



FINANCE AND PERFORMANCE COMMITTEE
PWYLLGOR CYLLID A PHERFFORMIAD

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Enabling Actions: Value Opportunities
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Executive Director of Finance

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

The Finance Team has produced a merged value opportunities catalogue drawing together clinical pathway value opportunities, national enabling actions and low-value elimination opportunities, “the catalogue”.

This report sets out the intended scope and positioning of the catalogue as the Year 1 deployment set within the broader value and productivity programme and identifies what the catalogue covers.

Cefndir / Background

The catalogue is not intended to be the complete response to becoming a value-managed system, however provides an important starting point in acquiring and assimilating value opportunities currently available.

Asesiad / Assessment

What the Catalogue Covers

The catalogue is strong on secondary care operational productivity. Each opportunity is described with a narrative, source documents, implementation evidence and quantified impact.

What Sits Outside Year 1 Scope

The following domains are not in the catalogue. They require system-level investment in data, relationships or infrastructure that the Year 1 deployment set helps to build.

Digital as a Value Domain

The catalogue includes AI-supported radiology triage and digital therapy delivery. It does not treat digital as a systematic value driver: remote monitoring, CRM-enabled care co-ordination, home-based technology, or workflow redesign enabled by the flow system. These sit within the Digital work programme and will form part of the year 2 catalogue as implementation matures.

Primary Care and Community Re-design

The catalogue is largely hospital-facing. Cluster-based models, practice variation, social prescribing and health coaching at scale are not included.

Equity Measurement

The catalogue does not include differential impact by deprivation. This reflects the current state of the data infrastructure. As Patient-Reported Outcome Measure (PROM) data from the automated data collection and analysis software, 'Promptly', matures and population health intelligence develops, equity dimensions can be layered onto the opportunity set. This is a Year 2 to 3 requirement.

Workforce Capability

The catalogue addresses workforce cost controls (agency reduction, job planning, sickness absence). It does not address workforce as a value opportunity: new roles, skill-mix redesign, retention as productivity, training pipeline as capacity. These require workforce planning infrastructure that sits outside the current programme scope.

Prevention Economics

Table A covers clinical prevention interventions. The broader prevention economics programme, including spend measurement, partnership with Public Health Wales, and the case for shifting the NHS spend profile, is a parallel workstream. Its outputs will inform future catalogue iterations, however the analytical work is still in development.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **TAKE ASSURANCE** that there is a clear catalogue of low investment/high value opportunities that now need to be converted into delivery.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3	Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly
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	savings and opportunities report to the Committee.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	2. Timely 3. Effective 4. Efficient 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 5. Whole systems perspective
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Extensive research on value opportunities and enabling actions.
Rhestr Termiau: Glossary of Terms:	Contained within the body of the text
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian:	Value for money inherent within the report.

Financial / Service:	
Ansawdd / Gofal Claf: Quality / Patient Care:	Patient outcomes inherent within the report.
Gweithlu: Workforce:	Delivering sustainable services and reducing demand.
Risg: Risk:	Risk to long term financial sustainability.
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

TABLE A

Prevention

Domain	Value change	Clinical rationale	Evidence source	Scale of potential opportunity (if available)
Adult obesity	Systematic brief intervention with <i>active referral</i> to Tier 2 weight management (including digital platforms)	30-second GP or clinician interventions with active referral markedly increase uptake of structured programmes; sustained modest weight loss at population scale prevents diabetes, CVD, cancer and MSK disease	Adult Obesity Strategic Options Appraisal; NICE NG246; BWeL trial	Cost-saving over 20 years; Tier 2 referrals ~£45–55 per person; population-level reach
Adult obesity	Commission digital weight management platforms (Tier 2/3) for rural access	Digital platforms deliver 9–12% weight loss at 1–2 years, comparable to pharmacotherapy for a fraction of the cost; eliminates rural access barriers	Adult Obesity Strategic Options Appraisal; NICE early value assessment	Saves clinician time; scalable to thousands; lower cost than GLP-1s
Adult obesity	Expand bariatric surgery access in line with NICE NG246	Most cost-effective obesity intervention; large and durable reductions in mortality, diabetes and CVD	Adult Obesity Strategic Options Appraisal; NICE NG246	~£7,000 per QALY; ~£49m net benefit per 1,000 procedures; NHS payback ~5 years
Adult obesity	Targeted GLP-1 (tirzepatide/semaglutide) prescribing for highest-risk cohorts	Produces 15–22% weight loss and major cardiometabolic benefit; prevents diabetes and CVD when targeted	Adult Obesity Strategic Options Appraisal; NICE TA875/TA1026	Individually cost-effective (£15k–£19k per QALY) but high budget impact if untargeted
Adult vaccination	Default pre-scheduled appointments with SMS call-and-recall	Largest and most consistent increases in adult vaccine uptake; exploits behavioural “opt-out” effects	Adult Vaccination Value Appraisal; RCT and meta-analysis evidence	10–15 percentage-point uptake increase across programmes
Adult vaccination	Close influenza uptake gap in over-65s	Influenza admissions drive winter bed pressure; Hywel Dda has lowest uptake in Wales	Adult Vaccination Value Appraisal; Public Health Wales	Vaccinating additional ~6–7k people prevents ~60–80 admissions and 10–15 deaths per season

Adult vaccination	Accelerate RSV vaccination ahead of 80+ expansion	RSV causes substantial winter admissions and mortality in older adults; new programme underperforming	Adult Vaccination Value Appraisal; UK and Scottish real-world data	~62% reduction in RSV hospitalisations in vaccinated cohorts
Adult vaccination	Maximise PCV20 pneumococcal transition	Cost-saving vaccine switch preventing invasive disease and pneumonia	Adult Vaccination Value Appraisal; JCVI modelling	£3.10–£5.90 return per £1; ~£5–6m attributable to Hywel Dda population
Alcohol harm reduction	Establish Alcohol Care Teams (ACTs) across acute sites	Opt-out hospital-wide screening and treatment reduces admissions, LOS and readmissions	Alcohol Harm Reduction Appraisal; NENC, Salford, Bolton evidence	~£5 return per £1; ~4 bed days freed per patient; £1–1.5m annual avoided costs
Alcohol	Systematic AUDIT-C screening with brief intervention across all settings	ABI reduces consumption with NNT ~10; very brief advice is as effective as longer counselling	Alcohol Harm Reduction Appraisal; Cochrane; SIPS trial	Cost-saving long-term; £6,900 per QALY under pessimistic assumptions
Alcohol	Close pharmacotherapy gap (acamprosate, naltrexone)	Highly effective, low-cost relapse prevention; major current under-treatment	Alcohol Harm Reduction Appraisal; NICE CG115	NNT 9–12; large untreated population → high latent value
Alcohol	Target high-impact cohorts (frequent attenders, older adults, liver disease)	Concentrates resources where harm and cost are highest	Alcohol Harm Reduction Appraisal	£3–£29 return per £1 across targeted models
Smoking cessation	Implement CURE-model inpatient tobacco dependency treatment	Highest ROI of any NHS intervention; treats smoking as a clinical condition	Smoking Cessation Evidence Appraisal; CURE/Ottawa model	~£487 per QALY; ~£30 public value per £1; thousands of bed days freed
Smoking	Universal Very Brief Advice with opt-out referral	Low-cost, system-wide reach; increases quit attempts and medication use	Smoking Cessation Evidence Appraisal; Cochrane	Near-zero marginal cost; population-level effect
Smoking	Financial incentives for pregnant smokers	Doubles quit rates; prevents neonatal complications and long-term harm	Smoking Cessation Evidence Appraisal; CPIT III; NICE NG209	~£2 healthcare savings per £1; rapid payback
Smoking	Pre-operative cessation pathway linked to waiting lists	Reduces surgical complications and length of stay	Smoking Cessation Evidence Appraisal; Cochrane	Cost-saving; payback within <1 year
Childhood obesity	Whole-school prevention (Daily Mile, nutrition standards)	Universal reach; extremely low cost per QALY; equitable	Childhood Obesity Strategic Options Appraisal; NICE NG246	£682–£3,300 per QALY; ROI up to 8:1

Childhood obesity	Early years family programmes (HENRY / PIPYN)	Strongest evidence-based service intervention for reducing reception-age obesity	Childhood Obesity Strategic Options Appraisal; Leeds / PIPYN evidence	Modest cost; measurable prevalence reduction in deprived groups
Childhood obesity	Breastfeeding peer support and BFI maintenance	Most cost-effective public health intervention; reduces obesity risk 13–27%	Childhood Obesity Strategic Options Appraisal	~£193 per family; NHS savings up to £50m nationally
Childhood obesity	Minimum viable Level 3 paediatric weight management service	Addresses severe obesity early, preventing lifelong cost trajectory	Childhood Obesity Strategic Options Appraisal	Prevents high-cost adult disease; hub-and-spoke scalable
Childhood vaccination	Automated bilingual reminder/recall with escalation	Most cost-effective uptake intervention; addresses access failures	Childhood Immunisation Strategic Evidence Review; Cochrane	5–8 percentage-point uptake increase; £6–£50 per additional child
Childhood vaccination	Dedicated immunisation coordination team	Reduces practice variation and missed opportunities	Childhood Immunisation Strategic Evidence Review; NICE NG218	Sustained system-wide improvement; low staffing cost
Childhood vaccination	Mobile and community-based catch-up delivery	Overcomes rural access barriers; improves equity	Childhood Immunisation Strategic Evidence Review	25–26 percentage-point increases in targeted areas
Childhood vaccination	Opportunistic vaccination at all clinical contacts	Captures missed doses during admissions and routine care	Childhood Immunisation Strategic Evidence Review	~65% uptake when offered in hospital
Childhood vaccination	Presumptive communication and MI training	Dramatically increases acceptance among hesitant parents	Childhood Immunisation Strategic Evidence Review	Up to 25-fold difference in acceptance vs participatory framing

Diagnosics and Therapies

Domain	Value change	Clinical Rationale	Evidence Source	Scale of potential opportunity (if available)
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Radiology	Embed iRefer clinical decision support into electronic requesting	Reduces inappropriate imaging; shifts/cancels low-value requests safely	RCR iRefer evidence and deployment examples cited in appraisal	20% reduction in unnecessary examinations; real-world: 6.3% changed test + 2% cancelled; ~£40k/yr licence with ~£330k/yr avoided imaging cost per trust
Radiology	Strengthen radiographer/radiologist vetting and protocolling using RIS workflows	Vetting safely cancels unnecessary referrals without missed significant pathology	BMUS/Hull audit and NHS vetting module examples	90.5% of vetted-out ultrasound referrals required no onward imaging; example site achieved 20%+ increase in scans vetted per day (with very low breach rate)
Radiology	Deploy speech recognition for all reporting	Eliminates transcription delays and materially improves report turnaround	Studies and NHS implementations cited (e.g., Imperial)	Report turnaround improvement described as "24-fold"; example: report availability from ~72 hours to <4 hours with speech recognition + PACS optimisation
Radiology	Maximise PACS capability and implement cross-site reporting via unified worklists	Improves prioritisation and turnaround across multi-site service; prevents "secondary site" deprioritisation	Unified worklist QI study + RCR Networked Reporting Platform guidance referenced	QI evidence: consolidating multiple worklists into one improved turnaround and removed deprioritisation effects
Radiology	Expand reporting radiographer workforce (start with plain film / CT head)	Workforce multiplier with diagnostic performance comparable to radiologists for defined scopes	Meta-analysis and national surveys cited	Meta-analysis: 92.6% sensitivity and 97.7% specificity for plain radiograph reporting; Band 7–8a cost vs consultant radiologist costs also set out
Radiology	Deploy CXR AI triage to accelerate pathways and clear backlogs	Speeds time-critical triage (e.g., suspected lung cancer) and reduces backlog reliance on outsourcing	NHS deployments and AI fund examples cited	Examples: CXR-to-CT time reduced 7→3 days; 71% reduction in suspected lung cancer waiting times; 4,415-CXR backlog cleared in 3.5 days (example)
Radiology	Deploy fracture detection AI in urgent care	Reduces missed fractures (patient safety + litigation risk) and reading time	NICE Early Value Assessment recommendation and modelling cited	30% fewer missed fractures; 36% decrease in reading time; national modelling: net saving £3.63m/year and reduced

				missed-fracture returns by 21,674 cases
Radiology	Scale point-of-care ultrasound (POCUS) to deflect formal imaging demand	Answers clinical questions at bedside; avoids formal ultrasound and CXR requests in key acute settings	Studies cited (acute medicine/internal medicine)	73.1% of POCUS scans did not lead to departmental imaging request; 67% reduction in diagnostic tests; 87% reduction in odds of CXR referral (study cited)
Radiology	Separate obstetric ultrasound from radiology into maternity (midwife sonographers)	Frees radiology ultrasound capacity for non-obstetric demand	Wales exemplar and workload share cited	Obstetric scanning described as 20–30% of total ultrasound workload
Dietetic	Implement ONS prescribing review (inpatient + discharge + community interface)	High rates of inappropriate ONS prescribing; stopping inappropriate ONS produces immediate recurrent savings	National audits and examples cited; BAPEN estimate referenced	Inappropriate prescribing “as high as 75%” in some areas; BAPEN: £101.8m/yr potential NHS saving; example site: 75.4% ONS stopped after dietitian review as inappropriate
Dietetic	Improve MUST screening compliance and NICE CG32 nutritional support	Reduces LOS, readmissions and mortality associated with malnutrition; cost-saving at scale	NICE CG32 + BAPEN modelling cited	Potential net savings for Hywel Dda estimated at ~£460k–£560k per year from screening compliance alone (as scaled in appraisal)
Dietetic	Expand structured diabetes education (DESMOND / X-PERT / DAFNE) using group delivery	Improves glycaemic control and outcomes; group model is most efficient	Evidence for DESMOND/DAFNE/X-PERT summarised	DESMOND cited as £2,092 per QALY (real-world delivery); group delivery ~£69 per patient (as quoted)
Dietetic	Develop diabetes prevention programme (DPP-equivalent)	Prevents progression to Type 2 diabetes; long-term cost saving	NHS DPP evaluation + economic evidence cited	NHS DPP: adjusted HR 0.80; completers: 37% reduced chance at 24 months; “cost-saving by year nine” and 98.1% probability cost-effective (as cited)
Dietetic	Establish Type 2 diabetes remission (total diet replacement) pathway	High remission rates; reduces medication use and adverse events	DiRECT + DROPLET evidence summarised	DiRECT: 46% remission at 12 months; 36% at 24 months; “60% off all antidiabetic medication at two years” (as cited)
Dietetic	Use NICE-EVA supported digital weight management	Extends reach; non-inferior outcomes to	NICE Early Value Assessment and platform evidence cited	NICE estimate: reach 48,000 additional patients and save

	platforms (Oviva / Second Nature etc.)	face-to-face; addresses access constraints		145,000 clinician hours (as cited)
Dietetic	Provide group dietetic low-FODMAP education for IBS	High response rates; group model is efficient and safer than unsupported self-directed approaches	Monash/KCL evidence cited; group delivery support cited	70–80% symptom response reported in appraisal; group model explicitly described as more resource-efficient
Dietetic	Embed dietetic components into ERAS pathways	Reduces complications and length of stay	ERAS evidence cited in appraisal	Full ERAS implementation described as ~50% complication reduction and ~30% LOS reduction (as cited)
Physio	Implement STarT Back stratified care for low back pain	Improves pathway efficiency and reduces direct NHS cost per patient (and wider societal costs)	Lancet RCT evidence cited in appraisal	NHS saving £34.39 per patient and societal saving £675 per patient (as cited)
Physio	Expand group-based MSK programmes (ESCAPE-pain; plus rehab groups)	Delivers equivalent outcomes at lower cost; increases throughput	ESCAPE-pain evidence and costings summarised	ESCAPE-pain ROI £8.83 per £1; healthcare utilisation costs £1,525 lower per person over 2.5 years (as cited)
Physio	Deploy digital MSK self-management (e.g., getUBetter)	Reduces physiotherapy referrals, GP contacts, and medication; deflects waiting list demand	getUBetter evaluation cited	ROI £4.20 per £1; physio referrals –20%; GP follow-ups –13%; MSK meds –50%; “half” of waiting list patients no longer needed appointment; remaining needed 40% fewer appointments (as cited)
Physio	Implement/scale First Contact Physiotherapists (FCPs) in primary care	Manages majority of MSK presentations without secondary care referral	Evaluation findings cited (e.g., Downie / national evaluation)	87.3% managed within primary care; orthopaedic referral rate reported at 3% (example evaluation cited); recommended staffing ratio 1 per 10,000 population stated
Physio	Optimise self-referral/direct access and triage models	Reduces cost per episode and wait times; reduces DNAs	Scottish trial + PhysioDirect evidence cited	Self-referral: £66.31 vs £88.99 per episode; PhysioDirect median wait 7 vs 34 days; 55% fewer non-attended face-to-face appointments
Physio	Establish 7-day inpatient physiotherapy (priority wards)	Reduces length of stay and supports flow;	Neuro 7-day evidence + cost utility referenced	Neuro example: LOS reduced 32 → 23.4 days (8.6 days

		evidence strongest in neuro and respiratory		reduction); NICE cost-utility described as cost-saving (–£90 per patient)
Physio	Implement AI-assisted triage (e.g., Phio-type platform)	Reduces waits and releases clinical hours for complex care	Service evaluations cited	Wait time reduced 11.5 → 3.7 weeks; 1,240 clinical hours released; ROI £2.00 per £1 year 1 rising to £2.33 by year 3 (as cited)
Podiatry	Establish/strengthen MDT diabetic foot teams (NICE NG19 compliant)	Most effective limb-salvage model; prevents amputations and reduces mortality	Ipswich model + systematic reviews/meta-analyses cited	Major amputations reduced 62–82% (Ipswich model as cited); meta-analysis RR for major amputation 0.45 (as cited); appraisal indicates large cost avoidance per prevented amputation (see next row)
Podiatry	Prioritise prevention of amputations/ulcers via high-risk foot protection	DFU precedes most amputations; prevention is highest ROI	NICE NG19 + NDFA context cited	Each prevented amputation saves ~£50k–£100k (as cited); each avoided DFU frees ~£7,800 direct NHS spend (as cited)
Podiatry	Close the offloading gap (TCC/irremovable offloading as default for eligible DFU)	Offloading is gold standard; improves healing and prevents progression	NICE NG19 / IWGDF guidance and healing evidence cited	Healing in 72–100% within 5–8 weeks reported; implementation gap described as very low uptake in UK examples
Podiatry	Implement telemedical diabetic foot monitoring	Reduces hospital days and costs; can reduce amputations	TELEPIED + meta-analysis cited	TELEPIED: hospital days 13.4→7.1; costs €7,185→€3,471; meta-analysis RR amputation 0.64 and cost reduction €4,158 per patient
Podiatry	Shift community podiatry from demand-led to needs-led (risk stratification; move low-risk nail care to third sector)	Frees specialist capacity for limb-salvage and high-risk work; avoids false economy of withdrawing high-risk care	Risk-stratification model + third-sector exemplars described	Third-sector nail care costs quoted (£10–£22 / visit vs NHS podiatry £40–£80+), described as 75–85% cost reduction
Podiatry	Expand podiatric surgery (day case, local/regional anaesthesia)	Substitutes for orthopaedic activity at	UK multicentre outcomes and cost comparisons cited	Cost per case ~£1,889 vs orthopaedic tariffs £3,000–£5,000+; example 200

		lower cost; short RTT and high satisfaction		cases/yr saves ~£422,200 (as cited)
Podiatry	Create inpatient podiatric “high-risk foot coordinator / ward surveillance”	Reduces DFU LOS and bed-day burden (“time is tissue”)	Great Western Hospital example cited	LOS reduced 33.7→23.3 days (10.4 days) with annual savings £234,000 (as cited)
Podiatry	Adopt prefabricated-first orthoses (reserve custom for complex cases)	Equivalent outcomes for common conditions at much lower unit cost	Evidence summary cited	£20–£60 prefabricated vs £200–£400 custom; £150–£350 saving per patient (as cited)
OT	Expand OT-led reablement services	Reduces ongoing social care packages; high probability of cost-effectiveness	Glendinning et al. evidence cited	60% reduction in ongoing social care costs; 98% probability cost-effective (as cited)
OT	Implement targeted OT home hazard modification for high-risk fallers	Strongest falls effect when targeted to prior fallers/high risk	Cochrane evidence cited	Falls reduced 26% overall; 38% in those with falls history (as cited); £7.50 health/care savings per £1 spent on adaptations (as cited)
OT	Deploy OT in ED/MAU for admission avoidance and “Home First”	Early functional assessment + rapid response supports safe non-admission	Examples cited (e.g., Rapid Response, EIV)	Admission avoidance described at 70–80% for certain models; Norfolk model ROI 9.6:1 (as cited)
OT	Implement PIFU across outpatient OT pathways	Reduces unnecessary scheduled follow-ups; supports prudent care	NHSE modelling + examples cited	0.8–1.8 fewer follow-ups per patient (modelling cited); example: 23% discharged to PIFU and only 18% re-accessed within 6 months (as cited)
OT	Expand telehealth OT (follow-up, hand therapy, some home assessments)	Improves access in rural geography; non-inferior outcomes for several conditions	Systematic reviews and time-saving evidence cited	Telehealth home assessment reduces median therapy time 160 → 40 minutes per encounter (as cited)
OT	Community OT for dementia (structured programme)	Improves function and carer competence; evidence of cost savings in cited model	Graff et al. evidence cited	Mean total costs €1,748 lower per dyad over 3 months; 94% probability of dominance (as cited)
OT	Seven-day OT / therapy services on acute wards	Improves discharge flow and reduces LOS	UK trust examples cited	Reported 2-day LOS reduction; 426 bed-days released; weekend discharges

				>60 per weekend in cited case example
OT	Delirium prevention pathway (HELP-style interventions)	Reduces delirium and falls; reduces downstream institutional care	HELP trial/meta-analysis cited	Delirium incidence reduced 40% (original trial cited); meta-analysis OR 0.47 for delirium and OR 0.58 for falls; cost savings per hospitalisation also cited
OT	Implement IPS/vocational rehabilitation (OT-linked model)	Reduces inpatient bed use and improves employment outcomes in serious mental illness	IPS economic evidence cited	“At least £20,000 per person over five years” savings cited; Danish RCT: IPS cheaper with better outcomes (as cited)

Planned Care

Domain	Value change	Clinical rationale	Evidence source	Scale of potential opportunity (if available)
Dermatology	Mandate store-and-forward teledermatology for all routine GP referrals	Safely triages lesions and inflammatory conditions; majority of referrals do not require face-to-face dermatologist review	25+ years evidence; Consultant Connect Wales data; Cardiff & Vale experience	40–50% referral avoidance; ~£200k–£300k p.a. avoided outpatient cost
Dermatology	Deploy AI-assisted skin cancer triage (DERM) on urgent suspected cancer pathway	AI sensitivity comparable to dermatologists and superior to GP assessment; safely discharges benign lesions	NICE HTE24 (May 2025); NHS England pilots; Skin Analytics deployments	~50% reduction in USC referrals; £1.70–£2.30 ROI per £1; ~900 appointments saved per 10k referrals
Dermatology	Expand GPwER and nurse-led lesion assessment clinics	Extends workforce capacity in context of consultant shortage; high diagnostic concordance	Salisbury et al. BMJ; BAD frameworks; GIRFT dermatology	Up to 50–80% of referrals managed outside consultant clinics
Dermatology	Implement PIFU for stable chronic dermatology conditions	Majority of scheduled follow-ups add limited value; patients rarely re-present	GIRFT; NIHR PIFU evaluations; Swansea Bay PKB use	~30% reduction in follow-ups; significant consultant time release
Dermatology	Home phototherapy for psoriasis	Clinically equivalent to hospital phototherapy; avoids biologics escalation	NHS Tayside rural model; BAD guidance	£229–£314 per course vs £7k–£12k biologics; £135k–£235k p.a. for ~20 patients

Endoscopy	Full FIT triage compliance for symptomatic lower GI referrals	FIT safely rules out colorectal cancer and prevents unnecessary colonoscopy	NICE DG56; NHS England modelling	Prevents >100,000 colonoscopies nationally; £5 test vs £372 procedure
Endoscopy	Surveillance list validation against 2019 BSG guidance	Large proportion of surveillance colonoscopies no longer indicated	BSG 2019; JAG	Up to 70% reduction in surveillance demand (zero-cost intervention)
Endoscopy	Nurse-led Cytosponge service for Barrett's pathway	Discharges majority of reflux patients without gastroscopy	BEST3 RCT; NHS England pilots; HTW guidance	78% discharged without endoscopy; ~£400 saving per patient
Endoscopy	Transnasal endoscopy for diagnostic gastroscopy	No sedation; faster throughput; nurse-delivered	NHS Supply Chain; Cardiff & Vale pilot	~30% unit cost reduction; ~£95k p.a. per typical DGH
Endoscopy	AI-assisted polyp detection at colonoscopy	Improves adenoma detection, reducing repeat surveillance	NICE draft GID-DG10118; HTW guidance	Minimal marginal cost; long-term reduction in repeat scopes
ENT	Direct-access community audiology and ear-care pathways	Majority of ENT referrals are non-surgical hearing conditions	NICE NG98; GIRFT ENT	40–50% demand diversion from ENT clinics
ENT	Strict application of EBI criteria (tonsillectomy, grommets)	Large volumes of surgery deliver limited or no benefit outside criteria	NATTINA; Cochrane; NHS EBI programme	Removes substantial proportion of patients from surgical waiting lists
ENT	Advice & Guidance via Consultant Connect	Specialist advice resolves referrals without outpatient attendance	Consultant Connect Wales data; GIRFT	~30–70% referral avoidance depending on pathway
ENT	PIFU for stable ENT follow-up	Follow-ups drive disproportionate clinic load	ENT UK PIFU guidance; GIRFT	25–40% reduction in follow-ups
ENT	One-stop neck lump clinics	Low cancer conversion but high clinic burden; one-visit diagnosis	Wolverhampton & UK series	Fewer appointments per patient; cancer pathway capacity release
Ophthalmology	Expand community optometry monitoring (WGOS 4)	Stable glaucoma and retina safely managed in primary care	WGOS data; Swansea ODTG; RCOphth	Up to 80% of stable glaucoma patients retained in community
Ophthalmology	SLT as first-line glaucoma treatment	Drop-free control; fewer visits and surgeries	LiGHT trial; NICE NG81	£451 saving per patient; 97% cost-effective
Ophthalmology	HVLC cataract lists and ISBCS	Dramatically increases throughput per session	GIRFT; BICAT-NL RCT	25–59% productivity gain; ~£345 saving per patient
Ophthalmology	Nurse-led injection services	Safe, effective substitution for consultant delivery	Moorfields & GWH audits	Frees consultant capacity; no safety penalty

Ophthalmology	Biosimilar switching and longer-acting agents (faricimab)	Reduces visit frequency and drug spend	NICE TA800; TENAYA/LUCERNE	Halves injection visits for majority; material recurrent savings
T&O	Eliminate low-value surgery (arthroscopy, shoulder decompression)	Strong RCT evidence of no benefit over conservative care	NEJM, CSAW, EBI	15–20% of elective activity avoidable
T&O	First Contact Physiotherapists as default MSK entry point	Majority of MSK presentations managed without secondary care	BJGP trials; NHS evaluations	~40–67% reduction in orthopaedic referrals
T&O	Structured exercise programmes (ESCAPE-pain / GLA:D)	Delays or avoids joint replacement with better outcomes	NICE CG177; ROI studies	£8.83 return per £1; major demand reduction
T&O	PROMs-driven shared decision-making	Identifies patients unlikely to benefit from surgery	Welsh PROMs; registry data	10–20% reduction in surgical conversion
T&O	PIFU and virtual fracture clinics	Follow-ups are largest avoidable volume	GIRFT; Glasgow VFC model	20–30% follow-up reduction; ~65% virtual discharge
Urology	mpMRI-first prostate cancer pathway	Avoids unnecessary biopsy; faster diagnosis	PROMIS; PRECISION; NICE NG131	~27–28% avoid biopsy; 28-day faster diagnosis
Urology	Transperineal prostate biopsy under local anaesthetic	Eliminates sepsis risk; day-case delivery	TRANSLATE; PREVENT trials	Near-zero sepsis; bed-day avoidance
Urology	Advice & Guidance for benign urology	Majority of LUTS and BPH manageable in primary care	GIRFT/BAUS toolkit	~25–40% referral avoidance
Urology	Nurse-led cystoscopy and haematuria clinics	Expands diagnostic capacity without consultants	BAUS evidence; UK series	Significant cancer pathway capacity release
Urology	Minimally invasive BPH treatments (UroLift/Rezum)	Day-case alternatives to TURP with better recovery	NICE MTG49/58	£569–£1,242 saving per patient
Follow-up	Systematic PIFU / SOS adoption across specialties	Most follow-ups add little clinical value	NIHR; GIRFT; NHS England	20–30% reduction in follow-ups; 30k–50k slots p.a.
Follow-up	Clinic template standardisation	Variation wastes capacity within existing sessions	GIRFT Further Faster	15–30% capacity gain without pathway change
Follow-up	Virtual and asynchronous follow-up	Reduces DNAs, travel burden, and clinician time	TEC Cymru; systematic reviews	DNA reduction ~50%; high patient satisfaction
Follow-up	Condition-specific remote monitoring	Replaces visits with higher-value data	NICE DG61; disease-specific trials	50–70% reduction in routine follow-ups (condition-dependent)

Mental Health and Learning Disabilities

Domain	Value change	Clinical Rationale	Evidence Source	Scale of potential opportunity (if available)
ND	Deploy QbTest across all four hospital sites	Reduces clinician time and speeds diagnostic decisions for ADHD assessment; increases diagnostic confidence	NICE DG60; AQUA RCT; real-world service evaluations summarised in appraisal	20–30% reduction in clinician assessment time; 30% capacity increase; time to diagnosis reduced by 153 days; ROI £5.97 per £1; 4 devices = £2,140 annual licence plus per-test cost
ND	Introduce nurse-led ADHD assessment pathways (with supervision and NMP development)	Specialist nurses can diagnose and manage ADHD with training; reduces dependence on consultant psychiatrists	Dundee pathway evidence; UKAAN standards described; systematic review noting no significant prescribing differences (nurse vs doctor)	Cost per assessment reduced from £900–£1,500 (consultant-led) to £400–£700 (nurse-led); 4 Band 7 nurses could deliver 600–800 additional assessments/year
ND	Implement pharmacist-led titration/monitoring (independent prescribers)	Offloads titration workload (3–4 weekly reviews over 12–16 weeks) from medical/nurse teams; improves physical monitoring adherence	Hertfordshire CAMHS example; pharmacist-run clinic evidence summarised in appraisal	2 Band 8a pharmacist prescribers (£150k–£160k p.a.) to release capacity equating to 400+ additional assessments
ND	Implement tiered autism assessment (triage + single-clinician standard + MDT complex)	Reserves full MDT assessment for complex cases; reduces average assessment time without compromising diagnostic quality for straightforward presentations	NHS England framework permitting single-clinician standard assessment; RE-ASCeD findings summarised	30–40% reduction in average assessment time across caseload (as described); tiered “Tier 2” standard assessment cost stated at £400–£600 vs ~£850 MDT median (child)
ND	Create combined neurodevelopmental pathway (ADHD + ASD single point of access)	High co-occurrence; reduces duplicated history taking and multiple queues; improves patient flow	Co-occurrence evidence; Peterborough integrated pathway; direction of policy described in appraisal	Removes dual waiting; appraisal estimates total annual investment £615k–£780k could deliver 1,500–2,500 additional assessments/year and clear

				backlog in ~3–5 years (modelled)
ND	Active waiting list validation and digital pre-assessment questionnaires	Removes inactive cases and reduces clinician time per assessment; improves triage quality	Operational evidence described in appraisal (validation typical 10–20% reduction; digital pre-assessment saves 30–45 mins)	10–20% waiting list reduction via validation; 30–45 minutes clinician time saved per assessment via digital pre-assessment (as described)
ND	Negotiate funded shared care and replace “re-enter NHS queue” policy for private diagnoses with verification	Shared care rejection is a bottleneck; current approach forces privately diagnosed patients back into NHS assessment queue	Shared care acceptance rate in Wales cited; appraisal’s prescribing strategy section	Wales shared care acceptance cited at 19%; addressing this unlocks prescribing capacity and reduces repeat assessment demand (quantified acceptance rate given)
Crisis management	Extend adult sanctuary / crisis café provision to 7 days per week across all three counties	Provides face-to-face alternative to A&E/inpatient on nights currently uncovered; reduces admissions and detentions	Aldershot Safe Haven outcomes summarised; Welsh sanctuary gap analysis	Appraisal states crisis alternatives could reduce psychiatric admissions by 20–30%; current adult provision operates 4 days/week leaving 3 days with no adult face-to-face alternative
Crisis management	Establish a 6-bed adult crisis house (first in Wales), hub-and-spoke model	Residential alternative for people too unwell for home but not requiring ward admission; shorter stays at lower cost with higher satisfaction	Alternatives Study; systematic reviews and RCT evidence described; cost comparisons provided	£200–£300 per night (7–14 days) vs £450–£550 per night (42 days) for ward; breaks even diverting 26–42 admissions/year; per diverted admission saving ~£19,250 (as modelled)
Crisis management	Measure and improve CRHTT fidelity (CORE CRT scale), strengthen gatekeeping and (where feasible) 24/7 effectiveness	CRT effectiveness depends on fidelity and gatekeeping; structured fidelity improvement reduces admissions	CORE CRT Fidelity Scale; national audit showing no teams at high fidelity; CORE cluster-RCT evidence summarised	Fidelity improvement support produced mean 8.1-point increase and associated fewer admissions (as described); appraisal notes rural staffing needs may require enhanced WTE due to travel
Crisis management	Re-establish street triage / control-room mental health triage with police (especially	Reduces Section 136 use and inappropriate conveyance; prevents gaps created by police	Dyfed Powys pilot data and national comparators summarised	Pilot cited: 25 Section 136 detentions averted early; comparator scheme cited

	after Right Care Right Person)	withdrawal from health-only calls		56% reduction; Section 136 event cost estimated £1,650–£2,430
Crisis management	Embed peer support in crisis step-down and ensure follow-up within 24–72 hours	Step-down contact reduces repeat attempts/readmissions; peer support reduces readmissions	Lancet RCT of peer supported self-management; follow-up meta-analysis described	Peer support RCT: 29% readmission vs 38% control; step-down follow-up meta-analysis pooled RR 0.48 for repeat attempts (as stated)
Crisis management	Use cost substitution logic to reduce out-of-area placements and inpatient spend	Crisis alternatives are lower cost per episode and can substitute for high-cost beds	Cost gradient table and admission reduction modelling in appraisal	Out-of-area placements cited up to £2,000/night; admission reduction modelling: 10% = £1.47m NHS bed savings; 20% = £2.94m; 30% = £4.41m (as modelled)
Follow up	Systematic CMHT caseload review and structured step-down/discharge programme	Evidence suggests 20–50% of CMHT caseload may be stable and manageable in primary care; reduces unproductive follow-up	Evidence and exemplars summarised; Welsh Measure Part 3 safety net highlighted	Releasing 20% could free 3–5 WTE community practitioners and avoid £600k–£2.4m annual secondary care costs (as stated)
Follow up	Substitute consultant follow-ups with nurse/pharmacist non-medical prescriber clinics (medication review, depot, lithium, clozapine pathways)	Shifts routine follow-up off consultants to preserve scarce medical time for complex care; supports safer, standardised monitoring	Scoping review of 63 studies on NMP; examples listed in appraisal	Target stated: redirect 40% of consultant follow-up PAs; workforce requirement described as 2–3 additional non-medical prescribers (Band 7–8a)
Follow up	Implement Patient Initiated Follow-Up in secondary mental health with safety-net contacts	Reduces routine follow-ups that show little outcome benefit; supports patient choice and reduces travel burden	NHS Greater Glasgow and Clyde PIFU programme described; NHS England ambition referenced	Target stated: 25% reduction in routine follow-ups; typical reductions cited 25–30% in other specialties; high mental health DNA baseline (14–20%) highlights waste to reclaim
Follow up	Digital-first follow-up (telephone/video default for “functional” appointments) with digital exclusion mitigation	Suitable for medication reviews and stable follow-ups; improves access across rural geography; must address severe mental illness digital exclusion	TEC Cymru and Wales-wide evidence described; digital exclusion evidence summarised	Target stated: 50% of routine follow-up delivered virtually; digital exclusion cited: 42.2% of people with severe mental illness lack basic digital skills

Follow up	PRISM-type integrated primary-secondary model (co-locate MH practitioners in GP practices with virtual psychiatrist clinics)	Improves flow and reduces acute demand by integrating care around primary care clusters	PRISM model outcomes cited in appraisal	Integrated cohort outcomes: A&E attendances down 61%, inpatient admissions down 75%, GP appointments for comorbid conditions down 73% (as stated)
Follow up	Strengthen safety-critical discharge and follow-up standards (72-hour post-discharge follow-up, family engagement, audit)	Post-discharge risk is high and non-attendance is associated with readmission; safety net must underpin optimisation	NCISH and HIW findings summarised; safety features described	Post-discharge suicides cited as 11% of patient suicides; 72-hour follow-up compliance in England cited 73.5% (target 80%); DNA follow-up after admission linked to 25% readmission vs 10% for attenders
Follow up	Establish a low-intensity workforce (MHWP/PWP equivalent) to scale guided self-help and behavioural activation	Wales lacks the low-intensity layer that enables scale in England; low-intensity treats high volumes at lower unit cost	PWP model, cost per recovered patient and workforce details described in appraisal	10 MHWPs estimated to cost ~£560k p.a. and deliver ~2,500 treatment courses/year; cost per recovered patient cited ~£1,043 low intensity vs ~£2,895 high intensity (as stated)
Follow up	Scale blended digital CBT (digital modules + brief supporter contact)	Digital-only completion is poor; blended models improve uptake/adherence and reduce face-to-face session requirement	SilverCloud national use described; evidence on supported vs unsupported cCBT and blended adherence summarised	Blended model described: uptake ~91% and adherence ~81% vs ~22% uptake for digital-only; halves face-to-face sessions (10 vs 20) (as stated)
Follow up	Expand group therapy programmes (psychoeducation, group CBT, MBCT) including virtual groups	Group delivery reduces cost per patient while maintaining comparable outcomes for many conditions; suitable for rural areas via virtual delivery	Meta-analyses on group vs individual CBT; MBCT evidence; online group review cited	Group therapy cost reduction stated 75–87.5% (groups of 8–12); estimated 500–1,000 additional treatment courses/year at ~1/4 of individual cost (as modelled)
Follow up	Train existing staff rapidly in behavioural activation and expand delivery (including group BA)	BA is NICE-recommended, comparable effectiveness to CBT, lower cost, and can be delivered after short training	Meta-analysis comparisons and training duration described in appraisal	Training cost cited £30k–£50k for 20 staff; impact cited 500–1,000 additional treatment courses/year; time to impact 2–3 months (as stated)

Follow up	Implement active waiting list management (SMS reminders, opt-in confirmation, immediate Step 1–2 interventions)	Long waits increase DNA and deterioration; active waiting reduces waste and risk while patients wait	Evidence on DNA and SMS effects; rapid intake model described in appraisal	Patients waiting >180 days are 10× more likely to DNA; SMS reminders reduce DNAs by 25–28%; projected 15–25% reduction in wasted capacity from DNAs (as stated)
Follow up	Introduce self-referral / single point of access via 111 Option 2	Improves access and outcomes; reduces GP bottleneck and improves reach to underserved groups	IAPT self-referral benchmark and Hywel Dda 111 Option 2 pathway direction described	Estimated 15–25% increase in appropriate referrals based on IAPT experience (as stated)
Follow up	Implement systematic session-by-session outcome monitoring (PHQ-9/GAD-7 model)	Enables benchmarking, recovery measurement, early non-response detection and efficient stepping	IAPT completeness benchmark and PCMIS features described in appraisal	Impact described: 10–15% recovery improvement; 25% reduction in sessions via earlier non-response detection (as stated)

Chronic Conditions

Domain	Value change	Clinical Rationale	Evidence Source	Scale of potential opportunity (if available)
ACSC	Scale community IV therapy / OPAT for cellulitis (plus selected complicated UTI and low-risk pneumonia)	Safely treats IV-antibiotic eligible patients without admission; large bed-day release with equivalent outcomes	NHS England OPAT business case; BSAC registry; RCT evidence for outpatient IV antibiotics in cellulitis; service examples cited	Hywel Dda estimate: 6,000–8,000 avoidable admissions and £20–35m annual spend; OPAT average 16 avoided inpatient days per patient; OPAT delivered at 20–50% of inpatient cost; 10% reduction frees 4,000–5,500 bed days (~12–15 beds)
ACSC	Improve continuity of primary care (organisational/scheduling change)	Near-zero marginal cost intervention associated with fewer ACSC admissions, strongest for hypertension/anaemia	Practice-level cross-sectional study and longitudinal studies cited in report	9% reduction in ACSC admissions associated with better continuity; least continuity associated with 2.27× higher hazard of emergency admission in older patients
ACSC	Expand and protect Same Day Emergency Care (SDEC)	Enables ambulatory management of high-volume	NHS Long Term Plan target; Directory of Ambulatory	Wales SDEC: ~7,500 people/month access and ~80% discharged same day; high-performing units reduce

	pathways (incl. paramedic direct referral)	acute presentations that are often admitted by default	Emergency Care; Wales SDEC programme and direct paramedic referral policy cited	admissions 25–30%; cost savings per avoided admission £1,000–£3,000 depending on condition
ACSC	Implement targeted structured medication reviews (SMRs) in primary care (high-risk meds)	Preventable adverse drug events drive avoidable admissions; focusing on high-risk drugs addresses multiple ACSCs	Evidence on proportion of admissions attributable to adverse drug events; mapping of implicated drug classes in report	Preventable adverse drug events estimated at 5–8% of all hospital admissions; intervention targets (e.g., diuretics, NSAIDs, anticoagulants, antihypertensives) align with ACSCs
ACSC	Population-scale home blood pressure monitoring (with telemonitoring support)	Low-cost tool to improve BP control and address fastest-growing ACSC (hypertension admissions)	TASMINH4 and programme evidence cited	Hypertension admissions cited as +122% post-pandemic; BP monitors ~£20 per patient; self-monitoring + telemonitoring reduced SBP by 3.4–4.4 mmHg in trial evidence cited
ACSC	Accelerate HealthPathways as integrating platform (extend to ambulance and pharmacies)	System capability approach reduces multiple ACSCs simultaneously through standardised pathways and rapid advice	Canterbury comparator and HealthPathways adoption in Wales described	Canterbury: 30% fewer admissions than national average; Hywel Dda has already adapted 100+ pathways and is advised to scale further (report target given)
COPD	Deliver the “basic COPD care” bundle reliably (PR, smoking cessation, vaccinations, self-management plan, comorbidity optimisation)	Large outcome gap because most patients miss proven basics; closes evidence-to-practice gap	Asthma + Lung UK Cymru survey findings cited; guideline alignment referenced	Only 7% of COPD patients in Wales received all five elements of basic care (down from 17%); Hywel Dda COPD emergency admission spend estimated £4–6m/year
COPD	Scale pulmonary rehabilitation, including virtual models (build on VIPAR) and fast-track post-exacerbation PR	PR has definitive evidence for QoL and function; post-hospital PR reduces readmissions; virtual delivery mitigates rural travel barrier	Cochrane evidence (PR RCTs); Thorax 2024 post-exacerbation meta-analysis; Hywel Dda VIPAR described	Hywel Dda had lowest PR referral rate in Wales at 31% (audit cited); post-hospital PR reduces readmissions OR 0.48; PR ~£280 per patient and cost-effective at £2,000–£8,000 per QALY
COPD	Implement Hospital at Home for exacerbations using DECAF risk stratification	Reduces readmissions and bed days; high patient preference; admission avoidance alternative to default hospitalisation	Cochrane review; DECAF-directed model evidence cited; NICE NG115 recommendation noted	Cochrane: readmission RR 0.76; DECAF model saved £1,016 per patient over 90 days and achieved fivefold reduction in median bed days; 90% patient preference cited
COPD	Standardise and enforce COPD discharge bundle	Addresses post-discharge failure point driving high readmissions	National implementation data	UK evaluation: bundle completion 2.2% (admission) and 7.6% (discharge); London readmission

	completion with compliance tracking		and London bundle outcomes cited	trend shifted from +2.13%/yr to -5.32%/yr post-implementation
COPD	Implement community pharmacy COPD programme (inhaler technique + adherence protocol)	Inhaler errors are common and linked to exacerbations; pharmacies are accessible across rural footprint	PHARMACOP trial evidence summarised	PHARMACOP: inhaler technique +13.5%, adherence +8.5%, and 72% reduction in hospitalisation (rate ratio 0.28) with protocolised pharmacist care
COPD	Run targeted case-finding (high-risk smokers, structured screening)	Early diagnosis with guideline care reduces utilisation; misdiagnosis wastes resources	TargetCOPD and COPD-UCAP trial evidence cited	TargetCOPD: new diagnosis rate 7.45× routine care; COPD-UCAP: 52% reduction in respiratory healthcare utilisation (IRR 0.48) with early diagnosis + guideline care
COPD	Prioritise smoking cessation with high-ROI models	Largest disease-modifying lever; strongest prevention economics	Lung Health Study; pharmacotherapy evidence; CURE model cited	Sustained quitters: FEV1 decline 31 ml/yr vs 62 ml/yr; CURE model cost per QALY £487 and public value return £30.49 per £1 invested (as cited)
Frailty	Deploy CGA-based Hospital at Home (frailty-focused, rural-adapted hub-and-spoke)	Strongest combined evidence for keeping people alive and at home; reduces residential care placement and costs	Cochrane CGA evidence; Cochrane Hospital at Home evidence; UK multisite RCT results cited	Hospital at Home reduces residential care placement RR 0.53; UK CGA-HaH RCT cited £2,265 savings per person and 3 fewer hospital days at 1 month; “Frailty virtual ward” example cited 96% admission avoidance in one programme; CGA cost-effectiveness cited
Frailty	Scale Otago Exercise Programme (target high-risk older adults)	High-certainty evidence for falls reduction; designed for home delivery and rural applicability	Cochrane-level evidence summarised; Otago RCT evidence cited	Otago reduces falls 35–40%; cost ~£218 per participant/year; net benefit £903 per participant after prevented falls (figures cited)
Frailty	Proactive frailty identification (eFI2) + anticipatory care planning	eFI2 is a zero-marginal-cost case finder; ACP reduces hospital deaths and readmissions when implemented	eFI/eFI2 validation evidence cited; ACP evidence cited	HomeHealth RCT cited: 35% reduction in emergency admissions (IRR 0.65) and incremental costs -£796; ACP: low baseline (only 4.8% with evidence of ACP) and strong association with preferred place of death metrics cited
Frailty	Systematic medication review and deprescribing (STOPP/START, STOPPFrail,	Polypharmacy amplifies frailty harm; high prevalence of	STOPP/START and STOPPFrail evidence; anticholinergic-falls	Frail inpatients: ~10 meds average; potentially inappropriate prescribing up to 60% in nursing homes;

	STOPPFall; focus anticholinergic burden)	inappropriate prescribing especially in nursing homes	interaction evidence cited	STOPPFrail RCT reduced meds by 2.6 per patient; anticholinergic drugs in frail: falls OR 3.84 (as cited)
Frailty	Embed delirium prevention bundles (HELP/POD style) with mandated screening (4AT)	Delirium increases mortality and admission likelihood; substantial preventable fraction with low-cost bundle	HELP evidence and POD programme evidence cited	Delirium preventable 30–40%; HELP reduced delirium 40%; POD programme cited incremental net monetary benefit £2,200 per patient and cost-effectiveness £1,057 per QALY; hip fracture delirium prevention cited very high net benefit
T1D	Expand CGM and hybrid closed-loop (HCL) with explicit equity strategy and workforce enablement	Largest glycaemic/time-in-range gains; strongest value in those with poor control; reduces hypoglycaemia and complications	DIAMOND, GOLD, HypoDE, ADAPT, Control-IQ and NICE TA943 evidence summarised	ADAPT: HbA1c reduction 1.4% and TIR +26.7–28.1 points in high HbA1c group; NICE TA943 cites ICER £12,398/QALY using higher baseline HbA1c pilot data; report notes potential to avoid £3–5m annually in complications/emergency costs within 5 years
T1D	Maximise structured education throughput (DAFNE; plus accessible resources)	Highest value, lowest cost intervention; reduces DKA and severe hypoglycaemia; cost-saving	DAFNE RCT and real-world audit; Sheffield model; REPOSE pump cost-effectiveness cited	DAFNE reduces DKA 62% and severe hypo requiring emergency treatment 82%; cost-saving (dominant) with lifetime saving £1,494 per patient (model cited); pumps on top of DAFNE cited £142,195/QALY (REPOSE)
T1D	Implement Diabetes & Emotional Health “7 A’s” across teams + routine distress screening; add integrated psychology capacity (3DFD logic)	Psychological distress is common and drives poor control and admissions; integrated approach reduces utilisation	Diabetes distress prevalence evidence; 3DFD outcomes cited; 7 A’s model cited	Diabetes distress affects 20–42%; 3DFD model cited: 45% drop in A&E visits, 43% fewer admissions, 22% fewer bed days and £850 saved per patient
T1D	Adopt virtual clinic model for routine tech reviews (remote data review)	Matches rural geography; frees face-to-face capacity for initiation and complex care	Telehealth equivalence evidence summarised in report	Expected impact stated: 30–40% reduction in routine face-to-face appointments (as described), enabling workforce redeployment to technology initiation
T1D	Strengthen transition service (young adult clinics +	Transition period is peak risk for DKA and disengagement;	Holmes young adult clinic evidence; other	Dedicated young adult service cited: 0.5% HbA1c improvement, one-third

	coordinator; structured transition framework)	structured models improve attendance and reduce DKA	transition studies summarised	DKA reduction, and programme costs covered by reduced admissions (as described)
T1D	Pregnancy pathway: universal CGM/HCL for T1D pregnancy + structured pre-conception programme	Improves neonatal outcomes and reduces NICU admissions; cost-saving	CONCEPTT trial; AiDAPT trial evidence summarised	CONCEPTT: LGA reduced 49%, NICU admissions >24h reduced 52%, neonatal hypoglycaemia reduced 55%; NNT 6 to prevent one NICU admission; cost saving ~£2,500 per pregnancy cited
T2D	Fix albumin-to-creatinine ratio (ACR) testing gap and protocolise renal protection (SGLT2i + finerenone where indicated)	Biggest missed window for preventing/delaying CKD progression and dialysis	DAPA-CKD, CREDENCE, FIDELITY evidence summarised; Wales ACR testing gap cited	Wales ACR check cited 17%; Hywel Dda annual return modelled £500k–£1.2m with ROI 8:1–15:1 (Tier 1 business case)
T2D	Switch suitable patients from sulfonylureas to SGLT2 inhibitors (cardio-renal protection)	Reduces hypoglycaemia risk and provides HF/renal protection; generic SGLT2 now low cost	EMPA-REG, DAPA-HF, DAPA-CKD and class evidence summarised	Generic dapagliflozin cost cited ~£150–200/year; Tier 1 return modelled £200k–£400k annually with ROI 5:1–8:1 (as stated)
T2D	Establish Type 2 diabetes remission programme (DiRECT-style total diet replacement)	Evidence of remission and long-term cost saving; reduces complications and medication need	DiRECT trial + follow-up; NHS T2DR programme outcomes cited	DiRECT: 46% remission at 12 months; 36% at 24 months; lifetime saving £1,337 per participant cited; Tier 2 investment £250k–£350k/yr (200–250 participants) with returns rising over time
T2D	Scale structured education (DESMOND / X-PERT; include digital and Welsh-language delivery)	Improves glycaemia and reduces medication escalation; cost-effective	DESMOND and X-PERT evidence summarised	DESMOND real-world ICER cited £2,092/QALY; X-PERT HbA1c effect and NNT cited (NNT 4 to prevent medication escalation)
T2D	Strengthen multidisciplinary foot team coverage and rapid access	Prevents amputations and deaths; mandated pathways	NICE NG19 requirement; systematic review evidence summarised; Wales diabetic foot data cited	MDFT reduces major amputations 38–80% (range cited); Hywel Dda DFU prevalence estimate 2–2.5% of diabetes population at any time (as cited)
T2D	Expand prevention and early detection (AWDPP plus pharmacy FINDRISC screening)	Prevention evidence base is among strongest in medicine; pharmacy is accessible channel	DPP/DPS/Da Qing evidence summarised; AWDPP described	Hywel Dda prediabetes estimate 35,000–42,000; AWDPP described (brief intervention model) and early evaluation noted; pharmacy screening cost cited £28.65 per person (as cited)

Heart failure	Scale the four-pillar GDMT rapid optimisation using pharmacist-led One-Stop Clinics (STRONG-HF style)	Strongest preventable mortality lever; rapid titration reduces death/readmission	STRONG-HF evidence; One-Stop clinic performance described	STRONG-HF: 34% reduction in death or HF readmission; Hywel Dda clinics reduced optimisation time from 63 weeks to 7.4 weeks (as stated)
Heart failure	Establish a dedicated heart failure virtual ward (admission avoidance + early supported discharge)	Reduces admissions/readmissions and is lower cost per bed-day; fits rural model using existing telehealth base	Liverpool and Imperial programme evaluations cited; Hywel Dda telehealth base noted	Liverpool: net cost benefit £1,135 per patient; Imperial: 74% reduction in admissions and 57% reduction in A&E attendance (as cited); projected package net annual benefit £1.2–£1.8m cited for integrated programme
Heart failure	Expand heart failure specialist nurse capacity for post-discharge follow-up	Nurse-led follow-up reduces death/readmission and days in hospital	Blue et al. RCT and systematic review evidence cited	Blue et al.: 39% reduction in death or HF readmission; HF admissions reduced from 45 to 19 and mean HF bed days halved (as described); report models staffing need and returns
Heart failure	Systematic iron deficiency screening + IV iron infusion service	Treatable driver of symptoms and admissions; IV iron reduces HF hospitalisations	FAIR-HF, CONFIRM-HF, AFFIRM-AHF, IRONMAN, meta-analysis evidence cited	AFFIRM-AHF: 26% reduction in HF hospitalisations; meta-analysis cited RR 0.72; up to 50% of HF patients iron deficient (as stated)
Heart failure	Close diagnostic gap via NT-proBNP rule-in/rule-out and targeted screening of high-risk groups	Many HF cases undiagnosed; NT-proBNP is effective gateway to echo and early therapy	NICE diagnostic thresholds; STOP-HF; ECHOES; SOLVD prevention evidence cited	Estimated HF burden 7,500–8,500 vs ~3,500 on GP registers (diagnostic gap 4,000–5,000); STOP-HF: 45% reduction in new LV dysfunction/HF and 40% reduction in emergency CV hospitalisations (as cited)
Heart failure	Spread advanced HF supportive/palliative care pathway across counties	Improves QoL and avoids futile admissions near end of life	PAL-HF trial evidence; Pembrokeshire pathway outcomes described	Pembrokeshire pathway: 100% satisfaction on feeling listened to and 86% agreement on improved care coordination (as stated)
Heart failure	SGLT2 inhibitor optimisation across HFrEF and HFpEF	Disease-modifying across EF spectrum; reduces HF hospitalisation	DAPA-HF, EMPEROR-Reduced, EMPEROR-Preserved, DELIVER and NICE appraisals cited	DAPA-HF: NNT 21; HFpEF approvals and ICERs cited (e.g., HFpEF ICER £8,715/QALY); report sizes HFpEF cohort (~2,600–3,000) from its HF estimates

National Enabling Actions

Strategic priority	Enabling action (national wording)	Translated action	Key metric / deadline (from Annex)
Productivity	Utilisation of total factor productivity model; set out actions and quantified productivity impact to increase total productivity from baseline	Use TFP as the single productivity framework: baseline, interventions, quantified impact by driver (workforce, theatres, diagnostics, flow), and quarterly assurance reporting.	Quantified productivity increase in 2026/27 from baseline
Mental Health	Material reduction in out of area placements in 2026/27 and associated costs	Deploy crisis alternatives, caseload review, step-down / repatriation governance, and placement challenge panels with weekly grip.	Material reduction (no numeric target specified in Annex)
Timely Access to Care	Improve implementation and delivery of HVLC theatre lists: cataract, arthroplasty, HVLC general surgery	Standardise theatre templates, list discipline, and case selection. Use HVLC as default where clinically appropriate and monitor list productivity.	Cataract: 90% lists 7 per list by end Q2; Arthroplasty: 90% lists 4 primary joints/day by end Q2; General surgery: 90% time achieve ≥6 HVLC procedures/all-day list by end Q2
Building Community Capacity	Support rollout of NHS Wales app incl. uptake for repeat prescriptions	Target adoption by designing repeat prescribing default pathways; reduce transactional practice activity.	Uptake for repeat prescriptions (no numeric target specified)
Maximising Value for Money	Non-pay: implement Value & Sustainability Board recommendations incl. mandated product choice	Lock in standard product choice, maximise market share and remove unwarranted variation; monthly compliance reporting.	Implementation of VSB recommendations (no numeric target specified)
Maximising Value for Money	Medicines Management: implement high value medicines VSB programme delivering opportunities across programme areas	Implement switching and pathway optimisation for high-value medicines; ensure uptake across teams and sites.	Deliver opportunities against programme areas (no numeric target specified)
Maximising Value for Money	Estate: strengthen actions to improve estate utilisation incl. repurposing & disposal of under-utilised estate	Estate utilisation reviews; repurpose/dispose where appropriate; link to CSP configuration and non-pay savings.	Improved utilisation including repurposing/disposal (no numeric target specified)

Maximising Value for Money	CHC: implement VSB recommendations incl. actions to improve clinical and financial effectiveness of packages of care	Standardise CHC review cadence, challenge panels, and package optimisation with clinical leadership.	Implementation of VSB CHC recommendations (no numeric target specified)
Improving Value, Optimising Outcomes & Minimising Variation	Progress with VSB HVHI pathway – Bone Health	Implement proactive fracture risk identification, treatment optimisation, and falls/fracture pathway redesign.	Progress with pathway (no numeric target specified)
Workforce Productivity	Job planning: >90% consultants have agreed job plan at all times by 30 Sep 2026 aligned to demand/capacity	Job planning compliance becomes a capacity management tool; align PAs to service demand and productivity metrics.	>90% by 30 September 2026
Workforce Productivity	Agency expenditure: sustained reduction; target 30% reduction in 2026/27 from 2025/26 outturn and no off-contract	Tighten controls, eliminate off-contract, shift to substantive/bank and improve roster discipline.	30% reduction in 2026/27 from 2025/26 outturn; no off-contract
Workforce Productivity	Fully implement Variable Pay & Agency Control Framework WHC	Full compliance with WHC actions; embed assurance and escalation on exceptions.	Full implementation (no numeric target specified)
Workforce Productivity	HSW/Admin/Estates&Ancillary agency: those not yet at zero to deliver zero by 30 Sep 2026	Targeted elimination plan by staff group; standard controls and reporting.	Zero by 30 September 2026 (for orgs not already there)
Workforce Productivity	Reduce sickness absence in 2026/27 vs 2025/26 through adherence to attendance policies and OH minimum service levels	Strengthen attendance management; standardise OH access and line management interventions.	Reduction vs 2025/26 (no numeric target specified)
Timely Access to Care	Full implementation of National Optimal Pathway (NOPs) in Cancer	Implement pathway discipline, straight-to-test, and diagnostic sequencing per NOPs; track compliance.	Full implementation (no numeric target specified)
Timely Access to Care	Theatre session utilisation improved to GIRFT standard of 85%; late starts/early finishes/overall utilisation KPIs underpin standard	Introduce utilisation KPIs, address late start/early finish causes, enforce list discipline and schedule control.	85% utilisation standard; KPIs for late starts (>15 mins) and early finishes (>60 mins)

Timely Access to Care	Consistent clerical and clinical validation using national SOP: any patient waiting >26 weeks validated	Routine validation of >26 week waits, with oversight of non-admitted closed pathways volumes as proxy.	Validate all >26 week waits (no numeric beyond threshold); monitor closed pathways volumes
Timely Access to Care	Referral return rate of 20+% and/or reduced referral rate per 100,000 by Dec 2026 using Health Pathways optimally	Use referral optimisation, Advice & Guidance, and pathway discipline to reduce inappropriate referrals.	≥20% referral return rate by December 2026 and/or reduced referral rate per 100,000
Timely Access to Care / UEC	Ambulance handovers: all within max 45 mins; aim >90% in 15 mins by end 2026/27	Front door streaming, early discharge focus, and flow discipline to meet handover standards.	Max 45 mins; aim >90% in 15 mins by end 2026/27
UEC	Deliver all OHFF principles incl. 7-day working, leaner processes, efficient discharge transport, increasing weekend discharges	Adopt OHFF minimum principles across sites; track weekend discharge and transport efficiency.	Deliver minimum principles (no numeric target specified)
UEC	Deliver SDEC and acute frailty services at front door in line with national policy and AFS Framework	Implement SDEC/AFS front-door models and staffing; align with six goals programme.	Deliver in line with policy (no numeric target specified)
UEC	Deliver community-based falls response framework and prevention/early intervention	Implement falls response in community; integrate with prevention work.	Deliver minimum principles (no numeric target specified)
UEC	Deliver SPOA framework; scale “call before convey” and urgent response; strengthen integration with WAST/LAs	Single point of access with tailored interventions for frail older adults; BAU call-before-convey.	Deliver minimum principles (no numeric target specified)
Population Health & Prevention	Ensure progress of focused Diabetes HVHI pathway	Implement diabetes HVHI actions (pre-diabetes, care processes, inpatient harm) and report progress.	Progress (no numeric target specified)
Improving Value, Optimising Outcomes & Minimising Variation	Eradicate unsupported systems/devices and ensure clear cyber response plan	Asset inventory and removal of unsupported systems; tested cyber response plan and governance.	Eradicate unsupported systems and have response plan (no numeric target specified)

Actions Closed From Last Year

Category in Annex	Action (national wording)	Status / interpretation	Why it matters for 2026/27 delivery
Actions not rolled forward (note: action completed)	Implementation of CIN follow up criteria prospectively/retrospectively to established follow-up waiting lists	Completed; should remain BAU.	Prevents unnecessary follow-up demand re-accumulating.
Actions not rolled forward (BAU)	Protect planned care inpatient/day case/theatre recovery capacity from unscheduled care pressures on 90% of days	Completed; BAU expectation.	Maintains elective productivity and prevents RTT regression.
Actions not rolled forward (BAU)	Monitor DNA/CNA rates for every outpatient clinic; when >5% implement overbooking	Completed; BAU expectation.	Protects outpatient capacity and reduces wasted slots.
Actions not rolled forward (monitor via programme/performance)	Implement national guidelines with thresholds by CIN incl. SOS/PIFU by default	To become BAU but monitored.	Reduces follow-up burden and improves access.
Actions not rolled forward (BAU)	Day surgery rates: BACDS day case rate 70% from Apr 2025 moving to 80% by end Jun 2025	Completed; BAU expectation.	Reduces bed usage and improves flow.
Actions not rolled forward (taken forward elsewhere)	Maintain actions within 50 Day challenge deliverable consistently	Taken forward under OHFF under UEC.	Ensures continuity within UEC flow programme.
Actions not rolled forward (BAU)	All new cataract referrals direct listed to treatment stage following admin triage by end Q2	Completed; BAU expectation.	Improves pathway efficiency and reduces outpatient steps.

Reducing Low Value Activity

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Diabetes	Routine HbA1c in well-controlled T2DM more than twice annually	Stable patients gain nothing from quarterly testing; guidelines support 6-monthly monitoring	NICE NG28 do-not-do; Choosing Wisely UK - Diabetes UK/ABCD 2016	Est. 500,000+ excess tests/year NHS England (NHS RightCare 2019 diabetes pack)

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Diabetes	Urine dipstick for microalbuminuria when ACR already established	Dipstick has poor sensitivity/specificity; ACR is the validated measure and should not be duplicated	NICE NG28; Choosing Wisely Canada - nephrology	High volume low-yield test; estimated duplicate testing affects ~30% of diabetes reviews (audit data)
Diabetes	Annual retinal screening in T2DM patients with consistently normal retinas for 2+ years	NHS Diabetic Eye Screening Programme evidence supports extended interval to 2 years for low-risk patients	NHS DESP evidence review 2020; Scanlon et al. Diabetologia 2015	~600,000 patients potentially eligible for biennial rather than annual screening (DESP data)
Diabetes	Routine foot X-ray in uncomplicated diabetes annual review	No diagnostic value without clinical suspicion of Charcot, fracture or osteomyelitis	Choosing Wisely USA - AACE 2013	High frequency; no published UK aggregate; opportunity significant in primary care
Diabetes	Inpatient sliding scale insulin for well-controlled T2DM on oral agents having minor procedures	Variable rate IV insulin increases hypoglycaemia risk with no benefit in stable T2DM	JBDS Guidelines 2016; NICE NG17; NHS Diabetes Inpatient Audit 2022	NHS Diabetes Inpatient Audit: ~18% of inpatients on inappropriate insulin regimes
Diabetes	Routine cholesterol testing more than annually in statin-treated T2DM with stable lipid profile	Once on optimal statin therapy and stable, annual or less frequent review is adequate	NICE NG28; Choosing Wisely UK - RCGP 2016	Moderate volume; overlaps with other CVD risk monitoring requests
Diabetes	Inpatient HbA1c in acute medical admission for non-diabetic patients without risk factors	Acute stress hyperglycaemia does not diagnose diabetes; HbA1c unreliable acutely	ADA Standards 2023; NICE NG17	NHS data suggest up to 15% of inpatient HbA1c requests are inappropriate (local audit literature)
Diabetes	Referral to dietetics for T2DM patients on low-risk oral agents with no weight concern and stable glycaemia	Stable well-controlled patients receive no incremental benefit; high-risk patients are displaced	NICE NG28 care pathway; NHS RightCare diabetes pathway tool	Displaces capacity needed for newly diagnosed and high-risk cohort
Diabetes	Self-monitoring blood glucose strips for T2DM not on insulin or sulphonylurea	No evidence of benefit on glycaemic outcomes; adds cost without value in this population	NICE NG28; Choosing Wisely UK - ABCD/Diabetes UK 2016; Malanda et al. Cochrane 2012	NHS spend on strips est. £150m/year; NICE estimates 25-30% inappropriate in T2DM (NG28 impact)

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Diabetes	Specialist outpatient follow-up for stable T2DM managed in primary care	No clinical benefit over GP-led care for well-controlled T2DM; guidelines support primary care management	NHS RightCare diabetes pathway; NICE NG28; Atlas of Variation 2020	Atlas of Variation shows 3-fold variation in T2DM outpatient rates across CCGs
Frailty	Polypharmacy medication continuation without annual structured review in frail elderly	Prescribing cascade and drug burden cause falls, delirium, hospitalisation; structured deprescribing reduces harm	Choosing Wisely UK - BGS 2016; NHS STOPP/START criteria; Gnjjdic et al. JAMA IM 2012	King's Fund: 1 in 4 hospital admissions in over-65s attributable to adverse drug events
Frailty	Tight glycaemic control (HbA1c <53mmol/mol) targets in frail elderly with T2DM	Hypoglycaemia risk outweighs benefit; relaxed targets (58-70mmol/mol) recommended for frail older adults	NICE NG28; Choosing Wisely UK - BGS/ABCD; Sinclair et al. Diabetes Care 2011	NHS Diabetes Inpatient Audit: hypoglycaemia prevalent in elderly inpatients; high iatrogenic burden
Frailty	Bone density (DXA) scanning in frail elderly already on treatment	Does not change management in treated patients; risk of over-investigation	Choosing Wisely UK - BGS 2016; NICE NG187	Moderate volume; DXA requests in already-treated 80+ cohort lack clinical utility
Frailty	CT/MRI brain in delirium workup without focal neurology or new onset seizure	Delirium is rarely caused by intracranial pathology in absence of focal signs; investigation rarely changes management	Choosing Wisely UK - BGS 2016; British Geriatrics Society delirium guideline 2019	High volume inpatient investigation; BGS audit suggests >40% of delirium imaging is low yield
Frailty	Cardiac monitoring (24-hour tape) for unexplained falls in frail elderly without cardiac symptoms	Falls in frail older adults are predominantly mechanical/multifactorial; cardiac cause rare without symptoms	NICE NG56 falls guideline; Choosing Wisely UK - BGS 2016	Falls are the most common reason for emergency admission in over-65s; significant over-investigation
Frailty	Hospital admission for frail elderly presenting with simple UTI or low-grade infection manageable at home	Hospitalisation causes deconditioning, delirium, iatrogenic harm; virtual ward/HITH models effective	NHS England Frailty toolkit; Choosing Wisely UK - BGS; NHSE GIRFT emergency medicine	NHS England: up to 30% of emergency admissions in frail elderly potentially avoidable

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Frailty	Nutritional supplementation (ONS) prescribed without dietetic assessment or MUST score in community	MUST-guided prescribing is indicated; blanket ONS prescribing in non-malnourished patients is wasteful	NICE CG32; BAPEN MUST guidelines; NHS England medicines optimisation	ONS prescribing cost ~£100m/year NHS; significant proportion without formal assessment
Frailty	Catheterisation for urinary incontinence in frail elderly without clinical indication (urinary retention, wounds)	Urinary catheters cause CAUTI, delirium, functional decline; continence care pathway preferred	Choosing Wisely UK - BGS 2016; NICE CG139; SIGN 88	NHS Safety Thermometer: catheter-associated UTI accounts for ~40% of HAI in older patient ward audits
Frailty	Cardiopulmonary resuscitation (CPR) for frail elderly with poor prognosis without DNACPR discussion	CPR in frailty has extremely low survival to discharge; distressing without benefit; ReSPECT process recommended	Choosing Wisely UK - RCP/BGS 2016; Ebell et al. Arch IM 2013; NHS ReSPECT programme	NHS: approximately 70% of hospitalised frail patients lack documented advance care plan
Frailty	Proton pump inhibitors continued without review in frail elderly on no NSAIDs or anticoagulants	PPI deprescribing safe in absence of ongoing indication; reduces C.diff risk, drug burden, cost	NICE: medicines deprescribing; STOPP criteria; Choosing Wisely Canada - gastroenterology	NHS PPI spend ~£100m/year; estimated 30-40% without active indication (STOPP audit literature)
ACSC	Emergency admission for COPD exacerbation without prior pulmonary rehabilitation offer	Pulmonary rehab reduces hospitalisation by 50%; failure to offer PR upstream generates avoidable admissions	NICE NG115; Cochrane: Puhan et al. 2016; NHS RightCare COPD scenario	NHS RightCare: up to 4,700 avoidable COPD admissions per 100,000 population in high-admission areas
ACSC	Emergency admission for HF without optimised community HF nurse follow-up post-discharge	Community HF nursing reduces readmission; gaps in service generate avoidable returns	NICE NG106; Blue et al. Lancet 2001 (RCT); NHS GIRFT cardiology	30-day HF readmission rate ~24% nationally; community service gaps account for significant proportion
ACSC	Emergency admission for asthma without documented inhaler technique check in prior 12 months	Poor technique is the most common modifiable cause of asthma hospitalisation	Choosing Wisely UK - SIGN 158; BTS/SIGN asthma guidelines; NHS RightCare respiratory pack	NRAD 2014: 50% of asthma deaths associated with suboptimal primary care; inhaler technique rarely recorded

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
ACSC	Emergency admission for cellulitis managed in hospital when ambulatory IV therapy pathway available	OPAT/HITH cellulitis management equivalent in outcomes; significant cost and capacity difference	NICE NG141; PHE/BSAC OPAT guidance; Tice et al. CID 2004	NHS GIRFT: cellulitis among top 5 highest-variation inpatient admissions; OPAT pathway underutilised
ACSC	Emergency admission for hypoglycaemia in insulin-treated diabetes without structured education review	Structured education (DAFNE, DESMOND) reduces severe hypoglycaemia; failure to refer upstream generates avoidable presentations	NICE NG17; DAFNE trial BMJ 2002; NHS RightCare diabetes pathway	NHS Diabetes Inpatient Audit: hypoglycaemia admissions concentrated in patients without education record
ACSC	Emergency admission for urinary tract infection in older women managed in hospital without OPAT assessment	Uncomplicated UTI in elderly women manageable with oral antibiotics in community with safety netting	PHE antibiotic guidelines; NICE NG109; NHS Getting It Right First Time emergency medicine	UTI one of top 3 ACSCs by volume; significant variation in admission rates by CCG (Atlas of Variation)
ACSC	A&E attendance for dental pain - management in secondary care rather than urgent dental care pathway	Secondary care manages symptoms not cause; urgent dental care pathway is the appropriate destination	NICE CG151; NHS dental commissioning framework; PHE oral health data	NHS England: 40,000+ A&E attendances annually for dental pain; most avoidable with adequate dental access
Heart Failure	Echocardiogram repeated annually in stable HFrEF on optimised therapy without clinical change	No clinical benefit of routine annual echo in stable optimised patients; repeat only on clinical deterioration	NICE NG106; Choosing Wisely USA - ACC/AHA 2012; ESC HF guidelines 2021	High volume; ACC estimates >1 million unnecessary echos/year in US; UK data limited but extrapolatable
Heart Failure	BNP/NT-proBNP repeated at every clinic visit in stable chronic HF	Serial biomarker measurement in stable patients adds cost without management change; reserve for suspected deterioration	Choosing Wisely USA - ACC/AHA; ESC 2021; NICE NG106	Moderate volume; test overuse documented in audit literature
Heart Failure	Routine 24-hour ambulatory BP monitoring in HFrEF without hypertensive complication	Not indicated as standard monitoring; adds cost without value in this population	NICE NG106; NICE NG136 hypertension guideline	Small but consistent overuse in HF follow-up outpatient clinics
Heart Failure	Specialist HF outpatient review of stable patient	Annual review adequate in stable, optimised HF; frequent	NICE NG106 follow-up recommendations; NHS RightCare HF scenario 2018	GIRFT Cardiology 2021: significant variation in HF outpatient follow-up

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
	every 3 months without clinical indication	visits use capacity without benefit		frequency without outcome correlation
Heart Failure	Intravenous diuretics in decompensated HF without consideration of outpatient/day-case IV diuretic pathway	Day-case IV diuretic clinics equivalent in outcomes, reduce length of stay and inpatient cost	Bhimaraj et al. JACC HF 2014; NHS Improvement HF pathway toolkit	NHS improvement data: day-case diuretic pathway reduces LOS by avg. 3.2 days vs admission; underused
Heart Failure	Coronary angiography in HFpEF without ischaemic symptoms or positive non-invasive testing	Diagnosis of HFpEF does not routinely require invasive coronary assessment; low yield in absence of ischaemic features	ESC HF guidelines 2021; Choosing Wisely USA - ACC 2017	Moderate volume; angiography carries procedural risk without clear benefit in this subgroup
COPD	Spirometry repeated annually in stable COPD without change in clinical status	Spirometry results do not alter management in stable COPD; repeat only on clinical indication	NICE NG115; Choosing Wisely UK - PCRS/BTS 2015; GOLD 2023	High volume primary care test; estimated 30-40% without clinical justification (primary care audit data)
COPD	Chest X-ray at every COPD exacerbation without clinical suspicion of complication	CXR rarely changes management in moderate exacerbations; reserve for suspicion of pneumonia, pneumothorax, effusion	BTS COPD guidelines; Choosing Wisely USA - CHEST 2016; GOLD 2023	High volume; radiation exposure without incremental value in uncomplicated exacerbations
COPD	Short-acting bronchodilator (SABA) rescue inhaler provision without stepping up to ICS/LABA in high-use patients	Frequent SABA use is a marker of inadequate control warranting step-up; prescribing more SABA is low-value	BTS/SIGN asthma/COPD guidelines; NICE NG115; GOLD 2023 step-up criteria	NHS primary care data: SABA-only prescribing prevalent; NHS England inhaler optimisation programme addresses this
COPD	Outpatient pulmonary rehabilitation referral delay post-exacerbation beyond 4 weeks	Early PR after exacerbation (within 4 weeks) reduces readmission; delay negates benefit	Puhan et al. Cochrane 2016 (RCT evidence); NICE NG115; BTS PR quality standards	NHS RightCare: PR referral post-exacerbation varies from 2% to 38% by CCG; most areas under-refer
COPD	LTOT prescription in COPD without two resting PaO2 measurements below threshold on air	LTOT criteria require two qualifying ABG measurements; inappropriate	NICE NG115; BTS LTOT guidelines; MRC LTOT trial original evidence	NHS: LTOT costs approx. £3,000/patient/year; prescribing variation

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
		prescription costly and ineffective		suggests inappropriate use in subset
COPD	Theophylline initiation in COPD without specialist review	Theophylline has narrow therapeutic index, high interaction risk; not recommended as first- or second-line by NICE	NICE NG115; GOLD 2023; BTS guidelines	Declining use but persistent prescribing in some areas; deprescribing opportunity in polypharmacy patients
Cancer	Routine CEA monitoring in colorectal cancer surveillance beyond 5 years in remission	Evidence supports CEA monitoring for 5 years post-curative resection; continued monitoring beyond this is low yield	NICE NG151; ASCO CRC guidelines; Jeffery et al. Cochrane 2019	Significant volume of long-term follow-up; NHS RightCare cancer packs document variation in follow-up intensity
Cancer	Annual CT surveillance of non-small cell lung cancer treated curatively beyond guideline period	No RCT evidence that extended imaging surveillance improves survival; follow-up schedule should be protocol-driven	NICE NG122; Choosing Wisely USA - ASCO 2012; ESMO guidelines	High cost per scan; radiation exposure; ASCO estimates significant proportion of surveillance outside evidence base
Cancer	PSA monitoring post-prostatectomy more than quarterly in first year without clinical indication	Quarterly PSA in stable post-treatment patients offers no advantage over standardised schedule	NICE NG131; EAU prostate guidelines; Choosing Wisely USA - AUA 2013	Moderate volume; PSA testing very high in post-treatment cohort
Cancer	Tumour markers (CA-125, CA19-9, AFP) in asymptomatic general screening	No evidence of mortality benefit; false positives cause harm (unnecessary investigation, anxiety)	Choosing Wisely UK - RCR 2016; USPSTF recommendations; Jacobs et al. Lancet 2016 (UKCTOCS)	High volume; RCR audit found significant inappropriate use of tumour markers in primary care
Cancer	Routine bone scan in low-risk prostate cancer without symptoms of metastasis	Bone scan positive rate <1% in low-risk, PSA<10 prostate cancer; not recommended by guidelines	NICE NG131; Choosing Wisely USA - ASTRO/AUA 2012; EAU guidelines	High volume test; unnecessary radiation; ASCO/ASTRO estimate >20% performed outside guideline criteria
Cancer	Outpatient oncology follow-up for low-risk breast cancer (stage I/II) replaced by patient-initiated follow-up	Systematic review shows remote/patient-initiated follow-up equivalent in detecting recurrence; frees capacity	NICE NG101; Grunfeld et al. Lancet 1996 RCT; NHS RightCare cancer pathway	NHS: 1.5 million outpatient cancer follow-up appointments per year; NHS Long Term Plan targets shift

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
				to supported self-management
Cancer	Annual mammography surveillance in low-risk DCIS patients beyond first 5 years	Risk stratification allows longer interval mammography in low-risk DCIS; annual not required throughout	NICE NG101; NHS Breast Screening Programme guidance	Moderate volume; NHS breast screening capacity under pressure; risk stratification under-applied
Cancer	CT chest in surveillance of early-stage testicular cancer on standard watch-and-wait protocol beyond schedule	Protocol-driven surveillance is evidence-based; deviation adds radiation dose without benefit	NICE NG167; ESMO testicular cancer guidelines; Rustin et al. 1997	Moderate volume; generally young patients with long life expectancy; cumulative radiation concern
Outpatients	Routine post-operative follow-up at 6 weeks for uncomplicated surgical procedures with no complications	Most post-op follow-up adds no value for uncomplicated cases; advice line/self-care equivalent	NHS England Outpatient Transformation Programme 2019; GIRFT post-operative review work	NHS England: 30-40% of outpatient activity estimated as low-value follow-up (Long Term Plan)
Outpatients	First outpatient appointment not preceded by GP-requested investigations (duplicate testing at first appointment)	Testing at first appointment that duplicates recent GP tests wastes resource and delays diagnosis	NHS RightCare outpatient pathway; GIRFT general surgery; NHS Improvement outpatient redesign	Significant volume; NHS estimates 15-20% of new outpatient appointments involve repeat of already-available tests
Outpatients	Specialist follow-up for conditions managed as well in primary care (stable hypothyroidism, well-controlled hypertension, stable gout)	No clinical benefit of specialist-led follow-up for stable conditions within GP competency	NHS RightCare population health data; NICE pathway reviews; Atlas of Variation	Atlas of Variation 2019: 3-5 fold variation in follow-up rates for conditions fully manageable in primary care
Outpatients	Telephone/video follow-up booked as face-to-face clinic without clinical justification	Remote consultation equivalent or superior in many conditions; face-to-face overuse constrains capacity	NHS England Outpatient Transformation; COVID-era evidence synthesis (NHS Improvement 2021)	Post-pandemic data: reversion to face-to-face in conditions suited to remote consultation represents capacity loss
Outpatients	Consultant-led routine review for conditions that	Nurse/AHP-led follow-up equivalent in outcomes for	NICE technology appraisals and guideline implementation; NHS workforce evidence	Significant opportunity; NHS Long Term Plan cites

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
	could be delivered by clinical nurse specialist or AHP	chronic disease management in many specialties		workforce substitution as major outpatient reform lever
Urology	Urine culture in asymptomatic bacteriuria in non-pregnant adults without urological instrumentation planned	Treating asymptomatic bacteriuria causes antibiotic resistance with no benefit in non-pregnant, non-pre-surgical adults	Choosing Wisely UK - BAUS 2016; Choosing Wisely USA - IDSA 2011; Nicolle et al. CID 2019	BAUS estimate: significant proportion of urology cultures are for asymptomatic patients; antibiotic stewardship issue
Urology	Cystoscopy surveillance for low-grade, low-stage (Ta G1) bladder cancer beyond current BAUS schedule	Evidence supports protocol-driven surveillance; over-surveillance at 3-monthly intervals adds cost without benefit	BAUS NICE NG2; EAU bladder cancer guidelines; Choosing Wisely UK - BAUS 2016	High volume procedure with procedural discomfort; BAUS data show variation in surveillance frequency
Urology	PSA testing in men with <10 years life expectancy or significant comorbidity	Diagnosis and treatment will not improve life expectancy; test creates anxiety and downstream low-value investigation	Choosing Wisely UK - BAUS/RCPATH 2016; USPSTF PSA recommendations 2018; NICE NG131	High volume; PHE data: PSA testing concentrated in elderly with limited life expectancy
Urology	Imaging (renal US, CT KUB) for asymptomatic microscopic haematuria in low-risk patients	Risk stratification identifies low-risk patients (young, female, no smoking history) where imaging has minimal yield	BAUS microscopic haematuria guidelines 2020; NICE NG12; Choosing Wisely UK - BAUS	BAUS: low-risk microscopic haematuria investigation accounts for significant proportion of urology referrals; yield very low
Urology	Urodynamics before treatment of uncomplicated stress urinary incontinence in women	Urodynamic testing before initial conservative or surgical treatment does not improve outcomes in uncomplicated SUI	Choosing Wisely UK - BAUS 2016; NICE NG123; Hilton et al. NEJM 2015 (VALUE trial)	HIGH volume; VALUE trial definitively showed no benefit; NICE NG123 explicitly does not recommend routine urodynamics first-line
Urology	Prostate biopsy for PSA elevation without mpMRI pre-assessment	mpMRI prior to biopsy reduces unnecessary biopsy and detects clinically significant cancer with greater accuracy	Choosing Wisely UK - BAUS 2016; Ahmed et al. Lancet 2017 (PROMIS trial); NICE NG131	PROMIS trial: 27% of men could avoid biopsy with MRI-first pathway; NICE now recommends mpMRI before biopsy

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Urology	Routine post-vasectomy semen analysis repeated after two consecutive negative results	Single negative result at 16 weeks in correctly performed vasectomy is sufficient; repeat testing low-value	BAUS vasectomy guidelines; Faculty of Sexual and Reproductive Healthcare	Moderate volume; laboratory and patient burden without incremental value
Ophthalmology	Routine stable glaucoma monitoring at frequency exceeding guideline (e.g. 3-monthly when stable)	Stable, controlled glaucoma can safely be monitored annually; over-monitoring creates pressure on capacity without benefit	NICE NG81; Choosing Wisely UK - RCOphth 2018; Hatt et al. Cochrane 2020	GIRFT Ophthalmology 2021: ophthalmology has highest volume of 'lost to follow-up' due to capacity crisis driven partly by over-scheduled follow-up
Ophthalmology	Cataract surgery in second eye when first-eye vision is adequate for patient's functional needs	Bilateral cataract surgery should be need- and functional-outcome driven; bilateral listing without functional assessment is low-value	NICE NG77; Choosing Wisely UK - RCOphth 2018; NHS GIRFT Ophthalmology 2021	GIRFT: significant variation in bilateral cataract surgery rates; some areas listing routine second-eye without functional need assessment
Ophthalmology	Pre-operative assessment tests (ECG, FBC, clotting) as routine for cataract surgery under local anaesthetic	Routine pre-op medical testing for cataract under LA has no evidence of benefit; Cochrane review confirms no impact on outcomes	Choosing Wisely UK - RCOphth 2018; Keay et al. Cochrane 2019; NHS GIRFT Ophthalmology	GIRFT: routine pre-op testing for LA cataract adds significant cost and visit burden with no clinical benefit
Ophthalmology	Diabetic maculopathy monitoring at fixed intervals without using treat-and-extend protocol	Treat-and-extend protocols safely extend injection intervals in stable DME; fixed 4-weekly intervals waste capacity	NICE TA274/TA346; Ohji et al. Ophthalmology 2020; RCOphth AMD/DME pathway guidance	RCOphth: adoption of treat-and-extend could reduce injection visit numbers by 25-35% in stable patients
Ophthalmology	Ophthalmic review for stable patients with no sight-threatening condition in hospital eye service when community optometry pathway available	Community optometry follow-up equivalent for stable conditions; hospital eye service capacity should be reserved for complex/sight-threatening cases	NHS England Ophthalmology Transformation Programme 2022; RCOphth community eye care standards	NHS England: ~30% of HES follow-up could be safely managed in community optometry setting (NHSE transformation estimate)
ENT	Grommets (ventilation tubes) for otitis media with effusion	Watchful waiting for 3 months is standard; spontaneous	NICE NG91; MRC TARGET trial; Choosing Wisely UK -	NICE NG91: grommets only after persistent OME >3

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
	(OME/'glue ear') without watchful waiting	resolution in >80% of children within 3 months of diagnosis	ENTUK 2016; Browning et al. Cochrane 2010	months with hearing impact; variation in surgery rates 3-fold across England (Atlas)
ENT	Tonsillectomy for recurrent sore throat not meeting SIGN/NICE Paradise criteria	Tonsillectomy confers modest benefit only when meeting criteria (5+ episodes/year for 2+ years); lower thresholds not evidence-based	NICE NG34; SIGN 117; Lau et al. BMJ 2014; Choosing Wisely UK - ENTUK	NHS Atlas of Variation: 4-fold variation in tonsillectomy rates by area; over-threshold rates suggest criteria not applied consistently
ENT	Routine audiological testing at ENT follow-up for stable hearing loss managed with hearing aids	Hearing aid review and audiological follow-up is an audiology function; ENT specialist time not needed for stable aidable loss	NHS audiology pathway; Choosing Wisely UK - ENTUK 2016; NHSE transformation programme	GIRFT ENT: large volume of ENT follow-up attributable to conditions manageable in audiology pathway
ENT	CT sinuses as first investigation for uncomplicated recurrent acute rhinosinusitis	CT sinuses rarely changes management in recurrent acute rhinosinusitis; reserve for chronic, complicated or surgical planning cases	Choosing Wisely UK - RCR/ENTUK; EPOS guidelines 2020; NICE CKS rhinosinusitis	RCR radiological audit: CT sinus requests from primary care for acute/recurrent acute rhinosinusitis common and largely low yield
ENT	Nasal endoscopy for allergic rhinitis managed adequately in primary care	Allergic rhinitis diagnosis does not require endoscopy; specialist referral and endoscopy overused for condition manageable with intranasal steroids and allergy testing in community	NICE CG134; BSACI allergic rhinitis guidelines; Choosing Wisely UK - ENTUK 2016	Significant volume; allergic rhinitis among most common ENT referrals; most cases do not require endoscopy
Dermatology	Punch biopsy of lesions clearly identifiable as benign (seborrhoeic keratosis, benign naevi) by dermoscopy	Dermoscopy by trained clinician has sensitivity/specificity sufficient to avoid biopsy of clearly benign lesions	Choosing Wisely USA - AAD 2018; BAD dermoscopy standards; Vestergaard et al. JEADV 2008	Moderate volume; BAD audit data suggest 15-20% of lesion biopsies are clearly benign on pre-procedure dermoscopy
Dermatology	Patch testing for urticaria/eczema without adequate prior treatment trial with topical therapies	Patch testing appropriate for contact dermatitis diagnosis; reflexive use for urticaria or	BAD guidelines; Choosing Wisely USA - AAD 2015; NICE eczema guidelines NG190	Moderate volume; patch testing in inappropriate populations delays diagnosis

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
		atopic eczema without prior management is low-value		of contact dermatitis in genuine cases
Dermatology	Systemic immunosuppressants (methotrexate, ciclosporin) initiated for mild-moderate psoriasis without adequate topical therapy	Step-up therapy requires prior adequate topical treatment; systemic therapy initiation without stepwise approach is inappropriate	NICE NG153; BAD psoriasis guidelines; Choosing Wisely USA - AAD 2015	Moderate volume; prescribing audit data show step-up not consistently applied before systemic initiation
Dermatology	Routine follow-up of excised low-risk (stage IA) primary melanoma beyond NICE-recommended schedule	NICE follow-up schedule for low-risk melanoma is evidence-based; extra visits above schedule do not improve detection of recurrence	NICE NG14; Choosing Wisely USA - AAD/ASCO 2018; Garbe et al. JEADV 2020	Significant volume; melanoma is the most common cancer leading to prolonged dermatology follow-up; schedule variation documented
Dermatology	Specialist dermatology follow-up for controlled mild-moderate chronic skin conditions (e.g. mild psoriasis, acne) manageable in primary care or via teledermatology	Primary care with teledermatology advice is evidence-based for stable, non-complex skin conditions; specialist follow-up displaces new patient capacity	NHS GIRFT Dermatology 2021; BAD standards; NHS England Advice and Guidance programme	GIRFT Dermatology 2021: significant proportion of dermatology follow-up for conditions safely managed in primary care with remote specialist input
Dermatology	Allergy testing (RAST/skin prick) for idiopathic chronic urticaria without H1-antihistamine trial	Allergy testing in idiopathic urticaria has very low diagnostic yield; H1-antihistamine trial should precede investigation	EAACI/WAO urticaria guidelines 2022; NICE CG57; Choosing Wisely USA - AAD	Moderate volume; allergy testing ordered reflexively without prior antihistamine trial in primary and secondary care
T&O	Arthroscopic knee surgery (washout/debridement) for osteoarthritis of the knee without locked joint or loose body	Multiple RCTs show no benefit over sham surgery; explicitly a do-not-do in NICE guidelines	NICE NG226 do-not-do; Moseley et al. NEJM 2002 (RCT sham surgery); Kirkley et al. NEJM 2008; Choosing Wisely UK - BOA 2014	BOA/NICE: estimated 5,000-10,000 arthroscopies/year for OA knee in England without clinical indication; GIRFT T&O flagged
T&O	Spinal fusion for non-specific low back pain without structural instability,	No benefit over conservative management in non-specific LBP; surgical complication	NICE NG59; Choosing Wisely UK - BOA/SBNS 2014;	NICE NG59: back fusion only for specific indications; NHS atlas shows significant

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
	deformity or neurological compromise	risk present; conservative care should be exhausted	Fairbank et al. Lancet 2005 (SPORT trials)	variation; GIRFT spine report 2019
T&O	Pre-operative X-ray/MRI for standard total hip/knee replacement in patients with established radiological diagnosis	Repeat imaging before standard primary arthroplasty in patients with established diagnosis adds cost without value	Choosing Wisely UK - BOA 2014; GIRFT T&O 2015; BOA consent and planning guidance	GIRFT T&O: significant imaging duplication at pre-operative stage; GIRFT reported as moderate-volume waste
T&O	Shoulder arthroscopy for subacromial impingement syndrome (rotator cuff related shoulder pain) without adequate conservative therapy	CSAW trial showed no benefit of arthroscopic subacromial decompression over sham or exercise; exercise should be first-line	Choosing Wisely UK - BOA 2014; Beard et al. Lancet 2018 (CSAW RCT); NICE guidance	CSAW (Lancet 2018): sham surgery equivalent to arthroscopy; significant volume procedure with no benefit beyond conservative care
T&O	Urgent MRI in acute mechanical low back pain without red flags in primary care	Red flag-negative mechanical LBP does not benefit from early MRI; imaging leads to over-treatment without improving outcomes	NICE NG59; Choosing Wisely UK - RCR/RCGP 2013; Deyo et al. JAMA 1992; Jarvik et al. JAMA 2003	RCR audit: LBP is consistently among top sources of inappropriate MRI requests in primary care
T&O	Post-operative physiotherapy for uncomplicated total hip replacement without functional assessment	Not all THR patients need formal physiotherapy; structured function-based discharge pathway reduces unnecessary sessions	NICE NG157; GIRFT T&O; RCT evidence shows home-based exercise equivalent in uncomplicated THR	GIRFT T&O: variation in post-THR physio referral from 2 to 14 sessions across providers without outcome correlation
T&O	Vertebroplasty or kyphoplasty for osteoporotic vertebral fracture without severe persistent pain after conservative measures	Sham-controlled trials show no benefit over placebo; vertebroplasty should be reserved for refractory cases	Choosing Wisely UK - RCR/BOA; Buchbinder et al. NEJM 2009; Kallmes et al. NEJM 2009 (sham RCTs)	Two sham-controlled RCTs (NEJM 2009): no benefit vs sham injection; NHS practice remains variable
T&O	Fracture clinic follow-up for minor undisplaced fractures (e.g. undisplaced 5th metatarsal, isolated distal fibula) that can be safely	Virtual fracture clinic model safe and effective for defined fracture types; reduces face-to-face attendance without clinical risk	Choosing Wisely UK - BOA; NHS GIRFT T&O; NICE fracture pathway guidance; BMJ virtual fracture clinic studies	GIRFT T&O: virtual fracture clinic now adopted in ~60% of trusts; sites not yet adopting represent significant conversion opportunity

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
	managed via virtual fracture clinic			
Endoscopy	Repeat colonoscopy for small (<10mm) hyperplastic polyps in distal colon at 3-year surveillance interval	Hyperplastic polyps carry negligible malignant risk; 10-year recall or discharge is evidence-based	NICE NG151; BSG post-polypectomy surveillance guidelines 2020; Choosing Wisely UK - BSG 2016	BSG: adoption of 2020 post-polypectomy guidelines could reduce surveillance colonoscopy volume by ~40%
Endoscopy	Upper GI endoscopy for uncomplicated GORD without alarm symptoms in patients under 55	Uncomplicated GORD managed with PPI; endoscopy below 55 without alarm features has minimal yield and does not change management	NICE CG184; BSG dyspepsia guidelines; Choosing Wisely UK - BSG 2016	BSG: approximately 20-25% of dyspepsia referrals lack alarm features in under-55s; significant low-yield endoscopy volume
Endoscopy	Repeat OGD surveillance for Barrett's oesophagus at intervals shorter than BSG guideline	BSG-recommended intervals are evidence-based; more frequent surveillance does not reduce mortality and consumes capacity	BSG Barrett's oesophagus guidelines 2014; Choosing Wisely UK - BSG 2016; NICE guidance	BSG audit: ~30% of Barrett's surveillance performed at shorter-than-guideline intervals; significant capacity waste
Endoscopy	Colonoscopy for change in bowel habit in patients under 50 with no alarm features and FIT negative	FIT-first pathways highly effective in ruling out CRC; colonoscopy without FIT testing in low-risk patients is over-investigation	NICE NG12; NHS FIT implementation evidence; Mowat et al. Gut 2019	NICE NG12 and NHS England Faster Diagnosis Standard: FIT-first pathways reduce unnecessary colonoscopy by ~30-40%
Endoscopy	ERCP as primary diagnostic tool for biliary/pancreatic investigation when MRCP available	Diagnostic ERCP carries significant risk (pancreatitis 3-5%, perforation); MRCP provides equivalent diagnostic information non-invasively	Choosing Wisely USA - ASGE 2012; NICE NG104; BSG biliary guidelines	Moderate volume; ERCP as pure diagnostic tool largely superseded by MRCP and EUS; variation in practice persists
Endoscopy	Repeat colonoscopy for uncomplicated colitis surveillance at intervals shorter than BSG guideline based on disease activity	Disease activity and extent should guide interval; blanket annual surveillance in low-risk quiescent colitis is not indicated	BSG IBD surveillance guideline 2019; NICE NG185; Choosing Wisely UK - BSG	BSG audit: over-surveillance of low-risk colitis diverts capacity from higher-risk patients who need timely colonoscopy

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Mental Health	Antipsychotic prescribing for behavioural and psychological symptoms of dementia (BPSD) as first-line without non-pharmacological approach	Non-pharmacological approaches are first-line; antipsychotics increase mortality, cerebrovascular events, accelerated cognitive decline	Choosing Wisely UK - RCPsych/BGS 2016; NICE NG97; Banerjee 2009 report to DH; Cochrane Ballard et al. 2006	NHS: ~180,000 people with dementia prescribed antipsychotics/year; DH Banerjee report estimated two-thirds inappropriate
Mental Health	Hospital admission for deliberate self-harm (DSH) without clear medical or psychiatric indication	Majority of DSH presentations do not require inpatient admission; assessment and community follow-up is appropriate for most	NICE NG225; NCISH data; NHS crisis care concordat; RCPsych standards	NCISH: significant variation in admission rates for DSH across NHS trusts; 2-fold variation without clear outcome difference
Mental Health	Benzodiazepine prescribing for insomnia for more than 4 weeks without review and taper plan	Benzodiazepines for insomnia should not exceed 4 weeks; long-term prescribing causes dependence with no efficacy beyond short-term	NICE CG192; Choosing Wisely UK - RCPsych/RCGP 2016; Morin et al. Lancet 2009	NHS primary care data: significant proportion of long-term BZD prescriptions lack active review; NHS long-term plan includes deprescribing target
Mental Health	Antidepressant prescribing for mild depression without prior structured psychological therapy offer	CBT/psychological therapy is the guideline-recommended first-line for mild depression; medication for mild depression without therapy offer is low-value	NICE NG222; Choosing Wisely UK - RCPsych 2016; Cuijpers et al. meta-analysis 2019	NHS: access to IAPT/Talking Therapies highly variable; antidepressant prescribing for mild depression reflects access gap not clinical appropriateness
Mental Health	Inpatient psychiatric admission for early psychosis without community treatment team (EIP) wraparound assessment	EIP teams evidence-based to reduce inpatient days and improve outcomes in first-episode psychosis; admission without EIP engagement is inferior care	NICE NG185; NHS England EIP standards; IRIS programme evidence; Kuipers et al.	NHS England: EIP 2-week standard; significant variation in EIP access associated with increased inpatient use
Mental Health	Routine CT/MRI brain for first episode of psychosis in young adults without neurological signs or trauma history	Neuroimaging in first-episode psychosis has low diagnostic yield in absence of focal neurology; not recommended as routine	Choosing Wisely USA - APA 2015; NICE CG178; Sommer et al. Psychological Medicine 2007	Moderate volume; imaging anxiety-provoking and resource intensive; yield <2% for clinically actionable findings in uncomplicated FEP

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Physiotherapy	Ultrasound therapy for musculoskeletal soft tissue injuries	Multiple systematic reviews show ultrasound no better than sham/placebo for most MSK indications	Choosing Wisely USA - APTA 2014; Cochrane: Robertson et al. 2001; Gam & Johannsen 1995 systematic review	High volume; widely used; APTA Choosing Wisely recommendation specifically targets this
Physiotherapy	Passive modalities (TENS, heat pads, ultrasound) as primary treatment for non-specific low back pain	Active exercise-based physiotherapy is first-line; passive modalities alone have no durable benefit and create dependency	NICE NG59; Choosing Wisely UK - CSP 2016; van Tulder et al. Cochrane 2006	CSP: passive modality use in LBP prevalent despite NICE guidance; CSP Choosing Wisely recommends active over passive approaches
Physiotherapy	Routine physiotherapy assessment for uncomplicated minor MSK injuries in A&E before self-management advice	Self-management advice and exercise information equivalent to physiotherapy assessment for minor MSK; frees AHP capacity	NICE MSK guidelines; GIRFT physiotherapy work; NHS ESCAPE-pain programme evidence	Moderate volume; variation in A&E physiotherapy use nationally; structured self-management pathways underused
Radiology	MRI lumbar spine for acute non-specific low back pain (< 6 weeks, no red flags) in primary care	Early MRI in acute LBP does not improve outcomes; causes over-medicalisation and increases surgery rates	NICE NG59; Choosing Wisely UK - RCR 2013; Deyo et al. JAMA 1992; Webster & Cifuentes JOM 2010	RCR audit: LBP consistently top 3 inappropriate MRI category; NHS England radiology optimisation programme targets this
Radiology	CT pulmonary angiography (CTPA) without pre-test probability assessment (Wells score/D-dimer)	CTPA without clinical pre-test probability scoring leads to significant overuse; low-probability/D-dimer negative patients do not need CTPA	Choosing Wisely UK - RCR 2013; NICE NG158; Wells et al. NEJM 2003; PIOPED II data	RCR: CTPA is one of the most rapidly growing and overused investigations; Wells/D-dimer pathway adherence variable
Radiology	Bone X-ray for acute ankle injury without Ottawa Ankle Rules application	Ottawa Ankle Rules have 100% sensitivity for fracture; routine ankle X-ray without rule application leads to over-imaging	Choosing Wisely UK - RCR/RCEM 2013; Stiell et al. JAMA 1994 (Ottawa Rules original); Cochrane validation	RCR: ankle X-ray among most common A&E requests; Ottawa Rules reduce imaging by ~30-40% in validation studies
Radiology	Pre-operative CXR as routine for elective surgery in patients without cardiorespiratory symptoms or abnormal examination	Routine pre-op CXR has <0.1% clinically useful yield in asymptomatic patients; rarely changes management	Choosing Wisely UK - RCR 2013; NICE preoperative testing guideline NG45; Archer et al. Cochrane 2005	NICE NG45 explicitly does not recommend routine CXR for most elective surgery; significant ongoing overuse documented in audit

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
Radiology	Follow-up X-ray for undisplaced fractures not requiring immobilisation	X-ray follow-up for fractures managed conservatively and healing as expected changes management in <1% of cases	Choosing Wisely UK - RCR/BOA; GIRFT T&O; Royal College of Radiologists guidance	RCR: follow-up fracture X-rays among commonly identified low-yield requests; virtual fracture clinic model addresses this
Pathology	Routine full blood count and U&E before low-risk elective surgery in healthy patients	Yield of abnormal results requiring management change is <1% in healthy, low-risk patients; NICE NG45 does not recommend	NICE NG45; Choosing Wisely UK - RCPATH 2016; Smetana & Macpherson JAMA 2003	NICE NG45 impact: NHS England estimates significant reduction in routine pre-operative testing possible; adherence variable
Pathology	ESR testing when CRP available for the same clinical indication	ESR has lower specificity and more variables confounding result than CRP; rarely adds clinical information when CRP requested	Choosing Wisely UK - RCPATH 2016; RCPATH test requesting guidelines	RCPATH audit: duplicate ESR/CRP requesting common in secondary care; CRP sufficient in almost all indications
Pathology	LFT panel in all patients on statins at every review without symptoms of hepatotoxicity	Statin-associated liver injury is rare; routine LFT monitoring in asymptomatic patients on statins is not recommended	Choosing Wisely UK - RCPATH/RCGP 2016; NICE CG181; Law et al. BMJ 2006	High volume primary care test; NICE explicitly does not recommend routine LFT monitoring in statin-treated patients
Medicines	Proton pump inhibitors continued without active indication (no NSAID use, no anticoagulant, no high-risk GI history)	PPI overprescribing is pervasive; deprescribing safe in absence of indication; risks include C.diff, hypomagnesaemia, fracture	SIGN 167; Choosing Wisely UK - RCGP 2016; Forgacs & Loganayagam WJG 2008; Choosing Wisely Canada	NHS PPI spend ~£100m/year; estimates suggest 40-60% without active indication (NHS England medicines optimisation)
Medicines	Hypnotic prescribing (zopiclone, zolpidem, temazepam) for insomnia continuing >4 weeks in primary care	z-drugs and BZDs for insomnia produce tolerance within 2 weeks; long-term prescribing causes harm, dependence, falls risk in elderly	NICE CG192; Choosing Wisely UK - RCGP/RCPsych 2016; SIGN 76	NHS primary care: millions of hypnotic prescriptions annually; NHS Scotland SIGN estimate >50% exceed 4-week appropriate duration

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Medicines	Antibiotics for uncomplicated upper respiratory tract infection (viral URTI)	Antibiotics provide no benefit in viral URTI; drive resistance; delayed prescribing equally effective where antibiotics genuinely needed	Choosing Wisely UK - RCGP 2016; Cochrane: Arroll et al. 2005; NICE NG120 antimicrobial prescribing	PHE: NHS England ~9 million antibiotic prescriptions for URTI/year; estimated 75% without clear indication (AMR strategy data)
Medicines	Antibiotics for acute otitis media in children aged 2-12 without perforation or severe symptoms	Spontaneous resolution in ~80%; analgesics first-line; watchful waiting with delayed prescribing reduces antibiotic use without harm	Choosing Wisely UK - RCPCH/RCGP 2016; NICE NG91; Tahtinen et al. NEJM 2011; Cochrane Sanders et al.	NHS: AOM is the most common reason children are prescribed antibiotics; delayed prescribing strategy underimplemented in primary care
Medicines	Cough medicines (OTC expectorants, suppressants) in children under 12	No evidence of benefit in children; regulatory guidance advises against; prescribing by GPs as low-value as OTC purchase	Choosing Wisely UK - RCPCH; MHRA regulatory position 2009; Cochrane: Smith et al. 2014	MHRA action restricted OTC use in under-6s; primary care prescribing continues in some areas; patient education is the lever
Medicines	Vitamin D supplementation at high dose without deficiency confirmed by blood test	Standard supplementation (400-800IU) appropriate population-wide; high-dose treatment requires confirmed deficiency	Choosing Wisely UK - RCPath/RCGP; NICE PH56; Martineau et al. BMJ 2017 (meta-analysis)	High and increasing volume of vitamin D testing and high-dose prescribing; NHS spend rising rapidly; RCPath audit cites overuse
Medicines	Opioid escalation for chronic non-cancer pain without functional outcome assessment	Opioid dose escalation in chronic non-cancer pain not supported by evidence beyond short-term; causes dependence and harm	Choosing Wisely UK - RCPain/RCGP; NICE NG193; Chou et al. Ann IM 2015; Cochrane Chaparro et al.	NHS England opioid strategy: 5.6 million patients prescribed opioids in England; 500,000 on long-term opioids; high proportion for chronic non-cancer pain without review
Medicines	Bisphosphonate continuation beyond 5 years without fracture risk reassessment (drug holiday consideration)	After 5 years, bisphosphonate drug holiday appropriate for lower-risk patients; continuation without review not evidence-based	NICE NG187; Choosing Wisely USA - ASBMR 2014; Black et al. NEJM 2012 (FLEX trial)	Moderate volume; FLEX and HORIZON trials inform drug holiday evidence; NHS prescribing data show continuation without review common

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Medicines	Initiating antibiotic treatment for asymptomatic bacteriuria in non-pregnant, non-surgical patients	Treating asymptomatic bacteriuria drives resistance; clinical benefit only in pregnancy and pre-urological surgery	Choosing Wisely UK - RCGP/BIA 2016; NICE NG109; Nicolle et al. CID 2019; Cochrane	PHE/NHS England antimicrobial stewardship programme: ASB treatment a major driver of UTI-related antibiotic resistance
Medicines	Compound analgesics (co-codamol, co-dydramol) for mild pain in elderly without clear indication for opioid component	Low-dose compound opioids poorly titrated, often subtherapeutic; contribute to opioid use disorder and constipation in elderly	Choosing Wisely UK - BGS/RCGP; SIGN 136; STOPP/START criteria	NHS primary care: co-codamol among highest-volume analgesic prescriptions; STOPP criteria flag in elderly; significant prescribing pattern issue
Gynaecology	Routine hysteroscopy for postmenopausal bleeding without prior endometrial thickness assessment (transvaginal US)	TVUS endometrial thickness measurement (<4mm) has excellent negative predictive value; hysteroscopy not required if thin endometrium	Choosing Wisely UK - RCOG 2016; NICE NG12 and NG126; Smith-Bindman et al. JAMA 1998	RCOG audit: significant proportion of hysteroscopy referrals have not had prior TVUS; pathway redesign opportunity
Gynaecology	Colposcopy referral for CIN1 without watchful waiting per NHSCSP guidance	CIN1 regresses spontaneously in >60% within 2 years; watchful waiting recommended before colposcopy	NHSCSP guidance 2020; NICE CG27; Choosing Wisely UK - RCOG 2016; Ostor IJGO 1993 natural history data	NHSCSP: significant variation in CIN1 management; immediate colposcopy at CIN1 not aligned with guidance in many settings
Gynaecology	Pelvic MRI as first investigation for suspected uncomplicated uterine fibroids	Pelvic ultrasound is first-line; MRI appropriate for complex or pre-surgical cases; use of MRI first-line is overinvestigation	NICE NG88; RCOG fibroid guidelines; Choosing Wisely UK - RCOG 2016	Moderate volume; MRI cost substantially higher than USS; pathway adherence variable in secondary care
Cardiology	Exercise ECG as first investigation for suspected stable angina	NICE NG185: CT calcium scoring and CT coronary angiography are first-line; exercise ECG has poor sensitivity/specificity for stable angina	NICE NG185; Choosing Wisely UK - NICE/BCS 2016; SCOT-HEART trial 2015; Fihn et al. JACC 2012	NICE NG185 updated stable chest pain pathway to CTA-first; significant variation in adherence to updated pathway

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Cardiology	Echocardiogram as routine investigation for palpitations without structural heart disease history or ECG abnormality	Echo in palpitations with normal ECG, no symptoms of HF and no cardiac history has very low yield	Choosing Wisely UK - BSEC/BCS; NICE CG180; AHA/ACC palpitation guidelines 2017	BCS/RCP audit: echo in palpitation workup overused; majority of positive findings do not change management
Neurology	Brain MRI for tension-type headache without red flags	Tension headache diagnosis is clinical; MRI in red flag-negative cases has negligible yield and patient reassurance value is short-lived	Choosing Wisely UK - ABN 2016; NICE CG150; Frishberg N Engl J Med 1994; Howard et al. JNNP 2006	ABN Choosing Wisely: brain imaging in headache is one of the most commonly identified low-value neurology investigations
Neurology	EEG as routine investigation for first syncope without clinical features of seizure	Syncope is rarely epileptic in origin; EEG in first syncope without seizure clinical features has very low diagnostic yield	Choosing Wisely UK - ABN 2016; NICE NG109; ACC/AHA syncope guidelines 2017	ABN audit: EEG requested in syncope without seizure features in significant proportion of neurology referrals
Respiratory	Home sleep study (polysomnography) repeated within 12 months for confirmed OSA on CPAP without clinical deterioration	Repeat sleep study on established CPAP without symptom change or compliance concern does not alter management	Choosing Wisely USA - AASM 2014; BTS OSA guidelines; NICE TA139	Moderate volume; sleep service demand high; repeat PSG in stable CPAP patients a consistent audit finding
Respiratory	Chest CT follow-up for pulmonary nodules below Fleischner Society size threshold	Fleischner criteria: sub-5mm nodules in low-risk patients do not require follow-up CT; over-investigation generates anxiety and radiation	Choosing Wisely USA - CHEST 2016; Fleischner Society guidelines 2017; MacMahon et al. Radiology 2017	High volume; significant variation in adherence to Fleischner criteria across NHS radiology departments
Palliative Care	Routine bloods and observations in patients on an active palliative care pathway who are in the dying phase	Observations and blood tests in dying patients cause distress without benefit; comfort-focused care should replace routine monitoring	Choosing Wisely UK - RCPCH/RCP 2016; Marie Curie end of life care standards; NICE NG142	NHS: routine observations in last days of life continue widely; RCP guidance explicit on withdrawal; significant practice variation
Palliative Care	Hospital admission for end-of-life patients whose preferred place of care is home or hospice	Preferred place of death is home in 70%+ but achieved in <25%; hospital admissions	NICE NG142; Dying Well Community Charter; NHS England End of Life Atlas 2017	NHS England: estimated £500m/year additional cost of hospital over preferred

Domain	Low-Value Activity	Clinical Rationale	Evidence Source	Scale of Opportunity
		at end of life are costly and distressing		community end-of-life care; significant QALY loss