Waiting List Management

Final Internal Audit Report

2024/25

Cardiff and Vale University Health Board

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Executive Sign Off	July 2025
Audit Committee	September 2025
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Executive Summary

Purpose

The review of Waiting List Management was completed in line with the 2024/25 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

Overview

During 2020/21, planned care services had to be paused to allow the NHS to respond to the immediate demands and challenges of the COVID-19 pandemic. This, along with other factors such as a rise in referral rates and worsened population health because people have not accessed services in recent years, has inevitably resulted in longer waiting lists and increased waiting times for diagnostics and treatment.

The Welsh Government published, 'Our programme for transforming and modernising planned care and reducing waiting lists in Wales' (April 2022)[1]. As a result, recovery targets were set which are required to be regularly monitored and reported on by the Health Board. All Health Boards must ensure that they have appropriate systems in place to capture the information necessary to meet and report on these requirements.

The Health Board has made measurable progress against its 2024/25 commitments, reducing 104-week waits to 1,632 patients by April 2025, below the target of 1,800. Diagnostic waits, while still high, have also improved, with 14,750 patients waiting over eight weeks compared to a target of 15,052. However, the 2025/26 ministerial priority of eliminating 104-week waits and achieving full compliance with the 8-week diagnostic standard presents a significant challenge.

We have concluded **reasonable** assurance on this area. We note that the Health Board still has very high waiting list numbers, however, our assurance rating reflects the fact that the processes in place for recording, managing and monitoring the waiting lists are generally effective.

The significant matters requiring management attention include:

- Staff receive training and have access to a number of guides on how to use the Patient Management System (database for waiting lists). However, we note that there is no formal process to assess or ensure understanding and correct application of the rules and validation of waiting lists.
- The current use of multiple patient prioritisation frameworks across service areas risk inconsistent scheduling, and standardisation is recommended to protect the "treat in turn" principle.
- Whilst there are arrangements in place to validate waiting lists, there is a lack of a structured system to report on trends/share lessons learnt from the outcomes of validation exercises.
- The Waiting Well Support Service has established a strong support model for long-wait patients, but its impact is currently restricted to a few specialties due to resource limitations, delaying broader rollout to other high-demand areas.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Updated RTT (Referral to Treatment) guidance was issued by Welsh Government in April 2025 but the Health Boards intranet site still references the 2017 RTT rules.

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[1] Our programme for transforming and modernising planned care in Wales and reducing the waiting lists (gov.wales)

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	Waiting lists are in place that are maintained and up-to-date, with adequate controls to detect where patients are on several pathways.	1	**Reasonable**
2	Effective arrangements are in place for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation).	2	**Reasonable**
3	Effective action plans and monitoring arrangements are applied to reduce the waiting times for patients, with appropriate reporting to the Health Board and Welsh Government.	3	**Reasonable**
4	Adequate arrangements are in place to communicate with patients waiting for health care services, including the offer of additional support if required.	4	**Reasonable**

Findings & Agreed Action Plan

Objective 1: Waiting lists are in place that are maintained and up-to-date, with adequate controls to detect where patients are on several pathways.	**Reasonable**

Overview / Summary of Observations

Our fieldwork confirmed that the Health Board has a comprehensive suite of policies, procedures, and training materials aligned with the Welsh Government's 2025 Referral To Treatment (RTT) rules. These include clear guidance on referral handling, prioritisation, review frequency, and managing patients on multiple pathways. The Health Board's intranet hosts a dedicated RTT webpage, which outlines operational processes and staff responsibilities. Although the intranet site still references the 2017 RTT rules, updated RTT guidance has been issued by Welsh Government in April 2025.

Responsibility for waiting list management is shared between the Central Validation Team (CVT) and operational service areas. The CVT performs quality assurance work on waiting lists to ensure RTT compliance. At the directorate level, service managers, clinic coordinators, and booking clerks manage referrals, validate data, and track RTT pathways. This dual structure ensures both central oversight and local responsiveness, allowing for specialty-specific workflows while maintaining adherence to national standards.

The primary system used is the Patient Management System (PMS), which records referrals, tracks RTT pathways, and schedules appointments. We note that Ophthalmology, one of our three sampled service areas, also uses the Open Eyes system for clinical prioritisation and pathway management. These systems are integrated with features such as automated RTT clock controls, colour-coded breach alerts, and referral linking to prevent duplication. This digital infrastructure supports real-time, accurate tracking of patient journeys.

PMS is supported by quick guides and e-learning modules, ensuring staff are trained in referral validation, RTT clock management, and communication protocols. Training materials, SOPs, and user guides are available on the Health Board's intranet, ensuring accessibility and regular updates.

However, despite the availability of training resources and system guides, there is currently no formal mechanism in place to assess staff's understanding or ensure the correct application of RTT rules and validation procedures in practice. This gap presents a risk to data quality and consistency, particularly given the complexity of RTT pathways and the importance of accurate waiting list management.

Key Findings		Risk & Impact	Agreed Management Action
1	**RTT/Waiting List Validation training** The Health Board has developed a wide range of quick reference guides and e-learning modules to support staffs understanding of Referral to Treatment (RTT) rules. However, there is no consistent or formal mechanism in place to assess, record, or evaluate staff comprehension and application of these rules in practice and of the steps to be followed during the validation of waiting lists.	Inconsistent application of RTT rules across departments. Reduced data quality and inaccurate RTT clock starts/stops.	**Agreed Action:** The Health Board will implement a formal and consistent process to assess and record staffs understanding of RTT rules following training. This will include mandatory assessments, periodic refresher evaluations, and integration of results into performance reviews. Doing so will provide assurance that staff are equipped to apply RTT and waiting list validation principles accurately and consistently.

	This gap mirrors a similar issue identified at Swansea Bay UHB, where training was delivered but staff lacked foundational knowledge, impacting data quality and pathway management.	Delays in patient treatment due to mismanaged pathways. Increased risk of non-compliance with national targets. Reputational damage and potential regulatory scrutiny.	**Expected Evidence of Implementation:** RTT/Waiting list validation training – noting that this has now been done through a combination of the new RTT rules coming into effect in April 2025 and also the HB learning from its end of year validation process.
		Medium Priority	**Officer:** Catherine Wood – Managing Director of Planned Care **Target Implementation Date:** Complete
	Theme: Training & Development	Control Design	

Objective 2: Effective arrangements are in place for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation).	**Reasonable**

Overview / Summary of Observations

Discussions with staff from across our sampled areas of General Surgery, Ophthalmology and Orthopaedics and a review of the records held within the PMS database confirmed that patient risk reassessment and the clinical prioritisation across services are primarily clinician-led, focusing on those with the longest waits or those flagged through clinical or administrative triggers. High-risk conditions are prioritised, and patients are clinically vetted at referral and again during validation exercises, particularly for long waiters. Daily or weekly reviews of system-generated reports help identify patients needing urgent attention. While some areas involve clinicians more actively, others rely on administrative staff for routine validation, with clinical input as needed.

Classifications within the PMS system allow for a two-tier grading with "Urgent" or "Routine". Some services also reference national prioritisation frameworks (such as the Royal College of Surgeons). Walkthroughs with staff from our sampled areas determined that risk is assessed based on condition type and urgency, with clinical notes reviewed to support decision-making. Initial vetting is typically clinician-led, while ongoing validation may be managed administratively, with clinicians consulted for specific cases or concerns.

All prioritisation activity is documented within the patient management system, which tracks urgency codes, referral dates, and clinical notes. Communication with patients is facilitated through template letters and automated workflows, ensuring documentation is stored and accessible.

The frequency of reassessment varies by urgency. Urgent cases are reviewed more frequently or prioritised for immediate booking, while routine cases are typically reviewed every six months in line with national guidelines. Triggers for reassessment include patient deterioration, extended waiting times, administrative validation cycles, and new clinical information.

Evidence of frequent review and reprioritisation includes daily or weekly validation processes, regular performance meetings, and clinician-led prioritisation. Sample testing of 30 patient pathways (10 from each speciality) confirmed that risk assessments and prioritisation were consistently performed by clinical staff, with documentation recorded in the system. While some areas do not use national prioritisation standards, all samples reviewed showed recent validation and appropriate assignment of priority.

As detailed above the Health Board service areas use a mix of prioritisation methods—including the traditional Urgent/Routine classification and the Royal College of Surgeons' categories—which can create confusion when allocating appointments and challenge the consistency of the "treat in turn" principle. While audit sample testing did not identify any instances where patients were treated out of turn, the coexistence of multiple prioritisation frameworks presents a potential risk to equitable and timely patient care.

Key Findings		Risk & Impact	Agreed Management Action
2	**Prioritisation methodologies** Sample testing and discussions with key leads across our sampled service areas identified the Health Board continues to use the Royal College of Surgeons (RCS) clinical prioritisation matrix, a framework introduced during the COVID-19 pandemic. While this model was appropriate during emergency response phases, its ongoing use alongside the traditional Urgent/Routine	Inconsistent patient prioritisation frameworks pose a risk to equitable scheduling.	**Agreed Action:** The Health Board will standardise the use of patient prioritisation frameworks across all service areas or clearly define how multiple systems should be applied in practice, to ensure consistency in scheduling and safeguard the integrity of the "treat in turn" approach.

	classification may now be skewing waiting list management. For example, a patient previously categorised as Priority 3 under the RCS matrix could be overtaken by a newly referred Priority 2 patient—despite both being considered 'routine' under the standard model—potentially disrupting the fairness of the "treat in turn" principle. Although no breaches were identified in our audit testing, this dual system presents a risk of inconsistent prioritisation and scheduling.		**Expected Evidence of Implementation:** Removal and stop use of RCS methodology
		Medium Priority	**Officer:** Catherine Wood – Managing Director of Planned Care **Target Implementation Date:** 30th September 2025
	Theme: Quality, Safety & Patient Experience	Control Design	

Objective 3: Effective action plans and monitoring arrangements are applied to reduce the waiting times for patients, with appropriate reporting to the Health Board and Welsh Government.	**Reasonable**

Overview / Summary of Observations

The Health Board has established a comprehensive governance framework to monitor and manage patient waiting times, with clear reporting lines both within the Health Board and to Welsh Government. A review of the Corporate Risk Register as of May 2025 confirms that long waits are recognised as a significant clinical risk, these risks underscore the importance of robust validation processes and prioritisation mechanisms to mitigate potential harm.

Monitoring arrangements are embedded across multiple levels of the organisation. Waiting time performance, particularly breaches of the 104-week referral-to-treatment target and the 8-week diagnostic standard, is consistently reported through Integrated Performance Reports. These are reviewed at Board level, the Finance and Performance Committee, and the Senior Leadership Team. Weekly operational meetings are held for high-risk specialties, including ophthalmology, general surgery, and orthopaedics, where performance data is scrutinised and actions are tracked.

The Health Board has made measurable progress against its 2024/25 commitments, reducing 104-week waits to 1,632 patients by April 2025, below the target of 1,800. Diagnostic waits, while still high, have also improved, with 14,750 patients waiting over eight weeks compared to a target of 15,052. However, the 2025/26 ministerial priority of eliminating 104-week waits and achieving full compliance with the 8-week diagnostic standard presents a significant challenge.

To support these goals, a range of initiatives have been implemented. These include direct listing of cataract referrals following administrative triage, overbooking outpatient appointments to offset non-attendance, protecting planned care capacity from unscheduled pressures, and improving theatre utilisation through better scheduling and high-volume, low-complexity lists. These actions are supported by ongoing validation efforts and pathway redesigns, such as See on Symptoms and Patient Initiated Follow-Up models.

Reporting mechanisms are well-established, and there is evidence of responsive action when performance deteriorates. While progress is evident, sustained focus is required to address persistent pressures in key specialties and to meet the ambitious targets set for the coming year.

While validation processes are in place and central validation teams are actively identifying common errors in service-led validation, there is currently limited formal reporting or thematic analysis of these recurring issues. Embedding a structured lessons learned approach — including regular reporting on common validation errors and sharing insights across specialties — could enhance consistency, reduce rework, and support continuous improvement in waiting list accuracy and prioritisation.

Key Findings		Risk & Impact	Agreed Management Action
3	**Data quality feedback loop/Lessons Learnt** The central validation team plays a critical role in identifying and correcting errors in waiting list data submitted by service areas. While the team is aware of recurring issues—such as incorrect RTT clock starts, misclassification of patient priority, and incomplete pathway information—there is currently no formal mechanism for reporting these trends or sharing lessons learned	Insufficient monitoring / inaccurate record keeping.	**Agreed Action:** The Health Board will develop a structured reporting mechanism within the central validation function to capture, analyse, and disseminate common validation errors and data quality issues identified during routine checks. This should include: • A quarterly summary report of recurring validation issues by specialty;

	across specialties. The absence of structured feedback loops limits the Health Board's ability to drive consistency, reduce repeat errors, and improve the overall quality of waiting list data. Although we have sighted evidence of waiting list validation taking place, the opportunity to use this intelligence to inform training, improve data entry practices, and strengthen local validation processes is not being fully realised. This gap is particularly relevant given the scale of the waiting list challenge and the reliance on accurate data to support prioritisation, performance reporting, and patient safety.		• Thematic analysis to identify root causes and trends; • Targeted feedback to service areas with recommendations for improvement; and • Integration of findings into training and guidance materials for local validation teams This approach would support a culture of continuous improvement, enhance data quality, and strengthen the Health Board's ability to manage waiting lists effectively and equitably.
			Expected Evidence of Implementation: Quarterly validation report to be shared with the senior Leadership Team
		Medium Priority	**Officer:** Catherine Wood – Managing Director of Planned Care **Target Implementation Date:** 30th September 2025
	Theme: Lessons Learnt	Control Design	

Objective 4: Adequate arrangements are in place to communicate with patients waiting for health care services, including the offer of additional support if required.	**Reasonable**

Overview / Summary of Observations

The Health Board has developed a structured and patient-centred approach to supporting individuals on long elective waiting lists through its Waiting Well Support Service (WWSS), prepare well and prehab2rehab services. These initiatives align with the Welsh Government's "Promote, Prevent and Prepare" directive and aims to provide proactive communication and tailored support to patients waiting over 104 weeks.

These support services do not manage waiting lists directly but they receive extracts from specialty teams to identify patients requiring contact. Communication is typically initiated via the bilingual Envoy text messaging system, with follow-up by phone or email where appropriate. The WWSS team uses a bespoke module within the PARIS system to record patient interactions, although integration with PMS remains limited. While the WWSS has only recently transitioned to using PARIS, efforts are underway to centralise data and improve visibility across systems.

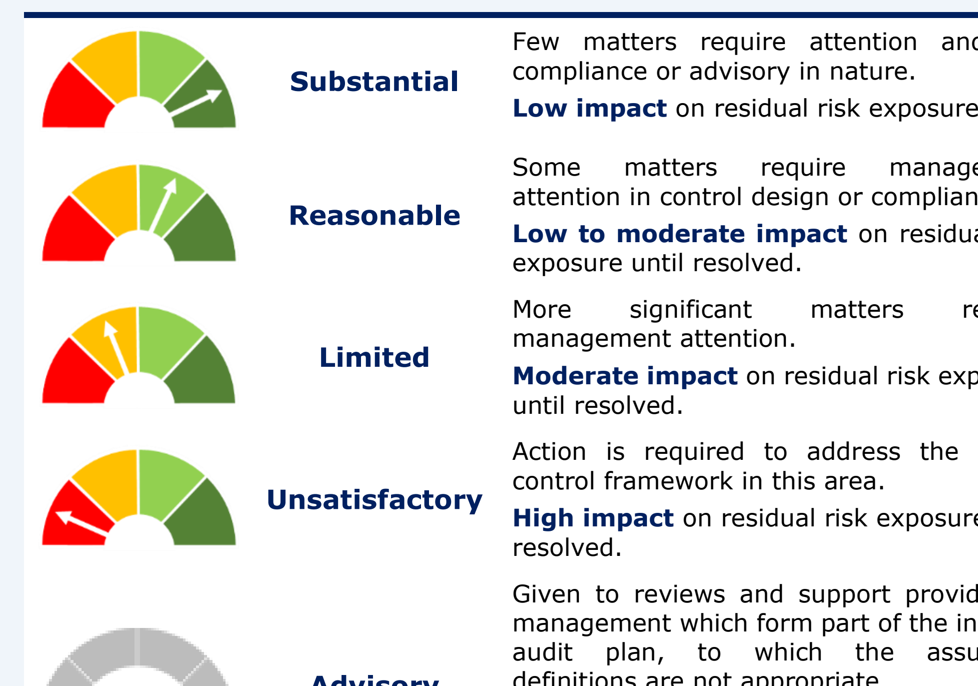
Our audit included meetings with key staff, including a clinician from the WWSS, and a review of 10 patient records from General Surgery. All sampled patients had been waiting over 104 weeks. The purpose of the testing was to confirm that the WWSS had made contact attempts, rather than to assess completion of health questionnaires, as the service operates on a self-referral basis. In all cases, we found evidence that the WWSS had reached out via text. Where patients responded, the team followed up with health questionnaires and appropriate support.

We note that the WWSS is also not operating across all specialties at the moment, although plans are in place to expand to high-demand areas like spinal surgery.

Key Findings		Risk & Impact	Agreed Management Action
4	**Waiting Well Support Service remit expansion** The Waiting Well Support Service (WWSS) at the Health Board was launched in October 2024 as a proactive initiative to support patients experiencing long waits for elective care. While the service has made commendable progress in establishing a structured communication and support model, its current scope is limited to a small number of specialties—namely General Surgery (hernia and gall bladder), Orthopaedics (hip replacements), and more recently, total knee replacements. Discussions with the WWSS team confirmed that this limited coverage is due to capacity constraints and the sheer volume of patients on waiting lists. Plans are in place to expand the service to other high-demand areas, such as spinal surgery and gynaecology, but these have not yet been implemented.	Patients in high-risk specialties may continue to deteriorate without support. The Health Board may face increased complaints and reputational risk.	**Agreed Action:** The Health Board will prioritise a phased expansion of the WWSS, beginning with specialties that have the longest waiting times and highest clinical risk—such as spinal surgery and ophthalmology. This should be supported by a resource plan to ensure adequate staffing and digital infrastructure. A benefits realisation framework should also be developed to evaluate the impact of the expanded service and inform future scaling. **Expected Evidence of Implementation:** Rollout of WWSS and expansion of peri-operative optimisation offers
		Medium Priority	**Officer:** Catherine Wood – Managing Director of Planned Care and Emma Cook - Deputy Director of Therapies & Health Science
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 30th September 2025

Appendix A

Assurance Opinion



Opinion	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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