Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Deep Dive: Elective Orthopaedics

Quality, Safety and Experience Committee

December 2025

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview and update on the current state of Elective Orthopaedic Service provision across Hywel Dda University Health Board

- The Committee wishes to explore the consequences of the current fragility within Elective Orthopaedic services under Clinical Service Plan (CSP) 1.
- This review will consider how these vulnerabilities are influencing service delivery, including any related incidents and complaints and consideration around patient experience and any clinical safety concerns.
- The report will also describe the short-term actions (both implemented and proposed) designed to address these pressures while awaiting the final CSP recommendations.

Overview

This paper highlights the clinical, operational, and patient experience challenges arising from service fragility and sets out the interim steps being taken to reduce associated risks.

Background - Fragility

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Why is Elective Orthopaedics Fragile?

Elective Orthopaedic services within the Health Board are currently regarded as fragile due to a significant backlog and prolonged waiting times for treatment. These challenges primarily stem from the disruption caused by the COVID-19 pandemic, which resulted in widespread cancellations of elective appointments and procedures, alongside reduced theatre capacity. Despite recovery efforts, referral-to-treatment times remain extended, creating sustained pressure on service delivery and patient experience.

What do we need to do?

The Clinical Services Plan sets out a strategic approach to stabilise and improve elective orthopaedic services. Key aims include:

- **Restoring Activity Levels:**
  Achieve at least pre-COVID activity levels as a baseline, supporting recovery and reducing waiting times.
- **Improving Access:**
  Deliver sustainable improvements in patient access to elective orthopaedic care, ensuring timely treatment and better outcomes.
- **Addressing Backlog Pressures:**
  Respond effectively to waiting list growth and the loss of activity during the pandemic through targeted and sustainable interventions.
- **Regional Collaboration:**
  With increased national emphasis on regional working, future orthopaedic service models need to reflect collaborative approaches across Health Boards

Background – CSP Scope Limitations

The Clinical Services Plan (CSP) currently focuses solely on elective orthopaedics and excludes trauma services. This separation is problematic because the two areas are highly interdependent. The majority of clinical priorities which influence delivery of activity reside within the Trauma component of Trauma and Orthopaedics (T&O). In addition the majority of the fragilities related to T+O reside within the trauma service component. Considering elective orthopaedics in isolation is therefore problematic, leading to several challenges, including:

- **Shared Workforce Pressures:** Surgeons, anaesthetists, and theatre staff often work across both elective and trauma lists; any change in trauma demand impacts elective capacity.
- **Theatre Capacity Conflicts:** Trauma cases frequently take clinical priority, reducing elective theatre time and complicating scheduling.
- **Financial and Operational Planning:** Resource allocation and investment decisions for elective care cannot be fully effective without factoring in trauma demand and emergency pressures.
- **Impact on Service Resilience:** Trauma surges (e.g., seasonal increases or major incidents) can destabilise elective recovery plans if not accounted for in modelling.
- **Pathway Interdependencies:** Pre-operative and post-operative support services (e.g., imaging, physiotherapy) are shared, so planning for elective alone risks bottlenecks in these areas.

A holistic approach that considers both elective and trauma is essential to ensure sustainable improvements and avoid unintended consequences for service delivery.

Background –Fragility Impact

Issues of Significance to the Health Board

- **Patient Safety and Experience:** Prolonged waits increase the risk of deterioration in patients' conditions, impacting quality of life and clinical outcomes.
- **Operational Pressures:** High waiting list volumes place strain on scheduling, workforce, and theatre utilisation, limiting flexibility for urgent cases.
- **Reputational Risk:** Failure to meet national targets and patient expectations may affect public confidence in the Health Board.
- **Financial Impact:** Extended waits can lead to increased complexity of cases, higher treatment costs, and potential penalties for non-compliance with performance standards.

Background – Fragility Impact

- **<u>Consideration of National and Local Objectives</u>**
- **National:**
  - Achieving compliance with Welsh Government targets for elective recovery and waiting times
  - Delivery of sustainable improvements in planned care as outlined in national recovery frameworks

- **Local:**
  - Implementation of the CSP to stabilise and strengthen elective orthopaedic provision.
  - Reduction of backlog through targeted initiatives such as additional theatre sessions, outsourcing, and improved patient flow.
  - Enhancing patient communication and experience during extended waits

Background – Minimum Standards

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British Orthopaedic Association Standards (BOASts) – Providing a Continuous Safe Elective Orthopaedic Environment

The BOA Standards (BOASts) for elective orthopaedics were published and implemented in February 2021. This marked the formal inclusion of elective orthopaedic standards within the BOASt framework, expanding beyond trauma to ensure safe, consistent elective care through physical and operational separation from emergency activity. Central to this is the concept of a **ring-fenced pathway**, which includes:

- **Dedicated Facilities:** A defined unit or ward exclusively for elective orthopaedic patients undergoing clean procedures, distinct from trauma or acute areas.
- **Ring-Fenced Theatre and Bed Base:** Protected theatres and inpatient beds reserved solely for elective cases
- **Exclusive Workforce Allocation:** Staff assigned specifically to the elective pathway, avoiding cross-cover with trauma or emergency services to reduce disruption and maintain infection control standards.
- **Standard Operating Procedures (SOPs):** Clear governance for admission, discharge, and escalation policies including enablement of effective administration to support regular audit of ring-fenced pathway.
- **Infection Control Measures:** Screening and decolonisation protocols prior to admission, with individual rooms available for patients with implant infections if required.

These standards aim to optimise resource use, minimise cancellations, and improve patient outcomes by ensuring elective orthopaedic services operate within a protected and auditable environment.

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Assessment Overview – Key Themes

Access & Capacity

- Referral to Treatment (RTT) Performance trends – Significant reduction in Stage 1 and whole pathway waits. Longest treatment waits reduced from 4 years in 2024 to 2 years in 2025 improving **Timely** care.

- Theatre Constraints – lack of Day Surgery Unit (DSU) General Anaesthesia (GA) provision impacting on what procedures can be undertaken. We have to utilise main theatre inappropriately as a result just to access GA provision
- Pre-assessment Capacity Issues – Current pre-assessment capacity does not match demand. This impact on the **effectiveness** of the service and our ability to populate theatre lists **timely** in line with the 6:4:2 mod

- Consenting review requirements - The long interval between the first outpatient appointment and surgery currently requires a second consent review immediately prior to procedure. This ensures the patient still agrees to the surgery, understands the risks, and confirms that the planned procedure, specific surgical approach and kit/implant requirements remain appropriate demonstrating delivery of **Safe** care. Absence of pooling across Arthroplasty Consultants also means this additional consenting clinic appointment is necessary. This impacts on the availability of new patient clinic slots.

Workforce & Service Fragility

- British Orthopaedic Association Standards (BOASts) require 24/7 medical cover for elective inpatients – this is currently delivered through variable pay in PPH and implementation of a sustainable model of cover is required. An SBAR proposing additional junior doctor recruitment has been developed for Care Group and subsequent executive approval.
- Sub-specialty workforce issues – Recruiting a Foot and Ankle Consultant has proven difficult, impacting service resilience
- BGH medical staffing fragilities – Vulnerabilities due to an ageing workforce and recruitment challenges associated with its rural location
- Outpatient clinic estate capacity – The current outpatient capacity impacts the ability to structure clinics in the most clinically appropriate and efficient way. For example, we wish to run a multi-disciplinary clinic in PPH on a Wednesday consisting of 3 revision surgeons and an Advanced Nurse Practitioner but there is no outpatient space. This results in patients often having multiple outpatient attendances.

Assessment Overview – Key Themes

- **Quality & Safety**
- Deviation from PPH Critical Care Standard Operating Procedure (SOP) since January 2025 – as referred to in Critical Care Deep Dive presented to QSEC in September 2025.
- Complaints and incident data – volumes of complaints have remained at similar levels over the last 3 years however it is important to distinguish that elective Orthopaedics cannot be considered in isolation and the data will include trauma complaints and incidents. The number of incidents reported over the same period has decreased although it is difficult to identify if incidents have reduced or whether there is a lack of incident reporting.
- National Joint Registry (NJR) data entry – There has been significant NJR Data entry resource shortfalls since September 2024.
- Regional Collaboration Challenges – Challenges around regional working with SBUHB due to different clinical and administrative systems which make it difficult to share patient information and align pathways. For example, differing patient administration systems, theatre management systems, dashboard, virtual v's paper pre-assessment. The implant portfolio for both Health Boards is widely different resulting in financial penalties/implications.
- **Innovation & Improvement -**
- Introduction of Waiting List Support Service – Provides advice and guidance to patients whilst they are on a waiting list.
- Orthopaedic Prehabilitation Service - Monitors and optimises patients whilst waiting for surgery
- Allied Health Professional (AHP) developments – The majority of joint replacement clinic follow up activity is delivered by AHP's. Integration of AHP's within T+O teams is also quite advanced in comparison to other HB's e.g shoulder, podiatry and arthroplasty.

Assessment – Access and Capacity

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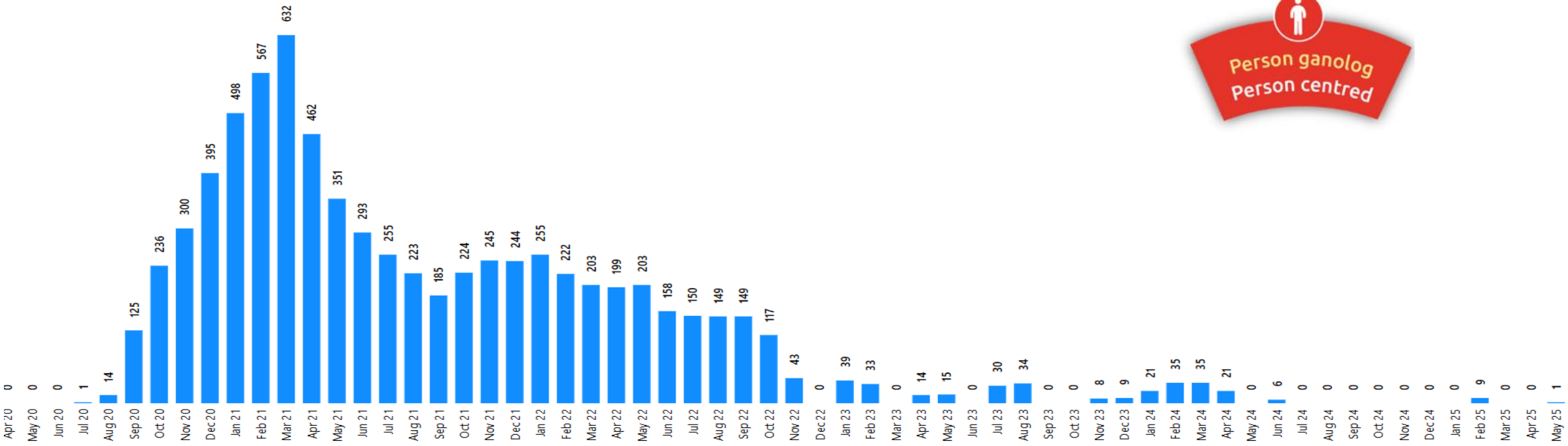
Waiting List Backlog

- *52-week Stage 1 breaches (Source Power BI Dashboard)*



Assessment Overview – Access and Capacity

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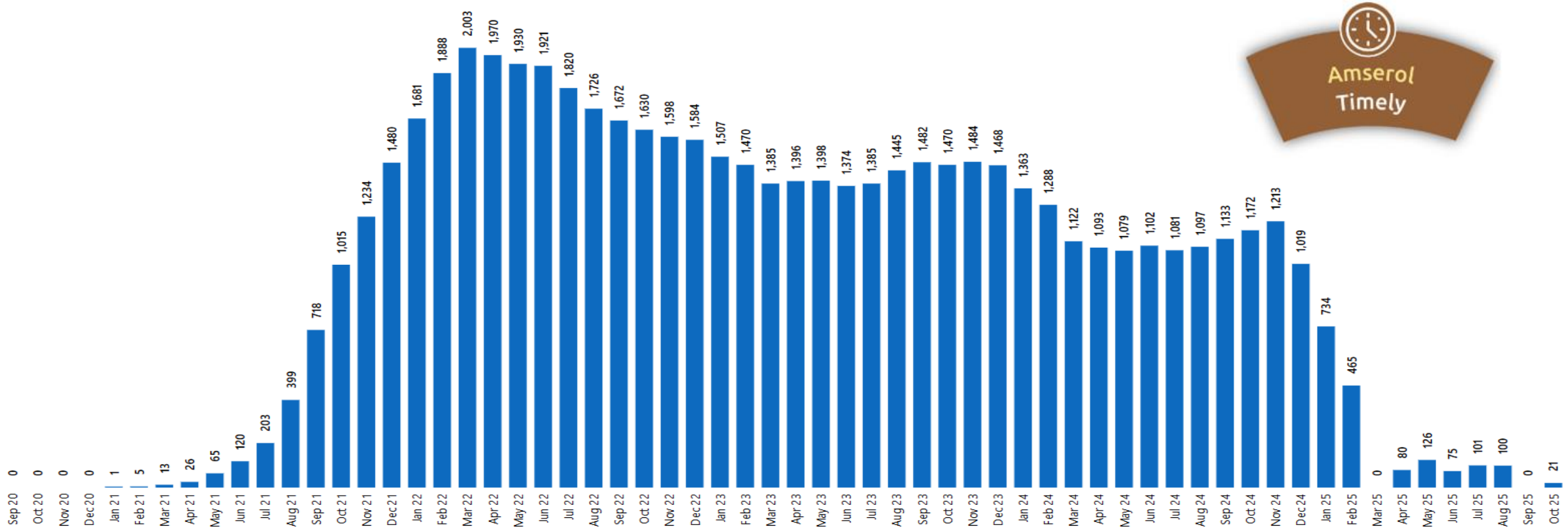
Waiting List Backlog

- *104 week Whole Pathway breaches (Source Power BI Dashboard)*



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Assessment Overview – Access and Capacity

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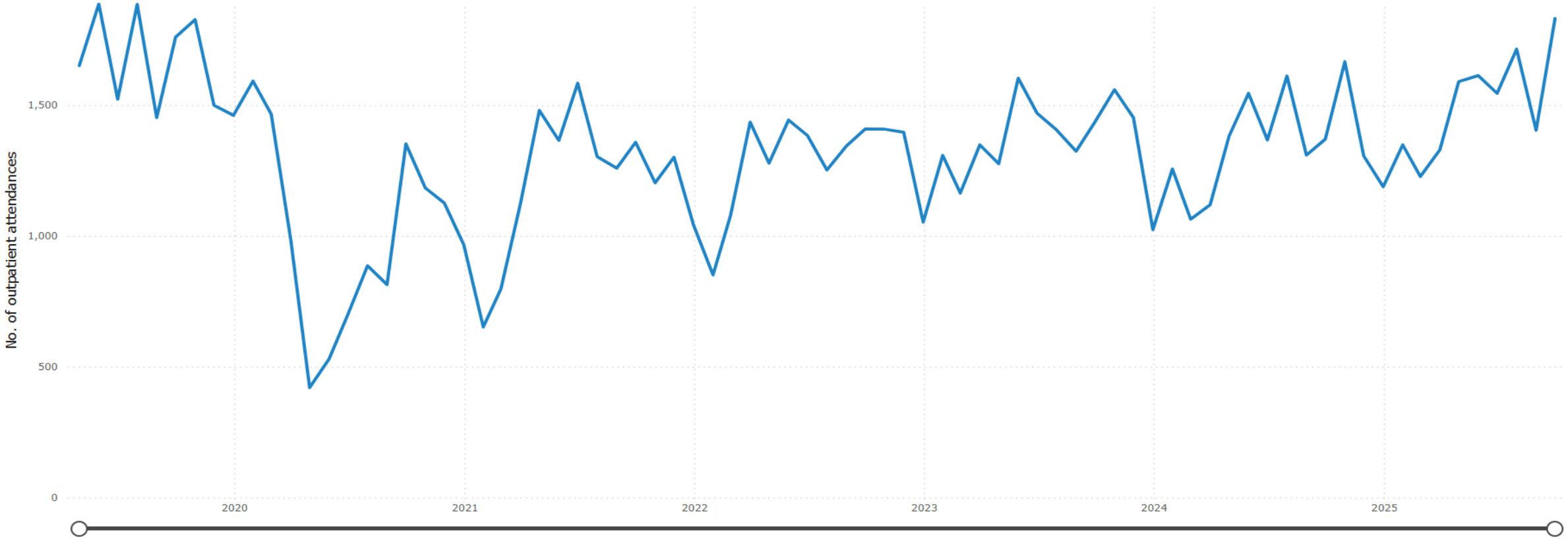
Stage 1 outpatient activity – Pre-covid v's current (Source: Outpatient Dashboard – Power BI)



- Unfortunately, the Health Board's Power BI Dashboard does not produce outpatient activity data from pre-covid.
- However, the data above has been obtained from the all-Wales Power BI Dashboard and includes pre-covid activity however cannot disaggregate the fracture clinic activity so this is included.

Assessment Overview – Access and Capacity

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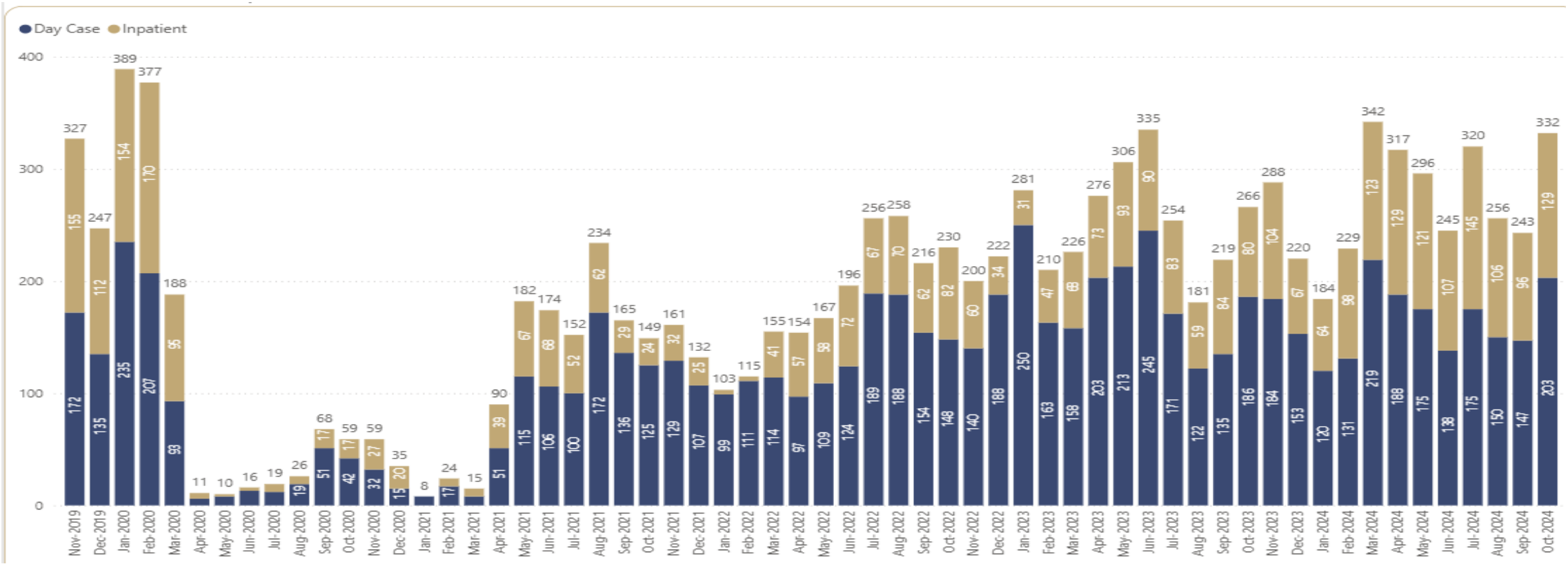
Stage 4 inpatient/cay case activity - Pre-Covid v's current (Source IRIS Power BI)



- Total volumes of inpatient activity across the Health Board is lower compared with pre-covid levels as a result of WGH delivering day case work only post Covid. This is as a direct result of the site not being able to BOA Standards.
- However there was a significant increase in inpatient activity in March 2024 when we were provided with the full allocation of 20 main theatre sessions

Assessment Overview – Access and Capacity

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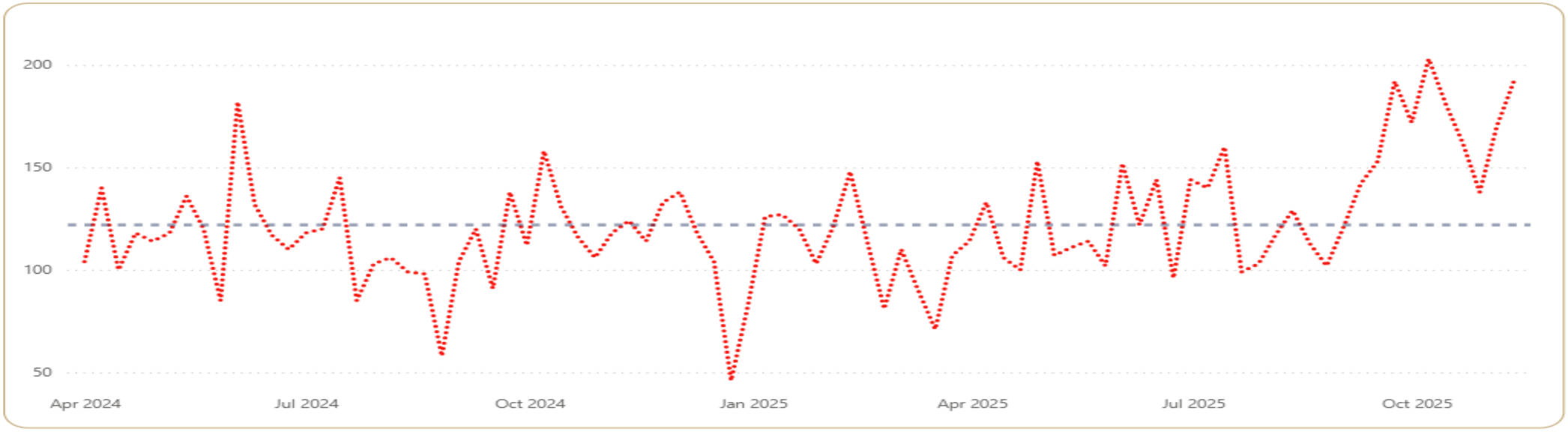
Daycase/inpatient Referrals *(Source IRIS, Power BI)*

- *Significant increase in daycase and inpatient referrals since commencement of stage 1 insourcing activity. Stage 4 total volume has grown by* almost 800 since September 2025 with average conversion rates of 50%



Assessment – Access and Capacity

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Current Theatre capacity:

Site	Funded Inpatient Sessions	Funded Day Case Sessions	Funded Ward Beds	Comments
Bronglais General Hospital	5	0	8	Inpatient activity is prioritised - some limited day case activity at this site is planned
Glangwili General Hospital	0	0		Acute trauma only. No elective activity.
Withybush General Hospital	0	15	0	We only have access to 6 main theatre sessions and 5 day theatre sessions (11 sessions in total) due to Main Theatre 4 being closed. Day case activity only at this site due to there being no dedicated ward however this is GA activity for fairly major cases (ACL reconstruction, forefoot procedures, shoulder scopes and not just HVLC LA cases. DSU at WGH provides simultaneous support for multiple lists but pre-op reviews and assessment require improvements.
Prince Philip Hospital	20	11	21	Funded for 11 GA day surgery sessions but only have access to 4. 1 cannot be staffed and 6 are provided on an LA only basis due to anaesthetic shortages. The large amount of activity delivered in DSU PPH could be delivered in a procedure room
TOTAL	**25**	**25**	**29**	

Assessment – Workforce & Service Fragility
Current Funded Staffing

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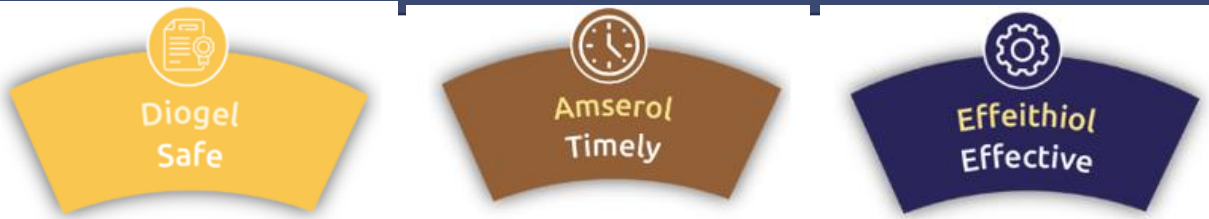
Staff Group	Withybush General Hospital	Bronglais General Hospital	Prince Philip Hospital
Consultant	5	4 (1 vacancy)	14
Middle Grade	5 Specialty Doctors	4 (1 vacancy)	1 Associate Specialist 8 Specialty Doctor 2 ST Highers
Resident Doctor	5 Clinical Fellow (1 vacancy) 1 F2	2 Clinical Fellows 4 F2's 2 F1's	1 Senior Clinical Fellow 8 Clinical Fellows 2 F2's 1 CT
Nursing	1.0 B8a Surgical Care Practitioner		3 B8a Specialist Nurse/Advanced Nurse Practitioners

Assessment – Quality & Safety



- **Access to Critical Care**

- Carmarthenshire Critical Care has provided an amended patient pathway through PPH Intensive Care Unit (ICU) since July 2022 supported by a SOP. Following concerns from clinical incidents in late 2024, a GGH ICU clinician-led decision to manage patients outside of the SOP was made in January 2025. This has led to a decrease in patients remaining in PPH and an increase in transfers to GGH. However, with PPH being the main inpatient site for elective Orthopaedics and the need to provide activity in line with British Orthopaedic Association Standards (BOASts), an ICU/Enhanced Care Unit (ECU) pathway for orthopaedics needs to remain at PPH.
- On clinical review it became apparent that the vast majority of the patients who were cancelled for lack of ICU care did not need ICU care. Instead, they require enhanced care and therefore have been managed in the Surgical ECU in PPH.
- If true ICU care is required, the anaesthetic team will stabilise and transfer to GGH appropriately.

Linked to Risk 1880 – Risk to the sustainability of critical care services due to fragility of medical workforce.

Assessment – Quality & Safety

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

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Complaints

Data considerations: It is important to note that the available complaint data does not differentiate between Trauma / Orthopaedics; all reporting combines these two areas into a single dataset. Complaints will have unscheduled care elements (ward, nursing, ED) but show on the T&O dashboard. PALS complaints have not been included in these figures but will equate to significant numbers. Despite these being an obvious concern, the significance of the trauma risks take priority.

Year (January to December)	Total Number of complaints	Comments	STEEEP Principles
2023	188	9 were escalated to redress – Grade 3) and relate to: 5 x Clinical Treatment decisions, 2 x Clinical assessment decisions, 1 x delays to treatment, 1 x communication issues. 44 were early resolutions. Themes for complaints were largely related to communication, the clinical assessment and diagnosis and delays to treatment	
2024	248	7 were escalated to redress – Grade 3) and relate to: 2 x Clinical Treatment decision, 1 x Clinical assessment decision, 1 x Intraoperative complication, 2 x post surgical complication, 1 x delays to treatment 37 were early resolutions Themes for complaints were again largely related to communication, the clinical assessment and diagnosis and delays to treatment	
2025	208 (up until 31/10/25)	A lot are not closed cases so will not have been escalated to redress yet. 3 escalated to redress but no final BOD decision reached yet. 58 remain open. 45 were early resolutions that have been closed	

Assessment – Quality & Safety

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

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Incidents

2023

106 incidents reported in 2023 for Orthopaedics (16 around pressure damage which sits under nursing, 9 about inappropriate behaviour or physical assault to a staff member. Post investigation reveals: 51 no harm, 53 low harm, 2 moderate harm (treatment/procedure not given as directed and treatment or procedure delayed).

2024

90 incidents reported in 2024 for Orthopaedics. Communication classification saw an increase. 15 incidents were relating to the treatment or procedure issues but the specific details of this vary significantly with no common theme. 50 no harm, 35 low harm, 1 moderate Incorrect removal of drain), 3 severe (missed diagnosis), 1 blank (still under investigation)

2025

49 incidents reported up until 17/11/25. 14 relating to the treatment/procedure however this classification seems to have been assigned to incident where, in previous years, a different classification has been used which makes an assessment of the significance of this difficult. 19 no harm, 9 low harm, 20 blank (still under investigation)

Assessment – Quality & Safety

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Data

National Joint Registry (NJR) - Significant NJR data entry resource shortfalls at PPH since September 2024 as Clinical Audit withdrew their data input support.
Of note is that the resource shortfall was due to vacancies and FCG subsequently declined approval to re-appoint into post. This impacted NJR and NHFD data entry for WGH and GGH also but falls outside of the scope for this specific elective orthopaedics deep dive. Efforts to reduce the backlog have commenced but NHFD is a higher clinical priority to clearance of the NJR backlog will take longer.

Waiting List – The absence of clinical condition or sub-specialty information makes analysing, understanding and managing waiting lists difficult.
For example, as at 16/11/25 the Primary Targeting List (PTL) report shows:
Stage 1 – 3461 patients waiting, only 1959 (56.6%) have a clinical condition/sub-specialty coded
Stage 4 – 5012 patients waiting, only 1935 (38.6%) have a clinical condition/sub-specialty coded
There is a proposal from the Welsh Orthopaedic Network Clinical Implementation Network (CIN) around defining clinical conditions and prioritisation at time of triage and national support from DHCW is required.

Regional System Variation – There are challenges in regional collaboration with Swansea Bay University Health Board due to differences in clinical and administrative systems, which hinder patient information sharing and pathway alignment. Examples include variations in patient administration systems, theatre management platforms, dashboards, and approaches to pre-assessment (virtual versus paper-based).

Assessment – Innovation and Improvement

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Waiting List Support Service (WLSS) – A single point of contact for patients awaiting planned care.

- All newly listed patients are proactively contacted by the WLSS on listing. Offered in the early stages of a patient's pathway to prepare patients as per 3P's programme.
- Patients are also provided with information and the contact number of the service on their listing letter.
- The WLSS offers holistic support to patients based on their individual needs and circumstances.
- The service utilises PROM/ health questionnaires (EQ-5D-5L/ Waiting Well About You) to help identify needs and stratify patients accordingly.
- 3,738 Orthopaedic contacts over the last 12 months
- Interventions mostly around self-management, preventing deterioration and promoting healthy lifestyle
- 1% of patients escalated to specialty for review
- 7% of patients escalated to clinical leads within the WLSS
- 6% of patients signposted to their GP for either a new health issue or a deterioration in general health

Assessment – Innovation and Improvement

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Waiting List Support Service – Stratification Criteria

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

Assessment – Innovation and Improvement

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Orthopaedic Prehabilitation Service

- Tier 1: 8-week online prehabilitation programme on a digital personal held health record
- Tier 2: 'Live' virtual group prehabilitation supported by technology enabled care (12 sessions over 12 weeks)- exercise and educational facilitated group consultations and remote monitoring of patients (weight, blood pressure, heart rate and blood saturation)
- Tier 3: Virtual 1:1 sessions for individuals with more complex care needs or not suitable for group consultations

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- 41% of patients lost weight
- 27% of patients had increased levels of physical activity
- 36% improved their Oxford scores (improved function and reduced pain in their joint)
- 45% of patients reported improved quality of life

"I've lost 1 stone since the start of this programme and the monitoring devices, particularly the weighing scale has helped. Knowing that your team is looking at the results, it gave me motivation, and I would not have lost this weight otherwise."

"I have found the programme life changing. It provided me with the 'jolt' I needed to make changes and improve my health. I can't speak highly enough of the team, the programme has been hugely beneficial. I am continuing with a healthy eating diet and exercise at home"

Assessment – Innovation and Improvement

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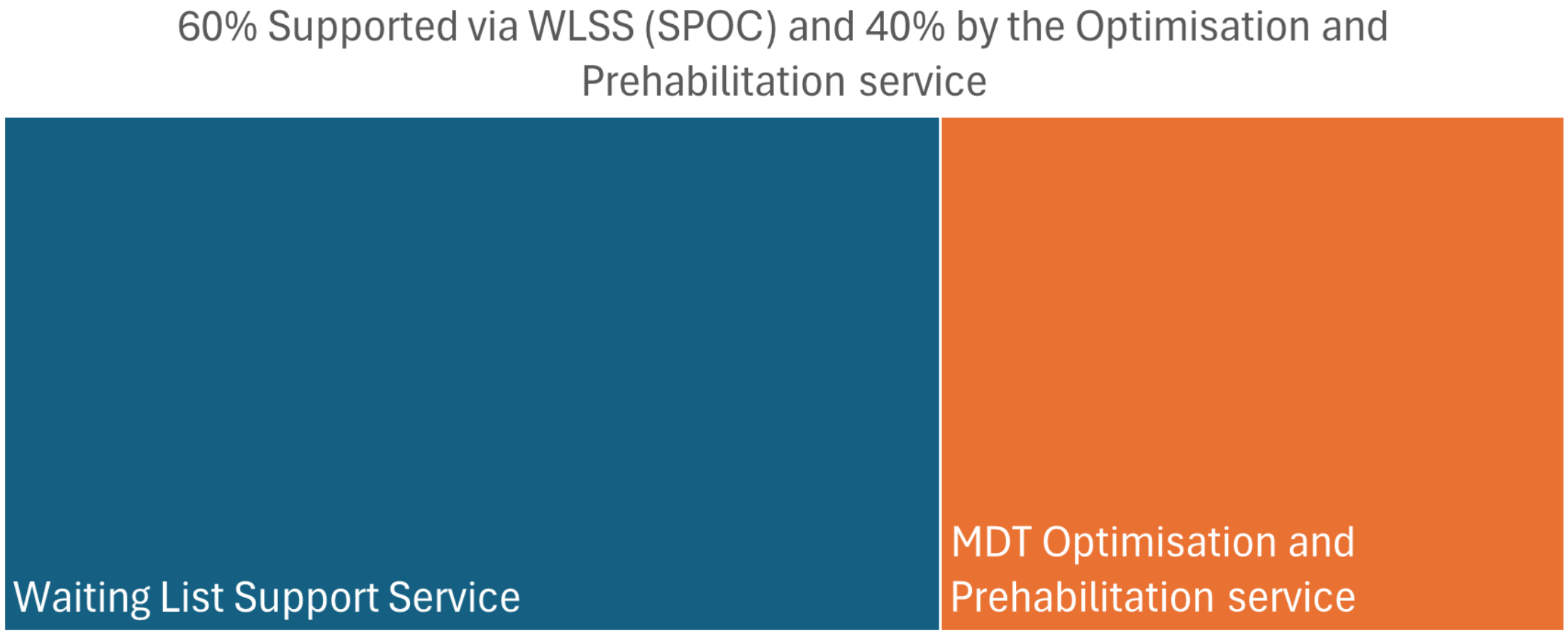
Stratification of newly listed Orthopaedic Patients



Recommendations / Conclusions / Points to Note

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- **Regional Collaboration with SBUHB –** Challenges have been experienced around delivery of arthroplasty but positive steps seen across other sub-specialties. The Foot and Ankle arthritis network is delivering its first dual operating Total Ankle Replacement in PPH on a SBUHB patient on 21/11/25. Positive collaboration is already established between hand and wrist surgeons with plans for implementation of a dual regional block list commencing in Quarter 4 2025/2026. Development of these regional working pathway delivers **efficient** and **effective** care for patients.
- **Consenting clinic slots** – The need for consenting slots will reduce as time in between clinic and theatre reduces improving **timely** services. However, moving to a pooled model will increase the requirement for this to comply with consenting best practice.
- **Waiting List Trends** - The insourcing stage 1 activity will significantly reduce stage 1 waits but will create a shift from outpatient delays putting increased pressure to deliver treatments. It is important that the quality of the additional stage 1 activity delivered is reviewed and audited to ensure it aligns with national and local conversion rates and is delivered **Safely** and **Efficiently**. Work on this supported by the Clinical Lead for T&O has commenced.
- **Patient Outcomes and Quality Monitoring** - There is a need to strengthen assurance around **safe** and **effective** care and patient outcomes by introducing monthly reviews of elective orthopaedic activity and routinely auditing key quality indicators. These should include surgical site infection rates, complications, and revision rates, ensuring continuous improvement and compliance with best practice standards. Resource limitations to date have prevented the establishment of these processes. An agreed arthroplasty governance process will address this but will result in an impact to elective service delivery (circa 2 sessions per month) for theatre to be stepped down during this process. However, there is currently a lack of admin and operational management resource to support the implementation and running of this.
- **Implementation of Virtual Joint School** – resource requirement to support for this **person-centred** intervention. Recommended intervention in Optimisation Framework, A Healthier Wales and 3P's programme.

Recommendations / Conclusions / Points to Note cont…

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- **Increasing throughput** - Delivery of 4 joint GIRFT Metric will ensure **Timely** and **Efficient** care. However surgical time is, in the main, static and opportunities to deliver 4 joints sits predominantly outside of the Consultant Orthopaedic Surgeon's control. i.e. Prompt start time, early sending, regular theatre teams and anaesthetist supporting consultants alongside the alignment of job plans to theatre session start times and ensuring adequate theatre workforce.
- **Outcome of CSP(1)** – some proposals provide additional elective inpatient activity which will support continued **Timely** intervention and reduction of waiting list volumes for inpatients.
- **Pre-assessment** - the lack of capacity to POAC clinically urgent patients resulting in delays to provision of care in urgent patients e.g. complex arthroplasty-have to utilise GGH instead of PPH, ST knee-utilise trauma list, ST shoulder and elbow-utilise trauma list. results in cancellations as fragility trauma given priority. Dedicated capacity should be provided for this to ensure **Effective** and **Efficient** use of theatre space.

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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.