



Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planned Care Recovery 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Director of Operational Performance and Delivery

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

On 30 June 2026, the NHS Wales Deputy Chief Executive wrote to Chairs and Chief Executives of all Health Boards requesting:

- By 19 July 2026 - plans for elimination of Referral to Treatment (RTT) pathway 104 week waits by March 2027 (to include regional plans where service delivery is not considered to be sustainable and solutions cannot be secured individually by Health Boards)
- By 31 July 2026 - submission of a Board approved Planned Care Plan by 31 July 2026 to cover all required pathway transformation and productivity actions and deliverables

In response and to enable compliance with the above deadline, an Extraordinary Meeting of the Finance and Performance Committee has been scheduled for 27 July 2026 to consider the Hywel Dda University Health Board (HDdUHB) Planned Care Plan.

The Finance and Performance Committee is requested to endorse the attached Planned Care Recovery and Delivery Plan on behalf of the Health Board.

Cefndir / Background

In March 2026, the Board approved the Annual Plan for 2026/27. In respect of RTT performance, the Plan outlined the following delivery commitments by March 2027:

- RTT Total Pathway wait (104 weeks) – no more than 5,507 breaches
- RTT Stage 1 wait (26 weeks) – no more than 9,316 breaches

- Diagnostics Direct Access waits (8 weeks) – no more than 5,564 breaches

Following submission of the Annual Plan, the Health Board's planned care delivery commitments have been subject to significant challenge from Welsh Government and NHS Performance and Improvement with the request for plans and associated delivery trajectories to be re-examined and revised by 31 July 2026.

RTT performance during Q1 2026/27 has been within trajectory levels during the period with significantly fewer total pathway and Stage 1 breaches than forecast in the Annual Plan. In part, performance during the period has been influenced by supplementary activity delivered during Q1, resourced via the 2025/26 National Outpatient Appointment (OPA) Insource initiative and internal Health Board recovery funding applied during Q1.

In June 2026, Welsh Government launched its new NHS Wales Integrated Planned Care, Diagnostic and Cancer Plan for 2026/27, centred around an integrated pathway focus on the three pillars of:

- Referral and early diagnosis
- Capacity, productivity and treatment
- Follow up, surveillance and living well

On 17 June 2026, the Welsh Government announced additional funding support to enhance planned care recovery to enable rapid reduction of longest waiting times and sustainable improvement in performance. This funding will be deployed through a national delivery model, with access to funding dependent on evidence of delivery, improvement and an agreed trajectory of performance.

In response, Health Boards have been requested to develop plans to provide:

- Immediate and sustained focus on 104-week waits, ensuring these are eliminated as quickly as possible and do not reoccur. There should be a consistent reduction over the remainder of this year with the objective to get to zero as soon as is possible.
- Maximisation of internal capacity as the priority, before recourse to external provision.
- Use of external capacity only where necessary and aligned to national and regional procurement approaches.
- Delivery through regional and national collaboration, not isolated to organisational approaches where current or additional resources are more effective.
- Demonstration of sustainable change, not short-term activity increases.
- Measures to manage potential growth in demand to enable a reduction in overall waiting list volumes alongside waiting times

The Welsh Government expectation is that:

- 104-week waits are eliminated as a matter of urgency
- 8 weeks is the maximum wait for diagnostic tests
- Plans are credible, detailed and deliverable and clearly align to NHS Wales Planned Care Optimisation Framework standards for productivity and efficiency
- Health Boards take full ownership, including formal sign-off of transformation commitments and plan objectives

The specific request of health boards was for two separate submissions as below:

- By 19 July 2026 – Health Boards submit plans for the elimination of 104-week waits – where service delivery (for example, Orthopaedics) is not sustainable a regional submission is required.
- By 31 July 2026 – A Board approved Health Board Planned Care Plan which covers all the required actions and deliverables.

An interim plan for recovery of 104-week waits was submitted on Monday 20 July 2026. Submission was deferred until 20 July 2026 at the request of Swansea Bay University Health Board due to the regional component of the recovery plans for orthopaedics and ophthalmology.

The content of this interim recovery plan is reflected in the broader, more comprehensive Planned Care Delivery and Sustainability Plan which the Committee is requested to consider and endorse at its Extraordinary Committee meeting on 27 July 2026.

Asesiad / Assessment

The Plan has been structured to reflect the principles of the new national approach to improvement of Planned Care and Diagnostic pathways, centred around an integrated pathway focus on the three pillars of:

- Referral and early diagnosis
- Capacity, productivity and treatment
- Follow up, surveillance and living well

This plan describes progress achieved by the Health Board to date towards sustainability of its planned care pathways and highlights those specialty areas where further work is required to ensure sustainability for the longer term.

The Plan also details the progress achieved by the Health Board in transforming the way in which planned care pathways are delivered and the further actions the Health Board will deliver, reflecting the NHS Wales Planned Care Optimisation Framework standards for productivity and efficiency. Given the breadth of the Optimisation Framework and component elements of the Planned Care 3 Pillars, a summary description is provided in the Plan, supported a detailed Addendum document which itemises and evidences the progress and further actions related to individual elements.

Where sustainability gaps remain, the Plan includes in-year recovery proposals where additional capacity is required to enable achievement of required milestones in respect of 104-week RTT and 8-week diagnostic waits by March 2027. Beyond the productivity improvement measures already reflected and built into delivery plans for 2026/27, the modelling undertaken highlights a remaining delivery gap which will necessitate additional capacity to enable compliance with required delivery targets by Match 2026/27.

This currently entails a forecast in-year recovery cost of £11.6m and is summarised below:

Specialty	Insourcing / WLJ	Rate (£)	Cost (£)	Outsourcing cases	Rate (£)	Cost (£)	Regional cases	Rate (£)	Cost (£)	
Trauma & Orthopaedics	450	£5,000	£2,250,000	109	£9,094	£991,246	182	£2,530	£460,460	£3
Ophthalmology	0	£0	£0	1,200	£1,407	£1,688,400	0	£0	£0	£1
ENT	229	£3,000	£687,000	68	£2,500	£170,000	0	£5,000	£0	£1
Urology	210	£5,000	£1,050,000	0	£6,044	£0	0	£5,000	£0	£1
Dermatology	43	£2,500	£108,425	0	£6,044	£0	0	£5,000	£0	£1
TOTAL EXTERNAL ASK	932		£4,095,425	1,377		£2,849,646	182		£460,460	£7

Diagnostics	Cost (£)
Endoscopy / Urology	£630,000
Cardiology	£220,000
Radiology Reporting to support 8 weeks and Cancer (subject to confirmation)	£2,400,000
Pathology Diagnostics & Reporting	£800,000
Programme Administrative & Support Team Costs	£321,952
POPS	£178,334
Total	£4,550,286

The detail of these recovery solutions is described in the Plan.

Central to effective delivery of planned care pathways is the sustainability of and capacity within key diagnostic services. These are a critical dependency, not only to delivery of a maximum 8 week wait for diagnostics but also for RTT pathways and Single Cancer Pathway delivery.

Committee members will be aware of significant data quality and accuracy concerns in respect of Radiology demand, activity and performance data following the implementation of the new RAD+ Radiology system in December 2025. Since implementation in December 2025, reported Radiology breach performance has deteriorated at a much greater pace than forecast. This pattern has continued during Q1 and is not easily explained by analysis of current demand and activity data.

In response to concerns escalated, a Task and Finish Group has been established to investigate and assure/validate the Radiology performance data, jointly chaired by the Digital Director and Service Director for the Allied Health and Health Sciences Clinical Care Group, with support from the wider Radiology, Informatics and Performance teams. The Task and Finish Group is working to a deadline of 31 July 2026 to complete its work and inform a robust performance delivery trajectory for the remainder of 2026/27.

The Radiology recovery proposals currently reflected in the Plan should therefore be regarded as provisional and subject to further review / amendment, pending the outcome of the Task and Finish Group work. For the benefit of Committee members, the project plan and governance structure which underpins the Task and Finish Group is appended for information.

This Planned Care Delivery and Sustainability Plan appended also describes the way in which the Health Board is working regionally with Swansea Bay University Health Board to address fundamental sustainability challenges in key specialty areas, both to secure in year compliance with Planned Care delivery targets for 104-weeks and 8-weeks during 2026/27 and progress towards sustainable delivery models for the longer term.

[Argymhelliad / Recommendation](#)

The Finance and Performance Committee is asked to consider and:

- **ENDORSE** the Planned Care Delivery & Sustainability Plan for submission to Welsh Government by 31 July 2026; and
- **NOTE** the provisional assessment included in the in-year recovery proposals for Radiology diagnostic capacity and that this is subject to revision pending the outcome of the Radiology Data Task and Finish Group review.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective 5. Equitable 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care 4. Positive futures
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of 7. Improve health and well-being by focusing on prevention and early intervention, while working in

	partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As set out in the paper and national Planned Care Plan
Rhestr Termau: Glossary of Terms:	Included in the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	In financial plan; future savings identified against the investment will not be delivered.
Ansawdd / Gofal Claf: Quality / Patient Care:	Delivery of timely, appropriate interventions.
Gweithlu: Workforce:	Additional temporary staff appointed in the event of WG approval of recovery support
Tegwch Iechyd: Health Equity:	Not Applicable

Risg: Risk:	Harms associated with extended waiting times will not be addressed.
Cyfreithiol: Legal:	Failure as a Health Board and public service provider to look after the health and welfare of our population in line with required standards.
Enw Da: Reputational:	Cessation of a clinically led development risks loss of confidence of medical staff. Cessation of developments that have been described as Wales-leading risks national reputational harm. Failure to deliver the national targets risks wider reputational harm and confidence in the Health Board.
Gyfrinachedd: Privacy:	No risk to privacy identified
Cydraddoldeb: Equality:	Existing development of SDEC and CSHs does not provide universal cover to all users of the UEC services



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Planned Care Delivery & Sustainability Plan 26/27

31st July 2026

Contents & Recovery Roadmap

Planned Care Sustainability & Recovery Plan 2026/27



The structure follows the recovery from productivity and transformation, through delivery of the nationally directed ambitions, to investment, sustainability and governance.

Section	Purpose	Key message
1 Executive Summary	Strategic context and productivity roadmap	How the plan delivers national priorities through transformation, productivity and targeted investment.
2 Pillar 1: Referral & Early Diagnosis	Reducing avoidable demand	Establishes validated demand, strengthens referral quality and reduces avoidable entry into planned care pathways.
3 Pillar 2: Capacity, Productivity & Treatment	Maximising internal capacity	Demonstrates further productivity gains, theatre optimisation and treatment capacity improvement.
4 Pillar 3: Follow-Up, Surveillance & Living Well	Reducing future demand	Transforms follow-up, surveillance and patient support pathways to release capacity and prevent recurrence.
5 Elimination of 104-Week Waits & Partial 8-Week Diagnostic Recovery 2026/27	Delivery trajectories and recovery plans	Sets out planned actions, assumptions and trajectories to reduce 104-week waits and support partial diagnostic recovery.
6 Funding Requirement & Residual Gap	Evidence-based investment proposition	Shows where validated residual demand remains after productivity and transformation opportunities have been pursued.
7 Regional Collaboration & Sustainability	Solutions at scale	Sets out regional opportunities, workforce sustainability, service resilience and longer-term models of care.
8 Governance & Organisational Oversight	Assurance and delivery control	Sets out oversight, accountability, measures, milestones and escalation routes to maintain grip on delivery.
9 Conclusions & Next Steps	Board / WG decision narrative	Summarises delivery commitments, remaining decisions, next actions and the sustainable recovery proposition.

Roadmap: National direction → three pillars → 104-week and diagnostic recovery → funding/residual gap → regional sustainability → governance and oversight → next steps

Executive Summary: Our Approach to Planned Care Recovery

A productivity-first plan which balances national milestone delivery, pathway transformation and longer-term sustainability



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Our approach

Hywel Dda's Planned Care Sustainability and Recovery Plan sets out a single, integrated approach to delivering planned care pathways for the population: reduce avoidable demand, maximise productive capacity, transform follow-up and surveillance, and target additional support only where residual demand and capacity gaps remain.

National delivery priorities

- Eliminate 104-week RTT waits by March 2027
- Eliminate >8-week diagnostic waits
- Manage growth and demand across all pathway stages

Plan ambition

To create a sustainable planned care system by combining productivity, transformation and targeted recovery support, aligned to NHS Wales planned care optimisation principles.

In year provisional recovery requirement

£11,995,817

The approach is structured around four linked delivery tests

1

Grip on demand

Referral optimisation, Primary Care interface, validation and early diagnosis

2

Productivity first

Theatre, outpatient, virtual and pathway productivity before additional capacity

3

Target capacity

Additional resource focused only where latest data shows residual excess demand

4

Regional sustainability

Longer-term solutions with Swansea Bay UHB for shared specialty challenges

This is not an activity-only recovery plan: it describes how the Health Board will change pathway demand, productivity and sustainability while securing national milestone delivery.

Executive Summary: Planned Care Sustainability & Recovery Plan 2026/27

Productivity roadmap, transformation commitment and targeted recovery support



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Strategic narrative

Hywel Dda's Sustainable Planned Care Recovery Plan is built on a productivity-first approach in line with the National Priorities. Through strengthened referral management, closer working with Primary Care, expansion of Community HealthPathways, treatment productivity and follow-up optimisation, the Health Board will continue to reduce avoidable demand, improve pathway quality and increase patient access. The next phase scales Surgical Hub accreditation, POPS/prehabilitation, Capsule Sponge, CIN-aligned follow-up models and wider pathway transformation.

Plan ambition

Eliminate 104-week waits, support partial 8-week diagnostic recovery and create a sustainable planned care system.

Total recovery
funding ask

£11,995,817

Pillar 1: Referral & Early Diagnosis

Reduce avoidable demand and validate need

Already embedded / underway

- RTT validation and waiting list quality improvement
- Referral management and consultant triage processes established
- Community HealthPathways embedded to improve referral quality and support Primary Care
- Reduced waiting list growth through demand management and pathway optimisation

Planned scale-up and productivity ambitions

- Strengthen referral management at the Primary Care / Secondary Care interface
- Expand Community HealthPathways adoption across Primary Care
- Increase direct-to-diagnostic and straight-to-test pathways
- Expand professional triage and continue validation activity

Pillar 2: Capacity, Productivity & Treatment

Maximise capacity and treatment throughput

Already embedded / underway

- Theatre optimisation and productivity improvement programmes
- Virtual outpatient models established as a productivity lever
- Cataract/HVLC productivity improvements
- Initial POPS and prehabilitation implementation supporting surgical readiness

Planned scale-up and productivity ambitions

- Achieve Surgical Hub accreditation and embed GIRFT standards
- Expand POPS across additional specialties and wider cohorts
- Extend prehabilitation pathways to improve fitness for surgery
- Further improve theatre utilisation, cancellations and list productivity

Pillar 3: Follow-Up, Surveillance & Living Well

Reduce future demand and release capacity

Already embedded / underway

- FIT pathways embedded within surveillance and diagnostic optimisation
- Follow-up validation, specialty benchmarking and waiting list governance
- SOS/PIFU infrastructure established across specialties
- Appointment avoidance and reduction in waiting list growth through validation and pathway optimisation

Planned scale-up and productivity ambitions

- Align specialties to CIN guidance and Optimisation Framework principles
- Reduce follow-up ratios and release outpatient capacity
- Fully implement and maximise Capsule Sponge pathways
- Develop Patient Service Centre as a future transformation enabler

Hywel Dda will continue to maximise productivity by reducing avoidable demand, optimising treatment capacity and transforming follow-up pathways. This Plan combines Primary Care pathway optimisation, treatment productivity and outpatient transformation to deliver sustainable recovery, eliminate long waits and improve patient outcomes.

Executive Summary: Critical Dependencies, Sustainability Gaps & Targeted Support

Diagnostics is a system dependency, and unresolved gaps require targeted capacity and regional solutions



Diagnostic challenge: Diagnostic recovery is critical not only to the 8-week diagnostic standard, but also to RTT pathway progression and Cancer delivery. Without diagnostic flow, treatment capacity cannot be fully utilised and waiting list growth cannot be controlled.



Targeted diagnostic recovery focus

- Radiology and pathology capacity to support diagnostic and cancer pathway recovery
- Endoscopy sustainability, FIT pathway optimisation and cancer pathway support
- Urology diagnostics and echocardiography to reduce pathway bottlenecks
- Diagnostic recovery positioned as an enabler of 8-week, RTT and Cancer delivery

Sustainability gaps requiring focus

- Assessed excess demand over capacity remains in key specialties despite productivity and optimisation
- Specialties include Ophthalmology, Pain Management, Cardiology diagnostics, General Surgery, Urology and T&O
- Not all specialties create an in-year 104-week delivery gap, but all require longer-term sustainability focus
- Regional planning with Swansea Bay UHB is required for shared specialty challenges

What we are asking for A targeted recovery funding ask of £11,995,817 to support residual capacity, workforce and productivity requirements where local optimisation alone will not deliver March 2027 milestones or longer-term sustainability.

Executive conclusion: the approach combines pathway transformation, diagnostic recovery, productivity grip and targeted regional solutions to deliver recovery now and build sustainable planned care pathways for the future.

Executive Summary: Productivity gains - Overall Waiting List Impact: Size and Shape Over 12 Months

Evidence of material reduction across the full RTT pathway and first outpatient stage



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Board message

Over the 12 months from July 2025 to June 2026, Hywel Dda has reduced the overall RTT waiting list and materially reduced the new outpatient waiting list, while validation and pathway redesign have improved the quality of the residual waiting list. Remaining pressure is concentrated in longer-wait and capacity-constrained specialties.

RTT list reduction -6,967 Jul 25 to Jun 26	RTT reduction -7.4% 93,521 to 86,554	Current 104w 254 Jun 2026	104w low point 3 Mar 2026	New OPD reduction -11,226 Jul 25 to Jun 26	New OPD reduction -22% 50,621 to 39,395	Current 26+ OPD 4,376 Jun 2026
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Size of the waiting lists

- Overall RTT list reduced from 93,521 to 86,554 between July 2025 and June 2026.
- New outpatient list reduced from 50,621 to 39,395 over the same period.
- The reduction shows that demand management, validation and productivity actions are influencing total list size.
- June 2026 shows a small new outpatient increase that requires continued referral management, validation and productivity grip.

Shape of the waiting lists

- RTT remains a cumulative picture across outpatient, diagnostic and treatment stages.
- New outpatient waits form the first stage of the RTT pathway and are a leading indicator for future treatment demand.
- Residual long-wait pressure is concentrated in Ophthalmology and Orthopaedics.
- The current new outpatient 26+ cohort remains material at 4,376 patients in June 2026.

Validation and list quality

- RTT validation reviewed 35,396 pathways and removed 17,819 pathways, a 50% removal rate.
- FUWL validation reviewed 32,565 pathways and removed 8,740 pathways, a 27% removal rate.
- Validation improves confidence in the residual waiting list and helps target recovery capacity to patients still waiting for treatment or clinically necessary follow-up.
- The residual list is therefore a clearer view of real recovery demand.

Interpretation for Board / WG

The past 12 months show a material reduction in both the overall RTT list and first outpatient demand. The shape of the list has also changed: productivity and validation have improved list quality, but the remaining pressure is concentrated in long-wait, diagnostic and treatment-stage capacity constraints.

Takeaway: Hywel Dda has reduced both total RTT and new outpatient list size, while improving the shape and quality of the residual list so recovery capacity can be targeted more effectively.

Executive Summary: Maximising Productivity: What Hywel Dda Has Achieved So Far

Evidence that the Health Board is actively managing demand, improving flow and converting capacity into patient outcomes



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Summary narrative

The Health Board has achieved significant progress in reducing overall waiting times and waiting list volumes across pathway stages, with a strong track record of reducing waits in line with national delivery targets. The data demonstrates active demand management at the front door, productive use of outpatient capacity and strong theatre utilisation across challenged specialties.

Referral vetting

31%

returned after clinical
vetting

WG target

20%

referral vetting benchmark

Outpatient outcome

>50%

do not progress beyond
first OPA

FUWL / population

17%

lowest in Wales

OPD activity

+12%

above pre-Covid levels

Virtual consults

6,060

planned across 5
challenged specialties

FU slots released

5,704

through outpatient actions

New appointments

1,440

additional access created

Outpatient productivity delivered

- Outpatient activity is running 12% above pre-Covid levels.
- 31% of referrals are returned following clinical vetting, exceeding the 20% Welsh Government target.
- Over 50% of outpatients do not progress beyond first outpatient attendance through discharge, SOS and PIFU pathways.
- Follow-up waiting list per head of population is the lowest in Wales at 17%.
- DNA rates are at their lowest level in two years.

Capacity converted into access

- Follow-up reduction has been implemented systematically across ophthalmology, dermatology, ENT, neurology and rheumatology.
- PIFU, SOS, virtual consultations and first-appointment discharge protocols are being used to release capacity.
- 6,060 virtual consultations are planned for 2026/27.
- 5,704 follow-up slots are released and 1,440 additional new patient appointments created.
- Every released follow-up slot is converted directly into new patient access.

Theatre productivity delivered

- Theatre utilisation is strong across challenged specialties.
- ENT: 93%; Ophthalmology: 89.5%; Trauma & Orthopaedics: 84.9%; Urology main theatre: 83%.
- Average utilisation across 4,619 sessions was 79.3%, treating 16,536 patients.
- Theatre REST and GiRFT work are targeting late starts and early finishes.
- Achieving 85% utilisation would yield approximately 1,073 additional patients per annum.

Board message

These metrics demonstrate a service that is actively managing demand before patients reach secondary care, reducing avoidable follow-up, converting released capacity into new access and maximising use of existing theatre capacity before seeking additional resource.

Takeaway: The residual recovery challenge is not explained by absence of productivity action. It reflects remaining specialty, diagnostic and capacity constraints after substantial internal improvement has already been delivered.

Executive Summary: Productivity Evidence by challenged Specialty and Diagnostics



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Where strong productivity has been achieved and where residual gaps reflect genuine capacity or diagnostic constraints

Strategic narrative

The 104-week constraint review shows that several challenged specialties are already operating close to, or above, expected productivity levels. Where gaps remain, the evidence points to structural demand, workforce, estate and diagnostic constraints rather than avoidable inefficiency.

Ophthalmology

- Largest contributor to RTT gap: 3,607 Stage 4 patients, including 3,336 cataracts.
- Theatre utilisation at 89.5%.
- 104-week constraint review shows only a 0.3 percentage point utilisation gap.
- AVH fully utilised five days a week with cataract and injection sessions.
- 3,000+ cataracts outsourced per annum.

Trauma & Orthopaedics

- Core plan strengthened to 1,291 arthroplasty cases, +161 cases on 2025/26 actual.
- T&O utilisation at 84.9%.
- Step-up to four joints per list progressing.
- Extended DSU sessions at Prince Philip support additional cases.
- 418 clinical validation adjustments in 2025/26.

Dermatology & ENT

- Dermatology skin cancer SCP performance is 93.9%.
- Dermatology insourcing and 955 summer MOPS uplift support demand management.
- ENT utilisation is 93.1%, above GiRFT target.
- ENT recurrent outpatient gap addressed through substantive appointment of existing locum.
- ENT Stage 4 gap requires additional WLI capacity.

Urology

- Urology is the most consequential pathway for cancer SCP and RTT performance.
- Stage 4 deficit of 465 patients split between main theatre and day surgery.
- Late-start driver is mainly job-planning related, with surgeons in outpatient clinics.
- Improvement is critically dependent on MRI and CT capacity.
- Galeas Bladder pilot is being assessed to release flexible cystoscopy capacity.

Diagnostics: critical dependency for RTT and cancer recovery

- Diagnostic demand is growing year on year due to clinically mandated investigations, cancer pathway requirements and population need.
- Radiology activity grew 9.6% year on year; MRI grew 33.7%; CT grew 15.4%.
- Urology and lower GI account for nearly half of cancer-related radiology demand and over 64% of the SCP backlog.
- Every patient waiting beyond eight weeks for diagnostics adds to RTT backlog and affects cancer delivery.

Cellular pathology and endoscopy pressure

- Cellular pathology demand is 43% above its 2022 baseline and 35% above its funded baseline.
- USC specimens have grown 80% since 2019; nearly 45% of specimens now carry cancer or urgent priority.
- The service is absorbing approximately 300 cancer cases per week.
- Endoscopy demand is projected to grow by 5% in 2026/27 and is a gateway for lower GI cancer and urology diagnostics.

Board message

The evidence shows that Hywel Dda is already maximising productivity across outpatient, theatre and specialty pathways. The remaining challenge is concentrated in high-demand specialties and diagnostic services where growth, cancer requirements and funded capacity constraints create a residual gap.

Takeaway: Further recovery requires continued productivity action plus targeted capacity and diagnostic support where demand now exceeds sustainable funded capacity.

Executive Summary: Assessed Demand & Capacity Sustainability Gaps

Specialties where the latest assessment identifies excess demand over capacity not currently resolved through productivity and optimisation measures

Board message: These specialties have an assessed sustainability imbalance. Not all result in an in-year 104-week pathway delivery gap, but they require regional focus to develop longer-term capacity, workforce and pathway solutions.

Specialty	Stage 1 Demand gap	Stage 4 Sustainability gap	Latest assessed issue	Implication / required focus	Risk
Ophthalmology	Yes	Yes	Cataracts sustainability gap	Regional cataract productivity and capacity solution required	High
Pain Management	Yes	Yes	Capacity pressure linked to long-term sickness	Requires resilience plan and regional options for sustainable access	High
General Medicine	Yes	No	Recurrent Stage One demand signal	Monitor through demand management and pathway optimisation	Med
Cardiology	Yes	Yes	Diagnostic capacity gap	Manage as part of diagnostic recovery with echo and other functional test capacity	High
Dermatology	Yes	No	Recurrent Stage One demand signal	Continue productivity, referral management and pathway review	Med
Neurology	Yes	No	Recurrent Stage One demand signal	Maintain recovery focus and consider regional resilience if gap persists	Med
Paediatrics	Yes	No	Recurrent Stage One demand signal	Monitor growth and align with community pathway improvement	Med
General Surgery	No	Yes	Waiting list has grown steadily since 2024	Longer-term regional sustainability solution required	High
Urology	No	Yes	Inpatient capacity gap of 2 lists per week	Regional focus on theatre access, diagnostics and pathway flow	High
T&O	No	Yes	Inpatient and day case gap, mainly arthroplasty; PPH DSU GA limitation; soft tissue pressure; consultant retirement	Regional orthopaedic model required to address capacity and workforce fragility	High

Key point: The sustainability gap represents excess demand over capacity based on latest available data. The response should target regional solutions where local productivity and optimisation will not fully close the gap.

Purpose of the Hywel Dda Planned Care Sustainability & Recovery Plan

Board narrative: how the plan responds to national priorities and translates them into local delivery



Overarching purpose

This Plan describes the Health Board’s overarching approach to delivering planned care pathways for its population, in line with national priorities for 2026/27 and the new national improvement approach for planned care, cancer and diagnostics.

National priorities for 2026/27

- How we plan to:
- eliminate 104-week waits
 - eliminate >8-week diagnostic waits
 - manage growth and demand to mitigate total waiting list growth at all stages

Three-pillar framework

- How we manage:
- referral and early diagnosis
 - capacity, productivity and treatment
 - Follow-up, surveillance and living well

Progress and sustainability

- Sets out progress achieved towards sustainable planned care pathways
- Highlights specialties where further work is required for longer-term sustainability

Transformation focus

- Describes pathway transformation achieved to date
- Sets out further actions aligned to the NHS Wales Planned Care Optimisation Framework standards for productivity and efficiency

Critical diagnostic dependency

The diagnostic challenge is a critical dependency for the whole Plan. Diagnostic recovery is not only required to deliver the >8-week ambition, but is also essential to support RTT recovery, cancer pathway delivery, timely clinical decision-making and sustainable patient flow across the entire planned care pathway.

Where sustainability gaps remain

- Includes proposals where additional capacity is required to achieve required milestones for 104-week RTT and 8-week diagnostic waits by March 2027
- Positions additional capacity as support for the residual gap after productivity and transformation actions have been pursued

Regional working with Swansea Bay UHB

- Describes how the Health Board is working regionally with Swansea Bay UHB to address fundamental sustainability challenges in key specialties
- Supports both in-year delivery during 2026/27 and progress towards longer-term sustainable delivery models

Board interpretation

- This is a delivery, transformation and sustainability plan
- It links national priorities, productivity standards, diagnostics and regional solutions into one recovery narrative

Board message: The Plan sets out how Hywel Dda will deliver national planned care ambitions by combining productivity, pathway transformation, diagnostic recovery, additional capacity where required and regional collaboration to create a sustainable planned care system.

Scope of this Recovery Delivery Plan

Two complementary plans – different purposes, shared ambition

This interim submission meets the immediate Welsh Government requirements. The wider Planned Care Recovery Plan will provide the broader strategic context

Interim Recovery Delivery Plan

Focus: Immediate recovery and compliance with criteria issued by Welsh Government

Purpose	Elimination of 104-week waits and recovery of 8-week diagnostic waits
Focus	Immediate recovery actions and short-term trajectories
Evidence	Demand & capacity modelling, productivity assumptions and recovery plan
Funding	Funding demand and capacity gap after productivity and transformation
Risks	Immediate risks and mitigations to deliver recovery



Planned Care Recovery Plan

Focus: Long-term transformation, productivity and sustainable planned care

Purpose	Long-term transformation strategy and sustainable improvement
Focus	Outpatients, theatres, workforce, digital, service redesign and wider system change
Evidence	Benchmarking, productivity insights, digital opportunities and quality metrics
Investment	Longer-term investment case, affordability and sustainability
Risks	Strategic and medium-term risks to sustainable performance
Accountability	Board assurance framework, metrics and reporting to monitor delivery

The Interim Recovery Delivery Plan provides immediate assurance that we can eliminate 104-week waits and recover diagnostics over eight weeks.

The Planned Care Recovery Plan provides the broader assurance the Board needs to assess productivity, efficiency and long-term sustainability.

National Planning Framework

NHS Wales Planned Care, Cancer & Diagnostics Improvement Plan 26/27



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PLANNED CARE, CANCER & DIAGNOSTICS IMPROVEMENT PLAN

Three pillars to improve access, productivity, outcomes and experience for people in Wales



PILLAR 1: REFERRAL & EARLY DIAGNOSIS

Right patient, right test, right time

PLANNED CARE PRIORITIES



- Community HealthPathways (CHPs) implemented consistently
- Advice & Guidance (A&G) to support primary care decision making
- Referral optimisation, triage and vetting to the right service
- Straight-to-test pathways to reduce diagnostic delays



CANCER PRIORITIES

- Implement National Optimal Pathways (NOPs) for all tumour sites
- Ensure NG12 / DG30 compliance
- Referral optimisation audits at priority sites
- Pathway optimisation to share and scale best practice
- Straight-to-test and rapid diagnostic pathways to reduce time from suspicion to diagnosis



DIAGNOSTICS PRIORITIES

- Expand use of biomarker testing to aid risk stratification & triage
- Reduce diagnostic tests of low clinical value
- Expand use of alternative diagnostic tests



PILLAR 2: CAPACITY, PRODUCTIVITY & TREATMENT

Right care, delivered efficiently

PLANNED CARE PRIORITIES



- Clinic template and utilisation improvement
- Theatre productivity and elective optimisation
- Peri-operative assessment and patient pathway optimisation
- Surgical hub accreditation and networked delivery models
- Diagnostics community, regional and network models



CANCER PRIORITIES

- Treatment pathway productivity
- MDT modernisation and innovation programme
- Tumour Site Improvement Programmes
 - Breast
 - Lower GI
 - Urology (Prostate)
 - Gynaecology (Endometrial)
 - Skin



DIAGNOSTICS PRIORITIES

- Pathology digitisation programme
- Diagnostic dataset to support demand and capacity planning for:
 - Imaging
 - Pathology
 - Endoscopy



PILLAR 3: FOLLOW-UP, SURVEILLANCE & LIVING WELL

Right follow-up, right support

PLANNED CARE PRIORITIES



- Default to Discharge (D2D) as standard
- Patient Initiated Follow-up (PIFU)
- Review Before Rebook (RBR)
- See on Symptoms (SOS) models
- Use of digital and remote monitoring where appropriate



CANCER PRIORITIES

- Personalised and Evidence Based Follow-Up
- Surveillance Reform
- Quality and Person-Centred Care
- Rehabilitation and Supported Self Management



DIAGNOSTICS PRIORITIES

- Surveillance and monitoring tests available in a timely manner
- Point-of-care and community diagnostic solutions
- Use data and genomics to inform surveillance strategies

FOUNDATIONS – ENABLERS OF IMPROVEMENT



GOVERNANCE & ACCOUNTABILITY

- Strong clinical leadership and clear accountability
- National, regional and local governance alignment
- Regular review and escalation of performance and variation
- Cancer assurance



WORKFORCE & CAPACITY

- Right workforce, right skills and development; right place
- Plan for future demand and capacity
- Pathology and diagnostic workforce investment
- MDT evolution and support



DIGITAL, DATA & PATHWAY INTEGRATION

- Integrated planned care, cancer and diagnostics dashboards
- Timely, accurate and complete data
- Codopocasts vignits
- Actionable insights
- Palatable and public reporting
- Transparency and public reporting



QUALITY, PATIENT EXPERIENCE & ENGAGEMENT

- Quality and Safety
- Patient Experience
- Person-Centred Care
- Public and patient involvement



PARTNERSHIP & COPRODUCTION

- Work with primary care, third sector and local authorities
- Patient and public involvement
- Equity of access and outcomes
- Community HealthPathways and self-management support

OUR SHARED OUTCOMES BY 2027/28



Improved outcomes and experience for people with cancer and planned care needs



Reduced variation in access, outcomes and experience across Wales



75% Suspected Cancer Pathway target achieved



Eliminate 104 week waits



Reduce the number of patients waiting >62 days on a cancer pathway by March 2027



95% of patients wait no more than 8 weeks for a diagnostic test



Sustainable and efficient use of resources across the system

Pillar 1: Referral & Early Diagnosis



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Preventing unnecessary demand and establishing a validated baseline for recovery

STRATEGIC OBJECTIVE

To establish a robust understanding of current demand and ensure patients enter, remain on and progress through planned care pathways appropriately, providing a validated baseline from which recovery can be safely delivered.

Key Goal 1 – Establish Robust Baseline for Recovery

Develop a single, validated understanding of treatment and diagnostic demand to provide the foundation for recovery planning, trajectory management and funding requirements.

Delivery Methods

- Clinical validation of long wait cohorts
- Administrative validation of RTT pathways
- Diagnostic validation
- Validation of RTT stage and pathway status
- Confirmation of patient readiness

Key Goal 2 – Reduce Avoidable Demand

Reduce unnecessary demand entering planned care pathways through strengthened referral management and clinical prioritisation.

Delivery Methods

- Community HealthPathways
- Consultant vetting
- Professional triage
- Referral optimisation
- CIN standards
- Strengthened referral management

Key Goal 3 – Maximise Outpatient Capacity

Release outpatient capacity for new patients through optimisation of follow-up pathways.

Delivery Methods

- Expansion of Patient Initiated Follow-Up (PIFU)
- Follow-up validation
- Reduction in low-value follow-up activity
- Specialty benchmarking
- Outpatient pathway redesign

Pillar 1: Referral & Early Diagnosis

Chapter introduction: validated baseline, demand control and next productivity gains



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This section explains how Hywel Dda is reducing avoidable demand before patients enter planned care pathways and how further productivity will be maximised through front-door controls.

Purpose of this chapter

To demonstrate that referral management, professional triage, Community HealthPathways, validation and outpatient transformation are already improving productivity and creating a reliable baseline for recovery planning.

What has been achieved

- Waiting list quality has improved through validation and pathway review.
- Avoidable demand is being reduced before patients enter secondary care pathways.
- New outpatient and RTT reductions provide evidence of productivity-before-investment.
- Referral management and HealthPathways are already embedded as demand-management enablers.

Further productivity plans

- Expand consultant-led professional triage across all specialties.
- Strengthen referral standards and Community HealthPathways adoption.
- Increase direct-to-diagnostic routes where clinically appropriate.
- Reduce variation in referral management performance.
- Continue rolling validation to maintain list quality.

Why this matters

- The residual waiting list becomes a more accurate view of patients still requiring assessment, diagnostics or treatment.
- Scaling triage and referral optimisation helps reduce new demand entering the system.
- Variation reduction provides further opportunity without waiting for investment.

Funding request link

- Funding is being requested only after avoidable demand has been actively managed.
- Additional capacity should therefore be directed at validated residual demand, not untested pathway volume.
- This strengthens assurance that investment will target patients requiring care.

Chapter message

Pillar 1 shows that avoidable demand is being reduced and that further productivity will come from scaling triage, referral optimisation and validation before additional capacity is deployed.

Pillar 1: Referral & Early Diagnosis

Chapter introduction: quantified baseline, demand control and next productivity gains



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This chapter shows quantified evidence that Hywel Dda is reducing avoidable demand before patients enter planned care pathways, improving waiting list quality and creating a more reliable baseline before further funded capacity is deployed.

Purpose of this chapter

To demonstrate that referral management, professional triage, Community HealthPathways, validation and outpatient transformation are already delivering measurable productivity and strengthening the case for targeted recovery funding.

-11,226

New OPD list
Jul 25 to Jun 26

-22%

New OPD reduction
50,621 to 39,395

-6,967

RTT list reduction
Jul 25 to Jun 26

17,819

RTT validation
50% removals

8,740

FUWL validation
27% removals

344

HealthPathways
92k page views

4,376

26+ OPD
Jun 26

What has been achieved

- **-11,226** reduction in the new outpatient list, a 22% reduction from 50,621 to 39,395.
- **17,819 RTT** pathways removed through validation from 35,396 reviewed, creating a cleaner recovery baseline.
- **8,740 FUWL** removals from 32,565 follow-up pathways reviewed, reducing avoidable follow-up demand.
- **344 pathways** live through Community HealthPathways, with 92k page views supporting front-door demand management.

Further productivity plans

- **Scale triage** from current referral management into consistent consultant-led professional triage across specialties.
- **Reduce ROTT variation** where referral-management performance ranges from 5% to 64% across specialties.
- **Convert released capacity** including 5,704 follow-up slots into new outpatient access and long-wait recovery.
- **Maintain validation** with 2.0 WTE Band 3 capacity restored and focus on Stage 3 pathways.

Why this matters

- **Residual demand** is more accurate after 26,559 combined RTT and FUWL removals.
- **Referral control** means capacity is focused on patients still requiring assessment, diagnostics or treatment.
- **Current pressure** remains visible, with 4,376 patients still waiting 26+ weeks for first outpatient appointment.
- **Targeted productivity** provides further opportunity before additional funded capacity is deployed.

Funding request link

- **Evidence first** funding is being requested after avoidable demand has been actively managed.
- **Capacity ask** is therefore directed at validated residual demand, not untested pathway volume.
- **Productivity baseline** strengthens assurance that investment will target patients requiring care.
- **Board message** internal optimisation has already delivered measurable list-shape improvement.

Chapter message

Pillar 1 demonstrates a productivity-first case: outpatient demand has reduced by 22%, 26,559 RTT/FUWL pathways have been removed through validation, and further funding is being linked to validated residual demand after front-door controls have been applied.

Pillar One: Productivity-first recovery evidence

Productivity, demand management and outpatient conversion



Metric	Evidence	Submission value
Outpatient activity	12% above pre-Covid	Capacity already expanded from existing resources
Referral returns	31% after clinical vetting	Exceeds WG 20% target and avoids inappropriate entry
Discharge / SOS / PIFU	>50% do not progress beyond first attendance	Routine follow-up avoided where clinically appropriate
Follow-up conversion	5,704 follow-up slots released	Converted directly into new patient access
DNA rates	Lowest level in two years	Improves productive use of clinic capacity



What is already maximised

- Referral vetting exceeds WG target.
- Clinical validation and redesign are systematic.
- PIFU, SOS and first-appointment discharge are embedded.
- Clinic time released from follow-up becomes new access.



Why residual gap remains

- RTT gaps are concentrated in challenged specialties.
- Requirement remains after productivity, utilisation and validation.
- Further recovery needs targeted capacity or regional/commissioned activity.

Pillar 2: Capacity, Productivity & Treatment



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Eliminating long waits through internal productivity, targeted capacity and regional collaboration

STRATEGIC OBJECTIVE

To eliminate current 104-week waits and recover diagnostic waits over eight weeks through maximum use of internal productivity, targeted additional capacity and regional collaboration.

Key Goal 1 Maximise Internal Capacity and Productivity

Deliver the maximum sustainable activity from existing Health Board resources before accessing additional external capacity.

DELIVERY METHODS

- Theatre timetable redesign
- Job plan alignment
- Treat in Turn
- Day Case First
- CIN productivity standards
- HVLC
- Improved POA
- Theatre & clinic utilisation

Key Goal 2 Deliver Targeted Recovery of Backlogs

Implement specialty and modality-specific recovery plans to eliminate current long waits and reduce backlogs.

DELIVERY METHODS

- Priority recovery plans for challenged specialties
- Delivery of diagnostics recovery programme
- Diagnostic investment proposal
- Independent sector capacity where required

Key Goal 3 Maximise Regional Recovery Opportunities

Utilise regional collaboration and nationally commissioned capacity where internal optimisation alone cannot deliver recovery trajectories.

DELIVERY METHODS

- Regional arthroplasty model
- Regional cataract model
- Assessment of pooled waiting lists
- Regional anaesthetic solutions
- Independent sector capacity where required
- Regional diagnostic opportunities

Pillar 2: Capacity, Productivity & Treatment

Chapter introduction: maximising internal capacity and further productivity before investment



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This section explains how Hywel Dda has maximised existing planned care capacity and how further productivity will be pursued alongside targeted recovery investment.

Purpose of this chapter

To demonstrate that theatre optimisation, day-case transformation, virtual models of care, POPS / prehabilitation, surgical hub development and specialty productivity programmes are already improving delivery and reducing long waits.

What has been achieved

- Virtual outpatient models are embedded as a productivity lever.
- Cataract HVLC activity is achieving higher throughput against standards.
- POPS and prehabilitation support readiness, length of stay and day-case opportunities.
- Surgical hub and theatre improvement programmes provide a framework for sustained optimisation.

Further productivity plans

- Expand Surgical Hub models and accreditation standards.
- Increase day-case rates and HVLC pathways where clinically appropriate.
- Further optimise theatre utilisation, list planning and cancellations.
- Expand virtual models of care where clinically appropriate.
- Extend POPS / prehabilitation and cohort-reduction approaches.

Why this matters

- Productivity gains are continuing, but residual demand still exceeds sustainable capacity in several specialties.
- Further gains depend on consistent adoption of standards, workforce resilience and theatre/session utilisation.
- Capacity is being maximised before additional funding is requested.

Funding request link

- The ask is positioned as a capacity requirement after productivity optimisation.
- Investment complements, rather than replaces, continuing productivity programmes.
- Funding is targeted to the residual demand-capacity gap that cannot be resolved by internal optimisation alone.

Chapter message

Pillar 2 demonstrates that internal productivity is being maximised and further gains will continue, but the remaining backlog requires additional capacity alongside ongoing improvement.

Pillar 2: Capacity, Productivity & Treatment

Complete section summary: what this chapter covers and why it matters



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The earlier quantified slides included the strongest numerical evidence, but this version now reflects the full Pillar 2 chapter: internal productivity, treatment capacity, cohort reduction, diagnostics, POPS/prehabilitation, Surgical Hub accreditation and regional/additional recovery capacity.

Purpose of Pillar 2

To demonstrate that the Health Board is maximising existing capacity and productivity before seeking further recovery investment, and to define where targeted additional capacity is still required to reduce long waits.

Goal 1: maximise internal capacity

- Theatre optimisation, day case and HVLC improvement
- Cataract productivity and capacity utilisation
- Orthopaedic and general surgery productivity
- Virtual models of care to release face-to-face capacity
- DNA reduction and targeted overbooking
- Treat in Turn / cohort reduction as an assurance lens

Goal 2: targeted backlog recovery

- POPS and prehabilitation to improve readiness and reduce avoidable intervention
- Diagnostic endoscopy sustainability and additional lists
- Echocardiography recovery and costed additional capacity
- Cellular pathology cancer recovery and recurrent pressure
- Backlog recovery aligned to 104-week and 8-week diagnostic milestones

Goal 3: regional recovery opportunities

- Regional ophthalmology and cataract recovery options
- Regional orthopaedic delivery and arthroplasty capacity
- Use of available partner capacity where it improves sustainability
- Networked surgical hub and regional pathway opportunities
- Funding targeted to residual gaps after productivity actions

Chapter conclusion

- Pillar 2 is not a general capacity request
- It evidences what has already been optimised internally
- It sets out what will be scaled next
- It identifies where demand exceeds sustainable funded capacity
- It links the ask to validated residual gaps and delivery milestones

Chapter message

Pillar 2 brings together the productivity story and the residual capacity ask: maximise theatres, clinics, pathways and treatment models first, then apply targeted investment only where the remaining gap cannot be closed internally.

Pillar 2: Quantified Achievements Already Delivered

Evidence that internal productivity has been maximised before additional recovery investment



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This slide combines the headline numbers from across the Pillar 2 section, showing that Hywel Dda is already delivering productivity through theatre utilisation, cataract HVLC, virtual care, POPS/prehabilitation and regional capacity thinking.

93%

ENT util.
above target

89.5%

Ophthalmology
utilisation

84.9%

T&O util.
near target

83%

Urology
main theatre

4,619

Sessions
12 months

16,536

Patients
treated

8+

Cataract HVLC
per AVH list

26.46%

Virtual FU
current

85%

POPS
managed

Theatre productivity

- ENT 93%, ophthalmology 89.5%, T&O 84.9% and urology main theatre 83% demonstrate strong utilisation in challenged specialties.
- Across 4,619 theatre sessions, 16,536 patients were treated, averaging 3.58 patients per session.
- Theatre REST and GiRFT work target late starts, early finishes and session utilisation.
- At 85% utilisation, the modelled opportunity is approximately 1,073 additional patients per annum.

HVLC and specialty productivity

- AVH cataract HVLC exceeds the 7 cataracts per session target with 8+ eyes / patients per session.
- Routine cataracts are segmented into high-volume models while complex and urgent care is reserved for acute capacity.
- Orthopaedic plans strengthen arthroplasty delivery and support long-wait recovery.
- Dermatology, ENT, urology and ophthalmology evidence shows where productivity is high but demand still exceeds capacity.

Outpatient and perioperative models

- Virtual outpatient delivery is established: 18.26% of new activity and 26.46% of follow-up activity are currently virtual.
- POPS / prehabilitation supports optimisation of frail or high-risk patients, with around 85% successfully managed via the service.
- Around 5% of patients identify that an alternative pathway may be preferable.
- These models support readiness, reduced length of stay, day-case opportunity and better use of capacity.

Regional and capacity evidence

- Regional NPTH orthopaedic modelling indicates one weekly list could treat approximately 168 patients per year.
- This equates to around 21% of a projected 808-patient 104-week breach position.
- The model demonstrates how targeted regional capacity can complement internal productivity.
- Funding is linked to residual validated demand, not replacement of productivity work.

Board message

The quantified evidence demonstrates that internal productivity is being pursued across theatres, outpatient delivery, cataract HVLC, POPS/prehabilitation and regional capacity options before additional recovery funding is requested.

Pillar 2: Quantified Next Actions and Ambitions

What we will do next to maximise productivity further



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The next phase is to scale proven productivity levers, close measurable performance gaps and use targeted recovery capacity where internal optimisation cannot close the residual demand-capacity gap.

85%

Theatre ambition
utilisation

1,073

Potential gain
patients/year

35%

Virtual new
ambition

50%

Virtual FU
ambition

16.74pp

New gap
to ambition

23.54pp

FU gap
to ambition

1,291

Core T&O
arthroplasty cases

168

Add. list
patients/year

808

104w
risk

Scale theatre productivity

- Move theatre utilisation towards 85% and realise the modelled 1,073 additional patients per annum opportunity.
- Continue start-time, finish-time, list productivity, cancellation and turnaround improvement through Theatre REST and GIRFT work.
- Treat Surgical Hub accreditation as the formal productivity and assurance framework: 85% touch-time utilisation, >90% on-time starts, <1% on-day cancellations, BADS day-case rates and protected elective lists.
- Use accreditation evidence, gap analysis and cohort reduction to ensure hub capacity is protected, productive and focused on long-wait recovery.

Expand digital and outpatient models

- Increase new outpatient virtual activity from 18.26% towards 35%.
- Increase follow-up virtual activity from 26.46% towards 50%.
- Close the 16.74pp and 23.54pp gaps to virtual delivery ambition.
- Use virtual models to protect face-to-face capacity for patients requiring examination, treatment or complex decisions.

Expand optimisation and HVLC

- Expand POPS / prehabilitation across wider specialties and patient cohorts.
- Use optimisation and shared decision-making to improve readiness and reduce avoidable intervention.
- Maintain and expand HVLC cataract pathways where workforce allows.
- Increase day-case rates and improve flow through strengthened perioperative pathways.

Target residual capacity gaps

- T&O core plan supports 1,291 arthroplasty cases, an uplift on previous delivery.
- Regional NPTH model could add 168 patients per year per weekly list and address a material share of 104-week risk.
- Diagnostic endoscopy, echocardiography and cellular pathology remain critical Pillar 2 recovery dependencies.
- Funding should target validated residual gaps after productivity has been scaled.

Chapter message

The ambition is clear: use Surgical Hub accreditation as the organising standard for theatre productivity, protected elective capacity and future funding assurance, alongside digital models, HVLC pathways and perioperative optimisation.

Pillar 2: Surgical Hub Accreditation as a Core Productivity Lever

Strengthening the Board message on accreditation, assurance and future funding alignment



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Surgical Hub accreditation should be presented as more than a compliance exercise. It is the national framework for protecting elective capacity, standardising high-productivity theatre practice and demonstrating readiness for future planned care funding models.

MAG 4b National requirement accredit all hubs	12 months Timescale national expectation	Cohort 1 Cohort status HDUHB participant	PPH Hub site designated hub	4 theatres Scope 2 DSU + 2 main	24 Aug Evidence date submission due	5 Domains accreditation areas
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Why accreditation matters

- MAG Recommendation 4b states that health boards should seek accreditation for all Surgical Hubs, and that this should be a condition of further funding.
- The programme aligns planned care recovery with a formal national assurance process and future funding models.
- It provides a structured way to evidence safe, high-quality, efficient and sustainable elective care.
- It strengthens Board assurance that productivity commitments are measurable and auditable.

What is already underway

- HDUHB is part of Cohort 1 of the Welsh Government Surgical Hub Programme.
- The designated surgical hub is Prince Philip Hospital, covering the DSU and main theatre facilities.
- The accreditation process focuses on four theatres: two DSU theatres and two main theatre theatres.
- Governance is in place, self-assessment and evidence collation are in progress, and an improvement plan has been created.

Productivity standards

- Accreditation criteria frame productivity through 85% touch-time utilisation, >90% on-time starts and <1% on-day cancellations.
- BADS day-case rates and ring-fenced elective lists provide the standard for protected, high-productivity delivery.
- Five accreditation domains cover patient pathway, staff and training, clinical governance and outcomes, facilities/ring-fencing, and utilisation/productivity.
- These standards give a clear operational framework for ongoing improvement.

Next actions and ambition

- Create the linked evidence repository and ensure mandatory evidence is captured.
- Progress mock accreditation and formal site visit arrangements with NHS P&I.
- Deliver improvement plans for preferred criteria, identifying where business case or planned care investment may be required.
- Use accreditation to embed a repeatable, high-quality surgical productivity model across planned care.

Board / WG message

Surgical Hub accreditation is the assurance mechanism that links productivity, protected elective capacity and future funding. It demonstrates that Hywel Dda is not simply seeking more activity, but is embedding a nationally recognised standard for sustainable, high-productivity elective care.

Supporting patients through appropriate follow-up, surveillance and alternative models of care

STRATEGIC OBJECTIVE

Optimise follow-up and surveillance pathways, ensuring outpatient capacity is used appropriately, unnecessary follow-up activity is reduced, and patients are supported through alternative models of care where clinically appropriate.

Key Goal 1 – Optimise Follow Up Pathways

Reduce low-value follow-up activity and release outpatient capacity for new patients.

Delivery Methods

- Patient Initiated Follow Up (PIFU)
- Follow-up validation
- Reduction in routine follow-up
- Specialty benchmarking
- CIN standards

Key Goal 2 – Optimise Surveillance Pathways

Ensure surveillance activity is clinically appropriate and delivered through the most effective pathway.

Delivery Methods

- Review surveillance protocols
- Biomarker-led pathways
- FIT
- Capsule Sponge
- Alternative surveillance models
- Risk stratification

Key Goal 3 – Support Patients through Alternative Models of Care

Reduce avoidable hospital attendance whilst maintaining safe, person-centred follow-up.

Delivery Methods

- Advice & Guidance
- Digital follow-up
- Self-management
- Living Well approaches
- Primary care/community pathways

Pillar 3: Follow-Up, Surveillance & Living Well

Chapter introduction: reducing future demand and maximising released capacity

This section explains how Hywel Dda is reducing avoidable follow-up demand, optimising surveillance pathways and supporting patients through alternative models of care.

Purpose of this chapter

To demonstrate that PIFU/SOS, CIN-guided validation, FIT testing, Capsule Sponge, Waiting Well / WLSS and digital patient support are reducing future demand and releasing capacity for patients waiting longest.

What has been achieved

- Follow-up and surveillance pathways are being redesigned to reduce low-value routine activity.
- Effective outpatient management has moved a significant cohort to discharge or SOS/PIFU.
- CIN, validation and pathway controls support list quality and governance.
- FIT, Capsule Sponge, WLSS and PSC provide patient-centred transformation enablers.

Further productivity plans

- Increase adoption of SOS/PIFU pathways across specialties.
- Extend CIN methodology and validation to additional cohorts.
- Expand FIT and Capsule Sponge pathways to reduce demand on traditional diagnostics.
- Develop Waiting Well, WLSS and Patient Service Centre digital engagement.
- Convert released follow-up capacity into new outpatient activity.

Why this matters

- These programmes reduce future demand, release capacity and improve patient experience.
- They help prevent recurrence but cannot fully clear the existing patient backlog.
- The next productivity gain is converting released capacity into Stage 1 and diagnostic access.

Funding request link

- The funding ask remains necessary to clear the existing backlog while these transformation programmes prevent recurrence.
- Investment should sit alongside ongoing demand reduction, surveillance redesign and digital patient support.
- This provides assurance that growth in capacity will be used productively.

Chapter message

Pillar 3 shows that future demand is being reduced and further productivity will come from expanded SOS/PIFU, surveillance redesign, digital patient support and active conversion of released capacity.

Pillar 3: Follow-Up, Surveillance & Living Well

Complete section summary: reducing future demand and maximising released capacity

This chapter explains how Hywel Dda is reducing avoidable follow-up activity, optimising surveillance pathways and supporting patients while they wait, while ensuring released capacity is converted into new outpatient and diagnostic access.

Purpose of Pillar 3

To evidence that PIFU/SOS, CIN-guided validation, FIT, Capsule Sponge, Waiting Well/WLSS and digital patient support reduce future demand, release capacity and support sustainable recovery.

Goal 1: optimise follow-up pathways

- Increase adoption of SOS and PIFU pathways across specialties.
- Apply CIN guidance and align non-CIN specialties to equivalent standards.
- Use clinical validation and specialty benchmarking to improve list quality.
- Reduce avoidable routine follow-up activity and release capacity.
- Convert released capacity into new outpatient activity and long-wait recovery.

Goal 2: optimise surveillance pathways

- FIT pathways are embedded as surveillance and diagnostic optimisation enablers.
- Capsule Sponge is positioned as a planned scale-up and alternative surveillance model.
- Surveillance redesign reduces demand on traditional diagnostics and endoscopy capacity.
- Risk stratification supports the right patient, right test and earlier escalation.
- Released diagnostic capacity supports RTT and cancer recovery.

Goal 3: support patients while waiting

- Waiting Well and WLSS provide a single point of contact and holistic support.
- PROMs and health questionnaires support identification of needs and deterioration.
- Patient support improves readiness for treatment and escalation where required.
- Patient Service Centre is a future digital / access transformation enabler.
- Digital patient communication can support PIFU, SOS and validation pathways.

Chapter conclusion

- Pillar 3 reduces future demand, but does not remove the whole existing backlog.
- The benefit comes from systematic follow-up conversion, surveillance redesign and active patient support.
- Funding should sit alongside these transformation actions to clear the residual backlog.
- The key operational requirement is converting released follow-up capacity into Stage 1 and diagnostic access.

Chapter message

Pillar 3 is the demand-reduction and capacity-release pillar: it prevents recurrence, improves patient support and converts avoidable follow-up into capacity for patients waiting longest.

Pillar 3: Quantified Achievements Already Delivered

Evidence of follow-up demand reduction, capacity release and patient support

The data demonstrates that follow-up transformation is already producing measurable capacity release and improved list shape. The next step is to ensure released slots are actively converted into Stage 1 and diagnostic recovery capacity.



Follow-up capacity released	Waiting list impact	Pathway and governance gains	Waiting Well / WLSS impact
210,548 follow-up appointments were delivered in 2025/26, showing the scale of the opportunity. - A 20% conversion releases 42,109 slots; a 30% conversion releases 63,164 slots. - Q4 conversion identifies 10,525 released slots that can be redirected into Stage 1 activity. - This gives a direct productivity route from follow-up reduction to new outpatient access.	- The >100% delayed cohort reduced by 14.2% between 1 July 2025 and 30 June 2026. - Q4 conversion reduces the modelled >26-week position to 2,908 patients. - Full-year conversion reduces the modelled >26-week position to 1,052 patients. - The benefit depends on template redesign and operational grip to convert released slots into new activity.	- Follow-up validation and specialty benchmarking are established. - CIN guidance and equivalent standards provide the clinical framework for reducing unwarranted routine review. - SOS/PIFU infrastructure provides the mechanism for clinically safe discharge and patient-led access. - FIT pathways are embedded as surveillance and diagnostic optimisation enablers.	- WLSS provides a single point of contact for planned care patients. - Holistic support, PROMs and health questionnaires support risk identification and treatment readiness. - Proactive contact for newly listed patients strengthens patient support while waiting. - PKB-enabled communication is a future digital pathway development.

Board message

Pillar 3 already has quantifiable benefit: 42,109 to 63,164 potential follow-up slots, a 14.2% reduction in the >100% delayed cohort and modelled improvement in the 26-week position if released capacity is converted into new access.

Pillar 3: Next Actions and Productivity Ambitions

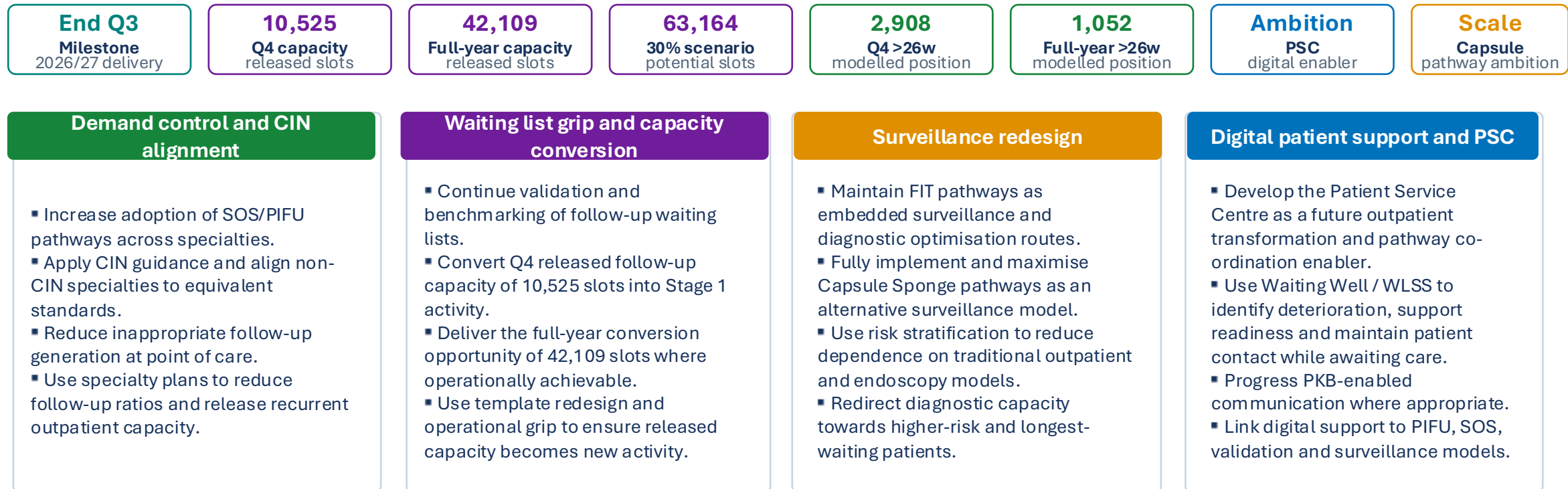
Scaling demand reduction, surveillance redesign and digital patient support



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The next phase is to make the capacity-release benefit real by scaling SOS/PIFU, applying CIN guidance, standardising surveillance redesign and developing digital patient support, while actively converting released follow-up capacity into new outpatient and diagnostic access.



Chapter message

The Pillar 3 ambition is to turn follow-up reform into measurable Stage 1 and diagnostic capacity: reduce future demand, prevent recurrence and convert released capacity into access for patients waiting longest.



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Elimination of 104 week waits and 8-week Diagnostic Recovery 26/27

Elimination of 104-Week Waits & Partial 8-Week Diagnostic Recovery

Chapter introduction: residual recovery challenge after productivity improvement

This chapter brings together the evidence from Pillars 1-3 and demonstrates why targeted investment remains necessary to eliminate 104-week waits and support partial recovery of >8-week diagnostic waits during 2026/27.

Purpose of this chapter

To show that productivity gains have already been realised, explain where residual constraints remain, and position diagnostics as a critical dependency for RTT, cancer and planned care recovery.

What has been achieved

- RTT waiting list reduced by 6,967 patients, a 7.4% reduction from 93,521 to 86,554.
- New outpatient waiting list reduced by 11,226 patients, a 22% reduction from 50,621 to 39,395.
- RTT validation reviewed 35,396 pathways and removed 17,819 pathways.
- Theatre utilisation is strong in key challenged specialties, including ENT 93%, Ophthalmology 89.5%, T&O 84.9% and Urology 83%.

Remaining specialty constraints

- Residual 104-week risk is concentrated in Ophthalmology, Trauma & Orthopaedics, Urology, ENT and Dermatology.
- These services have already applied productivity, pathway and validation actions.
- The remaining challenge reflects sustainable capacity gaps, not a lack of productivity action.
- Recovery therefore requires targeted additional activity alongside continued improvement.

Why diagnostics matter

- Diagnostics are a critical gateway for RTT, cancer and planned care recovery.
- Radiology, pathology, endoscopy and echocardiography determine the pace at which patients can progress to clinical decision and treatment.
- Delays beyond eight weeks increase RTT backlog and affect cancer pathway delivery.
- Diagnostic recovery must therefore be treated as a system enabler, not a standalone target.

Funding request link

- The costs in radiology and pathology have been increased deliberately in the Plan.
- These services support 8-week diagnostic recovery, 104-week RTT recovery and cancer pathway delivery.
- Investment should be viewed as system-enabling capacity.
- The ask sits after productivity, validation and pathway redesign have been applied.

Chapter message

The remaining 104-week and diagnostic challenge follows significant internal productivity improvement. The funding request targets the residual demand-capacity gap and the diagnostic infrastructure required to deliver RTT, diagnostic and cancer recovery together.

Quantified Progress Already Delivered

Waiting list reduction, validation and productivity improvements across the pathway



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The evidence below demonstrates that the Health Board has not moved directly to a funding ask. It has first reduced waiting list size, improved waiting list quality and increased productivity through validation, outpatient transformation and theatre optimisation.

-6,967 RTT list reduction Jul 25 to Jun 26	-7.4% RTT reduction 93,521 to 86,554	-11,226 New OPD list Jul 25 to Jun 26	-22% New OPD reduction 50,621 to 39,395	17,819 RTT validation pathways removed	35,396 RTT reviewed pathways	3 104w low point Mar 2026	254 Current 104w Jun 2026
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Waiting list size and shape

- Overall RTT list has reduced by 6,967 patients from July 2025 to June 2026.
- New outpatient list has reduced by 11,226 patients over the same period.
- This demonstrates demand management and productivity at the front door and across the pathway.
- Residual pressure is concentrated in longer-wait and capacity-constrained cohorts.

Validation and list quality

- RTT validation reviewed 35,396 pathways and removed 17,819 pathways.
- Follow-up validation also supports improved waiting list accuracy and list governance.
- Validation creates a more accurate baseline for recovery and funding assumptions.
- The residual list is therefore more likely to reflect genuine demand and requiring recovery capacity.

Theatre productivity evidence

- ENT utilisation 93%, Ophthalmology 89.5%, T&O 84.9% and Urology 83%.
- Across 4,619 sessions, 16,536 patients were treated, averaging 3.58 patients per session.
- Theatre REST and GiRFT improvement work continues to target late starts, early finishes and utilisation.
- Further improvement remains, but the data shows strong productivity in challenged specialties.

Why this matters

- The remaining 104-week challenge is not an opening position.
- It follows productivity, validation, outpatient transformation and theatre optimisation.
- The funding ask is therefore directed at the residual gap after internal actions have been applied.
- This strengthens the evidence base for targeted recovery investment.

Board message

Hywel Dda has reduced both RTT and new outpatient waiting lists and improved list quality through validation. The residual 104-week gap remains after substantial internal productivity and pathway management activity.

Diagnostics: Critical Enabler of RTT and Cancer Recovery

Radiology, pathology, endoscopy and echo capacity underpin the whole recovery plan



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Diagnostic recovery is not a standalone programme. Diagnostic capacity determines whether patients can move through RTT pathways, whether cancer patients receive timely diagnosis and staging, and whether the 8-week diagnostic ambition can be recovered.

+9.6%

Radiology activity
year on year

+33.7%

MRI demand
year on year

+15.4%

CT demand
year on year

+43%

Pathology demand
above 2022 baseline

+35%

Funded baseline
above funded level

+80%

USC specimens
since 2019

~300

Cancer cases
processed each week

Radiology pressure

- Radiology activity has grown 9.6% year on year.
- MRI demand has increased by 33.7% and CT demand by 15.4%.
- This growth is driven by clinically mandated investigations and cancer pathway requirements.
- Radiology is therefore a non-discretionary constraint on RTT and cancer recovery.

Cellular pathology pressure

- Cellular pathology demand is 43% above the 2022 baseline and 35% above the funded baseline.
- USC specimens have increased by 80% since 2019.
- Nearly half of specimens now carry cancer or urgent priority.
- The service is processing approximately 300 cancer cases per week.

Cancer pathway dependency

- Urology and Lower GI carry the greatest diagnostic pressure.
- Together, these pathways account for nearly half of all cancer-related radiology demand.
- They also account for more than 64% of the SCP backlog.
- No cancer pathway reaches treatment without diagnostic capacity for investigation, diagnosis or staging.

System impact

- Diagnostic waits directly add to RTT backlog when patients cannot progress to decision or treatment.
- Radiology and pathology capacity determine the pace of cancer recovery.
- Endoscopy and echo are also critical diagnostic gateways.
- Diagnostic recovery must be treated as a whole-system enabler.

Board message

Diagnostic recovery underpins 8-week diagnostics, RTT recovery and cancer pathway delivery. Radiology and pathology capacity should be treated as system-enabling capacity, not standalone diagnostic cost pressure.

What will additional investment deliver?

Targeted recovery capacity after productivity, validation and pathway redesign



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The investment requirement should be read as a targeted recovery intervention after internal productivity actions have already been applied. It supports three interdependent outcomes: 104-week RTT recovery, diagnostic recovery and cancer pathway recovery.

104-week recovery

- Targeted specialty capacity for Ophthalmology, T&O, ENT, Urology and Dermatology.
- Supports elimination of residual 104-week waits during 2026/27.
- Builds on validation, cohort reduction and productivity actions already undertaken.
- Focuses funding on patients still requiring treatment after internal optimisation.

Diagnostic recovery

- Additional radiology, cellular pathology, endoscopy and echocardiography capacity.
- Supports partial recovery of waits over 8 weeks.
- Improves clinical decision-making and progression through RTT pathways.
- Reduces diagnostic bottlenecks that otherwise create downstream treatment delays.

Cancer recovery

- Improves access to investigation, diagnosis, staging and treatment decisions.
- Particularly important for Urology and Lower GI pathways, which carry the greatest diagnostic pressure.
- Supports improvement in suspected cancer pathway performance.
- Reduces risk that cancer recovery stalls because diagnostics cannot keep pace with demand.

Radiology and pathology narrative

The radiology and pathology costs within this Plan have been intentionally increased because these services do not support diagnostic recovery alone. They are system-enabling services that underpin >8-week diagnostic recovery, 104-week RTT recovery and cancer pathway delivery.

Why Recovery Remains Challenging Despite Productivity Improvement

The case for targeted system-enabling investment



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This section closes the loop between the previous productivity chapters and the funding requirement. It shows that the residual ask follows productivity optimisation, and that diagnostics are a critical dependency across all recovery objectives.



What productivity has already achieved

- Reduced total RTT and new outpatient waiting list size.
- Removed non-active pathways through validation.
- Improved theatre utilisation and specialty productivity.
- Released follow-up capacity and reduced future demand.

What still constrains recovery

- High-volume specialty gaps remain in Ophthalmology, T&O, Urology, ENT and Dermatology.
- Diagnostics constrain RTT and cancer progression.
- Radiology and pathology demand has grown beyond funded capacity.
- Endoscopy and echo remain critical gateways to recovery.

What investment enables

- Elimination of residual 104-week waits.
- Partial recovery of >8-week diagnostics.
- Improved cancer staging, decision-making and treatment access.
- Sustainable recovery rather than short-term waiting list reduction alone.

The funding request follows, and does not replace, productivity improvement. It is targeted at residual specialty and diagnostic constraints that prevent delivery of 104-week RTT recovery, diagnostic recovery and cancer recovery within sustainable funded capacity.

Diagnostic Recovery: Targeted Specialty Improvement Plans

Making key diagnostic constraints visible within the 104-week and 8-week recovery narrative



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Board message: Diagnostic recovery is being managed through targeted specialty plans, not solely through overall investment. These areas support long-wait elimination, cancer pathway performance and achievement of the 8-week diagnostic standard.

Endoscopy

Delivered

- FIT pathway embedded
- Triage and demand management strengthened
- Productivity gains already realised

2026/27 Priorities

- Deliver Endoscopy Sustainability Plan
- Improve list utilisation and session productivity
- Support cancer pathway recovery and surveillance demand

Impact

- Reduces long diagnostic waits
- Supports faster cancer diagnosis

Urology Diagnostics

Delivered

- Key diagnostic bottlenecks identified across RTT and cancer pathways
- Opportunity to standardise prioritisation and pathway grip

2026/27 Priorities

- Improve access to diagnostic investigations
- Reduce delay between referral, diagnostics and decision to treat
- Strengthen clinical validation and harm-aware prioritisation

Impact

- Improves flow into treatment
- Supports 104-week elimination

Echocardiography

Delivered

- Long-wait pressure recognised as part of diagnostic recovery
- Diagnostic throughput identified as a pathway constraint

2026/27 Priorities

- Target longest-waiting patients
- Grow workforce resilience and skill mix
- Improve utilisation of current capacity and reporting turnaround

Impact

- Supports timely treatment decisions
- Reduces diagnostic list growth

Delivery ask: targeted diagnostic workforce, capacity and productivity support across radiology, pathology, endoscopy, urology diagnostics and echocardiography, with regional collaboration where it adds capacity, resilience or productivity.

Recovery Support Required: insourcing, outsourcing and regional capacity



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Indicative external funding requirement by specialty, split by delivery route and rate assumptions

Insourcing / WLI
892

Insourcing cost
£4.09m

Outsourcing cases
1,377

Outsourcing cost
£2,849,646

Regional cases
182

Recovery Support Required
£11,955,817

Specialty	Insourcing / WLI	Rate (£)	Cost (£)	Outsourcing cases	Rate (£)	Cost (£)	Regional cases	Rate (£)	Cost (£)	Total (£)
Trauma & Orthopaedics	450	£5,000	£2,250,000	109	£9,094	£991,246	182	£2,530	£460,460	£3,701,706
Ophthalmology	0	£0	£0	1,200	£1,407	£1,688,400	0	£0	£0	£1,688,400
ENT	229	£3,000	£687,000	68	£2,500	£170,000	0	£5,000	£0	£857,000
Urology	210	£5,000	£1,050,000	0	£6,044	£0	0	£5,000	£0	£1,050,000
Dermatology	43	£2,500	£108,425	0	£6,044	£0	0	£5,000	£0	£108,425
TOTAL EXTERNAL ASK	932		£4,095,425	1,377		£2,849,646	182		£460,460	£7,405,531

Diagnostics	Cost (£)
Endoscopy / Urology	£630,000
Cardiology	£220,000
Radiology Reporting to support 8 weeks and Cancer (subject to confirmation)	£2,400,000
Pathology Diagnostics & Reporting	£800,000
Programme Administrative & Support Team Costs	£321,952
POPS	£178,334
Total	£4,550,286



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Regional Programme

Regional Context



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Welsh Government has made clear that **regional collaboration** will be an important component of planned care recovery where it provides the most effective and sustainable solution.



Initial discussions have commenced with **Hywel Dda University Health Board** to explore opportunities for regional delivery, particularly in relation to arthroplasty and cataract surgery. Whilst these discussions are at an early stage, both organisations recognise that they face similar workforce and capacity challenges, including anaesthetic workforce constraints.



Further work is required to understand the **operational, clinical and governance implications** of pooled waiting lists and shared delivery models, ensuring that any regional solution supports **equitable access** whilst maintaining the progress already achieved by Swansea Bay.



The Health Board also recognises that **regional collaboration** may provide **wider opportunities** across diagnostics, workforce and procurement as recovery planning develops.

Regional Planning Principles



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The Health Board's approach to regional planned care recovery is aligned to the emerging South West Wales Regional Planning Principles.

Regional Planning Principle	How reflected within this Recovery Delivery Plan
1 Population Benefit First	Recovery proposals prioritise improving access and reducing waits for the South West Wales population rather than organisational boundaries.
2 Patients Should Wait Less Because We Work Together	Regional opportunities have been identified for arthroplasty, cataracts, diagnostics and workforce collaboration where these will improve patient access.
3 Capacity Should Be Used Before New Capacity Is Created	The Plan demonstrates a clear “productivity before investment” approach, maximising existing regional theatre, diagnostic and workforce capacity before seeking additional funding.
4 Clinical Quality and Outcomes Must Be Maintained or Improved	Regional proposals will only be progressed where clinical quality, patient experience, governance and outcomes are maintained or enhanced.
5 Mutual Benefit, Pace and Sustainability	Regional solutions will be implemented where they provide reciprocal benefit, can be delivered at pace and contribute to the long-term resilience and sustainability of planned care services.

These principles provide the **strategic framework for regional recovery planning** and demonstrate a shared **commitment to improving patient access** through collaboration, productivity and sustainable service redesign across South West Wales.

Regional Recovery Workstreams



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We are working with Hywel Dda University Health Board to develop regional solutions where these improve patient access and represent better value than individual approaches. Local productivity remains the first priority.

	ORTHOPAEDICS	OPHTHALMOLOGY (CATARACTS)	DIAGNOSTICS
Current Position	Significant orthopaedic backlog remains despite ongoing local recovery actions and productivity improvements.	Significant regional cataract backlog requiring accelerated recovery to achieve equitable waits across both organisations.	Both organisations experiencing similar demand and capacity pressures across key diagnostic modalities.
Emerging Regional Approach	- Reciprocal regional capacity model, with Swansea Bay supporting Hywel Dda through arthroplasty capacity and Hywel Dda supporting Swansea Bay through hand surgery capacity. - Hywel Dda's proposal includes investment for regional arthroplasty capacity (182 patients), alongside local productivity and external capacity measures. - Further modelling is underway to confirm patient flows, operational arrangements and the impact on both organisations. Regional Capacity 182 patients Regional arthroplasty activity proposed within the Hywel Dda submission (funding requested by HDUHB).	- Hybrid model emerging as preferred: - utilise outsourcing arrangements (SpaMedica) to reduce backlog quickly - develop sustainable Regional Cataract Hub from April 2027. - Hybrid approach balances immediate backlog reduction with longer-term sustainability.	- Continue local recovery plans whilst exploring regional workforce, reporting and procurement opportunities where beneficial. - Further regional opportunities will be explored following completion of local recovery planning.
Key Dependencies	- Anaesthetic workforce - Theatre capacity - Clinical agreement - Impact of pooled waiting lists (future) - Implant / equipment compatibility - Mutual agreement of patient transfer and commissioning arrangements - Cross-Health Board governance and	- Pre-assessment capacity - Patient transport - OpenEyes / WPAS interoperability - Administrative support - Procurement arrangements	- Workforce shortages - Reporting capacity - Digital and IT interoperability - Similar pressures across both Health Boards - Future pooled list modelling (future)
Immediate Next Steps	- Agree regional operating model and governance - Finalise patient flow and referral arrangements - Support Hywel Dda to mobilise regional arthroplasty capacity - Complete operational and financial modelling	- Confirm preferred regional option - Understand existing national package (SpaMedica) - Complete financial modelling - Agree implementation plan and phasing	- Continue joint discussions - Identify regional opportunities - Align funding proposals where appropriate - Develop joint procurement options

Further joint operational meetings with Hywel Dda are scheduled for next week to refine options, complete modelling and agree the final regional proposal for inclusion in the 31 July submission to NHS Wales Performance and Improvement.

Developing a Sustainable South West Wales Elective Care System

Neither Hywel Dda Health Board nor Swansea Bay Health Board can sustainably address every specialty challenge in isolation. By working together as a system across South West Wales we will:

Work as one system

Use evidence to guide decisions

Focus on population benefit

Build resilient and sustainable services



OUR COMMITMENT: We are committed to working in true partnership with Swansea Bay University Health Board to understand our combined demand and capacity, identify the best opportunities for collaboration and deliver sustainable elective care for the people of South West Wales.

Regional working is not about doing the same things together. It is about doing the right things together, for the right specialties, in the right way, for the benefit of our population.

Regional Delivery Priorities

Focused initial priorities with a pathway to develop future regional solutions



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Our regional priorities reflect the areas of greatest opportunity and impact. They have been informed by our initial regional assessment and will continue to evolve as the combined regional demand and capacity assessment identifies opportunities for collaborative delivery.

Working together

Evidence-led

Population
focused

Delivering
sustainable
services

IMMEDIATE REGIONAL DELIVERY PRIORITIES

- 1 Cataracts**
Develop and expand the Amman Valley Cataract Hub, working collaboratively across South West Wales to reduce waits and improve outcomes.
- 2 Orthopaedics**
Continue to develop the regional orthopaedic programme, including Prince Philip Hospital and NPTH capacity and future variation / impact modelling.
- 3 Theatre insourcing**
These immediate priorities are already progressing through established regional programmes and will deliver early impact for our populations.

DEVELOPING FUTURE REGIONAL SOLUTIONS

Informed by the completed regional demand and capacity assessment

- 1 Diagnostics**
Develop regional diagnostic solutions across imaging, endoscopy and functional services to reduce waits and improve productivity.
- 2 Radiotherapy**
Strengthen the South West Wales radiotherapy service model to ensure resilient and sustainable delivery for our population.
- 3 Digital**
Maximise the benefits of digital solutions, AI and data to improve productivity, access and patient experience.
- 4 Workforce**
Develop shared workforce solutions to address shortages, build resilience and support sustainable services.
- 5 Anaesthetics**
Develop regional anaesthetic services and workforce models to improve resilience, support elective recovery and reduce variation in practice.

These priorities will continue to evolve as the combined regional assessment identifies opportunities to pool capacity, develop shared service models and quantify residual regional investment requirements in each specialty.

Our approach ensures that we focus on the right priorities now, whilst building the evidence base to design the most effective and sustainable regional solutions for the future.

Developing a Sustainable Elective Hub Strategy

Building the right infrastructure to deliver regional solutions now and in the future



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Our Elective Hub Strategy will enable us to deliver regional solutions that improve access, reduce waits and create sustainable capacity across South West Wales.

Patients at the
centre

Working as one
system

Scalable and
sustainable

High quality and
safe

OUR PHASED APPROACH

PHASE 1

Building our regional hub foundations
(2026/27)

Amman Valley Cataract Hub

Expanded regional cataract surgery to reduce waits and improve patient experience.

Regional Orthopaedic Hub(PPH), (NPTh)

Continue to grow regional arthroplasty capacity and pathway integration.

PHASE 2

Expanding sustainable models across
additional specialties (2027/28 -
2028/29)

External Hub models

Diagnostics, endoscopy and other high-
impact pathways.

Develop shared service models

Build regional services around sustainability
and resilience.

Workforce productivity and digital enablement

Use data, AI and standardised pathways to
optimise performance across hubs.

PHASE 3

South West Wales Elective Care
Network (2028/29 onwards)

Integrated elective care network

Fully integrated pathways and capacity
across South West Wales.

Aligned governance and incentives

Joint planning, prioritisation and resource
allocation across the system.

Continuous improvement

Embedding innovation, quality improvement
and patient-centred care.

WHAT OUR HUB STRATEGY WILL DELIVER

- Shorter waits through capacity that is targeted to need.
- Better outcomes through safe and consistent care.
- Better use of resources by pooling capacity and matching demand.
- A stronger future with resilient elective services.

Our hub strategy will be informed by the combined regional demand and capacity assessment, ensuring we invest in the right services, in the right places, for the benefit of patients across South West Wales.

OUR COMMITMENT: progress Phase 1 immediately while building the evidence and partnerships needed to expand and evolve our hub models into a fully integrated South West Wales Elective Care Network.

Regional Recovery Workstreams



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We are working with Swansea Bay University Health Board to develop regional solutions where these improve patient access and value. Local productivity remains the first priority.



ORTHOPAEDICS

Current position

Significant orthopaedic backlog remains despite local recovery actions and productivity improvements.

Emerging regional approach

- Develop regional arthroplasty model using capacity across both organisations.
- Model the impact of regional capacity options on both Health Boards.

Key dependencies

- Anaesthetic workforce
- Theatre capacity
- Clinical agreement
- Equipment compatibility

Immediate next steps

- Refine preferred model
- Complete patient impact modelling
- Finalise costing



OPHTHALMOLOGY (CATARACTS)

Current position

Significant regional cataract backlog requiring accelerated recovery to achieve equitable waits.

Emerging regional approach

- Hybrid model emerging as preferred: outsourcing now, Regional Cataract Hub from April 2027.
- Balance immediate backlog reduction with longer-term sustainability.

Key dependencies

- Pre-assessment capacity
- Patient transport
- OpenEyes / WPAS interoperability
- Procurement arrangements

Immediate next steps

- Confirm preferred regional option
- Understand national package
- Complete financial modelling



DIAGNOSTICS

Current position

Both organisations are experiencing similar demand and capacity pressures across key diagnostic modalities.

Emerging regional approach

- Continue local recovery plans whilst exploring regional workforce, reporting and procurement opportunities.
- Explore further regional opportunities after local recovery plans are complete.

Key dependencies

- Workforce shortages
- Reporting capacity
- Digital / IT interoperability
- Future pooled list modelling

Immediate next steps

- Continue joint discussions
- Identify opportunities
- Align funding proposals

Regional Orthopaedics : 2026/27 Priorities and Enabling Actions

Developing a clinically-led regional orthopaedic service across South West Wales

Strategic ambition: develop a clinically-led regional orthopaedic service that supports the 36-week target by 2030, responds to GIRFT and National Clinical Strategy recommendations and enables future Regional Surgical Hubs.

2026/27: Future Direction

- Refresh single regional demand and capacity modelling and assumptions.
- Establish a single regional methodology.
- Enhance the regional dashboard with RTT data.
- Run multi-stakeholder regional design workshops to develop an evidence-based regional strategy.

2026/27: Foundations for Regionalisation

- Refresh governance and leadership arrangements.
- Resolve regional funding and contractual frameworks.
- Standardise clinical pathways, pre-assessment and orthopaedic protocols.
- Rationalise orthopaedic kit and support cross-site working.
- Centralise booking and operational functions.
- Transition towards patient pooling and a single regional waiting list.

Digital Regional Service

- Improve interoperability.
- Develop a digital roadmap for regional working.
- Explore shared information systems and processes.

End-state enabler	Purpose
Standardised Clinical Pathways & Protocols	Consistent access and treatment approach
Integrated Digital Infrastructure	Shared intelligence and interoperability
Centralised Operational Functions	Booking, pathway and administrative grip
Unified Governance & Leadership	Regional oversight and accountability
Regional Workforce Strategy	Sustainable regional capacity and resilience

Expected benefits

- Reduced waiting times and equitable access.
- Greater resilience and improved workforce sustainability.
- Enhanced quality and safety.
- More efficient use of regional capacity.

Submission message: the 2026/27 programme moves regional orthopaedics from established foundations to a unified, clinically-led regional service model.

Regional Orthopaedics: Progress to Date (2023–2026)

Building the foundations for a clinically-led regional orthopaedic service

Overall achievement: significant progress has been made in reducing long waits, improving cross-Health Board collaboration and establishing the foundations for a clinically-led regional model.

Regional clinical pathways

SOP

arthroplasty pathway foundation

Workforce development

Regional

responsibilities embedded

Sub-specialty networks

3+

hand, ankle, shoulder / elbow

Infrastructure

Dashboard

system-wide visibility

Executive approval

Oct 2025

direction and principles



Regional Clinical Pathways

- Regional Arthroplasty SOP agreed and implemented.
- Treatment of Swansea Bay patients at Prince Philip Hospital enabled.
- “Getting Ready for Surgery” protocol adopted across both Health Boards.



Regional Workforce Development

- Arthroplasty consultants and locums appointed with regional responsibilities.
- Regional working embedded in consultant job descriptions and recruitment processes.



Sub-specialty Regional Networks

- Hand Surgery Network established and delivering regional operating lists.
- Ankle Arthritis Network operational with cross-border patient treatment.
- Shoulder and elbow regional MDTs and joint operating arrangements established.



Infrastructure & Governance

- Regular Regional Operations Group meetings established.
- Regional dashboard developed for system-wide visibility, planning and performance management.
- Strategic Direction and Guiding Principles approved by both Executive Teams.

Submission message: the programme has moved from recovery-focused initiatives towards a shared regional strategy, providing a foundation for the next phase of regionalisation.

Future Regional Ophthalmology: Priorities & Vision

Towards a single integrated regional Eye Care Service for South West Wales

Vision: a single integrated regional Eye Care Service delivering equitable access, improved resilience, shared workforce and clinical expertise, integrated pathways and digital systems, and sustainable reduction in waiting times and risk of sight loss.

● Regional Clinical Pathways

- Prioritise delivery across VR, IVT and Glaucoma.
- Develop regional VR on-call service.
- Consistent waiting list management.
- Further pathway standardisation across Health Boards.

● Regional Workforce Model

- Shared workforce planning.
- Development of regional on-call arrangements.
- Improved workforce resilience.
- Reduced dependency on locums.

● Capacity & Performance

- Refresh regional demand and capacity modelling.
- Regional performance dashboard.
- Benchmark activity, expenditure and workforce deployment.
- Address theatre utilisation inequalities.

● Digital Convergence

- Complete OpenEyes rollout.
- Integrate ERS and WGOS pathways.
- Improve data transparency and regional performance intelligence.

End-state enabler	Purpose
Standardised Clinical Pathways & Protocols	Consistent regional care model
Integrated Digital Infrastructure	Shared intelligence and interoperability
Centralised Operational Functions	Operational grip and coordination
Unified Governance & Leadership	Regional accountability
Regional Workforce Strategy	Sustainable capacity and resilience

Opportunities ahead

- Move from mobilisation into strengthened early delivery.
- Standardise priority pathways and build infrastructure for the integrated service.
- Expected benefits: reduced waits, equitable access, resilience and reduced sight loss risk.

Submission message: the next phase should strengthen capacity, standardise priority pathways and build the infrastructure required for a fully integrated regional Eye Care Service.

Regional Eye Care Programme: Progress to Date

Building the foundations for a regional Eye Care Service (2024–2026)

Programme aim: deliver short-term recovery and longer-term transformation towards a fully integrated South West Wales Eye Care Service with shared governance, workforce and operational arrangements.

Governance

Nov 2024

Programme Board established

Principles agreed

May 2025

regional intentions approved

Operational group

Jul 2025

delivery and integration

Workforce

VR consultant

regional recruitment completed

Digital

OpenEyes

implemented in Swansea Bay;
prep in HDdUHB

Governance & Collaboration

- Regional Eye Care Programme Board established.
- Regional Principles and Intentions agreed across Glaucoma, Cataract, Medical Retinopathy and Paediatric Ophthalmology.
- Regional Operational Group established to drive delivery and operational integration.

Workforce Development

- Regional Vitreoretinal Consultant recruitment completed.
- Medical Retina Consultant recruitment progressing.
- Regional workforce model and shared service approach in development.

Digital Transformation

- OpenEyes EPR implemented within Swansea Bay.
- Preparatory work underway in Hywel Dda.
- Regional alignment progressing across ERS and WGOS pathways.

Pathway Development

- Early regional service model work completed.
- VR pathway and regional VR on-call arrangements developing.
- Alignment of glaucoma, VR and IVT pathways underway.
- Regional demand/capacity planning and dashboard development underway.

Key challenge: significant variation in ophthalmology capacity remains across the region, including theatre list capacity and workforce/operational constraints.



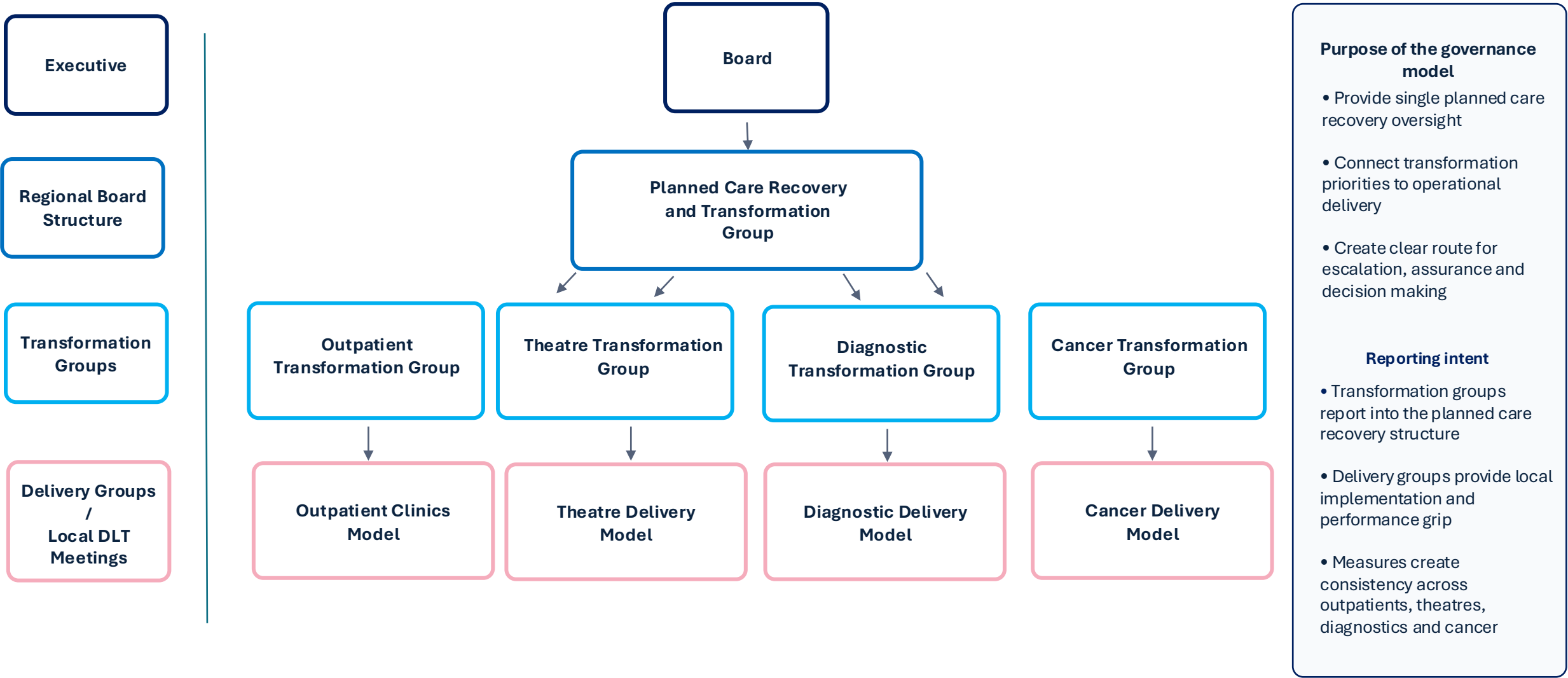
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Governance and Organisational Oversight

Governance and Organisational Oversight

Reporting Governance Structure



Key message: the governance structure aligns executive oversight, transformation groups and local delivery mechanisms so that recovery priorities, risks and measures can be managed consistently across planned care, diagnostics and cancer.

Governance and Organisational Oversight

Priorities for Transformation Groups



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Transformation Groups	Outpatient Transformation Group	Theatre Transformation Group	Diagnostic Transformation Group	Cancer Transformation Group
Pillar 1: Referral and Early Diagnosis	Improve referral quality, triage and pathway entry through A&G, referral criteria and straight-to-test approaches.	Ensure surgical pathways are ready before listing, with diagnostics, pre-op and clinical validation complete.	Improve right test, first time through straight-to-test, biomarkers, risk stratification and reduced low-value tests.	Support faster diagnosis through NOP compliance, NG12 / DG30 compliance and straight-to-test uptake.
Pillar 2: Capacity, Productivity and Treatment	Improve clinic productivity, template compliance, utilisation, unused slots and flow through outpatient sessions.	Improve theatre productivity, cases per list, utilisation, cancellations, late starts, early finishes and treat-in-turn.	Improve diagnostic capacity, turnaround, reporting backlog management and activity versus capacity planning.	Improve cancer treatment flow, MDT decision making, pathway breach management and priority tumour pathways.
Pillar 3: Follow-up, Surveillance and Living Well	Release follow-up capacity through discharge, PIFU, SOS, re-access monitoring and routine follow-up reduction.	Standardise post-treatment discharge and review criteria, reducing unnecessary routine post-operative follow-up.	Improve surveillance diagnostics, monitoring tests and community / point-of-care solutions.	Expand personalised follow-up and living-well models, supported self-management and re-access pathways.

Key message: each transformation group has a consistent role across the three recovery pillars: improve pathway entry, increase productive capacity and release follow-up / surveillance capacity.



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Planned Care Recovery and Transformation Group

Measures for Transformation Groups

	Outpatients	Theatres	Diagnostics	Cancer
Pillar 1: Referral & Early Diagnosis	Referral quality and pathway entry Measure: % referrals triaged / vetted before booking Evidence: A&G use, referral criteria compliance, straight-to-test uptake	Surgical pathway readiness Measure: % patients listed with diagnostics, pre-op and clinical validation complete Evidence: avoidable delays before surgery, readiness at listing	Right test, right time Measure: % eligible patients on straight-to-test / risk-stratified pathways Evidence: biomarker use, alternative tests, reduction in low-value requests	Faster diagnosis Measure: time from suspicion to diagnosis Evidence: National Optimal Pathway compliance, NG12 / DG30 compliance, straight-to-test uptake
Pillar 2: Capacity, Productivity & Treatment	Clinic productivity and flow Measure: clinic utilisation and patients seen per session Evidence: template compliance, unused slots, DNA / CNA rate	Theatre productivity and treatment delivery Measure: theatre utilisation and cases per list Evidence: cancellations, late starts, early finishes, treat-in-turn compliance	Diagnostic capacity and turnaround Measure: % patients waiting over 8 weeks and test-to-report turnaround Evidence: activity vs capacity plan, reporting backlog, networked reporting	Cancer treatment flow Measure: time from diagnosis to treatment decision and decision to treatment Evidence: MDT deferrals, pathway breach reasons, priority tumour pathway performance
Pillar 3: Follow-up, Surveillance & Living Well	Follow-up capacity release Measure: reduction in routine follow-up backlog Evidence: % discharged, PIFU / SOS uptake, re-access rate	Post-treatment discharge and review Measure: % post-op pathways with agreed discharge / follow-up criteria Evidence: PIFU / SOS use, routine post-op follow-up reduction, re-access rate	Surveillance diagnostics Measure: % surveillance / monitoring tests completed within agreed timeframe Evidence: overdue surveillance tests, community / point-of-care uptake	Personalised follow-up and living well Measure: % eligible patients on personalised follow-up Evidence: routine follow-up reduction, supported self-management plans, re-access time



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Planned Care Delivery & Sustainability Plan 26/27

Supporting addendum document.



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Appendices Pillar 1

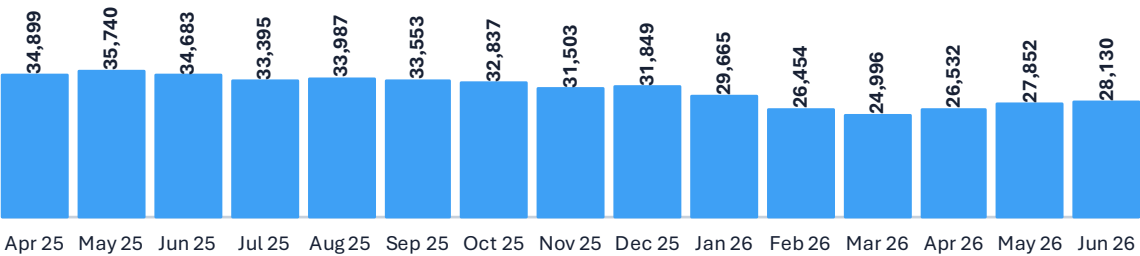
Current position: recovery progress and waiting list impact

Planned Care Recovery and Sustainability Plan | June 2026 position

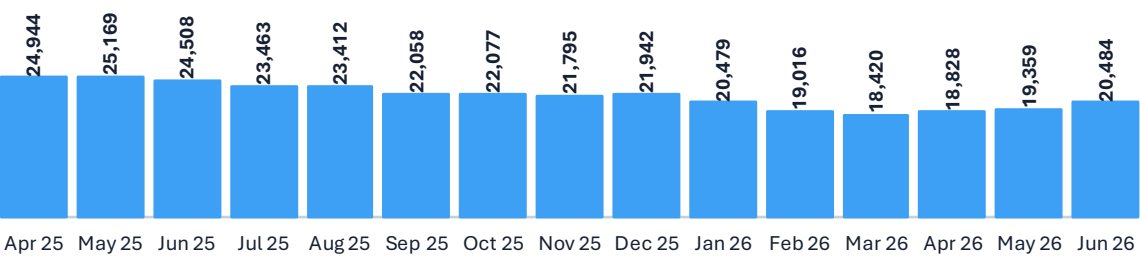


Recovery activity has delivered material reductions across the 26, 36 and 52-week cohorts. The June 2026 104-week position has increased to 254, demonstrating the need for a sustainable capacity solution to maintain gains and prevent recurrence.

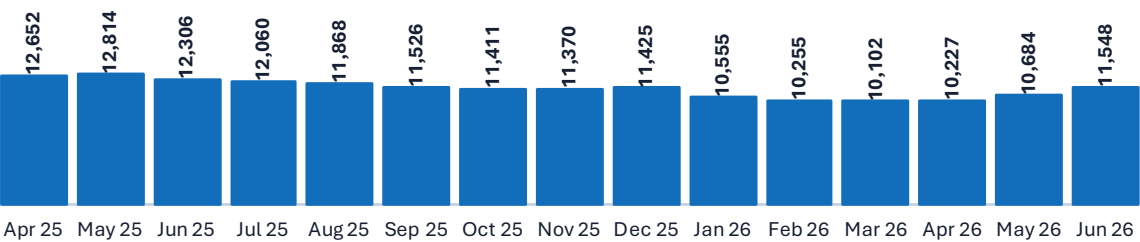
Patients waiting 26 weeks and over



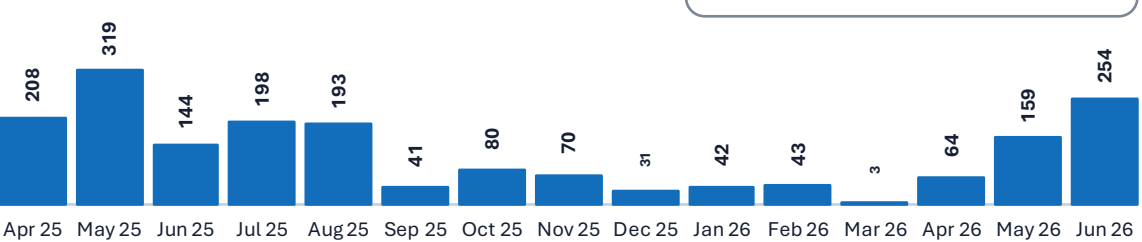
Patients waiting 36 weeks and over



Patients waiting over 52 weeks



Patients waiting over 104 weeks



104-week position
254 patients | Jun 2026

Interpretation: validation, outpatient transformation, productivity improvements and targeted recovery capacity have reduced the longest-waiting cohorts materially. The recent increase in 104-week waits reflects residual demand and capacity constraints in challenged specialties, strengthening the case for continued recovery funding and sustainable pathway redesign.



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Planned Care: New Outpatient Waiting List Recovery and Productivity Impact

Total list reduction

-11,226

Jul 25 to Jun 26

Percentage reduction

-22%

50,621 to 39,395

June movement

+783

from May 26

Current 26+ cohort

4,376

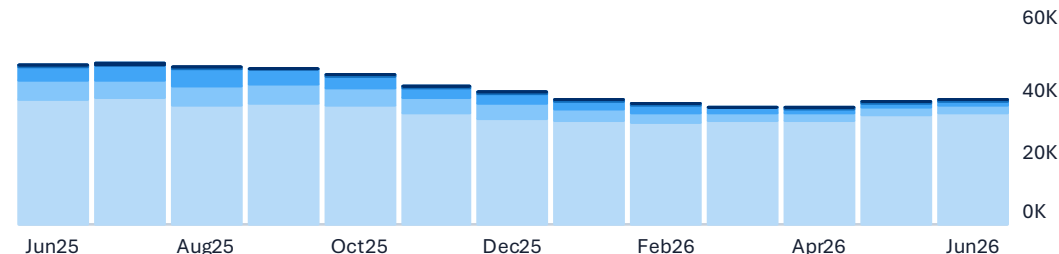
Jun 26

Productivity gains: referral management, professional triage, Community HealthPathways, validation and outpatient transformation are reducing avoidable demand and improving list quality.

Total New Outpatient Waiting List

Total patients waiting by length of wait

Under 26 26 to 35 36 to 52 53 to 104 105+

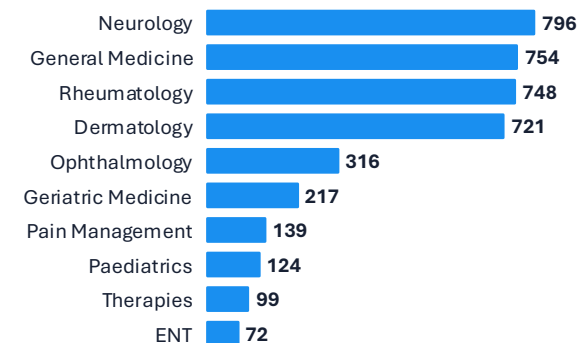


Grouped waits with totals

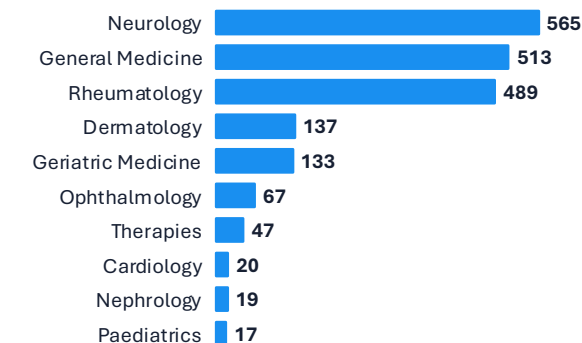
Date	Under 26	26 to 35	36 to 52	53 to 104	Total
Jun 26	35,019	2,334	1,869	173	39,395
May 26	34,222	2,382	1,903	105	38,612
Apr 26	32,854	2,243	1,872	39	37,008
Mar 26	32,591	2,361	2,190	-	37,142
Feb 26	32,047	2,862	2,929	15	37,853
Jan 26	32,489	3,541	3,239	16	39,285
Dec 25	33,356	4,443	3,879	7	41,685
Nov 25	35,229	4,663	3,782	1	43,675
Oct 25	37,725	5,306	4,170	6	47,207
Sep 25	38,071	6,181	4,453	-	48,705
Aug 25	37,697	5,738	5,737	190	49,362
Jul 25	39,764	5,529	5,212	115	50,621
Jun 25	39,471	5,637	5,270	71	50,449

Specialties contributing to longest new outpatient waits as of 30 June 2026

Specialties with most 26-week breaches



Specialties with most 36-week breaches



Specialties with most 52-week breaches



Productivity gains highlighted

- 11,226 fewer patients than July 2025
- 22% reduction in total new outpatient list
- Residual long waits concentrated in a small number of specialties
- Targeted productivity actions can therefore be focused where impact is greatest

Interpretation: new outpatient demand is materially lower than July 2025, demonstrating the impact of referral optimisation, validation and transformation work. The June increase and concentration of 26/36/52-week breaches in Neurology, General Medicine, Rheumatology and Dermatology indicate where the next phase of productivity and recovery focus should be targeted.



Planned Care: New Outpatient Waiting List Recovery and Productivity Impact

The RTT waiting list reflects the full patient pathway across outpatient, diagnostic and treatment stages. The overall list has reduced since July 2025, while remaining long-wait pressure is concentrated in Ophthalmology and Orthopaedics, where demand continues to exceed available capacity.

RTT list reduction

-6,967

Jul 25 to Jun 26

Percentage reduction

-7.4%

93,521 to 86,554

104w low point

3

Mar 26

Current 104w

254

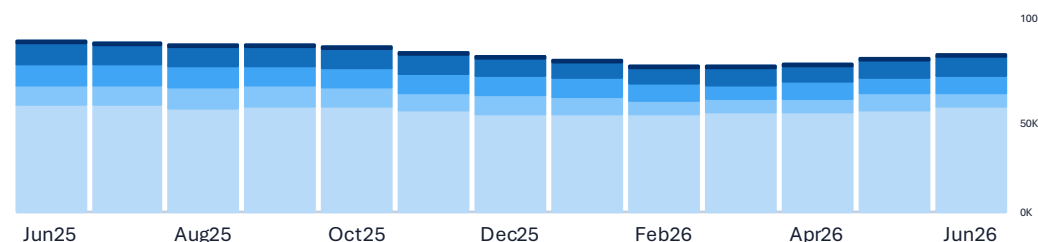
Jun 26

Productivity gains: validation, outpatient transformation, theatre productivity, SOS/PIFU expansion, follow-up validation and focused specialty trajectories are improving list quality and targeting capacity.

Total RTT Waiting List

Total patients waiting by length of wait

Under 26 26 to 35 36 to 52 53 to 104 105+

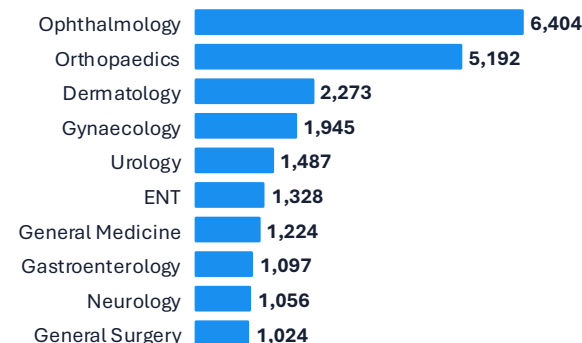


Grouped waits with totals

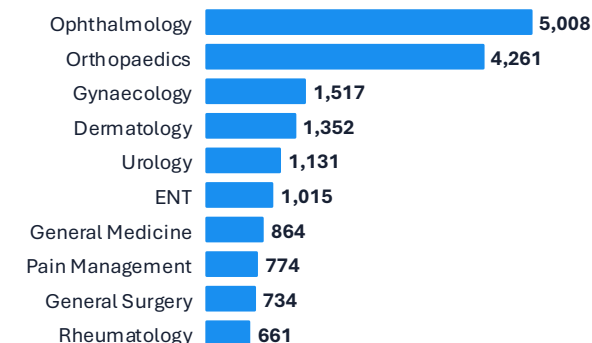
Date	Under 26	26 to 35	36 to 52	53 to 104	105+	Total
Jun 26	58,278	7,730	8,998	11,294	254	86,554
May 26	56,664	8,585	8,713	10,525	159	84,646
Apr 26	55,389	7,599	8,636	10,163	64	81,851
Mar 26	55,446	6,629	8,351	10,099	3	80,528
Feb 26	54,283	7,483	8,795	10,212	43	80,816
Jan 26	54,492	9,252	9,962	10,513	42	84,261
Dec 25	54,224	10,030	10,569	11,394	31	86,248
Nov 25	56,191	9,800	10,475	11,300	70	87,836
Oct 25	57,993	10,856	10,729	11,331	80	90,989
Sep 25	58,176	11,633	10,591	11,485	41	91,926
Aug 25	57,718	10,712	11,643	11,675	193	91,941
Jul 25	59,810	10,132	11,519	11,862	198	93,521
Jun 25	59,343	10,326	12,289	12,162	144	94,264

Specialties driving long RTT waits as at 30 June 2026

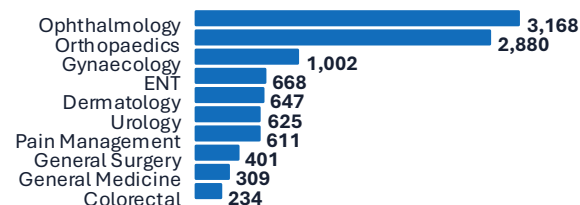
Specialties with most 26-week breaches



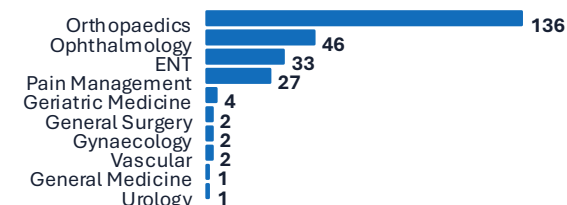
Specialties with most 36-week breaches



Specialties with most 52-week breaches



Specialties with most 104-week breaches



Interpretation: RTT validation, outpatient transformation and targeted recovery have reduced the overall RTT list by 6,967 patients since July 2025. The remaining long waits are concentrated in Ophthalmology and Orthopaedics, supporting a focused recovery investment and productivity plan to maintain progress and prevent recurrence.

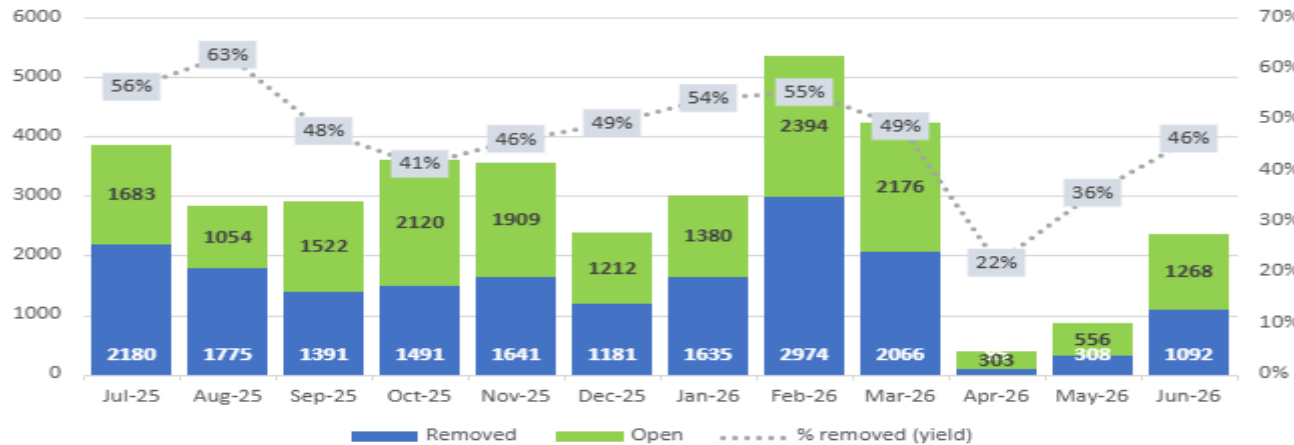
Pillar 1 Goal 1& 3, Validation



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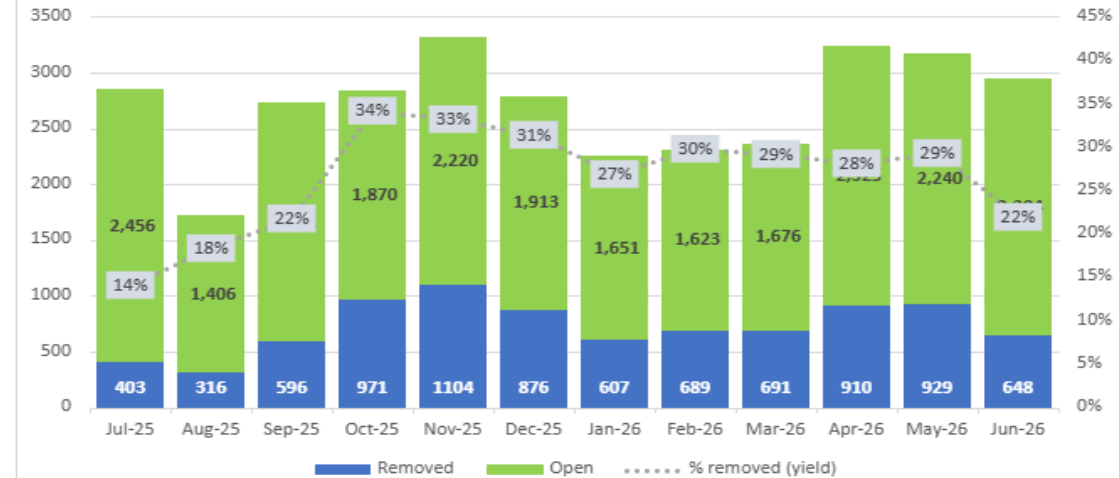
RTT Validations



Referral to Treatment (RTT) validation

- Over the 12-month period July 2025 to June 2026, 35,396 RTT pathways were validated, resulting in 17,819 removals, a 50% removal rate.
- This materially reduces the open RTT position, improves PTL accuracy and enables operational teams to focus recovery capacity on patients with an active treatment requirement.
- Validation volumes were lower in April and May due to temporary staffing constraints; capacity is being restored through the addition of 2.0 WTE Band 3 posts and a continued focus on Stage 3 pathways.
- Patients not visible on PTL but present on active waiting lists have been reviewed and referred to specialties for clarification, strengthening waiting list governance and recovery assurance.

FUWL Validations



Follow-Up Waiting List (FUWL) validation

- Over the same 12-month period, 32,565 follow-up pathways were validated, resulting in 8,740 removals, a 27% removal rate.
- This reduces avoidable follow-up demand and supports release of clinical capacity that can be redirected towards new outpatient access, long-wait management and overall waiting list stabilisation.
- Current focus includes WGOS referrals into Primary Care Ophthalmology, CIN-based outcome recording, validation of the longest-wait patients from 2022 and earlier, and diagnostic follow-up work linked to the HBSUK project.
- The overall impact is improved list quality, reduced administrative and clinical risk, stronger specialty assurance and a clearer view of the residual demand that requires recovery capacity.

Overall waiting list impact: validation removes pathways that no longer require active management, improves confidence in the residual waiting list, and helps target recovery capacity to patients still waiting for treatment or clinically necessary follow-up.

Pillar 1: Goal 2 Referral Management

Actions, pathway impact and WG submission message

Pillar 1 Prevent avoidable demand entering the RTT pathway, improve the quality of the waiting list, and create a clearer residual capacity requirement for the Welsh Government submission.

Referral management pathway impact



What has been delivered

- Sustained referral vetting and removal of referrals that do not require active secondary care management.
- Straight-to-test use for a proportion of suspected cancer pathway referrals.
- Improved visibility of annual referral flow and demand entering Stage 1.

What this means for waiting lists

- Fewer avoidable additions to the outpatient waiting list.
- More reliable understanding of the residual active demand requiring capacity.
- Improved focus of recovery activity on patients who require specialist assessment or treatment.

Next productivity focus

- Standardise professional triage across specialties.
- Strengthen Community HealthPathways and referral criteria.
- Develop benchmark for average time to triage and report trend through recovery governance.

WG submission narrative

Referral management demonstrates that Hywel Dda is actively applying productivity-before-investment principles. The 29% removal rate shows that avoidable demand is being managed before patients enter the waiting list. The residual waiting list and long-wait position is therefore be presented as the remaining capacity requirement after internal triage, validation and pathway optimisation have already been applied.

Pillar 1: Goal 2 Referral Management

Evidence of demand control and productivity delivered

Referral management is already reducing avoidable demand entering the planned care pathway. Over the 12 weeks to April 2026, 29% of referrals were removed other than treated, supporting a more accurate waiting list and ensuring outpatient capacity is directed to patients who require specialist assessment.

Average referrals

2,723

per week

Removed other than treated

795

29% per week

Net additions

1,928

weekly additions

Annual referrals

~140k

41k vetted / 98k additions

SCP straight to test

38.2%

May 2026

Urgent / SCP referrals

32%

categorised urgent/SCP or both

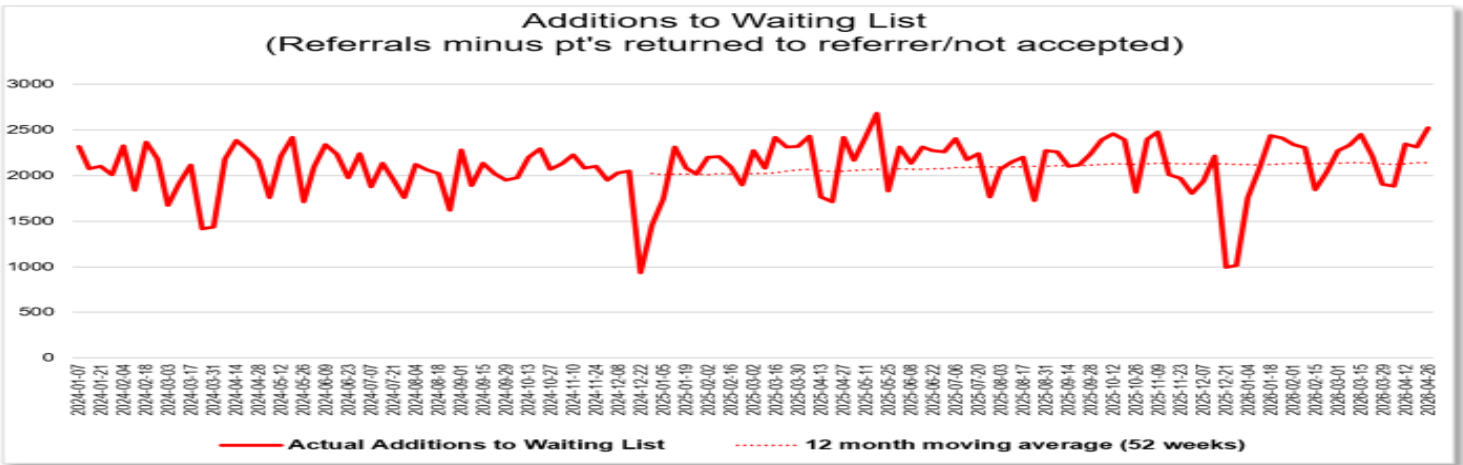
Productivity gains evidenced

- 29% of referrals removed other than treated through referral management, advice and guidance or non-acceptance.
- Approximately 41,000 referrals annually are vetted before adding patients to the waiting list.
- Professional triage improves list quality and reduces avoidable first outpatient demand.

Waiting list impact

- Reduces avoidable additions to RTT Stage 1 and improves the quality of the residual waiting list.
- Supports targeted use of outpatient capacity for patients who require specialist assessment.
- Provides a measurable demand-management lever within Pillar 1 recovery.

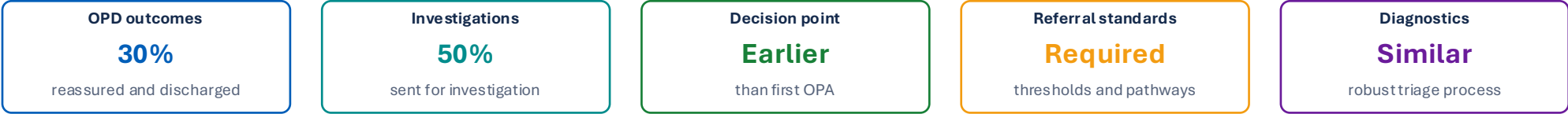
Additions to Waiting List: referrals minus patients returned to referrer / not accepted



Interpretation: despite weekly variation in referral additions, the 12-month moving average indicates ongoing demand and pressure. The 29% removal rate demonstrates productivity already delivered and strengthens the case for continued professional triage, Community HealthPathways and referral optimisation.

Pillar 1: Goal 2 Referral & Early Diagnosis

Professional triage and agreed standards to prevent avoidable outpatient demand



Editable referral pathway infographic



Strategic objective

- Move decision-making from first outpatient attendance to expert triage.
- Use senior experienced consultants with an interest in transformation.
- Avoid unnecessary waiting and direct patients to the right pathway earlier.

Enablers required

- Agreed thresholds for secondary care referral, diagnostics and treatment.
- Use Community HealthPathways where local standards are not yet agreed.
- Align referral triage with diagnostic triage.

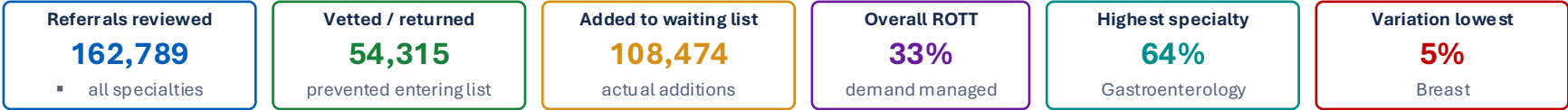
Outpatient capacity controls

- Standard clinic templates.
- Overbooking for DNA where clinically and operationally appropriate.
- Consistent booking and utilisation grip across specialties.

Pillar 1: Goal 2 Referral Management Productivity Impact

Demand managed before patients enter the outpatient waiting list

Referral management is preventing a substantial volume of avoidable demand from entering secondary care waiting lists. Across all specialties, 54,315 referrals have been vetted, returned or redirected before outpatient appointment allocation, demonstrating that productivity measures are being applied at source before additional recovery capacity is requested.



Productivity gains delivered

- 54,315 referrals prevented from entering outpatient waiting lists.
- 33% overall referral management rate across specialties.
- Referral optimisation directs patients to the most appropriate pathway.

Waiting list impact

- Reduced unnecessary first outpatient appointments.
- Improved quality of demand entering RTT pathways.
- More capacity available for patients requiring specialist intervention.

Opportunity to reduce variation

- High-performing specialties show what can be achieved through stronger triage and pathway optimisation.
- Low ROTT specialties identify where targeted improvement support is required.

Referral management by specialty: demand reviewed, demand returned and actual additions

Specialty	All	Vetted / Returned	Actual Additions	% ROTT
301 - Gastroenterology	10,228	6,547	3,681	64%
320 - Cardiology	11,210	7,058	4,152	63%
303 - Clinical Haematology	3,157	1,969	1,188	62%
104 - Colorectal	13,195	6,653	6,542	50%
302 - Endocrinology	2,261	1,097	1,164	49%
191 - Pain Management	1,332	589	743	44%
100 - General Surgery	5,222	2,255	2,967	43%
361 - Nephrology	1,057	441	616	42%
420 - Paediatrics	6,267	2,401	3,866	38%
107 - Vascular	1,813	686	1,127	38%
340 - Respiratory Medicine	6,721	2,534	4,187	38%
430 - Geriatric Medicine	1,667	604	1,063	36%
410 - Rheumatology	3,553	1,272	2,281	36%
307 - Diabetic Medicine	1,241	372	869	30%
101 - Urology	7,585	2,271	5,314	30%
400 - Neurology	4,318	1,179	3,139	27%
130 - Ophthalmology	18,720	4,767	13,953	25%
110 - Trauma & Orthopaedics	10,207	2,533	7,674	25%
300 - General Medicine	5,967	1,448	4,519	24%
330 - Dermatology	16,888	3,420	13,468	20%
120 - ENT	10,097	1,969	8,128	20%
328 - Stroke Medicine	710	114	596	16%
502 - Gynaecology	13,545	1,847	11,698	14%
103 - Breast	5,828	289	5,539	5%
Grand Total	162,789	54,315	108,474	33%

WG submission message: the residual waiting list should be viewed as remaining demand after pathway optimisation, consultant triage, advice and guidance, and referral management have already been applied.

Pillar 1: Goal 2 Community Health Pathways Productivity Impact

Standardised pathway guidance to improve referral quality and reduce avoidable outpatient demand



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Community HealthPathways provides a sustainable demand-management mechanism that standardises referral practice, improves referral quality and supports patients to be managed in primary care where specialist intervention is not required. This strengthens Pillar 1 by reducing unwarranted variation before patients enter secondary care waiting lists.

Published pathways

344

programme outputs

Referral pages

210

referral / information

National lead pathways

83

HDUHB lead region

Page views

92,000

to date

Programme maturity

Year 4

midway through delivery

Top pathways

Carpal Tunnel

Abnormal LFT / HRT also high

Local evaluation is underway to quantify the impact on referrals, demand and pathway compliance.

Productivity gains delivered

- Standardised referral criteria across primary and secondary care.
- Improved referral quality before patients enter specialist services.
- Supports advice, guidance and referral optimisation.

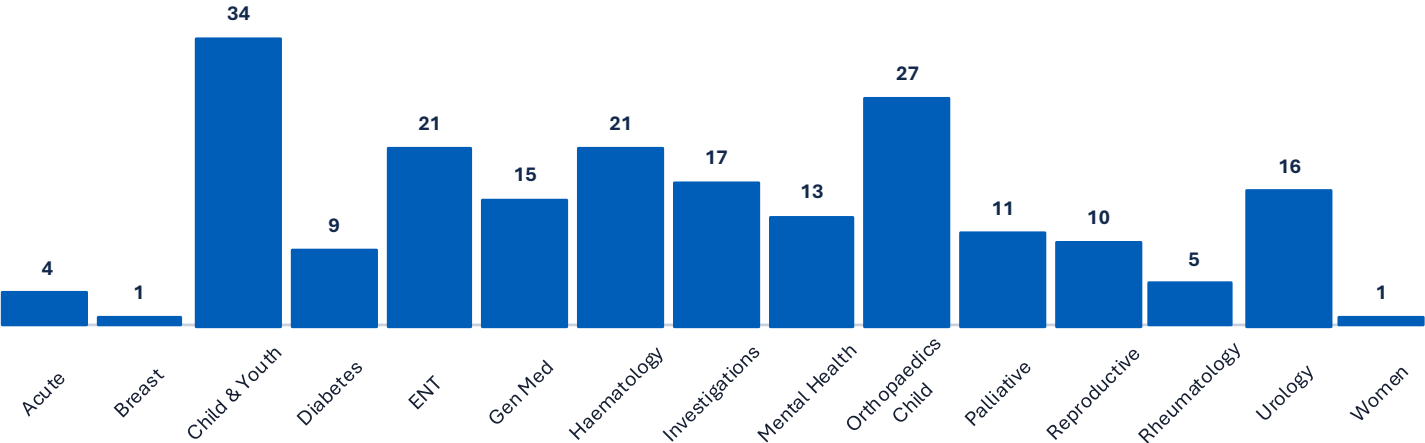
Waiting list impact

- Helps reduce avoidable outpatient demand entering RTT pathways.
- Supports appropriate management closer to home where clinically suitable.
- Improves the quality of referrals reaching secondary care.

WG submission relevance

- Demonstrates productivity-before-investment by controlling demand at source.
- Provides an enabling platform for sustained referral management.

Published pathways by specialty



Waiting list impact statement

With 344 published pathways and 92,000 page views, Community HealthPathways is a key enabler of referral management. It supports consistent referral decisions, reduces unwarranted variation and helps ensure secondary care capacity is focused on patients who need specialist intervention.



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Appendices Pillar 2

Pillar 2 Goal 1: Optimisation, Prehabilitation and POPS

Capacity, productivity and treatment — eliminating long waits

Strategic intent: expand the current multidisciplinary Optimisation and Prehabilitation service into a comprehensive POPS model to support 104-week recovery and wider planned care transformation.



Current service model

Tiered virtual holistic MDT optimisation and prehabilitation service supported by remote monitoring for high-risk and/or frail surgical patients.



Target cohort

High-risk/frail patients awaiting arthroplasty, inpatient general surgery and gynaecology; proposed expansion includes over-65s waiting over 104 weeks.



Patient outcomes

Aims to optimise health and wellbeing before surgery, reduce support needs on discharge and set personalised goals through shared decision making.



Productivity impact

Supports reduced length of stay, surgical admission capacity and increased opportunities for day-case procedures.

Evidence from current model

- Around 85% of high-risk/frail patients are successfully managed via the service
- Around 5% of frail/high-risk patients identify an alternative pathway as preferable
- Demonstrable outcomes include BP management, weight loss, increased physical activity, activation, quality of life and Oxford scores

WLSS / PROM stratification criteria used to target optimisation support

Stratification Criteria (based on PROM results)	
RED ➤ Refer to Optimisation and Prehabilitation Service	▪ BMI greater than 35 or less than 18.5 ▪ Exercise: 1 hour or less per week. ▪ EQ-5D-5L Scores: Score 5 in MOBILITY, SELF-CARE & USUAL ACTIVITIES
AMBER ➤ Contact/ review from WLSS Nurses	▪ BMI between 30 and 35 ▪ EQ-5D-5L Score 4 in MOBILITY, SELF-CARE and USUAL ACTIVITIES. ▪ Score 5 in PAIN / DISCOMFORT and ANXIETY / DEPRESSION ▪ VAS Scores: Less than 20 ▪ Comorbidities: Responds 'yes' to any comorbidity (even if more than 1) ▪ Polypharmacy: 4 or more medications
YELLOW ➤ Contact from non-clinical call handler ➤ MECC conversation	▪ BMI of between 25 to 29 ▪ Exercise: More than 1 hour and up to 2 hours & more than 2 hours and up to 3 hours. ▪ EQ-5D-5L Score 2 or 3 in MOBILITY, SELF-CARE and USUAL ACTIVITIES, PAIN / DISCOMFORT and ANXIETY / DEPRESSION ▪ VAS Score: 20 up to 60. ▪ Smoking: Smoker ▪ Alcohol: 14 or more units per week.
GREEN ➤ Open access to WLSS and Waiting Well resources online ➤ No additional intervention required.	▪ BMI: of 18.5 up to 25. ▪ Exercise: Above 3 hours per week. ▪ EQ-5D-5L: Level 1 in all domains ▪ VAS Score: more than 60. ▪ Comorbidities: Does not score 'yes' to any comorbidities. ▪ Polypharmacy: Less than 4 medications ▪ Smoking: Non-smoker

Pillar 2: POPS and Prehabilitation

Stratified surgical decision-making for higher-risk patients



POPS decision pathway infographic



Why POPS matters

- Surgical interventions in over-60s and over-70s are growing.
- The cohort is higher risk and more likely to require complex pre-assessment, inpatient or higher dependency care and social care support.
- The strategy supports better early decisions for patients and services.

Delivery model

- Each Health Board should have a POPS service.
- Scrutinise current Stage 4 waiting list for all patients over 65.
- Prospectively assess appropriately frail patients at triage or vetting.

Resource proposal

- 12 consultant sessions.
- 2 x Band 7 nurses.
- 1 full-time administration support.
- Resource described as small compared with the release and service improvement expected.

POPS Workforce and Finance Tables

Current funding at risk and proposed POPS / prehabilitation expansion

Financial ask: maintain the current optimisation/prehabilitation capability while expanding to a comprehensive POPS model and adding focused 104-week POPS clinic capacity.

1. Current workforce model

Current Optimisation / Prehabilitation Workforce Model	Cost (£)
1 WTE Band 7 Physiotherapist	73,469
1 WTE Occupational Therapist*	73,469
1 WTE Dietician*	73,469
1.6 WTE Band 4 Therapy Assistant Practitioner	64,269
0.4 Band 8a Pharmacist*	31,433
0.6 Band 3 Administrative Support	19,296
Total	335,405

* Current funding at risk due to previous short-term WG funding.

Total: £335,405

3. Additional 104-week POPS clinic capacity

Additional workforce for POPS clinics only – 104 weeks	Cost (£)
0.2 WTE Band 7 Physiotherapist	14,694
0.2 WTE Band 7 Occupational Therapist	14,694
0.2 WTE Band 7 Dietician	14,694
0.2 Band 8a Pharmacist	15,717
0.2 Band 3 Administrative Support	6,432
1 WTE Band 4 Nursing Assistant Practitioner	40,168
0.4 WTE B8a Advanced Frailty Practitioner	33,713
2 Consultant sessions per week	38,231
Total	178,334

Initial focus: older people >65 years waiting over 104 weeks.

Total: £178,334

2. Proposed POPS / prehabilitation model

POPS / Prehabilitation Workforce Model	Cost (£)
1.2 WTE Band 7 Physiotherapist	88,163
1.2 WTE Occupational Therapist	88,163
1.2 WTE Dietician	88,163
1.6 WTE Band 4 Therapy Assistant Practitioner	64,269
0.5 Band 8a Pharmacist	42,141
0.8 Band 3 Administrative Support	25,728
1 WTE Band 4 Nursing Assistant Practitioner	40,168
0.4 WTE B8a Advanced Frailty Practitioner	33,713
2 Consultant sessions per week	38,231
Total	508,739

Total: £508,739

The proposal protects current prehabilitation productivity gains and adds POPS capability to support over-65s waiting over 104 weeks, wider planned care transformation and identification of alternative pathways where appropriate.

Pillar 2 Goal 1: Virtual Models of Care Productivity Impact

Increasing outpatient productivity and releasing face-to-face capacity



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Virtual outpatient delivery is increasing clinic productivity, improving patient access and preserving face-to-face capacity for patients requiring examination, procedures or complex decision-making. Current performance demonstrates progress, with a clear opportunity to increase utilisation towards the Health Board ambition.

New activity virtual

18.26%

current delivery

Follow-up virtual

26.46%

current delivery

New activity target

35%

minimum ambition

Follow-up target

50%

minimum ambition

New gap

16.74

remaining opportunity

Follow-up gap

23.54

remaining opportunity

Virtual optimisation is a productivity lever rather than a standalone access metric.

Productivity gains delivered

- Reduced requirement for face-to-face clinic capacity.
- Increased flexibility in clinician job planning and clinic utilisation.
- Improved patient access and reduced travel burden.

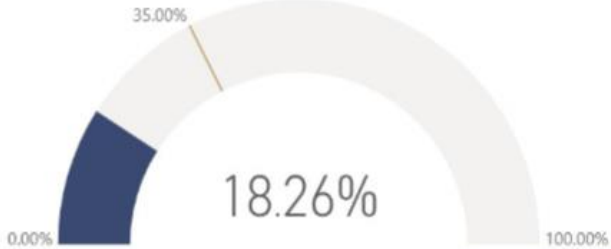
Waiting list impact

- Supports outpatient transformation and waiting list recovery.
- Enables face-to-face capacity to be prioritised for complex patients.
- Creates opportunities for PIFU, CIN and remote monitoring pathways.

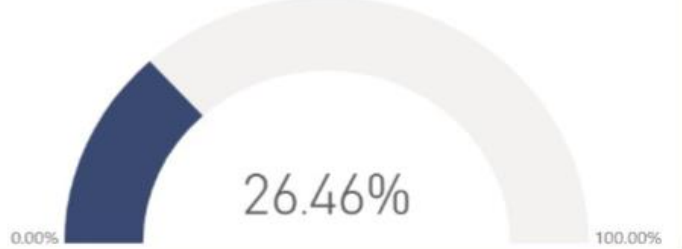
Strategic opportunity

- Increasing virtual utilisation towards 35% new activity and 50% follow-up would release further physical clinic capacity.

Min no. of New OPD appointments to be virtual = 35% (for the selected period)



Min no. of FU OPD app's to be virtual = 50% (for the selected period)



WG submission message

Virtual models of care show that Hywel Dda is already using outpatient capacity more productively. Further movement towards the minimum virtual delivery ambitions would release additional face-to-face capacity for patients with the greatest clinical need and support RTT and follow-up waiting list recovery.

Interpretation: virtual activity is already converting outpatient demand into a lower-estate, more flexible model of care. The remaining delivery gap to 35% new and 50% follow-up virtual activity provides a clear further productivity opportunity.

Theatre Productivity & Efficiency



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Hywel Dda has undertaken a comprehensive review of elective productivity and capacity through internal planned care recovery and improvement work.



This has identified opportunities to improve productivity and release additional capacity through:



Implementation of redesigned theatre timetables



Improved alignment of job plans with available theatre capacity



Increased theatre utilisation



Day Case First



Treat in Turn



Reduction in late cancellations



Improved pre-operative assessment



Outpatient transformation and reduction in unnecessary follow-up activity



Improved validation and booking processes, including strengthened central validation capacity



These initiatives are already underway and form the foundation of the Health Board's recovery approach. Consistent with Welsh Government expectations, Hywel Dda's approach is to maximise internal productivity before seeking additional external capacity.



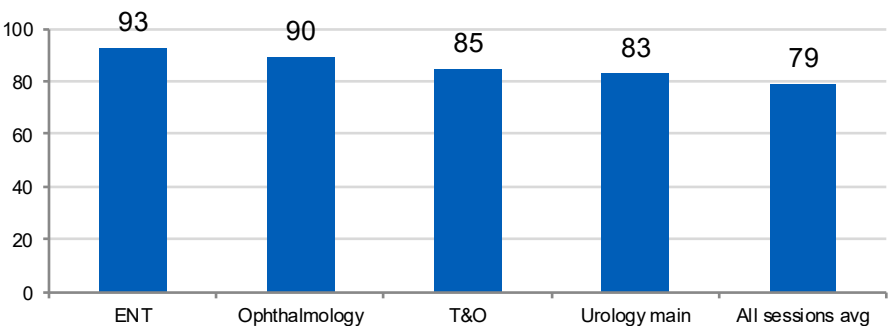
Residual demand and capacity gaps, where they remain following optimisation, have been identified through specialty-level demand and capacity modelling and form the basis of the funding requirements described later within this plan.

Pillar 2, Goal 1, Theatre Productivity

High Utilisation in challenged specialties; recovery ask framed as residual capacity gap

Theatre utilisation is strong across the challenged specialties. The remaining ask should be framed as the capacity requirement left after measurable productivity gains.

Theatre utilisation across challenged specialties



Constraint review findings

- Four of five challenged specialties have minimal gap to GiRFT or are above target.
- Ophthalmology gap is 0.3 percentage points, equivalent to 4 theoretical patients.
- ENT is already above target at 93.1%; T&O is close to standard at 84.9%.
- Only urology has a material gap in the constraint review, at 78.1%.
- This supports the position that the external recovery ask is a capacity requirement, not a productivity gap.

Potential gain if 85% reached

1,073

additional patients p.a.

Activity delivered

16,536

patients across 4,619 sessions

Average throughput

3.58

patients per session

External ask framing

Capacity

not productivity gap

The submitted recovery requirement is what remains after every credible internal action has been exhausted.

Theatre Optimisation: Day Surgery & Capacity

Conversion Pillar 2, Goal 1

Using day-case conversion to increase productive elective capacity

Theatre utilisation is already supporting capacity conversion, with 12,834 day-case procedures delivered up to June 2025. At 75%, the day surgery rate remains close to the BADS benchmark of 80%, with further opportunity to release inpatient capacity for complex activity.

Day case rate 75% current position	BADS benchmark 80% target rate	Day cases 12,834 procedures	Inpatients 4,300 procedures	Remaining gap 5pp to 80% benchmark	Workstream Active Theatre Optimisation
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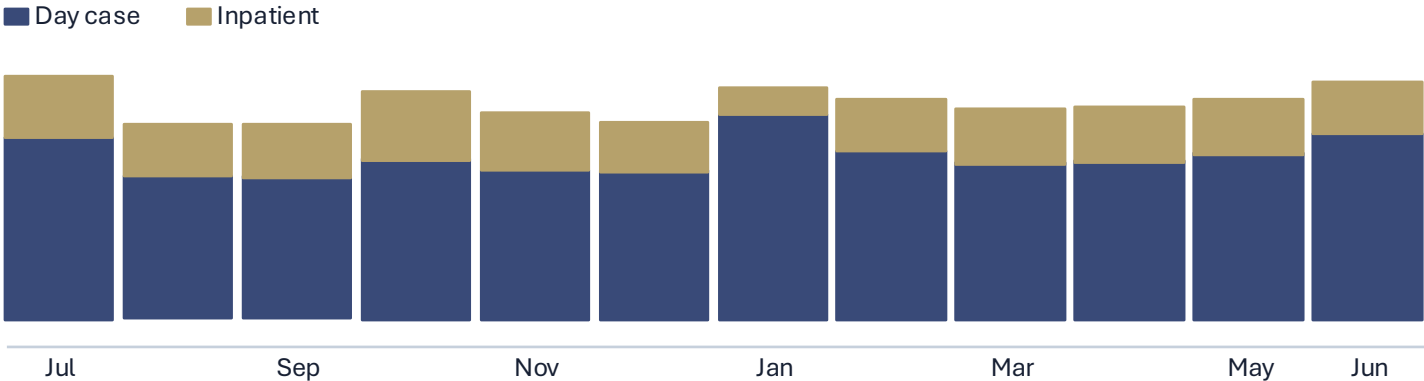
Current position

- 12,834 day-case procedures delivered, representing 75% of theatre procedures.
- 4,300 inpatient procedures delivered, representing 25% of procedures.
- Variation remains in Breast, ENT and Paediatrics, primarily linked to geography.

Waiting list benefit

- Increased day-case utilisation reduces inpatient bed dependency.
- Inpatient capacity can be prioritised for more complex or urgent procedures.
- More day-case delivery increases productive activity within existing theatre estate.

Monthly theatre procedures by day case / inpatient split



WG message: increasing day surgery rates towards the 80% BADS benchmark provides a tangible productivity opportunity, reducing inpatient bed pressure and supporting additional elective throughput within existing capacity.

Theatre Optimisation Programme: 20% Productivity Opportunity

Reducing lost session time and improving utilisation of existing theatre capacity



Further theatre productivity gains are available through reduced late starts, reduced early finishes and improved session utilisation. The key delivery requirement is alignment of clinical job plans, theatre shift start and finish times, and theatre workforce availability.

Productivity opportunity

~20%

identified improvement

Focus area

Late starts

reduce lost time

Focus area

Early finishes

improve session use

Key dependency

Job plans

align to sessions

Constraint

Workforce

fallow list challenges

Governance

CCG led

optimisation workstream

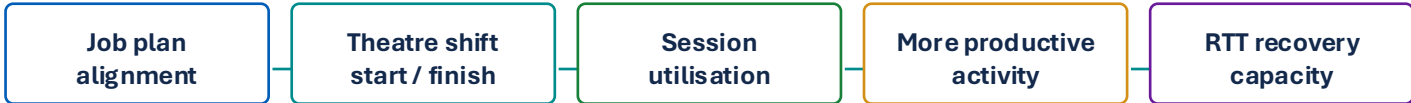
Efficiency opportunity

- Approximately 20% improvement opportunity identified through theatre optimisation.
- Focus on reducing late starts and early finishes.
- Improved session utilisation is required to move towards target levels.

Key constraints

- Clinical job plans and theatre shift start/finish times require alignment.
- Fallow lists remain challenging due to theatre workforce availability.
- Execution requires refreshed Clinical Care Group leadership.

Theatre optimisation route to waiting list impact



Programme priorities

Priority	Expected productivity effect
Reduce late starts	Increase usable operating time within existing sessions
Reduce early finishes	Improve completed activity per theatre session
Align job plans and shift times	Reduce avoidable mismatch between clinical and theatre capacity
Strengthen workforce planning	Reduce fallow list impact and improve resilience

WG submission message: Theatre optimisation is one of the largest internal productivity opportunities available. By reducing session inefficiencies and improving utilisation of existing capacity, Hywel Dda can deliver additional activity and support RTT recovery without relying solely on new capital or recurrent investment.

Surgical Hub Accreditation Programme: Purpose, Aim and Objectives



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Accreditation readiness and planned care sustainability

Purpose: support safe, high-quality, efficient and sustainable planned care services through the development, optimisation and accreditation of Surgical Hubs across the Health Board.

Ministerial context

MAG 4b

accreditation expected within 12 months

Accreditation focus

Mandatory + preferred

evidence identified, collated and maintained

Programme aim

Accredited Hubs

high-standard planned care services

Assurance route

Peer review

readiness and evidence repository

Funding alignment

Future model

condition of further funding

Programme purpose

- Develop, optimise and accredit Surgical Hubs across the Health Board.
- Provide a structured approach to accreditation preparation.
- Identify, collate and maintain mandatory and preferred evidence in line with national expectations.
- Support assurance, readiness for peer review and alignment with future planned care funding models.

Aim

- Establish and maintain accredited Surgical Hubs.
- Deliver high-quality, high-standard planned care services.
- Improve patient pathways and strengthen operational efficiency.
- Support sustainable improvements in planned care performance.
- Demonstrate continuous improvement, shared learning and best practice through the Strategic Programme for Planned Care accreditation process.

Key objectives

- Prepare Surgical Hubs for accreditation by identifying and maintaining mandatory and preferred evidence.
- Deliver against national expectations including MAG recommendation 4b.
- Improve efficiency and pathway delivery through streamlined surgical pathways, patient flow, theatre utilisation and productivity.
- Support teams to recognise contribution to high-quality surgical care and service improvement.

Submission message: Surgical Hub accreditation is a national requirement and a local improvement mechanism linking evidence, assurance, pathway quality, productivity and future planned care funding readiness.

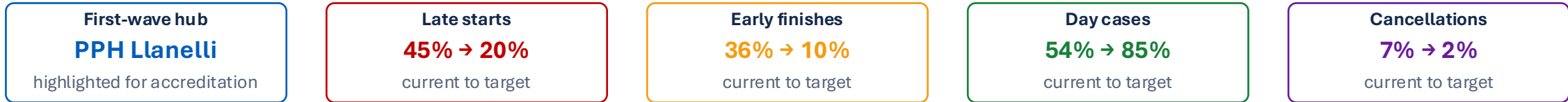
Pillar 2: Surgical Hubs and Theatre Productivity



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Accreditation and productivity grip to address the Stage 4 tail



Stage 4 delivery logic



Three solutions

- POPS service creating 15% Stage 4 reduction, prospectively and retrospectively.
- Better utilisation of current Stage 4 capacity.
- Conversion of follow-up capacity to new capacity, allowing consultant capacity to be reallocated to Stage 4.

Accreditation benefit

- Surgical Hub Accreditation establishes best practice.
- Develops a culture of more efficient use of current activity.
- Creates improvement learning that can cross-pollinate into other theatre areas.

Productivity focus

- Reduce late starts.
- Reduce early finishes.
- Increase day-case rate.
- Reduce cancellations.
- Use accreditation as a route to sustained operational grip.

Surgical Hub Accreditation: Immediate Next Steps and Delivery Controls

Evidence collation, Steering Group progression and readiness for accreditation review

The immediate priority is to move from programme set-up into evidence collation, gap closure and accreditation readiness, with clear timescales and communication to Surgical Hub teams.

Immediate next steps

- Retrieve and collate mandatory and preferred evidence for accreditation.
- Confirm and communicate the finalised filing structure by 24 August 2026.
- Progress actions through the 2nd Steering Group Meeting on 30 July 2026.
- Ensure Surgical Hub teams understand accreditation requirements, evidence expectations and timescales.
- Develop a clear action plan to address evidence gaps and support readiness for accreditation review.

Programme activities underway

- Steering Group established with specialty and site representation.
- Theatre Improvement Group coordinating planned care theatre improvement.
- Task and Finish groups established for targeted improvement areas.
- Specialty and site self-assessments completed against hub / optimisation criteria.
- Detailed improvement plans developed across hub domains.

Key risks / dependencies

- Investment likely required for digital pre-op, eConsent, diagnostics, support services, transport, prehabilitation and regional operating models.
- Accreditation assurance requires reliable data on utilisation, cancellations, day-case rates, LOS, POA readiness and support service delays.
- Workforce shortages and limited pre-assessment capacity may affect compliance and delivery pace.
- Some improvement actions depend on digital solutions not yet confirmed.

Assurance focus	Action / milestone
Evidence repository	Create linked evidence repository with all mandatory evidence captured
Filing structure	Confirm and communicate finalised structure by 24 August 2026
Steering Group	Progress actions through 2nd Steering Group Meeting on 30 July 2026
Accreditation readiness	Mock accreditation and site visit preparation with NHS P&I
Gap closure	Action plan to address evidence gaps and investment-dependent criteria

Decision focus: endorse the evidence collation approach, confirm the filing structure timescale, and maintain escalation for investment-dependent accreditation gaps.

Utilisation

High-volume low-complexity delivery and residual workforce constraint

Cataract surgery demonstrates successful application of High Volume Low Complexity principles. AVH delivery exceeds the 7 cataracts per session target, while acute site capacity is appropriately reserved for complex, urgent and training cases. The remaining limitation is workforce capacity, not productivity design.

Productivity target
7
cataracts per session

AVH productivity
8+
eyes / patients per session

HVLC compliance
100%
AVH sessions

Acute sessions
5
weekly sessions

HVLC model
Established
outsourced by default

Main constraint
Workforce
primary limiting factor

Current model uses pathway segmentation: routine HVLC through high-volume models, complex/urgent cases through acute site capacity.

Productivity gains delivered

- High Volume Low Complexity cataract model established at AVH.
- AVH sessions deliver 8+ eyes/patients per session, exceeding the target of 7.
- Outsourced activity is HVLC by default and supports long-wait recovery.

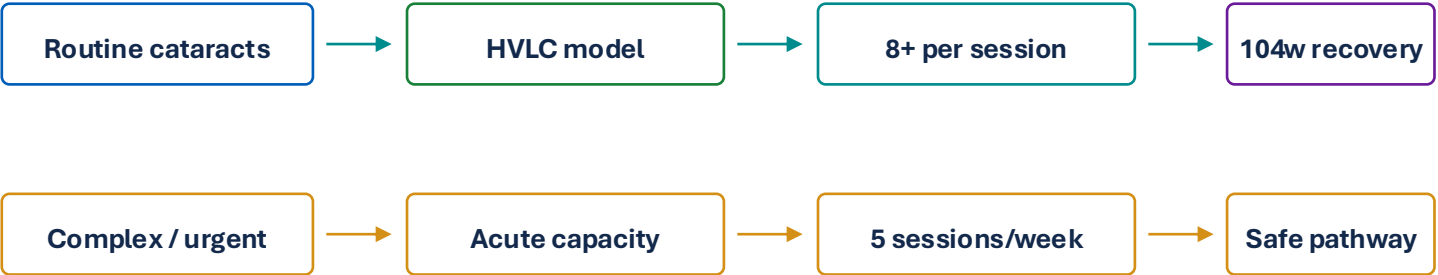
Waiting list impact

- Routine cataract patients can be treated through HVLC pathways.
- Complex and urgent patients are managed through dedicated acute site capacity.
- Supports continued progress towards long-wait reduction and 104-week recovery.

Residual constraint

- Further gains are constrained by workforce capacity, not by absence of a productivity model.

Cataract productivity model: capacity segmented by case complexity



Productivity position: AVH HVLC delivery exceeds the target; acute site sessions are correctly excluded from HVLC productivity comparison because they include complex, urgent and training activity.

WG submission message

The Health Board has implemented an effective HVLC cataract model that exceeds the established productivity standard. Further improvement is constrained primarily by workforce availability, requiring supplementary capacity to maintain long-wait recovery while internal resilience is built.

Pillar 2: Productivity Improvement - Orthopaedics & General Surgery

GIRFT and HVLC standards driving elective productivity and waiting list recovery

Orthopaedics and General Surgery have established measurable productivity standards aligned to GIRFT and HVLC principles. Activity gains have already been delivered, with further opportunity available through consistent surgeon practice, anaesthetic support, theatre shift alignment and regional collaboration.

Orthopaedic target

4 joints

per all-day list

Surgeons at target

4 of 13

31% routinely delivering

Orthopaedic growth

+29%

N=208 IP cases

Arthroplasty units

2

dedicated units

Gen Surg target

6 HVLC

per all-day session

Current delivery

12 of 45

26% sessions at 6/list

Residual opportunity is consistency and capacity alignment rather than absence of productivity standards.

Productivity gains delivered

- Orthopaedic demand and capacity plans aligned to GIRFT standards.
- GA day case lists already deliver in line with GIRFT expectations.
- 29% increase in orthopaedic inpatient activity achieved between March 2024 and March 2025.
- Two dedicated arthroplasty units established across the Health Board.

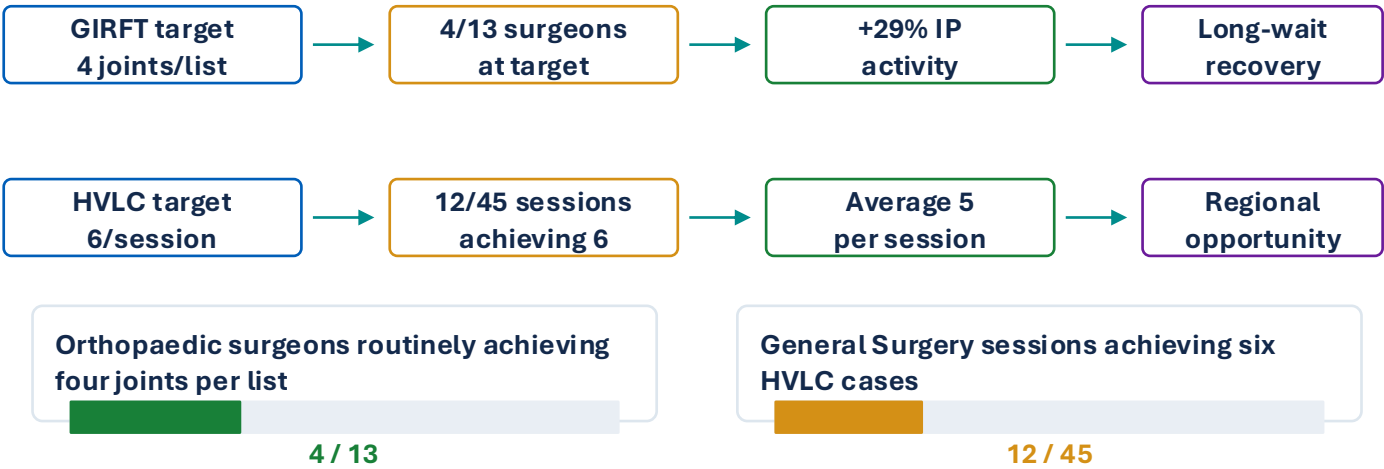
Waiting list impact

- Improved productivity supports long-wait arthroplasty recovery.
- Dedicated arthroplasty capacity enables more efficient pathway management.
- Further movement to four joints per list would increase capacity without additional theatre sessions.

Further improvement opportunity

- Increase consistency of surgeon productivity, anaesthetic support and theatre shift alignment.

Productivity pathway: standards established, delivery improving, residual gap targeted



WG submission message

Orthopaedics and General Surgery already have measurable productivity standards and have demonstrated increased throughput. The next productivity gain is driven by consistent adoption of best practice, optimised theatre utilisation and targeted regional collaboration to maximise existing capacity before additional infrastructure is requested.

Hywel Dda is using cohort reduction rather than S4 Treat in Turn alone to provide a more meaningful assessment of activity delivered against the longest-waiting patient cohorts. This supports more accurate productivity monitoring and clearer specialty-level ownership.

52-week OPD cohort

1,441

remaining at 13/07/2026

104-week RTT cohort

1,995

remaining at 13/07/2026

Monitoring approach

Cohort

reduction methodology

Review level

Specialty

cohort / non-cohort activity

Productivity focus

Long waits

capacity targeted to cohorts

Use as a recovery
delivery measure, not
just a technical
performance metric.

Why S4 Treat in Turn is limited

- Includes urgent pathway patients.
- Includes personalised ophthalmology targets.
- Includes shorter waiting day cases and day treatments.
- Includes OPD procedures undertaken outside a theatre environment.

HDUHB alternative approach

- Measures actual cohort reduction against required trajectories.
- Monitors percentage cohort and non-cohort activity volumes by specialty.
- Creates clearer accountability for long-wait reduction.

How the cohort approach improves productivity focus

Identify longest
waiting cohorts

Set reduction
trajectory

Monitor specialty
delivery

Prioritise
capacity

Reduce long
waits

Productivity impact

- Capacity is deployed against patients waiting longest.
- Activity is better aligned to planned recovery trajectories.
- Specialties can track whether activity is reducing the right cohort.

Waiting list impact

- Improves focus on 52-week OPD and 104-week RTT reductions.
- Supports more transparent recovery delivery reporting.
- Helps demonstrate measurable progress against priority cohorts.

Cohort Reduction Trajectory and Productivity Impact

Using trajectory monitoring to evidence waiting list recovery



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Current trajectory monitoring demonstrates ongoing reduction of long-wait cohorts. The charts show the position for 52-week OPD and 104-week RTT cohorts, with activity delivery being monitored against required recovery volumes.

52-week OPD

1,441

cohort volume

104-week RTT

1,995

cohort volume

Date

13/07/2026

visible chart callout

Trajectory

Required

reduction monitored

Capacity focus

Priority

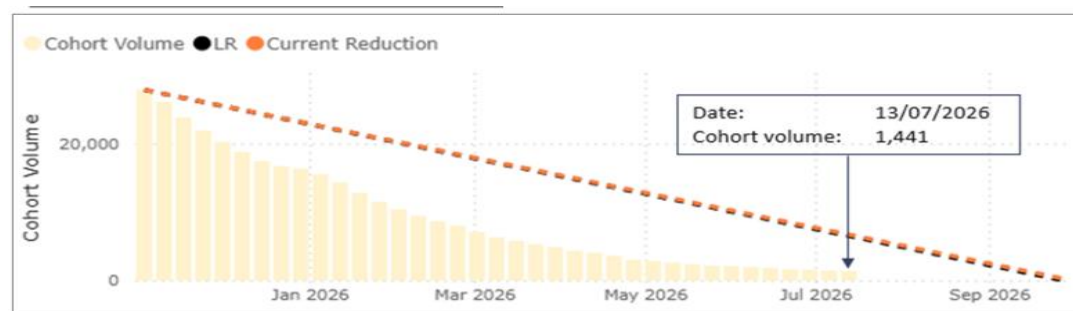
long-wait cohorts

Reporting

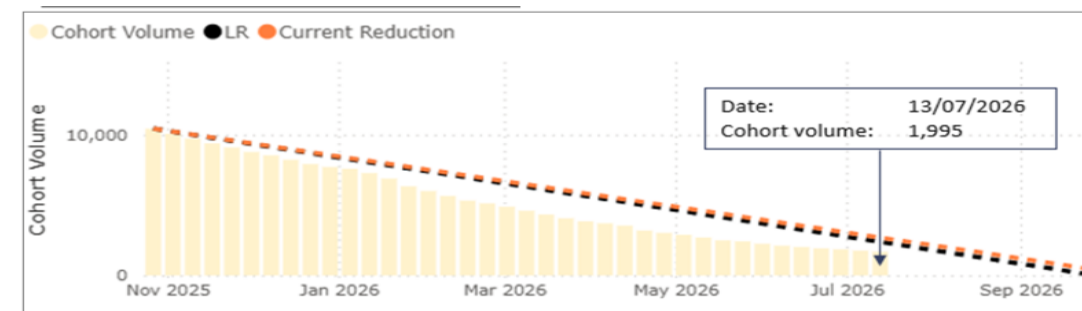
Monthly

specialty review

52-week OPD cohort reduction



104-week RTT cohort reduction



Productivity benefits

- Directs capacity to the longest-waiting cohorts.
- Improves visibility of whether activity is reducing target cohorts.
- Supports specialty-level recovery grip.

Waiting list impact

- Supports reduction of 52-week OPD and 104-week RTT waits.
- Improves transparency of recovery delivery against required volumes.
- Strengthens evidence of measurable long-wait improvement.

WG submission message

Cohort-based monitoring provides a more meaningful measure of treatment effectiveness, ensuring available capacity is directed towards reducing the longest-waiting patient cohorts and delivering measurable waiting list improvement.

Orthopaedic Treat in Turn Position

Context and operational considerations for the reported T&O position

The reported Orthopaedic Treat in Turn position should be interpreted with caution. The metric is materially influenced by local service delivery models, workforce constraints and clinically appropriate patient management decisions that are not fully reflected in the headline position.

Reported position

Poor
requires contextual
explanation

Withybush model

Day case
lower complexity activity

Bronglais model

LA lists
protecting activity

Optimisation

Clinical
fit-to-proceed decisions

Assurance lens

Cohorts
long-wait trajectory

Productivity evidence

+29%
orthopaedic IP activity

**Recommendation: interpret
alongside activity, cohort reduction
and recovery trajectory.**

Why Treat in Turn appears poor

- Withybush delivers elective orthopaedics as day-case surgery; patients selected are typically lower-complexity and may have shorter waits.
- Bronglais has used local anaesthetic lists to protect activity during anaesthetic workforce shortages.
- Optimised patients may return with substantial accrued waits and then be appropriately offered early treatment.

Operational assurance

- Capacity is used to maximise patient access and avoid avoidable lost activity.
- Clinical prioritisation remains the primary consideration when patients are fit and ready to proceed.
- Decisions are made to optimise patient outcomes rather than improve a single performance metric.

Balanced performance assessment

- Treat in Turn should be interpreted alongside activity delivered, long-wait cohort reduction and trajectory performance.
- Headline treat in turn does not fully account for mixed pathway delivery models.
- A poor treat in turn position does not, in isolation, demonstrate poor waiting list management.

Why the headline measure needs interpretation



Evidence to support narrative

- Orthopaedic inpatient activity increased by 29%.
- Dedicated arthroplasty units are established.
- Day-case pathways are being maximised.
- Local anaesthetic lists are protecting activity despite workforce pressures.

Further evidence to add if available

- Withybush day-case orthopaedic activity volumes.
- Bronglais local anaesthetic list activity volumes.
- 104-week and 52-week cohort reduction trajectories.
- Arthroplasty conversion and long-wait performance.

Board / WG narrative

Whilst the reported Treat in Turn position is amongst the lowest in Wales, the measure does not fully reflect HDUHB day-case service models, local anaesthetic pathways, optimisation requirements and operational decisions designed to maximise available capacity. It should therefore be considered alongside activity delivered, cohort reduction, waiting list trajectories and overall recovery progress.

Gastrointestinal Endoscopy Diagnostic Sustainability Plan 2026-2028

Endoscopy demand is forecast to increase by 5% per annum

2026/27 Capacity Gap: Baseline deficit of 4 endoscopy lists per week, driven by a 5% increase in elective demand and a further 10% increase in inpatient/emergency demand.

2027/28 Capacity Gap: Further baseline deficit of 4 endoscopy lists, driven by 5% increase in elective demand and a further 10% increase in inpatient/emergency demand.

Proposed Short Term Mitigation (*whilst recruitment for longer term plan is mobilised*):

- Continue 4 additional insourced/WLI lists per week from September 2026 to March 2027, utilising vacant weekend endoscopy capacity
- Cost: £508,400 non-recurrent investment (September 2026-March 2027)
- Impact if not funded: 588 patients projected to breach the 8-week GI diagnostic target by March 2027.

Proposed Sustainable Mitigation:

- Uplift baseline endoscopy staffing establishment to enable delivery of additional core endoscopy sessions from March 2027 to meet demand growth projections in 2026/27 and 2027/28.
- Cost: £597,401 recurrent annual investment
- Benefits: Reduced reliance on insourcing and providing a sustainable long-term solution to meet future demand growth

Failure to invest in both the recovery & sustainability plan for GI endoscopy will result in 588 8-week diagnostic breaches by March 2027 - and a total forecast breach position of 1,836 breaches by March 2028.

This will also impact the Health Board's maintenance of JAG accreditation.

Sustainable Investment Request – Two-Year Plan to Address Gastrointestinal Endoscopy Baseline Capacity Deficit

Mobilise recruitment to substantive posts in parallel with the temporary insourcing solution, allowing sufficient time for recruitment, onboarding and endoscopy skill-mix development prior to transition to a sustainable workforce model.

1 WTE B8A Clinical Endoscopist - £84,282 p/a
1 WTE B5 Endoscopy Pre-Assessment Nurse - £50,525 p/a
4.3 WTE B5 Registered Endoscopy Nurse – £217,258 p/a
4 WTE B3 Endoscopy Health Care Support Worker – £141,336 p/a
Total Cost in 2026/27 (based on 3 months' salary) - £123,351

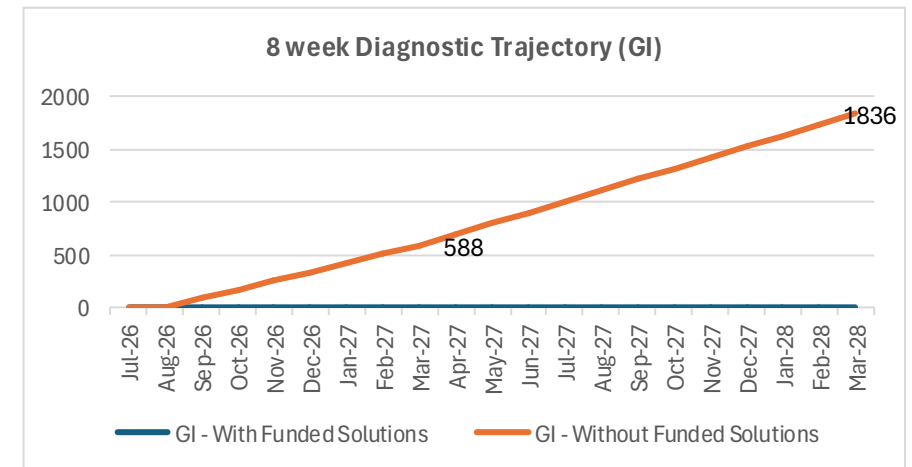
**costs based on top of scale*

Total Recurrent Investment Ask : £597,401 p/a

£493,401 (pay)

£104k (non-pay)

Annual cost avoidance of £416,800 (when sustainable plan is compared with the annual cost of insourcing @ £1.1m p/a)



Capsule Sponge & Colon Capsule Service Development

Evidence is growing for innovative diagnostic tools which are easily accessible, minimally invasive and cost-effective to be used as a solution to ease the burden on endoscopy services.

Capsule Sponge

The Health Board has established a pilot on capsule sponge (using funding supplied from the National Endoscopy Programme). The service pilot has been predominantly focused on risk stratifying patients due to undergo Barrett's surveillance, which has supported the service in clearing the backlog of patients overdue their surveillance endoscopy procedure.

The service is also due to roll-out a pilot for the use of capsule sponge for reflux patients as a triage tool to identify patient need for upper GI endoscopy. Early evidence suggests this could reduce the demand for upper GI procedures, easing the burden on endoscopy capacity and ensure more appropriate and timely allocation of resources.

The service is currently being led by a Physician Associate, training as an upper GI clinical endoscopist, with oversight from a Consultant Gastroenterologist.

The research outputs and evidence collated as part of the pilot are due to be considered by the Health Board for a decision about on-going/permanent investment.

Colon Capsule

In the same vein, the Health Board is due to commence a pilot in colon capsule services – to research and collate evidence of the benefits the service could present to providing additional diagnostic capacity within the lower GI pathway.

The long-term aim is for the service to seek permanent investment to roll-out the service.

Productivity gains from these new initiatives would support sustainable endoscopy planning from 2028 onwards.



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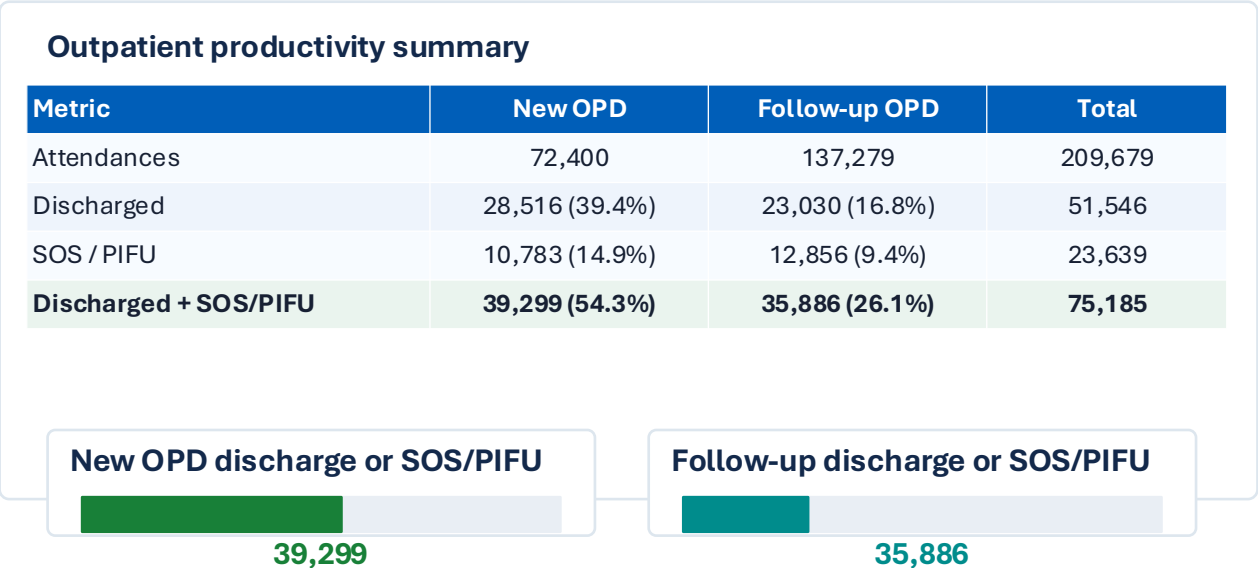
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Appendices Pillar 3

Pillar 3 : Effective Outpatient Management

Discharge, SOS and PIFU pathways reducing future outpatient demand

Effective outpatient management is reducing avoidable future demand through discharge, see-on-symptom and patient-initiated follow-up pathways. In 2025/26, 75,185 outpatient attendances ended in discharge or SOS/PIFU, demonstrating a material productivity benefit and helping release clinic capacity for patients requiring specialist review.



Productivity gains delivered

- 39,299 new patients avoided routine follow-up through discharge or SOS/PIFU.
- 35,886 follow-up patients discharged or moved to SOS/PIFU.
- CIN guidance is supporting follow-up cohort validation.

Waiting list impact

- Reduces future outpatient demand.
- Releases clinic capacity for new referrals and long-wait patients.
- Improves quality and relevance of follow-up waiting lists.

Next improvement opportunity

- Increase consistent adoption of SOS/PIFU pathways.
- Reduce variation between specialties.
- Expand follow-up validation and CIN implementation.

WG submission relevance

- Shows productivity-before-investment already delivered.
- Demonstrates active management of avoidable demand.
- Supports the case that residual waits are a genuine capacity gap.

Outpatient productivity is already delivering material demand reduction. Across new and follow-up pathways, 75,185 patient contacts have either been discharged or moved onto SOS/PIFU management pathways, reducing future outpatient demand and releasing clinical capacity for patients requiring specialist intervention.

Faecal Immunochemical Testing (FIT) – Pathway Productivity



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Since the introduction of FIT in Primary Care in November 2025 & the roll-out of a Health Board Primary/Secondary Care lower GI pathway:

FIT Pathway Impact: Outpatients & Productivity (Lower GI)

Gastroenterology:

- ~ 400 OPAs have been avoided (Dec 2025–Mar 2026) – representing a 35% reduction in outpatient appointment demand
- Projected 1,200 annual outpatient appointments avoided and £320.4k annual productivity gain.

Colorectal:

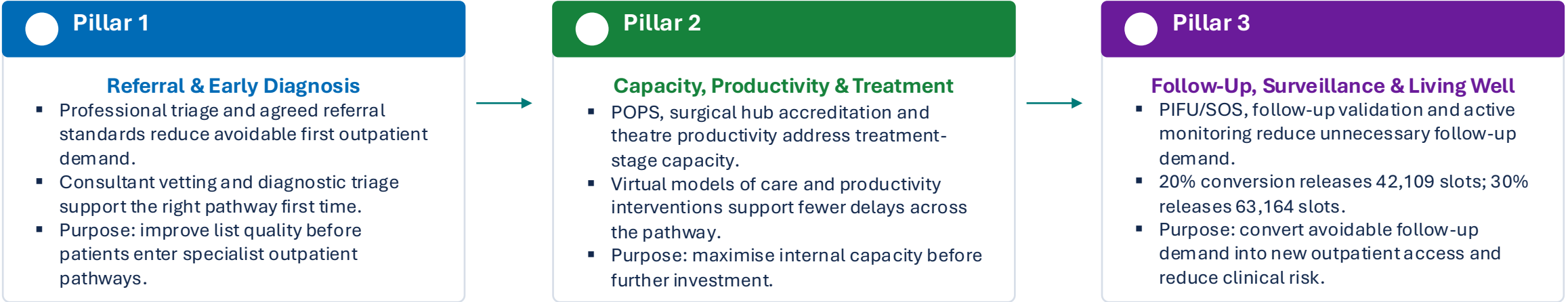
- ~ 900 OPAs have been avoided (Dec 2025–Mar 2026) – representing a 75% reduction in outpatient appointment demand
- Projected 2,700 annual outpatient appointments avoided and £720.9k annual productivity gain.

FIT Pathway Impact: Cancer Pathway, Endoscopy & Radiology (Lower GI)

- Lower GI straight-to-test rates improved from 20% to 50–55%, avoiding unnecessary pre-diagnostic OPAs and reducing 14 days on average from the single cancer pathway.
- USC referrals increased by 18%, supporting earlier diagnosis and improved compliance with the 62-day target.
- 28-day cancer performance for lower GI improved from 28% to 60–65% (representing a 40% improvement).

Reducing avoidable follow-up demand, releasing outpatient capacity and preventing recurrence of long waits

A three-year outpatient transformation approach focused on reducing avoidable follow-up, converting released capacity into new outpatient access, and preventing recurrence of long waits.



Follow Up Outpatient Plan – Pillar 3: Follow-Up, Surveillance & Living Well

Assurance priorities, Stage 1 recovery benefit and clinical engagement roadmap to end of Q3 2026/27

Combined recommendation: keep this as one executive slide, with all delivery dates expressed as end of Q3 2026/27, so the slide links actions, clinical engagement and 26-week benefit in one view.



Priority 1: Demand control

- Strengthen front-end referral management.
- Reduce inappropriate follow-up generation at point of care.
- Apply CIN guidance and align non-CIN specialties to equivalent standards.
- Delivery milestone: end of Q3 2026/27.

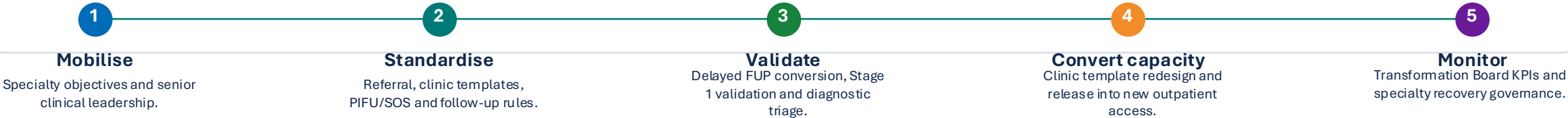
Priority 2: Waiting list grip

- Systematic follow-up and Stage 1 validation across specialties.
- Auditable governance for list control.
- Administrative validation with standard discharge / PIFU letters.
- Delivery milestone: end of Q3 2026/27.

Priority 3: Capacity conversion

- Convert follow-up capacity into new outpatient activity.
- Align clinic templates with demand and national expectations.
- Use Q4 and full-year modelling to quantify Stage 1 impact.
- Delivery milestone: end of Q3 2026/27.

Clinical engagement and delivery roadmap to end of Q3 2026/27



WG submission message

Follow-up recovery should be presented as a Pillar 3 whole-system recovery programme: demand control, validation/list grip and capacity conversion, delivered by end of Q3 2026/27 and linked directly to Stage 1 26-week recovery.

Pillar 3: CIN, SOS & PIFU Transformation Programme

Clinical governance framework underpinning follow-up demand reduction

The CIN, SOS and PIFU programme provides the clinical governance framework underpinning Hywel Dda outpatient transformation. It enables systematic follow-up validation, supports discharge and PIFU decisions, and helps reduce avoidable routine follow-up demand while maintaining clinical oversight.



Productivity gains delivered

- Validation team identifies follow-up patients that contravene CIN guidance for clinical review.
- Weekly follow-up reports include clinical condition and consultant compliance.
- Over 100,000 patients have been placed on SOS/PIFU pathways.

Waiting list impact

- Discharge, SOS and PIFU approaches have stemmed follow-up waiting list growth.
- Reduces unnecessary routine follow-up appointments.
- Releases outpatient capacity for new referrals and long-wait patients.

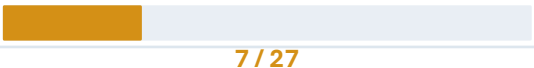
Transformation opportunity

- Expand CIN guidance beyond the current seven specialties and apply methodology to historical cohorts.

Follow-up transformation model: clinical governance to released capacity



CIN guidance specialty coverage



Specialties supported by clinical pathways



Strategic value: the programme demonstrates active demand management rather than reliance solely on additional capacity.

WG submission message

CIN, SOS and PIFU implementation is a core outpatient productivity intervention. More than 100,000 patients have been managed through SOS/PIFU pathways, supported by dedicated validation processes and weekly compliance reporting, helping contain follow-up demand and release capacity for patients requiring active specialist management.

Pillar 3: Delivery of effective New outpatients



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2025/26 there were 72,400

New attendances

- 28,516 (39.4%) patients were discharged.
- 10,783 (14.9%) patients were put on an SOS or PIFU pathway
- A total of 39,299 (54.3%) patients either put on an SOS/PIFU pathway or discharged
- Some pathways discharge rather than CIN recommendation of SOS/PIFU

Attended

Main specialty	Future Appointment	Future Appointment %	SOS/PIFU	SOS/PIFU %	Discharged	Discharged %	SOS/PIFU + Discharged	SOS/PIFU + Discharged %	Total Attendance
104 - Colorectal	319	12.70%	386	15.37%	1807	71.93%	2193	87.30%	2,512
100 - General Surgery	143	13.48%	390	36.76%	528	49.76%	918	86.52%	1,061
107 - Vascular	101	19.54%	49	9.48%	367	70.99%	416	80.46%	517
103 - Breast	980	22.72%	31	0.72%	3303	76.56%	3334	77.28%	4,314
328 - Stroke Medicine	198	25.00%	0	0.00%	594	75.00%	594	75.00%	792
191 - Pain Management	65	29.55%	47	21.36%	108	49.09%	155	70.45%	220
330 - Dermatology	1,567	33.04%	541	11.41%	2635	55.56%	3176	66.96%	4,743
300 - General Medicine	518	34.60%	18	1.20%	961	64.20%	979	65.40%	1,497
502 - Gynaecology	2,242	34.65%	1038	16.04%	3191	49.31%	4229	65.35%	6,471
120 - ENT	2,011	38.55%	497	9.53%	2709	51.93%	3206	61.45%	5,217
301 - Gastroenterology	847	40.35%	200	9.53%	1052	50.12%	1252	59.65%	2,099
320 - Cardiology	1,145	44.23%	279	10.78%	1165	45.00%	1444	55.77%	2,589
400 - Neurology	865	45.12%	360	18.78%	692	36.10%	1052	54.88%	1,917
110 - Trauma & Orthopaedics	6,707	47.28%	5081	35.82%	2398	16.90%	7479	52.72%	14,186
101 - Urology	1,210	47.69%	364	14.35%	963	37.96%	1327	52.31%	2,537
340 - Respiratory Medicine	1,180	50.99%	65	2.81%	1069	46.20%	1134	49.01%	2,314
430 - Geriatric Medicine	573	59.19%	15	1.55%	380	39.26%	395	40.81%	968
420 - Paediatrics	1,692	59.77%	199	7.03%	940	33.20%	1139	40.23%	2,831
130 - Ophthalmology	6,827	64.71%	1002	9.50%	2721	25.79%	3723	35.29%	10,550
410 - Rheumatology	1,260	66.11%	193	10.13%	453	23.77%	646	33.89%	1,906
302 - Endocrinology	808	77.25%	21	2.01%	217	20.75%	238	22.75%	1,046
303 - Clinical Haematology	734	83.31%	0	0.00%	147	16.69%	147	16.69%	881
361 - Nephrology	365	87.11%	1	0.24%	53	12.65%	54	12.89%	419
307 - Diabetic Medicine	744	91.51%	6	0.74%	63	7.75%	69	8.49%	813
Total	33,101	45.72%	10783	14.89%	28516	39.39%	39299	54.28%	72,400

Pillar 3: Delivery of effective Follow Up outpatients



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2025/26 there were 137,279 follow up attendances

- 23,030 (16.8%) patients were discharged.
- 12,856 (9.4%) patients were put on an SOS or PIFU pathway
- A total of 35,886 (26.1%) patients either put on an SOS/PIFU pathway or discharged
- Some pathways discharge rather than CIN recommendation of SOS/PIFU
- FU validation team utilising CIN Guidance to streamline cohorts of recommended clinical validation

Attended

Main specialty	Future Appointment	Future Appointment %	SOS/PIFU	SOS/PIFU %	Discharged	Discharged %	SOS/PIFU + Discharged	SOS/PIFU + Discharged %	Total Attendance
100 - General Surgery	55	13.13%	118	28.16%	246	58.71%	364	86.87%	419
328 - Stroke Medicine	98	15.99%	0	0.00%	515	84.01%	515	84.01%	613
104 - Colorectal	233	22.32%	151	14.46%	660	63.22%	811	77.68%	1,044
191 - Pain Management	55	26.96%	8	3.92%	141	69.12%	149	73.04%	204
107 - Vascular	246	36.61%	89	13.24%	337	50.15%	426	63.39%	672
110 - Trauma & Orthopaedics	12,286	53.95%	5694	25.00%	4794	21.05%	10488	46.05%	22,774
320 - Cardiology	1,421	59.01%	271	11.25%	716	29.73%	987	40.99%	2,408
400 - Neurology	1,111	61.52%	501	27.74%	194	10.74%	695	38.48%	1,806
502 - Gynaecology	5,078	66.06%	1030	13.40%	1579	20.54%	2609	33.94%	7,687
430 - Geriatric Medicine	1,742	66.11%	134	5.09%	759	28.80%	893	33.89%	2,635
420 - Paediatrics	3,820	66.48%	694	12.08%	1232	21.44%	1926	33.52%	5,746
300 - General Medicine	1,170	67.59%	85	4.91%	476	27.50%	561	32.41%	1,731
330 - Dermatology	4,560	68.93%	628	9.49%	1427	21.57%	2055	31.07%	6,615
301 - Gastroenterology	3,817	71.73%	305	5.73%	1199	22.53%	1504	28.27%	5,321
101 - Urology	7,948	73.29%	1331	12.27%	1566	14.44%	2897	26.71%	10,845
120 - ENT	5,316	73.89%	511	7.10%	1367	19.00%	1878	26.11%	7,194
340 - Respiratory Medicine	3,298	75.06%	262	5.96%	834	18.98%	1096	24.94%	4,394
103 - Breast	4,005	78.42%	124	2.43%	978	19.15%	1102	21.58%	5,107
130 - Ophthalmology	17,734	84.02%	568	2.69%	2806	13.29%	3374	15.98%	21,108
302 - Endocrinology	2,798	88.24%	16	0.50%	357	11.26%	373	11.76%	3,171
410 - Rheumatology	4,933	90.85%	292	5.38%	205	3.78%	497	9.15%	5,430
361 - Nephrology	2,274	93.12%	3	0.12%	165	6.76%	168	6.88%	2,442
307 - Diabetic Medicine	2,735	94.90%	8	0.28%	139	4.82%	147	5.10%	2,882
303 - Clinical Haematology	14,660	97.53%	33	0.22%	338	2.25%	371	2.47%	15,031
Total	101,393	73.86%	12856	9.36%	23030	16.78%	35886	26.14%	137,279

Pillar 2 DNA Rates Outpatient Clinics Productivity Improvement (PI)

Baseline evidence for targeted productivity improvement

Monthly clinic and subspecialty DNA reporting provides the evidence base for targeted overbooking where DNA rates are consistent. This gives services a practical method to recover capacity that would otherwise be lost through non-attendance.

Combined DNA

6.62%

23,981 patients

New OPD DNA

7.48%

10,215 patients

Follow-up DNA

6.01%

13,766 patients

Reports

Monthly

clinic / subspecialty

Scrutiny

Regular

per specialty

Reminder process

Text

routinely issued

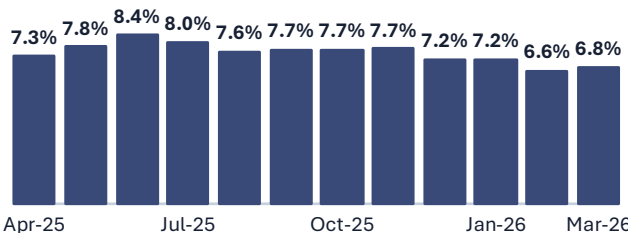
Why this supports productivity

- Identifies clinics where capacity is repeatedly lost to DNA.
- Enables overbooking to be targeted rather than applied as a blanket rule.
- Supports productivity monitoring by service, clinic and subspecialty.

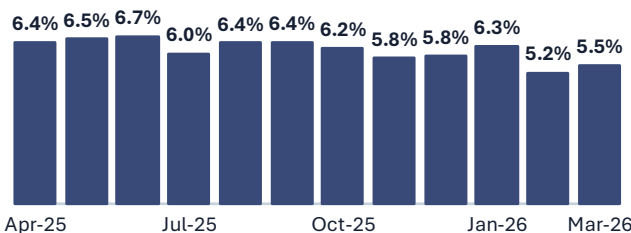
Operational caveats

- Higher DNA areas highlighted include Community Paediatrics and Ophthalmology.
- Ophthalmology has specific challenges linked to last-minute transport cancellations.
- Overbooking should only be used where safety, estate and staffing risks are manageable.

New OPD DNA rate trend



Follow-up DNA rate trend



Slide message: DNA reporting is not just a performance measure; it is a productivity tool that can support targeted clinic overbooking and release additional attended activity where local DNA patterns justify it.

Targeted Overbooking Model: Two Slots per Eligible Clinic



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Scenario modelling for productivity and waiting list impact

A controlled overbooking model can convert some DNA risk into additional attended capacity. The modelling below is illustrative: benefit depends on the number of eligible clinics selected, whether additional booked patients attend, and whether local clinical and operational controls are in place.

Overbooking rule

+2

slots per selected clinic

Per 100 clinics

+200

additional booked slots

DNA opportunity

23,981

annual combined DNA

New OPD opportunity

10,215

annual new DNA

FU opportunity

13,766

annual FU DNA

Full offset point

11,991

clinics x two slots

Illustrative capacity release model

Eligible targeted clinics	Extra booked slots	Share of annual DNA opportunity
100	200	0.8%
2,000	4,000	16.7%
5,000	10,000	41.7%
10,000	20,000	83.4%
11,991	23,982	Full theoretical offset

Implementation controls

- Use clinic-level DNA reports to identify eligible clinics.
- Set specialty rules for overbooking and escalation.
- Monitor conversion of extra booked slots into attended activity.

Waiting list impact

- Additional attended activity can support new outpatient access and follow-up recovery.
- Targeted use avoids overburdening clinics where DNA patterns do not support overbooking.

Safety and quality controls

- Exclude clinics with inappropriate clinical risk or space constraints.
- Review staffing, rooming and waiting-room capacity before implementation.
- Reduce overbooking where DNA rates improve.

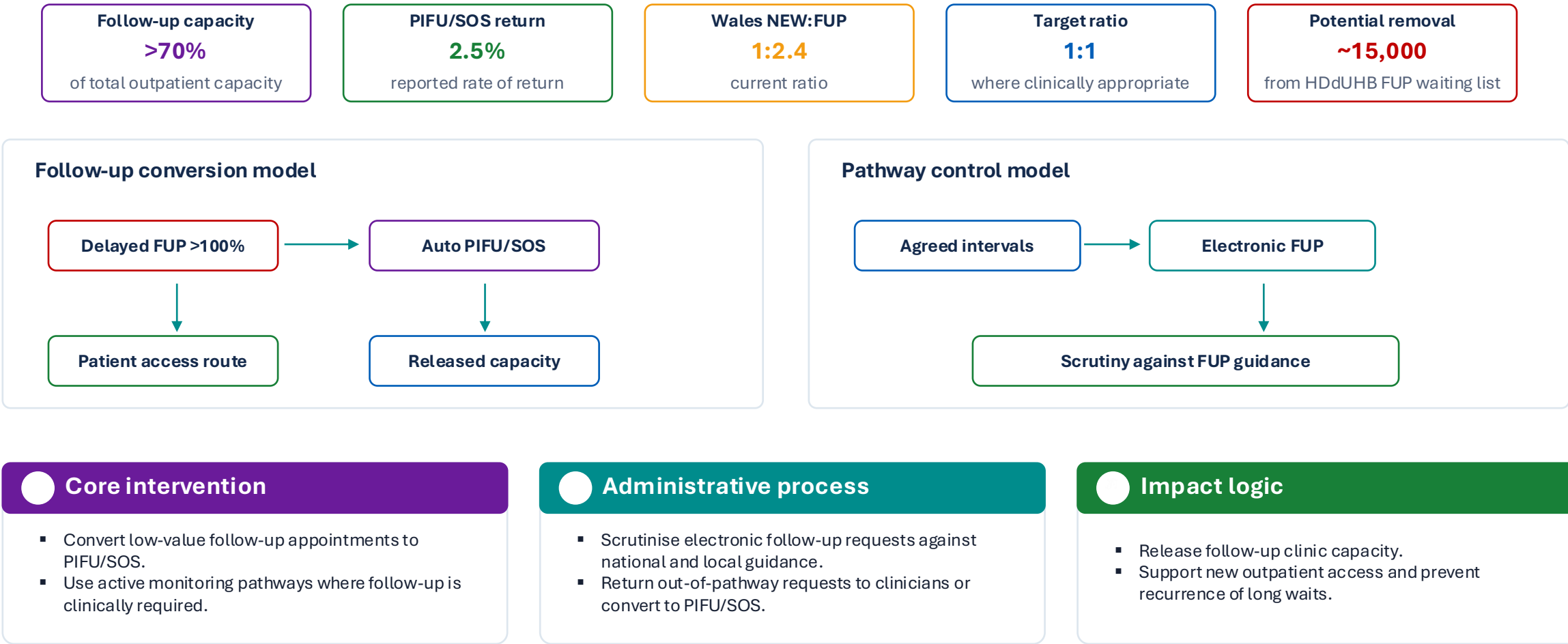
WG narrative

- This demonstrates operational productivity before additional investment.
- The residual waiting list remains after active management of lost capacity.

WG submission message: Targeted overbooking by two slots per eligible clinic is a practical productivity lever to recover activity otherwise lost through DNA. The approach should be governed at specialty level and capped by observed DNA opportunity, with implementation limited to clinics where risk is manageable.

Pillar 3: Follow-Up, Surveillance & Living Well

Converting low-value follow-up into PIFU/SOS and new outpatient capacity



Pillar 3: Waiting Well and WLSS

Patient support, risk identification and readiness for treatment while waiting



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The Waiting List Support Service provides a single point of contact for patients awaiting planned care, offering holistic support to help patients remain well, identify deterioration and prepare for treatment while they wait.

Service model
Single point

contact for planned care

Patient support
Holistic

needs-based support

Risk ID
PROMs

health questionnaires

Access model
Proactive

newly listed patients

Wider access
Open

any WL patient can contact

Digital pathway
PKB

communication
development

Recovery role
Enabler

PIFU / SOS / validation

Promote: keeping patients well

- Making Every Contact Count and “What Matters to You” conversations.
- Self-management resources including apps, EPP programmes, third-sector organisations and public health resources.
- Support for NERS, smoking cessation and healthy lifestyle choices.

Prevent: identifying deterioration

- Holistic assessment supports prevention of deconditioning and symptom deterioration.
- Red-flag script, frailty screening and Waiting Well PROM inform risk identification.
- Risk stratification and agreed escalation routes into services and third sector / social services.

Prepare: treatment readiness

- Information to help patients prepare for treatment through digital and non-digital routes.
- Online prehabilitation programmes supported through Patients Know Best.
- High-risk patients can be referred to specialist MDT Prehabilitation and Optimisation using a risk stratification tool.

Waiting Well pathway contribution to planned care recovery

Contact

Assess

Stratify

Support

Prepare

Waiting list impact

- Supports patients while they wait and provides earlier identification of deterioration.
- Helps improve readiness for treatment and may reduce avoidable delays where escalation or preparation is required.

Transformation link

- PKB-enabled communication provides a platform for wider outpatient transformation.
- Supports the wider pathway around PIFU, SOS and validation.

Board / WG narrative

WLSS provides the patient-facing infrastructure for sustainable recovery by supporting patients to remain well, identifying deterioration and preparing patients for treatment.

Patient Service Centre: Strategic Direction and Ambition

Moving from fragmented access to a patient-centred, digitally enabled service model

The strategic ambition is to create a single, patient-centred service model that brings together appointment management, referral coordination, follow-up care, patient support, data management and communication, supported by a 360° view of patient interactions with the Health Board.

Current position Fragmented multiple channels / systems	Strategic model Single point contact and coordination	Patient view 360° unified patient interaction view	Patient role Self-managing digital engagement and control	Delivery model Platform inc. call centre + DHCW	Implementation Pilot then rollout	Ambition Patient-centred accessible and consistent
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Do Minimum	Less Ambitious	Preferred Way Forward	More Ambitious
Scope HDUHB plus initial community	Scope HDUHB plus initial community	Scope HDUHB plus initial community	Scope Extended beyond HDUHB
Solution Initial 360° View + PKB for minimal patient engagement	Solution Full 360° View and patient self-management	Solution Full 360° View and patient self-management	Solution Maximum capabilities
Delivery DHCW + PKB + call centre	Delivery Product + DHCW + PKB + call centre	Delivery Platform inc. call centre + DHCW	Delivery Platform + DHCW + external 24x7 call centre
Rollout Phased over longer time	Rollout Phased over longer time	Rollout Pilot and then rollout	Rollout Pilot and then rollout

Strategic direction

- Centralise patient access and communication into one coordinated service model.
- Retain non-digital routes while strengthening digital self-service options.
- Build a platform for wider planned care, community and patient support transformation.

Critical success factor	Preferred Way Forward	More Ambitious
Benefits	Strong	Strongest
Risks	Manageable	Higher
Strategic fit	Good	Strong
Value for money	Strong	Good
Achievability	Manageable	Higher risk
Costs	Moderate	Higher

Recommended ambition

- Use the Preferred Way Forward as the core implementation position.
- Treat the More Ambitious model as a future expansion pathway once the platform is proven.
- Begin through a patient cohort pilot and scale across services.

Patient Service Centre: Benefits and Digital Enablers

Delivering better patient experience, operational productivity and digitally enabled care

The Patient Service Centre enables a more consistent, proactive and digitally supported patient experience by combining a single point of contact with patient self-management, integrated information, platform capability and national digital services.

Patient benefits

- Improved self-service and satisfaction through digital tools.
- Shorter waiting times and improved access to care.
- Better visibility of information and one place to engage with services.

Operational benefits

- Reduced missed appointments and cancellations, freeing clinical capacity.
- Lower administrative burden and reduced postage costs.
- More accurate information available to call handlers and staff.

Workforce and system benefits

- Improved staff productivity and ability to focus on patient care.
- Unified patient records support better decision making and care coordination.
- Reduced carbon footprint through digital-first processes.

Digital enablers required to deliver the ambition

360° View

Integrated view of records and patient interactions

PKB

Patient engagement and self-management

NHS Wales App

Wider digital patient access

DHCW systems

Integration with national platforms

Platform + call centre

Single front door and workflow support

Data & analytics

Service management and benefits tracking

Non-digital access

Inclusive access routes maintained

Benefits to track after implementation

- Administrative time spent managing patient queries
- Appointment DNA rates where patients gain more control over appointment timings
- Call handling performance and cost per call
- Patient experience and satisfaction
- Postage and paper process reduction
- Waiting time and access improvements

Board / WG narrative

The PSC is a digital and service transformation enabler. It creates a single patient-centred access model, improves the quality of patient communication, supports self-management and provides the digital infrastructure required to reduce avoidable demand, improve productivity and release clinical capacity.

Patient Service Centre: Benefits Realisation KPIs

Tracking delivery of the patient-centred service model after implementation

The Patient Service Centre document identifies that post-implementation benefits realisation will require specific metrics that are tracked and monitored. These KPIs should be used to demonstrate value, productivity improvement and patient-centred benefits after implementation.

PSC-B001
Admin time
cost per call reduction

PSC-B002
DNA rate
reduction in missed appts

PSC-B005
Right place
first-time resolution

PSC-B006
Self-serve
patient engagement use

PSC-B007
Satisfaction
improved patient experience

PSC-B011
Postage
reduced letter costs

Benefit ID	KPI / measure	Calculation / data source	Benefit type
PSC-B001	Administrative time and cost per call	(Baseline cost per call – new cost per call) × annual call volume; time and motion study. Current timings: Contact Centre 2m43s, Communication Hub 3m40s, 111 #2 14m.	Productivity / cashable
PSC-B002	Appointment DNA rate reduction	Track reduction in DNA rates as patients have greater control over appointment timings.	Clinical capacity release
PSC-B005	Right place first time	Track improvement in accuracy of information available to call handlers and patients.	Patient / non-cash releasing
PSC-B006	Patient self-service uptake	Track use of patient engagement features and self-service capability.	Patient / qualitative
PSC-B007	Patient satisfaction and experience	Track satisfaction improvement linked to better information, less wasted time, lower waits and more time spent on care.	Patient / non-cash releasing
PSC-B008	Time for patient care	Track staff time released from admin tasks and finding patient information.	Patients and staff / non-cash releasing
PSC-B009	Staff recruitment and retention	Track improvement in staff experience of working at HDUHB.	Staff and Health Board / cash releasing
PSC-B010	Administrative process costs	Track reduced costs as less time is spent managing patient queries.	Health Board / cash releasing
PSC-B011	Postage costs	Track reduction in letters sent to patients and GPs.	Health Board / cash releasing

Recommended reporting approach
Use a benefits dashboard with baseline, target, current performance, trend and owner for each KPI. Report monthly during pilot and then through regular service governance after rollout.

Board / WG narrative
The PSC benefits framework provides the evidence base to demonstrate value: reduced administration, fewer DNAs, increased self-service, improved patient experience and lower transactional costs.



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Appendices

Recovery

Recovery Delivery Plan at a Glance



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A summary of the key national asks and productivity opportunities already being delivered by Hywel Dda.

Before identifying any residual investment requirement, Hywel Dda has systematically reviewed productivity opportunities across theatres, outpatients, diagnostics, workforce and regional collaboration.

National Requirement	HDUHB Position / Our Commitment	National Support Required
 Eliminate 104-week waits	Deliver a credible trajectory through productivity improvement, pathway redesign, regional collaboration and targeted recovery capacity. This would enable achievements of 104 weeks for cataract delivery noting the additional further improvement proposals detailed later in the plan.	£6.9m external treatment recovery ask
 Recover diagnostic waits over eight weeks	Modality recovery plans across Endoscopy, CT, MRI, Ultrasound, Echo and other priority pathways, maximising productivity before investment. Radiology recovery will be included in the submission 31 st July The cost included within this submission are subject to confirmation and or amendment by the 31 st July 2026	£3,349,950
 Maximise theatre productivity	Theatre timetable redesign, Treat in Turn, Day Case First, surveillance dashboard, job plan alignment and reduction in missed opportunities.	No additional funding requested
 Maximise outpatient productivity	Central validation, clinical validation, AI-supported pathway review, PIFU expansion, booking optimisation and discharge improvement.	No additional funding requested
 Regional collaboration	Implement agreed regional delivery proposals where these provide greatest benefit for the population, aligned with agreed regional design principles.	Regional investment requirement: TBC / subject to agreement
 Governance, assurance and delivery	Programme governance, demand and capacity modelling, productivity surveillance and monthly trajectory reporting to assure delivery.	No additional funding requested

National decision requested

-  Endorse recovery trajectory
-  Support treatment recovery investment
-  Support diagnostic recovery investment
-  Support regional proposals

Every investment request within this submission has been modelled on the assumption that available productivity, pathway redesign, validation and regional opportunities are delivered first. Funding requested therefore represents the residual demand and capacity gap remaining after optimisation.

Executive Summary



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PURPOSE

This submission sets out Hywel Dda University Health Board's approach to maintaining compliance with the 104-week RTT standard and recovering delivery of the 8-week diagnostic standard.

It demonstrates how the Health Board has systematically reviewed productivity, demand, capacity and regional opportunities before identifying any requirement for additional investment.



CURRENT POSITION

The Health Board continues to maintain:



254

patients waiting over 104 weeks for treatment



78

patients waiting over 52 weeks for a first outpatient appointment

The principal delivery risk now relates to diagnostic capacity, particularly MRI, non-obstetric ultrasound and endoscopy.



APPROACH

A structured approach consistent with Welsh Government guidance has been adopted:

- Systematic review of productivity opportunities
- Specialty-level demand and capacity modelling
- Clinical validation of assumptions
- Pathway redesign
- Regional collaboration
- Targeted recovery planning

Additional investment has only been modelled where productivity opportunities and service redesign have been incorporated into the underlying assumptions.



KEY CONCLUSIONS

The modelling demonstrates that:



Recurrent productivity improvements are capable of **mitigating a significant proportion** of future demand.



Structural recurrent deficits remain within a **limited number of specialties and diagnostic modalities**.



Targeted investment is therefore required to **eliminate residual 104-week and diagnostic breaches** whilst maintaining delivery thereafter.



INVESTMENT REQUIREMENT

The additional investment requested is: **£11,955,817**



Targeted

Focused on specialties and diagnostic modalities with the greatest risk.



Conditional

Subject to delivery of the productivity assumptions set out in this plan.



Investment is intended to support recovery on an interim basis as work to deliver sustainability within the system.

Scope of this Recovery Delivery Plan

Interim Recovery Delivery Plan – immediate recovery and compliance with Welsh Government requirements

This interim submission meets the immediate Welsh Government requirements and provides assurance on the route to eliminate 104-week waits and recover diagnostics over eight weeks.

Interim Recovery Delivery Plan – 19 July 2026		
Focus: Immediate recovery and compliance with criteria issued by Welsh Government		
	Purpose	Elimination of 104-week waits and recovery of 8-week diagnostic waits
	Focus	Immediate recovery actions and short-term trajectories
	Evidence	Demand & capacity modelling, productivity assumptions and recovery plan
	Funding	Funding demand and capacity gap after productivity and transformation
	Risks	Immediate risks and mitigations to deliver recovery
	Accountability	Executive commitments and monitoring through recovery governance



Immediate assurance
Route to eliminate longest waits and recover diagnostics.



Productivity first
Internal capacity, validation and pathway redesign before additional investment.



Targeted investment
Only where residual gaps remain after productivity assumptions.

Key Priority Specialties within the 104-Week Plan



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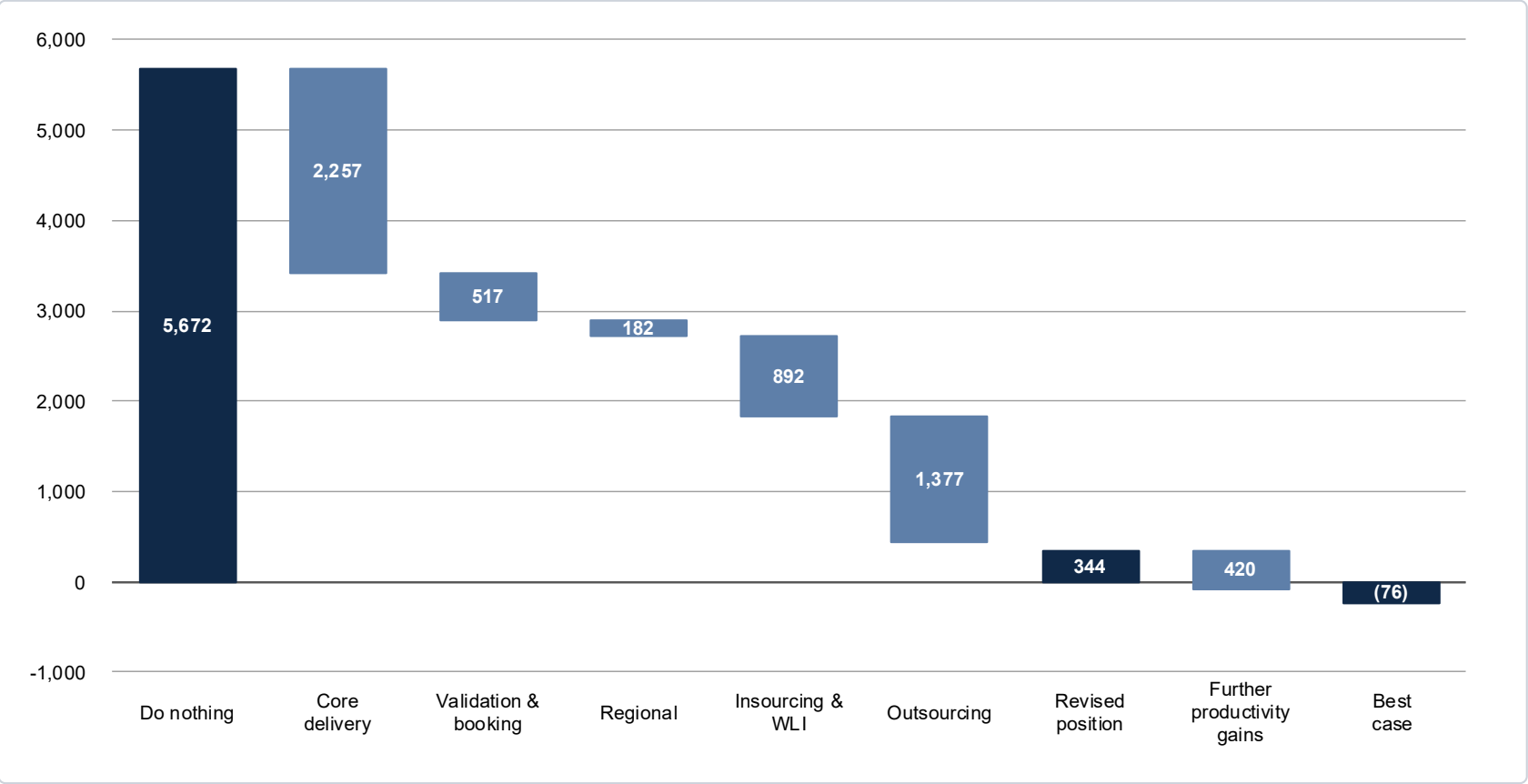
Hywel Dda priority areas, immediate recovery route and where regional collaboration is required

Priority area	Issue for Hywel Dda?	Immediate 104-week recovery approach	Regional collaboration?	Included in immediate plan?	Regional sustainability proposal
Radiology	✓	Local recovery plans and modality trajectories to address current reporting and diagnostic backlog.	✓	✓	Future regional radiology collaboration and shared reporting model.
⊙ Anaesthetics	✓	Insourced / regional anaesthetic workforce to maximise elective activity and protect theatre capacity.	✓	✓	Regional workforce solution to improve resilience.
Orthopaedics	✓	Regional orthopaedic capacity solution alongside productivity, list utilisation and targeted recovery actions.	✓	✓	Regional orthopaedic programme and pooled delivery model.
Cataracts / Ophthalmology	✓	Rebalance waiting lists and use available outsourcing / regional capacity where this improves equity of wait.	✓	✓	Longer-term regional waiting list and capacity planning.
ENT	✓	Local targeted recovery scheme, with insourcing / procurement route where required.	N	✓	N/A
Urology	✓	Weekend insourced operating lists and protected routine cohort capacity alongside USC pressures.	N	✓	N/A
General Surgery	✓	Local recovery through HVLC, Day Case First, theatre utilisation and targeted insourced lists.	N	✓	N/A
Gynaecology	✓	Local recovery through theatre utilisation, pathway redesign and Pentrox-enabled productivity.	N	✓	N/A
Pain Management	✓	Additional job-planned sessions and cohort validation, subject to evidence confirmation.	N	✓	N/A
Dermatology	✓	Committed insourcing and validation approach to maintain stage 4 recovery trajectory.	N	✓	N/A

Stage 4 waits over 104 weeks: options to achieve the RTT position

DO NOTHING	CURRENT RUN RATES	WITH COUNTED ACTIONS	BEST CASE IF VALIDATED	EXTERNAL FUNDING ASK
5,672	3,415	344	(76)	£7,405,531m

From do nothing to best case: patients over 104 weeks at 31 March 2027



Options to achieve the 104-week RTT position

2,257	Core delivery	Continuation of current validated run-rate and service delivery plans.
517	Validation / booking	Administrative and clinical validation, booking grip and removal of avoidable waits.
182	Regional support	Regional collaboration where this provides sustainable access and capacity.
892	Insourcing / WLI	Additional sessions targeted to specialties with residual treatment gaps.
1,377	Outsourcing	National or contracted capacity to close the remaining high-volume gap.
420	Productivity validated	

Decision focus: fund only the residual demand and capacity gap after productivity, validation, booking and regional options have first been applied.

Stage 4 waits over 104 weeks: Reconciled Specialty Return

By-specialty contribution to total exposure, counted recovery actions and residual after productivity validation

Total exposure 5,672	Current run-rate position 3,415	Counted recovery actions 3,071	Revised position 344	Productivity that lands 420	Residual if validates 0
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Specialty	Total exposure	Weekly run rate	Core delivery to March	Position before recovery actions	Enabling: validation and booking	Transformation: PIFU and POPS	Regional working	Insourcing and WLI	Outsourcing	Counted recovery actions	Revised position on returns	Productivity Opportunity	Productivity confirmed	Residual if productivity validates
Trauma & Orthopaedics	1,858	20.00	746	1,112	217	37	182	410	109	955	157	184	157	0
Ophthalmology	1,819	15.00	559	1,260	103	0	0	0	1,200	1,303	(43)	130	0	0
Gynaecology	551	9.93	370	181	20	10	0	0	0	30	151	455	151	0
Pain Management	460	9.20	343	117	30	0	0	0	0	30	87	93	87	0
ENT	345	0.75	28	317	20	10	0	229	68	327	(10)	10	0	0
Urology	287	0.70	26	261	31	15	0	210	0	256	5	20	5	0
General Surgery	164	3.15	117	47	20	0	0	0	0	20	27	20	20	0
Dermatology	85	1.12	42	43	0	0	0	43	0	43	0	0	0	0
General Medicine	11	0.07	3	8	8	0	0	0	0	8	0	0	0	0
All other specialties	92	0.63	23	69	69	30	0	0	0	99	(30)	0	0	0
TOTAL	5,672	60.55	2,257	3,415	518	102	182	892	1,377	3,071	344	912	420	0

Regional Orthopaedics

Phased orthopaedic recovery through productivity improvement, regional capacity and elective expansion

In line with Welsh Government expectations, HDUHB's plan maximises internal productivity and capacity opportunities before considering external solutions as detailed below:

Further Activity

1,102 patients

patients to 104 weeks by End of March 2027

Internal Productivity and Capacity Measures

£1,489,761

643 patients

Regional Capacity Measures

£460,503

182 patients

External Capacity Measures

£1,831,246

277 patients

Benefits

- Rapid reduction of 104 week waits
- Demonstrates full optimisation of internal capacity before reliance on external providers, reducing reliance on higher-cost options.
- Delivers sustainable productivity improvements through achievement of GiRFT standards of 4 joints per list
- Increases elective throughput through improved theatre utilisation, backfill opportunities and weekend operating
- Supports Treat in Turn principles through enhanced clinical and administrative validation
- Strengthens regional collaboration between Hywel Dda and Swansea Bay to maximise capacity
- Reduced risk of harm from prolonged wait times

Risks / considerations

- Assumption: core elective orthopaedic theatre lists remain fully staffed throughout the planning period, with appropriate anaesthetic and theatre workforce provision maintained and no deterioration in existing staffing pressures. No reduction in core elective capacity due to emergency pressures, sickness absence, industrial action or staffing shortages.
- Assumption: delivery of additional activity is subject to sufficient bed, theatre and workforce capacity.
- Risk: Utilisation of Neath Port Talbot by HDUHB: Availability of familiar kit/implants and availability of anaesthetic resource.
- Risk: Midweek backfill opportunities at PPH: Lack of appetite from surgeons and Anaesthetists.
- Risk: Existing gaps relating to anaesthetic provision on core lists.

Cost summary

By March 2027	Volume (& Total)	Cost (& Total)
Internal Productivity and Capacity Measures	643	£1,489,761
Regional Capacity	182 (Total 825)	£460,503 (Total £1,950,264)
External Capacity Measures	277 (Total 1,102)	£1,831,246 (Total £3,781,510)

Regional Cataract Recovery – Options for Consideration

Regional partners have jointly developed and assessed a number of delivery models to support recovery of cataract waiting times. The options below represent the two most credible approaches currently under consideration for inclusion within the regional submission to Welsh Government.

	Regional Approach 1 Comprehensive Regional Recovery	Regional Approach 2 Targeted Regional Recovery
Aim / Impact on waits	Reduce waiting times for both Health Boards so that patients are treated within 52 weeks SBUHB Current: ~68 weeks Target: within 52 weeks HDUHB Current: 104+ weeks Target: within 52 weeks	Level out waiting times between the two Health Boards at 70 weeks SBUHB Current: ~68 weeks Target: 70 weeks HDUHB Current: 104+ weeks Target: 70 weeks
Indicative WG Funding	£8.9m (SBUHB £3.5m / HDUHB £5.4m)	£3.8m (HDUHB only)
Benefits	▪ Delivers recovery for both organisations to within 52 weeks ▪ Promotes equitable access across South West Wales ▪ Supports development of a sustainable regional cataract model from 2027/28 ▪ Incorporates training opportunities to strengthen future workforce resilience	▪ More affordable in the short term ▪ Levels out waits between organisations at 70 weeks, reducing unwarranted variation ▪ Pragmatic interim recovery option where affordability is the primary consideration
Key Considerations	▪ Higher upfront investment ▪ Greatest regional benefit and longer-term sustainability ▪ Requires continued outsourced provision for both Health Boards (including training commitments)	▪ Lower cost but only addresses HDUHB backlog ▪ Limited direct improvement for Swansea Bay ▪ Fewer opportunities to develop a sustainable regional service model
Both options remain subject to regional discussion and formal agreement between Swansea Bay UHB and Hywel Dda UHB before inclusion within the final submission to Welsh Government.		

Regional Approach 1

Comprehensive regional route: both Health Boards move towards 52 weeks

This approach is the comprehensive regional option. To reach 52 weeks across both Health Boards requires £8.9m, with the source model showing SBUHB £3.5m and HDUHB £5.4m.

104-week baseline
£1.6m

HDUHB 104-only component

HDUHB 52-week element
£5.4m

HDUHB contribution

SBUHB 52-week element
£3.5m

SBUHB contribution

Total 52-week ambition
£8.9m

regional comprehensive route

Planning assumption
170–190/week

required cataract volumes

Benefits

- Equal waits across the region.
- Uses existing outsourcing arrangements before moving to sustainable regional solution.
- Procurement approved.
- Full package including pre-assessment provided by SpaMedica.
- No deterioration in SBUHB current performance.
- Enables proposal for regional cataract hub from April 2027.

Risks / planning assumptions

- Provider ability to increase activity from mid-August to required volumes.
- Any mobilisation delay increases weekly activity required.
- Assumes consistent activity and does not account for planned/unplanned downtime.
- Weekly volumes may be affected by patient choice, DNA rates, cancellations and clinical suitability.
- 170–190 cataracts/week is a planning assumption for 52 weeks.

Explicit cost and volume summary

By March 2027	Volume / scope	Cost
Clear 104 RTT only	1,200 HDUHB cataracts	£1.2m
HDUHB to 70 weeks	2,380 further patients	£2.3m extra
Both HBs to 52 weeks	Regional comprehensive option	£8.9m
Split of £8.9m	SBUHB £3.5m / HDUHB £5.4m	£8.9m

Important: the 52-week ambition is a separate regional approach and requires £8.9m. It should not be read as the same as the £1.2m 104-only clearance cost.

Decision message: Approach 1 is the more comprehensive regional recovery option, delivering the 52-week ambition but requiring the higher £8.9m regional funding envelope.

Targeted HDUHB route: clear 104-week cataract cohort and move HDUHB towards 70 weeks

This approach is HDUHB-focused. The £1.2m relates to clearing the 104-week cataract cohort only; the 70-week step requires additional funding on top of the current £9,346,465 recovery ask.

104-week cohort only
£1.6m
1,200 HDUHB cataracts

Additional 70-week step
£2.3m
2,380 further HDUHB patients

HDUHB target
70 weeks
HDUHB-focused recovery

Total to 70 weeks
£3.5m
£1.2m + £2.3m

Funding status
Additional
above current £9.3m ask

● Benefits

- Procurement approved.
- High patient satisfaction and minimal complications/risk.
- Full package including pre-assessment.
- Outsourcing staff already in post.
- 20% of outsourced lists required as training lists to support sustainability.

● Risks / considerations

- Higher cost and reduced value for money.
- Does not support long-term sustainability.
- Fragmented pathways and continuity-of-care risk for complex patients.
- Public concern regarding private provider use.
- Ability to deliver required volumes over 100/week.
- Clinical suitability threshold for outsourced patients.

● Explicit cost position

Cost component	Volume	Cost
104-week cataract cohort only	1,200	£1.2m
Additional HDUHB 70-week step	2,380	£2.3m
Total HDUHB 70-week route		£3.5m

Important: the 70-week step is not part of the £1.2m 104-week clearance cost. It requires additional funding above the current circa £9m recovery ask.

Decision message: Approach 2 is a targeted, HDUHB-only route to 70 weeks. It is faster and more focused, but does not deliver the full regional 52-week ambition.

External funding ask: insourcing, outsourcing and regional capacity

Indicative external funding requirement by specialty, split by delivery route and rate assumptions

Insourcing / WLI 892	Insourcing cost £4.09m	Outsourcing cases 1,377	Outsourcing cost £2,849,646	Regional cases 182	Total external ask £11,955,817
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Specialty	Insourcing / WLI	Rate (£)	Cost (£)	Outsourcing cases	Rate (£)	Cost (£)	Regional cases	Rate (£)	Cost (£)	Total (£)
Trauma & Orthopaedics	450	£5,000	£2,250,000	109	£9,094	£991,246	182	£2,530	£460,460	£3,701,706
Ophthalmology	0	£0	£0	1,200	£1,407	£1,688,400	0	£0	£0	£1,688,400
ENT	229	£3,000	£687,000	68	£2,500	£170,000	0	£5,000	£0	£857,000
Urology	210	£5,000	£1,050,000	0	£6,044	£0	0	£5,000	£0	£1,050,000
Dermatology	43	£2,500	£108,425	0	£6,044	£0	0	£5,000	£0	£108,425
TOTAL EXTERNAL ASK	932		£4,095,425	1,377		£2,849,646	182		£460,460	£7,405,531

Diagnostics	Cost (£)
Endoscopy / Urology	£630,000
Cardiology	£220,000
Radiology Reporting to support 8 weeks and Cancer (subject to confirmation)	£2,400,000
Pathology Diagnostics & Reporting	£800,000
Programme Administrative & Support Team Costs	£321,952
POPS	£178,334
Total	£4,550,286



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Diagnostics

Gastrointestinal Endoscopy Diagnostic

Recovery 2026/27

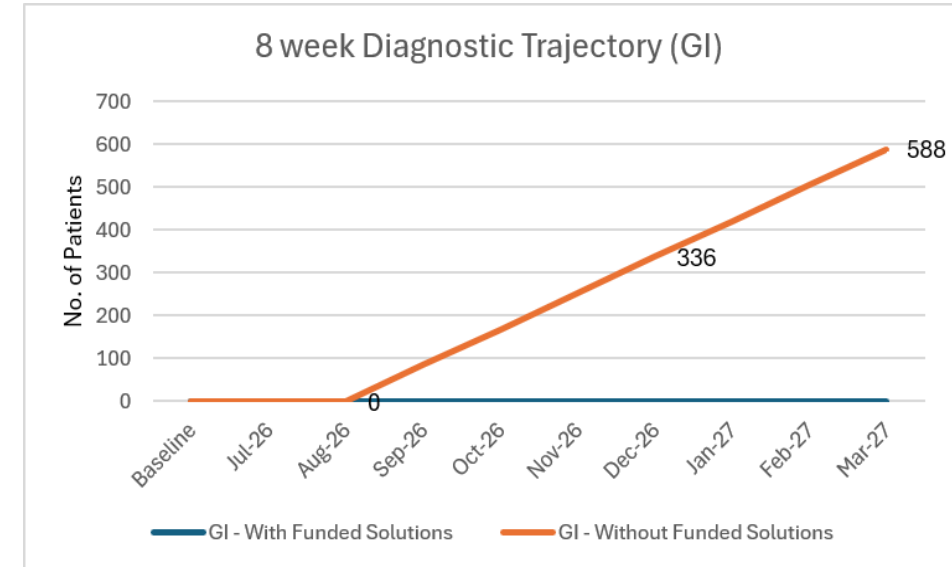
Current Capacity Gap: Baseline deficit of 4 endoscopy lists per week, driven by increasing demand (+5% elective demand and +10% inpatient/emergency demand) exceeding current staffed capacity.

Primary Cause: Insufficient baseline capacity to meet forecasted demand - mainly due to insufficient staffed theatre capacity.

Former Mitigation / Proposed Mitigation & Funding:

- **Former mitigation:** Delivery of 4 additional lists per week through a blended WLI's and insourcing model funded through core resources.
- **Proposed mitigation:** Continue 4 additional insourced/WLI lists per week from September 2026 to March 2027, utilising vacant weekend endoscopy capacity.
- **Funding required:** £509k non-recurrent investment (£16,400 per week for 31 weeks).
- **Impact if not funded:** 588 patients projected to breach the 8-week GI diagnostic target by March 2027.

Sustainable Solution: Increase the substantive endoscopy nursing and clinical endoscopist workforce establishment to deliver additional capacity within core services, reducing reliance on insourcing and providing a sustainable long-term solution to meet future demand growth.



Investment Request in 2026/27 £509k

Non-recurrent funding to maintain four additional endoscopy lists per week through additional internal activity – September 2026 to March 2027.

This will support delivery of current GI diagnostic endoscopy performance whilst sustainable workforce solutions are implemented.

Productivity and Efficiency

Extensive productivity and efficiency measures are already in place and have maximised utilisation of available capacity; however, these actions cannot fully address the underlying capacity shortfall, and investment is required to prevent deterioration in 8-week diagnostic performance.

Urology Diagnostic Recovery 2026/27

Current Capacity Gap

Cystoscopy

- Shortfall of approximately **20 patients per month**
- Equivalent to **2 additional 10-patient cystoscopy sessions per month**

Recovery Actions

- Secure 2 additional cystoscopy sessions per month through insourcing arrangements/WLI.
- Maximise utilisation of existing lists through reduced DNA rates and improved booking practices.
- Explore nurse-led cystoscopy expansion where clinically appropriate.
- Review theatre and endoscopy utilisation to identify opportunities for additional urology diagnostic capacity.

Urodynamics

- Baseline backlog of approximately **50 patients**
- Waiting list growth of approximately **5 patients per month**

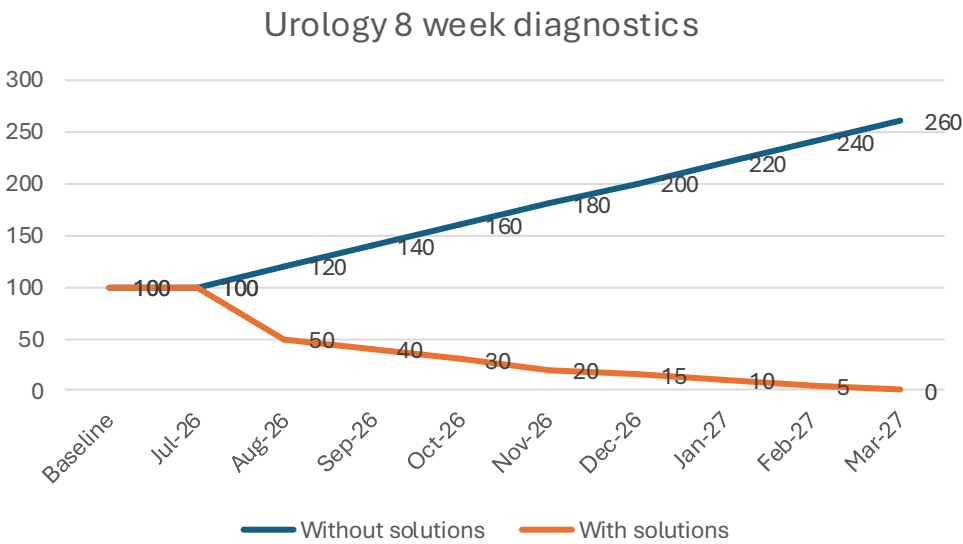
Recovery Actions

- Increase Urodynamics capacity through additional clinics/sessions.
- Review referral criteria and pathway adherence to ensure appropriate utilisation.
- Implement waiting list validation to remove duplicates, patients no longer requiring investigation, and alternative pathway patients.
- Develop sustainable capacity to eliminate the existing backlog and accommodate ongoing demand growth.

Modality	Measure	Baseline	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Endoscopy - Urology/ Urodynamics	Patients waiting over 8 weeks	100	100	120	140	160	180	200	220	240	260
Endoscopy - Urology/ Urodynamics	Patients waiting over 8 weeks	100	100	50	40	30	20	15	10	5	0

With no solutions

With solutions



Total Investment Required

Service	Cost
Flexible Cystoscopy Recovery	£63,000
Urodynamics Recovery	£56,000
Total Urology Recovery Investment	£119,000

Echocardiography Capacity and Demand

Position, recovery trajectory and costed insourcing requirement

Current position

- Sustained demand growth and longstanding workforce deficit are creating operational pressure.
- Urgent two-week referrals represent around 20% of demand and require protected capacity.
- Without action, the breach position is expected to deteriorate further.

Measure	Value	Implication
2024/25 demand	12,580	Baseline referral pressure
2025/26 demand	14,170	Increase of 1,590 / 12.6%
Predicted demand less 10% ROTT	12,395	Demand after adjustment
Core annual capacity	10,045	Substantive annual service capacity
Annual deficit	2,350	Gap to be bridged
Monthly deficit	196	Growth in breaches if no mitigation

Current waiting list

2,332

patients

>8-week breaches

791

34% of list

Core capacity

10,045

echoes per year

Annual demand after ROTT

12,395

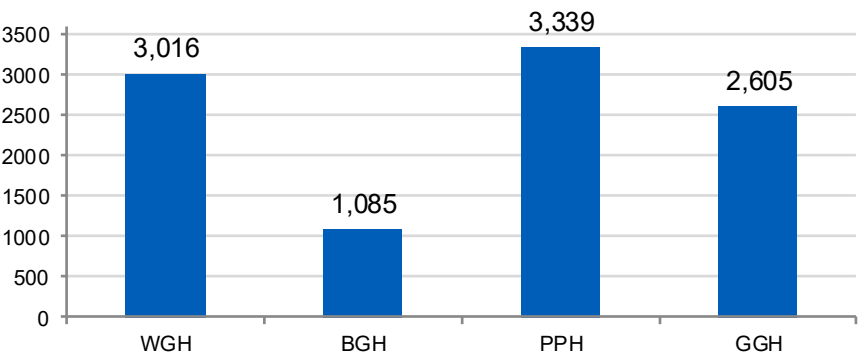
forecast after 10% ROTT

Gap

2,350

196 per month

Capacity by site



Monthly Activity and Outcome

Additional capacity profile and expected breach reduction

Month	Gap capacity	Backlog reduction	Total additional	Waiting list	>8w breaches	Outcome
July	-	-	-	2,332	791	Baseline
August	196	200	396	2,132	591	Initial reduction
September	196	200	396	1,932	391	Continued recovery
October	196	200	396	1,732	191	Breaches reducing
November	196	200	396	1,532	0	Breaches eliminated
December	196	-	196	1,532	0	Maintain demand
January	196	-	196	1,532	0	Stabilised
February	196	-	196	1,532	0	Sustained
March	196	-	196	1,532	0	Maintain zero

Total additional echoes
2,368

Waiting list reduction
2,332 to 1,532

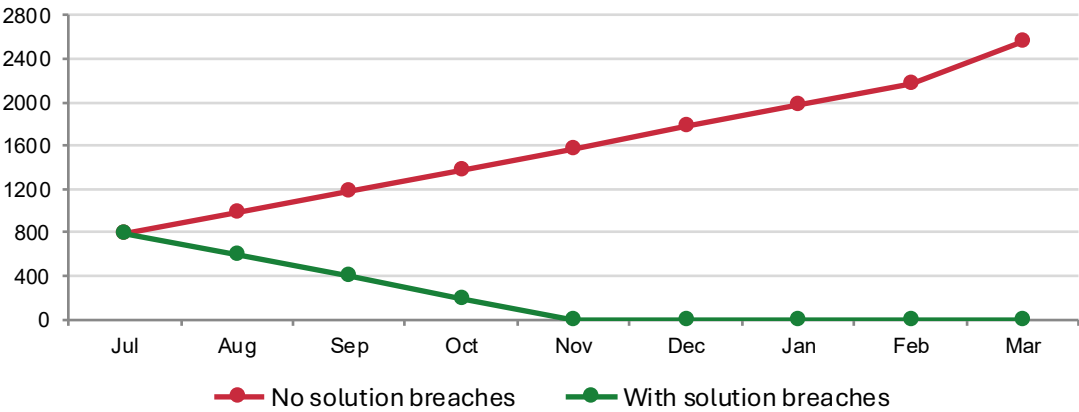
Breach position
791 to 0

Trajectory: With and Without Additional Capacity

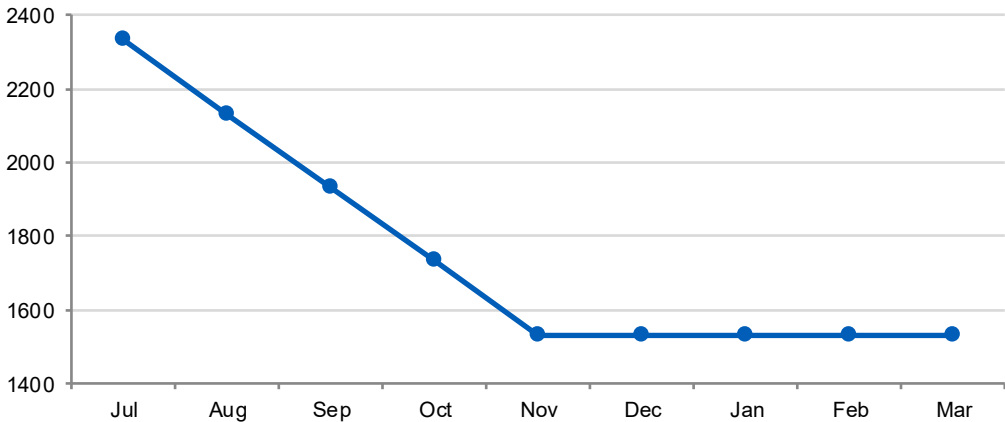
Breaches over 8 weeks and waiting list impact through March 2027

The source trajectory reduces breaches from 791 to zero by November with additional activity, while the no-solution trajectory deteriorates towards March 2027.

Projected >8-week breach trajectory



Waiting list position with recovery



Recovery proposal

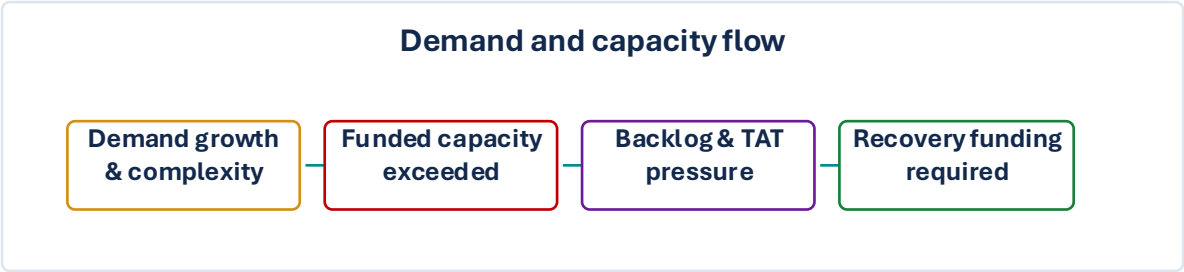
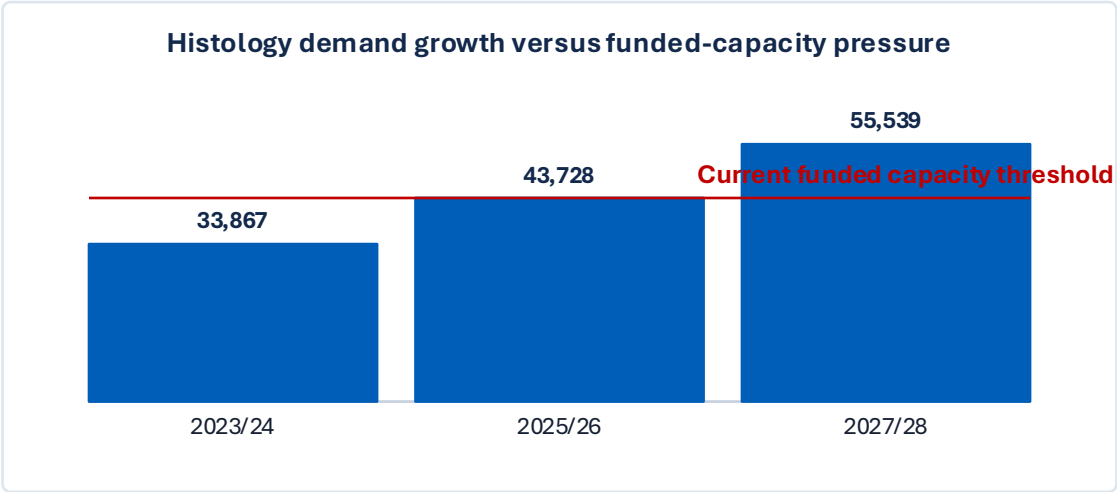
- Deliver additional insourced echocardiography activity from August to March.
- Provide 396 additional scans per month August-November, then 196 per month December-March.
- Eliminate >8-week breaches by November in the trajectory and maintain zero thereafter.
- Total funding requirement: **£224,960** for 2,368 additional echocardiograms.

Cellular Pathology: Demand and Capacity Gap

Cancer recovery funding requirement – recovery element only

Demand for Cellular Pathology now exceeds funded capacity, creating a recurrent cost pressure of approximately £800k per annum to maintain current performance. The gap is driven by increasing histology demand, case complexity and short turnaround requirements in USC pathways.

Histology demand 33,867 2023/24	Histology demand 43,727.6 2025/26	Projected demand 55,539+ by 2027/28	Annual gap 20,000+ specimens	Current pressure £800k per annum	Q1 support £240k non-recurrent	Funding end Aug 2026 non-recurrent support
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What is driving the gap

- Rising demand and case complexity.
- Workforce shortages increasing pressure on service delivery.
- USC pathways require shorter turnaround times.

Recovery focus

- Maintain existing performance rather than fund wider growth headroom.
- Funded recovery capacity reduces deterioration risk while demand continues to rise.
- Ask limited to the current recovery cost pressure of c. £800k.

Key message: the recovery ask is driven by a clear demand-capacity mismatch. Without recurrent support for the current recovery element, the underlying £800k cost pressure remains and further deterioration is likely once non-recurrent funding ends.

Cellular Pathology: Impact of Unfunded Recovery Capacity

Backlog, diagnostic turnaround and cancer pathway risk

If recovery capacity is not funded, the service expects backlog growth, diagnostic reporting delays, deterioration in USC and cancer pathway performance, and increased patient safety risk. This also creates a material risk of higher-cost outsourcing.

Backlog rise 400 → 2,000+ after agency delays	USC median TAT 11 days from 7/8 days	No action backlog ~4,300 annual cases	Outsourcing cost £1.139m estimated to clear backlog	Risk score 25 no funded cancer recovery	Patient impact High diagnosis & treatment delays
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Clinical and pathway impact

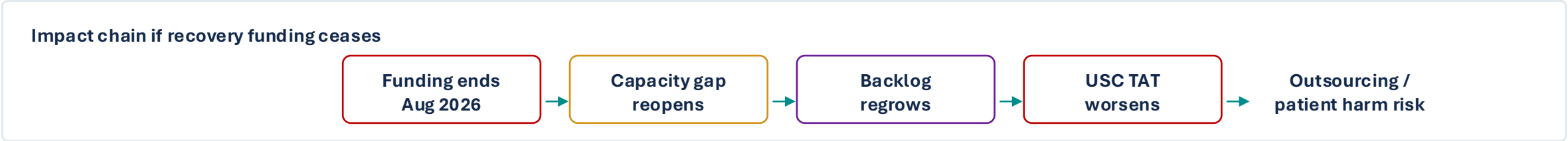
- Backlogs and diagnostic reporting delays would increase.
- USC, SCP and wider cancer pathway performance would deteriorate.
- Delayed reporting may result in missed therapeutic windows and avoidable harm.

Operational impact

- Routine backlog would need to grow if cancer work continues to flow into Pathology.
- Agency staffing and overtime have stabilised the position but are dependent on funding.
- Workforce fragility, burnout and attrition risks increase if mitigation ceases.

Financial and risk impact

- Backlog recovery may require higher-cost outsourcing.
- Previous trajectory suggests approximately 4,300 annual backlog cases without mitigation.
- Estimated outsourcing cost for this scale is approximately £1.139m plus additional administration.



Key message: the £800k recovery funding is a cost-avoidance and patient-safety intervention. It is materially lower than the estimated outsourcing cost that may be required if backlog growth is allowed to recur.

Cellular Pathology: Recovery Cost Requirement

Recovery element only – circa £800k to maintain current performance

The recovery element should be presented as the circa £800k recurrent requirement to maintain current performance and mitigate the current Pathology cost pressure. This does not include the wider £1.6m sustainability option for growth, accreditation, MDT and wider service headroom.

Recovery ask
£800k
rounded recovery element

Exact cost pressure
£801,086.82
SBAR value

Monthly support
£60k
immediate recommendation

Q1 funding
£240k
already used non-recurrently

Avoided outsourcing risk
£1.139m
if backlog grows

Scope
Recovery
not £1.6m headroom

Cost item / scenario	Value	Purpose / interpretation
Current recovery cost pressure	£801,086.82 p.a.	Maintain current service performance and mitigate the existing cost pressure
Rounded recovery element for WG slide	£800k p.a.	Clear presentation value for the recovery element only
Immediate support requirement	£60k per month	Maintain mitigation arrangements and minimise further backlog growth
Q1 non-recurrent support already used	£240k	Temporary support provided from recovery budgets
Potential outsourcing exposure if unfunded	£1.139m	Estimated cost to clear a 4,300-case backlog
Recommended slide position	£800k recovery ask	Focus only on current recovery requirement, not the £1.6m sustainability option

What the £800k supports

- Mitigation of the current £800k recurrent cost pressure.
- Maintenance of current service performance.
- Some substantive, more cost-effective capacity solutions.

What it does not cover

- It does not provide full headroom for growth, accreditation, MDT and wider sustainability requirements.
- The wider sustainable option remains £1.6m, but this slide is focused on the recovery element only.

Board / WG narrative: The immediate recovery requirement is c. £800k recurrent funding to maintain current Cellular Pathology performance, control backlog growth and reduce the risk of higher-cost outsourcing. This is a targeted recovery ask and should be distinguished from the wider £1.6m sustainability requirement.



Radiology data task & finish group

Project overview

21st July 2026



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CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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1. Project overview

Statement of need

Since the RAD+ system was introduced to Hywel Dda in December 2025, there are concerns over the accuracy of the health board's Radiology figures reported to Welsh Government for the 8 week wait breaches. The health board have been unable to produce reliable trajectories for improvement.

Project aim

To investigate and resolve data quality issues for Radiology and produce expected trajectories within (a) current resources and (b) what could be achieved if additional recovery funding is made available.

Project work packages and leads

Work package	Lead(s)	Support
1a. Data quality: Investigate data quality relating to our 8-week Radiology breach submission and resolve any issues identified	David Sheppard	Alyn Morgan, Sarah Proctor, Nina Ralph
1b. Data quality: Determine if the data contains duplicate records and take action to address where needed	Julia Chambers, Nina Ralph	
1c. Data quality: Ensure our 8-week Radiology breach submission is inline with national guidance and consistent with other health boards	Tracy Price, Nina Ralph	Sarah Proctor, Gareth Beynon, David Sheppard, Alyn Morgan
1d. Data quality: clinical audit to validate breach position. Support required from NHS Performance & Improvement	Keith Jones	Sara Quarrie, Sarah Proctor, Bevan Howells
2. Review available capacity, both in terms of staff and machines	David Sheppard, Alyn Morgan	Sarah Proctor
3. Add a function to the health board's Radiology dashboard that allows the user to filter on records relating to our 8-week Radiology breach submission	David Sheppard, Gareth Beynon	Alyn Morgan, Sarah Proctor, Nina Ralph,
4. Produce demand and capacity tools for MRI, CT, NOUS and other	David Sheppard	Alyn Morgan, Sarah Proctor, Nina Ralph
5. Produce trajectories for expected breaches in 2026/27 within existing capacity and what can be achieved with additional recovery monies	David Sheppard, Sarah Proctor	Alyn Morgan, Nina Ralph, Keith Jones, Shaun Ayres



2. Roles & governance

Radiology Data Task and Finish (T&F) Group

The group will meet every Tuesday morning for 45 minutes.

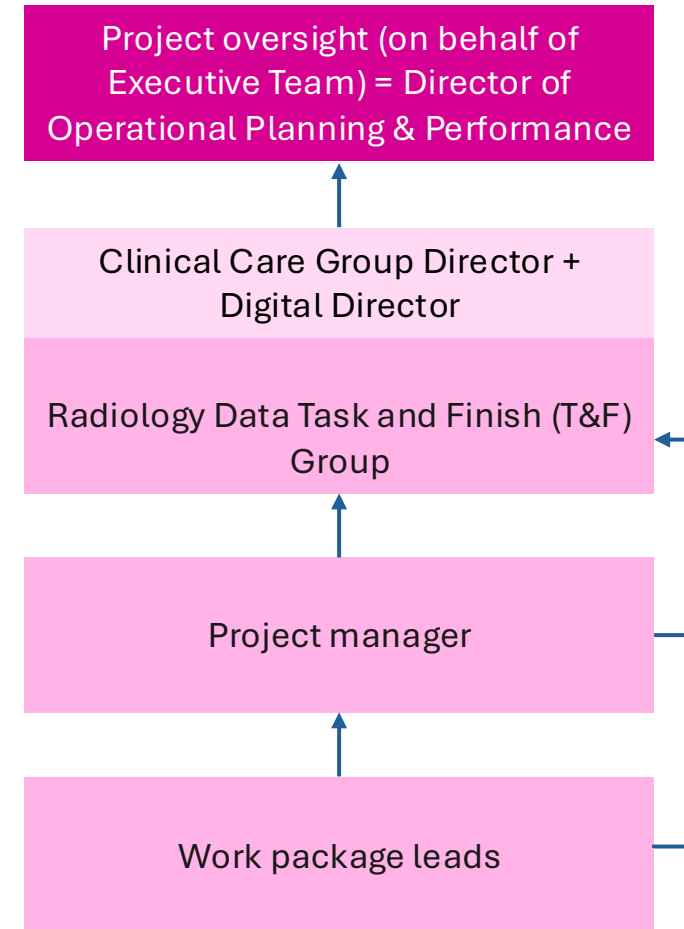
Meetings will be head via Teams and chaired by the Digital Director or Clinical Care Group Director.

- Project leads – Sara Quarrie, Clinical Care Group Director + Anthony Tracey, Digital Director
- Project manager – Tracy Price, Head of Performance
- Operations
 - Sarah Proctor, Deputy Head of Radiology
 - Julia Chambers, Primary Care Manager
- Corporate
 - Gareth Beynon, Head of Information
 - David Sheppard, Performance Improvement Analyst
 - Alyn Morgan, Performance Improvement Analyst
- Oversight
 - Keith Jones, Director of Operational Planning & Performance

Other project team members

- Nina Ralph, Radiology Systems Manager
- Shaun Ayres, Director of Delivery

Project governance





3. Project plan

Below is the **project plan as of 21st July 2026.**

	Performance Team		Radiology service		Reduced capacity
	Primary Care Team		Information Development		

	June		July				August				
	22 nd	29 th	6 th	13 th	20 th	27 th	3 rd	10 th	17 th	24 th	31 st
Data review and data quality	Provide data for review										
	Support data review and sense check										
	Review and provide feedback										
Capacity and equipment review	Set up template	Review capacity and supply list of equipment / downtime									
Produce D&C tools	Prep 4 D&C tools alongside data review				DS leave	Finalise and issue					
		Check data/feed back issues			Sign off						
IRIS Radiology dashboard	Advise Information on tweaks required				Update dashboard						
			Resolve queries								
8-week breaches trajectories				Start mapping	DS leave	Finalise and issue					
					Sign off						

* Service sign off



5. Risks & issues

As at 21st July 2026, the risks and issues below have been identified.

Status	Type	Description	Owner	Mitigating actions	Other points to note
Exisiting	Issue	Conflicting priorities within the Performance Team with corporate reporting responsibilities	Tracy Price	Other Performance Team members have been asked to pick up IPAR and BAF related tasks	
Exisiting	Issue	Lack of experience within the Performance Team in producing robust trajectories	Tracy Price	• Keith Jones and Shaun Ayres to provide advice and support as needed • Planned Care SDM provided template	
Exisiting	Risk	Possibility 8-week breaches are not being reported consistently across Wales. Progress may be delayed whilst national agreement is reached.	Tracy Price	Meeting set up with Welsh Government for 15 th July 2026	



6. Action log

See action log for further details on actions, leads and progress: [Radiology data T&F group - action log.xlsx](#)