Finance & Performance Committee

Wed 11 January 2023, 09:30 - 12:30

Microsoft Teams

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Agenda

09:30 - 09:55
25 min

1. Preliminary Matters

Finance & Perfromance Committee Agenda- Wednesday 11th January 2023.pdf (2 pages)

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Committee Action Log- January 2023

Attachment *Chair*

1.4 FPC Action Log January 2023.pdf (3 pages)

1.5. Minutes of the meeting held on the 5th October 2022

Attachment *Chair*

1.5 Draft F&P Committee Minutes- 05-10-22 (Chair approved).pdf (10 pages)

09:55 - 09:55
0 min

2. Committee Governance

No items included on this agenda.

09:55 - 11:05
70 min

3. Assurance in respect of Organisational Performance Management

3.1. Performance Overview Report with Exception Reporting:

Attachment *Director of Planning and Performance*

3.1 ABUHB at a Glance November 2022- Integrated Performance Dashboard.pdf (2 pages)

3.1.1. Planned Care Recovery Programme, including a focus on Eye Care, ENT and Orthopaedic Spines

Attachment *Director of Planning & Performance*

3.1a Planned Care Update F&PC January 2023 (1).pdf (10 pages)
3.1a_App1_Welsh Government- Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales.pdf (43 pages)

3.1.2. Urgent Care Demand and System Impact- Six Goals for Urgent and Emergency Care

Attachment *Director of Planning & Performance*

- 3.1b Six Goals Urgent and Emergency Care.pdf (7 pages)
- 3.1b_App1_ Six Goals Programme Plan.pdf (11 pages)

3.2. Getting It Right First Time Reviews:

3.2.1. Stroke Services

Attachment *Head of Service Planning*

- 3.2a Stroke GIRFT Update - F&P Committee Jan 2023 (002).pdf (5 pages)
- 3.2a_App1_RNOH GIRFT ABUHB.pdf (37 pages)
- 3.2a_App2_GIRFT Stroke Action Plan- narrative response.pdf (7 pages)
- 3.2a_App3_ToR National Stroke Programme Board.pdf (9 pages)

3.2.2. Trauma and Orthopaedic Services

Attachment *Director of Operations*

- 3.2b GIRFT and NCSOS Update Paper.pdf (8 pages)
- 3.2b_App1_ABUHB GIRFT Report.pdf (12 pages)
- 3.2b_App2_NCSOS Report.pdf (73 pages)
- 3.2b_App3_Combined Action Plan (Draft) Delivery Plan.pdf (3 pages)
- 3.2b_App3a_Combined Action Plan (draft) Summary.pdf (7 pages)
- 3.2b_App3b_Combined Action Plan (draft) Pivot.pdf (1 pages)
- 3.2b_App4_Orthopaedic Improvement Steering Group.pdf (4 pages)

3.3. COMFORT BREAK- 10 MINUTES

11:05 - 12:25
80 min

4. Assurance in Respect of Financial Management and Performance

4.1. Financial Outlook for 2023/24 & Allocation letter 2023/24 Briefing

Attachment *Director of Finance, Procurement & VBHC*

- 4.1 Financial outlook allocation letter brief_final_23.01.05.pdf (9 pages)
- 4.1_App1_Allocation Letter briefing 2023_24 v4_23.01.02.pdf (9 pages)

4.2. Underlying Position Review & Forecast

Attachment *Director of Finance, Procurement & VBHC*

- 4.2 Underlying deficit analysis v5 23.01.23_final.pdf (9 pages)

4.3. Financial and Budget Planning Principles 2023/24

Attachment *Director of Finance, Procurement & VBHC*

- 4.3 Budget Planning Principles 2324 _final_23.01.02.pdf (7 pages)

4.4. Efficiency Opportunities for 2023/24

Attachment *Director of Finance, Procurement & VBHC*

- 4.4 FPC Report - Efficiency Opportunities 23-24_final.pdf (7 pages)
- 4.4_App1_Theatres Dashboard (To Oct 22).pdf (2 pages)
- 4.4_App1a_Theatres Dashboard (Definitions).pdf (1 pages)
- 4.4_App1b_Theatres Dashboard (Output).pdf (1 pages)
- 4.4_App2_British Association of Day Surgery (BADS) Comparison Analysis (To Oct 22).pdf (1 pages)
- 4.4_App2a_ BADS Summary Detail.pdf (1 pages)
- 4.4_App2b_BADS Data MM.pdf (3 pages)

- 4.4_App2c_BADS Sheet 2.pdf (1 pages)
- 4.4_App2d_BADS Sheet 3.pdf (1 pages)
- 4.4_App2e_BADS LKPs.pdf (1 pages)
- 4.4_App3_Cataracts Update (To Oct 22).pdf (11 pages)

12:25 - 12:30
5 min

5. Other Matters

5.1. To confirm any key risks and issues for reporting/escalation to Board and/or other Committees

Verbal *Chair*

12:30 - 12:30
0 min

6. Date of the next meeting is Wednesday 21st June 2023

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

FINANCE & PERFORMANCE COMMITTEE AGENDA

Date and Time	**Wednesday 11th January 2023, 9.30am**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 5th October 2022	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**COMMITTEE GOVERNANCE**		
2.1	There are no items for inclusion in this section		
3	**ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT**		
3.1	Performance Overview Report with Exception Reporting: a) Planned Care Recovery Programme b) Six Goals for Urgent and Emergency Care	Attached	Director of Planning & Performance
3.2	Getting it Right First Time Reviews: a) Review of Stroke Services b) Update on Orthopaedic Improvement Programme	Attached	Head of Service Planning/Director of Operations
4	**ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE**		
4.1	Financial Outlook & 2023/24 Allocation letter Briefing	Attached	Director of Finance & Procurement
4.2	2022/23 Forecast Closing Underlying Position	Attached	Director of Finance & Procurement
4.3	2023/24 Budget Planning (Delegation) Principles	Attached	Director of Finance & Procurement
4.4	Efficiency Opportunities 2023/24	Attached	Director of Finance & Procurement
5			**ITEMS FOR INFORMATION**
5.1	There are no items for inclusion in this section		
6	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: 21st June 2023		

KEY: Strategic Priorities	
Priority 1	• Every Child has the Best Start in Life
Priority 2	• Getting it Right for Children and Young Adults
Priority 3	• Adults in Gwent Live Healthily and Age Well
Priority 4	• Older Adults are Supported to Live Well and Independently
Priority 5	• Dying Well as part of Life
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance

Motion to Exclude Members of the Public and the Press
There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting: "Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest". *Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960*

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Finance & Performance Committee
January 2023 Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the FPC and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the FPC these actions will be taken off the rolling action sheet.)

Agreed Actions Key:

Overdue	Not yet due	Due	Transferred	Complete	In progress

Action Ref	Action Description	Due date	Lead	Progress	Status
FPC 0607/09 ABUHB's Efficiency Review and 'Compendium' Presentation	Opportunities to link the 'Compendium' with the Corporate Risk register, which could provide further assurance to the Committee were noted. It was agreed that Head of Strategic Financial Planning and Head of Risk and Assurance would meet to discuss this further outside of the meeting.	**October 2022**	**Head of Corporate Services, Risk and Assurance/Head of Strategic Financial Planning**	In discussion with the Director of Corporate Governance it has been determined that the Compendium is to be used to inform service and strategic planning, which would in turn inform strategic risk management, where necessary.	**Closed**

FPC 0510/06 Committee Strategic Risk report	A detailed discussion on risks associated with the current Ukraine conflict to come back to a future Committee meeting.	**Feb 2023**	**Head of Corporate Services, Risk and Assurance**	This will be discussed by the Audit, Risk and Assurance Committee (In Committee) in February 2023.	**Transferred**
FPC 0510/09.1 Revenue Financial Forecast Review 2022/23	Presentation slides on identified savings and associated risks to be shared with members.	**Oct 2022**	**Assistant Finance Director/ Secretariat**	Slides shared with members.	**Complete**
FPC 0510/09.2 Revenue Financial Forecast Review 2022/23	A forecast of monthly expenditure, including a forecast of delivery for each theme, would be presented to Board members at the upcoming Board development session.	**Nov 2022**	**Chief Executive**	Forecast expenditure was presented to Board members at the Board development session on the 23rd November 2022.	**Complete**
FPC 0510/12.1 Performance Exception Reporting; Planned Care	An update on Planned Care would be covered in the Board Strategic Session on Wednesday 11th October 2022	**Jan 2023**	**Director of Planning & Performance**	The Board Strategic session in October 2022 was cancelled. A Planned Care Assurance Report is included on the F&P Committee agenda for 11th January 2023 (item 3.1).	**Complete**
FPC 0510/12.2 Performance Exception Reporting; Six Goals of	An update on the appointed Social Care and Regional Analytics leads, listed as 'to be confirmed' within the report, to be shared with members outside of the meeting.	**Dec 2022**	**Director of Planning & Performance**	Information shared with members outside of the meeting.	**Complete**

Urgent and Emergency Care					
FPC 0510/12.2 Performance Exception Reporting; Six Goals of Urgent and Emergency Care	A deep dive on SDEC to come back to a future meeting.		**Director of Planning & Performance**	A deep dive into SDEC was presented to the Partnerships, Population Health & Planning Committee.	**Transferred**

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Finance & Performance Committee held on Wednesday 5th October 2022 at 9.30 am via Teams

Present:	
Richard Clark	Independent Member (Chair)
Pippa Britton	Interim Vice Chair (Vice-Chair)
Iwan Jones	Independent Member
Shelley Bosson	Independent Member

In attendance:	
Rob Holcombe	Interim Director of Finance, Procurement & Value Based Healthcare
Chris Dawson-Morris	Interim Director of Planning & Performance
Nicola Prygodzicz	Chief Executive
Rani Mallison	Director of Corporate Governance
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
James Calvert	Medical Director
Suzanne Jones	AFD Financial Planning
Chris Commins	AFD Out of Hospital Services
Philip Meredith	Finance Business Partner
Greg Bowen	Assistant Finance Director
Nathan Couch	Audit Wales

Apologies:	
Leanne Watkins	Director of Operations

	Preliminary Matters
FPC 0510/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
FPC 0510/02	**Apologies for Absence** Apologies for absence were noted.
FPC 0510/03	**Declarations of Interest** There were no Declarations of Interest to record.
FPC 0510/04	**Committee Action Log** The Committee discussed the actions and members were assured that the remaining action *FPC 0607/09* was in progress. Members thanked the teams involved for the completion of previous actions.

FPC 0510/05	**Draft Minutes of the meeting held on 6th July 2022** The minutes of the Finance and Performance Committee meeting held on the 6th of July 2022 were noted as a true and accurate record.
	Committee Governance
FPC 0510/06	**Committee Strategic Risk Report** Danielle O'Leary (DO), Head of Corporate Services, Risk and Assurance, presented the report to the Committee. Members were informed that the report included an overview of the profile of risks reflecting service demands. Pippa Britton (PB), Interim Vice Chair, noted the conflict in Ukraine was monitored on the risk register and queried how often it was discussed by the Health Board. The following was discussed: • A dedicated meeting on the Ukraine crisis takes place monthly. The risk was considered alongside the *CRR033 Civil contingencies Act compliance* risk. • The Health Board attended monthly Gwent Local Resilience Forum meetings, addressing the current conflict, alongside key stakeholders, and partners. A detailed discussion on risks associated with the current Ukraine conflict to come back to a future In-Committee meeting. **Action: Head of Corporate Services, Risk and Assurance/secretariat** Shelley Bosson (SB), Independent Member, queried if the 'balance' trend for risk '*CRR032 Failure to achieve underlying recurrent financial balance due to ongoing service pressures, under-achievement of recurrent savings and efficiency delivery and investments not supported with recurrent funding sources'* was correct. Rob Holcombe (RH), Interim Director of Finance, informed members that the Health Board were aiming to improve the position. At the time of reporting the position was balanced, however new information indicated that the position may worsen. Members thanked the DO for the comprehensive presentation of risks associated with the Committee business. The Committee; - • **NOTED** the contents of the report. • **ENDORSED** the proposal to de-escalate CRR020 from the Corporate Risk Register. • **ACKNOWLEDGED** the updates that had been received and reflected in the appendices for the last reporting period.
	Assurance in Respect of Financial Management & Performance
FPC 0510/07	**Financial Understanding of Health Board Commissioned Services** Suzanne Jones (SJ), Assistant Finance Director of Financial Planning, supported by Philip Meredith (PM), Finance Business Partner, presented an overview of Health Board Commissioned Services to the Committee. Members were informed that Commissioning included assessing needs, planning, and prioritising, purchasing, and monitoring health services, providing the best health outcomes for the Health Board's population.

Long Term Agreements (LTA) with commissioning providers were discussed. LTAs were negotiated annually, however during COVID, to provide stability to providers, block contracting arrangements were agreed with no performance variation. 2022-23 was noted as a transitional year as the Health Board moved back to historic LTA arrangements.

Health Board Commissioning expenditure trends were steady, noting increases in both Cardiff and Velindre LTA's. Income from services provided by the Health Board had decreased, due to a decrease in income of £2.2m from the Powys LTA, as a result of a reduction of the Health Board's patient flow from Powys since the opening of the Grange University Hospital, and changes in Nevil Hall Hospital. It was agreed that the income pressure would be borne by Commissioning, with delegated budget remaining in Divisional funding. Some budget has been allocated for income cover mitigation.

The Health Board as a commissioner of services was discussed, alongside financial risks. The following was noted:

- The Health Board's largest yearly contribution was £135.6m to Welsh Health Specialised Services Committee (WHSSC). Health Board representatives met with WHSSC monthly to discuss key strategic issues and monitor progress against yearly plans. A key financial risk was recovery, noting that England were recovering faster than Wales, alongside sustainability of specialised services and financial pressures from new technologies.
- The Health Board's share of the Emergency Ambulance Services Committee (EASC) was £43.5m. EASC management teams had an operational focus. Future developments were noted as investment in additional capacity and National Collaborative Commissioning Unit (NCCU) development of a Sexual Assault Referral Centre.
- Cardiff and Vale University Health Board's LTA baseline value was £35m, covering elective and emergency services. Members were informed of the repatriation of Neurology services to the Health Board, bringing care closer to home. There was a focus on returning to 2019-2020 baseline levels, noting positive delivery for emergency service and concern around current delivery for elective inpatients.
- Cwm Taf Morgannwg University Health Board LTA baseline value was £23m, covering emergency services and some elective pathways. Further data analysis would be required to understand the low numbers of emergency inpatients in comparison to high numbers of Accident and Emergency attendances.
- Velindre NHS Trust LTA baseline was approximately £30m, covering activity and National Institute for Health and Care Excellence (NICE) pharmaceuticals. Current concerns over radiotherapy performance and waiting times were noted; a Clinical Operational group had been established to consider waiting time issues. NICE growth of 21% was noted as an issue, impacting IMTP cost pressures yearly. A new contract had been implemented in 2022, ensuring costs and activity were accurately reflected for each Health Board.
- The Health Board commissioned secondary care acute services from Health Boards in England, providing care for Health Board residents living on the Wales/England boarder. In addition, the Health Board was funded for the care of circa 10,000 English residents with Welsh GPs.
- LTAs were monitored through monthly meetings with Welsh providers and quarterly meetings with English providers, focusing on service

issues and improvement, quality of care for patients and waiting times. Current key quality and waiting time issues were discussed.

- The Major Trauma Centre, commissioned by WHSSC, annual costs were £14m for the Health Board. Concerns over relative usage by Health Boards were discussed, with a current evaluation process underway alongside peer and Welsh Government reviews.
- The centralisation of regional Vascular Services commenced in July 2022, with an annual cost of £2.7m. A review would be undertaken during the first year of implementation.

Opportunities in the current LTA process were discussed, alongside long-term opportunities in restructuring LTA's, promoting a value approach, focusing on outcomes, incentives, risks, and rewards.

Rob Holcombe (RH), Interim Director of Finance, discussed repatriation of services and informed members that prior to any repatriation, the Health Board considered the ability to deliver a quality service at the volume required. Members were informed that a process of unwinding current arrangements with LTA's in Cwm Taf Morgannwg University Health Board had commenced, with further assessment on impact to be undertaken. Members were invited to contact the finance team outside of the meeting for any further information.

Nicola Prygodzicz (NP), Chief Executive, informed members that since the opening of the Grange University Hospital (GUH) there had been a reduction in Health Board patients presenting at Cwm Taf Morgannwg University Health Board's emergency departments. Two points were raised for review:

1. The possibility that the Flow Centre model may not be directing ambulances into GUH that would have previously gone to Prince Charles Hospital.
2. Prince Charles Hospital transferring patients back to GUH, who historically, due to geographical factors, may have gone to Prince Charles Hospital to be treated, honouring the Health Board's contract with Prince Charles Hospital to provide the best care closer to home.

Shelly Bosson (SB), Independent Member, requested the following information:

- As part of the business case for GUH, was the Health Board aware of an income reduction after the opening of the hospital, and why Powys residents were arriving at Prince Charles Hospital?
  NP informed members that during the business case for GUH, it was presumed that elective Powys patients would go to GUH. Emergency patients are currently directed to Prince Charles Hospital, as the closest Emergency site. Where the Health Board has seen a reduction is in our patients going to Cwm Taff Morgannwg. RH informed members that the offer to Powys for patient care in Health Board hospitals continued, and the mitigation of any associated risk had been factored into the financial plan as far as possible, within resources.
- How the Health Board ensured value for money with the Long-Term Agreements (LTAs)?
  RH discussed that across Wales there were not standardised LTA agreements. Further work was being undertaken to ensure value for money with Health Board LTAs.
- Why was faster recovery in England an issue for Welsh Health Boards?

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	Members were informed that NHS Organisations in England overperforming could be a potential financial risk for the Health Board. • Was there a requirement for Health Board LTAs be refreshed, based on current demand and capacity issues? Members were informed that, as reported, block contracts were utilised during Covid to align with all-Wales and Welsh Government funding. This year the Health Board had revisited pre-Covid contract terms. Work was underway with All-Wales Finance Directors to reconfigure LTAs going forward. • What was the Rutherford Capacity? Members were informed that the Health Board's initial financial plan with Velindre Cancer Centre was delivering core levels. Velindre Cancer Centre outsourced some additional services to the Rutherford Centre. Due to the closure and liquidation of the Rutherford Centre, Velindre Cancer Centre may not be able to deliver at current levels. Pippa Britton (PB), Interim Vice Chair, requested the protocol in cases where the Health Board had commissioned services and the Commissioner was not delivering at agreed levels of patient quality and outcomes. RH informed members that based upon patient activity, both financial incentives and penalties were built into original contracts for most commissioned services. Patient quality through commissioned services was monitored closely through the governance of other Health Board providers, Board papers, reports and through Health Inspectorate Wales (HIW) and Care Quality Commission (CQC) in England, including patient feedback. In addition, a previous suggestion by the Health Board to monitor patient quality and care through all-Wales Datix access; this had not been agreed at present. Access to patient quality information and outcome data through private providers was discussed; it was noted that quarterly reports were provided to the Health Board providing key performance indicators, data sets from patient surveys and complaints, lessons learnt and clinical governance information. Members requested further information on commissioned services through Emergency Ambulance Services Committee (EASC) and inter-site transport. Members were informed that concerns had been raised internally around the utilisation of inter-site transport. Further work was being undertaken, alongside EASC, to address concerns. Members were reassured that this was closely monitored through the Patient Quality, Safety and Outcomes Committee. Richard Clark (RC), Committee Chair, questioned whether there was capacity for the Health Board to provide additional services as a commissioned provider. RH informed members that the Health Board has arrangements in place and income streams as a provider. However, due to current demand, capacity and workforce issues the Health Board was struggling to deliver services to the current portfolio of patients and this would require consideration prior to providing additional services to other commissioners.
FPC 0510/08	**Finance Performance Report, Month 5 2022/23** Rob Holcombe (RH), Interim Director of Finance, provided the update outlining the Health Board's financial performance, for the month of August 2022 (month 5) and the year-to-date performance position for 2022/23. The report summarised the Health Board's performance against financial targets, statutory financial duties and forecast position.

	At Month 5, the revenue position was reported as £17.441m deficit with a forecast year-end out-turn reported position as break-even. The significant risk to this forecast was considered by the Board at the September 2022 Board meeting. The following was discussed: • Cost pressures were noted as a similar trend to previous months. • Variable pay cost pressures were driven by service pressures and response to Covid. • A surge in bed requirements, driven by acuity of patients, transfer delays and urgent care pressures. • Vacancy covers, due to current workforce issues and ability to recruit, noted as a national issue. • Non-pay cost pressures were driven by the hike in energy prices. • The Capital forecast was balanced. • Cash targets were within limit and were forecast to be achieved. • Public Sector Payment policy was achieved for month 5 and will be monitored. The Board had approved the 2022/23 – 2024/25 IMTP initial Budget delegation plan for 2022/23 as well as an update for quarter 2. Welsh Government had approved the IMTP which assumed financial balance. Shelley Bosson (SB), Independent Member, requested further information on divisional forecast savings, as outlined in the report. Members were informed that the Health Board was achieving on primary Care levels due to savings in medicines management. The Committee **RECEIVED** the report for **ASSURANCE** and compliance and **NOTED** the Welsh Government Monitoring Return report for information.
FPC 0510/09	**Revenue Financial Forecast Review 2022/23** Rob Holcombe (RH), Interim Director of Finance, presented the update on the forecast revenue resource position for the financial year 2022/23, based on August 2022 (month 5) financial reporting, highlighting the potential risk of not achieving financial balance if spend levels continue at current rates. The Committee was requested to review and consider the detailed risks, as outlined in the report, focusing on the core position outlined. In addition, members were advised that the report outlined key focus areas for saving opportunities to mitigate risks for 22/23. Members were advised of the potential deficit of £49m based on current service assumptions if no further action is taken, however a range of between £30m to £40m was considered more likely, on the basis that potential opportunities to reduce expenditure were identified and progressed. Health Board recurrent and non-recurrent income had reduced by £54m in comparison to 2021. However, expenditure had not reduced to that level. A broad range of factors driving the current financial position were noted as follows: • Variable pay, driven by bed requirements and urgent care demand. • Transfer delays had increased cost pressures. • Prescribing costs had increased, although some savings had been recognised in medicine management.

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- Community Health Council (CFC) fee levels had increased.
- Health Board testing regimes and plans were in excess of Welsh Government funding.
- Service recovery plans for elective and medicine service, including backfill and waiting list costs.
- Insourcing and outsourcing.

The appendix provided included details of financial drivers at Divisional levels.

Members were informed that the Executive Team had held several workshops identifying specific savings schemes for immediate focus, as outlined in the report. In addition, establishment of a dedicated financial recovery turnaround group to monitor progress was being considered.

Greg Bowen (GB), Assistant Finance Director (AFD), supported by Chris Commins (CC), AFD Out of Hospital Services and Suzanne Jones (SJ), AFD Financial Planning, presented the identified savings and associated risks to the Committee, subject to further review. Presentation slides to be shared with members. **Action: Assistant Finance Director/Secretariat**

Finance Teams would be working on a robust action plan, alongside Executive Leads, around potential savings, as outlined in the report. Members were informed that information discussed was a mixture of reporting as of month 5 and updated intelligence based on mid-month reporting. A Board Briefing session was due to take place, focused on the Financial Forecast Review, with opportunities for further discussion.

Nicola Prygodzicz (NP), Chief Executive, informed members of next steps, continuing to focus on opportunities for improvement with the least impact on services. Finalisation of the forecast position, including key drivers, actions for improvement and other options to improve on the financial forecast would be shared and discussed with Welsh Government. In addition, monthly dedicated financial recovery meetings would take place with Executive Leads.

Pippa Britton (PB), Interim Vice Chair, , was reassured by the monitoring and discussion and requested regular updates on the financial forecast to the Board. RH reassured members that the 'flash reports' had been reintroduced, containing financial forecast information, ensuring Board members receive regular updates outside of the Board and Committee meetings. RH invited members to contact him outside of the meeting with any further queries.

Iwan Jones (IJ), Independent Member, welcomed the governance of the financial forecast at Board level, and queried the following:

- How was the final figure reported? RH informed members that a figure was determined, and the Health Board had the ability to identify any risks to that position as part of Welsh Government reporting.
- Noting the Health Board's statutory requirement to achieve financial balance, what were the political implications to the Health Board if this was not achieved? RH informed members that there was a statutory requirement to break even over a three-year period. Currently, the Health Board did not have the finance from the previous two years to forecast breakeven. Determined by Welsh Government, the NHS Escalation Framework would be enacted as part of Welsh Government intervention. The Chief Executive discussed factors influencing

	increased spends such as the medicines market and variable pay and informed members that the Health Board accepted its responsibility to break even. Any potential enhanced monitoring would be dependent on the financial position in January 2023, when a tripartite review is undertaken by Welsh Government, Health Inspectorate Wales (HIW) and Audit Wales. RC requested assurance to the Committee and Board of a turnaround plan for the next 6 months and requested assurance that all budget holders were aware of their responsibility to deliver savings. NP informed members that a forecast of monthly expenditure, including a forecast of delivery for each theme, would be presented to Board members at the upcoming Board development session. **Action: Chief Executive** The Committee thanked the finance teams for the update. The Committee: • Received the report for **ASSURANCE,** noting the significant risk of achieving financial balance if no pro-active action is taken and the likely deficit. • **CONFIRMED** the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.
FPC 0510/10	**ABUHB Budgetary Control and Finance Control Procedure** The Committee received the report, describing key financial controls and governance rules and behaviours which the organisation had established to ensure expenditure is managed within available resources. The report aligned to Welsh government requirements and best practice financial control procedures. The report highlighted that the Health Board was facing significant service and workforce pressures which were driving financial challenge and significant risk to delivering financial balance for 2022/23. Iwan Jones (IJ), Independent member, highlighted that budgetary control issues were currently discussed at the Audit, Risk and Assurance Committee and requested further clarification if this should be overseen by the Finance and Performance Committee instead. Rani Mallison (RM), Director of Corporate Governance, informed members that breach of delegated budget responsibilities should rest with the Audit, Risk and Assurance Committee. The Committee **NOTED** the report for **INFORMATION**.
	Assurance in Respect of Organisational Performance Management
FPC 0510/11	**Performance Management Report- Committee to receive report that was presented to September Board** The Committee received the report, outlining a high-level overview of activity and performance at the end of July 2022, with a focus on delivery against key national targets included in the performance dashboard. The Committee **NOTED** the report.
FPC 0510/12	**Performance Exception Reporting; -**

Cancer
James Calvert (JC), Medical Director, presented the report, illustrating the current cancer performance and identifying improvements to address any challenges.

Performance against the 62-day Single Cancer Pathway was discussed, noting that the Health Board last achieved the 75% compliance in 2018. Provisional data for August 2022 suggested an approximate 47% level of compliance. Performance data suggested that the difficulties would continue due to levels of unprecedented demand, with a 26% increase in overall cancer referrals since 2019. Demand and capacity issues influencing the pathway were discussed, as outlined in the report.

Health Board plans to improve patient care and wait times was discussed as follows:

- Insourcing additional capacity on the Endoscopy pathways, improving wait times from 12 weeks to 22 days, noting further opportunity for improvement.
- A business case had been approved to outsource routine pathology, improving pathways in skin cancers.
- A training programme had been piloted for pathway managers, adopted at an All-Wales level. Pathway managers would be a point of contact for patients who cancel appointments to support the patient in facilitating an appointment as soon as possible.
- Radiology and Histopathology have moved into a new Division, providing more scrutiny and oversight on planning for improvement.
- A Clinical Reference Group had been established with all tumour sites, with a plan to bring first contact on the cancer pathway within 14 days from 37% to over 80% of cases.
- A 'working group' had been set up alongside Velindre Cancer Centre, to improve the interface of the cancer pathway for patients.
- Actions were being taken to address workforce issues.

The Committee thanked the Medical Director, **NOTED** the report, and supported the continued multidisciplinary efforts to address the challenges identified.

Planned Care
Chris Dawson-Morris (CDM), Interim Director of Planning & Performance, informed members that an update on Planned Care would be covered in the Board Strategic Session on Wednesday 11th October 2022. **Action: Interim Director of Planning & Performance**

Six Goals of Urgent and Emergency Care
CDM presented the paper, outlining the Health Board's "Six Goals for Urgent and Emergency Care" Programme and associated performance and financial status. Key actions were discussed, noting progress made during the introduction of Same Day Emergency Care SDEC, alongside plans to duplicate SDEC in Ysbty Ystrad Fawr Hospital.

Financially, the program was supported by Welsh Government Funding totalling £2.96M of which most has already been committed to UPC & SDEC Services.

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	Shelley Bosson (SB), Independent Member, requested an update on the Social Care and Regional Analytics leads, listed as 'to be confirmed' within the report. CDM informed members that these positions had been filled and an email would be shared outside of the meeting confirming this. **Action: Director of Planning** Members requested a deep dive discussion on SDEC at a future meeting. **Action: Interim Director of Planning and Performance** The Committee thanked the Interim Director of Planning and Performance for the update and the comprehensive report, noting the helpful metrics. The Committee **NOTED** the report.
FPC 0510/13	**Information Governance Performance Indicators** Jonathan Meredith (JM), Head of Information Governance, presented the report to the Committee, providing performance information regarding the Health Boards compliance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018). The Key Performance Indicators used for monitoring compliance against GDPR and Information Governance Legislation, alongside the Health Board's management of information relating to patients and staff were discussed. Members were informed that the NHS Wales Information Governance Toolkit was completed yearly by Health Boards across Wales. Health Board compliance with the Welsh Information Governance Toolkit for 2021/2022 was 95%, noted as one of the highest scores in Wales. The Committee received the report for **ASSURANCE.**
	Other Matters
FPC 0510/14	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no items to escalate.
	Date of Next Meeting
FPC 0510/15	The date of the next meeting was noted as: - Wednesday 11th January 2022 via Microsoft Teams.

DRAFT

Integrated Performance Dashboard

November 22

Appendix 1

Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement	RTT	Patients waiting less than 26 weeks for treatment	Nov-22	95%	**61.4%**	62.0%	↓		59.4%	58.4%	58.3%	59.8%	61.9%	61.2%	61.4%	62.1%	62.1%	61.2%	60.9%	62.0%	61.4%
		Patients waiting more than 36 weeks for treatment	Nov-22	0	**34921**	34750	↓		34582	34254	34542	33947	32202	33177	32959	33570	34998	36051	35395	34750	34921
		Patients waiting more than 8 weeks for a specified diagnostic	Nov-22	0	**4137**	4048	↓		5979	6120	5495	4574	4300	4305	4266	3871	3882	3641	3706	4048	4137
		Patients waiting more than 14 weeks for a specified therapy	Nov-22	0	**450**	516	↑		629	891	1111	997	866	574	412	403	371	419	518	516	450
	Follow Up	Number of patients waiting for a follow-up outpatient appointment	Nov-22	69268	**117900**	116844	↓		112915	113705	112312	112359	113107	114624	113809	114441	117711	117586	119848	116844	117900
		Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Nov-22	3903	**20622**	20894	↑		17805	18504	18604	18032	17939	18787	18402	19055	21650	21306	21676	20894	20622
	HRF	% of R1 patients who are waiting within 25% in excess of their clinical target date	Nov-22	95%	**56.8%**	55.6%	↑		60.0%	59.4%	58.6%	59.0%	59.5%	57.7%	56.8%	55.4%	53.6%	54.4%	54.7%	55.6%	56.8%
	STROKE	% stroke patients directly admitted to acute stroke unit ≤4 hours	Oct-22	50%	**20.0%**	25.0%	↓		8.2%	18.5%	12.5%	14.0%	14.5%	10.3%	21.7%	25.9%	10.7%	25.0%	25.0%	20.0%	
		% of stroke patients assessed by a stroke consultant ≤24 hours	Oct-22	85%	**80.0%**	92.7%	↓		87.1%	77.8%	78.9%	93.0%	94.3%	96.7%	100.0%	94.5%	89.7%	50.0%	92.7%	80.0%	
		% of stroke patients receiving the required minutes for speech and language therapy	Oct-22	57%	**30.0%**	26.7%	↑		15.5%	13.1%	28.1%	53.5%	13.6%	20.0%	46.9%	39.0%	39.4%	33.1%	26.7%	30.0%	
		Percentage of stroke patients who receive mechanical thrombectomy	Oct-22	10%	**0.0%**	2.5%	↓		2.0%	1.4%	1.4%	1.5%	0.5%	0.8%	1.6%	1.9%	3.4%	0.0%	2.5%	0.0%	
	ED	Category A ambulance response times within 8 minutes.	Nov-22	65%	**55.2%**	56.4%	↓		57.2%	57.6%	56.5%	58.1%	57.4%	59.6%	59.3%	55.0%	62.7%	56.1%	59.3%	56.4%	55.2%
		Number of ambulance handovers over one hour	Nov-22	0	**841**	882	↑		804	720	791	853	737	794	847	793	808	782	789	882	841
		% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Nov-22	95%	**72.3%**	73.9%	↓		71.9%	74.1%	76.3%	74.9%	73.7%	76.4%	74.2%	71.4%	73.0%	75.6%	74.8%	73.9%	72.3%
		Number patients waiting > 12 hrs in ABUHB A&E departments	Nov-22	0	**1662**	1689	↑		1413	1270	1241	1354	1509	1229	1378	1658	1607	1437	1415	1689	1662
	Cancer	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	Oct-22	75%	**53.3%**	54.2%	↓		58.1%	66.7%	56.6%	64.4%	59.7%	56.9%	53.4%	49.4%	50.4%	53.0%	54.2%	53.3%	
	MENTAL HEALTH	Assessment by LPMHSS within 28 days of referral.	Jul-22	80%	**91.6%**	78.3%	↑		88.9%	86.3%	48.2%	83.7%	77.5%	65.6%	82.7%	78.3%	91.6%				
		Interventions ≤ 28 days following assessment by LPMHSS.	Jul-22	80%	**27.8%**	18.1%	↑		22.6%	22.3%	14.1%	13.1%	10.7%	11.2%	14.6%	18.1%	27.8%				
		Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Jun-22	80%	**72.0%**	72.0%	↑		77.5%	75.7%	77.2%	74.6%	72.3%	69.3%	72.0%	72.0%					
	CAMHS	4+ Weeks Waiting List	Jul-22	80%	**98.1%**	97.7%	↑		100.0%	94.7%	96.2%	97.2%	100.0%	96.3%	98.3%	97.7%	98.1%				
		Neurodevelopmental (iSCAN) Waiting List	Nov-22	80%	**47.8%**	47.7%	↑		76.8%	68.1%	65.7%	60.1%	56.2%	53.2%	47.3%	47.5%	47.2%	47.7%	47.7%	47.7%	47.8%
	HCAIS	Cases of e coli per 100k population (rolling 12m)	Nov-22	67	**54.33**	55	↑		54.66	55.5	56.34	57.17	58.01	56.84	57.51	55.67	55.02	57.17	56.84	55	54.33
		Cases of staph aureus per 100k pop (rolling 12m)	Nov-22	20	**23.74**	23.91	↑		24.24	23.91	22.57	22.74	22.4	22.07	22.07	23.07	22.01	22.74	23.24	23.91	23.74
		Clostridium difficile cases per 100k pop (rolling 12m)	Nov-22	25	**32.93**	34.1	↑		31.43	32.26	31.76	32.93	34.27	34.94	35.27	32.93	33.51	32.6	33.77	34.1	32.93
		Cases of klebisella per 100k population (rolling 12m)	Nov-22		**16.88**	16.22	↓		17.55	17.55	16.38	16.22	15.55	15.88	15.88	15.38	18.51	15.38	17.22	16.22	16.88
		Cases of aeruginosa per 100k population (rolling 12m)	Nov-22		**3.51**	4.01	↑		5.52	5.18	5.02	5.18	5.18	5.18	4.85	4.68	3	4.35	4.18	4.01	3.51
		Cumulative number of laboratory confirmed bacteraemia cases - Klebsiella sp	Nov-22	8	**11**	5	↓		7	8	4	6	6	10	9	9	9	8	15	5	11
		Cumulative number of laboratory confirmed bacteraemia cases - Aeruginosa	Nov-22	2	**1**	3	↑		4	0	3	2	2	0	1	3	2	3	1	3	1

Integrated Performance Dashboard

November 22

Appendix 1

Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Aim 1: People in Wales have improved health and well-being with better prevention and self-management	SMOKING CESSATION	Percentage of adult smokers who make a quit attempt via smoking cessation services	Jun-22	1.25%	**1.2%**	na	↓			3.2%			4.3%			1.2%					
	CHILDHOOD IMMUNISATION	Percentage of children who received 2 doses of the MMR vaccine by age 5	Sep-22	95%	**90%**	na	↓			90%			92%			91%			90%		
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Sep-22	95%	**94%**	na	↓			97%			95%			94%			94%		
	MENTAL HEALTH	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (under 18)	Jun-22	90%	**99%**	99%	↓		98%	94%	98%	95%	80%	99%	99%	99%					
		Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Jun-22	90%	**75%**	80%	↓		87%	83%	82%	78%	81%	78%	80%	75%					
Aim 3: The health and social care workforce is motivated and sustainable	W&D	% PADR / medical appraisal in the previous 12 months	Aug-22	85%	**64%**	63%	↑		59%	59%	61%	60%	58%	59%	60%	62%	63%	64%			
		Monthly % hours lost due to sickness absence	Aug-22	7%	**7%**	7%	↑		7%	7%	6%	6%	7%	7%	7%	7%	7%	7%			
		Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	Aug-22	85%	**82%**	82%	↑		77%	78%	73%	73%	74%	75%	81%	81%	82%	82%			
Aim 4: Wales has a higher value health and social care system	CODING	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Sep-22	95%	**87%**	85%	↑		86%	86%	85%	85%	86%	87%	86%	87%	88%	85%	87%		
	AGENCY	Agency spend as a percentage of total pay bill	Aug-22	10%	**9%**	10%	↑		10%	10%	10%	10%	11%	9%	10%	10%	10%	9%			

Trend Key

- ↑ Achieving rating target and improved against previous reported position
- ↓ Achieving rating target but deteriorated against previous reported position
- ↑ Not achieving rating target but improved against previous reported position
- ↓ Not achieving rating target and deteriorated against previous reported position

If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 3.1a

Aneurin Bevan University Health Board

Planned Care Recovery Programme

Executive Summary

The challenge in Planned Care is not to be understated, post pandemic, as we mobilise to return to pre-COVID activity as well as responding to unprecedented backlogs of patients on our waiting lists.

The Welsh Government Published "Our Programme for transforming and modernising planned care and reducing waiting lists in Wales" on 26th April 2022. The document sets out the Welsh Governments ambition for Planned Care Services with four commitments:

- Increase Health Service Capacity
- Prioritise Diagnosis and treatment
- Transform the way planned care in provided
- Provide better information and support to patients

Within the programme the Welsh Government have set a series of ambitious targets for Planned Care Services. The Health Board has had a Planned Care Programme for several years, including programmes on the transformation of Outpatients and Cancer Services. In light of the new national programme, the need to accelerate the recovery of planned care services and learning from the pandemic, as set out the in the IMTP, the Health Board has reset and relaunched the organisations Planned Care Programme.

The organisation is already making progress in many areas and this report provides an updated view of the position as at the end of November 2022 that last validated month of reported data.

The Board is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Chris Dawson-Morris, Interim Director of Planning

Report Author: Rachel Savery, Senior Programme Manager, Hannah Brayford, Senior Planning Manager, Ruby Punchard, Senior Programme Manager

Report Received consideration and supported by :

Executive Team		**Committee of the Board**	Finance & Performance Committee

Date of the Report: 28th December 2022

Supplementary Papers Attached: Our programme for transforming and modernising planned care and reducing waiting lists in Wales

Purpose of the Report

The Planned Care Programme was identified as a priority programme for 2022/23 in the 2022/25 IMTP approved by the Board in March 2022. The Planned Care Programme re-launched in June 2022, and brings together existing programmes, as well as new key workstreams identified by our IMTP alongside those set out by Welsh Government in the national programme.

The Minister has set a number of Priorities for Planned Care Recovery, with a particular focus on patients waiting 52 weeks for new outpatient appointments with an aim to remove these by the end of the year and to eliminate 104 week waits for treatment by 2024.

This report sets out the current position and planned trajectories for the Health Board for tackling the long waiters.

Background and Context

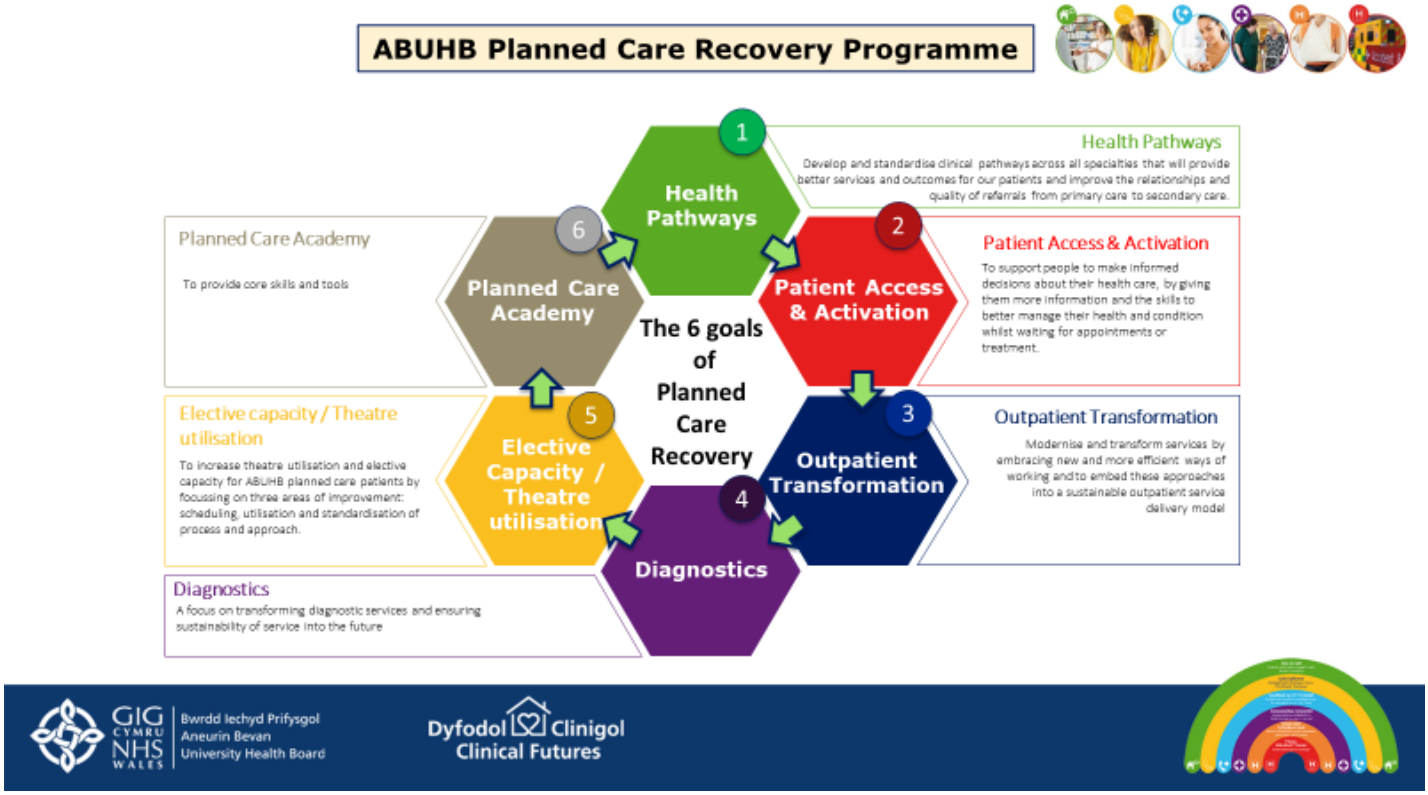
In forming the Planned Care Recovery Programme the Health Board has agreed the below as our Planned Care Principles. These provide a set of guiding principles to support out decision making:

- Reducing Health Inequality will be core to decision making
- Sustainability of service delivery for the long term
- Focussing on clinical need in prioritisation
- Maximise an individual's time, both citizens and staff
- Intelligence led decision making, with a common and shared understanding of delivery
- System based decision making

The Programme is structures around 6 goals of Planned Care that sit within the programme are

- Health Pathways
- Patients Access and Activation
- Outpatient Transformation
- Diagnostics
- Elective Capacity / Theatre Utilisation
- Planned Care Academy

These goals cover each aspect of the patient pathway ensuring a joined up and strategic approach to transformation and making the best use of the resources available.



Core metrics were agreed at the September Programme Board for the overall programme, and are:

- RTT 52- and 104-week delivery and trajectories, in line with ministerial priorities.
- Treat in Turn rates – this is the principle of treating the longest waiting patient in turn (whilst also accommodating clinical urgency)
- Activity levels- This is recovering activity to pre-covid levels

These metrics will be overseen by the Planned Care System Leadership and Response (SLR) group, which had its inaugural meeting on the 9th of September 2022. Here, detailed performance analysis will occur in relation to programme and workstream metrics, with trajectories informing activity levels, working closely with operational teams delivering against these targets. We have developed Treat in Turn metrics by speciality and sub-speciality to understand the granularity of the performance data.

Real time Demand and Capacity modelling is underway, to ensure all specialities and sub-specialities are clear on the demand and required response to hit target. Activity levels have been mapped against demand as detailed below:

Overview of health board performance

View of waiting list

*Outpatient 52 and 104 Week Cohort December 2022 as at **05/12/2022***

Row Labels	52 Week Cohort (Current Week)	Predicted 52 Week Cohort Dec 2022	Over 52 Weeks (Current Week)	104 Week Cohort Dec 22 (Current Week)	Predicted 104 Week Cohort Dec 22	Over 104 Weeks (Current Week)	% Attendance (4 week average)against 2019-20	OpAttendances (4 Week Avg)
Family and Therapies								
Cardiology	0	0	0	0	0	0	103%	4
Gynaecology	454	288	294	0	0	0	131%	259
Paediatric	0	0	0	0	0	0	118%	74
Medicine								
Cardiology	32	0	0	0	0	0	150%	193
Care Of The Elderly	0	0	0	0	0	0	106%	56
Clinical Pharmacology & Therapeutics	1	1	0	0	0	0		2
Diabetes & Endocrinology	0	0	0	0	0	0	111%	73
Gastroenterology	101	0	17	0	0	0	117%	146
Infectious Diseases	0	0	0	0	0	0	51%	2
Nephrology	0	0	0	0	0	0	145%	17
Neurology	0	0	0	0	0	0	146%	87
Respiratory	0	0	0	0	0	0	112%	135
Stroke	0	0	0	0	0	0		12
Scheduled Care								
Chemical Pathology	53	43	49	0	0	0	105%	17
Clinical Haematology	0	0	0	0	0	0	92%	138
Dermatology	20	0	6	0	0	0	109%	305
Ear Nose & Throat	3715	3247	3435	1049	868	974	88%	194
General Surgery	103	24	48	1	1	1	127%	424
Ophthalmology	2883	2461	2533	4	0	0	110%	241
Orthodontics	161	147	144	0	0	0	83%	13
Pain Management Service	0	0	0	0	0	0	56%	23
Radiology	0	0	0	0	0	0	189%	12
Restorative Dentistry	0	0	0	0	0	0	24%	3
Rheumatology	1	1	1	0	0	0	129%	55
Trauma & Orthopaedic	2486	1908	2264	451	351	388	106%	320
Urology	993	791	912	118	89	97	87%	128
Vascular Surgery	0	0	0	0	0	0		35
Grand Total	**11360**	**9058**	**10031**	**1624**	**1293.25**	**1460**	**113%**	**3027**

Assessment and Conclusion

The progress against ministerial Priorities and Trajectories as at December 2022 is shown below

Progress against Ministerial Priorities and Trajectories

	Measure	Target	Forecast Mar-22	Projection APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
ACCESS TO TIMELY PLANNED CARE	Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2024	8,946	6,514	6,029	5,813	4,485	3,962	3,618	3,251	2,899	2,719	2,222	2,059	2,383
	Progress			6,514	6,029	5,813	5,778	5,730	5857	5773	5886				
	Q2 Model refresh										4466	4412	4165	4095	4201
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by October 2022	9,975	8,925	9,147	9,381	9,200	9,000	9,000	9,100	9,200	9,300	9,300	9,300	9,300
	Progress			8,925	9,147	9,381	10,076	10,373	10831	10883	11033				
	Q2 Model refresh										9810	9902	9540	9709	10007

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Dyfodol Clinigol Clinical Futures

As can be seen in the table, the Health Board has made some progress in reducing waits for patients and performance for both areas is broadly in line with forecast activity. Aggregating the data to an organisational level masks that in many specialty areas performance levels have already been achieved and the challenge remains in a handful of particular specialties. In particular Orthopaedics, ENT (Ear Nose and Throat) and Ophthalmology.

Specialty	Over 52 Weeks	Cohort Dec 22	With Booked Date			Grouped Waits	% of over 52 weeks total	With Booked Date		
			Total	In Cohort	% Rate			Total	In Cohort	% Rate
Ear Nose & Throat	3435	3715	554	333	60.11%					
Ophthalmology	2533	2883	776	223	28.74%					
Trauma & Orthopaedic	2264	2486	1032	356	34.50%	> 50 over 52				
Urology	912	993	475	82	17.26%	weeks at	99%	3681	1202	33%
Maxillo-Facial	328	357	174	56	32.18%	census date				
Gynaecology	294	454	592	123	20.78%					
Orthodontics	144	161	78	29	37.18%					
Chemical Pathology	49	53	48	3	6.25%					
General Surgery	48	103	1115	49	4.39%	> 0 and < 50				
Gastroenterology	17	101	705	101	14.33%	over 52 weeks	1%	2723	170	6%
Dermatology	6	20	482	16	3.32%	at census date				
Rheumatology	1	1	308	1	0.32%					
Pain Management Service	0	0	65							
Diabetes & Endocrinology	0	0	294							
Respiratory	0	0	429							
Cardiology	0	32	800	32	4.00%					
General Medicine	0	0	0							
Nephrology	0	0	80							
Radiology	0	0	16							
Neurology	0	0	226			No patients	0%	2741	33	1%
Infectious Diseases	0	0	1			over 52 weeks				
Restorative Dentistry	0	0	7			at census date				
Stroke	0	0	16							
Clinical Haematology	0	0	199							
Clinical Pharmacology & Therapeu	0	1	15	1	6.67%					
Vascular Surgery	0	0	187							
Paediatric	0	0	293							
Care Of The Elderly	0	0	178							
Grand Total	**10031**	**11360**	**9145**	**1405**	**15%**			**9145**	**1405**	**15%**

An exercise in waiting list validation is an important tool in providing accurate data about progress, as some patients find that their circumstances have changed result of the long waiting times. Through this patent communication exercise 8,625 letters have been sent out to out longest waiting patients and above 70% have requested to stay on list for completed periods. 1,864 patients have been removed from the list through removals other than treatment (ROTT).

Orthopaedics Update:

The Orthopaedic position continues to improve at both 52 and 104 weeks. The Directorate aimed to eliminate 104-week outpatient waits in all subspecialties with the exception of spines, which is forecasted to be approximately 350 patients by the end of December.

Consultant capacity remains a challenge in key sub-specialties. Interviews are being held for an arthroplasty consultant vacancy in mid-January and likely to take up post before or shortly after the end of the fiscal year along with two further consultants returning to work following extended periods away from the service, significantly increasing capacity.

Demand and capacity planning is underway for 2023/24 and aims to eliminate 52-week outpatient waits within the fiscal year. Spines is recognised as the key challenge to achieving this goal and the Directorate have recently met with a GIRFT (Getting it Right First Time) spinal expert. The Directorate has commenced planning on the necessary service change to move to the GIRFT advised model and recruitment is underway for two specialty doctors to support this significant service redesign.

ENT Update:
Within this specialty there has been a significant focus on Paediatrics with no over 52 week waits for this patient group. The top 10 longest waiters are now all on the treatment stage and the teams are considering further opportunities for improvements through the outpatient transforms work. On-going effort to validate the waiting list are also taking place.

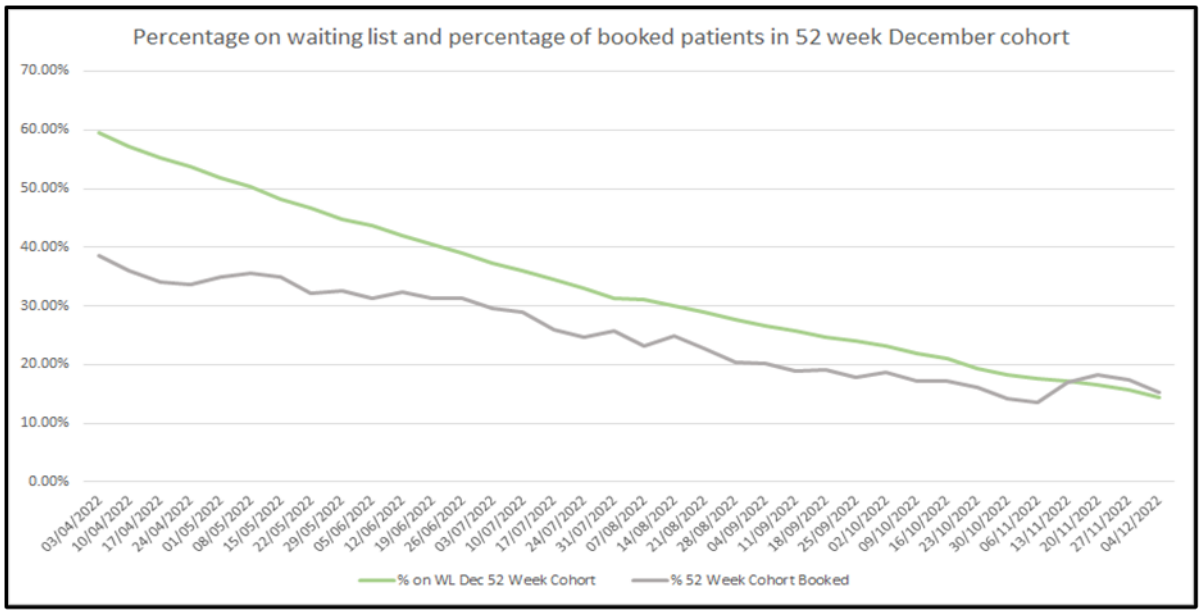
The primary constraints for ENT are staffing with significant consultant vacancies

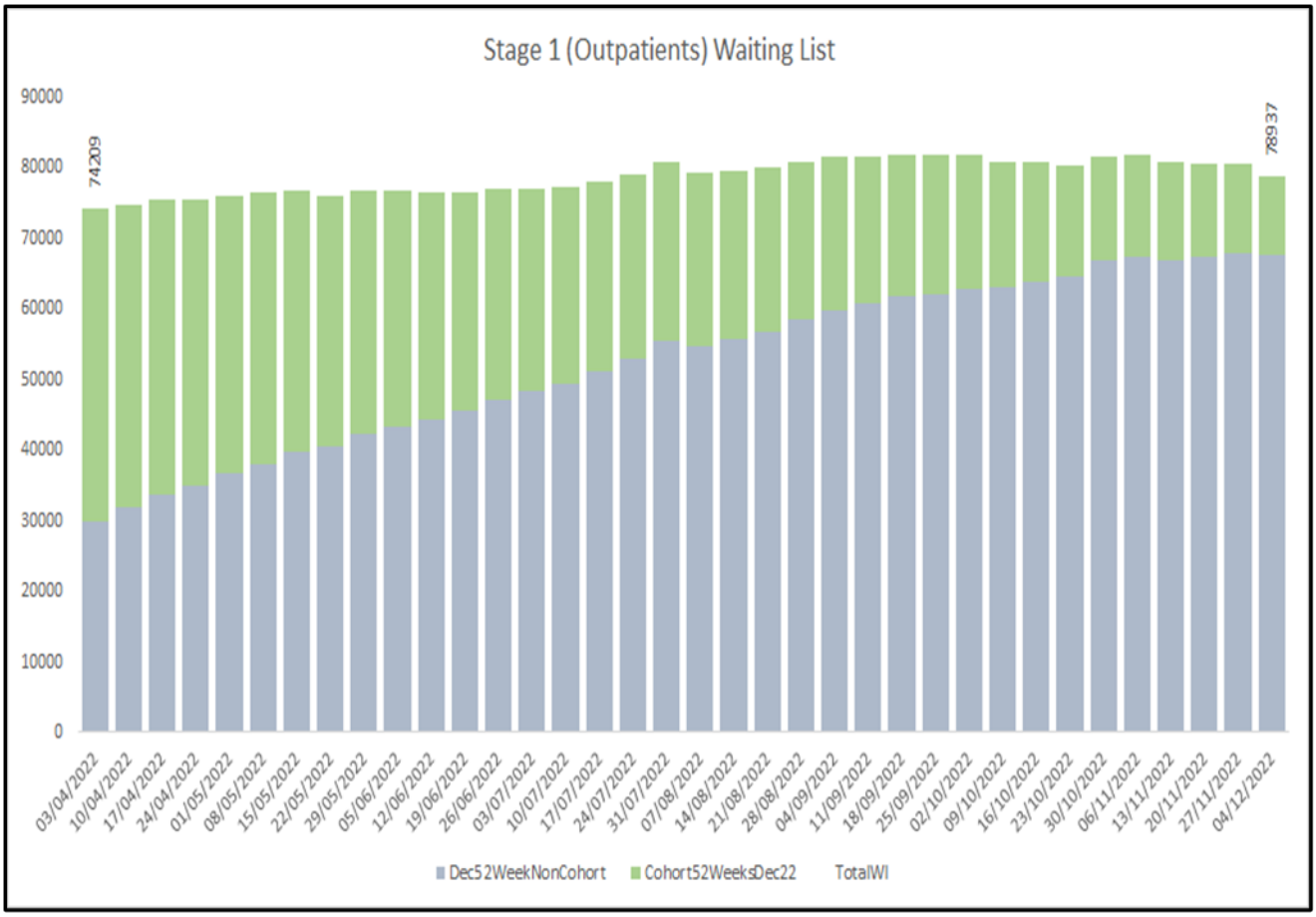
Row Labels	52 Week Cohort (Current Week)	Predicted 52 Week Cohort Dec 2022	Over 52 Weeks (Current Week)	104 Week Cohort Dec 22 (Current Week)	Predicted 104 Week Cohort Dec 22	Over 104 Weeks (Current Week)	% Attendance (4 week average)against 2019-20	OpAttendances (4 Week Avg)
Ear Nose & Throat	3715	3247	3435	1049	867.5	974	88%	194
Grand Total	**3715**	**3247**	**3435**	**1049**	**867.5**	**974**	**88%**	**194**

Ophthalmology Update:
Within this area there is significant focus on cataracts as the largest patient group of over 52-week waiters, but there are no waits over 104 weeks within this specialty. The Health Board is working regionally with Cardiff and Vale University Health Board to utilise additional capacity at UHW to support reduction of the treatment waiting list.

The team have renewed efforts on Glaucoma patients and the team are looking at a rapid access clinic to increase patient numbers and additional support follow up patients over target. Primary Care links are being strengthened and work to further understand patient needs and investigate reasons for non-attendance are being undertaken.

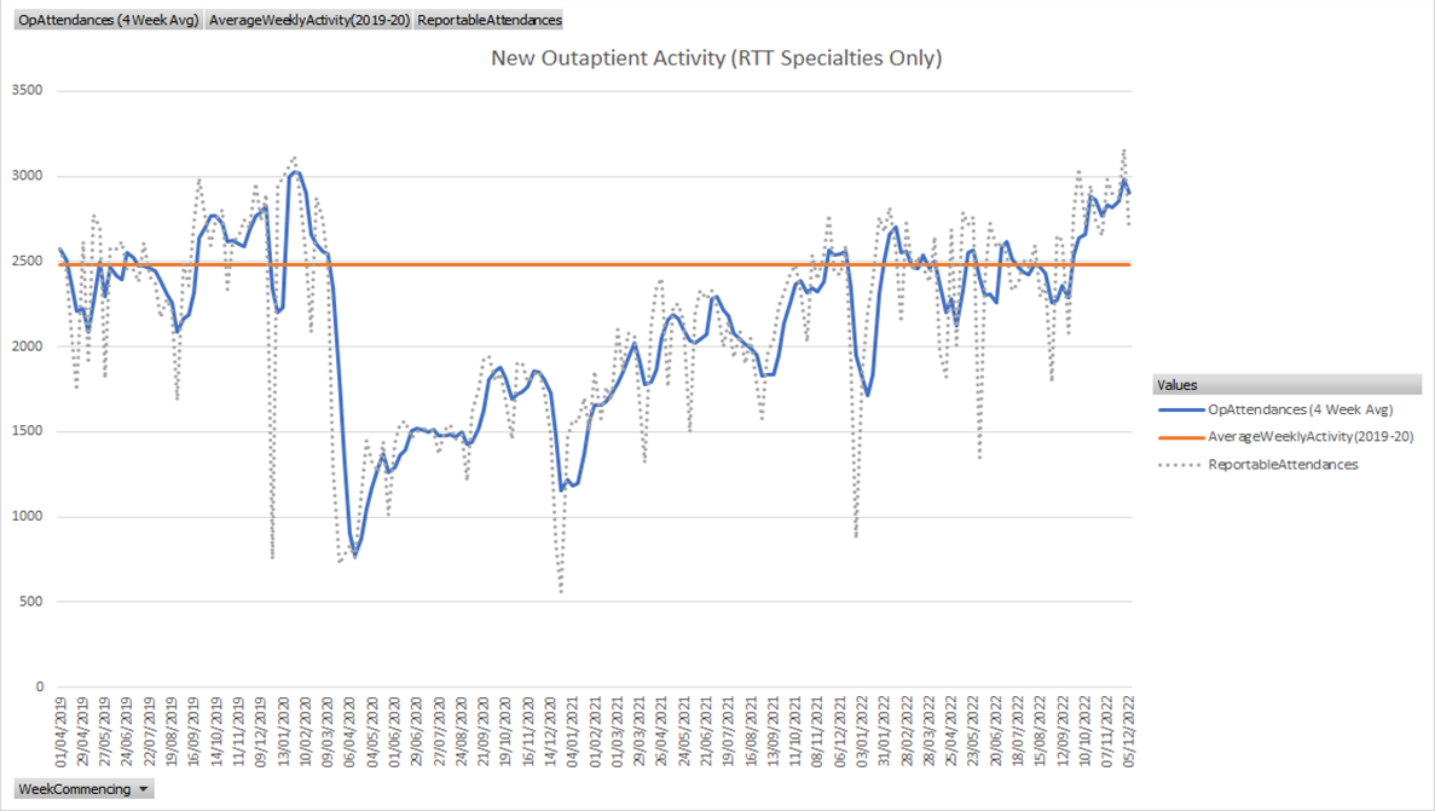
Treat In Turn Level
The Health Board has been challenged to utilising and targeting capacity at the longest waiting cohort of patients. This has to be balanced with treating clinical urgency, revised guidance from the Welsh Government set out the longest waiting patients should be given similar priority to the most clinically urgent patients. Of the patients on a wating list in the Health Board 14% are in the cohort who would breach 52 weeks by the end of December. As set out in the graphs below there has been steady progress in booking these patients into clinics, demonstrating effective use of capacity overall by the organisation. Whilst these is again variation by speciality overall there is improvement in treat in turn rates.





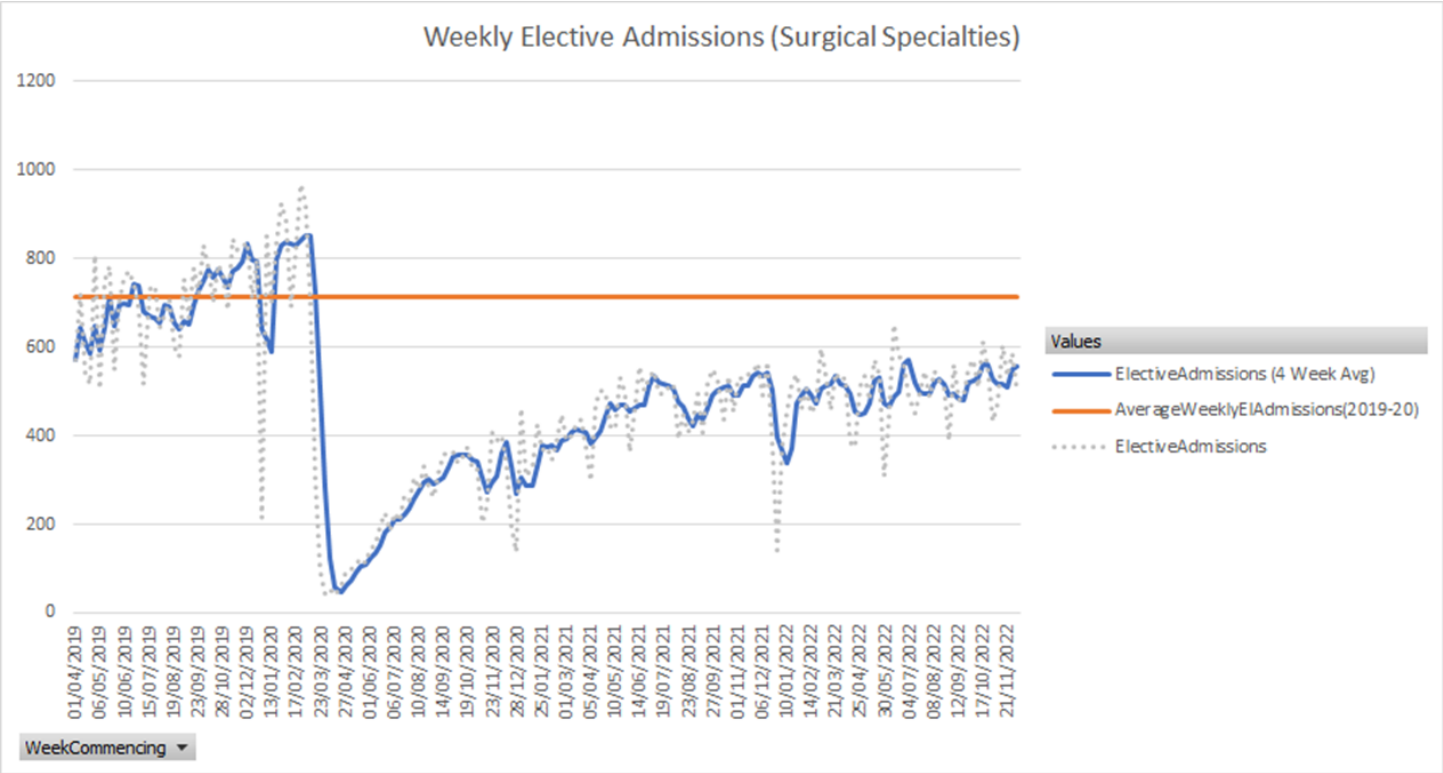
Activity Vs Pre Covid

Outpatient activity has already exceeded pre-pandemic levels at a cross organisational level. As can be seen in the graph below, with some specialties significantly improving activity. However, performance does vary and targeted work in underway through the outpatients element of the programme to support these specialties.



Row Labels	% Attendance (4 week average) against 2019-20	OpAttendances (4 Week Avg)
Family and Therapies		
Gynaecology	114%	226
Paediatric	129%	81
Medicine		
Cardiology	142%	160
Care Of The Elderly	90%	47
Diabetes & Endocrinology	107%	71
Gastroenterology	114%	136
Infectious Diseases	44%	2
Nephrology	146%	17
Neurology	147%	86
Respiratory	121%	140
Stroke		11
Scheduled Care		
Chemical Pathology	99%	14
Clinical Haematology	128%	147
Dermatology	148%	268
Ear Nose & Throat	94%	207
General Surgery	126%	414
Maxillo-Facial	76%	60
Ophthalmology	127%	244
Orthodontics	83%	13
Pain Management Service	51%	21
Radiology	161%	10
Rheumatology	145%	60
Trauma & Orthopaedic	105%	315
Urology	86%	121
Vascular Surgery		37
Grand Total	117%	**2907**

In relation to treatments activity has also increased significantly with activity to November back to 78%. Again, there is variation by specialty. Some of this variation is driven by changes in practice and new service models. For example, a new Ambulatory Gynaecological has been established, moving procedures to day case activity.



Row Labels	%El Admissions 4 Week Avg v 201920	Elective Admissions (4 Week Avg)
Ear Nose & Throat	83.02%	30
General Surgery	75.53%	166
Gynaecology	56.56%	32
Maxillo-Facial	91.09%	45
Ophthalmology	63.51%	64
Trauma & Orthopaedic	93.09%	144
Urology	77.34%	73
Vascular Surgery		3
Grand Total	**78.14%**	**556**

Recommendation

The Committee is requested to note the contents of the paper and the early stages of the Planned Care Recovery Programme.

The Committee is also requested to note the challenging environment that the Programme sits within, to increase efficiency and performance activity at no additional cost to the organisation.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk areas and mitigation plans are inherent throughout the Programmes and align to the Corporate Risk Register. The programme and work areas all have risk registers
Financial Assessment, including Value for Money	As set out in the IMTP Planned Care is an area of opportunities for improved efficiency and value for money will be a core element of the programme
Quality, Safety and Patient Experience Assessment	Quality, Patient Safety and Patient Experience underpins the whole Planned Care Programme and runs as a theme throughout the work areas. In particular the patient experience whilst waiting is a core element of the plan.
Equality and Diversity Impact Assessment (including child impact assessment)	Key issues are reflected within the Programme with Reducing Health Inequality a guiding principle
Health and Care Standards	The Health and Care Standards underpin the Programme
Link to Integrated Medium Term Plan/Corporate Objectives	The Programme is one of the Clinical Futures Priorities set out in the IMTP for 22/25
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The Plan demonstrates an integrated approach to working across the Health Board and with partners and combines both short and long term goals. Sustainability is a core principle of the programme
Glossary of New Terms	Planned Care Recovery Programme – PCRP Referral to treatment - RTT Ear, Nose and Throat - ENT
Public Interest	This report has been written for the public domain.

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

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

APRIL 2022

gov.wales

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

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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:

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.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2022 Agenda Item: 3.1b

Aneurin Bevan University Health Board

Six Goals for Urgent and Emergency Care – Finance and Performance

Executive Summary

This paper outlines the Health Board's most recent performance status in relation to Urgent and Emergency Care and the proposed plans for making system improvements via the "Six Goals for Urgent and Emergency Care" Programme.

The Performance Data highlights some areas that have deteriorated and some with signs of improvement. However, it must be noted that this is snapshot from November 2022 and the current situation is expected to show an even more challenging picture for December.

However, through the Six Goals and other IMTP programmes there is considerable ambition and determination to deliver improvements for the population of Gwent and our staff. The Programme reflects this with numerous projects on-going and at various stages of life cycle.

The Board is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Leanne Watkins, Director of Operations	
Report Author: Simon Roberts, Senior Programme Manager, Clinical Futures	
Date of the Report: 3rd January 2023	
Supplementary Papers Attached: Appendix 1 – Six Goals Programme Plan	

Purpose of the Report

To provide the Committee with an overview of the Aneurin Bevan Initial 'Six Goals' Programme and associated performance and financial status.

Detailed Update

Performance

The last full performance report submitted on behalf of the Health Board was for the period November 2022. The below table represents the reported performance for Urgent care for that period.

Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend
Category A ambulance response times within 8 minutes.	Nov-22	65%	**55.2%**	56.4%	↓
Number of ambulance handovers over one hour	Nov-22	0	**841**	882	↑
% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Nov-22	95%	**72.3%**	73.9%	↓
Number patients waiting > 12 hrs in ABUHB A&E departments	Nov-22	0	**1662**	1689	↑

Table 1.1 Nationally reported Urgent Care measures for November 2022

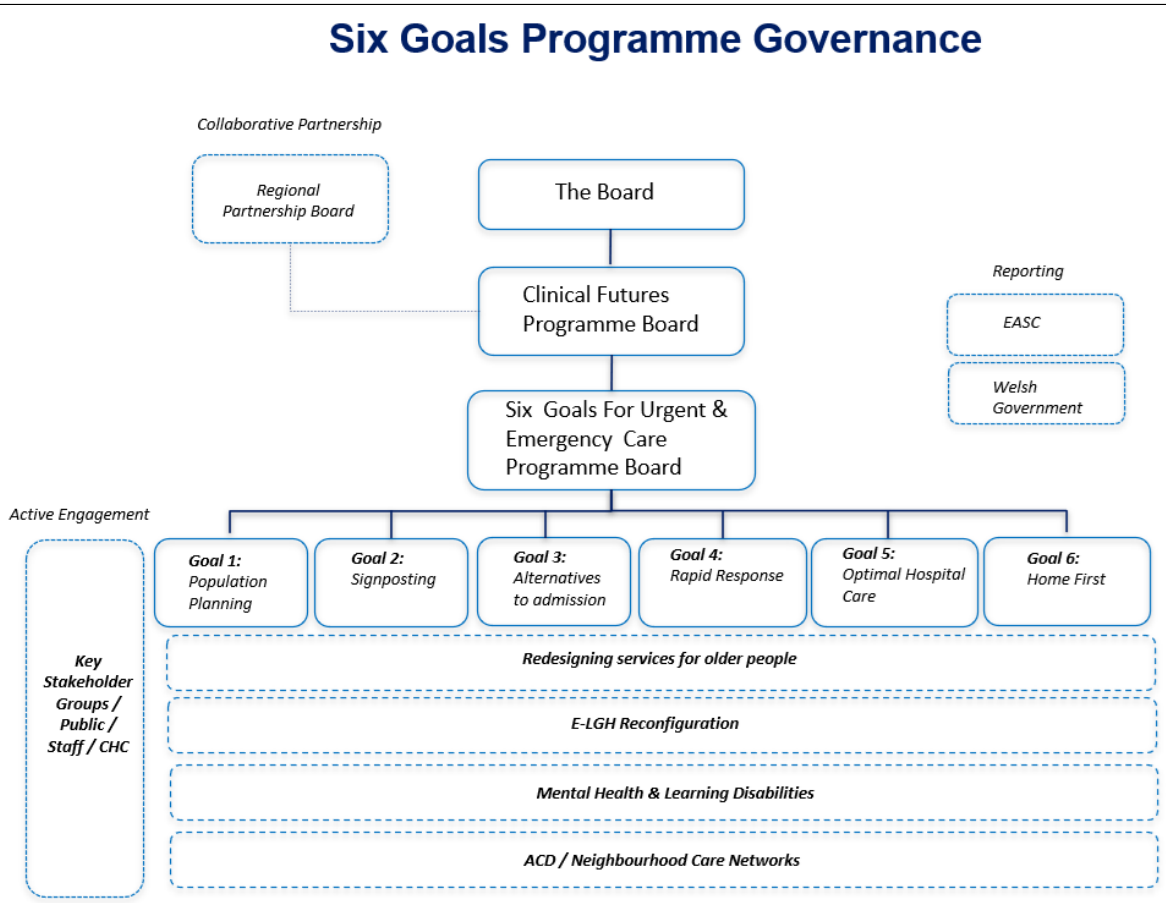
The data reflects what is a generally deteriorating position that is being felt both within Gwent but also nationally as we move further into winter. However, there are some areas that demonstrate improvement.

Category A ambulance response times within 8 minutes has deteriorated to 55.2% although the number of ambulance handovers within ABUHB exceeding 1 hour has improved to 841 occurrences. The proportion of patients waiting more than 4 hours within A&E (all sites) has deteriorated to 72.3% however the number of patients spending more than 12 hours in A&E has improved to 1662.

It is anticipated that December performance will be challenged even further due to a number of factors widely reported on nationally. These include factors such as higher levels of respiratory infections (flu, Covid-19, Strep A) in circulation combined with areas of staff shortages and strike action all affecting demand and subsequent ability to manage that demand.

In response to these pressures, the Six Goals for Urgent and Emergency Care Programme is already established with Six workstreams led by a mix of clinical and managerial leaders represented from both primary and secondary care.

The programme governance structure is as per below and recognizes key links to other IMTP programmes as well as the importance of reporting to the Regional Partnership Board and engagement with the CHC.



A national six Goals Programme Board exists to give strategic oversight and assurance for the delivery of Programme objectives. The Board is supported by a Programme integration group which consists of senior responsible officers (SROs) tasked with developing national action plans for each of the Six Goals intended to enable Health Boards and partners to deliver the policy vision.

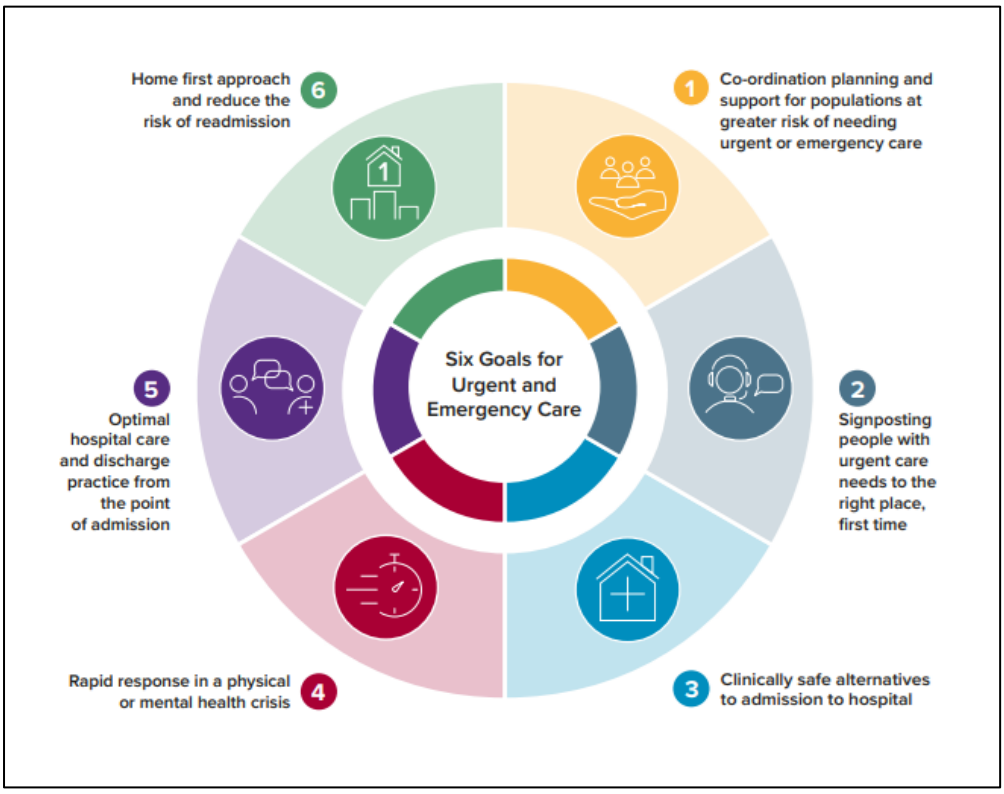
Welsh Government has indicated that two key priorities of programme are implementation of Urgent primary care Centers (UPC) and Same Day Emergency Care (SDEC) supported by £2.96M of revenue funding until 2025/26. The Programme plan addresses each of these areas.

Assessment and Conclusion

Progress Summary by Goal as of December 22

The Health Board has seen broadly positive momentum through each of the goals in the context of significant operational pressure. The connections between programmes are starting to mature, it is clear that projects in Goal 1 and 6 will primarily be driven through the 'Redesigning Services for Older People '(RSfOP) Programme.

Engagement with Welsh Government continues to build momentum with Welsh Government and national goal lead representation at programme board.



Goal 1: A ' High intensity User Service Model' exists within ABUHB where referrals are made to a Lead Nurse who is able to make the right community or social referral required to support the patient in safe discharge. However, the model requires strengthening to sustain and grow which is supported by the national Goal 1 lead. A Business case is in development and funding source required for this – closely linking with National Goal 1 lead to develop.
In addition, Proactive Falls and Frailty service scoping and design will form part of Goal 1 but is driven by the RSfOP Programme.

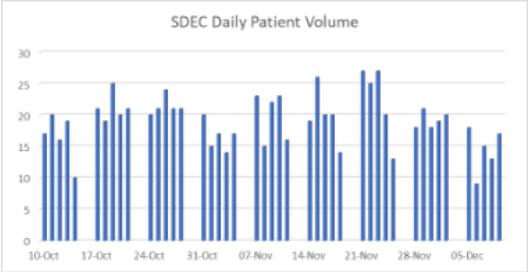
Goal 2: Urgent primary Care centres are already established with a number of referral streams including 111 and re-directions from Minor Injury Units or A&E. UPC has seen significant demand recently notably linked to Strep A concerns. Recently the National UPC programme led a peer review of our service, and the findings will be analysed, and action plan developed in early 2023. In Addition, a UPC model review is planned in February 23.

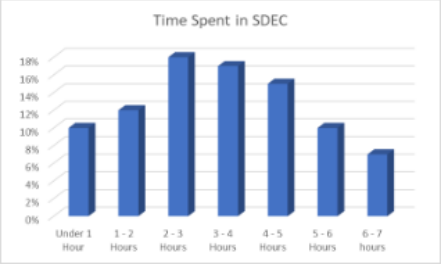
Goal 3: Same Day Emergency Care (SDEC) at the Grange opened in August 22, largely receiving General Surgery Patients however there are plans to maximize the capacity offered by SDEC by integrating Acute Medicine into the model. SDEC at Ysbyty Ystrad Fawr (YYF) opened in October 22, seeing 'ambulatory' medical patients referred from the AMU.

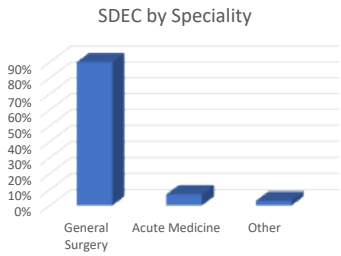
Further services based on the same day ambulatory care model have been implemented in the organisation. Respiratory Ambulatory Care (RACU) funding has been extended to March 23 with the centre established in the Royal Gwent Hospital. A Gastroenterology

Ambulatory Care (GACU) model provides consistent service and includes admission avoidance. Further detail on the SDEC service models and other existing services that work to the same principles are included below for information:

SDEC GUH at a Glance 8/8/22– 9/12/22







1667 Patients seen

Average 19 Patients per day

169 Next day Returners

Median time <3.5 hours

1320 patients Discharged Same Day (79%)

347 Admissions

Progress Summary

- Surgical model well developed :
  - Primarily GP referred via Flow Centre
  - Some Direct from ED Triage streaming
- Working with Trauma to introduce a pathway in Dec 22
- Plans to utilize for Acute Oncology patients in Feb 23
- Ad-hoc utilization forMaxfax, Gynae and Gastro
- Continue to explore speciality inreach
- Overall aim remains to embed an Acute Medicine Model but requires system wide capacity & workforce planning

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Dyfodol Clinigol Clinical Futures

Enhanced Local General Hospital Medical Assessment Units

- Approx 50 referrals (WAST and GP) streamed per day to eLGH (3 sites) via Flow centre
- Patients who meet criteria who do not require The Grange for assessment
- Approx 8 referrals per day from Minor Injury Units
- 80% + Assess out rates from eLGH MAUs

SDEC at The Grange

- Primarily General Surgery from GP via Flow Centre, some from ED
- Introducing a wider range of specialty same day access
- Plan to fully adopt for Acute Medicine linked to workforce change across system
- Mean range 17 to 29 Patients per day, plan to double via acute medicine roll out

SDEC at Ysbyty Ystrad Fawr

- Referrals from Medical Assessment Unit
- Primarily COTE patients
- 7 – 10 patients per day

Respiratory Ambulatory Care Unit (RACU) St Woolas

- GP Referrals from Flow Centre
- 7 - 8 patients per day
- *5 day 900-1300 – next day referrals until 4pm*

Gastroenterology Ambulatory Care Unit (GACU) Royal Gwent

- GP Referrals from Flow Centre and some from ED
- Mostly planed appointments but some acute / admission avoidance
- 2-4 acute referrals per day
- *5 day 900-1600*

In Addition, to support the principles of Goal 3 'admission avoidance' an Advanced Paramedic Practitioner (APP) is working in the flow centre from December 22 to support direction to the right place first time and also support joined up working between ABUHB and WAST. A Frailty Assessment Service Pilot planned in Jan 23.

Goal 4: ABUHB has received funding via the Six Goals national 'Innovation Fund' to support implementation of an electronic Triage solution for ED and MIUs. The eTriage project board has been established, aiming to implement in Q2 2023 which will improve clinical visibility of the often very busy waiting areas and improve patient experience.

Ambulance handover improvement is a key focus of Goal 4 and there is a plan to pilot a push model of flow in Q4 22. This would encourage timely referrals of limited patients to specialities at given times of the day ensuring that clinical risk is more equitable across a hospital site.

Goal 5: A re-energized Discharge planning framework will be launched in January 2023 in collaboration with the Delivery Unit. So far, training has been completed at eLGH sites with Focused engagement led at 3 wards on at each site to engage staff and generate ideas for improvement linked to Multi-Disciplinary Team Board rounds, daily huddles, red/green days and criteria led discharge.

Goal 6: A business case has been approved to provide additional First Front Door Therapies staff dedicated to ED to support a 'home first' approach. The first team member started in Late December with on-going recruitment to additional therapies posts. Homeward bound Nurse led wards have been developed at 2x eLGH sites for Medically Fit For Discharge patients with the aim that this provides more suitable care for those not requiring regular medical intervention and encouraged reablement.

In Summary, it is generally accepted that there is no one single solution to alleviate some of the challenges faced currently, however through a mix of tactical and strategic initiatives incremental improvement can be made to improve patient care and staff wellbeing in what is an increasingly challenging environment.

Recommendation
The Committee is asked to note the contents of this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the financial benefits are being assessed to ensure value for money.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.

Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact, but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Six Goals is part of both short- and long-term strategy
	Integration – It is anticipated that Six Goals will have a positive impact upon the well-being of staff and population
	Involvement – Involvement of various internal and external groups is continuous
	Collaboration – Collaboration with various internal and external groups is continuous
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report not to be published.

Six Goals Programme Plan
December 2022

Six Goals Work Programme

Six Goals For Urgent & Emergency Care Programme

Goal 1: *Population Planning*

High Intensity Service Users

Proactive Falls

High Risk Adult Cohort

Goal 2: *Signposting*

Urgent Primary Care Centres

NCN Signposting

111 & Option 2

Goal 3: *Alternatives to admission*

SDEC / Hot clinics

Flow Centre Development

One directory

Scheduled MAU slots

Goal 4: *Rapid Response*

Physician response unit

eTriage

Mental Health services

ED referral Improvement

WAST Improvement

Goal 5: *Optimal Hospital Care*

Discharge Pathways

SAFER Principles

Education & Training

PSAG Boards

Goal 6: *Home First*

ED Therapy services

MFFD Cohort

Trusted Assessor Model

Rapid Response and Community resilience

Six Goals Plan

A high level overview of activity and deliverables planned to 2024

Workstream	2022 Q2	2022 Q3	2023 Q4	2023 Q1	2023 Q2	2023 Q3	2024 Q4	Key Upcoming Dates
Goal 1 *Population Planning & Intervention*	HISU: Business Case Development (Expansion & Integration)	RSfOP 2: Community Falls response/Prevention		RSfOP 1:Proactive Frailty (HRAC)				**Oct 22** - Falls Response Mapping **26th Oct 22** - HISU Business case to PIP **19th Sept 22** - RSfOP 1 Project team recruitment to commence
Goal 2 *Signposting*	UPC GUH Audit	Signposting Table top	111 Option 2 Development	GP+	ACD : ACD Development	MSK 1 : Therapies MIU/UPC		**Oct 22** - Signposting Tabletop Analysis **Nov 22** - MH Single point of access via 111 go-live
Goal 3 *Safe Alternatives to Admission*	SDEC CEPOD Pilot Scheduled AMU Slots	SDEC GUH (Phases 1-4) SDEC: RACU (Respiratory - to Mar 23) SDEC YYF Pilot to Mar 23 CF7 Pathways (eLGH) Flow Centre APP Pilot		RSfOP 2: Hot Clinics/Ambulatory Care	One SPA review (FC & SPA)			**17th Oct 22** - SDEC CEPOD PIlot at RGH **Oct 22** - YYF SDEC planned commencement **Nov 22** - Flow Centre APP Pilot **Nov 22** CF7 pathway Proposals to LMC
Goal 4 *Rapid Response*	Review of MH pathways and referral	PRU Business Case eTriage Implementation	WAST Improvement plan					**26th Oct 22** - PRU Business case to PIP **Oct 22** - Commence etriage T&F group **Oct 22** - MH Pathway volume/outcome review to Execs
Goal 5 *Optimal Hospital Care*	GUH Patient Pathways (1, 2 , 3) Discharge Planning Reviews eLGH: eLGH Reconfiguration	Education and Training PSAG Improvement with Digital enablers Roles/Responsibilities Task & Finish						**Sept 22** - Discharge Planning training at 3 sites **Oct 22** - eLGH Flow Centre 'table top' analysis **Oct 22** - GUH clear status pathways flowdown to staff
Goal 6 *Home First*	MFFD Cohort Begin joint trusted assesor model discussions RSfOP: Direct Access Pathways	Front Door Therapies GUH & Criteria led discharge pilot	RSOP 1: Extension of Core Rapid Medical (HCSW 8-8) RSOP 1: Urgent Responsive Care at Home (Overnight HCSW)					**13th Oct 22** - MFFD Proposal to Execs **Nov 22** - Rapid Response negamenet events **Nov 22** - Advertise posts for Overnight HCSW **Dec 22** - 1st Therapies posts recruited to

Denotes Governance outside of Six Goals Programme

Denotes funding through RIF

Goal Leadership:
- Will Beer
- Dr Graeme Yule

Goal 1: Population, Planning, Prevention

	Work Area	Actions	Lead/Sub Lead	Timeframe	Progress
1.1	**High Intensity Users**	• Develop business for enhanced integrated model including community outreach, joining up response to frequent attenders to ED, OOHs, WAST and facilitating care plans • Integrated processes with Health Inclusion Service to support vulnerable service users (drug users, sex workers, homeless, refugees) • Further integration with other agencies via community panel meetings including Welsh refugee support, housing, The Wallich etc) • Consider hub approach to bring together support services, located near to RGH, to support redirection	Will Beer/Victoria Goodwin	Q3 2022/2023 Q3 2022/2023 Q4 2022/203 TBC/longer term plan	- Business Case is developed and will be submitted via PIP process however **funding source not yet identified** - Linking with National Goal 1 lead for possible funding and model design
1.2	**Proactive Frailty (High Risk Adults Cohort)** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Building upon the work of the High-Risk Adults Cohort Project, implement a process to ensure multi-agency and proactive management of those who are at risk of frailty or of whose risk is increasing. • Scope pilot in one area • Plan and design systematic implementation including identifying resource requirements	Will Beer/Mel Laidler	Scoping -2022/2023 (programme resource dependant) Implementation- 2023/204	- Successful Winter Bid to Regional Integrated Fund to bring forward planning and scoping phase to Q3/Q4 2022/2023 (project manager, medical sessions, project support) -Project Manager post on trac
1.3	**Proactive and preventative response to falls in the community** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Work in partnership to develop a proactive and preventative falls programme in the community • Map the current falls provision across the CRTs • Support Monmouthshire NCN as 'test bed' Borough for Household Cavalry approach • Scope a preventative and proactive community falls programme/action plan	Will Beer/Karen Hatch	Scoping - 2022/2023 Implementation- 2023/2024	-Monmouthshire proposal in development and seeking funding via Integrated Partnership Board- **Dec 2022** -Initial review of CRT Falls mapping to be discussed at the community falls group on 3rd Nov - **Nov 2022** - Gap analysis and rolling prevention campaign development

Goal Leadership:

- Dr Alice Groves
- Dr Alun Walters
- Rebecca Pearce

Goal 2: Signposting

	Work Area	Actions:	Lead (s)	Timeframe	Progress
2.1	Public Communications and Engagement	- Linking to Nye Bevan Champions forum (Third Sector) - Linking to large local employers - Start local and national messaging campaign via Six Goals Comms plan	Dr Alice Groves/Rebecca Pearce / James Hodgeson	- Through Winter	
2.2	Urgent Primary Care Centres (UPCC)C 24/7 Development	- In-hours Primary Care escalation - Re-directions review of outcomes - Scoping re-directions from GUH - GP+ (Access to diagnostics etc) - Ensuring pathway consistency	Dr Alice Groves/Rebecca Pearce	- On-going - Q2/Q3 2022 - TBC	Adastra outages has severely hampered progression during August /September
2.3	Think 111	- Develop working group to review TOR and risk associated with criteria - Development of MH services via option 2	Dr Alice Groves/Rebecca Pearce	- Q2 2022 - Q3 2022	Mental Health Single point of Access to begin from November via 111 option 2
2.4	WAST Remote Support	- Initial process Commenced May 22 - Professional support out of hours	Dr Alice Groves/Rebecca Pearce	- Implemented - On-going	
2.5	NCN Signposting	- Develop signposting in the community strategy i.e IAA Team (Information, advice and assistance), booklets, practice care navigation	Dr Alice Groves/Rebecca Pearce	- On-going	Mapping session held November, need to engage primary care signposting through

Goal Leadership:
- Paul Underwood
- Dr Paul Mizen

Goal 3: Safe Alternative to Admission

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.1	Flow Centre Advanced Paramedic Practioner (APP)	Pilot ahead of winter, an APP at the Flow centre to improve patient flow and reduce conveyance This is to test and strengthen the workforce model, senior decision-making function and provide additional advanced clinical assessment skills. Options to access existing WAST/HB pathways	Dr Paul Mizen / Paul Underwood	Q3 22/23	Progressing with WAST, scope/cost model operating 9am-9pm, 7/7 aligned to the demand. 66% of WAST referrals via Flow Centre are between 9am and 9pm, with 33% occurring overnight 9pm - 9am. Training and SOP agreed. APP is in the FC effective 12th Dec
3.2	Clincal Frailty 7 Pathway	The development of an clinical frailty score pathway to improve the flow of older patients through our system via the Flow Centre. Essentially ensuring that the patient is seen at the right time, in the right place by the right person. The pathway will aim to stream patients who meet the clinical criteria to an eLGH site for initial assessment, improving flow and optimising patient outcome	Dr Paul Mizen / Paul Underwood	Q4 22/23	A series of appropriate questions has been agreed following discussion with the frailty team and is based on the clinical frailty score. Proposal taken to Medical Leadership Group and LMC. Plan to commence in Dec 22
3.3	Same Day Emergency Care (SDEC)	Implement SDEC at the GUH in a phased approach for General Surgery with Flow centre referrals followed by ED streaming and wider specialities engagement. Develop the wider staffing model for Acute Medicine. Pilot of SDEC at YYF commenced 31st Oct 22 through to March 23 (RIF funded) Ensure continued service of the Respiratory Ambulatory Care unit (RACU) . RACU currently sees 40- 50 patients per week directed from GPs via the Flow Centre GAMACU 20 – 40 keeping well (3500 per year). 5-10 acute reviews . Helpline calls, referrals from FC, some direct	Dr Paul Mizen / Paul Underwood	Q4 22/23	SDEC GUH opened on 8th August 22. Plan to grow Acute Med and interim options including T&O. volume is 80 – 120 per week. YYF SDEC opened on 31st October, seeing 25 – 35 patients per week RACU funding extended, constant volume GACU 25% acute 2 to 4 ascitic drains / IBD flare ups that would have been GUH admitted and MAU assessment time

Goal Leadership:

- Paul Underwood
- Dr Paul Mizen

Goal 3: Safe Alternative to Admission…continued

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.4	Scheduling of Urgent Care – MAU Royal Gwent Hospital	Five scheduled urgent care slots per day have been introduced in the Acute Medical Unit (AMU) at the Royal Gwent Hospital (RGH) for GP referred patients via the Flow Centre. Primarily aiming to avoid overnight admissions of lower acuity patients	Dr Paul Mizen / Paul Underwood	On Hold	Currently paused. Low patient volume, requires further communications work via NCNS.
3.5	Service Access Points, Directory & Virtual Advice	Reviewing all entry points into the system across secondary/primary/community care. Establish a baseline of the current service provision including, how the service is accessed, operating hours, volume of activity etc This includes review of existing services across Single Point of access (SPA) and the Flow Centre and consideration of changes resulting from Redesigning Services for Older people Programme	Dr Paul Mizen / Paul Underwood	Q4 23/24	Engagement required across primary, secondary, community and local authorities to develop an options appraisal Joint mapping workshop scheduled in January 23
3.6	Elderly Frailty service at the Grange (Pilot)	Development of an Elderly Frailty assessment pathway at the Grange supported with specialist staff	Tracy Morgan / Diane Murray	Q4 23/24	Pilot scheduled to begin at GUH in January 23

Goal Leadership:
- Dr Alastair Richards
- Steve Bonser

Goal 4: Rapid Response Actions

	Work Area	Actions:	Sub Lead (s)	Timeframe	Progress
4.1	ED Referral Improvement	Improvement of the referral to speciality process from ED. Currently a manual process with variation in process time for referral T&F group established to begin in Q4 to define proposed improved process	Dr Paul Mizen / Simon Roberts	Q4 22/23	Paper drafted. Meeting held with Juniors and specialists. Pilot scoping
4.2	PRU Business Case development	Work with partnership with WAST to understand the shared strategy in relation to PRU Develop a business case to ensure PRU Service continuation	Steve Bonser/ Carl Ashford	Q3 22/23	Business case developed, Further discussion required on the clinical model
4.3	E-Triage System	Work to seek funding to adopt and embed E-Triage technology within the GUH Emergency Department E-triage technology offers the opportunity to improve reception and nursing available time and the ability to promote redirection based on algorithm set by us	Simon Roberts/ Roxanna Williams	Q4 22/23	Funding for a 1 year pilot has been agreed. First Project Board held 26th Oct Contract ready for signatures, carrying 3 key risks
4.4	HB/WAST Improvement plan integration	As part of the 6 Goals Programme, Goal 4 workstream should be developed in partnership with WAST to ensure both improvement plans are reflected and agreed upon	Steve Bonser	Q3 22/23	WAST nomination received to participate in Goal 4 to support joined up approach
4.5	Mental Health Pathways Demand and Outcomes	Ensure all pathway information is available and accessible. Complete analysis on pathway demand and outcomes . Develop the MH single point of contact service to commence in November (also accessible via 111)	Michelle Forking	Q3 22/23	Demand analysis on-going due to complete in Q3. MH Single point of access to commenced in November

Goal Leadership:

- Sue Pearce
- Sandra Mason

Goal 5: Optimal Hospital Care Actions

	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.1	Discharge Policy & Pathways	Update of HB discharge policy to ensure policy reflects current environment and best practices in discharge planning. This aims to provide clear definitions and guidelines in the following areas – 1) Roles & Responsibilities, 2) Escalation methods 3) Red/Green day process 4) Standard pathway terminology to be used across the HB Awaiting launch of DU discharge framework	Sue Pearce / Sandra Mason	Q2 2023	Discharge policy T&F group to be established, meetings to start next week GUH pathway clarity is already in motion, 3 clear pathways for internal navigation (Remain at GUH/Step-down /Fit for discharge) . Communications to follow in Sept. Handbook also developed. Red/Green day refresher training on-going, needs to be reflected in the policy.
5.2	Embed Safer principles	There is variable use of the SAFER principles across the Health Board and there is a need to relaunch and embed the principles of SAFER, including the importance of daily senior review, setting the EDD/MFDD at early stage and to plan discharge from admission To embed the MDT approach to Board Rounds to ensure that all care is coordinated by the whole team, with the aim to reduce 'waits' for each input to happen. Refreshing the use of red/green day processes	Sue Pearce / Sandra Mason	Q3 2023	Work is being undertaken on the eLGH sites to re-focus on optimising discharge planning. A ward has been identified at each site to start with and will roll out to all wards, using a phased and supportive approach was considered the best approach. The SAFER principles are key to the optimising patient discharge programme. Focus to date has been on the setting of meaningful estimated discharge dates, daily board rounds and timely discharges as early in the day as possible. As part of the national work the SAFER principles have been reviewed and amended these will be launched with the framework in the next few weeks. In the interim
5.3	Education and Training	Education & Training package to be developed to increase discharge planning awareness and knowledge. This includes accountability, impact on flow and the wider organisation. This will cover both mandatory training and refresher training.	Sue Pearce / Annie Lewis	Q1 2023	Reviewing mandatory corporate training package, proposal of addition D2RA modules. Training days planned in Sept, Oct, Nov and Dec within Medicine. Sessions covered several aspects to include roles and responsibilities. This will be a rolling programme over the next 6 months across the eLGH sites. It is envisaged that this will improve knowledge and skills around discharge planning, leading to reduced length of stay and optimise the patient journey.

Goal Leadership:

- Sue Pearce
- Sandra Mason

Goal 5: Optimal Hospital Care Actions …continued

	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.4	Patient Status at a Glance Boards (PSAG)	The PSAG Boards to be standardised, across the GUH and ELGHs to Plan for every patient Review digital enhancements either STREAM or existing careflow technology	Sue Pearce / Sandra Mason	Q2 2023	PSAG Boards redesigned within Medicine at RGH. Further feedback required from tests of change as above. An audit tool has been developed and audits will commence throughout November to review the information recorded on patient status boards. All wards hold regular board rounds and in most areas this is daily. The introduction of afternoon huddles is also being rolled out across sites. The huddles support a review of the actions agreed at the morning board round and identifies any issues with proceeding with these, it also facilitates an update on any changes that require escalation. Further exploration required regarding digital options
5.5	Performance monitoring	Development of Discharge dashboard to enable visibility for daily/ weekly snapshot of medically fit delays by reason, site and LOS. Also trend analysis for delay types.	Sandra Mason / Owain Sweeting	Published September 2022	Completed - ongoing review of measures to ensure report is fit for purpose

Goal leadership:

- Mel Laidler
- Collette Kiernan
-

Goal 6 : Home First Actions

	Work Area	Actions:	Lead (s)	Timeframe	Progress
6.1	Front Door Therapies & Criteria Led Discharge	Business case development to provide ED GUH therapy provision (on a 5-day service initially) to increase the number of patients returned home direct from ED Once established, evaluate and pursue business case for 7-day coverage Once staff in place, test 'criteria led discharge ' at the front door	Collette Kiernan / Emma Ralph	Q3 22/23	Senior Physio in place, recruitment to follow in December for OT, Asistants therapy practitioners in Dec/Jan
6.2	'Homeward Bound' Nurse led capacity for MFFD patients	Alternative bedded capacity (taking learning from the Step Closer to Home pathway to develop a centralised model of support) Wards at 3x sites identified, SOP developed, Staffing and GP provision for medical input arranged.	Tracy Morgan / Sue Pearce	Q3 22/23	Going live at RGH 11th Dec, YYF on 18th Dec and NHH in January pending GP provision
6.3	Trusted Assessor Model	Work with partners to develop an agreeable trusted assessor model drawing on past experience and models used in other regions	Mel Laidler / Collette Kiernan	TBC	Proposal for GASP around definitions presented
6.3	Urgent Response Care (Older People)	Proposal for a small-scale approach to develop two teams of HCSW working initially in the out of hours period 8 pm to 8am, seven days per week. Each team would consist of two Health Care Support Workers who are trained to undertake observations and provide personal care and support to people to enable them to stay safely in their own home	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF
6.5	Extending CRT Model	extend the operational hours for CRT rapid up to 8pm Monday to Friday, by Jan/Feb 23. It is proposed that by recruiting additional support now, it would be possible to make the existing CRT medical team more robust across all areas and develop a weekend response in the same timescale.	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 3.2a

Aneurin Bevan University Health Board

Review of Stroke Services

Executive Summary			
This paper provides an update of progress in respect of the ongoing review of stroke services within the Health Board and the proposed service response, informed by a report and recommendations from the national 'Getting it Right First Time' team. An overview is also provided in respect of plans to establish national and regional stroke networks across Wales.			
The Board is asked to:			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			X
Note the Report for Information Only			
Executive Sponsor: Peter Carr, Director of Therapies & Health Sciences			
Report Author: David Hanks, Head of Service Planning			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board: Finance & Performance Committee**	
Date of the Report: January 2023			
Supplementary Papers Attached: Appendix 1 – Health Board Stroke Report Appendix 2 – GIRFT Action Plan Appendix 3 – ToR National Stroke Programme Board			

Purpose of the Report
To note contents and endorse the proposed actions.

Background and Context
Stroke services are provided in a number of sites across the Health Board, with acute / hyper-acute beds focussed on the Grange University Hospital (GUH) and rehabilitation services provided at Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr. There is a strong and acknowledged evidence base supporting a range of time-sensitive interventions in response to an acute stroke, thereby providing optimal treatment and recovery potential. These include the administration of medications and the delivery of thrombolysis for appropriate cases within a specified time window. Performance

management against these interventions was originally developed as 'intelligent targets' 15 years ago, and these have now evolved into the Sentinel Stroke National Audit Programme (SSNAP) which provides a national database into which a wide range of performance data can be entered and monitored.

The Health Board has an established Stroke Delivery Group, chaired by the Executive Director of Therapies & Health Science, which provides a strategic overview and direction for stroke services, monitoring performance and agreeing development actions / interventions as considered appropriate.

The Group has long acknowledged the evidence base for timely treatment and recognises the commitment and dedication shown by the multi-disciplinary team and supporting workforce to provide the highest possible standards of care. However, concerns have grown in recent months that the severe and ongoing pressures within the urgent care system have constituted a significant barrier to the delivery of optimal stroke care, with significant adverse impact on service performance as represented in the SSNAP data for the Health Board. The Group has therefore made clear its intention to address and improve the situation, based on best practice, organisational consensus and a robust action plan.

As part of this intention, the Group - in liaison with other Executive colleagues – agreed in 2022 to commission a review of the service by the national 'Getting It Right First Time' (GIRFT) team. The team have an established track record and reputation following visits to over 100 stroke services across the UK, and the key benefits of the review were considered to be: -

- A comprehensive and objective external review of current service / position
- An assessment of performance against established national benchmark criteria
- An ability to provide innovative solutions and learning
- A series of short- and medium-term recommendations for service improvement

The GIRFT team duly visited the Health Board in May 2022, visiting the sites at GUH, RGH, NHH and YYF. Time was spent with the service teams on each site, with initial verbal feedback / impressions provided on the day and to be followed by a formal report and recommendations.

Assessment and Conclusion

Outline of recommendations

The final report from the GIRFT team was received in September 2022 and is attached as Appendix 1. The report includes a total of 20 short- and medium-term recommendations, from which the key priorities are seen to be as follows: -

- Provide supernumerary specialist stroke nurse presence at GUH on a 24/7 basis to ensure ownership and direction of the stroke patient pathway
- Enhance pre-hospital notification arrangements to ensure elimination of avoidable delays at the front door
- Increase thrombolysis rates to be consistently within agreed national norms
- Raise organisational priority for patients gaining access to the acute stroke unit within four hours

- Widen range of workforce options / competence to ensure 24/7 ability to perform swallow assessments
- Review rehabilitation / early supported discharge pathway, with emphasis on seven-day access to therapies, (this being considered likely to involve utilising fewer rehabilitation sites in the Health Board)
- Ensure robust arrangements for patient review six months post-discharge
- Support development of clinical leadership for the service

Response and action plan

A number of actions have been or are being undertaken in response to the report as follows: -

- A task & finish group – chaired by the Executive Director of Therapies & Health Science – has been established and is meeting regularly to focus on the response
- The task & finish group has reviewed the recommendations and has developed a short / medium term action plan, with a core theme of enhancing the ability of the service to deliver an optimal patient pathway. A summary narrative and proposed action plan (which continues to be updated to reflect the latest position) is attached as Appendix 2
- Monthly implementation support meetings are ongoing with the GIRFT team clinical leads
- It is intended to take a summary paper with proposals for the development of the service to the Executive Team, with a view to these being incorporated into the Health Board's IMTP and supporting business cases to be brought for consideration as appropriate
- Longer term actions will be overseen by the Stroke Delivery Group over the coming months

Establishment of the National Stroke Programme Board and plans to create National and Regional Stroke Networks

The NHS Wales Health Collaborative Executive Group (NHSWHC CEG) is the responsible governance group for the current Stroke Implementation Group (SIG).

In June 2022 the CEG endorsed the establishment of a National Stroke Programme Board (NSPB), supported by a core programme team within the NHS Wales Health Collaborative. The newly established National Stroke Programme Board (NSPB) met for the first time in October 2022; it will provide oversight of the national stroke programme and will work in partnership with the regional stroke programmes to improve the stroke pathway and develop a programme of work to scope out and develop comprehensive regional stroke centres (CRSCs). A draft Terms of Reference is attached as Appendix 3.

The CEG also endorsed the recommendation that:

1. the planning assumption that four CRSCs and regional Operational Delivery Networks (ODNs) are required and that regional work within the programme should be structured accordingly
2. the National Stroke Programme Board produces a clear and unambiguous case for change demonstrating current outcomes and the expectations for improvement by delivery of the national standards and the new service models that will follow.

The purpose of the National Stroke Programme Board is listed in the Terms of Reference and which, amongst other things, includes developing a full programme business case.

The initial meeting in October suggested this was about supporting the establishment of four comprehensive regional stroke centres. At this meeting it was requested (by Peter Carr) that the maturity of stroke services in each region must be assessed to determine future investment and to ensure parity of central resource allocation across Wales, whatever the maturity of each region. In addition, at the meeting it was made clear (by Peter Carr) that investment in the comprehensive regional stroke centres in isolation of the sub-acute stroke rehabilitation pathway would be failure.

Whilst further work is required to determine the scope of the four CRSCs and ODNs across Wales, it has been accepted from the offset that ABUHB will form its own regional ODN with its CRSC already established at the Grange University Hospital, mainly because this regional model/configuration was already consulted on and agreed through previous South Wales regional planning work and because the ABUHB number of strokes for its population meets the accepted threshold for CRSCs.

In establishing a regional ODN for the ABUHB population, the first step will be to appoint a ODN Programme Manager, with funds made available by the National Programme and the post reporting to the Medicine Division. ABUHB will now be required to review its internal governance arrangements for stroke delivery to reflect the establishment of its ODN, and it is proposed that an ABUHB Stroke Operational Delivery Network Board be established, replacing the existing Stroke Delivery Group.

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It is acknowledged that there are significant challenges involved in achieving the above aims, including the availability of investment funds, maintaining the discipline of stroke priorities within a severely pressurised urgent care system and motivating a dedicated but exhausted workforce. However, it is considered that the GIRFT recommendations have delivered important additional strategic momentum to the need to address the current service issues. This, together with the public support for the aims received from both the Delivery Unit and Health Inspectorate Wales now provide a key opportunity to make sustainable improvements to the Health Board's stroke services, to the benefit of many patients over the coming months and years.

Recommendation
The Finance and Performance Committee is asked to: - 1. Note the current position and the progress made to date 2. Note the GIRFT report/recommendations and the proposed response of the Stroke Delivery Group 3. Confirm support for the proposed response and actions, which will include bringing proposals/business cases to the Executive Team for targeted investment where appropriate.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The GIRFT work stream has been largely based on a risk assessment of the adverse impact of wider system pressures on the stroke pathway and the recommendations in this paper are intended to address and mitigate these risks

Financial Assessment, including Value for Money	Stroke pathway interventions are fully-evidenced based and it is acknowledged that compliance with these provides an optimal value-based healthcare outcome in terms of system efficiency, length of stay, recovery and clinical outcomes
Quality, Safety and Patient Experience Assessment	The GIRFT initiative places a high priority on enhancing quality standards and the patient experience, and is fully supported by stakeholders / partners such as the Stroke Association and Health Improvement Wales
Equality and Diversity Impact Assessment (including child impact assessment)	It is intended that the improvements in the service generated by implementation of the action plan will give real quality benefits to all stroke patients, regardless of background and protected characteristics
Health and Care Standards	The GIRFT initiative aligns closely with a number of the Health and Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	The consequent action plan for stroke services will form a key priority within the 2023/24 IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Implementation of the action plan will support the intentions of the Act in the following ways:-
	Long Term – addressing the long term needs of the population and organisation by providing enhanced and more effective services to meet future stroke demand.
	Integration – providing an improved and integrated service configuration in response to the current concerns of service consistency, sustainability and access.
	Involvement & Collaboration – the action plan has been developed in collaboration with all key stakeholders across the service and has been endorsed by the multi-disciplinary task & finish group which includes the Delivery Unit and the Stroke Association
	Prevention – implementation of the action plan across the whole patient pathway will support the prevention of future challenges of key service access and delivery and hence improve population health.
Glossary of New Terms	New terms are explained within the body of the document
Public Interest	The GIRFT report is being made widely available to all stakeholders and other health boards as part of public interest sharing of best practice and lessons learned

GETTING IT RIGHT FIRST TIME

Stroke Medicine Review Report

Aneurin Bevan University Health Board

September 2022

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the Wales Planned Care Board team. It aims to identify improvements in stroke services at ABUHB to help them ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Dr David Hargroves Consultant Stroke Physician, East Kent Hospitals University Foundation Trust (EKHUFT), Clinical lead for Stroke, EKHUFT & South East (Wessex, BOB, Kent, Surrey and Sussex) for NHSE/I, National Speciality Adviser for the National Stroke Programme for NHSE, National Clinical Lead for Stroke (GIRFT) for NHSE/I and;

Dr Deb Lowe, Consultant Stroke Physician & Geriatrician Wirral University Teaching Hospital, National Clinical Director for Stroke Medicine – NHSE&I, Senior Clinical Advisor for Stroke Medicine – NHSI GIRFT Programme

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1. Introduction

Getting It Right First Time (GIRFT) is a national programme designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The ambition of the programme in Aneurin Bevan UHB is to identify examples of innovative, high quality and efficient service delivery as well as identifying areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. RNOH/GIRFT worked closely with the National Clinical Lead for Stroke in Wales, Dr Shakeel Ahmad, to ensure that this project is aligned with the Wales Stroke Strategy.

2. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Aneurin Bevan University Health Board (ABUHB), to conduct a review of their Stroke services using the GIRFT methodology, with the aim to support the Health Board with effective delivery, structure and performance of their stroke services.

This Programme of work is split into three phrases:

1) RNOH/GIRFT delivered a summit meeting on Thursday 27th January 2022 to provide colleagues from ABUHB with an overview of the GIRFT Programme and the GIRFT stroke workstream in England and to explain the principles and approach of the stroke programme planned for ABUHB.

2) The RNOH/GIRFT team visited all four stroke units in ABUHB on 11th May 2022; Nevill Hall Hospital (NHH), Ysbyty Ystrad Fawr (YYF), Royal Gwent Hospital (RGH) and The Grange University Hospital (GUH). A deep dive review and feedback meeting was conducted at GUH with key stroke staff attending either in person or joining virtually from the other three sites that had been visited earlier in the day.

3) Once this report has been delivered and the recommended actions made clear, the GIRFT Stroke Clinical Leads will hold a series of virtual monthly implementation support meetings. The purpose of these meetings will be to support and challenge the ABUHB clinical, operational and analytical teams to implement the recommendations from this report and to leave a legacy of sustainable quality improvement.

This document captures the key findings and recommendations arising from the visit to ABUHB by Dr David Hargroves and Deb Lowe on the 11th, May 2022. We are extremely grateful to all those who attended our visit and gave such open and honest feedback.

This report is a companion document to the Health Board Provider Level SSNAP Datapack. Many of the process markers of performance used in the GIRFT stroke analysis come from The Sentinel Stroke National Audit Programme (SSNAP). This is a major national healthcare quality improvement programme based formerly at the Royal College of Physicians (RCP) in

London, now housed within the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is a single source of stroke data in England, Wales, and Northern Ireland. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

3. Aneurin Bevan University Health Board

The Aneurin Bevan University Health Board (ABUHB), which was established on the 1st October 2009, covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys and services a population of 600,000 and has approximately 850 stroke admissions per year. It employs over 14,000 staff, two thirds of whom are involved in direct patient care. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

ABUHB has a new specialist and critical care centre, the Grange University Hospital (GUH), which opened in November 2020, has 560 beds and features a 24-hour Acute Assessment Unit, Emergency Department and Helicopter Pad. It provides a 24/7 Emergency Service for patients that need specialist and critical care. Upon opening, GUH became the only Hyper Acute Stroke Unit in ABUHB, taking over this role from the Royal Gwent Hospital (RGH), based in Newport. RGH is one of three enhanced Local General Hospitals operating in ABUHB, the others being Nevill Hall Hospital (NHH), in Abergavenny, and Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. Each of the Local General Hospitals provides therapy and rehab services for stroke patients. Most patients are admitted via the Flow Centre to GUH for their acute phase of care. Any self-presenters at the ELGhs or patients who have had a stroke whilst on an ELGH site are assessed and depending on clinical presentation are almost always "dripped and shipped" to GUH.

There are also Community Hospitals and facilities which were not included in this review but may care for some patients once they have completed their stroke pathway and awaiting discharge as a step-down facility. These are:

1) St Woolos Hospital (Newport) 'Ruperra' ward and formally dedicated to Stroke Rehabilitation. However, when GUH opened this ward moved to the ELGH and is now a community ward.
2) County Hospital (Pontypool) this hospital receives patients who normally reside in Torfaen, from both the Royal Gwent and Neville Hall Hospitals for rehabilitation after stroke,
3) , provide some community based inpatient stroke rehabilitation services.
4) Monnow Vale, (Monmouth) provides community based inpatient rehabilitation, not specifically for stroke patients
5) Ysbyty Aneurin Bevan (Ebbw Vale) provides community based inpatient rehabilitation, not specifically for stroke patients
6) County Hospital (Pontypool) community based inpatient rehabilitation, not specifically for stroke patients

3.1. ABUHB and Its People

The strength of a National Health Service is in its people. The power of an organisation is so often in the loyalty, dedication, shared purpose and clear vison of its staff to deliver the best care they can and to always put the patient at the centre of everything they do. We were impressed by the culture and leadership at all the hospitals, which became evident within a few minutes of meeting the multi-disciplinary teams.

We also witnessed frustration and fatigue; to be expected at the end of a two-year pandemic, but this ran deeper and relates to a longer duration than the pandemic as it was clear that many felt unable to influence change within their organisation, yet still were willing and able to speak up and express their desire to drive the necessary changes forward.

We were told that the workforce challenges throughout NHS Wales are significant across medical, nursing and therapy teams, but are particularly marked in some of the ABUHB hospitals. BASP-Stroke-Medicine-Workforce-Requirements-Report and the https://www.hee.nhs.uk/our-work/hee-star are useful bench marking tools which the ABUHB stroke team may wish to use to address these workforce challenges.

There is good evidence for working within networks and we were very pleased to hear that the Welsh Stroke Strategy looks to support the development of stroke networks across Wales, to share knowledge, information, facilitate inter-organisational collaboration and learning and manage change. This will require excellent leadership, and we were impressed to see so many natural leaders across the professions whose skills need to be harnessed to support delivery of high-quality care.

4. Service Overview

The following Service Overview was provided by ABUHB prior to the meeting and discussed during the deep dive session. Additional information was gathered in the pre-visit virtual meeting and in the meetings with staff on the day.

SERVICE OVERVIEW – Aneurin Bevan University Health Board					
1	**Population served**	Total Number: 600,000 in ABUHB			
2	**Hospital beds in total in individual hospitals**	Where based and Total Number: 1217 RGH 218 NHH 212 YYF 227 GUH 560			
3	**Stroke beds**	Number of beds Stroke Rehab RGH 24 Stroke Rehab NHH 22 Stroke Rehab YYF 15 Hyper Acute Stroke GUH 12+ 3 general medicine	Base and No. of Hasu=1 HASU GUH HASU 12 beds specifically for HASU the ward is 15 bedded with the additional 3 beds used for GM patients		
4	**Stroke Consultants**	Number per site RGH- 1 Consultant NHH – 1 consultant YYF – 1 consultant GUH – 4 consultants	Number On-Cal 8 Stroke-only	Further detail: i.e. 5/7 or 7/7 service 1:8	

		Total DCC's:45,	Consultants on-call:	
5	**Stroke Nurses**	WTE Number 4	Hours of Cover 7am -5pm	Plans in discussion for 12 hour cover when vacancies filled and staff trained.
6	**Stroke Ward Staffing**	Registered Nurses: 3 day 3 night Health Care support: 3 day 3 night Nursing Bands: Band 6 x2 Band 5 Band 3 Band 2	Therapists: SLT 0.7WTE dedicated SLT for HASU 1WTE SLTA FOR HASU (No other sites have stroke specific staff. Only able to provide 4 day dysphagia cover. Occupational Therapists: GUH 0.8WTE BAND 7, 0.6 BAND 6 RGH= 1 WTE BAND 7, 1WTE BAND 6, 1WTE B5, 1WTE BAND4 1 WTE B3 NHH: 0.8 WTE BAND 6, 1WTE BAND 5, 0.8 WTE BAND 4 YYF: 1WTE BAND 6, 1WTE BAND5 1WTE BAND 3 AND 0.8 WTE BAND 8A FLOATING Physiotherapist: GUH 2 WTE YYF 2.5 WTE RGH 3.6WTE NHH 3.3 WTE	Extra Detail: 1 ward manager, supernumerary to numbers by day (M-F)
7	**Psychology**	1 WTE Psychologist for Stroke 1 WTE Assistant		Based in Community Neuro rehab service but in reach to wards and

		psychologist for Stroke 1 WTE Consultant psychologist for Stroke and Neurological conditions		provide life after stroke psychology service through 1:1 interventions and group based psychoeducational modules
8	**ESD and community stroke rehab Service**	5 days Cover 0800-1700	Speech Therapy 1.2 WTE OT 3.2 WTE Physio 2.8 WTE Dietitian 0.4 WTE Therapy Assistant Practitioner: 5.6 WTE Life after Stroke Wellbeing practitioners: 1.8 WTE	Extra detail: 1 physio is also Team Lead so has 0.3 WTE dedicated to managerial role. All patients can access the service based Niwrostiwt Neuro Recovery College which delivers education on common stroke issues and opportunities for personal recovery.
9	**6/52 and 6/12 Review Process**	6 weeks follow up consultants 6/12 is completed by CNS		
10 11.	**Stroke imaging** **Relationship with IAT Centre & Hours of Service:**	Access to CTA: hours / per day 24 hours a day Access to CTP: hours / per day 0 Hours a day Access to AI: Y/N Not available But funding been approved the Welsh Government recently **Access to MRI first line for acute stroke and TIA patients?: There are no dedicated slots for stroke and TIA but this is available daily.** **Current waiting for TIA imaging. MRI two weeks, CT one week, Carotid doppler one week.** **Inpatient CT 10 min to 1 hour, MRI 2 to 24 hours (same day 60%, next day 40 %), MRI Scans requested after 3 pm mostly done next day.** Modality used for carotid imaging? Carotid Doppler Please describe: Bristol South meads 8am to 6 Pm 7 days a week		

Most of this report focuses on the performance and data we have for ABUHB's hyper-acute stroke service, as the GIRFT methodology relies heavily on the use of data to drive improvement. This, however, is only one part of the complex pathway of stroke care within this hospital group. It was important to the visiting team to understand the flow, the facilities, and the people within the three surrounding stroke units to enable a rounded discussion at the deep dive meeting held at GUH and to support the development of strategic and quality improvement recommendations.

4.1. Nevill Hall Hospital

The NHH Rehab Team

Nevill Hall Hospital (NHH) in Abergavenny has 213 inpatient beds and a wide range of services including a 24/7 nurse led minor injuries unit and a medical assessment unit.

The stroke ward at NHH had 28 beds when we visited, 24 beds were funded and 21 of these were stroke beds; the remaining were general care of the elderly beds. The team informed us that on average, 20% of the beds were occupied by acute stroke admissions; these patients don't get entered in to SSNAP as this hospital is not classed as a routinely admitting stroke unit. The model in ABUHB is that all patients should come through the Flow Centre for admission at the GUH not ELGHs. There is access to thrombolysis 24/7 and a 'drip and ship' model is employed with some but not all patients moving to The Grange for their hyper-acute stroke care. The length of stay was reported to be 42 days. As the ward is mixed, this figure also included patients classed as "General Medicine and Care of the Elderly".

There are two medical consultants that support the unit, one substantive and one locum consultant that is going through the Certificate of Eligibility for Specialist Registration (CESR) route. The medical lead at this ward is very clearly a highly valued member of the team and there was a positive inclusive culture felt on the ward. The ward has two foundation doctors and one CMT doctor during the week. There had been two experienced Clinical Nurse Specialists supporting the ward on a pro-rata basis that had moved to the Grange when the HASU was centralised in 2021. These posts have not been backfilled on the ELGH sites. We were pleased to hear that ABUHB had recruited two new Nurse Consultants in other areas so there could be scope to develop similar roles in Stroke

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was a very high level of neuro-rehabilitation expertise within the group of senior therapists that we were able to meet. Of note there was only 0.6 WTE dysphagia trained Speech and Language Therapy provision. At the time of the review, it was reported that there was no psychology support but in theory there is usually 4 hours

per week of support for inpatients. The role of rehabilitation assistants was recognised and their ability to support 7 day working with the correct supervision was supported.

Access to Early Supported Discharge (ESD) and Community Rehabilitation Teams (CRT) was variable. There was usually at least a 1 week wait to access 'ESD' and there was no enablement/domiciliary care included within the commissioned service. The ESD responds to received referrals within 1 day of discharge Monday – Friday. Contact is via telephone triage – if same day assessment is indicated, it is available (staffing challenges may sometimes affect this). If same day assessment is not indicated, we target the right profession to complete the assessment – this approach is based on the Malcolmess Care Aims intended outcomes framework and aims to get the right person out to assess at the right time. This allows stroke survivors to settle at home and explore their new functional status so that when we assess they are able to identify hopes and goals in a more meaningful way than they can on the first day home from hospital when they are often very tired and just needing time. The pathway was commissioned for 3 months, but this could be extended based on patient need. If a patient was discharged to a nursing home, there appeared to be less access to specialist stroke rehabilitation. The ESD team works with people for up to 3 months (average 8 weeks). If ongoing support is required, this is arranged through outpatient physio/SLT services. The clinical psychology team support over a longer time frame up to and over one year.

Social work support is locality based and can be variable with significant delays for packages of care. It is not unusual to wait 4 weeks for a larger package of care and even longer delays for nursing home placements.

There had previously been a commissioned Stroke Association Family and Carer support worker service across ABUHB, but this service had been decommissioned. Following the end of the commissioned stroke association service, Life-After Stroke support is provided through 2 Life after Stroke wellbeing practitioners who are embedded in the Community Neuro Rehab Service. The recently appointed2 practitioners will support anyone who has had a stroke in the past year and provides face to face, telephone and virtual support as appropriate. The service sends a letter and leaflet contact for people to request support. The service will also in reach to the stroke units if in reach support is requested by the ward staff.

The estates at Nevill Hall were sub-optimal for delivery of effective rehabilitation. There was inadequate therapy space and no quiet space for speech and cognitive assessments. Toilet facilities were mixed sex, and you could not enable patients requiring a hoist for transfer to use the bathrooms. Some of the environmental constraints within this ward could be addressed by returning the ward to 24 funded beds and utilising the released space to address the above concerns.

4.2. Ysbyty Ystrad Fawr

The YYF Rehab Team

Ysbyty Ystrad Fawr (YYF) in Hengoed has 164 inpatient beds and has a Minor Injuries Unit, medical assessment unit included within its services. It has 30 rehabilitation beds, 15 of which are usually occupied by stroke patients. It was reported that the length of stay is approximately 42 days on this ward. At times the stroke ward may be occupied with more General Medical or Care of the Elderly patients so the length of stay will be affected by this. It was also reported that it was unusual for acute stroke patients to present to this hospital and only a handful of patients had been transferred to The Grange by 'drip and ship'. This is because all patients are managed through the flow centre and directed to the GUH. Stroke patients are referred from the HASU at GUH into this unit for rehabilitation. This makes flow management and discharge planning difficult, as the ward works with multiple locality social work teams and different commissioned community CRT services and one ESD team. There seemed to be a lack of a commissioned pathway for complex neurological rehabilitation.

There is a single-handed consultant who is job planned to deliver 6 PAs to support the service and there has been a Stroke Consultant vacancy at this site for almost 5 years. There are additional ward rounds by a Care of the Elderly Consultant but when the Stroke Consultant is away, there is usually only one ward round per week. Junior doctor support can be variable but on average there are 5 junior doctors including F2's, GPVTS and two registrars. There was an excellent culture of training and education within the unit and supported places to attend the Welsh Stroke Conference each year. There was good support from ward-based pharmacists for safe prescribing.

There was excellent nursing leadership, as with all the hospitals we visited, but there are significant nursing recruitment challenges at YYF with a 50% nursing vacancy rate despite attempts at international recruitment. Band 4 nurses had recently been appointed using band 5 funding.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1.2 WTE SLT for the entire hospital; of this, only 0.6 WTE is dysphagia trained SLT. The remaining 0.6 WTE is for communication only. At the time of the review, it was reported that there was no psychology support but in theory there is usually support for inpatients from an in-reach on referral model. There is a very limited spasticity service offered at this hospital with ad hoc support available. The senior physiotherapist was also being trained to administer Botox therapy which is to be commended.

There is good social work support and a discharge coordinator role but still major delays in accessing packages of care and nursing home places.

Follow up post discharge is delivered at 6 weeks by the Stroke Consultant, but there is no routine 6 month follow up.

The ward was made up entirely of single rooms. Whilst this has some advantages for privacy and infection control, there is evidence that stroke patients in the rehabilitation phase get a lot of benefit from the socialisation of communal bay accommodation and therapy spaces. The toilet facilities could not accommodate patients that needed to be hoisted. The rehabilitation therapy space was not based on the rehabilitation ward and was not exclusively reserved for the rehabilitation ward.

4.3. Royal Gwent Hospital

The RGH Rehab Team

Royal Gwent Hospital in Newport has approximately 370 inpatient beds and again a 24/7 Minor Injuries Unit and Medical Assessment Unit amongst its services. There are 24 stroke rehabilitation beds, and these are usually exclusively occupied by stroke patients with the occasional complex neurological rehabilitation patient. The average length of stay is

approximately 44 days. There are some self-presenting stroke patients making up around 10-15% of all admissions; these patients are rarely moved to The Grange.

The Medical Consultant cover is currently being provided by a Consultant from The Grange who carries out a twice weekly ward round. The ward is also supported with daily specialty doctor cover; this is clearly not a sustainable model and new consultant appointments were being explored to support the medical workforce. There are 4 junior doctors that support this ward, one foundation doctor and three middle grade speciality doctors.

There were significant challenges across nursing recruitment with 5 RN vacancies and 4 CSW vacancies at the time of our visit. It was clear to see that there was strong nursing leadership as this unit has previously been a nurse led rehabilitation unit, but frustration was expressed with the ongoing recruitment difficulties. There was a good working relationship between the therapy and nursing teams with key interventions to support nursing workload.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1 WTE band 6 SLT for the entire hospital. There was a reported delay of 3-4 weeks for PEG insertion. There is psychology support from an in-reach on referral model.

There were similar challenges to NHH and YYF with access to ESD and CRT, with a perception of a delay in availability onto ESD. NHH ESD responds to received referrals via a telephone call the day after discharge from hospital. Assessment is undertaken on the same day when required. Delays in packages of care, which sit within Social Services / Community Resource Team (CRT) is still a concern and may delay access. Only patients that were fit for transfer could be discharged for home therapy, with only one patient able to do so. Neuro-rehabilitation out-patient services were only available for Physiotherapy.

There are significant delays to access packages of care and nursing home placements. Stroke patients are moved to other ward areas to support flow due to discharge delays if they are no longer receiving active rehabilitation. It was reported that on average 15% of patients were medically optimised for discharge.

There were two large therapy areas on the ward but no quiet room for speech and cognitive assessments. There was one bathroom accessible for hoist transfer patients. Group rehabilitation was offered, and Occupational Therapists had changed working patterns recently to support morning Personal Activities of Daily Living (PADL) assessment and to support the nursing staff.

4.4. The Grange University Hospital

The GUH Rehab Team

As described earlier, this new hospital has 560 beds and provides all Specialist and Critical Care services for Gwent. It is also a major Trauma Centre for the region as well as being ABUHB's Acute Stroke Centre. It has 15 stroke beds, 12 of which are funded Hyper-Acute Stroke Unit beds, with an average length of stay of 6 days. It is difficult to meet the 4 hour target for admission as beds are not ring-fenced and frustration was expressed about the inability to manage their own beds.

There are 7 side rooms, two bays with 4 monitored beds in each and one therapy room on the ward (which at times of high demand in the hospital overnight was being used as a General Medical patient bed, although this has now been removed from the site escalation plans)

There are 4 stroke consultants that support the acute stroke pathway. There are 6 Neurologists that are employed by this Health Board and are based at the Royal Gwent Hospital, but only one works within the stroke team. A total of 8 consultants support the on-call rota from the four ABUHB hospitals. There is remote PACS radiology access to support remote review of brain scans

There were reported to be excellent nursing levels and no issues with recruitment. There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was 0.8 WTE SLT in post but 1.4WTE funded Speech and Language Therapy. There was no dietician support for the stroke unit with psychology support being offered as an in-reach service to the ELGH rehab site.

The acute care pathway was reviewed during our discussions with the team, and we had the opportunity to 'walk' the stroke pathway from A&E to radiology and up to the ward. Pre-alerts do occur directly to the stroke nurses but there is often limited information, which does not

enable pre-registration. Stroke Specialist Nurses are available Monday to Friday, 8am to 5pm and outside these times the Medical Registrar supports acute stroke assessments in A&E. An A&E sister commented during the visit, that she couldn't understand why the stroke review team would visit the resuscitation /high intensity A&E area as "stroke patients should never be assessed here". This was concerning, as acute stroke patients are some of the most acutely unstable patients in the emergency department. We accept that this may have been the opinion of an individual, but parity of esteem for stroke patients and support for the stroke team in A&E is essential to a successful stroke pathway.

Following initial review, suspected stroke patients go directly to CT +/- CT Angiogram. This pathway is less streamlined out of hours. Artificial Intelligence decision support software is not used, nor is Commuted Topography Perfusion (CTP), to support recanalization referrals and decisions. Thrombolysis is given in A&E. MRI is available 0730 to 2000 7 days a week for investigating minor strokes and stroke mimics and CT provision is available 24/7.

Thrombectomy services are delivered at Bristol South Mead Neuroscience Centre, 8am to 6pm, 7-days a week. There are good relationships between the referring hospital and the Neuroscience centre, although Thrombectomy rates remain well below a potential target of 8-10% of all stroke patients.

There are no specific TIA and Minor Stroke out-patient clinics delivered at GUH as the model for GUH does not include an outpatient footprint. These are all provided by the three other hospitals. Patients wait between 5 and 6 days to be seen and there is no provision for 'one stop assessment'. There is no access to first line MRI imaging, as per NICE guidelines, and patients often wait up to a week for brain and carotid imaging. Vascular surgery centralised in SE Wales on 18th July 2022 and is performed at the Regional Vascular Unit at the University Hospital of Wales in Cardiff. Intracerebral Haemorrhage Patients requiring Neurosurgical Intervention are also managed here.

5. SSNAP Data Performance Metrics: Findings and Recommendations

The recommendations that we have made in the report have been based upon the data accessible to us at the time of the visit to ABUHB and within the SSNAP published annual portfolio reports. It is also based on information from Trust Executives, Clinical Leads and Operations Managers on the pre-visit meeting and at the site visits. These are not exhaustive but are key areas that if focused on will reduce unwarranted variation and improve delivery of services along the stroke pathway.

During the deep dive visit on 11th May 2022, RNOH/GIRFT presented performance data for SSNAP registered routinely admitting stroke services in Wales, benchmarked against all stroke units in Wales and against the English national average. GUH is represented as the single routinely admitting stroke service in ABUHB; however, it is recognised that there are patients directly admitted to ELGHs and may not transfer to GUH (and therefore not included in SSNAP data). This included data from the most recent published SSNAP data available for the period October 2021-December 2021. Although this represents only a short period in time, having reviewed annual data in preparation for this visit, the Clinical Leads are confident that this quarterly data is representative of the performance out with this timeframe, and that recommendations are all relevant for future quality improvement.

5.1 Stroke Activity and Performance

Figure1

Routinely Admitting Team	Admissions (Oct 21 - Dec 21)	SSNAP level	SSNAP score	*Case ascertainment band*	*Audit compliance band*	Combined Total Key Indicator level
Grange University Hospital	186	D	48.4	A	B	D
Glan Clwyd District General Hospital	95	D	59	A	A	D
Maelor Hospital	92	D	42.5	C	A	D
Ysbyty Gwynedd	88	D	44	A	A	D
University Hospital of Wales	178	C	64	A	A	C
Prince Charles Hospital	135	C	65	A	A	C
Princess Of Wales Hospital	70	D	45.6	B	A	D
Bronglais Hospital	28	B	71.7	A	A	B
Prince Philip Hospital	40	B	72	A	A	B
West Wales General	44	C	63.2	B	B	B
Withybush General Hospital	45	A	81.7	A	B	A
Morriston Hospital	153	D	59	A	A	D

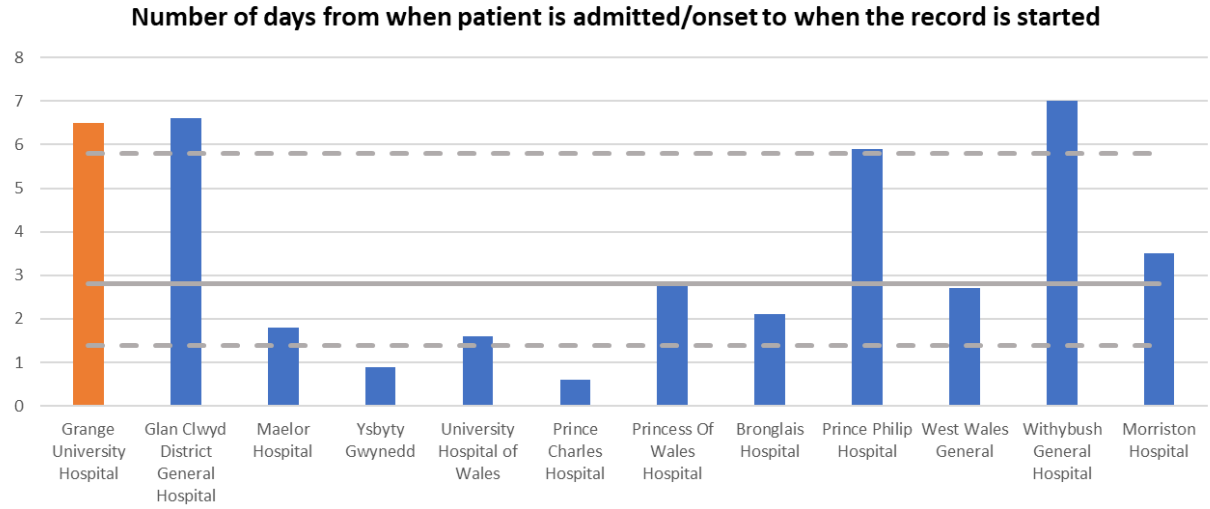
5.2 SSNAP Patient-Centred Data (routinely admitting teams)

Figure2

	Patient Centred Data										
Routinely admitting teams	Scan	SU	Throm	Spec Asst	OT	PT	SALT	MDT	Std Disch	Disch Proc	PC KI
Grange University Hospital	A	E	D	D	B	B	D	E	D	C	D
Glan Clwyd District General Hospital	B	E	D	D	C	C	B	C	A	C	C
Maelor Hospital	B	E	B	D	D	D	D	B	C	D	D
Ysbyty Gwynedd	C	E	E	D	E	D	D	C	A	D	D
University Hospital of Wales	B	E	E	E	B	A	C	B	B	A	C
Prince Charles Hospital	A	E	C	E	A	B	C	D	B	B	C
Princess Of Wales Hospital	B	E	C	E	C	D	E	E	A	C	D
Bronglais Hospital	A	C	B	B	C	B	C	C	A	E	B
Prince Philip Hospital	A	D	E	A	C	B	B	B	A	C	B
West Wales General	A	E	C	B	C	B	C	B	A	C	B
Withybush General Hospital	A	B	B	A	B	A	C	B	B	A	A
Morriston Hospital	C	E	D	B	C	B	C	D	B	C	D

5.3 Admission to record start

Figure3



Grey lines show the median and interquartile range of sites in England

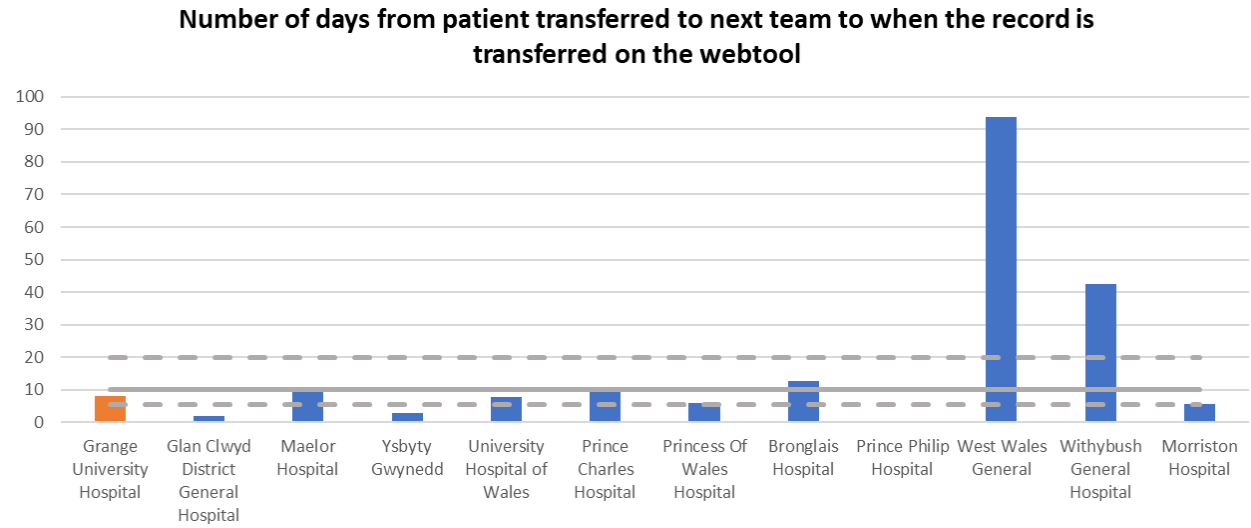
Team-centred results at team level for Audit Compliance measure C5.1

Source: SSNAP Oct 2021-Dec 2021

Number of days from when patient is admitted/onset to when the record is started – 6.5 days

5.4 Delay (days) between clock start and date of starting electronic SSNAP record

Figure 4



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Audit Compliance measure C4.4

Source: SSNAP Oct 2021-Dec 2021

Number of days from patient transferred to next team to when the record is transferred on the webtool – 7.9 days

Analysis from the most recent SSNAP process markers (fig 1 and 2) at the time of this review demonstrated:

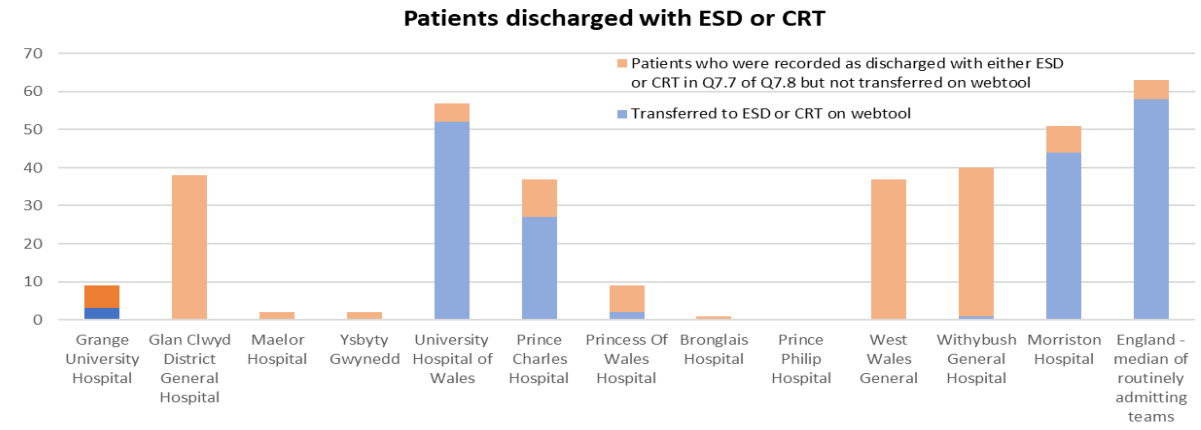
- A good level of case ascertainment band
- Excellent data submission for time to first scan
- There is significant opportunity for improvement in the timely access to the stroke beds at GUH with specialist assessments (particularly SLT) and access to mechanical thrombectomy
- Improvement is required in audit compliance, with significant delays of 6.5 days from admission to records starting respectively (fig 3)
- MDT working and discharge processes are lacking in the SSNAP record

SSNAP collects data on the whole care pathway from initial arrival at hospital, through all inpatient settings, across ESD and community rehabilitation and up to a six-month follow-up appointment. Use of SSNAP is an imperative to drive quality improvement. Recognising that the overall aim of SSNAP (fig 4) is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients is vitally important. SSNAP operates through manual provider level data entry. Acknowledging that SSNAP is only as good as the data submitted is paramount; all efforts should be made to ensure data is entered as accurately possible

Recommendation 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.

5.5 Patents discharged with ESD or CRT

Figure 5



Team-centred results at team level for Audit Compliance measure C4.6
Source: SSNAP Oct 2021-Dec 2021

Total number of patients discharged with ESD or CRT: 9x patients

- ***Transferred to ESD or CRT on webtool – 3x patients***
- ***Patients who were recorded as discharged with either ESD or CRT in Q7.7 of Q7.8 but not transferred on webtool – 6x patients***

Local intelligence suggests the number of patients supported with ESD during this timeframe was 31 referrals accepted from GUH during Q3 of 2021 (total number of referrals received from all sites including Cardiff and England was 85).

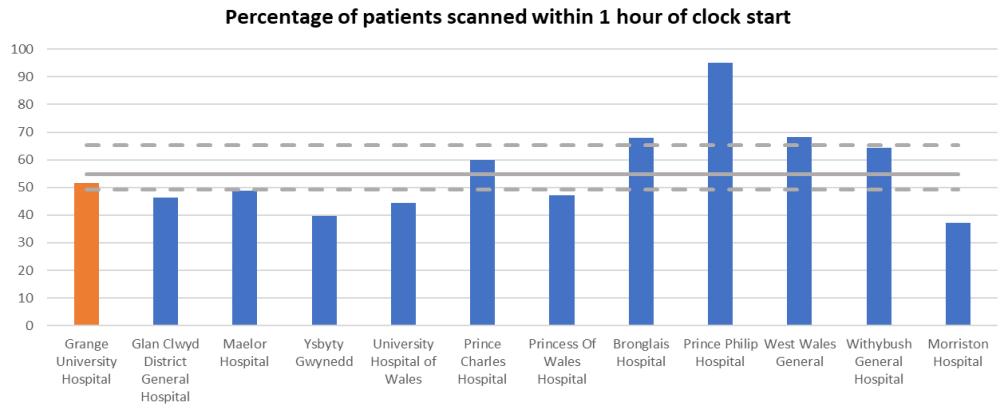
There was wide variation in the access to ESD as recorded on SSNAP. At GUH, the rate of patients discharged with ESD or CRT is significantly lower than the England median. Continued rehab may be delivered at ELGH sites.

Recommendation 2: Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)**) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.**

6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics

6.1 Percentage of patients scanned within 1 hour of clock start

Figure 6



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 1.1A

Source: SSNAP Oct 2021-Dec 2021

Percentage of patients scanned within 1 hour of clock start – 51.6%

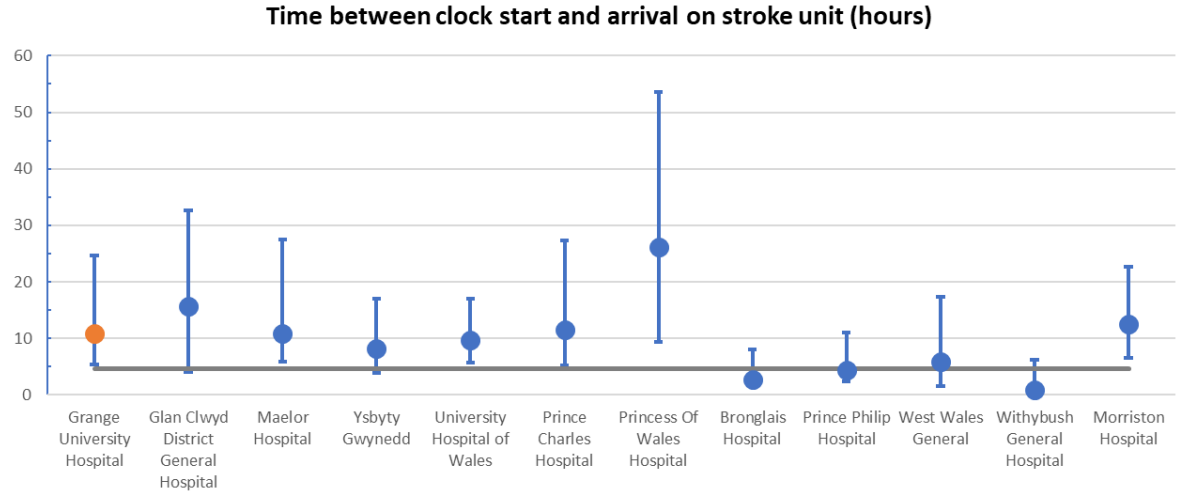
GUH's percentage of patients scanned within 1 hour of clock start was slightly lower than the national average.

Pre-hospital identification of suspected stroke patients could reduce delays to scanning and delivery of emergency treatment and stroke unit admission.

Recommendation 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 National-stroke-service-model-integrated-stroke-delivery-networks**.**

6.2 Clock start to stroke time

Figure 7



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient centred results at team level for Key Indicator 2.2A

Source: SSNAP Oct 2021-Dec 2021

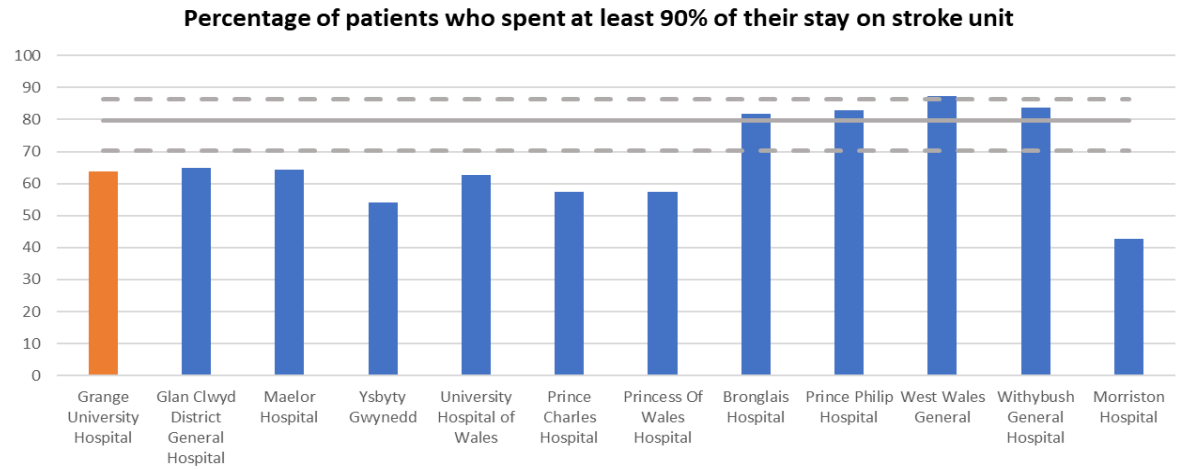
Time between clock start and arrival on stroke unit (hours) – 10.85

Timely admission to a Stroke Unit is considered a vital aspect of hyper acute care. GUH rates are on a par with the Welsh average, but are however, below the England average rates. There is inadequate bed capacity at GUH to enable all stroke patients to have an admission within 4 hours of presentation to hospital and enable equitable access to evidence-based stroke unit care for all.

Recommendation 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.

6.3 Stay on stroke unit

Figure 8



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 2.3A

Source: SSNAP Oct 2021-Dec 2021

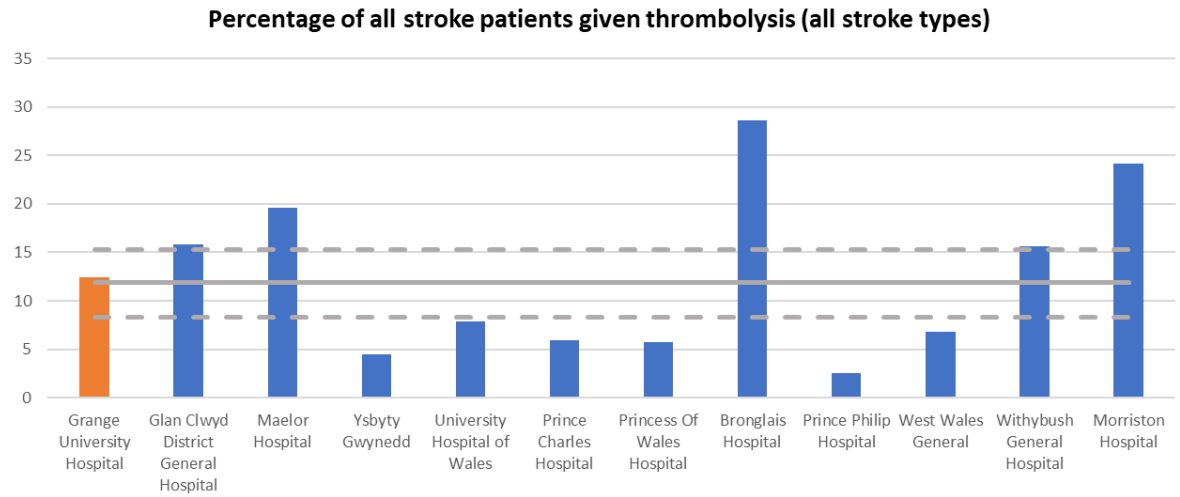
Percentage of patients who spent at least 90% of their stay on stroke unit – 63.9%

The GUH rates for accommodating patients for 90% of their in-patient stay on a stroke unit is lower than the England median. Patients that spend greater than 90% of their time on a stroke unit have fewer severe complications compared to those spending less than 90% of their inpatient stay on stroke units. The RGH reported moving stroke patients to other wards when they were medically optimised, to release beds. This will also have a positive impact on the 90% stay target.

Recommendation 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging (see fig 7 and 8) should help to release bed capacity and increase access.

6.4 Thrombolysis rate (all stroke)

Figure 9



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 3.1A

Source: SSNAP Oct 2021-Dec 2021

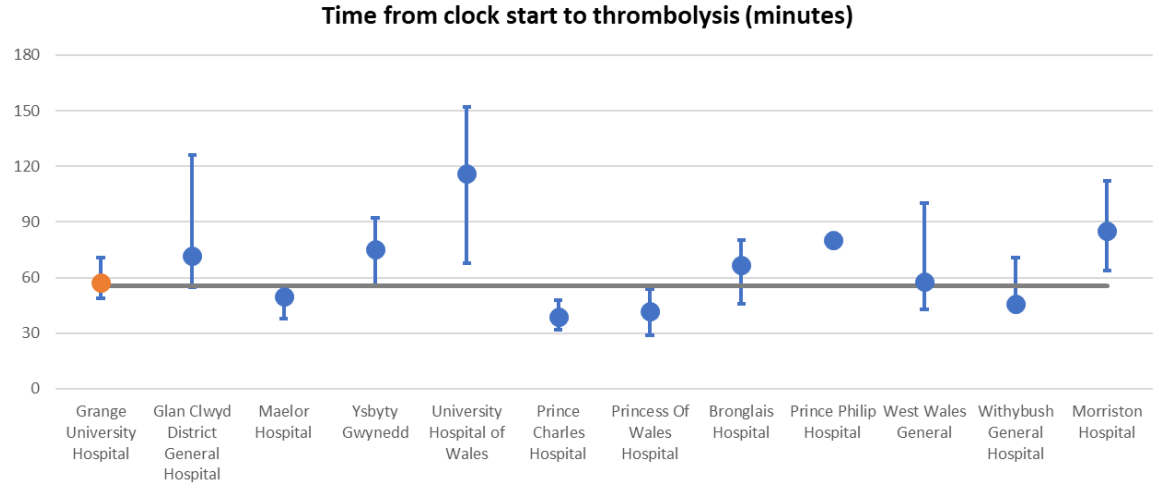
Thrombolysis rate – 12.4%

The thrombolysis rates are slightly above the England national average of 12%.

Recommendation 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.

6.5 Clock start to thrombolysis

Figure10



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 3.5A

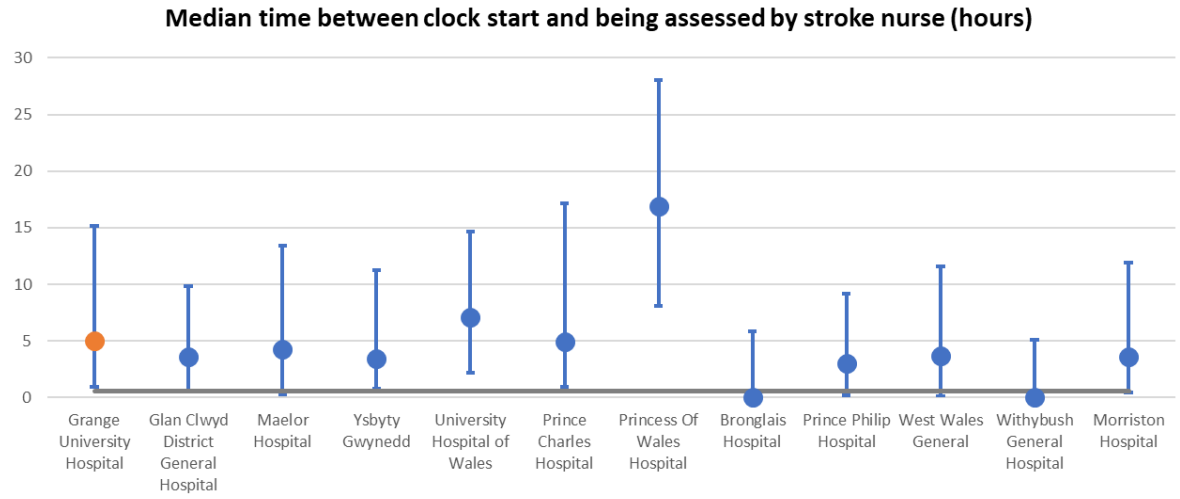
Source: SSNAP Oct 2021-Dec 2021

Time from clock start to thrombolysis (minutes) – 57mins

The GUH is providing timely access to thrombolysis from admission. Rates are in line with the median of sites in England. Aiming for a target closer to 30 minutes is gold standard and is being achieved in many highly performing stroke units in England, aided mostly by pre-registration of patients, immediate review by the stroke team and going straight to CT scanning.

6.6 Median time between clock start and being assessed by stroke nurse

Figure 11



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.4A

Source: SSNAP Oct 2021-Dec 2021

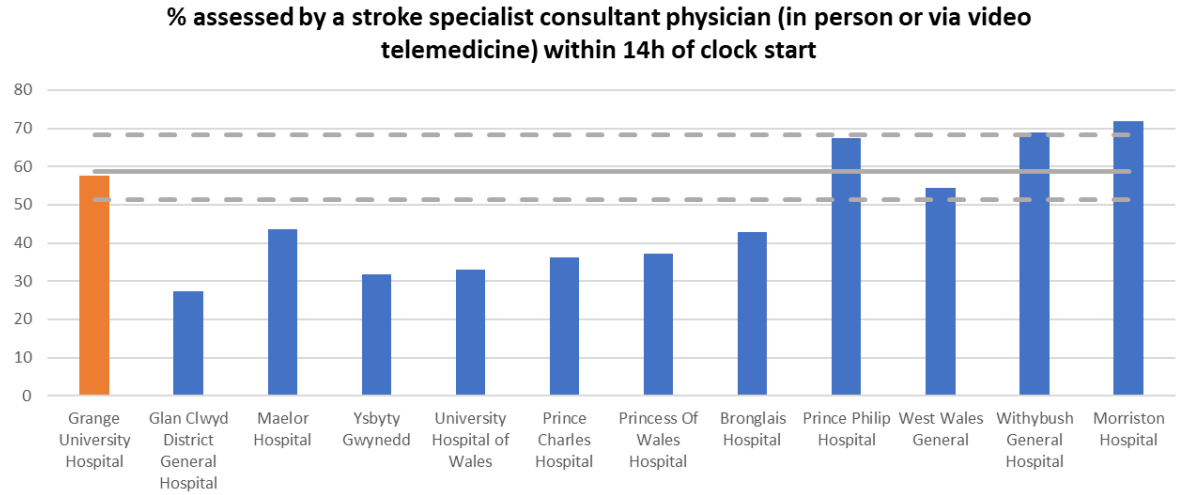
Median time between clock start and being assessed by stroke nurse – 4.95hr

GUH's median time between clock start and being assessed by a stroke nurse is 4.95 hours. There is variation due to GUH's inability to deliver a Stroke Specialist Nurse Assessment out-of-hours (outside of Monday-Friday 8am to-5pm).

Recommendation 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.

6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs

Figure 12



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Item Reference G9.19

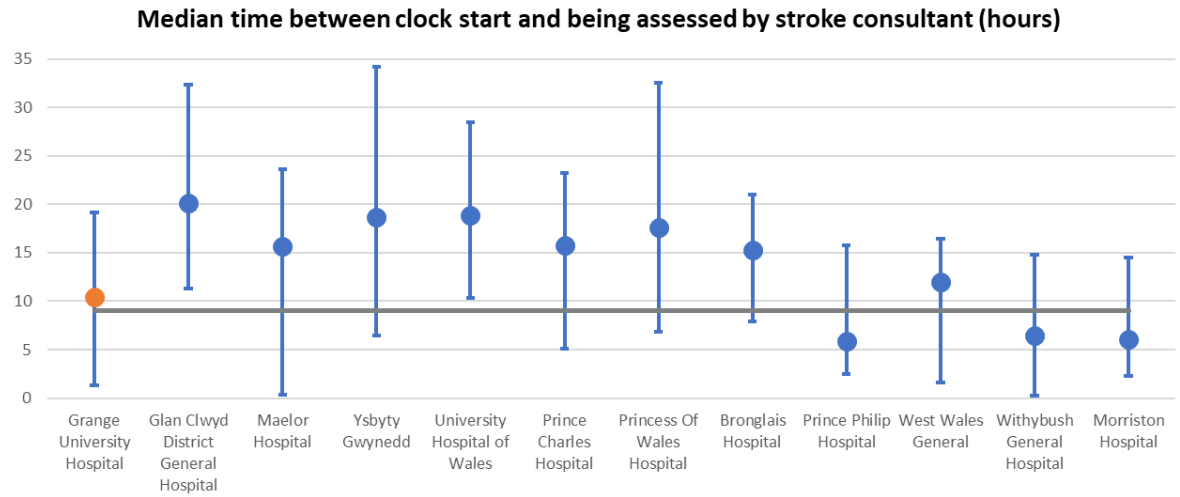
Source: SSNAP Oct 2021-Dec 2021

% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start – 57.5%

Good practice identified: The percentage of patients assessed by a stroke specialist consultant physician within 14hrs of clock start is in line with the English national average.

6.8 Specialist consultant assessment – Time between clock start and being assessed

Figure 13



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.2A

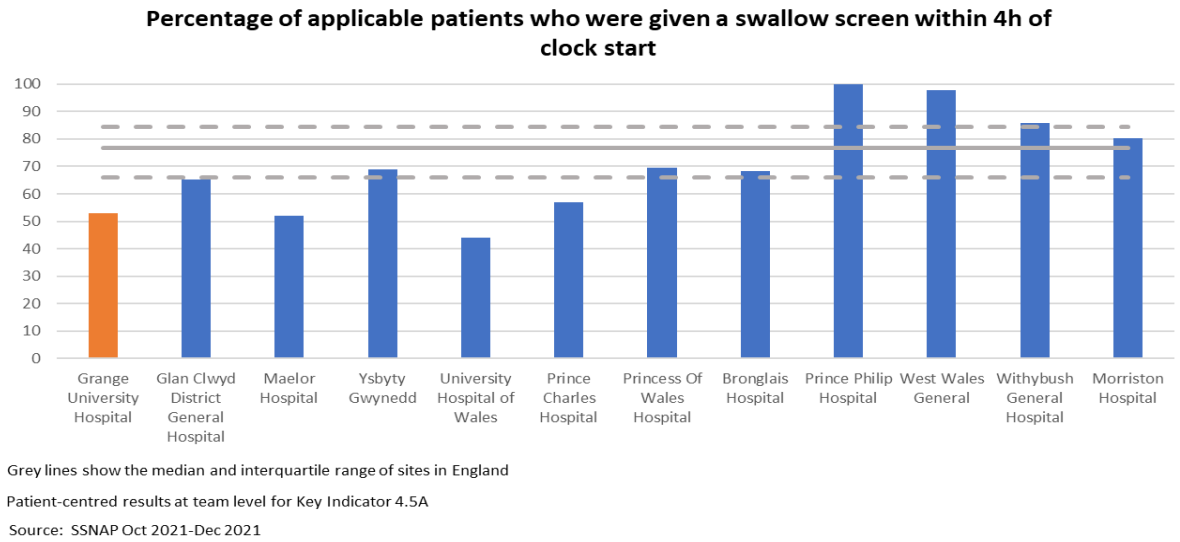
Source: SSNAP Oct 2021-Dec 2021

Median time between clock start and being assessed by stroke consultant (hours) – 10.37hrs

GUH are in line with the national average for the median time taken for first consultant review.

6.9 Swallow screen within 4 hours

Figure14



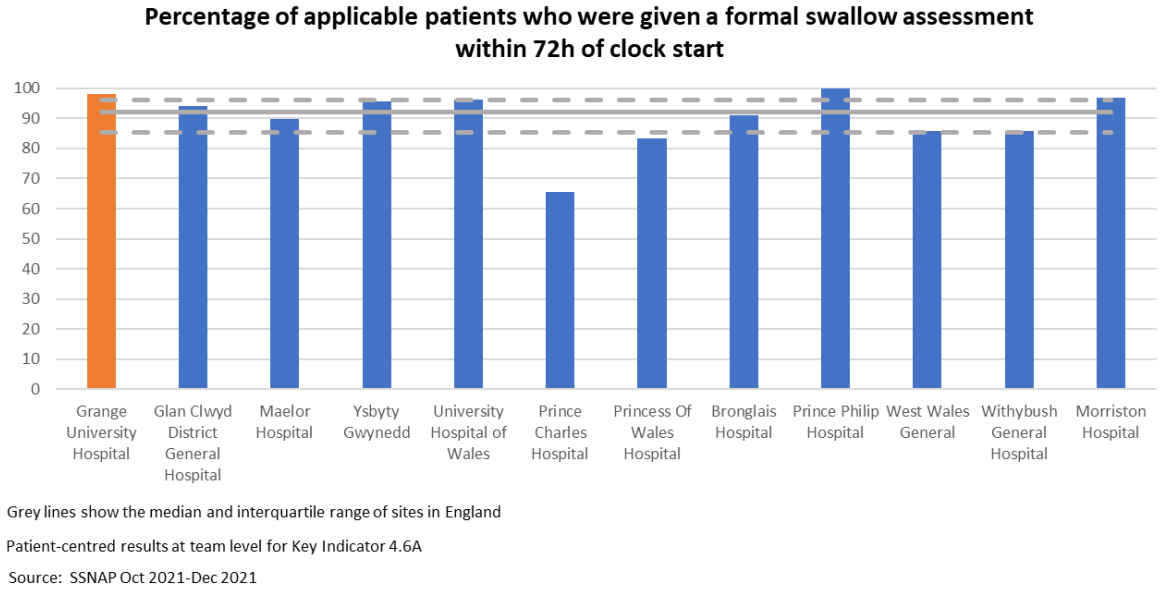
Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – 52.8%

Only 52.8% of patients accessed a swallow screen within 4 hours, this is significantly lower than the national average.

Recommendation 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.

6.10 Swallow Screen within 72hrs of clock start

Figure15

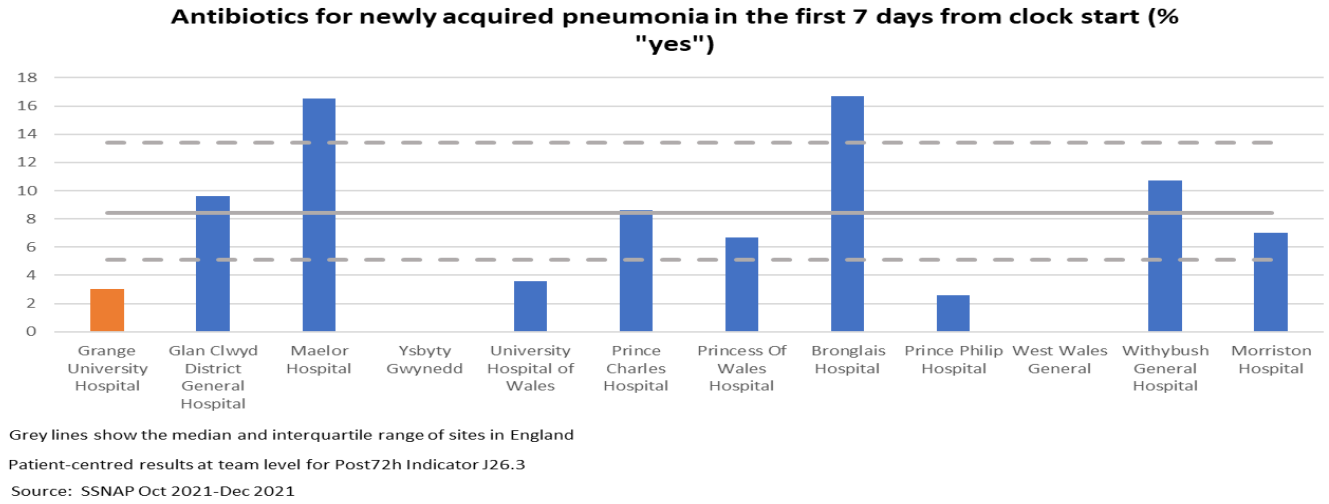


Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start - 98.2%

Good practice identified: 98.2% of GUH's patients accessed a formal swallow assessment by a Speech and Language Therapist within 72 hours of clock start. This is in the top quartile when compared with NHS Trusts in England.

6.11 Antibiotics for newly acquired pneumonia

Figure16



Antibiotics for newly acquired pneumonia in the first 7 days from clock start – 3 cases

Good practice identified: The data shows a low use of antibiotics for presumed pneumonia within the first 7 days of admission. This may be due to good processes being in place regarding swallow screening.

6. MDT Working

There is good evidence of early supported discharge and the delivery of therapy in people's homes.

There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

There is significant room for improvement in discharge processes and services i.e. social, packages of care and availability of care homes. Offering a stepdown for these patients to encourage flow across GUH and the rehab sites should be a priority. A goal should be to maximise support for patients who are most impaired and dependant following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

Recommendation 9: ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.

The community discharge pathway demonstrated a time based model, the current commissioned pathway is for 3 months. The Stroke Association carers support pathway has not been fully embeded in all units, with significant gaps in two thirds of the units. Currently,

patients in a residential or nursing home in this region do not have access to rehabilitation, other than ESD to people who meet the ESD criteria. People with more significant impairment requiring additional staffing to undertake effective rehab do not fit the criteria. The ESD rehab programme is time limited but there is a Neuro recovery college model which provides a range of educational modules covering fatigue management, living well with stroke, GRASP upper limb rehab, rebuilding your life after stroke, community exercise. These modules are open for people to attend and provide support for much longer than 3 months for ESD. The Life After Stroke wellbeing practitioners also support on a longer term basis as do the clinical psychology team. We also informed that there is also a pathway to which works in partnership with the DWP to support people back into employment and or voluntary roles.

The psychology team routinely provide life after stroke support. The Acquired Brain Injury (ABI) team have also stepped in to provide longer term rehab on a number of occasions. Both the ABI and psychology resources are small and we have worked hard to prioritise people who are most in need of ongoing support. The basis of our prioritisation is risk to wellbeing and ability of people who are already proximal to manage this risk.

The Niwrostiwt Recovery College was developed by the ABI and psychology teams to support us in our commitment to doing the most good for the most people, whilst minimising harm and maximising autonomy. Whilst led by the ABI team the Niworstiwt is a collaboration between CNRS ABI & Stroke teams, people with lived experience of stroke and brain injury, Headway and the Stroke Association. The latter organisations contribute to the Stiwt's steering group.

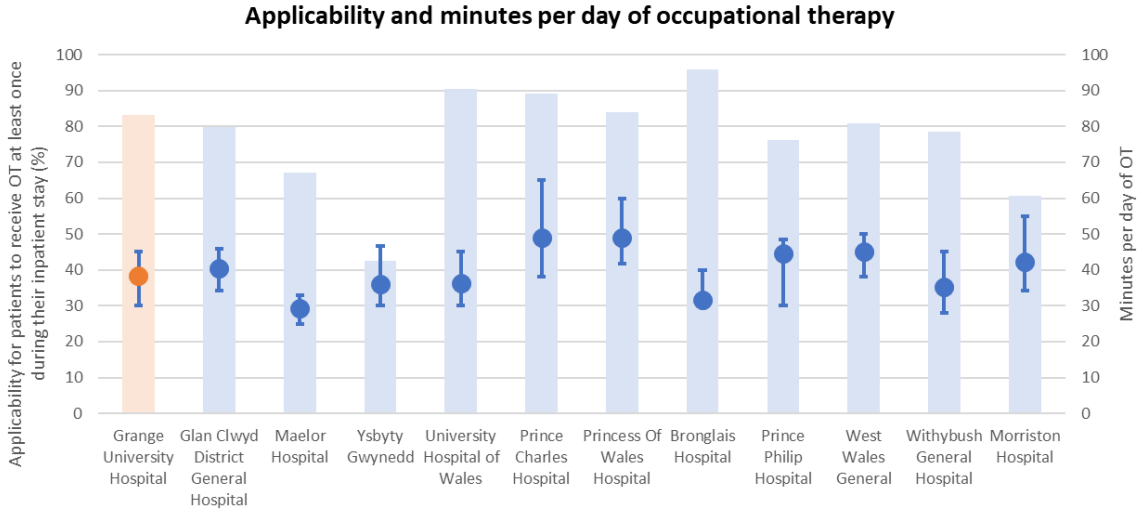
Recommendation 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).

Recommendation 11: Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.

Recommendation: 12: Embed the National Stroke Service Model in ABUHB
https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf

7.1 Applicability and minutes of OT

Figure17



Bars show the % of patients applicable to receive physiotherapy at least once during their inpatient stay (England median is 87%). Dots show the median minutes receiverd per day (and interquartile range)

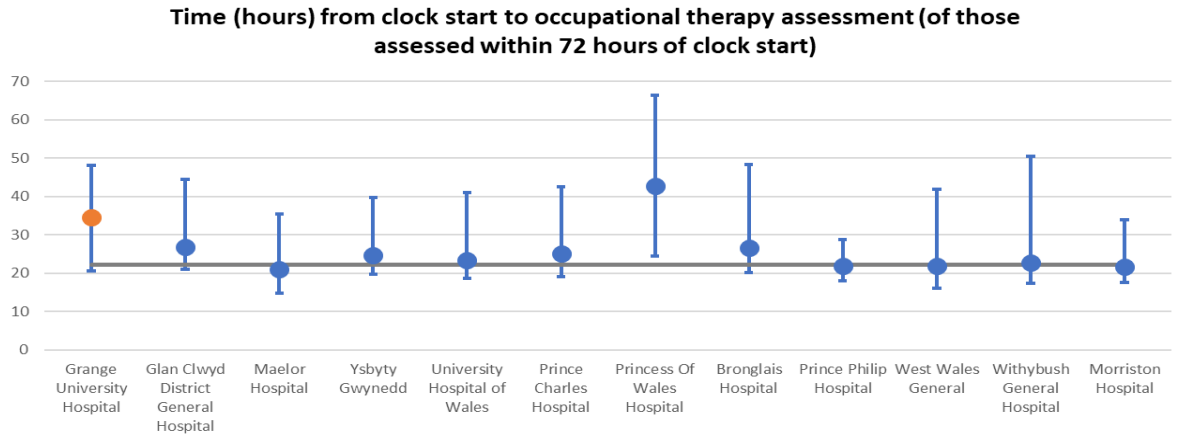
Patient -centred results at team level for Key Indicators 5.1A and 5.2A

Source: SSNAP Oct 2021-Dec 2021

Applicability and minutes per day of OT – 38.38%, in line with Wales's average

7.2 Clock start to OT assessment time

Figure18



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

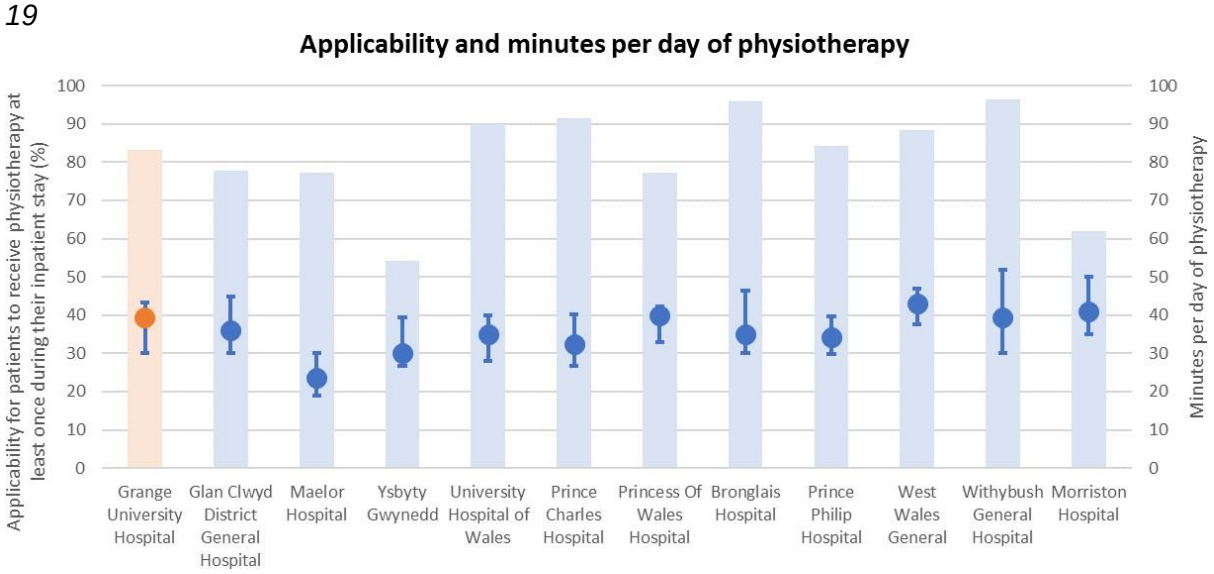
Patient-centred results at team level for Key Indicator 8.2A

Source: SSNAP Oct 2021-Dec 2021

Time from clock start to occupational therapy assessment – 34.35 hours

7.3 Applicability and minutes of physiotherapy

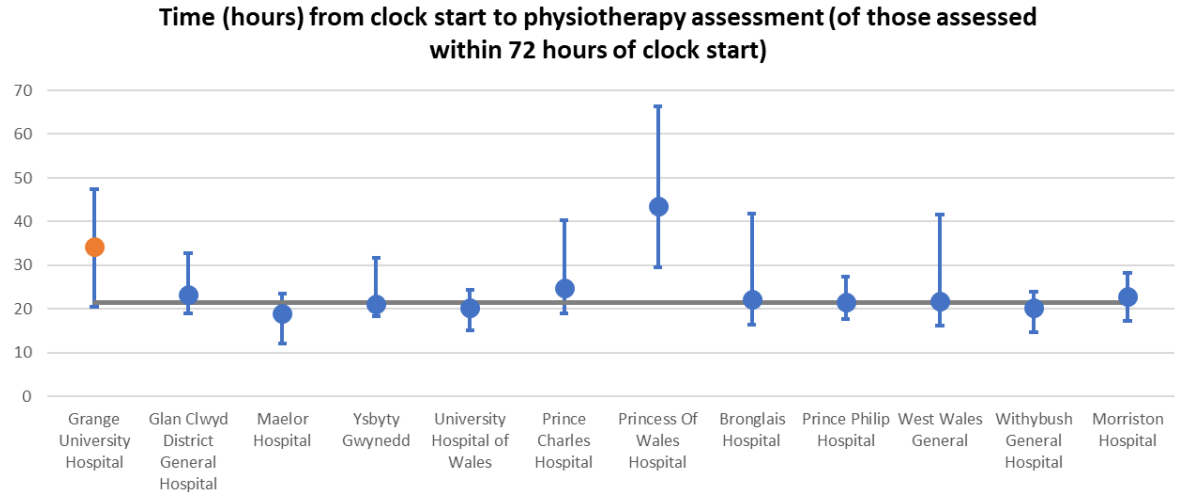
Figure 19



Applicability and minutes per day of physiotherapy – 39.2% in line with Wales's average

7.4 Clock start to physiotherapy assessment time

Figure20



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.4A

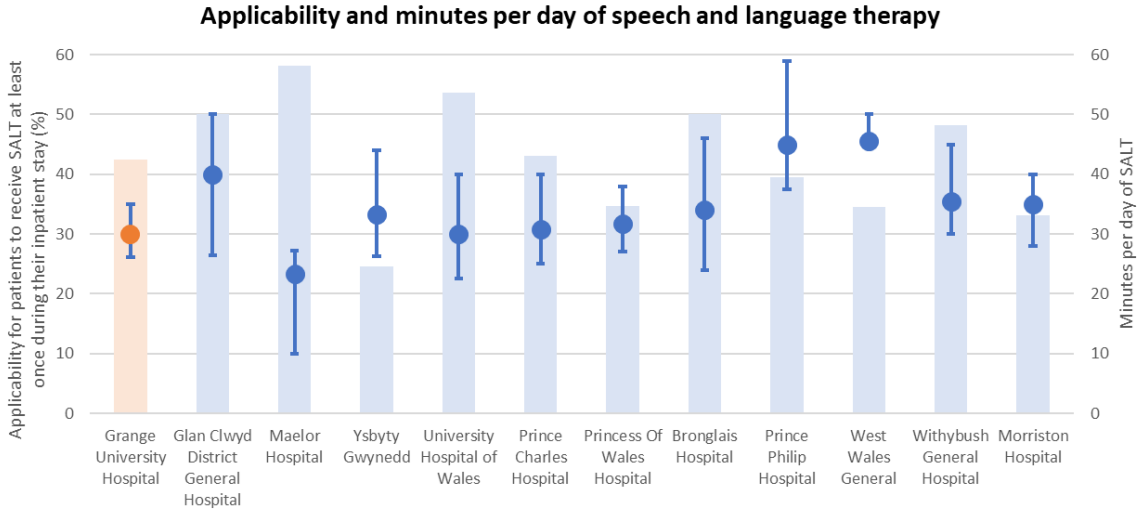
Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start) – 34.17%

Recommendation 13: Ensure 7 day access to physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients

7.5 Applicability and minutes of SALT

Figure21



Bars show the % of patients applicable to receive speech and language therapy at least once during their inpatient stay (England median is 54.4%). Dots show the median minutes receiverd per day (and interquartile range)

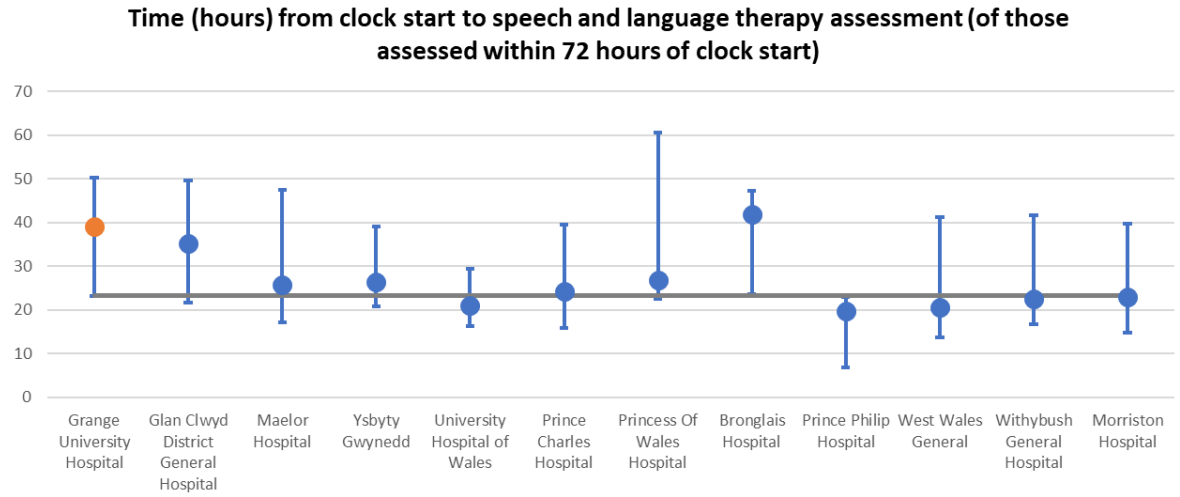
Patient -centred results at team level for Key Indicators 7.1A and 7.2A

Source: SSNAP Oct 2021-Dec 2021

Number of minutes per day on which SALT is actually received – 30%, below Wales's average.

7.6 Clock start to SALT assessment time

Figure22



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.6A

Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to speech and language therapy (SLT) assessment (of those assessed within 72 hours of clock start) – 39.05hrs

There is variation in the timely access to speech and language therapy services (see fig 21 and 22), as well as to physiotherapy and occupational therapy. The HASU currently provides a 5-day service for speech and language therapy. There are significant challenges in this pathway. The SSNAP standard is that sites should have at least two of the therapies shown available seven days a week. In most units, this is physiotherapy and occupational therapy.

Recommendation 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.

Currently not meeting the SSNAP 5 day standards for intensity of therapy, so it is clear that a review of rehabilitation staffing is required to meet 5 days before expansion to days can be considered. Expanded use of rehabilitation assistants and group therapy sessions to be considered. It may be worth exploring a virtual liaison tele-swallow service given the extreme staffing pressure within speech and language therapy.

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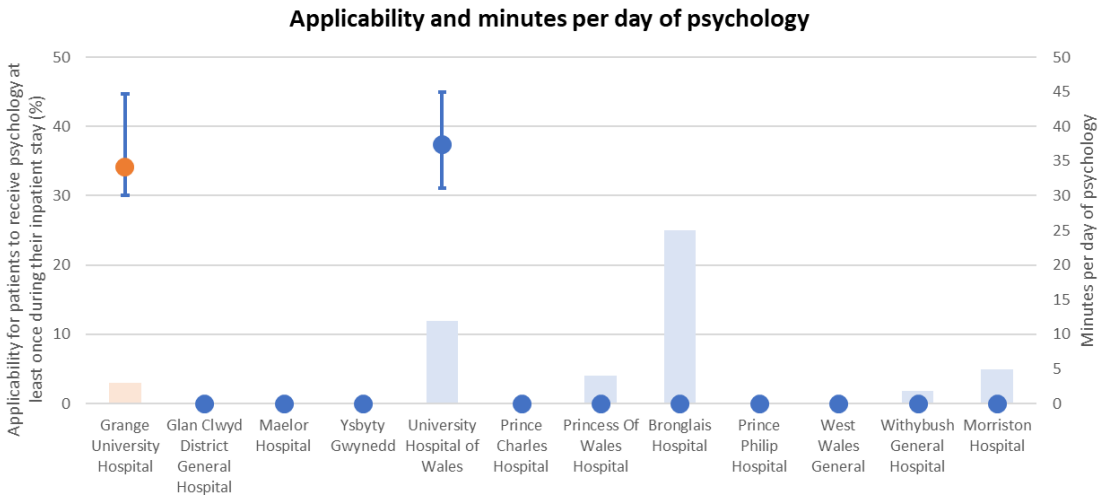
7.7 Applicability and minutes per day of psychology

Figure23



Bars show the % of patients applicable to receive psychology at least once during their inpatient stay (England median is 3.2%). Dots show the median minutes receiverd per day (and interquartile range)

Patient-centred results at team level for Item Reference J7.3-J7.7

Source: SSNAP Oct 2021-Dec 2021

% of the patient's days at in hospital (out of period patient requires psychology across all teams) on which it is received by the patient – 34.2%

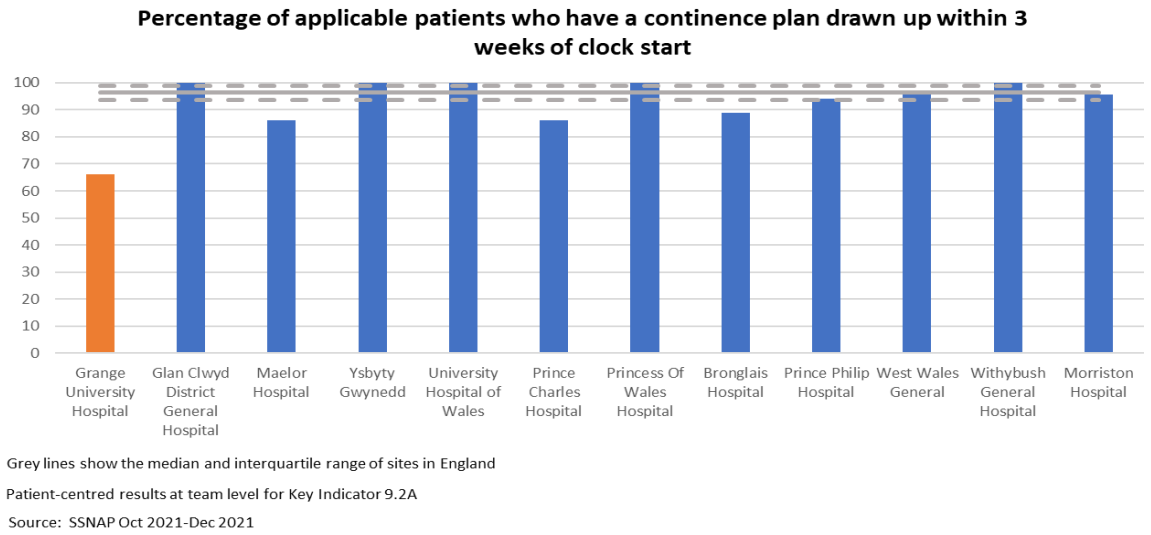
Assess to neuropsychology is variable across the region. A high proportion of patients (1 in 3) may require psychological support post-event. The current psychology model is 1 session of in reach per week for each ELGH based stroke unit. However, at the time of the GIRFT visit the psychology resource was significantly depleted by absences. We are told this has improved now, although there have not been any applicants to cover fixed term appointments, through secondments or agency staff. The psychology service provides support across the whole pathway and takes referrals from medics, primary care and healthcare professionals.

The ABUHB CNRS psychology team work across the width and along the full length of the stroke pathway. In practical terms this involves responding to requests for assistance from the HASU, the three sub-acute rehabilitation wards, the three Early Supported Discharge Teams, the ABUHB Living Well-After Stroke Service, and colleagues working in community services supporting stroke survivors. The CNRS psychology team have also been instrumental in the establishment of the Neurological Conditions Recovery College.

Recommendation 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.

7.7 Continence plans

Figure 24



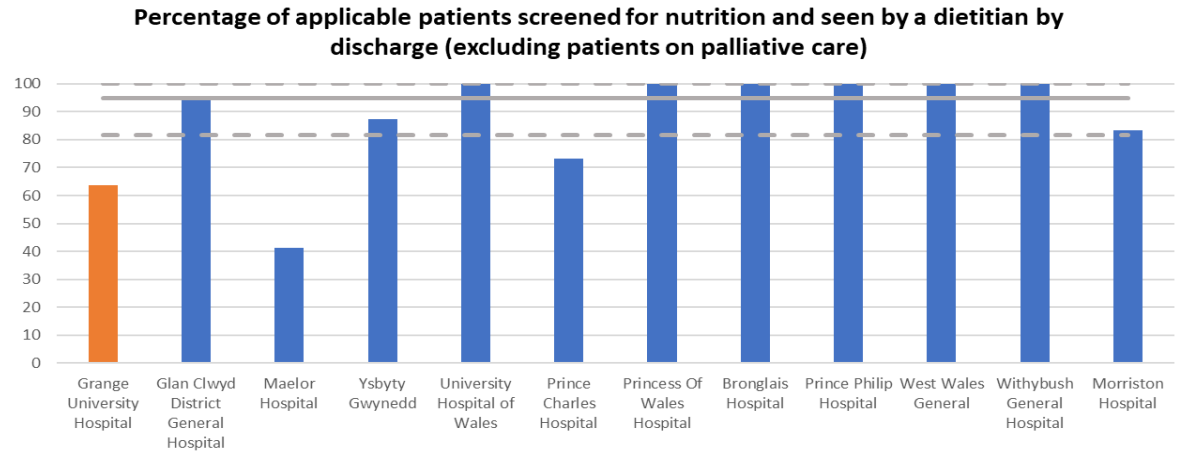
Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start – 66.1%

The data showing the percentage of patients who have continence planning within 3 weeks of admission is low in comparison to the national average. This is likely to be an issue with documentation in medical notes and hence data reporting.

Recommendation 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.

7.8 Nutrition screening and seen by dietician at discharge

Figure25



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key indicator 9.1A

Source: SSNAP Oct 2021-Dec 2021

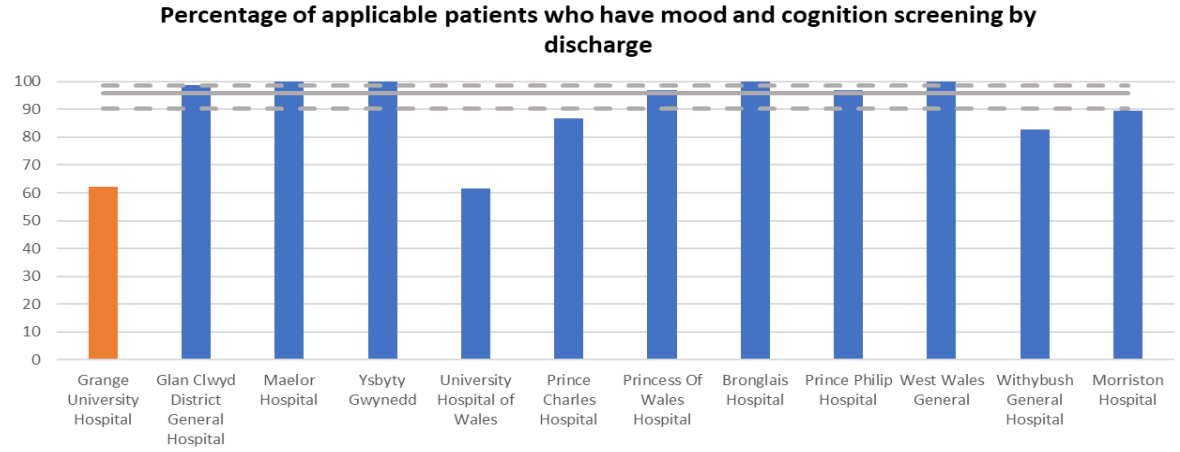
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care) – 63.6%, below Wales average

The data showing the percentage of patients who have been screened for nutrition and been seen by a dietitian by discharge is low in comparison to both the English and Welsh national averages. This is likely to be due to an issue with documentation and hence data reporting. We were informed that all patients assessed by ESD teams have a nutritional screen completed.

Recommendation 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.

7.9 Mood and cognition screening by discharge

Figure26



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.3A

Source: SSNAP Oct 2021-Dec 2021

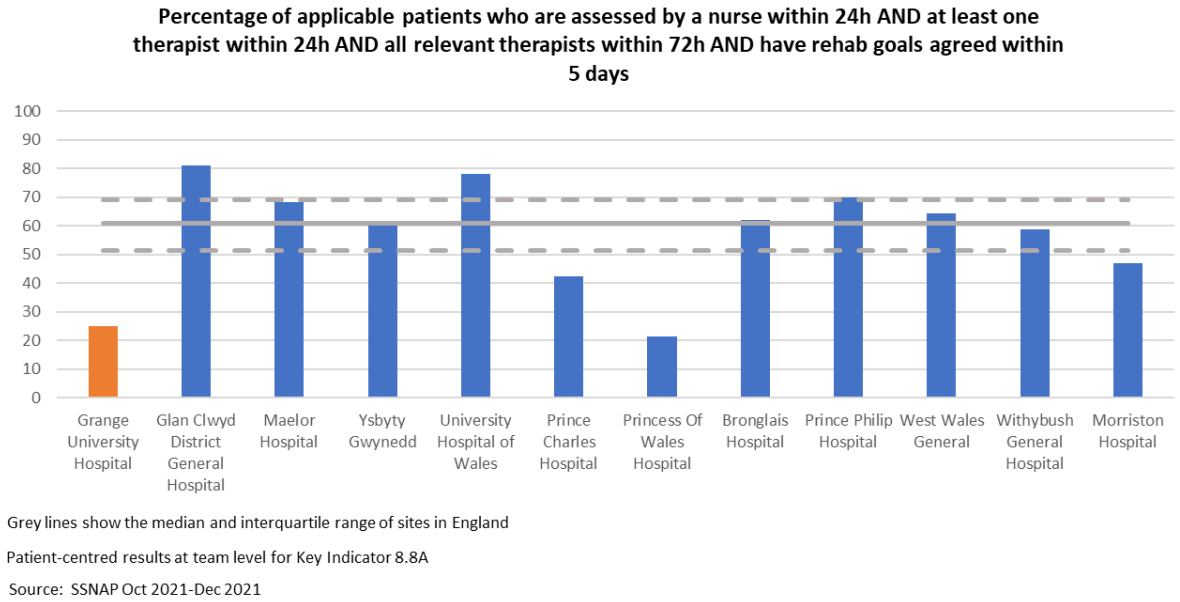
Percentage of applicable patients who have mood and cognition screening by discharge – 62.1% which is below the Wales average.

It was evident there is focus on mood and cognition assessment. The data showing the percentage of patients who have mood and cognition screening by discharge is low in comparison to the national average. This is likely to be an issue with documentation and hence data reporting.

Recommendation 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.

7.10 Nursing therapy and rehab goals

Figure27



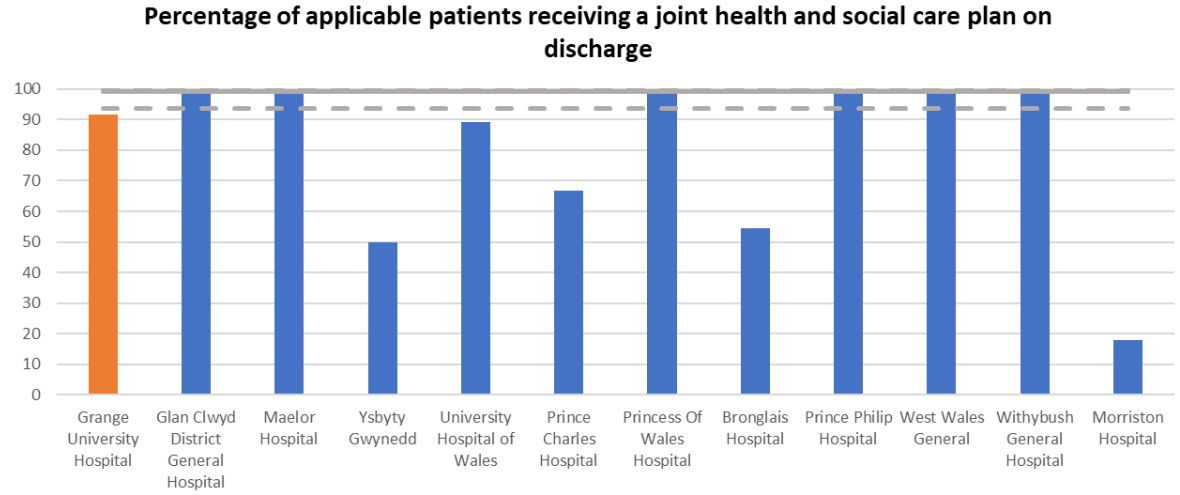
Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days – 25%

This performance measure (see fig 27) may be related to poor documentation, which makes it difficult for a data clerk to record that this target has been met. Although goals are often set, this may not be clearly documented following MDT discussions.

Recommendation 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.

7.11 Joint health and social care plan by discharge

Figure28



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.1A

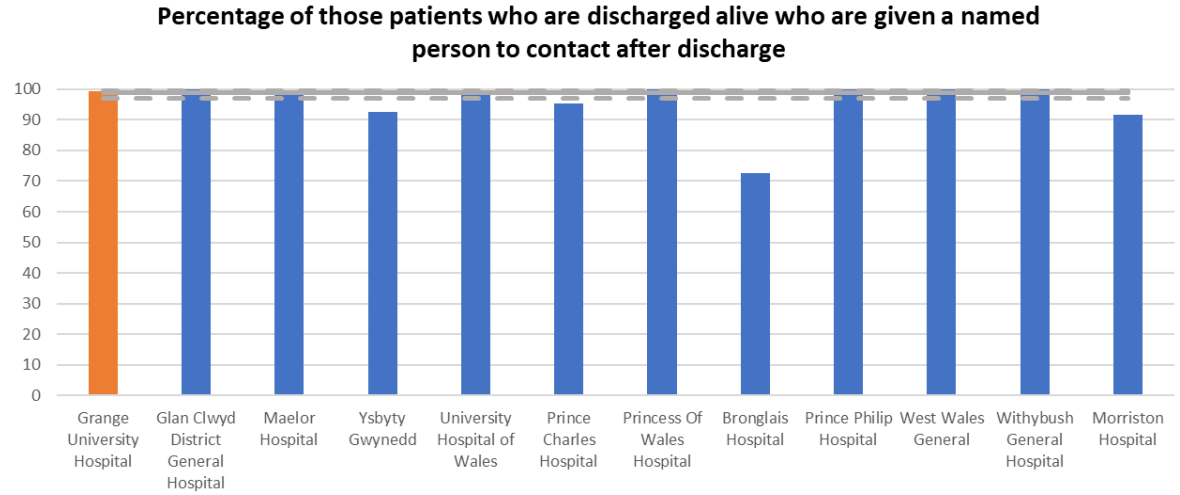
Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients receiving a joint health and social care plan on discharge – 91.7%

Joint health and social care planning by discharge is delivered and documented in over 90% of patients, this is below the English national average.

7.12 Discharged with a named contact

Figure29



Grey lines show the median and interquartile range of sites in England

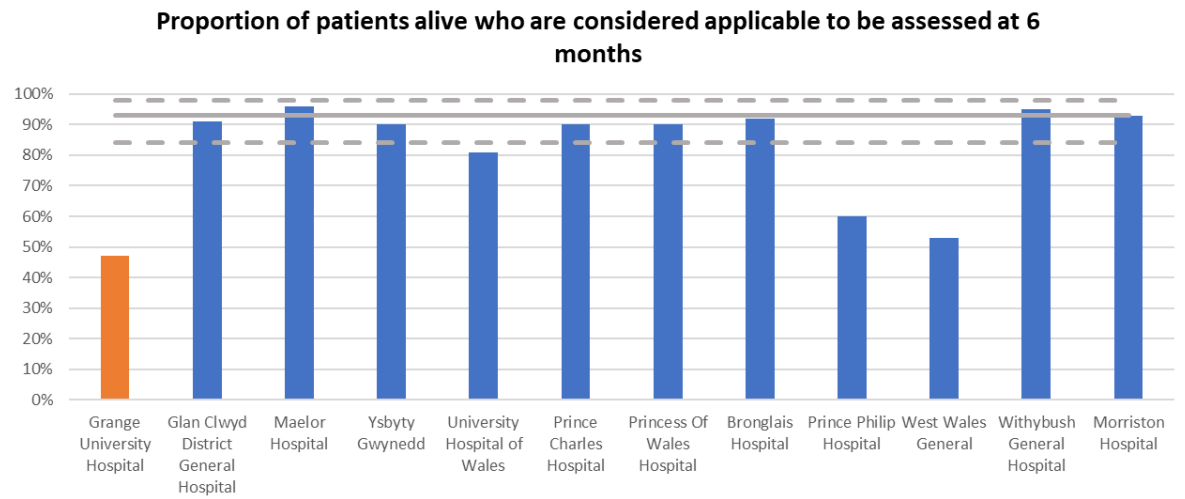
Patient-centred results at team level for Key Indicator 10.4A

Source: SSNAP Oct 2021-Dec 2021

Percentage of those patients who are discharged alive who are given a named person to contact after discharge – 99.3%

7.13 Patients applicable for a 6-month assessment

Figure 30



Grey lines show the median and interquartile range of sites in England

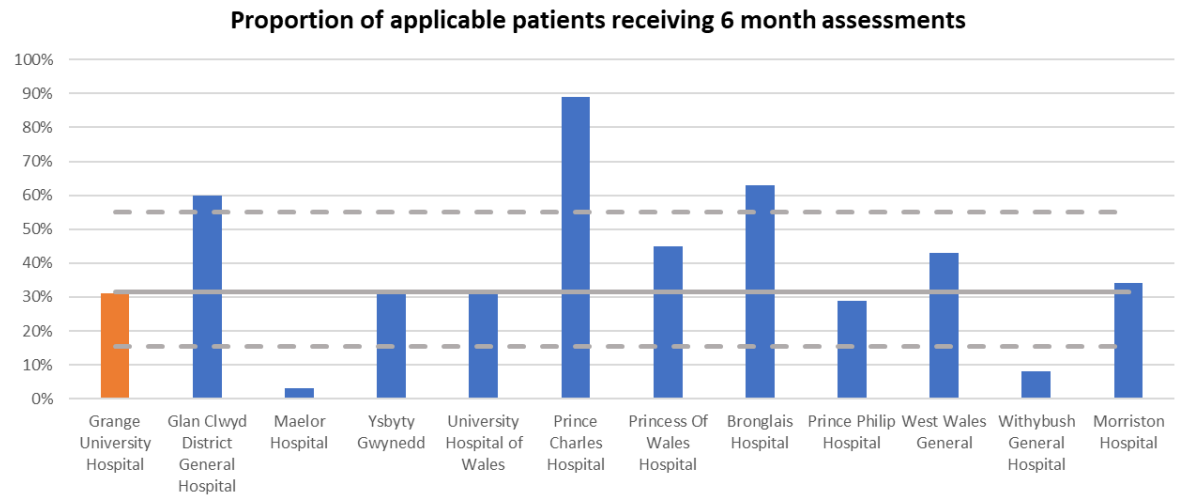
Team-centred results at team level for Item Reference B12.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of patients alive who are considered applicable to be assessed at 6 months – 47%, below Wales's average.

7.14 Applicable patients receiving 6-month assessments

Figure31



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B13.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of applicable patients receiving 6-month assessments – 60%

There is unwarranted variation in the proportion of patients who receive a 6-month assessment.

Delivering an adequate review post discharge is essential to ensure that patients have completed all the necessary investigations to identify the aetiology of stroke, have had access to appropriate post discharge rehabilitation, are taking appropriate secondary prevention and are having their risk factors for recurrent stroke adequately managed. This

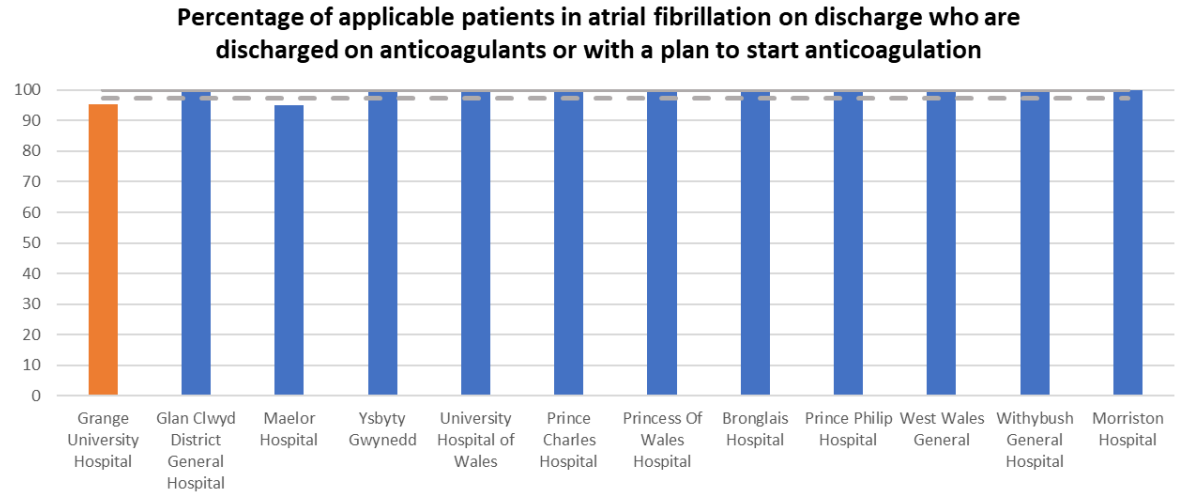
does not need to be delivered by a secondary care stroke physician and is often more effectively delivered by community stroke nurses who deliver a more holistic approach

Recommendation 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.

8 Secondary prevention

8.1 If in atrial fibrillation, discharged on anticoagulants

Figure32



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.3A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation – 95.2%

9 Summary of Recommendations

The table below summarises the recommendations made in the body of this report and is intended to serve as a useful tool for action planning.

Table of Recommendations

#	Recommendation
1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
2	Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.
3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.
4	ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.
5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for

	imaging should help to release bed capacity and increase access.
6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.
8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.
9	ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.
10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).
11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.
12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf
13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.
14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.
15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.
16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.
17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.
18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.
20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool:https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf

GIRFT Stroke Action Plan (narrative response)

No.	Recommendation	Health Board Response	Proposed Action Owner(s)
	ACUTE SERVICE		
1	**Real time data recording with regular audit meetings to review SSNAP data accuracy**	Recommendation supported in principle, although recognise the practical challenges involved for clinical staff. Establishing the SSNAP co-ordinator as a permanent post in the service is an important first step. <u>Proposed actions</u> • Urgent plan for replacement of SSNAP data co-ordinator • Prepare business case for permanent funding for the SSNAP co-ordinator post • Establish robustness and accuracy of SSNAP data as a standing audit meeting topic • Seek advice from GIRFT team regarding successful examples of real time data entry • Include as part of formal proposal paper to go to Executive Team • (Note – recognise that higher banded role may be very useful for overseeing and expediting patients through the system)	**Rhys Monk** Tanya Richards Yaqoob Bhat
2	**Commission an ESD pathway process flow map – expected that this will lead to reduction in number of rehabilitation units**	Accepted as an important pre-requisite for longer term review of rehabilitation service provision <u>Proposed actions</u> • Prepare initial mapping based on previous work undertaken within therapies / seek additional modelling support • Seek recent examples (via GIRFT) from other services to ensure comprehensive coverage • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Adele Griffiths** David Hanks Collette Kiernan Medicine Division
3	**Consistent process for pre-notification of acute stroke presentations to the stroke team, optimising and thereby optimising access to imaging**	This is recognised as a critical first step to consistent timely assessment and delivery of thrombolysis therapy for all appropriate patients. An efficient and effective pathway will involve the ability of public / community to recognise and act on acute stroke symptoms, clear lines of communication with WAST, robust ownership of stroke pathway within GUH, understanding of pathway within ED and responsive radiology capacity. This is inevitably also linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse	Sue Pearce Febe Palmer Tanya Richards Samantha Hurn (WAST) Mike Jenkins (WAST)

		Proposed actions • Review current pathway in consultation with WAST / ED colleagues and identify current areas / causes of delay • Assess potential for further community publicity programme for FAST etc • Work closely with Delivery Unit review of stroke radiology pathway • Build in to plan / business case for 24/7 specialist nurse presence and role	
4	**Develop strategy to ensure prompt transfer of patients to acute stroke unit i.e. within four hours**	It is recognised that delays in transfer to the stroke unit are strongly related to severe pressures within the wider urgent care system and the subsequent utilisation of all available acute beds when managing clinical risk at the front door. Progress with this recommendation is also again linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse, but it is important to identify and address any readily avoidable areas of delay as soon as possible Proposed actions • Urgent review of existing operational policies with aim of identifying early actions that reduce blockages and delays • Discuss options with Operations team to assess realistic and sustainable protocol for element of bed protection, given severe wider operational pressures. • Aim to establish 'stroke champions' within the emergency department • Develop proposal that sets out the conclusions from the above and incorporates the beneficial impact of other related recommendations / work streams • Include as part of formal proposal paper to go to Executive Team	Peter Carr Carl Rees Yaqoob Bhat Rhys Monk David Hanks
5	**Ensure access to the stroke unit for stroke patients for 90% of their stay**	It is considered that progress on recommendations 2 and 4 will be highly influential in delivering this recommendation as a positive consequence. Emphasis should therefore be placed on the former to avoid complication and duplication of service effort. Proposed actions • Ensure clear data on current patient stays and ward locations • Pursue actions in respect of recommendations 2 and 4 • Measure improvements in compliance as / when progress with the above is delivered • Ensure benefits of element of ringfencing	**Tanya Richards** **Rhys Monk** **Carl Rees**
6	**Optimise thrombolysis pathway to ensure rates of 15-20% of acute stroke presentations have opportunity for thrombolysis**	Pleasingly, the service is currently delivering thrombolysis rates within this target range, but it is recognised that further improvement is desirable to ensure consistent delivery. It is considered that progress on recommendations 3 and 7 (together with the forthcoming Delivery Unit review of stroke radiology pathways) will be highly influential in delivering this	**Yaqoob Bhat** **Rhys Monk** Tanya Richards

		recommendation as a positive consequence. Emphasis should therefore be placed on the former to avoid complication and duplication of service effort. <u>Proposed actions</u> • Pursue actions in respect of recommendations 3 and 7 • Work closely with DU review of stroke radiology pathway to assess any further sources of delay • Continue Clinical Director-led weekly audit of thrombolysis activity and metrics to measure improvements in compliance as / when progress with the above is delivered	
7	**The service should aim for 24/7 supernumerary specialist nurse cover to be the key point of contact and 'own' the priority of driving patients through the stroke pathway**	The emphasis placed on this by the GIRFT team as a key priority action is noted. Whilst there is a clear cost implication, it is intended that this should be one of the first actions to progress as an important step in strengthening the Health Board commitment to an optimal stroke pathway. <u>Proposed actions</u> • Develop practical plan / business case for increasing specialist nurse establishment to deliver 24/7 coverage • Include as part of formal proposal paper to go to Executive Team • Progress business case through usual Health Board scrutiny procedures	**Sue Pearce** **Rachel Pritchard** Febe Palmer Tracey Morgan Peter Carr
8	**Ensure 24/7 availability of ED or stroke staff competent and able to provide swallow screening within two hours**	Some progress has been made in respect of training additional staff groups for this competence, but the need to continue and embed arrangements is acknowledged. Once again this is linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse, which could provide consistent additional expertise. Initial screening as a triage for more detailed swallow assessment – important to maintain key professional role of SLT <u>Proposed actions</u> • Meet with ED team to review current arrangements to establish baseline position and realistic gap to address for consistent delivery • Progress rollout of training for additional staff groups e.g. ED / ward nursing staff (noting link with ED 'stroke champions')	Sue Pearce Chris Morgan Claire Parks Roxy Williams Febe Palmer Tanya Richards Jenna Adams Alison Williams

9	**Put cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.**	This is considered to be an important area for development and will be fully supported through the Medicine Division and the Executive-led Stroke Delivery Board Proposed actions • Seek further guidance from GIRFT team and Stroke Network • Discuss requirements at Stroke Delivery Board • Develop Divisional / Directorate plan as part of wider training & development strategy – to include within job plans • Confirm nominations	**Chris Heath** Collette Kiernan Directorate / Divisional team
10	**Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).**	This relates to a wide-ranging recommended model of stroke care in the community, much of which is contained within the other specific recommendations within the GIRFT report. It is considered that a more general review of the model and analysis of the remaining compliance gaps in the Aneurin Bevan service forms part of the longer-term agenda of the Stroke Delivery Group once the specific actions linked to other recommendations have been progressed / implemented. It is recognised that this model will influence the operation of the ESD pathway	Peter Carr
11	**Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.**	The importance of ensuring good levels of support for carers is noted and the service would wish to work closely with the Stroke Association to identify priority areas for further work. Proposed actions • Prepare baseline assessment of current provision against the SACS pathway • Consider and prepare a gap analysis / development plan, based on observed best practice and gaps identified	David Hanks Rachel Pritchard Katie Chappelle Adele Griffiths
12	**Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf**	This relates to a wide-ranging recommended model of stroke care delivery, much of which is contained within the other specific recommendations within the GIRFT report. It is considered that a more general review of the model and analysis of the remaining compliance gaps in the Aneurin Bevan service forms part of the longer-term agenda of the Stroke Delivery Group once the specific actions linked to other recommendations have been progressed / implemented.	Peter Carr Yaqoob Bhat

13	**Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.**	It is considered that this and a number of the other recommendations are closely linked to wider reviews of therapy resourcing and distribution, and to the desirability of changes to the configuration of stroke rehabilitation services generally referenced in recommendation 2. It is therefore intended that this and the other relevant recommendations are considered as part of the discussions with the senior therapies management team, informed by the conclusions of the ESD pathway mapping and analysis from the specific therapies mentioned. <u>Proposed actions</u> • Prepare initial ESD mapping based on previous work undertaken within therapies • Prepare baseline assessment of existing physiotherapy provision and options for delivering the seven-day / 45 minute standards • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Collette Kiernan** Sarah Carrington Suzanne

14	**The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working**	As above, it is considered that this and a number of the other recommendations are closely linked to wider reviews of therapy resourcing and distribution, and to the desirability of changes to the configuration of stroke rehabilitation services generally referenced in recommendation 2. It is therefore intended that this and the other relevant recommendations are considered as part of the discussions with the senior therapies management team, informed by the conclusions of the ESD pathway mapping and analysis from the specific therapies mentioned. <u>Proposed actions</u> • Prepare initial ESD mapping based on previous work undertaken within therapies • Prepare baseline assessment of existing therapy provision and options for delivering seven-day working • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Collette Kiernan** Adele Griffiths

15	**Deliver adequate psychological and emotional support for stroke survivors and their families.**	This is acknowledged as an important element of support for stroke patients and their families, and an area that should be prioritised. Whilst definitions of 'adequate' may be difficult, we would wish to learn from existing examples of best practice and to develop the service locally as a high bench-marked level of provision. Recognised that emphasis needs to be placed on the rehabilitation element of the pathway to avoid a medical focus. <u>Proposed actions</u> • Prepare baseline assessment of current provision and benchmark against peers, informed by current good practice guidelines, research evidence of benefits etc • Consider and prepare a gap analysis / development plan / business case for the service, based on bench-marked practice and gaps identified • Include as part of formal proposal paper to go to Executive Team	**Daryl Harris** Helen Hak
16	**Ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.**	This is acknowledged as an important part of patient well-being and recovery, and that it is important that the work being undertaken is fully documented and reported as required. <u>Proposed actions</u> • Ward teams to review current practices, informed by current good practice and agree standard procedures to ensure consistent delivery and documentation of care • Consider and prepare action plans if required to address any gaps in service • Include as part of formal proposal paper to go to Executive Team if/as needed	**Sue Pearce** **Rachel Pritchard** Febe Palmer Suzanne Bryant
17	**Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.**	The importance of good nutrition as a core element of physical recovery and rehabilitation is acknowledged and supported. Note potential lessons from recent pilot in T&O service <u>Proposed actions</u> • Review current pathway, informed by current good practice and agree standard procedures to ensure consistent delivery and documentation of care • Consider and prepare action plans if required to address any gaps in service • Include as part of formal proposal paper to go to Executive Team if/as needed • Consider input from nutritional support worker pilots	Catherine Jones / **Louise Evans** Febe Palmer
18	**Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held**	This aligns closely with the work to develop psychological and emotional support for the service, and these points will be picked up as part of that workstream.	**Daryl Harris** Helen Hak

	to provide assurance.		
19	**Ensure 24 / 72 hour care bundles are delivered consistently. Improve documentation of MDT goal setting in case notes.**		**Sue Pearce** **Rachel Pritchard** Helen Hak
20	**Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.**	Post-discharge reviews are recognised as an important element of continuing stroke care and of ensuring maximum long-term rehabilitation and recovery. It is considered that the recommended establishment of a 24/7 specialist stroke nurse presence would support progress with maintaining robust review arrangements. <u>Proposed actions</u> • Prepare assessment of current baseline provision and of the practicality and cost of standardisation under the GM-SAT tool • Prepare business case as appropriate for proposed implementation	**Yaqoob Bhat** **Sue Pearce**

GIG CYMRU NHS WALES | Grŵp Gweithredu Strôc Stroke Implementation Group

National Stroke Programme Board *Terms of Reference*

Author: Lynda Kenway, Stroke Implementation Group Manager

Reviewed by:

Approved by:

Date: 30/07/2022	**Version:** v0c

Purpose and Summary of Document:

This paper sets out the terms of reference for the Stroke Implementation Group's National Stroke Programme Board.

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1 Introduction

Stroke is the fourth leading cause of death in Wales, and it can have a significant long-term impact on survivors. There are currently almost 70,000 stroke survivors living in Wales, and an estimated 7,400 people experience a stroke each year. Stroke can change lives in an instant, but with the right support, people can make a good recovery.

The NHS Wales Health Collaborative Executive Group (NHSWHC CEG) is the responsible governance group for the Stroke Implementation Group (SIG) and the National Stroke Programme Board (NSPB). The NHS WHC CEG reports to the NHS Wales Collaborative Leadership Forum. The National Stroke Programme Board (NSPB) provides oversight of the national stroke programme and works in partnership with the regional stroke programmes to improve the stroke pathway and develop a programme of work to scope out and develop comprehensive regional stroke centres (CRSCs). This paper sets out the terms of reference for the National Stroke Programme Board.

2 Background

The Stroke Implementation Group was established in 2013 to provide national leadership and support for the delivery of effective person-centred, value-based, stroke care in Wales.

The Stroke Implementation Group identifies priority areas for collaboration to improve the provision of stroke services at a regional or national level and facilitates decision making which is in the best interests of the regional or national population, as appropriate, based on the best evidence available. The Collaborative Executive Group is the responsible governance group for the Stroke Implementation Group team and National Stroke Programme Board and approves the SIG work programme.

This programme has been established on the request of the NHSWHC CEG following several reports and papers setting out the various challenges for stroke services in Wales. In June 2022 the CEG endorsed the establishment of a National Stroke Programme Board (NSPB), supported by a core programme team within the NHS Wales Health Collaborative. The team will oversee a consistent approach to the establishment of regional stroke networks which deliver a sustainable stroke service model for Wales that meets national stroke standards and improves outcomes for patients.

The CEG also endorsed the recommendation that:

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1) the planning assumption that four regional CRSCs and ODNs are required and that regional work within the programme should be structured accordingly
2) the National Stroke Programme Board produces a clear and unambiguous case for change demonstrating current outcomes and the expectations for improvement by delivery of the national standards and the new service models that will follow.

The Collaborative Programme Team comprises of representatives from the Stroke Implementation Group:

- Senior Chief Executive Lead for Stroke – (CEO Swansea Bay University Health Board)
- National Clinical Lead for Stroke
- National Nurse Lead for Stroke
- National AHP Lead for Stroke
- SIG Manager/National Programme Manager
- SIG Senior Project Support Officer

Activities of the Programme Team are supported by NHSWHC leads from:

- Senior Management Team
- Planning
- Communications & engagement
- Finance & resources

3 Purpose and roles

The purpose of the National Stroke Programme Board is to provide:

- executive guidance to the National Stroke Programme
- detailed oversight of the work to develop comprehensive regional stroke centres and operational delivery networks. Ensuring that regions are supported to develop standardised programme plans
- develop a clear process to evaluate and scrutinise regional plans ensuring that there is an independent panel in place to provide assurance
- determine the national case for change
- agree national standards, guidance, service specifications and pathways
- support the public and professional engagement and consultation process
- Develop a full programme business case

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In fulfilling the above purpose, the NSPB will act on behalf of the Collaborative Executive Group, working within the parameters set by that group, and will be informed by the Stroke Implementation Group work programme.

Specific roles of the NSPB are to:

- support the delivery of the agreed work programme through prioritisation and the identification and resolution of issues affecting progress which need the input and agreement of senior stakeholders
- receive and review reports from the agreed subgroups and regional programmes on delivery against the agreed priorities and timelines, and hold the regions CEOs to account for this delivery
- Seek assurance that regional boards are on track to deliver against the agreed priorities, and escalate any identified risks/issues concerned
- consider and resolve dependencies between activities within the programme and dependencies related to other local, regional, and national work
- ensure the identification and management of risks associated with the programme
- formulate and agree key recommendations to the Collaborative Executive Group, and, in some cases for eventual approval by Boards, in terms of:
    - programmes, projects, and activities to be continued or added to the work programme, through annual and in year review
    - decisions and actions stemming from work undertaken by the Programme Team, where this has impacts across organisational boundaries
    - the closure of existing programmes, projects and activities, on completion or for other reasons
    - the allocation of resources to support the delivery of the programme
    - reports, business cases and other representations to be made to Welsh Government and external stakeholders in support of the delivery of the programme
- ensure that the work of the Programme Team is communicated appropriately to all relevant stakeholders in NHS Wales and to relevant external stakeholders
- consider direct requests from Welsh Government for the Programme Team to take on new work or expand existing programmes of work, ensuring those agreed are consistent with the remit of the programme and can be met either through existing resources or are supported by additional resources from Welsh Government

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4 Guiding principles

In conducting its business, the National Stroke Programme Board will:

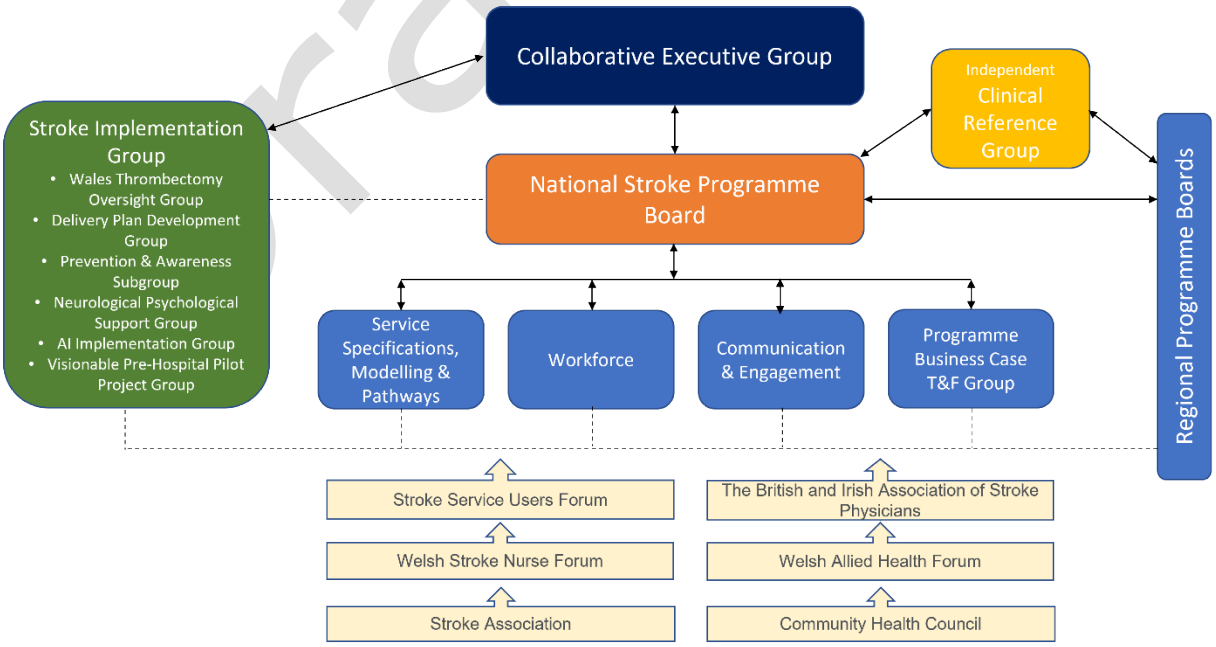
- work in a spirit of collaboration, with trust and respect in support of the needs of the current the population of Wales and future generations
- support the principles of prudent healthcare
- be guided by the best available evidence

5 Authority and reporting

The National Stroke Programme Board will act as an executive subgroup of, and be accountable to, the Collaborative Executive Group. The SRO will report to each meeting of the Collaborative Executive Group on the activities of the NSPB.

Decisions made by the NSPB that would have a material impact on services delivered by health boards, trusts, or special health authorities, on the content of the work programme will be advisory to the Collaborative Executive Group and will be referred to that Forum for agreement. Where necessary, such recommendations may need to be agreed by individual boards or regions.

The NSPB has no specific delegated authority from statutory health bodies, although Chief Executives may make commitments via the Collaborative Executive Group within the normal limits of their delegated authority.



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6 Membership

The membership of the board will be consistent of representatives from:

- health board Director of Finance
- health board Director of Planning
- health board Director of Nursing
- health board Directors of Therapies and Health Science
- health board Medical Director
- health board Director of Workforce and Organisational Development
- NHS Wales Delivery Unit
- Welsh Government
- Emergency Ambulance Service Committee
- Welsh Health Specialist Service Committee
- Health Education & Improvement Wales
- Digital Health Care Wales
- Welsh Ambulance Service Trust
- Community Health Council
- Stroke Association representative
- communications & engagement leads
- regional stroke programme managers

The programme should also seek to engage with external clinical advisors who will provide advice to the Board as well as supporting development of the programme

The Programme Board should be underpinned and supported by professionals from the pathway, together with wider enabling and ancillary services including:

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- Allied Health Profession leads – physiotherapy, Occupational therapy, dietetics, speech and language therapy, psychology
- Community Rehabilitation Teams
- Health board stroke clinical leads
- Improvement Cymru
- Primary Care
- Radiology services
- Research
- Social care teams
- Value Based Health Care

In addition, the following will be invited to attend meetings of the NSPB:

- Collaborative Senior Management Team members and other senior managers where relevant to the topics under discussion
- Strategic Clinical Advisor, Welsh Government
- A minute taker provided by the Collaborative Team

Other individuals may be invited to attend specific meetings of the NSPB, at the discretion of the Chair, where this will facilitate the work of the group.

7 Chair

The National Stroke Programme Board will be chaired by the SRO for the lifetime of the Programme.

8 Arrangements for meetings

8.1 Frequency of meetings

The Programme Board will meet quarterly, except in cases where the Chair agrees that there is sufficient business to justify convening additional meetings.

Meetings of the Programme Board will be scheduled for 12 months ahead, and any cancellations or changes will be notified at least seven days in advance.

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8.2 Circulation of papers

Agendas, supporting papers and minutes of the previous meeting will be circulated to members of the Programme Board at least five days before each meeting.

8.3 Quorum

The quorum for meetings of the Programme Board shall be 50% of the group's full members.

8.4 Attendance

Except in exceptional circumstances, all members of the Programme Board should endeavour to attend all meetings of the group. If unable to attend a specific meeting, members may nominate a deputy, at executive director level, to represent them.

8.5 Decision making

Bearing in mind that key decisions are advisory to the Collaborative Executive Group, the Programme Board will seek to reach decisions by consensus. If that is not possible, decisions will be referred to the Collaborative Executive Group, making the Group aware of the nature of the disagreement and the split of views.

8.6 Withdrawal of individuals in attendance

At the discretion of the Chair, any, or all individuals in attendance at a meeting of the Programme Board (i.e., non-members) may be asked to withdraw from parts of the meeting, to facilitate full and frank discussion.

9 Conduct of urgent business

Where urgent business is required to be conducted between meetings, the Chair will arrange for members views to be sought by email and the outcome will be reported to the next meeting of the Programme Board.

10 Support

The Programme Board will be supported administratively by the Programme Team. In liaison with the Chair, the Programme Team will be responsible for:

- setting the schedule of meetings
- booking meetings

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- sending invitations to attend meetings on behalf of the Chair
- preparing and circulating agendas, papers and minutes
- maintaining and following up on a list of agreed actions
- preparing reports for the Collaborative Executive Group
- facilitating the conduct of urgent business by email

11 Review

These terms of reference will be reviewed by the Programme Board at least annually and any changes will be ratified by the Collaborative Executive Group.

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GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 3.2b

Aneurin Bevan University Health Board

Update on Orthopaedic Improvement Programme

Executive Summary			
Following the pandemic, the number of people waiting to start treatment in Wales was at a record high. Elective orthopaedics had been at a standstill for almost 2 years with growing waiting lists, making it a key priority for the Welsh Government's Planned Care Recovery strategy. The receipt of two key reports; GIRFT and NCSOS, earlier this year led to the establishment of an Orthopaedic Improvement Steering Group to oversee the delivery of a combined action plan to fulfil the recommendations and improvement work.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			√
Note the Report for Information Only			
Executive Sponsor: Leanne Watkins, Director of Operations			
Report Author: Ian Jenkins, Assistant General Manager			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board Finance & Performance Committee**	√
Date of the Report: December 2022			
Supplementary Papers Attached: Appendix 1 – ABUHB GIRFT Report Appendix 2 – NCSOS Report Appendix 3 – Combined Action Plan Appendix 4 – Orthopaedic Improvement Steering Group ToR			

Purpose of the Report

The purpose of this report is to provide an update on the Health Board's progress on delivering the actions and recommendations from the GIRFT & NCSOS reports received for Orthopaedics.

Background and Context

Introduction

Following the pandemic, the number of people waiting to start treatment in Wales was at a record high. Elective orthopaedics had been at a standstill for almost 2 years with growing

waiting lists, making it a key priority for the Welsh Government's Planned Care Recovery strategy.

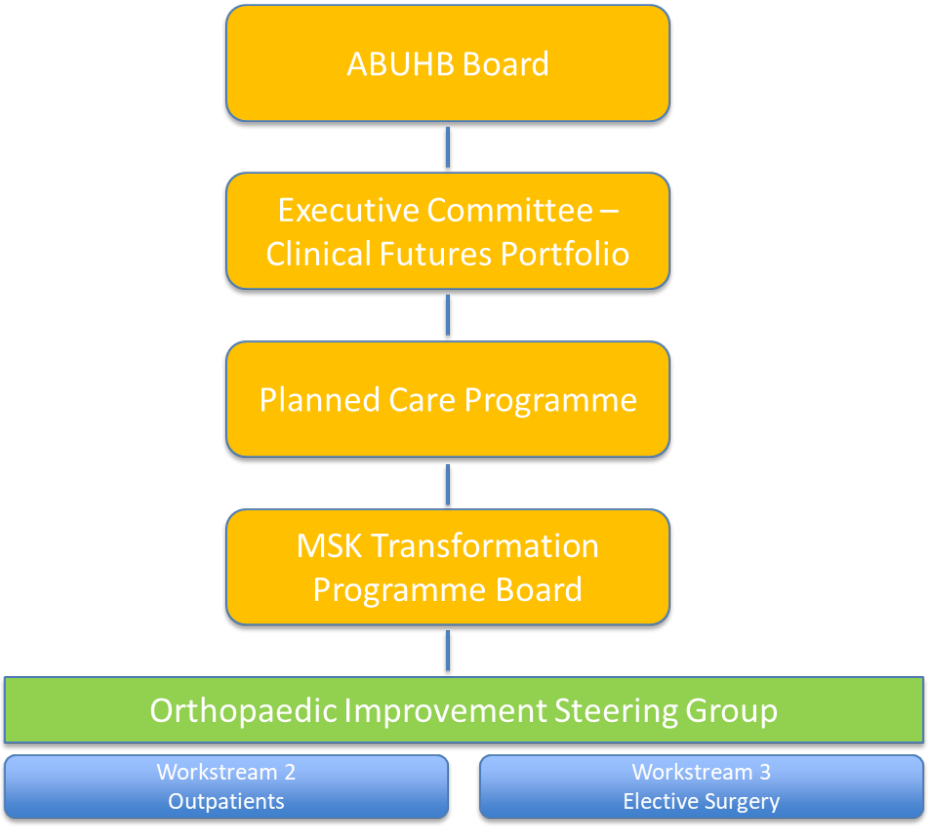
In addition, the GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by Welsh Government to conduct a full review of Welsh Orthopaedic Services using the GIRFT methodology and HVLC principles **(Appendix 1).** This dovetails with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) report **(Appendix 2**). The two reports contain a number of recommendations and actions which have been compiled into a combined action plan **(Appendix 3).**

Structure

The Executive Team has previously noted the national Planned Care Board focus to address the increasing challenge of long waiting times and large waiting lists for MSK assessment and treatment. MSK Transformation was identified as a strategic opportunity and priority for the 2022/23 IMTP, along with the need for an MSK Transformation Programme to be established, reviewing the entire MSK pathway.

Recognising the breadth of the pathway, the MSK Transformation Programme Board was established to support this vital work in several workstreams as detailed below.

Workstream 1 was long established by the time the GIRFT and NCSOS reports were published and following the publication of these reports a new Orthopaedic Improvement Steering Group (OSG) was established to work through the actions from these reports and take forward workstreams 1 and 2. The Director of Operations; Leanne Watkins, provides executive leadership for Workstreams 2 & 3 of MSK Transformation via the OSG.



The GIRFT and NCSOS combined action plan is a core responsibility of the OSG and is the mechanism for reporting progress to the Planned Care programme along with external stakeholders.

Assessment and Conclusion

The Directorate of Trauma and Orthopaedics accepted the contents of both reports and welcomed many of the actions and recommendations. However, the scale of the challenge was immediately apparent as the combined action plan included a total of 87 actions. The themes of the actions are outlined below:

- Quality & Patient Safety (33 actions)
- Restart & Recovery (30)
- Regional Working (5)
- Trauma Service (7)
- General/Other (12)

Orthopaedic Improvement Steering Group (OSG)
The OSG was established with wide representation to ensure engagement from the start. With the exception of August, the OSG have met monthly since its inception to highlight issues and report on progress/escalations.

The first meeting took place on Monday 6th June 2022.The outline action plan **(Appendix 3)** was accepted but it was acknowledged there was a need to prioritise and determine timelines/milestones on the key actions to ensure a delivery focus with specific goals and outcomes.

It was also agreed there should be a financial reconciliation of core versus additional activity for this programme of work closely linked to the value-based healthcare delivery.

Alongside this was the need for a comprehensive orthopaedic 'dashboard' to include waits, waiting times, theatre productivity, workforce availability i.e., vacancy rates, sickness etc. Whilst all of this information was available it was scattered over a number of sources. It was agreed that a single dashboard encompassing all this information would be developed with clinical support to underpin the improvement work.

Terms of reference for the OSG are included as **Appendix 4**, which have been agreed and singed off by the group.

Progress
Following two years of the pandemic and limited outpatient and operative capacity the initial focus was on restarting services and recovery. Rapid progress was made restarting services and within a short period of time all capacity with the exception of one theatre was brought back online. The single theatre not yet online has had little impact as the Directorate have worked flexibly moving consultants to alternative capacity; usually another theatre due to leave, to mitigate the impact.

The below table shows the progress against the actions to date:

Status	**#**	**%**
Completed	46	55%
Green (plan in place)	14	17%
Amber (awaiting plan)	18	21%
Red (outside of Directorate's gift)	6	7%

Several actions merged due to similarity therefore 84 total rather than 87

After bringing services back online the focus then moved onto Quality and Patient Safety (QPS). The Directorate was able to complete several QPS actions linked to GIRFT principles quickly due to the clinical model in place within the UHB. The Orthopaedic Surgical Unit (OSU) was established well ahead of the first GIRFT review on what has become the HVLC (High Volume Low Complexity) and LVHC (Low Volume High Complexity) principle. Ysbyty Ystrad Fawr (YYF) and Nevill Hall Hospital (NHH) have expanded the HVLC capacity within the UHB and the Royal Gwent (RGH) has become the centre for LVHC surgery.

The switch to QPS actions which are audit heavy inevitably slowed down the rate of action completion to allow sufficient time for audits and clinical discussion to be facilitated. Several audits have now been completed but several more are ongoing with results expected in December. When results/data is compiled, clinical discussions will be facilitated in the monthly Directorate and subspecialty meetings with progress and outcomes fed back to the OSG.

There has also been progress and developments across many of the other actions as well. Most notably in relation to pathway redesign, the Arthroplasty surgeons have agreed an extensive change to post operative follow up with agreement to PIFU (Patient Initiated Follow Up) at the one-year review provided satisfactory progress has been determined. Clinical practice has now changed to support this agreement and administrative actions are ongoing to move the relevant patients on the existing waiting lists to PIFU with over 2,300 (of 4,000) already completed

The next priority improvement initiative that the Directorate is preparing to undertake is a Day case Major Joint project. Additionally following the changes to the major joint follow up pathway additional work is now commencing in other subspecialties with Hands next in line.

Some of the progress to date has been detailed above but below are some further highlights of achievements since the GIRFT review:

- Advanced Clinical Practitioner (ACP) led shoulder replacement follow up
- ACP led post operative shoulder Arthroscopy follow up with PROM collection
- Extended Scope Physio (ESP) led spinal rehab clinics
- ESP led spinal injection lists
- Virtual pre-assessment clinics
- One stop carpel tunnel
- Future spinal service model agreed

The last action has only recently been agreed in principle and whilst detailed work on the future elective service model has not yet been determined the outline model described to the Directorate by the GIRFT spinal expert was very well received. The Directorate believe the model has the potential to support recovery, dramatically improve pre-pandemic waiting times and make the elective service sustainable.

The redesign of the elective spinal service will be a priority workstream for the 2023/24 fiscal year.

Activity

The outcome of the focused work on restart and recovery has enabled the directorate to bring all capacity, with the exception of one theatre back online. Whilst it would be ideal to have the remaining RGH theatre online, due to consultant leave the Directorate have managed to move consultants between theatres and occasionally alternative clinical sessions to mitigate its impact.

The result of this work led to a lengthy period where core outpatient delivery was ahead of pre-pandemic levels, however this has since fallen marginally behind primarily due to two consultants unfortunately having long term sickness absences.

Core outpatients is averaging five fewer attendances per week than before the pandemic and total outpatient delivery (including additionally funded clinics) a little further behind with 18 fewer attendances on average per week.

There has been a noticeable change in patient behaviour post covid and most specialties have seen increased volumes of DNA and CNA. Orthopaedics has been no exception to this trend and the DNA rate has climbed from 3.5% to 4.7% while CNA has climbed from 4.9% to 5.5%. The impact of this increase is considerable and accounts for an additional 112 fewer attendances for the year to date compared with the same period in 2019. Despite these increases the Directorate's DNA rate compares favourably with the Welsh average and CHKS per group which are 8% and 7.2% respectively.

The opening of GUH had a profound impact on consultant job plans however the Directorate is confident that when the two absent consultants return to work and a vacancy; which is currently out to advert, is recruited, delivery will exceed pre-pandemic levels as the new job plans do have greater new outpatient capacity. This has been achieved at the cost of follow up only clinics which have been abandoned in favour outpatient transformation and changing patient pathways to manage follow up differently.

The major joint PIFU work is an example of the transformation which is well underway however even before this initiative commenced the Directorate were sustaining a follow up waiting list of approximately 10,500 patients. This has reduced to approximately 8,500 with a further 2,000 major joint patients yet to be moved to PIFU.

Unfortunately, treatment capacity will not benefit from job plan changes as in outpatients. The new job plans will deliver on average 21 fewer treatments per week which whilst consistent with delivery for the year to date has been impacted by the absence of two senior surgeons.

Treatment capacity was more difficult to bring back online for a variety of reasons but staffing including anaesthetics were the most significant. The Directorate have made use of what has been made available wherever possible which often; over the summer particularly, resulted in theatre sessions without anaesthetic support. Therefore, the Directorate scheduled day case lists which increased the number of patients treated and improved delivery against the annual plan these lists did not necessarily include the highest priority or longest waiting patients.

There is a more significant variance in total treatment delivery which is largely due to availability of additional theatre sessions due to staffing difficulties. This has increased over recent months in line with an improving staffing position however the pension issue continues to limit the appetite of many consultants for additional sessions.

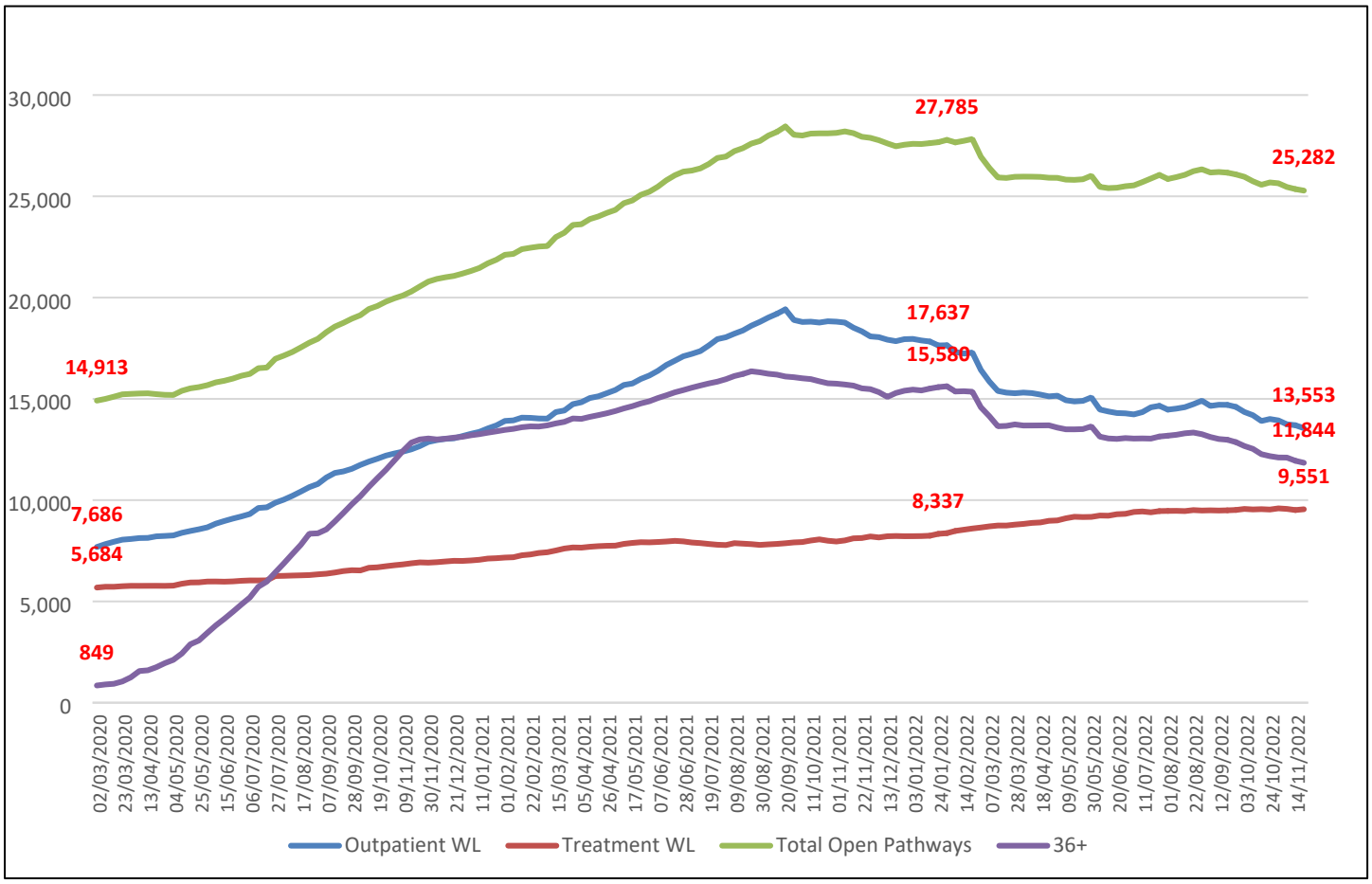
Weekly Average Comparison 2019 and 2022
(Up to end of week 34)

Metric	2019	2022	Weekly Variance	Performance Against 2022/23 Plan
Core Outpatients	165	160	-5	-588 (90%)
Total Outpatients	272	254	-18	-524 (94%)
Core Treatments	104	83	-21	+13 (100%)
Total Treatments	146	111	-35	+313 (109%)

Conclusion

The Directorate welcomed both reports and has dedicated time and effort to undertake the actions and continue to transform services. Excellent progress has been made to date and real momentum has been generated.

The below chart shows the change in key metrics from the beginning of the pandemic to date with data points labelled at the beginning of the pandemic, the time of the GIRFT review and the latest data.



The chart shows that significant progress had already been made from the peak waiting list and 36+ week waiting patients by the time of the GIRFT review. However, since the GIRFT review:

- Total waiting list has reduced by 2,390 (9%)
- Outpatient waiting list has reduced by 4,084 (23%)
- 36+ weeks waiting patients have reduced by 3,736 (24%)

However, the treatment waiting list has increased by over 1,200 (15%) patients as a result of addressing the outpatient backlog. The increase in the treatment waiting list was an inevitable consequence of working through the outpatient backlog which has focused on urgent and the longest waiting patients due to the potential clinical risk.

The Directorate is actively exploring service transformation options to support the treatment waiting list backlog and some plans have been described above. However, service transformation ideas are now being presented by consultant teams who are actively leading their development and implementation. The Directorate is committed to service transformation and achieving sustainability going forward.

Recommendation
The Finance & Performance Committee is requested to note the progress made in delivering the actions and recommendations from the GIRFT and NCSOS reports.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*Failure to address the elements outlined within the plans will result in potential harm to patients, increased waiting times, patients' complaints, inability of the HB to manage waiting times and difficulties in providing sustainable options*
Financial Assessment, including Value for Money	*A financial reconciliation of core versus additional activity for this programme of work is being undertaken, closely linked to the value-based healthcare delivery.*
Quality, Safety and Patient Experience Assessment	*The recommendations and actions outlined in the plan will improve access for patients thus improving patient quality, safety and experience through improved access. There are a number of actions directly related to Quality & Patient Safety.*
Equality and Diversity Impact Assessment (including child impact assessment)	*This programme of work will not have an adverse equality or diversity impact but will improve access to outpatients/treatment for orthopaedic patients.*
Health and Care Standards	*Timely access to services.*
Link to Integrated Medium-Term Plan/Corporate Objectives	*The Orthopaedic Improvement work programme is managed by the MSK Transformation Programme and Planned Care Recovery in ABUHB, both of which are priority programmes as outlined in the IMTP and Clinical Futures Strategy.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** *This work programme fits into the longer-term strategy for orthopaedics and is key to delivering the Health Board's key priorities.*
	Integration – *This work programme ensures that there is a focus on the whole system approach in terms of patient pathways.*
	Involvement – *This proposal will support a range of services across secondary care.*
	Collaboration – *It is imperative that patients are part of the transformation programme.*
	Prevention – *Improved access to diagnostics will improve population health. Links to prehab in the HB will improve patient outcomes.*
Glossary of New Terms	*N/A*
Public Interest	*N/A*
Equality and Diversity Impact Assessment (including child impact assessment)	*This programme of work will not have an adverse equality or diversity impact but will improve access to outpatients/treatment for orthopaedic patients.*
Health and Care Standards	*Timely access to services.*

Link to Integrated Medium-Term Plan/Corporate Objectives	*The Orthopaedic Improvement work programme is managed by the MSK Transformation Programme and Planned Care Recovery in ABUHB, both of which are priority programmes as outlined in the IMTP and Clinical Futures Strategy.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** *This work programme fits into the longer-term strategy for orthopaedics and is key to delivering the Health Board's key priorities.*
	Integration – *This work programme ensures that there is a focus on the whole system approach in terms of patient pathways.*
	Involvement – *This proposal will support a range of services across secondary care.*
	Collaboration – *It is imperative that patients are part of the transformation programme.*
	Prevention – *Improved access to diagnostics will improve population health. Links to prehab in the HB will improve patient outcomes.*
Glossary of New Terms	*N/A*
Public Interest	*N/A*

Royal National Orthopaedic Hospital NHS Trust

GETTING IT RIGHT FIRST TIME

GIRFT Orthopaedic Review

Aneurin Bevan University Health Board

May 2022

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) team and the Wales Planned Care Board team. It aims to enable the urgent restoration of elective orthopaedics and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Introduction

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Welsh Government, to conduct a full review of Welsh Orthopaedic Services using the GIRFT methodology and HVLC principles. Throughout, the team has worked very closely with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) team and will continue to do so. In addition to reports for each Health Board, RNOH/GIRFT will write a National Wales Orthopaedic report detailing the findings and the priority and cross cutting recommendations. This report will dovetail with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) report.

The ambition of the programme is to help each Welsh Health Board and NHS Wales to urgently restore elective orthopaedics to the maximum levels possible and identify examples of innovative, high quality and efficient service delivery in the system. The programme will look at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. It also will aim to assess whether the Health Boards are using their existing resources and provisions effectively and delivering the best outcomes for patients.

The RNOHGIRFT team conducted a programme of data analysis, followed by a virtual “deep dive” engagement with ABUHB, delivered by Professor Tim Briggs CBE (GIRFT Programme Chair and National Director of Clinical Improvement for the NHS) on Wednesday 9th February 2022. This report details the findings and recommendations arising from the data analysis and deep dive engagement and is a companion document to the GIRFT data pack.

The GIRFT and High-Volume Low Complexity (HVLC) Programmes

Getting It Right First Time (GIRFT), is a clinically led, data driven programme of healthcare quality improvement, developed in the NHS in England. The fundamental belief of the GIRFT programme is that within a healthcare system, unwarranted variation exists across a range of clinical processes (such as patient pathways, clinical practice, procurement, and prevention of litigation), and addressing this unwarranted variation can deliver better quality of care and outcomes for patients. The core principle of the programme is that it is a clinically led, peer-to-peer, data driven approach to healthcare improvement.

GIRFT is an enabler of the High Volume Low Complexity Programme (HVLC). This is aimed at supporting elective recovery, post pandemic, and the development of standardised patient pathways across regions. The programme supports the establishment of fast-track surgical hubs for high-volume procedures, where possible, and helps partners to agree system-wide theatre principles (e.g. accepting day surgery as the default), and theatre efficiencies (e.g. the number of cases per theatre list). It has led to the reduction of patient waiting lists for operations and to improvements in outcomes and access to care, helping the people who have the most urgent health needs receive treatment fastest.

Programme Objectives

The aim of the programme is to identify improvement opportunities within orthopaedic services in Wales in order to inform short, medium and long-term transformation plans. This is done by:

- identifying system and organisation level unwarranted variation in access to and outcomes from care being delivered
- driving for ‘top decile’ GIRFT performance of outcomes, productivity, and equity of access
- standardising procedure-level clinical pathways to be agreed across all providers developed by ‘expert advisory panels’ supported by professional societies and the work of the Wales Clinical Orthopaedic Strategy team

- informing the decision making process on the potential establishment of surgical hubs for high volume elective procedures
- agreeing principles for working across clinical and operational groups e.g. theatre principles
- leaving a legacy of sustainable quality improvement by working in partnership with your clinical, operational and analytical teams so that you are able continue implementation and tracking progress at the end of our work with you

Central to these objectives will be the creation of delivery plans for HVLC activity by March 2022 to develop pathways, utilise best practice, and improve theatre efficiency and productivity and day case rates as outlined by GIRFT best practice.

The Current State of Orthopaedics in NHS Wales

The number of people waiting to start treatment in Wales is at record high. Elective orthopaedics has been at a standstill for almost 2 years with growing waiting lists. With over 30% of 104-week waiters being for an orthopaedic procedure (see Table 1), it is imperative that orthopaedic elective care is restarted with immediate effect.

Table 1

Waiting List	Patients - All Wales	Patients - Orthopaedics	Percentage
RTT Pathways	124371	35439	28%
104 week waiters	27234	11799	43%
80+ week waiters	38539	16053	42%

(Data as of December 2021)

As a result of elective orthopaedics being on hold for almost 2 years, patients have been treated by the Independent Sector whilst staff at the hospitals in Wales have had no facilities or theatres to carry out elective work. This has caused frustration for consultants and has demonstrated poor use of an expensive resource. In addition, this has had a negative effect on trainee orthopaedic surgeons, who have been struggling to access the appropriate training in elective orthopaedics.

Impressions and Outcomes of the ABUHB Deep Dive Meeting of 9th Feb 2022.

RNOH/GIRFT were impressed by the engagement of Health Board staff with this Programme and the excellent attendance at the deep dive meeting. This provides an insight into the level of concern that Health Board staff have about the current orthopaedic service provision. The meeting consisted of a review of the Health Board data and discussions about the key issues and risks surrounding the urgent restart and effective delivery of orthopaedic services. The detail around this variation and the recommended improvements can be found in the **Orthopaedics Action Plan in Annex A.**

RNOH/GIRFT have made several cross cutting and priority **executive recommendations.** We think the implementation of these recommendations is essential if the Health Board is to deliver robust and durable orthopaedic services effectively and safely for patients in the short, medium and long term. We strongly believe that is the best way to make a significant reduction of orthopaedic waiting lists. We request that the Health Board Executive Team provide a response to these high priority recommendations.

Findings and Executive Recommendations

We found clinical staff morale to be low. There was frustration that changes to restart orthopaedic surgery, following Covid, are taking much longer than necessary.

The RNOH/GIRFT team found that the plans to restart elective surgery and to reduce significant waiting lists are not widely known and seem to be lacking pace. This may be contributing to issues with patient safety (whilst they are stuck on long waiting lists) and staff morale. We found that patients on long waiting lists were deconditioning and their conditions worsening; this was becoming a duty of candour issue.

In our review of data across ABUHB and in individual hospitals, we note that there is variance in performance between hospitals. This suggests a lack of collaboration and that they are working in silos, however we do note that this should improve given the new Health Board model of care structure.

RNOH/GIRFT therefore make the following **executive recommendations** to ABUHB:

Executive Recommendations
1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as one Health Board and not hospital by hospital.
2. Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation
3. Ensure that the Health Board orthopaedics lead implements the changes required to minimise unwarranted variation and that regular progress is provided to the Executive Team and Steering Group.
4. ABUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent needto re-engage with clinicians to rebuild trust and ensure that clinicians are listened to andinvolved at each stage of restart and change proposals. It is imperative that clinicians are an integral part of the “sign off” and delivery of changes.
5. Carry out a staff survey without delay to understand the issues affecting staff morale and how these can be addressed. We consider that improved and open communication with colleagues about the short, medium and long term plans will help to improve staff morale. We do recognise, that there are a number of recent factors affecting staff morale.
6. Implement elective recovery at pace. We are aware that capital investment is currently limited. However, most of our recommendations rely on better use of existing assets and on using revenue budgets and resources more efficiently. We expect that an urgentinitial plan, which sets out how the Health Board will fully restart orthopaedic surgery tobe in place, no later than the end of March 2022. Any barriers or risks to delivery of thisplan need to be urgently resolved. The plan should include a communication and engagement plan with all patients so that patients fully understand the timetable for their surgery.
7. Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient’s home prior to admission. For emergency admissions (e.g. fracture neck of femur), patients should be assessed early on during their admission to agree their likely support package, which can be tweaked if the patient’s condition changes. Currently, a Social Services assessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficient use of valuable beds, thereby reducing elective surgical admissions. We needa risk share between the hospitals and Social Services as elective patients are disadvantaged due to lack of bed availability.
8. Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recorded and used across all Health Boards.
9. Set up a cross Health Board initiative to ensure that litigation claims are regularly reviewed in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation

could be improved. Claims should be discussed in clinical governance meetings to share the learning; junior doctors should also be involved in these review meetings. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed. Note that we did find some good practice in reviewing litigation claims but we think it could be improved.

10. Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.

11. Create and implement a workforce plan both short, medium and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.

14. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following:
    a. Carry out full demand and capacity planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve ABUHB. It is crucial that elective recovery is seen as a regional imperative with all Health Boards working together. This will ensure that ALL existing assets available for Orthopaedic elective recovery are utilised.
    b. Set up a weekly sitrep specifically focused on elective recovery to the Executive on waiting lists to include the number of patients and volumes categorised by: ASA score; time on waiting list; operations carried out; expected monthly operations; forward targets to reduce lists and delivery against these targets. This should also include the number of operations expected to be delivered as a day case. We suggest that to gain the best momentum in elective recovery that the sitrep should cover all elective surgery and not just orthopaedics. In our report to the Welsh Government, we will be recommending that these sitreps are provided weekly until Elective Recovery is on track and less of a risk to patients.
    c. Establish a delivery model to restart elective recovery. This needs to be established at pace. GIRFT supports in principle, the long term plans to create an elective hub at the Grange site, currently the trauma centre for both HVLC and LVHC procedures provided all other capacity and existing assets are fully utilised for elective care, and in the interim, utilise the Royal Gwent for complex LVHC workload, HVLC case-mix at St Woolas and day-case procedures at Ystrad Fawr Hospital. However, the longer-term strategy must be co-ordinated nationally in line with the recommendations of the NCSOS project, so that any major infrastructural changes are implemented with regional and national context. ABUHB must ensure these sites have the appropriate staffing levels to sustain services during periods of additional pressure.
    d. Utilise fallow capacity at Nevill Hall as a mutual aid regional resource to provide elective capacity on a regional basis for North and East CTM, ABHB, CVHB (if

needed) and South Powys (this needs to be set in the context of recovery for a other specialties)

e. Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.
f. Develop an enhanced recovery unit at The Grange site, this is to be operated 24 hours a day, seven days a week that allows upskilled nurses to provide care and assessment to the sickestand most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.
g. Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.
h. Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, Occupational Therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.
i. Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day.
j. Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring “top decile” outcomes and using the GIRFT theatre principles and expected productivity as a steer.
k. Where there is recognised “good practice” in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.
l. Review emergency and urgent pathways to improve patient flow.
m. Review of patients that are deconditioning on the waiting list, identify patients that require urgent care by looking at good practice from other Health Boards.
n. Determine effective and efficient follow up plans – which are carried out virtually if possible but with appropriate safety netting in place where needed.
o. Review of patients with high BMI and weight management services and identify improvement strategy and how to best respond to patients wanting surgery with high BMI.

Annex A: Orthopaedics Action Plan

Activity/ Metric	Meeting outputs	Agreed actions / Recommendations
Elective hip replacement		
Fixation method for elective hip replacements (%) − Patients 65+ years	Low usage of fully cemented hip fixations being used on patients over 65+ years (approx. 25%). This is due to consultant preference, approx. 50/50 split. ABUHB feel this could be due to consultants being de-skilled in using the fully cemented sockets. High usage of uncemented hip fixations being used on patients over 65+ years (approx. 35%)	**RNOH/GIRFT recommends:** ABUHB to increase the usage of fully cement hip fixations in patients over 65+years. At least 80% of patients over 70 years of age should be receiving a fully cemented or hybrid hip replacement. This is compliant with the standardised Hip replacement in HVLC (High Volume Low Complexity) endorsed by the BOA. **RNOH/GIRFT recommends:** ABUHB to ensure relevant training is provided for fully cemented hip fixations. **Opportunity for learning best practice:** Hywel Dda have a high usage of fully cemented hip fixations on patients over 65+ years and have better outcomes and low revision rates.
5 and 10-Year Revision Rate Hip Primary	Good 5-year elective hip revision rates, however room for improvement if the Health Board were to change the choice of fixations. **<u>Good practice identified:</u>** ABUHB have rationalised the hip and knee implants. High 90-day mortality rates for primary hips at Nevill Hall and Royal Gwent.	**RNOH/GIRFT recommends:** For ABUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation. **RNOH/GIRFT recommends:** A review of 90-day primary hip 90-day mortality rates to be carried out.
Elective knee replacement		
5 and10-Year Revision Rate Elective Knee -	Variation within the Health Board of elective knee revision rates. Nevill Hall is a Signiant outlier on 5-year and 10-year revision rates. Royal Gwent has slightly higher elective knee revision rates.	**RNOH/GIRFT recommends:** Review of elective knee revision rates and establish an improvement strategy. **RNOH/GIRFT recommends:** Reduce the number of surgeons carrying out primary knee surgery as

	St Woolas has good 5-year elective knee revision rates. High 90-day mortality rates at Nevill Hall.	the revision rates are high. Centralise the elective knee surgery to be carried out at one hospital. **RNOH/GIRFT recommends**: ALL Hip and knee revisions to be discussed in Health Board Regional MDTs prior to surgical intervention. . **RNOH/GIRFT recommends:** A review of 90-day primary knee 90-day mortality rates to be carried out.
Elective joint procedure for adults – PEDW		
Hip Procedures Knee Procedures Shoulder Procedures Elbow Procedures Hand and Wrist Procedures Ankle Procedures	High volume of hip and knee activity carried out at ABUHB. High volume of shoulder activity carried out at ABUHB. Arthroscopy data looks to be underreported, generally the arthroscopy data is poor. High shoulder subacromial decompression activity at St Woolas. All cases go through the appropriate pathway including physiotherapy before being offered surgery. High volume of ankle arthrodesis indicating ankle decision making is good and adhering to best practice. **<u>Good practice identified:</u>**	**RNOH/GIRFT recommends:** Centralise hip and knee revision surgery and foot and ankle arthrodesis to be carried out at one site. **RNOH/GIRFT recommends:** Undertake a review of arthroscopy and ankle activity data to identify the correct volumes and develop an improvement strategy to improve reporting of this data. **RNOH/GIRFT recommends:** Review of NHS shoulder subacromial decompression activity ensuring evidence is being used and these patients have gone through the appropriate pathway including physiotherapy before being offered surgery.

	- Shoulder replacement surgery has been centralised and carried out at St Woolas. - High volume of ankle arthrodesis in comparison to ankle replacements, indicating ankle decision making is good and adhering to best practice.	
Elective joint replacement length of stay (days) PEDW		
Primary hip replacement Revision hip replacement Primary knee replacement Revision knee replacement Primary shoulder replacement Revision shoulder replacement Primary elbow replacement Revision elbow replacement Wrist replacement Primary ankle replacement Revision ankle replacement Knee ligament reconstruction Shoulder sub acromial decompression Shoulder rotator cuff Wrist arthrodesis (fusion) Ankle arthrodesis (fusion)	Variation in length of stay rates across the hospitals in ABUHB. Higher length of stay rates for hip and knee replacements and hip and knee revisions than the national average. High lengths of stay rates shoulder replacement. Elbow replacement length of stay rates are extremely high.	**RNOH/GIRFT recommends, urgent attention required:** ABUHB to undertake a review of hip and knee primary and revision length of stay rates and develop an improvement strategy. Centralise hip and knee revision activity to reduce length of stay rates. **RNOH/GIRFT recommends:** Review of elbow replacement length of stay rates and establish an improvement strategy. **RNOH/GIRFT recommends**: to consider whether hip and knee day case surgery could be more broadly used for some patient groups. National day Surgery Delivery Pack can be found via the following link: Best practice library - day surgery - Getting It Right First Time - GIRFT **RNOH/GIRFT recommends:** Improve enhanced recovery by having physiotherapy service available on weekends to mobilise the patients for earlier discharge. When ABUHB develop the elective hubs, it is imperative that they are staffed appropriately to maximise outcome and improve patient flow.

		Opportunity for learning best practice A fully integrated 'discharge to assess' system for returning patients home safely from hospital has been implemented in Swindon. NHS England » Swindon's discharge to assess model
Primary hip		
Elective primary hip replacement with cemented fixation for patients 70+ Years	Outlier in usage of fully cemented hips, extremely low usage.	**RNOH/GIRFT recommends**: Cement THR in patients over 70 years old provides best outcomes.
Average length of stay for patients receiving elective primary hip replacement (days)	High length of stay rates for patients receiving elective primary hip replacement.	**RNOH/GIRFT recommends** Consider measuring in hours opposed to days.
Return for another hip procedure (on the same side) within 1 year for patients 60+ years	**Good practice identified:** Good return to theatre rates for another hip procedure within 1-year.	**RNOH/GIRFT recommends:** Consider post-operative follow ups to be carried out virtually.
Primary Knee		
Elective knee replacement for patients 60+ years average length of stay	Length of stay is in line with the national average, there is room for improvement.	**RNOH/GIRFT recommends:** to consider whether hip and knee day case surgery could be more broadly used for some patient groups. National day Surgery Delivery Pack can be found via the following link: Best practice library - day surgery - Getting It Right First Time - GIRFT
Return admission within 1 year for another knee procedure on the same knee for patients 60+ years following primary knee replacement	**Good practice identified:** Good return to theatre rates for another knee procedure within 1 year.	**RNOH/GIRFT recommends:** Consider post-operative follow ups to be carried out virtually.
Elective knee replacement for patients 60+ years who had an arthroscopy less than 1 year previously	Noted: the data for this metric will not currently a true reflection of the activity as many of the pts are still on the w/list over 1yr.	**RNOH/GIRFT recommends:** For ABUHB to undertake regular peer arthroplasty reviews of surgeon level data also reviewing low volume activity.
Primary Shoulder		
Elective shoulder replacement for patients 60+ years average length of stay	Length of stay is in line with the national average, there is room for improvement.	

Return for another shoulder procedure (on same side) within 1 year, for patients 60+ years	St Woolas is an outlier with high return to theatre rates. Royal Gwent has good return to theatre rates.	**RNOH/GIRFT recommends:** St Woolas to review return to theatre rates for another shoulder procedure within 1 year.
Surgeon Data		
Number of surgeons assigned to providers over three-year period	Low volume surgery identified in primary hip, hip revision, knee primary, knee revision and shoulder revision.	**RNOH/GIRFT recommends:** ABUHB toundertake a review of low volume surgeons acrossthe totality of their practice. Surgeons delivering low volumes of both hip and knee revisions annually should no longer be performing this surgery. Operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications and cost.
Procedures with adverse events - % of procedures with an adverse event		
2020 (1 year) National Joint Registry (NJR) Data Hip Knee	High adverse event rates for hip and knee at St Woolas. **Nevill Hall** Hip Primary: 0.58% Knee Primary: 0.00% **Royal Gwent** Hip Primary: 0.63% Knee Primary: 0.00% **St Woolas** Hip Primary: 2.96% Knee Primary: 0.58% **Ybsysty Ystrad Fawr** Hip Primary: No Value Knee Primary: No Value **ABUHB** Hip Primary: 1.65% Knee Primary: 0.25%	**RNOH/GIRFT recommends**: Review to be carried out of adverse events for primary hip and knee at St Woolas Hospital. A review of the theatre adverse events/ NJR data to be carried out annually.
PROMs - Average health gain - Case-mix adjusted Oxford hip/knee score		
2019/20 (1 year) Hip Primary	No data available	**RNOH/GIRFT recommends:** ABUHB to collect PROMs data, to discuss and review PROMs score internally on an annual basis.

Hip Revision Knee Primary Knee Revision		
SSI		
Hip replacement Hip replacement - Inpatient and Readmission Knee replacement – Inpatient Knee replacement - Inpatient and Readmission		**RNOH/GIRFT recommends:** Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning.

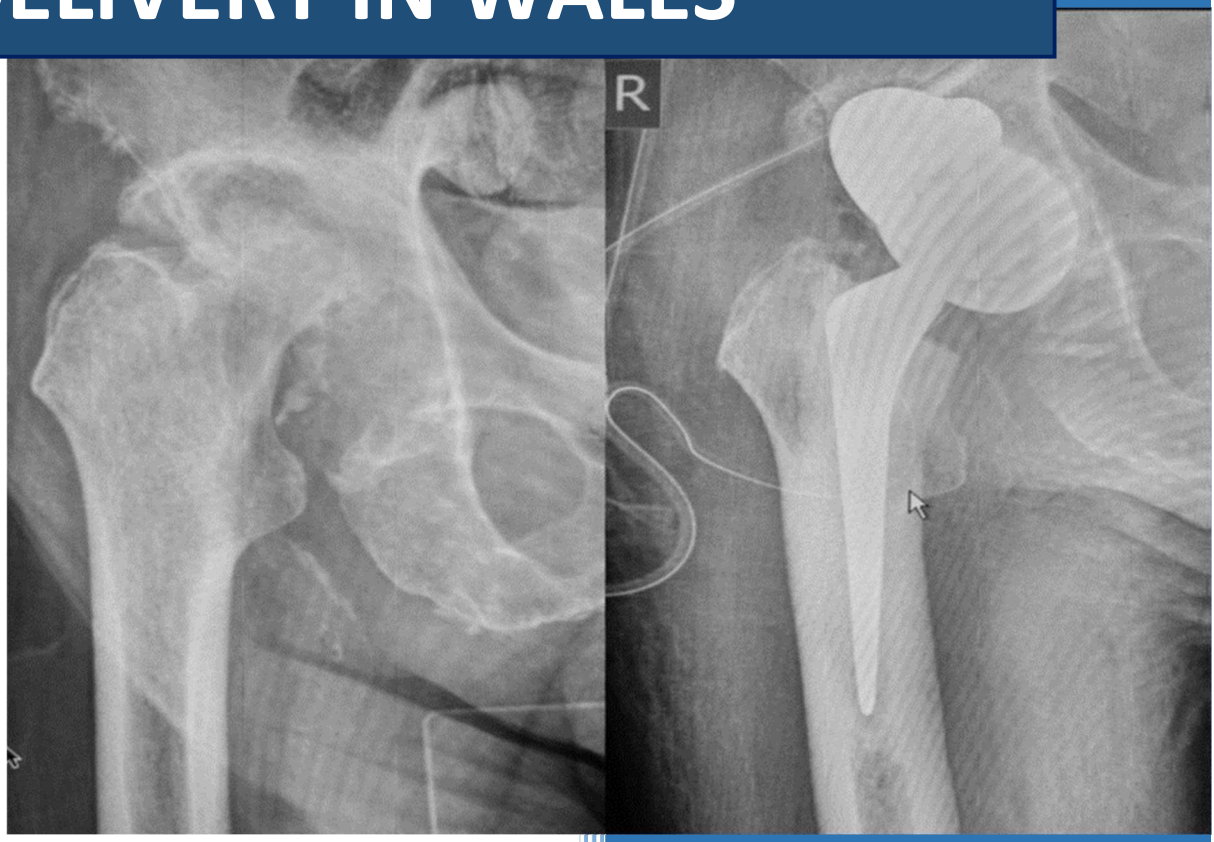
Nevill Hall	Royal Gwent	St Woolas	The Grange	YYF
0	0.2			
5.7	4.7			
	0			
0	1.5			

Litigation		
Total number of T&O claims Total costs involved with T&O	Number of claims: 19 Total costs of claims: £ 5,454,777	**RNOH/GIRFT recommends:** ABUHB to regularly review with the claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed.

Welsh Orthopaedic Board National Clinical Strategy for Orthopaedics

2022

THE NATIONAL BLUEPRINT FOR ORTHOPAEDIC SURGICAL DELIVERY IN WALES



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NCSOS

3/31/2022

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1 Foreword

TBC

2 Executive Summary

The NCSOS was commissioned by Welsh Government and challenged to think ambitiously with one primary objective - to define the most effective service model to deliver elective orthopaedic surgical care.

The message of this report should not be misinterpreted; elective orthopaedics and trauma services in Wales are in a perilous state of near collapse; it is time for Welsh Government to match the ambition of the clinical voice.

A failure to rapidly progress the recommendations of this report will inevitably lead to the conclusion that Wales cannot deliver safe elective orthopaedic care, and in this event, should be clearly articulated to the population.

While the project has provided a suite of eight documents to address a wider range of whole pathway recommendations, actions and solutions, ultimately this final report, NCSOS 3 describes the "*National Blueprint for Orthopaedic surgical delivery in Wales*".

The message to the intended audience of this report is unambiguous:

Welsh Government - this report is the aggregated work conducted by all 157 orthopaedic surgeons in Wales and provides the clinically led solution to a longstanding issue, based on an objective data based analysis of a magnitude and detail that has never been carried out before. The message of the clinical voice is simple: all of the recommendations and actions provided in the NCSOS suite of documents must be addressed to avoid continued patient harm. A task of such scale can only be conducted through a **fully resourced Welsh Orthopaedic Network (W.O.N.), with central strategic influence, and operational authority. The specification of this Network is defined in this document and it must be established within 3 months.**

Welsh Government – Elective Orthopaedic surgery provision will never be provided to the required standard and safety in the existing estate; reverting to pre-pandemic will lead to continued patient harm. **Three orthopaedic hubs must be developed at pace in North Wales, South West Wales and South East Wales. There must be a signal of intent to progress this capital planning work within three months, by initiating a focused options appraisal workstream, with a limited time frame of three months to decide on hub locations, based on the following specifications** -

> **North Wales** – 6 theatres. Between 23-39 beds*. Either on the same site (but separate building) as Ysbyty Glan Clwyd, Rhyl, or another centrally accessible site but with all of the required interdependencies consultant anaesthetist/intensivist ward care 24/7. **DO NOT** sign off any local Betsi

Cadwaladr Health Board capital strategy that does not meet the required standards for North Wales defined in this document section 7.

South West Wales – 7 theatres. Between 38 to 65 beds*. On an acute site (Morriston or Prince Phillip Hospital) or another centrally accessible site but with all of the required interdependencies consultant anaesthetist/intensivist ward care 24/7. Even if not chosen as the main Hub due to interdependency feasibility, Neath Port Talbot Hospital will still have a very important role as a daycase and ambulatory trauma site and its development should continue.

South East Wales – 11 theatres. Between 59 to 102 beds*. This should be located near the M4 junction 32. With this geographical location, it will be accessible to patients and staffing groups throughout the region. It should be feasible to staff to a high interdependency specification without needing to be on an existing DGH site. *(*bed modelling heavily dependent on pathway transformation/ LOS and backlog clearance model – see section 5 & 7.3)*

Welsh Government- DO NOT assume that musculoskeletal pathway transformation will lead to the solution in isolation; whilst urgently needed, without the necessary investment in estate, patients will continue to come to harm and suffer prolonged delay to valuable treatment. **DO NOT** consider investment in estate without transformation of musculoskeletal pathways; this will lead to inefficient use of a valuable resource.

HB executive teams – **DO** enact immediate recovery solutions advised by Getting it Right First Time (GIRFT) and NCSOS report 1, with urgency in order to keep patients safe, but **DO NOT** progress any strategic health board level plans that do not meet the long term specifications set out in this document. All strategic plans must have Wales Orthopaedic Network oversight, without this they will be to the detriment of the national orthopaedic blueprint, will not work and will consequently affect patient safety, service sustainability and delivery and performance.

HB executive teams – The daycase delivery network defined in this document is within your gift to establish immediately. **DO** provide your orthopaedic teams with the necessary theatre, ward and interdependency requirements needed to match the 10% above demand model described in this document. The Cwm Taf Morgannwg executive team must collaborate with Swansea Bay & Cardiff to mitigate their lack of daycase capacity.

Clinicians – DO continue to engage and contribute to the establishment of the W.O.N and national clinical reference groups. Begin, within your capacity, to collaborate with colleagues and develop the CRGs, MDTs and clinical networks necessary to form the foundations of the W.O.N in readiness for its formal establishment. The validity and strength of the recommendations provided in the NCSOS reports are a true reflection of what the unified clinical voice can achieve.

3 Introduction - Why are we here?

The provision of elective orthopaedics in Wales has been a concern for clinicians and Welsh Government (WG) for decades as it has continued to fail in the delivery of timely services to the population. The utilisation of waiting list initiative sessions and private sector outsourcing on a recurring annual basis to successfully achieve referral to treatment (RTT) targets has to a certain extent hidden these failures. Since 2015, in excess of £300M of public money has been provided to health boards to address long waiting times for planned care, a significant proportion of which has been allocated to elective orthopaedics. Despite this allocation there continues to be systemically longer waiting times for people requiring surgical treatment and a postcode lottery for services due to inequitable access nationally.

Over the last twenty years, several reports[1,2] have drawn attention to, yet have failed to address, the chronic issue of under-resourced elective orthopaedic capacity in the face of increasing demand. In 2014, Welsh Government commissioned a national review of orthopaedic services by Getting it Right First Time (GiRFT)[6] but did not implement its recommendations to increase and protect elective orthopaedic activity. The failure to effectively increase elective orthopaedic capacity at a time of increasing unscheduled care demand, has further destabilised the provision of elective orthopaedics over the last seven years and the Pandemic has simply exposed a failing service.

Initiation of the National Orthopaedic Programme in 2011, formation of the National Orthopaedic Innovation board in 2012 and Planned Care Programme Board in 2015 was intended to provide a specific focus on orthopaedic delivery and recovery, however, despite this focus health boards in Wales appear unable to resolve the issue of delivering an effective elective service. Some health boards continue to function within territorial silo's, with fragmented services and intermediate term planning which repeatedly fails to address the ongoing gap between capacity and demand or to address the continued pressure on elective orthopaedic capacity from unscheduled care demand.

The Planned Care Programme has as its main focus, the non-surgical elements of the musculoskeletal pathway, leading to the adoption of a musculoskeletal (MSK) triage and treatment service (CMATS/MCATS) and the outpatient transformation programme. Despite the recommendations of GiRFT, there has been very little focus on the facilities, estate, manpower and interdependencies necessary to deliver effective high quality surgical treatment.

In September 2021, the National Clinical Strategy for Orthopaedic Surgery (NCSOS) project was commissioned by the planned care programme, to address this lack of focus on surgical provision so that an evidence based long term blueprint

for orthopaedics could be developed, allowing a transition to a sustainable elective orthopaedic service for the population of Wales.

The project scope involved a series of national subspecialty workshops, consultant workforce and capital infrastructure review, and a detailed data analysis of the orthopaedic backlog and demand at subspecialty and procedure level. This involved engagement from all the orthopaedic surgeons and operational managers from across the nation and was supervised by a national clinical reference steering group (CRSG) comprised of senior clinicians and management. The project structure and methodology is attached (Annex 1). The project outputs will see the publication of eight reports in March/ April 2022 (Annex 2-8):-

NCSOS Report 1	Orthopaedic Recovery, Urgent – For Immediate Action
NCSOS Report 2a	General Pathway Guidelines and Recommendations
NCSOS Report 2b	Shoulder & Elbow Surgery Pathway Guidelines and Recommendations
NCSOS Report 2c	Hand & Wrist Surgery Pathway Guidelines and Recommendations
NCSOS Report 2d	Hip Surgery Pathway Guidelines and Recommendations
NCSOS Report 2e	Knee Surgery Pathway Guidelines and Recommendations
NCSOS Report 2f	Foot & Ankle Surgery Pathway Guidelines and Recommendations
NCSOS Report 3	The National Blueprint for Orthopaedic Surgical Delivery in Wales

Spinal surgery and paediatric surgery are not within the project scope as they have separate WHSSC commissioned work-streams which are ongoing. The interdependency of trauma and elective care is well understood and whilst inefficiencies in trauma pathways have been noted within the suite of documents, a separate work stream is required to improve these pathways.

During the meetings of the sub-specialty clinical reference groups it became clear that elective orthopaedic services are now in a state of near collapse and episodes of patient harm are frequent and ongoing. Clinicians have exercised their duty of candour to report these incidences and the actions that are immediately necessary to prevent further patient harm in all health boards are the subject of Report 1 (Annex2).

The current crisis in elective orthopaedic provision requires a completely fresh and novel approach to the future provision of elective orthopaedic surgery; nationally, we must do things differently. This will necessitate the major barriers identified during the project work-streams preventing transition to a high quality service for the population of Wales be addressed, as outlined below:

3.1 Workforce & Estate

Capacity and demand have been unbalanced in Wales for decades; systems of care have never been specified or resourced to meet the demand. Attempts have

instead focussed on numerous centrally driven attempts to re-design musculoskeletal pathways that have failed to address this increasing demand. The absence of investment in capital estate (to provide physical capacity) and/or workforce improvements to provide a high quality efficient service (and thus release further capacity) means that the gap between capacity and demand has increased rather than decreased. Instead, financial investment has been provided as non-recurrent annual funding for waiting list initiatives (WLI) and outsourcing.

Investment in estate and manpower is urgently required so that the gap between capacity and demand is removed. This should be undertaken on the basis of accurate data collection and systems modelling, reaching an accurate and strictly defined model of estate requirements. Investment in staffing to drive best practice pathway development and performance is also required; this needs a structured recruitment, development and training plan co-ordinated centrally.

3.2 Silo working

The failure of health boards to provide the required solutions over the last two decades suggest that the answers to the problem do not lie in the gift of individual health boards alone and neither can the solutions be provided by simply repeating the processes of the past. Furthermore, silo working prevents sharing of crucial staffing resource and further harms recruitment and retention, and staff morale.

Elective orthopaedic services cannot be considered within health board boundaries alone and must be designed and developed on a local, regional, supra-regional and subspecialty basis. This should be based on strong clinical engagement via subspecialty clinical reference groups, development of best practice pathways and regional working for all staff groups.

3.3 Commissioning

The historic funding model in Wales does not incentivise improvements in productivity and efficiency, unlike in NHS England where tariff and payment by results is a significant driver. Furthermore, RTT has driven provision of non-recurrent financial support on a yearly basis to achieve waiting times targets, thus rewarding poor performance. Accurate modelling of capacity and demand and ongoing monitoring will remove the need to continue in this inefficient way, with potential to save significant sums of money spent on waiting list initiatives and reinvest it into sustainable service models.

There is a compelling argument for a change to the funding model for elective orthopaedics in Wales, linked to performance metrics that drives high quality, efficient practice. This recommendation is echoed by the recent GiRFT reviews.

3.4 Clinical prioritisation

Effective clinical prioritisation does not currently exist within elective orthopaedics. The "urgent", "soon" and "routine" categories are crude and subjective. RTT is used as a prioritisation tool without clinical basis. RTT targets in NHSW have never been aligned with those in NHSE and are currently twice those of NHSE. Having an agreed maximum length of wait is reasonable, but not having any other way of clinically prioritising patients is not.

A national clinical prioritisation tool for each sub-specialty must be developed so that patients can be appropriately clinically prioritised and treated according to clinical urgency. The maximum waiting time should be aligned as closely as possible with NHSE and advice of the CRGs.

3.5 Governance and performance management

Despite the focus of the planned care programme, significant variation in performance remains (GiRFT [Annex9]), with data collection and monitoring of clinical outcomes poor. RTT targets are frequently managed in Q4 of each financial year by using outsourcing, waiting list initiatives and waiting list validation. This takes significant management resource away from core and potentially clinically more important duties. It is therefore necessary to create a system that meets population need, and is driven by measurement of patient outcome and experience, not waiting time alone.

A new approach is required by the formation of a Welsh Orthopaedic Network within the National Clinical Framework, which would encompass all multidisciplinary elements of the orthopaedic pathways. This will work collaboratively with the central musculoskeletal team/network for cross cutting themes. This is discussed further in section 9.

This report provides clinically driven solutions to resolve these issues and provides a framework for delivery.

As a nation and an NHS we are at a crossroads; healthcare demand and patient expectations are at an all-time high and morale of the healthcare workforce is at an all- time low. Staff are tired and demoralised following the Pandemic. This calls for

new service models that enable person centred healthcare, delivered by a workforce that feels valued.

The NHS transformed healthcare delivery in response to the Pandemic, with examples of innovation delivered at a scale and pace that is unprecedented but demonstrates what can be achieved when resources are unconstrained. However, in responding to the emergency, elective services were stood down, physical estate converted for alternative use, together with human resource.

Reset and Recovery plans are now a priority. This report provides solutions that align with the National Clinical Framework to create a sustainable orthopaedic service for Wales that:

- Facilitates regional working to create a balanced service model.
- Segregates and protects emergency and elective care to minimise disruption day-to-day.
- Uses technology to achieve best practice.
- Measures patient outcomes to achieve best value.
- Attracts and retains the very best workforce.
- Improves patient experience and outcome.

4 Health Board and Geographical Context

There is little interaction between health boards in terms of patient flow apart from designated specialist or tertiary services e.g. paediatric orthopaedics and spinal surgery; services which are provided according to poorly understood SLA's (these examples are currently undergoing a WHSSC commissioned service specification and network development review independent of the NCSOS). There is no planning of specialist services according to population demand or consideration of the necessary capacity to service it.

Each health board develops its Intermediate Medium Term Plan (IMTP) in complete isolation of other health boards and there is no consideration of how certain elements of service planning could be shared, even where the provision of that service is failing in terms of delivery and performance or sustainability e.g. complex arthroplasty provision. Many health boards cannot clearly articulate their plans for elective orthopaedic services within their IMTP.

Whilst a comprehensive review of each health board is beyond the scope of this project, important aspects of each health board in the context of the challenges of provision of elective orthopaedics, and also the high level opportunities for future provision, are set out below. These will be discussed in further detail in section 7.

4.1 Hywel Dda University Health Board

Hywel Dda (HD) has multiple sites all providing some element of acute and elective activity, although services are managed and planned on a whole health board basis and there is clinical leadership with responsibility for the service health board wide. The three sites in the south of HD have reasonable horizontal road links by way of the A40, A48 and M4, however Bronglais Hospital (BGH) in the North is distant and relatively isolated. Services in BGH are fragile in terms of sustainability on 5-10 year horizon scanning, but are currently sustainable as a result of subspecialty referral to other hospitals within the health board. BGH has an important strategic role as part of a network of orthopaedic daycase units providing local care for Powys and South Gwynedd as part of the Mid Wales healthcare plan(Annex10) and could form part of a regional HVLC network for this population. This is considered in section 7. Prince Phillip hospital (PPH) in the south has historically provided over 60% of total elective activity for the health board with shorter length of stay than most other units in Wales and is potentially strategically very important for the health boards of South West Wales (SWW). It has an on-site medical intake and ITU. There is scope to increase the two laminar flow theatres to four, and a two laminar flow daycase unit is opening in May 2022. It can therefore contribute to any combination of HVLC, LVHC and daycase delivery networks as described in section 7. The overarching health board strategy will need to be aligned with the NCSOS if this is to be achievable. More detail on the strategic vision for the intended new hospital in HD and its impact on PPH in the medium to long term, which may have a key role within the SWW orthopaedic delivery network (see section 7), must be articulated by the health board. Withybush General Hospital (WGH) will have an important role as part the daycase delivery network for the population of Pembrokeshire.

4.2 Betsi Cadwaladr University Health Board

Despite being one organisation since 2009, there appears to be little if any consideration of how elective orthopaedic capacity could be provided as a whole across the entire health board. There is little if any networking of clinical subspecialty services in BCU with all three units working in isolation and there is no health board clinical lead for T&O. Central has access to Abergele as a cold elective site, although the capacity at this location is reduced from pre-pandemic state, and there is no sharing of this ring fenced resource with the other health board orthopaedic units. The other sites have no ring-fenced elective capacity and are continually at risk of unscheduled care pressures and loss of capacity. A great deal of activity leaves the health board towards English providers by way of

Provider	RJAH	Countess of Chester	Other English	Total
	1231	219	114	1564

Fig 1. BCU Outsourced Activity.2018/2019

outsourcing and patient flows directly from primary care; this activity has never been considered historically within D&C planning (see fig.1 above) and could all be provided within BCU, where the sub-specialty skills are already established. Furthermore, there are critical volumes for some subspecialty procedures e.g. TAR, TER, TSR, revision hip and knee arthroplasty; despite there being sufficient surgeons within the health board to provide the service, the volumes are not sustainable due to patient flows outside of the health board. Future plans include the creation of regional treatment centres (RTC) although the location, number and size of these units has not been fully considered. There is an opportunity for one of the RTCs to be developed in line with the recommendations of this report so that it has the appropriate specification to deliver care as part of the National Blueprint, appropriate for the clinical and demand capacity modelling that is described in section 7. In addition, despite bordering North Powys, BCU undertook only four cases for Powys in 2018-19, whereas RJAH in Oswestry undertook over 1100 cases for Powys. There is opportunity therefore for BCU to provide commissioned activity for Powys within BCU and by providing commissioned activity within Powys via a visiting clinician model and regional passport and the opportunity to repatriate patients from NHS England providers, removing concerns around critical volume services and thus make services more locally sustainable.

4.3 Powys Health Board

Powys has no host inpatient unit and commissions all of its elective inpatient activity from other providers. The majority of its orthopaedic inpatient activity is undertaken in English providers (Robert Jones and Agnes Hunt, Oswestry and Wye Valley) although it borders every other health board in Wales aside from Cardiff and Vale. There are current benefits to these commissioning arrangements as a result of shorter NHS England elective orthopaedic waiting times comparative to Welsh providers. Powys does have some day case theatre capacity in South and Mid Powys (Brecon and Llandrindod Wells respectively) and its own theatre staff, but commissions' anaesthesia and surgical provision via an "in-reach" model. There is no existing theatre provision in North Powys, although there are plans to establish a community healthcare hub with associated daycase unit in Newtown. Commissioning arrangements are complex due to the geography and infrastructure of the county, resulting in different arrangements with multiple different providers. Theatre sessions are currently underutilised due to workforce fragilities and limitations of an in-reach model and patchwork approach to booking of sessions based on consultant availability, but at the same time a large number of daycase treatments are commissioned outside the health board despite the facilities being present within the health board to provide lower complexity treatments closer to the patient's locality. The table below demonstrates the day case activity currently provided outside Powys which could be repatriated (fig.2).

Provider	Powys	HD	SBU	AB	BCU	CTM	CAV	RJAH	Wye	Other English
Total Elective	298	78	73	202	4	22	21	1169	336	13
Daycase	298	43	52	73	4	14	11	716	131	6

Fig 2 – Powys activity outsourced 2018-19

There is no clinical lead for T&O or MSK within Powys and the CMATS service exists in isolation with only limited support from primary and secondary care, meaning that pathways are fragile, although the recent appointment of a consultant MSK physiotherapist should improve this aspect.

Opportunities exist in Powys for stronger commissioning arrangements with neighbouring Welsh health boards which could feed into their IMTP and demand and capacity (D&C) plans for inpatient treatments. This would serve a dual benefit of improving sustainability and resourcing of NHSW health board services, whilst also delivering care more locally for the patient. In addition to inpatient work, targeted local commissioning arrangements with individual surgeons and anaesthetists from neighbouring health boards would allow greater utilisation of existing theatres within Powys and allow repatriation of large volumes of patients treated in England.

Creation of additional capacity with a daycase theatre unit in Newtown would create additional capacity for its population but also for South Gwynedd as part of the Mid Wales healthcare plan (see below). National MSK pathway development and involvement of MSK clinicians within sub-specialty MDT in line with NCSOS reports 2a-f would allow greater consistency of clinical practice and reduce variation and make services easier to plan

4.3.1 Mid Wales Joint Committee for Health and Care Strategic Intent 2018-2021

The vision of the Mid Wales Joint committee for Health and Care (MWJCH) (Annex10) is to ensure that the population of Mid Wales is provided with equitable access to high level, safe, sustainable, bilingual and high quality integrated health and care services. The mid wales region encompasses areas of Hywel Dda, Powys and South Gwynedd:

The area of Mid Wales covers the counties of Ceredigion, Powys and South Gwynedd (formerly known as the county of Meirionnydd) with a population of approximately 245,000 people. The majority of the region is rural with some very sparsely populated areas with little or no access to public transport.

Fig. 3 Mid Wales Region

The vision and strategic intent of the MWJCH therefore must be considered in conjunction with any consideration of regional provision in neighbouring areas. Most of the vision and strategic intent of MWJCH is in keeping with the design principles of NCSOS.

4.4 Cwm Taf Morgannwg University Health Board

CTM is similar to BCU in that despite being a single organisation since 2009, its hospitals are all managed as silos and there does not appear to have been any consideration as to how services could be provided on a whole health board level. There is currently no over-arching clinical lead for T&O and each individual silo has a separate clinical lead. In addition, the recent addition of Princess of Wales hospital (POWH) following the separation from SBU does not appear to have prompted a review of services across the health board footprint, and instead appears to have simply created yet another silo working in isolation. Clinicians in POWH still have access to beds and theatre sessions at Neath Port Talbot hospital (NPTH) whereas clinicians at other sites in CTM do not have this access. Elective services in Prince Charles (PCH) and Royal Glamorgan (RGH) units are not ring-fenced and are under constant threat as a result of unscheduled care pressures. The recent changes in Aneurin Bevan health board (ABHB) and removal of the emergency department from Neville Hall (NH) to the new Grange site have also had a negative effect on patient flow in PCH with trauma patients from North AB and South Powys who would usually have attended NH, choosing to travel to PCH rather than the Grange site. Conversely, volumes of elective work commissioned by Powys within CTM is low, with only 22 cases in 2018-2019 despite excellent road links provided by the A470 to the PCH and RGH sites from South Powys and major towns and populations. The geographical location of CTM being sandwiched between SBU, CAV and Powys and having excellent horizontal (M4 and Heads of Valley) and vertical (A470) transport links means there are several potential opportunities for cross boundary working arrangements. West CTM and POWH has historically been aligned with SBU and utilised NPTH and this arrangement regionally could continue. Mid CTM and RGH is in relative proximity to CAV and regional working with CAV could be considered. North CTM and PCH are in relative proximity to NH and AB where there is scope for regional working. Clinicians from CTM do not currently provide any commissioned activity within South Powys although could do so in the future. This is discussed in section 7.

4.5 Swansea Bay University Health Board

SBU has an advanced strategic plan for the organisation and provision of elective capacity by developing the NPTH site as a HVLC unit. Its plans for LVHC are less clear as they necessitate interdependencies which do not exist in NPTH currently,

and ring fencing on the Morriston site remains challenging due to the competing and conflicting demands of its many regional and tertiary services and the intended unified secondary care medical take (from Singleton) impacting on available surgical beds. There is opportunity for NPTH to be developed into a regional Hub (see section 7) in conjunction with HD and West CTM although this will require provision of a PACU/enhanced recovery setup at the NPTH site. Alliance with HD for the LVHC cohort may be a more feasible option, at least in the short term, with ring-fenced beds already in place at the PPH site. Whichever model, there will still be a need for the provision of some ring fenced capacity at the Morriston site due to absent interdependencies at PPH e.g. vascular, renal dialysis.

Challenges for SBU continue to be around the Morriston site and the demands caused by tertiary specialist services which must be commissioned and resourced separately form routine secondary care services to avoid continued impact on local secondary care elective services.

4.6 Aneurin Bevan University Health Board

AB is perhaps the most advanced in terms of its ability to separate elective services from acute services as a result of additional capacity created by the opening of the new Grange Hospital site during the Pandemic. However, workforce implications mean that this additional capacity cannot be staffed sustainably at present. There have been attempts to release some elective capacity to assist CTM, but these attempts have failed due to the inability/reluctance to move staff across HB boundaries. The planned reconfiguration of acute services across the HB and creation of a single on call based at the Grange site has meant increased elective capacity which is not being utilised at the NH site. The laminar flow and elective bed capacity at NH could provide an additional regional elective centre for AB/CTM and Powys. AB already has a small HVLC type unit based in St Woolos but this does not have the necessary capacity to deliver all HVLC activity (see section 7). In addition, St Woolos does not provide LVHC capacity which is currently provided at the Royal Gwent site, not the Grange site due to reduced capacity and intended pathways at this site. This multi-site service is fragmented and there are sustainability issues in terms of all workforce.

4.7 Cardiff and Vale University Health Board

Pre-pandemic, Cardiff & Vale (CAV) had a cold elective unit based at UHL but the capacity of this unit has diminished over the pandemic due to other services being relocated. CAV suffers with similar issues as AB and SBU e.g. fragmentation of services and pathways of care post-pandemic e.g. trauma clinic located at distant

sites but also has similar issues at the UHW site due to specialist tertiary services (MTC/paeds/spinal) and lack of formal commissioning for some elements. CAV is also seen as an informal tertiary centre for complex lower limb revision arthroplasty but are not commissioned for this activity that often displaces core CAV secondary care activity. Opportunities exist for CAV to work more closely with South/Mid CTM for both HVLC and LVHC pathways (see section 7).

5 Methodology – Demand/Capacity Planning

Orthopaedic Surgery is a heterogeneous group of subspecialties with significantly differing requirements for some aspects but shared interdependencies in other areas. Therefore, any planning considerations must focus not only on those specific to each subspecialty but also those that can be shared for economies of scale.

Prior to the inception of the NCSOS project, there was no clear understanding of the detail of challenge that NHSW and WG faced to deal with the failing orthopaedic system. The magnitude was known, i.e. approaching 100,000 patients on an orthopaedic waiting list, 6308 waiting over two years for treatment, but exactly what sub-specialty, procedure (and hence resource/ infrastructure) these patients were waiting for, was not, thus making any capacity planning beyond health boards impossible. Furthermore, there was no knowledge outside each health board regarding consultant workforce availability, skill mix and speciality training and all recruitment was being managed in health board silos without any reference to the regional context or demand. This silo working also left services and pathways exposed to variation through un-standardised clinical pathways, resulting in poor patient experience.

The objectives of the NCSOS project are outlined in (Annex1). The clinical pathways and workforce review at subspecialist CRG provides the basis of the procedure bundling, subspecialist interest, specialised procedure competencies and horizon scanning that underpins the subspecialty D&C data analysis. The main weakness of this element of the project was the inability to gain whole time equivalent (WTE) data from each surgeon, whether they are on 10 vs 12 session job plans, and their exact contributions towards their chosen elective sub-specialism. This is especially relevant for surgeons with more than one subspecialty e.g. Foot & Ankle and Paediatric orthopaedics.

This element of the analysis has to be interpreted with caution by executive teams as it may over or under demonstrate a Consultant workforce capacity to demand mismatch. Further national workforce WTE surveillance, including an annual trainee survey will need to be prospectively monitored through the W.O.N

and National CRGs as part of a continual horizon scan process. An initial trainee survey has been undertaken a part of the NCSOS project (Annex 12). As part of the NCSOS project a preliminary trainee survey has been performed to support this process. Therefore, for the purposes of this report, it must be noted that every surgeon has been assumed as one WTE and able to contribute one all day elective theatre list per week, for 42 weeks of the year, for their sub-specialties. Variants of this are modelled as described below, utilising 2 vs 2.6 session theatres lists, and 5 vs 6 day working. It is recognised however that in reality there will not be a "one size fits all" with regards to consultant job planning.

The demand-activity-capacity planning demonstrated in detail in the section below relies on six data sets which were analysed:

1. 19/20 PEDW activity data.
2. 18/19 demand data at procedure specific, OPCS and "free text" level.
3. Backlog data. Sept/ Oct 2021, again at procedure specific, OPCS and "free text" level.
4. External commissioner/ provider data.
5. National and NHSE theatre data.
6. NHSW, NHSE and benchmark/ "best practice" LOS data.

The theatre capacity allocation modelling has been derived from the volume of specific procedures, or in some circumstances, bundles of procedures defined by each CRG. By accumulating this total time load for each sub-specialty, then dividing by each procedure and bundles contribution to that load, allowed for modelling the number of expected case for an average list for that sub-specialty.

Whilst the report is focussed on sustainability of services, the sheer size of the backlog means that any sustainable solution needs to factor this additional activity into core work, not just for the short term (such as with WLI) but as part of a long term strategy.

External systems modelling and recovery is being utilised in some health boards, however much of this is based on crude historical activity without subspecialty or procedure level detail. It is also based on coding which the NCSOS project team identified as a major failing of the current systems that are used in NHSW. A significant proportion of the data available was identified as significantly inaccurate and/or duplicated, necessitating a comprehensive free text review of the entire national orthopaedic backlog and additions databases. This ensures the NCSOS database is as accurate as possible, but also highlights that previous data reviews that this project compares against, are not. Furthermore, previous demand capacity

modelling is based on data compromised by WLI activity and constrained by arbitrary RTT targets.

For the purposes of this report, various scenarios have been modelled accepting that it will take time to reduce the backlog in a sustainable and deliverable manner. A pragmatic approach has been taken, with capacity 10% above recurring demand with a "first in, first out" (FIFO) queue as a baseline. **This will be referred to as the *"10% model"* in this report**. Whilst this FIFO model does not factor-in competing urgent demands, it should be recognised that this system modelling is mainly concerned with the macro elective orthopaedic surgical delivery system, and concentrated on the large elective routine bulk of the waiting list (92%). In reality, if the recommendations of the NCSOS are met, the FIFO system will treat the vast majority of orthopaedic patients in a clinically safe time period. Any very urgent patients who are not, could be met through prospectively managed additional capacity which can be phased into core activity through W.O.N governance, as the service transformation evolves (see section 7).

This also provides a realistic model when considering available workforce and feasibility of delivery, and also provides some flexibility for predicted increase of demand with time due to demographic factors; in the current climate, this is very difficult to predict. Whilst this does not seem overly ambitious, it should be noted that this 10% model still represents procedure level activity which is far higher than both core activity and core plus additional WLI and backfill that was being provided pre-pandemic in most health boards.

Capacity and activity to meet demand (***"0% model")*** has also been presented for comparison, noting that this will never reduce the backlog, but *will* reduce the waiting time on the surgical lists to a constant time (varying between each sub-specialty and procedure depending on their backlog and activity required to meet demand).

Where clinically appropriate, more HVLC single procedure lists have also been modelled below. E.g. Primary TKR/ THR, CTDs. Where national procedure targets are already in existence, the NCSOS data was compared for validation, i.e. GiRFT recommended volumes for primary TKR, THR, UKRs and ACL reconstruction. In certain sub-specialty scenarios below, we have used higher percentage modelling above demand, to illustrate how the systems can be flexed to a more ambitious model, particularly for any speciality where the chosen recovery metrics take longer than three years.

The provision of a standardised 26 week RTT metric in terms of recovery times for each sub-specialty and procedure group is not feasible within this model as

outpatient delivery is not being considered within this project. However, WG are to release their reset and recovery plan which is likely to include "*no patient waiting longer than 1 year by March 2025* ***in most specialties"***. This is unlikely to include orthopaedics which will be an exception due to the size of the backlog, nonetheless, using this as a basis, if it is considered that the 50% of the waiting time will be outpatient, the other 50% surgical wait, an appropriate target would be to achieve a surgical waiting time of 26 weeks within at least three years as a first goal, and time taken to reduce the backlog by 50% as a second goal; all the models are therefore presented against these objectives. Clinical activity variables are also modelled and compared; e.g. 2.6 session days, 3 session days and 6 day working and provided recovery trajectory and workforce plans accordingly.

It should be noted that this model assumes the capacity and activity commences as per the state of the waiting list when the data was collected i.e. October 2021 and that the FIFO model commences at full capacity immediately. It does not consider the growth of the waiting list over the last six months and does not consider the considerable lead in time for any of these models to be operationalised. The possibility of short-term pump priming through WLI and outsourcing to address the backlog to mitigate any lead in time, and the lengthy time scales of backlog reduction in this report should not be discounted.

Bed modelling is clearly an important aspect of any capacity and estate planning. The NCSOS drew from 18/19 and 19/20 procedure specific level LOS data from NHSW HB sources and NHSE elective hub and GIRFT benchmark data sources, which allowed for calculation of bed days at HB, regional and national level. Various service models were reviewed including 0% and 10% above demand models for both NHSW procedure specific LOS vs NHSE and GIRFT benchmark LOS. This allowed for estimating the beds requirements if pathways and LOS remain the same compared to when pathways are transformed in line with GIRFT and the NCSOS recommendations detailed in reports 2a-f.

6 Subspecialty planning

6.1 General

There are approximately 30,000 patients on the elective orthopaedic surgical waiting list (excluding spinal surgery, paediatrics, needling procedures, scheduled trauma), with another 40,000 being added every year. The highest volume by patient number is knee surgery followed by hand and then hip surgery. It should be noted that hand surgery has a higher demand volume but the backlog is comparable to hip, suggesting that hand surgical patients are cleared more quickly. This is logical when considering the difference in surgical time, but also that hand surgery is predominantly daycase delivered and not as susceptible to inpatient bed pressures.

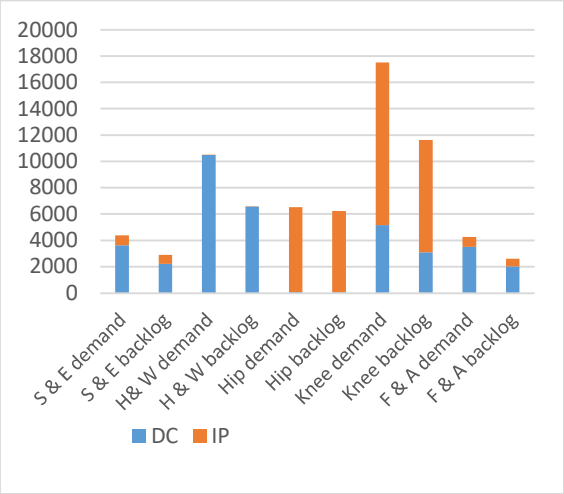


Fig.4. Daycase and inpatient backlog and demand per subspecialty.

46% of the backlog and 57% of additions are daycase, again supporting the statement that day surgery is cleared more effectively than inpatient surgery in Wales. Fig.4 shows the daycase and inpatient split by sub-specialty.

6.2 Shoulder & Elbow Surgery

Approximately 3200 patients requiring shoulder surgery are added to the waiting list nationally every year, 80% are daycase procedures. There are just over 2100 on the existing backlog of which 75% are daycase. This implies historical activity weighted towards daycase at the expense of inpatient. With activity matching demand, any new patient entering the queue will wait 48 weeks on the surgical list (assuming FIFO). The backlog will not be cleared. Using the 10% model, it will take three years to halve the daycase backlog but only seven months to reduce the surgical waiting time to 26 weeks. This still necessitates procedure level activity at least 200% above pre-pandemic levels but should be achievable within the current Consultant workforce and proposed theatre delivery models (see section 7). The 10% model is not as effective for inpatient shoulder surgery due to its relatively low demand. It will take 4.7 years to halve the backlog and just under four years to reach a 26 week wait.

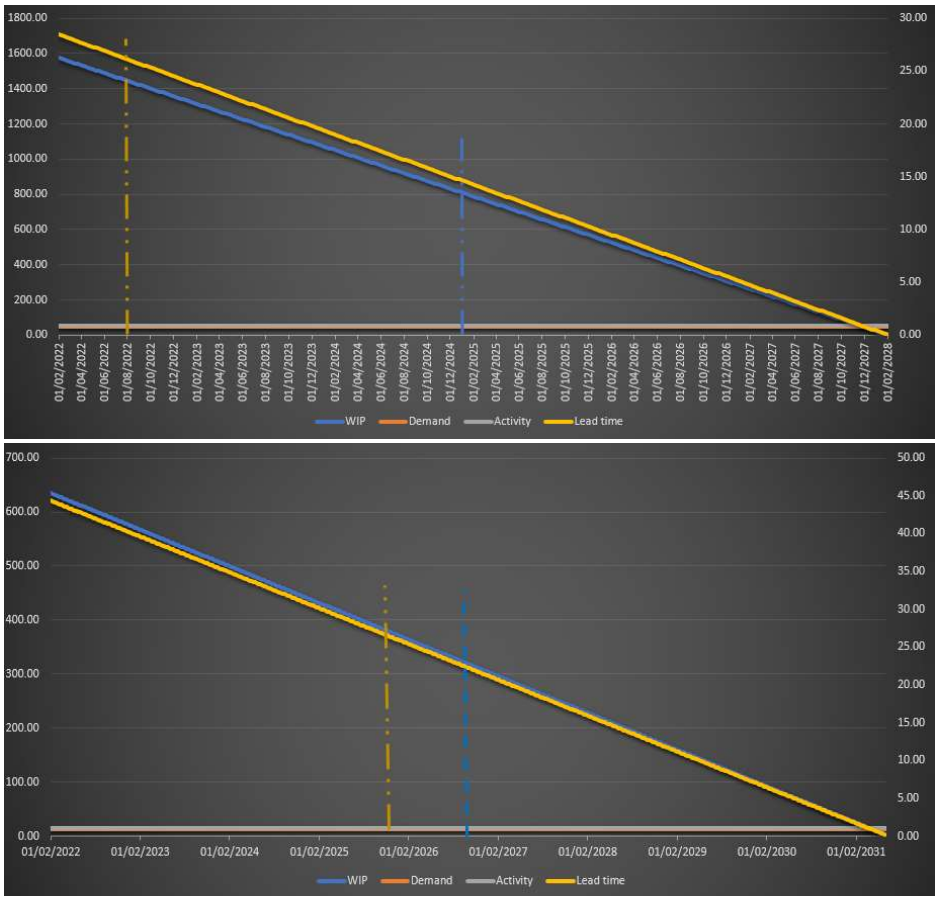


Fig. 5. Reduction of Shoulder (not including elbow) backlog. Top – Daycase. Bottom – inpatient.

Fig.6 Pump prime backlog clearance model Inpatient shoulder surgery

It will take 4.7 years to halve the backlog and just under 4 years to reach a 26 week wait. However, because of this relatively low demand, backlog clearance in each HB can be delivered within 12-13 months (except AB which will take 24 months due to higher demand) if prioritised and 3-4 sessions of theatre are dedicated to inpatient shoulder surgery weekly. With this model the surgical queue with reduce to 12 weeks with 7 months and any new patient entering the surgical list can immediately expect a waiting time of under 27 weeks.

At the time of writing there are 23 shoulder surgeons practicing in Wales. The general Shoulder surgeon workforce is robust on current and horizon scanning (fig.8) which local recruitment mechanisms should be able to manage. However, in order to meet demand, every shoulder surgeon must be enabled to deliver 2.6 sessions of elective theatre per week (see fig.7). This will still result in under establishment in AB and HD but slight over establishment in the other health boards, even when considering 10% additional capacity. Therefore, regional working must be implemented to deliver shoulder work for the residents of AB, CTM and CAV; and likewise in SB for HD residents (rather than short-term additional recruitment in AB and HD).

HB	Shoulder Consultants (n) current	Shoulder consultants required*		
		With 2 session lists 0% model	With 2.6 session list, 0% model	2.6 session, 10% model
AB	4	8.1	5	5.5
BC	5	5.7	3.4	3.8
CAV	4	3.7	2.3	2.5
CTM	5	4.5	2.8	3
HD	2	3.4	2.1	2.6
SB	3	3.5	2.2	2.4

*Fig.7. Required Shoulder surgeons to meet demand. *see methodology for assumptions*

More specialist competencies need a networked approach. There is a reasonable match of revision arthroplasty shoulder surgeons to the relatively low volume and demand for this patient cohort. To achieve minimum volumes, the shoulder subspecialty CRG recommends HB level "cohorting" of these patients to be kept to 1-2 surgeons per HB, with regional MDT to ensure cross regional working for sustainability in case of unexpected leave and future health board level recruitment issues. Whilst a lower number of higher volume surgeons serves to improve quality of care, it may leave HB level specialised services exposed, and fragilities must be mitigated with a networked regional approach to delivery. See report 2b "*S&E Guidelines and Recommendations".*

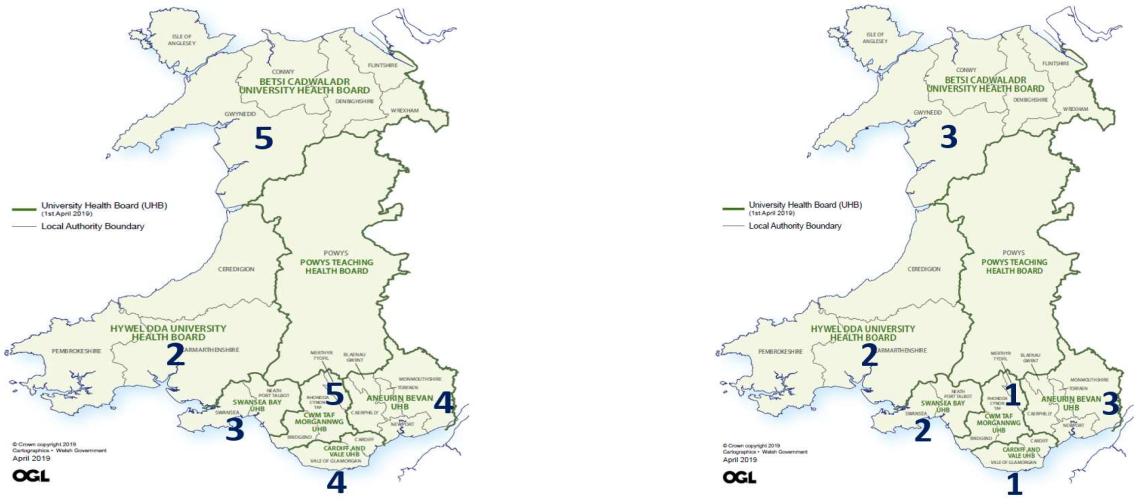


Fig. 8. Shoulder surgeons across Wales. (left – All shoulder surgeons, right – revision Arthroplasty surgeons)

In line with "*A Healthier Wales*", it is recommended most daycase shoulder surgeries be provided as local to the patient as possible through a network of orthopaedic daycase provider units; there is no reason to "over centralise" the majority of shoulder surgery. There is enough volume to sustain staffing skill mixes in HB designated DSUs. The infrastructure required to provide these pathways is not complex and has economies of scale with other arthroscopic and daycase Orthopaedic surgeries, again supporting more local models of care. We recommend orthopaedic daycase sites providing shoulder surgery in the locations as outlined in section 7.

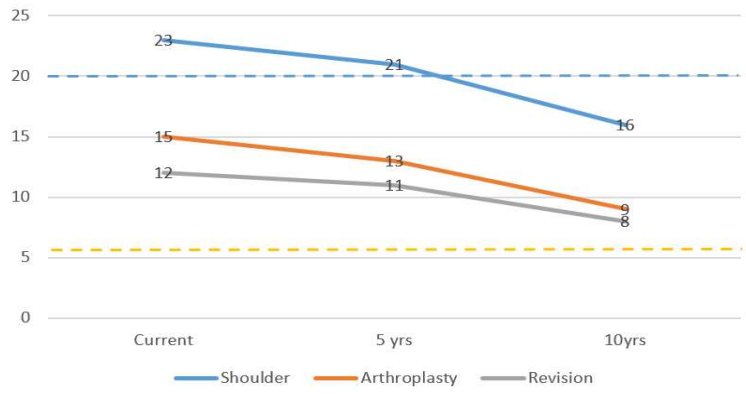


Fig. 9 Workforce for Shoulder Surgeons, current and horizon scan. Note below blue dotted line =inability to sustain consultant services for all shoulder, orange line – fragilities with shoulder arthroplasty

More specialised daycase shoulder & elbow procedures should be provided by a fewer number of surgeons so that volumes can be concentrated; this should be determined by the NSECRG. These procedures share most if not all of the interdependencies as simple shoulder and elbow daycase procedures and can be performed in the same setting. Inpatient shoulder surgery provision should be as per the different models in section 7 and part of an integrated regional system.

Lower volume, higher complexity and inpatient surgeries such as revision arthroplasty should be provided at regional level through clinical and delivery networks based on the subspecialty CRG outputs outline in NCSOS report 2b. This is clinically and resource preferential compared to the current model where these procedures are being provided patchily in every Orthopaedic unit, especially those health boards with multiple silo working units. Again, the locations are dependent on which model is chosen for the national blueprint but will require cross regional consultant and staff working and regular MDT and governance to allow for regionalisation (both clinically and delivery) as any identified fragilities mandate.

6.2.2 Elbow Surgery

There are no dedicated elbow surgeons in Wales; elbow surgery is delivered by a smaller cohort of Shoulder and Hand surgeons and therefore the implications on delivery must be considered in this context rather than in isolation.

70% of elbow surgery is unspecialised and daycase; the case volume and time load is relatively low, approximately 17% when combined with unspecialised daycase shoulder surgery, and even less when combined with hand surgery. The total national requirement for elbow surgical capacity to meet demand is only three 2-session lists per week. We therefore recommend that unspecialised elbow surgery continues to be delivered within established Shoulder and/or hand surgical lists and teams.

Specialised elbow surgery however is low volume and can be very complex surgically and infrastructurally for theatre and therapy teams. The elbow CRG recommends that a regional network for the delivery of total elbow replacements (TER) be established. Based on volume of annual additions to the waiting list and consultant workforce spread with the relevant competencies, it is recommended that the NSECRG and NHWCRG identify a maximum of four elbow surgeons with higher volumes in South Wales to deliver this care. It is not proposed that this service is centralised around one unit as this will likely have unintended consequences, e.g. impact on general complex elbow trauma care. However, the NHWCRG and NSECRG will need to work collaboratively to reduce the number of units these complex procedures are delivered through. Recommendations for North Wales are more challenging due to historical pathways of patient flows outside Wales and limited datasets. However, data from BCU suggests two additions internally per year and six cases per annum being externally provided. This level of activity would only support a single surgeon practice; however, the expected additions pro-rata according to population size would suggest that a two-surgeon model could be supported within a regional network. It is recommended that in North Wales this be with RJAH Oswestry, and that the majority of TER activity is repatriated to be undertaken within North Wales.

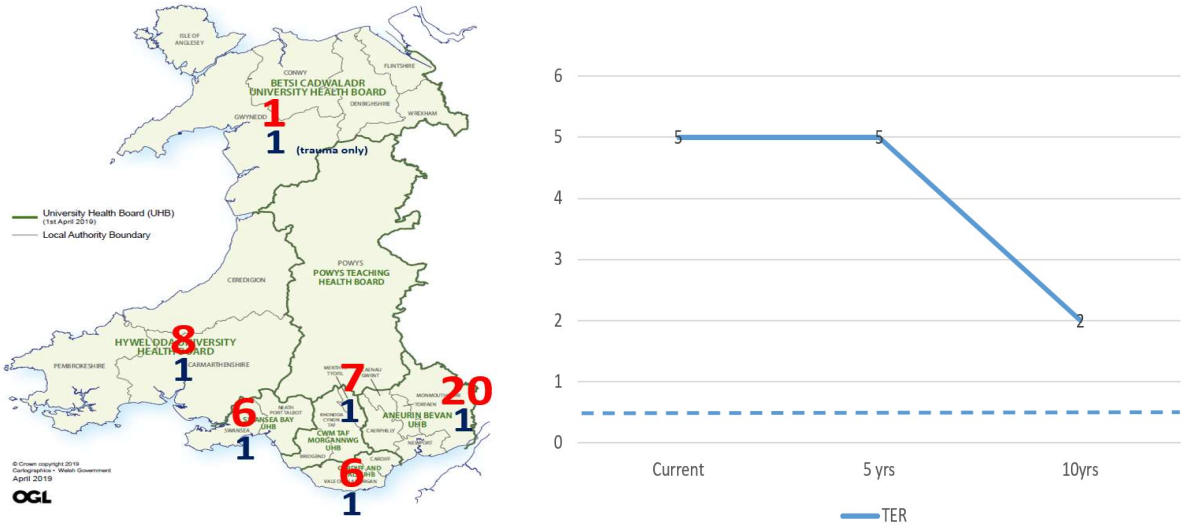


Fig. 10 – Left (map) Blue - TER surgeons in Wales. Red – TER annual demand. Right – Horizon scan TER surgeons. Blue dash – minimum WTE surgeon number to deliver national demand.

All TER surgeons must work in a clinical and delivery network to cross cover across HB boundaries. Dual operating is also encouraged to further improve minimum volumes, reduce variation and improve quality and safety. The implications for complex elbow fracture management are discussed in report 2b.

6.3 Hand & Wrist Surgery

Hand surgery can be delivered by both orthopaedic and plastic surgically trained surgeons. Whilst there are elements of specialised hand surgery that gravitate more towards one than the other e.g. microsurgical reconstruction to plastics, complex arthroplasty towards orthopaedics, the direction of hand surgery is towards post-CCT combined hand fellowships.

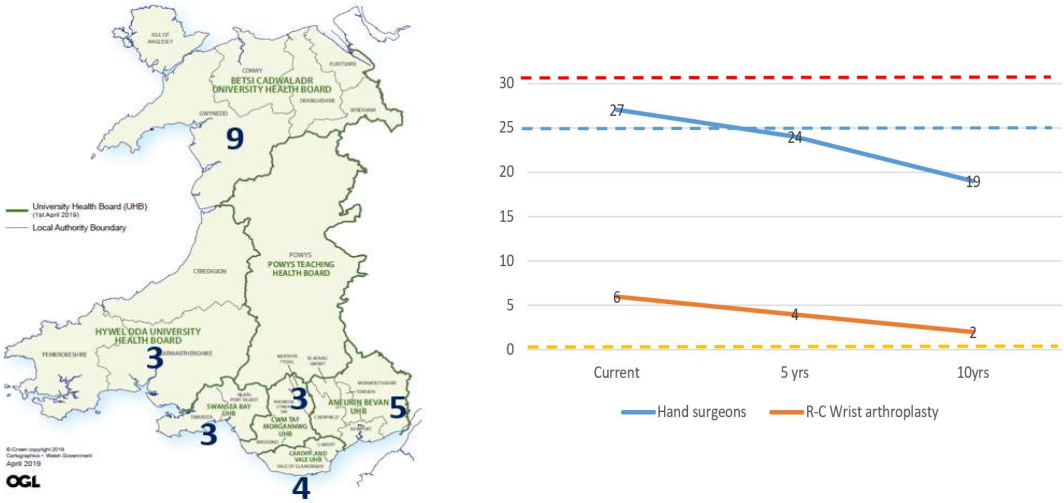


Fig 11. Hand Consultant Establishment (Left) and horizon scanning (right) – dash lines minimum WTE consultant number, red – 2 sessions theatre, blue – 2.6, orange 2 sessions R-C arthroplasty

There are 27 orthopaedic surgeons declaring an interest in hand surgery in Wales. The plastics surgical workforce is beyond the scope of this project but it is anticipated they will have a key role in the NHWCRG.

When considering the workforce requirements to meet demand, North Wales is over-establishment, South Wales is slightly under establishment, compounded further as the three surgeons in HD only equate to 1.2 WTE.

There is significant variation across Wales in terms of cases undertaken per session. The models within this report are based on national theatre time averages for procedures bundles and assuming an efficient theatre turn round. For hand surgery this demonstrates eight mixed unspecialised cases should be delivered on two session lists and ten in 2.6 sessions. With further improvements in theatre efficiencies such as CTD HVLC lists, the requirements for additional short-term recruitments could be reduced.

HB	Hand Consultants (n) current*	Hand consultants required*		
		With 2 session lists	With 2.6 session lists	10% additional activity over demand
AB	5	7	5.6	6.2
BC	9	5.2	4.1	4.6
CAV	4	6.7	5.4	5.9
CTM	3	4.6	3.7	4
HD	3	3.3	2.6	2.9
SB	3	4.5	3.6	4

*Fig. 12 Required hand surgeons to deliver model *see methodology for assumptions*

Approximately 10500 patients requiring hand & wrist surgery are added to the waiting list nationally every year, 99.9% are daycase procedures. There are just over 6500 on the existing backlog. To match capacity and demand will require a three-fold increase in national productivity compared to pre-pandemic. This will not improve the backlog position but will ensure that any new patients entering the surgical waiting list will have a 22 week wait. Using 10% over demand modelling will incrementally improve the RTT position and gradually reduce backlog to 50% in 2.5 years. This model still necessitates procedure based activity at least 400% above pre-pandemic levels but should be achievable within the current workforce and proposed theatre deliver models (see section 7).

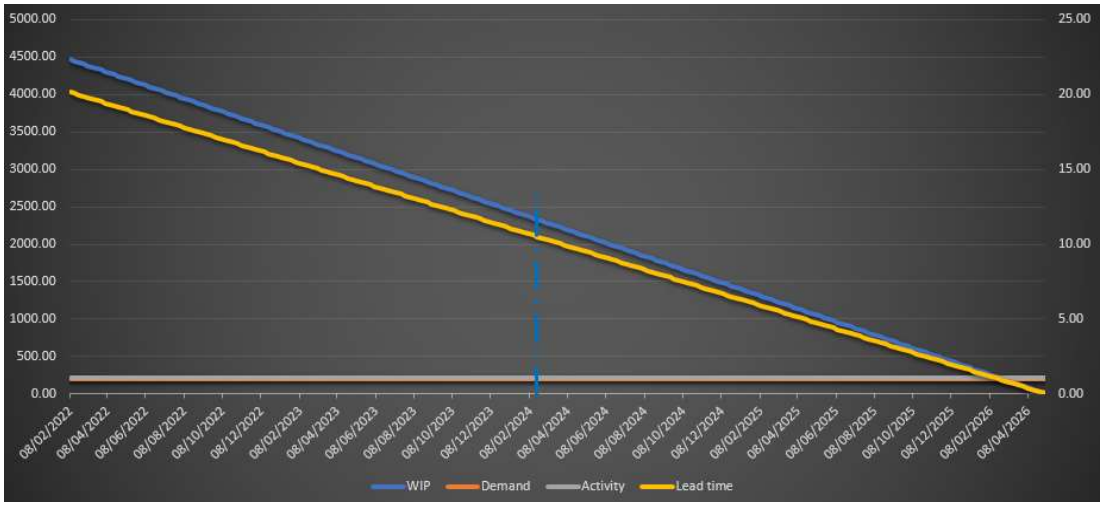


Fig. 13 - 10% over demand model for mixed unspecialised hand lists

Best practice suggestion

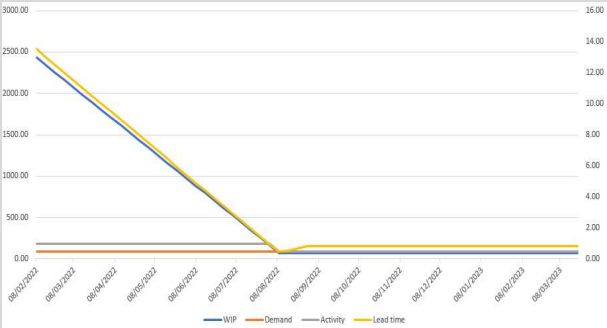


Fig 14. CTD backlog clearance with 2 x 2 session lists running with 15 cases per day in each HB.

The change to HVLC practice for high volume hand surgery could have a dramatic effect on waiting times for patients

The largest volume of hand surgeries are carpal tunnel decompressions which comprise almost 50% of the hand surgical additions and one third of the backlog. Fifteen CTDs can be performed in a two session day, therefore, more efficient HVLC type CTD lists could improve backlog management. With four sessions of CTD lists per week running to these parameters in each health board, the national CTD backlog could be cleared within one year, with room for slippage. Once the backlog is cleared, demand could be maintained with half of this activity.

83% of Hand surgery is unspecialised, daycase, high volume and quick turnaround. Even more so than Shoulder surgery, Hand surgery lends itself to being delivered through an Orthopaedic daycase delivery network ensuring timely access to all geographical locations in Wales as per "*A Healthier Wales*" principles. The NCSOS Hand surgical document details the optimal clinical pathways.

The exceptions are for the very low volume and potentially infrastructurally complex specialised procedures such as wrist arthroplasty. It is recommended that the number of surgeons that provide these low volume procedures is monitored by the NHWCRG within a W.O.N and kept to an optimal volume. For example, there are no fragilities with consultant establishment for radio-carpal arthroplasty in the next 10 years (fig. 11); however, this is including surgeons declaring an interest who do not have any backlog, additions or activity for these procedures. Fledgling clinical networks have already begun as a result of the NCSOS CRG meetings-see report 2c "*Guidelines and recommendations Hand & Wrist surgery*". However, for arthroplasty, the number of yearly national additions of wrist variant replacements is only nine per annum (two North Wales and seven South Wales) with another 3-4 cases undertaken annually outside Wales due to historical referral pathways in North Wales. The use of novel hand joint replacements is greater but still of low volume. It is therefore recommended that 2-3 surgeons in South Wales and a single surgeon in North Wales deliver this service, employing a mutual assistance model to ensure dual consultant decision making and dual consultant operating where deemed necessary, across HB boundaries and networks. In North Wales, this will necessitate a network involving a provider outside Wales. To ensure theatre staffing skill mix/exposure and equipment/

implant concentration, these complex procedures will need to be delivered in the provider hand unit within each regional network.

In principle, theses designated low volume specialised hand centres for SW are AB, CAV and SB hand units. It is recommended that a regional centre and specialised surgeon is identified in one of the Orthopaedic units in BCU. This overall number of providers may need to reduce further in the future but should be the decision of the NHWCRG, implemented through the W.O.N.

6.4 Hip & Knee Surgery

6.4.1 Arthroplasty

Hip and Knee operations comprise the largest theatre requirement (fig 15) per unit time. They are 3rd and 1st respectively in terms of patient number demand and backlog. Patients awaiting primary hip and knee arthroplasty comprise the largest volume and theatre time load within these subspecialties (85% and 55% respectively). The nature of these procedures is that they lend themselves to standardised pathways of care and surgical processes that maximise performance and efficiency, reduce variation of practice and improve quality and patient safety. It has been recognised for many years that cold elective sites are the standard of care for these Orthopaedic procedures. This was the recommendations of GiRFT in 2014-2015, which were not implemented in Wales. This has now been taken a step further in NHSE through the high volume low complexity programme (HVLC) championed by GiRFT. This has been proven with case examples in NHSE, to significantly enhance throughput and quality of care[3]. Working with the 10% over demand model, it will take just under five years to halve the primary hip (fig 16) and knee (fig 17) arthroplasty backlogs, and just over four years and three years to reduce the surgical waiting time to 26 weeks for THRs and TKRs respectively (assuming a FIFO queue). However, it should also be noted that the surgical waiting time in this queue system will immediately become 41-42 weeks. If the outpatient services are improved in a similar manner such that all patients are seen with 26 weeks, it is feasible that the whole pathway RTT could be less than one year within five years of instigating this model (this does not take into account any further drift of position from this point).

Subspecialty	Theatre minutes required (nationally)
Knee	1240895
Hip	758666
Hand & Wrist	582492
Shoulder & Elbow	569075
Foot & Ankle	411564

Fig. 15. Subspecialty load by required theatre time

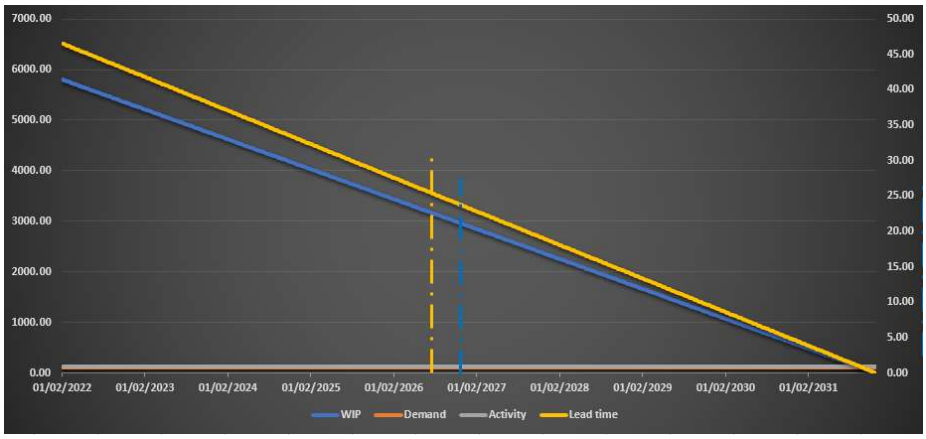


Fig 16 Primary THR 10% model

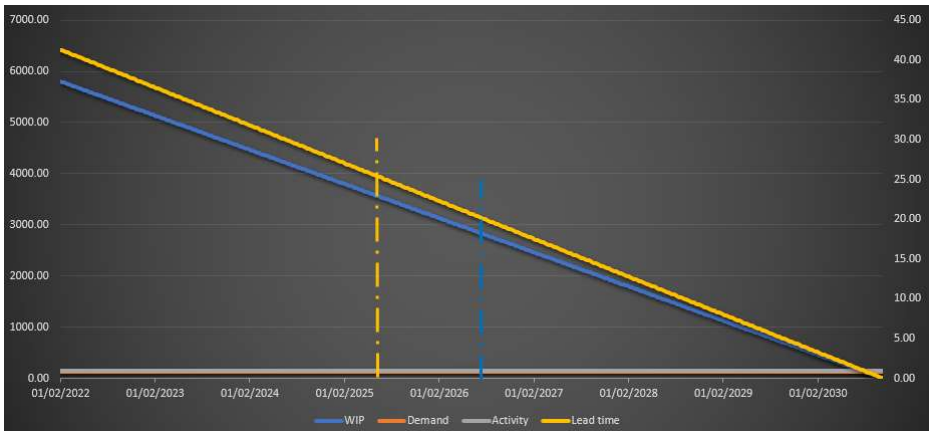


Fig 17. Primary TKR 10% model

This can only be achieved with more efficient theatre lists, HVLC philosophies and modes of delivery i.e. a lower number of higher volume centres. It is proposed that this pace of recovery is too slow and more radical solutions are required. A 20% over demand model is demonstrated below (fig 19). The additional theatre estate required is not unrealistic and can be reduced by 2.6 session and 6 day working. All models should be deliverable with the current national Consultant hip and knee surgical establishment (see fig 20/21) provided Arthroplasty is delivered through regional HVLC networks rather than at HB level where workforce fragilities is some areas will be exposed.

	AB	BC	CAV	CTM	HD	SB	Wales
19/20 activity	673	818	447	375	527	145	2167
Required activity	1294	1450	710	1148	1074	650	6325
% uplift	92	77	59	206	104	348	192
Theatres required daily (5/7)	3.24	2.92	1.56	2.73	2.32	1.36	14.14
Theatres required daily (6/7)	2.70	2.44	1.30	2.28	1.94	1.14	11.79
2.6 sessions 5/7	2.59	2.34	1.25	2.19	1.86	1.09	11.31
2.6 sessions 6/7	2.16	1.95	1.04	1.82	1.55	0.91	9.42

Fig 18. THR 10% model and required activity above 19/20 baseline.

	AB	BC	CAV	CTM	HD	SB	Wales
19/20 activity	673	818	447	375	527	145	2167
Required activity	1411	1582	774	1253	1171	709	6900
% uplift	110	93	73	234	122	389	218
Theatres required daily (5/7)	3.53	3.18	1.70	2.98	2.54	1.49	15.42
Theatres required daily (6/7)	2.95	2.65	1.42	2.48	2.11	1.24	12.85
2.6 sessions 5/7	2.83	2.55	1.36	2.39	2.03	1.19	12.34
6/7	2.36	2.12	1.13	1.99	1.69	0.99	10.3

Fig 19. THR 20% model and required activity above 19/20 baseline.

The effect of out-sourcing as a result of recovery efforts during the pandemic must also be considered, and may result in some deviation from predicted modelling with the majority of arthroplasty backlog now representing a more medically or surgically complex cohort.

It is a key recommendation of the NCSOS and the view of every orthopaedic surgeon in Wales that elective orthopaedic cold site hubs should be developed in Wales. These will provide HVLC pathways but for economies of scale and strong clinical reasoning may need to provide care for low volume high complexity (LVHC) patient cohorts. Options for this are discussed in section 7.

For HVLC hip and knee arthroplasty these options will need to provide a network of hub sites with a total of 11-16 (depending on model of delivery, 2 -2.6 sessions, 5-6 day working) laminar flow high specification theatres.

This will need to be in addition to 1-2 LVHC/ revision Arthroplasty lists per day in SW and 1-2 LVHC lists per week in NW (fig 51). As stated above, this should be achievable from a consultant workforce standpoint (see fig 20/21) although it should be noted that there will be consultants who will have to deliver non primary arthroplasty surgical activity (e.g. Revisions, soft tissue knee) which will reduce their available sessions for HVLC lists, therefore, careful system-wide job planning will need to be undertaken and co-ordinated through the W.O.N and CRGs. Further detail on network and MDT arrangements can be found in reports 2d and 2e.

HB	Primary Hip Consultants (n) current	Primary Hip Consultants (n) actual (when accounting for revision activity)	Hip consultants required*			
			With 2 session lists	With 2.6 session lists	10% additional activity over demand 2.6 sessions	20% additional activity over demand 2.6 sessions
AB	12	10.6	7	5.6	6.2	6.7
BC	20	18.9	7.8	6.3	6.9	7.5
CAV	8	7.1	3.8	3.1	3.4	3.7
CTM	10	9.2	6.2	5	5.5	6
HD	12	10.5	5.8	4.6	5.1	5.6
SB	5	4.5	3.5	2.8	3.1	3.4

*Fig.20. Required Hip surgeons to meet primary demand. *see methodology for assumptions*

HB	Primary Knee Consultants (n) current	Primary knee Consultants (n) actual (when accounting for revision activity)	Knee consultants required*			
			With 2 session lists	With 2.6 session lists	10% additional activity over demand	20% additional activity over demand
AB	12	10.7	11.3	9	9.7	10.9
BC	22	21.2	8.7	7	7.7	8.3
CAV	8	6.9	5	4	4.4	4.8
CTM	18	17.4	9.3	7.4	8.1	8.9
HD	13	12.2	7.6	6.1	6.6	7.2
SB	8	7.8	4.2	3.4	3.7	4

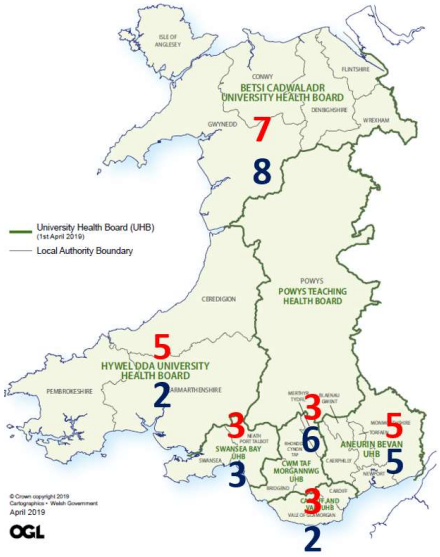
*Fig.21. Required knee surgeons to meet primary demand. *see methodology for assumptions.*

Low volume high complexity (LVHC) cases such as revision arthroplasty have greater co-dependency requirements, which are discussed further in NCSOS reports 2a, 2d & 2e. However, overall volumes of this cohort appear to be relatively stable or decreasing nationally, possibly as a result of treatment via trauma pathways following acute presentation during the pandemic. It must be noted that the past failures of the orthopaedic system have disallowed this patient cohort access to the appropriate specification unit, and pathways that necessitate use of trauma capacity for this cohort and not appropriate. Acute sites which used to be the surgical delivery units for this patient cohort are no longer available due to non-orthopaedic priorities such as unscheduled care, trauma and cancer.

There is a sustainable consultant revision hip and knee arthroplasty workforce spread across Wales. Minimum procedure volumes will need to be monitored through the NHCRG and NKCRG prospectively. Horizon scanning (fig. 23) does not reveal any fragilities for at least 10 years nationally, provided revision arthroplasty is managed through regional clinical and delivery networks. This data must be interpreted with caution however, as it assumes that revision arthroplasty surgeons only perform revision arthroplasty, and through revision-only theatre lists. This is not the case, and is unlikely to be a realistic or desirable model for a number of clinical, operational and logistical reasons. The required revision arthroplasty establishment will likely need to be greater than illustrated in (fig.22), however the required uplift is well within what can and should be mitigated through a revision network approach.

HB	Revision Hip Consultants (n) current	Hip consultants required*		Revision Knee Consultants (n) current	Knee consultants required*	
		With 2 session lists	20% additional activity over demand 2.6 sessions		With 2 session lists	20% additional activity over demand
AB	5	1.4	1.1	5	1.3	1
BC	8	1.1	0.9	7	0.8	0.6
CAV	2	0.9	0.7	3	1.1	0.9
CTM	6	0.8	0.6	3	0.6	0.5
HD	2	1.5	1.2	5	0.8	0.6
SB	3	0.5	0.4	3	0.2	0.2

*Fig.22. required revision Hip & Knee surgeons to meet revision demand. *see methodology for assumptions.*



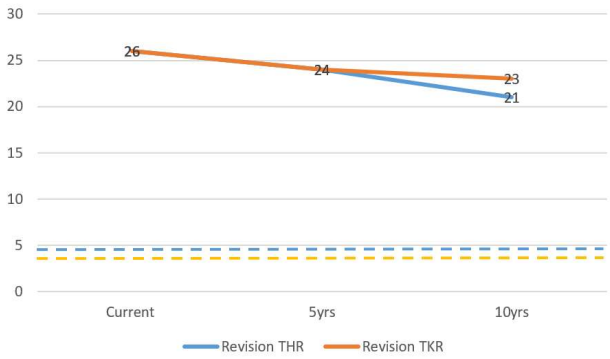


*Fig.23. Left – Revision hip (blue) and knee (red) surgeons in Wales Right – horizon scan. Minimum Revision THR (blue dash) and TKR (orange dash) surgeons required nationally. *see methodology for assumptions.*

6.4.2 Partial knee arthroplasty/Unicondylar and Patello-femoral joint replacement

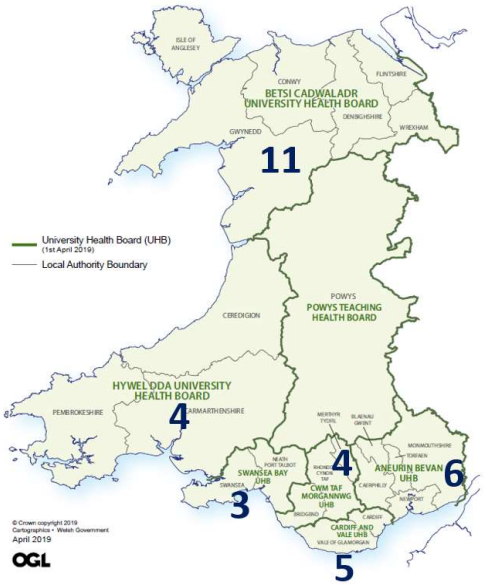


Fig.24. UKR surgeons in Wales by HB

Partial knee replacement surgery is more aligned with soft tissue knee surgery in terms of performing surgeon skill set and associated procedure bundle. UKR and PFJR also lend themselves to same day admission and discharge albeit via a traditional inpatient model rather than via day surgery network. Volumes of both UKR and PFJR show regional variation in terms of annual additions; approximately 1100 are added per annum nationally, with almost half added in AB but only 16% from HD, SBU and BCU combined. This suggests fewer surgeons in these health boards who consider these procedures as reasonable options for their patient cohort; this may be related to difference in surgical training history and philosophy, and also patient demographics. The evidence base for the benefit of these procedures is growing and irrespective of lower volumes in these regions currently, the likely volumes will increase. The knee CRG recommend that partial knee replacement should be concentrated to ensure minimum volumes and sustainable practice. Based on demand data, there is enough volume to sustain these services

in a reduced number of surgeons in each health board via local networks. This should be further co-ordinated by the NKCRG through the W.O.N as outlined in NCSOS report 2e and section 7 below. Whilst the clinical networks should remain local, the delivery of these procedures do lend themselves to being provided through HVLC principles which in turn may be delivered in regional centres in line with primary arthroplasty discussed above.

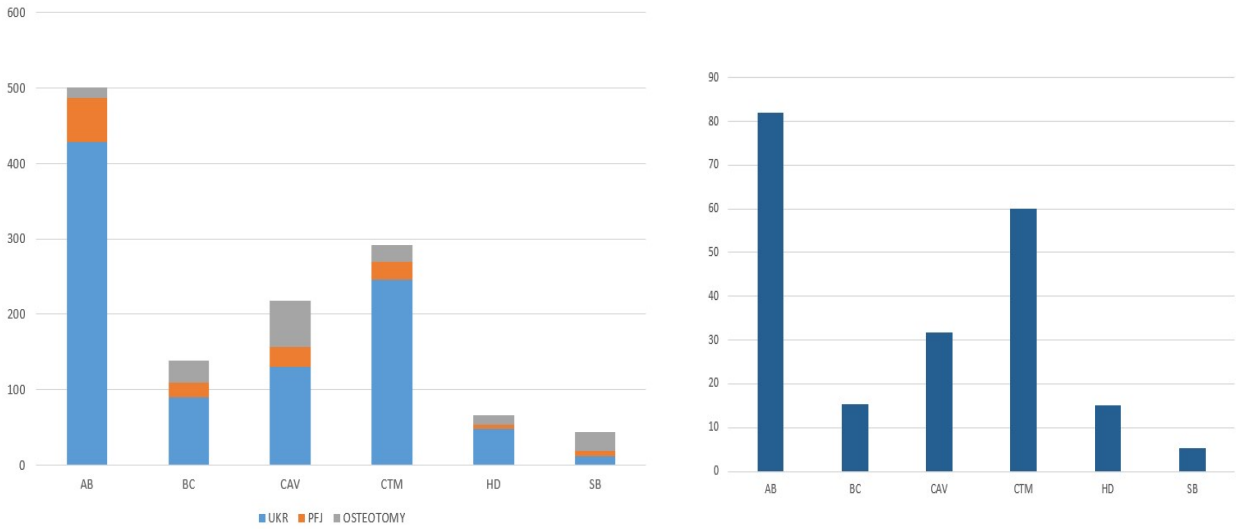


Fig. 25. Left – Knee joint preservation procedures by HB. Right: UKR/PFJ per 100,000 population.

Same day arthroplasty - An increasing number of arthroplasty cases can be delivered on the basis of same day discharge i.e. day case arthroplasty. These cases require the same support mechanisms as overnight stay arthroplasty and should be undertaken via similar pathways; day case units do not have the necessary interdependencies or facilities. Whilst Wales is some way behind England in same day discharge, small numbers of units have undertaken modest numbers of day case arthroplasty and the volumes will increase rapidly as units adapt to the needs of a rapid orthopaedic recovery and increased bed utilisation. High rates of day case arthroplasty can only be achieved with as many local HVLC hubs and units as possible so that travel times to the unit are minimised, a crucial enabler of day case arthroplasty; the fewer number of hubs, the fewer patients will be eligible for day case arthroplasty. This must be considered when appraising options for the long term blueprint.

6.4.3 Non Arthroplasty Knee Surgery

Knee surgery is a broad range of pathways and procedures. The majority of remaining pathways have potential to be provided on a daycase basis (see fig. 28) In line with "*A Healthier Wales*", we recommend most daycase knee surgeries be provided as local to the patient as possible through a network of orthopaedic daycase provider units; there is no reason to "over centralise" the majority of day case knee surgery. Most of these are high volume, relatively low infrastructure

requirements (e.g. knee arthroscopy, meniscal repairs, primary ACL reconstruction) with a sustainable local workforce. The infrastructure required to provide these pathways is not complex and has economies of scale with other arthroscopic and daycase orthopaedic surgeries, again supporting more local models of care.

Procedure	Complexity	Bed specification	Demand	Backlog	Theatre Time demand (mins)
Arthroscopy	unspecialised	Daycase	4058	2173	250,378
Meniscal repair	specialised	Daycase	224	286	15,568
Primary ACL	unspecialised	Daycase	879	627	104,601
Revision and complex soft tissue	specialised	Inpatient	98	71	17,640
Osteotomy	specialised	Inpatient	162	204	30,294
PF dysfunction	specialised	Inpatient	255	179	30,855
Novel Grafts	specialised	Daycase	25	6	3000

Fig. 28 non-arthroplasty knee surgery procedures

Similar to shoulder and elbow surgery, there are some treatment pathways which are more complex despite being predominantly daycase delivered. Some of these pathways can be delivered across the entire network as volumes support a multi surgeon practice and the interdependencies are similar to routine day case knee surgery e.g. revision ACL surgery.

However, there are some day case procedures that necessitate greater centralisation to concentrate practice and maintain volumes e.g. complex multi-ligament reconstruction; this should be determined by the NKCRG within the W.O.N.

Osteotomy surgery is more aligned with soft tissue and partial knee replacement surgery in terms of performing surgeon skill set and associated procedure bundle. Volumes are generally lower than for partial knee replacement, but the patient cohort demonstrates similar demographics. There is regional variation demonstrated with lower volumes in AB, suggesting more osteotomy suitable patients listed for UKR in this HB. The knee CRG recommend that osteotomy should be concentrated to ensure minimum volumes and sustainable practice. Volume of additions support a health board based model that does not require regionalisation, with practice concentrated in 2-3 surgeons in each health board.

Complex surgery for patella-femoral dysfunction is more aligned with soft tissue knee surgical skill sets and similar arrangements as per osteotomy and partial knee replacement. i.e. health board based pathway with concentrated practice amongst 1-2 surgeons per health board. Regionalisation is not required. The only sub group is those patients requiring trochleoplasty, where volumes of additions and backlog is very low. The knee CRG recommend that this should be concentrated on a supra-regional basis to two surgeons for the purposes of sustainability.

6.4.4 Hip Preservation Surgery

Hip preservation surgery (young adult hip surgery) is a fairly new and growing subspecialty. Consequently, there are few surgeons that subspecialise. There is also uncertainty regarding true patient need due to immature front-end pathways. The surgeries are therefore low volume and some are very complex i.e. Peri-acetabular osteotomies. There are currently three surgeons in SBU, and 2 each in CAV and AB in South Wales who practice varying degrees of hip preservation. There are also 2 declaring an interest in CTM although there are nil such procedures on the backlog or demand for this HB (fig. 26). In North Wales there are 2 surgeons who perform hip arthroscopies and work that is more complex is transferred to Oswestry.

The balance of hip arthroscopy demand to surgical skill set is sustainable at present (fig 26), except in CTM where there is nil volume to maintain a hip preservation service. It is recommended that the existing arrangement for this procedure and pathway being delivered through a team of two surgeons in NW, two in SB, two in CAV and two in AB is appropriate and that it is maintained. However, in the circumstance of retirement such as with one hip arthroscopist in AB within 5 years, this should be bolstered through networking with CAV; rather than specific local level recruitments targeting this subspecialty as this would not be best use of resource based on current demand and horizon scanning (fig. 26). However, if through the networked approach and horizon scanning it becomes clear that there is a growing population need for this subspecialty, workforce and unit expansion can be considered in a regional and national context, governed by an overarching W.O.N and NHCRG.

HB	Demand (per annum)	Backlog	No. Surgeons
AB	33	26	2
BC	38	22	2
CAV	58	36	2
CTM	0	0	2
HD	0	0	0
SB	35	65	2

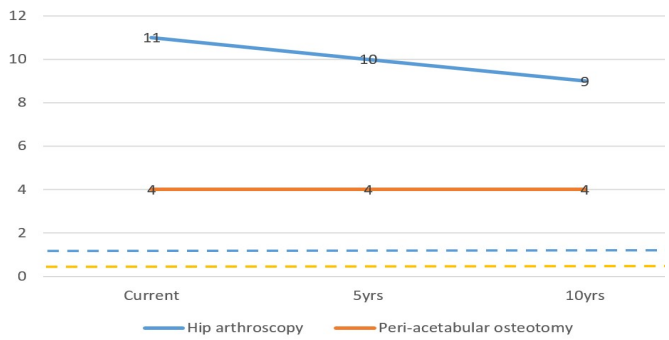


Fig.26. Left - Hip preservation demand, backlog and consultant surgeon establishment. Right – Horizon scanning.

The majority of hip preservation surgery is arthroscopic intervention. However, CAV also provide a much lower volume highly complex, peri-acetabular osteotomy service. This is the only unit in Wales that provides this. It is recommended that CAV is developed as the supra-regional centre for this service for South Wales. The low volume service in SW could become more sustainable by repatriating work from RJAH Oswestry. However the NHCRG should consider whether it should

continue its collaboration with RJAH, or commission the work from CAV. The latter option will sustain NHSW services from within, although may have a detrimental effect on patient journey and experience considering isochrones analysis (an example is provided below (fig. 27). An option appraisal must be clinically led and developed through the NHCRG within the W.O.N. Based on current volumes of demand, other units should not develop this service in Wales, however, the single surgeon providing this service in CAV must be supported by another surgeon from within the network. The NCSOS Hip preservation CRG have agreed on the two surgeons to provide this service in SW through a partnership between SB and CAV.

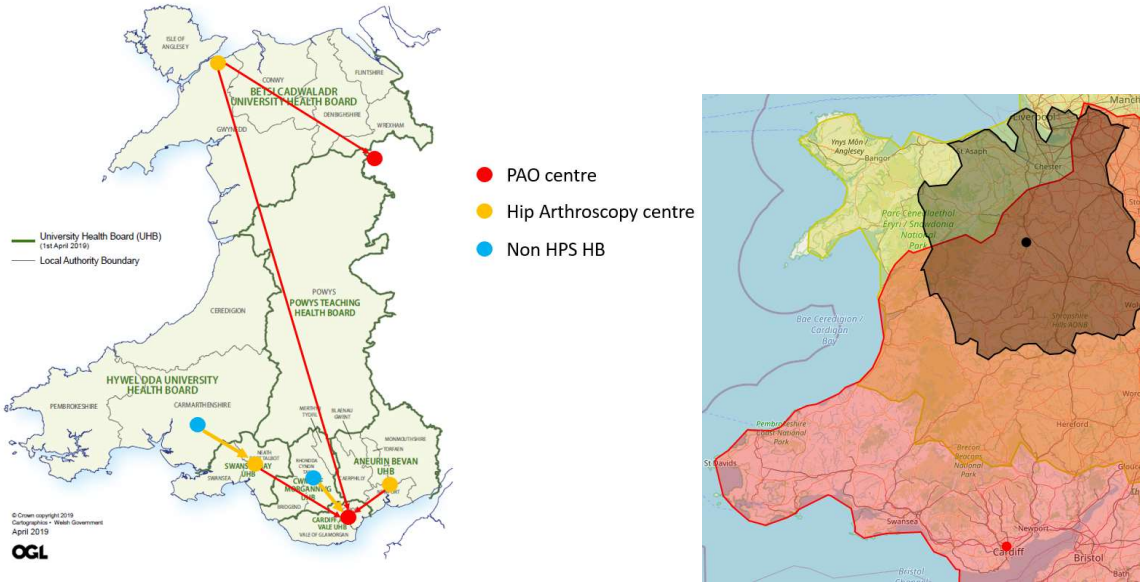


Fig. 27. Proposed National HPS network (left) and isochrones between UHL (3 hour – red) and RJAH (1 hour – black, 2 hour –green)

6.5 Foot & Ankle Surgery

Surgery for conditions relating to the Foot and Ankle are varied. The subspecialty as a whole is the lowest volume for all Orthopaedics within the scope of the NCSOS. However, within this are multiple pathways of varying complexity, approximately 80% are daycase (fig 29).

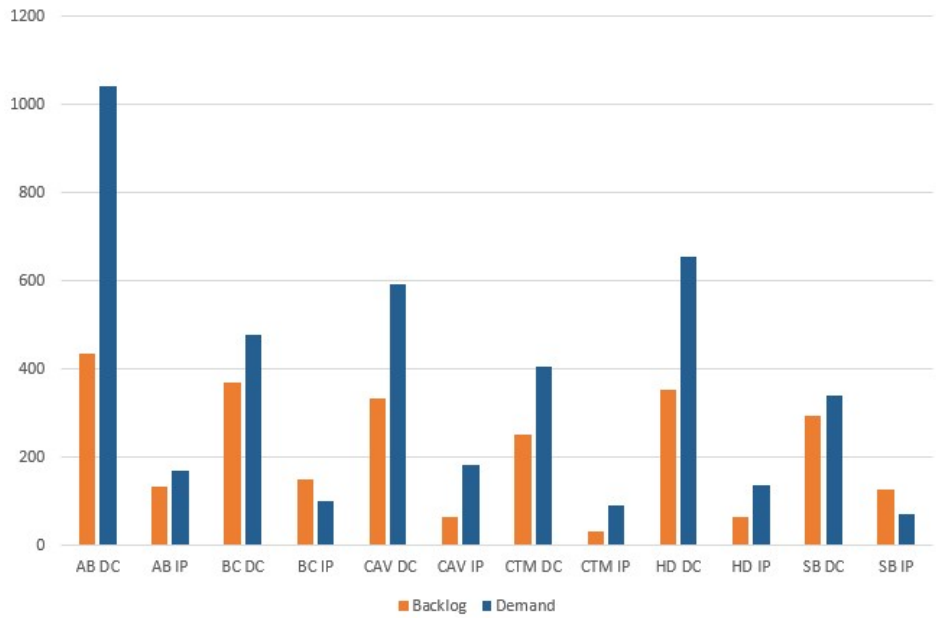


Fig. 29 Daycase/ Inpatient by backlog and demand per HB.

Just under 4300 patients are added to the Foot & Ankle waiting list every year, with 2600 currently in the queue. To reduce the daycase backlog by 50% with the 10% above demand FIFO model will take just under three years but only 22 weeks to reduce the surgical queue to a 26-week wait (fig.30).

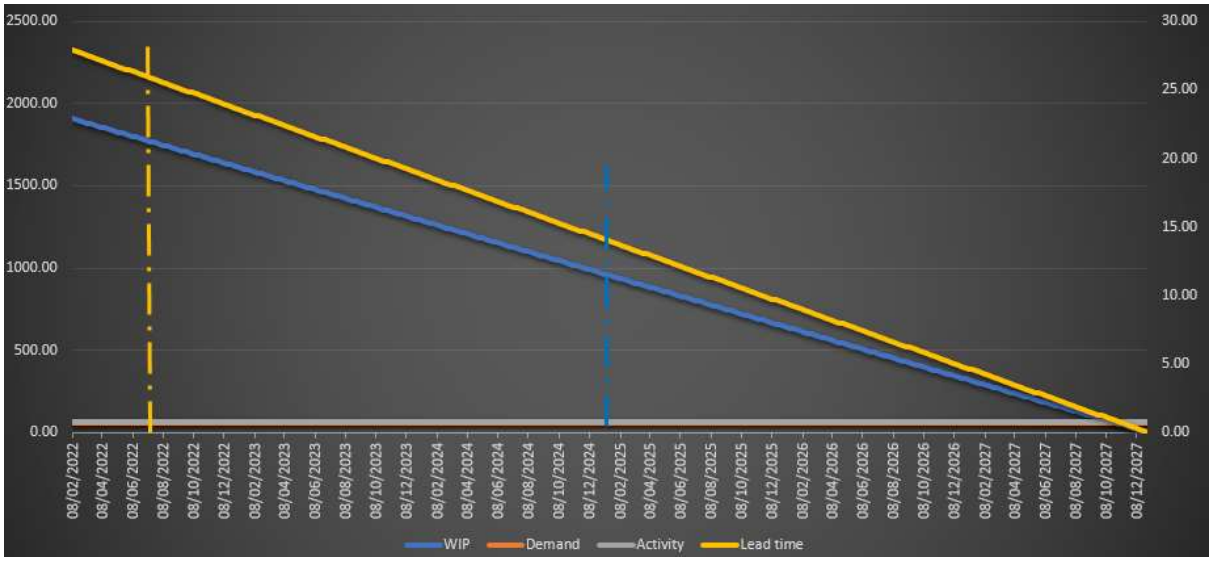


Fig. 30 - Daycase Foot & Ankle 10% model.

To deliver this will require the consultant workforce as outlined below (fig. 31) working across 13 daycase and 7 inpatient all day theatres per week in SW, and two daycase and one inpatient list per week in NW. This will require regional workforce models especially when considering than a number of Foot & Ankle surgeons have job plans mixed with paediatric orthopaedics.

HB	F & A Consultants (n) current	F & A consultants required*		
		With 2 session lists	With 2.6 session lists	10% additional activity over demand
AB	4	7	4.9	5.2
BC	6	3.5	2.4	2.6
CAV	5	5	3.5	3.7
CTM	3	3	2.1	2.2
HD	2	4.7	3.3	3.5
SB	4	2.5	1.7	1.8

Fig. 31- F & A workforce requirements / Weekly theatre requirements for Foot & Ankle comparing 0% and 10% model.

In line with "*A Healthier Wales*", we recommend most daycase foot and ankle surgeries be provided as local to the patient as possible through a network of orthopaedic daycase provider units; there is no reason to "over centralise" the majority of day case foot and ankle surgery. Due to the multiple low volume procedure pathways that comprise foot & ankle surgery, care must be taken not to over regionalise elements of this subspecialty. It may cause an unintended effect of destabilising otherwise well-functioning units. The infrastructure required to provide these pathways is not complex and has economies of scale with other arthroscopic and daycase Orthopaedic surgeries, again supporting more local models of care.

The workforce for unspecialised foot and ankle surgery is sustainable although there are some fragilities in HD and AB which should be managed through a workforce regional approach and mutual assistance agreements between SB and HD, and AB and CAV. This is preferential to unnecessary recruitment. In terms of low volume specialised surgery, the main consideration is the evolution of end stage ankle arthritis pathway and Total Ankle Replacement (TAR) networks. This is discussed further in the NCSOS report 2f. This is to be delivered through a single TAR surgeon per HB approach, which is currently a sustainable model, however regional alliances should be developed via a NFACRG and W.O.N for sustainability, pathway development and sharing best practice. CTM does not have any TAR surgeons and must formalise regional alliances with neighbouring HBs for this pathway immediately, if not already established. There may be the need to consider reducing the number of TAR provider centres according to advice from NFACRG as the networks mature.

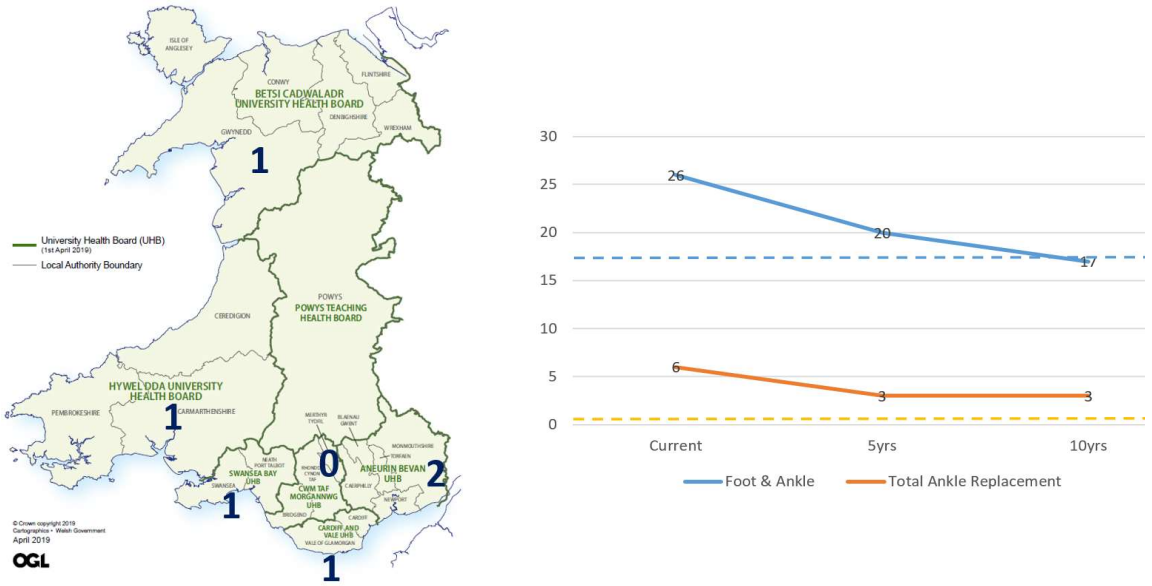


Fig. 32. Left – distribution of Total Ankle "replacers" in Wales. Right – Horizon scanning with minimum surgeon establishment for total Foot & Ankle (blue dash) and TAR surgeons (orange dash).

Highly specialised procedures such as MACI are very low volume and should be commissioned through IPFR. The sub-specialty CRG does not see any value in developing this service in Wales in the near future.

Treatment pathways for lower limb reconstruction post trauma and to address severe foot and ankle deformity are fragmented with no single provider within Wales able to consistently provide the service. Consequently, patients are often referred outside Wales for this treatment. The inception of the orthoplastics service in Morriston hospital and the interdependent skills required to provide this service are well aligned to the provision of a formal lower limb and foot and ankle reconstruction service. A formally commissioned service is required for Wales to provide the necessary treatment pathways within NHSW with the only site with the necessary skills and interdependencies being Morriston hospital/SBU.

7 The Surgical Blueprint – An Integrated Regional and cross subspecialty model of care and surgical delivery

The delivery of sustainable and high quality elective orthopaedic surgery cannot derogate from 3 key principles:

- Separation of elective planned care from unscheduled care for HVLC and LVHC.
- Separation of day case surgery from in patient surgery.
- Adoption of HVLC principles in both day case and inpatient surgery.

Any Proposed model must be able to achieve the above to be worthy of serious consideration and progression to a detailed options appraisal.

7.1 Daycase Delivery Networks

46% of the Orthopaedic backlog and 57% of all orthopaedic demand should be daycase procedures, even if current infrastructure and pathways manage as inpatients. Of these, 90% are unspecialised and should be delivered locally. Standardisation of clinical pathways through national implementation of the NCSOS reports 2a-f will promote good practice and reduce variation, all in line with the design principles of "*A Healthier Wales*"[4].

The required capital and human resource infrastructure is non-complex and sustainable throughout Wales. It also has significant environmental sustainability benefits through reduction in travel for the 14,000 daycase patients on the inpatient waiting and the 24,000 further daycase patients who are added to this backlog every year[6,7]. Of the latter group, over 8,000 are listed for local anaesthetic procedures that may take less than 10 - 20 minutes to perform. This patient cohort should not be required to travel vast distances.

It is recommended that an orthopaedic daycase network is formalised and performance monitored by an overarching Welsh Orthopaedic Network. Based on the integrated subspecialty demand and capacity modelling (fig.42) no major capital development is required beyond enhancing existing estate and/ or what is already accounted for in some health board plans. There will be certain specialised, more complex, lower volume daycase pathways and procedures, which will align to certain daycase units due to co-location, proximity to consultants and services with specialised competencies.

7.1.2 Aneurin Bevan Daycase Model

In AB (fig. 33) there are ten theatres that can be utilised for day surgery, but when considering laminar flow specification and the utilization of other specialities, only five at most have potential to deliver orthopaedic care sustainably.

HB	Unit	Daycase theatres	Laminar flow	Cold site
AB	Royal Gwent	1	0	Y
	St. Woolos	2	2	Y
	YYF	3	2	Y
	Neville Hall	4	1	Y
	The Grange	0		N

Fig 33. Facilities in AB that have potential to contribute to a National Orthopaedic daycase delivery network.

To meet its health board population day surgery demand, AB needs to provide 38 sessions per week to the array of subspecialists. This requires the number of theatres as illustrated in (fig. 41). This is achievable through a combination of four theatres within SW, NH and YYF. Which combination is used should be decided locally within the health board context, provided these minimum sessions are met. Monitoring health board performance metrics such as this will form the core work of the operational delivery arm of the W.O.N.

7.1.3 Betsi Cadwaladr Daycase Model

All the current DGHs and cold elective (Abergele) sites in BC have potential to provide elective orthopaedic daycase surgery (fig.34). All have a reasonable number of laminar flow theatres, which meet demand, even for the 10% above demand model. It should be noted that apart from the three in YG, they are all shared inpatient and daycase theatres and therefore will have competing pressures. If, however a standalone cold site is developed to unify the three orthopaedic departments inpatient activity onto one site, this will increase capacity in the local hospitals and ability to contribute to the daycase orthopaedic delivery network. The intended RTCs and/or Abergele may have important roles in unlocking great potential and the opportunity to transform daycase and inpatient elective orthopaedic services in NW as discussed below.

HB	Unit	Daycase theatres	Laminar flow?	Cold site
BC	W	4	4	N
	YGC	4	4	N
	A	2	2	Y
	YG	3	3	N
	RTC 1	?	?	Y
	RTC 2	?	?	Y

Fig 34. Facilities in BC that have potential to contribute to a National Orthopaedic daycase delivery network

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7.1.4 Cardiff and Vale Daycase Model

CAV only realistically have one site which can contribute to a daycase network. However, UHL and the attached CAVOC have between them seven daycase theatres of which four are laminar flow. This easily surpasses CAVs needs for its local waiting list (which may include regional work due to the specialised nature of some of the work CAV provides in particular for CTM). There is plenty of scope for UHL/ CAVOC to provide mutual aid in the short term (fig.41). In the medium to longer term it should form regional alliances developed clinically through the national CRGs and co-ordinated by the W.O.N, which will have an operational and strategic overview of

HB	Unit	Daycase theatres	Laminar flow?	Cold site
CAV	UHL/ CAVOC	7	4	Y
	UHW	0	n/a	N
	Noahs Arc	1	1	N

Fig 35. Facilities in CAV that have potential to contribute to a National Orthopaedic daycase delivery network.

where and how capacity is best utilised on behalf of regional rather than health board populations.

7.1.5 Cwm Taf Morgannwg Daycase Model

CTM has two daycase units attached to the acute sites of the North and East of the health board. Only one in the North is laminar flow. There is no DSU capacity in mid CTM (fig.36). This leaves the health board unable to provide the required capacity to deliver orthopaedic day surgery. However, as outlined above and below, there is potential day theatre capacity in UHL/CAVOC and NPTH. It is recommended that CTM collaborate with CAV and SB to develop long-term arrangements to enable CTM consultants and theatre teams to operate out of these sites and create regional daycase hubs as part of the wider daycase delivery network. This would be preferential to developing additional daycase orthopaedic capacity within CTM unnecessarily. There would need to be central control to ensure these regional modes of working are sustained for the benefit of the wider population. The W.O.N and proposed daily sitrep(Annex9) with operational oversight of the day-to-day running of these units and associated patient flows would provide this (see section 8).

HB	Unit	Daycase theatres	Laminar flow	Cold site
CTM	PCH	2	1	N
	RGH	0	n/a	N
	POW	2	0	N

Fig 36. Facilities in CTM that have potential to contribute to a National Orthopaedic daycase delivery network

7.1.6 Hywel Dda Daycase Model

Due to the population being spread over a large geographical area, often with poor travel links, it is vital that HD has a robust daycase delivery network in place. Fortunately, it has capacity to do so with sufficient daycase capacity on all four sites by way of recent reconfiguration of inpatient delivery and existing daycase units. Of these there are four laminar flow theatres across three of these sites. WGH can serve the population of Pembrokeshire, BGH likewise for Ceredigion and PPH for Carmarthenshire (fig.37). However, within this HB "arm" of the daycase delivery network, there will need to be some movement of patients through the overlaying subspecialty networks as outlined in the sections above and subspecialty reports 2b-f, to provide for the more specialised procedures e.g. specialised daycase knee and shoulder surgery.

HB	Unit	Daycase theatres	Laminar flow	Cold site
HD	WGH	3	1	N
	BGH	1	1	N
	GGH	1	0	N
	PPH	2	2	N

Fig 37. Facilities in HD that have potential to contribute to a National Orthopaedic daycase delivery network.

7.1.7 Swansea Bay Daycase Model

HB	Unit	Daycase theatres	Laminar flow?	Cold site
SB	NPT	2 (+2)	0 (+2)	Y
	SGH	2	0	Y
	MDU	0	n/a	N

Fig 38. Facilities in SB that have potential to contribute to a National Orthopaedic daycase delivery network.

SB has no dedicated laminar flow daycase capacity at present although the two laminar flow theatres in NPTH are used for day surgery as required. The two theatres in the dedicated day unit in SGH are utilised for a combination of elective and trauma orthopaedic and plastics hand surgery; and ophthalmology (fig.32). However, this day unit is being developed into a regional eye centre. This is offset by the parallel development of NPTH into an elective orthopaedic unit, with plans to create an 8-theatre suite with five being laminar flow, estimated completion by March 2023. The health board vision is for these theatres to be increasingly utilised for parallel streams of daycase and inpatients. This will likely create opportunity for regional working with CTM as discussed above.

7.1.8 Powys Daycase Model

HB	Unit	Daycase theatres	Laminar flow	Cold site
P	BWM	1	1	Y
	LWMH	1	1	Y

Fig 39. Facilities in PTHB that have potential to contribute to a National Orthopaedic daycase delivery network.

Powys currently has laminar flow day surgery facilities in Brecon and Llandrindod Wells with services provided via an in-reach model (fig. 39). Fragilities in core theatre staff and limitations on in reach provision mean these sessions are currently under-utilised. Powys is also developing plans for a health care hub with co-located day surgical hub in the North of Powys (Newtown). All these sites could provide capacity not only for Powys patients to be repatriated from English providers, but also capacity for adjacent HB's within a national day case network.

Powys	Sessions required (repat from NHSE) per week	
	DC	IP
S & E	1.5	0.5
H & W	1.85	0.04
Hip	0.02	3.3
Knee	1.3	3.8
F & A	1.6	0.6
Total	6.27	8.84

Fig 40. Sessions of NHSE commissioned Powys surgical activity for potential repatriation

The only Powys data available is activity rather than demand. However, using this as a crude surrogate, the required capacity to deliver the same activity as NHSE approximates to x3 all day 2 session lists per week. The majority of this activity is unspecialised and could be managed locally in Powys with appropriate pathway management. The alternative would be to repatriate to neighbouring NHSW HBs.

7.2 Daycase network summary

What is described is a feasible, sustainable orthopaedic daycase delivery network in terms of locations, theatre capacity and unspecialised and specialised consultant workforce. It does not require massive capital outlay. However, in rural units there is the issue of case-mix, which can lead to poor efficiency. This can be resolved by smart scheduling.

The key enabler to successful implementation is health board collaboration, to ensure the network functions across and within health board boundaries (especially those with multiple units, to avoid silo working); then regionally through an alliance. This will most effectively be managed through the proposed W.O.N. (see section 9).

HB	Meet demand (0%)				10% Above			
	Weekly sessions		Number of theatres per day		Weekly sessions		Number of theatres per day	
			2 session	2.6 session			2 session	2.6 session
AB	38	29	3.8	2.9	42	32	4.2	3.2
BC	26	20	2.6	2	30	22	2.9	2.2
CAV	29	22	2.9	2.2	32	24	3.2	2.5
CTM	27	21	2.7	2	30	23	3	2.3
HD	16	12	1.6	1.2	18	13	1.8	1.4
SB	17	13	1.7	1.3	19	16	1.9	1.5
NW	26	20	2.6	2	30	22	2.9	2.2
SW	127	97	12.7	9.6	141	108	14.1	10.9

Table 41. Daycase sessional requirements in each HB and supra-regionally.

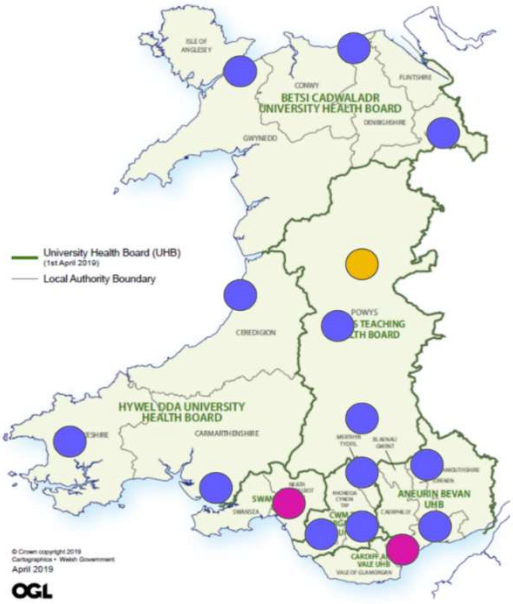

Fig 42 Proposed National Daycase Delivery Network (Blue HB based, yellow intended, pink regional remit)

7.3 Inpatient Elective Delivery Models

The delivery of inpatient Orthopaedic surgery can be planned in five broad ways –

1. ***Revert to Pre-Pandemic.***
2. ***Do minimum***. Use existing infrastructure differently.
3. ***Intermediate - hybrid.*** HVLC centres. LVHC regional alliances on existing acute sites.
   a. HB based
   b. Regional based.
4. ***Intermediate - full.*** Regional orthopaedic hubs for HVLC and LVHC.
   a. Co-located to existing acute site for interdependencies.
   b. Distant to acute site. Consultant intensivist led and delivered interdependency service (SWLEOC model).
5. ***Do maximum.*** Supra-regional orthopaedic hospitals.

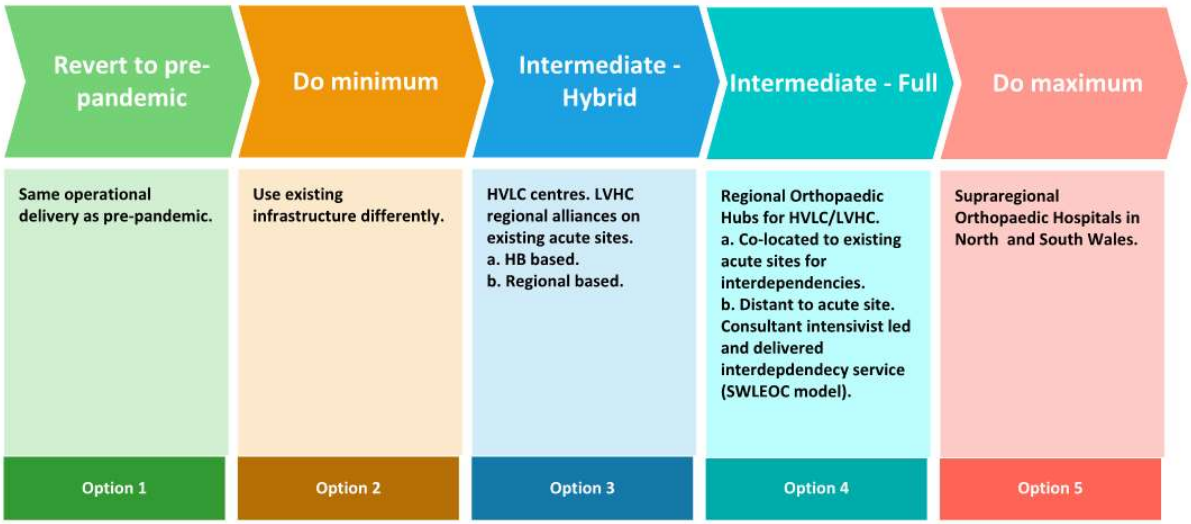

Fig. 43 Elective Orthopaedic inpatient delivery models

7.3.1 Revert to Pre-Pandemic

Reverting to orthopaedic surgery being provided over 21 sites in Wales, of which 10 are acute sites, is not an option. Patients will continue to come to harm. Demand will continue to outstrip capacity. Orthopaedic capacity will continue to be deprioritised in favour of unscheduled care, trauma and cancer demands. Furthermore, if this option is chosen, there is a real risk of disfranchising all of the orthopaedic surgeons in Wales and whole system collapse. This will impact on primary and social care resulting in a public health crisis. This option does not allow the 3 key principles and cannot be considered.

7.3.2 Do minimal - Use existing infrastructure differently

For this option to be appropriate, the estate utilised will have to provide ring-fenced capacity, physically separated from an acute site with unscheduled care pressures. Fig. 44 illustrates the orthopaedic theatre capacity in Wales. For example, to meet demand at health board level, assuming 5/7 two session day working, BCU will need to provide a minimum of 8 sessions/ 4 theatres of orthopaedic inpatient theatre capacity (HVLC and LVHC, 0% model) and associated bed base, **per day,** to keep the waiting list stable. This is assuming a maximally utilised theatre with one patient entering the anaesthetic room the moment the previous patient enters recovery. BCU only have two cold site laminar flow theatres (Abergele) and therefore cannot support this model. With six day working the requirements are still in excess of capacity. With disaggregation of the LVHC demand (which could be provided on an acute site), again, the HVLC capacity is still inadequate. Further capital builds will need to be developed (see below) or the model will need to revert to "business as usual" with use of acute site theatres. This latter circumstance will likely result in the "same problems as usual", continued system failures and be of no long-term benefit to patients.

HB		Unit	Laminar flow Ortho theatres	HVLC/ LVHC	Cold site
AB		Royal Gwent	4	HVLC	Y
		SW	2	HVLC	Y
		YYF	1	HVLC	Y
		NH	1	HVLC	Y
BC		A	2	HVLC	Y
		RTC 1	?	?	Y
		RTC 2	?	?	Y
CAV		UHL	7	HVLC/ LVHC	?AMAU?
CTM		-	-	-	-
HD		PPH	2	HVLC/ LVHC	AMAU
SB		NPT	2 (3 further March 2023)	HVLC	Y

Fig. 44. All potential cold site inpatient theatres in existing infrastructure in Wales.

In South Wales, the feasibility of this option is slightly more open to discussion. There are currently 19 theatres over 7 sites (4 in AB) in SW that fit this specification if you include the Royal Gwent where the longer term plan is unclear. For HVLC, at HB level only AB and CAV have enough theatres to deliver this for their population. However, the capacity in AB is split across four dated sites. CTM have no internal cold site capacity. HD & SB have 80% of required capacity but both have plans already in place to increase this in PPH and NPTH respectively. When these are operational, only CTM should require HVLC "mutual aid" and use of other health board

HB	Unit	Theatres competing for daycase and inpatient models *i.e. cannot been factored both models.*
AB	SW, YYF, NH	4
BC	A, RTC 1, RTC 2	A – 2, RTCs - ?
CAV	CAVOC	4
SB	NPT	2

Fig 45. Theatres that cannot be factored into daycase and option 2 inpatient models.

HVLC sites. This is working on a very large assumption that this theatre capacity is ring fenced for inpatient orthopaedic surgery alone. Even so, health board level silo working has implications on staffing, workforce, economies of scale and variation in practice potentially leading to poorer outcomes. This is not conducive to HVLC or centre of excellence philosophies. This is already being experienced in AB who cannot staff their four theatre sites.

The most important obstacle to this model however, is the that the majority of existing infrastructure that it is based on, will also be required for the daycase delivery network described above. Both delivery models cannot co-exist (fig. 41/42), therefore, new capacity will have to be built.

Once more, this option does not adhere to the 3 key principles without considerable investment and changes to pathways.

7.3.3 Intermediate, hybrid – Combination of regional HVLC Orthopaedic centres and existing infrastructure for LVHC

To provide sustainable, high quality, high throughput inpatient orthopaedic care, the infrastructure must be separated from acute medical and surgical care i.e. cold elective orthopaedic sites. There is no debate to this point. **The two previous options are compromises to this.** The conundrum will always be, how to segregate from other specialities, yet still maintain the ability to deliver care for the maximal range of pathway and procedure complexity when considering the necessary interdependencies required.

An intermediate, pragmatic option is to develop **HVLC orthopaedic centres**, supplemented by existing acute site capacity for LVHC patients. The options for the LVHC units and discussion points around this are the same as outlined below. For completeness, health board and regional based models are considered.

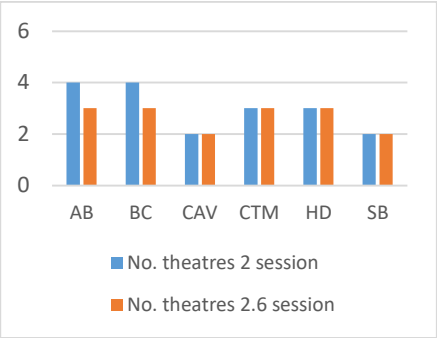

Fig 46. HB HVLC Model

With the local model, six new build HVLC centres would be developed in every HB except Powys (fig.46). With exception of BCU and possibly AB, none of the HBs has a demand that requires a centre larger than three theatres with 2.6 session day working and assuming efficient theatre delivery. If day surgery was bolstered on, this would increase the size and economies of scale with infrastructural costs human resource and equipment, but would compromise the local care

aspect of the daycase delivery network. This model does not make economical or clinical sense.

Therefore, it is recommended that any proposed HVLC centre must serve to a wider population than a health board boundary. This would justify a larger footprint new build that would achieve economies of scale in particular for the workforce, and reduce variation by developing high throughput, high quality and efficient pathways.

There is no debate that any proposed delivery models must consider the geographical challenges and distinctions between NW and SW. HVLC centres must be developed in both (fig.47). It is recommended that the demand in NW aligns to one HVLC centre of excellence. A 5-theatre complex, running 5/7 with 2 session days would cater for demand and reduce backlog as per the 10% over demand model discussed in the subspecialty sections above. This would leave scope to repatriate NHSE commissioned inpatient activity from Powys (fig.40) depending on the location of the patient and increase to 2.6 session days and reduce the backlog with pace. For primary THR and TKRs anywhere between 19 to 41 beds will be required depending on which % model of delivery and length of stay (see fig. 54). This size unit should be feasible to staff to a high specification as it will be drawing from all the hospitals across the A55 and will hopefully attract talent and enthusiasm from outside the existing system.

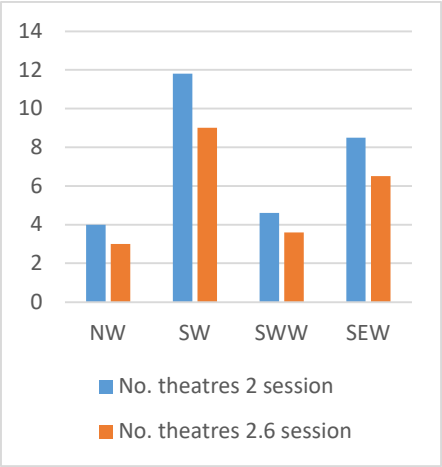

Fig. 47. *Regional HVLC model theatre requirements*

Three further HVLC centres of slightly larger size to that in NW Wales are recommended for SW. These will require 5 theatres per centre, although with 2.6 session and 6 day working this number could be reduced or utilised for over performance. The bed requirements are also larger per hub compared with NW (fig. 54). The SWW geographical spread and population necessitates a regional partnership between SB and HD to maintain volumes and form delivery and clinical networks that align (see NCSOS reports 2a-f and above sections). The population density, volume and consequent clinical demand is greater in SEW. There are also existing clinical networks that exist and those that need to be developed in line with the NCSOS recommendations, between CTM, CAV and AB. Delivery must align, therefore two SEW centres are recommended within this model. The only caveat being that the west of CTM may need specific consideration and be included in the delivery network of SWW. This will be more accurately managed prospectively as

the overlaying clinical and delivery networks evolve, under the direction of the W.O.N.

All of these centres should be underpinned by a partnership and memorandum of understanding between the health boards of SW. While the centres naturally align with their surrounding populations, it is recommended that the three centres can be accessed by all HBs. This will encourage a healthy competitive process between the centres and cultivate a culture of improvement, quality and efficiency. This will have to be enabled by alterations to how orthopaedic surgery is commissioned and contracted in Wales.

These proposals provide an opportunity to create centres of excellence. Dedicated staffing and protected from emergency pressures will improve recruitment and retention of all staff groups but particularly theatre staff which is especially fragile across Wales. Furthermore, it provides an environment in which to implement best practice, subsequently achieving the best patient outcomes.

Due to the nature of HVLC, the sites chosen for the new builds do not need to be constrained to be near acute sites. The key geographical priority is that the HVLC centres are accessible to all patients and deliverable. The main enabler to the latter is workforce. **It must be noted the presented options are for discussion, other options may be considered, based on access to land banks etc. – which was not part of this project scope.**

In SWW the HVLC centre preliminary options are

- NPTH development
- PPH development
- HD new build at St Clears
- New build new site (example here being Nr. Cross Hands)

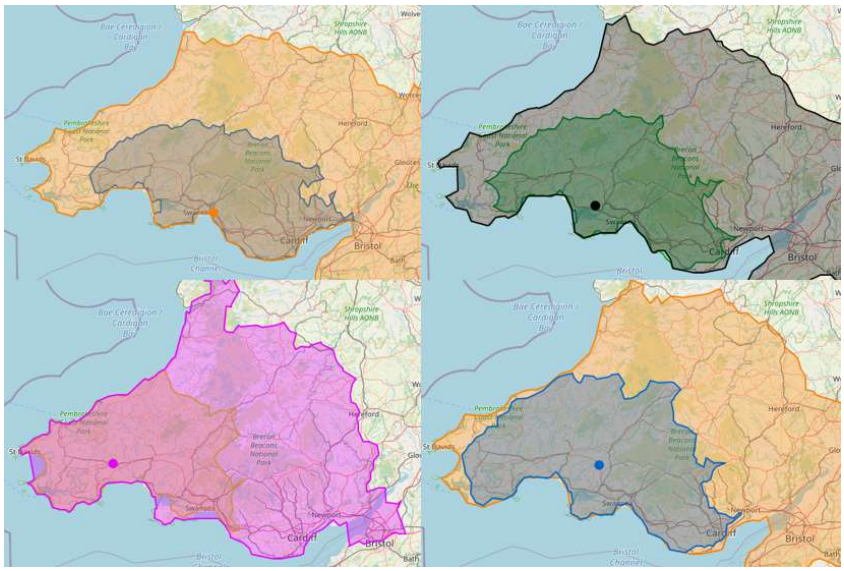

Fig.48. 1 & 2 hour isochrones for NPT (top left), PPH (top right) and proposed new hospital site HDda Nr. St Clears (bottom left) and hypothetical Nr. Cross Hands A48 (bottom right).

Fig, 48 illustrates the isochronal overlay of these units. The 1-hour isochrones of PPH and NPTH are fairly similar. Both easily reached beyond CTM west with NPTH extending the 1 hour isochrone to the Severn bridge. To the west, PPH is almost exactly one hour from Haverfordwest. NPTH extends to Narberth. Neither cover a

significant proportion of Pembrokeshire or Ceredigion in one hour but both span these areas and beyond Aberystwyth within two hours. The proposed HD new hospital "somewhere between St. Clears and Narberth" covers all of Pembrokeshire and Southern Ceredigion within 1 hour but at a cost of not reaching as far as CTM. However, in two hours all the hospitals can reach beyond the border.

In SEW the HVLC centre preliminary options are x2 of the following:

- Royal Glamorgan development
- Grange new build development
- New build new sites

During the GIRFT deep dives there were discussions of new build developments being proposed in the Royal Glamorgan (plans from the mid-2010s) and very early intentions of AB to develop an elective centre on the Grange site. There are also elective surgical reconfiguration plans for UHL. Further hypothetical sites based on ease of access to staff from all contributing existing orthopaedic units and access for AB, CAV & CTM patients, have also been reviewed. The most accessible near Junction 32 M4 is also illustrated (Fig. 49) with isochronal overlays. Due to the more densely populated area in SEW, 30 minutes and one hour isochrones have been used. All four demonstrated options are viable for the patient population of all three HBs who have travel times within one hour. The key determinant will be staffing. The centres must be located to ensure ease of access for all staff groups. The 30 minute isochrones would suggest to maximise staffing population spread, a north east and south west option should be chosen. E.g., Northern AB based site combined with Llantrisant/ Bridgend based site.

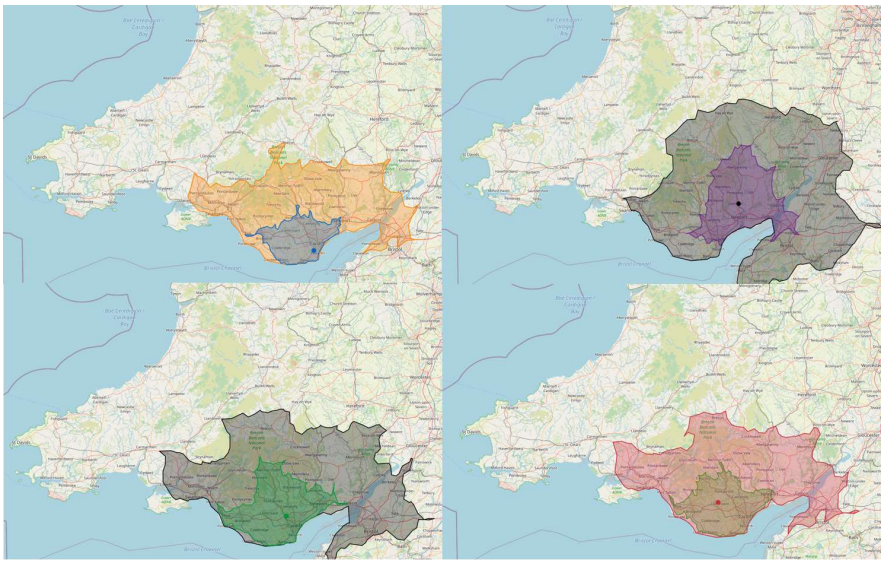

Fig. 49. 30 & 1 hour isochrones for UHL (top left), Grange (top right), hypothetical junction 32 M4 centre (bottom left) and Royal Glam (bottom right) develoipments .

Only two of the existing hospital sites in their current specification will be able to provide the necessary interdependencies for LVHC surgery such as revision arthroplasty and/or the medically complex **within a ring-fenced environment away from unscheduled care pressures**. UHL/ CAVOC is being developed as a higher complexity elective centre as per the health board strategy to remove as much elective surgery away from UHW as possible. This site could be developed into a regional Orthopaedic LVHC centre for SEW. The demand would match capacity when excluding the four CAVOC theatres required for the daycase delivery network. This may be very difficult to achieve when considering the health board context with all of the competing specialised surgical services. PPH would also be an appropriate LVHC unit due to its onsite critical care and medical teams. Neither UHL nor PPH have onsite vascular cover. This would need to be provided via an SLA.

Low Volume High Complexity (Surgical or medical)

HB	Unit	Laminar flow theatres	Comments – suitability for LVHC	Cold site
AB	The Grange	2	Unscheduled care only.	N
CAV	UHW	3	Nil realistic capacity. MTC. Regional centre for many specialised services.	N
	UHL	3	Competing services, otherwise good option.	AMAU
CTM	RGH	3	No vascular onsite but nil regional services competing demands	N
	POW	3	Less involved with inpatient elective Orthopaedic surgery	N
	PCH	1	Geographic isolation/ access	N
HD	PPH	2	No vascular, otherwise good option	AMAU
SB	MDU	15	Excellent interdependencies, unwillingness/ inability of HB to ring fence Orthopaedic capacity	N

Fig. 50. Brief appraisal of existing sites that may provide LVHC.

Additional potential LVHC sites in SW, are listed in (fig. 50). All of these however have significant competing unscheduled care pressures. An additional concern for LVHC procedures being done in units where HVLC is not, is the reduction in exposure and training for the allied heath team members and potential for quality and safety issues.

The “Intermediate - hybrid (HVLC centres)” option has advantages over “do minimal” and “revert to pre-pandemic” in that the HVLC cohorts will have access to care, but the issues still persist regarding the LVHC cohorts whose care will still need to be provided on an acute site. The historical difficulties of maintaining these pathways to the necessary standard in terms of ring fencing and theatre capacity does not provide the confidence that this is a viable option.

However, there is greater confidence in the development of a regional model for the LVHC cohort and a reduction of LVHC sites, requiring a mandate through W.O.N and accountability being placed at the host health board executive team in partnership with the commissioning health boards through a memorandum of

understanding. This approach would effectively remove the bed stock and theatre capacity from the control of local sites and health board teams, which may create additional unscheduled care pressures and affect pathways of care for other specialties for the LVHC site in question and may necessitate capital investment at these sites to accommodate the LVHC cohort.

7.3.4 Intermediate, Full - Combined HVLC/ LVHC Orthopaedic Hubs

It is not unreasonable to doubt the ability of NHSW systems to be able to maintain LVHC pathways through acute sites due to all the reasons outlined in the suite of NCSOS reports. Two tier systems where patients are discriminated against if they have more complex pathology by precluding them from accessing surgical care through LVHC units –v- other patients with less complex HVLC treatable conditions will continue to exist. To obviate this, full **Orthopaedic HVLC/LVHC Hubs** will need to be developed. When considering the additional theatre and bed stay "ask" for these centres (fig. 44 & 54), the uplift is justifiable. The vital consideration is how to provide the key interdependencies to maintain patient safety.

HB	Meet demand (0%)			10% Above		
	Weekly sessions	Number of theatres per day		Weekly sessions	Number of theatres per day	
		2 session	2.6 session		2 session	2.6 session
AB	45.8	4.6	3.5	52	5.2	4
BC	37.6	3.8	2.9	42	4.2	3.2
CAV	23.6	2.4	1.8	28	2.8	2.2
CTM	30.2	3.0	2.3	34	3.4	2.6
HD	31	3.1	2.4	36	3.6	2.8
SB	20.2	2.0	1.6	24	2.4	1.8
NW	37.6	3.8	2.9	42	4.2	3.2
SW	150.6	15.1	11.6	166	17.4	13.4

Fig. 51. Inpatient (HVLC/LVHC combined) sessional requirements in each HB and supra-regionally.

Two interdependency options exist.

(i) The first is to develop these orthopaedic hubs on acute sites, in distinct separate buildings safe from medically fit for discharge and unscheduled care pressures/surge. These hubs can be supported by SLAs with acute site interdependency services. This will be much easier to implement if services are commissioned appropriately.

(ii) The alternative option is to develop hubs that have enhanced post-operative recovery/ PACU models of care underpinned by intensivist/ anaesthetics delivered ward care supported by advanced allied health and nursing practitioners. The benchmark in SWLEOC is a team of 21 consultant intensivists delivering 24/7 resident ward care, 5-6 as fulltime employees, the remainder as additional duties above their base hospital contracts. This

is unlikely to be feasible at a regional level in Wales due to the differences in consultant demographic and availability. A middle grade resident anaesthetic rota with senior non-resident cover is likely to be more achievable.

Utilising the data as discussed in previous sections, but considering the additional volume, population size and staffing pools a hub would need to draw from, it is recommended that while the NW configuration remains the same i.e. one site, SW will need only two hubs.

The NW hub will need six theatres and between 23 to 39 beds to ensure future proofing, again heavily dependent on service model and LOS. In model (i), it will need to be on one of the acute hospital sites. The BCU executive team in partnership with the W.O.N and WG will need to identify this site at pace. In model (ii), any location is possible but logic would dictate a central location along the A55.

The SW hubs will need to be SWW and SEW. This is geographically logical for the patient although isochrones lean towards the SWW hub to be more towards SB such that it can service HD, SB and CTM west. This spread will also ensure the sizes of the hubs are not too disparate. In this model, the SEW hub will need at least eleven theatres and 59 to 102 beds, SWW – seven theatres through 38 to 65 beds. As per above, there should be a memorandum of understanding and partnership between all health boards such that they can all access both sites, and promote a healthy competitive yet collaborative and learning process between the two hubs.

The locations of the SWW is still in line with the isochrones based discussions in (fig.49) above, although in addition, Morriston must be considered within the options for a co-located Orthopaedic Hub due to its high specification of interdependencies and surrounding land banks.

For SEW, the reduction from two HVLC centres to one larger Orthopaedic Hub will necessitate further discussion and compromise to the location to ensure maximal population cover and staffing accessing. Fig. 52 (near M4 junction 32), would seem a sensible logical starting point for discussion i.e. M4 corridor for East-West access, near CTM, CAV and AB borders, near the A470 for North-South access.

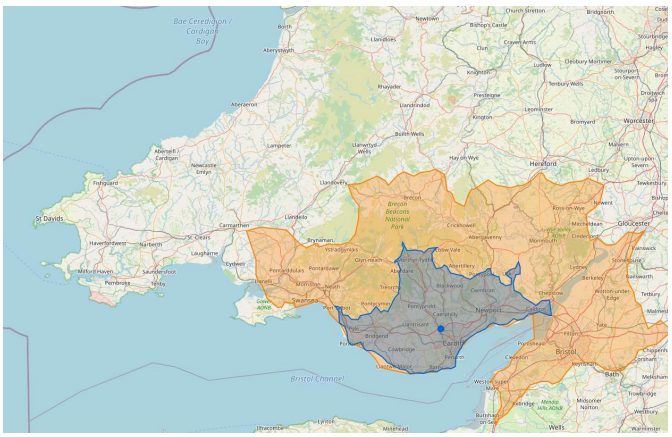

Fig 52. Possible site for SEW Elective Orthopaedic Hub (HVLC, LVHC). 30 mins. and 1 hour isochrones.

7.3.5 Do maximum. Supra-regional Orthopaedic Hospital in SW.

Developing the options a step further in SW, a fully resourced inpatient **Orthopaedic hospital** serving all SW health boards and South Powys for HVLC and LVHC inpatient workload would maximise economies of scale, create the potential for a world-class centre of excellence through centralisation of skill mix, staff training, research and innovation. This would require an 18-theatre suite for traditional models of five day two session working, however with 2.6 session days, and six day working could be reduced to 14 theatres or less. The bed requirement is significant (between 97 to 167 beds) unless major transformational changes are made to pathways and LOS. There would be potential for such a large-scale hospital to co-locate other sub-specialties including elective spinal surgery, elective trauma reconstruction, orthoplastics and ALAC as well as co-locate a large outpatient and specialist MSK radiology department to increase its viability. Paediatric Orthopaedic surgery would still need to stay within the scope of its current service model due to the co-dependencies in Noah's Ark, Cardiff.

Whilst a centre of excellence has many positives in terms of recruitment and retention, the necessary staffing for this option would remain challenging. The scale of staffing resource required would mean it would be unlikely to attract sufficient existing staff from other units without destabilising services at these units e.g. scrub staff and physiotherapists for trauma and daycase networks. A recruitment and training plan to provide new staff for a new orthopaedic hospital and/or backfill vacancies at other sites would require 3-5 years of planning to ensure training placements of all necessary staff groups to be planned in advance.

Depending on location, some surgical (and anaesthetic) staff may need to travel in excess of 90 minutes to reach the workplace, however, this would only occur once in a normal working week. However, other staff groups such as nursing staff, theatre scrub teams, therapies staff i.e. the core staffing groups of the hospital, may need to make this journey daily which would have an adverse effect on recruitment and create additional workforce challenges or possibly make it unviable.

One of the main enablers to reduce bed occupancy and length of stay is day case arthroplasty. A unit located greater than 30 minutes from such a large proportion of the population would not be able to support the necessary same day arthroplasty cohort, meaning that a single unit would require more beds in comparison to several units more local to a greater proportion of the population.

The isochrones demonstrate travel time for workforce with different locations across SW as an example for 30 minutes travel time (dark shading) and 1 hour travel time (light shading) – fig.53.

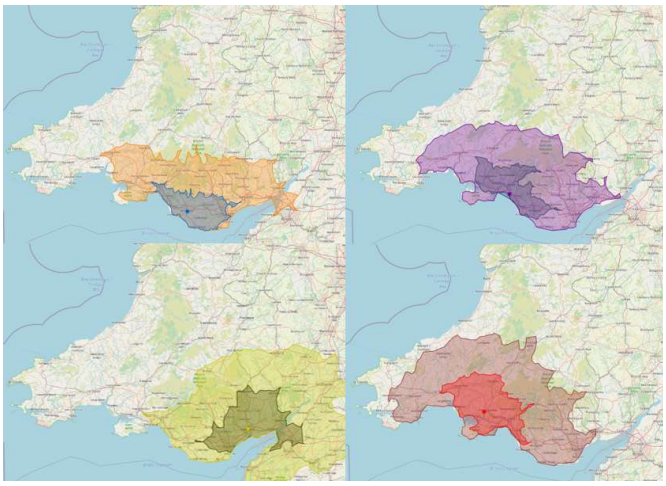

Fig. 53. Isochrones example for Hospitals based in Bridgend (top left), Port Talbot (top right), Newport (Bottom left), Hendy (Bottom right).

A unit of this size and scope dealing with HVLC and LVHC, with senior surgical staff from multiple distant units as "visiting surgeons" would necessitate a robust out-of-hours model with senior anaesthetic and medical support as is in place at SWLEOC. The proposed super orthopaedic hospital for SW would serve a population 3-4 times the size of SWLEOC which itself is supported by 21 anaesthetists from multiple other hospitals within a short travel time. The scale of senior anaesthetic and medical support required would necessitate the SW super hospital to be located further to the SE of Wales to take advantage of the numerous existing hospital staff groups, thus distancing the unit even further from the more rural areas of West Wales which would be against "A Healthier Wales" principles.

A further consideration and possible enabler would be to marry this orthopaedic hospital with similar specialised elective surgical hospitals within a super-site elective "complex". This would aid with interdependencies/ support services economies of scale, but such an ambitious transformative concept and programme would likely take decades to evolve, and span numerous senior HB, NHSW and political administrations, with the incumbent problems that brings with it.

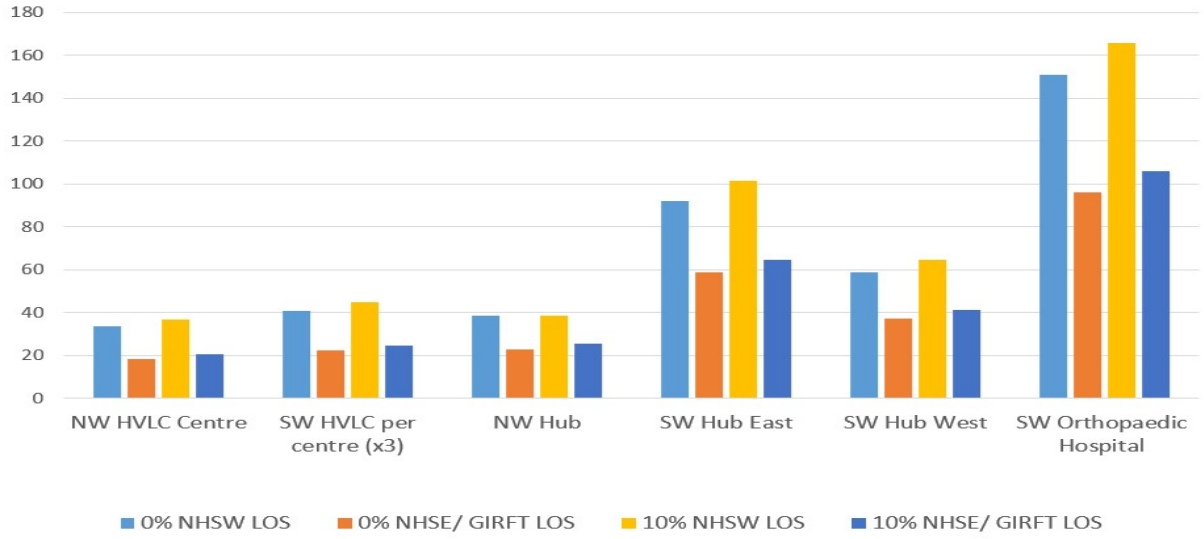

Fig. 54. Approximate bed requirements per model. See assumptions in methodology section.

7.4 Inpatient Elective Delivery Models Summary

Unlike the daycase network, there is no single clear optimal model for the delivery of inpatient elective orthopaedics. It is clear however that of the 5 options, "revert to pandemic", "do minimal" and "supra-regional" have either clinical safety or delivery and performance issues or are simply not feasible from a workforce perspective, and should be discounted.

The remaining "intermediate hybrid" and "intermediate full" options will be heavily reliant on the key enablers of provision of capital estate and key interdependencies, collaborative working between HB's and across HB boundaries to ensure successful implementation, as well as pathway transformation, all of which will most effectively be managed through the proposed W.O.N. (see section 9).

Of these two remaining options, the "intermediate hybrid" is perhaps the weakest option as it is heavily reliant on the need for ring-fencing on an existing site with uncontrollable unscheduled care demand. Whilst the "intermediate full" provides the greatest requirements for capital expenditure, it also provides the most coherent option for sustainable service delivery, efficiency and quality improvement.

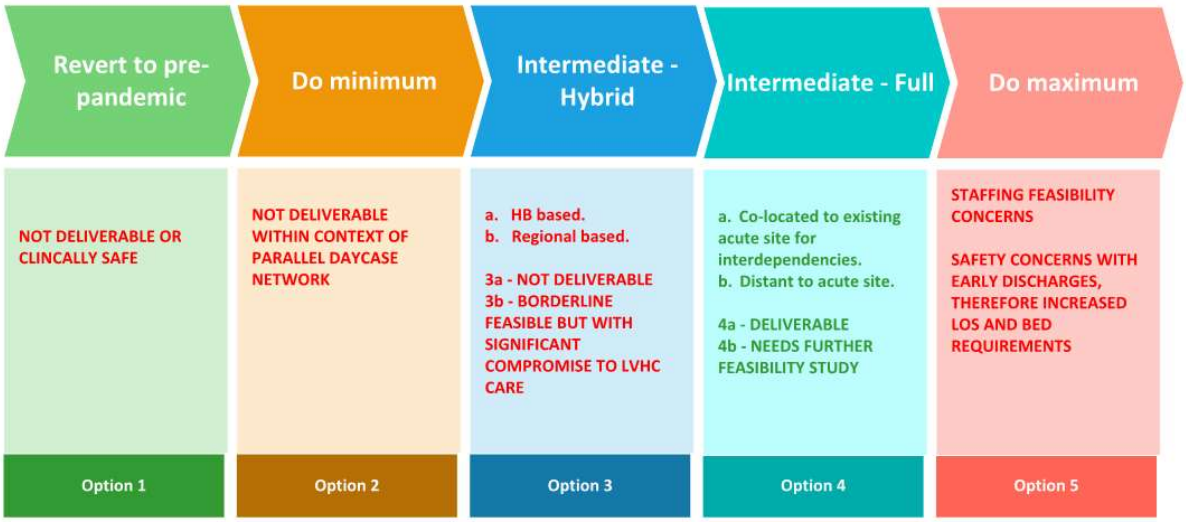

Fig. 55. Summary of elective inpatient options and preliminary viability.

8 The onward and wider Journey: A National Orthopaedic & Musculoskeletal Operational Delivery Network

It is clear that the magnitude of work required, implementing at pace and at scale the recommendations of the NCSOS project documents 1,2a-f and 3, will require a vehicle that can co-ordinate multiple programmes, with a fully resourced infrastructure to deliver. The recommendations of the recent GIRFT reviews are also clear that an operational delivery network for Orthopaedics that has authority to hold Healthboards and government to account needs to be instituted immediately. This section sets out the vision for a national Welsh Orthopaedic Network (WON) that must be commissioned in order to achieve these overarching aims.

8.1 Policy Context

The Welsh Government "*A Healthier Wales*" sets out the ambition for Wales to create a fit for purpose, and sustainable health and care system. Principles of *"Prudent healthcare"* call for an evaluation of the most effective ways to deliver services to the most people and are embedded within the Value Based Healthcare (VBHC) approach. The "*National Clinical Framework"* is underpinned by the principles of VBHC by supporting the creation of a learning health and care system and describes how the design and delivery model of clinical services will achieve this aim. The associated implementation programme outlines how clinical networks should interlink to deliver a person centred service to Wales. This will occur though

the development of national pathways that support strategic, operational and clinical requirements.

The NCSOS project recommendations meet the vision of the NCF through:-

- Planning for strategic population needs above the organisational interest and beyond the constraints of their boundaries.
- Creating a system that is co-ordinated nationally, but delivered locally.
- Designing a clinical delivery network that works with other stakeholders and networks to create a comprehensive end-to-end pathway for person centred care.
- Stimulating a revolution in the way health care delivery is provided in Wales from within the system.

Further to this, the recommendations outlined adhere to the prudent healthcare principles of:

- Reducing inappropriate variation.
- Caring for those with the greatest health needs first.
- Doing only what is needed and “do no harm”.
- Reducing inappropriate variation through evidence based approaches.
- Promoting equity and co-production with equal partners.

And the core principles of VBHC:

- Person centred care.
- Data driven approach with digital transformation and a “learning system”.
- Implementation and standardisation across NHS Wales.
- Communication, engagement and education with patients and health professionals.
- Demonstrating impact and value.

The National Planned Care Programme 5 goals outline the principles of appropriate referrals, advice and guidance, treat accordingly, follow up prudently and measure what is important. The recommendations in this report complement the delivery of these principles.

8.2 Welsh Orthopaedic Network

Musculoskeletal conditions are the third leading cause of disease burden in Wales after Cancer and Cardiac causes[5], the latter of which have established networks in place for many years.

An appropriately commissioned Wales Orthopaedic Network (WON) would ensure that the NCSOS and GIRFT recommendations within the combined suite of documents are realised and maintained. It will also enable prospective identification of need and development for further programmes. The past failures of previous reviews[1,2,6] clearly illustrates the inability of current WG, NHSW and HB structures to implement recommendations at scale and pace. To achieve this, the WON must have direct national operational oversight and authority to hold HBs and underperformance to account, be able to implement operational and strategic change at scale and have an efficient seamless governance structure allowing action to be taken at pace. This will only be possible will delegation of authority over Orthopaedic pathways from the HBs to the WON, combined with a Network executive committee/ Board structure with accountable senior officers representing the HB CEOs and WG, complimenting the dedicated WON National Clinical director, management team and other board members as proposed below.

The network will organise programmes of work, which ensure collaboration from all stakeholders to provide expert support across wider health pathways. The WON would work in collaboration with the strategic aims of the WG musculoskeletal team ensuring that focus is applied across the entire pathway so that care is provided equitably in terms of quality and access.

The WON outcomes would include:

- Remove the barriers to change imposed by individual organisational boundaries.
- End the postcode lottery - providing equal access across Wales.
- Immediate identification of delivery underperformance and alteration of patient flows and service commissioning in response, at pace, where there is risk of patient harm.
- Collaborative multidisciplinary co-production involving patient groups and third sector representation.
- Improved patient experience and outcomes.
- To embed the principles of Value based healthcare.
- Greater integration of primary and secondary care services.
- To develop and implement a Wales wide governance structure and process of system evaluation, performance and quality improvement.
- To facilitate a network wide workforce development plan.

Outline Welsh Orthopaedic Network (WON)

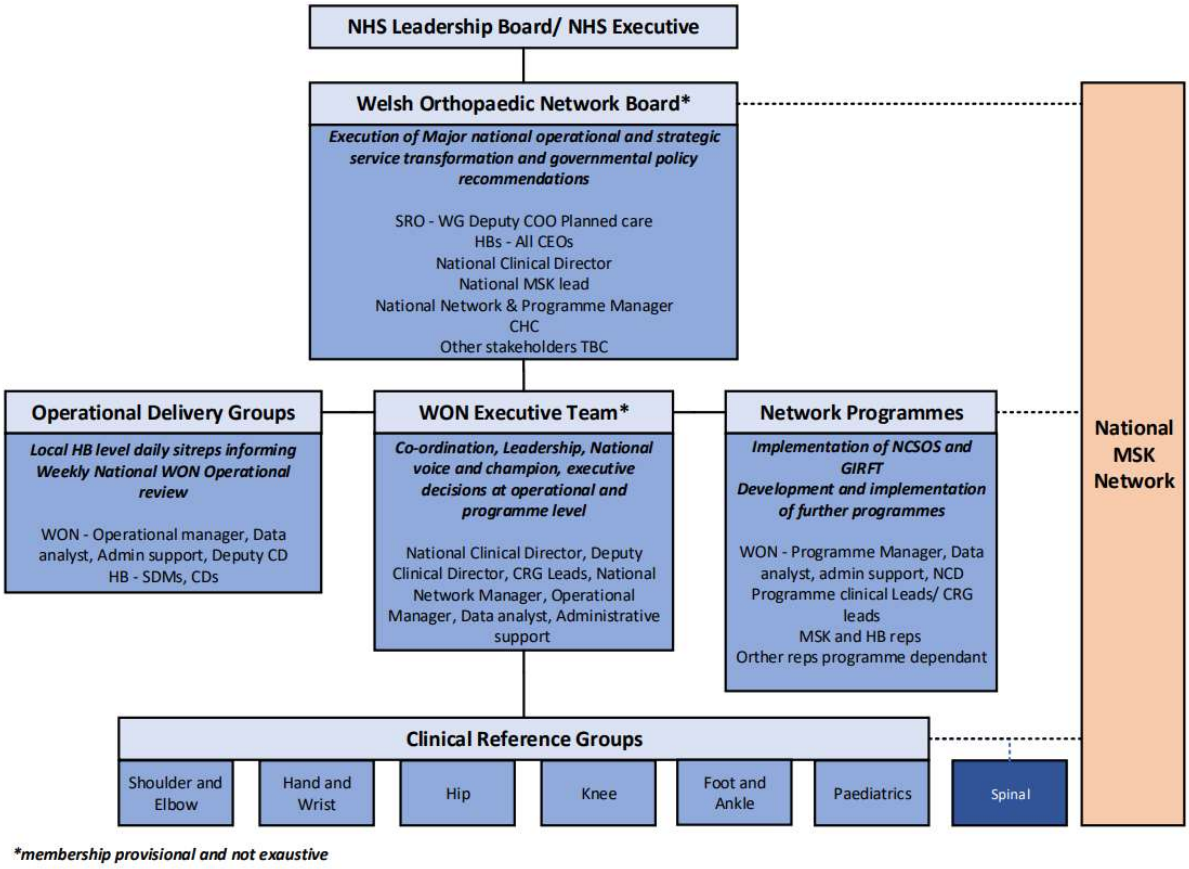

Fig. 56 Proposed network structure.

The above image provides an outline structure, role and key interfaces for the Welsh Orthopaedic Network. It is proposed this would report directly to the NHS Executive/ Leadership board but in order to ensure the WON remains effective, all implementation authority is delegated to the WON executive team and Board. The terms of delegation, including distinction between what the executive team vs the WON board have authority over will need further defining through a memorandum of understanding between all 7 HBs and WG.

8.3 Network Structure

Each of the outline roles below will provide support to the delivery of the national orthopaedic delivery strategy.

Role	WTE	Band	Key Role/responsibilities
National Network Manager	1	8C	National leadership role operating across health board boundaries. Key link to HB Executive (COO) level. Programme management.

			Oversight and delivery of plans including implementation of GiRFT and NCSOS. Lead and influence system change across a range of stakeholders. National leadership voice in "Comms" with NHS Wales/stakeholders/patients/population. Strategic link to other clinical networks/interdependencies.
National Clinical Director	4 sessions p. week	Consultant Orthopaedic Surgeon	Clinical Leadership National champion/facilitator Over-arching direction for subspecialty and network operational CRGs
Programme Manager	1wte	8a	Manage day to day operational delivery Co-ordinate monitoring tools Engagement/documentation Project management Supporting sub-spec workstreams Risk management Key link to HB at operational level
Programme Support Officer	1wte	Band 5	Co-ordinate meetings Diary management Minute taking Document management Sub-group activities
Data Analyst	1wte	Band 5	Data collection Design and development of datasets Statistical analysis Network internal and external reporting requirements
Sub-Specialty Clinical leads 1 x Shoulder & Elbow 1 x Hand & Wrist 1 x Hip 1 x Knee 1 x Foot and Ankle 1 x Paediatrics	4 sessions p. month	Consultant Orthopaedic Surgeon	National leadership within sub-specialty Lead sub-specialty work programme priorities. Escalate issues and work with stakeholders on resolving contentious issues. Reports to CD and NNM Supported by PM and Admin

Fig 57. Proposed network key roles

8.4 Clinical Reference Groups

The clinical reference groups will take forward the GiRFT[6] and NCSOS recommendations set out in Reports 2a-f. Each sub-specialty CRG will have programme manager support and support from the wider network.

The CRGs will work across other clinical networks to develop MDT stakeholder involvement, including primary care, radiology, microbiology, therapies, paediatrics,

spinal and health board key management. They will oversee task and finish groups where required and work to eradicate variation.

A paediatric CRG has been added to take forward the actions arising from the recent specialised and non-specialised surgery service specs developed under an NHS Collaborative consultation.

8.5 Network Connections

The WON will not be working in isolation but in collaboration with other networks within Wales to support collaborative and multidisciplinary design and delivery.

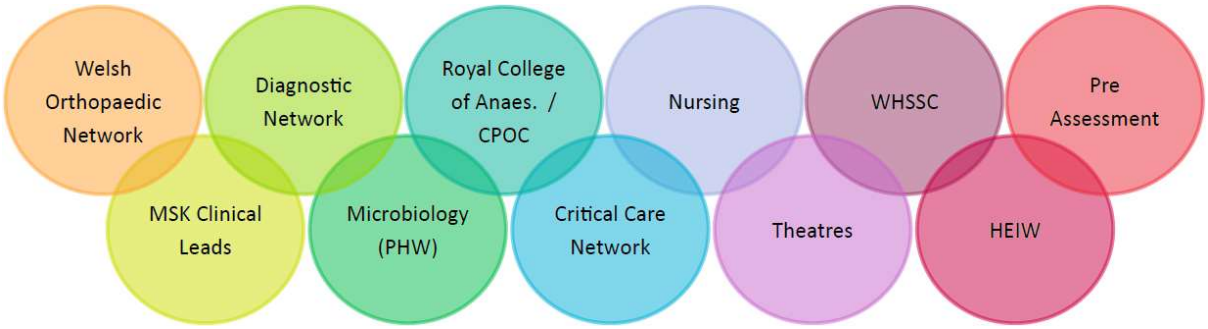

Fig. 58. Collaborative networking

Other associated teams would include:

Value Based Healthcare Team for - PROMS/PREMS outcome measures at each stage of the pathway. One system is needed i.e. all musculoskeletal orthopaedic providers need to use the same system to the same specification. Plan nationally with subspecialty CRGs to monitor outcomes.

Digital - link to the Digital services for patients and Public (DSPP) Programme.

Financial Delivery Unit / Delivery Unit – as required.

Regional Elective Centres: Implementation of regional centres; contracting arrangements/memorandum of understanding; rationalise implants/equipment/protocols and procedures.

Trauma: It has been noted through the NCSOS project processes, that a significant proportion of trauma sits outside of the scope of the major trauma network (MTN) and has many gaps, issues and risks. It is recommended that any intended WON

commissions a further workstream to identify these needs in greater detail and defines the role of the WON with regards to Trauma, including #NOF, ambulatory trauma.

8.6 Structure & Accountability

It is recommended that the network report directly to the NHS Executive. However, if the Network were to be hosted by a health board, this will support better access to data and guarantee ease of communications channels with the clinical workforce.

8.6.1 Network Board

The network board must constitute senior decision makers. It is recommended that All HB CEOs and the WG planned care deputy COO are required. Either a nominated CEO or the NHSW deputy COO should act as the SRO for the network with delegated responsibility from all 7 HBs. The national MSK lead, CHC and other stakeholders to be confirmed will make up the board. It is anticipated that the board will delegate most responsibility and authority to the executive committee to ensure that the majority of operational and strategic changes can be implemented at pace but with the necessary level of governance. Major national service changes will need to be authorised at board level. The distinction between what the Board authorise vs delegate to the executive committee will need to be defined during the establishment of the WON through a memorandum of understanding between all 7 HBs and WG/ NHSW. It is also anticipated that the Network Board will also advise on governmental policy where it relates to Orthopaedic systems and interfaces.

8.6.2 Network executive committee

The following membership is proposed*:

- Network Manager
- Clinical Director
- CRG clinical leads
- Clinical and managerial lead from each health board
- Musculoskeletal lead
- VBH lead
- Workforce lead
- Spinal network clinical director

8.6.3 Network role

- To link together the individual components of NHSW health boards to support services being provided along local, regional and tertiary lines.
- To monitor compliance with pathways according to agreed KPIs.
- To hold health boards to account for all aspects of orthopaedic service delivery and where necessary exert operational authority to mandate changes to service delivery, which may include involvement of other health boards.
- To provide independent clinical and managerial support to health boards to address issues of performance and delivery of services.
- Oversee implementation of work plans of sub-specialty CRGs.
- To address existing gaps in service provision, in particular those identified by the NCSOS project and GiRFT.
- To prospectively identify and address service issues, risks and gaps.
- To monitor progress against recovery plans.
- Leadership role for delivery of implementation of long-term plan.
- Align and inform national strategy – 5 goals planned care / 6 goals USC/ ViH / Recovery.
- Strategic link outlined above in Network connections.
- Engaging with third sector partners and public.
- Developing a national orthopaedic research programme.

8.6.3 Role & responsibility of health boards

- SDM and CD HB leads to represent on CRGs
- HB link with National Network Manager & Clinical Director
- Regular updates with MD & CEO/COO
- Co-ordinate planning and development of orthopaedic services in line with national strategy
- Co-ordinate necessary recruitment strategies / appointments in line with national strategy

8.7 Quality metrics and Performance Monitoring

The network will establish key **Quality** metrics nationally and for each sub-specialty CRG. These will include*:

- PROMS/PREMS
- ViH Hip / Knee dashboards

- Compliance with pathways / variation
- Staff & patient surveys
- Litigation
- Complaints & Concerns themes /learning
- National Joint Registry
- Serious incidents
- Never Events
- Audits / Research
- Model healthcare - GiRFT
- Public Health Wales (SSI/deep infection rates)

The Network will monitor key **Performance** metrics including*:

- Waiting times
- Capacity & Demand
- Activity
- NHFD
- TARN
- Theatre productivity
- HVLC / HCLV
- Coding

**List not exhaustive*

9 Conclusion

The suite of eight NCSOS reports (1,2a-f and this report 3) provide a range of whole system and pathway recommendations required to:

a) **Recover and restart Orthopaedic surgery.**
b) **Transform orthopaedic pathways from primary care through to post-operative stages, underpinned by Value Based Healthcare.**
c) **Transform the clinical networks of orthopaedic surgical delivery.**
d) **Develop the necessary capital estate required to deliver safe, effective, orthopaedic surgical care in line with pathway transformation and clinical networks.**

The focus of this report, NCSOS 3, is to provide a prescriptive framework on which all of these recommendations can be realised. Therefore, the following very defined next steps are strongly recommended to be instigated at pace by WG and stakeholders -

1) **Establish a fully resourced Welsh Orthopaedic Network** with authority to implement the range of actions/recommendations as outlined in NCSOS 1, 2a-f and the GIRFT reports. The Welsh Orthopaedic Network should work collaboratively with any future musculoskeletal network to ensure that clinically driven improvements in musculoskeletal pathways are realised.

2) **Empower clinicians** via sub-specialty clinical reference groups within the WON, to drive the necessary transformational changes to sub-specialty musculoskeletal pathways.

3) **Develop three new build standalone orthopaedic hubs in NW, SWW and SEW**. The specifications and rationale for these hubs is detailed within this document. Whilst the document discusses a range of "options", it is very clear that only the orthopaedic combined HVLC/ LVHC hub option is viable. All other options are either unsafe or unfeasible (or both). This will require significant capital investment but, when combined with the work of the W.O.N and CRG's, will enable high quality, sustainable and value based healthcare pathways. These in turn will provide significant clinical and economical return on investments in the medium to long term, across the entire pathway from social and primary through to secondary and tertiary care. These hubs must transcend health board based governance structures and be managed centrally through the WON and via a partnership between all seven health boards through a memorandum of understanding. This is the only way the hubs will be able to provide a functioning, fair and equitable service for the whole population of Wales.

   The **North Wales** plan is unambiguous. It must be managed through a single, 6 theatre hub with integrated clinical networks and pathways. Within this hub, the three BCU orthopaedic units must work collaboratively as a team to foster a whole HB approach to the delivery of elective orthopaedic care. Similarly, HB executives must work collaboratively with their clinicians and ensure that any HB strategic ventures such as the RTCs, deliver the requirements for an orthopaedic hub to the specification detailed in this document. Alternatively, further central investment will be needed to separately fund an orthopaedic hub and centre of excellence outside of the RTC project. Work must be repatriated from NHSE to ensure funding streams are channelled into stabilising and developing NHSW NW orthopaedic services. The surgical expertise and enthusiasm is already there and the population volume can sustain almost all orthopaedic surgery.

   South West Wales must have a 7-theatre hub and provide for HD, SB and west CTM. The details for the delivery of the clinical network models are detailed in the NCSOS suite of documents, which will be delivered, governed and

underpinned by the WON. Due to the geographical spread of SWW, this is most likely to be achievable if the hub is located on the same site, but a separate building, as one of the DGH sites to ensure interdependency support, with the most reasonable sites worthy of consideration being the Morriston and PPH land sites. Work in NPTH is progressing but will only deliver orthopaedic hub level services if the interdependency workforce issues are resolved, which at present are challenging. Nonetheless, the NCSOS recommend that the devolvement of NPTH continue, as it will at least serve a significant role as part of the SWW daycase delivery network, including ambulatory trauma, and, if interdependency work progresses well, may develop as a potential hub site candidate. Alternative sites as the hub solution for SWW could be considered, but these must be ambitious and of high specification to deliver almost all orthopaedic care and peri-operative needs for the entire population of South West Wales whilst also respecting the likely workforce models required.

South East Wales must have at least an 11 theatre hub and provide for AB, C&V and mid and North CTM, again based on clinical networking. Due to the population and staffing densities and number of existing units, SEW has the opportunity more so than SWW for a standalone hub independent of an acute site. Again, the NCSOS do not recommend constraining potential hub sites to those that are currently under, or intended for general HB development. Whilst some existing sites may be appropriate, NCSOS also recommends that novel locations be strongly considered in any options appraisal, based on accessibility to the patient population and workforce groups.

The hubs must collaborate and engage in a learning system to ensure innovation, progression and refinement of pathways, to minimise variation and to improve quality, safety and sustainability. The hubs in SW in particular must work as a whole system to ensure that patients from both the SEW and SWW catchments have access to the same standard of care, which will drive improvement and standardisation between both hubs.

Furthermore, any capital estate development (and MSK pathway transformation) must consider the population of Powys so that elective activity for this population can be provided as close to their home residence, whilst recognising that for some of the population of Powys, treatment pathways based within NHSE may be more appropriate.

The locations of the three hubs will always be contentious if based purely on opinion and isolated aspects of the pathway. The significant due diligence and data analysis of the NCSOS project has provided a detailed steer for this, although prior to final agreement on the capital builds, a full options appraisal

will need to be performed. This however should only take at most a 3-6 month process split over 2-3 meetings with involvement of a relevant and broad group of stakeholders. The NCSOS recommendations have reduced the number of options significantly; therefore, the formal appraisal process should be deliverable in this focused period. The sites must not be constrained by current initiatives or HB plans; they must be chosen based on what is best to deliver the most effective orthopaedic service for the population.

Options to include spinal surgical demand and capacity should also be considered within these orthopaedic hubs and similarly, ambulatory trauma within the daycase network. These were outside of the scope of the NCSOS but can be integrated within the options appraisal process. The W.O.N and Spinal Services Network should work collaboratively to develop this.

The capital build options appraisal and establishment of the W.O.N must commence seamlessly and immediately from the moment the NCSOS reports are published and delivered to WG. However, the necessary improvements in musculoskeletal treatment pathways will not be resolved by these capital build options alone. Wholescale improvements are required to address all of the outstanding risks and issues that exist within current musculoskeletal treatment pathways, and the two must be developed in parallel to achieve a high quality efficient elective orthopaedic service.

The NCSOS project was commissioned due to the need for a new approach to the delivery of elective orthopaedic surgery in Wales. The project was designed to draw on the wealth of clinical experience from within the entire Welsh orthopaedic consultant body, through the project steering group and sub specialty CRG's. Additionally, the project team drew on national and international benchmarking by its collaboration with GiRFT; never before has a project of such scope and clinical engagement been undertaken.

The NCSOS reports cannot suffer the same fate as "An Orthopaedic Plan for Wales" (2005) or "A National Review of Elective Orthopaedic Services in Wales" (2014/15) by GIRFT. **Failure to act on the recommendations and outcomes of the NCSOS reports will lead to the inevitable collapse of orthopaedic surgical services in Wales. In this eventuality, clinicians, managers, chief executives and politicians will have a duty of candour to advise the public as such, and look to NHSE and central UK government for support.**

10 Acknowledgements

We would like to express our gratitude and thanks to all those orthopaedic surgeons across Wales (Annex 11) who contributed to the sub-specialty workshops by contributing and completing the specialist/ non specialist procedure, and pathway proformas.

We also extend thanks to the Health Board clinical leads and management leads who continued to support the project through the Clinical Reference Steering Group.

The membership of the CRSG is outlined below.

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Alun John, Consultant Orthopaedic Surgeon, C&VUHB
Stephen Jones, Consultant Orthopaedic Surgeon, C&VUHB

A particular note of thanks also to the health board informatics leads, without whose support we would not have been able to complete this work:

Dilwyn Bull – Aneurin Bevan UHB
Richard Walker/Bill Hildyard – Betsi Cadwaladr UHB
Kerry Ashmore – Cardiff & Vale UHB
Rob Jones – Cwm Taf Morgannwg UHB
Gareth Beynon/Jason Linehan – Hywel Dda UHB
Joanne Emms/Stephen Jones – Swansea Bay UHB
Chris Jones, Healthcare systems engineering team, Swansea Bay UHB
Charlie Mackenzie, Head of SLR and External Commissioning, Swansea Bay UHB

Thanks also to the work of the subspecialty groups:

- Shoulder & Elbow
- Hand & Wrist
- Hip
- Knee
- Foot & Ankle

Thanks to Juliet Clutton for assisting with the Wales Trainee Survey.

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A final thankyou to the Welsh Orthopaedic Board (WOB).

11 Appendices

No	Title	Attachment
Annex 1	NCSOS Project Structure/Methodology	
Annex 2	NCSOS Report 1 Immediate Risks & Issues	
Annex 3	NCSOS Report 2a General Pathway Recommendations	
Annex 4	NCSOS Report 2b Shoulder & Elbow Pathway Recommendations	
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12 References

[1] CONTENTS (wales.nhs.uk) – An Orthopaedic Plan for Wales (Welsh Assembly Government)

[2] Review_of_orthopaedic_ENG__2015_6.pdf (audit.wales) – A review of Orthopaedic Services Wales Audit office 2015

[3] https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/12/GIRFT_HVLC_Guide_Edition_2_FINAL.pdf

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[5]National Clinical Framework

[6]GiRFT 2015

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Programme Plan and Gantt Chart

Programme Name: Orthopaedic Improvement
Executive Sponsor: Leanne Watkins
Clinical Lead: Huw Pullen
SRO: Ian Jenkins

Start Date 01 Jul 22 Activity (A)
Last Updated 12 Oct 22

DOMAIN	UNIQUE ID	ACTION	Lead	Progress	Start	Finish
RESTART & RECOVERY						
Hands	33	All HB should ensure immediate relocation of non-surgical services from existing day case theatre capacity.	Subspecialty Clinical Leads	A		
Nursing	11	While re-deployment of staff may be a short term solution, sustainable teams need to be planned to avoid weakening existing service requirements in MSK.	Ian Jenkins	G	04 Jul 22	
	14	Ring fenced bed capacity to support inpatient surgery restart.		C		
	26	Ring fenced capacity for LVHC and infected/revision arthroplasty must be provided outside existing trauma capacity within all HB's	Ian Jenkins	C		
PAC	57	Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day.		C		
Reporting	13	Weekly sit-rep reports to be provided to Welsh Government of surgical activity, reporting the treatment function and clinical prioritisation.	Information/ Lightfoot	G		
	18	Monitoring and reporting of the LVHC waiting list cohort and activity.	Information/ Lightfoot	G		
	50	Set up a daily sitrep specifically focused on elective recovery to the Executive on waiting lists	Information/ Lightfoot	G		
Subspecs	62	Determine effective and efficient follow up plans – which are carried out virtually if possible but with appropriate safety netting in place where needed.	Subspecialty clinical leads	G	01 Jul 22	
Theatre	55	Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	Ian Jenkins	C		
UHB	10	Services require national funding and local implementation to ensure equity of access and service delivery.	Welsh Government	R		
Steering	16	Establishment of enhanced recovery units to increase the number of patients suitable for HVLC surgical pathways.		C		
	24	(Re-)Establishment of core orthopaedic anaesthetic services.		C		
	40	Implement elective recovery at pace. We are aware that capital investment is currently limited. However, most of our recommendations rely on better use of existing assets and on using revenue budgets and resources more efficiently. We expect that an urgent initial plan, which sets out how the Health Board will fully restart orthopaedic surgery to be in place, no later than the end of March 2022. Any barriers or risks to delivery of this plan need to be urgently resolved. The plan should include a communication and engagement plan with all patients so that patients fully understand the timetable for their surgery.		C		
	47	Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following:		C		
	51	Establish a delivery model to restart elective recovery. This needs to be established at pace. GIRFT supports in principle, the long term plans to create an elective hub at the Grange site, currently the trauma centre for both HVLC and LVHC procedures provided all other capacity and existing assets are fully utilised for elective care, and in the interim, utilise the Royal Gwent for complex LVHC workload, HVLC case-mix at St Woolos and day-case procedures at Ystrad Fawr Hospital. However, the longer-term strategy must be co-ordinated nationally in line with the recommendations of the NCSOS project, so that any major infrastructural changes are implemented with regional and national context. ABUHB must ensure these sites have the appropriate staffing levels to sustain services during periods of additional pressure.		C		
	53	Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.		C		
	54	Develop an enhanced recovery unit operated 24 hours a day, seven days a week, that allows upskilled nurses to provide care and assessment to the sickest and most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.		C		
	58	Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.		C		
N/A	4	Reintroduction of face to face clinics for first outpatient and pre-surgery reviews of long waiting (delayed) patients		C		
	5	Establishment of the minimum outpatient capacity required to re-evaluate patients prior to surgery to avoid cancellation of procedure on the day.		C		
	6	Video consultations to be focused on follow up or review clinics and supported by quality and performance monitoring via the National Outpatient Transformation programme.		C		
	7	Minimum level outpatient capacity should be reinstated immediately.		C		
	8	Consultant job plans must recognise all necessary outpatient capacity.		C		
	12	Theatre capacity for P2/3 orthopaedic cases must be provided immediately.		C		
	15	Urgent designation of elective/emergency patient flow in line with Gift recommendations to support HVLC surgical pathways.		C		
	21	Orthopaedic booking teams (outpatient and theatre) teams need to be re-established and supported to work collaboratively within and across system boundaries.		C		
	22	Review of pre-assessment process locally to match theatre restart.		C		
	23	Reintroduction of consultant consenting clinics to match theatre capacity.		C		
QUALITY & PATIENT SAFETY						
Directorate	9	Prehabilitation services need to be established to support patients on the waiting list for orthopaedics, in line with UK guidance.	Mr Pullen/Ian Jenkins	A		
	61	Review of patients that are deconditioning on the waiting list, identify patients that require urgent care.	Mr Pullen/Ian Jenkins	A		
	81	Consider post- operative follow ups to be carried out virtually.		C		
	86	ABUHB to collect PROMs data, to discuss and review PROMs score internally on an annual basis.	Ian Jenkins	A		
Elbow	76	Review of elbow replacement length of stay rates and establish an improvement strategy.	Mr Kulkarni	A		

Programme Plan and Gantt Chart

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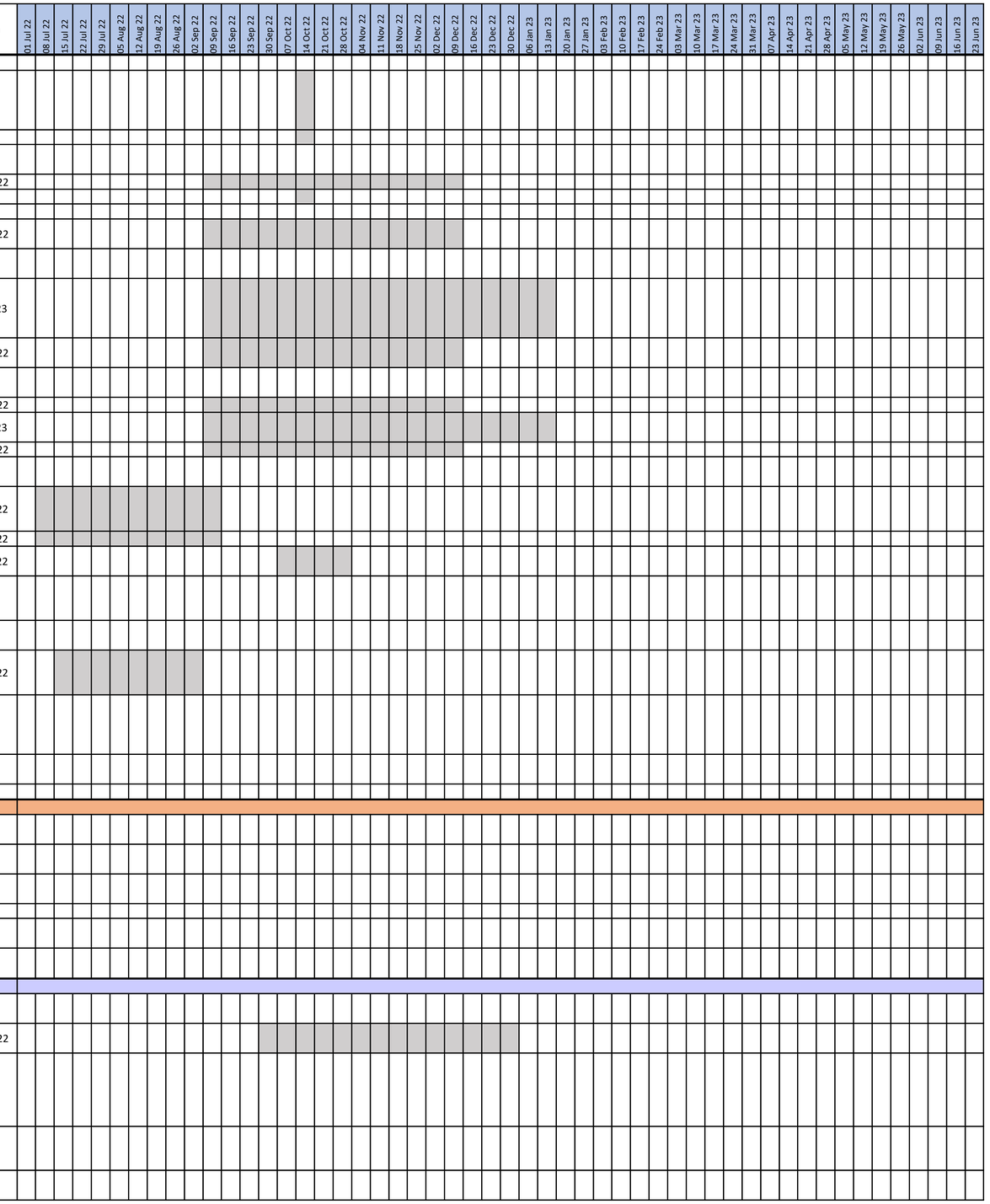
Start Date 01 Jul 22 Activity (A)
Last Updated 12 Oct 22

DOMAIN	UNIQUE ID	ACTION	Lead	Progress	Start	Finish
F&A	30	All HB's must ensure diabetic MDFS in place immediately		C		
Hip	64	ABUHB to increase the usage of fully cement hip fixations in patients over 65+years. At least 80% of patients over 70 years of age should be receiving a fully cemented or hybrid hip replacement. This is compliant with the standardised Hip replacement in HVLC (High Volume Low Complexity) endorsed by the BOA.	Mr Pullen/WOB	A	18 Oct 22	
	65	ABUHB to ensure relevant training is provided for fully cemented hip fixations.	Mr Pullen/WOB	A	18 Oct 22	
	66	For ABUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation.		C		
	67	A review of 90-day primary hip 90-day mortality rates to be carried out.	Mr Akhtar	G	13 Sep 22	09 Dec 22
	79	Cement THR in patients over 70 years old provides best outcomes.	Mr Pullen/WOB	A	18 Oct 22	
Hip & Knee	70	ALL Hip and knee revisions to be discussed in Health Board Regional MDTs prior to surgical intervention.		C		
	75	ABUHB to undertake a review of hip and knee primary and revision length of stay rates and develop an improvement strategy. Centralise hip and knee revision activity to reduce length of stay.	Mr Akhtar	G	13 Sep 22	09 Dec 22
	77	Consider whether hip and knee day case surgery could be more broadly used for some patient groups.	Ian Jenkins	A		
	84	ABUHB to undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering low volumes of both hip and knee revisions annually should no longer be performing this surgery. Operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications and cost.	Mr Lewis & Mr Akhtar	G	13 Sep 22	16 Jan 23
	85	Review to be carried out of adverse events for primary hip and knee at St Woolos Hospital. A review of the theatre adverse events/ NJR data to be carried out annually.	Mr Lewis & Mr Akhtar	G	13 Sep 22	09 Dec 22
Hip, Knee & F&A	72	Centralise hip and knee revision surgery and foot and ankle arthrodesis to be carried out at one site.		C		
Knee	68	Review of elective knee revision rates and establish an improvement strategy.	Mr Lewis & Mr Akhtar	G	13 Sep 22	09 Dec 22
	69	Reduce the number of surgeons carrying out primary knee surgery as the revision rates are high. Centralise the elective knee surgery to be carried out at one hospital.	Mr Lewis & Mr Akhtar	A	13 Sep 22	16 Jan 23
	71	A review of 90-day primary knee 90-day mortality rates to be carried out.	Mr Lewis & Mr Akhtar	G	13 Sep 22	09 Dec 22
	82	For ABUHB to undertake regular peer arthroplasty reviews of surgeon level data also reviewing low volume activity.		C		
Shoulder	74	Review of NHS shoulder subacromial decompression activity ensuring evidence is being used and these patients have gone through the appropriate pathway including physiotherapy before being offered surgery.	Mr Mehta	G	11 Jul 22	13 Sep 22
	83	St Woolos to review return to theatre rates for another shoulder procedure within 1 year.	Mr Mehta	G	11 Jul 22	13 Sep 22
Subspecs	73	Undertake a review of arthroscopy and ankle activity data to identify the correct volumes and develop an improvement strategy to improve reporting of this data.	Mr Kadambande	C	12 Oct 22	28 Oct 22
Legal	43 & 88	Set up a cross Health Board initiative to ensure that litigation claims are regularly reviewed in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved.	Leanne Watkins	R		
PAC	41 & 56	Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient's home prior to admission.	Rachel Challenger/Sue Pearce	R		
Physio	78	Improve enhanced recovery by having physiotherapy service available on weekends to mobilise the patients for earlier discharge. When ABUHB develop the elective hubs, it is imperative that they are staffed appropriately to maximise outcome and improve patient flow.	Physio	G	21 Jul 22	05 Sep 22
Reporting	44 & 87	Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.	Rachel Challenger	A		
	63	Review of patients with high BMI and weight management services and identify improvement strategy and how to best respond to patients wanting surgery with high BMI.	Ian Jenkins	C		
	80	Consider measuring in hours opposed to days.	Information /Lightfoot	C		
TRAUMA						
Trauma	2	Trauma theatre allocation must match HB demand and not be absorbed within elective orthopaedic capacity.	Mr Lloyd	A		
UHB	1	Patients presenting with general trauma pathology e.g. hip fractures, must have equity of access with other general medical and surgical unscheduled presentations requiring inpatient admission.	Mr Lloyd	A		
	3	Trauma capacity to be provided within context of whole surgical unscheduled and elective activity, on a clinically priority basis.	Mr Lloyd	A		
Steering	60	Review emergency and urgent pathways to improve patient flow.	Mr Lloyd	A		
N/A	28	Outpatient and surgical capacity for acute knee injury management must be made available in all HBs immediately.		C		
	31	Outpatient and surgical capacity for acute shoulder and elbow injury management must be made available in all HBs immediately.		C		
REGIONAL WORKING						
Hip & Knee	27	A national Revision Arthroplasty MDT must be established with participation from all units and central funding for microbiological support.		C		
Steering	17	Urgent designation of regional LVHC surgical hubs within existing acute sites to provide mutual aid surgical pathways for complex patients.	Mr Pullen	A	03 Oct 22	31 Dec 22
	49	Carry out full demand and capacity planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve ABUHB. It is crucial that elective recovery is seen as a regional imperative with all Health Boards working together. This will ensure that ALL existing assets available for Orthopaedic elective recovery are utilised.	Mr Pullen	C		
UHB	19	Immediate collaboration between HBs to ensure co-ordinated staffing recruitment drives with workforce models that maximise flexibility, efficiency, regional working and supports support staff well-being.	Mr Pullen	A		
	52	Utilise fallow capacity at Nevill Hall as a mutual aid regional resource to provide elective capacity on a regional basis for North and East CTM, ABHB, CVHB (if needed) and South Powys.	Mr Pullen	C		



Programme Plan and Gantt Chart

Programme Name: Orthopaedic Improvement
Executive Sponsor: Leanne Watkins
Clinical Lead: Huw Pullen
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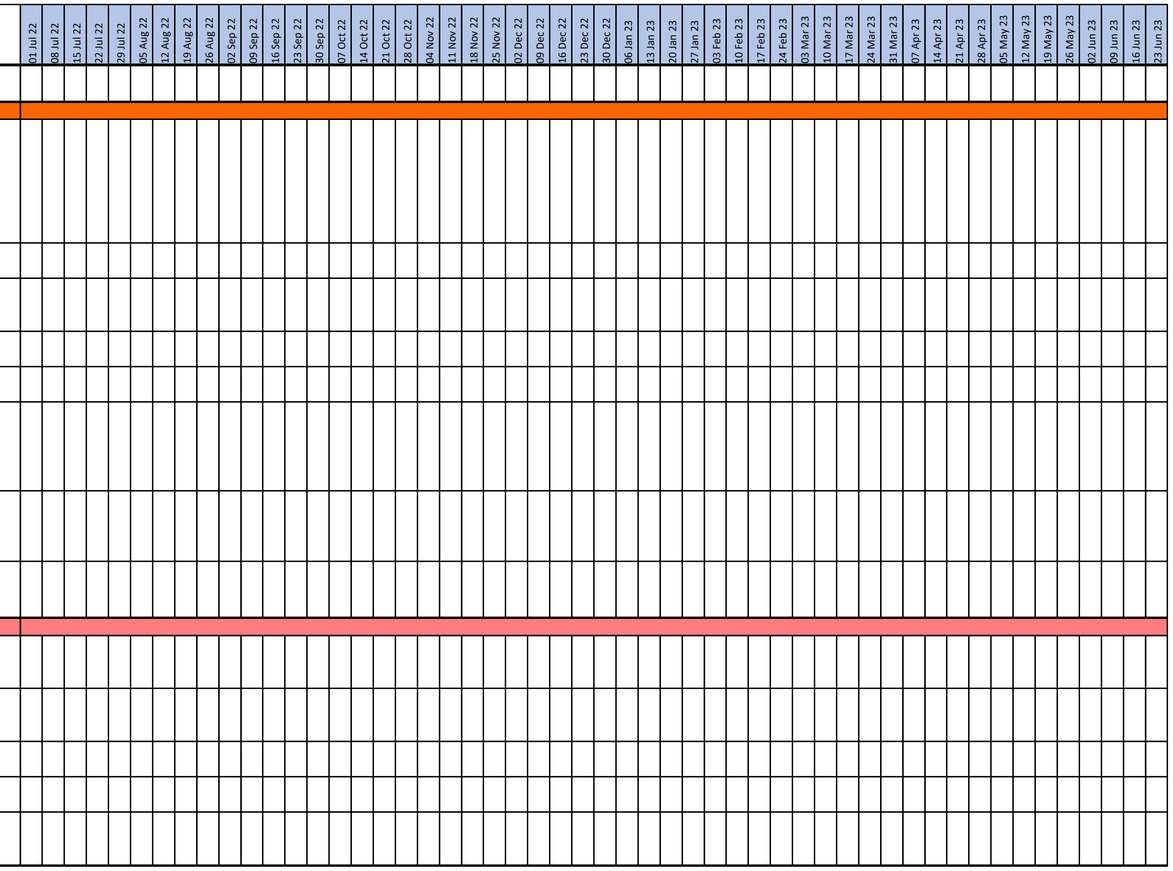
Start Date 01 Jul 22 Activity (A)
Last Updated 12 Oct 22

DOMAIN	UNIQUE ID	ACTION	Lead	Progress	Start	Finish
	59	Where there is recognised "good practice" in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.		C		
GENERAL						
HR	45	Create and implement a workforce plan both short, medium and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.	Workforce	A		
Steering	34	All HB executive, clinical and operational teams to review their Gift reports and address the individualised HB recommendations.		C		
	35	The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as one Health Board and not hospital by hospital.		C		
	36	Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation		C		
	37	Ensure that the Health Board orthopaedics lead implements the changes required to minimise unwarranted variation and that regular progress is provided to the Executive Team and Steering Group		C		
UHB	38	ABUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent need to re-engage with clinicians to rebuild trust and ensure that clinicians are listened to and involved at each stage of restart and change proposals. It is imperative that clinicians are an integral part of the "sign off" and delivery of changes.	Leanne Watkins/ABUHB Exec	R		
	39	Carry out a staff survey without delay to understand the issues affecting staff morale and how these can be addressed. We consider that improved and open communication with colleagues about the short, medium and long term plans will help to improve staff morale. We do recognise, that there are a number of recent factors affecting staff morale.	Angela Palfrey	R		
N/A	42	Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recorded and used across all Health Boards.		C		
NOT RELEVANT						
WG	20	Immediate WG review of how theatre staffing groups are can be appropriately recognised and incentivised to support and improve efficiencies of the increasing volume of core and additional sessions that will be required to recover Orthopaedic services.	WG	C		
	25	Incorporation of trainee requirements into regional / collaborative planning for elective delivery.	Huw Pullen/Angela Palfrey/Leanne Watkins	R		
Steering	29	All HBs must ring fence MRI capacity for acute knee patients. Short-Medium term commissioning through local private providers should be considered if immediate HB delivered capacity is not feasible.		C		
	32	All HBs to commission ring fenced USS capacity for acute soft tissue shoulder and elbow injuries utilising local private providers if necessary.		C		
N/A	46	As part of the medium and longer term orthopaedic plan, all outsourcing and external commissioning of services should be reviewed. The aim should be to deliver all outsourced activity to the same level and standard e.g. the minimum number of knee revisions by one consultant.		C		



Report	Action Type	Report Action Number	Unique Identifier	Action	Domain	Sub Domain	Status	RAG	Comments	Update 03/10
NCSOS	Key	1	1	Patients presenting with general trauma pathology e.g. hip fractures, must have equity of access with other general medical and surgical unscheduled presentations requiring inpatient admission.	Trauma	UHB	Ongoing		The UHB is currently in the process of reviewing the trauma model following the opening of the GUH. This remains a core principle of the trauma service and will form a key aspect of the review.	Pick up via Trauma subgroup.
NCSOS	Key	2	2	Trauma theatre allocation must match HB demand and not be absorbed within elective orthopaedic capacity.	Trauma	Trauma	Ongoing		The UHB is currently in the process of reviewing the trauma model following the opening of the GUH. D&C is a fundamental aspect of the review.	Pick up via Trauma subgroup.
NCSOS	Key	3	3	Trauma capacity to be provided within context of whole surgical unscheduled and elective activity, on a clinically priority basis.	Trauma	UHB	Ongoing		The UHB is currently in the process of reviewing the trauma model following the opening of the GUH. This remains a core principle of the trauma service and will form a key aspect of the review.	Pick up via Trauma subgroup.
NCSOS	Key	4	4	Reintroduction of face to face clinics for first outpatient and pre-surgery reviews of long waiting (delayed) patients	R&R	N/A	Complete		All core outpatient capacity back online.	
NCSOS	Key	5	5	Establishment of the minimum outpatient capacity required to re-evaluate patients prior to surgery to avoid cancellation of procedure on the day.	R&R	N/A	Complete		All core outpatient capacity back online.	
NCSOS	Key	6	6	Video consultations to be focused on follow up or review clinics and supported by quality and performance monitoring via the National Outpatient Transformation programme.	R&R	N/A	Complete		Video consultations in place and the Directorate is actively seeking further opportunities to move F2F to virtual.	
NCSOS	Key	7	7	Minimum level outpatient capacity should be reinstated immediately.	R&R	N/A	Complete		All core outpatient capacity back online.	
NCSOS	Key	8	8	Consultant job plans must recognise all necessary outpatient capacity.	R&R	N/A	Complete		All scheduled activity is recognised in consultant job plans.	
NCSOS	Key	9	9	Prehabilitation services need to be established to support patients on the waiting list for orthopaedics, in line with UK guidance.	QPS	Directorate	Ongoing		Directorate to review existing UK guidance.	
NCSOS	Key	10	10	Services require national funding and local implementation to ensure equity of access and service delivery.	R&R	UHB	Ongoing		Significant plans ready to be implemented when additional funding is made available.	Low priority. Links with benchmarked activity forecasting. Rob G to flag with Rob H.
NCSOS	Key	11	11	While re-deployment of staff may be a short term solution, sustainable teams need to be planned to avoid weakening existing service requirements in MSK.	R&R	Nursing	Ongoing		Plan in place, D7E to be reopened on the 4/7	
NCSOS	Key	12	12	Theatre capacity for P2/3 orthopaedic cases must be provided immediately.	R&R	N/A	Complete		90% of CF theatre model are back online.	
NCSOS	Key	13	13	Weekly sit-rep reports to be provided to Welsh Government of surgical activity, reporting the treatment function and clinical prioritisation.	R&R	Reporting	Ongoing		Meeting arranged to outline metrics with Information and Lightfoot	
NCSOS	Key	14	14	Ring fenced bed capacity to support inpatient surgery restart.	R&R	Nursing	Complete		C7E and OSU online with plans in place to bring D7E online in July.	
NCSOS	Key	15	15	Urgent designation of elective/emergency patient flow in line with Gift recommendations to support HVLC surgical pathways.	R&R	N/A	Complete		CF model has clear separation of elective and emergency pathways with all trauma centralised at GUH.	
NCSOS	Key	16	16	Establishment of enhanced recovery units to increase the number of patients suitable for HVLC surgical pathways.	R&R	Steering	Complete		In place at RGH.	
NCSOS	Key	17	17	Urgent designation of regional LVHC surgical hubs within existing acute sites to provide mutual aid surgical pathways for complex patients	RW	Steering	Ongoing		Directorate's CF model makes extensive use of daycase and low acuity operating with a centralised high acuity site which focuses on LVHC surgery along with the most acute patients. The UHB remains committed to all existing regional discussions and is ready to participate in regional D&C.	Local position in relation to LVHC by December. Mutual aid/regional timescales TBC.
NCSOS	Key	18	18	Monitoring and reporting of the LVHC waiting list cohort and activity.	R&R	Reporting	Ongoing		Meeting arranged to outline metrics with Information and Lightfoot	
NCSOS	Key	19	19	Immediate collaboration between HBs to ensure co-ordinated staffing recruitment drives with workforce models that maximise flexibility, efficiency, regional working and supports support staff well-being.	RW	UHB	Ongoing		The UHB remains committed to all existing regional discussions and is ready to participate in coordinated and regional recruitment.	Regional Clinical Lead contributed on behalf of ABUHB (Mr Pullen). Awaiting regional conversations to begin.
NCSOS	Key	20	20	Immediate WG review of how theatre staffing groups are can be appropriately recognised and incentivised to support and improve efficiencies of the increasing volume of core and additional sessions that will be required to recover Orthopaedic services.	Not Relevant	WG	Complete		WG Action	
NCSOS	Key	21	21	Orthopaedic booking teams (outpatient and theatre) teams need to be re-established and supported to work collaboratively within and across system boundaries.	R&R	N/A	Complete		All admin teams have been returned to the Directorate.	

NCSOS	Key	22	22	Review of pre-assessment process locally to match theatre restart.	R&R	N/A	Complete		PAC capacity either back online or sufficient alternatives being utilised to meet theatre demand.	
NCSOS	Key	23	23	Reintroduction of consultant consenting clinics to match theatre capacity.	R&R	N/A	Complete		All consent consenting clinics are back online.	
NCSOS	Key	24	24	(Re-)Establishment of core orthopaedic anaesthetic services.	R&R	Steering	Complete		All but one theatre back online and taking leave into account nearly all theatre sessions are currently being accommodated.	
NCSOS	Key	25	25	Incorporation of trainee requirements into regional / collaborative planning for elective delivery.	Not Relevant	WG	Ongoing		Deanery Action	Huw to bring this up in WOB. Leanne to pick up with Tim Briggs. Angela to bring up with W&OD.
NCSOS	Hip	26	26	Ring fenced capacity for LVHC and infected/revision arthroplasty must be provided outside existing trauma capacity within all HB's	R&R	Nursing			Plan in place, linked to action 11 above	
NCSOS	Hip	27	27	A national Revision Arthroplasty MDT must be established with participation from all units and central funding for microbiological support.	RW	Hip & Knee	Complete		Directorate has an established MDT in place for both Hip and Knee where all revisions amongst other complex procedures are discussed. The Directorate would be happy to engage in discussions to establish a wider regional/national forum.	
NCSOS	Knee	28	28	Outpatient and surgical capacity for acute knee injury management must be made available in all HBs immediately.	Trauma	N/A	Complete		All core outpatient capacity back online.	
NCSOS	Knee	29	29	All HBs must ring fence MRI capacity for acute knee patients. Short-Medium term commissioning through local private providers should be considered if immediate HB delivered capacity is not feasible.	Not Relevant	Steering	Complete		Not an issue within ABUHB.	
NCSOS	Foot & Ankle	30	30	All HB's must ensure diabetic MDFS in place immediately	QPS	F&A	Complete		Well established within the UHB however vascular centralisations may require changes to existing pathways.	
NCSOS	Shoulder & Elbow	31	31	Outpatient and surgical capacity for acute shoulder and elbow injury management must be made available in all HBs immediately.	Trauma	N/A	Complete		All core outpatient capacity back online.	
NCSOS	Shoulder & Elbow	32	32	All HBs to commission ring fenced USS capacity for acute soft tissue shoulder and elbow injuries utilising local private providers if necessary.	Not Relevant	Steering	Complete		Not an issue within ABUHB.	
NCSOS	Hand & Wrist	33	33	All HB should ensure immediate relocation of non-surgical services from existing day case theatre capacity.	R&R	Hands	Ongoing		To be discussed in all subspecialty meetings and available capacity to be prioritised if necessary.	
NCSOS	Health Board Specific	34	34	All HB executive, clinical and operational teams to review their Gift reports and address the individualised HB recommendations.	General	Steering	Complete		Process established to address actions and recommendations	
GIRFT	Executive Recommendations	1	35	The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as one Health Board and not hospital by hospital.	General	Steering	Complete		Steering Group established for the whole Directorate which does not function on a site by site basis.	
GIRFT	Executive Recommendations	2	36	Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation	General	Steering	Complete		All actions and recommendations included in this combined action.	
GIRFT	Executive Recommendations	3	37	Ensure that the Health Board orthopaedics lead implements the changes required to minimise unwarranted variation and that regular progress is provided to the Executive Team and Steering Group	General	Steering	Complete		CD integral part of the planned process.	
GIRFT	Executive Recommendations	4	38	ABUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent need to re-engage with clinicians to rebuild trust and ensure that clinicians are listened to and involved at each stage of restart and change proposals. It is imperative that clinicians are an integral part of the "sign off" and delivery of changes.	General	UHB	Ongoing		The UHB have launched stages 2 and 3 of the high priority MSK programme which the actions from GIRFT and NCSOS will be addressed. The steering group and lead clinicians are included and essential to delivering he agenda across all MSK programmes. The UHB recognises that further improvement is necessary in communicating with the wider clinical teams and this will be addressed as a priority by the steering group for this work going forward.	Leanne to pick this up with Executive Team in terms of wider comms and engagement with staff. All to provide views on what comms would be useful/format.
GIRFT	Executive Recommendations	5	39	Carry out a staff survey without delay to understand the issues affecting staff morale and how these can be addressed. We consider that improved and open communication with colleagues about the short, medium and long term plans will help to improve staff morale. We do recognise, that there are a number of recent factors affecting staff morale.	General	UHB	Ongoing		Plans to undertake as part of the wider planned care programme as the UHB recognises that this is relevant to all teams and not limited to Orthopaedics.	Angela Palfrey to pick up staff wellbeing survey.

GIRFT	Executive Recommendations	6	40	Implement elective recovery at pace. We are aware that capital investment is currently limited. However, most of our recommendations rely on better use of existing assets and on using revenue budgets and resources more efficiently. We expect that an urgent initial plan, which sets out how the Health Board will fully restart orthopaedic surgery to be in place, no later than the end of March 2022. Any barriers or risks to delivery of this plan need to be urgently resolved. The plan should include a communication and engagement plan with all patients so that patients fully understand the timetable for their surgery.	R&R	Steering	Complete		Theatre 4 at RGH remains the only capacity without a timeline to be brought back online. All other capacity not online has separate actions.	
GIRFT	Executive Recommendations	7	41	Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient's home prior to admission. For emergency admissions (e.g. fracture neck of femur), patients should be assessed early on during their admission to agree their likely support package, which can be tweaked if the patient's condition changes. Currently, a Social Services assessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficient use of valuable beds, thereby reducing elective surgical admissions. We need a risk share between the hospitals and Social Services as elective patients are disadvantaged due to lack of bed availability.	QPS	PAC			All elective patients are assessed by physio and OT prior to admission either in F2F clinics or virtually with all necessary equipment provided prior to admission. Engagement with social services will be necessary to change the current policy of waiting until patients are medically fit before referrals can be made.	Rachel Challenger to link with Sue Pearce re: ongoing work in Goals 5 & 6
GIRFT	Executive Recommendations	8	42	Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recorded and used across all Health Boards.	General	N/A	Complete		PROMs not yet in place and unfortunately no data to review. Plans in place to implement PROMs platform this year.	
GIRFT	Executive Recommendations	9	43	Set up a cross Health Board initiative to ensure that litigation claims are regularly reviewed in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. Claims should be discussed in clinical governance meetings to share the learning; junior doctors should also be involved in these review meetings. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed. Note that we did find some good practice in reviewing litigation claims but we think it could be improved.	QPS	Legal			This is much wider then Orthopaedics and needs to be implemented and led by cross divisional or corporate team. The Directorate does facilitate audit meeting monthly with the full medical team which are used for similar purposes locally at present and could be amended to meet the expanded remit.	Litigation issues raised in other GIRFT reports too - Leanne to pick up with TPW.
GIRFT	Executive Recommendations	10	44	Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.	QPS	Reporting			This is much wider then Orthopaedics and needs to be implemented and led by cross divisional or corporate team. The Directorate does facilitate audit meeting monthly with the full medical team which are used for similar purposes locally at present and could be amended to meet the expanded remit.	Rachel Challenger leading SSI work. Tracey Rich leading case reviews. Link with IPC to look at themes.
GIRFT	Executive Recommendations	11	45	Create and implement a workforce plan both short, medium and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.	General	HR	Ongoing		Scoping exercise to be undertaken involving all stakeholders across the pathway. Workforce to lead.	IJ to pick up workforce planning via IMTP for next year.
GIRFT	Executive Recommendations	12	46	As part of the medium and longer term orthopaedic plan, all outsourcing and external commissioning of services should be reviewed. The aim should be to deliver all outsourced activity to the same level and standard e.g. the minimum number of knee revisions by one consultant.	Not Relevant	N/A	Complete		ABUHB Have not outsourced Orthopaedic patients in recent years	
GIRFT	Executive Recommendations	13	47	Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following:	R&R	Steering	Complete		Elective recovery has progressed significantly since the publication of both reports and a comprehensive D&C plan has been developed and is being delivered. Further plans are ready to be implemented should additional funding be made available. The UHB remains committed to all existing regional discussions and is ready to participate in regional D&C.	

GIRFT	Executive Recommendations	14a	49	Carry out full demand and capacity planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve ABUHB. It is crucial that elective recovery is seen as a regional imperative with all Health Boards working together. This will ensure that ALL existing assets available for Orthopaedic elective recovery are utilised.	RW	Steering	Ongoing		Elective recovery has progressed significantly since the publication of both reports and a comprehensive D&C plan has been developed and is being delivered. Further plans are ready to be implemented should additional funding be made available. The UHB remains committed to all existing regional discussions and is ready to participate in regional D&C.	Completed
GIRFT	Executive Recommendations	14b	50	Set up a daily sitrep specifically focused on elective recovery to the Executive on waiting lists to include the number of patients and volumes categorised by: ASA score; time on waiting list; operations carried out; expected monthly operations; forward targets to reduce lists and delivery against these targets. This should also include the number of operations expected to be delivered as a day case. We suggest that to gain the best momentum in elective recovery that the sitrep should cover all elective surgery and not just orthopaedics. In our report to the Welsh Government, we will be recommending that these sitreps are provided daily until Elective Recovery is on track and less of a risk to patients.	R&R	Reporting	Ongoing		Meeting arranged to outline metrics with Information and Lightfoot	
GIRFT	Executive Recommendations	14c	51	Establish a delivery model to restart elective recovery. This needs to be established at pace. GIRFT supports in principle, the long term plans to create an elective hub at the Grange site, currently the trauma centre for both HVLC and LVHC procedures provided all other capacity and existing assets are fully utilised for elective care, and in the interim, utilise the Royal Gwent for complex LVHC workload, HVLC case-mix at St Woolos and day-case procedures at Ystrad Fawr Hospital. However, the longer-term strategy must be co-ordinated nationally in line with the recommendations of the NCSOS project, so that any major infrastructural changes are implemented with regional and national context. ABUHB must ensure these sites have the appropriate staffing levels to sustain services during periods of additional pressure.	R&R	Steering	Complete		Vast majority of the Directorates' capacity is back online with plans in place for the remaining elements. By the beginning of July only one theatre will be offline from the whole estate.	
GIRFT	Executive Recommendations	14d	52	Utilise fallow capacity at Nevill Hall as a mutual aid regional resource to provide elective capacity on a regional basis for North and East CTM, ABHB, CVHB (if needed) and South Powys	RW	UHB	Complete		Directorate has offered fallow capacity to CTM which wasn't taken forward. Other UHB Directorates are developing plans to utilise any fallow assets but the UHB remains open to supporting any neighbouring UHB with any remaining capacity.	Offered to help CTM but no uptake.
GIRFT	Executive Recommendations	14e	53	Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.	R&R	Steering	Complete		Directorate has access to Elective beds on multiple sites so not relevant.	
GIRFT	Executive Recommendations	14f	54	Develop an enhanced recovery unit operated 24 hours a day, seven days a week, that allows upskilled nurses to provide care and assessment to the sickest and most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.	R&R	Steering	Complete		Similar facility currently in place at RGH.	
GIRFT	Executive Recommendations	14g	55	Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	R&R	Theatre	Ongoing		Two sites currently operate three session days and one of which is setup to operate over seven days. Operative list length will be a key element of MSK workstream 3 which will facilitate a wider debate and review opportunity to 'right size' list length to specific subspecialties to explore opportunity for productivity gains.	
GIRFT	Executive Recommendations	14h	56	Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, Occupational Therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	QPS	PAC			All elective patients are assessed by physio and OT prior to admission either in F2F clinics or virtually with all necessary equipment provided prior to admission. Engagement with social services will be necessary to change the current policy of waiting until patients are medically fit before referrals can be made.	Rachel Challenger to link with Sue Pearce re: ongoing work in Goals 5 & 6
GIRFT	Executive Recommendations	14i	57	Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day.	R&R	PAC	Complete		Directorate has the best utilisation of PAC clinics in the UHB with utilisation maintained above 90%. Additionally YYF coming back online on 4th July, and NHH on 11th July.	

GIRFT	Executive Recommendations	14j	58	Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring “top decile” outcomes and using the GIRFT theatre principles and expected productivity as a steer.	R&R	Steering	Complete		Directorate's CF model makes extensive use of daycase and low acuity operating with a centralised high acuity site which focuses on LVHC surgery along with the most acute patients.	
GIRFT	Executive Recommendations	14k	59	Where there is recognised “good practice” in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.	RW	UHB	Complete		Welsh Orthopaedic Board has provided a decent platform for the sharing of good and best practice but the UHB would welcome further opportunities to share and learn from other organisations.	
GIRFT	Executive Recommendations	14l	60	Review emergency and urgent pathways to improve patient flow.	Trauma	Steering	Ongoing		The UHB is currently in the process of reviewing the trauma model following the opening of the GUH. All emergency pathways will be reviewed as part of the wider review including step down.	Pick up via Trauma subgroup.
GIRFT	Executive Recommendations	14m	61	Review of patients that are deconditioning on the waiting list, identify patients that require urgent care.	QPS	Directorate			There have been extensive discussions on this in an number of forums and they all come back to requirement for clinical review. Particularly given the volume of patients on the waiting lists it has the potential to burn through clinical sessions massively impacting on capacity. Alternative national solution maybe necessary.	IJ to link with Swansea to see what they are doing. Currently using our clinical time to see and treat patients. Deterioration should be picked up via usual route (e.g GP)
GIRFT	Executive Recommendations	14n	62	Determine effective and efficient follow up plans – which are carried out virtually if possible but with appropriate safety netting in place where needed.	R&R	Subspecs	Ongoing		PIFU agreed for all major joints at one year appointment however discussions and pathway reviews will continue across all subspecialties. Process to periodically review pathways along with latest guidence.	
GIRFT	Executive Recommendations	14o	63	Review of patients with high BMI and weight management services and identify improvement strategy and how to best respond to patients wanting surgery with high BMI.	QPS	Reporting	Ongoing		Historic difficulty in identifying patient BMI data within WPAS which has been discussed at length at Welsh Orthopaedic Board. Progress to be discussed at arranged meeting.	BMI conversations taken offline.
GIRFT	RNOH/GIRFT Recommendations	15	64	RNOH/GIRFT recommends: ABUHB to increase the usage of fully cement hip fixations in patients over 65+years. At least 80% of patients over 70 years of age should be receiving a fully cemented or hybrid hip replacement. This is compliant with the standardised Hip replacement in HVLC (High Volume Low Complexity) endorsed by the BOA.	QPS	Hip	Ongoing		Being discussed at WOB in September.	
GIRFT	RNOH/GIRFT Recommendations	16	65	RNOH/GIRFT recommends: ABUHB to ensure relevant training is provided for fully cemented hip fixations.	QPS	Hip	Ongoing		Mr Akhtar	
GIRFT	RNOH/GIRFT Recommendations	17	66	RNOH/GIRFT recommends: For ABUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation.	QPS	Hip	Complete		Process agreed at Directorate on 11/07/2022 for all surgeons.	
GIRFT	RNOH/GIRFT Recommendations	18	67	RNOH/GIRFT recommends: A review of 90-day primary hip 90-day mortality rates to be carried out.	QPS	Hip	Ongoing		Mr Akhtar	
GIRFT	RNOH/GIRFT Recommendations	19	68	RNOH/GIRFT recommends: Review of elective knee revision rates and establish an improvement strategy.	QPS	Knee	Ongoing		Mr Lewis	
GIRFT	RNOH/GIRFT Recommendations	20	69	RNOH/GIRFT recommends: Reduce the number of surgeons carrying out primary knee surgery as the revision rates are high. Centralise the elective knee surgery to be carried out at one hospital.	QPS	Knee	Ongoing		Elective Knee surgery is centralised at RGH/OSU based on acuity of patients. Mr Lewis to lead review of number of surgeons undertaking elective knee surgery.	
GIRFT	RNOH/GIRFT Recommendations	21	70	RNOH/GIRFT recommends: ALL Hip and knee revisions to be discussed in Health Board Regional MDTs prior to surgical intervention.	QPS	Hip & Knee	Complete		Directorate has an established MDT in place for both Hip and Knee where all revisions amongst other complex procedures are discussed. The Directorate would be happy to engaged in discussions to establish a wider regional forum.	
GIRFT	RNOH/GIRFT Recommendations	22	71	RNOH/GIRFT recommends: A review of 90-day primary knee 90-day mortality rates to be carried out.	QPS	Knee	Ongoing		Mr Lewis	

GIRFT	RNOH/GIRFT Recommendations	23	72	RNOH/GIRFT recommends: Centralise hip and knee revision surgery and foot and ankle arthrodesis to be carried out at one site.	QPS	Hip, Knee & F&A	Complete		Hip and knee revision surgery is centralised to RGH/OSU based on acuity of patients. F&A service adhere to BOFAS recommendations in regards to horizontal arthritis network with regular multi-consultant complex F&A clinic.	
GIRFT	RNOH/GIRFT Recommendations	24	73	RNOH/GIRFT recommends: Undertake a review of arthroscopy and ankle activity data to identify the correct volumes and develop an improvement strategy to improve reporting of this data.	QPS	F&A	Complete		Review has been completed and with the exception of two patients all were coded appropriately. The numbers suggest that the volume if appropriate for F&A Services and is done regularly. The operating surgeon will ensure that the code is appropriate when entering surgical note on ORMIS for all future procedures.	
GIRFT	RNOH/GIRFT Recommendations	25	74	RNOH/GIRFT recommends: Review of NHS shoulder subacromial decompression activity ensuring evidence is being used and these patients have gone through the appropriate pathway including physiotherapy before being offered surgery.	QPS	Shoulder	Ongoing		Mr Mehta, agreed at Shoulder subspecialty meeting on 11/07/2022 for presentation at Septmber meeting	
GIRFT	RNOH/GIRFT Recommendations	26	75	RNOH/GIRFT recommends, urgent attention required: ABUHB to undertake a review of hip and knee primary and revision length of stay rates and develop an improvement strategy. Centralise hip and knee revision activity to reduce length of stay rates.	QPS	Hip & Knee	Ongoing		Hip and knee revision surgery is centralised to RGH/OSU based on acuity of patients. Mr Lewis (Knee) & Mr Akhtar to undertake review of primary and revision LOS and if necessary develop an improvement strategy.	
GIRFT	RNOH/GIRFT Recommendations	27	76	RNOH/GIRFT recommends: Review of elbow replacement length of stay rates and establish an improvement strategy.	QPS	Elbow	Ongoing		Mr Kulkarni	
GIRFT	RNOH/GIRFT Recommendations	28	77	RNOH/GIRFT recommends: to consider whether hip and knee day case surgery could be more broadly used for some patient groups.	QPS	Hip & Knee	Ongoing		The Directorate is eager to progress daycase major joint project and is keen to ensure it is included in the MSK stage 3 workstream.	
GIRFT	RNOH/GIRFT Recommendations	29	78	RNOH/GIRFT recommends: Improve enhanced recovery by having physiotherapy service available on weekends to mobilise the patients for earlier discharge. When ABUHB develop the elective hubs, it is imperative that they are staffed appropriately to maximise outcome and improve patient flow.	QPS	Physio	Ongoing		Physio support is currently available on all sites over the weekend with the notable exception of NHH. A business case has been written outlining the resource and financial implications which is progressing through the relevant internal processes.	
GIRFT	RNOH/GIRFT Recommendations	30	79	RNOH/GIRFT recommends: Cement THR in patients over 70 years old provides best outcomes.	QPS	Hip	Ongoing		Mr Akhtar	
GIRFT	RNOH/GIRFT Recommendations	31	80	RNOH/GIRFT recommends Consider measuring in hours opposed to days.	QPS	Reporting	Ongoing		Meeting arranged to outline metrics with Information and Lightfoot	
GIRFT	RNOH/GIRFT Recommendations	34	81	RNOH/GIRFT recommends: Consider post- operative follow ups to be carried out virtually.	QPS	Directorate	Complete		Directorate has long history of undertaking virtual FU and more recently have moved to video based FU. This will continue to develop as pathways are reviewed.	
GIRFT	RNOH/GIRFT Recommendations	35	82	RNOH/GIRFT recommends: For ABUHB to undertake regular peer arthroplasty reviews of surgeon level data also reviewing low volume activity.	QPS	Knee	Complete		Process agreed at Directorate on 11/07/2022 for all surgeons.	
GIRFT	RNOH/GIRFT Recommendations	36	83	RNOH/GIRFT recommends: St Woolos to review return to theatre rates for another shoulder procedure within 1 year.	QPS	Shoulder	Ongoing		Mr Mehta, agreed at Shoulder subspecialty meeting on 11/07/2022 for presentation at Septmber meeting	
GIRFT	RNOH/GIRFT Recommendations	37	84	RNOH/GIRFT recommends: ABUHB to undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering low volumes of both hip and knee revisions annually should no longer be performing this surgery. Operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications and cost.	QPS	Hip & Knee	Ongoing		Mr Lewis & Mr Akhtar	
GIRFT	RNOH/GIRFT Recommendations	38	85	RNOH/GIRFT recommends: Review to be carried out of adverse events for primary hip and knee at St Woolos Hospital. A review of the theatre adverse events/ NJR data to be carried out annually.	QPS	Hip & Knee	Ongoing		Clinical leads; Mr Lewis (Knee) & Mr Akhtar, to undertake annual review of adverse events/NJR data at OSU	
GIRFT	RNOH/GIRFT Recommendations	39	86	RNOH/GIRFT recommends: ABUHB to collect PROMs data, to discuss and review PROMs score internally on an annual basis.	QPS	Directorate	Ongoing		Contract being finalised for application which facilitates PROMs being finalised with supplier.	

GIRFT	RNOH/GIRFT Recommendations	40	87	RNOH/GIRFT recommends: Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning.	QPS	Reporting			This is much wider then Orthopaedics and needs to be implemented and led by cross divisional or corporate team.	Rachel Challenger leading SSI work. Tracey Rich leading case reviews. Link with IPC to look at themes.
GIRFT	RNOH/GIRFT Recommendations	41	88	RNOH/GIRFT recommends: ABUHB to regularly review with the claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed.	QPS	Legal			This is much wider then Orthopaedics and needs to be implemented and led by cross divisional or corporate team. The Directorate does facilitate audit meeting monthly with the full medical team which are used for similar purposes locally at present and could be amended to meet the expanded remit.	Litigation issues raised in other GIRFT reports too - Leanne to pick up with TPW.

Domain	(All)
Sub Domain	(All)

Count of Unique Identifier	Column Labels			
Row Labels	**Complete**	**(blank)**	**Ongoing**	**Grand Total**
GIRFT	18	7	28	53
NCSOS	22	1	11	34
Grand Total	**40**	**8**	**39**	**87**

Orthopaedic Improvement Steering Group

Terms of Reference

Document History:

Amended by	Version	Status	Date	Purpose of Change
Ruby Punchard	v0.1	Draft	27/05/2022	First draft
Ruby Punchard	V0.2	Draft	29/06/2022	Add principles
Ruby Punchard	V0.3	Draft	05/07/2022	Edit membership/quoracy

1) Purpose

The number of people waiting to start treatment in Wales is at record high. Elective orthopaedics has been at a standstill for almost 2 years with growing waiting lists, making it a key priority area for Welsh Government's recently published Planned Care Recovery strategy.

In addition, the GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by Welsh Government to conduct a full review of Welsh Orthopaedic Services using the GIRFT methodology and HVLC principles. This dovetails with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) report. The two reports have a number of recommendations and actions which have been compiled into a Combined Action Plan.

The Executive Team has previously noted the national Planned Care Board focus to address the increasing challenge of long waiting times and large waiting lists for MSK assessment and treatment.

MSK Transformation has been identified by Aneurin Bevan University Health Board (ABUHB) as a strategic opportunity and priority for the 2022/23 IMTP, along with the need for an MSK Transformation Programme to be established, reviewing the entire MSK pathway.

The Orthopaedic Improvement SG will oversee the improvement work directly related to these reports under the auspices of Workstreams 2 and 3 of the MSK Transformation Programme.

Recognising the breadth of the pathway, the MSK Transformation Programme Board will support the work to take place in workstreams, as detailed below:

Workstream 1
Community Therapy

Workstream 2
Outpatients

Workstream 3
Elective Surgery

Workstream 4
Post-operative

2) Principles

The Steering Group will hold itself to the following principles:

- Putting patients first
- Openness and transparency
- Expectation of feedback within profession
- Acting as an ambassador for the workstream
- Respectful challenge
- Deliverable
- Realistic
- Silence as acceptance

3) Duties

The Steering Group's role is to oversee and facilitate the combined action plan resulting from the national reports by:

a. Ensuring appropriate representation & engagement from the start
b. Agreeing guiding principles of how the work will be undertaken
c. Establishing a communications strategy for key stakeholders
d. Reviewing, agreeing and prioritising key actions
e. Agreeing ownership of actions & establishing the sub groups
f. Developing an Elective Recovery Plan to ensure all capacity is maximised
g. Providing updates and reports to the MSK Transformation Programme Board

4) Membership

Name & Job Title	**Role on Steering Group**
Leanne Watkins, Director of Operations	Executive Sponsor (Chair)
Huw Pullen, Clinical Director	
Daniel Parfitt, Deputy Clinical Director	
John Lloyd, Deputy Clinical Director, Trauma Clinical Lead	
Amanda Hale, Divisional Nurse Scheduled Care	
Sarah Beuschel, Lead Nurse for QPS	QPS Lead
Ian Jenkins, AGM Scheduled Care	T&O Directorate Manager
Andy Bagwell, Medical Lead for Operations	
Collette Kiernan, Clinical Director, Therapies	Therapies rep

Radiology representative	
Gwawr Evans, AGM Theatres and Anaesthetics	
Robert Gordon, Finance BPA Julie Williams, Finance BPA	Finance rep
Angela Palfrey, Workforce BPA	Workforce rep
Trish Chalk, Head of System Planning	Planning support
Ruby Punchard, Senior Programme Manager	Programme support

Members have a responsibility to:

- Attend the meetings and support identified subgroups;
- Provide a named deputy with sufficient seniority for occasions where members are unable to attend.

Quorum
The group will be quorate if at least 50% of group members are present, including a clinical representative from Orthopaedics, Therapies and Nursing.

Each member is able to nominate a pre-named alternate who can act and make decisions in their absence.

Attendees
Others will be co-opted on to the Steering Group as and when required.

5) Subgroups

The combined action plan has a total of 87 recommendations and actions which have been grouped into the following subgroups:

- Quality & Patient Safety (33 Actions)
- Restart & Recovery (30)
- Regional Working (5)
- Trauma Service (7)
- General/Other (12)

6) Structure, reporting and accountability

7) Meetings

The Steering Group will meet monthly for one hour. The meeting duration will be extended if required.

Papers, including an agenda, will be circulated to members at least five working days in advance to allow sufficient time for review.

Minutes of meetings will be produced, and a draft agreed by the Chair prior to the distribution of the papers.

8) Review

Once agreed, the Terms of Reference will be reviewed yearly with the first review due in June 2023.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 4.1

Aneurin Bevan University Health Board

Financial Outlook & 2023/24 Allocation Letter Briefing

Purpose of the Report			
This report provides a strategic financial outlook for 2023/24 to 2025/26, identifying the likely sources of income which may be available to form a Health Board 2023/24 financial plan, the operational challenges and expenditure pressures facing the Health Board, including the significant underlying financial deficit entering the 2023/24 financial year. Further details and analysis are provided in the accompanying reports to the committee under agenda item 4 (Underlying Position, Budget Setting, Efficiency opportunities). The 2023/24 allocation letter was received on 22nd December 2022 and a comprehensive briefing is included.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	√		
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe – Executive Director of Finance, Procurement & VBHC			
Report Author: Suzanne Jones – Interim Assistant Director of Finance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board Finance & Performance Committee**	
Date of the Report: January 2023			
Supplementary Papers Attached: Appendix 1- Allocation Letter Briefing Appendix 2 - Statutory Financial Duties Appendix 3 – Glossary			

Executive Summary

The Health Board has a statutory requirement to operate within its available funding, specifically to establish a 3 year IMTP that delivers the objectives of the organisation and WG and delivers financial balance over a rolling 3 year period.

The 22/23 IMTP identified a financial strategy and plan that focussed on sustainability and identified a 3-part plan of Core, Covid and Exceptional costs, with a recurrent savings requirement to balance the core financial plan to operate within the available funding of £1.6bn.

The current financial year has been a very challenging one for financial and operational pressures, despite the additional covid and exceptional costs funding received.

ABUHB has reported a likely forecast 'core' deficit for 2022/23 of £37m.

Additional non-recurrent funding has been received or anticipated during 2022/23 for:

- Covid national schemes £27m
- Local Covid Schemes £45m
- Exceptional Cost funding (ie. Energy) £18m, tbc

Funding to this level is not available for 2023/24 and initial intelligence from WG is that 2024/25 will see funding uplifts reduce further.

The core position is driven by operating efficiencies not being delivered aligned with the 22/23 IMTP aspirations, there are several reasons for this including: -

- a lack of delivery at pace of transformational priority programmes, expected to deliver recurrent savings,
- failure to fully mitigate IMTP cost risks,
- historical commitments (opening underlying deficit) not funded, including GUH commitments, that have not been able to be mitigated through savings delivery and
- exceptional operational pressures across the NHS and health and social care system driving workforce and other cost pressures, specifically bed pressures, DToC's, medicines costs, CHC costs and variable pay requirements.

ABUHB has an emerging underlying deficit of potentially c. £100m for the end of 2022/23, this is subject to more detail review as part of the IMTP process.

This means the Health Board will start 2023/24 with a spending level (before any new commitments agreed for 2023/24) that it cannot afford, the 23/24 allocation and assumed income will not be sufficient to meet these forecast costs without the delivery of significant cost reductions and savings. The degree of savings that can be achieved over the 3-year IMTP timeframe will need to be carefully considered to develop the revised financial strategy and plan for the IMTP.

The global economic crisis post covid is impacting on the government's ability to fund public services to the levels aspired to historically. The future WG funding for health and social care will be a challenging proposition for NHS Wales to manage.

Going forward ABUHB will need to consider the choices it makes in terms of priorities that provide a SUSTAINABLE safe and harm free service to our population and patients, but also where we may need to reduce low value services to balance the financial position. The proposition for 23/24 will need to be cognisant of:

- The need to continue with the additional structures established focussing on financial performance and savings delivery
- The ability to operate in a stronger governance environment
- Develop ownership of the challenge by all staff
- How budget setting and delegation is aligned with accountability for both financial target and service performance delivery
- WG expect a 2.5% saving to be delivered by each NHS Wales organisation
- The explicit expectation of delivery of increased efficiencies – then to determine if we 'do more' or do the same and 'spend less', (the latter will be an unfamiliar concept in ABUHB).
- The need to reduce spending & generate CASH releasing savings

- The need to 'shift' resources as part of making the best use of resources
- The allocation letter for 23/24 and potential additional funding opportunities
- The commitments to partnership & joint working priorities
- The uncertainty of the operating environment and external factors
- Be prepared to consider difficult choices

Revenue Allocations for 2023/24

Allocations increased by £17m for ABUHB, but after top slices there is £9.4m available as extra funding for 2023/24. This initial figure will be updated as additional allocations are published.

Recommendation
The Board is requested to note this paper and receive as part of the assurance process for developing the 2023/24 to 2025/26 IMTP and financial strategy and 2023/24 financial plan.

Background and Context

Governance
The Health Board has a statutory requirement to operate within its available funding, specifically to establish a 3-year IMTP that delivers the objectives of the organisation and WG and delivers financial balance over a rolling 3 year period.

Specifically, the Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it or its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

In order to deliver these targets, the health board has established Standing Orders and Standing Financial Instructions supported by Policies and Procedures. There are also external scrutiny bodies that support governance & performance e.g., Audit Wales, Health Inspectorate Wales.

Additionally, during 2022/23 the Health Board has established a revised Board governance structure, with further arrangements established particularly focussing on financial performance.

The challenging financial outlook would indicate the need to continue to operate with the additional arrangements focussing on financial performance and savings delivery into 2023/24.

2022/23 Financial Plan and Performance

2022/23 IMTP
Following the extreme system and workforce pressures driven by Covid and the opening of the Grange University Hospital, the 22/23 IMTP identified a financial strategy and plan that aligned with Board financial principles and focussed on sustainability, ensuring the £1.6bn budget was allocated for GUH commitments beyond the original plan and other unfunded commitments prior

to new investments. Part of this approach was to remove historical pressures and bring current issues to the forefront for more pro-active budgetary management. In order to balance the financial plan a recurrent savings requirement of £26m was identified, with the expectation that additional costs of circa £19m would be mitigated and any further new cost pressures would be managed. Savings opportunities were identified, and a corporate transformation approach was agreed to drive cost reductions for 2022/23 through the priority PMO schemes.

2022/23 Financial Performance
The uncertainty of 2022/23 presented by responding to the continued implications of Covid, the exceptional international, national, and local circumstances driving service pressures for ABUHB during the year. These have had serious implications and consequences for the service, workforce, and financial performance of the health board, as well as the NHS across the UK.

The current financial year has been a very challenging one for financial and operational delivery, despite the additional covid and exceptional costs funding received.

For the first time since its establishment, ABUHB has reported a likely forecast 'core' deficit for 2022/23 of £37m.

The core position is driven by operating efficiencies not being delivered aligned with the 22/23 IMTP aspirations, there are several reasons for this including: -

- a lack of delivery at pace of transformational priority programmes, expected to deliver recurrent savings,
- failure to fully mitigate IMTP cost risks,
- historical commitments (opening underlying deficit) not funded, including GUH commitments, that have not been able to be mitigated through savings delivery and
- exceptional operational pressures across the NHS and health and social care system driving workforce and other cost pressures, specifically bed pressures, DToC's, medicines costs, CHC costs and variable pay requirements.

Additional non-recurrent funding has been received or anticipated during 2022/23 for:
Covid national schemes £27m
Local Covid Schemes £45m
Exceptional Cost funding (i.e., Energy) £18m

The allocation letter has confirmed non-recurrent funding to this level will not be available for 2023/24 and initial intelligence from WG is that 2024/25 will see funding uplifts reduce further. There remain further opportunities to secure centrally held funds, but these remain uncertain and will likely be directed to specific WG priorities.

Underlying Position

ABUHB started 2022/23 with an opening underlying deficit of £20m, with the aim to deliver recurrent savings to improve this position to £8m by the end of 2022/23. Due to the pressures experienced during the year, reported in Board Finance reports, the Board has been unable to deliver efficiencies to the level aspired to and has been forced to manage service pressures through higher cost solutions like variable pay. The bed compliment for ABUHB has not operated in line with plans and acuity, lengths of stay and DToCs are driving costs beyond those previously experienced.

As a result, there is an emerging underlying deficit of potentially c.£100m for the end of 2022/23, this is subject to more detail review as part of the IMTP process but can be outlined in broad terms as:
2022/23 Deficit £37m

Local Covid funding not available for 23/24 £45m
Exceptional costs not discretely funded in 23/24 £18m, tbc

(See the Underlying Paper ref. 4.2 for more details)

Implications & Risks for 2023/24 to 2025/26

The underlying forecast means the Health Board will start 2023/24 with a spending level (before any new commitments agreed for 2023/24) that it cannot afford, the 23/24 allocation and assumed income will not be sufficient to meet these forecast costs without the delivery of significant cost reductions and savings.

The degree of savings that can be achieved over the 3-year IMTP timeframe will need to be carefully considered to develop the revised financial strategy and plan for the IMTP.

The global economic crisis post covid is impacting on the government's ability to fund public services to the levels aspired to historically. The future WG funding for health and social care will be a challenging proposition for NHS Wales to manage.

Going forward ABUHB will need to consider the choices it makes in terms of priorities that provide a SUSTAINABLE safe and harm free service to our population and patients, but also where we may need to reduce low value services to balance the financial position.

The ABUHB proposition for 23/24 and longer term will need to be cognisant of:

- The need to continue with the additional structures established focussing on financial performance and savings delivery
- The ability to operate in a stronger governance environment
- Develop ownership of the challenge by all staff
- How budget setting and delegation is aligned with accountability for both financial target and service performance delivery
- The explicit expectation of delivery of increased efficiencies – then to determine if we 'do more' or do the same and 'spend less', (the latter will be an unfamiliar concept in ABUHB).
- The need to reduce spending & generate CASH releasing savings
- The need to 'shift' resources as part of making the best use of resources
- The allocation letter for 23/24 and potential additional funding opportunities
- The commitments to partnership & joint working priorities
- The uncertainty of the operating environment and external factors
- Be prepared to consider difficult choices

Revenue Allocations for 2023/24

The 2023/24 revenue Allocation letter was received on the 22nd of December 2022 and highlights the financial implications for Aneurin Bevan University Health Board's (ABUHB) 2023/24 Financial Plan.

Baseline funding for 2023/24 has increased by **£60.7m** compared to 2022/23 (baseline). A detailed breakdown of the increase is shown in the Appendix. The 'true' net uplift to the Health Board i.e., excluding committed and directed funding, is **£9.4m** as follows:

Net funding uplift	2023/24 funding (£'000)
Core uplift 23/24	17,262
Planned and Unscheduled Care sustainability	(9,419)
Value Based recovery	(192)
Mental Health core uplift 23/24	1,961
Other funding movements	(231)
Total	**9,382**

Key points to note:

- Funding for NHS pay awards in 23/24 will be held centrally (in full) and allocated to the Health Board once awards are made.
- Funding for ongoing national Covid responses, specifically; mass vaccination, Test, Trace and Protect and the provision of PPE will be held centrally and allocated based on actuals during 23/24. Other Covid related costs will need to be met by Health Boards (unless informed otherwise).

  It should be noted that further clarification was received on the 22nd of December via a separate Welsh Government route to the allocation letter describing funding for Public Health response including Covid-19 as well as Adferiad (Long Covid).
  - *Response to Health Protection measures - £4.8m (non-recurrent)*
  - *Mass vaccination - £8.1m (non-recurrent)*
  - *Adferiad (Long Covid) - £0.9m (tbc recurrent)*

  This is excluded from the remaining report due to being treated separately by WG.

- General Medical Services (GMS), Pharmacy and General Dental Services (GDS) contractor allocations have been issued at 22/23 recurrent levels at this stage. A supplementary allocation will be issued when contract agreements have been confirmed.

The 2023/24 allocation, anticipated allocations and income are currently estimated to be **£1.602bn** *(excluding notified covid funding and capital charges funding),* compared with £1.56bn for 2022/23.

Summary

2022/23 has seen exceptional external factors drive an exceptional operational response in ABUHB. The resultant financial challenges have generated a likely forecast deficit for 2022/23 and a significant increased underlying deficit into 2023/24.

The funding identified (so far) for 2023/24 will be insufficient for ABUHB to afford to operate as it is currently and will require ABUHB to identify cost reductions through improved efficiency and making prioritised choices to meet its statutory duties.

This challenging position is replicated across many organisations in NHS Wales.

ABUHB has established a financial recovery approach that should help the organisation deliver the cost reductions, with the engagement and ownership of the staff across the organisation.

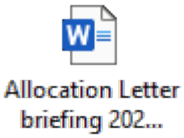
The Health Board needs to deliver financial balance over a rolling 3-year period and this needs to be considered as part of the financial strategy for the 2023/24 to 2025/26 IMTP.

Recommendation
This report provides a strategic financial outlook for 2023/24 to 2025/26, identifying the likely sources of income which may be available to form a Health Board 2023/24 financial plan, the operational challenges and expenditure pressures facing the Health Board, including the significant underlying financial deficit entering the 2023/24 financial year. Further details and analysis are provided in the accompanying reports to the committee under agenda item 3. The 2023/24 allocation letter was received on 22nd December 2022 and a comprehensive briefing is included. ***The Committee is asked to:*** • Note this paper and receive as part of the assurance process for developing the 2023/24 to 2025/26 IMTP and financial strategy and 2023/24 financial plan.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings required to manage within allocated resources & the impact of Covid-19 & external factors.
Financial Assessment, including Value for Money	This paper provides a strategic overview of the financial outlook for 2023/24 to 2025/26.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The financial plan will be developed from the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance
Link to Integrated Medium-Term Plan/Corporate Objectives	This paper provides details of the factors impacting on the Health Board's Financial Plan for 2023/24, including allocation of resources to support agreed priorities.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – note the IMTP 3-year plan. **Integration** – investment plan will need to recognise Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the public domain

Appendix 1

Allocation Letter Briefing 2023/24



Appendix 2

Statutory Financial Duties

1. Expenditure should not exceed aggregate funding over a period of 3 financial years, and
2. Prepare a plan (in line with point 1) which improves the health of the population and is approved by Welsh Government Ministers.

Ref: NHS (Wales) Act 2014

Extract from the LHB's Standing Financial Instructions (SFIs)

"Prior to the start of the financial year, the Director of Finance will…prepare and submit budgets for approval and delegation by the Board. Such budgets will:

1. *Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and medium term financial plan…,*
2. *Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce Plans, and*
3. *Be prepared within the limits of available funds."*

Appendix 3

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
ICF	Intermediate Care Fund
RAG	Red / Amber / Green Savings Rating
WG	Welsh Government
PIP	Health Board's Pre-Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RTT	Referral to Treatment
WCCIS	Welsh Community Care Information System
NICE	National Institute for Clinical Excellence

AWMSG	All Wales Medicines Strategy Group
RPB	Regional Partnership Board
SLC	Speech, Language Communication
CAMHS	Children & Adolescent Mental Health Services
NCN	Neighbourhood Care Network
AOF	Annual Operating Framework
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission
COTE	Care of the Elderly

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Aneurin Bevan University Health Board
Allocation Letter Briefing 2023/24

Executive Summary

This briefing summarises the funding headlines announced in the revenue Allocation letter and highlights the financial implications for Aneurin Bevan University Health Board's (ABUHB) 2023/24 Financial Plan.

Baseline funding for 2023/24 has increased by **£60.7m** compared to 2022/23 (baseline). A detailed breakdown of the increase is shown in the Appendix. The 'true' net uplift to the Health Board i.e. excluding committed and directed funding, is **£9.4m** as follows:

Net funding uplift	2023/24 funding (£'000)
Core uplift 23/24	17,262
Planned and Unscheduled Care sustainability	(9,419)
Value Based recovery	(192)
Mental Health core uplift 23/24	1,961
Other funding movements	(231)
Total	**9,382**

Key points to note:

- Funding for NHS pay awards in 23/24 will be held centrally (in full) and allocated to the Health Board once awards are made.
- Funding for ongoing national Covid responses, specifically; mass vaccination, Test, Trace and Protect and the provision of PPE will be held centrally and allocated based on actuals during 23/24. Other Covid related costs will need to be met by Health Boards (unless informed otherwise).

  It should be noted that further clarification was received on the 22nd December via a separate Welsh Government route to the allocation letter describing funding for Public Health response including Covid-19 as well as Adferiad (Long Covid).

  - *Response to Health Protection measures - £4.8m (non-recurrent)*
  - *Mass vaccination - £8.1m (non-recurrent)*
  - *Adferiad (Long Covid) - £0.9m (tbc recurrent)*

  This is excluded from the remaining report due to being treated separately by WG.

- General Medical Services (GMS), Pharmacy and General Dental Services (GDS) contractor allocations have been issued at 22/23 recurrent levels at this stage. A

supplementary allocation will be issued when contract agreements have been confirmed.

Introduction

This briefing summarises the funding headlines announced in the revenue Allocation letter and highlights the financial implications for Aneurin Bevan University Health Board's (ABUHB's) 2023/24 Financial Plan.

The Ministerial letter to Chairs formally issued the 2023/24 revenue allocations to Health Boards this was received by the Health Board on the 22nd December 2022. The allocation reflects the Minister for Health and Social Services decisions about the distribution of resources to Health Boards for the forthcoming year.

Health Boards are expected to achieve and deliver the statutory duties and ministerial priorities in line with the Welsh Government annual priorities for 2023/24, in particular:

Cooperation with local authorities – Some of the overall NHS budget has been held centrally to encourage the maximum amount of cooperation with local authorities and will be allocated when progress is being made to enhance community-based services to support closer partnership with social care.

Sustainability funding – Across Wales, £50m of the £170m issued recurrently in 2022/23 for *Planned and Unscheduled Care Sustainability* funding is being taken back centrally to pump prime the delivery of regional solutions. This includes areas such as diagnostics and surgical centres and to drive improvements in productivity and change against a number of key indicators –e.g. treat in turn, GIRFT, extended sessions, lists etc. For ABUHB, this equates to a baseline funding reduction of **£9.4m**.

The following points relate to other Welsh Government centrally held funding:

- Funding for NHS pay awards in 2023/24 is being held centrally and will allocated to Health Boards once awards are made.

- Funding for ongoing national Covid responses, specifically; mass vaccination, Test, Trace and Protect and the provision of PPE will be held centrally and allocated based on actuals during 2023/24. Other Covid related costs will need to be met by Health Boards (unless informed otherwise).

  It should be noted that further clarification was received on the 22nd December separate to the Allocation letter describing funding for Public Health response including Covid-19. It describes additional non-recurrent funding as follows: -

  - *Response to Health Protection measures - £4.8m*
  - *Mass vaccination - £8.1m*

  E-mail confirmation was also received with regards to recurrent Adferiad (Long Covid) funding on the 22nd December outside of the allocation letter. This funding will be confirmed in early 2023.

- GMS, Pharmacy and GDS contractor allocations are issued at this stage at 2022/23 recurrent levels. A supplementary allocation will be issued when contract agreements have been confirmed.
- Revenue funding for SIFT and Research and Development will be issued as direct funding to Health Boards.
- Allocations for accelerated depreciation, AME depreciation for donated assets and DEL and AME impairments will be issued as direct funding to the relevant Health Boards and NHS Trusts. This also applies to any increases in depreciation related to approved schemes with confirmed strategic support.
- Funding will be held centrally within the Welsh Government NHS budget to recognise the impact of NICE mandated Advanced Therapeutic Medicinal Products.
- Funding will continue to be held centrally to fund the costs of purchasing cystic fibrosis medicines Orkambi and Symkevi and to maintain access to Kalydeco.
- Funding for education and training investments in 2023/24 will continue to be provided directly to HEIW from the Welsh Government NHS budget, rather than directly to Health Boards.
- As in 2022/23, funding to cover the increased employer's contribution for the NHS Pension Scheme will be held centrally.

Revenue Allocation categories

Hospital and Community Health Services (HCHS) is derived from the 2022/23 baseline funding, adjusted for recurrent and new funding issued. The HCHS Revenue allocation is divided into *discretionary*, *ringfenced* and *directed* expenditure funding. It is the total funding available to the Health Board to fund Hospital and Community Healthcare Services, and Primary Care prescribing costs.

- ***Ring fenced allocations*** – represents the minimum the Health Board must invest in specific areas. Total ringfenced funding for 2023/24 is £213.4m and equates to just over 14% of the Health Boards total funding for 2023/24. Ring fencing restraints continue for Learning Disabilities, Mental Health, Planned and Unscheduled Care Sustainability funding, Regional Integration Fund and Depreciation costs. For 2023/24, Renal Services (£9.5m), Treatment fund (£3.0m), Paramedic Banding (£1.7m) and clinical desk enhancements (£0.1m) have been re-categorised from ring fenced to discretionary. Health Boards are free to invest additional funding in ring fenced services.
- ***Directed Expenditure*** – is allocated for specific purposes where the Health Board provides an Agency basis i.e. pass through for Welsh Government or lead organisation for other Health Boards. This is not part of the population-based funding. Directed Expenditure Allocations total £21.5m, the majority of which is attributed to the 111 Roll-out programme (£15.3m), and the new hosting arrangements for the Six Goals funding (£4.5m).

Other significant areas of funding within the Health Board's total revenue allocations relate to Primary Care Contracts; General Medical Services (GMS), General Dental Services (GDS), and Community Pharmacy. Allocations for GMS, and the *Designed to Smile* and *Gwên am Byth* oral health improvement programmes within the GDS contract, are ringfenced in terms of the definition above.

Summary of Allocations

Initial baseline funding allocations for the Health Board total £1,480.4m (£1,419.8m, baseline 2022/23). The increase in the baseline from 2022/23 of **£60.7m** will include the recurrent impact of funding issued during 2022/23, new committed funding for 2023/24, and inflationary uplifts. A summary of the increase in baseline funding across funding categories is shown in the table below, with a detailed breakdown contained within the Appendix:

Category	2022/23 Baseline £M	2023/24 Allocation letter £M	Change in baseline allocation £M	% change
HCHS and Prescribing				
Discretionary	1,003.8	1,071.6	67.9	6.8%
Protected and Ringfenced	233.2	213.4	(19.8)	-8.5%
Directed Expenditure	17.0	21.5	4.5	26.5%
Total HCHS and Prescribing	**1,254.0**	**1,306.5**	**52.5**	**4.2%**
General Medical Services	102.0	107.9	5.9	5.7%
Community Pharmacy	32.8	33.4	0.6	1.8%
General Dental Services	30.9	32.7	1.7	5.5%
Total baseline allocations	**1,419.8**	**1,480.4**	**60.7**	**4.3%**

Table 1 - Summary Revenue Allocations 2023/24

A summary of the main movements within each category are:

- **HCHS Discretionary**: funding has increased by £67.9m due to the 2022/23 pay award (£34.4m), the 2023/24 core uplift (£17.3m) and the re-categorisation of funding from ring fenced as detailed in the sections above (£14.3m).
- **Ringfenced**: reduction of £19.8m due to re-categorisation of funding to HCHS discretionary (-£14.3m) and a reduction in funding for Planned and Unscheduled Care Sustainability (-£9.4m), offset by additional core uplift funding for Mental Health (£2.0m), Critical Care funding including WHSSC and PACU (£0.9m), and an increase in Genomics for Precision Medicine Strategy (£0.8m).
- **Directed expenditure**: £4.5m of new funding for Innovation and Delivery fund (Six Goals funding) for which ABUHB is the host.
- **Primary Care contracts:** Contract negotiations for GMS and GDS have not been finalised for 2023/24, therefore allocations have been issued on the same basis as 2022/23 with adjustments made for known 2022/23 recurrent changes. A supplementary allocation will be issued when the 2023/24 contract agreements are confirmed.

The allocations for GMS and elements of the GDS contract noted above remain ringfenced, therefore the funding indicates the minimum required spend within each of these areas. The Health Board may, however, invest additional discretionary funding in these services.

The 2023/24 baseline allocation for the Health Board has increased by **£60.7m** compared to 2022/23. The 'true' net uplift to the Health Board i.e., excluding funding previously anticipated, and committed funding, is **£9.4m**. This amount is derived in Table 2 below.

Net funding uplift	2023/24 funding (£'000)
Core uplift 23/24	17,262
Planned and Unscheduled Care sustainability	(9,419)
Value Based recovery	(192)
Mental Health core uplift 23/24	1,961
Other funding movements	(231)
Total	**9,382**

Table 2- Net uplift summary

Notes to Table 2:

- ***Core uplift for 2023/24* - £17.3m (£28.8m, 2022/23)** – The Welsh Government draft budget provides £90 million of funding across Welsh Health Boards to meet core and inflationary cost pressures for 2023/24, including National Finance Agreement costs for NHS Wales. The Health Board's element equates approximately a 1.5% increase (2.8% increase, 2022/23) on the total of recurrent discretionary allocation, ring fenced (excluding mental health and depreciation) and Directed Expenditure. Core uplift funding is issued to:

    - meet core and other inflationary cost pressures
    - address the impact of the pandemic on underlying financial positions and provide support for new non-pay cost growth.
    - to fund non-pay inflationary cost increases and growth in the Healthcare Agreements for services provided by other Health Boards and NHS Trusts.

  The application of the core uplift will be determined via the IMTP & Budget setting Process.

- ***Planned and Unscheduled Care Sustainability* -£9.4m (reduction) -** The 2023/24 initial baseline allocation for the Health Board includes a reduction of £9.4m due to a ministerial decision to retain centrally £50m of the initial £170m issued to Health Boards in 2022/23. The centrally held funding will be used to pump prime the delivery of regional solutions such as diagnostics and surgical centres and to drive improvements in productivity and change. Following the reduction, the funding included in the ABUHB recurrent position for 2023/24 is £22.6m.

- ***Value Based Recovery -£0.2m (reduction)*** - a reduction of £1 million has been applied to the £15 million Value-Based Recovery funding across Wales. The funding

included in this allocation will also be supplemented with £5m held centrally within Welsh Government to support the development of Value Based Healthcare.

- ***Mental Health core uplift* £2.0m -** additional funding for Mental Health (£3.8m 2022/23), to fund unavoidable cost growth.
- **Other funding movements -£0.231m (reduction)** – relating to transfers of NHS Collaborative funding to the newly established NHS Executive (£0.260m), and a £37k adjustment to the 111 service top slice resulting in net additional funding to the discretionary position.

Further Notes on other allocations.

- **Covid funding** - Funding for ongoing national Covid responses, specifically; mass vaccination, Test, Trace and Protect and the provision of PPE will be held centrally and allocated based on actuals during 2023/24 (as in 2022/23).

  The impact of the pandemic on the provision of Health Board services (outside of national schemes) is expected to be met from the funding allocations detailed within this briefing.

  It should be noted that further clarification was received on the 22nd December separate to the Allocation letter describing funding for Public Health response including Covid-19. It describes additional non-recurrent funding as follows: -

  - *Response to Health Protection measures - £4.8m*
  - *Mass vaccination - £8.1m*

  E-mail confirmation was also received with regards to recurrent Adferiad (Long Covid) funding on the 22nd December outside of the allocation letter. This funding will be confirmed in early 2023.

- **2022/23 pay award** – Funding included in the baseline allocation for the 2022/23 pay award (£34.4m), incorporates holiday pay on overtime, Real Living Wage for Bands 1 and 2 and the pay award elements for LTAs, WHSSC and EASC.

- **Regional Integration Fund –** A further £191k (£1m across Wales) for Carers funding, previously allocated non-recurrently, has been added to the RIF baseline for 2023/24

- **Post Anaesthetic Critical Care Unit (PACU)** – Funding for PACU and Critical Care previously allocated in year has been added to the critical care element of the ring-fenced tables.

- **Mental Health transfers from central budgets –** In addition to the core uplift of £2.0m, Mental Health ringfenced baseline funding for 2023/24 has now incorporated £200k in relation to All-age MH Tier 0/1 funding, £20k for Veterans funding, and a reduction of £24k for Mental Health Network NHS Collaborative funding transferring into the newly established NHS Executive.

- **Depreciation:** The DEL depreciation budget remains ring-fenced and is a non-cash allocation. The depreciation ring-fence includes the allocation made here as well as for any non-recurrent funding that is issued in-year to cover accelerated depreciation, DEL impairments and further support for strategic schemes and baseline pressures.

- **111 rollout:** Total Directed funding of £15.28m for the rollout programme, a reduction of £193k from 2022/23 levels (£37k of which was reinstated to Health Board discretionary funding).

- **Substance Misuse:** this remains ring-fenced in 2023/24 and will be withheld from Health Boards until confirmation is received from the Chair of the relevant Area Planning Board (APB) that the use of these resources complements the delivery of the Welsh Government Substance Misuse Delivery Plan (£3.2m for the Health Board following an uplift of £63k).

- **Infrastructure SIFT:** Funding for infrastructure SIFT has been included as a Directed Expenditure Allocation. This funding must be used to support medical undergraduate education, and recipients of this funding will still be required to account for its use as part of the annual SIFT accountability agreements.

Anticipated Allocations

The funding included in the baseline position for the Health Board (i.e. detailed within this document) is recurring in nature and will form part of the rolled-forward baseline position for future years. The Health Board also assumes further funding within its financial plan which can be recurring or non-recurring and will be indicated by way of individual WG funding letters during the financial year.

These additional allocations can be 'anticipated' within the financial position in situations where official confirmation from Welsh Government has been received by the Health Board that funding will be received for a specified period of time (e.g. successful bids for projects), or funding is recurring in nature however is not included within the baseline allocations for the Health Board (e.g. due to uncertainty of the period of the activity or if the funding values can vary significantly from one year to the next). A full list of anticipated allocations is reported to the Board, and to Welsh Government as part of the monthly reporting timetable.

A list of anticipated allocations assumed for 2023/24 as of January 23, can be reviewed in the Appendix.

The Minister for health and Social Services reiterates in the allocation letter covering page that the focus remains on prevention and to optimise clinical outcomes, along with operating within the available resources with the development and delivery of an agreed 2023/24 (and beyond) plan that reflects the HB's statutory requirements and responsibilities.

Financial Planning team
December 2022

Appendix

2023/24 Baseline movements	Recategorise funding	Committed programme	Available for decisions	23/24 £
HCHS Discretionary				
DHCW Hosting SLA lost income		139,000		**139,000**
Flu Vaccination funding (extended Flu)		832,000		**832,000**
Ophthalmic lead adjustment		(60,000)		**(60,000)**
Revised 22-23 Cost Uplift Factor (CUF) England		209,951		**209,951**
Treatment fund			(6,000)	**(6,000)**
Paramedic banding	1,730,970			**1,730,970**
Clinical Desk enhancements	105,195			**105,195**
Treatment fund	2,992,225			**2,992,225**
Renal Services	9,491,679			**9,491,679**
Adjustment to top slice: 111 service			37,000	**37,000**
Adjustment : SPCC Adjustment for Programme Management office		120,000		**120,000**
Obesity pathway funding		550,000		**550,000**
Innovation funding (SBRI and RIIC Hubs)		250,000		**250,000**
NHS Executive Baseline Adjustment			(237,985)	**(237,985)**
Pay award		34,441,000		**34,441,000**
Core uplift 23/24			17,262,000	**17,262,000**
Ringfenced				
Critical care funding (including WHSSC funding and PACU)		904,000		**904,000**
Planned and Unscheduled Care Sustainability			(9,418,673)	**(9,418,673)**
Value based Recovery			(191,860)	**(191,860)**
Genomics for Precision Medicine Strategy (inc new Genetic Tests)		836,000		**836,000**
Regional Integration Fund *(Carers funding)*		191,000		**191,000**
Paramedic banding	(1,730,970)			**(1,730,970)**
Clinical Desk enhancements	(105,195)			**(105,195)**
Treatment fund	(2,992,225)			**(2,992,225)**
Renal Services	(9,491,679)			**(9,491,679)**
Mental Health Services				
In year change: Veterans Funding		20,250		**20,250**
All-age MH Tier 0/1 funding (commenced in 2021-22)		200,000		**200,000**
Mental Health Network (NHS Collaborative into NHS Executive)			(23,630)	**(23,630)**
Core uplift 2023-24 (1.5%)			1,961,000	**1,961,000**
Directed Expenditure				
111 roll out (includes £50k top sliced above)		(193,000)		**(193,000)**
National Allied Health Professional Lead		85,000		**85,000**
National Nursing Lead for Primary and Community Care		80,000		**80,000**
Innovation & Delivery Fund/Programme Management costs		4,529,000		**4,529,000**
GMS Contract				
21-22 recurrent agreement Pay & Expenses agreement		2,258,000		**2,258,000**
DDRB Pay & Expenses agreement 22-23		3,595,000		**3,595,000**
Pharmacy Contract				
2022/23 additional contract funding		576,000		**576,000**
Dental Contract				
In year allocation: 22-23 pay uplift		1,713,000		**1,713,000**
	-	**51,276,201**	**9,381,852**	**60,658,053**

Anticipated funding - January 2023

HCHS	£'000
(Provider) Substance Misuse & increase	3,184
(Provider) SPR's	112
(Provider) Clinical Excellence Awards (CDA's)	298
CAMHS In Reach Funding	778
Technology Enabled Care National Programme (ETTF)	1,800
Informatics - Virtual Consultations	1,065
Invest to Save Omnicell	(410)
National Clinical Lead for Falls & Frailty	26
National Clinical Lead for Primary and Community Care	113
AHW:Prevention & Early Years allocation	1,171
WHSSC - National Specialist CAMHS improvements	139
Same Day Emergency Care (SDEC)	1,560
OP Transformation-Dermatology Specialist Advice and Guidance	22
OP Transformation-Dermatology Nurses Surgical Skills Study Day	4
Strategic programme Primary Care within A Healthier Wales (additional posts)	130
Learning Disabilities-Improving Lives	64
Nurse Operation lead pump-prime funding 22-23 (18mths)	34
WHSSC All Wales Traumatic Stress Quality Imprmt (ANEHFS 13 21/22)	159
Children & Young People MH & Emotional Wellbeing (ANEHFS 16 21/22)	200
Memory Assessment Services - Gwent RPB (ANEHFS 37 21/22)	565
EASC/WAST Improvements in MH Emergency Calls (ANEHFS 54 21/22)	51
WHSSC - Impl of National Specialist CAMHS Improv. (ANEHFS 90 21/22)	131
NHS Pay enhancement Band 1 to 2 - 3% uplift 21-22 (ANEHFS 21/22)	152
Nosocomial Covid 19 cases - Investigation and learning	753
Urgent Primary Care	1,400
PSA self-management Programme Platform development	465
Invest to Save - Overseas Nurse Recruitment	(313)
VBH: Heart Failure and Rehab in the Community	506
Digital Medicines transformation team	236
Total HCHS anticipated allocations	**14,396**

GMS	
GMS Refresh	1,603
Primary Care Improvement Grant	142
Total GMS anticipated allocations	**1,745**

Total Anticipated funding at January 23	**16,141**

- ***There is a risk to the HB position if the anticipated allocations are not received.***

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 4.2

Aneurin Bevan University Health Board
Finance & Performance Committee

2022/23 Forecast Closing Underlying Position

Purpose of the Report			
The Health Board is required to produce a financial plan as part of the IMTP process for 2023-26. The plan should be in accordance with the aims and objectives of the Integrated Medium-Term Plan for 2023/24 through to 2025/26. Specifically, there is a requirement to review, analyse and confirm the Health Board's underlying financial position carrying forward into the 2023/24 financial year. This paper reflects: • The current financial forecast position in the context of underlying deficit, • A review of key changes which increase the underlying deficit, • A review of Covid and Exceptional current expenditure, • An analysis of key underlying drivers/issues for underlying deficit, • Assessment of likely underlying position and range for 31/3/23.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			√
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe – Director of Finance, Procurement & VBHC			
Report Author: Suzanne Jones – Interim Assistant Director of Finance			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board Finance & Performance Committee**	
Date of the Report: January 2023			
Supplementary Papers Attached: Appendix 1- Statutory Financial Duties Appendix 2 – Glossary			
Executive Summary			
This paper sets out the potential underlying financial deficit position which would carry forward into 2023/24 as part of the IMTP financial plan. In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historical investment decisions sustainable.			

The assessment of the underlying position is subject to many factors, most notably the non-recurrent and recurrent nature of spending decisions and the availability of recurrent funding, which may change during the year and during the development of the IMTP for 2023/24.

This analysis of the underlying deficit has been undertaken using a "corporate top-down" and "divisional bottom-up" approach. These approaches are used to provide a range and an assessment of the likely position at this point.

The likely underlying deficit can be presented in summary across the following areas: -

- Current 2022/23 financial forecast - £37m
- Non-recurrent provision releases (inc. annual leave) - £19m
- Reduction in variable pay not required for annual leave – (£19m)
- Local Covid plans 2022/23 - £47m
- Non-recurrent local Covid plans – (£16m)
- Exceptional costs (energy) - £15m
- 2022/23 agreed investments impacting 2023/24 - £9m
- Estimated total - £92m

This analysis sits within the range of potential underlying position of £90m to £116m

Key issues which are driving the current underlying deficit are summarised as follows: -

- Prescribing on-going growth and average per item
- CHC demand and cost per packages increases
- Operational nursing factors including GUH
- Operational medical factors including GUH
- Other staffing investments (including pharmacy, therapies and facilities)
- Other cost pressures e.g., drugs, managed practices, commissioning

The position is under regular review and excludes a number of elements which are assumed to be mitigated through operational management, short-term savings and other local opportunities.

Recommendation
The Committee is requested to

- **Note** the potential underlying deficit position for 31st March 2023 as within the range of £90m to £120m and
- **Approve** the use of this range as part of the draft IMTP submission to Welsh Government.

The final IMTP financial plan will be presented for approval by the Board in March 2023.

Background and Context

1.0 Financial Reporting and Governance

The Health Board is required to report the Health Board underlying deficit position on a monthly basis to Welsh Government through the monthly monitoring returns (MMR) as well as reporting this through Executive and Board financial reports. Specifically, this should highlight key operational and areas of expenditure without funding for future years. This will also include non-recurrent benefits (e.g., savings plans which only achieve for the current financial year) as well as short-term, non-recurrent funding.

To improve the underlying position, the Health Board should aim to develop revised service, workforce and financial plans in order to deliver underlying balance or re-align resources accordingly within the overall Health Board financial envelope.

In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historical investment decisions sustainable.

2.0 Current 2022/23 financial forecast

At Month 8, November 2022, the forecast year end revenue position is now a £37m deficit (£54m MYR deficit less £17m revised savings plan). The revenue position still has risks to be managed in order to achieve the reported deficit forecast.

The current financial forecast is assumed to carry forward into 2023/24 as an underlying deficit. There are elements of expenditure in 2022/23 that will be non-recurrent, and it is assumed the £17m savings are recurrent for the purposes of estimating the underlying position.

3.0 non-recurrent provisions

An element of the financial forecast deficit described in section 2 has been the release of key provisions which have resulted in a financial benefit in 2022/23. The largest value relates to the provision made for additional paid and carry forward annual leave in 2021/22.

In regards the Annual leave accrual the brought forward accrual value from 2021/22 was £19.603m

The forecast assumes release of the annual leave provision for 2022/23 to match expected costs.

It is assumed that variable pay to cover additional annual leave brought forward due to covid would not be incurred in the future as normal annual leave policies have been re-established for 2022/23.

The HB does not expect to have favourable impacts of provisions as part of its financial planning for 2023/24.

4.0 Local Covid plans

The Health Board is reporting costs for additional capacity and maintaining Covid-19 safe and compliant operational service delivery across all sites, as part of the other additional Covid-19 costs section. The cost impact of responding to Covid-19 and emergency system pressures along with increased patient acuity will be closely monitored and the implications for Q4 will continue to be reviewed and appropriately reflected in future monthly reports.

The current forecast for local Covid costs in 2022/23 is c.£46.7m and is summarised below.

Category	2022/23 £'000
A1. Cleaning Standards Relating to COVID-19 (Table A5 on the MMR tab B3)	2,201
A2. Increased bed capacity specifically related to COVID-19	10,748
A3. Other Capacity & facilities costs	7,287
B1. Prescribing charges directly related to COVID symptoms	12
C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	14,610
D1. Discharge Support	7,472
D5. Other Services that support the ongoing COVID response	1,899
E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income	2,490
Total	**46,720**

An initial assessment of these costs for 2023/24 assumes that there will be a significant reduction given the assumption of reduced Covid impact to patient pathways. The *reduction* in costs is summarised as follows: -

- Estates and facilities non-recurrent costs – (£8m)
- Workforce and surge capacity reduction – (£7m)
- All other non-recurrent cost reduction – (£1m)

If these costs continue, they will need to be captured as new year 2023/24 local covid costs, which do not have a funding source.

Note – There is an assumption that no cost pressures will generate from national Covid schemes for 2023/24.

5.0 Exceptional cost pressures

At this stage it is assumed the current forecast would result in an c.£13m to £18m underlying financial pressure for energy across the Health Board. It is confirmed that real living wage and pay award costs will be funded by WG. The increased costs of real living wage for external providers is regarded as an inflationary cost pressure and outside of the underlying deficits described.

6.0 2022/23 agreed investments impacting 2023/24

An estimated value of c.£9m is assumed for the full year impact of Executive & Board decisions made in 2022/23 relating to 2023/24 investments.

Investment	23/24 £'m
RGH Endoscopy Unit / JAG Accreditation Workforce Model	4
Diabetes business case (Medicine RGH pumps)	2
Nurse staffing levels act	1
Pathology related schemes	1
Primary Care audiology and other schemes	1
Total	**9**

7.0 Divisional Analysis

Divisional financial analysis is undertaken regularly through monthly financial reporting. In addition, financial analysis for the IMTP was undertaken in October which identified new pressures. A large number of factors have been listed and split into the following issues: -

Key issues which are driving the underlying deficit are summarised as follows: -

- Prescribing on-going growth and average per item – c. £12m
- CHC demand and cost per packages increases – c. £17m
- Operational nursing factors including those linked to GUH – c. £30m
- Operational medical factors including those linked to GUH – c. £27m
- Other specific staffing issues (pharmacy, therapies, facilities) – c. £8m
- All other issues – c. £25m

Prescribing

The current prescribing budget as at 2022/23 is in the region of £99.2m. This baseline, in broad terms, will fund approximately 15.8m prescriptions at an average price per item of around £6.00. In addition, the budget assumes a level of NCSOs and Non-Category M drug expenditure.

In 2022/23 the average price per item has steadily increased as well as the number of prescriptions (item growth). Part of this increase relates to the introduction of 56 day prescribing but the assumed change (resulting decrease) in prescriptions has not fully materialised for a number of reasons. The current and predicted number of prescriptions for 2022/23 is approximately 16.7m prescriptions with an average price per item of £6.74. This is under constant review particularly with review of certain "baskets" to highlight significant variation.

CHC growth

Adult Complex Care has a reported underlying position of c£0.5m, paediatric placements (in the region of 30 out of county) are relatively small but are steadily growing (underlying deficit c.£0.5m).

The largest financial pressure is within Mental Health CHC, current budget is approximately £30m which funds approximately 300 patients with an average price per patient of £0.1m. The current 2022/23 forecast is over 430 patients at an average price per patient of £0.105m. There are around 260 forecast Mental Health patients with the remaining 170 patients related to Learning Disabilities.

Operational nursing factors

A combination of operational pressures, the impact of Covid with increasing acuity coupled with the introduction of GUH as well as the Nurse staffing levels act has resulted in an increasing underlying deficit for nursing. It is difficult to fully display all operational reasons perfectly since they overlap however a list of issues is described as follows: -

- Community hospitals surge capacity and enhanced care
- Mental Health increased acuity
- Scheduled Care impact of GUH and other operational pressures
- Medicine and Urgent Care impact of GUH and increased capacity
- Medicine operational issues
- Medicine increased acuity and enhanced care
- Respiratory High Care beds

Current bed plans for 2023/24 assume a bed base that remains 100 beds above the Clinical Futures model of 1,478 (exc. Mental Health). Approximately 50 (tbc) extra beds are within community hospitals and coupled with significantly increased enhanced care are the key issues for Primary Care and Community Services.

Increased acuity and Mental Health levels of observation variable shifts are the main reasons for the underlying deficit within Mental Health. Delayed Transfer of Care present and on-going challenge to throughput and ward efficiency. In addition, further operational pressures such as sickness, maternity leave and vacancy cover present an on-going and increasing financial pressure.

The impact of GUH in relation to increased nursing support in Urgent Care, increased staffing ratios following nurse staffing level act reviews and increased acuity as well as enhanced care variable pay shifts present an increased financial challenge to the HB.

Operational medical factors

A combination of operational pressures, the impact of Covid coupled with the introduction of GUH as well as service specific vacancies have resulted in a large financial pressure for medical costs

across the Health Board. As with nursing, it is difficult to fully display all operational reasons perfectly since they overlap however an indicative split is described below: -

- On-going cover of vacant or unfunded Consultant sessions,
- Cover of operational pressures such as sickness or specific working patterns,
- The cover of junior doctor/middle grade posts which were not filled from via Deanery and are therefore covered through premium expenditure,
- On-going recruitment and retention issues across specific specialities,
- Amended rosters and working patterns resulting from GUH and re-designed pathways.

It should be noted that there is an underlying operational pressure of £2.5m to £3m for Managed Practices that is not included in the above.

The medical e-system and related work with variable pay will aim to mitigate some of these issues but the financial pressure will remain significant. There is a requirement to complete workforce establishments aligned to current work patterns across each Division.

Other specific staffing

This section describes a number of staffing areas outside of medical / nursing which have specific underlying pressures. The deficits described are dependent on the area concerned but mainly relate to operational pressures such as cover of vacancies and sickness as well as investments in services on a shorter-term basis pending review which have continued. The main areas (not exclusive list) are listed as follows: -

- Scheduled Care including theatres staffing
- Pharmacy investments including GUH staffing
- Therapies in GUH
- Clinical Support (Radiology and Pathology)
- Facilities staffing including HSDU / GUH related
- Medicine - Physiologists

Other specific highlighted issues

Whilst the list is not exhaustive, there are various issues which are highlighted and require resolution either through funding or via additional plans in order to mitigate the underlying deficit stated. Some of the issues with significant costs are listed below: -

- Impact of 2022/23 Welsh Risk Pool costs
- Energy price increases
- Director of Operations areas including Transfer Lounge, Hospital @ Night and the Flow Centre
- Microsoft Office 365, and other Informatics costs including those linked to GUH
- Commissioning issues including reduced Powys income and increasing Velindre costs
- Managed Practice – increasing costs due to number of practices and use of locums

8.0 Summary Underlying Position Range

The table below outlines the potential range of underlying deficits for ABUHB based on current information.

Category	Best case £'m	Likely case £'m	Worse case £'m	Worst case £'m
Current Divisional 2022/23 financial forecast	54	54	54	54
2022/23 savings and mitigating actions (assumed recurrent)	(17)	(17)	(17)	(17)
Current 2022/23 financial forecast	**37**	**37**	**37**	**37**
Non-recurrent provision releases (inc. annual leave)	19	19	19	19
Reduction in variable pay not required for annual leave	(19)	(19)	(19)	(19)
Local Covid plans 2022/23	47	47	47	47
Non-recurrent local Covid plans	(16)	(16)	(16)	(16)
Exceptional costs (energy)	15	15	15	15
2022/23 agreed investments impacting 2023/24	9	9	9	9
Total	**92**	**92**	**92**	**92**
Reduction in current cost assessment	(2)			
2022/23 savings and mitigating actions are non-recurrent			16	16
Non-recurrent local Covid plans remain resulting in cost pressures				8
Total	**90**	**92**	**108**	**116**

Recommendation

The Committee is requested to:

- **Note** the potential underlying deficit position for 31st March 2023 as within the range of £90m to £120m and
- **Approve** the use of this range as part of the draft IMTP submission to Welsh Government.

The final IMTP financial plan will be presented for approval by the Board in March 2023.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings / recovery actions required to manage within allocated resources.
Financial Assessment, including Value for Money	This paper provides details of the potential underlying deficit moving into the 2023/24 financial year.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The underlying deficit is based on the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance
Link to Integrated Medium-Term Plan/Corporate Objectives	This paper provides details of the underlying deficit position which supports the Health Board's Financial Plan for 2023/24.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – note the IMTP 3-year 2023/24-2025/26. **Integration** – investment and savings plan recognise Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities.

	Collaboration – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of budget plans as a priority.
Glossary of New Terms	Provided
Public Interest	*Written for the public domain*

Appendix 1

Statutory Financial Duties

1. Expenditure should not exceed aggregate funding over a period of 3 financial years, and
2. Prepare a plan (in line with point 1) which improves the health of the population and is approved by Welsh Government Ministers.

Ref: NHS (Wales) Act 2014

Extract from the LHB's Standing Financial Instructions (SFIs)

"Prior to the start of the financial year, the Director of Finance will…prepare and submit budgets for approval and delegation by the Board. Such budgets will:

1. *Be in accordance with the aims and objectives set out in the Integrated Medium-Term Plan and medium-term financial plan…,*
2. *Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce Plans, and*
3. *Be prepared within the limits of available funds."*

Appendix 2

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
WG	Welsh Government
PIP	Health Board's Pre-Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RPB	Regional Partnership Board
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission

COTE	Care of the Elderly
HSDU	Hospital Sterilisation and Disinfection Unit
NCSO	No Cheaper Stock Obtainable

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 15th January 2023 Agenda Item: 4.3

Aneurin Bevan University Health Board
Finance & Performance Committee

2023/24 Budget Planning (Delegation) Principles

Purpose of the Report			
The Health Board is required to set budgets prior to the beginning of the financial year, which are in accordance with the aims and objectives of the Integrated Medium-Term Plan for 2023/24 through to 2025/26. Specifically, this means preparing and setting budgets within available funds. This paper sets out the budget planning principles for the Board to set the budgets for the current IMTP period. It describes: • The responsibilities and requirements of the budget planning process, • The previous year's methodology, and • A suggested new approach to budget setting.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report		√	
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe – Executive Director of Finance, Procurement & VBHC			
Report Author: Suzanne Jones – Interim Assistant Director of Finance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board Finance & Performance Committee**	
Date of the Report: March 2022			
Supplementary Papers Attached: Appendix 1 – Glossary			
Executive Summary			
This paper sets out the principles and proposed approach to delegating funding at the start of the 2023/24 financial year within the expected total available resources (£1.6bn). In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the budget setting plan needs to be focussed on making historical investment decisions sustainable and making the best use of current resources. The expected purpose of budget planning principles is that the total Health Board budget value equals its available resources. Due to the underlying deficit within Aneurin Bevan Health Board this will mean that some (or all areas) will not have budget equal or greater than the forecast expenditure, thus creating a deficit that will need to be managed. Whether this can be managed			

in year or requires a multi-year approach is to be determined. In this instance the budget planning principles will determine where the shortfall sits to be managed most effectively.

As a result of the financial situation of the Health Board this paper is suggesting a new approach and methodology used. To inform the committee this paper describes the previous methodology, a possible new approach and areas to be considered.

The Committee is asked to note and approve the proposed changes to the budget planning approach for 2023/24.

Background and Context

1.0 Financial Governance

The financial provisions and obligations of the Health Board are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure that the Health Board meets its statutory obligation to perform its functions within its available financial resources.

The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it or its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The details and requirements for the two duties are set out in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." 12b) Statutory Duties of Welsh Health Boards.pdf (wales.nhs.uk)

To be successful in meeting these targets the Health Board is required to set budgets, prior to the start of the financial year, and these should be in accordance with the aims and objectives of the Integrated Medium-Term Plan for 2023/24 through to 2025/26. Specifically, this means preparing and setting budgets within available funds and delegating them in line with the Health Board's Standing Financial Instructions (SFIs) and financial policy on budgetary control.

The Health Board has a well-established budgetary control procedure that describes delegation and accountability. The budget planning principles is concerned with how the amount delegated to individual areas is determined.

In view of the forecast deficit in 2022/23 and the associated levels of risk there was increased oversight by the Board, the Executive Committee and the Finance and Performance Committee. It is recommended these arrangements should be extended into 2023/24.

2.0 Previous Budget setting principles

To support the resource allocation process, the Health Board has previously set out the following resource allocation principles to prioritise resources and delegate budgets and applies to the full revenue resource funding:

The Health Board's intention in producing a financial plan previously has been to take an approach that appreciates the on-going changing and uncertain environment. In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historical investment decisions sustainable.

As part of developing its service, workforce and financial plans the Health Board developed a financial plan in 4 elements:

- Improving sustainability of historical investment commitments & identifying core service requirements for recovery
- Identifying efficiency & value savings requirements & risks to mitigate
- Identifying exceptional national cost pressures (Real Living Wage, NI, Energy)
- Identifying estimated Covid response costs (local and national)

The following are wider considerations to the application of budgets:

1. For established services, plans should demonstrate:
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales' and reduce socio-economic disadvantage?
   - Efficiency and productivity improvements which achieve (or aim to achieve) excellence.
2. Addressing the underlying financial position – service and workforce plans which demonstrate 1. (above) should be funded appropriately before considering new investments,
3. Savings plans should demonstrate delivery before approving new funding or re-investment,
4. Where savings have been identified, for new service proposals plans should demonstrate:
   - Fit with the Clinical Futures strategic direction of ABUHB,
   - If they are approved priorities,
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales?', and
   - Efficiency and productivity improvements which achieve (or aim to achieve) excellence,
5. The Board may choose to establish reserves which support key priorities and where plans require further development. This may include non-recurrent, tapered, or recurrent funding,
6. Pay awards to be funded in line with Welsh Government allocations, and
7. If funding becomes available or there is a level of savings achievement greater than the IMTP then the Board should consider and establish an appropriate contingency reserve, considering the level of financial risk within the IMTP.

In addition to these principles the Health Board has a duty to consider the requirements of 'Wellbeing and Future Generations Act', the 'Foundational Economy' and the Decarbonisation agenda.

3.0 Previous Budget Delegation Methodology

1. The Health Board has a recurrent allocation baseline to enable the planning of core services, this budget has been delegated over the years and generally remains on a historic basis, as agreed in previous IMTP's.

2. The Health Board receives in year allocations from WG usually for a specific reason. These are delegated to the most suitable service area following agreement from the CEO and are listed in the monthly finance report. The delegation is reflective of whether the allocation is recurrent or not.
3. The Health Board is notified of new annual allocations around Christmas time for the following year, any increases in this are delegated according to the IMTP approved and authorised by the Executive team and the Board. In 2022/23 the discretionary uplift agreed by the Executive team and presented to the Board was applied as follows:
   - Underlying deficit including Medical & Nurse Staffing and Facilities pay and non-pay,
   - Clinical futures medical, nursing & clinical posts,
   - Clinical futures facilities services,
   - Mental Health (CHC), Nursing staffing, external commissioning including specialist services and corporate directorates
   - Inflationary uplifts of 2.8% for LTA's including WHSSC & EASC, and
   - Signed off Specialised Services plans developments (WHSSC & EASC)
   - Community Hospitals additional capacity
   - Nurse safer staffing levels
   - Medical safer staffing levels
   - Inter-site transport service
   - Birth rate plus staffing levels
   - Digital ICU, RISP & LINC
4. A high-level exercise was then carried out to indicate where savings and efficiency opportunities existed to reach a balanced core plan, however, this was not enacted via budget adjustments.
5. The re-allocation of an underspend was also not agreed
6. Any movements of responsibilities were actioned.

4.0 Budget Planning Principles for Consideration

Individual Divisions are carrying material forecast deficits to the extent that it could be perceived that some of these are so significant that the Divisions are unlikely to recover back to a break-even position within one year. Therefore, the following approach has been suggested as a new methodology.

Step 1:

- Each of the Divisions actual expenditure within the underlying position is reviewed, this will be assessed for;
  - Is it a committed cost?
  - Is the level of spend realistic?
  - Can the spend be 'turned off'?
  - What are the implications for activity / service of changing any of the underlying expenditure assumptions?
- Each of the Divisions will be asked to review any unavoidable new expenditure in 2023/24;
  - Is it truly unavoidable?
  - Is it demand / service growth v Inflationary growth?

Step 2:

- All of the savings' opportunities for that Division will be available for discussion, this will include transactional, operational and transformational savings, including reviews and reference to the compendium, benchmarking and other national work.
- The savings and opportunities will be reviewed and where they are felt reasonable and achievable the forecast expenditure will be expected to reduce accordingly.

Step 3:

- Once the overall expected expenditure level of the Division is deemed reasonable a draft budget will be allotted. This will not be in accordance with existing budgets, so if there are areas spending less than their current budget the budget will effectively be reduced and re-allocated.

For consideration:

- The main risk of this approach is that there will not be enough budget to cover this draft budget, the question is how the deficit is to be apportioned? This could be based on relative size of expenditure, relative size of budgets, set % split etc.
- If budgets cannot be reasonably set for spend levels, then extended timeframes for financial balance will need to be considered
- The benefit maybe that the overall deficit is more fairly shared amongst Divisions with capacity to make the efficiencies.
- There may be regional issues that need to be accounted for not yet in a division's plans.
- Further work on Partnerships may be required
- Local Health Board priorities may change
- Divisional Directors may still not be confident to sign off delegation letters that say break-even.
- Covid and exceptional costs may change.
- WG may top-slice part of the allocation, which budget to reduce would need to be agreed.

5.0 Value, Efficiency & Savings assumptions

ABUHB needs to further develop the savings approach introduced during 2022/23, this will ensure focus and ownership from senior leaders. This should be further developed to ensure accountability at delegated budget levels.

The current multi-disciplinary team approach (PMO, Planning, Value, Finance, Workforce, Information, ABCi) via the prioritisation programmes should be revisited to ensure they are driving transformation for sustainable service delivery, improved patient outcomes and efficiency.

Financial Recovery Governance needs to continue.

6.0 Contingency

The Health Board annually considers the level of contingency (or uncommitted reserves) to support the organisation as part of delegating budgets. Evidence indicates that a contingency of between 2% and 5% is desirable.

Due to the level of financial risk, including savings required, to deliver the financial position during 2022/23 no contingency was available. However, the CEO is keen to establish such a contingency for use for emerging pressures during 2023/24. An acceptable level of which will need to be determined but will require funds to be directed away from current delegated budget holders.

7.0 Proposed Budget Delegation

A proposal for budget delegation for 2023/24 will be prepared for consideration once:

- The budget planning principles have been agreed, and
- The implications of the allocation letter for 2023/24 have been determined.

This will be in line with directions from the Executive team and presented to the Board for approval.

Recommendation
The Health Board is required to set budgets prior to the beginning of the financial year, which are in accordance with the aims and objectives of the Integrated Medium-Term Plan for 2023/24 through to 2025/26. Specifically, this means preparing and setting budgets within available funds. This paper sets out the budget planning principles for the Board to set the budgets for the current IMTP period. It describes: • The responsibilities and requirements of the budget planning process, • The previous year's methodology, and • A suggested new approach to budget setting. **The Committee is asked to note and approve the proposed changes to the budget planning approach for 2023/24.**

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings required to manage within allocated resources & the impact of Covid-19.
Financial Assessment, including Value for Money	This paper provides details of the proposed budget delegation for 2023/24 financial year, based on agreed principles and the Health Board's Annual plan.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The delegation of budgets is based on the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance
Link to Integrated Medium-Term Plan/Corporate Objectives	This paper provides details of the budgetary framework and delegation proposal which supports and the Health Board's Financial Plan for 2023/24, including allocation of resources to support agreed priorities.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – note the IMTP 3-year 2023/24-2025/26. **Integration** – investment plan recognises Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of budget plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the public domain

Appendix 1

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
ICF	Intermediate Care Fund
RAG	Red / Amber / Green Savings Rating
WG	Welsh Government
PIP	Health Board's Pre-Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RTT	Referral to Treatment
WCCIS	Welsh Community Care Information System
NICE	National Institute for Clinical Excellence
AWMSG	All Wales Medicines Strategy Group
RPB	Regional Partnership Board
SLC	Speech, Language Communication
CAMHS	Children & Adolescent Mental Health Services
NCN	Neighbourhood Care Network
AOF	Annual Operating Framework
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission
COTE	Care of the Elderly

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance & Performance Committee Wednesday 11th January 2023 Agenda Item: 4.4

Aneurin Bevan University Health Board

Efficiency Opportunities 2023/24

Purpose of the Report			
This report highlights to the Committee details of specific efficiency opportunities for Aneurin Bevan University Health Board for consideration moving into financial year 23-24. Further details and analysis are provided in the accompanying reports to the committee in the appendices to this report.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			√
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe – Executive Director of Finance, Procurement & VBHC			
Report Author: Greg Bowen – Assistant Director of Finance, Hospital & Corp Divisions			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board**	**Finance and Performance Committee**
Date of the Report: January 2023			
Supplementary Papers Attached: Appendix 1 – Theatres Dashboard (To Oct 22) Appendix 2 – British Association of Day Surgery (BADS) Comparison Analysis (To Oct 22) Appendix 3 – Cataracts Update (To Oct 22)			

Executive Summary

Aneurin Bevan University Health Board has significant efficiency opportunities going into 2023-24, with particular importance on putting concrete plans in place to deliver tangible improvements at scale in order to contribute to financial recovery and improved performance in terms of patient waiting times.

The Finance Team have performed some detailed work in Q3 of 2022-23 to highlight potential opportunities in the areas mentioned below:

- Operating Theatres
- Compliance with British Association of Day Surgery (BADS) guidance
- Productivity improvements for Cataract surgery in line with Getting It Right First Time (GIRFT) Recommendations

This list of opportunities is not exhaustive, and the current modelling techniques and approach can be adapted to report similar types of analysis on other services / specialties.

All three areas looked at provide ABUHB with some significant opportunity to make improvements, in turn reducing the reliance on the cost of variable activity in addition to creating a more sustainable workforce solution moving forward.

Recommendation

- Note this paper and the significant efficiency and patient benefit opportunities identified.
- Note Achievement of efficiency improvement will be dependent on management action at an operational level to work through the steps to actual delivery.
- Approve the approach as a mechanism for how ABUHB should use this data to drive efficiency improvements moving in to 2023-24.

Background and Context

ABUHB has some significant opportunities going into 2023-24, in terms of becoming more efficient with its current resources. This is particularly relevant considering the current financial position and potential outlook for 2023-24, and the rising volume of patients that are currently waiting for treatment on various elective care pathways.

By ensuring maximum patient throughput within our core available time, there is natural scope for the following:

- Improved performance on Waiting List targets
- Reduced or Zero reliance on variable activity i.e., WLI, Insourcing and Outsourcing
- Creation of a more sustainable and safe workforce solution for elective care pathways.

There are positive potential implications to the HB's overall financial position by having a clear focus in this area and driving the tangible operating efficiencies at scale that had been aspired to as part of the 2022-23 IMTP; but have not been achieved.

This report focuses on specific opportunities in the following areas:

1) Operating Theatres
2) Comparison of ABUHB current Length of Stay (LOS) profiles to those recommended by the British Association of Day Surgery (BADS)
3) Comparison of ABUHB current throughput levels to the Getting It Right First Time (GIRFT) recommendations

This list of opportunities is not exhaustive but represent some of the key areas that have been worked on by the Finance team in Q3 of 2022-23. Modelling and approaches used can quite easily be shifted into other service / specialty areas to provide similar analysis.

Operating Theatres

(Please see Appendix 1 for more details)

An ongoing piece of analysis has been built on the HB's operating theatre performance, which covers the whole of 2021-22 and 2022-23 to date (up to and including Oct 22).

An extract of the output of this can be seen below, this gives us timely data on the following key aspects:

- Activity
- List Types and Cases by List Ratios

- Timing Data
- Cancellations

Select Specialty: All Specialties
Select Site: All Sites

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21-22 trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	22-23 YTD trend
Activity																					
Number of Emergency Cases	575	541	616	555	544	471	518	462	511	522	477	542		489	525	521	523	516	549	564	
Number of Elective Cases	387	431	476	584	560	591	564	625	528	426	496	613		506	591	600	593	558	618	614	
Number of Elective Day cases	602	630	850	889	796	837	901	1,059	812	822	832	1,124		848	1,014	1,029	938	1,139	1,068	1,178	
Total Number of Cases	1,564	1,602	1,942	2,028	1,900	1,899	1,983	2,146	1,851	1,770	1,805	2,279		1,843	2,130	2,150	2,054	2,213	2,235	2,356	
Lists																					
Number of Emergency Lists	455	463	480	424	428	435	440	427	453	423	413	436		417	424	421	404	429	424	445	
Number of Elective Lists	365	359	401	469	419	469	465	518	446	355	409	555		438	501	481	480	465	513	518	
Number of Elective Day Case Lists	300	302	369	359	345	379	368	422	338	342	342	453		351	402	419	377	411	403	454	
Total Number of Lists	1,120	1,124	1,250	1,252	1,192	1,283	1,273	1,367	1,237	1,120	1,164	1,444		1,206	1,327	1,321	1,261	1,305	1,340	1,417	
Cases per List																					
Elective Cases per Elective List	1.1	1.2	1.2	1.2	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.1		1.2	1.2	1.2	1.2	1.2	1.2	1.2	
Elective Daycases per Elective Daycase List	2.0	2.1	2.3	2.5	2.3	2.2	2.4	2.5	2.4	2.4	2.4	2.5		2.4	2.5	2.5	2.5	2.8	2.7	2.6	
Number of Cases per List	1.4	1.4	1.6	1.6	1.6	1.5	1.6	1.6	1.5	1.6	1.6	1.6		1.5	1.6	1.6	1.6	1.7	1.7	1.7	
Timings																					
average anaesthetic time per case (minutes)	25	26	32	40	36	38	40	43	33	32	33	46		37	42	44	38	43	45	46	
average cutting time per case (minutes)	64	61	59	58	60	59	58	58	59	55	58	59		58	57	60	54	54	57	55	
average turnaround time per case	25	21	22	22	23	25	23	24	24	23	24	24		26	24	25	22	22	24	23	
Total Timing (elective only, including Daycase)																					
Total Anaesthetic Time (hours)	404	427	533	665	599	624	659	710	543	519	543	751		617	690	731	618	714	750	760	
Total Cutting Time (hours)	1,047	1,074	1,303	1,418	1,365	1,394	1,417	1,635	1,309	1,141	1,275	1,721		1,307	1,516	1,617	1,367	1,539	1,605	1,639	
Total Turnaround Time (hours)	250	223	302	335	333	363	377	431	351	318	346	464		380	433	453	401	435	457	494	
List Timeliness (elective only, including Daycase)																					
Percentage of lists that finished early	56%	51%	48%	54%	50%	55%	51%	46%	52%	50%	47%	49%		51%	47%	42%	47%	43%	44%	43%	
Percentage of lists that finished late	17%	16%	21%	18%	20%	16%	15%	16%	17%	16%	18%	18%		17%	19%	23%	17%	20%	21%	21%	
Percentage of lists that started late	41%	40%	45%	45%	47%	47%	53%	53%	50%	51%	51%	55%		56%	48%	51%	50%	49%	56%	55%	
Percentage of lists that start late and finish early	20%	16%	19%	23%	24%	25%	27%	24%	24%	26%	21%	26%		28%	22%	22%	22%	17%	23%	23%	
Early Finish Minutes Lost	25,192	24,439	24,303	30,479	23,755	31,527	28,517	28,808	27,868	23,678	23,467	33,113		28,651	29,466	24,276	25,457	21,050	22,786	25,727	
Late Start Minutes Lost	7,558	7,411	9,172	9,825	9,291	9,965	11,273	14,405	11,150	10,230	10,793	16,341		13,867	12,470	13,430	14,152	12,759	13,245	16,352	
Short Notice Cancellations																					
Cancellation No Bed	6	23	13	33	20	25	20	8	6	12	19	15		9	21	24	23	13	4	10	
Cancellation Hospital Other Non Clinical	54	60	85	98	82	110	83	96	125	100	142	146		122	117	147	97	97	153	119	
Cancellation Patient	54	61	51	62	71	86	65	64	56	58	60	69		55	56	47	75	58	90	93	
Cancellation Clinical	64	70	72	77	88	92	121	106	93	101	86	128		127	81	101	96	101	97	86	
Cancellation Critical Incident	-	-	-	1	2	7	7	2	3	7	27	-		4	13	6	23	5	2	-	
Total Cancellations	178	214	221	271	263	320	296	276	283	278	334	358		317	288	325	314	274	346	308	

As is illustrated above, the summary has been shown for All Specialties and All Sites, but the analysis is able to be filtered for individual Specialties / Sites or a combination thereof.

Several meetings have already been held with the Theatres Directorate on this, with more planned in January 2023, but this allows Finance to work closely with Clinical and Operational colleagues to get into the detail of current performance and to influence improvements in efficiency.

Key points to draw out of the Oct 22 YTD data as below:

- 177,413 minutes lost due to 'early finishes' (5.7% improvement Vs. 2021 – 22)
- 96,275 minutes lost due to 'late starts' (49.3% adverse movement Vs. 2021 – 22)
- 2,172 procedures cancelled (23.1% adverse movement Vs. 2021 – 22)
- Larger opportunities are in Trauma & Orthopaedic, General Surgery, and Obstetrics & Gynaecology, though all areas have significant opportunity.

Focus from January 2023 is to determine what the potential volume of lost procedures is based on this data, and work with colleagues to determine the root causes for inefficiency.

<u>British Association of Day Surgery (BADS)</u>

(Please see Appendix 2 for more details)

A further ongoing piece of work is to look at ABUHB's current Day Surgery performance and Length of Stay (LOS) profiles vs the guidelines issued by the British Association of Day Surgery. This work has also been updated recently to compare current Day Surgery rates against other Welsh HB's.

An extract of the output of this can be seen below, but this work allows us to look at the detail of current ABUHB Length of Stay (LOS) profiles with both the BADS guidelines and other Welsh HBs.

Select Speciality	Orthopaedic Surgery
Select Period	2022-23
Cost per Bed day	£ 453
Efficiency	£ 213,163

		BADS TARGET					ABUHB % RATE					PEERS % RATE					ABUHB vs BADS					Difference to Peer Profile					
	AB Procedures in Period	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	Bed day Opportunity
BADS: Primary total prostetic replacement of the knee	220	0%	10%	10%	15%	65%	0%	0%	0%	0.91%	99%	0%	0.58%	7.9%	24.9%	67%	0%	-10%	-10%	-14%	34%	0%	-1%	-8%	-24%	32%	140
BADS: Unicompartmental (minimally invasive) knee replacement	48	0%	40%	50%	10%	0%	0%	0%	2.08%	2.08%	96%	0%	2.27%	15.9%	36%	45%	0%	-40%	-48%	-8%	96%	0%	-2%	-14%	-34%	51%	108
BADS: Primary total prostetic replacement of the hip	80	0%	10%	10%	15%	65%	0%	0%	0%	1.25%	99%	0%	0%	13.4%	29.4%	57%	0%	-10%	-10%	-14%	34%	0%	0%	-13%	-28%	42%	52
BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair	146	0%	99%	1%	0%	0%	0%	76%	19.2%	4.1%	0.68%	0%	89%	9.7%	1.01%	0.41%	0%	-23%	18%	4%	1%	0%	-13%	10%	3%	0%	42
BADS: Removal of internal fixation from bone/joint, excluding K-wires	82	0%	90%	10%	0%	0%	0%	72%	13.4%	4.9%	9.8%	4.8%	80%	10.7%	2.27%	2.27%	0%	-18%	3%	5%	10%	-5%	-8%	3%	3%	8%	35
BADS: Bunion operations with or without internal fixation and soft tissue correction	72	0%	95%	5%	0%	0%	0%	62%	29.2%	2.78%	5.6%	0%	76%	21.2%	1.92%	0.64%	0%	-33%	24%	3%	6%	0%	-14%	8%	1%	5%	34
BADS: Autograft anterior cruciate ligament reconstruction	42	0%	90%	10%	0%	0%	0%	62%	26.2%	11.9%	0%	0%	70%	29.1%	0%	1.16%	0%	-28%	16%	12%	0%	0%	-8%	-3%	12%	-1%	17
BADS: Examination/manipulation of joint under anaesthetic +/- injection	535	0%	100%	0%	0%	0%	58%	40%	1.31%	0%	0.56%	36%	63%	1.19%	0.274%	0.091%	58%	-60%	1%	0%	1%	22%	-23%	0%	0%	0%	16
BADS: Lengthening/shortening of tendon(s)	9	0%	90%	10%	0%	0%	0%	33%	44%	0%	22.2%	0%	63%	22.9%	8.6%	5.7%	0%	-57%	34%	0%	22%	0%	-30%	21%	-9%	17%	9
BADS: Carpal tunnel release	253	0%	100%	0%	0%	0%	0%	98%	1.19%	0.40%	0.40%	0%	99%	1.11%	0%	0.171%	0%	-2%	1%	0%	0%	0%	-1%	0%	0%	0%	8
BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair	22	0%	90%	5%	5%	0%	13.6%	64%	13.6%	9.1%	0%	0%	77%	21.1%	0%	1.75%	14%	-26%	9%	4%	0%	14%	-13%	-8%	9%	-2%	4
BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow	30	0%	100%	0%	0%	0%	0%	93%	3.3%	3.3%	0%	0%	88%	7.9%	2.63%	1.32%	0%	-7%	3%	3%	0%	0%	5%	-5%	1%	-1%	3
BADS: Excision of ganglion	13	0%	100%	0%	0%	0%	0%	85%	15.4%	0%	0%	0%	98%	2.47%	0%	0%	0%	-15%	15%	0%	0%	0%	-13%	13%	0%	0%	2
BADS: Repair of hand or wrist tendon	13	0%	95%	5%	0%	0%	0%	85%	15.4%	0%	0%	0%	79%	20.9%	0%	0%	0%	-10%	10%	0%	0%	0%	6%	-6%	0%	0%	1
BADS: Removal of foreign body from skin	13	0%	100%	0%	0%	0%	0%	92%	7.7%	0%	0%	27.1%	71%	2.08%	0%	0%	0%	-8%	8%	0%	0%	-27%	21%	6%	0%	0%	1
BADS: Primary reduction and open fixation of wrist	48	0%	60%	40%	0%	0%	0%	100%	0%	0%	0%	0%	79%	14.3%	4.8%	2.38%	0%	40%	-40%	0%	0%	0%	21%	-14%	-5%	-2%	
BADS: Exploration of sheath of tendon (eg trigger finger)	51	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	97%	2.17%	0%	0.54%	0%	0%	0%	0%	0%	0%	3%	-2%	0%	-1%	
BADS: Dupuytren's fasciectomy	37	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0.56%	96%	3.9%	0%	0%	0%	0%	0%	0%	0%	-1%	4%	-4%	0%	0%	
BADS: Excision of lesion of peripheral nerve	8	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	94%	5.6%	0%	0%	0%	0%	0%	0%	0%	0%	6%	-6%	0%	0%	
BADS: MUA Fracture and application of plaster cast	6	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	78%	20.4%	1.85%	0%	0%	-95%	95%	0%	0%	0%	-78%	80%	-2%	0%	0%	
BADS: Excision of nail / nailbed	5	70%	30%	0%	0%	0%	0%	100%	0%	0%	0%	10.8%	86%	2.70%	0%	0%	-70%	70%	0%	0%	0%	-11%	14%	-3%	0%	0%	

For the 7 months up to the end of October 22, there is an opportunity to save just over 2,000 bed days with a financial saving opportunity of £588k. Extrapolated, this would equate to approximately 3,430 bed says, with a full-year financial savings expectation of £1m.

Select Period	2022-23
Efficiency	£ 588,411

	Total Procedures	Opportunity Total Bed Day	Total Opportunity
Emergency Surgery	641	594	£ 129,439
Orthopaedic Surgery	1,733	471	£ 213,163
General Surgery	946	254	£ 55,351
Urology	1,950	251	£ 108,660
Gynaecology	1,210	157	£ 16,285
Breast	338	140	£ 30,419
ENT	1,919	43	£ 10,971
Paediatric Surgery	291	42	£ 12,816
Head and Neck	315	38	£ 9,538
Vascular	40	6	£ 1,328
Opthalmology	1,780	4	£ 196
Medicine	156	2	£ 245
	11,319	2,001	588,411

In addition to the efficiency opportunities, there are also Value Based Healthcare (VBHC) principles to consider here in terms of increased outcomes driven from reduced recovery time, an enhanced patient experience and minimising the risk of wound or hospital acquired infections.

Again, this work has been shared with the relevant Divisions and is being worked through, with further meetings scheduled for January 2023.

Cataracts

(Please see Appendix 3 for more details)

Work performed by the NHS Wales Finance Delivery Unit last year indicated an efficiency opportunity for ABUHB and showed that the HB was in fact an outlier having the lowest number of cases per list across Wales. This was based on pre-Covid data, so the Finance team have created a separate piece of analysis which again looks at activity up to and including October 2022.

The work performed on the 2022-23 activity has shown a wide range of Consultant Variation (as below). This has been shared with the relevant speciality, but a meeting has been arranged with the Divisional Director of Scheduled Care to discuss this data in more detail in January 2023, and the anonymity of the Consultants will be removed.

	Total Sessions	Total Procedures	Cases Per List	Avg Late Start	Avg Early Finish	Turnaround Time Avg	Utilisation%	% Early Finishes	% Late Starts	% Late Start and Early Finish
Consultant @ AB	41	183	4.5	8	87	5	66%	100%	27%	27%
Consultant @ AB	39	138	3.5	18	49	13	76%	58%	61%	28%
Consultant @ AB	34	182	5.4	4	49	4	105%	71%	3%	3%
Consultant @ AB	26	109	4.2	18	46	6	81%	69%	54%	35%
Consultant @ AB	19	84	4.4	15	46	5	89%	74%	47%	32%
Consultant @ AB	14	54	3.9	20	35	7	93%	50%	64%	36%
Consultant @ AB	13	36	2.8	19	86	7	58%	100%	54%	54%
Consultant @ AB	10	48	4.8	11	61	5	80%	90%	30%	20%
Consultant @ AB	10	41	4.1	9	58	7	74%	80%	20%	20%
Consultant @ AB	9	35	3.9	27	41	8	87%	33%	78%	11%
Consultant @ AB	9	33	3.7	7	74	5	79%	89%	11%	11%
Consultant @ AB	8	34	4.3	19	47	9	67%	50%	63%	38%
Consultant @ AB	5	19	3.8	12	81	5	70%	80%	40%	20%
Consultant @ AB	5	18	3.6	35	21	3	92%	20%	80%	0%
Consultant @ AB	4	22	5.5	49	9	14	103%	0%	100%	0%

GIRFT recommendations for high flow Cataracts lists is that the average for teaching lists should be 8 cases per list, and for non-teaching 10 cases per list.

There are clear efficiency opportunities for ABUHB by adopting the GIRFT recommendations.

At current rates of 4.2 cases per session, waiting lists are expected to increase year on year if we were to assume current demand remained constant.

At current rates

	Forecast						
	Nov	Dec	Jan	Feb	Mar-23	Mar-24	Mar-25
Waiting List Start	1091	1146	1201	1256	1311	1366	2026
Treatment Referrals	222	222	222	222	222	2664	2664
Removals**	-202	-202	-202	-202	-202	-2424	-2424
additional adjustments	35	35	35	35	35	420	420
Waiting List Finish	1146	1201	1256	1311	1366	2026	2686

In the absence of any efficiency improvements moving forward, the overall wait list is profiled to grow year on year; meaning it is likely that the service would request additional funding for variable activity (As an example, Outsourcing for Cataracts would cost more than £1k per procedure).

However, if the HB was to adopt GIRFT productivity levels now, then by performing 8 procedures per session the waiting list would be expected to be 'Zero' by the end of September 2023. Increases in throughput to recommended levels would in fact put the HB in the position of having excess capacity.

At 8 Procedures Per Session

Forecast						
Nov	Dec	Jan	Feb	Mar-23	Mar-24	Mar-25
1091	1001	911	821	731	641	0
222	222	222	222	222	2664	2664
-347	-347	-347	-347	-347	-4164	-4164
35	35	35	35	35	420	420
1001	911	821	731	641	0	0
					439	1519

Recommendation
This report provides an overview of some key efficiency opportunities for ABUHB moving in to 2023-24, identifying areas where improvements could be made. Further details and analysis are provided in the accompanying reports to the committee within the appendices. ***The Committee is asked to:*** • Note this paper and the significant efficiency and patient benefit opportunities identified. • Note Achievement of efficiency improvement will be dependent on management action at an operational level to work through the steps to actual delivery. • Approve the approach as a mechanism for how ABUHB should use this data to drive efficiency improvements moving in to 2023-24.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties if efficiencies are not delivered.
Financial Assessment, including Value for Money	This paper provides efficiency opportunities that could save significant expenditure for ABUHB in the future.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The financial plan will be developed from the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance

Link to Integrated Medium-Term Plan/Corporate Objectives	This paper provides details of the factors impacting on the Health Board's Financial Plan for 2023/24, including allocation of resources to support agreed priorities.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – note the IMTP 3-year plan. **Integration** – investment plan will need to recognise Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the public domain

Appendix 1

Theatres Dashboard Dec 22.x

Appendix 2

BADS Analysis Oct 22.xlsx

Appendix 3

Cataracts Update Dec 22.pptx

Glossary

ABUHB	Aneurin Bevan University Health Board
HB	Health Board
IMTP	Integrated Medium Term Plan
BADS	British Association of Day Surgery
GIRFT	Getting It Right First Time
LOS	Length Of Stay
VBHC	Value Based Healthcare

Scope

Uses Data sets, Ormis, Ormis Cancellations and Ormis Sessions
The following data is excluded from analysis;
Any procedure which does not have a patient identifier
Any activity against the following theatre/procedure rooms are excluded;

- Dept of Urology Endoscopy 1
- Dept of Urology Endoscopy 2
- GUH CT
- GUH ENDOSCOPY
- GUH MRI
- GUH PLEURAL PROCEDURES ROOM
- GUH TH1 INTERVENTIONAL RADIOLOGY
- GUH TH2 INTERVENTIONAL RADIOLOGY
- Intensive Care Unit
- NHH PLEURAL PROCEDURE ROOM
- ORAL SURG OPD2
- Recovery RGH
- RG Pleural Procedures Room
- RG RECOVERY ANNEX
- RG T15 Uro
- SWH Dermatology Room 1
- SWH Dermatology Room 2
- GUH MIDWIFERY THEATRE 1
- Vascular Theatre
- X-RAY Dept RGH
- GUH MIDWIFERY THEATRE 2
- Midwifery Theatre 1
- RG Paracentesis Procedures Room
- Midwifery Theatre 2
- NHH ITU
- NHH Midwifery Th 1
- GUH CATH LAB 1

Definitions

Activity	
Number of Emergency Cases	Number of cases where operation type classified as Emergency
Number of Elective Cases	Number of cases where operation type classified as Elective and Admission type is not Daycase
Number of Elective Daycases	Number of cases where operation type classified as Elective and Admission type is Daycase
Total Number of Cases	Sum of the above
Lists	
Number of Emergency Lists	Emergency Lists Identified where majority of cases on list are emergency procedures
Number of Elective Lists	Elective lists Identified where majority of cases on list are elective procedures
Number of Elective Day Case Lists	Day Case lists identified where solely Day Case Procedures take place
Total Number of Lists	Sum of the above
Cases per List	
Elective Cases per Elective List	
Elective Daycases per Elective Daycase List	Uses Activity and divides into number of Lists - As there are mixed lists above and the number of cases is used in activity using operation type
Number of Cases per List	
Timings	
average anaesthetic time per case (minutes)	Uses Needle to Skin (Induction) to Knife
average cutting time per case (minutes)	Uses Knife to knife finish. Where no timiings available for knife then operation start is used. When no timing is available for knife finish then operation finish is used. Maximum cutting time has been capped at 720 minutes. Any procedures with zero cutting or negative cutting time have been excluded
average turnaround time per case	Time between a patient leaving the operating room and next patient entering the operating room within a session. If according to the data the next patient enters before previous patient leaves the end time of previous patient is updated to match next patient entering and therefore, turnaround in this scenario will be zero. Assumption that 2 patients cannot be in an operating room at one time.
Total Timing (elective only, including Daycase)	
Total Anaesthetic Time (hours)	
Total Cutting Time (hours)	as time per case but for all elective activity (including daycase)
Total Turnaround Time (hours)	
List Timeliness (elective only, including Daycase)	
Percentage of lists that finished early	Early finishes defined as lists which finished more than 15 minutes early
Percentage of lists that finished late	Defined as lists which finished more than 15 minutes late
Percentage of lists that started late	Late Starts defined as list which started more than 15 minutes late
Percentage of lists that start late and finish early	
average touchtime utilisation percentage	Calculates sum of minutes of Patient in Anaesthetic Room to Patient Leave Operating room for all procedures in session and divides into available minutes for that session.
Early Finish Minutes Lost	Minutes of those lists which have been defined as Early finsih
Late Start Minutes Lost	minutes of lists which have been defined as Late Start
Short Notice Cancellations	
Cancellation No Bed	
Cancellation Hospital Other Non Clinical	
Cancellation Patient	Short Notice Cancellations are cancellation which have been cancelled the day before or on the day of procedure.
Cancellation Clinical	
Cancellation Critical Incident	
Total Cancellations	

Select Specialty: All Specialties

Select Site: All Sites

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21-22 trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	22-23 YTD trend	Nov-22
Activity																						
Number of Emergency Cases	575	541	616	555	544	471	518	462	511	522	477	542		489	525	521	523	516	549	564		-
Number of Elective Cases	387	431	476	584	560	591	564	625	528	426	496	613		506	591	600	593	558	618	614		-
Number of Elective Day cases	602	630	850	889	796	837	901	1,059	812	822	832	1,124		848	1,014	1,029	938	1,139	1,068	1,178		-
Total Number of Cases	1,564	1,602	1,942	2,028	1,900	1,899	1,983	2,146	1,851	1,770	1,805	2,279		1,843	2,130	2,150	2,054	2,213	2,235	2,356		-
Lists																						
Number of Emergency Lists	455	463	480	424	428	435	440	427	453	423	413	436		417	424	421	404	429	424	445		-
Number of Elective Lists	365	359	401	469	419	469	465	518	446	355	409	555		438	501	481	480	465	513	518		-
Number of Elective Day Case Lists	300	302	369	359	345	379	368	422	338	342	342	453		351	402	419	377	411	403	454		-
Total Number of Lists	1,120	1,124	1,250	1,252	1,192	1,283	1,273	1,367	1,237	1,120	1,164	1,444		1,206	1,327	1,321	1,261	1,305	1,340	1,417		-
Cases per List																						
Elective Cases per Elective List	1.1	1.2	1.2	1.2	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.1		1.2	1.2	1.2	1.2	1.2	1.2	1.2		-
Elective Daycases per Elective Daycase List	2.0	2.1	2.3	2.5	2.3	2.2	2.4	2.5	2.4	2.4	2.4	2.5		2.4	2.5	2.5	2.5	2.8	2.7	2.6		-
Number of Cases per List	1.4	1.4	1.6	1.6	1.6	1.5	1.6	1.6	1.5	1.6	1.6	1.6		1.5	1.6	1.6	1.6	1.7	1.7	1.7		-
Timings																						
average anaesthetic time per case (minutes)	25	26	32	40	36	38	40	43	33	32	33	46		37	42	44	38	43	45	46		-
average cutting time per case (minutes)	64	61	59	58	60	59	58	58	59	55	58	59		58	57	60	54	54	57	55		-
average turnaround time per case	25	21	22	22	23	25	23	24	24	23	24	24		26	24	25	22	22	24	23		-
Total Timing (elective only, including Daycase)																						
Total Anaesthetic Time (hours)	404	427	533	665	599	624	659	710	543	519	543	751		617	690	731	618	714	750	760		-
Total Cutting Time (hours)	1,047	1,074	1,303	1,418	1,365	1,394	1,417	1,635	1,309	1,141	1,275	1,721		1,307	1,516	1,617	1,367	1,539	1,605	1,639		-
Total Turnaround Time (hours)	250	223	302	335	333	363	377	431	351	318	346	464		380	433	453	401	435	457	494		-
List Timeliness (elective only, including Daycase)																						
Percentage of lists that finished early	56%	51%	48%	54%	50%	55%	51%	46%	52%	50%	47%	49%		51%	47%	42%	47%	43%	44%	43%		0%
Percentage of lists that finished late	17%	16%	21%	18%	20%	16%	15%	16%	17%	16%	18%	18%		17%	19%	23%	17%	20%	21%	21%		0%
Percentage of lists that started late	41%	40%	45%	45%	47%	47%	53%	53%	50%	51%	51%	55%		56%	48%	51%	50%	49%	56%	55%		0%
Percentage of lists that start late and finish early	20%	16%	19%	23%	24%	25%	27%	24%	24%	26%	21%	26%		28%	22%	22%	22%	17%	23%	23%		
Early Finish Minutes Lost	25,192	24,439	24,303	30,479	23,755	31,527	28,517	28,808	27,868	23,678	23,467	33,113		28,651	29,466	24,276	25,457	21,050	22,786	25,727		-
Late Start Minutes Lost	7,558	7,411	9,172	9,825	9,291	9,965	11,273	14,405	11,150	10,230	10,793	16,341		13,867	12,470	13,430	14,152	12,759	13,245	16,352		-
Short Notice Cancellations																						
Cancellation No Bed	6	23	13	33	20	25	20	8	6	12	19	15		9	21	24	23	13	4	10		0
Cancellation Hospital Other Non Clinical	54	60	85	98	82	110	83	96	125	100	142	146		122	117	147	97	97	153	119		0
Cancellation Patient	54	61	51	62	71	86	65	64	56	58	60	69		55	56	47	75	58	90	93		0
Cancellation Clinical	64	70	72	77	88	92	121	106	93	101	86	128		127	81	101	96	101	97	86		0
Cancellation Critical Incident	-	-	-	1	2	7	7	2	3	7	27	-		4	13	6	23	5	2	-		0
Total Cancellations	178	214	221	271	263	320	296	276	283	278	334	358		317	288	325	314	274	346	308		0

Select Period	2022-23
Efficiency	£ 588,411

	Total Procedures	Opportunity Total Bed Day	Total Opportunity
Emergency Surgery	641	594	£ 129,439
Orthopaedic Surgery	1,733	471	£ 213,163
General Surgery	946	254	£ 55,351
Urology	1,950	251	£ 108,660
Gynaecology	1,210	157	£ 16,285
Breast	338	140	£ 30,419
ENT	1,919	43	£ 10,971
Paediatric Surgery	291	42	£ 12,816
Head and Neck	315	38	£ 9,538
Vascular	40	6	£ 1,328
Opthalmology	1,780	4	£ 196
Medicine	156	2	£ 245
	11,319	2,001	588,411

Select Period	2021-22
Efficiency	£ 976,595

	Total Procedures	Opportunity Total Beds	Total Opportunity
Emergency Surgery	1,200	1,100	£ 239,907
Orthopaedic Surgery	2,257	659	£ 298,378
Urology	4,113	450	£ 194,917
General Surgery	1,590	412	£ 89,733
Gynaecology	2,343	284	£ 29,576
Breast	548	186	£ 40,536
ENT	3,536	142	£ 36,166
Head and Neck	649	103	£ 26,173
Opthalmology	4,101	95	£ 4,644
Vascular	87	44	£ 9,660
Paediatric Surgery	362	22	£ 6,680
Medicine	403	2	£ 224
	21,189	3,500	976,595

Source CHKS: 15th December 2022

**22-23 are YTD figures to Oct*

Select Speciality	Orthopaedic Surgery
Select Period	2022-23
Cost per Bed day	£ 453
Efficiency	£ 213,163

		BADS TARGET					ABUHB % RATE					PEERS % RATE					ABUHB vs BADS					Difference to Peer Profile					Bed day Opportunity
	AB Procedures in Period	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	OP	Zero LoS	One Day	Two Day	Two Days +	
BADS: Primary total prostetic replacement of the knee	220	0%	10%	10%	15%	65%	0%	0%	0%	0.91%	99%	0%	0.58%	7.9%	24.9%	67%	0%	-10%	-10%	-14%	34%	0%	-1%	-8%	-24%	32%	140
BADS: Unicompartmental (minimally invasive) knee replacement	48	0%	40%	50%	10%	0%	0%	0%	2.08%	2.08%	96%	0%	2.27%	15.9%	36%	45%	0%	-40%	-48%	-8%	96%	0%	-2%	-14%	-34%	51%	108
BADS: Primary total prostetic replacement of the hip	80	0%	10%	10%	15%	65%	0%	0%	0%	1.25%	99%	0%	0%	13.4%	29.4%	57%	0%	-10%	-10%	-14%	34%	0%	0%	-13%	-28%	42%	52
BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair	146	0%	99%	1%	0%	0%	0%	76%	19.2%	4.1%	0.68%	0%	89%	9.7%	1.01%	0.41%	0%	-23%	18%	4%	1%	0%	-13%	10%	3%	0%	42
BADS: Removal of internal fixation from bone/joint, excluding K-wires	82	0%	90%	10%	0%	0%	0%	72%	13.4%	4.9%	9.8%	4.8%	80%	10.7%	2.27%	2.27%	0%	-18%	3%	5%	10%	-5%	-8%	3%	3%	8%	35
BADS: Bunion operations with or without internal fixation and soft tissue correction	72	0%	95%	5%	0%	0%	0%	62%	29.2%	2.78%	5.6%	0%	76%	21.2%	1.92%	0.64%	0%	-33%	24%	3%	6%	0%	-14%	8%	1%	5%	34
BADS: Autograft anterior cruciate ligament reconstruction	42	0%	90%	10%	0%	0%	0%	62%	26.2%	11.9%	0%	0%	70%	29.1%	0%	1.16%	0%	-28%	16%	12%	0%	0%	-8%	-3%	12%	-1%	17
BADS: Examination/manipulation of joint under anaesthetic +/- injection	535	0%	100%	0%	0%	0%	58%	40%	1.31%	0%	0.56%	36%	63%	1.19%	0.274%	0.091%	58%	-60%	1%	0%	1%	22%	-23%	0%	0%	0%	16
BADS: Lengthening/shortening of tendon(s)	9	0%	90%	10%	0%	0%	0%	33%	44%	0%	22.2%	0%	63%	22.9%	8.6%	5.7%	0%	-57%	34%	0%	22%	0%	-30%	21%	-9%	17%	9
BADS: Carpal tunnel release	253	0%	100%	0%	0%	0%	0%	98%	1.19%	0.40%	0.40%	0%	99%	1.11%	0%	0.171%	0%	-2%	1%	0%	0%	0%	-1%	0%	0%	0%	8
BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair	22	0%	90%	5%	5%	0%	13.6%	64%	13.6%	9.1%	0%	0%	77%	21.1%	0%	1.75%	14%	-26%	9%	4%	0%	14%	-13%	-8%	9%	-2%	4
BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow	30	0%	100%	0%	0%	0%	0%	93%	3.3%	3.3%	0%	0%	88%	7.9%	2.63%	1.32%	0%	-7%	3%	3%	0%	0%	5%	-5%	1%	-1%	3
BADS: Excision of ganglion	13	0%	100%	0%	0%	0%	0%	85%	15.4%	0%	0%	0%	98%	2.47%	0%	0%	0%	-15%	15%	0%	0%	0%	-13%	13%	0%	0%	2
BADS: Repair of hand or wrist tendon	13	0%	95%	5%	0%	0%	0%	85%	15.4%	0%	0%	0%	79%	20.9%	0%	0%	0%	-10%	10%	0%	0%	0%	6%	-6%	0%	0%	1
BADS: Removal of foreign body from skin	13	0%	100%	0%	0%	0%	0%	92%	7.7%	0%	0%	27.1%	71%	2.08%	0%	0%	0%	-8%	8%	0%	0%	-27%	21%	6%	0%	0%	1
BADS: Primary reduction and open fixation of wrist	48	0%	60%	40%	0%	0%	0%	100%	0%	0%	0%	0%	79%	14.3%	4.8%	2.38%	0%	40%	-40%	0%	0%	0%	21%	-14%	-5%	-2%	
BADS: Exploration of sheath of tendon (eg trigger finger)	51	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	97%	2.17%	0%	0.54%	0%	0%	0%	0%	0%	0%	3%	-2%	0%	-1%	
BADS: Dupuytren's fasciectomy	37	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0.56%	96%	3.9%	0%	0%	0%	0%	0%	0%	0%	-1%	4%	-4%	0%	0%	
BADS: Excision of lesion of peripheral nerve	8	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	94%	5.6%	0%	0%	0%	0%	0%	0%	0%	0%	6%	-6%	0%	0%	
BADS: MUA Fracture and application of plaster cast	6	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	78%	20.4%	1.85%	0%	0%	-95%	95%	0%	0%	0%	-78%	80%	-2%	0%	0%	
BADS: Excision of nail / nailbed	5	70%	30%	0%	0%	0%	0%	100%	0%	0%	0%	10.8%	86%	2.70%	0%	0%	-70%	70%	0%	0%	0%	-11%	14%	-3%	0%	0%	

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18			
Description		Total Procedures	OP Target	Zero LoS Target	One Day Target	Two Day Target	Greater than 2 days	OP Rate	Zero LoS Rate	One Day Rate	Two Day Rate	Greater Than Two Day Rate	Peer OP Rate	Peer Zero LoS Rate	Peer One Day Rate	Peer Two Day Rate	Peer Greater Than Two Day Rate	Opportunity BADS	Year	Specialty	yearspecc concat
BADS: Incision and drainage of skin abscess - Emergency	BADS: Incision and drainage of skin abscess - Emergency2021-22Emergency Surgery	447	0%	100%	0%	0%	0%	2.24%	52%	23.3%	8.1%	14.1%	7.2%	35%	22.3%	10.3%	25%	366	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Appendicectomy (including laparoscopic) - Emergency	BADS: Appendicectomy (including laparoscopic) - Emergency2021-22Emergency Surgery	262	0%	15%	80%	5%	0%	0%	1.91%	34%	34%	30.5%	0%	3.12%	35%	28%	34%	271	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Incision and drainage of skin abscess - Emergency	BADS: Incision and drainage of skin abscess - Emergency2022-23Emergency Surgery	239	0%	100%	0%	0%	0%	0.42%	52%	24.3%	7.5%	15.9%	5.7%	35%	22.7%	11.5%	24.7%	208	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Primary total prostetic replacement of the knee	BADS: Primary total prostetic replacement of the knee2021-22Orthopaedic Surgery	278	0%	10%	10%	15%	65%	0%	0%	1.08%	3.2%	96%	0%	0.33%	7%	31.2%	61%	168	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Incision and drainage of perianal abscess - Emergency	BADS: Incision and drainage of perianal abscess - Emergency2021-22Emergency Surgery	125	0%	95%	5%	0%	0%	0%	16.8%	50%	18.4%	15.2%	0%	22.4%	49%	15.9%	12.4%	159	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Appendicectomy (including laparoscopic) - Emergency	BADS: Appendicectomy (including laparoscopic) - Emergency2022-23Emergency Surgery	127	0%	15%	80%	5%	0%	0%	3.9%	26.8%	31.5%	38%	0%	2.83%	34%	27.9%	35%	145	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Primary total prostetic replacement of the knee	BADS: Primary total prostetic replacement of the knee2022-23Orthopaedic Surgery	220	0%	10%	10%	15%	65%	0%	0%	0%	0.91%	99%	0%	0.58%	7.9%	24.9%	67%	140	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Unicompartmental (minimally invasive) knee replacement	BADS: Unicompartmental (minimally invasive) knee replacement2021-22Orthopaedic Surgery	58	0%	40%	50%	10%	0%	0%	0%	0%	8.6%	91%	0%	2.75%	23.9%	26.6%	47%	128	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Endoscopic resection/ destruction of lesion of bladder	BADS: Endoscopic resection/ destruction of lesion of bladder2021-22Urology	422	0%	60%	35%	5%	0%	0%	42%	46%	6.9%	4.5%	0%	44%	37%	10.8%	7.6%	119	2021-22	Urology	2021-22-Urology
BADS: Primary repair of inguinal hernia	BADS: Primary repair of inguinal hernia2021-22General Surgery	415	0%	90%	10%	0%	0%	0%	71%	23.6%	3.13%	2.65%	0%	82%	14.1%	2.13%	1.60%	115	2021-22	General Surgery	2021-22-General Surgery
BADS: Unicompartmental (minimally invasive) knee replacement	BADS: Unicompartmental (minimally invasive) knee replacement2022-23Orthopaedic Surgery	48	0%	40%	50%	10%	0%	0%	0%	2.08%	2.08%	96%	0%	2.27%	15.9%	36%	45%	108	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair	BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair2021-22Orthopaedic Surgery	214	0%	99%	1%	0%	0%	0%	60%	33%	5.6%	1.40%	0%	91%	8.5%	0.45%	0.227%	101	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Laparoscopic cholecystectomy	BADS: Laparoscopic cholecystectomy2021-22General Surgery	549	0%	75%	25%	0%	0%	0%	65%	30.1%	2.73%	2.55%	0%	56%	35%	5%	4.2%	100	2021-22	General Surgery	2021-22-General Surgery
BADS: Resection of prostate by laser	BADS: Resection of prostate by laser2021-22Urology	90	0%	80%	20%	0%	0%	0%	1.11%	78%	14.4%	6.7%	0%	11.3%	60%	21%	8.1%	96	2021-22	Urology	2021-22-Urology
BADS: Endoscopic resection/ destruction of lesion of bladder	BADS: Endoscopic resection/ destruction of lesion of bladder2022-23Urology	213	0%	60%	35%	5%	0%	0%	32%	54%	7.5%	6.6%	0%	40%	43%	8.5%	8.2%	93	2022-23	Urology	2022-23-Urology
BADS: Incision and drainage of perianal abscess - Emergency	BADS: Incision and drainage of perianal abscess - Emergency2022-23Emergency Surgery	70	0%	95%	5%	0%	0%	0%	30%	31.4%	14.3%	24.3%	0%	30.3%	38%	20.7%	10.8%	90	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Suture of skin wound - Emergency	BADS: Suture of skin wound - Emergency2021-22Emergency Surgery	100	50%	50%	0%	0%	0%	0%	48%	33%	7%	12%	0.95%	60%	20.9%	8.7%	9.5%	83	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Closure ileostomy	BADS: Closure ileostomy2021-22General Surgery	42	0%	20%	30%	50%	0%	0%	0%	0%	0%	100%	0%	0%	0.97%	12.1%	87%	71	2021-22	General Surgery	2021-22-General Surgery
BADS: Extraction of cataract +/- implant	BADS: Extraction of cataract +/- implant2021-22Opthalmology	3637	0%	100%	0%	0%	0%	15%	84%	0.82%	0.055%	0.33%	7.3%	92%	0.52%	0.065%	0.213%	70	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Laparoscopic cholecystectomy	BADS: Laparoscopic cholecystectomy2022-23General Surgery	341	0%	75%	25%	0%	0%	0%	63%	32%	2.93%	2.05%	0%	59%	31.5%	4.7%	4.7%	65	2022-23	General Surgery	2022-23-General Surgery
BADS: Ureteroscopic extraction of calculus of ureter	BADS: Ureteroscopic extraction of calculus of ureter2021-22Urology	78	0%	70%	30%	0%	0%	0%	10.3%	73%	11.5%	5.1%	0%	57%	30.4%	7.1%	5.4%	63	2021-22	Urology	2021-22-Urology
BADS: Primary total prostetic replacement of the hip	BADS: Primary total prostetic replacement of the hip2021-22Orthopaedic Surgery	105	0%	10%	10%	15%	65%	0%	0%	1.90%	3.8%	94%	0%	0.50%	8%	29.5%	62%	59	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Endoscopic insertion of prosthesis into ureter	BADS: Endoscopic insertion of prosthesis into ureter2021-22Urology	104	0%	90%	10%	0%	0%	0%	44%	49%	2.88%	3.8%	0%	63%	25.4%	5.1%	6.4%	58	2021-22	Urology	2021-22-Urology
BADS: Primary repair of inguinal hernia	BADS: Primary repair of inguinal hernia2022-23General Surgery	225	0%	90%	10%	0%	0%	0%	73%	21.8%	2.67%	2.67%	0%	79%	17.2%	2.96%	1.03%	57	2022-23	General Surgery	2022-23-General Surgery
BADS: Tonsillectomy (Adult)	BADS: Tonsillectomy (Adult)2021-22ENT	48	0%	90%	10%	0%	0%	0%	10.4%	56%	29.2%	4.2%	0%	59%	36%	2.27%	2.69%	56	2021-22	ENT	2021-22-ENT
BADS: Laparoscopic cholecystectomy - Emergency	BADS: Laparoscopic cholecystectomy - Emergency2021-22Emergency Surgery	51	0%	25%	25%	0%	50%	0%	0%	3.9%	9.8%	86%	0%	7.5%	15.3%	13.7%	63%	54	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Simple mastectomy (without axillary surgery)	BADS: Simple mastectomy (without axillary surgery)2021-22Breast	74	0%	75%	25%	0%	0%	0%	17.6%	72%	6.8%	4.1%	0%	30.1%	49%	6.8%	14.5%	54	2021-22	Breast	2021-22-Breast
BADS: Therapeutic endoscopic operations on uterus (including endometrial ablation)	BADS: Therapeutic endoscopic operations on uterus (including endometrial ablation)2021-22Gynaecology	552	50%	45%	5%	0%	0%	11.1%	78%	8.2%	1.63%	1.09%	8.6%	85%	5.6%	0.93%	0.169%	54	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Primary total prostetic replacement of the hip	BADS: Primary total prostetic replacement of the hip2022-23Orthopaedic Surgery	80	0%	10%	10%	15%	65%	0%	0%	0%	1.25%	99%	0%	0%	13.4%	29.4%	57%	52	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Resection of prostate by laser	BADS: Resection of prostate by laser2022-23Urology	43	0%	80%	20%	0%	0%	0%	4.7%	67%	23.3%	4.7%	0%	0%	63%	15.8%	21.1%	46	2022-23	Urology	2022-23-Urology
BADS: Repair of hand or wrist tendon - Emergency	BADS: Repair of hand or wrist tendon - Emergency2021-22Emergency Surgery	52	0%	95%	5%	0%	0%	0%	50%	21.2%	15.4%	13.5%	0%	69%	15.7%	7.4%	8.3%	46	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Laparoscopic total/subtotal abdominal hysterectomy	BADS: Laparoscopic total/subtotal abdominal hysterectomy2021-22Gynaecology	54	0%	50%	30%	20%	0%	0%	0%	59%	27.8%	13%	0%	2.59%	47%	25.6%	24.5%	45	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Anterior colporrhaphy	BADS: Anterior colporrhaphy2022-23Gynaecology	45	0%	80%	15%	5%	0%	0%	0%	84%	11.1%	4.4%	0%	4%	49%	37%	9.3%	42	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair	BADS: Arthroscopy of knee including meniscectomy, meniscal or other repair2022-23Orthopaedic Surgery	146	0%	99%	1%	0%	0%	0%	76%	19.2%	4.1%	0.68%	0%	89%	9.7%	1.01%	0.41%	42	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Suture of skin wound - Emergency	BADS: Suture of skin wound - Emergency2022-23Emergency Surgery	65	50%	50%	0%	0%	0%	0%	62%	24.6%	3.08%	10.8%	0.51%	61%	21.1%	8.4%	9.1%	41	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Endoscopic laser fragmentation of calculus of kidney	BADS: Endoscopic laser fragmentation of calculus of kidney2021-22Urology	26	0%	90%	10%	0%	0%	0%	3.8%	58%	7.7%	30.8%	0%	49%	39%	4%	8.9%	41	2021-22	Urology	2021-22-Urology
BADS: Tonsillectomy (Paediatric)	BADS: Tonsillectomy (Paediatric)2022-23Paediatric Surgery	62	0%	70%	30%	0%	0%	0%	11.3%	84%	3.2%	1.61%	0%	45%	52%	1.96%	1.23%	40	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Bunion operations with or without internal fixation and soft tissue correction	BADS: Bunion operations with or without internal fixation and soft tissue correction2021-22Orthopaedic S	53	0%	95%	5%	0%	0%	0%	49%	32%	7.5%	11.3%	0%	74%	23.1%	0.54%	2.15%	40	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Anterior colporrhaphy	BADS: Anterior colporrhaphy2021-22Gynaecology	41	0%	80%	15%	5%	0%	0%	0%	83%	12.2%	4.9%	0%	3.9%	41%	41%	14.5%	40	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Diagnostic endoscopic examination of pharynx/ larynx +/- biopsy	BADS: Diagnostic endoscopic examination of pharynx/ larynx +/- biopsy2021-22ENT	2880	0%	99%	1%	0%	0%	97%	1.56%	1.39%	0.49%	0%	85%	12.3%	1.97%	0.194%	0.081%	39	2021-22	ENT	2021-22-ENT
BADS: MUA Fracture and application of plaster cast - Emergency	BADS: MUA Fracture and application of plaster cast - Emergency2021-22Emergency Surgery	49	95%	5%	0%	0%	0%	0%	59%	16.3%	10.2%	14.3%	18.1%	39%	27.7%	5.4%	10.2%	39	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Simple mastectomy (without axillary surgery)	BADS: Simple mastectomy (without axillary surgery)2022-23Breast	44	0%	75%	25%	0%	0%	0%	13.6%	68%	9.1%	9.1%	0%	18.6%	52%	11.2%	18.6%	39	2022-23	Breast	2022-23-Breast
BADS: Removal of internal fixation from bone/joint, excluding K-wires	BADS: Removal of internal fixation from bone/joint, excluding K-wires2021-22Orthopaedic Surgery	142	0%	90%	10%	0%	0%	0%	75%	14.8%	7%	2.82%	7.3%	77%	9.7%	2.18%	3.4%	39	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Simple mastectomy with axillary surgery	BADS: Simple mastectomy with axillary surgery2021-22Breast	50	0%	75%	25%	0%	0%	0%	10%	82%	6%	2%	0%	16.2%	48%	13%	22.4%	38	2021-22	Breast	2021-22-Breast
BADS: Wide local excision of breast (Including Wire Guided)	BADS: Wide local excision of breast (Including Wire Guided)2021-22Breast	173	0%	95%	5%	0%	0%	0%	75%	24.3%	1.16%	0%	0%	71%	19.6%	7.2%	2.25%	37	2021-22	Breast	2021-22-Breast
BADS: Closure ileostomy	BADS: Closure ileostomy2022-23General Surgery	22	0%	20%	30%	50%	0%	0%	0%	0%	0%	100%	0%	1%	1%	14%	84%	37	2022-23	General Surgery	2022-23-General Surgery
BADS: Transanal excision of lesion of anus	BADS: Transanal excision of lesion of anus2021-22General Surgery	26	40%	35%	25%	0%	0%	0%	19.2%	11.5%	54%	15.4%	0%	56%	31.4%	9.9%	2.48%	37	2021-22	General Surgery	2021-22-General Surgery
BADS: Transluminal operations on iliac and femoral artery	BADS: Transluminal operations on iliac and femoral artery2021-22Vascular	44	0%	85%	15%	0%	0%	0%	43%	27.3%	18.2%	11.4%	0%	53%	18.3%	15.1%	13.7%	36	2021-22	Vascular	2021-22-Vascular
BADS: Autograft anterior cruciate ligament reconstruction	BADS: Autograft anterior cruciate ligament reconstruction2021-22Orthopaedic Surgery	66	0%	90%	10%	0%	0%	0%	47%	42%	9.1%	1.52%	0%	71%	25.1%	3.9%	0.32%	36	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Transanal excision of lesion of anus	BADS: Transanal excision of lesion of anus2022-23General Surgery	23	40%	35%	25%	0%	0%	0%	17.4%	8.7%	52%	21.7%	0%	61%	28.8%	3.4%	6.8%	35	2022-23	General Surgery	2022-23-General Surgery
BADS: Removal of internal fixation from bone/joint, excluding K-wires	BADS: Removal of internal fixation from bone/joint, excluding K-wires2022-23Orthopaedic Surgery	82	0%	90%	10%	0%	0%	0%	72%	13.4%	4.9%	9.8%	4.8%	80%	10.7%	2.27%	2.27%	35	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Examination/manipulation of joint under anaesthetic +/- injection	BADS: Examination/manipulation of joint under anaesthetic +/- injection2021-22Orthopaedic Surgery	687	0%	100%	0%	0%	0%	56%	41%	1.89%	0.44%	0.73%	37%	62%	0.87%	0.269%	0.202%	34	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Bunion operations with or without internal fixation and soft tissue correction	BADS: Bunion operations with or without internal fixation and soft tissue correction2022-23Orthopaedic S	72	0%	95%	5%	0%	0%	0%	62%	29.2%	2.78%	5.6%	0%	76%	21.2%	1.92%	0.64%	34	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Endoscopic insertion of prosthesis into ureter	BADS: Endoscopic insertion of prosthesis into ureter2022-23Urology	56	0%	90%	10%	0%	0%	0%	48%	41%	5.4%	5.4%	0%	65%	25%	3.4%	6.7%	32	2022-23	Urology	2022-23-Urology
BADS: MUA Fracture and application of plaster cast - Emergency	BADS: MUA Fracture and application of plaster cast - Emergency2022-23Emergency Surgery	40	95%	5%	0%	0%	0%	0%	52%	27.5%	10%	10%	13%	46%	24.8%	8.4%	8%	31	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Simple mastectomy with axillary surgery	BADS: Simple mastectomy with axillary surgery2022-23Breast	29	0%	75%	25%	0%	0%	0%	10.3%	66%	13.8%	10.3%	0%	21.6%	59%	9.2%	10.3%	29	2022-23	Breast	2022-23-Breast
BADS: Termination of Pregnancy	BADS: Termination of Pregnancy2021-22Gynaecology	115	0%	99%	1%	0%	0%	0%	83%	10.4%	5.2%	1.74%	0%	76%	17.9%	4.2%	2.11%	29	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Posterior colporrhaphy	BADS: Posterior colporrhaphy2021-22Gynaecology	38	0%	70%	25%	5%	0%	0%	5.3%	84%	5.3%	5.3%	0%	4.9%	56%	32%	7.3%	29	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Laparoscopic oophorectomy and salpingectomy (including bilateral)	BADS: Laparoscopic oophorectomy and salpingectomy (including bilateral)2021-22Gynaecology	71	0%	80%	15%	5%	0%	0%	49%	38%	11.3%	1.41%	0%	47%	41%	8.6%	4.1%	28	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Endometrial biopsy/ aspiration + hysteroscopy	BADS: Endometrial biopsy/ aspiration + hysteroscopy2021-22Gynaecology	481	90%	9%	1%	0%	0%	34%	61%	4.2%	0.62%	0.42%	67%	30.9%	1.47%	0.179%	0.139%	27	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Endoscopic extraction of calculus of bladder	BADS: Endoscopic extraction of calculus of bladder2021-22Urology	49	0%	60%	40%	0%	0%	0%	33%	51%	4.1%	12.2%	0%	34%	32%	18.3%	15.4%	27	2021-22	Urology	2021-22-Urology
BADS: Hemithyroidectomy, lobectomy, partial thyroidectomy	BADS: Hemithyroidectomy, lobectomy, partial thyroidectomy2021-22Head and Neck	50	0%	30%	70%	0%	0%	0%	2%	74%	22%	2%	0.42%	2.51%	69%	18%	10.5%	27	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Laparoscopic total/subtotal abdominal hysterectomy	BADS: Laparoscopic total/subtotal abdominal hysterectomy2022-23Gynaecology	28	0%	50%	30%	20%	0%	0%	0%	50%	36%	14.3%	0%	1.67%	49%	30.6%	18.9%	27	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Primary reduction and open fixation of wrist - Emergency	BADS: Primary reduction and open fixation of wrist - Emergency2021-22Emergency Surgery	26	0%	60%	40%	0%	0%	0%	23.1%	38%	11.5%	26.9%	0%	51%	25.6%	10.9%	13%	26	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Removal of foreign body from skin - Emergency	BADS: Removal of foreign body from skin - Emergency2021-22Emergency Surgery	41	0%	100%	0%	0%	0%	0%	61%	26.8%	7.3%	4.9%	5.8%	71%	11.9%	6.2%	5%	23	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Posterior colporrhaphy	BADS: Posterior colporrhaphy2022-23Gynaecology	26	0%	70%	25%	5%	0%	0%	0%	85%	11.5%	3.8%	0%	2.27%	66%	27.3%	4.5%	22	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Excision of parotid gland	BADS: Excision of parotid gland2021-22Head and Neck	14	0%	15%	70%	15%	0%	0%	0%	7.1%	28.6%	64%	0%	9.6%	40%	24.4%	26.3%	22	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance	BADS: Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance2021-22Brea	69	0%	95%	5%	0%	0%	0%	67%	32%	1.45%	0%	0%	59%	26.3%	11.4%	3.4%	21	2021-22	Breast	2021-22-Breast
BADS: Tonsillectomy (Adult)	BADS: Tonsillectomy (Adult)2022-23ENT	28	0%	90%	10%	0%	0%	0%	32%	57%	7.1%	3.6%	0%	62%	35%	0.90%	2.41%	20	2022-23	ENT	2022-23-ENT
BADS: Wide local excision of breast (Including Wire Guided)	BADS: Wide local excision of breast (Including Wire Guided)2022-23Breast	78	0%	95%	5%	0%	0%	0%	72%	25.6%	2.56%	0%	0%	60%	22%	14%	4.2%	20	2022-23	Breast	2022-23-Breast
BADS: Ureteroscopic extraction of calculus of ureter	BADS: Ureteroscopic extraction of calculus of ureter2022-23Urology	37	0%	70%	30%	0%	0%	0%	24.3%	68%	8.1%	0%	0%	62%	26.1%	7.5%	4%	20	2022-23	Urology	2022-23-Urology
BADS: Laser surgery to vocal cord (including microlaryngoscopy)	BADS: Laser surgery to vocal cord (including microlaryngoscopy)2021-22ENT	17	0%	95%	5%	0%	0%	0%	17.6%	53%	23.5%	5.9%	0.94%	67%	26.4%	1.89%	3.8%	19	2021-22	ENT	2021-22-ENT
BADS: Tonsillectomy (Paediatric)	BADS: Tonsillectomy (Paediatric)2021-22Paediatric Surgery	26	0%	70%	30%	0%	0%	0%	0%	96%	3.8%	0%	0%	45%	51%	3.02%	1.21%	19	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Laparoscopic cholecystectomy - Emergency	BADS: Laparoscopic cholecystectomy - Emergency2022-23Emergency Surgery	18	0%	25%	25%	0%	50%	0%	5.6%	0%	5.6%	89%	0%	7.3%	12.7%	16.4%	64%	19	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Haemorrhoidectomy including staples	BADS: Haemorrhoidectomy including staples2021-22General Surgery	54	0%	100%	0%	0%	0%	0%	76%	18.5%	1.85%	3.7%	0%	87%	10.1%	2.70%	0%	18	2021-22	General Surgery	2021-22-General Surgery
BADS: Repair of umbilical hernia (Adult)	BADS: Repair of umbilical hernia (Adult)2021-22General Surgery	131	0%	90%	10%	0%	0%	0%	82%	13.7%	2.29%	1.53%	0.37%	86%	9.2%	2.20%	2.56%	17	2021-22	General Surgery	2021-22-General Surgery
BADS: Autograft anterior cruciate ligament reconstruction	BADS: Autograft anterior cruciate ligament reconstruction2022-23Orthopaedic Surgery	42	0%	90%	10%	0%	0%	0%	62%	26.2%	11.9%	0%	0%	70%	29.1%	0%	1.16%	17	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Reduction of fractured mandible - Emergency	BADS: Reduction of fractured mandible - Emergency2021-22Emergency Surgery	28	0%	20%	70%	10%	0%	0%	21.4%	28.6%	28.6%	21.4%	0%	13.3%	30.7%	37%	19.3%	17	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Examination/manipulation of joint under anaesthetic +/- injection	BADS: Examination/manipulation of joint under anaesthetic +/- injection2022-23Orthopaedic Surgery	535	0%	100%	0%	0%	0%	58%	40%	1.31%	0%	0.56%	36%	63%	1.19%	0.274%	0.091%	16	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Sentinel lymph node biopsy/Axillary sample/Axillary clearance	BADS: Sentinel lymph node biopsy/Axillary sample/Axillary clearance2021-22Breast	32	0%	95%	5%	0%	0%	0%	50%	47%	3.12%	0%	0%	41%	45%	9.8%	4.9%	15	2021-22	Breast	2021-22-Breast
BADS: Repair of hand or wrist tendon - Emergency	BADS: Repair of hand or wrist tendon - Emergency2022-23Emergency Surgery	17	0%	95%	5%	0%	0%	0%	47%	29.4%	5.9%	17.6%	0%	71%	11.1%	9.7%	8.7%	15	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Haemorrhoidectomy including staples	BADS: Haemorrhoidectomy including staples2022-23General Surgery	47	0%	100%	0%	0%	0%	0%	70%	27.7%	2.13%	0%	0%	88%	10.5%	1.32%	0%	15	2022-23	General Surgery	2022-23-General Surgery
BADS: Removal of foreign body from skin - Emergency	BADS: Removal of foreign body from skin - Emergency2022-23Emergency Surgery	22	0%	100%	0%	0%	0%	0%	55%	36%	0%	9.1%	9.6%	73%	11.1%	3.7%	2.96%	14	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Repair of recurrent inguinal hernia	BADS: Repair of recurrent inguinal hernia2021-22General Surgery	32	0%	90%	10%	0%	0%	0%	59%	28.1%	12.5%	0%	0%	68%	23.5%	2.94%	5.9%	14	2021-22	General Surgery	2021-22-General Surgery
BADS: Endoscopic extraction of calculus of bladder	BADS: Endoscopic extraction of calculus of bladder2022-23Urology	16	0%	60%	40%	0%	0%	0%	6.2%	75%	6.2%	12.5%	0%	41%	34%	17.6%	8.1%	14	2022-23	Urology	2022-23-Urology
BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair	BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair2021-22Orthopaedic	51	0%	90%	5%	5%	0%	11.8%	59%	21.6%	3.9%	3.9%	0%	81%	17%	0%	2%	13	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Endoscopic resection of prostate (TUR)	BADS: Endoscopic resection of prostate (TUR) 20	29	0%	15%	45%	40%	0%	0%	0%	45%	41%	13.8%	0%	6.4%	42%	31.5%	19.7%	13	2022-23	Urology	2022-23-Urology
BADS: Therapeutic endoscopic operations on uterus (including endometrial ablation)	BADS: Therapeutic endoscopic operations on uterus (including endometrial ablation)2022-23Gynaecology	273	50%	45%	5%	0%	0%	9.9%	82%	6.6%	0.37%	0.73%	11%	81%	5.4%	1.32%	0.73%	12	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Termination of Pregnancy	BADS: Termination of Pregnancy2022-23Gynaecology	60	0%	99%	1%	0%	0%	0%	82%	15%	3.3%	0%	0%	16.7%	67%	6.7%	10%	12	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Excision of lesion of parathyroids	BADS: Excision of lesion of parathyroids2021-22Head and Neck	12	0%	60%	40%	0%	0%	0%	0%	67%	25%	8.3%	0.46%	3.2%	84%	8.7%	3.2%	12	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Excision/destruction of lesion of anus	BADS: Excision/destruction of lesion of anus2021-22General Surgery	41	0%	100%	0%	0%	0%	0%	78%	17.1%	2.44%	2.44%	0.55%	91%	6.3%	0.82%	1.09%	12	2021-22	General Surgery	2021-22-General Surgery
BADS: Excision/destruction of lesion of mouth	BADS: Excision/destruction of lesion of mouth2021-22Head and Neck	44	0%	100%	0%	0%	0%	0%	91%	0%	0%	9.1%	52%	19%	17.5%	1.59%	9.5%	12	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Primary reduction and open fixation of ankle - Emergency	BADS: Primary reduction and open fixation of ankle - Emergency2022-23Emergency Surgery	10	0%	25%	50%	25%	0%	0%	0%	30%	20%	50%	0%	27.7%	16.2%	14.6%	42%	12	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Repair of umbilical hernia (Adult)	BADS: Repair of umbilical hernia (Adult)2022-23General Surgery	84	0%	90%	10%	0%	0%	0%	82%	14.3%	1.19%	2.38%	0%	81%	15.4%	1.60%	1.60%	12	2022-23	General Surgery	2022-23-General Surgery
BADS: Sentinel lymph node biopsy/Axillary sample/Axillary clearance	BADS: Sentinel lymph node biopsy/Axillary sample/Axillary clearance2022-23Breast	20	0%	95%	5%	0%	0%	0%	50%	40%	10%	0%	0%	31.1%	51%	6.7%	11.1%	11	2022-23	Breast	2022-23-Breast
BADS: Endoscopic resection of prostate (TUR)	BADS: Endoscopic resection of prostate (TUR) 20	47	0%	15%	45%	40%	0%	0%	2.13%	53%	38%	6.4%	0%	9.8%	39%	34%	17.6%	11	2021-22	Urology	2021-22-Urology
BADS: Anterior and posterior colporrhaphy	BADS: Anterior and posterior colporrhaphy2022-23Gynaecology	10	0%	60%	35%	5%	0%	0%	0%	70%	10%	20%	0%	0%	47%	25%	27.8%	11	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance	BADS: Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance2022-23Brea	53	0%	95%	5%	0%	0%	0%	79%	18.9%	0%	1.89%	0%	56%	38%	6.2%	0%	10	2022-23	Breast	2022-23-Breast
BADS: Anterior and posterior colporrhaphy	BADS: Anterior and posterior colporrhaphy2021-22Gynaecology	15	0%	60%	35%	5%	0%	0%	0%	87%	13.3%	0%	0%	2.17%	50%	37%	10.9%	10	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Hemithyroidectomy, lobectomy, partial thyroidectomy	BADS: Hemithyroidectomy, lobectomy, partial thyroidectomy2022-23Head and Neck	27	0%	30%	70%	0%	0%	0%	0%	93%	7.4%	0%	0%	0%	66%	20.5%	13.1%	10	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Primary reduction and open fixation of ankle - Emergency	BADS: Primary reduction and open fixation of ankle - Emergency2021-22Emergency Surgery	12	0%	25%	50%	25%	0%	0%	8.3%	42%	8.3%	42%	0%	23.1%	16.3%	13.6%	47%	10	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Excision of lesion of lip	BADS: Excision of lesion of lip2021-22Head and Neck	86	0%	100%	0%	0%	0%	0%	93%	3.5%	2.33%	1.16%	30.6%	64%	3.5%	1.76%	0%	10	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Carpal tunnel release	BADS: Carpal tunnel release2021-22Orthopaedic Surgery	284	0%	100%	0%	0%	0%	0%	97%	2.46%	0%	0.35%	0%	100%	0.33%	0%	0.066%	10	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Lengthening/shortening of tendon(s)	BADS: Lengthening/shortening of tendon(s)2022-23Orthopaedic Surgery	9	0%	90%	10%	0%	0%	0%	33%	44%	0%	22.2%	0%	63%	22.9%	8.6%	5.7%	9	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Removal of prosthesis from ureter	BADS: Removal of prosthesis from ureter2021-22Urology	117	80%	20%	0%	0%	0%	0%	93%	6%	0.85%	0%	12.9%	79%	5.3%	1.06%	1.98%	9	2021-22	Urology	2021-22-Urology
BADS: Insertion or removal of breast prosthesis	BADS: Insertion or removal of breast prosthesis2022-23Breast	13	0%	99%	1%	0%	0%	0%	46%	46%	0%	7.7%	0%	52%	46%	1.85%	0%	9	2022-23	Breast	2022-23-Breast
BADS: Excision of lesion of parathyroids	BADS: Excision of lesion of parathyroids2022-23Head and Neck	11	0%	60%	40%	0%	0%	0%	0%	82%	18.2%	0%	0%	5.2%	90%	4.2%	1.04%	9	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Reduction Mamoplasty	BADS: Reduction Mamoplasty2022-23Breast	10	0%	75%	25%	0%	0%	0%	10%	70%	20%	0%	0%	45%	40%	10%	5%	9	2022-23	Breast	2022-23-Breast
BADS: Endoscopic laser fragmentation of calculus of kidney	BADS: Endoscopic laser fragmentation of calculus of kidney2022-23Urology	9	0%	90%	10%	0%	0%	0%	22.2%	67%	0%	11.1%	0%	53%	37%	1.75%	8.8%	8	2022-23	Urology	2022-23-Urology
BADS: Vaginal hysterectomy (including laparoscopically assisted)	BADS: Vaginal hysterectomy (including laparoscopically assisted)2021-22Gynaecology	11	0%	60%	35%	5%	0%	0%	9.1%	73%	9.1%	9.1%	0%	1.96%	44%	35%	19%	8	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Carpal tunnel release	BADS: Carpal tunnel release2022-23Orthopaedic Surgery	253	0%	100%	0%	0%	0%	0%	98%	1.19%	0.40%	0.40%	0%	99%	1.11%	0%	0.171%	8	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Endometrial biopsy/ aspiration + hysteroscopy	BADS: Endometrial biopsy/ aspiration + hysteroscopy2022-23Gynaecology	195	90%	9%	1%	0%	0%	28.7%	67%	3.6%	0%	0.51%	72%	26.4%	1.32%	0.189%	0.227%	8	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Operations on foreskin -circumcision, division of adhesions (Adult)	BADS: Operations on foreskin -circumcision, division of adhesions (Adult)2021-22Urology	94	0%	99%	1%	0%	0%	0%	91%	7.4%	1.06%	0%	0%	92%	5.8%	0.99%	0.99%	8	2021-22	Urology	2021-22-Urology
BADS: Excision/destruction of lesion of anus	BADS: Excision/destruction of lesion of anus2022-23General Surgery	35	0%	100%	0%	0%	0%	0%	83%	14.3%	0%	2.86%	0.56%	94%	4.5%	0%	0.56%	8	2022-23	General Surgery	2022-23-General Surgery
BADS: Insertion or removal of breast prosthesis	BADS: Insertion or removal of breast prosthesis2021-22Breast	14	0%	99%	1%	0%	0%	0%	50%	43%	7.1%	0%	4.5%	51%	36%	3.6%	4.5%	8	2021-22	Breast	2021-22-Breast
BADS: Re excision of margins	BADS: Re excision of margins2022-23Breast	21	0%	99%	1%	0%	0%	0%	71%	23.8%	0%	4.8%	0%	76%	21%	1.80%	1.20%	8	2022-23	Breast	2022-23-Breast
BADS: Primary reduction and open fixation of wrist - Emergency	BADS: Primary reduction and open fixation of wrist - Emergency2022-23Emergency Surgery	8	0%	60%	40%	0%	0%	0%	0%	75%	12.5%	12.5%	0%	55%	22%	8.8%	14.5%	8	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Therapeutic laparoscopic procedures including laser, diathermy and destruction eg endometriosis, a	BADS: Therapeutic laparoscopic procedures including laser, diathermy and destruction eg endometriosis, a	43	0%	85%	10%	5%	0%	0%	70%	25.6%	2.33%	2.33%	4.1%	58%	24%	6.2%	8.2%	7	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Repair of hand or wrist tendon	BADS: Repair of hand or wrist tendon2021-22Orthopaedic Surgery	35	0%	95%	5%	0%	0%	0%	89%	2.86%	2.86%	5.7%	0%	71%	23.1%	1.54%	4.6%	7	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)	BADS: Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)2021-22General S	11	0%	20%	70%	10%	0%	0%	9.1%	45%	27.3%	18.2%	0%	13.7%	47%	23.5%	15.7%	7	2021-22	General Surgery	2021-22-General Surgery
BADS: Surgical removal of impacted/ buried tooth/teeth (Adult)	BADS: Surgical removal of impacted/ buried tooth/teeth (Adult)2021-22Head and Neck	385	0%	100%	0%	0%	0%	0%	99%	0.52%	0.260%	0.260%	9.1%	89%	1.01%	0.168%	0.34%	7	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Excison/biopsy of lesion of pinna	BADS: Excison/biopsy of lesion of pinna2021-22ENT	163	0%	100%	0%	0%	0%	0%	98%	1.23%	0.61%	0.61%	9.1%	90%	1.25%	0%	0%	7	2021-22	ENT	2021-22-ENT
BADS: Laser surgery to vocal cord (including microlaryngoscopy)	BADS: Laser surgery to vocal cord (including microlaryngoscopy)2022-23ENT	8	0%	95%	5%	0%	0%	0%	25%	62%	12.5%	0%	0%	71%	25.7%	0%	2.86%	7	2022-23	ENT	2022-23-ENT
BADS: Lengthening/shortening of tendon(s)	BADS: Lengthening/shortening of tendon(s)2021-22Orthopaedic Surgery	8	0%	90%	10%	0%	0%	0%	62%	12.5%	0%	25%	0%	72%	21.6%	4.1%	2.70%	6	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Transluminal operations on iliac and femoral artery	BADS: Transluminal operations on iliac and femoral artery2022-23Vascular	6	0%	85%	15%	0%	0%	0%	33%	33%	16.7%	16.7%	0%	55%	21.2%	11.8%	11.8%	6	2022-23	Vascular	2022-23-Vascular
BADS: Polypectomy of internal nose	BADS: Polypectomy of internal nose2021-22ENT	9	0%	90%	10%	0%	0%	0%	44%	33%	22.2%	0%	1.94%	68%	28.2%	1.94%	0%	6	2021-22	ENT	2021-22-ENT
BADS: Surgical removal of impacted/ buried tooth/teeth (Adult)	BADS: Surgical removal of impacted/ buried tooth/teeth (Adult)2022-23Head and Neck	180	0%	100%	0%	0%	0%	0%	99%	0%	0%	1.11%	10.2%	89%	0.99%	0%	0%	6	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Reduction of fractured mandible - Emergency	BADS: Reduction of fractured mandible - Emergency2022-23Emergency Surgery	19	0%	20%	70%	10%	0%	0%	26.3%	31.6%	37%	5.3%	0%	5.9%	22.4%	48%	23.5%	6	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Operations on urethral orifice	BADS: Operations on urethral orifice2021-22Urology	9	0%	99%	1%	0%	0%	0%	56%	22.2%	22.2%	0%	0%	86%	12.7%	0%	1.27%	6	2021-22	Urology	2021-22-Urology
BADS: Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)	BADS: Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)2022-23General S	7	0%	20%	70%	10%	0%	0%	14.3%	28.6%	28.6%	28.6%	0%	10.5%	63%	15.8%	10.5%	6	2022-23	General Surgery	2022-23-General Surgery
BADS: Laparoscopic oophorectomy and salpingectomy (including bilateral)	BADS: Laparoscopic oophorectomy and salpingectomy (including bilateral)2022-23Gynaecology	30	0%	80%	15%	5%	0%	0%	70%	23.3%	0%	6.7%	0%	47%	42%	9.2%	2.50%	6	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Reduction of fracture of zygomatic complex of bones - Emergency	BADS: Reduction of fracture of zygomatic complex of bones - Emergency2022-23Emergency Surgery	4	0%	60%	40%	0%	0%	0%	0%	50%	25%	25%	0%	15.4%	23.1%	35%	26.9%	5	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Repair of rectal mucosal prolapse	BADS: Repair of rectal mucosal prolapse2021-22General Surgery	3	0%	70%	30%	0%	0%	0%	33%	0%	0%	67%	0%	50%	16.7%	16.7%	16.7%	5	2021-22	General Surgery	2021-22-General Surgery
BADS: Injection or banding of haemorrhoids	BADS: Injection or banding of haemorrhoids2022-23General Surgery	28	100%	0%	0%	0%	0%	64%	25%	7.1%	0%	3.6%	16.2%	82%	1.71%	0%	0%	5	2022-23	General Surgery	2022-23-General Surgery
BADS: Correction of entropion	BADS: Correction of entropion2021-22Opthalmology	72	90%	10%	0%	0%	0%	0%	96%	2.78%	0%	1.39%	0.42%	99%	0.85%	0%	0%	5	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Enucleation of cyst of jaw	BADS: Enucleation of cyst of jaw2021-22Head and Neck	18	0%	100%	0%	0%	0%	0%	83%	5.6%	11.1%	0%	12.4%	67%	16.9%	2.25%	1.12%	5	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Female sterilisation	BADS: Female sterilisation2021-22Gynaecology	41	20%	80%	0%	0%	0%	0%	88%	12.2%	0%	0%	0%	94%	0%	3.2%	3.2%	5	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Treatment of anal fistula with seaton suture	BADS: Treatment of anal fistula with seaton suture2021-22General Surgery	40	0%	95%	5%	0%	0%	0%	88%	10%	0%	2.50%	0%	94%	6.1%	0%	0%	5	2021-22	General Surgery	2021-22-General Surgery
BADS: Excision/destruction of lesion of mouth	BADS: Excision/destruction of lesion of mouth2022-23Head and Neck	20	0%	100%	0%	0%	0%	0%	85%	10%	0%	5%	46%	44%	0%	0%	9.8%	5	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Vasectomy	BADS: Vasectomy2022-23Urology	175	80%	20%	0%	0%	0%	0%	99%	0%	0.57%	0.57%	0%	100%	0%	0%	0%	5	2022-23	Urology	2022-23-Urology
BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow	BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow2021-22Orthopaedic Surge	28	0%	100%	0%	0%	0%	0%	89%	3.6%	7.1%	0%	0%	93%	6.7%	0.67%	0%	5	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Vaginal hysterectomy (including laparoscopically assisted)	BADS: Vaginal hysterectomy (including laparoscopically assisted)2022-23Gynaecology	7	0%	60%	35%	5%	0%	0%	0%	86%	14.3%	0%	0%	3.6%	57%	23.8%	15.5%	5	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Diagnostic laparoscopy	BADS: Diagnostic laparoscopy2022-23General Surgery	31	0%	90%	10%	0%	0%	0%	81%	16.1%	0%	3.2%	0.73%	69%	16.1%	8.8%	5.8%	5	2022-23	General Surgery	2022-23-General Surgery
BADS: Therapeutic endoscopic operations on pharynx	BADS: Therapeutic endoscopic operations on pharynx2022-23ENT	4	0%	70%	30%	0%	0%	0%	25%	25%	25%	25%	0%	58%	16.7%	8.3%	16.7%	5	2022-23	ENT	2022-23-ENT
BADS: Treatment of anal fistula with seaton suture	BADS: Treatment of anal fistula with seaton suture2022-23General Surgery	28	0%	95%	5%	0%	0%	0%	82%	14.3%	3.6%	0%	0%	95%	2.63%	1.32%	1.32%	5	2022-23	General Surgery	2022-23-General Surgery
BADS: Intranasal antrostomy including endoscopic	BADS: Intranasal antrostomy including endoscopic2021-22ENT	9	0%	95%	5%	0%	0%	0%	67%	11.1%	22.2%	0%	0%	64%	36%	0%	0%	5	2021-22	ENT	2021-22-ENT
BADS: Modified radical mastoidectomy (including meatoplasty)	BADS: Modified radical mastoidectomy (including meatoplasty)2021-22ENT	26	0%	80%	15%	5%	0%	0%	65%	30.8%	0%	3.8%	0%	55%	39%	3.03%	3.03%	4	2021-22	ENT	2021-22-ENT
BADS: Endoscopic incision of outlet of male bladder	BADS: Endoscopic incision of outlet of male bladder2022-23Urology	3	0%	50%	50%	0%	0%	0%	0%	33%	33%	33%	0%	9.1%	73%	18.2%	0%	4	2022-23	Urology	2022-23-Urology
BADS: Reduction of fracture of zygomatic complex of bones	BADS: Reduction of fracture of zygomatic complex of bones2021-22Head and Neck	4	0%	60%	40%	0%	0%	0%	0%	50%	50%	0%	0%	28.6%	71%	0%	0%	4	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Endovascular Aneurysm Repair	BADS: Endovascular Aneurysm Repair2021-22Vascular	6	0%	5%	60%	35%	0%	0%	0%	33%	33%	33%	0%	0%	23.8%	38%	38%	4	2021-22	Vascular	2021-22-Vascular
BADS: Diagnostic endoscopic examination of pharynx/ larynx +/- biopsy	BADS: Diagnostic endoscopic examination of pharynx/ larynx +/- biopsy2022-23ENT	1500	0%	99%	1%	0%	0%	96%	3.3%	1.07%	0%	0.067%	86%	11.3%	1.97%	0.081%	0.189%	4	2022-23	ENT	2022-23-ENT
BADS: Excision of parotid gland	BADS: Excision of parotid gland2022-23Head and Neck	7	0%	15%	70%	15%	0%	0%	14.3%	43%	14.3%	28.6%	2.67%	16%	39%	25.3%	17.3%	4	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Surgical trabeculectomy or other penetrating glaucoma procedures	BADS: Surgical trabeculectomy or other penetrating glaucoma procedures2021-22Opthalmology	24	0%	100%	0%	0%	0%	0%	83%	16.7%	0%	0%	0%	100%	0%	0%	0%	4	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Excision lesion of eyelid (Adult)	BADS: Excision lesion of eyelid (Adult)2021-22Opthalmology	77	95%	5%	0%	0%	0%	0%	97%	1.30%	0%	1.30%	12.9%	86%	0.98%	0.163%	0.163%	4	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Operations on nipple	BADS: Operations on nipple2021-22Breast	4	0%	100%	0%	0%	0%	0%	25%	50%	25%	0%	10.3%	89%	0.85%	0%	0%	4	2021-22	Breast	2021-22-Breast
BADS: Removal of prosthesis from ureter	BADS: Removal of prosthesis from ureter2022-23Urology	48	80%	20%	0%	0%	0%	0%	92%	8.3%	0%	0%	9%	81%	7.1%	1.58%	1.06%	4	2022-23	Urology	2022-23-Urology
BADS: Correction of hydrocele (Adult)	BADS: Correction of hydrocele (Adult)2022-23Urology	26	0%	100%	0%	0%	0%	0%	88%	7.7%	3.8%	0%	0%	81%	13.5%	2.70%	2.70%	4	2022-23	Urology	2022-23-Urology
BADS: Excison/biopsy of breast tissue including wire guided	BADS: Excison/biopsy of breast tissue including wire guided2021-22Breast	63	0%	95%	5%	0%	0%	0%	89%	11.1%	0%	0%	1.38%	86%	11.3%	0.83%	0.276%	4	2021-22	Breast	2021-22-Breast
BADS: Evacuation of retained products of conception - Emergency	BADS: Evacuation of retained products of conception - Emergency2021-22Emergency Surgery	3	0%	95%	5%	0%	0%	0%	33%	33%	0%	33%	0%	28%	48%	20%	4%	4	2021-22	Emergency Surgery	2021-22-Emergency Surgery
BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair	BADS: Therapeutic arthroscopy of shoulder - subacromial decompression, cuff repair2022-23Orthopaedic	22	0%	90%	5%	5%	0%	13.6%	64%	13.6%	9.1%	0%	0%	77%	21.1%	0%	1.75%	4	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Primary repair of femoral hernia	BADS: Primary repair of femoral hernia2021-22General Surgery	8	0%	95%	5%	0%	0%	0%	75%	12.5%	0%	12.5%	0%	74%	17.6%	5.9%	2.94%	4	2021-22	General Surgery	2021-22-General Surgery
BADS: Excision of submandibular or sublingual gland	BADS: Excision of submandibular or sublingual gland2021-22Head and Neck	5	0%	30%	70%	0%	0%	0%	0%	60%	40%	0%	0%	22.9%	58%	8.3%	10.4%	4	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Excison/biopsy of breast tissue including wire guided	BADS: Excison/biopsy of breast tissue including wire guided2022-23Breast	54	0%	95%	5%	0%	0%	0%	89%	11.1%	0%	0%	0%	83%	12%	3.8%	0.75%	3	2022-23	Breast	2022-23-Breast
BADS: Myomectomy (including laparoscopically)	BADS: Myomectomy (including laparoscopically)2021-22Gynaecology	4	0%	50%	30%	20%	0%	0%	50%	0%	0%	50%	84%	0%	4.9%	1.23%	9.9%	3	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Laparoscopic Repair of incisional hernia	BADS: Laparoscopic Repair of incisional hernia2021-22General Surgery	7	0%	40%	50%	10%	0%	0%	28.6%	43%	14.3%	14.3%	0%	33%	0%	33%	33%	3	2021-22	General Surgery	2021-22-General Surgery
BADS: Correction of ptosis of eyelid	BADS: Correction of ptosis of eyelid2021-22Opthalmology	18	0%	100%	0%	0%	0%	0%	89%	5.6%	5.6%	0%	0%	98%	2.20%	0%	0%	3	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Radiofrequency ablation of varicose veins (VNUS)	BADS: Radiofrequency ablation of varicose veins (VNUS)2021-22Vascular	19	80%	20%	0%	0%	0%	0%	95%	0%	0%	5.3%	0%	100%	0%	0%	0%	3	2021-22	Vascular	2021-22-Vascular
BADS: Biopsy/Cauterisation/Curettage of lesion of eyelid	BADS: Biopsy/Cauterisation/Curettage of lesion of eyelid2021-22Opthalmology	79	95%	5%	0%	0%	0%	91%	7.6%	0%	0%	1.27%	30.3%	70%	0%	0%	0%	3	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Extraction of cataract +/- implant	BADS: Extraction of cataract +/- implant2022-23Opthalmology	1451	0%	100%	0%	0%	0%	20.3%	80%	0%	0%	0.069%	6.3%	93%	0.61%	0.048%	0.240%	3	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Dupuytren's fasciectomy	BADS: Dupuytren's fasciectomy2021-22Orthopaedic Surgery	33	0%	100%	0%	0%	0%	0%	91%	9.1%	0%	0%	0%	94%	5.3%	0%	0.48%	3	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Excision of lesion of peripheral nerve	BADS: Excision of lesion of peripheral nerve2021-22Orthopaedic Surgery	13	0%	100%	0%	0%	0%	0%	77%	23.1%	0%	0%	0%	86%	12.2%	2.04%	0%	3	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Excison/biopsy of lesion of pinna	BADS: Excison/biopsy of lesion of pinna2022-23ENT	91	0%	100%	0%	0%	0%	0%	99%	0%	0%	1.10%	5.3%	93%	1.69%	0%	0%	3	2022-23	ENT	2022-23-ENT
BADS: Endoscopic incision of outlet of male bladder	BADS: Endoscopic incision of outlet of male bladder2021-22Urology	6	0%	50%	50%	0%	0%	0%	0%	100%	0%	0%	0%	30.8%	54%	15.4%	0%	3	2021-22	Urology	2021-22-Urology
BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow	BADS: Neurolysis and transposition of peripheral nerve eg ulnar nerve at elbow2022-23Orthopaedic Surge	30	0%	100%	0%	0%	0%	0%	93%	3.3%	3.3%	0%	0%	88%	7.9%	2.63%	1.32%	3	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Vitrectomy using pars plana approach	BADS: Vitrectomy using pars plana approach2021-22Opthalmology	3	0%	98%	2%	0%	0%	0%	67%	0%	0%	33%	0%	95%	3.4%	1.03%	0.114%	3	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Evacuation of retained products of concept	BADS: Evacuation of retained products of concept2022-23Gynaecology	2	0%	95%	5%	0%	0%	0%	0%	50%	50%	0%	0%	0%	100%	0%	0%	3	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Repair of rectal mucosal prolapse	BADS: Repair of rectal mucosal prolapse2022-23General Surgery	4	0%	70%	30%	0%	0%	0%	50%	25%	0%	25%	0%	33%	33%	22.2%	11.1%	3	2022-23	General Surgery	2022-23-General Surgery
BADS: Excision/biopsy/sampling of lymph node for diagnosis (cervical, inguinal, axillary)	BADS: Excision/biopsy/sampling of lymph node for diagnosis (cervical, inguinal, axillary)2021-22General Su	66	0%	95%	5%	0%	0%	52%	42%	3.03%	3.03%	0%	5.3%	65%	20%	5.8%	4.2%	3	2021-22	General Surgery	2021-22-General Surgery
BADS: Microdochotomy + other operations on duct of breast	BADS: Microdochotomy + other operations on duct of breast2021-22Breast	31	0%	99%	1%	0%	0%	0%	90%	9.7%	0%	0%	0%	91%	9.4%	0%	0%	3	2021-22	Breast	2021-22-Breast
BADS: Re excision of margins	BADS: Re excision of margins2021-22Breast	38	0%	99%	1%	0%	0%	0%	92%	7.9%	0%	0%	0%	79%	16.2%	3.5%	1.31%	3	2021-22	Breast	2021-22-Breast
BADS: Reduction of fracture of zygomatic complex of bones - Emergency	BADS: Reduction of fracture of zygomatic complex of bones - Emergency2021-22Emergency Surgery	4	0%	60%	40%	0%	0%	0%	25%	50%	25%	0%	0%	11.5%	35%	42%	11.5%	2	2021-22	Emergency Surgery	2021-22-Emergency Surgery

BADS: Cystostomy and insertion of suprapubic tube into bladder	BADS: Cystostomy and insertion of suprapubic tube into bladder2022-23Urology	13	0%	80%	20%	0%	0%	0%	62%	38%	0%	0%	0%	61%	27.8%	2.78%	8.3%	2	2022-23	Urology	2022-23-Urology
BADS: Laparoscopic Repair of incisional hernia	BADS: Laparoscopic Repair of incisional hernia2022-23General Surgery	1	0%	40%	50%	10%	0%	0%	0%	0%	0%	100%	0%	0%	25%	12.5%	62%	2	2022-23	General Surgery	2022-23-General Surgery
BADS: Posterior excision of lumbar disc prolapse including microdiscectomy	BADS: Posterior excision of lumbar disc prolapse including microdiscectomy2021-22Orthopaedic Surgery	2	0%	30%	50%	20%	0%	0%	0%	50%	0%	50%	0%	2.13%	70%	23.4%	4.3%	2	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Renal biopsy	BADS: Renal biopsy2022-23Medicine	19	0%	90%	5%	5%	0%	0%	74%	26.3%	0%	0%	0%	81%	10.3%	3.4%	5.2%	2	2022-23	Medicine	2022-23-Medicine
BADS: Destruction of lesion of cervix uteri (including loop diathermy and laser)	BADS: Destruction of lesion of cervix uteri (including loop diathermy and laser)2021-22Gynaecology	282	90%	10%	0%	0%	0%	85%	14.5%	0.71%	0%	0%	72%	26.4%	1.02%	0.204%	0.102%	2	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Operations on turbinates of nose (laser, diathermy, out fracture etc)	BADS: Operations on turbinates of nose (laser, diathermy, out fracture etc)2022-23ENT	13	0%	100%	0%	0%	0%	0%	92%	0%	7.7%	0%	4%	74%	20%	2%	0%	2	2022-23	ENT	2022-23-ENT
BADS: Excision of ganglion	BADS: Excision of ganglion2022-23Orthopaedic Surgery	13	0%	100%	0%	0%	0%	0%	85%	15.4%	0%	0%	0%	98%	2.47%	0%	0%	2	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Correction of ectropion	BADS: Correction of ectropion2021-22Opthalmology	25	90%	10%	0%	0%	0%	0%	92%	8%	0%	0%	1.28%	99%	0%	0%	0%	2	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Excision of ganglion	BADS: Excision of ganglion2021-22Orthopaedic Surgery	25	0%	100%	0%	0%	0%	0%	96%	0%	4%	0%	0%	100%	0%	0%	0%	2	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Correction of hydrocele (Adult)	BADS: Correction of hydrocele (Adult)2021-22Urology	20	0%	100%	0%	0%	0%	0%	90%	10%	0%	0%	0.85%	86%	9.3%	0.85%	2.54%	2	2021-22	Urology	2021-22-Urology
BADS: Operations on turbinates of nose (laser, diathermy, out fracture etc)	BADS: Operations on turbinates of nose (laser, diathermy, out fracture etc)2021-22ENT	4	0%	100%	0%	0%	0%	0%	50%	50%	0%	0%	7.3%	73%	14.6%	2.44%	2.44%	2	2021-22	ENT	2021-22-ENT
BADS: Enucleation of cyst of jaw	BADS: Enucleation of cyst of jaw2022-23Head and Neck	9	0%	100%	0%	0%	0%	0%	78%	22.2%	0%	0%	15.4%	74%	10.3%	0%	0%	2	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Operations on foreskin -circumcision, division of adhesions (Paediatric)	BADS: Operations on foreskin -circumcision, division of adhesions (Paediatric)2021-22Paediatric Surgery	32	0%	100%	0%	0%	0%	0%	94%	6.2%	0%	0%	0%	98%	2.44%	0%	0%	2	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Colposcopy (+/- biopsy)	BADS: Colposcopy (+/- biopsy)2021-22Gynaecology	52	95%	5%	0%	0%	0%	96%	0%	3.8%	0%	0%	99%	0.59%	0.049%	0%	0%	2	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Elective Cardioversion	BADS: Elective Cardioversion2021-22Medicine	103	0%	99%	1%	0%	0%	0%	99%	0%	0%	0.97%	0%	97%	1.55%	0.34%	0.69%	2	2021-22	Medicine	2021-22-Medicine
BADS: Optical Urethrotomy	BADS: Optical Urethrotomy2021-22Urology	3	0%	95%	5%	0%	0%	0%	33%	67%	0%	0%	0%	66%	23.7%	6.2%	4.1%	2	2021-22	Urology	2021-22-Urology
BADS: FESS Endoscopic uncinectomy, anterior and posterior ethmoidectomy	BADS: FESS Endoscopic uncinectomy, anterior and posterior ethmoidectomy2022-23ENT	4	0%	95%	5%	0%	0%	0%	50%	50%	0%	0%	0%	36%	59%	0%	4.5%	2	2022-23	ENT	2022-23-ENT
BADS: Other endoscopic procedures on ureter	BADS: Other endoscopic procedures on ureter2022-23Urology	2	0%	90%	10%	0%	0%	0%	0%	100%	0%	0%	0%	61%	18.4%	10.5%	10.5%	2	2022-23	Urology	2022-23-Urology
BADS: Orchidectomy	BADS: Orchidectomy2022-23Urology	22	0%	99%	1%	0%	0%	0%	91%	9.1%	0%	0%	0%	77%	15.1%	2.74%	5.5%	2	2022-23	Urology	2022-23-Urology
BADS: Tympanoplasty	BADS: Tympanoplasty2021-22ENT	5	0%	95%	5%	0%	0%	0%	60%	40%	0%	0%	0%	76%	22.5%	1.18%	0%	2	2021-22	ENT	2021-22-ENT
BADS: Myomectomy (including laparoscopically)	BADS: Myomectomy (including laparoscopically)2022-23Gynaecology	2	0%	50%	30%	20%	0%	0%	50%	0%	0%	50%	17.9%	28.6%	10.7%	25%	17.9%	2	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Orchidectomy	BADS: Orchidectomy2021-22Urology	53	0%	99%	1%	0%	0%	0%	98%	0%	1.89%	0%	0%	76%	18.2%	1.82%	3.6%	1	2021-22	Urology	2021-22-Urology
BADS: Repair of hand or wrist tendon	BADS: Repair of hand or wrist tendon2022-23Orthopaedic Surgery	13	0%	95%	5%	0%	0%	0%	85%	15.4%	0%	0%	0%	79%	20.9%	0%	0%	1	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Operations on foreskin -circumcision, division of adhesions (Adult)	BADS: Operations on foreskin -circumcision, division of adhesions (Adult)2022-23Urology	80	0%	99%	1%	0%	0%	0%	98%	2.50%	0%	0%	0%	88%	8.1%	1.35%	2.70%	1	2022-23	Urology	2022-23-Urology
BADS: Myringotomy +/- insertion of tube, suction clearance (Paediatric)	BADS: Myringotomy +/- insertion of tube, suction clearance (Paediatric)2022-23Paediatric Surgery	28	0%	100%	0%	0%	0%	7.1%	89%	3.6%	0%	0%	0.70%	90%	9.2%	0%	0%	1	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Adult)	BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Adult)2021-22ENT	56	95%	5%	0%	0%	0%	0%	98%	1.79%	0%	0%	1.69%	93%	5.1%	0%	0%	1	2021-22	ENT	2021-22-ENT
BADS: Marsupialisation of Bartholin cyst	BADS: Marsupialisation of Bartholin cyst2021-22Gynaecology	6	25%	75%	0%	0%	0%	0%	83%	16.7%	0%	0%	0%	78%	22.2%	0%	0%	1	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Injection or banding of haemorrhoids	BADS: Injection or banding of haemorrhoids2021-22General Surgery	47	100%	0%	0%	0%	0%	49%	49%	2.13%	0%	0%	19.1%	79%	1.60%	0%	0%	1	2021-22	General Surgery	2021-22-General Surgery
BADS: Removal of foreign body from skin	BADS: Removal of foreign body from skin2022-23Orthopaedic Surgery	13	0%	100%	0%	0%	0%	0%	92%	7.7%	0%	0%	27.1%	71%	2.08%	0%	0%	1	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Cone biopsy of cervix uteri (including laser)	BADS: Cone biopsy of cervix uteri (including laser)2021-22Gynaecology	457	50%	50%	0%	0%	0%	99%	0.66%	0.219%	0%	0%	93%	6.6%	0.183%	0%	0.183%	1	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Simple extraction of teeth	BADS: Simple extraction of teeth2021-22Paediatric Surgery	82	0%	100%	0%	0%	0%	0%	99%	1.22%	0%	0%	0.96%	97%	1.65%	0.137%	0.137%	1	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Cystostomy and insertion of suprapubic tube into bladder	BADS: Cystostomy and insertion of suprapubic tube into bladder2021-22Urology	20	0%	80%	20%	0%	0%	0%	85%	10%	0%	5%	0%	57%	26.5%	8.2%	8.2%	1	2021-22	Urology	2021-22-Urology
BADS: Exploration of sheath of tendon (eg trigger finger)	BADS: Exploration of sheath of tendon (eg trigger finger)2021-22Orthopaedic Surgery	45	0%	100%	0%	0%	0%	0%	98%	2.22%	0%	0%	0%	99%	0.68%	0.34%	0%	1	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Surgical trabeculectomy or other penetrating glaucoma procedures	BADS: Surgical trabeculectomy or other penetrating glaucoma procedures2022-23Opthalmology	9	0%	100%	0%	0%	0%	0%	89%	11.1%	0%	0%	0%	100%	0%	0%	0%	1	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Endoscopic examination of urethra +/- biopsy	BADS: Endoscopic examination of urethra +/- biopsy2021-22Urology	44	0%	100%	0%	0%	0%	0%	98%	2.27%	0%	0%	0%	92%	4.9%	0.97%	1.94%	1	2021-22	Urology	2021-22-Urology
BADS: Surgical removal of impacted/ buried tooth/teeth (Paediatric)	BADS: Surgical removal of impacted/ buried tooth/teeth (Paediatric)2022-23Paediatric Surgery	29	0%	100%	0%	0%	0%	0%	97%	3.4%	0%	0%	0%	95%	3.6%	0.90%	0%	1	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Correction of squint (Adult)	BADS: Correction of squint (Adult)2021-22Opthalmology	29	0%	100%	0%	0%	0%	0%	97%	3.4%	0%	0%	0%	97%	1.49%	1.49%	0%	1	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Excision of accessory breast tissue	BADS: Excision of accessory breast tissue2022-23Breast	3	0%	99%	1%	0%	0%	0%	67%	33%	0%	0%	0%	100%	0%	0%	0%	1	2022-23	Breast	2022-23-Breast
BADS: Excision of submandibular or sublingual gland	BADS: Excision of submandibular or sublingual gland2022-23Head and Neck	3	0%	30%	70%	0%	0%	0%	0%	100%	0%	0%	0%	16%	56%	16%	12%	1	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Evacuation of retained products of conception - Emergency	BADS: Evacuation of retained products of conception - Emergency2022-23Emergency Surgery	2	0%	95%	5%	0%	0%	0%	50%	50%	0%	0%	0%	14.3%	50%	21.4%	14.3%	1	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Microdochotomy + other operations on duct of breast	BADS: Microdochotomy + other operations on duct of breast2022-23Breast	11	0%	99%	1%	0%	0%	0%	91%	9.1%	0%	0%	0%	82%	14%	4%	0%	1	2022-23	Breast	2022-23-Breast
BADS: Reduction of fracture of zygomatic complex of bones	BADS: Reduction of fracture of zygomatic complex of bones2022-23Head and Neck	3	0%	60%	40%	0%	0%	0%	33%	67%	0%	0%	0%	20%	80%	0%	0%	1	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Polypectomy of internal nose	BADS: Polypectomy of internal nose2022-23ENT	12	0%	90%	10%	0%	0%	0%	83%	16.7%	0%	0%	0%	72%	28.3%	0%	0%	1	2022-23	ENT	2022-23-ENT
BADS: Therapeutic endoscopic operations on pharynx	BADS: Therapeutic endoscopic operations on pharynx2021-22ENT	4	0%	70%	30%	0%	0%	0%	50%	50%	0%	0%	0%	39%	47%	5.3%	7.9%	1	2021-22	ENT	2021-22-ENT
BADS: Carotid endarterectomy	BADS: Carotid endarterectomy2021-22Vascular	11	0%	5%	60%	35%	0%	0%	0%	73%	18.2%	9.1%	0%	0%	14.3%	62%	23.8%	1	2021-22	Vascular	2021-22-Vascular
BADS: Other endoscopic procedures on ureter	BADS: Other endoscopic procedures on ureter2021-22Urology	3	0%	90%	10%	0%	0%	0%	67%	33%	0%	0%	0%	59%	25%	7.4%	8.8%	1	2021-22	Urology	2021-22-Urology
BADS: Diagnostic endoscopic examination of bladder (including any biopsy)	BADS: Diagnostic endoscopic examination of bladder (including any biopsy)2021-22Urology	2641	90%	5%	5%	0%	0%	0%	99%	1.17%	0.038%	0.038%	14%	83%	1.91%	0.32%	0.38%	0	2021-22	Urology	2021-22-Urology
BADS: Diagnostic endoscopic examination of bladder (including any biopsy)	BADS: Diagnostic endoscopic examination of bladder (including any biopsy)2022-23Urology	1149	90%	5%	5%	0%	0%	0%	97%	2.35%	0.261%	0.35%	14.5%	83%	2.01%	0.243%	0.291%	0	2022-23	Urology	2022-23-Urology
BADS: Therapeutic laparoscopic procedures including laser, diathermy and destruction eg endometriosis, a	BADS: Therapeutic laparoscopic procedures including laser, diathermy and destruction eg endometriosis, a	123	0%	85%	10%	5%	0%	0%	82%	16.3%	1.63%	0%	0.47%	58%	30.2%	5.7%	6.1%	0	2021-22	Gynaecology	2021-22-Gynaecology
BADS: ERCP	BADS: ERCP2021-22Medicine	107	0%	50%	30%	20%	0%	0%	83%	7.5%	6.5%	2.80%	0%	77%	5%	11.4%	6.2%	0	2021-22	Medicine	2021-22-Medicine
BADS: Primary reduction and open fixation of wrist	BADS: Primary reduction and open fixation of wrist2021-22Orthopaedic Surgery	77	0%	60%	40%	0%	0%	0%	87%	13%	0%	0%	0%	84%	14%	1.75%	0%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Diagnostic laparoscopy	BADS: Diagnostic laparoscopy2021-22General Surgery	63	0%	90%	10%	0%	0%	0%	92%	6.3%	1.59%	0%	0%	74%	16.8%	7.2%	2.40%	0	2021-22	General Surgery	2021-22-General Surgery
BADS: Implantation of cardiac pacemaker	BADS: Implantation of cardiac pacemaker2021-22Medicine	61	0%	50%	40%	10%	0%	0%	95%	3.3%	1.64%	0%	0%	86%	10.7%	1%	2.10%	0	2021-22	Medicine	2021-22-Medicine
BADS: Renal biopsy	BADS: Renal biopsy2021-22Medicine	52	0%	90%	5%	5%	0%	0%	92%	1.92%	5.8%	0%	0.68%	81%	12.8%	0.68%	4.7%	0	2021-22	Medicine	2021-22-Medicine
BADS: ERCP	BADS: ERCP2022-23Medicine	50	0%	50%	30%	20%	0%	0%	84%	6%	4%	6%	0%	83%	6.8%	4.4%	5.4%	0	2022-23	Medicine	2022-23-Medicine
BADS: Primary reduction and open fixation of wrist	BADS: Primary reduction and open fixation of wrist2022-23Orthopaedic Surgery	48	0%	60%	40%	0%	0%	0%	100%	0%	0%	0%	0%	79%	14.3%	4.8%	2.38%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Elective Cardioversion	BADS: Elective Cardioversion2022-23Medicine	47	0%	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	97%	2.37%	0%	1.05%	0	2022-23	Medicine	2022-23-Medicine
BADS: Bone marrow biopsy	BADS: Bone marrow biopsy2021-22Medicine	45	0%	90%	5%	5%	0%	0%	100%	0%	0%	0%	14%	85%	0.50%	0%	0.70%	0	2021-22	Medicine	2021-22-Medicine
BADS: Septoplasty of nose	BADS: Septoplasty of nose2021-22ENT	43	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	86%	13.9%	0%	0.34%	0	2021-22	ENT	2021-22-ENT
BADS: Septoplasty of nose	BADS: Septoplasty of nose2022-23ENT	37	0%	95%	5%	0%	0%	0%	97%	2.70%	0%	0%	0%	72%	24.4%	2.03%	1.22%	0	2022-23	ENT	2022-23-ENT
BADS: Pilonidal sinus surgery -laying open or suture/ skin graft	BADS: Pilonidal sinus surgery -laying open or suture/ skin graft2022-23General Surgery	37	0%	95%	5%	0%	0%	0%	97%	2.70%	0%	0%	0%	79%	17.3%	2.47%	1.23%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Liver biopsy	BADS: Liver biopsy2021-22Medicine	35	0%	80%	10%	10%	0%	0%	89%	11.4%	0%	0%	2.47%	81%	10.7%	2.47%	3.7%	0	2021-22	Medicine	2021-22-Medicine
BADS: Excision/biopsy/sampling of lymph node for diagnosis (cervical, inguinal, axillary)	BADS: Excision/biopsy/sampling of lymph node for diagnosis (cervical, inguinal, axillary)2022-23General Su	23	0%	95%	5%	0%	0%	61%	35%	4.3%	0%	0%	21.2%	53%	18.3%	2.88%	4.8%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Bone marrow biopsy	BADS: Bone marrow biopsy2022-23Medicine	21	0%	90%	5%	5%	0%	0%	100%	0%	0%	0%	9.3%	91%	0%	0%	0.202%	0	2022-23	Medicine	2022-23-Medicine
BADS: Total/Subtotal thyroidectomy	BADS: Total/Subtotal thyroidectomy2021-22Head and Neck	18	0%	0%	70%	30%	0%	0%	5.6%	67%	22.2%	5.6%	1.19%	1.19%	71%	13.7%	13.1%	0	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Modified radical mastoidectomy (including meatoplasty)	BADS: Modified radical mastoidectomy (including meatoplasty)2022-23ENT	15	0%	80%	15%	5%	0%	0%	87%	13.3%	0%	0%	0%	46%	46%	7.1%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Implantation of cardiac pacemaker	BADS: Implantation of cardiac pacemaker2022-23Medicine	15	0%	50%	40%	10%	0%	0%	80%	20%	0%	0%	0%	91%	6.1%	0.87%	1.75%	0	2022-23	Medicine	2022-23-Medicine
BADS: Operations on urethral orifice	BADS: Operations on urethral orifice2022-23Urology	8	0%	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	90%	6.1%	0%	4.1%	0	2022-23	Urology	2022-23-Urology
BADS: Tympanoplasty	BADS: Tympanoplasty2022-23ENT	4	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	79%	18.8%	1.71%	0.85%	0	2022-23	ENT	2022-23-ENT
BADS: Total/Subtotal thyroidectomy	BADS: Total/Subtotal thyroidectomy2022-23Head and Neck	4	0%	0%	70%	30%	0%	0%	25%	75%	0%	0%	0%	0%	68%	17.8%	14.4%	0	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Carotid endarterectomy	BADS: Carotid endarterectomy2022-23Vascular	4	0%	5%	60%	35%	0%	0%	0%	75%	25%	0%	0%	0%	15.8%	47%	37%	0	2022-23	Vascular	2022-23-Vascular
BADS: Liver biopsy	BADS: Liver biopsy2022-23Medicine	4	0%	80%	10%	10%	0%	0%	75%	25%	0%	0%	0%	86%	8.2%	0.68%	4.8%	0	2022-23	Medicine	2022-23-Medicine
BADS: Orchidopexy-bilateral	BADS: Orchidopexy-bilateral2021-22Paediatric Surgery	3	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	69%	23.1%	7.7%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Intranasal antrostomy including endoscopic	BADS: Intranasal antrostomy including endoscopic2022-23ENT	2	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	69%	24.1%	0%	6.9%	0	2022-23	ENT	2022-23-ENT
BADS: Primary repair of femoral hernia	BADS: Primary repair of femoral hernia2022-23General Surgery	2	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	94%	0%	0%	6.2%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Adenoid Surgery (Paediatric)	BADS: Adenoid Surgery (Paediatric)2022-23Paediatric Surgery	2	0%	90%	10%	0%	0%	0%	100%	0%	0%	0%	0%	72%	27.8%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Incision and drainage of perianal abscess	BADS: Incision and drainage of perianal abscess2022-23General Surgery	1	0%	95%	5%	0%	0%	0%	100%	0%	0%	0%	0%	50%	33%	0%	16.7%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Ossiculoplasty	BADS: Ossiculoplasty2021-22ENT	1	0%	90%	5%	5%	0%	0%	100%	0%	0%	0%	0%	86%	14.3%	0%	0%	0	2021-22	ENT	2021-22-ENT
BADS: Appendicectomy (including laparoscopic)	BADS: Appendicectomy (including laparoscopic)2021-22General Surgery	1	0%	15%	80%	5%	0%	0%	100%	0%	0%	0%	0%	33%	33%	33%	0%	0	2021-22	General Surgery	2021-22-General Surgery
BADS: Diagnostic arthroscopic examination of shoulder joint	BADS: Diagnostic arthroscopic examination of shoulder joint2021-22Orthopaedic Surgery	1	0%	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Primary reduction and open fixation of ankle	BADS: Primary reduction and open fixation of ankle2021-22Orthopaedic Surgery	1	0%	25%	50%	25%	0%	0%	100%	0%	0%	0%	0%	33%	40%	13.3%	13.3%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Excision of lesion of testis	BADS: Excision of lesion of testis2021-22Urology	1	0%	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	86%	14.3%	0%	0%	0	2021-22	Urology	2021-22-Urology
BADS: Repair of recurrent inguinal hernia	BADS: Repair of recurrent inguinal hernia2022-23General Surgery	7	0%	90%	10%	0%	0%	0%	86%	14.3%	0%	0%	0%	81%	16.7%	2.08%	0%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Pilonidal sinus surgery -laying open or suture/ skin graft	BADS: Pilonidal sinus surgery -laying open or suture/ skin graft2021-22General Surgery	35	0%	95%	5%	0%	0%	0%	94%	5.7%	0%	0%	0%	89%	9.4%	1.25%	0.62%	0	2021-22	General Surgery	2021-22-General Surgery
BADS: Cone biopsy of cervix uteri (including laser)	BADS: Cone biopsy of cervix uteri (including laser)2022-23Gynaecology	295	50%	50%	0%	0%	0%	100%	0.34%	0%	0%	0%	93%	6.5%	0.62%	0%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Vasectomy	BADS: Vasectomy2021-22Urology	272	80%	20%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Urology	2021-22-Urology
BADS: Nasal septum cauterisation (and bilateral)	BADS: Nasal septum cauterisation (and bilateral)2021-22ENT	210	0%	100%	0%	0%	0%	97%	3.3%	0%	0%	0%	80%	17.5%	1.75%	0%	1.17%	0	2021-22	ENT	2021-22-ENT
BADS: Destruction of lesion of cervix uteri (including loop diathermy and laser)	BADS: Destruction of lesion of cervix uteri (including loop diathermy and laser)2022-23Gynaecology	144	90%	10%	0%	0%	0%	85%	14.6%	0%	0%	0%	65%	32%	2.88%	0%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Nasal septum cauterisation (and bilateral)	BADS: Nasal septum cauterisation (and bilateral)2022-23ENT	138	0%	100%	0%	0%	0%	96%	4.3%	0%	0%	0%	88%	10.9%	0.78%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Excision lesion of eyelid (Adult)	BADS: Excision lesion of eyelid (Adult)2022-23Opthalmology	67	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	12.4%	87%	0%	0.32%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Laser iridotomy	BADS: Laser iridotomy2021-22Opthalmology	67	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	99%	0.53%	0%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Surgical removal of impacted/ buried tooth/teeth (Paediatric)	BADS: Surgical removal of impacted/ buried tooth/teeth (Paediatric)2021-22Paediatric Surgery	66	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	98%	1.65%	0.55%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Simple extraction of teeth	BADS: Simple extraction of teeth2022-23Paediatric Surgery	57	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	1.69%	97%	0.73%	0.242%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Myringotomy +/- insertion of tube, suction clearance (Adult)	BADS: Myringotomy +/- insertion of tube, suction clearance (Adult)2021-22ENT	54	0%	100%	0%	0%	0%	11.1%	89%	0%	0%	0%	29.8%	66%	3.05%	0%	0.76%	0	2021-22	ENT	2021-22-ENT
BADS: Biopsy/Cauterisation/Curettage of lesion of eyelid	BADS: Biopsy/Cauterisation/Curettage of lesion of eyelid2022-23Opthalmology	53	95%	5%	0%	0%	0%	74%	26.4%	0%	0%	0%	16.4%	81%	1.37%	0%	1.37%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Laser iridotomy	BADS: Laser iridotomy2022-23Opthalmology	52	99%	1%	0%	0%	0%	100%	0%	0%	0%	0%	99%	0.84%	0%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Exploration of sheath of tendon (eg trigger finger)	BADS: Exploration of sheath of tendon (eg trigger finger)2022-23Orthopaedic Surgery	51	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	97%	2.17%	0%	0.54%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Correction of entropion	BADS: Correction of entropion2022-23Opthalmology	48	90%	10%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Colposcopy (+/- biopsy)	BADS: Colposcopy (+/- biopsy)2022-23Gynaecology	45	95%	5%	0%	0%	0%	98%	2.22%	0%	0%	0%	99%	0.57%	0.038%	0%	0.038%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Orchidopexy	BADS: Orchidopexy2021-22Paediatric Surgery	41	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	92%	7.9%	0%	0.50%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Excision of lesion of lip	BADS: Excision of lesion of lip2022-23Head and Neck	40	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	23.2%	76%	0%	0%	1.22%	0	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Dupuytren's fasciectomy	BADS: Dupuytren's fasciectomy2022-23Orthopaedic Surgery	37	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0.56%	96%	3.9%	0%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Adult)	BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Adult)2022-23ENT	35	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	2.94%	97%	0%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Paediatric)	BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Paediatric)2021-22Paediatric	30	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Correction of squint (Paediatric)	BADS: Correction of squint (Paediatric)2022-23Paediatric Surgery	29	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	95%	4.9%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Removal of foreign body from skin	BADS: Removal of foreign body from skin2021-22Orthopaedic Surgery	29	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	26.8%	71%	1.79%	0%	0%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Excision of lesion of canthus	BADS: Excision of lesion of canthus2021-22Opthalmology	28	95%	5%	0%	0%	0%	7.1%	93%	0%	0%	0%	0.77%	98%	1.54%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Radiofrequency ablation of varicose veins (VNUS)	BADS: Radiofrequency ablation of varicose veins (VNUS)2022-23Vascular	25	80%	20%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Vascular	2022-23-Vascular
BADS: Exposure of buried teeth (Paediatric)	BADS: Exposure of buried teeth (Paediatric)2021-22Paediatric Surgery	24	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	4.8%	93%	1.20%	1.20%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Exposure of buried teeth (Paediatric)	BADS: Exposure of buried teeth (Paediatric)2022-23Paediatric Surgery	23	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	1.67%	93%	5%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Myringotomy +/- insertion of tube, suction clearance (Adult)	BADS: Myringotomy +/- insertion of tube, suction clearance (Adult)2022-23ENT	22	0%	100%	0%	0%	0%	41%	59%	0%	0%	0%	17.6%	82%	0%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Excision of lesion of canthus	BADS: Excision of lesion of canthus2022-23Opthalmology	22	95%	5%	0%	0%	0%	4.5%	95%	0%	0%	0%	18.9%	80%	1.11%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Correction of ectropion	BADS: Correction of ectropion2022-23Opthalmology	20	90%	10%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Excision of nail / nailbed	BADS: Excision of nail / nailbed 2021-22Orthopaedic Surgery	20	70%	30%	0%	0%	0%	0%	100%	0%	0%	0%	6.2%	94%	0%	0%	0%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Myringotomy +/- insertion of tube, suction clearance (Paediatric)	BADS: Myringotomy +/- insertion of tube, suction clearance (Paediatric)2021-22Paediatric Surgery	20	0%	100%	0%	0%	0%	5%	95%	0%	0%	0%	5.7%	82%	11.4%	0.81%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Orchidopexy	BADS: Orchidopexy2022-23Paediatric Surgery	19	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	95%	5.2%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Incision and drainage of skin abscess	BADS: Incision and drainage of skin abscess2021-22General Surgery	18	0%	100%	0%	0%	0%	56%	44%	0%	0%	0%	74%	21%	0.84%	0.84%	3.4%	0	2021-22	General Surgery	2021-22-General Surgery
BADS: Correction of squint (Paediatric)	BADS: Correction of squint (Paediatric)2021-22Paediatric Surgery	18	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	93%	7%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Excision of lesion of eyebrow	BADS: Excision of lesion of eyebrow2021-22Opthalmology	15	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	6.5%	91%	2.60%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Blepharoplasty	BADS: Blepharoplasty2022-23Opthalmology	14	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Endoscopic examination of urethra +/- biopsy	BADS: Endoscopic examination of urethra +/- biopsy2022-23Urology	14	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Urology	2022-23-Urology
BADS: Correction of squint (Adult)	BADS: Correction of squint (Adult)2022-23Opthalmology	13	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	95%	4.9%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Exposure of buried teeth (Adult)	BADS: Exposure of buried teeth (Adult)2021-22Head and Neck	13	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	18.2%	82%	0%	0%	0%	0	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Herniotomy / Ligation of patent processus vaginalis	BADS: Herniotomy / Ligation of patent processus vaginalis2022-23Paediatric Surgery	12	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	81%	19.2%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Exposure of buried teeth (Adult)	BADS: Exposure of buried teeth (Adult)2022-23Head and Neck	11	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Excision of lesion of eyebrow	BADS: Excision of lesion of eyebrow2022-23Opthalmology	11	95%	5%	0%	0%	0%	9.1%	91%	0%	0%	0%	4.4%	93%	2.22%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Blepharoplasty	BADS: Blepharoplasty2021-22Opthalmology	11	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0.90%	98%	0.90%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Operations on foreskin -circumcision, division of adhesions (Paediatric)	BADS: Operations on foreskin -circumcision, division of adhesions (Paediatric)2022-23Paediatric Surgery	10	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	98%	1.85%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Herniotomy / Ligation of patent processus vaginalis	BADS: Herniotomy / Ligation of patent processus vaginalis2021-22Paediatric Surgery	10	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	92%	7.9%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Excision of lesion of penis	BADS: Excision of lesion of penis2021-22Urology	10	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	90%	2.50%	0%	7.5%	0	2021-22	Urology	2021-22-Urology
BADS: Correction of ptosis of eyelid	BADS: Correction of ptosis of eyelid2022-23Opthalmology	9	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	98%	1.96%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Biopsy/Sampling of conjunctival lesion	BADS: Biopsy/Sampling of conjunctival lesion2021-22Opthalmology	9	99%	1%	0%	0%	0%	0%	100%	0%	0%	0%	0%	98%	1.96%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Excision of lesion of peripheral nerve	BADS: Excision of lesion of peripheral nerve2022-23Orthopaedic Surgery	8	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	94%	5.6%	0%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Paediatric)	BADS: Manipulation under anaesthesia of fractured nose (as sole procedure) (Paediatric)2022-23Paediatric	8	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	5.3%	95%	0%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Biopsy/Sampling of conjunctival lesion	BADS: Biopsy/Sampling of conjunctival lesion2022-23Opthalmology	6	99%	1%	0%	0%	0%	0%	100%	0%	0%	0%	0%	96%	3.8%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: MUA Fracture and application of plaster cast	BADS: MUA Fracture and application of plaster cast2022-23Orthopaedic Surgery	6	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	78%	20.4%	1.85%	0%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Excision of epididymal lesion	BADS: Excision of epididymal lesion2022-23Urology	6	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	96%	4%	0%	0%	0	2022-23	Urology	2022-23-Urology
BADS: Removal of ventilation device	BADS: Removal of ventilation device2021-22ENT	6	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	17.4%	83%	0%	0%	0%	0	2021-22	ENT	2021-22-ENT
BADS: Laser photocoagulation of ciliary body	BADS: Laser photocoagulation of ciliary body2021-22Opthalmology	6	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Excision of nail / nailbed	BADS: Excision of nail / nailbed 2022-23Orthopaedic Surgery	5	70%	30%	0%	0%	0%	0%	100%	0%	0%	0%	10.8%	86%	2.70%	0%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Division of tongue tie	BADS: Division of tongue tie2022-23Paediatric Surgery	5	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	26.7%	71%	2.22%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Correction of hydrocele (Paediatric)	BADS: Correction of hydrocele (Paediatric)2022-23Paediatric Surgery	5	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Foam sclerotherapy of varicose veins	BADS: Foam sclerotherapy of varicose veins2022-23Vascular	5	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	12.5%	88%	0%	0%	0%	0	2022-23	Vascular	2022-23-Vascular
BADS: Foam sclerotherapy of varicose veins	BADS: Foam sclerotherapy of varicose veins2021-22Vascular	5	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Vascular	2021-22-Vascular
BADS: Female sterilisation	BADS: Female sterilisation2022-23Gynaecology	4	20%	80%	0%	0%	0%	0%	100%	0%	0%	0%	0%	80%	17.8%	2.22%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Division of tongue tie	BADS: Division of tongue tie2021-22Paediatric Surgery	4	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	65%	35%	0%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Removal of ventilation device	BADS: Removal of ventilation device2022-23ENT	3	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	25%	75%	0%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Laser photocoagulation of ciliary body	BADS: Laser photocoagulation of ciliary body2022-23Opthalmology	3	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Operations on nipple	BADS: Operations on nipple2022-23Breast	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	6.9%	88%	3.4%	1.72%	0%	0	2022-23	Breast	2022-23-Breast
BADS: Excision pre-auricular abnormality	BADS: Excision pre-auricular abnormality2022-23ENT	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Dacryocystorhinostomy including insertion of tube	BADS: Dacryocystorhinostomy including insertion of tube2022-23Opthalmology	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	50%	35%	5%	10%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: MUA Fracture and application of plaster cast	BADS: MUA Fracture and application of plaster cast2021-22Orthopaedic Surgery	2	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	77%	20.1%	2.16%	0.72%	0%	0	2021-22	Orthopaedic Surgery	2021-22-Orthopaedic Surgery
BADS: Excision lesion of eyelid (Paediatric)	BADS: Excision lesion of eyelid (Paediatric)2021-22Paediatric Surgery	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	15%	85%	0%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Correction of hydrocele (Paediatric)	BADS: Correction of hydrocele (Paediatric)2021-22Paediatric Surgery	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Operation(s) on varicocele	BADS: Operation(s) on varicocele2021-22Urology	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	Urology	2021-22-Urology
BADS: Frenuloplasty of penis	BADS: Frenuloplasty of penis2021-22Urology	2	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	96%	0%	0%	3.6%	0	2021-22	Urology	2021-22-Urology
BADS: Endovenous laser treatment (EVLT)	BADS: Endovenous laser treatment (EVLT)2021-22Vascular	2	80%	20%	0%	0%	0%	0%	100%	0%	0%	0%	0%	50%	0%	0%	50%	0	2021-22	Vascular	2021-22-Vascular
BADS: Pinnaplasty (including bilateral) (Adult)	BADS: Pinnaplasty (including bilateral) (Adult)2022-23ENT	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Marsupialisation of Bartholin cyst	BADS: Marsupialisation of Bartholin cyst2022-23Gynaecology	1	25%	75%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Repair of umbilical hernia (Paediatric)	BADS: Repair of umbilical hernia (Paediatric)2022-23Paediatric Surgery	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Treatment of ingrowing toenail	BADS: Treatment of ingrowing toenail2022-23Paediatric Surgery	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Excision of lesion of penis	BADS: Excision of lesion of penis2022-23Urology	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	88%	4.2%	4.2%	4.2%	0	2022-23	Urology	2022-23-Urology
BADS: Excision pre-auricular abnormality	BADS: Excision pre-auricular abnormality2021-22ENT	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	92%	7.7%	0%	0%	0	2021-22	ENT	2021-22-ENT
BADS: Excision/treatment of anal fissure	BADS: Excision/treatment of anal fissure2021-22General Surgery	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0	2021-22	General Surgery	2021-22-General Surgery
BADS: Dacryocystorhinostomy including insertion of tube	BADS: Dacryocystorhinostomy including insertion of tube2021-22Opthalmology	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	56%	44%	0%	0%	0	2021-22	Opthalmology	2021-22-Opthalmology
BADS: Repair of umbilical hernia (Paediatric)	BADS: Repair of umbilical hernia (Paediatric)2021-22Paediatric Surgery	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	93%	7.1%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Treatment of ingrowing toenail	BADS: Treatment of ingrowing toenail2021-22Paediatric Surgery	1	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	25%	75%	0%	0%	0%	0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Mastopexy	BADS: Mastopexy2022-23Breast	0	0%	75%	25%	0%	0%	0%	0%	0%	0%	0%	0%	67%	0%	33%	0%	0	2022-23	Breast	2022-23-Breast
BADS: Ossiculoplasty	BADS: Ossiculoplasty2022-23ENT	0	0%	90%	5%	5%	0%	0%	0%	0%	0%	0%	0%	60%	40%	0%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Septorhinoplasty +/- graft/implant	BADS: Septorhinoplasty +/- graft/implant2022-23ENT	0	0%	90%	10%	0%	0%	0%	0%	0%	0%	0%	0%	58%	33%	8.3%	0%	0	2022-23	ENT	2022-23-ENT
BADS: Adenoid Surgery (Adult)	BADS: Adenoid Surgery (Adult)2022-23ENT	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	77%	0%	0%	23.1%	0	2022-23	ENT	2022-23-ENT
BADS: Laparoscopic gastric banding	BADS: Laparoscopic gastric banding2022-23General Surgery	0	0%	50%	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Excision/treatment of anal fissure	BADS: Excision/treatment of anal fissure2022-23General Surgery	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Appendicectomy (including laparoscopic)	BADS: Appendicectomy (including laparoscopic)2022-23General Surgery	0	0%	15%	80%	5%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0	2022-23	General Surgery	2022-23-General Surgery
BADS: Operations to manage female incontinence	BADS: Operations to manage female incontinence2022-23Gynaecology	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	0	0%	55%	40%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0	2022-23	Gynaecology	2022-23-Gynaecology
BADS: Apicectomy	BADS: Apicectomy2022-23Head and Neck	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	75%	25%	0%	0%	0%	0	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Reduction of fractured mandible	BADS: Reduction of fractured mandible2022-23Head and Neck	0	0%	20%	70%	10%	0%	0%	0%	0%	0%	0%	0%	67%	0%	0%	33%	0	2022-23	Head and Neck	2022-23-Head and Neck
BADS: Vitrectomy using pars plana approach	BADS: Vitrectomy using pars plana approach2022-23Opthalmology	0	0%	98%	2%	0%	0%	0%	0%	0%	0%	0%	0%	96%	3.7%	0.41%	0%	0	2022-23	Opthalmology	2022-23-Opthalmology
BADS: Diagnostic arthroscopic examination of shoulder joint	BADS: Diagnostic arthroscopic examination of shoulder joint2022-23Orthopaedic Surgery	0	0%	99%	1%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Posterior excision of lumbar disc prolapse including microdiscectomy	BADS: Posterior excision of lumbar disc prolapse including microdiscectomy2022-23Orthopaedic Surgery	0	0%	30%	50%	20%	0%	0%	0%	0%	0%	0%	0%	0%	85%	15.4%	0%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Primary reduction and open fixation of ankle	BADS: Primary reduction and open fixation of ankle2022-23Orthopaedic Surgery	0	0%	25%	50%	25%	0%	0%	0%	0%	0%	0%	0%	40%	20%	0%	40%	0	2022-23	Orthopaedic Surgery	2022-23-Orthopaedic Surgery
BADS: Orchidopexy-bilateral	BADS: Orchidopexy-bilateral2022-23Paediatric Surgery	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	79%	21.4%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: EUAAnus/Fibreoptic Sigmoidoscopy	BADS: EUAAnus/Fibreoptic Sigmoidoscopy2022-23Paediatric Surgery	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery

BADS: Excision lesion of eyelid (Paediatric)	BADS: Excision lesion of eyelid (Paediatric)2022-23Paediatric Surgery	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Repair of hypospadias	BADS: Repair of hypospadias2022-23Paediatric Surgery	0	0%	75%	15%	10%	0%	0%	0%	0%	0%	0%	0%	80%	17.5%	2.50%	0%		0	2022-23	Paediatric Surgery	2022-23-Paediatric Surgery
BADS: Endoscopic insertion of prosthesis to compress lobe of prostate	BADS: Endoscopic insertion of prosthesis to compress lobe of prostate2022-23Urology	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2022-23	Urology	2022-23-Urology
BADS: Excision of lesion of testis	BADS: Excision of lesion of testis2022-23Urology	0	0%	99%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%		0	2022-23	Urology	2022-23-Urology
BADS: Operation(s) on varicocele	BADS: Operation(s) on varicocele2022-23Urology	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	50%	50%	0%	0%		0	2022-23	Urology	2022-23-Urology
BADS: Frenuloplasty of penis	BADS: Frenuloplasty of penis2022-23Urology	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	95%	5%	0%	0%		0	2022-23	Urology	2022-23-Urology
BADS: Optical Urethrotomy	BADS: Optical Urethrotomy2022-23Urology	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	68%	16.2%	10.8%	5.4%		0	2022-23	Urology	2022-23-Urology
BADS: Biopsy of artery (including temporal)	BADS: Biopsy of artery (including temporal)2022-23Vascular	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	92%	0%	0%	7.7%		0	2022-23	Vascular	2022-23-Vascular
BADS: Creation of arteriovenous fistula for dialysis	BADS: Creation of arteriovenous fistula for dialysis2022-23Vascular	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	89%	5.7%	3.02%	1.89%		0	2022-23	Vascular	2022-23-Vascular
BADS: Varicose vein surgery	BADS: Varicose vein surgery2022-23Vascular	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	98%	0%	0%	2.38%		0	2022-23	Vascular	2022-23-Vascular
BADS: Endovenous laser treatment (EVLT)	BADS: Endovenous laser treatment (EVLT)2022-23Vascular	0	80%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%		0	2022-23	Vascular	2022-23-Vascular
BADS: Endovascular Aneurysm Repair	BADS: Endovascular Aneurysm Repair2022-23Vascular	0	0%	5%	60%	35%	0%	0%	0%	0%	0%	0%	0%	0%	23.5%	53%	23.5%		0	2022-23	Vascular	2022-23-Vascular
BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	0	0%	55%	40%	5%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%		0	2022-23	Emergency Surgery	2022-23-Emergency Surgery
BADS: Excision of accessory breast tissue	BADS: Excision of accessory breast tissue2021-22Breast	0	0%	99%	1%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2021-22	Breast	2021-22-Breast
BADS: Reduction Mamoplasty	BADS: Reduction Mamoplasty2021-22Breast	0	0%	75%	25%	0%	0%	0%	0%	0%	0%	0%	0%	32%	54%	14.3%	0%		0	2021-22	Breast	2021-22-Breast
BADS: Mastopexy	BADS: Mastopexy2021-22Breast	0	0%	75%	25%	0%	0%	0%	0%	0%	0%	0%	0%	80%	20%	0%	0%		0	2021-22	Breast	2021-22-Breast
BADS: Pinnaplasty (including bilateral) (Adult)	BADS: Pinnaplasty (including bilateral) (Adult)2021-22ENT	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	50%	50%	0%	0%	0%		0	2021-22	ENT	2021-22-ENT
BADS: Septorhinoplasty +/- graft/implant	BADS: Septorhinoplasty +/- graft/implant2021-22ENT	0	0%	90%	10%	0%	0%	0%	0%	0%	0%	0%	0%	59%	30.8%	5.1%	5.1%		0	2021-22	ENT	2021-22-ENT
BADS: FESS Endoscopic uncinectomy, anterior and posterior ethmoidectomy	BADS: FESS Endoscopic uncinectomy, anterior and posterior ethmoidectomy2021-22ENT	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	2.27%	45%	48%	2.27%	2.27%		0	2021-22	ENT	2021-22-ENT
BADS: Adenoid Surgery (Adult)	BADS: Adenoid Surgery (Adult)2021-22ENT	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	79%	21.1%	0%	0%		0	2021-22	ENT	2021-22-ENT
BADS: Laparoscopic gastric banding	BADS: Laparoscopic gastric banding2021-22General Surgery	0	0%	50%	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0	2021-22	General Surgery	2021-22-General Surgery
BADS: Incision and drainage of perianal abscess	BADS: Incision and drainage of perianal abscess2021-22General Surgery	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	91%	9.1%	0%	0%		0	2021-22	General Surgery	2021-22-General Surgery
BADS: Operations to manage female incontinence	BADS: Operations to manage female incontinence2021-22Gynaecology	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	75%	25%	0%	0%		0	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Evacuation of retained products of concept	BADS: Evacuation of retained products of concept2021-22Gynaecology	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	25%	50%	25%	0%		0	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	0	0%	55%	40%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0	2021-22	Gynaecology	2021-22-Gynaecology
BADS: Apicectomy	BADS: Apicectomy2021-22Head and Neck	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Reduction of fractured mandible	BADS: Reduction of fractured mandible2021-22Head and Neck	0	0%	20%	70%	10%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2021-22	Head and Neck	2021-22-Head and Neck
BADS: Adenoid Surgery (Paediatric)	BADS: Adenoid Surgery (Paediatric)2021-22Paediatric Surgery	0	0%	90%	10%	0%	0%	0%	0%	0%	0%	0%	0%	84%	14.5%	0%	1.61%		0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: EUAAnus/Fibreoptic Sigmoidoscopy	BADS: EUAAnus/Fibreoptic Sigmoidoscopy2021-22Paediatric Surgery	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Repair of hypospadias	BADS: Repair of hypospadias2021-22Paediatric Surgery	0	0%	75%	15%	10%	0%	0%	0%	0%	0%	0%	0%	64%	34%	1.37%	0%		0	2021-22	Paediatric Surgery	2021-22-Paediatric Surgery
BADS: Endoscopic insertion of prosthesis to compress lobe of prostate	BADS: Endoscopic insertion of prosthesis to compress lobe of prostate2021-22Urology	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%		0	2021-22	Urology	2021-22-Urology
BADS: Excision of epididymal lesion	BADS: Excision of epididymal lesion2021-22Urology	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	93%	2.44%	2.44%	2.44%		0	2021-22	Urology	2021-22-Urology
BADS: Biopsy of artery (including temporal)	BADS: Biopsy of artery (including temporal)2021-22Vascular	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	88%	6.2%	3.12%	3.12%		0	2021-22	Vascular	2021-22-Vascular
BADS: Creation of arteriovenous fistula for dialysis	BADS: Creation of arteriovenous fistula for dialysis2021-22Vascular	0	0%	95%	5%	0%	0%	0%	0%	0%	0%	0%	0%	88%	6.4%	3.2%	2.34%		0	2021-22	Vascular	2021-22-Vascular
BADS: Varicose vein surgery	BADS: Varicose vein surgery2021-22Vascular	0	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	96%	3.16%	1.05%	0%		0	2021-22	Vascular	2021-22-Vascular
BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	BADS: Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopical	0	0%	55%	40%	5%	0%	0%	0%	0%	0%	0%	0%	16.7%	50%	16.7%	16.7%		0	2021-22	Emergency Surgery	2021-22-Emergency Surgery

a	b	c	Total Procedures	Bed Day Opportunity	Opportunity		
Emergency Surgery	2022-23	Emergency Surgery-2022-23	641	593.76	129,439.03	218.00	129,439.03
Orthopaedic Surgery	2022-23	Orthopaedic Surgery-2022-23	1733	470.56	213163.227	453	213,163.23
General Surgery	2022-23	General Surgery-2022-23	946	253.90	55351.2028		
Urology	2022-23	Urology-2022-23	1950	250.95	108660.268		
Gynaecology	2022-23	Gynaecology-2022-23	1210	156.59	16284.9336		
Breast	2022-23	Breast-2022-23	338	139.54	30419.4366		
ENT	2022-23	ENT-2022-23	1919	43.19	10971.276		
Paediatric Surgery	2022-23	Paediatric Surgery-2022-23	291	42.44	12815.8532		
Head and Neck	2022-23	Head and Neck-2022-23	315	37.55	9537.7		
Vascular	2022-23	Vascular-2022-23	40	6.09	1327.62		
Opthalmology	2022-23	Opthalmology-2022-23	1780	4.00	196.12593		
Medicine	2022-23	Medicine-2022-23	156	2.15	244.758		

Tables of cost

Emergency Surgery	£	218
Orthopaedic Surgery	£	453
Urology	£	433
General Surgery	£	218
Opthalmology	£	49
ENT	£	254
Breast	£	218
Gynaecology	£	104
Paediatric Surgery	£	302
Vascular	£	218
Head and Neck	£	254
Medicine	£	114

assumptions:
Emergency Care= Non Elective x2
Breast = Gen Surgery
Vascular = Gen Surgery
Head &Neck = ENT
Medicine = Acute Medicine
Paediatric Surgery = Paediatrics

** Gynae 2021/22 not used due to result being £1,561 compared to £104 2019/20*

LKPs

Emergency Surgery	2021-22	
Orthopaedic Surgery	2022-23	
Urology		0
General Surgery		
Opthalmology		
ENT		
Breast		
Gynaecology		
Paediatric Surgery		
Vascular		
Head and Neck		
Medicine		
	0	

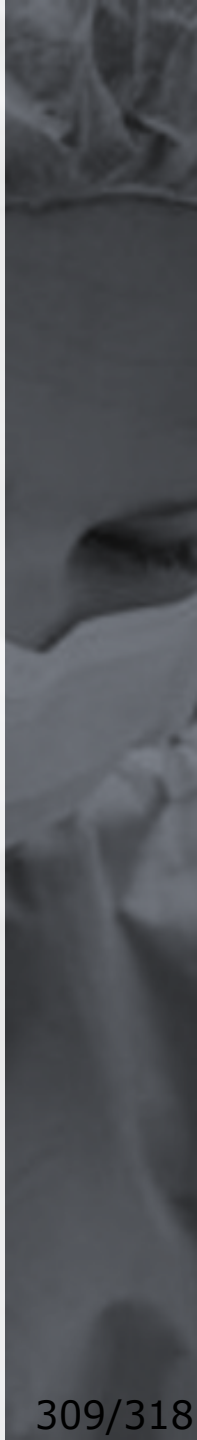
Cataracts Theatre Analysis

Ophthalmology Update

REPORT ANALYSES OPHTHALMOLOGY FROM 2019-20 TO 2021-22 AND THE PROCEDURES CARRIED OUT ACROSS THE HEALTH BOARD.

IT ANALYSES CATARACTS IN GREATER DETAIL AND WHERE AVAILABLE BENCHMARKS PERFORMANCE INTERNALLY AND EXTERNALLY

CATARACTS PROCEDURES ARE IDENTIFIED USING OPCS CODES – C712, C719, C751, C752, C753, C754, C758, AND C759



Sessions

	2019-20	2020-21	2021-22	2022-23 (to Oct)	Trend
			Sessions		
Cataracts Only Sessions	533	158	422	246	
Mixed Cataracts	197	60	139	90	
All Other Ophthalmology Sessions	247	95	168	161	
			Operations		
Procedures in Cataracts Only Session	2,421	635	1,763	1,036	
Mixed Sessions;					
of which cataract	406	146	340	216	
of which non-cataracts	255	63	167	115	
Procedures in Other Sessions	629	181	406	402	
			Cases Per List		
CPL Cataracts Sessions	4.5	4.0	4.2	4.2	
CPL Mixed Cataracts Sessions	3.4	3.5	3.6	3.7	
CPL Other Ophthalmology Sessions	2.5	1.9	2.4	2.5	

83%

Cataracts are completed on Cataracts only Lists

Girft Recommends

8 to 10

High Flow Cataracts Procedures per Session

71%

Procedures in Ophthalmology are Cataracts

KPI's - Trend

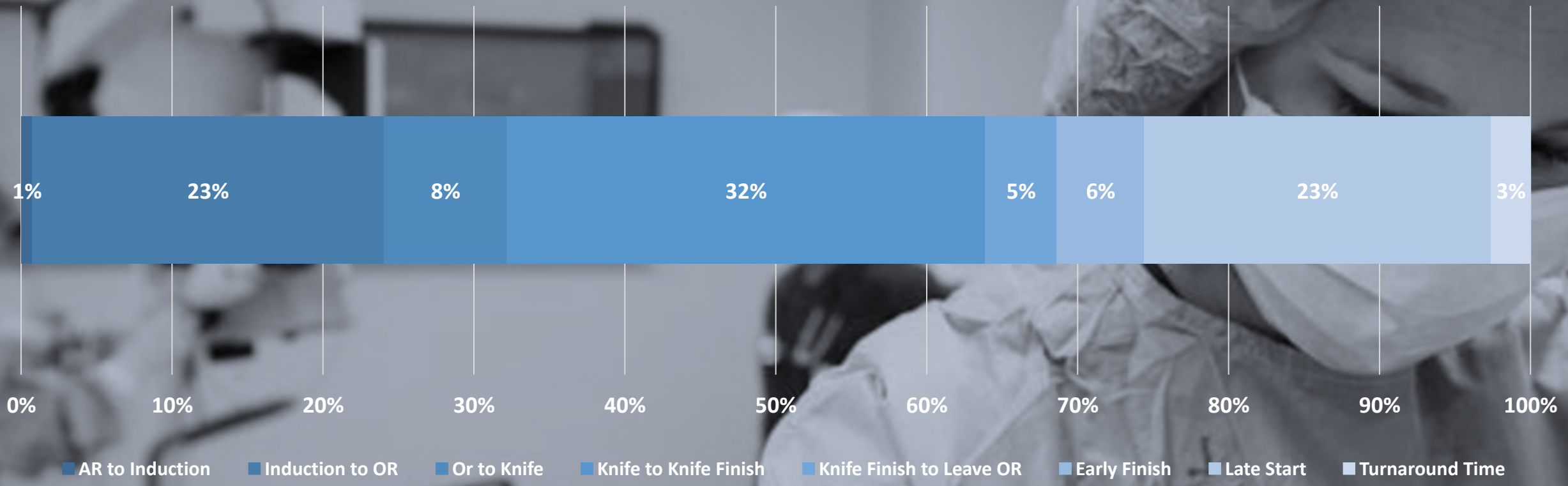
	2019-20	2020-21	2021-22	2022-23 (to Oct)	Trend
Cataracts Sessions					
Average Cutting Time	19	21	19	19	
Average Late Start Minutes	16	11	15	14	
Average Early Finish Minutes	46	56	53	52	
Theatre Utilisation	87%	82%	83%	82%	
Average Turnaroud Time	7	7	6	6	
Mixed Sessions					
Average Cutting Time	26	25	23	25	
Average Late Start Minutes	12	10	14	17	
Average Early Finish Minutes	45	40	37	42	
Theatre Utilisation	76%	79%	82%	83%	
Average Turnaroud Time	12	13	12	12	
Non-Cataracts Sessions					
Average Cutting Time	41	49	43	38	
Average Late Start Minutes	19	32	27	24	
Average Early Finish Minutes	44	58	36	46	
Theatre Utilisation	65%	57%	68%	64%	
Average Turnaroud Time	11	15	8	10	

Cutting Time - Knife to Knife Finish

Utilisation – Active Time with Patient divided into Available Minutes*

*Utilisation of >100% can be achieved if patient is being anaesthetised while another patient is being operated on.

Cataracts Only Sessions – 22/23



Theatre and Site Comparison – Cataracts Only

	Total Sessions	Total Procedures	Cases Per List	Avg Late Start	Avg Early Finish	Turnaround Time Avg	Utilisation
NHT2	2	6	3.0	33	60	7	50%
NHT3	21	84	4.0	16	43	10	68%
RGT18	89	349	3.9	15	58	7	80%
RGT19	134	597	4.5	13	58	6	84%

91%
of Cataracts Surgery Performed at **RGH**

RGT 19
has the Highest number of Cases, Sessions, Cases per List, and Utilisation Rate

RGH has on average each session finishing
58
Minutes Early

Consultant Variation 22/23 – Cataracts Only Lists

	Total Sessions	Total Procedures	Cases Per List	Avg Late Start	Avg Early Finish	Turnaround Time Avg	Utilisation%	% Early Finishes	% Late Starts	% Late Start and Early Finish
Consultant @ AB	41	183	4.5	8	87	5	66%	100%	27%	27%
Consultant @ AB	39	138	3.5	18	49	13	76%	58%	61%	28%
Consultant @ AB	34	182	5.4	4	49	4	105%	71%	3%	3%
Consultant @ AB	26	109	4.2	18	46	6	81%	69%	54%	35%
Consultant @ AB	19	84	4.4	15	46	5	89%	74%	47%	32%
Consultant @ AB	14	54	3.9	20	35	7	93%	50%	64%	36%
Consultant @ AB	13	36	2.8	19	86	7	58%	100%	54%	54%
Consultant @ AB	10	48	4.8	11	61	5	80%	90%	30%	20%
Consultant @ AB	10	41	4.1	9	58	7	74%	80%	20%	20%
Consultant @ AB	9	35	3.9	27	41	8	87%	33%	78%	11%
Consultant @ AB	9	33	3.7	7	74	5	79%	89%	11%	11%
Consultant @ AB	8	34	4.3	19	47	9	67%	50%	63%	38%
Consultant @ AB	5	19	3.8	12	81	5	70%	80%	40%	20%
Consultant @ AB	5	18	3.6	35	21	3	92%	20%	80%	0%
Consultant @ AB	4	22	5.5	49	9	14	103%	0%	100%	0%

Consultant Variation 22/23 – Example

	Total Sessions	Total Procedures	Cases Per List	Avg Late Start	Avg Early Finish	Turnaround Time Avg	Utilisation%	% Early Finishes	% Late Starts	% Late Start and Early Finish
Consultant @ AB	41	183	4.5	8	87	5	66%	100%	27%	27%

Finishes Session Avg

87

Mins Early

Average Active Time Per Case

27

mins

If **3** Carried out then Avg would be **7.5** per session vs GIRFT Recommended at 8/10

Active Time in a Session is **123** Mins (of 210)

3

Lost Cases Per session

123 Lost cases since 1st April 2022

22-23 YTD

	Actual							
	Apr	May	Jun	Jul	Aug	Sep	Oct	Average
Waiting List Start	704	736	824	860	909	958	1021	
Treatment Referrals	227	251	233	210	199	233	201	222
Removals**	-198	-213	-223	-189	-187	-218	-187	-202
additional adjustments	3	50	26	28	37	48	56	35
Waiting List Finish	736	824	860	909	958	1021	1091	

Average of 179 procedures per month

**There are additional Removals on waiting list outside of procedure

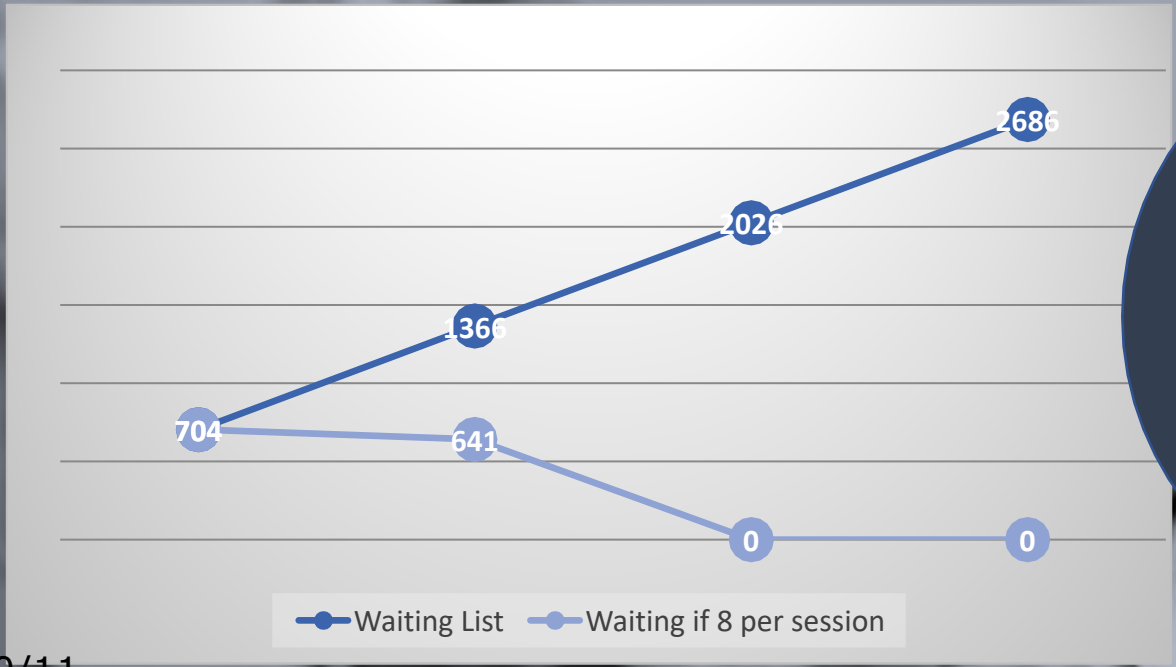
Cataracts Forecast

At current rates

	Forecast						
	Nov	Dec	Jan	Feb	Mar-23	Mar-24	Mar-25
Waiting List Start	1091	1146	1201	1256	1311	1366	2026
Treatment Referrals	222	222	222	222	222	2664	2664
Removals**	-202	-202	-202	-202	-202	-2424	-2424
additional adjustments	35	35	35	35	35	420	420
Waiting List Finish	1146	1201	1256	1311	1366	2026	2686

At 8 Procedures Per Session

	Forecast						
	Nov	Dec	Jan	Feb	Mar-23	Mar-24	Mar-25
	1091	1001	911	821	731	641	0
	222	222	222	222	222	2664	2664
	-347	-347	-347	-347	-347	-4164	-4164
	35	35	35	35	35	420	420
	1001	911	821	731	641	0	0
						439	1519



At Current Rates of

4.2

Cases Per Session - Waiting List is Increasing year on year with expected demand

If Performing **8** procedures per session, the WL will be **zero** by September '23

If **8** Operations Per Session is adopted in Cataracts

169

Sessions per year can be saved when the WL is at zero

Summary

Further Work

- AM/PM Analysis
- Session Length (All day lists)
- Day of Week analysis
- Further Use of Benchmarking tools including GIRFT measures
- Opportunity in £
- Ongoing Performance Measurement
- Modelling Opportunity in Mixed Lists