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16 December 2022

Dear Russell,

Follow up questions after general scrutiny session on 6 October 2022

We are writing in response to your letter dated 25 October 2022, following the general scrutiny session held on 6 October.

Please find attached at annex 1 responses to the questions raised.

Please do not hesitate to contact us, should you require further clarification.

Regards

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Annex 1

1. In your Programme for transforming planned care, you make a commitment to form a Diagnostics Board to bring together key partners from across the NHS and social services. Please can you provide an update on the work of the National Diagnostics Board, including further details on the diagnostics approach for Wales and how the Board is working with national programmes such as Imaging, Pathology and Endoscopy.
Response The National Diagnostic Board for Wales has been established to provide leadership for the prioritisation of diagnostics services as set out in *Our Plan for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales* published in April 2022. The Board has been meeting bimonthly since May 2022 and Senior Responsible Owners of the relevant national programmes are members of the board, this has recently changed to bi-monthly. The Board is currently finalising a diagnostics strategy for the long-term sustainability of services. This strategy will incorporate measures to increase capacity, such as Regional Diagnostic Hubs. It also recognises the integral need for workforce. As such, the Board has commissioned Health Education and Improvement Wales to develop an action plan to address diagnostics workforce challenges in Wales.
2. In our recent report, Waiting well? The impact of the waiting times backlog, we recommended that the Welsh Government should support health boards to routinely publish waiting times data disaggregated by specialty and hospital (recommendation 17). In your response, you accepted our recommendation, explaining that it was an action in your Programme for transforming planned care. Please provide us with an update on the implementation of recommendation 17.
Response Working with the 111 national website, we have started to publish waiting times data disaggregated by specialty and health board. This is available to the public at https://111.wales.nhs.uk/PlannedCare/Default.aspx We have developed this site based upon the evaluation of the English and Scottish publications and added additional features such as visual representation of the waits through graphs, the inclusion of two data points the median (middle point) and the 90th percental to present a realistic view of the waiting times. Phase two of this resource will follow in April 2023 and will include information and videos to support people to keep well whilst they are waiting.
3. Does the Welsh Government monitor/publish data on new patient pathways waiting for first outpatient appointment per month vs patient pathways that receive their first outpatient appointment per month (i.e. closed pathways), as clearing the backlog depends on the difference between these rates. What analysis has the Welsh Government done with NHS Wales on how much capacity needs to increase to clear the backlog
Response Welsh Government publish both Open and Closed pathway information via the StatsWales website and can be found at Referral to treatment (gov.wales). The closed pathway information includes all reasons for removal (i.e. attendance at an appointment, no longer requires treatment, did not attend etc.) and relates to patients at all stages of their care, this information cannot currently be

disaggregated. New Outpatient attendance activity informs on the pathway volumes that have been closed per month.

Management information (not published data) obtained weekly by health boards is being used by the planned care innovation and recovery team, to provide more detailed analysis to understand health board demand and capacity challenges. This is being used to provide internal improvement trajectories for each health board to address their delivery to meet the nationally agreed measures, to clear the backlog.

4. Could you share the data guidance on what's included in each treatment function as reported on StatsWales, and confirm whether this is consistent across all health boards i.e. what general surgery covers, what's included in diagnostic services etc. How does Welsh Government ensure consistency in how the data is recorded by different health boards

Response

Digital Health and Care Wales (DHCW) are responsible for the assurance and development of all NHS Wales data standards which ensure that data submitted on a national basis is consistent. DHCW maintain the NHS Wales Data Dictionary which is a guide to the definitions, collection and interpretation of nationally agreed data standards adopted by the NHS in Wales. They are also responsible for issuing Data Standards Change Notices (DSCNs) which are the mandates to the NHS and partner organisations and system suppliers to ensure that they are able to support any new or changed data standards.

Data submitted by health boards to DHCW each month undergoes consistency and validation checks before being sent to colleagues in the Knowledge and Analytical Services (KAS) within Welsh Government ahead of publication.

Work is currently being undertaken by DHCW, Welsh Government and health board colleagues to review particular treatment function codes to ascertain whether it is possible to provide data at a more granular level.

5. Can you provide clarification on how this data is being reported for NHS Wales? For example, could you provide an explanation of the data on the number of patient pathways waiting by stage of pathway and what is being measured i.e. what each of the following covers: those waiting for diagnostic or therapeutic interventions, those waiting for a diagnostic or Allied Health Professional (AHP) test, intervention or result and those waiting for a follow up outpatient appointment or decision.

Response

Referral to Treatment (RTT) Referral to treatment (gov.wales). waiting times in Wales are made up of a four stage of pathway. The stage of pathway is used to identify the point at which a patient is currently waiting in respect of their overall diagnosis and treatment.

- **Stage of pathway 1** - Waiting for a new outpatient appointment.
- **Stage of pathway 2** – Waiting for a diagnostic or Allied Health Professional (AHP) test, intervention or result.

- **Stage of pathway 3** – Waiting for a follow-up outpatient appointment or waiting for a decision following:
    - An outpatient appointment.
    - A diagnostic or AHP intervention result.
    - Or where the patient is waiting, and the stage is uncertain/unknown.

- **Stage of pathway 4** - Waiting for an admitted diagnostic or therapeutic intervention (i.e., treatment) only.

Whilst in the majority of patient pathways patients move from one stage to the next in sequence, this is not always the case. For example, a GP may refer a patient directly for a diagnostic procedure, therefore the patient will start their pathway at stage 2. Changes in clinical practice may introduce more variation over time. Therefore, the stages are not intended to be in chronological order only, as patients may commence their pathway at any one of the stages listed above.

There is a separate data collection and publication of Diagnostic and Therapy Services Waiting Times to report on waits which are outside of a RTT pathway. These can be direct primary care bookings or part of a follow-up requirement; each have their separate targets 8 weeks for diagnostics and 14 weeks for therapy AHP waits.

6. During the session you referred to recent and planned summits, including one focusing on orthopaedics and one on cancer. Could you provide further information about when the summits took place, who attended, what was discussed and the outcomes. It would also be helpful if you could indicate whether there's a public note of the meetings.

Response

There have been four Ministerial summits held, the first was orthopaedics in August, followed by cancer in October, urgent and emergency care and ophthalmology in November and an ENT summit will be held in December.

Attendance at these summits has included Chief Executives, Chief Operating Officers, Directors of Planning, Clinical Leads and Speciality Divisional Managers.

The following actions were agreed following the cancer summit:

The following commitments have been agreed and progress against these will be monitored closely:

- Health boards to reduce the number of people waiting over 62 days for their treatment to start in line with agreed trajectories.
- Health boards to plan to achieve 70% performance by the end of the financial year.
- Where possible health boards will implement straight to test pathways and establish one stop diagnostic clinics. This will reduce the need for outpatient clinics and reduce the length of time in the diagnostic pathways.
- Implement the national optimal pathways, this will aid in streamlining pathways with a particular focus on the front end of the pathway.
- Health boards to plan their cancer workforce to meet forecast demand, specifically clinical and medical oncology, cancer nurse specialists, medical physics and therapeutic radiographers.
- Health boards to continue to develop their business intelligence to improve their grip and control over services
- Health boards to maintain good communication and support services for all patients but in particular those waiting over 62 days. The Wales Cancer Alliance agreed to support health boards with this
- The Wales Cancer Network and the Planned Care Improvement and Recovery team to share good practice examples across all health boards and facilitate this learning.
- Health boards to work together on a regional and national basis to support the workforce shortages and capacity gaps at a local level.

- The Planned Care Improvement and Recovery team to lead on developing regional solutions and co-ordinating national initiatives.
- The Wales Cancer Network to produce a cancer services action plan.

Following the orthopaedic summit in August, the following has happened:

- Health boards have developed action plans to implement the GIRFT (Getting it Right First Time) proposals and the national pathways. The Planned Care Improvement and Recovery Team are following these up with health boards and making sure these actions are implemented.
- The Deputy Chief Medical Officer wrote to health boards to outline the position with regards to long waiting patients and that those waiting over 104 weeks should be placed in the same category as urgent patients when booking appointments.
- Progress has been seen in the number of open pathways waiting over 104 weeks, with the number at the end of September showing 16,554, the lowest it has been since December 2021. We expect to see further progress as health boards continue to implement and increase treat in turn rates, with the longest waiting patients being seen.
- For orthopaedics, latest management data shows that at an all-Wales level, treat-in-turn rate was 44% for outpatients and 33% for treatment - this compares to 26% for other specialities. An improvement since the summit.
- Activity levels, whilst not yet at levels I would like to see them at, have risen throughout the year from 52% in April to 69% in September. Day case activity levels have risen from 51% to 72% whilst inpatient activity levels have risen from 52% to 66%.

Considerable effort is being made to increase and maintain orthopaedic elective capacity over the winter months and this includes:

- Additional capacity has been made available at Prince Philip Hospital, through the installation of two new day theatres that should provide up to 4,600 additional procedures per year. The new theatres are scheduled to start working at the beginning of December.
- Swansea Bay UHB is rearranging orthopaedic services within the health board so that the majority of routine orthopaedics will be carried out at Neath Port Talbot Hospital, leaving the more complex work for Morriston. As part of the plan to increase orthopaedic activity, additional physiotherapy resource commenced at Neath Port Talbot clinics in November. A dedicated 10 bedded elective orthopaedic ward (Clydach ward) became operational in Morriston site during November to provide capacity for complex orthopaedic cases.
- Cwm Taf Morgannwg are centralising inpatient orthopaedic work at the Royal Glamorgan Hospital, leaving Prince Charles site for more daycase activity.
- Cardiff and Vale has the Cardiff and Vale Orthopaedic Centre (CAVOC), which offers protected activity.
- In Aneurin Bevan UHB, the health board is looking at the way to make best use of the hospital sites, with services delivered at Ysbyty Ystrad Fawr, Royal Gwent, Nevill Hall and St Woolos. This includes working regionally with Cardiff and Vale and Cwm Taf Morgannwg UHBs.
- In North Wales, the health board is developing proposals to undertake additional orthopaedic activity at one of their sites whilst they continue work on designing the diagnostic and treatment hubs for the region.

Attached is the final report following the cancer summit, this has been widely circulated through the Wales Cancer Network.

Cancer Summit
report 12 October 20

7. There are still concerns among stakeholders about the scrutiny and accountability arrangements for Regional Partnership Boards. What actions are planned to strengthen these arrangements and ensure that RPBs are delivering their objectives

Response

Regional Partnership Boards (RPB) are not a legal entity in their own right. Proposals as part of the Rebalancing Care and Support White Paper to create corporate legal status for RPBs was strongly rejected by statutory partners, although other key stakeholders such as providers and the third sector were in favour. Ministers agreed that in line with consultation responses RPBs would not at this stage be moved to having corporate legal status, but instead current arrangements would be strengthened and clarified.

Through the Governance and Scrutiny Task and Finish Group under the Rebalancing Care and Support Programme work had been undertaken with a range of internal and external stakeholders to review and make recommendations to strengthen scrutiny and accountability arrangements relating to RPBs.

The recommended improvements will result in changes being made to the Part 9 Statutory guidance which sets out the expectations and responsibilities of RPBs. It is intended that the amended Part 9 guidance will be out for consultation in April 2023.

The recommended areas for strengthening fall into 3 main categories.

1 **– Clarification of duty to co-operate and accountable bodies**

Given RPBs are not a legal entity in their own right they cannot have legal duties placed on them and therefore cannot be held legally to account. The duty to co-operate therefore firmly sits on Local Authorities (LAs) and Local Health Boards (LHBs). Work has been completed to ensure the revised Part 9 guidance more clearly articulates where the duty to co-operate lies and the role and function of the RPB in supporting Local Authorities and Health Boards to exercise their legal duty to co-operate. Given the legal duty to co-operate and the specific membership of the RPBs they should be viewed as an extension to these statutory bodies rather than a separate stand-alone organisation.

2 – Effective Scrutiny arrangements

The task and finish group has explored effective scrutiny from a number of different aspects;

- **LA and LHB scrutiny arrangements in relation to exercising their own duty to co-operate** – *New guidance will include an expectation that statutory partners ensure their own internal scrutiny processes consider how well they are meeting their own duty to co-operate*
- **Scrutiny of RPBs as an effective vehicle to support LAs and LHBs in exercising their duty to co-operate** – *New guidance will include the invitation for LAs and LHBs to consider developing regional scrutiny arrangements with delegated responsibilities to provide a more streamlined scrutiny process for regional working.*

- **RPB Scrutiny of the effectiveness of their own planning and delivery arrangements** – *new guidance will include the requirement for RPBs to undertake regular self-assessment and improvement activity. Work is also underway to agree the role CIW and HIW can play in triangulating evidence to support self-assessment processes*

3 – Balancing accountability across Local Authorities and Local Health Boards

Although the duty to co-operate is placed on Local Authorities and Local Health Boards equally there is a perceived imbalance whereby in Local Authorities the Director of Social Services is named as the accountable Executive Officer but there is currently no equivalent in Local Health Boards. Work is underway to build on existing governance and legislative arrangements to place a requirement on Local Health Boards to identify a named Executive Director to be the accountable officer on behalf of the Board for delivering against their duty to co-operate. Existing accountability arrangements at a Welsh Government level include;

- quarterly meetings between Ministers and RPB Chairs and Leads,
- quarterly reporting on spend of the Regional Integration Fund
- Regular Relationship Manager meetings between RPB Leads/teams and Welsh Government Officials
- Submission of annual reports to Ministers on progress more generally towards delivery of their Area Plans.

8. In your written evidence you outline steps taken by the Welsh Government to improve recruitment to public appointments. What assessment has been made of whether these steps have led to the desired outcomes, for example increased number of applications and greater diversity among applicants for public appointments in health and social care.

Response

A pilot initiative incorporating the training and development programmes were completed at the end of October. An interim assessment of delivery and ultimately impact is underway. The Public Bodies Unit intend to roll out the programmes again in 2023-24 taking the learning from year one. The effectiveness of interventions will be fully evaluated along with consideration of future support and awareness. I will work closely with the Minister for Social Justice who has policy responsibility for overall public appointments in Wales and will raise how the findings from these and future initiatives can be best shared with the Committee in due course.

In 2021 – 2022, women secured 55.3% of regulated health and social care appointments (excluding reappointments) versus 56.4% for all regulated appointments (health, social care and public bodies), 21.1% were disabled people verses 16.4% for all appointments, and 10.5% of appointments in health and social care were secured by Black, Asian and Minority Ethnic people versus 10.9% for all appointments.

9. What are the emerging conclusions from the NHS Wales Public Appointees Task and Finish Group, and what actions will the Welsh Government be taking to implement any recommendations made.

Response

Whilst I am still awaiting the report of the NHS Wales Public Appointees Task and Finish Group the group has concluded that whilst the NHS recovers from COVID 19 it is even more important to ensure roles appear attractive to those who may be considering a public appointment. In response they have developed model role profiles for Chairs, Vice-Chairs and Independent Members of NHS organisations in

Wales to clarify the expectations placed upon these post holders and ensure they have the required skills and experience to undertake their roles. The Group has also developed a model candidate pack which introduces the important role candidates will perform, an introduction to the NHS organisation they are applying to and the fact that we are seeking applications from people who will bring their lived experience to NHS Boards. NHS organisations are already using the packs, ensuring they are published in a much more attractive format which it is hoped will also increase interest in the roles.

One of the reasons for establishing the Group related to reports of the high demands placed on the time of Independent Members in the NHS when compared to other sectors. This has been a long-standing issue and anecdotally it is thought this may be impacting on the ability to attract people into some of the harder to fill roles. The intention is to identify sustainable solutions, working with NHS organisations to mitigate against this in future and I look forward to receiving the advice of the Group and Officials in the coming weeks.

10. During the session you agreed to provide further information about what constitutes good practice in respect of follow up appointments for people who have had cataract appointments—for example to prevent scar tissue forming—and whether this is being consistently applied across Wales.

Response

In Wales, all routine follow-up appointments for people who have had cataract surgery take place in primary and community care by Eye Health Examination Wales (EHEW)-accredited optometrists. This greatly increases the availability and accessibility of these appointments. In August 2022 there were 770 EHEW accredited practitioners offering EHEW at 312 practices with coverage in all Cluster areas across Wales.

Following cataract surgery, patients are given clear written instructions from the Hospital Eye Service (HES) regarding the timing of their visit to their referring optometrist for continuity of care and postoperative assessment, and the provision of spectacles as required. For most patients this will be four to six weeks after surgery.

Patients will be seen in an optometric practice for a sight test (either General Ophthalmic Services (GOS) or private sight test depending upon eligibility), followed by an in-depth assessment of the anterior segment of the eye to assess the cataract operation wound site, anterior chamber and intra ocular lens (this is undertaken through an EHEW band 3 assessment).

If, during the eye health examination, unexpected symptoms or post operative signs are found that require further investigation, or if referral back to ophthalmology HES may be indicated, further investigations will take place at the optometry practice (through EHEW band 2 assessment) to either prevent or further inform that referral back to the hospital eye service.

In all cases, whether an EHEW Band 2 or Band 3 postoperative assessment is performed, a report is returned by the examining optometrist to the ophthalmology unit where surgery took place and the patient's GP detailing the results of the examination.

This process and required clinical examinations, are clearly laid out in the optometry EHEW clinical manual and is, therefore, consistently applied across all health boards. This will continue to be the case following the introduction of new

contracted terms of service for optometry (summer 2023), when EHEW accreditation will become the new minimum standard for providing primary eye care services in Wales. All current EHEW services are included in the new contract – including post-operative cataract follow-up.

11. Further to our correspondence in July and September, could you provide us with an update on the work that has taken place over the summer to progress the women and girls' health action plan, and when you anticipate the plan will be published.

Response

A survey into women's health, launched by Judith Paget, NHS Chief Executive, on 5 August attracted close to 4,000 individual responses from women and girls aged 16 to 85 and above. Their responses have provided incredibly rich detail on the issues and concerns affecting women and their health in Wales which will enable the NHS to identify the key themes and issues that the service must target in the development of a Women's Health Plan.

The NHS Collaborative have produced ***A Discovery Report: Foundations for a Women's Health Plan*****.** This report is the first phase of the development of a 10-year Women and Girls' Health Plan for Wales and presents the state of the nation for women's health in Wales, combining an evidence review of women's health with the voices of women and girls in Wales. The Report provides a framework for next steps and includes priority actions for improvements. The Report is due to be published by NHS Wales in December.

12. What plans are in place to ensure that ensure that hospital staffing levels are safe

Response

The Workforce Strategy published by Health Education and Improvement Wales and Social Care Wales sets out our long-term vision and actions for the health and social care workforce. We are also developing a shorter-term plan to help deal with current pressures on our workforce. This year we are investing record levels in training and professional education, £262m, including more training places than ever before. We are also recruiting international nurses to close the vacancy gap in the short and medium term.

13. What is being done to develop interim care services and strengthen community services

Response

The Regional Investment Fund (RIF) is a key lever to drive change and transformation across the health and social care system and in doing so will directly support implementation of several key pieces of policy and legislation. The RIF enables delivery of new national models of integrated care in six priority areas including services to help people stay well at home, prevent admission to hospital and support swift and safe discharge from hospital. The resource predominantly funds staff posts in those areas or contracts/grants to third sector providers to deliver a community response.

The six national models of integrated care are:

- Community based care – prevention and community coordination
- Community based care – complex care closer to home
- Promoting good emotional health and well-being (Nyth / Nest)
- Supporting families to stay together safely, and therapeutic support for care experienced children

- Home from hospital services
- Accommodation based solutions

The population groups targeted by this RIF are:

- Older people including people with dementia
- Children and young people with complex needs
- Carers and young carers
- People with learning disabilities, neurodiverse and neurodevelopmental conditions
- People with emotional health and mental well-being needs

In this first year Welsh Government officials are working with Regional Partnership Boards on developing a set of robust plans which create a strong foundation for the next five years whilst considering where some enhancement or acceleration of those services or projects may provide additional capacity and resilience this winter.

Primary care plays an important role here. The Primary Care Model for Wales (PCMW) is the transformational model for community-based services, which is a place-based approach to sustainable and accessible local health and well-being care. The PCMW aspires to provide integrated care for people with multiple care needs. Effective working means GPs and advanced practitioners have more time to care for people with multiple needs, who are often elderly with more than one illness, at home or in the community.

People with both health and social care needs can be supported by uninterrupted care from community resource teams and other integrated local health and care teams. Welfare, housing and employment problems can be better managed through a whole system, multiprofessional approach. Coordinated teams are also well placed to care for acutely ill people who can be treated at home and at community centres. These community teams can also facilitate a faster discharge from hospital. This seamless model offers a more proactive and preventative approach to care, and when people are treated earlier, they respond better to advice and support for self-care, which results in better outcomes and experiences for people and carers.

Implementation of the PCMW and ACD programme during 2022-23 marks a new stage in the development of clusters across Wales, offering the opportunity for primary care and wider system colleagues to review progress, share good practice and plan future development within the context of a national common framework.

14. What steps are being taken to improve ambulance performance

Response

An active national ambulance improvement plan is in place and delivering a wide range of actions. The plan incorporates actions delivered by WAST, joint actions between WAST and Health Boards and Health Board specific actions. The intended outcomes of the plan focus on better management of 999 patient demand in the community, increased ambulance capacity and reducing ambulance patient handover delays.

Key actions are as follows:

- **Management of 999 patients in the community**: additional Welsh Government funding (£250,000) has been provided to implement new triage and video consultation software. Around 4,000 patients a month are now

safely discharged over the telephone without the need for an ambulance response;

- **Recruitment** – Welsh Government has allocated an additional £3m to WAST for an extra 100 ambulance clinicians, who are in training and will all be in place to respond to patients from 23 January 2023. This is in addition to 263 frontline staff recruited over the previous two years.
- **Ambulance patient handover improvement plans** – each health board and acute hospital site has a plan;
- **Ambulance workforce efficiencies** to unlock ambulance capacity – new staff rosters which better align available capacity to demand will be in place by the end of November; with an equivalent efficiency of around 72 whole time equivalent (WTE) staff; an attendance management programme to reduce sickness absence;
- Improvement in the availability and accessibility of alternative pathways to direct demand away from busy emergency departments and improve ambulance patient handover; and
- Health board actions to improve patient flow through hospital systems.

On 28 November, the Minister held a national summit attended by over 40 representatives from across NHS Wales, where she reiterated her expectations that health boards must work together, and with the Welsh ambulance service and partners to ensure patients within their communities receive safe and timely access to assessment and treatment and ensuring ambulance crews are available to respond when needed, through a whole system approach.

We are investing £25m annually to support local, regional and national delivery against the Six Goals for Urgent and Emergency Care , our five-year strategy published earlier this year to drive a whole-system transformation of access to urgent and emergency care.

15. In your view, what are the main challenges hindering the integration of health and social care in Wales.

Response

International evidence tells us that integration of health and social care is a long-term journey and will require an effective combination of structural, system, process, cultural and behavioural change to be realised.

To date some notable progress has been made in Wales including:

- the establishment of 7 Regional Partnership Boards (RPBs) which have had a significant improvement on promoting and improving relationships across health, social care, the third sector, housing and providers – this has provided a robust foundation to support joined up responses during the Covid 19 response and winter planning
- RPBs have also made significant progress in driving forward citizen and carer engagement and co-production and putting it as the heart for service planning, design and delivery
- Significant WG investment through RPBs (ICF, TF and now the RIF) has generated some notable integrated services/models of care have been established and are now being scaled up across Wales i.e. preventative community coordination, Discharge to Recover then Assess, Integrated Autism Services
- Joint strategic commissioning, planning and market shaping work
- Co-ordinating an integrated approach to Winter Planning and response
- Co-ordinating and securing integrated health and social care responses to alleviating system pressure during covid 19 and aligning RIF investment

- Developing a 10-year strategic capital investment plan for health and social care (for publication alongside their Area Plan in April 2023)
- Co-ordinating capital investments under the new £50m a year Integration and Rebalancing Capital Fund and the £60m a year Housing with Care Fund.
- Leading work to meet the programme for government commitment in relation to developing 50 integrated health and social care hubs.

'Improving quality, efficiency, and population health have all been aims of integration, but are rooted in complex problems heavily constrained by broader government policies that influence the distribution of resources across health and social care, and ability for people to lead independent, healthy lives.' (Nuffield Trust 2021). To address this we need to ensure our approach to creating an integrated health and care system in Wales addresses all of the following aspects:

- The need to create and communicate a clear, shared vision and leadership model for an integrated system
- Facilitate the necessary structural, legislative and strategic transformation in order to address barriers to integration and create opportunities for greater organisational collaboration and integration
- Support operational transformation ensuring we create an integrated workforce, the right skills, culture and conditions to grow more collaborative and integrated ways of delivering services across organisational boundaries.

In order to mainstream integrated ways of working Local Authorities and Health Boards will need to invest core resources in integrated services and reach beyond the resources allocated to them by Welsh Government for management via RPBs. They will also need to bring their wider organisational capacity into supporting integrated planning and delivery.

New models of leadership will also be required to create the right values, behaviours and culture to enable integrated working across sectors and ensure it becomes fully embedded within the health and social care system.
In addition to this further work is needed within Welsh Government to ensure a coherent and aligned policy context that will secure the ongoing shift away from medical to social, from acute to community, from intervention to prevention and from single agency to partnership. Integration must be firmly embedded across the wider health and social care policy context. There are currently a range of separate but inter-connected programmes of work which complement each other in terms of direction and intention but have created a complex landscape for delivery partners to navigate. The development of a health and Social care outcome Framework should help to provide joint strategic direction to jointly improve the population of the citizens of Wales.

16. Are you confident that the actions you are taking to engage the wider population in preventing ill health, including chronic conditions such as diabetes, will be effective.

Response
We have developed a comprehensive set of actions to prevent ill health and are constantly re-evaluating these to ensure that they are effective. These actions include:

General public health improvement/promotion

Obesity and smoking are drivers of inequalities given their impact on people's life expectancy and healthy life expectancy, and people who are from the most deprived areas are more likely to be obese or to smoke than those in the least deprived. On obesity, we are committing over £13m of funding to our forthcoming Healthy Weight: Healthy Wales 2022-24 Delivery Plan to tackle obesity; with action to reduce diet and health inequalities across the population at its core. On smoking, earlier this year we published our Tobacco Control Strategy and our first two-year delivery plan for 2022-24. In recognition of the health inequalities which arise as a result of smoking, tackling inequality is noted as one of the strategy's core themes. We have reprioritised the £7.2m annual Prevention and Early Years funding from April 2022, which will be used by Directors of Public Health across all Local Health Boards to specifically support interventions in the obesity and tobacco policy areas in line with our Healthy Weight: Healthy Wales and Tobacco strategies. The £5.9m Healthy and Active Fund (HAF) available over 4 years (2019-2023) is funding 16 projects aiming to improve mental and physical health by enabling healthy and active lifestyles. Projects funded by the HAF seek to reduce inequalities in outcomes for one or more of the following groups: children and young people; people with disability or long-term illness; people who are economically inactive or who live in areas of deprivation; and older people and those around the age of retirement from work.

Healthy Weight: Healthy Wales Strategy
We invested £5m over 2021-22 to bring together internationally evidenced programmes that supported crucial changes. We acknowledge that despite this funding overweight and obesity continues to rise in Wales, as over the rest of the UK, but this investment has provided a springboard for delivery in 2022-24. The scale of the challenge has been amplified by the pandemic and we are investing over £13m across 2022-24 to support a whole systems approach to tackle it together. The plan for 2022-24 has been developed in partnership with our stakeholders and is part two of five to support the delivery of our ten-year strategy. We will continue to work with our stakeholders to demonstrate tangible and measurable change for the people of Wales. The Healthy Weight: Healthy Wales Strategy and its Delivery Plans are evidenced based. We have explored international evidence of what works in terms of halting and declining obesity rates.

All Wales Diabetes Prevention Programme (AWDPP)
The All Wales Diabetes Prevention programme is being funded through Healthy Weight: Healthy Wales until 2024. The AWDPP builds on approaches piloted in two separate primary care clusters, Afan Valley and North Ceredigion, where a brief intervention was offered to a targeted population. We have invested £1m annually into this Programme. Public Health Wales are leading the programme and recruiting at a local health board level is ongoing to establish diabetes prevention teams. The programme will initially be rolled out to 14 primary care clusters across Wales (2 per health board area; 92 GMS Practices), with additional clusters anticipated to adopt the model through alternative funding streams. To support the launch, a video outlining the AWDPP, frequently asked questions (FAQs) and the AWDPP protocol, outlining the delivery approach for the programme, were published.

Diabetes Remission Project: Even when people are diagnosed with Type 2 pre-diabetes, we still want to support them to manage their weight and where possible put the disease into remission. The Diabetes Remission Project will in the first instance be available for 150 patients across Wales to facilitate weight loss and diabetes remission and/or regression. It will enable dietitians across all seven

health boards to provide intensive support to 150 patients over a 12-month period and 100 per cent funding of the meal replacement product.

17. Are appropriate services and patient pathways in place to support people in Wales with chronic conditions such as Myalgic Encephalomyelitis (ME) and Chronic Fatigue Syndrome.

Response

We recognise that there are insufficient services and patient pathways in place to support people in Wales with chronic conditions such as Myalgic Encephalomyelitis (ME) and Chronic Fatigue Syndrome (ME/CFS). Welsh Government with Health Boards are currently considering options to address the inconsistent and inequitable access to services for people with ME/CFS, fibromyalgia, and other post viral conditions often associated with complex multi-symptom presentations.

Following the allocation of funds to support the development of Adferiad services for long COVID, Health Boards have been asked to seek opportunities to expand the access model to Adferiad services and pathways to include people with conditions such as ME/CFS.

Policy officials are linked to the work of the UK government who announced in May this year that it would develop a cross-government delivery plan on ME/CFS, to be published May 2023. Details and learning from this work will be used to support the ongoing policy development in Wales.

18. Following the update you provided on 19 October 2021, are you are able to provide any further update on the clinical case for the new Velindre Cancer Centre

Response

The health boards in southeast Wales continue to work with Velindre Cancer Centre through the Collaborative Cancer Leadership Group to develop the clinical model for non-surgical oncology across the region. This includes development of regional cancer datasets to support effective planning and prioritisation and alignment of local strategies.

The criteria for all admissions to Velindre Cancer Centre, both scheduled and unscheduled, has been revised, implemented, and audited. An acute deteriorating patient pathway has been put in place.

The Regional Acute Oncology Service (AOS) model has been agreed following a clinically led engagement process across the region. The resulting business case was also agreed by all four organisations. The funding, implementation plan and SRO are all in place and appointments are being made to AOS oncology sessions. A new regional multi-disciplinary team for ‘cancers of unknown primary’ – which are cancers with undetermined origin – is in place.

Further work is required to confirm the Velindre outreach requirements and to develop the phase two business case for acute oncology.

A service specification for a tripartite Cardiff Cancer Research Hub (CCRH) has been agreed in principle by Velindre University NHS Trust, Cardiff and Vale University Health Board, and Cardiff University. This will be supported by the agreement of joint research priorities and investment strategy. The project brief and project board terms of reference have also been approved.

Cardiff and Vale University Health Board and Velindre University NHS Trust will jointly consider the optimal configuration for haemo-oncology services including the location for systemic anti-cancer therapy delivery in future. More broadly, discussions are taking place with other health boards on potential service changes.

19. Can you provide an update on the provision of gender identity services in Wales following changes at the Tavistock Gender Identity Clinic?

Response

We are committed to improve the Gender Identity Development pathway (GIDs) and the support available for young people in Wales. We are also fully committed to ensuring that stakeholders in Wales, including young people themselves, will be engaged when we are at a point of developing a service for Wales.

WHSSC's annual commissioning intentions document has been shared with Health Boards and includes an ask for expressions of interest to host a Gender Identity Development service for Wales. In the interim, the Welsh Health Specialised Services Committee (WHSSC) continues to work closely with the Cass Review team as we currently commission the service through NHS England. As part of this work, NHS England is also planning an engagement process and Welsh patients will be included as part of that plan. This will ensure that young people are engaged in the development of any future plans.

Following the recent announcement that NHS England will cease contracting with the Tavistock and Portman service, the WHSSC is working closely with NHS England to ensure Welsh children and young people have access to the regional centres whilst the development of a clinical model for Wales is explored.

The current priority is to manage the clinical risk associated with young people on the waiting list and those already under the care of the GID service. WHSSC's representation on the NHS England Programme Board will ensure the timely involvement of Welsh stakeholders and young people in the development of future services through a nationally lead and supported engagement strategy