Managing outpatients

Hywel Dda University Health Board

May 2026

About us

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Audit snapshot

What we looked at

1 Our review assessed whether Hywel Dda University Health Board (the Health Board) has effective arrangements in place to manage its outpatient appointments. In doing so, we assessed progress in implementing recommendations made in our 2015 and 2017 follow-up outpatient reviews.

Why this is important

2 Outpatient services perform a critical role in a patient’s health journey, supporting more patients than any other hospital department. Follow-up outpatient appointments make up the largest element of outpatient activity. These appointments are typically used to review a patient’s condition after surgery or a procedure, administer medication, manage pain levels and chronic conditions, or monitor signs of deterioration.

3 During 2014-15, the Auditor General reviewed the management of follow-up outpatients across all health boards in Wales. Our 2015 Review of Follow-up Outpatient Appointments at the Health Board found that information on the scale of delayed follow-up outpatient appointments was unreliable and the Health Board was not doing enough to assess clinical risk or prioritise outpatient service modernisation.

4 We made nine recommendations, which focused on:

- outpatient services transformation;
- data quality;
- follow-up outpatient reporting; and
- clinical risk assessment.

5 Our 2017 progress review found the Health Board had made slow progress in addressing our recommendations. We also made two new recommendations on data quality.

6 In April 2020, NHS Wales published a strategy and action plan called Transforming the way we deliver outpatients in Wales, which was refreshed in 2023. The strategy sets out the need to accelerate the development of new ways of working, the adoption of new technologies, the self-management of stable long-term conditions, as well as the importance of sharing best practice.

What we have found

7 The Health Board has significantly reduced the number of patients waiting over one year for a first outpatient appointment, meeting the Welsh Government target by March 2025. However, the focus on first outpatient appointments has affected its ability to reduce the number of patients experiencing delayed follow-up outpatient appointments, with numbers continuing to increase. In October 2025, approximately 17,000 patients were waiting twice as long as they should be for a follow-up outpatient appointment.

8 The Health Board clearly understands the barriers to improving outpatient services and is taking steps to modernise and improve service efficiency. In October 2025, over half of patients were discharged at the first outpatient appointment or referred to a self-management pathway. However, Did Not Attend (DNA) rates are still high. In October 2025, the DNA rates were 7.2% for new outpatient appointments and 6.0% for follow-up outpatient appointments. The Health Board does not have a long-term plan to address challenges and develop sustainable outpatient services for the future.

9 Board oversight of outpatient performance is strong, and operational arrangements are improving. However, Board level reporting of harm caused by long outpatient waits needs strengthening. While validation processes are in place, they focus only on patients with very long waits. Improvements are needed in clinical validation and proactive harm identification.

What we recommend

10 We have made two new recommendations to the Health Board, these focus on:

- developing a long-term plan for outpatient services; and
- improving clinical and administrative validation.

Key facts and figures

Of the ten outstanding recommendations from our 2015 and 2017 reviews, five are complete, four are in progress and one is superseded.

Under the Welsh Government's escalation and intervention arrangements the Health Board is at Level 3 for planned care.

The Health Board met Welsh Government's target of zero patients waiting over a year for a first outpatient appointment by March 2025. Since then, performance has slightly deteriorated with 190 patients waiting more than a year in August 2025.

In October 2025, 72,025 patients were waiting for a follow-up outpatient appointment, compared to 108,089 patients at the time of our 2017 review (February 2017).

In October 2025, 16,558 patients waiting for a follow-up outpatient appointment were delayed twice as long as they should be, compared to 16,481 patients in October 2024 and 15,571 in October 2023.

In October 2025, Did Not Attend (DNA) rates were 7.2% for new outpatient appointments, above the Wales average of 6.7%, and 6.0% for follow-up appointments, below the Wales average of 6.3%.

The services with the highest waits for follow-up outpatients' appointments are ophthalmology, urology, dermatology, ear, nose and throat, rheumatology and paediatric.

Our findings

Outpatient performance

While long waits for first outpatient appointments have improved, the Health Board is still missing targets for delayed follow-up appointments

11 The COVID-19 pandemic had a significant impact on planned care service delivery with the total number of patients:

- on the Health Board waiting list rising from 56,313 in March 2020 to 86,829 in March 2022;
- waiting for a new outpatient appointment rising from 37,170 in March 2020 to 59,374 in March 2022; and
- waiting longer than a year for a new outpatient appointment rising from 2 in March 2020 to 12,852 in March 2022.

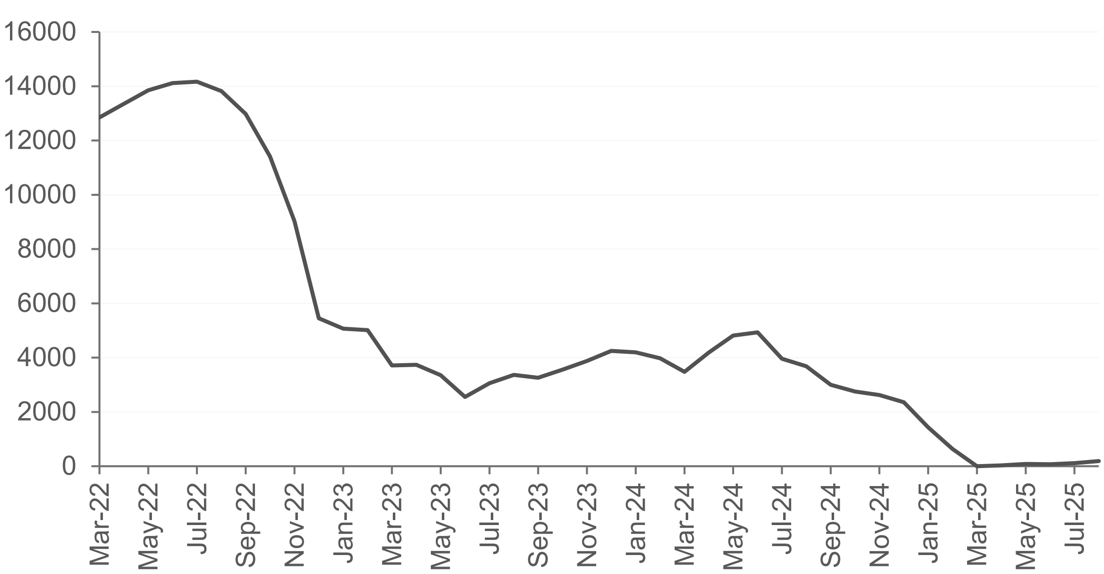
12 In April 2022, the Welsh Government set a requirement that no-one should be waiting more than a year for their first outpatient appointment in most specialties by Spring 2025.

13 Since December 2022, the Health Board has significantly reduced the number of patients waiting more than a year for their first outpatient appointment, meeting the target of zero by March 2025 (**Exhibit 1)**.

14 The Health Board was only one of three health boards to meet the target. Performance has slightly deteriorated since March with 190 patients waiting more than a year in August 2025. These patients relate to four specialties[1], the majority of which are waiting for an appointment in geriatric medicine.

[1] Geriatric medicine, ophthalmology, general medicine, and dermatology

Exhibit 1: number of patient pathways[2] waiting over 12 months for first outpatient appointment (by provider) – March 2022 to August 2025



Source: Referral to treatment times, Welsh Government

15 The number of patients waiting for a follow-up outpatient appointment has decreased since the pandemic. At the time of our 2017 review, the number of patients waiting for a follow-up outpatient appointment was 108,089 (February 2017), compared to 72,025 in October 2025.

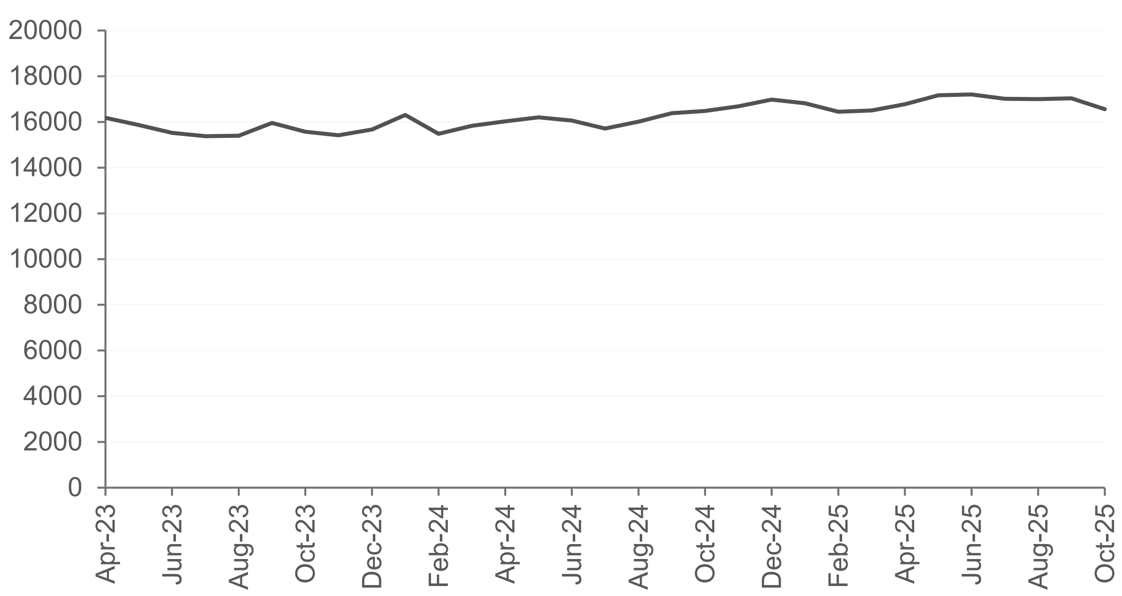
16 In February 2017, the Health Board reported 25,089 patients waiting for a follow-up appointment which is delayed. However, at that time, the Health Board was only reporting patients who did not have a booked appointment. The total number of patients delayed is likely to have been significantly higher. In October 2025, the Health Board reported a total of 29,129 patients waiting for a follow-up appointment which is delayed.

[2] Data is based on patient pathways. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once.

17 In April 2022, the Welsh Government also reset a requirement for NHS bodies to reduce the number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% (that is, they are waiting twice as long as they should). This is an issue because the longer a patient waits, the higher the chance of harm, especially for serious health conditions.

18 In February 2017, we reported that just over 15,000 patients were delayed twice as long as they should be, although this figure excluded patients who had a booked appointment. In April 2023, the total number of patients delayed twice as long was reported as 16,181. While this number reduced during 2023, the number of patients delayed twice as long has been steadily increasing since July 2024, rising to 16,558 in October 2025 (**Exhibit 2).**

Exhibit 2: number of patients waiting for a follow-up outpatient appointment twice as long as they should be – April 2023 to October 2025



Source: Welsh Government

19 Many of the patients (44%) waiting for a follow-up outpatient appointment delayed twice as long as they should be, relate to ophthalmology. This is a high-risk specialty with a greater risk of harm to patients because of delayed treatment.

20 The total number of patients on the follow-up list and the number delayed however is the second lowest in Wales.

Outpatient services transformation

While the Health Board is working to modernise outpatient services, it lacks a long-term plan for service transformation

21 The Health Board clearly understands the barriers to improving outpatient services. These include outdated facilities, geographically dispersed services, staffing shortages and waiting list backlogs in some areas. There is also resistance to change, for example adopting virtual appointments.

22 However, the Health Board does not have a long-term plan to address these challenges and develop sustainable outpatient services for the future. Our 2025 Planned Care Review also highlights the lack of long-term plans for planned care. In the medium term, the Health Board is working to modernise outpatient services for some specialties through its Clinical Services Plan. However, the plan only focuses on the most fragile services[3], with plans currently in the development phase[4]. There are also digital projects which feed into outpatient transformation.

23 The Health Board recognises the importance of modernising its approach to managing outpatient care, adopting national strategies[5] and Clinical Implementation Network (CIN) guidance for service transformation. The Health Board's 2025–26 Annual Plan sets out a range of measures to improve service efficiency, promote self-management pathways and address long waiting times.

24 The Health Board is starting to move away from issuing routine follow-up appointments. Where clinically appropriate, it discharges patients after their first outpatient appointment or puts them on a self-management pathway.

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[3] The Clinical Services Plan covers the following services: Critical Care, Dermatology, Emergency General Surgery, Endoscopy, Ophthalmology, Orthopaedics, Radiology, Stroke, and Urology.

[4] The public consultation for the Clinical Services Plan ended on 31 August 2025.

[5] Outpatient transformation as set out in Welsh Government's Our programme for transforming and modernising planned care and reducing waiting lists in Wales (April 2022).

25 The Health Board is starting to see some success. In October 2025, 39% of new outpatients were discharged after their first appointment. This approach is well used in specialties such as general surgery, gynaecology, and ear, nose, and throat. In addition, 15% of new outpatients were discharged to See on Symptom (SOS) or Patient Initiated Follow-Up (PIFU) pathways. Our analysis also indicates that there is a steady increase in the use of PIFU and SOS pathway for follow-up outpatients.

26 This approach ensures the prudent use of follow-up appointments and minimises the follow-up backlog from growing. The Health Board appointed a project lead responsible for collecting and analysing SOS and PIFU data. This enables clinicians and senior managers to review performance on a weekly basis and make data-driven decisions. It is also monitoring outpatient clinic start and finish times to improve operational efficiency across departments. However, there is no reporting on the use of virtual appointments.

27 The Health Board is not having as much success in reducing its Did Not Attend (DNA) rates. In October 2025, the Did Not Attend (DNA) rate for new outpatient appointments was 7.2%, which is higher than the Wales average of 6.7%. For follow-up appointments, the DNA rate was 6.0%, although lower than the Wales average of 6.3%. The cost of appointments lost to DNA in October 2025 was equivalent to £132,690[6]. The Health Board is working to digitalise its appointment letters, as one of the reasons patients miss appointments is because appointment letters arrive too late. This is part of wider plans to develop a digital patient service centre, allowing patients to manage their own appointments.

[6] Based on an average cost of £120 for a new outpatient appointment, and £90 for a follow-up appointment.

28 Since September 2025, the Health Board has focused on reducing outpatient waits over 26 weeks, as part of the Welsh Government's Planned Care Improvement Recovery Plan[7] to cut 200,000 waits by March 2026. The Health Board aims to deliver over 15,000 additional appointments through insourcing, starting with ophthalmology, trauma and orthopaedics, and urology.

29 While the Health Board's current actions are practical given the scale of waiting list challenges, they are short-term in nature. A longer-term outpatient plan is needed, with a clear vision and roadmap aligned to the Health Board's long-term strategy and enabling plans, such as digital and estates[8].

[7] The Welsh Government's Planned Care Improvement Recovery Plan for 2025-26 is a national strategy aimed at reducing waiting times and improving access to planned care services across NHS Wales.

[8] The Health Board is currently refreshing its long-term strategy and digital and estates plans.

Oversight and monitoring

Board oversight of outpatient services is strong, and operational arrangements are improving, but Board level reporting of harm caused by long waits needs strengthening

30 The Health Board is working to improve leadership and accountability for outpatient services.

31 The Chief Operating Officer oversees planned care, including outpatient services. In April 2025, the Health Board introduced a new operational structure, placing outpatient services within the Planned and Specialist Clinical Care Group. This group is led by a newly appointed leadership team that provides both clinical and operational oversight. However, the structure is still being set up, and the structures below the leadership level are currently unclear. The new structure also includes a programme lead for planned care transformation.

32 Previously, the Clinical Director of the Planned Care Directorate also served as Deputy Clinical Lead for the NHS Wales Planned Care Programme, which helped apply Clinical Implementation Network guidelines across specialties.

33 Executive and operational oversight of outpatient performance is improving. Performance is routinely reviewed through:

- Executive Improving Together Sessions;
- Integrated Quality, Finance, Performance and Delivery Group;
- Referral to Treatment (RTT) optimisation meetings (previously Watchtower meetings); and
- Planned and Specialist Clinical Care Group Integrated Governance meetings.

34 The fortnightly integrated governance meetings are new, and the agenda alternates between finance and performance, and quality and safety. However, it is unclear where outpatient transformation activities are reported operationally.

35 The Health Board is now reporting the numbers of booked and un-booked follow-up outpatients with a target date to Welsh Government. This was an issue highlighted in our earlier reports. However, in October 2025, 38,514 patients were not booked, of which 21,410 patients were delayed. Positively, all patients on the follow-up list have a target date. Our previous reviews also highlighted variation between monthly data submissions to Welsh Government and internal reports. The Health Board has since strengthened the reporting process to improve consistency across reports.

36 There is good Board level oversight of outpatient performance. Both the Board and the Finance and Performance Committee regularly receive the Integrated Performance Assurance and the Escalation Oversight and Highlight reports. These reports track key metrics such as long waits for first appointments, delayed follow-ups, and eye care measure performance. They also explain the challenges and outline actions being taken to improve service performance, including efforts to modernise.

37 The Digital, Data and Innovation Committee and the Quality, Safety and Experience Committee also receive updates on key areas, such as progress with digital outpatient appointment letters and the Welsh Government's Planned Care Improvement Plan. However, without a long-term outpatient plan, most updates focus on short-term actions to reduce waiting lists.

38 Our 2025 planned care review found that the Health Board needs to strengthen Board level reporting on actual harm resulting from long planned care waits. We made a similar recommendation in our 2015 outpatient follow-up review. A report on the impact of long waits was expected to go to the Quality, Safety and Experience Committee in October 2025, but this has been delayed.

39 The Health Board reported that risks from delayed follow-up appointments are not recorded on its operational risk register. While there is a corporate risk linked to meeting Ministerial priorities for planned care recovery, this does not cover follow-up appointments because most fall outside the referral-to-treatment pathway. As a result, the risk of failing to reduce the number of patients waiting twice as long as they should for follow-up care is not captured.

Clinical risk assessment

While some validation processes are in place, they focus on long waits. Improvements are needed in clinical validation and proactive harm identification

40 Validating the outpatient waiting list enables the Health Board to better understand and manage service demand. It is a key process to ensure patients are seen on time, reducing the risk of avoidable harm. Some clinical conditions require more urgent attention, so regular administrative and clinical validation of waiting lists is essential to keep patients safe.

41 In 2015, we recommended implementing systems to identify patients at risk of irreversible harm from delayed follow-ups and develop targeted interventions to mitigate these risks. Our 2017 progress review found that despite identifying high-risk patients and updating clinical outcome forms, poor compliance and system limitations hindered timely follow-ups. Risks of harm remained due to inconsistent data capture and slow clinical validation.

42 Since our previous reviews, 21 specialties have adopted the updated clinical outcome forms. Each specialty now monitors its own forms and uses sample audits to check accuracy and compliance. While the forms help services to identify high-risk patients, it is unclear how the Health Board uses this information to prioritise patients at risk of irreversible harm from delays.

43 For example, the Health Board has the poorest performance against the Welsh Government's eye care measure. In October 2025, only 37.5%[9] of patients with the highest risk category (R1)[10] were waiting within their target date or within 25% beyond it.

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[9] The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

[10] The highest risk is known as Risk Factor 1 or R1. The R1 category is for patients assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

44 Additionally, as highlighted in **paragraph 19**, many ophthalmology follow-up appointments are delayed twice as long as they should be. This presents a significant risk of avoidable harm to patients. The Health Board acknowledges this issue, and ophthalmology is one of the fragile services being address through its Clinical Services Plan.

45 The Health Board has two administrative validation teams, looking at new and follow-up appointments. Following CIN guidelines to ensure data quality, the team conduct twice yearly validation of patients delayed by more than 100%. The Health Board reports that on average, through validation, about 20% of patients are removed from the waiting list or directed to self-management pathways. However, it is unclear how high-risk patients with shorter delays are monitored to ensure they are not coming to harm.

46 The Waiting List Support Service allows patients to self-report issues, but the service is not integrated into the validation process.

47 The team shares data from the validation exercise with specialties for clinical validation. The Health Board reported that clinical engagement in validation varies across specialties, though CIN guidelines have helped increase participation. There is currently no benchmark for clinical validation. Work is underway through a national transformation workstream to engage clinicians in clinical validation and introduce it into consultant job plans.

48 Our 2025 planned care review found that while the Health Board uses the Datix system to record clinical risks from treatment delays, there is no consistent approach across specialities for assessing and reporting risk of harm. We made a recommendation that the Health Board develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties.

49 Our previous reviews highlighted issues with data quality. We recommended identifying and addressing waiting list errors, including providing feedback to those involved in data entry to support learning. Weekly meetings with the follow-up validation team now help identify recurring issues and error patterns, with feedback shared via the validation manager or directly with specialties. Since June 2024, defined administrative validation outcomes, including reasons for removal and error details, are also tracked, reported, and shared as relevant to support continuous improvement.

50 However, issues can still arise due to system upgrades to WPAS, which may inadvertently introduce new errors. More broadly, the Health Board has a focus on improving the quality and use of data. As part of this work, it is conducting a series of data quality deep dives, including a review of current processes and validity of RTT waiting times.

Recommendations

51 We have made two recommendations; one replaces a recommendation from our 2015 and 2017 work.

52 The status of the 2015 and 2017 recommendations is set out in **Appendix 2**.

R1 The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is (**paragraph 29**):

- aligned with its long-term strategy and enabling plans such as digital and estates;
- based on current and projected future demand for services;
- costed, at minimum for the medium term (3-5 years);
- supported by resource plans i.e. financial, workforce and infrastructure;
- supported by clear delivery actions and milestones; and
- approved by the Board.

R2 The Health Board should improve the quality of its information and reduce harm by embedding a programme of regular participation of clinical validation across all specialties (**paragraph 47**).

Appendices

1 About our work

Scope of the audit

We looked at whether the Health Board has effective arrangements in place to manage its outpatient appointments. We also assessed the extent to which the Health Board has addressed audit recommendations from our follow-up outpatient reviews in 2015 and 2017.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have realistic plans to improve outpatient and follow-up outpatient services?
- Does the Health Board have appropriate leadership arrangements to drive improvements in outpatient services and address barriers that might inhibit progress?
- Does the Health Board have good quality information to effectively manage its outpatient service and reduce the risk of patient harm?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it had:

- made the expected progress in implementing our 2015 and 2017 follow-up audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the audits.
- current and longer-term plans in place to manage outpatient services.

Methods

We undertook our audit work between March and October 2025.

We reviewed the following key documents:

- Outpatient services transformation and improvement plans;
- Operational and executive level groups papers related to outpatient transformation;
- Outpatient programme governance and oversight arrangements;
- Performance dashboard for outpatient services;
- Board and committee papers;
- Operational and corporate risk registers; and
- Procedures for clinical assessment of patients waiting for a new or follow-up outpatient appointment.

We interviewed the following:

- Chief Operating Officer;
- Service Director for Planned and Specialised Care;
- General Manager for Cancer and Planned Clinical Care Group;
- General Manager Scheduled Care; and
- Validation Manager.

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2015 and 2017 recommendations. The Health Board submitted a completed self-assessment on 21 March 2025.

2 Previous recommendations

Our 2017 progress review found that eight of the nine recommendations made in our 2015 Review of Follow-up Outpatients Appointments were outstanding. We also made two new recommendations (recommendations 10 and 11). Below is the status of these recommendations based on our review.

Outpatient services transformation

R8 Develop and implement lean clinical condition pathways to improve quality, safety, and efficiency of service (**In progress, paragraph 23**).

R9 Plan for longer-term modernisation of outpatient services by taking stock of: (**Superseded by 2025 R1**)

- clinical resources, including medical, nursing, and allied health practitioners, required;
- the change capacity and skills required; and
- internal and external engagement with stakeholders.

Data quality

R1 Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy, and minimise the need for ongoing validation (**Complete, paragraph 49**).

R10 As part of the administrative validation process, ensure that there is a process in place to feedback the causes of errors to those involved in the data entry process, to ensure that learning takes place and that action is taken to reduce the same errors occurring again in the future (**Complete, paragraph 49**).

R11 Embed a programme of clinical validation across all specialties to ensure that patients waiting on the follow-up list are appropriate and to identify opportunities for managing this cohort of patients differently (**In progress, paragraph 47**).

Follow-up outpatient reporting

R2 Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable (**Complete, paragraph 35**).

R3 Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template (**Complete, paragraph 35**).

R4 Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and that this is reported to relevant subcommittees so that the Board can take assurance from monitoring and scrutiny arrangement (**In progress, paragraph 38**).

Clinical risk assessment

R6 Put in place systems and processes that will allow the Health Board to identify patients with conditions where they could come to irreversible harm if delays occur in follow-up appointments (**Complete, paragraph 42**).

R7 Develop targeted interventions to minimise the risk to patients with conditions where they could come to irreversible harm if delays occur in follow-up appointments (**In progress, paragraph 42**).

3 Key terms in this report

Term	Description
100% delayed	100% delayed" means the patient's planned care activity (such as a follow-up or treatment) has been delayed by twice the target time set for that activity.
Administrative Validation	Administrative validation is the process of verifying that non-clinical data—such as patient demographics, appointment details, or waiting list entries—is accurate and correctly recorded in administrative systems.
Clinical Validation	Clinical validation is the process of checking that a documented diagnosis is supported by clear clinical evidence in the patient's record to ensure accuracy and compliance.
Clinical Implementation Networks	Clinical Implementation Networks (CIN) are collaborative groups established under the National Clinical Framework to implement evidence-based clinical improvements.
DNA rate	Did Not Attend (DNA) rate, refers to instances where a patient fails to attend a scheduled appointment without prior notice.
Executive Improving Together	Executive Improving Together in Hywel Dda is a framework where the Executive Team leads continuous improvement by aligning goals, using data dashboards, and fostering a culture of problem-solving and innovation to deliver better outcomes.
IQFPD	Integrated Quality, Finance, Performance and Delivery (IQFPD) Group is an executive

	governance group within Hywel Dda University Health Board. Its role is to oversee and coordinate the delivery of the Health Board's Annual Plan, ensuring alignment across quality, finance, performance, and operational delivery, while managing risks and supporting Welsh Government improvement requirements.
Patient Initiated Follow-Up	Patient Initiated Follow-Up (PIFU) gives patients the flexibility to arrange their follow-up appointments only when they feel they need them, rather than being scheduled for routine check-ups at fixed intervals.
Referral to Treatment	Referral to Treatment (RTT) is the time from when a patient is first referred for specialist care to when they start their treatment, covering all steps like consultations, tests, and pre-treatment processes.
See on Symptom	See on Symptom (SOS) is an outpatient care model that allows patients to self-refer for follow-up only if symptoms reappear or worsen, rather than attending routine scheduled appointments.
WPAS	Welsh Patient Administration System (WPAS) is the largest IT system in NHS Wales. It is designed to manage patient administrative data across secondary care settings.

4 Management response

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is (paragraph 29): • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services;	HDUHB Outpatient Annual Plan (2026/27) is in development but is reliant on service specific demand and capacity planning. The annual plan for OPD is being developed in partnership with digital, estates, finance, and workforce. This comprises of the following elements which will be delivered over the course of the 4 quarters of the year 2026/7. By the end of Q4 (2025/26) the longer-term plan for Outpatients into 26/27 will be drawn together using all components as noted below: **Q1** • The Care group will consolidate all key work to date. A full review of available estate will be scoped in line with longer term Clinical Service strategy and fragile services delivery working in collaboration with our estates and capital departments.	31/3/2026 31/3/2026 01/06/2026	Planned Care and specialist services Director of Planning and Performance General Manager (LH) Head of Nursing (JS)

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	• costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	• Future delivery is dependent on the outcome of the HDUHB strategy objectives and the Clinical Service Planning (CSP) outcomes. • Initial costings will be worked on to include estates work needed and co- dependant recruitment of skilled staff. Key areas of work include: • Digital Transformation • OPD workforce plan is currently looking at different models of care to support our population. This is being led by the Nursing team. This would include extended roles, staff working to top of their licence, increasing training opportunities, specialist skills. This includes nursing support staff such as Health Care Support Workers. • Capacity and demand planning will underpin required models of OPD delivery including use of digital technology and WG mandated use of CIN pathways **Q2** • All estate plans completed and costed, and funding routes identified • Workforce training needs analysis completed and initiated • Alternative models of delivery becoming embedded into systems	31/06/2026 31/06/2026 31/03/2026 - 30/06/2026 30/06/2026 30/06/2026 30/06/2026	Transformation Programme Lead (SH)

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Q3 • Review of all key components to be scoped and any remedial actions taken on failure to deliver **Q4** • Clinical Services Plan initiation particularly in fragile services • Scoping of completed extended practice roles and how they can support delivery 2027/28 • Continued use of digital frameworks to support delivery of Outpatients services All these key actions will be underpinned by the progressive transformation of delivery including and not exclusive to improvements in DNA, SOS/PIFU usage, clinic utilisation improvements, OPD booking model being digitalised and improved use of Health Care pathways.	01/07/2026 - 30/09/2026 31/03/2027 31/03/2027 31/07/2026 31/01/2027	
R2	The Health Board should improve the quality of its information and reduce harm by embedding a programme of regular participation of clinical	The Health Board currently undertake ad-hoc clinical validation. All long waiting patients (104 weeks RTT & Delayed Follow ups) are validated. This is by administrative staff who manually interrogate the WPAS system.		General Manager (LH) Clinical Director (MH)

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	validation across all specialties (paragraph 47).	Most specialties undertake clinical validation of referrals as part of their on-call session. HDUHB routinely return 30% of referrals with advice & guidance. To implement a regular clinical validation requires changes to job plans which will take time to embed. This means that F2F clinic appointments will be reduced freeing up job plan time to clinically validate into practice. An enabling action that will support resource re-allocation is the elimination of longest waiting follow up patients. Historic follow ups (i.e. over 2 years) are being moved over to SOS/PIFU pathways (as per Clinical Implementation Guidelines). Stepped timeframe as noted in Date column **Step 1.** This supports the timeframe for the enabling actions to be completed regarding the transfer of historic follow ups and recruitment into admin validation and training. **Step 2** Supporting all Clinical validation to be factored into job plan consolidating work already being undertaken.	Initial completion date 30th June 2026 Further date of 31st July 2026	

About us

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