

Surgical Hubs in Wales: From Elective Recovery to Sustainable Planned Care



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There is now broad agreement across Welsh policy, clinical and operational leadership that elective recovery cannot depend on a stop-start model of care. NHS Wales has made progress in reducing long waits, but the scale of demand remains substantial. In March 2026 there were just under 666,700 referral to treatment pathways waiting to start treatment in Wales, with just over 95,900 pathways waiting more than a year and just over 166,800 waiting more than 36 weeks. That is a better position than the peak years of the backlog, but it is still far from a system that can rely on business as usual.

The deeper lesson is that elective recovery is not only about the size of the waiting list. It is about how resilient the service model is when emergency pressure rises, estates work disrupts normal activity, or workforce availability tightens. Welsh Government's planned care programme recognised this early. It set out a commitment to reduce cancellations by creating dedicated surgical facilities and separating planned care from urgent and emergency care. It also called for ring-fenced dedicated capacity, regional treatment and diagnostic centres, and action to reduce unwarranted variation in theatre productivity.

That direction of travel is strongly reinforced by the wider evidence base on surgical hubs. The Royal College of Surgeons has argued that hubs only work properly when they have genuinely protected, ring-fenced resource. Its review highlighted why separation matters: elective and emergency care compete for the same beds, staff, diagnostics and theatre access, which makes planned surgery vulnerable to seasonal pressures and spikes in unscheduled demand. The same report cited GIRFT survey findings that 94% of hub respondents had seen a positive impact on activity levels, including fewer cancellations, better theatre utilisation and reduced lengths of stay, while 91% reported a positive impact on patient waiting times.



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Importantly, this is no longer only an English conversation. The independent Ministerial Advisory Group review of NHS Wales performance and productivity, published in 2025, concluded that designated surgical hubs with clearly defined roles and ring-fenced facilities can significantly enhance patient experience, reduce waiting times and improve safety by standardising practice and reducing cancellation risk. The review linked hubs directly to broader theatre productivity reform, recommending local Theatre Optimisation Boards, accreditation against GIRFT-style standards, and a day-case-by-default approach where clinically appropriate. It also argued that hubs should be treated as regional and national assets that improve equitable access across Wales rather than being seen as isolated local initiatives.

What does that mean in practice? First, a hub is not simply extra space. It is a designed elective pathway. The core ingredients are protected access, clear clinical scope, pre-assessment discipline, efficient

patient flow, and a workforce model that supports predictable throughput. The Ministerial Advisory Group review makes the productivity point very clearly. Improving performance is not only about building more estate. It is also about eliminating late starts, early finishes, low theatre utilisation and avoidable variation between lists. In other words, the best surgical hub is not just a place. It is an operating model.

Second, successful hub models do not all look the same. The Royal College identifies integrated hubs within hospital sites, stand-alone hubs and specialist hubs. Most hubs surveyed by GIRFT were based within existing hospital estates, which matters for Wales because it suggests that many systems can move faster by reconfiguring and protecting existing capacity rather than waiting for a major new build. That is particularly relevant where capital pressures, decant programmes and estate constraints make conventional delivery too slow.

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This is where flexible healthcare infrastructure such as Vanguard's Welsh experience becomes important. At Cwm Taf Morgannwg University Health Board, a critical incident at Princess of Wales Hospital forced an urgent decant of services. Local leaders said the result was the loss of around a third of physical theatre and endoscopy capacity, with major implications for waiting times and patient care. Working with Vanguard, the health board developed a plan to add four surgical theatres, two wards and an endoscopy complex at Royal Glamorgan Hospital. The endoscopy complex opened within six weeks of groundworks, while the four-theatre, two-ward surgical facility was delivered within nine weeks. The result was not merely additional space. It was a functioning elective environment with reception, consultation rooms, staff welfare space, wards, treatment rooms, recovery areas and scope sterilisation.



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The operational feedback from that project is instructive. **Sarah Edwards** said the configuration mirrored the health board's current service and supported an efficient admission and discharge pathway. **Rhys Hopkins** highlighted the benefits of bringing teams back together in one environment, preserving efficiency and morale during disruption. Staff liked the layout and reported that the environment felt more spacious than expected, while early patient feedback was strongly positive. This matters because the value of a surgical hub is judged in daily operating reality. If the environment integrates cleanly with existing pathways and is accepted by teams, activity follows more reliably.



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There is also a governance lesson here. The Royal Glamorgan deployment did not succeed purely because it was fast. It succeeded because it was collaborative and operationally grounded. Sarah Edwards described a multidisciplinary task-and-finish approach established within 48 hours, spanning estates, facilities, therapies, radiology, health and safety, admissions and ward support. **Gethin Hughes** emphasised both speed and flexibility, describing the need to stand up as much additional capacity as possible in the shortest time and to configure the environment so a broad procedural range could move through it. Good elective infrastructure is therefore not only a construction story. It is a service design story.



Gethin Hughes
COO, CTM UHB



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The final lesson for NHS Wales is about permanence of intent. Hub thinking should not be reserved only for crises. The Royal College has warned that Welsh surgeons face particularly acute theatre access problems, with more than 60% citing lack of theatre access as a major barrier to delivering care. Meanwhile, external evidence on hub performance continues to strengthen. GIRFT reported in 2024 that newly opened hubs in England undertook 21.9% more high-volume, low-complexity elective surgery in their first year than they would have done without a hub, while pre-pandemic hubs also delivered more elective surgery overall and shorter hospital stays. That suggests that hubs are not simply pressure valves. Done well, they are productivity assets.



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For NHS Wales, the practical implication is straightforward. Protected elective capacity should now be treated as part of modern core infrastructure, not an optional add-on. Health boards need solutions that can preserve surgery through refurbishment, create capacity at pace when demand or disruption hits, and support longer-term transformation of planned care.

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