WHC (2026) 035

Llywodraeth Cymru
Welsh Government

WELSH HEALTH CIRCULAR

Status: Compliance

Category: Policy

Title: Theatre Charter

Date of Expiry: No expiry date

Action by: All NHS health boards and trusts

Required by: Immediately

Sender: Steve Thomas
Head of Planned Care Policy
Health, Care & Prevention Group
Welsh Government

Welsh Government Contacts:
Steven Thomas: Steven.Thomas045@gov.wales

Enclosures: Letter from Steve Thomas

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Implementation of the Theatre Charter

Chief Executive Officers, NHS health boards and trusts
Chief Operating Officers, NHS health boards and trusts
Medical Directors, NHS health boards and trusts

23rd November 2026

Dear Colleagues,

This Welsh health circular requires all NHS health boards and trusts providing theatre services to implement the NHS Wales Theatre Charter (see Annex 1).

Purpose

Operating theatre capacity is one of the most valuable and constrained resources within NHS Wales. At a time when services continue to address significant waiting list challenges, rising demand and increasing complexity of patient needs, it is essential that every theatre session delivers the maximum possible value for patients. The Theatre Charter has therefore been developed to establish a consistent, evidence-based approach to theatre planning, preparation and delivery across Wales.

The Charter brings together nationally agreed standards, best practice guidance and the principles contained within the Elective Optimisation Programme. It provides a clear framework for the management of the entire surgical pathway, from referral and decision to treat through to theatre delivery, postoperative discharge planning and continuous improvement. Its purpose is to create greater consistency, strengthen multidisciplinary working and ensure that avoidable delays, cancellations and lost theatre time are minimised.

Why implementation is important

Despite significant efforts by clinicians, operational teams and managers across Wales, variation in theatre utilisation remains. Delayed starts, avoidable cancellations, incomplete pre-operative

preparation and late changes to theatre lists reduce the number of patients that can access treatment and diminish the value achieved from available capacity.

Implementation of the Theatre Charter will support Health Boards to:

- Improve patient access to planned care and reduce waiting times.
- Reduce avoidable on-the-day cancellations.
- Improve patient experience and confidence in the planned care pathway.
- Increase theatre productivity and utilisation.
- Support delivery of national planned care recovery and improvement objectives.
- Improve consistency of practice across Health Boards through adoption of agreed national standards.
- Strengthen governance, accountability and continuous improvement arrangements.

Most importantly, implementation will help ensure that patients receive the right treatment, in the right place, at the right time, with care that is safe, efficient and patient-centred.

Implementation expectations

All Health Boards are required to formally adopt the Theatre Charter and embed its principles within local theatre management arrangements.

Implementation should include:

- Alignment of local theatre policies, procedures and operational standards with the requirements of the Charter.
- Active engagement of surgeons, anaesthetists, nursing teams, operational managers, administrative teams and supporting services in delivery of the Charter.
- Establishment or utilisation of Theatre Optimisation Groups (TOGs) or Theatre Utilisation Groups (TUGs) to oversee implementation and ongoing compliance.
- Integration of Charter requirements into theatre scheduling, pre-assessment, waiting list management and theatre day delivery processes.
- Regular review of theatre performance metrics and utilisation data.
- Use of the national theatre optimisation dashboard to monitor performance, benchmark progress and identify opportunities for improvement.

- Systematic review of cancellations, delays, overruns and unused capacity to identify learning and drive continuous improvement.
- Routine reporting through agreed local, regional and national governance arrangements.
- The Theatre Charter (see Annex 2) poster should be displayed in all relevant clinical areas.

Health Boards should take immediate steps to undertake a baseline assessment against the Charter standards and develop local implementation plans to address any identified gaps. Progress should be reviewed regularly through established governance structures.

A shared responsibility

The successful implementation of this Charter relies on collective ownership. Optimising theatre capacity is not solely the responsibility of theatre teams; it requires collaboration across the entire planned care pathway. Clinicians, managers, administrators and support services all have a critical role in ensuring patients are appropriately prepared, lists are robustly planned and available capacity is used effectively. Implementation will be formally reviewed in line with agreed monitoring and governance arrangements.

By adopting and implementing this Charter, organisations are making a commitment to delivering patient-centred care, reducing inefficiency and ensuring the best possible use of NHS resources for the benefit of patients across Wales.

Thank you for your continued leadership and support in improving planned care services.

Yours sincerely,



Steve Thomas
Pennaeth Polisi Gofal Wedi'i Gynllunio / Head of Planned Care Policy
Cynllunio, Perfformiad, Cyflawni a Goruchwylio'r GIG
NHS Planning, Performance, Delivery and Oversight
Y Grŵp Iechyd, Gofal ac Atal / Health, Care and Prevention Group
Llywodraeth Cymru / Welsh Government

CC:

Jacqueline Totterdell, Director General of Health and Social Services/Chief Executive NHS Wales, Welsh Government
Nick Wood, Deputy Chief Executive NHS Wales, Welsh Government
Jeremy Griffiths, Director of Operations, Welsh Government
Liz Davies, Planned Care Policy Lead, NHS Performance and Improvement.
Ken Harries, Clinical Lead, Strategic Programme for Planned Care, NHS Performance and Improvement
Richard Egan, Clinical Lead, Strategic Programme for Planned Care, NHS Performance and Improvement
Deb Lewis, Specialist Operational Advisor for Planned Care Recovery
Brett Denning, Assistant Director, Strategic Programme for Planned Care, NHS Performance and Improvement
Bethan Clift, Principal Programme Manager, Strategic Programme for Planned Care, NHS Performance and Improvement
Andrew Sallows, National Director - Planned Care, NHS Performance and Improvement
Philip Barry, Director of Operational Improvement, NHS Performance and Improvement

Annex 1

NHS Wales, Theatre Charter

Reference Number	EOP/001
Version	V1.1
Replaces	N/A
Issue Date	5th November 2026
Review Date	5th November 2027
Authors	Ken Harries I Co-National Clinical Director, Strategic Programme for Planned Care Bethan Clift I Principal Programme Manager, Strategic Programme for Planned Care
Approvals	Ken Harries I Co-National Clinical Director, Strategic Programme for Planned Care
Document Location	Elective Optimisation Programme

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Introduction

Operating theatre capacity is one of the most valuable resources available to the NHS. To improve patient outcomes, reduce waiting times, minimise cancellations, and maximise productivity, all theatre lists must be planned, prepared, and delivered in accordance with nationally agreed standards and the Optimisation Frameworks.

This Charter establishes the principles, behaviours, and operational standards required to ensure every theatre list is utilised effectively, efficiently, and safely. It promotes shared ownership across clinical, operational, administrative, and managerial teams and supports a culture of continuous improvement, accountability, and collaboration.

Core Principles

Patient First: All decisions relating to theatre utilisation should prioritise patient safety, experience, access, and outcomes.

Preparation Prevents Cancellation: The majority of delays and cancellations can be prevented through early identification and management of clinical, operational, social, and logistical issues.

Right Patient, Right Procedure, Right Place, Right Time: Patients should undergo surgery in the most appropriate setting, according to clinical need, urgency, and available capacity.

Shared Ownership: Effective theatre utilisation is the responsibility of the entire multidisciplinary team. Clinicians, managers, nursing teams, administrators, and supporting services must work together to deliver efficient patient pathways.

Standardisation: Variation in process should only occur where clinically justified. Agreed national standards and Clinical Implementation Network (CIN) guidance should underpin theatre management across all Health Boards.

Continuous Improvement: Performance should be reviewed routinely, with learning from both successes and failures used to drive ongoing improvement.

Patient Pathway Standards

Stage 1: Referral Management
Optimisation Framework Core Domains: 2.1.1, 2.2.1-2.2.2

Standard: All referrals should be received and managed electronically and assessed against nationally agreed referral pathways. Refer to the All Wales Effective Referral Triage Model Standard Operating Procedure V1.0.pdf

Expectations

1.1 Patients with potentially surgical conditions should be triaged appropriately.

1.2 Referrals should be clinically vetted by designated clinicians utilising agreed national and local pathways.

1.3 Patients with modifiable risk factors should be identified early and signposted to:

- Smoking cessation services
- Weight management programmes
- Frailty assessment and Optimisation services
- Prehabilitation pathways
- Anemia management

1.4 Frailty screening should be completed for all eligible patients.

1.5 Straight-to-test pathways should be utilised where appropriate.

1.6 Clinical urgency grading should follow national guidance.

Stage 2: Outpatient Assessment and Decision to Treat
Optimisation Framework Core Domains: 2.3.1-2.3.8

Standard: Patients should only be added to the surgical waiting list following a fully informed shared decision-making process and when surgery represents the agreed next step in management.

Expectations

2.1 Patients should only be listed when fit for surgery or enrolled onto an agreed optimisation pathway.

2.2 Referral to Pre-Assessment where applicable

2.3 Consent discussions begin at the earliest opportunity.

2.4 Electronic consent should be initiated during outpatient consultation.

2.5 Procedure-specific patient information should be provided.

2.6 Standardised clinic documentation should be utilised.

2.7 Clinical urgency categories should be applied consistently.

2.8 Patients suitable for pooled waiting lists, regional capacity, and high-volume pathways should be identified at listing.

2.9 Potential Golden Patients and Standby Patients should be identified where appropriate.

Stage 3: Patient Optimisation and Pre-Assessment

Optimisation Framework Core Domains: 2.5.1-2.5.4

Standard: All patients listed for surgery should undergo appropriate optimisation and pre-operative assessment before allocation to a theatre list.

Expectations

3.1 Electronic pre-assessment should be the default approach.

3.2 Patients should complete the All-Wales Health Screening Questionnaire.

3.3 Patients requiring further assessment should be directed to the appropriate pathway.

3.4 Frailty, anaesthetic, perioperative medicine, and specialist reviews should occur as required.

3.5 Patients should only be added to a surgical waiting list when they are expected to be fit to proceed to treatment in line with current guidelines. Patients requiring optimisation that will extend beyond such timescales should normally remain within an optimisation pathway until they are ready for surgery.

3.6 Patients should be supported to improve fitness through:

- Waiting Well programmes

- Prehabilitation
- Frailty pathways
- Smoking cessation
- Weight optimisation programmes

Stage 4: Waiting List Management

Optimisation Framework Core Domains: 2.5.2, 2.5.5, 2.5.7, 2.5.8

Standard: Waiting lists should be actively managed and clinically validated to ensure patients remain appropriate and available for surgery.

Expectations

4.1 Administrative validation should occur at least quarterly.

4.2 Clinical validation should occur at least six monthly.

4.3 Patients should be treated according to clinical urgency.

4.4 A robust 6-4-2 scheduling policy is in place with 2-week list sign off agreed by the theatre team, surgeon and anaesthetist.

4.5 A fit-for-surgery standby patient pool should be maintained.

4.6 Admission and discharge requirements should be identified in advance.

4.7 Expected waiting times should be communicated clearly to patients.

Stage 5: Two-Week List Lockdown

Optimisation Framework Core Domains: 2.5.6, 2.6.3

Standard: All theatre lists are finalised and clinically reviewed at least two weeks prior to surgery; all lists must align with nationally agreed standards.

Expectations

Two weeks before surgery, the following must be confirmed:

5.1 Surgical review completed.

5.2 Anaesthetic review completed.

5.3 Consent valid and complete.

5.4 Investigations reviewed.

5.5 Required equipment available.

5.6 Imaging available.

5.7 Perioperative care requirements confirmed.

5.8 Admission arrangements confirmed.

5.9 Discharge arrangements confirmed.

5.10 Social care requirements identified.

5.11 Golden Patient confirmed.

5.12 Standby Patient confirmed.

5.13 Patient attendance confirmed.

5.14 All specialists requirements are documented on theatre list.

5.15 Any outstanding issue should trigger immediate action by a designated theatre scheduling manager.

Stage 6: Theatre Day Delivery

Optimisation Framework Core Domains: 2.6.2, 2.6.3, 2.6.6

Standard: The theatre day should be delivered according to agreed operational standards designed to maximise utilisation and minimise avoidable delays.

Expectations

Before Theatre Commences

6.1 Elective beds are protected and available.

6.2 Golden Patient is ready for surgery.

6.3 First three patients are admitted between 07:30 and 08:00.

6.4 Documentation checks are complete.

6.5 Consent is confirmed.

6.6 Discharge plans are confirmed.

6.7 Auto-send processes are utilised.

Team Brief

A multidisciplinary team brief should occur before commencement of surgery and include:

6.8 WHO Checklist requirements.

6.9 Review of list, with particular reference to the first three patients.

6.10 Potential list risks.

6.11 Equipment requirements.

6.12 Staffing concerns.

6.13 Escalation arrangements.

List Delivery

6.14 Anaesthetic start before 09:00.

6.15 Prompt theatre starts are expected.

6.16 Rolling WHO checks should be undertaken between cases.

6.17 Theatre flow should be maintained with minimal interruptions.

6.18 Theatre utilisation should reflect CIN and GIRFT standards.

6.19 Day-case pathways should be maximised wherever clinically appropriate.

6.20 Electronic theatre documentation should be completed contemporaneously.

6.21 Nurse-led discharge should be the default for appropriate day-case procedures.

Expected Outcomes

6.22 On-day cancellation rates below 2%.

6.23 Reduced late starts (GOV.Wales, 2026)

6.24 Reduced early finishes (GOV.Wales, 2026).

6.25 Maximised theatre productivity (GOV.Wales, 2026.

6.26 Improved patient experience.

Stage 7: Team Debrief and Continuous Improvement
Optimisation Framework Core Domains: 2.6.4, 2.8.4, 2.8.6

Standard: Every theatre list should generate learning that supports improvement across the service.

Expectations

Following each list:

7.1 A structured team debrief should occur.

7.2 Delays, cancellations, overruns, and unused capacity should be discussed.

7.3 Good practice should be identified and shared.

7.4 Avoidable cancellations should undergo formal review.

7.5 Outcomes from the debrief should be routinely reported through local Theatre Optimisation/ Utilisation Groups (TOG/TUG).

7.6 Learning should inform future list planning and service redesign.

7.7 Actionable concerns outside of theatre productivity should be reported through established local process.

Governance and Accountability

Health Boards should ensure:

- A TOG/TUG oversees implementation of this Charter.
- Theatre productivity metrics are reviewed regularly.
- Compliance with CIN guidance is monitored and reported.
- Clinical and operational leadership arrangements are clearly defined.
- Improvement actions are tracked and reviewed.
- Performance is routinely reported through Health Board, Regional, and National governance structures.

Charter Commitment

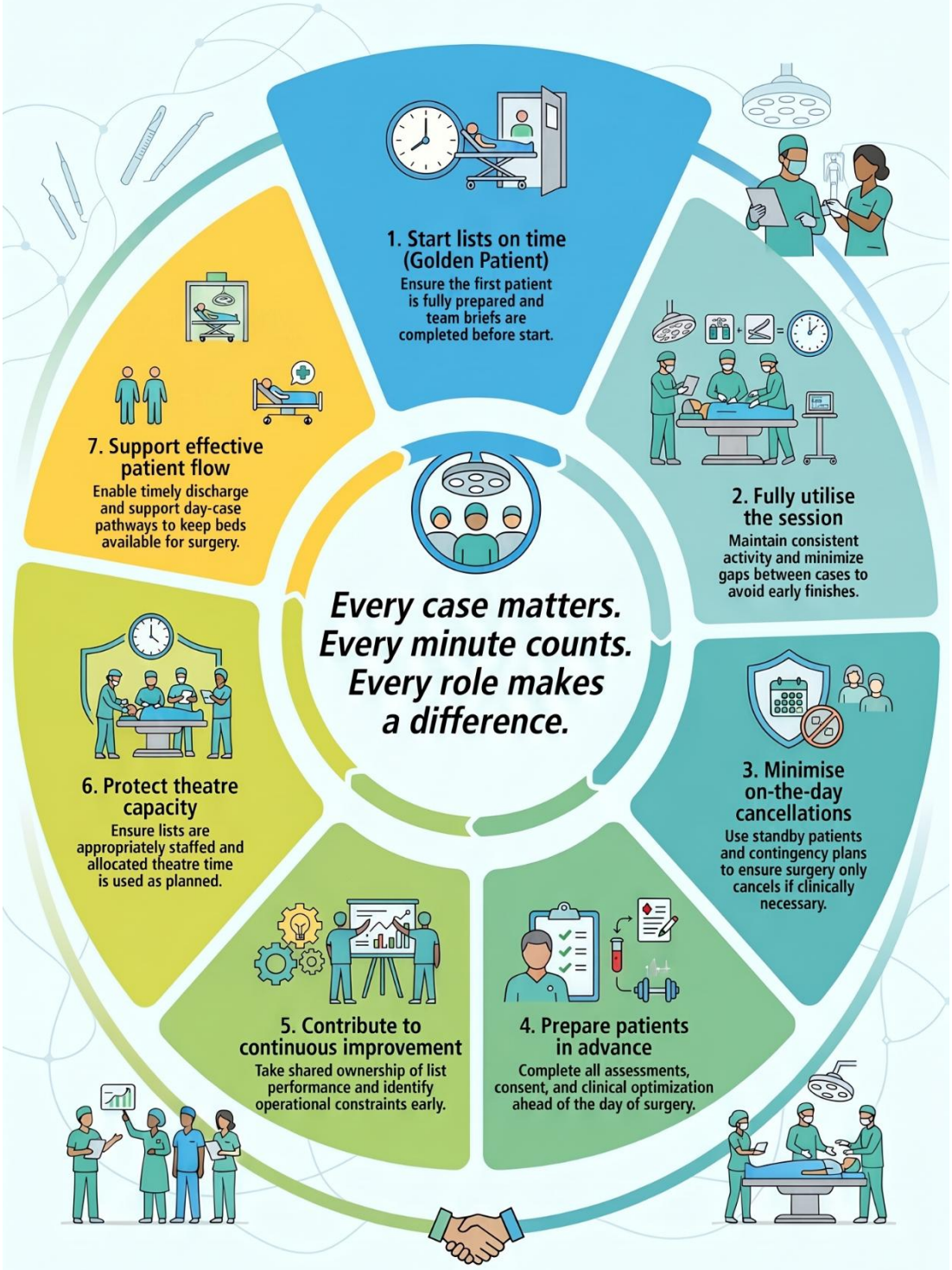
By adopting this Theatre List Charter, teams commit to:

- Delivering patient-centred care.
- Maximising the value of every theatre session.
- Reducing avoidable cancellations and delays.
- Supporting timely treatment for patients.
- Working collaboratively across organisational boundaries.
- Embedding the principles of the Optimisation Frameworks into everyday practice.
- Utilising the national theatre optimisation dashboard, to benchmark improvement - Planned Care Programme - Theatre Dashboard - Report — Power BI

Success will be measured not simply by the number of operations undertaken, but by the consistency, reliability, and efficiency with which patients move through the surgical pathway.

NHS Wales

Getting the Best from Our Theatres



Our Shared Ambition

High-Performing Teams Deliver

Consistently starting on time and delivering full lists improves outcomes for all patients.

NotebookLM