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Russell George MS
Chair
Health and Social Care Committee

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Dear Russell

I am writing in response to your letter of 22 November regarding additional funding for planned care services. I have addressed each query separately.

What factors may be contributing to the variation in the length of time people are waiting to start treatment in different health board areas, and what role does the Welsh Government have in facilitating the sharing of learning and innovation between health boards?

The reasons for the variation are multi factual, and in many cases existed prior to COVID-19. They include the ability to recruit staff, geography of local areas, and variation in deprivation rates across Wales.

The COVID-19 pandemic has further exposed these factors and in some cases, compounded the impact. It has also raised different issues.

Examples being:-

The geography and estate of hospital sites: the ability of health boards to provide safe green pathways segregated from acute sites to review and treat patients. National guidance provided during COVID-19 clearly indicated the importance of protecting patients from the risk of COVID-19 transmission and dividing the estate based on risk of transmission. Some health boards, such as Cardiff and Vale, were able to respond to this. Others such as Hywel Dda and Cwm Taf Morgannwg struggled as unscheduled care, urgent and planned care are all delivered on one site.

The availability of additional resources/capacity to support health board delivery: During the early part of the pandemic, health boards attempted to secure private sector capacity to deliver NHS treatments. They offered safer environments and additional staff to provide urgent appointments, follow-up reviews, diagnostics and treatments while NHS staff were

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deployed to deal with COVID-19 care. The geography and availability of these resources across Wales varied and as such, caused variation in resources available to each health board. Joint working across health board areas particularly for cancer was encouraged and supported through the cancer network. More recently, securing additional capacity has been the responsibility of each health board as part of their recovery plans, the level of availability across Wales however still varies.

Infection Prevention Control arrangements: National guidance has supported health boards to manage their estates to mitigate the risk of hospital acquired COVID -19 infection. While this has reduced incidents, it has not eradicated it. There has been a series of incidents across various sites, which has resulted in sites periodically closing to elective care, and affecting further the available capacity to treat patients.

Management of waiting lists focused on clinical risk rather than chronological order: Clinical need, in particular cancer care, has always taken priority on the use of planned care resources (outpatients, diagnostics and treatments). This approach has been the main guiding principle during COVID-19, and this has had a significant effect on the waiting lists. Waiting list management pre COVID used chronological (length of wait) to determine the next routine patient to be treated across each speciality area. At present, there is limited capacity available for routine patients for review and/or treatment. Pre-COVID-19, each specialty would be allocated an annual share of the planned care resources for them to manage their own waiting list. During COVID-19, planned care resources are pooled together and available theatre slots are allocated based on clinical risk, with emergency and urgent care taking priority. This has resulted in services such as planned orthopaedics having a wider disproportionate reduction of their traditional share of resources compared to areas such as colorectal surgery, who have a higher percentage of urgent cancer treatments. Pre-COVID-19, orthopaedics had an existing demand and capacity imbalance, an area of focus for the planned care programme, the imbalance has significantly widened during COVID-19.

The Welsh Government role has been to provide national guidance and policy support to ensure safe and effective delivery of NHS and social care during the COVID-19 pandemic. Where appropriate, health boards have been able to adapt and revise guidance based on local risk assessment. A recent impact is the ability, if safe to do so, to reduce social distancing in outpatient areas from two meters to one. Health boards with more modern estate and no recent hospital acquired transmission episodes have been able to do implement the change; this has not been possible for all across Wales.

The sharing and learning across health boards for planned care has mainly come through the work of the National Planned Care Programme. It has provided guidance and support to develop and implement innovation and new ways of working to maximise planned care activity while balancing issues affecting capacity.

Annex 1, gives some examples of variations across the specialities and demonstrates why and where there is variation, and gives examples of transformation and sharing of learning.

The £170m is to be divided equally between health boards on a population basis. In determining this allocation, what account has been taken of any variation in the demographics, degree of deprivation or the extent of the waiting times backlogs in each.

The allocation of the £170m uses the same formula share used for the NHS annual funding. This takes into account:

- Population
- Demographic factors (age / sex)
- Additional health needs (specifically standard mortality ratios and long- term

limiting illness).

Within the allocation letters to the health bodies, the priority for agreeing regional work/plans was stressed. This is to include proposed joint arrangements across organisations, including the role of national groups in providing advice, guidance and support. The aim of this regional working is to mitigate some of the issues than have created variation across health boards, such as ability to recruit, and the protection of resources, (regional centres will be separate from acute care and the effected by unscheduled care pressures)

The additional £170m is described as annual funding; for how many years do you expect this funding be available?

The funding is recurrent and it is expected to be used to fund a substantive increase in baseline NHS costs to support recovery of planned routine care through new delivery models and recruitment of additional permanent staff. As with the rest of the UK public sector, we only have certainty on the budget for the next three years, but that does not mean that this funding would end after the three years, it will form part of regular review of the national budget. I have been clear that planned care recovery will take the whole of the Senedd term.

You have asked health boards to develop plans for how they will use this funding to transform their services; when do you anticipate these plans will be published, and what period do you expect the plans to cover

Health Boards and NHS Trusts are normally required to develop three-year Integrated Medium Term Plans (IMTPs) setting out how they expect to deliver healthcare services for their local population. The usual planning and delivery arrangements for NHS Wales and social care, including the IMTP process, paused in March last year to ensure our health and social care organisations were able to respond to the outbreak of the Coronavirus pandemic.

During the pandemic, NHS organisations have instead been required to plan their services in line with a number of specific NHS Wales COVID-19 Operating Frameworks, which set the operating requirements focussing on essential services, urgent and emergency care, along with detailed capacity and workforce planning, aligned with the Ministerial priorities and focussed on the four harms. A NHS Wales Planning Framework followed these for 2021-22 requiring annual plans, which included the need to demonstrate how they plan for recovery.

Whilst the immediate priority is for our health and social care services to focus on the challenges we are facing during the winter, our services must also be able to plan the delivery of safe and sustainable services beyond this period. I therefore re-established the IMTP planning cycle and published the NHS Wales Planning Framework for 2022-25 on 9 November 2021.

The Framework signals both my ambition and commitment to look ahead to resetting services and driving recovery as we move forward into next year and beyond. The Framework reflects my priorities, which I communicated in the summer, and sets the direction for the year ahead. These will include the anticipated impact of the proposals against the additional funding provided by Welsh Government towards recovery and service transformation. I expect submission of the IMTPs for 2022-25 to Welsh Government by 28 February 2022, these will be robustly assessed to ensure we have clear delivery plans going forward. Health boards will be responsible for publishing their plans on their individual websites following approval by their Boards.

Yours sincerely,

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Minister for Health and Social Services

Appendix A:

Orthopaedics

At the end of September 2021, there were almost 9,500 patients waiting more than 105 weeks (two years) for treatment – the majority at treatment stage. Over 50% of the extreme long waiting patients are waiting for orthopaedic treatments.

It is recognised that the delivery of orthopaedic services in Wales has been significantly affected due to the lack of access to surgical theatres since March 2020, the availability of staff and infection control requirements the main limiting factor. For health boards which have returned to some levels of activity, they remain impacted by infection control restrictions which reduce number of patients treated on each list, as well as bed pressures from unscheduled care leading to postponements.

Prior to the pandemic, additional treatment capacity was routinely being provided into Orthopaedist services through Welsh Government waiting list initiative funding to support evening / weekend activity, as well as outsourcing to private providers. Despite the support, some health boards had not reduced their maximum waiting times below 12 months. The health boards with longer pre-pandemic lists continue to have the highest number of patients waiting more than 105 weeks for treatment. There are a complex set of issues, which has, and continues to affect the capability of health boards to provide timely treatment.

ABUHB has the largest total waiting list, and largest number of patients waiting over a year for first outpatient appointment. The health board also has the largest number of patients listed for treatment and around 1500 of whom have waited over 105 weeks. ABUHB have recently reopened their orthopaedic theatres with plans to reduce numbers in the coming months.

BCUHB has a higher proportion of patients at first outpatient stage (almost 2:1 ratio) and around 1,800 patients waiting over 105 weeks for surgery. Locally, teams are split across three localities although progress is being made in developing network arrangements across the areas to support collaboration. Surgery has not reopened to great volumes.

CVUHB has twice as many patients waiting for first outpatient review than for treatment. There are lower numbers of patients exceeding 105 weeks at both stages and the health board has returned some surgical capacity to the team.

CTMUHB has similar numbers of patients awaiting first outpatient to treatment, although there are low long waiting numbers for outpatients, around 1000 patients have waited over 105 weeks for surgery. Limited operating is occurring in CTM and the orthopaedic teams are working in a three site/ team model will little evidence of collaboration.

HDUHB has some of the lowest numbers of patients waiting at all stages, and those waiting longer. Only 660 patients are waiting over 105 weeks for surgery. This reflects the managed waiting list prior to COVID. In the health board, there is minimal surgery occurring and is not predicted to be available until spring 2022, although outsourcing has been commissioned.

SBUHB is not an outlier in terms of first outpatient waits, however they have some often highest long waiting patients, with around 2,400 waiting over 105 weeks for treatment and a further 2,000 waiting between 36 and 52 weeks. This reflects the challenges the health board faced prior to COVID with the loss of inpatient orthopaedic beds in 2019 and increased reliance on outsourced activity. Minimal inpatient surgery has been undertaken locally for a significant period and has adversely impacted complex patients requiring surgery in the main Morriston site.

The growth in the number of first outpatient waiting times has been impacted by requirements to physically examine / manipulate limbs as well as access radiographic imaging in order to plan treatment. In order to prevent multiple appointments the clinical consensus is that first outpatient appointments require a face to face appointment.

The priority of orthopaedic care against other clinical specialties has been reported to be low in all health boards, resulting in a low priority for access to limited outpatient and treatment facilities. The backlogs are especially challenging in hip / knee replacement surgery which requires inpatient facilities. The delay in surgery has also impacted on the overall health of patients who are generally being classified as more medically complex and requiring enhanced surgical / anaesthetic support.

Clinical pathways and the identification of alternative processes for the delivery of care have formed a central part of the Orthopaedic Clinical Strategy development and will be part of the orthopaedic "get it right first time" (GIRFT) review. There is an acknowledgement that radical rethinking of how services are provided is required to reduce waiting times.

Ear Nose & Throat (ENT)

ENT now has the 4th largest waiting list of all specialities. The Welsh ENT Board has identified that the size of the backlog in secondary care requires the NHS to work differently with primary care colleagues in order to support patients. Cardiff & Vale have been leaders in the development of health pathways, use of SOS/PIFU and specialist advice and guidance in order to realign resources to reduce demand. The board is working to spread this learning across Wales and standardise referral and support guidance where possible as there is unwarranted variation in place.

Unlike some other surgical specialities, the waiting list burden in ENT is at first outpatient stage rather than treatment. This reflects challenges in higher risk close airborne examination and diagnostics requiring PPE and room cleaning between patients which has significantly reduced patient flow. Suspected cancer referrals generally require laryngeal scoping and other diagnostics to exclude diagnosis and resources have been focused on these areas.

Like other surgical activity, return to pre-COVID levels have been variable. CVUHB / BCUHB have the highest activity levels at 58% compared to pre-COVID, while SB have the lowest at 22%

Ophthalmology

Prior to the pandemic, there were historical performance issues throughout Wales. Health boards including Cwm Taf Morgannwg, Betsi Cadwaladr and Hywel Dda were all struggling to perform against the Eye Care Measures. This poor performance was in part, due to the lack of utilisation of optometric services and the reliance on hospital eye services

Cardiff and Vale developed new technologies such 'Open Eyes' – an electronic patient record management system that allows clinicians and managers access to real time business intelligence to better manage their services. As a result, funding has been provided for the system to be rolled out to all health boards. It is expected to significantly improve the way in which care is delivered. They have also implemented See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) to small cohorts of patients.

Swansea Bay University Health Board have undertaken extensive work on long waiting lists ensuring that all records are clinically validated and have commenced a diabetic referral refinement programme. This work has reduced the number of patients who require hospital

interventions, allowing for hospital capacity to be used elsewhere. The pilot has the potential to be used by other health boards.

Health boards who have utilised Ophthalmic Diagnostic Treatment Centres (ODTCs) to manage conditions such as glaucoma have been able to reduce waiting times and backlogs of patients.

The variation in waiting times for ophthalmology has been impacted by COVID – 19. At the start of the pandemic, all routine activity was halted. Eye care services were only available for patients who were at risk of sight loss and irreversible harm. This caused the backlog of patients waiting for treatment to increase. As health boards began to reinstate services, activity however is lower than desired due to COVID restrictions.

The Welsh Government has facilitated clinically led task and finish groups, involving all key stakeholders from all over Wales, to review and refine key pathways including utilising all available professionals such as Optometrists. This once for Wales approach to care ensures that all patients receiving treatment have equitable access to the relevant services, reducing inequalities in health care and embedding sustainable, best practice models of care into Ophthalmology. To facilitate this work and other areas of eye care services the Welsh Government has released funding for services to implement new innovative and sustainable ways of working.

In addition, the Royal College of Ophthalmology have undertaken a review of eye care services in Wales. The review concluded with ten key recommendations that the Welsh Government will work with the Welsh Ophthalmic Planned Care Board to review the recommendations and develop an action plan to take them forward.

Dermatology

The national review of dermatology services identified variation at the front of the pathway due to various teledermatology models, which are limited to expansion due to infrastructure, workforce and technology. A national programme of work is underway to establish a remote all wales pathway whilst organisations are managing those issues which will allow for expansion once the model has developed. Not all treatments (sub speciality conditions) within dermatology are offered at all health boards for example Biologics, Iontophoresis - due to several factors, including the recruitment of staff with expertise / interest in a treatment; the availability of facilities to perform specialist procedures; the collaboration with other specialist teams; and the number of cases to support the safe introduction of a service. The transition from a consultant delivered to a consultant led service model impacts on those waiting, and an integrated workforce plan is needed to use alternative practitioners and clinicians rather than the traditional dermatology consultant, whilst some organisations have embraced this model others are limited due to resource retention.

Urology

The Welsh Urology board have identified a significant number of benign conditions, which are waiting, particularly at the follow up pathway. Of the follow up cohort 30% being prostate cancer – currently only two health boards in Wales offer a supported self-management pathway. This approach has demonstrated to release approximately 60% of the prostate follow up capacity, a national programme of work is underway to implement an all Wales model. There are limited referral and follow up guidelines for Urology, following an audit of these services, the supporting and community services offered to support urology teams vary and with guidelines in place this will standardise those pathways to reduce the variation.