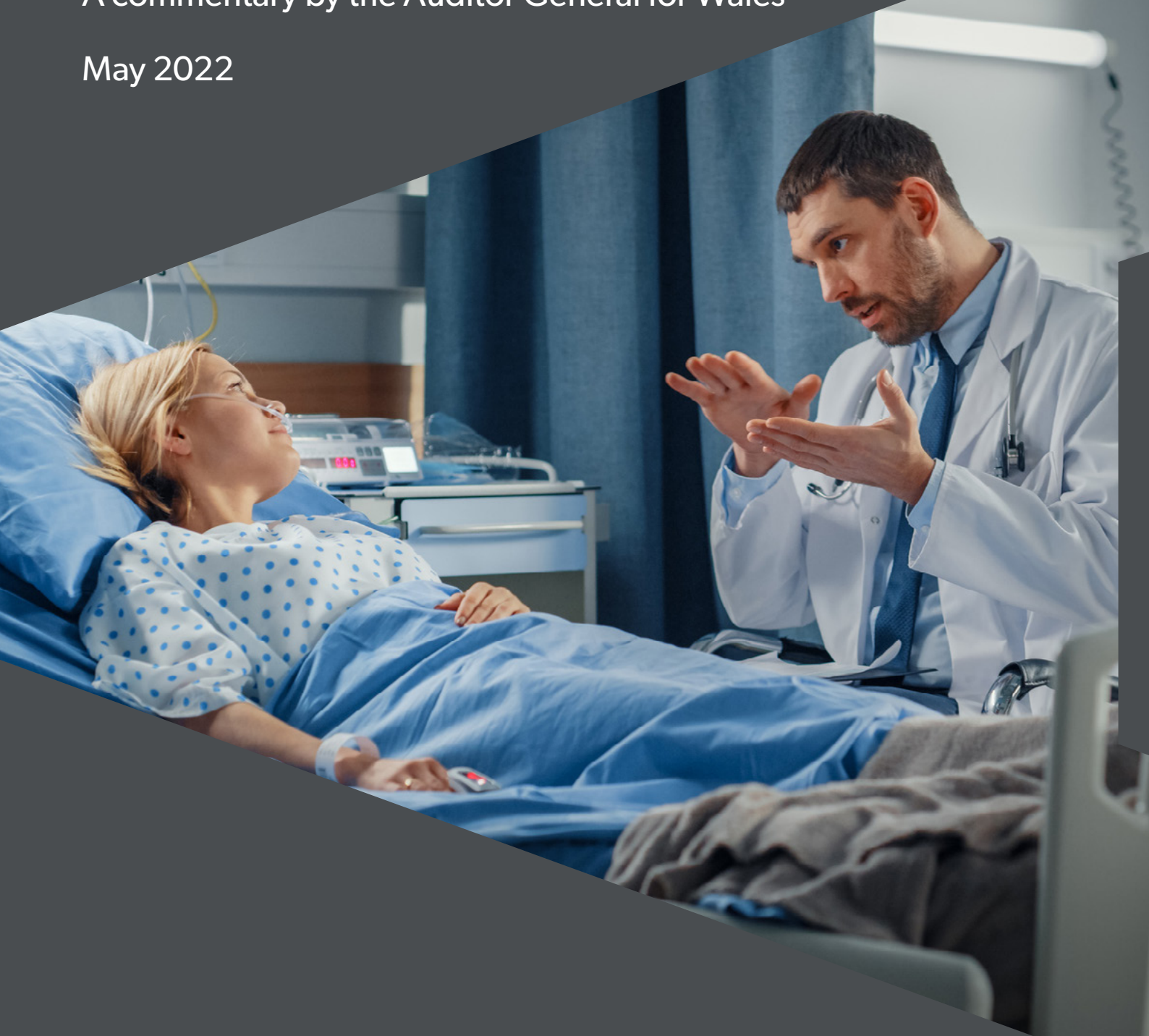


Tackling the Planned Care Backlog in Wales

A commentary by the Auditor General for Wales

May 2022



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Summary report

Context

- 1 The waiting list backlog is one of the biggest challenges facing the NHS in Wales. Waiting times for planned care have long been a problem in Wales. The COVID-19 pandemic and the impact it has had on NHS capacity has made the situation much worse. The number of patients on a waiting list for planned care has grown to a scale never seen before. Tackling that backlog is a herculean task for the NHS. It is also a real worry from the perspective of patients, some of whom are waiting in pain, whose condition is deteriorating and some of whom have now been waiting well over a year just to find out what is wrong with them.
- 2 This report sets out the main findings from the Auditor General's high-level review of how NHS Wales is tackling the backlog of patients waiting for treatment and responding to the challenges facing planned care. It describes the scale of the backlog of patients waiting for treatment and the wider challenges of delivering planned care. The report also sets out key actions NHS Wales needs to take to tackle the challenges in planned care. This report focuses on services subject to the Welsh Government's referral to treatment target¹.

1 Other services, such as treatment for cancer, are subject to different targets and not covered by this report.

Key messages

A note on patients and pathways

Throughout this report we talk about patients waiting for treatment. Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once. As a result, the total number of people waiting for treatment will be lower than the total number of pathways. At the time of preparing this report, figures to show how many individual patients are waiting for treatment were not published by NHS Wales.

- 3 As in other parts of the UK, NHS waiting lists in Wales have grown significantly since the start of the pandemic. In Wales, waiting lists grew by 51% from March 2020 to February 2022 when there were 691,885 patients² on a planned care waiting list. 251,647 of these patients had been waiting for more than 36 weeks and 406,743 were still waiting for their first outpatient appointment to discuss their condition and agree a course of action.
- 4 Although the rate of growth in the overall waiting list has slowed in recent months, there remains a risk that the drop in referrals that was seen during the pandemic has created a hidden or latent demand that will present itself at some point. Compared to pre-pandemic levels we estimate that there are some 550,000³ 'potentially missing' referrals that could ultimately find their way back into the system.
- 5 The Welsh Government has made £200 million available during 2021-22 to help tackle the backlog. However, NHS bodies have found it difficult to spend the money. NHS bodies had identified ways to spend £146 million but £12.77 million of that was returned to Welsh Government at the end of March 2022.

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- 2 Using the 'open' pathway measure of patients currenting waiting for treatment. Each pathway represents a patient waiting but a patient may have more than one health condition and therefore be on the waiting list more than once.
 - 3 Our figure differs slightly from the 500,000 in the Welsh Government's national plan to transform planned care published in April 2022.

- 6 Whilst additional funding is going to be essential, in and of itself, it will not solve the problem. The NHS needs to increase its activity if it is going to make inroads into the waiting list backlog and there are some significant barriers that need to be overcome in order to do that. These include the on-going impact of COVID on services and staff, a tired workforce with staff shortages, recruitment and retention challenges, limitations in the current NHS estate that can hinder the ability to quickly reshape services, and limited sources of additional capacity such as the private sector.
- 7 The ability to increase planned care activity will also depend on the availability of beds. The number of NHS beds in Wales has fallen steadily over many years. At present the system is also experiencing real difficulties in discharging medically fit patients, due in part to staff and capacity shortages in the social care sector.
- 8 Our reasonable case scenario modelling has indicated that it could take as much as seven years before waiting list numbers return to pre-pandemic levels. Exactly how long it will take will depend on a range of different factors that are not easy to predict, including the extent to which the latent or hidden demand caused by the pandemic re-appears. And some specialties will take longer than others to return waits to pre-pandemic levels.
- 9 What is clear is that the NHS will need a stronger focus on doing things differently. Planned care capacity needs to be better protected, and not routinely used as the system 'safety valve' and either stopped or reduced when there is increased pressure such as in the winter months.
- 10 Surveillance of patients whilst they are on the waiting list also needs to be carefully managed to minimise and ideally avoid them coming to harm as a result of long waits for treatment. To help achieve that, performance measures need to have a greater focus on patients' clinical needs rather than simply how long they have been waiting.
- 11 A long-term challenge such as the waiting list backlog needs a long-term plan supported by investment. In respect of the latter, the announcement of £185 million additional revenue guaranteed per year over the next four years to support waiting list recovery is significant. It is crucial that this investment is used wisely and that all opportunities to maximise efficiency and modernise services are taken.
- 12 Whilst the immediate challenge is to tackle the huge backlog that has built up, the ultimate goal must be to create a planned care system that can sustainably balance capacity and demand, something that has been a significant challenge for the NHS in Wales for many years.



The COVID-19 pandemic will leave the NHS with many enduring legacies not least the significant impact it has had on waiting times for planned care. Just as the NHS rose to the challenge of the pandemic, it will need to rise to the challenge of tackling a waiting list which has grown to huge proportions. Concerted action is going to be needed on many different fronts, and some long-standing challenges will need to be overcome. Additional money has been made available and it is imperative that it is used to best effect to ensure there are equitable and targeted approaches that meet the planned care needs of the people of Wales.



Adrian Crompton

Auditor General for Wales

Key facts

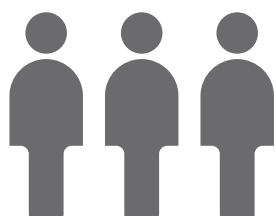
691,885

Total number of people on a waiting list in Wales



50%

increase in total numbers waiting from February 2020 to February 2022



406,743

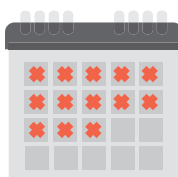
Number of people waiting for first outpatient appointment



Collectively orthopaedics, general surgery and ophthalmology make up **39%** of the total waiting list

53%

of people waiting over **26 weeks** for treatment



56,516

Number of people waiting more than **2 years** (105 weeks) or more

£146.1m

Estimated additional revenue funding allocated to support planned care recovery during 2021/22¹



£185m

Additional revenue funding made available per year²

notes*

Data as of February 2022 unless otherwise stated

- ¹ The Welsh Government made £200m available to support recovery in 2021/22. Of this, only £146.1m was allocated and estimates indicate that of this £12.77m will be returned
- ² £170 million recurring funding plus an additional £15 million per year for the next 4 years.

Recommendations

- 13 In **Exhibit 7** of this report, we highlight a number of key actions that we think are going to be needed as part of the approach to tackle the waiting list backlog. The Welsh Government published its national plan to transform and modernise planned care and reduce waiting times in April 2022⁴. Our recommendations are based around the key actions needed to successfully implement the plan. Whilst they are directed towards the Welsh Government in respect of its system leadership role in setting a framework for planned care recovery, it is recognised that their implementation will, to a large part, be dependent on the plans and activities of individual NHS bodies.

Recommendations

- R1 The national plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail on how it will transform planned care. To implement its plan, the Welsh Government should work with health bodies to set appropriately ambitious delivery milestones to measure progress of delivery of the new ways of working set out in the plan.
- R2 The Welsh Government should ensure that its national plan is accompanied by a clear funding strategy. This should include identification of the longer-term capital investment that is going to be needed and processes to ensure that revenue funding will support sustainable service transformation.

4 [Our programme for transforming and modernising planned care and reducing waiting lists in Wales](#): Welsh Government, April 2022

Recommendations

- R3 The national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies to develop a workforce plan to build and maintain planned care capacity to support recovery and tackle the waiting list backlog. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them.
- R4 The national plan includes a new diagnostics board but does not set out the system leadership arrangements needed to drive through the entirety of the plan. The Welsh Government should identify and implement such system leadership arrangements based on ensuring that lessons are learnt from weaknesses in previous national planned care programme board arrangements.
- R5 The Welsh Government should ensure it has the necessary processes, policy frameworks and programme and performance management arrangements to ensure NHS bodies:
- a effectively manage clinical risks and avoidable harms associated with long waits for diagnosis and treatment;
 - b maintain a focus on the efficient, effective and economical delivery of planned care pathways in line with prudent healthcare principles and which make best use of new technologies; and
 - c enhance communication with patients to ensure they are informed about how long they can expect to wait, how to manage their condition while waiting, and what to do if their condition worsens or improves.

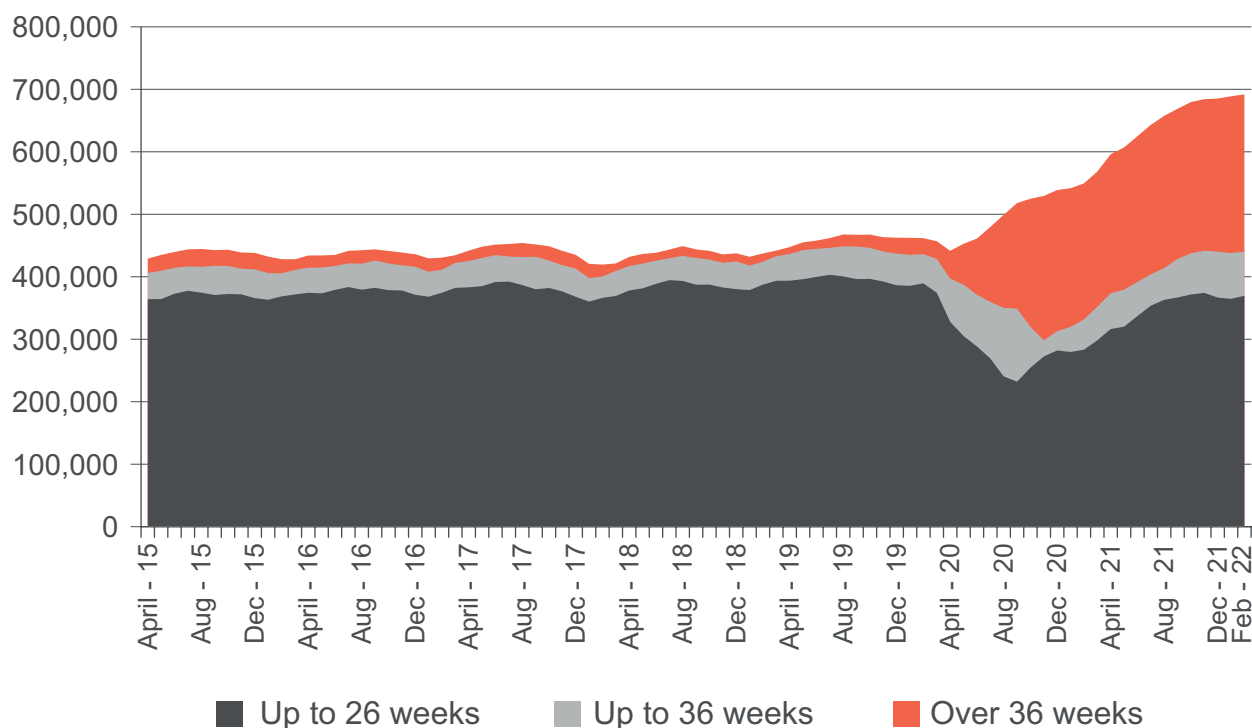


What is the scale of the challenge?

The numbers of people waiting for planned care, and the length of time they are waiting has increased significantly

- 1.1 The impact of the pandemic on planned care waiting times is clear. There was an immediate increase in the numbers of people waiting from April 2020, and numbers have continued to rise.
- 1.2 In February 2022, there were 691,885 patients waiting on the referral to treatment list (**Exhibit 1**). Of those 251,647 (36%) had been waiting more than 36 weeks. 406,743 patients (59% of all those waiting) were waiting for their first outpatient appointment to discuss their condition and agree a course of treatment. Of those, 146,198 (36%) had been waiting more than 36 weeks for their first outpatient appointment.
- 1.3 Since the beginning of the pandemic, the total number of people waiting for a diagnostic test increased from around 110,000 to nearly 165,000 in February 2022. Typically, during 2018-19 and 2019-20 there were around 15,000 diagnostic waits over eight weeks, but this rose to over 74,000 in January 2022. February 2022 figures showed some improvement with just over 66,000 waiting over eight weeks.

Exhibit 1: number of people waiting for planned care April 2015 – February 2022



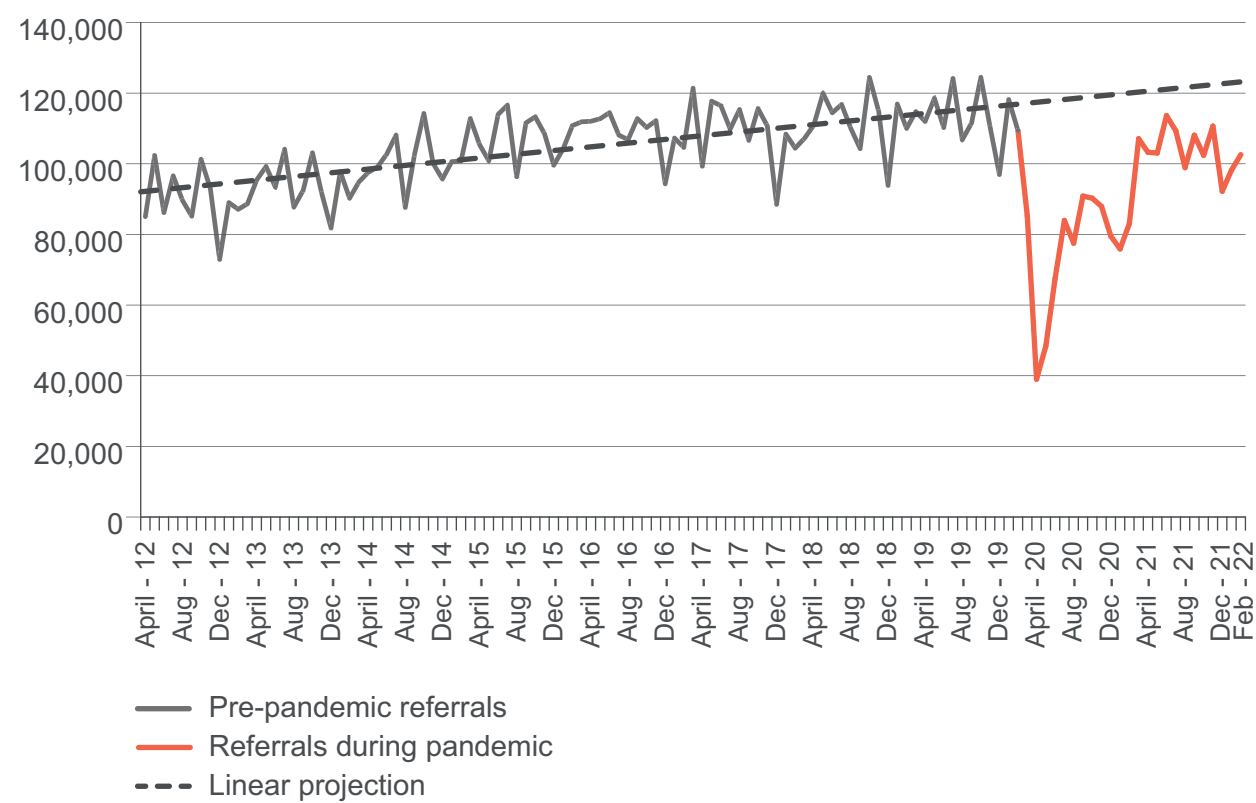
Source: Audit Wales analysis of Welsh Government data

- 1.4 There is variation in the length of time patients wait for treatment depending on where they live. For instance, November 2021 figures show that people living in the Hywel Dda University and Powys Teaching Health Board areas were least likely to have waited over 36 weeks whilst residents of Betsi Cadwaladr and Cwm Taf Morgannwg University Health Board areas were the most likely to have experienced such waits.
- 1.5 The Senedd Health and Social Care Committee held an inquiry into the impact of the waiting times backlog. Responses⁵ to the Committee's consultation on waiting times demonstrate the serious impact of long waits on different patients. Patient representatives also raised concerns with us about the impact on patients. Along with some health board officials, they told us that by the time some patients are treated, their conditions have worsened and that for some patients the deterioration has been significant enough for them to present at emergency departments.

⁵ Health and Social Care Committee, **Inquiry into the Impact of Waiting Times Backlog on People Waiting for Diagnosis or Treatment**, November 2021 – March 2022.

1.6 The direct and indirect impact of COVID-19 may increase the quantity and complexity of demand for planned care. **Exhibit 2** shows that whilst referrals for a first outpatient appointment have increased steadily for years, they fell dramatically at the start of the pandemic and have not fully returned to pre pandemic levels. Our analysis suggests that the total reduction in referrals equates to around 550,000 ‘potentially missing’ patients when comparing referrals from March 2020 to February 2022 data against the 2019-20 referral averages. Our calculation of ‘missing’ patients is a conservative estimate. There may also be additional new demand both from the direct impact of COVID-19, and the indirect impacts of the pandemic on citizens’ health and well-being.

Exhibit 2: referrals for a first outpatient appointment April 2012- February 2022

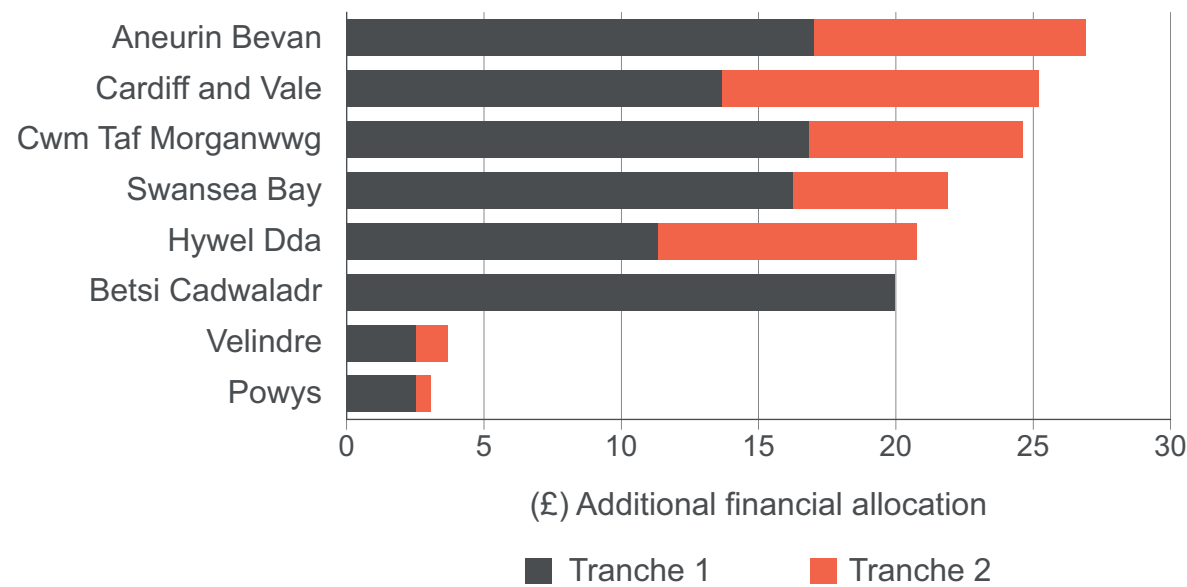


There are significant factors restricting planned care activity

NHS bodies are struggling to spend all of the Welsh Government’s funding for planned care

1.7 The Welsh Government made two announcements for additional funding to support recovery, with a combined value of £200 million in 2021-22⁶. At the time of writing this report, the Welsh Government had allocated £146.1 million of the £200 million indicating that NHS bodies have found it difficult to identify and spend on costed recovery programmes in the short term. The £146.1 million funding was provided in two tranches and **Exhibit 3** shows these individual allocations. The allocations have been based on bids from NHS bodies into the Welsh Government. The first tranche generally follows a population-based allocation, the second is based on the ability of NHS bodies to productively utilise the funding to support improvement.

Exhibit 3: 2021-22 financial allocations to support health and care recovery



Source: Audit Wales of Welsh Government data

6 [Announcement of additional allocation 20 May 2021](#) and [Announcement of additional Welsh Government allocation](#), 19 August 2021

- 1.8 Health boards also told us that spending the money has been more difficult than expected and some have been unable to spend all of it⁷. Estimates indicate that £12.77 million will be returned. Health boards have looked to secure additional planned care capacity by outsourcing some activity and insourcing staff resources where possible. The private healthcare sector in Wales is small and in part relies on NHS consultants seeing private patients in their own time. Welsh health boards are competing with NHS England to secure private capacity from across the border. As a result, health boards told us it was difficult to find enough additional capacity and where they had contracts with private providers, delivery often fell short of the number of patients agreed at the outset.
- 1.9 Some health boards said that they lacked suitable physical space to conduct additional planned care activity in accordance with infection prevention and control measures. Modifications to existing hospital estates are likely to require capital funding but constraints on the amount of capital funding that is available was cited by some as a further impediment.
- 1.10 A longer-term approach to funding can assist with plans to address the backlog. The Welsh Government is providing more certainty over future funding by guaranteeing an additional recurring £170 million annual funding for planned care for three years from 2022-23. On top of the recurring funding, the Welsh Government announced an additional £15 million annual funding up to 2025-26 to support delivery of its national plan.
- 1.11 Whilst the additional £146.1 million allocation in 2021/22 did not result in an overall reduction of waiting lists, it has appeared to help reduce the rate at which the waiting list has grown.

⁷ As of March 2022, NHS bodies had returned just over £12.77 million of the recovery funding for tranches 1 and 2.

The NHS Wales workforce is tired, stretched thinly and under pressure

1.12 Health board officials told us that staff capacity was their biggest challenge in delivering planned care. Our Picture of Healthcare report explains that the NHS Wales workforce has increased in recent years but there are specific and long-standing shortages in some areas, such as anaesthetists, radiologists and nurses. The pandemic has left a legacy of a tired workforce with increased rates of sickness absence. There are also concerns that more staff are leaving or retiring early due to the pandemic. Recruitment challenges also persist with NHS bodies competing in a small pool for medical staff and for the first time, several are reporting shortages of administrative staff to book and schedule clinic and theatre time.

Curtailling planned care remains the default position when there is increased emergency care demand in the system

1.13 The cessation of planned care at the start of the pandemic was necessary given the circumstances but it also reflected a default NHS response to pressure on the system. Cancelling or curtailing planned NHS care has long been used as the system 'safety valve' when emergency demand is high such as during the winter months. In the past, health boards have planned their elective activity around likely peaks in emergency care, attempting to catch-up during quieter periods. The Welsh Government is currently updating its escalation framework setting out how health bodies should respond to differing levels of emergency pressure. The current situation is different. Urgent and emergency care pressure on the NHS is likely to remain high for some time as a result of dealing with on-going COVID related illness and patients who had not sought help earlier in the pandemic who are now presenting with more serious symptoms. It may be unrealistic to wholly protect planned care capacity from emergency care pressures, but if the current imbalance continues, Wales will see large waiting lists and long waits for many years.

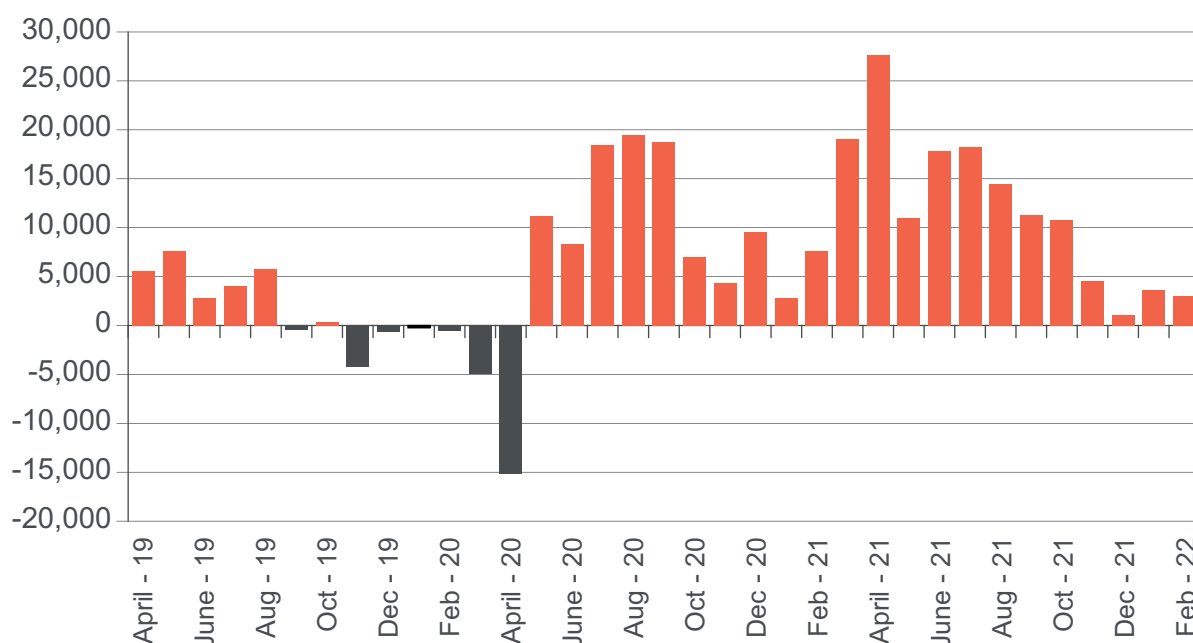
Medically fit patients are occupying NHS beds

- 1.14 As set out in Our Picture of Healthcare report, NHS bed numbers in Wales steadily decreased in the years before the pandemic from around 12,100 in 2010-11 to around 10,300 in 2020-21. Several health boards are finding it difficult to discharge patients effectively to free up beds for new patients. Some health boards told us that they can have several hundred medically fit patients occupying hospital beds at any one point in time. These patients are typically waiting for social care packages, either to support them living in their home, or in a care home whilst others are waiting for access to other health professionals such as physiotherapists before they can leave hospital.

Tackling the backlog of patients waiting for treatment could take years

1.15 **Exhibit 4** shows the month on month increase or decrease of the waiting list between April 2019 and February 2022 and demonstrates how the number of patients on waiting list has grown each month since the start of the pandemic. It also shows that since July 2021, the rate of waiting list growth is generally decreasing.

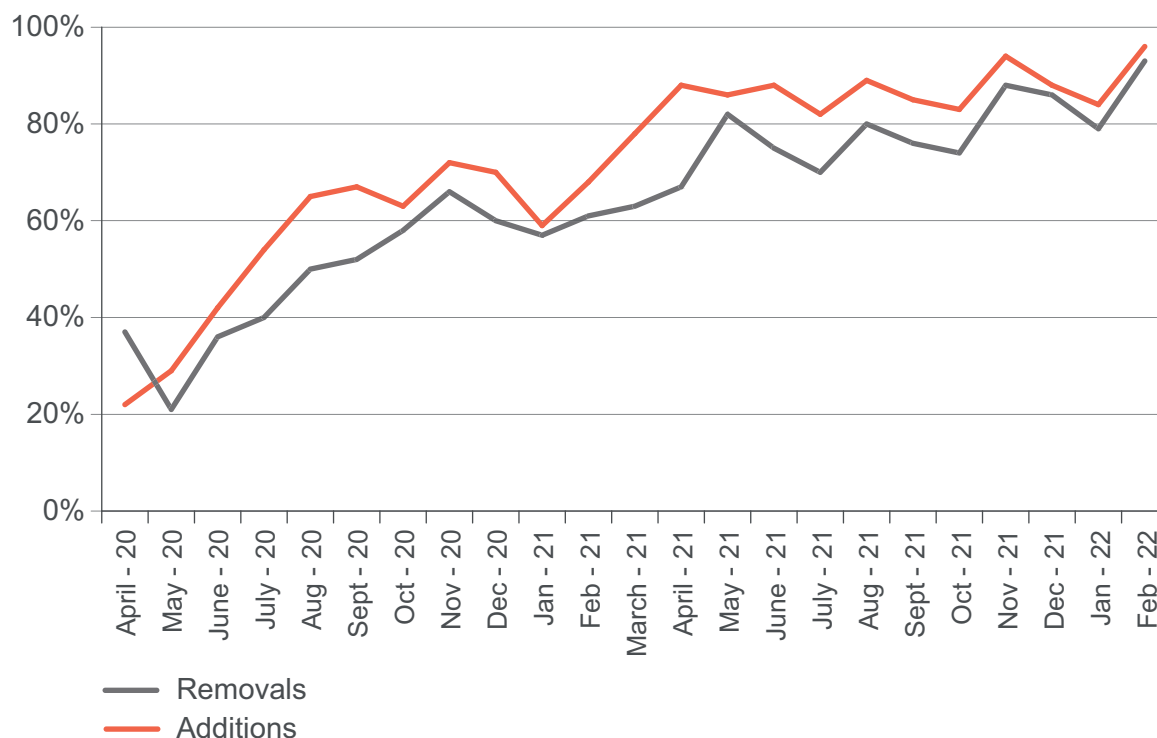
Exhibit 4: all Wales – month on month growth (orange) or decline (grey) in the numbers of people on the waiting list



Source: Audit Wales analysis of Welsh Government data

1.16 The slow-down in growth of the waiting list reflects the fact that the number of people removed from the waiting list has been gradually increasing. **Exhibit 5** shows that over the autumn and early winter of 2021, the gap between the number of people added to the waiting list (additions) and the number of removals (either through treatment or because they no longer needed treatment) shrunk. A continuation of this trend such that removals exceed additions will be needed to start to bite into the waiting list backlog.

Exhibit 5: estimated additions and removals from the waiting list compared to 2019-20

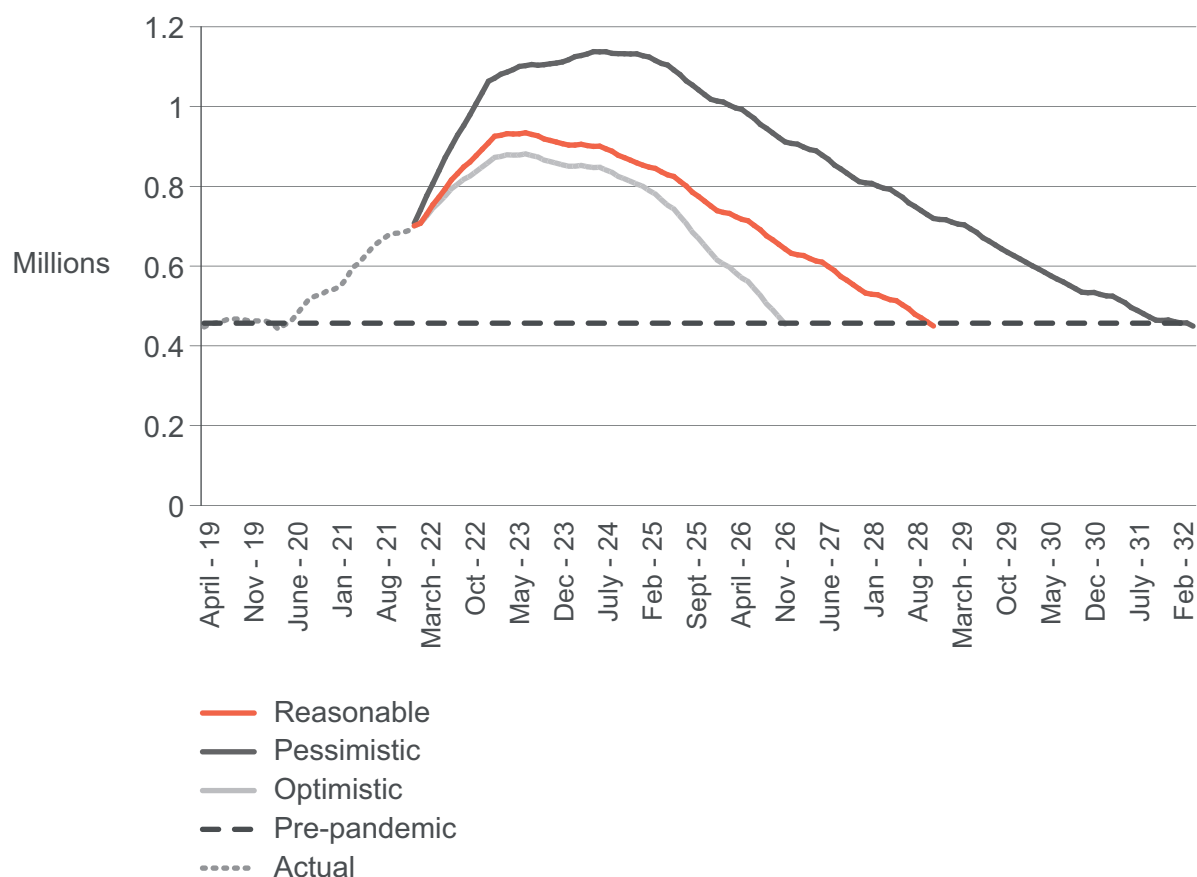


Note: More detail on how we calculated additions and removals from the waiting list is provided in **Appendix 1**.

Source: Audit Wales analysis of StatsWales data

1.17 We have used Welsh Government data to work out how long it could take NHS Wales to get waiting lists back to March 2020 levels⁸. We developed three illustrative scenarios: reasonable, pessimistic and optimistic. The modelling (**Exhibit 6**) for our reasonable scenario suggests that the waiting list could peak in 2023 but return to pre-pandemic levels by 2029. In our optimistic scenario the return to pre-pandemic levels shifts forwards to 2027 whereas in our pessimistic scenario, the waiting list would remain above pre-pandemic levels until 2032.

⁸ Appendix 1 sets out how we modelled the scenarios.

Exhibit 6: illustrative scenarios of waiting list numbers

Source: Audit Wales analysis of StatsWales data

1.18 The key variables in our modelling cover the rate at which people are added to the waiting list over time and the extent to which the potentially 'missing' patients or latent demand returns. Our modelling does not consider possible new or more complex demand as a result of population health trends or the impact of COVID-19. It also makes different assumptions about the rate at which the NHS is able to remove people from the list. The ability to remove patients is determined largely by capacity and will be influenced by several factors, especially in the short-term:

- the prevalence of COVID-19 in the community significantly reducing, with a resulting drop in COVID related hospitalisations;
- possible relaxation of COVID-19 infection control measures in hospital
- workforce capacity increasing; and
- the extent that additional funding made available over the next three years is able to be used to best effect.

- 1.19 The model above is illustrative and covers the whole waiting list. It is acknowledged that each planned care specialty is different and will have differing rates of demand and capacity. Specialities such as Ophthalmology and Orthopaedics, for example could take far longer to recover than others because these specialities were stretched before the pandemic. Equally, other specialties may be able to move more quickly.



What does NHS Wales need to do to tackle the challenges in planned care?

- 1.20 From our discussions with both NHS bodies and the Welsh Government, it is clear that tackling the planned care backlog is a key priority. Investment has been identified, plans are being developed and evidence of early progress in some areas is starting to emerge.
- 1.21 However, the scale of the challenge is huge and it will require the NHS to transform at a scale and pace not seen before. The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.
- 1.22 A renewed focus on driving as much efficiency as possible out of existing resources is going to be essential. But this by itself won't be enough, and additional capacity will need to be identified to initially tackle the backlog and then balance demand and capacity in a way which has not been done previously.
- 1.23 In a context of many patients having to wait a very long time for their treatment, the NHS will need to ensure that it has the necessary prioritisation and review mechanisms to identify those patients who need to be seen more urgently to minimise avoidable harm. There also needs to be an enhanced approach to communicating with patients while they wait to help them manage their condition and know what to do if their condition gets worse.
- 1.24 These key actions are explored further in the graphic below.

Exhibit 7: key actions for NHS Wales to tackle the challenges in planned care

Clear national vision and supporting investment



The Welsh Government's plan to transform and modernise planned care and reduce the backlog should be supported by frameworks with ambitious goals and milestones to recover and transform planned care. The plan should be informed by a realistic assessment of the capacity that is likely to be available to achieve these. It must be supported by an investment strategy which includes a more strategic and longer-term approach to capital funding to facilitate the required changes to NHS estates needed for planned care recovery.

Strong and aligned system leadership



A system is needed that translates national vision into local action, recognising that the previous national programme board arrangements had limited success. Clinical and managerial leadership within organisations needs to be aligned around a common purpose and lessons learnt from how the NHS and its partners responded to COVID need to be transferred to help tackle the longer term planned care challenges.

Renewed focus on system efficiencies



Using existing resources to best effect should be a key priority. This will mean doing things differently by improving existing processes and systems. It will also mean doing different things and rethinking how, where and from whom patients get the advice and treatment they need. Constraints associated with infection prevention and control will need to be factored in but a focus on prudent healthcare principles and key efficiency measures should be maintained. Opportunities to make best use of new digital technologies need to be secured and ways of speeding up diagnostic tests explored.

Build and protect planned care capacity



Additional capacity is undoubtedly going to be needed in the short term and clear plans are going to be needed to identify where this is going to come from. The extent to which planned care capacity can be protected from emergency care pressures should also form part of national and local planning. The Welsh Government frameworks should support health boards to prioritise emergency care at times of great pressure but must also help them to balance the needs of patients waiting for planned care. Some health boards have made progress in creating dedicated facilities for elective work which have seen some success. Whilst it may not always be practical or the best use of resources to physically separate facilities, the system does need to think differently about how it protects planned care. A more collective approach to capacity planning across health board boundaries is going to be needed alongside a critical review of the number of staffed beds required in the system. This will also include a need for effective workforce planning at local, regional, and national levels.

Manage clinical risks and avoidable harms



Management of the planned care system will need to shift to one that is based on the clinical need of patients rather than how long they have been waiting. Performance monitoring should be based around recommended lengths of waits for different categories of clinical priority with a focus maintained on minimising the extent to which patients' conditions deteriorate whilst they are waiting. There needs to be a particular focus on monitoring the condition of patients who face long waits for their first outpatient appointment. The role that general practice can play in prioritising and managing patients waiting for treatment also needs to be considered.

Enhanced communication with patients



Building on existing mechanisms, NHS bodies will need to ensure they are communicating effectively with patients about the likely time they will need to wait, how to manage their condition whilst they wait and what to do if their condition worsens or improves. Given the numbers of patients waiting, NHS bodies will need to ensure that they are investing sufficient resources into patient information and communication.



Appendix

1 Our approach

1 Our approach

The evidence base for our work comes from reviews of documents and metrics on planned care, and interviews with health board and Welsh Government officials and patient representatives. Our data analysis is based on Welsh Government data on StatsWales.

Our scenario modelling in **Exhibit 6** draws on some initial modelling work carried out by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit was:

- removals are calculated by taking the number of patients waiting over 4 weeks (ie, they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- additions are the people reported in the monthly figures who have been waiting less than 4 weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (**see paragraph 1.6**) by evenly spreading differing proportions of the potential missing 550,000 referrals over 2022-23. Those proportions varied depending on an optimistic, reasonable or pessimistic scenario. **Exhibit 8** sets out our modelling assumptions.

Exhibit 8: waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	100%	100%	100%
Annual increase in additions 2025 onwards	0.5%	0.5%	0%
Latent ‘missing’ referral demand presenting	40%	50%	30%
Activity/removals compared to 2019-20 levels during:			
2022-23	101%	95%	101%
2023-24	103%	95%	103%
2024-25	105%	100%	105%
2025 onwards	110%	110%	115%

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.



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Our Ref: JP/MR/LC

24 June 2022

Dear Adrian

Audit Wales Report - Tackling the Planned Care Backlog in Wales

Thank you for sharing a copy of your report into tackling the planned care backlog in Wales with me.

You will be aware the Minister for Health and Social Services published our Planned Care Recovery Plan – “Our programme for transforming and modernising planned care in Wales and reducing waiting lists” at the end of April. The plan outlines how we will transform the way services are delivered and reduce waiting times in Wales during the remainder of this Senedd term. The plan also responds to many of the points raised in your report.

I will respond to each of your recommendations in turn.

Recommendation 1:

The national plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail on how it will transform planned care. To implement its plan, the Welsh Government should work with health bodies to set appropriately ambitious delivery milestones to measure progress of delivery of the new ways of working set out in the plan.

Accept

Response:

The Welsh Government plan - Our programme for transforming and modernising planned care in Wales and reducing waiting lists contains a number of challenging but achievable ambitions, the first of which is to reduce the number of open pathways over 52 weeks for a

<p>first outpatient appointment to zero by the end of this calendar year.</p> <p>Andrew Sallows has been appointed as the Director for Planned Care Recovery and is undertaking a baseline assessment for each health board to understand what they need to do to achieve these targets. These plans will contain delivery milestones and Andrew will be ensuring these are achieved.</p>
<p>Recommendation 2:</p> <p>The Welsh Government should ensure that its national plan is accompanied by a clear funding strategy. This should include identification of the longer-term capital investment that is going to be needed and processes to ensure that revenue funding will support sustainable service transformation.</p>
<p>Accept</p>
<p>Response:</p> <p>The Welsh Government has made £170 million of additional recurrent funding available specifically for planned care to address the backlog and develop sustainable services. A further £20m has been allocated to developing sustainable value-based healthcare solutions with £15m allocated to planned care transformation.</p>
<p>Recommendation 3:</p> <p>The national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies to develop a workforce plan to build and maintain planned care capacity to support recovery and tackle the waiting list backlog. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them.</p>
<p>Accept</p>
<p>Response:</p> <p>A national workforce plan is being developed and should be completed by the autumn as highlighted in the Recovery Plan.</p>
<p>Recommendation 4:</p> <p>The national plan includes a new diagnostics board but does not set out the system leadership arrangements needed to drive through the entirety of the plan. The Welsh Government should identify and implement such system leadership arrangements based on ensuring that lessons are learnt from weaknesses in previous national planned care programme board arrangements.</p>
<p>Accept</p>
<p>Response:</p> <p>A national diagnostic board has been set up, chaired by the Deputy Chief Executive, NHS Wales. This Board has already met.</p> <p>Lessons learnt from the planned care programme arrangements have been shared with the team establishing the national diagnostic board.</p>

Recommendation 5:

The Welsh Government should ensure it has the necessary processes, policy frameworks and programme and performance management arrangements to ensure NHS bodies:

- a) effectively manage clinical risks and avoidable harms associated with long waits for diagnosis and treatment;
- b) maintain a focus on the efficient, effective and economical delivery of planned care pathways in line with prudent healthcare principles and which make best use of new technologies; and
- c) enhance communication with patients to ensure they are informed about how long they can expect to wait, how to manage their condition while waiting, and what to do if their condition worsens or improves.

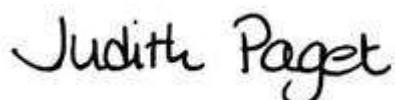
Accept**Response:**

- a) The Planned Care Recovery Plan is clear that clinical risk must take priority in the management of waiting lists and patient prioritisation. We are committed to reduce long waiting times and will ensure we support those who are waiting. Lengths of waits for both clinically urgent and long waiters will be monitored by the Director for Planned Care Recovery.

The need to reduce harm from waits has also been targeted through the agreed milestones in the plan, with an urgency to reduce lengths of waits for outpatients being the first milestone (no open pathway over 52 weeks for a first outpatient appointment by end of December 2022). It is recognised that this is the first clinical opportunity to assess a patient's clinical need since referral and early diagnosis helps to effectively assess risk of harm.

- b) I am chairing the NHS Wales Utilisation of Resources Group, (this replaces the National Efficiency Group). This group will be looking at efficiency and effective application of prudent and value-based healthcare principles.
- c) Our planned care recovery plan is clear that we need to improve communication with patients and to support them better whilst they are waiting for their appointments and treatment.

Yours sincerely



Judith Paget CBE

cc: Cabinet mailbox
Mark Isherwood MS, Chair, PAPAC
CGU mailbox



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: CEO9519
Gofynnwch am/Please ask for: Alex Harries
Rhif Ffôn /Telephone: 01267 239569
Dyddiad/Date: 29th July 2022

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David Thomas
Audit Director
Audit Wales

By email only to: Dave.Thomas@audit.wales

Dear David

RE: Tackling the Planned Care Backlog in Wales

Thank you for the invitation to provide a short narrative response which sets out how Hywel Dda University Health Board is currently addressing the issues identified in the Auditor General's recent report.

In line with your request and to aid consistency, we have structured our comments around the challenges posed in Exhibit 7 of the Auditor General's report.

1. Clear National Vision and Supporting Investment

Through our 3 year Recovery Plan, initially submitted in March 2022 and refreshed in June 2022, we have set out our delivery ambitions for 2022/23 and beyond, including an assessment of the progress we believe we can make towards delivery of the Ministerial Milestones set for the 2022/23 year.

Our plans are based on a realistic assessment of the physical and staffing resources we have available to respond to this challenge, with planned expansion of our capacity phased through the remainder of the year.

The Auditor General's report commented on the significant barriers faced by health boards to our collective ambitions to rapidly increase the volume of activity we aspire to deliver for our populations. These apply equally across the Hywel Dda UHB region with the continuing legacy of COVID on our services and staff, a tired workforce and significant staff shortages all conspiring to limit the pace of our capacity expansion plans.

Swyddfeydd Corfforaethol, Adeilad Ystwyth,
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job,
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Cadeirydd /Chair
Miss Maria Battle

Prif Weithredwr/Chief Executive
Mr Steve Moore

Bwrdd Iechyd Prifysgol Hywel Dda yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Hywel Dda
Hywel Dda University Health Board is the operational name of Hywel Dda University Local Health Board

Mae Bwrdd Iechyd Prifysgol Hywel Dda yn amgylchedd di-fwg Hywel Dda University Health Board operates a smoke free environment

Despite this however, we are making steady progress. In keeping with the messages in the Auditor General's report, we recognise the critical importance of sustainable capital investment to support recovery planning in the longer term, as demonstrated through the planned opening of a new, dual theatre Modular Day Surgical Unit at our Prince Philip Hospital site in the weeks ahead. This £23m scheme, supported by Welsh Government, reflects our determination to expand our capacity and provide our population with the very best facilities in which to receive and deliver care.

In addition to the direct commissioning of additional activity volumes, we have utilised the recovery funding provided by Welsh Government to invest in our core capacity, increasing staffing levels where achievable, transforming the way in which we deliver eye care pathways across the acute and community interface, and investment in whole system pathway solutions designed to reduce pressure on bed capacity and enable the protection of wards to support elective care.

2. Strong & Aligned System Leadership

We recognise that clinical and managerial leadership needs to be aligned around a common purpose with a strong focus on innovation and learning from our experiences during the pandemic.

In Hywel Dda, we believe we are well-placed to provide this leadership, building on the strong reputation we have developed in recent years in the delivery of our planned care priorities.

We are fortunate to be supported by senior clinicians with a strong and proactive vision for planned care recovery and the recognition that successful delivery in the years ahead requires new thinking. Our Clinical Director for Scheduled Care has recently been appointed as the National Clinical Lead for Planned Care in Wales and our Clinical Lead for Orthopaedics holds a senior position within the Orthopaedic Planned Care Board.

Through their vision and exposure to new ideas from organisations around the UK, they are bringing fresh perspectives and offering a constructive challenge to our wider clinical body in the way in which we deliver planned care.

3. Renewed Focus on System Efficiencies

Building on this clinical and managerial focus on innovation, we have fully embraced new approaches to care delivery offered by the digital agenda. We are making strong progress in the adoption of virtual means of delivering care, increasing utilisation of self-care technologies to reduce the burden on scarce hospital resources and the increasing expansion of alternative pathways such as See on Symptom (SoS) and Patient Initiated Follow-Up (PIFU) mechanisms.

Across Hywel Dda, we have a lower proportion of our population receiving follow up care via traditional pathways than any other Welsh health board providing acute hospital care, reflecting our strong commitment to delivering outpatient services in an efficient and appropriate manner.

Our planned care clinicians are actively engaged in work to further improve our rates of operating theatre efficiency and productivity, taking learning from the recent GIRFT led reviews of orthopaedic and gynaecology services.

4. Build & Protect Planned Care Capacity

As reflected above, a key feature of our delivery plan for the period ahead is the step increase in capacity we aim to achieve through the addition of the Modular Day Surgical facility at Prince Philip Hospital. Through this facility, we have the potential to increase annual activity volumes by over 4000 patients when fully established.

We recognise that our geography poses some unique challenges in the way in which we plan and deliver care for our population. In advance of our longer term ambitions to reconfigure acute and community based care provision, including the planned development of a new acute hospital serving the emergency and elective care needs of our population across Pembrokeshire and Carmarthenshire, we have determined that opportunities in shorter term to radically change the locations from which we deliver surgical care are more limited. Our delivery plan for the short to medium term is therefore centred around the protection of elective ward capacity across our 4 acute hospital sites. In so doing, we have created two new dedicated elective ward areas which, we anticipate, will help to protect the volumes of elective activity we can deliver during the winter months as compared to previous years.

Allied to this is the work we continue to progress on a regional footprint. Building on the success we have already achieved in the agreement of regional pathways to support delivery of community and hospital based eye care, we are actively engaged in joint planning work with our colleagues at Swansea Bay UHB via our ARCH regional collaboration programme with a particular focus on opportunities in Endoscopy, Dermatology, Pathology and Orthopaedic services. This work includes consideration of how we can share both staffing and physical estate resources to maximise care provision for our respective populations.

5. Managing Clinical Risk & Avoidable Harms

As a consequence of the pandemic and the restricting impact on available capacity for planned care provision, our clinicians have placed a major focus on the risk stratification of patients waiting to access care.

Whilst the re-emphasis on more time-based delivery measures does pose health boards some challenges in balancing these two priorities, we regularly review our local adherence to 'treat in turn' principles (as informed by the assessed level of clinical priority/urgency of individual patients) and those patients waiting in the longest time bands as an indicator of potential risk and harm. Our secondary and primary care based clinical teams are regularly engaged in the clinical validation and review of patients waiting with capacity identified and protected within each specialty for prioritisation of the most urgent patients.

6. Enhanced Communication With Patients

To supplement the approach referenced above to managing clinical risk and avoidable harm, we established a comprehensive Waiting List Support Service during the pandemic as a measure of our commitment to invest our time and resources in supporting and communicating with awaiting access to care.

The primary aims of this service are to offer personalised contact to patients waiting, providing regular information about expected waiting times, offering a single point of contact and advice on self-management and appropriate actions if conditions deteriorate. The service also offers a mechanism by which we can measure harm, taking account of clinical assessments and patients self-assessments.

To date, we have contacted over 7,000 patients with approximately 20% actively engaging with the service for further support. In addition, over 4,500 patients have accessed our

online 'Preparing for Treatment' resources. Through the remainder of the summer period, we plan to contact an additional 5,000 patients with all patients waiting longer than 36 weeks receiving contact by November 2022.

As a supplement to the overview provided above, I have enclosed a copy of our Annual Recovery plan (both the submission to Welsh Government on 8th July 2022, as well as the previous March 2022 submission which includes detail on planned care on slide 35) which sets out how our planned care recovery priorities sit within the wider context of our overall recovery ambitions for our population.

Yours sincerely

A handwritten signature in dark ink that reads "Steve Moore". The signature is written in a cursive, flowing style.

Steve Moore
Chief Executive