Theatres Utilisation

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

Reasonable Assurance

Contents

Review Reference	SBU-2526-15
Fieldwork	June - August 2025
Executive Sign Off	30 September 2026
Audit Committee	20 November 2025
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Executive Summary

Purpose

To determine if adequate systems and controls are in place to ensure that theatre resources are efficiently and effectively utilised.

Overview

Swansea Bay University Health Board's (the health board) strategic ambitions for theatre services were outlined in its Clinical Services Plan (CSP) 2019–24. The CSP committed to remodelling surgical services by expanding planned surgery provision beyond Morriston Hospital and establishing distinct centres of excellence across its acute sites. Although the CSP referenced a Surgical Efficiency Optimisation Programme, its delivery appears to have been disrupted by the operational demands of the Covid-19 pandemic, with no further references identified. In 2023/24, responsibility for the operational management of theatres was transferred from the Morriston Service Group to the Neath Port Talbot Singleton Service Group.

A review of the health board's Annual Plan for 2024/25 identified 27 theatre-related Goal Method Outcome (GMO) entries spread across service groups, divisions, and specialties. The 2025/26 Annual Plan demonstrates increased clarity and strategic focus, with specific delivery actions (a health board change from the previous GMOs) under Planned Care, including Sustainable Surgical Pathway Redesign and Theatre Board Programme Delivery.

To support the above, the health board established the Surgical Pathway Delivery Programme (April 2024), applying healthcare systems engineering principles and a workstream approach to improving theatre productivity. The programme has introduced a tiered governance structure (strategic, operational, and process-focused groups) and sought to implement standardised scheduling practices, notably through the approval of the 6-4-2 Standard Operating Procedure (SOP). These initiatives have led to measurable improvements in some areas, including increased theatre activity within Neath Port Talbot theatres by 25%; and, from February 2025, there has been enhanced data transparency through the development and roll out of the Surgical Pathway Dashboard.

Despite these advancements, challenges remain. Issues in clinical engagement and resource constraints have affected the delivery of some programme components. While recognising the early stages of several governance mechanisms, further development is needed to ensure their effectiveness in driving theatre efficiencies and sustaining progress. Our review identified the operational, or 'ground-up', approach to uncovering opportunities for improved utilisation of existing capacity. However, future success will also depend on the health board clearly articulating its strategic direction and further defining the distinct roles and service profiles of its acute hospital sites to ensure alignment and coherence in optimising theatre usage.

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- The Theatres Quality and Safety Standards Framework remains unratified, with no progress towards implementation since its draft circulation in September 2024.
- Lack of formal attendance records and written updates limits oversight of both the Theatre Operational and Theatre Scheduling groups and compliance with new scheduling standards. Limited capacity within the theatre management structure and transformation support could impact the operation of new groups and processes.
- The Theatre Performance Framework lacks clarity of roles, responsibilities and implementation plans. There is no agreed set of indicators to inform future reporting. Incomplete submissions and limited actions in newly introduced service reports were also noted.
- Inconsistent attendance and failure to meet quorum requirements at the Theatres Board risk undermining it's decision-making and governance effectiveness.
- There is no structured reporting mechanism from Theatres Board to the Urgent and Emergency Care Board which may result in missed escalation or lack of sight of theatres developments.
- There are a number of associated supplementary scheduling SOPs which are to be developed, and it is unclear which are to be progressed, which could result in continued reliance on informal arrangements.
- High use of vague categories like "Other" and missing narrative detail in dashboard reports hinder effective root cause analysis of theatre delays.
- Inconsistent use of RAG ratings and milestone tracking weakens programme oversight and progress monitoring.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

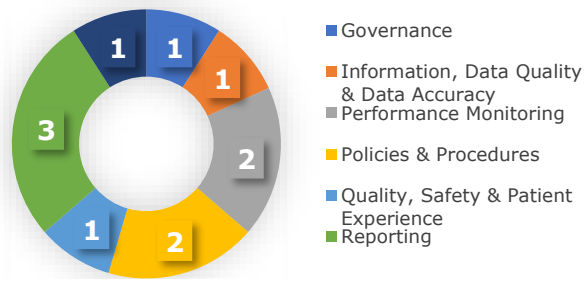
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Appropriate governance arrangements have been established to ensure the efficient use of theatre resources.	1, 2, 3, 4	**Reasonable**
2	Approved policies and procedures support the effective use of theatre resources, include clear roles and responsibilities, and are available to staff.	5, 6, 7	**Limited**
3	Key performance indicators are in place to monitor the efficiency and productivity of theatres, specifically in relation to utilisation, with actions to support improvement where required.	7, 8,	**Reasonable**
4	Mechanisms are in place to ensure the quality of data used for monitoring.	9	**Reasonable**
5	There is an appropriate framework in place for the reporting of theatre utilisation.	10, 11	**Reasonable**

Management Actions

1
High Priority

10
Medium Priority

Themes



Risk Types

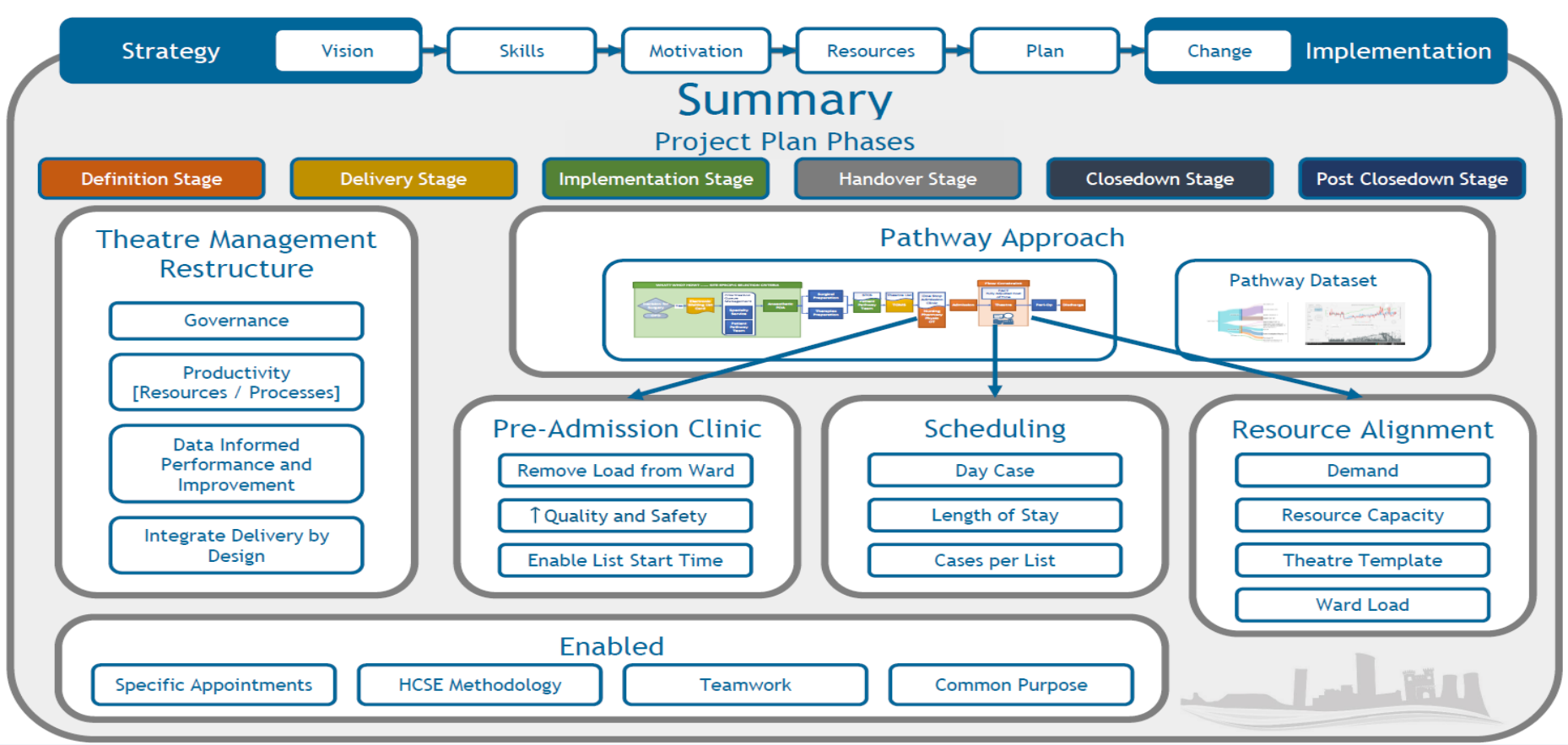
Quality or Safety Issues

Public Perception & Reputational Risk

Choose an item.

Choose an item.

At a glance - Surgical Pathway Delivery Programme scope/summary



Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements have been established to ensure the efficient use of theatre resources.	**Reasonable**

In April 2024, the Executive board approved the establishment of a Surgical Pathway Delivery Programme ('the programme'), supported by the health board's Transformation Office, to align with national expectations to optimise usage of theatres. The programme is being delivered through health care systems engineering principles (the 6 A's: Map, Measure, Model, Modify, Monitor, Maintain) and seven supporting workstreams have been established:(1) resources (including workforce, theatre environment, equipment), (2) scheduling and performance, (3) quality and safety, (4) data and digital, (5) finance, (6) service development, and (7) improvement. The programme presentation to the Executive board included a high-level outline of scope, purpose, methodology, measures, and membership for each workstream, emphasising the need to understand the pathway relationships in order to deliver improvements in theatre productivity.

Through the above programme there has been establishment of a Theatres Board ('TB', June 2024), Theatres Operational Group ('TOG', May 2025), and Theatres Scheduling Group ('TSG', January 2025), with TB having oversight of all programme workstreams; and TOG and TSG focused on areas of productivity and efficiencies. Terms of Reference (ToR) were available for each, although those for TOG were still to be approved in final by TB at the date we concluded our audit fieldwork. Review of ToR for each group found they were consistent in setting out each group's role, purpose, membership, meeting frequency, and reporting arrangements.

Review of papers and minutes for TB (June 2024 – July 2025) noted clinical attendance has impacted its quoracy, resulting in two meetings being cancelled (see **Key Finding 1**). We have been unable to verify quoracy and attendance at TOG and TSG meetings, despite ToRs requiring attendance records (see **Key Finding 2**). Additionally, while a summary of queries and proposed changes is circulated to the TSG membership after each meeting, there is no schedule of changes provided to TOG in line with its ToR (see **Key Finding 2**). We also identified that whilst TB reporting to the Planned Care Programme Board is well established (see objective 5), there are no mechanisms for reporting or escalation to the health board's Urgent and Emergency Care Board (see **Key Finding 3**), which may limit visibility of theatre developments. Whilst a governance framework has been established, management advised that there have been examples identified of actions and decisions which impact theatres being made outside of these groups.

Discussions with theatres management highlighted limited capacity within their structure to sustain all required operational and governance processes established to support scheduling, particularly when the transformation team support is redirected to other areas of the programme. Whilst informal, we were informed that a benchmarking exercise undertaken against scheduling resources in neighbouring health boards suggests that the health board may be under-resourced in this area. Additionally, a recent Audit Wales review of Planned Care arrangements[1] identified similar constraints within the transformation team's capacity (see **Key Finding 4**). At the TB meeting in June 2025, it was agreed that the Associate Medical Director for Transformation would undertake an evaluation of the programme to date and risks to programme delivery, with findings to be circulated to relevant Executives.

The Audit Wales review also identified a need for consistent approaches to demand and capacity planning, and completion of recommendations from Getting it Right First Time (GIRFT)[2] reports. Our review has identified similar themes, noting that while there is a focus on programme workstream delivery, work has not yet progressed to review activity delivered against planned objectives; and we have not duplicated these recommendations.

[1] Tackling the Planned Care Challenges – Swansea Bay University Health Board (Issued May 2025)

[2] Getting It Right First Time (GIRFT) is a national programme led by NHS England aimed at improving the quality of care and operational efficiency across NHS services, including theatres.

Key Findings		Risk & Impact	Agreed Management Action
1	**Theatre Board quorum and attendance compliance** Quoracy requirements include '*meetings must involve a minimum of 50% membership including at least the Chair, or deputy; a clinical lead representing at least five specialties, and representation from Finance.*' During the period reviewed (June 2024 to June 2025), two meetings (April 2025, July 2025) were cancelled due to the number of apologies received. Additionally, five meetings (June 2024, July 2024, November 2024, December 2024, and May 2025) were non-quorate due to the absence of clinical leads or directors from at least five of the required specialties. Notably, there was no attendance from the Clinical Director for Women and Children's Health across the period. Attendance was limited from other key roles including the Assistant Director of Operations for Urgent and Emergency Care (no attendance), the Executive Sponsor (Deputy Executive Medical Director – attended one meeting), and the Morriston Service Group Director (attended one meeting). The ToR also requires a Therapies representative to be included within its membership; however, no representative has been confirmed.	Lack of engagement undermines the Theare Board's effectiveness and confidence in decision making.	**Agreed Action:** • Review Terms of Reference for Theatres Board as part of the wider review into the Surgical Pathway programme • By November 2025, approve revised ToR confirming required membership and quorum. • From December 2025, maintain an attendance tracker and escalate any non-quorate meetings to the Chief Operating Officer within 5 working days. • Establish escalation protocols for non-quorate meetings. • Ensure Therapies representation is formally appointed. **Expected Evidence of Implementation:** • Revised Terms of Reference agreed and signed by service groups • Attendance tracker and escalation records in place for non-quorate meetings • Therapies representative appointed • Tracker in place and added to notes of meetings
		Medium Priority	**Officer:** Mark Davies Theatre Board Chair & Associate Medical Director, Surgery Division, in conjunction with Rhodri Davies, Associate Service Group Director, Surgery Division **Target Implementation Date:** 31 January 2026
	Theme: Governance	Control Operation	
2	**Theatre Operational Group & Theatre Scheduling Group – Weaknesses in meeting administration and information flow** The ToR for both the Theatre Scheduling Group (TSG) and Theatre Operational Group (TOG) require that meeting attendance be formally recorded. However, this process is not currently in place for either group.	Lack of attendance records may not highlight disengagement and reduce accountability. Informal reporting limits transparency,	**Agreed Action:** • Implement formal attendance recording for both TOG and TSG meetings and a written fortnightly update by October 2025**.** • Audit compliance quarterly beginning from January 2026.

Key Findings		Risk & Impact	Agreed Management Action
	Additionally, the TSG is expected to provide the TOG with a documented schedule of theatres use changes and agreed actions. Our review found that updates are shared verbally only, which limits the TOG's ability to effectively monitor compliance with the 6-4-2 SOP—a core requirement of its ToR.	hinders decision-making, and prevents identification of issues and trends.	**Expected Evidence of Implementation:** • Attendance records in place for TSG and TOG • Fortnightly update report from TSG to be provided to TOG. • Audit compliance outcomes.
		Medium Priority	**Officer:** Victoria Gibbs, Chair of TSG & Directorate Manager, Theatres and Anaesthetics, in conjunction with Rhodri Davies, Chair of TOG & Associate Service Group Director, Surgery Division **Target Implementation Date:** 28 February 2026
	Theme: Reporting	Control Design	
3	**Lack of formal reporting from Theatre Board to Urgent and Emergency Care Board** The Theatre Board (TB)'s TOR state that it should *report progress to both the Planned Care and Unscheduled Care Boards*. While a highlight report is regularly submitted to the Planned Care Programme Board, there is no formal reporting mechanism to the Unscheduled Care Board (now known as the Urgent and Emergency Care Board). Both boards are chaired by the Chief Operating Officer, however the absence of a structured reporting process creates a risk that urgent or emergency care-related decisions or issues discussed by the TB may not be appropriately captured or escalated.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	**Agreed Action:** • As part of the review of the Theatres Board Terms of Reference, evaluate whether formal reporting to UEC Board is required. • By November 2025, decide and document in the revised ToR the agreed reporting route (regular highlight report or formal statement of non-requirement).
			Expected Evidence of Implementation: • Revised Terms of Reference for Theatres Board and first report/minute of decision.
		Medium Priority	**Officer:** Mark Davies, Theatre Board Chair & Associate Medical Director, Surgery Division, in conjunction with Rhodri Davies, Associate Service Group Director, Surgery Division **Target Implementation Date:** 31 December 2025
	Theme: Reporting	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
4	**Limited capacity to deliver and sustain theatre utilisation improvements** Discussions with key stakeholders highlighted limited capacity within the theatre management structure to sustain all required processes established to support scheduling, particularly when the transformation team support is redirected to other areas of the programme. Themes and trends from initial TSG meetings has allowed for identification of local process issues which impact the efficiency of scheduling procedures, alongside identifying constraints to the current clinical model in use for Neath Port Talbot site theatres. However, the ability to identify and address issues in future will be constrained by available resources. We were informed that informal benchmarking against scheduling resources in neighbouring health boards suggests that the health board may be under-resourced in this area. This is consistent with findings from a recent Audit Wales review of Planned Care arrangements, which also highlighted capacity constraints within the transformation team.	Limited capacity to sustain theatre improvement processes risks undermining the effectiveness and longevity of gains made. Without adequate resources, new scheduling practices and service changes may not be embedded, reducing overall impact.	**Agreed Action:** • Review and assess current resource levels within theatre management and scheduling functions, including benchmarking against comparable health boards. • By December 2025**,** complete a resourcing plan to address identified gaps, prioritising areas critical to sustaining scheduling improvements. • Review capacity annually each September, starting 2026. • Ensure there are clear exit plans in place for when Transformation Team input is redirected. • Consider reallocating or enhancing capacity in line with programme priorities and emerging operational needs.
			Expected Evidence of Implementation: • Theatres management resource assessment and benchmarking completed • Resourcing plan developed in line with benchmarking recommendations • Exit plans in place for agreed service handover from Transformation team
		Medium Priority	**Officer:** Victoria Gibbs Directorate Manager, Theatres and Anaesthetics
	Theme: Resourcing	Control Design	**Target Implementation Date:** 31 December 2025

Objective 2: Approved policies and procedures support the effective use of theatre resources, include clear roles and responsibilities, and are available to staff.	**Limited**

Through the work of the Scheduling and Performance workstream there has been development, approval and implementation of a theatres scheduling standard operating procedure ('the 6-4-2 SOP') to improve clarity and consistency across scheduling processes. The 6-4-2 SOP, approved by Theatres Board in December 2024, was adopted across all health board sites in January 2025 in conjunction with the centralisation of Service Group scheduling meetings into the newly established TSG.

Review of the 6-4-2 SOP confirms that it defines roles and responsibilities for theatre management and surgical services and aligns with national good practice. As noted within *audit objective 3,* the adoption of the 6-4-2 SOP alongside TSG arrangements resulted in an initial 36% increase (which has reduced to c.25%) in activity undertaken within Neath Port Talbot theatres, where the SOP was originally piloted ahead of wider roll out across other sites.

Theatres management staff described the SOP as a significant step forward in improving transparency and control over theatre scheduling. However, its introduction prompted concerns from clinicians involved in cancer and emergency care, who highlighted potential risks to theatre access under the rigid scheduling model. In response, a draft SOP titled *Management of Late Theatre Changes* was under consultation at the closure of audit fieldwork, to address processes within the 0–2 week scheduling window. The need to undertake this further consultation means that the formal review of the 6-4-2 SOP originally due for March 2025 has not taken place (see **Key Finding 5**).

There are a number of supporting documents mentioned within the 6-4-2 SOP which are yet to be developed. Other SOPs which have featured within TOG discussions, such as the *On the day - Cancellation SOP* and *Prioritisation SOP*, should be considered as part of the broader SOP review process (see **Key Finding 5**).

Separately, the Quality & Safety workstream has developed a draft Theatre Quality and Safety Standards (TQS) Framework, which was shared with the TB in September 2024. The framework spans over 50 pages and includes detailed standards, measures, and criteria. However, it remains unratified due to limited clinical engagement (see **Key Finding 6**). Several surgical specialties are hosted within the Morriston Service Group, and currently, there is no combined quality and safety report that consolidates all incidents and reporting related to surgical and theatre services. This gap reinforces the need to progress and implement the TQS to ensure consistent oversight and reporting across theatre services.

Eight Never Events have occurred in theatres over a two-year period, prompting the establishment of a Silver Command structure in July 2025 to escalate concerns within the Surgical Division within Neath Port Talbot Singleton Service Group (NPTSSG) that hosts theatres management. A theme identified within three recent Never Events is of non-compliance with National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs). A Never Event improvement plan, developed by Theatres management, has been presented to both NPTSSG Quality, Safety and Risk group alongside inclusion within the Theatres Quality and Safety highlight report. The improvement plan included a survey to assess staff awareness and training on safety standards. Findings included that no local records were maintained to confirm staff training or induction. Actions are being progressed, including the introduction of human factors training and eLearning resource to be added to ESR. Discussions were ongoing to determine whether this training should be mandated for all theatre staff and clinicians. Recognising there is a scheduled audit of NatSSIPs and LocSSIPs within our 25/26 Internal Audit Plan (quarter 4), we will consider the outcome of these training discussions at that time.

	Key Findings	Risk & Impact	Agreed Management Action
5	**Incomplete development and review of scheduling SOPs** Following the introduction of the 6-4-2 Theatre Scheduling SOP, clinicians involved in the treatment of cancer and emergency patients requested further clarification regarding the management of changes within the 0–2-week period. In response, a draft SOP titled Management of Late Theatre Changes was under consultation at the time fieldwork concluded. The 6-4-2 SOP also references several supporting documents intended to strengthen the scheduling process, which have yet to be developed. These include: • Extension of Theatre Lists • Cancellation of Theatre Lists • Backfill of Theatre Lists • Reallocation of Theatre Lists • Patient Allocation • Equipment Allocation In addition, discussions with the Theatre Operational Group (TOG) identified the need for further SOPs covering On-the-Day Cancellations and Prioritisation of Theatre Lists. While the 6-4-2 SOP includes a suggested three-month post-implementation review, this had not yet been undertaken. Given the ongoing development of the late changes SOP and the identification of additional supporting documents, there is an opportunity to use the review process to confirm and formalise the full suite of supplementary guidance required to support consistent and effective scheduling practice.	Lack of embedded scheduling policy could result in inconsistent practices, unclear management of late changes, and operational inefficiencies. This risks reduced theatre utilisation, scheduling conflicts, and compromised service delivery.	**Agreed Action:** • Formalise the 2 week scheduling SOP and undertake the post-implementation review of the 6-4-2 SOP by January 2026, incorporating feedback and identifying required supplementary SOPs as part of wider review of programme. • Publish a register of all required supplementary SOPs (e.g. cancellations, prioritisation, patient/equipment allocation) to ensure consistent scheduling practices by February 2026**.** **Expected Evidence of Implementation:** • SOPs in place and monitoring mechanisms agreed • Development of a SOP register • Post implementation review
		Medium Priority	**Officer:** Victoria Gibbs**,** Directorate Manager, Theatres and Anaesthetics **Target Implementation Date:** 28 February 2026
	Theme: Policies & Procedures	Control Design	
6	**Delayed approval and implementation of Theatre Quality Safety Standards Framework** The TQS Framework was developed by the Quality and Safety Workstream to map and align professional and regulatory standards across theatre, anaesthetic, and surgical services. It also aims to support the development of metrics for ongoing quality and safety reporting.	Increased risk of patient harm through lack of agreed standards and oversight across surgical and theatre services.	**Agreed Action:** • Secure executive sign off and publish a concise version of the framework for clinical teams by December 2025**.** • Align the framework with existing governance and reporting structures and agree the implementation and monitoring mechanisms • Launch a consolidated quality and safety report to highlight current gaps and reinforce the case for

Key Findings	Risk & Impact	Agreed Management Action
Although a draft version was presented to the TB in September 2024, the framework remains unapproved due to limited engagement from clinical representatives in the consultation process, despite escalation efforts through this forum and the Planned Care Programme Board. Currently, there is no integrated quality and safety report that consolidates incidents and reporting across surgical and theatre services. This gap further reinforces the importance of progressing and implementing the TQS Framework.		adoption through a simplified implementation plan by March 2026. • As part of the wider review of Theatres Board governance, review Terms of Reference for the Quality and Safety workstream. **Expected Evidence of Implementation:** • Alignment of Q&S Framework with existing governance and reporting structure. • Summarised Q&S framework with governance, expectations and monitoring set out. • Executive sponsorship agreed. • Consolidated Quality and Safety report. • Review of Quality and Safety workstream ToR.
	High Priority	**Officer:** Jonathan Gates, Head of Nursing, Surgery Division **Target Implementation Date:** 31 March 2026
Theme: Quality, Safety & Patient Experience	Control Design	

Objective 3: Key performance indicators are in place to monitor the efficiency and productivity of theatres, specifically in relation to utilisation, with actions to support improvement where required.	**Reasonable**

The health board has developed a Theatre Performance Framework (TPF) incorporating indicators from key strategic drivers:

- Cabinet Secretary's Enabling Actions
- NHS Wales Elective Theatre Optimisation Dataset
- Getting It Right First Time (GiRFT)

The TPF was shared with the Theatre Board and Planned Care Programme Board in March 2025. At the date of audit fieldwork, finalisation had been delayed pending clarification from Welsh Government on metric definitions. The health board has also raised concerns about some of the proposed indicators being adopted nationally.

Review of the TPF confirmed there are a number of indicators included across a total of six subheadings (productivity & utilisation, efficiency metrics, patient experience & flow, patient outcomes & safety, workforce & staffing metrics; and cost & financial performance). For productivity & utilisation, there are six externally set key performance indicators (KPIs) and 11 internal measures covering activity volume, theatre time usage, cancellations, and reallocations. Efficiency metrics include 10 externally set KPIs aligned to throughput, case complexity, timing, and compliance with GiRFT standards and high-volume low-complexity procedures, with internal measures focused on case mix, recovery, and patient arrival timings. However, the framework does not currently set out how it is to be implemented, or associated responsibilities linked to its use (see **Key Finding 7**).

A key development to support the monitoring of theatre activity is the Surgical Pathway Dashboard ('the dashboard'). Replacing three previous dashboards in use across theatres and surgical services, this offers a consolidated view of theatre performance. It enables data review by site, specialty, and time period, with drill-down capability to individual consultant and theatre lists. Executive summary views and RAG ratings are also included across a range of indicators such theatre effectiveness and utilisation, time lost due to late starts/early finishes, turnaround time loss, and cancellations.

Analysis of the dashboard has indicated to Theatres management that early finishes are a more significant contributor to lost theatre time than later starts. Our own review of data over a 12 week period (April 2025-June 2025) concurs with this assessment, identifying that 62% of theatre lists finished more than 15 minutes early, with 45% attributed to "planned work complete", suggesting there could be opportunities to include additional activity. TOG meetings have recently incorporated service and specialty-level reporting based upon extracts from the dashboard; and recognising that this was still at the embedding stage, we noted inconsistencies in submissions and the potential for greater focus on actions (see **Key Finding 8**).

The establishment of TSG and adoption of the 6-4-2 SOP has allowed the health board to identify some key constraints affecting the utilisation of theatres on the NPT site. These include misalignment of consultant job plans, limited patient suitability and pre-assessment challenges. TOG has requested that five services review their case mix for the site, and a separate working group has been formed (external to the theatre programme) to review the site's medical model.

Discussions within TSG and TOG have also identified cancellations due to insufficient numbers of pre-assessed patients. A Pre-Assessment Scheduling Group has been formed to review nursing, health care support worker, and anaesthetic processes. Work to date has identified the absence of a Health Screening Questionnaire (HSQ) to filter waiting lists, and a lack of validated patients. Actions were being taken forward by the group to improve prioritisation and capacity mapping. The health board has identified a shortfall of approximately 15 whole-time equivalent (WTE) anaesthetists relative to service demand. To address this, adjustments have been made to the 6/4/2 scheduling process, delaying the

point at where anaesthetists are allocated to provide services with greater flexibility. In June 2025, it was agreed that the Resource workstream would prioritise the development of an Integrated Workforce Plan for Anaesthetics, beginning with the implementation of a dedicated workforce calculator as an initial step.

Key Findings		Risk & Impact	Agreed Management Action
7	**Gaps in implementation and accountability within Theatres Performance Framework** The Theatres Performance Framework (TPF) sets out a range of measures and targets, incorporating both national and external drivers alongside local indicators. These cover domains including productivity, utilisation, efficiency, patient safety, and workforce metrics. The implementation of the TPF has been delayed whilst awaiting clarification from Welsh Government on metric definitions. However, the framework does not specify the actions to be taken or escalation processes to follow when performance falls below expected levels. Additionally, it lacks reference to the escalation protocols set out in the health board's existing Performance and Assurance Framework, limiting its effectiveness as a performance management tool.	Lack of implementation detail within the Theatres Performance Framework could limit its effectiveness in driving accountability, performance improvement and timely escalation of issues.	**Agreed Action:** • Issue implementation guide with named leads, priority metrics and escalation triggers by January 2026**.** • Define priority metrics to be reported to Theatres Board and Planned Care Board on a monthly basis. • Align escalation processes with the Health Board's existing Performance and Assurance Framework. • Make Theatre Performance Framework Dashboard a standing monthly item at Theatres and Planned Care & Cancer Boards by February 2026**.** **Expected Evidence of Implementation:** • Performance framework implementation guidance in place. • Board minutes evidencing dashboard reporting. • Embedded performance framework in quarterly performance review cycle and on scheduled workplans for the above forums. • Clear understanding across surgical specialties of expectations within the framework, which are regularly reviewed and minuted in meetings.
		Medium Priority	**Officer:** Victoria Gibbs, Directorate Manager, Theatres and Anaesthetics **Target Implementation Date:** 28 February 2026
	Theme: Policies & Procedures	Control Design	
8	**Inconsistent use and limited impact of service-level reports within Theatre Operational Group** The Theatre Operational Group (TOG), established in April 2025 has provided a forum to discuss and address issues identified	Opportunities to address inefficiencies and poor utilisation may	**Agreed Action:** • From November 2025, all relevant services to submit a standardised monthly report to the Theatre Operational Group, TOG to log and chase any gaps.

Key Findings	Risk & Impact	Agreed Management Action
from TSG including early finishes, NPT site constraints and identification of suitable patients to increasing utilisation; and the challenges raised within pre-assessment processes. From July 2025, service and specialty level reports have been introduced within the TOG, incorporating data from the Surgical Pathway Programme dashboard. These reports are intended to support analysis of priority areas for improvement, and we recognise these arrangements were in their infancy at the time of our review. Recognising the above, our review of report frequency and content highlighted opportunities to strengthen the tracking of actions and timescales. There is also the opportunity to further consider how the dashboard could be used effectively in time i.e. with the use of thematic or rotational reviews rather than regular report.	be missed due to inconsistent reporting and limited follow-up on identified issues.	• Focus on key metrics in phases to adopt action learning approach to improving performance. • Provide guidance and support to services on interpreting dashboard data and identifying actionable insights. • Monitor report submissions and follow-up actions to ensure accountability and progress tracking. • Review impact and refine report template by April 2026. **Expected Evidence of Implementation:** • Evidence of surgical specialties regularly submitting reports to TOG – agendas for TOG meetings to be used as evidence. • Support for directorate management teams in place for dashboard reporting. • TOG to monitor actions and progress with key metrics.
	Medium Priority	**Officer:** Rhodri Davies, Chair of TOG & Associate Service Group Director, Surgery
Theme: Performance Monitoring	Control Design	**Target Implementation Date:** 30 April 2026

Objective 4: Mechanisms are in place to ensure the quality of data used for monitoring. **Reasonable**

The health board uses Theatre Operating Management System (TOMS) for its scheduling and documenting of theatre activity. A dedicated intranet page supports users with a guide and instructions for running data quality reports and managing case/session entries. Within TOMS, approximately 160 predefined categories are available for recording reasons for late starts, early finishes and case/list cancellations. Users are encouraged to include free text narrative to accompany the categorisation selected. While entries have historically lacked sufficient detail, recent improvements have been noted following efforts to encourage theatre teams to provide supporting information.

TOMS data feeds into the Surgical Pathway Dashboard, which we reviewed for a 12-week period (April – July 2025). In line with the 6-4-2 SOP, cancellations within the 0-2 week window should be minimised. Our review identified 873 cases (15%) cancelled within two weeks, and 386 cases (6%) cancelled on the day:

Cancellation category - week 0-2	% of cancellations (number of cases)	Cancellation category - on the day	% of cancellations (number of cases)
Emergency case taking priority	14% (123)	Clinically unfit	16% (63)
Patient postponed by hospital	14% (121)	Insufficient theatre time	12% (48)
Booked in error	11% (98)	Patient cancelled - unwell	10% (38)
Patient cancelled, appointment inconvenient	10% (85)	Patient - Did not attend	8% (30)

From our review of the dashboard data, we confirmed that reasons were included for the majority of entries (95% for two-week cancellations, and 90% for on-the day). The 'booked in error' category warrants further attention, noting a number of these entries held variations of the same wording (error/booked in error) listed, limiting insight into underlying causes (see **Key Finding 9**).

Theatre activity reports are generated on a weekly basis by the Theatres Data and Business Analysis Manager, these combine dashboard extracts and cancellation data and shared with senior management. These activity reports are included in Theatre Operational Group (TOG) agendas but we found no evidence of structured review or discussion. While TOG service reports (see objective 3) include on-the-day cancellation numbers or percentages, they do not include the categorisation or supporting narrative (see **Key Finding 9**)

Key Findings		Risk & Impact	Agreed Management Action
9	**Limited insight from Theatre Operating Management System Reporting** The Theatre Operating Management System (TOMS) is used to record late starts, early finishes, and cancellations, with approximately 160 available classification categories to support data entry. While entries generally included supplementary commentary alongside the selected codes, a review of data over a 12-week sample period found that 32% of late starts were collated under the category 'Other'. The Surgical Pathway Dashboard does not provide accompanying free-text explanation for late starts categorised	Missed opportunities to address recurring causes of late starts due to overuse of generic categories like 'Other' and lack of supporting narrative, limiting the ability to	**Agreed Action:** • By January 2026, mandate free-text narrative to be added when "Other" is selected and provide user guidance. • Provide training or guidance on accurate categorisation and the importance of detailed entries. • Introduce quarterly audits of TOMS entries to identify patterns and improve data quality by April 2026. • Use findings from detailed entries to inform targeted improvement actions and service-level feedback.

Key Findings	Risk & Impact	Agreed Management Action
as such, and this detail is also absent from the theatre summary reports submitted to the TOG. This lack of specificity limits the ability to understand and address the underlying causes of late starts, reducing the effectiveness of performance monitoring and improvement efforts.	identify and act on underlying issues.	**Expected Evidence of Implementation:** • Reduced use of the category 'Other' within TOMS system, ensuring accurate free text narrative for appropriate entries. • Evidence the ability to maximise opportunities on late start intelligence and act accordingly via the Theatre Scheduling Group and feed quarterly audit outcomes into Theatres Board via update reports.
	Medium Priority	**Officer:** Rhian Medwell / Will Windsor, Deputy Heads of Nursing, Surgical Division
Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30 April 2026 (and dependent on TOMS functionality)

Objective 5: There is an appropriate framework in place for the reporting of theatre utilisation.	**Reasonable**

Since the establishment of the TB in June 2024, a structured approach has been adopted to reporting through the use of highlight reports for each Surgical Pathway Programme workstream. These reports are comprehensive in format, detailing the scope and intended outputs of each workstream; alongside individual milestones, due dates, RAG assessments, and narrative updates on current progress and planned activity. They also include summaries of risks, issues, decisions, and escalations. A consolidated TB highlight report summarising key developments across all workstreams is presented to the Planned Care Programme Board.

Our review of the Resource and Quality & Safety workstream reports found that delays or lack of progress are generally acknowledged within the narrative updates. However, revised completion dates are not consistently provided when delays occur (see **Key Finding 10**). This reflects broader challenges around capacity within both the theatre management and transformation teams, as previously noted under Objective 1.

As referenced in Objective 3, the TOG has recently begun reviewing service-level performance reports. While this marks a positive development, the format and methodology of these reports requires further refinement (see **Key Finding 8**). In July 2025, TOG discussed the need to identify a core set of performance indicators from the Theatre Productivity Framework (TPF) to underpin a monthly report for submission to both the TB and the Planned Care Programme Board. At the date of audit fieldwork, these indicators had not yet been agreed. In its management response to the Audit Wales report *Tackling the Planned Care Challenges* (see Objective 1), the health board committed to defining its criteria for cancellations and utilisation and agreeing a baseline position by June 2025 (see **Key Finding 11**).

The Performance and Finance Committee (PFC) has received periodic reports on theatre utilisation and performance. Between 2021 and 2024, seven reports were submitted. Since April 2024, reports have included data from the Getting It Right First Time (GiRFT) programme and updates on the Surgical Pathway Programme. The most recent report, submitted in December 2024, noted progress in the development of the Surgical Pathway Dashboard. Integration of this dashboard into future reports is expected to enhance the level of detail available to the PFC, offering more granular insights than previously available.

The health board's Integrated Performance Report, presented to both the PFC and the Board, includes key theatre KPIs such as utilisation rate, percentage of late starts and early finishes, and operations cancelled on the day. The indicator for cancellations within 28 days has recently been removed, reflecting the implementation of the 6-4-2 SOP, which anticipates cancellations occurring earlier in the scheduling process. As of July 2025, theatre data was temporarily withdrawn from the report pending validation of reported metrics, the health boards utilisation rate for the previous 12 months varying between 50-60%, whereas the rate reported by the dashboard has the figure at 78%.

Key Findings		Risk & Impact	Agreed Management Action
10	**Inconsistent use of RAG ratings and milestones in Surgical Pathway Highlight Reports** There is an established process through which workstreams submit highlight reports to the TB, with consolidated summaries subsequently reported to the Planned Care Programme Board. While these reports provide narrative updates, our review identified inconsistent use of RAG ratings and milestone due	Ineffective reporting of progress may impact the ability to monitor workstream delivery and identify delays , reducing oversight	**Agreed Action:** • Standardise the use of RAG ratings and milestone due dates across all highlight reports by December 2025 • Provide guidance to workstream leads on completing reports consistently, including expectations for updating timelines when delays occur. • Theatre Board to review and challenge overdue milestones monthly from January 2026.

	Key Findings	Risk & Impact	Agreed Management Action
	dates. This limits transparency and hinders effective tracking of progress across workstreams.	and limiting timely intervention.	**Expected Evidence of Implementation:** • Guidance produced for workstream leads to support highlight report completion. • Robust highlight reports are submitted to Theatres Board from all workstreams. • Theatre board minutes to evidence review of milestone status and challenge of those overdue. • Review workstreams as part of wider review of Theatres Board to ensure the correct governance structure is in place to take key priorities forward under Theatres Board.
		Medium Priority	**Officer:** Mark Davies Theatre Board Chair & Associate Medical Director, Surgery Division, in conjunction with Rhodri Davies, Associate Service Group Director, Surgery Division **Target Implementation Date:** 28 February 2026
	Theme: Reporting	Control Operation	
11	**Delays in agreement and reporting of theatre performance and utilisation metrics** Following the approval of the Theatre Performance Framework in March 2025, implementation has been delayed pending clarification from Welsh Government regarding several proposed national measures. While discussions have taken place regarding which indicators from the framework should be reported to the TB and the	Gap in current performance reporting arrangements may reduce visibility of theatre activity, limiting oversight and the ability to identify and	**Agreed Action:** • Agree and commence monthly reporting of final theatre utilisation metrics (linked to key finding 7) by January 2026 for inclusion within Theatre Board, and Planned Care and Cancer Board reporting.

Key Findings	Risk & Impact	Agreed Management Action
Planned Care Programme Board, a final decision remained outstanding at the time of fieldwork completion. As a result, there has yet to be regular reporting of performance and utilisation metrics shared with both groups. In its response to the Audit Wales report *Tackling the Planned Care Challenges* (see objective 1) the health board committed to the following with ongoing monitoring being as outlined and reported formally to the Planned Care Board: • *outline a rationale for measurement of cancellations/utilisation (end of May 2025)* • *the baseline will then be set (completion end of June),* These commitments remained outstanding at the date our audit fieldwork concluded.	respond to emerging issues or delays. **Medium Priority**	**Expected Evidence of Implementation:** • Theatre board minutes showing agreed metrics and first monthly report to Theatre Board, and Planned Care and Cancer Board. **Officer:** Victoria Gibbs, Directorate Manager, Theatres and Anaesthetics **Target Implementation Date:** 31 January 2026
Theme: Performance Monitoring	Control Design	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

 **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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