Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Our programme for transforming and modernising planned care and reducing waiting lists in Wales

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Contents

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Foreword

At the start of the pandemic in Wales, we made the difficult decision to temporarily postpone people's appointments, treatments and operations to allow the NHS to focus on treating those who were seriously ill with COVID-19. Over the course of the pandemic, services have been restarted and activity restored, but the measures we have needed to put in place to prevent the spread of this awful virus and protect staff, patients and their families, have had and continue to have an impact on the number of people who can be seen and treated.

The pandemic has not gone away. Vaccinations have weakened the link between the virus, serious illness and hospitalisation but every new wave of infections results in more people with COVID-19 coming into hospital for treatment; sees NHS staff fall ill with the virus and puts new pressure on the health and care services. As this plan is being published, we have seen the highest number of COVID-19 patients in hospital since early March 2021.

The NHS has done an amazing job responding to the pandemic and rolling out our hugely successful vaccination programme, which has undoubtedly saved lives and prevented thousands of people from needing hospital care. But, unfortunately, we know the pandemic has caused wider health harms – these are most evident in growing waiting lists, and in many cases waiting times, for planned care.

This is not unique to Wales – waiting lists have grown in each of the UK nations during the pandemic. They are likely to continue growing over the coming months as people who were unable to be seen during the height of the pandemic come forward to be seen, diagnosed and treated.

We need a determined effort to ensure people waiting for appointments and treatment are seen as quickly as possible and in order of clinical priority. We have been clear that it will take at least the course of this parliamentary term to reach the levels at which we were pre-pandemic, when waiting times were falling. As we progress with this plan, we will ensure measures are in place to support those who are waiting. This is our priority and we will work with the NHS and its dedicated staff to achieve the ambitions set out in this plan.

The scale of this task after the past two years of the pandemic is significant, but we are confident that, with the incredible skills and dedication of our NHS workforce and by embracing new ways of working and technology and with significant investment in our systems, we can and will turn this around.

During the pandemic, services had to be paused to respond to the immediate demands and challenges of COVID-19 and capacity has been reduced by infection prevention and control requirements. But heroic efforts have been made by the NHS over the past two years with almost 250,000 outpatients being seen every month,1,550 elective admissions, 1,600 emergency admissions each day and more people than ever have been checked and treated for cancer.

Reducing waiting times will require new solutions and a range of actions. We will need to redesign and establish new expectations about what the NHS will do in the short and medium term, while ensuring there is wellbeing support for those who are waiting. We will do all we can to provide people with alternative options to surgery, where appropriate, and address inequalities.

This plan sets out a number of clear priorities for action over the next four years. They focus on immediate actions to release capacity to enable the NHS to see and treat more people and some slightly longer-term actions which will continue to transform the service, in line with the vision set out in A Healthier Wales.

In publishing this plan, we are making four clear commitments to people in Wales to help them access the health advice and services they need:

We will increase health service capacity:

- Better access to healthcare closer to home – to doctors, nurses, dentists, optometrists and other healthcare professionals who work together so people receive the right care from the right professional.
- Improved and timelier access to treatments and diagnostic procedures.
- Increase support for clinicians so they have more time to care, using new technology, which reduces administration and improves communication.
- Develop regional treatment and diagnostic centres to further increase capacity.

We will prioritise your diagnosis and treatment:

- Better prioritisation of treatment for those people with suspected cancer or other urgent conditions. There will be a focus on children, early diagnosis and treatment.
- Clinicians will work with you to make sure your treatment options are the best for you.
- For those people who have been waiting a long time, there will be access to a national patient information website and support services to help you get ready for treatment.

We will transform the way we provide planned care:

- More care and support will be available from a wider range of local services and healthcare professionals to help you stay well and remain at home.
- We want to make services more efficient and reduce cancellations by creating dedicated surgical facilities and separating planned care from urgent and emergency care.
- Provide local access to diagnostic procedures, with more tests undertaken at the same time.
- Transform the way we deliver outpatient services to focus on more efficient and effective services – some may be available closer to home.

We will provide better information and support to patients:

- Better information for people waiting for treatment, including greater access to personalised information.
- More help so people can decide which treatment is the most appropriate for them.
- Targeted, accessible support if you are waiting for treatment and to help you prepare for surgery.
- More opportunities for people to provide rapid feedback to the NHS, which will be used to improve services.

This plan sets out a number of key ambitions to reduce waiting times for people in Wales:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022.
- Eliminate the number of people waiting longer than two years in most specialities by March 2023.
- Eliminate the number of people waiting longer than one year in most specialities by Spring 2025.
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.

We are extremely grateful to the NHS workforce – their efforts have helped to maintain services and care for people across Wales throughout the pandemic. They will play a critical role in delivering this plan to reduce waiting times.

Eluned Morgan MS

MINISTER FOR HEALTH
AND SOCIAL SERVICES

Judith Paget

NHS WALES
CHIEF EXECUTIVE

Executive summary

Over the last two years, the focus for the NHS has been on the coordinated response to the COVID-19 pandemic, as well as continuing to respond to people with urgent, emergency and essential health conditions.

As a result, the number of people waiting – and the time people are waiting – for planned care services are now longer than ever, and the NHS faces the challenge of meeting the needs of almost 700,000 people. It is also estimated that around 500,000 referrals have not been received in secondary care services over the last two years.

Since March 2020, the total waiting list and those waiting more than 36 weeks has grown markedly. At the end of February 2022, the total waiting list was 691,885 (an increase of 235,076 on March 2020) and the number of people waiting more than 36 weeks was 251,647 (an increase of 223,353 on March 2020). It will take a whole-system effort to reduce these figures and ensure people are seen in a timely manner – just as they were before the pandemic.

Planned care – also known as elective care – is the name the NHS gives to health services and treatments, which are required following a referral from a GP or another health professional. Planned care can be an outpatient appointment, dental support, optometry treatment, mental health intervention or a surgical procedure, such as a joint replacement or cataract surgery. Appointments and treatments, including surgery, are pre-arranged and planned in advance.

This plan focuses on the planned care which is predominantly linked to waiting lists, but recognises that in other areas such as dentistry and primary care we also need a strong focus on increasing treatments and capacity.

It sets out our intentions to recover, reset and transform planned care services over the remainder of this parliamentary term. We will do this by:

- Focusing on clearing the backlog of those waiting for treatment by creating additional activity.
- Resetting the service with a focus on a value-led and efficient service model.
- Driving transformation by embedding sustainable change.

The delivery of planned care has been disrupted by the pandemic. Some services were paused to enable NHS organisations to respond to the immediate demands and challenges of the pandemic. Capacity has been reduced by infection prevention and control requirements. Waiting lists have grown significantly as a result, and are likely to continue growing over the coming months as people who deferred being seen during the height of the pandemic come forward to be seen, diagnosed and treated. This is as much the case for mental health-related conditions as for physical health.

The pandemic has exacerbated existing health inequalities and created new vulnerabilities. We must ensure these inequalities in access to, delivery and quality of healthcare services are not amplified further, but reduced as part of sustainable recovery.

New referrals for planned care have increased over the last 12 months and are back to the levels we would expect to see, but we remain concerned about the potential missing referrals. These individuals may be in pain with deteriorating conditions, which may result in serious population health challenges. We expect that those will present with their symptoms over the coming months. For this reason, we do not think that the waiting list will start to stabilise for the next nine to twelve months, perhaps longer.

We are continuing to see a greater number of people with serious problems presenting themselves in our urgent and emergency care system and this is likely to continue over the next year. Urgent and planned services are interconnected and a sustained higher need for emergency procedures will constrain capacity for planned care work.

This plan builds on the priorities within the **NHS Planning Framework** (November 2021). It is based on the vision in A Healthier Wales, the five goals for planned care and the National Clinical Framework to ensure sustainable, prudent and value based services as close to home as possible. It also further strengthens integration between primary care, community services and secondary care and between health and social care.

The aim is to accelerate health and care recovery in the short to medium term focusing on stabilising and recovering the waiting lists, whilst developing and embedding longer-term transformative and innovative change.

The goals for planned care transformation announced in September 2021 to support sustainable services are the basis upon which this plan is developed. They are:

5 **Measure what's important:** Transforming care to better meet the clinical need of the patient.

1 **Effective referral:** Ensure that referral guidance and thresholds are in place to ensure that those most in clinical need are referred to the appropriate setting.

4 **Follow up prudently:** Giving individuals more choice and control over their care.

2 **Advice and guidance:** Develop access to high quality advice and guidance to enable informed decision making for individuals as well as primary and secondary care clinicians.

3 **Treat accordingly:** Access to appropriate care at the right time at the right place.

This plan has been developed to support clinical teams within the NHS in Wales and is key in the delivery of a sustainable and modern planned care service, which operates across the whole country to support the most effective and appropriate treatment.

The plan sets out four key outcomes as guiding principles for the delivery of our recovery and transformation and these have been used to develop the seven priorities we set out within the plan.

- Equitable and timely access to a quality service.
- Modernised planned care service.
- Quality driven clinical pathways.
- Sustainable workforce.

The plan lays out a number of key objectives which lay at the heart of what needs to be achieved if we are to reduce waiting times and transform service delivery:

- **Focusing on those with greatest clinical need**
  Clinical prioritisation of the waiting and supporting those who are waiting for treatment will be the key elements of meeting this objective.
- **Increasing the capacity of the health service**
  Investing more in our services, developing and expanding capacity, a focus on local service delivery, care closer to home, where appropriate and regional centres to support high volume services.
- **Transform services to be sustainable for the longer term**
  We must build into our plans a model that is both sustainable and able to meet the needs of our future service plans. We will utilise the learning from our approach in the COVID-19 pandemic and embed new ways of working to support a modern planned care model.

The priorities to guide, support and influence our recovery planning and investment decisions are:

- Transformation of outpatients.
- Prioritisation of diagnostic services.
- Focus on early diagnosis and treatment of suspected cancer patients.
- Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities.
- Eliminating long waiters at all stages of the pathway.
- Build sustainable planned care capacity across the care pathway
- The provision of appropriate information and support to people.

The impact of COVID-19

Widening health inequalities

The Welsh Government is committed to reducing health inequalities. The pandemic has highlighted and worsened health inequalities and poor population health. Reducing health inequalities will enable more people to live longer, healthier and more productive lives. Through improving levels of general physical and mental health, the need for costly clinical interventions may reduce and in the long term reduce pressure on the NHS. How we spend money on planned care will also be an important consideration, with the foundational economy and socio-economic duty in mind. Our priority is to maximise how NHS and recovery funding is spent in Wales.

We will take a more targeted approach in the delivery of our healthcare services, for example within our screening, immunisation and vaccination programmes. Two of the biggest causes of avoidable ill health and death, and drivers of health inequality, are smoking and obesity. To tackle these and other health inequities, health bodies in Wales working with Public Health Wales will continue to promote healthier lifestyles including encouraging people to achieve and maintain a healthy weight, be more physically active and stop smoking. We will develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into our pathways. Communications, awareness raising and proactive support through clusters will be targeted upon areas and individuals with the greatest health inequality. Through delivering on these measures we will reduce the number of people who will need planned care intervention in future.

Workforce capacity and wellbeing

The health and care workforce have responded to the challenges of the pandemic, with resilience, determination and a strong sense of shared professional endeavour. They have delivered with huge energy and commitment, innovating and learning at an incredible pace, delivering treatment and care in new ways, as well as working across traditional professional and geographic boundaries.

The pandemic response has left many people within the workforce exhausted and as a result, many are reflective about the next steps in their working life. Some who were redeployed into different roles in the pandemic response are keen to return to their previous speciality or to move to new challenges. Others will have been shielding or developed long COVID or other health conditions during the pandemic and will have concerns about how they will be able to return to work in the short term. These different experiences will mean that we need to engage our workforce as we plan our recovery and reset to and understand the long-term workforce capacity, development and support they need both to recuperate and rebuild for the future.

The global competition for highly skilled health workforce is very challenging and we will not be able to recruit our way out of the challenges that we face to avoid the availability of workforce becoming a limiting factor on our delivery ambitions. We have already used our successful Live Train Work campaign to attract overseas NHS workers. We have committed to spending £262m annually to equip and train the next generation of health workers with the skills that we need to develop the workforce of the future. We will build on this work by developing a coordinated and focussed workforce plan to underpin this planned care recovery plan which builds on the foundations of innovation and change that were experienced during the pandemic response.

Primary and Community Care

Primary care services, General Practitioners (GPs), dentists, opticians and pharmacists on average undertake around 90% of all NHS activity. The primary care workforce adapted very quickly in response to the pandemic and adopted a new clinical model at pace to support those in need of care. District and community nurses have been very effective at developing and delivering new models of care. They have maintained high levels of activity over the last year seeing the most urgent cases face-to-face while undertaking more virtual activity where appropriate. Digital tools have been developed to enable remote consultations where clinically safe, resulting in a new blended model.

Primary and community care teams across Wales have adapted to new ways of communicating where clinically appropriate, including telephone and digital consultations, thereby ensuring people have access to the support they require. Cluster working successfully, ensured that urgent care was always available for those requiring it.

The **General Medical Services (GMS) Contract** agreement dated December 2021 will see significant changes to the way people access their GP services. The new Access Commitment, effective from April 2022, will build on and support a blended model of access. It will also ensure a more planned and forward-looking approach is taken to managing public need. This is a significant step towards improving access to services, a Programme for Government commitment.

The Access Commitment will require practices to adapt current systems to ensure people are able to contact them throughout the day, and advance booking of routine appointments will be available. There is a clear emphasis on individual need being met at the first point of contact, although not in a clinical sense, but rather that people will be informed of their next step, without the need to contact their GP practice on multiple occasions.

Many of those on a waiting list will return to their GP on a number of occasions for additional help and support. Clinicians are noting that people on waiting lists may experience worsening conditions, and primary care services are having to provide extra support to those whilst they wait. We have introduced e-advice; this new functionality allows primary care to e-mail the specialist team and access immediate advice about how to treat the individual. This will support the GP's decision-making and the care they are able to provide.

Our longer-term strategy is to develop an effective approach to referral management with clear end-to-end pathways that enable primary and community care to effectively support and manage patients with access to a wider range of care closer to home. Our aim is for people to only go to a district general hospital if this is the right thing for them.

Working with professionals in primary and community care, health boards will need to develop a communications strategy that will support those whilst waiting, in managing their conditions or in advising them about their conditions and expectations about their waiting times. Communications nationally and locally will also focus upon encouraging these individuals to seek help if they are unwell[1].

Dentistry is a complex area of primary care as the nature of treatment means it requires enhanced infection control measures. We are making steady progress with recovery of dental services and as dentists respond to new ways of working, activity is still 50% compared to the same period pre-pandemic. Necessary public health measures mean fewer people can be 'seen' in a session. Priority is being placed on those with highest risk and needs, this includes children who are in high risk groups, particularly those from disadvantaged socioeconomic backgrounds. More routine care will be provided as we move through recovery phases where throughput is able to increase safely and provide services in the community to support people's needs closer to home.

People at greatest risk of sight loss and irreversible harm have continued to be seen and treated by optometry services throughout the pandemic. The use of technology has allowed clinicians to virtually review and provide treatment in a safe and timely manner. The reform of current service models and contract presents an opportunity to develop and implement innovative changes reflecting the agreed future approach for eye health in Wales. The new optometry contract will include both 'core' and 'enhanced' service provision. This allows high street optometrists to provide services that go well beyond eye tests and will help us to reduce our optometry waiting lists by a third.

The focus will be on delivering more services in the community so people do not have to travel to a hospital and this means professionals in the community and in hospital eye departments are able to work at the top of their licence. Work is already underway to train more 'independent prescribing optometrists' to treat a range of conditions instead of referring people to their GP for an appointment. This will provide further opportunities for treatment in the community rather than travel to hospital.

Community pharmacy services will continue to be promoted as an alternative to visits to urgent care services. They will play a vital role in supporting patients who may be already on a waiting list or require onward referral.

CASE STUDY

All community pharmacies in Wales are able to offer an extended range of services via a national clinical community pharmacy service, including treatment for common minor ailments, access to repeat medicines in an emergency, annual flu vaccination, and some forms of emergency and regular contraception

1 https://primarycareone.nhs.wales/topics1/strategic-programme/

Allied Health Professionals (AHPs)

During the pandemic, Allied Health Professionals (AHPs), such as physiotherapists, occupational therapists, podiatrists, paramedics and speech and language therapists have worked together in multi-professional teams, adopting new digital ways of working, to deliver the highest quality of care and improve health outcomes. We want people to have more opportunity for direct access to a wider range of AHPs in the community without the need to be referred by another health professional.

Strengthening telephone and e-advice services during the pandemic has also provided better communication between primary, community and secondary care, allowing people to be managed closer to home and providing access to diagnostic tests and specialist advice for primary care colleagues.

People are experiencing delays in their planned reviews for long term health conditions. More collaboration between professionals in our communities at cluster level will make effective use of everyone's time and expertise in delivering timely care and support for people to manage their condition and stay well.

Mental Health

Evidence suggests that levels of depression and anxiety have increased during the pandemic and remain higher than pre-pandemic estimates[2]. The impacts have not been felt consistently across all groups, and have disproportionately affected those with pre-existing mental health conditions, young adults, Black, Asian and Minority Ethnic communities, those in lower income households and women. Children and young people's mental health and wellbeing has also been particularly impacted.

Mental health services were classed as essential services during the pandemic and overall, there is evidence of a suppression of demand across mental health services in Wales during the period of the pandemic. There was a surge in demand post lockdown which has led to increased waiting times and service pressure. Specialist services, especially those supporting young people with eating disorders, have seen a very high number of referrals coinciding with a return to school for most children in Wales. There have been indications from services across the country of increased complexity in some presentations, not just with mental illness and disorders but also with accompanying social and emotional health issues.

There is a broad consensus that there is likely to be a longer-term impact on the population of mental health and increased demand for mental health services. That is why the Welsh Government spends more on mental health than any other aspect of the health service – around £760m each year. Delivering on our Programme for Government commitment we are also investing an additional £50m rising to £90m in 2024/5 to support mental health. This investment will support mental health services but also boost prevention and a de-medicalisation of our approach to mental health where appropriate. We will continue to fund this important service but will ensure that where appropriate we de-medicalise our approach to mental health services.

Increase in the number of people waiting for treatment

There are now significantly more people listed for outpatient appointments, diagnostic and treatment services than before the pandemic. Waiting lists are at their highest levels ever recorded. Over 60% of people on the waiting list

2 https://gov.wales/sites/default/files/publications/2020-10/technical-advisory-cell-coronavirus-covid-19-and-health-inequalities.pdf

are waiting for their first outpatient appointment. The specialities, which have the greatest number of people waiting, are trauma and orthopaedics, ophthalmology, ear nose and throat (ENT), general surgery, urology, gynaecology and oral surgery.

Outpatient activity has continued throughout the pandemic and clinicians have been very effective at using new technology to support individuals and to manage their conditions. Despite this, there is a significant number of people who have waited over a year, with some waiting over two years, since their original referral. Infection prevention and control requirements and staff availability mean that, across Wales, outpatient activity is below levels we used to undertake. Levels of planned care activity have been markedly lower throughout 2020 and 2021 when compared to historic levels.

The delays in outpatient appointments, diagnostic tests and surgery have a direct impact upon those waiting and their families and carers. Delays are of greater relative significance in young children. Longer waits are resulting in existing conditions worsening. It is hard to quantify the extent of that harm, however clinicians are reporting examples including people presenting with late stage cancer, more complex cataracts, and people who were walking with a stick now needing wheelchairs. Delayed presentations may result in increased emergency activity and the need for more complicated procedures, which may result in more admissions to critical care and longer lengths of stay. There is also evidence that long waits for health interventions are resulting in increased emotional and mental health concerns amongst those waiting. This means that required interventions can be far more complex, outcomes may be potentially worse, and recovery could take longer.

Long waiting times also impact upon the way people live their lives. They may make it hard for people to live independently, travel, exercise, work or even leave the house. We will support people while they are waiting, helping them to keep healthy and well.

Long outpatient waits carry risk to people in two areas: firstly, these people are largely “unknowns”, relying only on a referral letter with limited supporting diagnostic information. There is, therefore, a risk that these people may need urgent treatment. Secondly, people report that uncertainty about diagnosis is adding to the stress of waiting. A focus on outpatient and diagnostic stages will help to alleviate this uncertainty for people, and manage the risk of further harm.

Urgent and emergency care

Access to urgent and emergency care has changed rapidly during the pandemic so that people continue to be treated safely. Reconfiguration of hospitals to ensure bed spacing and physical distancing to keep people safe, and prevent transmission of the virus, have reduced capacity in emergency departments and hospitals as a whole.

Critical care services expanded quickly to respond to COVID-19. Additional beds, ventilators and oxygen provision were required to meet demand. Bed capacity expanded from the baseline position of 152 critical care beds to in excess of 300. To meet this requirement, other hospital areas such as theatres were converted into emergency critical care environments, but have now ceased to be used for this purpose. To support senior critical care colleagues, staff redeployed from other service areas were moved and upskilled.

Response times for ambulances, and handover delays have been affected by the need for ambulance staff to put on personal protective equipment, increased staff sickness and absence, as well as the necessity to deep-clean vehicles once they have transferred.

The reset of planned care and the delivery of efficient urgent and emergency care services are inter-connected. One cannot be achieved without the other. Urgent and emergency care, critical care and cardiology departments amongst others are seeing increased demand as a direct consequence of the long waiting lists. Planned care services are unable to respond due to limited bed availability due to the delays in discharging urgent and emergency cases.

Social care

The pressures on social care staff have been immense over the last two years and it is anticipated that this will continue. They have played a critical role in the frontline response to COVID-19 by continuing to provide support to the most vulnerable in the most challenging and unprecedented circumstances. This renewed focus on the social care workforce has re-emphasised the different experiences of health and social care workers as professionals, together with the need to ensure that greater parity in reward and esteem between health and social care workers is achieved.

COVID-19 has also had adverse effects on the wellbeing of older people in care homes. The mobility and circulatory conditions of older people have deteriorated in lockdown, along with increasing accounts of loneliness and depression, with little access to routine health care, such as wellbeing support for people with mental ill-health, dementia or cognitive needs; access to dietetic or speech and language therapy, podiatry, physiotherapy, occupational therapy and rehabilitation, recovery or re-ablement. Many care homes have, at different times, struggled with severe staff shortages either though sickness or staff needing to isolate to reduce the risk of onward transmission of the virus.

Significant pressures on the social care system are impacting on timely discharges from hospital and the availability of care at home. This can also impact on the support available for recovery and rehabilitation after surgery. From 1 April 2022, we will be introducing the Real Living Wage to social care workers which will help with retention and attracting people to work in this essential service.

Transformation of outpatients

Why are we doing this?

Each year there are around 3 million outpatient appointments in NHS Wales. They are undertaken by clinical specialists for examinations, to undergo treatment, have a medications review, or to receive the results from diagnostic tests.

The reason for an outpatient appointment is varied, but it needs to be clinically appropriate. Traditionally they are characterised by a visit to a hospital or more recently a virtual review to see a clinical team in a pre-arranged location and time for a clinical review.

The majority of first outpatient appointments are triggered in response to a request from a GP or other health professional in primary and community care to help with diagnosis, either because more specialist advice is needed or because primary and community care colleagues need access to specialist diagnostic tests.

Increased waiting times, delays in follow-up appointments and public feedback clearly show that the traditional model for delivering outpatient services does not meet people's needs or expectations.

International healthcare research has shown that while a great deal of outpatient consultations are adding value to the delivery of care; there is also a proportion, which are not. "**A Healthier Wales**", the Welsh Government strategy for the delivery of seamless health and social care services, is quite clear that people should only go to a hospital when they need care, advice or services which cannot be delivered elsewhere. We will seek to use health economics / value in health as methods to measure efficiency and quality in healthcare to look at whether activity is appropriate and where people can best be diagnosed and treated in community based services.

Through innovation and flexibility, new approaches have been incorporated into outpatient services during the pandemic demonstrating the pace at which transformational change can be achieved. It is now time to embed transformational change into a sustainable delivery model that will improve care and outcomes in the future.

What we want to achieve

The traditional model of outpatient services has to change. People should no longer need to see a consultant for advice or reassurance, services must look at supporting colleagues in primary and community care in different ways. This can be done by using new testing technologies (diagnostics) to rule out common complaints and provide advice earlier in the patient journey.

This would create capacity within secondary care to accommodate the more specialist work, and would create more flexibility in primary and community care to give clinicians the information and treatment options that they and their population need.

Support for people must be made available and services need to be delivered and designed in conjunction with the needs of the individual and population rather than the needs of NHS organisations. We are accelerating arrangements for local health and care professionals to come together to plan to deliver a wider range of community based and coordinated health and care services.

How we will do this

Advice and guidance
We will introduce a system to provide efficient, integrated e-referral and e-advice to manage care. Better-enabled communication, advice and guidance provided to primary care with access to consultant advice on investigations, interventions and potential referrals. This will enable the management of non-urgent cases in the most appropriate setting, helping reduce unnecessary referrals into secondary care.

Effective referral
A national approach to develop co-produced pathways will be implemented. This will be supported by a digital interface, which will be responsive to the needs of services and individuals in order to maximise outcomes, and avoid unnecessary appointments. Initial focus will be on the ten highest demand conditions. Our focus will be on person-centred care closer to home, by the right clinician at the right time and minimising the avoidable delays to treatment.

Integrated clinical pathways will be implemented, to reduce referrals with little or minimal benefit to the patient.

Immediate roll out of national pathways
See-On-Symptom (SOS) and Patient Initiated Follow-Up (PIFU) as an alternative to face-to-face follow-ups will be rolled out as a priority. SOS and PIFU will reduce the number of low-value contacts, release clinical capacity to deliver services to those who need it most and reduce waiting times.

The initial focus will be the development of SOS and PIFU pathways and resources in the ten specialties with highest demand and greatest delays. It is anticipated that 20% of all outpatient reviews will have an outcome of SOS or PIFU.

Harnessing digital technology
The pandemic has accelerated adoption of digital technologies to reduce the need for face-to-face contact to deliver safe care through virtual appointments where clinically appropriate to do so. We will work towards accelerating the embedding of virtual approaches and offer telephone and video appointments so that 35% of new appointments and 50% of follow up appointments are delivered virtually.

We will maximise the benefits of video consultations and group clinics, focussing on the highest demand specialities and adapt the model to deliver virtual joint schools and virtual surgery schools, supporting people to prepare for treatment and maximise their health outcomes and recovery.

In doing this we will make provision for the digitally excluded to avoid exacerbating inequalities, by setting up virtual centres in rural communities to prevent people having to travel to hospitals.

We will explore other means of telemedicine to build on existing models that allow the remote diagnosis and treatment, without the need for attending a hospital setting.

Waiting list management
Prior to 2020, demand for outpatient services was increasing at an average of 4% per annum whilst capacity remained unchanged, leading to longer waiting times and delays in both treatment and review.

Those that have been waiting for a long period are at risk of harm; those waiting for an initial consultation may be at greater risk as often the only means of triage is the referral letter. We will seek to identify and prioritise the clinical needs of those waiting and focus on those in greatest need, ensuring they are seen first and consider the specific needs of children.

We will focus on those categorised as urgent and those who have been waiting the longest. We will ensure access to evidence based interventions in primary and community care, to enable people to actively maintain their health and abilities while waiting.

Follow up prudently
As innovative ways of delivering services are embedded, where clinically appropriate it is intended that discharge will become the default position for post-treatment.

We will maximise the use of alternative pathways to avoidable low-value routine follow-ups such as SOS, PIFU and self-management.

Virtual appointments will be offered where reviews are clinically indicated with face-to-face follow up offered based on clinical need.

Self-management
We will build on established self-management models as a core component of person-centred care providing information and education to support and empower people with long-term health conditions to understand and manage their own health and wellbeing effectively.

We will support the effective navigation around the health system through digital platforms for patients, to increase people's confidence and ability to self-manage conditions.

This will reduce the number of face-to-face follow-ups and the number of presentations in primary care as people become more confident and know how to cope with and manage their symptoms, and navigate the system effectively.

CASE STUDY

Prostate cancer patients in North Wales can now review their blood results online as soon as they are available thanks to the implementation of a new remote Prostate Specific Antigen (PSA) tracking programme. Following treatment for prostate cancer, patients require regular PSA blood tests between three, six and 12 months to monitor their progress. In a new digital approach to aftercare, the blood test taken by the GP or hospital is now automatically loaded into a PSA tracker system, which is checked by Urology nurses. The tracker system helps the clinical staff to monitor the results of regular PSA tests and recall patients quickly to hospital if they are concerned. Those who have PSA levels that are normal will not be followed up with an outpatient appointment at the hospital. Patients can access their blood results through the tracker and speak directly with one of the nurses if they have any questions.

The prioritisation of diagnostic services

Why are we doing this?

Diagnostics are an essential component of nearly all pathways and provide the evidence base upon which clinical decisions are made. Diagnostic capacity in NHS Wales does not currently meet the demands on the service.

COVID-19 has acutely exacerbated pre-existing service fragilities, and diagnostic throughput is slower due to increased infection prevention and control measures. Backlogs across NHS Wales are currently at a substantial level with the number of people waiting for diagnostics standing at 106,723 in February 2022.

It is anticipated that there will be a latent backlog of people who have yet to be referred for diagnostic tests or who will require repeat testing due to delays in other parts of the pathway. This will further escalate the number of people on waiting lists, and will place additional pressure on an already fragile system.

What we want to achieve

We need to build capacity. More equipment, new facilities and expansion of the diagnostic workforce will be critical if we are to provide an effective and efficient planned care service.

Diagnostic services need to be planned and delivered differently. Currently, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way, for example diagnostic hubs and community provision. Digital connectivity and appropriate use of artificial intelligence assisted workflow will be important in transforming services.

We will build on the work already in place, for example - developing business cases for Community Diagnostics Hubs (CDHs) or other diagnostics centres, whilst ensuring the overall provision across Wales is optimal.

How we will do this

Leadership
We will form a Diagnostics Board. The board will bring together key partners from across the NHS and Social Services, and will have delegated authority from the NHS Wales Leadership Board to provide direction on all diagnostics related matters including service models and allocation of available resources. The board will use input from national programmes such as Imaging, Pathology and Endoscopy and agree a holistic diagnostics approach for Wales.

Planning
We will use the existing Integrated Medium Term Plan (IMTP) process to work with health boards to prioritise diagnostics and identify the gaps in demand and capacity at a local and national level.

Short Term Capacity
'COVID-19: Looking forward' recognises diagnostics services require significant support to recover post pandemic, and substantial funding will be required to secure short-term capacity if we are to avoid further growth in the demand backlogs

We will take forward the proposal developed by the Imaging Programme to lease staffed scanners and associated reporting, and deploy these across Wales to get the number of people waiting and waiting times to pre-pandemic levels as soon as possible.

Delivery Model
We will mandate the National Diagnostics Board to review pathways in order to reduce unnecessary tests and support professionals to work at the top of their licences.

The Board will develop proposals around long-term capacity needs and identify the most appropriate delivery methods to support sustainable service transformation.

Community Hubs
The Richards Independent Review of Diagnostics Services (October 2020) pointed to the need for investment in equipment, facilities and workforce, with Community Diagnostic Hubs established away from acute hospital sites. This model of hub provision has broad support from professional bodies (e.g. British Medical Association (BMA) Wales and advocated for increased access to diagnostics, in their letter to Welsh Government in May 2021). We will establish a network of local community hubs to co-locate frontline health and social care and other services. These will provide a consistent approach to support health checks for people in deprived areas and potentially detect health issues that can be treated to prevent the conditions worsening.

CASE STUDY

Investment in a new MRI scanner at Princess of Wales Hospital provides greater comfort for patients and superior image quality, as well as reducing the time it takes to perform a scan. This means they will be able to see and diagnose more patients earlier. The AIR™ Recon DL package is a pioneering, deep-learning based reconstruction algorithm applied to the raw scan data to improve Signal to Noise Ratio (SNR) and image sharpness. The team at Princess of Wales is also the first in the UK to install a TELEMED projector system. Ceiling tiles above the scanner have been swapped for illuminated panels made up of blue sky, cherry blossom and sunshine to help patients relax. This system brings great benefit to patients, particularly those suffering with claustrophobia and young paediatric patients.

Focus on early diagnosis and treatment of suspected cancer patients

Why are we doing this?

Each year around 165,000 people in Wales are referred with a suspected cancer. Over 90% will not have cancer, but the impact of waiting for a cancer diagnosis to be ruled out or confirmed is one, which causes untold anxiety and stress to the individual and their families. Evidence shows that delay in diagnosis leads to poorer outcomes for cancer, and often more complex treatment options.

Wales is facing some of the most difficult and challenging times for cancer. Some cancer services, including cancer screening, were paused for a very short period at the very start of the pandemic. A significant reduction in the number of suspected cancer referrals was noted at the beginning of the pandemic as patients decided not to come forward to "protect the NHS", but also due to fear of becoming exposed to COVID-19 themselves.

It is estimated that about 4,500 fewer people were diagnosed and treated for cancer than we might have experienced based on previous years. However, people are now presenting with suspected cancer at a higher rate than we have ever experienced. We are treating more people each month than any previous recorded years. More people are also now presenting as an emergency, and some are presenting with more advanced cancers.

The system was struggling to cope pre pandemic with suspected cancer referrals and subsequent diagnostic tests rising at 10% year-on-year. Now with current infection control measures and workforce challenges, it does not have the capacity to deal with the current demand. The cancer workforce is a combination of generic primary and secondary care teams, but also highly specialised imaging experts and surgical and non-surgical specialists, and the pandemic has also exposed the fragility of the cancer workforce in terms of recruitment, age profile, and importantly retention of this clinical group.

The impact of all of this is showing in our cancer waiting times, which are at their worst since reporting began. Many people are waiting far longer than the target 62 days from the point that cancer is suspected, to the time they have their first definitive treatment.

What we want to achieve

We want to explore, test and embrace new ways of working, some of which we learned through COVID-19 and others, which will be new. We want to change the way the system works so we can actively move people through their cancer pathway so that we maximise early presentation, diagnosis and treatment. This will drive improved recovery from cancer.

Cancer pathways need to remain person centred, so that people are well informed, supported, and receive holistic and personalised care. The approach will support keeping people as engaged and as well informed as possible and encourages and enables them to be as fit as possible for their treatment. In line with our ambition to deliver Prudent Healthcare, our approaches to true co-production and meeting people's needs will need to improve, with self-management and digitised solutions to care where this is appropriate.

Our approach for cancer recovery focuses on the backlog of those who are waiting too long on their cancer pathway, but also works towards a more sustainable approach to transformed pathways and ways of working which will deliver more robust, efficient, and timely pathways and services for future cancer care.

Our cancer waiting times need to improve. It is recognised that cancer is not a single disease and some tumours require far more urgency than that of others. However, we must develop the capacity in the system to be able to investigate, treat and support them all in a timely way.

How we will do this

Communication with the public and encouraging those with need to come forward
We know that many people did not come forward during COVID-19, however referrals are starting to exceed pre pandemic levels. We will continue to promote key messages about cancer symptoms and encouraging people to come forward with suspected cancer. This will include joint working with NHS England on the roll out of cross-border public information campaigns where appropriate. We will ensure that people understand that they are on a suspected cancer pathway, and what to expect next and when. They will receive information and support to help them make better decisions and to stay well whilst they wait and optimise their health.

Embedding optimal pathways for cancer
Evidence shows that reducing variation using agreed and evidence based patient pathways can reduce avoidable delays. People move through a series of appointments, investigations and treatments as they progress through their cancer journey. We will streamline these pathways, minimising the number of visits someone must make and coordinating tests into bundles that can happen together. This includes personalised patient-initiated follow-up pathways for cancer, which are already offering more personalised care for breast, colorectal and prostate cancer patients. The agreed National Optimal Pathways (NOPs) now cover approximately 70% of cancer incidence in Wales and we will focus improvement in compliance with these. Focus on the high-volume cancers will not be at the expense of all other cancers.

Focus on getting the first outpatient appointment as early as possible
Wherever possible, appropriate multi-disciplinary staff should be empowered to request and progress the patient pathway according to pre-agreed protocols. Gold standard pathways will combine first clinician review (usually first outpatient appointment) with as many diagnostic results as possible. To minimise time to diagnosis and first definitive treatment, first outpatient contact should happen within 10 days of the point of suspicion.

Rapid diagnostics to support early detection and diagnosis of cancer, and support straight to test and one stop clinics where possible
We will streamline the diagnostic part of the pathway to drive efficiency and access. Revision of working arrangements, and the ambition to deliver extended hours across seven days through a flexible approach to job planning will be required to support hot reporting which will be essential. Investment in artificial intelligence and digitisation of services such as cell pathology will support efficiency and protect clinician capacity. The opportunities afforded by joining up diagnostic services in a regional or community diagnostic centre are significant for the early detection and diagnosis of cancer and we will establish two centres this year. These centres will enable us to deliver bundles of tests in a single appointment, with a potential to ring-fence the facility for cancer and planned care cases only.

Improving access to treatment
The ability to separate lower acuity cancer pathways from emergency centres can improve access and reduce risk of cancellations. We will ask health boards to further explore planned care diagnostic and treatment sites, where appropriate including regional solutions for green sites. Amended treatment regimens which were developed during the pandemic will continue to be used where clinically appropriate, resulting in reduced hospital visits, reduced inpatient stays, and released capacity.

CASE STUDY

The South West Wales Cancer Centre, from Spring 2022 will offer Stereotactic Ablative Radiotherapy (SABR), a specialist technique to cure early lung tumours, which is more effective than standard radiotherapy for early stage lung cancers. The precision and accuracy of the SABR technique allows a safer lower dose to be delivered to normal tissue surrounding the tumour. This means potentially curative treatment can be offered to some patients who otherwise would not be able to have treatment for their lung cancer due to their other medical illnesses. As well as avoiding the need for much longer journeys to Cardiff, the availability of SABR means the number of radiotherapy sessions for suitable patients will be between just three and eight, rather than the 20 using conventional radiotherapy. The outcome for patients using SABR is as good as for those who had undergone surgery, but was less invasive and with a quicker recovery time. The South West Wales Cancer Centre has also trialled and implemented a revolutionary new approach to treating breast cancer, reducing the treatment from 15 days to just five

Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities

Why are we doing this?

Clinical need, in particular cancer care, has always taken priority on the use of health care resources. This approach, through the use of triage, has been long established. It continued to be the main guiding principle during the pandemic and this has had a significant impact on waiting lists, with clinically non-urgent individuals in particular seeing their waiting times increase considerably throughout the last two years.

It is important that clinical teams continue to focus on reviewing and treating those in most clinical need first. NHS Wales has utilised a risk-based approach to prioritisation for surgical interventions. This was based on clinical guidance from the Royal College of Surgeons of England and now managed by the Federation of Surgical Specialty Associations.

We recognise that people waiting too long continue to experience pain and symptoms, and need ongoing advice and support. Without available treatment, this will continue to be provided from primary care, putting additional strain on our primary care services.

As we reset our health service we need to recognise that conditions that are deemed clinically non-urgent will impact on lifestyles in a way that risks increasing inequalities, for example isolation, inability to work or provide care, higher risk of trips and falls. Our approach must consider what matters to people and outcomes across the whole system.

Whilst secondary care clinicians have reviewed their waiting lists over the last 18 months to manage immediate risk, this is not a substitute for treatment. Many people will have seen their conditions worsen during their long waits. In addition to this, individuals will decompensate and become less fit if they have limited mobility as a result of their untreated condition. This is likely to lead to worse surgical outcomes, increased admissions to critical care and longer inpatient stays. Because of inherent risks in lengthy waits, most people listed for surgery are likely to need re-assessment, adding to the demand on secondary care. Access to prehabilitation and strengthening programmes will help overcome this.

Outpatients are a particular concern. There are many urgent outpatient referrals that have been waiting for over two years for a review and there is considerable concern that the size and length of waits for outpatient reviews may include unmet urgent and cancer demand. 60% of people on the waiting list are waiting for a first outpatient appointment.

What we want to achieve

In April 2021, NHS Wales agreed on a consistent, national approach to review outpatient waiting lists. The purpose of this was to firstly, make contact with those and to reassure them that they were not forgotten. Secondly, it was to understand the health status of the individual and to determine whether their symptoms have deteriorated which may indicate the need for an earlier review. Finally, it was important to determine whether an appointment is still needed, as they may have had further treatment from primary care, private providers, pharmacy or their condition had improved.

We will continue to prioritise those with life threatening conditions ensuring the most seriously ill are seen as quickly as possible.

How we will do this

Ensure accuracy of waiting lists
The current waiting list needs to be constantly reviewed and validated to ensure that the list is accurate and up to date through administration validation. This must not be a one off validation exercise at the end of the year, but something that is automated and happens every day.

Subsequent clinical validation is also vital to ensure that urgent cases are identified quickly and accurately. This will also help to identify alternative pathways for primary care clinicians in need of immediate advice and guidance.

Ensure that children's services are prioritised
Waiting times for children must be considered differently to waiting times for an adult, as the illness will represent a higher proportion of a child's whole life and potentially have permanent long term impact on growth and development. We will ensure that children's elective care is prioritised, as we respond to the needs of each child. Waiting lists can now be measured by age allowing the recovery of children's health services to be managed effectively with their needs considered separately from those of adults.

Focus on clinically urgent
We will develop and embed a consistent approach to clinical validation to determine those with higher risk of harm. This approach will identify those with the most urgent conditions to ensure they are diagnosed and treated as quickly as possible.

Review the national referral to treatment (RTT) guidance
The national guidelines for RTT were written and implemented in 2009. Much has changed since then and there are many examples in the current guidelines where less urgent cases may be prioritised over those most in need. We will review these and ensure that they support effective clinical decision making across the whole system, including advice and guidance to primary care.

Additional treatment options, including through community based multi-professional teams, self-management and group clinic approaches need to be acknowledged to move away from the current binary "surgery or not" view.

For many, referral onto a 26-week pathway may not be the optimum option and we will seek to implement component waiting times as part of our approach to waiting list management.

Referral refinement
Primary care have the option to grade an outpatient referral as one of three categories: suspected cancer, urgent and routine. We will review outpatient referral categories and consider whether a different referral approach

may be more effective in supporting individuals, primary care and clinical teams

Eliminate unwarranted clinical variation
Clinical outcomes combined with patient reported outcomes clearly indicate that not all services are operating at the same levels.

Utilising the National Clinical Framework and our Clinical Networks we will review and challenge unwarranted clinical variation.

Treatment thresholds
Simply reviewing and redefining treatment thresholds such that people are turned away from secondary care without further options to support primary care colleagues does not meet either the individual or clinical need.

In line with the National Clinical Framework and the move to treating people closer to home, we will need to provide funded and staffed treatment options within a primary/community setting.

This is part of developing a whole system approach to personalised care. Working through our clinical boards and clinical networks with multi-disciplinary input from primary and secondary care colleagues we will review referral and treatment thresholds for the top 10 most commonly referred conditions into secondary care.

Health inequalities
As our system is reset, it is important that no one is left behind and that everyone is able to access health services regardless of their characteristics in line with clinical need. Working nationally and locally, further analysis of the waiting list needs to be undertaken to ensure that we really understand variations in access not only from where a person lives but also by their relevant characteristics such as their age, ethnicity, sexuality and condition. This will support better planning and allocation of resources to ensure that activity is based on clinical need.

CASE STUDY

In response to patient need, Aneurin Bevan University Health Board has implemented a new pathway for patients who require remotely programmable hearing aids. Previously patients would have three booked face to face appointments – initial assessment, hearing aid fitting and follow-up appointment and ongoing reassessment, follow-up and repairs. The new process requires one booked appointment for hearing test and fitting. There are virtual appointments pre and post clinic and ongoing support via phone triage. This has increased the focus in terms of patient education and self-help. The use of Attend Anywhere helps with lip reading – particularly as no PPE was required. The BeMore app integrated in this pathway allows patients to make small adjustments to the setting on their aids, use GPS to set up favourite programmes in certain locations, adjust the volume, reduce wind noise and background noise as well as adjust the bass and treble. For tinnitus patients they could adjust the tinnitus calming sounds or switch them off. The use of this app significantly reduced the need for face to face follow ups as patients were able to make small changes to settings and from patients feedback increased/enhanced their hearing aid use.

Eliminating long waiters at all stages of the pathway

Why are we doing this?

A planned care pathway known as Referral to Treatment (RTT) consists of four stages, new outpatients, diagnostics, decision to treat, and treatment. During the pandemic not only has the total number and length of pathway waits increased, but also the number and length of waits at each stage. We have too many people waiting at each stage of the pathway and this is causing us great concern as we are unable to quantify what harm people may have come to whilst on the waiting list.

However, historic approaches to reducing waiting list volumes and waiting times have not provided a sustainable solution and given the nature of the activity they are time-limited and can be very expensive.

A critical factor to support effective treatment is to identify as early as possible what if any treatment is required. Early diagnosis reduces unknown risk and provides patients earlier information on their options, and clarifies urgency of treatment requirements.

What we want to achieve

The immediate focus has to be the reduction of the waiting list so that we minimise the impact of the pandemic on outcomes. This will not be easy and in some specialities, it may take many years to recover our waiting list position.

NHS organisations will need to approach this through a combination of the following:

- Delivering evidence based treatments that add value.
- Additional sessional work at weekends and evenings.
- Partnering with the independent sectors to develop new approaches and models of care.
- Regional options which will allow protected planned care capacity at a higher volume than traditional hospital based theatres.
- Consolidating urgent and emergency services to free capacity for planned care.
- Transformation and introduction of new models of care at practice, cluster, hospital and health board level.

CASE STUDY

The waiting times for cataract operations in Cardiff and Vale University Heath Board have grown considerably, with waits over two years for many patients. Funding from Welsh Government has created two new theatres with an admission/discharge area to run high volume cataract surgery, treating between 16 and 20 patients a day.

How we will do this

Patient communication
Health boards need to provide patients with the options and choices that are available to them. The intention is to provide as much care as close to home as possible. However, if we are to make rapid improvements to the waiting lists, and consolidate best practice, then some people may need to be treated at a different site and travel further than they traditionally had to. Evidence shows that high volume surgery centres provide better outcomes for people. These changes are likely to be permanent and we need to be clear about the changing face of surgical centres with our population.

We will engage with those people waiting for treatment to discuss whether the planned intervention is suitable, noting that things may well have changed since they were added to the waiting list. Those waiting 52 weeks or more will be reviewed every six months or more frequently depending on their clinical needs until they are treated or discharged.

We will seek to set up communication hubs to support people accessing the information and support they need to understand their waiting times and what they need to do in case their condition worsens.

Validate waiting lists
Our waiting lists are not as accurate as we would like. Some patients may be on duplicate pathways, some will have had treatment, or have been discharged and changes may not be updated on the lists. Our starting point has to be to ensure that our waiting lists are as accurate as possible.

Focus on activity and performance
We will set some clear targets for improvement, working with health boards to understand the operational requirements to deliver this plan. We will use data to track weekly progress through weekly situation reports. This will ensure immediate action should activity dip.

Utilise entire clinical teams and wider estate
A clinician has historically undertaken clinical reviews. During the pandemic, the wider team have been utilised in different ways. We will seek to ensure that clinical reviews are undertaken by wider multi professional teams including primary and community care to increase the availability of resources, and provide care closer to home.

Outsourcing, insourcing and commissioning
Our biggest challenge in increasing short-term activity is the availability of the workforce and the physical capacity to undertake the work. We will seek to utilise the private sector where

appropriate, undertake additional insourcing and extra lists within our clinical teams. Whilst not part of our longer-term intention, we recognise the need to utilise all available capacity to support reducing waiting times and offer equitable access for all patients in Wales whilst we seek to build longer term sustainable solutions.

Regional approaches

Resources and demand are not always equitable across health boards. We will introduce regional and wider models of care to ensure equitable access. This may involve regional waiting lists, the transfer of patient care across health board boundaries, central hubs that offer those waiting a long time a more suitable appointment or the national commissioning of services.

We will seek to support health boards with specific challenges in a particular area. This may be through mutual aid with clinical teams supporting remotely, or clinical teams moving.

Access to rehabilitation, social prescribing and recovery services

Access to therapeutic services, rehabilitation and social prescribing is essential for the completion of appropriate treatment and care and for improving outcomes in any health service. We will build capacity through new ways of working and expansion and utilisation of the AHP workforce.

Build sustainable planned care capacity

Why are we doing this?

Planned care capacity has struggled to meet the demand for care for many years. The challenges we face now are not new and have been worsened by the pandemic. As we recover our waiting lists, it is not enough to get back to the pre-COVID levels of activity, we need to fundamentally transform our system and ensure we have sufficient capacity to meet the needs of our population in the future.

What we want to achieve

This is the opportunity to radically transform the way services are designed and delivered, ensuring that the best possible outcomes are achieved. It will be important to separate emergency care away from planned care, securing dedicated capacity. We need to plan how we can ensure the delivery of planned care over 52 weeks, seven days and 15 hours a day to maximise throughput in a sensible and sustainable manner.

How we will do this

Ring fenced dedicated capacity
Demand for planned care services does not stop over the winter months, however we traditionally have seen significant drops of activity in the winter. The demand for unscheduled care resources, usually beds, outstrips the allocated capacity and the clinical need dictates that resources are moved from planned care. We will plan for planned care to be managed on a 52 weeks, seven days and 15 hours a day basis.

Eliminate variation in activity to deliver efficiencies
We know that not all services operate to the same level of productivity and that there is considerable variation across the system.

We will work to manage this variation whether it exists in theatre productivity, day case activity or start and finish times, and increase activity for certain procedures to levels recommended by Royal Colleges.

A review of clinical services will be undertaken to identify areas of unwarranted variation, comparing locally, nationally and with trusts in other UK nations. We will work with NHS organisations to ensure those recommendations are implemented.

Regional working and treatment centres
Some services need to be regionally planned and delivered. This approach allows NHS organisations to support others by understanding what the demand and capacity is across a region and agreeing how best this can be delivered.

We will develop a network of regional clinical teams and centres flexibly to meet local demand. For some services, treatment centres or centres of excellence may be the best option. The development of green or cold sites will be considered for many routine procedures, which may mean that people will have to travel to access care in another health board. We will ensure that those with travel challenges receive the support they need to access their care.

Prehabilitation starting on referral
It is essential that we maximise everybody's fitness for surgery to ensure the best outcomes.

This will reduce cancellations on the day and allow theatres to operate at full capacity. We will develop and embed a standard prehabilitation approach to improve outcomes and we will utilise Patient Reported Outcome Measures (PROMs) to support this.

Supporting referral for early diagnostic test

We will identify pathways where diagnostics are best undertaken prior to a referral to streamline the patient journey.

Streamlining pathways

Many of our pathways are over-complicated and it is difficult for individuals to understand where they are in their pathway and results in multiple appointments on different sites. Our pathways need to be streamlined to remove unnecessary steps and where possible move to a one-stop shop approach to reduce the number of appointments needed.

CASE STUDY

During the pandemic, the Cardiac Rehabilitation Service at Cardiff and Vale University Health Board became a virtual service and feedback has highlighted that many patients preferred this model. The newly improved service has been designed to enable patient care to be delivered closer to home. Patients can access cardiac rehabilitation classes in a range of ways through home-based, digital and face-to-face clinics. Remote patient assessments with a specialist nurse are offered through “Attend Anywhere” home visit clinics. These clinics are available from all multi-disciplinary teams and provide specialised and individualised rehabilitation advice.

The provision of appropriate information and support to people

Why are we doing this?

We need to do more to improve communication with people before they access planned care and whilst they are waiting for their appointments and interventions. It is important to make sure that support and information is easily accessible to those who are waiting. The third sector and voluntary organisations play a vital role in supporting people. Organisations such as Age Cymru, Royal National Institute of the Blind (RNIB), Cymru Versus Arthritis, various cancer charities, the British Heart Foundation and others have played an important role over the last two years and we need to build on this alongside the national communication and engagement programme.

Social prescribing plays a key part in supporting people. It is a way of linking people to community-based, non-clinical support, taking a holistic approach, which recognises that the health of a person is determined by a range of social, economic and environmental factors; supporting people to take greater control of their own health and supporting the broader preventative agenda.

What we want to achieve

We want to support people to make informed decisions about their health care. This starts with giving people more information and the skills to better manage their health and condition. To do this we need to be honest and transparent about the challenges in the system by providing accurate and up-to-date information on waiting times, as well as information about what can be done to keep well whilst waiting.

NHS organisations' websites and relevant correspondence need to have clear structures that signpost those waiting, to appropriate support from third sector organisations. This is an important aspect of the mental health services' approach to supporting people on waiting lists.

There is an opportunity to build upon, for those who are able, digital solutions through the NHS Wales app. This should include appointment management or signposting to wider services to better manage and support people. It should support, rather than replace measures to bring total waiting times down and increase access to the right care.

It is important that communication is undertaken in many formats to ensure that people are not digitally excluded. We will look at how we capture and identify how people want to be communicated with, including language, disabilities and their preference on written or electronic communication. Primary and community care play a critical role in public communication, as they are often an individual's

first interaction with the health service. We will work with supporting organisations such as Digital Communities Wales and Education Programmes for Patients (EPP Cymru).

To do this we will need to be honest and transparent about the challenges in the system. We will need to be able to provide people with an accurate and up-to-date waiting times position and information about what they can do to keep well whilst they are waiting. We need to offer access to information and support which will enable them to stay healthy and well before and after their treatment.

How we will do this

Improved transparency and information on waiting times
People will have clear and simple information about how long they will be expected to wait, information about how they can access support and who to contact should they have any concerns.

NHS organisations need resourced capacity to provide this support. We are considering how best this is done as well as understanding the type of information that will be useful and meaningful to those waiting for outpatient appointments and planned care surgeries. A number of approaches piloted by health boards over the last two years will be the foundation and vehicle to develop the future solutions for Wales.

Support for people to help them manage their conditions
Planned care recovery will be underpinned by a commitment to fundamentally transform the waiting list into a preparation list. This will allow people to be fully supported by the right health professional in using the waiting period proactively to improve their health, make informed decisions, and prepare physically and mentally for their operation or other treatment and recovery. Any intervention carries risk, and surgical intervention is no exception. This approach will also provide alternatives to surgery where appropriate, helping people to make informed choices and manage their conditions without surgery, using evidence-based approaches and clinical support, for as long as possible.

Supporting people to prepare for surgery
Too many operations are cancelled because people were not fit for the surgery or anaesthetic they were listed for. Of equal concern are the high number of people who are at risk of complications post-surgery because they are over-weight or suffer from long-term conditions that may not be controlled effectively. We will introduce integrated models of prehabilitation and rehabilitation as standard elements of all pathways.

E-See on Symptoms (eSoS)
To further embed SOS in clinical pathways and enhance communications with clinical teams we will develop an electronic system. This will allow access to clinical advice directly from their clinical teams without having to return to primary care.

Co-production
We will involve the public in service design and transform services through co-production and collaboration. We want patients to help inform and support pathway developments so that services are designed in line with their needs.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)
We will develop and embed patient reported outcomes and experience measures into all pathways and collect these digitally where possible as routine to provide enhanced opportunity to collect information and evaluate the quality of patient care, building on the work undertaken by the Value in Health programme.

National communications
The Welsh Government will work with NHS organisations to co-ordinate messaging to explain changes and developments in planned care at national level. Health boards will be able to use this messaging to help present the changes and developments at a local level.

CASE STUDY

The Hywel Dda University Health Board Waiting List Support Service provides patients awaiting treatment with clinical support and well-being advice over the telephone and via email. The service covers patients waiting in a range of specialities including ear nose and throat, orthopaedics, urology, ophthalmology, and dermatology. Patients are contacted directly with regards to how to access support. The service provides reassurance, offers a single point of contact, through which to give advice and guidance should symptoms deteriorate and sign post patients to online well-being resources to help them to maintain and optimise their health.

Our enablers

Planned care does not exist in isolation and impacts across all areas of the health service. The implementation of this 2026 plan cannot be delivered in isolation.

It will require a whole systems approach to deliver solutions and the outcomes that matter. As we reset and rebuild our health care services, we must ensure that our solutions maximise low or no carbon options

We have identified five enablers that are pivotal in making this plan work.

Building a Sustainable Workforce

Our Workforce Strategy for Health and Care in Wales sets the vision and direction for us to deliver these ambitious plans. We will work collaboratively with NHS organisations, supported by Health Education and Improvement Wales (HEIW) and the NHS Wales Shared Services Partnership working together to deliver a sustainable workforce across Wales. In doing so, we remain committed to the principles of social partnership and involving and engaging our workforce in our plans to develop and deliver the workforce of the future which is aligned to the ambitious changes that we plan for the delivery of health and care services in Wales.

We are committed to further enhancing our health and wellbeing offer to support our workforce and to work in social partnership to understand what more we need to do to retain the skills and experience of our experienced colleagues within the NHS. We will focus on additional recruitment into the workforce, and on providing excellent education and training opportunities to build and develop the future workforce. We will continue to develop more flexible approaches to 'grow our own' workforce to better match our workforce to local and regional circumstances. We will work with our social partners to ensure that the pay and terms and conditions of our workforce remain attractive and flexible enough to support the development of new ways of working and deliver the priorities set out in this plan.

We know that simply continuing to grow the existing workforce will not be enough to deliver our plans and we will need to find ways to release additional capacity and work in different ways to deliver for the people of Wales. Robust workforce planning will be used to ensure that we find ways to better match the capacity and skills of the workforce to the demand for services resulting not only from the pandemic but the underpinning changes in demographics, patterns of ill health, and the opportunities provided by new technology and new models of service delivery.

We will develop multidisciplinary 'teams around the patient' ensuring that all members of the team have the support and professional development they need to use their skills and work at the top of their license to deliver their role effectively. This will include the development of new roles to deliver care for service users and to better support our registrant workforce to ensure their roles and the wider workforce are safe, high quality and sustainable. We will

also develop a voluntary reservist NHS health support team that we can surge at times of pressure, especially the winter. We will maximise the use of technology as we develop new ways of working to ensure that these help our workforce to become more productive and free their skills to apply in areas where they can add most value.

Trainee surgeons and other members of the clinical team have struggled to undertake effective training opportunities during the pandemic. We will address this through our plan.

We will develop in social partnership a Workforce Delivery Plan for Wales which incorporates these commitments and will enable the delivery of this plan as it is implemented.

Infrastructure and estates

The current health infrastructure is a key factor impacting upon planned care delivery and expansion. Health board estates are no longer the sole resource for seeing and treating our patients. We will need to ensure that we use the physical estate as efficiently as possible, for example reviewing the opening times of current facilities such as outpatients, maximising community and primary care premises to enable care close to home and extending the use of non-NHS premises such as leisure centres and community hubs. Equally important is the wider infrastructure, including virtual resources such as digital where appropriate. This means improved sharing of patient information across primary and secondary care, availability of patient notes electronically, clear transfer of information between primary, secondary and community/ local authority staff and ensuring that citizens have access to high quality information and advice to support self-care models.

Delivering more one-stop, integrated services where people are seen and treated in a single appointment has evidenced better seamless pathways and outcomes. This needs to be accelerated where possible, as do rapid and community diagnosis clinics. The challenges we face are too large for health boards to tackle alone. Guided by the criteria in the National Clinical Framework, some services will need to be delivered at regional or even national levels and supported by third sector, local authority or independent contractors, working under clear guidance from the NHS. Working to agreed and co-produced patient pathways will enable this new way of working to be extended.

We expect health boards to plan services regionally for those high volume, low complexity interventions such as cataracts, non-complex orthopaedic surgery, diagnostic procedures such as endoscopy and for specialised services, where it is not possible to meet demand with minor and localised uplifts in capacity.

Clinical and pathway redesign

Doing things the way we have always done will not reset or transform planned care services. We need to relook at how we deliver services and implement new clinical pathways in line with best practice and the recommendations from clinical networks, embedding the principles of the National Clinical Framework.

Engaging health economic strategies as part of the reset and transform process will ensure benefits to patients from transformed planned care services are maximised as much as possible. We will use health economist engagement to explore options to improve efficiency so new clinical pathways are making the best use of resources.

Data and digital

Digital technology and innovation has been instrumental in maintaining and evolving care and servics during the pandemic. It has been used to revolutionise delivery of appropriate service change at pace. Virtual reviews for outpatients adopted with vigour in April 2020, received very positive patient feedback. Whilst these are not suitable for all conditions, feedback and evaluation demonstrates that virtual reviews are more suitable than face-to-face activity in some circumstances. We will establish national guidance that identifies the conditions and patient types that are suited to virtual reviews. We will seek to use digital technology to implement self-management learning from the Prostate Cancer self-management programme across Wales and implement e-SOS (see-on-symptoms) as a digital approach to managing follow-ups.

We will seek to develop a planned care portal alongside the NHS Wales app which will be used to inform patients and provide up-to-date information on waiting times and available support services.

This plan will be underpinned by accurate data. Targets and performance management will be developed alongside a real-time, visibility of the waiting list by sub speciality, robust demand and capacity plans that will enable teams to work effectively. We will use the management information to enable and support clinically led discussions on prioritisation and service developments.

CASE STUDY

Previously, patients living in north Wales had to travel to England for robot-assisted surgery. From June, robotic arms will be used to perform some surgeries at Ysbyty Gwynedd in Bangor, as part of plans to establish an “all-Wales robotic assisted surgery network”.

The robotic arms will be used by the NHS to perform procedures for some prostate and gynaecological cancers, and some procedures on the digestive system, kidneys and bladder.

The jointed arms with surgical instruments at the end are used to perform keyhole surgery, and are moved by a surgeon who controls them via a computer. Cameras on the arms let the surgeons see what is happening, and they can zoom in and magnify the area being operated on. Keyhole surgery with a robotic arm has many advantages for patients compared to open surgery. “The wounds are smaller, there’s less blood loss, a shorter hospital stay and an earlier recovery, allowing a person to return to work sooner.”

We will consider the scope for changing how delays to treatment are measured, to reflect the entire individuals' journey, from referral to treatment, with appropriate targets.

There is consensus that two targets should be considered.

- Referral to decision to treat to encourage fast diagnosis.
- Decision to treat to start of treatment.

Communications and engagement

The relationship with the public needs to change, enabling them to become partners in their health care. This starts with providing people with the information, skills and the ability to manage as much of their own health as possible. Communications and engagement with the public in Wales about changes in planned care must happen on a multi-level basis both nationally and locally. It is important that key information for the public, and more specifically patients, are from the appropriate messenger.

National communications will be led by Welsh Government, setting out the context, the challenges, ambitions and changes that will be seen on a national basis. This could include working with local health boards to showcase examples of best practice being applied at a local level. Through the well-established Help Us Help You campaign, public facing messages will include messages on appropriate ways to access NHS services, self-care and maintaining health and wellbeing whilst waiting for treatment. Public Health Wales will also play an important role through their ongoing work tackling smoking and obesity on a national level.

It is important that the national messages are amplified and adapted locally by health boards and other NHS Wales organisations. The national messages should be adapted for local population needs and signpost local service delivery, taking into account those areas with the greatest health inequalities. This will also include specific signposting to local support services to help people to achieve and maintain a healthy weight, be more physically active and cease smoking.

Direct patient engagement will be delivered on a local level, through the planned care services, local communication hubs, and individual health professionals. Supporting the personalised care approach, this will include personalised clear and simple information about how long they will be expected to wait, information about how they can access support, how to manage their condition, social prescribing and who to contact should they have any concerns.

Third sector organisations continue to play a vital role in this area. There is an opportunity to build upon, for those people who are able, digital solutions through the NHS Wales app to support patients needing care. We will involve the public more in service design and transform services through co-production and collaboration. Increasingly, measurement of PROMs will evidence that we are delivering what is important to them, a key aim of value-based care.

Delivering this plan

In October 2021, NHS organisations were given a recurrent allocation of £170m to support planned care recovery plans, which were to be developed alongside Integrated Medium Term Plan (IMTPs).

This investment enables:

- Implementation of the recommendations of the National Endoscopy Programme.
- Regional cataract services in line with advice from the Planned Care programme.
- Regional plans for aspects of orthopaedic services based on the orthopaedic clinical strategy work.
- Strengthened diagnostic and imaging services based on advice commissioned from the National Imaging Programme.
- Implementation of the Critical Care Plan developed by the Critical Care Network.
- Plans for improving cancer and stroke services.

£20m a year has been invested to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. This will support NHS recovery, with a focus on delivery of high value interventions that ensure improved outcomes for patients and support service sustainability and reducing waits for treatment over the medium term.

This investment will give greater focus on delivery of outcomes that matter for patients and will complement the implementation of plans currently being developed to tackle the immediate backlog of patients waiting for treatment. Adopting a value-based healthcare approach is an important element of service transformation.

In order to support planned care sustainable transformation, an investment of £15m to support the planned care five goals for transformation is being allocated in line with the actions in this plan.

There are a number of risks associated with delivering this plan, including the ongoing prevalence of COVID in our lives. We will therefore continue to assess our ability to deliver this plan throughout the next four years, issuing updates against our progress.

Glossary

AHP	Allied Health Professionals. Registered clinical staff other than doctors and nurses.
BMA	British Medical Association
Cardiology	Outpatient and treatment of diseases of the heart
CCT	Certificate of Completion of Training
CDH	Community Diagnostic Hub. Centre where diagnostic tests are undertaken outside of a hospital environment
Clinical Networks	Linked groups of health professionals and organisations from primary, secondary, and tertiary care working in a co-ordinated manner to ensure equitable provision of high quality effective services
Cluster	Local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities
CPD	Continuing Professional Development
Cold sites	Sites or areas which are dedicated to providing planned or elective care.
Community care	Care provided either in a patients home or a community hospital as an in or outpatient.
Community pharmacy	High street pharmacy providers.
Dermatology	Speciality treating diseases of the skin
Dentistry	Treatment of the teeth and gums.

Diagnostics	Use of a test to diagnose a medical condition. Includes blood tests, imaging (radiology) and other tests.
Dietetics services	Expert support in the management of conditions related to diet and the practical application of the scientific understanding of nutrition.
e-advice	Using digital means of messaging to provide advice.
Endoscopy	An examination of the digestive tract using cameras.
ENT	Speciality treating diseases of the Ear, Nose and Throat
EPP	Education Programmes for Patients
E-SOS	Electronic See on Symptoms, where patients can request a review when necessary for a set period of time via messaging or electronic means.
General Surgery	Speciality treating diseases of the digestive system and other areas not covered by specialist teams
GMS	General Medical Services
GP	General Practitioner
Gynaecology	Speciality treating diseases of the female reproductive system.
HEIW	Health Education Improvement Wales
IMTP	Integrated Medium Term Plan
MRI	Diagnostic scan that provides precise details of soft tissue imaging.
Multi-disciplinary staff	Staff from different professions and groups working collaboratively to provide patient care
National Imaging Programme	Supports the development of high quality, effective and sustainable imaging services in NHS Wales that provide the best outcomes for Welsh patients and future generations
NHS	National Health Service

NHS Wales App	Digital application being designed to provide a central place for patients to access information and digital health tools.
NICE	National Institute of Clinical Excellence. Reviews clinical evidence and publishes best practice guidance.
NOP	National Optimal Pathway. The standard agreed way for care to be provided to the people of Wales for specific conditions
Occupational therapy	An allied health care profession supporting people to maintain meaningful activities of daily life.
Ophthalmology	Speciality treating diseases of the eye
One-stop	The delivery of diagnostic, review and treatment in a single visit.
Oral surgery	Speciality treating diseases and injury to the face, oral cavity, neck, mouth and jaw.
Orthopaedics	Speciality treating diseases of the Musculoskeletal system (bones)
Outpatients	Patients seen and treated without requiring admission to hospital.
PIFU	Patient Initiated Follow Up
Physiotherapists	An allied health profession supporting the promotion, maintaining and restoration of physical movement.
Podiatry	An allied health care profession supporting the care of the foot and lower limbs
PPE	Personal Protective Equipment
PREMS	Patient Reported Experience Measure
PROMs	Patient Reported Outcomes Measures
Prehabilitation	MDT led intervention prior to treatment or surgery with the aim of limiting the impact and reducing the recovery time.

Programme for Government	Commitments of Welsh Government over the term of office.
PSA	A blood test that is measured to detect prostate cancer in men.
Rehabilitation	MDT led intervention after injury, treatment or surgery to support recovery or adjust to achieve optimum levels of physical activity.
RNIB	Royal National Institute for the Blind
RTT	Referral to Treatment
SABR	Stereotactic Ablative Radiotherapy
Self-management	Active participation by a patient in his or her own health care decisions, intervention and management.
SoS	See on Symptoms
Social prescribing	Referring patient to support in the community in order to improve health and wellbeing.
Speech and language therapy	An allied health care profession supporting children and adults who have difficult in talking, eating or swallowing.
Trauma	Injury caused by an accident.
Urology	Speciality treating diseases of the urinary tract.