GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Swansea Bay UHB's Sustainable Planned Care Plan

2026 – 2029

Our plan for a sustainable, productive
and patient-centred planned care system

CARING for each other

WORKING TOGETHER for our patients

ALWAYS IMPROVING how we do things

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Executive Summary

Swansea Bay UHB's Planned Care Recovery Plan 2026 – 2028

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Our plan sets out how we will secure a sustainable, productive and patient-centred elective care system for the population we serve, delivering the ambitions of the Welsh Government's three recovery pillars.

OUR PURPOSE

To recover long waits and build a resilient elective care system that prevents waiting lists from growing again, improves patient experience and health outcomes, and delivers better value for public money.

FOR OUR PATIENTS
Shorter waits, the right care first time, closer to home where possible.

FOR OUR COMMUNITIES
Improved health and wellbeing through earlier intervention and prevention.

FOR OUR SYSTEM
A sustainable model of care that makes best use of our resources and partnerships.

OUR APPROACH

Our plan is built on the three Welsh Government recovery pillars, working together in an integrated way to deliver sustainable improvement.

PILLAR 1: REFERRAL & EARLY DIAGNOSIS
Reduce unnecessary demand and ensure the right patients are seen, at the right time.

PILLAR 2: CAPACITY, PRODUCTIVITY & TREATMENT
Maximise the productivity of our existing capacity before seeking additional investment.

PILLAR 3: FOLLOW-UP, SURVEILLANCE & LIVING WELL
Transform follow-up care and empower people to manage their health with confidence.

KEY PRIORITIES

- **Understand & reduce demand:** Standardised referral criteria, advice & guidance, referral optimisation and validation.
- **Maximise productivity:** Outpatients, theatres, diagnostics and workforce transformation.
- **Transform follow-up care:** N:FU improvement, PIFU/SOS and risk-stratified surveillance.
- **Work together regionally:** One system approach across South West Wales to deliver better outcomes.
- **Invest wisely:** Target investment only where a genuine capacity gap remains after all other opportunities.

OUR AMBITION

By 2028 we will have a sustainable elective care system where:

- No patients wait over 104 weeks for treatment and diagnostic waits are within 8 weeks.
- Patients receive the right care, in the right place, first time.
- Our services are productive, efficient and focused on continuous improvement.
- We work seamlessly with partners across our region for the benefit of our population.
- People are supported to live well and stay well for longer.

WHAT WE ARE ASKING FOR

To support the delivery of this plan we are asking for:

- Sustained investment aligned to the three recovery pillars.
- Support to enable regional solutions and pooled capacity.
- Continued national support for digital, workforce and productivity programmes.
- Flexibility to reinvest savings in transformation.

This investment will deliver lasting improvements in access, outcomes and value for our population.

OUR VALUES IN ACTION | CARING for each other | WORKING TOGETHER for our patients | ALWAYS IMPROVING how we do things

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How this Plan Responds to Welsh Government Expectations

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Demonstrating that the Welsh Government's recovery pillars have been translated into a sustainable elective care operating model.

Welsh Government expectation	How Swansea Bay has responded	Evidence within this plan
1. Understand future demand	Demand has been remodelled using referral optimisation, HealthPathways, validation, straight-to-test, advice & guidance and future demand forecasting to identify the true underlying demand for elective care.	Future demand model, demand & capacity methodology, referral optimisation, validation.
2. Maximise existing capacity	Productivity opportunities across outpatients, theatres, diagnostics and workforce have been systematically challenged before identifying additional capacity requirements.	Productivity strategy, Deloitte theatre redesign, outpatient productivity, diagnostics productivity.
3. Transform pathways	Planned care transformation is embedded throughout the plan, including pathway redesign, PIFU, surveillance, digital opportunities and workforce redesign to create sustainable capacity.	Transformation programme, follow-up strategy, digital transformation, workforce model.
4. Deliver regionally	Regional demand and capacity modelling has been undertaken to identify pooled capacity, shared pathways, regional hubs and opportunities to reduce duplication across South West Wales.	Regional elective care model, Orthopaedics, Cataracts, Diagnostics, Specialist Services.
5. Invest only where a genuine residual gap remains	Investment assumptions have only been modelled after demand reduction, productivity improvement, transformation and regional opportunities have been exhausted.	Capacity gap assessment, investment waterfall, financial model.
6. Deliver sustainably	Delivery is supported through executive oversight, benefits realisation, performance management and a long-term operating model designed to maintain recovery beyond 2027.	Roadmap, governance, benefits framework, delivery milestones.

This plan demonstrates that proposed investment represents the **residual requirement** following systematic assessment of future demand, productivity, transformation and regional opportunities, providing assurance that additional investment **supports long-term sustainability** rather than short-term recovery.

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Our Sustainable Planned Care Plan – At a Glance

A whole system response to deliver sustainable planned care for our population

OUR AIM
Zero patients waiting over 104 weeks for treatment and 8 weeks for diagnostics, with sustainable, high quality care for the future.

Our approach: maximise productivity, transform pathways, harness digital and regional opportunities, and invest only in the residual gap

OUR SIX STRATEGIC TENETS

1. PRODUCTIVITY

- Theatre productivity and utilisation improvement (85% ambition)
- Theatre timetable redesign and job planning alignment
- Outpatient productivity and clinic efficiency
- Diagnostic utilisation and yield mprovement
- Reducing variation and unwarranted practice
- Clinical validation and follow up transformation

2. DEMAND MANAGEMENT

- Standardised referral criteria (Professional triage)
- Advice & guidance and signposting
- Same day / straight through test (STT) pathways
- High impact test and referral management
- Reducing inappropriate referrals and follow ups

3. PATHWAY TRANSFORMATION

- Follow-up redesign (PIFU / SOS) and national follow-up criteria
- One stop / STT and alternative pathway models
- Pre-surgical optimisation, prehabilitation and patient optimisation
- Frailty, complex and POPS models of care
- Optimised surgical pathway and peri-operative model (iHSQ)
- Specialist advisory and MDT models

4. DIGITAL ENABLEMENT

- AI-enabled letter validation and duplicate removal
- AI referral screening and pathway support
- NHS Wales App and SBU Patient Portal
- Virtual consultations and remote monitoring
- Ambient Voice Technology (clinical documentation)
- Digital optimisation of systems and processes

5. REGIONAL WORKING

- Shared capacity for orthopaedics (arthroplasty), ophthalmology (cataracts) and other specialties
- Diagnostics collaboration and radiotherapy optimisation
- Hand surgery reciprocity and workforce collaboration
- Use existing regional capacity before purchasing additional capacity

6. TARGETED INVESTMENT

- Investment in residual recurrent capacity (treatment, outpatients, diagnostics) where gap remains after all other opportunities maximised
- Investment in transformation and digital enablers to deliver sustainable change
- Non-recurrent investment to accelerate recovery and transformation

WHAT THIS MEANS FOR PATIENTS

1. PRODUCTIVITY	2. DEMAND MANAGEMENT	3. PATHWAY TRANSFORMATION	4. DIGITAL ENABLEMENT	5. REGIONAL WORKING	6. TARGETED INVESTMENT
More appointments and treatments available, reduced waiting times, better use of clinical time.	Right patient, right care, first time – fewer unnecessary referrals and tests.	More streamlined and joined up pathways, reduced delays and cancellations, better outcomes.	**Easier access, more choice in how care is delivered, and better experience.**	Patients wait less by working together across health boards, with consistent quality.	**Sustainable delivery for today and for the future – protecting access and quality of care.**

KEY ENABLERS

Workforce
Up-skilling, new roles, and right skills in the right place

Data & Intelligence
Improved data quality, analytics and performance insight to drive action

Governance & Delivery
Strong programme governance, clinical leadership and benefits realisation

Commissioning & Contracts
Aligned contracts and performance management to drive outcomes

Quality & Patient Experience
Person-centred care, safer care and improved experience

THE IMPACT WE WILL DELIVER

Zero
>104 week waits for treatment

8 weeks
Diagnostics waits achieved

24,962
Outpatient follow up reductions targeted

Increased capacity
through productivity and transformation

Best use of investment
Targeted to the residual gap

This plan is ambitious, evidence-driven and deliverable. | It prioritises our patients, uses resources wisely and creates a sustainable planned care system for the future.

What this Plan Asks For

Delivering sustainable planned care through recovery, transformation, productivity and targeted investment

Priority	What this plan commits to delivering
Deliver Sustainable Recovery	Sustain elimination of 104-week waits, restore delivery of the 8-week diagnostic standard, maintain waiting list control and protect elective performance despite continuing growth in demand.
Optimise the Surgical Pathway	Implement a comprehensive Pre-Surgical Optimisation Programme including intelligent health screening (iHSQ), prehabilitation, POPS, anaesthetic optimisation, pain optimisation, frailty pathways and digital patient preparation to improve outcomes, reduce cancellations and maximise theatre productivity.
Transform Outpatients	Reduce unnecessary outpatient demand through professional triage, standardised referral criteria, straight-to-test pathways, patient initiated follow-up (PIFU), surveillance redesign, clinical/admin validation, consultant productivity improvements and expanded multidisciplinary models of care.
Deliver Digital Transformation	Deploy AI-supported validation, AI referral screening, Ambient Voice Technology, NHS Wales App, Patient Portal, Hybrid Mail, Theatre Management System, virtual consultations, digital pre-assessment (iHSQ) and PRO-MAPP.
Improve Productivity Before Investment	Deliver measurable improvements in theatre utilisation, consultant job planning, outpatient productivity, follow-up ratios, day surgery performance, scheduling and pathway redesign before seeking additional recurrent investment.
Develop Sustainable Clinical Services	Address underlying recurrent demand-capacity gaps across Radiology, Endoscopy, Diagnostics, Oncology, Neurophysiology, Cellular Pathology, Psychological Therapies, Special Care Dentistry and other priority services.
Strengthen Regional Working	Develop a sustainable South West Wales elective care system through shared capacity, regional clinical networks, mutual aid, workforce collaboration and coordinated delivery of specialist services.
Target Investment Only Where Required	Following delivery of productivity, transformation, digital and regional opportunities, seek targeted investment to address the remaining workforce, infrastructure and capacity gaps necessary to deliver sustainable planned care.

Funding Requirements Summary

Our funding requirement reflects both the recurrent capacity gap associated with the traditional delivery model and the targeted transformational investment required to deliver a sustainable planned care system.

	2026/27			2027/28		
Area	Cases	£ Low	£ High	Cases	£ Low	£ High
Treatment	1,954	6,814,966	9,836,934	2,535	6,348,336	8,653,336
Diagnostics	35,735	6,092,739	6,092,739	32,692	8,642,614	8,642,614
Cancer	4,733	3,815,344	3,815,344	14,199	4,014,123	4,014,123
Outpatients	1,080	217,873	217,873	1,080	217,873	217,873
Community By Design	5,260	664,000	664,000	4,893	553,900	553,900
Pre-Surgical Optimisation		1,274,264	1,358,138		1,696,102	1,821,912
Administration		995,699	995,699		437,548	437,548
Professional Triage		75,464	75,464		75,464	75,464
Digital		61,815	61,815		79,223	79,223
Other		668,429	668,429		668,429	668,429
Total Cost	**48,762**	**20,680,593**	**23,786,434**	**55,399**	**22,733,612**	**25,164,422**

- Funding methodology agreed with Executive Team and Performance & Finance Committee.
- Combines investment required to close the underlying recurrent capacity gap with one-off transformational investment.
- Investment supports sustainable recovery rather than short-term activity alone.
- Transformation initiatives reduce future reliance on recurrent funding and improve long-term productivity – further work planned to understand how we robustly evidence these.

The funding ask should be considered as a single integrated investment proposition to deliver recovery, sustainability and transformation.

Our Strategic Response

Redesigning elective care by systematically challenging productivity, transformation, digital innovation and regional delivery before identifying any residual capacity requirement.

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OUR APPROACH

Rather than relying on short-term additional activity, Swansea Bay's Sustainable Planned Care Plan adopts a systematic approach to redesigning elective care.

The plan is built on the principle that additional investment should only be sought where a genuine residual demand and capacity gap remains, following comprehensive assessment of opportunities to:

- **Improve productivity** across outpatients, theatres, diagnostics and workforce.
- **Transform pathways** to reduce unnecessary demand and release sustainable capacity.
- **Harness digital innovation** to improve access, efficiency and patient experience.
- **Maximise regional collaboration** through shared capacity, pooled waiting lists and specialist service models.

This creates a transparent and evidence-based route from current demand to residual investment, ensuring every opportunity to improve the existing system has been fully explored before seeking additional capacity.

OUR STRATEGIC PRINCIPLES

Prevention before addition

Reducing avoidable demand before increasing capacity.

Treat-in-turn

Ensuring fair, clinically prioritised access for patients.

Productivity before investment

Maximising existing resources before seeking additional funding.

Regional before local duplication

Delivering services collaboratively wherever this improves outcomes.

Digital before manual

Using technology and automation to simplify pathways.

PIFU or discharge by default before routine follow-up

Transforming follow-up care to create sustainable capacity.

Sustainability over short-term recovery

Investing in long-term system redesign rather than temporary activity.

Together these principles provide the strategic framework for a sustainable elective care system that delivers **better outcomes** for patients, makes **best use of NHS resources** and supports **long-term recovery** across South West Wales.

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Future Planned Care Operating Model

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A sustainable, integrated approach delivering better outcomes for our patients and our system

Prevention

Proactively supporting health and wellbeing to reduce demand and improve long-term outcomes.

Referral Management

Ensuring the right patient, to the right service, at the right time through clear pathways and clinical triage.

Diagnostics

Increasing access to high quality diagnostics to support timely and accurate decision-making.

Treatment

Delivering safe, effective and standardised care through consistent clinical pathways and best use of capacity.

Follow-up

Providing timely, targeted follow-up and ensuring patients receive the right support in the right place.

Living Well

Supporting recovery and long-term wellbeing through rehabilitation and community-based services.

Regional Delivery

Working in partnership across our region to deliver sustainable, equitable care for our communities.

Our Model. Our Patients. Our Region.

A sustainable planned care system that delivers better outcomes today and for the future.

Redesigning care.
Reducing waits.
Improving lives.

REDUCING future demand

MAXIMISING productive capacity

CREATING sustainable capacity

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Strategic Principles

The principles that will guide our decisions and actions as we recover and transform planned care

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1 Prevention before addition

We will reduce unnecessary demand and prevent future waiting lists from growing.

2 Treat-in-turn

We will prioritise patients fairly and transparently based on clinical need and time waited.

3 Productivity before investment

We will maximise the productivity of our existing capacity and workforce before seeking additional investment.

4 Regional before local duplication

We will work together across South West Wales to use capacity once, share where it makes sense and avoid duplication.

5 Digital before manual processes

We will use digital solutions and automation to improve access, efficiency and patient experience.

6 PIFU before routine follow-up

We will reduce unnecessary follow-up by using patient initiated follow-up and remote monitoring where appropriate.

7 Sustainability over short-term recovery

We will deliver solutions that are sustainable, financially responsible and build a resilient planned care system for the future.

These principles underpin every decision we make and every action we take.

They ensure our recovery is equitable, sustainable and focused on delivering the best possible outcomes for our patients and communities.

Our values in action

CARING for each other

WORKING TOGETHER for our patients

ALWAYS IMPROVING how we do things

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Current Position and Recovery Requirement

The case for change

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Planned care pressures remain a significant challenge for our patients and our system.

Total RTT waiting list
Our total RTT waiting list remains high, with demand continuing to exceed sustainable capacity.

104 week waits
While we have significantly reduced long waits, the risk of further 104 week waits remains without continued focus.

Diagnostic 8 week waits
Performance against the 8 week diagnostic standard is below target in a number of key modalities.

Follow up backlog
A large follow up backlog is reducing our capacity to see new patients and extending waits.

Key specialty pressures
Some specialties face significant pressure due to demand, workforce and capacity constraints.

A snapshot of our current position

65,700+ patients waiting for treatment (RTT total waiting list) (May 2026)

0 patients waiting over 104 weeks for treatment (May 2026)

15,200 patients waiting over 8 weeks for diagnostics (June 2026)

200,000+ patients waiting for a follow-up appointment (May 2026)

Specialty pressures include:
Orthopaedics, Ophthalmology, ENT, Gynaecology, Dermatology, Urology and General Surgery

Our vision for sustainable planned care

To deliver recovery through transformation rather than temporary additional activity.

By reducing unnecessary demand, maximising productivity, transforming follow up care and working together across our region, we will build a planned care system that is sustainable, resilient and focused on our patients.

Present Waiting List Position

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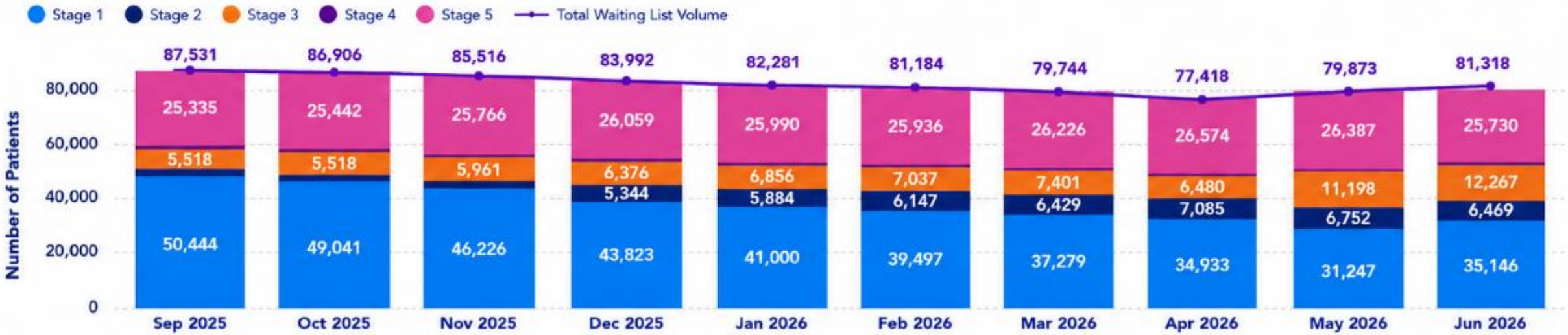
Our focus remains on managing demand, reducing waits and ensuring sustainable capacity across the patient pathway.

Waiting List Volume – Month on Month



The UHB made significant reductions in the number of patients waiting for a new outpatient appointment in H2 25/26 through the national HBS insourcing initiative, but has subsequently **rebounded by 10,000**.

The majority of the increase in demand for diagnostic tests, arising from the conversions of the additional work, was managed by additional capacity from diagnostic insourcing and overtime initiatives. **However these largely ceased on 31st March.**

In Q1 2026/27, the new outpatient list has been growing by **2,000 per month**, the diagnostic list by **500 per month**, whilst the tx list is stable.

We anticipate that as the **diagnostic backlog** is addressed, conversions to treatments will increase and the **predicted underlying deficit in treatment demand and capacity** will be exposed.

Present Waiting List Position: Stage 1

SBUHB has maintained a maximum wait for a new outpatient of 52 weeks since October 2023.

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Top 15 Specialties by Stage 1 Max Wait (weeks) as at 30 June 2026

Main Specialty	Stage 1 Max Wait (Weeks)
Breast	23
Cardiac Surgery	39
Cardiology	50
Cleft	20
Dermatology	36
ENT	26
Gastroenterology	44
General Surgery	24
Gynaecology	37
OMFS	52
Ophthalmology	52
Plastic Surgery	34
Spinal	41
Thoracic	17
T&O	46
Urology	26
Vascular	26

Stage 1 Current Trajectory

In the first 3 months of Q1 2026/27
Av. Demand = 2,240 per week
Av. Activity = 1,760 per week
WIP (queue) is growing by 480 per week on average (25,000 p.a)

- Demand vs activity at stage 1 for the past 12 weeks and modelled wait based on list size, adjustments and urgency assumptions is shown below. Urgent and routine queues have started to grow again, since the HBSUK outsourcing ended.
- The main specialities with the biggest gap between demand (additions) and activity (removals) are Derm, Gastro, Gynae, ENT, Ophthalmology and T&O. Derm, GS, Gynae, Plastics & Urology have USC waiting times for NOP > 2 weeks.

WIP, Demand and Activity by Week Start Date

	Cancer				Non-cancer					
	Avg Demand	Avg Activity	Net WIP	Est. Wait (wks)	Avg Demand	Avg Activity	WIP	Est. Wait (wks)	Net Change	Awaiting Grad
Breast	61.6	58.4	157	2.3	53.5	42.6	396	9.3	10,271	-
Burns					17.3	17.0	24	1.4	2,025	1
Cardiac					10.9	12.0	111	9.3	-1,110	17
Cardiology					152.7	112.4	2493	22.2	20,123	753
Cleft					3.1	2.4	45	10.6	-0.67	5
Clinical Neuro-physiology					66.5	71.4	757	10.6	4,498	5
Dermatology	65.4	47.6	445	17.8	165.1	69.8	4462	49.9	75,531	1356
ENT	22.1	20.2	32	0.9	132.8	97.2	2019	20.5	35,667	73
Gastroenterology	18.1	19.7	54	-1.5	106.6	43.9	2437	55.5	50,283	711
General Surgery	22.3	20.2	80	4.0	133.8	119.7	1697	14.2	4,408	36
Gynaecology	13.3	12.9	94	0.6	124.1	64.7	2269	35.1	25,511	57
OMFS	19.9	10.8	99	-0.4	83.2	61.7	3806	61.7	21,511	571
Ophthalmology	2.2	2.4	6	-0.2	262.0	212.8	2363	11.1	-29,25	551
Plastic Surgery	46.8	36.4	232	0.4	112.3	91.5	1255	13.7	-24	80
Spinal	0.2	0.1	23.7	0.1	24.2	22.6	507	22.3	1,435	76
Thoracic	3.5	3.1	3.2	0.4	3.0	3.7	20	5.4	-0.76	2
Trauma & Orthopaedic					377.3	343.0	4054	11.8	-34,33	197
Urology	20.4	21.8	54	-1.3	77.4	83.3	833	10.0	4,891	8
Vascular					38.9	25.4	800	31.5	13,49	13

Demand is increasing across both cancer and non-cancer pathways

Activity has improved but remains below demand

WIP is growing – highlighting the need to increase sustainable activity

Stage 2: Follow Up Waiting List: Current position:

Current snapshot shows 209k patients waiting; 92k are >25% past target and 68.5k are >100% past target.

209.2k

Total FUP WL

103.5k

Before target

49%

13.4k

0–25% late

6%

23.8k

25–100% late

11%

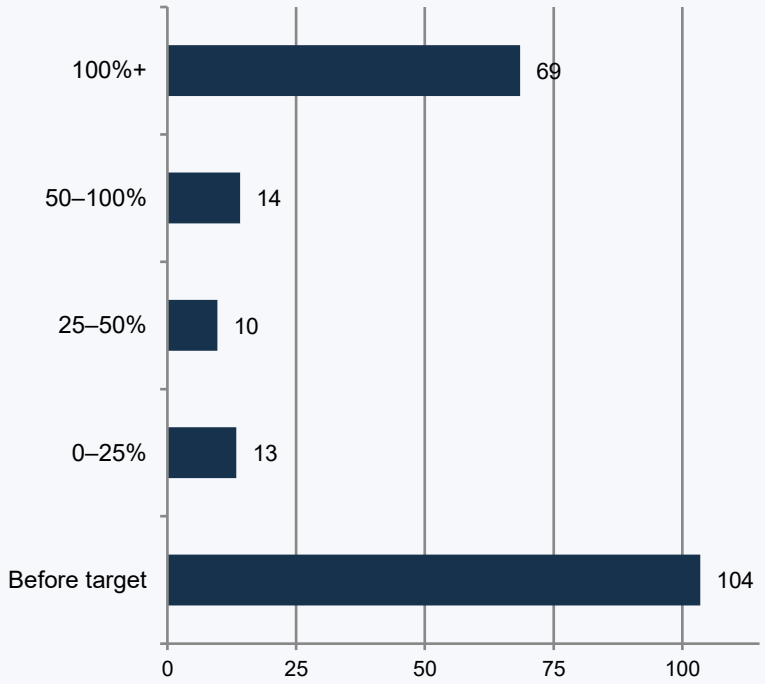
68.5k

>100% late

33%

Rank	Specialty / group	Total WL	>25% late	% >25%	>100% late	% >100%
1	Psychotherapy	1,419	1,289	91%	1,276	90%
2	Gynaecology	14,779	11,487	78%	10,466	71%
3	Obstetrics AN	1,716	1,190	69%	1,143	67%
4	OMFS	5,558	4,011	72%	3,475	63%
5	Anaesthetics	594	426	72%	355	60%
6	Gastroenterology	11,329	7,951	70%	6,246	55%
7	Vascular Surgery	1,858	1,204	65%	1,028	55%
8	Mental Illness	11,925	7,722	65%	6,027	51%
9	Rheumatology	8,299	5,202	63%	3,791	46%
10	Midwifery	1,048	512	49%	470	45%
11	CAMHS	1,804	1,021	57%	798	44%
12	ENT	5,992	3,557	59%	2,495	42%
13	T&O	14,396	7,532	52%	6,025	42%
14	Restorative Dentistry	1,175	565	48%	476	41%
15	Plastic Surgery	7,720	3,804	49%	3,015	39%
16	MfE	2,392	1,110	46%	936	39%
17	Other <500 WL	2,238	1,089	49%	794	35%
18	Orthodontics	2,755	1,049	38%	826	30%

Current waiting list by target status



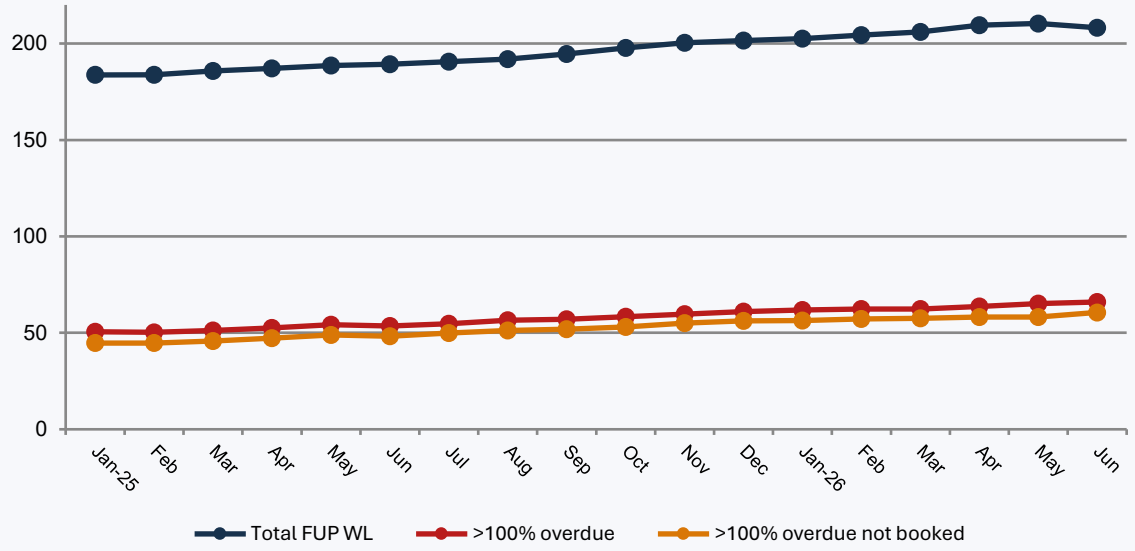
Concentration

Gynaecology, Gastroenterology, Mental Illness and T&O are the largest >100% cohorts and together account for c.42% of the >100% overdue list. : the >100% cohort is a patient-safety and governance risk, especially where not booked.

Source: current Swansea Bay follow-up waiting list snapshot. Percentages rounded; specialties ranked by >100% volume in table.

Stage 2 Trend: the follow-up list has grown, but specialty trajectories differ

Monthly extract shows total follow-up list +24.4k from Jan-25 to Jun-26; recent Mar–Jun 2026 movement is flatter but not evenly distributed.



+24.4k

total FUP WL Jan-25→Jun-26

+15.4k

>100% cohort Jan-25→Jun-26

60.6k

>100% and not booked at Jun-26

Specialties increasing total FUP WL

Growing list	Jan25→Jun26	Mar→Jun26	Jun26 WL
T&O	+3,203	-438	14,183
Gastroenterology	+1,853	-359	11,377
Gynaecology	+1,754	-164	14,778
Neurology	+1,293	-317	7,713
OMFS	+1,279	+529	5,527
Diabetes	+1,156	-149	6,764
ENT	+1,114	-255	5,951
Ophthalmology	+1,094	+3,370	20,555
MfE	+803	+178	2,320

Specialties reducing total FUP WL

Reducing list	Jan25→Jun26	Mar→Jun26	Jun26 WL
General Surgery	-608	-803	7,771
Endocrinology	-467	+83	2,921
Dermatology	-116	-169	6,000
Rehabilitation	-83	-2	341
General Medicine	-7	-186	5,911
Nephrology	56	-20	4,035
Cardiology	62	+29	7,763
Restorative Dentistry	78	-2	1,141
Orthodontics	88	-11	2,738

Source: monthly trend table, Jan-25 to Jun-26. Monthly extract total at Jun-26 is 208,100, compared with current snapshot total of 209,158.

Present Waiting List Positions: Stage 3

SBUHB has maintained a maximum wait for referral to treatment of 104 weeks since March 2025

Number of patients waiting >8 weeks by specialty
At 30 June 2026

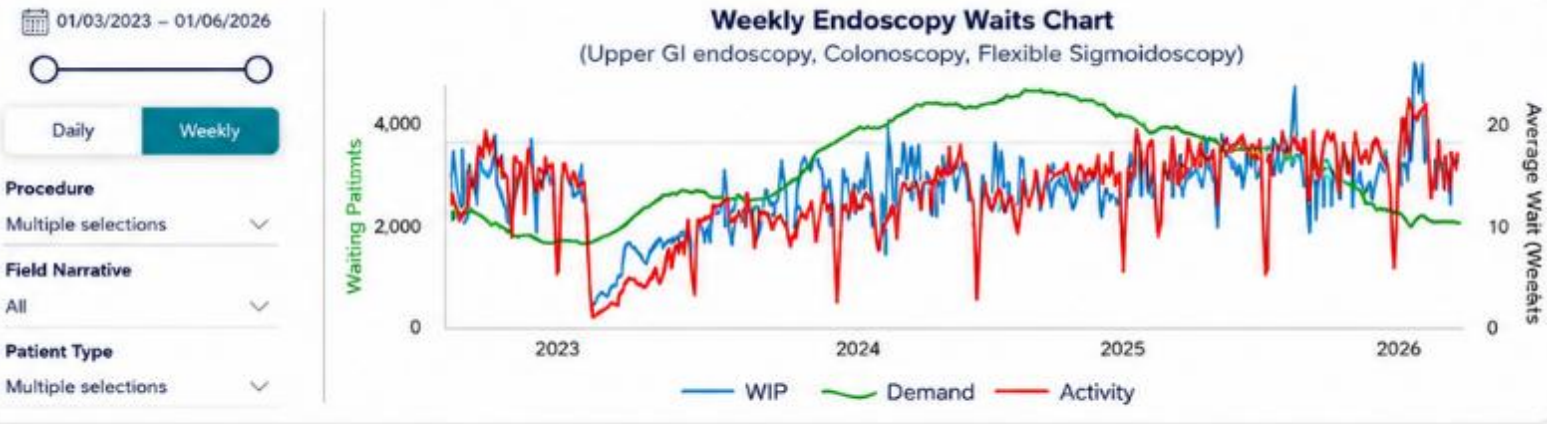
Diagnostic modality	>8 weeks at end of June
Computed Tomography	1,803
Ultrasound	1,190
Endoscopy	909
Magnetic Resonance Imaging	745
MSK Ultrasound	365
Head and Neck Ultrasound	190
Sleep studies	111
Cardiac	64
Barium	43
PET CT	31
Nuclear Medicine	28
Vascular Ultrasound	14
Fluoroscopy	10
Neurophysiology	1
Total	**5,504**

Source: WPAS at 30 June 2026

The quality of the waiting list and activity data for radiology in 2026/27 has been adversely impacted by the introduction of the new Radiology information system.

For Endoscopy, there has been a slight improvement in >8-week position across endoscopy week on week, however, we are still seeing the conversion effect of the 1,660 additional patients seen by HBSUK in Q4 in our performance data.

The BSW waiting list continues to grow at a rate of 14 patients per week with an average waiting time of 12 weeks.



Bowel Screening Waits

	Avg Demand	Avg Activity	WIP	Est. Wait (Weeks)	Net Change (vs. May)
Colonoscopy	29.93	15.52	188	12.11	14.41
Flexible Sigmoidoscopy	1.72	1.42	4	2.82	0.30

Despite data system challenges, we are maintaining close oversight of diagnostic waits and taking targeted actions to reduce backlogs and improve patient experience.

Better health
Better care Better lives

Present Waiting List Position: Stage 5

SBUHB maintains a maximum wait for referral to treatment of 104 weeks since March 2025

The table below shows the max wait by specialty as at 30 June 2026

Demand vs activity at stage 5 for the past 12 weeks and modelled wait based on list size, adjustments and urgency assumptions is shown below. Urgent and routine queues have started to grow again, since the HBSUK outsourcing ended.

Demand remains at pre HBSUK outsourcing initiative levels in Q1 2026/27 April 1st to date. There are sizeable underlying deficits in a number of large specialty areas. Including Orthopaedics, GS, ENT & Ophthalmology Services are working to reduce the modelled wait for cancer down to c.4 weeks.

Main Specialty	Stage 5 Max Wait (Weeks)
Breast	49
Cardiac Surgery	52
Cardiology	NA
Cleft	55
Dermatology	NA
ENT	104
Gastroenterology	NA
General Surgery	104
Gynaecology	104
OMFS	104
Ophthalmology	104
Plastic Surgery	104
Spinal	103
Thoracic	26
T&O	104
Urology	99
Vascular	78

Main Specialty	Cancer (Per Week)					Non Cancer (Per Week)				
	Avg Demand	Avg Activity	WIP (Queue)	Est. Wait (Weeks)	Net Change	Avg Demand	Avg Activity	WIP (Queue)	Est. Wait (Weeks)	Net Change
Breast	8	8	36	4	0	2	1	29	35	1
Burns	0	0	0	0	0	2	1	5	2	0
Cardiac	0	0	0	0	0	6	5	104	20	0
Cleft	0	0	0	0	0	2	3	56	22	-1
ENT	2	3	6	2	-1	31	24	2355	98	7
General Surgery	11	10	73	7	0	49	29	2915	101	20
Gynaecology	6	7	33	5	-2	10	11	991	90	2
OMFS	3	3	11	4	0	16	13	1142	88	3
Ophthalmology	0	0	0	0	0	165	144	6411	44	21
Plastic Surgery	31	38	284	7	-7	45	51	3006	59	6
Spinal	0	0	0	0	0	16	10	586	87	6
Thoracic	2	3	1	0	-1	3	3	7	2	0
Trauma & Orthopaedic	0	0	0	0	0	103	89	8597	97	15
Urology	12	11	104	10	1	22	18	887	48	3
Vascular	0	0	0	0	0	13	10	180	19	4
Total	**74**	**83**	**548**	**40**	**-9**	**483**	**411**	**27522**	**814**	**72**

Stage 5 Current Trajectory:

In the first 2 months of Q1 2026/27 **Avg. Demand = 557** per week, **Avg. Activity = 494** per week, **WIP** (queue) is **growing by 63** per week on average.

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52 weeks: Modelled annual demand and capacity for the new outpatient stage of the main pathways

Main Speciality	Recurrent Demand: Applies RoTT at 10%				Capacity		Demand to meet Ca & 52 weeks in			
	Annual USC demand	Annual Urgent demand	Annual Routine demand	Annual Total demand (RoTT at 10%)	Expected activity per week	Dem cap W/L change expected	Backlog to meet 2 wk USC new outpatient component wait	Backlog to meet 52 weeks	Total demand in 26/27	52 week breaches expected assuming 100% TiT
Breast	2710	1616	769	5397	5408	-11	30	0	5427	19
Burns	0	795	0	842	932	-90	0	0	842	-90
Cardiac	0	136	342	507	877	-370	0	0	507	-139
Cardiology	0	2671	3696	6743	6028	715	0	0	6743	715
Cleft	0	8	120	136	113	23	0	0	136	23
Clinical Neuro-physiology	0	22	2979	3178	3597	-419	0	0	3178	-419
Dermatology	2895	6224	1293	11025	7427	3598	433	0	11458	4031
ENT	961	2841	2860	7055	6041	1014	0	0	7055	1014
Gastroenterology	858	2908	1537	5616	3341	2275	15	69	5701	2360
General Surgery	1031	2597	2897	6910	7605	-695	37	0	6947	-658
Gynaecology	556	1605	3598	6099	4242	1857	16	0	6115	1872
OMFS	1359	1596	2002	5249	5001	248	28	315	5593	592
Ophthalmology	73	11248	206	12207	11358	849	0	0	12207	849
Plastic Surgery	2162	3723	1138	7437	7421	16	168	0	7605	944
Spinal	7	533	523	1127	1309	-182	0	0	1127	-182
Thoracic	147	86	31	280	304	-24	0	0	280	-93
Trauma & Orthopaedic	3	12360	4339	17686	17966	-280	0	0	17686	-280
Urology	880	1512	2145	4804	5781	-977	8	0	4812	-969
Vascular	0	857	785	1739	1361	378	1	0	1740	379
Pyschological therapies	0	0	2758	2758	1977	781	0	836	3594	1617
Special Care Dentistry	0	0	158	158	180	-22	0	0	158	-22
Neurodevelopmental	0	0	1085	1085	210	875	0	453	1538	1328
Total	**13642**	**53338**	**35261**	**108038**	**98476**	**9562**	**737**	**1674**	**110448**	**12895**

Position is for financial year 2026/27. Deficit of c. 9500 new outpatient appointments anticipated.

The UHB's annual plan sets out that efficiencies made from reducing follow ups, increasing outpatient utilisation and consultant productivity are contributing to the financial savings requirements. Thus no efficiencies are included.

104 weeks: Modelled annual demand and capacity for the treatment stage of the main pathways

Main Speciality	Recurrent Demand				Capacity	Dem cap W/L change expected	Demand to meet Ca & 104 weeks		
	Annual USC demand	Annual Urgent demand	Annual Routine demand	Annual Total demand			Backlog to meet 4 wk USC tx comp wait	Backlog to meet 104 weeks	Total demand in 26/27
Breast	390	66	39	495	468	27	3	0	498
Burns	0	7	62	70	74	-4	0	0	70
Cardiac	0	156	100	257	384	-127	0	0	257
Cleft	0	3	89	93	110	-17	0	0	93
ENT	97	877	565	1540	1417	123	0	0	1540
General Surgery	499	1053	1216	2769	2032	737	32	0	2801
Gynaecology	257	269	175	702	936	-234	5	0	707
OMFS	120	530	234	885	810	75	1	0	886
Ophthalmology	0	3171	4562	7734	7501	233	0	0	7734
Plastics	1462	1365	721	3549	4088	-539	132	0	3681
Radiotherapy	35195	0	0	35195	32524	2671	200	0	35395
Spinal	0	369	140	509	516	-7	0	0	509
Thoracic	85	81	42	210	290	-80	0	0	210
T&O	3	1665	3162	4832	4611	221	0	0	4832
Urology	553	479	538	1571	1504	67	62	0	1633
Vascular	0	140	471	612	494	118	0	0	612
Total	38661	10231	12116	61023	57758	3265	435	0	61458

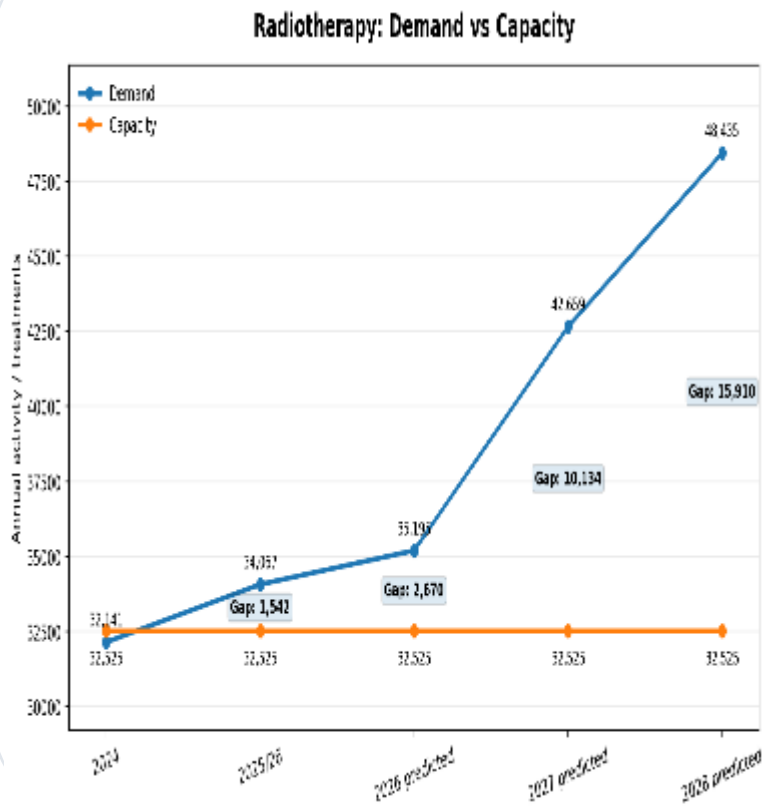
Present recurrent demand and capacity position for patients at the treatment stage

Waiting list grows by net 594 cases in the year (3265 inc RT points), theatre rescheduling process is underway to rebalance across specialties

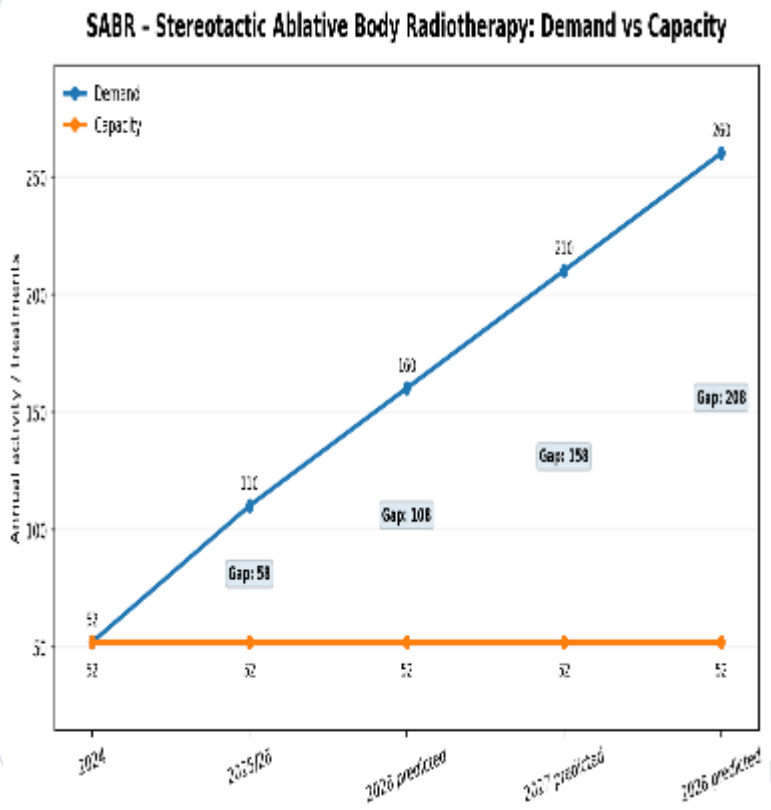
Stage 5: Oncology Demand versus capacity outlook – Planned Care

- Radiotherapy demand is forecast to outstrip capacity materially from 2026 onwards, with the gap widening to c.15.9k by 2028.
- SABR shows the steepest proportional growth: demand rises from 52 in 2024 to 260 by 2028 against flat capacity of 52.
- Chemotherapy demand also exceeds current capacity from 2026, reaching a projected gap of c.6.1k by 2028.

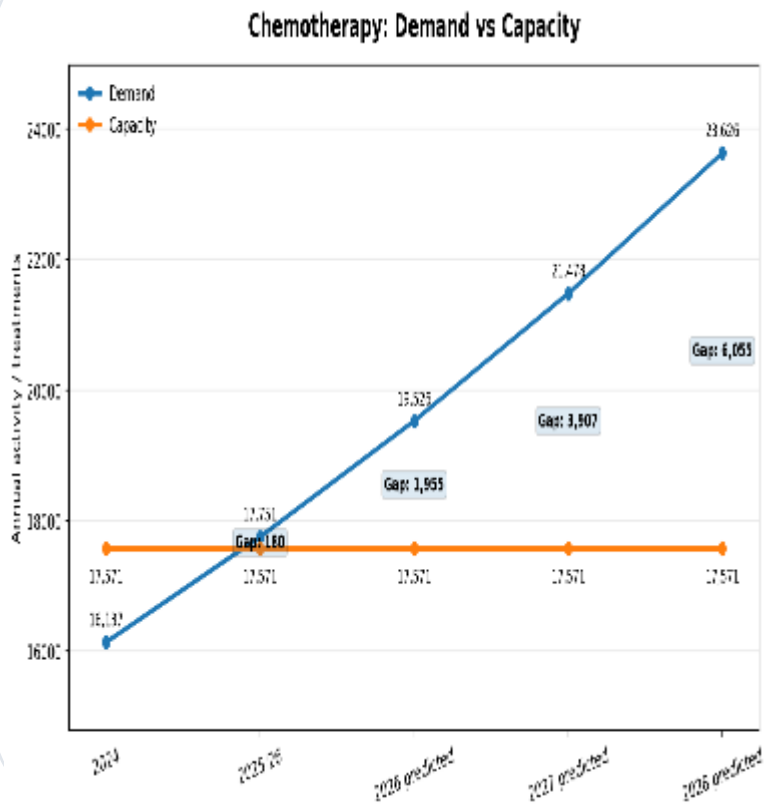
Radiotherapy



SABR – Stereotactic Ablative Body Radiotherapy

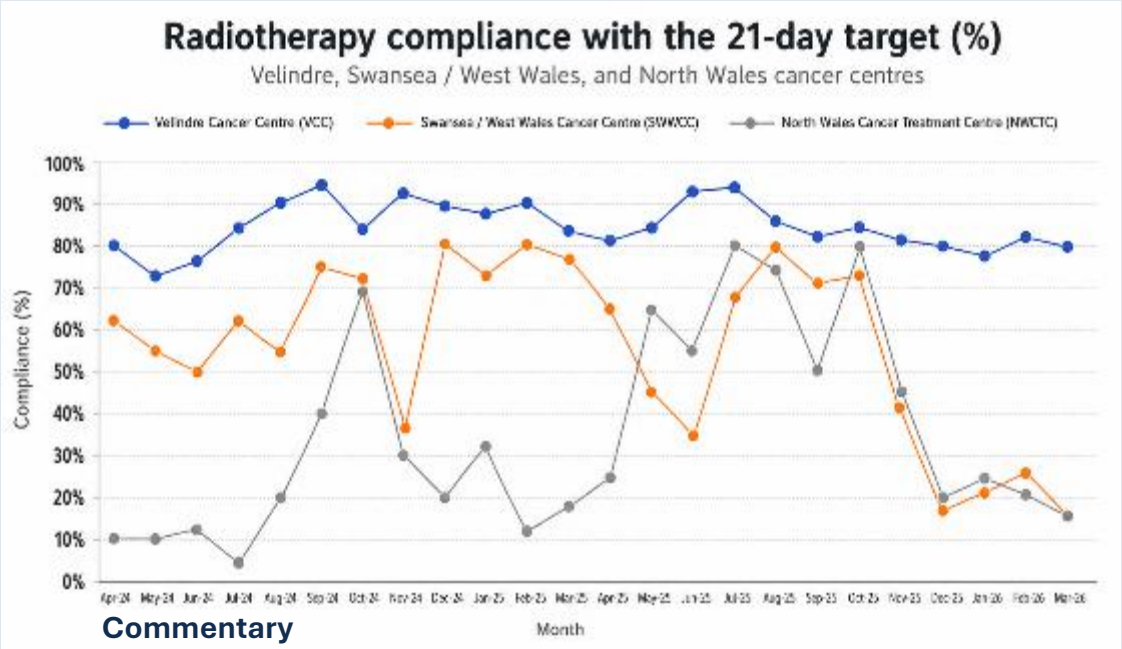


Chemotherapy

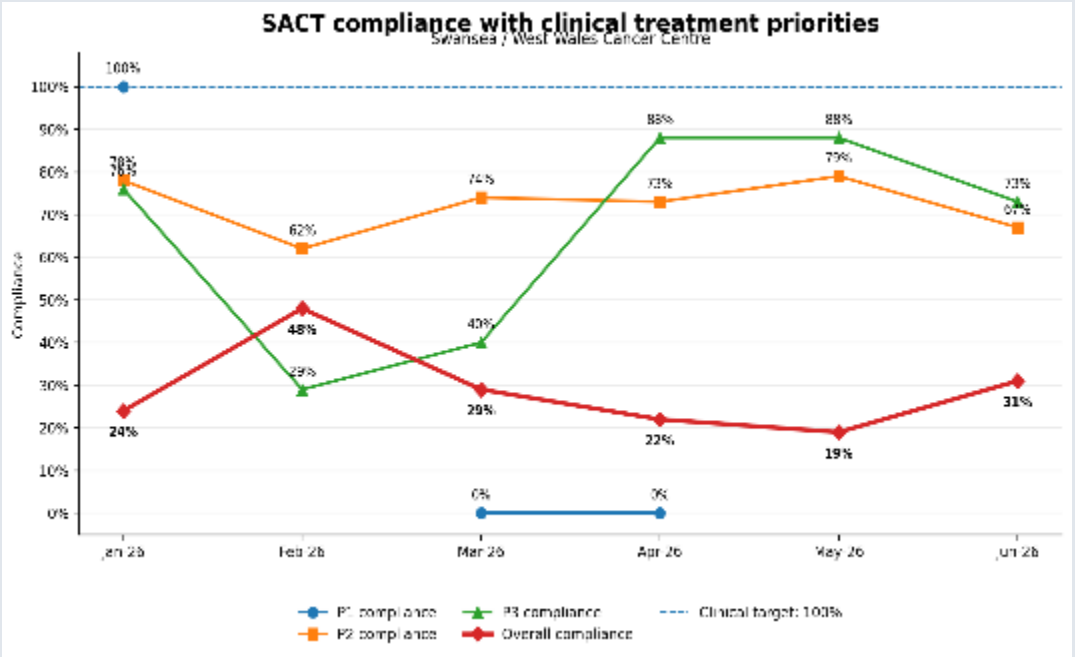


Oncology: Clinical target compliance

Radiotherapy 21-day target across Wales &SACT treatment priority compliance for The West Wales Cancer Centre



Commentary



Present backlog waiting > target	
Radiotherapy	200
SABR	0
Chemotherapy	65

104 weeks: Modelled end of year breach position for the main surgical pathways

Main Speciality	March 2027 Cohort >=104 Week waiters @15/5/2026.	Weekly USC Activity Required if D=A	Weekly URGENT Activity Required if D=A	Weekly ROUTINE Activity Required if D=A	TOTAL Activity to balance TOTAL Demand	Current TOTAL Activity Levels	Weekly Activity Required to Deliver Zero Breaches on 31/3/2027	Current Total >= 104 Week Cohort Activity per WEEK	Gap per WEEK Current Vs Needed Total Activity >=104 Week Cohort	Gap with Increase in Activity from Lost Opportunities	No. of Patients @ 31/3/2027	Gap per Week with Avoidable Cancellations on the Day Prevented	No. of Patients @ 31/3/2027
Breast	2	7	1	1	9	9	0.04	1	0.0	0.0	0.0	0.0	0.0
Cardiac	58	NA	4	2	6	6	1.27	2	0.0	0.0	0.0	0.0	0.0
Cleft	1	NA	0	2	2	2.5	0.02	2	0.0	0.0	0.0	0.0	0.0
ENT	900	3	21	11	35	27	19.69	15.12	4.6	3.3	149.4	2.3	103.7
General Surgery	722	10	26	16	52	39	15.79	18.72	0.0	0.0	0.0	0.0	0.0
Gynaecology	346	6	10	8	24	19.3	7.57	9.65	0.0	0.0	0.0	0.0	0.0
OMFS	448	2	11	5	18	12.8	9.80	8.064	1.7	0.7	33.6	0.4	19.9
Ophthalmology	362	0	32	40	72	77	7.92	23.1	0.0	0.0	0.0	0.0	0.0
Plastics	737	34	38	15	87	81	16.12	20.25	0.0	0.0	0.0	0.0	10.0
Spinal	145	0	13	3	16	9	3.17	4.14	0.0	0.0	0.0	0.0	0.0
Thoracic	7	2	3	0	5	3	0.15	0	0.2	0.0	0.0	0.0	0.0
T&O	3080	0	40	52	92	70	67.38	46.2	21.2	16.7	762.3	15.7	716.6
Urology	81	11	10	10	31	28	1.77	22.4	0.0	0.0	0.0	0.0	0.0
Vascular	10	0	5	7	12	9	0.22	1.17	0.0	0.0	0.0	0.0	0.0
	*ROTT of Cohort Adjusted for @ 50%									Total	945.3	Total	850.2

Ortho breach posn by sub spec	cohort 15/5/26	present act p.w.	activity from back (assume 2/3)	wks remaining	exp activity from cohort	Breaches	Rott assumed	Rott	Restated Breaches
FA	320	7.5	5	45	225	95	15%	48	47
Hands	772	17	11	45	510	262	15%	115.8	146
Hips	534	12	8	45	360	174	15%	80.1	94
Knees	1179	22	15	45	660	519	15%	176.85	342
Shoulders	271	4	3	45	120	151	15%	40.65	110
Spines	289	8.3	4	45	187	102	50%	144.5	0
Total	3365	71	46	270	2062	1303	1	606	740

As a consequence of the underlying deficit, we anticipate challenges in all specialties maintaining 104 weeks.

After factoring in efficiency gains, modelling indicates challenges of 850 for the surgical pathways.

104 week delivery - Summary of anticipated breaches and costs

	ENT	Plastics	OMFS	T&O Hips & Knees	T&O Hands	T&O Shoulder	T&O Foot & Ankle	Special Care Dentistry	Psych therapies	Neuro Developmental	Radiotherapy	Total
Breach patients at 31/03/2027	104	10	20	364	216	126	11	169	836	98	200 courses	**2,154**
Total Cost	£328,446	£37,898	£87,087	£1,747,978	£468,560	£777,044	£49,764	£1,104,638	£911,464	£311,540	£1,096,271	**£6,920,690**

In addition to the modelling identifying 850 surgical 104 week breaches by March 2027, the UHB has identified 3 other services where patients are, and will continue to face waits of over 104 weeks if the demand capacity position is not addressed. These are:

- Special care dentistry (adults and paeds) – 169 people (Regional service)
- Psychological therapies – 836 people
- Neuro-developmental – 15 children (This assumes the new service guidelines addresses all of the long waits for the ASD service

The total cost of mitigating the modelled risk of the UHB having 104 week breaches is estimated at £5.37m

In addition there is an underlying deficit within radiotherapy, amounting to 2671 LINAC points of work that needs to be provided if the South West Wales region is to deliver on Elective targets of 3 weeks, the cost of which is £1.096m in 2026/27.

8 weeks: Modelled annual demand and capacity for the Key Diagnostic Services

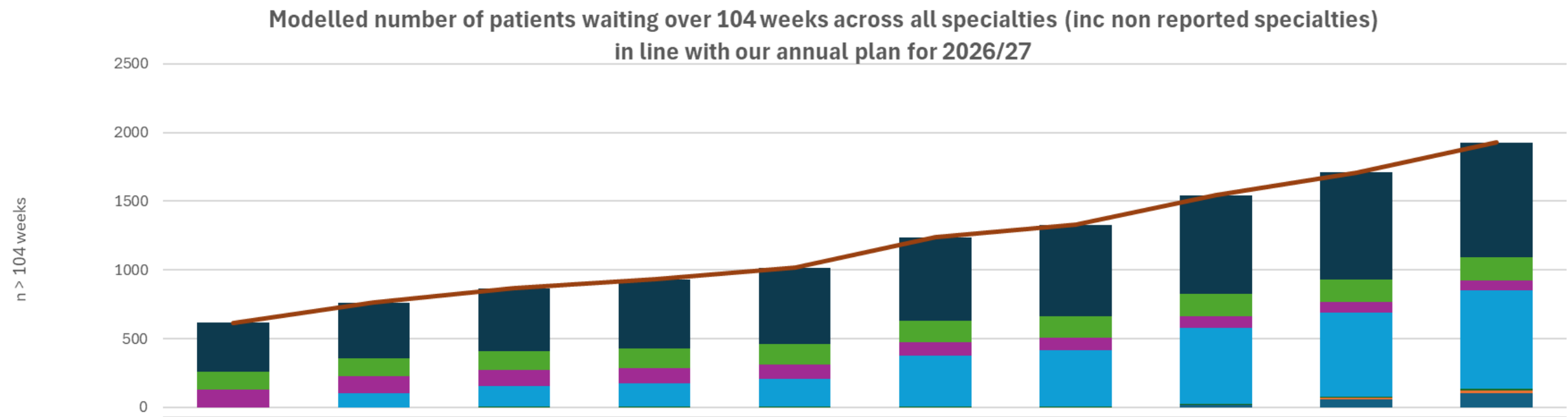
nostic >8 week position	Radiology (patients)			Endoscopy inc BSW (as points)				Neuro physiology (patients)	Dexa (patients)	Cellular Pathology	Audio vestibular	Total
(incorporating Cancer requirements)	MR	NOUS	CT	Colonoscopy inc BSW	Gastroscopy	Flexi sigmoids	Endoscopy total inc BSW					
Core capacity 26/27	25740	36677	51300	*15626*	*9126*	*1300*	*26052*	2991	7855	155416	6764	
Demand 26/27	31507	42439	56500	*17228*	*8736*	*1092*	*27056*	3218	10081	177672	7100	
Rec annual Deficit	5767	5762	5200	*1602*	*-390*	*-208*	*1004*	227	2226	22256	336	
Breaches >8 weeks June 26	814	1759	1803	*780*	*432*	*84*	*1296*	10	2396	5844*	54	15272
breaches >8 weeks March 27	2140	1566	1462	2381	42	-124	*2299*	185	4633**	22768	206	37558
Cost of delivery	£1.61m for Radiology			Est: £1.019m for Endoscopy				£108k	£472k	£2.47m	£58k	£5.74m
									best case for Mar'27 is 2076 > 8 weeks with investment	*5844 is the total cell path backlog		

The table above shows the modalities where modelling has identified challenges in meeting the 8 week standard. (n.b. Dexa & Audiodivestibular are presently 'unreported' specialties).

The UHB has historic underlying deficits in its demand and capacity position for its diagnostic services. This position was exacerbated by the organisation working with HBS UK to deliver >20,000 additional new outpatient appointments in H2 2025/26.

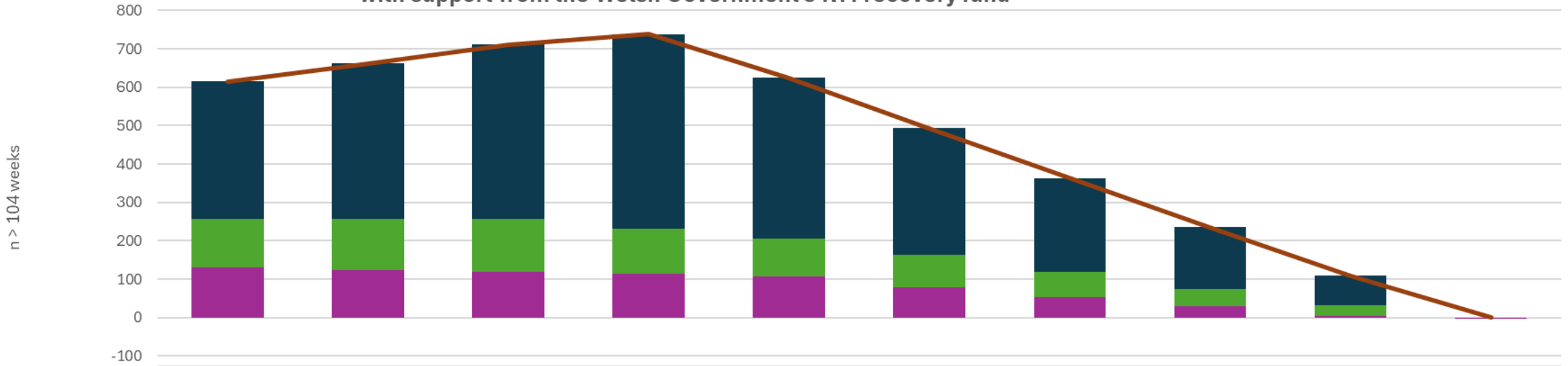
Trajectories suggest that it will take 12 months to reduce the regional (SWW) DEXA waiting time to below 8 weeks, due to scanner availability & workforce – there would be patients waiting >8 weeks at 31/3/27

104 week delivery - trajectories – All services- as per annual plan



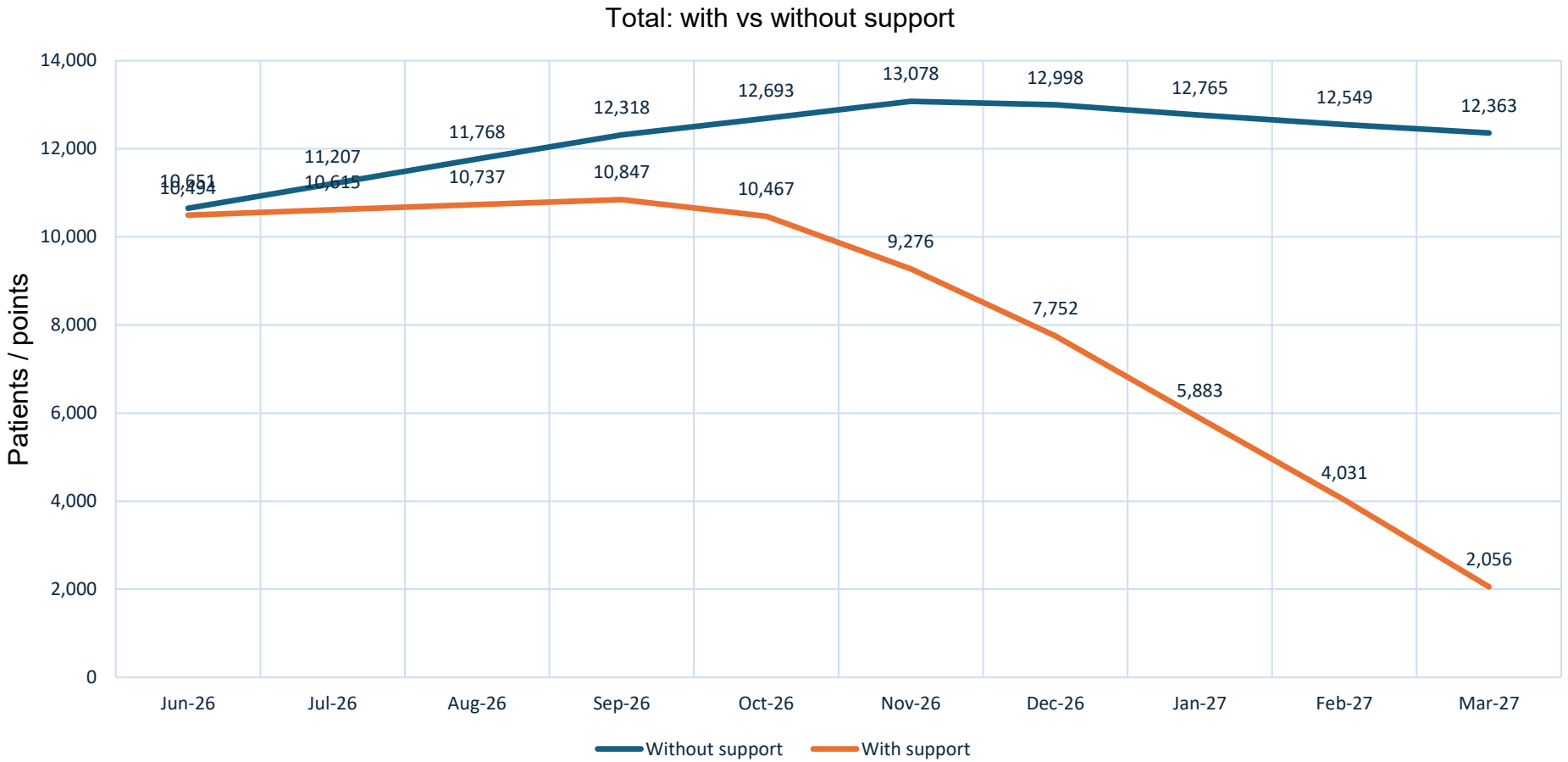
	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Psychological therapies	357	405	455	506	558	611	665	721	778	836
Special care dentistry	128	133	137	142	146	151	155	160	164	169
Neurdevelopment	130	124	119	114	106	98	91	85	78	74
T&O	0	100	153	169	203	373	410	552	612	716
Plastics (Dieps)	0	1	2	3	4	5	6	7	8	10
OMFS	0	0	0	0	0	0	0	0	9	20
ENT	0	0	0	0	0	0	0	20	60	104
Total	615	763	866	933	1017	1238	1327	1544	1709	1929

104 week delivery - trajectories – All services- subject to support from Welsh Government RTT recovery fund

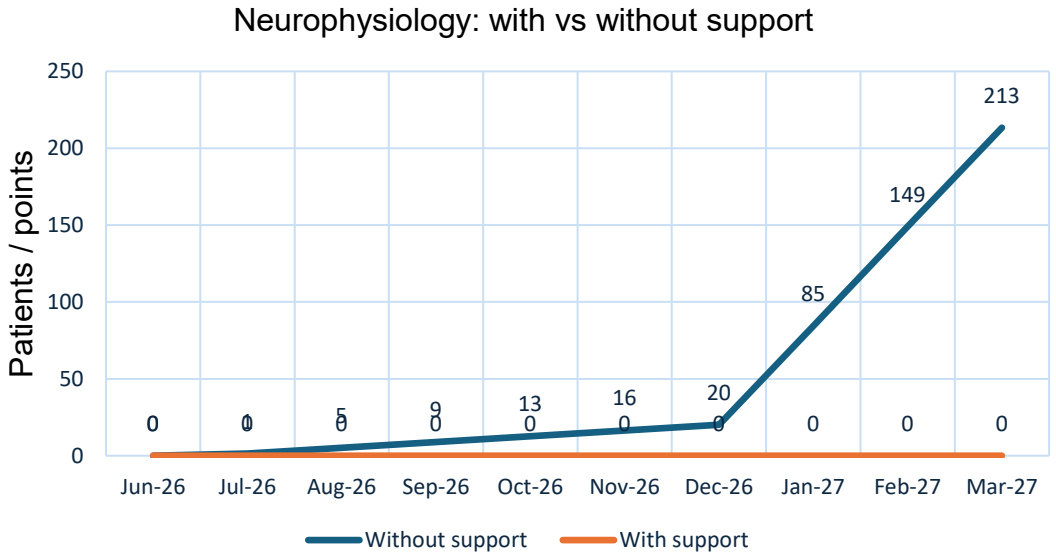


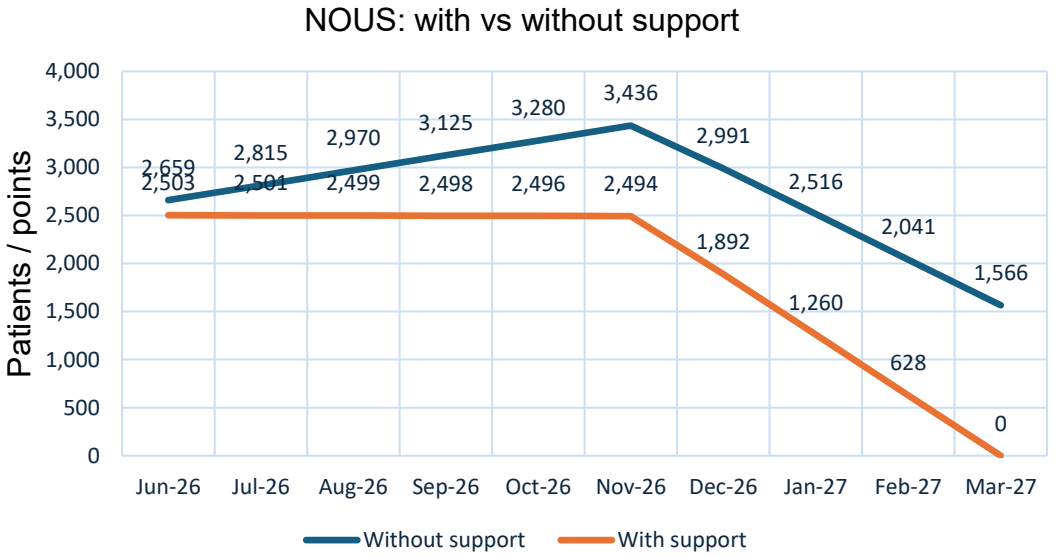
	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Psychological therapies	357	405	455	506	418	331	245	161	78	0
Special care dentistry	128	133	137	119	101	82	64	46	27	0
Neurdevelopment	130	124	119	114	106	80	54	29	4	0
T&O	0	0	0	0	0	0	0	0	0	0
Plastics (Dieps)	0	0	0	0	0	0	0	0	0	0
OMFS	0	0	0	0	0	0	0	0	0	0
ENT	0	0	0	0	0	0	0	0	0	0
Trajectory with support	615	662	711	738	624	493	363	236	109	0

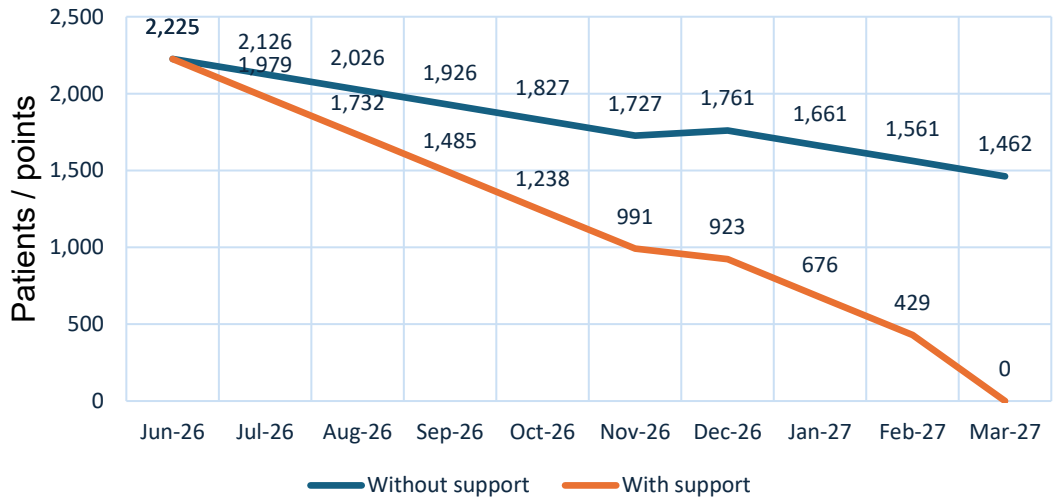
8 week delivery - Diagnostic trajectories – All modalities

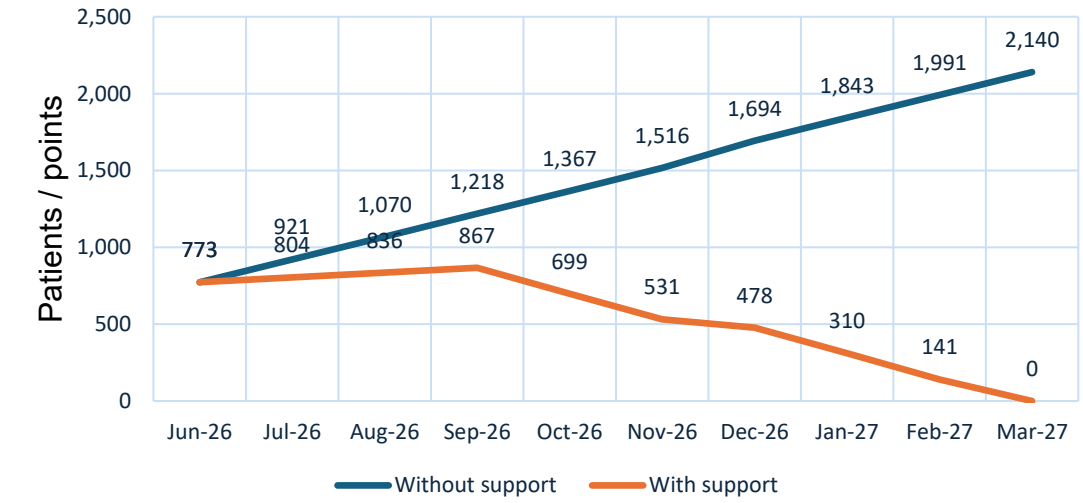


8 week delivery - Diagnostic trajectories

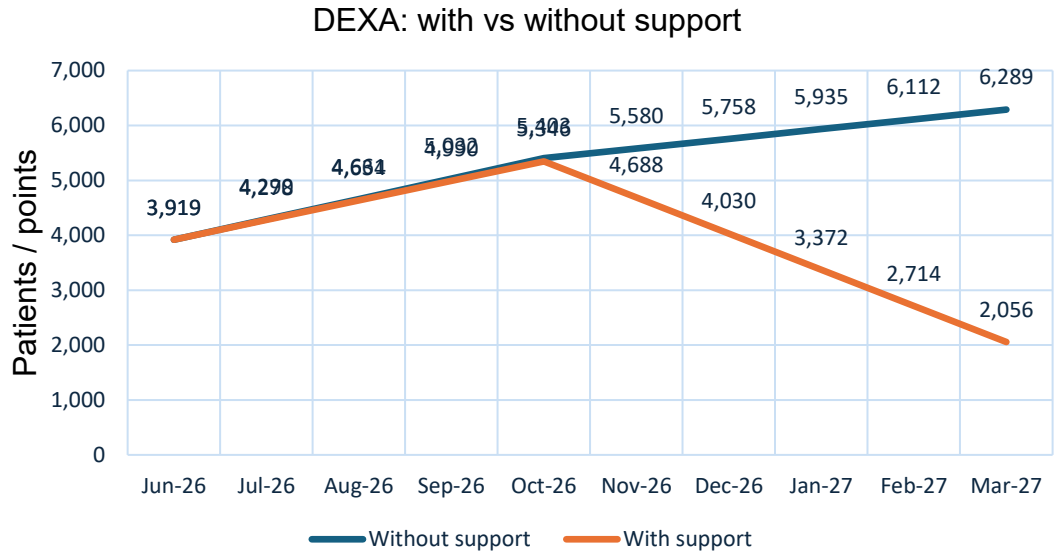


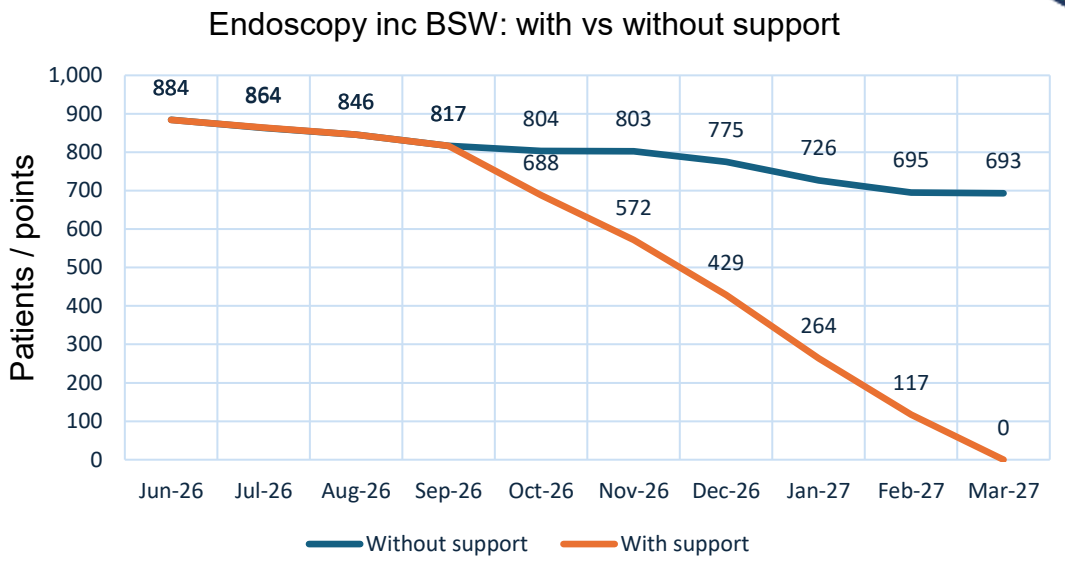


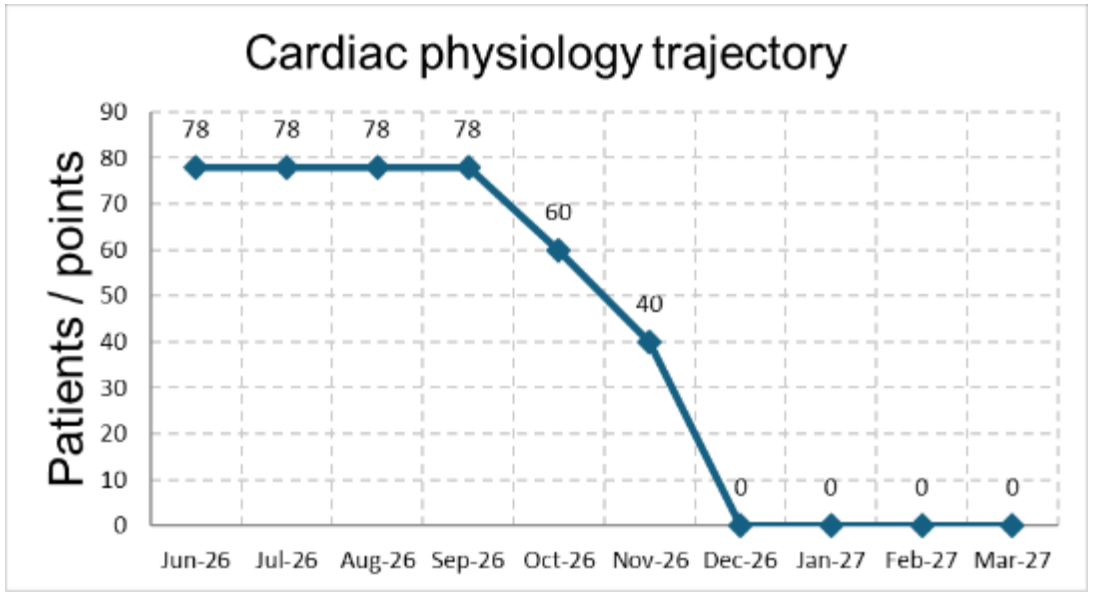




8 week delivery - Diagnostic trajectories







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Productivity Before Investment

Un Bae Ar y Cyd
One Bay Way

Productivity & Efficiency

We have taken a **comprehensive review** of elective productivity and capacity through our internal Planned Care Improvement Programme.

This has identified significant opportunities through our Recovery & Sustainability programme.
These opportunities are not intended to release additional capacity.

Their purpose is to improve cost effectiveness and take cost out of the system.
We will re-commission this activity to achieve sustainability in planned care.

- **Implementation of redesigned theatre timetables**
- **Improved alignment of job plans with available theatre capacity**
- **Increased theatre utilisation**
- **Day Case First**
- **Treat in Turn**
- **Reduction in late cancellations**
- **Improved pre-operative assessment**
- **Outpatient transformation and reduction in unnecessary follow-up activity**
- **Improved validation and booking processes, including establishment of a central validation team**

These initiatives are **already underway** and form the foundation of the Health Board's recovery approach. Consistent with Welsh Government expectations, the Health Board's approach is to **maximise internal productivity** before seeking additional external capacity.

Residual demand and capacity gaps, where they remain following optimisation, have been identified through specialty-level demand and capacity modelling and form the basis of the funding requirements described later within this plan.

Productivity Improvements Already Delivered

Evidence of progress achieved through better use of existing capacity

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The Health Board has already taken significant action to release capacity, improve flow and strengthen operational control.

1 More productive use of theatres

8,052 patients treated across **3,480** theatre sessions between February and June 2026.

6 of 8 assessed specialties operating above the Model Hospital good peer-group benchmark for cases per list.

Productivity gains have shifted the principal improvement focus away from unused theatre capacity and towards preventing avoidable cancellations.

2 Fewer missed theatre opportunities

Average monthly missed opportunities reduced from 193.3 (Jul 2025 – Mar 2026) to 90.3 during Apr – Jun 2026.

53% reduction

Total avoidable theatre inefficiencies reduced from 332 per month to 231 per month.

30% reduction

This indicates stronger scheduling, improved utilisation and more patients being booked into available operating capacity.

3 Stronger waiting list control

Swansea Bay has maintained **zero** reported treatment waits over **104 weeks.**

The Health Board has also maintained **zero** first outpatient waits over **52 weeks.**

Clinical and administrative validation has **strengthened the understanting** of the true waiting list position and improved the quality of the baseline used for planning.

4 Improved operational controls

Pre-operative assessment and readiness controls have been **strengthened.**

Prospective list-composition rules have been **embedded** using procedure duration, complexity, turnaround and site constraints.

Booking intervals of **6 / 4 / 2 / 1 weeks** and earlier escalation are being used where lists are at risk of being under-booked.

5 Productivity infrastructure established

- Theatre timetable **redesign and alignment** of job plans to available capacity are underway.
- Treat in Turn, Day Case First and theatre surveillance arrangements are **established** as core improvement approaches.
- Central and clinical validation, booking optimisation and outpatient follow-up transformation are now **embedded** within the Planned Care Improvement Programme.
- **Pre-surgical optimisation infrastructure** established including frailty identification and optimisation, standardised readiness assessment and dedicated validation and booking functions.

The Health Board has already delivered measurable improvements in theatre productivity, waiting list control and operational efficiency.

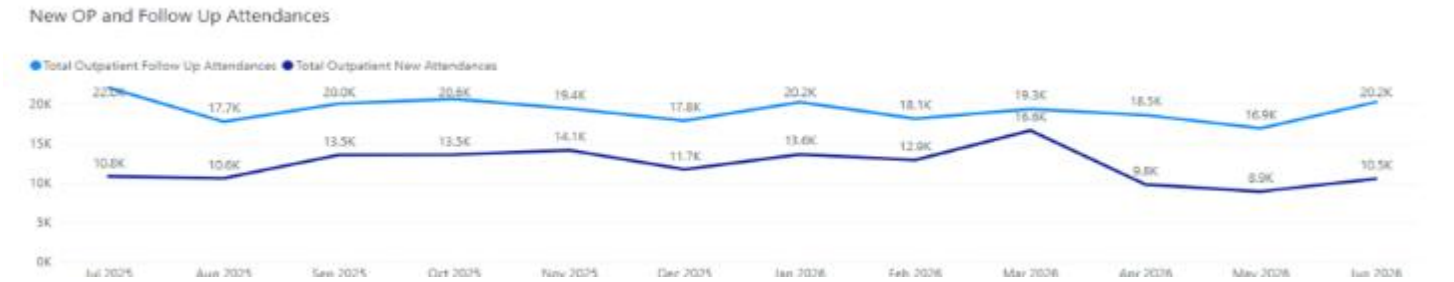
The Sustainable Planned Care Plan builds on these proven foundations to release further capacity through transformational redesign rather than short-term recovery measures.

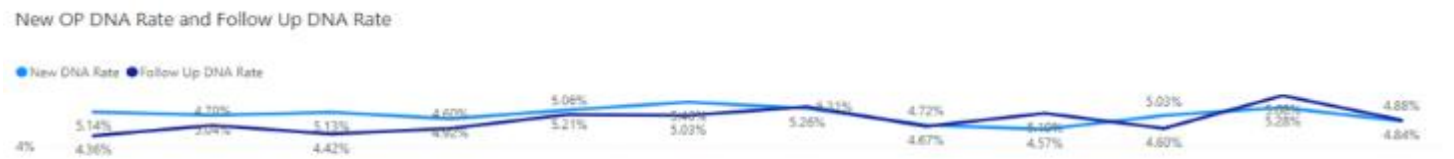
Data period: February – June 2026 unless otherwise stated

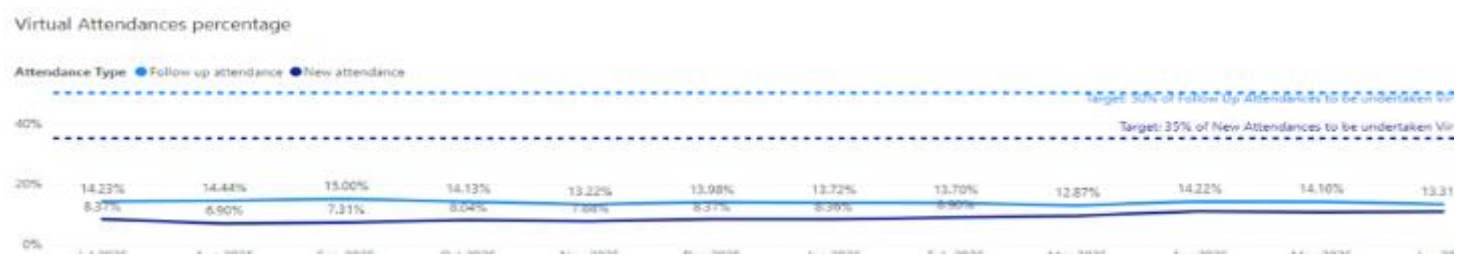
Outpatients: outcome & productivity measures

Productivity dashboard

12-month view to June 2026 | activity, DNA, virtual attendances and PIFU/SOS outcomes







Current position

DNA is relatively controlled; the bigger productivity gap is virtual delivery and PIFU/SOS uptake.

5.04%
New O/P DNA

4.85%
F/u O/P DNA

4.00%
DNA booked within 2 weeks

6.01%
DNA booked >2 weeks ahead

14.6%
Latest new-attendance PIFU/SOS outcome rate

Priority messages

- Short-notice booking appears to reduce DNA: c.2 percentage points lower when booked within two weeks.
- Virtual attendances are materially below target: latest rates are c.13% follow-up and c.11% new.
- PIFU/SOS for new patients has improved to c.15%, but still sits below the 20% ambition.

Source: outpatient activity and outcome dashboard extracts provided by service

Reducing Follow Up appointments: CHKS benchmark: targeted ratio opportunity

Aggregate positive opportunity is 25.9k follow-ups / 6,465 hours, but specialty-level clinical testing is essential before converting this into delivery assumptions.

Description	Fups per New Jan 25 - Dec 25 based on activity	Peer N:Fup Value	Potential opportunity (F/Ups)	Indicative Additional pts
Total	2.1	1 : 1.94	25862	1772-8778
Dermatology	2.9	1 : 1.75	8857	2362
Adult Mental Illness	4.5	1 : 2.08	5852	1434
Oral Surgery	1.9	1 : 1.33	3036	912
Cardiology	1.4	1 : 1.09	2306	890
Paediatrics	2.0	1 : 1.52	2001	663
General Surgery	1.4	1 : 1.26	1484	455
Respiratory Medicine	2.0	1 : 1.60	1796	579
Ear Nose and Throat	1.3	1 : 1.17	1095	345
Gastroenterology	1.6	1 : 1.46	730	247
Medical Oncology	13.5	1 : 9.5	4008	364
Cardiothoracic Surgery	3.1	1 : 2.29	677	149
Haematology (Clinical)	8.9	1 : 7.5	1574	175
Chemical Pathology	2.7	1 : 1.59	298	96
Endocrinology and Diabetes	3.7	1 : 3.6	361	71
Rehabilitation Medicine	2.8	1 : 2.63	65	16
Dental Medicine	2.7	1 : 2.15	28	8
Orthodontics	10.4	1 : 10.3	133	11

25.9k
aggregate positive F/U opportunity

6,465
hours potentially released

1,772–8,778
modelled additional patients

These opportunities form part of our recovery and sustainability plan to reduce costs by reducing capacity. The benefits will not be available to support addressing the new outpatient deficit.

Specialty	Fups per New Jan 25 - Dec 25 based on activity	Peer N:Fup Value	Potential opportunity (F/Ups)	Indicative Additional pts
Obstetrics	1.2	1 : 3.15	-12635	-2717
Trauma & Orthopaedics	1.4	1 : 1.55	-6157	-1734
Palliative Medicine	0.8	1 : 4.6	-8223	-1246
Midwifery	2.8	1 : 4.8	-7718	-1135
General Medicine	0.2	1 : 1.60	-3490	-1126
Gynaecology	0.9	1 : 1.02	-2178	-721
Old Age Psychiatry	1.7	1 : 2.55	-2054	-529
Pain / Anaesthetics	1.2	1 : 2.05	-1751	-493
Renal Medicine	5.6	1 : 7.5	-3964	-440
Rheumatology	3.8	1 : 4.7	-2469	-398
Neurology	1.8	1 : 2.09	-1430	-350
Geriatric Medicine	0.9	1 : 1.32	-848	-301
Urology	2.0	1 : 2.16	-1117	-268
Diagnostic Imaging	0.3	1 : 1.02	-725	-240
Ophthalmology	2.9	1 : 2.98	-891	-179
CAMHS	6.1	1 : 6.7	-1189	-148
Clinical Oncology	6.5	1 : 6.9	-947	-113
Restorative Dentistry	4.1	1 : 4.7	-619	-100
Paediatric Neurology	1.5	1 : 2.99	-442	-98
Clinical Psychology	3.2	1 : 5.5	-646	-96
Orthoptics	2.2	1 : 2.66	-322	-77
Perinatal Psychiatry	0.6	1 : 3.3	-324	-61
Physiotherapy	0.9	1 : 2.42	-48	-12
Clinical Genetics	0.1	1 : 0.53	-19	-8
Medical Psychotherapy	5.8	1 : 5.8	-49	-7
Plastic Surgery	2.9	1 : 2	8584	2146

Source: user-supplied CHKS peer benchmark. Opportunity = theoretical reduction in F/U demand/activity if Swansea Bay moved to CHKS peer F:New ratio; hours and indicative patients use the user-supplied timing assumptions.

Monitoring Compliance and Progress: Theatres Productivity

Live performance monitoring to ensure delivery against productivity standards

Better health
Better care
Better lives

We actively monitor theatre productivity using a suite of local watch metrics aligned to national best practice standards. These metrics provide early warning of emerging issues, drive action and support continuous improvement across all sites and specialities.

Theatre watch metrics are encompassed in **weekly flash reports** to Executives and included within our routine performance reporting to the **Performance and Finance Committee.**

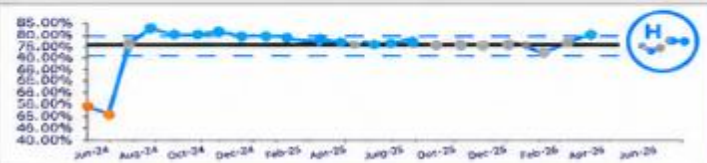
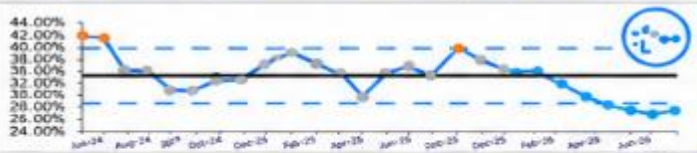
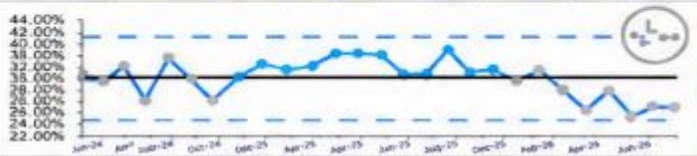
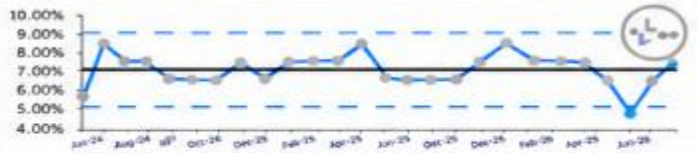
HOW WE MONITOR

- Real-time dashboards populated from theatre systems and validated data sources.
- Monthly reporting through Theatres Operational Group and Planned Care & Cancer Programme Board.
- Exception-based management with actions for metrics outside target.
- Trend analysis to identify themes and improvement opportunities.

GOVERNANCE & ASSURANCE

- Oversight at Theatres Operational Group and Planned Care & Cancer Programme Board.
- Performance escalated through Clinical Committee and Executive Team as required.
- Actions tracked and embedded into Divisional Improvement Plans.

SBUHB LOCAL WATCH METRICS – THEATRES (LATEST POSITION)

Performance Measure	Target	Trend (24 Months)	Latest Position	Latest Month	Frequency
Theatre Utilisation	>85%		81%	June 2026	Monthly
Late Starts > 15 mins	<20%		27%	June 2026	Monthly
Early Finishes > 60 mins	<10%		27%	June 2026	Monthly
% Cancelled Operations on the day	0%		8%	June 2026	Monthly

WHAT THIS TELLS US

- Overall utilisation remains strong and above target, sustaining delivery.
- Focus areas are reduced late starts, early finishes and same-day cancellations.
- Actions are in place and tracked with clear ownership and timescales.
- Continuous monitoring, learning and improvement embedded.

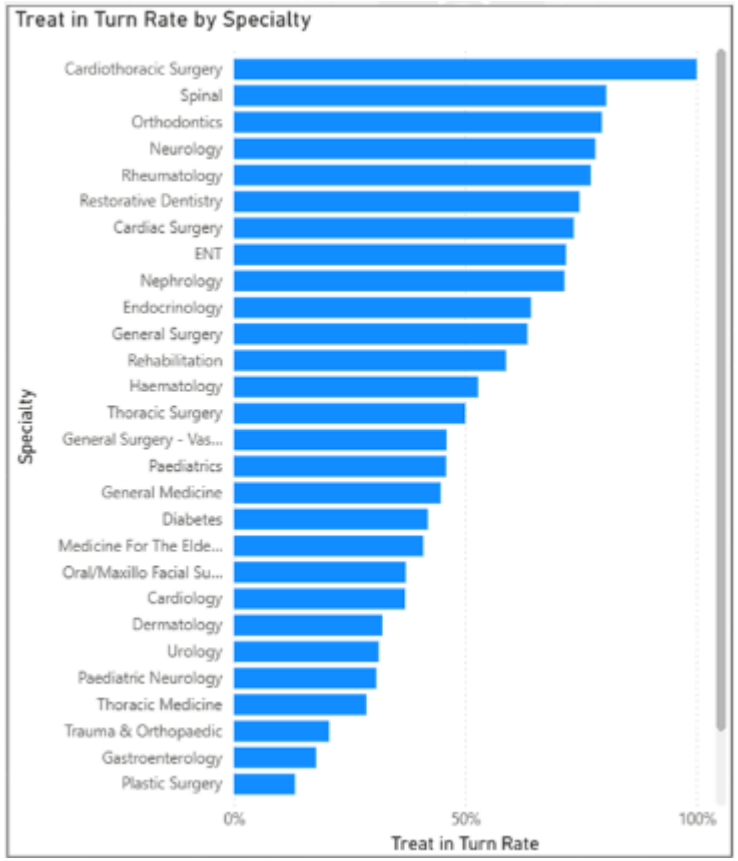
These watch metrics drive accountability, support early intervention and ensure we maintain high productivity standards to maximise capacity and improve patient outcomes.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

Treat in turn Management

Overall rates are reported, currently available high level reports lack sophistication to differentiate for clinical priority and sub specialty (e.g.paeds).

Weekly management compensates for this, focussing on understanding the rationale for treating out of turn, with assurance sought at 6-4-2 and RTT touchpoint meetings.



	Booked Admission per Speciality			
	Number of Booked Admissions	Priority Breakdown	Shortest Wait	Longest Wait
Breast	14	7 USC	1 weeks	5 weeks
		7 Urgent	0 weeks	15 weeks
		Routine		
ENT	57	8 USC	0 weeks	21 weeks
		33 Urgent	4 weeks	102 weeks
		16 Routine	49 weeks	103 weeks
General Surgery	111	15 USC	2 weeks	20 weeks
		60 Urgent	0 weeks	103 weeks
		36 Routine	12 weeks	99 weeks
Gynaecology	93	33 USC	2 weeks	75 weeks
		36 Urgent	0 weeks	103 weeks
		23 Routine	0 weeks	103 weeks
OMFS	26	2 USC	1 weeks	4 weeks
		17 Urgent	2 weeks	102 weeks
		7 Routine	1 weeks	103 weeks
Spinal	17	16 Urgent	0 weeks	97 weeks
		1 Routine	21 weeks	21 weeks
T&O	129	74 Urgent	0 weeks	102 weeks
		55 Routine	0 weeks	107 weeks
Urology	117	42 USC	1 weeks	39 weeks
		51 Urgent	0 weeks	71 weeks
		24 Routine	0 weeks	98 weeks
Total	564			
Breakdown				
USC	107			
Urgent	294	1x Awaiting Grading		
Routine	162			

104 weeks: Productivity gains have shifted the improvement focus from unused capacity to reducing day-of-surgery cancellations

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Swansea Bay University Health Board

Productivity gains have supported increased theatre use across a number of specialties, reducing missed opportunities and improving our ability to treat more patients.

Missed Opportunities

List Speciality	Missed Opportunities		Total Cases Cancelled OTD		Total avoidable inefficiencies	
	Mthly avg: Jul - Mar	Mthly avg: Apr-Jun26	Mthly avg: Jul - Mar	Mthly avg: Apr-Jun26	Avg Mthly total	Avg Mthly total
Breast	1.8	1.0	4.6	5.7	6.3	6.7
ENT	4.9	0.0	7.7	8.7	12.6	8.7
General Surgery	21.0	13.7	19.8	16.0	40.8	29.7
Gynaecology	21.0	12.0	20.0	17.7	41.0	29.7
Obstetrics	0.9	0.7	4.8	3.3	5.7	4.0
OMFS	3.6	2.3	4.1	6.0	7.7	8.3
Ophthalmology	69.4	24.0	21.9	25.7	91.3	49.7
Plastic Surgery	24.9	1.0	26.0	26.0	47.9	27.0
Spinal	2.7	0.7	8.3	5.0	11.0	5.7
Thoracic	1.2	0.7	3.9	5.0	5.1	5.7
Trauma & Orthopaedic	21.4	13.0	2.6	4.0	24.0	17.0
Urology	12.3	8.3	12.0	11.7	24.3	20.0
Vascular	8.2	13.0	5.8	5.7	14.0	18.7
Total	**193.3**	**90.3**	**138.3**	**140.3**	**332**	**231**

Red = Deterioration Blue = Improvement

Productivity use of theatres and benchmark comparison

List Speciality	Feb-June 26 Sessions Used	Patients operated on	pts per list	Model Hospital benchmark cases per list
Breast	95	194	2.0	2.16
ENT	239	603	2.5	2.16
General Surgery	571	892	1.6	1.59
Gynaecology	276	620	2.2	2.06
Obstetrics	52	105	2.0	-
OMFS	230	364	1.6	2.25
Ophthalmology	334	1,938	5.8	4.03
Plastic Surgery	375	674	1.8	2.34
Spinal	153	214	1.4	-
Thoracic	59	112	1.9	-
Trauma & Orthopaedic	669	1,470	2.2	2.16
Urology	319	660	2.1	2.06
Vascular	108	206	1.9	-
Grand Total	**3,480**	**8,052**	**2.3**	**-**

Source: Deloitte model hospital CQC Good peer Group

How to read

Green Performance above model hospital benchmark

Red Performance below model hospital benchmark

Not available Benchmark not available for comparison

Key insights

More patients treated

6 out of 8 specialties are now operating above the model hospital CQC Good peer group benchmark for cases per list in 2026.

Fewer missed opportunities

The number of missed opportunities has reduced from **332** (July 25–Mar 26) to **231** in Q1 (Apr–June 26).

Focus on cancellations

A small number of specialties have seen an increase in on-the-day cancellations. This is consistent with higher theatre utilisation and more patients being booked into operating lists.

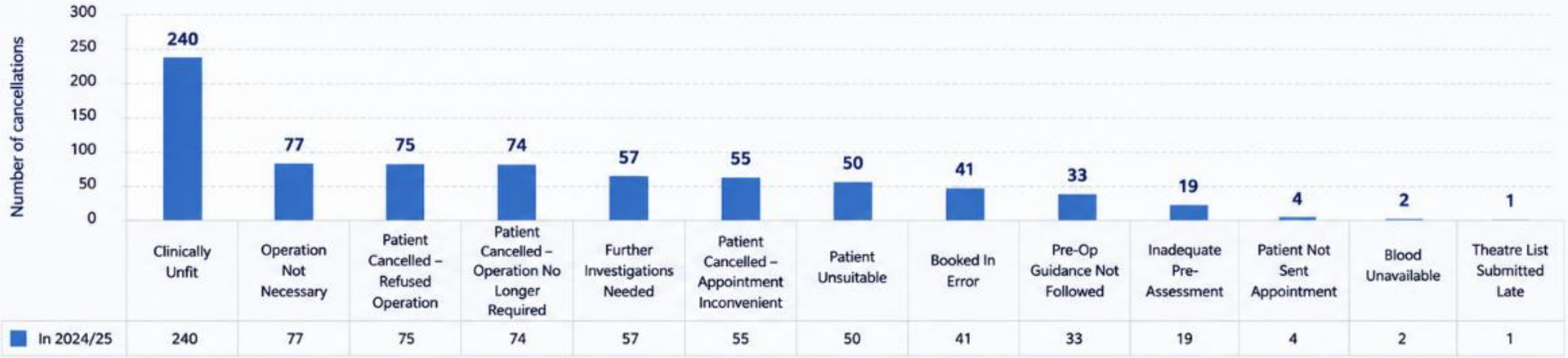
Targeted improvement work is now focused on reducing day-of-surgery cancellations in these specialties.

We are developing reports to routinely monitor compliance with the **4 joints, 7 cataracts and 6 hernias on a HVLC List.** These reports are being incorporated into our **6-4-2 and Theatre Optimisation Group meetings.**

Case Cancellations On The Day – Last 12 Months

Number of same day cancellations in 2024/25 which were potentially avoidable by reason (total = 728)

Average 60 potentially avoidable cancellations per month



	Clinically Unfit	Operation Not Necessary	Patient Cancelled – Refused Operation	Patient Cancelled – Operation No Longer Required	Further Investigations Needed	Patient Cancelled – Appointment Inconvenient	Patient Unsuitable	Booked In Error	Pre-Op Guidance Not Followed	Inadequate Pre-Assessment	Patient Not Sent Appointment	Blood Unavailable	Theatre List Submitted Late
In 2024/25	240	77	75	74	57	55	50	41	33	19	4	2	1

Of the total cases cancelled on the day, 728 in 2024/25 were considered to have been potentially avoidable, averaging 60 per month.
In response we have strengthened **pre-operative assessment and readiness controls**, using the cancellation-reason data to quantify the proportion of cancellations that can reasonably be prevented and the additional cases expected from the intervention.
We have also embedded **prospective list-composition rules** using procedure duration, turnaround, complexity and site constraints, with booking at 6/4/2/1 intervals and **early escalation** where a list is at risk of being under-booked.

Key takeaways

728 potentially avoidable same day cancellations in 2024/25 (60 per month on average).

Top reasons: Clinically unfit (240), Operation not necessary (77) and Patient cancelled – refused operation (75).

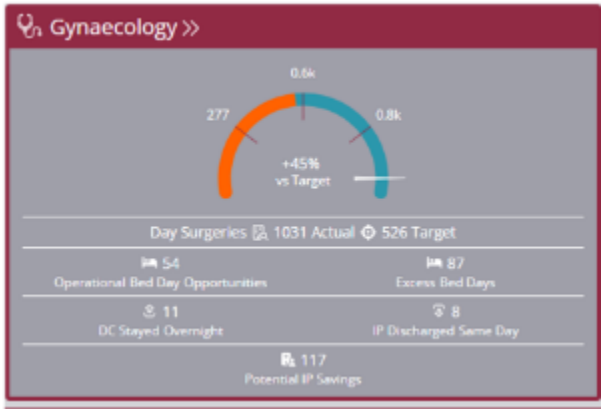
Stronger controls in place on pre-operative assessment, readiness and list composition to reduce avoidable cancellations.

Goal: Reduce day-of-surgery cancellations and maximise theatre capacity for patient benefit.

Focus remains on preventing cancellations through better patient optimisation, communication and scheduling discipline.

CHKS: SB UHB BADs Results 2026 YTD

Specialty	Actual day surgeries	Target day surgeries	Activity volume variance	Activity achievement vs target	Operational bed day opportunities	Excess bed days	Day cases stayed overnight	IP discharged same day	Potential IP savings
Gynaecology	1,031	526	+505	196.0%	54	87	11	8	117
Ophthalmology	2,484	2,371	+113	104.8%	24	52	21	0	103
Oral & Maxillofacial	478	461	+17	103.7%	34	60	14	1	0
ENT	1,827	1,792	+35	102.0%	32	41	22	14	24
Vascular	66	66	0	100.0%	3	7	2	1	15
Plastic Surgery	25	26	-1	96.2%	2	5	1	1	0
Urology	780	812	-32	96.1%	62	88	6	28	561
Paediatric Surgery	196	206	-10	95.1%	15	14	11	11	0
Orthopaedics Elective	586	669	-83	87.6%	86	164	14	16	74
Orthopaedics Trauma	70	77	-7	90.9%	8	35	0	70	7
General Surgery	173	210	-37	82.4%	47	90	29	5	3
Bariatric Surgery	0	5	-5	0.0%	7	20	0	0	0
Emergency Surgery	96	157	-61	61.1%	70	117	0	96	41
Breast	99	175	-76	56.6%	77	142	21	18	6
Endocrine Surgery	0	33	-33	0.0%	33	35	0	0	0
TOTAL	**7,911**	**7,586**	**+325**	**104.3%**	**554**	**957**	**152**	**269**	**951**



Productivity Initiatives Planned for 2026/27

A comprehensive programme to release further capacity and improve patient flow

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Our productivity programme focuses on the key drivers of demand, capacity and flow across the planned care pathway.
Each workstream will deliver measurable benefits to increase capacity, reduce waiting times and improve patient experience.

1. Demand Management & Referral Productivity

DELIVERABLES

- Professional triage by specialty
- AI-enabled pathway screening
- HealthPathways expansion
- Straight-to-test optimisation
- Alternative diagnostic pathways

EXPECTED BENEFIT

- Reduction in inappropriate referrals
- Reduced outpatient demand
- Faster pathway progression

2. Outpatient Productivity

DELIVERABLES

- National follow-up criteria implementation
- Validation letter exercises
- Default discharge approach
- PIFU/SOS expansion
- AI-supported follow-up validation

EXPECTED BENEFIT

- Reduced follow-up backlog
- Improved FU:new ratio
- Increased capacity for new patients

3. Workforce Productivity

DELIVERABLES

- Right clinician, right follow-up
- Top-of-licence review
- Expanded nurse/AHP-led models
- Reduced consultant follow-up burden

EXPECTED BENEFIT

- Increased consultant capacity
- Improved access for new patients
- More sustainable workforce model

4. Theatre & Treatment Productivity

DELIVERABLES

- Treat-in-turn implementation
- Theatre utilisation improvement
- Day Case First expansion
- One-stop and HVLC pathways
- Reduced cancellations

EXPECTED BENEFIT

- Increased throughput
- Improved productivity standards
- Improved waiting list performance

5. Diagnostic Productivity

DELIVERABLES

- Radiology AI
- Endoscopy/NOUS validation
- Reporting optimisation
- 6-day working plans
- DNA/CNA reduction

EXPECTED BENEFIT

- Faster diagnostics
- Reduced 8-week waits
- Improved utilisation

6. Digital Productivity

DELIVERABLES

- Ambient Voice Technology
- AI referral screening
- AI letter validation
- Patient Portal
- Theatre system redevelopment

EXPECTED BENEFIT

- Reduced administration
- Faster clinical decision making
- Increased clinical capacity

These initiatives will work together to reduce demand, improve productivity and increase capacity across the planned care pathway.

- More patients seen sooner
- Reduced waits and backlogs
- Improved productivity and utilisation
- Better value from existing resources
- Improved patient experience and outcomes

Optimising Consultant Job Planning to Increase Productivity – An Indicative Approach

Specialty	Cumulative Sessions OPD (Job Plan)	Cumulative OPD Sessions (Actual)	Sum of Q2 26_Attend/DNA	Variance	Cumulative Theatre Sessions (Job Plan)	Cumulative Theatre Sessions (Actual)	Variance
Breast	100	226	2119	127	67	77	10
Cardiology	335	238	1845	-97			
Cardiothoracic	105	411	2728	306	276	263	-13
Dermatology	221	366	4096	146			
ENT	274	247	2583	-27	242	216	-26
Gastroenterology	226	140	1172	-86			
General Medicine	0	300	1858	300			
General Surgery	393	285	2839	-108	697	427	-270
Gynaecology	421	826	6112	405	254	348	94
Haematology	274	599	2500	325			
Medicine For The Elderly	168	123	1001	-45			
Neurology	520	317	2140	-202			
OMFS	270	203	1551	-68	160	354	194
Ophthalmology	527	1285	10520	758	299	223	-76
Orthodontics	168	163	2586	-5			
Plastic Surgery	388	812	4828	423	829	468	-361
Rehabilitation	69	35	242	-34			
Spinal	202	124	836	-77	218	124	-94
Trauma & Orthopaedic	690	282	3823	-408	1050	475	-575
Urology	213	540	4363	327	333	252	-81
Vascular	104	9	52	-94	168	108	-60
Total	**5666**	**7531**	**59794**	**1865**	**4593**	**3335**	**-1258**

- Figures show sessions templated v delivered in Apr-Jun 26 & indicate services for potential productivity gains.
- As part of our financial recovery plan we are seeking to deliver the same level of activity through fewer sessions.
- Figures require validation to account for on-call and sickness (which presently are in the job plan column)
- Further validation also required to ensure sessions are core and consultant delivered

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Pillar 1: Referral & Early Diagnosis

Un Bae Ar y Cyd
One Bay Way

Demand Management Strategy for Outpatients

Ensuring the right patient receives the right care, first time

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The Health Board will move from managing waiting lists to managing demand, ensuring patients are directed to the most appropriate pathway at the earliest opportunity.

How we will manage demand and reduce avoidable additions to the waiting list

1. REFERRER

Referral submitted

Referral includes minimum dataset

2. REFERRAL OPTIMISATION

Standardised Referral Guidance

- Standardised referral guidance
- Agreed referral thresholds
- Decision support tools
- Local pathway information

3. ADVICE & GUIDANCE

Consultant & Specialist Advice

- Advice without appointment
- Primary care support
- Community management
- Reduce unnecessary referrals

4. REFERRAL REVIEW

Professional Triage & Consultant Vetting

- Clinical prioritisation
- Straight-to-Test
- Direct-to-Diagnostics
- Community alternatives
- Reject inappropriate referrals where clinically appropriate

5. RIGHT PATHWAY, RIGHT CARE

Patients directed to the most appropriate option

- Outpatient Clinic
- Straight-to-Test
- Community Service
- Advice & Guidance Outcome

Key components of our demand management approach

Standardised Referral Guidance
Comprehensive pathway content and referral guidance for referrers.

Advice & Guidance
Consultant and specialist advice without the need for a face-to-face appointment.

Community Alternatives
Appropriate use of community services and primary care management.

Referral Criteria
Clear inclusion and exclusion criteria to ensure referrals meet clinical need.

Consultant Vetting
Clinical filtering and validation to ensure appropriate referrals enter the pathway.

Professional Triage
Skilled triage to prioritise, redirect or manage referrals safely.

Feedback to Referrers
Timely feedback, education and learning to support referral quality.

Data & Reporting
Referral minimum dataset and outcome reporting to drive continuous improvement.

DATA & INTELLIGENCE

- Referral minimum dataset
- Referral outcome reporting
- Specialty and practice variation
- Demand trend analysis and forecasting
- Impact reporting to reduce inappropriate referrals

CONTINUOUS LEARNING & IMPROVEMENT

- Feedback loops to referrers
- Targeted education and support
- Benchmarking and performance review
- Standardised Referral Guidance content refresh
- Share learning across specialties and primary care

EXPECTED BENEFITS

- Reduced inappropriate and avoidable referrals
- Reduced outpatient demand and backlog
- Faster access for patients who need specialist care
- Better utilisation of consultant and diagnostic capacity
- More consistent referral quality and patient experience

By managing demand at every step, we will reduce avoidable additions to the waiting list and ensure patients receive the right care, in the right place, first time.

Professional Triage Strategy

Ensuring every referral reaches the right pathway, first time

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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

KEY MESSAGE

Professional triage will ensure referrals are assessed consistently against nationally agreed clinical pathways and local referral criteria, directing patients to the most appropriate pathway at the earliest opportunity while reducing inappropriate outpatient demand and unwarranted variation.

REFERRAL RECEIVED

Referral submitted by GP or clinician

DELIVERED BY THE MOST APPROPRIATE CLINICIAN

- Consultant
- Advanced Clinical Practitioner
- Specialist Nurse
- Advanced Nurse Practitioner
- AHP

Specialty-specific triage protocols supported by national clinical guidance, HealthPathways and AI-enabled decision support where appropriate.

PROFESSIONAL TRIAGE & CLINICAL ACCEPTANCE

Every referral assessed against agreed national and local clinical standards.

ACCEPT TO OUTPATIENT PATHWAY	Booked to the most appropriate clinic at the right time.
DIRECT TO STRAIGHT-TO-TEST	Patients sent directly for the most appropriate test.
DIRECT TO DIAGNOSTICS	Appropriate diagnostics arranged without outpatient appointment.
REDIRECT TO COMMUNITY SERVICE	Managed in primary/community care with specialist support.
ADVICE & GUIDANCE RETURNED TO REFERRER	Specialist advice provided to support management in primary care.
REFERRAL NOT ACCEPTED AGAINST AGREED CLINICAL CRITERIA	Does not meet agreed referral criteria – not appropriate for specialist pathway.

Professional triage ensures clinical consistency, reduces inappropriate referrals and aligns referral acceptance with nationally agreed pathways and local criteria.

CLINICAL GOVERNANCE & ASSURANCE

- National CIN pathways
- HealthPathways referral criteria
- GIRFT and best practice guidance
- Specialty clinical leadership
- Referral acceptance audit
- Outcome reporting and variation analysis
- Regular review and refinement of protocols

STANDARDISED CLINICAL DECISION-MAKING

- Specialty-specific triage protocols
- Alignment with nationally agreed CIN pathways
- HealthPathways integration
- AI-supported referral review where appropriate
- Consistent referral acceptance thresholds
- Appropriate redirection or rejection of referrals that do not meet agreed criteria

CLINICAL LEADERSHIP & RESOURCE

- Specialty clinical leads for triage
- Cross-disciplinary triage models
- Consultant, AHP, nurse and ACP triage where appropriate
- £75k programme investment for clinical leadership in triage
- Training, tools and AI enablement
- Prioritisation of challenged specialties

EXPECTED BENEFITS

- Fewer inappropriate referrals
- Reduced outpatient demand
- Faster access to the right pathway
- Improved pathway flow
- Reduced variation between specialties
- Better use of consultant capacity
- Improved patient experience

Every referral will receive a specialist clinical decision.

This is the foundation of demand management and the key mechanism for reducing avoidable additions to outpatient waiting lists.

FINANCIAL ASK

£75k investment requested for clinical leadership and governance of professional triage.

AI-Enabled Referral & Pathway Screening

Supporting safe, consistent and clinically led professional triage

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Artificial Intelligence will support—not replace—professional triage by providing clinicians with intelligent decision support, pathway recommendations and administrative insights.

Clinical judgement, accountability and referral acceptance decisions will remain with appropriately qualified healthcare professionals.

REFERRAL RECEIVED

From GP, primary care or other referrer

AI-ENABLED REFERRAL & PATHWAY SCREENING

- **Referral completeness** – Checks referral minimum dataset and identifies missing information.
- **Local referral protocols** – Applies local speciality referral criteria.
- **National CIN pathways** – Compares referral against nationally agreed pathways.
- **Suggested pathway options** – Recommends most appropriate pathway(s) for the patient.
- **Standardised Referral Criteria** – Assesses alignment with Standardised Referral Criteria for the specialty.
- **Referral quality checks** – Identifies duplicates, repeats and inappropriate routing.
- **Risk identification** – Flags red flags, urgency and patient safety considerations.
- **Administrative intelligence** – Supports validation, coding, triage prep and workload insights.

PROFESSIONAL TRIAGE

Consultant | ACP | CNS | AHP

Clinical judgement retained

- Reviews AI insights and pathway suggestions
- Applies clinical judgement and experience
- Confirms referral acceptance or redirection
- Determines most appropriate next step
- Safety, quality and accountability remain with the clinician

APPROPRIATE PATHWAY ALLOCATED

Outpatient Clinic	Booked to the most appropriate clinic at the right time.
Straight-to-Test	Patient directed straight to the most appropriate test.
Direct to Diagnostics	Diagnostics arranged without outpatient appointment.
Community Pathway	Managed in primary/community care with specialist support.
Advice & Guidance returned to referrer	Specialist advice provided to support management.
Referral not accepted against criteria	Does not meet agreed referral criteria – not appropriate for specialist pathway.

AI CAPABILITIES THAT ENABLE PROFESSIONAL TRIAGE

Intelligent Referral Screening

- Referral completeness
- Minimum dataset validation
- Duplicate detection
- Clinical coding & categorisation

Clinical Decision Support

- National CIN pathway alignment
- Standardised Referral Criteria guidance
- Local referral criteria
- Suggested pathway options
- Risk flagging & prioritisation

Professional Triage Enablement

- Consistent information for clinicians
- Reduced administrative review
- Faster triage decisions
- Reduced unwarranted variation
- Supports consultant, ACP, CNS & AHP triage

Continuous Learning & Improvement

- Outcome reporting
- Pathway performance analytics
- Referral quality feedback
- AI refinement through clinician oversight
- Pop-up prompts and intelligence

CLINICAL GOVERNANCE PRINCIPLES

- AI supports clinical judgement – it does not replace it.
- Referral acceptance remains a clinician-led decision.
- Recommendations are aligned to nationally agreed CIN pathways and local Standardised Referral Criteria.
- AI outputs are subject to clinical oversight, audit and continuous refinement.
- Patients with complex presentations remain under full professional review.

EXPECTED BENEFITS

- Reduce inappropriate referrals entering specialist pathways
- Faster and more consistent professional triage
- Greater alignment with nationally agreed pathways
- Reduced unwarranted variation between specialties
- Reduced administrative burden for clinicians
- More consultant time focused on complex decision-making
- Improved patient flow and outpatient productivity

AI-Enabled Referral & Pathway Screening will act as a digital co-pilot for Professional Triage—enhancing consistency, reducing variation and supporting clinicians to make faster, evidence-based referral decisions while maintaining full clinical accountability.

Pillar 2: Capacity, Productivity & Treatment

Our Productivity Philosophy
Optimise First. Invest Second.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Our approach is founded on a simple principle: every opportunity to release capacity through productivity, transformation and better utilisation of existing resources will be pursued before additional investment is sought. External capacity will only be commissioned where a demonstrable residual gap remains following optimisation.

THE PRODUCTIVITY HIERARCHY

A disciplined, evidence-based approach to releasing capacity and investing where it is truly required.

Release Capacity → Reduce Demand → Invest Only Where Necessary

STEP 4 — INVEST ONLY WHERE REQUIRED

Targeted investment to address residual capacity gap

- Internal recurrent growth
- Temporary recovery funding
- Regional solutions
- Independent sector
- External providers

Question
What targeted investment is required to close the residual gap?
Only where a residual gap remains following optimisation and transformation.

STEP 3 — RESIDUAL CAPACITY GAP

Robust demand and capacity assessment

- Quantified capacity modelling
- Demand forecasting
- Waiting list trajectory
- Productivity assumptions tested
- Evidence of residual gap

Question
After optimisation and transformation, what gap genuinely remains?
Data-led assessment to inform investment decisions.

STEP 2 — TRANSFORM PATHWAYS

Redesign care to reduce demand and improve flow

- Professional triage
- AI-enabled referral screening
- Straight-to-Test
- Treat in Turn
- Day Case First
- PIFU
- One-stop pathways
- Pre-surgical optimisation
- Community alternatives
- Reduce unnecessary variation

Question
Can the pathway itself be redesigned to reduce demand and improve flow?
Focus on transformation, innovation and redesign.

STEP 1 — OPTIMISE EXISTING CAPACITY

Maximise the use of what we already have

- Theatre utilisation
- Treat-in-turn
- Reduce cancellations
- Diagnostic productivity
- Outpatient productivity
- Workforce deployment
- Job planning
- Skill mix optimisation
- Digital enablement
- Better scheduling & sequencing

Question
Have we made the best possible use of what we already have?
Eliminate waste, improve productivity, release capacity.

OUR PRINCIPLES

- Optimise before investing
- Productivity before procurement
- Internal before external
- Sustainable before temporary
- Regional before independent sector
- Data-led investment decisions

Consistent with Welsh Government guidance, additional funded capacity will only be deployed where the Health Board can demonstrate that existing capacity has been fully optimised and a residual demand and capacity gap remains.

Delivering Value-Based Planned Care

Reducing Unwarranted Clinical Activity

Our ambition is to ensure every outpatient contact, investigation and intervention has a clear clinical purpose and delivers value for our patients.

1. Clinical Appropriateness

- Interventions Not Normally Undertaken (INNUs)
- Evidence-based thresholds
- National guidance
- Clinical exception process

2. Outpatient Value

- Review the need for routine follow-up
- Identify duplicate appointments
- Default discharge where appropriate
- Expand PIFU and SOS pathways
- Ensure the right clinician for the right need

3. Pathway Compliance

- Compliance with Standardised Referral Criteria
- CIN pathways
- Specialty protocols
- Clinical audit and monitoring

4. Diagnostic Value

- Appropriate investigation for the question
- Avoid duplicate or repeat testing
- Right test, first time
- Consider straight-to-test pathways

5. Continuous Review

- Specialty-led audits and reviews
- Identify variation in practice
- AI-supported insight and analytics
- Monitor outcomes and compliance

6. Clinical Governance

- Consultant and clinical ownership
- Clinical exception process
- MDT oversight for complex cases
- Patient-centred decision making

Outcomes & Benefits

- Every contact has a defined clinical purpose
- Consultant expertise focused on highest-value care
- Capacity redirected to new patients, diagnostics, long waiters and treatment pathways
- Improved compliance with national pathways and evidence-based criteria
- Better patient experience and outcomes
- Better use of NHS resources and improved productivity

Our Approach

Identify — Review activity, pathways and access criteria →

Assess — Evaluate clinical value and appropriateness →

Decide — Apply clinical judgement and exception process →

Act — Optimise pathway, discharge, PIFU or SOS as appropriate →

Monitor — Measure impact, learn and continuously improve

Clinical Exception Process

Where deviation from standard criteria is clinically appropriate, a documented exception process ensures transparency, clinical accountability and patient safety.

Our ambition is not simply to deliver more activity, but to ensure every outpatient appointment, investigation and intervention contributes measurable clinical value for our patients.

Right Contact. Right Clinician. Right Outcome.

Waiting List Assurance and Treat-in-Turn

Ensuring patients are booked fairly, transparently and in accordance with Welsh Government expectations

Better health
Better care
Better lives

Swansea Bay has a structured Treat-in-Turn assurance process that combines system reporting, operational review and clinical oversight to maximise compliance whilst recognising legitimate clinical and operational exceptions.

- Transparent monitoring
- Clinical oversight
- Exception reporting
- Continuous improvement
- Fair, equitable and efficient

OUR ASSURANCE PROCESS

1. SYSTEM REPORTING
Treat-in-Turn data extracted from STCS and reported via Power BI by specialty and sub-specialty.

2. WEEKLY OPERATIONAL REVIEW
Weekly Pre-Assessment meetings review upcoming theatre lists and Treat-in-Turn performance.

3. PATIENT-LEVEL VALIDATION
Undertake patient level review to confirm booking order and rationale, identifying list fillers and sub-specialty constraints.

4. CLINICAL / OPERATIONAL EXCEPTIONS
Exceptions identified, understood and documented where patients cannot be treated strictly in chronological order.

5. ESCALATION & IMPROVEMENT
Issues and exceptions escalated through RTT Touchpoint meetings for action and follow up. Performance and actions monitored weekly.

6. EXECUTIVE ASSURANCE
Summary of Treat-in-Turn performance and exception reporting provided to operational and executive leadership.

OUR ASSURANCE APPROACH

1. CONTINUOUS MONITORING
- Treat-in-Turn reported through Power BI.
- Patient-level detail available from STCS.
- Specialty and sub-specialty performance reporting.
- Trend monitoring and benchmarking over time.

2. WEEKLY OPERATIONAL REVIEW
- Weekly Pre-Assessment meetings.
- Review of upcoming theatre lists.
- Assurance that booking order is appropriate.
- Identification of potential issues early.

3. PATIENT-LEVEL VALIDATION
- Individual patient review.
- Theatre list validation.
- Confirmation of booking rationale.
- Identification of list filler patients.
- Sub-specialty constraints considered.

4. CLINICAL EXCEPTIONS
Not all patients can be treated strictly in chronological order.

Examples include:
- Clinical priority
- Sub-specialty expertise
- Theatre utilisation and efficiency
- List-filling opportunities
- Patient choice
- Service resilience

5. ESCALATION & IMPROVEMENT
- Exception reporting and documentation.
- Specialty challenge and support.
- Actions agreed and monitored.
- Continuous improvement in performance and processes.

POOLED WAITING LISTS
Where clinically appropriate, patients are managed within pooled waiting lists to maximise flexibility, reduce variation and ensure the earliest available capacity is used efficiently.

Pooled lists support fairness and help maintain Treat-in-Turn compliance across specialties.

WELSH GOVERNMENT STANDARD

50%

Minimum Treat-in-Turn rate by specialty

Supported through:
- Weekly monitoring and review
- Exception reporting
- Pooled waiting lists where appropriate
- Evidence of clinical prioritisation exceptions
- Specialty-level improvement actions
- Transparent reporting and escalation

FUTURE DEVELOPMENT
- Enhanced automated reporting
- Reduced manual validation
- Improved sub-specialty reporting
- More timely exception monitoring

Treat-in-Turn performance is actively monitored at patient level, enabling Swansea Bay to maximise compliance whilst ensuring clinically appropriate and operationally efficient use of theatre capacity.

KEY OUTCOME

Fair access for patients, optimal use of theatre capacity and compliance with Welsh Government productivity requirements.

Theatre Productivity Programme

Maximising the productivity of every theatre session before investing in additional capacity

Better health
Better care
Better lives

Our theatre productivity programme focuses on improving utilisation, reducing unwarranted variation and increasing productivity through standardisation, scheduling improvement and specialty-led transformation. Investment is targeted only where it supports sustainable productivity gains.

OUR THEATRE PRODUCTIVITY PILLARS

1 THEATRE UTILISATION

- Theatre timetable redesign
- Improved session utilisation
- Better alignment of capacity to demand
- Active management of start times and overruns

PROGRAMME STANDARD
85%
theatre utilisation

2 SCHEDULING & LIST OPTIMISATION

- Better list scheduling
- Reduced unused operating time
- Improved booking quality
- Reduced on-the-day disruption
- Enhanced use of Treat in Turn

3 SPECIALTY PRODUCTIVITY

Examples include:

- Cataracts
- Orthopaedic Joints
- General Surgery (HVLC)

Specialty productivity standards supported through benchmarking and continuous review.

4 DAY CASE FIRST

- Expand day case delivery where clinically appropriate and supported by infrastructure
- Optimise pre-assessment and patient flow
- Earlier discharge and supported recovery pathways

Our day case infrastructure is limited to some specialties. Expansion will be phased and aligned to infrastructure capacity.

5 CONTINUOUS IMPROVEMENT

- GIRFT-aligned improvement programme
- Clinical benchmarking and best practice
- Theatre surveillance and performance review
- Data-driven decision making
- Regular specialty productivity reviews

6 TARGETED INNOVATION

- New models of care
- Technology enablement
- Skill mix optimisation
- Focused investment in areas with proven productivity benefits

PRODUCTIVITY STANDARDS
(Programme Targets)

Theatre Utilisation 85%

Cataracts 7 cases per list

Orthopaedic Joints 4 joints per list

HVLC General Surgery (Selected Specialties) ≥6 procedures per list

Standards aligned to Welsh Government Productivity Guidance.

WHAT WE HAVE ACHIEVED AND ARE BUILDING ON

- Improved theatre utilisation in line with national trajectory
- On-the-day cancellations reduced and continuing to improve
- Better scheduling and booking quality driving higher productive sessions
- Day Case First culture growing across specialties where supported by infrastructure
- GIRFT reviews informing standardisation and pathway improvement
- Strong specialty leadership and active theatre productivity reviews

TARGETED ENABLING INVESTMENT

Urology Robotic Surgery

Investment Requirement

- 1.5 x Surgical Care Practitioner (SCP)

Expected Benefits

- Increased robotic surgery throughput
- Nurse-led LATP biopsy
- Reduced reliance on consultant-delivered non-operative tasks
- Improved theatre efficiency
- Increased capacity within existing robotic infrastructure

Important – Infrastructure Consideration

We do not currently have the day case infrastructure to support the maximisation of HVLC activity across all specialties. Expansion of day case and HVLC models will be phased and aligned to infrastructure availability and clinical priorities.

Productivity is monitored through specialty benchmarking, theatre surveillance, data analysis and delivery against agreed productivity standards, ensuring improvement is sustained over time and that we continue to deliver the best outcomes for our patients.

Optimise before we invest

Right patient
Right surgery
Right time

Better outcomes
Better productivity
Better value

Cataract Surgical Hub Proposal – Singleton Day Surgery Unit

Submitting our bid for accreditation through the NHS Wales Surgical Hubs Programme

Better health
Better care
Better lives

Swansea Bay University Health Board is submitting a bid for accreditation of a Cataract Surgical Hub based within the Singleton Day Surgery Unit as part of the second cohort of Expressions of Interest.

Accreditation will formally demonstrate the quality, efficiency and sustainability of our service whilst supporting continued development and better outcomes for our patients.

- Demonstrate quality and excellence
- Improve productivity and efficiency
- Strengthen elective care delivery
- Position as a leading centre for cataract care across Wales

OUR PROPOSAL

- We are submitting a bid for accreditation of a Cataract Surgical Hub at Singleton Day Surgery Unit. *Part of the second cohort of Expressions of Interest.*
- Strong engagement and support from the Clinical Lead, Service Manager, Cataract Lead and Clinical Service Manager, with a shared commitment to securing accreditation.
- Accreditation will showcase our excellence and provide a platform to drive ongoing improvement in pathways, outcomes and patient experience.
- Success would make us the first accredited Surgical Hub within Swansea Bay University Health Board and, potentially, the first accredited Cataract Hub in Wales.

WHY NOW?

- Aligns with our ambitions to strengthen elective care delivery and reduce waiting times.
- Showcases the excellent work already undertaken within Cataract Surgery at Singleton Day Surgery Unit.
- Positions our service as a leader in high-quality, sustainable cataract care across Wales.

ACCREDITATION FRAMEWORK

A comprehensive evidence-based framework across multiple domains

- Patient Pathways
- Governance and Quality
- Workforce and Leadership
- Productivity and Efficiency
- Facilities and Infrastructure
- Ring-fencing and Capacity

The framework requires robust evidence across all domains to demonstrate compliance with NHS Wales Surgical Hubs accreditation standards.

OUR APPROACH AND TIMELINE

1. **Review requirements** – Detailed review of the accreditation framework and evidence required.
2. **Evidence gathering** – Identify and collate evidence across all domains with the clinical team.
3. **Develop submission** – Compile and prepare robust bid documentation.
4. **Internal validation** – Quality assurance and sign-off process.
5. **Submit by late August** – Target submission of accreditation bid.

We recognise the considerable effort required; however, there is strong commitment across the team to invest the time and resource needed to achieve accreditation.

STRATEGIC BENEFITS

- Strengthens our position as a centre of excellence for cataract care.
- Drives continuous improvement in quality, productivity and patient experience.
- Supports sustainable use of resources and capacity.
- Enhances reputation regionally and nationally.
- Contributes to our ambition to lead elective care improvement in Wales.

This bid is an important step in our journey to become a leading provider of high-quality, efficient and sustainable cataract care – improving outcomes for our patients today and for future generations.

Theatre Digital Transformation

Modernising the digital infrastructure supporting surgical services

Redevelopment of the Theatre Management System will modernise the core digital infrastructure supporting surgical services, improving operational efficiency while creating a platform for future AI-enabled productivity improvements and regional collaboration.

TRANSFORMING OUR THEATRE MANAGEMENT SYSTEM

CURRENT STATE

Existing Theatre Management System

- ⊗ Cannot be developed further
- ⊗ Limits future innovation and efficiency

FUTURE STATE

Modern Digital Platform
Redevelop / replace the Theatre Management System to create a future-proof digital infrastructure.

→

Improved Data Capture
Better quality and completeness of theatre data to support safe and efficient care.

→

Improved Operational Efficiency
Streamlined processes and improved efficiency across theatre operations.

→

AI-Enabled Process Improvement
Use of AI to streamline processes and identify further efficiencies.

→

Future Regional Opportunities
Enable regional collaboration with Hywel Dda and support regionally delivered surgical specialties.

INDICATIVE INVESTMENT

£200,000

Supports:

- Theatre Management System redevelopment
- Options appraisal with Hywel Dda
- Regional opportunity exploration
- Local implementation and delivery planning

EXPECTED IMPACT

- More efficient theatre operations
- Improved data quality and visibility
- AI-enabled process improvements
- Stronger foundation for regional working
- Enables sustainable productivity gains across surgical services

Modern Digital Platform

- Redevelop / replace the Theatre Management System
- Establish a modern, scalable and future-proof platform
- Support sustainable theatre operations and innovation

AI-Enabled Efficiency

- AI-supported process streamlining
- Identification of further efficiencies
- Platform for future AI-enabled innovation

Regional Collaboration

- Joint options appraisal with Hywel Dda
- Explore shared regional opportunities
- Supports regional surgical specialties currently delivered across Health Boards

Better Operational Information

- Improved data capture
- Improved operational efficiency
- Better visibility of theatre activity to support decision making

Modernising the Theatre Management System will establish the digital foundations required to support future productivity improvements, regional collaboration and AI-enabled innovation across surgical services.

Better Data · Better Efficiency · AI Innovation · Regional Collaboration

Ambient Voice Technology for Clinical Productivity

Reducing documentation burden. Improving patient care. Releasing clinician time.

KEY MESSAGE: Ambient Voice Technology supports sustainable outpatient productivity by reducing documentation burden and improving the speed and quality of clinical communication.

WHERE WE WILL DEPLOY

Across multiple Planned Care settings

OUTPATIENT
Clinic consultations across specialties

COMMUNITY
Community clinics and services

INPATIENT
Ward rounds and inpatient settings

HOW AMBIENT VOICE TECHNOLOGY WORKS

Captures clinician–patient conversation securely → Automates clinical documentation at the point of care → Checks and structures information for accuracy and completeness → Generates high-quality outputs and correspondence faster

Secure, compliant and integrated with our clinical systems

INDICATIVE INVESTMENT

£215,000

Recurrent cost to be confirmed

Investment supports:

- Deployment across outpatient, community and inpatient settings
- Licences, implementation and integration
- Change management, training and support
- Benefits realisation and evaluation

BENEFITS FOR CLINICIANS

Time released
Less time on documentation, more time with patients

Reduced cognitive load
AVT captures and drafts notes so clinicians can focus on care

Improved experience
More natural consultations and less screen time

Improved wellbeing
Reduced administrative burden supports staff morale and retention

DRIVING OUTPATIENT PRODUCTIVITY AND QUALITY

Faster clinic correspondence
Clinic letters produced more quickly and consistently

Improved timeliness and quality
Clinical records are more timely, complete and accurate

Reduced administrative delay
Less time spent typing and chasing documents

Better communication and continuity
Clearer and faster information for primary care, other providers and patients

Safer transitions of care
Key decisions and risks shared earlier to support safe handovers

Supports sustainable productivity
Makes best use of existing capacity and supports planned care objectives

EXPECTED OUTCOMES

- More clinician time for direct patient care
- Faster, higher quality clinical correspondence
- Improved patient experience and understanding
- Safer care and fewer delays in follow-up actions
- Better use of resources and improved productivity

IMPACT FOR PATIENTS AND THE SYSTEM

- Faster receipt of clinic letters and results
- Fewer delays in follow-up appointments, referrals and prescriptions
- Clearer, more timely communication improves patient confidence
- Reduced re-contact caused by missing information
- Stronger capacity, productivity and quality outcomes

Ambient Voice Technology will help clinicians spend more time with patients and deliver high-quality documentation faster – improving care, efficiency and outcomes across our Planned Care services.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Pillar 3:

Follow-Up, Surveillance and Living Well

Un Bae Ar y Cyd
One Bay Way

Sustainable Follow-Up Operating Model

Ensuring follow-up appointments are delivered only where they add clinical value

Better health
Better care
Better lives

Sustainable recovery requires Swansea Bay to stop unnecessary follow-up demand recycling back into the outpatient system. Our future operating model ensures patients receive follow-up only where clinically necessary, releasing capacity for new patients while maintaining safe, high-quality care.

Around 60%
of outpatient activity relates to follow-up appointments[1]

EVERY PATIENT LEAVES CLINIC WITH A DEFINED FOLLOW-UP STRATEGY

First Outpatient Appointment / Review

Clinical Decision Making
Does this patient require ongoing specialist follow-up?

RISK-BASED SURVEILLANCE
Follow-up intensity matched to individual clinical risk.

PIFU PATIENT INITIATED FOLLOW-UP
Patient contacts the service when they need further support.

SOS SUPPORTED OPEN ACCESS
Open access for advice, assessment or treatment when required.

SUPPORTED DISCHARGE
Discharge once ongoing specialist follow-up is no longer required.

DIGITAL COMMUNICATION & MONITORING
Letters • SMS • Patient Portal • Virtual Review • Remote Monitoring
Providing information, advice and support in the most appropriate way.

PATIENT LIVING WELL
Supported to stay well with clear safety-netting and routes back into care when needed.

OPERATING PRINCIPLES

1. **CLINICAL VALUE FIRST**
Follow-up provided only where it improves clinical outcomes.

2. **NATIONAL FOLLOW-UP CRITERIA**
Standardised application of national and specialty guidance.

3. **DEFAULT DISCHARGE**
Discharge becomes the default once specialist follow-up is no longer clinically required.

4. **PIFU & SOS**
Patients have the right to access care when they need it, not because the diary says so.

5. **RISK-BASED SURVEILLANCE**
Intensity and frequency of follow-up matched to clinical risk and need.

6. **DIGITAL COMMUNICATION**
Using digital channels to inform, support and monitor patients, reducing unnecessary appointments.

CLINICAL ASSURANCE

- National guidance and specialty protocols underpin decision making
- Clinical oversight and governance
- Clinical exception reporting
- Outcome monitoring and continuous quality improvement
- Safe, consistent and equitable care for every patient

BENEFITS OF THE SUSTAINABLE FOLLOW-UP MODEL

MORE CAPACITY FOR NEW PATIENTS
Releasing outpatient appointments for those who need them most.

REDUCED FOLLOW-UP WAITING LISTS
Fewer unnecessary appointments and shorter waits.

IMPROVED PATIENT EXPERIENCE
Timely access to support in a way that is convenient and appropriate.

BETTER CONSULTANT PRODUCTIVITY
Focus clinical time on patients who need specialist input the most.

SAFE, EFFECTIVE CARE IN THE RIGHT PLACE
Care provided closer to home where possible, with clear safety-netting.

SUSTAINABLE OUTPATIENT RECOVERY
Stopping demand recycling back into the system and sustaining capacity.

Our future operating model assumes follow-up becomes the exception rather than the default. Follow-up will increasingly be delivered through risk-based surveillance, patient-initiated follow-up, supported open access and digital communication, ensuring outpatient capacity is focused where it delivers the greatest clinical value.

1. Deloitte Outpatient Productivity Pack, May 2026

National Follow-Up Criteria and Default Discharge

Standardised follow-up criteria informed by national best practice

Better health
Better care
Better lives

National guidance requires Health Boards to implement default discharge, Patient Initiated Follow-Up (PIFU) or Supported Open Access (SOS) arrangements where clinically appropriate and to reduce follow-up backlog pressures.* Our plan sets out a consistent, specialty-led approach to ensure follow-up occurs only where it adds clinical value.

OUR FOLLOW-UP REFORM APPROACH

1 MANDATE NATIONAL FOLLOW-UP CRITERIA BY SPECIALTY

- Adopt national follow-up criteria and relevant guidance for all specialties.
- Ensure consistent application across all services.

2 SPECIALTY-LEVEL REVIEW OF EXISTING FOLLOW-UP LISTS

- Review current follow-up cohorts against national criteria.
- Identify patients no longer requiring routine follow-up.
- Prioritise based on clinical risk and waiting times.

3 VALIDATION LETTER EXERCISES

- Issue validation letters to patients.
- Confirm need for continued follow-up.
- Remove cases where no response indicates discharge is appropriate.

4 DEFAULT DISCHARGE WHERE CLINICALLY APPROPRIATE

- Discharge becomes the default once follow-up is no longer clinically required.
- Clear safety-netting and advice provided to patients.

5 PIFU OR SOS WHERE CLINICALLY INDICATED

- Offer Patient Initiated Follow-Up (PIFU) or Supported Open Access (SOS) for patients who may need future input.
- Patients access care when they need it, not because the diary says so.

6 EXCEPTION REPORTING WHERE CONTINUED FOLLOW-UP IS REQUIRED

- Clinicians record clear rationale for continued follow-up outside of standard criteria.
- Ensures clinical oversight and accountability.

7 ONGOING REVIEW AND MONITORING

- Regular review of follow-up activity and outcomes.
- Monitor use of PIFU, SOS and discharge rates by specialty.
- Report performance through governance arrangements.

OUR PRINCIPLE

Follow-up is a clinical decision, not a default process.

- Evidence-based follow-up
- Consistent application
- Right care, right time
- Safe discharge with easy routes back into care

HOW THIS REDUCES FOLLOW-UP BACKLOG PRESSURES

PREVENTS UNNECESSARY FOLLOW-UP

Patients discharged or managed via PIFU/SOS are removed from routine follow-up lists.

RELEASES CAPACITY

Reduces demand on clinics, diagnostics and administration, creating capacity for new patients.

SHORTENS WAITING TIMES

Focus on patients who need specialist follow-up most, improving flow and reducing waits.

IMPROVES PRODUCTIVITY

Less routine follow-up activity allows clinicians to prioritise complex care and new patients.

BETTER PATIENT EXPERIENCE

Patients empowered to self-manage and access care when needed, with clear support.

ENABLERS FOR SUCCESS

- Specialty leadership and clinical ownership
- National guidance and standardised criteria
- Digital systems to support discharge, PIFU and SOS
- Patient communication and engagement at the centre
- Data, reporting and governance oversight

OUR TARGET

Maximise the use of default discharge, PIFU and SOS across all specialties to reduce unwarranted follow-up and backlog pressures.

SUCCESS MEASURES

- Increased discharge rate
- Increased PIFU/SOS uptake
- Reduction in follow-up activity
- Reduced follow-up waiting lists
- Improved new patient capacity

Routine follow-up will become the exception rather than the default. We will follow national best practice to ensure patients only remain on our follow-up lists when it adds clinical value.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

PIFU, SOS and Patient Communication

Empowering patients to access the right care, at the right time, in the right way

Better health
Better care
Better lives

Our model is delivered safely by combining Patient Initiated Follow-Up (PIFU), Supported Open Access (SOS) and clear patient communication. Patients are empowered to manage their care, with easy access to advice and support when they need it, and clear escalation routes if their condition changes.

OUR MODEL IN PRACTICE

FIRST APPOINTMENT
Patient seen and management plan agreed.

FOLLOW-UP OPTION AGREED
Clinician and patient agree the most appropriate follow-up approach.

PIFU
PATIENT INITIATED FOLLOW-UP
Patient contacts us when they need further support.

SOS
SUPPORTED OPEN ACCESS
Pre-defined access to advice, assessment or treatment when required.

LIVING WELL
Patient supported to stay well, with clear advice and escalation routes if needed.

SAFETY NETTING AT EVERY STEP
Clear information, escalation routes and clinical oversight ensure patients are safe and supported.

SPECIALTY-LEVEL ROLLOUT

1. **SPECIALTY READINESS**
Specialties review criteria, letters and processes to confirm readiness.

2. **PILOT & REFINE**
Pilot in selected clinics, gather feedback, refine and standardise.

3. **STAGED ROLLOUT**
Roll out across specialties in priority order based on impact.

4. **MONITOR & IMPROVE**
Monitor uptake, outcomes and patient experience. Continuous improvement through data and feedback.

PATIENT COMMUNICATION

Clear, consistent messages in the right format and through the right channels

HYBRID MAIL
Personalised letters explaining the agreed follow-up approach, safety netting and how to get in touch.

SWANSEA BAY PATIENT PORTAL
View follow-up plan, access advice, request support and communicate securely with your care team.

NHS WALES APP
Access information, health advice, appointments and notifications on the go.

PATIENT INFORMATION
Easy to understand information about PIFU, SOS, when to contact us and how we will keep them safe.

SAFE ACCESS WHEN PATIENTS NEED IT

SOS ESCALATION ROUTES

Patient contacts us via agreed route → Triage by clinical team → Advice, assessment or treatment as clinically indicated → Return to PIFU or Living Well

PATIENT SAFETY NETTING

- Clear information on warning signs and when to seek help
- 24/7 advice where appropriate
- Easy routes to escalate concerns
- Clinical oversight and audit of outcomes

WHAT PATIENTS TELL US THEY VALUE

- Knowing how and when to get help
- Not having routine appointments they don't need
- Easy access to advice and support
- Clear information in the format they prefer

BENEFITS OF PIFU, SOS AND EFFECTIVE COMMUNICATION

EMPOWERS PATIENTS
Patients are in control of their care and access support when they need it.

REDUCES UNNECESSARY APPOINTMENTS
Less routine follow-up releases capacity.

FASTER ACCESS
Patients who need specialist input are seen sooner.

SAFE AND SUSTAINABLE
Robust safety netting and escalation routes ensure patients remain safe.

BETTER EXPERIENCE
Convenient, flexible and clear communication in the way patients choose.

MORE CAPACITY
Capacity released supports treatment, diagnostics and new patient demand.

We will use PIFU, SOS and effective communication to ensure follow-up only happens where it adds clinical value, supporting patients to live well while releasing capacity for those who need it most.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

Supporting Patients to Wait Well and Live Well

Transforming waiting time into an opportunity to improve health, prepare for treatment and support long-term wellbeing

Better health
Better care
Better lives

Our ambition is to move from routine hospital follow-up to proactive patient partnership. Through risk-based surveillance, our Waiting Well programme and supported self-management, **we help patients remain well, prepare for treatment and rapidly access care if needed.**

- Right follow-up for the right patients
- Empowered patients and self-management
- Better outcomes and improved experience
- Sustainable care and reduced future demand

1. RISK-BASED SURVEILLANCE

Focused follow-up for patients who genuinely need it.

- Aligned to national surveillance guidance and best practice
- High-risk patient cohorts identified
- Clinically determined review intervals
- Consultant oversight and governance
- Regular review of criteria to reduce over-surveillance

Ensure specialist time is targeted where it is needed most.

2. WAITING WELL

Proactive support from the point patients join the waiting list.

- Swansea Bay Waiting Well Service
- Digital health assessment
- Personalised lifestyle conversations and support
- Weight management guidance and resources
- Single Point of Contact (SPOC)
- Signposting to local and national support services

Promote • Prevent • Prepare – helping patients feel informed, confident and supported while they wait.

OUR FUTURE OPERATING MODEL

Supporting patients throughout their waiting journey

3. LIVING WELL

Supporting patients to stay well and manage their health.

- Self-management education and resources
- Healthy weight and nutrition
- Physical activity and recovery
- Smoking cessation support
- Mental wellbeing support
- Signposting to community, voluntary and third-sector services
- Long-term condition support

Helping patients live well beyond routine hospital care.

4. RAPID RE-ACCESS

Easy and timely access if needs change.

- Patient Initiated Follow-Up (PIFU)
- See on Symptom (SOS)
- NHS Wales App
- Swansea Bay Patient Portal
- Virtual advice and triage where appropriate

Patients know how to get help quickly without routine appointments.

FUTURE OPPORTUNITY

FUTURE DEVELOPMENT

REGIONAL DIGITAL WAITING WELL PROGRAMME

Working with Hywel Dda UHB and the National 3Ps Programme to develop a regional eight-week digital prehabilitation programme.

Potential components:

- Exercise and physical activity
- Nutrition and healthy weight
- Psychological wellbeing
- Preparing for surgery
- Repeatable throughout the patient journey
- Scalable across South West Wales

Building on existing 3Ps content to provide consistent, prevention-focused support across our region.

THE BENEFITS FOR PATIENTS AND OUR SYSTEM

- Improved patient experience and satisfaction
- Better prepared for treatment and recovery
- Reduced deterioration and complications while waiting
- Greater self-management, confidence and health literacy
- Reduced unnecessary follow-up and clinic appointments
- Better clinical outcomes and more sustainable planned care

Swansea Bay will transform waiting time into preparation time—using every interaction as an opportunity to promote health, prevent deterioration and empower patients to remain well. This supports better outcomes, a more sustainable planned care system and our ambition to deliver person-centred care.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

Digital Enablers to Support Sustainable Follow-Up

Bringing our patient-facing digital offer together to improve access, experience and outcomes

Better health
Better care
Better lives

Our digital tools make it easier for patients to get the right information and support, when and where they need it. They underpin our follow-up reform by enabling Patient Initiated Follow-Up (PIFU), See on Symptom (SOS) and default discharge to be delivered safely and at scale.

- Put patients in control
- Faster communication
- Less admin and delay
- Safe, effective and sustainable

1 NHS WALES APP

One secure access point for patients

- Access to information, appointments, prescriptions and messages on the go
- Push notifications and reminders
- Supports PIFU, SOS and default discharge pathways
- Promotes self-management and early help seeking

Driving adoption to make digital access the default choice for patients.

2 SWANSEA BAY PATIENT PORTAL

Your follow-up, your way

- View follow-up plan and care information
- Secure messaging with care team
- Request advice or provide updates
- Access to letters, results and advice
- Supports PIFU, SOS and default discharge

Improving visibility and engagement, reducing phone calls and clinic contacts.

3 HYBRID MAIL

The right information, the right way

Print + Digital = Patient choice

- Personalised letters printed and sent
- Digital copy by SMS or email (where patient consents)
- Faster, more reliable communication
- Reduces postal delays, returns and admin
- Supports PIFU, SOS and default discharge

Faster, more consistent communication that patients value and act on.

4 VIRTUAL CONSULTATIONS

Care without the journey, where appropriate

- Video or telephone consultations
- Suitable for many follow-up and advice appointments
- Improves access and convenience
- Supports PIFU, SOS and default discharge
- Reduces DNA and unnecessary visits

Delivering the right care, in the right place for patients.

IMPACT OF OUR DIGITAL ENABLERS

EMPOWER PATIENTS
Patients can access care, information and support when they need it.

FASTER COMMUNICATION
Timely information, reminders and responses help patients take action sooner.

REDUCED ADMIN & DELAY
Lower postal workload, fewer calls and less manual processing for staff.

SUPPORTS FOLLOW-UP REFORM
Enables PIFU, SOS, default discharge and living well with safe escalation routes.

BETTER OUTCOMES
Early help seeking, improved experience and reduced unnecessary appointments.

OUR INVESTMENT IN DIGITAL ENABLERS

These digital enablers are core to our follow-up reform and productivity ambition.

VIRTUAL CONSULTATIONS
Indicative recurrent cost:
£60k per annum

CURRENT CONTRACT
Circa **£32k** including VAT

FOUNDATIONS FOR SUCCESS

- Patient digital inclusion support
- Information governance & data security
- Staff training and digital confidence
- Integrated systems and data sharing
- Continuous measurement and improvement

Digital access, clear communication and virtual care are central to delivering sustainable follow-up.
They help our patients stay well, access the right care when needed and free capacity for those who need it most.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

Transformative Enablers

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Pre-Surgical Optimisation
Swansea Bay Transformation Model

Preparing the Right Patient,
in the Right Place,
at the Right Time.

Un Bae Ar y Cyd
One Bay Way

Pre-Surgical Optimisation Programme

An integrated investment to improve patient outcomes, reduce cancellations and maximise surgical productivity

Better health
Better care
Better lives

Investing across our pre-surgical optimisation pathway enables earlier identification, proactive optimisation and the right intervention for every patient – ensuring they are ready for surgery at the right time, in the right place, by the right team.

OUR INTEGRATED PRE-SURGICAL OPTIMISATION MODEL

iHSQ DIGITAL ASSESSMENT
- Early risk identification
- Digital questionnaires
- RAG stratification
- Determines pathway and priority

PREHABILITATION & OPTIMISATION
- Lifestyle & health optimisation
- Physical activity
- Nutrition & weight management
- Smoking cessation

POPS (FRAILTY & COMPLEX PATIENTS)
- Frailty assessment
- Co-morbidity optimisation
- Medication review
- Geriatric assessment
- Tailored optimisation plan

ANAESTHETIC OPTIMISATION
- Specialist anaesthetic assessment
- Optimisation of high-risk conditions
- Surgicol fitness & timing
- Early removal from waiting list where appropriate

OPIP (ALTERNATIVE TO SURGERY)
- Genicular nerve procedure
- Radiofrequency ablation
- Non-surgical pain management
- Avoids unnecessary surgery

BOOKING & VALIDATION
- Patient booking
- Clinical validation
- RTT compliance
- Pathway coordination
- Communication and governance

BOOKING • VALIDATION • PATHWAY COORDINATION
Ensuring the right patient is booked for surgery in the right place, at the right time

OPTIMISED PATIENT FOR SURGERY
Right Patient • Right Place • Right Time • Right Team

TOGETHER THESE INVESTMENTS WILL DELIVER

- Earlier identification of patients requiring optimisation
- Reduced day-of-surgery cancellations and avoidable delays
- More efficient use of theatre capacity
- Better patient outcomes and experience
- Reduced demand for surgery where clinically appropriate
- Sustainable planned care recovery through pathway transformation

PROGRAMME INVESTMENT

WORKSTREAM	PURPOSE	RESOURCE REQUIREMENT
iHSQ Digital Assessment	Early risk identification and proactive pathway management	Systems & implementation investment
Booking & Validation	Efficient booking, validation and pathway coordination	2.0 WTE Band 3
Prehabilitation & Optimisation	Improve patient fitness and readiness for surgery	4.4 WTE (3.0 WTE essential + 1.4 WTE development)
POPS (Frailty & Complex Patients)	Optimise frail and complex patients	6.5 WTE
Anaesthetic Optimisation	Specialist assessment and optimisation of high-risk patients	8.5 WTE
OPIP (Alternative to Surgery)	Provide non-surgical pain intervention where appropriate	3 DCC + Band 3 admin + consumables

TOTAL INVESTMENT ASK 21.4 WTE*
plus systems, implementation and consumables

*Includes WTE in Prehabilitation (3.0 essential + 1.4 development), POPS (6.5), Anaesthetic Optimisation (8.5), Booking & Validation (2.0)

Collectively, these investments establish a single, integrated pre-surgical optimisation model that prepares patients earlier, improves theatre productivity and delivers safer, more sustainable planned care across Swansea Bay.

The Optimised Surgical Pathway

Ensuring every patient is ready for surgery first time, every time

A whole-pathway approach that brings together digital assessment, clinical optimisation and operational readiness to ensure patients are prepared for surgery at the earliest opportunity, improving outcomes, reducing cancellations and maximising the productivity of every theatre session.

OUR END-TO-END PRE-SURGICAL OPTIMISATION PATHWAY

1 Referral Accepted for Surgery

- Accepted for surgery
- Appropriate pathway
- Clinical decision

2 Waiting List Validation

- Waiting list validation
- Patient choice
- Clinical review
- Pathway confirmation

3 Digital Risk Assessment (iHSQ)

- Digital questionnaires
- Risk identification
- Early optimisation
- Remote assessment

4 Risk Stratification

- Identify clinical risk
- Determine additional support needs
- Direct to appropriate interventions

5 Targeted Optimisation (where appropriate)

Prehabilitation

- Lifestyle optimisation
- Nutrition
- Exercise
- Smoking cessation
- Patient preparation

POPS Assessment (where appropriate)

- Frailty assessment
- Co-morbidity optimisation
- Medicines review
- Geriatric assessment

6 Anaesthetic Review

- Fitness for surgery
- Shared decision-making
- Final optimisation
- Theatre readiness

7 Optimised for Surgery

- Optimised and ready
- All risks managed
- Fit for surgery
- Ready for theatre

8 Enhanced Recovery

- Faster recovery
- Reduced length of stay
- Better outcomes
- Patient empowered

CORE COMPONENTS THAT ENABLE SUCCESS

DIGITAL ENABLEMENT

- iHSQ digital assessments
- ProMAPP and digital tools
- Electronic workflow
- Integrated systems and data

CLINICAL OPTIMISATION

- Prehabilitation and lifestyle support
- POPS and frailty assessment
- Anaesthetic optimisation
- Medicines review and management
- Shared decision-making

OPERATIONAL READINESS

- Validation and pathway management
- Booking and scheduling
- Theatre coordination and planning
- Continuous monitoring
- Escalation and governance

THIS PATHWAY IS UNDERPINNED BY

- Clinical Leadership
- Patient Engagement
- Data Intelligence
- Continuous Improvement

EXPECTED OUTCOMES

- **Fewer day-of-surgery cancellations** — Patients optimised before theatre
- **Improved theatre utilisation** — More efficient use of existing capacity
- **Better patient outcomes** — Safer care and improved results
- **Faster recovery and discharge** — Reduced length of stay and complications
- **Increased day case surgery** — More care delivered closer to home
- **Sustainable productivity** — Better use of resources and reduced waste

By optimising patients before admission rather than reacting on the day of surgery, Swansea Bay will improve patient outcomes, reduce avoidable cancellations and maximise the productivity of every theatre session.

Better Health | Better Care | Better Lives

iHSQ in Action: Transforming Pre-Surgical Care

Intelligent digital risk assessment driving earlier optimisation and better outcomes

iHSQ Intelligent Health Screening Questionnaire

iHSQ intelligently screens and stratifies risk, enabling targeted optimisation and proactive intervention before surgery. This leads to better prepared patients, fewer delays and improved outcomes.

THE PATIENT JOURNEY

Listed for Surgery
Patient added to waiting list

→

Digital iHSQ Assessment
Patient completes questionnaire online or via app

→

Intelligent Risk Assessment
AI-powered risk stratification (95%+ accuracy)

→

Personalised Intervention
Targeted optimisation based on individual risk and needs

→

Ready for Surgery
Optimised patient, better outcomes and fewer delays

Continuous monitoring and support throughout the pathway

RISK STRATIFICATION (RAG)

LOW RISK
- Low risk identified
- Standard care pathway
- Routine monitoring

MODERATE RISK
- Some risk factors
- Targeted optimisation
- Specialist support as needed

HIGH RISK
- Multiple / complex risks
- Intensive optimisation
- Multi-disciplinary intervention

Right patient, right care, right time

AREA OF OPTIMISATION

MEASURABLE IMPACT IN SWANSEA BAY

3,564	81%	1,176	700+	475	55%	95%+
Patients Monitored	Patient Compliance	Physiotherapy Referrals	Medical Optimisation Prompts	Smoking Cessation Referrals	Maintained or Improved Mobility	Risk Stratification Accuracy

BEFORE AND AFTER: GENERAL SURGERY (OVER-65s)

BEFORE iHSQ & OPTIMISATION — >1,000 patients waiting

~90% REDUCTION

AFTER 12 MONTHS — ~100 patients waiting

KEY OPERATIONAL BENEFITS

- **Continuous Monitoring** Ongoing patient engagement and progress tracking
- **Proactive Intervention** Early identification and timely action on risks
- **Better Preparation** Patients optimised for surgery earlier in their pathway
- **Fewer Delays** Reduced risk of day-of-surgery cancellations and postponements
- **Personalised Care** Tailored support to individual needs and circumstances
- **Improved Outcomes** Better recovery, fewer complications and higher satisfaction

Winner of the NHS Wales Award for Value Based Healthcare in the Elective Care category (2025)
Recognising innovation that delivers measurable benefits for patients and the healthcare system.

> *iHSQ has revolutionised how we prepare patients for surgery. By identifying risks early and intervening sooner, we are seeing real improvements in outcomes and efficiency across our services.*
>
> – Swansea Bay Clinical Team

WHY IT MATTERS

Smarter screening	Targeted care	Earlier action	Better outcomes
Identifies risks accurately	Right support for the right patients	Intervene early, not react late	Improved results for patients

iHSQ is a key enabler of our Optimised Surgical Pathway, helping us deliver safer care, reduce waiting lists and maximise the productivity of every theatre session.

Better Prepared Patients | Fewer Cancellations and Delays | Improved Outcomes | Maximised Theatre Productivity

Prehabilitation & Patient Optimisation

Expanding multidisciplitiony support to improve patient readiness for surgery

Better health
Better care
Better lives

Investing in prehabilitation and optimisation enables more patients to arrive fit for surgery, reducing avoidable delays, late cancellations and complications, improving outcomes and maximising the productivity of our surgical capacity.

CURRENT POSITION

The current Prehabilitation service supports patients awaiting hip and knee replacement who are affected by obesity, frailty or reduced mobility.

Working alongside the iHSQ digital pathway and POPS, the service identifies patients who require optimisation before surgery.

Patients across other planned care specialties do not have equal access to structured prehabilitation support, limiting earlier intervention, increasing variation and contributing to avoidable delays and cancellations.

INVESTMENT PROPOSAL

Extend our successful Prehabilitation service to all eight planned care specialties to deliver equitable access to multidisciplinary optimisation support.

This will improve patient readiness, reduce avoidable delays and maximise theatre productivity across all surgical pathways.

ADDITIONAL AHP SUPPORT ENABLED BY EXPANSION

- Specialist AHP management of patients with high BMI outside of specific surgery guidelines (up to 15% of lists)
- AHP support for frailty patients requiring domiciliary visits
- AHP support for low mobility or sedentary waiting list patients (up to 25% of lists)

WHY INVESTMENT IS REQUIRED

- Earlier identification of patients requiring optimisation
- Targeted intervention for obesity, frailty and long-term conditions
- Improved preparation for surgery across all specialties
- Reduced late cancellations and day-of-surgery deferrals
- Better utilisation of theatre capacity
- Improved patient outcomes and experience

WORKFORCE REQUIREMENT

ESSENTIAL PACKAGE		
Band 6 Dietitian	Deliver and support all obesity assessments and management	1.0 WTE
Band 4 Therapy Practitioner	Deliver and support patient education workshops and exercise classes	1.0 WTE
Band 3 Pathway Support (Digital/iHSQ)	Non-digital support to guide and manage patients onto the iHSQ digital platform	1.0 WTE
ESSENTIAL PACKAGE TOTAL		**3.0 WTE**

ADDITIONAL DEVELOPMENT CAPACITY (REQUIRES ESSENTIAL PACKAGE)		
GP Sessions (2 sessions/week)	Medical optimisation of identified patients with specific comorbidities (e.g. hypertension, anaemia, T2DM)	0.2 WTE
Band 8a Team Lead	Line management of the extended prehabilitation workforce	0.5 WTE
Band 8a Psychologist	Support obesity patients with complex mental health needs	0.2 WTE
Band 6 Occupational Therapist	Early planning for patients with complex discharge needs	0.5 WTE
ADDITIONAL CAPACITY TOTAL		**1.4 WTE**

TOTAL RESOURCE ASK (3.0 WTE Essential + 1.4 WTE Additional Development Capacity) **4.4 WTE**

EXPECTED BENEFITS

- More patients fit for surgery
- Fewer cancellations and delays
- Reduced complications and readmissions
- Improved patient experience
- Reinforces equity across all specialties
- Sustainable elective care recovery

This investment creates a consistent, multidisciplinary prehabilitation model across all planned care specialties, supporting earlier optimisation, better outcomes and sustainable use of existing surgical capacity.

POPS, Frailty & Complex Patient Pathways

Delivering safer surgery for frail and complex patients through multidisciplinary peri-operative care

Better health
Better care
Better lives

Swansea Bay will introduce and scale a comprehensive POPS model for patients undergoing intermediate, complex and complex-plus surgery, ensuring earlier identification of frailty, proactive optimisation and delivery of care in the most appropriate surgical setting.
This supports the Board commitment to implement POPS for all eligible patients by October 2026.

POPS PATHWAY: EARLIER IDENTIFICATION → BETTER DECISIONS → BETTER OUTCOMES

1. ELECTIVE SURGICAL REFERRAL

Patients referred for intermediate, complex or complex-plus surgery

2. FRAILTY SCREENING

- Early frailty identification
- Clinical risk stratification

3. COMPREHENSIVE GERIATRIC ASSESSMENT (POPS)

- Medical optimisation
- Medication review
- Functional assessment
- Shared decision-making

4. INDIVIDUALISED PERI-OPERATIVE PLAN

- Optimise
- Proceed
- Delay for optimisation
- Alternative treatment where appropriate

5. RIGHT PATIENT RIGHT SITE RIGHT SUPPORT

Care delivered in the most appropriate surgical setting with the right peri-operative support in place

WHY INVEST?

- Existing POPS model already established within Swansea Bay.
- Local evidence demonstrates significant impact on patient flow and outcomes.
- Reduces over-65s on general surgical pathways from over 1,000 to ~100 in the last 12 months.
- 10–20% of elective surgical patients are frail and likely to benefit from POPS review.
- Improved peri-operative optimisation, outcomes and patient experience.
- More efficient use of theatre capacity and time.

WHO WILL BENEFIT?

- Older adults
- Patients living with frailty
- Multiple long-term conditions
- Polypharmacy
- Intermediate, complex and complex-plus surgery

Approximately **10–20%** of elective surgical waiting list patients are expected to benefit from POPS assessment before surgery.

KEY BENEFITS

- Earlier frailty identification
- Better shared decision-making
- Improved peri-operative optimisation
- Fewer cancellations and complications
- Improved theatre productivity
- Better patient outcomes

WHERE CARE WILL BE DELIVERED

Following POPS assessment, patients will be allocated to the most appropriate surgical site according to clinical need, procedure complexity and peri-operative support requirements.

- Morriston Hospital
- Neath Port Talbot Hospital
- Singleton Hospital

Ensuring patients receive care in the right place with the right expertise and support.

INITIAL IMPLEMENTATION RESOURCE (12-MONTH FIXED TERM)

Subject to Welsh Government non-recurrent funding

POPS EXPANSION

- **2.5 WTE Consultant Peri-operative Physicians (fixed term)**
  Specialist peri-operative medicine input for complex needs and frailty
- **2.0 WTE Band 6 Clinical Nurse Specialists (fixed term)**
  POPS assessment, coordination and patient optimisation
- **2.0 WTE Band 7 Advanced Practitioners (fixed term)**
  Advanced clinical assessment and peri-operative care planning

PURPOSE

Establish and scale the Swansea Bay POPS model for patients undergoing intermediate, complex and complex-plus surgery, embedding multidisciplinary peri-operative optimisation across planned care.

FUTURE DEVELOPMENT

Following evaluation of the initial implementation

- Expansion of peri-operative medicine capability
- Development of common regional POPS pathways
- Integration with digital risk assessment (iHSQ)
- Embedding within sustainable planned care pathways
- Longer term workforce requirements informed by benefits realised and future funding arrangements

STRATEGIC ALIGNMENT

POPS is a core component of our tiered patient optimisation model:

- iHSQ identifies risk early
- Prehabilitation supports optimisation for all patients
- POPS provides enhanced multidisciplinary peri-operative care for the highest-risk 10–20%

The workforce requirements presented within this plan align with the enabling investment identified within the Interim Recovery Plan. Initial 12-month fixed-term implementation resource will establish and embed the expanded POPS model, with longer-term workforce requirements informed by evaluation of benefits realised and future service sustainability.

Working together to deliver safer surgery, better outcomes and sustainable planned care.

Booking, Validation & Pathway Coordination

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Operational coordination underpinning the pre-surgical pathway

Dedicated operational teams ensure patients are identified, validated, booked and progressed efficiently through the pre-surgical pathway, maximising theatre productivity and ensuring RTT compliance.

1. BOOKING

- Coordinates patient appointments
- Patient communication and contact
- Pre-Assessment Clinic scheduling
- Manages iHSQ workflow and booking triggers
- Ensures RTT compliant booking and pathway management

RESOURCE
1.0 WTE Band 3
Pathway Coordinator

2. VALIDATION

- Validates waiting lists and clinical data
- Identifies and maintains patient cohorts
- Prioritises patients for optimisation
- Monitors pathway progression
- Provides reporting, assurance and data quality

RESOURCE
1.0 WTE Band 3
Validation Coordinator

3. PATHWAY COORDINATION

Coordinates patients and information across the pre-surgical pathway:

- iHSQ
- PRO-MAPP
- Pre-Assessment Clinic
- Prehabilitation
- POPS
- Anaesthetics
- Theatre Booking

Ensuring timely information flow, escalation management, patient communication and that each patient continues to progress safely through the pathway.

OPERATIONAL COORDINATION DELIVERS

- Accurate RTT management
- Early identification of optimisation needs
- Improved patient flow and experience
- Reduced late cancellations and deferrals
- Improved theatre productivity
- Appropriate allocation to Morriston, NPT and SGH

CARING for each other
WORKING TOGETHER for our patients
ALWAYS IMPROVING how we do things

Better health. Better care. Better lives.

Orthopaedic Pain Intervention Pathway (OPIP)

Reducing demand for surgery through evidence-based alternatives

Better health
Better care
Better lives

The Orthopaedic Pain Intervention Pathway provides anaesthetic-led pain interventions for carefully selected patients who have been assessed by Orthopaedics but are unsuitable for surgery because of frailty, significant co-morbidity or limited rehabilitation potential. This improves patient outcomes while reducing unnecessary demand on surgical capacity.

WHO BENEFITS?

- Patients already assessed by Orthopaedics
- Significant surgical risk
- Frailty
- Multiple long-term conditions
- High peri-operative risk
- Limited rehabilitation potential
- Primary symptom is pain from a single affected joint (knee, hip, shoulder or wrist)

Important

Patients remain under the care of the referring orthopaedic team. Patients with widespread pain or multiple joint pain are referred to the Persistent Pain Service via the usual pathway.*

* Referral criteria and pathway overview – OPP Persistent Pain

OUR PATHWAY: TARGETED ALTERNATIVE TO SURGERY

1. ORTHOPAEDIC ASSESSMENT
Patient assessed by orthopaedic surgeon and considered that surgery/ arthroplasty would be beneficial for treatment of pain.

2. NOT SUITABLE FOR SURGERY
- Frailty
- Significant co-morbidity
- High peri-operative risk
- Limited rehabilitation potential

3. REFERRAL TO OPIP
Referral via agreed pathway by orthopaedics team.

4. ANAESTHETIC-LED ASSESSMENT
Anaesthetic and pain medicine assessment including history, examination & appropriate risk assessment.

5. PAIN INTERVENTION
Genicular nerve procedures & radiofrequency ablations tailored to appropriate co-morbidities and pain interventions.

6. FOLLOW-UP & OUTCOME REVIEW
Structured follow-up and repeat intervention where appropriate.

Progression to radiofrequency or further / as selected patient needs.

Better pain control • Avoided surgery • Improved quality of life

KEY BENEFITS

- Better pain control and function
- Reduced demand for surgery
- Better use of orthopaedic capacity
- Improved patient experience and choice
- Fewer unnecessary procedures and risk
- Better value for the NHS and system

CLINICAL IMPACT

ONLY AROUND 5%
of patients assessed within OPIP subgroups* progress to surgical intervention.

Approximately 95% avoid surgery through an alternative evidence-based pathway.

ANAESTHETIC-LED GENICULAR NERVE SERVICE
Delivered through the Pain Management Service.

SUPPORTS PATIENTS
with significant co-morbidity and high peri-operative risk.

RELEASES MORRISTON CAPACITY
By providing effective alternatives to surgical intervention.

INITIAL IMPLEMENTATION RESOURCE (12-MONTH FIXED TERM)

Subject to Welsh Government non-recurrent funding

CLINICAL CAPACITY
- 3 DCC total (clinic capacity) (equivalent to ~15 five-hour sessions per month)
- Anaesthetic-led genicular nerve service
- Increased access to non-surgical pain interventions

ADMINISTRATIVE SUPPORT
- Band 3 Administrative (fixed term) 7.5 hours per week (0.2 WTE)
- Waiting list management & referral triage
- Booking, scheduling & outcome monitoring
- Pathway governance

PURPOSE OF INVESTMENT

Expand the Orthopaedic Pain Intervention Pathway to provide timely access to evidence-based alternatives to surgery, reducing demand on orthopaedics outpatients, theatre and inpatient capacity whilst improving outcomes for patients who are unlikely to benefit from operative intervention.

HIGH VALUE, LOW COST

A relatively modest investment in specialist clinical sessions and pathway administration enables:
- Earlier intervention
- Reduced surgical demand
- Better patient experience
- More efficient use of orthopaedic capacity

OPIP is an integral component of our planned care strategy – delivering safe, effective alternatives to surgery for the patients who are unlikely to benefit from operative intervention, while releasing capacity for those who will.

Helping us deliver better outcomes, better value and a more sustainable planned care system.

Specialist Clinical Workforce to Deliver the Pre-Surgical Pathway

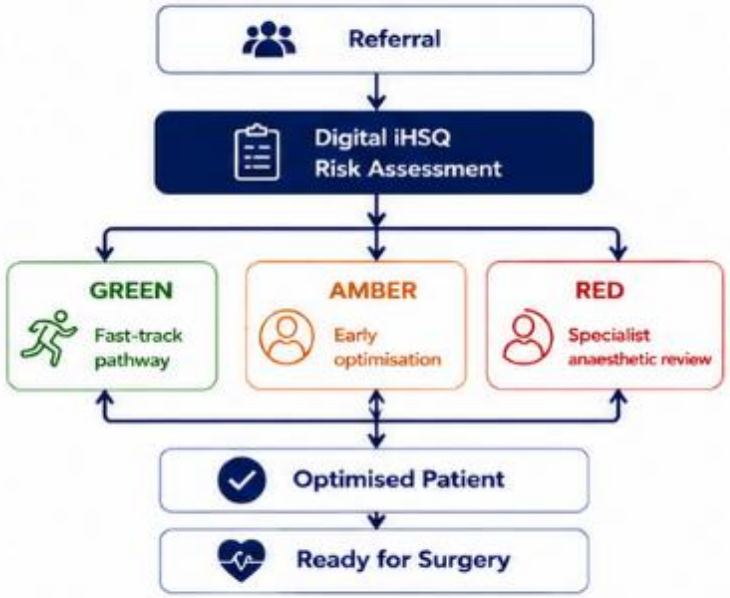
Better health
Better care
Better lives

Providing the specialist expertise required to deliver early optimisation, reduce cancellations and sustain elective recovery.

The rollout of iHSQ enables early identification of higher-risk patients. Delivering the benefits of this digital pathway requires specialist clinical capacity to assess, optimise and prepare patients before surgery, reducing cancellations, improving outcomes and supporting sustainable elective recovery.

Early optimisation | Clinical leadership | Better outcomes | Reduced delays | Sustainable recovery

THE PRE-SURGICAL PATHWAY



CLINICAL WORKFORCE TO ENABLE THE PATHWAY

1. SPECIALIST CLINICAL ASSESSMENT

Consultant Anaesthetists

- Assessment of higher-risk patients identified through iHSQ
- Senior anaesthetic review and clinical decision making
- Determining surgical fitness and timing
- Supporting patient optimisation before surgery
- Reducing avoidable day-of-surgery cancellations

RESOURCE REQUIREMENT

4–5 consultant assessment clinics per week

2. CLINICAL OPTIMISATION

Band 6 Specialist Nurse

- Clinically screen Red patients identified through iHSQ
- Coordinate referral to optimisation pathways
- Refer patients to specialist services (e.g. diabetes, cardiology, immunotherapy)
- Monitor patients whilst awaiting surgery to ensure optimisation is achieved

RESOURCE REQUIREMENT

0.2 WTE Band 6

(delivered across two experienced nurses for resilience and leave cover)

3. CLINICAL LEADERSHIP & GOVERNANCE

Consultant Clinical Leadership

- Leadership of iHSQ implementation
- Clinical pathway design, mapping and RAG validation
- Dashboard development and data review
- Governance, oversight and quality assurance
- Continuous improvement and pathway development

RESOURCE REQUIREMENT

- **2 consultant PAs per week iHSQ implementation and clinical leadership**
- **1 consultant session per week Pre-surgical clinical oversight and governance**

4. PATHWAY COORDINATION

PAC Administration

- Administrative support for referrals and investigations
- Pathway coordination and patient communication
- Pre-assessment governance and oversight
- Supporting referrals, investigations and optimisation activity generated through the pathway
- Paediatric pre-assessment pathway support

RESOURCE REQUIREMENT

- **0.4 WTE PAC administrative support**
- **1 paediatric anaesthetic session per fortnight**

BENEFITS FOR PATIENTS

- ✓ Earlier identification and optimisation
- ✓ Fewer delays and cancellations
- ✓ Reduced complications
- ✓ Better surgical outcomes
- ✓ Improved experience and confidence

BENEFITS FOR SERVICES

- ✓ Reduced repeat pre-assessment
- ✓ Improved theatre utilisation
- ✓ Reduced wasted appointments
- ✓ More efficient use of consultant time
- ✓ Sustainable 104-week delivery

BENEFITS FOR THE SYSTEM

- ✓ Reduced length of stay
- ✓ Fewer complications and readmissions
- ✓ Better use of critical care capacity
- ✓ Improved overall elective flow
- ✓ Better value and productivity

FUTURE SPECIALIST OPTIMISATION

Further work will quantify the specialist optimisation capacity required following rollout of iHSQ, including diabetes, cardiology, immunotherapy and other specialist services receiving referrals through the pathway.

GUIDING PRINCIPLE

Patients are monitored and optimised whilst they wait, entering formal pre-assessment **only when surgery is likely within the next 3–6 months.**

Digital transformation identifies the right patients. Specialist clinical expertise ensures they are optimised at the right time, maximising theatre productivity whilst improving patient outcomes.

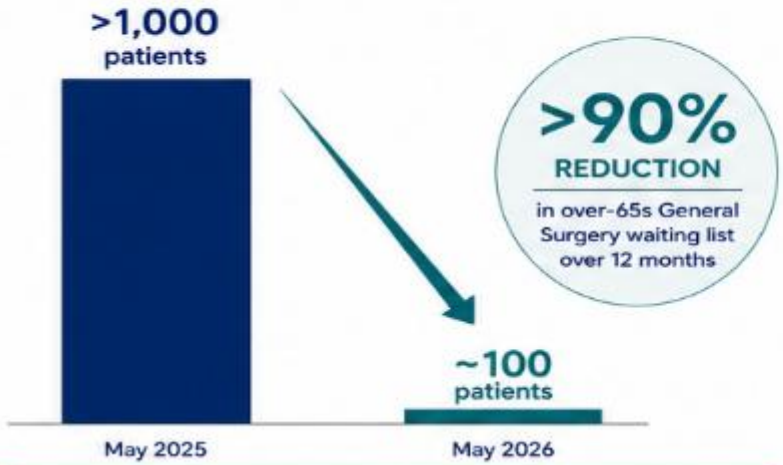
Proof That Our Model Works

General Surgery (Over-65s) – *A blueprint for sustainable planned care*

>90%
REDUCTION
in over-65s General Surgery waiting list over 12 months

The integration of digital assessment, validation, POPS, pathway redesign and site streaming has transformed the General Surgery pathway for patients aged over 65, reducing the waiting list from over 1,000 to approximately 100 over the last 12 months.

OVER-65s GENERAL SURGERY WAITING LIST



>90%
REDUCTION
in over-65s General Surgery waiting list over 12 months

Achieved within existing capacity through pathway redesign and patient optimisation, not additional surgical capacity.

WHAT CHANGED?

- **Validation** – Rigorous validation and clinical review to ensure the right patients remain on the waiting list.
- **Digital Pre-Surgical Assessment (iHSQ)** – Digital questionnaires and risk assessment to identify needs early and stratify patients.
- **POPS** – Targeted assessment and optimisation for older and frail patients.
- **Site Streaming** – Patients directed to the most appropriate site to improve efficiency and reduce delays.
- **Clinical Pathway Redesign** – Standardised pathways, reduced unwarranted variation and improved end-to-end flow.

Optimised Patient Flow
Shorter waits, fewer delays, better outcomes.

WHY IT WORKED – KEY SUCCESS FACTORS

- **Clinical leadership** – Strong clinical engagement and ownership.
- **Digital enablement** – iHSQ and digital tools providing data and insights.
- **Multidisciplinary working** – Integrated approach across surgery, anaesthetics, geriatric medicine, nursing and therapy.
- **Earlier optimisation** – Intervening sooner to improve fitness for surgery.
- **Continuous validation** – Regular review to keep waiting lists accurate and clinically appropriate.
- **Standardised pathways** – Consistent processes and reduced unwarranted variation across sites.

WHAT THIS HAS DELIVERED

- **Waiting list reduced** – From over 1,000 to approximately 100 patients.
- **Better patient optimisation** – Patients better prepared for surgery, with risks identified and managed early.
- **Improved flow** – Faster progression through the pathway with fewer bottlenecks.
- **Reduced delays** – Fewer long waits and shorter time from listing to treatment.
- **Better theatre utilisation** – More efficient use of existing operating capacity.
- **Better patient outcomes** – Improved experience, fewer cancellations and complications.

THIS DEMONSTRATES THAT...

- Pathway redesign delivers sustainable improvement.
- Optimisation can reduce demand before additional capacity is commissioned.
- Digital and clinical transformation work best when implemented together.
- The model is transferable to other specialties and patient groups.

A MODEL FOR SCALE

We will now apply this proven model across:

- Orthopaedics
- Urology
- Gynaecology
- ENT
- General Surgery
- Other elective specialties

This pathway demonstrates that sustainable improvements in planned care are achieved not through additional operating capacity alone, but through redesigning pathways, optimising patients and improving flow across the whole system.

Better Prepared Patients | Better Outcomes | Maximised Productivity

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Regional Elective Care System

From Local Recovery to Regional Operating Model

Un Bae Ar y Cyd
One Bay Way

Regional Planning Principles

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

The Health Board's approach to regional planned care recovery is aligned to the emerging South West Wales **Regional Planning Principles.**

Regional Planning Principle	How reflected within this Recovery Delivery Plan
1 **Population Benefit First**	Recovery proposals prioritise **improving access and reducing waits for the South West Wales population** rather than organisational boundaries.
2 **Patients Should Wait Less Because We Work Together**	Regional opportunities have been identified for **arthroplasty, cataracts, diagnostics and workforce collaboration** where these will improve patient access.
3 **Capacity Should Be Used Before New Capacity Is Created**	The Plan demonstrates a clear **"productivity before investment"** approach, maximising existing regional theatre, diagnostic and workforce capacity before seeking additional funding.
4 **Clinical Quality and Outcomes Must Be Maintained or Improved**	Regional proposals will only be progressed where **clinical quality, patient experience, governance and outcomes** are maintained or enhanced.
5 **Mutual Benefit, Pace and Sustainability**	Regional solutions will be implemented where they provide **reciprocal benefit,** can be **delivered at pace** and contribute to the **long-term resilience and sustainability** of planned care services.

These principles provide the **strategic framework for regional recovery planning** and demonstrate a shared **commitment to improving patient access** through collaboration, productivity and sustainable service redesign across South West Wales.

Regional Recovery Workstreams

We are working with Hywel Dda Univesity Healt Healtn Board to develop regional solutions where these improve patient access and represent better value than individual approaches. Local productivity remains the first priority.

Mutual Regional Support: Swansea Bay and Hywel Dda are working together to provide reciprocal regional capacity where this delivers greater benefit for patients. This includes **Swansea Bay supporting Hywel Dda's orthopaedic recovery** through regional arthroplasty capacity, whilst **Hywel Dda will provide regional hand surgery capacity** for Swansea Bay. Investment requirements are reflected within the respective Health Board submissions.

	ORTHOPAEDICS	OPHTHALMOLOGY (CATARACTS)	DIAGNOSTICS
Current Position	Significant orthopaedic backlog remains despite ongoing local recovery actions and productivity improvements.	Significant regional cataract backlog requiring accelerated recovery to achieve equitable waits across both organisations.	Both organisations experiencing similar demand and capacity pressures across key diagnostic modalities.
Emerging Regional Approach	• Reciprocal regional capacity model, with Swansea Bay supporting Hywel Dda through arthroplasty capacity and Hywel Dda supporting Swansea Bay through hand surgery capacity. • Hywel Dda's proposal includes investment for regional arthroplasty capacity (182 patients), alongside local productivity and external capacity measures. • Further modelling is underway to confirm patient flows, operational arrangements and the impact on both organisations. Regional Capacity **182 patients** — Regional arthroplasty activity proposed within the Hywel Dda submission (funding requested by HDUHB).	• Hybrid model emerging as preferred: – utilise outsourcing arrangements (SpaMedica) to reduce backlog quickly – develop sustainable Regional Cataract Hub from April 2027. • Hybrid approach balances immediate backlog reduction with longer-term sustainability.	• Continue local recovery plans whilst exploring regional workforce, reporting and procurement opportunities where beneficial. • Further regional opportunities will be explored following completion of local recovery planning.
Key Dependencies	• Anaesthetic workforce • Theatre capacity • Clinical agreement • Impact of pooled waiting lists (future) • Implant / equipment compatibility • Mutual agreement of patient transfer and commissioning arrangements • Cross-Health Board governance and	• Pre-assessment capacity • Patient transport • OpenEyes / WPAS interoperability • Administrative support • Procurement arrangements	• Workforce shortages • Reporting capacity • Digital and IT interoperability • Similar pressures across both Health Boards • Future pooled list modelling (future)
Immediate Next Steps	• Agree regional operating model and governance • Finalise patient flow and referral arrangements • Support Hywel Dda to mobilise regional arthroplasty capacity • Complete operational and financial modelling	• Confirm preferred regional option • Understand existing national package (SpaMedica) • Complete financial modelling • Agree implementation plan and phasing	• Continue joint discussions • Identify regional opportunities • Align funding proposals where appropriate • Develop joint procurement options

Timescales

Further joint operational meetings with Hywel Dda are scheduled for next week to refine options, complete modelling and agree the final regional proposal for inclusion in the **31 July** submission to NHS Wales Performance & Improvement.

Developing a Sustainable South West Wales Elective Care System

Working together to deliver better outcomes for our population

Better health
Better care
Better lives

Neither Swansea Bay University Health Board nor Hywel Dda University Health Board can sustainably address every specialty challenge in isolation.
By working together as a system across South West Wales we will:

- Work as one system
- Use evidence to guide decisions
- Focus on our population
- Build resilient and sustainable services

WHY REGIONAL WORKING MATTERS

- Demand for elective care continues to grow across South West Wales.
- Specialist capacity and workforce are limited and cannot always be developed locally.
- By working together we can share capacity, reduce variation and improve access.
- Patients should wait less and receive high quality care wherever they live.
- Regional collaboration strengthens sustainability and makes best use of our collective resources.

OUR APPROACH: FROM LOCAL ASSESSMENT TO REGIONAL SOLUTIONS

1. LOCAL ASSESSMENT COMPLETED
Both Health Boards have completed detailed specialty demand and capacity assessments.

2. SHARED REGIONAL UNDERSTANDING
Initial comparison has identified common challenges and potential opportunities for collaboration.

3. COMBINED REGIONAL ASSESSMENT
We have agreed a common methodology to combine our models into a shared regional view.

4. EVIDENCE-BASED REGIONAL SOLUTIONS
The combined assessment will inform the most effective regional service and investment decisions by specialty.

OUR SHARED AMBITION

To create a South West Wales Elective Care System where patients benefit from:

- **Shorter waits** through increased capacity and better flow.
- **High quality care** delivered in the right place by the right team.
- **Resilient services** that can adapt to future demand and change.
- **Best use of resources** by reducing duplication and sharing expertise and technology.
- **Equitable access** for our whole population, now and in the future.

OUR COMMITMENT

We are committed to working in true partnership with Hywel Dda University Health Board to understand our combined demand and capacity, identify the best opportunities for collaboration and deliver sustainable elective care for the people of South West Wales.

Regional working is not about doing the same things together – it is about doing the right things together, for the right specialties, in the right way, for the benefit of our population.

Regional Demand & Capacity Assessment

Building a shared evidence base to inform sustainable regional service models

Better health
Better care
Better lives

Both Health Boards have completed local specialty demand and capacity assessments. Initial comparison demonstrates common challenges and potential opportunities for collaboration across South West Wales.
A combined regional demand and capacity assessment will now be completed to determine the most appropriate regional solutions by specialty.

Working together | Evidence led | Population focused | Stronger together

INITIAL REGIONAL ASSESSMENT

Specialty	Swansea Bay Position	Hywel Dda Position	Initial Regional Opportunity
Cataracts	Sustainability challenge	Sustainability challenge	Develop regional hub model
Orthopaedics	Sustainability challenge	Sustainability challenge	Existing regional programme
Gynaecology	Potential complementary capacity	Sustainability challenge	Assess regional support opportunities
Urology	Sustainability challenge	Sustainability challenge	Joint demand & capacity assessment
Radiology	Sustainability challenge	Sustainability challenge	Shared workforce and AI opportunities
Endoscopy	Sustainability challenge	Sustainability challenge	Regional productivity review
Dermatology	Sustainability challenge	Sustainability challenge	Workforce collaboration
Anaesthetics	Workforce constraint	Workforce constraint	Regional workforce planning
Special Care Dentistry (Adults & Paediatrics)	Sustainability challenge	Sustainability challenge	Continue regional service review & sustainability plan
DEXA Scanning	Sustainability challenge	Meets current demand	Assess long-term sustainability & capacity options

Potential complementary capacity | Shared pressure / challenge | Existing regional programme

AGREED REGIONAL METHODOLOGY

A common framework for demand, capacity, activity, workforce and productivity will be used to produce a combined regional view by specialty.

OUR COMMITMENT – DURING 2026/27 WE WILL JOINTLY:

- Complete a combined regional demand and capacity assessment.
- Quantify complementary capacity across South West Wales.
- Identify opportunities for shared service delivery and pooled capacity.
- Quantify residual regional investment requirements.
- Develop evidence-based regional service models.

Regional solutions will differ by specialty. The combined assessment will determine where existing capacity can be pooled, where regional hub models should be developed and where additional investment remains necessary.

Regional Delivery Priorities

Focused initial priorities with a pathway to develop future regional solutions

Better health
Better care
Better lives

Our regional priorities reflect the areas of greatest opportunity and impact. They have been informed by our initial regional assessment and will continue to evolve as the combined regional demand and capacity assessment identifies opportunities for collaborative delivery.

Working together

Evidence led

Population focused

Delivering sustainable services

IMMEDIATE REGIONAL DELIVERY PRIORITIES

Cataracts

Develop and expand the Swansea Bay Cataract Hub, working collaboratively across South West Wales to reduce waits and improve outcomes.

Orthopaedics

Continue to develop the regional orthopaedic programme (including NPTH) to increase capacity, reduce variation and improve patient experience.

These immediate priorities are already progressing through established regional programmes and will deliver early impact for our population.

DEVELOPING FUTURE REGIONAL SOLUTIONS

Informed by the combined regional demand and capacity assessment

Diagnostics

Develop regional diagnostic solutions across imaging, endoscopy and functional services to reduce waits and improve productivity.

Radiotherapy

Strengthen the South West Wales radiotherapy service model to ensure resilient and sustainable delivery for our population.

Digital

Maximise the benefits of digital solutions, AI and data to improve productivity, access and patient experience.

Workforce

Develop shared workforce solutions to address shortages, build resilience and support sustainable services.

Anaesthetics

Develop regional anaesthetic services and workforce models to improve resilience, support elective recovery and reduce variation in practice.

These priorities will continue to evolve as the combined regional assessment identifies opportunities to pool capacity, develop shared service models and quantify residual regional investment requirements in each specialty.

Our approach ensures that we focus on the right priorities now, whilst building the evidence base to design the most effective and sustainable regional solutions for the future.

[redacted]

Developing a Sustainable Elective Hub Strategy

Building the right infrastructure to deliver regional solutions now and in the future

Better health
Better care
Better lives

Our Elective Hub Strategy will enable us to deliver regional solutions that improve access, reduce waits and create sustainable capacity across South West Wales.

- Patients at the heart
- Working as one system
- Scalable and sustainable
- High quality and safe

OUR PHASED APPROACH

1 PHASE 1
Building our regional hub foundation (2026/27)

Swansea Bay Cataract Hub
Expanding regional cataract surgery to reduce waits and improve patient experience.

Regional Orthopaedic Hub (NPTH)
Continue to grow regional orthopaedic capacity and pathway integration.

Deliver early impact through established regional programmes.

2 PHASE 2
Expanding successful models across additional specialties (2027/28 – 2028/29)

Extend hub models to additional specialties
Diagnostics, endoscopy and other high volume pathways.

Develop shared service models
Build regional centres of excellence where collaboration improves sustainability.

Maximise productivity and digital enablement
Use data, AI and standardised pathways to optimise performance across hubs.

Scale regional delivery to create resilient capacity and reduce unwarranted variation.

3 PHASE 3
South West Wales Elective Care Network (2028/29 onwards)

Integrated elective care network
Fully integrated pathways and capacity across South West Wales.

Aligned governance and planning
Joint planning, prioritisation and resource allocation across the system.

Continuous improvement
Embedding innovation, quality improvement and patient-centred care.

Deliver a sustainable, system-wide model for the long term.

WHAT OUR HUB STRATEGY WILL DELIVER

Shorter waits
Increased capacity and better flow across the region.

Better outcomes
High quality, safe and consistent care for our population.

Better use of resources
Pooling capacity and expertise to reduce duplication and maximise value.

A stronger future
A resilient and sustainable elective care system for generations to come.

Our hub strategy will be informed by the combined regional demand and capacity assessment, ensuring we invest in the right services, in the right places, for the benefit of patients across South West Wales.

OUR COMMITMENT: Progress Phase 1 immediately, while building the evidence and partnerships needed to expand and evolve our hub models into a fully integrated South West Wales Elective Care Network.

Digital Transformation Portfolio

Digital technologies enabling productivity, pathway redesign and sustainable planned care recovery

Better health
Better care
Better lives

Digital investment is not presented as standalone technology. Each digital solution directly **enables pathway redesign, productivity improvement, patient empowerment or more effective use of clinical capacity**, supporting delivery of the **Sustainable Planned Care Recovery Plan.**

THE ELECTIVE CARE PATHWAY

1. **REFERRAL & DEMAND MANAGEMENT** — Right patient, right pathway, right time
2. **DIAGNOSTICS** — Timely and accurate investigations
3. **OUTPATIENTS & CLINICAL ASSESSMENT** — Efficient assessment and decision making
4. **TREATMENT** — Safe, effective treatment in the right setting
5. **FOLLOW-UP & LIVING WELL** — Right follow-up, the right way, when needed

Digital solutions span the entire elective care pathway

DIGITAL ELECTIVE CARE PLATFORM

Connecting patients, clinicians and services across the elective pathway

1. AI-ENABLED CLINICAL DECISION SUPPORT

- AI-enabled referral screening
- AI-supported letter validation
- Radiology AI

Supports demand management and clinical decision-making.

2. DIGITAL PATIENT EXPERIENCE

- NHS Wales App
- Swansea Bay Patient Portal
- Hybrid Mail
- Virtual Consultations

Giving patients easier access to information, appointments and advice.

3. DIGITAL TREATMENT PATHWAY

- iHSQ
- PRO-MAPP

Preparing patients for surgery through digital optimisation.

4. CLINICAL PRODUCTIVITY

- Ambient Voice Technology

Reducing administrative burden and increasing clinical productivity.

5. OPERATIONAL MANAGEMENT

- Theatre Management System

Improving scheduling, utilisation, productivity and operational visibility.

6. INTELLIGENCE & CONTINUOUS IMPROVEMENT

- Data integration
- Digital workflow
- Performance reporting
- Benefits realisation

Using real-time information to improve performance and support decision-making.

HOW DIGITAL ENABLES OUR THREE PILLARS

PILLAR 1 – PREVENT UNNECESSARY DEMAND

- AI-enabled referral screening
- Radiology AI
- AI-supported letter validation
- Digital diagnostics insight
- Referral optimisation and triage

PILLAR 2 – DELIVER TREATMENT MORE PRODUCTIVELY

- Theatre Management System
- Ambient Voice Technology
- iHSQ
- PRO-MAPP
- Operational intelligence and reporting

PILLAR 3 – PREVENT UNNECESSARY DEMAND RETURNING

- NHS Wales App
- Swansea Bay Patient Portal
- Hybrid Mail
- Virtual Consultations (PIFU/SOS support)
- Patient communication and self-management

BENEFITS OF OUR DIGITAL PORTFOLIO

- Better patient experience and empowerment
- Improved clinical productivity and capacity
- Reduced administrative burden
- Faster, easier communication
- Better operational intelligence and visibility
- Sustainable planned care recovery

Digital technology underpins every element of the Sustainable Planned Care Recovery Plan.
By connecting patients, clinicians and operational teams through a single digital ecosystem, Swanesa Bay will improve productivity, redesign pathways and create a more sustainable elective care service.

Right patient. Right time. Right care.
Keeping people well, supporting them to live well.

Clinical Administration Redesign Programme

A modern administrative operating model to maximise clinical productivity and reduce avoidable demand

We will fundamentally redesign the **clinical administration** function, moving from transactional administration towards proactive pathway management, ensuring every patient is on the right pathway, at the right point in time, with the right clinician. This programme will release clinical capacity, improve productivity and create the infrastructure required to sustain planned care recovery.

57,781 pathways to be validated

~11,557 pathways anticipated reduction

400 hours of validation, assurance & training per week

Improved productivity and sustainable **RTT compliance**

TRANSFORMING HOW WE WORK TO CREATE CAPACITY

RIGHT PATIENT > RIGHT PATHWAY > RIGHT TIME > CLINICAL CAPACITY RELEASED, REDUCED DEMAND, SUSTAINABLE PLANNED CARE

1 WAITING LIST INTELLIGENCE

- Health Board Validation Hub
- Digital patient validation
- RTT assurance
- Data quality improvement
- AI-enabled waiting list intelligence

OUTCOME
Accurate understanding of true demand

2 CLINICAL PATHWAY MANAGEMENT

- Consultant cohort validation
- PIFU expansion
- SOS pathways
- Standardised referral criteria
- Clinical discharge optimisation

OUTCOME
Reduced unnecessary outpatient demand

3 MODERN CLINICAL ADMINISTRATION

- Partial booking
- Clinic cashing-up
- Standard operating procedures
- Automation and digital tools
- Digital patient communications
- Administrative workflow redesign

OUTCOME
More efficient administrative processes supporting clinicians

4 WORKFORCE CAPABILITY

- RTT Academy
- Validation accreditation
- Standardiecomptcesses
- Cross-specialty workfiots
- Sustainable governance model

OUTCOME
A skilled workforce focused on pathway management rather than transactional administration

INVESTMENT REQUIREMENT

£704k

Investment to deliver digital validation, pathway redesign, RTT assurance, workforce capability and modern clinical administration.

KEY ENABLERS

- Digital transformation
- Strong clinical leadership
- Standardised processes
- Data quality and AI insights
- Robust governance and quality assurance

ENABLING ALL THREE WORKFORCE STRATEGY PILLARS

PILLAR 1 – REDUCE DEMAND
Reduces unnecessary referrals, follow-ups and administrative waste through validation, PIFU, SOS and pathway optimisation.

PILLAR 2 – MAXIMISE PRODUCTIVITY
Improves clinic utilisation, reduces DNAs, corrects RTT positions and frees clinical capacity to treat more patients.

PILLAR 3 – TRANSFORM WORKFORCE
Builds a skilled, empowered clinical administration workforce supported by digital tools, training, RTT assurance and modern processes.

Residual gap and investment case

Funding Requirements Summary

Our funding requirement reflects both the recurrent capacity gap associated with the traditional delivery model and the targeted transformational investment required to deliver a sustainable planned care system.

	2026/27			2027/28		
Area	Cases	£ Low	£ High	Cases	£ Low	£ High
Treatment	1,954	6,814,966	9,836,934	2,535	6,348,336	8,653,336
Diagnostics	35,735	6,092,739	6,092,739	32,692	8,642,614	8,642,614
Cancer	4,733	3,815,344	3,815,344	14,199	4,014,123	4,014,123
Outpatients	1,080	217,873	217,873	1,080	217,873	217,873
Community By Design	5,260	664,000	664,000	4,893	553,900	553,900
Pre-Surgical Optimisation		1,274,264	1,358,138		1,696,102	1,821,912
Administration		995,699	995,699		437,548	437,548
Professional Triage		75,464	75,464		75,464	75,464
Digital		61,815	61,815		79,223	79,223
Other		668,429	668,429		668,429	668,429
Total Cost	**48,762**	**20,680,593**	**23,786,434**	**55,399**	**22,733,612**	**25,164,422**

- Funding methodology agreed with Executive Team and Performance & Finance Committee.
- Combines investment required to close the underlying recurrent capacity gap with one-off transformational investment.
- Investment supports sustainable recovery rather than short-term activity alone.
- Transformation initiatives reduce future reliance on recurrent funding and improve long-term productivity – further work planned to understand how we robustly evidence these.

The funding ask should be considered as a single integrated investment proposition to deliver recovery, sustainability and transformation.

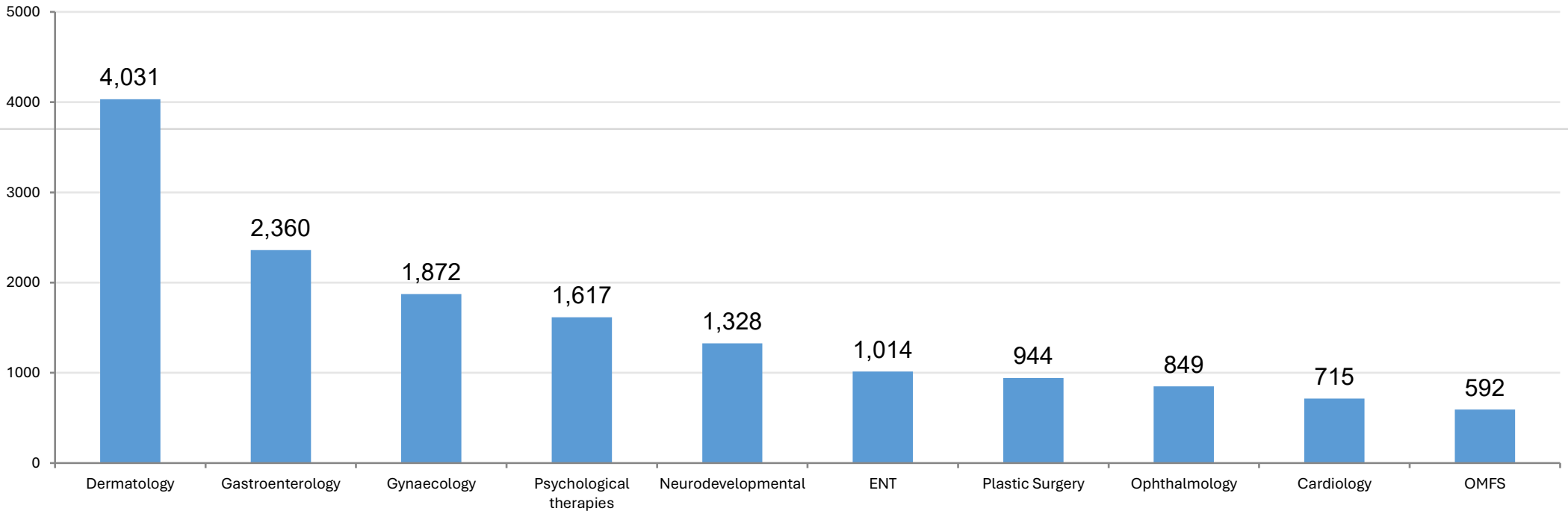
Outpatients: Achieving sustainable services

Latest demand and capacity control totals applied; focus is the recurrent new outpatient deficit and the 2026/27 breach exposure after known backlog requirements.

108,038	98,476	9,562	737	1,674	110,448	12,895
annual recurrent demand RoTT applied at 10%	annual recurrent capacity / activity	recurrent demand–capacity gap	USC backlog to meet 2-week component	backlog to meet 52 weeks	total 26/27 demand including backlog	52-week breaches expected assuming 100% Treat in Turn

Top 52-week breach exposure by specialty

Top 10 specialties account for the vast majority of the positive breach exposure before service-level offsets are applied.



Priority specialties: strategic opportunities

Specialty	Gap	Biomarker	STT/direct dx	N:F opp.	Main Opportunity
Dermatology	**3,598**	✗	✓	2,362	Telederm/dermoscopy/virtual skin pathway can replace F2F attendance
Gastroenterology	**2,275**	✓	✓	247	FIT/calprotectin/STT endoscopy/capsule can avoid or bypass OPA
Gynaecology	**1,857**	✓	✓	-721	CA125, ultrasound one-stop, hysteroscopy/biopsy, straight-to-CT
ENT	**1,014**	✗	△	345	Direct audiology and one-stop neck lump work are cohort-specific
Neurodevelopmental	**875**	✗	✗	147	Guidelines/digital/service model
Ophthalmology	**849**	✗	✓	-179	Community OCT/images/fields/pressures + virtual review can avoid OPA
Psychological therapies	**781**	✗	✗	0	Workforce/service model solution
Cardiology	**715**	✓	✓	890	NT-proBNP/community ECG/echo/CTCA can avoid or redirect referrals
Vascular	**378**	✗	✓	0	Vascular lab duplex/ABPI may replace some outpatient clinics
OMFS	**248**	✗	△	912	Mainly one-stop H&N / neck-lump pathway compression
Cleft	**23**	✗	✗	0	-
Plastic Surgery	**16**	✗	△	2,146	Selected skin lesion direct-to-procedure; avoid double counting

Outpatients: Achieving sustainable services: Prioritised approaches

Priority bridge candidates

- Dermatology – telederm / virtual skin lesion pathway
- Gastroenterology – FIT, calprotectin, STT endoscopy / capsule
- Gynaecology – CA125, ultrasound one-stop, hysteroscopy
- Cardiology – NT-proBNP, community ECG, echo / CTCA
- Ophthalmology – community OCT / virtual review
- Vascular – vascular lab / duplex / ABPI

Conditional or pathway compression

- ENT – direct audiology and selected one-stop neck-lump work
- General Surgery – only colorectal / upper-GI components
- Breast – triple assessment mainly compresses pathway
- OMFS / Plastic Surgery – selected H&N or skin lesion cohorts
- Spinal / T&O – MSK triage, not blanket direct imaging
- Thoracic – straight-to-CT; may increase diagnostic demand

Guidelines / service model or capacity

- Psychological Therapies – workforce / service model solution
- Neurodevelopmental – guideline / digital / capacity solution
- Special Care Dentistry – treatment capacity / regional solution
- Burns, Cleft – no issues
- Clinical Neurophysiology – STT ruse
- Urology – strong STT routes

Outpatients: Achieving sustainable services: Detail by specialty I

Main speciality	Annual recurrent demand (RoTT 10%)	Annual recurrent capacity/activity	Recurrent gap Demand - capacity	Cancer / surveillance pressure	Admin & clinical validation	Professional triage	Biomarker opportunity	Biomarker / rule-out test	Straight-to-test / direct diagnostic pathway	Test / pathway position / future state	Likely effect on first new OPA demand	N:F opportunity (CHKS)	Consultant productivity opportunity	AI / AVT
Breast	5,397	5,408	-11		✓	✓	✗	No routine biomarker to avoid referral identified	△	One-stop triple assessment: clinical assessment + mammography/ultrasound + biopsy	Pathway compression; generally does not remove the initial breast diagnostic attendance	0		
Burns	842	932	-90		✓	✓	✗	None identified	✗	No routine national biomarker / STT pathway identified	-	0		
Cardiac	507	877	-370		✓		✗	Not generally applicable to cardiac surgery referrals	△	Cardiology diagnostic pathways before cardiac surgical referral	-	0		
Cardiology	6,743	6,028	**715**		✓	✓	✓	NT-proBNP/BNP for suspected heart failure; selective familial hypercholesterolaemia genetic testing	✓	Community ECG/ambulatory ECG; echocardiography; CT coronary angiography for selected chest-pain pathways	Can avoid some referrals and route others directly to the correct diagnostic/specialist pathway	890		
Cleft	136	113	**23**		✓		✗	None identified	✗	GDP referral	-	0		
Clinical Neuro-physiology	3,178	3,597	-419		✓	✓	✗	None identified	✓	Direct non-complex neurophysiology, e.g. nerve conduction studies for carpal tunnel syndrome	Can bypass a consultant new outpatient appointment for protocol-defined referrals	0		
Dermatology	11,025	7,427	**3,598**		✓	✓	✗	No established routine biomarker for referral avoidance	✓	Teledermatology with clinical photographs/dermoscopy; virtual urgent skin-cancer pathway; direct booking to skin surgery for selected lesions	Can replace face-to-face new attendances and avoid referrals for suitable cases	2,362		Potential – AlaMD subject to evaluation
ENT	7,055	6,041	**1,014**		✓	✓	✗	No broad referral-avoidance biomarker identified	△	Direct audiology for defined hearing pathways; one-stop neck-lump assessment with ultrasound/FNA at first attendance	Partial: can bypass ENT clinic in audiology cohorts or compress the head-and-neck pathway	345		
Gastroenterology	5,616	3,341	**2,275**	Increase (BSW) + FIT	✓	✓	✓	Faecal immunochemical test (FIT); faecal calprotectin; coeliac serology where clinically indicated	✓	Straight-to-test colonoscopy/CT colonography/colon capsule; upper-GI capsule sponge for eligible reflux/Barrett's cohorts	Can avoid referral/endoscopy in low-risk cohorts and bypass the initial outpatient appointment in selected referrals	247		
General Surgery	6,910	7,605	-695	Increase (BSW) + FIT	✓	✓	△	FIT for colorectal/lower-GI component only	△	Colorectal STT colonoscopy/CTC/colon capsule; selected upper-GI/HPB diagnostic bundles	Can reduce/bypass new appointments in defined subspecialty pathways; not applicable to the whole general-surgery caseload	455		
Gynaecology	6,099	4,242	**1,857**		✓	✓	✓	Serum CA125 for suspected ovarian cancer; selected tumour markers in younger patients where indicated	✓	Ultrasound-led one-stop clinic; outpatient hysteroscopy/biopsy; straight-to-CT for high-risk ovarian presentations	Can bypass a conventional first consultant appointment for protocol-defined cohorts	-721		

Outpatients: Achieving sustainable services: Detail by Specialty II

Main speciality	Annual recurrent demand (RoTT 10%)	Annual recurrent capacity/activity	Recurrent gap Demand - capacity	Cancer / surveillance pressure	Admin & clinical validation	Professional triage	Biomarker opportunity	Biomarker / rule-out test	Straight-to-test / direct diagnostic pathway	Test / pathway position / future state	Likely effect on first new OPA demand	N:F opportunity (CHKS)	Consultant productivity opportunity	AI / AVT
OMFS	5,249	5,001	**248**		✓	✓	✗	No broad referral-avoidance biomarker identified	△	One-stop head-and-neck/neck-lump diagnostics with imaging and FNA/biopsy for selected suspected-cancer cases	Mostly pathway compression; limited whole-specialty demand avoidance	912		
Ophthalmology	12,207	11,358	**849**		✓	✓	✗	No routine blood biomarker for referral avoidance	✓	Community optometry imaging/OCT, visual fields and pressures with virtual ophthalmology review	Can avoid hospital new outpatient attendance and reserve clinics for treatment/high-risk cases	-179		
Plastic Surgery	7,437	7,421	**16**		✓	✓	✗	No routine biomarker identified	△	Teledermatology/dermoscopy with direct-to-procedure booking for selected skin lesions	Can avoid a plastic-surgery clinic for selected lesions	2,146		
Spinal	1,127	1,309	-182		✓		✗	None identified	△	Community MSK interface triage with protocol-based imaging and direct surgical referral where indicated	Can reduce inappropriate surgical referrals; not a blanket direct-MRI pathway	0	Potentially	
Thoracic	280	304	-24	Increase (lung scans)	✓	✓	✗	No routine biomarker identified for referral avoidance	✓	Straight-to-CT before first lung/pleural cancer outpatient appointment	Can rule out disease or ensure the first specialist contact is decision-ready	0		
Trauma & Orthopaedic	17,686	17,966	-280		✓	✓	✗	None identified	△	Community MSK/FCP triage, selective imaging and direct surgical referral for patients likely to require surgery	Can reduce inappropriate orthopaedic new referrals	-1,734	Potentially	
Urology	4,804	5,781	-977		✓	✓	✓	PSA; selected testicular tumour markers (AFP, β-hCG, LDH) in appropriate pathways	✓	Haematuria one-stop ultrasound/CT urography + flexible cystoscopy; mpMRI-first prostate pathway; urodynamics/direct cystoscopy	Can bypass the initial outpatient appointment and avoid onward referral in selected patients	-268		
Vascular	1,739	1,361	**378**		✓	✓	✗	No routine biomarker identified	✓	Vascular laboratory assessment: duplex ultrasound and protocol-based physiological testing such as ABPI	Diagnostic work can replace some outpatient clinics	0	Potentially	
Psychological therapies	2,758	1,977	**781**	Ongoing increase (c.200 p.a.)	✓	63 cases	✗	No validated biomarker for routine demand management	✗	Not applicable	No biomarker/STT bridge	0		
Special Care Dentistry	158	180	-22		✓		✗	None identified	✗	Not applicable	No biomarker/STT bridge			
Neurodevelopmental	1,085	210	**875**		✓		✗	No validated routine biomarker for ADHD/ASD diagnosis	✗	Not a straight-to-test pathway	No biomarker/STT bridge	147		42 cases (Magic Notes)
TOTAL	**101,292**	**91,262**	**10,030**									**4,602**		

Psychological therapies: recurrent capacity gap and staged recovery plan

2,758	1,977	781	63	£0.60m–£2.90m	8.5–32 WTE
annual demand RoTT at 10%	expected activity	headline recurrent gap	professional triage impact included	staged staffing options	additional workforce depending on service model

Demand / capacity scenarios

Model	Capacity to treat	Shortfall	Staff required	Planning interpretation
Current lean model	1,714	716	8.5 WTE	minimum stabilisation ask
Moderately lean model	1,285	1,145	19 WTE	recovery model
NICE-compliant model	959	1,471	32 WTE	development trajectory

Investment options

Route	Cost	Purpose	Caveat
Stabilise / lean	£595k	restore minimal establishment; avoid further deterioration	does not deliver NICE compliance
Recover / moderate	£1.90m	increase capacity and reduce backlog over time	still short of full NICE model
Develop / NICE	£2.90m	move toward OAAT/open-access and NICE-aligned treatment	requires recurrent workforce expansion

Actions to bridge the recurrent gap

1 Immediate stabilisation
Confirm the baseline model and fund the minimum establishment required to stop further deterioration in the size of the waiting list and the waiting time position.

2 Increase clinical throughput without double-counting savings
Use professional triage, group work where clinically appropriate, standardised pathways and administrative streamlining.

3 Recurrent workforce route
Phase recruitment across low-intensity therapists, high-intensity therapists, senior therapists and psychology leadership, using short-term capacity only as a bridge to substantive posts.

4 Model of care development
Move toward one-at-a-time / open-access therapy and NICE-aligned provision, recognisingthis as a development trajectory rather than a Year 1 guaranteed efficiency.

Neurodevelopmental: recurrent capacity gap and staged recovery plan

1,085	906	210	+251	445	0
gross annual demand	net demand after guidelines	core capacity	identified service improvements	residual capacity to identify	modelled recurrent deficit after additional capacity is secured

Capacity bridge: from gross demand to balanced recurrent position

Bridge step	Cases	Meaning for the plan
Gross recurrent demand	1,085	baseline annual demand across ADHD / dual / ASD pathways
Guideline impact	-179	50% reduction assumed in ASD demand
Net demand	**906**	capacity requirement after demand management
Core capacity	210	current recurrent assessment capacity
Identified improvements	+251	Band 8A, Magic Notes, Wellness / Youth Justice and new model
Residual capacity to secure	**445**	**n**

Bridge component	Impact	Action required
Application of new guidelines	179	confirm adoption and monitoring of reduced ASD demand
0.8 WTE Band 8A from Oct	42	confirm recurrent funding and start date
Magic Notes productivity	42	track realised clinical capacity gain
Wellness Centres / Youth Justice	20	agree joint-post model and governance
New service model incl. AI	147	clinical lead expects minimum 6/week; validate run-rate
Additional capacity required	**445**	**recurrent workforce / regional capacity ask**

Actions to bridge the recurrent gap

- **Demand reduction:** implement the new guidelines and audit the actual ASD demand avoided.
- **Productivity through AI and job plan review:** Magic Notes and AI-enabled pathway gains.
- **Build recurrent workforce/capacity:** define the 445-case residual as the capacity still to be secured through workforce, joint posts or regional/system solutions

Endoscopy sustainability plan

Demand/capacity bridge for 2026/27 recurrent endoscopy capacity, including screening growth, Neath early-diagnosis effect and symptomatic FIT-positive pathways.

27,784
expected 2026/27 demand points

26,052
recurrent activity points

1,732
net recurrent gap points pa

87
whole-day lists required net recurrent

£0.74m
net recurrent list cost @ £8,516/day

Demand/capacity position by procedure type

The recurrent gap is driven by colonoscopy; gastroscopy and flexible sigmoidoscopy are modelled with small surpluses.

Modality	Demand	Activity	Gap pa	Gap pw	Whole-day lists	Cost
Colonoscopy	17,956	15,626	+2,330	+31	116	£991,900
Gastroscopy	8,736	9,126	-390	-8	-20	-£166,055
Flexisigmoidoscopy	1,092	1,300	-208	-4	-10	-£88,563
Total	**27,784**	**26,052**	**+1,732**	**+19**	**87**	**£737,283**

Colonoscopy uplift included in demand: +728 points pa

Screening growth +68 • Neath early-diagnosis programme +60 • symptomatic FIT-positive pathways +600

Sustainability solution and assumptions

1 Efficiency prerequisite

Demand/capacity assumes delivery of list utilisation, points per list, numbers of sessions on list, reduced cancellations/DNAs and efficient room turnaround.

2 Develop colonoscopy surveillance workforce

Train and accredit nurse endoscopists for colonoscopy surveillance through the national HEIW programme, reducing reliance on medical endoscopist capacity.

3 Demand substitution and pathway redesign

Use capsule sponge endoscopy and maintain FIT-led risk stratification / validation so suitable patients avoid conventional endoscopy where clinically appropriate.

4 Regional delivery with Hywel Dda UHB

Collaborate on a South West Wales endoscopy solution: shared training, mutual aid, screening/surveillance resilience and recurrent capacity options.

Audio-vestibular and DEXA sustainability plan

Both models depend on sustaining productivity measures before residual capacity is funded: list/session utilisation, skill-mix, reduced DNA and pathway redesign.

Audio-vestibular

1,774	261	22 wks	142	154.5	c.9.3
on list	breaching standard	longest wait	routine demand p/w	capacity p/w	extra sessions p/w

Demand / capacity position

Cohort	Std	List	Breach	Demand/wk	Capacity/wk	Extra sess/wk	Skill mix
Adult	14 wk RTT	1,258	28	60	43	6	Band 5
Paeds	6 wk	425	179	62	50	2	Band 6
Diagnostic	8 wk	91	54	20	16	2	Band 5 + 0.25 Band 7
Total		**1,774**	**261**	**142**	**154.5**	**c.9.3**	

Solution and productivity assumptions

- Sustainability to meet demand on a recurrent basis requires c.9.3 additional 3.75-hour sessions per week, targeted by cohort and skill mix.
- Adult audiology PIFU has reduced hearing-aid follow-ups to c.25% of initial demand and DNA to <1% for this appointment type.
- Paediatric self-referral, gatekept by HV / SaLT, has improved engagement and reduced preschool DNA.
- Service will continue trials of shorter appointments, pre-reassessment triage and BPPV skill-mix pilot.

Service intends to use additional sessions as targeted recovery capacity while locking in PIFU, self-referral and skill-mix changes as recurrent sustainability measures.

DEXA scans

+10%	5,366	2,076	Jul-27	19.2k	2nd
demand growth p.a.	peak >8wk Oct-26	>8wk Mar-27	modelled clearance	27/28 activity	scanner from Nov-26

Scenario 7: second scanner, staffing and performance improvement

Metric	2026/27	2027/28	Meaning
Demand + deferred + DNA	11,451	12,420	includes +10% demand growth p.a.
Revised activity	11,939	19,200	2nd scanner + weekends/evenings from Nov-26
Net annual capacity effect	+488	+6,780	backlog reduction / headroom
>8 wk backlog at year end	2,076	0	model clears during 27/28
Peak risk	5,366 in Oct-26	cleared by Jul-27	before full Nov-26 model takes effect

Solution and productivity assumptions

- Plan requires additional staff and a second scanner to be implemented from Nov-26 with adequate staffing, including weekends.
- Reintroduce long weekend scanning sessions and Sunday use of the mobile scanner.
- Improve evening performance, lunchtime productivity and admin support to reduce lost slots.
- Maintain DNA improvement plan: the plan assumes DNA performance improves once staffing and booking resilience are restored.
- 2026/27 reduces the backlog but does not fully clear the >8-week backlog; full benefit is realised in 2027/28.

DEXA is a phased sustainability plan — stabilise and reduce backlog in 2026/27, then clear and sustain 8-week compliance in 2027/28 , but is dependent upon the second scanner and full staffing model being delivered.

Radiology Scanning demand: recovery restores the in-year position, but the recurrent gap remains

Recast assumption: recovery schemes are non-recurrent and should not be treated as future baseline capacity.

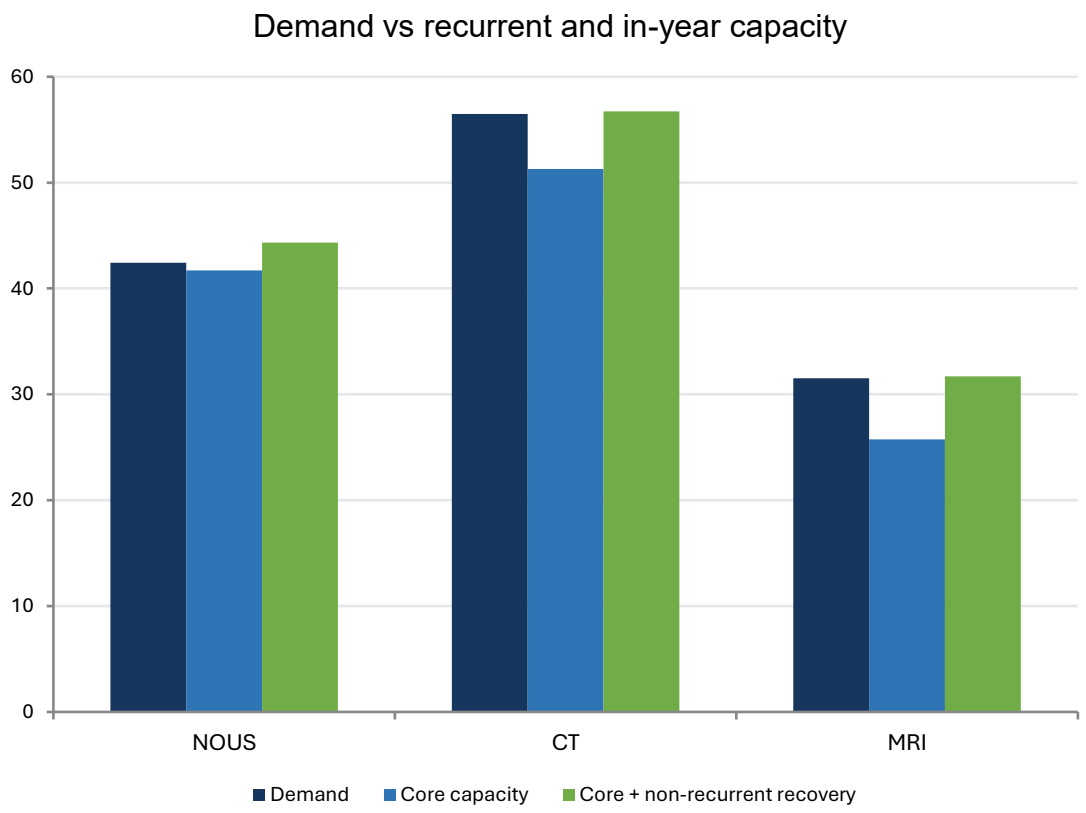
130,446
Annual scanning demand
NOUS, CT and MRI exams

118,759
Core recurrent capacity
91.0% of current demand

11,687
Underlying recurrent gap
capacity to replace recurrently

14,004
In-year recovery
non-recurrent exams

2,317
In-year w/l reduction
only after recovery schemes



Modality	Demand	Core capacity	Recurrent gap	Non-recurrent recovery	26/27 In-year backlog reduction
NOUS	42,439	41,719	720	2,619	1,899
CT incl. cardiac	56,500	51,300	5,200	5,414	214
MRI incl. cardiac	31,507	25,740	5,767	5,971	204
Total	130,446	118,759	11,687	14,004	2,317

Once the 8-week backlog is recovered, the sustainable ask is the 11,687 recurrent underlying gap, plus growth, resilience and reporting.

Radiology Productivity benchmark

Area	Local position	Benchmark / case mix judgement	Outcome
CT	~2.92 scans/hour weighted	Broadly in line with NHS England 3–4/hour. Justified as Cardiac CT takes longer; Morriston 24/7 rate is lower because overnight elective demand is not available.	**Positive: Not assuming a major CT productivity deficit; focus on scheduling, cancellations and pathway-specific rates.**
NOUS	20-minute average for non complex - 2.4/hour overall	NHS England comparator is 3/hour. But injection/procedure work and complexity must be weighted before converting this to a cashable gain.	**Positive: Requested P& I set national standard to avoid differences across HBs, which results in flow of staff to less demanding environments.**
RIS vetting	Some vetting already in place	King's RIS module case study increased scans vetted per day by >20%; this is a vetting-throughput benefit, not a 20% demand reduction.	**Assume 1–2% net demand avoidance / test-change sensitivity until local data proves more.**
Plain film reporting	100 reports/session	GIRFT range broadly 91–130	**Benchmark-consistent**

Modality	Recurrent gap	Targeted efficiency to test	Indicative gain
NOUS	720	Professional triage	424
CT	5,200	1–2% RIS vetting demand avoidance	565–1,130
MRI	5,767	1–2% RIS vetting demand avoidance	315–630
Total	11,687	NOUS + CT/MRI vetting	1,714–3,012

Radiology sustainability approach - Scanning

Modality	Core gap	Efficiency & productivity actions	Recurrent capacity solution	Residual position
NOUS	720	Nurse-referral vetting; NIAW training cases; case-weight simple vs procedural/injection lists	Service plan: 10 consultant sessions + advanced practice sonography + support/admin	**Likely bridgeable; exact residual depends on NIAW sessions and vetting rate**
CT incl. cardiac	5,200	Nurse-referral vetting where applicable; RIS breach / utilisation control; no generic uplift to 24/7 or cardiac CT	Phase 1 weekday extension + weekend CT service; preserve acute overnight capacity Phase 2: weekend CT at Morriston, NPTH and Singleton	**Likely bridgeable; - requires recruitment**
MRI incl. cardiac	5,767	RIS recovery control; reporting prioritisation; no blanket scan-rate assumption due protocol complexity	Weekend three-scanner operation + Morriston MRI2 once commissioned	**Likely bridgeable; - requires recruitment**

Radiology sustainability approach - Reporting

RCR-aligned reporting standards in plan

USC	Treatment dep.	Urgent	Routine
3 days	7 days	7 days	28 days

Implementation focus: faster prioritisation, clearer breach reporting and protected specialist reporting time.

Area	Current / funded position	Gap	Efficiency & control actions	Recurrent capacity solution	Status
MRI reporting	Demand 31,507; funded capacity 21,216 incl. Everlight-funded 3,744 reports	**10,291 reports 20 sessions**	RIS prioritisation and breach visibility; match reporting capacity to scan expansion; protect reporting DCC	Add recurrent MRI reporting sessions alongside weekend / MRI2 scanning expansion	**Capacity growth required**
CT reporting	Demand 56,500; funded capacity 51,300; 29 consultant sessions + 6 Everlight sessions	**5,200 reports 10 sessions**	Nurse-referral vetting where applicable; RIS breach control; preserve acute and cardiac CT complexity	Add CT reporting sessions; acute CT / out-of-hours model remains a separate option	**Targeted ask**
Nuclear Medicine / PET	NM reporting 4 sessions; PET delivered through JCC-funded arrangements	**4 sessions**	Prioritise reports through RIS; clarify commissioned PET growth and local reporting requirements	Increase NM reporting from 4 to 8 sessions and define JCC-funded PET growth route	**Bridgeable once commissioned**
Cardiothoracic / lung	Cardiac CT 3→5 sessions; cardiac MRI 3.5→7 sessions; lung cancer / biopsy growth	**10.5 sessions**	Pathway-based TAT control for cardiac and lung cancer; case-weighted productivity rather than simple report counts	Add cardiothoracic reporting and biopsy resilience for regional cardiac and lung screening growth	**Strategic growth pressure**

Radiology Resource and cost requirement

Costs remain a planning envelope; mandated schemes are included as mechanisms to reduce residual ask rather than generic productivity assumptions.

c. £4.8m pa

54.5 WTE costed

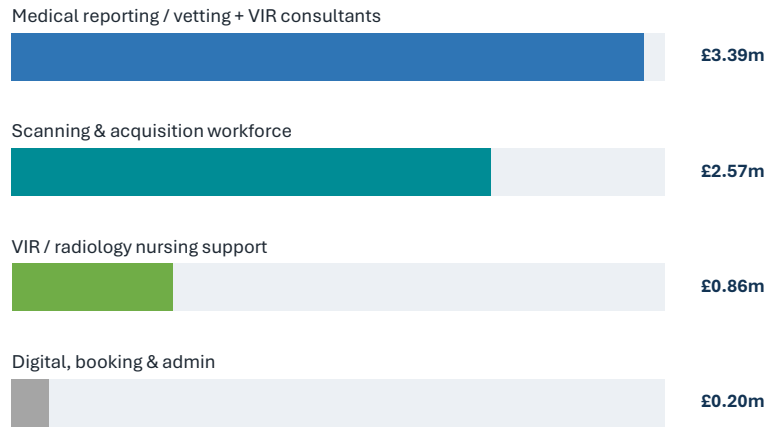
62.5 DCC sessions/week reporting, specialists and vetting

Admin + data standards £0.06m in current envelope

+ £1.55m OoH option not in core envelope

Component	WTE	Cost	Mandated scheme / purpose
Reporting, specialist consultants and vetting	12.69	£2.43m	Improve reporting times; includes 15 vetting sessions to support demand reduction and IR(ME)R justification
CT expansion	8.15	£0.51m	Recurrent extended-day / weekend capacity; protects acute overnight and cardiac complexity assumptions
MRI expansion — phases 1 and 2	14.7	£1.02m	Weekend scanning and Morriston MRI2 capacity; reporting capacity must be aligned
NOUS and NIAW training route	3.7	£0.18m	Core sonography, advanced practice and support; NIAW cases/training agreement to be quantified separately
Data standards and admin	1.8	£0.06m	Breach reporting, booking validation, productivity dashboard and recovery control
VIR and radiology nursing	13.5	£0.97m	Interventional resilience; possible +£0.27m if full service-plan VIR WTE confirmed

Where the recurrent envelope sits



Counting rule: NIAW NOUS cases, nurse-referral vetting and RIS data-standard benefits should reduce the residual capacity ask only once local run-rate and denominator data are available.

Not yet included: acute CT/OoH final model, MRI2 capital, contrast and consumables, implementation/training, and net benefit from reduced insourcing/outsourcing.

Source: Radiology Sustainability Plan Costing v6 and Sustainable Services Plan V6. Figures rounded; finance validation still required.

Vascular interventional radiology: investment case

Business case reinforces the need to stabilise a fragile regional service, address hidden demand and build a sustainable workforce model.

Fragile core service
One substantive VIR consultant; locum / SLA cover is used to sustain inpatient and emergency provision.

Capacity deficit
+432 procedures p.a. peer-adjusted estimate; 42% uplift required

Regional dependency
VIR supports vascular, major trauma, renal, cancer, bleeding and stroke pathways across South West Wales.

Preferred direction
Full-service model moves toward 24/7 provision and a centre of excellence over five years.

Resource requirement in radiology plan

Workforce role	WTE
Consultant(s)	2.0
Cross-site modality lead (B8a)	1.0
Superintendent radiographer (B7)	1.5
Radiographer (B6)	3.5
Nursing (B6)	4.0
Nursing (B5)	4.0
Nursing associate (B4)	1.0
IR stock co-ordinator (B3)	1.0
Total	**18.0**
Total excluding consultants	**16.0**

What will be gained from the investment

Capacity	Stabilises core VIR capacity and reduces reliance on variable locum / short-term external support.
Access	Creates capacity to address unmet demand and bring more appropriate minimally invasive procedures in-house.
Outcomes	Supports fewer amputations, shorter waiting times / length of stay and safer day-case or less invasive care.
Efficiency	Improves stock control, procedure flow, MDT use and operational resilience across dependent pathways.
Sustainability	Builds a training and development platform, supporting recruitment, retention and progression to centre of excellence.

Business case context: preferred full-service model steady-state annual cost c. £4.03m, c. £2.45m incremental vs BAU. Capital / non-pay activity costs are excluded; business case notes data limitations and recommends stronger demand, activity and reporting infrastructure.

Neurophysiology and cellular pathology sustainability plan

Neurophysiology

3,218
annual demand

2,991
expected capacity

227
annual deficit

365
present waiting list

187
current breaches

Key actions to achieve sustainability

- Appoint two practitioner neurophysiologists and enrol them on the national training programme to create a sustainable future workforce as consultant sessions reduce.
- Use skill mix to protect core diagnostic capacity and reduce reliance on a single consultant model.
- Validate and clear the surveillance backlog and breaches, with priority management of long waiters.
- Commit to service efficiencies through standardised referral criteria, pathway vetting and maximum use of protocol-driven testing / reporting.
- National and regional determination of role of insourcing in this service.

Neurophysiology requires succession planning and skill-mix expansion to close a relatively modest recurrent gap

Cellular pathology

177,672
annual demand

155,416
core capacity

22,256
26/27 deficit

5,869
current backlog

11,786
recurrent deficit

Key actions to achieve sustainability

- Appoint additional consultants and combine this with outsourcing to address the immediate backlog while building recurrent reporting capacity.
- Adopt recognised good practice through digital pathology / networked reporting, advanced practitioner / biomedical scientist roles, and standardised demand management.
- Use outsourcing as a tactical backlog and resilience measure.
- Strengthen regional collaboration and subspecialty consolidation where this improves resilience and turnaround times.

Measure	26/27	Recurrently
Impact of CTM LTA ceasing	4,500	9,000
Impact of locum consultant starting	857.5	1,470
Backlog by Mar-27	22,768	11,786
Indicative cost	–	£1.884m

Cellular Pathology requires a recurrent workforce and productivity solution, supported by outsourcing and modernised reporting pathways.

Treatment delivery plan: residual gaps and regional solutions

Recovery & Sustainability Programme opportunities are assumed within our Annual Plan as cost savings; we have identified where they are being actively pursued as part of this programme

61.2k	57.8k	3.4k	12	9	WG alignment point: count productivity once — savings or recovery capacity, not both
annual demand	current activity	expected W/L pressure	specialties: theatre efficiency opportunity	specialties: consultant productivity opportunity	

Main Specialty	Annual Total demand	Current TOTAL Activity Levels	Dem-cap W/L change expected	Theatre Efficiencies OTD cx + Session Utilisation	Consultant productivity (sessions and templates)	Cases per list (Deloitte Model Hospital)
Breast	495	468	27	✓	—	—
Burns	70	74	-4	-	—	—
Cardiac	257	384	-127	-	✓	—
Cleft	93	110	-17	-	—	—
ENT	1,540	1,417	123	✓	✓	—
General Surgery	2769	2,032	737	✓	✓	—
Gynaecology	702	936	-234	✓	—	—
OMFS	885	810	75	✓	—	✓
Ophthalmology	87734	7,501	233	✓	✓	—
Plastics	3,549	4,088	-539	✓	✓	✓
Radiotherapy	35,195	32,524	2,671	-	—	—
Special Care Dentistry	153	94	59	-	—	—
Spinal	509	516	-7	✓	✓	—
Thoracic	210	290	-80	✓	—	—
T&O	54,832	4,611	221	✓	✓	—
Urology	1,571	1,504	67	✓	✓	—
Vascular	612	494	118	✓	✓	—
Total	**61,176**	**57,758**	**3,418**			

Delivery narrative

- Gross demand-capacity pressure is ,3418 cases, with the largest pressures in Radiotherapy, General Surgery, Ophthalmology and T&O.
- Productivity schemes are being progressed through theatre utilisation, OTD cancellation reduction, job-plan/template review and cases-per-list benchmarking.

Special care dentistry: recurrent treatment-stage gap

MDT assessment capacity is sufficient recurrently (+22), but the service still carries 300 patients on the waiting list, 108 waiting over 104 weeks and a 97% conversion to treatment. The recurrent issue is therefore treatment capacity, not assessment capacity.

158	180	+22	153	94	-59	1.1
annual MDT demand	MDT assessment capacity	assessment surplus	annual treatment demand	treatment capacity	recurrent treatment deficit	lists per week treatment deficit

Assessment model and current pressure

Cohort	MDT demand	MDT capacity	Surplus	Waiting list	>104	Tx conv.
Paeds	63	72	+9	154	57	97%
Adult	95	108	+13	146	51	97%
Total	**158**	**180**	**+22**	**300**	**108**	**97%**

Treatment demand / capacity model

Cohort	Tx demand	Tx capacity	Deficit	Lists/wk reqd	Current	Gap
Paeds	61	47	-14	1.22	1.0	0.2
Adult	92	47	-45	1.84	1.0	0.8
Total	**153**	**94**	**-59**	**3.06**	**2.0**	**1.1**

Key point: assessment capacity is not the constraint; the unresolved recurrent gap sits in treatment capacity, equivalent to c.59 patients per annum or c.1.1 lists per week.

Actions to bridge the recurrent gap

1 Validate and prioritise

Using the available MDT assessment capacity to validate demand, clinically prioritise the backlog and maintain tight Treat in Turn discipline across the 300-patient waiting list and 108 over-104-week waits.

2 Seek regional solutions

The recurrent treatment gap is dependent upon identification of appropriate theatre availability. AS specialist paediatric work. The UHB continues to explore opportunities across the region where we can provide additional treatment capacity

3 Optimise local treatment capacity

Model assumes 100% utilisation - no cancellations and maximised productivity from the existing 2 weekly treatment lists while scoping whether capacity can move closer to the modelled 3.06 lists per week requirement.

Oncology sustainability plan: radiotherapy, SABR and SACT

Demand exceeds recurrent capacity from 2026 and widens materially by 2028; the bridge requires regional radiotherapy infrastructure, SACT chair expansion and pharmacy/nursing workforce resilience.

2,670	108	1,955	15,910	£6.832m	+4 chairs	£0.702m
2026 RT gap + 200 backlog	2026 SABR gap flat capacity at 52	2026 SACT gap + 65 backlog	RT gap by 2028 without Linac growth	WG capital ask 5th Linac	SACT expansion by 2027/28 model	FYE for first 4 SACT chairs

Demand / capacity position

Treatment stream	2026 demand	Recurrent capacity	2026 gap	2028 gap	Backlog > target
Radiotherapy	35,195	32,525	2,670	15,910	200
SABR	160	52	108	208	0
Chemotherapy / SACT	19,526	17,571	1,955	6,055	65

Scale of the recurrent bridge

2026 gaps are already material: radiotherapy requires c.2.7k additional slots and SACT c.2.0k attendances. SABR demand triples against flat capacity. By 2028 the combined pressure is dominated by radiotherapy and SACT growth.

Efficiencies have already absorbed significant growth with chair utilization between 90-11%; sustainability cannot rely on further generic productivity gains alone.

Target issue: radiotherapy 21-day performance is volatile and SACT overall compliance remained low in Jan–Jun 2026, with June at 31%

Sustainability solution

1 Radiotherapy and SABR capacity

- Progress 5th Linac BJC: capital £6.832m from Welsh Government and £2.8m recurrent revenue requirement shared with Hywel Dda (£1.4m each).
- Aim for clinical delivery of 5th LINAC in Q2 2027/28, subject to approval and construction timetable.
- Develop 6th / twin bunker option for replacement resilience and future Linacs 6–7; seek design funding and align with regional SWWCC model.
- Enable adaptive radiotherapy, SRS/SABR and complex treatments locally, reducing reliance on outsourcing.

2 SACT / chemotherapy chair capacity

- Additional pharmacist posts are critical - 4 additional CDU chairs required in 2026/27, FYE £701,973 plus pharmaceutical costs.
- Longer-term model is to continue adoption of subcutaneous delivery, increases time to delivery and enables greater throughput per chair, but is dependent upon pharmacist capacity.: Aim in 2027/28 to reset chair utilisation towards the safe 80–85% range.
- Maintain tiered SACT training / passport approach to bring nurses into safe administration more quickly while preserving competence.

3 Pharmacy, workforce and regional enablers

- Resource pharmacy verification, technical services, supportive medicines and outsourcing administration in parallel with chair expansion.
- Bridge to TrAMS: use outsourced dose-banded / pre-filled SACT where feasible until the South-East hub comes on stream in 2027/28.
- Continue collaboration with Hywel Dda, Cancer Performance & Improvement and regional oncology governance for capacity, prioritisation and resilience.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Delivery, Governance and Assurance

Un Bae Ar y Cyd
One Bay Way

BOARD COMMITMENTS

Board commitments to deliver sustainable planned care

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Bae Abertawe

Swansea Bay University Health Board

The Board is committed to the following nine priorities to deliver recovery, sustainability and transformation.

1 Eliminate 104-week waits

We will eliminate patients waiting over 104 weeks for treatment at the earliest opportunity.

2 Restore the 8-week diagnostic standard

We will restore performance against the 8-week diagnostic standard and sustain delivery.

3 Implement POPS by October 2026

We will implement full Pre-Operative Optimisation (POPS) pathways by October 2026.

4 Deliver professional triage and referral management

We will implement professional triage and standardised referral criteria to reduce unwarranted demand.

5 Achieve accredited surgical hub status

We will achieve and sustain accredited surgical hub standards across our main sites.

6 Transform follow-up and surveillance

We will reduce follow-up demand and redesign surveillance to achieve a 1:1 follow-up to new ratio.

7 Strengthen diagnostic workforce and capacity

We will expand and upskill diagnostic workforce and increase capacity to meet demand.

8 Deliver and sustain productivity standards

We will deliver all agreed productivity standards and sustain improvements over time.

9 Lead regional collaboration and shared delivery

We will strengthen regional partnerships and deliver shared solutions across South West Wales.

These commitments are fundamental to accessing investment, driving transformation and delivering sustainable planned care for our population.

Our Transformation Delivery Framework

A structured approach to delivering sustainable planned care transformation

Better health
Better care
Better lives

We will deliver transformation through a disciplined, clinically-led approach that focuses on reducing unnecessary demand, improving productivity and releasing capacity for patients who need it most.

1 STRATEGIC PRIORITIES

- Executive Board approved transformation priorities
- Alignment with regional strategy and Welsh Government requirements
- Investment decisions informed by demand, capacity and productivity analysis
- Focus on value, quality and patient outcomes

2 PROGRAMME DESIGN

- Redesign pathways and service models
- Demand and capacity modelling
- Productivity and efficiency opportunities
- Digital and data enablement
- Workforce and infrastructure planning
- Define success measures and benefits

3 CLINICAL ENGAGEMENT

- Strong clinical ownership and leadership
- Specialty engagement and co-design
- Workforce involvement and development
- Clinical governance and quality assurance
- Patient and public involvement

4 IMPLEMENTATION

- Phased implementation of agreed changes
- Local delivery within a regional context
- Operational change and process improvement
- Digital solutions and tools embedded
- Change management and communication support

5 PERFORMANCE & BENEFITS MONITORING

- Track performance against key metrics
- Monitor productivity and capacity release
- Benefits realisation and financial impact
- Risk and issue escalation and mitigation
- Regular reporting to assure delivery

6 CONTINUOUS IMPROVEMENT

- Learn, adapt and refine throughout
- Scale successful initiatives
- Embed best practice and innovation
- Annual review and refresh of priorities
- Sustainable change for long-term impact

Our Approach: Transformation will be delivered collaboratively across clinical teams, operational services and corporate functions, working together with our regional partners to improve access, reduce waits and deliver the best possible care for our population.

GUIDING PRINCIPLES

- Patients at the heart
- Clinically-led and evidence-based
- Working together regionally
- Focus on productivity and value
- Quality, safety and equity in everything we do
- Continuous learning and improvement

Our Governance & Assurance Framework

Strong governance, clear accountability and robust assurance to deliver our transformation commitments

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Our governance framework ensures clear accountability, clinical leadership and active oversight of delivery, risk and benefits realisation.

- Accountable leadership
- Active assurance
- Informed decisions
- Managed risk
- Delivery focus

EXECUTIVE OVERSIGHT

- Overall accountability for delivery of the Planned Care & Cancer transformation strategy.
- Agree strategic priorities, investment and major decisions.
- Monitor delivery, risks and benefits through regular reporting.
- Ensure alignment with organisational objectives and national expectations.

REPORTED TO & ASSURED BY:
Executive Huddle
Executive Board

PROGRAMME GOVERNANCE

- Planned Care, Cancer & Diagnostics Programme Board oversees delivery of strategy and transformation workstreams.
- Provides strategic direction, removes barriers and ensures cross-programme alignment.
- Clinical Directorate and divisional leadership provide challenge and clinical oversight.
- Regional governance through established regional clinical groups.

REPORTED TO & ASSURED BY:
Executive Huddle
Executive Board

OPERATIONAL DELIVERY

- Operational teams deliver agreed initiatives and service changes.
- Weekly planned care touchpoints oversee trajectories, risks and mitigation.
- Specialty recovery groups provide oversight of actions and theatre list validation.
- Clinical and operational leads ensure delivery within services and escalate issues as required.

REPORTED TO & ASSURED BY:
Planned Care, Cancer & Diagnostics Programme Board

ASSURANCE & REPORTING

- Performance, finance and benefits information reviewed monthly.
- Treat-in-Turn, validation, productivity and diagnostic standards actively monitored.
- Exception reporting and escalation processes in place.
- Regular reporting to Performance & Finance Committee and Executive Board.

REPORTED TO & ASSURED BY:
Performance & Finance Committee
Executive Board
Welsh Government

Clear accountability
Defined roles and responsibilities at every level of our governance structure.

Active oversight
Regular review and challenge of delivery, risks, issues and mitigations.

Evidence based
Decisions informed by robust data, modelling and clinical insight.

Risk aware
Proactive identification and management of risks and dependencies.

Patient focused
Assurance is aligned to our mission to improve outcomes for our patients.

We are committed to transparent reporting, effective decision-making and continuous assurance to ensure successful delivery of our sustainable planned care strategy.

Working together with our Regional Partners

Our Benefits Realisation & Performance Framework

Measuring what matters, realising benefits and ensuring transformation delivers for our patients

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We will track the right measures to ensure our transformation programmes deliver the expected outcomes, release capacity and improve patient experience whilst achieving value for money.

- Data driven decisions
- Early identification
- Accountability and challenge
- Continuous improvement
- Value and sustainability

OUR PERFORMANCE & BENEFITS FRAMEWORK

PRODUCTIVITY

- Theatre utilisation (6-4-2 compliance)
- Treat-in-Turn rate (≥50% by specialty)
- Late starts and early finishes
- On the day cancellations
- Outpatient productivity (FU:new ratio)
- Diagnostic productivity and throughput

Outcomes

- More capacity released
- Reduced waste and variation
- Better use of our resources

TRANSFORMATION

- PIFU and SOS uptake
- AI-supported letter validation volumes and outcomes
- CIN compliance and referral optimisation
- Validation programme completion
- Waiting Well & Living Well engagement
- Pre-surgical optimisation and pathway adoption

Outcomes

- Reduced unnecessary follow-ups
- Improved compliance and consistency
- Improved patient experience

OUTCOMES

- 104-week waits (reported and unreportable)
- 52-week outpatient waits
- 8-week diagnostic standard
- Waiting list size and age profile
- New outpatient capacity
- Patient experience and feedback

Outcomes

- Reduced waits
- Access for those who need it most
- Better experience and outcomes

FINANCIAL & BENEFITS

- Capacity released (activity and value)
- Workforce utilisation and efficiency
- Recurrent productivity savings
- Cost avoidance and investment impact
- Benefits realisation against business case

Outcomes

- Sustainable use of resources
- Investment delivers measurable benefits
- Financial value realised

REPORTING & ASSURANCE ROUTE

Monthly Performance & Benefits Dashboard
Integrated reporting of key metrics across all domains

→

Performance & Finance Committee
Challenge, oversight and exception reporting

→

Executive Board
Strategic oversight, decision making and assurance

→

Welsh Government
Transparent reporting of performance, progress and benefits realisation

Our commitment

We will be transparent, evidence based and outcome focused. Our reporting will drive improvement, enable early action and ensure we deliver the best outcomes for our patients and communities.

OUR BENEFITS REALISATION PRINCIPLES

- Clear outcomes aligned to our strategy
- Evidence based and measurable
- Shared accountability
- Regular review and challenge
- Continuous learning and improvement

Key Risks and Mitigations

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	Risk	Mitigation
	**Welsh Government funding is not confirmed at the level required to close the residual gap.**	• Prioritise internal productivity, validation and transformation actions; maintain clear modelling of the residual gap; escalate investment dependencies through Executive and Board governance.
	**Productivity improvements are not delivered at the pace required.**	• Implement specialty-level productivity oversight, monthly reporting, named operational ownership, benefits tracking and escalation for under-delivery.
	**Workforce constraints limit delivery of additional activity or recurrent sustainability actions.**	• Align workforce plans with recovery trajectories, pursue recruitment and retention actions, develop skill-mix solutions and explore regional workforce options.
	**Demand growth exceeds modelled assumptions.**	• Strengthen referral optimisation, Advice and Guidance, validation, demand management and primary-secondary care interface working.
	**Regional solutions take longer to agree or implement.**	• Continue local recovery actions while developing regional options through agreed governance, with clear clinical, operational and financial evaluation.
	**Operational pressures, cancellations or bed constraints reduce elective productivity.**	• Strengthen scheduling discipline, cancellation review, ring-fenced capacity where possible, pre-assessment and escalation of constraints through operational governance.

These risks and mitigations will be actively monitored through Executive, Operational and Board governance as we deliver our Planned Care Sustainable Plan and recovery programme.