Agenda – Public Accounts Committee

Meeting Venue:	For further information contact:
Committee Room 3 – Senedd	**Fay Buckle**
Meeting date: Tuesday, 24 November 2015	Committee Clerk
	0300 200 6565
Meeting time: 09.00	SeneddPAC@Assembly.Wales

1 Introductions, apologies and substitutions

(09.00)

2 Papers to note

(09.00–09.05) (Pages 1 – 3)

Governance Arrangements at Betsi Cadwaladr University Health Board: Letter from Simon Dean, Interim Chief Executive, Betsi Cadwaladr University Health Board (16 November 2015)

(Pages 4 – 13)

Health Finances 2013-14: Letter from Director General Health and Social Services Group/NHS Chief Executive, Welsh Government (16 November 2015)

(Pages 14 – 25)

3 NHS Wales Health Board's Governance

(09.05–10.35) (Pages 26 – 50)

Research Briefing

Dr Andrew Goodall – Director General of Health and Social Services/Chief Executive, NHS Wales, Welsh Government

Joanna Jordan – Director of Mental Health, NHS Governance and Corporate Services, Welsh Government

Martin Sollis – Director of Finance, Welsh Government

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

(10.35)

Item 5

5 NHS Wales Health Board's Governance: Consideration of evidence received

(10.35-11.00)

Concise Minutes – Public Accounts Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: Tuesday, 17 November 2015

Meeting time: 09.00 – 11.03

This meeting can be viewed on Senedd TV at:

http://senedd.tv/en/3284

Attendance

Category	Names
Assembly Members:	Darren Millar AM (Chair) Mohammad Asghar (Oscar) AM Mike Hedges AM Sandy Mewies AM Julie Morgan AM Jenny Rathbone AM Aled Roberts AM Alun Ffred Jones AM (In place of Jocelyn Davies AM)
Witnesses:	Simon Dean, Betsi Cadwaladr University Health Board Peter Higson, Betsi Cadwaladr University Health Board
Committee Staff:	Fay Buckle (Clerk) Claire Griffiths (Deputy Clerk) Joanest Varney-Jackson (Legal Adviser) Dave Thomas (Wales Audit Office) Huw Vaughan Thomas (Wales Audit Office)

	Mike Usher (Wales Audit Office)

Transcript

View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 The Chair welcomed the Members to the meeting.

1.2 Apologies were received from Jocelyn Davies. Alun Ffred Jones substituted.

2 Papers to note

2.1 The papers were noted.

2.1 NHS Wales Health Board's Governance: North Wales Community Health Council Health Inspectorate Wales Mini-Summit Submission (May 2015)

3 NHS Wales Health Board's Governance

3.1 The Committee scrutinised Simon Dean, Interim Chief Executive and Dr Peter Higson, Chair, Betsi Cadwaladr University Health Board, as part of the inquiry into health board governance.

3.2 Simon Dean agreed to send further information on:

- Co-locality across the Board's area in relation to GP out of hours services
- Specific areas identified about the capacity of the non-executive team and how the Board plans to improve this
- Current figures showing attendance at Board meetings
- Following the forthcoming Board meeting, a note on the decision taken to co-ordinate the current committee structure
- Total costs, to date, of the independent advisors appointed to assist the Board and the evaluation of their use
- The rise in maternity services being provided at the Countess of Chester Hospital
- An update on the Board's proposals for Primary Care
- Confirmation as to whether the Holden Report was shared with the Welsh Government and Healthcare Inspectorate Wales

- How the Board has improved its complaint handling procedure and how it tracks complaints once in the system including long standing complaints and whether these will be completed by the end of the March 2016
- What is the process within the Health Board regarding the handling of CHC reports

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

4.1 The motion was agreed.

5 NHS Wales Health Board's Governance: Consideration of evidence received

5.1 Members discussed the evidence received.

GIG CYMRU NHS WALES
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Betsi Cadwaladr
University Health Board

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Dyddiad / Date: 16th November 2015

Dear Mr Millar

RE: Robin Holden Report

Further to your request via the PAC committee clerk I have now had the opportunity to consider your request for a copy of the report undertaken by Robin Holden in 2013/14. The report was the result of an investigation commissioned under the raising staff concern/ whistleblowing policy and looked into concerns raised about the management of the mental health clinical programme group in their dealings with the Hergest Unit and a variety of other issues relating to the Hergest Unit.

The Health Board has made a decision to withhold the full report but can now provide a redacted version of the summary and recommendations. The remainder of the report is withheld under Section 41 – information provided in confidence. The Health Board has reached this decision because individual witnesses will have had an expectation that their statements provided as part of a whistleblowing investigation would be kept in strict confidence and to release this information may constitute an actionable breach of confidence.

This exemption is an absolute exemption and therefore does not require the public interest test to be applied. However we recognise the public interest in this information being released. The Health Board has therefore further considered this element and agree that whilst there is a public interest in the disclosure of information relating to concerns raised about the Health Board's delivery of services to the public and there is a public interest in knowing that such concerns have been fully investigated and appropriate action taken, there is also a public interest in maintaining the confidentiality of information provided in confidence as part of the investigation. If details of individuals' testimony were to be disclosed, individuals may lose trust in the Health Board and may be reluctant to raise concerns or take part in future investigations of this nature, which would not be in the public interest.

I have also attached a copy of the action plan which summaries the actions taken to date in response to the recommendations made, to provide continued assurance that the issues have been addressed.

I also thought it may be helpful to provide some background and context: In January 2014 the Health Board considered a report at its public meeting about the Hergest Unit which had been subject to external reviews and improvement processes. The Health Board was also updated on the latest review by Healthcare Inspectorate Wales (HIW) and action plan plus the review by the Royal College of Psychiatrists (RCS).The Board determined that a consolidated action plan be developed to ensure that all issues arising from the various reviews and improvement processes be coordinated and progressed.

In June and July 2014 the Health Board considered an update report on the Hergest Unit at its public meetings setting out in detail the progress made regarding the consolidated action plan. It was also provided with an update on the visit by HIW to the Hergest Unit on the 12th May 2014. The Quality and Safety Committee of the Board also undertook detailed review of the improvement processes in the Hergest Unit at its meetings in June and July 2014.

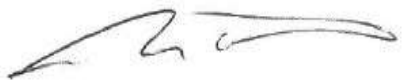
In summary, this is a historical report about the Hergest Unit from more than two years ago. It was commissioned by the Health Board to get an independent view after staff working on the front line raised concerns. The report identified that on some wards there had been a significant breakdown in relationships between frontline staff and more senior management. It recognised some of the issues that had contributed to this and the report made valuable recommendations, all of which we have taken action on or addressed. In turn, they have also positively influenced the ongoing work with regards to mental health services across North Wales.

Since this time there has been a fundamental restructuring of leadership and management arrangements in mental health services, with new senior management appointments and clinical leadership. A considerable amount of work has been undertaken in terms of staff and patient engagement, increasing access to activities and therapies for patients, improving the internal and external environments on the Hergest Unit and these matters continue to be monitored by the Health Board's Mental Health Improvement Group established In June 2015 under the leadership of the Chief Operating Officer with the Vice Chair of the Health Board in attendance. The work from the group has been reported publicly as part of the 100 day plans and continues to be monitored as part of the special measures programme.

The Board acknowledges there is still significant further work to be done to address concerns within adult and older persons' mental health services more widely which have caused concern in relation to the way in which services are currently provided, and the adequacy of governance arrangements in place to assure quality and safety of care.

Taken together, these concerns have triggered mental health services being subject to special measures for the next two years as confirmed by the Deputy Minister in November. This is welcomed by the Health Board and we are committed to working productively with the internal and external support and advice provided by Welsh Government.

Yours sincerely



Simon Dean
Interim Chief Executive

Enc: 1) Holden Report Summary and Recommendations
2) Holden Report Recommendation Action Plan

Raising Staff Concern / Whistleblowing Policy - WP4 - Investigation Report - into the concerns raised about the "Management of the Mental Health Clinical Programme Group in their dealings with the Hergest Unit and a variety of other issues relating to the Hergest Unit".

Author - Robin Holden 17th January 2014

8. Summary

8.01 The vast majority of the Whistleblowing testimonies emanate from Staff on Cynan and Aneurin Wards. The staff on Taliesin Ward seem better engaged in the HIP process. [redacted]

8.02 With the exception of Taliesin Ward, the Hergest Unit is in serious trouble. Relationships between Staff and Management at Matron level and above have broken down to a degree where Patient care is in undoubtedly being compromised.

8.03 The lines of communication are critically weak and although regular management returns are received from the Wards one has to question whether these adequately reflect the worrying standards of the care being provided and the inherent level of clinical risk. These systemic communication weaknesses have been brought about, to a large degree, by a lack of presence on the Wards by Senior Managers. To be fair, this lack of presence is understandable to a degree, bearing in mind the geography of the BCUHB, the complexity of the CPG and the distances that the Senior Management Team have to travel in order to discharge their duties.

8.04 The HIP is a useful document which harvests the recommendations of both HIW and the DSU. However the execution, appears to be process driven. Meetings take place in which progress is monitored and next steps planned, but Ward Staff attendance is sparse due to the pressures being experienced on the Wards. There is no agreed vision or shared values to underpin the HIP. All eight work streams are being implemented concurrently and at pace. The process of change is seen as bewildering at the Ward level. The HIP, consequently, has little ownership at the Ward level and is seen as a top down, distant document of low priority on a day to day basis.

8.05 There has been a critical underestimation of the training and personal development required by qualified and unqualified Ward Staff in order to prepare them for the journey ahead. There is little doubt that with the time imperatives involved Senior Managers have become frustrated at the pace of change and the tendency to shove a little harder, it would appear, has been met with increased resistance and conflict leading to the reported breakdown in relationships and ineffective implementation of some of the HIP work streams Staff morale has plummeted. Staff feel unheard and powerless. There is no trust in the Managers above Ward level. Consequently any Management interventions, even if well intentioned, are open to misinterpretation, further reinforcing the belief system that has become established.

8.06 During interviews with Managers there is acknowledgement that their approach to change could have been handled better and a willingness to attempt to engage more effectively with Staff. There is already some evidence of this in some of the later interviews, where staff advise that Ward rosters are being arranged in such a way that more Staff are able to attend HIP events. Also the ACOS (Nursing) has markedly increased his presence on the Unit.

9. Recommendations -

1. The current arrangements for the Management of the CPG are unwieldily. Responsibilities and lines of management are unclear. Relationships between

significant numbers of Staff and Unit/Senior Managers have broken down. There appears to be a high number of temporary and interim posts. The BCUHB needs to review management arrangements of the CPG with a view to strengthening local management of the whole system. The temporary and interim posts need to filled with substantive post holders as soon as possible.

2. The issues surrounding the lack of constructive engagement between the Senior Management Team and the staff of the Hergest Unit needs to be addressed urgently. This critical breakdown in communication has created a worrying poverty of leadership in the Unit.
3. Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit. The recently vacated Programme Manager post, could potentially be redesigned as an Advanced Nurse Practitioner or Nurse Consultant role developing and promulgating excellence in Acute Mental Health Nursing in the Hergest Unit and across the Health Board.
4. Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers. [redacted] Very skilled mediation will be necessary and HR advice will need to be sought on how best to facilitate this. This is such a critical area that it may be that expertise will need to be brought in if not available within the Health Board.
5. A structured programme of safety walk arounds and Ward visits should be implemented by the Senior Management Team in order to improve their presence on the wards.
6. Arrangements for regular briefing of Staff need to be implemented.
7. Steps need to be taken to better engage Staff in the change process . The current implementation plan is clearly in difficulty.
8. The Communication Strategy needs to be rethought. It needs to reflect the need for staff to be fully engaged on a personal level.
9. Change champions need to be identified throughout the unit, including the more junior and unqualified Staff. Arrangements should be put in place to ensure their time is protected to to enable their full participation. This approach would, in part, mirror the successful inclusive approach to change adopted by the current Interim Modern Matron when Ward Manager on Taliesin.
10. The concurrent implementation of the eight HIP work streams needs to be reconsidered. A glance at the plethora of implementation documents on the HIP notice board is a manifestation of the difficulties being experienced by the current implementation process. A better approach may be to consider the relative urgency of the work streams and prioritise them into smaller steps, in which the staff are engaged.
11. Arrangements need to be made for the Ward Staff to have opportunity engage with external networks of similar organisations. This is particularly important considering the relative isolation, geographically, of the Unit. Otherwise the opportunities for sharing and learning from best practice will be extremely limited.
12. A training and development programme, including arrangements for Appraisal, Management Supervision and Clinical Supervision, needs to be implemented for all Staff in the Unit. The weekly minuted Ward Managers meetings need to be reinstated without delay.
13. A system of recognition would be helpful where the contribution of individual Staff is celebrated.
14. Urgent attention needs to be paid to the how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. This discrepancy is deserving of detailed scrutiny.

15. Staffing should be planned in such a way that it would be exceptional for Staff working a twelve hour shift to be unable to take a break.
16. The issues surrounding the Junior Doctors Rota need to resolved urgently.
17. The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed. The Ward Staff find the current arrangements difficult and it is likely that the current situation will have a deleterious effect on recruitment and retention of Senior Medical Staff.
18. The current arrangements for the care of frail elderly Patients needs to be urgently reconsidered. It is clearly unacceptable for the needs of frail vulnerable people to be neglected in the way that has been reported.
19. The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patients.

Holden Report - Recommendations

	Main Recommendation	Action to Date	Future Actions
1	The current arrangements for the Management of the Division are unwieldily. Responsibilities and lines of management are unclear. Relationships between significant numbers of Staff and Unit/Senior Managers have broken down. There appears to be a high number of temporary and interim posts. The BCUHB needs to review management arrangements of the Division with a view to strengthening local management of the whole system. The temporary and interim posts need to filled with substantive post holders as soon as possible.	The Division has now put in place Locality Managers as opposed to Health Board wide 'Programme Managers'. The Locality Manager for Adult Services West is based in the Hergest Unit and has managerial responsibility for the Acute Wards, Home Treatment Team, Psychiatric Liaison Service and the associated County wide CMHTs. There are several regular points of contact between the team leads (ie Hergest Service Improvement Group, Senior Nurses Meetings, Locality Meetings) as well as the more impromtu discussions needed as required.	Meeting frequencies and agendas may need to change once a Divisional Structure has been agreed.
2	The issues surrounding the lack of constructive engagement between the Senior Management Team and the staff of the Hergest Unit needs to be addressed urgently. This critical breakdown in communication has created a worrying poverty of leadership in the Unit.	Engagement with staff has taken place at several levels with the introduction of the regular Senior Nurse meetings, Band 5 Development Days, HCA development forums and more broadly with the establishment of the Ward Managers network.	A Matrons Forum is now in development
3	Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit. The recently vacated Programme Manager post, could potentially be redesigned as an Advanced Nurse Practitioner or Nurse Consultant role developing and promulgating excellence in Acute Mental Health Nursing in the Hergest Unit and across the Health Board.	This has not been progressed as Locality Manager replaced Programme Manager	Development of Advanced Nurse Practitioner role needs to progress in collaboration with medical colleagues to ensure clarity of accountability and responsibility.
4	Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers. [redacted] Very skilled mediation will be necessary and HR advice will need to be sought on how best to facilitate this. This is such a critical area that it may be that expertise will need to be brought in if not available within the Health Board.	External candidate is now in post as Modern Matron.	
5	A structured programme of safety walk arounds and Ward visits should be implemented by the Senior Management Team in order to improve their presence on the wards.	Initial Safety Walk arounds and ward visits have been completed across the Health Board area. Initial work underway in relation to a Division – specific “Safety Walkabout Prompt card” for impromptu visits to ward areas from senior staff (e.g execs).	Follow-up 'unannounced' visits are now planned.
6	Arrangements for regular briefing of Staff need to be implemented.	Originally via Hergest Update Letter. The Division now has a newsletter in place and is looking to strengthen its communication channels. The newsletter is shared regularly with all staff and all staff are encouraged to participate in populating this with good news stories and achievements from across the Division. Each month, following the Board Meeting, a Team Brief is prepared by the Communications Team and this is shared with all Senior Managers across the Division. The information is then cascaded through staff groups at team meetings to ensure that all staff are regularly updated about developments within the organisation.	

Holden Report - Recommendations

	Main Recommendation	Action to Date	Future Actions
7	Steps need to be taken to better engage Staff in the change process. The current implementation plan is clearly in difficulty.	A model for change has been discussed and shared with the operational team. A further workshop has been arranged to share ideas and issues that need to be addressed and an improvement programme will commence. Four community based workshops attended by 250 people including service users and carers, partner organisations and staff to discuss the change process and strategy. An additional nine workshops for staff in adult mental health services (AMH) and child and adolescent mental health services (CAMHS) with 130 attendees were also facilitated.	
8	The Communication Strategy needs to be rethought. It needs to reflect the need for staff to be fully engaged on a personal level.	The Communication Strategy for the organisation is currently being refreshed. Each month, following the Board Meeting, a Team Brief is prepared by the Communications Team and this is shared with all Senior Managers across the Division. The information is then cascaded through staff groups at team meetings to ensure that all staff are regularly updated about developments within the organisation. Within the Division, a regular newsletter is shared with all staff and all staff are encouraged to participate in populating this with good news stories and achievements throughout the Division.	
9	Change champions need to be identified throughout the unit, including the more junior and unqualified Staff. Arrangements should be put in place to ensure their time is protected to enable their full participation. This approach would, in part, mirror the successful inclusive approach to change adopted by the current Interim Modern Matron when Ward Manager on Taliesin.	As part of the Band 5 Development days - all the staff nurses gave witten 'pledges' as to their commitment going forward in developing the service alongside their specific areas of interest.	
10	The concurrent implementation of the eight HIP work streams needs to be reconsidered. A glance at the plethora of implementation documents on the HIP notice board is a manifestation of the difficulties being experienced by the current implementation process. A better approach may be to consider the relative urgency of the work streams and prioritise them into smaller steps, in which the staff are engaged.	Hergest Improvment Workstreams were brought under the remit of: **Hergest Service Improvement Group** (Monthly multi-dsicplinary with service user and carer representatives) **Clinical Governance Meeting** (Monthly multidisciplnary meeting including local clinical governance lead). Chaired by Acute Care Psychiatrist. **Unit Health & Safety Meeting** (Quarterly multi-department meeting) Chaired by the Modern Matron, in turn reports to Locality H&S. Minutes of the above meetings are circulated for distribution to the department teams.	
11	Arrangements need to be made for the Ward Staff to have opportunity engage with external networks of similar organisations. This is particularly important considering the relative isolation, geographically, of the Unit. Otherwise the opportunities for sharing and learning from best practice will be extremely limited.	As part of the AIMS accreditation process the Ward Managers and a nominated deputy attended the Aims Reviewers course run by the Royal College of Psychiatry. To date the Ward Managers have undertaken several external visits to UK wide Units as part of accreditation teams. The PICU ward team have continued their membership of the National Association of Psychiatric Intensive Care Units and attend its annual learning conference.	The nominated Deputies are now being given this opportunity to participate in external AIMS visits.

Holden Report - Recommendations

	Main Recommendation	Action to Date	Future Actions
12	A training and development programme, including arrangements for Appraisal, Management Supervision and Clinical Supervision, needs to be implemented for all Staff in the Unit. The weekly minuted Ward Managers meetings need to be reinstated without delay.	Senior Nurses Meeting is now firmly established and well attended. Initially as a weekly meeting due to the volume of work to be processed, this is now fortnightly to allow work to be undertaken. Chaired by the Modern Matron. PADR rates for the Unit are well maintained and training compliance closely monitored.	
13	A system of recognition would be helpful where the contribution of individual Staff is celebrated.	Staff have been entered for the BCU awards schemes & nursing celebrations.	
14	Urgent attention needs to be paid to the how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. This discrepancy is deserving of detailed scrutiny.	Benchmarking excersise has been completed across the Health Board area and staffing templates develped using the Hirst methodology. These templates have been recruited to and are within the Hirst reccomendations for best practice areas.	
15	Staffing should be planned in such a way that it would be exceptional for Staff working a twelve hour shift to be unable to take a break.	Following the benchmaking work undertaken with regard to staffing establishments the wards are now staffed to recommended levels. Short notice sickness absence and vacancies can provide a considerable challenge in maintaining staffing but this is proactively managed by the Matron and Ward Managers.	
16	The issues surrounding the Junior Doctors Rota need to resolved urgently.	We currently have a full 1:9 rota for East and West. We also have a permanent rota co-ordinator who makes sure that gaps are filled promptly. We have an OOH protocol, which is being updated, but is still valid.	
17	The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed. The Ward Staff find the current arrangements difficult and it is likely that the current situation will have a deleterious effect on recruitment and retention of Senior Medical Staff.	We have an accepted Acute Care Policy and most importantly a PICU Policy. A formal review of older people's consultant model is being commissioned. A medical management structure has been proposed and is awaiting approval. Further work is ongoing to ensure compliances with job plans.	
18	The current arrangements for the care of frail elderly Patients needs to be urgently reconsidered. It is clearly unacceptable for the needs of frail vulnerable people to be neglected in the way that has been reported.	The management of Frail client was identified as a priority area. Historically the West has not had a seperate Older Persons Funtional Illness unit. Instead this client group are nursed within adult acute care wards. The initial proposal was to establish 'Frailty Bays' where Frail individuals could be nursed seperately. However, bed pressures has dictated that the client groups have continued to be nursed together. Local resolutions have focussed on the the use of single rooms but clearly this is potentially isolating and brings its own demands in terms of increased staffing to maintain observation levels.	The ongoing management of this client group needs consideration with regard to the establishment of a dedicated unit/ward.
19	The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patients.	It has been agreed that ward rounds will take place at set times to enable protected nursing time for patient care is afforded. This will be revisited within a revised model of care.	

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

Darren Millar AM
Chair
Public Accounts Committee

Our Ref: AG/MR/KH

16 November 2015

Dear Mr Millar

WAO Report into Elective Waiting Times

When I sent my initial response in to the Auditor General's report into elective waiting times in Wales, I agreed to provide a follow-up response after six months. This I have attached to this letter.

As you can see, a great deal of work has been undertaken in the intervening months since my first response. The Welsh Government has been engaging with health boards and the general public to discuss waiting times and communication.

As part of this work, a national self assessment assurance process was completed in June 2015. The results of the review were to design and run a workshop with the NHS, WAO and CHC representation to explore a number of the recommendations within the WAO particularly around patients understanding of the RTT pathway. This workshop took place at the end of August 2015.

Following the meeting, a task and finish group has been established to further explore a national approach to patient communication. The work from this group will be used to pull together revised RTT guidance and updated guide to good practice.

Yours sincerely

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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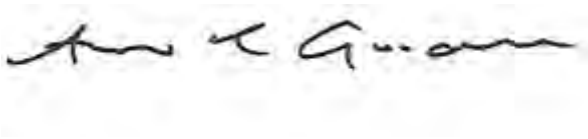

Dr Andrew Goodall

HSS EXTERNAL (WAO / PAC) AUDIT MONITORING REPORT

IAS or WAO Report (Date Issued)	Total No. of Report Recs	Recs O/S	Recommendation Summary	Original Target Date	Latest Target Date	Comments
WAO NHS Waiting Times for Elective Care in Wales: January 2015 *Detailed supportive action plan to address all recommendations being developed. Completion dates for each recommendation will be updated once support actions and individual leads identified.*	9	7	**Recommendation 1** The Welsh Government has not formally reviewed its approach to managing waiting times in light of a sustained deterioration in performance and the challenges of real terms cuts to spending on health. However, with the introduction of a new planning framework, a Planned Care Programme and a range of prudent healthcare initiatives, there are positive signs of a clearer direction for elective care in an environment of austerity. While the Welsh Government is responsible for setting the overall direction, it is for health boards to plan and deliver sustainable and appropriate waiting times. The Welsh Government should therefore work with NHS bodies to: • Review and set out the principles, priorities and intended outcomes for elective care, within the	**1st stage (scoping) completed 31 July 2015 (achieved)**	**1st stage completed next stage 31 October 2015** **Final stage to be completed by 31 March 2016**	The recommendation has been accepted in full. The first stage scoping exercise was completed by the end of July. On recommendation 1a, this has been taken forward by the Planned Care Programme, which has used the principles of prudent health to prioritise the four top surgical elective specialities, which are ophthalmology, orthopaedics, urology and ENT. Each area has a dedicated implementation plan and implementation board, chaired by a clinician and with further clinical and management representation. The key aim of the implementation plan is do develop sustainable models of delivery based on prudent health principles, clinical evidence and development of more outcome based focussed patient outcomes. On recommendation 1b, each of the Planned Care Implementation plans have been supported by a Delivery Unit demand and capacity modelling tool to identify both capacity required to remove backlog and to deliver a sustainable model. In the IMTP guidance for 2016/17, health boards will need to demonstrate completion of this tool supported by their implementation plan and evidence of sustainable services going forward.

			context of the wider healthcare system: to include a fundamental review of current waiting times targets and whether they are an effective method to prioritise resources towards those most in need; • Develop a shared understanding of demand and capacity across the NHS and develop a realistic timeframe for reducing elective waiting times and the backlog of patients in line with any changes to the targets resulting from R1(a) above; and • Assess the costs, benefits and barriers related to adopting seven-day working across the elective care system. **Lead: Andrew Carruthers**			Closure of recommendation 1a and 1b will be evidenced through the IMTP 2016/17 which will be received in early 2016 and should demonstrate effective demand and capacity planning to develop sustainable services to achieve the required access targets for the four specialities. With regard to recommendation 1c, Welsh Government continues to work with health boards and trusts to assess the need for seven day working. However, we feel that this is wider than just elective care and should be reviewed as a whole system issue. We have seen evidence of expanding capacity for clearance of backlog using weekend and evening sessions, but these have been additional rather than core hours. We would encourage this to offer flexibility to better manage peaks and troughs within the year. We are aware of seven day working already being in place in some therapy services across Wales, to support elective care flow, such as physiotherapy weekend work to support orthopaedics. It is the responsibility of health boards to assess the costs and benefits of this within their overall IMTP.
			Recommendation 2	**31 July 2015** Initial	**Completed this is imbedded**	The recommendation has been accepted in full. This recommendation has been adopted as a principle going forward in future work

			Our review found that aspects of the current design and operation of the outpatient system is not as efficient and patient focused as it could be. The Welsh Government and NHS bodies should work together to radically re-shape the outpatient system. In doing so, they should build on the prudent healthcare principles, to enable the emergence of a system that is based more on need, patients' own treatment preferences, use of technology and which reduces the risk of over-treatment and an overreliance on hospital-based consultants to diagnose and advise on treatment. **Lead: Andrew Carruthers**	scoping plan completed	**as a principle going forward through existing programmes**	linked to both the planned care programme and the development of prudent health policy development This is a key area of focus for each of the Planned Care national plans using the prudent health principles for outpatient care. Health boards are reporting progress against these and sharing good practice as appropriate. Each of the national surgical implementation plans looks at the capacity requirements for outpatients, both new and follows up, and the appropriateness and need for consultant face to face review. Example of this is the proposed orthopaedic follow up requirement which has reduced the number of face to face reviews significantly looking at virtual clinics, nurse led clinics and surveys. ENT has looked at alternative pathways through audiology and where appropriate "straight to test" opportunities and DU is working with each speciality area to evidence the most clinically effective pathways to treatment. It is therefore felt that it is not a generic solution for outpatient redesign, rather a set of principles to be applied to clinical pathways maximising patient's needs, clinical resources and innovative use of technology developments. This will be a pivotal piece of work through the PCP, where sharing of best practice will

						be a common theme. It is noted that all health boards have internal operational groups looking at outpatient services they will be instrumental in implementing these required changes in the future. A series of workshop around implementation of prudent Health Principles are in progress outpatient redesign will form part of these discussions.
			Recommendation 3 We found that in some cases, patients could be facing substantially longer waits if they cancel their appointments because they can find themselves going to the back of the queue. The Welsh Government should review RTT rules and the way in which they are interpreted and applied locally to ensure patients are not being treated unfairly as a result of current approaches to resetting patients' waiting time clocks. **Lead: Andrew Carruthers**	**31 July 2015** Scoping of initial work completed	**30 November 2015**	The recommendation has been accepted in full. The first stage scoping exercise was completed by the end of July'15. With health boards self assessing their use of the rules and documentation they use to communicate with the patient. An event with the NHS and with patient representation took place on 27 August 2015 to test and review current guidance and rules in regards to the overall findings from the original WAO review. A Task and Finish group, with Welsh Government and NHS representation has been established to agree a set of all Wales principles around communication with patients around everyone's roles and responsibilities. Part of this review has identified the need for an all Wales information leaflet to be developed to explain waiting times rules in Wales, not just for RTT. This will clarify the patient's and hospital's responsibilities and the implications of cancellations on their particular pathway. It

						has also been noted that this needs to start at referral in primary care and there needs to be better understanding by referrers of the process and options to start the co-production dialogue with patients.
			Recommendation 5 A significant minority of patients in our survey were unaware of what would happen to them if they cancelled, did not attend or were unavailable for appointments. The Welsh Government and health boards should work together to better communicate with patients about their responsibilities, those of the different parts of the NHS and what they should expect when they are in the elective care system. **Lead: Andrew Carruthers**	**By 31 July 2015** Initial scoping completed	**30 November 2015**	The recommendation has been accepted in full. This recommendation will be covered in the actions highlighted above in R3. It is proposed that Recommendations 3 and 5 are merged with the joint action highlighted above which will address both recommendations.
			Recommendation 6 The Welsh Government publishes some data on waiting times, but it could provide more useful information to help support scrutiny and management of waiting times, as well as providing local information that would be more helpful for	**30 November 2015**	**31 March 2016**	The recommendation has been accepted in full. We acknowledge that publishing more information about waiting times will be of benefit to patients, and we note the above possible examples of how we could enhance our current planned care reporting to the general public. The Welsh Government's Knowledge and Analytical Services have examined what additional information can be

			patients on a waiting list. The Welsh Government should therefore publish more detailed national and local information: • Publish waiting times at different parts of the patient pathway (component waits) • Reporting separately waiting times for urgent and routine cases, for both the closed and open pathway measure • Publishing the date for the closed pathway measure which separates out admitted and non-admitted patients • Publishing median and 95th percentile waiting times. **Lead: Andrew Carruthers**			published, including 95th percentile and median waits. However, care needs to be taken on what additional information is made available, as with any potential additional reported measure, we would want to be assured that it appropriately provides additional context to the planned care services actually being delivered, and is not in any way misleading to patients. Another key consideration will be who publishes any additional information. Welsh Government made a commitment 18 months ago to publish less data centrally, with Health Boards publishing more locally. This will be an important factor in deciding what information is most helpful to inform the public of the time they will most likely have to wait. Knowledge and Analytical Services have started to change the way that monthly NHS performance data is published, following the consultation 'Proposals concerning the publication of official statistics'. Whilst the Outpatient Referrals and Delayed Transfers of Care release have moved to the new format, RTT and DATS have not. They will be the last set to be moved. It is planned that the first data release will be in January 2016 with the first analytical release containing median waits and component waits in early March 2016 (for the 3 months to Dec 2015).Whilst this is later than originally planned, it is important that the first release of median and component waits

						is accompanied by suitable commentary which would be a key part of the new analytical release. However, we do have some immediate issues with some of the detail. With regard to publishing data on waiting times for urgent and routine cases, this information is not collected. In addition, the benefit of publishing both sets of data would not be apparent, as if a patient is referred as a routine patient, but is subsequently changed to an urgent patient, their waiting time as an urgent patient would be incorrectly shown. Similarly, data on closed pathways split by admitted and non-admitted patients is not collected centrally. It is recognised that publishing outpatient and direct access diagnostic waiting times would prove useful for patients. Our initial reaction to reporting waiting times based on the administrative capture of urgency is one of concern. This is because it can, and will be misinterpreted, e.g. patients can wait a period of time as routine outpatient, re-visit their GP, get expedited and their urgency changed, this would be reported as a long waiting urgent. In a similar way, a patient may have a diagnostic whilst on a pathway and that can change their clinical priority, it does not mean they waited a long time as an urgent patient. Data is captured locally on closed pathways

						information, and in theory, it could be mandated and thereafter published for both admitted and non-admitted patients. It is important that we carefully scope and understand all the potential implications and consequences from developing new measures. We are clear that any new measure published either locally or nationally should support the provision of a more appropriate understanding of waiting times in Wales.
			Recommendation 7 Many people we spoke to on our local fieldwork identified current IT systems as a barrier to improving services and managing patients, although it is unclear to what extent any problems lie with the systems themselves or the way they are being used. The Welsh Government should carry out a fundamental review of the ICT for managing patients across the patient pathway and how it is being used locally and develop actions to address any problems or concerns that are identified. **Lead: Andrew Carruthers**	**31 July 2015** (Initial scoping work completed)	**30 November 2015**	The recommendation has been accepted in full. The completed scoping exercise through the health board self assessment exercise has identified areas for future focus. It is anticipated that further clarity will be gathered at the joint NHS / WG event at the end of August. NWIS are invited to attend to understand any issues raised. It is proposed that a developmental IT programme is agreed to support the more effective electronic management and reporting of RTT in light of any proposed amendments. A date for this is still to be agreed. There is a national programme in place that is delivering a national standardised platform for delivering informatics support in the NHS particularly supporting the patient journey across sectors and organisations. The IMTP process is key to driving

						collaboration between organisations and making sure the IT needs of the health boards and trusts form the core of the NWIS work programme and the revised strategy. A refresh of the eHealth and Care strategy is being developed. One of the first actions of the strategy work was to undertake an independent 'stocktake,' completed in 2014 and this is being used, along with extensive engagement, to inform the refreshed strategy. Any additional requirements to support the NHS in managing the patient pathway not already being addressed will be included in the new strategy and the implementation programme that follows it.
			Recommendation 9 Cancellations can result in inefficient use of NHS resources and cause frustration for patients. At present, the data on cancellations is incomplete and inconsistent, despite work by the Welsh Government to introduce an updated dataset. The only data that exists covers cancelled operations and health boards appear to be recording the reasons for cancellations differently. The Welsh Government and health boards should therefore work together to:	**31 July 2015** (Initial scoping completed)	**30 November 2015**	The recommendation has been accepted in full. The event at the end of August was used to explore how we will work with the health boards to agree and define a set of definitions to support cancellations along the RTT pathway in line with the agreed revised rules and reporting. Further work is planned on this area going forward. Health boards should be reporting postponed procedure data based on the DSCN that was issued in 2013. We plan to work with HBs and NWIS around the capability of the Myrddin system to report and record cancellations along a patient pathway, from outpatients through diagnostics to treatment.

			• Ensure that there are comprehensive, agreed and understood definitions of cancellations, and the reasons for them across the entire waiting time pathway to include outpatients, diagnostics, pre-surgical assessment and treatment • Ensure that reliable and comparable data on cancellations (and the reasons for them) is collected and used locally and nationally to scrutinise performance and target improvement activities.			Welsh Government will work with the NHS as part of the review of the guidance to clarify the rules associated with pathway management and its implications. A patient leaflet is being planned to inform patients of their responsibilities and consequences around cancellations The potential burden of capture and reporting for a national report is a key factor to consider the real benefit for having national data. We would however expect health boards to both collect and act upon the information locally as part of their service redesign and future demand and capacity planning.

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