Agenda – Public Accounts Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Monday, 7 November 2016
Meeting time: 13.45

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

(13.45 – 14.00 Private pre-meeting)

1 Introductions, apologies, substitutions and declarations of interest

(14.00)

2 Paper(s) to note

(14.00) (Pages 1 – 5)

Hospital Catering and Patient Nutrition: Additional information from Aneurin Bevan University Health Board (20 October 2016)

Hospital Catering and Patient Nutrition: Additional information from the Welsh Government (26 October 2016)

3 Governance Arrangements at Betsi Cadwaladr University Health Board: Progress report from the Welsh Government

(14.05–14.20) (Pages 6 – 14)

Research Briefing
PAC(5)-08-16 Paper 1

Dr Andrew Goodall – Director General/NHS Chief Executive
Simon Dean – Deputy Chief Executive NHS Wales
Albert Heaney – Director, Social Services and Integration, Welsh Government

Jo Jordan - Director of Mental Health, NHS Governance & Corporate Services, Welsh Government

4 Unscheduled Care: Progress report from the Welsh Government

(14.20-14.35) (Pages 15 - 33)

Research Briefing
PAC(5)-06-16 Paper 2

Dr Andrew Goodall - Director General/NHS Chief Executive
Simon Dean - Deputy Chief Executive NHS Wales
Albert Heaney - Director, Social Services and Integration, Welsh Government
Jo Jordan - Director of Mental Health, NHS Governance & Corporate Services, Welsh Government

5 National Framework for Continuing NHS Healthcare: Progress report from the Welsh Government

(14.35-14.50) (Pages 34 - 51)

Research Briefing
PAC(5)-08-16 Paper 3

Dr Andrew Goodall - Director General/NHS Chief Executive
Simon Dean - Deputy Chief Executive NHS Wales
Albert Heaney - Director, Social Services and Integration, Welsh Government
Jo Jordan - Director of Mental Health, NHS Governance & Corporate Services, Welsh Government

6 Review of the impact of Private Practice on NHS Provision and Orthopaedic Services

(14.50 - 15:05) (Pages 52 - 180)

Research Briefing - Review of the impact of Private Practice on NHS Provision

PAC(5)-08-16 Paper 4 – Auditor General for Wales Report – Review of the impact of Private Practice on NHS Provision
Research Briefing – Orthopaedic Services
PAC(5)-08-016 Paper 5 – Auditor General for Wales Report – Orthopaedic Services
PAC(5)-08-16 Paper 6 – Welsh Government Response to the Auditor General for Wales' Reports

Dr Andrew Goodall – Director General/NHS Chief Executive
Simon Dean – Deputy Chief Executive NHS Wales
Albert Heaney – Director, Social Services and Integration, Welsh Government
Jo Jordan – Director of Mental Health, NHS Governance & Corporate Services, Welsh Government

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

(15.05)

Items 8 and 10

8 Consideration of progress reports on health issues

(15.05-15.20)

(Break 15.20 - 15.30)

9 Valedictory session: Sir Derek Jones, Permanent Secretary, Welsh Government

(15.30 - 16.45) (Pages 181 - 194)

Research Briefing

Sir Derek Jones - Permanent Secretary, Welsh Government

10 Valedictory session: Consideration of evidence received

(16.45–17.00)

Concise Minutes - Public Accounts Committee

Meeting Venue:

Committee Room 3 - Senedd

Meeting date: Monday, 31 October 2016

Meeting time: 14.00 - 15.00

Attendance

Category	Names
Assembly Members:	Nick Ramsay AM (Chair) Rhun ap Iorwerth AM Mohammad Asghar (Oscar) AM Neil Hamilton AM Mike Hedges AM Rhianon Passmore AM Lee Waters AM
Wales Audit Office:	Huw Vaughan Thomas Matthew Mortlock
Committee Staff:	Fay Buckle (Clerk) Meriel Singleton (Second Clerk) Claire Griffiths (Deputy Clerk) Joanest Varney-Jackson (Legal Adviser) Jonathan Baxter (Researcher) Martin Jennings (Researcher) Gregg Jones (Researcher) Rhayna Mann (Communications Officer)

1 Introductions, apologies, substitutions and declarations of interest

1.1 The Chair welcomed Members of the Committee.

1.2 There were no apologies.

2 Paper(s) to note

2.1 The papers were noted.

2.2 The Committee agreed:

- NHS Wales Health Board's Governance: Additional information from Healthcare Inspectorate Wales – to ask HIW for a further update on voluntary lay reviewers in summer 2017; and
- Scrutiny of Accounts: Additional information from Careers Wales – to seek further clarification as to the rationale as to why all the previous local authority pension schemes have not been merged into one.

2.1 NHS Wales Health Board's Governance: Additional information from Healthcare Inspectorate Wales (10 October 2016)

2.2 Hospital Catering and Patient Nutrition: Letter from Mike Hedges AM, Chair of Petitions Committee (17 October 2016)

2.3 Scrutiny of Accounts: Additional information from the Welsh Government (17 October 2016)

2.4 Scrutiny of Accounts: Additional information from Careers Wales (19 October 2016)

2.5 NHS Wales Health Board's Governance: Additional information from the Welsh Government (21 October 2016)

3 Rail Services: Auditor General for Wales report

3.1 The Committee agreed that as the Economy, Infrastructure and Skills (EIS) Committee are scheduled to undertake an inquiry into rail services, Public Accounts Committee would not undertake an inquiry. Members agreed that the Chair would write to the Chair of EIS Committee requesting that issues highlighted in the discussion be included in their inquiry.

4 Coastal flood and erosion risk management in Wales: Correspondence

4.1 The Committee agreed to undertake a short inquiry into this issue specifically looking at strategic overview.

5 Housing Associations: Scoping paper on possible inquiry

5.1 The Members considered and discussed the scoping paper regarding a possible inquiry into housing associations.
5.2 Members agreed to undertake an inquiry subject to inclusion of additional terms of reference.

6 Implications for Wales of Britain exiting the European Union

6.1 The Members considered and discussed the scoping paper regarding a possible inquiry into implications for Wales of Britain leaving the European Union.
6.2 Members asked the Clerking Team to revise the paper and bring back to Committee for further consideration.

Public Accounts Committee

PAC(5)-08-16 PTN1

7 November 2016

Hospital Catering and Patient Nutrition: Additional information submitted from Aneurin Bevan University Health Board (ABUHB)

During the evidence session on 17 October, the issue of the absence of a Halal menu at Royal Gwent Hospital was raised. ABUHB confirm that such a menu is always offered and an example is attached.

The issue of patients who are diabetic being informed to bring in their own meals was also raised. ABUHB advise that this is totally against their processes as they do not want to compromise food hygiene regulations by encouraging this practice. Diabetic menus are adaptive ones and ABUHB are not unique in not having a diabetic menu.

The standard menu is designed to offer high energy choices and 'healthier' options for patients with diabetes, obesity, heart disease. The healthier options on our menu meet the national criteria for total fat, saturated fat, sugar and salt and are coded accordingly.

ABUHB appreciate that Members may have garnered anecdotal comments via Facebook rather than quote genuine actual complaints submitted. One such comment referred to a television programme Nevill Hall Hospital took part in featuring celebrity chefs including James Martin. Whilst he was critical of catering services in several English Hospitals – he was extremely generous in his praise for the organisation and service quality at our site. His only complaint which became a bit of a crusade was about the absence of Welsh lamb on our menus. (This is down to affordability).

However ABUHB always welcome feedback and suggestions on how they can improve their catering services to the public. They will shortly be undertaking a large scale review of their patient menus and as part of that seek the views of patients, carers and appropriate staff.

Finally, ABUHB would like to invite the Committee Members to visit one of our hospitals to see hospital catering at the 'sharp end' and follow a meal from production to the patient.

Aneurin Bevan University Health Board

20 October 2016

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Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

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

Llywodraeth Cymru
Welsh Government

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

Ein Cyf/Our Ref:MS/JM

26 October 2016

Dear Mr Ramsay,

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

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

'… the Committee would be appreciative to seek clarification from the Welsh Government on who the All Wales Hospital Menu Framework Group reports to.'

Health organisations report on nutrition to Welsh Government through the compliance with health care standards 2.5 and the supporting guidance. The All Wales Menu Framework Group provides briefings to Welsh Government Public Health Division to update them on progress made on work such as the development of chefs and recipes and the development of training for caterers. Future reporting is being reviewed as the All Wales Menu Framework Group works more closely with the Nutrition and Catering Group.

Following the discussion about the quality of food in hospitals, the Chief Executive of Cwm Taf Health Board has agreed to provide a 'tasting experience' of hospital food for members of the Public Accounts Committee at a time that is convenient to the members.

Yours sincerely

Andrew Goodall

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

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Welsh Government

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

Our Ref: AG/KH

17 October 2016

Dear Mr Ramsay

Public Accounts Committee – Update on Governance Issues at BCUHB & wider issues emanating from the inquiry

Since the last update on 24 November 2015, BCUHB has made progress in a number areas under Special Measures. In May 2016, BCUHB reported on phase one under the arrangements set out in the special measures improvement framework published in January 2016. This sets out the criteria and milestones the health board will need to meet for de-escalation.

The report and progress was discussed at a tripartite meeting between Welsh Government officials, the Wales Audit Office and Healthcare Inspectorate Wales on 8 June and the Cabinet Secretary for Health, Well-being and Sport issued a written statement on progress on 24 June 2016. This noted the good progress being made:

- In the leadership with key appointments including a substantive Chief Executive, Medical Director, Nurse Director, Director of Mental Health and three independent members.
- In governance improvements including an on-going board development programme and a reformed committee structure implemented.
- On a comprehensive recruitment campaign to improve medical staffing levels in maternity services to attract nurses and resident consultants.
- On the decision, following a comprehensive public consultation to maintain safe maternity services across the three major hospital sites.
- In appointing a midwifery consultant to lead work on normality in childbirth.

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- Noting the improvements that are enabling the return of student midwives to the Ysbyty Glan Clwyd maternity unit.
- On implementing a new management structure based on three geographical area teams, to improve the effectiveness of the leadership arrangements for Primary Care and Community Services.
- On implementing a new model of primary care to deliver services to the Prestatyn community as a result of the local GPs giving notice to terminate their contract.
- In improving the resilience of the out-of-hours service with recruitment of GPs and nurse practitioners to improve rota fill rates in the east area.
- In steps to re-connect with the public including an agreed engagement strategy, attending community events and working with stakeholders.
- In improving governance arrangements in mental health services and improving compliance with the mental health measure.

Since June the health board has also demonstrated further progress in approving and submitting the full business case for the Sub Regional Neonatal Intensive Care Centre (SuRNICC) to Welsh Government, endorsing the approach to development of the strategy – Living Healthier, Staying Well in the July Board and engaging external support to improve the cultural and clinical leadership in maternity services in Ysbyty Glan Clwyd.

It has also commenced the development of the Mental Health Strategy with engagement of users and carers, third sector and system wide partners to ensure that the strategy reflects the needs of the whole population. The Triumvirate model of Director, Medical Director and Nurse Director is now implemented within Mental Health Services, this will provide the leadership to deliver on priorities and improve BCUHB responsiveness under key domains including the Mental Health Measure and Putting Things Right.

The report from BCUHB on progress against the phase two milestones under the improvement framework is due December 2016.

Work has also progressed on the recommendations Welsh Government accepted in its response to the previous Committee's report on 'Wider issues emanating from the governance review of Betsi Cadwaladr University Health Board'.

In response to recommendations 1 and 2 - Welsh Government is now obtaining data/evidence on board attendance for those independent members being recommended for re-appointment and for this to be considered by the Chair as part of their recommendation for re-appointment when assessing satisfactory performance. The information is also provided in the advice on re-appointments to the Cabinet Secretary. Welsh Government has also reviewed that the latest round of 2015 LHB and NHS Trust Annual Governance Statements contain information on Board member attendance.

On the third recommendation on enhancing and sharing of good practice -
Board Secretaries now meet on a monthly basis to share common concerns and good practice. Welsh Government also regularly attends these meetings. This forum provides an opportunity to actively enhance the sharing of good practice in relation to governance in

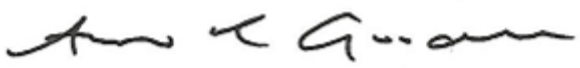
addition to the guidance to support the delivery of the standards around governance, leadership and accountability including the Good Governance Guide which is currently being updated and the Auditor General's memorandum on governance by Welsh Government and NHS bodies. We are also exploring other opportunities to share outcomes of commissioned work with us and across health organisations.

We continue to pursue improvements in our search and tracking capability on ministerial correspondence. For example, letters from Ministers to NHS Chairs which highlight patient concerns are monitored by the Chief Executive of the NHS so that trends can be brought to the attention of the relevant health board and trust Chief Executives and addressed accordingly.

With regard to recommendation 16 on an update on the progress achieved against the Marks review recommendations, most of the issues are operational matters for HIW. We will prepare a joint update with HIW by the end of October, 2016.

On recommendations (23 &24) in relation to the proposals in Green Paper we are preparing advice for the Cabinet Secretary that include looking at the current and future remit and functions of HIW.

Yours sincerely



Dr Andrew Goodall

Agenda Item 4

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

Our Ref: AG/JM

18 October 2016

Dear Mr Ramsay

Public Accounts Committee – update on Unscheduled Care

The Committee wishes to receive an update on how the NHS Wales is coping with unscheduled health care at present and whether there have been any peaks which have meant that elective surgery has had to be cancelled this year. The Committee would also welcome an update on the winter 2016 planning proposals.

The committee will wish to note that the Health and Social Care Committee is currently undertaking an inquiry into NHS winter preparedness for winter 2016/17.

Context

The complexity of delivering unscheduled care services is evident across the UK and cannot be underestimated. Health inequalities in deprived areas resulting in slower increases in life expectancy, poverty, fuel poverty and the inability of local authority spending to adult social care (most notably the elderly) to keep pace with increasing demand are all factors that cause substantial and unrelenting pressure on unscheduled care services.

Demand on unscheduled care services

On an average each day in 2015/16, the NHS in Wales saw nearly 2,765 people through its Emergency Departments; received 1,232 999 ambulance calls; offered over 800 NHS Direct Wales calls; and over 1500 out of hours care calls.

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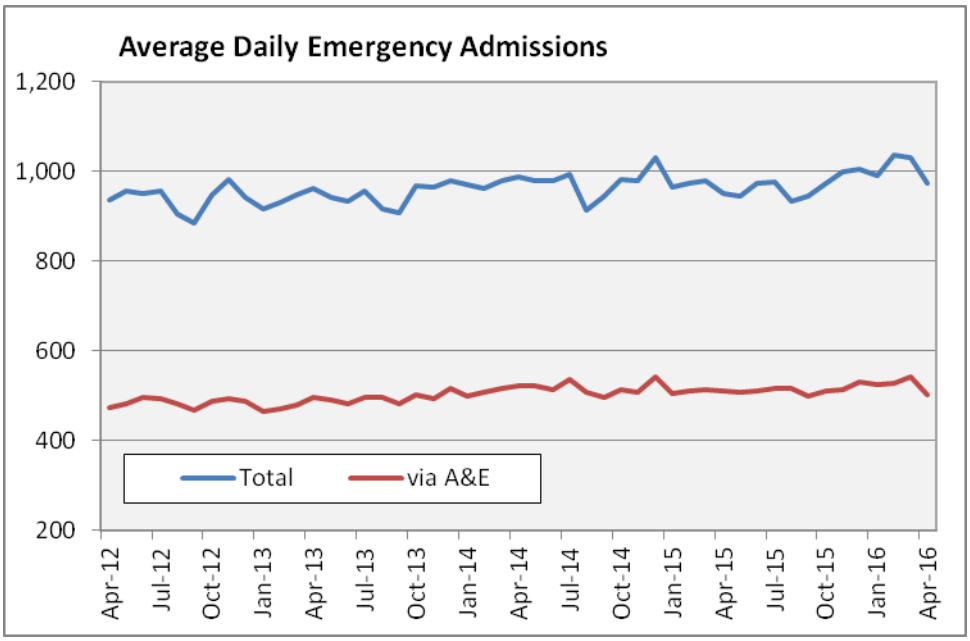
The unscheduled care system is faced with increasing activity and patient acuity. Over the last 12 months, more than one million people have attended emergency departments across Wales. This is 3% higher than the previous 12 months ending August 2015.

Changes in how people live their lives and the success of the NHS in keeping people alive for longer means demand for care is rapidly rising. An ageing population, combined with more people having increasingly complex needs, means that demand for health and social care services is predicted to grow rapidly in coming years. This often manifests in peaks in emergency admissions to hospital, which has seen a gradual increase over the past four years as illustrated in chart 1 overleaf.



Performance against key unscheduled care indicators

The emergency ambulance services clinical response model pilot is providing faster responses to people who need an immediate intervention from our emergency ambulance crews. Almost 80% (78.1%) of the most life-threatening calls received a response in fewer than eight minutes in August, meeting the target for the eleventh successive month. A similar model has been formally adopted by the Scottish Ambulance Services, and there is significant international interest in replicating the Welsh approach.

Despite over 69 more ED attendances per day in 2015/16 compared to 2010/11 the vast majority of people who access EDs are admitted or discharged within the four hour standard, which is one of the toughest standards across developed countries.

A high level summary of performance against key emergency care access targets is provided in *Annex A.*

Facts on peaks in demand on unscheduled care and elective surgery cancellations

- Each year, more than 330,000 elective admissions take place across Wales;
- Nearly half of all postponements are by the patient;
- In Wales, the data covers all postponed procedures, whether it was due to take place in a theatre or an outpatient setting, and even if the procedure was postponed with more than two weeks notice;
- The number of short notice non-clinical postponements fell by 1% in 2015-16 compared to 2014-15;
- Over the last two years, the number of short notice non-clinical postponements has fallen by 14%;
- 14% of short notice postponements were because the patient did not turn up. When this happens, it means the slot cannot be used by other people; and
- Health boards are using different forms of communication to remind patients of their appointment, including text messaging and automated phone messages.

There will always be times when a procedure needs to be postponed due to emergencies, however, we expect all health boards to make sure they plan services to minimise the risk of postponements. This will include reducing the amount of planned elective activity over the winter period to enable unscheduled care admissions to be accommodated;

We have a national efficiency board, chaired by the Chief Executive, NHS Wales – one area they are looking at is theatre efficiency and there is a national event taking place shortly to share good practice. Further, following work by the Wales Audit Office, each health board has actions in place to improve theatre efficiency.

National activity to support local health and care systems to cope with demand on unscheduled care services

To ensure the health and social care services are best placed to manage pressures arising from the change in demand for services described above, a number of national actions are being put in place.

<u>Guiding people to the right care and support, in the right place and at the right time</u>

The Choose Well campaign is nationally led with health boards and other organisations participating in local and national activity using the identity, targeted materials and messaging from the national campaign. For the coming winter, Choose Well will complement other winter health campaigns such as Beat Flu; Stay Healthy This Winter; Spread the Warmth (Age Cymru); and Prudent prescribing / Choose pharmacy.

The campaign will adopt a whole family approach, targeting parents of young children and older people and their carers.

- Ensure target audiences have access to information about what services are available as alternatives to A&E in their area, including pharmacies, minor injuries units and GP out of hours;
- Increase awareness of community pharmacy services and increase the number of people accessing community pharmacy services when they have a minor ailment;
- Increase the number of people accessing self-care information and advice from NHS Direct when they have a minor ailment;
- Promote NHS Direct as a source of information on local services and alternative services to A&E.
- Increase awareness among target groups of the actions they can take to avoid A&E in non-urgent cases, and benefits of those actions to them;
- Link effectively with other winter health campaigns including *Beat Flu* and Age Cymru's *Spread the Warmth* to increase the reach of key messages.

<u>How are we attempting to influence a change in people's behaviour?</u>

It is clear that alongside traditional projects to improve service performance and quality, we need to become more sophisticated in the way we engage stakeholders and the wider public. There is a growing evidence base and plenty of experience across NHS Wales, to confirm that incorporating community engagement and consultation into local service development, contributes significantly to making those changes more sustainable. Helping to align expectations with service design and delivery and maintaining strong trusting relationships with communities, is now an accepted part of the job to provide safe and effective care.

To realise the strategic opportunity that exists in leveraging population level behaviour change, we first need to make best use of the improvement resources currently available and ensure that an element of this valuable resource is targeted at earlier steps in the unscheduled care pathway.

A working group will be established by Public Health Wales to lead on Communication, Engagement and Behavioural Change and consider how population behavioural change should be taken forward.

<u>Navigating people through a complex and confusing system when they unexpectedly need care, support or advice</u>

We are developing a national directory of services to enable fast assessment of patient symptoms and need, and immediate direction to the best medical care, advice or information for citizens.

The non-emergency 111 service will provide a real opportunity to co-ordinate and manage the demand of unscheduled care for NHS Wales, meet the needs of patients within their own communities, avoid unnecessary hospital admission and reduce demand on acute hospital services.

Primary and community care initiatives to reduce demand on unscheduled care services

24 'pacesetter projects' are being funded by the Welsh Government that fall into broad themes that aim to address current challenges for Primary Care across Wales and test out innovative models for delivering healthcare services, for example. These projects include a focus on alleviating unscheduled care demand on primary care services, for example:

- GPs working within a multi-professional Primary Care team are able to spend more time with acutely unwell patients and those with complex conditions, in addition to having protected time for leadership and innovation.
- A 'Hub' model used to triage and direct patients to the appropriate professional within an enhanced Multi Disciplinary Team, so patient access is improved and the GP has time and resource to manage more complex cases, often earlier in the patient pathway. This is intended to support a reduction in the chances of admission.

Falls prevention is a key issue in the improvement of health and wellbeing amongst older people and can significantly help reduce the demand for unscheduled care services. There are a number of work streams in place to both prevent falls and to support people who have fallen and reduce the risk of them having further falls.

The Falls Prevention Network is co-ordinated by the Older People Commissioner's Office and consists of representatives from the Welsh Government, Ageing Well Wales, Health Boards and a number of third sector organisations with an interest in preventing falls. The work of the Network helps older people to maintain their health and well-being, live longer in their own homes and remain active in their communities.

The Multiagency Falls Collaborative for Wales aims to support practitioners and community-based teams to improve care for patients who have fallen. The aim of the collaborative is to reduce mortality and harm to adults who have fallen, and are at risk of further falls, by providing a structure around which to align and develop community services.

Winter preparedness

Winter is always a very challenging time for our health and social services, in the UK not just Wales, and there will always be times when demand places our services under great pressure, needing local escalation.

Health Boards and Trusts, as part of their IMTP process, review previous winter plans and performance each year and then develop plans for the forthcoming winter period.

As part of this process Health Boards implement their unscheduled and urgent care improvement plans and consider the priorities that have been confirmed as part of their individual IMTP process for 2016/17.

Health Boards, the Welsh Ambulance Service and local authorities have reflected on last winter, which saw some days where our urgent and emergency care services experienced significant surges in demand above and beyond which could have been anticipated. We also directed the health and social care organisations to start planning for winter 2016/17 earlier than ever before this year. We made our expectation clear for resilient and integrated winter plans through clear guidance and a number of events at which organisations have had an opportunity to share lessons learned and good practice from previous winters. All draft plans were received by 16 September and will be made publically available by the end of October 2016.

We have seen improvements in performance against the key unscheduled care indicators over the last six months, although we recognise the slight drop in A&E performance in September. A number of suites have demonstrated local improvements in recent weeks and we are working with health boards to achieve further improvements across Wales leading into the winter period. Health Boards, the Welsh Ambulance Service and Local Authorities will be expected to regularly keep their plans under review to understand how they are impacting on their performance during the winter period, and ensure they can respond accordingly.

<u>Monitoring and surveillance</u>

Public Health Wales influenza and infection control surveillance will support health boards with weekly updates.

Welsh Government officials will also provide scrutiny on a regular basis for assurance through:

- Daily national executive-level emergency pressures conference calls will be held at 11 o'clock, seven days a-week. An additional 4 p.m. conference call will also be trialled for a week in November for organisations reporting emergency pressures escalation level 4 in line with the *national escalation and de-escalation action plan,* to encourage active de-escalation.

- Fortnightly calls will be held between Welsh Government and a nominated health board winter resilience lead between 1 December 2016 and 31 March 2017 to track delivery against actions described in local winter plans.Weekly calls will be held over the winter months between Welsh Government and Directors of Social Services to monitor unscheduled pressures. This will help to ensure that decisions are based on the very best information available and that good practice and learning is disseminated effectively.

- Welsh Government officials will track progress on delivery of winter specific initiatives described in other parts of the UK to support the evaluation process and inform planning and delivery in 17/18.

Evaluating delivery of services over winter

A Welsh Government and Unscheduled Care Programme sponsored review event will be held in March / April 2017 to support NHS and local authority colleagues' evaluation of delivery and performance, and planning for winter 17/18.

A review of overall delivery and performance during the winter period will be presented to the national Unscheduled Care Programme Board in spring 2017.

National Unscheduled Care Programme

The National Programme for Unscheduled Care was established to facilitate and enable transformational change and improvement for unscheduled care services in Wales by promoting a more prudent, whole system approach, with better integrated health and care services.

The Programme provides a framework, within which regional and local initiatives can be shared and supported across the whole system and draws on best practice from the UK and beyond. As well as engaging widely with a range of stakeholders within health and social care in Wales, the programme supported a Welsh delegation who recently met with NHS Scotland to explore opportunities to build a mutually beneficial relationship and share learning on local delivery of unscheduled care services. Similar opportunities will also be explored with colleagues in Northern Ireland and used to inform the future development and provision of services to patients in Wales.

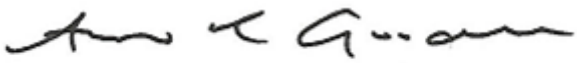
A central tenet of the Programme is to promote a better understanding of the unscheduled care system and establish a baseline assessment of the current system. Welsh health boards will be participating in NHS Benchmarking Network audits relevant to unscheduled care services. The NHS Delivery Unit has also undertaken a piece of work to identify current in-hospital unscheduled care activity. Work is ongoing to identify relevant activity in pre- and post-hospital settings to enable a whole system view of unscheduled care in wales and facilitate improved integration of services. This work will support to develop of an intelligent suite of measures to accurately reflect patient experience across the whole unscheduled care services and facilitate whole system improvements.

Collaboration across national programmes

There is a developing level of integration between the programmes in an effort to achieve the best overall outcomes, and to achieve the adoption of a whole system approach to the planning and delivery of health and care services across all health and care pathways

There is significant cross representation among the programme boards and sub-groups and regular engagement between programme leads.

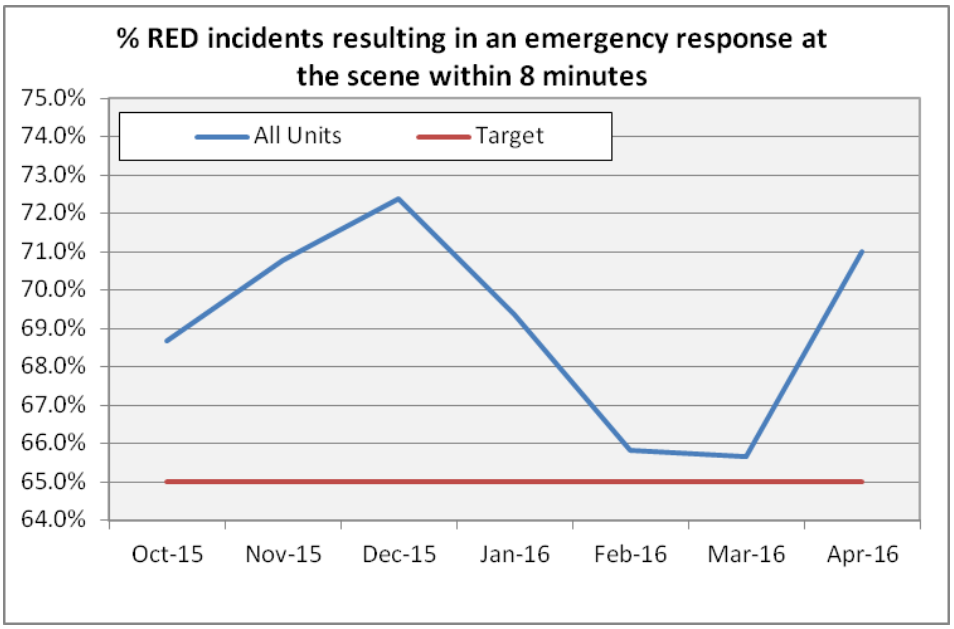
Yours sincerely

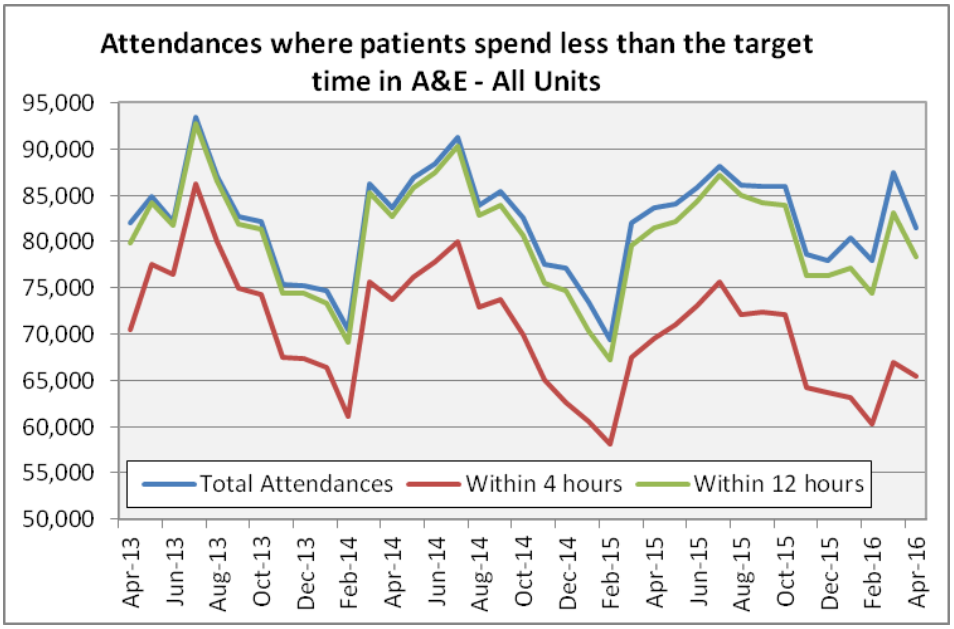


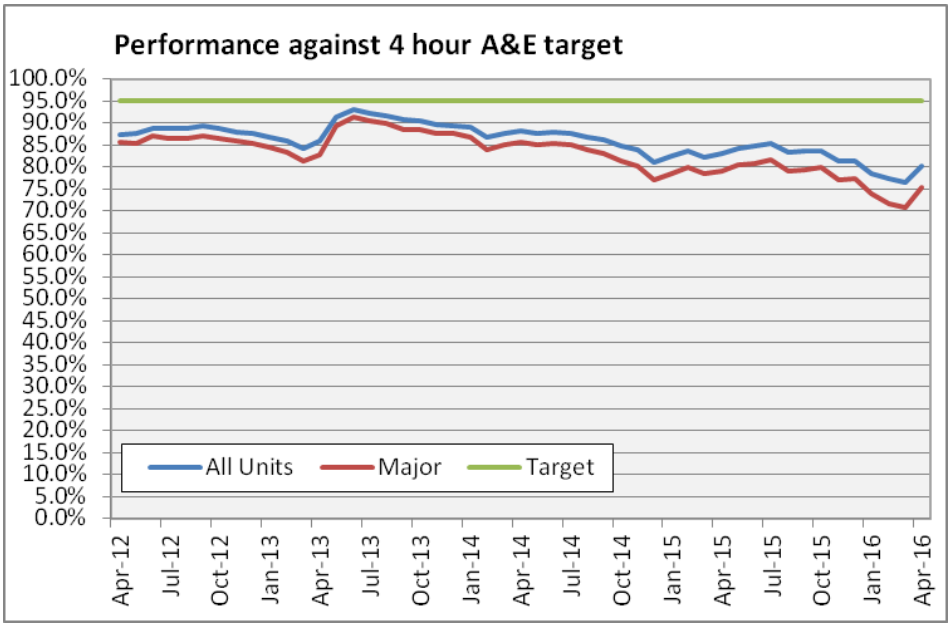
Dr Andrew Goodall

Annex A

Unscheduled Care - Progress against key indicators






Performance against 4 hour A&E target
100.0%
95.0%
90.0%
85.0%
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75.0%
70.0%
65.0%
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Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

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

Llywodraeth Cymru
Welsh Government

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

Our Ref: AG/JM

18 October 2016

Dear Mr Ramsay

Public Accounts Committee – update on Continuing NHS Healthcare

Continuing Healthcare (CHC) is a complete package of ongoing care arranged and funded solely by the NHS through Local Health Boards (LHBs), where an individual's primary need has been assessed as health-based.

The Welsh Government is responsible for providing policy direction, guidance and advice to health boards on CHC. The National Framework for CHC sets out a mandatory process for NHS Wales, working together with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care for adults.

Retrospective Claims

The retrospective claims process has been established to consider claims from individuals or their family/representative that they should have been eligible for CHC funding for past care needs but, for a number of reasons, they were either not assessed or not determined eligible, and thus were required to contribute to the cost of their package of care. If, on review, the conclusion is that the person should have been found eligible for CHC then the individual/their estate is reimbursed by the relevant health board.

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Phases for Retrospective Claims

Phase	For Claim Applications Submitted	Limits of Claim Periods to be Reviewed		Target Review Timescale
		Powys	HBs	
Phase 1	Up to 15/08/2010	01/04/1996 to 15/08/2010	N/A	-
Phase 2	From 16/08/2010 to 30/04/2014	01/04/2003 to 31/07/2013	01/04/2003 -	30/06/2014
Phase 3	From 01/05/2014 to 31/07/2014	01/04/2003 to 31/07/2013	01/04/2003 -	2 Years
Phase 4	From 01/08/2014 to 31/10/2015	N/A	01/08/2013 -	1 Year
Phase 5	From 01/11/2015 to 31/10/2016	N/A	01/10/2014 – 30/10/2015	6 Months
Phase 6	From 01/11/2016 to 30/09/2017	N/A	31/10/2015 – 31/10/2016	6 Months

Previous Scrutiny

This area has been subject to scrutiny by the previous Public Accounts Committee (PAC). It PAC issued a number of recommendations in December 2013 regarding the implementation of the CHC Framework. The Welsh Government submitted evidence to the PAC on its progress with implementing those recommendations and a follow-up report was issued in March 2015. This recognised that improvements had been made but concerns remained about delays and possible inconsistencies in health board decision making.

Further detail on progress against each of the recommendations in the follow-up report follows. This includes, under recommendation 3, the latest position regarding the number of claims currently in the system and the anticipated time to process them.

Welsh Government Position against Public Accounts Committee CHC Recommendations

PAC Recommendation 1
The Committee recommends that, to ensure confidence in the quality and consistency of decisions on continuing healthcare funding awards, the annual audit samples of all Health Boards should be undertaken independently, by the same team.
Welsh Government Position
Following the Committee's recommendation an independent audit of all Health Boards was undertaken in Autumn 2015 by the National Director for Complex Care, the Director of the National Project in Powys and a Welsh Government policy lead for Continuing Healthcare. This will be done again, by the same team, during October and November 2016 and for future years. Health boards have provided assurance that the feedback and recommendations provided have been actioned. Compliance against recommendations is also monitored through the National Complex Care Board, which is co-chaired by the Director of Social Services and Integration and the Chief Executive of Powys Teaching Health Board. The annual report due to be published in November will also be a vehicle for demonstrating health boards' progress on delivering improvements in implementing the NHS Continuing Healthcare Framework**.**
Recommendation 2
The Welsh Government should provide the Committee with details of the outcomes and findings from the on-going review of cases with learning disabilities, which is concluding in March 2015.
Welsh Government Position
There have been some concerns that the CHC Framework may not be an appropriate approach for those individuals with a learning disability (LD). LD is not an illness and services for people with a LD should be provided via a social model rather than a medicalised approach, seeking to support independent living and allowing individuals to retain a voice and control over the support they receive. What is important is that outcomes are in the best interest of the individual and that health boards are being consistent in the way that they apply the Framework to people with a LD. The Welsh Government undertook work as part of the development of the 2014 National Framework to consider how best to address issues around LD and CHC. A key issue is how the cognition domain within the Decision Support Tool operates for those with an LD. Some assessments appear to identify cognition related needs as low (the rationale being this is a behaviour

that is expected and usual for the individual) whilst others score high (leading to an increased chance of eligibility for CHC).

In 2015 Health Boards undertook reviews of joint funded LD cases to ensure that eligibility for CHC had been explicitly considered and discounted before constructing joint funded packages of care. This process is ongoing, with eligibility considered at the next review for all joint funded LD cases.

Health boards also undertook a dip sampling exercise to assess whether the primary health need was appropriately considered in determining eligibility. A sample of Learning Disability cases were also included as part of the sample audit undertaken in 2015.

These exercises showed there was clear evidence that decisions taken were in the best interests of individuals although there were some differences in the way that needs are considered, especially in relation to cognition. Two workshops have been held with members of the Learning Disability Advisory Group (LDAG) to discuss these issues and they have also been considered by the National Complex Care Board. We will use the opportunity to further refine the Framework in this area when we update it next year.

The Learning Event, to be held in November 2016, will also help to embed consistency in the way the Framework is being implemented in respect of people with a Learning Disability.

Recommendation 3

The Committee recommends that the Welsh Government continues to monitor Health Boards' progress in processing retrospective claims and if necessary, refer claims not processed within the prescribed deadline to the Powys Project and provides the Committee with an update before the summer recess.

Welsh Government Position

An update was provided in July 2015. This confirmed that health boards had transferred the backlog of Phase 2 and Phase 3 cases to the Powys project.

<u>Summary of latest position</u>

A summary of the latest position in respect of claims currently in the system can be found in the table below.

Powys project		received	completed	to be processed
	Phase 2	941	377	564
	Phase 3	1514	301	1213
		2455	678	1777

Health Boards		received	completed	to be processed
	Phase 2	595	546	49
	Phase 3	224	103	121
	Phase 4	533	306	227
	Phase 5	98	21	77
		1450	976	474

Health boards transferred a total of 941 Phase 2 cases to the Powys project. As at September 2016, 377 cases have been completed. Many Phase 2 claims have lengthy claim periods (up to 10 years) and this has led to longer than anticipated processing times due to the volumes of records that have to be reviewed. In order to overcome this, and in the interests of probity and the public purse, an amended process has been introduced in order to identify the appropriate period that should be considered for retrospective CHC eligibility, rather than considering the full period of the claim in all cases. This process has been approved by the Public Services Ombudsman for Wales. Using this new process it is anticipated that all claims will be completed by December 2017.

The project is also dealing with the processing of 1514 Phase 3 claims. 301 have been completed and this leaves 1213 cases to be reviewed. The revised process is also being applied to Phase 3 claims. The published target of reviewing all claims within two years of the date of activation remains achievable and it is anticipated that all Phase 3 claims will be completed by the middle of 2018.

Of the 595 Phase 2 claims that remained with health boards, 546 of these have been completed. Of the 224 Phase 3 claims that remained, 103 have been completed. 51 of the outstanding claims in relation to Phase 2 and 3 are awaiting the necessary documentation to start the review from the claimant. In relation to Phase 2 and 3 an expectation was set that these would be processed within two years of receipt of the necessary information. Whilst this timescale has not been achieved in the majority of Phase 2 claims (hence revised arrangements were put in place) there are currently no reported breaches in relation to Phase 3 claims.

A total of 533 Phase 4 claims have been received, with 306 of these having been completed. Health Boards have provided assurance that the 12 month timescale for processing Phase 4 claims once all the necessary documentation has been received remains realistic in the majority of cases.

A total of 98 Phase 5 claims have been received to date. 21 of these have been completed. The claim period closes on 31 October 2016. Health

Boards will have 6 months to review these cases once they have received all the necessary documentation from the claimant.

We monitor monthly progress on retrospective claims and the National Complex Care Board also monitors progress on a quarterly basis.

Recommendation 4

The Committee recommends that the Welsh Government reports to the Committee before the summer recess on the expansion of the local and national recruitment programme and whether this has led to improvements in the time taken to process current and future claims.

Welsh Government Position

An update was provided in July 2015. This confirmed that the necessary recruitment within the Powys project was underway and it was expected to reach full staffing capacity by November 2015.

However, recruitment has continued to be a challenge and a risk to the timely processing of current and future claims, particularly for the Powys project, due to the temporary and specialist nature of the roles which give rise to highly skilled and motivated staff who then look for opportunities to progress. Over recruitment is being pursued by the Project in order to mitigate against high turnover of staff.

Recruitment at both local and national level is reported to Welsh Government on a monthly basis and is discussed quarterly at the National Complex Care Board.

Recommendation 5

The Committee recommends that the Welsh Government monitors Health Boards to ensure that the shorter processing deadline for more recent claims does not result in unintended consequences of longer resolution times for long-standing claims which are unresolved.

Welsh Government Position

Progress on processing claims is monitored on a monthly basis and quarterly by the National Complex Care Board. The revised model for Phase 2 and 3 claims agreed in 2015 has led to improvements in the time taken to process claims although some issues remain as set out above. Both the National Project and Health Boards are alive to the need to ensure resources are positioned so as to enable the timely processing of more recent claims whilst continuing to make good progress on the long standing claims. This has been evidenced in the monthly returns on retrospective claims submitted to Welsh Government.

Recommendation 6

The Committee recommends that the Welsh Government ensures that governance arrangements are clear and well understood in relation to complex care. This will include monitoring the effectiveness of such arrangements and the engagement of members of the National Complex Care Board and any task and finish groups which support its work.

Welsh Government Position

The Wales Audit Office report identified the need for improved governance and accountability arrangements around complex care, with a recommendation that a National Complex Care Board (NCCB) be established to oversee the delivery of national policy. Each Health Board has considered and approved the Governance and Accountability Framework and this has been operational since 2014. It includes:

- The establishment of a NCCB, chaired jointly by the Welsh Government's Director of Social Services and Integration and the Chief Executive of Powys Teaching Health Board;
- The establishment of a Performance and Operations (i.e. operational delivery) Group comprising of CHC leads in each HB, to oversee the implementation of CHC and other complex care policy through to delivery via robust service models;
- The establishment of a Stakeholder Reference Group to act as a broad expertise base to advise the national Board as necessary;
- The establishment of a Retrospective Claims Management Group (RMG) chaired by the Chief Executive of Powys Teaching Hospital and attended by the CHC Retrospective Lead from the National Project, each Health Board and Welsh Government to specifically monitor and oversee the management of retrospective claims

The NCCB held its first meeting in early 2015 and meets bi monthly. Its role is to have strategic oversight of complex care related issues; oversee the implementation of policy; seek to ensure consistent and robust service models are in place; and be the main point of contact with Welsh Government policy officials. The NCCB comprises senior Health Board and Welsh Government representatives, with access to wider advice and guidance via the Welsh Government established Stakeholder Reference Group (SRG).

The effectiveness of these arrangements is monitored on an ongoing basis, with consideration being given to the role and function of the various groups and adjustments made as necessary.

Recommendation 7
In addition to the current leaflets that are designed to be accessed once an individual is 'in the system'; the Committee recommends that the Welsh Government publishes a general public information leaflet on continuing health care. These leaflets should be shared with health and social care professionals and distributed widely, including being made available in doctors' surgeries.
Welsh Government Position
Information materials for the public were reviewed in 2015 and again in 2016 and copies of a general public information leaflet have been sent to health boards for distribution to a wide range of organisations, settings and services. This leaflet, along with other guidance and information relating to CHC is also available electronically on the Welsh Government website and the jointly owned NHS and Welsh Government Complex Care and Information Support Site (CCISS).
Recommendation 8
The Committee recommends that mandatory guidance is issued to Health Boards and social care providers on where information in relation to continuing health care should be made available. This should include the provision of information to individuals (and/or their family members) who are in, or prior to admission into a care home, including details of how the Decision Support Tool is applied to individuals being assessed for Continuing Healthcare.
Welsh Government Position
A Welsh Health Circular was distributed to all health boards and social care providers in July 2015, setting out where such material should be distributed. It is also available on the Welsh Government and the NHS websites. The guidance directs health boards to undertake best practice by distributing to an enclosed standard distribution list as a minimum such as local care homes, GP surgeries, frontline services, and health and social care professionals. It places the onus on health boards to ensure the material is provided to individuals so it is widely available. This includes prior to admittance to a care home and how the Decision Support Tool is applied to individuals being assessed for CHC.
Recommendation 9
The Committee remains concerned about the awareness, quality and level of provision of advocacy services provided by different Local Health Boards and is supportive of patients and carers understanding

their options and the decision-making process as well as healthcare professionals. The Committee recommends the Welsh Government reports to the Committee before the summer recess, on how it intends to improve the consistency, quality and awareness of advocacy services.

Welsh Government Position

An update was provided to the Committee in July 2015. This stated that Welsh Government would ask health boards for an update on their position on advocacy and the approach taken. It also confirmed that the role of the advocate has been clarified in the Practitioners' Frequently Asked Questions booklet and that advocacy would be considered as part of health boards self-assessments.

The 2014 CHC Framework states that health boards and local authorities should make individuals aware of local advocacy services that may be able to offer advice and support. It also states that health boards need to consider the adequacy of advocacy services for those who are eligible or potentially eligible for CHC, and whether any action is needed to address any shortfalls.

The updates and the self-assessment reports of Autumn 2015 indicated that there was some lack of clarity amongst practitioners about the role and types of advocacy that are available and in some cases health boards had not established whether the quality and level of advocacy provision was adequate.

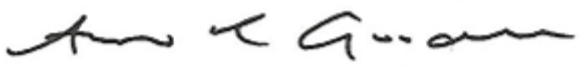
In order to address this, the Welsh Government issued a briefing on the different types of advocacy that exist and which health boards should be providing or facilitating access to. It has also asked the Welsh Institute for Health and Social Care to undertake a scoping study focusing on the experience of users/patients/carers, advocates and staff involved in the CHC process and decision making and this will also give us some useful information about the adequacy and effectiveness of advocacy services.

The last annual sample audit indicated that in many cases, family members or carers act as advocates and that a need for specific advocacy teams for continuing healthcare had not been identified. Health boards have also told us that the role of the Care Co-ordinator and Registered Nurse in improving communication and engagement with individuals and their families has led to greater knowledge and confidence in the process and has meant that demand for advocacy has reduced. Whilst processes and the commissioning of advocacy differ across health board boundaries, they are all managing the need for advocacy within their current systems and resources.

There has also been considerable action on advocacy in its wider form relating to the Social Services and Well-being (Wales) Act. A code of

practice on advocacy has been published and this reinforces local authorities' and local health boards' duties to evidence need through the joint population needs assessment and utilise partnership and co-operation powers to jointly commission advocacy services for their area and to utilise the pooled funding arrangements

Yours sincerely



Dr Andrew Goodall

Document is Restricted

11 February 2016

Archwilydd Cyffredinol Cymru
Auditor General for Wales

A Review of the Impact of Private Practice on NHS Provision

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

The Wales Audit Office study team comprised Anne Beegan, Nigel Blewitt, Sara Utley and Verity Winn under the direction of David Thomas

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Summary report

Summary

Background

1 Private healthcare offers alternatives to government-run publically funded healthcare systems. Private healthcare by definition operates outside the bounds of government control and receives funding only from patients and their insurance policies, although the provision of private healthcare is regulated through a number of bodies including Healthcare Inspectorate Wales.

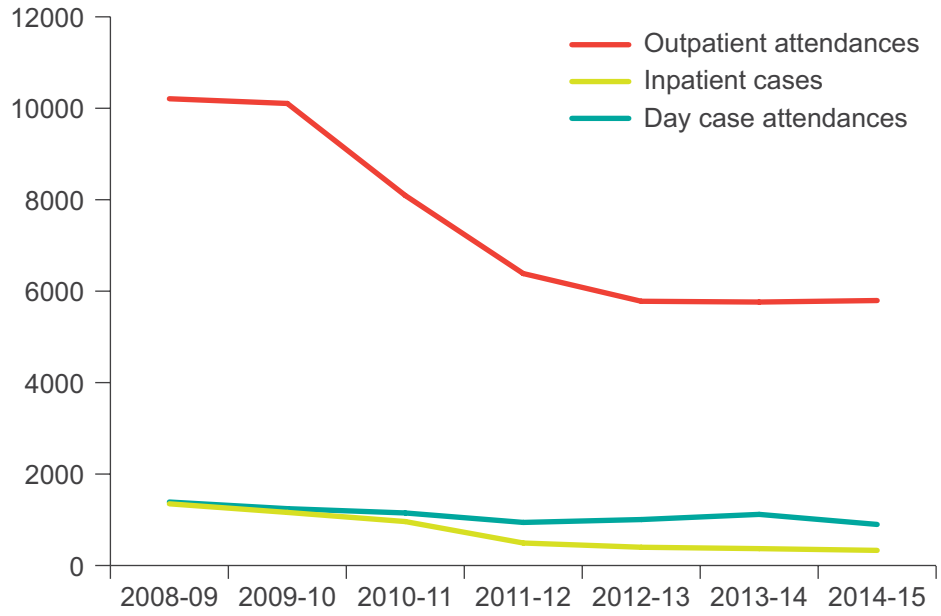
2 There are many reasons that patients choose to receive private healthcare, one of which is the ability to access healthcare much more quickly than the current waiting times for NHS treatment. There are wide ranges of treatments provided through private healthcare, including those currently available through the NHS such as hip replacements and Magnetic Resonance Imaging (MRI) scans. Private healthcare also offers patients access to treatment not available through the NHS, such as cosmetic surgery. Other reasons for choosing private healthcare include the flexibility for patients to choose when and where they receive treatment, to choose which consultant or specialist provides their care and the ability to seek a second opinion on treatment advice received through the NHS.

3 Based on the latest figures from Healthcare Inspectorate Wales[1], there are currently 21 private and independent hospitals and clinics in Wales. Some of these provide specialist treatment such as podiatric treatment or specialist knee treatment. However, a number provide a broad range of services available on the NHS. These are set out in Appendix 1.

4 Private healthcare can also be provided through private treatment rooms, and agreed private consultation and treatment sessions within NHS facilities. No information on private activity undertaken in private and independent settings is available in the public domain. However, data submitted to the NHS Wales Informatics Service (NWIS) and reported through Welsh Government statistics[2] would indicate just over 7,000 instances of private practice outpatient and inpatient activity (excluding diagnostic tests and therapy interventions) occurred in NHS facilities during 2014-15, although this has reduced over the last six years, from 13,000 recorded in 2008-09 (Figure 1). The level of private practice activity undertaken in NHS facilities in 2014-15 accounts for just 0.02 per cent of the total level of outpatient and inpatient activity across the NHS during the same period, which was reported to be in excess of 4 million.

1 Establishments registered as independent clinics or hospitals (acute) on the Independent Healthcare Register, Healthcare Inspectorate Wales, April 2014
2 www.gov.wales/docs/statistics/2015/150114-health-statistics-wales-2014-chapter-16-en.xls

Figure 1 – Private practice activity undertaken in NHS facilities



Source: Wales Audit Office analysis of PEDW data, Welsh Government statistics

5 During 2014-15, there were 5,795 private outpatient appointments reported in NHS facilities, compared to 3.1 million NHS outpatient appointments. The highest numbers of private outpatient appointments were in Abertawe Bro Morgannwg, Aneurin Bevan and Betsi Cadwaladr University Health Boards accounting for 91 per cent of all private outpatient appointments in the NHS (see Appendix 2, Figure 1). The highest volumes of private outpatient appointments in 2014-15 were in Ophthalmology, and Trauma and Orthopaedics, accounting for 51 per cent (see Appendix 2, Figure 2). The number of private outpatients per specialty varies considerably across Wales.

6 There were 1,229 privately funded hospital admissions to NHS hospitals in 2014-15, compared to 915,000 NHS hospital admissions. The highest numbers of privately funded admissions were also to Abertawe Bro Morgannwg, Aneurin Bevan and Betsi Cadwaladr University Health Boards. The majority (898) of private patients were treated as a day case, which reflects an increasing shift from inpatient to day-case activity. The remaining 331 patients required one or more nights in hospital as part of their treatment. Across Wales, the highest volumes of private hospital admissions were in Ophthalmology and Trauma and Orthopaedics, which accounted for 48 per cent. General Surgery, Urology and Cardiology also made up a further 36 per cent of activity, although activity levels by specialty vary across Wales (see Appendix 2, Figure 3).

7 Many consultants who provide private healthcare are also employees of the NHS. The NHS body that employs them should agree the time they spend providing private healthcare, ensuring that their private commitments do not adversely affect the provision of NHS services. Patients can access private healthcare through a GP referral or by contacting a private consultant directly. Many patients will choose to receive the totality of their treatment privately, particularly if they are in receipt of private health insurance, whilst others will choose to revert to NHS treatment following an initial private consultation and/or diagnostic test.

About this report

8 During an inquiry following the Auditor General's report **Consultant Contract in Wales: Progress with Securing the Intended Benefits** (February 2013)[3], the National Assembly's Public Accounts Committee (the Committee) raised questions about 'whether private practice created the potential opportunity for 'queue jumping' NHS waiting lists'. Evidence provided to the Committee by the Welsh Government indicated that there are rules and procedures in place to prevent private patients 'queue jumping'. However, further evidence provided by two health boards suggested that the extent to which these rules were being robustly applied differed across organisations. Commenting on this issue in its report on **Consultant Contract in Wales: Progress with Securing the Intended Benefits** (September 2013)[4], the Committee concluded that there was a lack of clarity on whether 'queue jumping' was happening in practice. It recommended that the Auditor General should examine NHS bodies' processes and procedures for patients moving between private and NHS practice. During its inquiry, members of the Committee also raised concerns about how NHS bodies go about recouping costs from private work undertaken in NHS facilities.

9 In response to the Committee's concerns and specific recommendation in relation to 'queue jumping', the Auditor General has undertaken an examination of national and local approaches to managing the impacts of private practice on NHS provision. This report presents the findings from that work and sets out a number of recommendations for the Welsh Government and health bodies.

3 www.audit.wales/publication/consultant-contract-wales-progress-securing-intended-benefits
4 www.assembly.wales/Laid%20Documents/CR-LD9466%20-%20Report%20of%20the%20Public%20Accounts%20Committee%20on%20'The%20Consultant%20Contract%20in%20Wales%20Progress%20with%20securing-09092013-249813/cr-ld9466-e-English.pdf Report of the Public Accounts Comm ittee on 'The Consultant Contract in Wales: Progress with securing the intended benefits'

Our approach

10 Our approach has involved analysis of private practice data relating to activity undertaken in NHS facilities and information, together with fieldwork visits to a number of health boards. Visits included reviewing pathway information for private patients who had received an initial private consultation and were then placed on the NHS waiting list, noting that due to the lack of available information relating to patients who are seen in a private or independent setting, the sample only included patients who received the initial private consultation in an NHS facility. Visits also included reviewing financial data to track through whether the costs associated with private practice activity undertaken in NHS facilities were recouped. We have reviewed data relating to 2014-15 to provide the most up-to-date position on private practice within the NHS; however, to enable us to understand the total length of time these patients waited and to allow sufficient time for income to be recouped, we have also considered data relating to 2013-14. Further details of our audit approach are provided in Appendix 3.

Main conclusions

11 Private practice represents a very small and reducing level of activity when compared to the totality of NHS activity that takes place in Wales. Nonetheless, this review has shown that health bodies are not effectively managing the impact of private practice on NHS activity. Some are failing to recoup all the costs associated with private practice work that takes place on NHS premises and there is potential for patients to gain an unfair advantage by paying for an initial private consultation or diagnostic test and then reverting to an NHS waiting list, although insufficient data exists at present to allow any definitive conclusions to be drawn on whether this is happening in practice.

12 Various guidance exists on how private patients should be transferred to NHS treatment but there are inconsistencies in its content and the way it is used by staff. Welsh Government guidance suggests that private patients should be placed at the start of the waiting list, while UK-wide guidance, including that issued by the British Medical Association (BMA), indicates that they should be placed on the list at the point in which they would be had they received their consultation through the NHS. The main waiting times guidance used by NHS staff in Wales, however, does not refer at all to the management of private practice and many staff are unaware of the Welsh and UK-wide guidance.

13 There is no requirement for health boards to identify private patients entering NHS pathways, which makes it difficult to differentiate these patients from NHS patients referred by GPs and consequently to undertake any detailed analysis of whether those patients who pay for an initial consultation and then join an NHS waiting list get treated more quickly.

14 Where patients' initial private consultation takes place in an NHS facility, it is possible to undertake some analysis of how quickly they are treated when reverting to the NHS for treatment, and to compare this to standard NHS waiting times. As part of this review such an analysis was undertaken and identified that actual waiting times vary significantly. When compared against both the average wait for NHS patients, and the point by which 95 per cent of all NHS patients have been treated, no clear pattern is observed. Some private patients who transferred to an NHS list were treated more quickly than the NHS average, although a large proportion of these were identified as urgent patients, so a shorter wait would be expected, while others actually waited longer. The data reviewed would suggest that the majority of private patients who transfer to the NHS for their treatment are generally managed in line with NHS patients. However, a much larger set of data would need to be analysed to confirm this emerging conclusion.

15 The ability of a consultant to undertake private practice work can be an important factor in attracting high calibre individuals to NHS consultant posts. Moreover, NHS organisations can generate income from private practice work undertaken in their facilities which can then be invested in NHS services. The basic principle underpinning guidance on private practice is that it should not impact on NHS provision. However, the guidance which exists lacks clarity as to when and how much private practice can take place in the NHS. Arrangements are in place to ensure that consultants are aware of the guidance but there is little consideration of private practice activity as part of the consultants' job planning process, and there are no monitoring mechanisms to ensure that the activity is not taking place during periods where consultants are committed to working for the NHS. Many operational staff are not aware of the guidance and directorate managers typically lack awareness of private practice activity taking place within their own clinical areas. Along with inaccuracies in the data held on patient administration systems, the weaknesses in controls around private practice in the NHS limits the necessary assurance that NHS capacity and resources are not used inappropriately.

16 While there is a general perception that private practice activity takes place during out of hours and weekends, we identified that 98 per cent of private practice in NHS facilities takes place during the week. While some of this is managed before and after NHS sessions, and in dedicated sessions, which is acceptable practice, a number of cases were found to be taking place during periods when consultants are committed to working for the NHS. There is evidence that private practice will sometimes be cancelled to accommodate NHS pressures; however, health boards are not fully recognising the impact on capacity from private patients, particularly in relation to bed capacity.

17 All health boards have policies and procedures in place to recoup the costs of private practice. However, the administrative processes to ensure that the health boards receive the income are cumbersome and reimbursements are often based on incorrect information. Private practice and finance teams are reliant on timely and accurate information being sent by consultants and their staff. To ensure that patients are billed correctly, it is necessary to crosscheck multiple sources of information. The tariffs for private practice across Wales vary and not all cost information is up to date and reflective of the true cost to the service. A review of the finance information relating to a sample of private practice patients identified that whilst most health boards appear to be recouping the costs of private practice, a quarter of activity takes more than three months to be paid and six per cent of activity was not being recouped at all.

Recommendations

Recommendations	
R1	The guidance from the Welsh Government on how to manage private patients onto the NHS waiting list conflicts with other guidance and is not reflected in the routine referral to treatment documentation used by NHS bodies, resulting in a lack of awareness and inconsistencies on where private patients are placed if they join an NHS waiting list. The Welsh Government should therefore adopt the approach set out in UK-wide and professional body guidance, ensuring that the referral to treatment documentation used by NHS bodies is updated to reflect this. Health boards and trusts then need to ensure that this guidance is implemented by all staff involved in the administration of referral to treatment pathways within health boards and trusts.
R2	There is currently no requirement for health boards and trusts to identify private patients reverting to NHS treatment on their patient administration systems, which makes it extremely difficult to establish whether these patients are gaining faster access to NHS treatment. The Welsh Government should update the NHS Wales Data Dictionary and mandate the identification of private patients entering NHS waiting lists to enable regular monitoring to take place. Through the revised guidance set out in recommendation 1, the Welsh Government should also set out an expectation that health boards and trusts will regularly monitor the waiting times for this cohort of patients.
R3	Private practice can play an important role in attracting consultants and generating income for the NHS yet local policies lack clarity on when and how much private practice can take place in the NHS, and monitoring arrangements to ensure that NHS provision is not affected are weak. Where private practice is undertaken in NHS facilities, health boards and trusts should ensure that policies clearly state when and how much private practice, and specifically inpatient activity, can take place to minimise the impact on NHS resources. Private practice activity should be collected and reported in line with the requirements of the Competition and Markets Authority, and this information should routinely form part of the annual job planning process for all relevant consultants to ensure policies are complied with.
R4	The processes for recouping the costs associated with the provision of private practice within NHS facilities are cumbersome and often reliant on out-of-date and incorrect information. Health boards and trusts should ensure that sufficient attention and resources are given to the cost recovery process. The level of resources should be reflective of the scale of private practice undertaken but should be sufficient enough to provide robust assurances to boards that income is being appropriately recovered. A single-invoice system can assist with full cost recovery and has already been adopted in a number of health boards. Those health boards and trusts which are not currently operating this system should give urgent consideration to doing so.

Part 1

Despite high-level guidance that private patients should not be able to access subsequent NHS care quicker than NHS patients, weaknesses in local systems increase the risk of inequitable access to treatment

There is guidance on how private patients should be transferred to NHS treatment but there are inconsistencies in its content and the way it is used by staff

1.1 Various Welsh Health Circulars (WHCs)[5] leading up to the implementation of Referral to Treatment Time (RTT) targets in 2009 set out guidance on how to manage referrals from private practice. Both WHC (2006) 081 and WHC (2007) 075 refer to private patients wishing to transfer to an elective NHS pathway stating that 'where a patient wishes to transfer to an elective NHS pathway for treatment following a private consultation, they must first be seen in an NHS outpatient or pre-assessment clinic. The 26-week pathway will commence upon receipt of the referral. A patient who has been seen in a private capacity will join at the start of the 26-week pathway or at the outpatient stage, whichever is earliest, and the time they will wait will be based on their clinical priority only.'

1.2 If the principle set out in the WHCs is adopted, then patients who seek an initial private consultation who then transfer to an NHS waiting list, would always be placed at the start of the pathway, as this will always be the earliest point in the process. This would potentially mean they would have a longer wait than those who are already on the pathway as a result of an NHS referral.

1.3 The principle set out in the WHCs also conflicts with other guidance in existence which all make reference to 'patients who have had a private consultation for tests and diagnosis can still have treatment on the NHS and that the position on the NHS waiting list should be the same as if the original consultation was on the NHS'. This other guidance includes that issued from the BMA Medical Ethics Department on the interface between NHS and private treatment[6], the NHS Direct Wales (NHSDW) website[7] and the Code of Conduct for Private Practice issued by the Department of Health[8] which is recognised by clinicians and used in Wales.

1.4 Our work has shown that awareness amongst NHS staff of the principles for managing private patients onto the NHS waiting list, either those set out in the WHCs or in the other NHS guidance, is limited. NHS staff who manage waiting lists routinely refer to the rules for managing RTT[9], yet there is no reference in this document as to how private patients wishing to join the NHS waiting list should be managed.

5 WHC(2006) 081 Access 2009 – Delivering a 26 week patient pathway, WHC(2007) 041 – Access 2009 – Referral to treatment time measurement, WHC(2007) 051 – 2009 Access – Delivering a 26 week patient pathway – Integrated delivery and implementation plan and WHC(2007) 075 – 2009 Access Project – Supplementary guidance for implementing 26 week patient pathways

6 BMA Ethics, **The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland**, May 2009

7 www.nhsdirect.wales.nhs.uk/encyclopaedia/w/article/waitingtimes/

8 A Code of Conduct for Private Practice – guidance for medical staff, Department of Health

9 Rules for RTT.

1.5 All health boards have developed local policies or guidelines that set out the principles governing private practice, with clear emphasis on ensuring that private practice does not disadvantage NHS patients in any way or lead to faster treatment for private patients who subsequently revert to NHS status. However, with the exception of the Cardiff and Vale University Health Board policy, none of the policies refer to where private patients should be placed on the NHS waiting list when they transfer. The focus of such documents is much more on the management of private practice activity within the NHS and the recouping of costs, which is discussed later in this report. The guidance for Cardiff and Vale University Health Board, however, does refer to the principle of placing private patients at an appropriate point on the waiting list in line with the Department of Health guidance.

1.6 Not surprisingly, because of the conflicting guidance, there are differences across Wales as to where private patients transferring to the NHS waiting list are placed. Health boards and staff who are more aware of the WHC guidance will place private patients at the start of the 26-week pathway, while others will place them at a point which is deemed appropriate had they received their initial assessment on the NHS. However, making an assessment of where on the NHS pathway to place a private patient is extremely difficult given that NHS Wales currently lacks clarity on the expected waits relating to the different stages that make up the RTT pathway[10]. It is therefore difficult for staff to make a judgement as to where patients would have been on the list had they received NHS treatment, as waits for each NHS patient are highly variable. This results in private patients joining the pathway at a point which may or may not be comparable to NHS patients. Had component waiting times for receiving inpatient treatment been measured, then waits for NHS patients, regardless of whether their initial consultation was NHS or private, would be more comparable. Following the Auditor General's report **NHS Waiting Times for Elective Care in Wales**, the Welsh Government has committed to publishing component waiting times.

10 The RTT pathway consists of four stages: stage 1 (waiting for a new outpatient appointment), stage 2 (waiting for a diagnostic or Allied Healthcare Profession (AHP) test, intervention or result), stage 3 (waiting for a follow-up outpatient appointment or waiting for a decision) and stage 4 (waiting for an admitted diagnostic or therapeutic intervention (ie. treatment)).

On the whole, health boards are unable to identify private patients reverting to NHS care which makes it difficult to ensure that they are not being treated more quickly than NHS patients

1.7 None of the existing Welsh or UK-wide guidance makes reference to how a private patient wishing to transfer to an elective NHS pathway should be referred across to the NHS. This is replicated in local policies with the exception of the policy for Betsi Cadwaladr University Health Board which stipulates that 'private patients who transfer to NHS status must always be referred back to their GP'.

1.8 The minimum data sets currently applied to NHS Wales do not require patients referred via a private or independent setting to be identified as such on the patient administration system. Consequently, private patients transferring to the NHS are recorded as a GP, or in some cases, a consultant referral on the system. This means that staff are unable to identify these patients on the patient administration systems which makes it is very difficult to monitor the waiting times for these patients across Wales.

1.9 Most health boards have a central process for adding patients to waiting lists, and unless it is clear on the referral that the patient has already received a private consultation, booking clerks will add them to the start of the 26-week pathway, which complies with the WHC guidance but conflicts with the other guidance in circulation. All referrals, however, should be classified according to whether they are 'routine' or 'urgent'[11] based on clinical need and it is this that will determine their priority on the waiting list.

1.10 Given the difficulties associated with identifying these patients, health boards are not routinely checking that private patients who transfer to the NHS are not receiving faster treatment. The health board staff we spoke to confirmed that it was difficult to identify private patients who changed status in order to monitor the length of time they waited for treatment. Several health boards said that a lack of capacity limits their ability to monitor patient pathways, whilst some felt that the exercise would require more resources than were justified given the relatively small numbers of patients involved.

11 The 'urgent' category applies to patients with urgent suspected cancers as well as patients who are urgent for other reasons.

1.11 Despite these comments, one of the health boards we visited had implemented mechanisms that assisted in identifying private patients who subsequently join NHS waiting lists. The compliance team at Aneurin Bevan University Health Board runs daily checks on current waiting list data to look for anomalies and was confident that this would identify patients who had experienced unusually short waits. The Health Board has developed a bespoke code to identify private patients who have 'changed status' to become an NHS patient, which is recorded on its patient administration system. However, this daily spot check relies on the experience of compliance staff rather than a more formal audit process.

1.12 None of the health boards we visited have conducted any kind of review of the classification of cases to understand the degree of urgency in order to monitor whether some of these patients have been falsely classified as 'urgent' to expedite their treatment. One person told us it would be useful to conduct peer reviews, which examined 'urgent' and 'routine' classifications; however, it was recognised that this process would require additional resources.

An analysis of the limited data which exists does not allow any definitive conclusions to be drawn on whether private patients who revert to an NHS list get treated more quickly

1.13 Given the challenges associated with identifying patients who have chosen to receive NHS treatment following a private consultation, we have reviewed a sample of the cohort of patients who attended a private consultation in an NHS facility to understand how many of those patients reverted to NHS treatment and how long they waited for NHS treatment.

1.14 Our review focused specifically on a sample of patients attending private consultations in Aneurin Bevan, Abertawe Bro Morgannwg, Betsi Cadwaladr and Hywel Dda University Health Boards during 2013-14. Of the 416 patients reviewed, we found that 81 were recorded as reverting to NHS for further treatment, of which 26 went on to have an elective NHS hospital admission. Seventeen of these patients (65 per cent) were classified as 'urgent' on the waiting list, with all private patients admitted for NHS treatment in Aneurin Bevan University Health Board classified as 'urgent' (Figure 2).

Figure 2 – Number of private patients reverting to NHS treatment during 2013-14 that went on to have an elective hospital admission

Health Board	Number of patients seen as private in NHS facilities	Number of patients who reverted to NHS for further treatment	Number of patients who reverted to NHS and went on to have an elective hospital admission	Number of patients admitted as 'urgent'
Abertawe Bro Morgannwg	116	19	2	1
Aneurin Bevan	120	40	12	12
Betsi Cadwaladr	117	6	6	1
Hywel Dda	63	16	6	3
Total	416	81	26	17

Source: Wales Audit Office analysis of health boards' patient administration systems

1.15 The waiting times for the 26 private patients who went on to receive further treatment on the NHS was compared to the average waits experienced by NHS patients to see if there was any evidence of 'queue jumping' by the private patients when they reverted to the NHS lists. To form as complete a view as possible, the analysis involved a comparison to both the average wait for NHS patients treated in the same specialties and health boards, and also to the point by which 95 per cent of all patients have been treated. The results of this analysis are shown in Figure 3, which superimposes the waits of each of the individual private patients onto the average and 95th percentile NHS waits, and also shows which private patients were classified as urgent at the point when they joined the NHS list.

1.16 Five of the 26 patients actually experienced much longer waits than those experienced by 95 per cent of NHS patients, even though some of these were classified as urgent. This might be due to local interpretation of guidance with some private patients positioned right at the start of the 26-week pathway. It may also reflect some patients choosing to receive a private consultation after already being on an NHS waiting list for some time.

1.17 Figure 3 indicates that the remaining 21 private patients were treated within the average and 95th percentile NHS waiting time. However, this does not necessarily mean that they received quicker treatment than corresponding NHS patients as the average and 95th percentile waits shown in the diagram will be made up of a very wide range in individual NHS patient waits, reflecting issues such as urgency and type of treatment, the need for sub-specialist treatment and choice as to where to receive treatment. A much more detailed examination of the data than was possible within the scope of this audit would therefore need to be undertaken in order to provide a more definitive answer on whether private practice patients can 'jump the queue' by joining an NHS list. This would need a much larger data set than is currently available, supplemented by more detailed case-by-case reviews of both private and NHS patients receiving like-for-like treatment.

1.18 Such an analysis could usefully include an assessment of whether private patients who are classified as urgent when they join an NHS list receive quicker treatment than NHS patients who are similarly categorised. At present such an analysis is not possible as NHS waiting time data does not differentiate between urgent and routine patients. The Auditor General's report on **NHS Waiting Times for Elective Care in Wales** included a recommendation to address this as part of a number of actions to make published NHS waiting time data more meaningful.

Figure 3 – Actual waiting times for private patients transferring to NHS treatment that went on to have an elective hospital admission, compared with the average wait for the same specialty and health board and the 95th percentile

Source: Wales Audit Office analysis of health boards' patient administration systems

Part 2

Health boards are not managing the impact of private practice on NHS resources and activity effectively

Local guidance lacks clarity on when and how much private practice can take place in NHS facilities, and health boards lack controls to ensure that private practice work is not impacting on the provision of NHS services

2.1 It is important to note that private practice plays a crucial role in attracting consultants to work in Wales, and when managed appropriately, private practice in the NHS can generate income for health boards to invest in NHS provision. Both the guidance from the Department of Health and the BMA Medical Ethics department makes reference to how private practice should be managed appropriately, stating that:

- The provision of services for private patients should not disrupt NHS services.
- With the exception of the need to provide emergency care:
  - NHS commitments should take precedence over private work where there is a conflict, or potential conflict, of interests; and
  - practitioners should not provide private patient services that will involve the use of NHS staff or facilities, unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient.

2.2 During our fieldwork, health boards cited the main source of information to manage private practice in the NHS as the Department of Health's Code of Conduct for Private Practice 2003, referred to as 'The Green Book'. Some of their own policies reflect the code of conduct and for some, there is clear guidance based on which clinics or theatre slots can be used for private practice. In many cases, health board policies state that private activity can only take place in agreement with the health board either through a private patient office, or through the relevant directorate. In both Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards, private practice activity is, in part, facilitated through dedicated private facilities, namely the Bridgend Clinic and the Glan Usk Suite.

2.3 However, policies lack information on the volume of activity permitted or how they intend to manage the impact on NHS patients, with health boards telling us that the volume of private activity is so small it does not warrant a definition as it is unlikely to impact on NHS patients. There is also no reference in any policy to how activity should change with the seasons, given that NHS services are likely to experience greater demand during the winter period. Nor is there reference to how private practice undertaken in the NHS fits into the job planning process for consultants and how compliance with job planning principles is measured.

2.4 Several of the health boards we visited have registers for consultants wishing to conduct private work and most include links to the BMA guidance and the Consultant Contract, which provide guidance for consultants on the principles governing private work. We have not tested compliance with these registers but are aware that the registers for both Betsi Cadwaladr and Hywel Dda University Health Boards are not regularly maintained.

2.5 Where a private patient office exists, staff within these offices will book patients into private theatre lists or clinic slots, but this is only the case in Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards. In other health boards and for activity that falls outside the two private practice facilities in Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards, consultants and their medical secretaries will arrange private practice activity. Awareness of local guidance on private practice in the NHS, however, varies. Some health boards ask clinicians to sign an agreement to confirm that they are fully aware of current policies and procedures relating to private practice in the NHS, while others have no mechanism for ensuring clear communication of policies to all relevant staff, including medical secretaries.

2.6 Aneurin Bevan University Health Board provides training to booking centre staff on private practice, which has developed a strong ethos amongst staff that NHS patients should not be disadvantaged because of private practice. This means that booking centre staff act almost as ‘gatekeepers’ alerting the compliance team of potential issues.

2.7 However, we found that typically directorate managers in the sites we visited across Wales had little knowledge of how private practice in the NHS is managed. Indeed many did not know the extent to which private practice activity is undertaken within their own directorates, despite small but not insignificant levels of private practice being reported in some of their directorates. This lack of knowledge therefore makes it difficult for managers to provide assurance that private activity is not occurring during clinicians’ contracted NHS hours and is not having a knock-on impact on NHS resources. This impact could include placing demands on bed capacity if private patients are admitted over the weekend and then need to stay on an NHS ward; or affecting the start of NHS clinics or theatre activity due to overruns with private consultations.

2.8 Several health boards told us that private practice does form part of the job planning discussion with consultants and job plans do include information on private practice. However, the focus of these discussions is on private practice activity undertaken outside of the NHS. Health boards recognised that there are no routine checks of whether private work on NHS facilities is taking place, and if so, when and where. Abertawe Bro Morgannwg University Health Board identified that it would be very difficult to monitor when private activity takes place because consultants regularly change private clinic and theatre times to accommodate changes to their NHS schedule.

2.9 Information relating to private practice activity in the NHS is not readily available to those who need it, and when it is, there are weaknesses with the accuracy of the data. Patients receiving private healthcare within the NHS should be recorded on the patient administration system as private patients. During our fieldwork, we found a number of administrative errors on the patient administration systems resulting in:

- NHS patients incorrectly recorded and reported as private patients; and
- private patients seen in private clinics and noted on the patient administration system as being private, but recorded as NHS patients.

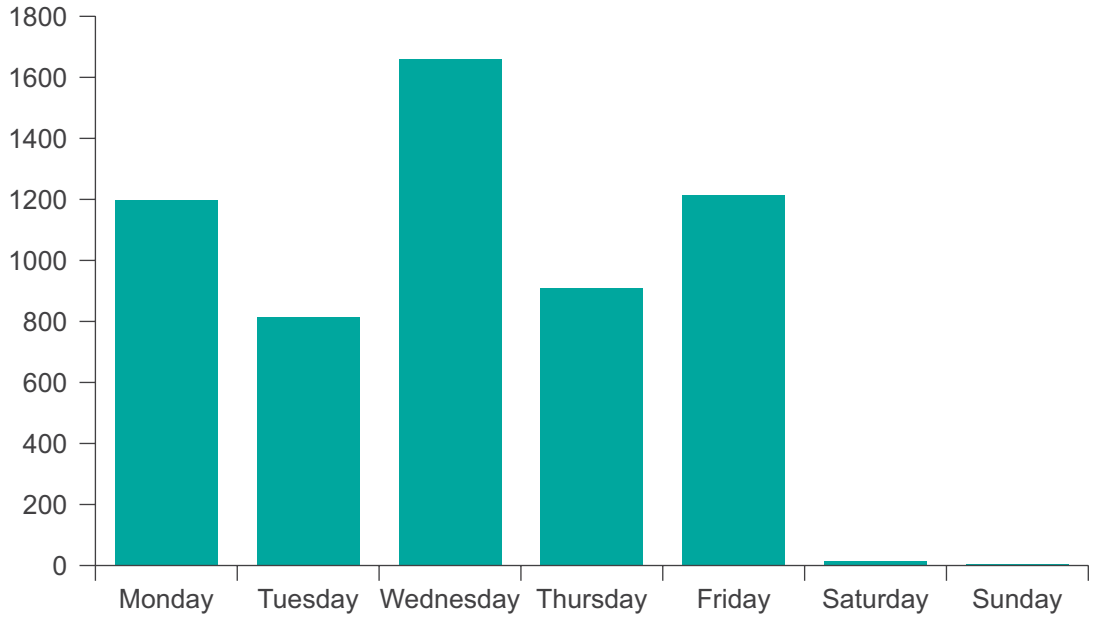
2.10 During our visit to Abertawe Bro Morgannwg University Health Board, staff told us that none of the private outpatients seen at the Bridgend Clinic are recorded on the health board's patient administration system. This represents approximately 10,000 outpatients a year. Similar issues have also been raised in other health boards where it has been difficult to identify the true scale of private practice taking place. Health board systems for identification of private patients are routinely paper-based, relying on consultants identifying patients and therefore it is possible that the data reported to the NHS Informatics Service is not an accurate reflection of private practice in NHS facilities in Wales.

A significant proportion of private practice takes place during the week and while some of this is managed out of hours and in dedicated sessions, it is highly likely to be impacting on NHS resources

2.11 There was a perception by the operational staff to whom we spoke in health boards that private activity within NHS facilities takes place either before or after NHS clinics, or outside the consultants' contracted NHS hours. As part of our review, we have analysed the data relating to all private patients recorded as being treated in the NHS during 2014-15 to get a view of when private practice activity actually takes place and the extent to which it has the potential to impact on NHS capacity and resources.

2.12 During 2014-15, 5,975 private outpatient appointments were held, accounting for 3,996 patients. Our analysis has identified that almost all of these outpatient appointments were held on a weekday (Figure 4).

Figure 4 – Number of private outpatient appointments held in NHS facilities by day of the week in 2014-15

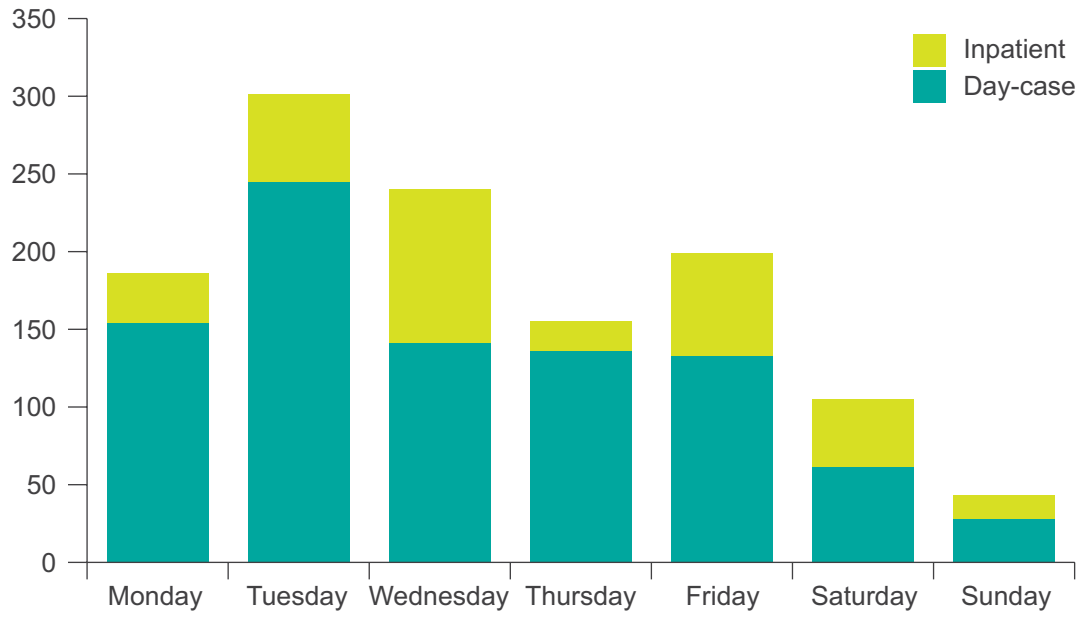


Source: Wales Audit Office analysis of PEDW data

2.13 Data available from NWIS does not include the outpatient appointment time and therefore it is difficult to know at what time of the day these patients are being seen and how this related to scheduled NHS time. Some private patients are seen during the normal working day for genuine reasons. A large proportion of private outpatient appointments held in Cardiff and Vale University Health Board relate to the provision of IVF treatment which is recognised as being a privately funded service. At Aneurin Bevan University Health Board, 211 out of a sample of 220 outpatient consultations were held in the Glan Usk suite, which is the dedicated private facility. However, a review of a sample of 60 private outpatient appointments held in Hywel Dda University Health Board, which has no dedicated private facilities or clinic sessions, identified that 40 per cent were seen before 9am or during lunchtime (between 12pm and 2pm), while the remaining 60 per cent of appointments were held during NHS sessional time. A review of job plans for some consultants confirmed the potential for private patients to be seen during NHS sessions.

2.14 During 2014-15, there were 1,229 private admissions to NHS hospitals, of which 331 required overnight stays. Whilst we were told that many private admissions to NHS hospitals, particularly day-case admissions, took place on a Saturday, our analysis has found that 88 per cent of such admissions actually took place on a weekday (Figure 5).

Figure 5 – Number of private hospital admissions (inpatient and day-case) to NHS facilities by day of the week in 2014-15



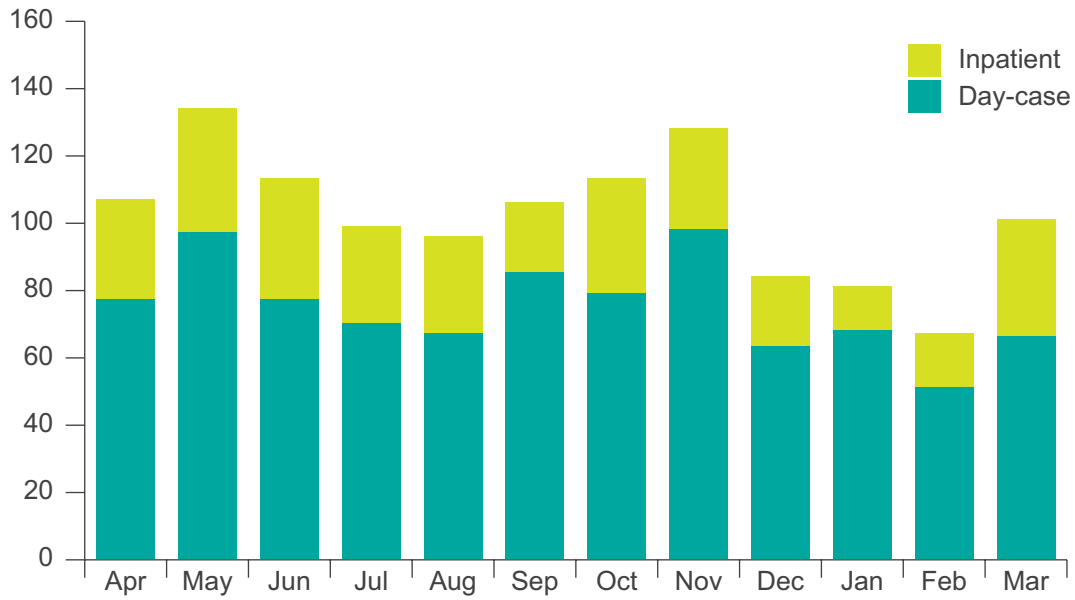
Source: Wales Audit Office analysis of PEDW data

2.15 Again, data available from NWIS does not include the admission time and therefore it is difficult to know whether these patients are being admitted during NHS time. However, given the time needed to recover from a day-case procedure, it is likely that many of these patients will have been admitted during the day. We did find that a number of private ophthalmology patients at Betsi Cadwaladr University Health Board were operated on during NHS theatre times. It was not possible to determine whether these private sessions were booked in to 'backfill' theatre time that could not be used for NHS patients or whether they were using theatre capacity at a time that could have been made available to NHS patients. However, we found that the system for booking private ophthalmology patients at the health board was open to abuse as there was no oversight to make sure that consultants' secretaries did not book private patients into NHS theatre sessions.

2.16 Aneurin Bevan, Abertawe Bro Morgannwg, and Cardiff and Vale University Health Boards reported the highest numbers of private patients who stayed in hospital for at least one night. These patients accounted for 1,305 bed days in total with an average length of stay of 5.1 days (see Appendix 2, Figure 4). In Aneurin Bevan University Health Board, 108 admissions during 2014-15 accounted for 495 bed days. These admissions were in a variety of specialties: cardiology; general surgery; gynaecology; and trauma and orthopaedics. Whilst these patients undoubtedly required specialist care which might not have been available elsewhere, it is reasonable to assume that some of these occupied NHS beds during their stay, given that patients admitted to the Glan Usk suite are transferred to an NHS ward after the first overnight stay.

2.17 Pressure on hospital beds becomes more acute during the winter. Whilst the number of private admissions to NHS hospitals fell during the winter months, some private activity continued (Figure 6).

Figure 6 – Number of private hospital admissions to NHS facilities by month



Source: Wales Audit Office analysis of PEDW data

2.18 At Abertawe Bro Morgannwg, Aneurin Bevan, and Cardiff and Vale University Health Boards, private activity over the winter included a small number of private inpatient admissions. Despite the small numbers, these patients accounted for a considerable number of bed days, with 36 patients accounting for 308 bed days. The data does not tell us whether these admissions were urgent or routine private patients but regardless this is a considerable number of bed days, which were not otherwise available for NHS patients. We found little evidence of planning from health boards to manage the impact of private patients on NHS bed capacity. Abertawe Bro Morgannwg University Health Board completes a risk assessment, including an estimate of length of stay in hospital, prior to admission for private cardiology patients. Similarly, Aneurin Bevan University Health Board completes a risk assessment which is considered at the daily capacity meeting, but we found no evidence of similar risk assessments elsewhere.

2.19 Health boards did tell us that private patients will always be cancelled before NHS patients and we found several examples during our fieldwork of private activity being cancelled to allocate resources to NHS patients during bed pressures or for waiting list initiatives. The Glan Usk Suite at Aneurin Bevan University Health Board has subsequently changed status from a dedicated private facility to include a mix of private and NHS patients, and the Bridgend Clinic at Abertawe Bro Morgannwg University Health Board accommodates NHS patients when required.

2.20 Our work also considered the level of private radiological tests being undertaken within NHS facilities. In some health boards, we were told that privately funded diagnostic tests are carried out outside normal working hours but in other health boards, these tests are conducted where there is spare capacity and with approval of the relevant manager. During 2013-14, there were 2,400 private radiological tests undertaken in the NHS across Wales. Of these, 291 were for MRI. We do not have information relating to when tests were carried out in all health boards, but analysis of the data provided to us by Abertawe Bro Morgannwg, Aneurin Bevan and Cardiff and Vale University Health Boards indicates that 69 per cent of privately funded radiological tests were undertaken during normal working hours. Whilst the data is not definitive, it would be reasonable to conclude that this level of privately funded diagnostic work is going to have some impact on hospitals' ability to meet NHS waiting time targets for diagnostic tests.

Whilst most health boards appear to be recouping the costs of private practice, others are not doing this effectively due to cumbersome administrative processes and unreliable information

2.21 Health board guidance documents generally describe clear processes for recouping the costs of private practice from patients and insurance companies. Most set out clear roles and responsibilities, and have a series of forms for staff and patients to complete at different stages in the process. All health boards require self-funding patients to sign documents to show their intention to pay which includes an estimate of the charges they are likely to incur. This reflects the 'Green Book' guidance, which requires a commitment, or undertaking that patients will pay before providing private services within NHS facilities. In Aneurin Bevan University Health Board, there is also a requirement for self-funding patients to pay a 100 per cent deposit prior to admission. The application of the process for recouping costs is, however, fraught with a number of challenges.

2.22 Aneurin Bevan, Abertawe Bro Morgannwg and Betsi Cadwaladr University Health Boards each have a small dedicated team to oversee the management of private practice, typically comprising two or three members of staff. There are no resources in the other health boards and trusts, some of which have much lower levels of private practice activity. Responsibility for the invoicing process and the recouping of costs, however, generally falls to the finance team in all NHS bodies. Whist there is a requirement for health boards to record private patients on the patient administration system, the private practice offices and finance departments have to rely on timely and accurate information, detailing the patients' treatment plans, from consultants, their secretaries and clinical teams in order to raise an invoice. However, our work identified a number of occasions where this information is not complete, timely or just not being provided:

- staff at Betsi Cadwaladr University Health Board told us that they often did not get the required paperwork;
- late submission of information to the private practice office at Abertawe Bro Morgannwg University Health Board meant that patients were not signing a commitment to pay prior to their outpatient appointment taking place; and
- consultants in some specialties in Abertawe Bro Morgannwg University Health Board were failing to complete paperwork to declare private activity.

2.23 All health boards have a pricing tariff for private practice. Most are the result of negotiation with insurance companies, or based on BUPA tariffs with an annual uplift for inflation. Pricing tariffs for both Betsi Cadwaladr and Hywel Dda University Health Boards, however, were found to be out of date, with different tariffs for each hospital site in Hywel Dda University Health Board reflecting the arrangements that existed in the predecessor NHS trusts prior to NHS re-organisation in 2009. In contrast, the pricing tariffs for Abertawe Bro Morgannwg, Aneurin Bevan, and Cardiff and Vale University Health Boards were up to date and reviewed annually to ensure that the prices are a fair reflection of the costs.

2.24 What is included within the tariff, however, differs across Wales. The final price for a hospital admission can include a charge for the procedure with charges for the theatre use, an overnight stay and consumables such as prosthetics added on top, or a package price including all of these items and an estimate of the number of nights a patient is likely to stay. Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards also account for deterioration of equipment for diagnostic tests to ensure that income from private activity contributes to the sustainability of the service. The tariff for an outpatient consultation also varies from a flat rate per appointment, to the cost of the consultation being included in the professional fees, which then requires the consultant to pay for the use of a room.

2.25 The inclusion of professional fees within the invoice from the health board also varies across Wales. In most health boards, the consultant and anaesthetist will charge professional fees separately and the health boards will invoice just for the costs to the NHS. This results in the patients receiving multiple invoices, which is not always made clear to them upfront and on occasions, will result in disputes between the patient and the health board. In Abertawe Bro Morgannwg University Health Board, professional fees associated with clinical physiology are paid through the health board and show on the clinician's payslip. This provides an incentive to report private activity accurately and timely because clinicians only get paid if they submit a claim. Cardiff and Vale University Health Board is developing a similar system for all of its private practice with a single invoice system including professional fees for consultants, anaesthetists and any NHS facilities they use. Professionals will then receive payment as part of the health board's payroll process following receipt of the income from the insurance company or where relevant, the patient.

2.26 The process for recouping costs requires checks and balances to ensure that paperwork is completed and that the invoice is an accurate reflection of the costs incurred. Some health boards conduct monthly checks using data from the patient administration system to crosscheck the information with that provided by the consultants, such as procedure and length of stay although this is not always reliable given errors within the patient administration system as discussed in paragraph 2.9.

2.27 However, capacity is often an issue with some health boards unable to carry out these checks on a regular basis. This was particularly the case for Hywel Dda University Health Board where the responsibility for private practice activity was falling to one member of staff in the finance department, alongside their other responsibilities. Where the booking of private practice activity is routed through a central office, such as the Swansea-based private patient office in Abertawe Bro Morgannwg University Health Board, reports are produced on the number of admissions booked through the office so they can be crosschecked with the paperwork from consultants.

2.28 There is no formal and common IT solution for managing private practice within NHS Wales. This is resulting in private practice and finance teams using a combination of paper-based and electronic records. These often differ across sites within the same health boards, making the process of managing and monitoring private activity difficult and time-consuming. In some cases, in order to find out which procedure a patient had, whether they were charged accurately and whether they paid for their treatment, it is necessary to cross-reference information from two or three different systems, none of which are integrated in any way.

2.29 However, during our fieldwork, we identified several good examples of standalone databases being used to manage private practice. The Nevill Hall office at Aneurin Bevan University Health Board uses a system, which self-populates with information from the patient administration system. Cardiff and Vale University Health Board uses a spreadsheet to monitor private practice which includes patient contact details, details of the procedure they had, invoice number, price and payment date with a hyperlink to an individual charge sheet which breaks down costs for each patient. Having all of the information in one place makes it easier to deal with queries and enables the finance department to extract monthly data on income from private practice efficiently.

2.30 During 2013-14, the NHS in Wales reported receiving £8.5 million from private patient income. Although a substantive amount, this represents just 0.1 per cent of the total operational budget of the NHS in Wales. Abertawe Bro Morgannwg University Health Board received by far the largest proportion of this private income, at £3.3 million. As part of our work, we tested samples of private patient activity undertaken in NHS facilities during 2013-14 to understand the extent to which all appropriate costs for private practice activity are recouped by the health boards. The activity related to outpatient appointments, inpatient admissions and radiological tests. Our analysis identified that in six per cent of these cases, income from private practice activity was not recouped that should have been (Figure 7). The bulk of these cases where income was not properly recouped were in Hywel Dda University Health Board.

Figure 7 – Level of private practice activity undertaken in NHS facilities where income was not recouped appropriately

Type of activity	Sample size	Number of cases where income was not recouped appropriately	Percentage not recouped appropriately
Outpatient	450	22	5%
Inpatient	172	14	8%
Radiology	206	14	7%
Total	828	50	6%

Source: Wales Audit Office analysis of health board financial systems

2.31 Within the sample, we found a number of occasions where recouping the income was not appropriate because:

- patients were recorded incorrectly as private patients on the patient administration system when in fact they were receiving NHS treatment; and
- patients had cancelled or did not attend their private appointment.

2.32 These cases, however, take time and effort from the finance teams to understand why it is not appropriate to invoice for treatment due to the correct information not being available at the start of the process. On occasions, this has resulted in invoices being issued to patients who then inform the health board that they should not need to pay.

2.33 All health boards, with the exception of Hywel Dda University Health Board, produce monthly reports showing the income from private practice, and in Abertawe Bro Morgannwg, Aneurin Bevan and Cardiff and Vale University Health Boards, targets relating to income from private practice have been set. These reports, however, just show the monetary value and provide no information on the level of activity being undertaken, or whether the income recouped is the correct level of income for the activity. Our analysis also identified that although 51 per cent of invoices for private treatment in the NHS are paid within a month of the invoice date, 26 per cent take more than three months to be paid, with eight per cent taking more than six months and on occasion more than a year. While it is positive that on the whole the income for private practice activity is being recouped, cumbersome administrative processes and unreliable information mean that a financial burden relating to the provision of private practice healthcare is placed on the NHS until the point when those costs are recovered. In recognition of this, a number of health boards, particularly those with a greater level of private practice activity, have requested their internal audit function to undertake reviews in this area over the last 12 to 18 months. These reviews have identified specific actions that local teams need to take to strengthen their arrangements.

Appendices

Appendix 1 - Location of private hospitals and independent clinics in Wales

Appendix 2 - Analysis of private practice activity undertaken in NHS facilities

Appendix 3 - Audit approach

Appendix 1 - Location of private hospitals and independent clinics in Wales

1 North Wales Medical Centre, Llandudno, Gwynedd

2 Abergele Consulting Rooms, Abergele, Conwy

3 Spire Yale Hospital, Wrexham

4 Werndale Hospital, Bancyfelin, Carmarthenshire

5 Sancta Maria Hospital, Swansea

6 Vale Healthcare, Llantrisant, Vale of Glamorgan

7 Cyncoed Road Clinic, Cardiff

8 Spire Hospital, Cardiff

9 Consulting Rooms, Newport

10 St Joseph's Hospital, Newport

Appendix 2 - Analysis of private practice activity undertaken in NHS facilities

Figure 1 – Level of outpatient and inpatient private practice activity undertaken in NHS facilities during 2013-14 and 2014-15 by health board and trust

	Outpatient attendances		Inpatient cases		Day-case attendances	
Health board/trust	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Abertawe Bro Morgannwg (ABM)	1,159	1,329	100	74	141	124
Aneurin Bevan (AB)	2,087	2,105	101	108	152	101
Betsi Cadwaladr (BCU)	1,888	1,920	59	53	664	544
Cardiff and Vale (CV)	90	35	54	73	58	56
Cwm Taf (CT)	84	47	11	9	25	26
Hywel Dda (HD)	438	359	16	13	104	45
Powys (P)	4	-	-	-	-	-
Public Health Wales	-	-	-	-	-	-
Velindre	12	-	2	1	2	2

Source: Wales Audit Office analysis of PEDW data

Figure 2 – Private outpatient activity by specialty (2014-15)

Specialty	Appointments	Patients	Health boards with the highest volumes of activity (appointments)
Ophthalmology	2110	1180	BCU (1628), HD (258) and ABM (204)
Trauma and Orthopaedics	852	673	AB (607) and ABM (200)
Cardiology	434	385	AB (311) and ABM (108)
Dermatology	422	259	ABM (279) and AB (134)
General Surgery	421	362	AB (271) and ABM (105)
Gynaecology	301	232	AB (206)
ENT	251	203	All in BCU (187) and ABM (64)
Neurology	187	150	AB (168)
Gastroenterology	149	107	All in AB (141) and ABM (8)
Urology	146	123	AB (99) and ABM (43)
Respiratory Medicine	96	57	All in AB
Rheumatology	87	82	AB (72)
Cardiothoracic Surgery	84	55	All in ABM
Clinical Haematology	60	38	All in ABM
Pain Management	59	53	BCU (51)
Oral Surgery	20	19	All in BCU (20)
Clinical Oncology	27	8	All in ABM (27)
Forensic Psychiatry	77	73	All in ABM
General Medicine	9	9	HD (7)
Paediatrics	1	1	HD (1)
Plastic Surgery	1	1	ABM (1)
Anaesthetics	1	1	CT (1)

Source: Wales Audit Office analysis of PEDW data

Figure 3 – Privately funded admissions to NHS facilities by specialty (2014-15)

Specialty	Hospital admissions			Health boards with highest volumes of activity
	Total	Day case	Inpatient	
Ophthalmology	416	406	10	BCU (326)
Trauma and Orthopaedics	172	67	105	AB (83) and ABM (40)
General Surgery	157	97	60	AB (54) and BCU (50)
Urology	103	63	40	BCU (66)
Cardiology	91	81	10	ABM (34) and AB (25)
Gastroenterology	86	86	-	BCU (63)
ENT	50	36	14	BCU (27) and ABM (22)
Gynaecology	50	25	25	AB (23) and CT (18)
Cardiothoracic Surgery	40	1	39	All in ABM (24) and CV (16)
General Medicine	11	9	2	CV (10)
Pain Management	10	10	-	HD (7)
Clinical Oncology	8	1	7	All in BCU (6) and Velindre (2)
Oral Surgery	7	6	1	All in BCU (7)
Paediatric Surgery	6	2	4	All in CV (6)
Other	22	8	14	CV (8)

Source: Wales Audit Office analysis of PEDW data

Figure 4 – Privately funded inpatient admissions to NHS hospitals across Wales with a length of stay greater than zero (2014-15)

	Inpatient admissions	Bed days	Average length of stay
Abertawe Bro Morgannwg	74	444	6.0
Aneurin Bevan	108	495	4.6
Betsi Cadwaladr	53	143	2.7
Cardiff and Vale	73	366	5.0
Cwm Taf	9	168	18.7
Hywel Dda	13	35	2.7
Powys	-	-	-
Velindre	1	1	1.0
	331	**1,652**	**5.0**

Source: Wales Audit Office analysis of PEDW data

Appendix 3 - Audit approach

The review of private practice took place between August 2014 and May 2015. Details of the audit approach are set out below.

Document review

We reviewed relevant documents for all NHS bodies including:

- documents setting out the NHS body's policy on private practice including guidelines for patients accessing NHS treatment following a private consultation or diagnosis, and guidelines for clinicians conducting private work in NHS facilities;
- information on the billing mechanism for private work in NHS facilities;
- documents profiling demand and activity and how private work (including consultation, diagnosis and treatment) is planned in the light of this profile; and
- theatre lists, clinic lists and job plans that show the balance of private and NHS work and whether private patients are seen at the end of clinics or at other times.

We also reviewed any Welsh Government communication to NHS bodies setting out guidelines on private patients entering the RTT pathway and the management of private practice in NHS facilities.

Centrally collected data

We analysed all private practice outpatient and inpatient activity undertaken in 2013-14 and 2014-15, which was made available to us through the Patient Episodes Database for Wales (PEDW) analysis team. We also analysed all private practice radiological diagnostics undertaken in 2013-14, which was made available to us through the radiology departments across Wales.

Data testing

Focusing specifically on the health boards with the greatest levels of private outpatient and/or private inpatient activity (Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, and Hywel Dda), we reviewed a number of samples of private patient data with a specific focus on:

- mapping individual patient pathways and for those who received NHS inpatient treatment, identifying key milestone dates in their pathway in order to compare their total waiting time with that experienced by a typical NHS patient; and
- identifying each component of the private treatment the patients received in NHS facilities and matching the information with financial records from NHS bodies to understand the extent to which associated costs of treating those patients in NHS facilities had been recouped.

Interviews

Focusing on the same five health boards as the data testing exercise (Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, and Hywel Dda), we interviewed a range of staff to find out whether they have a clear policy and process for managing the impact of private practice on the NHS and to understand how these policies were implemented. Where they existed, this included interviewing private practice managers along with directorate managers for specialties that recorded high numbers of private practice activity.

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Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee
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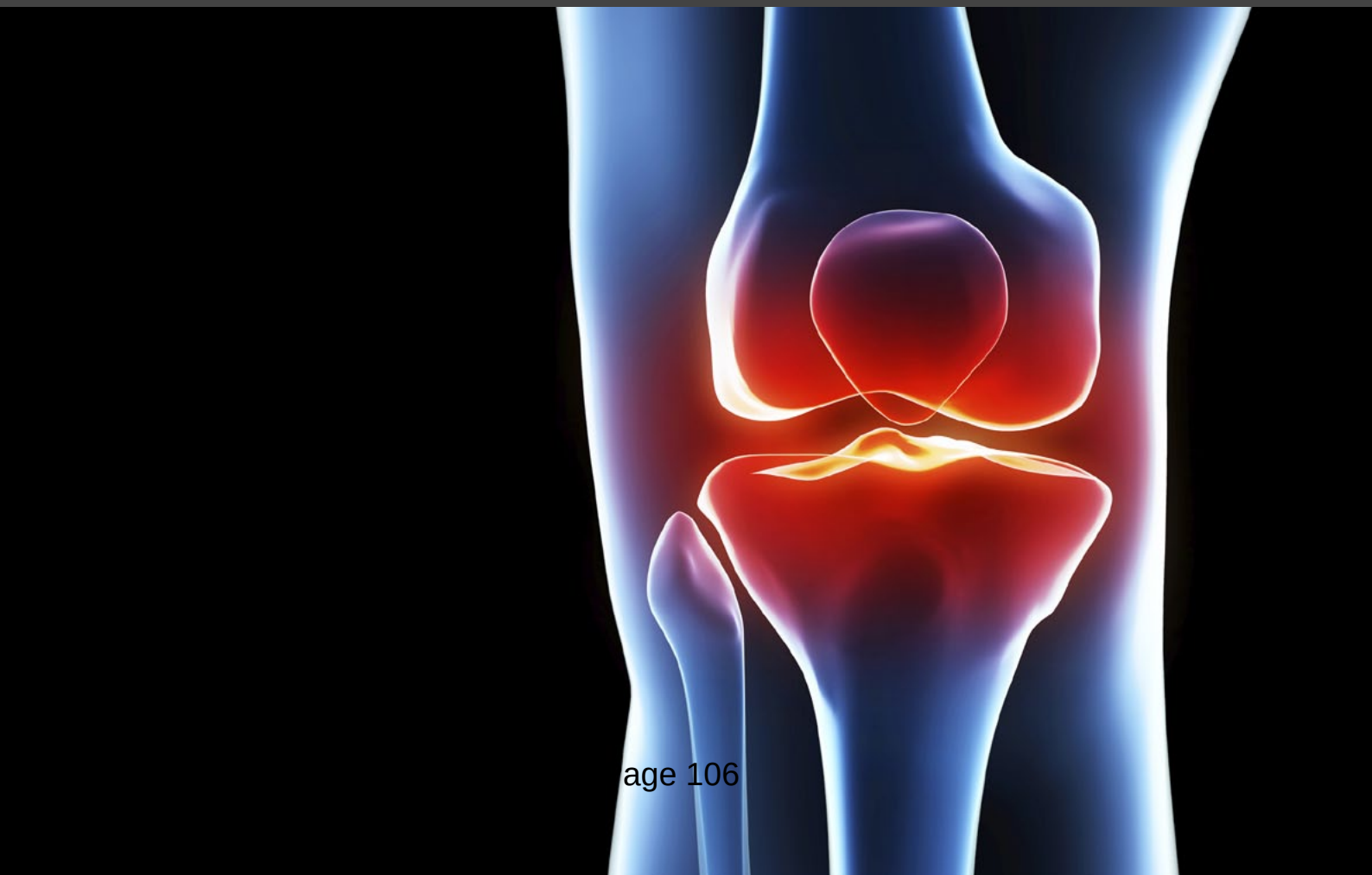
25 June 2015

Archwilydd Cyffredinol Cymru
Auditor General for Wales

A Review of Orthopaedic Services

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



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

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

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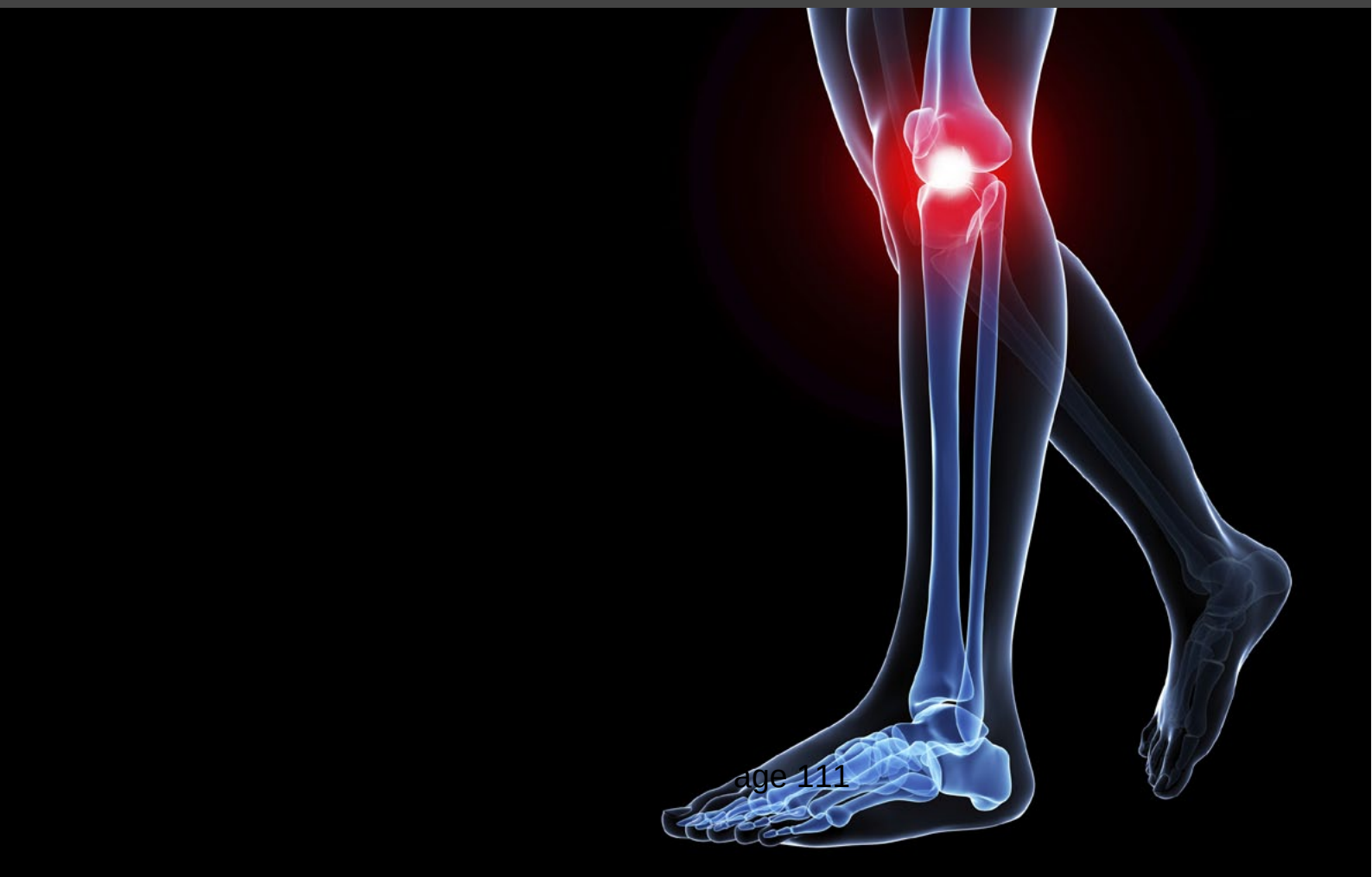


Summary

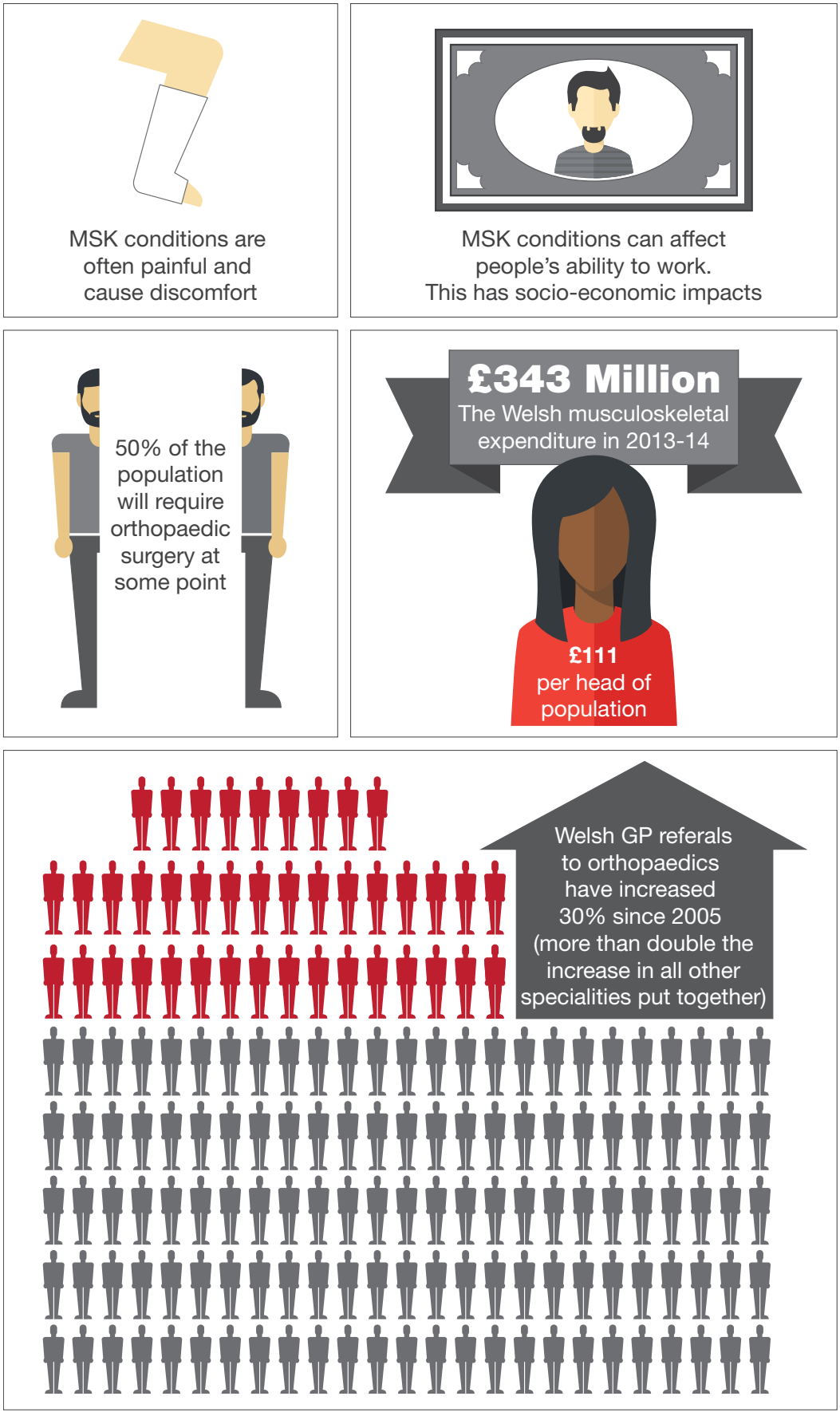
1 Orthopaedics is the branch of medicine that deals with the injuries and disorders of the musculoskeletal system, which includes the skeleton, muscles, joints and ligaments. Musculoskeletal services is a broader term that refers to all services involved in the care of patients with musculoskeletal conditions,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

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

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

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

Figure 1 – Musculoskeletal programme budget expenditure and demand



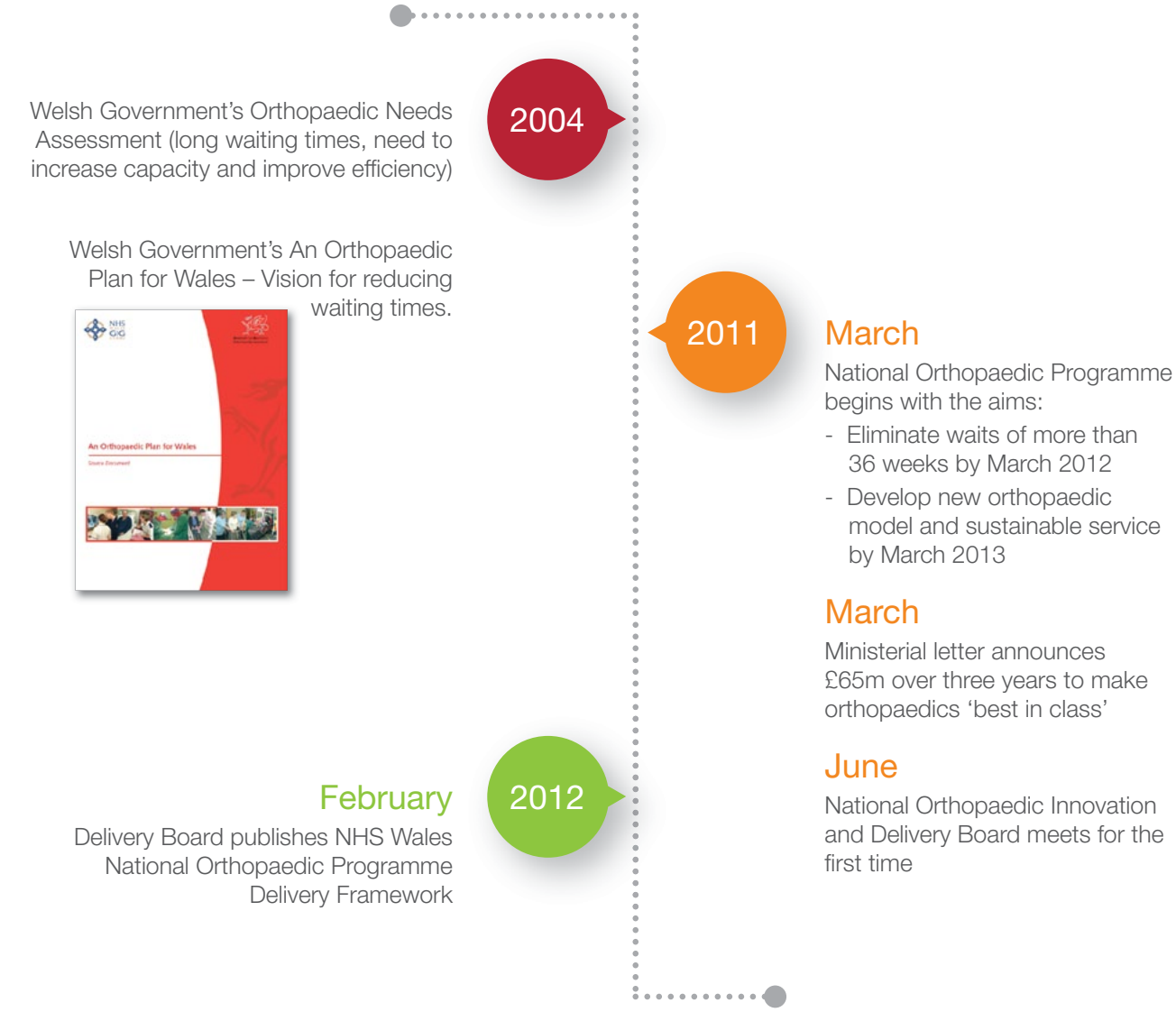
Source: Wales Audit Office use of figures from National Public Health Service[1], Stats Wales[2] and a Welsh ministerial letter[3].

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

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

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

Figure 2 – Timeline of key national musculoskeletal initiatives



Source: Wales Audit Office

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

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

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

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

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

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

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

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

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

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

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

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

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

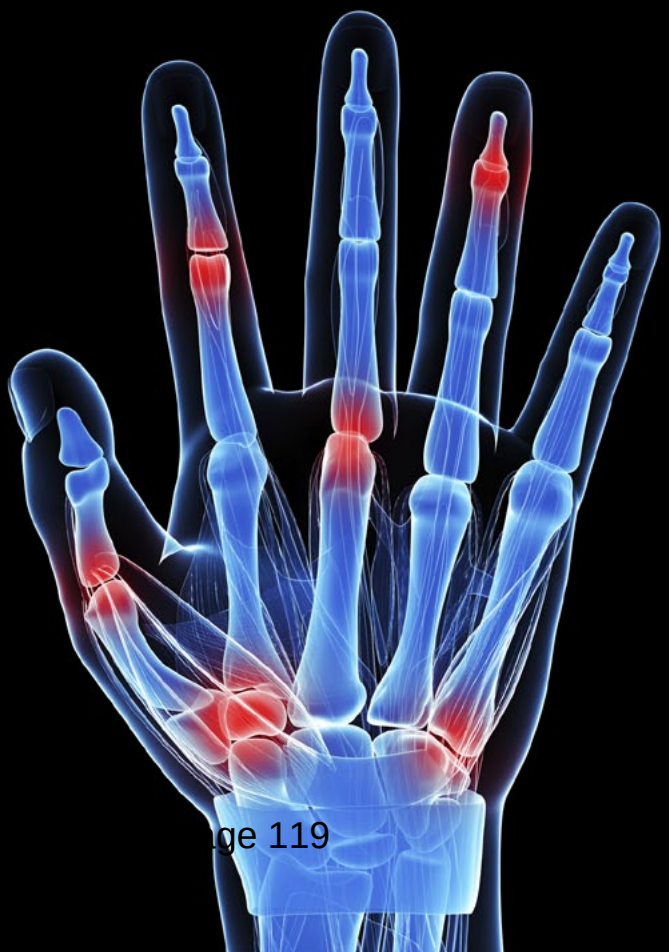
18 In 2014, the Minister for Health and Social Services introduced the concept of prudent healthcare into NHS Wales as a way of ensuring that services are delivered in a sustainable way. The principles are minimising avoidable harm, carrying out the minimum appropriate intervention and promoting equity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

Recommendations

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

Part 1

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



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

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

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

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

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

Source: Wales Audit Office

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

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

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

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

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

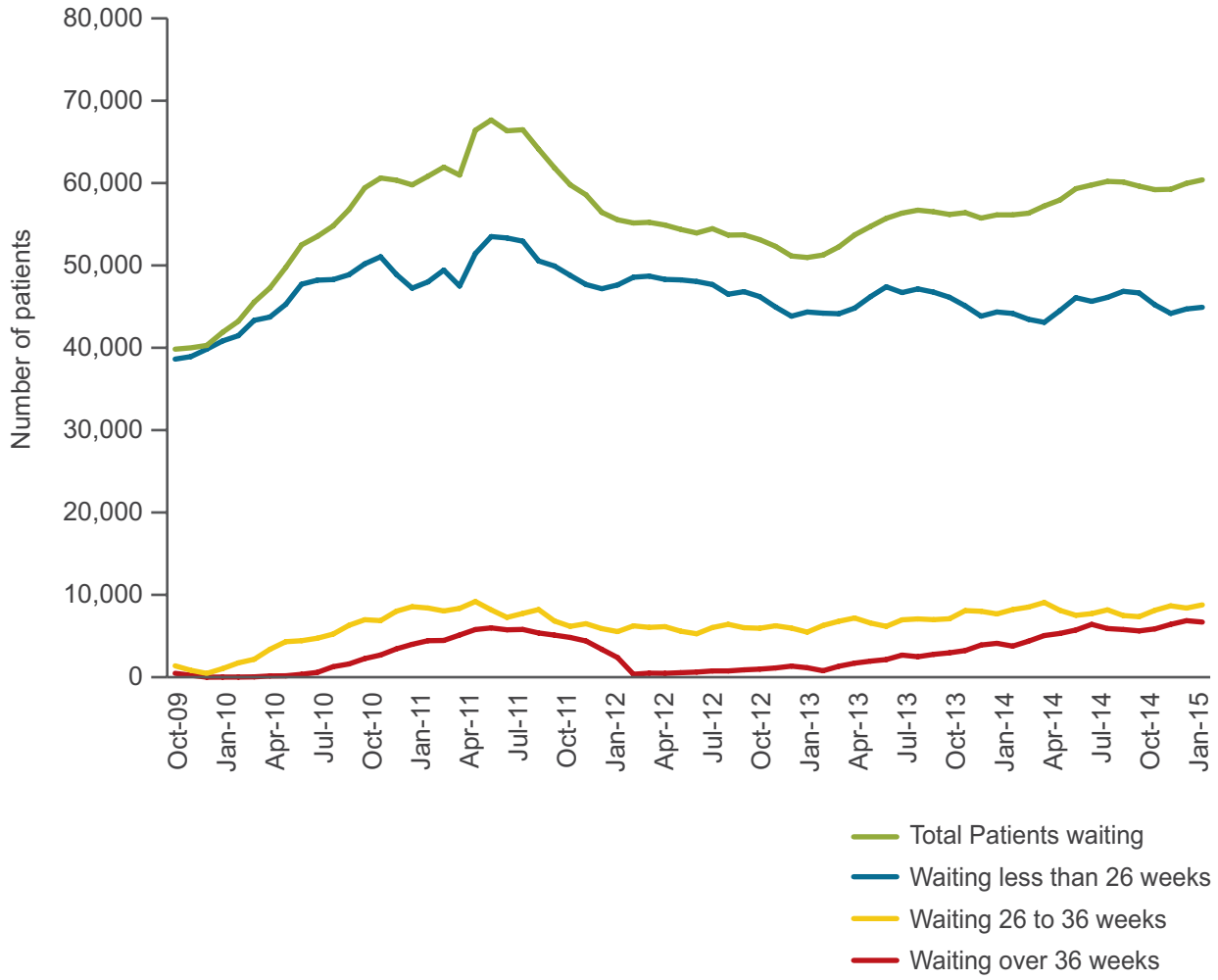
Source: Stats Wales

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

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

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

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



Source: Stats Wales

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

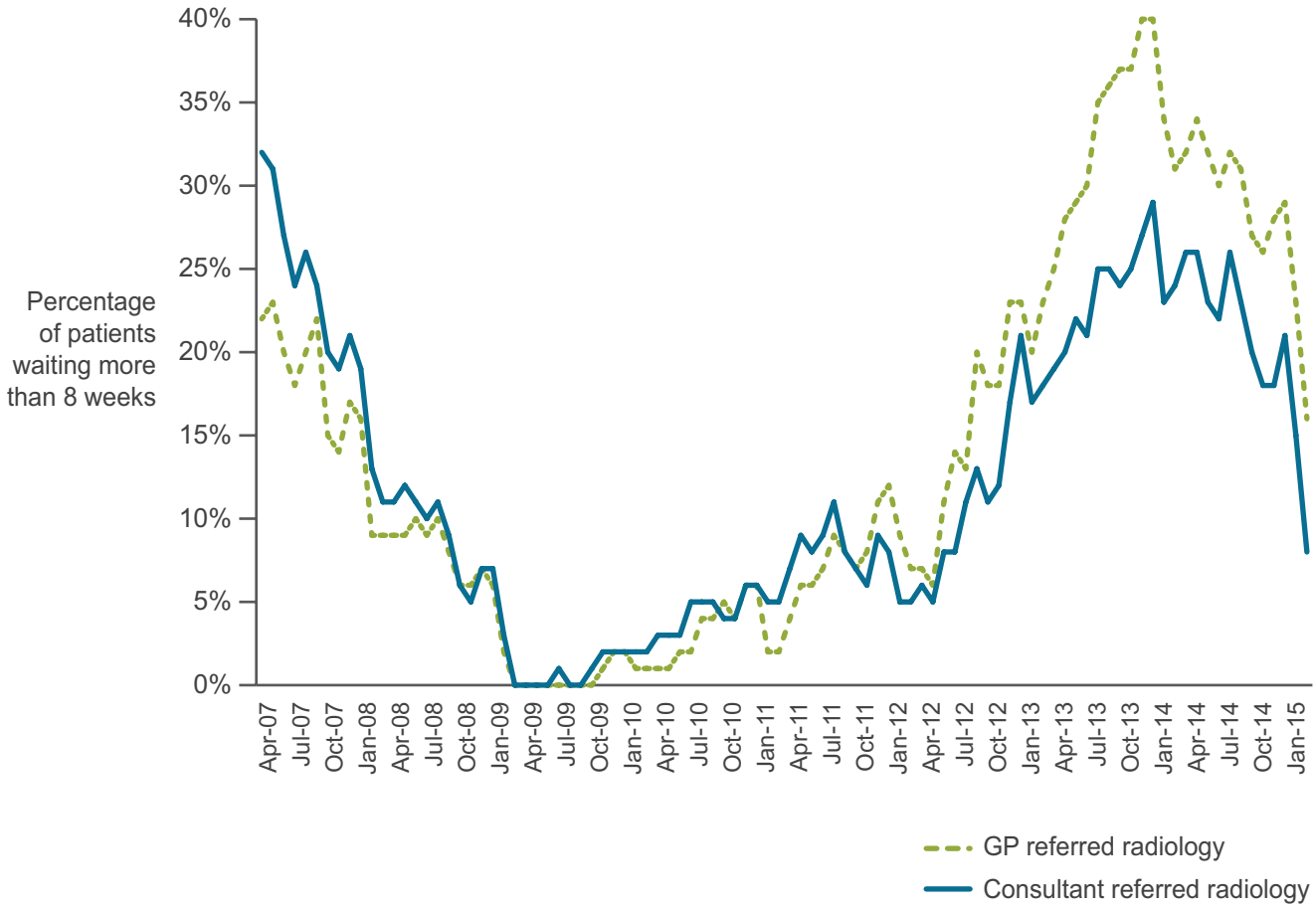
Source: Wales Audit Office fieldwork

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

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

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

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



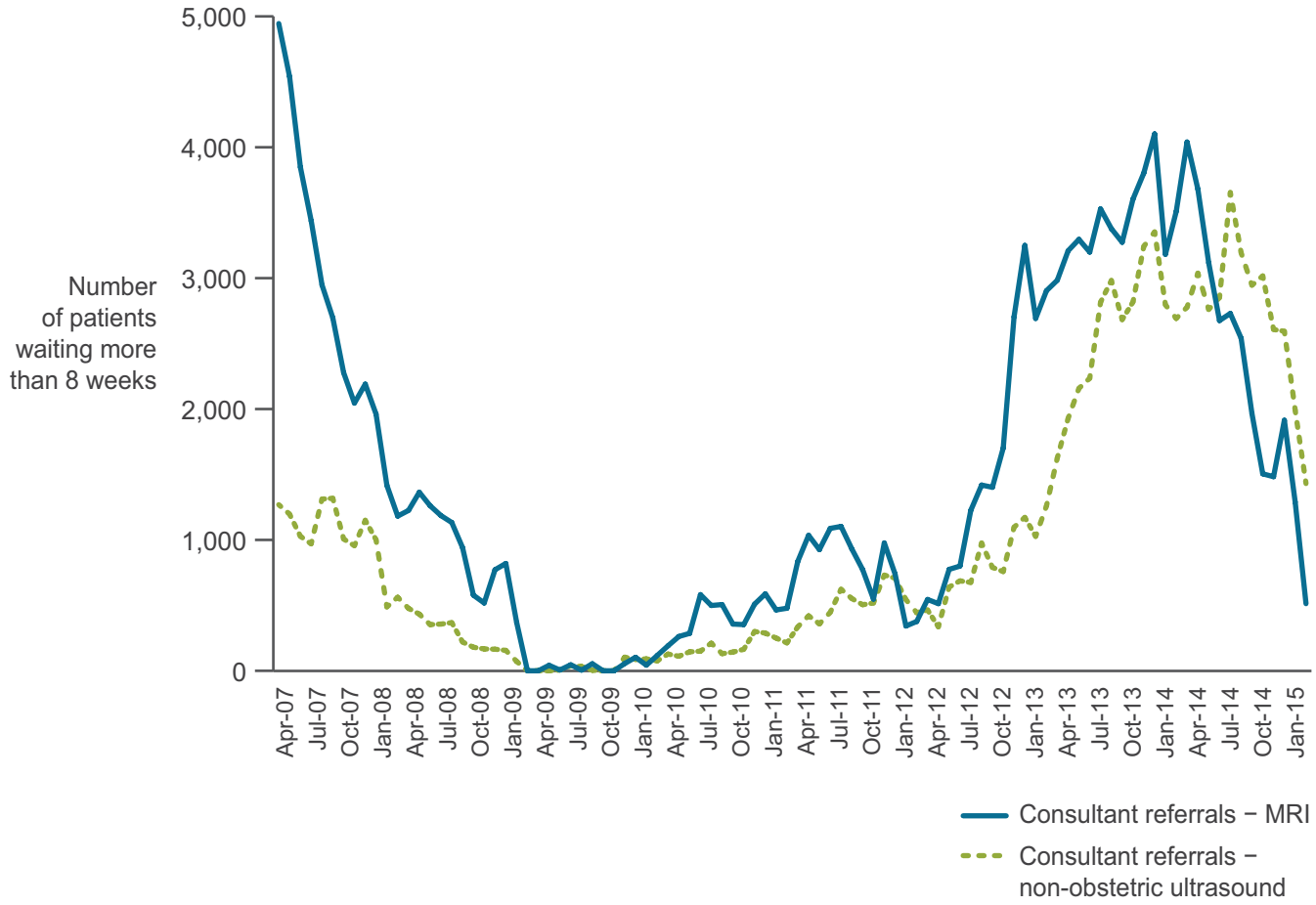
Source: Stats Wales

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

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

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

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



Source: Stats Wales

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

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

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

Source: Stats Wales

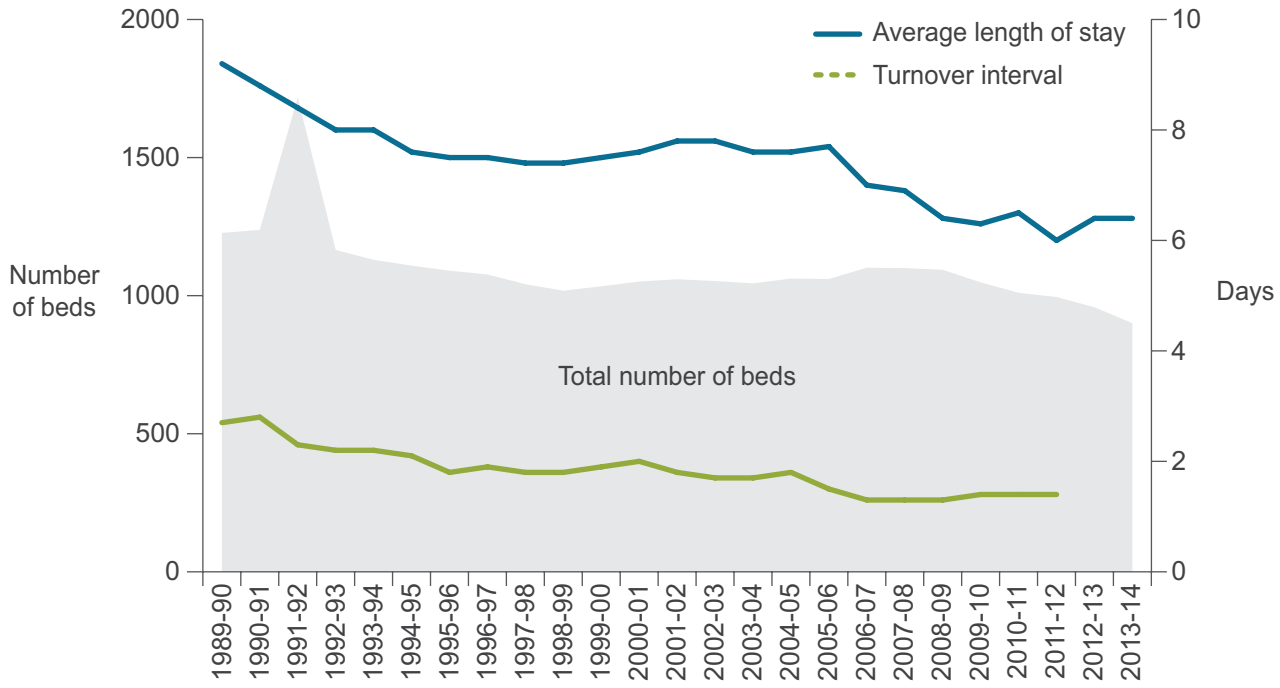
1.15 Demand on physiotherapy services, however, is partly determined by the level of throughput through the system. As outpatient departments or community based teams refer and assess more patients, more demand is placed on the physiotherapy teams. In contrast, as throughput slows down due to blockages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

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

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

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

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



Source: Stats Wales

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

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

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

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

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

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

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

Source: NHS Wales Informatics Service

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

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

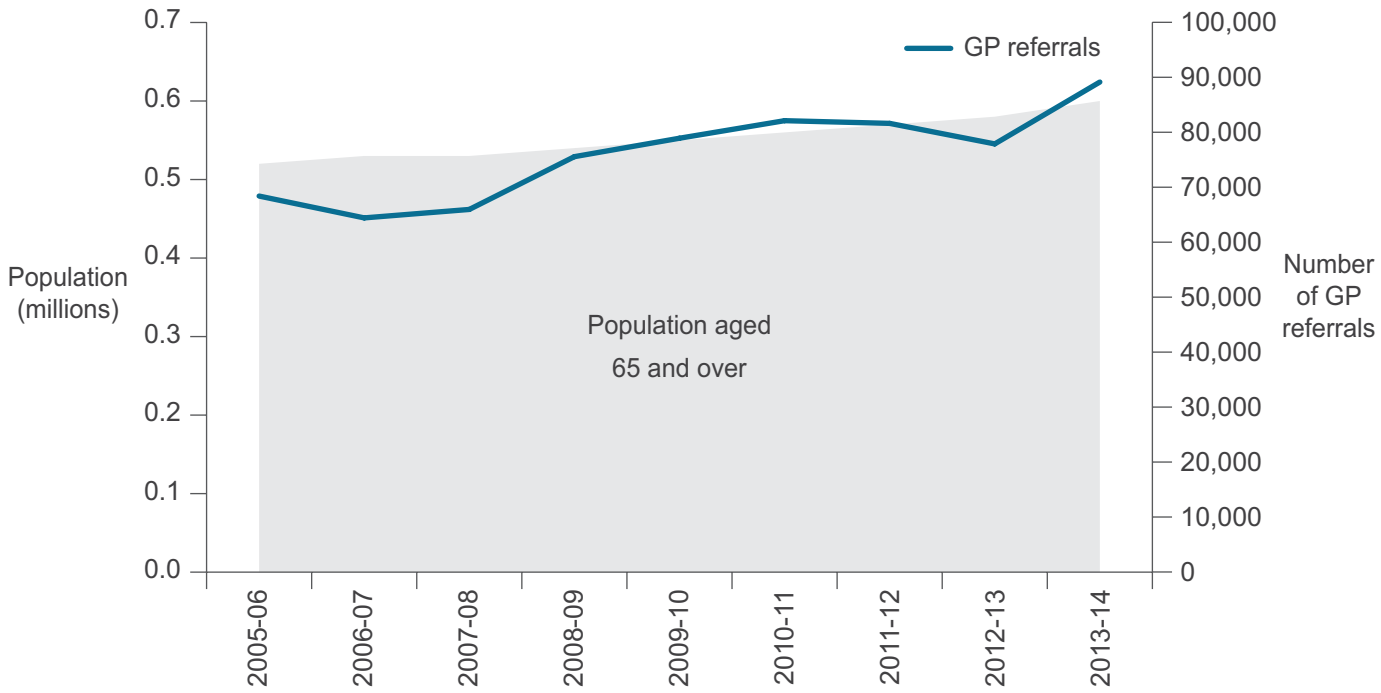
Health board	Elective orthopaedic patients	Elective hip replacements	Elective knee replacements
Abertawe Bro Morgannwg	3.9	6.5	5.4
Aneurin Bevan	4.1	6.6	5.5
Betsi Cadwaladr	3.4	4.7	4.5
Cardiff and Vale	4.1	5.9	6.5
Cwm Taf	4.6	7.2	5.9
Hywel Dda	3.1	5.5	5.4

Source: NHS Wales Informatics Service

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

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

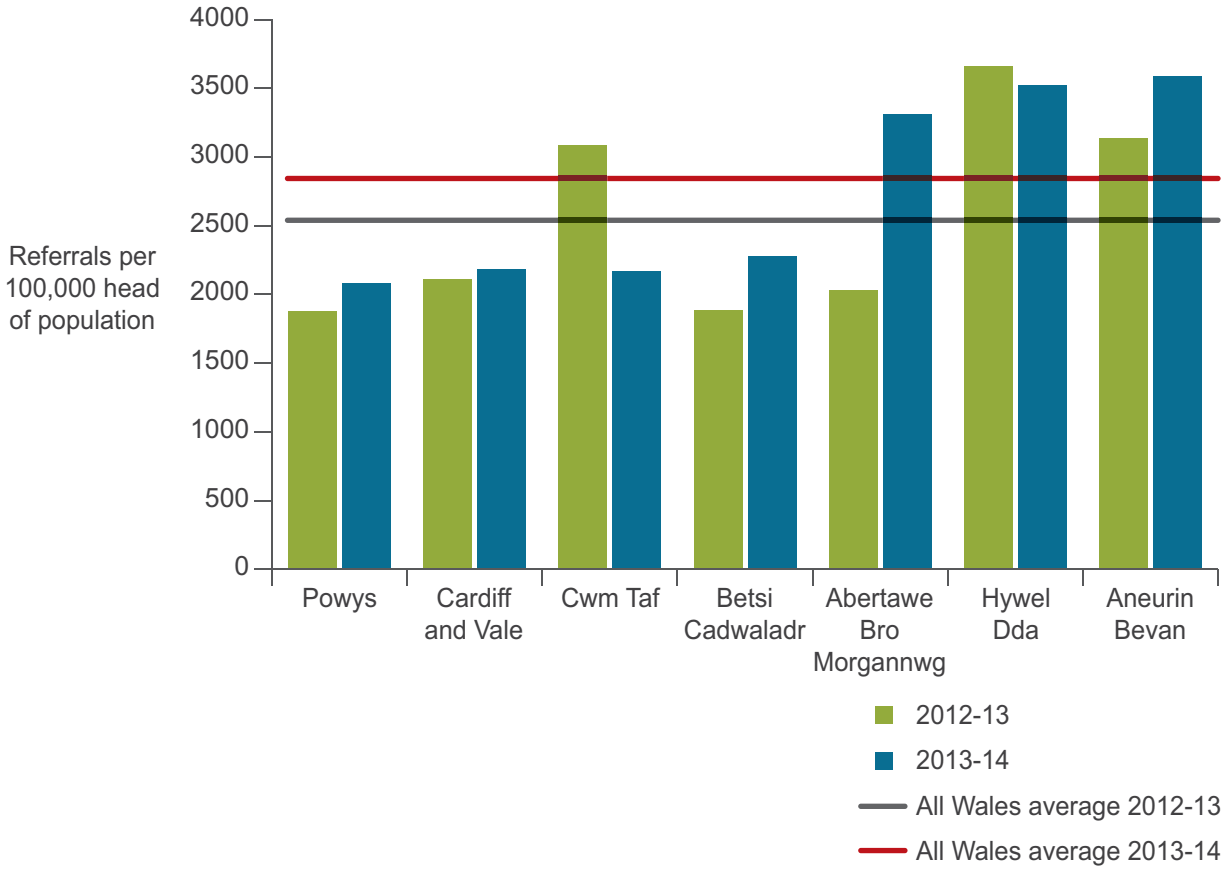
Figure 14 – Trend in GP orthopaedic referrals compared with trend in population



Source: Stats Wales and NHS Wales Informatics Service

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

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

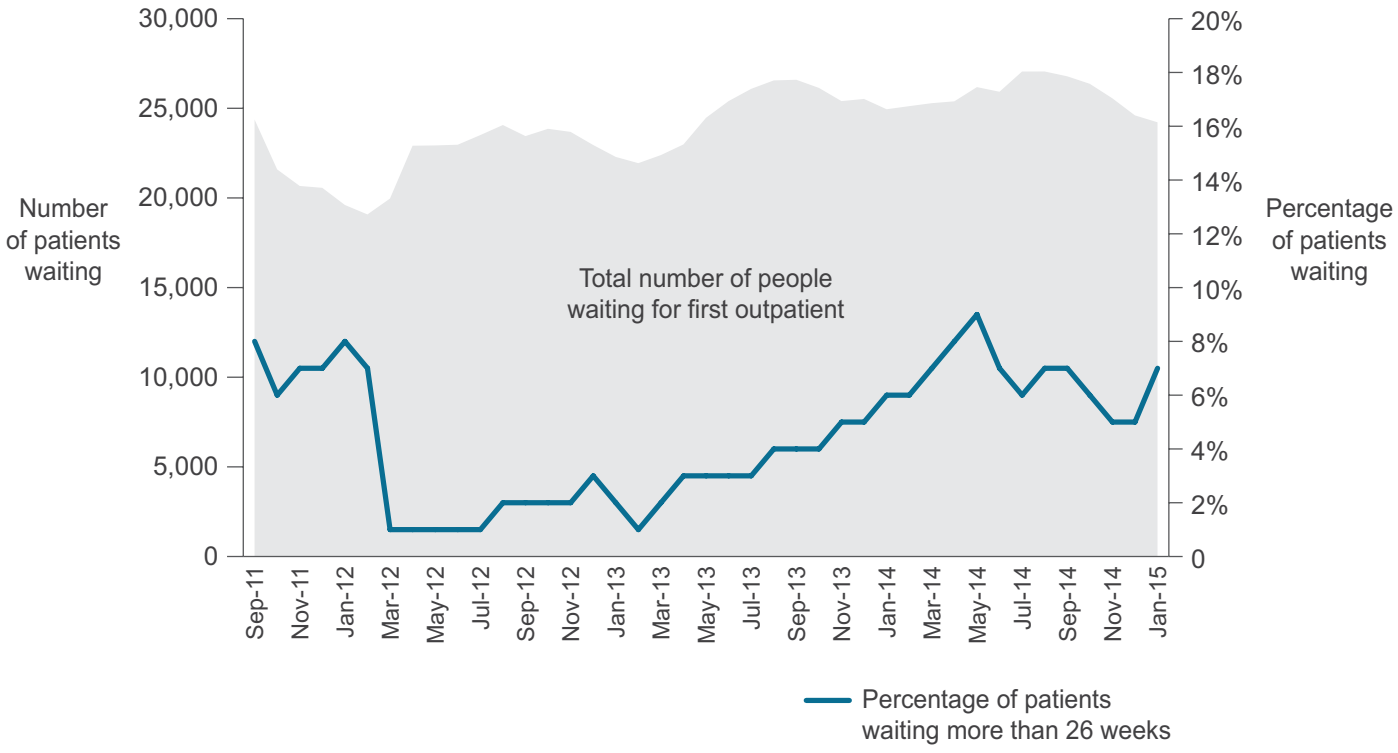


Source: Stats Wales

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

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

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



Source: Delivery Unit, Welsh Government

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

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

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

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

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

Source: Wales Audit Office

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

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

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

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

Source: Wales Audit Office

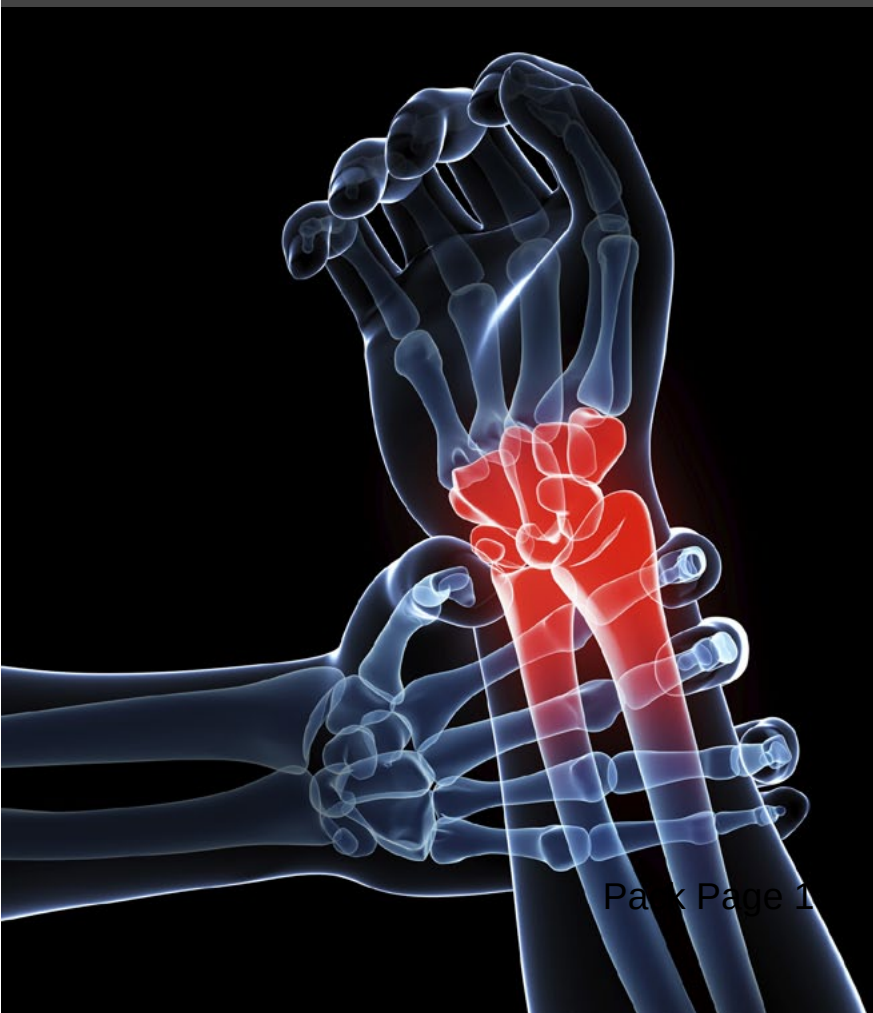
1.28 Figure 18 describes the all-Wales position and it should be noted that scope for improvements in the use of existing resources varies across the health boards in Wales. Appendix 5 shows how the parameters presented in Figures 17 and 18 vary by health board. We have prepared individual reports for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

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

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

Part 2

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

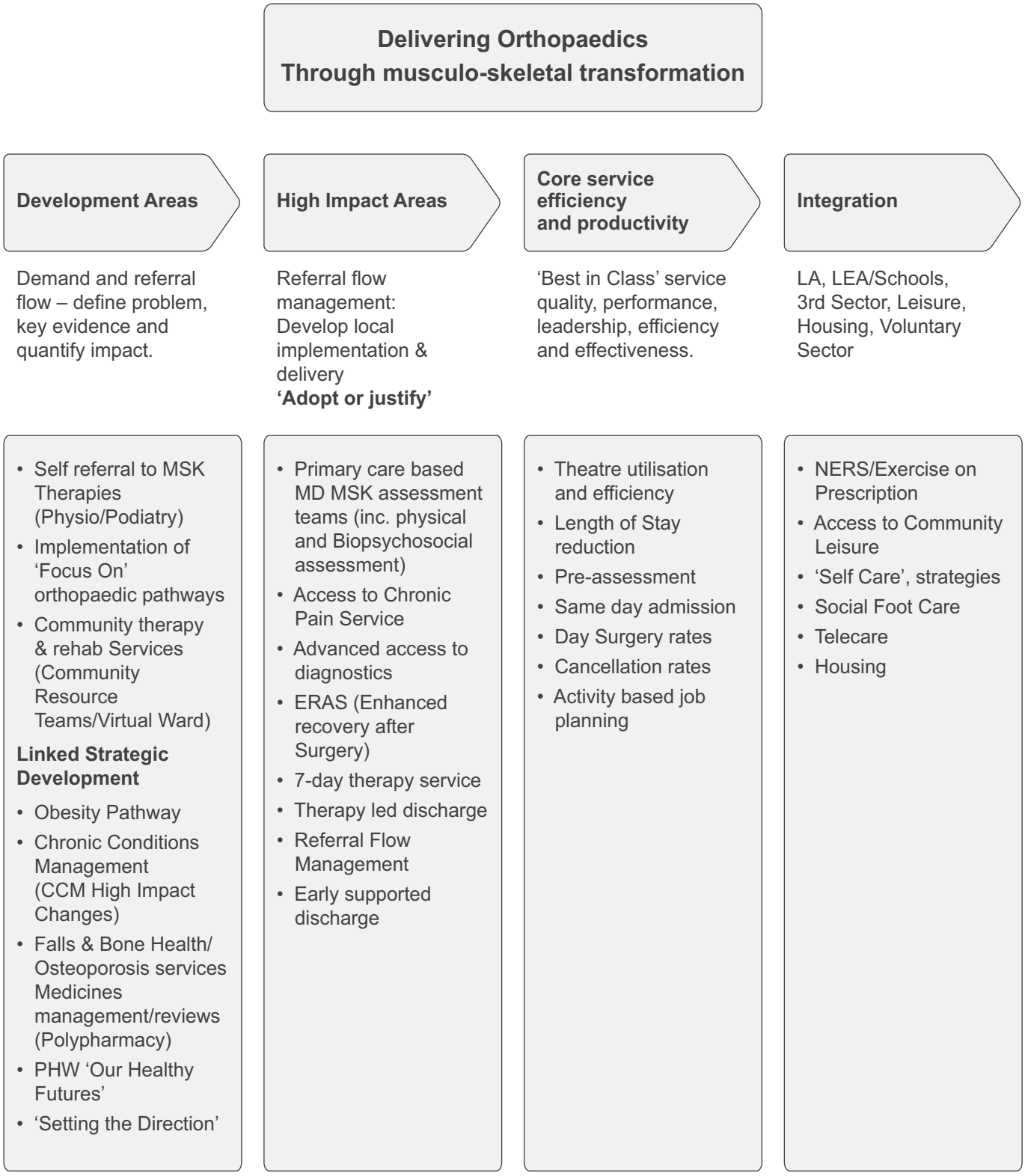
a recommendations for immediate implementation by September 2011 for health boards to implement by March 2012; and

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

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

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

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



Source: National Orthopaedic Innovation and Delivery Board, July 2011

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

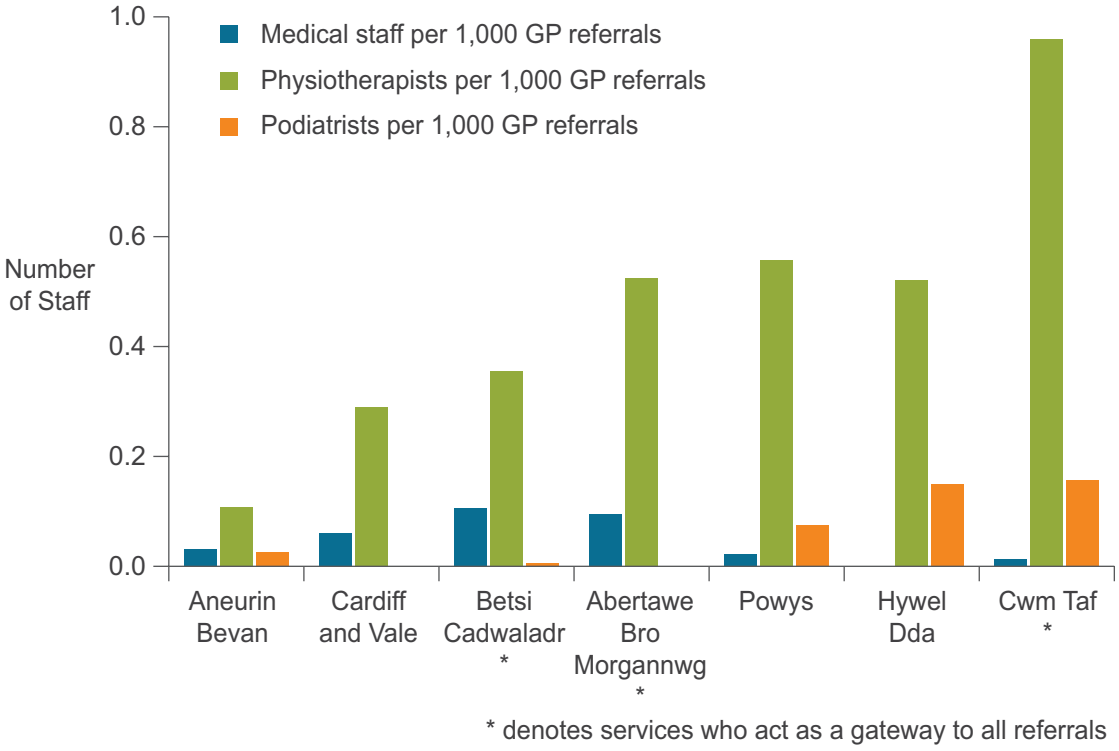
Figure 21 – Compliance with the key principles of the CMATS guidance

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

Source: Wales Audit Office fieldwork – health board surveys

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

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



Source: Wales Audit Office fieldwork

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

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

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

Monitoring of CMATS has been complicated by IT problems

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

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

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

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

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

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

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

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

Figure 23 – Tools for monitoring patient experience and outcomes

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

Source: Wales Audit Office fieldwork

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

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

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

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

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

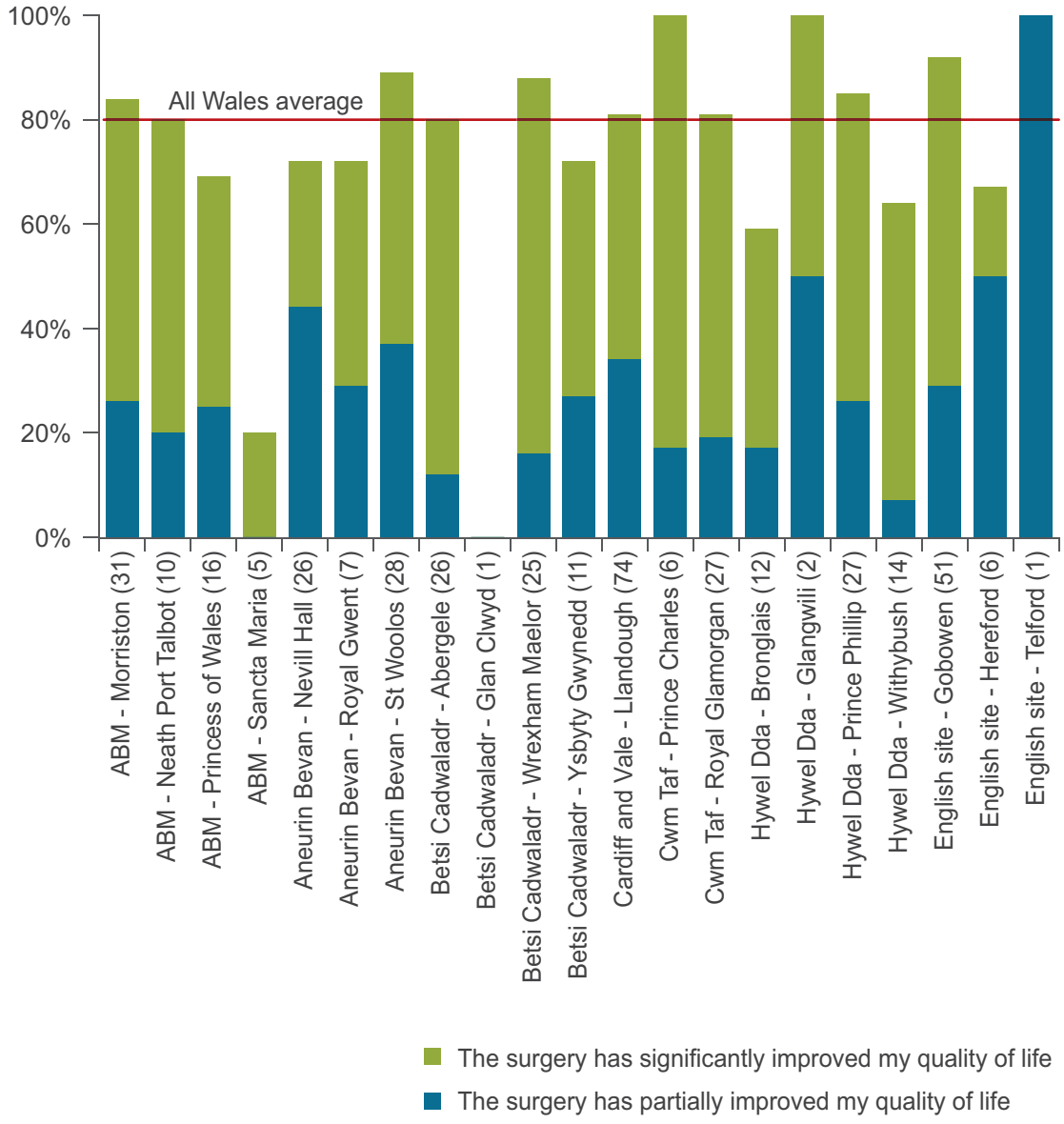
a 12 per cent of patients (56 out of 481) said that their quality of life had either got worse or had not improved;

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

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

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

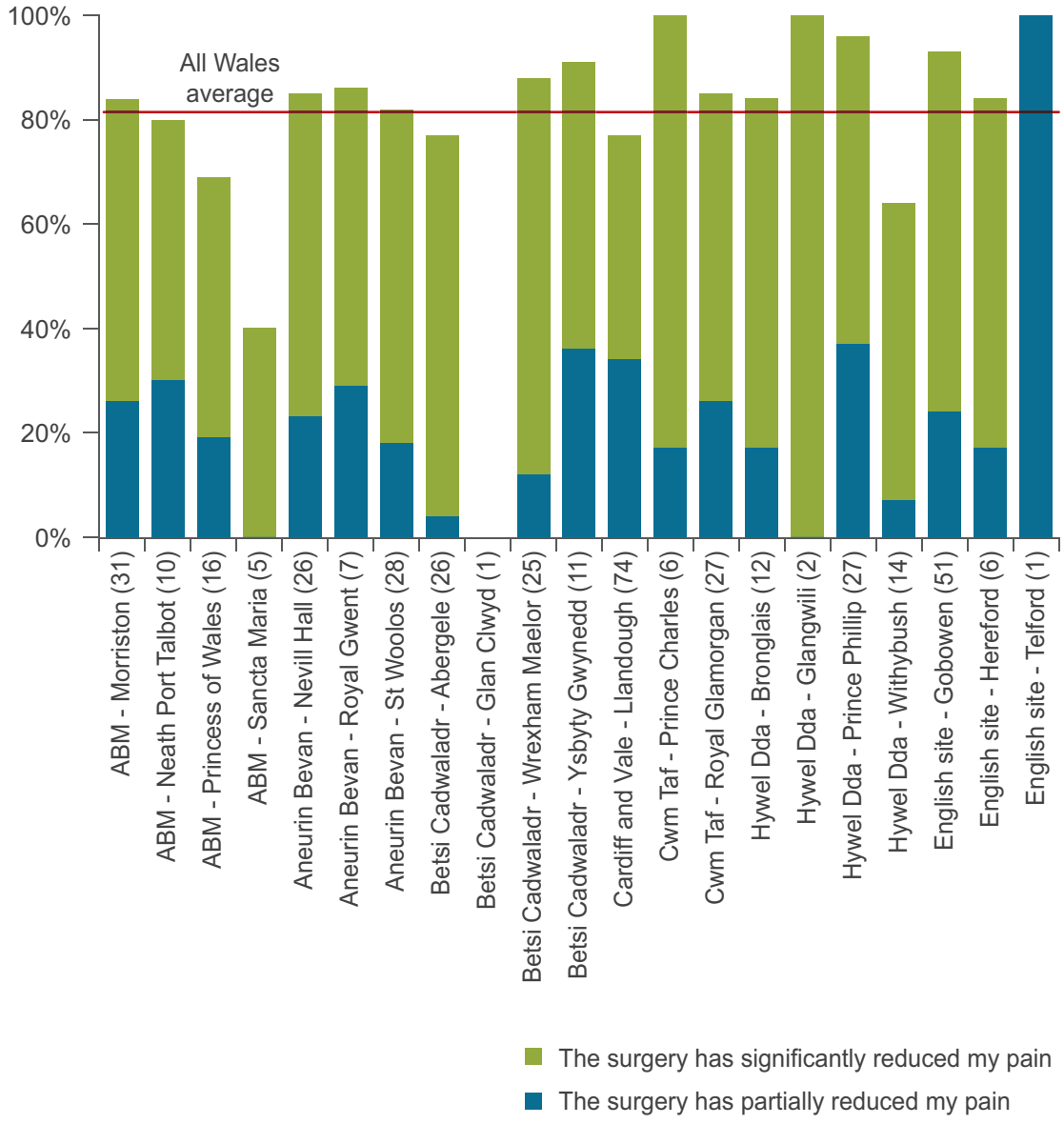
Figure 24 – Percentage of patients who reported that their knee replacement surgery had improved their quality of life (split by hospital provider)[26]



Source: Wales Audit Office

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

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



Source: Wales Audit Office

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

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

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

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

a minimising avoidable harm;

b carrying out the minimum appropriate intervention; and

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

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

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

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

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

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

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

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

Appendices

Appendix 1 - NHS Wales National Orthopaedic Programme Delivery Framework

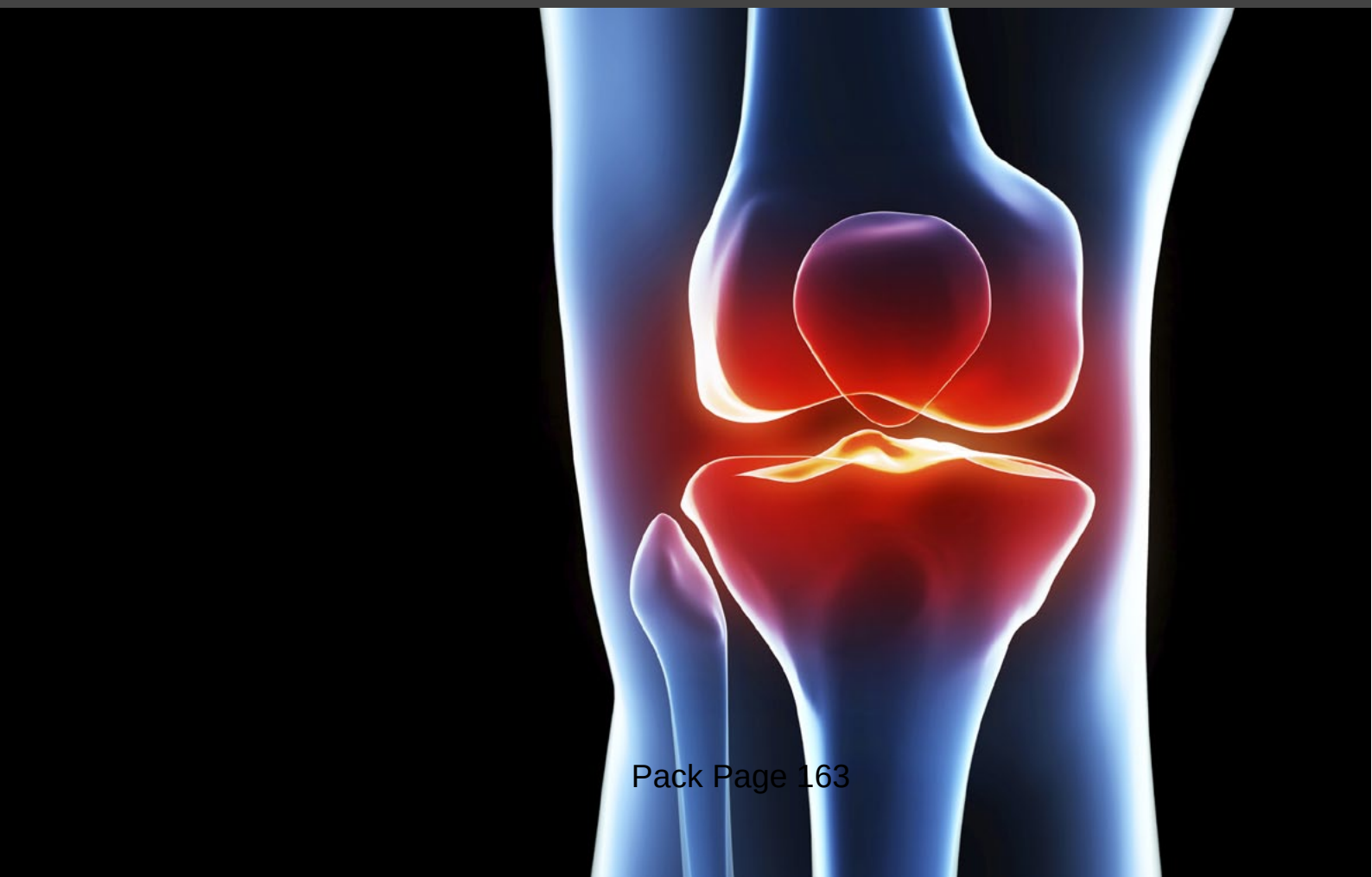
Appendix 2 - Details of the timeline shown in Figure 2

Appendix 3 - Methodology

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

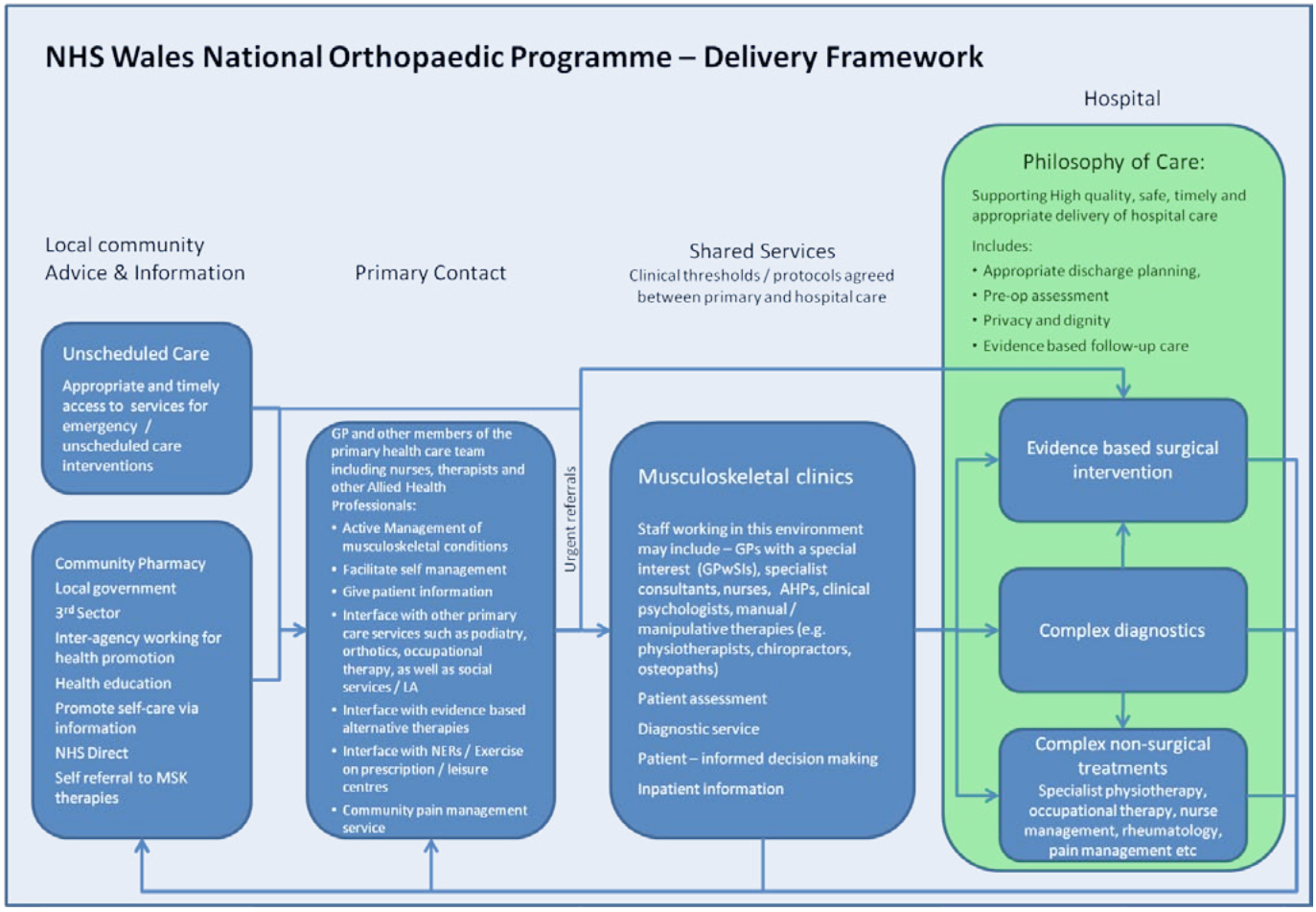
Appendix 5 - Allocation of central funding

Appendix 6 - Allocation of funds for sustainability projects



Appendix 1 - NHS Wales National Orthopaedic Programme Delivery Framework

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



Appendix 2 - Details of the timeline shown in Figure 2

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

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

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

Appendix 3 - Methodology

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

Document review

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

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

Centrally collected data

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

Health board survey

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

Patient survey

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

Interviews

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

Walkthrough of musculoskeletal services

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

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

During the walkthrough, we undertook:

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

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

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

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

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

Source: Wales Audit Office

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

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

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

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

Source: Wales Audit Office

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

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

Source: Wales Audit Office

Appendix 5 - Allocation of central funding

Recurrent allocation

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

Non-recurrent allocation – centrally allocated

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

Non-recurrent allocation for sustainability projects – bid funded

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

Appendix 6 - Allocation of funds for sustainability projects

Aneurin Bevan University Health Board	**£**
Community physiotherapy	£156,000
Therapy and GP-led referral management	£79,000
Joint Treatment programme	£176,000
Referral management model low back pain	£60,000
Service effectiveness and productivity	£81,000
Community based low back pain	£95,686
	£647,686

Abertawe Bro Morgannwg University Health Board	
Expansion intermediate care clinics	£189,000
Fracture liaison nurse	£44,000
Pain assessment/triage clinic	£38,300
Lifestyle programme	£59,500
Joint MCATS/F&A/podiatry clinics	£94,900
Psychology for chronic pain	£67,700
Locality schemes	£111,000
	£604,400

Betsi Cadwaladr University Health Board	
Lifestyle management	£351,366
CMATS	£138,181
OP Dupuytren service	£72,000
Fracture liaison	£87,000
Early supportive discharge service	£151,526
	£800,073

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

Source: Analysis of Delivery Board papers

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

Llywodraeth Cymru
Welsh Government

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

Our Ref: AG/JM

24 October 2016

Dear Mr Ramsay

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

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

Review of the Impact of Private Practice on NHS Provision

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

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Recommendation 2

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

Update Accepted

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

Recommendation 3

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

Update Accepted

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

Recommendation 4

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

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

Orthopaedic Services.

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

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

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

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

Recommendation 4

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

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

Recommendation 5

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

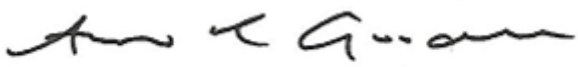
Update Accepted
Through the national orthopaedic implementation board they are currently developing a national specification for CMATS. Each health board will then be expected to review their service against the guidance to look at how their current provision meets the specification and how it could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

Recommendation 6:

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

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

Yours sincerely



Dr Andrew Goodall

Agenda Item 9

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