A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity

April 2025

Report by the External Ministerial Advisory Group on NHS Wales Performance and Productivity

Index

Foreword....2

1. Introduction to and approach of the Ministerial Advisory Group (MAG) 5

2. Executive Summary....6

3. Performance, Productivity, Financial and Organisational Context....11
   - 3.1 Performance Context....11
   - 3.2 Productivity Context....11
   - 3.3 Financial Context....11
   - 3.4 Organisational Context....12
   - 3.5 Meeting the Challenge....13

4. Detailed Findings....13
   - 4.1 Planned Care and Diagnostics....13
   - 4.2 Cancer....27
   - 4.3 Urgent & Emergency Care....34

5. Making Change Happen....42
   - 5.1 Operating Model and Accountability Frameworks....42
   - 5.2 Measuring Productivity 47
   - 5.3 Digital and Data....50
   - 5.4 The Regions and Capital as Levers for Change....53

6. Conclusion....58

Foreword

Dear Cabinet Secretary for Health and Social Care,

It gives me great pleasure to present the final report of the Ministerial Advisory Group (MAG) on improving the performance and productivity of NHS Wales in planned care, diagnostics, cancer and urgent and emergency care services.

As Chair of the MAG, I have endeavoured to ensure that the Group has adhered strictly to its terms of reference and not over-reached into other areas. This has been a challenge given that there is at best a blurred boundary between these services and, for example, local authority education and housing services or the full range of NHS primary care or mental health services.

As such, I will use the opportunity of this foreword to make some general reflections on the health and health services of Wales before signposting yourself and other readers through the rest of the document.

My first and most important reflection is that Wales should aspire to have the leading healthcare system in the world.

Wales has an excellent strategy in the 2018 'A Healthier Wales: Our Plan for Health and Social Care,'[1] and the health boards and the associated integrated care philosophy are a sound building block for achieving the Institute for Healthcare Improvement (IHI) triple aim[2] of improving the health of the population, improving patients' experience of care, and providing value for taxpayers' money by continuously reducing the cost of health care delivery.

Nonetheless, Wales starts from a challenging position.

On health, the Wellbeing of Wales report of 2024[3] shines a light on the structural health issues of the population in terms of its age profile, its geographical profile and its comparatively high levels of morbidity and mortality and reducing life expectancy compared with 2011/13. And health inequalities persist and worsen. Within the NHS itself waiting lists are at historically high levels and the service faces a very challenging financial position on both revenue and capital.

This is the starting point for our findings and recommendations on improving the experience of care and value for taxpayers' money across the four areas within the remit of our terms of reference.

In summary, it is the MAG's view that the operational performance of these core NHS services is in need of urgent attention and turnaround. This will require a new focus for leadership across the Welsh health care system away from the creation of the further strategy, policy and targets and towards a relentless focus on the delivery of existing

[1] A healthier Wales: long term plan for health and social care | GOV.WALES
[2] Improvement Area: Triple Aim and Population Health | Institute for Healthcare Improvement
[3] Wellbeing of Wales, 2024 [HTML] | GOV.WALES

performance and productivity commitments. Unless this is done there is a high risk that the incidence of patient harm will increase and that value for taxpayers' money will decrease.

The detailed recommendations are addressed throughout the body of this document and are listed in the Executive Summary. There is little that we recommend that could be described as new or radical and almost all of the core content of our recommendations features somewhere in the existing policy and planning framework. The challenge is effective implementation: finding the tools, the time and the tenacity.

In drawing our conclusions and recommendations we have worked within three broad criteria. Firstly, any recommendation should not require statutory legislation. Secondly that the recommendation should have practical utility in improving productivity and performance within a 24 month period. And thirdly that no recommendation should require the establishment of a committee or task and finish group that would need a life expectancy of more than three months. By necessity the recommendations are therefore more tactical and short-term than strategic or transformational, although we have aimed to ensure that they are aligned to the broader strategic direction and thinking of the Welsh system

Given the above, the golden thread running through our recommendations is that the following levers for change need to be pulled to maximum effect:

- A focus on using evidence-based standards and taking out unwarranted variation
- A strong and empowered clinical leadership voice
- Transparency of data and a commitment to "improving in public"
- Sharper accountability and performance management
- A reduction in bureaucracy and more effective operational management
- A narrowing of targets, and
- Aligning financial flows with performance priorities

Finally, I would like to thank my fellow MAG team members and colleagues across NHS Wales for the spirit in which they have embraced the MAG and its work. From the outset I asked that the work of the MAG be celebrated rather than tolerated and I believe that this has overwhelmingly been the case.

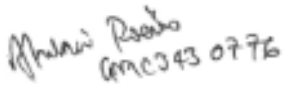
I hope that our report proves to be of value to the NHS in Wales and most importantly to the people of the land of my father. They deserve the best and you have the opportunity to give them the best: I hope you embrace it.

Yours sincerely,

Sir David Sloman (Chair)

MAG members:

Professor Tim Briggs



Dr Alastair Roeves

Professor Kevin Davies

Ed Rose

Professor Sally Lewis

Dr Tara Sood

Adam Roberts

Sir Paul Williams

1 Introduction to and approach of the Ministerial Advisory Group (MAG)

On 1st October 2024 the Cabinet Secretary for Health and Social Care announced the appointment of an external independent Ministerial Advisory Group (MAG) on Performance and Productivity in NHS Wales.

The Terms of Reference of the MAG specifies that the focus of the work is on performance and productivity within the clinical service areas of planned care, diagnostics, cancer and urgent and emergency care. Within this scope, the MAG was asked to offer external assurance on the effectiveness of current arrangements and to offer observations and recommendations on how these could be strengthened and improved.

The MAG was charged with completing its work by 31 March 2025.

From the outset the MAG was determined that its work should be clinically led, data driven and evidence based. A premium was placed on the practical utility of any recommendation, the evidence and data to support it, and its ability to have an impact within a 24 month period without the requirement for legislative change or additional bureaucracy.

In support of this approach the membership of the MAG retained a clinical majority at all times, and an even balance between those with deep working knowledge of the NHS in Wales and those with deep knowledge of healthcare systems elsewhere, in particular the NHS in England.

The MAG also ensured that its work was informed by front line clinicians as well as the input from NHS leaders and their teams across Welsh Government, NHS health boards and the broader Welsh NHS eco-system. Relevant strategy, policy and planning frameworks were also taken into consideration (see Annex A).

MAG members engaged with the health care system through both virtual and face to face meetings. They also undertook visits to six health boards in Wales (Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board and Swansea Bay University Health Board) in order to meet with executive teams and clinical leaders.

A full list of those with whom the MAG engaged is detailed in Annex B.

Building on this work and drawing on its collective knowledge and experience of UK and international health care systems, the MAG has identified the areas of strength, variation and opportunities for improvement. These are described in the narrative and the recommendations that make up the remainder of this report.

2 Executive Summary

There are 29 recommendations in this report: these are summarised below with an indicative timeline for implementation.

Planned Care

- **Recommendation 1**
  All health boards should develop a plan to reduce referrals to outpatients in high volume specialities with a particular focus on unwarranted variation and ensure the adoption of new models and best practice in outpatient management. Timescale – within 3 months.

- **Recommendation 2**
  All health boards should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management. Timescale – within 6 months.

- **Recommendation 3**
  All health boards should take action to improve waiting list management.

  3a) Better prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh Government for elective recovery. Timescale - within 3 months.
  3b) HEIW should set up an accredited training programme for waiting list management. Timescale - within 6 months.
  3c) Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26 and introduce a new national dataset to track progress. Timescale – within 12 months.

- **Recommendation 4**
  4a) All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management to be overseen by the establishment of Health Board Theatre Optimisation Boards. Timescale – within 6 months.
  4b) Health boards should seek accreditation for all Surgical Hubs and this should be a condition of further funding. Timescale – within 12 months.

- **Recommendation 5**
  A clear and identified funding stream should be centrally retained to establish a national dedicated fund for the use of the independent sector. Timescale – within 6 months.

Diagnostics

- **Recommendation 6**
  Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits. Timescale - within 6 months.

- **Recommendation 7**
  With the support of the Performance and Productivity Unit (PPU) (see Recommendation 19) regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future. This should include the full implementation of digital pathology as a key service enabler to address workforce shortages. Timescale – within 12 months.

- **Recommendation 8**
  Cardiff and Vale University Health Board should be required to submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound backlog over the course of 2025/26. Timescale – within 3 months.

Cancer

- **Recommendation 9**
  No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals. Timescale – within 3 months.

- **Recommendation 10**
  A ring-fenced fund, held centrally, should be created to directly fund the high-impact, nationally prescribed service changes described in Recommendation 9, which are monitored through the health board performance report (see Recommendation 21). Timescale – within 3 months.

- **Recommendation 11**
  The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care. Timescale – within 3 months.

- **Recommendation 12**
  The Cancer Network and the cancer arm of the Planned Care Recovery Programme should be merged to create a single team responsible for setting the strategic direction of cancer care in Wales and directing improvement activities to support this, led by a senior clinician and senior managerial lead, reporting to the National Medical Director and the Managing Director of the PPU. See Recommendations 19 and 20). Timescale – within 3 months.

- **Recommendation 13**
  Digital Health and Care Wales (DHCW) should develop a plan to begin collecting and publishing more granular tumour-level performance data from the beginning of the 2026/27 financial year at the latest. DHCW should also produce an options appraisal for the production of a linked dataset containing cancer and diagnostics waiting times data. Timescale – within 12 months.

Urgent & Emergency Care

- **Recommendation 14**
  Health boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care. Timescale – within 6 months.

  14a) Hospitals must ensure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways should be published within 3 months.
  14b) Welsh Government should run an audit of use of trusted assessors across the 7 health boards and 22 local authorities in May 2025, repeated in October 2025. This should be published in November with justification from the health board and/or local authority where this has not been implemented.
  14c) A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in emergency departments. This should be used to target investment in linked community services for winter and future budgets.

- **Recommendation 15**
  Health boards should ensure that no ambulance handover exceeds 45 minutes, with a focus on achieving the 15 minute handover target wherever possible. Timescale – within 6 months.

- **Recommendation 16**
  Progress against the Six Goals for Urgent & Emergency Care Programme should be reported publicly, using the monthly health board performance reports (see Recommendation 21). Timescale – within 3 months.

- **Recommendation 17**
  A consistent framework for escalation levels within the Urgent & Emergency care system should be introduced by October 2025, using the OPEL framework in England, adapted for the Welsh service where needed. Timescale – within 6 months.

The MAG identified several common themes and issues that affect all four key areas of focus. The following high-level recommendations are therefore applicable to each of these areas and cover the operating model and accountability framework, the system approach to productivity (including workforce), digital and data, and the role of regions and capital as levers for change.

Operating model and accountability framework

- **Recommendation 18**
  Welsh Government should consolidate all accountability and escalation meetings with health boards and trusts into individual monthly Performance and Productivity meetings, with a key focus on delivery against key areas of both performance and productivity, and progress against the recommendations of this report. Timescale – within 3 months.

- **Recommendation 19**
  A managing director should be appointed to directly manage and oversee the NHS Executive which will be renamed the Performance and Productivity Unit (PPU). Timescale – appointment within 3 months.

- **Recommendation 20**
  Medical leadership should be strengthened under the leadership of a new post of Medical Director of NHS Wales. This is a new post separate from and equal in status to the existing Chief Medical Officer post. Timescale – appointment within 3 months.

- **Recommendation 21**
  Health boards should commission the Welsh NHS Confederation to develop a standardised health board performance dashboard. The dashboard should be used in the public part of board meetings and to support the Performance and Productivity meetings. Timescale - within 3 months.

Measuring productivity

- **Recommendation 22**
  A total factor productivity model and workforce productivity model should be developed for NHS Wales and implemented in advance of the next budget. Timescale – within 12 months.

- **Recommendation 23**
  From the June health board meeting cycle of the 2025/26 annual year going forward, workforce head count and productivity data should be reported to the monthly public meeting of the health board. This should include data on both directly employed and the GMS and other independent contractor workforce. Working with the PPU the health boards should agree annual workforce productivity targets. Timeframe – within 3 months.

- **Recommendation 24**
  HEIW should work with the PPU (see Recommendation 19) to ensure that leadership programmes are in place to support the "threes at the top" of clinical services in health boards and trusts. Timescale – within 6 months.

Digital and Data

- **Recommendation 25**
  NHS Wales should commission from DHCW a comprehensive roadmap for the delivery of Missions 2 and 3 of its Organisational Strategy over a 24 month period, to be published within 6 months. No health board should move forward with any EMR or App development until the roadmap is agreed. Full consideration should be given to aligning the NHS Wales App with the NHS England App. Timescale – within 6 months.

- **Recommendation 26**
  The Cabinet Secretary for Health and Social Care should work with ministerial colleagues to prioritise the need to address Wales' data sharing policy and associated framework position with a view to accelerating the incorporation of datasets into the National Data Resource. Timescale – within 12 months.

The regions and capital as levers for change

- **Recommendation 27**
  In addition to the plan for pathology and endoscopy (Recommendations 6 and 7), health boards should work together as regions to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual and ongoing basis. To facilitate this work, resources and support will be provided by the PPU. Timescale – within 12 months.

- **Recommendation 28**
  The capital allocation should be uplifted on an ongoing annual basis and aligned to the annual planning and prioritisation process. Timescale – within 12 months.

- **Recommendation 29**
  Welsh Government should conduct a review of preferred options for generating non-exchequer capital for the Cabinet Secretary for Health and Social Care to consider ahead of 2026/27 capital round. Timescale – within 9 months.

3 Performance, Productivity, Financial and Organisational Context

The health and care system in Wales faces a major challenge. Demand is growing, costs are rising, public finances are stretched and a number of outcomes of care are falling behind relevant international comparators.

3.1 Performance context

There is evidence that outcomes, access measures and population health in Wales do not compare well with many European countries.

On health, the Wellbeing of Wales report of 2024[4] shines a light on the structural health issues of the population in terms of its age profile, its geographical profile and its comparatively high levels of morbidity and mortality and reducing life expectancy compared with 2011/13. On access measures, waiting lists are at historically high levels; specific details of access and performance in the areas of planned care, diagnostics, cancer and urgent and emergency care are described in the subsequent chapters of this report.

3.2 Productivity context

Whereas performance information is readily available there is less data and analysis of the productivity of the healthcare system. This issue is discussed in more detail in chapter 5.

3.3 Financial context

Pre-pandemic, Welsh Government commissioned external reviews from the Nuffield Trust ('A Decade of Austerity' 2014[5]), and The Health Foundation ('The path to sustainability' 2016[6]) which set out the conditions required for financial stability and sustainability of its NHS. This work suggested that stability was achievable through a combination of ongoing pay restraint, real terms funding growth to meet demand, with savings and productivity delivery in line with historic trends c1% - 1.5% per annum. However, these did not factor in the impact of the pandemic which, in common with other parts of the UK, led to a large increases in costs and demand which was supported by significant non-recurrent funding.

During recent years, health boards have found it increasingly difficult to deliver a sustainable financial position. Whilst additional funding has been allocated to the health budget and to the NHS this has largely been used to support pay awards, and unavoidable inflationary pressure and demand growth. This means that whilst the

[4] Wellbeing of Wales, 2024 [HTML] | GOV.WALES

[5] A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26 | Nuffield Trust

[6] The path to sustainability | The Health Foundation

revenue funding to support health in Wales is rising, there has been very little spare resource to support service transformation, and delivering a balanced budget has become increasingly difficult. This challenge is not unique to the NHS in Wales and is a common challenge across the UK and other healthcare systems and means that increased productivity will be needed to bridge the gap.

3.4 Organisational context

The National Health Services (Wales) Act 2006 established seven Local Health Boards (LHBs) in Wales, who have a statutory responsibility for planning, commissioning and providing services that meet the needs of the population they serve. This includes the responsibility across primary, community, and secondary care services alongside specialist services for the LHB area. In addition, NHS Wales comprises three NHS trusts, and two special health authorities, with a specific focus and remit.

The seven health boards are supported by the NHS Wales Joint Commissioning Committee (NWJCC) which commissions ambulance, 111 and specialised services on behalf of health boards. The NHS Wales Shared Services Partnership is an independent partnership directed by NHS Wales hosted by Velindre NHS Trust. The NHS Executive became operational on 1st April 2023, with a planned intent to operate on behalf of Welsh Government to provide strong leadership and strategic direction – enabling, supporting and directing NHS Wales to transform clinical services in line with national priorities and standards.

As an integrated planning system, the NHS Finance (Wales) Act 2014 introduced statutory duties for NHS bodies to prepare three-year plans that improve the health of the population, the provision of health care, and deliver financial balance over a three-year period.

The Health & Social Care Main Expenditure Group (MEG) is the budget for the Health, Social Care & Early Years Group in Welsh Government and is the largest budget area of Welsh Government, representing over half of the total budget. The budget includes the core funding for the NHS, supported by a financial operating model that has been largely designed to allocate resources to health bodies in order to discharge their statutory responsibilities. For the seven health boards resources are allocated to fund healthcare services for their resident population and should be considered alongside the NHS Wales planning framework which is the vehicle with which NHS bodies develop their plans to meet local requirements, ministerial priorities, and statutory duties.

Funding is a combination of un-hypothecated and hypothecated funding to support delivery of ministerial priorities and is largely driven by the Resource Allocation Formula. The formula is a needs-based population formula used to ensure the equitable distribution of additional allocations to health boards.

3.5 Meeting the challenge

The position on capital and revenue funding and the global workforce shortages mean that the challenges outlined above will, to a large extent, have to be met through improvements in productivity. This will necessitate clear structures, improved processes and focused leadership underpinned by excellence in operational management and service delivery. This will require alignment between a strong centre working with a collaborative group of health boards and trusts working collectively to a tighter set of objectives within a clear accountability framework and a commitment to transparency and 'improving in public'.

4 Detailed Findings

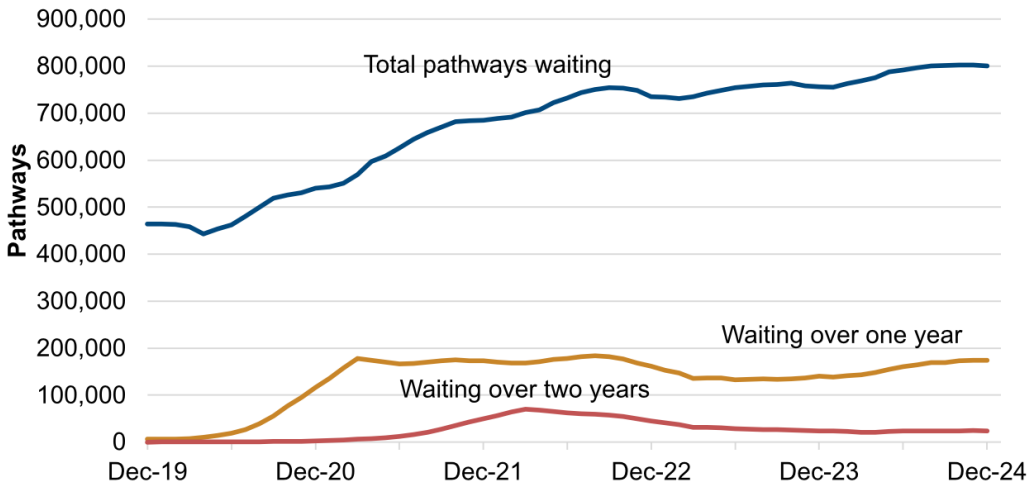
4.1 Planned Care and Diagnostics

Delays in elective care can have serious consequences for patients. As their condition worsens, they may need more medication, face frequent visits to doctors and hospitals (including emergency care), and see their treatments fail due to disease progression. In some cases, this can lead to permanent disability or even death.

The toll is not just physical. Patients may lose their ability to work, experience financial hardship, struggle with deteriorating mental health, and face additional stress within their families.

The main measure is the number of pathways where patients are waiting to start treatment. The graph below shows that this has been growing inexorably.

Patient pathways waiting to start treatment, December 2019 to December 2024[7]



Source: StatsWales, Referral to treatment

[7] NHS Activity and Performance Summary: December 2024 and January 2025 [HTML] | GOV.WALES

In December 2024, there were about 722,000 open consultant-led pathways in Wales[8], equivalent to 23 pathways (rather than patients) for every 100 Welsh citizens. For England, the figure in December was 13 open pathways for every 100 citizens. This means Wales would have to close more than 310,000 pathways before it reaches England's December level.

Currently there are 6 specialties that account for over 60% of the waiting lists: orthopaedics (including spinal surgery), ophthalmology, ENT, gynaecology, urology, and general surgery. Standardisation and adoption of the most common 29 pathways for these specialties would greatly improve productivity and efficiency.

Whilst in recent years some progress has been made to reduce very long waiting lists there has been little impact on the number waiting over one year.

The MAG identified the following key factors driving long waiting times:

- Growth in outpatient referrals
- Uneven adoption of best practice in referral management
- Unwarranted variation in outpatient management
- Poor waiting list management
- Sub-optimal theatre and surgical productivity
- The absence of protected high volume elective surgical capacity
- Sub-optimal use of the independent sector
- Bottle necks, capacity and management issues in diagnostics
- Very high numbers waiting in a few providers

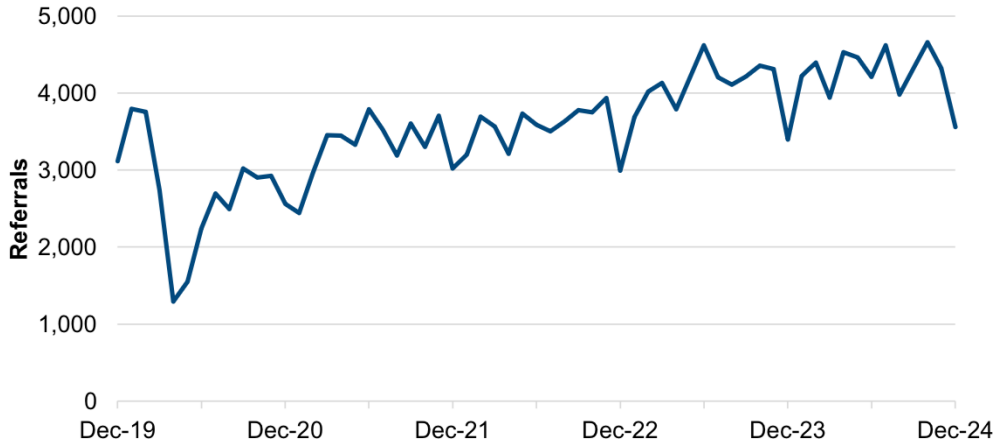
Each of these factors is considered in detail below.

Growth in outpatient referrals

Growth in outpatient referrals has exceeded population change with an average of 3,557 referrals for first outpatient appointments made per day in December 2024, an increase of 4.7% compared to December 2023. Whilst some of this growth relates to referrals between secondary care services, the bulk of referrals are from primary care. This is seen in other health systems and reflects pressure on primary care, changes in treatment guidelines, increased use of screening and patient choice.

[8] Whilst the graph shows over 800,000 pathways, the 722,000 has been calculated by removing some non-consultant led pathways which are not counted in England (see link above for further information).

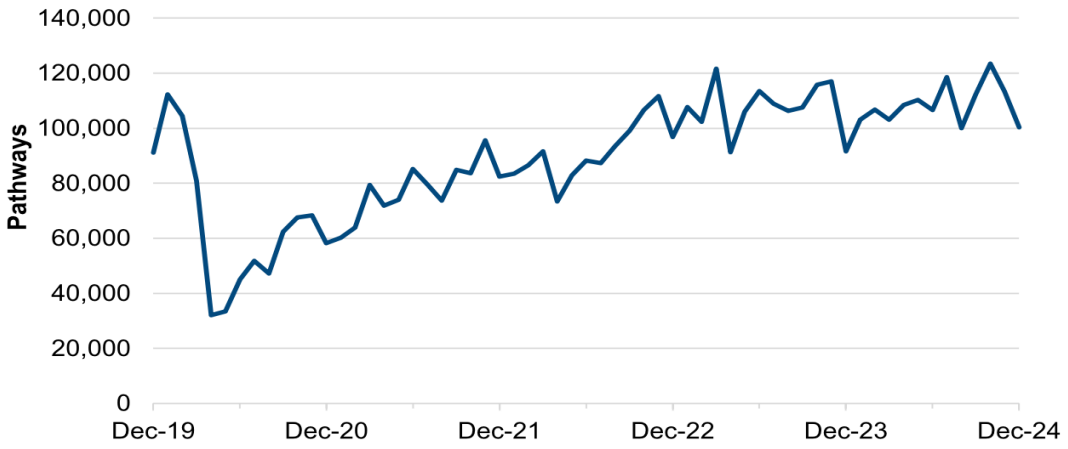
Average daily referrals for first outpatient appointment, December 2019 to December 2024



Source: StatsWales, Referrals

Welsh Government data shows that whilst the number of closed pathways – cases where patients have completed their outpatient journey – has steadily risen to pre-pandemic levels, this is not enough to address the backlog of new patients waiting to be seen and demand is greater than supply. As a result, the number of patients waiting more than a year has continued to increase.

Closed patient pathways, December 2019 to December 2024



Source: StatsWales, Referral to treatment

Pathways waiting more than a year for their first appointment, December 2019 to December 2024

Source: StatsWales, Referral to treatment

Uneven adoption of best practice in referral management

On its visits to the health boards, the MAG noted some examples of innovative schemes that offer patients and referrers alternatives to traditional consultant-led outpatient services;

- Swansea Bay University Health Board's primary care audiology service, where GPs can refer directly to audiologists based in the community for tinnitus, deafness and ear wax, leading to a reduction in ENT outpatient referrals.
- In Hywel Dda University Health Board, 30% of all referrals from primary care are diverted through advice and guidance and the 56% remainder who are seen in secondary care are either discharged at the first appointment and/or given a patient initiated follow up (PIFU) appointment.
- In Cardiff and Vale University Health Board, GP Clinical Editors have worked with radiology and MSK consultants and therapists to change the referral pathways for multiple spine, knee and shoulder conditions. By agreeing a community health pathway for each condition, GPs no longer have to refer to radiology for MRI or ultrasound scans prior to referral. The pathway directs them to refer to the community physiotherapy assessment service and has resulted in reductions in requests for scans of up to 92% with a consequent reduction in outpatient demand.

The Strategic Programme for Primary Care has identified a further 20+ services which are being provided in the community somewhere in Wales which if implemented at scale would reduce referral to outpatients.

Digitally enabled referral practice is inconsistently adopted. For example, in some health boards up to 40% of contacts between GPs and consultants are via e-Advice, a system that enables a clinical discussion between primary and secondary care without resort to outpatient referral. In other health boards electronic triage/grading of referral letters is not taking place, with a continued heavy reliance on traditional paper-based systems.

The table below shows the variable use of the consultant connect advice model. The MAG can see no reason why all health boards should not meet the level of the highest user.

Percentages of GP practices in Wales that requested advice and guidance via Consultant Connect in February 2025

	Practices making a call	Practices sending a message
Aneurin Bevan University Health Board	43.24%	48.7%
Betsi Cadwaladr University Health Board	27.72%	60.40%
Cardiff & Vale University Health Board	95.08%	1.64%
Cwm Taf Morgannwg University Health Board	36.54%	3.85%
Hywel Dda University Health Board	72.55%	33.33%
Swansea Bay University Health Board	64.58%	25.00%
Powys Teaching Health Board	56.25%	81.25%
All Wales	53.10%	35.24%

Source: NHS Executive management data based on health board returns on Consultant Connect activity

Given the above, the MAG believes that there is significant potential for reducing referrals to secondary care if all health boards adopt the range of interventions available. This includes full adoption of the National Community Health Pathway programme and full deployment of advice and guidance. The national funding for these schemes needs to continue.

Scope to improve outpatient management

During the health board visits, the MAG was informed of successful interventions aimed at improving outpatient flow and reducing waiting times. These included the extensive use of Patient Initiated Follow-Ups (PIFUs) - a national priority - which is a system that enables patients to be seen again if they develop a problem rather than being scheduled for a follow-up appointment. However, the adoption of PIFUs across and within the health boards was variable.

Additionally, other simple and proven interventions likely to yield significant productivity gains - such as reviewing and standardising outpatient clinical templates - have not yet been universally adopted.

The National Planned Care Programme has developed Further Faster guides for 16 specialties/subspecialties from the Getting in Right First Time (GIRFT) Programme[9] which describe the tools that can be used to optimise outpatient management. These include the standardisation of consultant specialty outpatient department (OPD) templates that specify the number of patients and the ratio of new to follow up patients

[9] The Getting It Right First Time (GIRFT) programme is designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

that should be seen in a four hour clinic. These blueprints, if fully adopted in Wales, would improve productivity and efficiency, and translate into improved quality of care by reducing waiting times for patients.

Waiting list management

The waiting list data suggests that differences in operational management practices are a significant cause of the intra-UK disparities. The number of patients waiting longer than a year reached a post-pandemic peak across England and Wales by Summer 2022. From this point onwards, the overall size of national waiting lists grew by 46% in England and 34% in Wales. Over the same period the NHS in England managed to reduce the number of patients waiting longer than a year by 50%, whilst in Wales the number increased by just under 1%.[10] This indicates that the NHS in England has been much more effective at treating non clinically urgent patients in date order, ensuring longer waiting patients are prioritised for treatment wherever possible even as the overall waiting list grows and average waiting times rise.

Put simply, the NHS in Wales has not been prioritising its available capacity for long-wait patients as rigorously as England. The latest data available to the MAG shows that there are just under 175,000 people waiting more than a year. Had the NHS in Wales instead been able to match the efforts of England, there would be 87,270 fewer patients waiting longer than a year for treatment than there are now.[11]

This is further evidenced in Welsh Government's Treat in Turn data[12] which shows that there is a 3 to 6-fold variation between health boards in terms of how effectively they are prioritising their longest waiting patients. For example, in the most recent data for ENT, almost 60% of planned procedures have been earmarked for the longest wait patients in Aneurin Bevan University Health Board, but the figure is only 10% in Cwm Taf Morgannwg University Health Board[13].

Ensuring that waiting lists are validated is a key part of the management of long waiting. The increase in the number of patients waiting rose from around 450,000 shortly before the pandemic to more than 800,000 today. During our visits MAG members were told that stretched clinical and administrative teams have been unable to perform regular checks on long-waiting patients as frequently as they did before the pandemic, resulting in far fewer patients being removed from the waiting list. In practice, this means many patients currently on waiting lists do not need to be there, potentially wasting appointments that could be used for other patients.

NHS Wales is aware of this and has issued guidance that validation should be a key focus for health boards. However, there is not currently any specific objective, nor any

[10] Whilst the two nations use slightly different data definitions, this analysis simply compares each nation's data to its own over the course of the last four years.
[11] StatsWales Referral to treatment
[12] NHS Executive management data based on health board returns on activity levels
[13] NHS performance for Welsh Local Health Boards: March 2025 [HTML] | GOV.WALES

national dataset which allows progress in each health board to be measured and tracked. The MAG were also told on the visits that the capacity to support the validation of lists is thin on the ground with relevant staff overstretched.

Equally, health boards did not appear to be aware of the OWLS scheme (Welsh Government legislation from August 2021 that enabled GPs to be remunerated for performing validations on their own patients at the health boards' request).

The MAG if of the view that the health boards should improve and implement best practice in prioritising available capacity for the longest-wait patients. Furthermore, such improvements should be a pre-condition for receipt of additional funding from Welsh Government for elective recovery. In order to ensure that health boards are fully held to account for these basic and essential processes around patient prioritisation Welsh Government should agree minimum standards based on the existing Treat in Turn dataset. Elective recovery funding for 2025/26 should be made conditional upon meeting these standards within a defined period of time.

The MAG also recommends that Health Education and Improvement Wales (HEIW) should set up an accredited training programme for operational teams in best practice in waiting list management. This is urgent and should commence within three months.

Recommendation 1:
All health boards should, within three months, develop a plan to reduce referrals to traditional outpatients in high volume specialities. Particular attention should be given to unwarranted variation and specialities where per capita referrals rates are above the national median.

Models that offer alternatives to traditional outpatient pathways should be rapidly identified and scaled. National Funding for Advice and Guidance and the National Pathways programme should continue.

From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Recommendation 2:
All health boards and trusts should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management, using existing specialty GIRFT health board and trust reports, the 16 specialty specific Further Faster guides, mandatory electronic triage of referrals, and adoption of the 29 pathways across the 6 specialties with the longest waits.

From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Recommendation 3:
All health boards and trusts should take action to improve waiting list management

3a) Better prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh Government for elective recovery. Welsh Government should agree minimum standards based on the existing Treat in Turn dataset, and elective recovery funding for 2025/26 should be made conditional upon meeting these in each individual health board within a defined period of time. **Timescale – within 3 months**

3b) HEIW should set up an accredited training programme for waiting list management, across both RTT and Cancer, aimed at Band 7 and Band 8 managers working in elective care. Over time, completion of this course should become an expectation for all managers working in these areas, in order to embed a consistent and shared set of skills across the country. **Timescale - within 6 months.**

3c) Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26, and introduce a new national dataset to track progress. If there is insufficient confidence this could be achieved in all health boards and trusts, Welsh Government should consider a nationally procured contract with an external company specialising in validation, to focus on areas unlikely to be able to complete this independently (although this could even be done on a once-for-Wales basis to cover the whole country, given the population size). This should be supported through Elective Recovery funding.

DHCW should also develop a new national dataset to track progress, either based on ROTT (removals from the list for reasons other than treatment) rates or manual health board and trust returns around the proportion of 36+ week waiters validated, which should be regularly discussed at the Performance and Productivity meetings described in Recommendation 18. **Timescale – within 3 months**

Improving theatre and surgical productivity

The MAG observed material variation in theatre productivity. This offers a significant opportunity for improved productivity and performance.

Welsh Government analysis shows that if between December and June 2024 90% of operating sessions had achieved the standard of seven cataract procedures per list then 2598 (42%) more patients could have been treated.[14] This would have been even greater if the GIRFT standard of eight to ten cataracts per four hour list was applied, a level of productivity agreed by the Royal College of Ophthalmologists.

In the same period meeting the standard of two patients per half day list for joint replacement would have allowed 632 (34%) more patients to be treated.

[14] NHS Executive management data based on health board returns on activity levels

There are similar issues related to late starts, early finishes, low theatre utilisation and lower than optimal use of day procedures. Addressing these inefficiencies does not require additional funding apart from the per patient cost of consumables and implants. GIRFT has already produced standards for theatre productivity including the minimum number of cases per list, day case rates and targets for theatre utilisation. The MAG supports the shift towards 'day case by default' in subspecialties such as joint implant surgery and the use of "Right Procedure Right Place" where patients are treated in procedure rooms rather than theatres. While time is needed for clinicians, managers, and patients to gain confidence in the safety of new approaches, the MAG believes that every health board should actively and rapidly adopt this best practice.

Prior to the MAG review a number of specialty reviews had already been requested and undertaken across all health boards in Wales from the GIRFT programme. These covered secondary care services such as gynaecology, orthopaedics, urology, ophthalmology, general surgery, theatres, and emergency departments (ED) and provided recommendations for service improvements. During the MAG visits we found that these recommendations had not been consistently implemented.

On the health board visits, MAG members heard that clinical leaders were keen to use the GIRFT programme and its associated tools. In discussion clinical leaders also identified the associated need for a clear and transparent link between individual job plans, appraisals and revalidation. In addition, clinicians asked for practical executive support for the rapid adoption of GIRFT standards and other good practice such as the Further Faster interventions and Patient Initiated Follow Up (PIFU).

Given the above, the MAG recommends that each health board should establish a Theatre Optimisation Programme Board that is co-led by a clinician and an operational manager with a remit to ensure immediate steps are taken to enhance theatre productivity in line with GIRFT standards. The national clinical lead for GIRFT and the implementation teams should work closely with the NHSE GIRFT Programme and the Wales National Clinical Specialty Working Groups to ensure all health board executive teams have reviewed and implemented the recommendations of GIRFT reviews in gynaecology, orthopaedics, urology, ophthalmology, general surgery, and theatre productivity. Performance data for theatre productivity and surgical hubs should be shared in the monthly Performance and Productivity meetings and at the local and national Theatre Optimisation Boards (see Recommendations 4 and 18).

In this context the MAG welcomed the Cabinet Secretary's letter of 20th December 2024 setting out priority enabling actions that NHS bodies should implement in 2025/26 on an 'adopt or justify' basis, including specific progress towards the delivery of GIRFT standards.

The need for protected high volume elective surgical capacity: Surgical Hubs

The MAG has reviewed the evidence supporting the protection of elective care beds from unscheduled care demand and concludes that designated Surgical Hubs, with clearly defined roles and ring-fenced facilities, can significantly enhance patient

experience, reduce waiting times, and improve safety by standardising practice and reducing the risk of cancellation due to emergency pressures. Surgical Hubs enable both outpatient and admitted surgical activities to be conducted for 48 weeks per year. Additionally, these hubs facilitate the exploration of new working methods, such as extended lists, weekend operations, high-flow lists, and super clinics for outpatient departments.

The MAG noted the successful implementation of Surgical Hubs in Wales and is aware that a number of surgical hubs have been identified (see Annex C) to form the first phase of a National Surgical Hub Implementation Programme. These hubs should be regarded as regional and national assets ensuring equitable access to timely care for all patients in Wales, regardless of their residence.

From the evidence of underperformance found at visits undertaken in six health boards, the MAG believes that every health board already possesses the necessary infrastructure in buildings and staff to establish dedicated Surgical Hubs, thereby accelerating productivity and performance improvements. All Surgical Hubs should be working towards 'day case by default' management of cases.

Given the size of the waiting lists, it is imperative that surgical hubs perform at optimum levels of productivity. In England, this objective has been supported by an accreditation process that uses a clear set of criteria around productivity, patient outcomes and patient and staff experience. We recommend that a similar process is established in Wales and that future waiting list funding could be contingent on compliance and adherence to the accreditation criteria.

Recommendation 4:
a) All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list). **Timescale – within 6 months.**

b) Health boards should seek accreditation for all current Surgical Hubs (listed in Annex C) from the National Medical Director (see Recommendation 20), within 6 months using standard GIRFT criteria including maximised theatre productivity (Annex D), and with all hubs to be accredited within 12 months. From June 2025, progress should be reported monthly to the public part of health board meetings, and the monthly Performance and Productivity meeting (see Recommendation 18).

Sub-Optimal use of the independent sector

There is a cultural reluctance, and a financial disincentive, to use capacity in the independent sector in Wales, despite this offering an opportunity to reduce long waits in key specialties.

Some of the largest groups of long-waiters in Wales represent high volume, low complexity cases suitable for independent sector providers. The specialty with the largest number of long-waiters in Wales (almost 25% of all patients waiting longer than a year) is ophthalmology[15], and more than half of these patients waiting for treatment are waiting for cataract surgery[16]. Numerous independent sector providers are capable of performing large volumes of cataract surgeries. In fact, more than one-third of all private sector admissions for self-pay and insured patients in Wales are for this procedure.[17] To genuinely prioritise the reduction of long-wait times on a longer-term basis, the increased utilisation of the independent sector would be a rapid and efficient solution.

With minimal consequences for failing to meet standards regarding long-waits, and a challenging financial backdrop, there is often little incentive for health boards to subcontract work to the independent sector in the first place. Contracting of the independent sector at health board level was described to us as "feast or famine", with short-term contracts often issued near the end of the year, rather than arrangements intended to supplement NHS capacity in a more planned way. This type of localised, short-term contracting is unlikely to provide optimal value for money and does not incentivise the independent sector to invest in the capacity and infrastructure necessary for sustainable support to the NHS in Wales.

The MAG is supportive of Welsh Government's efforts to actively expand use of the independent sector in recent months and believes this should become a more significant component of recovery plans in 2025/26. Beginning with ophthalmology as a test-case, NHS Wales should therefore agree national-level contracts with the independent sector, managed at regional level. These should be multi-year, and volumes agreed on the basis of realistic assessments of what the NHS will be able to achieve and how many long-wait patients would be better served at an alternative provider. The MAG understands that Welsh Government has calculated that almost 30,000 cataract patients are likely to still be waiting longer than 36 weeks at the end of 2025/26, so this should be the minimum volume of procedures contracted out to the independent sector.[18]

[15] StatsWales ,Referral to treatment
[16] NHS Executive management data based on health board returns on speciality data
[17] https://www.phin.org.uk/news/PHIN-Private-market-update-December-2024-Wales
[18] NHS Executive management data based on health board returns on activity levels

Recommendation 5:
A clearly identified funding stream should be centrally retained to establish a national dedicated fund for the use of the independent sector. This fund should be used where there are longer term sustainability challenges in demand/capacity that cannot be addressed through health boards delivering improvement using the new productivity standards and the other GIRFT interventions described in this report.

NHS Wales should enter into nationally negotiated, multi-year contract with the independent sector for ophthalmology in the first instance, with consideration given to replicating this arrangement for orthopaedics or dermatology if this first phase produces positive results. Contracts should then be regionally managed, modelling the success of the Southeast Wales cataract contracting in 2024/25, ensuring equity of access for all patients across the regional footprints.

In the longer-term, Welsh Government should commission an options appraisal on the opening up of choice of provider to referring clinicians and their patients in some specific, highly pressured specialties, and to include these independent providers on the choice menu.
Timescale – within 6 months.

Diagnostic capacity and bottle necks

Diagnostic delay causes anxiety and prolonged morbidity for patients and, for time-sensitive diagnoses, worsens outcomes.

Diagnostics have a critical role in ensuring timely and effective patient care. The programme for transforming and modernising planned care and reducing NHS waiting lists[19] commits that the NHS in Wales will eliminate waits of more than 8 weeks for diagnostics by 2026, but there has been little sign of progress with between 39,000 and 51,000 patients in this position each month over the past three years[20].

During the visits by the MAG, teams across Wales reported significant increases in demand, driven by changing clinical guidelines, screening and risk thresholds. The percentage of requests that are deemed urgent has also risen. For example, the proportion of histopathology tests relating to suspected cancer has risen from just over 10% in 2018 to more than 30% today[21]. One pathology team said, "*our USC histopathology demand has increased from 28% of our workload to 62% over 6 years*." The complexity of diagnostic information required for clinical decision-making has also increased and MDTs are often needed to support that activity. Coordination of MDTs can be challenging to schedule, leading to delays and consuming large amounts of radiologist and pathologist time. The MAG was told that often the impact on diagnostics was not fully considered when new guidelines were introduced. For example, changes

[19] Our programme for transforming and modernising planned care in Wales and reducing the waiting lists
[20] StatsWales, Diagnostic and therapy services
[21] NHS Executive management data based on health board returns on activity levels

to obstetric guidelines have put a strain on the capacity of non-obstetric ultrasound. These problems have particular significance for cancer services (see section 4.2).

The National Diagnostic Programme (part of the Planned Care Programme) has brought a welcome focus on these issues, although the availability of capital and workforce and the lack of data to inform planning are holding back progress.

Short term action is required to address the challenges within endoscopy and pathology and similarly with a localised issue in non-obstetric ultrasound. These are considered in more detail below. Imaging, with a few exceptions, has fewer pressing concerns and is not subject to any recommendations within this report.

Endoscopy

Endoscopy is under serious pressure, accounting for more than a third of all long wait patients, and has significant workforce constraints. For example, 35% ERCPists (those able to perform Endoscopic Retrograde Cholangio-Pancreatography) are due to retire within 5 years. Most units do not have a sustainable capacity model for the future with the exception of Swansea Bay University Health Board, who have sufficient space and a workforce plan that includes multiprofessional training. Over-reliance on non-recurrent funding is destabilising efforts to develop a sustainable workforce. Large sums of money are being spent on outsourcing and insourcing, neither of which are sustainable.

Comparing the number of endoscopy suites on a weighted population basis, Wales is adequately resourced at a national level, but this hides significant under-provision in Betsi Cadwaladr specifically, at 2.5 rooms per 100,000 >55 years compared to a national average of 3.5.[22]

Given the above, it is recommended that Welsh Government produces a national endoscopy transformation plan to be managed and delivered on a regional basis. The plan should be based on the following four pillars:

- Capital funding should be approved and allocated to BCUHB to create the three additional rooms required to adequately serve its population.

- A focus on improving utilisation and making the best use of existing capacity. The number of rooms in Wales relative to population size suggests under-utilisation must be a key driver of long waiting lists, but the lack of any national dataset means it is impossible to determine how well existing assets are being used. Rectifying this issue should be central to the national plan, with a national dataset and peer review process created around the widely accepted benchmark of ten points per endoscopy session (eight points for a training list). FIT status should be actively influencing decisions about colonoscopy, as indicated in Recommendation 9.

[22] MAG analysis following meetings with the health board

- Workforce planning to address the need for trained endoscopy practitioners and non-medical endoscopists (NMEs). HEIW should be commissioned to create a national training plan for expanded supply of NMEs, alongside a dataset to benchmark the proportion of endoscopies undertaken by NMEs in each health board.
- Rolling out of capsule sponge to relieve demand pressures, with a recent independent evaluation concluding it was "feasible, safe and acceptable", as well as "substantially reducing the endoscopy burden for routine reflux referrals".[23]

Recommendation 6
Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits. This should include prioritised capital for Betsi Cadwaladr University Health Board to bring it line with other health boards. In all other areas the focus should be on appropriate utilisation of existing resources, creating a national utilisation dataset (using GIRFT productivity benchmarks) which is reviewed regularly at the new Performance and Productivity Meeting (see Recommendation 18). HEIW should be commissioned to establish a new programme to expand Non-Medical Endoscopist training to rapidly expand the available workforce. Capsule sponge should be rolled out with a view to reducing demand for intervention endoscopy.
Timescale – within 6 months

Pathology

Pathology is the service that is almost universally under the most pressure, with median turnaround times twice as high as before the pandemic and running up to two months for routine tests in some health boards.[24] Some of the pathology estate is not fit for purpose and other sites do not have enough space for the equipment needed to adopt solutions which will help sustainability such as Digipath. There is a significant shortage of pathologists and in certain parts of Wales the service is critically fragile. [25]

Action is required to ensure that all regions have the necessary infrastructure to support digital pathology to agreed national standards through the prioritisation of the implementation of Digipath, thereby strengthening the resilience and productivity of services as the immediate priority. In parallel, the health boards should work together to develop regional plans for the transformation of pathology services. The plans should include workforce strategies for the training, recruitment, and retention of pathology staff, and capital plans to address critical estate and equipment issues.

[23] Use of a Non-Endoscopic Capsule-Sponge Triage Test for Reflux Symptoms: Results From the NHS England Prospective Real-World Evaluation - PMC

[24] MAG analysis following meetings with the Cancer Network
[25] MAG analysis following meetings with the Cancer Network

Recommendation 7
With the support of the proposed Performance and Productivity Unit (see Recommendation 19) regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future. The plan should include the full implementation of digital pathology as a key service enabler and address workforce, estate and equipment shortfalls. Timescale – within 12 months.

Targeting the longest waits

Whilst the MAG considered endoscopy and pathology to be the main modalities in need of systemic change, the single biggest driver of long diagnostic waits in Wales is in fact much more localised. Just under a third of all patients waiting longer than 8 weeks for their test in Wales are waiting for Non-Obstetric Ultrasound, compared to just 5% prior to the pandemic. Two-thirds of all of these patients are in a single health board: Cardiff and Vale University Health Board.[26] The MAG therefore also recommends that specific performance management arrangements are put in place with this health board to resolve this issue, with the independent sector being brought in to clear the backlog if sufficient progress is not being made within 3 months.

Recommendation 8
Cardiff and Vale University Health Board should submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound (NOU) backlog over the course of 2025/26 and should be held to account for the delivery of this. Independent Sector capacity should be employed if the health board has not made sufficient progress by the end of Quarter 1. **Timescale – within 3 months.**

4.2 Cancer

Cancer is the leading cause of death in Wales. The UK has one of the highest cancer mortality rates of all OECD countries and Wales has the second highest cancer mortality in the UK.[27] Given the known link between waiting times and mortality[28] the Welsh Government is rightly concerned that the backlog of patients waiting longer than the 62 day target is at its highest ever level[29], and that no health board has met the overall target (that 75% of patients should start their first definitive treatment within 62 days of first suspicion of cancer) since August 2020.[30]

Foundations are in place

Many of the foundations for improving the current level of cancer performance in Wales are already in place. The MAG was particularly impressed by the implementation of the

[26] StatsWales, Diagnostic and therapy services
[27] Cancer Services in Wales | Audit Wales
[28] Cancer waiting times: Latest updates and analysis
[29] NHS Executive management data based on health board returns on waiting lists
[30] Cancer Services in Wales | Audit Wales

single Suspected Cancer Pathway since 2019. This pathway has provided a national standard that is both relatively comprehensive in its patient coverage and sufficiently clear and straightforward to drive focus at both national and local levels. While some points of contention remain, such as the status of patients on adjuvant treatment, the MAG did not consider that any further changes to the standard were necessary at this time.

The quality and comprehensiveness of national data and analysis was also notable. The NHS Wales Executive has created excellent national business intelligence (BI) products within a relatively short period. Whilst some areas require further development, the MAG was impressed overall with the breadth and depth of insight available, which give the system the tools it needs to identify and co-ordinate the areas of required improvement.

MAG members also encountered numerous commendable proposals and ideas for performance improvement, both at the national and local levels. It is evident that cancer leaders are well-informed about the latest best practices being implemented in other nations and health systems and know which of these could bring about improvements in Wales.

Performance challenges are therefore not attributable to a lack of clarity regarding the headline standard that needs to be achieved, nor a lack of analytical insight about where the problems lie, nor the absence of knowledge about what needs to be done. Instead, the visits and interviews undertaken by the MAG suggested a chronic, and in some cases growing, inability to translate ideas into meaningful change.

Problems with planning and delivery

The years since the pandemic have seen a plethora of plans, summits, policy documents and best-practice recommendations, and this dilution of focus is a key contributing factor to the poor progress in actual delivery of meaningful change for patients.

There is no shortage of good ideas for improving cancer performance in Wales. Across the Welsh Government's 2021 *Quality Statement for Cancer*[31], the NHS Wales Executive's 2022 *Programme for transforming and modernising planned care and reducing waiting lists in Wales*[32] and the Cancer Network's 2023 *Cancer Improvement Plan*[33], there is an admirable level of aspiration and a wide range of sensible initiatives and pathway changes. But the resulting agenda is too broad and often too high level to result in any nationally significant and consistent change.

[31] The quality statement for cancer [HTML] | GOV.WALES
[32] Transforming and modernising planned care and reducing NHS waiting lists | GOV.WALES
[33] executive.nhs.wales/functions/networks-and-planning/cancer/cancer-improvement-plan-docs/full-plan/

Much of the content in these documents is the cumulative sum of individual health boards' own priorities rather than a set of clear, evidenced national priorities. The centre has too often appeared to view its role as to aggregate local ideas for improvement, rather than set out a clear, evidence-based national direction of travel. Whilst there is a strong focus on National Optimal Pathways (NOPs), these aggregate numerous desirable improvements and are often non-specific on how they should be delivered. The NHS Wales Executive itself accepts it cannot currently accurately measure if these are being implemented and relies on high-level health board self-assessment. In being asked to describe the relationship between these various national plans and the reality of local planning decisions at health board or trust, interviewees used words such as "*irrelevant*" and "*theoretical*."

One of the consequences of this approach is that, even where good ideas are proposed, there tends to be unwarranted variation in how they are implemented and a failure to realise the full benefits. In England, symptomatic FIT testing, for example, has meant Lower GI referrals for suspected cancer are 14% lower than expected this year, with more than 80% of these referrals now accompanied by a FIT test. This has supported a rate of performance improvement double that of all other cancers. In Wales, however, referrals are only 8% lower than expected, with only 70% of referrals accompanied by a FIT test and little observable impact on performance. Whilst all health boards told the MAG they were "*implementing FIT*," the situation appeared emblematic of the inconsistent and highly localised approach to implementing proven innovations. In the words of one interviewee, "*it is being done differently in almost every area*," and there did not appear to be any rigorous tracking of how FIT status is being used at triage, and in endoscopy departments, to focus resources on those with a higher risk of cancer. Teledermatology was another area where it was clear that there were multiple delivery models in use, with variable success and impact on performance.

The response to this lack of thorough implementation is too often to create another plan or initiative, despite the evidence this is no more likely to be delivered than the previous ones. Indeed, throughout this recent period of multiple plans being published, performance has flat lined within a range of c. 55-60%[34], whilst the backlog of patients waiting for care has steadily ticked upwards to a record high of 5,500[35]. Despite this, Welsh Government decided to announce an *increase* in the target from 75% to 80% by 2026 – another example of reaching for new policies or initiatives in preference to focusing on delivery of existing plans.

To break out of this dynamic, NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology. These should then form the basis of a much narrower, focused set of national support activities and accountability conversations with health boards over the course of 2025/26, alongside the continued local focus health boards will have on their more unique challenges. Together these tumour types account for three-quarters of all 62-day breaches,

[34] StatsWales, Cancer waiting times

[35] NHS Executive management data based on health board returns on waiting lists

meaning making progress in these areas would have a significant impact on national performance overall.

Recommendation 9
No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals. At the centre of this, drawing on the NOPs, NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology. These should then form the basis of a much narrower, focused set of national support activities and accountability conversations with health boards, alongside the continued local focus health boards will have on their more unique challenges. For Lower GI, this focus should be more consistent implementation of symptomatic FIT, with a new dataset created across endoscopy departments to assess whether capacity is being appropriately prioritised for FIT positive patients. For gynaecology, this should be the consistent provision of post-menopausal bleeding services; for breast the provision of breast-pain services; and for skin the more standardised provision of teledermatology services in primary care. In all cases, national specifications should ensure these initiatives are based in a primary care setting wherever possible, thereby reducing referrals to secondary care as a whole rather than substituting Single Cancer Pathway referrals for non-urgent referrals. **Timescale – within 3 months**

Misaligned financial flows

For cancer, financial flows in NHS Wales do not sufficiently incentivise performance improvement, with minimal amounts of funding hypothecated for specific improvement initiatives and minimal consequences for success or failure.

Whilst the MAG acknowledges the advantages of the current allocation model to health boards, it believes that stronger financial incentives are necessary for the NHS to improve performance in specific areas where a consistent national approach is required. There are numerous examples where improvement initiatives have been launched without dedicated ring-fenced funding, which means that even well-evidenced changes are therefore not necessarily fully implemented by health boards. When ring-fenced funding is available, such as the recent £1 million provided for performance improvement, it is often distributed based on local bids rather than national priorities. This approach appears to encourage competition among health boards for resources rather than fostering a strategic, nationally led agreement on what is optimal for the entire health system.

There is likewise no positive correlation between financial flows and performance improvements. In fact, many of the health boards the MAG consulted felt the opposite was true; that any additional funding made available mid-year would be directed to areas making the least progress, rather than those that had successfully implemented improvement initiatives. One interviewee stated that "*they [the NHS Wales Executive] will express frustrations, write us some letters, but ultimately there are no*

consequences." There was also frustration with these arrangements at the centre; two separate interviewees within the NHS Wales Executive said, "*we have no carrots and no sticks*." The MAG members were told that an internal paper within Welsh Government had been drawn up on "Levers for Change" in 2022 which considered different forms of financial incentives, but this does not appear to have resulted in any decisions or changes to date. It is the view of the MAG that the current approach is demonstrably not achieving the desired results and new incentive structures would be worth experimenting with.

The evidence base for the most effective pathway structures in cancer services is significantly stronger than in most other clinical areas, and the size of the NHS in Wales offers an opportunity to implement these consistently. Welsh Government should therefore strengthen the link between financial flows and interventions that drive improvement nationally, using clearly defined and transparent financial reward or financial clawback mechanisms. To complement this, the Welsh Government should also establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care (and aligned with the relevant NOPs and Community Health Pathways). Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of teledermatology arrangements outside of secondary care. The effectiveness of both sets of financial incentives should be independently evaluated a year after implementation, to begin to build an evidence base around the deployment of these types of incentives in Wales.

Recommendation 10
A ring-fenced fund, held centrally, should be created to directly fund the high-impact, nationally prescribed service changes described in Recommendation 9, which are monitored through the health board performance report (see Recommendation 21).
This fund could be created from a restructuring of the various, smaller ring-fenced amounts held centrally where there is limited evidence of impact; or alternatively by retaining a proportion of any new funds invested into the Welsh NHS in future financial years. Health boards must demonstrate the use of these funds for the specified initiatives using transparent national data collections, or else the funding should be withheld or subject to a clearly defined and transparent claw-back mechanism (depending on the approach used). **Timescale - within 3 months.**

Recommendation 11
The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care.
Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of teledermatology arrangements outside of secondary care. This will require changes in contracts at the cluster and practice level including updating the governance framework indicators by July 2025.
Timescale - within 3 months.

Leadership and oversight

National leadership of cancer policy and delivery is unnecessarily fragmented and complex, with three different teams responsible for policy (the Cancer Network), implementation (the Planned Care Recovery Programme) and oversight (Performance and Assurance).

Although the MAG was informed that these teams convene every six weeks to coordinate their actions, the current structure has resulted in diffused national ownership of the cancer improvement agenda, with no single individual clearly accountable for defining and coordinating improvement activities across Wales. Teams that should notionally be part of a single performance improvement architecture are instead pursuing duplicated health board engagement processes, clinical leadership roles, and strategy development. This is a key driver behind the emergence of multiple plans and lack of prioritisation of improvement efforts discussed under Recommendation 9. It has also created the conditions where too many leaders are able to say that issues crucial to improving cancer performance are "*someone else's job*." The MAG did not speak to a single interviewee who felt the current arrangements were working well.

In response to the recent Audit Wales review,[36] which stated that national leadership arrangements "need to be clarified and strengthened as a matter of urgency", Welsh Government has proposed a new Cancer Board to sit above these three functions. Whilst this may bring about some improvement, the MAG believes that this alone will not adequately clarify the roles of the constituent bodies reporting to it, nor how their respective work should influence one another, and that the integration of these separate teams needs to take place at a more fundamental, day-to-day level rather than via a higher-level board attempting to improve co-ordination.

The MAG considers that the Cancer Network should formally merge with the cancer arm of the Planned Care Recovery Programme, creating a single team which is responsible for setting out the strategic direction of cancer care in Wales and directing improvement activities. This combined team should be under the leadership of a single managerial

[36] Cancer Services in Wales | Audit Wales

lead and clinical lead that report to the Managing Director of the PPU and the National Medical Director (see Recommendations 18 and 19), and should be appointed via an open, competitive process and together be held accountable for improvements in cancer performance nationally. This single leadership team should then direct the work of both the strategy development and delivery aspects of the team's work. The team should work closely with the Performance and Productivity Unit (see Recommendation 19) to ensure health boards are held to account for the priority improvement initiatives described in Recommendation 9 and should direct the application of the financial incentives described in Recommendation 10.

Recommendation 12
The Cancer Network and the cancer arm of the Planned Care Recovery Programme should formally merge to create a single team responsible for setting the strategic direction of cancer care in Wales and directing improvement activities to support this, led by a senior clinician and senior managerial lead, reporting to the Managing Director of the proposed Performance and Productivity Unit and the National Medical Director. (see Recommendation 19 and 20). Timescale – within 3 months.

Improving data on performance

Whilst the quality and comprehensiveness of data required for cancer performance improvement in Wales is generally good, there are some further areas for development which could strengthen the current approach.

Overall, the MAG was impressed with the quality and comprehensiveness of data on cancer performance in Wales, as well as the work undertaken by the NHS Executive to create national dashboards and BI tools to support performance improvement. There were only two areas in which it felt further improvements should be made. The first of these relates to the granularity of tumour-level performance data which is collected and published nationally. It is impossible currently, for example, to compare health board performance on prostate cancer (which is contained within a wider "urology" category with bladder and other cancers), despite this likely being one of the most challenged tumour types nationally. The second of these relates to diagnostics data, where the lack of linkages between national cancer and diagnostic datasets means it is not possible to identify the exact bottlenecks in some more complex pathways, despite the fact this could be a useful guide for national capital planning and other purposes. The first of these issues should be easily resolvable by Digital Health and Care Wales (DHCW), and the second should be the subject of a more detailed options appraisal.

Recommendation 13
Digital Health and Care Wales (DHCW) should develop a plan to begin collecting and publishing more granular tumour-level performance data from the beginning of the 2026/27 financial year at the latest. DHCW should also produce an options appraisal for the production of a linked dataset containing cancer and diagnostics waiting times data, producing pathway-level insights into the key diagnostic drivers of long-waits at health board and at national level.
Timescale – within 12 months.

Cancer diagnostics

There is no national prioritisation or national planning for appropriate diagnostic capacity across Wales as a whole, even in areas driving poor cancer performance.

Members of the MAG were particularly concerned about the quality of endoscopy and pathology facilities observed in several health boards. Lower GI and upper GI cancers – the two tumour types heavily reliant on endoscopy for diagnosis – currently account for a quarter of all 62-day breaches. Median turnaround times in pathology, meanwhile, have doubled since the pandemic from 6 days to 12 days. The MAG heard that there were not clear national plans in place to develop capacity in these areas, with health boards left to put forward their own plans rather than the centre forming a clear idea of what national capacity was needed for Wales as a whole.

These issues are addressed through Recommendations 6 and 7 in the Diagnostics section of this report.

4.3 Urgent & Emergency Care

A system under pressure

Patients using ambulance services and emergency departments are experiencing long waits and while the clinical care is generally good, these delays impact detrimentally on patient experience and outcomes. Long ambulance waits outside hospitals mean that patients have to wait longer for an ambulance which again increases the clinical risk.

Emergency Department (ED) attendances in 2024 were 8.7% higher than 2017 partly driven by population changes but also possibly by changes in how patients use the service. Ambulance call-out rates have not grown at the same rate, although there has been a recent spike in (Red) 999 calls. However, response times are 50% longer for life threatening (Red) 999 calls than in 2019. For serious but not immediately life threatening (Amber) calls they are over 200% longer, on average.[37] Fewer than 70% of patients were admitted, discharged or transferred from the emergency departments within 4 hours in 2023/24, compared to over 82% in 2015/16, and a target of 95%. Over one in 10 attendances currently exceed 12 or more hours[38].

The pressure on emergency services is only partly due to rising demand. The main cause of extended time patients spend in the emergency department and other pressures is a lack of flow through hospitals. There were over one million attendances across Wales in 2023-24, the highest on record[39] but the problem comes when the emergency department (ED) cannot move the patient on to an inpatient ward, an

[37] Ambulance Service Indicators - NHS Wales Joint Commissioning Committee
[38] StatsWales, Emergency department, Ambulance services
[39] https://www.gov.wales/trends-nhs-urgent-and-emergency-care-activity-march-2024-html

appropriate alternative or be safely and easily discharged home. The result of this is overcrowding and busy-ness in the ED. This leads to patients being kept on trolleys and in corridors for extended periods and is a stressful environment for patients and staff.

The main reason that patients cannot be moved on to more appropriate settings is that Wales has a very large number of beds occupied by people who no longer need to be in a hospital but need a variety of other services or are waiting for decisions to be made about their care. These include waiting for:

- community services providing home healthcare
- for patients to choose a care home
- assessment by social care or for a social care funding package to be approved
- a place in a community hospital or care home to become free
- wait to transfer to a specialist centre

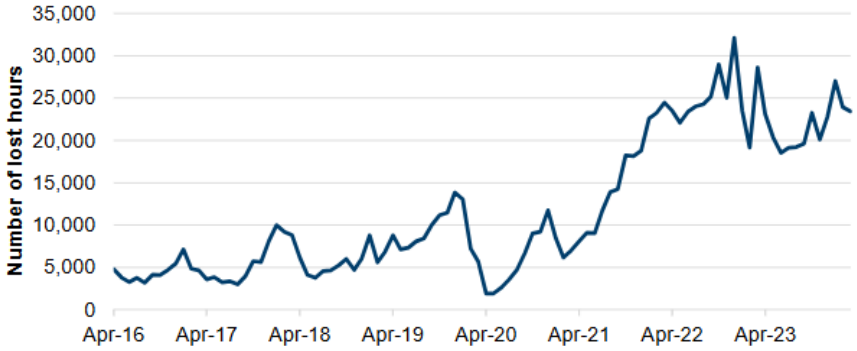
These delays are not solely as a result of problems with the system outside of the hospital. A significant number are the result of processes inside hospital caused by factors such as waiting for a doctor to approve documentation or waiting for drugs to take home. These challenges are exacerbated by the poor state of the digital infrastructure in hospitals across Wales.

Pathway of care delays (POCDs) account for around 1 in 7 (1500) of occupied acute beds, compared to 1 in 25 in 2019/20 (estimated based on available data).[40] The MAG observed multiple instances of frail patients being cared for in the corridors of emergency departments alongside high numbers of clinically optimised patients in the frailty wards. This is not good care, as unnecessary time spent in hospital can be detrimental to a patient's health and recovery. This is especially true for older patients, who have a greater risk of physical and cognitive decline including losing muscle mass, acquiring infections and other problems (Chen et al[41]). As a result, they may need a more intensive package of care when they are finally discharged than if they had gone home earlier.

This congestion and lack of flow also leads to longer ambulance handovers as if the emergency department is unable to move patients on then it cannot accept new ones. Over 260,500 hours were lost to handover delays in 2023/24 compared to 112,057 hours in 2019/20. The Welsh Ambulance Services University NHS Trust (WAST) estimated that a quarter of the fleet were outside of a hospital on average throughout December 2024, with an estimated cost of £46 million of productive time across 2024. More importantly, it means that while the ambulance crew is caring for a patient who cannot be offloaded, they are not available to answer calls from others whose need may be greater.

[40] NHS Executive management data based on health board returns on pathway of care delays
[41] https://onlinelibrary.wiley.com/doi/10.1002/gps.5687

Lost hours for the ambulance service following notification to handover at emergency departments, April 2016 to March 2024



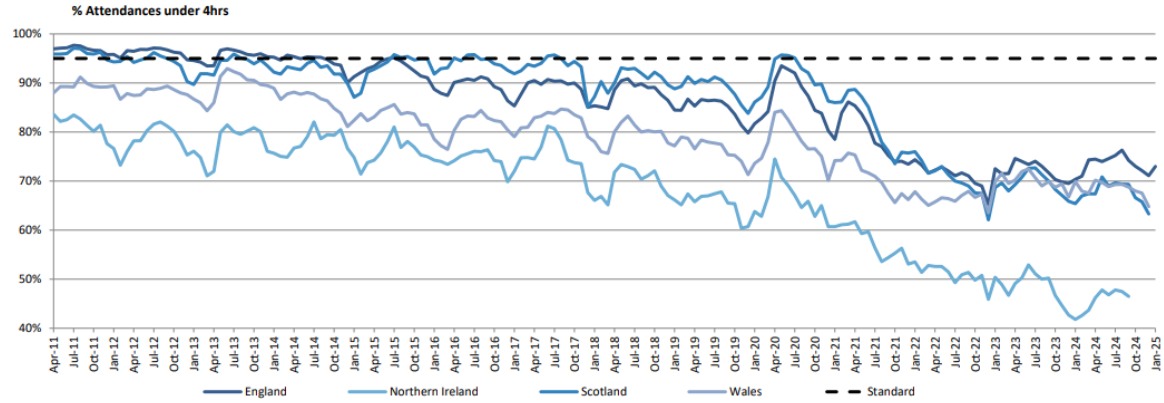
Source: Ambulance Service Indictors, Ambulance Service Indicators - NHS Wales Joint Commissioning Committee

These delayed pathways of care are not just an issue for patients and carers: they are also a significant cost to the health and care sector and the country as a whole. At an estimated £124 million a year, this equates to £1 in every £60 spent in the health and care sector. Adding the c.£50 million loss of ambulance productivity due to handover delays, the total cost is 0.9% of the total revenue spending for Wales.

There has been action in this area and there is a focus on improvement of urgent and emergency care (UEC) in Wales. Following decline against the 4-hour ED standards across the UK, improvement started earlier in Wales, remaining relatively stable since 2021/22 (see chart below). The Six Goals Programme for Urgent and Emergency Care (6 Goals)[42] is well regarded, with comprehensive coverage of the entire UEC pathway. In 2024 the GIRFT programme were commissioned to conduct detailed reviews of all 12 Emergency Departments across Wales.

The MAG observed several developing models of care that offer alternatives to admission, including Same Day Emergency Care (SDEC) models, and hospital at home or virtual ward services to ensure more people receive the care they need at home. Expansion of these services would undoubtedly provide a better patient experience for patients who are able to be managed by these services and support overall UEC flow and capacity, and opportunities here need to be explored and developed. We are also aware of the growing demand for diagnostics within the UEC pathway, to support earlier diagnosis, enhance the effectiveness of SDEC, and avoid admissions wherever possible. However, the recommendations in this report are targeted at where significant improvement is urgently needed, covering discharge delays, ambulance handovers, management of pressures in real time and increasing focus on the 6-goals programme.

[42] Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES



Source: StatsWales, Emergency department; NHS England, Statistics » A&E Attendances and Emergency Admissions; Department of Health, Emergency care waiting times | Department of Health ; Public Health Scotland, Monthly A&E Activity and Waiting Times - Datasets - Scottish Health and Social Care Open Data

Address delayed pathways of care

For all the reasons explained above, the predominant concern about urgent care raised by staff, the GIRFT reviews and as evidenced in the data is the pathways of care delays. This is one of the most significant barriers affecting NHS productivity and if it is to be resolved it will require a whole systems strategic shift in thinking, funding and governance. Delays are function of processes, partnerships between organisations, and of capacity in the community.

Recent lessons learned from the 50 day challenge to improve process management, together with the adoption of the Discharge to Recover then Assess (D2RA) Pathway and Trusted Assessor Model will, if mandated, yield some welcomed and immediate improvements in patient flow and long term care.

Trusted assessor

With 22 local authorities across Wales, strong partnerships with the seven health boards are essential. Research shows that the more local authorities are involved in a hospital's discharge processes the longer is the length of stay (Fernandez et al[43]). Nearly half of the POCDs are due to 'assessment issues' rather than capacity (46% in January 2025) highlighting the need for better partnership working.

In this context, the trusted assessor model should be a 'Once for Wales' requirement for all health boards and local authorities.[44] An audit should be run in May 2025 to establish where this is not happening, repeated in October 2025 with an expectation of full compliance. This should be published in November, along with a justification from the health board and/or local authority where this has not been achieved alongside a realistic timetable for subsequent implementation.

[43] https://pmc.ncbi.nlm.nih.gov/articles/PMC6158346/#:~:text=The%20results%20suggest%20that%20the,post%2Doperative%20lengths%20of%20stay.

[44] https://executive.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/trusted-assessor-role-guidance-pdf/

Discharge to Recover then Assess (D2RA)

NHS Wales has clear guidance[45] on processes for D2RA Pathways, based on the discharge to assess model proven to improve in length of hospital stay.[46] This guidance requires "*patients must be placed onto a D2RA Pathway*" and that "*for D2RA Pathways 1-3, patients must leave hospital within 48 hours (maximum) of being declared clinically optimised to do so*". The number of patients that are not discharged within 48 hours should be made public by pathway by hospital site, with those on pathway 0 used as a proxy for where hospital processes require improvement.

The capacity of services in the community

This is the biggest challenge for pathway of care delays and will require longer term solutions. The First Minister has stated that improving access to social care is one of her top four priorities[47], and an efficient health care system is not possible without a fully functioning social care system. However, not all delays are due to social care. Improving capacity of social care and community services will take time, so access to care at home must be prioritised for the pathways with the greatest delays, both POCDs and 12+ hour ED attendances.

Expansion of community services for adults with frailty would reduce delays, and the associated 12+ hour ED attendances. Alternatively, where patients on heart failure pathways are experiencing the longest delays, heart-failure virtual wards could be used to improve quality and efficiency. But the current data do not allow this level of insight.

Data should ideally be collected at patient level to inform this. However, lessons from England show this can take time to implement. Given the urgency, a rapid study should be conducted within three months to identify pathways with longest delays, particularly for cohorts that frequently experience long ED stays. Detailed demand and capacity analysis should then be performed across health and care services, with gaps backed by the investment required to provide care at home. Although this would primarily focus on reduced discharge delays, boosted capacity in the community would also provide alternatives to admission.

[45] https://www.gov.wales/sites/default/files/publications/2025-01/hospital-discharge-guidance-january-2025.pdf
[46] https://pmc.ncbi.nlm.nih.gov/articles/PMC6484156/
[47] "We have listened, we have learned and we will deliver" - FM announces Welsh Government priorities | GOV.WALES

Recommendation 14
Health boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care. Timescale – within 6 months.

a) **Hospitals must ensure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways to be published within 3 months.**
The Performance and Productivity Unit (see Recommendation 19) should then use pathways of care delays for patients requiring no onward care (pathway 0) as a proxy for where hospital processes must be improved to reduce delays.

b) **Welsh Government to run an audit of use of trusted assessors across the 7 health boards and 22 local authorities in May 2025, repeated in October 2025.** This should be published in November with justification from the health board and/or local authority where this has not been achieved alongside a realistic timetable for subsequent implementation.

c) **A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in ED.** This should be used to target investment in linked community services for winter and future budgets.

Address ambulance/ED handover delays

Long ambulance handover delays are a very significant issue across Wales with evident variation in performance. Ambulances are taking fewer people to hospital than before the pandemic, with 11,000 conveyances in January 2025 compared to 15,000 in January 2020[48]. Hours lost due to ambulance handover delays have doubled for the same period. The level of rapid improvement in certain sites across the UK shows what can be achieved with the right focus.

Following the implementation of absolute maximum handover time of 45 minutes in London, systems across England are now being asked to do the same.[49] NHS Wales should now do the same by October 2025, ahead of winter. This does not replace the 15 minute target but ensures ambulances can be released more rapidly back to the community. Where local circumstances mean a 45 minute maximum would be too great a risk to patient safety, an alternative should be agreed, with justification in the health board public board reports.

WAST needs to build on its work to hold or further reduce the number of conveyances to hospital by continuing the recent increase in cases treated at scene and increasing the

[48] Ambulance Services Indicators-NHSWJCC
[49] https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance

use of alternatives to hospital. This will need the support of a range of other services and will require active management and coordination to ensure that community and social care services can be rapidly mobilised when support is required. Attention to care homes and advanced care planning for patients at the end of life can also help reduce conveyances to hospital for those patients who wish to remain at home.

Recommendation 15
Health Boards should ensure that no ambulance handover should exceed 45 minutes, with a focus on achieving the 15 minute handover target wherever possible.
Where the 15 minute handover time target is not possible, an absolute maximum handover time of 45 minutes should be introduced by October 2025.
Timescale – within 6 months

Strengthen reporting, measurement and escalation

The Six Goals for Urgent and Emergency Care (6 Goals) Programme[50] covers improvement across the pathway, but published data does not reflect this.

The 6 Goals Programme is well regarded, with comprehensive coverage of the entire Urgent and Emergency Care (UEC) pathway. Improvement is supported by management data that are organised around each of the 6 goals, yet the data presented to the public are not. This is particularly evident in the new quarterly performance report for health boards[51], which presents the formal performance standards on ambulance response times and time spent in ED, not the breadth of the 6 Goals Programme.

Advancements in other areas of the pathway that enhance the care patients receive at or closer to home therefore go unrecognised. Conversely, lack of progress developing services closer to home will not be apparent to a health board's population.

To ensure alignment between operational focus and public commitment, the monthly health board performance reports should provide an assessment of progress against the established goals, utilising the information compiled for the Six Goals Board, starting from June's publication. The reports should include both validated and unvalidated data against the four hour standard to enhance transparency, in accordance with requests from the GIRFT programme and the Royal College of Emergency Medicine (RCEM). It may also include additional metrics used in the recent GIRFT reviews of the emergency departments if these represent an improvement on the current metrics. This should then be considered by the clinical group reviewing the current performance standards, to ensure future recommendations cover the whole UEC pathway.

[50] Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES
[51] https://www.gov.wales/nhs-performance-welsh-local-health-boards-december-2024-html

Recommendation 16
Progress against the Six Goals for Urgent & Emergency Care Programme should be reported publicly, using the health board performance reports (see Recommendation 21). Timescale – within 3 months.

Health boards should ensure that performance reports are aligned with the 6 Goals metrics before winter 2025/26 and made public from June. The report should include both validated and unvalidated four hour performance data. The clinical group reviewing performance standards should ensure that performance metrics cover the full UEC pathway.

Consistent measurement of pressure across Wales would allow faster more appropriate action in real time.

The nature of the UEC pathway means that service pressures and performance challenges can arise in real time. Wales has a clear structure for the escalation of real time pressures, centred on a daily call chaired by WAST. A new framework for Urgent and Emergency Care System Escalations has been developed, with recommended actions aligned with the 6 Goals Programme. This ensures that both short term escalation and long-term improvement are driven by the same underlying principles.

However, the escalation levels (1, 2, 3, or 4) are not objective and that resulting variation in application makes providing an appropriately targeted and consistent response difficult.

In England, this problem has been resolved with a clear and objective method to determine operational pressures escalation levels (OPEL). This has been developed by clinical and operational staff and is underpinned by a sophisticated digital system providing near real time data. As a result, pressures across the country are measured in a consistent way, allowing for a faster targeted response, including implementation of mutual aid.

Given the OPEL model was clinically led, and has been tested, NHS Wales should adopt this by October 2025, or a version with minor changes to adapt to the Welsh service. This would improve the real-time response to pressures in Wales and improve understanding of pressures across the Wales – England border. In alignment with the broader digital strategy, a digital solution should be explored to ensure the consistency and timeliness of reporting.

Recommendation 17
A consistent framework for escalation levels within the Urgent & Emergency care system should be introduced by October 2025, using the OPEL framework in England, adapted for the Welsh service where needed.
This recommendation should be enabled by the development of a “Once for Wales” digital support tool.

5 Making change happen

As part of its review the MAG considered a number of key enablers to improving productivity and performance, namely:

- operating model and accountability frameworks
- the system approach to productivity (including workforce)
- digital and data
- the regions and capital as levers for change.

5.1 Operating model and Accountability frameworks

The Parliamentary Review of Health and Social Care in Wales 2018[52] called for a clearer distinction between the national executive function responsible for strategically developing and managing the NHS, and the national civil service function responsible for supporting and advising ministers on the development of departmental and cross-governmental policy. From the evidence the MAG has gathered and the comments received this is considered to be sound advice.

When policy and delivery are synchronised and aligned they together make a powerful lever for change. However, from what the MAG has seen and heard there is a chasm between the ambitious agenda set by A Healthier Wales: Our Plan for Health and Social Care and the reality of performance on the ground, where services continue to be challenged to recover from the impact of the Covid-19 pandemic proceeded by over a decade of austerity.

The MAG heard from Welsh Government about its intent to strengthen and simplify the planning environment by increasing its expectations for the delivery of a smaller number of ministerial priorities as evidenced in the planning framework for 2025/26. This simplification will need to be supported by a strengthened focus by health boards on the delivery of the priority enablers that would improve productivity and performance. These are currently delivered to some extent across Wales but with a degree of variation that offers a significant opportunity for improvement.

The MAG supports this approach as this is not the time to over-burden the service with policy initiatives and excessive process and bureaucracy. Instead, the NHS needs a clear focus and a strong guiding hand underpinned by a performance improvement and management framework that drives service productivity and improves access and outcomes. As discussed elsewhere in this report, this needs to be complemented by

[52] Parliamentary Review of Health and Social Care in Wales Final Report

investment in operational management capability and better alignment of financial flows.

According to a background briefing paper presented to the MAG, the NHS Wales Executive (the Executive) was established in April 2023 to play this pivotal role, in support of Welsh Government.

"The purpose of the Executive is to drive improvements in the quality and safety of care and work on behalf of the Welsh Government and provide strong leadership and strategic direction - enabling, supporting and where necessary, directing the NHS in Wales to transform clinical services in line with national priorities and standards."

It was apparent in discussion across the Welsh health care system that the Executive has not reached this level of aspiration nor maturity.

It is the view of the MAG that one of the root causes of this is that the Executive is not an executive in any sense of the word. It has no executive function and no formal authority within the governance structure. It is in fact a resource of some 400 WTE people who have been brought together from a number of previous national bodies such as the Delivery Unit, Finance Delivery Unit, NHS Collaborative, and Improvement Cymru with the objective of creating a central and coordinated source of capacity and capability where the sum would be greater than the former disconnected parts. At the moment this is best described as early work in progress.

Some of this Executive resource is deployed in support of the work of the Value and Sustainability Board (VSB) and its five work streams (Workforce, Medicines/Prescribing, Continuing Healthcare/Funded Nursing Care, Non-pay & Procurement and Clinical Variation/Service Configuration). The MAG received consistent positive feedback about the work of the VSB from all stakeholders and believes it has the potential to be the building block for future work on productivity.

However, elsewhere there is a widely held and perceived view that at the centre of the NHS Wales there is an over-emphasis on policy creation, process management, and the generation of more objectives and targets overlayed with increasing layers of complexity and bureaucracy. This has served to blur the lines of accountability, with little to show in terms of improved productivity and performance.

As an example, post-pandemic it is evident that more - if not all - health boards have been placed in the performance management escalation machinery, with an associated increase in Welsh Government intervention. The result of this is that there are multiple interactions and meetings between Welsh Government and the health boards. There is a widely held view that this has increased the layers of complexity with the potential to blur accountability and obstruct progress, not least by placing an emphasis on reporting rather than action.

The MAG was told that "there are too many targets and insufficient sense of priority" and that "there are too many bodies confusing accountability". A recently departed health board CEO told the MAG "I've never seen as complicated a picture of who is

accountable for what", whilst a current health board CEO said, "we have made it so complicated that we are stifling ourselves".

Welsh Government has set out its intention to simplify this landscape and this has been progressed in the planning framework for 2025/26. The MAG supports this direction of travel but consider this needs to happen at greater pace to deliver the step change in productivity and performance required.

The MAG also heard from many sources that the clinical leadership voice is not strong or central enough in the current operating model. There are excellent clinical leaders in Wales but the work of the clinical networks, the medical directors in the health boards and the clinicians sitting in various roles in the current NHS Executive resource are not sufficiently aligned or anchored to the existing governance architecture. There is also cost-inefficient duplication and confusion about roles, as highlighted in the recent Audit Wales report on cancer services.

The MAG believes that strengthening and empowering clinical leadership at all levels - nationally, regionally, and within health boards and trusts - is crucial for addressing immediate performance and productivity challenges, as well as long-term clinical service transformation and sustainability.

Finally, another of the consistent messages the MAG heard was that there should be stronger central direction and a clearer mandate to the NHS in Wales where interventions are known to have proven benefit and utility. It is evident that the Cabinet Secretary for Health and Social Care has received the same message, as reflected in his letter to NHS Wales Chairs on 20th December, mandating a series of enabling actions on the basis of "adopt or justify." The MAG strongly concurs with this approach.

The MAG reflections above were supported by the Chief Executives who wrote to the MAG with the following suggested pointers to inform the recommendations its report (full list at Annex E):

- *Provide a clear operating framework describing the role of the NHS Executive and its relation to health boards/trusts with regard to oversight/performance management/delivery assurance.*

- *Streamline the various national groups/boards overseeing performance with the NHS Leadership Board being the single place to oversee quality/performance/ finance at a national level. Below this hold NHS Wales organisations to account through monthly meetings to review the same topics at a local level thus streamlining the multiple local assurance meetings currently in this space.*

- *Consider a role for a National Medical Director who has experience in direct service delivery and medical leadership who will drive and lead the national discussions with medical staff and support difficult service/clinical change discussions.*

- *Align expectations of efficiency and productivity in the planning framework for NHS organisations to ensure clear expectations of adoption of agreed clinical standards e.g. GIRFT/INNU.*

In parallel the MAG heard from Welsh Government of its frustration with a lack of progress in the delivery and implementation of key priorities such as GIRFT by health boards, resulting in a consequent increase in direction and escalation.

In light of the above, the following four recommendations are made:

Recommendation 18
Welsh Government should consolidate all holding to account and escalation meetings with health boards to single individual monthly performance and productivity meeting with each health board and trust. The meeting should focus on delivery against key areas of performance and productivity, and the recommendations of this report.

The CEO of NHS Wales should chair each Performance and Productivity meeting. The meetings should be attended by the CEO of the health board, and at a minimum the medical director, nursing director, finance director and those responsible for operational performance.

The outputs of performance meetings should be shared with the Cabinet Secretary and the Chair of the relevant health board or trust, with items escalated for discussion as appropriate. This would help clarity and delineate of the role of the Chief Executive and the Chair of each health board and trust, allowing the Chief Executive to focus on operational performance and allowing the Chair to focus on board governance, culture and managing the strategic relationship with the elected leadership of the local authorities and other key stakeholders. It would also alleviate the onerous duplication of time and effort created by the parallel operational oversight machinery currently in place between the Cabinet Secretary/health board/trust Chair and the NHS Wales/health board/trust CEOs.

The monthly performance meetings should replace all relevant existing monthly escalation and performance meetings. This should therefore replace the current JET, IQPD, oversight and escalation, and system NHS Performance Board meetings. The Oversight and Escalation framework should be enacted through these performance meetings.

The associated reduction in escalation interactions and meetings should allow health boards and trusts more time to focus on the immediate performance and productivity task. In parallel Welsh Government should consider strengthening the incentive and sanctions associated with delivery and non-delivery.

Recommendation 19
A managing director should be appointed to directly manage and oversee the NHS Executive which will be renamed the Performance and Productivity Unit (PPU). Timescale – appointed within 3 months.

The Managing Director (MD) should be of sufficient seniority to support the CEO of NHS Wales in holding their NHS colleagues to account. The Managing Director should be accountable to the CEO NHS Wales and be a member of the Welsh Government Executive Director Team (EDT). The Managing Director should have direct line management accountability for the budget and resources of the NHS Executive. This resource of around 400 WTE should be renamed the Performance and Productivity Unit (PPU). The Managing Director should ensure that these resources are transparently aligned to the single goal of improving the productivity and performance of the NHS across Wales. The Managing Director should review the options for how this resource is deployed, including out-posting to health boards and regions to support specific improvement interventions.

Recommendation 20
Medical leadership should be strengthened under the leadership of a new post of Medical Director of NHS Wales. This is a new post separate from and equal in status to the existing Chief Medical Officer post. The creation of this new post is essential to driving and delivering the performance and productivity agenda. Timescale – appointed within 3 months.

The Medical Director's priority responsibilities should include:

- Developing an organisational culture that supports the development of a continuously improving, clinically led and data driven NHS in Wales.
- To anchor and align the clinical leadership capacity and capability within the PPU and NHS Wales to the corporate performance, productivity and clinical transformation agenda.
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive the implementation of GIRFT recommendation detailed in this report and reiterated by the Cabinet Secretary in his letter to NHS Chairs on 20th December 2024.
- Through the health board and trust medical directors and the associated clinical leadership teams, to provide the clinical leadership to drive and support the recommendations detailed elsewhere in this report with regard to planned care, urgent care, cancer and diagnostics.
- To work with the regions, health boards and clinical networks to support, develop and implement regional solutions to fragile services as discussed later in this report.
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive and prioritise the implementation of HealthPathways (Pathway Alliance Programme).
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive the implementation of the Value and Sustainability Board agenda including high value pathway interventions and the medicines management work programme.
- To put in place mechanisms to ensure the alignment of job plans, appraisal and revalidation.

This revised performance management framework should be supported by the development of a standard performance dashboard that is used by all health boards as part of their monthly board meetings. This performance report should be discussed in the public part of the board meeting as a means of both increasing public transparency on performance and enabling health boards to compare performance (apples with apples) and hence to identify good practice and share learning.

It is recognised that currently all health boards produce their own performance reports set against the key metrics of the performance framework and publish these at health board meetings. However, as noted above the MAG consider that there is value in standardising the format and content of this reporting across the health boards.

Recommendation 21
Health boards should commission the NHS Welsh Confederation to develop a standardised health board performance dashboard. The dashboard should be used in the public part of board meetings and to support the P&P meetings. Timescale - this should be operational within 3 months.

5.2 Measuring productivity

Productivity

While there are multiple lenses on performance and clear progress on productivity in the five work streams of the Value & Sustainability Board (VSB) there is currently no single national measurement of the overall productivity of NHS Wales.

As such it is not possible to make an evidence-based assessment of the relative productivity, or the extent of improvement in productivity over time, or to set clearer expectations on productivity improvement to ensure maximum value for the Welsh taxpayer.

The MAG proposes that a national model to track productivity should be produced ahead of the next national budget to help inform spending decision and productivity requirements. This should track national Total Factor Productivity as a minimum and be developed in a way that allows for health board level productivity metrics and targets across primary, community, acute and mental health services. Given the model established by the ONS for UK and England, this may be a useful starting point for consideration.

Recommendation 22
A total factor productivity model and workforce productivity model should be developed for NHS Wales and implemented in advance of the next budget. Timescale – within 12 months.

Tracking workforce productivity

The annual spending on workforce by the Welsh NHS in 2023/24 was £5.9 billion, 58% of the total budget[53]. It is to be welcomed that workforce is one of the priority work streams of the Value and Sustainability Board, but by its own admission this area has received less attention than the other five priority areas. The notable exception is the excellent work on developing and implementing an agency control framework and international recruitment strategy to support a reduction in the reliance on agency workforce. This has reduced agency expenditure from £325m to £173m over the period 2022/23 to 2024/25.

As shown in the table below, between 2019 and 2024 there has been a 15.14% increase in the number of staff employed within the Health Boards across Wales, ranging from 8.77% in Cwm Taf Morgannwg to 22.54% in Hywel Dda.

Health Board	2019-JUN	2024-JUN	Difference	% increase
Aneurin Bevan University Health Board	11,387.46	12,961.70	1,574.24	13.82
Betsi Cadwaladr University Health Board	15,318.62	17,894.29	2,575.68	16.81
Cardiff and Vale University Health Board	12,824.02	14,885.25	2,061.23	16.07
Cwm Taf Morgannwg University Health Board	10,247.88	11,146.79	898.91	8.77
Hywel Dda University Health Board	8,389.40	10,280.65	1,891.25	22.54
Powys teaching Health Board	1,773.23	2,080.41	307.18	17.32
Swansea Bay University Health Board	11,153.98	12,609.59	1,455.61	13.05
All Wales	**71,094.59**	**81,858.68**	**10,764.10**	**15.14**

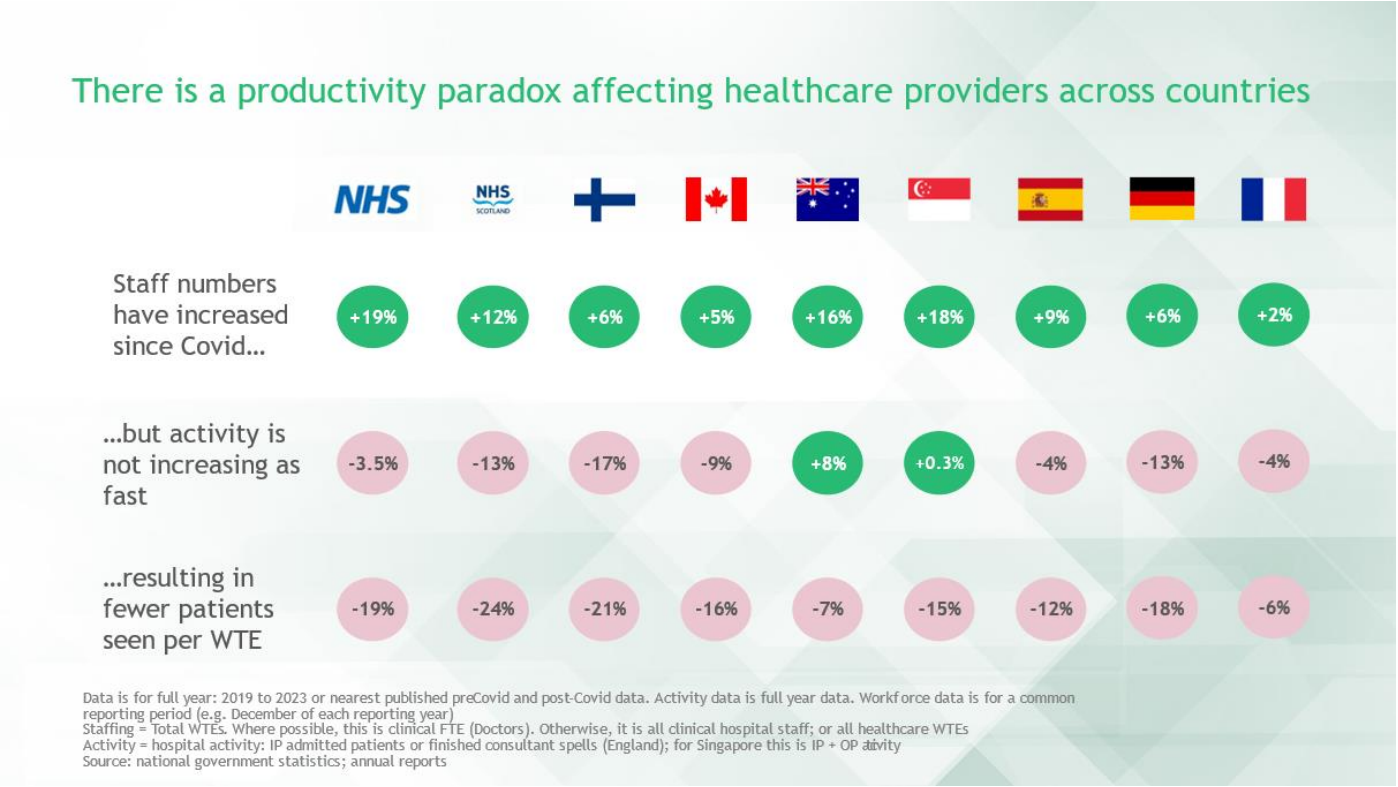
Source: StatsWales, NHS staff summary

Primary Care (GMS) staffing numbers have also increased although materially less so.[54] Across Wales there was an increase of 1.8 FTE staff per practice between September 2021 and September 2024, although the number of practices reduced by 20 (5.1%) in the same period. The largest increases occurred in direct patient contact workers (including Allied Health Professionals and Pharmacists) and administrative/non-clinical groups. However, comparing the same six months periods (April to September) in consecutive years, StatsWales[55] shows a 1.4% reduction in GMS activity from 2023/24 to 2024/25, representing a reduction of almost 136,000 appointments offered in general practice, out of a total of 9.62 million in the same period. The relative increase in hospital staff compared to primary care staff appears counterintuitive in the context of local and national policy "left shifts" from hospital to community and from sickness to prevention.

This overall increase in staffing levels across the Welsh NHS is mirrored in health care systems elsewhere. However, these health care systems are also performing proportionally less work and attending to fewer patients per staff member than they did

[53] NHS Summarised Accounts for 2023/24 gen-ld16720-saesneg-yn-unig.pdf
[54] StatsWales, General practice workforce
[55] StatsWales, General practice activity

five years ago. This trend is evident in the schematic below[56]. It would be surprising if Wales did not exhibit a similar pattern, although a detailed analysis has yet to be published. It is recommended that this analysis should be completed with 3 months of the receipt of this report. This should subsequently be reported quarterly as trend data in the monthly standardised health board performance report.



Recommendation 23
From the June health board meeting cycle of the 2025/26 annual year going forward workforce head count, full time equivalent staffing and productivity data should be reported to the monthly public meeting of each Health Board. This should include data on both directly employed and the GMS and other independent contractor workforce. Timescale – within 3 months.

Leadership development and management training

A step change in productivity will not occur without strong leadership and management, particularly at the level of the clinical service or division within the health boards and trusts. This is invariably driven through a triumvirate of a lead doctor and a lead nurse working alongside a lead manager and increasingly complimented by a lead allied health professional. These triumvirates need to be properly supported and resourced, with appropriate leadership and management development and training.

[56] BCG consulting. National government statistics; annual reports.

Time did not allow the MAG to fully consider and explore the extent to which leadership and management development is appropriately resourced and supported at national, regional and/or local level although undoubtedly there will be much good work in place. We would however recommend that current programmes are reviewed to ensure that they are aligned to the productivity and performance agenda, including the recommendations made elsewhere in this report about waiting list management and the implementation of GIRFT reports.

Recommendation 24
HEIW should work with the PPU to ensure that leadership programmes are in place to support the "threes at the top" of clinical services in health boards and trusts.
Timescale – within 6 months

5.3 Digital and data

Digital

People are increasingly used to interacting digitally with services at work and home through high quality apps and interfaces, but the NHS is not keeping pace with their experiences elsewhere.

Everyone that the MAG spoke to is frustrated by the current state of play. Failing to act will perpetuate the current pattern of fragmentation, inefficiency and slow digital adoption. Conversely, a consistent adoption and use of existing (let alone emergent) technologies would greatly improve operational performance and productivity, through for example electronic test requesting, better waiting-list management and referral management, and the introduction of ambient notetaking. This later intervention can make significant improvements in clinical productivity and reduce cognitive load and the risk of burnout.

Internationally health systems are developing digital systems to help patients access services and to help staff deliver high quality care. Digitisation of the NHS in Wales lags behind comparable national health care systems elsewhere. This is particularly the case for hospitals and community services. This is shown in the results of applying an internationally recognised measure of the adoption of digital systems called HIMSS Electronic Medical Record Adoption Model. All health boards were assessed at level 1 or below against the model (see table on the next page). The highest level of HIMSS adoption is level 7, with 0 being the lowest. Across Europe, the average level of adoption is 2 to 3.

Total HIMSS assessment for Wales including breakdown of aggregate score

	Total		Share by Stage						
Name	**Stage**	**Share**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Cwm Taf Morgannwg UHB	0	42%	64%	52%	61%	35%	40%	38%	38%
Cardiff and Vale University Health Board	1	22%	90%	34%	33%	18%	9%	14%	17%
Morriston Hospital	1	66%	93%	73%	78%	75%	71%	65%	59%
Betsi Cadwaladr University Health Board	1	59%	95%	80%	84%	77%	66%	65%	43%
Velindre Cancer Centre	1	58%	96%	83%	88%	65%	45%	53%	53%
Hywel Dda University Health Board	1	48%	90%	70%	69%	64%	43%	48%	37%
Aneurin Bevan University Health Board	1	47%	95%	81%	74%	45%	39%	39%	40%
Powys	1	47%	94%	48%	59%	32%	44%	43%	42%

Source: Digital Health & Care Wales[57]

The MAG would suggest that a nationally mandated digital health strategy with a realistic investment plan, interoperability standards and AI-driven decision support is crucial to transforming the productivity and performance of the Welsh healthcare system.

The Welsh Government published its digital strategy in 2023. Digital Health and Care Wales (DHCW) was established in 2021 and according to its 2023/24 Annual Report has a budget of £186m[58]. In 2024 it published its Organisational Strategy 2024-2030[59]. A one-page schematic of its strategic objectives is shown on the next page.

[57] The basis for the calculations is from the independent HIMSS EMRAM maturity assessments
[58] DHCW Annual Report 2023-2024
[59] https://dhcw.nhs.wales/files/dhcw-strategies-and-frameworks/digital-health-and-care-wales-organisational-strategy-2024-2030/

As such the issue is not a lack of strategy but a need for urgency in implementation.

The MAG therefore proposes that DHCW is commissioned to produce a road map for the delivery of Missions 2 and 3 of the strategy over a 24-month period. This roadmap should guide investment, with defined delivery milestones and accountability mechanisms, as well as clear roles and appropriate autonomy for health boards and trusts to act to meet local needs.

The roadmap should provide options for an Electronic Medical Record (EMR) for Wales, and it should also give full consideration to the merits of aligning the NHS Wales App with the NHS England App, thereby offering the potential for more rapid progress at lower cost. Until the roadmap is complete, no investment should be made in EMR or App development by any individual health board or trust.

Elsewhere in this report the MAG has recommended the development of a consistent framework for escalation levels within the urgent and emergency care system (see Recommendation 17). This recommendation should be enabled by the development of a “Once for Wales” digital support tool. This should allow for data to flow from health boards to a central system, allowing partners across Wales to manage pressures in real-time with a single version of the truth. This has successfully been achieved in other countries and should form part of this roadmap.

Recommendation 25
NHS Wales should commission from DHCW a comprehensive roadmap for the delivery of Missions 2 and 3 of its Organisational Strategy over a 24-month period, to be published within 6 months. No health board or trust should move forward with any EMR or App development until the roadmap is established. Full consideration should be given to aligning the NHS Wales App with the NHS England App. Timescale – within 6 months.

Data

The MAG was impressed by the quality of the data and the analytical expertise within the NHS Executive and elsewhere in Wales. This data can and should be put to work harder in the interests of improving performance and productivity and should be one of the key tasks for the new Managing Director of the PPU (see Recommendation 19).

The MAG was also pleased to learn that the new Welsh Emergency Care Data Set (WECDS) will be implemented by all health boards with major emergency departments, minor injuries units and same day emergency care services by the end of March 2026 including the delivery of two vanguard sites before or soon after 31 March 2025. It is important that these timelines are met and any obstacles removed.

However, data teams in and across Wales including those within DHCW have been held back from progressing work to support performance and productivity due to the lack of a policy position and framework on data sharing.

For example, primary care data cannot be routinely used for secondary purposes. One result of that is an inability to gain a whole pathway view of the data to inform performance management, resource allocation, quality, value and the transformation of services. In many ways this is the real purpose and prize for the health board integrated delivery model. More broadly, AI technologies to drive automation and productivity cannot be deployed unless there is consolidation of disparate datasets onto a large-scale data platform at the national level.

As such, there is an imperative to make urgent progress on the policy and legislative framework for data sharing.

Recommendation 26
The Cabinet Secretary should work with Ministerial colleagues to address Wales' data sharing policy and associated framework position with a view to accelerating the incorporation of datasets into the National Data Resource. Timescale – within 12 months.

5.4 The regions and capital as levers for change

The strategy for health and care in Wales is detailed in the 2018 'A Healthier Wales: Our Plan for Health and Social Care'. Given the scale of service transformation and

investment required, successful implementation is likely to require a clear route-map with detailed actions for the next one, three, five, and ten-year cycle. This would need to be based around the mission of adopting a population-based approach to prevention, shifting towards primary and community care, and strengthening partnerships, especially with social care. This would involve service transformation at national, regional and health board and trust level.

Although beyond the MAG terms of reference, there are a number of associated steps that could be taken quickly which would have a beneficial short-term impact on productivity and performance, namely developing effective regional planning and delivery machinery and optimising the availability and strategic allocation and use of capital.

Accelerating regional planning

The seven health boards are ideally placed to deliver an integrated care service, working to achieve the Institute for Healthcare Improvement (IHI) triple aim of improving patients experience of care, improving the health of the population, and providing value for taxpayer 'money by continuously reducing the per capita cost of health care delivery.

Currently, the approach to annual planning is based around the health boards. However, challenges to the resilience of a number of services means there is also a need to strengthen the process for planning at a wider regional footprint as it is inevitable that in the future some services will need to be commissioned, organised and delivered at supra-health board level. Otherwise access for patients, patient safety and value for money could be compromised by duplication or sub-optimal scale units.

Although not formally acknowledged in the legislative framework of the NHS in Wales, it is widely recognised that there are de facto three regional NHS geographies, namely North Wales (Betsi Cadwaladr University Health Board), Mid Wales (Powys Teaching Health Board, Hywel Dda University Health Board and Swansea Bay University Health Board) and South Wales (Cwm Taf Morgannwg University Health Board, Cardiff & Vale University Health Board and Aneurin Bevan University Health Board). These have the potential to provide a mechanism for addressing issues that require a supra health board approach.

During the course of the MAG visits and discussions with the health boards there was wide-spread acknowledgement of the need to accelerate regional working, as this was at variable stages of development with limited change in service models across regional footprints. Where formal discussion had started, progress appeared slow given the immediacy of the challenges including a list of seventy fragile services.

In his letter to Health Boards dated 20th December 2024 the Cabinet Secretary says "*I am concerned by some of the challenges that some health boards have faced in reaching agreement with each other on commissioning and providing services across organisational boundaries, and at the slow progress on regional working. This strikes to*

the heart of demonstrating how organisations can work effectively on a collaborative regional and national basis. I expect organisations to be proactive in reaching local agreements on relevant areas through the frameworks that have been set. Where these are not delivered, this will be regarded as a failure to develop a clear plan for the year ahead."

It is the view of the MAG that one of the main challenges lies in the capacity and commitment required, particularly for the health boards given their need to balance this regional work with their day-to-day health board responsibilities. This work is none the less essential and it is recommended that each region should develop focussed annual plans aligned to the performance and productivity agenda and supported by the resources of the PPU. In addition to improving cancer services, there are two other areas that should be a priority.

- **Diagnostic infrastructure** - This is critical to performance and productivity across all four of the focus areas of the MAG terms of reference. As noted elsewhere in this report, these services are fragile, in particular endoscopy and pathology. In this context the NHS in Wales should designate endoscopy and pathology services as the two priority fragile service that need to be addressed at national and regional levels. The specific recommendations on these areas are detailed in the diagnostics section of this report.

- **Fragile services -** At present there are eighteen acute sites in Wales for a population of approximately 3.2 million. Over seventy services are spread over these sites and bodies and are considered to be fragile, with resulting challenges in terms of sustainability, productivity and outcomes. Regional level planning will be required to develop solutions. Plans to transform services should be clinically led, evidence based, data driven, and should engage with Llais at the outset.

Recommendation 27
In addition to pathology and endoscopy (see Recommendations 6 and 7), health boards within each region should work together to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual basis. To facilitate this work, resources and support should be provided by the PPU as required. Timescale – within 12 months.

Capital as a lever for strategic change

Capital can be one of the most powerful levers for change and in other sectors of the economy has been a major driver of productivity growth. Lord Darzi observed about the NHS in England that '*in recent years it appears the NHS has been subject to a kind of capalitsation in reverse and forced to increase labour in relation to capital rather than the other way round.*'[60] One of the constant messages we heard is that the lack of sufficient capital investment in modern buildings, diagnostics and digital infrastructure is a significant barrier to improving productivity and performance. The MAG agrees that

[60] Independent investigation of the NHS in England - GOV.UK

the improvements and the associated service transformation required will not be achievable without short, medium and long-term capital investment.

As in England, NHS Wales has been challenged by having insufficient capital funding to meet service demands and the backlog maintenance bill is currently estimated to be £1.34 billion which is more than twice the annual capital budget and a larger proportion of the NHS budget than that for England.

The recent confirmation of an increase in the capital budget from £479m to £554m for 2025/26 is welcomed. However, unless the trend to increase the capital budget on an ongoing basis continues, it is difficult to envisage how a step change in longer term planning, productivity and performance can be delivered.

Discretionary capital is allocated to organisations, and this has increased from £83m to £100m for 2025/26. There are also a number of targeted investments to improve infrastructure such as emergency departments. These relatively small investments should be increased where possible as they can have a rapid and visible effect and improve patient experience, staff morale and efficiency.

The productivity challenge and the problem of fragile services will also require a strategic approach to investment. Some of these will require regional solutions and these should not be the result of negotiated trade-offs between health boards that avoid contentious issues. Compromise often gives rise to suboptimal solutions and a poor return on capital invested. As such all proposals for regional solutions should be the product of rigorous and independent and clinically led appraisals and include consideration of all options for non-exchequer sources of capital.

The development of a ten-year capital prioritisation framework by Welsh Government working with NHS bodies is positive. This should give a clear sense of the scale of potential capital investment required to meet service demands and their relative priority for NHS bodies. However, tough choices will need to be made. For instance, a greater spend on digital rather than buildings may not be popular but could provide a faster route to service transformation.

It is the view of the MAG that future plans to modernise the infrastructure cannot rely exclusively on an increase in public sector capital. Schemes as MIMs, PPIs, PFIs, leasing, or use of service contacts to leverage private sector capital could and should be further explored. The funding of the new Velindre Cancer Centre through the use of the mutual investment model shows that this can be done, although the availability of revenue funding to support these developments is crucial.

The MAG heard from NHS bodies that there may be scope to boost the capital allocation from the further sales of land or buildings. The MAG understands that NHS Wales has already made substantial progress in improving the utilisation of the estate and disposing of redundant land and buildings. Given the low-rise nature of parts of the NHS estate, this could be a further opportunity as part of longer-term plans. This should also be considered in the context of the broader piece of work looking at estates rationalisation in NHS Wales and maximising the use of public assets for public benefit

through continuing to work collaboratively with public sector partners in areas such as housing and economic development.

Recommendation 28
It is recommended that the health budget capital allocation is uplifted on an ongoing annual basis and is aligned to the annual planning and prioritisation process. Timescale – within 12 months.

Recommendation 29
Reliance on routine capital will not fully meet the capital requirements of service modernisation and transformation across NHS Wales.
Welsh Government should conduct a review of preferred options for generating non-exchequer capital for the Cabinet Secretary to consider ahead of 2026/27 capital round. Timescale – within 9 months.

6 Conclusion

Improvements on productivity and performance will only be delivered if there is alignment between a strong centre working with a collaborative group of health boards and trusts working collectively to a tight set of objectives within a clear accountability framework and a commitment to transparency and 'improving in public'.

In accordance with its Terms of Reference and a self-imposed criteria of short term utility, this report contains 29 recommendations. The implementation of the recommendations will be contingent on pulling the following levers of change to maximum effect:

1. A sharper focus on a tighter list of priorities.

2. The need to accelerate the adoption of validated best practice and to bring those with low levels of adoption close to the current best performers.

3. The importance of applying evidence-based standards for how care is organised and being challenging where this is not implemented.

4. The importance of leadership in making these changes, in particular medical leadership.

5. A greater focus on and improvement in basic operational management processes.

6. Transparent and rigorous accountability arrangements with a streamlined set of meetings – allowing boards and trusts to get on with driving change whilst ensuring that they are efficiently held accountable for performance.

7. Maximising the availability and return on investment of capital and better alignment of financial flows with the objectives of the system.

Annex A

Strategy, policy and planning frameworks taken into consideration by the MAG (only publicly available published documents have links included below):

Welsh Government Framework Documents

NHS Wales Planning Framework 2025-2028 (including letters to Chairs, Key Metrics and enabling actions) – Issued 20 December 2024 - Letter to Chairs: NHS Wales Planning Framework 2025/28; Letter to NHS CEOs: Supporting Governance Arrangements; Annex 1: Key Metrics; Annex 2: Enabling Actions.

NHS Wales Performance Framework 2025-2026 – Published 13 January 2025 - NHS Wales performance framework 2025 to 2026 | GOV.WALES.

NHS Wales Planning Framework 2024-2027 – Published 06 March 2024 - NHS Wales planning framework 2024 to 2027 | GOV.WALES.

NHS Wales Performance Framework 2024-2025 – Published 28 February 2024 - NHS Wales performance framework 2024 to 2025 | GOV.WALES.

NHS Oversight and Escalation Framework – Published 23 January 2024 - NHS oversight and escalation framework | GOV.WALES.

Unified Contract Assurance Framework – Published 02 October 2023 - Unified contract assurance framework: health boards and practices | GOV.WALES; Update provided to MAG 23 December 2024 - Summary Indicators and Weightings 2024.

Welsh Government Statements/Press Releases

Oral Statement: NHS Winter Pressures | GOV.WALES – Published 07 January 2025

Oral Statement: Waiting Times | GOV.WALES – Published 19 November 2024.

Written Statement: Initial response to the NHS Wales Accountability Review | GOV.WALES – Published 12 November 2024.

Written Statement: A Healthier Wales Actions Refresh | GOV.WALES – Published 04 December 2024.

Written Statement: Draft Budget 2025 to 2026 | GOV.WALES – First published 10 December 2024 – Updated 21 January 2025.

Written Statement: Improving Eye Care Services | GOV.WALES – Published 20 December 2024.

Ministerial Advisory Group: NHS Wales accountability review | GOV.WALES – Published 12 November 2024.

A Healthier Wales - Action refresh 2024-25 | GOV.WALES – First published 08 June 2018 – Updated 09 December 2024.

Report of the commission on public service governance and delivery | GOV.WALES – Published 12 August 2014.

Review of Health and Social Care in Wales: final report | GOV.WALES – Published 16 January 2018.

NHS Activity and Performance Summary: October and November 2024 | GOV.WALES – Published 19 December 2024.

NHS Activity and Performance Summary: November and December 2024 | GOV.WALES – Published 23 January 2025.

NHS Activity and Performance Summary: December 2024 and January 2025 | GOV.WALES – Published 20 February 2025.

Senedd Debates

NDM8785 Plaid Cymru Debate - NHS waiting times / Webcast - NDM8785 Plaid Cymru Debate - NHS waiting times – Debated in Senedd 15 January 2025.

Ministerial Summit Reports

Cancer summit: 18 September 2024 | GOV.WALES – Published 23 December 2024.

Welsh Health Circulars

Health board allocations: 2024 to 2025 (WHC/2023/048) | GOV.WALES – Published 08 January 2024.

Health board allocations: 2025 to 2026 (WHC/2024/051) | GOV.WALES – Published 27 January 2024.

Audit Wales Reports

Cancer Services in Wales | Audit Wales – Published 14 January 2025.

Other publications

Reflections on NHS Wales' escalation process: applying the observe, orient, decide and act loop | British Journal of Healthcare Management – Published 07 November 2024.

OECD Reviews of Health Care Quality: United Kingdom 2016 | OECD – Published 12 February 2016.

An Independent Evaluation of Wales' Suspected Cancer Pathway Programme Report | NHS Wales Executive – Published March 2024.

Sowing Seeds: High Performance Organisations | AcademiWales – First published 25 April 2016 – Updated 30 August 2018.

Independent investigation of the NHS in England | GOV.UK – First published 12 September 2024 – Updated 15 November 2024.

NHS England: Reforming elective care for patients | NHS ENGLAND – First published 06 January 2025 – Updated 09 January 2025.

Hospital of the Future: A Framing Paper | REFORM UK – Published 09 December 2024.

NHS England: NHS Delivery and Continuous Improvement Review: Recommendations | NHS ENGLAND – Published 19 April 2023.

Raising NHS capital funds: options for government | NHS Confederation – Published 17 October 2024.

Capital efficiency: How to reform healthcare capital spending | NHS Confederation – Published 11 February 2025.

Documents shared in response to meetings or information requests from members

Inpatient and Outpatient Waiting lists for each Health Board Sept-Dec 2024

Waiting List Information as of 06 January 2025

Diagnostic Analysis - 23 January 2025

Consultant Connect Activity Data Oct 2023 - Dec 2024

Information on the Ministerial decision to establish the NHS Wales Executive

Information on the National Strategic Clinical Networks

Aneurin Bevan UHB Annual Plan 2024/25

Betsi Cadwaladr UHB Three-Year Plan 2024/27

Cardiff & Vale UHB Annual Plan 2024/25

Cwm Taf Morgannwg UHB Three-Year Plan 2024/27

Hywel Dda UHB Annual Plan 2024/25

Powys Teaching HB Integrated Plan 2024/29

Accountability Review - Levers for Change Proposals October 2022

Outpatient Transformation Programme Update - 20 November 2024

Outpatient Transformation from the Medical Directors Forum – 04 October 2024

Eye Care Measures Performance in Southwest Wales – 23 September 2024 - provided by NHS Executive

Swansea Bay UHB Baseline against De-escalation Criteria – 16 October 2024

Swansea Bay UHB Cancer Performance – 21 October 2024 – provided by NHS Executive

Swansea Bay UHB Integrated Quality, Performance and Delivery meeting slide pack – 14 October 2024 – provided by NHS Executive

Swansea Bay UHB Joint Executive Team meeting data pack – 14 November 2024

NHS Leadership Board Organisation Performance Report 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 1: Improved Health & Wellbeing 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 2: More Accessible 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 3: Motivated & Sustainable 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 4: Improvement & Innovation 2024/25 – 22 October 2024

NHS Leadership Board NHS Performance Dashboard – 22 October 2024

Annex B

Members of the MAG engaged with the following people/organisations during their review:

25 October 2024 – Welsh Government. First Minister and Cabinet Secretary for Health and Social Care.

5 November 2024 – Welsh Government NHS Planning Team.

07 November 2024 – NHS Wales Executive Urgent & Emergency Care Six Goals Programme.

07 November 2024 – Welsh Government.

08 November 2024 – Welsh Ambulance Services University NHS Trust.

21 November 2024 – Welsh Government.

22 November 2024 – NHS Wales Executive Urgent & Emergency Care team and Getting it Right First-Time team.

26 November 2024 – NHS Wales Executive Planned Care and Diagnostics team and Welsh Government.

29 December 2024 – NHS Wales Executive Cancer Programme and Welsh Government.

5 December 2024 - NHS Wales Executive, and Welsh Government NHS Finance team.

10 December 2024 – Welsh Government NHS Escalation and Intervention team.

12 December 2024 – NHS Wales Executive Diagnostics team.

13 December 2024 – Welsh Government.

16 December 2024 – NHS Wales Executive Planned Care Programme.

16 December 2024 – NHS Wales Executive Performance & Assurance team.

19 December 2024 – Royal College of Emergency Medicine.

14 January 2025 – Chair of Academy of Royal Colleges.

15 January 2025 – NHS Wales health board Chairs.

15 January 2025 – Welsh Government.

17 January 2025 – NHS Wales Chief Executives.

20 January 2025 – Betsi Cadwaladr UHB external visit MAG.

21 January 2025 – Swansea Bay UHB external visit MAG.

21 January 2025 – Hywel Dda UHB external visit MAG.

22 January 2025 – Cwm Taf Morgannwg external visit MAG.

22 January 2025 – Cardiff & Vale UHB external visit by MAG.

25 January 2025 – Aneurin Bevan UHB external visit by MAG.

27 January 2025 – Chair and Chief Executive of Health Education & Improvement Wales.

28 January 2025 – Chair and Chief Executive of Llais.

29 January 2025 – Welsh Government.

29 January 2025 – Welsh Government, and NHS Wales Executive.

03 February 2025 – Welsh Government.

03 February 2025 – Chair and Chief Executive of Powys Teaching HB.

04 February 2025 – Chair and Chief Executive of Digital Health Care Wales.

06 February 2025 – Chair and Chief Executive of Welsh Ambulance Services NHS Trust.

06 February 2025 – Welsh Government, and NHS Wales Executive.

06 February 2025 – Chair and Chief Executive of Velindre University NHS Trust.

07 February 2025 – NHS Wales Executive Planned Care Programme.

11 February 2025 – Chair and Chief Executive of Public Health Wales.

12 February 2025 – Welsh Government.

17 February 2025 – National Clinical Lead for Cancer and NHS Wales Executive Cancer Strategic Network.

20 February 2025 – Welsh Government and Cabinet Secretary for Health and Social Care.

21 February 2025 – NHS Wales Health Collaborative.

21 February 2025 – Welsh Ambulance Services University NHS Trust.

28 February 2025 – NHS Wales Health Collaborative.

07 March 2025 – Welsh Government.

10 March 2025 – Welsh Government.

10 March 2025 - Welsh Government.

11 March 2025 - Welsh Government.

18 March 2025 – Welsh Government.

19 March 2025 – Cabinet Secretary for Health and Social Care.

Annex C

Suggested locations for surgical hubs

Number of Theatres at Existing Hubs and/or Non-Acute Elective Sites and Sites in Development: [61]

Region	Site	In Patient (IP) Day Case (DC)	Theatres	%	In Development	Theatres
North	Abergele	IP	4	10	Llandudno IP	2
	Llandudno	DC	1			
	Total		***5***			
South East	Llandough	IP/DC	11	41	Llantrisant Health Park IP/DC	12
	Nevill Hall	IP/DC	3			
	St Woolos	IP	2			
	Ystryd Fawr	IP&DC	4			
	Total		***20***			
South West	Neath Port Talbot	IP/DC	7	45		
	Prince Phillip	IP/DC	6			
	Singleton	IP/DC	9			
	Total		***22***			
Powys	Brecon	DC	1	4		
	Llandrindod	DC	1			
	Total		***2***			
Grand Total			**49**			14

[61] Source: Elective Optimisation Audit 2024. Caveat - interpretation applied to data provided

Annex D

Operating Principles for Surgical Hubs

All Surgical Hubs must meet strict criteria of operation which includes:

- Use GIRFT documents to guide the setting up and running of the surgical hubs and the best use of theatre staff.
- Define the number of cases per list for Orthopaedics, Spines, Urology, Gynaecology, ENT, Ophthalmology and General Surgery at GIRFT standards.
- Develop best practices in theatre productivity, with theatre utilisation capped at 85%.
- Extend theatre start times and finish times; utilise the whole day from 08.30-17.00 daily with capped theatre utilisation at 85%.
- Develop pathways to achieve best-in-class length of stay (LoS), such as hip and knee replacements with a LoS of less than two days, while increasing the number of day cases.
- Conduct pre-operative assessments using questionnaires, ensuring that only patients requiring face-to-face evaluations are seen.
- Establish a pool of patients prepared to be admitted across hub sites to minimise same-day cancellations and optimise the utilisation of available spaces.

Annex E

Comments from Chief Executives NHS Wales

National system

- Provide a clear operating framework describing the role of the NHS Executive and its relation to Health Boards/Trusts with regard to oversight/performance management/delivery assurance
- Streamline the various national groups/boards overseeing performance with the NHS Leadership Board being the single place to oversee quality/performance/finance at a national level. Below this hold NHS organisations to account through monthly meetings to review the same topics at a local level thus streamlining the multiple local assurance meetings currently in this space.
- Consider a role for a National Medical Director who has experience in direct service delivery and medical leadership who will drive and lead the national discussions with medical staff and support difficult service/clinical change discussions
- Align expectations of efficiency and productivity in the planning framework for NHS organisations to ensure clear expectations of adoption of agreed clinical standards e.g. GIRFT/INNU
- Design an up to date model for counting/paying for activity which sets a standard 'price' for activity against which health boards can assess their own efficiency/cost effectiveness. This would also support the move to more regional working.

Cancer

- Establish a single overarching cancer board to provide a coherent vision, strategy and policy position on all aspects of Cancer in Wales, supported by a single national delivery group led by the service (Health Boards / Trusts) and responsible for driving performance improvement, with regional and local sub-structures as required, taking into account the various models currently in use elsewhere across the UK.
- Consider whether Velindre University NHS Trust should (as the provider of the largest dedicated cancer centre in Wales) collaborate more with and explore opportunities for learning from the NHS England Cancer programme and be more aligned to the way in which the Clatterbridge, Royal Marsden and Christie support at a national and regional level.
- Consider (designed with input from experts at a UK level) delivering an operational development programme for COOs and ops managers across the statutory health bodies, to equip operational leaders with the latest skills and proven techniques in delivering cancer performance improvement.
- Consider whether there should be a dedicated cancer / USC diagnostic service, or at least protected capacity and pathways for USC pathway patients

Unscheduled Care

- Develop a plan to move to the 'Scheduled Emergency Care' model which senior leaders from NHS Wales have experienced in Denmark. This model has potential to unlock capacity issues in EDs, improve performance and encourage greater citizen responsibility.
- Develop shared performance scorecard for health and social care which holds both Health Boards and Local Authority for whole system performance.

Workforce

- Establish an Ops Academy to provide consistent training for operational managers/clinical leaders to ensure consistency of approach to waiting list management/flow management as well as best practice on service redesign and efficiency and productivity
- Consider how clinicians can be incentivised through contractual models to focus on productivity and efficiency i.e. moving away from time-based contracts for the elective part of their work

Digital and Data

- Prioritise investment to accelerate deployment of an Electronic Patient Record system across organisations to improve efficiency and productivity of staff and as a means to standardise pathways as well as providing better activity and outcomes data
- Set Digital Maturity targets for NHS Wales, which would in the short term, improve the uptake of the functionality already available such as electronic prioritisation of referrals and electronic test requesting which deliver efficiencies and provide opportunities for re-direct and demand management, reducing variation.
- The current policy environment does provide the levers needed to easily share information compliantly. Prioritise the development of digital and data policy for NHS Wales in order to collect, store and share data and information to support patient care, operational management, strategic planning, benchmarking and performance improvement and population health management. This will need to include overcoming the barriers to the sharing of primary care data as a matter of urgency.
- Expand the information and functionality available in the NHS Wales App to enable interaction between patient and clinician to shift to digital channels
- Implement plan for effective pan Wales and pan UK benchmarking to support performance improvement through an agreed range of datasets i.e. a 'model system' or something similar

Estates and Infrastructure

- Consider how the NHS could work with infrastructure partners to maximise opportunities with existing estate as well as exploring alternative models of capital funding to support improvements and new built infrastructure.