QSIC 2026_06_04 - Screening Update to QSIC – Appendix A

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Other (stated below) **Date of Meeting** 12 May 2026 **Agenda item:**

Breast Test Wales (BTW) Improvement Plan Update	
Executive lead:	Meng Khaw, Executive Director / National Director. Health Protection and Screening Services Executive Medical Director
Author:	• Dean Phillips, Head of Programme, Breast Test Wales

Approval/Scrutiny route:	• Screening Division SMT / BTW Performance Group - 06 May 2026 • HPSS Directorate Management Team – 12 May 2026

Purpose
To provide assurance on progress against the Breast Test Wales (BTW) Improvement Implementation Plan 2026-27, highlighting delivery progress, key risks, resource constraints and areas requiring escalation.

Recommendation:				
APPROVE ☐	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒
The Directorate Management Team is asked to: • Receive assurance that BTW Improvement Implementation has strengthened governance and monitoring arrangements and is progressing delivery across key improvement domains. • Consider ongoing progress updates, delivery constraints and assurance required to support BTW improvement.				

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	6 - A highly skilled, engaged and sustainable workforce
Strategic Priority/Well-being Objective	7 - Strong governance and system leadership

Summary impact analysis	
Equality and Health Impact Assessment	Improving reading timeliness, assessment timeliness and round length supports equitable access across Wales. Uptake and inequality work remains a priority and is being reviewed through the Uptake & Equities Group and programme governance.
Risk and Assurance	Key risks remain in North Wales assessment capacity, surgeon-dependent pathway constraints, workforce sustainability, round length recovery, mobile reliability and financial constraints affecting training and establishment planning. These are monitored through monthly improvement oversight and the BTW Performance Group.
Health and Social Care (Quality and Engagement) (Wales) Act	The programme supports safe, timely and effective care through strengthened governance, weekly monitoring, quality assurance, exception reporting and structured escalation of delivery risks.
Financial implications	Significant resource constraints remain. No dedicated training budget is currently available, several workforce business cases require further evidence or approval, and additional capacity options may require funding decisions.
People implications	Workforce resilience remains challenging across teams. New readers are progressing, but maternity leave, sickness, reliance on bank staff and limited establishment continue to affect sustainable delivery and capacity growth.

1 Background, Context & Executive Summary

The April position shows that the Improvement Implementation Plan has matured into an active delivery and oversight framework. Reading timeliness is broadly stable and weekly monitoring is embedded. Cross-regional reading support is operational and North Wales connectivity issues have been resolved. The main challenge has shifted from immediate reading recovery to sustaining resilience, improving the recall-to-assessment pathway, and mitigating workforce and surgical dependencies.

Assessment timeliness remains the most significant operational concern. Although radiology-led / surgeon-less clinics in North Wales have been successfully used and some single-handed clinic restrictions have been addressed, the pathway remains constrained by surgical capacity, postal and digital limitations, fixed nursing capacity and downstream treatment waits. Bringing double reading forward towards day 7 is now an important tactical action to support the three-week assessment standard.

Round length recovery continues to require validation, modelling and capacity action. The Performance Group confirmed that workforce capacity, mobile reliability, data definitions and the limits of NBSS appointment logic remain material constraints. Options such as extended days, overbooking and optimisation should be modelled carefully because they create staff, cost and future-round implications.

Uptake and equity actions are now Green but require stronger evidence base from the Uptake & Equities Group, clear priority cohorts, and measurable programme-level ownership. The Breast Screening Review remains at the communication stage and must be aligned to the Operational Plan once recommendations are confirmed.

1.1 April position at a glance

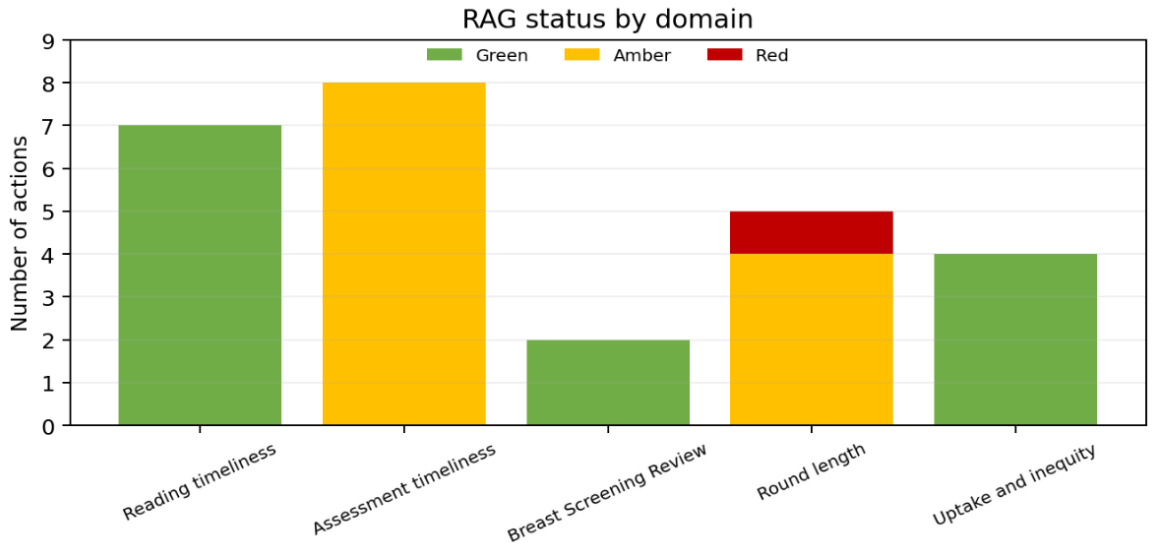
Key achievements	Key constraints / escalation	Immediate management actions
• Reading timeliness and normal results generally good; weekly monitoring in place. • Cross-regional support active and manager coordination strengthened. • North Wales connectivity issues resolved. • Radiology-led/surgeon-less North clinics successful and passed through MDT without major issues. • Uptake/equity actions now Green within the action tracker.	• Three-week assessment standard difficult due to postal delays, limited digital capability and assessment entering pathway around day 14. • Wrexham / Glan Clwyd pathway pressures and later pathway surgical waits. • Swansea surgical expansion blocked by fixed-term nursing hours. • Round length recovery constrained by workforce, mobile reliability and NBSS logic/data limitations.	• Bring double reading closer to day 7 where feasible. • Complete centre pathway walk-throughs from arbitration to assessment invite. • Quantify staff/session shortfall for summer pressures and business cases. • Escalate BCU surgical model and agree safe use of competent non-screening breast surgeons where appropriate. • Model extended hours/overbooking/optimisation before implementation.

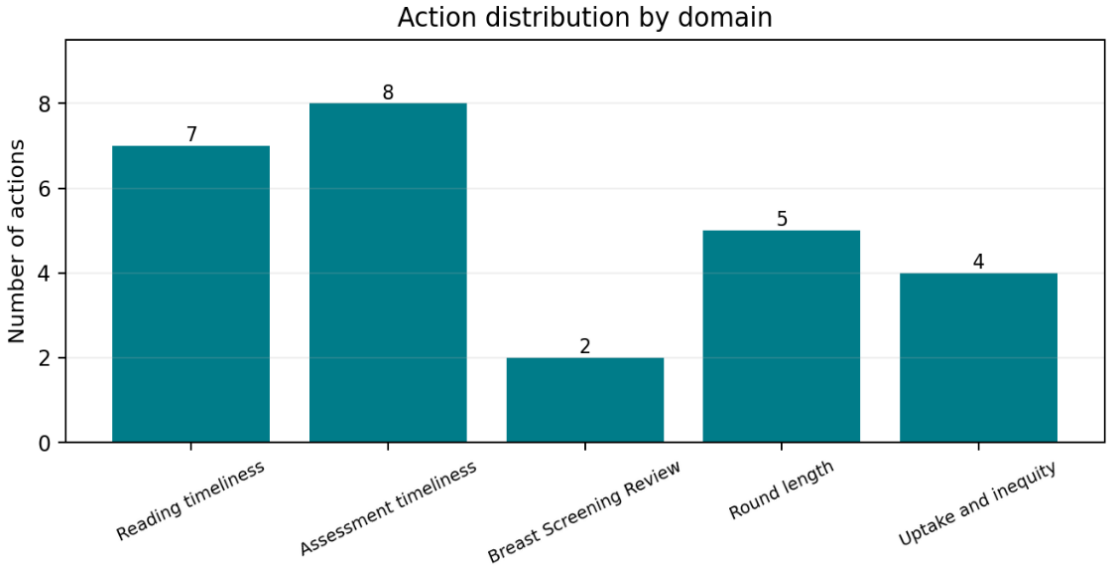
2 Improvement dashboard and trajectory

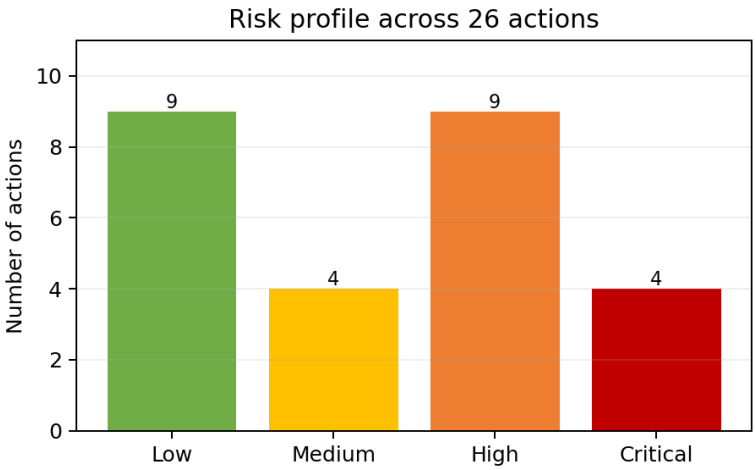
The dashboard below has been laid out separately from the narrative to improve readability. It summarises the current RAG profile, risk profile, delivery confidence and indicative delivery windows across the five improvement domains.

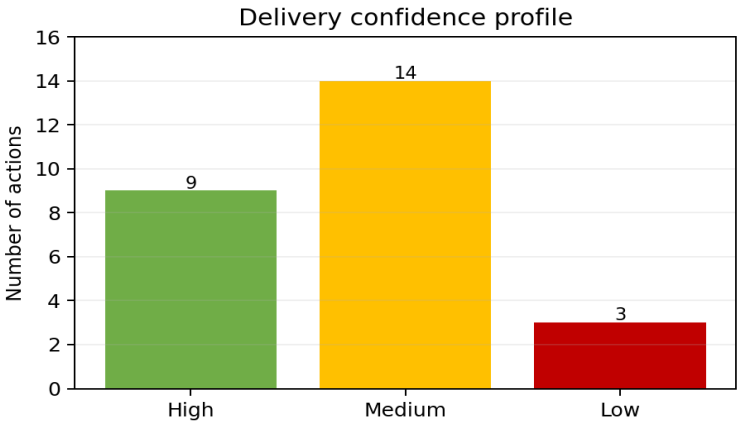
Interpretation note

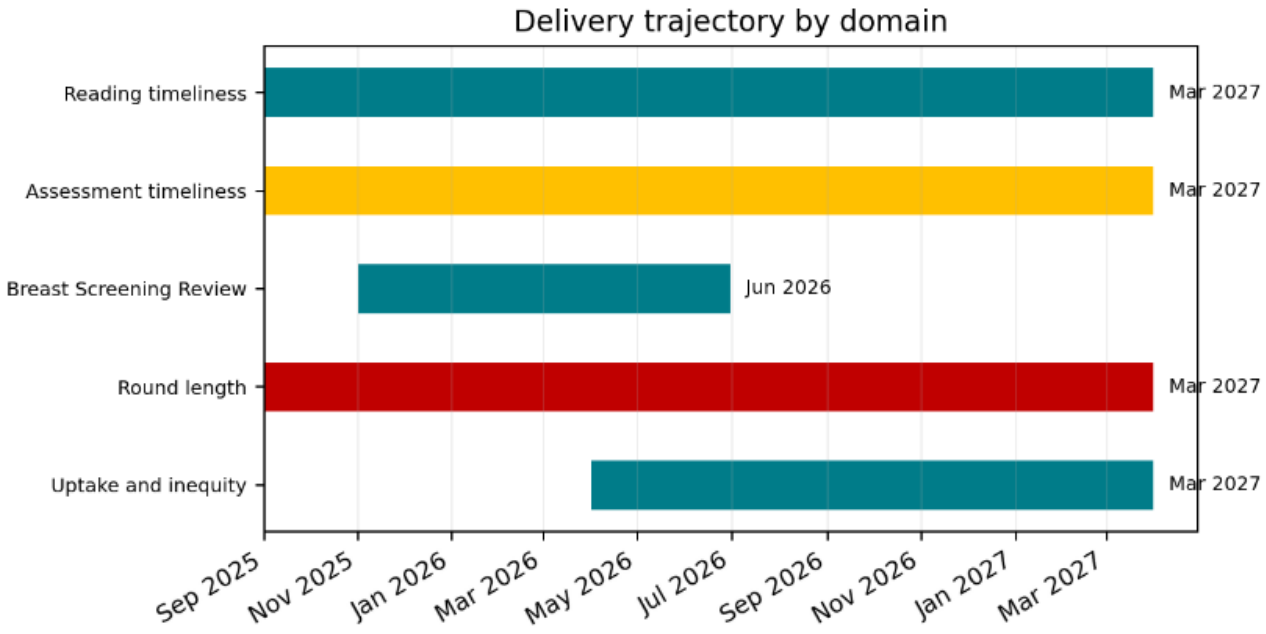
- The RAG and risk charts are management views based on the current action tracker and April Performance Group update.
- The trajectory chart is a milestone view, not a statistical forecast. Numerical SPAR trajectories should be added where available in future reports.











Current action profile

- 26 actions tracked across 5 domains
- RAG: 13 Green, 12 Amber, 1 Red
- Risk: 9 Low, 4 Medium, 9 High, 4 Critical
- Confidence: 9 High, 14 Medium, 3 Low

4 Domain updates, actions and trajectories

4.1 Reading timeliness

April position	All 7 actions Green. Delivery is stable but dependent on continued cross-regional support and reader availability.
Key April update	Most reading-related actions are already in place. Cross-regional reading support is active, North Wales connectivity is resolved, training/onboarding continues, and weekly monitoring confirms that extra evening/weekend reading is not currently required.
Trajectory / expected next position	Maintain Green position; formalise cross-site support and workflow by Jun-Sep 2026; continue training pipeline to Dec 2026 and weekly variance monitoring to Mar 2027.
Management focus	Sustain resilience rather than immediate recovery.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
a) Implement cross-regional reading support from West and South regions.	G	G	Medium Conf: Medium	Cross-regional support is active, particularly to support North. Coordination has strengthened through regular manager catch-ups. Readers need clearer prompts to look beyond their own centre due to multiple NBSS log-ins; early notice of anticipated absences is useful.	Next: Formalise cross-site protocol, reinforce reader prompts and maintain early absence-notification arrangements. Trajectory: Sustain compliance with reading timeliness through weekly monitoring; cross-site support protocol by Sep 2026.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
b) Improve cross-site reporting workflow through All-Wales workflow optimisation.	G	G	Medium Conf: Medium	Workflow optimisation continues. A single BTW worklist remains constrained by three NBSS instances, different regional work rates and variable film-loading speeds.	Next: Agree standard process and practical workarounds; document digital/system constraints for escalation. Trajectory: Reduced regional variation by Jun 2026; long-term improvement remains dependent on digital system capability.
c) Explore and deploy additional evening/weekend reading sessions if required.	G	G	Medium Conf: Medium	Additional evening/weekend reading is not currently required because reading is being monitored weekly and timeliness is generally good.	Next: Maintain contingency and activate only if variance or backlog growth emerges. Trajectory: No backlog growth; rapid response to demand spikes.
d) Ensure network connectivity is maintained in North Wales following resolution.	G	G	High Conf: Medium	North Wales connectivity issues have been resolved and are no longer the main barrier to reading timeliness.	Next: Continue monitoring reliability and escalate recurrent IT/network issues quickly. Trajectory: Network no longer a material barrier to reading timeliness.
e) Train and qualify new film readers across North Wales.	G	G	High Conf: Medium	Training and onboarding of new readers is ongoing with QA, sign-off and re-sit support continuing.	Next: Complete sign-off and supervisor QA requirements; monitor when new capacity is realised in rotas. Trajectory: Increased qualified reader capacity by Dec 2026 while maintaining QA standards.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
f) Introduce newly qualified radiologist and breast clinicians into reading rota.	G	G	High Conf: Medium	Rota integration remains in progress and is linked to joint appointment and training discussions.	Next: Confirm phased rota integration and ensure supervision/QA arrangements are documented. Trajectory: Improved resilience of the North Wales reading rota; April milestone to be confirmed/closed through ongoing rota planning.
g) Monitor reading timeliness and act upon variance.	G	G	Medium Conf: Medium	Reading timeliness and normal results are generally good; weekly monitoring remains in place.	Next: Maintain weekly dashboard review and escalation of variance through programme governance. Trajectory: Earlier identification and correction of performance drift through Mar 2027.

4.2 Assessment timeliness

April position	8 Amber actions. Improvement activity is active, but delivery remains fragile and dependent on Health Board surgical capacity, nursing support and pathway changes.
Key April update	Radiology-led / surgeon-less North clinics have been successful and some surgical restrictions have been addressed. However, postal/digital limitations, Wrexham / Glan Clwyd surgical waits and fixed-term nursing hours in Swansea continue to constrain the pathway.
Trajectory / expected next position	Bring double reading closer to day 7 and complete pathway walk-throughs in May. BCU milestones and Swansea nursing arrangements should be confirmed during Q1-Q2 2026/27. Sustained recovery target remains Mar 2027.
Management focus	Primary escalation risk for DMT.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
a) Actively manage assessment clinics around surgeon annual leave.	A	A	Critical Conf: Low	Radiology-led / surgeon-less clinics in North Wales have been successful and have gone through MDT without major issues. Capacity remains vulnerable to leave and surgical constraints.	Next: Continue advice/support on safe radiology-led practice and reuse of vacant clinic slots where feasible. Trajectory: Reduced leave-related disruption once revised clinical model is reliably embedded.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
b) Maintain core assessment capacity and avoid cancellations.	A	A	Critical Conf: Low	The three-week assessment standard remains difficult because of postal delays and limited digital capability; cases are entering assessment closer to day 14. North-West is manageable, but Wrexham / Glan Clwyd surgical waits are escalating.	Next: Bring double reading closer to day 7 where feasible; continue weekly BCU engagement and maintain rebooking arrangements. Trajectory: Stabilise clinic capacity during 2026/27; risk remains dependent on BCU surgical access and digital/postal constraints.
c) Build resilient nursing support during sickness/leave.	A	A	High Conf: Medium	Increasing surgical sessions in Swansea is currently blocked by nursing constraints; fixed-term nursing hours are insufficient to support substantive surgeons.	Next: Progress permanent nursing hours and review deployment options across regions. Trajectory: Improved nursing cover resilience once sustainable hours and deployment arrangements are agreed.
d) Recruit consultant surgeons (Hywel Dda, BCU) to strengthen workforce.	A	A	Low Conf: High	Hywel Dda surgeon April start is constrained by nursing hours; BCU discussions continue. BCU asked whether competent non-screening breast surgeons could support surgical cases, which was agreed in principle and fed back.	Next: Formalise job plan, permanent BCN support and BCU surgeon deployment arrangements. Trajectory: Additional consultant support by Sep 2026, with risk reducing when regular sessions are in place.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
e) Run additional assessment clinics in South and North Wales to reduce backlogs.	A	A	High Conf: High	No additional clinics are currently running; this will be reviewed if pressures increase. Staffing and clinic-model barriers must be resolved before opening extra clinics.	Next: Model staffing and clinic capacity; log cancellations/staff shortages on risk/Datix registers and regional reports. Trajectory: Ability to add clinics in North/South by Jun 2026 if workforce and model dependencies are resolved.
f) Resolve surgical restrictions in BCU (Wrexham/Llandudno).	A	A	High Conf: Low	Some single-handed clinic restrictions have been addressed. Delays later in the pathway remain a risk, with women potentially close to or beyond 62 days by assessment.	Next: Escalate surgical pathway concerns with BCU and agree deliverable model, including safe use of non-screening breast surgeons where appropriate. Trajectory: Agreed and deliverable surgical model for North Wales assessment.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
g) Work jointly with BCU on sustainable surgical provision aligned to need.	A	A	High Conf: Medium	Weekly communication with BCU is ongoing to progress an additional surgeon in North-West; a letter has been sent regarding surgical wait times.	Next: Define joint milestones, accountabilities and delivery dates; monitor Wrexham/Glan Clwyd position. Trajectory: Measurable cross-organisational pathway progress by Jul 2026.
h) Progress training of breast clinicians and radiologists to expand capacity.	G	A	High Conf: High	Training and joint working are progressing and remain linked to clinic delivery planning.	Next: Maintain training pipeline and quantify when new trained capacity will convert into clinic delivery. Trajectory: Expanded trained workforce by Dec 2026.

4.3 Breast Screening Review

April position	2 Green actions. Review activity is at communication/translation stage.
Key April update	No detailed Performance Group discussion was held. Work should continue to ensure service impacts and constraints are represented and recommendations are converted into owned actions.
Trajectory / expected next position	Align recommendations to the Operational Plan and Performance Group work during Q1-Q2 2026/27.
Management focus	Translate outputs into owned operational actions.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
a) Conduct internal review including document review, staff discussions, focus groups and surveys.	G	G	Low Conf: High	The Breast Screening Review is at the communication stage; no detailed discussion occurred at the Performance Group.	Next: Continue to ensure service views, impacts and constraints are represented as the review progresses. Trajectory: Review outputs aligned to Performance Group work and 2026/27 planning.
b) Produce report with recommendations and improvement proposals.	G	G	Low Conf: High	Recommendations will be aligned to the Operational Plan and improvement workstreams once confirmed. No comments or questions were received on the DMT paper at the Performance Group.	Next: Translate confirmed recommendations into owned actions with timescales, dependencies and escalation routes. Trajectory: Published recommendations translated into agreed improvement actions during Q1-Q2 2026/27.

4.4 Round length

April position	1 Red and 4 Amber actions. Workforce capacity is the key Red risk; modelling, mobile reliability, data validation and funding remain Amber.
Key April update	Round length strategy discussions highlighted data discrepancies, NBSS limitations, workforce constraints, mobile reliability and the need to model extended hours/overbooking/optimisation before implementation.
Trajectory / expected next position	Complete validation and modelling in Q1-Q2 2026/27; test staff appetite for extended hours; prepare summer workforce/business case paper; improve mobile reliability by Dec 2026 and restore sustainable capacity by Mar 2027.
Management focus	Recovery dependent on sustainable capacity and reliable data.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
a) Implement round-length modelling to prioritise longest waits.	A	A	Low Conf: Medium	Round length strategy was reviewed. Concerns remain about data discrepancies and comparisons with England due to system differences and NBSS average-based reporting.	Next: Meet with Innovation Team; gather intelligence from Dorset/England/Scotland on "next test due" and recovery strategies. Trajectory: Validated modelling and prioritisation approach during Q1-Q2 2026/27.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
b) Maintain regional workforce capacity (radiographers, admin, mobile teams).	A	R	Critical Conf: Medium	Staffing capacity remains the key limiting factor. Cardiff / Swansea and upcoming maternity leave pressures were highlighted; service capacity cannot be increased by reworking hours alone.	Next: Quantify reading/session shortfall, prepare summer staffing paper and support business cases; log shortages/cancellations consistently. Trajectory: Red until sustainable baseline workforce/funding is agreed; recovery target Mar 2027.
c) Improve reliability of screening mobiles through IMT.	R	A	High Conf: Medium	Mobile reliability remains a material dependency for round length, with breakdown/cancellation effects requiring continued monitoring.	Next: Continue IMT actions and monthly monitoring of mobile-related cancellations. Trajectory: Fewer mobile-related clinic cancellations by Dec 2026.
d) Validate round-length data calculations to ensure accurate monitoring.	A	A	Low Conf: Medium	Data discrepancies and system limitations were discussed. Accurate reporting remains essential for confidence in trajectories and recovery actions.	Next: Confirm definitions and reporting limitations with the Innovation Team; maintain SPAR validation and exception reporting. Trajectory: Assured and consistent round-length reporting by mid-2026.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
e) Secure funding for additional screening capacity if required.	A	A	Critical Conf: Medium	Extended days, overbooking and optimisation were discussed. Benefits must be modelled; extended hours would be additional, not replacement, hours and would incur extra cost.	Next: RadMans to test staff appetite for extended hours; DP/NL to prepare Bridgend/summer staffing paper; model cost and net benefit. Trajectory: Funding/capacity decision to support recovery by Jun 2026.

4.5 Uptake and inequity

April position	4 Green actions. Direction of travel is positive but requires the Uptake & Equities Group update and measurable priority cohorts.
Key April update	The action plan remains aligned to uptake analysis, targeted engagement, mobile accessibility and Screening Equity Strategy work. DP to update this section from Uptake & Equities Group discussion.
Trajectory / expected next position	Agree priority cohorts by May 2026; mobilise targeted engagement from Jun 2026; agree mobile accessibility improvements by Sep 2026; complete strategy implementation actions by Mar 2027.
Management focus	Ensure measurable priority cohorts and programme-level ownership.

Action	RAG *Last month*	RAG *This month*	Risk / conf.	April progress	Next action / trajectory
a) Analyse uptake by deprivation, geography and demographics to identify inequalities.	G	G	Low Conf: High	Update required from Uptake & Equities Group. Existing plan remains to define priority cohorts/areas using structured uptake analysis.	Next: Complete structured analysis and bring priority cohorts/areas back into improvement governance. Trajectory: Priority cohorts/areas agreed by May 2026.
b) Deliver targeted communication and engagement approaches.	G	G	Low Conf: High	Targeted engagement will continue, with communications and support roles to be defined across programmes.	Next: Align activity to priority cohorts and report through Uptake Group/Performance Group. Trajectory: Targeted activity mobilised from Jun 2026 to Mar 2027.
c) Improve accessibility of mobile screening locations.	G	G	Low Conf: High	Mobile siting/accessibility issues remain under review; extended clinic approaches should be trialled only where evidence suggests benefit.	Next: Identify practical accessibility improvements and prioritise areas where uptake/attendance is lower. Trajectory: Practical access improvements agreed by Sep 2026.
d) Update Screening Equity Strategy and implement recommendations.	G	G	Low Conf: High	Strategy update to align with Uptake Group actions and review recommendations.	Next: Draft recommendations with owners, milestones and measurable outputs. Trajectory: Updated strategy and implementation plan by Mar 2027.

6 Key risks and escalation requirements

Risk	Rating	April position	Required action
Assessment capacity - North Wales	High/Critical	BCU surgical capacity, Wrexham / Glan Clwyd waits and downstream 62-day pathway pressure remain the principal escalation risks.	Continue weekly BCU engagement; agree safe surgical model; include progress in monthly DMT exceptions.
Assessment pathway administration	High	Postal delays, limited digital capability and paperwork/batching processes can erode the three-week standard even where clinic dates are available.	Complete pathway walk-throughs; bring double reading towards day 7; streamline batching/letters where feasible.
Workforce resilience	Critical	Staffing shortages, maternity leave, bank reliance and Band 7s covering screening reduce reader/clinic resilience.	Quantify session shortfall; prepare business cases; log impact consistently on risk/Datix.
Hywel Dda surgeons	High	Sustainable increase in nursing hours is needed to support additional surgeons; fixed-term hours are insufficient.	Escalate permanent BCN/nursing hours decision and evidence impact of existing short-term approval.
Round length recovery	High/Critical	Workforce capacity, mobile reliability, data confidence and NBSS optimisation limits restrict recovery pace.	Complete modelling/validation; monitor mobile cancellations; model extended hours/overbooking before trialling.
Funding / training	High	No training budget and stalled business cases risk future workforce capacity.	Maintain escalation through improvement governance and link to sustainability/business case evidence.

7 5. Recommendation

- Receive assurance that the improvement plan is under active governance with 26 actions tracked across 5 domains and a defined delivery window to March 2027.
- Note that reading timeliness is currently stable but depends on sustained cross-regional support, reader availability and continued weekly monitoring.
- Escalate assessment timeliness and round length recovery constraints through DMT, with particular focus on BCU surgical capacity, Swansea nursing sustainability, workforce evidence and business case decisions.
- Endorse the cross-domain April action log and request that owners provide progress updates at the next Performance Group meeting.
- Agree that future updates include numerical SPAR trajectories where available, alongside the current RAG/milestone trajectory dashboard.

As above, The Directorate Management Team is asked to:

- **Receive assurance** that DESW Improvement Implementation Plan has been established and work priorities within the Programme are directed on addressing the actions outlined within timescales indicated.
- **Consider** ongoing progress updates and assurance required to Board for DESW Improvement Implementation plan governance.

QSIC 2026_06_04 - Screening Update to QSIC – Appendix B

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Other (stated below) **Date of Meeting** **Agenda item:**

Bowel Screening Wales (BSW) Improvement Plan Update	
Executive lead:	Dr Sharon Hillier (Director of Screening Services)
Author:	Steve Court (Head of Programme, BSW)

Approval/Scrutiny route:	Screening Division SMT – 05.05.2026 HPSS Directorate Management Team – 12.05.2026

Purpose
To provide an update on the progress of the BSW Screening Colonoscopy Improvement Project (SCIP) to the Public Health Wales Strategic Planning Executive Team

Recommendation:				
APPROVE ☐	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Directorate Management Team is asked to:

Receive **assurance** of the establishment of BSW Screening Colonoscopy Improvement Project (SCIP) to enable a collaborative approach between BSW, the health boards and external partners to reduce screening colonoscopy waiting times.

Consider ongoing progress updates and provide the assurance required to BET for the BSW Screening Colonoscopy Improvement Project (SCIP).

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	5 - Supporting a sustainable health and care system

Summary impact analysis	
Equality and Health Impact Assessment	To ensure equitable and timely access to screening colonoscopy across Wales
Risk and Assurance	See Risks below
Health and Social Care (Quality and Engagement) (Wales) Act	Quality Improvement
Financial implications	Possible financial implications of improvement recommendations (to be determined)
People implications	Not applicable

1 Background & Context

Bowel Screening Wales (BSW) commissions pre-colonoscopy assessment and screening colonoscopy from all seven health boards in Wales, with funding for both functions provided directly by Public Health Wales via the Long-Term Agreement (LTA) process.

The timeliness of screening colonoscopy across Wales is challenged, meaning the 4-week screening waiting time standard is not being achieved in any of the seven health boards (average waiting time currently of 7 weeks, range 5-12 weeks [24.04.26]).

The challenges contributing to the prolonged waiting times include:

- Lack of core screening capacity, caused by an insufficient number of accredited Screening Colonoscopists in some health boards to meet the required demand and a lack of accredited non-medical Clinical Endoscopists in Wales (just two individuals)
- Competing demands on a limited pool of accredited clinicians who also have responsibilities in non-screening endoscopy and wider medical and surgical services
- Competition for nursing and theatre space between screening and non-screening colonoscopy
- Increased demand resulting from the age expansion of the screening programme, combined with insufficient health board workforce and service planning to meet the modelled requirement for additional screening colonoscopy capacity
- Fragility of the service, with an inability to backfill lost screening lists caused by absences within the Screening Colonoscopist or Specialist Screening Practitioner (screening nurse) teams
- Lack of dedicated training and mentorship lists to assist candidates achieve screening accreditation in a timely manner
- Variation in service delivery models and planning for screening procedures
- Cross–health board referrals for screening colonoscopy, caused by participant choice or outcomes of pre-colonoscopy health assessments, can disrupt local planning and service delivery in the receiving health board
- Inconsistent performance against the LTA commissioning agreements, with most health boards failing to deliver the quantity of commissioned and funded index (first) colonoscopies required to meet the screening demand

In response to this lack of core screening capacity, most health boards have become increasingly reliant on insourcing arrangements to increase capacity and waiting time initiatives to reduce waiting times.

Actions Taken by BSW to Address This Issue

Screening colonoscopy waiting times have been challenged for a prolonged period and the following actions have and continue to be taken to address this issue:

- Timeliness for screening colonoscopy is monitored by BSW on a weekly basis and this information is shared across all the health board endoscopy teams (waiting time data)
- In collaboration with BSW, NHS Performance and Improvement has developed a bespoke bowel screening Patient Tracking List (PTL) that provides the health board endoscopy and cancer planning team's contemporaneous visualisation of the quantity of screening participants waiting pre-assessment and colonoscopy (data on the number of people waiting)
- BSW provides mentorship and practical support to aspiring Screening Colonoscopists awaiting formal accreditation assessment, with an additional Screening Colonoscopist based at Swansea Bay UHB recently accredited (18 April 2026)
- The BSW quality team meet monthly with each of the seven-health board screening endoscopy teams to discuss performance against the 4-week timeliness standard and discuss local options to increase capacity
- Public Health Wales has held a series of Executive-to-Executive meetings with each of the seven Health Boards to examine the challenges related to limited core screening capacity and extended waiting times. Following these discussions, the Chief Executive of Public Health Wales has formally requested recovery plans from all Health Boards; these have subsequently been received

The Screening Colonoscopy Improvement Project

On 2 February 2026, the BSW Programme Board approved the establishment of a formal project: the Screening Colonoscopy Improvement Project (SCIP). This 12-month, project-based approach will enable the screening programme to provide structured oversight and strengthen collaboration between BSW and the commissioned screening colonoscopy service providers, with the overall aim of improving the timeliness for screening colonoscopy across Wales. It is expected that the discussions and resulting recommendations will involve short, medium, and long-term changes to system wide service delivery and training functions. Consequently, any impact on waiting-time performance may not be immediate.

BSW has subsequently established an over-arching 'project board', tasked with advising, scrutinising and approving any recommendations to improve the operational delivery made by the five key discussion workstreams. The 'project board' membership has been agreed, as too has each of the discussion workstreams.

1.1. Scope of the Bowel Screening Wales (BSW) Improvement Plan

The overarching vision for BSW is that:

The SCIP will allow an opportunity for a coordinated and collaborative approach between BSW, the health boards and key partners to explore options for service improvement with screening endoscopy.

This will enable BSW to achieve its aim of:

- Increasing core screening colonoscopy capacity
- Improve service resilience
- Improve the timeliness for screening colonoscopy

1.2. BSW Improvement Plans: overarching aims & objectives

- Closer collaboration between the seven health boards, BSW and external partners (including the National Endoscopy Programme, Health Education and Improvement Wales, and NHS Performance and Improvement).
- The project will explore options to increase core screening colonoscopy capacity, increase screening endoscopy service resilience and reduce waiting times.

2 Improvement Plan Update

2.1 Overall Timeline

12-month project, with recommendations for improvement presented throughout the duration of the project.

2.2 Key Achievements (April 2026)

- The confidence in the each of stated health board recovery plans delivering their stated objectives has been assessed and this has been communicated to Welsh Government and fed back to each of the seven health boards
- The membership of the 'project board' has been finalised with the first meeting of the 'Board' held on 15 April 2026, at which the 'Board's' terms of reference was agreed and the project approach and scope approved
- The membership of each of the five main discussion workstreams has also been finalised, with the first meetings of each workstream taking place during the week commencing 05 May 2026
- Intelligence packs detailing the background information for each of the five workstreams have been finalised
- Membership of the SCIP has been further extended, with colleagues for the PHE I&I Hub recently recruited to the 'project board' and workstreams

2.3 Key risks, issues & dependencies

- Limited availability of clinicians and key external partners to contribute time to the project (possible, as this work is unlikely to be incorporated into existing job plans or workload commitments)
- Insufficient engagement from health board endoscopy services (unlikely, given current strong support for collaborative working)
- Competing priorities within BSW leading to project delays (unlikely, due to the 'appointment' of a dedicated Project Manager and the agreed priority status of this work within BSW)
- Reluctance from health boards to adopt proposed changes (possible; however, established escalation processes are expected to mitigate this risk)
- Financial implications of improvement recommendations, with insufficient
- funding posing a barrier to implementation (possible, particularly in the context of ongoing financial recovery requirements)
- Downstream additional demand for Pathology caused by any increase in screening colonoscopy activity as a direct consequence of improvements made by the SCIP (possible, as any increase in colonoscopy activity will generate additional demand for Pathology)

2.4 Improvement Area: Project Progress

The overall aims of this 12-month collaborative project are threefold:

1. Increase core screening colonoscopy capacity
2. Improve service resilience
3. With the ultimate aim of improving screening colonoscopy waiting times to the BSW 28-day standard (90% within 28-days)

2.4.1 Improvement Actions Update – Project Progress Update

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
a) Overarching Project Board Established			1. Inaugural meeting of the Project Board held on 15 April 2026 2. Project Board Terms of Reference discussed and approved during this first meeting SCIP scope and project approach discussed and ratified by the Project Board	• Project Board second meeting to be held in June to discuss the first set of recommendations.	Board meeting takes place as scheduled and all planned activities agreed. Minutes of Project Board meeting produced

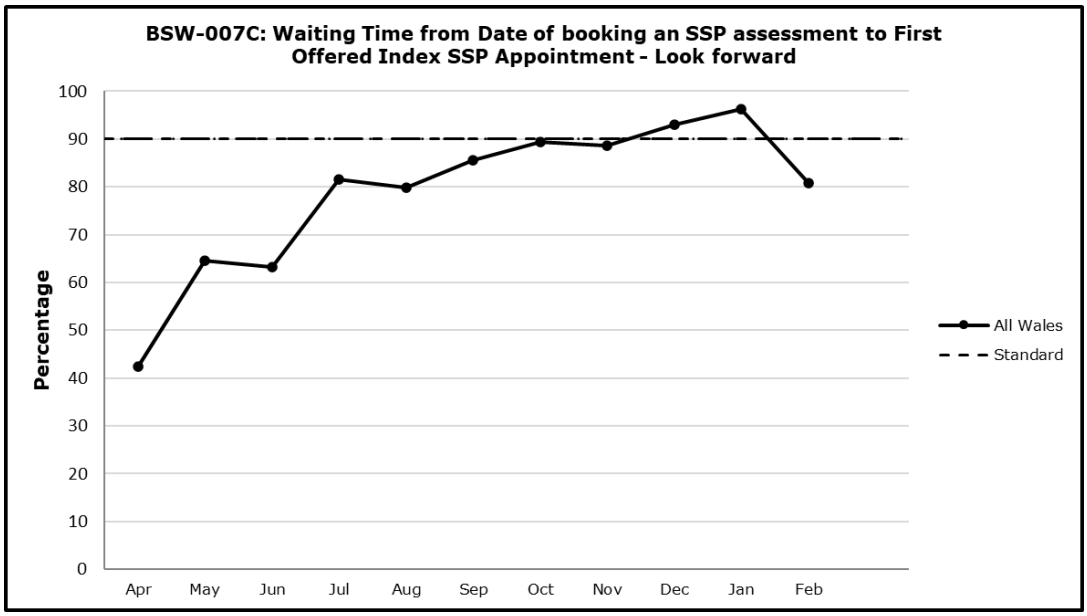
Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
b) Five Main Discussion Workstreams Established			1. Individual workstream chairs agreed 2. Second round of meetings between each of the five workstream Chairs and BSW project leads held (w/c 13 April 2026) 3. Membership of the five workstreams agreed and finalised 4. Dates for first round of monthly workstream meetings established and invitations issued 5. Intelligence packs for each of the workstreams finalised	• First meetings of the five discussion workstreams to be held (w/c 05 May 2026) • Discuss and agree Terms of Reference for each workstream at initial meetings.	All five workstream meetings convened on schedule First round of workstream meetings take place as scheduled to agree Terms of Reference, approach, scope and responsibilities and expectations
c) Options for improvement discussed and recommendations made at each workstream meeting for consideration by the Project Board			1. Project Board and workstream membership finalised 2. Intelligence packs for each workstream finalised	• Recommendation for improvement expected from May as April was focused on establishing foundational elements for the workstreams. These will go through	Workstreams meet as expected and options for improvement discussed at each

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
				governance process and inform overall project plan.	
d) To ensure candidates are assessed for JAG Accreditation in a timely manner			1. Two candidates assessed for JAG accreditation on 18 April 2026. 2. One candidate from Swansea Bay UHB successfully achieved JAG accreditation, the other did not reach the required standard	BSW Colonoscopy Panel meeting on 29 April to discuss the remaining candidates for possible assessment in June 2026	Candidate who are adequately trained are assessed in a timely manner
e) Ongoing Performance Management			1. Recovery plans received from all health boards and level of confidence in these achieving their stated aims accessed and communicated to both Welsh Government and the seven health boards 2. Monthly quality meetings with health boards continue.	Progress against stated recovery plans assessed by the SCIP	Improvements to screening colonoscopy waiting times in accordance with the declared individual health board recovery plans

3 Key Performance Metrics

3.1 Proportion of screening participants offered a pre-colonoscopy assessment with a Specialist Screening Practitioner (SSP) within the 14-day BSW standard (standard = 90% offered a pre-colonoscopy assessment within 14 days) – presented data from latest BSW performance report.

The graph and table below show that the proportion of screening participants offered a pre-colonoscopy assessment with a screening nurse within the 14-day BSW standard has improved steadily since April 2025 and exceeded the standard in December 2025 and January 2026 (96.3%). Performance deteriorated in February 2026, with 80.7% of participants offered their assessment within 14 days.



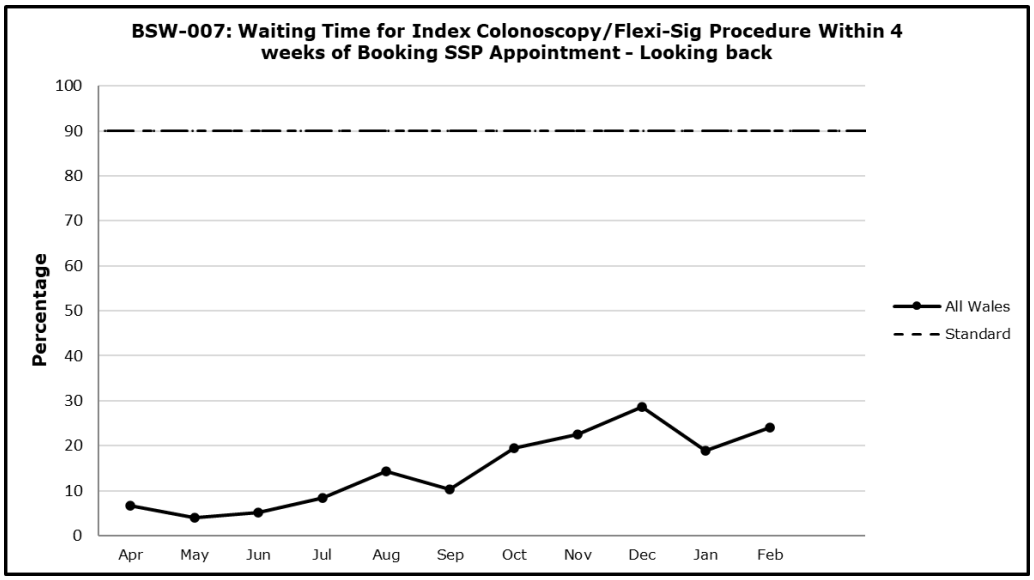
All Wales

Name	Standard	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026
Waiting Time from Date of booking an SSP assessment to First Offered Index SSP Appointment - Look forward	>= 90%	85.6%	89.3%	88.6%	93.1%	96.3%	80.7%

3.2 Proportion of screening participants who have offered a screening colonoscopy within the 28-day standard (standard = 90% offered a screening colonoscopy with 28 days) – presented data from latest BSW performance report.

The graph and data table below demonstrates that the proportion of screening participants offered a screening colonoscopy within the BSW 28-day (4 week) standard between April 2025 to February 2026 has gradually improved, although

was still significantly below standard. Performance deteriorated in January 2026, which reflects the lost lists over the Christmas and New Year period, and recovered slightly in February 2026 (24.1%).



All Wales

Name	Standard	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026
Waiting Time for Index Colonoscopy/Flexi-Sig Procedure Within 4 weeks of Booking SSP Appointment - Looking back	>= 90%	10.4%	19.4%	22.5%	28.6%	18.8%	24.1%

4 Aspirational Improvement Plan and Trajectory

4.1 Baseline Position (PTL data 13 April 2026 Q1 & 2)

Metric	Baseline
Total number of participants waiting for a screening colonoscopy	878
Number of participants waiting > 28 days for a screening colonoscopy	680
Weekly screening core capacity (4 participant lists)	39.75
Estimated weekly screening demand (4 participant lists)	56
Estimated weekly screening capacity gap (4 participant lists)	16.25

4.2 SMART Objectives

- Achieve ≥50% compliance with the BSW 28-day standard in 12 months (May 2027), ≥90% by November 2027 (18 months)
- Reduce the number of participants waiting longer than 28 days to <600 in 6 months (November 2026) and <450 (50%) in 12 months (May 2027)
- Reduce the average waiting time to 42 days by May 2027, 28 days by November 2027
- Reduce the median waiting time to 27 days by May 2027

- Achieve ≥90% compliance with the commissioned activity by March 2027

4.3 Aspirational Backlog Reduction Trajectory (Back to within the BSW 28-day standard)

Month	Backlog Size	% Within Standard
Baseline (April 2026)	680	22.6%
Months 1& 2 (May/June)	680	22.6%
Month 3 (July)	659	25%
Month 4 (August)	641	27%
Month 5 (September)	624	29%
Month 6 (October) – target <600 in backlog	598	32%
Month 7 (November)	571	35%
Month 8 (December 2026)	554	37%
Month 9 (January)	527	40%
Month 10 (February)	501	43%
Month 11 (March)	475	46%
Month 12 (April 2027) – target <450 in backlog	439	≥50%
Month 15 (July 2027)	264	≥70%
Month 18 (October 2027) – target 90% of participants waiting less than 28 days	88	≥90%

5 Recommendation

As above, The Directorate Management Team is asked to:

- Receive **assurance** of the establishment of BSW Screening Colonoscopy Improvement Project (SCIP) to enable a collaborative approach between BSW, the health boards and external partners to reduce screening colonoscopy waiting times
- **Consider** ongoing progress updates and provide the assurance required to BET for the BSW Screening Colonoscopy Improvement Project (SCIP)

QSIC Screening Update Appendix C

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Other (stated below) **Date of Meeting** 12 May 2026 **Agenda item:**

Diabetic Eye Screening Wales (DESW) Improvement Plan Update	
Executive lead:	Professor Meng Khaw, National Director for Health Protection and Screening Services
Author:	• Kate Morgan, Head of Programme, DESW • Bethan Bowden, Consultant in Public Health

Approval/Scrutiny route:	• Screening Division SMT – • HPSS Directorate Management Team – 12 May 2026

Purpose
To provide assurance on the current performance of the Diabetic Eye Screening Wales (DESW) programme in relation to the Improvement Implementation Plan, outlining key areas of work focus, and to provide timescales, risks, and delivery confidence associated with the plan.

Recommendation:				
APPROVE ☐	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Directorate Management Team is asked to:

- **Receive assurance** that DESW Improvement Implementation Plan has been established and work priorities within the Programme are directed on addressing the actions outlined within timescales indicated.

- **Consider** ongoing progress updates and assurance required to Board for DESW Improvement Implementation plan governance.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	Choose an item.
Strategic Priority/Well-being Objective	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	EqHIA is not required for the improvement implementation plan as part of current screening service delivery EqHIA in progress for evaluation of staged mydriatic approach
Risk and Assurance	Capacity within the Diabetic Eye Screening programme is recorded on the Corporate Risk Register. Implementation of the Improvement Plan is a key control in mitigating this risk.
Health and Social Care (Quality and Engagement) (Wales) Act	Health and Social Care Standards for NHS Wales Quality Themes: Theme 3 – Effective Care Theme 5 – Timely Care Theme 7 – Staff and Resources
Financial implications	There are no current financial implications as the improvement models aim to improve efficiencies with current screening resources.
People implications	Implementation of new clinic models of delivery will require a change in work patterns for staff members (moving to single role clinics from dual delivery of clinics). DESW staff have been involved in change management to implement other improvement and transformation initiatives and there is risk of change fatigue.

1 Background & Context

DESW (previously Diabetic Retinopathy Screening Service for Wales) was initially commissioned as a national service by Welsh Government in July 2002. DESW became operational in June 2003 and by 2005 delivered a service to participants in all Health Board areas. The service was hosted by Cardiff and Vale University Health Board until April 2016 when it transferred to join the other population-based Screening Programmes delivered by Screening Division, Public Health Wales.

DESW aims to detect diabetic retinopathy early and prevent sight loss from diabetic eye disease. Diabetic eye screening looks for signs of diabetic retinopathy before any symptoms are shown. Research evidence shows that with early identification and treatment; loss of vision can be prevented in 70–90% of people with sight threatening diabetic retinopathy. DESW is a targeted screening programme for all people aged 12 and over with diagnosis of diabetes, who are registered with a GP in Wales. People who are eligible are invited for retinal screening with DESW. Diabetic eye screening is an important part of diabetes care and is one of the nine care processes recommended by NICE for people living with diabetes.

It is estimated that there are more than 220,000 people in Wales who are living with diabetes, approximately 8% of the population. Since 2009/10, the number of adults aged 17 years or older living with diabetes in Wales has increased by 40% and if current trends continue, by 2035/36 an estimated 260,000 people will be living with diabetes in Wales, around 1 in 11 adults (17+ years old). This would be an increase of 22% compared to 2021/22. The increase in prevalence in diabetes has a direct impact on the demand for diabetes eye screening as every person with diabetes in Wales who is aged 12 or over should be invited on an annual or biennial basis for eye screening for the duration of their life.

Recent demand and capacity modelling undertaken by the PHW Data Science Team has identified that an estimated 15,000 appointments will be required every month to meet anticipated demand. With the current service delivery model in place, an average of 9,000 – 10,000 booked appointments are delivered a month.

1.1 Scope of the Diabetic Eye Screening Wales (DESW) Improvement Plan

The overarching vision for DESW is that:

Everyone eligible for eye screening can access a holistic, high quality and safe service in a timely, person-centred way.

This will enable DESW to achieve its aim of:

Reducing sight loss from diabetic retinopathy through the provision of excellent screening services to people with diabetes in Wales.

1.2 DESW Improvement Plans: overarching aims & objectives

Overarching Aim:
To improve DESW 12-month coverage for participants on the annual recall pathway. Coverage is defined as % of a defined cohort of eligible active participants who have a reported result in the last 12 months. The target is >= 80%

Objectives:

1) To implement and evaluate two alternative clinic templates which increase the appointment capacity by at least 25% across a minimum of 25% of available venues, using the same level of resources.
2) To evaluate the feasibility, safety, and acceptability of implementing a staged mydriasis protocol in DESW, where retinal images are initially captured without dilation, and dilation is used only when necessary.
3) To develop a standardised, staged mydriatic screening protocol for implementation across all DESW site types, increasing clinic capacity by a minimum of 50% in at least 40% of venues.
4) To streamline the management of low-risk participants through improved coding, accurate identification, and strengthened oversight to ensure that a minimum 33% of population transfer from annual recall to LRRP every month.
5) To optimise clinic efficiency through automation, targeted backfilling, and improvements to processes, ensuring that clinic utilisation is at a minimum of 90% at the beginning of every clinic day.
6) To strengthen organisational culture and build a resilient and confident workforce through enhanced leadership capability, empowerment, and consistent behavioural expectations, demonstrating a reduction in sickness levels consistently to less than 9% for year one, and working towards less than 5% for year two.

2 Improvement Plan Updates

During the last month, progress has continued across several key improvement areas within DESW. The camera evaluation undilated image capture has progressed well, with participant numbers exceeding target and no significant issues arising that could not be resolved quickly. Work has also continued to improve clinic utilisation, with performance remaining above target for most of April and ongoing evaluation of the Autobook module to support clinic filling. In parallel, further development has taken place in relation to service capacity, cultural improvement activity, and the review of Programme operational and quality assurance measures needed to support potential future changes to clinic delivery models.

2.1 Overall Timeline

The improvement work outlined within this plan will be undertaken from February 2026 to December 2027.

2.2 Key Achievements

- Retinal imaging without routine dilation evaluation commenced on 20 April 2026 and has generated image volumes above target within the first two weeks.
- A review of assurance measures introduced since 2019 has been completed, enabling a paper to be progressed on the potential reintroduction of single-person clinics.
- Clinic utilisation remained above the 90% target throughout April on a weekly basis, with only minimal dips below target on individual days.
- The Autobook module has continued to fill a high proportion of available appointments, including filling clinic weeks to 93% and 96%.
- Further planning has been progressed in relation to cultural improvement work, including renewed focus on Culture Club activity, management engagement, coaching-style workshops, and ESR compliance for managers.

2.3 Key risks, issues & dependencies

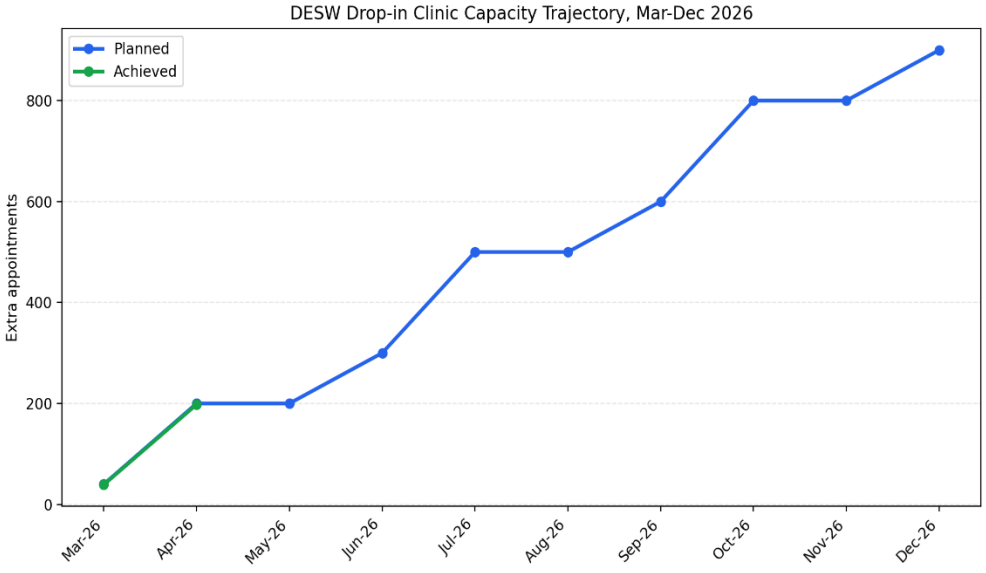
- Availability of administrative staff hours to support booking of two alternative clinic templates, as both require manual processes.
- Delays during in vacancy approval process causing extended timeframe in recruiting key frontline personnel.
- Staff sickness absence within the Programme, specifically those staff who are key in the delivery of clinics.
- The workshop session between DESW and People & OD has been delayed due to camera evaluation activity and manager availability.
- Anecdotal evidence suggests increased participant cancellations are linked to Autobook venue selection using straight-line rather than road-travel distance.
- Progress on improving the Autobook process is dependent on discussions with NEC and the potential use of allocated development days.
    - Any move towards reintroducing single-person clinics remains dependent on the outcome of the camera evaluation and agreement through Programme Board governance.

2.4 Improvement Area: Increasing Clinic Capacity – Service Improvement Project

2.2.1 Drop-In Clinic Template Model

A phased trajectory for increasing drop-in clinic appointment capacity has been modelled from March to December 2026. Delivery in the first two months was broadly in line with plan, with 39 additional appointments achieved in March against a plan of 40, and 198 achieved in April against a plan of 200. Based on current modelling, 200 additional appointments equate to a 2.16% increase in capacity, with the projected trajectory rising from 200 additional appointments in May to 900 in December. This represents an estimated capacity increase of 3.24% in June, staggered up to a 9.72% clinic capacity increase in December. This increase is supported by a phased staffing model, with one staff member utilising a maximum of 0.2 WTE of their time across a month until June, two staff members utilising 0.4 WTE of time between them a month from July, and three staff members utilising a maximum of 0.6 WTE combined from October onwards. Due to the manual processes required to achieve these numbers, this trajectory is very dependent on existing staff having workload capacity to complete the processes as required, and a full audit of time taken is required. To date this method of booking and running clinics is yielding good results with attendance and engagement from participants, so DESW is keen to experience and evaluate this method of inviting participants for at least six months.

Month	Planned extra appts	Achieved extra appts	Planned capacity increase	Achieved capacity increase	Staff resource (per month)
Mar-26	40	39	0.43%	0.42%	0.2 WTE
Apr-26	200	198	2.16%	2.14%	0.2 WTE
May-26	200	TBC	2.16%	TBC	0.2 WTE
Jun-26	300	TBC	3.24%	TBC	0.2 WTE
Jul-26	500	TBC	5.40%	TBC	0.4 WTE
Aug-26	500	TBC	5.40%	TBC	0.4 WTE
Sep-26	600	TBC	6.48%	TBC	0.4 WTE
Oct-26	800	TBC	8.64%	TBC	0.6 WTE
Nov-26	800	TBC	8.64%	TBC	0.6 WTE
Dec-26	900	TBC	9.72%	TBC	0.6 WTE



2.2.2 Low Risk Recall Pathway Clinics

To achieve a 25% increase in capacity across 33% of the population through the Low-Risk Recall Pathway (LRRP), an overall increase of 8.25% in total appointment capacity would be required. Based on the current baseline, this equates to approximately 780 additional appointments. Early delivery achieved 7 additional appointments in March, representing just 0.07% increase in capacity, and 35 additional appointments in April, representing a 0.37% increase. As May activity had already been booked, the planned trajectory was reprofiled by one month, with May remaining at 35 additional appointments. On this basis, there are plans to provide considerably more clinic appointments using this model, in the hope that eventually the LRRP model could rise progressively to 680 additional appointments by December 2026. This would be the equivalent to a 7.19% increase in overall capacity, slightly below the full 8.25% target but still representing substantial growth across the period. To evaluate whether this level of work is possible, the goal for June has been multiplied significantly to 130 additional appointments (1.35% increased capacity) to gage what the increased workload looks like for the staff involved. This will mean running approximately 19 LRRP clinics across the month.

Possible further trajectory if June's activity is manageable:

Month	Extra appointments	Approx no of LRRP clinics req.	Capacity increase
Mar	7	1	0.07%
Apr	35	5	0.37%
May	35	5	0.37%
Jun	130	19	1.37%
Jul	220	32	2.33%
Aug	310	46	3.28%
Sep	400	59	4.23%

2.4.3 Improvement Actions Update

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
a) Implement and evaluate drop-in clinic models to improve accessibility and increase appointment uptake.			Ran 20 drop-in clinics (198 extra clinic appointments) in April. Workload required to complete this was achieved.	Intend to run another 20 clinics in May (200 extra clinic appointments) with an audit of staff time taken to complete fully.	Number of additional appts created: 198 additional appts; 30.6% increased appointment capacity across 20 clinics. Number of drop-in participants who attended: 160 / 198; 80% attendance.
b) Introduce and test the LRRP clinic model across regions to enhance service efficiency and participant experience.			Ran 4 LRRP clinics - 2 in the South region, 1 in West, and 1 in North.	To run 6 LRRP model clinics across Wales, and to plan in a significant increase to test in June (approximately 19 clinics)	Number of additional appts created: 35 additional appts; 26.3% increased appointment capacity across 4 clinics. Number of participants successfully screened in shorter timeframe –
c) Strengthen clinic capacity and scheduling models to improve timeliness and expand appointment availability.			Continue work completed on evaluation reports for models using Model for Improvement methodology. Deadline for these to be finalised end of May 2026.	Evaluation required to understand staff hours needed to continue two alternative clinic templates, as manual processes required to action. Draft SOPs for both types of clinic templates to be drawn up.	9459 appointments available in April. Combined new clinic templates created 2.53% increase in capacity. Positive participant experience through SMS feedback – 96.65% overall experience user satisfaction figure for April. Neutral impact on staff wellbeing – staff sickness rates remaining average or below for month – April

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
					sickness recorded as 7.9% (above average).

2.5 Improvement Area: Retinal Imaging Without Routine Dilation

The camera evaluation study fully commenced on 20 April 2026. Two full weeks of data collection have now been completed, and the project is currently halfway through week three. As of 05 May 2026, a total of 538 participants have been screened and non-dilated images captured, of whom 470 have had their images graded on Test OptoMize. This is above the target of 451 participants required by this date, indicating strong uptake and providing assurance that sufficient image volumes are being generated to support a robust evaluation of the project. Overall, the project is progressing well. During the first three weeks, no issues have arisen that have not been corrected almost immediately, and staff have engaged positively with the opportunity to participate in an evaluation project.

In parallel with the retinal imaging evaluation, a review has been completed of the assurance measures introduced within the Programme since 2019, when single-person clinics were ceased following a serious untoward incident. A range of changes have since been implemented to strengthen the quality assurance and overall robustness of the Programme. On that basis, a paper is now being taken forward to the DESW Programme Board to seek agreement in principle to consider reintroducing a model of single-person clinics, should the camera evaluation prove effective and reduce the Programme's reliance on tropicamide dilation drops. This would enable two screeners to work alongside one another while each running their own clinic list, completing both the pre-screening and image capture elements of the appointment, and could increase clinic capacity by an estimated 40 to 50 per cent, depending on staffing and venue constraints.

2.5.1 Improvement Actions Update

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
a) Evaluate and implement an enhanced retinal imaging clinic model to improve efficiency, patient experience, and service flow.			Finalised instruction guides and SOPs for the evaluation clinics Training days run 8th and 13th April for staff involved. First day of evaluation clinics 20th April. Continued booking and inviting participants to these clinics for duration of project.	Continue camera evaluation clinics (4 x day) until 07 June 2026, monitoring numbers of participants and images captured to ensure adequate numbers obtained.	Programme requires 41 participants to engage with project and have successful non-dilated images captured per day. As of end of day on 05 May 2026: Target required: 451 participants Current position: 538 participants have taken part in the evaluation and had images captured. 470 have had the non-dilated images graded on Test OptoMize. 322 have had both the non-dilated images and dilated images graded.
b) Implement a staged mydriatic approach to optimise clinic capacity and improve participant experience.			Requires outcome of evaluation project before progressing.	Work to begin on this once evaluation is completed.	Work still determining what these measures will be. Possible options include:

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
					Increase in % appointment capacity % rate of inadequate images capture (to remain below current average) % of non-DR inadequate referrals (to remain below current average).

2.6 Improvement Area: Implementation of Low-Risk Recall Pathway

The improvement action to *'Improve the accuracy and consistency of Low-Risk Recall Pathway participant coding within OptoMize'* has now been successfully completed through the development and implementation of an automated coding script. This work was delivered on time and has introduced a more efficient method for monitoring participants who move each month from annual recall onto the LRRP, and vice versa from the LRRP back to annual recall. To strengthen oversight further, these figures will now be reported on a weekly basis through the DESW Operational Meeting, enabling any unexpected variation or deviation from trend to be identified and reviewed promptly. In addition, a meeting is being planned with NEC to support a clearer understanding of the current LRRP configuration, which was amended during the recent system upgrade in September 2025. This will provide key personnel within DESW with greater clarity on how the pathway is configured and improve the ability to identify quickly if it is no longer operating as intended.

2.6.1 Improvement Actions Update

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
a) Improve accuracy and consistency of LRRP			Review of March's LRRP data and gaining improved understanding of capacity	Action now completed.	Number of people on LRRP

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
participant coding within Optimize.			and demand in line with the LRRP clinics. Finalise methods of gaining metrics for measuring success and recording this in dashboard.	Success measures to be added to Programme dashboard.	% of people on LRRP as proportion of total population % of people who move from AR to LRRP each month % of people who return to AR from LRRP each month
Strengthen LRRP performance oversight by routinely monitoring SPAR data.			Meeting to be arranged and attended with NEC to gain clarification on design specification of DESW LRRP following upgrade in September 2025.	Meeting arranged with NEC for 12 May 2026. To continue monitoring performance of this pathway via regular review of measures in weekly Ops Meeting.	Number of people on LRRP % of people on LRRP as proportion of total population % of people who move from AR to LRRP each month % of people who return to AR from LRRP each month

2.7 Improvement Area: Improve Clinic Utilisation

April continued to demonstrate good clinic utilisation performance by the Screening Pathway Admin Team. Clinics began the month filled to 94.3% utilisation and ended April at 92.8%. Across the month, weekly utilisation was consistently maintained above the 90% target, with only three individual days falling below this level, at which point utilisation reached 89%. This demonstrates a sustained high level of performance in backfilling appointments, although it also highlights the ongoing challenge of maintaining utilisation at this level and the uncertainty around how the programme could consistently achieve the aspirational target of 95%.

In addition, the Autobook module continues to be used within booking processes and remains under active evaluation and monitoring. The number of participants being fed into the module on a weekly basis has been increased to provide a larger pool from which to fill clinics. Most recently, the system filled week 4 clinics to 93% and week 3 clinics to 96%, demonstrating that it can fill a substantial proportion of available capacity. However, anecdotal feedback suggests there has been an increase in clinic cancellations following bookings made through the Autobook system, and with this, an increase in telephone calls coming into DESW. This appears to be related to the current system settings, which select from four venues within a 20-mile radius of a participant's home address using 'as the crow flies' distance rather than road mileage. As a result, participants may be offered clinics that are geographically close in straight-line terms but less practical to access by road. A meeting is scheduled with NEC on 07 May 2026 to review how the system is operating and to explore whether venue data based on road mileage, which DESW produces, can be incorporated. This would provide a more accurate basis for booking participants into their nearest suitable venues. It is hoped that one of the allocated NEC development days could be used to support this work, with further information to follow the meeting.

2.7.1 Improvement Actions Update

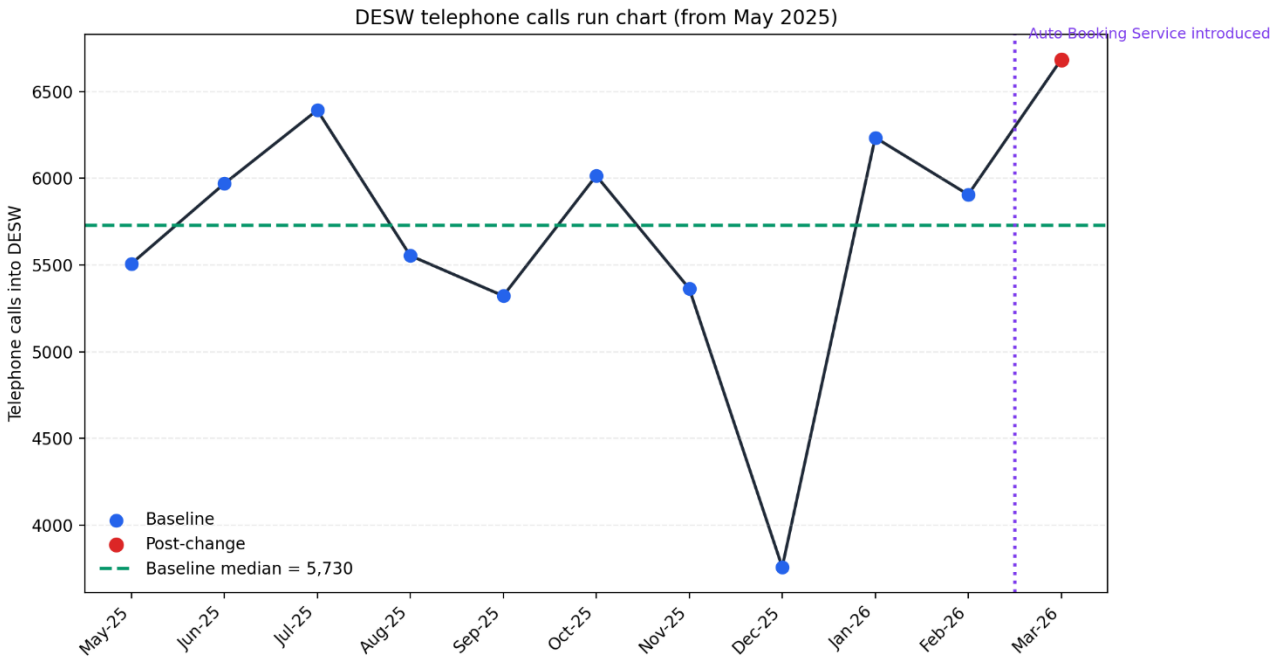
Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
a) Implement the Autobook module to automate appointment scheduling and improve service efficiency.			Evaluate behaviour of module week to week to identify any small changes required, as well as effectiveness and efficiency.	Meeting with NEC 07 May 2026 to discuss possible change to venue selection in configuration. Trial of increased participant numbers into Autobook based on geographical location.	Autobook ran: 05 May 2026 Week 4: 93% capacity filled Week 3: 96% capacity filled
Increase appointment availability through targeted backfilling to meet interim standards (80%, 85%, 90%).			Continue to monitor clinic utilisation on daily, weekly, and monthly basis to identify any trends in relation to underutilisation.	Collection of data to review clinic cancellation numbers based on booking via Autobook.	Clinic utilisation of 90% Ambition to achieve clinic utilisation of 95%

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
				Collection of data monitoring numbers of increased telephone calls into DESW.	
Strengthen digital access via NHS Wales App online booking.			Understand DHCW/NHS Wales App developer road map Identify opportunities for screening within NHS Wales app functionality	Continued activity as last month	Online booking for DESW on road map for NHS Wales App development.

2.5.2 Initial review of telephone calls into DESW

Based on the anecdotal feedback that there has been an increase in telephone calls and cancellations since the introduction of Autobook, a review of the previous ten months of data has been reviewed and plotted. The median number of telephone calls into DESW for the baseline period from May 2025 to February 2026 is 5,730. Using this median as the centre line for the run chart, DESW will continue to track this data as a balancing outcome measure regarding the introduction of Autobook. March 2026 represents the first data point after the implementation of the Autobook, which is above the baseline median. Additional data points over the next four months will be needed to determine whether this represents a sustained change or normal variation.

Month	Calls	Position vs median
May-25	5,507	Below
Jun-25	5,969	Above
Jul-25	6,393	Above
Aug-25	5,554	Below
Sep-25	5,322	Below
Oct-25	6,015	Above
Nov-25	5,364	Below
Dec-25	3,758	Below
Jan-26	6,235	Above
Feb-26	5,906	Above
Mar-26	6,685	Above



2.8 Improvement Area: Cultural & Workforce Sickness Levels Improvement Work

Following a meeting with the Assistant People & OD Partner for Screening, it has been recognised that there is a need to raise the profile of culture within DESW. The DESW LMT have agreed that this will be brought to the forefront of routine meeting agendas, with dedicated discussion taking place on a regular basis. There is also a need to reinvigorate the DESW Culture Club, including reviewing and strengthening its Terms of Reference and the overarching Action Plan. A key priority will be to secure stronger engagement and buy-in from those in leadership positions across the Programme, and alongside clear representation from all departments. This will support development of a more coordinated and sustained approach to addressing the cultural issues that continue to exist within DESW.

Planned activity includes the workshop-style session between DESW and People & OD regarding the Managing Attendance at Work Policy. Unfortunately, this has had to be postponed due to the ongoing camera evaluation work and the challenges of securing manager availability. In addition, a series of coaching-style workshops will be taken forward with all staff groups. This began last month with a workshop on managing change, which will be continued to be rolled out in May. Emotional intelligence has been identified as the next area of focus and work will be undertake putting this together with an aim to deliver in June and July. Further work will also be undertaken to ensure that all managers at Band 5 and above within DESW have the appropriate training scheduled on ESR, and that they are up to date and meeting the required competencies.

2.8.1 Improvement Actions Update

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
Strengthen a positive and empowered culture across DESW.			Discussed the Improvement Plan with POD regarding ongoing support and input. Managing Change coaching workshop held with all screeners in the south region.	Workshop style meeting to be arranged, likely to be in June post camera evaluation work. Managing Change coaching workshop to be held with all screeners in North and West.	Menti survey results captured with all DESW Staff to provide a baseline understanding and measure to identify change. To reassess in 9 months.
Embed DESW's "Why?" and support staff empowerment.			Training for all staff in relation to camera evaluation work.	Development of Emotional Intelligence coaching-style workshops.	Regular scheduled staff meetings Co-produced meeting objectives and topic areas Positive staff feedback on sessions
Build leadership capability across DESW.			Following discussions with POD, as above, to arrange relevant training as required for band 5 line managers and	Review of ESR of all staff in leadership positions to identify if relevant competencies are recorded and level of compliance.	Number of band 5 and above managers who have attended PHW Leadership and Management Academy training

Improvement Action	RAG *Last month*	RAG *This month*	Activity this month	Planned activity next month	Success measures
			above in relation to MAAW Policy.		Number of band 5 and above managers who have completed MAAW training.

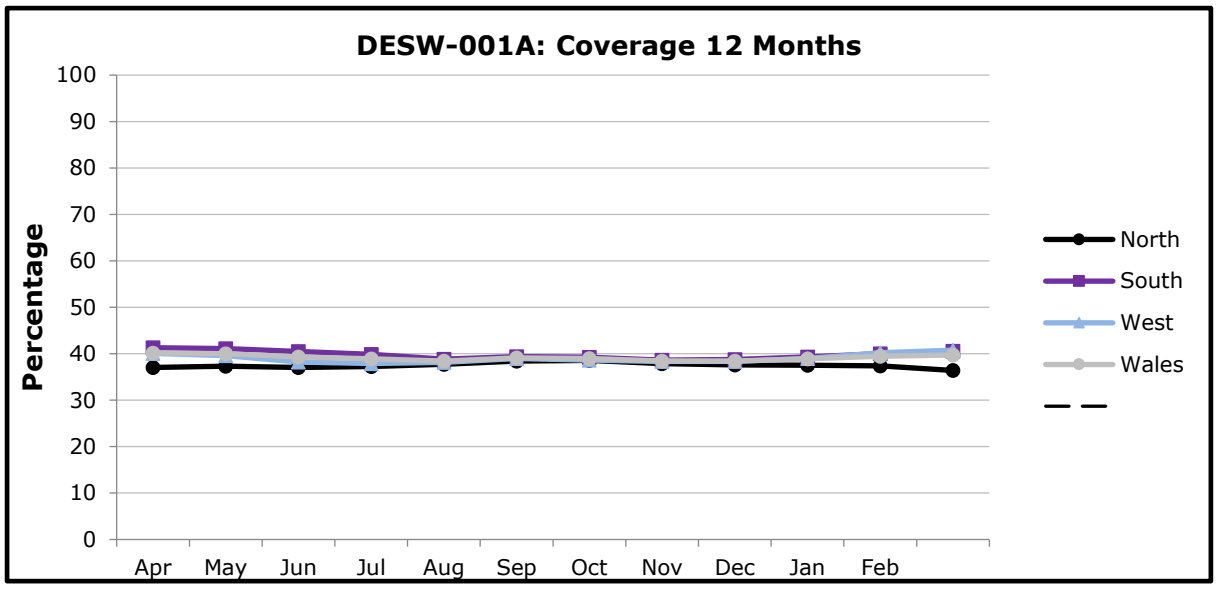
2.6.2 Updated DESW Sickness Rates

The updated 7-year average continues to show a clear seasonal pattern in sickness absence, with the highest average levels occurring in the winter months, peaking at 10.47% in December, and the lowest average level in April at 6.66%. The revised 2025–26 data has increased the 7-year averages across most months, particularly in the summer and autumn period, while maintaining the same overall trend of lower absence in spring and higher absence through late autumn and winter. Despite this adjustment to the average rates, April 2026 figures are showing an above average rate of sickness across the Programme.

Month	Previous 6-year average	2025–26	New 7-year average	2026–27
Apr	6.80%	5.79%	6.66%	7.90%
May	6.02%	6.99%	6.16%	
Jun	6.59%	9.39%	6.99%	
Jul	8.16%	11.53%	8.64%	
Aug	7.83%	10.84%	8.26%	
Sep	8.00%	10.79%	8.40%	
Oct	9.00%	10.30%	9.19%	
Nov	9.19%	10.27%	9.34%	
Dec	10.75%	8.76%	10.47%	
Jan	9.14%	7.85%	8.96%	
Feb	8.33%	7.10%	8.15%	
Mar	7.93%	6.84%	7.77%	

3 Key Performance Metrics

March 2026	
Criteria	Coverage: % of a defined cohort of eligible active patients who have a reported result in the last 12 months
Standard	>= 80%



DESW-001A: Coverage 12 Months												
2025/26	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
North	37.0	37.3	37.0	37.2	37.7	38.4	38.6	37.9	37.6	37.5	37.4	36.4
South	41.3	41.1	40.5	39.8	38.8	39.4	39.3	38.6	38.8	39.3	40.0	40.6
West	40.1	39.6	38.2	37.9	38.1	39.0	38.6	38.4	38.3	39.0	40.2	40.8
Wales	40.2	40.0	39.3	38.9	38.4	39.1	39.0	38.4	38.5	38.9	39.5	39.7

Numerator: Eligible active patients with a reported result in the last 12 months												
2025/26	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
North	10157	10279	10194	10151	10194	10471	10596	10402	10366	10388	10401	10236
South	32685	32547	32080	31355	30377	30875	30810	30245	30345	30640	31030	31488
West	10741	10619	10266	10156	10140	10388	10308	10158	10105	10225	10520	10712
Wales	53583	53445	52540	51662	50711	51734	51714	50805	50816	51253	51951	52436

Denominator: Eligible active patients												
2025/26	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
North	27427	27536	27517	27269	27029	27251	27474	27458	27548	27686	27805	28121
South	79141	79137	79162	78705	78282	78402	78471	78296	78233	77921	77573	77568
West	26780	26829	26864	26795	26602	26666	26690	26464	26360	26225	26180	26272
Wales	133348	133502	133543	132769	131913	132319	132635	132218	132141	131832	131558	131961

4 Recommendation

As above, The Directorate Management Team is asked to:

- **Receive assurance** that DESW Improvement Implementation Plan has been established and work priorities within the Programme are directed on addressing the actions outlined within timescales indicated.
- **Consider** ongoing progress updates and assurance required to Board for DESW Improvement Implementation plan governance.