Date	**04/11/2025**
Time	**13:00 - 15:00**
Location	**Microsoft Teams Meeting**

Extraordinary Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 4 November 2025

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1 **Welcome and Apologies**

Anna Lewis (Hywel Dda UHB - Independent Board Member)

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2 **Minutes of the extraordinary meeting that was held on 15 September 2025 and Table of Actions**

Anna Lewis (Hywel Dda UHB - Independent Board Member)

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3 **Urology Deep Dive**

30 min
Neil Griffiths (Hywel Dda UHB - Service Delivery Manager of Urology and Rheumatology), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

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4 **Dermatology Deep Dive**

30 min
Ceri Wisdom (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

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5 **Endoscopy Deep Dive**

30 min
Sara Jones (Hywel Dda UHB - Service Delivery Manager - Endoscopy & Gastroenterology), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

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6 **Date of Next meeting- 4 December 2025**

Table of contents

04/11/2025 13:00 - 15:00

1

13:00,

1 - Welcome and Apologies

Anna Lewis (Hywel Dda UHB - Independent Board Member)

2

2 - Minutes of the extraordinary meeting that was held on 15 September 2025 and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

2025-09-15 - Extraordinary Quality, Safety Experience Committee Meeting -~.pdf

Table of Actions Extraordinary QSEC 15 September 2025.pdf

UNAPPROVED MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING

DATE OF MEETING: **2:00 PM, Monday 15 September 2025**
VENUE: **Microsoft Teams**

PRESENT:
Anna Lewis (Hywel Dda UHB - Independent Board Member) (VC) (Chair)
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair) (VC) (Vice Chair)
Sarah Harraway (Hywel Dda UHB - Independent Board Member) (VC)
Chantal Patel (Hywel Dda UHB - Independent Board Member) (VC)
Michael Imperato (Hywel Dda UHB - Independent Board Member) (VC)

IN ATTENDANCE:
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (VC) (Lead Executive)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer) (VC)
Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality) (VC)
Donna Coleman (Llais Cymru/Citizens Voice Body Representative) (VC)
Eiry Edmunds (Hywel Dda UHB - Cardiac Consultant) (Deputy Medical Director) (VC)
Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health) (VC)
Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing) (VC)
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science) (VC)
Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding) (VC)

Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager) (VC)
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning) (VC)
Subhamay Ghosh (Hywel Dda UHB – Associate Medical Director For Quality & Safety) (VC) (part)
Lisa Humphrey (Hywel Dda UHB - General Manager) (VC)
Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC) (VC)
Senthil Kumar (Hywel Dda UHB - Consultant Physician) (VC)
Bethan Lewis (Hywel Dda UHB - Assistant Director of Public Health Strategic Business and Operations) (VC)
Caroline Lewis (Hywel Dda UHB - Service Delivery Manager ENT & General Surgery) (VC)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary) (VC)John Jenkins (Hywel Dda UHB - Committee Services Officer) (VC) (Secretariat)

MINUTES REF.	ITEM	ACTION
QSEC 25 (54)	WELCOME AND APOLOGIES	

Ms Anna Lewis welcomed all present to the Extraordinary Quality, Safety and Experience Committee (QSEC) meeting and advised that the purpose of the meeting was to receive assurance on three of the nine service areas considered fragile and under consideration through the Clinical Services Plan (CSP) consultation and advised that discussion of these services did not prejudice the CSP process and sought to enable the Board to be assured that the Committee had explored consideration of the services through the quality, safety and patient experience perspective.

Ms Anna Lewis advised that this was the first of three such sessions to examine the nine service areas with a second Extraordinary QSEC meeting scheduled in addition to the substantive meeting on 4 December 2025.

Apologies had been received from:

- Mr Mark Henwood, Executive Medical Director (Ms Eiry Edmunds deputising)

QSEC 25 (55) CRITICAL CARE

Ms Diane Knight introduced the deep dive into Critical Care and advised that the focus of the deep dive would `be on the Carmarthenshire element of the system as it presented the greatest fragility/challenge within the critical care system. The CSP has a broader scope & includes Withybush Hospital (WGH) and Bronglais Hospital (BGH) as a wider Health Board review.

Ms Knight advised that there had been a significant change to the Critical Care provision within Carmarthenshire in July 2022 due to a shortage of consultants within the Glangwili Hospital (GGH) and Prince Philip Hospital (PPH) Intensive Care Units (ICUs). Ms Knight advised that at that stage the number of consultants in post had reduced from 8 to 5 within a 5-month period due to a combination of retirement and ill-health.

Ms Knight advised that the consultant shortage in Carmarthenshire resulted in an amended patient pathway and escalation process from PPH ICU to GGH supported by a standard operating procedure (SOP).

Ms Knight advised that in January 2025 there had been a clinical-led decision made to apply professional judgement to the SOP which has led to a decrease in the number of patients remaining within the PPH ICU and an increase in the number of patients transferred to the GGH ICU. Ms Knight believed that the review and admission process had not changed. It had been previously agreed that a number of patients would remain within the PPH

ICU under the virtual care of the consultant group however in January 2025 the consultant group at Carmarthen felt that patients at PPH ICU could not be managed virtually from GGH and that all patients admitted to the PPH ICU at Level 2 (high dependency) or Level 3 critical care) would need to be transferred to GGH ICU and this process remains in place currently.

Ms Knight presented an analysis of data comparison from 1 January 2024 to 31 August 2024 compared to the same time period in 2025. Ms Knight advised that the only variable that had changed between the two periods was the clinical threshold for transfer of patients from PPH to GGH with the review, admission and referral processes having remained the same.

Ms Knight advised that there were 14 Critical Care Units in Wales that supported Level 3 patients with 4 of those located within Hywel Dda University Health Board (HDdUHB) which was reflective the dispersed population of the Health Board and the consequential challenges posed by such a dispersed population.

Ms Knight advised that the Faculty of Intensive Care Medicine (FICM) publishes the Guidelines for the Provision of Intensive Care Services (GPICS) detailing the recognised standards for critical care provision and made reference to the delivery of critical care services within a rural setting such as HDdUHB.

Ms Knight advised that the levels of dependency within Critical Care were:

- **Level 0:** patients whose needs can be met through the normal ward care in an acute hospital;
- **Level 1:** patients at risk of their condition deteriorating or recently relocated from higher levels of care and whose care can be met on an acute ward with additional advice and support from the Critical Care Team;
- **Level 2:** patients requiring more detailed observation or intervention or those stepping down from a higher level of care; and
- **Level 3:** patients requiring advanced repository support or basic respiratory support with the support of at least two organs systems and complex patients requiring support for multiple organ failure.

Ms Knight provided a review of the current Critical Care Capacity across the Health Board and advised that there were currently 20 Level 3 Critical Care beds with 1:1 nursing ratio however noted that with Level 2 patients requiring a 2:1 nursing ratio there was an opportunity to flex the bed capacity depending on the levels of patients admitted to the ICUs.

Regarding medical recruitment Ms Knight advised that in July 2025 a consultant lead for Critical Care had been appointed to support continuity and development of service provision within the Health Board.

Ms Knight advised that since January 2025, the Health Board was operating outside of the SOP with all Level 3 patients with multiple organ support or Level 2 patients predicted to require Level 3 care transferred to GGH at the earliest and safest opportunity. This decision was based on professional clinical judgement due to unresolved concerns of patient safety that were raised by ICU clinicians and the medical staffing challenge of having limited Specialty, Associate Specialist, and Specialist (SAS) doctors undertaking the senior ICU rota in Carmarthenshire created by recent staff departures to take up Deanery posts and 50% of offers of new posts declined within 10 days due to acceptance of alternative posts.

Ms Knight presented an assessment of the admission profile data at PPH and the current amended pathway but could not offer a rationale for the difference in numbers being admitted to the PPH ICU. It was apparent that the number of Level 2 patients retained at PPH had reduced and the number of patients transferred to GGH had increased. Ms Knight advised that a review of Datix incidents during the review period provided no indication of any patient safety or quality indicators that would have provided a rational for a reduction in the number of patients admitted to the PPH ICU.

Ms Knight advised that an assessment of the medical staffing within ICU in Carmarthenshire highlighted that 8 of the 9 currently funded consultant posts were currently filled with the consultant lead currently considering whether to recruit to the ninth post. Ms Knight advised that there were currently 22 funded SAS doctor posts with 16 currently in post, 2 currently on-boarding and 4 anticipated to be appointed from a current recruitment process that would result in full coverage of current on-call commitments.

Ms Knight advised that there were on-going clinically led discussions on the patient pathway at PPH as to whether it was necessary to formally amend the SOP with a need to maintain collaboration with medical recruitment and to support the medical stabalisation project while remaining committed to collaboration with the CSP process.

Mr Andrew Carruthers advised that he and Mr Mark Henwood had been engaged in on-going discussion with the medical and nursing teams within Critical Care at PPH to reiterate that the SOP that had been agreed by the Health Board Executive Team and approved by Board remained extant and that the change was in response to a heightened risk aversion from the consultant and ICU team at GGH and believed that the reduction in Level 2 being retained at PPH a result of the higher risk aversion. Mr Carruthers

believed that any discussion on a revision of the SOP was interconnected with the CSP process, and a decision could not be made that could potentially compromise the CSP process.

In response to a question from Ms Anna Lewis on whether there had been a change to clinical practice even if there had been no formal change to the SOP, Mr Carruthers believed that there was a level of complexity that was not uniform throughout the comparative time period and was highly dependent on individual clinical decision-making based on judgement and deliberation in accordance with the pathway in a subjective manner on a case-by-case basis.

Ms Eiry Edmunds agreed with Mr Carruthers and believed that there was no evidence of any changes to referral patterns and that further investigation was required to ascertain whether patients were being kept on wards longer and not being admitted to ICU. There was no evidence of any patients being inappropriately denied admission to ICU more in PPH than GGH or WGH. Mrs Sharon Daniel advised that the Health Board did record acuity data for all wards at PPH that could be reviewed retrospectively.

In response to a question from Mrs Daniel on whether there was any learning derived from an incident in December 2024, Ms Cathie Steel advised that the investigation was currently on-going however a review of the SOP on communication between Critical Care Units within the Health Board were undertaken to ensure patients were transferred in a timely manner.

Mrs Eleanor Marks believed that no inference was able to be made from a comparison of the 2024 and 2025 data and believed that any changes to procedure should have been presented to QSEC ahead of submission to Board for consideration as the change could be considered a service change and wished to receive assurance that the governance process had been followed.

Ms Donna Coleman advised that from a patient and family experience perspective that the travel distance between home and where patients received their care was a subject of strong feedback received through the CSP consultation process, especially for those without access to private modes of transport. Mrs Marks believed that there was a conundrum highlighted by the CSP consultation on the balance between the provision of the best possible care and the distance travelled for their care for both travel and for emotional and practical care-giver support.

In response to a question from Ms Sarah Harraway on the need for further investigation for why the overall number of referrals had decreased and what the drivers for that were, given that should the pattern reverse a significant level of additional pressure would be applied to ICU in GGH, Mrs Daniel advised that an analysis of trend data as opposed to snapshot data was required in addition **CS/DK**

to a consideration of the relevant staff survey data to triangulate the investigations further.

Ms Anna Lewis recognised that operational colleagues, both clinical and managerial, were committed to the provision of the best possible quality service in difficult and challenging circumstances and should always be supported to make the best decisions on a patient-by-patient basis for the patient quality, safety and experience.

Ms Anna Lewis believed that there was a need to undertake further investigations into the change in numbers of patients admitted to ICU at PPH and GGH that would not only inform what the drivers of the variation in numbers, it would also provide intelligence for the CSP process.

Ms Anna Lewis believed that there needed to be clarity on whether the clinical practice within ICU at PPH and GGH was going beyond the scope of the SOP and that there was a valid rationale for doing so or whether the SOP needed to be updated to reflect the changing circumstances within ICU in Carmarthenshire since July 2022 and that nothing should be done to undermine or prejudice the outcome to the CPS process and any long-term strategic work around Critical Care. Mrs Wilson agreed to review the governance process relating to the operation of the ICUs at PPH and GGH and to ensure there was no conflict with the CSP process. **JW**

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Critical Care.

QSEC 25 (56) EMERGENCY GENERAL SURGERY

Ms Caroline Lewis presented the deep dive into Emergency General Surgery to provide the Committee with an understanding of the impact of the fragility of the service provision and the management of incidents, complaints, patient experience and risks, how the out-of-hours surgical service was being maintained while the CSP was being progressed together with an update on the management of the Emergency General Surgery (EGS) rota for GGH and WGH.

Ms Caroline Lewis advised that in November 2022, the WGH consultant rota was a 1 in 5 rota that had become fragile due to a vacancy and ill-health that was covered by internal locums from GGH, BGH and WGH that had existed until April 2023 when it was felt that it was unable to continue. Ms Lewis advised that an interim model had been developed whereby the consultant on-call undertook a week at BGH and then a week at GGH however there were issues with the level of SAS doctor cover at WGH.

In response to the continued fragility of the on-call rota, the service has managed the risks pertaining to EGS on-call with the use of Medacs Healthcare agency provision with 7 Medacs consultants appointed between 8 August 2022 and 20 July 2025. Ms Caroline Lewis advised that substantive and locum recruitment had been attempted during this period, however the service had experienced a challenge to recruit to and retain consultants at WGH. Following an Escalation Meeting the service had an extraordinary meeting with the Health Board Executive Team who had given permission to recruit three consultants; a substantive consultant at GGH and two substantive consultants at WGH.

Ms Caroline Lewis advised that WGH remained a 1 in 4 rota comprised of 2 substantive consultants, 1 NHS locum consultant and one vacancy from 26 September 2025 that would be filled through the use of Medacs agency provision pending the on-boarding of the recently recruited consultant. Ms Caroline Lewis advised that GGH operated a 1 in 8 rota with 7.5 whole time equivalent (WTE) consultants on the rota with weekend gaps on the rota covered by internal locum cover from GGH consultants.

Ms Caroline Lewis advised that Between May and November 2023 an interim model was put in place for the out-of-hours on-call at WGH whereby patients requiring surgery were transferred from WGH to BGH or GGH on alternating weeks however concern was expressed amongst consultants with this model, in particular relating to delays with the Welsh Ambulance Service Trust (WAST) transport. The delays in patient transfers and the associated Datix incidents reported resulted in the cessation of this model.

Ms Caroline Lewis advised that in May 2023 there was a Getting It Right First Time (GIRFT) visit to General Surgery that resulted in 22 recommendations being made, all of which were now complete with 5 of those recommendations relating to EGS.

Ms Caroline Lewis presented a benchmark of the Health Board service in comparison to other Health Boards in Wales GIRFT had made the recommendation to move to two general surgery on-call rotas as opposed to three. Ms Caroline Lewis advised that other Health Boards in Wales had centralised their general surgery rotas with three Health Boards in Wales operating a 1 in 16 rota that was considered more attractive to potential candidates when recruiting and retaining surgeons into vacancies.

Mrs Daniel believed that there was a need to explore the incidents and complaints relating to patient experience further so that the Committee could gain an assurance on the quality, safety and patient experience elements of the service provision and advised that key performance indicator (KPI) data would be collated and would contribute towards the CSP discussion. **CS/OM**

Mr Lee Davies believed that with both Critical Care and EGS, the Health Board had reached a position of service failure before starting a process to reconfigure the service and that there were lessons to be learned from both service areas in preparing the medium-term planning for future fragile services.

Ms Anna Lewis believed that there was a circular problem of medical recruitment, the volume of clinical work and rota volatility that were all interrelated to each other and that while progress had been demonstrated within recruitment the volume of work per site was considered relatively low and posed a problem for recruitment and retention and for the quality of outcomes that the Health Board wished to achieve.

In response to a question from Ms Anna Lewis on what the response to the GIRFT was, Ms Caroline Lewis advised that following the GIRFT inspection, a follow-up meeting had been undertaken with other Health Boards in Wales to review the actions taken against each recommendation.

In response to a question from Ms Anna Lewis on what improvements were being made in response to the inspection, Mrs Wilson advised that actions were tracked through AMaT [the Health Board's clinical audit assurance system] that were presented to the Integrated Quality, Financial Performance and Delivery (IQFPD) Group for review and agreed to share a report on the GIRFT recommendations following the general surgery inspection. [JW] **JW**

Mr Davies advised that there had been a recent change to the recruitment process for general surgery whereby the Health Board recruited to the general surgery service as a whole as opposed to site-specific recruitment with job plans amended to reflect the change and believed that this made the vacancy more appealing to prospective candidates and that this was an important lesson to be learned for recruitment to other services to provide more sustainable services. Mr Davies also advised that other Health Boards had developed distinct upper and lower gastrointestinal rotas that added to the Health Board's challenge of recruiting into more frequent rotas as also in competition with other Health Boards who maintained subspeciality rotas that clinicians were more comfortable working within. Mrs Marks believed that the Health Board needed to be more adaptive to be a more attractive option for potential recruits.

In response to a question from Mr Michael Imperato on whether the change in recruitment process from site-specific to service-specific amounted to a service change, Mr Carruthers advised that the change was more an employment contractual change for staff as opposed to a service change. Ms Coleman advised that a service change was a change that impacted upon patients and that a contractual change for staff was not considered a service change. In response to the rationale for site-specific recruitment,

Mr Carruthers believed that this was a historic legacy for the Health Board and the change was required to reflect the fact that HDdUHB covered a large geographical area and that it would be beneficial for the Health Board's ability to deploy staff to any of its sites regardless of any service model.

Ms Lisa Humphrey left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Emergency General Surgery.

QSEC 25 (57) STROKE SERVICES

Dr Senthil Kumar presented the deep dive into stroke services and advised that the focus of the deep dive would be on the patient experience and the impact of the fragility of the service on incidents, complaints and risk given that discussions on the quality of the service had been extensively considered as part of the CSP consultation process.

Dr Kumar advised that stroke services were provided from the four acute hospital sites within HDdUHB with fragility issues relating to the medical workforce and compliance with the 2023 national standards and advised that the Health Board did not have access to a specialised Hyper-Acute Stroke Unit (HASU) and had a limited Integrated Community Stroke Service (ICSS), and psychological therapies to support early support, discharge and after-stroke care. Dr Kumar advised that there was no seven-day cover for medicine, clinical nurse specialist or therapy services within stroke services.

Dr Kumar advised that stroke patients who present within 4.5 hours of symptom onset were eligible for thrombolysis and advised that this could be extended to 9 hours with computerised tomography (CT) profusion imaging that was an evolving service that was awaiting implementation at all HDdUHB acute hospital sites to increase the treatment window for stroke patients.

Dr Kumar explained the patient journey from the initial presentation at ED or alerted within the hospital they received a CT scan and acute treatment was commenced ahead of transfer to the acute stroke unit for acute assessment and commencement of the rehabilitation phase ahead of discharge with the appropriate support and early support discharge (ESD) where the patient was eligible and advised that ESD was only available from the WGH site at present with the other acute sites having a Community Integrated Stroke Team with limited therapy provision.

Dr Kumar presented an assessment of the Sentinel Stroke National Audit Programme (SSNAP) performance measures and

highlighted that of the four acute hospital sites GGH exhibited particular challenges around patient access to a stroke bed within 4 hours and had struggled with this KPI over the past 12 months.

Dr Kumar highlighted the concern related to the provision of speech and language therapy that scored low within the SNAPP KPIs and advised that despite occupational therapy scoring high, this related to patients receiving assessment within the first 72 hours where the Health Board performed well however there were performance issues relating to patients receiving 45 minutes of treatment per day that the Health Board was not meeting its targets for.

Dr Kumar advised that CT scan data highlighted that PPH had the best performance for the recent reporting period for 20 minutes scans with underperformance at the GGH and WGH sites however there was an overall positive comparison for HDdUHB compared to against the rest of Wales. Dr Kumar highlighted that the highest performance for attendance at a Stroke Unit within 4 hours is being seen at WGH with 83% for the period and the lowest performance was seen at the GGH site as noted previously however BGH, PPH and WGH performance was above the UK national benchmark of 48%.

Mr Subhamay Ghosh left the meeting

Dr Kumar presented an overview of the stroke-specific ward incidents recorded between December 2024 and August 2025 and believed that the figures were average for the four acute sites and highlighted that GGH received the greatest number of patients so having the highest number of incidents was to be expected. Dr Kumar advised that the Operational Stroke Group had analysed the incidents and advised that the incidents related to:

- Delays in diagnosis and treatment
- Communication and handover failures
- Medication and prescription management issues
- Service provision and workforce gaps
- Patient safety, environment and experience

Dr Kumar believed that the greatest element contributing to incidents related to communication, either between doctors and nurses, between nurses or to patients or relatives.

Dr Kumar believed that the aim was to receive zero complaints regarding the stroke service and believed that the eight complains received between December 2024 and August 2025 was not unreasonably high and advised that the themes of complaints received related to communication, delays in diagnosis and delays in referrals to stroke services and noted that none of the complaints were considered to be in the major category of complaints received.

Dr Kumar advised that patient and family feedback indicated overall positive feedback for clinical staff performance with staff described as kind, compassionate, professional and helpful. Patient dissatisfaction related to communication for appointment scheduling, bed availability and parking. 99.46% of patients rated their service at least 8 out of 10.

Dr Kumar advised that none of the four acute sites or rehabilitation units met the staffing levels recommended by the Royal College Clinical Guidance for Stroke with one WTE specialist stroke nurse covering weekdays at each acute site with 0.5 WTE shortage at the GGH site that given the volume of patients who attend GGH causing an issue that the senior nursing team were working to address with annual leave, sickness and study leave currently being covered by the general nursing workforce as opposed to a specialist stroke nurse. Dr Kumar advised that a similar situation existed with Stroke Physician cover being provided from the general physician workforce. Dr Kumar believed that there was a vulnerability of the reliance of one speciality stroke clinician.

Dr Kumar highlighted that the therapy disciplines did not have seven-day coverage and that there was limited provision of therapies for stroke services at all hour acute sites and only 1.8 WTE psychology service provision was available across all of the Health Board that Dr Kumar believed was making a positive difference for patients since its introduction in 2024 and believed would continue to evolve to provide enhanced therapy services for Health Board patients.

Dr Kumar believed that the rehabilitation services provided by the Community Integrated Stroke Team (CIST) needed to evolve and currently provided a 5-day a week service in each of the three counties within the Health Board area.

Dr Kumar highlighted a number of critical medical cover issues that the service had experienced with sickness cover and advised that each acute site currently operated independently of each other with a lack of depth to the medical workforce cover resulting in difficulty in providing cover without having a consequential impact on the location providing the cover. Dr Kumar believed that the difficulty in providing adequate cover highlighted the fragility of the service.

Dr Kumar made reference to the CSP process and advised that stroke services were one of the nine service areas identified as a fragile service with a number of options developed through the Options Development Process that had been subject to public consultation from 29 May 2025 to 31 August 2025 with multiple alternative options having been suggested by the public and stakeholders for further consideration. Dr Kumar advised that public consultations had been supported by representatives from Betsi Cadwaladr University Health Board (BCUHB) and Powys Health Teaching Board (PHTB).

Dr Kumar advised that an assessment had been undertaken in December 2023 to assess the indicative requirements of enabling the four acute sites to deliver stroke services to the standards recommended by the Royal College of Physicians and had been superseded by the CSP to consider how services could be delivered to provide improved services within the current resource with the CSP providing indicative costs of options ranging between £3.439m and £4.978m with an additional capital cost of £920k.

Dr Kumar advised of the development of a regional strategy for the provision of HASUs with the National Strategic Clinical Network for stroke having produced a programme plan to deliver changes and present options to deliver Comprehensive Regional Stroke Centres (CRSCs) across Wales with a clinical specification having been produced for consultation with modelling work on-going to be completed during Winter 2025. Dr Kumar advised that a consultation on the proposed options for Health Boards in Wales to consider was anticipated within Q4 2025/26.

Dr Kumar advised that the CT Perfusion that was due to be implemented in Wales as part of the Optimal Imagine Pathway and that at present none of the acute sites within HDdUHB had access to CT Perfusion due to workforce and capacity constraints within the radiology service.

In response to a question from Mr James Severs on whether there were any opportunities to improve the performance of direct access to CT scanning, Dr Kumar believed that the issue of patients not receiving a scan within 20 minutes of arrival at hospital at GGH was impacted by the heightened demand at GGH compared to the other acute sites and advised that the Operational Stroke Group had representation from the radiology service to develop options to improve performance at GGH.

In response to a question from Ms Edmonds on whether HDdUHB was an outlier within Health Boards in Wales in not providing CT Profusion, Dr Kumar advised that Cardiff and Vale University Health Board (CVUHB) undertook CT Profusion and Swansea Bay University Health Board (SBUHB) undertook CT Profusion between 9 am and 5 pm on weekdays depending on clinician availability. Dr Kumar advised that all Health Boards in Wales were working towards availability of CT Profusion within 2026.

Mr Davies believed that the change in the methodology for capturing SSNAP data would provide greater clarity on whether the Health Board had deficiencies in performance and that due to the nature of the evidence-based nature of the SSNAP data that poor performance was reflected in poor outcomes for HDdUHB patients.

In response to a question from Ms Anna Lewis on the role families played in the rehabilitation process of stroke patients and the benefit for patients of having family able to visit as often as possible for as long as possible improving the patient rehabilitation and the challenges faced by families having to travel great distances to visit patients, Dr Kumar believed that distance and travel to visit patients had been a highly emotive question raised through the CSP consultation process and believed that there was strong qualitative evidence to confirm the positive contribution of familiar visitation had on patients recovering from stroke and there was a need to develop quantitative data to further evidence the impact on patient recovery. Dr Kumar believed that there was a balance to be made between providing the highest quality services as possible and providing services as close to the patient as possible.

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Stroke Services.

QSEC 25 (58) DATE OF NEXT MEETING

The date of the next regular QSEC meeting will be on 9 October 2025.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TABLE OF ACTIONS FROM EXTRAORDINARY QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING HELD ON 15 SEPTEMBER 2025

2	**Critical Care** To undertake a detailed investigation of the number of PPH ICU referrals data, to include trend data and an analysis of Staff Survey information.	**CS/DK**	**4 Dec 2025**	**In Progress**
2	**Critical Care** To review the governance process around the operation of the SOP within the Carmarthenshire Critical Care system and to ensure compliance with the CSP process.	**JW**	**4 Dec 2025**	**In Progress:** A review of the decision-making process and governance process around the operation of the SOP within the Carmarthenshire Critical Care system and to ensure compliance with the CSP process is due to be completed by 30th November 2025.
3	**Emergency General Surgery** To collate KPI data from EGS to provide an oversight of quality, safety and patient experience within the EGS service.	**SD/OM**	**4 Dec 2025**	**In Progress**
3	**Emergency General Surgery** To share the AMaT report following the GIRFT inspection of general surgery.	**JW**	**4 Dec 2025**	**The report will be shared ahead of the meeting on 4 November.**

SD: Sharon Daniel	**JW:** Joanne Wilson	**CS:** Cathie Steele	**OM:** Olwen Morgan	**DK:** Diane Knight	

3

30 Mins

3 - Urology Deep Dive

Neil Griffiths (Hywel Dda UHB - Service Delivery Manager of Urology and Rheumatology), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

Attachments

Deep Dive Urology.pdf

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

Deep Dive: Urology

Quality, Safety and Experience Committee

November 2025

Situation

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

- 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

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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

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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 improve rted by targeted investment requests.

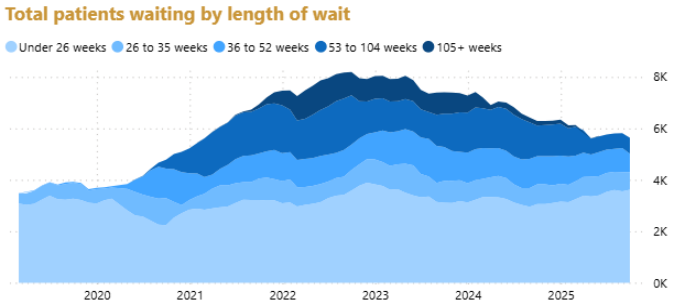
Assessment - RTT Performance

RTT Pathway Shift – April to September 2025

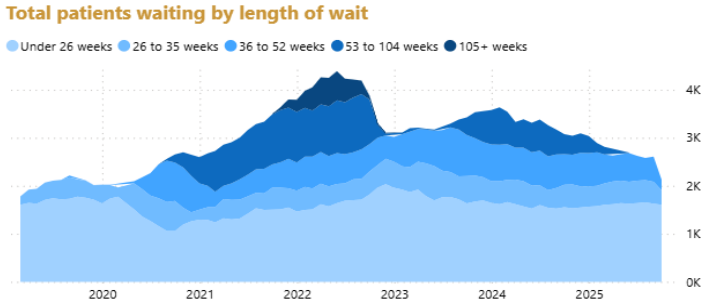
Recent RTT data for the Urology service across the Health Board highlights a shift in patient distribution across the pathway stages. This can be seen between April and September 2025. The number of patients awaiting a new outpatient appointment (Stage 1) reduced from 2,661 to 2,126, reflecting improved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

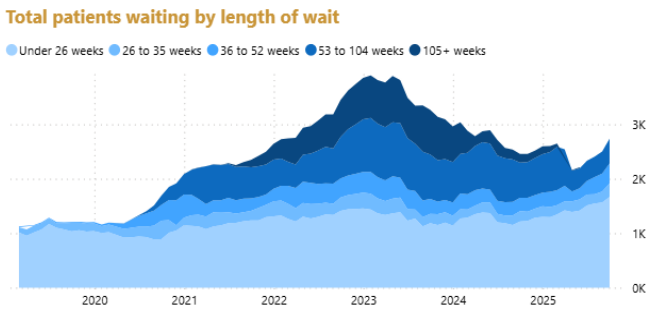
However, this shift also places increased pressure on inpatient and surgical capacity and contributes to ongoing challenges in meeting USC and diagnostic targets. The trend reinforces the need for sustainable redesign through CSP 1, including the development of a dedicated Urology Investigation Unit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



Total Waiting List



Stage 1 Waiting List



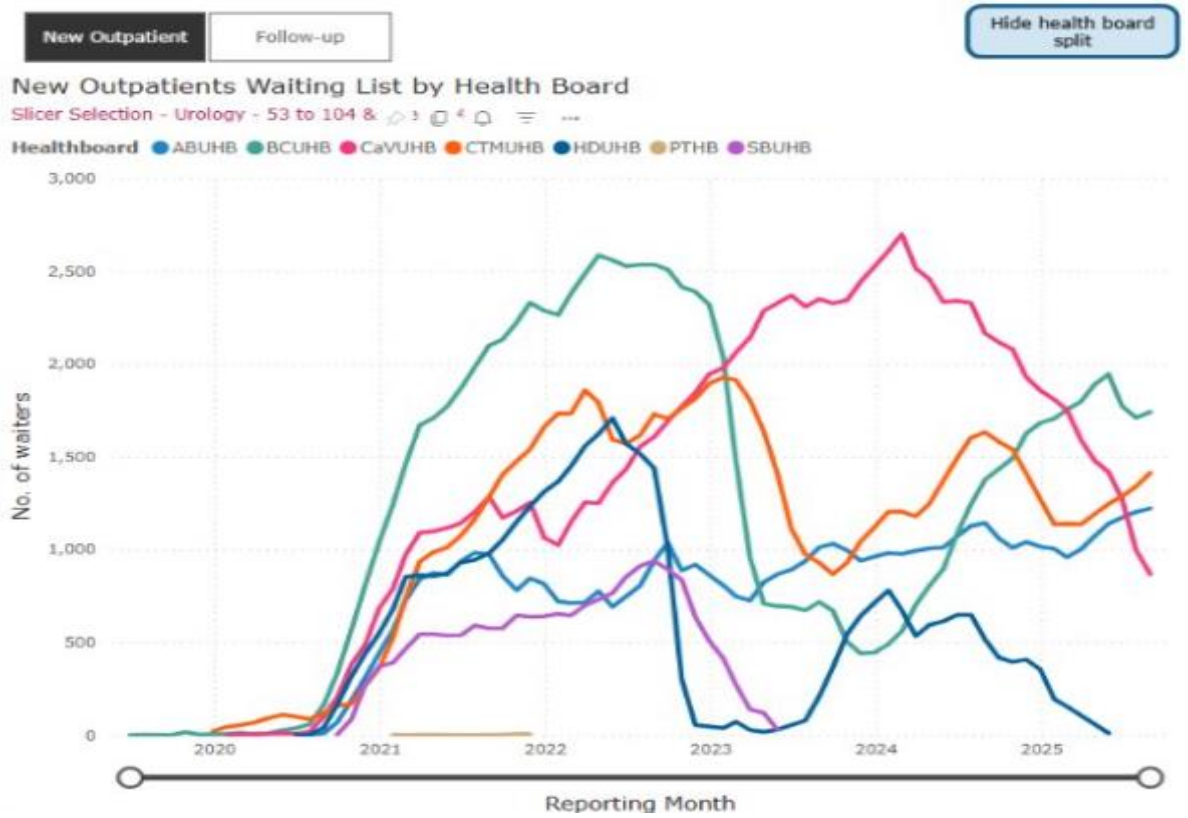
Stage 4 Waiting List

Source: Corporate Performance Dashboard.

Assessment - RTT Performance

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.

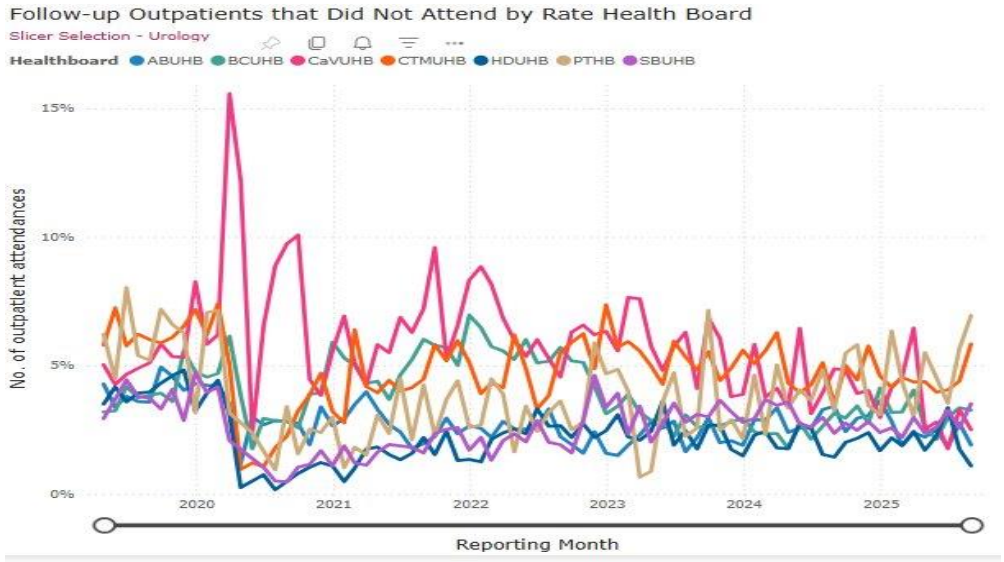


Source: Urology CIN Data set October 25

Assessment - RTT Performance

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

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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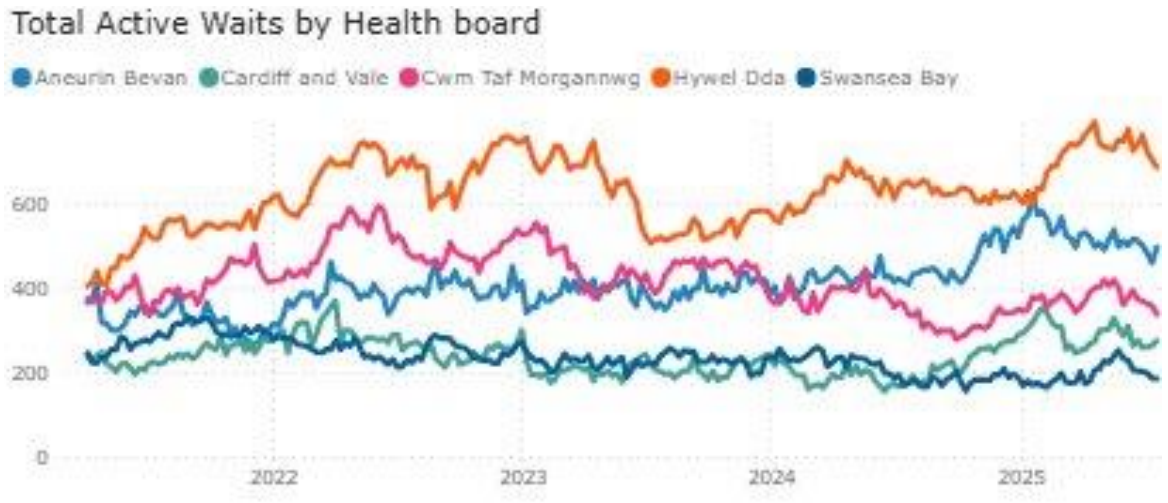
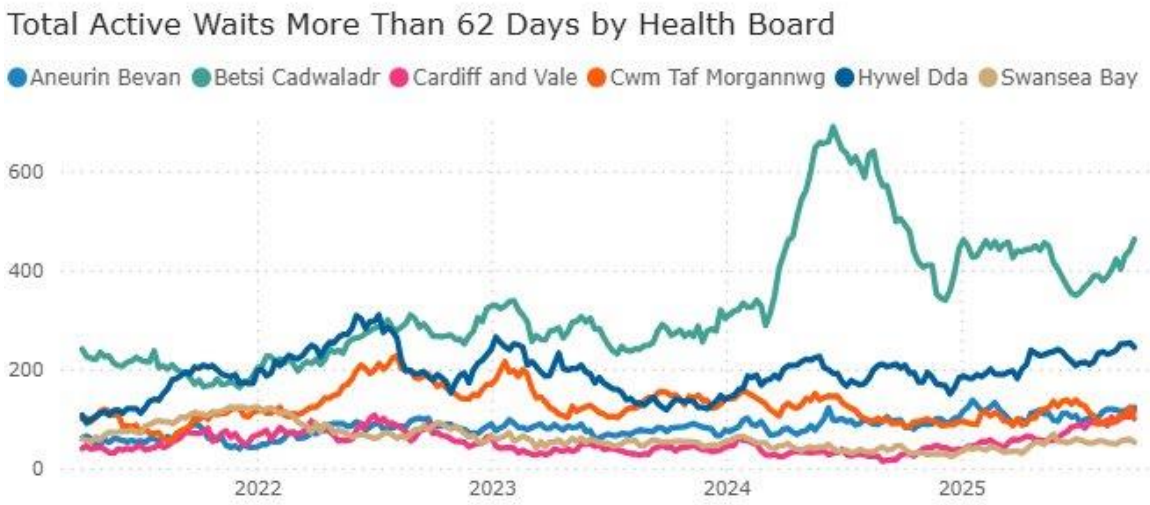
National Data Comparison

- 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.





Amserol
Timely

Effeithiol
Effective

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

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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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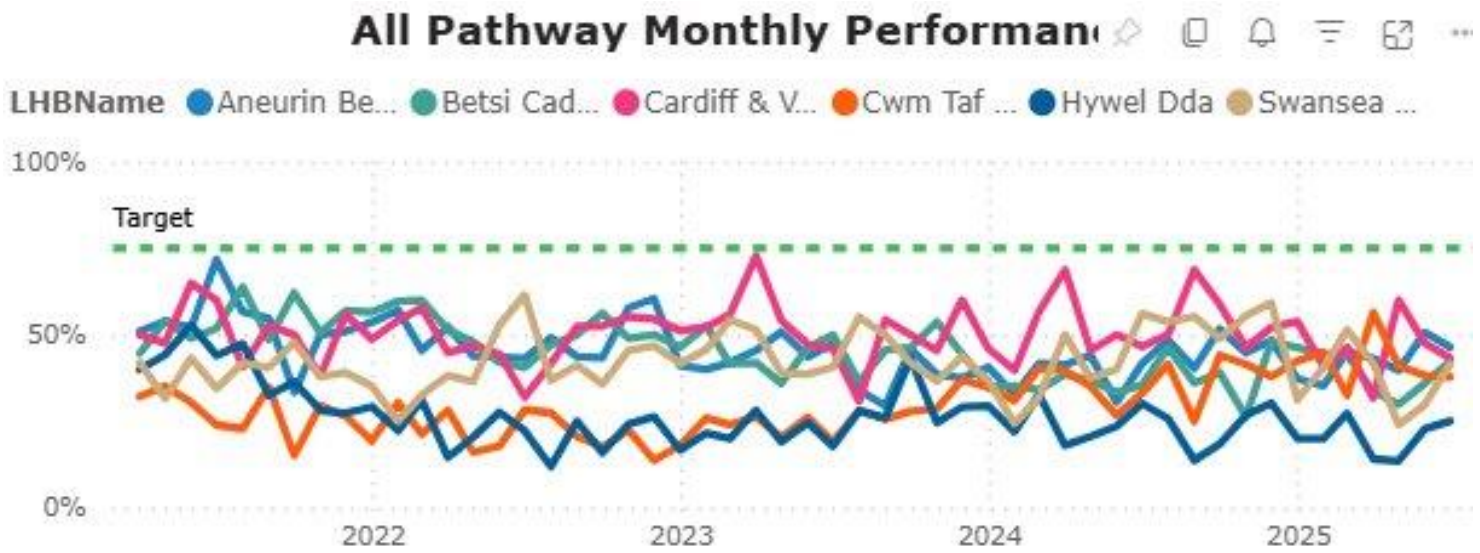
National Monthly Performance Data

- 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%**

Amserol Timely

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Source: Urology CIN Data set October 25

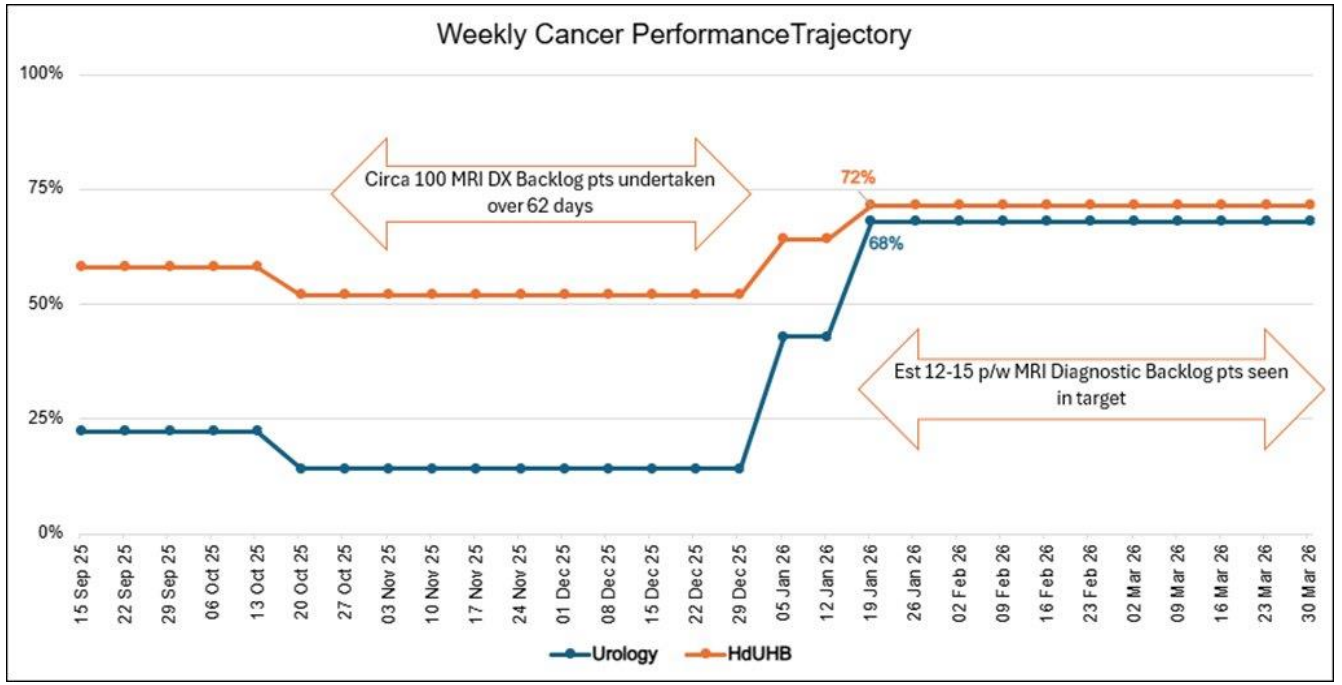
Assessment - Urology USC pathway

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%.



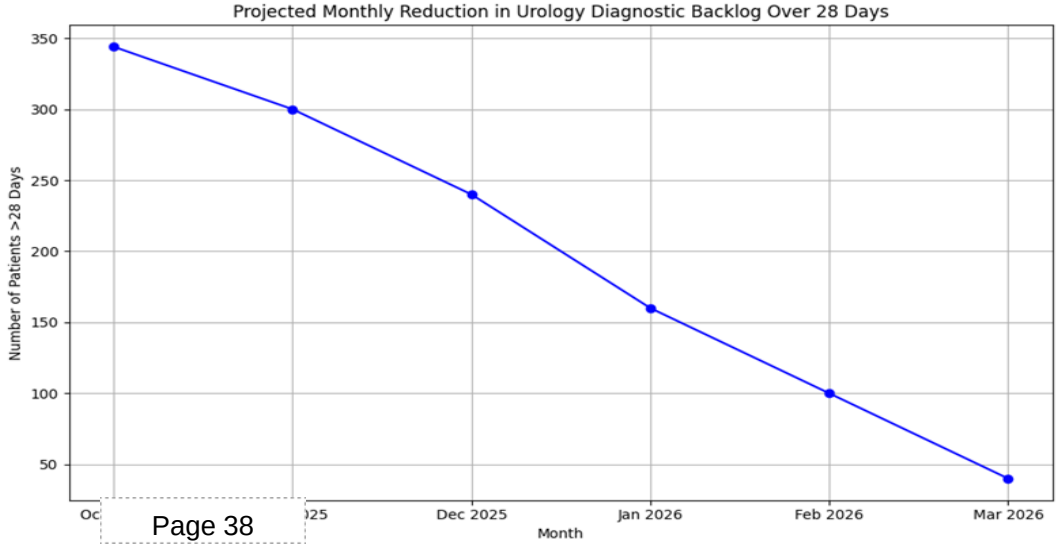
Assessment - Urology USC pathway

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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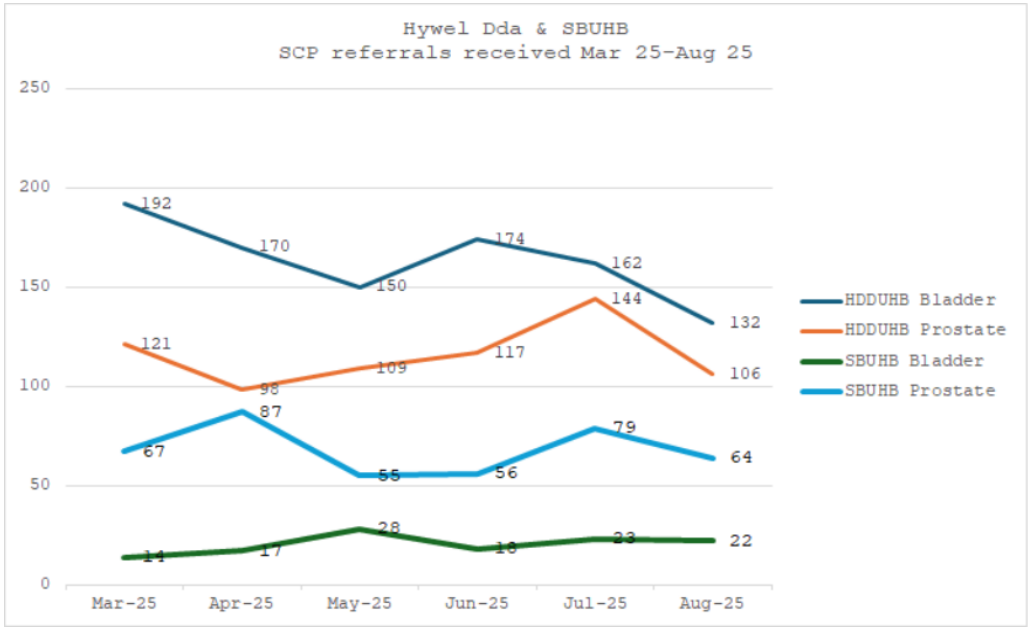
CNS team requirements

- 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

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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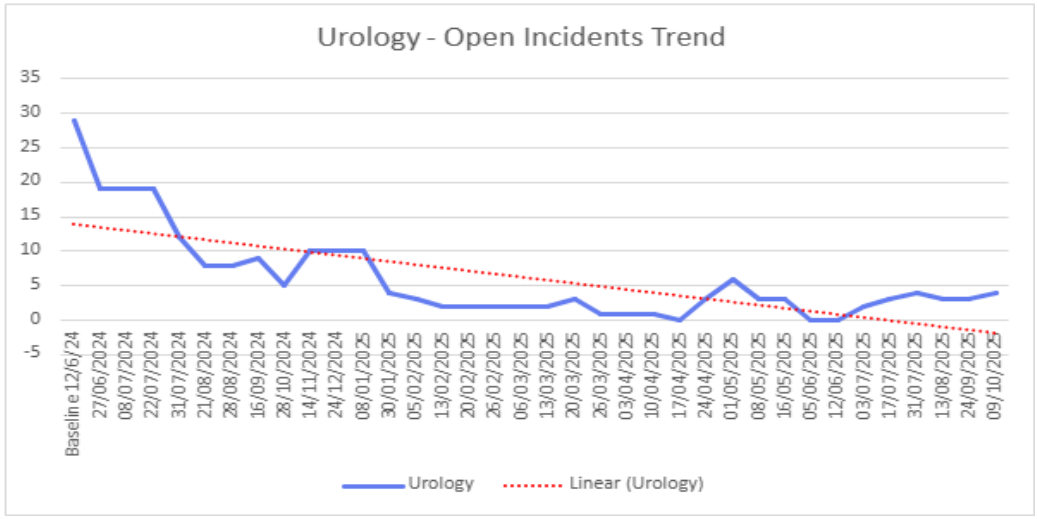
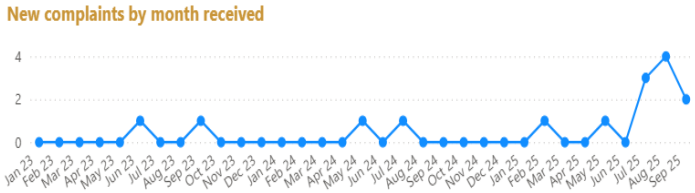
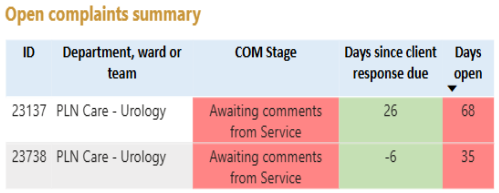
Complaints and Incident Reporting

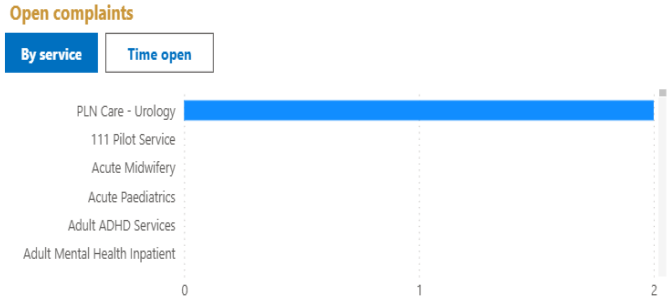
The improving position in managing complaints and incidents, as shown in recent data, reflects the impact of targeted recovery actions.

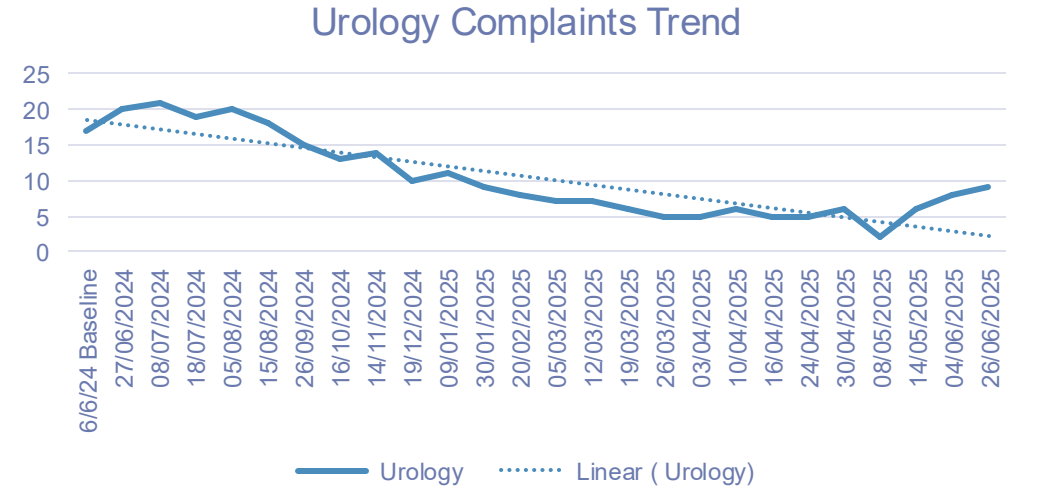
However, sustaining this progress requires investment in key enablers—particularly the expansion of the CNS workforce, additional theatre capacity, and continued pathway redesign. These measures directly address the root causes of patient dissatisfaction and clinical risk, and are essential to delivering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











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

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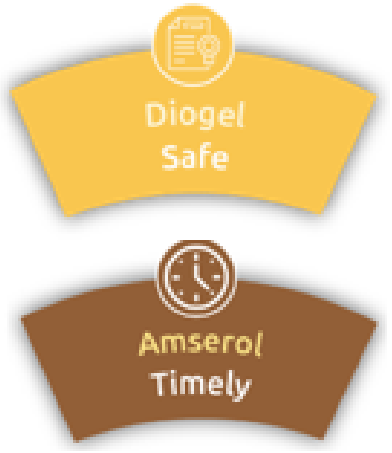
Consent Training Programme

- 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

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

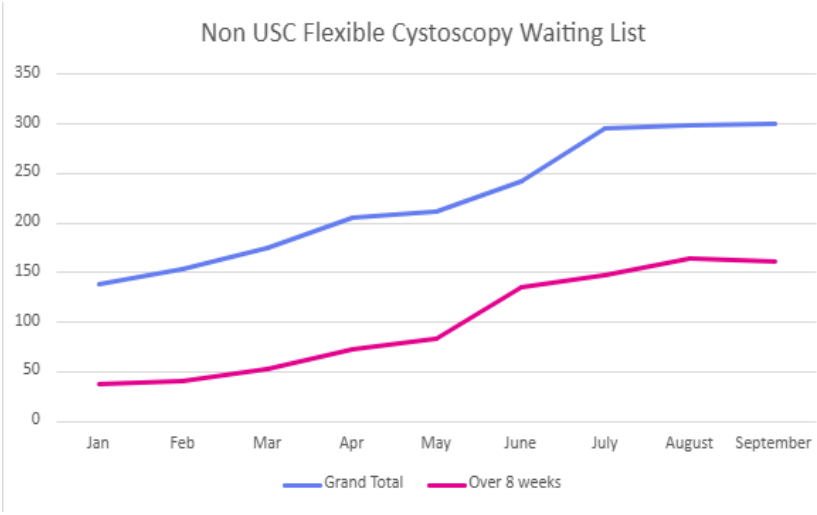
Relocate the existing 6.5 Urology flexible cystoscopy sessions from the Endoscopy Unit plus 4 additional to cover demand, to a suitable treatment room, recognising that these procedures do not require a full endoscopy theatre setting.
This would:

- 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

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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

- 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

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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

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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.

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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

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

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.

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

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.

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.

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.

4

30 Mins

4 - Dermatology Deep Dive

Ceri Wisdom (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

Attachments

Dermotology Deep Dive.pptx

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Deep Dive: Dermatology

Quality, Safety and Experience Committee

October 2025

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with an understanding of the impact of the fragility on current service provision, incidents, complaints, patients experience and risks and understand how these are being managed and how the dermatology service is being maintained and risks mitigated, whilst the outcome of the Clinical Services Plan (CSP) is awaited.

The service is providing an update the current dermatology provision in the absence of a substantive consultant and heavy reliance on insourcing and external providers to meet both ministerial and single cancer pathway targets.

Background

- Summary

The Dermatology Service currently operates under significant strain due to longstanding workforce shortages, limited clinical infrastructure, and rising demand, particularly regarding treatment space.

The reliance on external providers to maintain core functions—such as triaging, insourcing, and teledermoscopy, has created a service model that is inefficient, costly, and increasingly unsustainable. With little space to undertake appropriate training.

- Issues of significance to the Health Board

Despite having a comparable population to Swansea Bay University Health Board (SBUHB), HDdUHB's dermatology workforce and infrastructure are markedly under-resourced. While SBUHB employs 5.0 WTE Consultant Dermatologists, HDdUHB operates with only 1.4 WTE, and has been without a substantive Consultant Dermatologist since 2016. Moreover, the Health Board has the highest incidence of melanoma skin cancer in the UK, and is experiencing significant growth in referrals, up 122% compared to an all-Wales average of 5% (NHS Wales Performance and Improvement 2025). Cancer Research UK forecasts a 50% increase in skin cancer cases over the next 20 years, highlighting the critical need for a long-term service transformation.

Without targeted investment in clinical space, workforce, and operational resilience, HDdUHB will continue to struggle to meet both Urgent Suspected Cancer (USC) and Referral to Treatment (RTT) targets. This not only compromises patient safety and experience but also puts the Health Board at risk of ongoing performance deterioration and reputational harm. A set of proposals to address immediate capacity gaps and deliver a sustainable, value-for-money model of dermatology care have been put forwarded as part of the Clinical Services Plan (CSP).

Assessment – Safe

- Backlog in letters circa 1100
- Backlog in triaging circa 300
- 36% of complaints (816 total) relate to delays, cancellations, and results.
- 52% of incidents (56 reported from 2021-25 linked to medication errors (prescriptions), assessment delays and communication (cross sites).
- 1 Ombudsman case upheld in March 2024 relating to a patient's pathway September 2022 – January 2023 for acne
- 1 Minor Operative Procedure (MOP) room across HB vs. 55 USC patients/week → 15 patient/week shortfall.
- Prioritising cancer demand and meeting single cancer pathway (SCP) targets

Assessment – Timely

- 40% of referrals are inflammatory; 361 urgent patients with no appointment date.
- 1,393 RTT MOP patients waiting; 401 in 104 week target.
- Meeting SCP target utilising insourcing
- Meeting ministerial measures target utilising insourcing

Assessment – Timely, Single Cancer Pathway Performance

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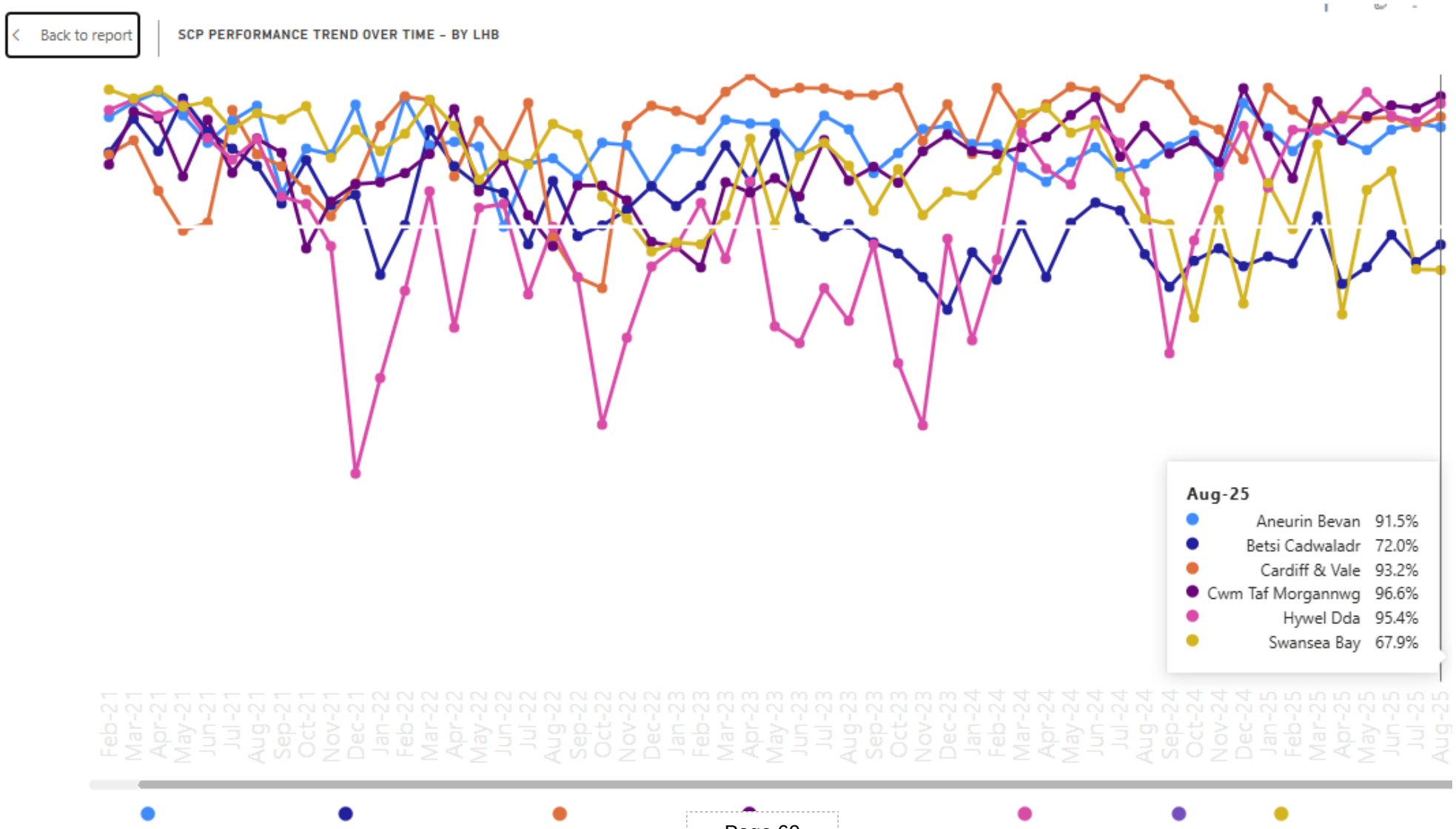
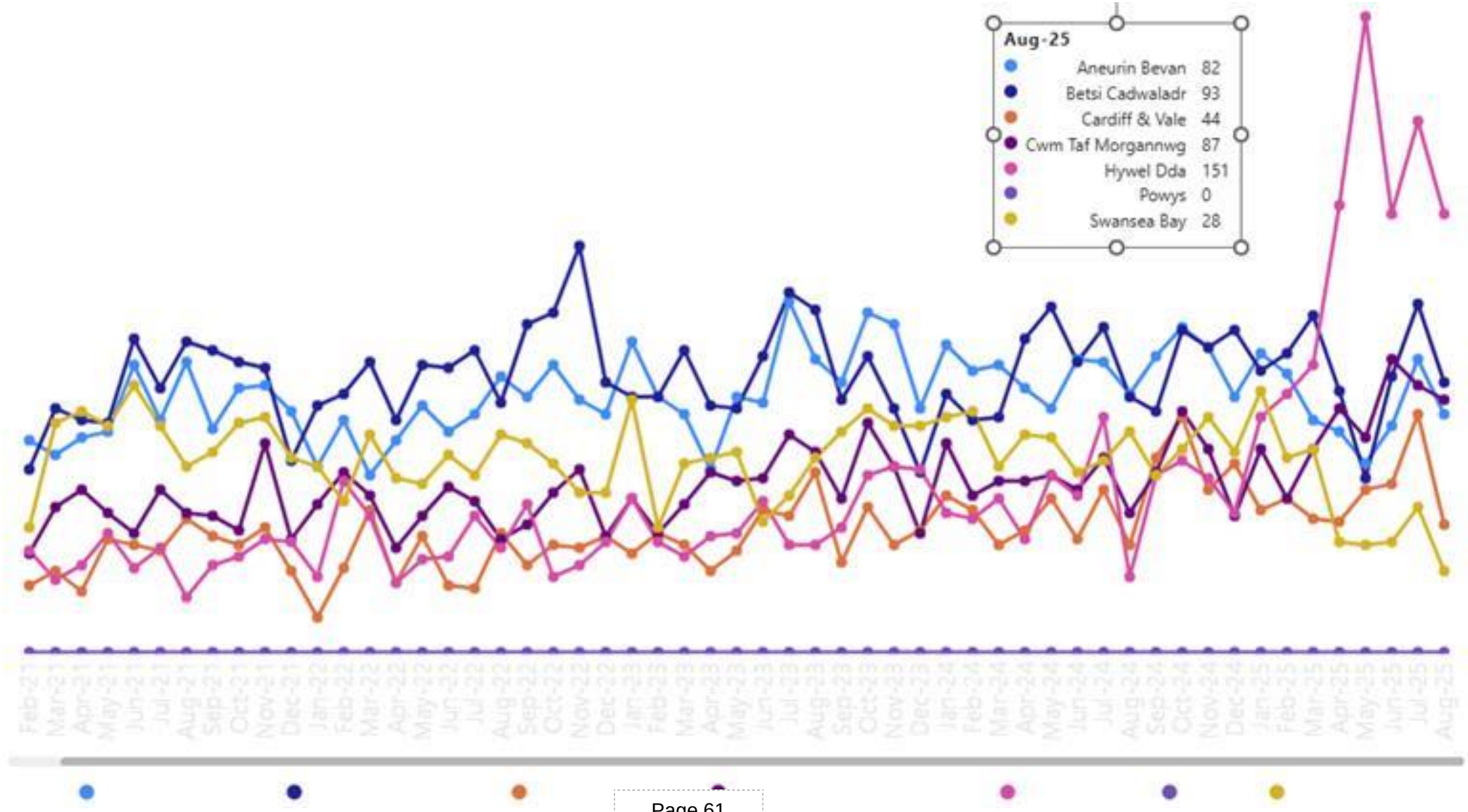


Assessment – Timely, Single Cancer Pathway Treatments



Assessments – Timely Referrals

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hide health board split

Show specialty split

MonthEnd	ABUHB	BCUHB	CaVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
August 2025	1,859	1,491	1,694	1,605	1,162	26	1,187	**9,024**
July 2025	2,324	1,905	1,975	2,044	1,433	33	1,431	**11,145**
June 2025	2,077	1,719	1,918	1,837	1,284	40	1,221	**10,096**
May 2025	1,966	1,703	1,824	1,875	1,215	34	1,249	**9,866**
April 2025	1,798	1,466	1,701	1,681	1,199	28	1,210	**9,083**
March 2025	1,718	1,490	1,710	1,134	1,149	35	1,119	**8,355**
February 2025	1,577	1,410	1,447	1,102	1,021	25	1,039	**7,621**
January 2025	1,572	1,432	1,599	1,069	1,071	37	1,124	**7,904**
December 2024	1,288	1,098	1,276	776	826	12	801	**6,077**
November 2024	1,588	1,354	1,533	983	1,013	26	1,044	**7,541**
October 2024	1,795	1,596	1,798	1,076	1,106	34	1,297	**8,702**
September 2024	1,729	1,474	1,687	1,068	1,098	26	1,257	**8,339**
August 2024	1,796	1,533	1,877	1,028	1,025	21	1,272	**8,552**
July 2024	2,036	1,636	1,937	1,086	1,062	26	1,399	**9,182**
June 2024	1,957	1,573	1,893	1,072	1,114	43	1,188	**8,840**
May 2024	2,185	1,682	1,922	1,057	1,147	42	1,383	**9,418**
April 2024	1,797	1,500	1,746	972	947	41	1,302	**8,305**
March 2024	1,676	1,386	1,509	682	939	29	1,106	**7,327**
February 2024	1,609	1,426	1,646	741	1,008	35	1,228	**7,693**
January 2024	1,658	1,384	1,634	821	924	39	1,133	**7,593**
December 2023	1,258	1,000	1,213	569	716	14	843	**5,613**
November 2023	1,623	1,241	1,655	861	970	25	1,080	**7,455**
October 2023	1,722	1,453	1,860	1,095	1,005	33	1,204	**8,372**
September 2023	1,886	1,537	1,860	1,083	1,134	49	1,204	**8,753**
August 2023	2,001	1,698	1,932	1,098	1,110	37	1,349	**9,225**
July 2023	1,936	1,671	1,802	1,037	961	39	1,290	**8,736**
June 2023	2,066	1,949	2,128	1,070	1,128	46	1,389	**9,776**
May 2023	1,779	1,765	1,781	946	1,156	28	1,239	**8,694**
April 2023	1,348	1,342	1,268	769	852	20	1,011	**6,610**
March 2023	1,653	1,545	1,661	814	995	29	1,088	**7,785**
February 2023	1,414	1,302	1,370	648	864	36	1,039	**6,673**
January 2023	1,360	1,238	1,353	692	923	30	964	**6,560**
December 2022	937	981	1,095	570	626	17	694	**4,920**
November 2022	1,402	1,497	1,506	805	958	43	968	**7,179**

Assessment – Timely, Referral to Treatments waits

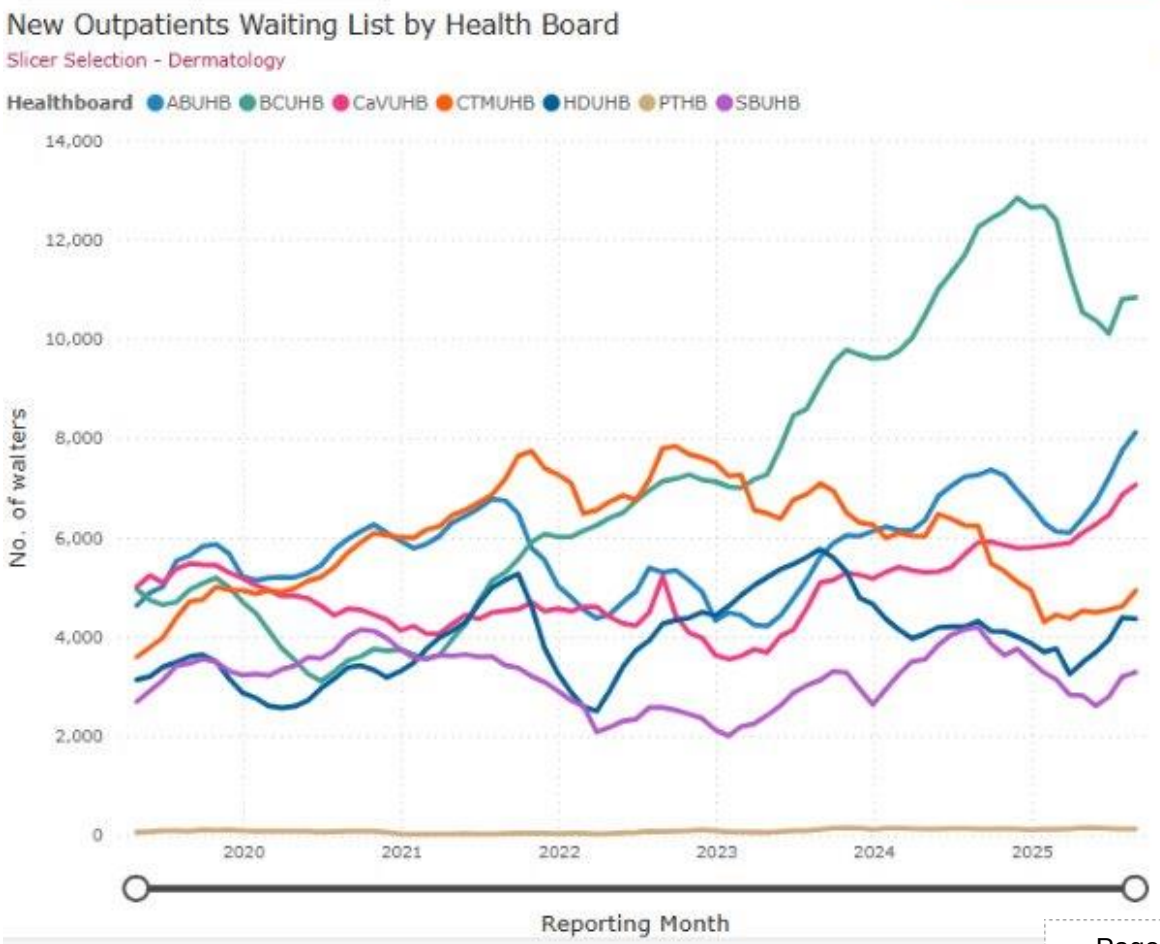
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Healthboard: All | Specialty Category: All | Specialty: Dermatology | Age Group For NewOP: All | WaitBand for NewOP: All

New Outpatient | Follow-up

Hide health board split

Show specialty split



MonthEnd	ABUHB	BCUHB	CaVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
August 2025	8,115	10,834	7,060	4,926	4,361	125	3,284	**38,705**
July 2025	7,753	10,796	6,857	4,611	4,383	129	3,193	**37,722**
June 2025	7,201	10,104	6,451	4,539	3,939	137	2,792	**35,163**
May 2025	6,728	10,370	6,261	4,490	3,688	150	2,607	**34,294**
April 2025	6,384	10,534	6,093	4,520	3,482	148	2,816	**33,977**
March 2025	6,096	11,343	5,883	4,362	3,248	126	2,829	**33,887**
February 2025	6,118	12,387	5,852	4,441	3,761	122	3,139	**35,820**
January 2025	6,292	12,667	5,815	4,296	3,687	123	3,276	**36,156**
December 2024	6,642	12,644	5,795	4,935	3,867	107	3,507	**37,497**
November 2024	6,945	12,840	5,783	5,101	3,999	124	3,753	**38,545**
October 2024	7,251	12,575	5,841	5,319	4,102	134	3,622	**38,844**
September 2024	7,362	12,419	5,913	5,474	4,109	124	3,856	**39,257**
August 2024	7,258	12,246	5,897	6,234	4,311	124	4,191	**40,261**
July 2024	7,221	11,687	5,658	6,241	4,203	132	4,142	**39,284**
June 2024	7,038	11,329	5,398	6,373	4,200	136	4,039	**38,513**
May 2024	6,832	11,003	5,313	6,466	4,187	129	3,837	**37,767**
April 2024	6,346	10,480	5,294	6,028	4,059	126	3,543	**35,876**
March 2024	6,143	10,017	5,336	6,031	3,963	131	3,503	**35,124**
February 2024	6,142	9,754	5,403	6,086	4,145	145	3,242	**34,917**
January 2024	6,215	9,618	5,304	5,987	4,351	142	2,951	**34,568**
December 2023	6,124	9,604	5,169	6,257	4,654	122	2,633	**34,563**
November 2023	6,026	9,680	5,246	6,300	4,781	141	2,949	**35,123**
October 2023	6,042	9,776	5,287	6,495	5,308	150	3,273	**36,331**
September 2023	5,878	9,520	5,139	6,940	5,593	146	3,302	**36,518**
August 2023	5,604	9,079	5,088	7,086	5,761	115	3,124	**35,857**
July 2023	5,149	8,589	4,572	6,872	5,601	96	3,019	**33,898**
June 2023	4,778	8,454	4,142	6,756	5,464	89	2,870	**32,553**
May 2023	4,426	7,824	4,010	6,375	5,359	78	2,614	**30,686**
April 2023	4,210	7,264	3,680	6,485	5,196	61	2,415	**29,311**
March 2023	4,238	7,169	3,746	6,545	5,033	62	2,248	**29,041**
February 2023	4,434	6,996	3,609	7,260	4,829	69	2,188	**29,385**
January 2023	4,483	7,020	3,546	7,235	4,614	66	2,003	**28,967**
December 2022	4,330	7,122	3,628	7,499	4,424	88	2,124	**29,215**
November 2022	4,903	7,161	3,980	7,604	4,496	106	2,357	**30,607**

Assessment – Timely, stage 1 total waiting list

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

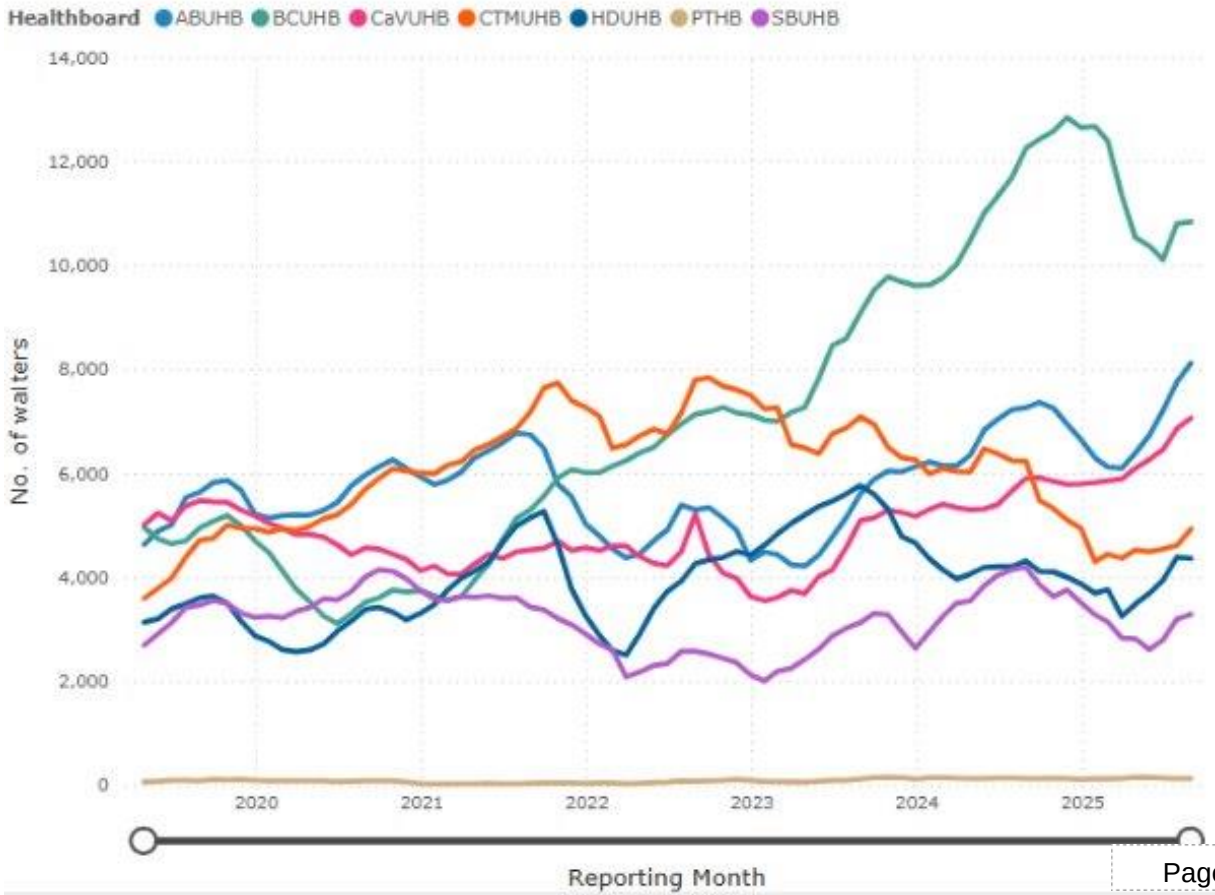
Healthboard: All | Specialty Category: All | Specialty: Dermatology | Age Group For NewOP: All | WaitBand for NewOP: All

New Outpatient | Follow-up

Hide health board split | Show specialty split

New Outpatients Waiting List by Health Board

Slicer Selection - Dermatology



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May 2025	6,728	10,370	6,261	4,490	3,688	150	2,607	**34,294**
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[illegible]er 2022	4,903	7,161	3,980	7,604	4,496	106	2,357	**30,607**

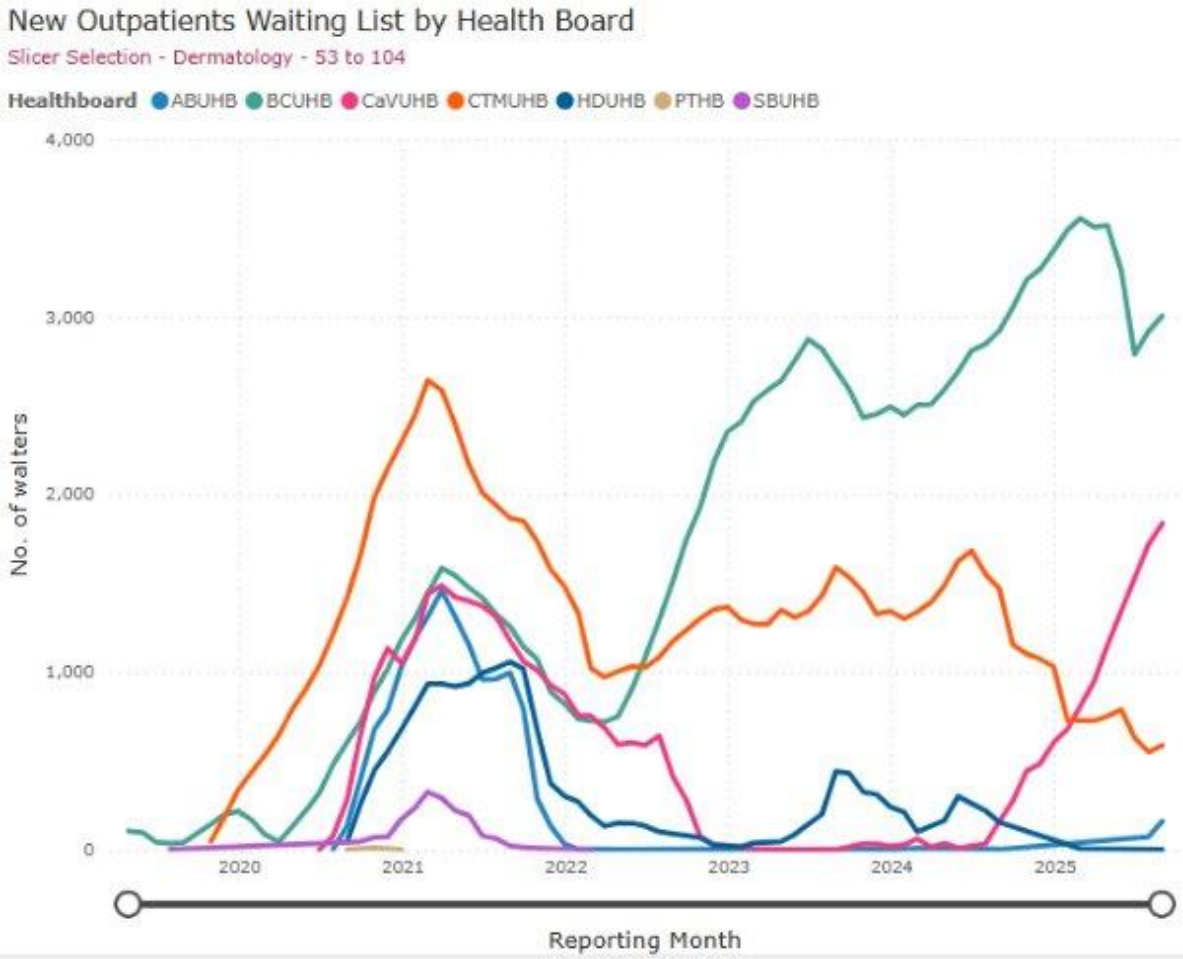
Assessment – Timely, stage 1, 53 weeks – 104 weeks

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

New Outpatient | Follow-up

Hide health board split

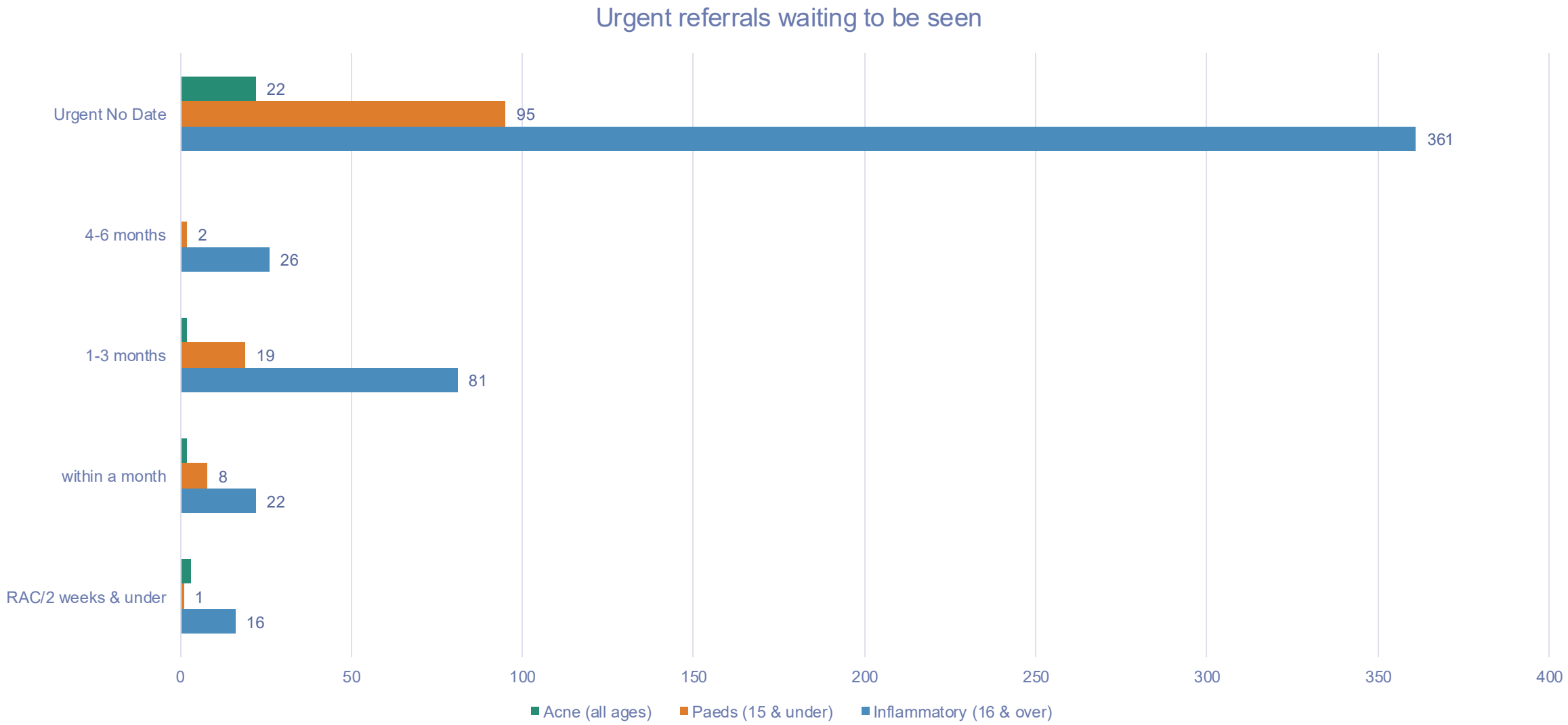
Show specialty split



MonthEnd	ABUHB	BCUHB	CaVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
August 2025	161	3,004	1,836	587	1			5,589
July 2025	74	2,917	1,718	551				5,260
June 2025		2,788	1,528	631				4,947
May 2025		3,259	1,343	789				5,391
April 2025		3,513	1,150	751				5,414
March 2025		3,505	945	726				5,176
February 2025		3,553	807	728	7			5,095
January 2025		3,489	680	727				4,896
December 2024		3,374	605	1,029				5,008
November 2024		3,266	484	1,074				4,824
October 2024		3,207	443	1,103				4,753
September 2024		3,050	272	1,155				4,477
August 2024	3	2,921	159	1,470	155			4,708
July 2024		2,846	35	1,551	220			4,652
June 2024		2,809		1,682	261			4,752
May 2024		2,692	10	1,625	300			4,627
April 2024		2,590	36	1,487	165			4,278
March 2024		2,506	14	1,393				3,913
February 2024	8	2,503	63	1,339	102			4,015
January 2024	5	2,446	28	1,299	211			3,989
December 2023	1	2,493	20	1,344	241			4,099
November 2023		2,451	34	1,326	312			4,123
October 2023		2,432	34	1,451	326			4,243
September 2023		2,588	16	1,533	430			4,567
August 2023		2,701	2	1,589	440			4,732
July 2023		2,818	1	1,431	202			4,452
June 2023	1	2,872		1,342				4,215
May 2023		2,754		1,308	87			4,149
April 2023	1	2,638	1	1,349	46			4,035
March 2023	2	2,586		1,269				3,857
February 2023		2,525	6	1,271	39			3,841
January 2023		2,408		1,293	17			3,718
December 2022		2,353		1,367				3,720
November 2022	1	2.178	31	1.350	26			3.586

Assessment – Timely, Urgent referral waits

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



Assessment – Efficient

- No substantive Consultant Dermatologist since 2016.
- Reliance on insourcing and external triage (Consultant Connect – £10k/month).
- Lack of dedicated dermatology hub and suspended phototherapy.
- Insufficient clinical and administrative space.
- Insourcing costs £500k - £700k
- 32% rise in melanoma (last decade); 50% projected increase in 20 years.
- Non-melanoma skin cancers = 43% of all cancers in Wales.
- Clinical Implementation Network (CIN) Optimisation framework - work in progress score 144/228

Assessment – Efficient (optimisation framework snapshot)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Domain	Delivery	Good practice	Maturity Matrix					Comments	Total	Max score
			Nothing yet planned	Planned	Early progress	Results	Maturity			
			0	-1	-2	-3	-4			
1.1.7	Future	Support GP practices to send high quality dermatoscopic images for lesion referrals						we will be issuing 1 Casio camera per practice as a project		
1.1.8	Future	All Referrals to include a formal assessment of frailty (clinical frailty score, performance status)								
1.1.9	Core	Standard advice and guidance responses are available for the most common referrals			Yes			All referrals are expected to have advice and guidance returned to GP, but we are in the process of standardising some of the common responses		
1.1.10	Core	Direct to clinical photography pathways are locally agreed								
1.1.11	Core	Direct to Treatment pathways are locally agreed with appropriate specialist advice and guidance provided where required								
1.1.12	Core	A system is in place for planned administrative validation of all patients that have been on the stage one pathway for 12+ weeks								
1.1.13	Future	A system is in place for clinical validation of all patients that have been on the stage one pathway for 26+ weeks								
1.1.14	Core	Job plans include designated time for clinical validation, triage, and provision of specialist advice and guidance							22	56
Reducing and Managing DNAs										
2.1.1	Core	All patients receive appointment reminders, including letters, emails, SMS, and/ or phone calls								
2.1.2	Core	The appointment booking process provides two-way communication enabling patients to confirm attendance, whilst conforming to health literacy principles						Minor operations; USC and telederm clinics.		
2.1.3	Core	DNA and CNA rates are routinely captured, audited and presented at departmental performance meetings								
2.1.4	Core	DNA (CNA) rates are used to facilitate overbooking clinics to maximise capacity								
2.1.5	Core	A list of patients that can attend at short notice is held to fill last minute slots created by cancellations								
2.1.6	Core	There is full compliance with health boards DNA / CNA policy							22	24
Remote appointments and consent										
3.1.1	Core	consultations is monitored within the department								
3.1.2	Core	Diagnostic test results are communicated to patients by letter, email or telephone wherever appropriate, in job-planned administrative sessions rather than clinic appointments								
3.1.3	Future	Electronic consent (eConsent) is routinely used for all patients considering surgery, with the process starting in the outpatients department or virtual consultation						would be accepted within the health board		
3.1.4	Future	Procedure-specific patient information sheets are available for all patients considering surgery, in both written and electronic formats, and where possible in the patients' first language							8	16

Assessment – Efficient, workforce comparison

HDdUHB (population 388,139) *Stats Wales		SBUHB (population 389,640) *Stats Wales	
Consultant (Plastics)	0.8 WTE	Consultant	5.0 WTE
Locum Consultant	2.6 WTE	Locum Consultant	0
Specialty Doctor	1.99 WTE	Specialty Doctor	5.0 WTE
Nursing	6.80 WTE	Nursing	6.0 WTE
Administration	5.60 WTE	Administration	9.54 WTE

Assessment – Efficient, current spend

Item	Current Annual Spend
Insourcing (current)	£300,000 (reducing to £100,000 in 2025/26)
Consultant Connect triaging	£120,000
Teledermoscopy SLA	£60,000
Total Potentially Reallocated	**£480,000**

Assessment – Efficient
Definition of 'Good' (staffing model additional)

Item	Description	Annual Cost Estimate
Consultant Workforce (Nurse Consultant)	2 x WTE Consultant	£250,000 – £300,000
Nursing Staff	7 WTE (1x Band 7, 2 x Band 5, 4 x Band 3)	£310
Administrative Support	2 WTE (Band 4 and Band 3)	£70,000
Booking Clerk	1 WTE (Band 4)	£30,000
Total Recurrent Cost (from 2026/27 onwards)	–	£660,000- £710,000

Assessment – Equitable

- Urgent patient waiting times prioritised the same as routine
- Unable to undertake see and treat – additional travel
- General Practitioners (GPs)provided with dermatoscopic cameras HB cannot assess dermatoscopic images
- Nurse led clinics across all 3 counties
- Training GP with Extended Roles (GPwER) to undertake MOPs
- Teledermoscopy offered across all 3 counties for both USC and Non-USC lesions
- Teledermatology with all GP referrals

Assessment – Person Centred

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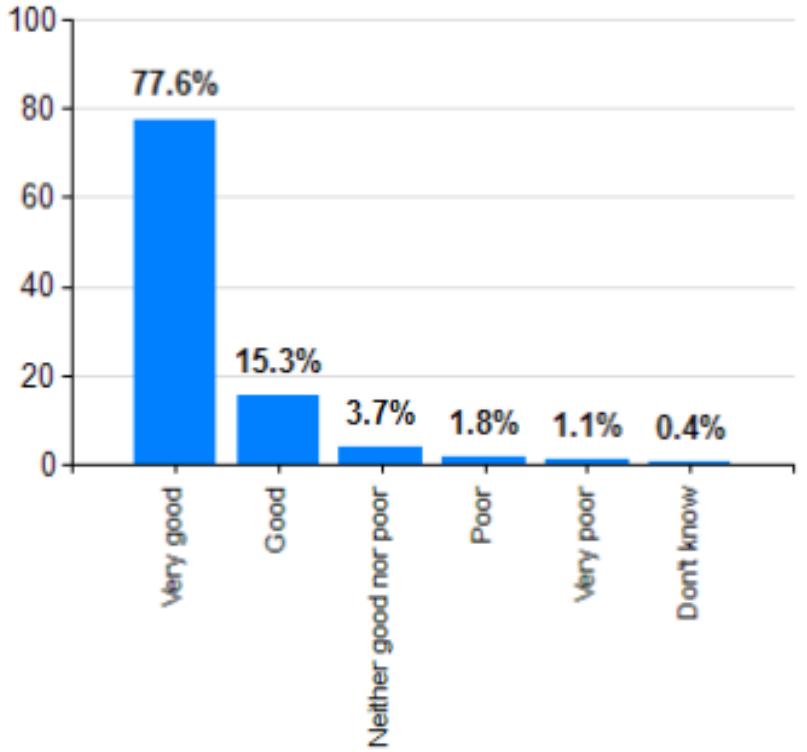
Patient Feedback following attendance at clinic

Available Answers	Responses	Score (%)
Very good	420	77.6%
Good	83	15.3%
Neither good nor poor	20	3.7%
Poor	10	1.8%
Very poor	6	1.1%
Don't know	2	0.4%
Total	541	100%



Data collection 1st January 2025 – 30th September 2025

(Civica data)

Assessment – Person Centred

Very Good feedback

- •Nurse was thorough, reassuring and had a polite caring manner
- •Everything was explained to me carefully, I felt very comfortable.

Good Feedback:

- •Quick and efficient in every respect
- •Appointment on time very helpful doctor

Neither Good nor Poor

- •I have waited nearly a year for this consultation, which seems excessive based on the potential skin cancer under consideration
- •I have a 3 hour round trip driving to and from the hospital for a consultation that took a few minutes and could have been carried out online. The lesion that I have had been seen by photographed by the local GP who made the first referral to Dermatology. I don't see why I had to drive a long way to be given a diagnosis that I already had and then to be told that I would be sent an appointment within 8 weeks. Time between GP referral and consultation was time wasted.

Poor

- •There was an extremely long wait to see a dermatologist and rheumatologist. Then it was a five hour round trip to see them. Ridiculous when there is a perfectly good hospital 10 mins away.

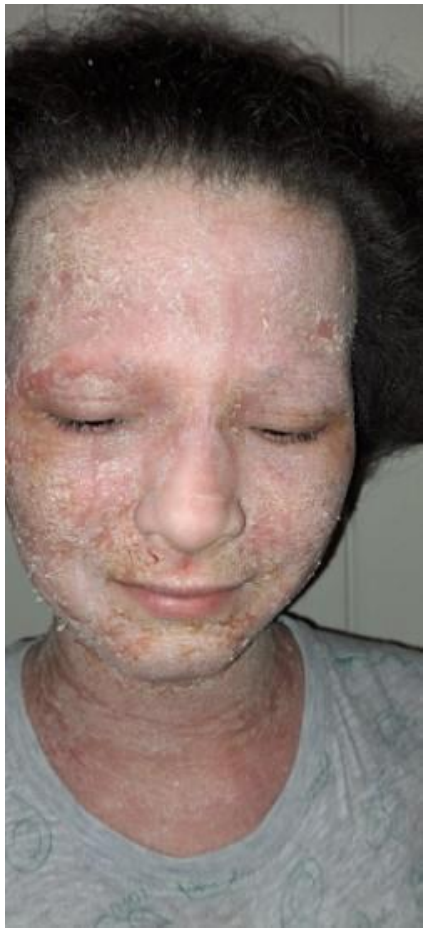
Very poor

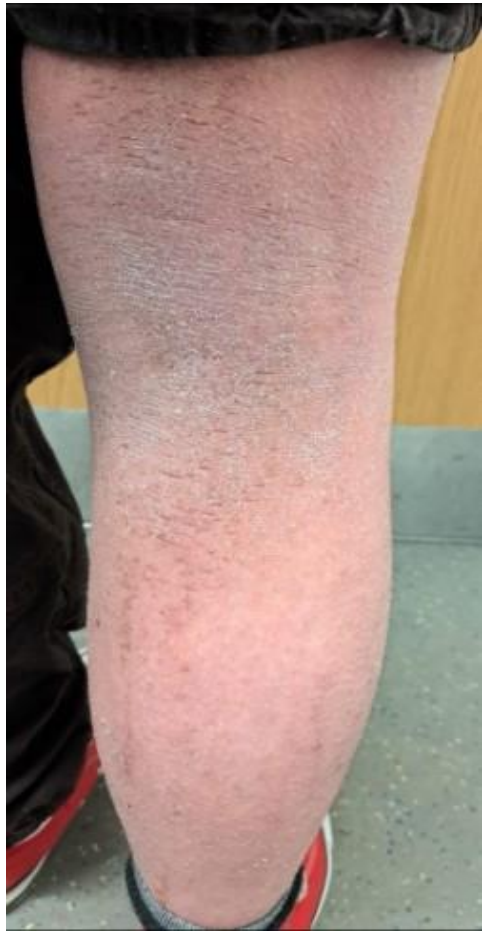
- •No it's a mess you have to board in a ward no privacy when that happens the staff there are overworked and still they go beyond the call of duty and deserve more then they are getting.

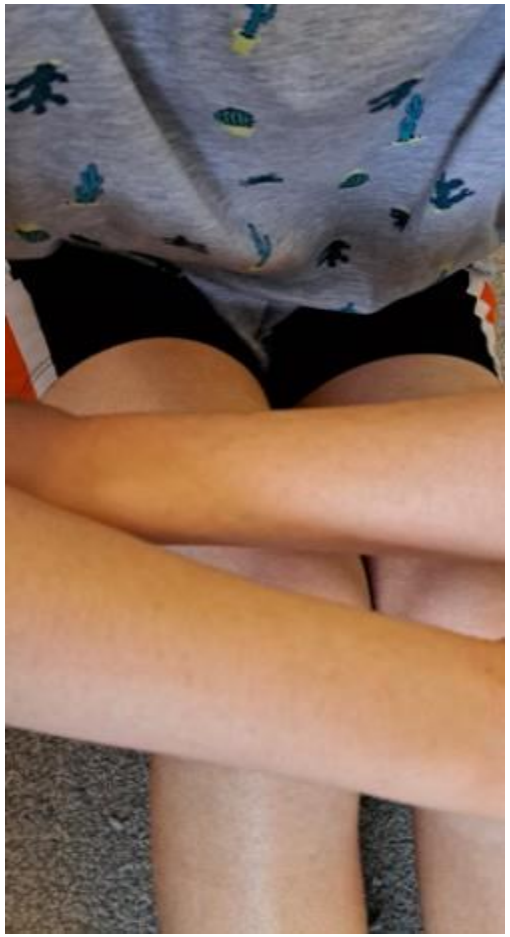
Assessment – Person Centred - Patient Story

- Patient Story – Paediatric Eczema patient (age 12)
- Exacerbation started in 2023 and no face to face appointment could be obtained by Dermatology due to lack of paediatric dermatologists
- Patient presented to ED Boxing Day 2023 – admitted
- Flare up required sedation and patient expressed wishes to die
- It took 5 days for a dermatologist to see her face to face immediately started paperwork to commence Duplimumab
- The Dermatologist agreed to start her on Cyclosporine as a bridging treatment until Duplimumab could be started.
- It took a further 6 weeks before Duplimumab was commenced.
- Outcome – complete skin transformation and improved mental health

Assessment – Patient Story before & after treatment







Assessment – Patient Centred, Learning

- Employed Locum Consultant with interest in Peadiatric dermatology
- Employed Advanced Pharmacist
- Rapid Access Clinics available
- Medical workforce on 'duty rota' weekly to respond to internal queries
- Weekly inflammatory MDT

Following Ombudsman case (rare side effect to treatment)

- National Acne treatment guidance changed Oct 2023
- No longer nurse led acne clinics
- All acne appointments face to face
- Recruited more Locum Consultants

Conclusion –
Next Steps being explored by the service to achieve sustainability

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- **Recruitment** of minimum 2 Consultant Dermatologists
- **Utilise DSU capacity** (3 rooms) – pending nursing and H&S support
- **Expand MOP capacity** – additional rooms (3 total) needed for "See and Treat" model
- **Increase admin staffing** to reduce backlog in letters and results
- **Create dedicated dermatology hub** to support workforce retention, equitable access, medical photography, phototherapy and adequate clinical space in one area
- **Upskill GPs** to undertake minor surgery in primary care
- **Develop sustainable workforce model** for long-term service resilience
- **Improve patient experience** through timely and consistent care

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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

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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

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

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.

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.

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.

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.

5

30 Mins

5 - Endoscopy Deep Dive

Sara Jones (Hywel Dda UHB - Service Delivery Manager - Endoscopy & Gastroenterology), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

Attachments

Endoscopy Deep Dive.pdf

Deep Dive: Endoscopy

Quality, Safety and Experience Committee

November 2025

Introduction

- This presentation aims to provide the Quality Safety and Experience Committee with an updated overview of the current state of Endoscopy service provision across Hywel Dda University Health Board.

- This presentation will seek to provide assurance on the delivery of safe, timely, equitable, efficient, effective and patient-centred endoscopy services across Hywel Dda University Health Board whilst a decision on the outcome of the Clinical Services Plan is awaited.

- The Endoscopy service has been included in the Clinical Services Programme to:
    1. ensure the on-going maintenance of JAG accreditation (standards closely aligned to the STEEEP principles); and
    2. support service expansion opportunities to improve & sustain delivery of waiting time standards.

- As such, both these aims will form the basis of this presentation's structure.

Introduction

- Following the COVID-19 pandemic, patients accessing endoscopy services within the Health Board have faced increased waiting times for diagnostic and surveillance procedures, driven by:
  - Reduced capacity during the pandemic, resulting in the development of waiting list backlogs *(Risk 1628)*;
  - Old and fragile equipment resulting in cancellation of endoscopy lists *(Risk 1521)*;
  - Demand out-stripping core capacity provision because of workforce deficits, further contributing to waiting list backlogs *(Risk 1580 & 1383).*

- Over the past 2 years, the service has implemented a series of recovery initiatives to address waiting time challenges, whilst in parallel, investing in permanent solutions to increase workforce capacity to deliver sustainable delivery of waiting times within core service provision.

- The service has also developed a robust asset register review programme to ensure ageing/fragile equipment is prioritised for replacement as part of the Health Board discretionary capital programme, with replacement equipment purchased over the past 2 years.

- Whilst targeted improvement has been achieved in clearance of the 8-week diagnostic backlog, with all patients now receiving procedures within the defined ministerial standard, there continues to be a backlog of circa 1,300 patients on the surveillance waiting list, with recovery expected by October 2026.

- Given demand for Endoscopy Services is projected to rise on an annual basis; the service has been included in the Clinical Services Programme to:
  1. ensure the on-going maintenance of JAG accreditation (standards closely aligned to the STEEEP principles); and
  2. support service expansion opportunities to improve & sustain delivery of waiting time standards.

1. Ensure the on-going maintenance of JAG accreditation (standards closely aligned to the STEEEP principles)

Situation - JAG Accreditation Standards

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

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- Endoscopy services across the UK are assessed by the Joint Advisory Group (JAG). 3 of 4 endoscopy units in Hywel Dda have been JAG accredited for the past 18 years – all but Prince Phillip Endoscopy Unit (due to the configuration of the unit).
- The award of JAG accreditation should provide a level of assurance with regards to the high-quality, safe and appropriate delivery of endoscopy services within Hywel Dda, delivered by a highly-trained, highly-supported and highly-motivated workforce.
- To maintain JAG accreditation, the service is required to meet rigorous quality standards, which are closely aligned to the STEEEP principles. These include:

1. **Leadership and organisation –** *Effective, Safe, Efficient*
2. **Quality –** *Effective, Safe, Efficient*
3. **Safety –** *Safe*
4. **Appropriateness and access –** *Timely, Equitable, Effective*
5. **Consent and patient information –** *Person-Centred, Safe, Effective*
6. **Person-centred care –** *Person-Centred, Effective Equitable*
7. **Performance and productivity –** *Efficient, Effective, Timely*
8. **Results –** *Effective, Safe, Efficient*
9. **Patient environment and equipment –** *Safe, Person-Centred, Efficient*
10. **Staffing the endoscopy service –** *Safe, Efficient, Timely*
11. **Endoscopist training –** *Safe, Effective, Efficient*

- As part of the JAG accreditation process, the service undertakes a series of pre-defined audits an annual basis, which provide an evidence base for service performance against the standards, allowing for identification of any gaps and opportunities to learn. These are reviewed at quarterly service QSE meetings.

Assessment – Complaints

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

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- Complaints data is presented on a quarterly basis through the Endoscopy QSE meetings, involving key medical, managerial and nursing staff across the service. Any identified opportunities for learning are also presented to ensure on-going improvement.
- On review of endoscopy complaints made between 2023-2025, the top 3 complainant themes mapped against the STEEEP principles are:

Effective Care (14 complaints between 2023-2025): lack of clinical clarity pre-procedure or poor follow-up.

- Patients felt their treatment was incomplete or ineffective – leading to anxiety pre- or post-procedure.

Timely Care (8 complaints between 2023-2024; 2 cases have been referred to the Redress Team for review): delays in diagnosis, long waiting times for cancer-related procedures, scheduling in-flexibility.

- Resulting in potential risk to patient outcomes due to delayed diagnosis or intervention.

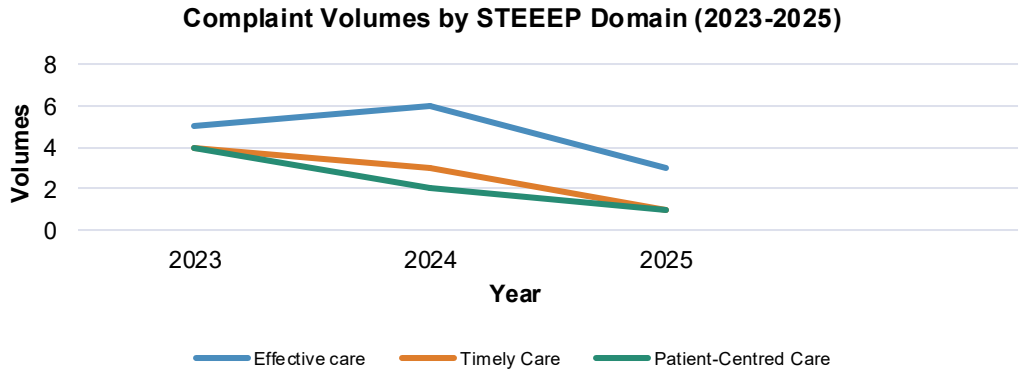
Patient-Centered Care (7 complaints between 2023-2025): poor communication, lack of consent clarity, dismissive staff attitudes.

- Patients felt unheard, misunderstood, reporting poor experience

Assessment – Complaints

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

As reflected in the graph below, there have been marked reductions in the volume of complaints received by the service between 2023-2025 – which is reflective of the service's on-going drive to improve patient care & service delivery.



Effective Care

- Lessons learnt: Improvements made in pre-procedure information for patients to support the consent process. New endoscopy reporting system adopted in 2023 to report procedure outcomes (with all patients presented a copy before discharge), complimented by a dedicated discussion with the endoscopist regarding procedure follow-up.

Timely Care

- Between 2023-2025, the service has seen a marked reduction in the volume of complaints relating to **timely care** – likely relating to the recovery of the diagnostic backlog, with waiting times now resorted within the 8-week diagnostic standard since March 2025. Whilst the service is continuing to recover waiting times for surveillance procedures, there have been no complaints received in relation to delayed access for surveillance in 2025. Full recovery of the surveillance backlog is expected by October 2026.

Patient-Centred Care

- Lessons learnt: The improvements made in pre-procedure information sent to patients has helped educate patients on what to expect during their endoscopy procedure experience. Any complaints relating to staff attitude are presented at weekly departmental meetings to ensure issues relating to communication are highlighted and addressed appropriately.

Assessment – Incidents

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

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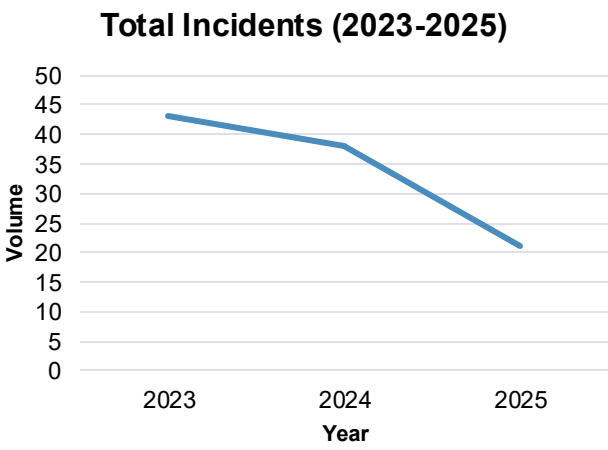
STEEEP Principle	No. of Incidents 2023	No. of Incidents 2024	No. of Incidents 2025	Common Themes
Effective	10	8	7	Diagnostic errors, procedural complications, treatment issues
Safe	7	7	4	Falls, sharps injuries, allergic reactions, procedural harm
Timely	15	12	3	Delays in diagnosis/treatment or procedure scheduling
Equitable	1	1	1	Access issues, referral errors, potential discrimination
Patient-centred	4	4	3	Communication failures, consent issues, inappropriate staff behaviour
Efficient	6	6	3	Equipment failures, staffing shortages, resource limitations



A thematic analysis of incidents reported between 2023-2025 indicates a reduction in incident numbers against the STEEEP domains.

- Incidents relating to **timely** access were consistently the highest but show a sharp reduction in 2025 - due to recovering waiting times.
- Incidents relating to **safety & effectiveness** demonstrate a steady decline, indicating improved patient safety practices – likely attributed to consistent feedback on lessons learnt through quarterly endoscopy QSE meetings.
- Incidents relating to **efficiency** peaked in 2024 but dropped to 0 in 2025 - reflecting improved reliability of equipment and resources.
- Incidents relating to **equity** remain unchanged between 2023 and 2025 – with only one reported per year.
- **Patient-centered** incident numbers have been consistently low – which is also reflective in the positive patient survey outcomes reported. Issues relating to consent and staff communication are also frequently discussed at the endoscopy QSE meetings.

This indicates that positive progress has been made in learning from the incidents that have been reported in the past, reflecting improvements in the culture of patient and staff safety, process adherence, timely access to procedures and equipment reliability.

Assessment – Patient Feedback

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

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Safety

- 90–100% of patients across the four sites reported satisfaction with privacy, dignity, comfort and staff communication across all sites.
- Equipment reliability issues noted at Bronglais Hospital (BGH) in 2023 & 2024 (this has now been addressed with purchase of new equipment in 2025).
- Sedation options flagged for review to improve patient comfort.

Timely

- Significant improvement in appointment waiting times across at all four sites between 2023 and 2024/2025.
- Glangwili Hospital (GGH) still faces parking-related delays.

Effective

- High ratings for care quality – with 90-97% of responses rates as excellent across the four sites.
- Post-procedure care praised at all sites, though GGH had gaps in discharge information for sedated patients.

Efficient

- Streamlined consent and discharge processes at most sites.
- Opportunity to improve discharge clarity for sedated patients (GGH) and maintain equipment reliability (BGH).
- Potential to improve the response rates to surveys at GGH and PPH.

Equitable

- Consistent high-quality care reported across all sites, including bilingual support.
- No disparities reported in access or treatment.

Assessment – Patient Feedback

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

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Patient-Centred

- Strong positive feedback on caring staff, clear communication and personalised attention.
- Facilities rated excellent for cleanliness and comfort; parking remains a challenge at GGH.
- Patients value tailored procedure preparation guidance and clear communication and explanation of procedure results.

Service Improvement Opportunities / Learning:

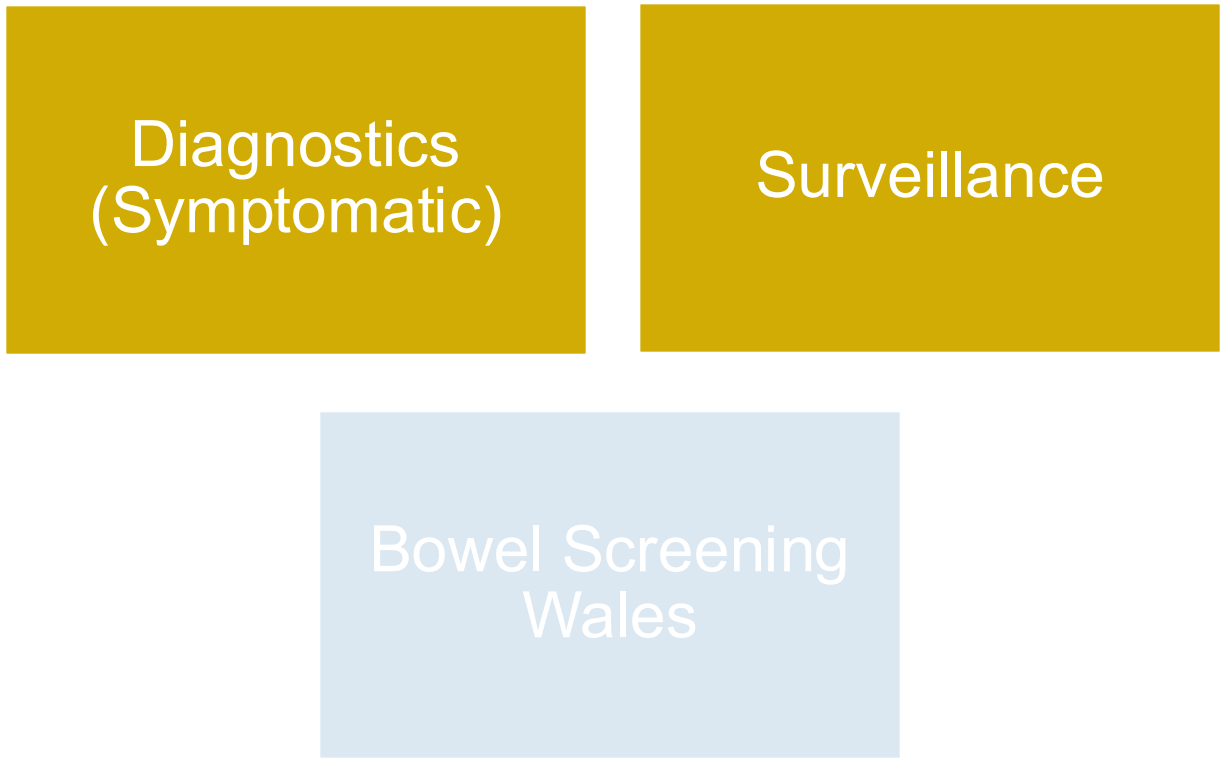
- **Safety:** Review communication with patients re: sedation protocols (as part of the admission process) – *this has led to updated changes to the pre-procedure documentation provided to patients, ensuring improved clarity on instructions for patients who may receive sedation during their procedure.*
- **Timely:** Continue to optimise scheduling and pre-assessment resource to maintain improved waiting times. Communicate potential parking constraints at GGH during the patient booking process.
- **Effective:** Enhance discharge communication & maintain high standards of care – *utilising improved pre & post procedure documentation.*
- **Efficient:** Increase survey response rates – *QR codes have been developed to advocate survey completion post-procedure.* Share positive feedback with staff.
- **Equitable:** Maintain provision of bilingual services & equity of access for all patients across the Health Board.
- **Patient-Centred:** Continue focus on staff communication and comfort – *through review of JAG audits at endoscopy QSE and departmental meetings.*

2. Support service expansion opportunities to improve & sustain delivery of waiting time standards

Situation

- There are three main elements to Gastrointestinal (GI) Endoscopy. The diagnostic (symptomatic) and surveillance pathways will form the main basis of this deep dive, given their focus as part of the Endoscopy developments within the Clinical Services Programme. Given the Bowel Screening Wales service is a Public Health Wales commissioned service, a short summary has been included within this presentation.

- Within Hywel Dda Health Board, endoscopy waiting time performance is managed and reported centrally, not on a site-specific basis.



Background – Diagnostic Waiting Times

Timely, Efficient, Equitable, Effective

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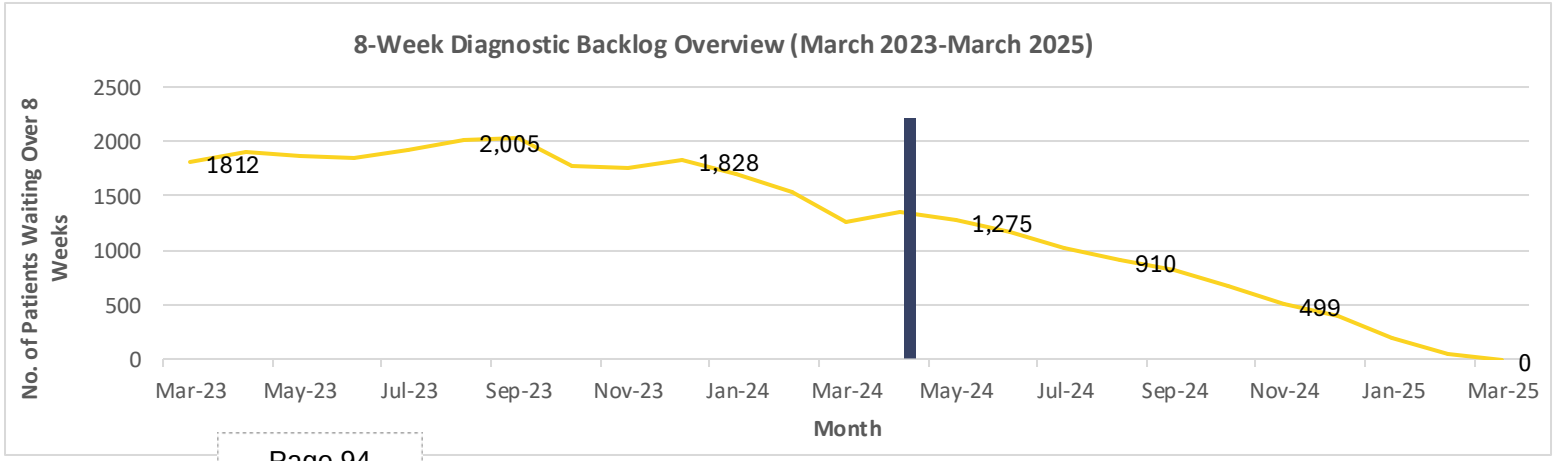
- Due to cessation of urgent and routine activity during the the covid-19 pandemic, a waiting list backlog developed, resulting in delays in patients receiving appointments for diagnostic endoscopy procedures.
- Whilst urgent suspected cancer procedures continued to be accommodated within 2 weeks, routine diagnostic endoscopy waiting times were as high as 100 weeks in September 2023 (compared to the 8-week ministerial standard), **affecting timely access to diagnosis for patients.**
- Whilst short-term funding allocations led to small improvements in backlog reduction, in parallel, the service was operating a D&C gap which was increasing the existing waiting list backlog.
- Following development of a business proposal, in April 2024, the endoscopy service received allocated planned care recovery funding to clear the waiting list backlog, whilst also increasing core capacity provision in parallel (avoiding generation of further backlog). This included:
  - ✓ Scheduling of additional activity via WLI's and insourcing to clear the waiting list backlog through a targeted recovery plan over 12 months;
  - ✓ Recruitment of additional workforce (including nurses and clinical endoscopist posts) to increase core service capacity to bridge the demand and capacity gap.
- Following completion of this recovery plan, diagnostic waiting times were restored to the 8-week ministerial standard in March 2025.
- Through annual plan investment proposals, the service has continued to invest in nursing and clinical endoscopist trainee posts, underpinned by up-to-date demand and capacity modelling, to ensure baseline capacity levels are in line with projected demand growth. This has supported the sustained delivery of the 8-week diagnostic target following completion of the recovery plan in March 2025.



Assessment – Diagnostic Waiting Times

Timely, Efficient, Equitable, Effective

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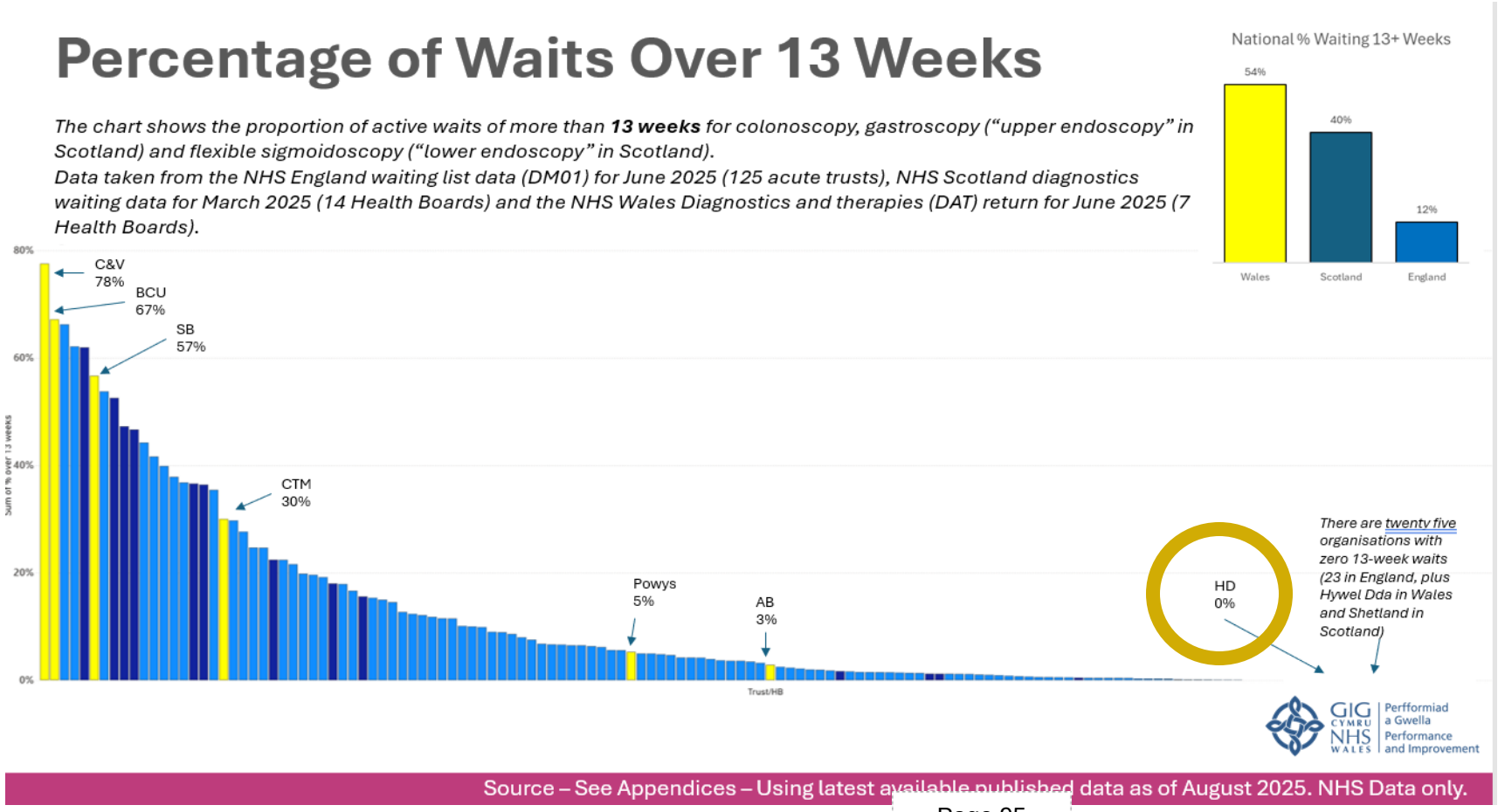
- The snapshot below (provided by the National Endoscopy Programme) provides a benchmarking comparison of endoscopy direct-access performance across Wales in August 2025.
- This reflects that Hywel Dda is the only Health Board in Wales with no patients waiting over 13 weeks for their direct-access procedure.



Assessment - Diagnostic Waiting Times

Timely, Efficient, Equitable, Effective

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- Future forecasting of projected demand growth year-on-year is key to ensuring sufficient plans are put in place to increase baseline capacity & maintain direct-access waiting times (whilst the outcome of the CSP is awaited).
- All funded endoscopy theatre capacity (Monday-Friday) is currently being utilised across the Health Board.
- To maintain timely access within ministerial standards, a further 3 sessions of capacity are required for GI endoscopy to meet demand growth projections for 2026/27 (accounting for the 5% increase for direct-access & symptomatic and 30% for inpatients/emergencies)

Plan A	**Year 1:** De-camp 3 urology sessions from GGH endoscopy – releasing 3 sessions of funded endoscopy theatre capacity to support delivery of GI endoscopy demand growth in 2026/27 **Year 2:** De-camp 3 urology sessions from PPH endoscopy – releasing 3 sessions of funded endoscopy theatre capacity to support delivery of GI endoscopy demand growth in 2027/28. From 2028/29 onwards, endoscopy will either require investment in evening/weekend sessions or a new theatre to accommodate demand growth (as defined by the CSP)	**Risks:** • This is predicated on the urology service identifying a suitable alternative treatment space to deliver flexi cystoscopy (treatment or outpatient facility - as this does not require a theatre setting for delivery).
Plan B	Increase endoscopy nursing establishment at GGH (by 3 sessions) to support delivery of GI endoscopy demand growth in 2026/27 using weekend theatre capacity (plus urology requirements). From 2027/28 onwards, endoscopy will either require further investment in evening/weekend sessions or a new theatre to accommodate demand growth	**Risks:** • Current service provision is Mon-Fri 9-5pm – would require a large scale OCP given current workforce arrangements. • Does not provide adequate inpatient/emergency capacity for demand growth expected in GI (already being realised) • Interdependency with HSDU & pathology • Equipment considerations • Weekend capacity currently being utilised for short-term uplift in capacity (surveillance and BSW recovery plans) until October 2026 at least. • S1 insourcing diagnostic conversions may also increase capacity requirements further • Cost of weekend enhancements for uplift in the nursing establishments

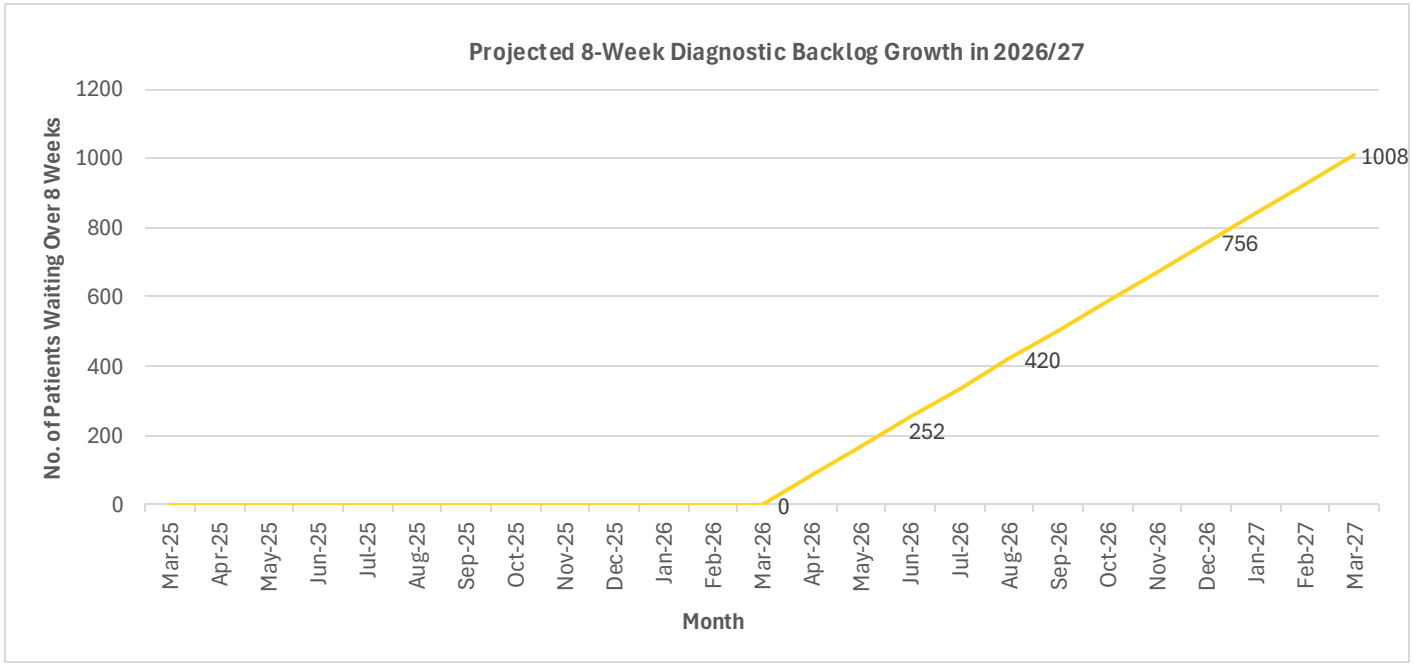
Assessment - Diagnostic Waiting Times

Timely, Efficient, Equitable, Effective

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Failure to implement a plan to address the known increase in demand projected for 2026/27 could result in a backlog of circa 1,000 patients being added to the diagnostic endoscopy waiting list.

- This would also affect delivery of the surveillance recovery plan expected to continue until October 2026, risking further increases in the surveillance waiting list backlog.



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Background – Surveillance Waiting Times

Timely, Efficient, Equitable, Effective

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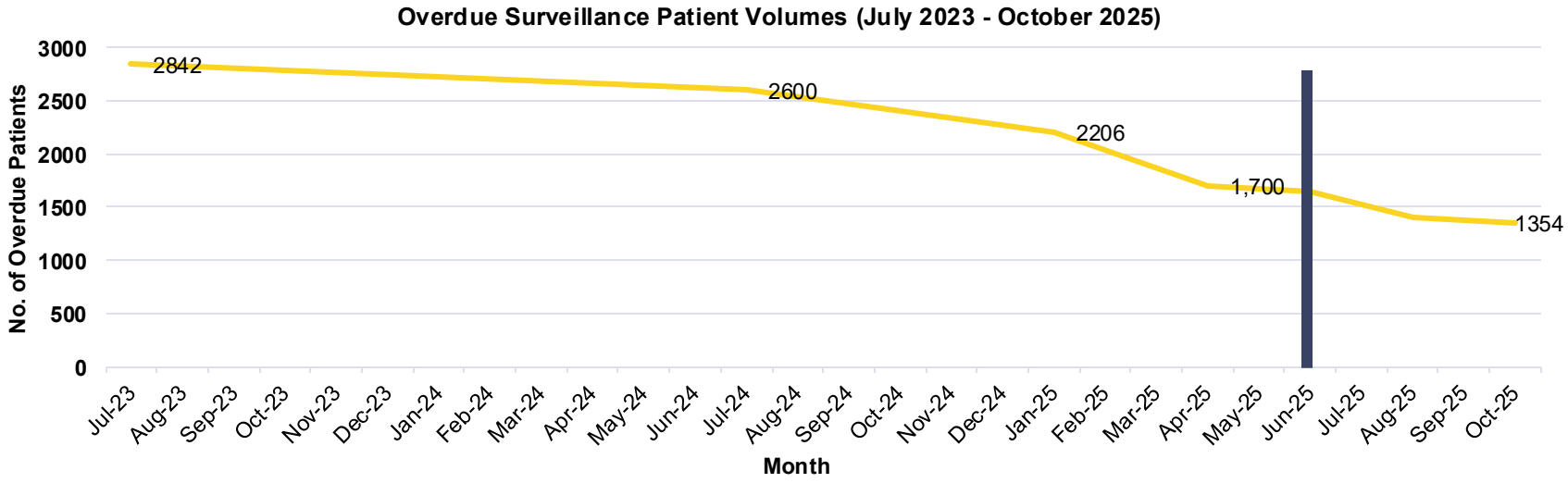
- Due to the capacity required to achieve this direct-access recovery programme, this limited the service's ability to address the backlog of surveillance patients who are overdue their endoscopy procedures.
- Surveillance activity was ceased during the pandemic, resulting in the development of a backlog, which reached its peak in July 2023, with circa 3,000 patients waiting beyond their targeted follow-up waiting time.
- In efforts to risk stratify this waiting list, clerical and clinical validation of this cohort has been actively undertaken to prioritise any high-risk cases for booking within core capacity.
- Following development of a business proposal, in June 2025, the endoscopy service an allocation of non-recurrent funding via the annual plan, to mobilise a targeted surveillance waiting list recovery plan.
- This includes:
  - Focused clerical & clinical validation of the entire surveillance waiting list (considering up to date BSG/NICE guidance and known cancer conversion rates to support decision making);
  - Planning of additional activity via WLI's to accommodate additional procedures to clear the waiting list backlog.



Assessment – Surveillance Waiting Times

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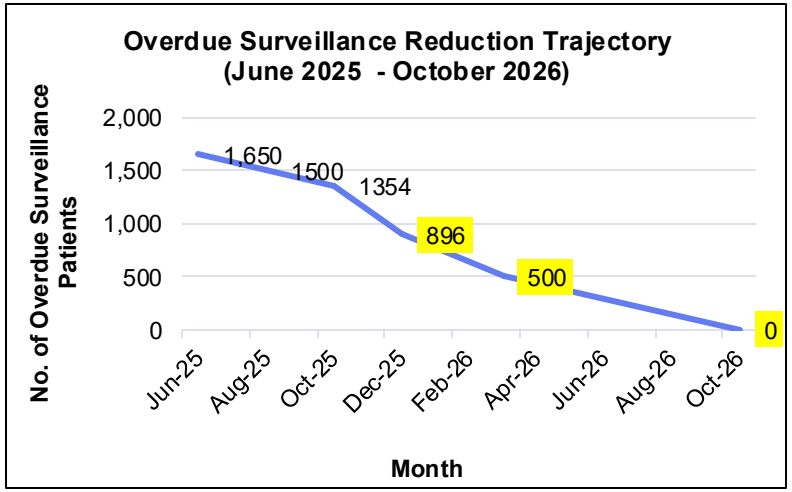
- At present, there are circa 1,300 patients left on the surveillance waiting list backlog (*(Risk Register No.1959)*

- From the clinical validation undertaken to date, a root-cause analysis review is currently being undertaken on 5 patients, to assess whether harm has been caused because of delayed access to their follow-up procedure. All 5 of these patients were due to have their procedure between 2020-2022 – resulting in a potential delay of between 3-5 years for their procedure.

- All patients due to be seen in 2023 have been clerically validated & no further instances of harm have been identified. The likelihood of harm to patients due to receive their follow up procedures in 2024 and 2025 is expected to be less, due to the reduced length of delay experienced.

- The root-cause analysis outcomes will be presented at the Endoscopy QSE meeting for review of lessons learnt.



- To ensure appropriate risk stratification of the waiting list, the service is continuing to clinically validate all patients on the waiting list backlog (considering up to date BSG/NICE guidance and known cancer conversion rates) to support decision making and prioritisation of any high-risk surveillance cases which need expediting.

- Through this, and the scheduling of increased volumes of waiting list initiatives (WLI's) over the next 6 months, the backlog is expected to reduce to circa 800 patients by December 2025 and is on trajectory to reduce to 500 patients by the end of March 2026.

- The Health Board has already committed to further non-recurrent funding until October 2026 to clear the remainder of the surveillance waiting list backlog.

Bowel Screening Wales (BSW)

Timely, Efficient, Equitable, Effective

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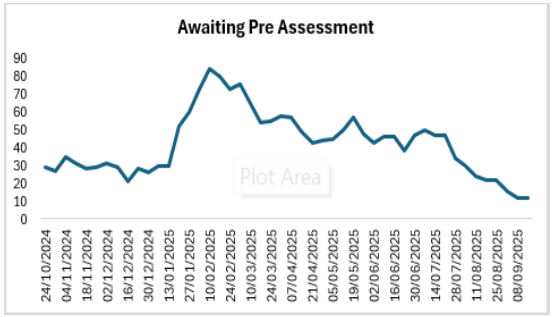
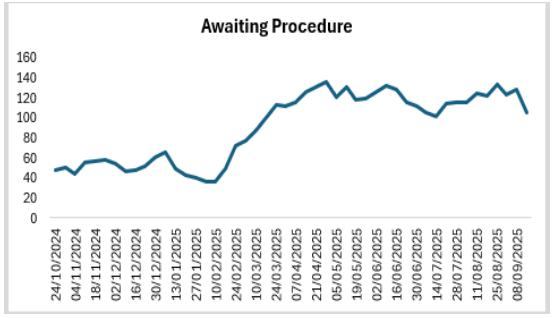
Background

- The roll-out of the BSW Optimisation Programme in October 2024 increased demand for screening colonoscopy by 25% within the Health Board.
- Service reliant on a small group of specialist workforce – limiting opportunities to increase core endoscopist capacity provision.
- Sickness in the nursing screening assessment team affected performance in January 2025.

Assessment *(Risk Register No.1959)*

- Service is operating a capacity gap of 1.5 lists per week – which is being mitigated by running WLI's using funding from the long-term agreement with Public Health Wales.
- Waiting times are improving. The backlog of patients waiting over 28 days on the BSW pathway has reduced from circa 150 patients in March 2025 to 70 patients (as at current).
- Average waits for screening colonoscopy are at 23 days – reduced from 35 days in January 2025.





Actions

- ❑ Continue to plan additional WLI's – to maintain baseline capacity.
- ❑ Explore market opportunities to insource screening colonoscopy procedures to address the backlog.
- ❑ Support new locum consultant (GGH) to enter the screening colonoscopy accreditation programme in next 6-12 months (once colonoscopy KPI's meet the BSW standards).
- ❑ Continue to explore opportunities to increase screening colonoscopy sessions within job plans.
- ❑ Develop standardised job plans for screening nurses to create further capacity in the team.

Actions & Conclusion

Actions for Improvement

Safe, Timely, Effective, Efficient, Equitable, Person-Centred

- Continue to progress with surveillance recovery plan to clear the backlog and restore timely access to surveillance procedures by October 2026.
- **Develop a proposal to increase endoscopy service capacity to support projected future demand growth in 2026/2027 – and year on year in advance of the CSP outputs.**
- Invest in further Clinical Endoscopist trainee roles to support endoscopist workforce supply, succession planning and future capacity expansion.
- Continued monitoring of capital asset registers to ensure appropriate prioritisation of replacement equipment as part of the Health Board's capital programme.
- Commence a targeted project to support optimisation of nursing workforce resource & the development of a Practice Educator role across the Health Board to support streamlining of training and skill-mix.
- Review newly developed JAG standards released in September 2025 in line with accreditation requirements.
- **Continue to complete quality and safety audits as outlined by JAG with quarterly presentation at endoscopy QSE meetings to review lessons learnt as part of service planning.**
- Continue to work with ARCH to explore opportunities for regional partnership with Swansea Bay UHB.
- Progress roll-out of a capsule sponge pilot – to gather evidence on the benefits for reduced endoscopy demand.
- Establish a Task & Finish Group across the Planned Care & Cancer and the Community and Integrated Medicine Care Groups to optimise Consultant Gastroenterology resource to support delivery of increased endoscopy capacity.

Conclusion

- By October 2026, timely access to surveillance endoscopy procedures will have been restored.
- Subject to implementation of further service expansion plans, direct-access endoscopy standards will be maintained in 2026/2027.
- **The service will continue to review demand and capacity modelling data to support subsequent annual planning expansion proposals, to ensure baseline capacity is sufficient to meet projected demand growth - in line with defined ministerial standards (whilst the outcome of the CSP is awaited).**
- Projected annual demand growth is a key foundation to the CSP planning approach.
- **Continue to use the JAG standards (linked to the STEEEP principles) as a framework to monitor quality, safety and patient experience across the service – with quarterly feedback through the Endoscopy QSE meetings.**

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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

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

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

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.

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.

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.

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.

6

6 - Date of Next meeting- 4 December 2025