Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 28 Ebrill 2015
Tuesday, 28 April 2015

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Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Jocelyn Davies	Plaid Cymru The Party of Wales
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur Labour
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mark Jeffs	Swyddfa Archwilio Cymru Wales Audit Office
Paul Meredith-Smith	Cyfarwyddwr, y Bwrdd Cynghorau Iechyd Cymuned yng Nghymru Director, Board of Community Health Councils in Wales
David Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Ruth Treharne	Cyfarwyddwr Cynllunio a Pherfformiad, Bwrdd Iechyd Prifysgol Cwm Taf Director of Planning and Performance, Cwm Taf University Health Board
Allison Williams	Prif Weithredwr, Bwrdd Iechyd Prifysgol Cwm Taf Chief Executive, Cwm Taf University Health Board
Mary Williams	Cadeirydd, Cyngor Iechyd Cymuned Cwm Taf Chair, Cwm Taf Community Health Council
Dr Paul Worthington	Prif Swyddog, Cyngor Iechyd Cymuned Cwm Taf Chief Officer, Cwm Taf Community Health Council

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Michael Kay	Clerc Clerk
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 09:04.
The meeting began at 09:04.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Welcome to today's meeting of the Public Accounts Committee. Just a few housekeeping notices: if I could remind everybody that the National Assembly for Wales is a bilingual institution and Members and witnesses should feel free to contribute to today's proceedings in either Welsh or English as they see fit, and, of course, there are headsets available for translation and they can be used also for sound amplification. If I could encourage everybody to switch off their mobile phones, or flick them on to 'silent' mode, so that they don't interfere with the broadcasting equipment, and just remind witnesses that the microphones are operated remotely; you don't have to press any buttons in order to ensure that you're heard and recorded. In the event of an alarm, we should follow directions from the ushers. We haven't received apologies for this morning's meeting, so we'll go straight into item 2 on our agenda.

09:05

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** We've got just two papers to note. We've got the minutes of our meeting held on 21 April. I'll take it that those are noted. And we have a letter from the Permanent Secretary in relation to our work on the scrutiny of accounts for 2013-14. I'll take it that that is noted.

Amseroedd Aros a Thargedau Perfformiad Allweddol y GIG
NHS Waiting Times and Key Performance Targets

[3] **Darren Millar:** Moving on, then, to item 3, NHS waiting times and key performance targets, I'm very pleased to be able to welcome to the table today Peter Meredith-Smith, director of the board of community health councils in Wales, Mary Williams, chair of Cwm Taf Community Health Council—welcome to you, Mary—and Dr Paul Worthington, chief officer, Cwm Taf Community Health Council. Welcome to you all. You will be aware that the Auditor General for Wales published a report in October of last year, looking at performance on waiting times for elective care in Wales. Actually, he published two reports, one on finances, which was in October last year, and the other, which was on elective waiting times, in January of this year. We've been looking at the report in some detail, taking evidence from Welsh Government and others, and we felt it was important to see where community health councils fitted in to these processes, particularly in terms of your overview in Wales and your oversight of individual health boards. So, with your permission, I'm going to come straight into questions from Members, and feel free to make any opening remarks in response to the first question. Over to you, Julie Morgan.

[4] **Julie Morgan:** Yes, thank you very much, Chair, and good morning. This is really a sort of general question, but how do you, as community health councils, and as the board of community health councils, see yourself and your role in holding the local health boards to account?

[5] **Mr Meredith-Smith:** Shall I take that introductory comment? Thank you for the opportunity to speak to you this morning. It's really pleasing that the committee is looking at the patient's perspective on this issue, because there's always a tendency to feature on the stats and so forth, so it's very pleasing. The overarching answer to your question is that we see ourselves as having a complementary role in terms of the performance management framework of the NHS. We are, quite clearly, not expert scrutinisers of the services, but we

do bring a very important perspective to the table, as it were, which is the perspective of the ordinary Welsh citizen, the person in the street. In terms of preparing for this committee this morning, we've given thought to how we can inform you in an evidence-based way and we're struck by the fact that there are two sources of evidence available to us, particularly from the board's point of view. One is the information that we glean from our concerns and complaints work, because we've got a database on that, so we've had a look at that. The other source of information for the board at the moment is the intelligence that we gleaned from the chief officers and the CHCs locally.

[6] Perhaps if I talk about the way they conduct their business, because that will give you a sense of how we undertake that scrutiny role, there are several ways that the CHCs would do that. Firstly, there is the important issue of the engagement with service users through patient engagement events and processes. Then, we glean information by way of our routine scrutiny work. We've obviously got the power to scrutinise health services, and, during the course of that, we get very interesting intelligence about the patient experience in relation to waiting times and so forth. Every CHC in Wales has some process in place that brings them together with LHB officers at a senior level. All of the CHCs would regularly, at chief officer and chair level, meet with the chairs and chief executives of the boards.

[7] There are various committees that we participate in that are relevant. They vary across Wales in terms of the fora and groups that we feed into, but probably the most important thing we do in terms of the hard data is that the CHCs attend all the LHB board meetings where there's a performance report, obviously, and we do have speaking rights at all those meetings. So, in terms of process, that's how we do that. But I would stress that the emphasis of our perspective is we're not expert scrutinisers like the audit office and so forth. It's very much the perspective of the lay person.

[8] **Julie Morgan:** You said at the beginning you saw yourself as complementary. Do you see yourself as challenging?

[9] **Mr Meredith-Smith:** Very much so. I think that in terms of—.You have to have a balanced approach to it. You have to have an understanding of these issues that are set out in the report that we're considering. Obviously, they are reports relating to last year. But, in terms of the intelligence that we are gleaning from the CHCs, very similar issues persist. We understand the challenges and we have some responsibility to work in partnership to move services on to get us to a better place, but that mustn't be a cosy relationship. It is a very challenging relationship and I think that the relationship between CHC chief officers and chairs and the chief execs and chairs locally is generally a healthy one.

[10] **Julie Morgan:** And what about Cwm Taf?

[11] **Ms M. Williams:** I approach this from a slightly different perspective, and from a lay member perspective, in that many of our members actually sit on the various committees or groups that UHW has in relation to various services. For example, one of our members sits on an ophthalmology group and another sits on the audiology committee. Those members are able to feed into those committees concerns that arise from their local communities. For example, there have been concerns about the waiting times for ophthalmology, and as result of those concerns we've been working very carefully with the university health board in terms of addressing waiting times. One of the ways that's being addressed is that the UHB has contracts with local opticians now, so that various diagnostic services that were previously carried out at the hospital are now carried out by local opticians, which means that it's much easier for older local needy people to access those services and it reduces the pressure on hospital times and waiting times there.

[12] **Julie Morgan:** You're saying that is as a result of your intervention.

[13] **Ms M. Williams:** As a result of our intervention. We've worked very closely with regard to that, yes. And it isn't just that service—we're involved in other services as well, for example audiology. Many of the technical services there now are being provided locally. As local members, we clearly advocate the needs of older people, at the top end of the Rhondda, for example, who have difficulties with transport. This provision of services at a local level means that it's much easier for them to access that.

[14] **Julie Morgan:** So, basically, you're saying that you influence policy through being members of these groups, working away in that sort of way, as well as dealing with complaints and the problems that exist.

[15] **Ms M. Williams:** That's right. I mean, as local people, we know the concerns about what's going on in our communities and we're able to bring that perspective to bear, then, in terms of the decision making by UHW.

[16] **Julie Morgan:** Thank you. Do you have anything to add?

[17] **Dr Worthington:** Just to follow on from what my chair says—that's incredibly useful. Peter talked earlier on about the fact that we attend the health boards regularly. We see the performance report that the health board receives as well and we ask questions of that. We've looked at areas of concern and there have been areas of concern around stroke, for example, around ophthalmology, and around some of the cancer elements. So, the performance report and attendance at the health board gives us that formal forum to ask those questions. We do meet regularly with both the chair and chief executive of Cwm Taf health board as well, where we talk about issues of concern. Equally, if I or my chair have intelligence about areas of concern, we pick up the phone. So, it is a constructive working relationship, but we're not afraid to challenge, in both the formal setting and the informal setting.

[18] The participation in service planning groups is incredibly important, because we get to, if you like, develop and inform and influence service change and service provision at a very early stage. We've done similar work on stroke. But, above all else, we have the ability to challenge them and we're not afraid to do that as well, and ask questions.

[19] Mary's absolutely right. Our perspective is a lay perspective, but as a CHC we have the right, and I think the duty, to ask hard questions and to challenge, and we don't shy away from doing that. It's a good relationship, a constructive relationship, but we have a structured process in place to ask questions when we have concerns.

[20] **Julie Morgan:** Thank you.

[21] **Darren Millar:** Sorry to have to say this, but we're up against the clock in these meetings, so if people can be brief with their questions and answers, I'd appreciate it. I've got two supplementaries on this and then I'm going to come to Sandy, but you've got a supplementary on this first, haven't you, Sandy?

[22] **Sandy Mewies:** Yes.

[23] **Darren Millar:** Very briefly, then.

[24] **Sandy Mewies:** Good morning to you. I was a member of a community health council myself and I'm astounded, actually, by the amount of work that you continue to do. It is important. The patient perspective is very important, because actually that's where most of us come from, isn't it? You know if you're going to get a bad service or a good service,

really, don't you? That's the thing.

09:15

[25] I was particularly exercised by the comment you made about ophthalmologists on the high street. That isn't just for your area—that's something the Welsh Government are trying to get people to do: to go along to opticians rather than to clog up the works with conjunctivitis, or something like that, which could be dealt with by an ophthalmologist. However, there has been a report recently, which pointed out that people still weren't going to the ophthalmologist and, while they were waiting for tests, their sight was deteriorating. Now, I'm just not sure in my own mind whether the problem is that the general public are still not aware—and there is a campaign going on now—that if they've got something that is not, I can't say 'not serious', because sometimes it can be, but for which they can go to the optician, to their ophthalmologist, and make an appointment there. In fact, I'm going to an optician soon to see—. I went to my doctor and he said, 'Oh, just go along to see the ophthalmologist; I think it's this, that and the other'. How aware do you think are the public that they don't have to go to the GP, they don't have to go to the eye hospital, they don't have to go to A&E. If they've got something concerning them, they can make an appointment with a high street ophthalmologist.

[26] **Ms M. Williams:** I think what I'm referring to are more specific services, where a person, for example, needs to be tested for eye pressure, which they would be having, under normal circumstances, in the hospital in preparation, perhaps, for an operation, or whatever. Also, I'm referring to post-operative services, where someone, for example, has had a cataract operation and would normally go to the hospital. What's happened is that there's a selective group of opticians who are carrying out extremely technological interventions, and in each of those cases where those patients are actually known to the hospital and on a waiting list, they are getting letters informing them now to go to a particular optician. The appointment comes through very quickly, there's no waiting, you're seen at the time you arrive, there's time to talk people through the processes. The feedback from people I talk to is that they are very happy with this situation.

[27] **Darren Millar:** What are the current ophthalmology waiting times in Cwm Taf, versus when you, as a community health council, brought your pressure to bear?

[28] **Dr Worthington:** So, what were the—

[29] **Darren Millar:** What are the current ophthalmology waiting times now versus when you brought your pressure to bear as a CHC?

[30] **Dr Worthington:** There still are difficulties. In the last report we had, there were still around 300 waiting over 52 weeks. They are still hard numbers and they still have staffing problems. It's an issue that we're scrutinising on a monthly basis, but the numbers are less than when the issue first came to our attention, and we see regular reports. At full council last week, we received an update on it. So, there's still a long waiting time, there are still problems, but they're less than when we first got on to this one with the health board.

[31] **Darren Millar:** Okay. One of the things we've had drawn to our attention is that, since the report was published, there's been further deterioration in waiting times across the board in Wales and in Cwm Taf. You wanted to come in, Peter, then I'll bring Jenny in.

[32] **Mr Meredith-Smith:** I think there's a range of issues. I'm very familiar with the RNIB work, and I think that you just can't be too flippant about the 40-odd people who are losing their sight every year because of these difficulties. I think we would take that incredibly seriously. There are a couple of points that I would make. I think the point that you

make is a very important one. From my perspective, in terms of the education of the public, I think that we've got quite an important role in that that's very undeveloped with us. The scrutiny stuff is pretty well developed. There's question marks as to how effective that has been in implementing change, but what's clear in terms of the reports that you're considering is that part of the waiting list pressure can be alleviated if the patients and the users of the service understand what the issues are, and so forth, and if you communicate with them, it actually improves on DNA, and so forth. So, I think you're right, I think that is a role that we need to develop. I think we're way off getting where we want to be with that.

[33] The other point that I would make in terms of that specific issue, and linking that to the first question as well, is just to give you a sense of how we, maybe, have a national join-up and impact. On that particular issue, I have met with the chief exec of RNIB so that we have a co-ordinated message going into Welsh Government. The other mechanism that I've developed since I've been in this post is that I now have regular formal meetings with the chief exec of NHS Wales and the chief nursing officer, actually, because she's got the policy lead for CHCs. I met with her yesterday for my six-weekly meeting, and we have an issue on the agenda there, which is about concerns and hot issues. We didn't talk about this issue yesterday, but that opportunity arises as well so that these data that are coming in from the—. There's no firewall between the centre, I guess, and the LHBs, because I have the opportunity to raises these issues.

[34] **Darren Millar:** Okay. Jenny Rathbone.

[35] **Jenny Rathbone:** One of the points that the auditor general's survey picked up was that a third of patients did not have it explained to them what would happen if they cancelled or failed to attend appointments. I wonder if you can explain to us what—

[36] **Darren Millar:** Jenny, this isn't a supplementary on the original stuff from Julie.

[37] **Jenny Rathbone:** Well, I thought that was—

[38] **Darren Millar:** We will move on to that subject, but if it's a supplementary on Julie's question, that's fine. If not, we're going to have to—

[39] **Jenny Rathbone:** I thought it was a key issue.

[40] **Darren Millar:** Okay. It is a key issue and we will touch on it. I'm afraid the clock is going to beat us if we're not careful, and I'm keen to get through the questions that we need to get through. So, I'm going to call Sandy next, and then Jocelyn Davies. I'll come to you afterwards.

[41] **Sandy Mewies:** Thank you, Chair. Well, as we've indicated, waiting times, obviously, are a big issue, because they're not good and the position seems to be deteriorating in some areas. That's not true of everywhere, but it is in some. One of the problems that we've talked about is the referral to treatment rules. Now, they impact in various ways, but one of the ways that they do have an impact, as far as I can see, is that again, it's a question of whether the public know that, if they don't respond to a letter, a phone call or whatever, they could be taken off a waiting list? Is there enough awareness of that? I certainly have had cases very recently where someone is in the queue, and has been in the queue for a very serious operation, has had various tests leading up to that, various scans, and all sorts of other things going on, and is aware that this person needs a major operation, but then got a letter to say, 'Do you want to stay on the waiting list?' Now, you've got the dilemma then of thinking, 'Well, what do they mean? Do I want to stay on the waiting list? They know I'm on the waiting list because I've got an appointment with Dr so-and-so coming up.' That's just one example, but some of these processes seem to be just that: they seem just to be a process,

which is very helpful to the board and the hospitals concerned, but maybe isn't terribly clear. What sort of impact have you seen? One of the things that I know that community health councils do very well indeed is interface with the public if they've got a problem. Sometimes, they come to people like us. Very often, they come to community health councils to say, 'We've got an issue here because this has happened'. What sort of evidence have you got of deterioration? Is it on the increase, that people are coming to you and saying, 'Because of this, my health has deteriorated'? Something needs to be done about this process.

[42] **Darren Millar:** Okay. You've got two questions there. One very clearly on whether patients understand the nature of when they're taken off a list or the clock is reset as a result of a cancellation; and the second one is about deterioration. I'll come to you, Mary.

[43] **Ms M. Williams:** Right. First of all, with regard to processes, they are often written in jargon, and letters are very often difficult to understand. As a CHC, we very much engage with the university health board in terms of translating documentation into straightforward, simple language. So, if, for example, we had a concern like you've raised with us this morning, we would look at that, work with members of staff at UHW to translate that into easily understandable language in terms of what it means for that individual.

[44] **Darren Millar:** Can I just check? So, the health board actually state in their letters, in Cwm Taf, that if they cancel an appointment or fail to turn up, their clock will be reset for waiting times?

[45] **Ms M. Williams:** No, usually, the situation is, 'Ring us if you have a problem'—

[46] **Darren Millar:** Yes, but it doesn't explain—

[47] **Ms M. Williams:** Then there'll be a conversation around that. So, that should obviously overcome that difficulty. But, if there are difficulties that we become aware of, we work to try to overcome those, as I say, by translating the situation into what it means for that individual.

[48] **Darren Millar:** For most people it will just have a time and a venue, and the name of the person that they're having the appointment with, won't it—the letter? I mean, it's pretty easy to understand. The point here is the rules around the clock resetting. Paul.

[49] **Mr Meredith-Smith:** There is an interesting underlying issue. Speaking from the point of view of the CHC and somebody who's been a manager and a clinician in the health service, there's a real debate to be had, and debate is being had, about the target-driven culture as opposed to the outcome-driven culture. You have a situation then where people who are in most need maybe don't get the service. The simple answer to your question is that they probably don't understand that. It doesn't feature highly in terms of the data that we get in terms of our complaints, which are reasonably consistent over time. We get somewhere in the order of about 260 to 300 approaches about issues to do with waiting times, and about 40% of those relate to out-patient issues. Most of those tend to relate to frustrations around communication, actually, if you drill down. So, that is really an issue. To put some balance in that, I think that what we need to remember is that this issue of waiting lists and waiting times doesn't actually feature very highly in terms of the stuff that we deal with in terms of formal concerns and complaints. It's quite low down the list.

[50] **Sandy Mewies:** Fine, thank you. That's interesting.

[51] **Darren Millar:** Sorry, patients coming to harm was the other question that Sandy raised. What's your experience within the basket of casework that you take up?

[52] **Mr Meredith-Smith:** Specifically on the stuff that we have hard evidence of, they are very small numbers, but every case where harm is concerned is one that we'd be concerned about, isn't it?

[53] **Darren Millar:** Would you be able to drop us a note on the proportion across Wales?

[54] **Mr Meredith-Smith:** Yes, we can probably have a look at that for you. Yes, certainly.

[55] **Sandy Mewies:** Thank you.

[56] **Darren Millar:** Jenny.

[57] **Jenny Rathbone:** In the context of prudent healthcare, one feature of which is co-production with the patient and the experts, what is your understanding of what actually happens when somebody has to cancel, you know, for a perfectly good reason, like they can't get somebody to care for their loved one? What do you think ought to happen?

[58] **Ms M. Williams:** From personal experience, I know that, if I have to cancel an appointment, I ring up because there's a line to contact a member of the team, and then we talk about another appointment that might be more convenient for me. There's a lot of effort going in to actually ensuring that we reduce DNAs by managing the system in that way.

[59] **Jenny Rathbone:** Okay, but I think one of the concerns that was picked up in the auditor general's report was that people who cancelled for perfectly valid reasons then had the clock reset and suddenly went back to the beginning, like in snakes and ladders. So, that is a concern, because it's illogical. I can't understand it. Is that still happening? Obviously, your situation was best practice, but is that still happening that people then just get penalised and put back to the back of the queue?

[60] **Mr Meredith-Smith:** Again, in terms of the small number of complaints that we deal with, that does feature in some complaints. You'd have to look—

[61] **Ms M. Williams:** We're not getting many, if any, complaints about that.

[62] **Dr Worthington:** We're not getting any specific complaints, but one of the things we do get quite a lot of feedback on is that, often, people are getting correspondence about appointments very, very close to the date and can't reorganise. That's something we pick up, not through specific complaints, but often through inquiries. That's something we are concerned about. I think that communication is important. If people have a legitimate reason for cancelling, there isn't a reason why they should be disadvantaged, and sometimes communication about that is a little fraught.

[63] **Jenny Rathbone:** Yet it appears to be happening, according to the auditor general's survey. So, what can CHCs do to rectify the practice in the health board?

[64] **Dr Worthington:** Any case that we come up against in relation to that we will talk to the health board about. We talk to the chief executive or patient support officer. So, if patients come to us with specific inquiries, we will raise those directly with the health board, but it is an interesting theme and I think we need to look at that a little more.

[65] **Mr Meredith-Smith:** There is a broader thing that we should be doing as well, because the real fix to this problem, which is also articulated in these reports, is that, actually, we spend a lot of money, a lot of time and a lot of effort focusing on the symptoms of underlying problems. We've got a role to play in terms of the modernisation of the service

and ensuring that that happens properly as well. Getting back to your original point, I mean, it can't be right that, if we've got a needs-based out-patient system, where you need to be seen because you're going to lose your sight or because of an issue, and you get to the point where you need that appointment, there's got to be a better way of doing it than just bumping somebody back to the back of the queue, hasn't there?

[66] **Darren Millar:** But you're supposed to be the patient watchdog, aren't you? So, you shouldn't just be waiting for complaints. If you know that the rules say that, if a patient cancels, the clock is reset—and that's what the rules say in Wales—surely you should be lobbying people to change the rules, shouldn't you? You should be asking the questions on a regular basis as to how many patients have had the clock reset this month as a result of them cancelling, sometimes for perfectly reasonable reasons, but that's not a question that features on a consistent basis from your boards.

09:30

[67] **Mr Meredith-Smith:** I have to be honest and say 'no'. I've given evidence to other committees, and where we are in terms of the stage of development at the centre, a level of systematic scrutiny of those headline issues is not where it should be, but it's not bad, given the resources we've got to do it, I guess, is the counter to that.

[68] **Darren Millar:** Okay. Aled, a quick supplementary, and then I'm going to come to Jocelyn.

[69] **Aled Roberts:** Rwyf am ofyn yn Gymraeg.

Aled Roberts: I'm going to ask in Welsh.

[70] Os ydych chi'n dweud eich bod chi ddim yn derbyn cwynion, a ydych chi'n mesur faint o gŵynion mae'r byrddau iechyd yn eu derbyn ynglŷn â'r ffordd y mae'n nhw'n ad-drefnu triniaethau?

If you are saying that you don't accept complaints, do you measure how many complaints the health boards receive about the way in which they are reorganising treatments?

[71] **Mr Meredith-Smith:** Sorry, we didn't hear that.

[72] **Darren Millar:** Is the translation not working?

[73] **Ms M. Williams:** No.

[74] **Jocelyn Davies:** Have you got it on channel 1?

[75] **Dr Worthington:** It is now.

[76] **Darren Millar:** Okay.

[77] **Aled Roberts:** Iawn, roeddwn i jest yn gofyn—

Aled Roberts: Okay, I was just asking—

[78] **Darren Millar:** Is that okay? Can you hear it? No? Is the volume on?

[79] **Ms M. Williams:** Okay.

[80] **Darren Millar:** Okay.

[81] **Aled Roberts:** Iawn. Os ydych chi'n

Aled Roberts: Okay. If you say that you

dweud nad ydych chi'n derbyn cwynion, fel cyngor iechyd cymunedol, a ydych chi'n mesur nifer y cwynion, neu, mae yna rai byrddau iechyd sydd ddim yn sôn am 'gŵynion', maent yn sôn am 'achosion o bryder', felly a ydych chi'n mesur y nifer o'r rheini sy'n cael eu derbyn, achos, yn amlwg, rydych chi'n dweud nad yw hyn yn llawer o broblem, ond nid dyna'r dystiolaeth rydym ni'n ei derbyn fel Aelodau Cynulliad?

don't receive complaints, as a community health council, do you measure the number of complaints, or, there are some health boards that don't talk about 'complaints', they talk about 'cases of concern', so do you measure the number of those that are received, because, evidently, you say that this is not much of a problem, but that's not the evidence that we've had as Assembly Members?

[82] Ac rydw i eisiau gofyn i chi hefyd a ydy'r ystadegau yma yn rhai cadarn, achos rwy'n dod ar draws achosion yn y gogledd, lle nid mater o'r claf ddim yn gwybod beth i'w wneud ydyw, ond mater o'r bwrdd iechyd yn ceisio mynd o amgylch yr ystadegau yma. Er enghraifft, y ffaith eu bod nhw'n gyrru llythyr allan yn rhoi apwyntiad efo 'apwyntiad wedi ei ganslo' wedi ei argraffu ar draws y llythyr. A hefyd, beth am y drefn lle mae yna apwyntiad yn cael ei gynnig, ond mae'r llythyr yn cyrraedd ddiwrnod ar ôl yr apwyntiad? Felly, jest i ofyn y cwestiwn y gwnaeth y Cadeirydd ei ofyn, pa mor aml ydych chi'n gofyn i'r byrddau iechyd yma ynglŷn â'r ffordd y maen nhw'n mynd ati i fynd o gwmpas y sefyllfa?

And I also want to ask you whether these statistics are robust, because I come across cases in north Wales, where it's not an issue of patients not knowing what to do, but rather, of the health board trying to get around these statistics. For example, the fact that they send a letter out giving an appointment, with 'appointment cancelled' printed across the page. And also, what about the system where appointments are offered, but the letter arrives a day after the appointment was supposed to be held? So, just to ask the question that the Chair asked, how often do you ask these health boards about the way in which they go about getting around the situation?

[83] **Mr Meredith-Smith:** Diolch. With regard to the first part of the question, in terms of the information that we gather, we gather information on all contacts, all concerns, and all complaints. So, when I'm referring to the information that I'm talking about, it's in the round. So, we do capture all that information in terms of any formal approaches.

[84] **Aled Roberts:** What, just approaches to you, or approaches to the health boards as well?

[85] **Mr Meredith-Smith:** No, I'm talking about our data now. So, in terms of your questions, generally—and I would look to my colleagues then, who are dealing with this on a day-to-day basis—as I've indicated, the level of sophistication at which we challenge that data, nationally, is not terribly sophisticated at the moment. To kick off, where I started off is that we are a lay organisation, and we don't have the capacity or expertise to do that to the extent that we would wish to, I guess. So, it is very dependent on the individual CHCs, and how they are challenging locally. So perhaps I'd—

[86] **Dr Worthington:** Yes, diolch. Peter's absolutely right—we have a limited resource. We don't just look at complaints; we have a lot of inquiries coming through, and we use that as the basis. We also have a quarterly complaints review meeting with the health board, where we look at the data that they use, and we scrutinise them hard as well. We also talk regularly to the members of the board about the data that are coming through, as well. But I would like more robust systems, locally, to look at those data in a lot more detail. You talk specifically about the letters that come out the day after, for example, in clinics. That's a very real problem, and that is something we do get some feedback on. I've had people I've talked to at public engagement events who've raised exactly those sorts of issues, and that's an area we want to try and focus a lot more on. What we've also found, for example, is that clinics are

often cancelled at fairly short notice, and are then having to be reorganised.

[87] **Aled Roberts:** So, what do the health boards say about that, then?

[88] **Dr Worthington:** Sometimes, it's around sickness, where you've got a limited amount of clinical staff, but there is, for example, an area around respiratory medicine where we've seen evidence that clinics have been cancelled at relatively short notice, with leave as the cause, and we've already started asking questions about that, as well. So, if we have evidence that comes to us, we will ask questions, and often it is about not just the big things, but about cancellation of specific clinics in a specific specialty. So, we do get those data. We'd love more data and that's something we want to work on, but we do ask the questions once we get those data.

[89] **Ms M. Williams:** Could I comment on concerns versus complaints? Some us went out on unannounced visits and had concerns about out-of-hours GP provision. There have been concerns about some of the GP provision, and those are concerns rather than complaints, which tend to come from individuals. If there are those concerns, we will raise them with the chair and the chief executive. There'll be formal notes of meetings to actually discuss those issues, and there'll be an ongoing paper chain of what's been going on, so we will actually have a record of our concerns and what's been done to address them, and we would then look at the outcome, having addressed those issues.

[90] **Aled Roberts:** I was thinking more of the situation where health boards are actually classifying issues raised as concerns where they're individual, I would suspect, in order to get the number of complaints down.

[91] **Ms M. Williams:** I wouldn't know about that. I can only talk about this from a CHC point of view.

[92] **Dr Worthington:** Can I just follow up on that briefly, Chair? Very briefly. I mean, one of the things that health boards are increasingly trying to do, if they've got a potential complaint, is to try and resolve it with a discussion with clinical staff, to try and get, if you like, a quick fix, so that actually they resolve the problems at an early stage rather than go through the complaints process. That's something we welcome, and something that we as a CHC often try to facilitate as well. But you're absolutely right: (a) any concerns should be taken seriously, but (b) we should be looking for robust and swift resolution to those problems as well.

[93] **Darren Millar:** Okay. Jocelyn Davies.

[94] **Jocelyn Davies:** Yes, I wanted to come back on this issue of if you cancel your appointment for a very good reason that's unavoidable—you can't get there if you're on holidays, I don't know, all sorts of reasons—then the patients don't know what the consequences are. Why haven't you insisted that the letter that goes to people offering them the appointment says, 'Get in touch with us if this isn't convenient, but if you cancel this appointment, you will go to the back of the waiting list'? Why haven't you insisted that that's in the letter, nice and clear, so patients know what the consequences are of cancelling because it's not convenient?

[95] **Ms M. Williams:** I haven't seen recent correspondence with regard to appointments. The last letter I saw clearly indicated that, if you can't keep this appointment, give us a ring and we will attempt to rearrange this. If this is an issue and it hasn't been brought to our attention, then clearly we need to look at it, but, hitherto, it hasn't been an issue for us.

[96] **Jocelyn Davies:** Okay, but we've got the auditor general's report that says that

people aren't aware that, if they cancel an appointment, there is a consequence for—. Members have asked you this question several times today. Can you make the assumption that I'm raising this concern with you—that people, patients in the Cwm Taf area, or wherever, don't know what the consequences are if they cancel the appointment? I know they're told they can cancel it, but do they know that, if they cancel it, they will slip down the waiting list, and not just be given another appointment? The clock is reset, which I'm taking to mean you fall down the waiting list. Why don't we just say that in a clear way ourselves?

[97] **Darren Millar:** We've got some specific examples, where one patient waited 68 weeks, but the official wait, according to the health board, was two weeks. Another waited 81 weeks, with an official wait of just five. Another, 86 weeks with an official wait of just seven weeks, because of this clock resetting.

[98] **Jocelyn Davies:** Okay, so perhaps you'll take that on board, and, in your communications with the health organisations in your area, what we would like to see is that it's clearly set out in the letter to patients when they're offered the appointment what will happen if they cancel it, because people might decide then that they will make other arrangements rather than lose their place on the waiting list—or you might get some more complaints.

[99] Have you got any evidence about the frequency and impact of short-notice cancellations by the hospitals? So, somebody's waiting for their operation, they've been waiting months, they think it's going to be next Monday, and they've been told now, 'Sorry, no bed available'. Have you any idea of the frequency or the impact of that? Paul.

[100] **Dr Worthington:** In terms of the stuff that I've looked at in preparation for this meeting, probably, numbers you can count on one hand in terms of the formal information. That's the simple answer. And, we've got a couple of vignettes on that. Not massive numbers.

[101] **Jocelyn Davies:** Not massive numbers.

[102] **Mr Meredith-Smith:** Not in terms of the stuff that shows on the database in terms of the approaches that were made on that specific issue.

[103] **Jocelyn Davies:** Okay. So, as to the database that you're talking about, is that complaints that come to you directly from an individual or the information that you're getting off the—

[104] **Mr Meredith-Smith:** That's the stuff that's in terms of formal approaches to the CHCs about issues, which would also include issues that are raised as formal concerns and those that become formal complaints.

[105] **Jocelyn Davies:** So, that's not the information that comes from the local health board to you about when this happens, this is—

[106] **Mr Meredith-Smith:** No. At the centre, we don't scrutinise that level of information; that happens via the CHCs, which then filter that information through. I guess that's a point—I'm not being defensive, but—

[107] **Jocelyn Davies:** No, no, no.

[108] **Mr Meredith-Smith:** I think that the point that I would keep reiterating is that we've got a headcount of 100 staff and 250 members that are volunteers, and we've got to make some judgments in terms of where you focus your attention. There's a lot going on in the NHS at the moment, isn't there, in terms of the service restructuring?

[109] **Jocelyn Davies:** Yes, and if people—

[110] **Mr Meredith-Smith:** So, judgments are made. I'm not saying this isn't important. We will certainly take away the points that you made, but I think that—

[111] **Jocelyn Davies:** No, no, no. Okay. So, people are not feeling that they can complain when—

[112] **Mr Meredith-Smith:** I spoke recently to the Health and Social Care Committee about another issue and my observation, in terms of scrutinising the information we've got for—. I was looking at it for another reason, but I think I described the Welsh people as very undemanding consumers of their health services. So, in fairness, in terms of the points that have been made around the table, I'm not saying that these issues are not problems, but all I can say to you, fairly is that if I don't refer to the data and the evidence that we have to support this point of view, all I'm giving you is an opinion, and I think that that's wrong. So, I'm not saying it's not a problem. Quite clearly, to complement the harder data that we've got, we've got the intelligence from the CHCs and, in summary—. I think that this is a report about a year ago, isn't it?

[113] **Jocelyn Davies:** Yes.

[114] **Mr Meredith-Smith:** What I would say is that the impression—no, it's not the impression—the evidence that we get from the seven CHCs across Wales is that that hasn't moved on much and, if anything, as you said yourself, there's been some deterioration.

[115] **Jocelyn Davies:** Okay.

[116] **Ms M. Williams:** Can I give you a live example? I was involved in an unannounced evening visit to our local district general hospital and, when I arrived, I discovered that many of the day operations that day had to be cancelled because of pressure over the weekend and the demand for beds. What I wasn't able to do was to then find out who those patients were who'd had their operations cancelled and their reactions to that. That would've gone beyond our remit, but we were clearly aware of the impact of the winter pressure on the operations on that particular day, but I'm aware that they were then rearranged for the ensuing few days after that.

[117] **Dr Worthington:** I was going to say that we know that there are certain times of year when cancellations of elective operations happen—winter emergency pressures—but, as a CHC, we don't have that information on a routine basis, week by week and day by day, but we know where the pressure points are.

[118] **Jocelyn Davies:** So, when you told us earlier about seeing the performance reports of the LHB board meetings, those aren't data that would come to the LHB board meetings in relation to performance—cancellations by the hospital at short notice of operations.

[119] **Dr Worthington:** Do you know, I can't remember if it's specifically in a performance report, but those sorts of data are important on a day-by-day basis, because we look at those performance reports on a monthly basis. That sort of day-by-day information the health board will have to manage its own performance, but we will get some information on cancelled operations at short notice. We will get that regularly from the health board. Some of that's in the performance report.

[120] **Jocelyn Davies:** I don't understand. I'm a bit confused now as to whether you have the information or you don't have the information. You get it through your performance

reporting, and you get it from time to time.

[121] **Dr Worthington:** Yes. We get it through the performance report, but also, what we don't do is get that on a day-by-day basis. We don't understand what's happening every single day; we'll get it on a more regular, monthly basis.

[122] **Jocelyn Davies:** So, can you give me a feel for the frequency, then, of cancellations at short notice by the hospitals through the performance report?

[123] **Dr Worthington:** We can. A lot of it is very seasonal, with emergency pressures. Those are where the pinch points are, particularly around the winter period, and we keep that under very close scrutiny. In the rest of the year, it's less frequent.

[124] **Jocelyn Davies:** Okay, thanks.

[125] **Darren Millar:** Mike, you wanted to come in next and then we'll go to Aled.

09:45

[126] **Mike Hedges:** I have three quick points, really. On something you said earlier, how do you distinguish between queries and complaints? Because, if somebody said, 'Why was my operation cancelled?', and if they'd said that to me, I'd treat that as a complaint. Would you treat it as a complaint, or would you treat it as a query? I tend to treat everything that comes to me as a complaint, unless it is seeking factual information, like, 'What day is the refuse going to be collected next week?'

[127] The second point is: I was surprised you said that day surgery was cancelled because of a lack of beds. My understanding is that day surgery, by its very nature, doesn't need or use beds.

[128] The third point is: do you know what is being cancelled because of inter-hospital transfers, so that the beds are being taken by people from another hospital and thus the surgery that was going to take place cannot because the bed has now gone to somebody coming from another hospital?

[129] **Mr Meredith-Smith:** Shall I take the first bit? I am talking about our dataset now. If you have an approach to the CHC, that's an approach, in that we've got an issue and, sometimes, somebody might ask about, 'Somebody said that I need to wait this long for this appointment', and if you say to them, 'Well, that's in line with the target', and if they can do that without exceeding the target, we'd log that, but it would go away. Then you'd have somebody who might have a more formal concern that could be resolved locally, and then you'd get a percentage of things that go through for us to support as a formal complaint through the complaints procedure in the NHS. So, those are the issues, and, in terms of our database, we collect all that information—but I'm talking about us, and not the way that the LHBs collect the information.

[130] **Ms M. Williams:** You asked a question about availability of beds.

[131] **Mike Hedges:** Yes.

[132] **Ms M. Williams:** Clearly, that's an issue across the whole of Wales in terms of winter pressures. Where we differ from other areas, I suppose, is that we don't have ambulances around the block and patients were being cared for on the Sunday in one of the side wards until the day ward was opened the next day, and they use those beds.

[133] **Mike Hedges:** It was day surgery I asked about, and what I asked was: why, with day surgery, do you need beds? Is the bed available? My understanding is that day surgery, by its definition, is done in the day. You come in, and I know people who have gone in to have their fingers dealt with, minor operations like that, and they've gone in and had the operation and they're home in a few hours.

[134] **Mr Meredith-Smith:** But, when they refer to a 'bed' in that situation, that's the ability to have the clinical space and the staff to undertake the procedure. You know, you can refer to the same thing. It's not about an in-patient bed that's blocked. There's an interesting point there that's featured in a few of these questions that we're not touching upon, I guess, which is that the conversation is about the management of the symptoms of these underlying problems, and what's said in the report is that the solutions have been traditionally to throw money at it, which actually has an impact in the system.

[135] You know, the other thing that I guess we would be scrutinising and we're keeping an eye on is that there have got to be some whole-systems fixes to this, and things like the south Wales programme are very relevant, where you've got the talk of the development of diagnostic hubs and so forth. That's the sort of thing that we would keep an eye on more strategically, because we've got concerns about the pace of change for those things, you know.

[136] **Darren Millar:** But, just getting back to this issue of beds, I mean, there are recommended occupancy rates, aren't there, by the royal colleges, et cetera, regarding beds? Clearly, the health boards aren't keeping in line with those recommended occupancy rates; they've got occupancy rates that are higher than that. So, if there is a peak in demand, it means that they have to then use the elective beds to soak up the additional patient pressure and, as a result of that, people are having operations cancelled. Presumably, there are theatre staff, surgeons, standing around, ready to go with operations, who are then redundant the day or for two days or three days, or however long the pressure is brought to bear. That's not a good use of resources, is it?

[137] **Mr Meredith-Smith:** The two issues that feature in terms of the intelligence that we get from the CHCs regularly in terms of this agenda are the bed issue and the system running hot, as you describe it, and the other issue is staffing issues.

[138] **Darren Millar:** And it's not just winter, though, is it?

[139] **Mr Meredith-Smith:** No.

[140] **Darren Millar:** So, what are you doing to hold the feet to the fire for the health boards, to make sure that they don't reduce bed numbers further, or that they have adequate beds at all times of the year to be able to cope with these things?

[141] **Mr Meredith-Smith:** And that is about our involvement in terms of the broader reconfiguration stuff, isn't it?

[142] **Darren Millar:** But you're suggesting that the reconfiguration is going to take away these peaks and troughs.

[143] **Mr Meredith-Smith:** No, what I'm saying is that's part of the solution; that doesn't mean we take our eye off the ball in terms of the issues that we're talking about. And it's these processes that, you know, we hold—. There are two things that we can do in law, aren't there? That's the issue that we're debating, and that's the theme, isn't it, in terms of what teeth we have on that? We can make referrals in terms of some of the service changes, and we have the right of access. We get frustrated occasionally that, sometimes, we don't have the

impact that we want, but that's the realism of the situation.

[144] **Darren Millar:** Mike had some other questions there about people being transferred.

[145] **Ms M. Williams:** Could I just come back on that very quickly? I think it is about managing demand. A huge amount of work has been done by some of the senior nursing staff in terms of managing that. They, on a daily basis, look at what the demands are for, where they're coming from, and they then look at ways perhaps of intervening and perhaps stalling some of that demand and managing that in a more effective way.

[146] **Darren Millar:** Right. Just turning back to Mike's other point about patients being sent to other hospitals as a matter of their choice, was it, Mike, for more complex cases?

[147] **Mike Hedges:** More complex cases being moved. I know Morriston better than I know any other hospital, and Morriston is a great importer of patients from west Wales for example. I assume the Heath is a big importer of patients from other hospitals. When that happens, it reduces the capacity of the hospital itself to do the work that is already programmed. I just wondered whether you had any examples of that.

[148] **Mr Meredith-Smith:** Paul, do you want to talk about the south wales plans?

[149] **Dr Worthington:** Yes, you're absolutely right; the University Hospital of Wales will take patients from elsewhere—tertiary. I think the issue is that the University Hospital of Wales, as well as being a specialist regional centre, is also the local Cardiff centre as well. That's the balance it always has to strike. That was one of the issues around the south Wales programme. And I think one of the concerns we do have is to ensure that UHW has the capacity to serve those two purposes in the future, for the Cardiff delivery and it will also have to absorb additional activity from elsewhere; that's the very nub of what it does at the moment and the nub of the south Wales programme. We need to make sure that, in the future, UHW has the capacity to absorb that additional workload.

[150] **Ms M. Williams:** Currently, however, the Royal Glamorgan Hospital will take patients from UHW when they've got pressures and demand pressures. And we usually have the flexibility to deal with that.

[151] **Darren Millar:** William Graham.

[152] **William Graham:** Your remit, in essence, is to deal with patients' complaints, isn't it?

[153] **Mr Meredith-Smith:** That's part of our remit; it's not the entire remit.

[154] **William Graham:** Part of your remit. So, to go back to the original point, which is—

[155] **Dr Worthington:** It's just as patients raise concerns.

[156] **William Graham:** How serious does a complaint have to be for you, as you say, to pick up the phone?

[157] **Dr Worthington:** We raise lots of issues. Some complaints we can deal with straightforwardly through the—

[158] **William Graham:** No; I'm asking how serious a specific complaint has to be. Give us an example.

[159] **Dr Worthington:** To give you an example, I've dealt with one recently where I contacted the medical director at the health board directly because we had a patient who was having difficulty in accessing regional services for some pain. They contacted me by e-mail; I phoned them and I had contact with the medical director the very same day. It's difficult to comment on individual cases, but if somebody comes through and you look at it and think 'That needs to be dealt with now and here and I need to speak to the chief executive', we will do that and all chief officers will be exactly the same across Wales.

[160] **William Graham:** So, would you like to give an idea how many of those serious complaints there'd be in any given period?

[161] **Dr Worthington:** We actually get very few of them, to be quite honest, but, when we do get them, we deal with them.

[162] **Ms M. Williams:** I think there is an issue about consenting to actually making a complaint and, very frequently, people don't want to give their formal consent for us to see through a complaint, but, in those circumstances, we would deal with it anonymously as a concern and raise it in that way.

[163] **William Graham:** Right. But you've seen this report from the auditor general and you've seen the evidence in that, which is, as you've already commented, a year old. And yet, individually, we're still getting all the same complaints and no doubt you are as well. So, as you say, nothing's moved further on.

[164] **Mr Meredith-Smith:** It's relatively consistent. As I say, they're low numbers for us in terms of this. Coming back to your first point, I think it's really important to stress that, in terms of the legal responsibility that we've got to assist the users of the NHS to raise concerns, it isn't purely complaints, and I would say that, largely speaking, anybody that really wants to go through the formal complaints process is supported in that. But, yes, it's a persistent issue, isn't it? I'm not here to defend the situation. The evidence is pretty self-evident, isn't it?

[165] **William Graham:** It is, yes.

[166] **Darren Millar:** Aled Roberts.

[167] **Aled Roberts:** As far as Cwm Taf is concerned then, how many active complaints would you have at any one time?

[168] **Dr Worthington:** I think, over the course of a year, we probably have around 120 formal complaints, but we have more than that in terms of concerns where people don't want to use the formal complaints process, but we will pick up their concerns or issues directly with the health board and get a resolution, and we're talking about a good few hundred. But, what we're finding in our complaints now is that although they're relatively small numbers—we're around 10% of the health board's total complaints—we're finding that they're more complex. For example, we'll find four or five different dimensions or questions within that. And that's a recognition of the fact that we get complaints, for example, about older people who will have several things wrong with them, or we're getting more mental health complaints where patients will have contact with maybe three or four different clinicians and their service. So, although the number of complaints we deal with as a CHC—around 120—is relatively small, that belies the fact that they could have a lot of dimensions to them, and be a lot more complex. And the same is the case across all the CHCs across Wales.

[169] **Mr Meredith-Smith:** I think the interesting issue, in terms of the points that were raised in the reports about communication with patients, in terms of the complaints in the

round across Wales—well, not complaints, but they approach us and they may have a complaint, and they say, 'Look, we've got an issue', and we'll talk it through—is that about 20% of those, I think, are immediately dealt with in terms of giving information to the people who approach us that might have been provided by the LHB, I guess.

[170] **Darren Millar:** But, to assist the committee in its work, you can send us a summary with a breakdown of those three categories—the information, concerns and complaints—by CHC, which would be helpful, so we can see if there are any particular parts of Wales where the pressures may be greater than others.

[171] I'm afraid the clock has beaten us this morning, but we're very grateful for you coming in today to put some oral evidence on the record. You'll be sent a copy of the transcript from today's proceedings, and the clerks will liaise with you about any further information that we may require. But, thank you very much, Peter Meredith-Smith, Mary Williams and Dr Paul Worthington for your attendance today.

09:58

Amseroedd Aros a Thargedau Perfformiad Allweddol y GIG
NHS Waiting Times and Key Performance Targets

[172] **Darren Millar:** Okay, we'll move on to item 4 on our agenda today, looking at NHS waiting times and key performance targets. I'm very pleased to be able to welcome Allison Williams, chief exec of Cwm Taf Local Health Board—welcome to you, Allison—and Ruth Treharne, director of planning and performance at Cwm Taf Local Health Board. Good morning.

[173] We've obviously received the Auditor General for Wales's report that was published in January of this year, which was looking at waiting times for elective procedures in the Welsh NHS. It was rather concerning to the committee to see that the trajectory had worsened over the 12-month period that the auditor general had looked at, which, of course, was up to March of last year. We've had further updates in advance of today's session that show that the situation has deteriorated even further since the publication of the report, including in your own health board area, Allison Williams. In fact, it appears that you haven't met the Welsh Government's target for patients waiting over 26 weeks since around September 2010. What on earth is going wrong? What action are you taking to remedy this situation so that patients aren't having to wait unacceptable lengths of time for their treatment?

[174] **Ms A. Williams:** There's been a considerable amount of work done, and if you look at the data that sit behind the main data set—if you're happy, I'll talk about the most up-to-date information—a considerable amount of work has been undertaken to reduce the waiting times. With the exception of ophthalmology, which I'd be very happy to talk about separately, if that would be helpful to the committee, we have had significant improvement in all other specialties across Cwm Taf. So, the overall numbers and the waiting times in other specialties have improved.

[175] **Darren Millar:** When you say 'significant improvement', is this the usual year end slight dip?

10:00

[176] **Ms A. Williams:** No. And one of the things that has changed, certainly within my own organisation, is the demand and capacity planning, and the maturity of the demand and capacity planning for elective activity, and the trajectories that we predict month on month. We submit those trajectories at the beginning of the year to Welsh Government; we track our

own performance against those trajectories monthly—we look at them weekly, but, through the board, we track them monthly. What you'll see against those trajectories is an improvement in all of the specialties month on month. There were a couple of blips in January, which was expected and reflected in our trajectories, because our demand and capacity planning recognises that, in January and February, on a planned basis, you will undertake less elective activity because of unscheduled care pressures. You will undertake more elective activity in the summer months. That's planned into those trajectories. With the exception of ophthalmology, we've consistently delivered on those trajectories over the last year.

[177] **Darren Millar:** So, can I just ask about these plans that you submit to the Welsh Government, demonstrating how you're going to wipe out the people who are waiting over the prescribed times, over a 12-month period? You've submitted those. Where are you supposed to be, according to the plan, versus where you actually are?

[178] **Ms A. Williams:** If I can exclude ophthalmology—and, as I said, I'll happily speak to that, if that would be helpful—if we look at the numbers, the total numbers that we've worked on, we're in the region of 400 patients short of the year-end position for this year—yet to be completely validated and signed off—than where we were expected to be.

[179] **Darren Millar:** So, in terms of the plan versus actual performance—. One point that the auditor general makes in his report is that, very often, the plans are unrealistic, health boards are not delivering against them, and no-one is really holding their feet to the fire to do so. He also mentions the pattern of not meeting the target, if you like, that there's always a dip towards the year end, as people are racing against the clock and there's an extra dollop of cash that comes in in order to assist in meeting targets. So, this is not just a feature of that, because you're talking again about performance between January and the year end, aren't you?

[180] **Ms A. Williams:** Ruth can talk to the detail, if that would be helpful, but we'd be happy to share with you our board report, which shows those trajectories month on month. These are in the public domain.

[181] **Darren Millar:** Yes, we can see them. Well, we can see the recently published figures, anyway.

[182] **Ms A. Williams:** What they will show is the tracker, through our board report, which demonstrates, month on month, what we're expecting to deliver, based on our demand and capacity plan, and where we have actually delivered that, specialty by specialty. We have that information. As I said, with the exception of ophthalmology, where we've had particular challenges this year, then we were less than 400 patients short of meeting the target.

[183] **Darren Millar:** And 400 patients would be what percentage of patients who are waiting currently in your health board area?

[184] **Ms A. Williams:** I couldn't give you the absolute percentage. I'd happily provide that after the committee, if that would be helpful, but it's a very small percentage.

[185] **Darren Millar:** Okay, because the figures that we've got make it clear that you're missing the targets by a wide margin. Jocelyn Davies.

[186] **Jocelyn Davies:** I suppose your target of where you expected to be isn't the target of where you'd want to be.

[187] **Ms Treharne:** No. Shall I—.

[188] **Jocelyn Davies:** Yes.

[189] **Ms Treharne:** In our three-year plan, for 2014-15, which was year 1 of our three-year plan, we set out our trajectory to achieve zero number of patients waiting over 36 weeks at the end of March just gone. So, the number Allison quoted of 404 is the number of patients waiting over 36 weeks at the end of March, compared to the zero we were anticipating. Within that, we have achieved similar number of patients waiting 36 weeks in eight of the specialties. As I say, that's excluding ophthalmology, where we have had some particular challenges. So, that trajectory has been coming down, but, unfortunately, it was 404, excluding ophthalmology, instead of the zero at 36 weeks that we had planned. But, that was heading down. In our plan, which we've just refreshed for the forthcoming three-year period, we are aiming for zero at 36 weeks at the end of 2015-16, which we anticipate we should achieve. But, in eight specialties, we did achieve it, which was a significant improvement in those specialities on the previous year.

[190] **Jocelyn Davies:** Okay, that was the point I—

[191] **Darren Millar:** And what about waits against the 26-week target?

[192] **Ms Treharne:** At the end of March, we're reporting—and these are provisional figures at the moment—87 per cent against the target, so that is under the target of 95 per cent. So, 87 per cent waiting fewer than 26 weeks.

[193] **Darren Millar:** Looking at the graphs here, it appears that you're just following the usual pattern of increase during the year, slight decrease towards the end, but the trajectory seems to me to be very, very clear. Would it be possible to have a copy of your plan, so that we can have a look at the performance and how it's mapped out?

[194] **Ms Treharne:** Yes, of course.

[195] **Darren Millar:** It would also be interesting, I think, to see exactly how your independent members, at board level, unpick that and bring some challenge to you. I'm going to bring in Sandy Mewies, who has got some questions on cancellations.

[196] **Sandy Mewies:** Yes. We've been talking quite a lot about cancellations and the reasons for them, and they are varied, aren't they? One of the things that is concerning to us, anyway, is that the public don't always seem to be aware that, if they get a letter saying, 'We want you here on 14 December' and they cancel because of various reasons and don't go, they can be pushed back in the waiting times. Do you make it very clear to people that this is something that can happen to them? Bearing in mind that the people you are writing to are ill, probably, do need treatment, which, in some cases, will be quite urgent, and will have a lot on their minds, is it quite clear to them what can happen?

[197] **Ms A. Williams:** Okay. There are two issues: one is where people do not attend; the other is where they cannot attend. The guide to good practice was issued several years ago now, which stipulates the guidance that the health boards must follow in managing people who cannot attend and cancel appointments. If somebody cancels an appointment once—and their letter states that if they cannot attend, they're asked to ring up and make a second appointment—then, they're not disadvantaged and another appointment is made for them. There is discretion on the part of the booking clerks, because there are some patients who might be in hospital for another reason, they may have carer responsibilities, or sometimes, we get it wrong and we don't notify them in time, so people are not penalised on that basis. They are given a second opportunity. If they cancel a second time, the letter makes it very clear that if they cancel a second time then they might be put to the back of the list. It's not

automatic, because all of the patients have a clinical review, so the consultants ultimately will check the notes of the patient. If they feel very strongly, 'No, we must try and get that patient in again', then they will have another attempt, although it is important that the GP, because the GP is often the only person who is in contact with that patient, is notified, and if there are genuine reasons, the GP can reinstate the patient on the waiting list. So, it's not as cut and dried as it might appear. We'd be very happy to provide you with copies of the letters that we issue to patients, if that would be helpful.

[198] **Sandy Mewies:** That would be good, because what's clear sometimes to people who are operating a process isn't clear to a recipient. I know I've had a case very, very recently of someone who was waiting for a very serious—and I mean serious—operation for a considerable time, who has had all the tests required, the scans, and then had a letter saying, 'Do you want to remain on the list?' Now, that's extraordinarily confusing, isn't it, when you know—well, you think you know—'I'm going to see that consultant on so-and-so, and he's going to tell me what that operation in that hospital is going to be, but they're asking me if I want to stay on the list'?

[199] **Ms A. Williams:** What you are describing is probably a waiting list validation process—

[200] **Sandy Mewies:** Yes, I'm sure it is.

[201] **Ms A. Williams:** —as opposed to a specific response to a patient not attending or cancelling an appointment. Organisations do regularly check that patients still wish to be on a waiting list. It's something that we do continuously—

[202] **Sandy Mewies:** But you don't look to see whether they are actually waiting for treatment.

[203] **Ms A. Williams:** We would, but you'd be surprised, as there are a number of people, even those who are waiting, for example, for major orthopaedic operations, who then change their minds and decide they don't want the surgery. So, there is a process of checking that patients still want their surgery. That is also good practice, so that we make sure that everybody who's on the waiting list is actively on the waiting list and not passively on the waiting list.

[204] **Sandy Mewies:** Could you send us examples, then, of the letters that you do send out for these different issues?

[205] **Ms A. Williams:** Yes.

[206] **Sandy Mewies:** I'd be quite interested to see them.

[207] **Jocelyn Davies:** Can I come back on that?

[208] **Darren Millar:** Yes, you can, Jocelyn.

[209] **Jocelyn Davies:** You said that the booking clerks have got some discretion, even on the first cancellation. So, if I ring up and I say, 'Well, I've got an appointment for the middle of August; I'm not able to attend', would I be asked why?

[210] **Ms A. Williams:** No, you wouldn't.

[211] **Jocelyn Davies:** On the first one.

[212] **Ms A. Williams:** On the first one, no.

[213] **Jocelyn Davies:** So, how are they exercising their discretion, then, on the first cancellation?

[214] **Ms A. Williams:** On the first cancellation, everybody is given the opportunity to rebook. And if a patient—

[215] **Jocelyn Davies:** But you did say, when you answered Sandy, that the booking clerk has got some discretion on the first cancellation as to whether it affects you on the waiting list.

[216] **Ms A. Williams:** I am sorry if I didn't make that clear. If you cancel the first time, that doesn't affect you on the waiting list.

[217] **Jocelyn Davies:** Right, okay.

[218] **Ms A. Williams:** On the first cancellation, you will be given a second appointment. One of the things—and I was listening to the earlier session with the community health council—that we are in the process of implementing across the whole of Cwm Taf is the text-and-remind service for out-patient appointments. We know it's not suitable for everybody, but significant numbers of people now do have mobile phones, so we are also using a text-and-remind service, whereby people get reminded of their appointment, so that that improves the do-not-attends, and also prompts people if they wish to cancel. It's better to cancel and rearrange than not to attend.

[219] **Jocelyn Davies:** Of course. Why do you think that the community health council didn't know that you weren't disadvantaged on the first cancellation? It was quite clear from the evidence that they gave us that they thought that you were. So, if the chair of the community health council, the officials and so on, don't know that you're not disadvantaged in terms of the waiting list on first cancellation—we certainly thought that you were—how do we expect patients to know that? It seems to me that, if they're confused about it, you can understand that everybody would be, including the auditor general.

[220] **Darren Millar:** Can we just try to clarify this, because it is an important point that we need to understand? Is it that—. If a patient cancels at their first opportunity to cancel an appointment, is the clock paused in any way, or stopped in any way? So, for example, if they're given an appointment in August, and they rebook it for September, presumably the health board doesn't want to be penalised either for the fact that the patient has asked for a postponement of four weeks—you don't want to be penalised against your target. How does that work, in terms of the clock, specifically?

[221] **Ms A. Williams:** If the patient asks for a deferral of their appointments, then the clock is stopped for that period of the requested deferral.

[222] **Darren Millar:** I see. Okay.

[223] **Ms A. Williams:** But they don't revert back to the beginning of the waiting list.

[224] **Darren Millar:** Until a second cancellation.

[225] **Ms A. Williams:** After the second cancellation, there is a clinical discussion with the consultants—'This patient's cancelled twice'. If the consultant wants them to be given a further appointment, then they will. Or the consultant may say, 'Well, let's refer them back to the GP', because, if they're not coming for their treatment, actually it's probably clinically

safer that the GP takes back the management. Then, the GP will determine with the patient about a referral back in.

[226] **Darren Millar:** So, a second cancellation either restarts the clock or results in referral back to primary care.

[227] **Ms A. Williams:** Yes.

[228] **Darren Millar:** Okay. So, they come off the waiting list altogether—some of them—on that second appointment. And it's at that point that discretion is used by the booking clerks.

[229] **Ms A. Williams:** Yes, because it may be that the patient is in hospital for another indication; you know, there may be health reasons or there may be carer reasons. But, if they're for non-health or non-carer reasons, then that patient would be taken off, in line with the guide to good practice guidance.

[230] **Darren Millar:** Okay. I've got three Members who want brief follow-ups on this. So, Jenny, Aled and then William.

[231] **Jenny Rathbone:** I'm struggling a little bit to understand why, if people do the right thing and ring up to say, 'I cannot make this appointment', in some instances they are getting penalised. Now, I understand that you think that, if they can't organise their carer arrangements on two occasions, they obviously aren't giving it the attention it deserves. But we want people to act responsibly and cancel their appointment rather than being DNA. So, aren't we just penalising them for doing the right thing, in that case?

[232] **Ms A. Williams:** The guide to good practice is very clear about the two opportunities. Bearing in mind that somebody, technically, should be on a waiting list because they need treatment, one would assume that they would prioritise their clinical treatment over most other things in life. We do exercise discretion. Technically, according to the guidance, we don't have to. We could, if somebody cancels twice, as is legitimate under the good practice guidance, take them off the waiting list. The fact that we exercise discretion where there may be illness or carer responsibilities is something that we as an organisation feel is important.

10:15

[233] **Jenny Rathbone:** Okay. I think that is reassuring. I had a question about the way in which we communicate with patients—I'll just keep going. I am surprised, listening to the CHC, that we communicate in the first instance by letter when an appointment has to be cancelled because the clinician is ill or for whatever reason. Why are we not using twenty-first century texts and e-mails in the first instance and then following up with a letter if we weren't able to get hold of them?

[234] **Ms A. Williams:** The text-and-remind service is something that we are bringing in from this month in Cwm Taf across all of our out-patient specialties. We're also bringing in a self-service check-in service into out-patients—a bit like what some of the GP practices have got—so that people can keep their own details; they're prompted to update their own details. We anticipate that between 60 per cent and 70 per cent of people will have mobile phones and will use that medium as an important way of receiving that information, but, other than that, at the moment, we have an automated letter-generating system that generates written letters to patients.

[235] **Jenny Rathbone:** But it can't just be apocryphal that people get letters that actually

refer to something that's happened—you know, the date's already passed by the time they get the letter. Why are we not ringing them up, e-mailing them, and hoping that we'll get the response that way?

[236] **Ms A. Williams:** We don't have e-mail addresses for a lot of people and we have been, I suppose, a bit slow out of the blocks as an NHS in terms of using e-mail as a mode of communication with patients. Some of that is because e-mails are not secure outside of the NHS system. So, for clinical data, we don't use e-mail communication in that way.

[237] **Jenny Rathbone:** But you could, surely, if you asked the patient, 'Is it all right if we—?'

[238] **Ms A. Williams:** Yes, but we've taken the view that the text and remind—because more people, particularly the elderly, have mobile phones than use e-mail every day. So, we've taken the view that the text-and-remind service is probably the first improvement that we would want to see. E-mail is something that we're going to have to consider, but it's not something that we are planning to do at the moment.

[239] **Jenny Rathbone:** Okay. Just going back to the letters that arrive after the date of the new appointment, presumably the patient isn't then penalised as a result of that. They ring up and say, 'It's all very well; I would have come if I'd known about it'—that wouldn't be counted as a cancellation.

[240] **Ms A. Williams:** No, it wouldn't.

[241] **Darren Millar:** What's your current rate of do not attends?

[242] **Ms A. Williams:** It varies by specialty, and it varies from about 6 per cent—and it's different for new and follow-up patients—up to, in some specialties, 20 per cent plus for follow-ups, but even for new appointments you might be surprised at the DNA rates. That's why we believe that the text-and-remind service will be a very helpful prompt to people. We also do offer a partial booking service so that people can book appointments at their convenience. So, it's even more difficult if we've booked an appointment to the convenience of the patient and then they're cancelling or DNA-ing. So, we believe that the text-and-remind service is an important tool in our armoury to reduce those levels.

[243] **Darren Millar:** Would you welcome the opportunity to use other tools—other forms of penalties, for example—as a board?

[244] **Ms A. Williams:** I don't think that it's reasonable to look at the use of punitive penalties, such as financial penalties. I think the real issue is trying to get the message out to the community about the cost to the NHS and the cost to other patients of missed and cancelled appointments.

[245] **Darren Millar:** Okay. Aled Roberts, William, and then I'm going to bring Mike in.

[246] **Aled Roberts:** Mae hanner yr achosion yn cael eu canslo gan yr ysbytai eu hunain. Rŷch chi wedi dweud wrth Jenny Rathbone nad oes cosb i'r claf os ydyn nhw'n derbyn llythyr am apwyntiad ar ôl yr apwyntiad ei hun. Ond a oes yna unrhyw fath o ganlyniad o ran y data eu hunain? A oes yna unrhyw fath o bwrpas iddyn nhw o ran y bwrdd iechyd? A ydy o'n stopio'r cloc, er

Aled Roberts: Half of the cases are cancelled by the hospitals themselves. You've told Jenny Rathbone that there is no penalty to the patient if they receive a letter about an appointment after the appointment itself. But is there any sort of outcome in terms of the data themselves? Is there any sort of purpose to them in terms of the health board? Does it stop the clock, for example?

enghraifft?

[247] Mae gennyf enghraifft yn y gogledd am lythyrau'n cael eu anfon allan am apwyntiad sydd erioed wedi cael ei gynnig a lle mae'r gair 'cancelled' wedi'i argraffu ar ei ben. A ydy hynny'n cyfrif fel cynnig apwyntiad, fel eich bod chi o fewn y 26 wythnos? Rwy'n pryderu nad yw'r ystadegau yma eu hunain yn gywir, heb sôn am y diffyg perfformio o ran ystadegau.

I have an example in north Wales of letters being sent out for appointments that have never been offered, where the word 'cancelled' has been printed at the top of the letter. Does that count as an offer of an appointment, so that you're within the 26-week period? I am concerned that these statistics aren't correct, not to mention the lack of performance in terms of statistics.

[248] **Ms A. Williams:** I'm absolutely clear that, if we cancel an appointment for a patient, then the clock is not stopped. That's a hospital-based cancellation; that's our issue, not the patient's issue, and the clock does not stop on those occasions.

[249] **Aled Roberts:** Ocê. A allwch chi esbonio rhywbeth felly? Rwyf wedi bod yn edrych ar yr ystadegau yma, ac mae yna lythyr sydd wedi ei anfon gan y bwrdd iechyd at y cyngor iechyd cymunedol yn dweud, er enghraifft, bod yn rhaid ichi aros dros 70 wythnos am apwyntiad yn y clinig poen yn ysbyty Wrecsam. Mae'r ystadegau'n dangos nad yw neb yn aros dros 52 wythnos, ond 70 wythnos yw'r amser arferol. Felly, beth sy'n gywir: yr ystadegau, neu'r llythyr sy'n cael ei anfon allan gan y bwrdd iechyd yn dweud bod yn rhaid ichi aros ar hyn o bryd dros 70 wythnos?

Aled Roberts: Okay. Can you explain something, therefore? I've been looking at these statistics, and a letter has been sent by the health board to the community health council saying, for example, that you have to wait over 70 weeks for an appointment in the pain clinic in Wrexham hospital. Statistics show that no-one is waiting more than 52 weeks, but 70 weeks is the usual time. So, what is correct: the statistics, or the letter sent out by the health board saying that you have to wait at the moment for over 70 weeks?

[250] **Ms A. Williams:** I'm afraid I don't know the detail in Betsi Cadwaladr. What I can do is speak for my own organisation. We have absolute transparency with our information. We don't have two different sets of data. The waiting list data are put to our board in public at every meeting. We have a finance and performance sub-committee of the board, which is chaired by one of our non-officer members. They scrutinise in great detail, every month, the waiting times position across all specialties. They have the ability to call in any specialty—and when I say 'any specialty', I'm talking about the clinicians and the managers at directorate level, to scrutinise directly their waiting times, and I would be very confident that any waiting times that are reported in my organisation are correct and it's only one data set that we're working from. So, if the waiting time is 70 weeks, it would be reported as 70 weeks.

[251] **Aled Roberts:** And is that data set the same data set that appears in the national statistics?

[252] **Ms A. Williams:** Yes, it is, because it's all fed from the same data source. So, our primary data source feeds Welsh Government and also feeds our own board reports. We don't keep any separate data sources at all.

[253] **Darren Millar:** There was this issue, wasn't there, back in 2011, when you were reviewing the list, that you took a huge cohort of patients off the list completely and didn't report on those at all? That's not happening any more, is it?

[254] **Ms A. Williams:** That was before I was chief executive of Cwm Taf health board.

We identified that, as the result of a year-end validation exercise, a number of people were taken off the waiting list who were subsequently put back on to the waiting list. I can give you absolute assurance that that is not something that happens in my organisation. The data are tracked. So, if you look month on month, and if you look at the March and April figures, for example, for this year, what you will see is an entirely predictable picture of exactly what you'd expect in terms of the demand and capacity plan. You're not going to see any significant drops and then spikes in people on the waiting list.

[255] **Darren Millar:** Okay. Ruth, you want to come in.

[256] **Ms Treharne:** Can I just add briefly that the other thing that we do do is make sure, when we report our data, both internally and to independent members, the board and community health councils, they have those data broken down by specialty. So, where there are areas of particular concern or interest, members are able to track month on month the specialty changes as well. So, if they are receiving reports possibly of difference, or they're wanting to track any detail, they've got a finer data set as well to look at and to track over a time period.

[257] **Darren Millar:** Okay, thank you for that. William.

[258] **William Graham:** How much discretion, then, does your booking team actually have? I had a complaint in your authority where a woman turned up with her son, but the consultant said, 'I've already seen him; I didn't want to see him again. I want him to see Mr Y.' So, she was put down as a 'did not attend'; the whole thing had to go around again. Now, to be fair, your complaints procedure worked well in that case and she was given an appointment fairly quickly, but how much discretion—when she rang up, of course, there was no discretion—is there if you haven't attended?

[259] **Ms A. Williams:** They would need to check with the appointing clinician, because, at the end of the day, what we're doing with appointments is managing clinical risk and clinical conditions. So, in an instance like that, my expectation is that the booking clerk would check with the clinical team and say, 'Is this a patient that needs to be seen?', the consultant says 'Yes'—

[260] **William Graham:** Not by the first consultant you'd seen. The first answer was, 'I've seen him, I can do nothing for him; he must now see Mr Y'.

[261] **Ms A. Williams:** In which case, then, we would've expected a consultant-to-consultant referral in that situation.

[262] **William Graham:** That had already taken place. The fault was with rearranging the appointment with the consultant.

[263] **Ms A. Williams:** Right. I'm afraid I don't know the detail of the specific instance, and I think that I would be unwise to say that we don't have errors in the system, because we won't always get it right. But what is important is that, if we do get it wrong, we have a degree of flexibility that is driven by the clinicians to be able to reappoint people.

[264] **William Graham:** So, just to establish that, when that person got in touch with the booking clerk, they didn't believe her, in essence, so how would that be easily solved? Could they say 'I will ring you back; I will check?' Should that be done?

[265] **Ms A. Williams:** They should, and the other thing is that it's important to remember that the GP must always be the effective clinical gatekeeper. My advice to people always is that if your condition's changed while you're on a waiting list, or if there are concerns, the

most effective way of dealing with that is that your GP speaks directly to the consultants. Then, clinician to clinician, they would determine the relative urgency of the need for the individual to be seen.

[266] **William Graham:** Thank you very much.

[267] **Darren Millar:** Mike Hedges.

[268] **Mike Hedges:** With regard to 'did not attends', I doubt whether it is a 'did not attend'; the reason they did not attend was because they were actually in hospital. Do you cross-reference the people who are coming in for day surgery or elective surgery against your hospital admissions using the hospital number to know whether people are available or not? I've dealt with two cases where people didn't attend because they were actually in hospital and couldn't attend.

[269] **Ms A. Williams:** Right. We wouldn't automatically, and, as you might imagine, we see almost 0.5 million out-patients every year in Cwm Taf alone. Because of that, the practicalities of checking those sorts of numbers would make it extremely difficult. We are reliant on the patients to inform us, and I'll be honest with you that patients are very good, because they will often say to ward staff, 'I've got an out-patient appointment tomorrow', and if we can, we will take the patient off the ward for their out-patient appointment. But, in those instances, if the patient did 'DNA' and it was because they were in hospital, that wouldn't be counted against them adversely as a 'DNA'. We would be able to use discretion to say, 'Well, that was really very unavoidable because the individual was ill and in hospital'.

[270] **Mike Hedges:** You said that would be very difficult. Why can't you just run a match against the two databases?

[271] **Ms A. Williams:** It's just the practicality with 0.5 million out-patient appointments.

[272] **Mike Hedges:** But you've got your appointments for tomorrow on a database. You've got your hospital admissions today on a database. Why can't you run those two databases against each other?

[273] **Ms A. Williams:** Because if we're actually looking at doing that so that we can make the appointment available for another patient, then we would have to do that at least seven days in advance to reutilise the appointment. So, it doesn't assist with the management of the clinic, and as we don't disadvantage the patient, then that would arguably be an unnecessary use of administrative time.

[274] **Mike Hedges:** I won't pursue this any further, but I know of patients who, at 24 hours' notice, would turn up for an out-patient appointment because they think it's very important for them. The question I have got is: do you actually study what is causing the length of your waiting lists and waiting times? Is it demand? Is it the fact that consultants are doing fewer patients per week than they used to do, which I understand from data is actually true? Or is it because beds are being taken up due to things like inter-hospital changes?

[275] **Ms A. Williams:** I'll ask Ruth to comment in a moment on the work that we're doing with individual consultant efficiencies. There is a multiplicity of factors. Bed availability can be a challenge for in-patient admissions. I'm very pleased to say that that is very much a reducing factor in Cwm Taf. We've halved the number of patients over the last 12 months who have been cancelled for unavailability of beds, and that's despite quite significant changes and some reductions in bed numbers that we've had in the health board, because it's not all about beds—it's about lengths of stay, about efficiency and about alternatives to in-patient care.

10:30

[276] If we take ophthalmology as an example, we've also had significant changes in the way that services are delivered. So, for example, there are some conditions, such as wet macular degeneration, where a patient who's referred then needs to have treatment every four weeks, and probably every four weeks for the rest of their life. So, you're building a cohort of patients in the system who are there requiring treatment—we're victims of our own success in many ways—for many years. So, the capacity and the demand are changing. So, that has had quite a significant impact on cataract waiting times, for example, and glaucoma follow-up. I think the CHC referred earlier to some work that we've done with optometrists in the community, so that we're moving the glaucoma follow-up into the community under clear supervision, with clear pathways of care and access back to the consultant to take some of that demand out of the system. So, some of it is the changing face of the treatment modalities that we have. We also do significant work on consultant efficiency. Ruth, I wonder whether you'd like to comment on that.

[277] **Ms Treharne:** Yes. Again, we provide quite detailed information, both to take management and clinical action but also to discuss with some of our board members around differences there may be in practice. So, where we maybe have some consultants whose waiting lists are greater than others, that's to understand whether the demand is higher for some than for others, whether we can use the clinical teams differently to support certain numbers of patients waiting and whether they could be treated by the consultants who maybe have some further capacity on their waiting lists. One of the real benefits of the work at the moment is that it's allowing us to share good practice. So, it's allowing, with the information we've got by consultant, the consultants to work through and understand and adopt different practices they might have about how those patients are being treated and being treated differently. So, we're sharing and learning amongst the clinical teams. So, we have some quite detailed information now by clinician. It allows us to have some of those conversations to help us deal with differences, if you like, in clinical practice and to share good practice amongst those teams.

[278] **Darren Millar:** Can I just ask you, you mentioned your cancellations due to bed numbers have halved over the past 12 months, so what proportion of your cancellations are as a result of bed pressures?

[279] **Ms A. Williams:** It varies throughout the year. If we look at January and February, the cancellations for bed purposes are higher. We had 641 cancellations for the whole of last year, which, as a proportion of 70,000 in-patient admissions, was a relatively small proportion, but for those 641 people it's clearly very distressing. Some of those will have been for clinical reasons. About half of them will have been for bed pressures, and one of the challenges that we have in managing demand and capacity, particularly when we know that January and February are going to be difficult, is that we always plan to do less activity in January and February as part of our overall profiling, and then we're constantly juggling—do we book people and have the risk of cancellation, or not book people and have the risk that we have an empty slot? So, people are advised when they're given the appointments that that may be a consequence of their appointments.

[280] **Darren Millar:** But, presumably, if you've got bed pressures, you've still got surgeons ready to go, you've still got the theatre staff ready to go, the nursing staff ready to go. So, what happens to them if operations are cancelled as a result of those bed pressures? Is that a resource that is just not used?

[281] **Ms A. Williams:** No. One of the things that we do is we profile the type of activity seasonally, so we would be doing more day case activity in the winter period where there isn't

a long length of stay. If we are under significant unscheduled care pressures—and, fortunately, with the way that we've worked in Cwm Taf and our flow programme, that is much less of a problem than it has been historically—those staff are redeployed to manage emergencies within the hospital, so that we actually recover the unscheduled care pressure much more quickly.

[282] **Darren Millar:** And that would apply even to specialist consultants?

[283] **Ms A. Williams:** Yes. You'd have surgeons working on the wards, because there are always surgical emergencies and surgical patients. You'd have theatre staff working in intensive care or accident and emergency departments because they're multiskilled. So, if we get into very significant unscheduled care pressures, then we will make sure that those staff are not underutilised but they're drawn to help us to clear the unscheduled care position so that we recover much more quickly. The other thing that we've tracked and that's been scrutinised by our board is the recovery period from unscheduled care pressures. What we've seen over the last two to three years is that, where a peak would perhaps take us three or four weeks to recover, we're now recovering in 36 to 48 hours.

[284] **Darren Millar:** You're describing some very good practice there. Is that practice consistent in other health board areas as well? I can recall being visited in my own constituency surgery by theatre staff who said, 'I've been stood idle for two days because there are no beds available for the patients who we're supposed to be caring for.'

[285] **Ms A. Williams:** I don't know the extent to which it is deployed across other health boards. What we did in Cwm Taf two years ago was we reinstated the hospital matron role on both of our main district general hospital sites, and that hospital matron has the authority and the ability to deploy the nursing staff, particularly, anywhere according to need. So, we've done that with the trade union support as well, because what you don't want to do is to move a nurse who hasn't got the skills to an area where she or he is feeling out of their depth.

[286] **Darren Millar:** Absolutely. Okay, thank you. Aled.

[287] **Aled Roberts:** Rydych chi wedi cyfeirio bod y gostyngiad yn nifer y gwlâu yn ffactor yn hyn. Rwyf jest eisiau gofyn i chi a oes gennych chi unrhyw sylw ar farn Coleg Brenhinol y Llawfeddygon sydd yn dweud bod cyfraddau defnyddio gwlâu yng Nghymru yn llawer iawn uwch a hwyrach bod yna heintiau a phethau'n datblygu o fewn yr ysbytai oherwydd hynny, sydd hefyd yn achosi problemau efo canslo triniaethau. A oes gennych chi unrhyw farn ar hynny?

Aled Roberts: You've referred that the reduction in the number of beds is a factor in all of this. I just want to ask you whether you have any comments to make on the view of the Royal College of Surgeons, which has said that the rates of bed utilisation in Wales is much higher and that perhaps infections and things develop within hospitals because of that, which also causes problems with cancelling surgeries. Do you have any views on that?

[288] **Ms A. Williams:** We've worked very hard in Cwm Taf around benchmarking our bed occupancy and our bed numbers. One of the commitments that we made to our community health council and our clinicians was that bed reductions have to be matched with bed equivalents in the community, because there's no point in reducing your beds if you've got nothing else to replace them with. We've been very fortunate to also secure spend-to-save moneys from Welsh Government to, for example, put in place community teams for stroke rehabilitation. So, our stroke length of stay has gone from 11 days to six days for acute stroke, because we're able to discharge people with proper community alternatives. That has meant that we've been able to sustain some bed reductions, and our bed occupancy has remained, on average, throughout the year—excluding paediatrics and obstetrics, because they artificially deflate the bed occupancy—running at just under 90 per cent, recognising that that is an

average, but that is what good practice would state that you need to run with. We have only been able to do that because of investment in community alternatives, which are better for patients.

[289] **Aled Roberts:** Are there any discussions, then, at a national level in Wales—the point the Chair made regarding good practice and comparisons—because, certainly, the 90 per cent figure is nowhere near the figure in some other areas. I mean, I think there were figures in the north where it was very much higher than that. Is there any connection, as far as you can see, in those national discussions between heavy usage and increased infection rates, and then leading to higher levels of cancellations in some health boards in Wales?

[290] **Ms A Williams:** If I can answer the infection question and then Ruth might answer on the sharing of best practice. The infection rates in Cwm Taf have historically been amongst the lowest in Wales and compare very well with international figures. What we're seeing with infections such as Clostridium difficile now is that the majority of people have community-acquired C. diff who are coming into hospital with it and then we're managing that. So, we're not seeing a correlation between bed reductions that we've made and any increase in hospital-acquired infections. Ruth, I don't know whether you want to comment on the national position.

[291] **Mr Treharne:** I think there are some connections being made, and some useful national work is being undertaken to help us share and learn from each other by way of good practice. Two examples struck me when you were asking the question. Allison gave the example of the stroke early supported discharge service that we've introduced into Cwm Taf. The stroke delivery group, one of the national service disease delivery groups, is seeing that as a priority as well to translate that good practice to others, so they're adopting that similar sort of service change. Then, secondly, we've got a national planned care group, which you may know of or may have taken some evidence from, which is helping us in particular specialties, like urology, ophthalmology, and general surgery, to adopt and share good practice again across ourselves as health boards in terms of developing better practices, really, in terms of how we do treat reduced demand, but also provide appropriate community and primary care service provision. So, those mechanisms are quite useful for us to use to share.

[292] **Aled Roberts:** Are there any figures available nationally to compare health boards as far as the availability of community step-down beds is concerned, and the removal of pressure on district general hospitals because of that?

[293] **Ms A. Williams:** There are on beds. There aren't any specific metrics on community alternatives. The way we look at it, we've got 80,000 beds in Cwm Taf; they're in people's homes. So, the bed is not the currency; the currency is the care that we provide to the individual. For example, in our stroke service, we've reduced that length of stay from 11 to 6 days in the acute stroke, not by putting people into a community bed, but by sending them home, and we've got in-reach community services daily for six weeks—intensive rehabilitation. It's been evaluated, and their rehabilitation potential is realised much quicker and much more effectively than if they'd been in hospital for rehabilitation.

[294] **Darren Millar:** Okay. Thank you. Sandy Mewies.

[295] **Sandy Mewies:** Thank you. Two points: I'm glad you clarified that, but beds are not always within—. They're not step-down, or not in institutions, they're actually—. What you're talking about here is services provided in the community that people can access easily from their own homes. But you did make a very good point, I think, which says that those services should be available before the other services are taken away, and I think that's terribly important.

[296] But you also mentioned ophthalmology, and you said at the very beginning about the changes. It's those dratted 'o' words, isn't it? I was asking the community health councils about optometrists on the high street, and there is a drive now to make sure that people with—I try to make this distinction—not not serious eye ailments, but they're things that perhaps you could go with to your optician and they would be picked up very quickly. That would stop that pressure within the ophthalmology services in hospitals. You seem to indicate that that's working well for you. Can you tell me why?

[297] **Ms A. Williams:** There are two components. One is patients directly themselves going to their optometrist with eye irritations, conjunctivitis, and I still think we've got a long way to go in educating the public to understand that that's an appropriate use of their optician. People often think they go to their optometrist for eye tests and for new glasses, so we've got a piece of work, I think, with the community more widely. That is picking up, and it's picking up as the GPs are signposting patients to those services, but what we were talking about, and what the community health council was talking about, is that there are certain optometrists—not all—that have developed certain expertise that we have accredited as part of the formal accreditation process, for example, to be managing glaucoma follow-ups, so they're not coming into the out-patient clinic anymore. They're managing the regular pressures, and they then have direct access to consultant ophthalmologist advice, because it's not always that the optometrist needs the ophthalmologist to see the patient; they often need a bit of advice, which is 'What do I do with this patient?', and because they're accredited as part of a pathway, they have direct access, and then those patients can get back in to be seen. The patients taking up this service like it because it's much more convenient for them.

[298] **Sandy Mewies:** On the high street. Could we ask for a note on—? We wanted to get that—. You wanted to talk. I'd like to see a note on that, please.

[299] **Darren Millar:** We'd appreciate that, especially given that it's the area where you're still having some big difficulties in terms of trying to manage those figures down. I've just got a few questions and one point of clarification I need to raise with you. If a patient moves into your area from another health board area in Wales, or indeed from England into Wales, does that have an impact on their waiting time and how you measure it?

[300] **Ms A. Williams:** I don't know in terms of outside of Wales; I'd have to check, but I can't imagine that it would be any different. But certainly, if a patient moves within Wales, they would have a choice whether or not they wish to access their treatment with the clinician that they're already on the waiting list for—a lot of patients prefer to do that, because they prefer to finish an episode of care—in which case it would then by charged to me as the resident health board. Or if they wish to transfer their care to us as a health board, they wouldn't be penalised.

[301] **Darren Millar:** They wouldn't be disadvantaged in any way.

[302] **Ms A. Williams:** No.

[303] **Darren Millar:** Okay.

[304] **Ms A. Williams:** But I'm afraid I don't know the answer on the English system. I'd need to check that.

10:45

[305] **Darren Millar:** You mentioned also follow-up appointments. One of the things that the auditor general's report picked up on was that not all health boards collate data on follow-up appointments—whether they're being missed or not or whether they're sufficiently

frequent. Does your health board collect data?

[306] **Ms A. Williams:** There's been a significant audit exercise that's been undertaken over the last six months, hasn't there Ruth?

[307] **Ms Treharne:** Yes.

[308] **Ms A. Williams:** It's been trawling through all of the long-term follow-up patients, because one of the issues has been the appropriateness of long-term follow-up and how many of those should actually either no longer be in follow-up at all or in follow-up in primary care. That's the work that we're just concluding and taking back to our board within the next two months. So, that's a piece of work that all of the health boards have been looking at. And these are what are called follow-ups not booked on a routine basis, so that people can't get lost in follow-up.

[309] **Darren Millar:** Obviously, with some conditions, such as cancer and cardiac care, if a clinician wants to see them within six months and they're not seeing them for two years, it can have a significant impact on the patient's outcomes, can't it? But you're satisfied that you're being able to pick up on those issues. Initial follow-ups are the most important, I suppose, aren't they, post treatment?

[310] **Ms A. Williams:** Yes, and I think—

[311] **Darren Millar:** So, where's that information being reported? Is it being reported in the public domain?

[312] **Ms A. Williams:** It's being reported through the boards. It's not separated out and reported separately; it's within our out-patient activity that is reported to the board. The issue here is that this big audit has been undertaken across all of Wales, looking at these patients. Arguably, if a patient is being followed-up for years—once a year or every six months—you have to question the value of that. Actually, the real issue is how we have proper pathways back into primary care and how those GPs can get advice and urgent appointments for their patients, if their condition changes.

[313] **Darren Millar:** Okay, but in terms of those conditions where a follow-up appointment is absolutely necessary, what assurances can you give and what information is in the public domain to be able to hold health boards to account for that? Can you also just tell us who commissioned the audit work that you just mentioned?

[314] **Ms A. Williams:** Right; we commissioned that.

[315] **Darren Millar:** Was that collectively as chief executives?

[316] **Ms A. Williams:** Collectively in discussion with the civil servants in Welsh Government. Also, the BMA, you may recall, had raised some concerns about this, so we've been working openly with clinical staff around this particular concern that they have. That audit will be reported back and through our board in the public domain, so there's absolute clarity about the forward management of that audit.

[317] **Darren Millar:** What's the timescale for that?

[318] **Ms A. Williams:** I'd need to put a note back in to the committee, but this is something being scrutinised by the finance and performance sub-committee of our board. We can let you know when that will be going into our public board arena.

[319] **Darren Millar:** Okay. In terms of getting the waiting times down, you've obviously had some success with some specialities, which is very encouraging. In the longer term, though, obviously the tradition has been, 'Let's have a waiting times initiative to manage things down', and then they just spike back up because there's a capacity issue in any case. What sort of action do you think needs to be taken in the longer term? Would you welcome another initiative to clear some backlog? What would you ask for in terms of support from Welsh Government?

[320] **Ms A. Williams:** I'll ask Ruth to speak in a moment in terms of our demand and capacity planning because, at the end of the day, our demand and capacity planning in the NHS has to be sensitive enough to be able to cope with what our projected and expected demand is. As an organisation, we have put any waiting list moneys that we have predominantly into investing in core capacity, because this sort of boom-and-bust approach to waiting list initiatives does not give you the sustainable results. What we have to do is to look at how our core capacity meets the demand for the service. Now, if I take our ophthalmology position, we have had sickness amongst three out of the six of our consultants, which was something that we couldn't have predicted. So, whilst our ongoing demand and capacity plan is balanced, because of some of the sickness issues that we've had, we've created a backlog. We will need to address that backlog through some sort of pulse-type action to then get us back onto an even keel. But, I personally am not in favour of waiting list initiatives as a substantive way of dealing with waiting lists.

[321] **Darren Millar:** But you're saying, sometimes, on some occasions, those things are useful in being able to play catch-up where you've had those sorts of unforeseen circumstances.

[322] **Ms A. Williams:** Yes, and appropriate.

[323] **Darren Millar:** Ruth, you wanted to come in.

[324] **Ms Treharne:** Yes, just to add, really, some of the work we've been doing to really move us away from overuse, if you like, of waiting list initiatives is to really try and get our system back into some balance, and we've had a really explicit focus on trying to improve our efficiency and productivity in terms of the use of the resources that we have, if you like. So, we've done quite a lot of work around some of our theatre demand/capacity-type work, to make better use of the theatre time we've got available, and we're also building in anticipated impact of our service redesign initiatives. So, within our demand/capacity models by specialty, we are actually building into those the anticipated impacts, for example, of the early supported discharge service we mentioned earlier, or the acute psychiatric liaison service we've just invested in recently. So, we have a sense of the positive impact that should have on releasing some of our capacity within service, and that's built into our demand/capacity models by specialty to enable us to have a much more sustainable system going forward, and we have invested—I think it's over the last two years, Allison—less and less, if you like, on more of these waiting list initiative-type pieces of work, and invested more into sustainable solutions for primary community services in particular, but having built the impact, or the anticipated impacts, of those into our demand/capacity models so we actually know whether we are or we aren't going to get the value, if you like, of those services on the more specialised and, often, the more expensive services in the district general hospital setting.

[325] **Darren Millar:** The clock has almost beaten us. I just want to ask for one final opportunity to nail this. The auditor general's report on waiting times was accompanied by a technical report, which of course has been validated in terms of its factual accuracy. Just going back to this issue of patients cancelling their own appointments, it says in the report, and I quote, on the first cancellation—could not attend—

[326] ‘the clock is reset but the patient must be offered a new appointment as soon as the patient is available. Patients can have one CNA at each stage of the pathway.’

[327] On the second one, the second cancellation, the clock stops and the patient is discharged, unless the consultant wants to keep them on for clinical reasons. So, it appears that the discretion is only actually on the second appointment, and on the first one, the clock is not paused, but it is actually reset. Can you confirm that that is the case to us and that you are not reporting information that is not in accordance with the information here, which we’ve had from the auditor general and which has been checked for factual accuracy?

[328] **Ms A. Williams:** We comply with the guide to good practice, and that is something that we audit for ourselves. So, I will happily go back and check against our procedures and provide you with a note to that effect, but I’m confident that we comply with the guide to good practice guidance.

[329] **Darren Millar:** And the description that you’ve given us today, in terms of, you know, the clock isn’t reset when a patient cancels, is accurate.

[330] **Ms A. Williams:** That’s my understanding.

[331] **Darren Millar:** That’s your understanding.

[332] **Ms A. Williams:** But I will check that.

[333] **Darren Millar:** Okay, thank you for that. If there are no further questions, that brings us to the end of the evidence session. Allison Williams, Ruth Treharne, thank you very much for your attendance. You’ll be sent a copy of the transcript, as is usually the case. Check it for factual accuracy, and the clerks will liaise with you about any additional information that you’ve said you will provide. Thank you very much indeed.

[334] **Ms A. Williams:** Thank you.

[335] **Ms Treharne:** Thank you.

10:53

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o’r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[336] **Darren Millar:** I’ll now propose, in accordance with Standing Order 17.42, that the committee resolves to meet in private for the remainder of today’s meeting and for our meeting on 5 May. Are Members content? I can see that Members are content, so we’ll go into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:54.
The public part of the meeting ended at 10:54.