



**Comisiwn  
Bevan  
Commission**

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# **ADOPT, SPREAD & EMBED**

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**COMPENDIUM OF PROJECTS  
PROPOSED FOR NATIONAL ADOPTION**



## Message from Helen Howson, Director, Bevan Commission

Incremental change is now no longer sufficient to address the mounting challenges facing our health and care system in Wales. To meet both current pressures and future demands, we must fundamentally transform the way we work. A core aspect of this will involve rethinking current approaches to how we adopt, spread and scale innovation across our health and care system.

To respond to this challenge, in 2020, the Bevan Commission, supported by Welsh Government, launched a national programme to explore how innovation could be more effectively spread and scaled across the health and care system. Building on the success and learning from that work and drawing on resources from the Planned Care Innovation Programme, the Commission has now initiated an ambitious 18-month '*Adopt, Spread and Embed*' programme to accelerate the wider implementation of proven innovations in the planned care arena.

This programme will not only support the scale-up of empirically validated projects, but it will also serve as a testbed for a national innovation adoption pathway, designed to enable more consistent and coordinated implementation processes across Wales. As such, six evidence-based exemplar projects have been selected by the NHS Wales Planned Care Board for wider adoption and spread. These projects, which are detailed further in the main body of this document, focus on priority areas including:

- Secondary prevention of osteoporotic fractures.
- Management of long waiters and gastroenterology pathways.
- Greener, more sustainable surgical practices.
- Perioperative care for older people.
- Enhanced efficiency in radiology.
- Community-based gynaecology services.

Each of these innovations is already demonstrating significant impact, improving clinical outcomes, reducing waiting times, lowering system costs, and enabling more sustainable models of care.

We now call on all health boards from across Wales to actively engage in this programme and support the adoption of these innovations that can deliver measurable benefit in their local context. By working together through shared learning, coordination, and collective commitment, we can drive forward smarter, more effective health and care services for the people of Wales.

## About the Adopt, Spread and Embed Programme

We are excited to invite you to engage with the Bevan Commission's [Adopt, Spread & Embed programme](#), an ambitious national initiative focused on accelerating the uptake of proven, high-impact innovations across NHS Wales.

Informed by leading implementation science research and international best practice, and tailored to Wales' unique context, the programme has been carefully designed to provide a robust, evidence-informed framework for the identification, adoption, and implementation of innovations at scale. By providing practical tools, structured guidance, and tailored support, the Adopt, Spread and Embed programme aims to help health and care teams replicate what works across Wales in their own organisations, facilitating higher quality, more efficient care in all areas of our system.

The programme supports both innovating and adopting teams with:

- Tailored mentorship and training throughout the 18-month programme.
- Access to bespoke resources, tools and techniques.
- Opportunities for pan-Wales collaboration and shared learning.
- Guidance on embedding and sustaining innovations over time.

By working together, we can address key barriers to the uptake of innovation and ensure that effective solutions are not only implemented, but embedded in practice, scaled with confidence, and sustained for long-term impact.

For further information, please contact the programme project manager Sarah Owen: [s.k.owen@swansea.ac.uk](mailto:s.k.owen@swansea.ac.uk)

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# Welsh Fracture Liaison Service

## Aneurin Bevan University Health Board

### Value Proposition:

In Wales, over 20,000 fragility fractures are expected each year, costing the NHS approximately £133 million annually, a figure projected to rise sharply with the ageing population. Beyond the financial burden, these fractures have a profound impact on individuals, often resulting in chronic pain, loss of independence, and increased morbidity and mortality, which in turn, drive further social and economic costs.

The Royal Osteoporosis Society (ROS) advocates for the implementation of Fracture Liaison Services (FLS), an evidence-based model, proven to significantly reduce the risk of secondary fractures. Consistent delivery of FLS across Wales has the potential to save the NHS an estimated £7.5 million annually, while also improving patient outcomes and reducing preventable harm. Recognising the value of this approach, the Welsh Government has made FLS delivery a formal requirement for all health boards, underscoring its national importance.

### Why Change is Needed:

Osteoporosis is a condition that silently weakens bones and affects 3.8 million people in the UK, with fragility fracture risk rising from 2% at age 50 to nearly 50% by 80 (NICE, 2023). In Wales, around 20,000 fragility fractures occur annually, a figure set to grow with our rapidly aging population.

Refracture risk is high: one-third of people aged 60–80 suffer a second major fracture within a year (Johnell et al. 2004). Without preventative approaches, older women face a 31% risk at five years, which ultimately will cost lives. Evidence shows FLS significantly reduces this risk in adults 50+ (Danazumi et al., 2024). Yet in 2022, 92% of eligible patients in Wales went untreated, leaving over 6,000 people at risk, placing additional pressure on services. The cost of inaction is high. Full and consistent implementation of the FLS model is now critical if we are to reduce harm, improve outcomes, and ensure sustainability.

### The Opportunity - FLS Early Intervention and Outreach Model:

FLS identifies people aged 50+ with fragility fractures and ensures timely osteoporosis treatment to prevent future breaks. Aneurin Bevan University Health Board's (ABUHB) FLS uses an innovative digital system that scans imaging reports (X-Ray, CT, MRI) for the term "fracture", enabling earlier diagnosis, faster care, and fewer referrals.

Following ROS targets of 80% identification, 50% treatment, 80% monitoring, the service is led by a consultant geriatrician with nurse specialists and coordinators. Patients receive remote assessments, with tests and treatment arranged as needed. High-risk patients are followed up at 16 and 52 weeks, and in-person appointments are reserved for clinical need, supporting net-zero goals. This contributes to national benchmarking across 73 UK FLS sites.

## FLS: Impact and Outcomes:

The introduction of a digital system at ABUHB FLS has *significantly improved case identification*, from 22.6% in 2021 to 61% in 2023, surpassing the national benchmark of 40.6% (a 169% increase). In 2024, cases have already exceeded 2,600, up 21% from 2023.

### Clinical and Operational:

- 66% of patients receiving bone treatment.
- 60% followed up at 16 weeks (three times the 2021 rate).
- Fewer refractures, less strain on urgent/planned care and social services, and better staff morale.
- Earlier identification, timely treatment, reduced fracture risk, and improved quality of life.

### Economic:

- £7.5M in NHS savings and £3.5M in social care.

### Environmental:

- Lower carbon footprint through fewer in-person appointments.

## Return on Investment:

Value-based economic modelling has demonstrated that NHS services can expect benefits of £7.5 million and social care services can expect benefits of £3.5 million *if the FLS model is applied fully and consistently over the next five years* (detailed assumptions and service level benefits can be provided). This is based on 2024 data with an anticipated total of 23,510 fragility fractures in Wales, against a £2.5 million to £4.9 million cost of running a Welsh National FLS per annum.

## Strategic and Policy Alignment:

- **Technical Planning Guidance 2025–2028:** FLS aligns with key ministerial and strategic priorities by supporting timely access to care, population health and prevention.
- **Promote, Prevent and Prepare for Planned Care (2023):** Advice and guidance to patients and individualised care along the pathway, efficiency of care and population health and prevention
- **Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. 2022:** FLS supports all five goals - effective referral, advice and guidance, treat accordingly, follow up accordingly and measure what's important.

## Implementation Milestones and Available Support:

All Welsh health boards are now delivering FLS in line with the national Quality Statement, with most having approved business cases and Betsi Cadwaladr currently developing theirs. *However, significant variation remains in implementation, especially around digital fracture identification and follow-up treatment.* To ensure equity and maximise impact, health boards should expand delivery in line with the performance milestones below. Reducing unwarranted variation is essential to improving both the effectiveness and efficiency of FLS across Wales.

Implementation Milestones	Timeline
KPI 2 + KPI 3 = 70% identification Sustain treatment above 50%, KPI 7 Improve KPI 9-11 – 60%	Year 2025
KPI 2 + KPI 3 = 80% identification Sustain treatment above 50%, KPI 7 Improve KPI 9-11 – 80%	Year 2026
ROS Standard 80/50/80 achieved and registered with International Osteoporosis Foundation as Gold Standard FLS	Year 2027

**Supporting resources include:** A business case, reporting benchmarks, resources for services, resources for patients, resources for primary care and resources for service improvement.

### Call to Action - Full Adoption of the FLS Model:

To ensure a consistent, high-impact approach to fragility fracture prevention, all *health boards in Wales are expected to adopt* and fully implement the FLS model. This scalable, financially sustainable service delivers a strong return on investment and aligns with NHS Wales strategic and ministerial priorities. Despite FLS being in place across Wales, variation in implementation, *particularly in digital fracture identification and follow-up treatment*, risks undermining equity and efficiency. Health boards are urged to approve their FLS business cases and deliver the service to the performance standards outlined above. Achieving this will ensure a prudent, value-based approach to reducing preventable fractures across the nation.

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# Building Capacity and Reducing Waits in Gastroenterology Planned Care

## Betsi Cadwaladr University Health Board

### Value Proposition:

Gastroenterology services across Wales are under significant pressure with long waiting lists and workforce shortages. This innovative model offers a cost-effective solution to these issues, by redirecting approximately 20% of functional gastroenterology referrals to a specialist clinic led by an Advanced Clinical Practitioner (ACP) Dietitian. By delivering tailored lifestyle interventions, medication reviews, and focused investigations, the service not only reduces unnecessary demand on overstretched consultant teams but has freed up hundreds of consultant appointments for more complex cases. At Wrexham Maelor Hospital, this approach over just a nine-month test period has cut routine waiting times from over three years to just three months, safely removed 318 patients from the waiting list, and released over £108,000 in consultant time. Importantly, patient outcomes have improved, with most cases effectively managed without consultant input, while serious underlying conditions, including cancers, have been identified earlier and escalated without delay.

### Why Change is Needed:

Routine gastroenterology waits in Wales exceed three years in some areas, driven by post-Covid backlogs, rising referrals, and consultant shortages. At Betsi Cadwaladr University Health Board (BCUHB), referrals have surged 70% since 2020, around 4,000 annually, far outpacing current capacity.

This demand-capacity gap threatens timely diagnosis and patient outcomes. The Welsh Government advocates reviewing workforce and skill mix models to address this. The Dietitian-Led Gastroenterology Clinic supports this approach, advancing national priorities to modernise outpatient care and build a skilled, sustainable workforce.

Proven effective in England, Ireland, and BCUHB, this ACP Dietitian model offers a scalable, cost-effective and efficient solution, which eases pressures on consultants, while improving access and outcomes for patients.

### The Opportunity - ACP Dietician-Led Gastroenterology Clinics:

The ACP Dietitian-Led Gastroenterology Service aims to:

- Reduce consultant waiting lists by at least 20%.
- Provide full clinical assessment, initiate first-line investigations, deliver timely diagnoses.
- Manage functional conditions independently without consultant input.
- Prescribe appropriate medications.
- Offer integrated support in a streamlined 'one-stop-shop' model.

National rollout would standardise care, improve quality for functional cases and enhance the efficiency of specialist resource use across Wales.



## Impact and Outcomes:

### Clinical and Operational:

- Reduced waiting times from over three years to three months.
- 500 additional consultant slots created; 318 patients safely removed from the waiting list.
- 18% increase in consultant capacity for urgent cases.
- ACP Dietitian assessments enabled earlier diagnosis of serious conditions, inc. cancers.
- 100% rated the service positively: 90% excellent, 10% very good.

### Economic:

- £108,000 in consultant resource released at Wrexham Maelor Hospital.

This demonstrates a cost-effective model which is supported by consultants; enables earlier intervention and reduces long term system costs.

### Breakdown of Costs and Return on Investment:

Costs are based on one ACP Dietitian per site. As site numbers vary, each health board should recruit, train, or utilise an existing ACP Dietitian at every gastroenterology site to ensure consistent, equitable service delivery.

Description of Cost	Cost Amount	Duration	Type
Staff salaries: Band 8A ACP Dietician	£77,462	Recurrent	Revenue

Investing £77,462 in an ACP Dietitian to support delivery of gastroenterology services per hospital site, reduces resource requirements by releasing £108,000 worth of gastroenterology consultant time. *A full business case with detailed costs and benefits is available to support this case for change.*

Beyond financial benefits, this role enhances service efficiency, reduces waiting times, and supports equitable access to specialist care across sites, delivering both economic and clinical value.

### Strategic and Policy Alignment:

The service directly supports the ministerial priority of timely access and reducing backlog waits. It aligns with key national strategies, including:

- **Technical Planning Guidance 2025–2028:** Timely access to care.
- **Promote, Prevent and Prepare for Planned Care (2023):** Advances patient-centred care through faster access, streamlined pathways, and better data.
- **Welsh Innovation Strategy (2023):** Supports goals to improve diagnostics, cut waiting lists, and strengthen the workforce.
- **Programme for Transforming and Modernising Planned Care (2022):** Enhances referrals, diagnostics, and outpatient capacity while reducing long waits.
- **GI Strategic Network Domains:** Delivers safe, timely, effective, efficient, equitable, and person-centred care.

## Implementation Requirements:

### Essential:

- Committed consultant gastroenterology time (1 hour a week) to provide supervision, mentoring and training.
- Dietitian to have undertaken clinical assessment and diagnostic training and to be able to request first line investigations.

### Ideal:

- Prescriber/working towards it; non-medical radiography requestor/working towards it.

## Implementation Milestones and Available Support:

Phase	Key Milestones	Timeline
<b>Phase 1:</b> Engagement & Planning	Engage key stakeholders to map service pathways, assess integration needs, review current resources, and secure additional resources. Identify pilot-ready sites and finalise referral routes and governance.	1-3 months
<b>Phase 2:</b> Workforce & Infrastructure	Recruit or identify ACP Dietician. Provide staff training on new integrated pathway and processes.	3-6 months
<b>Phase 3:</b> Pilot Rollout	Launch service and monitor patient outcomes and resource impact.	6-12 months
<b>Phase 4:</b> Evaluation & Long-Term Sustainability	Conduct comprehensive service evaluation with Value-Based Health Care teams. Confirm ROI, patient experience, and system efficiencies. Secure long-term funding and embed role into strategic planning.	12-18 months

**Supporting resources include:** Business case, job description and service procedural specification.

## Call to Action - Adoption of ACP Dietician-Led Gastroenterology Clinics:

Scaling the ACP Dietitian-Led Gastroenterology Service model across Wales presents a clear opportunity to reduce waiting times, optimise consultant capacity, and enhance patient outcomes in gastroenterology. Successfully implemented in Betsi Cadwaladr University Health Board, this cost-effective approach safely manages up to 20% of routine referrals, reducing waiting times from over three years to just three months. With strong clinical endorsement and demonstrable operational and economic benefits, this model is well-positioned for national adoption to support sustainable improvement in planned care services.

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# Carpal Tunnel Surgery – The Lean, Green, More Efficient Surgical Pathway

## Betsi Cadwaladr University Health Board

### Value Proposition:

Orthopaedic services in Wales face growing pressure, with long waits and limited theatre capacity delaying routine procedures like carpal tunnel surgery (CTS). This cost-effective model uses outpatient-based minor ops rooms, cutting procedure costs by 65%, clinical waste by 66%, and carbon emissions by 80%, while freeing up theatre time for complex cases. Successfully piloted for CTS, it offers a scalable solution for other routine surgeries, improving access, efficiency, and sustainability without compromising the quality of care.

### Why Change is Needed:

The pressure on orthopaedic services across Wales continues to grow. CTS, the most common surgical procedure in the UK, with over 80,000 cases annually, is increasingly affected by long waiting lists, a lack of main theatre availability, and the high cost of traditional surgical delivery. Main theatre time is a scarce and expensive resource, with staffing, space, and scheduling constraints limiting the ability to meet demand for routine procedures. Without alternative approaches, these pressures are likely to worsen, delaying treatment, increasing costs, and further exacerbating the backlog in planned care.

At the same time, the environmental impact of health care is substantial. The NHS produces 4% of the UK's emissions (NHS England, 2020), with surgical theatres generating 20–30% of hospital waste (Kwakye et al., 2011). Most of this waste comes from packaging and consumables, much of it unused or improperly recycled (Lee and Mears, 2012). Sustainable alternatives are urgently needed to reduce both care delays and the sector's carbon footprint.

### The Opportunity - A Lean, Green, Surgical CTS Pathway:

The proposed solution uses minor ops rooms, smaller drapes, and streamlined surgical kits, to deliver CTS, shifting this minor procedure out of main theatre. This frees up day case and laminar flow capacity for more complex surgeries. In Wrexham Maelor and Ysbyty Gwynedd, over 300 minor hand surgeries have been delivered through this “lean and green” model, cutting carbon emissions by 80%, costs by 65%, and clinical waste by 66%.

This approach halves CTS procedure time, reduces resource use and hospital visits, and supports faster patient turnover. Now adopted across all three BCUHB sites and by private providers, it offers a scalable, cost-effective, and sustainable pathway, that aligns with Wales' planned care recovery and net-zero goals.

### Impact and Outcomes:

#### Clinical and Operational:

- Procedure times and appointments reduced by 50%, with no complications and quicker patient turnaround. Fewer visits improve patient experience and free up system capacity for better care.

- The minor ops room eases pressure on day case wards and main theatres.

#### Economic:

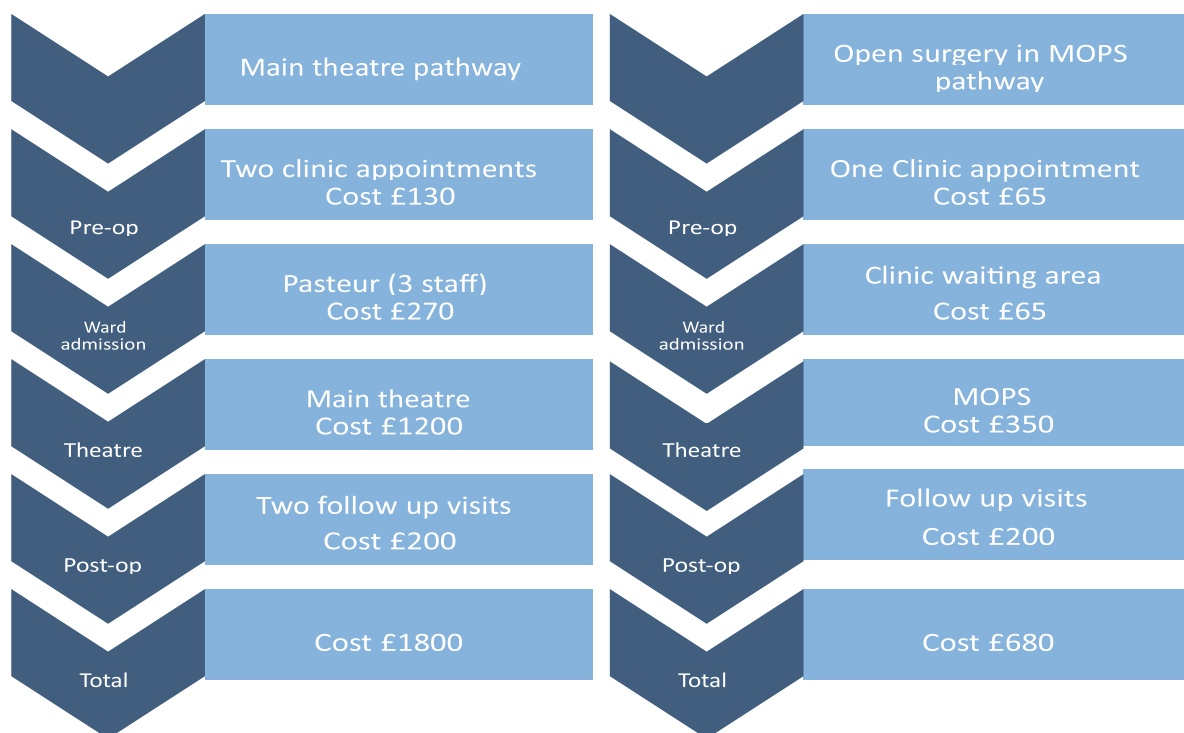
- £1,120 reduced resource utilisation per CTS.
- £37.42 per CTS procedure reduced costs due to smaller drapes and less equipment used (£11,226 to date with 300 procedures performed).

#### Environmental:

- Each procedure generates 22.14 kg less CO<sup>2</sup>, an 80% carbon reduction per case.

#### Breakdown of Costs and Return on Investment:

- The model makes use of existing outpatient staff and uses existing outpatient clinic rooms.
- There may be an initial outlay to ensure the identified minor ops room is fully compliant. In Wrexham the cost to adjust minor ops rooms in line with IPC standards was £6950 +VAT.
- £37.42 per CTS procedure reduced costs due to smaller drapes and less equipment used.
- £1,120 reduced resource utilisation per CTS as demonstrated in the diagram below which provides a cost comparison between the old and new way of working.



#### Strategic Alignment:

The lean green CTS pathway supports **NHS Wales Decarbonisation Strategic Delivery Plan (2021 - 2030)** by delivering efficient, low-carbon, high-throughput surgery outside main theatres. By accelerating treatment, reducing costs, reducing waiting lists and times, optimising theatre use, and expanding day-case capacity, it meets goals in the **Programme for Transforming and Modernising Planned Care (2022)**, the **Welsh Innovation Strategy (2023)**, and **NHS Wales Technical Planning Guidance (2025–2028)**.

## Implementation Milestones and Available Support:

Phase	Key Milestones	Timeline
<b>Phase 1:</b> Engagement & Planning	Engage critical stakeholders (clinical and service leads, support staff, management), review existing resources and additional requirements. Identify pilot-ready sites. Secure any additional resources required.	1-3 months
<b>Phase 2:</b> Workforce & Infrastructure	Adapt minor ops rooms as required. Provide staff training on model and protocols.	3-6 months
<b>Phase 3:</b> Pilot Rollout	Implement new pathway. Monitor patient outcomes and resource impact.	6-12 months
<b>Phase 4:</b> Evaluation & Long-Term Sustainability	Conduct comprehensive evaluation with Value-Based Health Care teams. Confirm ROI, patient experience, and system efficiencies. Embed service into strategic planning.	12-18 months

**Supporting resources include:** Evaluation report, case for change, service presentation and SOP.

### Call to Action: Adoption of the Lean, Green CTS Model:

Health boards across Wales have a key opportunity to lead in sustainable, efficient, patient centred care. The lean green carpal tunnel surgery pathway delivers:

- 80% carbon footprint reduction per procedure.
- 65% reduction in resource utilisation.
- Direct cost savings with reduced spend on surgical equipment.
- Increased theatre capacity for complex cases.
- Shorter procedures and fewer hospital visits.
- Reduced waiting lists through streamlined delivery.

This proven, low-resource model aligns with NHS Wales' decarbonisation and value-based care goals and is ready for national rollout.

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# Establishing a Perioperative Care of Older People Undergoing Surgery (POPS) Service in Elective General Surgery

## Cardiff and Vale and Swansea Bay University Health Boards

### Value Proposition:

Rising surgical demand among frail older adults has made the current preoperative model unsustainable, causing delays, complications, higher costs, and poorer outcomes. The POPS model embeds early comprehensive geriatric assessment (CGA) to optimise patients, support shared decision-making (with 1 in 7 opting out of surgery), and reduce system inefficiencies. Already used in Cardiff and Vale (CAV) and Swansea Bay (SB) University Health Boards, it aligns with national policy and could save around £5 million annually if rolled out Wales-wide. With over 6,000 frail patients awaiting surgery, now is the time to standardise care, reduce variation, and improve outcomes cost-effectively.

### Why Change is Needed:

The surgical population is ageing, with 45% of anaesthetic procedures undertaken in patients over 65, many of whom are frail. These patients face a four times higher risk of complications (60% vs 15%), longer hospital stays and loss of independence, especially following emergency laparotomy.

In Wales, 6,314 frail patients await surgery; in Swansea Bay, 1 in 3 frail inpatients are surgical cases. One-stop POPS clinics, embedding early CGA, has been shown to save £803 per patient (Hall et. al. 2023) and reduce hospital stays by 4.5 days (McEvoy et al., 2015).

Though CGA cuts emergency laparotomy mortality from 22.3% to 13%, only 23% of eligible Welsh patients receive it. With 14% regretting surgery, improved preoperative assessment and shared decision-making are crucial. Urgent workforce upskilling and adaptable perioperative pathways are needed to improve outcomes, reduce complications and costs, and deliver more efficient, patient-centred care.

### The Opportunity - POPS Model:

The POPS model uses CGA to shift surgical pathways from “waiting” to “preparation,” optimising health, function, and decision-making. It integrates medical, functional, and social assessments with shared decision-making, leading 1 in 7 patients to choose not to proceed with surgery, freeing up capacity.

Endorsed by the Centre for Perioperative Care (CPOC), POPS has been delivered in CAV and SB University Health Boards since 2020, led by consultant geriatricians supported by multidisciplinary teams. While local delivery can vary, consultant geriatrician involvement is essential. Frailty is identified via digital tools like Power BI and patient self-screening, supported by trained staff.

## Impact and Outcomes:

Demonstrated benefits of POPS in CAV and SB University Health Boards include:

### Clinical and Operational:

- 84% underwent shared decision making and optimisation in single clinic, reducing appointments and travel.
- 1 in 7 patients opted not to proceed with surgery.
- Medication rationalisation, improved safety and effectiveness.
- Improved access to social and third sector support.
- Strong positive patient feedback.
- Geriatrician input for 88% of National Emergency Laparotomy Audit (NELA) patients (up from 5%).
- Earlier discharge via pre-admission therapy referrals.
- Digital self-screening saves clinician time.
- 14% of high volume, low complexity patients removed from waiting lists.
- Reduced referrals to single-organ specialties, primary care, and anaesthetics.

### Economic:

- £41 saved per patient via medication review.
- £120k–£350k saved annually from SDM-related surgery deferrals.

### Breakdown of Costs and Return on Investment:

- **NHS Planned Care has secured initial funding for staff, equipment, and licensing across all health boards, and produced implementation plans. Long-term funding will need to be developed locally.**
- Capacity needs will differ by health board and may impact on the number of consultant sessions that need to be delivered.
- Salary estimates show in the table reflect the minimum required to establish a POPS service.

Description of Cost	Cost	Duration	Type
Staff salaries: 1 FTE Band 3 Admin / 1 FTE Band 6 CNS / JCF Approx. 3 Consultant sessions / week	£30,000 £50,00 £42,000	Recurrent	Revenue
IT - Laptop, Dictaphone:	£2,500	Non-recurrent	Capital
Digital systems - Promptly, Attend Anywhere	Approx £30,000	Recurrent	Capital (only required if not already licensed)
<b>Total</b>	<b>£154,500</b>		

Value-based economic modelling suggests that scaling this model across Wales could remove 884 patients from waiting lists with estimated savings of £3.3M in opportunity costs alone. Medication rationalisation would save >£258K whilst avoidance of additional primary and secondary care appointments could yield >£1.4M.

Metric	Projected Savings
Not proceeding	Opportunity cost £189K - £817K per University Health Board (UHB) per annum, total across Wales £3,357,128 per annum.
Medication savings	Annual recurring saving £41 per patient, £14637- £63181 per UHB, total across Wales £258,874 per annum.
Reduction in onward referrals*	Approximately £1,344,882 million per annum across Wales.

\* To single-organ specialities, anaesthetics or back to primary care.

### Strategic and Policy Alignment:

The service aligns with key national strategies, including:

- **CPOC and NELA:** Recommend CGA and geriatrician input for frail surgical patients.
- **A Healthier Wales:** Supports holistic, person-centred care.
- **NHS Wales Technical Planning Guidance (2025–28):** Aligns with care modernisation goals.
- **Promote, Prevent and prepare for Planned Care (2023):** Focuses on preparation over deconditioning.
- **Programme for Transforming and Modernising Planned Care (2022):** POPS improves flow and reduces backlogs.

### Implementation Requirements and Available Support:

Phase	Key Milestones	Timeline
<b>Phase 1:</b> Engagement & Planning	Engage critical stakeholders; review existing and available resources and secure any additional resources. Identify pilot-ready sites. Complete a baseline questionnaire of current service provision. Develop process pathways and governance documentation for local context.	1-3 months
<b>Phase 2:</b> Workforce & Infrastructure	Recruit/ identify staff to provide the service. Provide staff training on model and protocols.	3-6 months
<b>Phase 3:</b> Pilot Rollout	Implement the model in new health board areas, supporting early monitoring and iterative improvements.	6-12 months



<b>Phase 4:</b> Evaluation & Long-Term Sustainability	Conduct full-service evaluation, measure patient outcomes, ROI and cost-effectiveness. Embed service into strategic planning and secure long-term funding.	12-18 months
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**Supporting resources include:** Service model templates, workforce job descriptions, digital tool examples, implementation plans and short-term funds through NHS Planned Care.

### Call to Action - Adopting the POPS Model:

With nearly half of all surgeries in Wales involving patients over 65, many living with frailty, the need to modernise perioperative care is urgent. The POPS model offers a proven, person-centred solution that reduces complications, shortens hospital stays, and saves approximately £803 per patient through streamlined care and shared decision-making. Yet currently, only 23% of eligible patients receive the nationally recommended CGA. Health boards across Wales are urged to support the wider adoption and spread of the POPS service, which is accompanied by financial support. By doing so, we can improve outcomes, reduce avoidable surgery, and better support the 6,000+ frail patients awaiting treatment. Investing in this model now will futureproof surgical care for our ageing population.

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# Dedicated Radiology Pathway Navigation: Streamlining the Referral Pathway and Reducing Waits for CT, X-Ray and MRI

## Cwm Taf Morgannwg University Health Board

### Value Proposition:

Cwm Taf Morgannwg University Health Board's (CTMUHB) Radiology Navigator model tackles diagnostic delays and workforce pressures by embedding advanced practitioner radiographers to streamline cancer imaging.

### Clinical and Operational Impact:

- Colorectal cancer: 69% receive same-day staging CT; 69% cut in waiting time post-endoscopy.
- Lung cancer: 84% faster CXR reporting; 29% shorter CXR-to-CT interval; 67% faster GP referral to multi-disciplinary teams.

### Efficiency:

- 273 radiologist hours saved annually.
- 710 additional CTs delivered in 2024.

Aligned with national cancer priorities, the model improves outcomes, reduces inequalities, and relieves system pressure with low investment requirements.

### Why Change is Needed:

In Wales, lung and colorectal cancers are the leading causes of cancer deaths. Early detection is critical, lung cancer survival drops from 78% at stage 1 to 15% at stage 4 (WCN). Radiology demand is rising 11% annually (RCR, 2023), but staffing isn't keeping pace. Wales has the UK's lowest radiologist ratio (6.1 per 100,000), with a 30% shortfall. Reporting delays and bottlenecks are now compromising patient safety. Innovative solutions are urgently needed. CTMUHB's Radiology Navigator model, upskilling radiographers to support diagnostic pathways, has proven effective in meeting demand and improving outcomes. Similar success has been seen in Milton Keynes and South Tyneside and Sunderland NHS Foundation Trust.

### The Opportunity - Radiology Navigator Model:

The Radiology Navigator model embeds advanced radiographers in secondary care to streamline cancer imaging pathways.

### Navigators:

- Enable same-day CT/MRI access for urgent cancer cases.
- Act as a single point of contact for referrals.
- Run additional urgent suspected cancer CT sessions.
- Accelerate staging report turnaround.

In 2024, the Radiology Navigator delivered 710 CTs in additional capacity. Vetting CT referrals under Ionising Radiation (Medical Exposure) Regulations saved 273 hours of radiologist time (£26,070 per

annum). Navigators also reduce workload for clinicians and nurses, improving efficiency, timeliness, and patient experience.

### Impact and Outcomes:

Data comparing pre- (2019–2022) and post-intervention (2022–2024) periods shows significant reductions in lung and colorectal cancer diagnostic waits under the National Optimisation Pathway (NOP).

#### Clinical and Operational:

##### Colorectal Cancer:

- 69% received same-day staging CT (vs 0% in 2022).
- CT within 2.5 days (down from 8; 69% faster).
- CT reports completed in 1.63 days.

##### Lung Cancer:

- CXR reports in 0.3 days (84% faster).
- CXR-to-CT interval cut by 29%.
- CT reports in 1.3 days.
- CXR-to-MDT and CT-to-MDT times cut by 46% and 52%.

#### Workforce and Resource:

- Radiographer-led CT referral vetting saves 273.3 radiologist hours annually per hospital site, equivalent to £26K in radiologist time or 751 additional CT scans.
- Providing the achieved 710 additional urgent suspected cancer CT scans would otherwise require outsourcing via a mobile CT van at a cost of £68K per site. This highlights the scalable efficiency and cost-effectiveness of this radiographer-led model.

### Breakdown of Costs and Return on Investment:

Below represents the cost to implement a Radiology Navigator at one hospital site. Cost will vary by health board depending on the number of operational sites.

Description of Cost	Cost Amount	Duration	Type
Band 7 Advanced Practitioner Radiographer*	£53,278	Recurrent	Revenue

*\*Costs are based on entry grade band 7.*

The model constitutes an invest to save opportunity. Direct savings can be created through cost avoidance of outsourcing additional diagnostic capacity based on improved service efficiency and resource utilisation.

### Strategic and Policy Alignment:

The Radiology Navigator model aligns with key Welsh Government priorities (**NHS Wales Technical Planning Guidance 2025 – 2028**) by streamlining diagnostics, supporting early cancer diagnosis, and improving pathway efficiency. It advances outpatient transformation (**Programme for Transforming and Modernising Planned Care, 2022**), drives innovation and workforce support (**Welsh Innovation Strategy, 2023**), enhances individualised care and capacity and enables timely access (**Promote, Prevent and Prepare for Planned Care, 2023**). The model also **supports NOPs targets**.

## Implementation Requirements and Available Support:

Phase	Key Milestones	Timeline
<b>Phase 1:</b> Engagement & Planning	Engage critical stakeholders (clinical leads, radiology, management), review existing resources and secure additional requirements. Identify pilot-ready sites. Finalise referral pathways and governance documentation.	1-3 months
<b>Phase 2:</b> Workforce & Infrastructure	Recruit or identify Advanced Practitioner Radiographers. Provide staff training on Navigator model pathway and processes.	3-6 months
<b>Phase 3:</b> Pilot Rollout	Launch service and monitor patient outcomes and resource impact.	6-12 months
<b>Phase 4:</b> Evaluation & Long-Term Sustainability	Conduct comprehensive service evaluation with Value Based Health Care teams. Confirm ROI, patient experience, and system efficiencies. Secure long-term funding and embed Radiology Navigator role into strategic planning.	12-18 months

**Supporting resources include:** Job description, service protocols, service presentation material and Bevan Exemplar evaluation report.

## Call to Action - Adoption of the Radiology Navigator Model:

With strong alignment to national cancer priorities and demonstrable system-wide impact, the Radiology Navigator model is a proven, cost-effective innovation that delivers faster cancer diagnoses, improves patient outcomes, and significantly reduces pressures on radiology teams. The model has supported the reduction in lung cancer diagnosis times by over 50% and enabled same-day staging CTs for 69% of colorectal patients, transforming outcomes, especially for patients in Wales' most deprived communities.

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# Enhanced Community Gynaecology Service – Using Point of Care Diagnostics to Deliver Prudent Local Healthcare

## Hywel Dda University Health Board

### Value Proposition:

Women continue to face delays, misdiagnoses, and symptom dismissal due to gender bias in healthcare. The Enhanced Community Gynaecology Service (ECGS) is a consultant-led, one-stop shop model delivering fast, cost-effective diagnostics and treatment in local clinics. By combining ultrasound, biopsy, and minor procedures in one visit, it reduces pressure on urgent cancer pathways and cuts costs.

Tested in Hywel Dda University Health Board, ECGS reduced resource utilisation by £268 per patient, £73,968 in one year, and freed 276 urgent suspected cancer (USC) slots. National rollout could unlock £4.4 million in resources, improve access and equity, and support NHS Wales' goals for prudent, community-based care.

### Why Change is Needed:

Management of common gynaecological issues like HRT-related bleeding, pelvic pain, and postmenopausal bleeding is often fragmented, leading to unnecessary and costly urgent suspected cancer referrals, duplicated diagnostics, and longer waiting lists.

Up to 40% of women on continuous HRT experience irregular bleeding, causing avoidable referrals, especially in rural areas with limited access. Despite Getting it Right First Time (GIRFT) and the Women's Health Plan, progress is slow towards meeting challenging planned care and health equity needs.

In Wales, around 8% of HRT users (≈2,295 annually) are referred to secondary care for irregular bleeding, many unnecessarily via cancer pathways. With an ageing population and rising cancer rates, this approach is unsustainable.

### The Opportunity - ECGS Model:

Delivered by a consultant gynaecologist and band 5 nurse, the service operates a paperless system using the Welsh Clinical Portal (WCP), enabling real-time documentation, communication, and follow-up.

#### Three core pathways currently exist:

- HRT Bleeding Clinic – for unscheduled bleeding with ultrasound and biopsy access.
- Mixed Imaging Clinic – for endometriosis, polycystic ovary syndrome, and heavy menstrual bleeding.
- One-Stop Hysteroscopy and Ultrasound Clinic – for rapid USC assessment.

Standardised SOPs and referral guidance, including an All-Wales HRT Bleeding Pathway, support safe implementation. The model also supports training and workforce sustainability.

## Impact and Outcomes:

### Clinical and Operational:

- Diagnosis and management in one visit.
- Reduced inappropriate USC referrals.
- Faster access, improved convenience.
- High satisfaction from patients and clinicians.
- 276 USC slots freed annually.
- Radiology burden reduced.
- Improved flow.
- Paperless documentation and real-time results.
- Greener, more efficient service model.

### Economic:

- £73,968 resource release annually from radiology and gynaecology budget.
- £268 resource release per patient.
- No setup cost, repurposed existing equipment available.

### Environmental:

- Lower carbon footprint through fewer in-person appointments and paperless system.

## Breakdown of Costs and Return on Investment:

The table below outlines the resource requirements for running the ECGS clinic weekly. **Notably, HDUHB piloted the service using existing resources without additional investment**, a model likely replicable across most health boards.

Description of Cost	Cost Amount	Duration	Type
Gynae Consultant x2 Session 1 day/week	£28,000	Recurrent	Revenue
.2 FTE Band 3 Admin - 1 clinic day a week	£6,000	Recurrent	Revenue
.2 FTE Band 5 Nurse* - 1 clinic day a week*	£8,000	Recurrent	Revenue
Ultrasound machine**	Covered**	Non-recurrent	Capital
Clinic space		Recurrent	Capital
<b>Total:</b>	<b>£42,000</b>		

\* The nursing position could also be filled by a health care support role at a lower band.

\*\* An ultrasound machine has been secured for each health board to implement the service.

The table below shows the return on investment by moving to the new pathway.

Resource	Previous Pathway	Developed Pathway
Consultant appointment – new	£262	£262
Consultant appointment - follow up	£143	N/A
Ultrasound scan	£125	N/A
<b>Total</b>	<b>£530</b>	<b>£262</b>
<b>Resource released per patient</b>		<b>£268</b>
<b>Resource released in 1 year</b>		<b>£73,968</b>

### Strategic and Policy Alignment:

ECGS advances key national priorities by improving timely, person-centred care (**Women’s Health Delivery Plan 2025 - 2035**), delivering appropriate care efficiently (**Prudent Healthcare**), supporting early intervention for heavy menstrual bleeding, irregular bleeding, and endometriosis (**Menstrual Wellbeing Taskforce**), and prioritising diagnostics to reduce wait times (**Programme for Transforming and Modernising Planned Care, 2022** and **NHS Wales Technical Planning Guidance, 2025 -2028**).

### Implementation Milestones and Available Support:

Phase	Key Milestones	Timeline
<b>Phase 1:</b> Engagement & Planning	Engage critical stakeholders (clinical and service leads, primary care, radiology, management). Review existing resources and additional requirements. Identify pilot ready sites. Develop localised referral pathways and governance documentation.	1-3 months
<b>Phase 2:</b> Workforce & Infrastructure	Recruit or identify consultant gynaecologists and supporting staff. Secure or reallocate ultrasound equipment. Provide staff training on model, digital systems (e.g., WCP), and protocols.	3-6 months
<b>Phase 3:</b> Pilot Rollout	Launch ECGS clinic. Begin delivery of HRT bleeding, mixed ultrasound, and one-stop hysteroscopy clinics. Monitor patient outcomes and resource impact.	6-12 months
<b>Phase 4:</b> Evaluation & Long-Term Sustainability	Conduct comprehensive evaluation with Value-Based Health Care teams. Confirm ROI, patient experience, and system efficiencies. Embed service into local women’s health hubs. Implement digital data capture and feedback loops. Secure long-term funding and embed ECGS into strategic planning.	12-18 months

**Supporting resources include:** Business case/case for changes, service presentation, SOP and Bevan Exemplar evaluation report.

### **Call to Action - Adoption of ECGS Model:**

In Hywel Dda University Health Board, this proven, evidence-based model is delivering faster diagnoses, freeing up urgent suspected cancer slots, resource releasing over £73,000 a year from one consultant clinic day a week, and dramatically improving patient experience.

This easily scalable and prudent service:

- Solves a known, system-wide problem with a practical, proven solution.
- Meets the ambitions of the Women's Health Plan for Wales and the move towards Women's Health Hubs.
- Delivers value-based care, supports prudent healthcare, and generates a return on investment of over 150% within three years.

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