Appendix 1 Screening Programme Reports- performance metrics – Screening Division Senior Management Team meeting 17/11/25

Title of Report:	**Bowel Screening Wales Performance and Operation Report**
Meeting:	**Screening Division SMT 18 November 2025**
Period report covers:	**October/November 2025**
Responsible Officer:	**Steve Court**
Date Prepared	**17 November 2025**

Performance Metrics (from October 2025's Programme SPAR).

1. ***Screening Uptake and Coverage***

All Wales

Name	Standard	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	YEAR
Bowel Screening Uptake	>= 60%	63.4%	56.9%	65.3%	68.9%	65.2%	63.7%	62.5%
Bowel Screening Uptake - Prevalent round 1st Invite	>= 60%	52.7%	51.0%	52.3%	50.6%	51.4%	52.7%	53.1%
Bowel Screening Coverage	>= 60%	64.5%	62.9%	62.4%	62.6%	62.9%	62.1%	62.1%

Bowel screening uptake remains above 60%, with 63.7% uptake recorded in October and an annual rate of 62.5%. Uptake in the prevalent round continues to be below 60%, however, with just 52.7% uptake in October (annual rate 53.1%). BSW planned to start working with National Health Protection Support Team in November to target those aged 50 in the most deprived quintiles, but staffing issues within the BSW Pathway team has meant this project has been delayed until January 2026. The planned Communication campaign between January and March 2025 aimed at raising awareness amongst the younger age groups is not been taken forward as the possible funding steam has been allocated to the financial recovery plan.

2. ***Screening FIT Reject Rate***

All Wales

Name	Standard	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	YEAR
Bowel Screening Rejected Test Rate	<2%	2.2%	2.8%	2.0%	2.5%	2.7%	2.5%	2.4%

The proportion of screening FITs rejected by the laboratory in October reduced from September, with 2.5% rejected for testing (annual rate 2.4%). Participants sending expired collection devices or samples that have exceeded 14 days continues to be the main cause of sample rejection. Quality improvement actions have been implemented and have reduced rate to likely lowest level feasible.

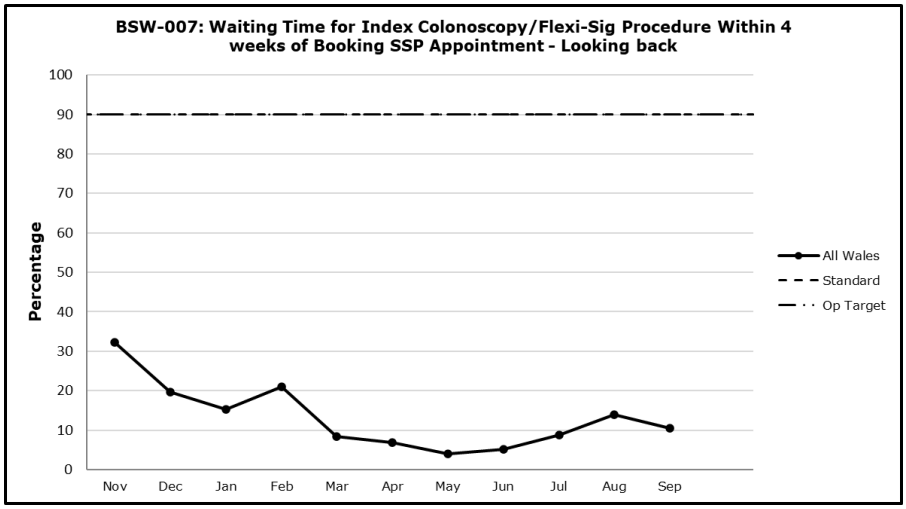
3. Cancer Detection

All Wales

Name	Standard	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	YEAR
Cancer Detection Rate at Index Colonoscopy/Flexi-Sig	>= 10%	7.9%	7.6%	5.0%	6.1%	5.3%	6.1%	6.3%

The annual cancer detection rate in September (6.1%) is similar to the annual average rate (6.3%). There continues to be a variation in the monthly reported cancer detection rate, which may continue until the full effect of optimisation are realised. The standard will be reviewed as sensitivity of the test has improved and this rate in line with programme in Scotland that has optimised.

4. Waiting Time for Screening Colonoscopy



BSW-007: Waiting Time for Index Colonoscopy/Flexi-Sig Procedure Within 4 weeks of Booking SSP Appointment - Looking back												
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ABU	31.0	10.0	6.5	11.8	6.9	24.1	10.9	6.1	2.4	1.1	1.0	
SBU	78.4	41.7	70.8	85.2	16.7	0.0	6.9	0.0	20.0	11.8	3.1	
BCU	5.4	1.0	3.8	10.9	0.7	4.3	4.7	7.6	8.5	6.7	12.2	
C&VU	12.3	7.4	2.9	10.0	1.6	1.6	0.0	3.2	8.3	6.3	6.7	
CTMU	9.2	1.9	6.0	3.1	1.4	0.0	1.1	0.0	3.6	25.4	10.4	
HDU	78.3	90.1	40.8	46.4	26.0	7.0	3.9	6.9	12.0	19.4	19.2	
PT	0.0	10.0	10.8	8.3	0.0	0.0	0.0	10.3	0.0	6.3	4.3	
All Wales	32.3	19.7	15.2	20.9	8.4	6.8	4.0	5.1	8.8	14.0	10.5	

Just 10.5% of FIT positive participants were offered their screening colonoscopy within 4 weeks in September (health board range 1-19%), which is a deterioration on the performance noted in August. However, the average waiting time for a screening colonoscopy in Wales has reduced, with screen-positive participants currently waiting between 7-8 weeks for their procedure (was 9 weeks at the time of the last SMT report in October).

BSW continues to work with the health boards to try to improve screening capacity and discussions on the themes highlighted at the recent round of Chief Executive meetings are continuing.

Other KPI Data

Screening FIT Positive - The screening FIT positive rate over the last six-month period has ranged between 2.3-2.6%, with the annual average currently at 2.6%.

All Wales

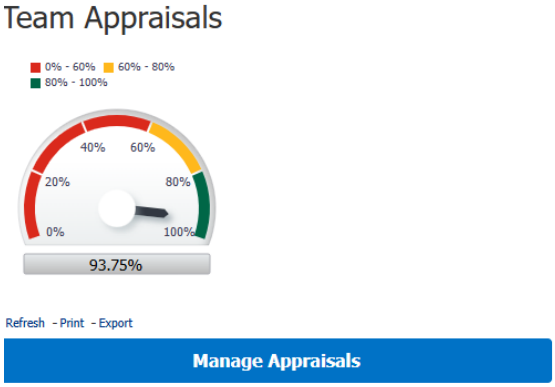
Name	Standard	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	YEAR
Bowel Screening Positive Test Rate	>=1%,<=2.5 %	2.6%	2.4%	2.4%	2.3%	2.6%	2.5%	2.6%

Polyp and Adenoma Detection Rates – Annual detection rates at colonoscopy for polyp and adenoma continue to be relatively high at 70.8% and 55.4%, respectively. The initial reduction in the monthly adenoma detection rate recorded in August (43.5%) has since improved to 57.8% as the histology reporting lag has been accounted for and this demonstrates the limitation associated with the most recent monthly rates within the SPAR.

All Wales

Name	Standard	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	YEAR
Polyp Detection Rate at Index Colonoscopy/Flexi-Sig	>= 50%	73.3%	73.0%	70.3%	74.3%	71.6%	67.0%	70.8%
Adenoma Detection Rate Index Colonoscopy/Flexi-Sig	>= 35%	56.2%	59.5%	56.4%	61.1%	57.8%	46.7%	55.4%

My Contributions –



Title of Report:	Breast Test Wales SMT Report
Meeting:	SDSMT
Period report covers:	November 2025
Responsible Officer:	Mr Dean Phillips – Head of Programme BTW

Performance Management:

- Timelines indicators across all regions are monitored via monthly SPAR, with a detailed round-length activity plan in place. In North Wales, low medical staffing levels are posing challenges in maintaining timeliness indicators. The region is also experiencing extended waits for assessment clinic appointments and film reading.

Mitigation – Clinic slots have been maintained by reworking rotas over October with forward planning into November. Overall numbers of participants waiting for assessment has reduced (circa 37 currently waiting for assessment)

- In the West and South East regions, long-term surgical sickness absences has been noted, further impacting service capacity.
-

Mitigation – Single handed clinics will be used to create capacity in assessment. HD and SBUHB are taking results.

- Backlog of screening mammograms to report in BTW North

Mitigation - To support BTW North, cross-site reading support has been implemented, and additional reporting activity sessions have been completed as planned. Further reading initiatives will be planned subject to funding. Longest wait is currently 4 weeks.

- Discussions are ongoing with Betsi Cadwaladr University Health Board (BCU) to agree a referral pathway for women seen in radiologically lead assessment clinics; however, there was no significant progress during October and no onward pathway has yet been agreed. This issue has now been escalated to CEO's

Mitigation – Meetings to discuss onward pathway for single handed clinics in progress. Long term surgical capacity to be explored with BCU at both the Wrexham and Llandudno sites

- My Contribution rates –78%

Title of Report:	Cervical Screening Wales Update Report
Meeting:	18 /11/25
Period report covers:	Oct/Nov 2025
Responsible Officer:	Lisa Henry, Head of Programme

Performance Metrics (current state, any changes, plan of action)

Uptake: 66.8% for all ages (July 2025) 25-29 year olds= 59.4%.(SPAR needs updating as still measuring screening within last 3.5 years and invitation is now 5 years for HPV negative).

- Laboratory turnaround times: 3 week and 4 week waiting times for screening and cytology test results were below the action threshold for May- September. The laboratory team have developed an action plan and have reported indicative improvements.
- Colposcopy waiting times: All Colposcopy referrals appointments were within standard for August 2025.
- Colposcopy Histology turnaround times: both 2 and 3 weeks targets above the action thresholds June-September 2025.
  - All Wales 2 week turnaround times= 72.1%
  - All Wales 3 week turnaround times = 82.9%

Plans going forward to support achievement of this SPAR are to:

Uptake:

- Self-sampling project: working toward implementation Summer 2026
- Bespoke invitation letter for first time invitee pilot commenced in October 2025
- "Miss you" cards pilot due to commence late November 2025
- Surge project, aiming to go live with CSW calls late November 2025
- A number of other improvement projects are underway across Wales lead by LNS and RMP's.

SE Histology results: C&V are now the only HB with sustained delayed Histology turnaround times. There is ongoing review and support to C&V to improve performance.

CSW Self Sampling

The first Project Board meeting was held in October. Since then, a decision matrix has been developed to support an objective selection of the preferred delivery model. A paper outlining the proposed eligibility criteria has also been prepared, recommending that only participants on routine recall be eligible for self-sampling at this stage. This paper will be presented to the Project Board in November for discussion and approval.

- My contribution rates 56.25% reported on ESR but 85% completed- exploring the difference

Title of Report:	Diabetic Eye Screening Wales Update Report
Meeting:	18th November 2025
Period report covers:	Oct / Nov 2025
Responsible Officer:	Kate Morgan, Head of Programme

Performance Metrics (current state, any changes, plan of action)

DESW-001A Coverage 12 Months >80%

DESW-001A: Coverage 12 Months												
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
North	39.5	38.6	37.6	37.2	36.8	37.0	37.3	37.0	37.2	37.7	39.1	39.4
South	40.7	40.8	41.2	41.6	41.3	41.3	41.1	40.5	39.8	38.8	39.9	40.1
West	43.1	42.6	42.1	41.5	40.9	40.1	39.6	38.2	37.9	38.1	39.4	39.7
Wales	40.9	40.7	40.6	40.7	40.3	40.2	40.0	39.3	38.9	38.4	39.6	39.9

The Increasing Clinic Capacity (ICC) project group is continuing, updates as below.

2:1 template model – The Programme has run one final trial of template of this clinic on 10th November, giving photographer screeners 6 minutes per participants increased from 5 minutes. Final evaluation of the data is to be completed, and the Programme will determine if the template model can be adopted or not.

Low Risk Recall Pathway (LRRP) template model – Repeat clinics have been run in October, at same clinic locations as before. Both clinics ran to time, and demonstrated a more able, less complex participant population. Feedback from the screeners is that the clinic is busy, but manageable. Plan to a further two clinics in alternative screening locations to see how well this works and the ability to spread this improvement, if the Programme agrees to take it forward. These clinics have been planned for December. Additional complexity in the organisation management has been identified in relation to the use of Autobook, so if the template model is deemed successful, an alternative means of booking these participants will need to be process mapped.

Drop-in Clinic template model – Pilot clinic ran successfully on 29th September with 7 drop-in slots available. 5 out of the 7 participants attended, and all arrived at the start time of their morning or afternoon session, however, no-one waited longer than 20 minutes before they could be seen. Staff reported to feel some pressure running the clinic this way but recognised the benefit of not losing two clinic appointment slots for the 2 participants who did not attend. Plan to repeat the clinic again in November, increasing the number of drop-in slots available. Plan to repeat the clinic again 9 December, increasing the number of drop-in slots to 6 in the morning and 4 in the afternoon.

Use of Tropicamide with new cameras – Participant information documents have been agreed by the project team, and the plan organise a pilot run through of what the clinic will look like, so that full timings and processes can be confirmed. We are waiting still waiting for the DPIA to be completed and approved but have provisionally identified that the 'go live' date for the evaluation clinics to be the 16th February 2026. Due to the way in which the clinics will be organised and run, it has also been agreed that we will print and post invitation letters and patient information in-house as this will significantly reduce any costs associated with this. Training sessions for all staff in DESW being co-ordinated, and an update email has been sent to all staff to inform them of the plans in relation to this project.

DESW-002 Uptake – percentage of eligible participants who have attended a screening invitation >80%

DESW-002: Uptake												
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
North	83.1	81.0	83.4	82.4	83.8	81.0	85.2	83.5	81.6	82.4	84.0	84.1
South	81.0	80.1	78.9	80.4	80.9	79.8	83.0	80.8	79.7	81.7	79.8	80.8
West	82.2	80.6	81.4	84.1	81.4	81.1	81.7	80.9	81.6	82.7	81.9	82.7
Wales	81.7	80.4	80.3	81.5	81.6	80.3	83.2	81.4	80.4	82.1	81.1	81.9

The training for the Surge team picking up additional cohort of DESW participants who do not attend their appointments has been completed, and this went live from the 27th October.

DESW-007 Grading Outcome Inadequate <3%

DESW-007: Grading Outcomes (Inadequate)												
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
North	6.5	6.1	4.9	7.2	5.5	5.8	6.7	7.0	6.9	6.2	7.2	6.7
South	6.0	6.2	5.6	6.1	5.0	5.1	5.1	5.9	5.3	5.6	6.1	6.9
West	6.4	5.1	5.5	4.6	5.2	5.3	5.9	5.3	5.0	5.1	5.5	4.5
Wales	6.2	6.0	5.5	6.1	5.1	5.3	5.6	6.0	5.5	5.6	6.2	6.3

Update to plan below –

Actions 3 and 4 are scheduled to be undertaken in the Screener Meetings week beginning 10th November, with paper being taken to DESW Programme Board in November too. Meeting with Informatics to discuss 007 SPAR specifically arranged for the end of November once Programme Board has been informed.

1) Paper to be taken to Programme Board and SMT to propose changes to the current DESW SPARs to bring them in line with the other UK nations.

2) Discussion with Informatics to determine how to run the report to generate 'avoidable' and 'unavoidable' inadequate images.
3) Further development of performance data to be fed back to screeners on a monthly basis, to not only support improvement, but celebrate high standards and good practice.
4) Training for the screener staff to provide them with the changes proposed, how the data is captured and what it is showing, and what additional mentoring and support can be given if required.

DESW-010 Referrals to Hospital Eye Services Within 2 Weeks of Screen Date (R3A urgent) >95%

DESW-010: Referral to Hospital Eye Services (R3A)												
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
North	90.5	72.2	72.7	95.0	87.5	54.5	77.8	100	93.3	26.9	78.6	76.5
South	96.3	90.7	65.2	95.8	78.0	60.9	79.4	95.6	94.7	38.9	55.6	88.4
West	94.7	87.5	64.7	90.0	77.3	38.5	80.0	100	85.7	38.1	60.9	90.9
Wales	94.7	85.7	66.2	94.9	79.5	53.2	79.0	97.2	82.5	34.9	61.6	85.9

Update to plan below –

Action 3 is completed. DESW LMT have agreed to change the reporting cut off point for urgent referral to be the end of day 14, instead of being exactly 14 days since the time of clinic appointment. Timer will also be taken from referral letter production, rather than the production of participant letter. Meeting held with Informatics to identify how this metric can be pulled to reflect this. Process within the Grading team has also been amended, with the production of the referral letter being generated and email being sent to the relevant Ophthalmology department immediately after the Referral Outcome Grade has been generated by the Graders, instead of at the end of the day or subsequent working day. Failsafe work with letters also happening at time of generation, and plan to work on Graders being able to undertake peer review to check and verify documentation. Paper submitted to DESW Programme Board for governance and approval on the 17th November.

1) Review the training plans to ensure that new staff and those returning to work after a period of absence are as streamline as they can be. New ideas of how to approach this training has been put forward by the Specialist Optometrist within the team, with a view to incorporating this in the next couple of months.
2) Begin work exploring the possibility of reducing the QA level to 10% for full competent ROG graders. This would bring the Programme in line with the rest of the UK and would free up graders' capacity.
3) Benchmarking against other UK nations to ensure that the measuring of this SPAR is capturing the best practice as it happens in reality i.e. taking the measurement point from the referral made and supporting this up to the end of day 14.

Title of Report:	Newborn Screening Update Report
Meeting:	18th November 2025
Period report covers:	17th October – 14th November 2025
Responsible Officer:	Jude Kay, Head of Programme

Performance Metrics (current state, any changes, plan of action)

Newborn Hearing (September 2025 Programme SPAR)

NBH-002B: Uptake (>=98%)

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All Wales	99.4	99.4	99.1	99.4	99.6	99.2	98.9	99.1	99.2	99.3	99.4	98.8

NBH-004A: Well babies timeliness of completion of screening (>=90%)

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All Wales	97.1	97.9	90.9	96.0	97.7	97.7	96.6	96.2	96.1	97.6	98.0	98.8

NBH-007A: Timeliness of completion of assessment (>=85%)

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All Wales	80.8	86.7	87.5	93.9	86.7	96.0	100.0	85.7	90.0	93.8	90.3	78.9

Small numbers impact % compliance (4 babies missed standard in Sep). Most babies are High Risk (NICU stay), with this resulting in deferred assessment for clinical reasons or reluctance by family to attend hospital for outpatient appointment following discharge. Detailed review of ABUHB performance underway as standards not achieved for last 3 months.

NBH-010: Screened babies referred for assessment (Between 1-2%)

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All Wales	1.4	1.3	1.0	0.8	1.2	1.3	1.2	1.1	0.8	0.9	0.9	0.9

Standard falling below lower threshold (1%) following improvements in referral specificity. This is expected to continue following protocol changes to prepare for both ears clear model. There are quality assurance measurements in place and close monitoring of outcomes for assurance.

Impact of service changes to maximise specificity:

- Well baby clinic AABRs 1/10/24 - -30/9/25. Referral rate for Well babies completing screening in community reduced by 65%. Of

completed Audiology assessments (27), 93% of babies have identified hearing loss (not only PCHI).

- Well baby repeat AABR in clinic SEW pilot 1/6/25-30/9/25. Small numbers (7) but referral rate for cohort reduced from 84% to 57% with all (3) referred babies being diagnosed with hearing loss (not only PCHI).

Bloodspot (October 2025 Programme SPAR)

NBSW-001D: Coverage (All) (>=95%)												
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
All Wales	95.6	95.6	95.5	95.6	95.7	95.7	95.7	95.7	95.7	95.7	95.5	95.5

NBSW-001A: Completeness of Offer (Newborns) (>=99%)												
2024-25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ABU	99.6	98.8	97.5	99.6	99.5	98.6	98.8	99.5	99.1	99.3	98.4	99.1
SBU	98.8	98.1	98.4	98.8	97.4	99.3	96.5	97.3	99.3	98.7	99.2	98.5
BCU	98.9	98.5	98.6	98.6	97.9	97.5	98.9	99.8	98.7	98.7	99.3	99.5
C&VU	98.0	98.7	97.5	98.2	98.3	97.7	97.9	97.7	98.3	98.7	98.3	97.9
CTMU	99.7	98.9	99.0	99.0	98.1	99.3	98.6	99.1	96.9	99.2	99.3	98.4
HDU	99.2	99.0	98.6	99.6	100.0	99.6	98.4	99.6	99.6	99.6	98.4	99.2
PT	97.2	98.8	98.8	98.8	96.7	98.8	97.3	100.0	97.5	100.0	98.6	97.8
All Wales	98.8	98.4	97.8	98.6	98.1	98.2	97.9	98.6	97.9	98.7	98.0	98.5

Completeness of offer requires receipt of the sample card in the lab by day 14 of life (including declines). Across Wales, October's performance related to 34 babies. Issues generally result from delayed/missed sample capture (failsafe trigger set at day 11), failure to promptly dispatch sample to lab. Causes include prioritisation of other activity, especially when there are staffing shortage, timing of visits which prevent drop off in time for the next courier collection and batching of samples before drop off. In addition to reminder messaging about timely dispatch, and the plan to further reduce the failsafe trigger it is anticipated that Badgernet implementation will support timely sample capture through the inclusion of a reminder for this activity.

NBSW-003J: Timely Collection of Sample (Day 4-6 of Life) (>=95%)												
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
All Wales	96.2	95.8	95.6	95.9	96.6	96.8	96.0	96.1	95.9	96.6	96.5	95.1

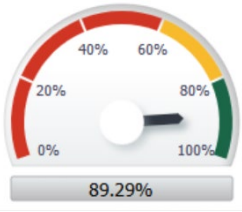
NBSW-004A: Avoidable Repeat Rate (<=2%)												
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ABU	2.6	5.1	3.9	5.8	3.7	2.5	2.1	3.3	2.1	3.2	2.7	2.6
SBU	4.3	8.3	5.7	5.6	7.0	2.7	3.4	3.0	4.8	3.8	2.0	4.9
BCU	7.5	5.9	6.0	3.9	4.3	4.6	4.2	3.4	3.6	2.1	5.0	2.7
C&VU	7.1	9.0	6.1	5.1	4.2	3.5	3.7	3.2	2.8	4.4	4.5	4.8
CTMU	8.3	9.9	7.6	5.4	5.2	2.6	5.7	3.6	1.5	4.4	6.2	3.2
HDU	3.8	8.1	3.2	6.6	5.6	4.8	1.2	3.5	4.6	4.7	5.7	3.1
PT	7.2	2.4	6.0	2.4	4.6	0.0	1.3	5.6	2.1	6.2	3.3	5.0
All Wales	5.7	7.3	5.5	5.2	4.7	3.3	3.4	3.4	3.1	3.7	4.3	3.6

Of which:

NBSW-004B: Poor Quality Repeat Rate (<=1.5%)												
All Wales	3.3	4.0	3.1	3.7	3.1	2.2	1.9	2.1	2.3	2.3	2.7	2.1

Management of this standard sits with HBs. Remains an area of focus with an action plan monitored by Programme Board and a range of embedded support mechanisms delivered by the programme. Staffing shortages in maternity services are impacting compliance. Recent reminder circulated to sample takers to mitigate the risk of increased rejections due to extended drying times in the wet weather. Involvement in research study for machine learning assessment of sample quality planned, noting remaining subjectivity of sample assessment process.

My Contribution Compliance @ 14/11/2025



Title of Report:	Wales Abdominal Aortic Aneurysm Update Report
Meeting:	12th November 2025
Period report covers:	October / November 2025
Responsible Officer:	Jeremy Surcombe, Head of Programme

Performance Metrics (current state, any changes, plan of action)

WAAASP-001A Screening Uptake 12 Months >80%

AAA-001a:												
2024/2025	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
N Wales	80.0	82.5	63.9	73.9	81.6	82.3	78.1	81.4	80.7	83.9	81.0	78.0
S E Wales	74.5	82.0	73.9	76.7	76.5	77.1	76.3	75.2	77.6	76.3	79.5	80.3
S W Wales	80.6	78.0	81.2	81.3	76.9	75.2	79.0	76.5	75.6	79.3	81.2	80.2
All Wales	77.6	81.0	73.0	77.2	78.0	78.0	77.6	77.1	77.7	79.5	80.2	79.9

Rolling 12 month performance remains steady through the programme, although August and September have held steady around the 80% standard for the last 3 months.

Whilst uptake at both 4 and 12 months has remained fairly static over the last 9 months, it has been observed that there are some high DNA rates for first appointments. The number of 1st appointment DNAs has plateaued.

Targeted interventions are being undertaken in the Butetown Clinic with Cardiff and Vale Health Board, however DNA rates have further increased as at September 2025. A further meeting with Public Health and the Primary Care and Community teams for that area of the Health Board took place in November 2025 and there is expected to be attendance at further focused community events in the area in spring 2026. There will also be some facilitated engagement with primary care providers in the area for screen use in their waiting areas.

Exploration into text message reminders started in December and a meeting with the Information Governance Team to talk through the DPIA formalities. A first review on who would receive text message reminders (i.e. would exclude ceased /ceased pending) took place. As at October, planning and working through the DPIA arrangements is ongoing. The first cohort of participants who will receive text message reminders will be surveillance men.

Work with Cardiff City Council and across Screening Division advanced well and outbound calls have been made to non-responders for 14 weeks. Data has been very encouraging and significant numbers of men contacted have been re-booked and AAAs have been detected in men who have not taken up their screening offer previously.

AAA-006 – Timeliness of Intervention

AAA-006: Timeliness of Intervention												
2024/2025	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
N Wales	0.0	0.0	0.0						0.0	0.0	0.0	0.0
S E Wales	0.0	0.0	0.0	33.3	33.3		0.0		0.0		0.0	33.3
S W Wales	50.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	50.0	0.0	0.0
All Wales	20.0	0.0	0.0	25.0	25.0	0.0	0.0	100.0	0.0	33.3	0.0	12.5

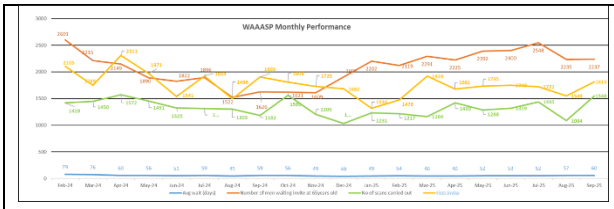
Timeliness of MDT intervention and treatment remains the sole SPAR indicator that is out of standard. This has been reviewed by the Programme Clinical Lead for Vascular Surgery.

This was discussed at the October 2025 WAAASP Programme Board. Meetings have taken place with North EVN, regarding safety and viability of service. Assurance has been sought and an internal briefing was discussed at May Programme Board to include a summary report of the March 2025 visit to Royal Stoke University Hospital, where all standard open repairs for the north of Wales are now sent (other complex open repairs are sent to Liverpool).

A review of the ongoing risk to provision of services in the South West EVN was undertaken by the Head of Programme, the Advisor for Vascular Surgery and the Clinical Imaging Advisor in November. The actions taken to increase Interventional Radiology staffing has remained stead and therefore risk levels have been reduced.

General Performance

Performance and recovery remains a standing item on the WAAASP Core Management Group and Programme Board agendas. Latest activity (to end of June) shows sustained recovery. Waiting time (days past an eligible man's 65th birthday) has reduced from over 300 days in August 2022 to 60 days at the end of September 2025, which is currently the latest available data.



There are currently 2,237 men over the age of 65 awaiting their invitation for screening (slightly up from 2,235 in the previous month). This compares to 7,251 in April 2023.

Whilst the introduction of Kimberley House as a key venue for the programme has been a major factor in securing future sustainability of performance in Cardiff, there are still some clinics across Wales that have challenged performance (whilst still being in standard). Following the successful go-live in May 2023, clinics within 30 minutes drive for a participant have continued to be re-mapped. The programme has re-mapped men from the existing Caerphilly venue to Kimberley House, Cardiff. Clinics that were in Ysbyty Dewi Sant have now been mapped to Rhos House and Talbot Green. Butetown Surgery in Cardiff is being maintained, however there is a survey of each participant who attends to ask whether they would have attended Kimberly House – these surveys were reviewed in March 2024 and a decision was made to continue to keep screening at Bute Town and take the support offered by SET to improve engagement. Staff have attended an ethnic minority community event in Grangetown in June 2025 and future engagement events are planned across Wales. This will hopefully have a positive impact for screening in that area, however, as at September, uptake remains low.

The latest data provides a more defined breakdown of the average and median wait in days across all regions. The programme's average wait to invite has stayed static with an average wait of 60 days for September 2025.

This shows the impact from the reduction of screeners in North Wales. Although we are still consistently achieving a stable amount for the average wait in days. It should be noted that cover across regions has been undertaken to prioritise backlogs and staff shortages where required. Therefore, performance will vary within regions and should not be viewed as a competitive data set.

The most challenged area (by health board) to find suitable venues is Hywel Dda – particularly Ceredigion. A summary of attempts to find suitable locations in the Aberystwyth area was shared with Hywel Dda Health Board in June but there has been no further update. Screening is taking place at the refurbished St David's Park, although it is noted that Trinity St David's indicated that they request payment for use of the room going forward.

My contribution compliance as at November 86.21%.