Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Deep Dive: Urology

Quality, Safety and Experience Committee

November 2025

Situation

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This report aims to provide the Quality, Safety and Experience Committee with an overview and update on the current state of Urology service provision across Hywel Dda University Health Board.

- The Committee is seeking to understand the impact of current service fragility within Urology as part of Clinical Service Plan (CSP) 1.
- How this fragility is affecting service provision, including any associated incidents, complaints, patient experience, and clinical risks.
- The report will outline the interim measures, both in place and planned; to manage these challenges while we await the outcome of the CSP.

This paper outlines the clinical, operational and patient experience impacts of fragility, and the interim actions underway to mitigate risk

Background

- The Urology service within the Health Board is experiencing sustained fragility due to workforce shortages, limited diagnostic and theatre capacity, and reliance on non-prospective emergency cover.
- From a Urology perspective *“Fragility is brought about where we cannot consistently meet demand due to workforce, infrastructure, or operational limitations, resulting in safety risks, delays, and reliance on temporary measures.”*
- Infrastructure constraints, particularly within Endoscopy and Imaging (Specifically MRI scanning), further impact service delivery.
- There have been consistent improvements in Referral to Treatment (RTT), outpatient and elective surgery waiting times, with the overall waiting list reducing from 8190 to 5636 in 3 years. The Urology service continues to face challenges in meeting the Unscheduled Care (USC) 62-day cancer targets and the 8-week diagnostic waiting time standard.
- The Urology service is included within CSP to help address underlying systemic challenges and support a sustainable redesign of care delivery. A key objective within the CSP is the establishment of a dedicated Urology Investigation Unit, where diagnostic activity is led by Clinical Nurse Specialists (CNS), enabling streamlined pathways and improved access to investigations.

Key Messages Overview

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- Urology service faces sustained fragility due to workforce and infrastructure constraints including Theatre capacity, treatment rooms for diagnostics and Endoscopy suite session capacity.
- This report includes an improvement trajectory supported by targeted investments and redesign plans.
- PROSTAD/CRUK pilot demonstrates potential for rapid diagnostic transformation.
- CNS team expansion will be critical to improving patient experience and pathway coordination
- Clear actions have been proposed to address diagnostic and treatment backlogs.

Defining a Good Service for the Health Board and Value Contextualisation

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- Consistent compliance with 28-day Faster Diagnosis Standard and 62-day USC targets. Improved diagnostic and treatment timelines reduce clinical risk and emergency admissions.
- Sustainable emergency Rota's with full prospective cover. Alignment with national standards ensures strategic relevance and funding eligibility.
- Reduced reliance on outsourcing and ad hoc arrangements.
- Improved patient experience metrics and continued trajectory of reduced complaints. Better patient outcomes and experience contribute to overall system efficiency.
- Equitable CNS coverage aligned with comparable Health Boards. Investment in CNS roles enhances continuity of care and multi disciplinary team (MDT) efficiency.

Short and Long-Term Plans for Urology

Short-Term Plan:

- MRI outsourcing, Local Anaesthetic transpereneal prostate (LATP) biopsy expansion, Follow-Up waiting list reduction.
- CNS team expansion, emergency rota costing, cystoscopy backlog solutions.

Long-Term Plan:

- Establishment of Urology Investigation Unit (UIU).
- Infrastructure investment in imaging and endoscopy.
- Strategic workforce planning and service redesign under CSP.

Assessment Overview – Key Themes

Access & Capacity

- Referral to Treatment (RTT) performance trends: Shift from outpatient delays to increased pressure on treatment capacity.
- Theatre constraints: Stones Pathway backlog (144 patients), prolonged stent dwell times.
- Diagnostic capacity challenges: Non-USC flexible cystoscopy backlog; two options proposed to address it.

Workforce & Service Fragility

- Emergency rota cover: Gaps in prospective cover due to budget not being aligned with increasing pressure on emergency admissions; need for investment to ensure safe, year-round service.
- CNS workforce requirements: Proposal for two additional Band 7 posts to support prostate and bladder cancer pathways. Again, due to budget not being aligned with demand.

Quality & Safety

- USC pathway fragility: MRI and LATP biopsy delays impacting 28-day Faster Diagnosis Standard.
- Complaints and incident themes: Linked to delays and communication gaps; improving trends but ongoing risks.

Innovation & Improvement

- PROSTAD pilot: Proof of concept for rapid diagnostic model; informs current improvement plan.
- Follow-up capacity redesign: Digital solutions and pathway optimisation to reduce unnecessary face-to-face appointments.

These slides collectively demonstrate a clear trajectory of improvement, supported by targeted investment requests.

Assessment - RTT Performance

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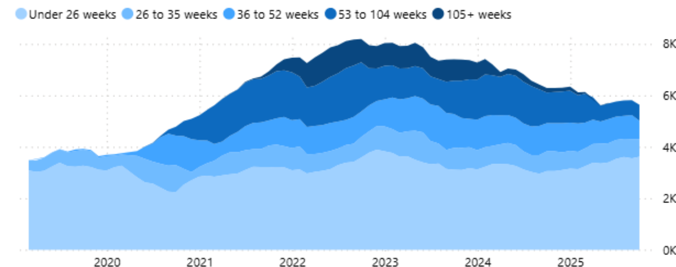
RTT Pathway Shift – April to September 2025

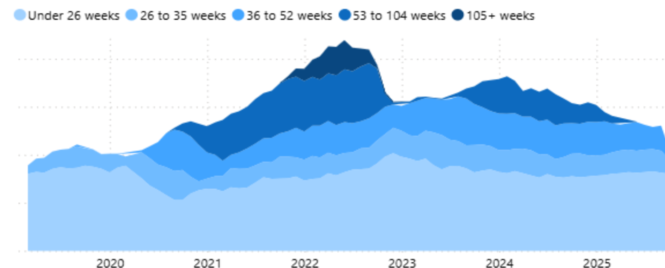
Recent RTT data for the Urology service across the Health Board highlights a shift in patient distribution across the pathway stages. This can be seen between April and September 2025. The number of patients awaiting a new outpatient appointment (Stage 1) reduced from 2,661 to 2,126, reflecting improved outpatient throughput and scheduling efficiency.

Conversely, there has been a corresponding increase in patients at Stage 4 (Admitted Diagnostic/Treatment), rising from 2,162 to 2,737 over the same period. This suggests that more patients are progressing through the pathway and reaching points of treatment.

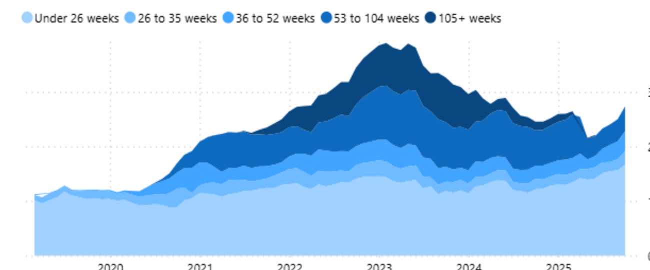
However, this shift also places increased pressure on inpatient and surgical capacity and contributes to ongoing challenges in meeting USC and diagnostic targets. The trend reinforces the need for sustainable redesign through CSP 1, including the development of a dedicated Urology Investigation Unit to support earlier diagnostics and streamline patient flow.



Total Waiting List



Stage 1 Waiting List



Stage 4 Waiting List

Source: Corporate Performance Dashboard.

Assessment - RTT Performance

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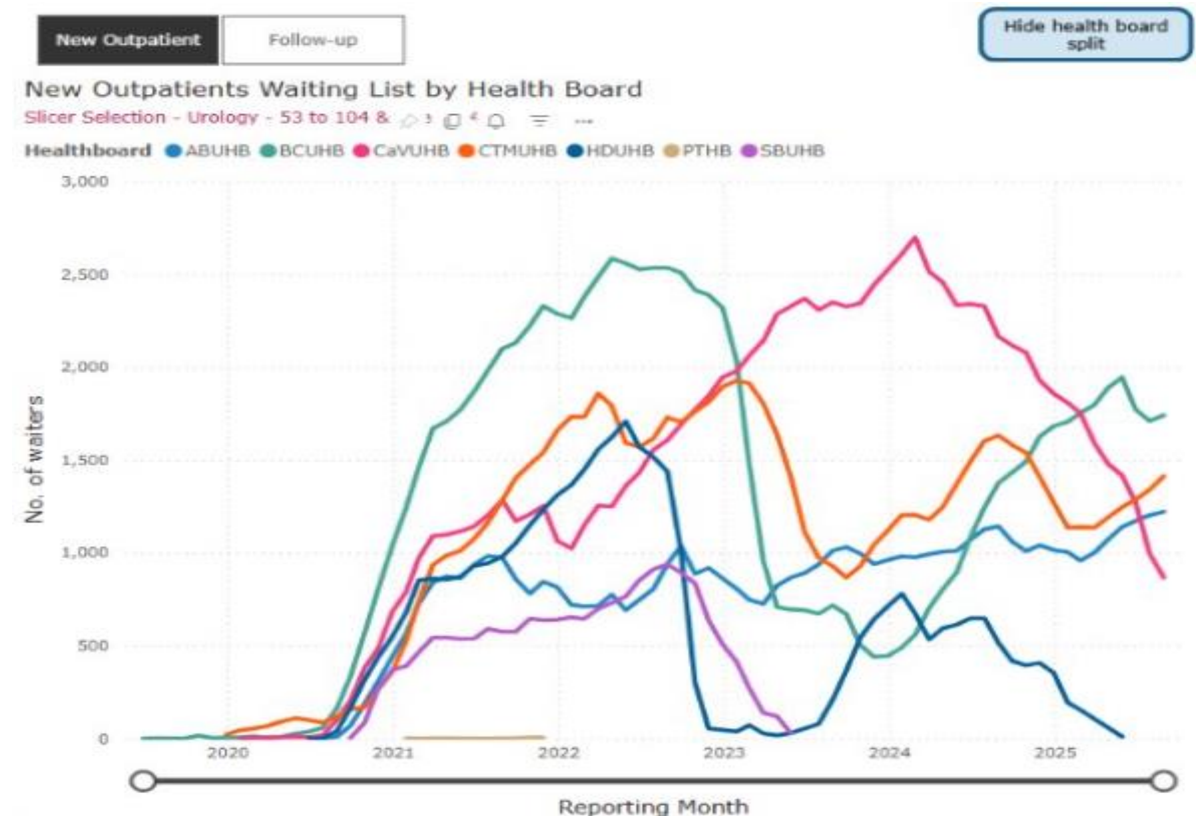
RTT Pathway National Data

- The focus on Stage 1 pathway reduction is reflected in the National data comparison. Only Hywel Dda and Swansea Bay have achieved zero patients waiting more than 52 weeks for first Outpatient Appointment.



Source: Urology CIN Data set October 25

Assessment - RTT Performance

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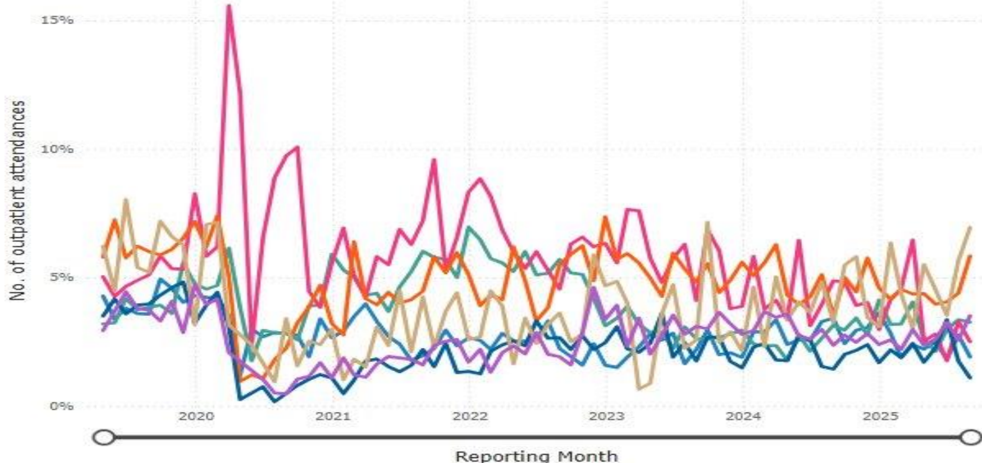
RTT Pathway National Data

- The focus on outpatient efficiency is demonstrated in the low 'Did not Attend' rates for all Outpatient Appointments compared with the national picture
- The overall average non-attendance rate for Urology New Outpatients across Wales as of August 2025 is 4.70%. Hywel Dda achieved 3.70% in August
- The overall average non-attendance rate for Urology Follow Up Outpatients across Wales as of August 2025 is 3.57%. Hywel Dda achieved 1.10% in August.



Source: Urology CIN Data set October 25

Aug-25	
Follow-Ups	
Health Board	**DNA Rate**
ABUHB	1.90%
BCUHB	3.30%
C&VUHB	2.50%
CTMUHB	5.80%
HDUHB	1.10%
PTHB	6.90%
SBUHB	3.50%

Aug-25	
New Outpatients	
Health Board	**DNA Rate**
ABUHB	4.70%
BCUHB	4.90%
C&VUHB	5.20%
CTMUHB	7.30%
HDUHB	3.70%
PTHB	2.00%
SBUHB	5.10%

Assessment - Theatre Capacity

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Stones Patient Pathway and Ureteroscopy Delays (Risk Register 1308)

In parallel to the increasing pressure on the Stage 4 position, the Urology service continues to face longstanding challenges within the Stones Pathway, as captured in Risk Register 1308.

As of the latest review:

- 144 patients are currently awaiting ureteroscopy, including 43 stent-related cases.
- Over 25 patients have been assessed as fit for surgery but remain unscheduled.
- This backlog has persisted for over three years, indicating systemic capacity constraints.

These delays pose significant clinical risks, including:

- Prolonged stent dwell times, increasing the risk of infection, encrustation, and pain.
- Delayed definitive treatment, negatively impacting patient quality of life and outcomes.
- Higher likelihood of emergency presentations due to complications.
- **Solution: To address these challenges, the service has identified the need for two additional Urology theatre lists per week — one dedicated to stone patients and one to Unscheduled Care (USC) cancer patients.** This targeted increase in theatre capacity would:
- Alleviate pressure at the back end of the USC pathway.
- Enable timely intervention for stone patients, reducing risk and improving outcomes.
- Support delivery against key performance targets and reduce reliance on emergency care.

Assessment - Urology USC pathway

The USC plan (Risk Register 2117) ***"Urology diagnostic backlog and trajectory to 28-day diagnosis compliance"***

The Urology USC pathway, particularly for prostate cancer, is under sustained pressure due to a combination of diagnostic bottlenecks and capacity constraints. Delays in MRI access, limited LATP biopsy availability (until recently restricted to one site), and pathology turnaround times have contributed to non-compliance with the 28-day Faster Diagnosis Standard.

Fragmented coordination between Radiology, Urology, and Pathology has further impacted flow.

Although outsourcing of MRI scans has been tendered and awarded, its delayed commencement has hindered recovery efforts. Internal MRI capacity remains under review, while Local Anaesthetic Transperineal Prostate biopsy (LATP) capacity has recently increased to 22 slots per week.

Despite early signs of improvement, the pathway remains fragile, with Urology accounting for 28% of the Health Board's diagnostic cancer backlog and prostate MRI delays contributing to approximately 60% of breaches.

Assessment - Urology USC National data

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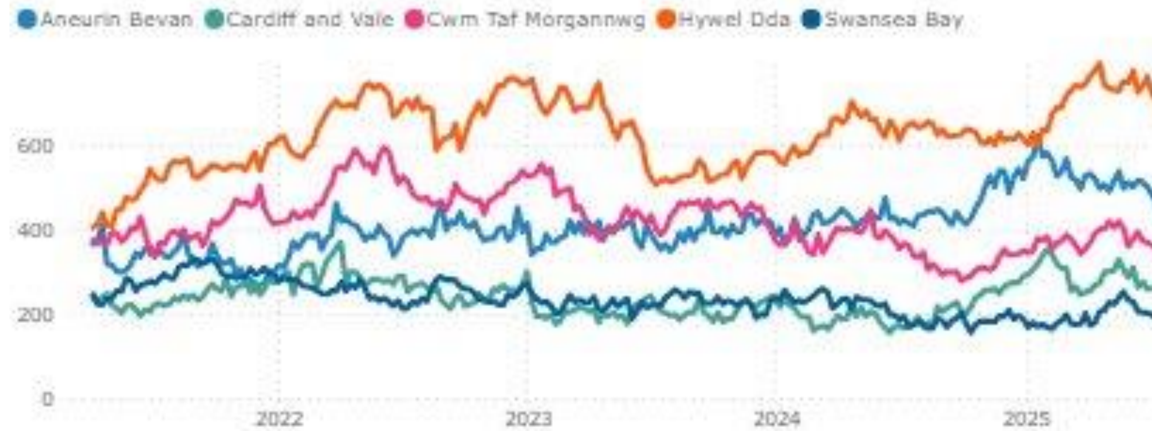
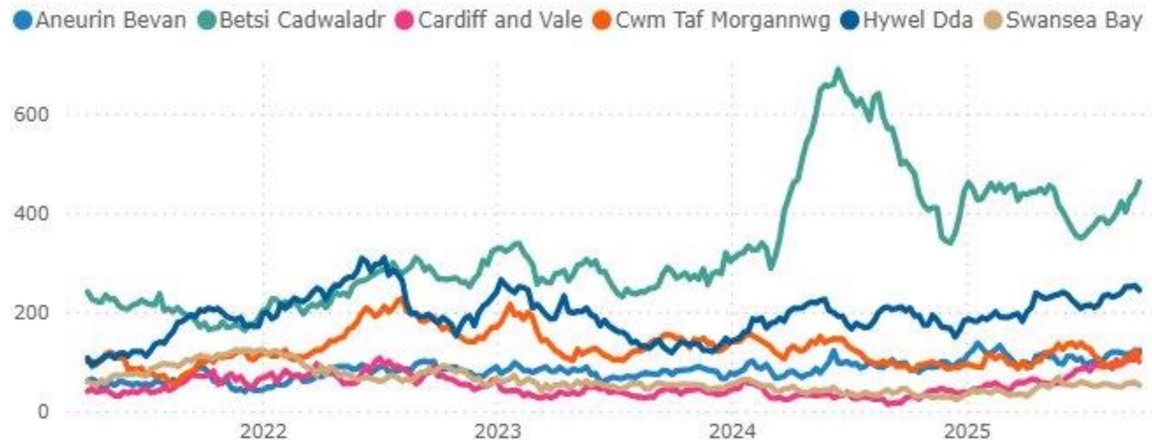
National Data Comparison

- The national comparison data provided by the Urology Clinical Implementation Network consistently places Hywel Dda at the top of all Health Boards for referral volumes and Total Active Waits
- Subsequently, Total Active Waits more than 62 days remains over 200 patients due primarily to the complex nature of the USC pathways and the multiple diagnostic challenges outlined in the Assessment of the pathway.





Source: Urology CIN Data set October 25

Assessment - Urology USC pathway

Cancer Research UK (CRUK) PROSTAD pilot

The PROSTAD project, developed by Hywel Dda University Health Board and funded by CRUK, ran as a 12-month pilot from June 2023 and provided proof of concept for transforming the prostate cancer diagnostic pathway.

The pilot demonstrated a 28-day reduction in time to diagnosis, improved patient experience, and enhanced clinical outcomes.

It introduced a rapid access model aligned with the National Optimal Cancer Pathway, featuring straight-to-MRI testing, expedited reporting, LATP biopsies, and a dedicated pathway navigator.

These results directly informed the current improvement plan, which seeks to scale the model through increased MRI capacity, regional MDT collaboration, and sustained investment in navigation and radiology support initially via outsourcing, with the aim of achieving national cancer targets and delivering long-term service sustainability.

Assessment - Urology USC pathway

CRUK PROSTAD pilot Patient Experience.

David Greenway's patient experience through the PROSTAD pilot pathway illustrates the speed, professionalism, and coordination delivered by the Urology and Radiology teams at Hywel Dda University Health Board. From his initial GP referral in October 2023 to a full diagnostic work-up—including MRI, biopsy, bone scan, and PET scan—completed by mid-December, the pathway demonstrated rapid access and clinical efficiency.

Despite the emotional toll of a prostate cancer diagnosis, David praised the compassionate support from staff, particularly the Urology Clinical Nurse Specialist (CNS) and pathway navigator, and the seamless diagnostic process that enabled timely decision-making.

His story underscores the value of the PROSTAD model in delivering person-centred, high-quality care and highlights the importance of sustaining this approach to improve outcomes and reduce patient anxiety.

Assessment - Urology USC pathway

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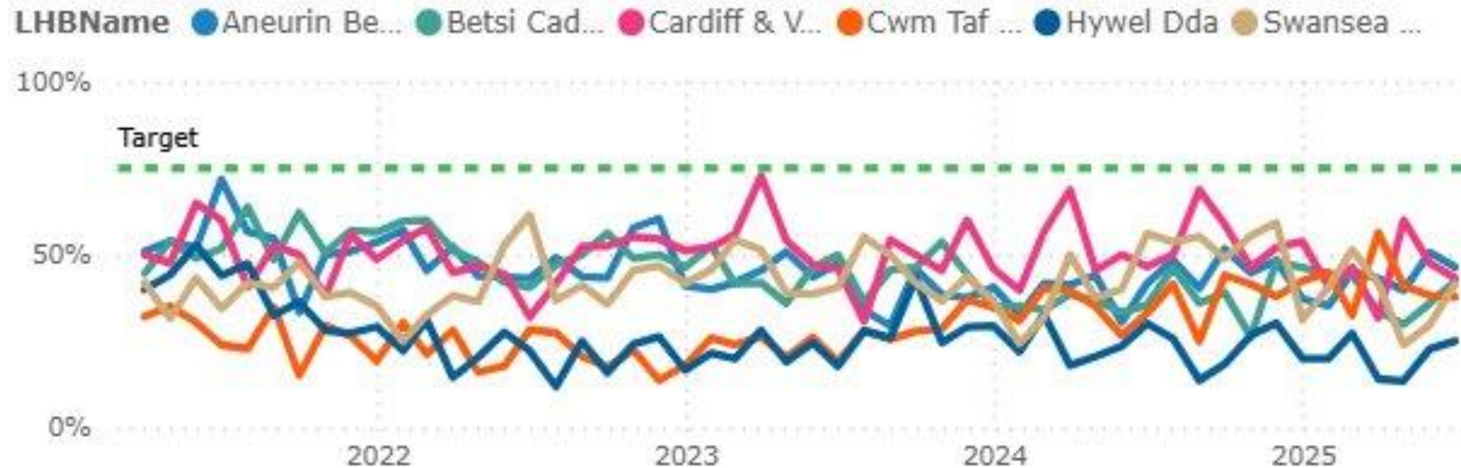
National Monthly Performance Data

- Hywel Dda's USC performance remains below the national average at 25%.
- The plan detailed in the subsequent slides shows a clear upward trajectory due to MRI outsourcing, LATP expansion, and PROSTAD model implementation.



HB	Performance
AB UHB	46.4%
BC UHB	42.4%
CTM UHB	37.8%
CV UHB	43.2%
HD UHB	25.0%
SB UHB	41.5%
All-Wales	**38.9%**

Source: Urology CIN Data set October 25

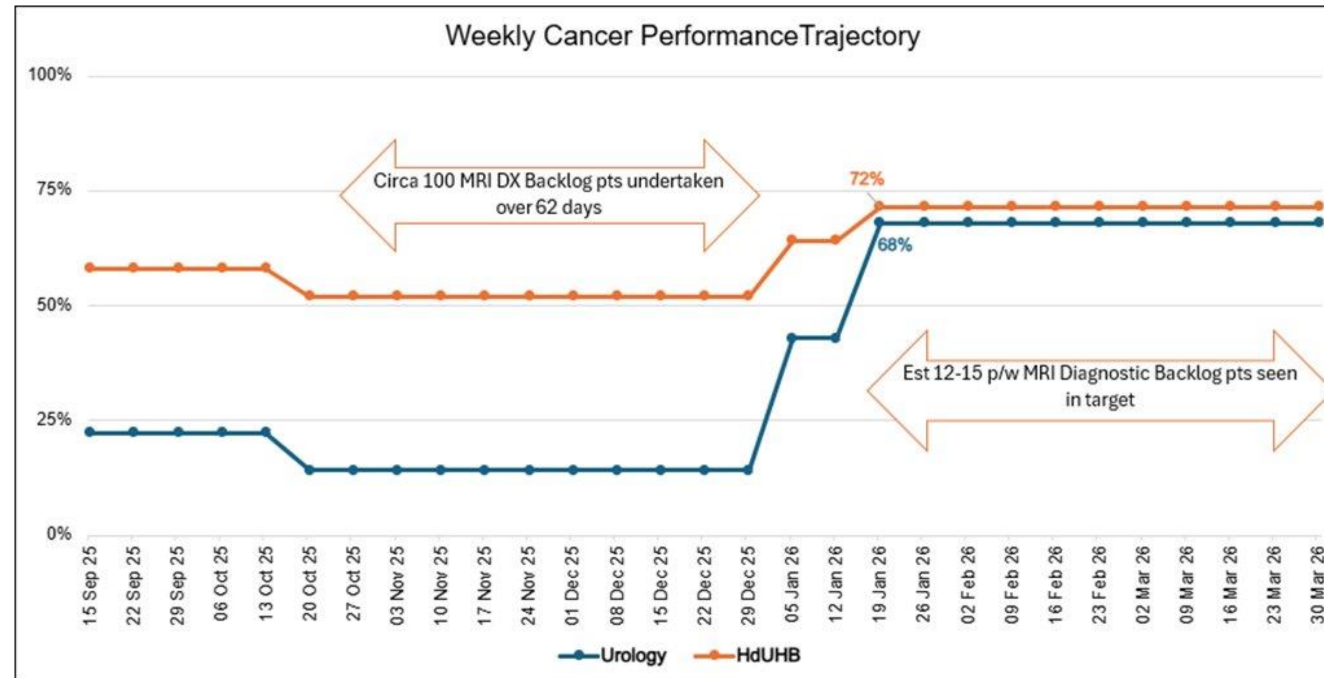
Assessment - Urology USC pathway

Urology USC Improvement plan presented to the Integrated Quality, Financial Performance and Delivery Group on 08 October 2025

The CRUK PROSTAD project directly influenced the key elements of the current USC improvement plan. The Urology diagnostic backlog is being actively managed through targeted recovery actions, with a clear trajectory toward 28-day diagnosis compliance. Continued monitoring and escalation of MRI outsourcing delays are essential to sustain progress.

Trajectory:

- With MRI outsourcing commencing mid-October and internal LATP capacity stabilised, compliance with 28-day FDS is projected to improve from November onwards.
- Between September 2025 and March 2026, the Urology pathway shows a projected improvement in compliance with the 62-day diagnosis to treatment target, rising from 22% to 68%.



Assessment - Urology USC pathway

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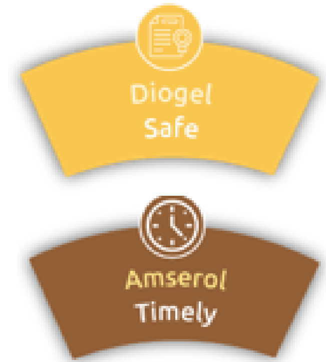
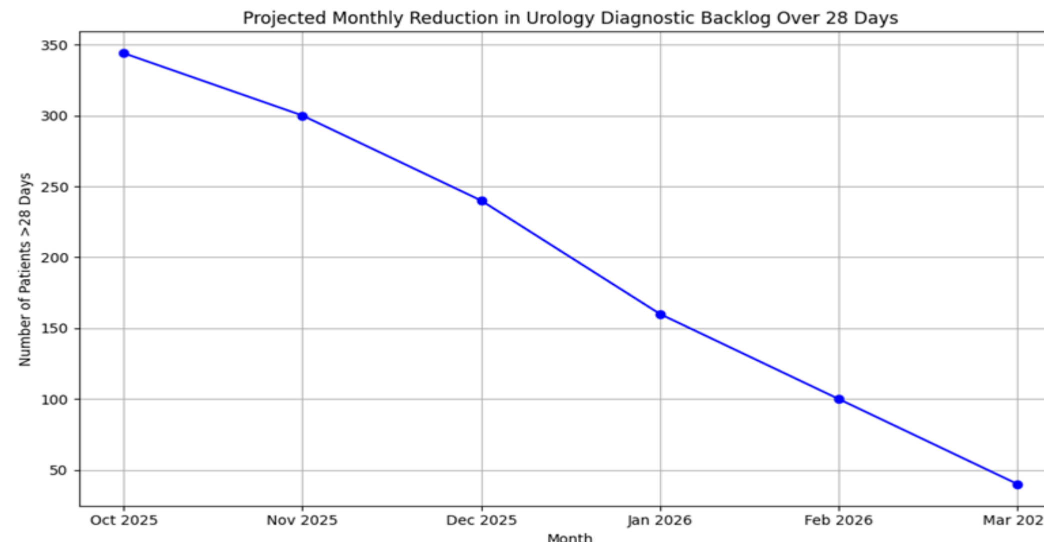
Urology USC Improvement plan presented to the Integrated Quality, Financial Performance and Delivery Group on 08 October 2025



- The initial drop in USC performance is explained by the treatment of long-waiting, non-compliant patients from the existing 62-day backlog, made possible by increased MRI capacity.
- The significant inflection point occurs in early January 2026, where compliance increases from 14.2% to 43%, coinciding with the outcomes from the commencement of MRI outsourcing and expanded LATP biopsy capacity.
- In contrast, the Health Board's overall 62-day compliance improves from 58.0% to 71.6%, reflecting the impact that planned Prostate pathway improvements may have on the overall Health Board performance.
- While Urology remains below the Health Board average throughout the period, the gap narrows significantly by March 2026, indicating a positive trajectory and the impact of targeted diagnostic interventions.

Diagnostic position over 28 days

- The total Urology diagnostic backlog over 28 days stands at 344 patients, with the Prostate MRI pathway contributing approximately 60% of this figure.
- A planned reduction begins in November as the recovery process commences, with the backlog expected to decrease steadily to March 2026, supported by increased MRI and LATP capacity and improved pathway coordination.



Assessment - Urology USC pathway

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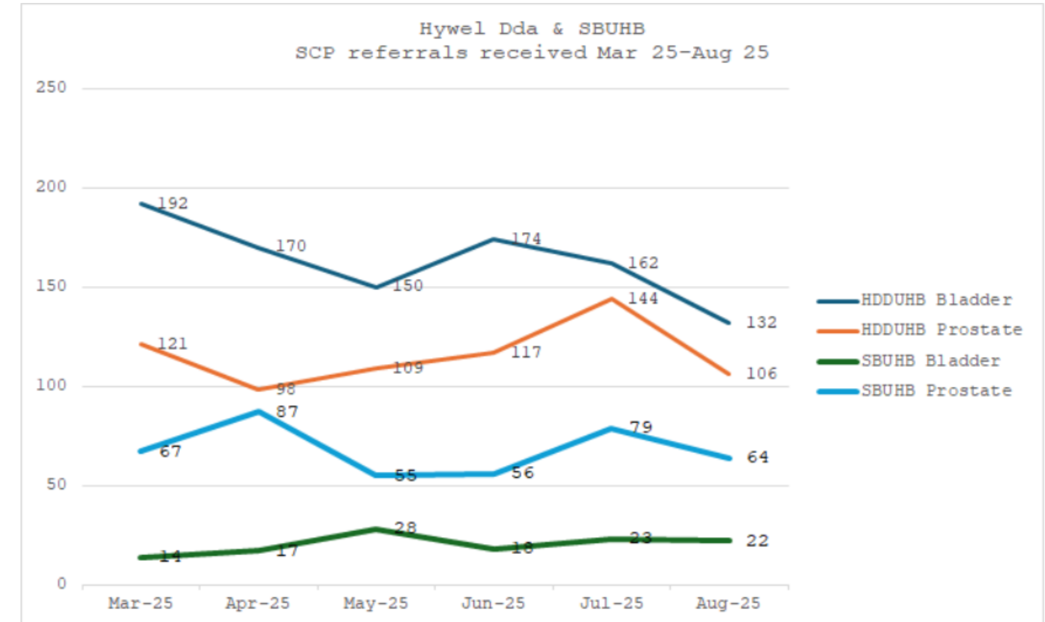
CNS team requirements

- As part of the final phase in strengthening the Urology USC pathway, The Urology team is proposing the expansion of its Clinical Nurse Specialist (CNS) team through the **appointment of 2 WTE additional Band 7 CNSs**—one dedicated to prostate cancer and one to non-muscle invasive bladder cancer (NIMBC).
- This request responds to rising cancer incidence, increasing complexity of care, and persistent workforce pressures that are impacting timely diagnosis, treatment coordination, and patient support. These roles are designed to act as key workers, providing continuity of care, personalised support, and clinical leadership across the pathway.
- They will enhance MDT efficiency, reduce delays, improve patient experience, and support national cancer targets including the 62-day pathway. The proposal aligns with the Wales Cancer Network Performance Plan and reflects a commitment to delivering equitable, high-quality cancer care across a geographically dispersed and rural population.
- A submission has been made by the CNS team to the Moondance fund for initial investment in the expansion of the team.
- Further to this submission, the Senior Nurse Manager and SDM will draft a paper outlining the inequity of CNS coverage between comparably sized Health Boards, Swansea Bay and Hywel Dda. Specifically focusing on the comparative demands on the service and the lack of investment in the CNS team.



Hywel Dda UHB at mid-2023		Swansea Bay UHB at mid-2023	
Total population: 385,386		Total population: 246,700	
Age (years)		Age (years)	Number (% of population)
0-15	86,603 (22.5%)	0-15	42,000 (17%)
16-64	230,288 (59.8%)	16-64	151,000 - 153,000 (61-62%)
65 and over	68,495 (17.7%)	65 and over	49,000 – 54,000 (20-22%)

Assessment - CNS Team Priorities

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Governance and Quality Assurance

- Establish quarterly Urology CNS Governance Forums under quality, safety and experience oversight to review:
    - Patient feedback (PREMs, Macmillan Welsh Survey)
    - Audit outcomes and pathway compliance
    - Incident and complaint themes linked to CNS support gaps
    - Embed CNS representation in MDTs and service redesign groups to ensure nursing voice in strategic decisions.

Workforce Establishment and Getting it Right First Time (GIRFT) Alignment

- GIRFT review identified severe under-establishment in CNS staffing.
- Current CNS roles have not been uplifted in line with service growth or complexity.
- Proposal for 2.0 WTE Band 7 CNSs (Prostate & NMIBC) to:
    - Reduce unsustainable caseloads
    - Improve continuity of care and pathway navigation
    - Support compliance with 62-day cancer targets and National Optimal Pathway standards

Assessment - CNS Team Priorities

Patient Support and Experience

- Significant gaps in emotional and informational support identified via:
- Macmillan Welsh Patient Experience Survey, Hywel Dda PREM (2022), CaPS & CISS feedback mechanisms
- CNS team to lead on:
  - Development of personalised care plans
  - Enhanced signposting to support services
  - Patient education materials tailored to diagnosis and treatment stages

Strategic Gap Analysis and Future Planning

- Conduct a full gap analysis against:
- National Optimal Cancer Pathway and Person-Centred Care Framework
- Collaborate with Lead Cancer Nurse and QI Team to:
  - Identify further uplift requirements
  - Benchmark CNS coverage against comparable Health Boards (e.g., Swansea Bay)

Assessment - Feedback and Incidents

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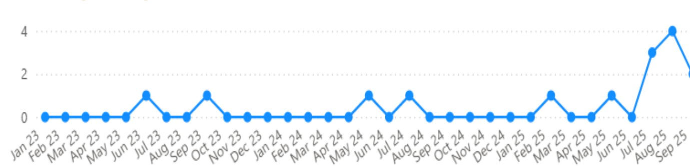
Complaints and Incident Reporting

The improving position in managing complaints and incidents, as shown in recent data, reflects the impact of targeted recovery actions.

However, sustaining this progress requires investment in key enablers—particularly the expansion of the CNS workforce, additional theatre capacity, and continued pathway redesign. These measures directly address the root causes of patient dissatisfaction and clinical risk, and are essential to delivering safer, more responsive care.

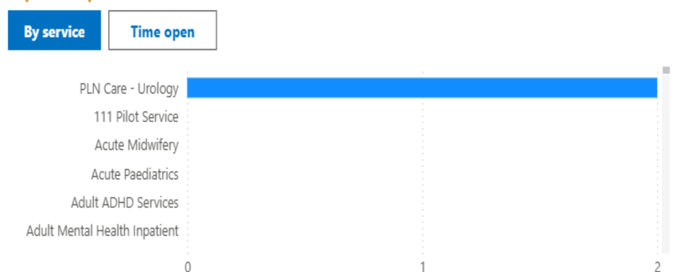
New complaints by month received

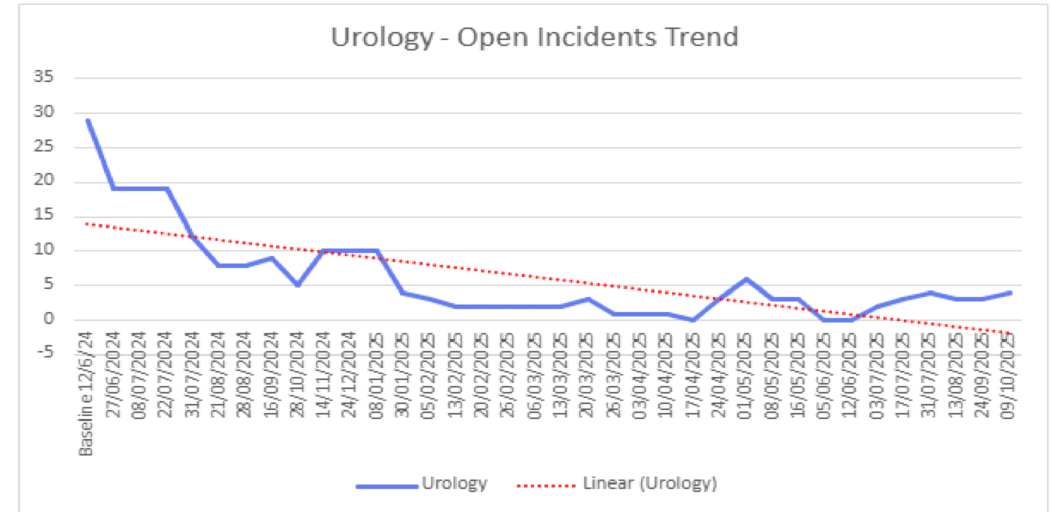


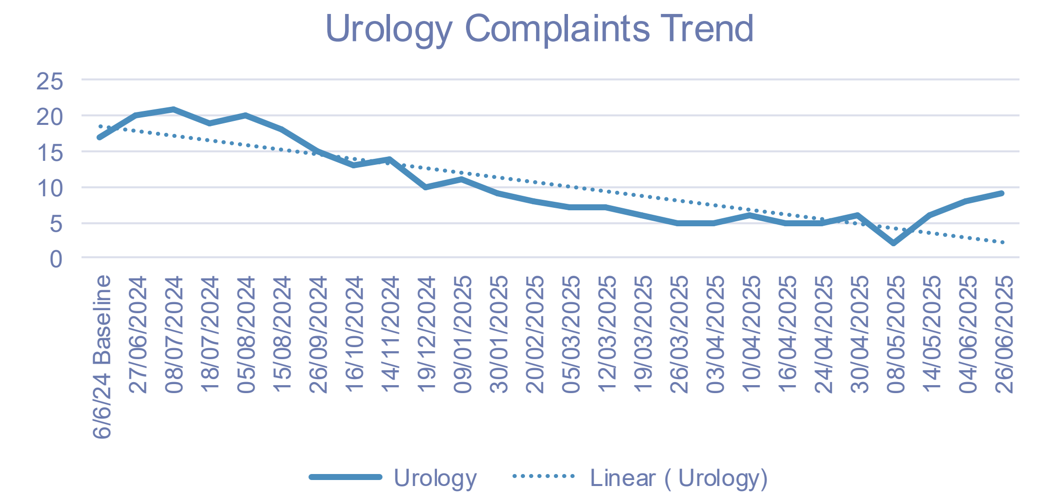
Open complaints summary

ID	Department, ward or team	COM Stage	Days since client response due	Days open
23137	PLN Care - Urology	Awaiting comments from Service	26	68
23738	PLN Care - Urology	Awaiting comments from Service	-6	35

Open complaints







Assessment - Thematic Overview

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Complaints and incidents within the Urology service continue to centre around delays in diagnosis, treatment, and communication, particularly affecting patients on the cancer and stones pathways. Patient feedback consistently highlights the emotional toll of prolonged waits, with anxiety and dissatisfaction being common themes. Cancelled Virtual Follow up appointments is a key theme.

While ward-based concerns and diagnostic delays remain prominent in complaints, incident reports are more frequently linked to procedural and treatment-related issues.

Significant breaches trigger harm reviews, and recurring themes are actively monitored through established governance processes.

Redress Summary:

Currently, two redress cases are under review:

- 1196/206 (due 01/12/25): A 2019 case involving misdiagnosed testicular cancer.
- RL17027 (due 23/11/25): A 2024 case involving the incorrect insertion of a suprapubic catheter.

Closed cases (no penalty):

- 1264/441: A 2008 case involving (ST) Trans Vaginal Tape. Consent concerns.
- 817/620: A 2016 case involving a neurological disorder and MRI scan.
- RL/871: A 2022 Rigid Cystoscopy delay.

Assessment - Clinical Governance Actions

Consent Training Programme

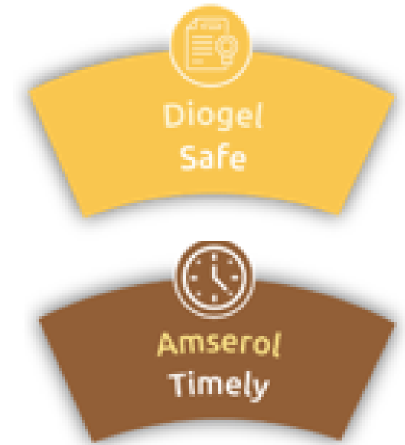
- Trigger: Closed Case 1264/441 (July 2025).
- Action: Full consent training delivered to Urology clinical team.
- Outcome: 85% compliance across consultants and registrars.
- Sustainability: Annual refresher and audit embedded.

Virtual Follow-Up Review

- Trigger: Recurring complaints re: cancelled virtual appointments.
- Action: Follow-Up Friday regime introduced.
- Outcome: Weekly validation and cleansing of follow-up lists now routine.

Transfusion Reaction Training

- Trigger: Recent transfusion reaction incident on Urology ward.
- Action: Collaboration with Transfusion Practitioner to deliver training.
- Scope: All ward nurses and on-call doctors included.
- Timeline: Training to be rolled out over the coming months.



Assessment - Diagnostic Capacity

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Endoscopy Capacity Constraint and Options for Non-USC Flexi Diagnostics

The recent growth in the non-USC flexible cystoscopy waiting list, as shown in the graph, highlights increasing demand for diagnostic capacity outside of urgent cancer pathways. The Endoscopy Team has confirmed they are unable to provide any additional sessions for Urology, creating a significant bottleneck in service delivery. Whilst the service has maintained low volumes of USC patients waiting more than 2 weeks for Cystoscopy, other non-USC waits have risen significantly. We are jointly exploring **two solutions:**

Option 1: De-camp Urology Flexi Cystoscopy from Endoscopy

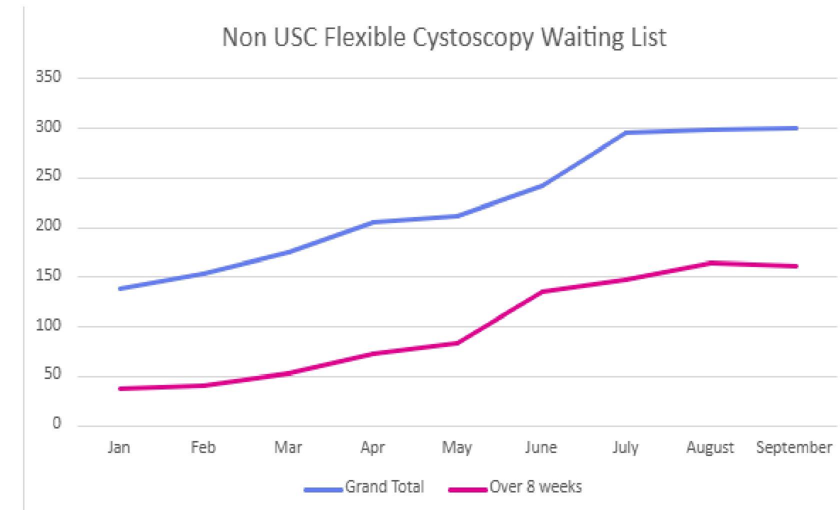
Relocate the existing 6.5 Urology flexible cystoscopy sessions from the Endoscopy Unit plus 4 additional to cover demand, to a suitable treatment room, recognising that these procedures do not require a full endoscopy theatre setting.
This would:

- Release capacity within Endoscopy for GI expansion, using existing theatre staffing.
- Be initially staffed by Endoscopy nurses to ensure clinical safety and continuity.
- Require investment to backfill Endoscopy posts and support transition to a dedicated Urology team.
- Align with the longer-term development of a Urology Investigation Unit (UIU) under the CSP.

Option 2: Extend Endoscopy Operating Hours

Expand operating hours at one Endoscopy Unit beyond the current 9–5, Monday–Friday schedule. This would require:

- Additional staffing investment:
- 3.2 WTE Band 5, 1.6 WTE Band 3, 0.4 WTE Band 2, 0.4 WTE Band 7
- **Plus, staff to support delivery of 4 additional sessions per week to meet Urology demand.**



Assessment - Emergency Rota

Prospective Emergency Rota Cover

The Urology service currently operates a 1:6 Consultant and Registrar emergency rota to provide consistent and sustainable cover for urgent urological presentations across Hywel Dda.

This model currently does not allow for full coverage of the 52 weeks of the year and leaves a 10-week gap where reliance on goodwill or ad-hoc arrangements and ADH spend is required.

Early exploration of costing the additional staff required to fulfil a full prospective rota is underway. This rota would support the broader service transformation, including improved USC performance, reduced delays in emergency diagnostics and interventions, and better alignment with national expectations for acute surgical services, and improve patient safety and continuity of care.

Solution: Support for the expansion of the on-call team on this basis would be required. Additional Registrar and Consultant to reduce the rota to 1:7 would achieve this.

Ref:

- BAUS Guidance (British Association of Urological Surgeons)
- GIRFT Urology Guide to Urgent and Emergency Care (2025)
- NHS England Seven-Day Services Clinical Standards

Assessment - Follow up capacity

Ongoing Urology Follow Up improvement plan

List Cleansing through CNS team

- Short term plan to focus on transferring patients onto suitable SOS and PIFU pathways
- Validation exercise weekly prior to Clinical Validation
- Implement Follow Up Friday regime of list cleansing

Process Optimisation

- Streamline administrative processes and develop patient flow diagrams for Active Monitoring Pathways.
- Clinical coding of the 2800 Follow Up patients with Blank codes through admin validation.
- Focus on grouping PSA Remote Monitoring patients.

Informatics work and Digital Solutions

- Work towards transfer of appropriate PSA surveillance and Post Op PSA surveillance patients onto the 'Remote Monitoring' WPAS option. Implement PKB as preferred method of information for patients once the integrated solution where data transfers between Clinical Portal and PKB, is available in March 2026

Clinic Adjustments

- Create capacity for consultants and registrars by creating CNS led Prostate review clinics. Requires the additional CNS team to support this development

Conclusion - Infrastructure Constraints

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- Limited MRI capacity delays USC diagnostics.
- Endoscopy unit unable to expand flexible cystoscopy sessions.
- Limitations on weekly Theatre capacity for Stones and USC lists.
- Lack of dedicated Urology diagnostic space impacts throughput.
- Reliance on single-site LATP biopsy until recent expansion.
- Constraints contribute to backlog and breach risks.

Conclusion - Actions Taken

- Improved outpatient throughput, reducing Stage 1 RTT backlog.
- Increased LATP biopsy capacity to 22 slots/week. Elimination of LATP Biopsy backlog and waiting list.
- Commenced MRI outsourcing plan to address diagnostic delays.
- Stabilised flexi cystoscopy USC waiting list.
- Implemented PROSTAD pilot, demonstrating 28-day diagnostic pathway success.
- Submitted CNS expansion proposal to Moondance Cancer Initiative.
- Initiated costing for prospective emergency rota cover.
- Developed options to address non-USC diagnostic Cystoscopy backlog.
- Targeted Clinical Governance Actions.

Conclusion - Next Steps and Areas Under Development

Securing Two Additional Urology Theatre Lists per Week

- Scoping the feasibility of securing two additional Urology theatre lists per week (one for stone patients, one for USC cancer patients) to reduce backlog and clinical risk.
- Reduces backlog and clinical risk (Risk Register 1308).
- Improves USC pathway flow and compliance (Risk Register 2117).

Expansion of the Emergency On-Call Rota

- Exploring options to expand the on-call team to deliver a fully prospective rota, improving safety and reducing reliance on ad hoc arrangements.
- Aligns with BAUS, GIRFT, and NHS England standards.

Exploring options for Endoscopy/Cystoscopy Expansion

- Continuing to assess and develop preferred options to address the non-USC flexible cystoscopy backlog, including:
- Option 1: De-camp Urology sessions from Endoscopy.
- Option 2: Extend Endoscopy operating hours.
- To restore diagnostic capacity and support GI expansion.

Band 7 CNS Posts

- Progressing the case for two additional Band 7 CNS posts to support prostate and bladder cancer pathways, aligned with national standards and equity across Health Boards
- Responds to rising cancer incidence and complexity.
- Enhances MDT efficiency, patient support, and pathway coordination.
- Supports national cancer targets and aligns with Wales Cancer Network Performance Plan.

Conclusion - Expected Outcomes and Ongoing Work

Ongoing Areas of Focus to Mitigate Interim Risks:

- Continued development of plans to improve compliance with national cancer targets.
- Ongoing work to reduce diagnostic and treatment backlogs through targeted interventions.
- Sustained efforts to enhance patient experience and reduce complaints.
- Exploration of solutions to deliver safer, year-round emergency cover.
- Progression toward a sustainable service model aligned with long-term CSP objectives.
- Risks remain under active review and escalation through established governance structures.

The Committee is asked to take assurance that these areas are being actively scoped and developed to mitigate service fragility while awaiting CSP 1 outcomes.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

The six domains of quality

Bwrdd Iechyd Prifysgol Hywel Dda
University Health Board

Diogel
Safe

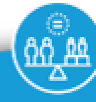
Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce

Effeithlon
Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.

Amserol
Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



Teg
Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Effeithiol
Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

Person ganolog
Person centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.