**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

9 January 2017

Dear Mr Ramsay

Public Accounts Committee – NHS Waiting Times for Elective Care in Wales & Orthopaedic Services

Thank you for your invitation to attend committee on 23 January 2017, in my role as Chief Executive of NHS Wales. I understand you wish to discuss NHS Waiting Times for Elective Care in Wales & Orthopaedic Services.

As requested, I enclose a written update in advance of my attendance.

Yours sincerely

Dr Andrew Goodall

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Public Accounts Committee - NHS Waiting Times for Elective Care in Wales

The Committee wishes to discuss the progress since the WAO report into NHS Waiting Times for Elective Care was published in January 2015. The report had nine recommendations and an update against those recommendations was provided in December 2016, as well as being included as an annex at the end of this letter.

Since the report was published in January 2015, the Welsh Government has been working closely with health boards and other interested parties, including representatives of the public, to address the recommendations. This has been achieved through national events, where health boards, Community Health Councils and patient groups have been represented and have been able to express their views.

A national Planned Care Programme (PCP) has been set up, led by a senior clinician from Aneurin Bevan University Health Board. The aim of the programme is to develop a strategic and sustainable service and improve patient experience. The programme has already launched four speciality plans that account for 70% of the long waiting patients and is now working on the next phase. The PCP is also leading on sharing best practice amongst health boards, based on actions currently underway in the speciality specific plans. Examples of this include the development of Ophthalmic Diagnostic and Treatment Centres (ODTCs), which were originally in place to deliver glaucoma support. Through the PCP, the Ophthalmic Board has been asked to explore ways of how the ODTCs can be used more widely to deliver other services.

Two national events have taken place to share good practice and to identify areas of priority for review. From these national events, two task and finish groups were established looking at patient communication and revision of the RTT guidance. The revision of the RTT guidance is underway and is linked with the re-launch of the Guide to Good Practice, a document that sets out principles for managing patients on an elective waiting list. The first part of the Guide to Good Practice will be launched at the end of March 2017.

The latest redraft of the RTT guidance has been circulated to an initial group of colleagues within the NHS for comment before being circulated wider. It is intended that the refreshed rules will be available for April 2017, and that this will be a living document with regular updates and a FAQ section.

Public engagement has also been sought as part of the redesign programme for outpatients to test and explore what is currently working well and what isn't. This has mainly been developed in North Wales, where a patient information leaflet has been developed in conjunction with patient groups and representatives of the Community Health Council.

The patient leaflet informs patients about the RTT process and their roles and responsibilities within it and is being tested at Betsi Cadwaladr Health Board. The leaflet clearly explains what the patient can expect after being referred by their GP to secondary care, and what is expected of them, outlining what could happen if the

patient does not turn up for an appointment and does not let the hospital know beforehand.

On publishing relevant data, we have worked with colleagues within Knowledge and Analytical Services (KAS). Data on median waits are now published; however, it was recognised that publishing data on waiting times for urgent and routine appointments would prove complicated, as patients can move from being urgent to routine and vice versa along the pathway, as this is a decision for the consultant responsible for a patient's care to make.

1. Performance

1.1 Referrals

The number of GP referrals, non-GP referrals and total referrals has increased since April 2012. Some of this increase is due to a change in reporting of non-GP referrals, but the overall number of GP referrals has increased. In the 12 months ending October 2016, the number of GP referrals was 9% higher than in the 12 months ending October 2013, and the total number of referrals was 16% higher.

1.2 Activity

Each month, there are around 28,000 elective admissions to NHS hospitals in Wales. This is as well as the 33,000 emergency admissions each month. The NHS in Wales does well to manage both the unscheduled and scheduled care demand on a day to day basis and the Committee has been updated previously on unscheduled care. To assist with unscheduled care, health boards refocus their planned care delivery to outpatients and day case activity, thus reducing the requirement on inpatient beds during the winter months.

The number of elective admissions over the 12 months ending October 2016 is 2.3% higher than the previous 12 months.

RTT data looks at waiting times for both open and closed pathways. For the period April to October 2015 and similarly for 2016, closed pathways for non-admitted and admitted patients have increased by over 27,000 or 4.7%. Of those, 26,000 more were closed for those waiting less than 26 weeks.

Data collected on closed pathways is for both admitted and non-admitted patients. With the growth of prudent healthcare and the redesign of the way services are delivered, we would expect to see a reduction in elective inpatient and day case activity for some pathways, as patients are more appropriately seen and treated via a non-admitted treatment. Examples include the changes in the ENT pathways, to community services and for some orthopaedic pathways, where exercise and weight management services have negated the need for surgery.

1.3 Waiting list size

Whilst the number of open pathways over 26 weeks and 36 weeks has reduced, the overall size of the waiting list has increased and is now 6% higher than it was in January 2015. However, it is 1% lower than the high point of August 2015.

1.4 Comparison with previous years

It has been a common historical occurrence each year that waiting times increase from the end of March, before reducing in the final quarter of the year. The final quarter is generally the busiest time when health boards are also trying to cope with unscheduled care pressures.

Despite the November 2016 position being an increase on the March 2016 position, the increase seen this year has been less than in previous years, showing a more stable position for improvement to the end of the financial year. The latest data, for the end of November 2016, shows that the increase this year has been 19%, whilst in 2015-16 there was a 37% increase in the number of open pathways over 36 weeks and in 2014-15, the increase was 86%. This has been achieved by health boards targeting the elective inpatient work earlier in the year which will enable them to focus on daycase and outpatient work in the final quarter whilst dealing with unscheduled care pressures, as they have set out in their Integrated Medium Term Plans, which show how they will use capacity and manage demand throughout the year.

This is shown in table 1 in the annex.

1.5 26 week position

When the report was published in January 2015, the 26 week RTT position in Wales was 84.3% against a 95% target. Since then, improvements have been seen, with performance in March 2016 being 86.8%, 2.5 percentage points higher than January 2015. Although there has been a slight deterioration recently, performance in November 2016 was 86.2%, which was higher than January 2015 and 2.7 percentage points higher than the low of 83.5% seen in December 2015.

A chart showing the performance since January 2015 is in the annex.

1.6 36 week position

Since the report was published in January 2015, waiting times in Wales for elective services have improved.

In January 2015, the number of open pathways over 36 weeks was 23,532; following additional support during 2015-16 to improve RTT and diagnostics by the end of March 2016, the number of open pathways fell to 17,190. This was the best position reported since May 2014.

Although there has been an increase in the number of open pathways over 36 weeks by November 2016 to 20,385, this was still a fall of 13% compared to January 2015.

The November 2016 position is an improvement of 8,269 (29%) compared to the high of 28,652 in August 2015 and is 5,487 (21%) better than November 2015.

All health boards in Wales are in a better position in November 2016 than they were in November 2015.

A chart showing open pathways over 36 weeks since January 2015 is shown in the annex.

1.7 52 week position:

Since January 2015, the number of open pathways over 52 weeks has increased from 3,335 to 4,570 at the end of November 2016. However, the figure now is 9% lower than the high of 5,042 in December 2015.

Where patients are waiting over 36 and 52 weeks, health boards are expected to carry out regular clinical and clerical validation to ensure that patients still require their appointments / procedures and are not coming to any clinical harm whilst waiting.

1.8 Cancer delivery

Cancer delivery has different targets to RTT, but it utilises the same capacity. Increases in demand and numbers treated in cancer can reduce the capacity available for more routine RTT pathways.

Although delivery against target remains a challenge for cancer services, more patients are being referred for cancer supported care and treated within target times than ever. Over the last 12 months, the number of referrals for urgent suspected cancer was 90,074. There were 73,787 referrals for the period October 2014 – September 2015. This is an increase of 22%.

In the last 12 months (November 2015 to October 2016), 6,210 patients newly diagnosed with cancer via the Urgent Suspected Cancer (USC) route started definitive treatment within the target time of 62 days. This is 8.4% (481 patients) higher than the previous 12 month period (November 2014 to October 2015) and is 39% higher than five years ago.

In addition, during the same period, 7,222 people started definitive treatment for urgent suspected cancer. This is 7.1% higher than the previous 12 months and 44% higher than five years ago.

In the last 12 months (November 2015 to October 2016), 9,522 patients newly diagnosed with cancer not via the Urgent route (NUSC) started definitive treatment within the target time of 31 days. This is 5.1% (465 patients) higher than the previous 12 month period (November 2014 to October 2015), but is 3% (292 people) lower than five years ago.

1.9 Diagnostics

Data for the end of November 2016 showed that 10,316 people were waiting over eight weeks for one of the specified diagnostic tests in Wales. This is 10,629 (51%) lower than January 2015, and is 63% lower than the highest number of patients over eight weeks recorded in January 2014.

During the last 12 months, the number of people waiting over eight weeks has reduced by 23%, and the majority (96%) of those currently waiting over eight weeks are waiting in South East Wales health boards (Aneurin Bevan, Cardiff and Vale and Cwm Taf). These health boards have plans in place to reduce waiting times by the end of March 2017 and are working to put sustainable services in place going forward. To tackle backlog, the health boards are outsourcing some activity and making use of mobile scanners.

The aim is that by the end of March 2017, of the reduced number of over eight week breaches the majority will be waiting for a diagnostic endoscopy only. We will expect IMTP submissions for next year to focus on how this is maintained and the remaining diagnostic endoscopy backlog removed.

1.10 Efficiency work

Individual measure bundles based on previous national efficiency measures have been developed for each health board. Each health board bundle has individual targets based on firstly reducing variation and then achieving national best in class.

These bundles are supported by a template for health boards to complete as part of their IMTP response to demonstrate how they plan to improve delivery against their targets. Compliance with these should unlock opportunities to transform services to support delivery of RTT and unscheduled care targets by releasing potential capacity within the system. This may be in terms of bed days, appointment slots or theatre operating sessions.

Progress against the trajectories will be monitored and performance managed through the established performance process. Quarterly progress reports will be provided to the national efficiency group for information.

1.11 Position in England

Long waiting times is not a phenomenon unique to Wales; performance in England has been deteriorating over the last year, and there has been a 13% increase seen in the number of open pathways in England over the last 12 months. There has also been a deterioration in 18 week performance, with the performance in October the lowest it had been since March 2011. In addition, the number of open pathways over 52 weeks in England at the end of October 2016 was the highest it had been since September 2012.

1.12 Actions to reduce waiting times

All health boards have action plans in place to reduce the number of open pathways over 36 weeks. This includes:

- Running additional sessions locally and securing treatment for some patients at alternative providers to reduce backlog, whilst health boards develop more sustainable services in line with their Integrated Medium Term Plans.
    - One example of this is in Aneurin Bevan UHB, who are sending ophthalmology patients to Bristol for cataract treatment while they develop services locally. The majority of routine cataract follow-ups are now being carried out by optometrists in the community, with nurse injectors working in the community to deliver AMD injections.
- In addition, some of the outsourcing also involves the external provider coming into the health board to carry out work on weekends and in the evenings, whilst using the health board resources, which may include health board staff.
    - An example being Hywel Dda for dermatology services.
- Health boards have also employed additional staff and 'upskilled' some staff such as Clinical Nurse Specialists, sonographers and Nurse Endoscopists to undertake activity previously undertaken by medical staff, and as such, increased capacity.
    - An example being Cwm Taf UHB, where they have changed the way ENT services are delivered, with primary and secondary care clinicians working together to develop referral criteria and pathways, with some services now being delivered in primary care by specialist nurses.
- As part of the development of integrated services, health boards have been working with primary care to develop services in the community to reduce referral to specialist care and provide assessment and treatment locally where clinically appropriate
    - An example being Clinical Musculoskeletal Assessment Team service CMATs, where primary care referrals are received, assessed and triaged to the most clinically appropriate pathway, not necessarily orthopaedic surgery. This has shown to manage patients successfully without the need for surgery.

2. Planned Care Programme

Recognising that waiting times were too long, we have established a clinician led Planned Care Programme (PCP) to improve patient experience and deliver a strategic and sustainable approach to planned care in Wales, supporting effective service change across a number of key specialities, including orthopaedics, ophthalmology, ENT and urology. A fifth speciality – dermatology - will be introduced shortly. The four specialities with plans already launched account for 70% of all open pathways over 36 weeks at the end of November 2016.

The aims of the programme are to improve patient experience across the planned care specialities, by ensuring that patients are seen in the right place, at the right

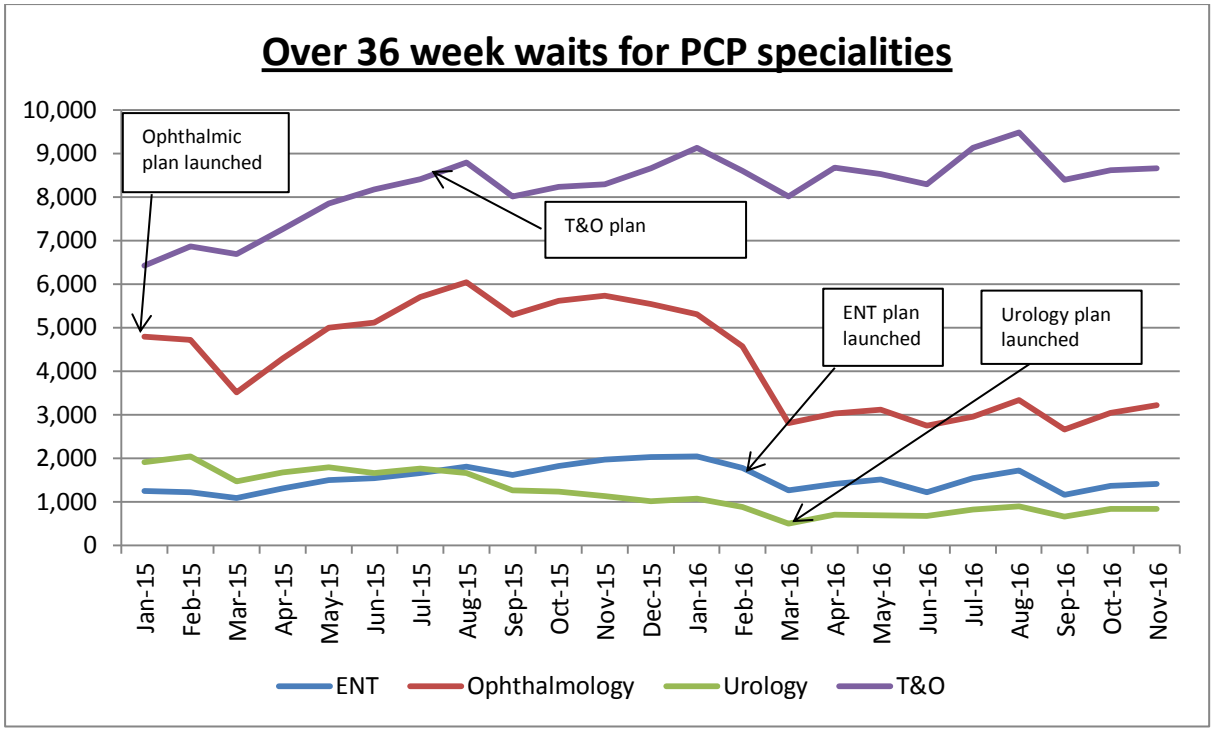
time, by the right professional, through the monitoring and analysis of Patient Reported Experience Measures (PREMS) by May 2020.

The Programme, through each of the clinically led groups, sets out clear expectations of the service and is working closely with each health board to ensure that new and appropriate pathways are designed and delivered as well as exploring innovative ways to ensure that systems are in place to manage demand for secondary care and to minimise the demand and capacity gap for each service. This will include the innovative use of primary care, as with the work currently being piloted for the ophthalmology programme, where routine follow-up appointments are being carried out in primary care by optometrists rather than in secondary care for cataract surgery patients, nurse injectors are being used in the community for AMD and the use of Ophthalmic Diagnostic and Treatment Centres are being used for glaucoma patients.

The national orthopaedic plan builds on the actions outlined in response to the WAO report into Orthopaedic Services in Wales, as well as the previous work undertaken as part of the National Orthopaedic Group. This includes building on the use of CMATs to triage patients to ensure that only those that require surgery progress and that other patients are referred to the most appropriate clinician to be seen.

Following an action in the prudent healthcare plan, the PCP has established an Outpatients Transformation Programme – this has the aim of radically transforming the way outpatient services are delivered in the longer term, whilst ensuring some short term improvements are seen over the next few months. This will include breaking down the barriers and the expectation that patients need to have a face to face meeting with a consultant in secondary care, and move towards an assessment with a trained member of a multi-disciplinary team who will be able to provide the appropriate advice and care in a setting that is closer to the patient's home. This is also the main area of joint links with the primary care programme. An example of this is in Cwm Taf UHB, who have developed a cardiac services model, with GPs with special interests working alongside consultants and pharmacists to deliver care in a community setting.

Long waits in three of the four planned care specialities have shown a reduction in breaches comparing October 2015 to October 2016. Over the last 12 months, 36 week breaches in ophthalmology have reduced by 43%, ENT by 28% and urology by 25%. However, it is noted that orthopaedic over 36 week breaches have shown a 4.2% increase over the same period. While it is recognised that more work is required to continue to improve on this position, the focus has helped health board clinicians and managers to review their service delivery models. While they are redesigning and building a more sustainable model, there remains a commitment to reduce the backlog.



3. Primary Healthcare

In the past, the referral to treatment target has been viewed as a secondary care measure, and as such, for managers and clinicians in hospitals to address. Through both the planned and primary health care programmes, the important and integral role of primary care is recognised. Through the planned care service specific plans, it clearly shows the importance of primary care and its critical role to the success of any future delivery of sustainable models.

The outpatient transformation programme is seen as one of the main links between the two programmes. The importance of prudent health co-production starts in primary care; this needs to be supported by improved communication, improved use of technology and improved access to advice and tests. The national digital health strategy is critical to supporting this agenda through the use of electronic patient information to support improved communication and patient outcomes and experience.

Examples being:

- The use of electronic referral and discharge letters supporting safe electronic communication across the pathway.
- Viewing access to all pathology and diagnostic tests regardless where they were requested or undertaken to aid informed referral and to reduce possible waste, through duplication of tests.

4. Regional Planning / Working

Through the IMTP planning process, we have tasked health boards to work together to look at developing regional solutions to deliver elective services. There are a

number of examples of regional planning / working already in place across Wales, and these include:

- the ARCH programme – a mechanism for strategic service planning discussions between Abertawe Bro Morgannwg and Hywel Dda University Health Boards and Swansea University;
- the Mid Wales Collaborative – which is looking at developing health services across Hywel Dda, Powys and Betsi Cadwaladr Health Boards;
- the South Central Acute Care Alliance (SCACA), comprising officials from Cwm Taf, Cardiff and Vale and Abertawe Bro Morgannwg Health Boards which has been established to implement the recommendations of the South Wales Programme in relation to the South Wales Central region; and
- the establishment of a major trauma network, including a trauma centre for South Wales, which has come from work carried out by the All Wales Health Collaborative;
- the development of a diagnostic hub in Cwm Taf to deliver diagnostic services for Cwm Taf and the surrounding areas;
- In addition, Cardiff and Vale University Health Board is developing services in partnership with its two local authority partners, i.e. Cardiff Council and the Vale of Glamorgan Council. This is more focussed on the strategic integration of health and social care across the region.

Annex 1

Chart 1: 26 week performance since January 2015

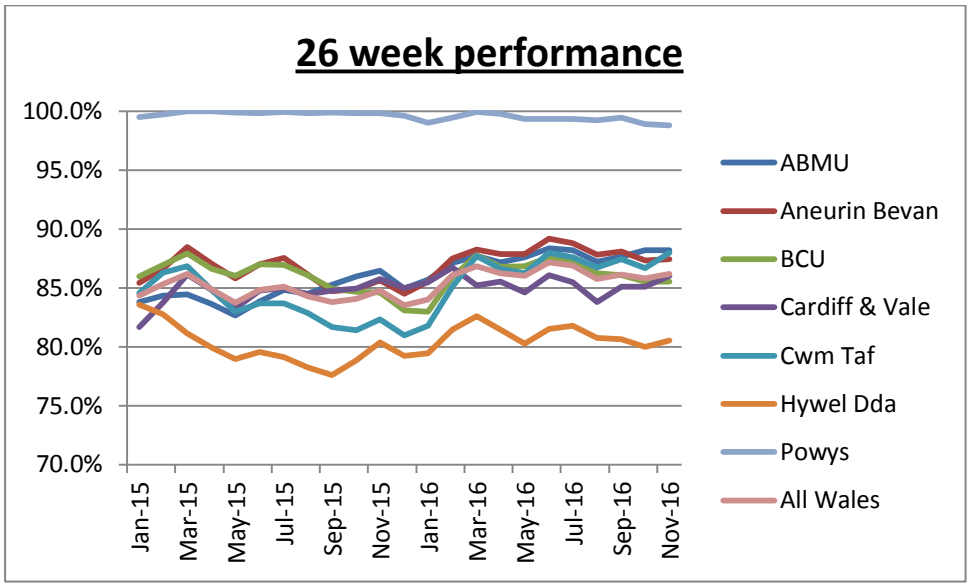


Chart 2: 36 week performance since January 2015

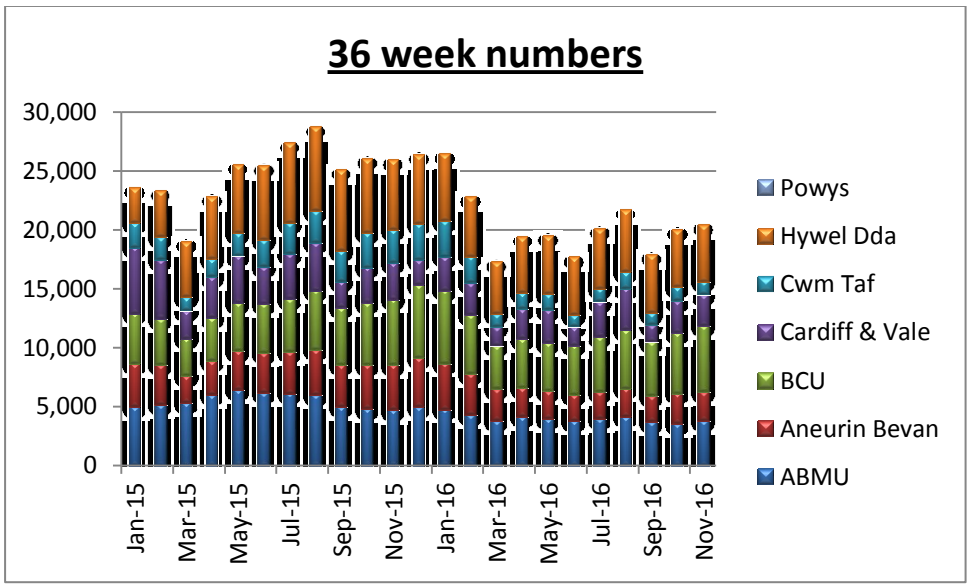


Chart 3: Diagnostic breaches since January 2015

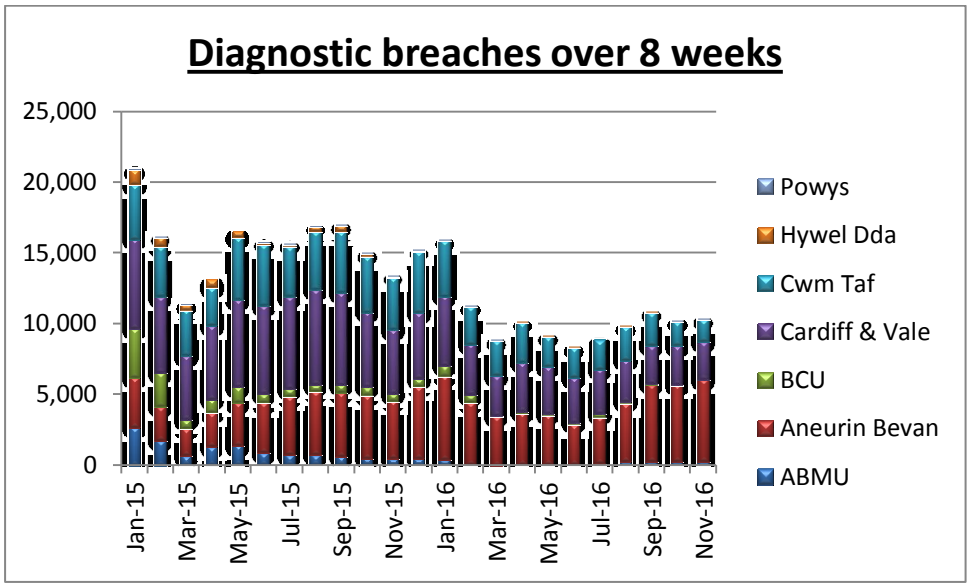


Table 1: Increase / decrease in waiting times

	Mar-12	Nov-12	inc / dec Mar-Nov	% inc / dec Mar-Nov	Mar-13	Nov-13	inc / dec Mar-Nov	% inc / dec Mar-Nov	Mar-14	Nov-14	inc / dec Mar-Nov	% inc / dec Mar-Nov	Mar-15	Nov-15	inc / dec Mar-Nov	% inc / dec Mar-Nov	Mar-16	Nov-16	inc / dec Mar-Nov	% inc / dec Mar-Nov
ABMU	236	340	-104	-44%	378	1,518	-1,140	-302%	2,095	3,997	-1,902	-91%	5,339	4,717	622	12%	3,843	3,817	26	1%
Aneurin Bevan		418	-418		431	1,418	-987	-229%	891	2,935	-2,044	-229%	2,329	3,817	-1,488	-64%	2,682	2,479	203	8%
BCU		355	-355		958	4,330	-3,372	-352%	2,911	4,601	-1,690	-58%	3,142	5,603	-2,461	-78%	3,666	5,575	-1,909	-52%
Cardiff & Vale	1,233	2,038	-805	-65%	2,497	2,806	-309	-12%	2,088	4,801	-2,713	-130%	2,378	3,116	-738	-31%	1,598	2,646	-1,048	-66%
Cwm Taf	145	495	-350	-241%	824	1,329	-505	-61%	638	1,487	-849	-133%	1,155	2,830	-1,675	-145%	1,120	1,138	-18	-2%
Hywel Dda		779	-779		326	1,868	-1,542	-473%	1,962	1,858	104	5%	4,595	5,789	-1,194	-26%	4,281	4,730	-449	-10%
Powys			0				0		1		1				0				0	
All Wales	1,614	4,425	-2,811	-174%	5,414	13,269	-7,855	-145%	10,586	19,679	-9,093	-86%	18,938	25,872	-6,934	-37%	17,190	20,385	-3,195	-19%