Agenda Item
3.3.2

Joint Commissioning Committee

Mechanical Thrombectomy Pathway Deep Dive Review

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Pwrpas yr Adroddiad / Report Purpose	For Noting

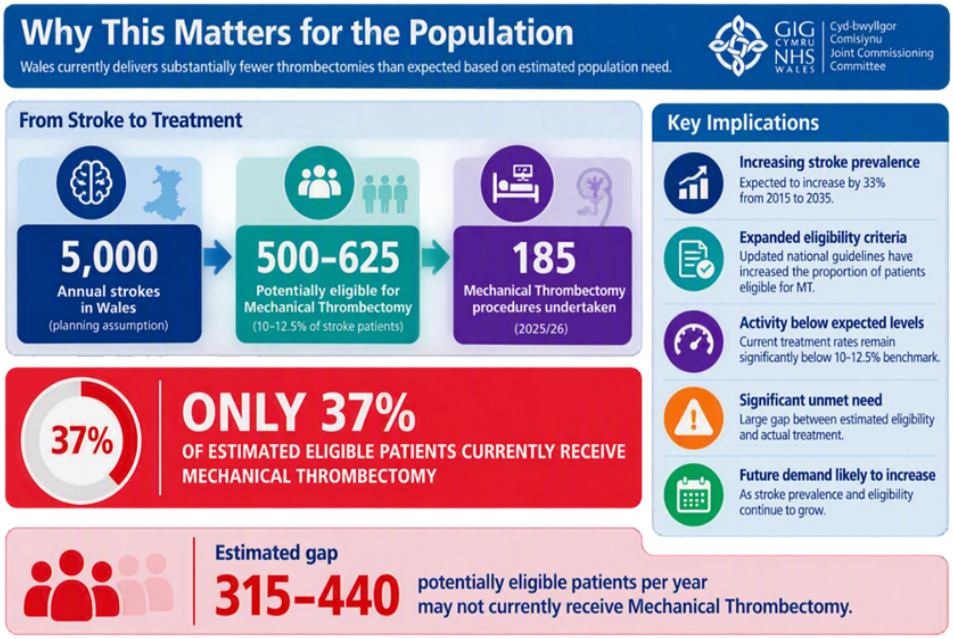
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Senior Leadership Team	16/11/2026	Noted
Joint Committee (In-Committee)	22/09/2026	Noted
Senior Leadership Team	16/09/2026	Noted

1. SITUATION/BACKGROUND

In 2025, around 6,000 people in Wales had a stroke. This number is rising, with projections suggesting up to a 50% increase in the number of people expected to have a stroke by 2035. Annually, stroke costs NHS Wales £220 million, and the Welsh economy £1.63 billion. Without intervention, this could rise to nearly £2 billion by 2035 (Stroke Association 2026). As the population ages and more people survive stroke, there is a growing need for investment in prevention, rehabilitation and long-term support.

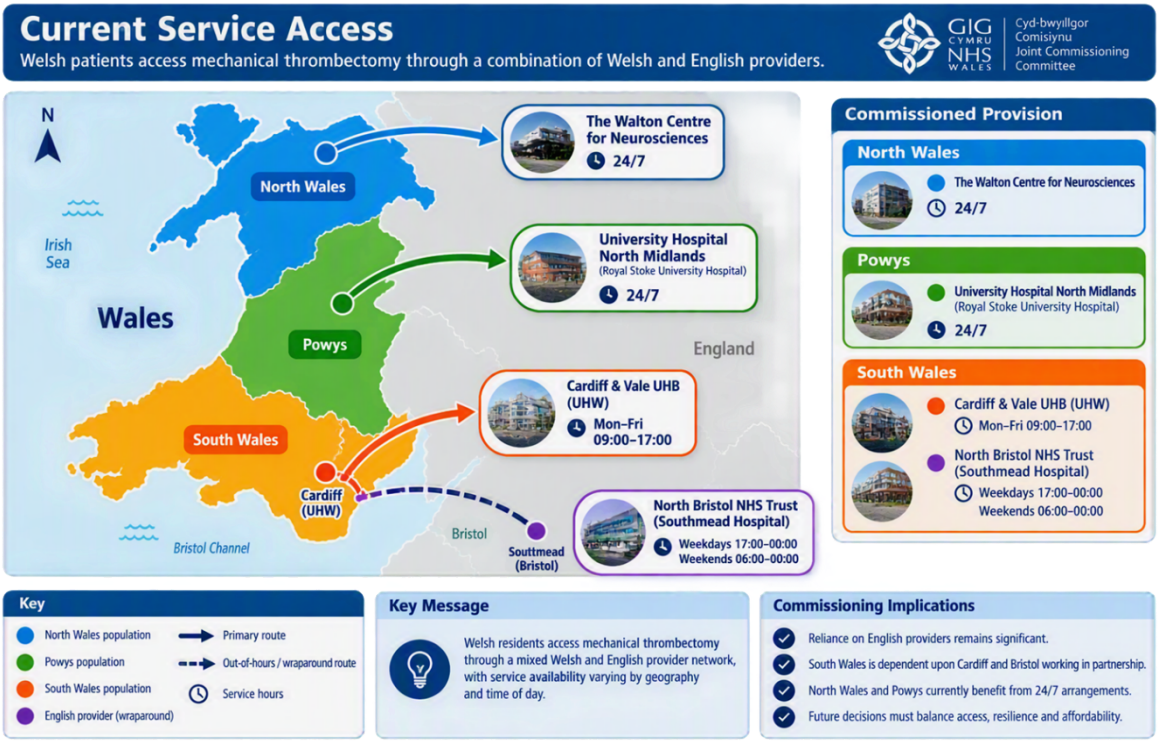
Historical planning assumptions have been based on approximately 10% of ischaemic stroke patients being eligible for Mechanical Thrombectomy (MT)[1], equating to 500 thrombectomy-eligible patients annually across Wales (333 patients in South Wales and 167 patients in North Wales in 2025/6). The level of activity through the commissioned pathways does not reflect this level of anticipated demand which has been explored through the deep dive review as summarised below in figure 1.

Figure 1 – MT Rates "Why This Matters for the Population"



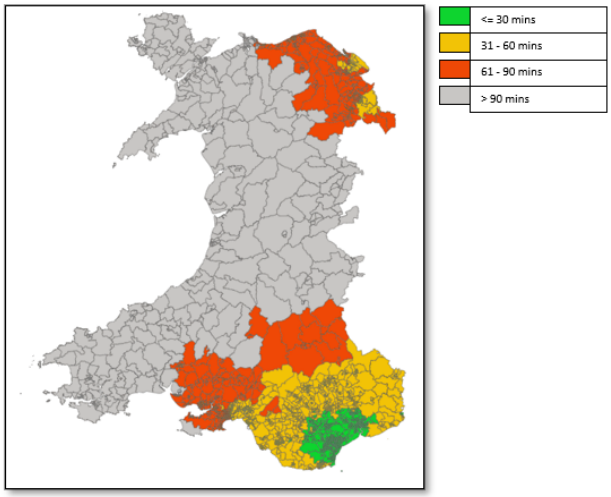
[1] McMeekin P, Flynn D, James M, Price CI, Ford GA, White P. Updating estimates of the number of UK stroke patients eligible for endovascular thrombectomy: incorporating recent evidence to facilitate service planning. Eur Stroke J. 2021 Dec;6(4):349 356. doi: 10.1177/23969873211059471. Epub 2021 Nov 16. PMID: 35342815; PMCID: PMC8948519.

Figure 2 – Current Commissioning Position and Service Access



The Deep Dive review has provided strategic insights, including confirmation of significant variation in access to MT services across Wales and evidence that current activity levels remain below estimated population need. This includes the North Wales population that has access to a 24/7 MT Service provided by The Walton Centre for Neurosciences. The deep dive has identified that inequity of access continues to be an issue for patients living in rural areas across Wales. Patients across North Wales have access to a 24/7 service at The Walton Centre, however in 2025/2026, BCUHB had an access rate of 2.6% which is below the rate of comparable Health Boards in South Wales where access is limited to 06.00 to 00.00. In the same period HDUHB had an access rate of 2.4% which is similar to BCUHB.

Figure 3 - Population drive time analysis for Welsh resident access to MT Centres (University Hospital for Wales, Southmead Hospital, Royal Stoke Hospital and The Walton Centre)



*Population within Drive Times of Centres	All Wales (Centres Overlapped) #	All Wales Cumulative (Centres Overlapped) %
<= 30 Minutes	777,840	25%
<= 60 Minutes	1,821,352	58%
<= 90 Minutes	2,547,201	81%
> 90 Minutes	599,940	19%

*Populations based on LSOA2011 and map is based on LSOA2021. Where there are LSOAs from LSOA2021 that don't exist in the LSOA2011 the populations have been assumed at 1,500 per LSOA.

The equity gap in MT access rate is consistent with the travel times. Approximately **600,000 people (19%) remain more than 90 minutes away** from a thrombectomy centre. These people are predominantly located in Mid Wales, Rural West Wales and parts of North Wales away from the A55 corridor. This is important because thrombectomy is one of the most time-sensitive interventions in healthcare. A patient within a 90-minute drive time may still experience:

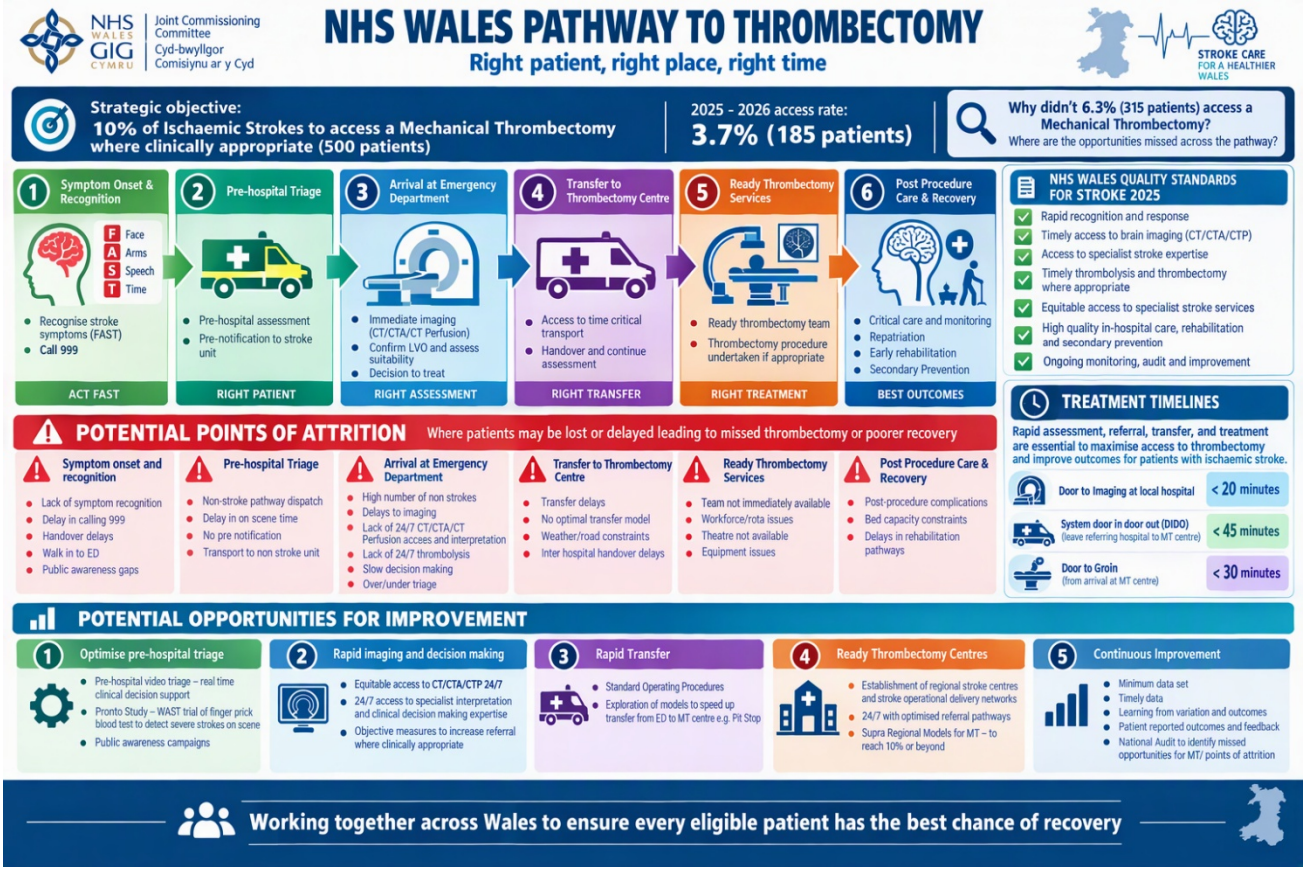
- Ambulance response delays
- On-scene assessment time
- Delays if self-presenting to the Emergency Department
- Transfer delays
- Imaging delays
- Inter-hospital transfers

Therefore, being within a 90-minute drive does **not** necessarily equate to treatment within the recommended thrombectomy timeframes. Additionally, in South Wales, the service at UHW is open to referrals between 09.00 to 13.00, therefore for referrals outside of these hours (between 13.00 to 20.00) travel times are extended by at least 50 minutes.

Whilst the establishment of the South Wales Thrombectomy Centre is a significant development for the population of South and South West Wales, MT rates remain influenced by factors beyond thrombectomy centre capacity and operating hours. Key constraints exist elsewhere in the pathway, including access to advanced imaging and expert interpretation, transfer and repatriation delays, workforce fragility, a high number of presentations at emergency departments and the absence of comprehensive data on unmet need. Addressing these system-wide barriers will be essential to maximise equitable access to MT and realise the full

benefits of the service. The stroke pathway is complex and as such clear, agreed protocols implemented consistently across Health Boards are essential to minimise delay. Figure 5 illustrates the pathway to MT, the stages and areas where delays may occur that need to be considered in the oversight of the stroke pathway by NHS P&I.

Figure 4 – The NHS Wales Pathway to Thrombectomy (whole pathway)



2. SPECIFIC MATTERS FOR CONSIDERATION

This report includes the following for consideration:

- A summary of the year 1 evaluation of the South Wales Thrombectomy Service.
- Readiness of the South Wales Thrombectomy Service to progress to phase 2 (08.00 to 20.00 Monday to Friday).
- The partnership with Bristol NHS Foundation Trust.[2]
- Availability of data to support commissioning decisions.
- System readiness for 24/7 and strategic context for consideration (National Clinical Plan for Stroke).

[2] Bristol NHS Foundation Trust was formed on 1 July 2026 following the merger of North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

- Potential commissioning configuration options for the South West and South Wales.

2.1 Evaluation of the South Wales Thrombectomy Service (phase 1/year 1)

As agreed by the Joint Committee in January 2024, a post implementation commissioning evaluation was scheduled following completion of Phase 1 (12 months post-implementation) to inform a recommendation on whether subsequent phases should proceed. Progression to each future phase was to be assessed against a range of factors, including the maturity of regional stroke services, workforce capacity, financial sustainability, and operational considerations, with a view to identifying opportunities for greater efficiency and economies of scale.

The NWJCC has been notified by CVUHB (Clinical Diagnostics and Therapeutics Board) that they are unable to submit a phase 2 business case at this time due to INR workforce constraints.

Outcomes

The first year of the South Wales Mechanical Thrombectomy Service demonstrated that the Phase 1 business case was implemented and delivered on its primary objective of establishing a safe, clinically effective regional thrombectomy service for the population of South Wales and South West Wales. The service commenced on 1 July 2025 and now provides a coordinated regional pathway serving a population of approximately 2.25 million people.

Overall, the service has demonstrated strong clinical outcomes (recanalisation rates consistent with leading UK MT centres, low critical care stays, low post-procedure death and complication profile), effective governance arrangements (including monthly regional quality and safety meetings), successful network implementation and good operational performance. A number of anticipated constraints identified within the original business case remain, particularly workforce capacity, limited operating hours, inter-hospital transfer delays and inequitable access for populations living furthest from Cardiff.

The service has not provided a detailed benefits realisation plan at this stage and highlighted the need for more resource to support data collection and reporting. The NWJCC is currently exploring direct access to SSNAP to support the benefits realisation reporting.

The business case projected 78 thrombectomy procedures per annum for Phase 1 (Monday-Friday 09:00-17:00). In the first 12 months of delivery 71 patients were transferred to University Hospital Wales and 52 procedures undertaken. The patients that were transferred but did not receive a MT either improved or were not suitable for the procedure.

Case Studies

The following case studies provide practical examples of how pathway performance directly influences access to MT. They demonstrate both the significant benefits achieved when patients access treatment rapidly and the consequences of pathway delays or geographical barriers, reinforcing the importance of continued service optimisation to improve equitable access across Wales.

Case : Timely access to MT

A patient presented with a severe stroke (NIHSS 19) underwent rapid assessment, imaging, thrombolysis and referral to UHW. The patient achieved a door-to-scan time of 13 minutes, a DIDO time of 77 minutes and received thrombectomy within 3 hours 58 minutes of symptom onset.

Successful reperfusion (TICI 3) was achieved, the patient repatriated the following day and was subsequently discharged home.

This case demonstrates how timely assessment, rapid imaging, efficient transfer arrangements and coordinated specialist intervention can result in excellent clinical outcomes and maximise the benefits of thrombectomy.

Case 2: Pathway delays resulting in lost treatment opportunity

A patient presented with a severe stroke (NIHSS 11) and experienced delays at multiple stages of the pathway, including imaging, referral processes and transfer arrangements.

Despite ultimately reaching UHW, the patient arrived 7 hours 47 minutes after symptom onset. Repeat imaging demonstrated stroke progression beyond the threshold for thrombectomy, and the patient required referral for hemicraniectomy.

This case illustrates how cumulative delays across the pathway can result in the loss of eligibility for thrombectomy, with significant implications for both patient outcomes and longer-term health and care needs.

Case 3: Geography and transfer time challenges

A patient presented with a severe stroke (NIHSS 22) received timely local assessment and referral.

The distance from the thrombectomy centre resulted in a transfer time of almost two hours. The patient arrived at UHW 6 hours 48 minutes after symptom onset, by which time repeat imaging demonstrated advanced stroke evolution and thrombectomy was no longer appropriate. The patient was referred for hemicraniectomy.

This case highlights the impact that geography and travel times can have on equitable access to thrombectomy services and demonstrates the challenges faced by patients living in areas that are remote from specialist treatment centres.

Constraints

- **Restricted operating hours** (09.00 to 17.00) – this equates to a 4 hour referral window between 09.00 to 13.00 which limits referrals. The 4 hour gap between the referral cut off and service closure is the same as Southmead Hospital as it accounts for patient work up (2 hours) and transport time (2 hours). The referral window is set to account for the longest travel times but requires review.
- **Workforce constraints** - ongoing challenges with Intervention Neuro Radiologist (INR) retention/recruitment) linked to National shortage.
- **Referral pathway issues** - attrition in the stroke pathway (not commissioned by NWJCC) leading to missed opportunities for a MT.
- **Delays in patient transfer from referring centres** - Door in Door Out (DIDO) which is the time taken from leaving the referring hospital to the MT centre exceeds 2 hours, the target is 45 minutes). However, with travel times in excess of 60 minutes for 20% of the catchment population, the target would only be achievable for those living closest to Cardiff. This may also be impacted by the high number of patients in Wales that present at the Emergency Department

Value for Money
As set out in the original business case, the service required pump-priming investment during Phase 1, with increasing value expected as the service progressed through subsequent phases. The projected cost per procedure (excluding WAST, devices and critical care) reduced from **£21.4k in Phase 1** to **£11.2k in Phase 4** (24/7 service delivery).

For the period July 2025 to June 2026, the actual cost per procedure for phase 1, excluding WAST, devices and critical care, was **£34.5k**. This is higher than the costs charged by NHS England providers; for example, the cost of a MT procedure (excluding transport, device and critical care costs) at The Walton Centre is approximately **£15.4k**.

The higher cost of a MT at the South Wales Thrombectomy Service compared to the business case reflects the lower-than-anticipated activity levels experienced by the service since its implementation with a dependency on the wider stroke pathway for throughput.

The service has reported periods of increased activity, including April to June 2026, when 19 procedures were undertaken. Should activity be sustained at this level over the longer term, the average cost per procedure would reduce and become more comparable to Southmead Hospital (Bristol NHS Foundation Trust).

The Cost of MT at Southmead Hospital
In 2018/19, NHS Wales agreed a local pricing arrangement with North Bristol NHS Trust for MT at Southmead Hospital as the national tariff was considered insufficient to cover service costs. A local bed-day rate was also introduced to support timely repatriation of Welsh patients. Since that time, the NWJCC has worked with the Trust to reduce the cost per case dependent on annual procedural volumes between **£27.4k to £22.3k** (excluding transport, critical care and devices), bringing prices closer to national tariff levels.

Following the implementation of the South Wales Thrombectomy Service in July 2025, a 6 month block contract was agreed with North Bristol NHS Trust for the period July to December 2025. This arrangement was intended to mitigate the risk of destabilising the MT service at Southmead Hospital resulting from a reduction in activity following the repatriation of weekday cases to UHW between 09:00 and 17:00, Monday to Friday.

The NWJCC continue to work with the Trust to improve value in the context of the additional costs of out of hours service provision (including weekends and bank holidays).

From a value-for-money perspective, consideration should be given to the length of time the service should remain in Phase 1, which represents the most expensive stage of delivery. Whilst value for money is important in the context of next steps, broader consideration needs to be given to the system benefits of a service being provided closer to

home and the platform it presents for the further development of services to reduce inequity for patients in West and Mid Wales.

Improved value for money could be achieved by:

- ***Extending the referral window beyond 4 hours to capture more MTs that might otherwise go to Southmead Hospital.***
- ***Improving the whole stroke pathway to increase utilisation of the South Wales Thrombectomy Centre and Southmead Hospital.***
- ***Reviewing the finances for both MT centres.***
- ***Strengthening collaborative working between the two centres to support the delivery of a sustainable 24/7 service.***

Equity of Access to MT by Health Board
The following table, contains data from SSNAP via the NHS P&I Stroke Dashboard including the number of MTs and access rate (% of strokes) by Health Board, comparing the 12 month period prior to the implementation of the South Wales Thrombectomy Service and following the 12 months of phase 1:

Health Board	July 2024-June 2025 (MTs/ Strokes)		July 2025-June 2026 (MTs/ Strokes)		Variance
ABUHB	37/758	4.9%	30/826	3.6%	↓
CVUHB	26/785	3.3%	37/759	4.9%	↑
CTMUHB	29/767	3.8%	20/975	2.0%	↓
HDUHB	21/780	2.7%	20/829	2.4%	↓
SBUHB	21/675	3.1%	30/621	4.8%	↑
All	134/3,765	3.5%	137/4010	3.4%	↔

(Data not available for PTHB)

This includes all MTs successfully performed between 6am to midnight by the SW Thrombectomy Service (09.00-17.00) or Southmead (17.00-0.00).
The access rate for CTMUHB appears low during this time but has improved, reaching over 7% in July and August 2026. The access rate for CVUHB remains lower than anticipated, with a high proportion of patients having a MT at Southmead which needs to be explored. Access for HDUHB remains low overall. The deep dive highlighted the dependencies on the wider stroke pathway impacting on MT access rates and as such this information cannot be viewed in isolation.

It is evident that an inequity of access continues for patients in HDUHB.

2.2 Readiness of the South Wales Thrombectomy Service to future phases
CVUHB has confirmed that the SW Thrombectomy Service is not currently in the position to submit a business case for phase 2 due to INR workforce constraints.

The SW Thrombectomy Service has cited the following areas of focus to build on year 1:

- Expanding service hours toward longer days, to 7-day and eventually 24/7 delivery – *The NWJCC requires a revised line of sight*.
- Reducing DIDO times and improving transfer performance across the region.
- Strengthening workforce and rota resilience in preparation for expansion.
- Expanding capacity in INR and across the multidisciplinary pathway.
- Developing outcome tracking and audit capability.
- Addressing geographic inequity, particularly for West Wales populations.
- Reviewing long-term service configuration to maximise equitable access.

Futureproofing the Workforce

According to the Royal College of Radiologists 2025 Census, the UK clinical and interventional radiology shortage stands at 32% and is projected to reach 40% by 2030 if unaddressed.

In response, the South Wales Thrombectomy Centre has developed a plan to address the INR workforce shortage which involves growing their own, with a Clinical Fellow already in training.

The current service remains in the most expensive phase of delivery and should not remain in Phase 1 indefinitely. A revised line of sight to 24/7 is required from the Health Board to support next steps.

2.3 The partnership with Bristol NHS Foundation Trust

Bristol NHS Foundation Trust have continued to engage in discussions regarding the development of a 24/7 service through extended access overnight for South West Wales and South Wales patients (subject to numbers) until the South Wales Thrombectomy Service is in a position to extend operating hours.

If there is a 50% increase in the number of people expected to have a stroke by 2035, an over reliance on CVUHB or Bristol NHS Foundation Trust is a risk. A continued partnership model approach between Bristol NHS Foundation Trust and CVUHB leading to a position of mutual aid would support future resilience.

2.4 Availability of data to support commissioning decisions

Evidence of Demand Overnight

- **NHS England -** A report by NHS England (2023) into Mechanical Thrombectomy delivery at 24 Comprehensive Stroke centres in England found the following:
  - More than half of MT activity occurs overnight in some centres.
  - The report recommends regional overnight rota solutions until workforce capacity improves.[3]

1. [3] NHS England (2023) *Mechanical Thrombectomy delivery in England: Final report*. London: NHS England.

- Current overnight staffing models are often unsustainable and rely on goodwill or existing on-call rotas.
- Out-of-hours MT affects both emergency and next-day elective services.
- Geographical access inequalities are magnified overnight.

- NHS Wales - NHS Wales P&I are undertaking an analysis of the unmet demand overnight by collating data for Ischaemic Strokes, with a NIHSS score of 6 and greater, which have presented within 12 hours of onset between the hours of 20.00 to 06.00 to support discussions with Bristol NHS Foundation Trust regarding an extension of service overnight.

Ambulance Arrivals

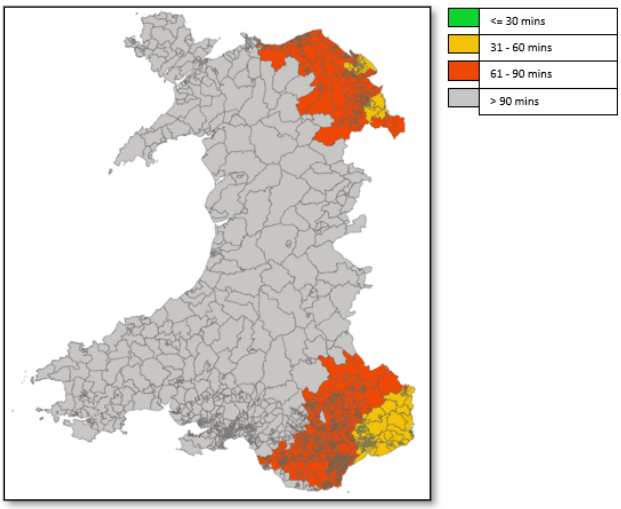
Arrival by ambulance generally leads to faster in-hospital assessment and higher rates of MT compared to self-presenting at an Emergency Department (ED), though pre-hospital ambulance delays can complicate this advantage[4]. The table below outlines the percentage of patients arriving by ambulance in September 2026 (no breakdown for PTHB available):

Health Board	Ambulance Arrivals (Stroke patients)	Emergency Department
ABUHB	72%	The Grange University Hospital
BCUHB	57%	Ysbyty Gwynedd (65%) Ysbyty Glan Clwyd (57%) Wrexham Maelor Hospital (50%)
CVUHB	40%	University Hospital Wales
CTMUHB	34.6%	Royal Glamorgan Hospital
HDUHB	49%	Glangwili General Hospital (46%) Prince Philip Hospital (70%
SBUHB	50%	Morriston Hospital
Wales	51.1%	

For comparison NHS England ambulance arrivals are on average 74%.

[4] Shaw L, Allen M, Day J, et al. (2026). *Specialist Pre-hospital Re-direction for ischaemic stroke thrombectomy (SPEEDY): study protocol for a cluster randomised controlled trial with included health economic and process evaluations*. BMJ Open, 16:e112545

Figure 5 - Population drive time analysis for Welsh resident access to MT Centres: Southmead Hospital, Royal Stoke Hospital and The Walton Centre



*Population within Drive Times of Centres	All Wales (Centres Overlapped) #	All Wales Cumulative (Centres Overlapped) %
<= 30 Minutes	5,789	0.2%
<= 60 Minutes	340,201	11%
<= 90 Minutes	1,836,350	58%
> 90 Minutes	1,310,791	42%

*Populations based on LSOA2011 and map is based on LSOA2021. Where there are LSOAs from LSOA2021 that don't exist in the LSOA2011 the populations have been assumed at 1,500 per LSOA.

Figure 6 provides a drive time analysis without the South Wales Thrombectomy Centre. This information is provided for consideration regarding potential commissioning configuration options. The removal of the MT centre results in a reduction from 58% of patients being within 60 minutes of a MT Centre to 11% (compared to figure 4).

For ambulance transport, based on the potential for increasing MT activity towards the aim of 10%, it is a likely planning assumption it will increase demand for time-critical inter-hospital transfers. This should be reflected in the transport demand and capacity modelling, alongside improvements in DIDO and wider pathway flow, in order to provide assurance that increased activity can be accommodated without adversely impacting existing Red/Emergency response performance.

2.5 System readiness for 24/7 and strategic context for consideration

Current activity levels remain below the estimated population need.

The evaluation of the South Wales Thrombectomy Service has identified that once patients are under the care of the regional service, they received the procedure within **56 minutes of arriving** (median door to groin time). For comparison, the NHS England Thrombectomy System Score metrics in 2025-2026 reported median door to puncture times of just over 1 hour. The quickest door to groin time reported by the SW Thrombectomy Service was **36 minutes** against a target of <30 minutes.

In more rural areas, patients often take significant time to reach their local Emergency Department to be scanned, assessed, identified and referred for MT prior to transfer to the MT centre. The infographic (figure 3) illustrates the potential points of attrition, required areas of focus and need for a referral pathway clinical audit to identify the missed opportunities and areas for improvement.

The readiness of the spoke sites to refer patients beyond the current referral window of 8pm is not confirmed and needs to be assessed by NHS P&I as not within the commissioning scope of the NWJCC.

There is currently a proposal in development at NHS Wales P&I, to set up working groups to focus on establishing baselines and performance measures, delays and variation at Pre-Hospital, DIDO/Spoke Site, Transfer, and the MT Centres. Strategic oversight would be provided by the National Stroke Hyper Acute Services Group, with the overarching aim of increasing MT access and reducing the time from symptom onset to groin puncture.

The original business case was predicated on alignment with the development of Comprehensive Regional Stroke Centres, HASUs and Stroke ODN services which have not progressed as anticipated. The NWJCC understands that the National Clinical Plan is in development which may be the catalyst for refocusing the regionalisation work but should not delay the consideration of next steps towards the commissioning of a 24/7 service.

2.6 Potential Commissioning Configuration Options (South Wales)
The aim of the following section is to facilitate discussion, with the aim of setting out potential options to be explored through next steps.

It is important to note that as set out in section 1.3, if there is a 50% increase in the number of people expected to have a stroke by 2035, an over reliance on either CVUHB or Bristol NHS Foundation Trust would present a longer term risk to the sustainability of MT services. A partnership approach between Bristol NHS Foundation Trust and CVUHB, leading to a position of mutual aid may support future resilience, particularly overnight.

As CVUHB are not in a position to submit a business case for phase 2 at this time, the following are options for consideration:

1. **Do nothing** - maintain current commissioning position.
2. **Get ready** – Maintain current commissioning position of shared model between CVUHB and Bristol NHS Foundation Trust. Focus on South Wales Thrombectomy Service and wider system readiness. Optimise referral window / revise operating hours to align with peak demand whilst CVUHB work on revised business case with line of sight to 24/7.
3. **Get ready and extend hours through Bristol NHS Foundation Trust** – Maintain shared model. Focus on South Wales Thrombectomy Service and wider system readiness **and** extend operating hours of Bristol NHS Foundation Trust overnight to provide **24/7 cover** (with reduced throughput on weekdays during South Wales Thrombectomy Centre referral hours), whilst CVUHB work on revised business case with line of sight to 24/7.
4. **Decommission** – Decommission the South Wales Thrombectomy Service and extend operating hours with Bristol NHS Foundation Trust to provide 24/7 cover (The associated risks to the wider South Wales neurosurgery and neurovascular services are outlined in the section below).

3. KEY RISKS

The South Wales Thrombectomy Service (CVUHB) remains in the most expensive phase of delivery and should not remain in Phase 1 indefinitely. The NWJCC requires clarity from CVUHB on readiness, timescales and a realistic route toward service expansion. At the same time, discussions with Bristol NHS Foundation Trust remain important to support resilience, equity of access and future demand growth.

Service expansion alone may not achieve the anticipated increase in MT activity unless referral pathways are optimised. National workforce modelling undertaken by NHS England in 2023 found that "*six centres report that more than 50% of cases occur out of hours*", highlighting the significant overnight demand associated with mechanical thrombectomy services and the importance of sustainable 24/7 workforce arrangements. Mills et al. (2024) observed an increase referrals and procedures as a result of moving from extended hours to 24/7 and overnight demand is reported by other centres[5]. The NWJCC will work with the National Stroke Hyper Acute Services Group to monitor system readiness and referral pathway optimisation.

Rurality and continued inequity of access. Patients living in rural areas across Wales and towards the boundaries of the catchment area face longer pre-hospital journeys plus longer journeys to the MT centre, together with limitations in local services (e.g. imaging and interpretation, out of hours rotas) contribute to reduced opportunity for MT. Whilst the North Wales population has access to a 24/7 service at The Walton Centre, access rates remain low, indicating that limitations in the stroke pathway and proximity to the MT Centre remain a risk and require monitoring and action. Additionally, NHS England (2023) highlighted that geographical access inequalities are magnified overnight. Achieving equity of care in remote geographical areas is a priority for the NWJCC Ambulance Directorate, which is working with the provider, focusing on improving rates of transport times where feasible and as part of their rural ambulance provision in Wales work, this will consider access to road ambulance and Emergency Medical and Retrieval Service (EMRTS). Addressing inequity of access requires a whole pathway approach, taking into account the future strategic direction set out by the National Clinical Plan.

Decommissioning the South Wales Thrombectomy Service would risk the viability of neurosurgical and neurovascular services by reducing the critical mass needed for a sustainable South Wales neurosurgical centre. Multi professional guidance sets out a range of standards and processes, including that neuro-interventional operators should (each) undertake a minimum of 40

[5] Mills, M.T., White, P.M., Dineen, R.A., McConachie, N.S., Murphy, S.J.X. and Binning, M.J. (2024) 'The move to 24/7 mechanical thrombectomy provision for ischaemic stroke: an observational study of the impact on referrals, activity, procedural efficacy, and safety at a supra-regional centre', *Journal of NeuroInterventional Surgery*. Available at: https://pubmed.ncbi.nlm.nih.gov/39387374/

cerebral endovascular interventions per annum, of which a reasonable proportion are thrombectomy.[6] The provision of a local MT service is an important enabler for recruitment to a sustainable INR service and a sustainable INR service is essential for the provision of neurosurgery services at CVUHB for the South Wales population.

An over-reliance on CVUHB or Bristol NHS Foundation Trust for the provision of MT for the South Wales and South West Wales population. If there is a 50% increase in the number of people expected to have a stroke by 2035 as projected, an over reliance on either CVUHB or Bristol NHS Foundation Trust is a risk. A continued partnership approach between Bristol NHS Foundation Trust and CVUHB leading to a position of mutual aid may be advantageous. Additionally, NHS England's report on the 24 Mechanical Thrombectomy Centres recommended regional overnight rota solutions until workforce capacity improved, which could be explored further.

Provision of £1.5m has been made in the IMTP but more funding may be required subject to next steps.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Maximise Value
	If more than one applies please list below: Improve equity and population health
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality**	Whole-systems Perspective
	If more than one applies please list below:

[6] NHSE Specialised Commissioning Specification – 1868 Stroke Thrombectomy Service for Acute Ischaemic Stroke - delivered in a non-neuroscience centre. (Adults), available at https://www.england.nhs.uk/wp-content/uploads/2021/01/1868 Thrombectomy-Service-Specification.pdf

(*Duty of Quality Statutory Guidance (gov.wales)*)	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** (*Duty of Quality Statutory Guidance (gov.wales)*)	Equitable
	If more than one applies please list below: Effective Efficient Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: The purpose of the deep dive has been to review the pathway, which includes the identification areas for improvement, therefore a separate QIA screen has not been undertaken. The review has highlighted inequity of access for those patients living furthest from the MT centre which will be considered through next steps. A QIA screen will be undertaken on commissioning options as they develop.
Cydraddoldeb	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: Equality Impact Assessment screening was not undertaken as this was a deep dive review. No material equality concerns have been identified that would trigger the need for a separate formal assessment at this stage.
Cyfreithiol / Legal	Yes (Include further detail below)	
	There are legal implications to consider as a result of not having a 24/7 service in place for the South West Wales and South Wales Population as patients may have an adverse outcome as a result of not having access to a MT between midnight and 06.00.	
Enw da / Reputational	Yes (Include further detail below)	
	17 out of 24 NHS England MT centres were 24/7 as of April 2026, with plans for all centres to be 24/7. NHS Northern Ireland have recently commissioned a 24/7 service. NHS Scotland still have limited access.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	A provision of £1.5m was made in the 2026-2027 IMTP to support service expansion which has not progressed as planned. The provision may continue to be made in the 2027-2030 IMTP Subject to Joint Committee approval on next steps.	

5. RECOMMENDATIONS

The members of the Joint Commissioning Committee are asked to:

- **Note** the contents of the paper including:
  1. **Requirement for a whole-pathway improvement** approach - Recognise that current thrombectomy activity is constrained by factors beyond thrombectomy centre operating hours, including advanced imaging access, transfer delays, proximity to MT centre, workforce limitations, referral pathway attrition and incomplete understanding of unmet need. Future commissioning actions should therefore consider the entire stroke pathway.

2. **Support for a future Clinical Audit of the National MT Referral Pathway** - Support the development of national clinical audit of the MT referral pathway to identify where eligible patients are lost from the pathway, quantify unmet need, and improve performance. The audit should assess variation at pre-hospital, spoke-site, transfer and thrombectomy centre stages. It is our understanding that NHS P&I are developing a proposal to establish working groups representative of these areas in preparation.
3. **Acknowledge the year 1 evaluation of the South Wales Thrombectomy Service –** Acknowledge the successful implementation, dependence on stroke pathway for throughput, workforce constraints that prevent progression to phase 2 and balance between value for money and system benefits of care closer to home. The identification of strategic lead for **Stroke and MT** in the health board would be helpful to drive the changes required to increase value (e.g. referral window extension), develop the partnership with Bristol NHS Foundation Trust and provide a continued focus on-line of sight to 24/7.
4. **Recognise the need for ongoing discussions with Bristol NHS Foundation Trust to provide interim resilience, overnight access and a longer-term sustainability** - Continue engagement with Bristol NHS Foundation Trust regarding provision of overnight and 24/7 cover options, ensuring service resilience as an interim commissioning option pending the SW Thrombectomy service expansion and development of a sustainable longer-term model.
5. **Prioritise reduction of transfer delays as a commissioning objective** – The Ambulance Directorate and Specialised Services Directorate continue to work together with the National Stroke Hyper Acute Services Group to reduce Door-In Door-Out (DIDO) times and inter-hospital transfer delays, recognising that current transfer performance significantly exceeds expected standards and may represent a major contributor to lost thrombectomy opportunities.
6. **Continue to address inequity of access** – This requires future service evaluations and performance reporting to include geographical equity measures, including thrombectomy eligibility, referral, transfer and treatment rates by Health Board and travel-time cohort. Particular focus should be given to patients living furthest from the MT centre to ensure service developments improve access across Wales
7. **Strengthen MT performance oversight** - Support the establishment of a minimum dataset and the proposed national work programme led by NHS Wales P&I including development of baseline measures, pathway performance indicators and system-wide monitoring arrangements under the oversight of the National Stroke Hyperacute Services Group. The SSNAP system is limited to provider use, NHS P&I do not have access. NWJCC access to the SSNAP data (anonymised) for Welsh patients needs to be explored.
8. **Make provision in the 2027-2030 IMTP -** Continue to make provision in the plan to support future service expansion.