Agenda – Public Accounts Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Monday, 9 January 2017
Meeting time: 14.00

For further information contact:
Fay Bowen
Committee Clerk
0300 200 6565
SeneddPAC@assembly.wales

Private

(The Committee agreed on 12 December 2016, a motion under Standing Order 17.42 to resolve to exclude the public from this meeting.)

1 Introductions, apologies, substitutions and declarations of interest

(14.00)

2 Paper(s) to note

(14.00 – 14.05) (Pages 1 – 5)

NHS Wales Health Board's Governance: Letter from Dr Kate Chamberlain, Healthcare Inspectorate Wales (12 December 2016)

(Page 6)

Hospital Catering and Patient Nutrition: Additional information from the Welsh Government (14 December 2016)

(Pages 7 – 10)

3 Committee working practices and procedures

(14.05 – 15.00) (Pages 11 – 23)

PAC(5)-01-17 Paper 1

4 Orthopaedic Services: Welsh Government Update

(15.00 - 15.20) (Pages 24 - 105)

Research Briefing
PAC(5)-01-17 Paper 2 - Auditor General for Wales Report
PAC(5)-01-17 Paper 3 - Welsh Government response to the Auditor General for Wales Report

5 NHS Waiting Times for Elective Care in Wales: Welsh Government Update

(15.20-15.40) (Pages 106 - 185)

Research Briefing
PAC(5)-01-17 Paper 4 - Auditor General for Wales Report
PAC(5)-01-17 Paper 5 - Welsh Government response to the Auditor General for Wales Report

(Break 15.40 - 15.50)

6 Regional Education Consortia: inquiry scoping paper

(15.50 - 16.20) (Pages 186 - 196)

PAC(5)-01-17 Paper 6

7 Auditor General for Wales - Forward Work Programme

(16.20 - 16.50) (Pages 197 - 205)

PAC(5)-01-17 Paper 7

8 Welsh Government in-coming Permanent Secretary: Consideration of draft letter

(16.50 - 17.00) (Pages 206 - 207)

PAC(5)-01-17 Paper 8

Concise Minutes – Public Accounts Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: Monday, 12 December 2016

Meeting time: 14.00 – 16.11

This meeting can be viewed on Senedd TV at:

http://senedd.tv/en/3905

Attendance

Category	Names
Assembly Members:	Nick Ramsay AM (Chair) Neil Hamilton AM Mike Hedges AM Neil McEvoy AM Rhianon Passmore AM
Witnesses:	James Price, Welsh Government Matthew Quinn, Welsh Government James Morris, Welsh Government
Wales Audit Office:	Huw Vaughan Thomas Andy Phillips Nick Selwyn
Committee Staff:	Meriel Singleton (Second Clerk) Claire Griffiths (Deputy Clerk)

Transcript

View the meeting transcript (PDF 965KB) View as HTML (965KB)

1 Introductions, apologies, substitutions and declarations of interest

1.1 The Chair welcomed Members of the Committee.
1.2 Apologies were received from Mohammad Asghar and Lee Waters. There were no substitutes.

2 Paper(s) to note

2.1 The papers were noted.
2.2 The Committee agreed the following action:
Valedictory session – The Chair to write to the Permanent Secretary seeking clarification of the true cost of counter-fraud measures and not just the staff resources of the Counter-Fraud Unit.
Cardiff Airport – The Chair to write to the Welsh Government seeking additional information on Cardiff Aviation Limited and specifically the due diligence exercise carried out in 2012.
Kancoat – The Chair to write to the Welsh Government requesting whether the risk of being dependent on a single supplier was identified and mitigated against. The Committee also wish to query the due diligence procedure given that it was based on a 2011 valuation and that the due diligence officer had suggested a new valuation be commissioned.
Welsh Government historic debt – The Committee agreed to include this issue in its scrutiny of the Welsh Government's Consolidated Accounts 2016-17 in autumn 2017. The Auditor General for Wales agreed to undertake some checks as to the origin of the debt and advise Committee accordingly.

2.1 Valedictory session: Additional information from Sir Derek Jones, Permanent Secretary, Welsh Government (24 November 2016)

2.2 Cardiff Airport: Additional information from the Welsh Government (28 November 2016)

2.3 Inquiry into value for money of Motorway and Trunk Road Investment: Additional information from the Welsh Government (28 November 2016)

2.4 The Welsh Government's Funding of Kancoat Ltd: Additional information from the Welsh Government (29 November 2016)

2.5 Governance Arrangements at Betsi Cadwaladr University Health Board: Additional information from Healthcare Inspectorate Wales (28 November 2016)

2.6 Governance Arrangements at Betsi Cadwaladr University Health Board: Additional information from the Welsh Government (29 November 2016)

2.7 Welsh Government historic debt: Letter from Simon Thomas AM, Chair of Finance Committee (29 November 2016)

2.8 Welsh Government investment in next generation broadband infrastructure: Additional information from the Welsh Government (30 November 2016)

2.9 Auditor General for Wales Report: Preparedness for the introduction of fiscal powers

3 Coastal flood and erosion risk management in Wales

3.1 The Committee scrutinised James Price, Deputy Permanent Secretary, Economy, Skills and Natural Resources Group, Matthew Quinn, Director, Environment & Sustainable Development and
James Morris, Head of the Flood & Coastal Erosion Risk Management Team, Welsh Government on coastal flood and erosion risk management in Wales.
3.2 James Price agreed to:

- Send a note on the possibility that future planning permission includes restrictions for developers to plant trees, restrict the use of block paving for example to reduce the impact of flooding.
- Send a note on the reality that poor land susceptible to flooding has been built upon and there is the possibility that further development will take place in the future.

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

4.1 The motion was agreed.

5 Coastal flood and erosion risk management in Wales: Consideration of evidence received

5.1 Members discussed the evidence received and agreed to publish a short report following their evidence sessions.

6 Community Safety in Wales: Auditor General for Wales Report

6.1 The Committee received a briefing on the Auditor General for Wales' report on his recent report on Community Safety in Wales.
6.2 The Committee agreed that the Chair would write to the Police and Crime Commissioners and on consideration of their responses, consider whether to hold oral evidence sessions on this issue.

7 The strategic approach of councils to income generation and charging: Auditor General for Wales report

7.1 The Committee received a briefing on the Auditor General for Wales' report on his recent report on the strategic approach of councils to income generation and charging.
7.2 The Committee agreed to hold an evidence session on this issue in spring 2017.

8 Hospital Catering and Patient Nutrition: Key issues

8.1 The papers were noted.
8.2 Members agreed to publish their findings in a short report.

Agenda Item 2.1

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Mr Nick Ramsay AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Eich cyf / Your ref
Ein cyf / Our ref

12 December 2016

Dear Mr Ramsay

Marks Review Recommendations

Thank you for your letter dated 6 December 2016 in response to my joint letter with Dr Andrew Goodall, which was considered at the Public Accounts Committee on 28 November.

The Public Accounts Committee has requested clarification on the number of GP practice inspections HIW has undertaken and the time period. During the 2015/16 inspection year, HIW undertook 27 GP inspections and during this inspection year 2016/17 we expect to undertake 28 GP inspection visits across Wales.

I would be happy to meet with you if you would like the opportunity for an informal discussion to explore the work of HIW in more detail. Please contact my office if you would like this to be arranged.

Yours sincerely

DR KATE CHAMBERLAIN
Chief Executive

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Agenda Item 2.2

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Nick Ramsay, AM
Chair – Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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Ein Cyf/Our Ref:JW/JM

14 December 2016

Dear Mr Ramsay,

RE: Public Accounts Committee – Hospital Catering and Patient Nutrition – Monday 17 October 2016 – Agreed Actions – All Wales Hospital Menu Framework

With reference to the Public Accounts Committee meeting on Monday 17th October 2016 regarding hospital nutrition, the Clerk of the Committee requested clarification by the end of October on 3 points

1. The revised project plan for the new nurse informacist who is scheduled to take up post at the end of October; and
2. The outcome of the consideration of the business case for the procurement of an IT catering system from the National Informatics Board meeting.
3. In addition, following earlier evidence from health boards, the Committee would be appreciative to seek clarification from the Welsh Government on who the All Wales Hospital Menu Framework Group reports to.

We responded to point 3 in our letter of 26 October 2016.

In response to point 1:

Nursing E Documentation Timeline Recommendation

Following the appointment of a dedicated NHS Wales Informatics Service resource to support the ambition to standardise and digitalise nursing documentation a basic review of current documents and processes has taken place. A more detailed review is necessary. The work will produce a standardised nursing assessment document along with other standardised documents for use in care planning and care delivery. It is anticipated that the work to produce standardised E nursing documentation will take three years to complete.

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This recommendation is based on the following requirements:

- Design to be embedded in the Welsh Care Records Service making the documentation patient specific therefore crossing healthcare settings. This is a "Once for Wales" concept. This requires analysis of existing e documentation
- In-depth review of current nursing documentation to include live clinical applications and national care standards, identifying current gaps and duplications in the existing documentation
- Develop governance strategies to support appropriate selection of documents and risk assessments for inclusion into the e documentation platform incorporating a multidisciplinary approach. This would also include high level sign off to reduce the risk of inappropriate risk assessment and document selection
- Introduction of health boards/trusts nursing documentation specialists, with high level sponsorship from Nurse Directors
- Recommendation **not** to implement on paper as this will not be like for like and will therefore not realise benefits, in addition paper will potentially reduce the quality of documentation due to dual processes and introduce patient risk
- Enable an agile approach to identification, design, testing, approval and implementation of e documentation as part of a rolling programme
- Sign off on selected current evidence based risk assessments with specialist nurse input
- Design to incorporate clinical decision support to improve patient safety and early identification of risk for patients
- Review and testing phase to include nursing input to ensure fit for purpose
- End user training to be completed. Required to ensure a smooth and safe transition and improve end user adoption
- Implement in one health board or trust for evaluation and issue resolution. Continuous roll out one health board/trust on a rolling schedule

The projected plan is dependent on IT infrastructure and the availability of equipment and resources to roll out this standardised approach.
The project plan overview is shown in Table 1

Table 1

Project task	Timeline		
	Year 1	Year 2	Year 3
Review of documentation			
Develop governance strategies			
Design clinical support system			
Review and test			
End user training year 3			

Finally, in response to point 2

The outcome of the consideration of the business case for the procurement of an IT catering system from the National Informatics Board meeting

As I advised, the catering business case was considered by the National Informatics Management Board (NIMB), including ensuring the technology would improve the existing systems and provide value for money. After a detailed discussion, whilst agreeing the principles of the case, NIMB requested that the business case be reviewed, with urgency, to ensure that costs and assumptions are accurate. Specifically, the potential benefits including invest to save principles needed to be confirmed. The provisional costs have also been challenged as these seemed to be excessive in contrast to some of the catering systems already in place. As a result, one practical option of procuring an existing health board system is being quickly reviewed as it may deliver both benefits and value for money. As I have indicated, the proposal must compete with other priorities for capital and revenue funding.

As part of this exercise, the different models of catering provision in place in Health organisations, including whether food is prepared locally at hospitals or centrally, and the impact those models might have on cost and savings potential, are also being examined to ensure a consistent all Wales provision. I have asked Health Boards and Trusts to work with the NHS Wales Shared Services Partnership to update information on the cost of patient and non-patient catering, wastage and the detail and length of current contracts, and this is continuing further to the business case assessment.

The National Dietetics Committee and the Informatics Planning and Delivery Group (a sub-group of NIMB made up of Associate Directors of Informatics, NWIS directors and Welsh Government officials) are also actively engaged in further scrutinising and advising on the updated business case. NIMB should make the final decision on the business case, informed by the findings and recommendations of those groups, in January. I will of course keep you informed.

Yours sincerely

Dr Andrew Goodall

Agenda Item 3

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Document is Restricted

25 June 2015

Archwilydd Cyffredinol Cymru
Auditor General for Wales

A Review of Orthopaedic Services

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Government of Wales the Government of Wales Acts 1998 and 2006.

The Wales Audit Office study team comprised Anne Beegan, Sian Davies, Andrew Doughton, Kate Febry and Stephen Lisle under the direction of David Thomas.

Huw Vaughan Thomas
Auditor General for Wales
Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

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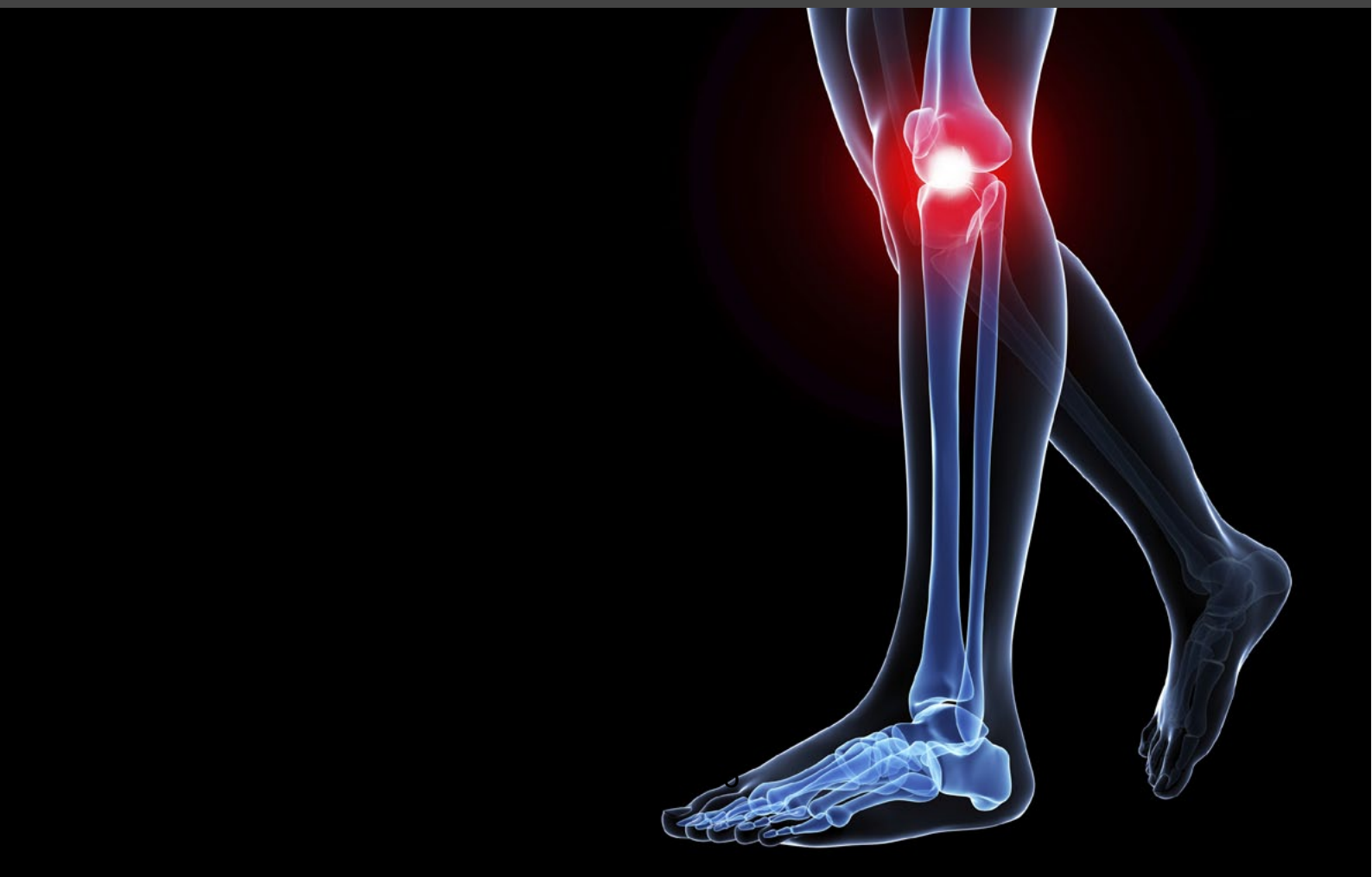
Summary report



Summary

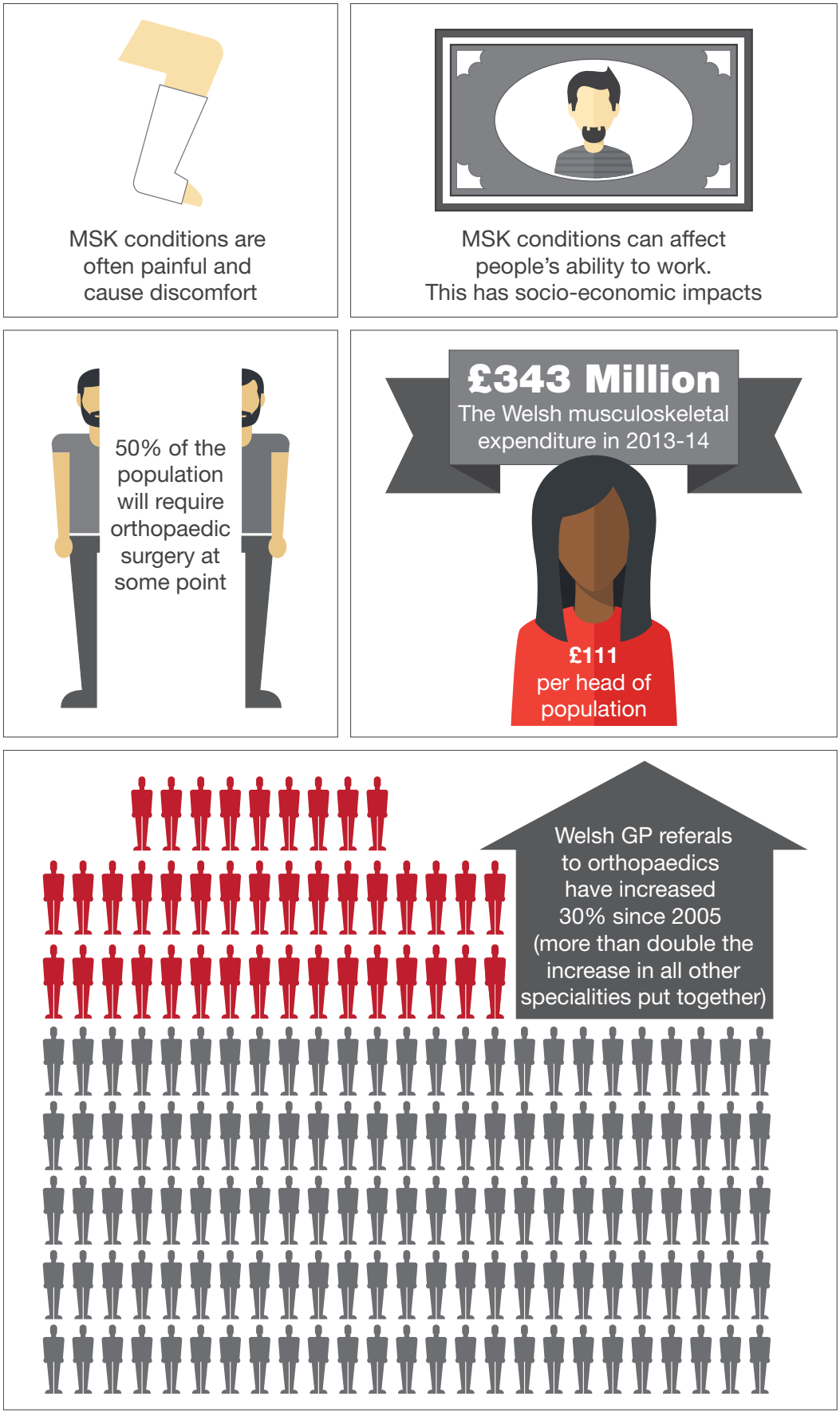
1 Orthopaedics is the branch of medicine that deals with the injuries and disorders of the musculoskeletal system, which includes the skeleton, muscles, joints and ligaments. Musculoskeletal services is a broader term that refers to all services involved in the care of patients with musculoskeletal conditions, including primary care services, physiotherapy, podiatry and rheumatology as well as traditional orthopaedic services. Figure 1 highlights some key statistics about the cost and demand arising from musculoskeletal conditions in Wales.

2 Orthopaedic surgery is costly for reasons including the use of expensive prostheses, advances in surgical technology that have considerable benefits for patients, and because of the general running costs of operating theatres. However, surgery is just one of many treatment options for patients with musculoskeletal complaints. Other options can include physiotherapy, pain relief and rehabilitation as well as improvements to lifestyle and exercise programmes to support patients to lose weight and reduce the pressure on their joints.

3 Demand for orthopaedic treatment has increased significantly over the last decade for reasons including the ageing population, growing levels of obesity and advancements in clinical practice as well as increased patient expectations.

4 Issues related to cost and demands on services leading to unacceptably long waits have prompted considerable national work on orthopaedic and musculoskeletal services in Wales since 2004. In 2011, a ministerial letter announced an investment of £65 million to improve orthopaedic service delivery. The funding was to be provided in tranches over three years. Central to the direction given by the letter was the need to develop sustainable orthopaedic services, rather than just investing in additional acute capacity. Figure 2 summarises these key national initiatives and actions, which are described in more detail in Appendices 1 and 2.

Figure 1 – Musculoskeletal programme budget expenditure and demand



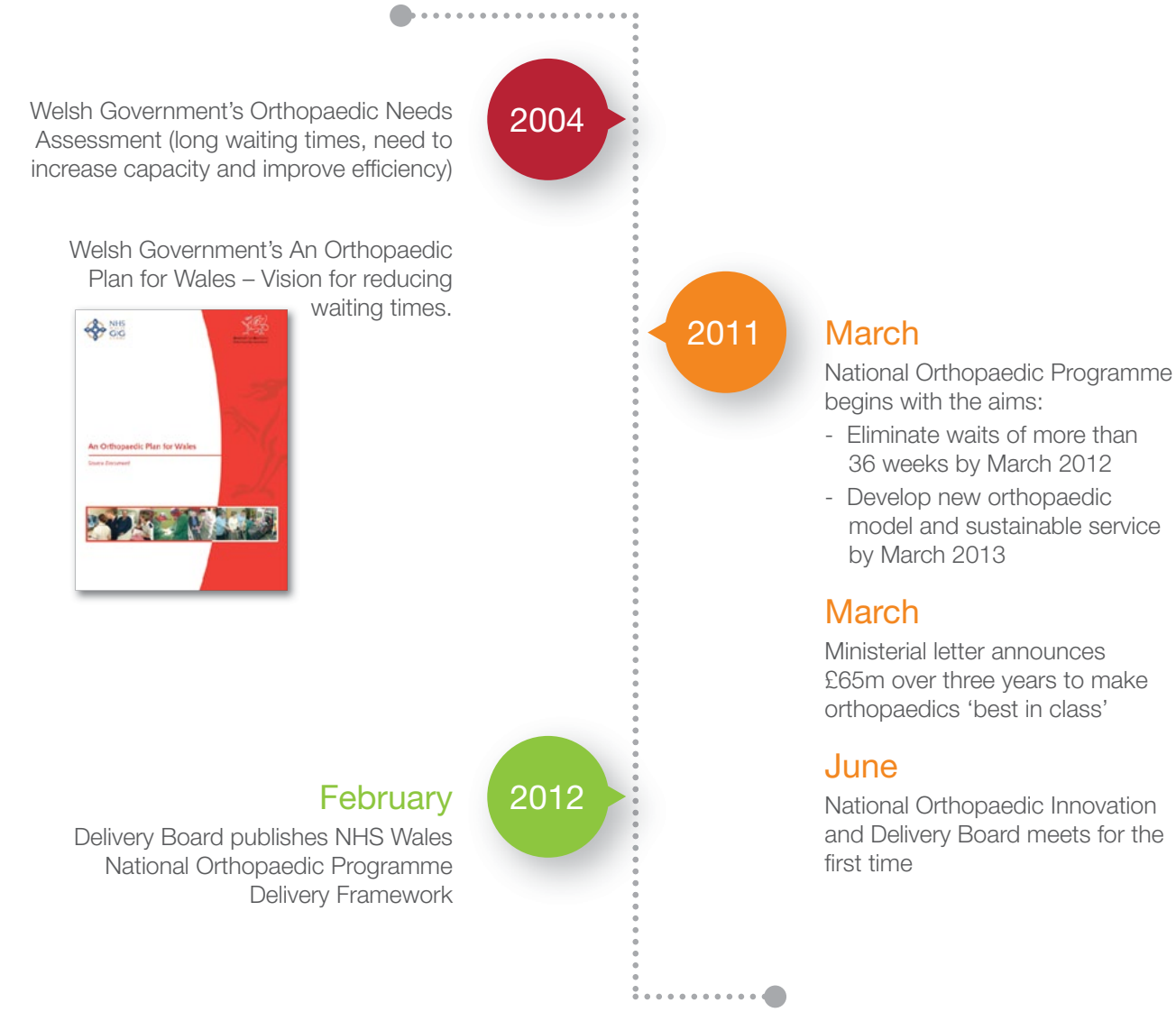
Source: Wales Audit Office use of figures from National Public Health Service[1], Stats Wales[2] and a Welsh ministerial letter[3].

1 National Public Health Service for Wales, **Access Project 2009, Predicted Future Changes in Orthopaedics in Wales: A Horizon Scanning Exercise**, October 2006. The National Public Health Service for Wales was one of the predecessor organisations that formed Public Health Wales.

2 Stats Wales, NHS Programme Budget – www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget. These data exclude the cost of care for people who suffer trauma and other musculoskeletal injuries.

3 Ministerial letter, **Waiting Times and Orthopaedic Services Update**, 10 March 2011

Figure 2 – Timeline of key national musculoskeletal initiatives



Source: Wales Audit Office

5 Given the considerable focus and investment in orthopaedics and musculoskeletal services in Wales in recent years, the Auditor General has undertaken an examination of the national and local approaches adopted to manage demand for these services and to secure a good return on the investment made. The review has also assessed the extent to which sustainable models of service delivery have been developed to help meet future demand.

6 Our approach has involved analysis of a wide range of data and information on orthopaedic services in Wales, together with fieldwork visits to a number of health boards and a survey of patients who have received an elective knee replacement. Each health board in Wales has received a bespoke local analysis of our data to help them understand how their musculoskeletal services are performing and identify where specific action needs to be taken. This report provides an all-Wales analysis of our findings and sets out a number of recommendations for the Welsh Government and health boards. Further details of our audit approach are provided in Appendix 3.

7 Our overall conclusion is that **orthopaedic services have become more efficient in the past decade but NHS Wales is not well placed to meet future demand because whilst there has been a focus on securing immediate reductions in waiting times, less attention has been paid to developing more sustainable, long-term solutions to meet demand.**

8 Waiting times for orthopaedic treatment have reduced over the last 10 years, helped by a drive from the Welsh Government to reduce the time which patients should be expected to wait. However, more recently, waiting times are increasing and people in Wales typically wait longer than those in some other parts of the UK. Increasing waits for diagnostic tests are an important factor in overall waiting times, and the way in which the newly implemented Clinical Musculoskeletal Assessment and Treatment Services (CMATS) are recorded means that overall waits for orthopaedic treatment may be underreported.

9 Orthopaedic resources are being used more efficiently than in the past. Whilst the number of orthopaedic beds is decreasing, health boards are using the remaining beds more efficiently, largely due to shorter lengths of stay and increased day-case rates. More patients are admitted on the day of surgery, minimising unnecessary overnight stays and the percentage of patients now treated as a day case has improved to 57 per cent. The average length of stay for elective orthopaedic treatment is now at 3.4 days and the length of time patients stay in hospital after joint replacement has reduced by a quarter.

10 Despite improvements in efficiency, NHS Wales is struggling to meet the demand placed on it from an increasing rate of GP referrals. The growth in GP referrals is accelerating at a faster pace than the growth in overall population, although variation across health boards would suggest that not all referrals are appropriate. Outpatient capacity, and in particular consultant staffing levels, have increased to meet demand but there is a growing number of patients waiting more than 26 weeks for their first outpatient appointment, and more recently, both outpatient and inpatient activity levels have reduced. By the time a decision to admit a patient for orthopaedic surgery is made, currently between 10 and 12 per cent of patients will have waited more than 26 weeks.

11 In 2011, the Welsh Government took the positive step of forming a national Innovation and Delivery Board (the Delivery Board) for orthopaedic services. The formation of the Delivery Board, with clearly defined objectives, generated an enthusiasm and impetus for change. This was supported by the £65 million of additional funding, that the minister made available, to reduce waiting times and develop sustainable solutions to managing orthopaedic demand.

12 The establishment of a Delivery Board was a positive move, but weaknesses in the way it was established prevented it from achieving some key objectives and its impact on waiting times was short-lived. The Delivery Board produced a clear and compelling vision for the improvement of orthopaedic services and established an appropriate infrastructure of task and finish subgroups to help achieve the vision, but the absence of senior health board executives on the board significantly weakened its ability to drive change at the local level.

13 The Delivery Board and its subgroups did achieve a short-lived improvement in waiting times, with nearly all health boards in Wales achieving the waiting times target in March 2012. However, there was limited success in driving through other priorities, particularly in relation to sustainable solutions to reducing demand and no health board in Wales has achieved the waiting times target since 2012. Despite the initial intention that just under half of the £65 million would be focused through the Delivery Board on sustainable solutions, the Welsh Government largely allocated the funds to support short-term improvements in waiting time performance and the funds ultimately available to support sustainable solutions were minimal.

14 The Delivery Board's impact waned during 2012-13. It last met in May 2013 with almost a year of the central funding remaining. The Delivery Board had a responsibility to monitor progress towards the implementation of its vision across Wales but while there is some evidence that it monitored its own progress, there is less evidence of a rigorous approach to monitoring progress by health boards. The recent establishment of the National Orthopaedics Board, a subgroup of the Planned Care Programme Board, provides a real opportunity to reinvigorate the work initiated by the Delivery Board and to work with health boards to progress with the implementation of the national vision for orthopaedics.

15 Our work has found that health boards have started implementing the national vision and all have made some progress in putting in place sustainable alternatives to orthopaedic surgery. There has been some good progress in developing lifestyle and exercise programmes that have the potential to reduce demand for orthopaedics, and all health boards have implemented CMATS. CMATS are a key part of the national vision for improving orthopaedic services but differences in clinical opinion on the effectiveness of this service model have hindered the pace of change. However, not all health boards are fully considering the whole system of musculoskeletal services when planning local change, and there is insufficient integration between these services and others involved in the totality of musculoskeletal care. These services also tend to be small, and funding pressures place them at risk. Health boards have largely spent the central funding on short-term solutions to tackle waiting lists rather than sustainable solutions.

16 There is a lack of information to understand whether patients are truly benefiting from musculoskeletal services in Wales. Health boards have data about lots of the individual elements of the musculoskeletal pathway but they collect little information on patient outcomes and experience. Monitoring of CMATS in some health boards is also made more difficult by information technology problems.

17 The results of our patient survey and other data reviewed as part of our work, suggests there is further scope to improve outcomes from musculoskeletal services. Our survey of patients undergoing knee replacement surgery reported that 79 per cent of the patients we surveyed said their orthopaedic surgery had improved their quality of life but a significant minority said it had made their symptoms worse or no better, and that their pain had also got worse or not improved. Although some caution needs to be applied to the accuracy of the data, surgical site infection rates are above the Welsh Government target and the rate of emergency readmission following elective orthopaedic surgery are high in some areas.

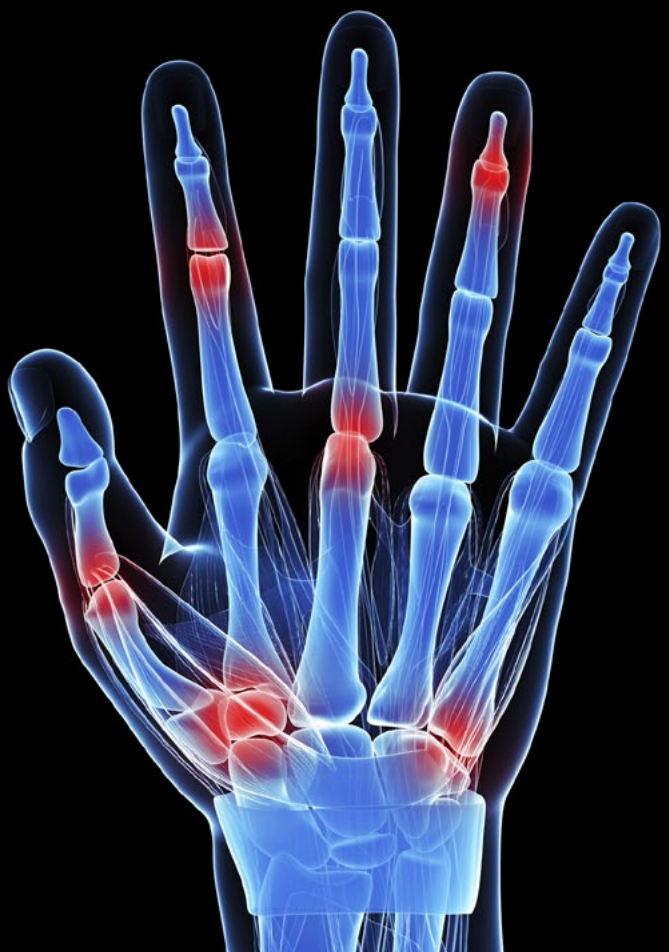
18 In 2014, the Minister for Health and Social Services introduced the concept of prudent healthcare into NHS Wales as a way of ensuring that services are delivered in a sustainable way. The principles are minimising avoidable harm, carrying out the minimum appropriate intervention and promoting equity between the people who provide and use services. Prudent healthcare is in its early stages of being embedded across Wales but the findings presented in this report would indicate that prudent healthcare principles offer a good model of improving the efficiency and effectiveness of orthopaedic services in Wales. Success will be dependent on the ability to work closely with patients to better manage demand and to fully understand where patient experience and outcomes can be improved. In order to drive maximum value out of investment in orthopaedic services, there will need to be a clearer focus on the entire musculoskeletal pathway, and better information on service delivery and patient outcomes.

Recommendations

Recommendations	
R1	The wait associated with the CMATS is currently excluded from the 26-week target, although some services are based in secondary care and there are variations in the way in which CMATS are operating. As part of the response to recommendation 3 in the Auditor General's report **NHS Waiting Times for Elective Care in Wales**, the Welsh Government should seek to provide clarity on how CMATS should be measured, in line with referral to treatment time rules, to ensure that the waiting time accurately reflects the totality of the patient pathway.
R2	Our work has identified that the rate of GP referrals across health board areas varies significantly per 100,000 head of population. The variations are not immediately explained by demographics suggesting differences in referral practices and potential scope to secure better use of existing resources by reducing inappropriate referrals. Health boards should ensure that clear referral guidelines are implemented and adhered to, and that appropriate alternative services are available and accessible which best meet the needs of the patient.
R3	Despite improvements in efficiencies, NHS Wales is still not meeting all of its efficiency measures related to orthopaedic services. Our fieldwork showed that there is scope for even better use of orthopaedic resources, particularly in relation to outpatient performance. As part of the response to recommendation 2 in the Auditor General's report **NHS Waiting Times for Elective Care in Wales**, the Welsh Government and health boards should work together to reshape the orthopaedic outpatient system and improve performance to a level which, at a minimum, complies with Welsh Government targets and releases the potential capacity set out in Appendix 4 of this report.
R4	Our work has identified that, at a national level, there were weaknesses in the ability to influence the delivery of the National Orthopaedic Innovation and Delivery Board's objectives within health boards and to monitor and evaluate efforts to improve orthopaedic services. When establishing similar national arrangements in the future, including the National Orthopaedics Board, the Welsh Government should ensure that the factors that led to the weaknesses in the Delivery Board are considered and actions are put in place to mitigate those weaknesses being repeated.
R5	All health boards have made some progress in putting in place alternatives to orthopaedic surgery, specifically CMATS, but our work found that these are often small scale, at risk of funding pressures and lack any evaluation. The Welsh Government and health boards should work together to undertake an evaluation of CMATS to provide robust evidence as to whether they are providing sustainable solutions to managing orthopaedic demand.
R6	NHS Wales collects and produces a great deal of information about the performance and activity of musculoskeletal services; however, data relating to patient outcomes and patient experience is much sparser. The Welsh Government and health boards should work together to develop a suite of outcome measures as part of the Outcomes Framework, supported by robust information systems, which provide comprehensive management information as to whether orthopaedic services are demonstrating benefits to patients and minimising avoidable harm.

Part 1

Orthopaedic services are more efficient and waits are shorter than a decade ago but performance against waiting time targets has deteriorated recently and demand is continuing to rise



Waiting times for orthopaedic treatment have reduced over the past decade but are longer than in England and Scotland, and increasing, with diagnostic waits an important factor

Waiting times for orthopaedic surgery have decreased in the long term but there has been a more recent deterioration in performance

1.1 Over the past 10 years, there has been an increased focus by the Welsh Government to reduce the maximum time patients should be expected to wait for orthopaedic treatment. Figure 3 shows that the maximum time orthopaedic patients should have expected to wait has reduced from a combined total of 32 months in 2004-05[4] for both GP referral to outpatient visit, and from outpatient to inpatient treatment, down to six months (26 weeks) in 2015-16 from GP referral to receipt of treatment.

Figure 3 – Trend in maximum expected wait set by the Welsh Government for orthopaedic treatment

Period	Maximum time patients should be expected to wait from referral to treatment (months)
2004-05	32
2005-06	24
2006-07	16
2007-08	10
2008-09	7.5
2009 to date	6

Source: Wales Audit Office

4 Target waits only relate to the outpatient and inpatient parts of the orthopaedic pathway. Many patients are likely to have also required diagnostics as part of the decision-making process. These waits were captured separately, with the target wait for diagnostics in 2004-05 at eight weeks.

1.2 The introduction of referral to treatment times[5] by the Welsh Government in 2009 shifted the focus to the total wait from the point of referral through to the end of treatment. This meant that diagnostic waits and the need for follow-up appointments as part of the consultation process were now included within the 26-week target[6]. Prior to 2009, diagnostic waits as part of the consultation process were captured separately; however waits for follow-up appointments were exempt from waiting times measures. In December 2009, performance against the referral to treatment times target peaked with 98.9 per cent of patients treated within 26 weeks.

1.3 Undertaking a longer-term trend analysis of waiting times for orthopaedic treatment is made difficult by differences in the way waiting time data was collected prior to the introduction of referral to treatment time targets in 2009. Figure 4, however, shows a steady improvement in the length of time patients were waiting for both outpatient and inpatient treatment between 2004 and the introduction of referral to treatment times in 2009. In 2004, many patients faced waits of up to 12 and 18 months for their first outpatient appointment, with a similar wait for inpatient treatment. By September 2009, a large majority of patients (89 per cent) were receiving their first outpatient appointment within 10 weeks of referral and 96 per cent of patients were receiving their inpatient treatment within 22 weeks.

Figure 4 – Trend in orthopaedic waiting times for outpatient and inpatient treatment between 2004 and 2009

	Cumulative percentage of patients attending a new outpatient appointment within…					Cumulative percentage of patients receiving inpatient treatment within…				
	10 weeks	22 weeks	6 months	12 months	18 months	10 weeks	22 weeks	6 months	12 months	18 months
September 2004	34	-	56	81	92	27	-	50	84	100
September 2005	39		65	91	100	36		65	97	100
September 2006	48	72	79	100		39	62	70	100	
September 2007	50	85	92	100		40	82	90	100	
September 2008	68	86	100			58	76	96	100	
September 2009	89	99	100			62	96	100		

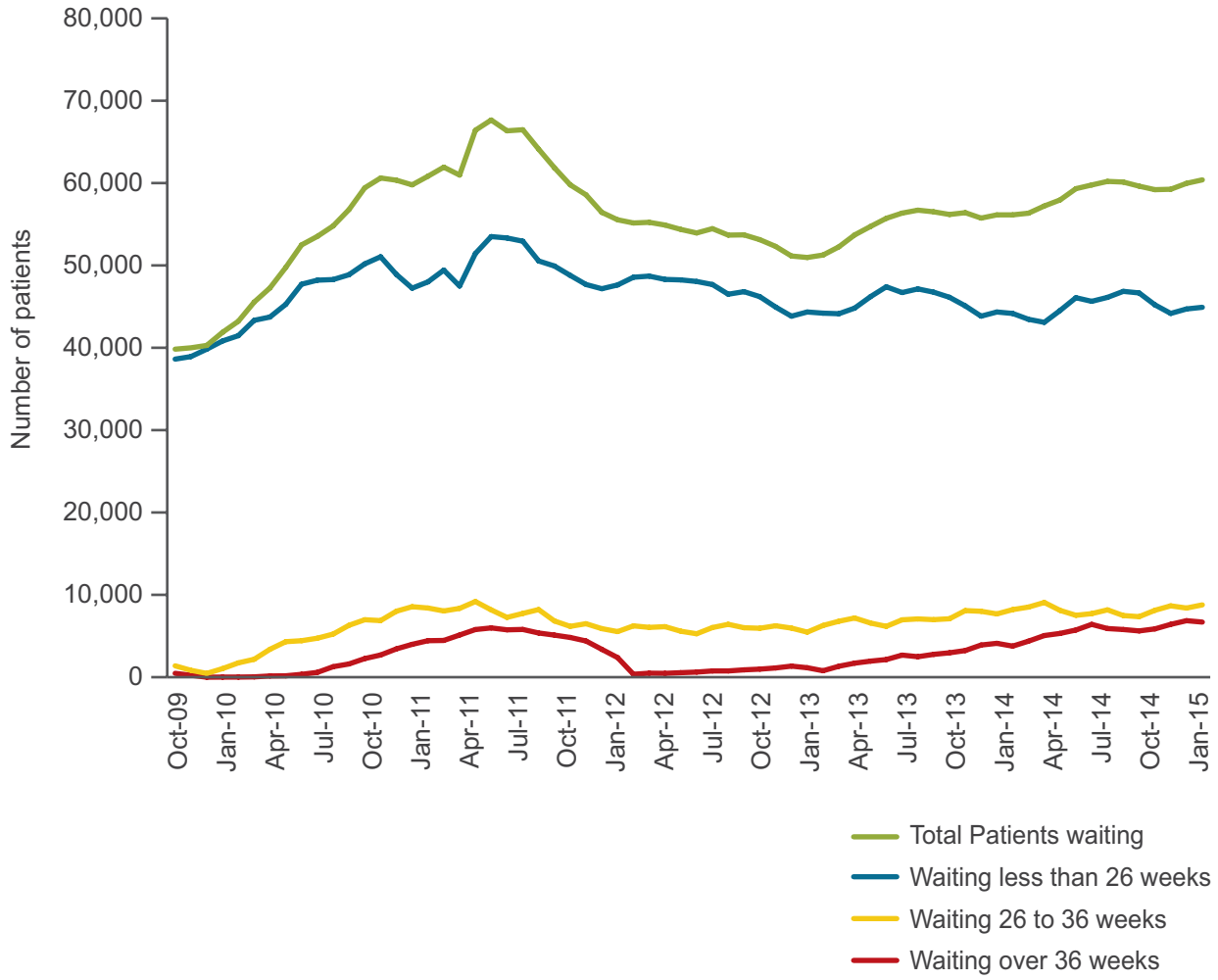
Source: Stats Wales

5 Welsh Health Circular (2007) 014 – **Access 2009 – Referral to Treatment Time Measurement**, Welsh Health Circular (2007) 051 – **2009 Access – Delivering a 26 Week Patient Pathway – Integrated Delivery and Implementation Plan** and Welsh Health Circular (2007) 075 – **2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways**

6 Prior to 2009, waits for orthopaedic treatment stopped at the point of first new outpatient appointment as part of the outpatient wait measure. Only when surgery was considered as appropriate treatment were waits for inpatient treatment started. Any waits associated with diagnostic tests were considered separately as part of the diagnostic waits measure. Waits associated with follow-up outpatient appointments needed to inform the surgical decision-making process were not measured.

1.4 Despite the overall improvements in waits for orthopaedic treatment up to September 2009, performance against the 26-week-wait target across Wales has not been maintained. Figure 5 shows that since 2010, there has been a growing percentage of patients waiting longer than 26 weeks for treatment. The percentage of patients waiting longer than 36 weeks peaked in 2011 but subsequently improved to less than one per cent by March 2012. Since April 2012, there has been a constant increase in the proportion of patients waiting longer than 36 weeks for treatment.

Figure 5 – Trend in orthopaedic waiting times since the introduction of referral to treatment times in 2009



Source: Stats Wales

1.5 All health boards met the waiting times target in March 2012 with the exception of Cardiff and Vale University Health Board where particular problems in relation to dealing with demand for spinal surgery had been identified. Since the financial year 2011-12, none of the health boards have met the 95 per cent target for trauma and orthopaedic patients waiting less than 26 weeks. Similarly, none of the health boards have met the target for treating all patients within 36 weeks.

1.6 NHS Wales has taken several actions in an attempt to address the deterioration in performance since early 2010, including placing two health boards under 'special measures'[7] and allocating monies to all health boards to specifically focus on reducing waiting times. The 'special measures' arrangements were lifted as a result of the improvements in the percentage of patients waiting more than 36 weeks during 2012. More latterly, health boards have been facing additional difficulties in meeting waiting times targets, particularly in relation to unscheduled care pressures. Some health boards formally announced the decision to postpone elective orthopaedic surgery for reasons including high levels of unscheduled care demand[8]. All health boards have dedicated elective orthopaedic beds. The ability to ring fence these beds, however, is reduced when there are increased pressures from unscheduled care, as these beds are then used to manage demand from trauma and non-orthopaedic emergencies, resulting in increased waits for an elective orthopaedic admission.

People in Wales wait longer for orthopaedic treatment than in England and Scotland but waiting times in Northern Ireland are similar to Wales

1.7 The Auditor General for Wales report on **NHS Waiting Times for Elective Care in Wales** has already shown that Scotland and England are performing better against more stringent referral to treatment time targets for elective care. We have observed similar patterns for orthopaedics. As referred to in the report on NHS Waiting Times, there is some inconsistency within the United Kingdom in the way that waiting times are measured. Using the same approach as that set out in the Auditor General report, Figure 6 gives as accurate a comparison as possible in relation to the percentage of patients waiting less than 26 weeks. We have also provided the average (median) waiting times for orthopaedics across England and Wales[9], which gives an indication of the relative lengths of wait for patients. Figure 6 indicates that waiting times for orthopaedic treatment in Wales are longer than in England and Scotland, but similar to Northern Ireland.

7 In 2010, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board were both placed under 'special measures' in relation to the provision of trauma and orthopaedic services. As set out in the NHS (Wales) Act 2006, Welsh ministers may take intervention following the breaching of waiting list targets when arrangements for the provision of services are deemed to require significant change. The subsequent introduction of a new escalation and intervention framework in March 2014 has introduced further definitions of when special measures should be utilised.

8 Betsi Cadwaladr University Health Board announced it was postponing elective surgery in January 2014. This involved a planned reduction in elective activity in line with expected increases in unscheduled care demand and a temporary suspension of some elective admissions at times when trauma patients were occupying beds on elective orthopaedic wards to prevent the risk of MRSA infection. Hywel Dda University Health Board had made a similar announcement in October 2013.

9 Currently, England is the only part of the UK that reports median waiting times for the full patient pathway based on the open measure. While there are some differences in how the data is measured – figures for Wales include adjustments while those in England do not – and which patients are included, it is possible to make a broad comparison between Wales and England.

Figure 6 – Comparison of orthopaedic waiting times in the United Kingdom

	Average (median) waiting times (weeks)	Percentage of patients waiting less than 26 weeks
England (February 2015)	6.4	97
Northern Ireland (December 2014)	-	72
Scotland (December 2014)	-	95
Wales (February 2015)	15.9	76

Source: Stats Wales, NHS England, the Department of Health, Social Services and Public Safety in Northern Ireland and NHS National Services Scotland

The way in which data for musculoskeletal assessment and treatment services are recorded can mean that orthopaedic waiting times for many patients across Wales are underreported

1.8 Over the last 10 years, all health boards have implemented a CMATS. CMATS are multidisciplinary teams aimed at offering a first point of contact for GP and emergency unit referrals for assessment and treatment of musculoskeletal-related pain and musculoskeletal conditions. CMATS will accept referrals, organise diagnostic investigation and initial management, and refer onward where appropriate. The emphasis is on therapeutic management and supported self-care with referral to secondary care only when there is a need for hospital-based specialist services.

1.9 National guidance states that CMATS should be treated as a diagnostic service with a target wait of eight weeks[10], although waiting times for CMATS are currently not formally monitored and reported. Consequently, when patients are referred by their GP to orthopaedic services, the wait associated with the CMATS is excluded from the 26-week target. Where the quality of a GP referral is of a high standard and it is clear to the CMATS that the patient's condition can only be met by specialist secondary care services, these referrals will be referred onwards within five working days and the impact on overall waiting times for orthopaedic care will be minimal. However, many patients will be required to attend a face-to-face assessment with the CMATS before an onward referral can be made.

1.10 Our fieldwork identified that for some health boards, waits for face-to-face assessment by CMATS during 2013-14 were reportedly as long as 14 weeks (Figure 7). Only Aneurin Bevan University Health Board and Powys Teaching Health Board were meeting the target wait of eight weeks. At the time of our work, the CMATS in Hywel Dda University Health Board was not acting as a single point of contact but instead was reviewing referrals for patients already on the orthopaedic waiting list. No data was available for Cardiff and Vale University Health Board.

10 Welsh Government Orthopaedic Innovation and Delivery Board – Clinical Musculoskeletal Assessment and Treatment Service – Guidelines and framework to underpin implementation by local health board

Figure 7 – Waits for a face-to-face assessment by CMATS during 2013-14

Health board	Wait (weeks)
Powys Teaching Health Board	4
Aneurin Bevan University Health Board	6
Abertawe Bro Morgannwg University Health Board	10
Cwm Taf University Health Board	13
Betsi Cadwaladr University Health Board	14

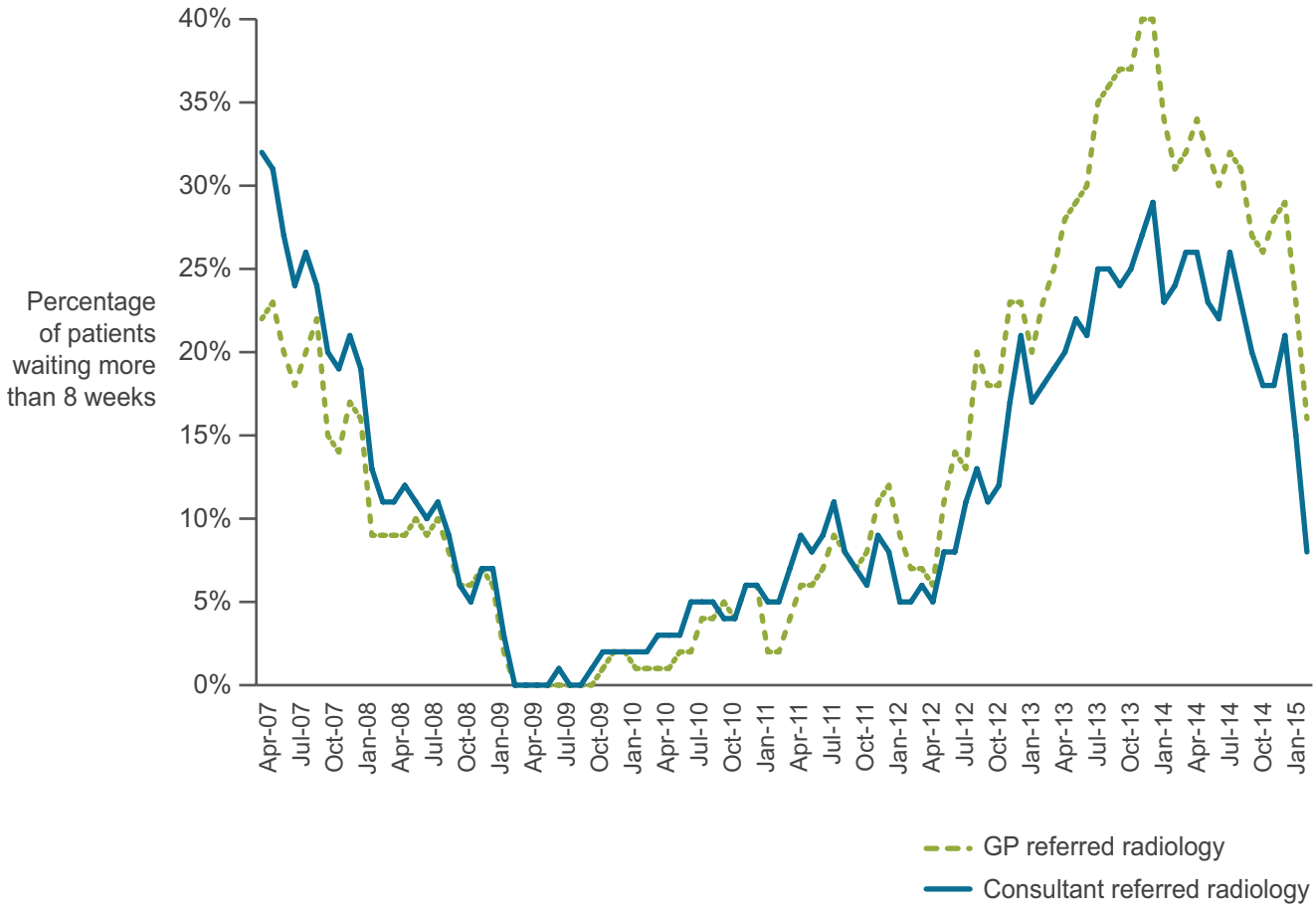
Source: Wales Audit Office fieldwork

There has been a sharp rise in the number of patients waiting more than eight weeks for diagnostic tests and more than 14 weeks for physiotherapy, which impacts on overall orthopaedic waiting times, although performance in these areas is starting to improve

1.11 People with musculoskeletal conditions often need diagnostic tests to provide clarity on the cause and extent of their problems. The Welsh Government's targets say that patients should wait no longer than eight weeks for diagnostic tests. Figure 8 shows significant improvement in waiting times for radiology tests up to early 2009. However, since the introduction of referral to treatment times in December 2009, there has been a sharp rise in patients waiting longer than eight weeks for radiology[11] tests, with performance starting to improve from early 2014.

11 Data taken from www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month and includes all referrals for radiology tests, and not just those for orthopaedic patients. Tests include barium enema, Computerised Tomography (CT) scans, Magnetic Resonance Imaging (MRI), non-obstetric ultrasound and nuclear medicine.

Figure 8 – Percentage of consultant and GP-referred radiology referrals where patients are waiting over eight weeks



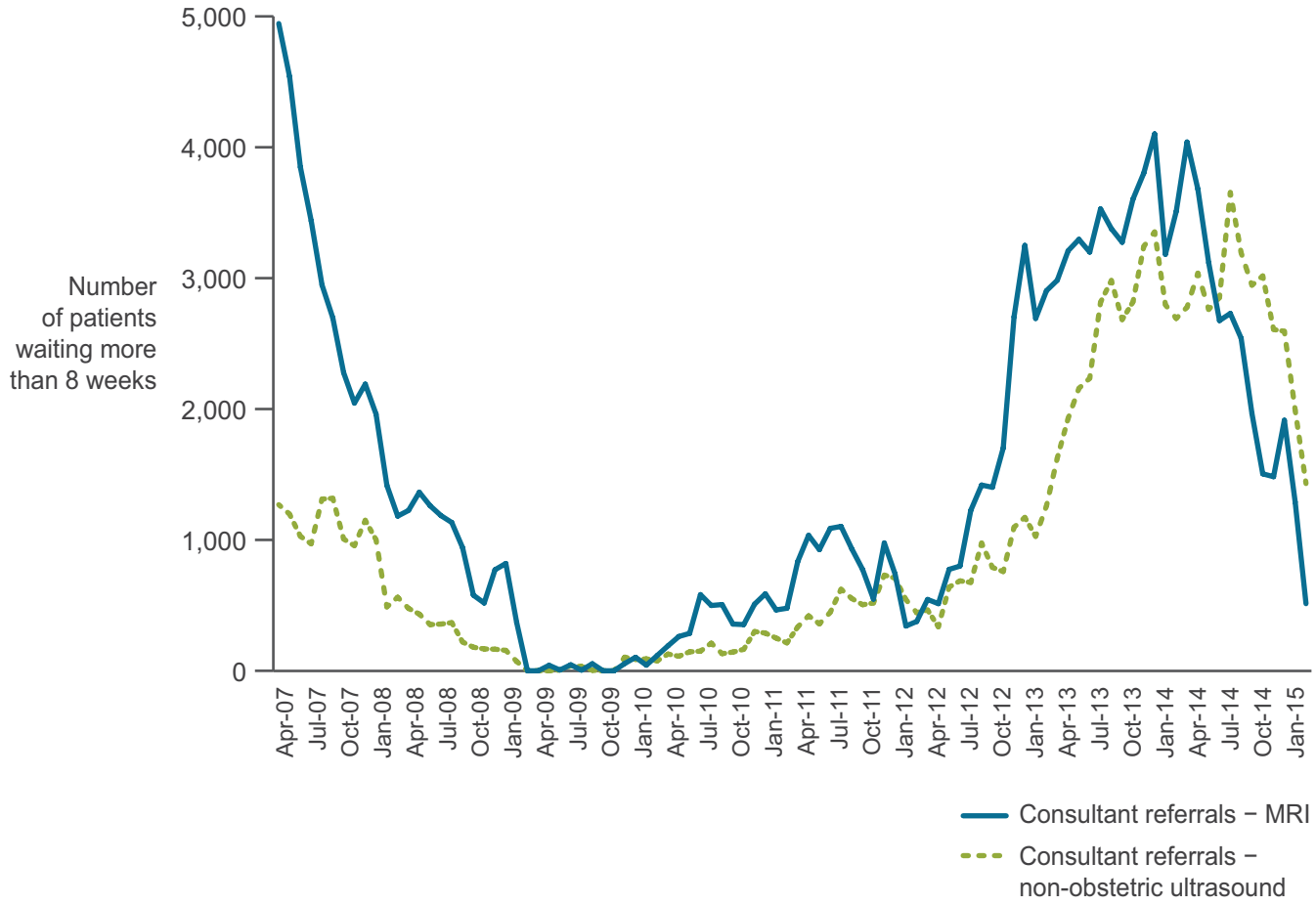
Source: Stats Wales

1.12 Common tests for patients with musculoskeletal conditions include ultrasound and Magnetic Resonance Imaging (MRI) scans. These account for approximately 70 per cent of all direct radiology referrals measured within the Welsh Government diagnostic waits indicator[12]. Figure 9 shows that despite significant improvements in waiting times up to December 2009, the number of patients waiting longer than eight weeks for an MRI scan has grown with the number waiting in April 2014 at 4,040 compared with 191 in April 2010[13]. This has subsequently reduced to 513 in March 2015.

1.13 There has been a similar increase in the number of patients waiting longer than eight weeks for ultrasound[14] scans. In April 2014, there were 2,778 patients waiting longer than eight weeks, up from 128 in April 2010. This has subsequently reduced to 1,431 in March 2015, although the national shortage of ultrasonographers being experienced across the UK continues to present challenges.

12 Routine diagnostic tests such as plain x-rays are considered as part of the referral to treatment times indicator and are expected to be achieved within the shortest possible wait, in order for NHS bodies to be able to maintain waiting times below 26 weeks.
13 Data taken from www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month – Radiology Consultant Referral – MR.
14 Data taken from www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month – Radiology Consultant Referral – Non Obstetric Ultrasound.

Figure 9 – Number of consultant MRI and ultrasound referrals where patients are waiting over eight weeks



Source: Stats Wales

1.14 People with musculoskeletal conditions also often require physiotherapy. The Welsh Government's targets say that patients should wait no longer than 14 weeks for therapy intervention. Figure 10 shows that the number of patients waiting more than 14 weeks for a physiotherapy appointment reduced considerably in 2007 and 2008, remaining low until mid-2011 but then rising to a peak in August 2012 before reducing again during 2013[15]. More recently, there has been a gradual increase in the number of patients waiting more than 14 weeks with four health boards (Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, and Hywel Dda University Health Boards) not meeting the Welsh Government target in March 2015.

15 Data taken from www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month - Physiotherapy Adult Services.

Figure 10 – Percentage of patients waiting more than 14 weeks for physiotherapy

Source: Stats Wales

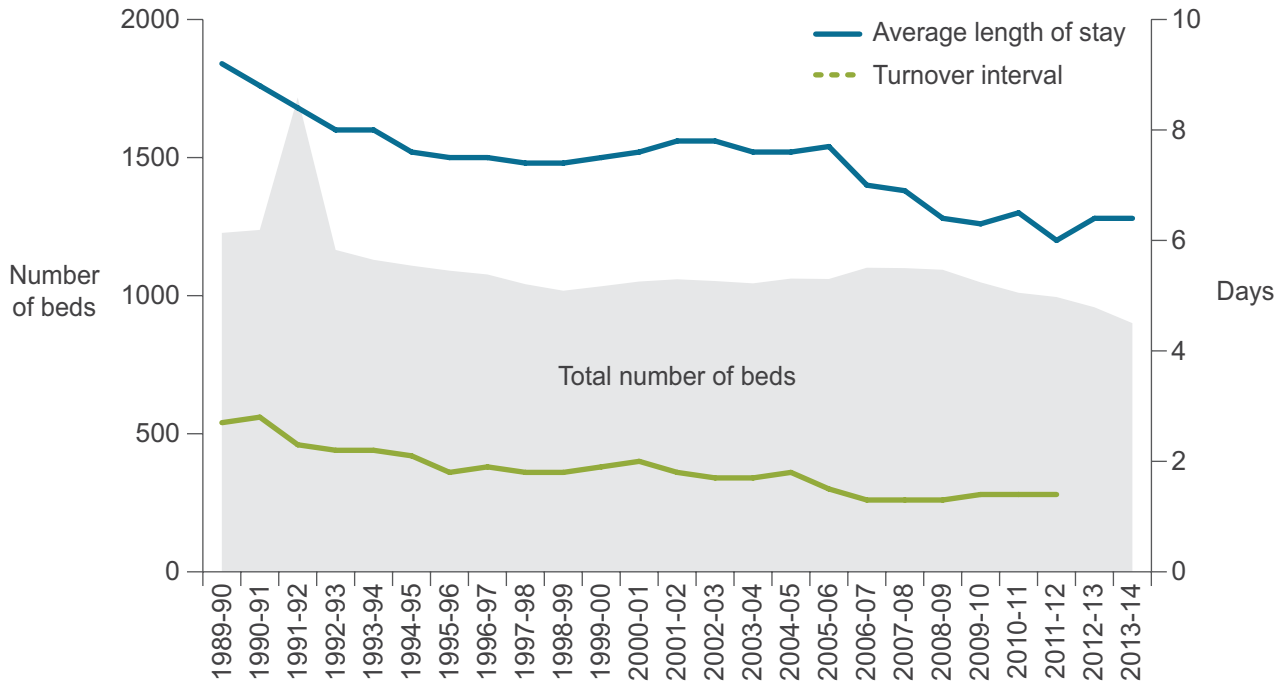
1.15 Demand on physiotherapy services, however, is partly determined by the level of throughput through the system. As outpatient departments or community based teams refer and assess more patients, more demand is placed on the physiotherapy teams. In contrast, as throughput slows down due to blockages in the pathway or a reduction in demand, the demand on physiotherapy services reduces. The reported improvements in compliance with the 14-week target during the period July 2012 to January 2014 reflect a period when the number of patients referred to physiotherapy services decreased.

The NHS in Wales is using its orthopaedic resources more efficiently than in the past but is not doing enough to address increasing demand

Whilst the number of orthopaedic beds is decreasing, health boards are using the remaining beds more efficiently, largely due to shorter lengths of stay and increased day-case rates

1.16 Whilst the number of orthopaedic beds in Wales has decreased from 1,227 in 1989-90 to 900 in 2013-14[16], Figure 11 shows that NHS Wales is using its remaining orthopaedic beds more efficiently. The average length of stay for orthopaedic patients (both elective and emergency) has decreased constantly over the past 24 years from 9.2 days to 6.4 days in 2013-14. The figure also shows a consistent decrease in the turnover interval[17] for orthopaedic beds, meaning that health boards are managing to reduce the gaps between one patient being discharged from an orthopaedic bed and the next patient being admitted. This is one way of measuring efficiency although caution needs to be given to ensure that a shorter turnover interval does not affect cleaning regimes to minimise hospital-acquired infection.

Figure 11 – Length of stay and bed turnover intervals for orthopaedic patients in Wales



Source: Stats Wales

16 Data taken from www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/NHSBeds-by-Specialty - Trauma and Orthopaedic.

17 The average length of time (in days) that elapses between the discharge of one patient and the admission of the next patient to the same bed over any period of time. Turnover intervals were no longer published from 2012 onwards.

1.17 These improvements have been helped by changes in clinical practices. Efficiencies have been secured by ensuring more patients have their orthopaedic surgery as day cases, meaning patients are admitted, treated and discharged on the same day. In 2009-10, on average, 49 per cent of elective orthopaedic patients were treated as a day case. In 2013-14, that position had improved to 57 per cent. In addition to securing more efficient use of hospital beds, increasing day case rates means patients are at less risk of suffering complications arising from hospital-acquired infections.

1.18 There has also been a greater focus on bringing patients into hospital on the day of surgery. In 2009-10, on average, 49 per cent of elective patients were admitted on the day of surgery. In 2013-14, that position had improved to 65 per cent. Previously, concerns raised over the ability to guarantee the availability of a hospital bed resulted in clinical practice to admit patients the night before surgery, resulting in an unnecessary overnight stay for many patients. The introduction of admission lounges in a number of hospitals across Wales has allowed patients the ability to come into a non-ward environment on the morning of surgery to wait in before their operation. This allows other patients to be discharged from the ward, freeing up the bed for the patient following surgery and reducing the turnover interval between patients.

1.19 More recent improvements have also been made in relation to the introduction of new initiatives such as 'joint schools'. Joint schools provide educational sessions for patients undergoing orthopaedic surgery including an opportunity for patients to practice physiotherapy exercises and techniques that will be required post-operatively. The joint school is held prior to hospital admission and research indicates that the approach results in quicker recovery post-surgery and a reduced hospital stay. Figure 12 shows the recent improvements in the average length of stay for elective hip and knee replacements, both of which comply with the Welsh Government targets for these procedures.

Figure 12 – Average length of stay (days) for elective hip and knee replacement patients

Procedure	Target	2009-10	2013-14
Elective hip replacement	6.1	8.2	6.1
Elective knee replacement	6.5	7.3	5.5

Source: NHS Wales Informatics Service

1.20 All of these improvements have helped secure continued improvements in the overall length of stay for elective orthopaedic patients. In 2009-10, the average length of stay was 3.9 days. In 2013-14, that position had improved to 3.6 days, which is below the Welsh Government target of four days. There is, however, variation across health boards (Figure 13).

Figure 13 – Average length of stay (days) for elective orthopaedic, hip and knee replacement patients in 2013-14

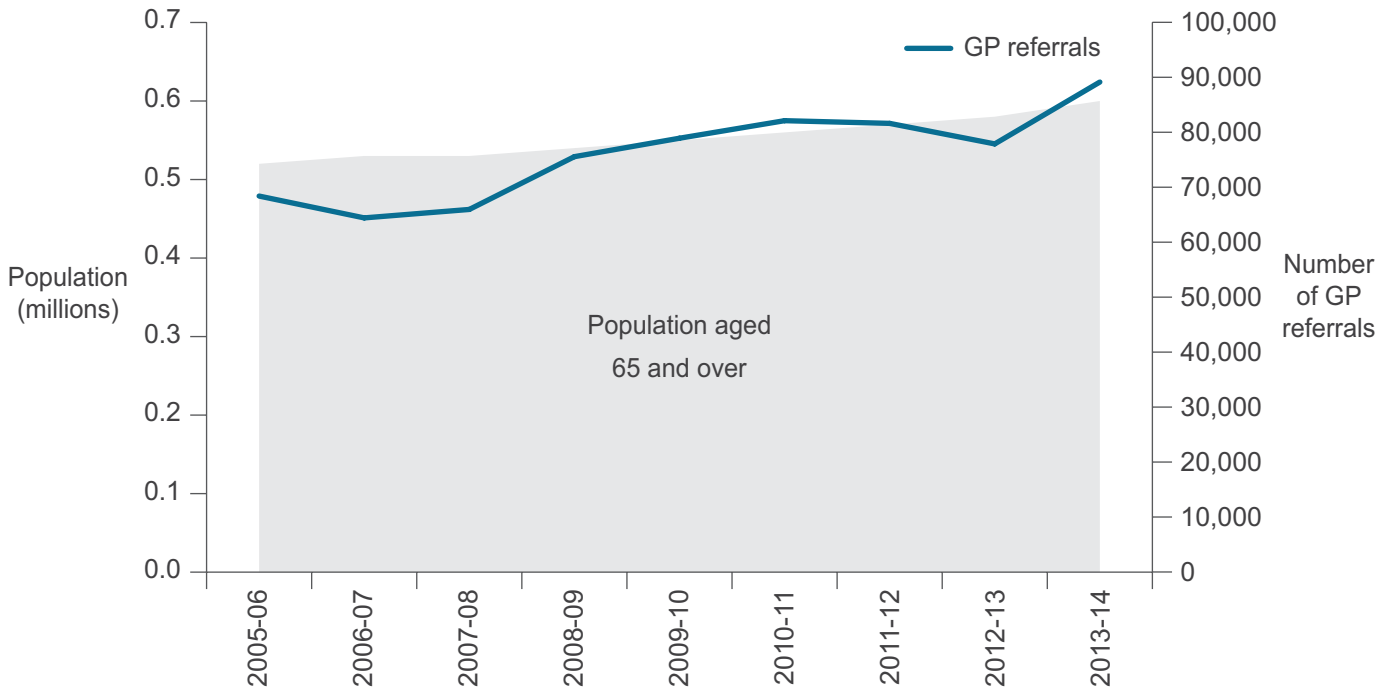
Health board	Elective orthopaedic patients	Elective hip replacements	Elective knee replacements
Abertawe Bro Morgannwg	3.9	6.5	5.4
Aneurin Bevan	4.1	6.6	5.5
Betsi Cadwaladr	3.4	4.7	4.5
Cardiff and Vale	4.1	5.9	6.5
Cwm Taf	4.6	7.2	5.9
Hywel Dda	3.1	5.5	5.4

Source: NHS Wales Informatics Service

Despite increased capacity and improved efficiency, NHS Wales is struggling to meet the demand placed on it from an increasing rate of GP referrals and activity levels are reducing

1.21 As shown in Figure 1 on page 8, the number of GP referrals to orthopaedic services has increased by 30 per cent since 2005. Over the same period, the overall population in Wales has increased by 3.8 per cent. An ageing population has the greatest impact on orthopaedic services and Figure 14 shows that the growth in GP referrals for orthopaedics is accelerating at a much faster rate than the growth in overall population aged 65 and over, which has increased since 2005 by 15.6 per cent.

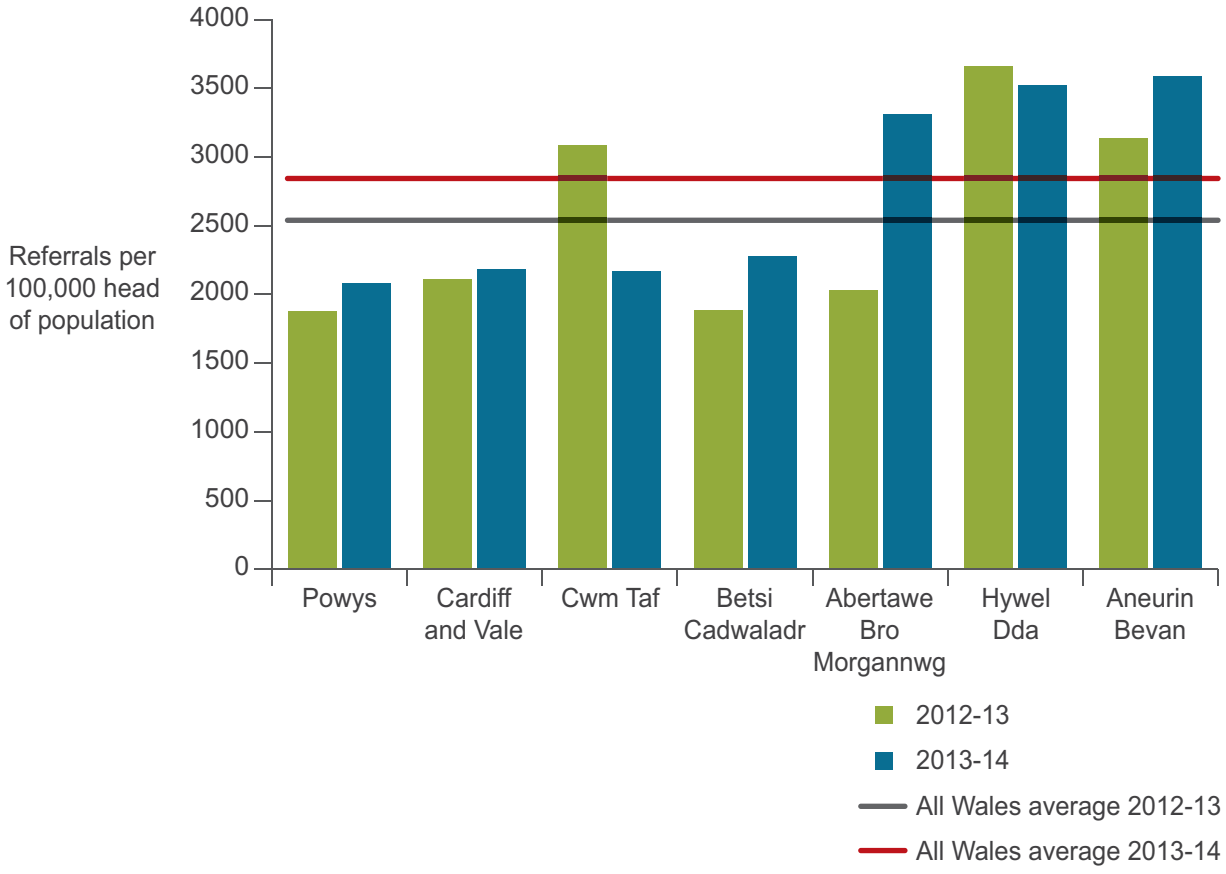
Figure 14 – Trend in GP orthopaedic referrals compared with trend in population



Source: Stats Wales and NHS Wales Informatics Service

1.22 Our analysis of the information that is available has identified that the rate of GP referrals across commissioning health board areas varies significantly per 100,000 head of population (Figure 15). The variations are not immediately explained by demographics, suggesting differences in referral practices and potential scope to secure better use of existing resources by reducing inappropriate referrals to outpatient departments. The reasons for higher referral rates can include a lack of referral guidelines, GP behaviours, patient expectations and a lack of services that offer alternatives to surgery. In addition, GP referrals across Wales only account for approximately 53 per cent of all referrals to orthopaedics. The way in which the local CMATS operates can influence the GP referral rate as referrals from some CMATS can be classed as GP referrals whilst others may be classed as referrals from other healthcare professionals.

Figure 15 – Rate of GP referrals per 100,000 head of population by commissioning health board

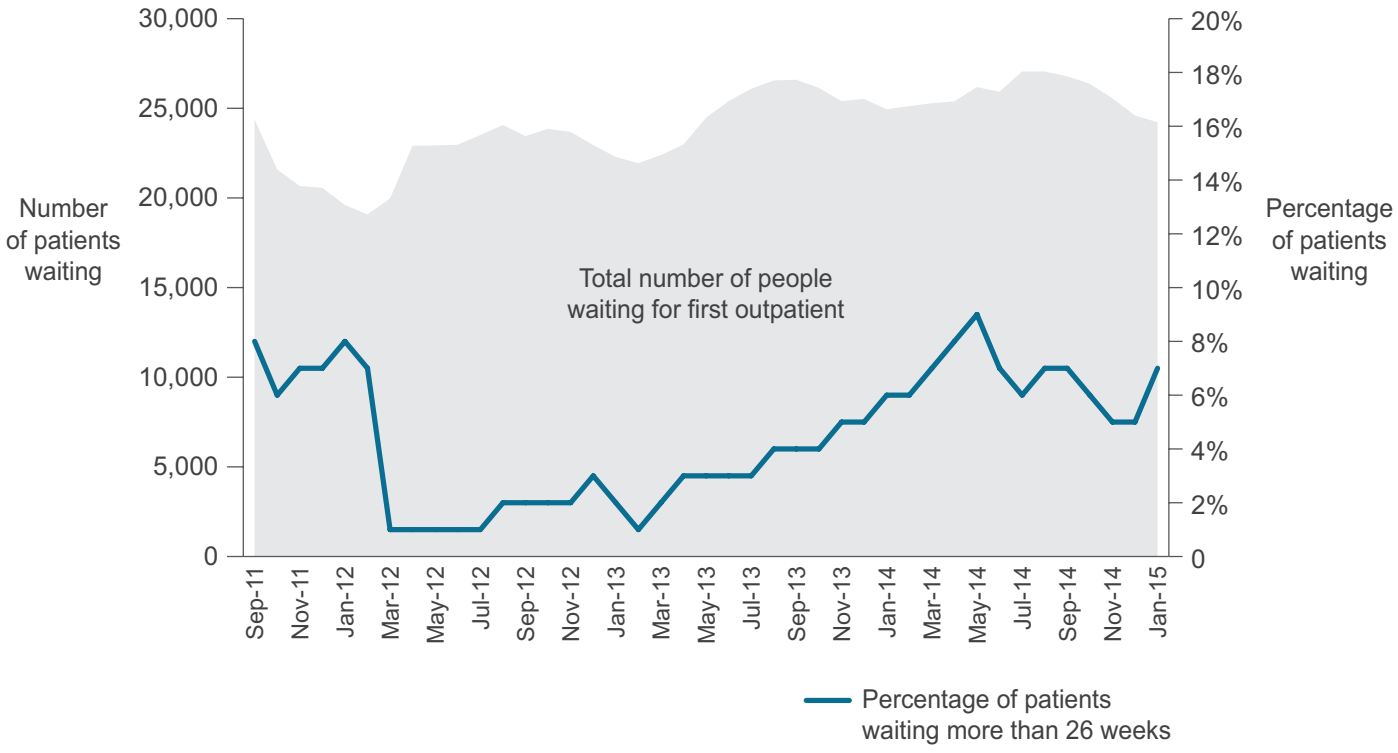


Source: Stats Wales

1.23 The increase in GP referrals has contributed to a sharp growth in new outpatient attendances. Between 2005 and 2012, there was a 32 per cent increase in new outpatient attendances, although the level since 2012 has started to decline. Whilst some of the increase will be as a direct result of the increased demand from GP referrals, it is also a product of more capacity within the system to see more patients. The number of trauma and orthopaedic consultants has increased almost two-fold from 86 Whole-Time Equivalents (WTEs) in 2005-06 to 143.2 WTEs in 2013-14.

1.24 Despite the increased level of consultant staff, NHS Wales is struggling to meet demand. Figure 16 shows an increasing trend in the number of patients waiting more than 26 weeks for their first outpatient appointment since April 2012. A review of activity levels has also identified that since 2012, there has been a reduction of 9.4 per cent in outpatient activity, which will contribute to an increase in waiting times.

Figure 16 – Number of patients waiting for a first outpatient appointment compared with the percentage of those waiting more than 26 weeks



Source: Delivery Unit, Welsh Government

1.25 Once patients are seen in the outpatient department, the pressure from demand on diagnostic and therapy services referred to in paragraphs 1.11 to 1.15 impacts further on the ability to see and treat orthopaedic patients within 26 weeks. Patients who are waiting for admission account for between 15 and 19 per cent of all patients on the orthopaedic waiting list at any one time. Our analysis of waiting times data has shown that by the time a decision to admit a patient for orthopaedic surgery is made, between 10 to 12 per cent of patients will have already been waiting more than 26 weeks and a further five to seven per cent of patients will breach the 26-week target while waiting for admission. Activity data also shows that there has been a 20 per cent reduction in elective activity since 2012. Unscheduled care pressures within orthopaedics do not explain this with a 7.5 per cent reduction in trauma activity during the same period; however, wider unscheduled care pressures are likely to have had an impact on the level of elective throughput.

There is still scope to make more efficient use of existing resources, although these would not be sufficient to meet the current demand and more fundamental approaches to demand management are going to be needed

1.26 Despite the positive improvements in efficiencies, NHS Wales is still not meeting all of its efficiency measures related to orthopaedic services. Our fieldwork showed that there is scope for even better use of orthopaedic resources, particularly in relation to outpatient performance. Figure 17 sets out performance across Wales against Welsh Government targets during 2013-14 and the potential impact improvements in the respective areas could have.

Figure 17 – Performance against Welsh Government targets in 2013-14 and impact on use of resources

Efficiency measure	Welsh Government target	2013-14 NHS Wales performance	Potential impact[18]
Reduced 'did not attend' rates for new outpatient appointments	Five per cent	7.8 per cent	Achievement of the Welsh Government target could free up an additional 4,079 new outpatient slots.
Reduced 'did not attend' rates for follow-up outpatient appointments	Seven per cent	8.9 per cent	Achievement of the Welsh Government target could free up an additional 5,748 follow-up outpatient slots.
Reduced number of follow-up appointments	1.9 follow-up appointments to every one new appointment	1.98 follow-up appointments to every one new appointment	Achievement of the Welsh Government target could free up an additional 11,184 follow-up outpatient slots.
Increased number of elective cases treated as a day case	75 per cent	57 per cent	Achievement of the Welsh Government target could free up a minimum of 6,949 bed days.
Increased number of elective patients admitted on the day of surgery	64 per cent	65 per cent	None as Welsh Government target being achieved by NHS Wales as a whole.
Reduced elective length of stay	Four days	3.6 days	None as Welsh Government target being achieved by NHS Wales as a whole.

Source: Wales Audit Office

1.27 In total, the potential impacts described in Figure 17 could create an extra 339 new outpatient slots, 1,411 follow-up outpatient slots and 579 bed days per month. However, Figure 18 shows that even if these improvements are secured, there would not be enough capacity to bring waiting times for orthopaedic treatment in line with the Welsh Government target based on the waiting times position at the end of January 2015.

18 Based on activity undertaken during the financial year 2013-14.

Figure 18 – Potential freed-up capacity compared with number of patients waiting more than 26 weeks

Freed-up capacity per month	Number of patients waiting more than 26 weeks at 31 January 2015	Shortfall
339 new outpatient appointment slots	1,756 patients waiting for first outpatient appointment	1,417
1,411 follow-up outpatient appointment slots	3,942 patients waiting for post-diagnostic follow-up appointment	2,531
579 bed days	2,795 patients[18] waiting for an elective inpatient admission with a target length of stay of four days	10,601

Source: Wales Audit Office

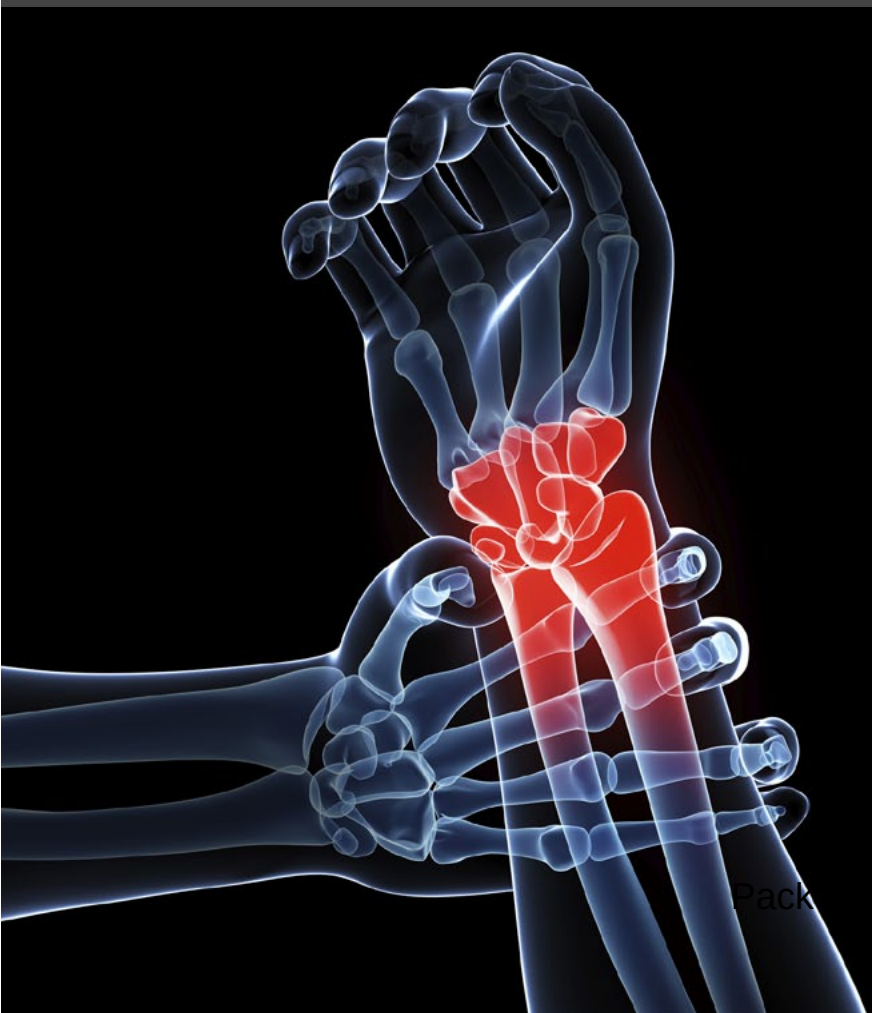
1.28 Figure 18 describes the all-Wales position and it should be noted that scope for improvements in the use of existing resources varies across the health boards in Wales. Appendix 5 shows how the parameters presented in Figures 17 and 18 vary by health board. We have prepared individual reports for each health board in Wales, highlighting where scope exists for improvements in use of existing resources based on an analysis of a range of performance data relating to musculoskeletal services. Individual health board reports can be accessed at www.audit.wales.

1.29 Whilst there remains further scope to improve efficiency, it is unlikely that improvements in these areas alone will secure the extent of improvement needed to offset the increasing demand across NHS Wales This suggests that health boards, in parallel with their continued efforts to improve efficiency, need to take more radical alternative approaches to meet orthopaedic demand in future. This would include such approaches as the further development of services to provide alternatives to surgery, implementation of more stringent thresholds for surgery to maximise the value added to patients' lives, and the stopping of interventions that have been clinically proven to provide limited benefit such as lumbar spine procedures.

19 Total number of patients waiting more than 26 weeks for an inpatient or day-case admission at the end of January 2015 was 11,179. Assumption that if Welsh Government targets were achieved 75 per cent of these patients would be treated as a day case.

Part 2

At a national level, there has been a clear commitment to improving musculoskeletal services with matching investment but the approach has had less impact than expected



The Welsh Government took the positive step of forming the National Orthopaedic Innovation and Delivery Board, whose work was supported by clear objectives and additional ring-fenced investment

2.1 The formation of the National Orthopaedic Innovation and Delivery Board (the Delivery Board) in June 2011 represented a positive step to drive improvement in orthopaedic services. Initially chaired by the then Chief Executive of NHS Wales, the Delivery Board had a high profile. During our fieldwork, we were told about a definite sense of enthusiasm and expectation from staff around the formation of the Delivery Board.

2.2 The Delivery Board's purpose was clear. It was designed to oversee progress towards the objectives of the National Orthopaedic Programme and provide leadership and guidance in the delivery of a new service model for orthopaedics. The objectives of the National Orthopaedic Programme were clear and had definite timescales. The objectives were:

a the elimination of waiting times for orthopaedic treatments in excess of 36 weeks by March 2012;

b the establishment of a modern, efficient service model for orthopaedics, based on best practice, across Wales by March 2013, including the full delivery of the three national 'Focus On' pathways[20]; and

c the establishment of a fully sustainable orthopaedic service across Wales, meeting all Annual Quality Framework requirements including national targets for waiting times, quality, safety and patient outcomes by March 2013.

2.3 The Delivery Board was supported by three task and finish subgroups that carried out considerable work on Public Health and Primary Care; Intermediate Care, and In-Hospital Care.

2.4 Central funding from the Welsh Government supported the work of the Delivery Board. In March 2011, the then Minister for Health and Social Services announced the availability of £65 million to NHS Wales over three years for improving orthopaedic services. In her statement, the minister said orthopaedic services in Wales would become 'best in class' in relation to efficiency, productivity and clinical outcomes. As well as using existing hospital capacity optimally, the minister stated an intention to 'maximise the range of alternative treatments to surgery'. The statement also said that additional orthopaedic capacity would be needed in the immediate term.

20 Focus On' pathways were developed to cover the management of knee replacements, hip replacements and emergency admission for fractured neck of femur, with the overall aim to set out evidence-based pathways of care that could be consistently applied across Wales.

2.5 The £65 million in additional funding is equivalent to approximately six per cent of the total expenditure for musculoskeletal services between 2011-12 and 2013-14[21]. Over the three years, it was proposed that £43 million was available on a recurrent basis, with a further £22 million available on a non-recurrent basis subject to meeting selection criteria set out by the Delivery Board.

The Delivery Board was set up to drive change but it did not achieve some objectives and its impact on waiting times was short-lived

The Delivery Board produced a clear and compelling vision for the improvement of orthopaedic services and established an appropriate infrastructure of task and finish groups to help achieve the vision

2.6 The Delivery Board succeeded in producing a vision for the future of orthopaedic services. The NHS Wales Orthopaedic Delivery Framework was presented to the Delivery Board in July 2011. It set out a vision for a new orthopaedics service model, a one-page strategy for transforming musculoskeletal services and details of how the implementation of the framework would be driven by the three task and finish subgroups set out in paragraph 2.3. The vision focused on the whole system starting from the prevention of musculoskeletal conditions, through to primary care and community interface services to hospital-based care. The one-page strategy (shown in Figure 19) was designed to be a starting point for establishing the detail within the framework and was supposed to be used by the Delivery Board and by each health board to ensure a whole-systems approach.

2.7 The document presented to the Delivery Board in July 2011 set out specific milestones for delivering the framework. The Delivery Board described the timescales as 'realistic but challenging'. This included the setting out of:

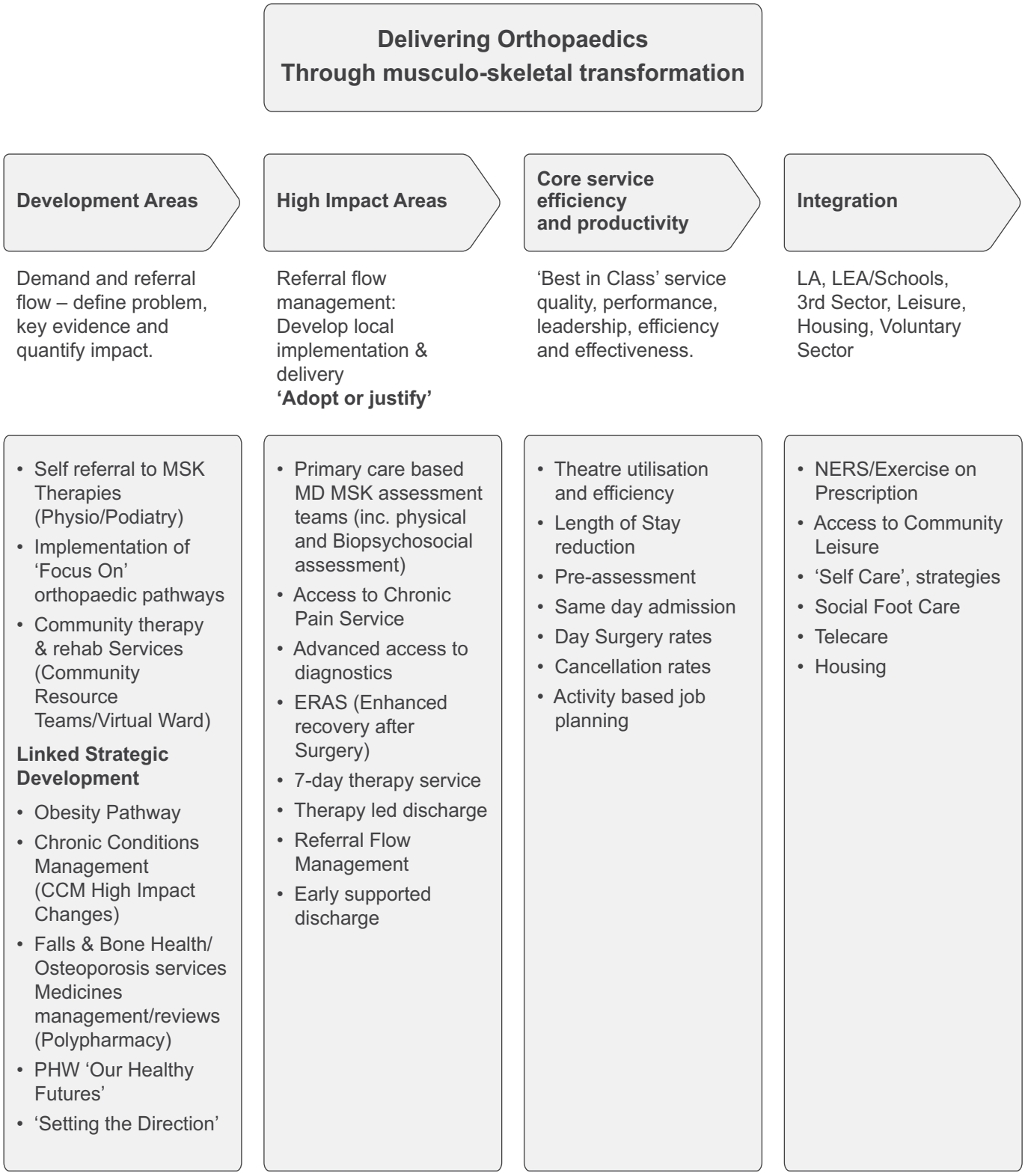
a recommendations for immediate implementation by September 2011 for health boards to implement by March 2012; and

b lower-priority recommendations (defined by the task and finish groups) in January 2012 for implementation by health boards in 2012-13.

2.8 Each of the subgroups set out development and implementation areas and how these were to be taken forward through a number of work streams within each of the task and finish groups. The chairs of the subgroups were held to account for progress against the development and implementation areas at Delivery Board. For the remainder of the Delivery Board's existence, the subgroups provided each meeting with an update on progress. These updates clearly show that each subgroup carried out considerable work.

21 Stats Wales, Programme budgets – www.statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget/NHSExpenditure-by-BudgetCategory-Year

Figure 19 – The one-page strategy for transforming musculoskeletal services



Source: National Orthopaedic Innovation and Delivery Board, July 2011

Despite initial intentions for the Delivery Board to drive sustainable development, the process for allocating funding was ultimately driven by the Welsh Government and the bulk of the funds available were targeted at securing immediate improvements in waiting time performance

2.9 The Welsh Government allocated the three-year recurrent element of the funding to health boards in 2011-12 and presented the allocation to the Delivery Board for information. This allocation was based on the level of activity required to reduce the imbalance in the waiting list position for orthopaedic services across Wales and provided the basis for future allocation of recurrent funding in 2012-13 and 2013-14.

2.10 The Welsh Government also allocated the non-recurrent funding in 2011-12 to eradicate backlog waiting lists that had built up since 2009, and specifically the waiting lists for foot, ankle and major spine treatment that had built up in Cardiff and Vale University Health Board. No recurrent funding was allocated to Powys Teaching Health Board given that orthopaedic waiting times at that time were being achieved.

2.11 The Delivery Board was responsible for considering the basis for distributing any unallocated portion of recurrent funding and the non-recurrent funding for 2012-13 onwards. At the February 2012 meeting of the Delivery Board, it was stated that health boards would be invited to bid against the non-recurrent funding, based on selection criteria established by a subgroup of the Delivery Board. This subgroup consisted of the NHS Wales Director of Operations, the NHS Wales Director of Finance, a consultant orthopaedic surgeon, a director of planning and a representative from the Welsh Government's Delivery and Support Unit. However, by May, the Delivery Board received a finance paper setting out the allocations of a large proportion of the non-recurrent funds from the Welsh Government. Of the initial £15.3 million of non-recurrent funding for 2012-13, this left just £4.2 million to be made available for health boards to submit proposals for sustainable solutions. Health boards were given just three weeks to submit bids.

2.12 In 2013-14, the non-recurrent funding was removed as the original three-year plan for the funding recognised that all of the backlog within the system should have been eradicated by year 3. However, a residual balance of £4.9 million on the recurrent funding was made available. This was used to extend the bids approved in 2012-13 by a further six months. Appendix 3 sets out the details of the allocation of the recurrent and non-recurrent funding during these three years, noting that just under £3 million of the £65 million was never allocated.

The work of the Delivery Board and its subgroups did facilitate a short-lived improvement in waiting times but there was limited success in driving other priorities, particularly in relation to the longer-term solutions to managing musculoskeletal demand

2.13 A specific aim of the national programme was to eliminate orthopaedic waiting times in excess of 36 weeks by March 2012. As mentioned in paragraph 1.5, this target was achieved in all health boards with the exception of Cardiff and Vale University Health Board. The reduction, however, was short-lived and waiting times increased steadily from April 2012.

2.14 A further aim of the national programme was to establish a fully sustainable orthopaedic service across Wales, capable of meeting all the relevant Annual Quality Framework requirements that existed at the time, including national targets for waiting times, by March 2013. However, by the end of the financial year 2012-13, 14 per cent of patients were waiting more than 26 weeks compared with the target of five per cent, with 781 patients waiting more than 36 weeks. This has subsequently risen to 3,770 patients waiting more than 36 weeks by March 2014 and more recently 6,861 in February 2015.

2.15 The Delivery Board's task and finish groups set out 15 priorities that they wanted to focus on in the first six months of their work. Figure 20 demonstrates the work that was carried out to respond to those priorities and shows that success in delivering the change and promoting local implementation was mixed.

Figure 20 – Progress in delivering the priorities of the task and finish subgroups

Priority	Achieved	Progress
Establish effective, good-quality interface clinics	✓	The chair of the Intermediate Care subgroup provided a paper to the Delivery Board in February 2012 that set out core guidance about the structure and function of the CMATS. The guidance included objectives for the CMATS, core principles, types of staff that should be involved, a service description, inclusion and exclusion criteria, and details of how performance should be monitored and evaluated including key performance indicators. The paper was updated and brought back to the Delivery Board in May 2012. The detailed guidance was issued to health boards via the chief executives and CMATS have been implemented in all health boards.
Community pain services	×/✓	A paper was brought to the May 2012 Delivery Board, which set out the proposed model for the provision of community based pain services. The availability of community pain services, however, remains variable with only four health boards providing these services.

Priority	Achieved	Progress
Develop referral thresholds and support the process by e-referral with mandatory fields	×	A paper was brought to the June 2012 Delivery Board including a proposal that guidance on thresholds would be required from the National Specialist Advisory Group (NSAG) and this would be required by 30 September 2012. In January 2013, the Delivery Board discussed the lack of progress in working with the NSAG. This guidance was never produced.
Increase direct engagement and co-ordinated involvement of social services with the orthopaedic service	×	A report to the October 2012 Delivery Board noted that further progress was required on this priority. No further updates were reported on this priority and our fieldwork identified no examples where direct engagement and co-ordinated involvement of social services was taking place.
Standardise (as much as is possible) pre-operative and pre-anaesthetic assessment across Wales	×	A report to the October 2012 Delivery Board noted that work had included the development of an outline of a desired process with the intention of developing standardised all-Wales pre-operative documentation. However, our health board surveys identified variation both in the operation of pre-operative assessment services, including documentation, within health boards and across Wales, and the time when pre-operative assessment is undertaken.
Introduce seven-day and extended-day working in therapies	×/✓	A paper provided to the January 2013 Delivery Board meeting noted that all health boards, except Powys, have therapy services for orthopaedic patients available on Saturday and Sunday. However, despite this, only one service involves staff working on a seven-day job plan. Our health board survey confirmed that whilst some physiotherapy provision is being offered at weekends and through extended working days, overall physiotherapy services remain a five-day service.
Theatre efficiency	×	The Welsh Government's Delivery and Support Unit (DSU) was involved in supporting health boards to deliver this priority by focusing on the time between one operation and the next. The approach included nominating a 'showcase' operating theatre in each health board with the DSU providing support and guidance on driving greater productivity. The final update from the subgroup to the Delivery Board in January 2013 showed that only Powys Teaching Health Board was typically achieving[22] the desired turnaround times of less than 20 minutes between patients.

22 The report presented data in the form of 80th percentile turnaround times.

Priority	Achieved	Progress
Standardisation of implant choice and improving the procurement process	×/✓	A procurement group took this work forward on a national basis, with a member of that group reporting to the Delivery Board. In November 2012, the NHS Wales Shared Services Partnership introduced an all-Wales contract for procuring orthopaedic implants. The partnership estimated that the contract would result in savings of around £1 million. However, our fieldwork identified that not all health boards were using the all-Wales contract to procure orthopaedic implants and that there remained variation in implant choice within and between health boards.
Promote and implement best practice fractured neck of femur care across Wales	✓	A number of workshops were held to share good practice regarding the treatment of fractured neck of femur cases. The DSU has continued to work alongside health boards to implement the 'Focus On' pathway for these patients.
Review follow-up regimes	×	Consideration was given to referral and follow-up criteria for arthroplasty and carpal tunnel syndrome in June 2012, with action to produce best practice guidelines. However, these have not yet been produced.
'Focus On' programmes	×/✓	'Focus On' pathways for common conditions are an example of a positive impact. A report to the July 2012 Delivery Board meeting noted that the hip and knee pathways were well established. A further pathway for community pain services was being developed but the report noted that much work remained. The implementation of the 'Focus On' pathways have been included within the Annual Quality and Delivery frameworks, but the pathways were not sent out with any guidance from the Delivery Board and there are no mechanisms in place to ensure full compliance with them at a local level.
The development of an orthopaedic surveillance and outcome system	×/✓	The Public Health and Primary Care Sub Group presented its final report on this priority to the Delivery Board in May 2012, which set out the development of the Secure Anonymised Information Linkage (SAIL) databank by Swansea University working with Cardiff and Vale University Health Board. The rollout across Wales, however, was reliant on implementation by the NHS Wales Informatics Service, which has not taken place.

Priority	Achieved	Progress
A shared decision-making model for clinical consultation	✗	In May 2012, the Public Health and Primary Care Sub Group provided the Delivery Board with a proposal to consider the application of 'Ask 3 Questions' to orthopaedic services in Wales with the support of the MAGIC (Making Good Decisions in Collaboration) programme team working with Cardiff and Vale University Health Board. The proposal said funding would need to be identified for the production of the associated materials to support this approach. No further updates were received.
A lifestyle programme for overweight people with musculoskeletal complaints	✗/✓	The Delivery Board was given details of several examples of lifestyle programmes in February 2012. The Delivery Board noted that detailed evaluation was required to ascertain the effectiveness of these schemes balanced against the indicative cost of fully delivering these services across Wales (in the region of £1.5 to £2 million). Our health board survey identified that lifestyle programmes were in place in all health boards except Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board.
Communication of preventative and promotional interventions with the public and the clinical community – beginning with that to support the back pain pathway	✗	Little progress was made in implementing this priority. The subgroup decided that £300,000 would be required for a publicity campaign and the funding requirement was a major barrier to making progress.

Source: Wales Audit Office analysis of papers from the Delivery Board and Wales Audit Office fieldwork

The Delivery Board ceased to meet with nearly a year of the Welsh Government funding remaining, central monitoring was insufficient and there were weaknesses in the way it influenced and evaluated efforts to improve orthopaedic services

There were some weaknesses in the Delivery Board's membership and the ability to influence the delivery of its objectives within health boards

2.16 The original 10 members of the Delivery Board were the NHS Wales Chief Executive, the Welsh Government's Directors of Operations and Finance, three consultant orthopaedic surgeons, a director of therapies and health science, a director of public health, a representative of the DSU and a GP.

2.17 Members of the Delivery Board clearly showed a commitment to driving improvements in musculoskeletal services but the membership and constitution of the Delivery Board contributed to difficulties in driving change at a local level. During our fieldwork, we heard criticism of the limited involvement in the Delivery Board of primary care, social services and Powys Teaching Health Board. In 2012, there was also some 'churn' in the group's membership when the Welsh Government's Director of Operations left to take up another job, and the NHS Wales Deputy Chief Executive replaced the Chief Executive as chair.

2.18 While each of the health boards was represented on the Delivery Board, with the exception of Powys Teaching Health Board, it was unclear if members were officially representing their health board or were simply members in a professional capacity. A key worker from the DSU was assigned to work with each health board on strategies for delivery. However, with limited representation of health board executives, there was an insufficiently strong connection between the work of the Delivery Board and local implementation of the national objectives. Minutes of the meetings of the Delivery Board were issued to chief executives along with any guidance that was developed through the task and finish groups, but a review of the arrangements within health boards would suggest that these were not always being passed to the relevant management teams within the health boards and considered at a service level.

The Delivery Board had a responsibility for monitoring progress towards the implementation of the national vision but there is little evidence of this happening at a local level with only minimal central monitoring on how the allocated monies were spent

2.19 Once the Delivery Board had set out its national vision, it had a responsibility for overseeing the implementation of the vision and monitoring progress across Wales. The terms of reference of the Delivery Board state: 'The Board will further be responsible for overseeing the implementation of the plans, and for providing assurance to the National Delivery Group that an appropriate direction is being taken in achieving the stated goals'.

2.20 There is some evidence that the Delivery Board monitored its own progress. For example, in October 2011, the Delivery Board considered a paper that reviewed the National Orthopaedic Programme and described progress to date.

2.21 There is less evidence of the Delivery Board taking a rigorous approach to monitoring progress at a local level. Although health boards were required to provide high-level reports on waiting times performance and visits to health boards were made, there was only minimal monitoring of the ways in which the health boards spent the central funding allocated to them. The September 2012 meeting of the Delivery Board noted confusion about how the funding was allocated and only then, 17 months after the funding was allocated, did the Delivery Board decide to request information from health boards on the extent of their progress in using the funding to implement sustainable solutions. The Delivery Board subsequently wrote to health boards in January 2013 to request the information and a summary paper was produced in June 2013. The paper was just three-pages long and there was very little detail about how the funding had been used.

2.22 In order to fully evaluate the efforts of improving orthopaedic services in Wales, it would be necessary to consider whether patients are now having better outcomes because of their treatment. Despite some efforts within the Delivery Board to focus on patient outcomes, information on outcomes remains sparse. As set out in Figure 20, the Public Health and Primary Care Sub Group did carry out work to develop an orthopaedic surveillance system, with one intention being to monitor patient outcomes. The Delivery Board had also discussed the possibility of procuring a new, all-Wales computer system for orthopaedics that would have many potential benefits, including improvement in the monitoring of patient outcomes. However, at the time of reporting, no system had been procured.

2.23 Our interviews with health board staff and our reviews of the Delivery Board's papers indicate that the initial enthusiasm and drive within the Delivery Board waned during 2012-13. In July 2012, the Delivery Board changed from monthly to bimonthly meetings and the Delivery Board met for the last time in May 2013, with almost a year of the central funding programme remaining.

2.24 The focus for orthopaedics is now considered as part of the National Planned Care Programme developed by the Welsh Government. A draft National Orthopaedic Implementation Plan has been developed and the National Orthopaedics Board, a subgroup of the Planned Care Programme Board, met for the first time in April 2015 to start to take this work forward. This mechanism provides a real opportunity to reinvigorate the work initiated by the Delivery Board and to work with health boards to implement the national vision for orthopaedics.

Part 3

Health boards have started implementing the national vision but not on the required scale and there is not yet enough information on outcomes to say whether change is benefiting patients

A range of planning and funding barriers has slowed the pace of change at a local level and health boards did not take full advantage of the opportunities provided by the central funding for orthopaedics

Clinical musculoskeletal assessment and treatment services are a key part of the national vision for improving orthopaedic services but differences in clinical opinion on the effectiveness of this service model has hindered the pace of change

3.1 The detailed guidance for the implementation of CMATS in Wales was issued to all health boards via the Chief Executives Group following the May 2012 Delivery Board. All health boards have implemented some form of the CMATS model. However, during our fieldwork, it became apparent that there are some fundamental differences of opinion between professional groups about the benefits of CMATS. There are clear tensions between some doctors and some therapists about the merits of the CMATS services. Some interviewees were confident that the CMATS model would be successful in diverting demand away from hospital-based orthopaedic services, while others felt that it would open the floodgates to create additional demand previously not referred into the system. Some interviewees also felt that CMATS would not divert demand but simply defer demand to a later date and felt that the funding used for CMATS would be better spent on increasing the number of consultant orthopaedic surgeons in Wales.

3.2 Where CMATS have been implemented, some of these services are not being used optimally because of problems with engaging doctors from primary and secondary care. Guidance indicates that the CMATS should include a GP with knowledge, skills and interest in musculoskeletal services but only four of the health boards have a CMATS model that has medical involvement. The CMATS model should also act as a single point of access to simplify the musculoskeletal referral pathways, but in some health boards across Wales, GPs are bypassing the CMATS and referring directly into secondary care. In Cardiff and Vale University Health Board, there is a ‘GP champion’ scheme which has been established as a local enhanced service within primary care to triage GP referrals for orthopaedics and identify patients who could be safely managed in primary care, reducing any unnecessary referrals onto secondary care services. These ‘GP champions’, however, appear to work in isolation from the therapeutic element of the CMATS model, with some suggestion that this was creating duplication of effort and tension between staff.

There are some examples of health boards not fully considering the whole system of musculoskeletal services when planning local change

3.3 If health boards are to drive improvement across musculoskeletal services, they need to take a holistic approach to change that considers the entire patient pathway. We found mixed effectiveness from health boards in this regard. For example, Hywel Dda University Health Board has a Musculoskeletal Forum that aims to improve whole-system engagement and the pathway for musculoskeletal patients, with a particular emphasis on prevention. In contrast, Cardiff and Vale University Health Board's Musculoskeletal Forum ceased following the change in the organisational structure in 2013, with the key specialities involved in the musculoskeletal pathway now represented through separate clinical boards. This was creating a barrier to taking an integrated approach to improvement.

3.4 During our interviews, we also heard views that the national vision of CMATS services is being implemented without fully considering the impacts on the rest of the musculoskeletal system. For example, some interviewees told us that a CMATS approach should not be rolled out without additional investment in core therapy services. This is because CMATS should lead to increased demand for core physiotherapy services as they divert more patients away from specialist orthopaedic services. Similarly, CMATS should be increasing the number of appropriate referrals to specialist secondary care services, and consequently, there should be increases in the number of patients who attend an orthopaedic outpatient appointment who go on to have surgical intervention. Without appropriate consideration of the impact on specialist secondary care resources, this increase will create additional pressure on the inpatient and theatre capacity.

Most of the additional £65 million of central funding was spent on tackling immediate waiting list pressures rather than sustainable solutions

3.5 The NHS in Wales has been trying to implement difficult changes to musculoskeletal services against a background of significant financial pressures. Our successive reports on NHS finances identified that NHS Wales has faced tougher financial settlements than its counterparts in other parts of the UK over recent years. The reports also say that NHS Wales is facing a growing challenge to deliver cost reductions without affecting patient experience, safety and quality. Additional funding has since been made available to NHS Wales in 2014-15 but these challenges will have doubtless complicated efforts to improve musculoskeletal services over the last three years.

3.6 Within this context, the provision of the additional £65 million of central funding over three years presented a considerable opportunity for NHS Wales. In addition to providing a means to tackle persistently long waits for orthopaedic treatment, a significant proportion of the central funding was also intended to be used to develop sustainable, long-term solutions to managing demand.

3.7 The additional funding was made available between 2011 and 2014, and was largely focused on tackling the orthopaedic waiting lists, with the majority of funding used to provide additional capacity to deal with the immediate demand on services. This included the introduction of additional theatre lists, the outsourcing of activity to third parties and the appointment of temporary staff. Much of this capacity was short-term, and once stopped, created the risk that waiting times would increase.

3.8 Non-recurrent funding allocated during 2012-13 to support the investment in longer-term sustainable solutions totalled just £4 million. Appendix 6 sets out how that money was allocated. A further £2.5 million was allocated in 2013-14 to continue the approved schemes for a further six months.

All health boards have made some progress in putting in place sustainable alternatives to orthopaedic surgery but the change has been small scale and funding pressures place these new services at risk

There has been some good progress in developing lifestyle and exercise programmes that have potential to reduce demand for orthopaedics

3.9 One of the priorities of the Public Health and Primary Care Sub Group was to develop and implement lifestyle programmes for overweight people with musculoskeletal complaints. The rationale for this priority is that overweight people can be more susceptible to musculoskeletal conditions because of the extra load being placed on their joints. The theory is that as an alternative to orthopaedic surgery, patients who receive conservative treatment through exercise programmes can have positive outcomes.

3.10 In 2011, Aneurin Bevan University Health Board developed and implemented a scheme called the Joint Treatment Programme for patients with hip or knee pain. The scheme focuses on education, exercise and weight loss. Patients were given information and conservative treatment at leisure centres, with the weight loss element run by a nutritionist. An evaluation of the scheme presented to the Delivery Board in February 2012 showed that 75 per cent of participants completed the eight-week programme and 83 per cent of those that completed the programme lost weight. Six months after the programme, 87 per cent of participants had sustained their weight loss. The financial evaluation of the scheme showed that for each patient completing the programme, it cost £239 compared with an average cost of £8,400 for total knee replacements.

3.11 In January 2012, Cardiff and Vale University Health Board launched a similar scheme called the Joint Care Pathway for knee pain patients. The scheme cost £123 per patient. Cwm Taf University Health Board has also developed the Orthopaedic Obesity Referral Pathway at an approximate cost of £445 per patient.

3.12 Our survey of health boards identified that weight loss schemes or community based lifestyle programmes are available in all of the health boards across Wales with the exception of Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board. GPs have direct access to these services but the capacity of these teams is small and referral is often restricted to particular catchment areas.

3.13 During our fieldwork, we also heard positive views about the National Exercise Referral Scheme (NERS). The scheme, which is run in partnership between local authorities, health boards and the Welsh Government, began in 2007 with the aim of increasing the number of people sustaining long-term physical exercise. This intends to improve physical and mental health. Service users typically receive an assessment and personalised exercise programme from an exercise professional and the sessions are usually run over the course of 16 weeks in leisure centres at a small cost to the service user. The NERS has different names in different local authority areas including Positive Steps, Winners and Health for Life.

3.14 An evaluation[23] of NERS published by the Welsh Government in 2010 concluded that the average cost per participant was £385 and that the scheme is 89 per cent likely to be cost effective. The review stated that it provided robust evidence for the long-term effectiveness of NERS for certain groups of users. During our fieldwork, physiotherapists in particular spoke highly of the NERS programme although they had concerns about its future sustainability given the pressures on local authority funding and potential closures of leisure centres.

There are some good examples of CMATS but these tend to be small, do not involve sufficient integration with other musculoskeletal services and funding pressures place these at risk

3.15 All health boards have implemented some form of the CMATS model, with Hywel Dda University Health Board establishing the CMATS most recently in 2013. There are variations in the way the CMATS operate with compliance with the key principles set out in the detailed guidance mixed across Wales (Figure 21). The services in Betsi Cadwaladr University Health Board are more established and are the only services fully complying with the key principles.

23 Welsh Government, The evaluation of the National Exercise Referral Scheme in Wales, 2010

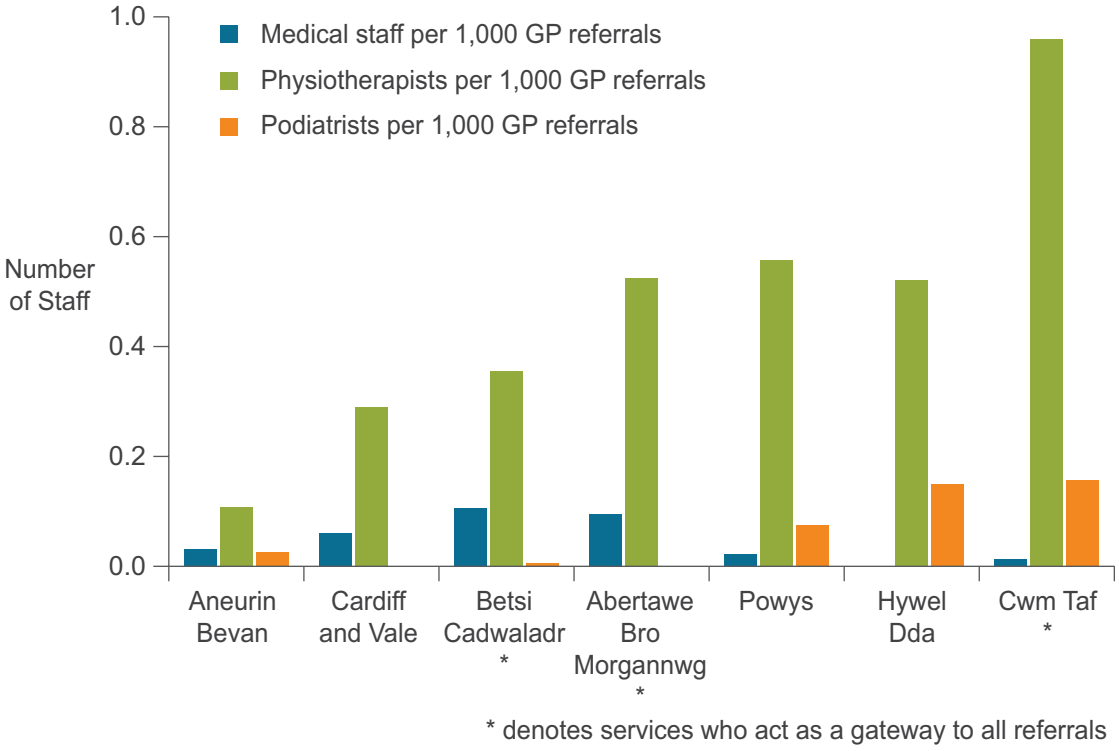
Figure 21 – Compliance with the key principles of the CMATS guidance

	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys
Clinics held in a combination of locality and secondary care centres	✓		✓	✓		✓	✓
All musculoskeletal referrals (with the exception of specific exclusions) will go to the CMATS	✓		✓		✓		
Staff have direct access to diagnostics	✓	✓	✓	✓	✓	✓	
The service consists of:							
Advanced practice physiotherapists	✓	✓	✓	✓	✓	✓	✓
Advanced practice podiatrists		✓	✓		✓	✓	✓
GPs with knowledge, skills and interest in musculoskeletal services	✓	✓	✓	✓			

Source: Wales Audit Office fieldwork – health board surveys

3.16 Although designed to be a multidisciplinary service, the CMATS model across Wales is predominantly led by the physiotherapy profession, with physiotherapists accounting for the largest majority of the staff. The level of resources available to CMATS, relative to workload, varies across health boards (Figure 22).

Figure 22 – CMATS staffing levels per 1,000 GP referrals for 2013-14



Source: Wales Audit Office fieldwork

3.17 Patients who are referred to the CMATS should be seen within an eight-week target. As identified in Figure 7, our fieldwork identified that only the CMATS in Aneurin Bevan University Health Board and Powys Teaching Health Board were meeting that target, to see patients in a timely manner, indicating possible capacity constraints within the teams. Indeed, our fieldwork found that the staffing levels in some CMATS are potentially problematic. Even though the CMATS in Powys Teaching Health Board is able to see patients within the eight-week target, the actual numbers of WTE staff within the service is extremely low with total staffing levels in the south locality area, for example, at just 0.1 WTE. This weakens the CMATS model as they are largely staffed by one or two members of staff in each locality as an additional responsibility to their main physiotherapy role. Should those staff be absent from work, the CMATS would not function.

3.18 There are also risks associated with the funding model of the CMATS in some parts of Wales. Some health boards used the non-recurrent monies allocated by the Delivery Board to fund their CMATS teams. The short-term nature of this funding creates risks for the sustainability of these services, although we are aware that at the time of reporting, all CMATS had been maintained during 2014-15 despite the non-recurrent monies coming to an end.

Health boards need to strengthen their monitoring of services and our own analysis suggests there remains scope to improve patient outcomes

Monitoring of CMATS has been complicated by IT problems

3.19 The core guidance for CMATS set out by the Delivery Board includes a mandatory set of key performance indicators. The results of our health board survey show that few health boards are collecting sufficient data to be able to monitor and report on these indicators. Our fieldwork found that CMATS have IT problems that make it difficult to monitor their own performance. For example, in some health boards, the CMATS staff need to input their activity and outcome information into standalone spread sheets rather than using the health boards' patient administration system. Other CMATS use the computer systems in the GP practices where they run their clinics but these are separate to the health board's central system, which makes central monitoring of performance difficult.

3.20 We were told that clinical staff in the CMATS do not have the capacity to undertake data entry as it would affect their ability to see patients. Some teams do include support staff within their staffing establishments to undertake administrative tasks. However, the hours allocated for such roles are generally minimal and not all of the teams actually had administrative staff in post.

3.21 Many of these services have not been in existence long enough for a comprehensive evaluation of the impact they are having. But, the difficulties in collecting performance, activity and outcome information from CMATS teams is a barrier that needs to be overcome in order to evaluate the long-term effectiveness of these services. Robust evaluations are going to be particularly important in ensuring clinical engagement and the cultural shift that is required if these services are to become mainstreamed longer term.

Health boards have data about lots of the individual elements of the musculoskeletal pathway but they collect little information about outcomes and experience

3.22 The data we have collated in this report and in our separate health board reports show that the NHS in Wales collects and produces a great deal of information about the performance and activity of musculoskeletal services. However, data relating to patient outcomes and patient experience is much sparser.

3.23 Our fieldwork did identify some actions that health boards are taking to measure patient experience (Figure 23); however, this is largely based around routine generic patient surveys and analysis of compliments and complaints.

3.24 In relation to outcomes, we found that where specific outcomes data are recorded, they predominantly relate to joint surgery. As mentioned in paragraph 2.23, the Delivery Board identified the need to procure an all-Wales computer system that would improve the measurement of outcomes. However, the system was not procured and only Cardiff and Vale University Health Board has taken this system forward as part of its wider focus on orthopaedic outcomes. Aneurin Bevan University Health Board has, however, developed a bespoke in-house database to monitor outcomes following shoulder surgery.

3.25 Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are tools used worldwide to provide a basis for measuring patient experiences and outcomes, including the impact of surgical interventions. The most common tool within orthopaedics is the Oxford Hip and Knee scores, which essentially are a scoring system designed to measure the impact that surgical intervention has on the level of pain and broader quality of life indicators experienced prior to surgery. In Wales, these tools were promoted through the Enhanced Recovery after Surgery (ERAS)[24] programme led by the NHS Wales 1,000 Lives Plus[25] team. PROMS also form part of the 'Focus On' pathways for hips and knees issued to all health boards for implementation through the Delivery Board. Although we found aspects of the principles of ERAS being applied across Wales, the most obvious being the introduction of 'joint schools' referred to previously in paragraph 1.20, we identified that not all health boards had adopted PROMS and PREMS for their orthopaedic patients.

Figure 23 – Tools for monitoring patient experience and outcomes

	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys
Patient surveys	✓	✓	✓	✓		✓	✓
Use of PROMS and PREMS (including the use of Oxford Hip and Knee scores)	✓		✓	✓		✓	
Participation in the National Joint Register	✓	✓	✓	✓	✓	✓	
Outcomes database		✓		✓			
Clinical audit reviews		✓		✓			
Compliments and complaints	✓	✓	✓	✓	✓	✓	

Source: Wales Audit Office fieldwork

24 Enhanced Recovery After Surgery (ERAS) is an evidenced-based, multi-modal, patient-centred method of optimising surgical outcome by improving both patient experience and clinical outcomes.

25 1,000 Lives Plus is the national improvement programme supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales.

Knee replacement surgery largely has a positive impact on patients but the results of our patient survey and other data suggest that there is further scope remaining to improve outcomes from musculoskeletal services

3.26 In order to gather our own data on patient experience and outcomes, we conducted a survey of patients who had undergone knee replacement surgery. We received responses from 481 patients living in Wales who had undergone surgery either in a Welsh health board or in an English NHS trust commissioned to provide elective orthopaedic treatment for Welsh residents. We chose this procedure because of a number of factors. Knee replacement surgery accounts for the largest proportion of inpatient admissions and hospital bed days for elective orthopaedic services. With an increase in the age of the population, along with a growing population who are actively involved in physical sports, effective knee replacement surgery can have a significant impact on the quality of life. The pathway for managing patients who require knee replacement surgery is clearly set out in the 'Focus On' pathway developed as part of the work undertaken by the Delivery Board. The pathway provided us with a sound baseline, on how services should be delivered for this cohort of orthopaedic patients, to measure against.

3.27 The results of the patient survey suggest that the majority of patients think their surgery improved their quality of life and reduced their pain. Figures 24 and 25 show patients' views on whether the surgery had improved their quality of life and their pain, showing the hospital where they received their care. However, a significant minority said the surgery had either made them worse or had no benefit. Across Wales:

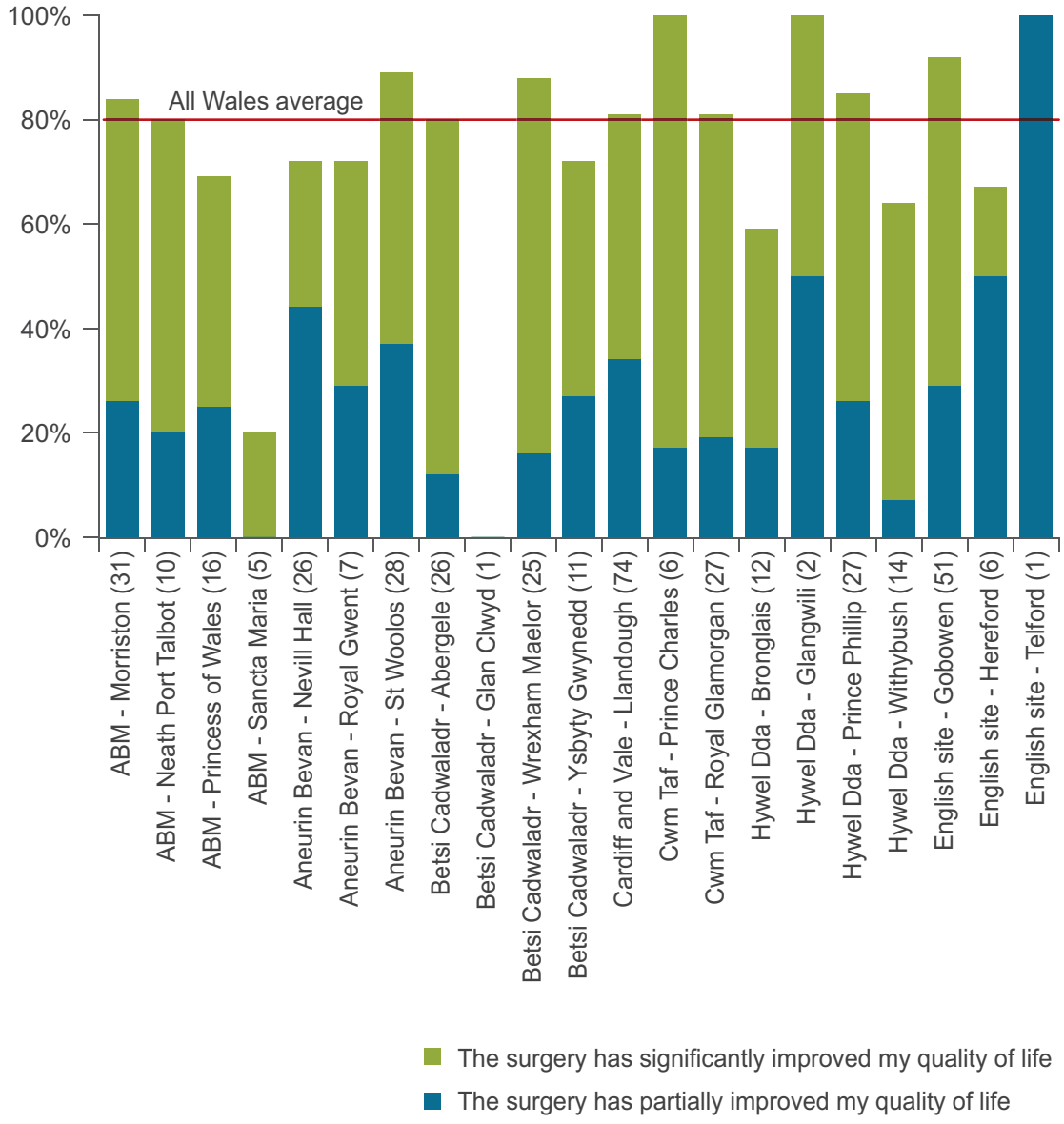
a 12 per cent of patients (56 out of 481) said that their quality of life had either got worse or had not improved;

b 10 per cent of patients said their surgery had either made their symptoms worse or had not improved their symptoms; and

c nine per cent said their surgery had either made their pain worse or had not improved their pain.

3.28 More detailed results from the survey are available here at www.audit.wales.

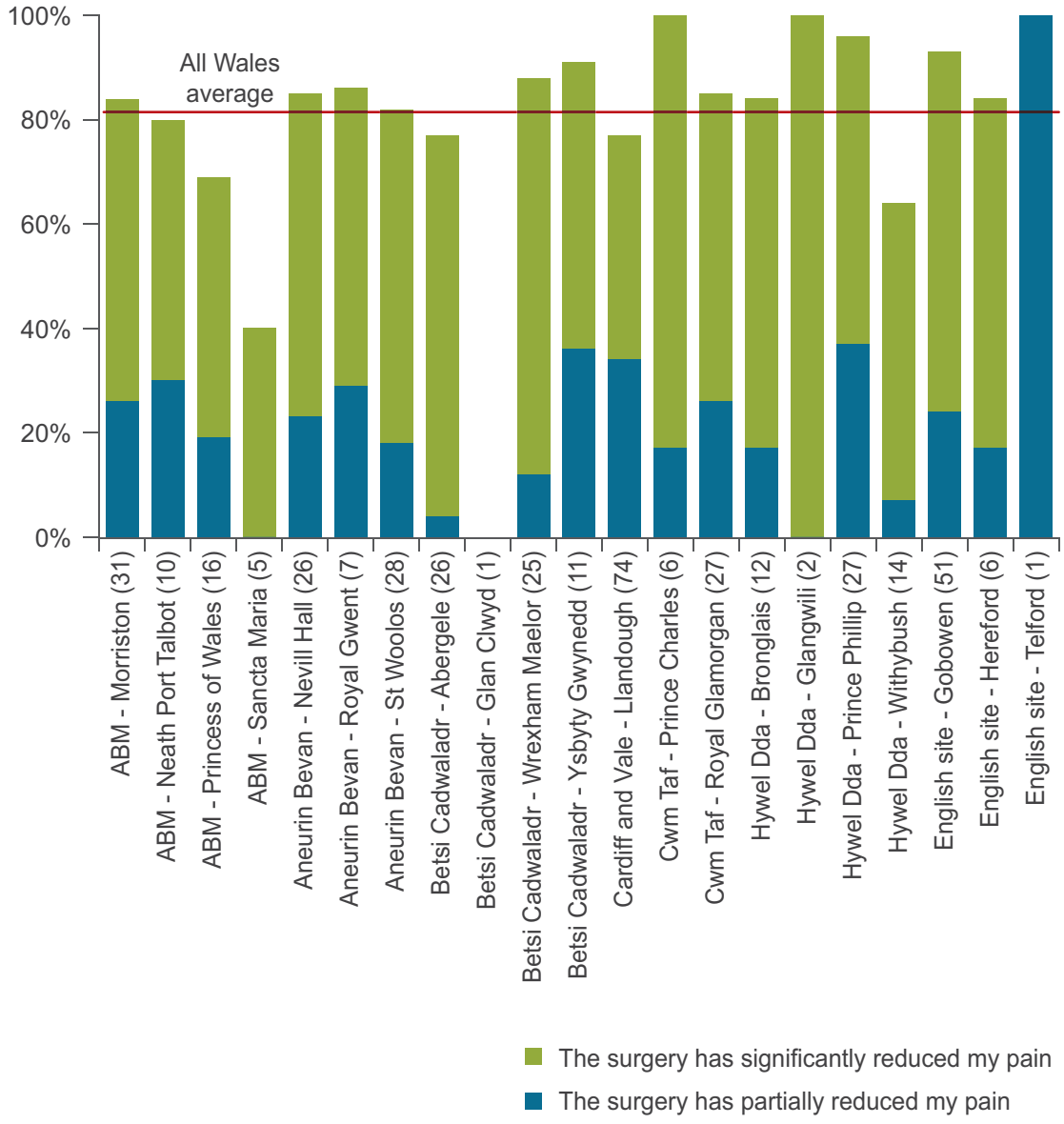
Figure 24 – Percentage of patients who reported that their knee replacement surgery had improved their quality of life (split by hospital provider)[26]



Source: Wales Audit Office

26 Some caution needs to be made in considering the results of the survey for individual hospitals where the number of responses for that hospital were small. Total sample sizes for each hospital site are included in brackets.

Figure 25 – Percentage of patients who responded that their knee replacement surgery had improved their pain levels (split by hospital provider)



Source: Wales Audit Office

3.29 In addition to surveying patients, we analysed other sources of information to assess whether orthopaedic surgery is resulting in positive outcomes for patients. The readmission rate for surgery can be an indicator of operations not going as planned or patients suffering unexpected complications. The rate of emergency readmission within 28 days of elective admission following a hip replacement ranges from 0.3 per cent in Cwm Taf University Health Board to 1.3 per cent in Betsi Cadwaladr University Health Board. The readmission rate for knee replacements is lower, ranging from zero per cent in both Cwm Taf University Health Board and Cardiff and Vale University Health Board to 0.2 per cent in Hywel Dda University Health Board.

3.30 The infection rate following surgery is another indicator of quality and outcome. The surgical site infection rates following hip and knee replacements vary significantly across Wales, although there are limitations to these data[27]. The average rate of infection across Wales is 1.5 per cent for hip replacements and 1.8 per cent for knee replacements. This compares against a Welsh government target of zero per cent. For the period 2013-14, the average rate of infection across England was 0.7 per cent for hip replacements and 0.5 per cent for knee replacements.

The lack of information and a whole-system approach to monitoring the delivery of musculoskeletal services within health boards is going to make the application of prudent healthcare principles difficult to implement

3.31 In 2014, the concept of prudent healthcare was introduced by the Bevan Commission[28] to reflect the underlying message that NHS Wales must change to better meet the needs of the people of Wales in a more sustainable way. It focuses on the key principles of:

a minimising avoidable harm;

b carrying out the minimum appropriate intervention; and

c promoting equity between the people who provide and use services.

3.32 Prudent healthcare is in its early stages of being embedded across Wales with the 1,000 Lives Plus improvement team tasked with supporting health boards as they seek to mainstream prudent healthcare into the way they deliver services. Nevertheless, to do this, health boards need to make sure that the arrangements are in place to ensure that the principles of prudent healthcare can be met.

27 We are unsure whether these data are collected consistently, there are time delays in clinical coding and there is variation in the return rate of valid infection reporting forms.

28 The Bevan Commission was originally established in 2008 to advise the Welsh Minister for Health and Social Services on promoting health and health services improvement in Wales. Since then, the commission's work has added significant value to the work of the Welsh Government and the NHS in Wales, including the development of the Bevan Commission principles and, more recently, the idea of prudent healthcare.

3.33 To fully implement the principles of prudent healthcare, management information needs to be able to reflect what happens on the ground. The focus needs to be on the totality of care and not the processes and procedures that are put in place to provide it. Information needs to demonstrate the benefits to patients as well as the harm, and best practice should become the norm. Staff need to work together to put the patient at the centre of care, with patients playing a key part in the decision-making process and only appropriate demand should drive capacity.

3.34 Our work, however, has identified that current systems do not provide the breadth of information needed to understand the entire musculoskeletal pathways. There is fragmentation of information systems between primary and secondary care, and community based services, such as the CMATS, are reliant on time-consuming manual processes to collect the necessary information.

3.35 Key measures for musculoskeletal services focus on processes and capacity constraints within health boards, with little information routinely available to boards to demonstrate the benefit or harm of the musculoskeletal services that they provide or commission from others. Key stakeholders within the pathways are managed in isolation and very few health boards have the mechanisms in place to bring these services together. This is particularly the case for Powys Teaching Health Board, which commissions its secondary care orthopaedics services from neighbouring NHS providers.

3.36 Despite the development of the ‘Focus On’ pathways, good practice is not being consistently applied across Wales. We have found no monitoring arrangements in place, which allows the totality of musculoskeletal services to be considered at a senior level. We found the same position at Board and subcommittee level, where the focus is predominantly on secondary care. Without the necessary information on how prudent healthcare is being applied within musculoskeletal services, NHS Wales cannot take the assurance that they are being delivered efficiently and effectively.

Appendices

Appendix 1 - NHS Wales National Orthopaedic Programme Delivery Framework

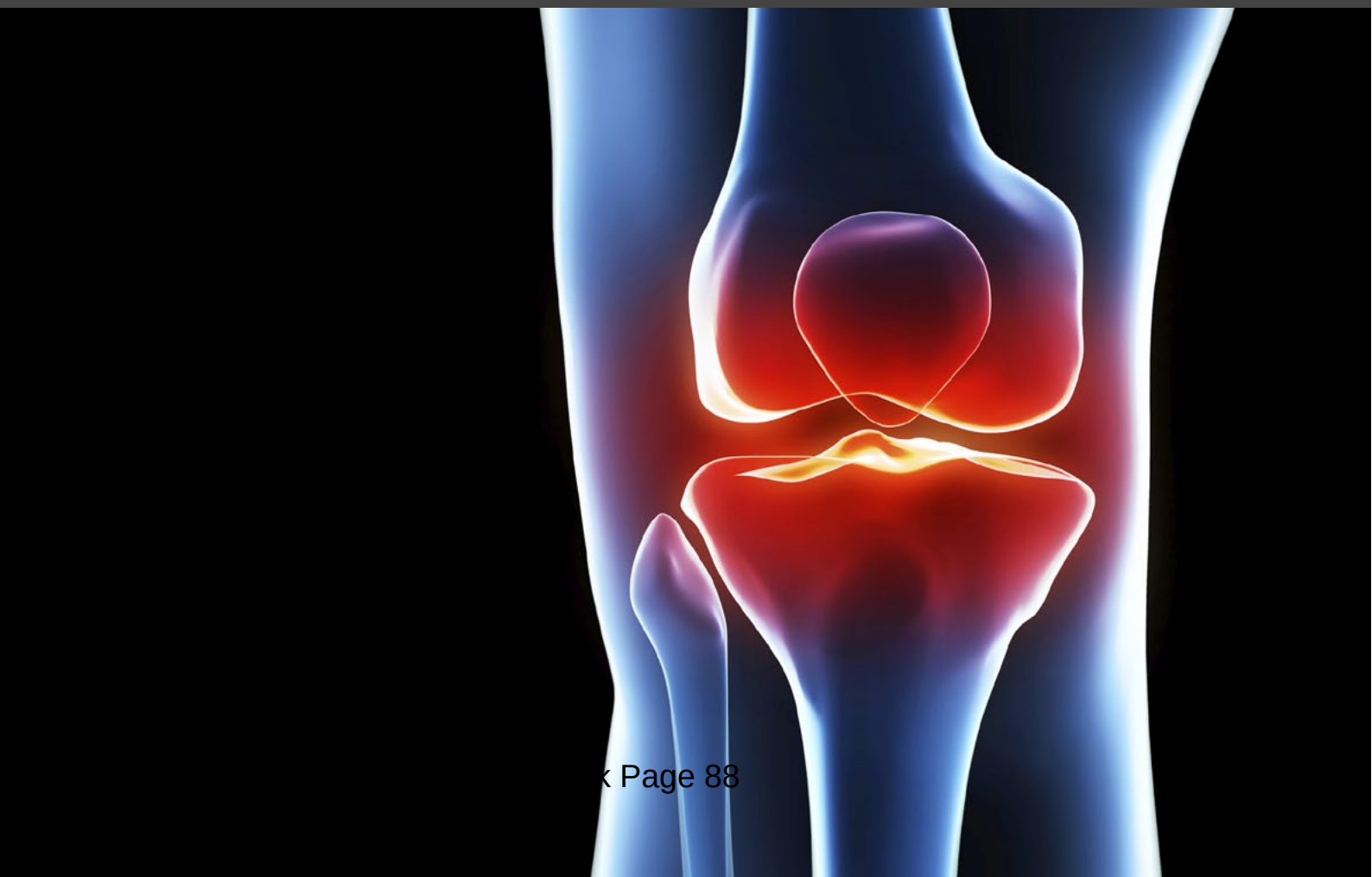
Appendix 2 - Details of the timeline shown in Figure 2

Appendix 3 - Methodology

Appendix 4 - Potential to free up capacity by improving performance against Welsh Government targets (by health board)

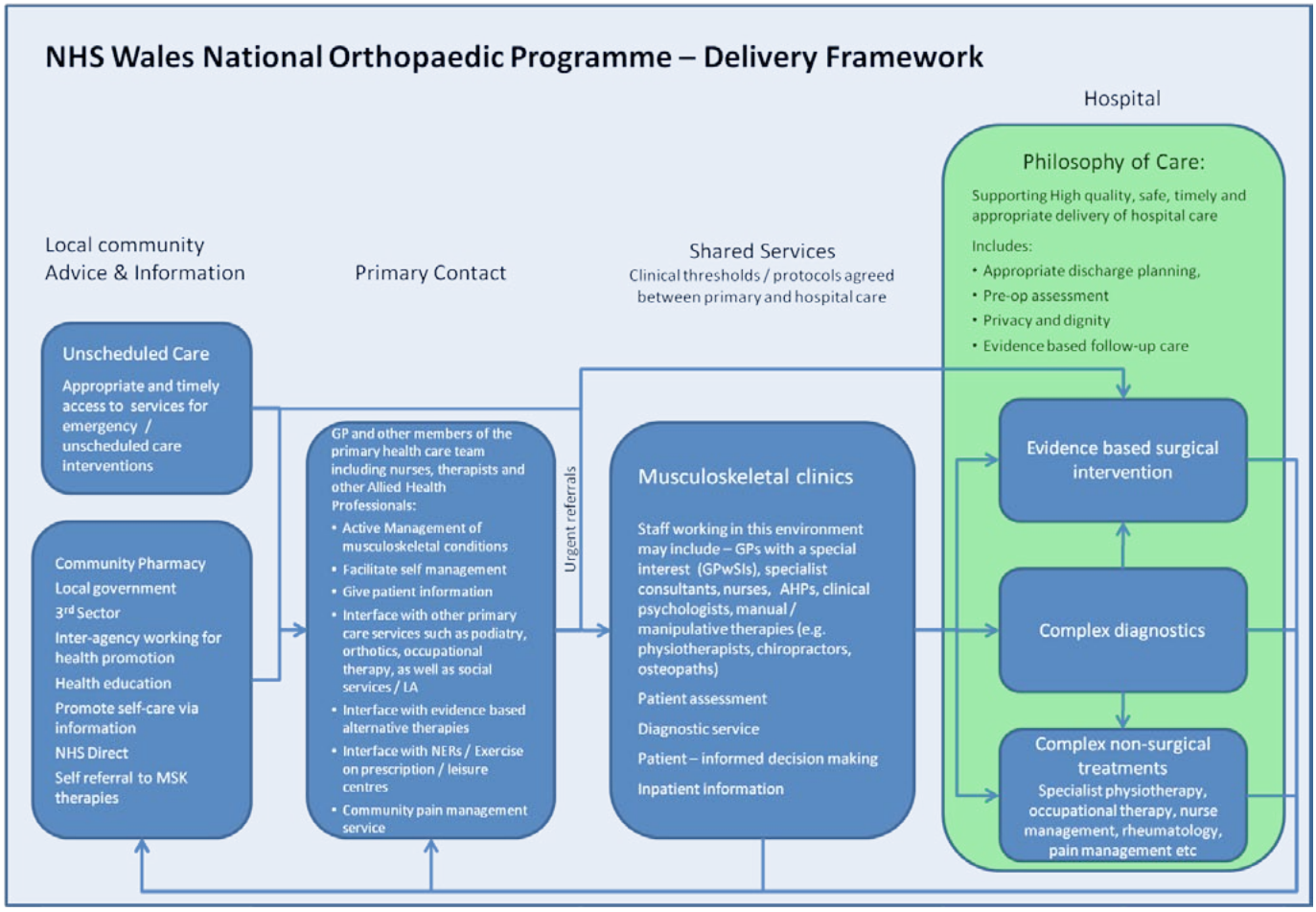
Appendix 5 - Allocation of central funding

Appendix 6 - Allocation of funds for sustainability projects



Appendix 1 - NHS Wales National Orthopaedic Programme Delivery Framework

The diagram below shows the delivery framework published in February 2012.



Appendix 2 - Details of the timeline shown in Figure 2

The information below provides detail to the timeline shown in the introduction to this report.

- The Welsh Government's National Orthopaedic Needs Assessment in 2004 highlighted unacceptably long waiting times and the need to increase capacity and improve efficiency through better management and innovation in service delivery. The Welsh Government then published **An Orthopaedic Plan for Wales**[29], which provided a vision for reducing orthopaedic waiting times and improving access to services.
- The Welsh Government created the National Orthopaedic Programme in March 2011 with the following objectives:
  - eliminating orthopaedic waiting times in excess of 36 weeks by March 2012;
  - establishing a new service model for orthopaedics by March 2013; and
  - establishing a fully sustainable orthopaedic service across Wales, meeting all national targets for waiting times, quality, safety and patient outcomes by March 2013.
- In March 2011, a ministerial letter announced an investment of £65 million to improve orthopaedic service delivery to ensure it becomes 'best in class'[30]. The funding is being provided in tranches over three years and is dependent on health boards delivering certain achievements. Central to the direction given by the letter was the need to develop sustainable orthopaedic services, rather than just investing in additional acute capacity. The letter stated that a public health campaign with a focus on obesity prevention, weight loss and increased fitness, would help secure a reduction in demand for orthopaedic surgery. However, the letter noted that this reduction in demand would take time and therefore additional capacity for orthopaedic surgery would be needed over the next five to 10 years.
- The Welsh Government's Orthopaedic Innovation and Delivery Board (the Delivery Board) first met in June 2011. Its purpose was to oversee the delivery of the National Orthopaedic Programme's objectives and 'to provide leadership and guidance in respect of the delivery of the new service model for Orthopaedics'. The Delivery Board has three subgroups that focus on Public Health and Primary Care, Intermediate Care and In-Hospital Care.
- In February 2012, the Delivery Board published the NHS Wales National Orthopaedic Programme Delivery Framework. The framework sets out a transformational approach to musculoskeletal service configuration and delivery. It also sets out arrangements for national monitoring and management of performance at a local level.

29 Welsh Government, **An Orthopaedic Plan for Wales**, July 2004
30 Ministerial letter, **Waiting Times and Orthopaedic Services Update**, 10 March 2011

Appendix 3 - Methodology

The review of orthopaedic services took place between June 2013 and January 2015. Details of the audit approach are set out below.

Document review

We requested and analysed a range of documents at both a national level and within each health board. This included:

- national documents relating to the National Orthopaedic Innovation and Delivery Board including the minutes of the board and its subgroups, the working papers to support the development of, and the monitoring against, the national orthopaedic framework, and the supporting papers associated with the allocation of the £65 million; and
- high-level health board documents relating to the strategic direction of local orthopaedic services and its supporting monitoring arrangements such as local needs assessments, operational plans, performance management reports, monthly financial returns, service evaluation reports and evidence of patient experience reports.

Centrally collected data

We analysed a range of readily accessible national data. A large proportion of this data is publicly available through the **Stats Wales** website with additional information available through other sources such as the **National Patient Safety Agency** and the **National Joint Registry**. A central data request was submitted to **NHS Wales Informatics Service** for data that can be obtained nationally by request. A more specific data request was built into a range of health board surveys for data only available through the health boards. Comparative information was obtained where appropriate from NHS Scotland, NHS England and NHS Northern Ireland. Financial information was made available through the Programme Management Unit in the Welsh Government to ascertain how much orthopaedic services cost across NHS Wales.

Health board survey

We asked health boards to complete a number of surveys, which were designed to capture both qualitative and quantitative information about musculoskeletal services. The surveys covered finance, primary care, community provision and rehabilitation, acute provision, workforce, and quality and safety.

Patient survey

We undertook a postal survey of all patients across Wales who had a full (or partial) knee replacement during January and February 2013. The aim of the survey was to understand the effectiveness of a specific aspect of orthopaedic services, understand the efficiency of services that patients have experienced and to understand the range of services that patients have accessed in comparison to the NHS Wales focus on knee pathway. We received a response from 481 patients (64 per cent) out of a total sample of 720 patients.

Interviews

We held a number of interviews at a national level, including interviews with representatives of professional bodies involved in the provision of musculoskeletal services.

Walkthrough of musculoskeletal services

We undertook a walkthrough in four hospital localities across Wales designed to see and understand key parts of the patient pathway. This included visiting the:

- CMATS
- Elective booking centre
- Outpatient department
- Radiology department
- Physiotherapy service
- Day surgery unit
- Operating theatres
- Orthopaedic wards

During the walkthrough, we undertook:

- a general observation around how the service operates;
- interviews with operational staff to understand the processes, issues and long-term sustainability; and
- a review of operational documentation including information provided to patients, policies and protocols, and referral guidelines.

We undertook the walkthrough in Betsi Cadwaladr University Health Board (Wrexham Maelor hospital), Cardiff and Vale University Health Board (Llandough hospital), Hywel Dda University Health Board (Prince Phillip hospital) and Powys Teaching Health Board (Llandrindod Wells hospital).

Appendix 4 - Potential to free up capacity by improving performance against Welsh Government targets (by health board)

Performance against Welsh Government targets in 2013-14 for orthopaedic outpatients and potential impact on use of resources per year if targets were achieved

Efficiency measures	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys
Reduced 'did not attend' rates for new outpatient appointments (five per cent target)							
2013-14 performance	7.2	7.6	7.2	12.2	8.7	7.5	2.0
Potential freed-up new outpatient slots if target achieved	728	757	620	847	588	584	-
Reduced 'did not attend' rates for follow-up outpatient appointments (seven per cent target)							
2013-14 performance	7.6	7.6	9.3	7.7	11.9	8.3	1.0
Potential freed-up follow-up outpatient slots if target achieved	611	1,045	1,348	43	2,209	528	-
Reduced number of follow-up appointments (1.9 follow-ups to one new)[31]							
2013-14 performance	1.7	2.2	1.9[32]	3.2	2.3	1.6	0.7
Potential freed-up follow-up outpatient slots if target achieved	-	8,032	1,083	15,433	6,871	-	-

Source: Wales Audit Office

31 We recognise that health boards are currently addressing the backlog of follow-up appointments which have built up over time which will have an impact on their ability to free up capacity in the short-term.

32 Actual performance in Betsi Cadwaladr University Health Board was just above the Welsh Government target at 1.94.

Performance against Welsh Government targets in 2013-14 for orthopaedic inpatients and potential impact on use of resources per year if targets were achieved

Efficiency measures	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys
Increased number of elective cases treated as a day case (75 per cent target)							
2013-14 performance	55.5	54.0	59.0	61.2	50.7	59.3	99.2
Potential freed-up bed days if target achieved	1,387	1,822	1,084	1,168	787	759	-
Increased number of elective patients admitted on the day of surgery (64% target)							
2013-14 performance	69.7	66.4	80.6	65.4	24.1	63.2	100
Potential freed-up follow-up outpatient slots if target achieved	-	-	-	-	613	19	-
Reduced elective length of stay (four days)							
2013-14 performance	3.6	3.7	3.4	3.9	4.0	2.9	1.5
Potential freed-up bed days if target achieved	-	-	-	-	-	-	-

Source: Wales Audit Office

Potential freed-up capacity per month compared with number of patients waiting more than 26 weeks

Efficiency measures	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys
New outpatient capacity							
Potential freed-up capacity per month	61	63	52	71	49	49	-
Number of patients waiting more than 26 weeks for first outpatient appointment at 31 January 2015	16	13	1,169	77	140	341	0
(Shortfall in new appointment slots)	45	50	(1,117)	(6)	(91)	(292)	-
Follow-up outpatient capacity							
Potential freed-up capacity per month	51	669	112	1,286	573	44	-
Number of patients waiting more than 26 weeks for follow-up outpatient appointment at 31 January 2015	116	60	153	429	45	215	0
(Shortfall in follow-up outpatient slots)	(65)	609	(41)	857	528	(171)	-
Inpatient capacity							
Potential freed-up capacity per month	116	152	90	97	66	63	-
Number of patients waiting more than 26 weeks for inpatient admission at 31 January 2015	2,590	3,137	2,190	1,088	465	1,704	0
(Shortfall in bed days)	(2,474)	(2,984)	(2,100)	(991)	(399)	(1,641)	-

Source: Wales Audit Office

Appendix 5 - Allocation of central funding

Recurrent allocation

Health board	2011-12 recurrent allocation	2012-13 recurrent allocation	2013-14 recurrent allocation
Abertawe Bro Morgannwg University Health Board	£1,973,700	£1,973,700	£1,973,700
Aneurin Bevan University Health Board	£2,194,290	£2,194,290	£2,194,290
Betsi Cadwaladr University Health Board	£2,670,300	£2,670,300	£2,670,300
Cardiff and Vale University Health Board	£1,613,790	£2,113,000	£1,613,790
Cwm Taf University Health Board	£1,195,830	£1,195,830	£1,195,830
Hywel Dda University Health Board	£1,462,860	£1,462,860	£1,462,860
Powys Teaching Health Board	£499,230	£499,230	£499,230
	£11,610,000	**£12,109,210**	**£11,610,000**

Non-recurrent allocation – centrally allocated

Health board	2011-12 non-recurrent allocation	2012-13 non-recurrent allocation	2013-14 non-recurrent allocation
Abertawe Bro Morgannwg University Health Board	£1,260,000	£1,700,000	-
Aneurin Bevan University Health Board	£1,700,000	£1,700,000	-
Betsi Cadwaladr University Health Board	£2,400,000	£2,400,000	-
Cardiff and Vale University Health Board	£2,280,000	£2,500,000	-
Cwm Taf University Health Board	£1,030,000	£1,100,000	-
Hywel Dda University Health Board	£1,050,000	£1,200,000	-
Powys Teaching Health Board	£0	£0	-
	£9,720,000	**£10,600,000**	

Non-recurrent allocation for sustainability projects – bid funded

Health board	2011-12 non-recurrent allocation	2012-13 non-recurrent allocation	2013-14 non-recurrent allocation
Abertawe Bro Morgannwg University Health Board	-	£650,000	£303,000
Aneurin Bevan University Health Board	-	£600,000	£308,000
Betsi Cadwaladr University Health Board	-	£800,000	£420,000
Cardiff and Vale University Health Board	-	£770,000	£579,000
Cwm Taf University Health Board	-	£510,000	£285,000
Hywel Dda University Health Board	-	£530,000	£396,000
Powys Teaching Health Board	-	£170,000	£128,000
	-	**£4,030,000**	**£2,419,000**

Appendix 6 - Allocation of funds for sustainability projects

Aneurin Bevan University Health Board	**£**
Community physiotherapy	£156,000
Therapy and GP-led referral management	£79,000
Joint Treatment programme	£176,000
Referral management model low back pain	£60,000
Service effectiveness and productivity	£81,000
Community based low back pain	£95,686
	£647,686
Abertawe Bro Morgannwg University Health Board	
Expansion intermediate care clinics	£189,000
Fracture liaison nurse	£44,000
Pain assessment/triage clinic	£38,300
Lifestyle programme	£59,500
Joint MCATS/F&A/podiatry clinics	£94,900
Psychology for chronic pain	£67,700
Locality schemes	£111,000
	£604,400
Betsi Cadwaladr University Health Board	
Lifestyle management	£351,366
CMATS	£138,181
OP Dupuytren service	£72,000
Fracture liaison	£87,000
Early supportive discharge service	£151,526
	£800,073

Cardiff and Vale University Health Board	£
GP orthopaedic referral management	£116,895
Musculoskeletal physiotherapy service self-referral model	£289,885
Lifestyle pathway development	£125,421
Back in action	£239,262
	£771,463
Cwm Taf University Health Board	
Extended scope physiotherapists	£127,073
Seven-day physiotherapy	£110,000
Musculoskeletal services	£30,000
Community chronic pain	£145,104
Community weight management	£101,466
	£513,643
Hywel Dda University Health Board	
CMATS	£528,494
	£528,494
Powys Teaching Health Board	
CMATS	£143,000
In-house podiatry	£28,000
	£171,000

Source: Analysis of Delivery Board papers

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Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol**

**Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group**

Llywodraeth Cymru
Welsh Government

Nick Ramsay, AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA

Our Ref: AG/JM

24 October 2016

Dear Mr Ramsay

Public Accounts Committee – update on implementation of recommendations from Auditor General for Wales reports:

- **Review of the Impact of Private Practice on NHS Provision (Published February 2016)**
- **Orthopaedic Services (Published June 2015)**

Review of the Impact of Private Practice on NHS Provision

Recommendation 1: The guidance from the Welsh Government on how to manage private patients onto the NHS waiting list conflicts with other guidance and is not reflected in the routine referral to treatment documentation used by NHS bodies, resulting in a lack of awareness and inconsistencies on where private patients are placed if they join an NHS waiting list. The Welsh Government should therefore adopt the approach set out in UK-wide and professional body guidance, ensuring that the referral to treatment documentation used by NHS bodies is updated to reflect this. Health boards and trusts then need to ensure that this guidance is implemented by all staff involved in the administration of referral to treatment pathways within health boards and trusts.
Update Accepted We will look to redefine the Welsh guidance as part of our review of the RTT rules to ensure consistency and then confirm requirements to the NHS for health boards and trusts to implement. This will form part of a proposed revised Welsh Health Circular (WHC) and guidance which will consolidate multi policy issues around the management and responsibilities of undertaking private practice within NHS facilities, any early draft has been developed and will be shared with NHS for initial thoughts.

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Recommendation 2

There is currently no requirement for health boards and trusts to identify private patients reverting to NHS treatment on their patient administration systems, which makes it extremely difficult to establish whether these patients are gaining faster access to NHS treatment. The Welsh Government should update the NHS Wales Data Dictionary and mandate the identification of private patients entering NHS waiting lists to enable regular monitoring to take place. Through the revised guidance set out in recommendation 1, the Welsh Government should also set out an expectation that health boards and trusts will regularly monitor the waiting times for this cohort of patients

Update Accepted

The Welsh Government will work with NHS bodies, to identify how to capture and report both private practice undertaken in NHS facilities and how patients may join an NHS waiting list from a previous private patient status and vice versa. This work will be assured by the Welsh Information Standards Board and, when approved, will be mandated through a Data Standards Change Notice and incorporated in the NHS Wales Data Dictionary.

Recommendation 3

Private practice can play an important role in attracting consultants and generating income for the NHS yet local policies lack clarity on when and how much private practice can take place in the NHS, and monitoring arrangements to ensure that NHS provision is not affected are weak. Where private practice is undertaken in NHS facilities, Health boards and trusts should ensure that policies clearly state when and how much private practice, and specifically inpatient activity, can take place to minimise the impact on NHS resources. Private practice activity should be collected and reported in line with the requirements of the Competition and Markets Authority, and this information should routinely form part of the annual job planning process for all relevant consultants to ensure policies are complied with.

Update Accepted

The Welsh Government is establishing, with NHS Employers, a Task and Finish Group in order to undertake a review of existing guidance to ensure it reflects all relevant responsibilities and strengthens existing monitoring arrangements. We have already reminded NHS organisations in Wales of their obligations under the Competition and Markets Authority Order.

Recommendation 4

The processes for recouping the costs associated with the provision of private practice within NHS facilities are cumbersome and often reliant on out-of-date and incorrect information. Health boards and trusts should ensure that sufficient attention and resources are given to the cost recovery process. The level of resources should be reflective of the scale of private practice undertaken but should be sufficient enough to provide robust assurances to boards that income is being appropriately recovered. A single-invoice system can assist with full cost recovery and has already been adopted in a number of health boards. Those health boards and trusts which are not currently operating this system should give urgent consideration to doing so.

Update Accepted The Welsh Government, in joint partnership with the NHS through the NHS Medical, Finance and Information Directors, will share processes from across Wales to agree an all Wales consistent process. A Welsh Government and NHS working group will be convened to maximise learning and best practice in support of a consistent approach to the management and reporting of private practice within and using NHS resources.

Orthopaedic Services.

The recommendations have been accepted and are being taken forward with the support of the national orthopaedic implementation group. A summary of progress against each action is captured below:

Progress against the recommendations for the WAO Orthopaedic review 2015
Recommendation 1 The wait associated with the CMATS is currently excluded from the 26-week target, although some services are based in secondary care and there are variations in the way in which CMATS are operating. As part of the response to recommendation 3 in the Auditor General's report **NHS Waiting Times for Elective Care in Wales**, the Welsh Government should seek to provide clarity on how CMATS should be measured, in line with referral to treatment time rules, to ensure that the waiting time accurately reflects the totality of the patient pathway.
Update Accepted Through the national orthopaedic implementation board they are currently developing a national specification for CMATS. This national specification will ensure compliance with the RTT revised rules and clearly state when an RTT clock should start and or stop. This will be reflected within the revised RTT guidance being reviewed as part of the recommendations to the **NHS Waiting Times for Elective Care in Wales**
Recommendation 2 Our work has identified that the rate of GP referrals across health board areas varies significantly per 100,000 head of population. The variations are not immediately explained by demographics suggesting differences in referral practices and potential scope to secure better use of existing resources by reducing inappropriate referrals. Health boards should ensure that clear referral guidelines are implemented and adhered to, and that appropriate alternative services are available and accessible which best meet the needs of the patient.
Update Accepted Referral guidance forms part of the national outpatient redesign programme which reports to the planned care board. Orthopaedic referral guidance will be covered through this and supported by the national orthopaedic implementation group to ratify national guidance as necessary.
Recommendation 3 Despite improvements in efficiencies, NHS Wales is still not meeting all of its efficiency

measures related to orthopaedic services. Our fieldwork showed that there is scope for even better use of orthopaedic resources, particularly in relation to outpatient performance. As part of the response to recommendation 2 in the Auditor General's report NHS Waiting Times for Elective Care in Wales the Welsh Government and health boards should work together to reshape the orthopaedic outpatient system and improve performance to a level which, at a minimum, complies with Welsh Government targets and releases the potential capacity set out in Appendix 5 of this report.

Update Accepted
Through the national efficiency board they have requested a review on possible national areas of focus to support NHS efficiency and productivity. Planned care and a number of possible efficiency measures have been proposed for review, this work includes measures for orthopaedics.

Recommendation 4

Our work has identified that, at a national level, there were weaknesses in the ability to influence the delivery of the National Orthopaedic Innovation and Delivery Board's objectives within health boards and to monitor and evaluate efforts to improve orthopaedic services. When establishing similar national arrangements in the future, including the National Orthopaedics Board, the Welsh Government should ensure that the factors that led to the weaknesses in the Delivery Board are considered and actions are put in place to mitigate those weaknesses being repeated.

Update Accepted
Regular reports on progress against the national orthopaedic plan is prepared and shared with NHS chief executives to raise its profile and challenge pace of change. It is expected that evidence of local planning in line with the national plan forms part of the assessment and agreement of the IMTPs each year

Recommendation 5

All health boards have made some progress in putting in place alternatives to orthopaedic surgery, specifically CMATS, but our work found that these are often small scale, at risk of funding pressures and lack any evaluation. The Welsh Government and health boards should work together to undertake an evaluation of CMATS to provide robust evidence as to whether they are providing sustainable solutions to managing orthopaedic demand.

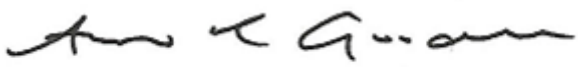
Update Accepted
Through the national orthopaedic implementation board they are currently developing a national specification for CMATS. Each health board will then be expected to review their service against the guidance to look at how their current provision meets the specification and how it could further improve.

Recommendation 6:

NHS Wales collects and produces a great deal of information about the performance and activity of musculoskeletal services, however, data relating to patient outcomes and

patient experience is much sparser. The Welsh Government and health boards should work together to develop a suite of outcome measures as part of the Outcomes Framework, supported by robust information systems, which provide comprehensive management information as to whether orthopaedic services are demonstrating benefits to patients and minimising avoidable harm.
Update Accepted National work on collecting patient reported outcomes (PROMs) and experience (PREMs) measures has begun with orthopaedics being the first area of review. The work commenced in BCU but is now being rolled out through a phased approach across all health boards.

Yours sincerely



Dr Andrew Goodall

Document is Restricted

Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee
PAC(5)-01-17 P4

27 January 2015

Archwilydd Cyffredinol Cymru
Auditor General for Wales

NHS Waiting Times for Elective Care in Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Government of Wales Act 1998 and 2006.

The Wales Audit Office study team comprised Mark Jeffs, Gareth Jones, Verity Winn and Steve Ashcroft under the direction of David Thomas.

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Contents

Summary

1 During our lifetimes, most of us will need some form of elective – or planned – NHS care. That could involve a diagnosis from a consultant or some form of planned surgery. The amount of time that patients wait to get a diagnosis or to get treatment matters a good deal to them. It is not the only thing that matters, but waiting times has been the key measure against which the Welsh Government and the public judges the performance of the elective care system. Since 2009, the NHS in Wales has been working to a target whereby at least 95 per cent of patients on a waiting list should be waiting less than 26 weeks and nobody should wait more than 36 weeks[1]. The waiting list includes patients at all stages from their referral through to starting treatment. Figure 1 provides a snapshot overview of the NHS waiting list in Wales in March 2014.

2 This report looks at how long patients are waiting for elective care. The report does not focus on emergency care nor care related to cancer – which is subject to separate targets – although it does consider the impact of prioritising these areas for elective care. In carrying out our work, we have sought to answer the overall question: 'Is NHS Wales' overall approach to managing elective waiting times effective?' To answer this question we looked at current performance, the underlying causes of waiting times performance and NHS Wales' plans to better manage waiting times. Our conclusions and our key findings are set out in this report. We are also publishing additional supporting information for readers interested in seeing more of the detailed analysis and data underpinning our findings:

   a a technical report with more data on performance and the causes of long waiting times;

   b a summary of the responses to patient surveys conducted as part of our review; and

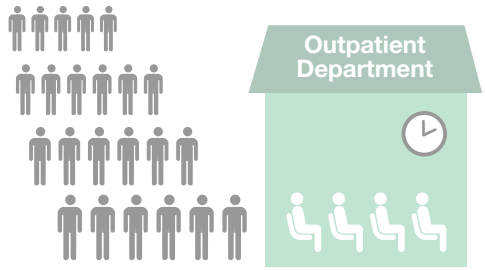
   c a compendium of good and promising practice.

3 Our overall conclusion is that while the vast majority of patients are treated within 26 weeks, the current approach does not deliver sustainably low waiting times. However, emerging plans do have the potential to improve the position if they are implemented effectively.

1 Some specific services are excluded from the waiting times target, including fertility treatment, screening services and routine dialysis. Further detail can be found in the publication **Rules for Managing Referral to Treatment Waiting Times**.

Figure 1 – A snapshot of the waiting list at March 2014

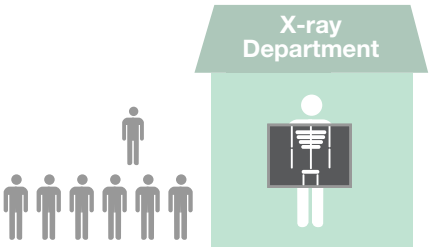
Outpatients



227,787 patients awaiting first outpatient appointment.

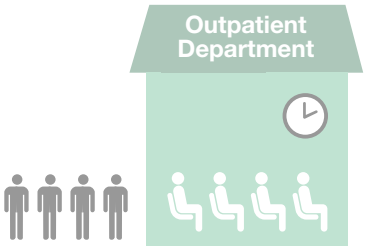
Median wait: **8.6** weeks

6% waiting over 26 weeks



66,920 patients awaiting a diagnostic test.

No median wait due to data consistency issues.

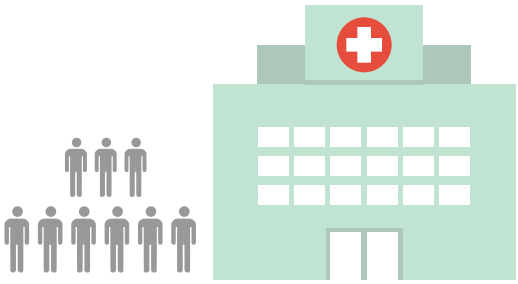


36,263 patients awaiting a decision following a diagnostic test.

Median wait: **12.9** weeks

12% waiting over 26 weeks

Inpatients



87,472 patients waiting for admission as an inpatient or day case.

Median wait: **16.3** weeks

26% waiting over 26 weeks

4 It is important to state that the vast majority of patients are seen and treated within 26 weeks and many are happy to wait for their treatment. Across 2013-14, the median waiting time of a patient on a waiting list in Wales was 9.9 weeks[2]. Figure 1 provides a snapshot of the median waits of patients at various stages of the patient pathway at the end of March 2014. However, performance against the Welsh Government waiting time targets has been declining significantly since 2009. In March 2014, 11 per cent of patients on the waiting list had been waiting more than 26 weeks and three per cent more than 36 weeks. There is evidence from independent reviews and our own survey that a minority of patients are coming to harm as a result of long waiting times. Moreover, despite some differences in the way they are measured, waiting times in Wales are longer than those in England and Scotland. The data which is available does not allow a similar comparison to be made to Northern Ireland.

5 The causes for the relatively long waits are complex but boil down to the inability of NHS Wales as a whole to sustainably match the supply of healthcare with demand for services. Some of the key factors that we see as having led to the current position are:

a the Welsh Government not updating its approach since 2009 to reflect the challenges of meeting waiting time targets in an environment of increasing financial and resource constraints, though this is now being addressed through the integrated medium-term planning process;

b a lack of recurrent capacity for elective care and a consequent over-reliance on short-term funding for activity outside of normal working hours to deliver quick but unsustainable reductions in waiting times;

c over-optimistic health board plans that are based on meeting targets rather than what can realistically be achieved;

d greater financial, staffing and bed resource pressures compared to similar parts of the UK;

e pressures from rising demand for elective care;

f pressures from emergency admissions, urgent cancer care and follow-up appointments which reduces the resources available for routine patients; and

g inefficient use of existing resources and capacity, including an over-reliance on seeing and treating patients in hospital when they could be managed in a primary care or community setting.

2 The ‘median waiting time’ is the length of time waited by the person in the ‘middle of the queue’. For example, if there were 100 patients in the queue and they were all lined up in the order of time they had been waiting, the median waiting time would be the length of time the 50th person had waited.

6 One of the key messages we want to emphasise is that the relatively poor performance on waiting times is not due to a lack of will or effort on the behalf of staff working in the NHS. Our evidence shows that the system – the thinking, planning and detailed processes – of elective care is the problem, not the staff. Indeed, a major part of the problem is that the NHS has become over-dependent on short-term initiatives that generally involve staff working extra hours in order to try to reduce the numbers of patients facing very long waits.

7 A key question is whether the NHS can sustainably meet waiting times targets given the current financial and capacity constraints. Pressure on financial, staffing and bed resources are more pronounced than other parts of the UK with similar social and economic circumstances to Wales. In some areas, a lack of capacity is constraining NHS Wales' ability to match the performance of other UK countries. Based on performance to date, it is unlikely that NHS Wales could achieve and sustain low waiting times if it tries to do more of what it has done in the past.

8 However, NHS Wales' emerging thinking on the future direction for elective care could lead to lower waiting times. In part, the solution is about local efficiency improvements to make better use of existing capacity. But the greatest opportunity lies with challenging and changing some of the basic assumptions about what support and treatments patients need and want and who is best placed to provide them. In some cases, patients do not need or want the expensive hospital-based services that the NHS currently offers them. It is difficult to be certain given the relatively unsophisticated data that exists on demand and capacity, but we expect that by doing things differently, health boards could free up significant capacity to see more patients (see Figure 2). Making better use of existing capacity could lead to shorter and more clinically appropriate waiting times for patients. Putting the promising ideas that the NHS now has – particularly through prudent healthcare – into practice will require bravery to take managed risks and hard work to overcome the practical obstacles that have sometimes impeded radical reform in the NHS. Our Good Practice Compendium sets out examples of practices from Wales and further afield that can help in thinking about different ways of working.

Figure 2 – Potential efficiency/capacity gains identified through the report

	Report reference	Potential capacity gains in the medium term with substantial reform	Potential capacity gains in the long term with continued substantial reform
Re-designing the outpatient model to reduce reliance on hospital consultant to provide diagnosis and advice by using other staff and technological solutions	Paragraphs 3.8 to 3.9	If five per cent of outpatient attendees were seen by other clinical staff, consultants could potentially see an extra 67,000 patients.	A 10 per cent shift would free up capacity for consultants to see an additional 135,000 patients.
Reducing the number of patients that do not attend their outpatient appointments (DNA)	Paragraphs 3.10 to 3.13	A one percentage point reduction in DNA could free up capacity to see an additional 2,900 patients.	A four percentage point reduction in DNA could free up capacity to see an additional 11,600 patients.
Reducing procedures known to be of low clinical value for many patients	Paragraph 3.3	A 25 per cent reduction would free up capacity for 8,400 procedures, 11,000 bed days. The value of this capacity would be in the order of £13 million.	A 50 per cent reduction could release capacity for 16,800 procedures, 22,000 bed days. The value of this capacity would be in the order of £26 million.
Reducing variation in clinical decision making and intervention rates	Paragraphs 3.4 to 3.7	If health boards reduced intervention rates to the average in the 16 procedures in our sample, it would free up capacity equivalent to 11,300 procedures and 28,000 bed days. The value of this capacity would be £16 million.	Reducing variation across all procedures could free up capacity equivalent to 32,000 procedures and 47,000 bed days [1].
Reducing lengths of stay	Paragraph 3.25	Reducing length of stay across emergency and elective systems to the average of Welsh providers each month would free up 40,500 bed days which would equate to around 13,300 elective patients.	Reducing length of stay to the best would free up 201,500 bed days which would equate to 76,200 elective patients.

Note

These are broad estimates that indicate what capacity could potentially be created by doing things differently. They should not be seen as targets or forecasts. In some cases, freed up capacity may be better used to provide 'headroom' or breathing space rather than used to treat more patients.

[1] It was beyond the scope of this study to identify the cost of variation across all procedures carried out across Wales.

Recommendations

Recommendation	
R1	The Welsh Government has not formally reviewed its approach to managing waiting times in light of a sustained deterioration in performance and the challenges of real terms cuts to spending on health. However, with the introduction of a new planning framework, a Planned Care Programme and a range of prudent healthcare initiatives, there are positive signs of a clearer direction for elective care in an environment of austerity. While the Welsh Government is responsible for setting the overall direction, it is for health boards to plan and deliver sustainable and appropriate waiting times. The Welsh Government should therefore work with NHS bodies to: a review and set out the principles, priorities and intended outcomes for elective care, within the context of the wider healthcare system: to include a fundamental review of current waiting times targets and whether they are an effective method to prioritise resources towards those most in need; b develop a shared understanding of demand and capacity across the NHS and develop a realistic timeframe for reducing elective waiting times and the backlog of patients in line with any changes to the targets resulting from R1(a) above; and c assess the costs, benefits and barriers related to adopting seven-day working across the elective care system.
R2	Our review found that aspects of the current design and operation of the outpatient system is not as efficient and patient focused as it could be. The Welsh Government and NHS bodies should work together to radically re-shape the outpatient system. In doing so, they should build on the prudent healthcare principles, to enable the emergence of a system that is based more on need, patients' own treatment preferences, use of technology and which reduces the risk of over-treatment and an over-reliance on hospital-based consultants to diagnose and advise on treatment.
R3	We found that in some cases, patients could be facing substantially longer waits if they cancel their appointments because they can find themselves going to the back of the queue. The Welsh Government should review RTT rules and the way in which they are interpreted and applied locally to ensure patients are not being treated unfairly as a result of current approaches to resetting patients' waiting time clocks.
R4	Our local fieldwork has identified pockets of good and interesting practice and innovation across the NHS in Wales. The Welsh Government, through the Planned Care Programme, should identify mechanisms to share interesting and good practice, in ways which enable frontline staff to share ideas and develop new approaches based on what works. This should include the use of statistical analysis to understand demand and plan capacity as set out in the 2005 NLIAH **A guide to good practice**.
R5	A significant minority of patients in our survey were unaware of what would happen to them if they cancelled, did not attend or were unavailable for appointments. The Welsh Government and health boards should work together to better communicate with patients about their responsibilities, those of the different parts of the NHS and what they should expect when they are in the elective care system.

Recommendation	
R6	The Welsh Government publishes some data on waiting times, but it could provide more useful information to help support scrutiny and management of waiting times, as well as providing local information that would be more helpful for patients on a waiting list. The Welsh Government should therefore publish more detailed national and local information: • publish waiting times at different parts of the patient pathway (component waits); • reporting separately waiting times for urgent and routine cases, for both the closed and open pathway measure; • publishing the date for the closed pathway measure which separates out admitted and non-admitted patients; and • publishing median and 95th percentile waiting times.
R7	Many people we spoke to on our local fieldwork identified current IT systems as a barrier to improving services and managing patients, although it is unclear to what extent any problems lie with the systems themselves or the way they are being used. The Welsh Government should carry out a fundamental review of the ICT for managing patients across the patient pathway and how it is being used locally and develop actions to address any problems or concerns that are identified.
R8	Capacity within secondary care is a major barrier to reducing waiting times. Welsh hospitals have higher occupancy rates than comparators elsewhere in the UK and clinicians raised concerns about the lack of flexibility in the system to manage peaks and troughs in demand from emergency care in particular. The Welsh Government and NHS bodies should review the approach taken to planning inpatient capacity across NHS Wales, to enable the NHS to better manage variation in emergency admissions at the same time as delivering sufficient elective activity to sustain and improve performance.
R9	Cancellations can result in inefficient use of NHS resources and cause frustration for patients. At present, the data on cancellations is incomplete and inconsistent, despite work by the Welsh Government to introduce an updated dataset. The only data that exists covers cancelled operations and health boards appear to be recording the reasons for cancellations differently. The Welsh Government and health boards should therefore work together to: • ensure that there are comprehensive, agreed and understood definitions of cancellations, and the reasons for them across the entire waiting time pathway to include outpatients, diagnostics, pre-surgical assessment and treatment; and • ensure that reliable and comparable data on cancellations (and the reasons for them) is collected and used locally and nationally to scrutinise performance and target improvement activities.

Part 1

Many patients face long waits for treatment and some other UK countries are doing better against more stringent targets

1.1 This part of the report examines the performance of the NHS in Wales against its targets for waiting times and looks at the experience of patients on waiting lists in Wales. It also compares performance in Wales to other parts of the UK where possible. A more detailed analysis of performance data can be found in our NHS Waiting Times for Elective Care in Wales: Technical Report.

Box 1: Approaches to measuring waiting times

The patient clock: Waiting times are measured using the concept of the patient clock. In Wales, England and Scotland the clock starts when a health board/provider receives a referral (usually from a GP). The clock stops when the patient starts their definitive treatment or a decision is made that treatment is not necessary. Treatment is not necessarily a procedure: for many patients, treatment involves getting advice at an outpatient appointment.

Open measure: Is a measure of the length of time patients wait who are currently on the waiting list. It is the preferred measure of the Welsh Government and is also used in England. The advantage is that it is a live measure of how the system is currently performing. The key disadvantage is that it does not reflect how long patients actually wait to get their treatment.

Closed measure: Is a measure of the length of time waited by patients who have received their treatment. The closed measure is used as a key measure in Scotland and England. The advantage of the measure is that it reflects the end-to-end waiting times. The main disadvantage is that it is not a live measure so does not show how long people currently on the list are waiting.

Clock pauses, resets and adjustments: NHS bodies can legitimately make 'adjustments' to the measures to reflect, for example, patient choices (like choosing to wait longer to allow for a planned holiday) and behaviour (such as not turning up for appointments). The rules for adjustments differ across the UK and are discussed in Part 3 of this report.

Data quality: There have been issues with the quality of published data on waiting times. In January 2014, the National Audit Office[3] found errors in some trusts' recording of waiting times figures for England and concluded that they 'need to be viewed with a degree of caution'. An Audit Scotland report in February 2013[4] found minor errors in waiting times data across Scotland. Our study has not included a review of the quality of Welsh referral to treatment data.

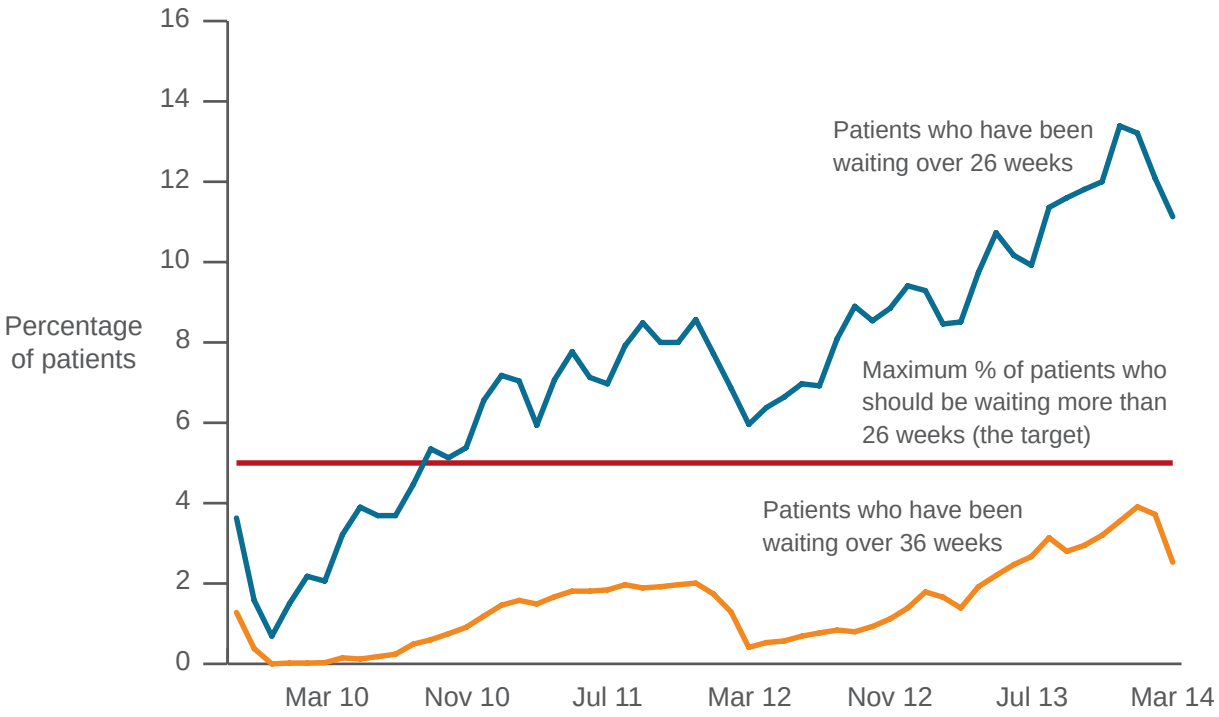
3 National Audit Office, **NHS Waiting Times for Elective Care in England**, January 2014
4 Audit Scotland, **Management of Patients on NHS Waiting Lists**, February 2013

Although most patients are treated within 26 weeks and many patients are happy to wait, performance is getting worse and is some way from meeting the targets

Waiting times performance has got steadily worse since December 2009 and the targets have not been met since September 2010

1.2 The Welsh Government's 'open measure' target states that at least 95 per cent of patients on the waiting list should have waited less than 26 weeks from the date of their referral. Nobody should be waiting more than 36 weeks for treatment. As Figure 3[5] shows, NHS Wales did meet the target at the end of 2009 but since then the proportion of patients waiting more than 26 weeks and 36 weeks has increased significantly. At the end of 2013-14, around 11 per cent of patients were waiting more than 26 weeks, and three per cent waiting more than 36 weeks.

Figure 3 – Patients on the list waiting more than 26 and 36 weeks



Source: Wales Audit Office analysis of Welsh Government data

5 Analysis is based on referral to treatment data for residents living in each health board area.

1.3 The overall figures mask some variation in terms of where people live and the type of condition they have. Residents living in the Powys Teaching Health Board area are least likely to be waiting more than 26 weeks, whereas residents in the areas covered by Cardiff and Vale University Health Board and Betsi Cadwaladr University Local Health Board face the longest waits. Shorter overall waits for Powys residents are likely due to these patients having much shorter waits for their initial outpatient appointment and diagnostic tests than in other parts of Wales.

1.4 Figure 3, above, does not include patients from Wales who are referred for treatment in England. The majority of these patients are referred from within the Betsi Cadwaladr University Health Board and Powys Teaching Health Board. Overall, Welsh patients face shorter waits for treatment in England than in Wales. However, in October 2012, Powys Teaching Health Board took a decision to extend waiting times targets for patients, including those referred to England[6], from 26 weeks to between 32 and 36 weeks (although it has reversed that decision in 2014-15). Therefore, waiting times for patients referred to England from Powys have been longer than those referred from within the Betsi Cadwaladr University Health Board area.

1.5 There are significant differences between specialties, with trauma and orthopaedics, oral surgery, ophthalmology, general surgery, pain management, restorative dentistry and urology patients facing the longest waits. The specialties with the longest waits tend to be those with the highest volume of patients. Specialities with the lowest waits (fewer than one per cent waiting over 26 weeks) include dental medicine, paediatric neurology, audiological medicine and paediatrics.

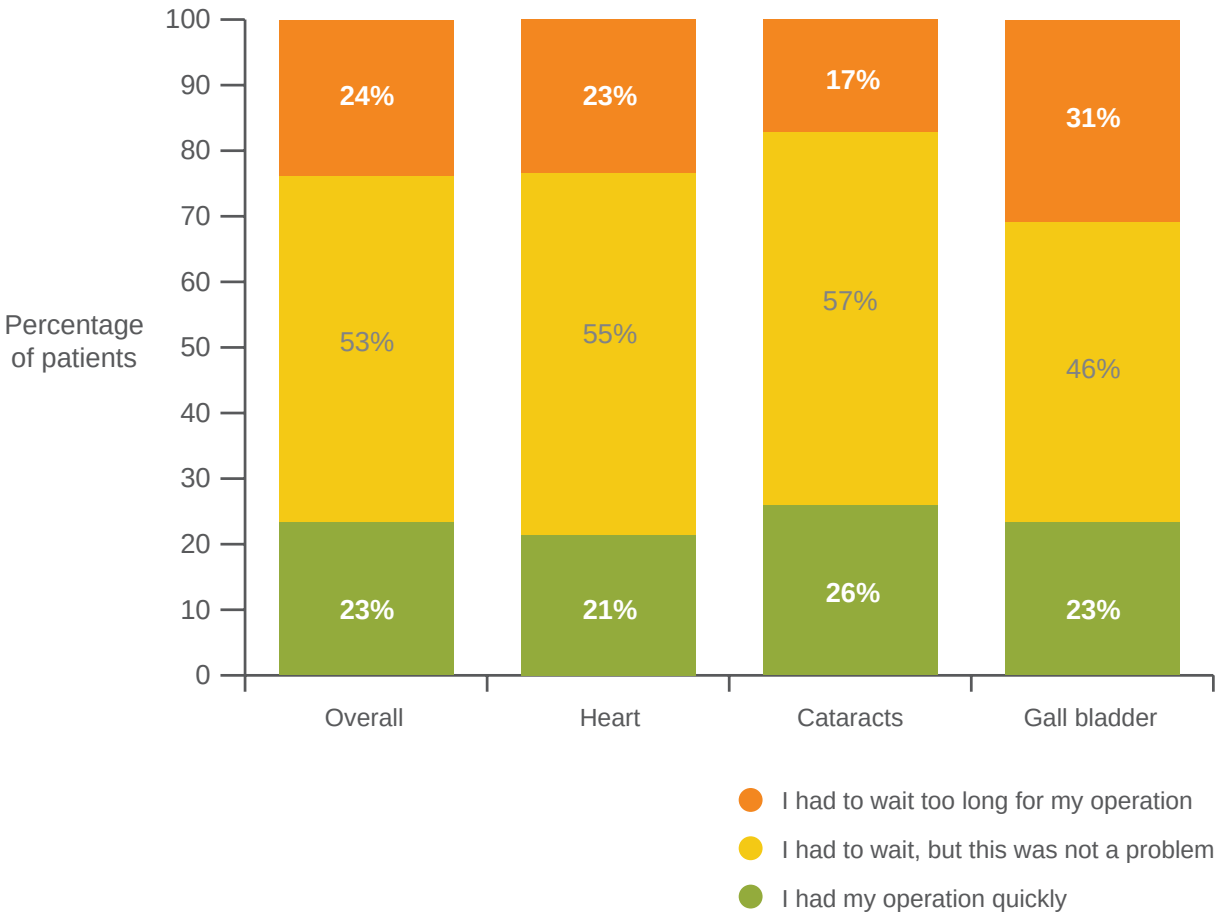
1.6 There are particularly long waits at certain parts of the patient pathway, especially waits for a first outpatient appointment and diagnostic tests. In March 2009, nobody waiting for a first outpatient appointment had been waiting more than 10 weeks. By March 2014, 38 per cent of patients had been waiting more than 10 weeks for their first outpatient appointment with six per cent (14,000 patients) waiting for more than 26 weeks. The national target for a patient's maximum wait for access to diagnostic tests is eight weeks. But in recent years, performance has not met those standards: In June 2014, 22,717 patients (28.7 per cent of patients) were waiting over eight weeks for diagnostic services compared to just 10 per cent in October 2009.

6 We understand that Welsh providers did not act on the decision to change the waiting times target for Powys residents.

Most patients are treated within 26 weeks and are happy to wait for some procedures but a significant minority feel that they waited too long

1.7 It is important to recognise that while a significant minority of patients face long waiting times, most people[7] are treated within 26 weeks. Moreover, most people who responded to our patient survey[8] who had recently undergone specific types of heart, cataract and gall bladder treatments said that waiting for their operation was not a problem (Figure 4). Some people appreciated being kept informed of expected waiting times whilst others were aware of the number of people waiting for treatment. The majority of patients who said that they were happy to wait for treatment had waited for more than four months for their operation.

Figure 4 – Patient views on the length of time they waited (by procedure)

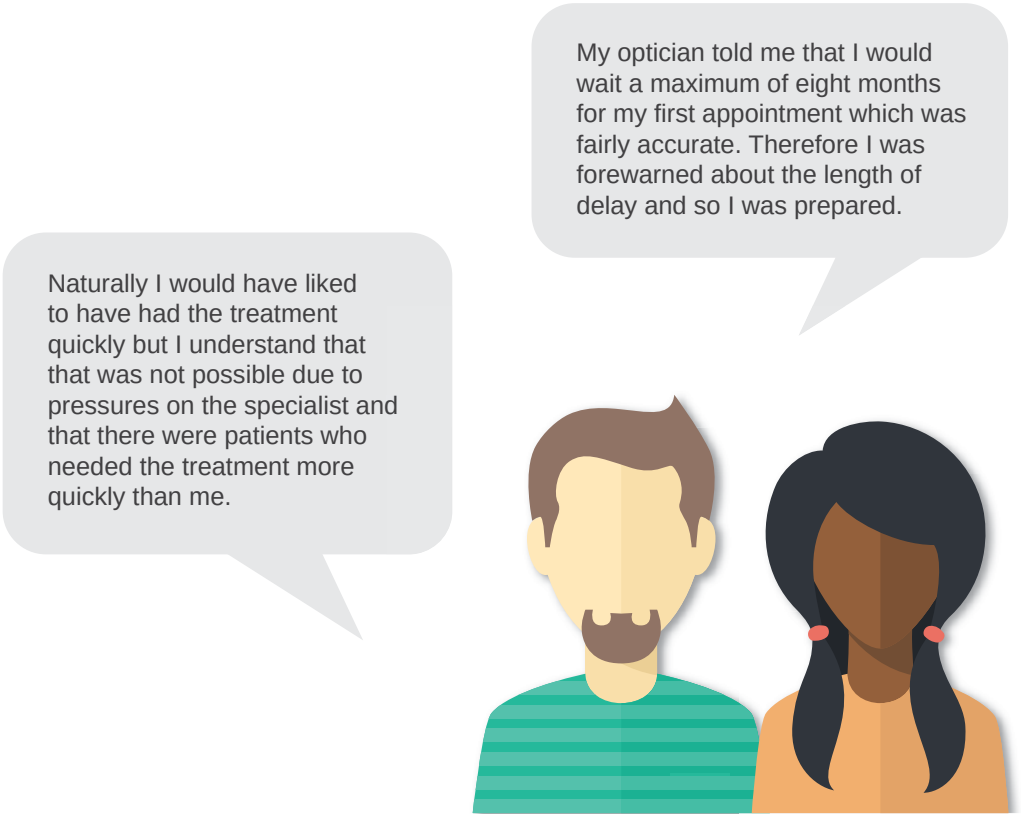


Source: Wales Audit Office patients survey

7 Figures from March 2014 show that 77 per cent of patients were treated within 26 weeks.

8 We conducted a postal survey of 900 patients who had undergone one of three procedures as an elective patient during October or November 2013. The procedures were cataract surgery, surgery to remove the gall bladder (both high-volume procedures with a high number of elective admissions), and catheterisation of the heart (a high-volume diagnostic procedure). We also conducted a shorter online survey targeted at patients who had undergone a planned operation in the last three years.

Comments from Wales Audit Office Citizen Survey



A significant minority of patients feel they wait too long and some patients are deteriorating and coming to harm while on a waiting list

1.8 The 26 and 36-week targets apply to all patients, but the NHS aims to see and treat those most in need more quickly. NHS bodies classify all patients on a waiting list according to whether they are 'routine' or 'urgent'[9]. In the first instance, the person referring the patient – usually a GP – will set out their classification. Each referral is then reviewed by a consultant who makes the final decision on whether the patient is routine or urgent. Health board systems are designed to ensure that urgent patients are treated more quickly than routine patients. The NHS data dictionary defines urgent as being patients who are at risk of material deterioration if he or she is not seen within four weeks. We were unable to get national data on the difference in waiting times for 'routine and 'urgent' patients. Figures provided by one health board show that while many urgent patients are waiting less than four weeks, there is a backlog of urgent patients in some specialities waiting significantly longer for a first outpatient appointment: in some cases, more than six months. We consider the complexities of clinical prioritisation in more detail in paragraphs 3.14 to 3.17.

1.9 Information about the effect of long waits on patient outcomes is not readily available but we do have evidence of some areas where patients are coming to harm. Recent reviews of patients waiting for cardiac surgery concluded that waiting times in South Wales for many patients are 'longer than clinically appropriate leading to excessive morbidity[10] and risk of mortality on the waiting list, poorer surgical outcomes, increased risk of emergency admission and reduced efficiency in resource utilisation'[11]. The reviews showed that 99 patients have died whilst on the waiting list for cardiac surgery in the last five years although because of existing co-morbidities it is not clear how many of these deaths were directly attributable to long waits. NHS Wales is putting in place a range of measures to address the long waits for cardiac patients and there are signs that waiting times for cardiac services in some parts of Wales have reduced during the early parts 2014-15 (NHS Waiting Times for Elective Care in Wales: Technical Report, paragraph 1.21). The Welsh Government and NHS bodies are taking action to improve the situation for cardiac patients (paragraph 1.21).

9 The 'urgent' category applies to patients with urgent suspected cancers as well as patients who are urgent for other reasons. Patients with urgent suspected cancer are managed to a separate target and are not included in the elective waiting times figures. To provide an indication of the urgency profile of the elective waiting list, one health board's data showed that in August 2013, 29 per cent of patients waiting for their first outpatient appointment and 28 per cent of patients on an inpatient/day-case waiting list were classified as 'urgent'.

10 'Excessive morbidity' in this context means that people are more unwell than they would be if they had not been waiting so long.

11 Welsh Health Specialised Services Committee: **Review of Cardiac Services** (March 2013), **Report of the Cardiac Surgery Working Group** (March 2013) and **Cardiac Summary Paper** (September 2013)

1.10 The Royal National Institute for the Blind (RNIB) has reported concerns that an estimated 48 patients a year are losing their sight while on a waiting list[12]. In 2013, RNIB conducted a survey of ophthalmology staff in Wales, followed by interviews in April 2014 to understand some of the issues highlighted by the survey. All of the ophthalmologists who took part in the interviews reported that patients are experiencing irreversible sight loss as a result of long waiting times. Some of the problems relate to patients waiting for follow-up appointments as well as those on a referral to treatment pathway. Since March 2012, the number of ophthalmology patients waiting more than 36 weeks rose from 28 patients to around 2,000 in May 2014. The Welsh Government and NHS bodies are working together to try to improve waiting times for ophthalmology patients. The RNIB has identified similar issues with ophthalmology in England[13].

1.11 The patient survey undertaken as part of this study found that almost a quarter of patients felt they had to wait too long for their operation. Many of the patients that felt that they waited too long reported concerns that their condition had deteriorated: with 29 per cent of patients reporting that their condition got worse while they were waiting. That figure rises to 40 per cent among patients who were waiting to have their gall bladder removed. Alongside the impacts on their physical health, patients also reported negative impacts on their economic wellbeing from missing work, social life, independence and emotional wellbeing. Below are some of the comments that patients made relating to the length of time they waited and their deterioration.

12 Dr T Boyce, **Real patients coming to real harm – Ophthalmology services in Wales**, RNIB, November 2014. The Royal College of Ophthalmologists response to the report states that 'Whilst not based on a robust study the findings in the report highlight the pressing need for joint work to protect the eye health of the population and prevent avoidable sight loss'. The RNIB report **Saving Money, Losing Sight,** November 2013, found that 'patients are going blind due to sizeable capacity problems in ophthalmology units across England'.

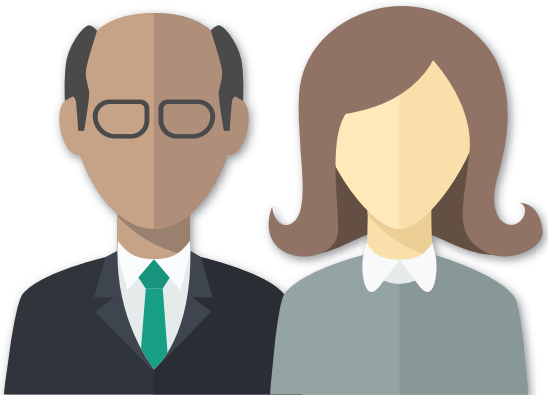
13 The RNIB report Saving Money, Losing Sight, November 2013, found that 'patients are going blind due to sizeable capacity problems in ophthalmology units across England'.

Comments from Wales Audit Office Citizen Survey

I was in pain more days while waiting for my operation. I was eating very little due to the pain and needing to take prescription painkillers very often. My work and whole life was affected.

My condition gradually deteriorated. I gradually became more breathless and had greater chest discomfort/pain. My mobility decreased and hobbies such as gardening were no longer able to be enjoyed by me. I even had to pay someone to mow my lawn!

I couldn't see where I was going and had a few falls and was bumping into things. I became afraid to go out and everyday tasks became a nightmare.



Scotland and England are performing better against more stringent referral to treatment time targets

1.12 The four countries of the UK have adopted different approaches to managing and measuring waiting times. As the Nuffield Trust highlights, these differences make comparing performance very difficult[14]. Like Wales, Scotland and England have targets covering the full period from referral to treatment. But the targets are based on a waiting time of 18 weeks: shorter than the 26-week target in Wales. Therefore, direct comparison against the targets is not possible. Northern Ireland has separate targets for stages of the patient journey which prevents direct comparisons to other parts of the UK both in terms of the targets themselves and performance against them. However, in theory the total maximum wait permissible within targets in Northern Ireland is longer than in other parts of the UK. In addition to the different targets, there are other factors that make comparison difficult. For example, the countries have different rules as to when NHS bodies can 'adjust' the waiting times of a patient (NHS Waiting Times for Elective Care in Wales: Technical Report, paragraph 1.15). In a further difference, the waiting times targets in Wales apply to a wider group of patients than other parts of the UK[15]. This does mean that the published RTT figures in Wales give a more complete picture of the number of patients waiting for treatment.

1.13 Figure 5 sets out the targets for each country and performance as at March 2014. It shows that England and Scotland are performing better against their more stringent targets. Scotland met its 18-week target while England met its target for non-admitted patients but just fell short of its target for admitted patients.

1.14 Average (median) waiting times give an indication of the relative lengths of wait for patients in the different countries. Currently England is the only part of the UK that reports median waiting times for the full patient pathway based on the open measure. While there are some differences in how the data is measured – figures for Wales include adjustments while those for England do not – and which patients are included (see paragraph 1.12), it is possible to make a broad comparison between Wales and England. Figure 6 shows the median waits of patients on a waiting list in England and Wales during 2013-14. In Wales, median waiting times ranged from nine to almost 11 weeks during the year compared to five and six weeks in England and North England[16]. England also reports figures for patients facing the longest waits: known as the 95th percentile[17]. These figures are not published in Wales, but the Welsh Government has data to show 95th percentile waiting times in Wales. Figure 7 shows that 95th percentile waiting times in Wales were around 33 weeks in Wales in 2013-14 compared to about 19 weeks in England and North England.

14 Nuffield Trust, **The four health systems of the United Kingdom: how do they compare?** 2014

15 In Wales, direct GP access diagnostic and allied health professional services is included in published data but we have removed these figures as they are not included in England and Scotland. There are some other differences in data as some consultant-led services are excluded from the published figures in Scotland.

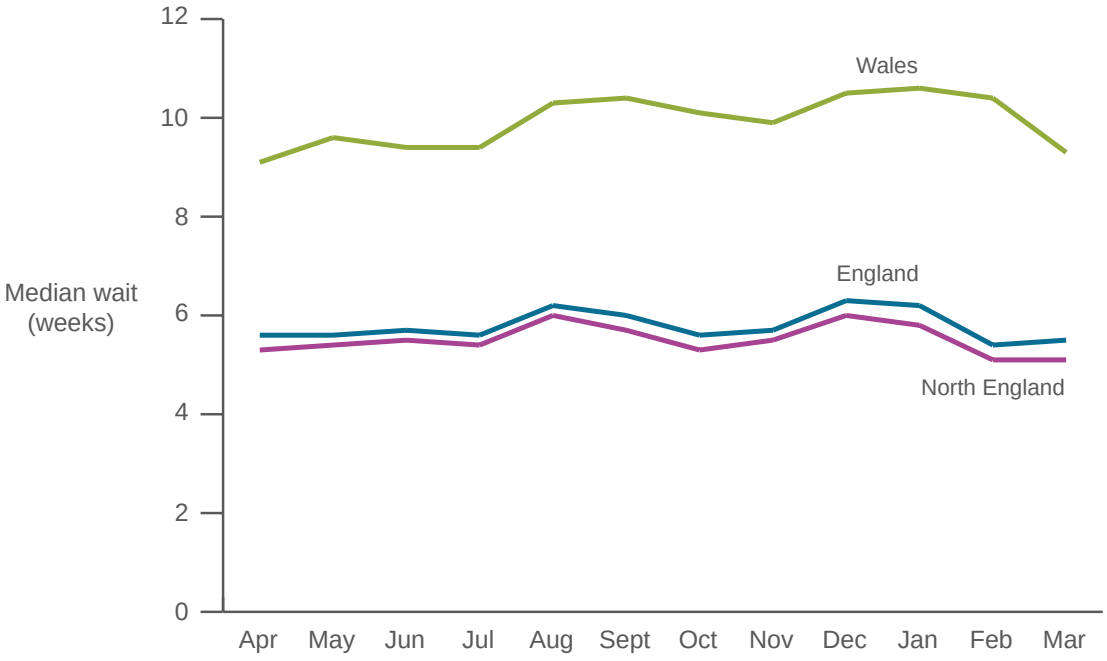
16 Differences in performance could reflect demographic issues, with Wales having an older population and specific issues around deprivation. We have therefore included figures for the north of England. Historically, the north east of England has been used as a comparator for Wales. However, changes to the structure of the NHS in England mean that the data for the north east is no longer published. The closest comparator is therefore the north of England, which includes the north east and north west of England.

17 The 95th percentile is an indicator of long waits. If there were 100 patients in the queue lined up in order of time they had been waiting, the 95th percentile would be the length of time the person in 95th place had been waiting.

Figure 5 – Comparison of targets and performance across the UK

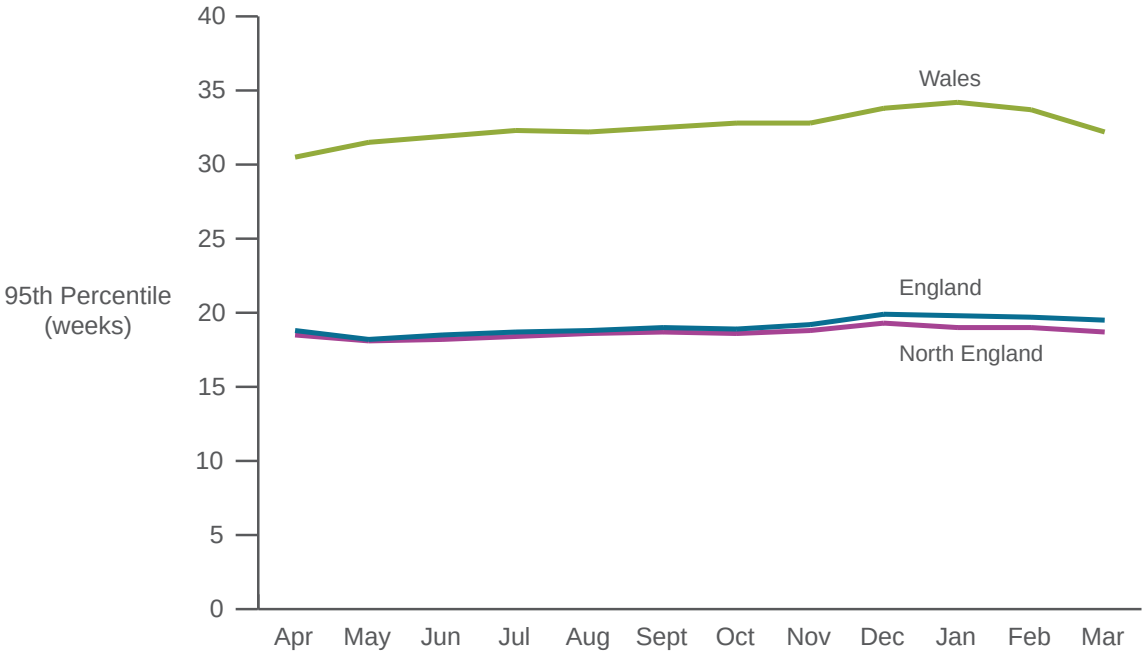
Target	Performance as at March 2014
Wales 95 per cent of patients on the waiting list should have waited less than 26 weeks from the date of their referral. Nobody should be waiting more than 36 weeks for treatment.	89 per cent of patients on the waiting list had waited less than 26 weeks and three per cent had been waiting more than 36 weeks.
England 95 per cent of non-admitted patients to start treatment within 18 weeks. 90 per cent of admitted patients to start treatment within 18 weeks. 92 per cent of patients on the waiting list should be waiting less than 18 weeks.	In England, 89 per cent of patients who were admitted to hospital and 96 per cent of non-admitted patients started treatment within 18 weeks. Of those on the waiting list, 94 per cent had been waiting less than 18 weeks. In the north of England 91 per cent of patients who were admitted and 97 per cent of non-admitted patients started treatment within 18 weeks. Of those on the waiting list, 95 per cent had been waiting less than 18 weeks.
Scotland 90 per cent of patients to start treatment within 18 weeks, within which: • 95 per cent of patients waiting for a first outpatient appointment should be waiting less than 12 weeks; and • all patients to start treatment within 12 weeks of the decision to treat.	90 per cent of patients started treatment within 18 weeks. 97.3 per cent of new outpatients had been waiting 12 weeks or less for an appointment. 97.3 per cent of patients were treated within 12 weeks (covers the quarter to March 2014).
Northern Ireland From April 2013, at least 70 per cent should wait no longer than nine weeks for their first outpatient appointment and none should wait more than 18 weeks, increasing to 80 per cent by March 2014 and no one waiting longer than 15 weeks. From April 2013, no patient should wait longer than nine weeks for a diagnostic test. From April 2013, at least 70 per cent of inpatient and day cases should be treated within 13 weeks and none should wait more than 30 weeks. This increased to 80 per cent by March 2014 with no patient waiting longer than 26 weeks.	Of those patients on an outpatient waiting list, 31 per cent had been waiting more than nine weeks and 15 per cent had waited more than 15 weeks. Of those on a waiting list for a diagnostic test, 15 per cent had been waiting more than nine weeks. Of those waiting for inpatient treatment, 33 per cent were waiting more than 13 weeks and nine per cent more than 26 weeks.

Figure 6 – Median waiting times for patients on an open pathway in England and Wales 2013-14



Source: Wales Audit Office analysis of Welsh Government and UK Government data

Figure 7 – 95th percentile waiting times for patients on an open pathway in England and Wales 2013-14



Source: Wales Audit Office analysis of Welsh Government and UK Government data

1.15 There is some comparable data for waiting times for the inpatient part of the patient journey. The Nuffield Trust has reported median wait for patients for seven common procedures[18]. The data shows an overall picture whereby between 2005-06 and 2009-10, median inpatient waits in Wales broadly matched Northern Ireland and were getting closer to those of England and Scotland. However, since 2009-10 median waits in Wales have increased significantly and in 2012-13 were much longer than Scotland and England[19].

Some patients wait longer than the official recorded waiting times show and there is scope to use the existing data to better reflect patient experiences

1.16 The reported figures do not fully reflect the actual length of time some patients have been waiting. Welsh Government guidance sets out several scenarios in which the patient 'clock' can be reset back to zero, including where the patient cancels an appointment or does not attend. We consider the rules on clock stopping and how they compare with England and Scotland in NHS Waiting Times for Elective Care in Wales: Technical Report, paragraph 1.15. The waits can also be adjusted if patients are unavailable for social or medical reasons. Clock resets in particular can result in significantly lower official waiting times than the actual waits patients have experienced. There is no national data on clock resets and health boards are not routinely capturing the information. There were around 38,000 cancellations of operations due to 'patient reasons' in 2013-14. According to the rules, in each case there should have been a clock stop or reset. There are cancellations at other stages – outpatients, diagnostics and pre-surgical assessment – which would also stop or reset the clock but these cancellations are not routinely measured by health boards. Data from one health board shows that clock stops or resets can result in significant differences between officially reported waits and actual waits:

a one patient waited 68 weeks but the official wait was two weeks;

b another waited 81 weeks with an official wait of five weeks; and

c another 86 weeks with an official wait of seven weeks.

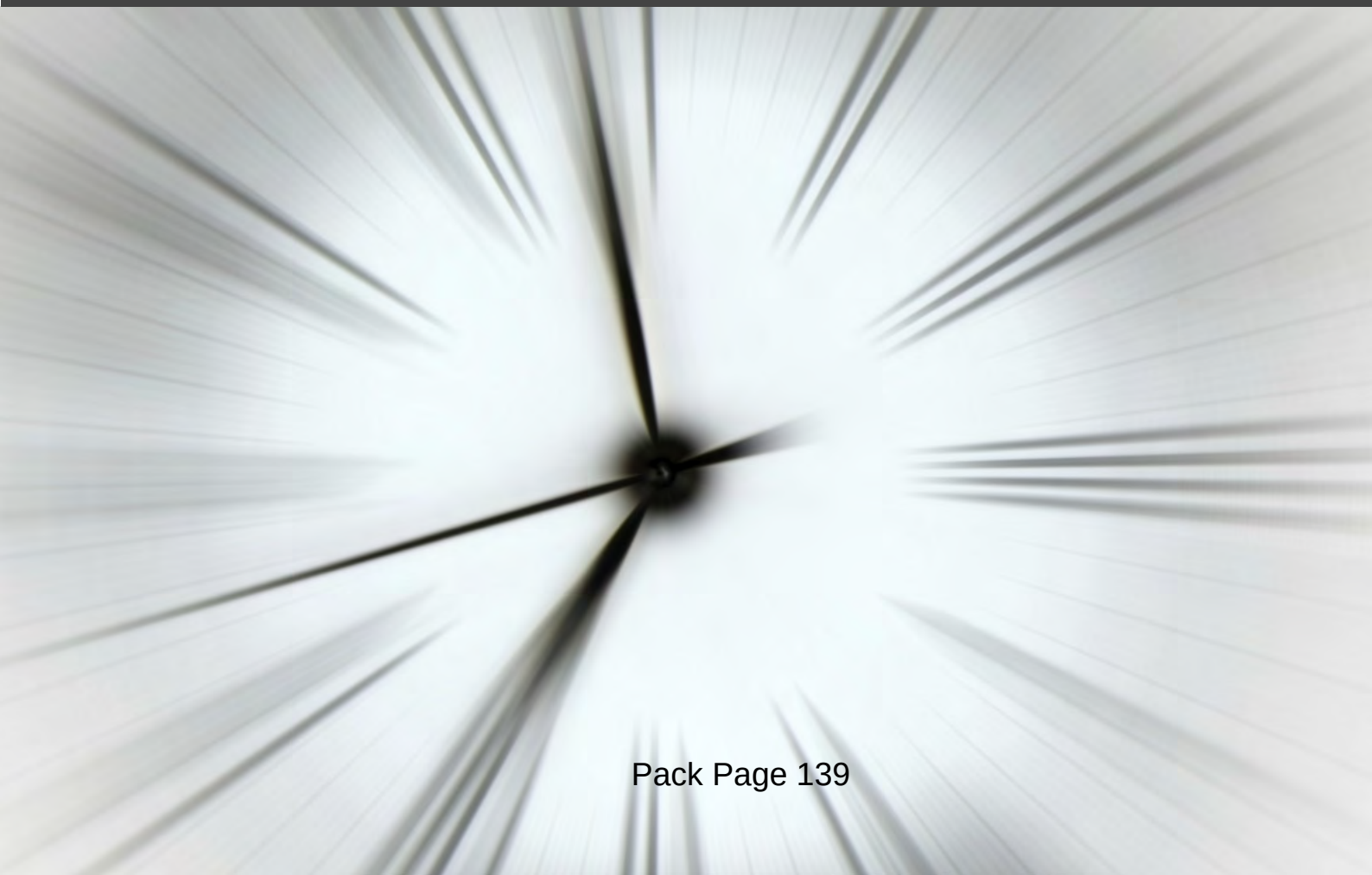
1.17 Unlike England, the data for Wales does not distinguish between admitted and non-admitted patients. The majority of patients on the waiting list will only require an outpatient appointment and will not go on to require an inpatient or day-case procedure. Because patients waiting for inpatient or day cases are in the minority, long waits for these patients can be masked by the overall figures which cover all patients and the whole period from referral to treatment. Our analysis of the open measure data showed that across 2013-14, around 30 per cent of patients waiting for an inpatient or day-case procedure had been waiting more than 26 weeks with around 11 per cent waiting more than 36 weeks.

18 Nuffield Trust, **The Four Health Systems of the United Kingdom: how do they compare?** 2014
19 Data for Northern Ireland for the period since 2009-10 is not available.

1.18 The published data does not show waits at different stages of the patient journey. We think that it would be helpful for patients to know how long they are likely to wait at the different points. The Welsh Government stopped measuring the ‘component’ parts of the patient journey in 2009-10 when it started measuring the full referral to treatment time. It started to again measure the components in September 2011 but does not publish this data.

Part 2

The main reason for long waiting times is the inability, despite a lot of effort, to sustainably match supply with patient demand



2.1 This part of the report considers the key causes behind the relatively poor performance of NHS Wales in relation to long waiting times and patient experiences. Fundamentally, the cause of long waiting times is that the NHS has not carried out sufficient activity to meet demand. Elective admissions have reduced since 2010-11 while demand has continued to grow steadily. With less activity to meet rising demand, a backlog has grown and waiting times have got longer. The analysis that follows looks in more detail at how this situation has arisen: the strategic direction that the Welsh Government has set and its management of the whole NHS to deliver waiting times targets. We then look at the underlying causes at a local level, including local planning and the use of resources.

The Welsh Government did not adequately consider how to sustain waiting time performance after 2009 and its approach to performance management has not been successful in securing achievement of waiting time targets

2.2 In common with several other political administrations around the world, the Welsh Government's strategy for securing timely access to healthcare treatment revolves around the delivery of waiting times targets. Based on an international review, the OECD has found that waiting times guarantees or targets are an effective part of a waiting times strategy[20]. However, the OECD found that they need to be underpinned by a method for ensuring that performance is improved and sustained. The OECD points to two methods associated with success:

a 'Targets and terror' – A euphemism for a form of hard performance management previously used in England and Finland whereby providers and senior managers faced tough sanctions for failure to meet the targets. The OECD reports that this approach, while effective in the short-term, is difficult to sustain over a long time.

b 'Targets and choice' used now in England as well as Portugal, the Netherlands and Denmark, where patients can choose providers with lower waiting times.

2.3 The Welsh Government's approach to performance management in relation to NHS waiting times has varied over time. Previously, the Welsh Government had a detailed project plan, Access 2009[21], to achieve the 26-week referral to treatment time target by December 2009. The plan involved an additional non-recurrent £80 million over four years. This funding aimed to deliver sustainable changes to the way health boards provided elective services as well as creating short-term capacity – through 'waiting list initiatives' (see Box 2) to address the backlog of long-waiting patients. The funding to NHS bodies was contingent on the Welsh Government agreeing annual local delivery plans which set out a detailed assessment of demand, capacity and planned improvements in efficiency such as reducing length of stay and increasing day surgery. Failure to deliver the targets was accompanied by financial sanctions, more detailed monitoring (in some cases daily) and intervention from the Delivery and Support Unit.

20 OECD, **Waiting times policies – what works?** 2013
21 See **2009 Access Project Welsh Health Circular**.

Box 2: Waiting list initiatives

Waiting list initiatives involve paying NHS staff to work outside their core hours – generally at weekends – to carry out elective activity. They can also involve commissioning elective activity from other private or NHS health providers. This activity has traditionally been classed as 'additional' rather than part of 'core' NHS elective activity. Waiting list initiatives have been used in the past to address long waiting times. They are often an essential part of a strategy to reduce a backlog of long-waiting patients. These types of initiatives mean the NHS does not create capacity/recruit staff that will not be needed once the backlog is cleared. However, waiting list initiatives are not a sustainable approach to balancing demand and capacity. They are a more costly way of delivering activity and they place pressure on medical staff who are being asked to work extra hours. Our local fieldwork suggests that staff are increasingly reluctant to take on this kind of work.

2.4 The Access 2009 project achieved its aim of meeting the 26-week referral to treatment time target in December 2009. However, no evaluation was undertaken by the Welsh Government to assess whether the project had been successful in supporting the re-shaping of local services to create a health system capable of sustaining waiting time target performance. Without this information, the Welsh Government was not in a position to know whether the achievement of the target was attributable to the strengthened performance management and additional funding that accompanied the Access 2009 project. Nor did it assess whether proper foundations had been laid to sustain waiting time performance beyond the life of the project. The Welsh Government did, as part of its routine performance management, recognise that the major challenge would be 'ensuring that supply and demand are balanced in an efficient, effective and economic manner' and set out a range of detailed remaining issues, including clearing some remaining backlog[22].

2.5 The period following the achievement of the targets coincided with changes in leadership in the Welsh Government Department for Health and Social Care and a different approach by the Welsh Government to managing the NHS. The Welsh Government stopped requiring NHS bodies to produce and agree the detailed local delivery plans setting out demand and capacity. Also, it stopped imposing financial sanctions for organisations that failed to meet waiting times targets.

2.6 The Welsh Government has maintained a systematic approach to the monitoring and challenging the performance of health boards since 2011. However, this has not been effective in improving waiting times. Our review of performance management meetings and communication shows a pattern whereby the Welsh Government insists that health boards produce trajectories showing they will meet the waiting times targets by the end of the financial year. The health boards produce trajectories, but these are generally very optimistic and are quickly missed. The health boards then provide explanations and new trajectories which are again quickly missed.

22 NHS Wales, **Annual Operating Framework 2010/2011**

2.7 The introduction of a new planning framework with a requirement for NHS bodies to produce three-year integrated medium-term plans has provided a stimulus for greater rigour to be introduced into NHS planning and performance management. The new arrangements mean the Welsh Government now requires a higher level of detailed information on capacity and demand: reintroducing some of the rigour associated with local delivery plans. But the impact of the new arrangements on elective waiting times is yet to be seen: despite health boards submitting plans for 2014-15 showing they would meet the targets, performance across Wales has continued to deteriorate.

2.8 Tellingly, the deterioration of waiting times has also coincided with unprecedented financial pressures for the NHS. The period during which the NHS improved waiting times performance was characterised by additional specific funding alongside real terms increases in spending across the NHS. As our work on health finances has shown, since 2010-11, the Welsh Government has adopted a different approach to protecting health spending from other parts of the UK. It has reduced spending in real terms and in 2013-14 spending per head of population in Wales was 12 per cent lower than in the north east of England.

2.9 We have seen no evidence that the Welsh Government has systematically assessed the impact that funding pressures would have on elective waiting times. When it became clear that waiting times were deteriorating, the Welsh Government did not re-assess the realism of its expectations in terms of delivering the targets. Nor has it robustly tested whether the most clinically urgent patients have been appropriately prioritised and protected during the period of declining performance. The Welsh Government intends that the Planned Care Programme and prudent healthcare principles will enable it to better understand and respond to the financial pressures (see Part 3).

2.10 In response to the decline in performance, the Welsh Government has provided health boards with additional short-term funding to support waiting list activity. There have been some positive efforts to encourage sustainable reform of services for orthopaedics and cardiac patients, accompanied by funding for short-term waiting list initiatives within the NHS and in the private sector. In February 2014, the Welsh Government decided to allocate an additional, non-recurrent, £2 million to health boards to carry out extra activity to accelerate their plans to reduce the number of patients waiting over 36 weeks by the end of March 2014. Whilst extra funding is always likely to be welcomed by NHS bodies, the Welsh Government recognises that it is not a long-term solution. Managers reported that when the funding became available in February 2014, it was increasingly difficult to convince clinicians to take on waiting list initiative work and some struggled to do the work by the end of March.

2.11 The Welsh Government clearly cannot be involved in the day-to-day management of waiting times. Until recently, it has focused on setting the policy direction through the target and providing challenge to the planning and delivery through performance management. In support of its performance management, it has provided some direction to health boards on the need for better planning and to improve efficiency. This is supported by in-year support and intervention by the Delivery Unit. However, the scale of the deterioration in waiting times and its coincidence with the period of austerity point to a need for an approach that is wider than just performance management against a national target. The Welsh Government has recognised the need for a broader approach. Part 3 of this report shows how the principles and ideas that are emerging as part of the 'prudent healthcare' and the Planned Care Programme alongside the three-year planning framework show how the Welsh Government is now moving towards clearer strategic leadership across the elective care system, although some significant issues remain to be worked through.

Health boards' planning of waiting times is generally unsophisticated and they have struggled to prioritise waiting times against competing pressures

Health boards' planning is hampered by a lack of sophisticated analysis of demand and capacity and plans are generally over-optimistic

2.12 Our review of health boards' self-assessments and local fieldwork found that, in general, health boards are struggling with planning for lower waiting times. Their plans are generally driven by the need to meet the targets. They produce plans showing what capacity is required in order to meet the targets by the year-end. In general, they identify likely demand using the previous year's activity and capacity in terms of the availability of consultants to provide outpatient and inpatient services. Health boards then set out the gap between the capacity they think they have and what they need in order to meet targets.

2.13 Before 2010-11, the capacity gap would have been filled to a large extent through funding for waiting list initiatives. However, financial pressures mean that is increasingly unavailable as an option. Over the period of Access 2009 and the subsequent decline in performance, health boards have not been able to plan and deliver new ways of working to sustainably match supply and demand without the need for waiting list initiatives. Generally they have continued to improve efficiency (see paragraphs 2.35 to 2.44) but have not radically re-shaped service provision, reduced activity that may have limited benefit for patients (see paragraph 3.3), or shifted activity away from hospitals in the ways they had originally intended. Nonetheless, there are some examples of good practice but these are not generally widespread (see our Good Practice Compendium).

2.14 Our review of health boards' plans showed that many do not have sophisticated information about demand which means that their analysis of the gaps can be unrealistic[23]. Demand, as measured by GP referrals, is rising[24]. But health boards have a fairly limited understanding of the drivers behind that increase, changes in the pattern of demand nor how much can be prevented by seeing and treating patients in different ways and in different care settings. Some have carried out demographic and population analysis, but generally this is focused on a small number of conditions such as diabetes and dementia and not incorporated into local elective care plans. Health boards do not have standardised information about the reasons that patients are referred for outpatient appointments: only what is in individual referral letters. As a result, health boards have very little population-level data about why patients are being referred for elective care, to inform their planning.

2.15 Our review found that health boards are not using factors such as age, complexity and co-morbidity[25] to match demand and capacity. As a result, plans do not take into account issues such as variation in the length of appointments patients will require, and the length of time in theatre different types of patients will need for their operations. Further, many health boards' plans do not consider bed availability and bed use. All health boards are conducting assessments of bed capacity to understand where possible surplus or shortfalls exist but it is difficult to see the link between these models and plans to match capacity to meet waiting list demand.

2.16 The availability of consultants is the primary capacity constraint that determines health boards' plans. Some health boards have sought to take account of constraints on staff capacity, such as annual leave and on-call duties, whereas others assume consultants will be available for the 42 weeks set out in their work contracts. Only one health board had incorporated expected levels of staff sickness on the availability of consultant capacity.

2.17 We have no doubt that health boards are committing much time and effort in trying to implement their plans. The senior managers and clinicians we met with feel under considerable pressure to improve performance and meet the targets. All of the health boards we visited had frequent meetings of senior managers that focused on delivering the planned trajectories. At these meetings, it was clear that the key barriers were being identified and action taken to address them. Nonetheless, despite the clear commitment and effort, for a variety of reasons – many of which are explored below – they were finding it increasingly difficult to bridge the gap between the capacity they have and what they need in order to achieve the reductions in waiting times they intended to achieve.

23 We do not have information on demand and capacity modelling from Powys Teaching Health Board. The health board has commissioned an independent review of demand and capacity which reported in December 2014.
24 Patients can be referred for treatment from other sources such as optometrists which are not included in these figures.
25 The term 'co-morbidity' describes two or more disorders or illnesses occurring in the same person.

Health boards face real capacity constraints with lower levels of funding and staffing than comparable areas in the UK and pressure on bed capacity, especially from unscheduled care

2.18 The period of declining elective waiting time performance has coincided with an unprecedented squeeze on finances across the NHS. One senior clinician told us when we asked about the causes of performance 'if it weren't for the financial position we would not be having this conversation'. The process through which financial pressures translate into decisions about capacity is complex. Most health boards have reduced the use of 'waiting list initiatives'. And some health boards have curtailed 'backfill', where a consultant is paid to cover sessions when another consultant is unavailable due, for example, to illness or annual leave. Some health boards decide to reduce activity in this way during the financial year as a result of wider financial pressures. As a result, they find themselves less able to bridge the gap between existing capacity and what is required to meet waiting times targets. Many health boards have emphasised that they have reduced 'additional' rather than 'core' activity. By this, they mean that they classify treatment paid for through waiting list initiative funding and backfill as 'additional' and not 'core'. In our view, this is an unhelpful distinction. From a patient perspective, all such activity is core, regardless of how it is funded.

2.19 On top of reducing or stopping additional activity at premium rates, other savings such as curtailing the growth in staffing levels or not recruiting to vacancies and reducing the number of hospital beds can also impact on waiting times. Across the elective care system, staffing and beds are the two primary capacity constraints that stop NHS Wales being able to balance supply and demand.

2.20 Delivering a balance between demand and capacity without being over-reliant on extra activity means having sufficient permanent staff to deliver the activity. We have compared some of the staffing characteristics in Wales to those in the north east of England. Medical staffing levels per head of population are lower in Wales (186 per 100,000 people) than the north east of England (219 medical staff per 100,000 people). In particular, Wales has fewer senior clinicians per head of population (73 per 100,000 people in Wales compared to 88 in the north east of England). Several health boards told us they had difficulty recruiting to some specialities. There are further challenges with the growth of sub-specialisation, where many consultants now specialise in a much narrower set of treatments than in the past. This causes problems of a lack of resilience: in some cases, there may be only one sub-specialist in a health board or region. If the sub-specialists are ill or unavailable, patients often have to wait longer.

2.21 The question of whether health boards have sufficient bed capacity is a complex one. Bed numbers have reduced significantly over the past 20 years. In 2012-13, Wales had slightly more beds per head of population than the north east of England, but was on a faster downward trajectory. More important than the bed numbers is the bed occupancy rates. Bed occupancy rates in Wales are considerably higher than the north east of England and most international comparators. They are some way above the 82 per cent that is recommended as safe by the Royal College of Surgeons. High bed occupancy rates are associated with poorer outcomes for patients, and periodic bed crises. High rates of occupancy also make the system more inefficient: for example, it is more likely that patients will be located in beds not intended for their speciality, meaning extra work is required to keep track of them and ensure they receive appropriate care[26].

2.22 Many health boards told us that in theory they had sufficient bed capacity to meet demand for elective care. However, much of their analysis is based on having all elective beds available at all times, high occupancy rates and assumptions based on how long the average patient stays in hospital. In practice, the length of stay varies from patient to patient. There will be times when wards have several patients who can be discharged quickly (therefore surplus capacity) and at other times there will be several patients who need to stay longer (therefore a lack of capacity leading to cancellations). To manage this variation, there needs to be 'headroom' to manage those periods when capacity is stretched. The lack of headroom as a result of high occupancy levels was reported as a concern by clinicians and managers across the health boards we visited.

2.23 The assumption that elective beds will be available for elective patients is not always sound. Elective bed capacity comes under constant pressure from rising demand in other parts of the NHS. In particular, peaks in demand for emergency care mean that emergency patients are sometimes admitted to beds intended for elective patients. Health boards then cancel elective procedures at short notice, much to the patient's frustration. Because emergency patients typically have longer length of stay, our analysis shows that each emergency patient in an elective bed means three elective patients cannot be treated as planned.

2.24 There is a particular issue with 'routine patients' facing growing waits where available capacity is prioritised to urgent patients. There has been a rise in the number of, and proportion of, patients referred to a consultant with urgent suspected cancer. As a result, more outpatient capacity is allocated to these patients. When diagnosis is confirmed, cancer patients often have complex needs, requiring longer lengths of stay and longer time in theatre, and so displace multiple elective patients. Whilst national data in this area is not readily available, figures from one health board show that the number and proportion of patients waiting for inpatient or day-case treatment classed as 'urgent' has been growing (Figure 8). With more capacity dedicated to urgent and cancer patients, routine patients end up waiting longer and longer. This 'crowding out' of routine patients as result of prioritisation of scarce capacity explains why routine patients may end up waiting a very long time before reaching the top of the list for treatment.

26 Bagust A, Place M, Posnett JW, **Dynamics of bed use in accommodating emergency admissions: stochastic simulation model**, British Medical Journal 1999. Jones R, *Hospital bed occupancy demystified,* British Medical Journal 2011. Schilling P, Campbell D, Englesbe M, Davis M, **A comparison of in-hospital mortality risk conferred by high hospital occupancy, differences in nurse staffing levels, weekend admission and seasonal influenza**, Medical Care 2010

Figure 8 – Proportion of those on an inpatient waiting list at one health board classed as ‘urgent’

Source: Wales Audit Office analysis of health board data

2.25 We considered the extent to which facilities such as diagnostic equipment, outpatient rooms and surgical theatres were a cause of long waiting times. We concluded that these are not currently a constraint on the system. For large parts of the evening and at weekends, many of these facilities are hardly used at all. The constraint is the availability of staff to use the facilities seven days a week. Several health boards recognised that staffing elective care seven days a week would improve patient experience and address capacity constraints but told us they were restricted by finances and recruitment problems, and current contractual arrangements.

2.26 Although health boards have found it difficult to balance waiting times targets with financial and capacity pressures, the relatively limited information about demand and capacity makes it difficult to reach a definitive conclusion on whether there are in fact insufficient resources to meet the current waiting time targets. More sophisticated planning is necessary in order to understand what demand could be avoided or met by adopting different models of care, in particular by helping treat people in primary and community based care settings. What is clear is that plans which are based upon doing ‘more of the same’ are going to be financially unsustainable. Part 3 of the report looks at emerging plans and how more radical transformation of services could free up capacity to treat more patients and potentially reduce waiting times.

Despite incremental improvements, existing capacity is not being used to meet demand as effectively as it could be

Despite getting more efficient, the whole outpatient system through which patients get a diagnosis and a decision on treatment is too cumbersome

2.27 The purpose of the outpatient system is to provide expertise and advice on treatment, supported by some diagnostic tests where appropriate. It involves a relatively short amount of clinical time. As Part 1 showed, waiting times for outpatient appointments and diagnostic tests has been growing significantly. Long waits for outpatients can be particularly distressing for patients: they may be desperate to know what is wrong with them, whether it is something serious and what options there are to make them better.

2.28 Fundamentally, the cause of long waits for outpatient appointments is a mismatch between demand and supply. The number of patients being referred for a first outpatient appointment has been steadily rising. However, after peaking in 2011-12, the total number of first outpatient appointments has since fallen. Therefore, the outpatient waiting list and waiting times have grown. Because of the limited information that health boards have about demand and capacity, it is not possible to conclude on the extent to which that mismatch is due to a lack of capacity or poor use of existing capacity. Looking at demand, the likelihood that GPs will refer patients to a specialist varies across Wales. This variation suggests that there is scope to reduce the number of people referred for an outpatient appointment although some variation may be due to differences in who is able to refer patients and demographics.

2.29 Our assessment and local fieldwork has shown that there is scope to make more efficient use of capacity. Some health boards allocate different lengths of time to each appointment. There is merit in health boards sharing learning to identify an optimal length that balances efficiency with the need for sufficient time for clinicians to talk to patients and provide advice and diagnosis. There is also scope to free up clinical and administrative capacity by addressing unnecessary complexity across the process for getting from the point of a referral from a GP (or other referrer) to setting up an appointment. There are multiple points at which the referral is passed from clinicians to clerks, and back to clinicians. Information about the referral is stored on paper and multiple ICT systems. Patients often end up having multiple contacts with the NHS in order to find out what is happening to them, what they need to do and, ultimately, to arrange for an appointment or a test. Some of the examples where activity could potentially be avoided and capacity redirected to more productive areas, are:

a **Avoidable activity in ‘booking centres’.** Several booking centre staff told us they were struggling to manage the high volume of calls, many of which (some estimated as much as 30 per cent) could have been avoided with better up-front communication with patients. Examples include patients wanting to know how much longer they would have to wait or wanting to know what letters they

have received actually meant. Further, during periods of high call volumes, some staff were making paper notes rather than entering appointment dates directly on the IT system, thereby increasing the risk of human error.

b **Duplication of activity entering data onto IT systems** because, for example, electronic referral systems, where they exist, and systems for recording diagnostic test results, do not 'speak to' the main patient database used for managing waiting times. Much of this activity would be avoidable if the ICT systems were compatible, and again, the reliance on duplicate entries increases the risk of human error.

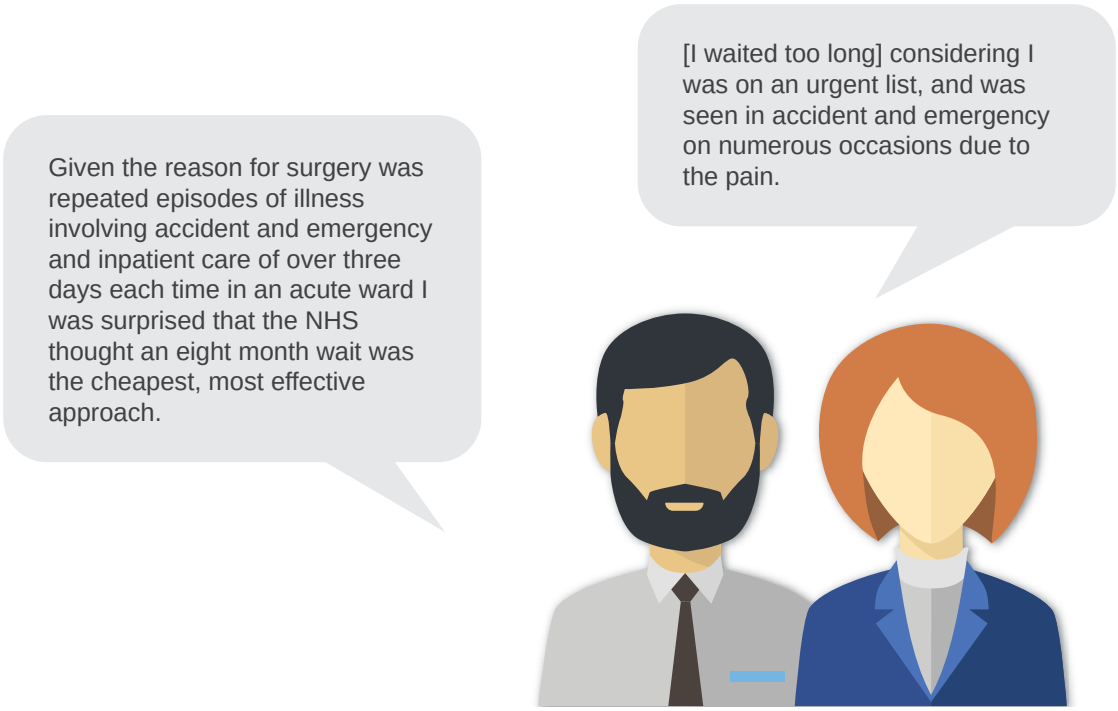
c **Activity to manage the reliance on paper records,** including having to enter data from electronic referrals and the extensive activity required to organise and physically transport patients' notes so that they are available for the outpatient appointment.

d **Restriction of diagnostic tests available to GPs** in some health boards means that patients may arrive at their outpatient appointment without results needed to make a diagnosis. The patient therefore needs to wait longer and have an additional outpatient appointment. It also means that GPs have no choice but to refer patients for an outpatient appointment if they feel patients need a particular test.

2.30 Most of the staff we spoke with reported that the ICT systems – in particular the Myrddin patient administration system – were a significant barrier to efficiently managing patients. Specific concerns from booking centre staff included the system creating duplicate records and appointments, and not being set up to easily find the next available appointment when patients call in. Managers reported concerns that the system did not provide them with the detailed management information about demand, activity and capacity that they needed to plan and manage the services.

2.31 There is also a lot of activity, and cost, directly associated with the relatively long waiting times for outpatient appointments. It takes up GP time to monitor patients and contact hospitals to request a review of the patient's priority if they deteriorate. It takes up consultant time to re-assess the priority of the patient. Also, booking centre staff told us they regularly receive calls from patients asking to be prioritised because they have got worse: booking centre staff then have to record the information and advise the patients to visit their GP. Clinicians we spoke to referred to growing numbers of expedite letters being requested and sent. Figures from one health board show that the proportion of patients waiting for a first outpatient appointment classed as 'urgent' has been increasing steadily over the past three years. Also, several patients in our survey reported that they had attended accident and emergency to manage their condition while they were waiting.

Comments from Wales Audit Office Citizen Survey



2.32 One example of 'wasted' capacity occurs where patients do not attend their outpatient appointment. The proportion of patients that do not turn up for outpatient appointments had been falling over the decade to 2009-10. However, since then the picture has worsened: 7.6 per cent of patients did not attend their first outpatient appointment in 2010-11; this rose to 8.9 per cent in 2013-14. We look at some ideas to increase rates of attendance in Part 3 and in our Good Practice Compendium.

2.33 The majority of outpatient appointments (around two-thirds) are for patients requiring 'follow-up'. In some cases, hospitals may be unnecessarily following up patients who could instead be seen by their GP or other health professional. Having a low ratio of new to follow-up appointments is therefore seen as an indicator of efficiency. The ratio of new to follow-up has been decreasing every year in the decade to 2011-12. However, the current position may not be so positive. There are no specific waiting times targets for follow-up appointments. With health boards focused increasingly on the 26 and 36-week targets, there has been less attention given to the management of follow-up appointments in recent years. Recent national scrutiny on this by the Welsh Government is resulting in health boards reviewing the current number of follow-up patients that are still in the system. Where necessary, health boards will need to manage clinical risks by re-directing capacity towards follow-up patients alongside work to validate and

check whether patients on the follow-up list need to be seen at all. In the short-term, the focus on follow-ups potentially reduces capacity to see and treat new patients. Over the long term, transformation of follow-up services could potentially free up capacity to see more new patients. The management of follow-up outpatient appointments by health boards is currently the subject of a separate review being undertaken by the Auditor General.

2.34 In Part 3, we consider how NHS Wales' emerging plans could help to re-think and re-shape the outpatient system to better respond to demand and free up consultant time.

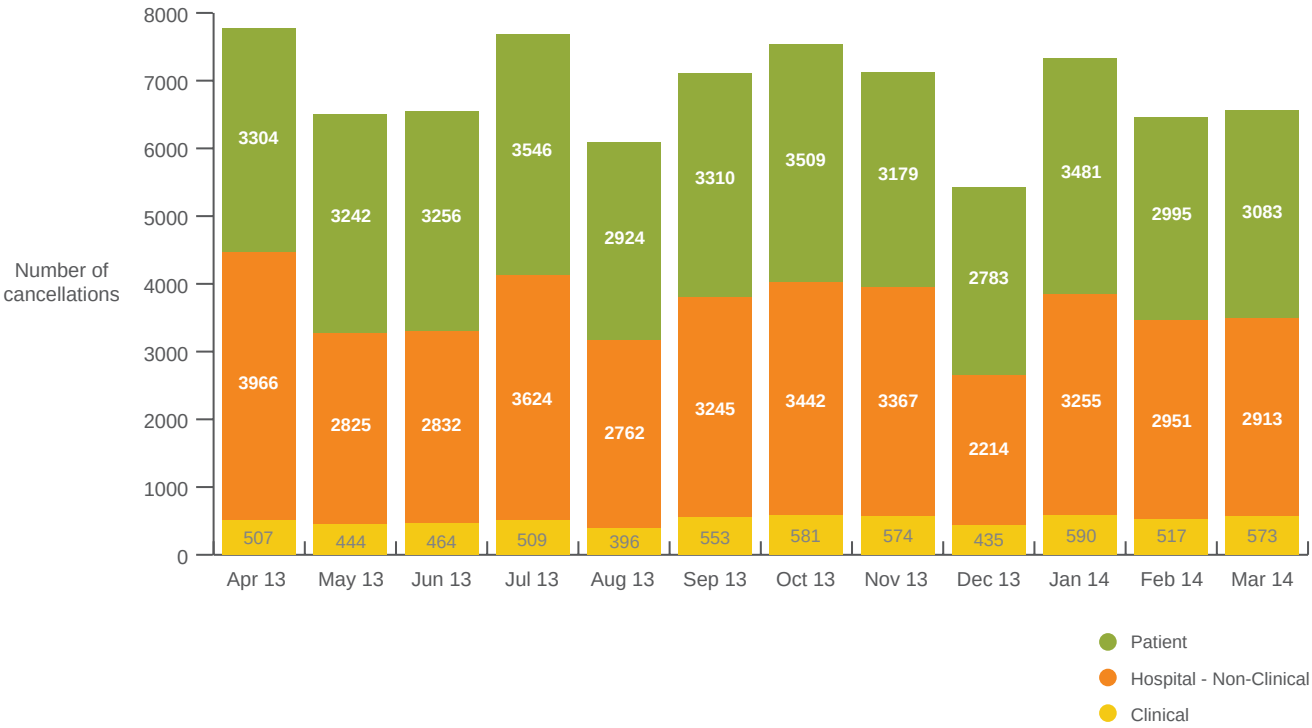
Inpatient services have been getting more efficient incrementally but there remains scope to step up the pace

2.35 This section considers the efficiency and effectiveness of the processes and systems to get patients treated as quickly as possible and to help get them back on their feet. In recent years, the NHS in Wales has focused on improving efficiency. During 2010 and 2011, a national Acute Productivity Board provided guidance on the top actions to improve efficiency across a range of areas. More broadly, a suite of efficiency and productivity data is available to help NHS bodies benchmark their performance, and target where specific action is needed. Some key markers of efficiency and productivity are considered in the following sections.

Cancellations

2.36 Short-notice cancellations of operations by hospitals are extremely frustrating for patients, while short-notice cancellations by patients can mean that scarce resources go unused. In 2013-14, there were 82,151 cancellations. Health boards reported that 38,612 were for patient reasons, 37,396 were cancelled by the hospital for non-clinical reasons and a further 6,143 were cancelled by the hospital for clinical reasons (Figure 9). Some patients do not turn up on the day and other reasons recorded for patients cancelling their operations are that the appointment was not convenient and patients no longer wanting the procedure. The main reasons for hospital cancelling procedures include a lack of available clinicians, a lack of ward and critical care beds and administrative error. The need to respond to peaks in unscheduled care will typically be one of the main reasons why health boards cancel elective care procedures.

Figure 9 – Reasons for cancellations



Note

We have some concerns that health boards' recording of the reasons for cancellations is not consistent, so these figures need to be treated with some caution.

Source: Wales Audit Office analysis of Welsh Government data

2.37 Health boards told us that they had experienced fewer cancellations during the winter of 2013-14 than the previous year (Figure 10). The proportion of procedures cancelled due to a lack of beds fell from 5.5 per cent in January 2013 to 2.9 per cent in January 2014. The Welsh Government and health boards invested a lot of time and effort developing plans to learn from and avoid some of the problems seen in emergency care during 2012-13. As part of these plans, several health boards made a planned reduction in activity over the period, with some stopping certain types of elective activity altogether. Health boards are making the decision to not schedule elective activity rather than cancel patients at short notice. While this is understandable and helps avoid high cancellations and frustrations for patients, it has left some health boards with a significant backlog of elective patients after the winter and has contributed to the difficulties in achieving waiting time targets.

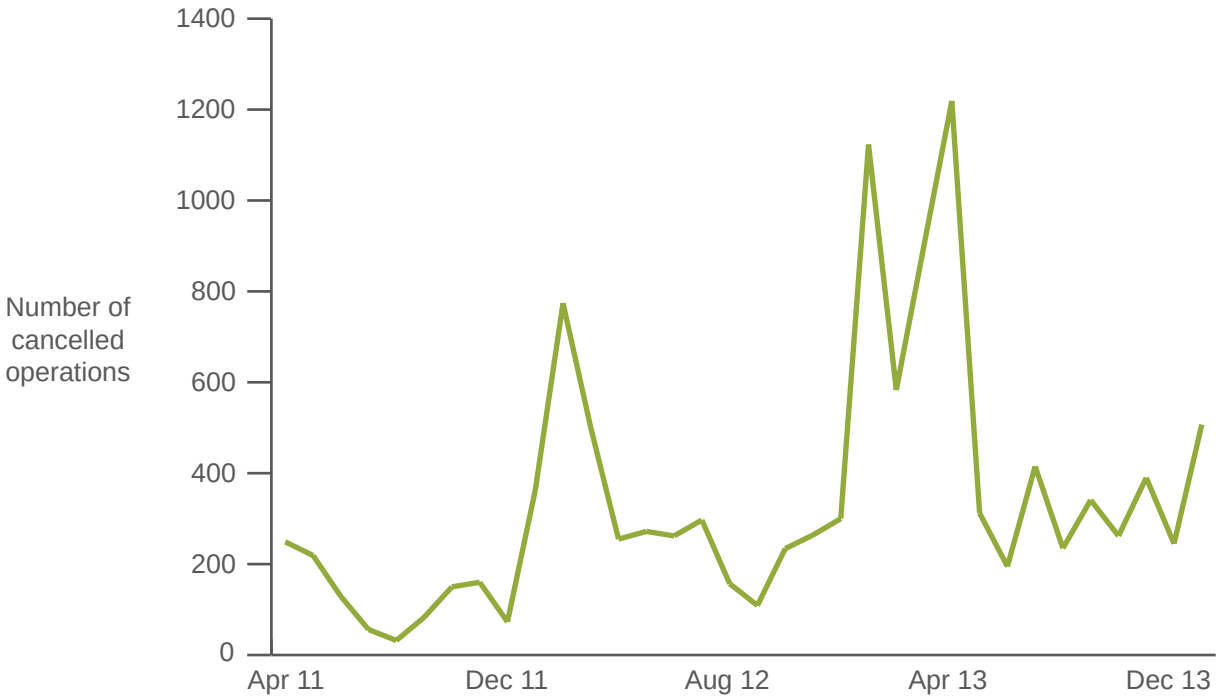
Comments from Wales Audit Office Citizen Survey

My operation was cancelled on seven occasions between February 2011 and November 2013, because of the lack of beds and the lack of communication between the departments (surgical and anaesthetics).

I was admitted, there was a bed, I was gowned up and ready to go to theatre and was told by the nurse on duty my operation was cancelled as there was an emergency and the consultant wouldn't have time. I was sent home with no future date and when I telephoned the waiting list clerk they couldn't offer me a new date.

It was difficult being deferred so often due to lack of beds, as arrangements at home had to be cancelled and rearranged each time.

Figure 10 – Cancelled operations at short notice due to lack of beds



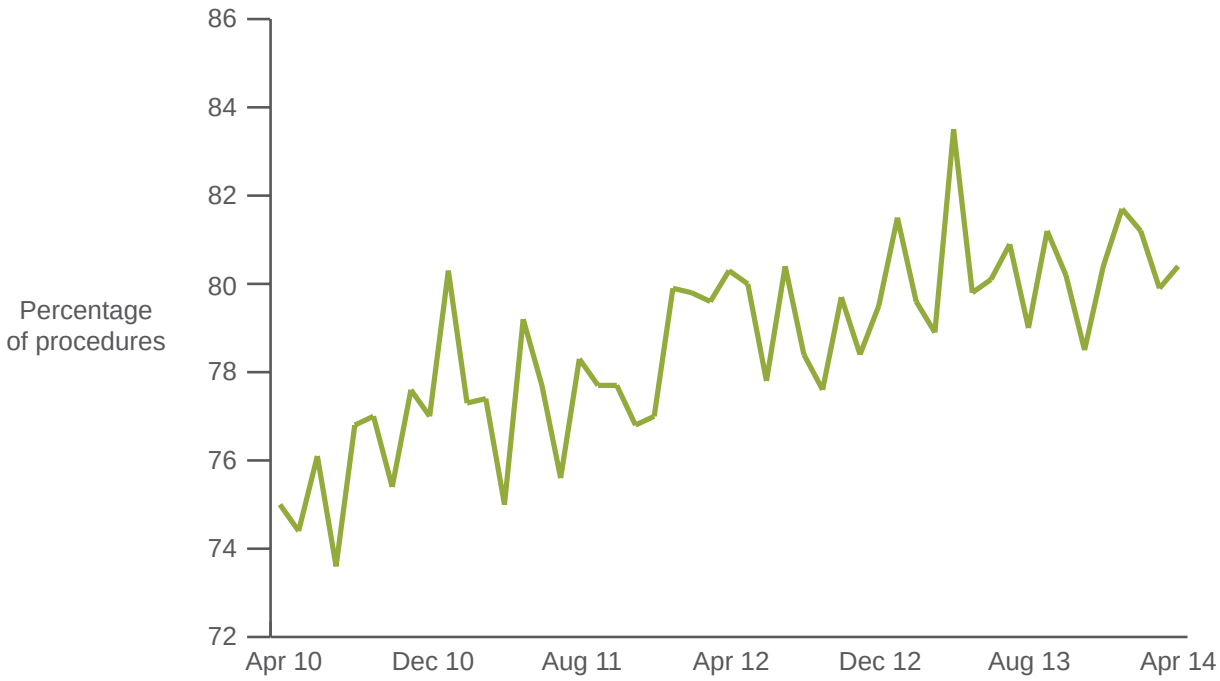
Source: Wales Audit Office analysis of Welsh Government data

Day surgery

2.38 Treating people as a day case is generally more efficient and is better for patients because they can get back on with their lives and are less exposed to the risks of hospital-acquired infections. Health boards have put a lot of effort into increasing the rates of day-case surgery for specific procedures where day surgery is known to be appropriate. The British Association of Day Surgery (BADS) has a list of 50 such procedures knows as the BADS basket. Across Wales, the proportion of such procedures that are carried out on a day-case basis has increased steadily over the past three years (Figure 11)[27]. This is a positive development and maintaining this direction of travel will assist in more efficient use of elective capacity.

27 The rate of other elective procedures carried out as day surgery has also increased from April 2010.

Figure 11 – BADS 50 procedures carried out as day surgery



Source: Wales Audit Office analysis of Welsh Government data

Theatre efficiency

2.39 The Auditor General is currently reviewing the use of theatres in six health boards. Emerging findings from that work suggest significant scope to make better use of expensive operating theatre time. Specific themes emerging from the work include:

a Problems freeing up beds for surgical patients causing procedures to be cancelled or delayed, with knock-on effects for other patients.

b Weaknesses in the way that theatre lists are planned, in terms of the numbers and order of patients having their surgery on any particular day. These weaknesses can result in late starts, last-minute disruption to the order of operations, cancellations of patients' procedures and early finishes.

c Many causes of inefficiency in theatres are not directly due to problems within theatres. For example, if patients are not assessed properly before their hospital admission, this can cause delays on the day of their surgery. And some patients have to wait in theatres after their surgery because there are difficulties freeing up a ward bed for them to return to.

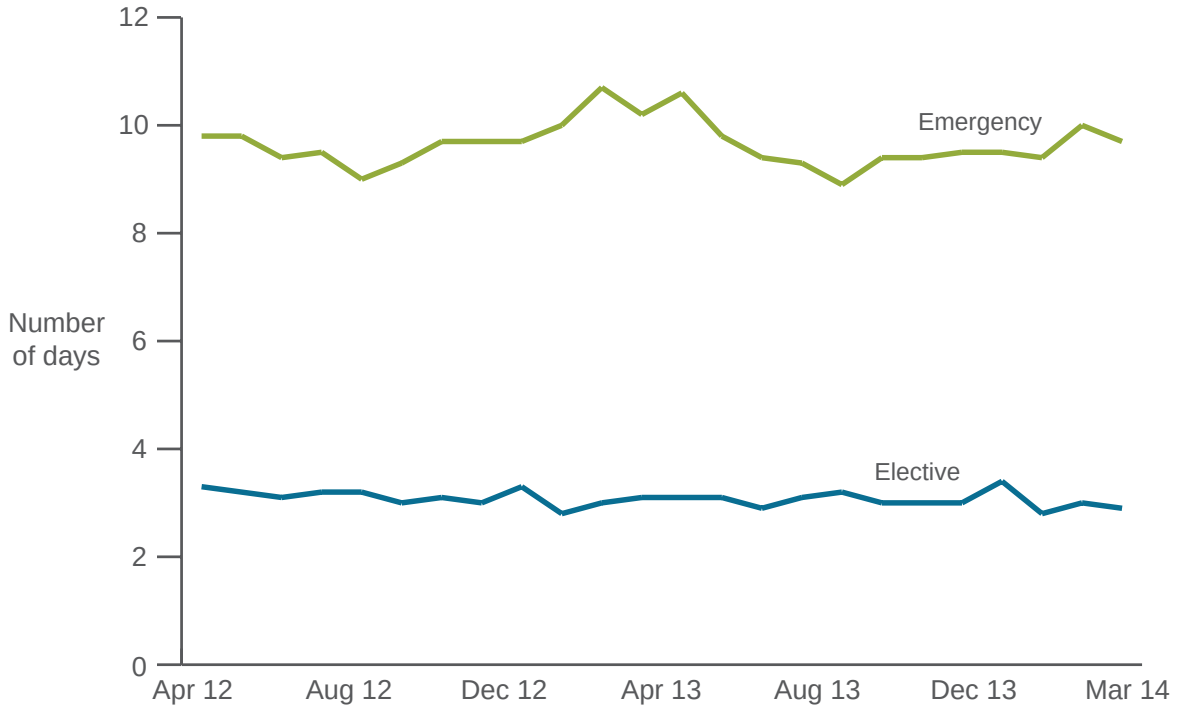
d There are some real weaknesses in the data available to assess theatre performance. A lack of good performance indicators and problems with data systems mean that some theatres have very little robust information that staff can use to drive improvement.

2.40 The Auditor General's work on operating theatres will result in specific local recommendations to the health boards concerned.

Length of stay

2.41 To increase the availability of beds, NHS bodies can improve throughput, by getting patients in and out more quickly so that the bed can be used by somebody else. Figure 12 shows that the average length of stay for elective patients has been reducing over recent years, from 3.2 days in April 2012 to 2.9 days in March 2014, (a reduction of 10 per cent). Health boards have managed to broadly sustain emergency length of stay during a period of increasing complexity and co-morbidity of emergency patients, particularly older patients. But they have struggled to secure a reduction in emergency length of stay.

Figure 12 – Average length of stay for patients



Note

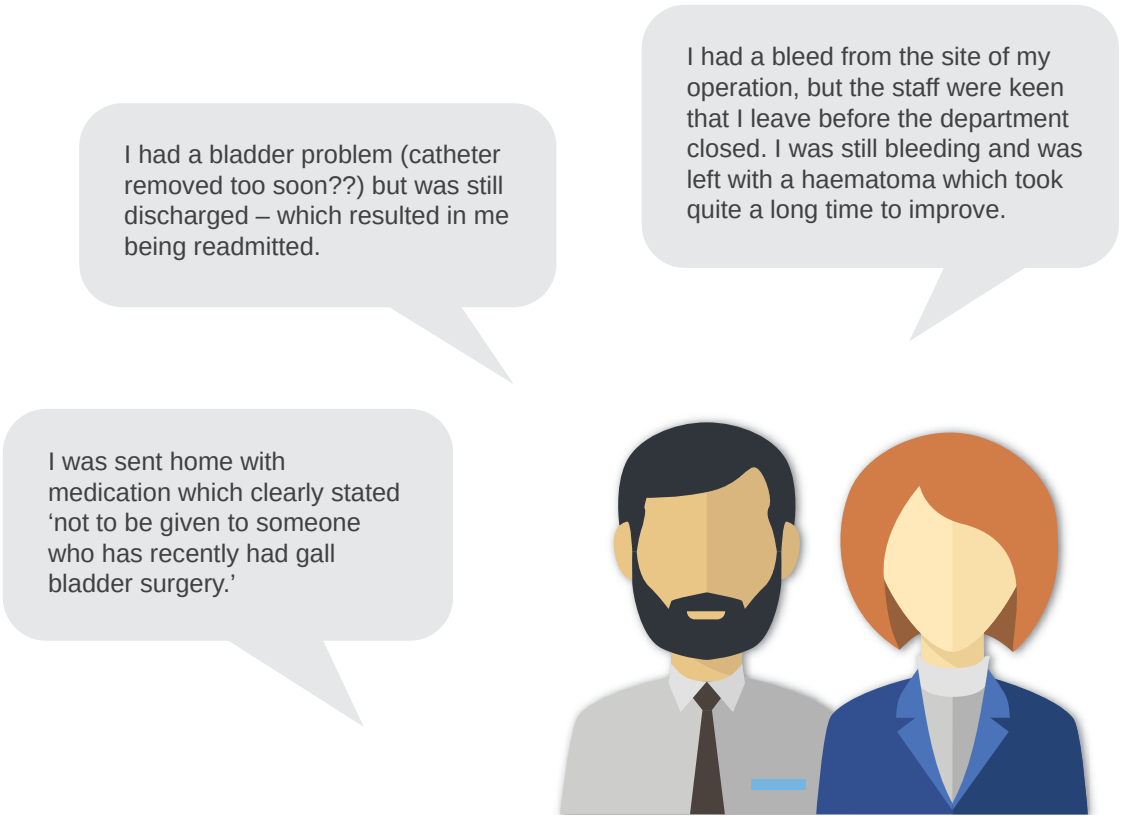
The elective figures cover elective patients for whom there is a length of stay target. It does not include all specialities. Emergency data does not include patients who stayed less than one day.

Source: Wales Audit Office analysis of Welsh Government efficiency dataset

2.42 There is considerable variation between health boards in terms of length of stay of both elective and emergency patients, which indicates that some may be making more efficient use of beds than others. We consider some examples of how length of stay can be reduced in Part 3.

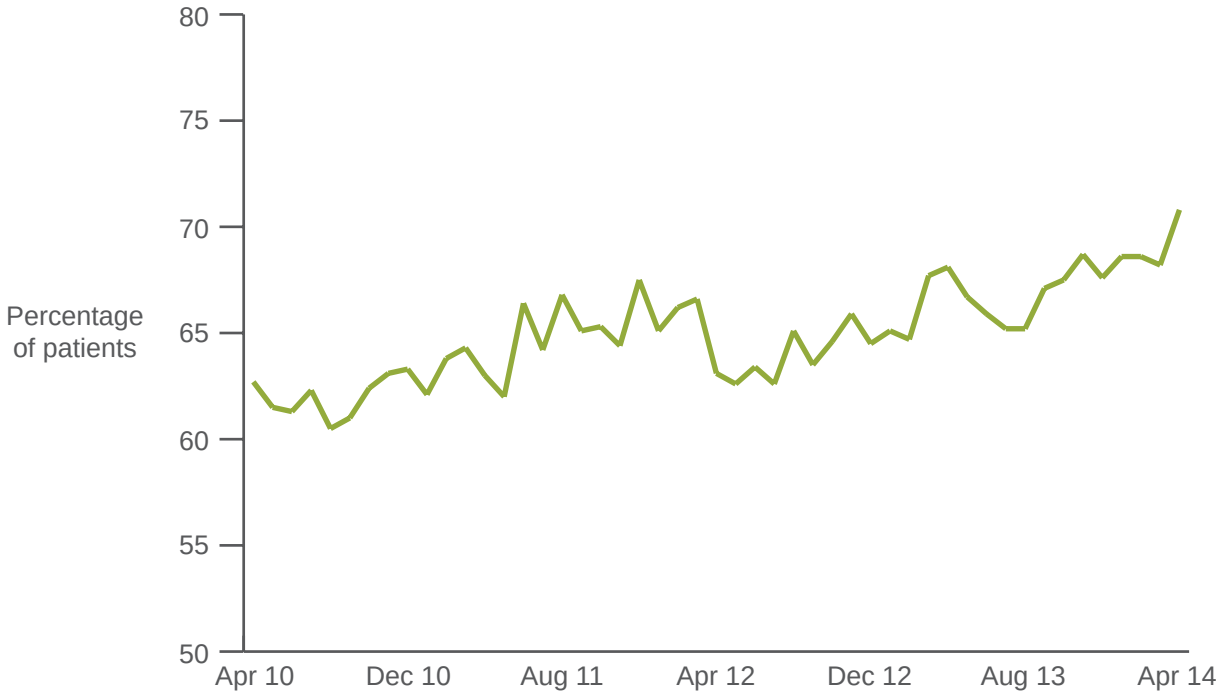
2.43 There is a need for some caution around the impact on patients of reducing lengths of stay. Overall, one in twelve patients in our survey– and one in five gall bladder patients – felt they had been discharged from hospital too soon. Some reported that they had to be re-admitted to hospital, some were given the wrong medication or not given advice and other patients felt that they did not have enough time to recover in hospital before being sent home.

Comments from Wales Audit Office Citizen Survey



2.44 The proportion of patients who are admitted on the day that their surgery is planned provides an indicator of the efficient use of bed capacity. There has been a sustained improvement overall but the pattern prior to August 2013 seems to be one of increases followed by sharp reductions (Figure 13). The sharp drops seem to follow periods of high cancellations due to lack of beds. The sustained rise during 2013-14 corresponds to a period where cancelled procedures had reduced. Our hypothesis, based on the findings of the review of cardiac care in Morriston Hospital[28], is that during periods of high cancellations, clinicians lose confidence that the bed will be available if the patient is not already admitted the day before.

Figure 13 – Proportion of patients admitted on the day of surgery



28 Stephen Dorman, **Cardiac Surgery Waiting List Mortality**, 2013

Part 3

The NHS will need hard work and bravery to act on emerging ideas for whole-system reform and pockets of innovation

3.1 This part of the report looks at the Welsh Government's plans for improving performance on waiting times. It looks in particular at the emerging ideas and plans for re-shaping the elective care system. It considers the broader work looking at re-thinking the purpose of the elective care system and how performance should be measured, with a particular focus on shifting towards measuring outcomes.

Through prudent healthcare in particular, the NHS is now challenging the current design of the elective care system

3.2 The Welsh Government is placing significant emphasis on the emerging 'prudent healthcare' agenda, initially developed by the Bevan Commission. The analysis that follows shows how the principles of prudent healthcare – as set out by the Welsh Government in 2014[29] – could be used to identify how the elective care system could be more 'prudent' and deliver shorter and/or more clinically appropriate waiting times for patients. The five principles are:

a Do no harm.

b Carry out the minimum appropriate intervention.

c Organise the workforce around the 'only do what only you can do' principle.

d Promote equity. The principle that it is the individual's clinical need which matters when it comes to deciding NHS treatment.

e Remodel the relationship between user and provider on the basis of co-production.

There is potential to free up significant capacity by implementing the principle of 'do no harm' and reducing activity where the risk of harm outweighs the clinical benefits

3.3 The principle of 'do no harm' means that the NHS should not carry out procedures where the risks outweigh the potential benefits. Some clinical procedures are known to be of limited clinical effectiveness for many but not all patients[30]. Despite longstanding guidance to reduce the volume of these procedures and all health boards having policies or plans to reduce the rates of these procedures they are still carried out in relatively high volumes across Wales. Our analysis shows that in 2012-13, the total cost of providing these procedures to admitted patients was around £51 million and in terms of capacity, these procedures took up around 44,358 bed days. We have not examined how many of these procedures were appropriate according to clinical guidelines[31]. The Welsh Government[32] is developing revised national guidelines for such procedures supported by an enhanced compliance regime for local health boards and trusts. Given the

29 **Prudent healthcare**

30 Based on work by Public Health Wales Observatory for Betsi Cadwaladr University Health Board, **Demand and Variation in Elective Surgical Procedures**, Public Health Wales Observatory, 2010 and **Variation in elective surgical procedures across Wales,** Public Health Wales Observatory, 2010. **NHS Waiting Times for Elective Care in Wales: Technical Report** provides more information.

31 Further work would be required to determine precisely the number of procedures which had limited clinical effectiveness for patients across Wales.

32 Welsh Government, **Delivering Prudent Healthcare in Wales**, 2014

considerable costs involved, there are potential savings to be found in addressing the level of procedures with limited clinical effectiveness conducted at each health board to reduce unnecessary activity and reduce costs.

There is indicative evidence of scope to free up capacity by implementing the principle of carrying out the minimum appropriate intervention and reducing variation in rates of surgical intervention

3.4 There is significant variation across Wales in the rates of surgical intervention. For example, patients aged 75 or over living in Betsi Cadwaladr University Health Board area are considerably more likely than those living in Hywel Dda University Health Board to have a cataract operation. Research literature highlights that such variation is common to all healthcare systems driven by both individual and organisational preferences and practices. Research evidence shows that identifying the underlying causes of variation may present opportunities to reduce harm and to improve quality, cost and clinical effectiveness[33].

3.5 The scale of variation raises the question of whether many patients could get better treatment outcomes through a less interventionist approach. Our survey of patients who had knee surgery showed that 10 per cent said that their surgery had either made their symptoms worse or did not improve their symptoms. Nine per cent said their surgery had either made their pain worse or had not improved their pain. Although a small sample, only half of the 95 people who responded to our online survey said that their operation significantly improved their quality of life. Thirteen people told us that their quality of life did not improve and in some cases their health deteriorated.

3.6 In order to provide an indication of the scale of capacity that could be freed up by reducing clinical variation, we have carried out some indicative cost calculations for the most common procedures. We looked at 13 procedures that accounted for around 20 per cent of bed days in 2012-13[34] and identified variation in intervention rates between health boards across different age ranges[35]. We calculated that if all health boards reduced their intervention rates to the average, there would be 11,300 (11 per cent) fewer procedures. Such a reduction would enable a capacity gain of 28,000 bed days, with a value of around £16 million. We have not carried out any work to verify that the average is the most clinically appropriate level and these figures can only be seen as indicative as it may be that some areas need to increase levels of intervention. But if a similar figure applied across the whole range of hospital activity, reducing variation in clinical practice could potentially free up significant capacity.

33 **Variation in elective surgical procedures across Wales**, Public Health Wales Observatory, 2010. **NHS Waiting Times for Elective Care in Wales: Technical Report** provides more information.

34 The total baseline of bed days in this calculation is bed days used by patients undergoing procedures where at least 33 per cent are admitted from a waiting list.

35 Using age ranges helps to account for demographic differences between the populations. However, because the age ranges in the data are broad, we were unable to adjust sufficiently to conclude that our estimates are fully age standardised.

3.7 There are several approaches that can be adopted to reduce variation in clinical practice. One approach is to introduce tight clinical thresholds for each procedure and to police them through a compliance regime. Other approaches involve better forms of 'feedback' or communication to clinicians, including:

a providing clinicians with data on their own rates of intervention and those of their peers;

b encouraging and enabling greater peer-to-peer learning to share up-to-date practices and provide supportive challenge;

c greater feedback from patients on what worked for them and whether interventions actually made a difference to their quality of life; and

d enabling patients to have a greater say and involvement in decisions about treatment in the first place (see paragraphs 3.10 to 3.13).

The outpatient system in particular could be radically redesigned and improved by widening the range of professionals able to provide diagnosis and advice to patients

3.8 One of the key barriers to patients getting timely expertise when they are in need of a diagnosis is the lack of capacity of consultants to provide sufficient outpatient appointments to match the number of referrals. The reliance on hospital-based consultants reveals underpinning and longstanding assumptions about who can provide expertise to patients and in what setting. Using the prudent healthcare principle that patients should only see a consultant if nobody else is capable of providing expertise, there is scope to re-think the consultant as the central focus of the outpatient system. Our Good Practice Compendium shows that some health boards are experimenting with alternative approaches to address the capacity gap and challenge these assumptions, such as:

a having advice provided by other professionals, such as opticians and advanced nurse practitioners;

b providing direct support to GPs to enable them to provide advice and treatment without needing to refer – for example, providing telephone advice lines or email for GPs to directly contact consultants;

c using technology, for example in tele-medicine, so that patients do not need to attend an outpatient appointment in person; and

d developing referral criteria and guidelines, supported by direct communication, so that GPs can be clear about where they should provide advice and diagnosis themselves without referring.

3.9 There is also scope to further develop alternatives by better matching provision to known patterns of demand. Although the NHS carried out around 5,000 different types of procedure during 2012-13, just five elective procedures accounted for 21 per cent of all admissions and 31 procedures for 50 per cent of admissions.[36] A similar pattern emerges when you look at individual specialities[37]. Given that a large part of what NHS Wales provides is predictable, there is scope to ensure that a wider range of clinical staff, not just sub-specialists, are able to diagnose these patients and decide on what treatment is required. Indeed, over the long term there may be scope to look at whether GPs and other healthcare practitioners with appropriate training could add patients to the waiting list for the most common procedures without their having to attend outpatients at all. The 2005 NLIAH *A guide to good practice* and the NHS Institute for Innovation and Improvement have advocated using this type of analysis to plan capacity.

There is potential to help reduce avoidable activity and improve patients' experiences through the principle of remodelling the relationship between user and provider on the basis of co-production

3.10 The co-production approach has developed in a number of countries. There are many different definitions, but in essence co-production is about public services doing things 'with' rather than 'to' the public. It changes the traditional 'deficit' model of healthcare where the professional instructs the patient based on their greater expertise to an 'asset-based' model where the patient is valued for their understanding of their health and is seen as an expert. Co-production also places greater responsibility on patients to manage their own health in order to reduce the likelihood of them needing healthcare.

3.11 Co-production could be a means to reduce variation in clinical decision making as well as improving patient experience. Research evidence[38] on 'patient preference misdiagnosis' shows that clinicians tend to assume that patients want the maximum healthcare they can get. In fact, where patients have a greater involvement in making decisions about referral and treatment, their preferences are generally to try alternative approaches to avoid escalating the level of clinical intervention. If there was a greater focus on understanding what the patient wants and helping patients to make decisions jointly with clinicians, a significant amount of elective activity could be avoided altogether. Importantly, this is not about rationing or not meeting need: costly clinical activity could be avoided while still meeting demand by providing patients with the service they want.

3.12 Co-production could also help to improve patients' experience of waiting. Our survey showed that patients who did not feel involved in decisions about their care were more likely to say that they had to wait too long for their operation and that their health got worse during this time.

36 These five accounted for 25 per cent of procedures where at least 33 per cent of admitted patients were from the waiting list.
37 **NHS Institute for Innovation and Improvement**
38 Mulley, A., Trimble, T. ELwyn, **G. Patient's Preferences Matter – Stop the silent misdiagnosis**, London: The King's Fund, 2012

3.13 Although there are several examples of individual initiatives – including the Magic approach at Cardiff and Vale University Health Board and the Choose Wisely approach (see Good Practice Compendium) – there is still a long way for the NHS to go in terms of moving towards co-production practices. Several people who responded to our online survey told us that doctors did not take enough time to discuss the risks and benefits of treatment with them. Our survey shows that for a significant minority of patients, the NHS is not adequately informing them about what will happen to them, let alone involving them as equal partners. Our survey showed that around a third of patients said that no one explained what would happen to their waiting time if they cancelled or failed to attend appointments (having their clocks reset or being removed from the list). A higher proportion (40 per cent) of patients said that no one explained what would happen if they were not available for an appointment for more than a two-week period (potentially being removed from the list). Some 30 per cent of patients were not given information about how long they could expect to wait for a first appointment to see a specialist. Around a quarter were still unsure how long they could expect to wait for treatment after the decision to operate had been made.

Focusing on equity and clinical need could address clinicians' concerns about the targets but is complicated in practice and some existing practice may be inequitable

3.14 The prudent healthcare principles suggest a move away from prioritising patients and resources on the basis of how long they have waited towards prioritising on the basis of clinical need. During our local fieldwork, several clinicians reported concerns that the waiting times targets did not have a clear clinical basis and could sometimes distort clinical prioritisation of resources. Our patient survey showed that patients had different views on whether they waited too long, depending on the type of procedure they underwent. The elective care system already prioritises urgent patients but it does not do so in a way that is directly related to their condition. Once classified as 'urgent', a patient goes to the back of the 'urgent' list regardless of whether their condition may require them to be seen more quickly than a patient further up the 'urgent' list. Similarly, not all 'routine' patients have the same level of clinical need and some may be more likely to deteriorate or experience pain than others.

3.15 While the principle that patients should be treated according to clinical need seems sensible, there are potential negative practical consequences in doing so. At present, health boards use templates that ring-fence appointments for a mixture of urgent, urgent suspected cancer, routine and follow-up patients. Introducing more categories of clinical need potentially makes the management of waiting lists less efficient. This is due to the impact of 'carve-out': the more a hospital 'carves out' the waiting list into sub-waiting lists (separate lists for each category of clinical need), the less efficient they become. The other consequence is that increased clinical prioritisation exacerbates the 'crowding out' of 'routine' patients as described in paragraph 2.24, with the result that those patients face even longer waits. One way

of avoiding the crowding out risk would be to adopt the type of clinical prioritisation system used in New Zealand. In New Zealand, patients are prioritised according to scores. Patients above a specific threshold are directly listed for surgery whereas patients below the threshold are referred back to their GP, potentially to wait until they deteriorate further and acquire additional points. The thresholds are determined by a combination of clinical criteria and capacity constraints. The New Zealand system avoids creating a long 'tail' of routine patients by preventing those patients below the threshold from being put on a waiting list in the first instance. Adopting a New Zealand-style approach would come with practical risks around the consistency of allocating points as well as the considerable political risks of adopting an approach that openly rations access to healthcare. The 2005 NLIAH **A guide to good practice**, which considered the New Zealand approach, concluded that 'points-based systems, or systems with many degrees of urgency, are not recommended'.

3.16 The 2005 NLIAH **A guide to good practice** recommends using the 'urgent' and 'routine' categories and prioritising entirely on the basis of urgency. That would mean not booking appointments for routine patients until all urgent patients had been given an appointment. If health boards adopted this approach, the current size of the backlog and capacity constraints mean that many specialities would only see and treat urgent and urgent suspected cancer patients for a significant period of time. Such an approach may be more 'equitable' in terms of matching capacity to clinical priority but would result in a significant deterioration in performance against waiting times targets and an even larger backlog of long-waiting routine patients. Over the long term, as NLIAH reported, 'the best method of safely and effectively prioritising patients is to ensure that no-one waits'.

3.17 Prioritisation is also determined to an extent by patients' own behaviour. Our local fieldwork has found that the application of some rules on patient cancellations in particular are having negative, inequitable impacts for patients. The rules state that when a patient cancels an agreed appointment, they should be given another appointment as soon as possible. However, the first time a patient cancels at any stage they have their clock reset to the date the patient notified the hospital of the cancellation. On second cancellation, they should be removed from the waiting list and referred back to their GP. Many patients will have genuine and legitimate reasons for cancelling appointments, such as ill health or unavoidable caring duties. There is a strong likelihood that patients who cancel end up waiting longer if they need further tests or treatment because of the way many health boards manage their waiting lists (see Box 3).

Box 3: Managing waiting lists – clinical referral date vs waiting list date

Health boards aim to treat patients in turn based on how long they have been waiting and depending on whether they are urgent or routine. Health boards have two different dates on which to base their calculation of how long patients have been waiting:

- The 'clinical referral date' which is the date the health board received the referral.
- The 'waiting list date' which is an adjusted date used for performance reporting and managing the targets. The waiting list date is reset when a patient cancels or does not attend an appointment.

The 2005 NLIAH **A guide to good practice** is clear that patient booking should be from the patient's perspective and patients should be treated in order of the clinical referral date. It says that using the waiting list date is 'unfair'. However, this element of the NLIAH guide is not reflected in the guidance issued to health boards. Because in many specialties patient booking is focused on avoiding breaches of the targets, health boards use the waiting list date as the basis for booking patients. As a result, patients who have had their clocks reset are potentially facing significantly longer waits to reach the top of the queue and get an appointment for treatment.

3.18 We compared the rules related to patient behaviour in Wales to those in place for England and Scotland (see NHS Waiting Times for Elective Care in Wales: Technical Report). The rules in England allow far fewer opportunities to stop patients' clocks and there is no provision for them to be reset. The rules in England are notably more focused on ensuring that the official waiting time reflects that actual amount of time that patients wait. The rules in all countries allow for patients to be taken off the waiting list and referred back to the GP if they do not attend appointments. There is, however, a notable difference in the perspective taken on patient cancellations: in Wales, the RTT Guidance treats cancellations as a negative patient behaviour, whereas the guidance for England treats any cancellation, right up to the last minute, as patients behaving positively to let the NHS know rather than simply not turning up. In Scotland, the patient clock can be reset if they cancel or do not attend but only where it is clinically appropriate and in the patient's best interests to do so.

The Welsh Government is moving towards clearer strategic leadership which will require bravery and determination across the NHS to enable whole-system change

The Welsh Government's emerging Planned Care Programme provides an opportunity to re-think the strategic direction and challenge assumptions about waiting list management

3.19 While the principles of prudent healthcare could underpin a more effective system, the NHS is yet to translate those principles into a clear strategy for elective care and waiting times. The Welsh Government is starting to work though the detailed issues and is developing a Planned Care Programme. The programme aims to provide strong clinical leadership for whole-system improvement in the quality, safety and performance of planned care services throughout NHS Wales. At the time of drafting this report, the programme was in its infancy with a lead clinician, a lead health board chief executive and an executive director recently appointed.

3.20 As the Welsh Government develops the Planned Care Programme, there is a need for a strategic articulation of the core priorities of the elective care system and the role of waiting times targets. The Welsh Government has signalled a desire to re-focus the whole NHS to move away from time-based targets towards measures of clinical need and outcomes[39]. As paragraphs 3.14 to 3.18 showed, that may require some difficult decisions to be made about the balance between efficiency and equity. And it is not yet clear how emerging ideas around co-production, with its focus on more individualised services, fits with an approach that involves a single target that applies to all patients. At the same time as signalling a shift in focus to outcomes, the Welsh Government has made clear to health boards that their integrated three-year plans must show how they will meet the 26 and 36-week waiting times targets by the end of 2014-15. There is a real challenge for the Welsh Government to send out a clear message on the need for long-term systemic reform to focus on better outcomes as well as putting pressure on health boards to take action to meet existing targets in the short-term.

3.21 The Welsh Government recognises the need to develop its own understanding of capacity, demand, costs and benefits if it is to provide clear direction. There is a need for better information on current and future demand and capacity to support robust plans to improve elective care and reduce waiting times. There is also a need to understand the potential scope for service change plans to meet demand without bringing patients into hospital, thereby free up hospital capacity. As was the case with Access 2009, if lowering waiting times remains an explicit goal, a twin approach is required to reduce the backlog over time and then balance demand and capacity over the longer term. A detailed understanding of future demand and capacity is essential to identify the potential resource implications and enable the Welsh Government to set out an achievable timetable for reducing the backlog and balancing the system.

39 Welsh Government, **Written Statement – Welsh Ambulance Services NHS Trust delivery of October 2013 eight-minute target and the introduction of the NHS Outcome Framework and development of future NHS measures**, 2013
Welsh Government, **New cancer waiting times piloted**, 2014
Welsh Government, **Together for Health: Eye Health Care Delivery Plan for Wales 2013-2018**, 2013

3.22 As it develops its new programme and looks to longer-term change, there is scope to revisit the assumption that some kind of waiting list and associated waiting times is necessary. Having a waiting list and associated waiting times comes with a cost: Part 2 set out some of the administrative and clinical costs to managing patients while they wait. But a waiting list also has potential benefits in terms of ensuring a smooth flow of patients to fill up clinics and theatre lists. There is an economic and clinical balance to be struck as to whether and at what level waiting times are optimal. We have seen no evidence that the Welsh Government determines its waiting times targets on the basis of this balance.

The Planned Care Programme has potential to strengthen sharing and learning from good practice to improve the efficiency of the elective care system

3.23 Part 2 of this report set out the areas where the elective care system is not currently efficient or prudent. In paragraphs 3.2 to 3.18, we considered the scope for different ways of working using the principles of prudent healthcare. There is also a set of more detailed efficiency improvements that can be made to release capacity to support lower waiting times. A good starting place is the 2005 Guide to Good Practice. It sets out a detailed analysis of how waiting list planning and management can be made more efficient and provides tools and analysis for use right across the patient pathway. Despite this information being promoted across Wales for nearly a decade, our review of health boards' self-assessments and our local fieldwork suggests that the examples of good practice have not been consistently learnt from and applied.

3.24 There are examples of promising practice around encouraging patients to attend their outpatient appointments included in our Good Practice Compendium. With around 290,000 patients not attending their appointments in 2010-11, there is scope to create significant additional capacity. Some examples of promising practice include the use of text messages to patients, with one trust in England using behavioural psychology to maximise the impact of the messages. Cardiff and Vale is also experimenting with its booking processes to remove patients who do not confirm the time of their outpatient appointments in advance (see our Good Practice Compendium). The approach is having promising early results in reducing non-attendance but the method appears to contradict Welsh Government guidance on booking appointments.

3.25 Another key area where there is scope to share good practice is detailed work to reduce the time a patient stays in hospital. Reducing length of stay is not simply a matter of getting patients out of the door more quickly. Reductions in length of stay need to be accompanied by improvements in detailed processes to ensure patients are still discharged safely, and, potentially, new ways of providing support to patients who still need a low level of care. Our Good Practice Compendium identifies two examples of process improvements from Cardiff and Vale University Health Board: discharge boards and the discharge lounge.

3.26 Health boards that are not already doing so could prioritise their effort to reduce length of stay in the areas where it is likely to have the biggest impact. As noted in paragraph 3.6, just 13 procedures account for around a fifth of bed days used across Wales. Our analysis also showed that the 'pareto' principle[40] applies in elective care, with 80 per cent of elective bed days used by 18 per cent of patients during the period April 2010 to March 2014. Just five per cent of elective patients accounted for around 50 per cent of bed days. Health boards can use this kind of analysis to focus their efforts on finding ways to reduce lengths of stay for the most capacity-intensive procedures and tailor support to groups of patients with very long hospital stays.

3.27 If health boards made significant progress on reducing length of stay, we calculate that in an optimistic scenario where every health board at least matches the Welsh average of 2013-14 each month across emergency and elective care, there would be additional bed capacity for around 13,300 patients. In a highly optimistic scenario, where every health board matches the best in Wales for 2013-14 in both elective and emergency, the equivalent additional bed capacity would be sufficient for an additional 76,000 patients in a year. There are, however, some significant caveats to accompany any consideration of length of stay:

a It would be unrealistic to expect all additional capacity to be converted into new elective patients, not least because of the need to free up capacity to create 'headroom' rather than use it for new patients.

b Freeing up bed days may help address issues where the beds are a constraint on the system, but will not address problems where the constraint is the availability of medical staffing.

c A growing number of older patients with more complex care needs may mean that despite efforts to improve systems and processes, lengths of stay do not reduce as much as they otherwise would.

d Discharging patients at an earlier stage of recovery means that the mix and condition of patients in hospital will change. There will be fewer patients with lower-level needs (as they will have been discharged) to be replaced by patients in an earlier stage of recovery with higher levels of need. This change has potential implications for staffing levels and associated costs.

3.28 One further area where there is clear scope to free up capacity is through reducing delayed transfers of care. While the position in Wales is improving: with a daily average of 17.8 delayed transfers per 100,000 population[41] in 2010-11 compared to 14.7 in 2013-14, progress with securing further reductions has begun to tail off. Successfully addressing delayed transfers of care will require joint working between the NHS and local government to ensure that older patients have the support they need to be able to move from hospital into an intermediate or social

40 The Pareto principle is also known as the 80/20 rule and 'the vital few'. It refers to the theory of Italian economist Vilfredo Pareto that in any situation or system 80 per cent of the outputs are a result of 20 per cent of the inputs. Pareto first observed that in 1900s Italy 80 per cent of the land was owned by 20 per cent of the population. This 80/20 split has been found to occur in many situations and systems.

41 This figure excludes mental health patients.

care setting and, wherever possible, to return to living more independent lives. This is a significant challenge given the funding pressures that are also being experienced in local government.

The NHS will need to be brave and work hard to overcome the hurdles that have hampered whole-system change in the past

3.29 The NHS in Wales has made many attempts to radically re-shape and redesign services in the past. Indeed, many of the principles of prudent healthcare and ideas about operational efficiency can be found in previous plans and strategies, such as the 2010 Five Year Framework[42]. Despite these various plans, there has been limited progress in fundamentally re-shaping the services that are offered to patients.

3.30 That is not to say that there has not been change and innovation. There are many eager staff with ideas and plans to improve their services. And the NHS has made a lot of progress in training staff in improvement methods. Our local work has identified a range of examples of local service innovation, many of which are set out in our Good Practice Compendium. However, many of the managers and clinicians who worked on those examples noted that it can take a considerable amount of time to introduce new ways of working.

3.31 That said, we also found that the squeeze coming from demand and financial pressures might be driving an increase in the pace of change. Some of the positive examples we found came about because the services were under severe pressure: waiting times were far from meeting the target, resources were being stretched and clinicians were concerned that they simply could not cope with the level of demand. As a result, they redesigned the processes and were prepared to take managed risks because the risks of doing nothing were even greater.

3.32 There is no shortcut to addressing the challenge of making change happen in the NHS. The enablers and barriers are multiple and complex. At a strategic level, considerable bravery will be required to re-think the waiting times targets in light of recent performance and current capacity, and re-prioritise services towards clinical need. Some of the principles and ideas in ‘prudent healthcare’ challenge assumptions and professional boundaries and may involve sharing and transfer of clinical risks, for example where people are diagnosed and treated by healthcare workers other than consultants. Many professionals will welcome those challenges while others may resist them. Some of the changes will involve taking financial risks on promising changes that could deliver better and more efficient care over the long term. Some managers and finance staff may understand and embrace such risks while others may resist change without a watertight cast-iron business case. All of these and more can combine to delay and hamper change. Encouraging and enabling more managed risk taking will require a significant degree of bravery and hard work, right across all parts of the NHS (See Box 4).

42 Welsh Government, **Delivering a Five Year Service, Workforce and Financial Strategic Framework for NHS Wales**, 2010

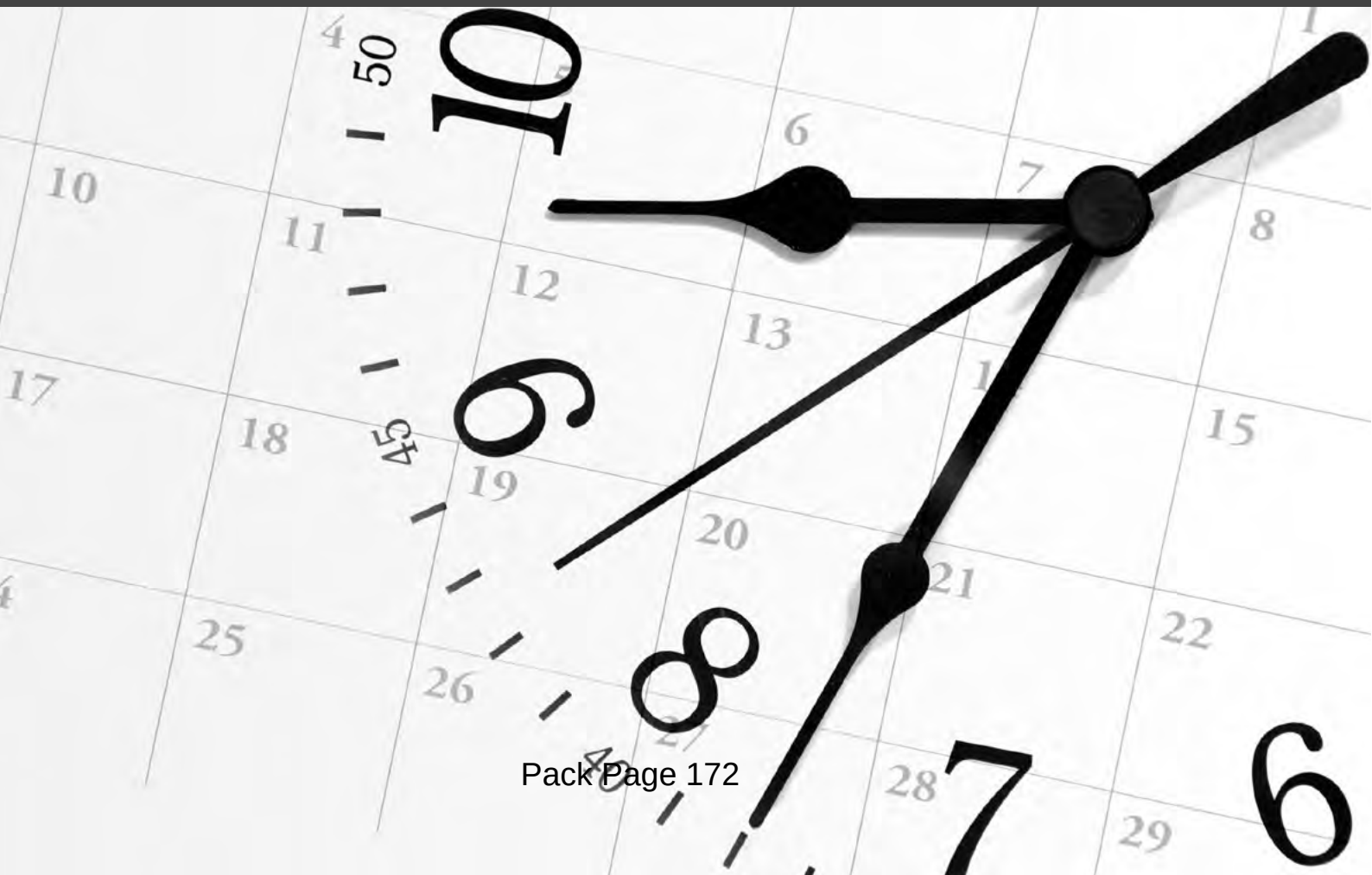
Box 4: Bravery and hard work

Why do we talk about being brave? Because taking managed risks is difficult. The easiest thing to do in any service is carry on with business as usual. However, the performance levels related to waiting times and future demand and financial pressures mean that more of the same is not an option. Taking the first step into uncertain waters – new service models for patients, changing clinical practices and actively enabling patients to choose for themselves what care they receive – needs people to be brave. And they need to be brave to be flexible and manage the inevitable barriers and problems that will come their way once new ways of working are put into practice and to accept the risk that things may not work out as planned.

And ‘hard work’? Because making change happen is hard work. The danger is that producing plans, strategies and ideas can be seen as an end in itself. Of course, planning is important but it is the hard work on the ground to change practice and thinking that will make the biggest difference for patients. Those managers and clinicians we spoke to told us of the determination and work they needed to put in to get their ideas off the ground.

Appendices

Appendix 1 - Audit methods



Appendix 1- Audit methods

Data analysis

We have examined various statistics to analyse the performance of NHS Wales, identify current trends and compare performance across health boards in Wales, including:

a data on admitted patients from the Patient Episode Database Wales (PEDW);

b data on waiting times for a first outpatient appointment from NHS Wales Informatics Service (NWIS);

c Welsh Government data on cancelled operations, day surgery rates, elective and emergency activity, length of stay, outpatient attendance and the average unit cost of treatment per procedure; and

d Stats Wales data on elective waiting times, GP referral rates and NHS beds in Wales.

We were unable to get national data on the number of patients waiting for treatment classed as 'urgent' and on the number of patients who had their referral to treatment 'clock' adjusted. In these cases, we used data from one health board to illustrate the point.

We have also used data from other parts of the UK and internationally to compare demand, capacity and performance where possible. The data sources include:

a NHS England Referral to Treatment and Hospital Episode Statistics;

b Information Services Division Scotland Referral to Treatment Statistics; and

c data from the Organisation for Economic Co-operation and Development (OECD) on elective waiting times, hospital beds and spending on health.

Our main report identifies a number of potential efficiency savings which have been calculated using the data described above and NWIS data on patient admissions from 1 April 2010 to 31 March 2014.

Document review

We have reviewed a range of documents published or provided by the Welsh Government including:

a strategic documents on the NHS Delivery Framework and Annual Operating Frameworks;

b documents setting out emerging plans for Prudent Healthcare and the Planned Care Programme;

c Welsh Government correspondence to health boards on waiting times; and

d notes of Quality and Delivery meetings where the Welsh Government discussed performance against waiting times targets with health boards.

The report also draws on research material from a number of sources including the Kings Fund, the Nuffield Trust, the OECD, Public Health Wales, the Royal National Institute for the Blind and the Welsh Institute for Health and Social Care.

Interviews

We interviewed senior Welsh Government officials to inform our view of the current strategic approach to managing waiting times. We also spoke to people from organisations representing NHS staff and patients including Aneurin Bevan Community Health Council, the Bevan Commission, the British Medical Association, the Royal College of Nurses, Royal National Institute for the Blind and the Royal College of Surgeons.

Local fieldwork

We asked all seven health boards to complete a self-assessment questionnaire during April 2014. The self-assessment focused on four key areas: the health boards' strategy to manage waiting times since 2009; their understanding of current performance; their understanding of the causes behind long waiting times; and plans to improve waiting times for the future. We also reviewed relevant health board documents including:

a strategic documents and plans to address elective waiting times;

b documents setting out the health board's approach to scheduling elective activity and matching capacity with demand;

c board papers relating to waiting times;

d internal reviews and audit reports relating to the accuracy of waiting times data;

e information provided to patients about waiting times; and

f documents relating to the impact of waiting times on patients.

We conducted more in-depth fieldwork at three health boards: Aneurin Bevan, Cardiff and Vale and Hywel Dda University Health Boards. Our work involved interviews with relevant staff, as well as observations of meetings and booking processes.

Patient experience survey

We conducted two surveys to understand patients' experience of waiting for NHS treatment comprising:

a A postal survey sent in April 2014 to a random sample of patients who had undergone three procedures as an elective patient during October and November 2013. We chose three high-volume procedures: cataract surgery; surgery to remove the gall bladder; and catheterisation of the heart. We sent the survey to 900 people and had 400 responses which is a response rate of 44 per cent.

b An online survey targeted at patients who had undergone a planned operation in the last three years. The survey was available on our website during May 2014 and achieved 95 responses.

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Llywodraeth Cymru
Welsh Government

Nick Ramsay AM
Chair
Public Accounts Committee

Our Ref: AG/MR/SB

19 December 2016

Dear Mr Ramsay

AGW Report into NHS Elective Waiting Times in Wales

Further to the request of 22 November sent to Martyn Rees for an update against the nine recommendations contained within the above report, please see attached response for Committee consideration prior to discussion at the PAC on 23 January 2017.

Yours sincerely

Dr Andrew Goodall

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Update on the Wales Audit Office recommendations contained within the report "NHS Waiting Times for Elective Care in Wales"

Recommendation 1
The Welsh Government has not formally reviewed its approach to managing waiting times in light of a sustained deterioration in performance and the challenges of real terms cuts to spending on health. However, with the introduction of a new planning framework, a Planned Care Programme and a range of prudent healthcare initiatives, there are positive signs of a clearer direction for elective care in an environment of austerity. While the Welsh Government is responsible for setting the overall direction, it is for health boards to plan and deliver sustainable and appropriate waiting times. The Welsh Government should therefore work with NHS bodies to: a) review and set out the principles, priorities and intended outcomes for elective care, within the context of the wider healthcare system: to include a fundamental review of current waiting times targets and whether they are an effective method to prioritise resources towards those most in need; b) develop a shared understanding of demand and capacity across the NHS and develop a realistic timeframe for reducing elective waiting times and the backlog of patients in line with any changes to the targets resulting from R1(a) above; and c) assess the costs, benefits and barriers related to adopting seven-day working across the elective care system.
On recommendation 1a, a new approach has been set out in the Planned Care Programme (PCP), based on emerging prudent healthcare principles. This will provide leadership to the NHS in reviewing and reinforcing principles and priorities for elective care, depending on clinical values, better use of the integrated care system in Wales, and a system of benchmarking cost and outcomes of procedures against top performing services. Developing a better understanding of the clinical needs of patients, will inform a review into the appropriateness of individual targets. While timeliness is an important measure of delivery it is recognised that this needs to be supported by the measurement of outcomes. Work has commenced on the development of orthopaedic patient reported outcomes (PROMS) and ophthalmology patient experience measures; these are two test areas from the planned care programme. By February 2017 all health boards will be able to report orthopaedic patient reported outcomes (PROMS), either through the nationally developed platform or through their local bespoke systems. This will provide them with data to start to analyses the effectiveness of their treatments. The PCP will utilise the national focus on pathways, providing specialty specific guidelines to optimise efficiency, cost, patient experience and outcomes. We will expect health boards to implement the national guidelines as appropriate.

As well as developing patient report outcomes and experience measures for treatment along the planned care pathway, to provide a quality context to support the current timeliness measure work has commenced on testing the appropriateness of the current 26 week target.

A Task and Finish group has been established with clinical and managerial members from WG and NHS, to propose a possible alternative to RTT for the measurement of ophthalmology. The group is expected to report their recommendations back to the Cabinet Secretary for Health Wellbeing and Sport by the end of March 2017.

This work will be used to test the concept of a generic waiting time target for all treatments.

On recommendation 1b, health boards have been working with colleagues in Welsh Government and the Delivery Unit to develop their understanding of capability for demand and capacity planning. We expect to see within the 3 year IMTPs and annual plans the proposed improvement plans to deliver reductions in breaches and to build their service delivery plans to deliver sustainable services so that demand and capacity are in balance.

With regard to recommendation 1c, we are working with health boards and trusts to assess, promote and where feasible, implement enhanced seven day services across all areas of the health system. In doing so, we are mindful that in describing seven day services, we have to be clear that this does not mean seven identical days of access or activity. Instead, it is access that ensures we both match available capacity and resources to population need.

In September 2015, through the Welsh Therapies Advisory Committee, a short guide was issued to the NHS to support planning and delivering seven day and extended working arrangements for therapy staff. The guidance was developed to reflect on the lessons learnt from the review of models across Wales. This provides a five-step model for health boards to evolve their local strategy for extending service coverage which can be used for any service, not just therapy services.

Seven day working and / or extended working is an expected approach as part of the NHS IMTP process. For planned care, we expect to see both short term flexible capacity development which may include seven day or extended hours working, but also to support sustainable service developments based on the assessment of need This advice forms part of the specific planned care guidance we provided as part of the national IMTP Planning Framework.

Recommendation 2

Our review found that aspects of the current design and operation of the outpatient system is not as efficient and patient focused as it could be. The Welsh Government and NHS bodies should work together to radically re-shape the outpatient system. In doing so, they should build on the prudent healthcare principles, to enable the emergence of a system that is based more on need, patients' own treatment preferences, use of technology and

which reduces the risk of over-treatment and an overreliance on hospital-based consultants to diagnose and advise on treatment.

Through the publication of the Prudent Healthcare document entitled – "Securing Health and Well-being for Future Generations" the need for changing the model of out-patients became a national project. Its initial purpose is to radically change the outpatient model, ensuring it is easier to access specialist advice to support decision- making in primary care.

At the start of 2016, a national joint programme across the NHS and Welsh Government was established, chaired by the CEO of Aneurin Bevan UHB. The work programme of the national group is to develop in two stages medium and long term goals inline with the WAO recommendation.

Areas of focus include:

- The four speciality areas of the planned care programme are supporting specific service redesign in referral management and the use of alternative management of referrals as part of their redesign for sustainable service models;
- The collection and sharing of learning from local outpatient redesign work across Wales and other areas such as England and Scotland. The aim is to develop a more consistent approach to redesign across the outpatient pathway;
- The commencement of engagement with the public in the development of a longer term vision for outpatient service redesign. In November 2016, the Cabinet Secretary for Health, Well-being and Sport launched a period of engagement with the public and clinicians across each health board to test and explore what is working well and what needs to change.

The medium term aspects of the programme will be run throughout 2017/18 supported by a national collaborative group to ensure learning is maximised across the health boards, supported by 1,000 lives.

The timeline for the more long term change in service redesign will be developed once the feedback from the public engagement exercise has been analysed and discussed, due to be completed by March 2017.

Recommendation 3

We found that in some cases, patients could be facing substantially longer waits if they cancel their appointments because they can find themselves going to the back of the queue. The Welsh Government should review RTT rules and the way in which they are interpreted and applied locally to ensure patients are not being treated unfairly as a result of current approaches to resetting patients' waiting time clocks.

A review of the current "Rules for managing referral to treatment waiting times" is being carried out, with a draft of the updated version out with the NHS for comments. This refresh, along with other work that has been carried out looking at communication with patients (see recommendation 5) and the

refresh of the Guide to Good Practice, will make clear the responsibilities of both health boards and patients. The revised rules make it clear to health boards how they should deal with patients who Could Not Attend appointments and those that Did Not Attend appointments, including what should happen to their waiting time clock. This is then explained to patients through the draft leaflet currently being tested in Betsi Cadwaladr health board.
Recommendation 4
Our local fieldwork has identified pockets of good and interesting practice and innovation across the NHS in Wales. The Welsh Government, through the PCP, should identify mechanisms to share interesting and good practice, in ways which enable frontline staff to share ideas and develop new approaches based on what works. This should include the use of statistical analysis to understand demand and plan capacity as set out in the 2005 NLIAH *A Guide to Good Practice*.
The Delivery Unit has continually identified and promoted good practice, specifically supporting the implementation of the focus on pathways to drive patient care, experience and efficiencies within the current systems. The Guide to Good practice document is being revised to reflect the changes in the RTT guidance. An initial workshop took place on 5 December. The statistical analysis by the NHS to understand and plan capacity, as part of the planned care programme will also be incorporated as part of the refresh of the *Guide to Good Practice*. The first stage of the refresh will be issued March 2017. The second phase will be issued in March 2018; this will reflect the work undertaken in the redesign of outpatients and the developments following the release of the revised RTT guidance. The examples collected and shared for the outpatient redesign project will also be used and reflected within the revised guidance. Through 1000 lives a national electronic platform for collecting and sharing god practice is being developed to support further collaboration The Planned Care Programme has built on this work and provides a platform for the good practice examples to be shared across NHS Wales. It is aggregating good practice into national individual specialty plans, four of which have already been published – orthopaedics, ophthalmology, ENT and urology. These plans collate into one document all of the existing guidance and best practice for the delivery of services in Wales. As part of its implementation, the PCP has established national speciality boards for each speciality which will support and monitor organisations delivery of the plan. Each of these speciality boards reports into the national planned care board. The PCP also established three reference groups which reflected the three prudent aspects of the planned care programme; integrated care, best in class and clinical value prioritisation. These reference groups provide support

to ensure each service specific programme plan reflected these three areas of focus. They provide the PCP Board with authoritative and independent advice on service change.

Recommendation 5

A significant minority of patients in our survey were unaware of what would happen to them if they cancelled, did not attend or were unavailable for appointments. The Welsh Government and health boards should work together to better communicate with patients about their responsibilities, those of the different parts of the NHS and what they should expect when they are in the elective care system.

As highlighted in recommendation 3, a working group has been looking at how to improve communication with patients and to articulate to them what can be expected of them when waiting for appointments and treatment. This will also clearly explain the consequences of not attending appointments and not letting the health board know beforehand.

Betsi Cadwaladr University Health Board is currently trialling a patient information sheet to be provided in primary care when a patient is referred, which informs patients about the process and highlights their role and responsibilities along the pathway. This is part of a booking project and patient feedback on the information leaflet, as part of the wider project, is being collected.

The BCU version has been shared with other health boards to adapt to reflect local requirements. It is also expected that patient information needs will be covered and developed as part of the refresh of the *Guide to Good Practice* first part to be completed March 2017.

Recommendation 6

The Welsh Government publishes some data on waiting times, but it could provide more useful information to help support scrutiny and management of waiting times, as well as providing local information that would be more helpful for patients on a waiting list. The Welsh Government should therefore publish more detailed national and local information:

- publish waiting times at different parts of the patient pathway (component waits);
- reporting separately waiting times for urgent and routine cases, for both the closed and open pathway measure;
- publishing the data for the closed pathway measure which separates out admitted and non-admitted patients; and
- publishing median and 95th percentile waiting times.

We acknowledge that publishing more information about waiting times will be of benefit to patients, and we note the above possible examples of how we could enhance our current planned care reporting to the general public.

The burden of reporting and the benefits for patients have been assessed and the agreed changes have been actioned to address this recommendation Following the Knowledge and Analytical Services consultation 'Proposals concerning the publication of official statistics', additional information has been incorporated into the new quarterly publication for RTT. Information on median waiting time down to health board and also for specific treatment functions is available with commentary providing context. Component waiting times have also been published, showing the waiting times at different parts of the pathway. This can be seen in the most recent quarterly release: http://gov.wales/statistics-and-research/referral-to-treatment-times

We are not able to publish all of the data suggested in the recommendation. With regard to publishing data on waiting times for urgent and routine cases, this information is not currently collected and could be complex to collect and explain. A large percentage of 'urgents' are patients covered under the 62 day suspected cancer route, which is already reported and monitored separately.

An urgency of pathway can be applied at anytime by the consultant who receives and manages a patient pathway. If a patient is changed at treatment stage to urgent but was routine in their initial stages, the total wait could still be long but appropriate This level of reporting is not felt to be beneficial at this time.

Similarly, data on closed pathways split by admitted and non-admitted patients is not collected centrally.

It is recognised that publishing outpatient waiting times would prove useful for patients. We encourage this to be locally provided as waits will vary potentially by site and speciality. Local reporting will help to support referrers such as GPs to give expected waiting times to patients when referring for outpatients or diagnostics.

The eight week standard for diagnostic tests is collected and reported monthly and provides information on potential waits for this stage in a RTT pathway.

Recommendation 7

Many people we spoke to on our local fieldwork identified current IT systems as a barrier to improving services and managing patients, although it is unclear to what extent any problems lie with the systems themselves or the way they are being used. The Welsh Government should carry out a fundamental review of the ICT for managing patients across the patient pathway and how it is being used locally and develop actions to address any problems or concerns that are identified.

A national programme is in place that is developing a national standardised platform for delivering informatics support in the NHS, particularly supporting the patient journey across sectors and organisations.

To support the planned care pathway (RTT) there is a NHS user group for the

Welsh patient administration system (WPAS formally Myrddin). All health boards except Cardiff and Vale use the system; full implementation for all sites across Betsi Cadwaladr is currently ongoing. The user group is used to support updates to reflect the requirements of the service to deliver the required level of pathway management.

To support RTT pathway management and to reflect comments from users, a new view for health boards will be made available in 2017 to support monitoring of the patient pathway. It allows a view of the patient's pathway across all booking systems, including diagnostics and theatre systems. This will support the effective management and monitoring of the waiting times between the stages of the RTT pathway this is an area previously highlighted as a barrier to support active and ongoing validation of pathways.

A refresh of the eHealth and Care strategy has been developed. One of the first actions of the strategy work was to undertake an independent 'stocktake,' completed in 2014 and this has been used, along with extensive engagement, to inform the refreshed strategy.

Recommendation 8

Capacity within secondary care is a major barrier to reducing waiting times. Welsh hospitals have higher occupancy rates than comparators elsewhere in the UK and clinicians raised concerns about the lack of flexibility in the system to manage peaks and troughs in demand from emergency care in particular. The Welsh Government and NHS bodies should review the approach taken to planning inpatient capacity across NHS Wales, to enable the NHS to better manage variation in emergency admissions at the same time as delivering sufficient elective activity to sustain and improve performance.

We expect health boards to undertake full capacity and demand analysis as part of their IMTP process. Additional training will be provided to support local skills in this area to be undertaken by the Delivery Unit proposed skills academy being supported to develop NHS core skills for effective planning.

Sustainable capacity planning also forms part of the planned care programme work for each of the speciality plans. Each health board is required to identify their recurrent capacity gaps and provide their plans on how they will close the gaps in line with the national models highlighted within the specific plans.

Recommendation 9

Cancellations can result in inefficient use of NHS resources and cause frustration for patients. At present, the data on cancellations is incomplete and inconsistent, despite work by the Welsh Government to introduce an updated dataset. The only data that exists covers cancelled operations and health boards appear to be recording the reasons for cancellations differently. The Welsh Government and health boards should therefore work together to:

- ensure that there are comprehensive, agreed and understood definitions of cancellations, and the reasons for them across the entire waiting time pathway to include outpatients, diagnostics, pre-surgical assessment and treatment; and

• ensure that reliable and comparable data on cancellations (and the reasons for them) is collected and used locally and nationally to scrutinise performance and target improvement activities.
Rather than collecting data on the number of cancelled operations, health boards in Wales agreed to change the data collection to cover all postponed admitted procedures. This took into account the inconvenience that having a procedure postponed at short notice has on a patient's life. Over the last couple of years, a great deal of work has taken place with health boards to ensure there is a consistent way of measuring the number of postponed admitted procedures, and in February 2013, a DSCN was issued to health boards detailing the reporting requirements. The new data collection went live in April 2013. Despite some initial technical difficulties, all health boards are now submitting data in the correct format. Following the specific Welsh Audit office report on operating theatres published in March 2016, the Welsh Government and the NHS have been working together to review the use of national and locally theatre specific efficiency measures. A national task and finish group with the NHS has been established to explore a new set of national measures. One area already highlighted for development is the measurement of avoidable cancellations. Initial scoping work across the health boards is being undertaken and will be discussed at the next meeting in January 2017.

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Agenda Item 7

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