Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Betsi Cadwaladr University Health Board

Date issued: May 2025

Document reference: 4664A2025

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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 Betsi Cadwaladr 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. 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 October 2024 and February 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 is currently at Level 5 escalation under the NHS Wales escalation and oversight framework and it continues to rely on significant additional non-recurrent strategic funding allocation. Its financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

Key facts

£114.5m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

199,249 the overall size of the waiting list at February 2025.

103% the percentage growth in the overall waiting list between April 2019 and February 2025.

29,553 the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has increased by 22%, since April 2022.

8,304 the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 53% since April 2022.

62% the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The number of ‘over 8 weeks’ diagnostic waits has increased by 23% since April 2022.

89% 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 73% reduction of ‘over 14 weeks’ therapy waits since April 2022.

54,096 number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has increased by 30% since April 2022.

Key messages

Overall conclusion

8 Overall, we found that **there are significant numbers of long patient waits indicating that the action the Health Board is taking to address this is not having the necessary overall effect. It needs to improve service efficiency, develop sustainable planned care improvements to meet growing demand, and strengthen reporting of harm that occurs as a result of a delay.**

Key findings

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

- Whilst the Health Board has set out plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to secure more sustainable improvements to planned care services.
- Despite a clear structure, the Health Board's Planned Care Program Board lacks delegated decision-making authority to set direction and allocate resources. It needs to strengthen how it uses business cases to drive improvement initiatives and link these cases effectively to an agreed planned care improvement programme. Lack of continuity of senior planned care leadership has been detrimental to improvement.
- The Health Board has received a total of £114.5 million in additional Welsh Government funding. However, this has been allocated primarily towards short-term reactive solutions without investment in longer term service transformation.
- Whilst the Health Board has begun to implement the Getting It Right First Time (GIRFT[4]) recommendations, there remain opportunities to improve efficiencies, particularly in relation to improving utilisation of theatres and outpatient services to improve efficiency and productivity.
- The Health Board is making effective use of day surgery, with 83% of elective surgery performed as day case, the highest in Wales.
- The Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy fully. Reporting on the incidence of harm associated with planned care waits needs to be improved.

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

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

- In overall terms, the continued growing backlog of people waiting to be treated presents a substantial problem for the Health Board. The size of the waiting list has increased from 98,190 in April 2019 to 199,249 treatment pathways in February 2025.
- The Health Board has not met the recent national planned care recovery targets:
  - The number waiting over a year for their first outpatient appointment has increased from 24,265 patient pathways in April 2022 to 29,553 in February 2025.
  - The number waiting over 2 years for treatment has reduced from 17,500 patient pathways in April 2022 to 8,304 on February 2025.
  - The Health Board did not meet the target of increasing the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. In February 2025, there remained 10,067 patients waiting over 8 weeks for diagnostics and 1,565 patients waiting for therapies over 14 weeks.

Barriers to improvement

- There are a number of barriers to further planned care improvement. These include growing service demand, capacity to support service transformation and absence of clinical leadership. The Health Board recognises these challenges but has not yet developed an overarching strategy to address these. Initiatives which aim to address immediate capacity challenges are relatively new and short term in nature. Further work is required to develop sustainable and transformative solutions to ensure the Health Board does not continue to face the same or greater challenges in future.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**.

Exhibit 1: recommendations

Recommendations
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. **(Exhibit 2)**
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).** 3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).** 3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**

Recommendations

Programme Board clinical leadership

R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:

- 4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**
- 4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**

Risk management

R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months **(Exhibit 3).**

Monitoring impact of additional funding

R6 The Health Board should strengthen its monitoring of the use and impact of the additional Welsh Government planned care funding **(Paragraph 24).**

Recommendations

Efficiency and productivity

R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:

- 7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**
- 7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**
- 7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand and address the root cause of surgical cancellations **(Exhibit 6).**
- 7.4 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**
- 7.5 Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**
- 7.6 Develop job planning policy and guidance **(Exhibit 6).**
- 7.7 Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align consultant capacity to meet service demand **(Exhibit 6).**
- 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**

Promote, Prevent and Prepare for Planned Care policy

R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7)**.

Recommendations

Risk of harm

R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:

- 9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**
- 9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**
- 9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**

Detailed report

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

10 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.

11 We found that **the Health Board's Annual Delivery Plan describes actions for planned care, however these are short-term in nature and lack detail on how successful delivery will be measured. The absence of a dedicated and costed, longer-term plan for planned care recovery means the Health Board has not determined the action needed to deliver more sustainable improvements to planned care services**.

Planned care improvement plans and the programme to deliver them

12 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

13 We found that **the Health Board has appropriately set out its short-term planned care improvement initiatives in its 2025-28 Integrated Medium-Term Plan. However, there is a notable absence of a dedicated short and longer-term plan that supports waiting list recovery and the development of efficient and sustainable planned care services. This is likely to affect the pace of improvement.**

14 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?	**No**	The Health Board's Annual Plan 2024-25 sets out the priorities for planned care. However, this is overly short-term focussed and lacks the necessary detail on longer-term sustainable planned care services. The Health Board has included planned care improvement requirements for 2025 onwards in its 2025-2028 three-year plan. This sets out six planned care workstreams that focus on short-term improvements and some limited pathway improvements. This includes workstreams on referral management, waiting list management, and outpatient, pre-operative and theatre efficiencies, and development of specialty level improvement plans. At present however, there is no stand-alone planned care recovery plan aligned to a clinical strategy. As a result, there is insufficient planning detail to address growing demand and reshaping services so that they are financially affordable **(Recommendation 1).**
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Annual Plan 2024-25 provides a financial plan for the organisation and sets out the Health Board's over-arching financial position. However, there is no costed planned care plan or route-map to financially sustainable services. This creates a lack of transparency on the affordability of current planned care service delivery **(Recommendation 1).** In the absence of a costed planned care improvement plan, the Health Board relies on short-term business cases which are of varying quality and additional Welsh Government funding.
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Annual Plan 2024-25 and the more recently developed 2025-2028 three year plan are both 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 developed improvement trajectories and system indicators aligned to Welsh Government escalation requirements. The improvement trajectories focus on eliminating the number of patients waiting more than 104 weeks. While the Health Board has made ongoing progress by increasing capacity, it is unlikely to meet this target. The Health Board's targets for addressing the growing number of patients waiting more one year are not credible based on growing demand and deteriorating performance.
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**Partially**	The Health Board's approach to capacity and demand modelling has focused on improving the quality of waiting list data to assess current and future demand. This analysis has been undertaken by the data performance and planning workstream but has not been rolled out across the organisation and all specialties. Further work is needed to understand core capacity and plan for additional capacity to meet immediate and longer-term requirements. **(Recommendation 2)**
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**No**	The Health Board has not set out how it will transform its clinical service models to make them more sustainable in the future. As outlined in its 2025-28 three-year plan, the Health Board intends to develop clinical services in line with its 10-year strategy and clinical services plan. This work will be commencing in 2026.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates?	**Partially**	The 2025-28 three-year plan outlines some limited digital, workforce and estates initiatives that will help improve some aspects of planned care service delivery, such as the new orthopaedic facility in Llandudno. However, the plan does not contain the level of detail needed for wider enabling services to support sustainable planned care service development.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

15 We found that **the current planned care programme arrangements are not effective in delivering planned care improvements. The Programme Board lacks authority and direction and there is insufficient clinical leadership and engagement. The absence of a standalone plan for planned care recovery and transformation compounds the issue**.

16 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?	**No**	The Health Board's Planned Care Programme Board has a clear structure. However, over the last year, the arrangements have lacked sufficient delegated decision-making authority to set direction and allocate resources. It is working in an environment where funding decisions can by-pass the Programme Board, with funding directly provided to the Health Board's Integrated Healthcare Communities. Consequently, the Programme Board has served as a discussion forum without being sufficiently able to provide leadership and direction needed to facilitate change **(Recommendation 3.1).** The Programme Board has lacked clarity on its programme of work due to the absence of an agreed overarching plan. Consequently, the draft terms of reference have been developed in isolation, and do not provide clarity of purpose. Members have raised issues regarding unclear reporting structures. There is no forward work programme to provide adequate assurance on overall progress delivery beyond updates from individual work streams. (**Recommendation 3.2).** Over the last year, the Programme Board has presented several business cases to the Executive team for approval. These cases have varied in quality, resulting in some not being approved. As some of these business cases for new initiatives are developed during the year, the lack of approval can delay implementation, impacting the timeliness of improvement. The Health Board needs to both: • strengthen its training approach for the development of planned care business cases (**Recommendation 3.3**); • prepare business cases much earlier in the year, or ideally on an ongoing cycle linked to a multi-year planned care programme (**Recommendation 3.4**).

Audit question	Yes / No / Partially	Comments
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**No**	There has been a lack of continuity of senior leadership for planned care over the last year. This has seen responsibility move from the Integrated Healthcare Community Director (East) to the Executive Medical Director, then to the Executive Director of Finance in summer of 2024 then to the newly appointed Chief Operating Officer. In addition, in March 2025, the Health Board's Assistant Director for planned care left. There is an urgent need to review Planned Care Programme Board leadership arrangements (**Recommendation 4**). The Heath Board appointed a Clinical Director for Planned Care in October 2024, however, there is limited clarity on this role or remit **(Recommendation 4.1).** Our work also suggests that given the longstanding absence of clinical strategy, that there is a real need for substantive speciality level clinical leads. These leads need to build consensus through the development of integrated specialty plans and drive efficient and affordable pathway changes to sustainably meet growing demand (**Recommendation 4.2**).
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Partially**	The planned care workstreams identify and report risks to the Programme Board, through a risk register. Higher rated risks are effectively escalated to the Executive Team to approve actions to address the risks. The Health Board also identifies planned care risks in the corporate risk register. However, the risk rating has not changed in the last twelve months and remains above risk appetite indicating current controls are not effective. The Health Board needs to ensure that the actions it is taking to address risks are effectively evaluated and monitored and appropriately challenge the impact of actions taken **(Recommendation 5).**
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	**Partially**	Planned care performance is reported to the Board and Performance, Finance and Information Governance Committee. However, with the significant increase in demand and the deterioration in performance, oversight and challenge will need to be strengthened. This will ensure better outcomes and allow for a thorough evaluation of the measures implemented to improve performance.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

17 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

18 We found that **since 2022-23 the Health Board has received a total of £114.5 million in additional Welsh Government funding. The Health Board is directing its additional Welsh Government funding towards tackling extremely long waits. There is limited use of the funding to support specialty level service transformation**.

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £114.5 million 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	38.4
2023-24	34.3
2024-25	34.5
Additional in-year Welsh Government allocation	7.3[5]
Total allocated	**114.5**

Source: Health Board financial self-assessment returns

20 The Health Board can appropriately account for the Welsh Government planned care funding it has received. We reviewed the use of the funding in 2023-24 in greater detail (**Exhibit 5)**. During that year, the Health Board predominantly used the funding on short-term initiatives rather than service transformation to enable lasting improvement. It used £18.2 million or 64% of total funding allocation on insourcing and outsourcing activity to increase capacity in the short-term.

[5] In December 2024, Welsh Government allocated a further £7.3 million in non-recurrent funding to reduce some of the longest planned care waits in the Health Board.

21 The Health Board continued to adopt the short-term funding model throughout 2024-25. While this will have contributed to limiting further growth in very long waits, it is not providing the sustainable solution needed.

Exhibit 5: use of the 2023-24 Welsh Government additional financial allocation, Betsi Cadwaladr University Health Board

	Performance improvement funding (£m)	Transformation fund (£m)
Mixed specialty insourcing (general surgery, ENT, urology, minor operations and pre-operative assessment)	1.5	
Dermatology contract extension	0.3	
Orthopaedics outsourcing	2.7	
Ophthalmology outsourcing	2.3	
Radiology recovery plan	4.6	
Endoscopy insourcing	5.9	
Planned care corporate capacity	0.7	
Stage 4 efficiencies	0.6	
Waiting list initiatives	1.6	3.8
Regional treatment centre closure	0.2	
Orthopaedic planned care sessions	0.5	
Validation and booking	0.4	
Insourcing internal support costs	1.2	
Additional activity - primary & secondary care drugs		3.2
Abergele high volume low complexity orthopaedics		0.2
Funding as a commissioner[6]	4.5	
Total allocated	**27.0**	**7.2**

Source: Health Board self-assessment returns

[6] This includes specialised services commissioning of £2.85 million and commissioning £1.6 million of planned care services from NHS England.

Monitoring impact of additional funding

22 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. We found that the **Health Board has reasonable arrangements to oversee the use of the additional Welsh Government planned care financial allocation, we have not seen evidence of monitoring its expected impact**.

23 The Planned Care Programme Board receives a financial report which provides a breakdown of planned spend for individual schemes from the sustainability fund, including any revised forecasts. The report indicates where planned spend is subject to further business case approval.

24 The Health Board also provides reports on proposed allocation of planned care funding at the Performance Finance and Information Governance Committee. While this reporting includes cost estimates, we have not seen any evidence of a more detailed monitoring whether the proposed investments have delivered the expected improvements **(Recommendation 6).**

Operational management of planned care

25 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

26 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 the Health Board is starting to implement the Getting it Right First Time recommendations and while it has been effective in its use of day case surgery, there remains significant opportunity to improve efficiency.**

27 **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	The Health Board have received reviews on general surgery, ophthalmology, orthopaedics, urology, gynaecology and operating theatre reviews. It has made variable progress in responding to GIRFT reviews, however the pace of delivery needs to improve particularly in relation to ophthalmology and orthopaedics. Whilst GIRFT was a specific workstream reporting into the Planned Care Programme Board, this has now ceased. Responsibility for implementing the recommendations is delegated to individual services. Consequently, there is now a loss of central reporting and assurance to the Planned Care Programme Board on progress in implementing GIRFT recommendations (**Recommendation 7.1**).
Arrangements for measuring and managing productivity of services	The Health Board has established an Elective Optimisation Programme. This oversees key performance metrics and a number of projects to review and monitor performance and standardise policies and procedures. Task and finish groups have been established with clear aims and performance measures these include: • Theatre dashboard – to monitor theatre utilisation including late starts and early finishes, high flow lists[7] and surgical cancellations. • Policies and procedures – to review policies, standardise and implement best practice across to the Health Board. • Reviewing all sub-speciality pathways to ensure standardised way of working. • Reviewing demand against current capacity to meet future demand. Our analysis of efficiency data below and in **Appendix 3** indicates there remain significant opportunities for improvement in efficiency.

[7] Delivering High Flow Lists - Getting it Right First Time Guidance for Health Bodies

Opportunity area	Audit findings
Reducing the number of cancelled operations	The Health Board, through its Elective Optimisation Programme has begun to scrutinise the high volume of surgical cancellations. **Exhibit 20** shows the total number of cancellations almost reached 4,700 for the 12-month period to February 2025 **(Recommendation 7.2)**. This is the highest of all Welsh health boards. **Exhibits 21** shows the cancellation reasons with "other" being the highest category recorded. This approach to recording cancellations does not assist the Health Board in understanding and addressing the underlying causes of short-term cancellations. The Health Board should prioritise accuracy in reporting to ensure the actions it plans to take are effective and resources allocated appropriately. **(Recommendation 7.3)**
Improving operating theatre utilisation	Whilst the Health Board has strengthened its arrangements for monitoring theatre utilisation, these are yet to improve performance. The Elective Optimisation Programme group is responsible for overseeing theatre utilisation through monitoring of the Theatre Dashboard metrics. The GIRFT target for theatre utilisation stands at 85%. The Health Board's integrated performance report indicates that monthly performance varies between 74% and 67% in the last twelve months with no meaningful improvement. Key contributors affecting theatre utilisation are late and early finishes which have remained significantly above GIRFT targets. **(Recommendation 7.4)**
Making use of "virtual" outpatient appointments	Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of healthcare acquired infections. The Health Board recognises the variance in take up and engagement across services post-Covid and the risk of not being able to meet the target of increasing the volume of virtual appointments. **Exhibit 19** shows that virtual appointments are not well adopted by the Health Board, currently the lowest in Wales at 12.2% of all outpatient appointments in the 12-month period to February 2025. **(Recommendation 7.5)**

Opportunity area	Audit findings
Reducing non-attendance at outpatient appointments	The Health Board is working to reduce non-attendance at outpatient appointments. The Health Board introduced its Patient Access to Planned Care Policy in January 2025. This sets out implications for non-attendance and policy exceptions. Weekly reporting and escalation to Access Meetings ensures oversight of "Did Not Attend" (DNA) rates. The Health Board is developing standardised operating procedures (SOPs) for the management, monitoring and reporting of DNAs supported by a move to a centralised management of booking services. **Exhibit 18** shows some recent improvement in outpatient "did not attend" rates to around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025 representing a lost opportunity cost of around £5.8 million.
Making more use of day case surgery	The Health Board is performing effectively in its use of day case surgery. **Exhibit 22** indicates that the 83% of the Health Board's elective surgery is day case and is positively the highest in Wales.
Effective consultant job-planning	The Health Board does not have effective consultant job-planning arrangements. At the time of our review there was no agreed Job planning policy in place **(Recommendation 7.6**). A recent internal audit report in January 2025 indicated compliance with Welsh Government requirements[8] for annual job plan review is at 66% against a target of 90%. **(Recommendation 7.7).**
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	There is limited evidence to demonstrate the use of pooled lists by the Health Board, noting some progress in dermatology. The Health Board has identified that it needs to fully roll out the Welsh Admin Portal to enable it to effectively manage and pool waiting lists across Integrated Healthcare Communities. **(Recommendation 7.8).**

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

[8] National consultant contract in Wales

Protecting and increasing planned care capacity

28 We examined the actions that 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.

29 We found that **the Health Board is taking measures to protect its elective capacity, but it needs to do more. Whilst it has secured additional capacity through insourcing, outsourcing and waiting list initiatives, these measures are unsustainable in the longer term.**

30 The Health Board has had some success protecting planned care capacity from wider service pressures in a small number of areas. This is particularly notable where services are physically separated from the major hospital sites. This includes orthopaedics and ophthalmology services in Abergele Hospital and surgical services in Llandudno General Hospital. As highlighted previously, the reasonably high level of day-case surgery also helps to protect planned care services from wider unscheduled care and medical pressures. Nevertheless, short-term surgical cancellation data indicates that the Health Board cancels operations because of unscheduled care pressures and wider capacity issues in hospitals.

31 To further protect services, the Health Board is planning a new elective orthopaedic hub at Llandudno General Hospital. The aim of this initiative is to reduce pressure on planned care services from unscheduled emergency care and reduce waiting times for this challenged service. The Health Board has secured £29.4 million additional Welsh Government capital funding in November 2023. While work is progressing on this facility, it is delayed and the original ambition to open in early 2025 has not been met. It is now unlikely that this will be achieved by the end of 2025.

32 The Health Board is insourcing and outsourcing services as a means to increase planned care capacity to help meet its short-term needs. In 2023-24, the Health Board spent £6.8 million on insourcing and outsourcing contracts for six key specialties, primarily for orthopaedics and ophthalmology with a further £5.9 million allocated to endoscopy diagnostics and £4.6 million on radiology recovery. The Health Board allocated £3.8 million to transform planned care services however it is not clear which initiatives were implemented from this additional funding. The Health Board continues to utilise premium weekend working to increase capacity in the short-term. This is neither financially sustainable nor is it an effective means of improving efficiency and risks reducing staff resilience.

Managing clinical risk and harm associated with long planned care waits

33 Long patient waits increases the risk of preventable 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.

34 We found that **the Health Board is starting to take action to implement the Welsh Government's Promote, Prevent and Prepare policy, but is yet to be fully rolled out across all specialties. Overall engagement in the implementation of the policy needs to increase with strengthened reporting on actual harm resulting from delays.**

35 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[9]?	**Partially**	The Health Board has been slow to implement the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps). Its "Self-Care While You Prepare" service is currently only available to patients in four specialties: general surgery, orthopaedics, ophthalmology and dermatology. The Health Board has experienced delays in recruiting clinical and administrative staff to effectively meet demand and manage risk of harm resulting from delays. The Health Board needs to complete its recruitment and ensure the service covers all specialties **(Recommendation 8).**

[9] Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

Audit question	Yes / No / Partially	Comments
Is the Health Board assessing the risk to patients waiting the longest?	**Partially**	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. 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)**.
Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Quality and Safety Committee?	**No**	We found insufficient arrangements for routinely reporting clinical risks associated with waiting list delays to the Board and its committees. Despite the largest waiting list and some of the longest waits in Wales, there have been no reports to the Quality, Safety and Experience Committee regarding patient harm as a result of delayed treatment **(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?	**No**	The Health Board's primary focus is eliminating long waiting lists. The Health Board should ensure the development of clinical plans for all challenged services to ensure higher risk patients are prioritised appropriately **(Recommendation 9.3)**
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 does not have a mechanism for monitoring and recording the number of patients leaving planned care waiting lists in favour of private treatment.

Source: Audit Wales fieldwork

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

36 We analysed current 'Referral to Treatment'[10] 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.

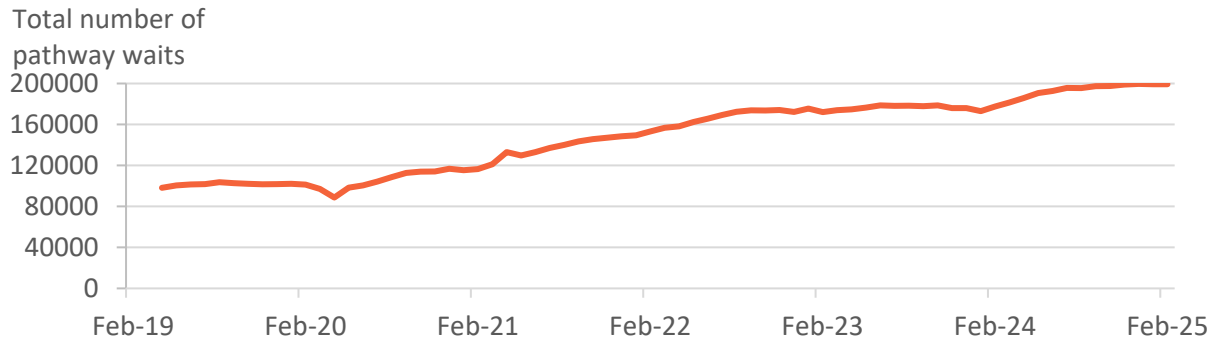
37 We found that **the Health Board has increasing numbers of waits and at the same time is not meeting Welsh Government performance targets. The growing number numbers of patients waiting over a year for treatment is of significant concern**.

The scale of the waiting list

38 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 **the continued growing backlog of people waiting to be treated presents an increasing and significant challenge for the Health Board. There are now nearly 200,000 open treatment pathways[11].**

39 **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 98,190 in April 2019 to 199,249 treatment pathways in February 2025. The action that the Health Board is taking to reduce the overall numbers of people waiting is not resulting in sufficient impact.

Exhibit 8: Planned care waiting list size, Betsi Cadwaladr University Health Board

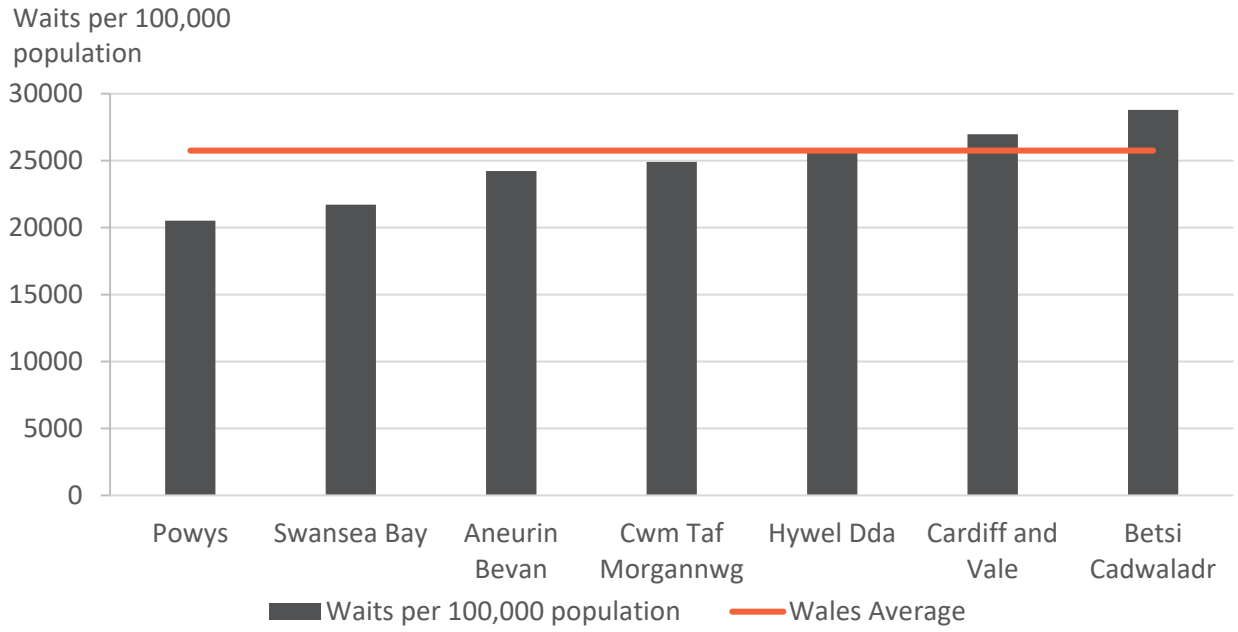


Source: Welsh Government, Stats Wales

[10] 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.

40 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. It shows that the Health Board has a higher proportion of waits compared with other health boards in Wales.

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

41 We looked at the progress that the Health Board is making against the Welsh Government's aims[12]. 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**[13]).
- 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.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

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

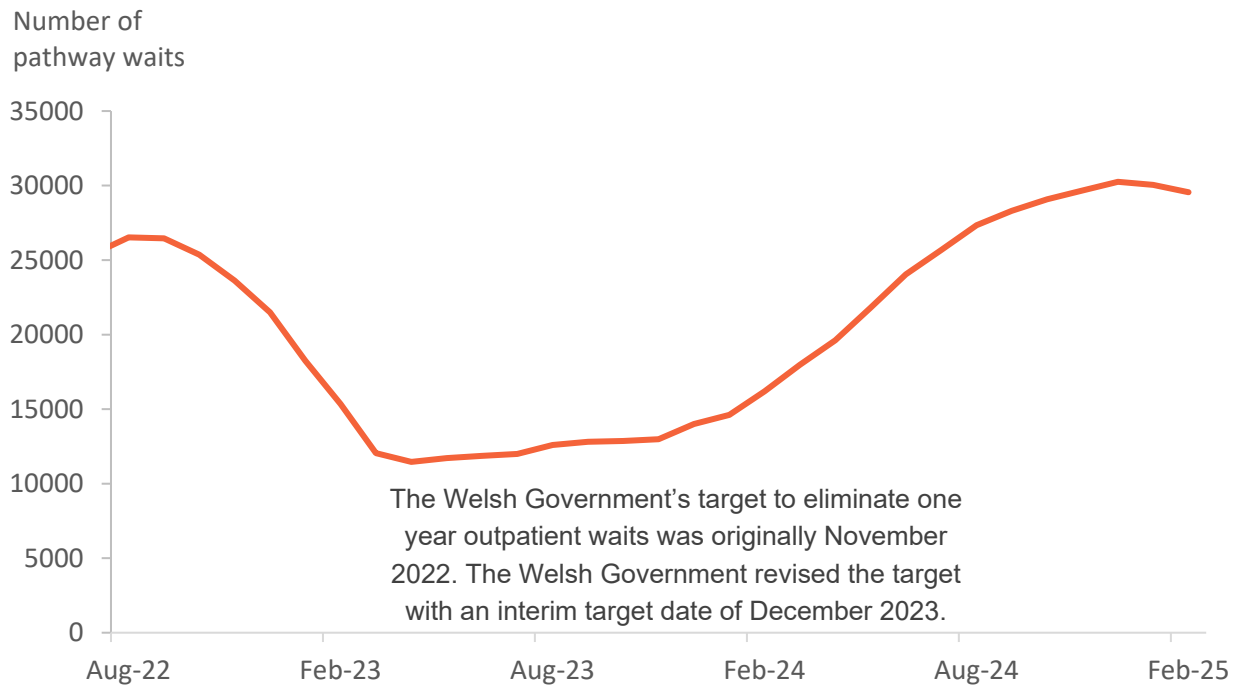
[13] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

42 We found that **the Health Board did not meet the Welsh Government's targets and despite making reasonably good progress initially performance has recently deteriorated.**

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

43 **Exhibit 10** shows Health Board 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. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year. Performance substantially deteriorated during 2023 and 2024, and it is only recently starting to marginally improve.

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

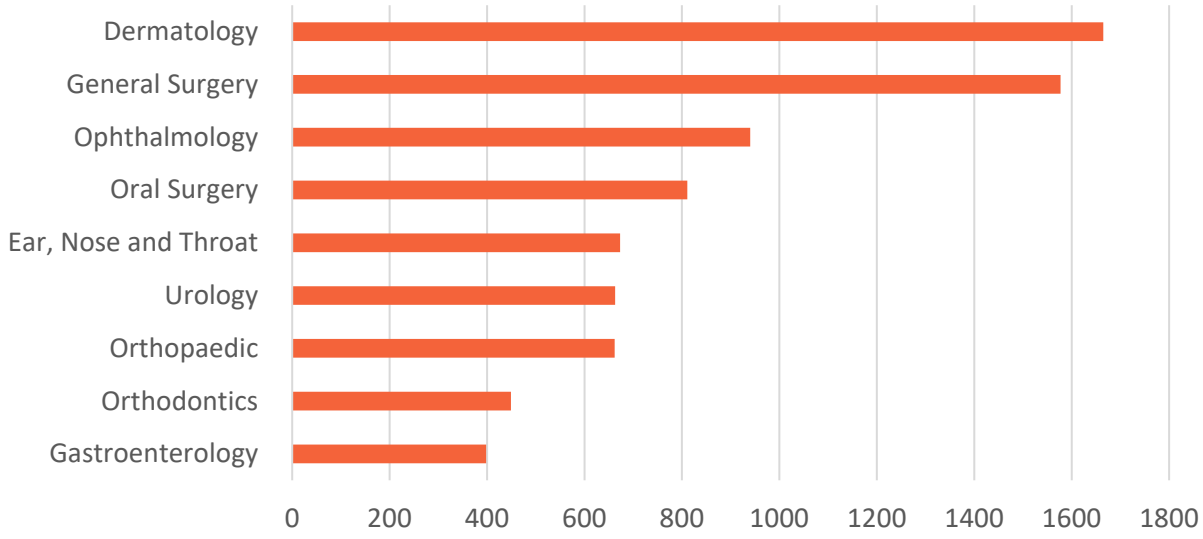
Eliminate the number of pathways longer than two years in most specialties by March 2023

44 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024 and early performance improvement has not been maintained. Of those waits currently over 2 years, **Exhibit 12** shows that extreme waits are across a range specialties, but include dermatology, general surgery, ophthalmology and oral surgery.

Exhibit 11: the number of planned care waits over 2 years, Betsi Cadwaladr University Health Board

Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, Betsi Cadwaladr University Health Board

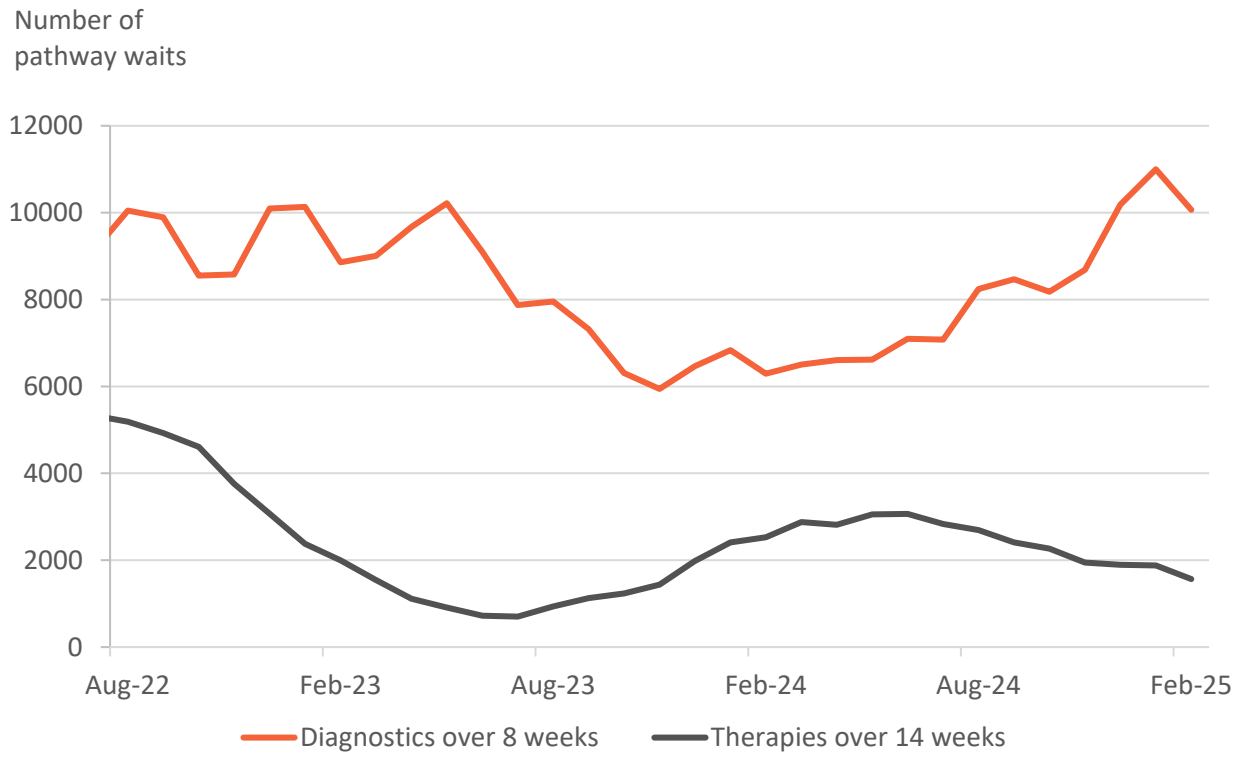


Source: Welsh Government, Stats Wales

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

45 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. The Health Board is not meeting its targets for therapy or diagnostic waits (**Exhibit 13**). Of its diagnostic services, diagnostic endoscopy and to an extent neurophysiology diagnostics are of greatest concern because of the volume and proportion of very long waits in these areas. Physiotherapy waits also appear to be a challenge for the Health Board.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14 week target), Betsi Cadwaladr University Health Board

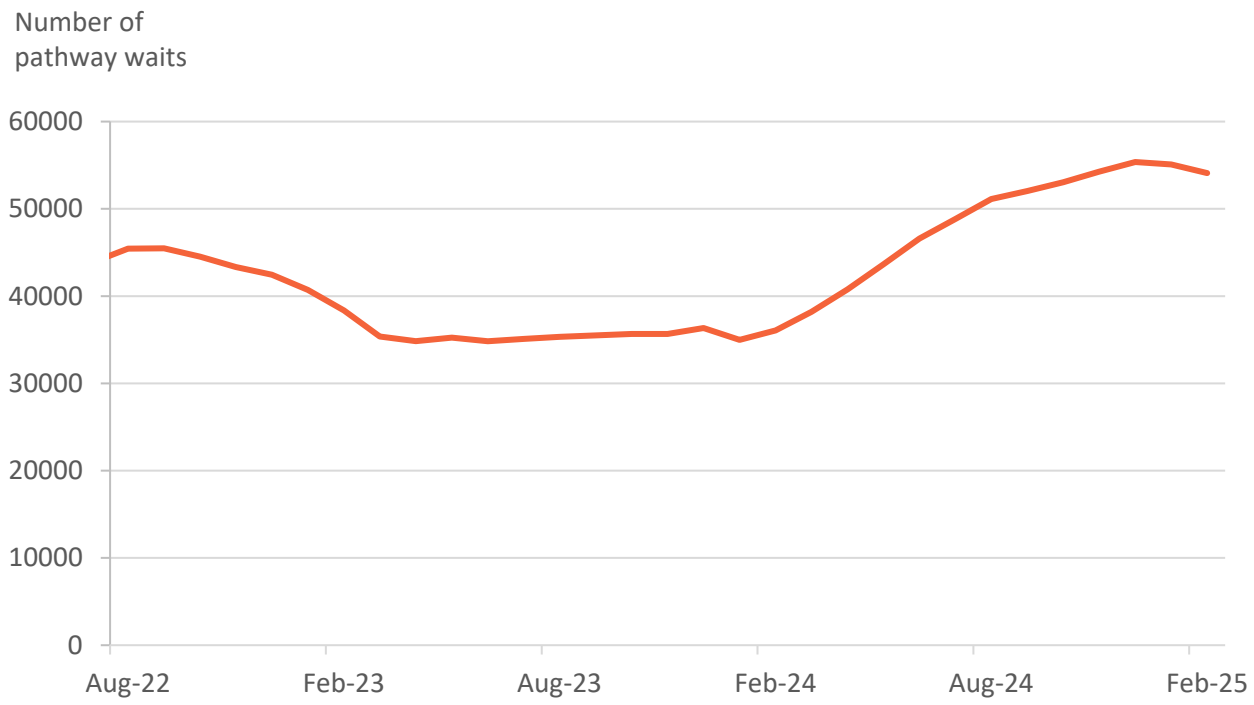


Source: Welsh Government, Stats Wales

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

46 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows deterioration in performance in 2024 reaching the highest ever recorded level of one year waits at the Health Board in December 2024. The position has marginally improved since.

Exhibit 14: the number of pathway waits that are over a year, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Barriers to further improvement

47 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.

48 We found that the Health Board recognises the barriers to improvement but is significantly affected by increasing service demand, capacity pressures and a lack of clinical leadership to drive change and recovery.

49 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is significantly increasing demand for services. The Health Board is making some progress in reducing the number of extreme waits, however referral levels are increasing (**Exhibit 16, Page 39**). At the same time, our analysis of the levels of medical and surgical admissions indicates that service activity is slightly lower than 2019 levels (**Exhibit 17, Page 39**). This suggests an increasing gap between demand and supply which the Health Board must address.
- **Workforce capacity** – The Health Board has identified that staffing issues are a further challenge to delivery. This includes recruitment to key roles such as anaesthetists and some wider theatre staffing. This has contributed to difficulties optimising theatre capacity.
- **Capacity to support transformation** - The Health Board has deliberately focused on addressing immediate demand and reducing waiting lists without appropriate analysis of its core capacity. This alongside wider resourcing challenges is limiting opportunities for more long-term transformation work and the ultimate need to implement sustainable modernised services.
- **Clinical leadership –** The absence of a Medical Director and shortage of clinical leadership in the planned care programme, particularly for challenged services has impeded delivery progress.
- **Clinical strategy –** The Health Board does not have an overall clinical strategy and individual service plans for challenged services to support planned care recovery. As a result, the Health Board is adopting an ineffective reactive approach which lacks clarity and consistency across the Integrated Health Communities.

50 The Health Board has begun to take action to address some of these barriers. To address issues with theatre utilisation it has established the Elective Optimisation Programme to scrutinise performance and drive change, as described in **Exhibit 6.** The Health Board is also taking action to increase the use of the Abergele hospital for ophthalmology procedures.

51 The Health Board has recently identified short-term measures to address capacity issues in response to increased demand in dermatology including additional locum recruitment and the use of minor operation procedures at Connah's Quay Health Centre.

52 The actions the Health Board has taken, including the appointment of an Interim Medical Director are at their early stages and further work is required to ensure the Health Board does not continue to face the same or greater challenges in future.

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: • Planned care programme initiation document. • Annual plan. • Performance, Finance and Information Governance committee papers • Planned care programme board papers • Quality, Safety and Equality Committee papers • Public Board meeting papers. • Executive team papers • GIRFT reviews • Corporate risk register • Planned care programme risk register • Performance reports • Terms of reference • Internal audit reports
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Interim Director of Finance – Senior Responsible Officer for planned care. • Interim Chief Operating Officer • Assistant Director for planned care. • Integrated Health Community – Planned Care Director. • Lead Clinical Director for planned care • Outpatient Lead • Finance Lead for planned care • Quality, Safety and Equality Committee Chair

Element of audit methods	Description
	• Promote, Prevent, Prepare Lead
Observations	We observed the Planned Care Programme Board in December 2024.
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: • 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.

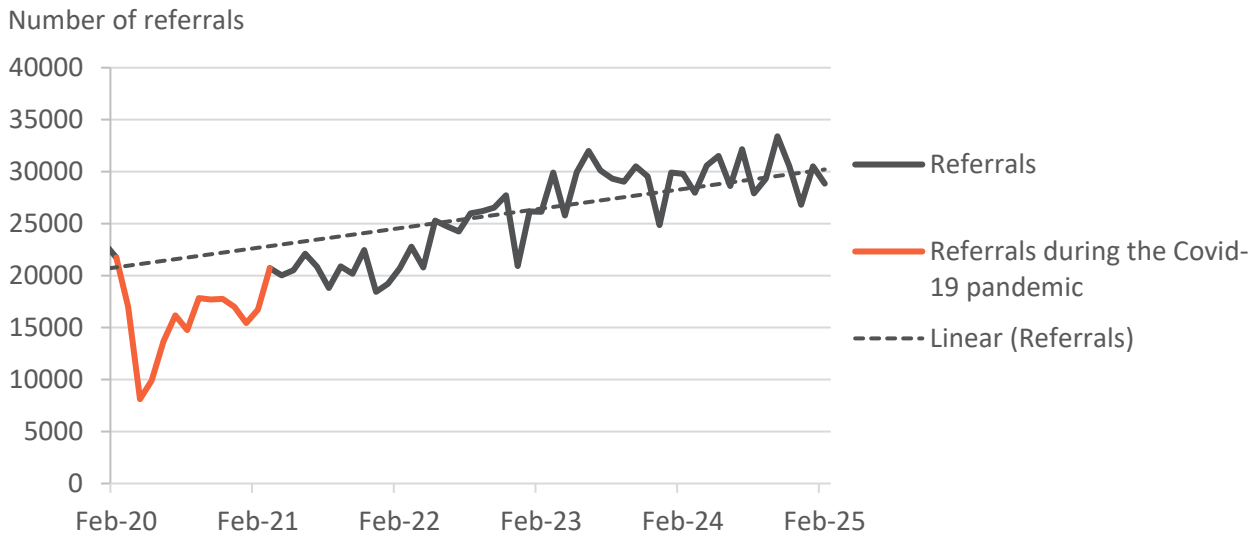
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been 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 (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend 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; • 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 & 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. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

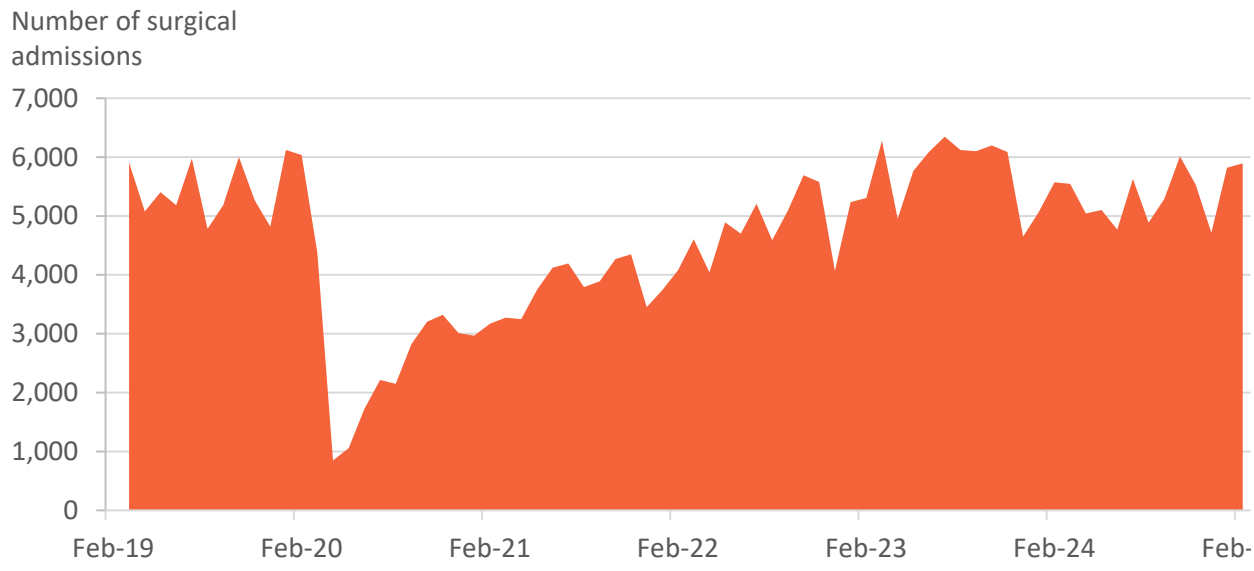
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels, Betsi Cadwaladr University Health Board

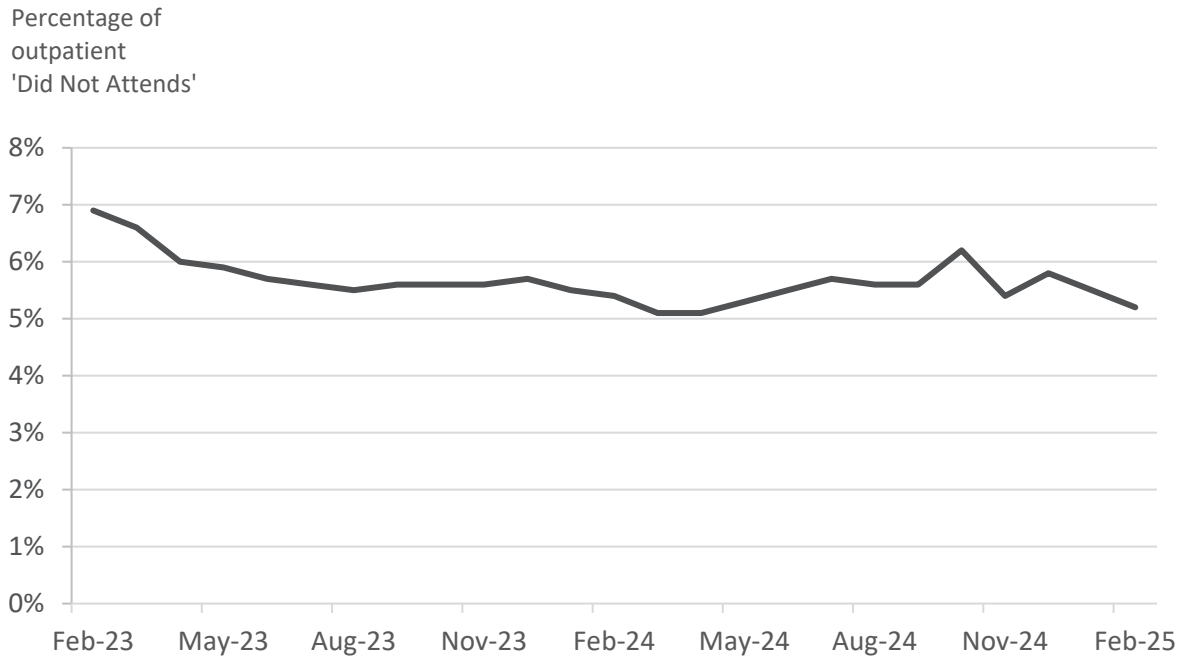


Source: Digital Health and Care Wales secondary care dashboard

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 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £5.8 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £1.15 million.

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

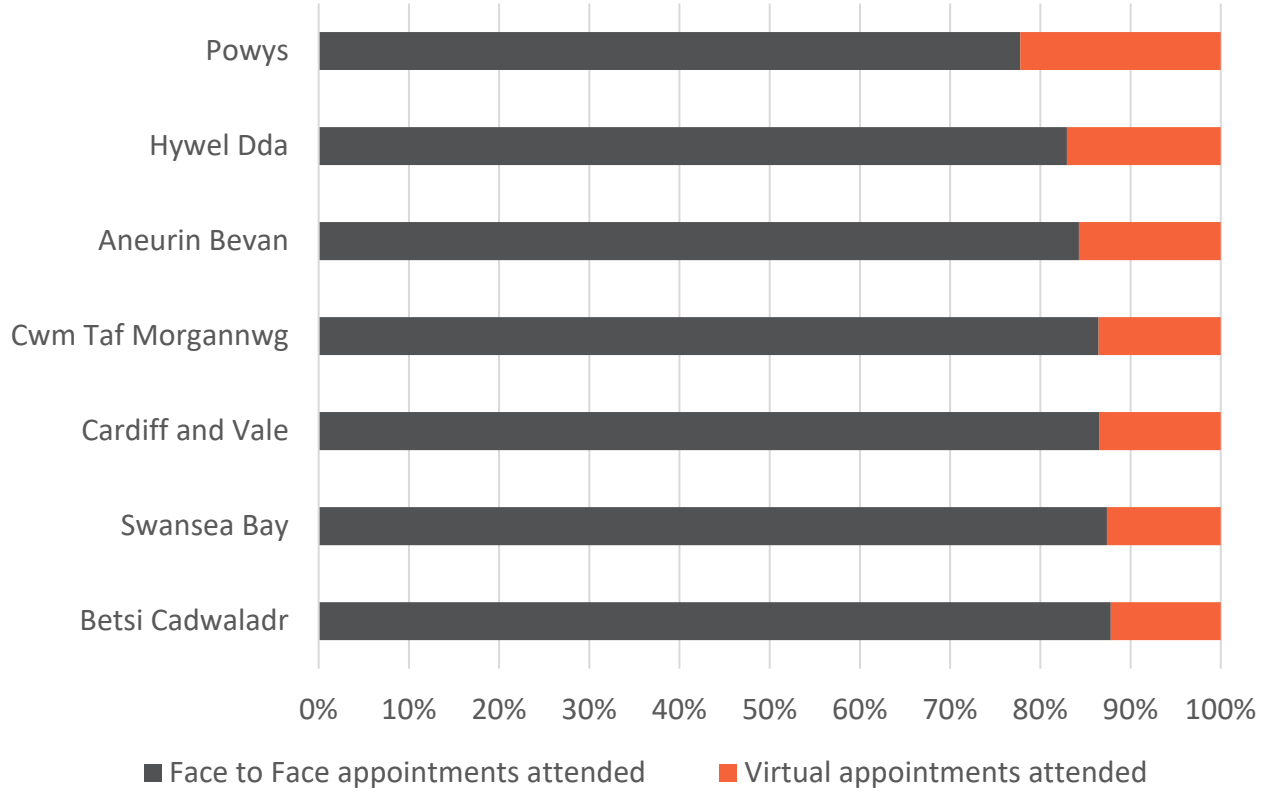


Source: Digital Health and Care Wales secondary care dashboard and datasets

54 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 and is the lowest in Betsi Cadwaladr University Health Board.

[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.

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

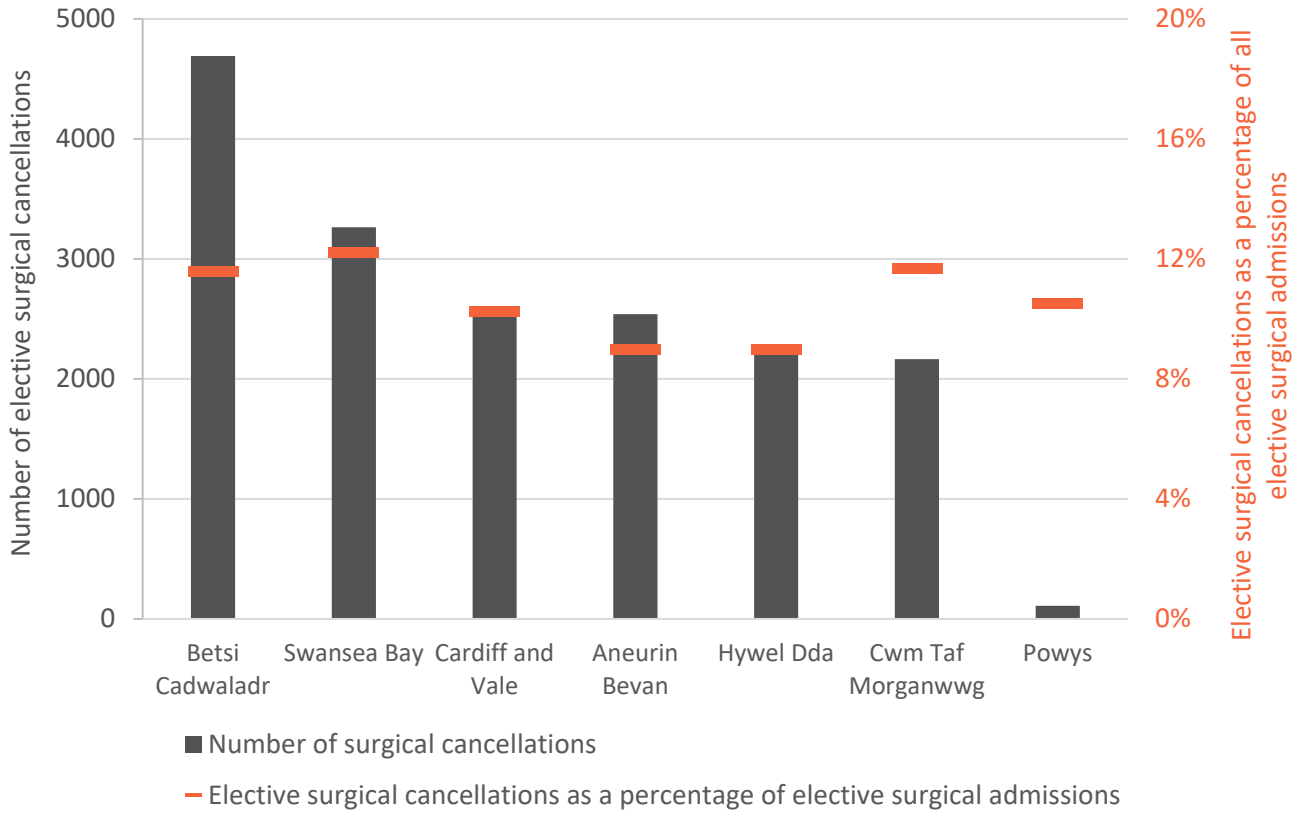


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

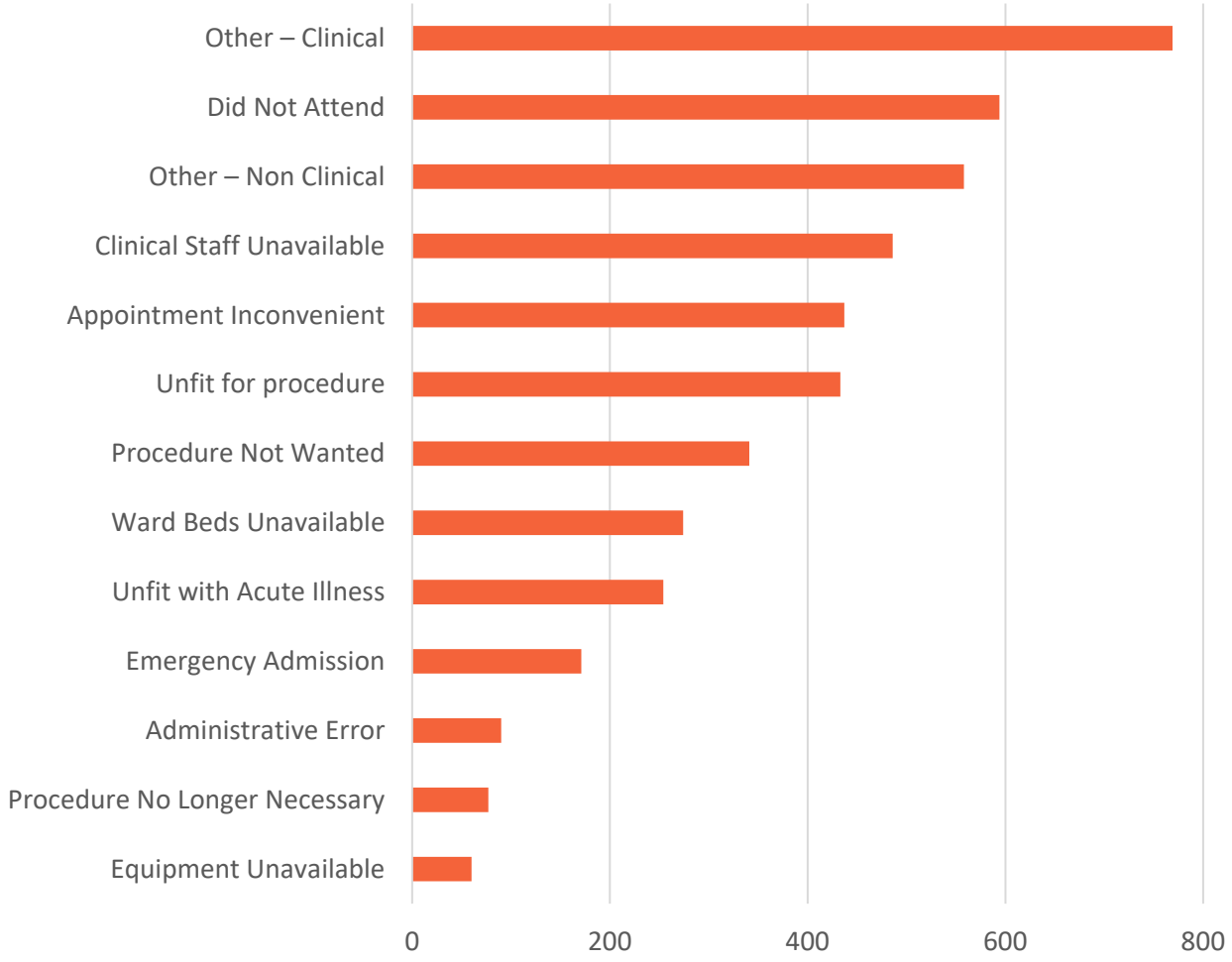
55 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board was almost 4,700 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 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, Betsi Cadwaladr University Health Board

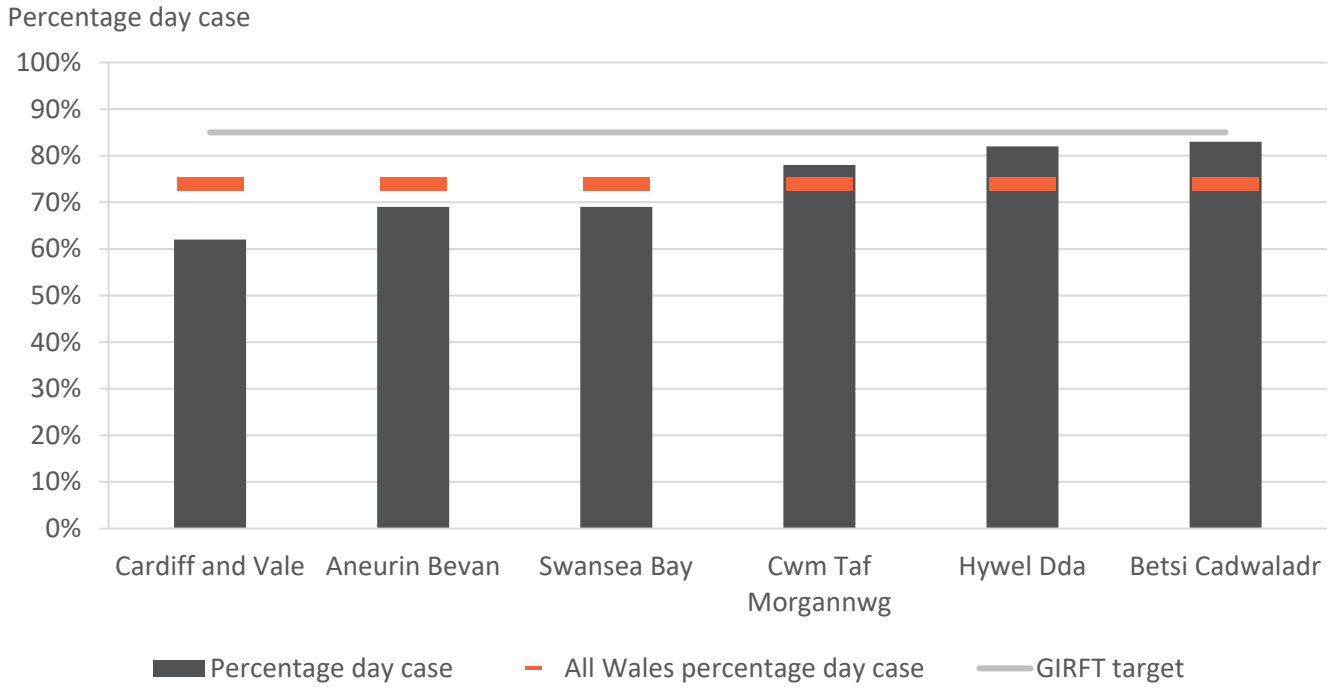


Source: Health Board submissions to the Welsh Government

Day case surgery

56 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 83% of the Health Board's elective surgery is day case and positively is the highest in Wales.

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



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

[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

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