Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol a Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General and Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair
Public Accounts Committee
Cardiff Bay
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Our Ref: AG/MR/TLT

4 March 2015

Dear Darren

Re: Auditor General for Wales Report – NHS Waiting Times for Elective Care in Wales

I am writing in response to your letter of 28 January 2015 regarding the above report.

The Welsh Government has welcomed the report and the recommendations contained within it. We are pleased that it recognises the work already underway, including the implementation of prudent healthcare principles and the establishment of a Planned Care Programme (PCP), and how this is being used to share good and innovative practice. We recognise that there is still further work to be done to improve waiting times, and to design a system that meets the needs of an ageing population.

It is clear that there are themes running through all of the recommendations that refer to the "Rules for Managing Referral to Treatment Waiting Times" and for the need for the Welsh Government to work with health boards and trusts to deliver the required improvements in planned care across Wales. I therefore wanted to advise you that in response to the report, a review and refresh of the current "*Guide to Good Practice"* and the *"Rules for Managing Referral to Treatment Waiting Times"* will be undertaken. I believe this will provide a vehicle for ensuring a consolidated response to most, if not all, of the recommendations. I am also clear that the PCP Board, and its associated workstreams, provide a robust mechanism through which the Welsh Government can work with health boards and trusts to deliver real, sustained improvement in planned care services.

I can confirm that we will be accepting all the recommendations in the report, and I will now respond to each one in turn.

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Recommendation 1

The Welsh Government has not formally reviewed its approach to managing waiting times in light of a sustained deterioration in performance and the challenges of real terms cuts to spending on health. However, with the introduction of a new planning framework, a Planned Care Programme and a range of prudent healthcare initiatives, there are positive signs of a clearer direction for elective care in an environment of austerity. While the Welsh Government is responsible for setting the overall direction, it is for health boards to plan and deliver sustainable and appropriate waiting times. The Welsh Government should therefore work with NHS bodies to:

a) review and set out the principles, priorities and intended outcomes for elective care, within the context of the wider healthcare system: to include a fundamental review of current waiting times targets and whether they are an effective method to prioritise resources towards those most in need;
b) develop a shared understanding of demand and capacity across the NHS and develop a realistic timeframe for reducing elective waiting times and the backlog of patients in line with any changes to the targets resulting from R1(a) above; and
c) assess the costs, benefits and barriers related to adopting seven-day working across the elective care system.

On recommendation 1a, a new approach has been set out in the recently established Planned Care Programme (PCP), based on emerging prudent healthcare principles. This will provide leadership to the NHS in reviewing and reinforcing principles and priorities for elective care, depending on clinical values, better use of the integrated care system in Wales, and a system of benchmarking cost and outcomes of procedures against top performing services. Developing a better understanding of the clinical needs of patients, will inform a review into the appropriateness of individual targets.

The PCP will utilise the national focus on pathways, providing specialty specific guidelines to optimise efficiency, cost, patient experience and outcomes although the principles will still have to be owned and implemented on a local basis.

On recommendation 1b, the Integrated Medium Term Planning (IMTP) process and the specialty specific planned care programmes both require health boards and trusts to provide comprehensive evidence of their capacity and demand plans. The detail contained within the IMTP templates for 2015/16 will provide details of anticipated and actual volumes which will be monitored and performance managed at the regular monthly quality and delivery meetings that the Welsh Government has with individual health boards. This is an enhanced level of detail over planning guidance issued for the previous cycle in 2014/15. As such, IMTPs will drive accountability for delivering improved planned care services in Wales through the existing performance management arrangements.

Welsh Government has maintained its approach around the requirement to deliver waiting times targets while agreeing that the purpose of the new PCP is to develop “sustainable” services, which in this context means matching capacity and demand. In many instances, health boards will need to increase their “core” capacity (either by improved productivity or investing in new capacity) rather than investing in waiting list initiatives.

Equally importantly, health boards will develop new ways of measuring and managing capacity and demand for elective services and achieve sustainable services using prudent health care principles. These service changes will be balanced and include new ways of managing variation, co-production by means of patient activation (information and peer

support) and improve decision making and benchmarking of “value” against best in class services. In addition, we will support new approaches to patient empowerment that deliver improvements in individual wellbeing, rather than necessarily higher use of invasive treatments.

The PCP will work with the NHS to help drive and actively manage demand and capacity across the patient pathway through a process that will work on a specialty by specialty basis and this data will be reported in national specialty boards meeting on a regular basis to develop a shared understanding of demand and capacity across the NHS the necessary measures to provide balanced services.

Individual health boards, in turn, will assume responsibility for investigating the impacts of specific speciality changes including the costs of the new services.

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

Any assessment of seven day working will need to incorporate the whole health system, and cannot just be isolated to scheduled care. If we were to only explore the expansion of elective care over seven days, we are only likely to further compound the pressures on unscheduled care, as the bed capacity bottleneck in the current system would remain in the absence of ring fenced elective capacity.

Recommendation 2

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

Improving and refining the outpatient system has been identified as a major priority work programme for the Planned Care Programme (PCP). In doing so, the PCP will research and define the detail of the programme. Moving from the current traditional outpatient model to something more appropriate for modern healthcare needs will require a service that is centred around maximising the expertise of individual clinicians appropriately and optimising the use of existing and emerging technology. The PCP is developing speciality specific delivery plans, and these will be used to help drive change, piloting and implementing more efficient models of care, exploring the role of primary and community services in the delivery of this service in the future. The PCP seeks to empower patients in order that they can co-produce their own well being, as well as contributing to service change. This will lead in the longer run to less of a reliance on the traditional use of a hospital consultant, and enable patients to be seen by enhanced nurse practitioners, specialist nurses and therapists, as well as being seen by specialists in primary care, as the NHS looks to reshape the workforce to meet modern patient demands.

In order to shape the future of the NHS workforce, the Welsh Government has committed to

developing a national workforce strategy over the next year. This will be informed by health board and trust IMTPs and any other initiatives as they emerge. Where appropriate, in redesigning outpatient services, the programme will make the necessary links to the developing workforce strategy.

This process will involve patient activation, decision support tools to help patients make appropriate lifestyle choices that aid their health and well-being, as well as developing different community models and social networking.

A refreshed eHealth & Care strategy is being developed; This will promote the need to have informed citizens, patients, health and care professionals and service providers. To be "informed" will require better data provided by better digital tools. These should cover all aspects of patients and citizens experience within health and care systems.

In addition, we will revisit the longer term strategy for the management of patients on accessing and entering the secondary care health system in its entirety and the interface with primary care. The newly published primary care plan articulates the Welsh Government's strategy for better integrating healthcare across Wales. Successful implementation will be key to the development of patient pathways that address current interface challenges between community, primary and secondary care. Whilst we recognise that there are some areas of good practice in place in Wales, we are constantly looking to learn from other health systems, both in the UK and beyond.

Recommendation 3

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

A review of the way the waiting times rules are applied and interpreted will be carried out over the coming months, together with the re-launch of an enhanced suite of tools to help the NHS modernise the way they deliver services. Alongside this, the current rules will be reviewed in conjunction with a refresh of the NLIAH *'Guide to Good Practice'.*

The rules and guidelines for managing patients who cancel their appointments are clearly articulated in the "Rules for managing referral to treatment waiting times," which was last updated in September 2011. As stated in the above document, the underlying purpose of the target and associated rules is to ensure that "all patients should receive excellent care without unnecessary delay". They also highlight that in achieving this, both the NHS and patients have a responsibility in the arrangement. The NHS should deliver high quality care within the target time, and the patient should make themselves available for treatment within reasonable timescales.

The current rule in the case of patient cancellations is based on the proviso that adjustments can take place, providing the health board makes a reasonable offer of appointment in the first instance. We recognise that it is possible that the interpretation of such rules at a local level, may lead to some variable practice. To address this, in collaboration with the Delivery Unit we have a process that will assure and audit health board's compliance with the national rules and definitions. In response to the report we will review that process, with a view to enhancing the level of assurance it can provide.

Recommendation 4
Our local fieldwork has identified pockets of good and interesting practice and innovation across the NHS in Wales. The Welsh Government, through the PCP, should identify mechanisms to share interesting and good practice, in ways which enable frontline staff to share ideas and develop new approaches based on what works. This should include the use of statistical analysis to understand demand and plan capacity as set out in the 2005 NLIAH *A Guide to Good Practice*.
The Delivery Unit has continually identified and promoted good practice, specifically supporting the implementation of the focus on pathways to drive patient care, experience and efficiencies within the current systems. The PCP will build on this work and provide a greater platform for the good practice examples to be shared across NHS Wales. It is aggregating good practice into national specialty plans. These plans are considered by health board Chief Executives, and once endorsed, are then included as part of each health board's Integrated Medium Term Plan. For example, the PCP has already issued WHC(2015)003 – National Ophthalmic Implementation Plan. This collates into one document all of the existing guidance and best practice for the delivery of ophthalmic services in Wales. As part of its implementation, the PCP has established a national speciality board for ophthalmology which will support and monitor organisations delivery of the plan. This will help share and implement best practice in ophthalmic services across Wales. The next speciality for which a similar plan is being developed is orthopaedics. The PCP is supported by a reference group, which is designed to provide the PCP Board with authoritative and independent advice on service change. We will continue to encourage the use of statistical analysis by the NHS to understand and plan capacity, and this will be incorporated as part of the refresh of the *Guide to Good Practice* as well.
Recommendation 5
A significant minority of patients in our survey were unaware of what would happen to them if they cancelled, did not attend or were unavailable for appointments. The Welsh Government and health boards should work together to better communicate with patients about their responsibilities, those of the different parts of the NHS and what they should expect when they are in the elective care system.
We expect health boards to clearly communicate to patients correct information about their expected wait for appointments and treatment. As part of the refresh to the *Guide to Good Practice*, which will incorporate a refresh of the RTT guidelines, we will ensure that clear instructions are contained about informing patients of what is expected of them during the process. We will also explore with health boards through the National Service Users Experience (NSUE) Group how to improve communication between NHS and patients as a patient navigates their way through the RTT pathway. We recognise that there is scope to improve all communication between the NHS and patients. This will need to be flexible to ensure it meets the various communication needs of our population. Over the next six months, we will

engage with the NSUE to agree potential actions and develop timelines. This will also feed into the health board communication plans.

Recommendation 6

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

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

We acknowledge that publishing more information about waiting times will be of benefit to patients, and we note the above possible examples of how we could enhance our current planned care reporting to the general public. The Welsh Government's Knowledge and Analytical Services are currently examining what additional information can be published, including 95th percentile and median waits. However, care will need to be taken on what additional information is made available, as with any potential additional reported measure, we would want to be assured that it appropriately provides additional context to the planned care services actually being delivered, and is not in any way misleading to patients.

Another key consideration will be who publishes any additional information. Welsh Government made a commitment 18 months ago to publish less data centrally, with Health Boards publishing more locally. This will be an important factor in deciding what information is most helpful to inform the public of the time they will most likely have to wait.

Knowledge and Analytical Services will be publishing plans for changing the way that monthly NHS performance data is published shortly, following the consultation 'Proposals concerning the publication of official statistics'. Additional information, as detailed above, could be incorporated into the new publication.

However, we do have some immediate issues with some of the detail. With regard to publishing data on waiting times for urgent and routine cases, this information is not collected. In addition, the benefit of publishing both sets of data would not be apparent, as if a patient is referred as a routine patient, but is subsequently changed to an urgent patient, their waiting time as an urgent patient would be incorrectly shown.

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

It is recognised that publishing outpatient and direct access diagnostic waiting times would prove useful for patients.

Our initial reaction to reporting waiting times based on the administrative capture of urgency is one of concern. This is because it can, and will be misinterpreted, e.g. patients can wait a period of time as routine outpatient, re-visit their GP, get expedited and their urgency changed, this would be reported as a long waiting urgent. In a similar way, a patient may have a diagnostic whilst on a pathway and that can change their clinical priority, it does not

mean they waited a long time as an urgent patient.

Data is captured locally on closed pathways information, and in theory, it could be mandated and thereafter published for both admitted and non-admitted patients.

It is important that we carefully scope and understand all the potential implications and consequences from developing new measures. We are clear that any new measure published either locally or nationally should support the provision of a more appropriate understanding of waiting times in Wales.

Recommendation 7

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

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

The IMTP process is key to driving collaboration between organisations and making sure the IT needs of the health boards and trusts form the core of the NWIS work programme and the revised strategy.

A refresh of the eHealth and Care strategy is being developed. One of the first actions of the strategy work was to undertake an independent 'stocktake,' completed in 2014 and this is being used, along with extensive engagement, to inform the refreshed strategy. Any additional requirements to support the NHS in managing the patient pathway not already being addressed will be included in the new strategy and the implementation programme that follows it.

Recommendation 8

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

As part of the IMTP submission, health boards are required to provide a detailed breakdown of their current and future bed capacity based on their anticipated future demand levels.

We will be scrutinising the plans to assure that the assessment is accurate and that the health boards are responding by assuring capacity is in place, especially in light of any proposals to further reduce the bed base. We would expect any proposed reductions to be supported with evidence of the alternative services that were being put in place, and for

efficiency and productivity improvements that will be delivered to enable the change to the shape of the bed stock.

All health boards produced winter plans that show how they deal with pressures over the winter months. When doing this, they plan to reduce the number of elective inpatients to enable them to have sufficient capacity to deal with the expected increase in unscheduled care pressures.

Recommendation 9

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

- ensure that there are comprehensive, agreed and understood definitions of cancellations, and the reasons for them across the entire waiting time pathway to include outpatients, diagnostics, pre-surgical assessment and treatment; and
- ensure that reliable and comparable data on cancellations (and the reasons for them) is collected and used locally and nationally to scrutinise performance and target improvement activities.

Rather than collecting data on the number of cancelled operations, health boards in Wales agreed to change the data collection to cover all postponed admitted procedures. This took into account the inconvenience of having a procedure postponed at short notice has on a patient's life.

Over the last couple of years, a great deal of work has taken place with health boards to ensure there is a consistent way of measuring the number of postponed admitted procedures, and in February 2013, a DSCN was issued to health boards detailing the reporting requirements. The new data collection went live in April 2013. Although there are some problems with reporting the specific reason correctly at present due to technical issues, the broad category for cancellation is being reported. The technical issues are being investigated.

We would agree that health boards and trusts should know the cancellation reasons for outpatient, diagnostics and pre-operative assessment as part of their overall understanding of the services they deliver and to enable them to plan in the future.

In a similar manner to the RTT rules and guidelines, we will work with health boards to assure that there is a consistent understanding and application of the cancellation definitions, and to ensure they have the 'business' information they require across the patient pathway.

As you will appreciate, it would be inappropriate for me to put timescales against a number of these recommendations at present, as they require a great deal of thought and planning. You will appreciate that work is already progressing in some areas, namely work around the Planned Care Programme, and where actions can be taken quickly, we will envisage doing this.

I will write to you again with a further update once the timescales have been agreed.

Yours sincerely

Dr Andrew Goodall