ANNEX 3 – Cardiff and Vale Health Board review

CAV has one site that can deliver elective orthopaedic surgery – University Hospital Llandough (UHL) and the co-located CAVOC. UHL does have an acute medical take but whilst the distinction between these two sites is not physical, it is operationally completely separate, ring fenced and has never been breached. There are four laminar flow theatres in CAVOC, two in UHL and a further two non-laminar flow in UHL. There are three non-laminar flow day theatres in UHL also. Spinal surgery is no longer in UHL so this orthopaedic capacity is ring fenced for elective orthopaedic surgery. Trauma has now been moved back to UHW.

The current CAV theatre capacity and recovery strategy is significantly less than could be achieved in the model that the NCSOS 3 report was based on. This is due to staffing limitations and other competing specialities. Two theatres run three days per week and three theatres two days per week, mixed between daycase and inpatient (Fig 1).

There are plans to develop a further two laminar flow theatres in UHL for orthopaedics by May 2026. The health board strategy is for the four UHL laminar flow theatres to be used predominantly for arthroplasty/implant surgery and two of the non-laminar flow for other elective orthopaedic surgery. This will be dependent on sub specialty discussion and appropriate case-mix. For the purposes of NSCOS modelling LF has been appropriated to majority of daycase specialties except hand surgery which has been modelled all NLF. The HB should be encouraged to increase the proposed 2026 theatre allocation in UHL for Orthopaedics to allow increased regional remit. This should be discussed within the SEW regional Orthopaedic breakout project and WON.

Current/Actual								
	Total Demand	Consultant Capacity	UHW	St Josephs	UHL/Cavoc		Total	Available Capacity
					LF	NLF		
Daycase Capacity			**0**	**2**	**10**	**5**	**17**	
S&E (87%)	4.26	3.71			3.71			
H&W (67%)	10.58	7.09		2		5		-0.81
Hip	0.12	0.12			0.1			
Knee	4.83	4.83			3			
F&A (162%)	6.00	6.00			4			
Total	25.80	21.75	0	2	10.81	5	17.81	
Inpatient Capacity					**14**		**14**	
S&E	1.12	0.97			1			
H&W	0.02	0.01			0.02			-0.52
Hip HVLC (199%)	7.46	7.46			4			
Hip LVHC (131%)	2.21	2.21			2.2			
Knee HVLC (442%)	8.07	8.07			4			
Knee LVHC (1400%)	4.42	4.42			3			
F&A (162%)	0.32	0.32			0.3			
Total	**23.65**	**23.49**			**14.52**	**0**	**14.52**	

CAV Fig 1. Current capacity

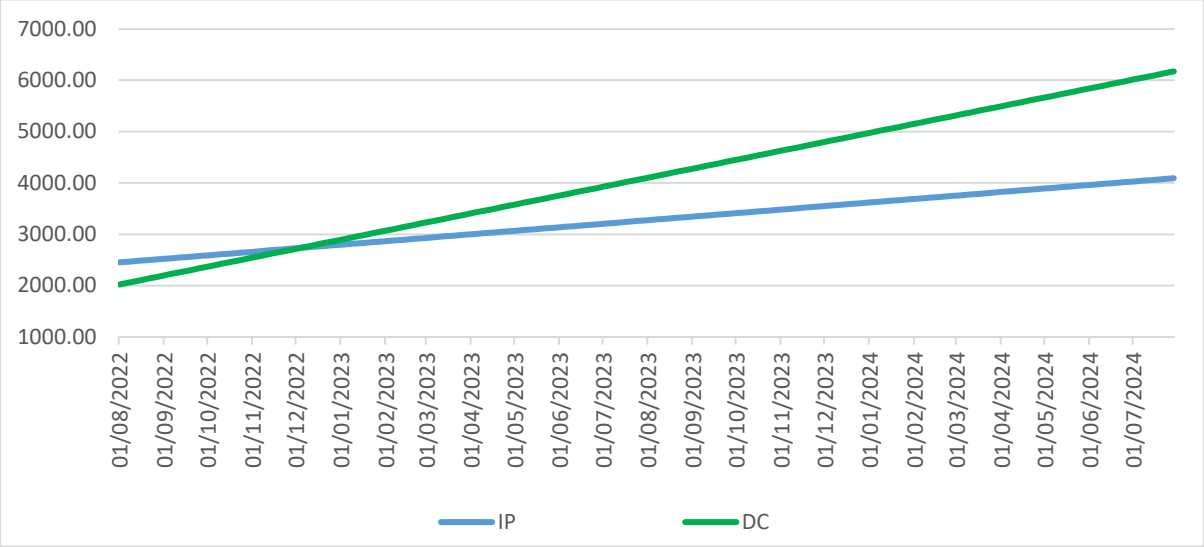
2026								
	Total Demand	Consultant Capacity	UHW	NA	UHL/Cavoc		Total	Available Capacity
					LF	NLF		
Daycase Capacity			**0**	**0**	**18**	**30**	**48**	
S&E (87%)	4.26	3.71			5.1			
H&W (67%)	10.58	7.09				7.09		23.11
Hip	0.12	0.12			0.1			
Knee	4.83	4.83			5.5			
F&A (162%)	6.00	6.00			7.1			
Total	29.06	24.81	0		17.8	7.09	24.89	
Inpatient Capacity			**0**	**0**	**24**	**0**	**24**	
S&E	1.12	0.97			1			
H&W	0.02	0.01						18.4
Hip HVLC (199%)	7.46	7.46			7.5			
Hip LVHC (131%)	2.21	2.21			2.2			
Knee HVLC (442%)	8.07	8.07			8.1			
Knee LVHC (1400%)	4.42	4.42			4.4			
F&A (162%)	0.32	0.32			0.3			
Total	**23.65**	**23.49**			**23.6**	**0**	**23.6**	

CAV Fig 2. CAV. 0% Model. Mapping required Consultant WF to available estate. 2026.

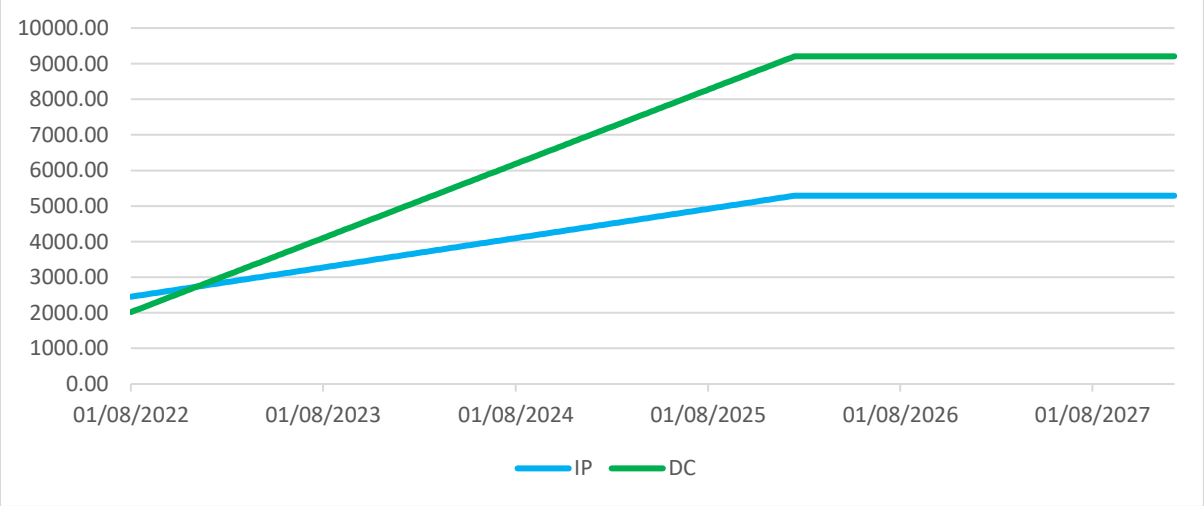
Service Model	Daycase Demand	Daycase Capacity	Daycase Deficit/Surplus	Inpatient Demand	Inpatient Capacity	Inpatient Deficit/Surplus
Current Model	26	17	-9	24	14	-10
HB/NCSOS Strategy 2026	26	28	+2	24	24	-

CAV Fig 3. Current versus 2026 model Summary

Extrapolating the current CAV capacity is modelled in Fig. 4. The daycase and inpatient backlogs will almost double in two years. If the intended 2026 strategy is fulfilled however, the 0% model can be met in all but shoulder & elbow which has a minor consultant staffing deficit – this could easily be mitigated with job planning changes. The overall daycase CAV backlog could be reversed but this would be to the detriment of regional mutual aid possibilities. The inpatient capacity will only reach 0% model, with no regional aid capacity. It would also necessitate daycase procedures to be performed in non-laminar flow environments. We recommend that the WON and constituent subspecialty CRGs review the various orthopaedic procedures with a view to concluding which procedures can be performed in non-laminar flow theatres.



CAV Fig 4. DC & IP backlog with current capacity



CAV Fig 5. Backlog with 2026 intended capacity

CAV report significant frailties in their interdependency workforce, particularly in theatre scrub staff with high numbers of WTE vacancies as a result of low staff morale and opportunities in the independent sector and neighbouring HB's.