Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

23/1/2017

Agenda'r Cyfarfod
Meeting Agenda

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Committee members in attendance

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Rhianon Passmore Bywgraffiad|Biography	Llafur Labour
Nick Ramsay Bywgraffiad|Biography	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Lee Waters Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Dr Frank Atherton	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Andrew Carruthers	Cyfarwyddwr Cyflawni Rhaglen, Llywodraeth Cymru Delivery Programme Director, Welsh Government
Simon Dean	Dirprwy Brif Weithredwr, GIG Cymru Deputy Chief Executive, NHS Wales
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol, a Phrif Weithredwr GIG Cymru Director General of Health and Social Services, and Chief Executive of NHS Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office

Mike Usher	Swyddfa Archwilio Cymru Wales Audit Office

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Matthew Richards	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Meriel Singleton	Ail Glerc Second Clerk

Dechreuodd y cyfarfod am 15:00.
The meeting began at 15:00.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Nick Ramsay**: I welcome Members back to this meeting of the Public Accounts Committee. Headsets are available for translation and sound amplification. Translation is on channel 1. Any problems from the witnesses, just let me know. Can I remind Members to ensure that electronic devices are on silent? In the event of an emergency, follow directions from the ushers. We have received one apology today, from Neil Hamilton, and no substitutions. Can I invite any declarations of registrable interests from Members? No. Okay.

Papurau i'w Nodi
Papers to Note

[2] **Nick Ramsay**: Item 2—first of all we have to agree the minutes from the last meeting. Are Members happy to agree those? Good. Okay, secondly, we've got a couple of letters to note. First of all, the Welsh Government's funding of Kancoat Ltd and letters from the Welsh Government on 6 January and 16 January 2017. Happy to note those letters? Also, there's the Welsh Government's acquisition of Cardiff Airport letter from the Welsh Government on 16 January 2017. Happy to note? Yes. Great.

Amseroedd Aros y GIG ar gyfer Gofal Dewisol yng Nghymru a Gwasanaethau Orthopedig: Y Wybodaeth Ddiweddaraf gan Lywodraeth Cymru
NHS Waiting Times for Elective Care in Wales and Orthopaedic Services: Update from the Welsh Government

[3] **Nick Ramsay:** Items 4 and 5: NHS waiting times for elective care in Wales and orthopaedic services. Although these issues are shown separately on the agenda, it's inevitable that there's going to be some overlap—I understand that and I'm sure our witnesses will as well—but I will be taking the items in the one evidence session. Can I welcome our witnesses to the meeting? There are four of you—would you like to state your name, positions and organisations for the Record of Proceedings?

[4] **Dr Goodall:** Yes. I'm Andrew Goodall, I'm the director general for the health and social services group and the NHS Wales chief executive.

[5] **Dr Atherton:** Good afternoon. Frank Atherton, I'm the Chief Medical Officer for Wales.

[6] **Mr Dean:** Good afternoon. Simon Dean, deputy chief executive of NHS Wales.

[7] **Mr Carruthers:** Afternoon. Andrew Carruthers, delivery programme director.

[8] **Nick Ramsay:** Great. Thank you for being with us this afternoon. We have quite a few questions for you. I know you have given us a fair amount of time but, nonetheless, we do have a lot questions. So, if at any point I'm moving things on, it's not that I'm not listening to what you're saying, it's just that we're trying to get through as much information as possible. If I can kick off with the first question: quite simply, why is it taking so long to implement some of the changes recommended by the auditor general? Dr Goodall.

[9] **Dr Goodall:** The NHS is a very complex environment. Obviously, we're overseeing a number of different organisations. There are all sorts of different ways of improving our waiting times, but I think the key is to try to move our services on to a more sustainable footing for the future. I think

we've done that successfully over a number of years and at various times, but it's not a static environment. So, I think we are working in an arena with lots of different things that the NHS can do and offer. Changes around practice and technology, looking back over the last 10 years, the extent to which examples like day surgery have changed, and minimally invasive surgery—lots of different things to do. But we have had a context of growing demand and expectations into the system.

[10] So, if I just choose two areas: on the general referral position, over the last two to three years, we've seen a 9 per cent increase in referrals. So, whatever plans health boards are putting in place, they need to respond to the growth in demand, and we'll come back to—under questioning, perhaps—some of the use of the three-year integrated medium-term plans that we've put in place at this stage.

[11] If you look at some of the specific areas where patients will obviously have very significant need and need to be dealt with on a timely basis, we've seen areas like cancer materially increase over the last five years, so our numbers—. Every month we're producing the cancer figures and we have the highest numbers of patients treated ever—for a December, for a November, for a September. And just over this last year we've had an 11 per cent increase in cancer urgent referrals into the system as well. So, I would say that we're not working in a static position, and I think that there are always different ways that clinicians can find ways of responding to that.

[12] I think the struggle in reality, though, for the health boards is that we think that they have found it difficult to probably rightly balance the demand coming into their system with the capacity and the range of services that are really available. I think that the Wales Audit Office—both reviews—highlighted this as the real challenge. I think we've tried to help health boards, certainly since the introduction two and a half years ago of the three-year planning process, to be clearer about them using the numbers, to be more sophisticated in their analysis, to not just address the backlog that's there—the number of patients already on the books—but actually to forecast into the future. I think that has improved and developed over the last two or three years, but it's still variable sometimes amongst some of the individual health boards. I would say that on the figures that we've had in our integrated medium-term plans over these last 12 months, it probably feels like a better range of data that we've had included in those figures, but even then, during the year, we can see various changes happening.

[13] There are many different reasons. Perhaps I could also just reflect that we need to recognise that the health system works, needing to balance both emergency pressures and also pressures around our planned services. So, it is really important that we find all mechanisms to free up bed capacity and to look at efficiencies, both around the emergency system as well as on the planned care basis. I think that we've been trying to ensure that all of those plans come together in the three-year plans, and that we do look at the whole system. But we still have patients who still need to be addressed, with longer waiting times than we would expect.

[14] My final initial comment, Chair, would be to say: however, we have managed to both stabilise and improve the waiting time position over these last 18 months in particular. As of the end of March in 2016, it was the best reported waiting times position that we'd had for around two years. We expect to see further improvement towards the end of this financial year, by the time that March has elapsed, and that we'll see further improvements both on diagnostics and also on the referral to treatment. Although some of that will have been extra activity taking place through the year, there are a number of specialties, and I'm very happy to talk through those, that will have put in some more sustainable solutions.

[15] **Nick Ramsay:** You've just led neatly into my next question, which was about the end of the financial year. What level of performance against the RTT targets is the Welsh Government expecting national health bodies to achieve by that point?

[16] **Dr Goodall:** We've been expecting to maintain an improvement trajectory, building on the confidence that we've had, not least over these last 12 months or so. Our current waiting times position, compared with November last year—these are the latest available figures—are over 20 per cent better than they were at the same point last year, so we've been able to maintain that. Often the winter period for other pressures can tend to demonstrate a deterioration in some of the waiting lists and times, and generally speaking across Wales, we've seen that stabilise. So, every health board is in a better position at the moment than they were last year, and there will be a further push towards the end of March for improvements there. As an example, we're expecting that our diagnostic position will be materially improved, even from where it got to at the end of March. We had a peak of around 28,000 patients waiting for over eight weeks. We think we could be as much as 80 per cent, if not more, lower than that peak that happened a couple of years ago. On our patients who are waiting over target

at this stage, we again expect that to be a reduced position. We have plans from every individual health board in Wales. We were meeting with some of those yesterday, who were confident that they should be achieving the numbers. So, we won't remove or eradicate those numbers, but we will maintain the improvement trajectory that has been set out in the three-year plans and also our oversight and our monitoring arrangements.

[17] **Nick Ramsay**: A couple of supplementary questions before I bring Oscar in. First of all, Lee Waters.

[18] **Lee Waters**: Thank you. Thank you, Mr Goodall. I just want to pick you up on the point you made there about improved performance compared with previous years. In your letter to the committee, you said that, despite the extra throughput you've described, you've been able to achieve this better performance, partly by focusing on expanding the planned work earlier in the year when the system was under less pressure from winter pressures. I'm just wondering if you can tell us how you can do that, because presumably there isn't any extra capacity in the system, so how is it you can do more in one part of the year?

[19] **Dr Goodall**: Well, I think we can do it through a number of different routes. Certainly as the WAO report highlighted, we know that we can be more efficient in a number of aspects. So, if I can give you one example: it highlighted about the 'did not attend' rates for orthopaedic outpatients that were running at about 7.9. That's now reduced to 7.1, so we can actually create some natural capacity. One of the things that we've, however, emphasised this year is really for there not to be a reliance on chasing down targets just because it's the end of a financial year. I think there's been a cycle in place across the NHS in Wales of allowing a position to be achieved at the end of a financial year, and then to allow pressures to be built up. We've actually asked organisations to both use their existing capacity and some of the addition plans they would normally put in place during the winter months, but to just start them earlier and sooner. I think this is the first period of time that we've seen, actually, just a more stable position on the waiting list that would normally deteriorate for this almost heroic rush to the end at the end of March. I think it's been a much more balanced position, and I think, actually, there's been an advantage there for patient experience and also for patient outcomes.

[20] **Lee Waters**: Those sorts of interventions you describe would apply all year round, wouldn't they? The improvement in the non-attendees would be

all year round. I'm still not clear how it is you're able to free up extra capacity in one part of the year.

[21] **Dr Goodall:** Simon.

[22] **Mr Dean:** Yes, essentially, we do it by evening out the pressure that the system is under, so rather than it being in the last three or four months of the year, when everyone is working incredibly hard to manage both unscheduled care demand and a large number of waiting lists, to spread that activity over a longer period in the earlier part of the year, over the summer period, when, despite peaks and troughs, the unscheduled care pressures tend to be lower. So, it's allowing the system to balance the unscheduled care demand alongside the scheduled care demand, over a 12-month period rather than over a four or five-month period, as well as addressing some of the things that Dr Goodall has mentioned. So, it's making sure we're maximising our potential, both in terms of physical capacity and time.

[23] **Lee Waters:** And you're clearing the decks, I guess, then, are you? In the winter period, you're planning fewer operations, fewer elective operations.

[24] **Mr Dean:** Yes, because we expect there to be peaks in unscheduled care demand, but there are often peaks in the summer months as well. But we're giving ourselves a longer period of time in which to do the planned work.

[25] **Lee Waters:** Is it true that the window, when there's less pressure, is getting smaller and smaller?

[26] **Mr Dean:** Well, the health service is busy all year round, that's for sure. That's why we have to be certain that the system is working at its maximum capacity for 12 months of the year, rather than allowing waiting lists to build up, and then having to make a heroic push through to the end of the year. So, we're trying to get ahead of the game, rather than be recovering a position that has built up through a year. But the NHS is busy all year round, that's for certain.

[27] **Lee Waters:** Are you outsourcing some of this work? Is that how you're creating extra capacity?

[28] **Mr Dean:** Yes, we do outsource work and we do it through more

efficient use of the capacity in the system, through creating additional capacity, through introducing new pathways, which manage demand in a different way, which may have resulted, for example, in years gone by, in an in-patient procedure, perhaps, being a day case, or an in-patient procedure perhaps being managed in a different way, which doesn't require an operative intervention at all. So, it's a range of different responses that include maximising NHS capacity, modernising the way in which services are delivered and then outsourcing capacity where that is helpful to it.

[29] **Lee Waters:** Does that include buying in private sector provision?

[30] **Mr Dean:** Yes, it does. Yes.

[31] **Lee Waters:** I guess one of the concerns we'll come back to is the general critique in the auditor general's report of the sustainability of the sort of approach where you just mop up short-term pressures by doing things like that.

[32] **Dr Goodall:** I think that we've been able to change around some of those services. So, again, I think the report gives a very balanced view on the challenges and the changes that need to be put in place. We can look at areas like orthopaedics where, where there was a lot of variation before, at least we do have musculoskeletal services in place that can filter people from GP referral and fast-track diagnostics as necessary and get people to a therapist rather than, perhaps, to the individual clinician. We've got examples in ophthalmology where we've been able to change a service that, traditionally, has been very located in the hospital, and use the optometrist experience out in the community. And rather than being a pocket of good practice, that is something now that is a core part of delivery at this stage.

[33] I think it would also be right to say that, from a pressure perspective, we obviously still continue to make sure that patients can have planned admissions during the winter months. As part of our winter planning for last winter, we were able, in January to March, to have 3,000 extra elective admissions into the system, compared with the previous year. So, although we try to spread and distribute it, it doesn't stop us still trying to improve the mechanisms for getting in-patients through what are often quite difficult winter months.

[34] **Lee Waters:** Okay, thank you.

[35] **Nick Ramsay:** Rhianon Passmore, did you have a supplementary?

[36] **Rhianon Passmore:** Thank you. You've mentioned the increase in terms of referrals and you've mentioned increase in terms of cancer referrals, in particular, and we are all aware of issues of increases around diabetes and obesity. In terms of working at maximum capacity and optimum capacity, which has been the theme of what's been said already today, and with regard to a different way of working and a different agenda for change with prudent healthcare, moving forward, how confident do you feel that, with the increasing elderly population and the increasing age of our population who are using our healthcare services in Wales, we are going to be able to meet the demand for the NHS, moving forward?

[37] **Dr Goodall:** I think if we look at our demand on the basis of what we've done in the past, I don't think that helps. That's the principle that we've been trying to change within the three-year planning process. It's really about making sure that we can scan and look forward. I think the tradition has been to look at the existing waiting list and assume some growth. Critically, for the future, we need to be doing a population assessment, so a real needs-based approach to actually what it means. And it won't be a surprise that if we have a growing older population, one would expect that there will probably be a higher level of cataract operations that are going to be needed for the future, or that we're going to see an additional level of hip and knee replacements that are happening.

15:15

[38] I think, traditionally, many of these have just been simply about the numbers rather than really standing back. So, it's been quite important, around the specialty boards that have been put in place, to make sure that there is a public health contribution around those discussions to make sure that we're able to do this.

[39] I think, equally, we need to be looking at—again, as the Wales Audit Office report highlights—some of the variation across health boards. So, some reasons for variation may well be about the nature of a local population, but, actually, some examples probably are less explainable. And I think we have a responsibility to try and use the data. So, I think the message really is about using the three-year plans to look forward, to have numbers that are in there, rather than just look at last year's experience and roll over with a little bit of a change. I think that, when we look back at some of the

numbers that we've experienced, not least over the last decade, and we see there's been a 35 per cent increase in day cases and we've seen about a 70 per cent increase in overall admissions, it just shows that we're not managing a static system.

[40] The final thing I would say is just that the NHS is great at finding innovation, new technology, new practices that can assist, so even if you look at the traditions around cataract surgery, for example, these would often be longer-stay patients traditionally, and, clearly, we've changed this into an environment where people are pretty much walking out of a clinic environment. We need to make sure that we keep up to pace with those kinds of developments as well.

[41] **Nick Ramsay**: You painted a picture there to Rhianon Passmore, and earlier when I asked the initial question, of very much running to stand still, if that's the right expression to use. Because the situation is deteriorating in terms of the numbers accessing the system, you're having to make all of these innovations just to keep up with where you are at the moment. That sounds a very unstable situation, moving forward.

[42] **Dr Goodall**: I think we need to do that and can do that, but it's why it's also important to recognise that there are improvements and efficiencies that can be made. I now chair a group that's looking at value and efficiency. It's been really useful, actually, as part of the general evidence that we look at, not just to look at examples like the Lord Carter review of all sorts of spend and procurement in the English system—we've actually been able to draw in the Wales Audit Office recommendations on these to say that, actually, if we're able to improve a number of measures, ranging from length of stay to follow-up rates, we would actually be able to get more patients treated in our system. And it's probably true to say that maybe that has been the pattern for us since we originally met the target back in 2012.

[43] The one thing that I would counter at this stage is that we have been able, at least over this last 18 months, to get ourselves back on track and not just to stabilise the position, but actually to demonstrate that we will have improved waiting times. That was true of where we got to by the end of March 2016, and it will be true of where we will end up at the end of March 2017. So, we will end up with a few residual specialties. I know, as your discussion will go on, it will probably highlight, however, that, of all of the specialties that we have providing demand into the system, orthopaedics is probably the specialty that is the hardest to resolve and respond to, and will

probably require a greater range of sustainable solutions to come through, even with a lot of good practice in place at this stage. Simon.

[44] **Mr Dean:** Just one example that may come up later in the discussion is that the use of patient-reported outcome measures in Cardiff over the last 12 months has resulted in a 90 per cent reduction in the number of follow-up out-patient appointments. That's a huge change that allows that clinical time to be used to see the new patients. So, as Dr Goodall said, it's going to be a combination of measures that are required, including the—. Because people will get ill with something, and it will usually lead to treatment, so it is about making sure that we are preventing, putting in place new models of care, and putting in place efficient models of care to deal with the increase in demand that will come with an ageing population. That, I think, is at the heart of the prudent healthcare debate.

[45] **Nick Ramsay:** Mohammad Asghar.

[46] **Mohammad Asghar:** Thank you very much and good afternoon, gentlemen. I heard very carefully your answers to all my colleagues regarding the demand, capacity and challenges. So, basically, my question is on waiting times in south-east Wales. Our Welsh Assembly Government spends one quarter of our budget on the NHS, we all know this, but the complaints about the services I get in my surgery are more than 50 per cent on the NHS. The waiting time is one of the top ones. Exactly two years ago—exactly; January 2015—the auditor general concluded that the main reason for long waiting times is the inability to sustainably match supply with patient demand in Wales. Given these comments, what progress has the Welsh Government made in ensuring that this is addressed? As Nick just said earlier, in the last two years, we haven't achieved what we're supposed to be achieving—why?

[47] **Dr Goodall:** Well, firstly, by taking it very seriously and making sure that we do utilise it, and that it is used in our discussions about our expectations for the system. I think, secondly, to make sure we're able to use it as a reference point within the three-year plans for different organisations, so it becomes part of our challenge mechanism. I think, increasingly, around starting to use a discipline that, if there are finances and resources in the system, and people don't achieve the outcomes that we expect, we actually do do something about that. As part of general support and allocations into the NHS system this year, earlier this year, there were four organisations, which, although there had been some improvement, had actually not made the progress that we would have expected on waiting times. Funding was

recovered from them, because they had clearly been given it in terms of the outcome that had been expected to be maintained. And I would say that, certainly under the direction of the Cabinet Secretary, that will continue to be the case—that, despite it being a very busy environment for the NHS, and the need to see additional patients, it's important that we focus on the outcome being about good patient experience, but, actually, a reduced waiting time and a reduced waiting list. So, I think that will increasingly be the case.

[48] I think it has taken more time to develop some of the proposals on a national basis. We obviously oversee very large organisations in Wales, and we are making sure that we're very clear about the expectations there. But it's true to say that one of our reasons for putting in the national speciality boards—whether that's the national orthopaedic programme, for example—was to make sure that, rather than just criticising the health boards on the ground, actually, we were providing them with direction, support, and actions that we felt would make a difference. Originally, when the review was done, we were progressing those different speciality plans. We now have those in place for four individual specialities—orthopaedics, ophthalmology, ear, nose, and throat, and urology. Because they have gained good clinical ownership, we see this as a pattern for ongoing support within the service in Wales. I have to say that all of the chairs and the clinicians around the table have acted in a really good way to take responsibility for these issues, and we'll be extending it even to other specialities like dermatology, which means that we'll have covered the majority of areas.

[49] But I think we have to still be clear about our expectations for patients. So, it's really important that, irrespective of any targets, people need to be moved through the system as quickly as possible. It's a core part of the business, not just of our three-year plan, but, actually, of our performance management approach, that we actually do see a reduction and a difference. And I would hope that a balance between supporting some of the development of more sustainable solutions in some of our areas, ranging from ophthalmology and orthopaedics and ENT, through to our more rigorous central monitoring, with similar expectations, do become important.

[50] **Nick Ramsay:** Frank, any reflections from you, maybe about clinicians?

[51] **Dr Atherton:** Well, maybe from a clinical point of view. You're absolutely right that demand is increasing. There is so much we can do in terms of improving efficiency, and we've talked a little bit about those, about using performance management and building extra capacity within the

system. But the thing that I've seen in the time that I've been here in Wales is also that we need to, and we are in the process of, re-engineering the system, so changing the system so that demand and capacity become more aligned. And, one of the great strengths, of course, in Wales is these prudent healthcare principles, which a couple of questioners have mentioned in relation to this. So, when I look at how we're applying that in Wales, I start with the principle of co-production. And, so, the nature of the patient-clinician interaction is changing. So, Choosing Wisely is helping us in terms of thinking about patients' options, so that a patient who simply sees a GP isn't automatically referred, that the nature of that discussion is along the questions of, 'Well, what are my options?', 'What are the harms and benefits?', 'What is in my best interest?', and also, 'What can I do to support myself?'. So, some of the prevention agenda comes in there.

[52] We're also seeing the principle of clinicians working at the limits of their practice coming into play, and different skill bases being used. So, lots and lots of example in Wales: for example, electrophysiologists, electrocardiography technicians, running clinics that treat arrhythmia rather than people having to be referred to a cardiologist. We've seen nurse practitioners, optometrists, providing injections for wet age-related macular degeneration, which can lead people to go blind, which is a major cause of referral into the optometry services. So, there are many, many examples of where we're using the workforce that we have, and the capacity that we have, in very different ways. I think all of those things come together in terms of changing the system and not just running with the system that we currently have.

[53] **Nick Ramsay:** Very briefly, Oscar.

[54] **Mohammad Asghar:** Thank you very much, Chair. Another area that I'm very concerned about is that patients have got a special relationship with their GPs. And GPs, when they give a referral to the hospital, then they have to wait for the hospital; there is nothing between the GP and the patient. Do you have any sort of system in place where GPs are totally informed on when the waiting time is going to be finished for their patient?

[55] **Dr Goodall:** Yes, there are mechanisms in place and also we've been trying to support some of that with our development around electronic referrals so that there is a way of a much faster engagement with the GPs on some of the expectations. But I also think that the key to some of this is about the way in which GPs are involved in the development of the pathway

itself, so, rather than being told what the hospital is going to do next, actually, they can be part of the solution here and with the support around the patient. So, in your area, Aneurin Bevan, they've done some work around osteoarthritis of the knee—some really good results there. It really just moves people's perspective from expecting to just simply work their way through the system and end up with an operation, because the different examples of actions in place are ranging from weight loss through to exercise referral therapy and towards lifestyle advice. They may be discharged into the secondary care service, but it may be to see a physiotherapist. GPs have been a proper part of that process to make sure that it was in line with their expectations.

[56] I think equally, we're seeing, with the musculoskeletal teams on orthopaedics—I'm sorry to cut across the areas of topic today, but inevitably they are examples—those teams, although traditionally they have been on the hospital side, are increasingly being focused around primary and community services. I think that is an ideal environment for GPs to feel that they are not just being listened to, but they're actively participating in the management of the patient.

[57] **Nick Ramsay**: I anticipated at the start that we'd be jumping around a bit. It's very difficult not to with something like this. Okay, Neil McEvoy and then Lee Waters.

[58] **Neil McEvoy**: Thanks. Looking at waiting times and looking at the auditor general's report in January 2015, it says the health boards' planning of waiting times is generally unsophisticated; they struggle to prioritise and struggle with planning for lower waiting times. It says that there are some examples of good practice, but that that's not generally widespread and that health boards don't have standardised information. I just wondered whether things had improved by now and how are senior people recruited to the health boards and what can be done to improve matters, really.

[59] **Dr Goodall**: It's probably just worth going into a bit of detail on the three-year planning mechanism, because that has been introduced while the recommendations and the guidance came through. I just wonder, Simon, if it's worth just reflecting on support for planners in the first place and maybe your take on the way the numbers have improved over the last three years as well.

[60] **Mr Dean**: Yes, thank you. Planning on one level sounds incredibly

straightforward, but it is very, very complicated, because there are so many different assumptions within the planning process that don't need to vary by much to make the end result quite a way out of kilter. So, we have a delivery unit, which is a group of people who sit within the NHS, but we manage their workload. They have expertise in analysis and process mapping and planning and they support health boards in developing their skills. Health boards have been at variable stages of their own development. I bring the directors of planning together on a regular basis and we've created a strong peer-support network at director level and at operational planner level. We've created a community of practice in modelling and informatics. So, the NHS—and academia, actually—is seeking to learn from itself and from colleagues, from the examples of good practice that do exist across NHS Wales, how to mainstream those skills across the NHS more generally.

[61] We also work with colleagues such as the benchmarking institute, which covers the UK, who have a lot of expertise. So, we're seeking to build, to increase, that level of professionalism in the planning and analytical community. We've got some excellent planners and we've got some very, very good analysts. We probably haven't got quite enough of either, so we need to be developing those skills to make sure that our organisations are able to plan a complex series of often overlapping pathways over a period of time, which takes account of a lot of variables, whether those are variables in demand or variables, for example, from the pressures of unscheduled care to the variables that happen, actually, through workforce considerations. If a consultant, for example, leaves, or a key nurse specialist leaves, that can create a blip in the system.

[62] **Neil McEvoy:** How are senior people recruited to the health boards—chairs, for example?

[63] **Mr Dean:** Chairs are through a public appointment process. Chief executives, directors and other senior managers are recruited through appropriate recruitment processes that have the right level of oversight. So, a chief executive appointment, would have—well, Dr Goodall is on the panel, and it would be the chair, and members of the health board, you'd have an external assessor, various forms of assessment centre and then, as you go in to the organisation, the processes are appropriate to the role that's being recruited to. But it's always based on competencies required to do the job successfully.

15:30

[64] **Dr Goodall**: It's important to recruit the right individuals at the clinical level as well. I think that's one thing that the planned care board has done in general terms in the setting of these specialty areas. It's brought the clinicians into the room. They have wanted to push their own developments for services as well as have an understanding, and I think it's given a much clearer sense, clinically, of the difference between the demand and the capacity that they want to see in the system as well.

[65] **Neil McEvoy**: I'm more interested in the boards. I appreciate what you're saying there. Because reading this report they seem to be failing, struggling with planning, not much good practice and not standardised information. But if you look at, for example, just three chairs that I can think of—Andrew Davies, Maria Battle, David Jenkins—they're all prominent Labour Party members. I think what concerns the public is whether or not we're being short-changed and whether or not the Welsh NHS is struggling due to politics.

[66] **Nick Ramsay**: Neil, I don't think that that's a question for Dr Goodall or his colleagues to answer.

[67] **Neil McEvoy**: With respect, Chair, there are three chairs of health boards in Wales—

[68] **Nick Ramsay**: It's a politically loaded question and—

[69] **Neil McEvoy**: None of them have any medical qualifications, no medical background, but they all chair health boards. They all chair a health board. That is relevant.

[70] **Nick Ramsay**: You've made your point, but you don't have to answer that question.

[71] **Mohammad Asghar**: Can I add something?

[72] **Nick Ramsay**: I've got to move on, because Lee Waters has been waiting to come in for about 10 minutes. I'll bring you in later, Oscar.

[73] **Lee Waters**: Thank you. Can I just return to the chief medical officer's point about system re-engineering and prudent healthcare? You described a different mindset amongst clinicians. The auditor general in his report

described resistance to change. I was just wondering if you could talk a little bit about that and what you're doing to overcome it.

[74] **Dr Atherton:** Yes, certainly. Clinical practice changes take time, that's for sure, and there can be resistance from clinicians, sometimes, to change. There's no doubt about that. What we've seen in Wales is that we have various tools and ways of getting around that. Dr Goodall has spoken about involving clinicians very much in pathway design. That's a really important principle. There's also something about breaking down old traditions and traditional ways of working. So, in the past, primary care and secondary care clinicians would work in very separate ways. There are many examples in Wales where that's no longer the case. I'm thinking of an example in Canton and Pontcanna, where general practices, rather than referring patients to a paediatric clinic, will keep the referrals in-house and the paediatricians from the hospital will come and work alongside the general practitioners. That helps both in terms of the patient, because the patient gets care closer to where they are, where they're living, but also in terms of building the skills of the general practice workforce. So, those older boundaries are breaking down, I sense that. We also have management tools within the health system. So, medical appraisal is much stronger now than it used to be. The clinicians are held much more to account within the health system for how they behave and how they work. All clinicians now have to have an annual appraisal, which includes the way in which they interact with patients and with colleagues. So, we do have mechanisms for changing behaviour but, for sure, it takes time to make those clinical changes. But we are seeing them, I believe, in Wales.

[75] **Lee Waters:** Are you satisfied that the pace of change is keeping up with the demand for change?

[76] **Dr Atherton:** I think there's always more that we can do, but I do believe that, if I look back at my own professional lifetime, I've seen enormous changes in the way that clinicians work and I see some fantastic examples of good working. So, I do believe we're on the right trajectory.

[77] **Lee Waters:** There's a section in the auditor general's report that talks about clinical procedures that are known to be of limited clinical effectiveness. In 2013, which were the last figures, it showed that an analysis of patients admitted having these procedures that were of little clinical effectiveness came to £51 million and over 44,000 bed days. We've heard talk about—. There is good practice, for sure, but I'm just a little concerned

that the inevitable cultural resistance to change is not going to respond sufficiently quickly given what Dr Goodall described about the extra pressure the system's under.

[78] **Dr Atherton:** It's a good question and we take that point very carefully about the procedures of limited clinical value. Many health systems are trying to address that issue. We've had an approach in Wales, again, through prudent healthcare, of addressing that. Within those four specialty groupings, we have identified—the clinicians have actually identified—areas that they call DNDs—do-not-do procedures—and they do align very closely with those issues you're talking about. We do have examples, very good examples, of where clinical activity has changed. So, in ophthalmology, for example, excision of benign eyelid lesions, which really is largely a cosmetic issue, has reduced from 203 in 2014-15, down to 187 last year, and in the first half of this year 55. So, we have trajectories on issues like that, on which we can demonstrate we are making change. Do we need to go further? Absolutely. And we need clinical leadership to do that. What I've discovered in my working career is that making these changes with the profession is really important, as opposed to imposing them as top-down targets, which really create a backlash. So, there are plenty of other examples—tonsillectomies is often the one that's cited—and we've seen a reduction of about a third between 2010-11 and 2015-16, last year. So, there are plenty of examples where we do have a good—

[79] **Lee Waters:** That's an interesting one, isn't it? In that one, as you say, that's a no-brainer, agreed by many people to be a largely pointless procedure, and you've only seen a reduction by a third.

[80] **Dr Atherton:** Well, you can't say that tonsillectomies are never required. There is a degree of clinical judgment and there are also thresholds that have been applied. So, with regard to do-not-do procedures, something like tonsillectomies would have a threshold applied. NICE guidelines would suggest that if you have six or more episodes of tonsillitis within a year period, then it would be appropriate. So, some tonsillectomies are still justified, and that's a clinical decision.

[81] **Lee Waters:** The auditor general's report to us says that the work to review the target is generally vague and other than an alternative pilot for ophthalmology, the evidence from the local audits is that the continuing practice of simply managing the old performance trajectories is continuing. So, this is a high-level policy commitment, but in terms of change on the

ground, the progress is worryingly slow.

[82] **Dr Goodall:** I think there is an opportunity, however, in some areas, to look to change the nature of the target around the clinical and the patient experience. So, for example, in an area like ophthalmology, on the one hand there's an outstanding discussion about access and waiting times for cataracts—at what point they've developed sufficiently to operate—but there are other concerns as well about the need to manage patients on a follow-up basis because of ongoing issues around glaucoma, for example, and ensuring that people don't deteriorate. So, in that particular example, we've brought together a task and finish group, we have clinicians involved, we also have interested organisations like the RNIB involved, who've had some very strong reflections, actually, about what is the best balance of targets to come through. But we do need to continue to improve to get waiting times down for patients and we know from patient satisfaction surveys, of course, that people will still continue to express that, when they want to be seen in the system, they want to be seen as quickly as possible. I think we've been able to demonstrate a lot of that under the cancer banner. We need to continue the improvements that we've put in place over this last 18 months to keep getting overall numbers down for all specialties.

[83] **Nick Ramsay:** Rhianon Passmore.

[84] **Rhianon Passmore:** Thank you, Chair. How do you balance the concerns that the planned care programme board isn't as ambitious and bold as it could be in some of the very strategic change management and cultural shifts within systems and within the capacity of people working within the NHS, who are working at maximum capacity—how do you balance that in terms of what we need to be able to do so that we can get to that place that we all want? And in terms of that vision, what does it look like in terms of that NHS in the future?

[85] **Dr Goodall:** Firstly, to recognise that practice and developments will come through, so we'll have things now that people will stay in hospital for seven to 10 days for that will end up being overnight surgery, if not day surgery. We know these experiences because of many of the examples that have happened in Wales, and certainly the development of minimally invasive surgery. I think that, as we go forward, we do need to be open to the fact that there will be new opportunities to deal with things in different ways. We still feel that there are patients coming through the system that could have been better supported by alternatives. Sometimes, the tradition of referral

into the NHS from GPs has been because they've perhaps not always trusted that a patient would be seen speedily and certainly, from our historic levels, I think our waiting times are much improved at this stage. I just wondered, Simon, if it was worth just outlining some of the perspectives around the support we give.

[86] **Mr Dean:** Yes. The thought in my head is—. Dr Atherton has talked about the importance of clinical leadership. What we have to do is to align clinical leadership against the managerial ability to support change. I think both of those two things need to come together. I personally think that the planned care programme board and the four specialty boards have been very ambitious. I think they are very focused. They are leading groups of clinicians who want to make change.

[87] What we need to see more of—and it is happening, but we need to see more of it—is, if you like, the managerial infrastructure helping the clinicians put those changes in place, because it's not usually as simple a matter as a doctor deciding to do something different when they walk into their consulting room the following day. It's usually about a whole team of people changing the way in which they work. It may be about changes to the infrastructure that's available to them, whether that's different types of members for a team, whether it's about different facilities, or whether it's about different equipment. So, I think the benefit of the planned care programme, as Dr Atherton said, is about getting that clinical leadership in place that is pointing the way for the changes that would be of benefit to patients, and very much driven by a clinical perspective. What we're looking for is the health boards—particularly the health boards—to get alongside those changes and to work with their local clinicians to implement them in a way that is appropriate and deliverable and also allows the local challenge to local clinicians, driven by the advice coming from the programme board. I think that's a very powerful combination to get right. The expression of that we want to see coming through the three-year plans, because we need all of these things to line up. So, improving hip and knee practice in orthopaedics, improving shoulder surgery, improving ophthalmology, and ENT—we've got to see all those things come together in the overall capacity available within an individual health board, in order that we don't find that people are trying to use the same capacity and that things are colliding. So, this is where the planning element becomes really important, and that only works if you have clinicians of all disciplines—I'm not just talking about doctors—but of all disciplines working alongside management colleagues to put in place the enablers that will allow change to flourish.

[88] **Rhianon Passmore:** Okay. So, that makes sense in terms of the agenda, moving forward, but how do we then get local health boards to aggressively take up this mandate? We've talked quite a lot about the three-year planning process. What is the impediment, then, to getting all local health boards to adopt consistency of approach and vigour around this? What is stopping that?

[89] **Mr Dean:** I don't think there are any impediments that are stopping it. I think we're talking about quite significant change on a large scale, which takes organisation and time. So, we're seeing very good examples of change in elements of the service in different health boards, so it's not as if one or two health boards are forging ahead and the rest are doing nothing; that would be a completely unfair reflection. Every health board is making good progress in some areas. What we have to do is to get that broader alignment across the whole of the system, and part of that is by the focus for individual health boards, and a key part of our role is to drive that through our planning expectations and then through our performance management processes, and to be quite insistent that we can understand and see that improvement—not necessarily moving from a standing start to top gear overnight, because that doesn't tend to happen, but that we can see improvement over an acceptable period of time and then, critically, the NHS learning from itself. So, where there is really good practice, where there is change that has been implemented successfully in one part of Wales, how does the rest of Wales learn what enabled that change to work?

[90] **Rhianon Passmore:** With respect, in terms of the clinical musculoskeletal assessment and treatment service and in terms of the musculoskeletal programmes that are out there, you mentioned Aneurin Bevan health board, and we know—and this is always the egg to crack—that we have got good practice out there that doesn't get spread across local health boards. We know, for instance around obesity and other areas, that some local health boards have managed to do huge things that are not being replicated. So, in terms of that as an issue for the NHS and our planning processes moving forward, have you got any comment to add to what we are doing around that issue?

[91] **Mr Dean:** Perhaps to take CMATS as a good example, the orthopaedic programme board has been working on a standardised approach to CMATS. Actually, there's a meeting tomorrow, and the expectation is that we'll sign off a document that will set out a shape for CMAT services across Wales,

which we would then be expecting the NHS to pick up and to adopt. So that will be clinically, professional-led advice on what a CMAT service should do and some of the key principles that should underpin it.

15:45

[92] So, that will provide a valuable source of evidence to health boards that are looking at how to provide CMAT services. It also provides something that we can test health boards against, because the thinking has been done. So, the question then moves into is the implementation is progressing at pace, and it may be—to pick up a theme that Dr Atherton mentioned—that a particular health board is finding some elements of the change difficult for one reason or another, but having a standardised approach will allow it to sharpen the focus on those areas where the health board needs support.

[93] **Nick Ramsay:** As predicted, the carefully-structured session has merged orthopaedics and elective care. I'm going to bring Mike Hedges in now, and then if we've got—I know they've merged together—any final questions, for now, on elective care, then we'll move on properly to orthopaedics. But Mike Hedges.

[94] **Mike Hedges:** Mark Drakeford, a former health Minister, said to the Finance Committee either last year or the year before that you were twice as likely to have your tonsils removed if you lived on Ynys Môn than if you lived in Wrexham. Is that still true? And what do you do to identify the cause of outliers? You've talked about NICE clinical guidelines. What is the current position of those? Do surgeons and others have to follow NICE clinical guidelines, or can they ignore them?

[95] **Nick Ramsay:** Where are you most likely to lose your tonsils? [*Laughter.*] Down the back of the sofa.

[96] **Dr Goodall:** Just to comment on the variation question first of all, there can be different drivers around it. On the one hand, it will indicate that there are different clinical practices in place. That's what we're trying to challenge. For some aspects of access to specialties and support around waiting times, it will actually reflect that there is probably something about the population. The Royal College of Surgeons last week were reflecting on deprivation being a feature, for example, and it would be accounting for those. But, as the former health Minister outlined, I don't think that really defends those kinds of variations. The first thing is to make sure that the actual data are available

and visible. And, certainly, one of the core approaches of the specialty boards has been to really get into the detail of the data and just ask questions about why there is so much variation. You can see, on a range of different measures, that health boards may have some consistency on the one hand, but can be quite variable. Interestingly, Abertawe Bro Morgannwg University Local Health Board has the highest level of use of the musculoskeletal service, for example, which isn't probably explainable at this time.

[97] On the NICE guidelines, yes, there's an issue about complying—and, Frank, you may want to comment—but the tradition, I think, across the NHS in general terms across the UK is often that it feels like you're adding to the existing guidelines rather than substituting. I guess what we've been trying to do, through prudent healthcare, is demonstrate—not least with the NICE not-to-do list—to make sure that we remove those procedures out of the system and to actually free up capacity for all of the new developments that are happening. But, Frank, you may have a clinical perspective.

[98] **Dr Atherton:** Yes. I mean, absolutely, need varies across different areas, and so some variation is natural. It's an unfortunate fact that children in more deprived areas will suffer high levels of morbidity, and more episodes of tonsillitis. So, there may be some natural things in there. We do expect all clinicians to involve themselves in clinical audit. So, where we have variations in practice, that is one way of shining a light on that. As Dr Goodall says, getting the data right and providing that back to primary care and to secondary care providers is really important. Guidelines are guidelines. They're not prescribed, but there is an expectation that, if clinicians are not following clinical guidelines, they have good reasons for not doing that and that they're able to articulate that and answer those questions, if their peers were to ask them, as they will do occasionally, and give good justification for them. But guidelines are guidelines.

[99] **Nick Ramsay:** Okay. Briefly, Oscar.

[100] **Mohammad Asghar:** Very briefly. Thank you, Chair. I just heard now Mr Simon Dean saying that there was a big shortage of skills. Elective hospital care is provided by the specialists, and it's very important for patient care. So, is there any shortage of skills in that area, and that is why people are still waiting, and, waiting times, what is happening in Wales? What is the statistics all over? South-east Wales I know. Andrew has done a wonderful job there. I know, personally, that he has done quite a few things when he

was there as head of Aneurin Bevan health board, but what about the rest of Wales? And where are the statistics on the shortage of skills to stop waiting times?

[101] **Mr Dean:** Well, we do experience workforce challenges in the NHS across a number of disciplines. So, for example, nurse staffing, nurse recruitment, can be a challenge in parts of Wales. I think Dr Goodall mentioned earlier in the session, when we were talking about diagnostics, the number of long waits in south-east Wales. Endoscopy is a key issue there.

[102] So, there are always elements of skills that are not in the supply that one would like, and that's another reason why we need to be looking at change. So, following the principles of prudent healthcare, or, to put it the other way around, if we didn't follow the principles of prudent healthcare and pushed everything up to the highest possible level, I think we would find that the system was under real pressure. But, by following the principles of prudent healthcare, and by expecting colleagues to be operating at the top of their licence to practice, we actually can create capacity. So, nurse endoscopists are a relatively new phenomenon; you don't have to have the most highly trained doctor doing endoscopy. So, it's about how do we shape the workforce response within models of care that provide appropriate quality and safety of care that help us to manage our workforce challenges now and into the future.

[103] **Nick Ramsay:** That's great, thank you. Lee Waters.

[104] **Lee Waters:** Just to follow up on this, the idea of alternative pathways to create extra capacity, I know that Dr Goodall, when he was in his previous role, helped set up ABCi, which looked at innovation, and some of the work they've done suggests that many people who are on consultant waiting lists do not need to be on those waiting lists. So, I wonder what work's been done to follow that up on a cross-Wales basis, and whether or not you've looked at opportunities for non-consultants to do some of the diagnosis work to free up the consultant time.

[105] **Dr Goodall:** 'Yes', is the answer, and we do that in a number of ways. I think the push on the ophthalmology side to actually use primary care, community care, based optometrists, for example, to filter people through, the use of audiologists as a profession, alongside ear, nose, and throat surgeons—and not just the audiologists in the hospital setting, but those

that are actually located within the community settings—is part of it. Obviously, we have routine processes in place around waiting-times management about validating patients on lists and ensuring that they're there for the proper reasons at this stage. But, yes, we have been developing a number of different examples that can use practitioners for different reasons, both in our general system and around unscheduled care, but actually in our planned care system as well.

[106] I still think that there's an opportunity to work differently also with primary care. So, with the profession developing as well, we have GPs who not only want to do specific work in their practice, but tend to have interests around specialist areas, and they start to act as a really good filtering process themselves. We've particularly been able to grab that as part of the cluster developments in Wales to make sure that they're actually not dealing with it on behalf of just their GP practice, but actually for a much broader population as well. So, I think there are a number of areas that we are both developing and starting to see develop into more of a universal approach rather than the tradition, maybe, of an outstanding example of good practice.

[107] **Lee Waters**: One of the barriers to change identified by the auditor general was professional boundaries. Do you think that's a fair criticism?

[108] **Dr Atherton**: I think it was, and it still is to a degree. The answer I gave earlier about the shift in attitudes between primary and secondary care is one example of where that is changing. It's also changing between disciplines. We see work that was previously done by physicians done by nurse practitioners. I think a good example might be nurse practitioners running heart failure clinics, for example. Ten or 15 years ago that would have been unthinkable, but nowadays it's a good way of, again, freeing up capacity of those clinicians who can go on to do other things. So, again, there are plenty of examples of that, and the challenge I think, going forward, is to identify those successes and to scale them up—the previous question.

[109] **Lee Waters**: But we don't have 10 to 15 years, do we, to scale it up, to respond. You said yourself that the pressure the system is under is immense and unremitting, and I'm just concerned about the pace of change and the drive there is from the centre. We can have seminars and conferences on prudent healthcare, but, if the clinicians are resistant to change, it seems to me the tools at your disposal to alter that are quite limited.

[110] **Dr Goodall:** But I think that's also changed as well in respect of the demands and challenges that they face—and I think, again, that's why the specialty boards have worked for us. They've been very clear about their expectations to set out a specification for a service, what should be normal, where an audiologist should be used rather than a—. And they've actually brought together a clinical set of opinions, rather than us ending up having to almost negotiate individually with clinical teams. So, I think that's been a really strong aspect of the national programme. The issue that we need to move forward is, apart from just showing the good practice that exists, where we're moving more into what the compliance looks like. That's why I suggested earlier that, along with the Cabinet Secretary, we're just starting to reflect, looking forward around waiting times, how we can make sure that we have set expectations, but what happens when people don't get to the outcome that we expect. That's why I gave the example earlier that, when people didn't reach the waiting-times outcomes that we were expecting, we did remove some of the funding issued, just as one example of a more disciplined system.

[111] **Rhianon Passmore:** In regard to the themes so far around universality of approach, rather than silos of best practice, and the difficulties in cultural shift, clinically and otherwise, how are we actually disseminating our new vision, our new way of working, our preventative model in Wales, as far as medical training is concerned? Obviously, it's going to be a lot easier with the new cohort of registrars and trainee doctors and health professionals if we're doing it right from the beginning. Are we as up to date as we should be in terms of clinical training?

[112] **Dr Goodall:** Frank.

[113] **Dr Atherton:** Well, by coincidence, I met with the acting dean at Cardiff University—the dean of the medical school—this morning and we were talking about exactly this issue. I've only been here for six months, but what I've come to learn is that the curriculum has changed, so the way of teaching medical students now is very different to when I qualified; it's much more oriented around team-based working, and there are great initiatives around that and some good thinking in Cardiff about that. So, I was very reassured, on the basis of discussions, both that things are changing in terms of medical training and will continue to change. I think that's true not just in medical training, but across all disciplines of healthcare professionals, that the principle of multidisciplinary and multi-agency working is much more embedded in training programmes than it was even five, 10 or 15 years ago.

[114] **Dr Goodall:** Certainly, there was a tradition about developing highly experienced individuals through whatever process they went through for their degree-based learning and then assuming that they could participate as members of a team. I think, increasingly, you see the professions now very much mixing and mingling, as they go through the university process, in a bit of a different way.

[115] I think, also, to make some of the expectations real within Wales, developments like the Keir Hardie Health Park, the access to medical students that has come up there to actually look at that through the local population's eyes, has been quite important, and, hopefully, they'll act as good future recruitment for all practitioners, but particularly around doctors who want to stay in those Valleys communities.

[116] **Nick Ramsay:** On that positive point, we're moving formally on now to the orthopaedic section, which has been touched on before. Neil McEvoy, did you have any questions?

[117] **Neil McEvoy:** Yes, on whether the Welsh Government is confident that the national orthopaedic implementation board has been established in a way that avoids the weaknesses evident in the previous delivery board's arrangements. Who sits on it and how frequently does it meet?

[118] **Dr Goodall:** It's chaired by a clinician. I've been really pleased with the work of someone who's the clinical director down in the Abertawe Bro Morgannwg area. And, obviously, clinicians are contributing to this mechanism on top of their normal day-to-day lives, making sure that patients are treated.

[119] We have a range of individuals sat around the table. That includes, of course, representation from each of the health boards and that's deliberately targeting both managerial and clinical support. So, we make sure that those are connected discussions at this stage. Also, we've been able to ensure that there is broader representation around that board, as well, so we have a third sector perspective, not least through Age Concern and Arthritis UK. Also, I've made sure that we've got direct patient experience there. That's not necessarily been the way that we've organised some of these committees before, and also, of course, a broader community view, not least through the community health councils. We've reflected a lot on how these things all start with GPs and primary care to make sure, actually, that it's not just a hospital

model, and to make sure that we've got the GP voice around the table. They meet on a frequent basis. They're also repeated by local boards for these specialties within the individual health boards as well. I think that, yes, we've had to learn some lessons. I think there was some good progress with some of the original Access 2009 approaches that were taken and when the original orthopaedic delivery board was in place. I think, probably, the benefit we've got out of this arrangement is a much stronger clinical oversight and engagement with what's happening.

[120] I think we just need to make sure that our oversight of the system can make sure that, where there are particular developments that need to take place, we're getting a lot more into discussions around the regional spread of services where centres of excellence can be commissioned. The Royal Glamorgan Hospital has got a particular proposal about acting as a more specialist diagnostic hub. Probably, they can't be just negotiated by the individual health boards themselves, and we're probably going to have to oversee those individual areas.

[121] But I think, maybe, out of all of the specialties I was highlighting earlier—the Cabinet Secretary is already directing us to give an update around the planned care programme in general terms, but I think he would have expectations that we're going to have to still do something different for orthopaedics. If I look forward over the next 12 months or so, I think the majority of the other specialties, probably we will be able to demonstrate that the waiting times have improved and we've been able to get to target. I think orthopaedics is going to need us to get more strongly around the Welsh national orthopaedic board and actually do something a bit different on the next round of more sustainable services. But I think the clinical voice definitely works around that table.

[122] **Nick Ramsay:** Mike Hedges.

16:00

[123] **Mike Hedges:** Two questions. The first one is whether Government plans to develop a national specification for CMATS have been informed by any evaluation of the effectiveness of these services. The second question is: do you recognise this—elderly people living at home able to look after themselves end up going in for hospitalisation, spend a week or two weeks undergoing orthopaedic treatment and, at the end of that, have lost their capacity for independent living and end up having to go into a care home,

and whilst the operation has been a success and clinically it's a success, in terms of the life of that person, living with a small amount of pain has been turned into having to live in a care home?

[124] **Dr Goodall:** If I take the latter and, Simon, I wonder if you'll pick up the CMATS specification, and, Andrew, you might want to comment on that possibly as well. You're right, there is a danger that what we do, if we're not careful, in trying to focus on high-volume specialties is to lose the individual patient experience and outcome. So, the NHS treats 330,000 elective admissions a year, but everybody has got an individual set of circumstances. We need to make sure that when people are making decisions about operations, they do that on a proper basis with the full understanding of what it means in terms of their recovery. I think that some of the examples around all of the musculoskeletal models that are in place across Wales give feedback that a more open discussion with patients probably would lead to a number of individuals determining that they're more happy to manage and maintain their situation with, perhaps, current pain levels with other control rather than have to go for an operation. I think, sometimes, the operation itself is always seen to be a success—almost, that somebody would walk their way up Mount Everest on the back of it, whereas we probably sometimes need to be a bit more realistic about the recovery. I think our prudent healthcare approach is intending to make sure that patients can feel that they're participating in that set of decisions rather than ending up just with clinical teams making their diagnoses and moving on. It is true that, for older people, in particular, the hospital system, if you're not careful, can take their dependency away from them, and I think it's really important to be open on that, but I don't know if you have a clinical perspective on that, Frank.

[125] **Dr Atherton:** The only thing I would add to what Dr Goodall has said is that there's a much higher burden on clinicians nowadays to be very clear and explicit with patients about the risks and the benefits, and so the whole consenting process is much more important and is given more emphasis. I think that's right and proper. We have to be more open with the patients, not just about the long-term benefits, but about the risks that people are facing, and that, for sure, is one of them—that frail, elderly people will, unfortunately, lose some degree of functionality through a hospital admission. We can do whatever we can within the health system to minimise that through rehabilitation, through good post-operative care and through reducing length of stay, but that is a risk that people need to factor in.

[126] **Dr Goodall:** Just on the specification for the musculoskeletal services—

[127] **Mr Dean:** Yes, on the CMATS, I think I mentioned earlier that there's a paper going to the board tomorrow that was developed following a review led nationally. I've got the paper in front of me. It's quite clear about the aims, the objectives, the core principles, the inclusion criteria, the exclusion criteria, the performance indicators and how the triage process should work. So, it's a clinically developed specification to guide the shaping of a CMATS team that is based on precisely that evaluation of what's worked in Wales and elsewhere.

[128] **Nick Ramsay:** Rhianon Passmore is dying to come in at this point.

[129] **Rhianon Passmore:** You've touched upon my question there in terms of that model and the evaluation of that, so thank you for that. And in terms of how we assess the roll-out now, on a universal basis—that's something that is going to be of great experience, I know. Picking up on what Mike Hedges stated around orthopaedics and, in particular, elderly patients, can you just quickly outline the intermediate rehabilitative care emphasis in terms of where that pathway leads to for that particularly vulnerable group for me? Would you also agree that the importance of rolling out CMATS on an absolutely universal basis will be fundamental to the whole issue that we talked about earlier around silo working and in terms of the lessons that we can learn from this in terms of the other issues that are behind waiting lists? A slightly complex question, but just an update on intermediate rehabilitative care and how much emphasis we're placing on that.

[130] **Dr Goodall:** Well, again, it will be a factor for all individuals, but it's really quite critical for the management of older people and their assumptions. Certainly, what we want to have is a successful operation outcome. As colleagues will have commented already themselves, within some of the efficiencies, we've seen reductions in length of stay, and it's really important that people move through their acute period. But it is important that they have access to the proper therapy support, and that they're able to have the occupational therapy to support if they need to handle things in their home differently. I hope that, as a result of the musculoskeletal teams in general terms, there's been a more holistic assessment of the person before they simply ended up with an operation as an outcome.

[131] Hopefully, what we're seeing—and there are outcomes, as Simon said

earlier, where people are directed away from the traditional operation side—is that some people will simply make a choice to manage better with their current circumstances, maybe with some manual aids and some improved pain management. I think that's a perfectly appropriate conversation to have at this stage. But I do think it gives us learning about some of the other models in place, and it's why, as much as we push this as a musculoskeletal approach, actually it's why we've probably advocated the use of alternative practitioners like audiologists and optometrists in a very different way, because it was so successful, I think, on the orthopaedic side.

[132] **Mr Dean:** I think that one thing that perhaps we might be at risk of not emphasising sufficiently in this conversation is actually the enthusiasm there is for change. These are not changes that we, either centrally, or two or three clinicians, are seeking to impose on the clinical body; these are changes that the clinical body are developing for themselves. Having chaired the last meeting of the planning care board I was really struck by the clinical enthusiasm. They're actually champing at the bit to be able to bring these things forward because it's the right thing for their patients, and it allows different bits of the system to do the things that are their primary contribution, and to provide a wider range of choices and support for patients. It brings me back to this need to align the clinical vision of what the service could look like with the managerial infrastructure to enable it to happen. The trick is to blend those two.

[133] So, I would be expecting, subject to any clinical commentary on the detail—and I'm not a clinician, so far be it from me to comment on the detail, but on the assumption this is signed off by the orthopaedic board tomorrow, then that becomes a very strong piece of advice and guidance into the system that we will be asking questions of organisations about, 'How are you taking that forward?' It's back to Dr Atherton's point, about how do we engage the clinical body, make sure we're building on their enthusiasm, and align that into our planning and then our performance management discussion. So, for example, I would find it difficult to have a conversation with the health board—not that I think I would—in which they had an orthopaedic waiting list challenge and they didn't have the CMATS-type service. I would find that—well, actually, I think they would find that quite a difficult conversation, because I would be quite interested in why that might be the case. Critically, I would want to know what they were doing to implement one. Where they have them, I'd be wanting to make sure that they're maximising the potential benefits, because it's about aligning all the elements of the pathway. You can have a brilliant service, but it has to be of

sufficient quantity to benefit the whole cohort of appropriate patients, and that's back to the planning question again.

[134] **Nick Ramsay:** Lee Waters, did you want to come in?

[135] **Lee Waters:** Yes, I just want to take a step back a little bit and just reflect on the broad critique in both the reports from the auditor general, which keeps being touched upon, really, by all the evidence, and that's that the system is so busy short-term firefighting that it's not addressing the sustainable long-term changes that are needed, the additional money that is being put in is being spent on short-term waiting capacity, that the leadership has not been put in the right place in terms of the delivery board, and is not sufficiently senior and not sufficiently robust; and that the good practice you do cite is, and I quote, typically small-scale, at risk from funding pressures, and lacks evaluation of its effectiveness. What do you make of that broad critique put by the auditor?

[136] **Dr Goodall:** Well, I would hope that, to some extent, we can demonstrate how we have picked it up as a serious report, and looked to ingrain it. It's perhaps no coincidence that it's the same time that I think we've been pushing the NHS in a very different way about the discipline there is the system, the way we track through and monitor, and the way we very clearly set our expectations as well. So, I think that some of the response from that has therefore been, for example, improved waiting times. I think there is a danger, though, within our system, that if we're not careful, we ourselves can reinforce some of the more immediate-term priorities. It is a balance to make sure that we give enough headroom for organisations to actually think about the proper sustainable basis going forward.

[137] So, we have seen examples of individual areas of service—for example, in Cardiff, where they developed a different approach around an ambulatory care unit, for example, based at the Llandough hospital site that was intending to bring all of these things together in one place around a shared set of theatre suites and then put it in place, but they've been caught out slightly, perhaps, in terms of the way the demand has grown in the subsequent years.

[138] **Mr Dean:** I think we have to do two things at once. We don't have a static—and this is not the most elegant phrasing, so apologies for it—we haven't a static queue. We have to size the capacity to deal with the patients that present. So, we've got to make sure that our capacity is appropriate.

Alongside that, we've also got to deal with a pool of patients who are already waiting. So, we have to have sustainability in place, but we also have to have short-term measures to deal with—and this is the inelegant phrase—a backlog, because that's a non-recurrent backlog. So, we can't size our permanent capacity to deal with all of the people we will need to treat over the next two or three years, because if we did, we would end up with excess capacity, bizarre as that may sound. So, we have to put in place sustainable solutions whilst also addressing some of the non-recurrent needs. And we will—by the end of this year, we will have reduced the backlog by about 20 per cent in terms of the number of breaches from two years previously. So, we've got to keep that going down whilst putting in place a sustainable service platform that meets the, if you like, day-to-day additions to the list. I hope that makes sense. Because we have to do both of those things. So, the key is: we've got to do both of them, we can't do either just one or the other. So, I'd agree, just firefighting isn't sufficient, but ignoring the backlog wouldn't work either. I know that's not what you're suggesting. The trick is to get those two things in balance.

[139] **Lee Waters:** I understand that and, to be fair, I think the auditor general's report reflects that tension, but he concludes that the NHS isn't being sufficiently brave.

[140] **Mr Dean:** I think, if I may: 'concluded'—when he wrote the report. I think things have moved on since that report was written. The proof of the pudding will be in the testing of it in due course.

[141] **Lee Waters:** So, you think you're being braver now, do you? How can you tell us how you're being braver?

[142] **Mr Dean:** I think we are. I think if you look at the planned care programme, look at the specialty boards, those weren't in place when the auditor general wrote the report. I think we are seeing some good work starting. There is more to do, but I think the platform is there. The challenge, and it is a positive challenge for us, is to build on that.

[143] **Lee Waters:** In terms of the balance of the spend, one of the persistent critiques the auditor general's report made was that extra money that is released is spent on short-term, not systemic, change. So, given that you have responded to that, how much would you say—at an estimate, proportionally, of the extra money that is being released, how much of that is spent on long-term systemic change and how much is spent on short-

term firefighting?

[144] **Mr Dean**: That's an impossible question to answer, given the breadth of services that impact on—

[145] **Lee Waters**: Well, the previous situation was not very much, and you're telling me this is now out of date, so I'm just wondering if you can justify that.

[146] **Mr Dean**: I think what I'm trying to explain is there is additional money at the margin that is spent on elements of RTT, but the more important sum is actually how the core NHS spend is used across a whole range of services that impact on waiting times. Planned care is a very, very significant part of total NHS spend, and the additional sums of money at the margin are not the whole of it, by any means. So, we will invest—the Cabinet Secretary will invest those additional sums to add to what is already spent through the core NHS budget, and it's quite hard to disentangle. So, it isn't that all of the additional funding is used on non-recurrent work or it's all used on sustainable work. So, we have to be able to see it in the round. But it is quite a hard question to give a clear answer to, I'm afraid.

[147] **Lee Waters**: So, you're confident that, when the next audit is done, the judgment that the initiatives for reform were typically small scale, that will be revised.

[148] **Mr Dean**: Well, that will be a matter for the auditor general, but that is our opportunity, isn't it, as the NHS: it's the opportunity to respond to it?

[149] **Lee Waters**: I know what the opportunity is, I'm asking you whether or not you're confident that you're meeting it.

[150] **Mr Dean**: I believe that we are making good progress.

[151] **Dr Goodall**: And I would hope that some of the areas that we're going to have to call around the regional centres, for example—I think that's probably the last call, at this stage, that demonstrates that here will be something materially different. I think also some of the application of our capital funds as well, and the way we've tried to use that to invest in a number of different areas, whether it's additional CT scanners, for example—all of these are about driving the general waiting times position as well, and we'll be able to demonstrate some of that spend, too.

[152] I think, for me, the key is about the success of continuing with our cycle on the IMTPs. We looked back on this last year and we feel that the numbers have probably been the best that we've had to date, over this three-year cycle. It's just important to make sure that, as we go into 2017-18 and 2018-19, we can make that a better outcome. And, as I said earlier, at the moment, we think that, probably, for the majority of specialties, we can be confident that we're going to get that down. Orthopaedics is going to, however, require some dedicated time to build around the Welsh orthopaedic board and to step up some of the capacity. That's the one area that feels like it's going to be difficult—

16:15

[153] **Nick Ramsay**: Well, we often come back, in this committee and in the health committee, to the issue of the data that are available in the Welsh NHS. Linking in with what Lee Waters just asked you, to what extent does the Welsh Government and the NHS know whether urgent patients are being treated in a timely way? How reliable are the data that we have?

[154] **Dr Goodall**: We focus on a methodology and a principle that patients should be treated in turn according to their clinical priority. We introduced that methodology to ensure that there was a balance between the most urgent patients coming in through the front door, but equally that we would deal with the chronological order of when people were put on the list. So, I think there are specific and discrete areas where it's possible for us to comment on those areas so, yes, we do track cancer urgency and we're able to monitor patients. We do it under different and specific targets around 31-day and 62-day targets. I think the urgency label can be variable according to the individual clinician's views and, actually, according to the nature of the specialty as well. So, as an example, there have been really concerted efforts around cardiac surgery over the last 18 months to properly reduce waiting times that had lost some of their underlying control, and we've got that back in a much better position now, partly because whatever the debate about who's where on the list, for that overall category of patient it's just really important that they are all dealt with in an urgency criteria and they're seen as quickly as possible.

[155] Andrew, I don't know if there are reflections there about the guidance and where we are in general terms.

[156] **Mr Carruthers:** Yes, I can do that. I think the only other point I'd add to that as well is that when you're looking at urgency, it can be quite tricky because it's not unusual for patients to be expedited during the course of their pathway as well. So, they may come in with a very routine issue and then during the course of the process, they're identified as having something more urgent so they do get pulled forward. So, in terms of measuring that, that's quite difficult.

[157] In terms of the guidelines, we've been in the process of reviewing those. It was important to us that it wasn't just a technical exercise. We could have just sat down and looked at the words on a page and said, 'Yes, they're fine, let's put them out again.' We've embarked on a process of quite extensive engagement with the service. We've involved the patient representatives in that as well. It was interesting, because as a result of the engagement process we've been through, a lot of the feedback was that it wasn't so much the rules that were an issue for patients and the way they were applied, it was the fact that there was a lack of communication about what they were, a lack of understanding on their part about what they meant, and if the communication could be better with them, then that would go a long way to addressing the concerns.

[158] So, we've been through a process. We set up a series of sub-groups to take that forward and the guidelines have been out to consultation with the service on the initial draft since before Christmas. They'll be going back out again before the end of this month, and we'll look to issue those at the beginning of April. We also, from an initial national event at the start of the process, made a number of changes to appointment letters and correspondence that was being given to patients to make it much clearer about the range of options that might be offered to them in terms of treatment when they're put on a waiting list, and also in terms of the length of time they're likely to wait.

[159] **Nick Ramsay:** Okay, Mike Hedges then Lee Waters.

[160] **Mike Hedges:** I think there are two points I'd like to make on this, or questions I'd like to ask. I think one of the problems with the GP problem is that I've yet to know a constituent come to me without telling me that their GP referred them urgently. And I think that sometimes GPs need to be honest with their patients and tell them, 'I've referred you, but I haven't referred you as 'urgent' because'. But everybody tells me they've been referred urgently, and most of the time they haven't been referred urgently, and that's why

they haven't been dealt with quickly.

[161] The second point is that if you get it wrong, isn't there a danger of people ending up in A&E? I think that one of the problems we have with health is that we tend to look at each bit on its own without trying to look at it as a whole. So, we look at primary care, we look at secondary care, we look at A&E and we don't look at people looking after themselves and making sure they engage in healthy lifestyles at all. But isn't there a danger or do you see a danger that if people are not treated quickly enough, or as quickly as they need to be, they end up in A&E and end up being admitted that way?

[162] **Dr Goodall**: It's important that we look at waiting times in overall terms, but if you look at gall bladder operations, you can be on a list for a time. Of course, if problems develop with your gall bladder you can end up coming in as a 999 case through the front door. Every patient deserves to have a proper waiting time, for us to be very focused on reducing it for their experience. I think on the GP's understanding of what's going on, we are trying through other routes to try and make sure that there is better communication between individual GPs and those clinicians who are working in secondary care. So, our electronic referral systems that we've been introducing and rolling out, we've been doing that through the national information service in Wales. We now have hundreds of thousands of patients passing through this route. The benefit of it is that they get quickly in, but it also means very good, quick feedback, not least for the GPs, about whether the status that they've highlighted has been agreed or not. I think one thing that we need more of, however, is more discussion amongst primary care and hospital-based clinical teams about their respective understandings, and I'm hoping that the electronic systems in place should do that.

[163] On the issue around the deterioration of patients on waiting lists, Frank?

[164] **Dr Atherton**: If you think about deterioration, being on a waiting list is not a good thing. None of us want to be on a waiting list for anything, do we? But we have to remember that there are different levels of harm that can come from being on a waiting list. At the simplest level, it's an inconvenience; at a higher level, it might be that somebody's condition deteriorates and they might need urgent care, and that may lead to accident and emergency treatment or treatment elsewhere in the system; and, at the most severe risk, it can cause actual patient harm and be a threat to life. The example that we talked about earlier about cardiac surgery was an example

of where we have to put our priority, because at that extreme of potential harm on a waiting list, we really need to focus our efforts. So, yes, of course, there is a risk.

[165] On the question of general practice, and their behaviour, I don't think any general practitioner—. I know no general practitioner would knowingly mislead a patient, and so I think the answer is to get better information, both to the patient and to the general practitioner, about what is actually happening in the system.

[166] **Nick Ramsay**: Neil McEvoy, did you want to come in?

[167] **Neil McEvoy**: No. No further questions.

[168] **Nick Ramsay**: I misinterpreted your facial expression. Lee Waters, then Oscar.

[169] **Lee Waters**: Yes, I'd just like to pick up on something Mr Carruthers said about patient engagement. Any change management consultant will tell you that communication is the key. And I'm just reflecting on the letter that Dr Goodall sent to the committee, and the example cited there of public engagement is a patient information leaflet that's been developed in north Wales. Is there more going on than that?

[170] **Mr Carruthers**: I think that we've tried to ensure that throughout the planned care process we've got a better engagement with patients and patient representatives throughout. So, there are members on each of the speciality boards. There are also representatives that sit on the national programme board that oversees the speciality boards. I think as well, within the work streams, we've worked hard to involve the public and patients in the development of the speciality plans. They're an important part of the stakeholder engagement process. On some specific work we're doing around out-patients, we engaged with over 300 people to help devise the initial programme of work, which will be coming to the national executive board next month as a proposal for transforming out-patients. So, I think, at all stages of the—. Again, one of the successes, in addition to the clinical engagement aspect of the planned care programme, has been that we have involved the patient voice and taken on board that co-production message within the prudent healthcare principles much more strongly than we've ever done before.

[171] **Lee Waters:** And by patient voice, are you primarily referring to the community health councils?

[172] **Mr Carruthers:** No, no, we've actually got representatives of patient groups on those boards. So, there are representatives of the Royal National Institute of Blind People, for example, on the ophthalmology board.

[173] **Lee Waters:** Right. But these are essentially insiders, are they—people who are within the system, stakeholder groups and professional patient representatives? What work are you doing with the broader disengaged public?

[174] **Mr Carruthers:** Again, as a specific example, within the out-patient transformation group, we actually went out to five local communities and had engagement events with those to help test some of the principles that we're looking to explore in the out-patient transformation programme.

[175] **Lee Waters:** Okay. I just want to ask Dr Goodall more broadly on the indicators that are used to try and gauge patient experience particularly. The roll-out of that seems to be quite limited. Data on patient outcome and experience is much sparser than information on activity and performance, the auditor tells us. Are you intending to change that?

[176] **Dr Goodall:** We have changed it because we've commissioned, nationally, some work around patient outcomes and experience. So, through the patient reported outcome measures programme, we've done that through national technology funds. We've actually gone with orthopaedics as the first speciality that we wanted to implement it in, not least because of the scale of demand and challenge in place at this stage.

[177] There are other examples of us learning of more general specialities as well. So, Cardiff is doing some particular work for us on the general mix of specialities, but because of the criticism of the standardisation missing in general terms, we wanted to make sure that people didn't just develop the local outcome systems for patients; we wanted to have something that was a national framework. So, there's good progress being made on that. There are already around 1,000 different patient experiences that have come through that at this stage, and it is indicating that the world can look a little different when you balance not just the waiting time and access target, but actually you build it around what the patient's individual experience is likely to be for the future. So, I think there's some good feedback, particularly that being

piloted up in Betsi Cadwaladr. Simon.

[178] **Mr Dean:** Just to add to that, I have here the patient survey that's informing the orthopaedic work. So it's got a few general questions, the Oxford knee score, the Oxford hip score, some questions about general health and some demographic information. So, this is being piloted and has been in use in Cardiff for 12 months and, as I said earlier, it's led to a 90 per cent reduction in follow-ups. The plan is to move on to tonsillectomies next. Cardiff is also piloting some questions in non—I need to choose my words carefully—non-validated areas because the benefit of things—

[179] **Nick Ramsay:** We're back where we started in tonsillectomies, aren't we?

[180] **Mr Dean:** The benefit of things like the hip and knee scores is that it's a validated tool, but Cardiff's been doing some work in other areas and we're looking at a national, generic set of questions that we'll be testing through the coming financial year. So, work has started, again there's more to do, but the aim is to roll that out much more broadly because we believe it will have a significant benefit.

[181] **Lee Waters:** Can I just ask: by when do you expect to have that rolled out?

[182] **Mr Dean:** It'll be a rolling programme, so the orthopaedic work is in place in hip and knees. Cardiff is rolling out some work into medical specialties within the next month or so, and then national generic patient experience will be piloting the questions through next year. So, it's a rolling programme without, if you like, a definitive end date.

[183] **Nick Ramsay:** Okay, we're into the last five minutes now of this session, so if Members could be succinct with their questions—and feel free to be succinct with your answers as well—it helps me enormously. Neil McEvoy and then Oscar, Mohammad Asghar.

[184] **Neil McEvoy:** Just to follow on from what you said about patients' voices, I specifically wanted to talk about those people who've been on the cancer journey and who are in recovery and those on it now. Are there concrete opportunities for them to have input into the service? Because I went to an event last year for Cancer Voices—I couldn't go to this one because this year I had a funeral; I couldn't go last week—and they said, last

year, that there weren't opportunities. Has that changed?

[185] **Dr Goodall:** I think there are approaches. Certainly, the cancer network work for Wales has got a very good patient focus and the lead clinician there is always adamant—. I was chairing a meeting of all of the cancer leads—clinicians and managers across Wales—just to get some general progress, and I have to say that respective organisations with an interest in this area, so, Marie Curie and Macmillan, are really helpful as well—

[186] **Neil McEvoy:** Yes, but not charities because charities rely on funding from the Government at times; I mean individuals. The Cancer Voices network are people who have been through the journey and are still on it. Are there opportunities for them to systematically input their experience?

[187] **Dr Goodall:** Macmillan are a charity, but they've also given us access to patients who have been through the experience. So Velindre hospital, for example, have got a really good focus around that.

[188] **Neil McEvoy:** I appreciate the charity aspect of things, but they have a pecuniary interest in their dealings with the Government. Are there opportunities for individuals? There may not be, but will there be? Can you create that space in the system?

[189] **Mr Dean:** There are. I'll give you one practical example. I've spent four years as chief executive of Velindre NHS Trust and we had an extremely active patient group—

[190] **Neil McEvoy:** Which trust, sorry?

[191] **Mr Dean:** Velindre. I spent four years as chief exec there. We had a very, very active patient group, which were patients who had been, or were going through, care and they were extremely helpful and influential in sharing their experiences, and I can assure you that they were not backward in coming forward with both their praise and their suggestions for things that could be improved.

[192] **Neil McEvoy:** But could you create a systematic opportunity?

[193] **Mr Dean:** Yes, I think that all of the health boards create those opportunities within themselves.

[194] **Dr Goodall**: But there are opportunities to not just go for samples or individual patient experiences. If your question is gearing to, 'How do you capture everybody's experience as they go through?', and perhaps cancer is a good arena to go to, I think there is a possibility to move that on to a more system-wide approach so that it just feeds into the general way we do things. I'd be happy to just explore that and respond to you outside of here because there might be some potential for that.

[195] **Neil McEvoy**: Yes, thanks.

[196] **Nick Ramsay**: Mohammad Asghar.

[197] **Mohammad Asghar**: Thank you very much indeed. I personally had experience of three patients very recently. The three of them were over 65 and had had knee replacements. One started walking within two weeks, the second one after a couple of months, and the third is still in pain after six months. So, I'm not saying that the efficiency is not there—it's great—but the fact is: is there best practice that you share in the orthopaedic department in the NHS?

[198] **Dr Goodall**: Yes, there's a lot of best practice. Again, the national board has helped to some extent, but obviously there are very large departments of orthopaedic surgeons and broader clinical teams who work in the orthopaedic specialties. They have their audit processes in place; they have their peer-review mechanisms; they have opportunities to look at the quality and the outcomes. Actually, some of the benchmarking information that we've been having access to—that's another opportunity for us to ask questions about whether there are other sites elsewhere. How do clinicians like to learn, Frank?

16:30

[199] **Dr Atherton**: Clinicians do like to learn, of course, and it's an important part of our duty as clinicians that we continue to learn. But in terms of standards, there's an expectation that a clinician undertaking certain procedures would be doing a sufficient volume of activity. We talked about guidelines earlier; we expect clinicians to be following NICE guidelines or other guidelines and, if they're not following them, to have a good reason why they're not.

[200] We try to ensure standard use of prostheses that we know work and

are most effective. It's just a fact of life that there will be variation in patient outcomes—that's inevitable. The challenge, really, is for clinicians to get the best possible outcome overall for patients. Another way that we try to ensure that—and Dr Goodall mentioned audit—all clinicians are expected to involve themselves in clinical audit, and we do audit major pathways like orthopaedics as well. We're looking across the board at outcomes. So, better use of pathways and better use of audit, I think, are the key tools.

[201] **Nick Ramsay**: Thanks, Oscar. Mike Hedges.

[202] **Mike Hedges**: Neil McEvoy just mentioned Macmillan. Can you confirm that Macmillan are not funded via the Welsh Government?

[203] **Dr Goodall**: Macmillan are a charitable organisation. We have had examples where we've commissioned a patient experience survey. That is something that they have facilitated on our behalf, and that was through a proper process. But Macmillan is a charitable organisation that has its own outlook and, as with any other organisation, they're perfectly entitled to tender for various issues that we put out with a specification.

[204] **Neil McEvoy**: So, they do approach the Government for work. For me, it's a serious problem because, if you require a contract from somebody, if you receive funding, in the Wales of today, it does affect how you interact with Government. That's just a fact.

[205] **Nick Ramsay**: Can you address any questions to the witnesses, rather than each other? We can do that in the private session. That was a rhetorical question.

[206] **Neil McEvoy**: Sorry, Chair.

[207] **Nick Ramsay**: That's okay. Can I just ask you—? You mentioned earlier about how not everyone can be urgent and sometimes it's difficult to explain that. Does the reference to care for those with the greatest health need first in the updated prudent healthcare principles mean that the Welsh Government wants to see greater prioritisation on the basis of need and, if so, what effect will that have on the routine patients? Will that routine situation get worse?

[208] **Dr Goodall**: I think it is a core principle for us to focus—that every patient is able to have a response in line with their needs. I think, as I said

earlier, our methodology is to make sure that we treat in turn, on the balance of the clinical urgency, and I actually think prudent healthcare chimes with that. I think the extent to which we need to continue to develop innovative approaches, we need to increase the level of activity on the ground, rather than probably change the guidance, in order to develop a sustainable service—that's probably the real answer here. I think our existing methodology isn't in conflict at all with prudent healthcare principles.

[209] **Mr Dean**: There's a balance to strike here, isn't there? Because the risk is there will always be someone whose immediate need is more important and more urgent than mine at a certain point in time. We don't want to be in a position where people who have a need, but it may not be of the greatest urgency, continue to be leapfrogged in the queue by people who do have an urgent need. So, we've got to get a balance. We have to treat urgent need, but we also have to treat routine need as well.

[210] **Nick Ramsay**: Great. We have one minute left. Does anyone have any pressing immediate questions? No. Excellent. Can I thank our witnesses, Andrew Carruthers, Simon Dean, Dr Andrew Goodall and Frank Atherton, for being with us today? It's been really helpful. Good to see you again. We will be preparing a draft transcript of today's proceedings and we'll send that to you for you to check for any glaring inaccuracies. Thank you for being with us today.

16:34

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

Cynnig:

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

Motion:

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

Cynigiwyd y cynnig.

Motion moved.

[211] **Nick Ramsay**: Item 6—I propose, in accordance with Standing Order 17.42, that the committee now resolves to meet in private for item 7 of today's meeting. Are Members content? Great.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 16:34.
The public part of the meeting ended at 16:34.