Agenda - Public Accounts Committee

Meeting Venue:	For further information contact:
Committee Room 3 - Senedd	**Fay Bowen**
Meeting date: 20 May 2019	Committee Clerk
Meeting time: 13.15	0300 200 6565
	SeneddPAC@assembly.wales

(Private pre-meeting)

(13.15 - 13.30)

1 Introductions, apologies, substitutions and declarations of interest

(13.30)

2 Paper(s) to note

(13.30- 13.40)

2.1 Expenditure on agency staff by NHS Wales: Letter from the Welsh Government (25 April 2019)

(Pages 1 - 8)

2.2 Management of follow up outpatients across Wales: Letters from the Royal College of Physicians and the BMA

(Pages 9 - 19)

3 The Welsh Government's youth discounted bus fare scheme - MyTravelPass: Evidence Session with the Welsh Government

(13.40 - 15.10) (Pages 20 - 40)

Research Briefing

PAC(5)-13-19 Paper 1 - Welsh Government

Andrew Slade - Director General, Economy, Skills and Natural Resources Group, Welsh Government

Simon Jones - Director, Economic Infrastructure, Welsh Government

Sheena Hague - Deputy Director, Network Management, Welsh Government

Cynulliad Cenedlaethol Cymru National Assembly for Wales

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

(15.10)

Item 5

5 The Welsh Government's youth discounted bus fare scheme – MyTravelPass: Consideration of evidence received

(15.10 - 15.30)

**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

Our Ref: AG/SOT

25 April 2019

Dear Mr Ramsay

Expenditure on agency staff by NHS Wales

I am writing in response to your letter of 28 March 2019.

Welsh Government welcomes the January 2019 WAO report on expenditure on agency staff by NHS Wales which will inform future activity in Wales. We had already started significant work nationally to manage this expenditure which we shared with the WAO during completion of their report. It is encouraging that the observations made by the WAO on developing a single source of consistent data collection and strengthening leadership to steer the work and deliver future efficiencies are very much in line with our focus for phase two of this work programme.

We introduced a new national control framework in November 2017 approved by the Minister to reduce agency deployment and expenditure which enabled us to reduced expenditure by £30 million in 12 months between 2016-17 and 2017-18. This represents an improvement of 17% in the underlying spend and has reversed a pattern of annual increases.

This reduction resulted from joint working between Welsh Government and NHS organisations to implement a number of controls and management processes which were introduced by Welsh Government Health Circular WHC 2017-042 in November 2017 to reduce agency and locum deployment in NHS Wales organisations.

Alongside the controls on agency and locum deployment, we have also implemented a range of more strategic measures to build a sustainable substantive workforce against a background of the highest spend on record on the workforce, including our successful Train, Work, Live campaign.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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There has been progress in workforce recruitment, with a record number of staff working in the Welsh NHS. In September 2017 (the latest available official statistics) there were 77,917 full time equivalent (FTE) directly employed NHS staff in Wales. This was up 2.1% per cent (1,629) from 2016 and represents a record high.

In addition, in November 2018 the Minister for Health and Social Services announced a £114m investment package to support education and training programmes for healthcare professionals in Wales. This represents an increase of £7m compared with 2018/19.

We have achieved significant rapid reduction in spend on agency and locum staff through our new control framework. The information collection that underpins this control framework, alongside the analysis and reflections made by the WAO, has enabled us to identify the next steps for a second phase of the work to further reduce NHS reliance on agency and locum staff and to maintain this good progress

Whilst there is significant potential to further control agency and locum deployment, some organisations have made more progress than others. Welsh Government officials are therefore working with individual health boards to spread good practice and scrutinise their actions and exploring the potential benefits of organisations, including commercial options, who offer a range of services which aim to reduce agency and locum spend.

A breakdown of expenditure on agency and locum deployment across all staff groups in NHS Wales for 2018-19 has been included at Appendix 1.

Yours sincerely

Dr Andrew Goodall CBE

Staff Group	2018/19 Agency & Locum (paid at a premium) Expenditure (M11 Actual + M12 Forecast)											Staff Category as a % of Total Expenditure
	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	PHW	Velindre	WAST	Total	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Admin & Clerical & Board Members	1,223	269	1,672	421	993	239	70	763	1,093	160	**6,902**	4.9%
Medical & Dental	9,737	10,334	13,809	144	13,909	4,308	1,286	673	-	-	**54,200**	38.5%
Nursing & Midwifery Registered	11,575	7,358	12,428	9,442	6,741	14,216	2,074	-	4	-	**63,839**	45.3%
Prof Scientific & Technical	8	86	300	5	50	22	710	-	-	-	**1,181**	0.8%
Additional Clinical Services	851	48	25	15	342	138	368	-	101	-	**1,888**	1.3%
Allied Health Professionals	1,006	1,438	2,293	591	808	1,222	409	48	522	-	**8,337**	5.9%
Healthcare Scientists	201	716	213	164	296	168	-	642	44	-	**2,444**	1.7%
Estates & Ancillary	679	736	21	347	1	-	237	2	62	12	**2,097**	1.5%
Students	-	-	-	-	-	-	-	-	-	-	**-**	0.0%
Total NHS Wales	**25,280**	**20,985**	**30,761**	**11,129**	**23,139**	**20,313**	**5,154**	**2,127**	**1,826**	**172**	**140,887**	**100.0%**
As a % of Total	**17.9%**	**14.9%**	**21.8%**	**7.9%**	**16.4%**	**14.4%**	**3.7%**	**1.5%**	**1.3%**	**0.1%**	**100.0%**	
Total Forecast Pay Expend	**670,203**	**537,896**	**739,998**	**613,540**	**355,679**	**414,727**	**78,626**	**82,838**	**159,508**	**131,237**	**3,784,252**	
As a % of Total Pay Expend	**3.8%**	**3.9%**	**4.2%**	**1.8%**	**6.5%**	**4.9%**	**6.6%**	**2.6%**	**1.1%**	**0.1%**	**3.7%**	

Reasons for expenditure Agency/ Locum (paid at a premium)	2018/19 Agency & Locum (paid at a premium) Expenditure (M11 Actual + M12 Forecast)											% spend by Category
	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	WAST	Velindre	WAST	Total	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Vacancy	17,275	16,073	26,256	6,046	17,205	18,675	2,557	2,127	1,782	172	**108,168**	**76.8%**
Maternity/Paternity/Adoption Leave	-	174	533	650	114	49	73	-	-	-	**1,593**	**1.1%**
Special Leave (Paid) – inc. compassionate leave, interview	-	151	-	81	-	4	-	-	-	-	**236**	**0.2%**
Special Leave (Unpaid)	-	-	-	-	-	1	-	-	-	-	**1**	**0.0%**
Study Leave/Examinations	-	-	-	-	91	-	99	-	-	-	**190**	**0.1%**
Additional Activity (Winter Pressures/Site Pressures)	4,677	2,150	581	2,657	1,855	996	1,173	-	44	-	**14,134**	**10.0%**
Annual Leave	-	34	1,889	23	1,309	-	286	-	-	-	**3,541**	**2.5%**
Sickness	3,328	1,348	1,502	1,672	2,550	588	971	-	-	-	**11,958**	**8.5%**
Restricted Duties	-	-	-	-	15	-	-	-	-	-	**15**	**0.0%**
Jury Service	-	-	-	-	-	-	-	-	-	-	**-**	**0.0%**
WLI	-	818	-	-	-	-	-	-	-	-	**818**	**0.6%**
Exclusion (Suspension)	-	236	-	-	-	-	-	-	-	-	**236**	**0.2%**
Total NHS Wales	**25,281**	**20,985**	**30,761**	**11,129**	**23,139**	**20,313**	**5,158**	**2,127**	**1,826**	**172**	**140,892**	**100.0%**

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Mr Nick Ramsay AM
Chair, Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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Reference: AC/144/caf
Date issued: 13 May 2019

Dear Nick

Expenditure on agency staff by NHS Wales

Thank you for sharing with me Dr Andrew Goodall's letter of 25 April 2019 to the Committee, which set out the Welsh Government's response to my January 2019 report 'Expenditure on agency staff by NHS Wales'.

I am pleased to note Dr Goodall's positive comments on my report. However, I thought I should draw the Committee's attention to the fact that the figures included in the appendix to Dr Goodall's letter demonstrate that spending on agency staff increased once again in 2018-19, after having fallen in the previous year. This increase is not mentioned in the letter.

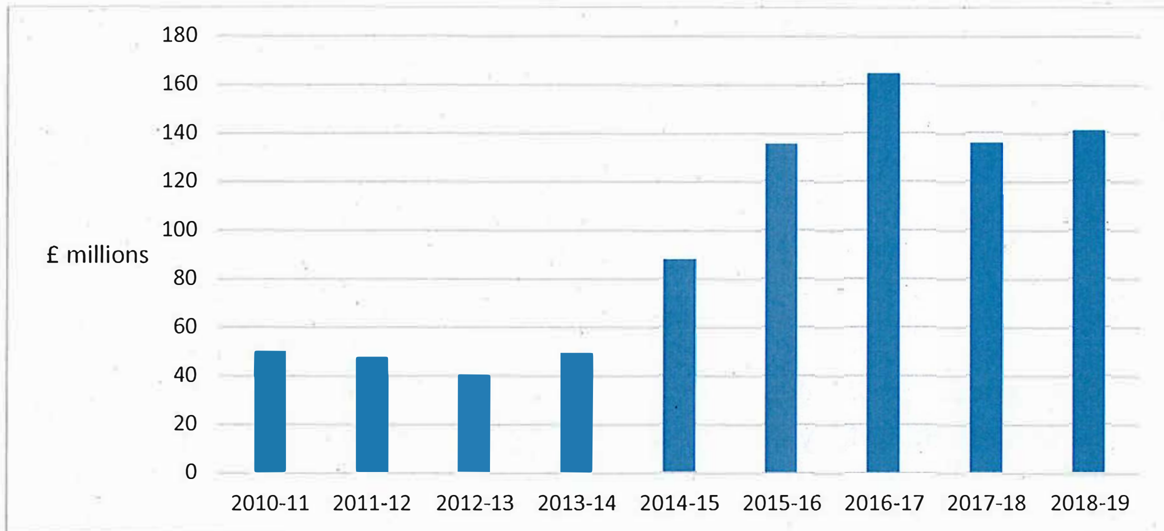
I also note that the Committee will have the opportunity to question witnesses from local health boards and from the Welsh Government on these issues at its upcoming evidence sessions on NHS Finances.

After a fall in 2017-18, overall agency expenditure again rose in 2018-19

As Dr Goodall notes, my report set out that overall expenditure on agency staff between 2016-17 and 2017-18 had fallen by £30 million (17 per cent), reversing the pattern of significant annual increases that had occurred since 2012-13.

However, and as shown in Exhibit 1 below, the data provided in Dr Goodall's letter indicates that during 2018-19 overall agency expenditure has actually increased by £5.2 million (4 per cent), to £141 million.

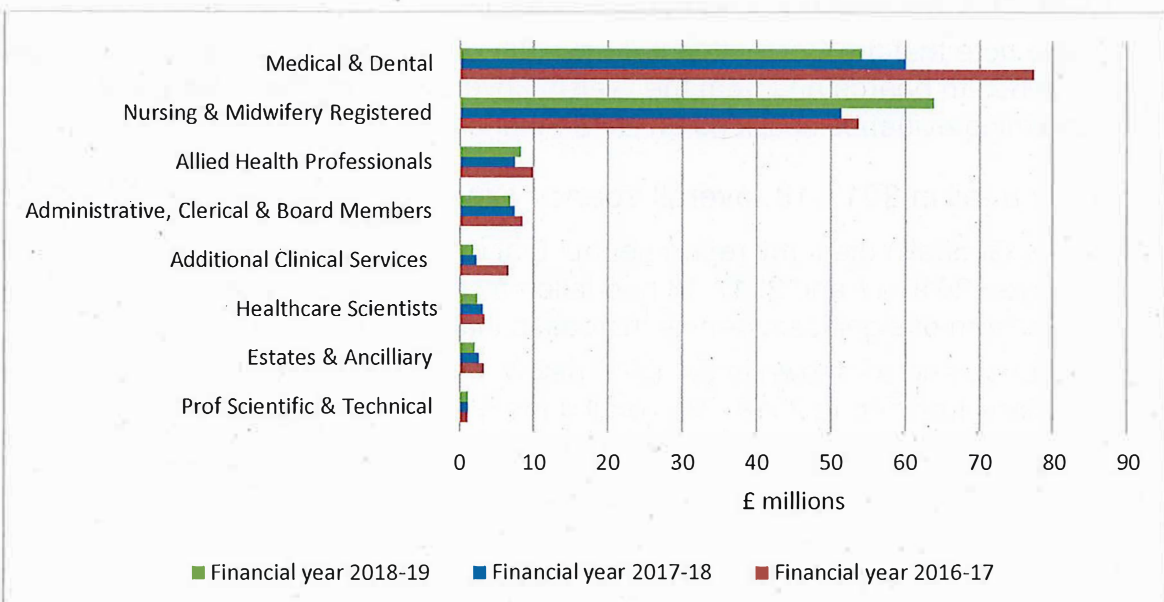
Exhibit 1: total NHS expenditure in Wales on agency staff between 2010-11 and 2018-19



Sources for all exhibits: 2010-11 to 2017-18: Workforce, Education & Development Services, NHS Wales Shared Services Partnership; 2018-19: Welsh Government.

Exhibit 2 provides a more detailed analysis of this rise in total annual agency staff costs. It shows that expenditure fell in all but two agency staff categories during 2018-19, and that the in-year rise is almost entirely due to significantly increased expenditure on Nursing and Midwifery agency staff.

Exhibit 2: NHS expenditure in Wales on agency staff by staff group between 2016-17 and 2018-19



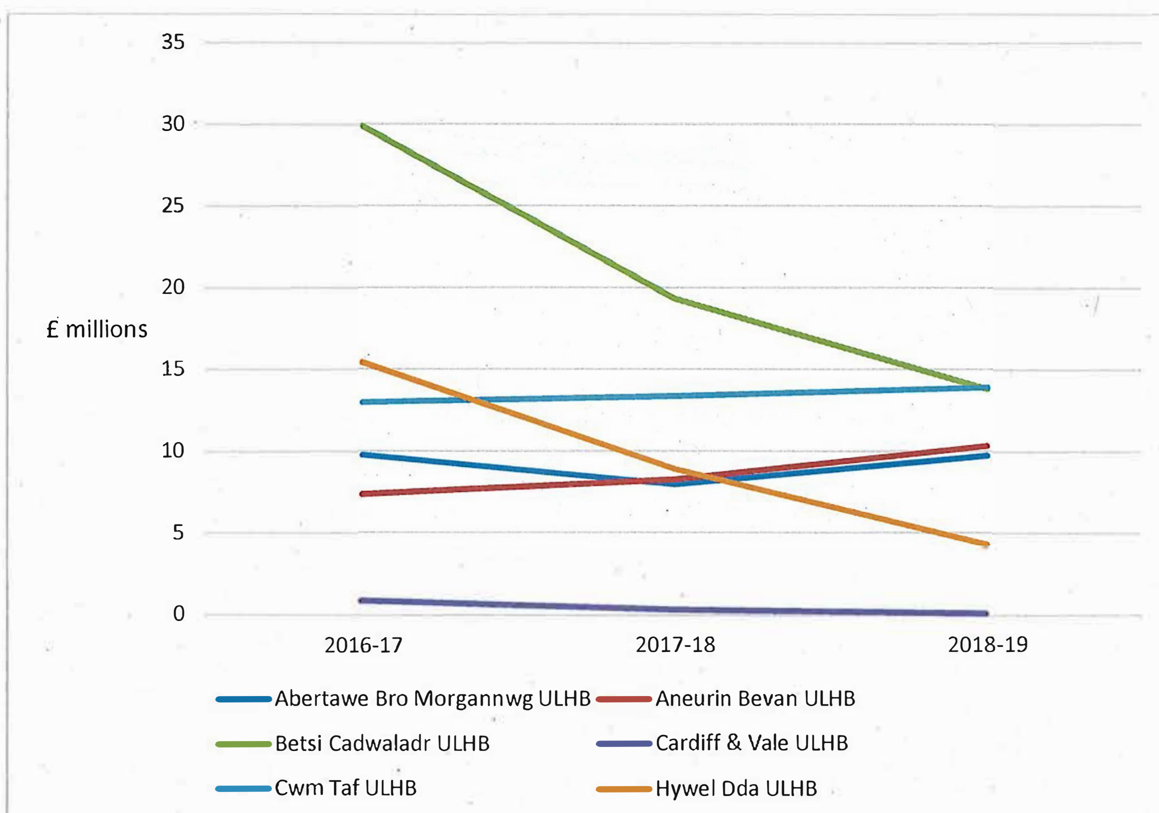
Costs of Medical agency staff fell by nearly 10 per cent

Our report focussed on all-Wales initiatives to control the cost of using (i) medical and (ii) nursing agency staff. The largest fall in agency expenditure from 2017-18 to 2018-19 is in the Medical and Dental agency staff category which has reduced by £5.8 million (9.7 per cent).

Welsh Health Circular WHC 2017-042, introduced in November 2017, required NHS Wales bodies to implement controls and management processes to reduce agency deployment and expenditure for medical and dental staff. Encouragingly, there has been a resultant fall of 30 per cent (£23 million) in expenditure on medical and dental agency expenditure between 2016-17 and 2018-19.

However, it is important to note that this reduction in medical and dental agency expenditure is localised - as shown in Exhibit 3, it fell in only three of the six largest health bodies.

Exhibit 3: expenditure on Medical & Dental agency staff at the six largest health bodies between 2016-17 and 2018-19

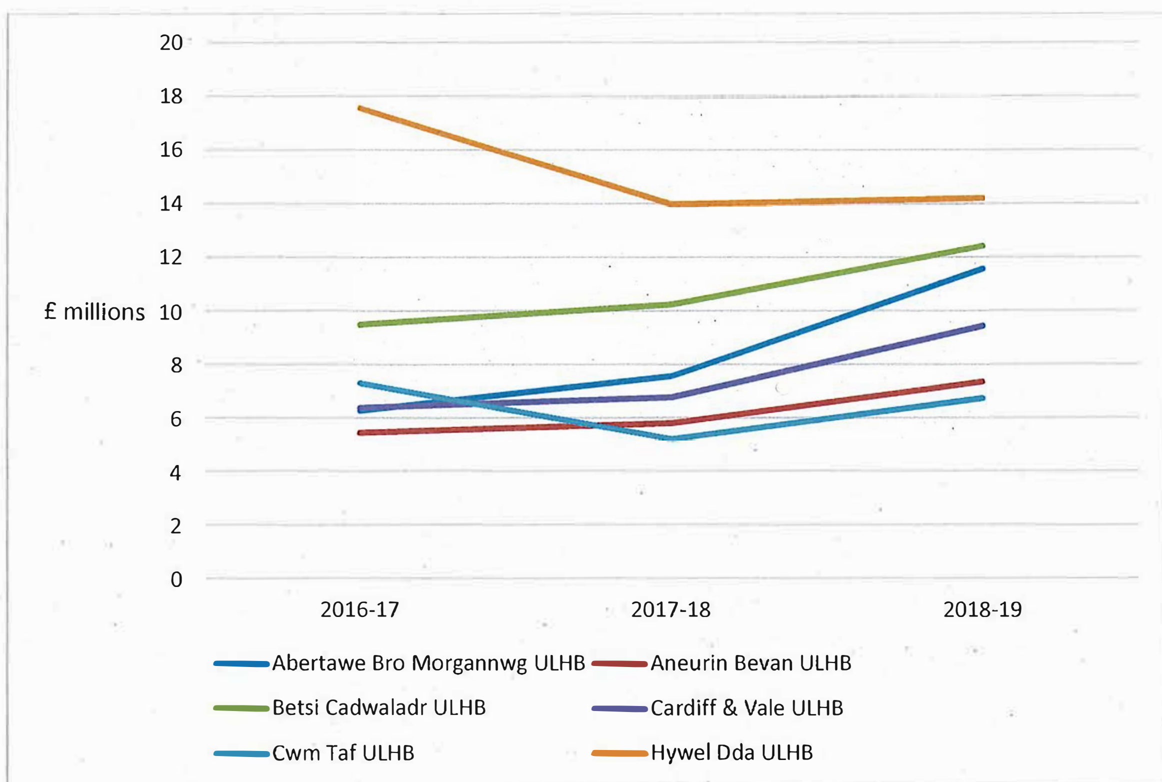


There were significant falls during 2018-19 at Betsi Cadwaladr ULHB (£5.5 million) and Hywel Dda ULHB (£4.6 million) but rises at Aneurin Bevan ULHB (£2.1 million) and Abertawe Bro Morgannwg ULHB (£1.8 million). The in-year movements at Cwm Taf ULHB and Cardiff and Vale ULHB were a rise of £0.5 million and a fall of £0.2 million respectively.

Costs of Nursing and Midwifery agency staff rose by 24 per cent

Expenditure on Nursing and Midwifery agency staff rose by 24 per cent to £63.8 million in 2018-19, having previously fallen to £51.4 million in 2017-18. As shown in Exhibit 4, all of the six largest health bodies have reported increases in agency expenditure for this staff category, with the scale of increase ranging from 1.6 per cent (£0.2 million) at Hywel Dda ULHB to 52.9 pe cent (£4 million) at Abertawe Bro Morgannwg ULHB.

Exhibit 4: expenditure on Nursing & Midwifery Registered agency staff at the six largest health bodies between 2016-17 and 2018-19



Phase Two of the Welsh Government's work programme

Dr Goodall's letter also refers to a second phase of the Welsh Government's work programme to reduce reliance on agency and locum staff across NHS Wales. At the time of our audit review last year, it was not yet clear what this second phase would involve and the initiatives it would include. Dr Goodall's letter provides relatively little by way of further information on the details of the phase two programme.

At its evidence session on NHS Finances with the Welsh Government, the Committee may therefore also wish to explore with the witnesses how that second phase of work is responding to the two key challenges that we identified in Part 4 of our report.

NHS Wales staff numbers continue to rise

In considering this updated information on Agency staff costs, the Committee may also wish to bear in mind the most recent available official statistics on the number of staff working in NHS Wales.

The latest statistical release by the Welsh Government shows that there were 79,054 full time equivalent directly employed NHS staff in Wales on 30 September 2018. This represents a rise of 1.4 per cent (1,083 staff) in the year from September 2017. Medical and dental staffing rose by 2.4 per cent (156 staff), whilst nursing, midwifery and health visitor staffing fell by 0.1 per cent (47 staff).

I trust that this additional information and analysis will be of assistance to the Committee in preparing for its evidence sessions on NHS Finances later this term.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Agenda Item 2.2

Inquiry into the management of follow up outpatients across Wales

RCP Cymru Wales response

About us

Our 36,000 members worldwide (including 1,300 in Wales) work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions, including stroke, care of older people, cardiology and respiratory disease. We campaign for improvements to healthcare, medical education and public health. We work directly with health boards, NHS Wales trusts and HEIW; we carry out regular 'local conversation' hospital visits to meet patients and front-line staff; and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales aims to showcase best practice in Wales through poster competitions and trainee awards. In July 2018, we hosted the inaugural and highly successful RCP membership (MRCP(UK)) and fellowship (FRCP) ceremony for Wales.

To help shape the future of medical care in Wales, visit our website:
www.rcplondon.ac.uk/wales

To tell us what you think – or to request more information – email us at:
wales@rcplondon.ac.uk

Tweet your support:
@RCPWales
#MedicineisBrilliant
#MeddygaethynWych

For more information, please contact:

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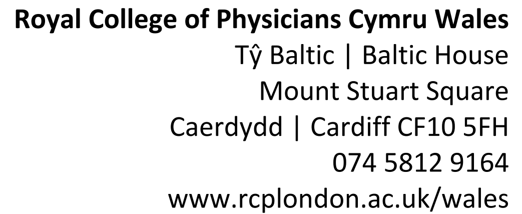

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Public Accounts Committee
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3 May 2019

Inquiry into the management of follow up outpatients across Wales

Thank you for the opportunity to respond to your inquiry into the management of follow up outpatients across Wales. The Royal College of Physicians (RCP) has worked with consultant physicians, trainee and specialty doctors, and members of our patient carer network in Wales to produce this response. We have also included a statement from colleagues at the Royal College of Ophthalmologists.

Both royal colleges would be happy to organise further written or oral evidence if that would be helpful.

Our response

The RCP recognises that the management of follow up outpatients in Wales poses a major clinical risk and we welcome the Wales Audit Office report and its recommendations. We agree that reform of the outpatient system is needed – while those with genuine problems need to be seen, many follow up appointments are unnecessary and take up clinical time which could be spent helping other patients. The system is also affected by widespread vacancies, rota gaps and a shortage of clinical staff. Technology could be used more widely and much more effectively, but its development has been slow.

> ***'Most clinics [are] heavily booked with new patients as this was a "target" – [this is] an example of distorting clinical practice to avoid penalties [and] has resulted in a huge number of patients waiting a long time for review … It will undoubtedly have added to medical assessment unit and emergency department attendances.'*** (Consultant physician, NHS Wales)

In the **Aneurin Bevan University Health board neurology service**, using a 'see on symptoms' approach, patients with certain long-term conditions (eg epilepsy, neuropathy, Parkinson's disease, MS) are responsible for liaising with the service, often through clinical nurse specialists. Advice is given over the phone, or by email or letter, which avoids unnecessary six month or annual reviews. For complex or urgent problems, a clinic appointment is scheduled. Some patients are naturally anxious that they will be lost in the system, so the process has built-in capacity to see patients at short notice, and recognises that the clinic appointment schedule must allow sufficient time to assess more complex cases.

The recent RCP report, *Outpatients: the future – adding value through sustainability*, found that the traditional model of outpatient care is no longer fit for purpose.[1] It places unnecessary financial and time costs on patients, clinicians, the NHS and the public purse. Its findings align with those of the Wales Audit Office in their 2018 report, *Management of follow up outpatients across Wales*.

‘Outpatient care represents the largest proportion of NHS contact with the public in the hospital setting.’[1]

We know that the traditional one-model-fits-all approach to outpatient care is not able to keep up with growing demand and fails to minimise disruption to patient lives. Clinicians are increasingly frustrated with, and fatigued by, growing pressures from waiting lists and overbooked clinics. Patients are frustrated by poor communication and long waiting times.

> ***‘Outpatient follow up is an interesting area. In many specialties, secondary care follow up is much needed but has huge resource limitations and in many instances, GP services are not able to cope with the follow up needs of patients. Recently one of our consultants retired, and a lot of his patient workload has been distributed between the rest of us, which has had an impact on the patients that we would normally follow up from our wards, the medical assessment unit and community care. I suspect it is the same for most specialist services.’*** (Consultant physician, NHS Wales)

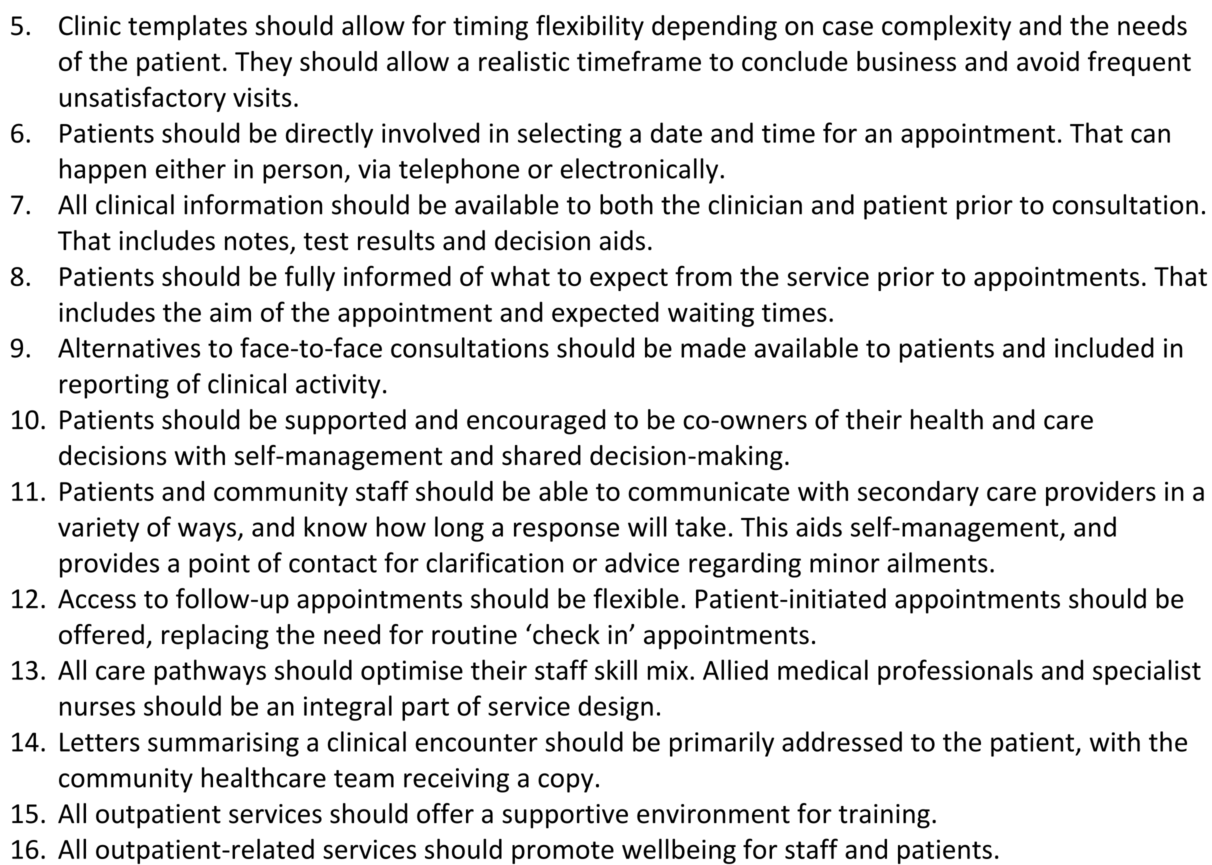
Health boards need to think differently about how they provide healthcare – for example, identifying the balance between cost and outcomes (value) and the long-term impact of the way they work (sustainability). This means taking into account all the costs related to an intervention, including loss of income to a patient attending an appointment and the impact of transport on public health.

The time has come to re-evaluate the purpose of outpatient care and align those objectives with modern-day living and expectations. This will require health boards to be more flexible, and allow patients more control over when and how they receive care. A key element of the redesign process is better use of the technology already available. It is up to the Welsh government to provide clear guidance and support to enable this transformation.

CARTREF (**CAR**e delivered with **T**elemedicine to support **R**ural **E**lderly and **F**rail patients) – is a telemedicine project that aims to improve access to care for frail older patients in rural north Wales. It was part of the RCP Future Hospital Programme which was established to implement innovative clinical changes across sites in England and Wales.[2] The Betsi Cadwaladr UHB project enables patients, especially those with chronic illnesses to have follow-up outpatient reviews closer to home. By using video clinics in primary care and community hospitals around Dolgellau, patients and relatives are able to meet specialists without travelling. The team worked with patients and carers to design the service model and can demonstrate patient satisfaction rates of 80%.

Principles for good outpatient care[1]

1. Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.
2. Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.
3. Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
4. All outpatient care pathways should aim to minimise disruption to patients’ and carers’ lives.



5. Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
6. Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
7. All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.
8. Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.
9. Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
10. Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.
11. Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.
12. Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
13. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.
14. Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.
15. All outpatient services should offer a supportive environment for training.
16. All outpatient-related services should promote wellbeing for staff and patients.

'Action is needed now to preserve our most precious sense before more patients come to harm'

Ophthalmology is one of the busiest outpatient specialties in the UK. The needs of an ageing population and the increase in chronic eye disease requiring long term treatment and follow up care have put the hospital eye service under unprecedented pressure. The current workforce is stretched to meet a predicted increase in demand of 40% over the next 20 years. However, ophthalmology continues to develop efficient and effective models of outpatient care; working in partnership with optometrists in and out of the hospital setting can decrease the number of false positive referrals into secondary care, the use of the multidisciplinary teamwork that optimises efficiency and value in the hospital setting, and the use of virtual clinics in the treatment of glaucoma.

The Royal College of Ophthalmologists welcomes the Senedd Public Accounts Committee inquiry into the management of outpatients, especially the focus placed on ophthalmology. It is important that the committee recognises the very real risk of loss of sight if follow up patients are not seen as indicated by the consultant in a time-appropriate manner. In 2017 the RCOphth British Ophthalmology Surveillance Unit found up to 22 patients per month losing sight as a result of hospital initiated delays to follow up appointments.[3] Action is needed now to preserve our most precious sense before more patients come to harm.

Liz Price, Communications Manager
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The Royal College of Ophthalmologists
18 Stephenson Way, London, NW1 2HD
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'One in four potential outpatient appointments in Wales are cancelled or reported as 'did not attend' (DNA).'[1]

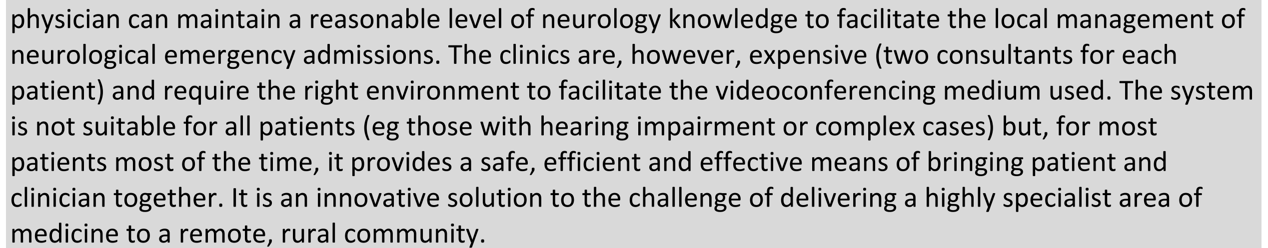
Next steps[1]

1. The Welsh government and NHS Wales should consider commissioning an external clinically-led whole system invited service review. This could take a cross-college approach.[4]
2. The NHS should support clinicians to deliver more specialist medical care in the community – the hospital without walls – and using new technology.
3. The wider healthcare team has a vital contribution to make – eg clinical nurse specialists, physiotherapists, and physician associates – and should be supported to play a key role in the management of patients with long term conditions.
4. Clinicians should think creatively about how they can support trainee doctors and medical undergraduate students to learn effectively from follow-up outpatients and their conditions.
5. Quality improvement (QI) projects should report on value as a whole, recognising the population and system effects of change as well as individual clinical outcomes.
6. Health boards should be appraised on the basis of clinical value, not units of physical interaction or activity.
7. National guidance for the oversight of outpatients as part of local governance structures should be developed and integrated in all health boards alongside mortality and morbidity reviews.
8. Specialist organisations and charities should work collaboratively to oversee the development of signposting to resources that support outpatient consultations, eg patient decision aids, preventing duplication of efforts locally.
9. NHS Wales, the Welsh government and local government need to work together to provide clear and structured guidance on how to build partnerships with the voluntary and community sectors. This should be created and supported by case studies.

'An innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community'

In the more rural areas of Wales, the challenge of providing high-quality specialist services is not insignificant. Bronglais Hospital serves a population of around 150,000 across Ceredigion, north Powys and south Gwynedd – our patients may travel for 2 hours or more to reach this site. Our tertiary referral centre for neurology is in Swansea – a round trip of about 150 miles. The road infrastructure is poor and, at many points in the year, the roads are full of heavy goods vehicles and holiday traffic. The consultant contract in Wales recognises travel from base to clinic time as a direct clinical care element; therefore, this round trip adds substantially to the allocation of direct clinical care time. To combat this, we have worked with colleagues in Swansea to establish a teleneurology clinic, which has been running for a number of years now. Initially, we linked with one neurologist every 6 weeks and now we link with two neurologists roughly every fortnight. To date, two patients have also had an emergency teleneurology consultation. The service is appreciated by patients (who do not have to travel), by their carers (who do not have to take time off work) and by clinicians (who no longer have to spent clinical time travelling between hospitals).

An early survey to judge acceptability of this model showed that, of 36 patients on the waiting list who responded, 90% accepted and 10% declined – 5% preferring to travel and 5% preferring to see their own GP. After the service was established, a further survey of 24 patients who had used the service showed that, of 19 respondents, 100% were happy with the consultation and would use the service again. From a local perspective, the service provides an invaluable educational opportunity. It means that a general


physician can maintain a reasonable level of neurology knowledge to facilitate the local management of neurological emergency admissions. The clinics are, however, expensive (two consultants for each patient) and require the right environment to facilitate the videoconferencing medium used. The system is not suitable for all patients (eg those with hearing impairment or complex cases) but, for most patients most of the time, it provides a safe, efficient and effective means of bringing patient and clinician together. It is an innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community.

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Cymru Wales

MANAGEMENT OF FOLLOW UP OUTPATIENTS ACROSS WALES

Inquiry by the National Assembly for Wales Public Accounts Committee

Response from BMA Cymru Wales

10 May 2019

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly's Public Accounts Committee into the findings of the Auditor General for Wales' report entitled 'Management of follow up outpatients across Wales'.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this inquiry, as it touches on a significant area of concern that we have been highlighting in recent years with both the Welsh Government and Welsh NHS employers. During this time, we have been raising this issue as a major concern at both national and local meetings.

We remain deeply troubled at the lack of tangible progress which has been made in addressing the extent to which follow up outpatient appointments are delayed since the Auditor General's first report which looked at the situation as it was in 2015-16. Regrettably, the Auditor General's 2018 report validates the stance we have been taking in continuing to raise concerns, as it echoes the observation of many of our members. We take no pleasure in the fact that the situation has appreciably worsened, as

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highlighted in the findings of the 2018 report. This highlights the failure of Welsh NHS organisations to take the issue sufficiently seriously.

We can only hope that this second report by the Auditor General will now lead to an escalation of the efforts being made to address the problem. There is a clear need in our view for appropriate resources to be allocated by health boards and trusts to addressing this issue. This needs to involve the allocation of funding as well as an appropriate staffing resource, but we would also note that not all solutions to the problem necessarily require additional expenditure.

In compiling this evidence, we have sought views from our members based on their own experience. We hope this can provide some pointers as to how the situation might be more effectively addressed.

We would certainly endorse all the recommendations in the report, including that "*health boards need to get better at assessing and managing the clinical risks to patients from delays in follow-up appointments*" and that there "*needs to be a greater focus on the management of follow-up outpatient appointments within national and local performance management arrangements*." These two issues are, to a large extent, interlinked in our view.

A huge part of the problem lies in the way the that formal target arrangements currently operate as this often takes precedence over clinical judgment as to when a patient needs to be seen. This is often down to the fact there is a target for when patients should be seen for their first outpatient appointment after being referred by their GP (known as the referral to treatment target, or RTT) but there is no equivalent target for when they should be seen for a follow-up appointment. This sometimes creates a perverse incentive for health boards to prioritise first appointments over follow-up appointments to ensure they meet their targets, which might be achieved only at the expense of delaying follow-up appointments.

We would recommend that how this system works must be reviewed. We need to move away from the problem that currently exists where the need to meet Welsh Government-set targets can over-ride informed clinical judgement on when patients should be seen.

We further note that when follow-up appointments are delayed in this way by health boards, the consultant overseeing the care of the patient in question is often not informed that this has happened and may only become aware the appointment was delayed when they next see the patient in question. As highlighted in the Auditor General's report, in worst-case scenarios a patient's health might have deteriorated irreversibly during the time their follow-up appointment was delayed – something that may have been avoided had the appointment taken place within the time-frame originally specified by the clinician who requested it.

The report notes the risk that this can pose to ophthalmology patients who could potentially even lose their sight as a result of a delayed follow-up appointment, but as the report acknowledges there can be similar risks in relation to other specialties. For instance, one of our members who is an ear, nose and throat (ENT) surgeon has pointed out that for his patients the potential exists for delayed follow-up appointments to lead to a permanent loss of hearing, an irreversible loss of balance or the development of facial palsy.

One concern our members highlight is a lack of consistent practice in dealing with follow-up outpatient appointments, which can vary between health boards, between specialties and between individual clinicians. Thus, whilst there are plenty of examples of good practice being employed, they are not being done so consistently. We are aware for instance that some consultants make a point of regularly assessing their own lists and initiate action themselves to ensure their follow-up appointments are not being delayed by addressing any backlog they might have. However, this is not something that happens routinely across the board.

Whilst some consultants regularly obtain their own figures for how many 'follow-up not booked' (FUNB) appointments they have on their list as a matter of routine, this is not universal. We would therefore

suggest that consideration is given to putting in place a mandatory requirement for health boards and trusts to supply every consultant who manages a list with details of how many FUNB appointments they have on either a monthly or quarterly basis.

One of our consultant members has highlighted the challenges he has had in ensuring he has no outpatient appointments classed as FUNB, as well as maintaining such a position once it has been achieved. After taking up his post, it took him four years to eliminate FUNB appointments from his list. However, events outside of his control have meant that he has not always been able to fully maintain such a position on a continuous basis. On one occasion, for instance, a software change introduced by his health board led to 150 patients being lost from his list. When this was discovered at a later date, and they were then added back to his list, he found himself with a backlog of 150 FUNB appointments which it took him 18 months to eliminate once again. On another occasion, he inherited 40 FUNB appointments from a colleague who had retired.

We would suggest that there is a clear need to ensure best practice is shared and that consultants are facilitated in adopting changes that would ameliorate this adverse position. The consultant referred to in the previous paragraph adopted a system for managing appointments that he had previously observed another consultant using, but we need to consider how such best practice sharing could be better promoted and adopted. One suggestion would be to hold a forum, or one-day conference, specifically about strategies for dealing with follow-up outpatient appointments – something that could potentially be undertaken on an annual basis.

Another suggestion that we support within the Auditor General's report is to review the need for so many patients to receive a follow-up outpatient appointment automatically after surgery. In the experience of our members, this is also an area in which there appears to be quite inconsistent practice between different hospitals and health boards.

A consultant dermatologist has pointed out that in her department patients are only seen after surgery if it is deemed that they require further treatment or assessment, but in a neighbouring hospital the practice there is to give every patient who has received a biopsy a follow-up appointment even when a carcinoma has been fully excised and needs no further treatment.

We note the necessity to ensure that outcomes are monitored and that feedback about quality and safety are essential, but there are many ways to collate such data using IT, telephone, or other means. One consultant gynaecologist reported that, due to cuts in staffing, their successful efficient nurse-led 'gynae reunion' session was stopped so patients are now followed up instead in consultant clinics. Health boards must be tasked with moving the service forwards – all too often our members report regression due to cost or staff constraints.

An ENT surgeon has noted that is now standard accepted practice not to see all patients automatically following surgery for tonsil removal, and that similar practice is now also being adopted in relation to patients who have had simple nose surgeries, e.g. septoplasty and simple functional endoscopic sinus surgery (FESS). Patients can however phone to request an appointment up to eight weeks following their surgery should a problem arise.

This surgeon has also pointed out that a consultant should be able to judge to a high level of accuracy (i.e. around 96%) whether or not a patient will need to be seen again following surgery. Through the use of such clinical judgment to determine whether or not patients will need to be seen in such circumstances, capacity can therefore be freed up to enable other patients to be seen in a more timely manner.

The key point here is that greater use of clinical judgement can help to minimise the risk that might exist to patients, as well as ensuring fewer patients who need a follow-up appointment have that appointment delayed. This can help reduce such delays without necessarily needing greater financial resource.

We note the emphasis that is placed on improving quality through better outcomes – be they clinical or patient-reported – so it also remains vital that follow-up data are collected, collated and utilised effectively in driving up standards and quality.

A further concern raised by a consultant oral and maxillofacial surgeon is that when he is scheduling a review appointment for a patient, he will not normally have any available appointments that are less than four months into the future because his clinics prior to this time will already be fully booked. On occasions when he judges he needs to see a patient again more quickly, e.g because the patient needs a scan or other investigation for suspected cancer or other serious conditions, he therefore has no choice but to overbook an earlier clinic. This can put other patients at risk who are already booked to be seen in these clinics, but whose appointments may then have to be delayed.

Some of our GP members have expressed concern regarding the frustration that delayed follow-up appointments cause to their patients. This in turn has workload implications for GP practices, as patients often contact them when they have been left waiting and are lacking information about what is happening. Again, we would point to the impact of differential practice. Some hospital departments will advise a patient of an alternative date for their appointment at the same time as letting them know it has been delayed, but others just advise patients to wait until they hear from them again before they will be given an alternative date whilst some require such patients to ring in to book an alternative date for their appointment.

GP practices are often asked to assist patients who have difficulty rearranging outpatient appointments that they are unable to make. Patients often find that the contact numbers provided on the letters they have received are permanently engaged, meaning they struggle to inform a hospital department they can't attend on the date offered. This can mean they are then being classed as DNA (did not attend) rather than CNA (could not attend), and this can then lead them to be discharged from the waiting list.

We are also aware of patients who have received letters advising them that their outpatient appointment has been rescheduled for an earlier date than their original appointment, but the letters advising them of this fact have not reached them until after their new appointment date has already passed.

Another concern GPs have highlighted is that patients are often asked by hospital departments to confirm that they are consenting to their referral, even though they have already opted in to being referred at the GP appointment they attended when it was agreed the referral should be made. We are further aware of instances where patients who have been referred for an assessment are then asked to confirm they consent to a procedure being undertaken, even though it may not be known at that stage if a procedure is in fact needed. Such patients may understandably be reluctant to do so until they have actually had their secondary care assessment. It is hard to see what the benefit of such confirmation requirements are, other than to remove patients from waiting lists that GPs have determined should be seen. This may help reduce waiting lists, but only in a manner which may be detrimental to the health of patients.

One suggestion put forward by a GP member is that there could be a dedicated person (or team) within each health board with responsibility for managing the situation for each patient. This person could act as an 'ongoing hospital care navigator', be a point of contact for patients and have responsibility for liaising with relevant specialty departments within the hospital. By acting as a channel for such communications, this could reduce the current multiplicity of calls to secretaries within hospital departments and contacts at GP surgeries. They could also have a role in requesting that follow-up appointments be expedited and chasing when responses are not being received, although clearly there would be a need to also ensure they were undertaking their roles with appropriate clinical input.

Another of our GP members has advised us of his experience as a member of the Dyfed Powys Local Medical Committee (LMC) in working with Hywel Dda University Health Board to address problems there around delayed follow-up outpatient appointments. Three years ago, he approached the health board's deputy chief executive with a proposal that the health board could commission GPs to look at cases once

appointments had reached six months delay compared to when a patient was supposed to have been seen. The idea was for GPs to review such cases to determine if the patients in question still needed a follow-up appointment, or if they could instead be discharged from the list to free up capacity and reduce waits for others. A subsequent meeting was held which also involved the chair of the LMC to further develop the proposal, draw up a potential service level agreement and consider an appropriate fee for the work as it would not be covered by existing contractual arrangements. The discussions considered five different specialties which it was felt should initially be targeted, because this is where the LMC felt the most difference could be made.

A pilot was subsequently undertaken for urology patients. It led to 6% of cases being immediately referred back to the clinic as being in need of urgent review, 54% being identified as suitable to be discharged from the list, with the remaining 40% of patients being recommended to remain on the list for a follow-up appointment. It is greatly disturbing that more than one in 20 patients were judged to be in need of urgent review when on a waiting list.

Regrettably, although funding to take this work forward was written in to the health board's RTT plan for 2019-20, it was not subsequently approved by the health board's executive team. This is clearly a deeply disappointing outcome, particularly given the fact that it is possible significant sums for negligence may have to be paid out for patients who have suffered deterioration to their health as a result of delayed follow-up appointments. Whilst the health board should of course be concerned about this, we would note that such payments come from the Wales Risk Pool rather from the health board's own budget. This is something the Welsh Government should perhaps seek to address, as it would surely be more cost effective, and significantly better for patients, for funding to be allocated to such initiatives rather than see much greater sums paid out in negligence claims.

In summary

We would reiterate our view that efforts to tackle this problem must now be appropriately escalated and that the issue needs to be given significantly greater priority by health boards, including at board level. More consistent practice needs to be adopted across health boards and hospital departments, as well as by individual clinicians. Where required, appropriate resources should be allocated, and initiatives should be supported across health boards that can address the underlying issues. More also needs to be done to facilitate the sharing of best practice.

Part of the solution involves reviewing the need for some patients to remain on lists awaiting follow-up appointments and for a change in adopted practice so that certain categories of patients aren't routinely seen for follow-up appointments when there may not be a clinical need. In addition, there are undoubtedly ways in which the current system for managing such outpatient appointments can be reformed to ensure it is more appropriately based on ensuring patients are seem in accord with assessed clinical need at the time a clinician has judged they should be seen. Perverse incentives in the way Welsh Government targets are currently applied need to be addressed to ensure that adhering to such targets does not over-ride clinical judgement.

We can only hope that this second report from the Auditor General will lead to this issue now being treated with the seriousness it deserves at health board level. It is deeply regrettable that the problem has significantly worsened overall since concerns we contributed to raising led to the first report being undertaken in 2015-16. We would therefore suggest that National Assembly committees should play a role in monitoring progress. We cannot afford to wait until another report is produced by the Auditor General in a few years' time only to discover that the situation has worsened yet again to the detriment of patients.

Agenda Item 3

By virtue of paragraph(s) vi of Standing Order 17.42

Document is Restricted

Evidence Paper in advance of the Public Accounts Committee Scrutiny Session – 20.05.2019

Auditor General for Wales Report on 'The Welsh Government's youth discounted bus fare scheme – 'MyTravelPass''

The purpose of this paper is to provide Written Evidence to the Public Accounts Committee on the Auditor General for Wales's fact-only Report on 'The Welsh Government's youth discounted bus fare scheme – 'MyTravelPass'.

Section 1: Key findings

Section 2: Development and introduction of MyTravelPass

Section 3: Operation of MyTravelPass between September 2015 and March 2017

Section 4: Operation of MyTravelPass since April 2017

Section 1: Key findings

In the absence of legislation enabling the Welsh Government to require bus operators' participation, the MyTravelPass scheme was introduced as and remains a voluntary arrangement between the Welsh Government and over 80 independent bus operators.

The Wales Audit Office (WAO) fact-only Report recognises that the amount of funding for the scheme in 2015-16 (£5m September 2015 to March 2016) and 2016-17 (£9.75m for the full financial year) was announced as part of a political agreement between Welsh Labour and the Welsh Liberal Democrats for the 2015-16 budget.

The announcement of the quantum of funding preceded Welsh Government negotiations with bus operators about the compensation to which they would be entitled for carrying 16 to 18 year olds at a discount. Those negotiations between the Welsh Government and the bus industry, represented by the Confederation of Passenger Transport (CPT), were undertaken against the background of an insistence by the CPT that the full amounts of funding already announced would be paid to them to secure the bus operators' participation.

Officials were nevertheless able to negotiate a scheme which both fulfilled and expanded on the original announcement without requiring funding additional to that already announced. Those enhancements secured one-third fare discounts not only for 16 and 17 year olds for bus journeys to and from training and employment, but for all 16, 17 and 18 year olds and for any journeys.

These negotiations also ensured that the already-announced funding would also be used to meet the associated administrative costs of Traveline Cymru (MyTravelPass), and for marketing & promotion.

The AGW Report correctly identifies that take-up of the MyTravelPass was lower than had initially been estimated. At that time, there was no equivalent scheme and by introducing a new and innovative offer to encourage more bus travel by younger people, the Welsh Government's estimates were inevitably broad.

As the scheme was voluntary and without a commitment to fund beyond 31 March 2017, operators were reluctant to withdraw their own commercial discounted fare schemes for younger people, fearing that they would lose touch with a key cohort of existing and potential future customers.

The retention of these operators' own schemes meant that younger people were able to obtain discounted fares for journeys on those operators' services, and had no immediate incentive to obtain a MyTravelPass instead – unless they habitually travelled on the buses of more than one operator. The Report acknowledges that when an operator ceased to offer its own products to this age group, there was a significant increase in the number of MyTravelPasses issued.

In addition to the AGW discussions with the Welsh Government's Internal Audit Service (IAS), the Welsh Government asked IAS to review the MyTravelPass arrangements for 2017-18, after the scheme had ceased to be a pilot. The IAS report was completed in November 2018 for the use solely by the Welsh Government. The report was clear that lessons could be learned, and the Welsh Government quickly implemented a number of actions – including reimbursing bus operators on the basis of the actual number of journeys undertaken. The Welsh Government continues to comply with and monitor the implementation of the IAS report, and officials are working closely with the WAO and IAS to identify and implement further opportunities to improve the scheme's management.

The CPT has welcomed the introduction of the 16 to 18 pilot, and its more recent extension to include 19 to 21 year olds. The CPT acknowledges that "discounted bus travel for more young people is a great incentive for customers to choose the bus over the car with all the environmental and active travel benefits adding further value to this excellent scheme for young people in Wales".

Section 2: Development and introduction of MyTravelPass

The AGW Report notes that the Welsh Liberal Democrats had published in March 2014 a report "A concessionary fare Scheme for Young People in Wales". This report recommended a national concessionary fare scheme based on a blanket reduced fare rate for 16-18 years olds and students to help reduce the cost of public transport and improve access to education, employment and training opportunities. The report estimated that such an initiative would cost between £2.4m to £40.6m depending on the level of concession offered and the age groups included.

The then Minister for Finance and Government Business announced in September 2014 a commitment to introduce by September 2015 a discounted bus fare scheme

for 16 and 17 year olds for travel to and from work or training. The amount of funding announced was £5m in 2015-16 (September 2015 to March 2016) and £9.75m in 2016-17 (for the full financial year).

Prior to that announcement the Bus Policy Advisory Group, in June 2014, had provided the then Minister for Economy, Science and Transport with recommendations about sustainable transport services in Wales, including that a youth concessionary fares policy be developed through further research and consultation.

In September 2015, the commitments made by Welsh Ministers in September 2014, were fulfilled in their entirety, which included the successful negotiation of enhancements that included extending the offer to all 16, 17 and 18 year olds, and for all of their journeys by bus, irrespective of purpose and for administration & marketing of the scheme.

These negotiations also enabled the Welsh Government to use the announced funds for 2015-16 and 2016-17 for the administration and marketing of the scheme. In those negotiations the CPT confirmed they expected the full amount announced for the pilot to be given to the bus industry for their volunteer participation in the pilot.
To ensure that a compliant scheme was in place by 1 September 2015, officials explored with local authority officers and the Confederation of Passenger Transport a range of ways to achieve and extend Ministers' original objectives. Extending the announcement to include all journeys by 16 to 18 year olds overcame the potential difficulties for bus drivers in verifying that pass holders were in fact travelling for the purposes of training or work. To attempt to do so could have led to disputes and delays, partly compromising the benefits of the offer and other passengers' experiences.

These negotiations with the bus industry were carried out at two levels – strategically with managing directors of Welsh bus companies (who were also CPT representatives) by members of the Welsh Government senior civil service, and a technical group consisting of Welsh bus companies operational staff, representatives of the Welsh Association of Transport Coordinating Officers (representative body of lead transport official from each the Welsh local authority) and the Welsh Government team members tasked with implementing the initiative.

In the absence of any existing schemes, officials were inevitably required to make certain assumptions about the potential take up and use of MyTravel Pass based on the mandatory free concessionary bus travel scheme. While recognising that the youth scheme was not free and provided one third fare discounts, rather than free journeys, we remain satisfied that the estimates were reasonable at that time and in the absence of an equivalent comparator scheme elsewhere in the UK. Experience has shown that younger people are less interested in discounted bus travel than was originally thought, and that relatively few of them travel on more than one bus operator's services.

As has been previously reported, the CPT in negotiations was determined to ensure that all of the funds that had been announced by Ministers would be used to support the bus network under what was, and remains, a voluntary arrangement.

Section 3: Operation of MyTravelPass between September 2015 and March 2017

The bus operators' firm conviction that the bus network must benefit from the full allocation of the funding announced did not waver during the pilot phase of the initiative.

In the absence of suitable ticketing machines during the pilot, it was not possible to record all journeys electronically and so link each journey to an appropriate payment. In the circumstances, negotiations with the CPT concluded that the funding should be allocated to each operator in accordance with two factors:

- first, the number of free concessionary bus journeys; and
- second, the registered mileage operated by each bus company.

In this way, operators were allocated shares of the total funding available for compensation according to how big a part each played in Wales's bus network.

For the reasons already described, operators also continued their own commercial discounted fare scheme for young people, reducing the number of MyTravelPasses issued and journeys undertaken under the scheme. Additionally, the bus operators declined to share details of the take up and use of their own schemes, citing the commercial sensitivities of such data.

The Welsh Government has acknowledged that the detailed mechanism for compensating bus operators during the pilot phase developed and agreed with the CPT during negotiations should formally have been reported to Ministers. There was nothing in the Ministers' original announcement which specified how Welsh Government funding would be allocated, so the use of mileage and concessionary journeys did not contradict anything that Ministers had said. While there was nothing inconsistent in this arrangement, it would have been better practice to have notified the Minister of the actual mechanism utilised for distributing the funding.

As the pilot phase came to a close, Ministers made it clear that they wished it to continue to offer one-third discounts for 16 to 18 year olds for all of their journeys until a new and better scheme could be devised. There then followed a detailed consultation during 2017-18 seeking views about what a new scheme might include.

Although the quantum of funding allocated in 2015-16 and in 2016-17 was significantly higher than in 2017-18, the bus industry has reported that the overall level of funding allocated under MyTravelPass pilot "helped operators to stabilise the bus network, making it more attractive to new and existing passengers". The CPT has added that "there was no question of bus operators making excess profits, still less of taking them from Wales and using them to compete unfairly elsewhere in Europe". During 2016 three bus companies went into administration: one factor that supported the Cabinet Secretary for Economy and Transport's five point plan to support the bus industry in Wales.

The CPT has reported "If the pilot had shown that level of reimbursement to operators was insufficient, we would not have been entitled to ask for more in retrospect. It is

inevitable that major initiatives like MyTravelPass will involve an element of risk on both sides, given the various uncertainties involved, and the impossibility of defining the "counterfactual" with complete precision".

Section 4: Operation of MyTravelPass since April 2017

The change in the level of compensation, marketing and administration to £1m from 1 April 2017 after the pilot phase and its associated Ministerial undertakings about the levels of funding reflects the use of data that was collected during the pilot phase, which confirmed a lower than expected take-up of MyTravelPass and fewer than expected journeys.

It also reflects improvements in the provision and capability of the electronic ticket machines operating in the Welsh bus fleet. These improvements allowed the Welsh Government and bus operators to agree that funding claims for compensation would be based upon the actual number of recorded journeys.

For marketing the scheme during 2017-18, the then Cabinet Secretary decided in response to criticism by the CPT of efforts to date that it, the CPT (representing organisations who are marketing bus services to attract passengers) should be invited to assume responsibility for marketing the scheme for the period 1 April 2017 to 31 March 2018 utilising funding from Welsh Government.

Officials convened discussions between the CPT and Traveline Cymru about the content of a new marketing campaign, and the CPT agreed with officials to a target of doubling the number of passholders and doubling the number of journeys year-on-year, and how funding would be claimed. The contractual arrangement for marketing and promotion plan and content was between the CPT and Traveline Cymru only.

During 2018-19 while the consultation responses were being considered, only a low level marketing of the scheme was undertaken. Following the Cabinet Secretary's decision to enhance the age range to include those aged 19, 20 and 21 years, and for marketing to be taken in-house, an extensive social media and promotional campaign was developed to coincide with the launch of the extended scheme.

The Committee may wish to note, that since the extension to the scheme went live, on 14 February 2019 for 19 – 21 year olds, 1,554 applications had been received as of 22 April 2019.

The Welsh Government continues to work closely with the CPT and our partners in local authorities to encourage more young people to use the bus for more of their journeys. The negotiations to implement the pilot, and the lessons learned from it, have been part of the process of establishing a fair long-term basis for the scheme. The Welsh Government has achieved a popular and growing scheme which demonstrates the benefits of working with our partners and that complies with the findings of the WAO and IAS reports.