Welsh language, quality and access considerations are embedded within decision making and are central to consultation readiness, reflecting their statutory, legal and reputational significance.

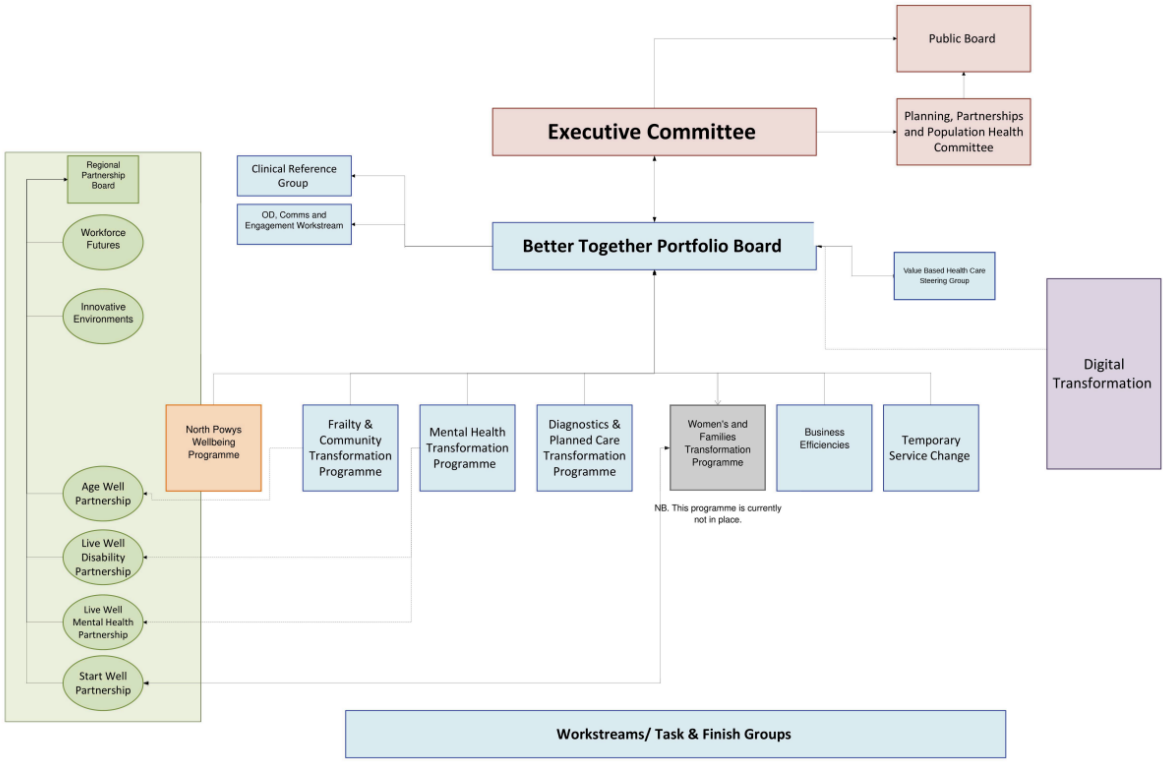
3.5 Governance and Assurance

Delivery of Phase 1 was overseen through established Better Together Portfolio governance arrangements, aligned to the Powys Health & Care Strategy and Integrated Medium-Term Plan (IMTP). This section outlines the governance arrangements, roles and responsibilities throughout the steps and the clinical and non-clinical assurance mechanisms that were in place to ensure appropriate scrutiny and assurance.

The options development process was managed through the Frailty and Community Programme and Mental Health Programme under Better Together. The responsibility for the development of options was delegated to the Senior Responsible Officers to manage via the Options Development Group (ODG). This group therefore reports directly into both programmes.

The diagram below describes the Better Together Portfolio governance structure.

Figure 9: Better together Portfolio Governance Structure



3.5.1 Key Groups and Responsibilities

The following governance arrangements are in place to ensure delivery of Better Together portfolio and have played a key role in providing oversight and delivery of the phase 1 options development.

- **Better Together Portfolio Board** - Oversees the portfolio, ensuring delivery of benefits aligned with the Health & Care Strategy, managing escalation of risks and issues, approval of key outputs and ensuring strategic alignment and assurance to the Executive Committee and Board.
- **Clinical Programme Boards** (Mental Health, Frailty & Community Model, Diagnostics and Planned Care) -Provides oversight of workstreams and task and finish groups delivering transformation projects and actions specific to a clinical area. Membership includes PAVO and Powys County Council.
- **Clinical Reference Group (CRG)** -Provision of clinical advice, challenge and assurance, for example, review of hurdle criteria and shortlisted options.
- **ODEC – Organisational Development, Engagement and Consultation** – Provision of strategic guidance and planning of organisational development, engagement, and communication activities, enabling stakeholders to transition smoothly and contribute to the change process. It is important to note that Llais Regional Director /their nominated representative is invited to attend and contribute to the group in an observer capacity.
- **Options Development Group (ODG) -** Responsible for development, refinement and testing of options across the service areas. Membership included clinical and operational lead(s) for each service, along with other clinical colleagues and representatives from enabling corporate services such as workforce, finance, estates, digital, organisational development and communications and engagement.

- **Task and Finish Groups** – Service specific groups supporting detailed option development, modelling, impact assessment and assurance. Membership included clinical, operational, workforce and finance representation.

The Improvement & Transformation team members provided facilitation and programme management support to the above groups.

3.5.2 Independent Advice and Guidance

INDEPENDENT CLINICAL EXPERTISE

Independent Clinical Expertise supported the process. This input is listed below:

- A Senior Associate with the International Foundation for Integrated Care (IFIC), who is a Professor and Consultant in Frailty, and also the Director of IFICs Country Hub in Scotland – An expert in policy and improvement programmes in Scotland on Long-Term Conditions, Healthcare Quality, Reshaping Care for Older People, and Integrated health and social care who provided subject matter expert advice in support of service redesign and patient pathway testing. They presented as keynote speaker at the second and third deliberative event, facilitated patient pathway testing, and associated workshops. Provided external clinical review of Demand & Capacity Modelling and acted as an appraiser for non-financial options appraisal sessions.
- The Clinical Director for Community Hospitals at Aneurin Bevan University Health Board (ABUHB) with a focus on Care of the Elderly. This individual provided subject matter expert advice in support of service redesign and clinical oversight requirements. Attended deliberative events and provided external clinical review of Demand & Capacity Modelling. Acted as an appraiser for non-financial option appraisal sessions. Since supporting this work, he has been appointed as Assistant Medical Director for community hospitals and teams, this includes leading on work to strengthen the clinical oversight model.
- Representatives from Mental Health and Urgent and Emergency Care NHS Wales Performance & Improvement who supported reviewing and development of Service Level Model of Care documents and acted as independent clinical appraisers for the Non-financial Options Appraisal events in September 2025 and April 2026.

Throughout the process an evidence-based approach was applied, drawing from local, national and international sources. Alignment to national evidence-based programmes was tested with representatives from national programmes invited to participate in deliberative and options appraisal events (e.g. Six Goals programme, National Programme for Mental Health; ICCS)

INDEPENDENT ENGAGEMENT AND CONSULTATION SUPPORT

During Stage 0-2 engagement, external support was provided by Practice Solutions who undertook a range of insight work initially focused on strengthening our understanding of needs and expectations across protected equality characteristics groups (Stage 0-1) and subsequently to build deep insights in relation to the scenarios and criteria being tested during Stage 2 engagement.

Following an external procurement process, PTHB secured two sources of independent advice and consultancy:

- HICO Ltd providing independent consultation assurance
- ORS providing independent survey and insight design, delivery and analysis

INDEPENDENT DEMAND AND CAPACITY MODELLING EXPERTISE – Adcuris Consulting LTD

The contract with external provider, Adcuris Consulting Limited, provided PTHB with demand and capacity modelling, to support service change. This contract included transfer of knowledge from the contractor to Health Board technical teams to support future internal modelling capability.

3.5.3 Check and Challenge and Assurance

The following assurance mechanisms were put in place to support delivery of Phase 1:

CLINICAL REFERENCE GROUP

The Clinical Reference Group (CRG) provided review and assurance throughout the process and was chaired by a Clinical Executive Director. The CRG met monthly, or as required and was tasked by the Portfolio Board to provide clinical scrutiny.

WORKFORCE & FINANCE CHECK AND CHALLENGE

This was a 2-stage process:

Stage 1: To review, test, and challenge the shortlisted options from a workforce and financial perspective, to ensure value and evidence-based service transformation options. This included a confidence assessment that the:

1. baseline was correct on workforce, commissioning and other factors included in the costing
2. workforce model is based on evidence, demand and capacity projections and assessed against benchmark practices
3. underlying assumptions will deliver the expected changes and outcomes particularly where investment is required

First line validation and quality assurance of the workforce and financial appraisal was undertaken by finance, workforce and Transformation & Value senior team to provide professional challenge on workforce, financial and deliverability assumptions.

Stage 2: To review the confidence assessment report from Stage 1 and identify any further actions, required to ensure robust options are put forward to Executive Committee and Board for decision for consultation.

This included Clinical Executives, finance, workforce, Transformation and Value Senior team.

Providing further assurance and professional assessment that the options proposed for consultation will deliver the expected changes and outcomes particularly where investment is required.

DEMAND AND CAPACITY KNOWLEDGE TRANSFER AND VALDATION

An internal knowledge transfer and validation process took place to ensure technical validation of the external demand and capacity modelling. This involved senior Finance, Information and Public Health colleagues.

ENGAGEMENT AND CONSULTATION ASSURANCE - HICO LTD

HICO is providing quality assurance support and advice on consultation good practice. However, any Consultation Mark award decision will be considered independently through the Centre for Consultation." A Consultation Mark is a quality standard and accreditation awarded to certify that public consultation processes meet high standards of compliance, rigour, and best practice.

4. STEPS TO CONSULTATION

The steps to consultation are outlined in **section 3.1**. Each step is described in more detail below.

Discovery activity was undertaken throughout 2024 through engagement with patients, communities, partners and stakeholders. Nationally, work with the Bevan Commission identified seven consistent themes across Wales, including prevention, workforce, access, communications and changing demographics, alongside a strong desire for radical change while retaining NHS core principles. Locally, the Better Together portfolio worked with Powys County Council, community and third sector organisations, town and community councillors, young people, Llais and voluntary sector partners across all 13 localities. This engagement highlighted key Powys specific challenges, notably access to and coordination of services, travel and transport in a rural county, workforce sustainability, ageing population, mental health, reliance on the voluntary sector, prevention and the importance of joined up working.

Dedicated engagement with young people emphasised mental health, healthy lifestyles, substance use, digital behaviour and transport barriers. Feedback from the third sector, Llais and consultation on temporary service changes reinforced these themes, particularly around access to care closer to home, equity of provision, support for carers, transport, delayed discharge and workforce constraints. Collectively, this comprehensive discovery activity provided a robust, triangulated evidence base to underpin the Case for Change and shape the long list and subsequent development of service options. A detailed description of Stage 0 discovery activity is provided in the Stage 0-2 Engagement Report at **appendix D.**

4.1 Step 1 – Case for Change and Models of Care (Including Stage 1 Engagement)

Step 1 focused on seeking feedback on the Case for Change through Stage 1 public and stakeholder engagement. It also included gathering and testing existing work on the future vision, models and care, and the development of hurdle and evaluation criteria, design and travel time principles.

4.1.1 Case for Change and Stage 1 Engagement

The Case for Change (**appendix B**) was developed by professionals across the organisation to provide a transparent, evidence-based rationale for change and a shared understanding of the challenges and opportunities facing health and care services in Powys. It established the baseline for options

development and was strengthened through targeted engagement during spring 2025 with groups representing equality protected characteristics and voices less heard.

The Case for Change was tested through Stage 1 engagement between March and April 2025 with staff, stakeholders and the public to validate its completeness and accuracy, ensuring it reflected "what matters" to patients, communities and partners. This approach supports NHS Wales service change requirements by evidencing proportionate and inclusive engagement (including engagement with representative bodies such as Llais) and by providing a clear audit trail demonstrating how feedback informed proposals.

Across engagement activity, there was clear support for change that brings care closer to home, improves equity of access, strengthens prevention, and supports more coordinated and sustainable models of care in Powys. Most stakeholders considered the Case for Change to provide a fair and accurate summary of the challenges facing local services, while noting some gaps, which are set out in the Stage 0–2 Engagement Report (**appendix D).** Feedback highlighted an urgent need to strengthen primary care and mental health provision, concern about the absence of a district general hospital (DGH), and the importance of delivering services closer to home in recognition of Powys' rurality.

Key recurring themes included strong civic pride in local hospitals and community services; concerns about distance and access to DGHs; inequitable access to care; the impact of an ageing population; the need for improved partnership working; challenges with patient communication and record sharing; opportunities for greater use of digital tools; links between rurality, isolation and health outcomes; workforce recruitment and sustainability; and ongoing pressures on NHS funding in Powys.

The Case for Change acted as a golden thread throughout the five-step process, with all options developed and assessed against their ability to address the issues identified. The options development process highlighted the need to balance trade-off's, particularly between addressing workforce fragility in a geographically dispersed population and ensuring sustainable, financially viable models of care. This led to consideration of options that enhance services, consolidate provision, or combine both approaches to best meet population needs.

To underpin option development with a robust evidence base, detailed technical chapters were produced for Primary Care, Community Services, Mental Health and Learning Disabilities, and Diagnostics. These technical documents were published following Stage 1 engagement and reviewed by the Options Development Group to distil key service specific issues. The accompanying data and evidence were central to ensuring options were developed and assessed consistently and objectively against priorities agreed through stakeholder engagement.

Evidence from Stage 1 engagement demonstrated a clear case for prioritising Adult Physical and Mental Health Community Services, with a focus on care closer to home, prevention and early intervention. This influenced decision making in relation to the phasing of Better Together with Adult Physical and Mental Health Community Services, including Urgent Care, Diagnostics, and Physical and Mental Health Community Inpatient services taken forwards as Phase 1.

Throughout the options development process, the Case for Change was repeatedly tested to ensure emerging options addressed the identified issues and supported improvement against the Duty of Quality and the Health and Care Quality Standards, particularly in relation to effectiveness, safety and experience.

4.1.2 Vision, Models of Care Concepts and Travel Time Principles

This step represented a key milestone in stakeholder mobilisation, engagement and alignment, delivered through multiple workshops facilitated by the Transformation & Value Team, with support from Organisational Development and Communications and Engagement colleagues. The Stage 1 engagement process enabled a wide range of stakeholders to contribute feedback on the key issues and potential opportunities associated with the development of future services in Powys. The feedback was triangulated and demonstrated strong consistency with the Case for Change, providing assurance that the programme was focused on the most significant and material issues ahead of options development. Engagement also generated a broad range of ideas, which were consolidated into a single evidence-set for further analysis and interrogation by internal professional staff, ensuring that a breadth of clinical, operational and corporate perspectives informed subsequent work.

The evaluation criteria and design principles were reviewed and tested against Stage 1 feedback, resulting in the strengthening of the person-centred element within the STEEEP assessment framework. In response to stakeholder concerns about travelling to services in a rural county, the travel time principles were also developed. An evidence base was assembled by the Transformation and Value Team and tested with clinical and professional colleagues, drawing on best practice guidance and comparable clinical models across the UK. Establishing these principles early in the process ensured a consistent and objective framework for option development and appraisal, enabling the impact of potential changes on patient travel times to be assessed against agreed and transparent standards. Further detail is included in the travel time analysis report (**appendix W)**. The hurdle criteria, evaluation criteria, design principles and travel time principles were all agreed and approved internally prior to options development, reinforcing objectivity and transparency throughout the process.

Alongside Stage 1 engagement, a series of internal clinical and professional workshops were delivered between March and May 2025. These sessions revisited the vision set out in the Health & Care Strategy and supported the development of system level models of care and underpinning principles, including design and travel time considerations, to inform options development. The Phase 1 scope of services, together with the hurdle and assessment criteria, were shared, tested and refined through these discussions to ensure appropriate rigour was applied throughout the five-step process. The workshops generated a long list of service ideas, with outputs captured in the relevant end-of-workshop reports (**Appendix D).**

This step represented a key milestone in stakeholder mobilisation, engagement and alignment, delivered through multiple workshops facilitated by the Transformation and Value Team, with support from Organisational Development and Communications and Engagement colleagues. The Clinical Reference Group met regularly to provide clinical input, challenge and assurance on the Case for Change, vision, design principles and assessment criteria. System Models of Care were updated in response to Stage 1 engagement feedback and retested through clinical and professional workshops and the Clinical Reference Group, enabling the development of a cohesive and shared ambition for systemwide transformation in collaboration with internal and partner stakeholders.

The table below provides an overview of the clinical and professional sessions delivered during this step:

Figure 10: Clinical & Professional Workshop Overview

Date	Event / Session	Delegates (no.)	Attendees / Representation	Purpose / Focus
13 March 2025	Primary Care (GMS focused) Session	43	Primary Care colleagues	Introduce Better Together and the Route Map to Sustainability; set out the design approach and Case for Change; explore option development to improve quality and resource use; capture priorities across Frailty & Community, Diagnostics & Planned Care and Mental Health; and agree ongoing Primary Care involvement.
1 May 2025	Physical Health Community Model Workshop (1 of 3)	23	PTHB, Local Authority, Primary Care	Confirm shared vision and guiding principles; outline the emerging community model; align stakeholders around the vision and confirm its value; outline the path forward; explore a broad range of future ideas/options; agree how these will be assessed and refined.
3 May 2025	Mental Health Community Model Workshop (1 of 3)	24	PTHB: operational services, planning, transformation, medicines management, Psychiatry, therapies	Confirm shared vision and guiding principles; outline the emerging community model; align stakeholders around the vision and confirm its value; outline the path forward; explore future ideas/options; agree how these will be assessed and refined.
12 May 2025	Physical Health Community Model Workshop (2 of 3)	38	PTHB, Local Authority, Primary Care, Pavo, British Red Cross	Outline the scope and overarching vision with a wider stakeholder group; use fictional case studies/personas to generate ideas for future support models; capture more detail to inform the 'long list' for options development.
15 May 2025	Mental Health Community Model Workshop (2 of 3)	28	PTHB, Local Authority, Primary Care, Pavo	Outline the scope and overarching vision with a wider stakeholder group; use fictional case studies/personas to generate ideas for future support models; capture more detail to inform the 'long list' for options development.
21 May 2025	Accelerated Community Model Psychiatry Workshop	14	PTHB, Primary Care	Additional workshop due to clash with commitments for mental health medical teams; outline scope of transformation work; begin developing ideas for the 'long list;' use fictional case studies/personas to generate and capture ideas for options development.

Date	Event / Session	Delegates (no.)	Attendees / Representation	Purpose / Focus
28 May 2025	Physical & Mental Health Community Model Workshop (3 of 3)	45	PTHB, Primary Care, PAVO, Local Authority	Final combined workshop to support accelerated development of physical and mental health community model (Better Together portfolio); bring together outputs from previous workshops; enable physical health, mental health and partners to review existing work and develop ideas further.

4.1.3 Progression to Step 2

The following outputs from Step 1 enabled progression to step 2:

- Stage 1 engagement outputs on the Case for Change were shared and discussed with ODG members to provide insights on what internal and external stakeholders felt were strengths, weaknesses, opportunities and threats.
- Hurdle Criteria, Evaluation Criteria, Design and Travel Time principles developed ready for testing with Public and stakeholders as part of Stage 2 Engagement.
- Agreed scope of services across the clinical service areas.
- Long List of Ideas generated through collaborative workshops with staff and partner organisations.

4.2 Step 2 – Develop Initial Options

Step 2 largely focused on analysing the feedback from the stage 1 engagement and developing a long list of options based on the ideas and solutions shared through Step 1. It was fundamental to developing six scenarios for how services could be provided in future, as a basis for Stage 2 Engagement.

4.2.1 Deliberative Event 1

A Deliberative Event took place in person on 3rd June 2025, full details of the session, outputs and delegates can be found in the report at **appendix D**.

71 delegates were in attendance from the following stakeholder groups:

- Representatives from Llais
- Service User Representatives
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations

Delegates listened to a series of presentations to set the context and prepare them for the deliberative discussions through focused table-based activities. This included feedback from internal and external stakeholders on the Case for Change and provided an opportunity for discussion and for people to add to the feedback on the Case for Change as a further check and challenge. The table groups were also asked to:

- Review the list of ideas or solutions for adults physical and mental health community services that were developed through the clinical and professional workshops and share their thoughts on what was missing to meet future population needs.
- Review and provide feedback on Stage 2 engagement content including six scenarios for how services could be delivered in the future (see **section 4.2.2**), design principles and proposed hurdle and assessment criteria that would be used to objectively assess and discount options.

The event was well attended and achieved positive feedback from independent observers (Practice Solutions) in its achievement of the intended objectives. The range of participants was felt to be broad and inclusive providing opportunity for further check and challenge on the case for change but also to gather insights from a variety of stakeholder perspectives to help shape future solutions ahead of the launch of Stage 2 engagement.
The Stage 2 Engagement Briefing was updated following the Deliberative Event and the outputs were collated into a report to be shared with ODG members to help shape the next step.

4.2.2 Stage 2 Engagement

The Stage 2 engagement on Adult Physical and Mental Health Community Services commenced during Step 2, it ran from 9 June until 27 July (throughout step 3-4) The Stage 2 Engagement Document "Better Together: Seeking Your Views on Adult Physical and Mental Health Community Services in Powys" (appendix C) set out why change is needed, our level of ambition to transform healthcare services, and how stakeholders could have their say. The Stage 2 Briefing was approved by the Better Together Portfolio Board on 16th September 2025 and Executive Committee on 26th September 2025.

The objective of the engagement period was to gather views on six scenarios for how future services could be provided for adult physical and mental health community services and to seek feedback from stakeholders on the draft design principles and assessment criteria used to develop and appraise options. Full details are provided in the Stage 0-2 Engagement report (**appendix D)**.
The Scenarios:

~~1. No change~~
2. Minor change and developments to the way we provide physical and mental health community services
3. More services in Powys are provided within "centres of excellence" including in Rural Regional Centres
4. Developing and expanding the range of services available in Wellbeing Hubs across Powys and strengthen Community Teams
5. Inpatient care, including community beds, is provided outside the county in neighbouring health boards

~~6. Provide a District General Hospital in Powys~~

These scenarios do not have to happen separately, and some could occur together.
Scenarios 1 and 6 must be ruled out. Change is needed to respond to the challenges we face. Because of the very rural nature of Powys, it is not feasible to have a DGH in the county.

The six scenarios developed during Step 2 were not intended to represent discrete implementable options. Instead, they acted as a structured device to explore the range of plausible futures, enabling stakeholders and clinicians to consider different balances of local provision, centralisation, integration and community-based care.

The scenarios set out with the intention to seek views about the advantages, disadvantages and how the scenarios could or would affect different people based on a range of factors. These factors were age, carer responsibilities, deprivation, disability, gender reassignment, marriage and civil partnership, race, religion & belief, sex, sexual orientation, and Welsh language. People were also asked if there were any other scenarios we needed to consider, as part of this work. It was emphasised that the scenarios do not all have to happen separately and that some could occur together.

Feedback on these scenarios was used to:

- identify common "desirable characteristics" of future services;
- test appetite for degrees of change and consolidation; and
- inform refinement, consolidation and removal of ideas during progression from the long list to the shortlist.

Section 4.3.2 describes how the insights and evidence base gathered in Stage 2 engagement were considered and reflected on by the ODG members and service area task and finish groups throughout the development of the options.

A summary of the Stage 2 Engagement approach is provided below:

- A public survey received 164 responses via online, paper and Easy Read formats, with feedback from Powys residents, health professionals and local organisations, and responses mapped by Primary Care Cluster locality.
- Public focus groups were delivered through five face-to-face community workshops (38 participants) and one online workshop (6 participants), alongside three staff focus groups (two face-to-face with 37 participants and one online with 60 participants), independently facilitated by Practice Solutions Ltd.
- Public drop-in sessions were held in five towns (Brecon, Welshpool, Ystradgynlais, Llandrindod Wells and Newtown), supplemented by attendance at a joint event in Machynlleth, capturing views from approximately 60 residents in total.
- Additional community outreach activity was undertaken by the Engagement Team to capture views from residents less likely to attend formal workshops or drop-ins.
- Targeted specialist and clinical engagement took place with clinical, medical and service management staff, Primary Care, Powys County Council and PAVO to explore emerging adult physical and mental health community models.
- Staff engagement reached 375 staff in person across multiple sites, with further information shared with 518 staff, ensuring broad representation across clinical and nonclinical roles and staff bands.

4.2.3 Primary Care Workshop (GMS Focus)

A Primary Care-focused workshop event was held on 17th June 2025. Participants' views were sought to gain a Primary Care perspective with a specific focus on General Medical Services (GMS). The event was facilitated by PTHB Directors and staff. It included 29 participants from within PTHB, Primary Care representatives from General Practice, Pharmacy and Dentistry and other partners. The aim of this session was to share and discuss the system models of care and the six scenarios for how future services could be provided for adult physical and mental health community services and to seek feedback from stakeholders as part of the Stage 2 engagement process. The outputs of this session reinforced the need for integrated, proactive, and locally responsive models of care in Powys. Attendees consistently called for better communication, smarter use of resources, and more equitable service delivery. The suggestions — ranging from virtual wards to place-based teams — were used for the refinement and further development of options.

4.2.4 Long List Ideas Review

Following the assimilation of ideas from Stage 1 engagement including clinical and professional workshops and the deliberative event, a long list of ideas was shared and reviewed by ODG members during a workshop on the 24th of June 2025. All the information was considered and debated in relation how the proposed ideas would best respond to the Case for Change and service issues. There were 68 ideas developed from the stakeholder events held in May 2025 and June 2025 (described in **section 4.1.2**). The purpose of the workshop was to review and refine the long list of ideas to create a series of potential options. Each idea was evaluated and categorised into a group of similar nature, value and outcome – enabling, service improvement or system transformation. These ideas were then further assessed and a decision made as to whether they would be taken forward onto the long list along with any supporting rationale. During these discussions there was a strong shift in conversation between ODG members to focus more on 'how' and 'where' services could be delivered in future. There was recognition that whilst the enabling and service improvement actions would help to deliver benefits to patients and staff, they did not go far enough in relation to the scale of change needed to address the current issues and to improve quality of care and make better use of resources.

This discussion led to the generation of the long list of options for 'how' and 'where' services could be provided in future. It included options which would enhance services and alleviate system pressure, for example the development of urgent care centres. As well as opportunities to consolidate services to improve standards and address workforce fragilities, for example the consolidation of mental health inpatient services on to fewer sites. Focused discussions took place about how people could be supported to remain at home and return home from hospital more quickly through the strengthening of community-based services, and how inpatient services could be consolidated onto fewer sites to improve workforce resilience, patient flow and reduce extended length of stay and patient deconditioning. The potential to consolidate inpatient services onto fewer sites also led to discussions about re-investment of financial savings into the adult community model.

Of the 68 ideas, 54 were agreed to progress to the Long List of Options, and they were grouped under the following service areas:

- 9 for Urgent Care Services
- 11 for Adult Community Model

- 10 for Adult Mental Health Services
- 10 for Diagnostics
- 14 for Adult Physical Health Inpatient Services

The options development methodology was agreed by ODG members on the 24th of June 2025. - This enabled a consistent and objective approach and outlined detailed requirements for each service area to produce an issues template with underpinning evidence base and to complete a long list option template detailing information on the option. This would provide sufficient information on the long list option for it to be reviewed and considered against the hurdle criteria by ODG members during Step 3 and 4. It was also agreed that service level models of care would be developed to provide detailed and evidenced based service requirements as a blueprint for the future model and basis on which to assess future options. The service models of care were developed with internal and external professional and clinical input and oversight and were approved through the relevant Programme Boards (Mental Health Service Model of Care was approved on 31st December 2025 and the Physical Health Inpatients, Community Model and Urgent Care Service Models of Care were approved on 8th October 2025).

The Clinical Reference Group were asked to review and provide feedback on the long list of options which was considered and incorporated into the development process.

4.2.5 Progression to Step 3

The following outputs from Step 2 enabled progression to step 3:

- System Models of Care reviewed and tested
- 54 Long List of options
- Service issues templates
- Service models of care
- Long list option templates completed
- Published Stage 0-2 Engagement Briefing

4.3 Step 3 and 4 – Review and Refinement of Options and Development of Short List Options

Step 3 and 4 focused on gathering additional information and refining the options. Stage 2 Engagement finished during this step. Each of the long list of options were assessed against the agreed hurdle criteria and either discounted or carried forward onto the short list. The short list options were then further developed including the development of workforce, financial and estate assessments.

4.3.1 Short List Options Development Week

The refinement of the long list of options into short list of options was facilitated through a collaborative, cross system working group during options development week referred to as the 'lock-in week,' which took place from 14th – 18th July 2025. This approach brought clinical and professional stakeholders together in a single location for the duration of the week to enable a structured, in-depth consideration and development of the shortlisted options. Participants included corporate operational and professional representatives, operational management and clinical leads, and colleagues from Planning, Workforce, Finance, Digital supported by the Improvement and

Transformation Team. The week concluded with formal feedback to Clinical and Operational Executive Directors, alongside an update session with Powys County Council and PAVO strategic leads to share the outputs from the week and to identify areas of alignment and joint opportunity.

The purpose of the week was to:

1. To assess the long list of delivery options against hurdle criteria to identify short listed options.
2. To develop short listed options into detailed options gathering information to confirm workforce and finance implications - responding to queries / actions to support updating of demand and capacity modelling.
3. In line with above, further gather information to support options development.
4. Agree priority areas for integration of physical and mental health, and agree common language / definitions for service areas to support understanding and wider communication.
5. To ensure inter-dependencies between options were understood and aligned, and identify wider inter-dependencies with partners.
6. Agree plan and deliverables for the following 8 weeks via Task and Finish groups.
7. Agree updates to master messaging and engagement with adult physical and mental health services.
8. Completion of Level 1 Impact Assessments for all short-listed options.
9. Development of workforce requirements for each option, with financial rigour applied.

During the week, the long-listed options for mental health, physical health, urgent care, community care and diagnostics were further developed, refined and then assessed against the agreed Hurdle Criteria by clinical, operational and professional colleagues to test strategic alignment with the Health and Care Strategy and Case for Change, clinical viability, deliverability and sustainability. It was agreed, at this stage, the Community Model options were not viable stand-alone options and therefore would be integrated with and hurdled through the Physical Health Options.

Options were refined and where appropriate discounted if they did not meet the agreed hurdle criteria. A clear rationale was required to support options being taken forward or discounted to ensure objectivity and consistency in approach. This process was facilitated and designed to maintain openness and transparency of decision-making. Each option was discussed and reviewed systematically with clinical and professional teams, who had the opportunity to validate and test their understanding of each of the options, and to challenge each other's views during the facilitated discussion before a conclusion and rationale was recorded.

The 'do previous' and 'do nothing' options did not meet the essential hurdle criteria but were taken forward as baseline comparisons so that people would be able to understand how the various options being proposed would differ from the current situation and pre-temporary service changes. It was also agreed that some of the do minimum options should be taken forward and further developed as transition options, whilst these options did not fully meet the hurdle criteria but were assessed as a potential shorter-term step warranting further exploration and testing to understand deliverability and impact.

Across all programmes, a total of 81 options were subject to Hurdle Criteria assessment. Those assessed as sufficiently viable progressed to further scrutiny, including consideration of clinical safety and quality, workforce sustainability, financial affordability and estates feasibility. Options representing minor variations or duplicative models were rationalised through this triangulated review. **Appendix L** provides the long list of options which were discounted.

The table below provides a summary of all the options

Figure 11: Long list to short list hurdling

Programme	Long list options assessed (Hurdle Criteria)	Options short-listed after hurdling	Long List Options discounted (see appendix
All programmes (total)	**81**	**38**	**43**
Mental Health	26	11	15
Physical Health	21	9	12
Urgent Care *	20	11	9
Diagnostics * *	14	7	7

* This includes three additional options that were developed in January 2026 following Executive's Check and Challenge session on 10th November 2025. There were 17 urgent care options taken through Hurdle Criteria during Lock-in Week, with 8 short-listed after hurdling and 9 options discounted.

* * Diagnostics and imaging were aligned within the original eight agreed urgent care shortlisted options to support configuration and alignment of services.

Further information was gathered during options development week to ensure robust evidenced based short-listed options. Demand and capacity modelling, activity, performance and finance data was gathered and analysed to inform workforce models for each option. Level 1 Impact Assessments were undertaken on all options that passed the Hurdle Criteria (**appendix M**).

At the end of each day each service group provided an update on their progress, and the wider ODG plus other participants provided feedback. At the end of the options development week there was a presentation to the Clinical Executives as part of the check and challenge, the group shared which options had been 'hurdled out' and discounted and which options were being carried forward as short-listed options for further development.

A breakdown of how the options were hurdled is provided below for each service area:

Mental Health

In total, 26 options were assessed and 11 options were agreed to be progressedas sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical viability, workforce sustainability, financial affordability and estates feasibility, and the removal of duplicative or marginally different variants, resulted in eight distinct, credible and deliverable options being agreed for the final shortlist.

Below is a list of themes on why some options were not progressed to the short list, due to not meeting the essential hurdle criteria:

- **Patient safety and quality standards:** Options were discounted where they could not reliably meet clinical/quality standards (for example, having the right environment, staffing levels and specialist input to deliver safe care).
- **Workforce sustainability** and ability to recruit/retain: Options were not progressed where there were significant staffing challenges or where service models would be difficult to staff safely now and into the future.
- **Strategic fit and alignment with national future models of care**: Options were discounted where they did not align with the Health and Care Strategy development of Rural Regional Centres or national direction of for modern mental health services.
- **Integration with community services and prevention/earlier intervention**: Options were not progressed where they did not create opportunities to strengthen community-based support, improve prevention and early help, or work more closely with physical health services.
- **Equity of access and travel impact across Powys**: Options were discounted where location or travel distance would disadvantage a larger proportion of the population, particularly where this could increase inequality of access.
- **Financial viability and value for money**: Options were not progressed where they were judged not to be financially viable or would not provide sufficient benefit relative to cost and risk.
- **Duplication or being better handled as a component within other options**: Some ideas for example, sanctuary and step-down approaches or gender-specific provision were not progressed as stand-alone options because they needed to be designed into other options to meet standards and deliver a coherent service model.

Physical Health

In total, 21 options were assessed 9 options were progressed as sufficiently viable to warrant further scrutiny. Subsequent triangulation of clinical feasibility, workforce sustainability, financial affordability and estates implications, and the removal of options representing minor variations, resulted in eight distinct, credible and deliverable options being agreed for the final shortlist.

Below is a list of themes on why some options were not progressed to the short list, due to not meeting the essential hurdle criteria:

- **Affordability and value for money –** options were not progressed where there was confidence there would be an increase in costs; they would worsen existing overspends or not represent an efficient use of available funding.
- **Workforce and resource efficiency –** options were not progressed where they did not make best use of staff capacity or would be difficult to staff sustainably.
- **Estate and infrastructure sustainability –** options were not progressed where the underlying model relies on an ageing or unsuitable estate.
- **Clinical safety, quality and standards –** options were not progressed where they would not meet expected clinical standards, or where quality and safety benefits could not be demonstrated.

- **Operational deliverability and evidence base –** options were not progressed where they were judged not to be practically deliverable (for example, spreading a smaller bed base across too many sites) or not supported by evidence.
- **Duplication or being better handled as a component within other options**: Some ideas were not progressed where they were absorbed into another option, duplicated another proposal (e.g., a bed type within a wider model).
- **Strategic fit and alignment with national future models of care**: Options were not progressed where they did not align with the Health and Care Strategy development of Rural Regional Centres or national direction, this included discounting of options where moving provision outside the area reduced local control over service quality, performance and expenditure.

Urgent Care

In total, 17 options were assessed5 options were progressed as sufficiently viable to warrant further consideration, during the Lock-in Week. Subsequent triangulation of clinical appropriateness, workforce sustainability, financial affordability and estates feasibility, and the identification of options that represented minor variations, led to discussions about aligning diagnostics and imaging within the 5 agreed urgent care shortlisted options, with diagnostics embedded as enabling components of those models. This approach reflects that the scope of this work considered only a limited element of diagnostics, with the comprehensive review of diagnostics planned as part of Phase 2 (Diagnostics and Planned Care) within the Better Together Portfolio.

(Note: Following Portfolio Board on 10th September 2025 an additional Urgent Care option was explored, meaning 6 options would be taken through non-financial options appraisal workshop on 11th September 2025. Following Executive's Check and Challenge session on 10th November 2025, additional options for urgent care were requested to be explored, bringing the total of options hurdled to 20, with 11 being taken through a further non-financial options appraisal workshop in April 2026 - reference **section 4.3.2**).

Below is a list of themes on why some options were not progressed to the short list, due to not meeting the essential hurdle criteria:

- **Does not address the case for change or meet future population needs:** options that largely maintained the existing model were not progressed because they would not resolve the key issues identified (e.g., future demand and service sustainability).
- **Insufficient activity/need to justify the number of centres:** options proposing provision across multiple sites were discounted where population needs, activity levels and travel-time considerations suggested that the service might not be sustainable and or would dilute clinical experience.
- **Ability to meet standards and provide safe, high-quality care:** options were not progressed where it was uncertain if they would consistently meet expected clinical standards, provide timely care, or maintain safe staffing/skill mix across all sites.
- **Workforce deliverability constraints:** some options were discounted because they would be difficult to staff sustainably (recruitment/retention, rota resilience, and reliance on scarce roles) or because they did not sufficiently reduce known workforce pressures.

- **Affordability and financial viability:** options were not progressed where costs, savings or overall financial viability needed further testing, or where there was insufficient evidence that the option would be affordable and sustainable.
- **Duplication / not a distinct option:** options were removed where they duplicated another option, or were later recognised as not independent (i.e., they described a variation or component of another option).

Diagnostics

In total, 14 options were assessed, 7 options were progressedas sufficiently viable to warrant further consideration. Subsequent triangulation of clinical appropriateness, workforce sustainability, financial affordability and estates feasibility, and the identification of options that represented minor variations, led to the discussion about to align diagnostics and imaging within the 5 agreed urgent care shortlisted options, with diagnostics embedded as enabling components of those models.

Below is a list of themes on why some options were not progressed to the short list, due to not meeting the essential hurdle criteria:

- **Affordability and financial deliverability**: options were not progressed where the costs could not be supported or did not represent value for money within the agreed financial envelope (e.g., proposals requiring additional equipment and supporting ongoing staffing that were not financially viable).
- **Not a standalone option (best delivered as part of another option)**: options were not progressed where they were components, enablers, or variants of a broader model already being taken forward (e.g., DEXA and point-of-care testing developments incorporated within a wider diagnostic option).

4.3.2 Refinement of short list options

After the options development week, the short-listed options were further refined iteratively following:

- Analysis of the draft stage 2 engagement outputs
- Sharing and testing of the options internally with some key stakeholders including partners.

A summary of the analysis of the draft stage 2 engagement outputs is as follows:

- Engagement feedback consistently indicated that “no change” or minor change options were not viable, reinforcing the need for substantial service transformation.
- Strong support emerged for strengthening care closer to home, influencing the prioritisation of community-based models linked to the inpatient bed base options
- Mental health services, transport and accessibility, primary care capacity, workforce sustainability, and social care and isolation emerged as dominant themes and were used to shape option design and mitigation considerations.
- Scenario testing showed support for more ambitious options (Scenarios 3 and 4), cautious interest in centres of excellence (with location concerns) and limited support for a shift to complete out-of-county provision of community inpatient beds.
- Targeted clinical engagement provided assurance that emerging options were clinically credible, deliverable and aligned to emerging models of care, while staff engagement

highlighted workforce and operational implications to be addressed through options refinement.

To address some of the stakeholder feedback and ensure better management of the inter-dependencies between the service options, it was proposed to combine some of service area options. The following was agreed with ODG (23rd July 2025)

- **Community Model options** would be aligned within Adult Physical and Mental Health Inpatient options to ensure integrated physical and mental health pathways.
- **Diagnostics options** would be aligned to Urgent Care, recognising that a full diagnostics review would be undertaken in Phase 2 under Diagnostics and Planned Care.

Technical work during lock, as well as testing and feedback, was led by clinical and professional teams in the Health Board and supported by independent experts. To ensure appropriate and robust stakeholder input and testing of the acceptability of the short-listed options, a second deliberative event was arranged. The stakeholder feedback from Stage 2 and the emerging short-listed options were then approved for sharing at a wider Deliberative event for further input and refinement.

4.3.3 Second Deliberative Event

A second Deliberative Event took place in person on 13th August 2025, full details of the session and outputs can be found in the report at **appendix D**

77 delegates were in attendance from the following stakeholder groups

- Llais
- Service Users
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations

The objectives for Deliberative Event 2 were to:

1. Provide the headline feedback on Stage 2 public, staff and stakeholder engagement activity
2. Inform and confirm, through delegate feedback, the revision of the long list of options to support the development of a short list of options
3. Invite further discussion and feedback on the identified shortlisted options
4. Share updates to the design, planning and assessment criteria, which we are using to inform how we make decisions.

Workshop exercises enabled delegates to review the draft models of care, test emerging short list options for adult physical and mental health community services and provide feedback on the assessment and evaluation criteria through facilitated table- and room-based discussions. Outputs were synthesised and reported back in plenary by Executive Directors acting as Room Chairs, with quality assurance checks undertaken by the Engagement Team on the day and final thematic verification completed by the Transformation & Value Team. Feedback was cross-referenced against

the shortlisted options to confirm completeness and alignment, with no material gaps identified and no requirement for additional options or fundamental changes to the shortlist.

Engagement consistently reinforced the Case for Change, highlighting challenges around fragmented service delivery, access and equity in a rural context, workforce sustainability, data maturity and integration of physical and mental health services, alongside strong support for integrated, person-centred, place-based models, care closer to home, improved digital enablement and strengthened partnership working. Overall, the event provided assurance that the shortlisted options remained robust, reflected stakeholder priorities, and aligned with recurring themes from earlier engagement, including a clear preference for transformational change consistent with the more integrated, community focused scenarios emerging from Stage 2 engagement.

The short-listed options were 'approved for progression' to the next step at the Frailty and Community Programme Board on 15th August 2025 and Mental Health Programme Board on 21st August 2025. This included the reduction to the 3 service areas and amalgamation of options (described above) results in 17 short listed options across the three service areas which ensured coherence across service areas and avoided duplication:

Figure 12: Adult Physical Health, including community – Five short listed options

Option number	Description
SL IPDO_001a	Do Previous: Put current hospital and community health services back to how they were
SL IPDO_001b	Do Current: Keep current hospital and community health services as they are now
SL IPDO_002b	Do Minimum: hospital bed numbers in Powys would remain the same (approx. 144 beds) but they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.
SL IPDO_005b	Do Mid-Range: There would be fewer hospital beds (approx. 90-100 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health. This option is the same as the previous one, but with closer working between mental health & physical health services
SL IPDO_008	Do maximum: There would be fewer hospital beds (fewer than 90 beds) in Powys than there are now, and they would be moved to fewer places to improve the quality of care. There would be more support to help people stay and recover at home, and closer working between mental and physical health.

Figure 13: Urgent Care Centres including Diagnostics – Four short listed options

Option number	Description
SL UCDO_001A	Do Previous: Put current hospital urgent care services back to how they were
SL UCDO_001B	Do Current: Keep current hospital and community health services as they are now
SL UCDO_013	Do Maximum: Even better local Urgent Care (2 x UCCs and 1 x MIIU in Powys)
SL UCDO_013ii	Do Maximum: Even better local Urgent Care on less sites (2 x UCCs)

Figure 14: Adult Mental Health, including older adult community - 8 short listed options

Option number	Description
SL MHDO02_001a	Do Previous: Put current hospital and community health services back to how they were
SL MHDO02_001b	Do Current: Keep current hospital and community health services as they are now
SL MHDO_003a	Do Minimum: Move older adult mental health functional inpatient services to Bronllys, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services
SL MHDO_004a	Do Mid-Range: Move mental health functional inpatient services to Brecon, with organic inpatient services provided at one site, maintain commissioning of out of area and integrate Older Adult Mental Health community services
SL MHDO_006a	Do Maximum: Move all functional and organic mental health inpatient services to Bronllys Hospital, bring back out of area patients to Powys, create community offer with physical health to meet holistic needs and provide focus on prevention, rapid response and early intervention
SL MHDO_007a	Do Maximum: Move all functional and organic mental health inpatient services to Brecon Hospital, bring back out of area patients to Powys, create community offer with physical health to meet holistic needs and provide focus on prevention, rapid response and early intervention
SL MHDO_008a	Do Maximum: Move all functional and organic mental health inpatient services to Newtown Hospital, bring back out of area patients to Powys, create community offer with physical health to meet holistic needs and provide focus on prevention, rapid response and early intervention
SL MHDO_010a	Do Maximum: Move all functional and organic mental health inpatient services to Brecon Hospital and Newtown Hospital, bring back out of area patients to Powys, create community offer with physical health to meet holistic needs and provide focus on prevention, rapid response and early intervention

Task and Finish Groups were established for each service group to progress the actions required to refine the short-listed options. These groups were chaired by the Senior Responsible Officers or Clinical Leads for the relevant programme or service area with support from clinical and operational leads, senior leads from corporate functions (WOD, Finance) and Improvement & Transformation team support. The work undertaken in the Task and Finish groups included

- Gathering of evidence base to underpin service level issues and models of care
- Detailed workforce modelling on the short-listed options
- Detailed financial modelling on the short-listed options
- Refinement and finalisation of Demand & Capacity Modelling for each service area
- SWOT analysis (**appendix V**)
- Completion of Level 2 Impact Assessments (**appendix Z.2**)
- Patient Pathway testing (**appendix T**)
- Travel Time analysis (**appendix W**)

4.3.4 Short List - Further Check and Challenge

Primary Care (GMS-Focused) Engagement Session – 4th September 2025

A Primary Care (GMS-focused) engagement session was held on 4 September 2025, attended by 34 delegates from PTHB, Primary Care and PAVO. This session formed part of the programme's ongoing engagement and assurance approach, providing a mechanism to validate progress, test emerging proposals, and ensure continuing alignment with the Case for Change. The session:

- provided a structured recap of feedback captured at the June workshop and set out progress on the development of adult physical and mental health community services, including the planned next steps;
- presented the emerging models of care, including how these were being tested through patient pathway work to assess feasibility and intended outcomes; and
- enabled discussion of the short-listed options identified for this phase, supporting transparency and early challenge from Primary Care and partners.

Clinical Reference Group (CRG) Check and Challenge – 5th September 2025

To strengthen clinical assurance and provide independent clinical scrutiny, the Clinical Reference Group (CRG) and wider senior organisational clinical representation was invited to a virtual Check and Challenge session on 5 September 2025, facilitated with participation from Senior Responsible Officers (SROs), Clinical Service Leads, and the Transformation and Value Team. In advance, CRG members were briefed that the purpose of the session was to apply their clinical expertise and experience to review, test and challenge whether the draft shortlisted options met the agreed Hurdle Criteria, ahead of the appraisal process and prior to public consultation.

To support objectivity, invitees were asked to undertake the review from the perspective of clinical professional judgement, rather than their current organisational role, and were advised that participation was voluntary, with the option to decline via line management if required.

The session sought a clear assurance judgement against the question:

"In your professional opinion, do the shortlisted options meet the Hurdle Criteria as set out in the information pack?"

The outputs, including key points of challenge and resulting actions/considerations, are captured in the session report (**appendix N**), providing an auditable record of clinical scrutiny undertaken as part of the options development and assurance process. As a result of this check and challenge option SL_MHDO 02_014 Remove all Mental Health Hospital beds was removed as the group felt confident this option did not meet the hurdle criteria and was not financially sustainable and would be detrimental to delivery of high-quality patient care.

4.3.5 Progression to Step 5

The following outputs from Step 4 enabled progression to Step 5:

- Documented long list of options and short list process, approved by ODG and assured via Clinical Reference Group
- Hurdling of the long list of options with clear rationale
- Development of short-listed options
- Demand and capacity modelling interim reports
- Outline Workforce, finance and estate assessments
- Service Issue templates and Service Level Models
- SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis
- Travel time analysis
- Level 1 Impact Assessments
- Final sign off Stage 0-2 Engagement Report

4.4 Step 5 – Score Short List of Options

Step 5 included a non-financial appraisal of the shortlisted options and further technical work including more detailed workforce, finance and estate assessments. There was additional scrutiny arrangements put in place to ensure validation and assurance for the demand and capacity modelling, workforce and financial appraisals.

4.4.1 Non-Financial Options Appraisal – Physical Health, Mental Health and Urgent Care

A non-financial options appraisal workshop was held on 11th September 2025, with membership made up of stakeholders across PTHB professionals and external stakeholders from clinical and professional backgrounds. The purpose of the workshop was to appraise the short-listed options for Phase 1. The intended outcome was to apply further rigour to the assessment process, using the expertise of attendees to provide a higher level of confidence in the options in forming recommendations to the Executive Committee and Board for public consultation.

Stakeholders included Clinical and Operational Executive Directors, Corporate operational and professional representatives, operational management and clinical leads, colleagues from Planning, Workforce, Finance, Digital, Performance, Primary Care, Powys County Council, PAVO, and external professionals to provide a level of independence. A comprehensive list of attendees is available in the full report (**appendix Y**). It did not include the public, community groups or service user representation due to the complexity of the technical information being shared and stakeholder engagement undertaken earlier in the process. Llais was invited to attend in an observer capacity but

declined. The event was supported by the Improvement and Transformation, Organisational Development, Information and Communication and Engagement teams.

Appraisers (25 in total) were asked to draw upon their clinical and/or professional expertise and experience to appraise the short-listed options, and informed this was an essential part of preparing for **Stage 3**, Public Consultation.

Supporting information was issued to appraisers in advance of the workshop, including:

- Better Together Case for Change
- Thematic technical chapters
- Programme ambitions
- System and service models of care

Delegate packs provided on the day included:

- System models of care
- Shortlisted options
- Assessment criteria and scoring framework
- Summary information from Level 2 Integrated Impact Assessments
- Travel Time Analysis
- SWOT analysis

A panel consisting of clinical and operational leads presented the scope, issues and options for their service area. Other panel members included Executive Director leads for Planning, Performance and Commissioning, Public Health, Primary Care, Community Services and Mental Health, and the Executive Medical Director. The Deputy Director of Engagement, Communication and Corporate Services and the Assistant Director of Quality & Safety were also in attendance as panel members. All panel members were available during the appraisal process to provide further detail and answer queries.

All scores were obtained digitally and updated into a spreadsheet, aligned to each appraiser, for every option, with high-level feedback given at the end of the session. The Transformation & Value Team managed the inputting of scores. Scoring was undertaken using an agreed scoring framework and the NHS Wales STEEEP six domains of quality as assessment criteria (see **section 3.3**). Sensitivity analysis was applied to test the scoring of each option through equal weighting, reverse weighting, clinical focus, patient focus weighting.

A summary of the non-financial appraisal scoring is provided below, full details are provided in the full report.

MENTAL HEALTH

Figure 15: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL MHDO02_001a	Do previous – before temporary services change	45.0	48.0	45.0	47.0	50.0	49.0	284.0	8	13.50	7.20	6.75	9.40	5.00	4.90	46.75	8
SL MHDO02_001b	Do current – no transformational change	45.0	47.0	49.0	45.0	48.0	52.0	286.0	7	13.50	7.05	7.35	9.00	4.80	5.20	46.90	7
SL MHDO_003a	Functional beds to Bronllys and integrated OAMH	71.0	64.0	72.0	70.0	52.0	62.0	391.0	6	21.30	9.60	10.80	14.00	5.20	6.20	67.10	6
SL MHDO_004a	Functional beds to Brecon and integrated OAMH	78.0	66.0	74.0	71.0	56.0	64.0	409.0	5	23.40	9.90	11.10	14.20	5.60	6.40	70.60	5
SL MHDO_006a	All beds to Bronllys and integrated OAMH community	98.0	87.0	95.0	95.0	73.0	77.0	525.0	3	29.40	13.05	14.25	19.00	7.30	7.70	90.70	3
SL MHDO_007a	All beds to Brecon and integrated OAMH community	100.0	86.0	98.0	90.0	74.0	87.0	535.0	2	30.00	12.90	14.70	18.00	7.40	8.70	91.70	2
SL MHDO_008a	All beds to Newtown or Welshpool and integrated	82.0	84.0	84.0	80.0	72.0	76.0	478.0	4	24.60	12.60	12.60	16.00	7.20	7.60	80.60	4
SL MHDO_0010a	All beds to Brecon and Newtown and integrated	110.0	108.0	108.0	99.0	111.0	109.0	645.0	1	33.00	16.20	16.20	19.80	11.10	10.90	107.20	1

In Summary:

- The highest scoring option was “Do Maximum” (SL MHDO_0010a).
- Excluding “do nothing,” “Do Minimum” (SL MHDO_003a) scored lowest.
- The “do current” option scored marginally higher than “do previous.”

URGENT CARE CENTRE (inc. DIAGNOSTICS)

Figure 16: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SLUCDO 001a	Do previous – before temporary services change	51.0	56.0	45.0	45.0	51.0	59.0	307.0	5	15.300	8.40	6.75	9.00	5.10	5.90	50.45	5
SLUCDO 001b	Do current – continue as now making temporary service	54.0	54.0	52.0	52.0	54.0	52.0	318.0	4	16.20	8.10	7.80	10.40	5.40	5.20	53.10	4
SLUCDO 001c	Do minimum – enhance existing MIU on fewer sites	67.0	67.0	63.0	63.0	62.0	64.0	386.0	3	20.10	10.05	9.45	12.60	6.20	6.40	64.80	3
SL UCDO_005	Close minor injury units and provide urgent care in other	51.0	47.0	48.0	48.0	56.0	52.0	302.0	6	15.30	7.05	7.20	9.60	5.60	5.20	49.95	6
SL UCDO_010	Better local urgent care (3 x minor injury & illness units in	85.0	81.0	81.0	76.0	80.0	80.0	483.0	2	25.50	12.15	12.15	15.20	8.00	8.00	81.00	2
SL UCDO_013	Even better local Urgent Care (2 x Urgent Care Centres and 1 x MIIU in Powys)	88.0	91.0	92.0	90.0	83.0	91.0	535.0	1	26.40	13.65	13.80	18.00	8.30	9.10	89.25	1

Note further non-financial appraisal workshop for urgent care options detailed in **section 4.4.6**).

In Summary:

- “Do Maximum” – enhanced local urgent care model (SL UCDO_013) scored highest.
- Excluding “do nothing,” SL UCDO_005 scored lowest.
- “Do current” scored higher than “do previous.”

PHYSICAL HEALTH INPATIENTS AND COMMUNITY SERVICES

Figure 17: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

		Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
		Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total unweighted	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL IPDO_001a	Put current hospital and community health services back to how they were pre	35.0	40.0	36.0	34.0	46.0	44.0	235.0	8	10.50	6.00	5.40	6.80	4.60	4.40	37.70	8
SL IPDO_001b	Keep current hospital and community health services as	49.0	47.0	49.0	48.0	49.0	50.0	292.0	7	14.70	7.05	7.35	9.60	4.90	5.00	48.60	7
SL IPDO_011	Remove physical Health	50.0	50.0	54.0	52.0	58.0	58.0	322.0	6	15.00	7.50	8.10	10.40	5.80	5.80	52.60	6
SL IPDO_002a	Same number beds on six sits and better Physical Health	72.0	70.0	65.0	66.0	70.0	69.0	412.0	5	21.60	10.50	9.75	13.20	7.00	6.90	68.95	5
SL IPDO_002b	Same number beds on six sits and better Physical Health Community and Mental Health	73.0	72.0	73.0	70.0	72.0	77.0	437.0	4	21.90	10.80	10.95	14.00	7.20	7.70	72.55	4
SL IPDO_005a	Few beds on three sites and better physical health	89.0	86.0	86.0	85.0	81.0	87.0	514.0	2	26.70	12.90	12.90	17.00	8.10	8.70	86.30	2
SL IPDO_005b	Fewer beds on three sites and better physical health community and mental health	89.0	87.0	89.0	88.0	82.0	90.0	525.0	1	26.70	13.05	13.35	17.60	8.20	9.00	87.90	1
SL IPDO_008	Even fewer beds on three sites and better physical health community and mental health	75.0	73.0	79.0	85.0	73.0	83.0	468.0	3	22.50	10.95	11.85	17.00	7.30	8.30	77.90	3

In Summary:

- "Do Mid-Range" (SL IPDO_005b) ranked highest.
- Excluding "do nothing," remove all physical health beds from Powys (SL IPDO_011) ranked lowest.
- Both "do nothing" options ranked lowest overall, with "do current" scoring higher than "do previous."

To conclude the analysis of stakeholder scoring demonstrated a high degree of correlation across the six STEEEP domains, indicating that stakeholders tended to assess options consistently across criteria. Correlation and sensitivity analysis confirmed that option rankings remained stable under different weighting scenarios, with no single criterion disproportionately influencing outcomes and the relative positioning of options remaining robust to changes in weighting assumptions. As the appraisal reflected the professional judgement of those present, the results are intended to be indicative and to inform further appraisal, engagement and consultation, rather than to constitute a final decision- making tool.

Across all service areas, scoring showed limited differentiation between shortlisted options. This reflects the similarities between models that had already progressed through multiple stages of screening, refinement and assurance, and which shared common enabling components and system interdependencies. The absence of significant separation between options should therefore not be interpreted as a weakness in the appraisal process.

The nonfinancial appraisal forms part of a wider, staged options development and assurance framework aligned with NHS Wales planning guidance and quality standards, and informed by engagement, clinical scrutiny and multiagency collaboration. Within this context, scoring was used to structure discussion, illuminate trade-offs and support professional judgement, rather than to produce a definitive or mechanistic ranking of options.

To support with evaluation and future event planning an optional anonymous survey was given to appraisers at the end of the workshop. Of 25 appraisers, 22 responses were received.

An Options Appraisal Workshop Summary Report was produced and received by the Better Together Portfolio Board on 16th September 2025 and Executive Committee on 17th September 2025. This included event evaluation feedback from participants. Additional sensitivity analysis was requested

which was incorporated into the final version of the report (**appendix Y**) strengthening assurance in the appraisal process.

4.4.2 Further Technical Development of Options

As described in **Section 5.4**, the Task and Finish Groups ran concurrently from the end of Step 3 and 4 through to Step 5, and the groups continued to report to the ODG and onwards into the relevant programme board. The following technical work was overseen and finalised by these groups during this period:

Detailed workforce modelling
Workforce models were developed and agreed for each shortlisted option with documented assumptions. These are based on Year 0 demand and have been reviewed by Senior Workforce leads who have provided additional support to strengthen the evidence base, benchmarking and assumptions where required.

Agreement of the baseline establishment for mental health medical and ward staffing was a key requirement which was not concluded until after later in Step 5 resulting in a delay to the mental health options recommendation workshop being conducted as described in Step 6.

Detailed financial appraisals
Financial modelling was developed iteratively and refined as the workforce models, demand and capacity analysis, and associated assumptions, were progressed and finalised, ensuring alignment with the refinement of options. Financial appraisals were developed and agreed for each shortlisted option with documented assumptions. This included financial modelling which was based on demand & capacity modelling assumptions, workforce models and commissioning assumptions. Finance leads worked collaboratively with SROs to update and finalise the financial modelling and to strengthen financial assumptions in line with the demand & capacity modelling outputs. The financial appraisal methodology is set out in **Section 3**. All options have been based on Year 0 costs for simplicity. However, each of the option short list options have been assessed by ODG members in their ability to meet future demand and population needs. A full economic and financial appraisal of all the options will be undertaken as part of the final Programme Business Case.

Estates Assessment
Estates assessments were undertaken for each shortlisted option lead by the Estates team in collaboration with SROs, clinical and operational leads. This provided an outline assessment of the estate implications for each of the short-listed options assessing and RAG rating the funding value banding i.e. less than £5m and the feasibility with supporting narrative (ADD link). Feasibility and capital assessments have not been undertaken for the purposes of consultation; these will be conducted following the consultation process when a final decision is reached as part of the final Programme Business Case – this will include a full economic and financial appraisal of the options.

Refinement and finalisation of Demand & Capacity Modelling
Further refinement and finalisation of demand & capacity modelling was overseen across the 3 service areas via the Task & Finish Groups working directly with the external consultant (Adcuris Ltd) to strengthen assumptions in line with the evidence base, local and independent clinical opinion, patient pathway testing outputs and feedback following review by Professor Anne Hendry and Dr Naeem Aziz as external clinical scrutiny.

The demand and capacity modelling has tested the impact of potential scenarios i.e. do nothing, mid-range realistic and achievable and aspirational ambitious and longer term. This have been aligned to the short-listed options to show future demand projections and have been considered as part of the workforce and financial modelling.

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

Patient Pathway Testing
Patient pathway testing was undertaken through two phases with the intention of testing and validating proposed models of care underpinning the shortlisted options with real patient scenarios.

Phase 1 was delivered through a day of care survey across all PTHB Community Hospital wards undertaken by Professor Anne Hendry and a series of retrospective patient case reviews undertaken by a PTHB GP with Extended Role in Frailty and a GP working in North Powys delivering primary care GMS services. Additional patient pathway testing for Mental Health was undertaken within the service area. Reports for Phase 1 Patient Pathway testing are at **appendix T**.

Phase 2 was delivered through a prospective week of care survey of Emergency Admissions for people aged 65+ to Wye Valley Trust in November 2025. Key stakeholders including Wye Valley Trust, Adult Social Care and Third Sector clinical and operational leads supported this survey and subsequent workshop session to explore the survey results and develop an action plan which was led by Professor Anne Hendry and the PTHB Urgent Care Transformation Lead. Using these outputs, an accelerated learning event was delivered in the North of the county with stakeholders including Shrewsbury and Telford Hospital NHS Trust (SATH) and Shropshire Community Trust (Shropcom) clinical and operational leads in March 2026. Reports for Phase 2 Patient Pathway testing are at **appendix R.**

Travel Time Analysis
A travel time analysis tool was commissioned by the Better Together portfolio for use in options development and impact assessment. The tool was used to assess all options ahead of the non-financial appraisal workshop in September 2025 and a report was produced; **appendix W**.
The tool has been actively utilised to further assess options during refinement, check, and challenge, and a second non-financial appraisal event in April 2026. Associated supporting analysis used in the second event is also provided at **appendix X**. The travel time analysis report has been reviewed by HICO Ltd as part of their assurance activity and the feedback will inform the final version which is produced as part of pre-consultation business case development.

4.4.3 Workforce & Finance Check and Challenge

The introduction of the workforce and finance check challenge resulted in an extension of the original timetable.

An initial validation of the workforce and financial appraisals was undertaken by the Director of Improvement and Transformation, Deputy Director of People and Culture, Deputy Director of Finance, Assistant Director Transformation &Value, Assistant Director of Finance and senior workforce and finance leads. Agreed next steps and further actions were captured in a decision and action log, which was assigned to relevant Task and Finish Groups to progress, ensuring continued rigour and governance as part of the options development process.

Workforce and Finance 'Check and Challenge' sessions were held on 22 October 2025 (Urgent Care options) and 24 October 2025 (Physical and Mental Health options) to provide targeted scrutiny of the shortlisted service transformation options.

The sessions brought together senior representatives from across PTHB People & Workforce and Finance functions, alongside Senior Responsible Officers, Clinical Leads, and members of the Improvement & Transformation teams. Attendance included the Director of Improvement and Transformation, Assistant Directors for Transformation and Value, and Improvement and Innovation, Deputy Directors of Finance and People & Culture, and relevant workforce and finance specialists.

The purpose of the sessions was to undertake a structured confidence assessment to:

- test the robustness and accuracy of baseline assumptions relating to workforce, commissioning and costings.
- assure that workforce models were evidence based, informed by demand and capacity projections, and appropriately benchmarked.
- assess whether underlying assumptions were sufficiently robust to deliver the expected outcomes, particularly where investment was required.
- review the Stage 1 confidence assessment and identify any further actions required to strengthen assurance prior to submission to the Executive Committee and Board for decision making ahead of consultation.

The sessions provided additional professional assurance that the refined options were credible, deliverable and affordable. Agreed next steps and further actions were captured in a decision and action log, which was assigned to relevant Task and Finish Groups to progress, ensuring continued rigour and governance as part of the options development process.

4.4.4 Clinical Executive 'Check and Challenge'

The Clinical Executive 'Check and Challenge' session took place virtually on 10th November 2025, attended by Clinical members of PTHB Executive Committee, with Senior Responsible Officers, senior operational and clinical representatives, and attendees from Improvement & Transformation teams. The aim of the session was to present shortlisted options, workforce and financial information to validate and test workforce and finance models and assumptions. The session provided assurances of the shortlisted options, patient pathway testing of the options and draft demand & capacity modelling outputs.
This resulted in some additional options being put forward for Urgent Care based on a 2-site configuration – this was driven by levels of demand and the affordability of the 3-site options with an enhanced service offering. The 2-sites configurations included the same 3 variants of service

offerings but across 2 sites. The sites included Newtown and Brecon and removing the unit in Llandrindod Wells or Newtown and Llandrindod Wells and removing the unit in Brecon.

A financial analysis was undertaken on the 2-site variants. The option for Newtown and Llandrindod Wells with removal of the Brecon unit was confirmed as not financially viable. The option for Newtown and Brecon and removal of the Llandrindod Wells unit was confirmed as financially viable. This highlighted the need to further stress test the 45-minute travel time principle and an assessment of 60-minute travel time principle was applied to all the options. Further workforce, financial and travel time information was gathered for the 2 site variants, and this information was shared at ODG on 7th January 2026. It was agreed to only take forward the 2-site variant which included Newtown and Brecon. These options are shared below:

The following options were agreed to be further appraised by ODG on 7th January 2026:

- 001Cii - Do Minimum in 2 units (make temporary service changes permanent and improve service on 2 units, close 2 units)
- 001D - Do Current on 3 units (continue as now on 3 sites, making temporary service changes permanent, close 1 site)
- 001Dii Do Current in 2 units (continue as now in 2 units, making temporary service changes permanent, close 2 units)
- 010ii - Do Mid-Range on less sites (2 x MIIUs in Powys, close 2 units)
- 013ii - Do Maximum on less sites (2 x UCCs, close 2 units)

This decision was ratified at the Community and Frailty Programme Board on 20th January 2026 and further demand and capacity modelling, travel time analysis, financial and estate assessment were undertaken.

Subsequently the 2-site variant data was presented to ODG and Executive Leads (Executive Medical Director and Executive Director of Primary Care, Community and Mental Health) and it was agreed these should be added to the shortlisted options and progressed through the full appraisal process. This decision was ratified through the Frailty & Community Programme Board on 10th March 2026. A second non-financial options appraisal took place on 21st April 26 – see section below **4.4.6**

4.4.5 Non-Financial Appraisal on Urgent Care Centre, including Diagnostics Options

Due to additional Urgent Care Centre options being requested, further work was undertaken to test the travel time principles for the 2-site options for patients to access urgent care services either within Powys or outside of Powys. These travel time principles were based on evidence from elsewhere and are contained in the travel time analysis report. Further work was undertaken to ensure benefits, risks and trade-offs of the 2-site options was available for comparison to the 3-site options during the non-financial appraisal process.

An additional non-financial options appraisal workshop took place on 21 April 2026 to consider all Urgent Care Centre and Diagnostics options following the addition of the 2-site variations. The same methodology was applied to the running of this session as for the previous session on 11th

September 2025 (detailed in **section 4.4.1**) but the approach was strengthened to reflect the evaluation feedback. Changes included dedicated time for delegates to read time information on the options and a single delegate pack with all information contained, along with a description of the options, what stays the same, what changes, risks and trade-offs, this pack did not include the updated SWOT analysis, this was subsequently updated after the workshop. Additional sensitivity analysis was also applied to reflect feedback previously received. Travel time analysis was completed for the additional options and included in delegate information packs. A summary of this additional analysis is included at **appendix W**.

Stakeholders included Executive Directors, Corporate operational and professional representatives, operational management and clinical leads, colleagues from Workforce, Finance, Primary Care, PAVO, and external professionals to provide a level of independence. A comprehensive list of attendees is available in the full report (**appendix X**). It did not include the public, community groups or service user representation due to the complexity of the technical information being shared and stakeholder engagement undertaken earlier in the process. Llais was invited to attend in an observer capacity but declined. Powys County Council, PAVO and WAST were invited but unable to attend. The event was supported by the Improvement and Transformation, Organisational Development, Information and Communication and Engagement teams.

A second non-financial options appraisal report was produced **(appendix X)** and contains full details of the methodology, attendees and scoring outputs. A summary is provided for the purpose of this report below.

URGENT CARE CENTRE (inc. DIAGNOSTICS)

Figure 18: Non-financial Options Appraisal Scoring Summary – Weighted and Unweighted

	Average Unweighted								Weighted (.3,.15,.15,.2,.1,.1)							
	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank	Safe	Timely	Effective	Efficient	Equitable	Person Centred	Total Weighted Score Provided	Rank
SL UCDO_001a	1.9	2.3	2.2	1.6	2.3	2.4	12.78	10	0.6	0.4	0.3	0.3	0.2	0.2	2.04	11
SL UCDO_001b	2.6	2.7	2.4	2.3	2.9	2.7	15.52	7	0.8	0.4	0.4	0.5	0.3	0.3	2.55	8
SL UCDO_001d	2.9	2.7	2.6	2.7	2.6	2.6	16.09	6	0.9	0.4	0.4	0.5	0.3	0.3	2.73	6
SL UCDO_001dii	2.5	2.0	2.3	2.5	1.8	2.0	13.22	9	0.8	0.3	0.3	0.5	0.2	0.2	2.30	9
SL UCDO_001c	3.1	3.0	3.0	3.0	3.0	2.9	18.00	5	0.9	0.5	0.5	0.6	0.3	0.3	3.02	5
SL UCDO_001cii	2.7	2.3	2.7	2.7	2.2	2.4	15.13	8	0.8	0.4	0.4	0.5	0.2	0.2	2.58	7
SL UCDO_005	2.0	2.0	2.2	2.0	2.0	2.2	12.35	11	0.6	0.3	0.3	0.4	0.2	0.2	2.04	10
SL UCDO_010	3.7	3.4	3.8	3.7	3.6	3.7	21.91	2	1.1	0.5	0.6	0.7	0.4	0.4	3.65	3
SL UCDO_010ii	3.4	2.9	3.3	3.4	2.6	2.9	18.43	4	1.0	0.4	0.5	0.7	0.3	0.3	3.18	4
SL UCDO_013	4.3	4.1	4.2	4.2	3.9	4.1	24.78	1	1.3	0.6	0.6	0.8	0.4	0.4	4.17	1
SL UCDO_013ii	3.8	3.4	3.9	3.8	3.3	3.6	21.83	3	1.1	0.5	0.6	0.8	0.3	0.4	3.70	2

In Summary:

- "Do Maximum" – enhanced local urgent care model on 3 sites (SL UCDO_013) scored highest.
- "Do Maximum" – enhanced local urgent care model on 2 sites (SL UCDO_013) scored 2nd highest.
- "Do current" scored higher than "do previous."

The appraisal outputs demonstrated a high degree of consistency across the STEEEP domains, with correlation and sensitivity analysis confirming that relative option rankings remained stable under multiple weighting scenarios. This indicates that no single criterion disproportionately influenced outcomes and that the results are robust to changes in weighting assumptions. As expected at this stage of the process, scoring showed limited differentiation between several shortlisted options, reflecting their shared design principles, common enabling components and interdependencies across urgent care services.

Across all sensitivity scenarios, one option (SL UCDO_013 – Do Maximum: Even Better Local Urgent Care, comprising two Urgent Care Centres and one Minor Injury and Illness Unit) consistently ranked highest. There was strong stakeholder consensus on this option, evidenced by low variation in scores across appraisers. Options associated with greater service withdrawal or reliance on alternative models scored lowest, particularly where concerns were raised regarding access, equity, safety, and system resilience.

The appraisal outputs are intended to be indicative and to inform the next stage of the decision-making process. They will be considered alongside financial, workforce and estates assessments, as well as engagement feedback and impact assessments, to support the identification of options proposed for public consultation. The workshop outputs therefore provide an important component of the wider, staged assurance framework, supporting informed consideration of trade-off's, risks and benefits rather than serving as a definitive decision-making tool in isolation.

5.FINALISATION OF OPTIONS

This section marks the transition from the short-listed options appraisal process to a proposed set of recommended options for formal public consultation.

5.1 Recommendations Workshop Sessions

Two recommended options workshop sessions were held to consider each of the options against the issues, service models, non-financial appraisal, financial appraisal and estate assessment to objectively discuss and consider which options should be recommended for public consultation.

The objectives of the sessions were:

- To review and assess Non-financial, Financial and Estates appraisals against the shortlisted options.
- To agree options recommended for consultation for each service area to be taken forward to the pre consultation business case for Executive Committee and Board consideration.

The inputs for the sessions included:

- Service models
- Demand & capacity modelling
- Estates assessments
- Non-financial appraisal outputs
- Financial appraisal outputs
- Summary of assumptions
- Scoring frameworks

During the workshop each option and its supporting evidence base was re-considered against how it would address the issues in the case for change and the hurdle criteria, but mainly the group discussion focused on the non-financial and financial appraisal and estate assessment to objectively discount or recommend options to proceed to the next stage. Options that were discounted had a clear rationale to explain why they were not recommended to move forward.

This process ensured robust options would be taken forward to the next stage for consultation with clear rationale. This applied across Physical Health Inpatients and Community Models, Urgent Care, and Mental Health services. The “Do current” and "Do Previous" options were discounted but will progress as baseline comparator options.

In addition to option selection, the group assessed readiness to proceed and identified any further actions required before an organisational decision on proceeding to public consultation. This provided clarity on next steps and any additional work needed to support assurance and decision-making.

The first workshop was held on 13th January 2026 and considered physical health and urgent care options. The mental health options were unable to be considered at this time due to decisions pending on the baseline establishment delaying finalisation of workforce and financial appraisal. 22 internal delegates were in attendance including clinical leads, senior responsible officers, medical and nursing professionals, workforce, finance, organisational development, estates and planning. The session was facilitated and documented by the Transformation and Value team.

During the session Physical Health options were progressed to a set of options recommended for consultation pending finalisation of demand & capacity modelling. Urgent Care (inc. Diagnostics) options were recommended for consultation subject to further work to be delivered through the Task & Finish group on additional 2-site variants (detailed in sections **4.4.5 – 4.4.6**).

The second recommended options workshop was held on 5th May 2026 and considered Mental Health options, revisited the Urgent Care options including the additional 2-site variants and ratified the previously agreed Physical Health recommendations. 20 internal delegates were in attendance including clinical leads, senior responsible officers, medical and nursing professionals, workforce, finance and organisational development. Estates and Planning representatives were invited to attend but unable to do so. It was noted in the session that some supporting information for the workshop was either in draft or requiring further update/ assurance, this was acknowledged and will be addressed as part of the next steps. The session was facilitated and documented by the Transformation and Value team. Final outputs are detailed in **section 5.2**.

5.2 Outputs from the Recommended Options Workshop

The Options Development Group has not selected a single preferred option at this stage. The options recommended to be progressed to the next stage represent credible and viable options that remain subject to further engagement, consultation and decision making. This is underpinned with a clear and transparent process that shows how short-listed options were appraised and discounted. Formal public consultation is intended to meaningfully inform any final decision on the agreed future option, including how identified risks, trade-offs and mitigations should be addressed. No final decisions have been taken, and outcomes remain open to change based on consultation feedback.

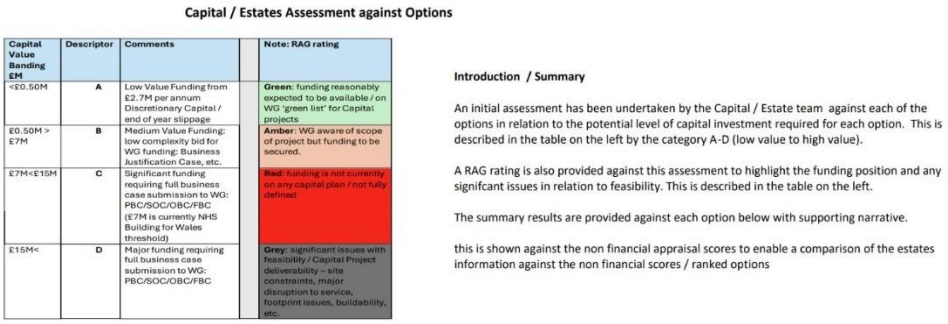
During the Recommended Options Workshop:

- 8 Physical Health options were reviewed which included different inpatient configurations dependent on the community model, distribution of inpatient sites, reablement model, diagnostics, and integration with mental health.
- 11 Urgent Care options ranged from restoring all Minor Injury Units (MIUs) to creating two fully integrated Urgent Care Centres (UCCs) across 3 or 2 sites. The appraisal considered travel times, workforce, diagnostics access, integration with physical health options, and financial sustainability.
- 8 Mental Health Options were reviewed which included different inpatient configurations, single and 2 site options, the majority of options included strengthening the Older Adults Community Mental Health services and reducing out of area placements.

The table below provides a summary of the combined outputs from each of the Recommended Options workshops held on the 13th January 2026 and 5th May 26 for each of the service areas.

Those options colour coded in green will be taken forward to the next stage, the options in blue are proposed to be discounted. In the tables below, the codes for the Estates Ratings are provided below:

Figure 19: Estate Assessment coding



Capital / Estates Assessment against Options

Capital Value Banding £M	Descriptor	Comments	Note: RAG rating
<£0.50M	A	Low Value Funding from £2.7M per annum Discretionary Capital / end of year slippage	**Green**: funding reasonably expected to be available / on WG 'green list' for Capital projects
£0.50M > £7M	B	Medium Value Funding: low complexity bid for WG funding: Business Justification Case, etc.	**Amber**: WG aware of scope of project but funding to be secured.
£7M<£15M	C	Significant funding requiring full business case submission to WG: PBC/SOC/OBC/FBC (£7M is currently NHS Building for Wales threshold)	**Red**: funding is not currently on any capital plan / not fully defined
£15M<	D	Major funding requiring full business case submission to WG: PBC/SOC/OBC/FBC	**Grey**: significant issues with feasibility / Capital Project deliverability – site constraints, major disruption to service, footprint issues, buildability, etc.

Introduction / Summary

An initial assessment has been undertaken by the Capital / Estate team against each of the options in relation to the potential level of capital investment required for each option. This is described in the table on the left by the category A-D (low value to high value).

A RAG rating is also provided against this assessment to highlight the funding position and any signifcant issues in relation to feasibility. This is described in the table on the left.

The summary results are provided against each option below with supporting narrative.

this is shown against the non financial appraisal scores to enable a comparison of the estates information against the non financial scores / ranked options

Figure 20: PHYSICAL HEALTH Outputs from Recommended Options Workshop & Rationale

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001a – Do Previous	Pre-temporary service changes	Discount (include as comparator only)	Ranked 8th financial and 8th non-financial appraisals. Estates rated A-Green. • Ranked lowest in both financial and non-financial appraisals. Does not meet future demand or address the case for change, for example reducing patient deconditioning and agency spend. Retained as baseline/comparator only.
001b – Do Current	Make temporary changes permanent	Discount (include as comparator only)	Ranked 7th financial and 7th non- financial appraisals. Estates rated A-Green. • Operationally stable short-term but does not address sustainability, demand growth, or workforce issues within the case for change. Retained as baseline/comparator only.

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
011 – Remove all Community beds	No local community inpatient beds; rely on community team, care homes and secondary care providers	Discount	Ranked 9th financial and 6th non-financial. Estates rated A-Green. • Higher cost associated from financial perspective i.e. commissioning costs) therefore unaffordable due to increased use of private sector and secondary care providers. Will have negative impact on Stroke Rehabilitation. Frailty recognised as syndrome –impact on community offer due to complexities. Does not improve access, does not address the issues within the case for change. Independent demand and capacity modelling indicates PTHB requires Community inpatient bed base to meet population needs. Option does not support with integration of physical and mental health services.
002a – Do Minimum	Same Community Inpatient bed numbers across 6 sites with stronger community model	Discount	Ranked 6th financial and 5th non-financial appraisals. Estates rated B – Green. • Option does not support with integration of physical and mental health services. Provides some efficiency required to operate within current funding envelope, but this is not enough in the longer term. In the short term would deliver benefits financially and non-financially and allow some investment into the community model to support people at home.
002b – Do Minimum + MH integration	Same Community Inpatient bed numbers across 6 sites with stronger community model with integrated physical and mental health services on some sites	Discount	Ranked 6th financial and 4th non-financial appraisals. Estates rated B – Green. • Option does support integration with physical and mental health. Provides some efficiency required to operate within current funding envelope, but this is not enough in the longer term. In the short term would deliver benefits financially and non-financially and allow some investment into the community model to support people at home. Could be considered as a transition option.
005a – Do Mid-Range	Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model	Discount	Ranked 4th financial and 2nd non -financial appraisals Estates rated D – Amber. • Option does not support with integration of physical and mental health services.
005b – Do Mid-Range + MH integration	Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model +	Proceed to next stage	Ranked 4th financial and 1st non-financial appraisals. Estates rated D – Amber. • Moderate delivery risk. Balances improved quality, MDT working, and community-based care while remaining more deliverable

Option Reference	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
	better join up with mental health		than two-site options. Requires workforce transformation and estate investment but agreed as a credible and balanced option.
008 – Do Maximum	Even fewer Community Inpatient beds reduced to 2 sites, with enhanced community model ++ and better join up with mental health	Proceed to next stage	Ranked 2nd financial and 3rd non-financial appraisals. Estates rated D – Amber. • Offers lowest net cost and strongest shift to care closer to home. Ranked 3rd non-financial but carries higher delivery and workforce risk and major estate dependence. Proceeding to consultation to test acceptability of scale of change versus benefits.

Figure 21: URGENT CARE Outputs from Recommended Options Workshop & Rationale

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001A – Do Previous	Pre-temporary service changes (4 MIUs)	Discount (include as comparator only)	Ranked 11th financial and 11th non-financial financial appraisals. Estates rated A- Green • Does not meet current or future demand and does not address the Case for Change. Ranked lowest in both financial and non-financial appraisals. Retained as baseline/comparator only.
001B – Do Current	Make temporary changes permanent	Discount (include as comparator only)	Ranked 8th financial and 8th non-financial appraisals. Estates rated A-Green • Fails to meet future demand and does not deliver required service improvement or resilience. Continued workforce fragility and variation in offer. Retained as baseline/comparator only.
001C – Do Minimum (3 MIUs)	3 MIUs: Newtown, Llandrindod, Brecon	Discount	Rank 6th financial and 5th non-financial appraisal. Estates rated B- Green. • Does not meet needs of population, does not extend scope – only supports some repatriation of patients from out of area. Requires investment but does not allow system integrations or allow integration with urgent care. Does not enhance the service to a level of impact that's sufficient to justify the level of negative impact.

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
001Cii – Do Minimum (2 MIUs)	2 MIUs: Newtown & Brecon	Discount	Ranked 5th financial and 7th non financial appraisals. Estates rated B – Green. • Does not meet needs of population, does not extend scope – only supports some repatriation of patients from out of area. Requires investment but does not allow system integrations or allow integration with urgent care. Does not enhance the service to a level of impact that's sufficient to justify the significant level of negative impact to 2 site reduction.
001D – Current on 3 sites	MIUs at Welshpool, Llandrindod, Brecon	Discount	Ranked 7th financial and 6th non-financial appraisals Estates rated A – Green. • Does not manage needs and future patient demand for urgent Care. It would reduce imaging offer provided locally. Doesn't alleviate demand on primary care services, potential to increase in some areas.
001Dii – Current on 2 sites	MIUs at Welshpool and Newtown & Brecon	Discount	Ranked 2nd financial and 9th non-financial financial appraisals. Estates rated B - Green. • Does not manage needs and future patient demand for urgent Care. It would reduce imaging offer provided locally. Doesn't alleviate demand on primary care services, potential to increase in some areas where MIU services are removed.
005 – Close all MIUs	All MIUs close; GP + community respons e only	Discount	Ranked 4th financial and 10th non-financial appraisals. Estates rated A - Green • Not aligned with strategic direction, capacity over cost/obligation to pull demand from A&E units. Non-financial ranked worst option. Alternative provision via GP supplementary services would only support some population needs, therefore significantly more people would travel out of county and there would potentially be gaps in meeting patient needs in some areas.
010 – Mid-Range (3 MI&IUs)	MIIUs at Newtown, Llandrindod, Brecon	Discount	Ranked 9th financial and 3rd non-financial financial appraisals. Estates rated C - Amber • Small investment required for this enhanced model which doesn't fully maximise benefits. Service offer does not enable integrated step-up provision through the interdependency with physical health options.

Option Ref	Option Description	Recommended Status	Rationale for proceeding to consultation or discounting options
010ii – Mid-Range (2 MI&IUs)	MI&IUs at Newtown & Brecon	Discount	Ranked 3rd financial and 4th non-financial financial appraisals. Estates rated B - Amber • Small investment required for this enhanced model which doesn't fully maximise benefits. Financially more viable through reduced sites. Service offer does not enable integrated step-up provision through the interdependency with physical health options.
013 – Maximum (2 UCCs + 1 MI&IU)	UCCs at Newtown & Brecon; MI&IU at Llandrindod	Proceed to next stage	Ranked 10th financial and 1st non-financial appraisals. Estates rated C - Amber • Offers the strongest clinical capability, governance, and integration with urgent pathways. Improves diagnostics provision, avoids unnecessary conveyance, and aligns with strategic direction for community-based urgent care.
013ii – Maximum (2 UCCs)	UCCs at Newtown & Brecon	Proceed to next stage	Ranked 1st financial and 2nd non-financial appraisal. Estates rated C – Amber • Delivers strong workforce sustainability and cost efficiency, but with greater access risks (notably Llandrindod) and impact on primary care. Agreed to proceed alongside Option 013 to enable a clear consultation comparison on access vs efficiency trade-offs.

Figure 22: MENTAL HEALTH Outputs from Recommended Options Workshop & Rationale

Option Ref	Option Description	Recommendation Status	Rationale
001a – Do Previous	Pre-temporary service changes	Discount (Include as comparator only)	Ranked 7th financial and 8th non-financial appraisals. Estates rated A- Green • Does not meet future demand and fails to address the case for change, including workforce fragility and reliance on out-of-county care. Ranked low in both non-financial and financial appraisals. Retained as baseline/comparator only.
001b – Do Current	Maintain current model with temporary service changes made permanent	Discount (include as comparator only)	Ranked 6th financial and 7th non-financial appraisals. Estates rated A- Green • Provides short-term stability but does not address sustainability, capacity issues, or meet future population needs and demand. Continues reliance on fragmented inpatient

Option Ref	Option Description	Recommendation Status	Rationale
			provision and external placements. Ranked low in option appraisal. Retained as baseline/comparator only.
003a – Do Minimum	Do Minimum: Functional beds to Bronllys + integrated OAMH community	Discount	Ranked 1st financial and 6th non-financial appraisals. Estates rated C- Amber • Non-financial appraisal ranked in bottom of half of options, financial appraisal ranked 1st. Estates rag is red as development is required. Travel distance consideration for all organic patients being accommodated in Ystradgynlais.
004a – Do Mid-Range	Functional inpatient beds at Brecon Powys site with integrated Older Adult MH community model	Discount	Ranked 1st financial and 5th non-financial appraisals. Estates rated D - Grey • This option improves quality and workforce efficiency through consolidation and strengthens integration with physical health and community services. The Estate assessment output is Red due to initial site feasibility prohibiting services being relocated o nto Brecon hospital site.
006a – Do Maximum	All functional and organic inpatient beds consolidated at Bronllys with enhanced care and strengthened community model	Proceed to next stage (subject to further actions)	Ranked 3rd financial and 3rd non-financial appraisals. Estates rated D - Red • This option offers a balance across quality, workforce sustainability and affordability, but has some limitations from a co-location with physical health perspectives, with community links and being geographically focused in the south. The option would improve clinical standards and provide a sustainable offer, reducing some reliance on out-of-county placements, as well as strengthening pathways. Requires estate investment and further testing on site feasibility to determine deliverability on Bronllys site. It's recommended this option is taken forward with the caveat that if the Bronllys site cannot be re-developed, an alternative site nearby could be explored as a mitigator.
007a – Do Maximum	All functional and organic inpatient beds consolidated at a single Brecon site	Discount	Ranked 3rd financial and 2nd non-financial appraisals. Estates rated D - Grey • Strong clinical and workforce case for consolidation, and brings benefits of co-location with physical health, but significant estate constraints on the Brecon site following initial

Option Ref	Option Description	Recommendation Status	Rationale
			feasibility means this option cannot be progressed on the Brecon site.
008a – Do Maximum	All beds to Newtown or Welshpool	Discount	Non-financial appraisal ranked 4th, finance appraisal ranked 2nd (with small net saving). Estates rated D - Red/Grey but risk of significant cost. • This option would have challenges with deliverability; there is a lack of confidence for recruitment in North with all services relocating and it would require significant OCP as existing staff based in the South would require relocating to the north.
010a – Do Maximum	Two-site inpatient model with beds split between North and South Powys with integrated community model	Proceed to next stage (subject to further actions)	Ranked 8 financial and 1st non-financial appraisals. Estates rated D – Red/Grey • This option performs best on access, equity and patient experience and co-location with physical health. However, it is least favourable financially, requiring significant workforce growth and additional recurrent investment. Proceeding only based on further work being undertaken to test affordability, workforce assumptions and confirm bed requirements.

The limitations of estate knowledge in the room were acknowledged along with further actions required to finalise the estate assessment. To be able to conclude the recommended options process the following actions were agreed:

Mental Health

- Further discussions with Estates team to investigate feasibility of single site in Brecon/ Bronllys area and further test the feasibility of two site option, with one site in Newtown and one site in Brecon/ Bronllys area
- Further work on option 10a do maximum to assess the workforce requirements and associated benefits to determine whether this option could be affordable.
- Completion of the workforce assumptions to provide further assurance around the workforce and financial appraisal.

Urgent Care

- Estate assessment of the 2 site options to ensure there are no estate issues which would impact on deliverability.

These actions have been progressed via ODG and the outputs have informed further discussion and decision making on the recommended options in Informal Executives on 21st May 26.

This has resulted in the discounting of the mental health option 010a: 2-site inpatient model with beds split between North and South Powys with integrated community model. Following further

review of the bed requirements, workforce model and underpinning staffing and commissioning assumptions, the model across the 2 sites is not deliverable and financially it is not affordable.

The workforce model and underpinning assumptions and updated financial appraisal were approved by the Mental Health Programme Board on 19th May 26, it is recognised that whilst internal assurances have been provided on these assumptions, this is limited due to insufficient external benchmarking information being available to test robustness of the assumptions applied.

A further review of the rationale and supporting evidence for why options have been discounted or taken forward will be undertaken by HICO as part of their independent assurance, in readiness for consultation.

5.3 Deliberative Event 3

It was recognised that there were some limitations with regards to public and service user involvement since the last Deliberative event in August 2025 so following the technical work undertaken during Autumn - spring, an additional event was agreed. This was designed to assess public and wider stakeholder acceptability of the options, as well as to strengthen confidence, transparency and consultation readiness in advance of formal public consultation.

The Deliberative Event took place in person on 10th June 2026, full details of the session, outputs and delegates can be found in the report at **appendix Z.1**. The purpose of the event was to present the options proposed for consultation and their underpinning rationale, validate and sense check appraisal assumptions and scoring, and systematically stress test identified risks, impacts and potential unintended consequences in readiness for consultation. The event was facilitated by independent consultants HICO Ltd.

120 delegates were in attendance from the following stakeholder groups:

- Representatives from Llais
- Service User Representatives
- Powys County Council
- Regional Partnership Board
- PTHB Clinical and Professional Teams
- PTHB Executive Directors and Corporate functions.
- Primary Care representatives.
- Representatives from externally commissioned secondary, community care and ambulance services
- Representatives from PAVO and Third Sector Organisations, including service users and carers
- Independent Clinical Experts

Delegates were asked to test the proposals of Better Together in changing adult urgent care, physical health and mental health services across Powys. No decisions were made at the event, and no decisions have been made as a result of it. The next step is a formal public consultation, where everyone in Powys will have the chance to have their say.

Delegate were assigned to discussion rooms across each service area, with two sessions in each. The table groups were asked:

Deliberative Event 3: Questions Used to Test the Proposals

1. Were the proposals believable?	2. What could go wrong?	3. Would the public trust this?	4. Personal postcards
Test whether the proposed changes felt realistic, understandable and supported by the evidence.	Identify delivery risks, unintended consequences and practical concerns.	Explore whether the public would see the proposals as credible, fair and transparent.	Capture individual reflections, concerns and key messages for the programme team.

The event was well attended and achieved positive feedback facilitated by independent observers (HICO Ltd) in its achievement of the intended objectives. The range of participants was felt to be broad and inclusive providing opportunity for further understanding of the proposals shared with delegates with the outputs of the day being collated into a report shared with ODG members to help shape the next steps.

The main message from the day "People at the event did not oppose the idea of change. In all three rooms, there was broad agreement that the current way of delivering services under pressure and that something needs to change. But people questioned whether the right conditions were in place to make change work – things like community services, social care, enough staff, transport, and a realistic plan. They broadly accepted the direction of travel. Their challenge was "can it be delivered?". During the Deliberative event there were some discussions on the single site mental health option, and a further action was agreed to look at the potential to commission inpatient services in the north of the County as part of the 2-site options.

The ODG met and agreed several actions because of the feedback during the event. This included further work on the mental health options as well as strengthening of the narrative around the community model, development of indicative phasing timetables to help people understand the potential sequence of activities for each recommended option and further work on understanding both the positive and negative impact of the proposed changes at a locality level. The findings from the event have been shared with the PTHB Board and discussed further with partners such as Primary Care and Social Care.

Further work on the mental health sub option was undertaken and the findings of this further exercise confirmed that the costs associated with a sub option of commissioned provision (3 beds) in the north would be maximum £11,778m, the costs of the Powys 2-site provider option 010a (two sites North and South) was £12.823m. Comparing these to the cost of recommended option 006a at £10.831m, means this option still remains the most affordable option. Whilst the North commissioned sub option supports the principle of care closer to home, this is marginally improved for some localities in the north, but the cost of the model significantly increases and the challenges of aligning community and inpatient provision prevail. On this basis Executive Committee confirmed on the 22nd July 26 that this sub option was not viable and agreed to continue to proceed with the recommended single site option to public consultation.

HICO have provided a briefing note on the single site option which has also been considered by Executive Committee ahead of the submission of the Pre-consultation Business Case.

6. CONCLUSIONS & RECOMMENDED OPTIONS FOR CONSULTATION

In summary, this Step Report marks the completion of Phase 1 of the Better Together Journey to Consultation, setting out a robust foundation for formal public consultation. Through a transparent and methodical appraisal process, a small number of credible and viable options for each service area have been identified, reflecting the complexities and interdependencies across the health system. This approach, in line with best practice for significant service change, ensures that future service models are both sustainable and responsive to the needs of patients, staff, and communities. The rigour and inclusivity of the process provide confidence to move forward to Stage 3, where the shortlisted options will be explored in greater depth with the public and stakeholders to inform the Final Business Case and subsequent decisions.

It is proposed the following options are progressed through the Health Board governance arrangements for decision on further testing through public consultation, ensuring that any final decisions are shaped by wider stakeholder input and local perspectives.

Figure 23: Recommended Options Summary Table

Option Ref	Option Description	Recommendation Status
Mental Health		
MH006a – Do Maximum	All functional and organic inpatient beds consolidated at Bronllys with enhanced care and strengthened community model	Proceed to next stage
Urgent Care & Diagnostics		
UC013 – Do Maximum (2 UCCs + 1 MI&IU)	UCCs at Newtown & Brecon; MIIU at Llandrindod	Proceed to next stage
UC013ii – Do Maximum (2 UCCs)	UCCs at Newtown & Brecon	Proceed to next stage
Physical Health		
PH005b – Do Mid-Range + MH integration	Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model + better join up with mental health	Proceed to next stage
PH008 – Do Maximum	Even fewer Community Inpatient beds reduced to 2 sites, with enhanced community model ++ and better join up with mental health	Proceed to next stage

7. Readiness for Board Decision on Consultation

In further preparation for readiness for a Board decision to proceed to public consultation the following next steps will be taken:

- **Finalise the Level 2 and Integrated Impact Assessments** - the Level 2 and Integrated Impact Assessments (see section 3 for description) will be finalised by Improvement and Quality & Safety leads, this will address feedback from HICO, and insights gathered at the Deliberative event.
- **Incorporating feedback from the Deliberative event -** further work is being undertaken to address the feedback from the Deliberative event, this will be reflected in the Pre-consultation Business Case and relevant technical appendices.
- **Finalisation of the consultation plan and stakeholder and staff engagement plan –** the ODEC group have finalised plans to ensure appropriate and effective stakeholder engagement in preparation for public consultation. The consultation plan will go to Public Board in July 26 for approval subject the approval of PCBC in September 26.
- **Development of pre-consultation business case** – the pre-consultation business case is being prepared and will be presented to the Board in September 2026 for decision to proceed to consultation.

8. TECHNICAL APPENDICES

Documents were available in working draft form throughout the options development process, with approval dates reflecting formal submission sign-off rather than first availability. Documents that are highlighted with target approval dates is because they are being refreshed or reviewed for sharing publicly.

The table below includes all technical documents for Phase 1 Option Development Process.

Appendices	Approval Date	Approved Via	Status
A - Portfolio Executive Plan	05.03.25	Executive Committee	Complete Include Old version
B - Overarching Case for Change	Due 20.08.26	Portfolio Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.1 - Mental Health Technical Chapter	Due 20.08.26	Mental Health Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.2 - Physical Health Technical Chapter	Due 18.08.26	Frailty & Community Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
B.3 - Primary Care Technical Chapter	Due 18.08.26	Frailty & Community Programme Board	Not yet due – light touch update to be included with PCBC submission in Public in Sept 26
C - Stage 2 Engagement Briefing	June 2025	Portfolio Board	Complete
D - Stage 0 and 2 Engagement Report	16.09.25	Portfolio Board	Complete
E - Stakeholder Engagement Oversight	09/06/26	ODEC	Review In progress To be included within PCBC submission to Board
G - System Model of Care – Mental Health	09.09.25	MH Programme Board	Complete
G - System Model of Care – Urgent Care	08.09.25	Frailty & Community Programme Board	Complete
G - System Model of Care – Physical Health	08.09.25	Frailty & Community Programme Board	Complete – Update required on social model for health to be included with PCBC submission in Public in Sept 26
J - Strategic Demand & Capacity Final Report	21.05.26	Portfolio Board	Complete

Appendices	Approval Date	Approved Via	Status
K - Long List of Ideas	18.06.25	ODG	Complete
L - Long List of options	Q1	Programme Boards	To be included within PCBC submission to Board in September 26.
M - Level 1 Impact Assessments on short list options	19.05.26 26.05.26	Programme Boards	Complete
N - CRG Check & Challenge Report	23.09.25	Programme Boards	Complete
O - Urgent Care Service Issues template	08.09.25 Due 18.08.26	Frailty & Community Programme Board	Previously approved but update required. To be included with PCBC submission in Public in Sept 26
P - Urgent Care Service Model of Care	03.12.25	Frailty & Community Programme Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
Q - Urgent Care Workforce Summary, assumptions and financial appraisal	26.05.26	Frailty & Community Programme Board	Complete. Approved via Chairs action 01/05/26, to be ratified at Programme Board
R - Urgent Care Phase 2 Patient Testing Pathway Report	10.02.26	Programme Board	Complete
O.1 - Physical Health Service Issues template	08.09.25 Due 18.08.26	Frailty & Community Programme Board	Previously approved but updated required. To be included with PCBC submission in Public in Sept 26
P.1 - Physical Health Service Model of Care	03.12.25	Frailty Programme Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
S - Physical Health Patient Pathway Testing inc Day of Care Survey	26.09.25	Executive Committee	Complete
Q.1 - Physical Health Workforce Summary, assumptions and financial appraisal	26.05.26	Frailty & Community Programme Board	Complete Approved via Chairs action 01/05/26, to be ratified at Programme Board
O.2 - Mental Health Service Issues template	23.10.25 Due 20.08.26	Mental Health Programme Board	Previously approved but updated required. To be included with PCBC submission in Public in Sept 26

Appendices	Approval Date	Approved Via	Status
P.2 - Mental Health Service Model of Care	14.01.26	Portfolio Board	Being updated following the Deliberative Event – revised version to be included with PCBC submission in Public in Sept 26
Q.2 - Mental Health Workforce Summary, assumptions and financial appraisal	19.05.26	Mental Health Programme Board	Complete Approved via Chairs action 01/05/26 and ratified at Programme Board 19/05/26
T - Mental Health Patient Testing Pathway Report	19.05.26	Mental Health Programme Board	Approved at Programme Board 19/05/26 subject to additional information provided in relation to the options. To be included within PCBC submission to Board In Committee 29th July 26.
U - Estate Assessments	26.09.25	Executive Committee	Updated estate assessment completed and enclosed.
V - SWOT Analysis	23.09.25 Due 20.08.26 / 18.08.26	Programme Boards	Review in progress. To be included with PCBC submission in Public in Sept 26
W - Travel Time Analysis Report	22.09.25	Chairs Action	Complete. Updated travel times analysis report approved at portfolio board 14/7.
X - non-financial option appraisal report – Urgent Care 21.4.26	26.05.26	Frailty & Community Programme	Complete
Y - non-financial option appraisal report – All services 11.09.25	16.09.25 17.09.25	Portfolio Board Executive Committee	Complete
Z - Recommended Options Workshop Report	13.05.26 19.05.26 26.05.06	ODG Programme Boards	To be included with PCBC submission in Public in Sept 26
Z.1 - Deliberative Event 10.6.26 Report	n/a	n/a	Complete report approved at portfolio board 14/7.
Z.2 - Level 2 Impact Assessments (Quality, EQIA, Health Impact)	13.05.26 16.06.26 18.06.26	ODG Programme Boards	To be included within PCBC submission to Board in Public in Sept 26