GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

A Report on Referral Management and Pathway Optimisation

Preliminary Findings and Next Steps

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Introduction

The increase in referrals and treatments delivered by NHS England providers has placed financial pressure on the commissioning arrangements managed by NHS Wales. Primarily this impacts the border commissioners Betsi Cadwaladr University Health Board (BCUHB) and Powys Teaching Health Board (PUHB), due to notable activity growth in cross-border service utilisation.

The NHS Wales Joint Commissioning Committee (NWJCC) is responsible for commissioning a range of services including Specialised Services, Mental Health, Vulnerable Groups, Learning Disabilities, and the Welsh Ambulance Services NHS Trust (WAST). While most English contracts are limited to specialised services, NWJCC holds full contractual responsibility for certain providers, encompassing both specialised and non-specialised elements. Notable examples include Liverpool Heart and Chest Hospital (LHCH) and The Walton Centre, where NWJCC acts as the sole contractor for all Welsh patient activity. This dual responsibility introduces complexity in managing demand and expenditure, particularly where non-specialised activity—such as general cardiology or elective procedures—has grown beyond planned levels.

This arrangement means that any growth in non-specialised activity—such as general Cardiology or Neurology procedures and drugs—within these contracts directly affects NWJCC's financial position. A referral management programme, therefore requires a strategic review of service utilisation, referral patterns, and potential opportunities for repatriation or pathway redesign to ensure sustainable commissioning and equitable access for Welsh patients; this may mean an alternative cross-border provider (NHS England/Wales). As such, achieving a sustainable commissioning budget will require a coordinated approach involving demand management, pathway redesign, and potentially the repatriation of services to Welsh providers where clinically appropriate. Engagement with Health Boards, clinicians, and provider trusts will be essential to ensure that quality of care is maintained while delivering financial sustainability.

Aims and Objectives

The aim of this work is to identify and implement where possible savings, value-based initiates, streamline care pathways, improve patient care and outcomes. Additionally, this work aims to categorise the activity and spend into specialised versus non-specialised where appropriate.

Methodology

The work has been underpinned by robust data analysis and benchmarking. Analysis so far has been carried out using a variety of data sources including NWJCC contract monitoring and DHCW data in collaboration with the commissioning teams and health board representatives. Additional work included a high-level review of the current NWJCC approval and funding processes.

Project Governance Structure

The governance structure of this programme of work is detailed in **Figure 1**. The Project Board makes recommendations through the NWJCC governance structure to the Joint Committee for decisions to support the delivery of the Project.

The current membership is comprised of the following:

- SRO: Stacey Taylor (Chair);
- CEO Sponsor and JCC Lead: Hayley Thomas;
- CCLG Leads: Nicola Johnson and Neil Windsor;
- Commissioner Clinical Lead: Iolo Doull;
- Health Board Clinical Lead: TBC
- Project co-lead and Working Group Chair: Sandra Tallon;
- Project co-lead: Saja Muwaffak;
- Project Manager: David Williams.

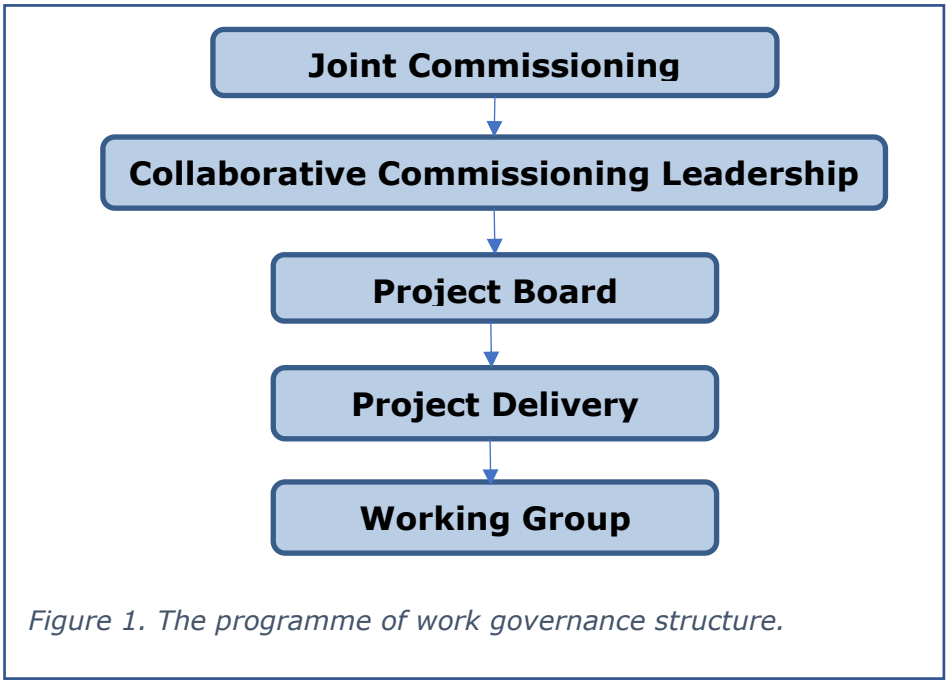


Figure 1. The programme of work governance structure.

Results

Analysis was carried out on different variables and potential drivers for change that could be explored further. However, this report only details those of most relevance to the work proposed for the next stages and inclusion in the 2027/26 Integrated Medium-Term Plan (IMTP Plan).

The spend, activity, and patient numbers going to cross border English providers has seen a sustained year on year growth (YOY). This is shown in **Figure 2** and **3A & B**. Although the biggest user of this route of care is Betsi Cadwaladr UHB (BCUHB), all other local health boards (LHBs) experience a YOY increase in the last 5 years.

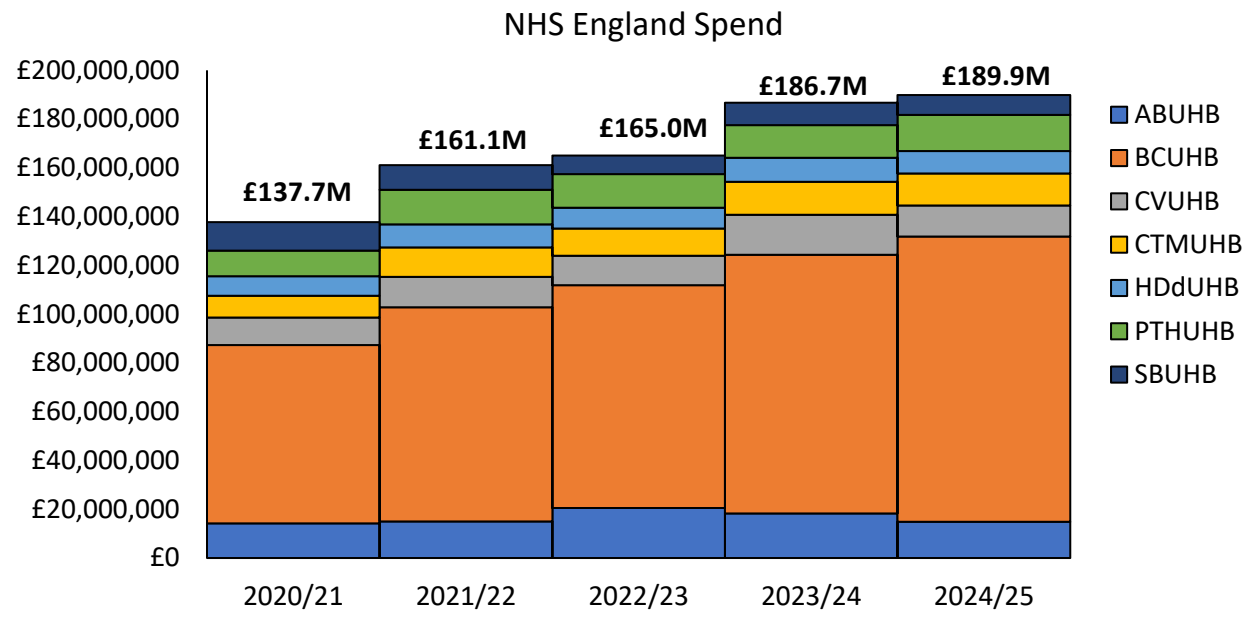


Figure 2. The total year on year spend on English provider by Local Health Board for NHS England contracts held by the NWJCC. MAIR Data

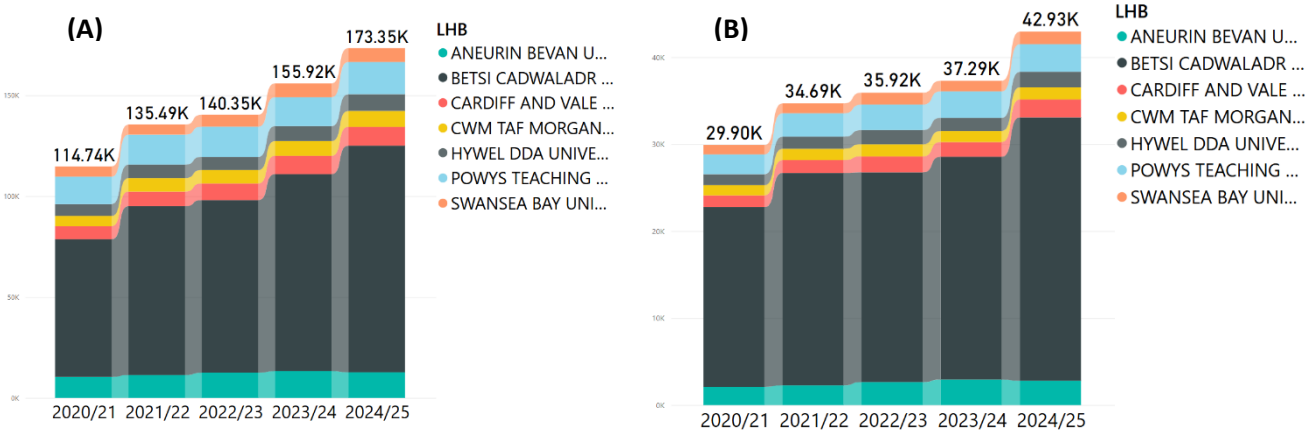


Figure 3. A) Change in activity count and B) change in patient number count between 2020/21 and 2024/25 across NWJCC funded English providers. MAIR Data

Specialties of Focus

The NWJCC contracts with c. 31 NHS England providers contracts and the broad selection of specialties funded to varying degrees, various approaches were considered for a prioritisation approach. One approach was to focus on the top 10 providers for spend which would have almost entirely just impacted BCUHB. The second approach was to consider the 10 specialties by spend and top 10 specialties by patient numbers. The latter approach was endorsed by the project board as it would also benefit other LHBs.

Additionally, the total expenditure for these specialties represented ~50% of the total spend on NHS England providers in 24/25. Furthermore, ~80% of that spend was across 5 providers: The Walton Centre, Liverpool Heart and Chest, University Hospital Bristol, University Hospital Birmingham and The AlderHey. Figure 4 also presents the highest impacted specialties in terms of patient numbers demonstrating 65% of patients that went to NHS England in 24/25.

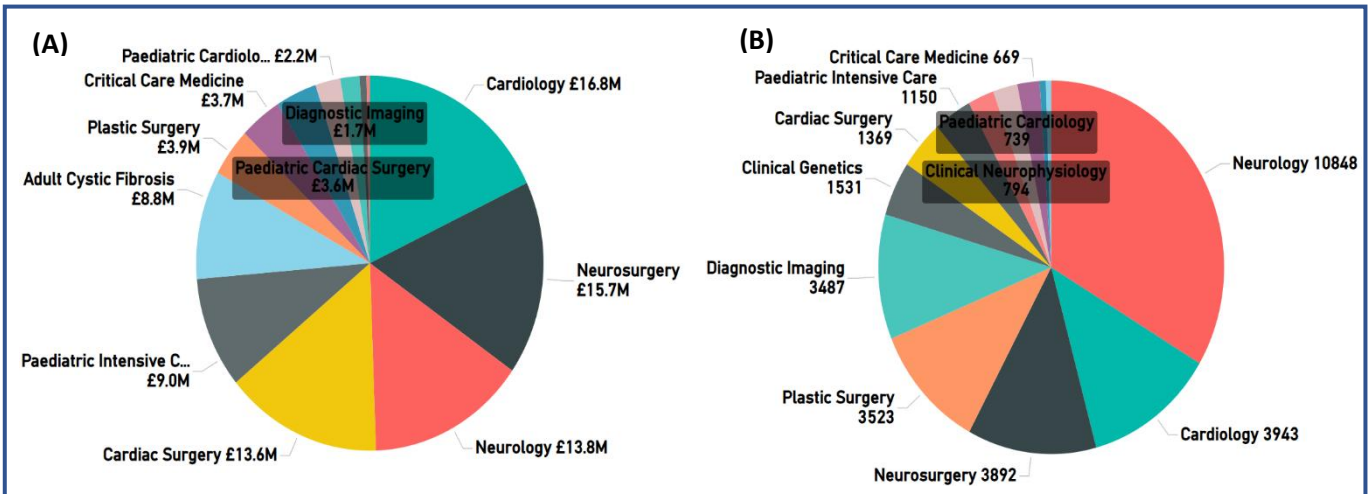


Figure 4. A) Spend and B) patient number of the selected 13 specialties in 2024/25. MAIR Data

New Outpatient Appointments

The YOY activity count and spend on new outpatient patient appointments has increased for the last 5 years (as shown in **Figure 5A &B**). Figure 5A shows the spend and activity for the entire NWJCC NHS England portfolio and Figure 5B shows the activity only for the 13 selected specialties.

It is worth noting that the current national target for new outpatient appointment waits is changing from 52 to 26 weeks in 2026/27. This means that more patients currently commissioned and funded by the NWJCC will breach this target unless actions to try and mitigate this issue are taken going forward. Further analysis is being undertaken to understand the impact of the 2026/27 target.

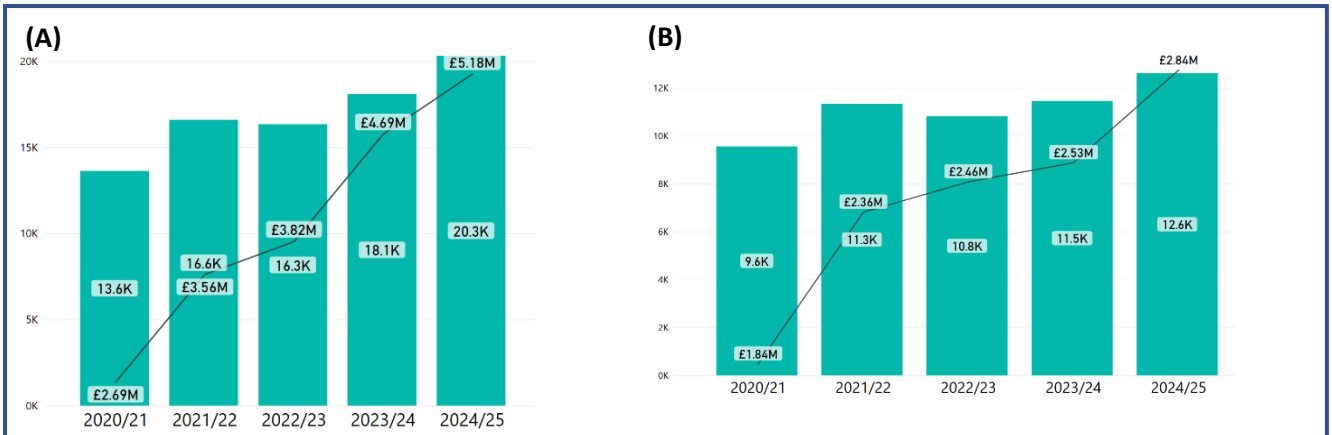
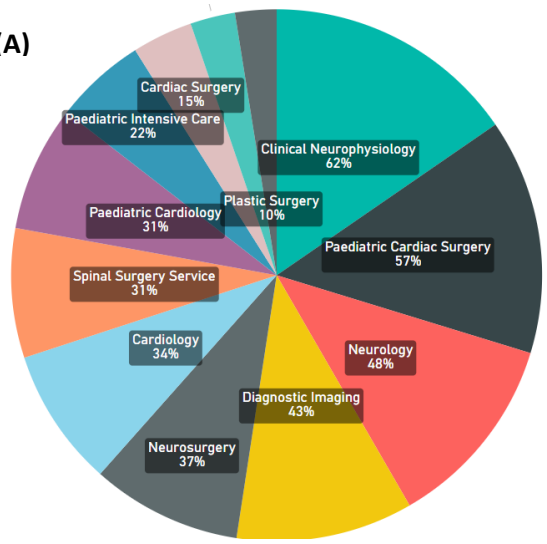


Figure 5. A) New outpatients spend and activity count on all specialties, B) spend and activity across the 13 selected specialties. MAIR data

Further analysis of DHCW data indicated a high level of new outpatient appointments that end at first attendance. **Figure 6** shows the size of the level such activity for the 2024/25, however similar trends were observed across the years. Spinal Surgery was included as it was highlighted by The Walton to be a specialty with a high number. This finding is interesting as it may indicate a level of inappropriate referrals and will need further review.

(A)



(B)

Specialty	(Unknown)	Further appointment set	Further appointment TBA	Last attendance	RTT-End point	RTT-Start point	Total
Neurology	9	369	3,101	3,160			**6,639**
Spinal Surgery Service	1	177	983	532		1	**1,694**
Cardiology	15	314	723	532	1		**1,585**
Neurosurgery	8	274	620	521		3	**1,426**
Diagnostic Imaging	19	116	346	363			**844**
Plastic Surgery	1	124	543	75	3		**746**
Cardiac Surgery	4	173	216	68			**461**
Paediatric Cardiology	2	9	127	61		1	**200**
Clinical Neurophysiology	1	15	34	80			**130**
Clinical Genetics	75	6	14	12	3		**110**
Paediatric Cardiac Surgery			15	20			**35**
Paediatric Intensive Care			7	2			**9**
Adult Cystic Fibrosis Service		4					**4**
Total	**135**	**1,581**	**6,729**	**5,426**	**7**	**5**	**13,883**

Figure 6. The % of new outpatient appointments not going anywhere for 2024/25. Spinal Surgery is included as it was highlighted by Walton to be a specialty with a high number of inappropriate referrals. DHCW Data

A target reduction of new outpatient appointments may lead to a reduction in activity caused by first and final appointments improvement in prioritisation. Furthermore, it may reduce the patient cohort waiting for outpatient appointments.

A 25% reduction in outpatient appointments as an example could reduce expenditure within NHS England on the 13 specialties by £710k or £1.3M if all NWJCC activity was targeted.

Currently commissioner and finance oversight of referral activity requires improvement. Therefore, to increase grip and control and commissioner oversight the project team are aiming to incorporate improved data on referral activity to the commissioning dashboards that will initially be used by the JCC team and then rolled out to Health Boards.

One of the enablers to increased referral oversight will also be access to the DHCW referral table which will enable access to live referrals and will be an action that will be implemented as part of the next stages of this work.

Follow-up Outpatient Appointments

The activity count and spend on follow-up outpatient appointments since 2020/21 is shown in **Figure 7** for the entire NWJCC NHS England portfolio (A) and the 13 selected specialties (B). The spend has doubled in the last 5 years with a significant increase in activity.

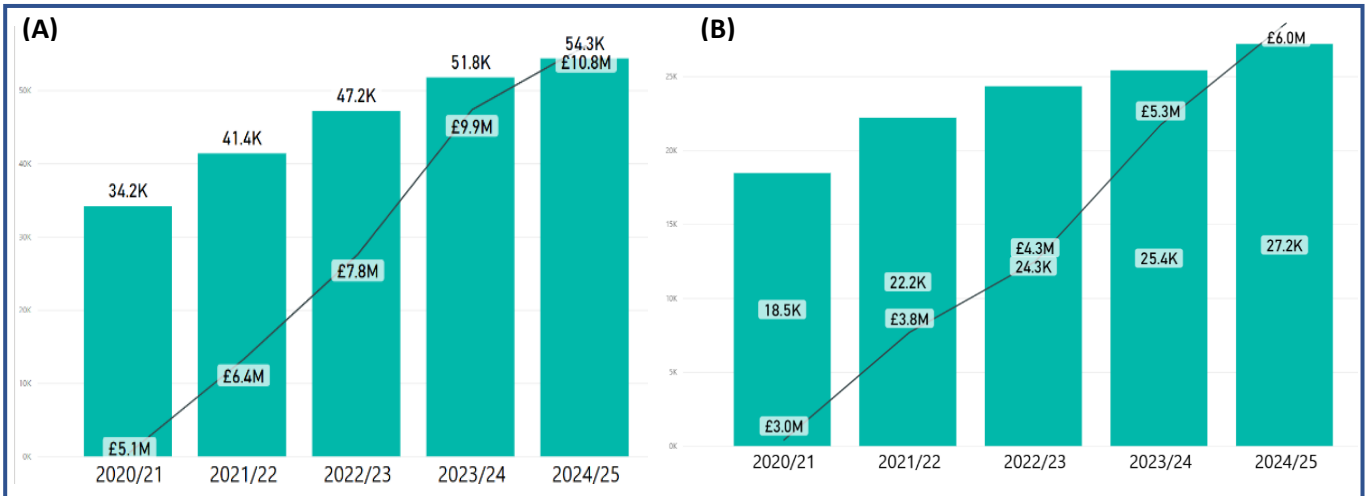


Figure 7. Follow-up outpatient appointments spend and activity count for NWJCC funded specialties across English providers, B) 13 selected specialties only. MAIR data

Furthermore, preliminary analysis indicates a wide variation in outpatient follow up rates between specialties and providers. There are also currently no national targets for follow up rates for various specialties.

According to the Welsh Government national performance framework, the number of patients waiting for a follow up appointment has increased YOY. A reduction of 25% from March 2025 baseline is expected for the number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%. This adds to the importance of a good grip and control of follow ups in 2026/27 for the NWJCC as it will help reduce waiting lists and unnecessary appointments for patients.

Three approaches can be taken to tackle this issue and achieve appropriate targets for follow ups:

1. The first one is the use of patient-initiated follow-ups (PIFUs) and See on Symptoms (SOS) approach.
2. The second is the setting a reduction target for all providers (e.g. 25%).
3. The final is carrying out a GiRFT benchmarking exercise to determine the ideal rates for various specialties which will take a longer time to complete and implement than the first two.

To give patients and their carers the flexibility to arrange their follow-up appointments as and when they need them, NHS England and Wales have been driving the roll out and expansion of PIFU and SOS.

PIFU and SOS are when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. The approach helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.

Conversion Rates for Surgical Specialties

Preliminary high-level analysis of MAIR data for conversion rates of new outpatient appointments to a procedure for surgical specialties indicates wide variation between specialties.

A detailed analysis of conversion rates for surgical specialties is therefore required with the aim of targeting surgical specialties with particularly low conversion rates for further investigation and potential improvements. Ensuring appropriate conversion rates will further ensure an improved control and rigour over outpatient appointments and referrals in general.

Non-designated Providers and Activity According to Resource Map

A level of non-designated provider activity was found across a number of NWJCC commissioned specialties. This can drive up spend and inappropriate activity by use of providers not currently designated by the NWJCC.

Therefore, several actions have been identified to reduce the inappropriate use of non-designated providers:

- Improving grip and control by the introduction of an additional patient approval process internally to the JCC and Health Board where non specialist and increase validation processes
- Transformation of the IPFR/ Prior Approval database to modernise and initiate live reporting
- Informing the designated providers about their status through the LTAs
- Considering request to non-designated providers to send referrals back to ensure activity is within agreed service lists and designated provider arrangements. This would require a high level of clinical engagement with Health Boards and careful management as clinical governance and safety
- Completing the update and publication of the NWJCC service directory and its circulation among health boards. It clearly lists the designated providers for the various specialties commissioned by the NWJCC

Furthermore, high level analysis has identified a level of non-specialised activity that does not match the resource map. Therefore, more detailed analysis is required to fully quantify the issues. Following, completion of the work review of reporting of the risk share for non-NWJCC commissioned activity is required.

Finally, a data validation procedure could then also be designed to identify and challenge such activity by providers.

Single Point of Access Referral Management System

A high-level review of the different referral processes and sources in Wales showed the lack of single point of access referral system. It has been shown that referrals can be submitted through emails, letters, utilise provider specific systems or specific arrangement between providers and referrers. Additionally, the type of referrer can be a GP, patient themselves, secondary care consultants, and various other allied healthcare professionals. These referrers can be from NHS Wales or England. There is therefore currently no national system with good clinical gatekeeping to ensure all cross border or Welsh referrals are appropriate, follow the right referral criteria, care pathways and are to the right providers.

For example, when the 13 specialties (+ spinal surgery) new outpatient appointments were analysed in terms of referrals sources it was shown that referrals sources vary but were mainly from secondary care consultants (**Figure 8** showing 24/25 activity). The main known referral parent organisations were BCUHB, Powys UHB and English providers themselves. Furthermore, the biggest providers for those specialties include The Walton, Robert Jones Agnes Hunt, and Liverpool Heart and Chest (**Figure 9**).

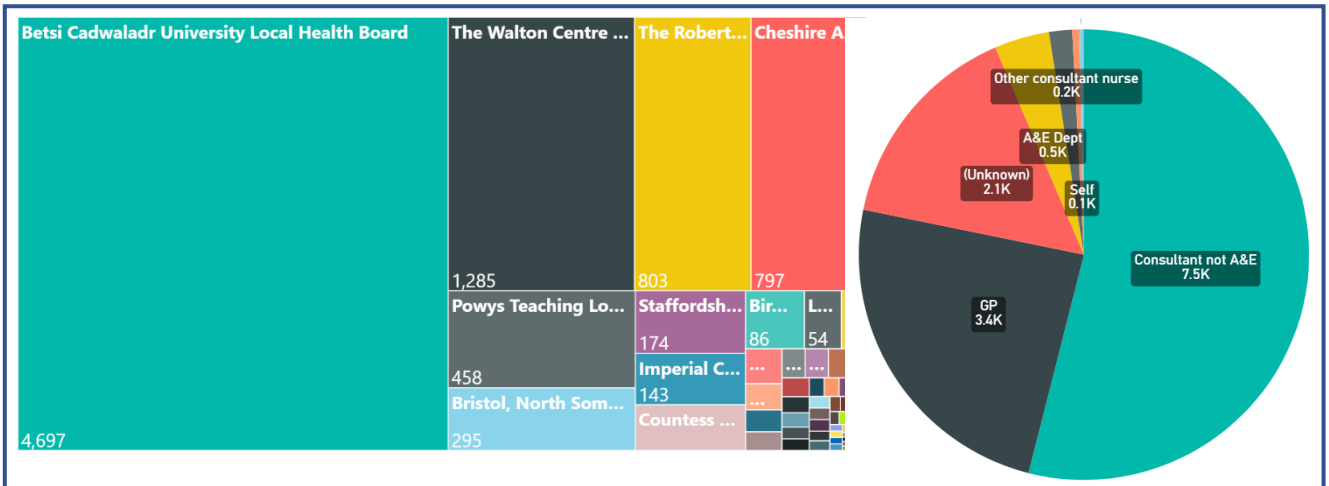


Figure 8. New outpatient activity by referrer parent organisation, and type of referrer for 24/25 for specialties outlined in Figure 6 for providers commissioned by the NWJCC. A) Known referring parent organisation B) Referrer type. DHWC Data

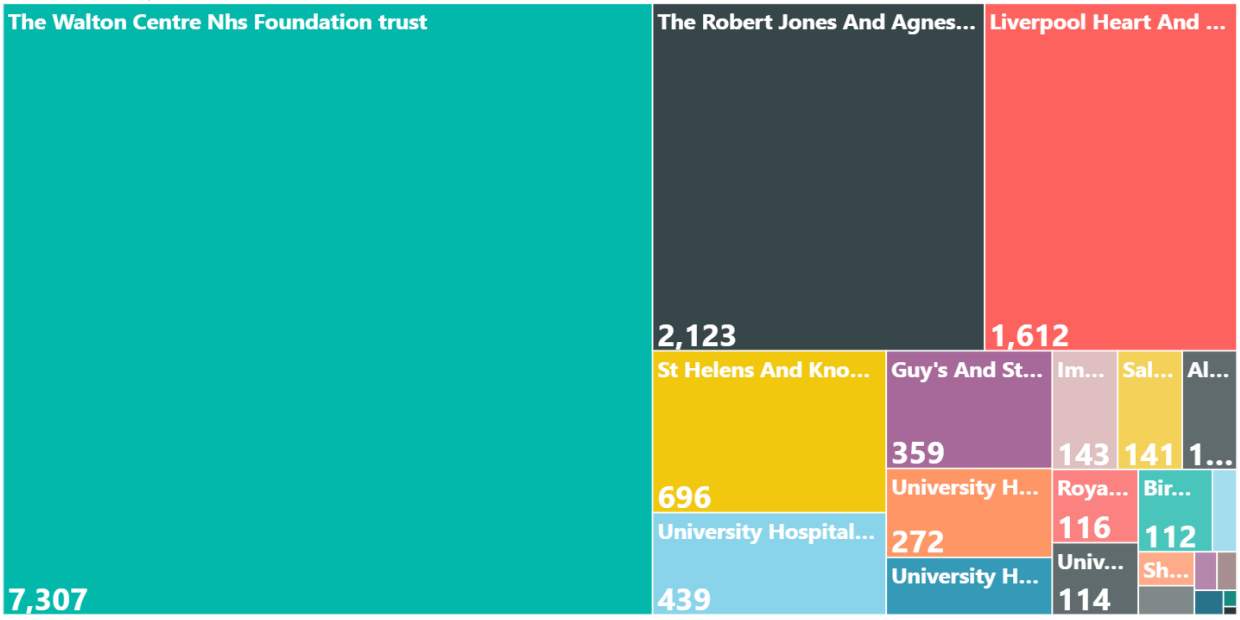


Figure 9. 2024/25 new outpatient activity by Provider Organisations for specialties in Figure 6

These findings highlight that a long-term solution is required to ensure a sustainable and appropriate cross border activity. This will be carried out through the close consideration of a Single Point of Access Referral Management system. Such system can bring a wide range of benefits which are listed in **Figure 10**.

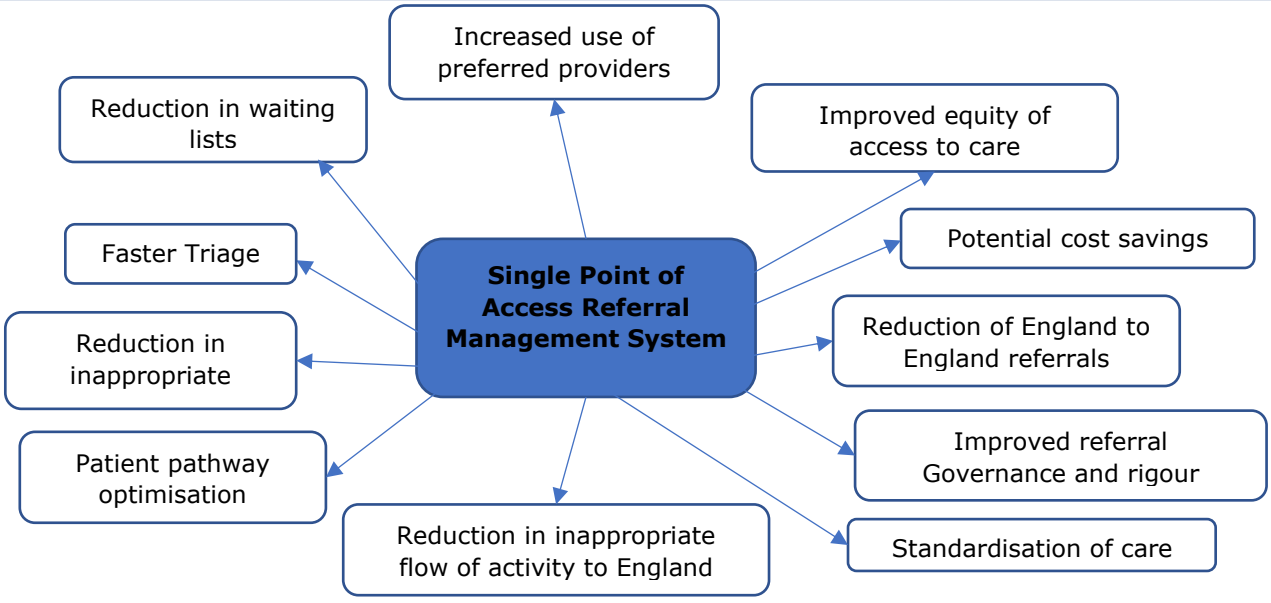


Figure 10. The potential benefits of a single point of access referral management system are highlighted.

In the short-term close working with referrers, particularly those with a high level of new outpatient activity that ends at first attendance is required to understand if such activity is warranted or unwarranted.

Finally work with current providers of such system and referring health boards to scope the feasibility and benefits of such option for Wales will need to form part of the next steps.

Data Quality Improvement and Standardisation.

One of the findings from this work is that coding completeness for data submitted by NHS England providers requires improvements. Therefore, there is ongoing work to develop and agree a set of contract monitoring MDS specifications during the 26/27 LTA agreements.

A contract dashboard will be developed and used during LTA meetings with NHS England providers. It will be used to discuss and potentially challenge non-designated provider activity and outside resource mapping activity as well as referral activity. This will improve control and rigour around commissioning and contracting.

Value & Intelligence Cross Border Dashboard Development

The current value and intelligence dashboard have been key in supporting the findings of this report. However, it requires further development to produce a tool that can be used by the NWJCC and LHBs to improve the understanding of cross border activity and care.

Summary

This report highlights that although demand for NHS England providers is increasing YOY, there are a number of opportunities that can be exploited to ensure a more sustainable and patient centred commissioning of cross border patient care. The work proposed in this report will also increase efficiencies in the ways of working in the NWJCC and increase control and rigour in commissioning and contracting.

A review of an appropriate level of targets for new outpatient activity is expected to decrease unnecessary and, in some cases, potentially inappropriate outpatient appointments through improved referral prioritisation. This will help minimise avoidable appointments for patients and may deliver cash-releasing savings. A carefully managed reduction in follow-up appointments is likely to generate similar benefits. However, both approaches must be evaluated across Welsh providers to ensure equity of access is maintained between regions and ensure progress is delivered clinically led.

Reducing inappropriate use of non-designated providers will strengthen economies of scale, promote equitable care delivery, and ensure that activity aligns with NWJCC service specifications and policies. In addition, collaborating with health boards to identify designated providers within non-specialised specialties could yield the same advantages.

Potential cost savings opportunities that could be exploited in this work are highlighted in **Table 1**. However, more work is required to refine these opportunities further.

Table 1. The table shows different scenarios of cost savings that could be realised based on 24/25 activity data.

Opportunity Type	Estimated Opportunity Based on (£)		Comment
	Total NWJCC NHS England	13 Specialties	
25 % Overall Reduction in New Outpatient Appointment	£1.3M *(Based on £5.18M New OP spend in 24/25*	£710k *(Based on £2.84M spend in 24/25)*	Could also reduce some elective activity
25 % Overall Reduction in Follow-up Outpatient Appointments	£2.7M *(Based on £10.8M spend in 24/25*	£1.5M *(Based on £6.0M spend in 24/25)*	Unlikely to affect elective activity
Actively monitor and realise any immediate cost release opportunities (especially for devices & drugs)	TBC	TBC	Would reduce spend but cannot currently be estimated
25% Overall Reduction in New outpatient appointments that do not go anywhere	TBC	£300k *(Based on £1.2M cost of 5,426 appointments in 24/25 an average spend of £225/appointment)*	Could reduce spend on new outpatient appointments
Ensuring Appropriate Conversion Rates of Surgical Specialties	TBC	TBC	Work done by Powys indicated an 80% target rate for new Outpatient Appointments to procedure. This approach will lead to reduction in appropriate new outpatient appointments

Improvements in data and coding quality and completeness will enhance commissioning oversight and control, supporting the NWJCC's ambition to become a centre of excellence for collaborative commissioning.

The long-term approach to referral management is a single point of access referral management system which will need to be considered closely as part Phase 3 of this work.

Timelines

Indicative Timelines	Milestones / Products
May 2025 - August 2025	**Initiation Phase (Complete)** • Ensure robust project management arrangements • Programme Initiation Document (PID) • Establish project team/structure

August 2025 – December 2025	**Phase 1 (Complete)** • Split the specialised vs non-specialised activity and spend for the various contracts • Identify and realise any recommissioning and cash release saving opportunities • Identify value-based initiatives • Analyse drivers for demand and change • Identify and tackle areas of improvement to data quality • Develop a value and intelligence dashboard
February 2026 – Oct 2026	**Phase 2 – Implementation of report findings and recommendations** • Contract commission dashboard development • Reduction of inappropriate non-designated provider activity • Review of risk share reporting in line with improved resource mapping activity monitoring • Commissioner sign off to prior approvals • IPFR / Prior Approval database transformation • Further development of value and intelligence dashboard • Development of a contract dashboard • Access to DHCW referral tables • Increase Commissioner oversight of referral activity • Agree the set of contract monitoring MDS specifications • Drive of PIFU and SOS for outpatient follow-ups • Carry out a GIRFT benchmarking exercise to determine appropriate follow-up rates for the various specialties • Determine and implement target reduction level of new outpatient appointments • Complete review of conversion rates for surgical specialties for commissioning team to tackle those with unwarranted variation • Benchmarking to ensure most value-based activity is funded • Review and automation of commitments • Begin work to determine best approach to the use of a single access referral management system • Review and update the current Referral Management Framework
Nov 2026 – Feb 2027	Phase 3 – Agree and propose an approach to a single access point of referral system
TBC	Phase 4 • Adopt any best practice findings or alternative patient pathways that lead to better patient outcomes through new service specifications, policies or commissioning/ recommissioning of services

Resources Required

Continued support and input from the NWJCC commissioning teams. Additionally, support from the health boards is required around referral optimisation and non-specialised activity. Finally, close working with the NWJCC quality and safety team is required to ensure that decisions are led by patient safety and equity of access. Continued engagement from Health Boards to build a sustainable solution across Wales.