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Finance and Performance Committee Demand and Capacity Planning 2026/27



- The Finance and Performance Committee is requested to **NOTE** progress to date in developing of demand and capacity (D&C) plans and related forecast performance trajectories for 2026/27
- Slides reflect progress to date against Planned Care (referral to treatment), Single Cancer Pathway (SCP), Diagnostics (8 weeks), Therapies (14 weeks) and Urgent and Emergency Care (UEC) metrics
- The Mental Health and Learning Disabilities (MHL) Clinical Care Group (CCG) is currently progressing performance trajectories for 2026/27 (outcomes not reflected in this paper).
- D&C modelling remains work in progress, to take account of continuing refinement of CCG plans, interdependencies between CCG plans and assessment of CCG Annual Plan submissions and associated delivery assumptions / requirements
- Slides also provide an illustrative assessment of the likely financial cost of recovery / closure of forecast delivery gaps versus the respective NHS Wales Performance Framework metrics for 2026/27 – confirmation of the forecast financial cost of recovery will be detailed in the draft Annual Plan for 2026/27 to be considered at the February 2026 Board Seminar



Planned Care (Referral to Treatment)

Planned Care (Referral to Treatment)



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- **2026/27 NHS Wales Performance Framework**

- Maximum 104-week waiting time for Total Pathway
- Maximum 26-week waiting time for Stage 1 (first outpatient appointment) – the previous maximum 52-week target wait has been removed

- **Baseline modelling based on core activity / capacity and derived demand in previous 12 months**

- CCG review of forecast budgeted / funded capacity for 2026/27 undertaken December 2025/January 2026 – excludes any non-funded / recovery funded activity assumptions
- Assumes forecast RTT performance as at March 2026
- Illustrative 3% allowance for (removals other than treatment (ROTT) assumptions
- Outpatient Transformation efficiency improvements assumed re-referral / demand management (see Supporting Appendices slides)
- Confirmation required of CCG delivery assumptions re further optimisation and productivity improvements relating to progress towards Getting It Right First Time (GIRFT) standards and theatre optimisation)
- Further assessment required of assumptions re regional capacity benefits which may emerge during 2026/27 from regional programmes re orthopaedics and ophthalmology

Planned Care (Referral to Treatment) Headlines



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- Forecast additional cost of achievement of Stage 1 (26 weeks) and Total Pathway (104 weeks) est **£8.61m** as below:
- **26-week Outpatient Department (OPD)** forecast achievement by March 2027 in all but 5 specialties. Potential 9,316 forecast delivery gap. Will require additional delivery solutions with a potential cost of **1.12m**
- **Maintenance of former 52-week OPD** maximum wait will require reprioritisation of existing resources between specialties to mitigate forecast delivery gaps in Rheumatology and Ear, Nost and Throat (ENT). Will also necessitate continued reliance on insourcing for Dermatology (£376k) funded as part of core CCG budget
- **104-week RTT** forecast potential delivery gap range of up to 5,507 breaches (worst case) or circa 4,465 breaches (if theatre cancellations can be mitigated and theatre optimisation improvements achieved). Worst case forecast would necessitate additional recovery solutions with a potential additional cost of circa **£7.49m**
 - £0.41m Urology
 - £1.3m Orthopaedics
 - £0.84m ENT
 - £4.6m Ophthalmology
 - £0.24m Dermatology

Planned Care (Referral to Treatment) Stage 1 (26 weeks) – Initial Assessment



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- No maximum 52 week wait target for 2026/27
- 52-week compliance requires additional solutions in Rheumatology and ENT (total £150k).
- Without recovery support for Ophthalmology, ENT, Dermatology, Neurology, Rheumatology , potential 9,316 patients waiting > 26 weeks by March 2027
- Efficiency (demand management) assumptions already assumed

26 Week OPD	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
100 - General Surgery	0	0	0	0	0	0	0	0	0	0	0	0
101 - Urology	0	0	0	0	0	0	0	0	0	0	0	0
103 - Breast	0	0	0	0	0	0	0	0	0	0	0	0
104 - Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
107 - Vascular	0	0	0	0	0	0	0	0	0	0	0	0
110 - Trauma & Orthopaedics	0	0	0	0	0	0	0	0	0	0	0	0
120 - ENT	42	83	125	167	208	250	292	333	375	417	458	500
130 - Ophthalmology	135	271	406	541	677	812	947	1083	1218	1353	1489	1624
191 - Pain Management	0	0	0	0	0	0	0	0	0	0	0	0
300 - General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
301 - Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0
302 - Endocrinology	0	0	0	0	0	0	0	0	0	0	0	0
303 - Clinical Haematology	0	0	0	0	0	0	0	0	0	0	0	0
307 - Diabetic Medicine	0	0	0	0	0	0	0	0	0	0	0	0
314 - Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0
320 - Cardiology	0	0	0	0	0	0	0	0	0	0	0	0
330 - Dermatology	433	867	1300	1733	2167	2600	3033	3467	3900	4333	4767	5200
361 - Nephrology	0	0	0	0	0	0	0	0	0	0	0	0
340 - Respiratory Medicine	0	0	0	0	0	0	0	0	0	0	0	0
400 - Neurology	102	204	306	407	509	611	713	815	917	1018	1120	1222
401 - Clinical Neurophysiology	0	0	0	0	0	0	0	0	0	0	0	0
410 - Rheumatology	64	128	193	257	321	385	449	513	578	642	706	770
420 - Paediatrics	0	0	0	0	0	0	0	0	0	0	0	0
430 - Geriatric Medicine	0	0	0	0	0	0	0	0	0	0	0	0
502 - Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2026/27 Without Funding	776	1553	2329	3105	3882	4658	5434	6211	6987	7763	8540	9316

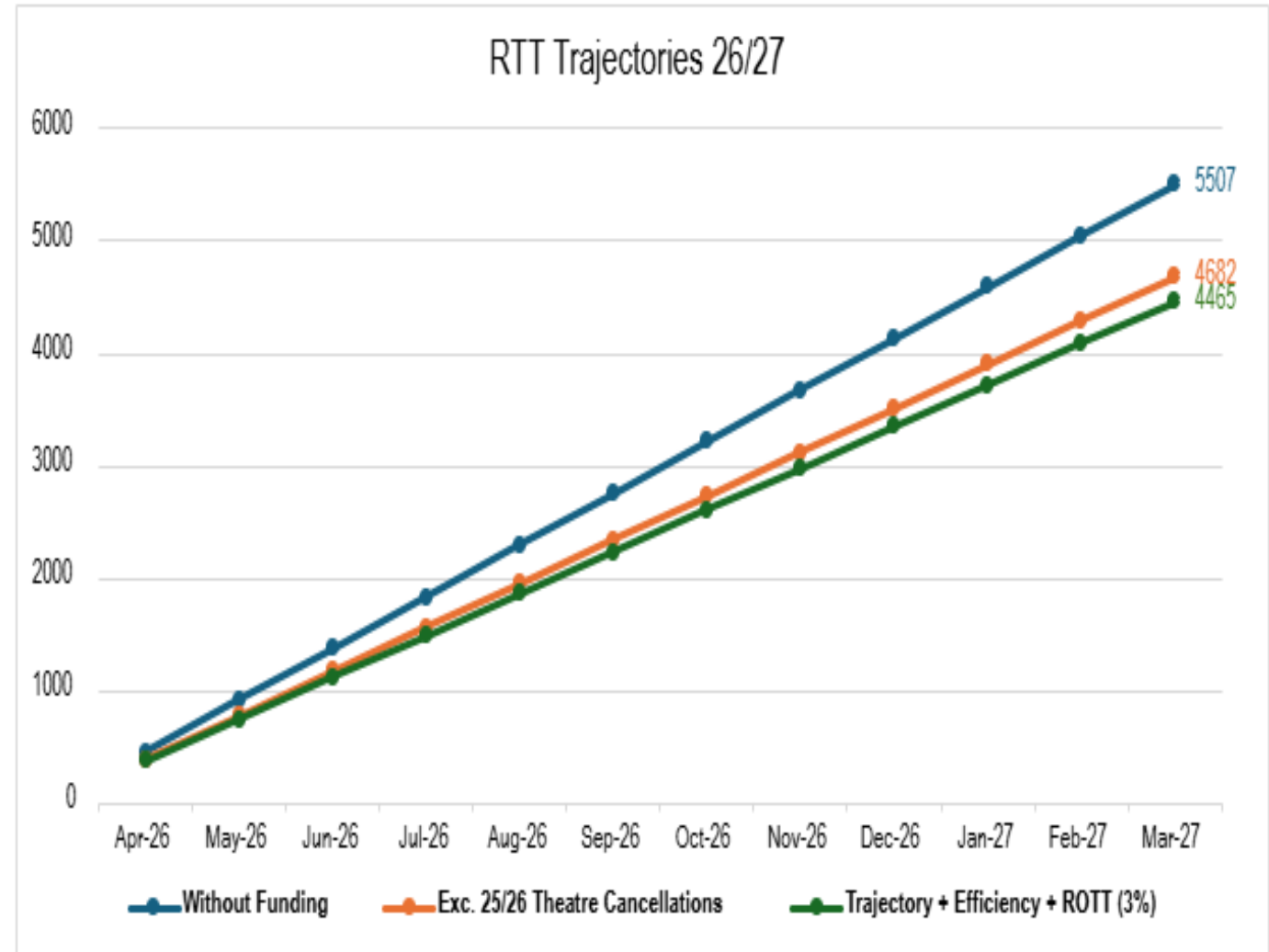
Trajectories 104-Week Referral To Treatment



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- Worst case trajectory N=5,507
- Subspecialty breakdown on following slide
- Mid trajectory for visualisation purposes demonstrates breach position without theatre cancellations
- Third trajectory includes efficiency and ROTT
 - Urology x 20
 - Dermatology x 32
 - Orthopaedic 24 included in D&C plan
 - ENT & Cataracts > 85% utilisation
 - ROTT @3% included for illustrative purposes



Planned Care (Referral to Treatment) Stage 4 / Total Pathway (104 weeks) - Initial Assessment



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- Without recovery support for Urology, T&O, ENT, Ophthalmology and Dermatology, potential for 5,507 patients waiting < 104 weeks by March 2027
- Trajectory in ENT likely Zero if Glangwili Hospital (GGH) sessions ran
- Each of the above specialties have required additional solutions (WLI / insource / outsource) during 2025/26
- ROTT / productivity assumptions / regional capacity and recovery resource assumptions yet to be applied

104 Week	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
100 - General Surgery	0	0	0	0	0	0	0	0	0	0	0	0
101 - Urology	39	78	116	155	194	233	271	310	349	388	426	465
103 - Breast	0	0	0	0	0	0	0	0	0	0	0	0
104 - Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
107 - Vascular	0	0	0	0	0	0	0	0	0	0	0	0
110 - Trauma & Orthopaedics	39	79	118	157	197	236	275	315	354	393	433	472
120 - ENT	31	62	94	125	156	187	218	249	281	312	343	374
130 - Ophthalmology	301	601	902	1202	1503	1804	2104	2405	2705	3006	3306	3607
191 - Pain Management	0	0	0	0	0	0	0	0	0	0	0	0
300 - General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
301 - Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0
302 - Endocrinology	0	0	0	0	0	0	0	0	0	0	0	0
303 - Clinical Haematology	0	0	0	0	0	0	0	0	0	0	0	0
307 - Diabetic Medicine	0	0	0	0	0	0	0	0	0	0	0	0
314 - Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0
320 - Cardiology	0	0	0	0	0	0	0	0	0	0	0	0
330 - Dermatology	49	98	147	196	245	295	344	393	442	491	540	589
361 - Nephrology	0	0	0	0	0	0	0	0	0	0	0	0
340 - Respiratory Medicine	0	0	0	0	0	0	0	0	0	0	0	0
400 - Neurology	0	0	0	0	0	0	0	0	0	0	0	0
401 - Clinical Neurophysiology	0	0	0	0	0	0	0	0	0	0	0	0
410 - Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0
420 - Paediatrics	0	0	0	0	0	0	0	0	0	0	0	0
430 - Geriatric Medicine	0	0	0	0	0	0	0	0	0	0	0	0
502 - Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2026/27 Without Funding	459	918	1377	1836	2295	2754	3212	3671	4130	4589	5048	5507

Planned Care (Referral to Treatment)

Critical Next Steps:



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- **Key next steps to refine RTT performance trajectories for 2026/27**
 1. Further review of ROTT assumptions by specialty for 2026/27 to inform reasonable planning assumption for next 12 months
 2. Confirmation of CCG plans re further optimisation and productivity improvements by specialty for 2026/27 (to include OP Transformation, progress towards GIRFT standards and Theatre optimisation) with quantification of additional capacity/activity benefits and/or reduced demand
 3. Agreement of planning assumptions re regional capacity benefits which may emerge during 2026/27 from regional programmes re orthopaedics and ophthalmology
 4. Agreement of plans for application of recurrent planned care recovery funding available to the Health Board to part mitigate potential breach volumes.



Single Cancer Pathway

Single Cancer Pathway (SCP)



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- **2026/27 NHS Wales Performance Framework**
 - 75% of patients to receive their first definitive cancer treatment within 62 days from point of suspicion
- **Modelling Assumptions:**
 - Assumes forecast SCP performance as of March 2027 (partly driven by non-recurrent Urology/diagnostic pathway actions/investments during Q4 2025/26)
 - **Current position:** 65.8% SCP (December 2025). Target: 75%. Gap: 9.2 percentage points. Backlog: 628 patients (+17.8% YoY).
 - **Key challenge:** Three tumour sites (Urology, Lower GI, Lung) account for 73.9% of the backlog. All three are diagnostically constrained. The Health Board already spends £3.53m a year on Radiology variable pay and outsourcing (plus circa £1.35m on Dermatology additional capacity) to enable current in-year performance improvement, but does not represent sustainable solutions
 - **Important note:** Modelling is drawn from multiple / individual CCG planning submissions, demand and capacity analyses, and financial returns. SCP assumptions and costs for Radiology diagnostic capacity cannot be viewed independently from overall Radiology diagnostic pathway requirements (8 weeks) given the critical and complex interrelationship between both pathways

Single Cancer Pathway (SCP) Delivery Scenarios



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- **4 potential scenarios:**

- **Do Nothing** - Assumes no investment decisions are taken, and all current non-recurrent investments will cease. Performance deteriorates to circa 49%-53% by mid-year. The backlog does not reduce; it grows. Targeted Intervention (TI) de-escalation criteria cannot be met for cancer performance.
- **Status Quo** – continuation of current non-recurrent investments (including the **£3.53m** on Radiology diagnostic capacity, circa **£1.35m** on additional Dermatology capacity but **excluding** additional non-recurrent actions during Q4 2025/26). Assuming temporary improvement to circa 70% by March 2026, performance is expected to plateau around 65–66% by Q2 2026/27. The backlog does not reduce; it grows to the low 400 range by end of Q2 2026/27.
- **Reasonable** – assumes total system spend of **£8.62m** across two CCGs, including the current £3.53m reflected in the ‘Status Quo’ option above to enable performance improvement to circa 74%. Further gains require histopathology and pathway transformation elements reflected in the Stretch scenario below. This is the recommended option.
- **Stretch Improvement** – as per ‘Reasonable’ delivery scenario plus additional radiology immediate recovery actions plus additional histopathology capacity (costs awaited). Assumes Urology reaching 54 -60% and Lower GI reaching 70–75% simultaneously – levels neither service has ever achieved. Included for consideration given the NHS Performance Framework target of 75%. Would necessitate an additional investment of £2.08m radiology recovery cost plus histopathology to delivery forecast performance of circa 78%.

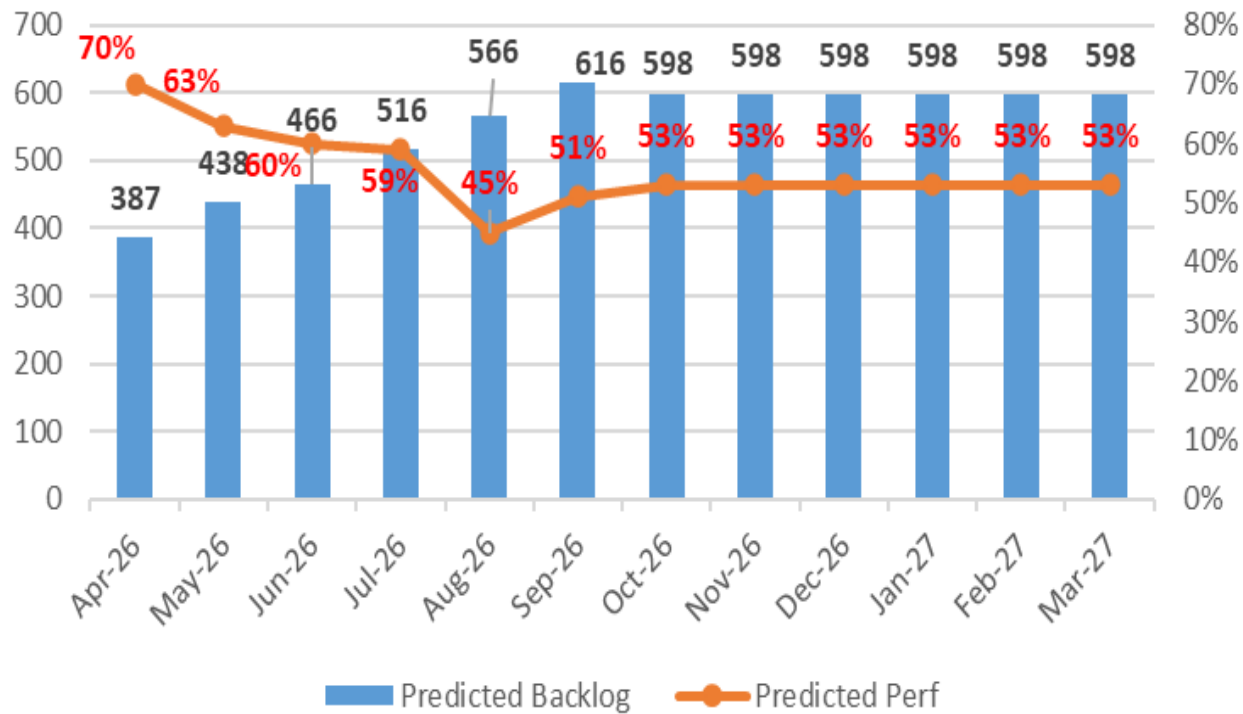
Single Cancer Pathway Forecast Trajectory 2026/27 - Do Nothing



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Predicted Backlog & Performance 26/27



This trajectory assumes that all investment insourcing/outsourcing and variable pay applied in 25/26 across all CCGs ceases (3.53/yr) and £1.35m of additional activity delivered within dermatology to meet the increased demand across (May – September 2026). To note, Histopathology is to be confirmed.

The combined impact would be growth in the 62-day backlog and a corresponding decrease in cancer performance to lowest point of 47% in August 26 which plateaus at 53% from October to March 2027 (assumes Dermatology performance decreases between May – September 2026 as additional activity to meet increased demand ceases)

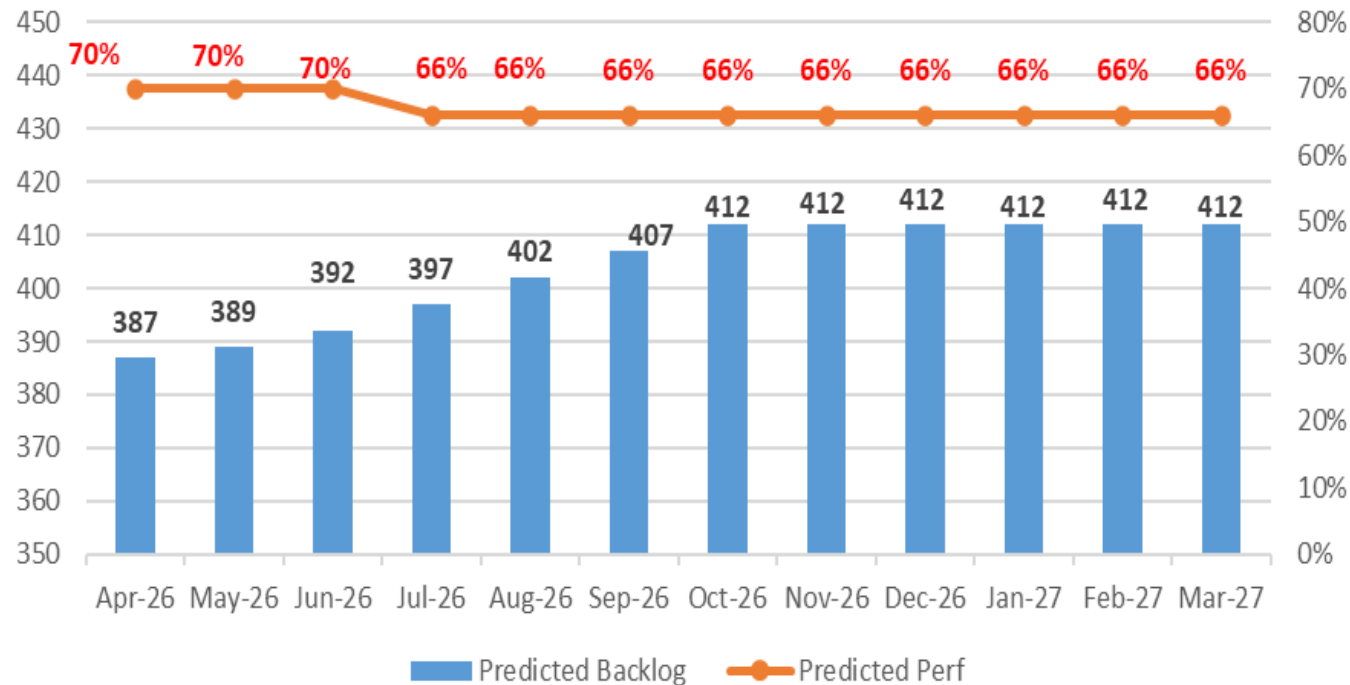
Single Cancer Pathway Forecast Trajectory 2026/27 - Status Quo



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Predicted Backlog & Performance 26/27



This trajectory assumes that all investment insourcing/outsourcing and variable pay applied in 25/26 across all CCGs continues (3.53/yr) and £1.35m of additional activity delivered within dermatology to meet the increased demand across (May – September 2026). To note, Histopathology is to be confirmed.

Performance plateaus at 66% from July 2026 in the absence of any additional investments agreed.

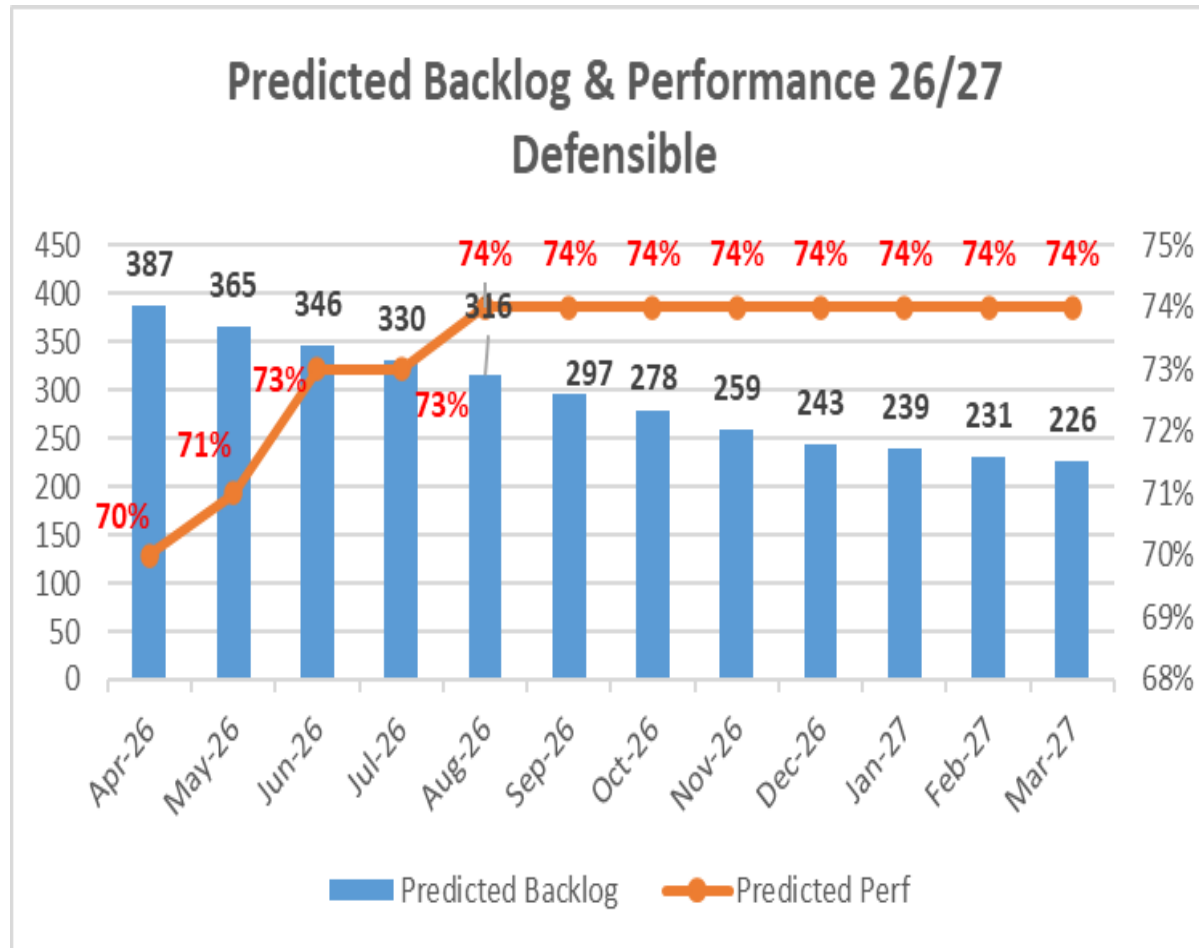
It is critical that Dermatology performance is maintained above 90% which requires additional activity to be delivered May – September 2026 in times of increased demand.

Single Cancer Pathway Forecast Trajectory 2026/27 – Reasonable Scenario



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Delivering the Reasonable trajectory (74%) requires total system spend of £8.62m across two CCGs, of which £3.53m is already incurred during 2025/26.

This also requires Planned and Specialist Care (P&SC) CCG new investment of £2.18m plus £1.35m dermatology sustainability and the AHP&HS CCG diagnostic investment is £1.56m (cancer radiology). Histopathology is to be confirmed.

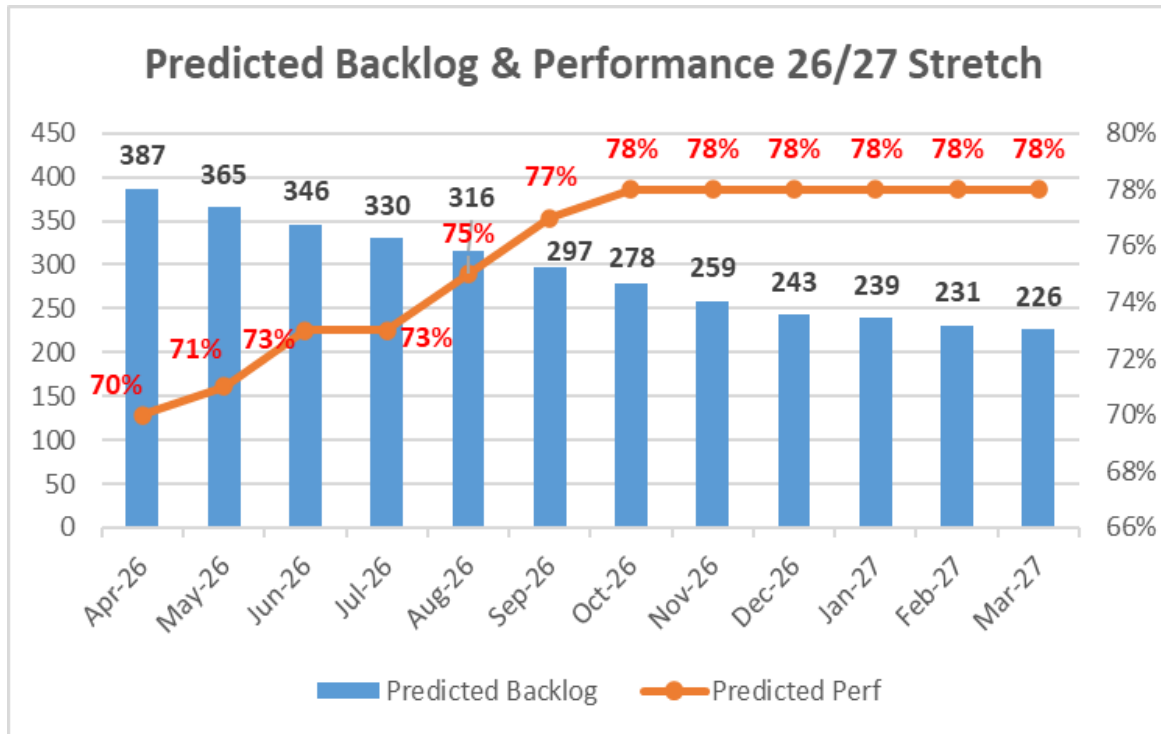
It is critical that Dermatology performance is maintained above 90% which requires additional activity to be delivered May – September 2026 in times of increased demand.

Single Cancer Pathway Forecast Trajectory 2026/27 – Stretch Improvement



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The Stretch (78%) scenario adds a further £2.08m radiology recovery plus To note, Histopathology is to be confirmed.

The Stretch trajectory (78%) additionally assumes Urology reaches 54–60% (contributing approximately +14–17pp) and Lower GI reaches 70–75% (+5–6pp). Neither service has historically achieved these levels.

Single Cancer Pathway

Key Considerations:



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- Cancer performance improvement and radiology capacity improvement are interlinked. No plan that treats them separately is credible.
- The total system cost to deliver 74% is approximately £8.6m. Of this, £3.5m is already being spent for no sustainable improvement. The incremental decision is approximately £5.1m across two CCGs.
- Urology is the single highest-value intervention. It accounts for 60% of the improvement potential and consumes the most diagnostic resource.
- Maintenance of Dermatology performance is critical to overall outcome. Losing skin cancer performance costs approximately 2pp off the aggregate – roughly equivalent to the total combined gain from Lung, Gynaecology, Upper GI, Haematology, Head and Neck, and Breast improvements.
- Clarity regarding histopathology impacts and associated costs must be resolved before the Stretch trajectory can be confirmed
- The 'Status Quo' cost is £3.53m/yr (plus £1.35m) to effectively standstill. If this is reduced, then so too is the SCP Performance. This is not a zero-cost option.



Diagnostics

Diagnostics: Endoscopy (GI and Urology)



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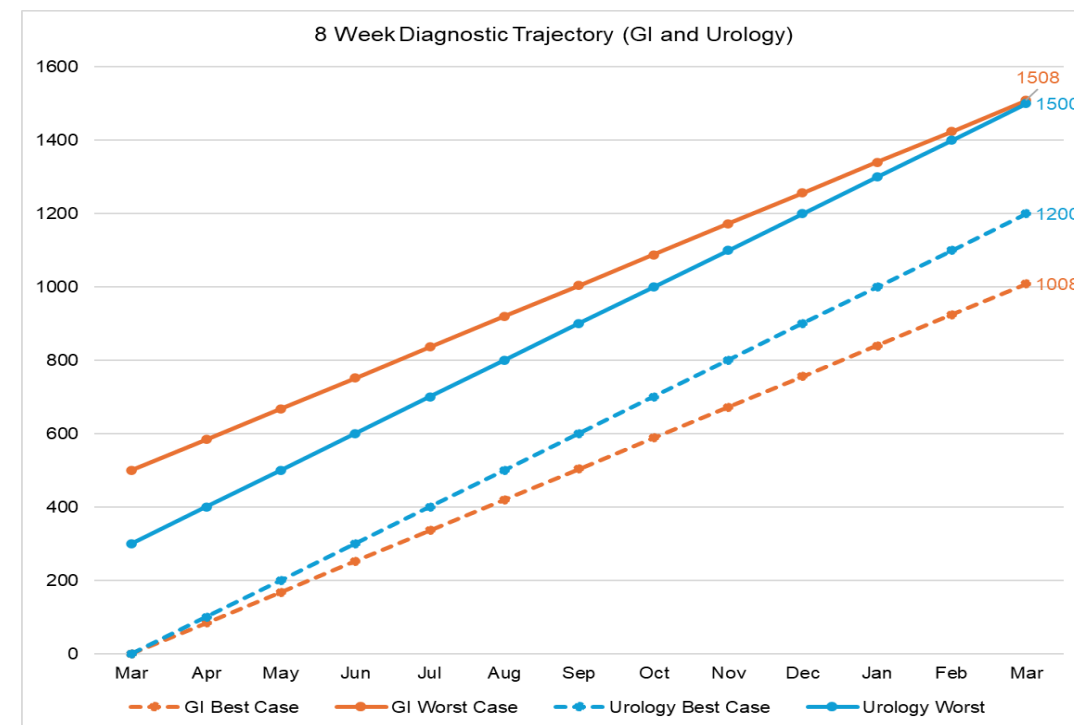
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Based on demand modelling projections for 2026/27:

- GI endoscopy demand is projected to grow by 5% in 2026/27, equating to an additional 21 patients per week (1,092 over the year). This equates to 3 additional endoscopy lists required per week, to maintain the 8-week diagnostic standard, surveillance compliance, and USC access. The D&C modelling for GI endoscopy is based on 7 patients per list (equating to 10-12 points as per endoscopy JAG guidelines) and also factors in ROTT (given all endoscopy referrals are vetted by a lead GI endoscopist to manage demand and appropriate prioritisation).
- Urology endoscopy demand is anticipated to equal 25 additional patients per week (1,300 over the year).

Using the demand growth projections summarised above, the GI and urology endoscopy modelling for 2026/27 is based on 2 scenarios (as reflected in the graph below):

- **Scenario 1** (*best case scenario*) assumes both the GI and urology backlog (diagnostic conversions generated on the back of the WG Stage 1 outpatient initiative) is cleared by the end of March 2026.
- **Scenario 2** (*worst case scenario*) assumes that the GI and urology backlog remains beyond March 2026 (worst case scenario patient figures have been included given the insourcing arrangement to accommodate these patients is still being mobilised) .



Diagnosics: Endoscopy (GI and Urology) Proposed Recovery Solution



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Assuming the patient backlog is cleared in both specialties, to address the recurrent capacity gap projected across GI and urology in 2026/27 (to sustain delivery of the Urgent Suspected Cancer (USC), surveillance and 8-week diagnostic standard), plans to increase baseline capacity include:

Plan A - Stop delivering urology (flexible cystoscopy) sessions in GGH endoscopy (interdependency with the roll-out of the Galeas bladder service in urology) - to release capacity in endoscopy theatres to uplift GI endoscopy capacity by 3 lists per week.

Plan A	Patient Volumes	Annual Cost
GI: Redeploy nursing staff currently utilised to deliver 3 urology endoscopy sessions in GGH - to support delivery of 3 new GI endoscopy sessions. Additional investment required to uplift the nursing/endoscopist establishment (by 6.58 WTE) in order to deliver GI sessions as opposed to urology sessions (staffing model is different)	21/week (1,092/yr)	£372k (already referenced in Single Cancer Pathway cost assumptions)
Urology: Roll-out of the Galeas bladder service (£283/patient)	25/week (1,300/yr)	£367,900k
	Total:	£739,900k

Plan B - The alternative would be to increase endoscopy nursing establishment at GGH (by 3 sessions for GI and 4 sessions for Urology) to support the delivery of both GI and urology endoscopy demand growth, using weekend/evening theatre capacity (given Monday-Friday capacity is fully utilised). This would sustain delivery of USC, surveillance and the 8-week diagnostic standards.

Plan B	Patient Volumes	Annual Cost
Urology and GI - Expand endoscopy capacity to include evening and weekend activity - which involves increasing the nursing establishment at GGH (by 14.29WTE) to enable delivery of increased urology and GI endoscopy sessions.	21/week (1,092/yr)	£1,209m
	25/week (1,300/yr)	

The cost difference between Plan A and Plan B equates to £469,100k. Patient volumes delivered through both plans are equal (1,092/year for GI and 1,300/year for urology). Plan A is the preferred option.

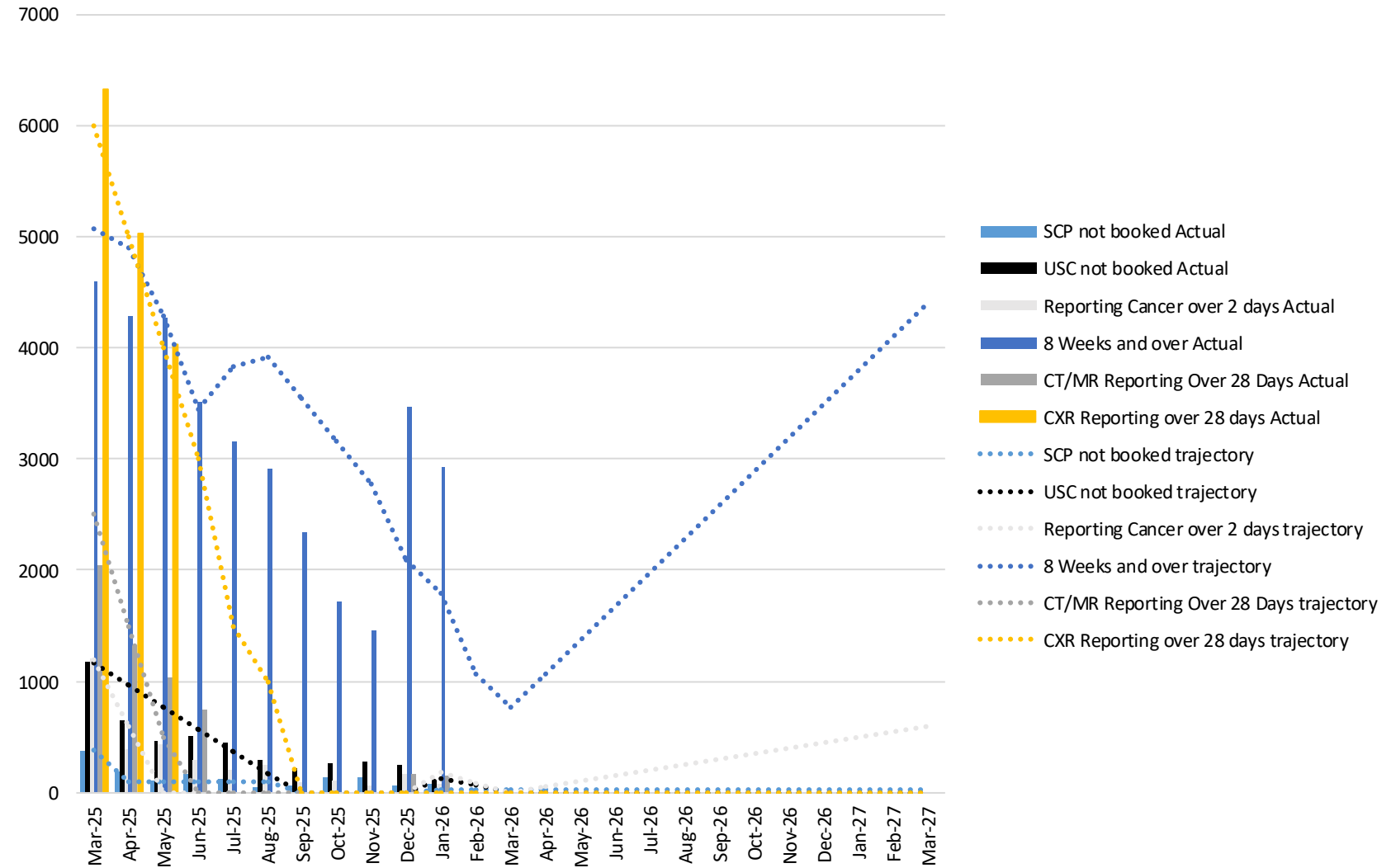
Diagnostics: Radiology



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- **Historical and forecast 5% increase in demand per annum**
- **8-week wait improved position by March 2026, supported by £3.4m recurrent stabilisation funding and £1.4m non-recurrent investment**
- **Without continuation of non-recurrent funding support, forecast increase in 8-week breaches during 2026/27 to circa 4,407 breaches by March 2027 and forecast deterioration in reporting cancer over 28 days**
- **MRI MSK pathway changes to meet national guidance will require potential movement of Radiology funding to Physiotherapy services (impact on trajectories being analysed)**





Therapies



2026/27 NHS Wales Performance Framework

- Maximum 14 week wait for Therapy referrals

CCG D&C Modelling for 2026/26 accounts for:

- Historical pattern of 14-week breaches in most of the therapy pathways post pandemic.
- During 2025/26, Therapy direct access (max 14-week wait) breaches have steadily deteriorated year to date rising from 2,216 breaches in March 2025 to 2,966 breaches in August 2025. Recent improvement noted during Q3 2025/26 with reduction of overall breaches to 2,719 in December 2025.
- The overall increasing trend in breach performance reflects significant increases in demand across the majority of therapy services pathways and limited scope to increase capacity within current agreed CCG financial limits
- Occupational Therapy (OT) has identified productivity opportunities in the Paediatric OT service (the majority of the OT breaches during 2025/26 sit with this team)
- Nutrition and Dietetics - significant increased referrals re selective eating. Previous recovery funded mitigation has not been successful due to increasing risk of harm to patients identified.
- Orthotics and Podiatry - new patient referrals have increased by circa 40% since 2019
- Physiotherapy - performance deterioration during 2025/26 driven by increasing referral demand across CMATS, Community and ICT, MSK and Paediatric teams since the COVID pandemic and has now increased above pre-pandemic levels.

Therapies Direct Access (14 weeks) – Initial Assessment

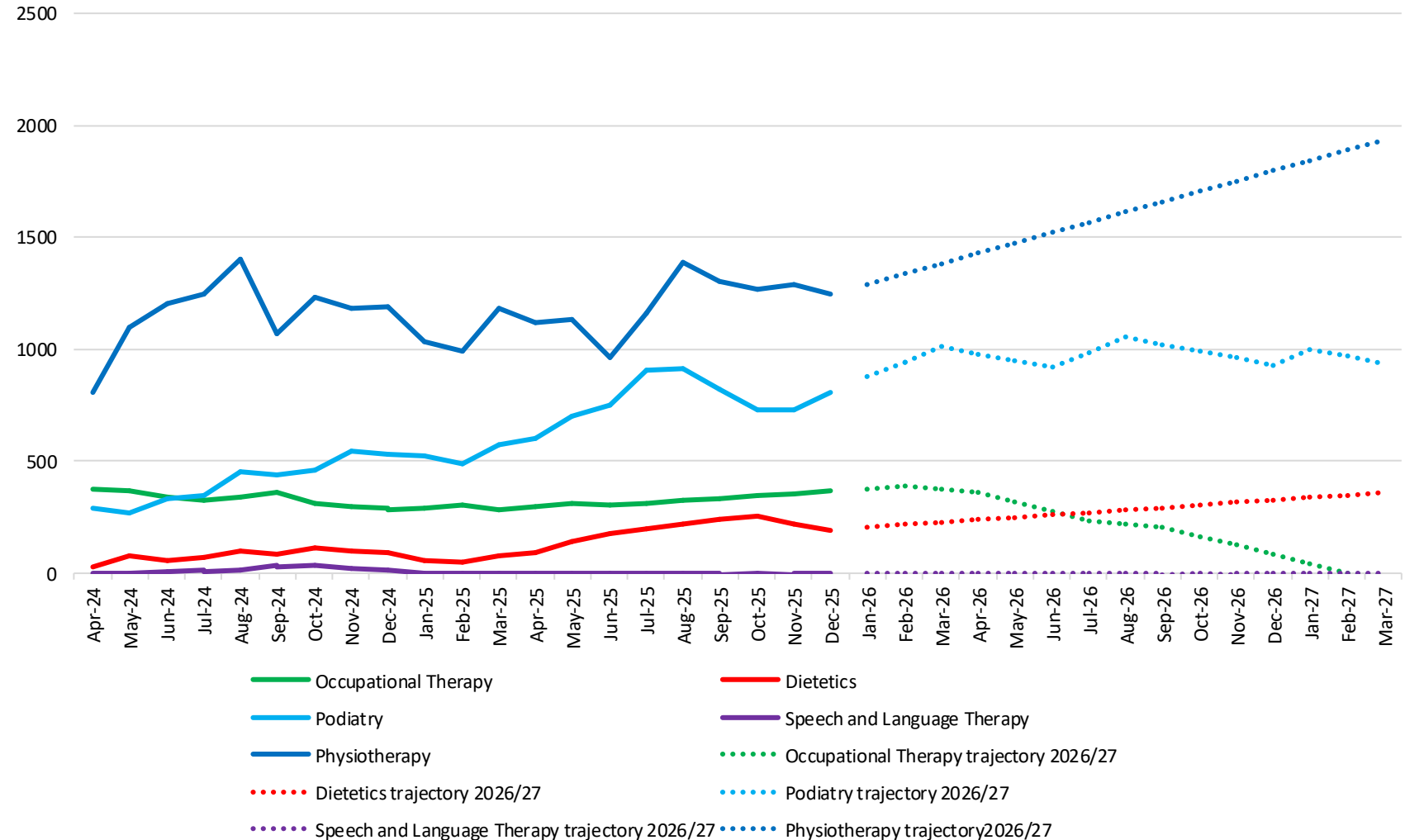


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- **SALT and Occupational Therapy forecast achievement of max 14-week wait**
- **Potential growth to circa 3,229 total breaches by March 2027 as below (without support for workforce expansion in each of the following):**
 - **Physiotherapy (1,934)**
 - **Podiatry (936)**
 - **Nutrition & Dietetics (359)**
- **Recovery to target performance by March 2027 will require 15 WTE with forecast additional £839k cost (see slide in supporting appendices)**

14 Week breaches trajectory 2026/27 - AH and HS CCG Therapies





Urgent and Emergency Care



- Modelling remains work in progress and the model currently addresses four critical urgent and emergency care (UEC) performance metrics monitored under the TI framework: ambulance handovers exceeding one hour, 12-hour emergency department waits, clinical assessment times, and pathway of care delays.
- Further work required re max 45 min ambulance handover requirement, % ambulance handovers < 15 mins, % patients who spend < 4hrs within ED
- Modelling utilises 4 separate statistical methods, combined and probability tested, taking account of historical and seasonal variations and trend analyses
- Key delivery assumptions include implementation of the UEC Business Case components of 7 Day Clinical Streaming (assumed implementation June 2026) and expanded SDEC model at WGH (assumed implementation July 2026)
- Key observations to date:
 - UEC Business Case is critical but not sufficient to enable achievement of all current TI de-escalation targets by March 2027
 - 68% probability of achieving the 1-hour TI ambulance handover target but low probability of achieving other metrics
- Additional site/system specific interventions required to improve performance forecasts

Urgent and Emergency Care



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MARCH 2027 PROJECTIONS VS TI TARGETS

Metric	TI Target	Do-Nothing / Status Quo	Post Implementation of UEC Business Case	Confidence Level (Likelihood of achievement)	Assessment
Ambulance Handovers >1hr	680	620	590	68.3%	TARGET ACHIEVABLE (moderate-high confidence)
12hr ED Waits (%)	7.0%	9.96%	8.73%	20.4%	GAP REMAINS (low confidence)
Clinical Assessment (mins)	60	74.5	71.8	18.2%	GAP REMAINS (very low confidence)
PoCD Delays	174	206	199	7.6%	GAP REMAINS (very low confidence)

RESIDUAL GAPS REQUIRING ADDITIONAL INTERVENTION

Metric	Target	BC Projection	Residual Gap	Primary Driver	Required Action
12hr ED Waits	7.0%	8.7%	+1.7pp	WGH (17.2% baseline)	SDEC expansion + pathway redesign
Clinical Assessment	60 mins	71.8 mins	+11.8 mins	GGH (78.8 mins baseline)	ED triage redesign
PoCD Delays	174	199	+25	WGH (63.9 baseline)	D2A acceleration, social care

STRATEGIC CONCLUSIONS

- **DO-NOTHING IS NOT VIABLE** — Performance deteriorates on all metrics without intervention
- **BUSINESS CASE IS NECESSARY BUT NOT SUFFICIENT** — Material improvement but gaps remain
- **SITE-LEVEL TARGETING IS CRITICAL** — WGH for 12-hour waits/Pathways of Care Delays, GGH for Clinical Assessment
- **3-MONTH CHECKPOINT REQUIRED** — If actual trajectory tracks better than forecast, revise upward

Demand and Capacity Planning 2026/27

Current illustrative Cost of Recovery



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- illustrative assessment of the likely additional financial cost of recovery / closure of forecast delivery gaps versus the respective NHS Wales Performance Framework metrics for 2026/27
- Confirmation of the forecast financial cost of recovery will be detailed in the draft Annual Plan for 2026/27 to be considered at the February 2026 Board Seminar
- Does not include MHLD and other non-direct D&C delivery priorities / costs highlighted within CCG Plans

Metric	Element	Forecast Recovery Cost
Planned Care RTT	Stage 1 (26 week max wait)	£1.12m
	Total Pathway (104 week max wait)	£7.49m
Single Cancer Pathway	Reasonable Scenario	£8.62m
Diagnostics	Endoscopy (Urology Galeas Bladder)	£0.37m
	Radiology	£1.40m
Therapies	14 week recovery	£0.84m
UEC	Current costs assumed within HB 2026/27 financial plan	nil
Sub Total		£19.84m



Supporting Appendices

Planned Care Referral To Treatment Stage 1 Efficiency

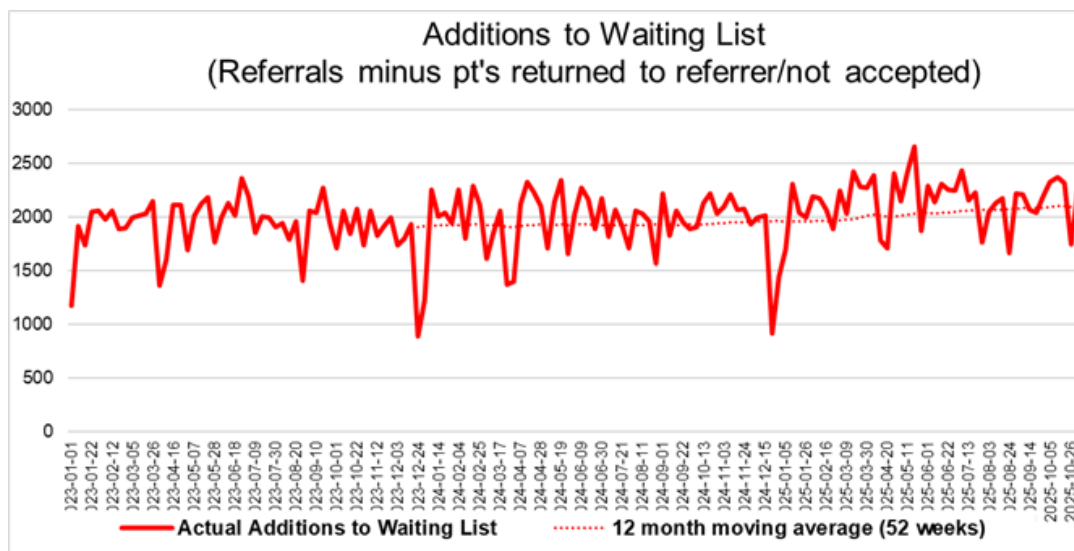


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Main speciality	Future Appointment	Future Appointment %	SOS/PIFU	SOS/PIFU %	Discharged	Discharged %	SOS/PIFU + Discharged	SOS/PIFU + Discharged %	Total Attendance
100 - General Surgery	1	5.00%	11	55.00%	8	40.00%	19	95.00%	20
101 - Urology	16	64.00%	1	4.00%	8	32.00%	9	36.00%	25
103 - Breast	18	22.22%	0	0.00%	63	77.78%	63	77.78%	81
104 - Colorectal	7	41.18%	2	11.76%	8	47.06%	10	58.82%	17
107 - Vascular	0	0.00%	0	0.00%	4	100.00%	4	100.00%	4
110 - Trauma & Orthopaedics	112	42.91%	89	34.10%	60	22.99%	149	57.09%	261
120 - ENT	63	38.65%	17	10.43%	83	50.92%	100	61.35%	163
130 - Ophthalmology	159	65.98%	7	2.90%	75	31.12%	82	34.02%	241
191 - Pain Management	12	54.55%	5	22.73%	5	22.73%	10	45.45%	22
300 - General Medicine	8	47.06%	0	0.00%	9	52.94%	9	52.94%	17
301 - Gastroenterology	23	47.92%	4	8.33%	21	43.75%	25	52.08%	48
302 - Endocrinology	9	81.82%	0	0.00%	2	18.18%	2	18.18%	11
303 - Clinical Haematology	20	86.96%	0	0.00%	3	13.04%	3	13.04%	23
307 - Diabetic Medicine	13	86.67%	0	0.00%	2	13.33%	2	13.33%	15
320 - Cardiology	12	52.17%	1	4.35%	10	43.48%	11	47.83%	23
328 - Stroke Medicine	2	16.67%	0	0.00%	10	83.33%	10	83.33%	12
330 - Dermatology	46	34.07%	10	7.41%	79	58.52%	89	65.93%	135
340 - Respiratory Medicine	14	42.42%	1	3.03%	18	54.55%	19	57.58%	33
361 - Nephrology	4	100.00%	0	0.00%	0	0.00%	0	0.00%	4
400 - Neurology	15	34.88%	4	9.30%	24	55.81%	28	65.12%	43
410 - Rheumatology	26	83.87%	2	6.45%	3	9.68%	5	16.13%	31
420 - Paediatrics	11	44.00%	3	12.00%	11	44.00%	14	56.00%	25
430 - Geriatric Medicine	10	76.92%	1	7.69%	2	15.38%	3	23.08%	13
502 - Gynaecology	47	33.33%	29	20.57%	65	46.10%	94	66.67%	141
Total	648	46.02%	187	13.28%	573	40.70%	760	53.98%	1,408

- 54% avoid future appointment
 - Discharged (40.7% / 760 pts)
 - SOS/PIFU (13.28% / 187 pts)
- Referral Management
 - 31% Referrals returned after vetting
- My Health Pathways
 - 271 published / 50k page views
- OPD Activity +12% vs pre-Covid
 - 6,742 (19/20 average)
 - compared to 7,848 up to September 2024 to 2025



Planned Care (Referral to Treatment) Former Stage 1 52-week Maximum Wait



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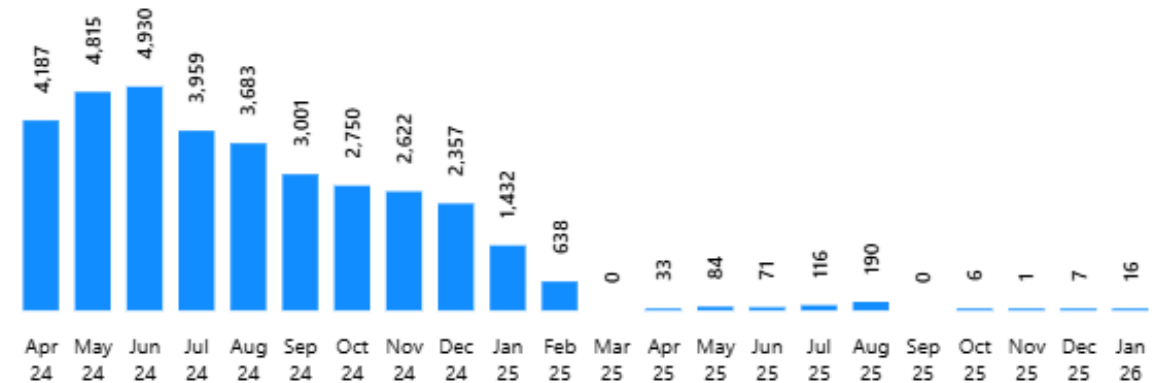
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52-week Outpatient target will be held with the following budget realignments/continuations:

- **ENT Consultant Locum** (20k pa)
- **Rheumatology Locum** (130k pa)
- **Dermatology** continuing with S1 insourcing (214k pa)
- **Neurology** continuing with insourcing (£162k p/a)

Continuation of insourcing (~ 376k resourced from P&SC budget)

Patients waiting over 52 weeks



*16 breaches in January are non-planned care specialties
Care group anticipate no breaches by March 2027*

Planned Care Referral To Treatment Theatre Optimisation



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Of lists delivered during 2025/26:

- **ENT** Theatre utilisation 93%
- **Ophthalmology** Theatre utilisation 89.5% (8 eyes a list including bi-laterals)
- **Orthopaedic** theatre utilisation 84.9%. 2 additional surgeons working towards 4 joints a list (24 joints included in 26/27 D&C plan). 4 joints a list at BGH unachievable due to environment. Increasing all surgeons to 4 per list requires consultant Anaesthetic cover, regular theatre teams, early team brief (with anaesthetist) and improved turnaround times. Consultant ability (& speed) varies.
- **Urology** utilisation @ GGH >200% (complex nephrectomy) main theatre PPH 83% (most activity). If 85% utilisation implemented at PPH Main = 20 additional patients could be treated across the year.
- **Dermatology** utilisation 77.1%. If increased to 80% an extra 32 patients could be treated. DSU mandate number of patients booked. Calculation includes DSU follow sessions.

Cancelled Sessions

- If Theatre sessions were not cancelled in GGH there would be 825 fewer RTT projected breaches in 26/27
- ENT would have had minimal breaches if 337 patients were not cancelled

Planned Care Referral To Treatment Theatre Cancellations (2025)



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Month / Specialty	Ophthalmology	ENT	Gynaecology	Obstetrics	General Surgery	Pain Management	Urology	Cardiology	Trauma & Orthopaedics	Dermatology	Paediatric Plastic Surgery	Gastroenterology	Community Paediatric Service	Colorectal	Grand Total
☰ 2025															
Jan	44	34	31	6	19	5	1	1	1		1				143
Feb	43	23	25	4	4	21	9	5	7					1	142
Mar	24	54	15	4	4		17	7	3						128
Apr	45	27	7	3	14	4	10	5			4				119
May	23	23	20	11	15	4	2	1							99
Jun	46	34	23	30	8	7	3	1	2	1					155
Jul	27	19	15	19	8	6	1	3		10					108
Aug	26	23	17	20	11	6	4	7	1		1	1			117
Sep	44	35	22	22	15	12	3	2			3		1		159
Oct	34	26	21	19	9	10	2		1						122
Nov	20	14	9	14	3	6	1	2	3						72
Dec	26	25	13	25	2		3	6		1					101
Grand Total	402	337	218	177	112	81	56	40	18	12	9	1	1	1	1465

- Table includes all GGH cancellations in 2025 (N=825)
 - Ophthalmology = 402
 - ENT = 337
 - Urology = 56
 - Orthopaedics = 18
 - Dermatology = 12

Single Cancer Pathway (SCP) Delivery Scenarios – Forecast Cost Summary



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Cost Category	Status Quo (66%)	Defensible (74%)	Stretch (78%)	Validation Status
Already committed (AHP)	£3.53m	£3.53m	£3.53m	Confirmed
P&SC Tier 1 Essential	–	£2.18m	£2.18m	Costed
P&SC Dermatology sustainability	£1.35m	£1.35m	£1.35m	Funding source TBC
AHP Cancer Radiology (Option 1)	–	£1.56m	£1.56m	AHP CCG decision
AHP Radiology Recovery (one-off)	–	–	£2.08m	Costed (V7)
Histopathology	–	–	TBC	Cost TBC
TOTAL SYSTEM COST	£3.53m	£8.62m	£10.70m+	
of which: already being spent	£3.53m	£3.53m	£3.53m	

Single Cancer Pathway (SCP) Delivery Scenarios – Forecast Cost (Key Components)



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Component	Cost	CCG Owner	Type	New / Existing	What It Buys
ALREADY COMMITTED (cost of inaction)					
Variable pay (radiology)	£1.90m	AHP	Recurrent	Existing	Sustains current 65–66%. No improvement.
Outsourced reporting	£1.63m	AHP	Recurrent	Existing	28,840 reports/yr at 4.4x internal cost. No pathway gain.
P&SC CCG TIER 1 – ESSENTIAL (new investment)					
Cancer Trackers & CNS (24 WTE)	£963k	P&SC	Recurrent	NEW	SCP data accuracy, pathway coordination. Enables all other improvements.
Urology Cancer Diagnostics	£848k	P&SC	Recurrent	NEW	Addresses 40.9% of backlog. Urology 19.2%→40%+.
Endoscopy Plan A (6.58 WTE)	£372k	P&SC	Recurrent	NEW	Prevents 888 diagnostic breaches. Enables LGI + UGI pathways.
P&SC CCG – DERMATOLOGY SUSTAINABILITY					
Derm insourcing (£964k) + seasonal (£382k)	£1.35m	P&SC	Recurrent + seasonal	RE-BASE needed	Protects Skin at 93.9%. Without it, aggregate drops ~2pp. Currently partly funded through recovery.
AHP CCG – CANCER RADIOLOGY					
Cancer Radiology Option 1 (Agency)	£1.56m	AHP	Recurrent	NEW	Closes 96 scan/wk cancer gap. CT + MRI capacity. Enables 72–74%.
STRETCH ADDITIONS					
Radiology Immediate Recovery	£2.08m	AHP	One-off + bridge	NEW	CXR backlog clearance, SCP reporting TAT, NOUS recovery. Enables 74–76%.
Histopathology baseline + capacity	TBC	AHP/Path	Unknown	TBC	169 cancer requests/wk. Prerequisite for 78%. Currently unknown constraint.

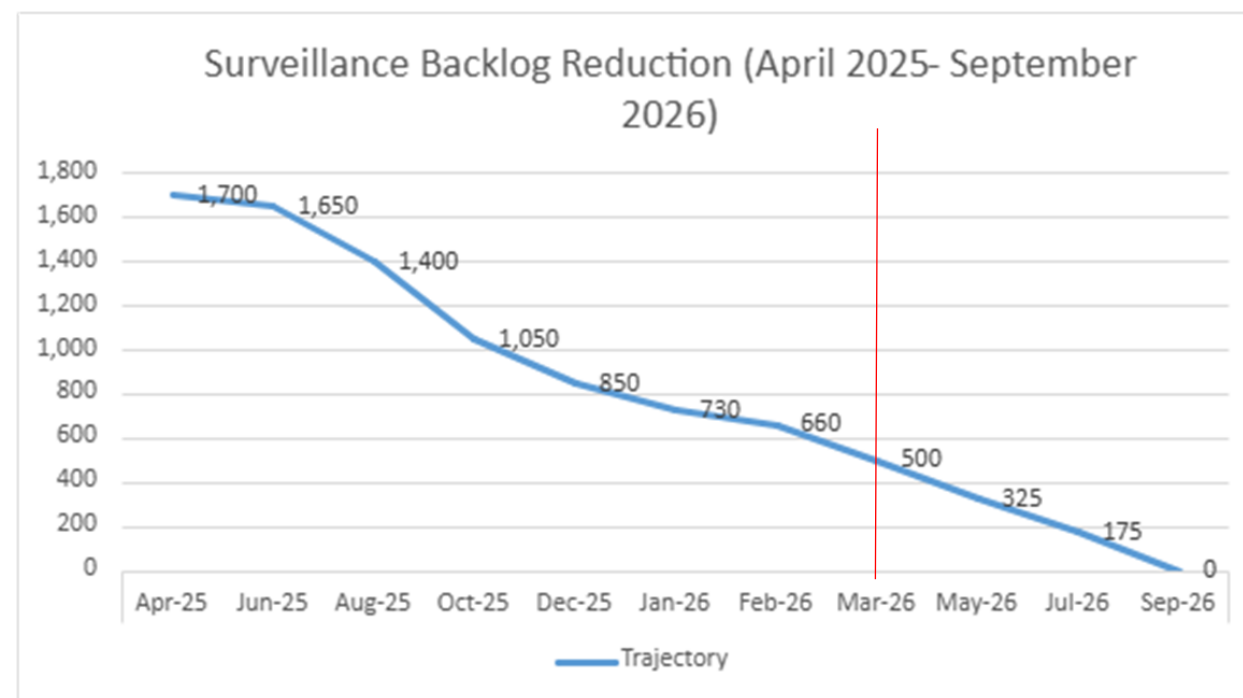
Diagnostics: Endoscopy (GI Surveillance)



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- The surveillance backlog for GI endoscopy is on trajectory to reduce to 500 patients by the end of March 2026 (as per plan submitted in 2025/26).
- £179k already allocated in 2026/27 to clear the remaining 500 patients, however this plan was based on the continued use of the planned additional activity rates being used via internal waiting list initiatives.
- Due to the cessation of the Planned Additional Activity Rate (PAAR) beyond end of March 2026 – the plan to accommodate the remaining 500 surveillance patients by September 2026 will need to be re-considered.
- A paper including an options appraisal is currently being drafted. In the event of potential reduced staff take up of internal WLI sessions, alternative solutions include mobilising an insourcing arrangement (in place of the waiting list initiatives proposed, using PAAR).
- A WLI (inc. PAAR) equates to £3,200k per list. An insourcing list equates to circa £5,600k per list.



Therapies - Summary Assessment of Potential Recovery Opportunities



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Recovery of waiting times to the 14-week target level will not be achieved without significant levels of additional workforce support:

- Successful recruitment of temporary external workforce solutions in Nutrition & Dietetics and Orthotics and Podiatry is considered unlikely due to previous experience
- Conversely, there is moderate confidence in successful recruitment of temporary workforce solution Physiotherapy (both temporary and substantive solutions are provided as requested)

- **Orthotics & Podiatry** recovery to **zero** breach performance is achievable in **February 2027** if successful substantive recruitment and start in post May 2026
- **Nutrition & Dietetics** recovery to **zero** breach performance can be achieved by **December 2026** in if successful substantive recruitment and start in post June 2026
- Recovery in **Physiotherapy** if successful phased recruitment of temporary or substantive workforce solutions **zero** breach position by **January 2027**

This basic D&C analysis will be refreshed through the full demand and capacity service review underway across these specialities and will provide a refined position once complete.

	Staff WTE	AfC	Cost Recurrent	Zero breach predicted
Nutrition and Dietetics	3.0	7	186k	Dec 2026
Orthotics and Podiatry	3.0 1.0	6 7	152k 62k	Feb 2027
Physiotherapy	5.0 3.0	6 7	253k 186k	Jan 2027
Total	15	-	839k	End of 2026/27

Table 1 - Summary additional workforce requirements highlighted by AH&HS CCG