Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Cardiff and Vale University Health Board

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Summary report

About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Cardiff and Vale University Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. The Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[3]);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on Tackling the Planned Care Backlog in Wales which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between September 2024 and March 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 The Health Board was recently escalated to 'Level 4' for finance, strategy and planning under the NHS Wales escalation and oversight framework. Its financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

Key facts

£69.3m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

139,786 the overall size of the waiting list at February 2025[4].

77% the percentage growth in the overall waiting list between April 2019 and February 2025.

13,099 the number of patient pathways waiting more than one year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of one year waits for an outpatient appointment has reduced by 9%, since April 2022[4].

2,028 the number of patient pathways waiting more than two years for treatment at February 2025 against a national target of zero waiting[4]. The number of two-year waits has reduced by 76% since April 2022.

44% the percentage of diagnostic test waits that are within eight weeks at February 2025 against a national target of 100%. Diagnostic waits that are 'over eight weeks' has increased from 4,850 in April 2022 to 14,086 in February 2025.

97% the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 88% reduction of 'over 14 week' therapy waits since April 2022.

28,933 the number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025[4]. This has increased by 7% since April 2022.

[4] Referral to treatment waiting list performance is reported by Health Board area of residence.

Key messages

Overall conclusion

8 Overall, we found that **despite work to drive operational service improvements, the Health Board's approach until recently did not achieve the desired positive impact on planned care performance. Consequently, the waiting list substantially grew during 2024. There is a risk that recent improvements are unsustainable and reliant on additional short-term funding. The Health Board, therefore, urgently needs a financially and clinically sustainable plan to meet growing service needs and secure improvements in planned care performance.**

Key findings

Action that the Health Board is taking to tackle the planned care challenge

- The Health Board's planned care developments are focussed on short-term improvements. While it is strengthening its planned care programme leadership, it is yet to set out the actions it will take to secure more sustainable improvements to planned care services.
- The Health Board has utilised the additional Welsh Government planned care funding for both planned care and some unscheduled care improvements. It is also facing a trade-off between planned care waiting list recovery and financial recovery, but it is struggling to develop approaches to achieve both.
- The Health Board has started to implement the Getting It Right First Time (GIRFT[5]) recommendations and is strengthening the oversight of these improvements. However, there remain opportunities to improve efficiencies, particularly in relation to improving outpatient 'did not attends' and short notice surgical cancellations, surgical productivity, and theatre utilisation.
- The Health Board has had some success in protecting planned care capacity from wider unscheduled care pressures. It has increased short-term planned care capacity through insourcing, outsourcing, waiting list initiatives and, to a limited extent, regional working.

[5] Getting It Right First Time (GIRFT) is a programme that aims to improve the quality and efficiency of hospital care.

- The Health Board is implementing the Welsh Government's Promote, Prevent and Prepare Policy[6], but progress is slow, and the service does not yet cover all specialties. The Health Board's arrangements for monitoring and reporting incidence of harm are good in ophthalmology services and it should build on this approach across all higher risk specialties.

Waiting list performance – is the action taken resulting in improvement?

- The continued growing backlog of people waiting to be treated presents an increasing problem for the Health Board. As of February 2025, there were around 140,000 open treatment pathways as compared to 80,000 immediately prior to the pandemic.
- The Health Board is not meeting most of the relevant Welsh Government targets that are due to date, and it is far from achieving the target to eliminate the number of people waiting longer than one year in most specialties by Spring 2025:
  - the Health Board initially made good improvement on its 52-week new outpatient waits. Performance then deteriorated between March 2023 and December 2024. Since December, recent improvements have reduced the level of over 52-week outpatients waits, marginally, to around 13,000.
  - the Health Board did not meet the revised Welsh Government target to eliminate waits over two years by March 2024. It made good progress to March 2023 but then performance plateaued until December 2024. Since December, the Health Board has made improvements and reduced the number of two-year waits to around 2,000 patients.
  - the Health Board largely met the target for therapy waits and is performing well in this area. However, while noting recent improvements, its performance for diagnostic tests within eight weeks remains the worst in Wales. There are currently over 14,000 patients waiting over eight weeks for diagnostics.
  - the number of people waiting longer than one year for treatment peaked in October 2024. There are currently nearly 29,000 patients waiting over a year for treatment, a reduction of around 3,300 since October.

Barriers to further improvement

9 Based on its current service model, the Health Board does not have sufficient core finance or workforce capacity to materially reduce waits to sustainable levels.

[6] Promote, Prevent and Prepare for planned care. Phase 1 was required to be delivered by March 2024. This included the establishment of a single point of contact for people to access information and support following referral to specialist secondary care.

While the Health Board understands its challenges, its necessary short-term focus is undermining its ability and capacity to plan for the future.

10 The Health Board recognises its barriers to planned care improvement and is introducing programme structures and groups to address these. However, the volume of planned care referrals is growing and there are wider competing pressures in other areas, including unscheduled care.

Recommendations

11 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 4**.

Exhibit 1: recommendations

Recommendations
Planning R1 The Health Board should: 1.1 develop an up-to-date planned care improvement plan and road map that articulates the design and delivery of sustainable specialty services in the medium to longer term. (**Exhibit 2**) 1.2 set out its projected costings against forecast demand over a three-to-five-year term with realistic and challenging milestones based on reasonable planning assumptions. (**Exhibit 2**)
Demand and capacity modelling R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across its specialties to inform short-term service capacity planning and longer-term service design. This should also consider changes in population demand for planned care services. **(Exhibit 2)**
Programme support for service transformation R3 The Health Board should build the required programme capacity and capability to support planned care specialties transformation. **(Exhibit 3)**

Recommendations

Risk management

R4 The Health Board should develop a planned care risk register that fully assesses and mitigates the key risks that inhibit short-term improvement and longer-term service transformation. **(Exhibit 3)**

Monitoring the progress of planned care programme delivery

R5 The Health Board should introduce quarterly committee reports to provide updates and assurance on the progress of planned care programme delivery milestones. This report should also describe where progress is off track, and key risks that inhibit short-term improvement and longer-term service transformation (as described in **Recommendation 4**). **(Exhibit 3)**

Monitoring impact of additional funding

R6 The Heath Board should strengthen its reporting to Board on the direct impact of the additional Welsh Government planned care funding. **(Paragraph 25)**

Efficiency and productivity

R7 The Health Board should:

- 7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. **(Exhibit 6)**
- 7.2 Develop and implement a plan to address high outpatient 'Did not attends'. **(Exhibit 6)**
- 7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. **(Exhibit 6)**
- 7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. **(Exhibit 6)**
- 7.5 Increase Day Surgery rates to the GIRFT level of 85%. **(Exhibit 6)**
- 7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90% of consultants have job plans. **(Exhibit 6)**

Recommendations

Promote, Prevent and Prepare for Planned Care Policy

R8 The Health Board should complete its implementation of the single point of contact for people to access information and support following referral to specialist secondary care. **(Exhibit 7)**

Managing clinical risks associated with long waits

R9 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks and with long waits by:

9.1 Developing and implementing a more consistent approach for assessing the risk of harm to patients caused by long waits across specialties. **(Exhibit 7)**.

9.2 Developing a routine report to be presented at the Quality Committee that reports risks and actual incidences of harm resulting from delays in access to treatment across all clinical specialty areas of concern. **(Exhibit 7)**

Detailed report

Action that the Health Board is taking to tackle the planned care challenge

12 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.

13 We found that **while the Health Board is focussing its efforts and additional funding to improve planned care performance and efficiencies in some areas, it lacks a robust short-term action plan. It has a reasonable emerging programme structure to drive improvement, but there is a concerning lack of longer-term service planning to create affordable and sustainable planned care service models. The Health Board is improving how it supports people that are waiting but it needs to strengthen reporting on patient harm associated with long planned care waits.**

Planned care improvement plans and the programme to deliver them

14 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

15 We found that **there are some promising initiatives to improve planned care in the short term. However, the Health Board lacks a robust plan to achieve Welsh Government's targets and there is no long-term plan to address growing demand and create financially sustainable planned care services**.

16 The findings that underpin this conclusion are summarised in **Exhibit 2**.

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	**Partially**	The Health Board currently does not have an overarching strategic longer-term plan for planned care that sets out how it will meet growing demand and create financially sustainable service models. However, it has started to develop a longer-term clinical services plan of which planned care will feature as a core element. **(Recommendation 1.1)** The Health Board has identified its short-term improvement actions for planned care in its Annual Plan 2024-25, although it does not provide clarity on how these will be delivered or the resources required to deliver them. These new initiatives include outpatients, operating theatres, diagnostics, robotics, and endoscopy improvements.
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Health Board's key strategies and plans, such as its Living Well, Caring Well, Working Together Strategy and Annual Plan 2024-25, do not sufficiently set out the financial and wider resource requirements to recover planned care services. It is using the additional Welsh Government planned care funding to create additional capacity, but this is expensive because it is driving short-term contracting of additional services and initiatives. There is also a tension between the Health Board's need to improve its current and future financial position and its level of investment in planned care. **(Recommendation 1.2)**
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Health Board's Annual Plan 2024-25 is sufficiently aligned to the ministerial priorities and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan.

Audit question	Yes / No / Partially	Comments
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	**Partially**	The Health Board has set sufficiently ambitious planned care waiting list targets. However, it has not clearly set out time-based milestones for the delivery of proposed service transformation. The milestones also lack a focus on impact, which will make it difficult for the Health Board to determine the extent to which its actions have made a real difference.
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**Partially**	The Health Board undertakes capacity and demand analysis to inform the assumptions that underpin the development of its Annual Plan 2024-25. While these arrangements are improving in some areas, such as spinal services, urology, ophthalmology, and endoscopy, there is a need to ensure its short and long-term demand and capacity modelling covers the breadth of planned care services. **(Recommendation 2)**
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**Partially**	Despite not having a clinical services plan yet, there are some limited examples where the Health Board has identified the transformational changes that it needs to make to make its services more sustainable in the future. This includes the development of a surgical hub in University Hospital Llandough, participation in the regional eye care approach, development of endoscopy services, and introduction of a diagnostics hub. However, the Health Board has not yet developed clear sustainable specialty level transformation plans for planned care. The range of clinical services plans do not currently meet this need.
Are plans for planned care improvement aligned to other key corporate plans such as the IMTP, and plans for workforce, digital and estates?	**No**	There is insufficient detail in the Annual Plan 2024-25 on planned care service transformation requirements and the necessary changes and investments required in workforce, digital and estates to support service change.

Audit question	Yes / No / Partially	Comments
Do the Health Board's planned care priorities align with those in other health boards and identify regional solutions to planned care recovery?	**Partially**	Regional partnerships between Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards are making some progress. Aneurin Bevan University Health Board is responsible for hosting the regional ophthalmology (cataracts) programme. Cardiff and Vale and Cwm Taf Morgannwg University Health Boards are starting to introduce regional orthopaedic arthroplasty and diagnostic services in the Llantrisant Health Park. While there are plans for regional services, interviewees suggested that the approach for pooling waiting lists and the perceived lack of equity of additional resourcing for regional services may be potential barriers to effective commitment to new developments. The Health Board is also jointly working with Swansea Bay University Health Board on tertiary specialised service developments.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

17 We found that, **at present, there is a strong bias towards short-term, but unsustainable, actions to reduce long waits. Whilst there is a developing programme structure to deliver planned care improvement, the Health Board needs to build and strengthen clinical leadership to drive the changes needed to create sustainable services for the longer-term.**

18 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

Exhibit 3: the Health Board's approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	**Partially**	The Health Board is in the early stages of implementing a revised Planned Care Programme Board and supporting delivery groups to drive improvement. This includes pathway efficiency focussed groups (outpatients, theatres and diagnostics) and specialty groups. Its Clinical Boards are responsible for operational service delivery improvements. Its improvement approach has been focussed on short-term operational delivery. However, it also needs to develop a transformation programme that has the capacity and capability to design and implement planned care service models that are sustainable in the longer term. The Health Board could achieve this through the development of its Clinical Services Programme. **(Recommendation 3)**
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**Partially**	There are clearly set out leadership roles, responsibilities and accountabilities for delivering planned care improvement. Clinical leadership for core planned care developments, such as inpatients, outpatients, and robotic surgery is clear and strengthening. However, we understand that clinical leadership at a specialty level is more variable. This appears, in some instances, to be affecting the Health Board's ability to gain clinical consensus on the important service transformation work and improvements that are needed.
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Partially**	The Health Board has not undertaken an overarching risk assessment on planned care programme and improvement delivery. **(Recommendation 4)** However, it has identified some programme risks relating to the regional programme delivery which help, to an extent, to understand some of the challenges that it faces when delivering improvements. The Health Board does utilise Clinical Board risk management arrangements to help manage operational delivery risks.

Audit question	Yes / No / Partially	Comments
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	**Partially**	Planned care performance is routinely reported to the Board and Finance and Performance Committee. However, there needs to be a clearer focus on reporting progress against improvement plan milestones so that there is assurance on the pace and impact of planned care changes. **Recommendation 5**

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

19 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

20 We found that **since 2022-23, the Health Board has received a total of £69.3 million in additional Welsh Government funding. While most of this additional funding has been allocated to planned care, a sizeable amount each year (around £2.4 million in 2023-24) is being spent to ease unscheduled care pressures. Similar to other health boards in Wales, it is focussing the funding on short-term improvements with limited investments in service transformation to help make planned care services financially sustainable in the long term.**

21 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £69.3 between 2022-23 and 2024-25 (**Exhibit 4**).

Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	22.6
2023-24	23.4

Financial year	Annual allocation (£m)
2024-25	23.3
Total allocated	**69.3**

Source: Health Board financial self-assessment returns

22 The Health Board can account for the additional planned care funding that is has received. We reviewed the use of the additional funding in 2023-24 in greater detail (see **Exhibit 5**). Most of this is being committed to short-term measures to cut waiting lists. Like other health boards in Wales, there is limited use of the funding to support transformation to make services more financially sustainable in the longer term. In addition, around £2.4 million of the funding is being used to support wider unscheduled care improvements. During 2023-24, the Health Board used around £11 million of its £23.4 million allocation to increasing planned care activity, £6.8 million on regional working, and a further £0.48 million on service transformation. It spent most of its additional funding on diagnostics and treatments across a range of specialties including radiology, endoscopy, cardiac diagnostics, pathology, and securing additional outpatient and treatment capacity. Where funding is supporting short-term service capacity increases, it is in the form of insourcing, outsourcing, and waiting list initiatives. While these help to reduce current levels of waits, they are not financially efficient. In addition, where the Welsh Government is providing additional funding at very short notice, the Health Board is at greater risk because it is difficult to properly test the market during procurement to ensure best value and quality.

23 The Health Board is under significant financial pressure. It is forecasting at £27.7 million deficit for the year ending March 2025, and we expect that its financial pressures will continue into the 2025-26 financial year. Overall, the Health Board's financial pressures may result in it making short-term financial recovery decisions that affect its ability to fully deliver on its planned care recovery ambitions.

Exhibit 5: Audit Wales analysis of the use of the 2023-24 Welsh Government additional financial allocation, Cardiff and Vale University Health Board

	Performance improvement funding (£m)	Transformation funding (£m)	Regional working and transformation (£m)
General outpatients	0.764		
Diagnostics (Radiology, Endoscopy, Cardiac diagnostics, Pathology and Medical Physics)	4.401	0.180	2.618
Therapies (Seven-day therapies and staffing)	0.457		

	Performance improvement funding (£m)	Transformation funding (£m)	Regional working and transformation (£m)
Planned care additional capacity (inc. theatres, anaesthetics, waiting list initiatives, insourcing and outsourcing)	5.592	0.296	4.165
Cancer services, central team funding	0.231		
Mental Health and Child and Adolescent Mental Health Service capacity	0.747		
Primary care (weight loss and dental)	0.136		0.030
Unscheduled care (flow and front door)	2.481		
Other costs (Clinical lead for planned care, pathway development, 3Ps support)	0.758	0.585	
Total allocated	**15.567**	**1.061**	**6.813**

Source: Health Board self-assessment returns

Monitoring impact of additional funding

24 We have considered the extent to which the Health Board oversees the use of the Welsh Government planned care financial allocations. We found that **it has tracked and analysed the additional Welsh Government planned care financial allocation to determine if it has had the expected impact on reducing the levels of waits. However, there is no reporting and scrutiny of this information at board and committee level.**

25 The Health Board's officers have a clear understanding of where it is intending to spend its additional planned care allocation and discuss the progress on specific funded initiatives at routine performance meetings. The Health Board has effective arrangements to track the use of the spending and the extent that it has had the desired short-term impact. The Health Board's Board Assurance Framework also makes it clear that there is a significant risk caused by a general 'lack of funding available for delivering planned care performance standards'. The Board and its Finance and Performance Committee are aware of additional planned care spending, but there is no routine reporting on the specific impact that it is having overall. **(Recommendation 6)**

Operational management of planned care

26 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to protect and increase its planned care capacity.

Maximising the use of existing resources

27 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found that **while the Health Board is taking action to improve efficiency and productivity, it has much more to do, particularly in ophthalmology and general surgery.**

28 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	There is mixed progress in responding to GIRFT reviews. The Health Board has received ophthalmology, general surgery, trauma and orthopaedics, gynaecology, ENT, dermatology and urology GIRFT reviews. It has made good progress in addressing recommendations within Orthopaedics and is seeking GIRFT surgical hub accreditation. However, limited progress in relation to ophthalmology and general Surgery is a significant concern, given the extent of long waits for these services. **(Recommendation 7.1)**
Arrangements for measuring and managing productivity of services	The Health Board is taking a number of actions aimed at increasing the productivity of services including: • Reintroducing a theatres delivery group to focus on productivity and efficiency, driven by clinicians. Specialty teams are focussing on reaching 95% utilisation for all theatres. • A well-established outpatient transformation programme which is rolling out: – See on Symptom/Patient Initiated Follow up pathways; – Patient Participation Booking; and – Health Board-wide programme of validation. • Implementing new MRI software to increase appointments and release radiology workforce time so they can report on more complex imaging. • Reporting on planned care efficiency measures to the Finance and Performance Committee and the Board. This includes efficiency trend data on outpatients, endoscopy, theatres and length of stay.

Opportunity area	Audit findings
Reducing non-attendance at outpatient appointments	**Exhibit 18** on page 40 shows that the Health Board's 'Did Not Attend' (DNA) rates within its outpatient clinics remain an ongoing challenge. In the 12-month period to February 2025, its DNA rate of 10.5% equated to a loss of approximately 60,450 outpatient appointments. If the Health Board could reduce its outpatient DNA rate to 8.4% (a reduction of 20%), it would provide around 12,100 additional outpatient appointments and avoid wasting the equivalent of approximately £1.81 million of NHS resources. **(Recommendation 7.2)**
Making use of 'virtual' outpatient appointments	Virtual outpatient appointments reduce the need for travel and can decrease the risk of healthcare-acquired infections. Between April 2024 and February 2025, 13.5% of all outpatient appointments in the Health Board were virtual (see **Exhibit 19** on page 41). The Health Board could consider further steps to increase the adoption of virtual outpatient appointments where feasible.
Reducing the number of cancelled operations	During the most recent 12-month reporting period, from March 2024 to February 2025, over 2,500 individual surgical procedures were cancelled within 24 hours. This represented approximately 10% of all elective surgical admissions (see **Exhibit 20** on page 42). The Health Board is focusing on its Pre-Operative Assessment Clinic to identify strategies for reducing surgical cancellations. However, patient-related causes are only part of the challenge; availability of clinical staff, equipment issues, and pressures from unscheduled care also contribute to the problem. **(Recommendation 7.3)**
Improving operating theatre utilisation	There are clear arrangements for monitoring and managing theatre utilisation. Specialty teams are focussed on increasing theatre utilisation, and we understand that the Health Board is bolstering these arrangements though the re-introduction of the Theatre Delivery Group. Overall, these arrangements appear to be having the desired impact by improving theatre utilisation to around 80% against a GIRFT target of 85%. However, some specialties, including ophthalmology, present a greater concern because session underutilisation is resulting in low productivity. **(Recommendation 7.4)**

Opportunity area	Audit findings
Making more use of day-case surgery	The Health Board is not yet maximising the use of day-case surgery. GIRFT recommends that on average, 85% of all elective surgery should be day case. As can be seen in **Exhibit 22** on page 44, for the period April 2024 to February 2025, 62% of all elective surgery within the Health Board was day case. This is well below the all-Wales average of 74%. While its higher proportion of specialist tertiary services may constrain day case use, the Health Board would benefit by: • setting an interim performance target for day-case surgery informed by peer performance in similar tertiary providers in NHS England; and • reviewing the surgical cases that can be converted to day-case lists. **(Recommendation 7.5)**
Effective consultant job-planning	The Health Board's arrangements for job planning are not effective. A recent Internal Audit report on the Surgery Clinical Board identified significant weaknesses in the job planning process, with only 27% of the senior medical workforce having a fully signed-off job plan and only 13% having had an annual review. While the Surgery Clinical Board is an extreme example, overall job planning levels across the organisation are too low. NHS Planning Guidance for 2025-26 requires 90% of consultants to have an agreed job plan by 30 September 2025. The Health Board needs to use individual and team-based job planning to maximise productivity and to act as a tool to transform services where needed. **(Recommendation 7.6)**
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	The Health Board has indicated that the pooling of waiting lists, particularly in relation to regional services, is not working well. This appears to be impacted by differing backlog challenges faced across the region and the levels of regional funding. Locally, the Health Board has indicated that its own services are not always implementing treat-in-turn either. We heard that some clinicians are working from the back of their individual list, and not from the back of the specialty's waiting list. For clinicians that have shorter waiting lists, this means they are seeing patients sooner than other clinicians with a longer individual waiting list.

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

Protecting and increasing planned care capacity

29 We examined the actions the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.

30 We found that the **Health Board has had some success protecting planned care capacity from wider unscheduled care pressures. It has also increased short-term planned care capacity, but this is not sufficient to reduce long waits, and financial pressures continue to restrain the pace of recovery.**

31 The Health Board is well positioned to protect elective capacity from broader service pressures. University Hospital Llandough offers acute surgical services, but it has no emergency department. This minimises disruption to elective services when there are other service pressures. The Health Board is also intending to further increase its surgical capacity at University Hospital Llandough. We note that the specialist nature of some complex surgical procedures undertaken at the University Hospital of Wales is a constraining factor that would limit the ability to move some services to Llandough.

32 The Health Board is using additional Welsh Government funding to boost capacity through insourcing, outsourcing, and waiting list initiatives, as well as enhancing core resources. For 2024-25, investments include dermatology, outpatients, diagnostics, orthopaedics, ophthalmology, therapy, theatre staffing, and consumables. It is also developing regional orthopaedic arthroplasty services.

33 Waiting list data for October 2024 to December 2024 indicates that despite increased investment, capacity is not currently sufficient and waiting lists are not materially reducing. Funding pressures are a clear factor. The Health Board considered a range of possible approaches to secure financial recovery in February 2024, which included slowing down investment in planned care. While the Health Board did not agree this approach, and conversely exceeded its budget on planned care by £3 million in 2024-25, it demonstrates the trade-off between financial recovery and planned care recovery which it is trying to balance.

Managing clinical risk and harm associated with long planned care waits

34 Long patient waits increase the risk of preventable and often irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

35 We found that **while the Health Board is strengthening its approach for managing the risk of and actual harm resulting from long waits, there is much more to do.**

36 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy[7]?	**Partially**	The Health Board is implementing the first phase of Welsh Government's Promote, Prevent and Prepare Policy (3Ps), although progress is varied by speciality. The national policy aims to ensure that support and information are easily accessible for those who are waiting for appointments and inventions in secondary care. The Health Board has set up prehabilitation (Prehab 2 Rehab) and is piloting a single point of contact service for hernia, hip, and gallbladder surgery patients. While there is a 'keeping me well' website, it is not clear from this or the main Health Board website how a patient can escalate a concern or the telephone number to use if they are deteriorating while waiting. **(Recommendation 8)**
Is the Health Board assessing the risk to patients waiting the longest?	**Partially**	The Health Board uses the Datix[8] system to record clinical risk resulting from a delay in treatment. The ophthalmology service has clear assessment arrangements. This is helping to identify patients that have come to harm. There are also arrangements for endoscopy and gastroenterology surveillance that feed Datix incident reporting if harm occurs. However, there is no consistent methodology throughout specialties to assess risk and inform reporting on the risk of harm or instances of recorded harm. **(Recommendation 9.1)**

[7] Promote, Prevent and Prepare for Planned Care Policy to ensure that support and information are easily accessible to those waiting for appointments and interventions.

[8] Datix is a risk management and incident reporting tool for recording and managing incidents, near misses, and potential risks to improve patient safety and continuous improvement.

Audit question	Yes / No / Partially	Comments
Is the Health Board routinely capturing and reporting evidence of harm resulting from waiting list delays and reporting on it to the Quality and Safety Committee?	**Partially**	Where there are more significant issues, such as when ophthalmology patients are waiting a long time on the follow-up list, these are reported appropriately to the Health Board's Quality Committee both in specific assurance papers and as part of routine National Reportable Incident reporting. For other specialties, the reporting of harms to committee is reliant both on the extent that patients are reviewed while waiting and clinical staff completing Datix forms. At present, there is no assurance that the approach is consistently applied. **(Recommendation 9.2)**
Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical risks in its approach to prioritising patients?	**Partially**	The Health Board has a Treat in Turn dashboard which it uses to inform the prioritisation process. Our fieldwork suggests clinicians are trying to balance the need to treat in turn with levels of clinical risk. The review arrangements in Ophthalmology and Endoscopy surveillance assist with this process. However, it is not clear how the Health Board balances the tension between tackling long waits and clinical risks for other specialties.
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	**No**	The Health Board has acknowledged that some patients will seek private treatment outside of the NHS due to the long waits they have experienced. It has not consistently monitored or reported these numbers; however, we understand that waiting list validation processes may capture this information in part.

Source: Audit Wales fieldwork

Waiting list performance – is the action taken resulting in improvement?

37 We analysed current 'Referral to Treatment'[9] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall levels of waits; and
- meeting Ministerial priorities and Welsh Government national targets.

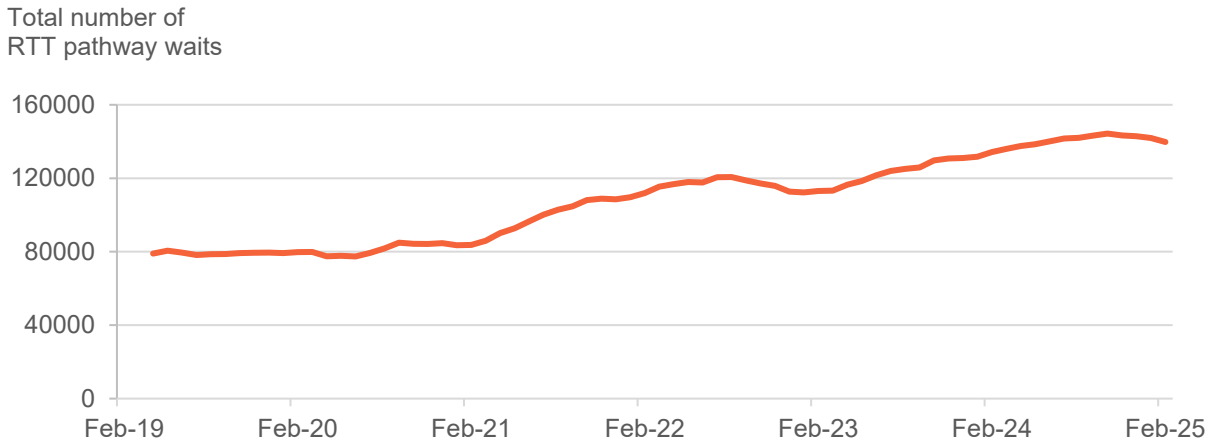
38 We found that **Health Board performance against national planned care recovery targets has worsened over the past year, with waits considerably higher than pre-pandemic levels.**

The scale of the waiting list

39 Across Wales, the scale and extent of waits substantially increased following the COVID-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list. We have also considered both the volume of waits for diagnostics and therapy services and trends in referral rates. We found that that **Health Board's waiting list is around 80% larger than it was at the start of the pandemic, and this presents a considerable challenge both now and in future.**

40 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019. This shows an increase in the size of the waiting list from 79,449 treatment pathways in November 2019 to 139,786 in February 2025.

Exhibit 8: Waiting list size by area of residence, Cardiff and Vale University Health Board

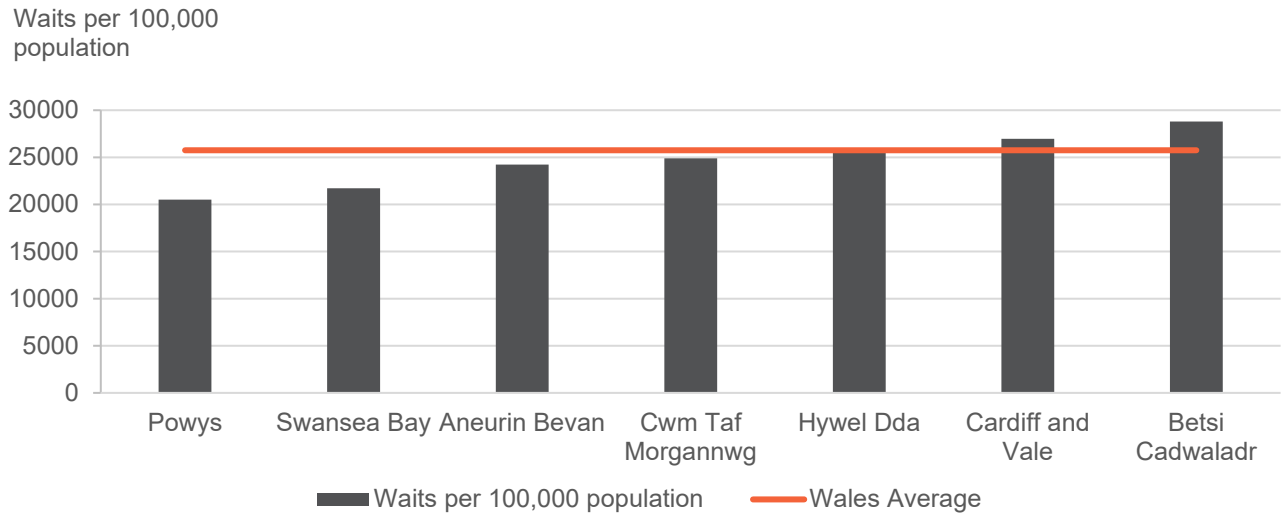


Source: Welsh Government, Stats Wales

[9] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow-up appointment or therapeutic intervention and treatment.

41 **Exhibit 9** provides a comparative picture of the volume of waits across Wales and shows that the Health Board has comparatively more waits per 100,000 population than most other health boards in Wales[10].

Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025



Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

Performance against national targets/priorities

42 We looked at the progress that the Health Board is making against the Welsh Government's aims[11]. These are:

- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[12]);
- eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**[6]);
- increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024; and
- eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

[10] Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people.

[11] We have not included the Welsh Government performance on cancer services as this is outside the scope of this review.

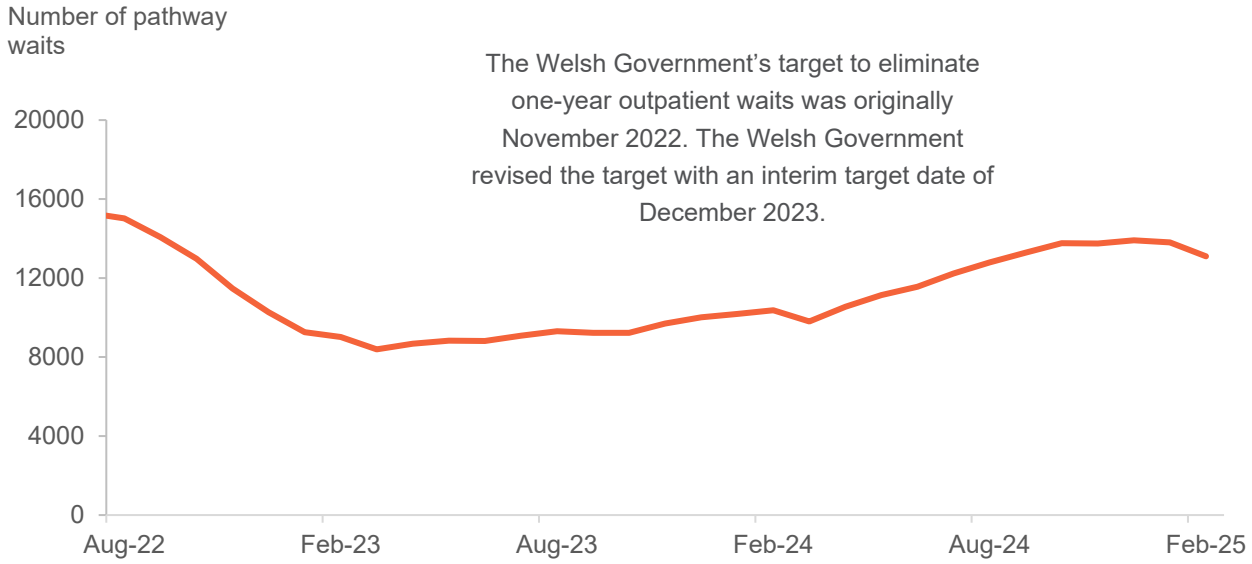
[12] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

43 We found that **while the Health Board made reasonably good progress initially, it did not meet the Welsh Government's waiting list reduction targets. Following a long period where waits deteriorated, performance recently started to improve.**

No one waiting longer than a year for their first outpatient appointment

44 **Exhibit 10** shows the Health Board's waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no one waited more than a year for their new outpatient appointments.

Exhibit 10: the number of first (new) outpatient appointment waits that are over a year since referral, by area of residence, Cardiff and Vale University Health Board

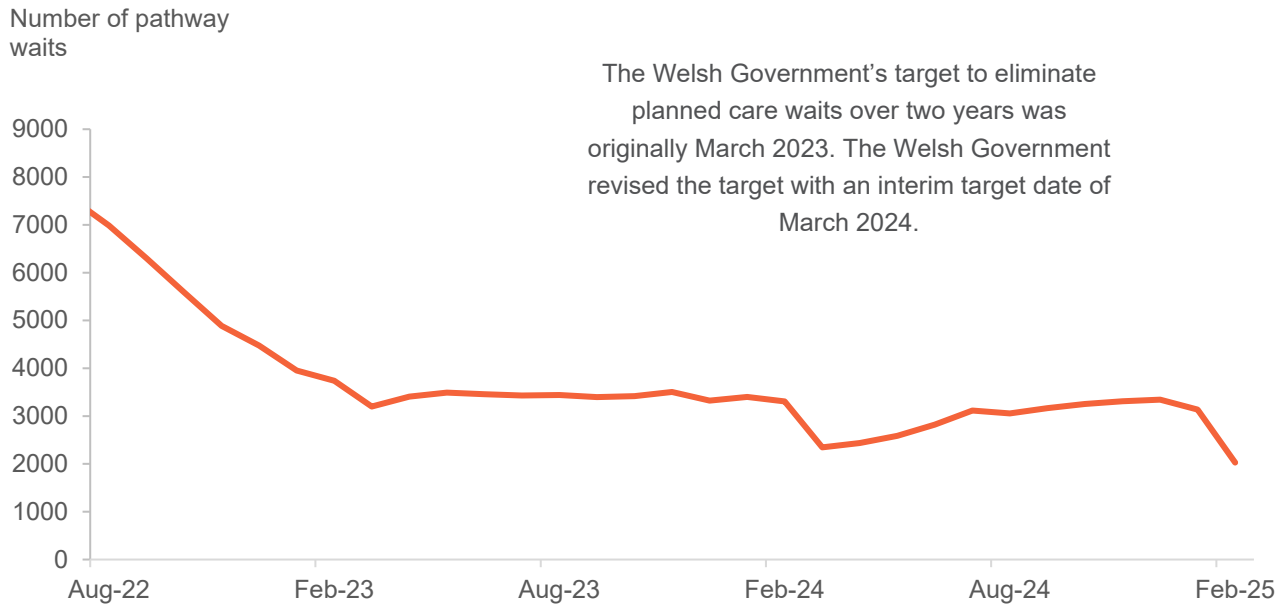


Source: Welsh Government, Stats Wales

Eliminate the number of pathways longer than two years in most specialties by March 2023

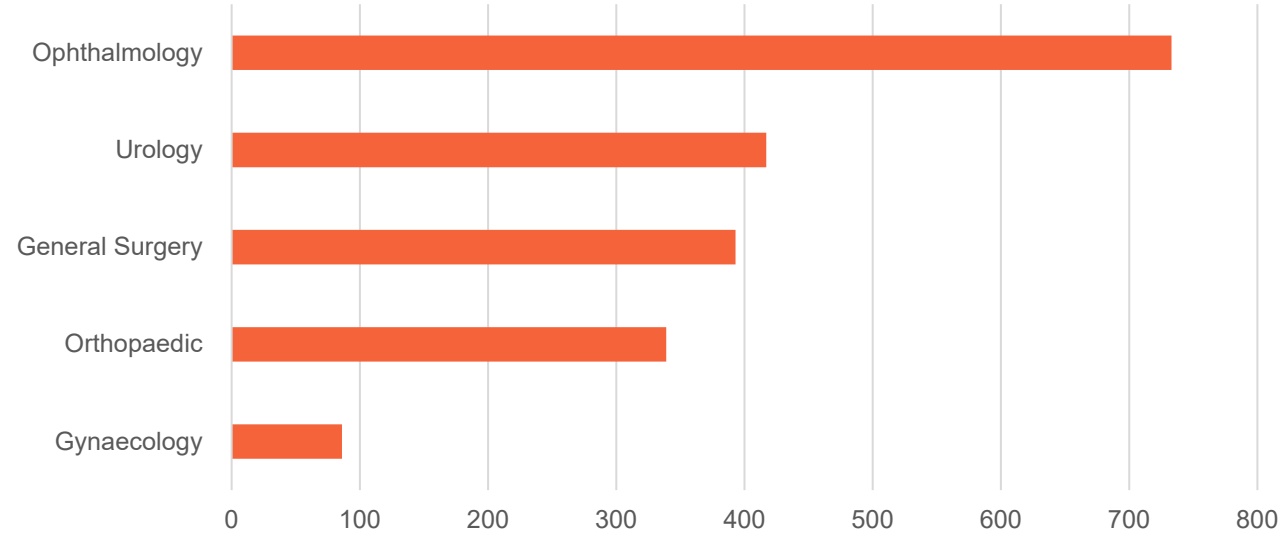
45 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over two years by March 2024. The Health Board has improved since December 2024, although there remained around 2,000 waits over two years as of February 2025. Of those long waits, **Exhibit 12** shows that ophthalmology and urology services are clear specialties of concern. Long waits in other specialties may also present an elevated risk of harm resulting from treatment delays.

Exhibit 11: the number of planned care waits over two years, Cardiff and Vale University Health Board



Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over two years by specialty as of February 2025, Cardiff and Vale University Health Board

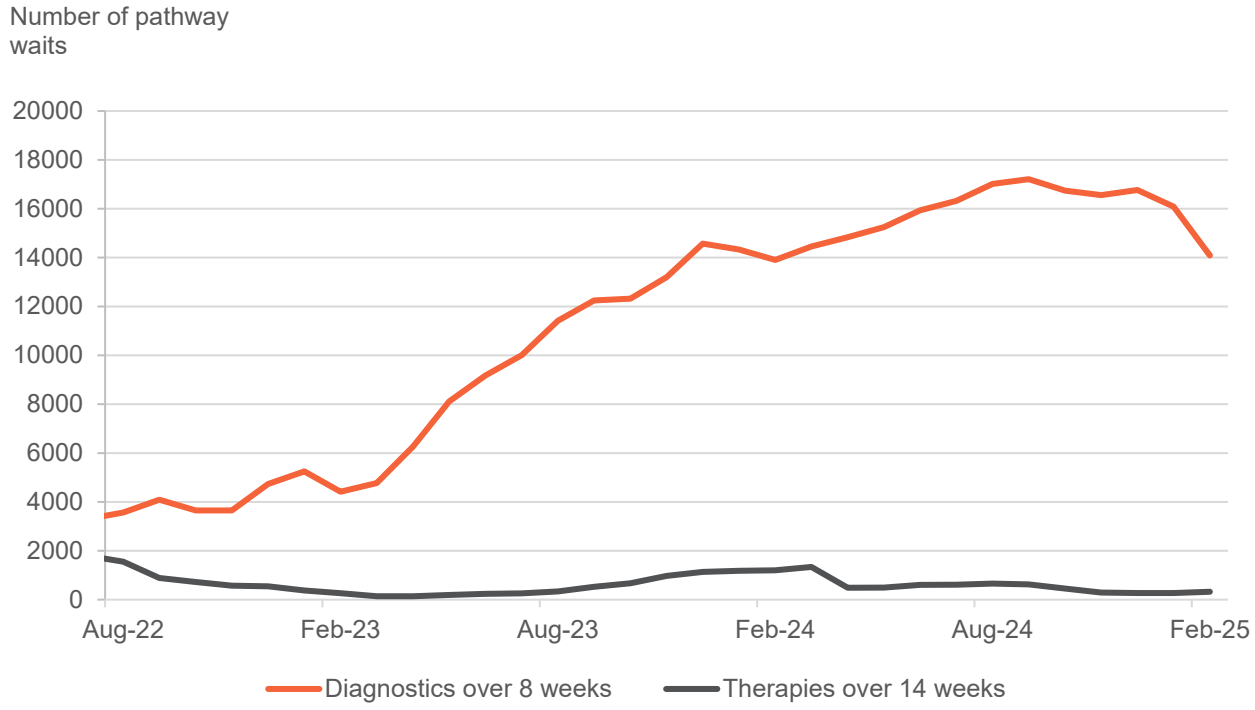


Source: Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

46 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. While the Health Board is broadly meeting its targets for therapy waits, it is failing to meet its target for its diagnostic services and performance deteriorated significantly during 2023 and much of 2024 (**Exhibit 13**). The last five months' performance shows promising signs of improvement. However, there remain particular challenges in diagnostic endoscopy and radiology because of the volume and proportion of long waits in those areas.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (diagnostic waits is an eight-week target, therapies waits is a 14-week target), Cardiff and Vale University Health Board

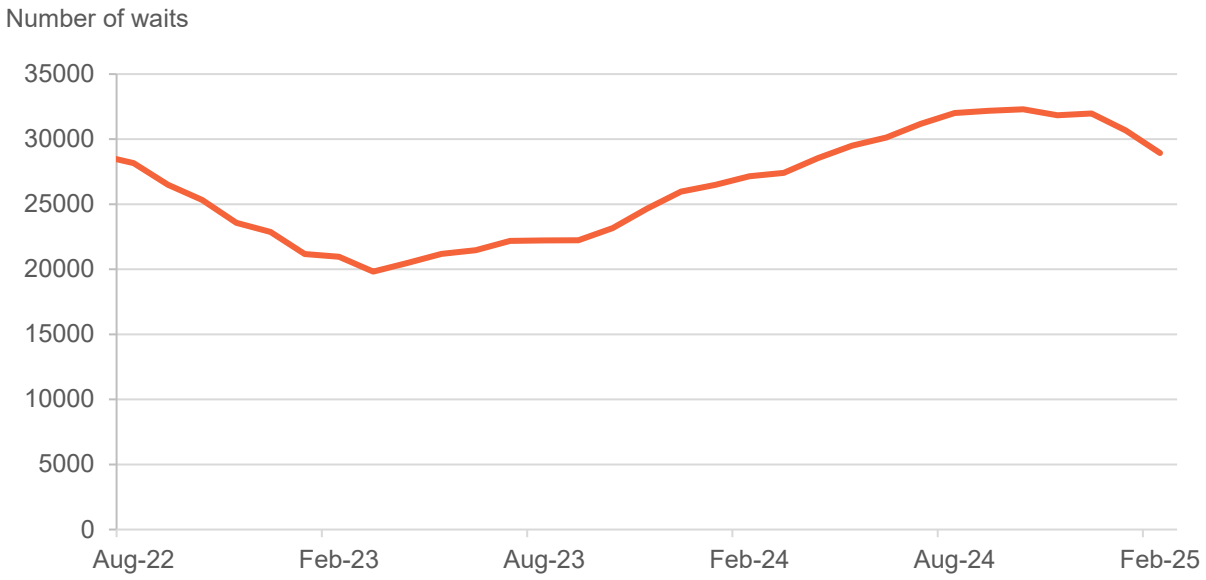


Source: Welsh Government, Stats Wales

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

47 The Welsh Government's longer-term ambition was to eliminate waits over one year in most specialties by the spring of 2025. **Exhibit 14** shows some improvement at the end of 2022 and early 2023. However, performance has since deteriorated. There are currently ten specialties where there are over 1,000 patients waiting a year or more. Ophthalmology has nearly 6,000 patients waiting over a year, but there are substantial pressures in general surgery, orthopaedics, gastroenterology, and urology.

Exhibit 14: the number of pathway waits that are over a year, Cardiff and Vale University Health Board



Source: Welsh Government, Stats Wales

Barriers to further improvement

48 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

49 We found that **there are significant barriers inhibiting the scale of planned care improvements required to materially reduce the Health Board's waiting list.**

50 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is increasing demand for services. Long-term referral demand is increasing (**Exhibit 16,** page 39) and at the same time, our analysis of the levels of medical and surgical admissions indicates that service activity is not consistently meeting 2019 levels (**Exhibit 17,** page 39). If the Health Board continues to increase its service activity, this may allow it to balance growing demand and supply, but it needs to ensure that its approach is financially sustainable.
- **Financial pressures** – The Health Board is experiencing financial pressures and is currently in Level 4 Targeted Intervention for finance, strategy and planning under the Welsh Government's NHS Wales Oversight and Escalation Framework. This may mean that it cannot increase planned care spending to the levels that would be needed to significantly reduce long waits.
- **Competing services pressures** – The Health Board is not only in a position where it needs to balance its investment in planned care with its overall financial position, but it is also facing competing priorities because of pressure in Unscheduled Care and Cancer service demand.
- **Workforce capacity** – The Health Board has identified that staffing issues are presenting operational challenges. This includes recruitment to key roles in operating theatres, which has resulted in difficulties optimising theatre capacity.
- **Capacity to support transformation** – The Health Board has deliberately focussed on addressing immediate demand and reducing waiting lists in the short term. This, alongside wider resourcing and capacity challenges, is limiting opportunities for more long-term transformation work and the ultimate need to implement sustainable modernised services. While it is supporting operational service improvements, there needs to be a far stronger focus on modelling of future service demand and designing service models and pathways to meet that demand.

51 The Health Board is struggling to respond to these challenges. There is clear recognition that it needs a better plan to help create financially sustainable services to help manage growth in demand. But its focus is on the short term and despite its actions, it is not making in-roads into its long waits. The Health Board recognises that it needs to do more to focus on prevention, wellbeing and develop community-based services to help manage appropriate demand out of an acute setting, but progress is slow.

52 As identified in **Exhibit 6**, it is progressing with development of its planned care improvement structures including reintroducing the theatres group and already established outpatient improvement group which is driving increased adoption of 'patient initiated follow-up'

pathways[13]. However, the Health Board will need to review and monitor progress to ensure positive results and value for money. In addition, more work needs to be done to ensure that transformation requirements are embedded in the Health Board's long-term plans for improvement, with appropriate resources in place to drive the changes needed.

[13] Patient Initiated Follow Ups - a healthcare approach where a patient actively contacts their healthcare provider to schedule a follow-up appointment based on their current symptoms or concerns.

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Public Board papers • Finance and performance committee papers • Quality committee papers • GIRFT reviews • GIRFT Action plans/monitoring • Internal Audit report on job planning (Surgical) • Job planning paper (January 2025) • Targeted Intervention Updates • Theatre productivity reports • Winter plan • 3Ps rollout plan • Board Assurance Framework • Corporate Risk Register • Clinical Board risk register • Cardiff and Vales Health Board Strategy to 2035 • Annual Plan 2024-25 including appendix A4 • Ophthalmology briefing note • Ophthalmology 104-week regional submission to the Welsh Government • Ophthalmology harm review template and reporting to committee • Cardiff and Vales Welsh Government Accountability requirements • Cardiff and Vale additional in-year funding letter • Board development papers for 2025-26 IMTP/Annual Plan • Surgery Clinical Board Review October 2024 • Rehab programme • Endoscopy recovery papers • Endoscopy surveillance process • Perioperative Theatre Workforce Deep Dive

Element of audit methods	Description
	• Action logs from COO performance meeting, Planned Care Board meeting and Outpatient Delivery meeting • Treat-in-turn dashboard • Planned care programme structure refresh
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Executive Director of Allied Health Professionals, Health Scientists and Community Services Development • Director of Planned Care • Chief Operating Officer • Finance Lead/Business Partner for Planned Care (Assistant Director of Finance) • Managing director for University Hospital, Llandough • Executive Nurse Director
Observations	We observed the Chief Operating Officer Performance Meeting.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: • made progress reducing the overall number of referral to treatment waits for planned care services; and • met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: • a clear, realistic and funded plan in place for planned care recovery in the short and longer term; and • a programme structure that appropriately supports the delivery of the plan.

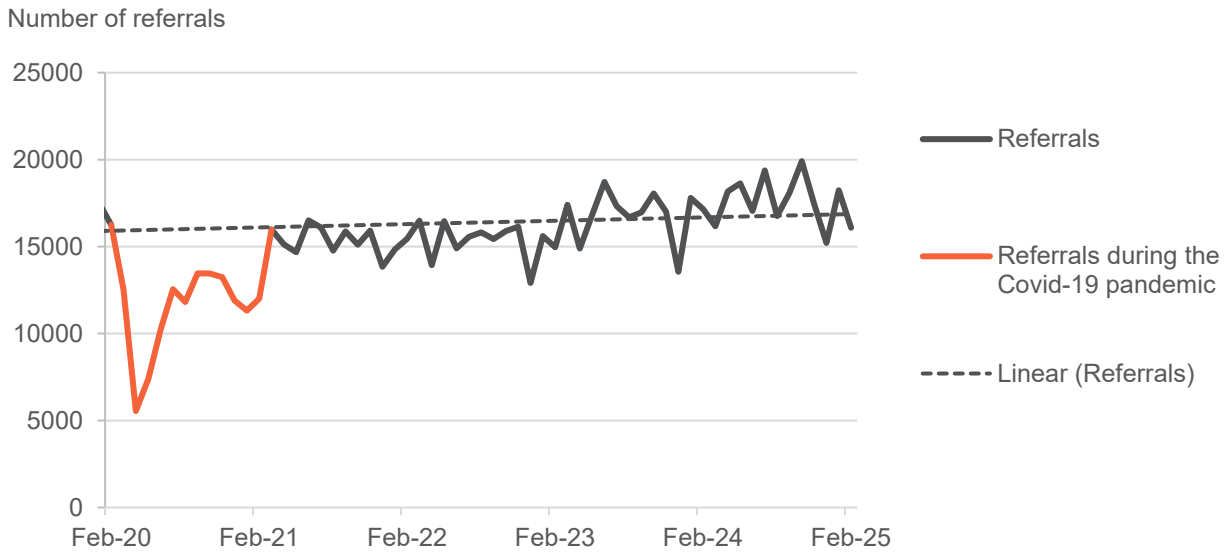
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies have been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (ie addressing waits and transforming services). • The Health Board can clearly demonstrate that the spending has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; and • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment and retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short-term and sustainable service models in the longer term; and • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

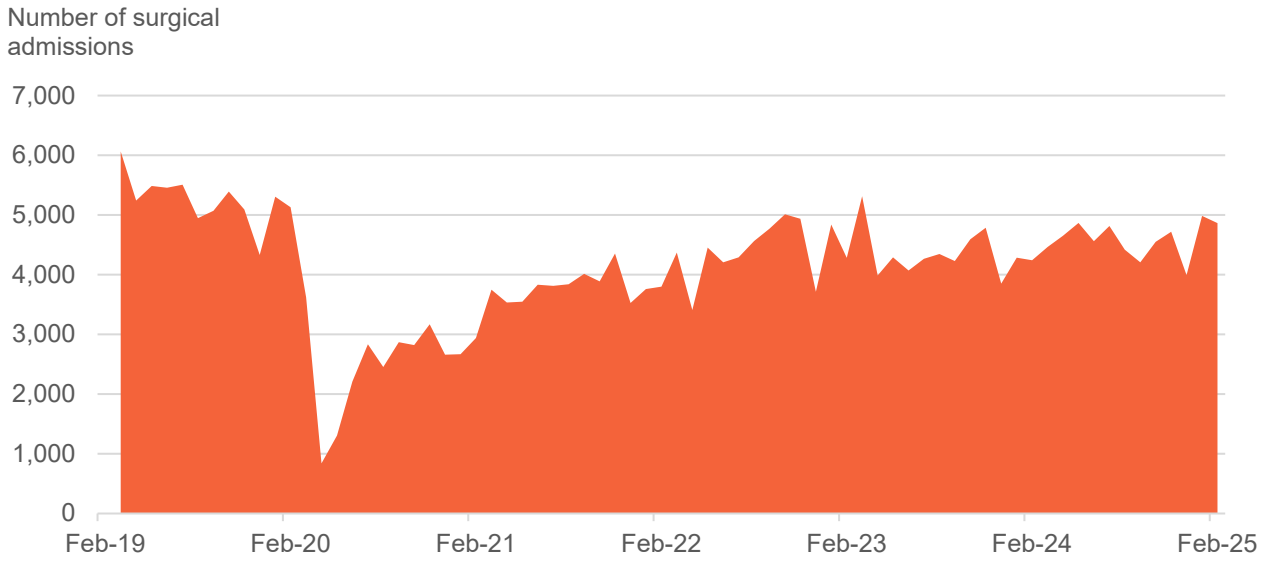
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Cardiff and Vale University Health Board



Source: Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels, Cardiff and Vale University Health Board

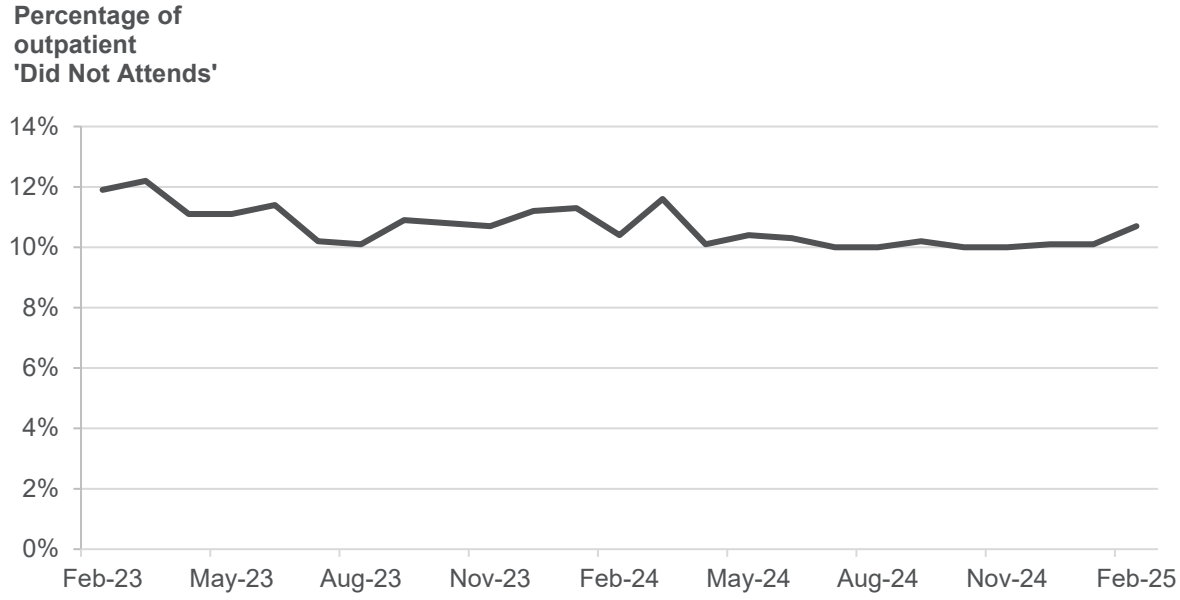


Source: Digital Health and Care Wales secondary care dashboard

Outpatient services

53 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' is around 10.5% of total outpatient clinic activity. This equates to around 60,450 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £9.1 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save approximately £1.81 million.

Exhibit 18: the number and percentage of outpatient 'Did Not Attends', Cardiff and Vale University Health Board

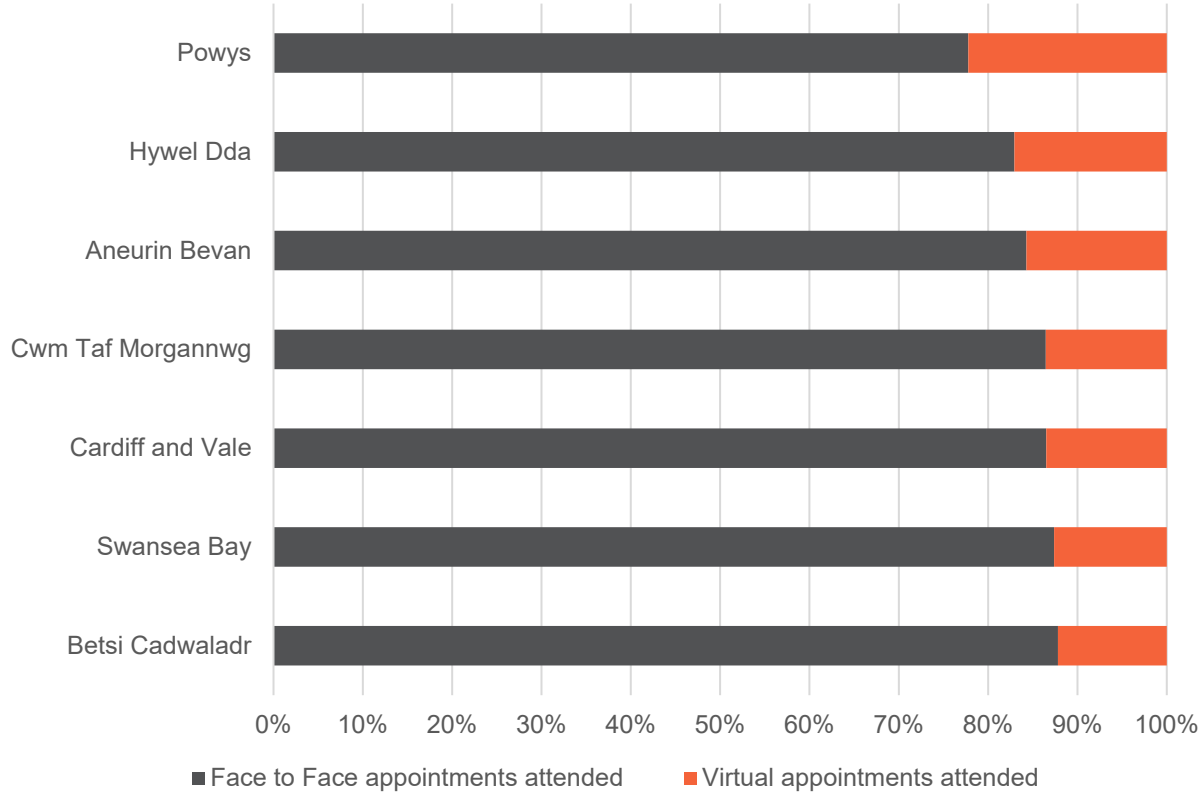


Source: Digital Health and Care Wales secondary care dashboard and datasets

[14] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

55 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well adopted in most health boards.

Exhibit 19: proportion of outpatient attendances that are virtual appointments, from April 2024 to February 2025

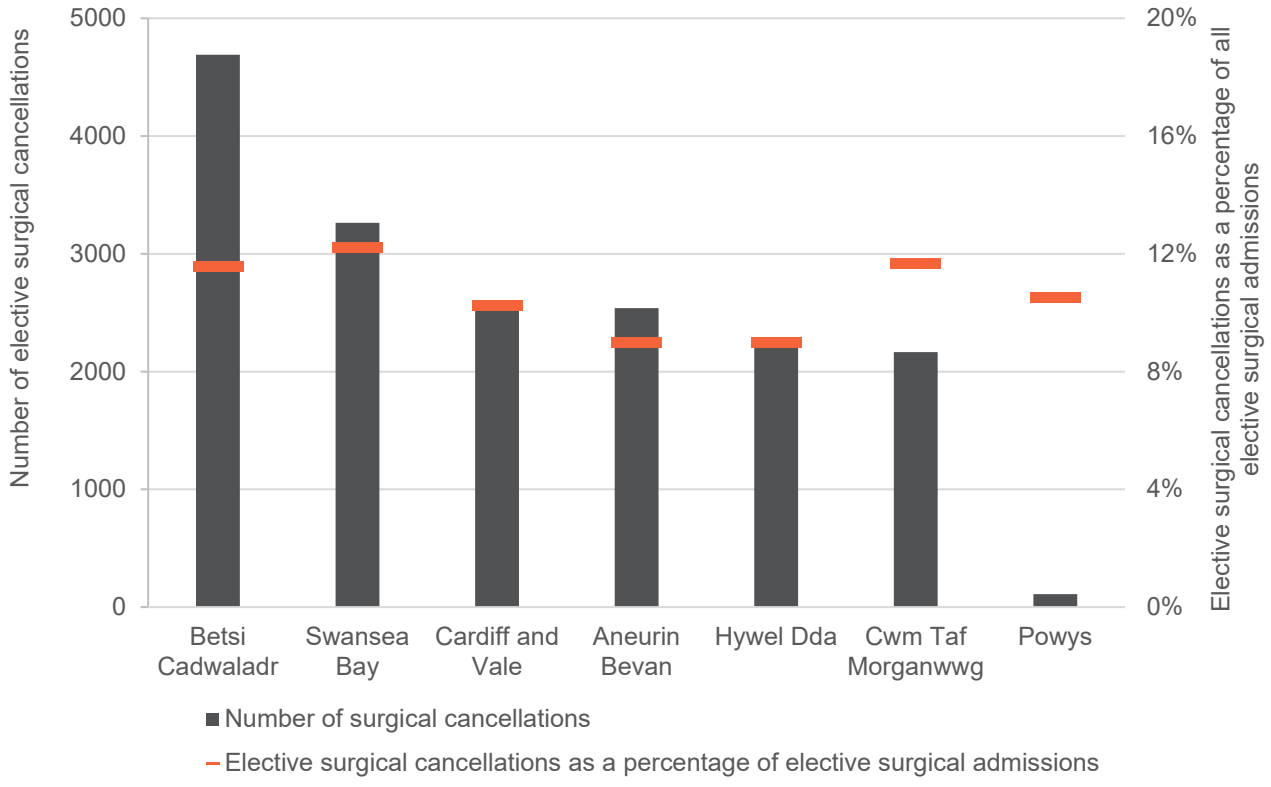


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

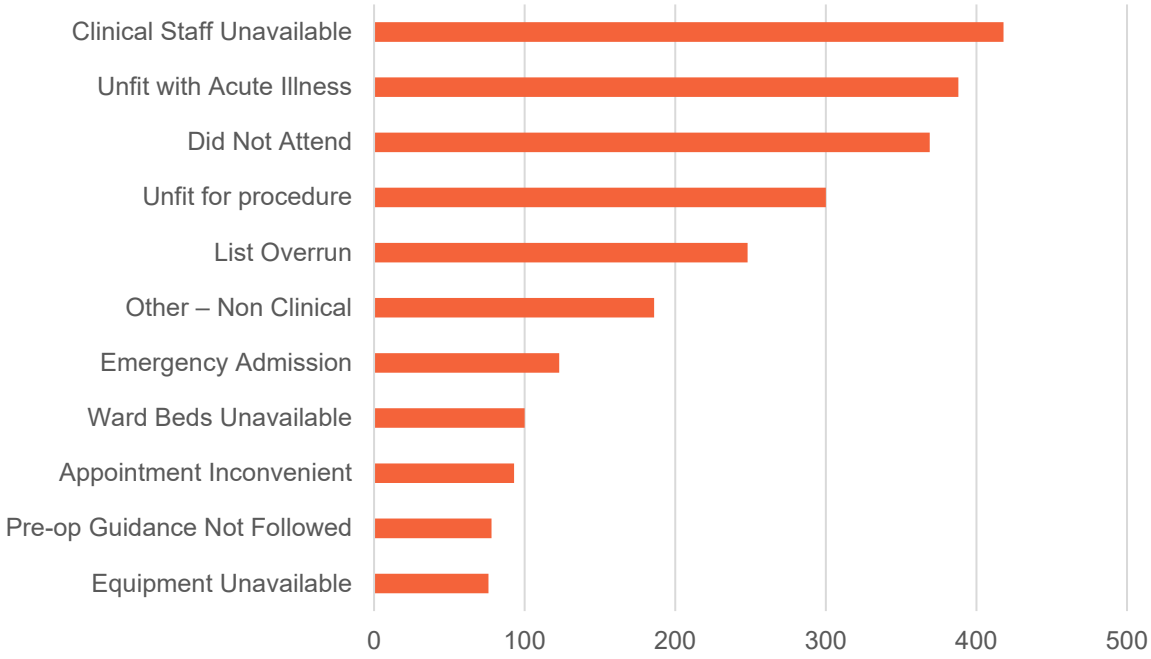
56 Short-notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board exceeded 2,500 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short-notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Cardiff and Vale University Health Board



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Day case surgery

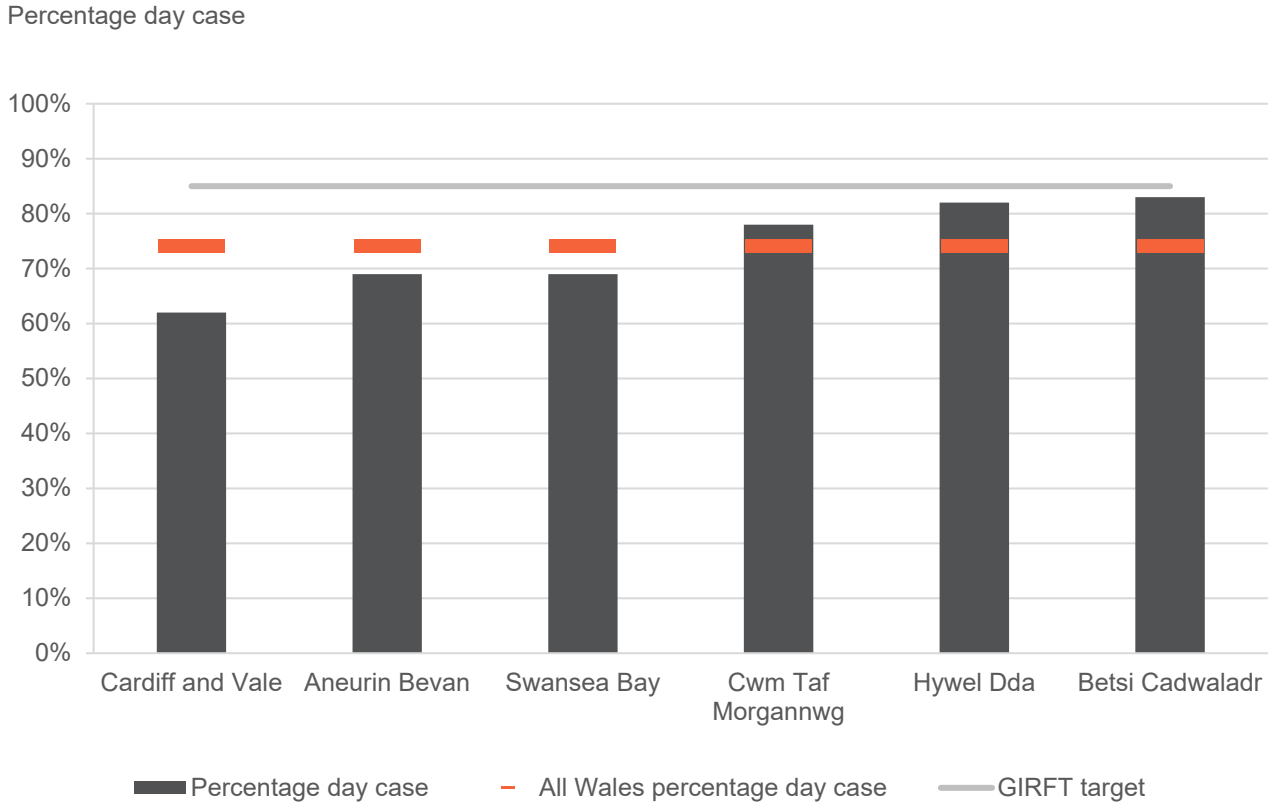
57 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient[15] and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective[16] surgery should be day case[17]. Our analysis in **Exhibit 22** indicates that 62% of the Health Board's elective surgery is day case.

[15] Paper outlines GIRFT's 'unique position' in supporting the NHS drive for net zero carbon emissions – Getting It Right First Time – GIRFT

[16] Elective surgery is the type of surgery associated with a planned care patient pathway.

[17] Getting it Right First Time – Elective Recovery High Volume Low Complexity guidance for health systems

Exhibit 22: proportion of elective surgery undertaken by Health Boards as day cases for the period April 2024 to February 2025



Source: Digital Health and Care Wales secondary care dashboard and datasets

Appendix 4

The management response to audit recommendations

Exhibit 23 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Planning R1 The Health Board should: 1.1 develop an up-to-date planned care improvement plan and road map that articulates the design and delivery of sustainable specialty services in the medium to longer term. (**Exhibit 2**) 1.2 set out its projected costings against forecast demand over a three-to-five-year term with realistic and challenging milestones based on reasonable planning assumptions. (**Exhibit 2**)	1.1 The Health Board has recently published a 10 year Clinical Services Strategy for Babies, Children and Young People Plan 2025. It is the aim of the Health Board to publish a similar long-term plan for planned care and unscheduled and emergency care. The Health Board recently refreshed its overall strategy, Shaping Our Future Wellbeing, which outlines our vision and strategic objectives for 2023-2035. Alongside that, work is underway to articulate the Health Board's Clinical Services Plan, of which the medium to long term for planned care is an integral part. It must be recognised, however, that the ever-evolving political context creates a dynamic planning environment with numerous short-term plans regarding buy out of the backlogs etc, that make a backstop position on demand and capacity challenging to create for the longer term.	March 2026	Managing Director for Planned Care

Recommendation	Management response	Completion date	Responsible officer
	1.2 The Health Board has submitted an Annual Plan for 2025-26 as per the requirements specified by the Welsh Government. Ministerial priorities are set on an annual basis as is the UHB allocation process. At present, we do not have the capacity or capability to work on a window any further ahead than this. Although having a line of sight to the Capital and Revenue requirements to deliver a sustainable planned care offer is something which we aspire to and is likely to be reinvigorated over coming months through our clinical Services Planning process.	March 2027	Director of Operational Performance and Planning

Recommendation	Management response	Completion date	Responsible officer
Demand and capacity modelling R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across its specialties to inform short-term service capacity planning and longer-term service design. This should also consider changes in population demand for planned care services. (**Exhibit 2**)	The Health Board has one centrally led team that undertakes demand and capacity modelling across all acute specialties. This is iterated quarterly and is the most mature demand and capacity process the organisation has instituted to date. Known changes in demand due to, for example, changes to screening programmes, are built into modelling, as well as seasonal changes. Whilst there is a robust demand and capacity process in place for RTT reportable specialties and the longest-waiting patients, this approach has been driven by operational pragmatism, in concentrating on RTT first due to significant capacity constraints within the team to date precluding the ability to take a broader approach. The ambition to broaden this to all planned care specialties, and to triangulate workforce, core activity demand and finance is live, and a process is currently being designed to build this into the 2026-27 planning cycle.	March 2027	Director of Operational Performance and Planning
Programme support for service transformation R3 The Health Board should build the required programme capacity and capability to support planned care specialties transformation. (**Exhibit 3**)	The Health Board's programme, transformational and service improvement resource is held in several areas, ranging from technical digital and capital programme management to operational capacity within acute services and the partnership space. The current focus of programmes and improvements in the planned care	Complete	Director of Operational Performance and Planning

Recommendation	Management response	Completion date	Responsible officer
	portfolio includes resource from the operational and improvement teams. The capacity of the planned care team specifically has increased due to the realigning of resource from within the Health Board and is being utilised to support the extensive data analysis and contract management required.		
Risk management R4 The Health Board should develop a planned care risk register that fully assesses and mitigates the key risks that inhibit short term improvement and longer-term service transformation. (**Exhibit 3**)	The delivery and accountability for delivery of the component parts of Planned Care sit within Clinical Boards and their Governance Structures. The Planned Care team need to ensure that Planned Care risks are referenced on Clinical Board risk registers.	March 2026	Managing Director for Planned Care

Recommendation	Management response	Completion date	Responsible officer
Monitoring the progress of planned care programme delivery R5 The Health Board should introduce quarterly committee reports to provide updates and assurance on the progress of planned care programme delivery milestones. This report should also describe where progress is off track, and key risks that inhibit short-term improvement and longer-term service transformation (as described in Recommendation 4). (**Exhibit 3**)	The planned Care Programme Delivery Measures for 2025-26 focus on delivery of Ministerial Priorities, Ministerial Enabling Actions for Planned Care and MAG recommendations. All of which are reported to both Senior Leadership Team and Board on a Quarterly basis.	Complete	Managing Director for Planned Care
Monitoring impact of additional funding R6 The Heath Board should strengthen its reporting to Board on the direct impact of the additional Welsh Government planned care funding. (**Paragraph 25**)	This is reported up to Planned Care Portfolio Board with a quarterly update to the Health Board's Senior Leadership Board, and onwards to Board. Specific reference to the additional Welsh Government funding will be made at the end of Q2 reporting period.	September 2026	Managing Director for Planned Care
Efficiency and productivity R7 The Health Board should: 7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT)	7.1 GiRFT recommendations, recommendations from the MAG report and NHS Executive's Enabling Actions for Planned Care are essentially the same framework of productivity, efficiency and grip and control of operational processes in acute services. This suite of measures now forms the basis of how the Health	March 2026	Director of Operational Performance and Planning

Recommendation	Management response	Completion date	Responsible officer
reviews and accelerate progress in ophthalmology and general surgery services. **(Exhibit 6)** 7.2 Develop and implement a plan to address high outpatient 'Did not attends'. **(Exhibit 6)** 7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. **(Exhibit 6)** 7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. **(Exhibit 6)** 7.5 Increase Day Surgery rates to the GIRFT level of 85%. **(Exhibit 6)** 7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90% of consultants have job plans. **(Exhibit 6)**	Board monitors progress and holds operational leaders to account. The Ophthalmology and General Surgery Directorates recently submitted a Maturity Matrix to their relevant national Clinical Implementation Group and scored approximately 45% maturity against the identified measures, meaning that there is evidence of maturity in some areas, although there remains considerable work to do. 7.2 Through the Outpatient Implementation Group, there is a plan to address high DNAs. This includes improving processes to address data quality and setting clear productivity guidance for the outcoming and 'cashing up' of clinics. NHS Executive have issued a directive for all high DNA clinics to be routinely overbooked, work on which has commenced in Orthopaedics and Ophthalmology. 7.3 Short notice cancellations are reported daily to Executive level of the Health Board and the organisation's weekly 6-4-2 theatre booking and confirmation cycle seeks to address all aspects of theatre utilisation. The organisation does not yet have one single plan to address the full range of short	September 2025 March 2026	Managing Director for Planned Care Director of Operations for Perioperative Care

Recommendation	Management response	Completion date	Responsible officer
	notice cancellations. These reasons are many and range from equipment failure, unplanned staff availability and short-term sickness of patients. There are many preventable aspects of these reasons, and the expectation is that a Theatre Improvement Programme, as directed in the MAG review, and following an internal review, will focus on this.		
	7.4 See 7.3 Above	March 2026	Director of Operations for Perioperative Care
	7.5 Currently at 69%. The organisation has a ready-made solution to increasing day surgery rates in the form of the Surgical Hub @Llandough. Workforce is currently the rate limiting factor to achieving 85% current indications suggest this wil.l be resolved by September	September 2025	Director of Operations for Perioperative Care
	7.6 Plans are in place to aim for 90% compliance by September 2025, although there is risk attached to this. A team-based approach to job planning is encouraged and is applied in the majority of specialties across the Health Board.	September 2025	Assistant Medical Director (Workforce)/Individual Clinical Board Directors

Recommendation	Management response	Completion date	Responsible officer
Promote, Prevent and Prepare for Planned Care Policy R8 The Health Board should complete its implementation of the single point of contact for people to access information and support following referral to specialist secondary care. (**Exhibit 7**)	The Health Board's single point of contact service is the Waiting Well Support Service. As issued to the Welsh Government in its Delivery Plan, new specialties and pathways are being brought into scope for the team in stages, with two additional specialties being added this month. As the Health Board does not have a unified patient administration system, the onboarding of specialties requires processes for lists of patients to contacted to be agreed and time built in for these to be uploaded and available digitally. This can be achieved and the team are happy to broaden their scope, and are focussing on the pathways and specialties in order of relevance, need and benefits to be realised. Executive Director of Therapies, Health Sciences and Community Development. The service is funded by the Welsh Government until 31 March 2026, meaning that a sustainability plan for ongoing support of this team is required by Q4 of this financial year.	March 2026	Executive Director of Therapies, Health Sciences and Community Development
Managing clinical risks associated with long waits	9.1 The expansion of the Waiting Well Support Service could address this. Text invitations to contact the WWSS include a shortened HSQ which is triaged by	March 2026	Assistant Director of Quality and Patient Safety

Recommendation	Management response	Completion date	Responsible officer
R9 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks and with long waits by: 9.1 developing and implementing a more consistent approach for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7)**; and 9.2 developing a routine report to be presented at the Quality Committee that reports risks and actual incidences of harm resulting from delays in access to treatment across all clinical specialty areas of concern **(Exhibit 7)**.	the team and directs how the patient is contacted, by whom and what information is provided. The Health Board's new outpatient Validation programme, mandated by the Welsh Government, includes invitation to complete a PROM. The scope of this validation is limited to first appointments only. 9.2 This requirement is being reviewed by the Assistant Director of Quality and Patient Safety which will include consideration of the following: • a review at pre-determined points during the patient pathway; • developing a way of cross-referencing long waiters with Datix recorded incidents; • reviews of expedited referrals; and • reviews of validated upgrading of urgency.	March 2026	Assistant Director of Quality and Patient Safety

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