GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

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<tr><td>Meeting Date</td><td colspan="2">27th September 2022</td><td>Agenda Item</td><td>4.1</td></tr>
<tr><td>Report Title</td><td colspan="4">Planned Care – Ministerial Priority Trajectories Update</td></tr>
<tr><td>Report Author</td><td colspan="4">Deb Lewis, Deputy Chief Operating Officer</td></tr>
<tr><td>Report Sponsor</td><td colspan="4">Inese Robotham, Chief Operating Officer</td></tr>
<tr><td>Presented by</td><td colspan="4">Deb Lewis, Deputy Chief Operating Officer</td></tr>
<tr><td>Freedom of Information</td><td colspan="4">Open</td></tr>
<tr><td>Purpose of the Report</td><td colspan="4">In May 2022, Welsh Government (WG) set out its ambitious intention for planned care recovery. The output of that ambition was a requirement for Health Boards to submit recovery trajectories against two specific priority areas:
• No patient will wait more than 52 weeks for a 1st outpatient appointment by end of 2022
• Patients will wait less than 104 weeks for treatment within most specialties by the end of 2022/23

On 21st June, the Health Board submitted its initial modelling results to WG with a covering letter that further work would be undertaken to refine the model with resubmission in 2 to 3 weeks.
This paper provides an update on the modelling and details the 2nd submission of trajectories to WG.</td></tr>
<tr><td>Key Issues</td><td colspan="4">The main issue is the current gap in the delivery of the Ministerial Priority requirement on planned care. The current trajectory has a gap of 9,767 patients in the 52-week cohort and 13,128 patients in the 104 week cohort.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☒</td></tr>
<tr><td>Recommendations</td><td colspan="4">The Committee is asked to:
• Note the work undertaken to date to develop robust revised planned care performance trajectories
• Endorse the approach to reporting and monitoring noted in Section 4 of the paper</td></tr>
</table>

EXECUTION OF THE RECOVERY AND SUSTAINABILITY PLAN 2022-25

1. INTRODUCTION

In May 2022, Welsh Government communicated to Health Boards its ambitious intention for planned care recovery. The output of that ambition was a requirement for Health Boards to submit recovery trajectories against two specific priority areas:

- No patient will wait more than 52 weeks for a 1st outpatient appointment by end of 2022
- Patients will wait less than 104 weeks for treatment within most specialties by the end of 2022/23

On 21st June, the Health Board submitted its initial modelling results to WG with a covering letter that further work would be undertaken to refine the model with resubmission in 2 to 3 weeks.

This paper provides an update on the modelling and details the 2nd submission of trajectories to WG.

2. BACKGROUND

The Recovery and Sustainability (R&S) Plan 2022-25 was endorsed by Management Board on March 23rd , approved by Board on March 31st and subsequently submitted to Welsh Government on March 31st for consideration.

One of the core components of the R&S Plan is the recovery of planned care, which had been impacted significantly by the pandemic. The WG recovery plan ask assumes that planned care activity levels have been resumed at pre-pandemic levels (19/20) and will be exceeded as a result of the additional recovery funded provided.

In line with this expectation, WG and Delivery Unit (DU) officials provided a reporting template for submission by 21st June. The template monitors the following:

1. Weekly cohort reduction trajectories for the 52+ week outpatient and 104+ week total waiting list ambitions.
2. Weekly breach reduction trajectories for both commitments.
3. Weekly new outpatient and inpatient / daycase activity percentage improvement trajectories.
4. Weekly Referral to Treatment (RTT) total waiting list volume trajectories.

The trajectories submitted by SBUHB on 21st June showed a deficit in delivery of the following:

- No patients waiting over 52 weeks for a 1st outpatient appointment – 13,916
- No patients waiting over 104 weeks for treatment in most specialties – 13,210

The covering letter highlighted that more work would be undertaken to refine the model and strengthen the plan in the following areas:

- Strengthening GP led services to prevent referral to secondary care and diagnose and/or treat at source.
- Developing demand management solutions across our systems of care.
- Considering the application of referral management criteria to be applied to existing lists and new referrals.

- Increasing core capacity for open pathways by diverting capacity previously assigned to follow up pathways as a result of:
  - modernisation of follow up system,
  - better use of clinic slots through partial bookings,
  - individual consultant productivity and
  - rigorous enforcement of DNA protocols
- The opening of further planned capacity in our system at Neath and Port Talbot

3. DEVELOPING THE TRAJECTORIES

As noted in the previous paper to Management Board (26th June), although a template was provided by WG, on review it was acknowledged that completion at an aggregated level would provide inaccurate assurance on the HB's ability to deliver on the ministerial priorities outlined above. Therefore, it was agreed the SBUHB submission would be developed "bottom-up" at an individual specialty level to provide the reporting assurance that DU required but also the granularity needed locally to drive delivery.

The initial modelling work was based on the current operating system continuing for the duration of this financial year but also played in assumptions on conversions rates and urgency rates. The further work has now included additional capacity and reduced demand where it can be predicted. There remains considerable work to do between the primary and secondary care systems to manage demand more appropriately, which will further benefit the position. In addition, a comprehensive validation exercise is currently underway across all specialties to ensure the records being reported are accurate. Currently the model assumes a 15% Removal other than Treatment (ROTT) rate, which may vary across specialties.

Also, due to the backlog volumes that have accumulated since March 2020, the activity levels themselves were not considered to be sufficient to develop backlog reduction trajectories. This is because the high volume of urgent referrals in the system are demanding a higher proportion of the total activity volume, leaving a smaller proportion to be allocated to the longer waiting routine patients (the backlog).

Therefore, the Healthcare System's Engineering Team were commissioned to develop a modelling methodology that predicts how the system would recover based on currently profiles of:

- Waiting lists
- Urgency rates
- Conversion rates
- Additional planned activity

The output of this modelling is best illustrated with an example – the General Surgery model for 52 weeks is used for reference:

General Surgery Trajectory

The RTT position for General Surgery at 19th June 2022 is as follows:

Measure	Activity
Stage 1 waits over 52 weeks	1242
Stage 1 cohort for 52 weeks by end of 2022	2732
Pre-COVID monthly activity levels	492
Current monthly activity levels	540 (+48)
Current monthly activity levels for urgent patients	440 (79%)
Current monthly activity levels for routine backlog removals	100
Assumed backlog removal of urgent patients	71
Monthly waiting list removals (not seen) - ROTT rate	25 (15%)
Total assumed activity to affect backlog per month	196
Modelled gap in delivery of 52 week target by end of 2022	932
Required additional monthly activity for cohort removals	150

As this example outlines General Surgery is unable to deliver the 52-week target by the end of 2022 without an additional 150 patients per month, which would need to be all long waiting patients. This is despite the service currently delivering over its pre-pandemic level (10% extra). This is due solely to the disproportionate allocation of that activity to shorter waiting, more clinically urgent patients in this specialty is predominantly suspected cancer patients.

Without this level of modelling, the HB's submission may have inaccurately predicted delivery of these Ministerial Priority measures. The HB now has the sophistication to monitor delivery against these trajectories and see if the system continues to respond in the same way. Should the proportion of urgent versus routine change in specialities the model will respond and reset the trajectories. For this reason, whilst the trajectories have been submitted to WG as requested, they remain dynamic and reflective of the systems continued recovery.

Revised Trajectories

Table 1 below illustrates the revised trajectories at specialty level and the change since the original modelling. As can be seen, there is significant improvement in the overall position against the 52-week target with a reduction of over 4,000 records, from 13,916 to 9,767.

There has been less of an improvement in the 104-week target which is not unexpected as the majority of the patients in this cohort are waiting for surgery (stage 5 patients). In addition to the backlog of stage 5 patients, due to the reduction in the

stage 1 cohort, more patients are being converted in this model compared to the first run. However, the Health Board is currently undertaking an extensive administrative validation exercise on all open RTT pathways which expected to have more of an impact on the 104-week cohort as it contains the stage 2 and 3 patients and where the biggest data quality issues lie. All specialties will be covered but the priority areas are the very long waits in Gynaecology and Orthopaedics. In addition to the internal validation a pan-Wales contract is currently being implemented using HBSUK to support. This will focus on contacting patients to see if treatment is still required rather than purely the administrative exercise.

	52 weeks			104 weeks		
Specialty	Original Gap	New Gap	+/-	Original Gap	New Gap	+/-
General Surgery	639	932	293	1640	2084	444
Vascular	565	0	-565	64	180	116
Breast	0	0	0	0	0	0
Urology	753	0	-753	84	391	307
Orthopaedics	4306	3818	-488	3309	3580	271
Spinal	0	0	0	568	487	-81
ENT	3801	2199	-1602	2747	1560	-1187
Ophthalmology	0	277	277	0	242	242
OMFS	2617	1519	-1098	1198	1040	-158
Plastics	90	0	-90	874	874	0
Gynaecology	427	304	-123	1770	1734	-36
Cleft	0	0	0	0	0	0
Cardiac Surgery	0	0	0	0	0	0
Thoracic Surgery	0	0	0	0	0	0
General Medicine	0	0	0	0	0	0
Cardiology	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0
Thoracic Medicine	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0
Endocrinel	0	0	0	0	0	0
Orthodontics	718	718	0	0	0	0
Paediatrics	0	0	0	0	0	0
Neurology	0	0	0	0	0	0
Gastroenterology	0	0	0	956	956	0
Haematology	0	0	0	0	0	0
Elderly Medicine	0	0	0	0	0	0
Dental Medicine Specialti	0	0	0	0	0	0
Paediatric Neuro	0	0	0	0	0	0
Nephrology	0	0	0	0	0	0
Rehabilitation	0	0	0	0	0	0
Pain Management	0	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0	0
TIA	0	0	0	0	0	0
Total Gap	**13916**	**9767**	**-4149**	**13210**	**13128**	**-82**

Table 1 – Revised Trajectory Comparison

Considerable effort has been put into the second round of modelling by both the clinical directorates and the Healthcare Systems Engineering Team, which is reflected in this improved position.

The first paper presented suggested that the initial submission represented the "worst case scenario" based on the current system. It should be noted that whilst these trajectories have been signed off by the Service Groups, they are predicated on delivery against workforce plans, such as new cohort of junior doctors and known recruitments. Any changes to those will be monitored closely to ensure recovery plans are developed and delivery stays on track.

4. Accountability and Monitoring of the Trajectories

The dynamic nature of the recovery necessitates scrutiny and monitoring, both internal and external to the organisation. The following outlines the monitoring and reporting structure that will be followed and how directorates will be held to account for the delivery of the trajectory levels.

External Monitoring

Following submission of the trajectories on 21st June, weekly and monthly monitoring meetings will be scheduled with WG / DU officials. The HB will be represented at the monthly meetings by the Chief Operating Officer and both Deputy Chief Operating Officers and by the Deputy Chief Operating Officers at the weekly meetings:

- Weekly combined meeting with all HBs. To focus on
  - Progress with ambition trajectories
  - Activity increase trajectories
  - Plans priorities in the coming week(s) + progress against previous week
  - Areas of Concern / Risks and mitigating actions

- Monthly HB focussed meeting, to focus on the above in more detail plus areas of efficiency such as:
  - Validation
  - Treat in turn
  - Plans for longest waits
  - Detailed speciality discussions / issues / areas of concerns
  - Progress on HB transformation measures
  - Progress on developing patient support and communication

- Weekly internal meeting which DU colleagues will join

Internal Monitoring

It is at the internal monitoring meetings where directorates and divisional managers will be held to account for delivery of the trajectories. Escalation for the non-delivery against the submitted levels will be to the Service Group Directors in the first instance and subsequently to the Planned Care Board and Management Board.

- Operational monitoring - the current weekly planned care performance management meetings will be utilised to:
  - monitor delivery of the trajectories and the areas of efficiency noted above
  - ensure core capacity is at or above 2019/20 levels

- ensure robust housekeeping is in place for RTT pathways
- further develop recovery plans as required for approval via Planned Care Board

- Formal monitoring / assurance
  - Service Group Performance Reviews
  - Planned Care Board
  - Management Board via the Performance Report
  - Performance & Finance Committee via the Performance Report

Efficiency Indicators

One of the core components for delivery of the trajectories is improving Treat-in-turn rates. This means ensuring that aside from clinical urgency, patients booked for outpatient appointments are booked in chronological order so that the longest waiting patients are treated. The tables below illustrate the treat-in-turn rates currently in the system i.e. all booked future appointments. Table 2 reflects appointments for patients categorised as routine priority and table 3 reflects all priority patients. The rates of patients booked from the 52-week cohort vary significantly by specialty. The 0% are predominantly with specialties that do not have patients waiting over 52 weeks. The specialties of most concern are Spinal, Trauma & Orthopaedics, Paediatrics and Urology. These rates will be reviewed at the weekly meetings and improvements in these specialties is required.

Booked Patients - Routine				
main_specialty_description	Not Cohort	Cohort	Grand Total	Cohort Booked %
Cardiac Surgery	33		33	0%
Cardiology	211	9	220	4%
Cleft	4		4	0%
Dental Medicine Specialties	5	2	7	29%
Dermatology	94	23	117	20%
Endocrinology	275		275	0%
ENT	11	112	123	91%
Gastroenterology	110	3	113	3%
General Medicine	6		6	0%
General Surgery	54	112	166	67%
Gynaecology	76	89	165	54%
Haematology	29		29	0%
Medicine For The Elderly	78		78	0%
Nephrology	79		79	0%
Neurology	145	19	164	12%
Ophthalmology	2		2	0%
Oral/Maxillo Facial Surgery	6	101	107	94%
Orthodontics		5	5	100%
Paediatric Neurology	3	5	8	63%
Paediatrics	144	16	160	10%
Pain Management	2	1	3	33%
Plastic Surgery	33	135	168	80%
Rehabilitation	17		17	0%
Restorative Dentistry	24		24	0%
Rheumatology	43		43	0%
Spinal	61	2	63	3%
Thoracic Medicine	133	5	138	4%
Thoracic Surgery	2		2	0%
Trauma & Orthopaedic	40	41	81	51%
Urology	67	50	117	43%
Vascular Surgery	6	109	115	95%
(blank)		1	1	100%
Grand Total	**1793**	**840**	**2633**	**32%**

Table 2 – Routine TinT

Booked Patients - ALL				
main_specialty_description	Not Cohort	Cohort	Grand Total	Cohort Booked %
Cardiac Surgery	41		41	0%
Cardiology	327	13	340	4%
Cleft	4		4	0%
Dental Medicine Specialties	7	5	12	42%
Dermatology	731	34	765	4%
Endocrinology	347		347	0%
ENT	85	118	203	58%
Gastroenterology	286	4	290	1%
General Medicine	36		36	0%
General Surgery	289	189	478	40%
Gynaecology	220	142	362	39%
Haematology	61	1	62	2%
Medicine For The Elderly	121		121	0%
Nephrology	103		103	0%
Neurology	278	21	299	7%
Ophthalmology	215	272	487	56%
Oral/Maxillo Facial Surgery	40	135	175	77%
Orthodontics	95	57	152	38%
Paediatric Neurology	10	5	15	33%
Paediatrics	192	16	208	8%
Pain Management	4	1	5	20%
Plastic Surgery	226	149	375	40%
Rehabilitation	21		21	0%
Restorative Dentistry	38		38	0%
Rheumatology	117		117	0%
Spinal	100	3	103	3%
Thoracic Medicine	193	6	199	3%
Thoracic Surgery	8		8	0%
Transient Ischaemic Attack	3		3	0%
Trauma & Orthopaedic	132	75	207	36%
Urology	201	75	276	27%
Vascular Surgery	24	114	138	83%
(blank)		1	1	100%
Grand Total	**4555**	**1436**	**5991**	**24%**

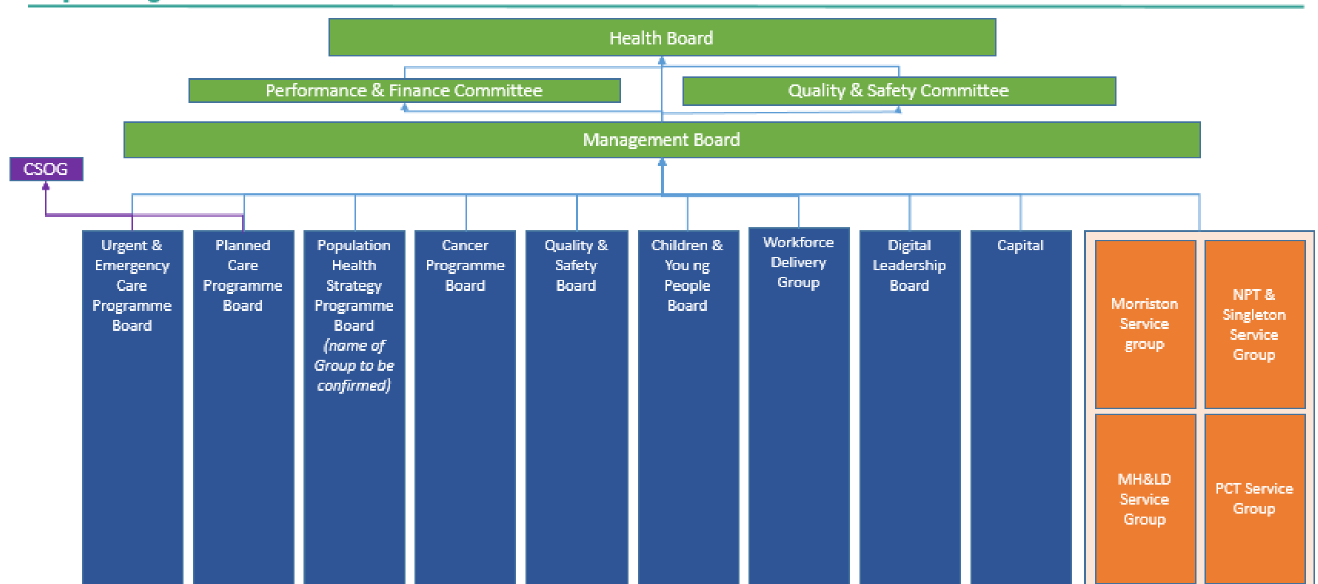
Table 3 – All Priority TinT

Alignment to the reporting of the Recovery and Sustainability Plan

The formal reporting against the delivery of the trajectories needs alignment to that of the R&S Plan. Service Delivery Groups are already expected to develop delivery plans to set out how they will support Implementation of the R&S plan, the GMOs assigned to them and their own service priorities to be reported at the quarterly Service Group Performance Reviews. This will now include the same requirement for the trajectories.

The below diagram sets out the reporting and governance structures to support delivery of the R&S Plan.

Reporting and Governance Structure



*The role of CSOG currently includes oversight of Annual Plan 2021-22 UEC and Planned Care interdependencies, public engagement and staff consultation and assurance of due governance for in-year service changes outwith the Annual Plan and oversight of delivery of the service change critical path 2022-23 and any requirements for public engagement and staff consultation.

The Board, Performance and Finance Committee and Management Board will receive, on a quarterly basis, a report on the delivery.

RECOMMENDATION

The Committee is asked to:

- **Note** the work undertaken to date to develop robust revised planned care performance trajectories
- **Endorse** the approach to reporting and monitoring

<table>
<tr><th colspan="3">Governance and Assurance</th></tr>
<tr><td rowspan="10">Link to Enabling Objectives
(please choose)</td><td colspan="2">Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities</td></tr>
<tr><td>Partnerships for Improving Health and Wellbeing</td><td>☒</td></tr>
<tr><td>Co-Production and Health Literacy</td><td>☒</td></tr>
<tr><td>Digitally Enabled Health and Wellbeing</td><td>☒</td></tr>
<tr><td colspan="2">Deliver better care through excellent health and care services achieving the outcomes that matter most to people</td></tr>
<tr><td>Best Value Outcomes and High Quality Care</td><td>☒</td></tr>
<tr><td>Partnerships for Care</td><td>☒</td></tr>
<tr><td>Excellent Staff</td><td>☒</td></tr>
<tr><td>Digitally Enabled Care</td><td>☒</td></tr>
<tr><td>Outstanding Research, Innovation, Education and Learning</td><td>☒</td></tr>
<tr><th colspan="3">Health and Care Standards</th></tr>
<tr><td rowspan="7">(please choose)</td><td>Staying Healthy</td><td>☒</td></tr>
<tr><td>Safe Care</td><td>☐</td></tr>
<tr><td>Effective Care</td><td>☒</td></tr>
<tr><td>Dignified Care</td><td>☒</td></tr>
<tr><td>Timely Care</td><td>☒</td></tr>
<tr><td>Individual Care</td><td>☒</td></tr>
<tr><td>Staff and Resources</td><td>☒</td></tr>
<tr><th colspan="3">Quality, Safety and Patient Experience</th></tr>
<tr><td colspan="3">No direct implications of this report, however the Plan is predicated on improving quality, safety and patient experience.</td></tr>
<tr><th colspan="3">Financial Implications</th></tr>
<tr><td colspan="3">Financial implications as a result of the delivery of these trajectories is incorporated into the Planned Care Recovery Plan.</td></tr>
<tr><th colspan="3">Legal Implications (including equality and diversity assessment)</th></tr>
<tr><td colspan="3">No direct implications of this report.</td></tr>
<tr><th colspan="3">Staffing Implications</th></tr>
<tr><td colspan="3">No direct impact outlined in this report however there may be staffing implications as a result of service models required to deliver on these trajectories – risks and implications to workforce form an integral part to planning arrangements.</td></tr>
<tr><th colspan="3">Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)</th></tr>
<tr><td colspan="3">No direct implications of this report.</td></tr>
<tr><td>Report History</td><td colspan="2">Management Board 24.08.2022</td></tr>
<tr><td>Appendices</td><td colspan="2">None</td></tr>
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