NHS WAITING TIMES IN WALES
EXECUTIVE SUMMARY

Report by Auditor General for Wales, presented to the National Assembly on 14 January 2005
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Although Wales spends more on health per head of population than England, people living in Wales have to wait significantly longer for elective health treatment than those in England.

The reduction of waiting times - waiting for a first outpatient appointment or for inpatient/day case surgery - is an important element of the health policy of the Welsh Assembly Government and one of the main expectations of patients. There have been some recent improvements in performance, principally reductions in over eighteen month outpatient and inpatient/day case waiting times, and improved waiting times for orthopaedic, cataract and cardiac surgery. Although most patients are assessed or treated well within the eighteen months maximum wait targets, in June 2004 some 7,105 patients had been waiting over eighteen months to see a consultant for the first time in outpatients and 1,447 inpatient/day cases had been waiting more than eighteen months for treatment.

Comparisons of the performance of the NHS in Wales with other parts of the United Kingdom are complicated by differences both of policy and in the way in which waiting times are measured. Devolution produces different health priorities and approaches. Welsh Assembly Government policy has sought to focus on the wider determinants of health, social care and well-being in order to tackle the underlying problems that generate the demand which comes to the NHS. As a consequence, there are differences in waiting time targets and priorities between Wales and other parts of the United Kingdom. Waiting time targets and actual waiting times remain considerably longer in Wales than those in England and Scotland (although shorter than those in Northern Ireland). Moreover, the rate of improvement in Wales has been slow: existing differences in waiting times are exacerbated by recent moves in England and Scotland to reduce waiting time targets still further, while Welsh waiting time targets have generally remained stable and unfulfilled.

There are also substantial regional variations in waiting times within Wales in which the length of wait depends on where patients live. Long waiting times are worst in south east Wales. Particular specialties also experience disproportionately long waiting times.

The current waiting time situation in Wales is inequitable, both within Wales and in comparison to the situation in England and Scotland. Although NHS Wales has had a better record in some other areas of health service delivery - such as waiting times in Accident and Emergency - urgent and concerted action is needed to improve elective service performance.

The causes of long waiting times in Wales are many and varied. Increasing demand, manifested by rising GP referral rates, is a major cause of long outpatient waiting times. Emergency and medical pressures are a major cause of inpatient/day case waiting times because the priority given to such patients encroaches on the capacity available for elective treatment. In addition, there are inefficiencies in the way NHS Wales uses its existing capacity - such as long average lengths of stay in hospital, long intervals between patients when beds are unused, and proportionately fewer patients treated on a day case basis compared with England and Scotland. If such inefficiencies were addressed, waiting times would reduce. There are also significant problems in discharging some patients from hospital, particularly where patients move from health care to social care provision. Although there has been a significant reduction, there remain high levels of delayed transfers of care; these delays take up acute hospital bed capacity and adversely affect waiting times.

There have been many local innovations which have contributed to improvements in waiting times in particular geographical areas or specialties. These typically involve the more flexible use of staff, waiting lists and process changes to accelerate the patient’s pathway through the system of health and social care.
However, the NHS in Wales has not yet delivered sustainable reductions in waiting times. The vast majority of the £3.6 billion the Assembly invests in health in Wales is allocated to Local Health Boards on a recurrent basis; however, the widespread use of waiting time initiatives using non-recurrent funding - treating over 40,000 patients at a cost of £36 million in 2002-03 and 2003-04 - has provided neither good value for money nor sustainable reductions in waiting times. The Welsh Assembly Government has introduced the Second Offer Scheme, which guarantees those waiting for inpatient/day case surgery an offer of alternative treatment if they are likely to wait over 18 months (12 months by March 2005). In addition, it has commissioned modelling work to assess the impact and achievability of setting particular waiting time targets. Nevertheless, further actions at both strategic and operational levels need to be progressed to provide sustainable solutions.

Initiatives treat the symptom - patients waiting - rather than the causes of long waiting times, reinforcing the imbalance in the way current services are set up. This reflects the weaknesses in performance management arrangements, which have provided neither strong incentives nor sanctions to improve waiting time performance. Moreover, the current arrangements are widely perceived to have rewarded organisations which fail to deliver on waiting times, although they also relate to the Welsh Assembly Government’s desire to equalise the existing widespread regional variations in waiting times. In contrast to England and Scotland, there is little discrete, protected elective capacity within the NHS in Wales to mitigate the effect of emergency and medical pressures. Waiting times must be a risk properly shared between the new commissioning bodies and providers. The Welsh Assembly Government needs to lead the strategic reconfiguration of the capacity of NHS Wales to ensure that the right services are available in the right place and, above all, within an appropriate waiting time.

The Welsh Assembly Government and local healthcare organisations need to grip this crucial issue to reduce waiting times to a similar level to those delivered in England and Scotland. The Welsh Assembly Government needs to develop a clear strategic vision about the proper configuration of services both on a regional and national level. This should take account of waiting times, demand and capacity, to ensure that some Welsh patients no longer face waiting times which are far in excess of what they should expect in a modern system of healthcare. All health bodies must recognise the need to address waiting times through a combination of better commissioning, strong performance management mechanisms, and effective and modern operational processes.
The waiting time position in Wales

1 Waiting times are an important element of health policy in all parts of the United Kingdom. NHS waiting times have been one of the most high profile issues in Welsh public services in recent years. This document contains the Executive Summary and Recommendations arising from the two-volume report by the Auditor General for Wales on NHS Waiting Times. The report provides an independent assessment of NHS Waiting Times and their management in Wales. Volume 1 of this report examines current waiting times in Wales; while Volume 2 examines the main causes of, and solutions for, long waiting times, and the effectiveness of the management of the waiting times problem by the Welsh Assembly Government and NHS Wales.

The significance of waiting times

2 The time that patients have to wait for treatment is very important to the users of NHS Wales. Waiting times for elective health services are subject to a series of Welsh Assembly Government targets. There are two principal waiting times measured by the Assembly: the wait between referral and a first outpatient appointment (the outpatient waiting time); and the period between the decision to admit the patient for treatment and the time they receive that treatment (the inpatient/day case waiting time).

3 The outpatient and inpatient/day case waiting lists cover only a minority of total activity in NHS Wales. The outpatient waiting list covers only first outpatient appointments, since the timing of follow-up appointments is driven by clinical need. Most outpatient appointments are follow-ups, rather than first appointments; and the majority of inpatient/day case admissions are emergency cases and do not come from the waiting list. Overall, we estimate that the waiting list covers just over one quarter of total NHS outpatient and inpatient/day case activity in Wales. Although waiting times are extremely important to patients, NHS Wales delivers a much wider range of services, of which some, such as Accident and Emergency services, have traditionally performed better than elective services.

Waiting time targets and their achievement

4 Devolution produces different health priorities and approaches. Welsh Assembly Government policy has sought to focus on the wider determinants of health, social care and well-being in order to tackle the underlying problems that generate the demand which comes to the NHS. Consequently, the Welsh Assembly Government has taken a different approach to health policy, characterised by its plans to implement the recent ‘Wanless’ review¹, which has resulted in differences in specific waiting time targets in comparison with other parts of the United Kingdom.

5 Although Wales spends more than the United Kingdom average per head of population on health and social care, waiting time targets in Wales are longer - a maximum waiting time of eighteen months for both outpatients and inpatient/day case treatment, supported by specific targets for particular inpatient/day case surgery - than those set in England and Scotland. In Northern Ireland a maximum waiting time target of eighteen months has been set for inpatient/day case treatment, although no targets are in place for outpatients.

6 We compared the maximum combined outpatient and inpatient/day case waiting time targets in each part of the United Kingdom - the Welsh figure of 36 months was longer than the 13 and 15 months in England and Scotland respectively. This difference is exacerbated by the fact that both England and Scotland are striving to achieve shorter waiting time targets, while general waiting time targets in Wales have remained static.

7 Despite the fact that the Welsh Assembly Government has set relatively long waiting time targets, NHS Wales has generally failed to meet them. At the end of June 2004, 1,447 and 7,105 patients had been waiting over eighteen months for inpatient/day case surgery and a first outpatient appointment respectively. NHS Wales has been waiting over eighteen months for inpatient/day case surgery and a first outpatient appointment respectively. Although these figures represent an improvement on the position in 2002, when waiting times in Wales were at their longest, they still represent a substantial number of patients. In the period between April 2000 and December 2003 there was a monthly average of over 4,700 patients who had been waiting more than 18 months for inpatient/day case treatment, and 9,400 for a first outpatient appointment.

¹ Review of Health and Social Care, commissioned by the Welsh Assembly Government and carried out in 2003 with advice from Derek Wanless (known as ‘the Wanless Review’).
8 NHS Wales has improved waiting times for particular surgical procedures, such as meeting the target that no one should wait over twelve months for routine cardiac surgery (reducing to ten then eight months by March 2004 and March 2005 respectively), or over six months for an angiography. Waiting times of over eighteen months have been largely eradicated for Orthopaedic surgery. However, NHS Wales still has not achieved its targets for cataract surgery, although waiting times for this procedure have improved. It has also published no information on compliance with its ten day target for patients to see a specialist after their GP refers them urgently with suspected cancer. We received information from six trusts, which suggested that none of the six trusts was compliant with the ten day target for all ten cancer types in the second half of 2003. In spite of this, most GPs believed that the ten day target had improved access to first outpatient appointments for patients with suspected cancer.

Variations in waiting times within Wales and compared with other parts of the United Kingdom

9 There is widespread variation in waiting times within Wales. Figure 16 in Volume 1 shows the considerable variation in the number of people per thousand head of population waiting over eighteen months in each Local Health Board area. Waiting times are longest in south east Wales, and shortest in north Wales; the results of our survey of GPs also reflected this pattern of regional variation in which waiting times depend on where patients live. In addition, particular specialties and trusts also have particularly acute waiting time problems, with two Welsh trusts - Cardiff and the Vale and Swansea2 - accounting for the majority of patients waiting over eighteen months.

10 Waiting time comparisons between different parts of the United Kingdom are not straightforward because of differences in the way patients are counted on the waiting list. Comparisons are particularly difficult for outpatients, where Wales includes a larger group of patients on its waiting list than the other parts of the United Kingdom, meaning that its waiting list includes between 20 and 30 per cent more patients. However, it remains possible to estimate relative differences in waiting time performance. Figures 17 and 18 in Volume 1 show that outpatient waiting times in Wales are longer than those in England but shorter than those in Northern Ireland - comparisons with Scotland are impossible because Scotland does not currently maintain a live outpatient waiting list. Figure 17 in Volume 1 also shows that there are more Welsh patients per thousand head of population waiting over three months for a first outpatient appointment than there are in England. As at March 2004, Figure 17 in Volume 1 shows that England had only 18 patients waiting over six months for a first outpatient appointment, whereas in Wales 68,845 patients had been waiting over six months (of whom 6,204 had been waiting over 18 months). Despite some differences in the way the outpatient waiting list is counted in England compared to Wales, which means that the Welsh list includes between 20 and 30 per cent more patients than it would if it applied the same definitions as England, there is a clear and material difference in outpatient waiting times.

11 Comparisons between inpatient/day case waiting lists are more straightforward. Figure 18 in Volume 1 shows that, while England and Scotland had largely eliminated waits of over one year and were working to shorter waiting time targets3 (Figure 7, Volume 1), there were over 8,000 people in Wales who had been waiting over a year at the end of March 2004, of whom 1,401 had waited over eighteen months. Only Northern Ireland consistently has longer inpatient/day case waiting times than Wales.

Other indicators of waiting times

12 The published statistics do not make clear how long those who have been waiting over eighteen months have actually been waiting. Our analysis showed that at the end of December 2003, 3,362 and 2,517 people had been waiting over two years for a first outpatient appointment and inpatient/day case treatment respectively4. More than one hundred people had been waiting over four years both for a first outpatient appointment and inpatient/day case treatment.

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2 These two trusts provide specialist services on a regional basis.
3 Within the particular definitions used in England and Scotland, of which full details can be found in Volume 1, paragraphs 4.12-4.14 and Appendix 4.
4 The inpatient/day case figures include patients waiting for tonsillectomies. See Volume 1, paragraph 3.14.
However, most Welsh patients do not experience waiting times of eighteen months. We examined completed inpatient/day case waiting times in three specialties\textsuperscript{5}, which showed that 70 per cent of patients received treatment within six months, and 85 per cent within one year.

The management of the waiting list

There has been considerable investment in waiting list management: validating the waiting list to make sure that those on the waiting list continue to require treatment; pooling waiting lists between consultants; and introducing a system whereby routine patients are treated strictly in date order according to when they were placed on the waiting list.

Despite considerable effort, there remain indications that waiting list management has not yet achieved the desired results in terms of ensuring that all patients on the waiting list are fit and able to undergo treatment. For example, the preparatory project for the Second Offer Scheme - which guarantees patients waiting for inpatient/day case treatment an offer of treatment by an alternative provider if they are likely to breach Welsh Assembly Government waiting time targets - resulted in the removal of 28 per cent of patients, contacted by trusts with an offer of treatment, from the waiting list without treatment.

The causes of, and solutions for, waiting times along the patient pathway

Outpatient waiting times

A major reason for long outpatient waiting times is increasing demand, the majority of which comes from GP referrals. Between 1997 and 2004 the number of people waiting for a first outpatient appointment more than doubled, while the number of first outpatient attendances provided rose by 16 per cent between April 2000 and March 2004.

Clinical priority should be the main driver of waiting time. Most GPs reported that they sometimes contact consultants directly to attempt to expedite their patient’s consultation because patients’ conditions deteriorated while they waited, with 25 per cent of GPs reporting that they did so ‘frequently’. This inevitably results in some routine patients falling further down the waiting list as other patients are seen ahead of them. Consequently waiting lists can develop ‘tails’ - large numbers of patients waiting a very long time on the back of the waiting list as they fall further down the queue as patients with higher clinical priority overtake them.

There are also concerns that some of the patients seen in outpatients may not really need to see a consultant. They may have been suitable for treatment in a setting outside the acute hospital or by another health professional, such as a physiotherapist or extended scope nurse practitioner. Consultants estimated that between 20 and 30 per cent of referrals they received in 2003 were inappropriate. This may reflect the absence of suitable alternatives to referral and increased pressure from patients on GPs to make referrals. Consequently, one of the most important functions for the new Local Health Boards is demand management, whereby they monitor and manage GP referral rates and develop alternative services and pathways to prevent unnecessary referral to consultants. Information about GP referrals is poor, and the task of influencing referral rates is extremely difficult, a situation compounded by the absence of any mechanism for consultants to feed back to GPs on any inappropriate referrals.

One of the major problems in outpatient departments has been the proportion of patients - historically between 10 and 12 per cent - who fail to turn up for their appointment (the ‘DNA rate’). Based on the cost of an outpatient appointment, this can be quantified as representing an annual opportunity cost of around £37 million. Each one per cent reduction in the DNA rate generates an efficiency gain worth approximately £3 million. The introduction of partial booking, whereby trusts contact patients to book an appointment six weeks before they are due to come in, has reduced DNA rates. However, the extent of partial booking varies, particularly its extension to follow-up appointments, which is disappointing given the potential of partial booking to improve the efficiency of outpatient services.

\textsuperscript{5} Trauma and Orthopaedics, General Surgery and Ophthalmology.
20 There is considerable scope to redesign the way outpatient services are provided, because they rely less on operating theatres and specific staff. Volume 2 of this report highlights a number of local initiatives, which have focused on streamlining the patient pathway by: using Extended Scope Practitioners - physiotherapists or nurses - to see patients instead of consultants; introducing Multi-Disciplinary Teams to assess and treat patients; developing the role and contribution of GPs; removing the need for an outpatient consultation altogether by introducing direct access to surgery; and improving waiting list management by pooling lists between consultants to equalise differential waiting times. All of these initiatives reduce the demand on consultant-led outpatient services, increase capacity and activity, and enable trusts to respond in a more flexible manner to rapidly increasing demand for outpatient services.

Diagnostic and therapy waiting times

21 Waiting times for diagnostic and therapy services have not traditionally been measured, and have formed a hidden waiting time within the patient pathway. Commendably, and uniquely within the United Kingdom, the Welsh Assembly Government is addressing this through its Diagnostic Services Strategy: it has begun collecting data on diagnostic and therapy waiting times and is working towards publishing waiting time information for such services.

22 Waiting times for diagnostic and therapy services are caused mainly by staff shortages, process and management inefficiencies and restrictions on the availability of services, either in terms of the times at which services are available, or in the protocols for referring patients to them. The development by NHS trusts of Integrated Care Pathways, which include diagnostic and therapy services, has considerable potential to reduce diagnostic and therapy waiting times, and to make more flexible use of staff.

Inpatient/day case waiting times

23 Emergency pressures, and the level of urgent work, are a major cause of long inpatient/day case waiting times. Wales has higher rates of emergency admissions than England. Emergency admissions have risen from 51 to 58 per cent of all hospital admissions between 1997-98 and 2002-03, during which time elective admissions have fallen as a proportion of all admissions. Effectively emergency pressures crowd out routine elective work and push up waiting times. Staff shortages are another key constraint - although there were 14 per cent more consultants in 2003 compared to 1999, 8.8 per cent of consultant posts were vacant in Wales in March 2004.

24 Recent reviews of the NHS in Wales, such as the ‘Wanless’ Review, have found that Wales does not use its existing capacity efficiently. There are several symptoms of inefficiency in the use of existing capacity, which contributes to long waiting times. For example, day case rates in Wales are generally lower than those in England. There are significant levels of cancellations because of bed availability. However, 27 per cent of short-notice cancellations arose because patients failed to attend, no longer wanted surgery or their appointment was inconvenient.

25 Despite having in total 32 per cent more beds per head of population than England, bed utilisation in Wales is less efficient than it should be and could release additional capacity. Average lengths of stay in Wales, the interval between a patient being discharged and the next patient admitted to a bed (known as the turnover interval), and the incidence of outliers - medical patients occupying surgical beds - are all relatively high. This is significant because the daily cost of an acute bed is £329. If the average length of stay in an acute bed reduced by one day (from its 2003-04 level of 7.1 days to 6.1 days), the resulting efficiency gain would release significant capacity to treat additional patients each year.

6 Review of Health and Social Care, commissioned by the Welsh Assembly Government and carried out in 2003 with advice from Derek Wanless (known as ‘the Wanless Review’).
26 In contrast to England and Scotland, there is currently relatively little protected elective capacity in Wales, although the Ambulatory Care and Diagnostic Unit in the University Hospital of Wales is one of the largest in the United Kingdom and there are proposed new Orthopaedic developments in Cardiff and Gwent which will provide protected elective capacity. England is developing a network of NHS and independent treatment centres to deal solely with diagnostic testing and elective surgery, unaffected by the medical and emergency pressures which so influence the ability of NHS Wales to deliver reasonable inpatient/day case waiting times for all patients. The Welsh Assembly Government has set some protected developments in train, but needs to do more to protect elective capacity from emergency pressures and develop sustainable solutions to the underlying causes of waiting times.

Delays in discharging patients

27 Delays in discharging patients from hospital are a serious obstacle to the efficient use of capacity in Welsh hospitals. There are two distinct types of delay, explained below.

- **Delayed discharges** occur when a patient’s stay in hospital is unnecessarily prolonged by inefficiencies in internal processes, such as delays in getting test results or the timing of physicians’ ward rounds. Such delays affect the speed with which hospitals can admit other patients to that bed.

- **Delayed transfers of care**, which tend to last much longer than delayed discharges, occur when a patient needs to move to a further care setting (this could be social service provision, another healthcare setting, the patient’s home, or that of their family or carer), which is not yet available.

28 Delayed transfers of care are the more serious obstacle in the system of health and social care. Excluding delayed transfers in Mental Health beds, there was a monthly average of 723 delayed transfers of care in Wales between November 2003 and June 2004, accounting for 6 per cent of all non-psychiatric beds and over 250,000 bed days each year. Although few delayed transfers of care are in surgical beds, tackling these delays could release capacity within the overall system to treat substantial numbers of elective patients from the waiting list each year.

29 The majority of delayed transfers did not result from delays in transferring to another healthcare setting - in June 2004, 33 per cent related to the interface between health and social care, and 41 per cent to the patient or their carer failing to accept an available package of care. The issue of patient choice is extremely sensitive, but has a substantial impact on the ability of the NHS to treat other patients if patients remain in hospital beds as they await their placement of choice.

30 There has been an overall reduction in delayed transfers of care (excluding delays in Mental Health beds) of 23 per cent between November 2003 and June 2004, although the trend has fluctuated. Wales counts a broader range of delays in its statistics than England and Scotland, which enables the Welsh Assembly Government to gain a better understanding of the impact of delayed transfers of care across the whole system. However, since the number of delayed transfers of care remains significant, there needs to be a concerted effort from all parties across health and social care - the Welsh Assembly Government, healthcare providers and commissioners, and local authorities - to sustain and improve on the initial reductions.

31 Health communities have developed a range of local solutions to reduce the incidence both of delayed transfers of care, and of delays in discharging patients arising from process inefficiencies. Health communities have sought to expand crucial intermediate care services, such as Rapid Response Teams and Reablement Teams, to prevent admission to hospital or to facilitate discharge. Trusts have redesigned their processes in areas such as agreeing target discharge dates at the point of admission, streamlining pharmacy arrangements and the use of discharge lounges to free up beds occupied by patients waiting to leave hospital.
Managing the waiting time problem

Waiting time strategy and performance management

32 The Welsh Assembly Government has not articulated clear and consistent waiting time targets - although the general outpatient and inpatient/day case targets have remained static, some targets have changed over time or been subject to caveats and exclusions. This is in contrast with England and Scotland, where there have been clear and specific medium-term targets, subject to clear timescales. The Welsh Assembly Government is currently undertaking a modelling exercise to inform future target-setting. Among other impacts, the modelling exercise should help the Welsh Assembly Government develop specific targets to reduce waiting times in support of the recent Orthopaedic Plan for Wales which did not include any specific commitments to improve waiting times in this specialty. The absence of a clear national strategy for waiting times prevents providers and commissioners from undertaking the longer-term planning and modelling required to deliver improved waiting times.

33 Performance management arrangements have not been effective in reducing long waiting times. There have been insufficient incentives and sanctions to secure improvements in waiting times. There is a particular concern that the performance management system has effectively rewarded failure, marked by the provision of additional non-recurrent funding to run waiting time initiatives (see paragraphs 34-39), and by allowing some health communities a tolerated number of breaches of maximum Welsh Assembly Government waiting times within their annual performance agreement. However, the approach taken by NHS Wales is to seek to balance effective incentives and sanctions with action to reduce the existing regional variations in waiting times.

Waiting time initiatives

34 The Welsh Assembly Government has made widespread use of waiting time initiatives - the provision of additional non-recurrent funding to treat patients either in the private sector or by paying NHS staff additional sums to deliver extra treatments within marginal capacity in existing NHS facilities (for example in the evenings or at weekends). Expenditure on initiatives was a small proportion of the discretionary funding of £2.5 billion provided to Local Health Boards and Health Commission Wales in 2004/05. In 2002-03 and 2003-04, the Welsh Assembly Government spent approximately £36 million on waiting time initiatives, of which 92 per cent was spent on treating those on inpatient/day case waiting lists, where the costs of treatment are much higher. Some 40,000 patients benefited from the initiatives carried out in 2002-03 and 2003-04.

35 In total, expenditure on waiting time initiatives grew by 49 per cent between 2002-03 and 2003-04, while expenditure in the private sector grew by 120 per cent over the same period, as marginal NHS capacity had been largely exhausted. Generally, trusts preferred to run initiatives in marginal NHS capacity because of cost and clinical effectiveness. For inpatient/day case procedures run in the private sector in 2002-03 and 2003-04, we found that private sector costs for certain procedures were between 17 and 78 per cent more expensive than the same procedure provided at marginal cost within existing NHS facilities. These five common procedures were also more expensive in 2002-03 and 2003-04, costing £1,113,000 more than the same procedure would cost under the Department of Health’s recently-announced tariff (which will provide English trusts with a set payment for each procedure carried out and did not exist when these procedures were commissioned in Wales).

36 When initiatives took place in marginal NHS capacity, there were variations in the rates paid to consultants and other staff, both within and between trusts. Each Trust undertook its own negotiations, often under severe time pressure as the funding was frequently released late in the financial year. The new consultant contract has set the cost of a waiting time initiative session at a flat rate of £500, which will better control the cost of initiatives and reduce duplication of negotiations, both within and between trusts.

37 There was a strong positive correlation between trusts’ share of total expenditure on both outpatient and inpatient/day case initiatives and the proportion of patients waiting over eighteen months. This reflects the perception that performance management arrangements effectively reward failure to deliver by allocating money to the organisations which had failed to meet targets. However, Welsh Assembly Government officials informed us that the allocation of initiative funding also reflects a desire to equalise the existing widespread regional variations in waiting times. Expenditure was strongly focused on particular specialties, particularly Trauma and Orthopaedics, which accounted for nearly two thirds of total expenditure on waiting time initiatives.

38 Although initiatives were clearly good for the 40,000 patients they treated in 2002-03 and 2003-04, they contributed little to sustainable improvements in waiting times - Wales’ recent waiting time performance has been characterised by sharp reductions in waiting times in the second half of the financial year after increases in the first. Initiatives have worked effectively where there is a short-term backlog, or where they run alongside and support a specific strategic development, such as cardiac initiatives run alongside the development of longer-term capacity. However, such initiatives treat the symptom, rather than the cause of long waiting times,
reinforcing the imbalances and weaknesses in the configuration of the current system instead of dealing with the long-term causes of long waiting times identified in this report. Initiatives are very expensive and consequently provide questionable value for money.

Assembly officials informed us that they are aware of the value for money weaknesses of waiting time initiatives, and intend to move away from their use through the Second Offer Scheme, which will have a central commissioning team for the whole of Wales. Consequently, the scheme has the potential to deliver a more strategic approach to commissioning from the NHS and private sector through its additional purchasing power as a single commissioner for Wales. However, there are some risks associated with the Second Offer Scheme, which will require careful management to ensure it has a beneficial impact, in particular if:

- there are disputes between providers and commissioners about the responsibility for funding procedures provided through the Second Offer Scheme;
- there are problems with the financial viability of trusts or Local Health Boards arising from exposure to financial liabilities under the Second Offer Scheme;
- a significant minority of patients refuse to travel to an alternative provider for treatment, which risks the scheme failing to improve the actual time patients wait; and
- the scheme acts as a possible perverse incentive to avoid tackling outpatient waiting times because that would increase the numbers waiting for inpatient/day case treatment, with an increased risk of financial liability on commissioners and providers for treating such patients under the Second Offer Scheme, or for breaching it.

Commissioning arrangements

Commissioning decisions affect waiting times - commissioners should commission services which can deliver the Welsh Assembly Government’s waiting time targets or such shorter waiting times as they can secure, retaining any improvements previously made. It is essential that commissioners investigate and understand the reasons for any significant variance against waiting time targets, manage demand for secondary care services and incorporate the causes of long waiting times into their commissioning strategy.

Spreading best practice

Innovations in Care is the part of the Health and Social Care Department responsible for driving change, modernisation and innovation within NHS Wales. It has spent £25 million on its various programmes between 2000-01 and 2004-05. It is widely regarded as having made a strong contribution to spreading best practice, although its impact in delivering sustainable reductions in waiting times has been weaker. There remains scope to develop further the role of Innovations in Care, particularly in engaging all clinicians in service modernisation, innovation and tackling the serious waiting time problem in Wales. Without clinical engagement and ownership, it is unlikely that managerial imperatives alone will deliver sustainable improvements in waiting times.
Recommendaions

Information

1. The Welsh Assembly Government should take urgent steps to reduce inequities in access to health services within Wales, and to drive the accountability of Local Health Boards for waiting times, using the index of waiting times per 1,000 head of population in each Local Health Board area as an indicator of performance.

2. Until there are no more long waiting times (of one year or more), the Welsh Assembly Government should consider publishing more specific data about actual waiting times (either average waiting times for completed treatments or distributions of ongoing waiting times by month).

3. The Welsh Assembly Government should effectively manage the SaFF target to establish information systems to publish information about compliance with its new pathway-based waiting time target for patients with suspected cancer.

4. Trusts, supported by the Welsh AssemblyGovernment’s performance management system, should ensure that their waiting list management is rigorous and minimises costly inefficiencies arising from patients remaining on waiting lists inappropriately.

Outpatient waiting times

5. The Welsh Assembly Government and trusts should accelerate the extension of partial booking to follow-up appointments to maximise its impact on the efficiency of outpatient clinics.

6. Trusts and Local Health Boards should continue to develop and expand existing outpatient innovations, which reduce the pressure on consultants and the acute hospital sector, in particular Extended Scope Practitioners, Multi-Disciplinary Teams, Integrated Care Pathways and the use of pooled waiting lists.

7. Local Health Boards should focus strongly on their demand management role to reduce the burden on outpatient services. They should develop better systems to:
   - capture information on GP referrals;
   - work closely with secondary care to establish simple mechanisms for consultants to feedback to GPs on the quality of referrals; and
   - inform GPs and consultants about alternatives to referral to outpatients.

Diagnostics and therapies

8. The Welsh Assembly Government should maintain its commendable focus on diagnostic and therapy waiting times, publish data on such waiting times, consider developing commissioning arrangements based on patient pathways, and seek wherever possible to move towards waiting time targets based on the patient’s pathway.

9. Trusts and Local Health Boards should seek to maximise access to diagnostic and therapy services in order to contribute to shorter waiting times at all stages of the patient’s pathway. The Welsh Assembly Government’s performance management processes should support this focus on diagnostic and therapy services.
Inpatient/day cases
10 Given the extent of last-minute cancellation by patients whose appointment was inconvenient, or who no longer wanted their operation, the Welsh Assembly Government and the NHS should consider extending, on a phased basis partial booking to day case and appropriate inpatient treatments, to minimise the opportunity cost of cancelled procedures (which is much higher than the equivalent opportunity cost for outpatients). Trusts should adopt this development and link it to pre-operative assessment.

11 Trusts, supported by the Welsh Assembly Government and Local Health Boards, should maximise the use of existing capacity to reduce waiting times. In particular they should focus on:
- reducing the average length of stay;
- reducing the interval between a patient being discharged from a bed and another one being admitted to that bed (this is known as the turnover interval);
- reducing the number of medical patients occupying surgical beds (known as outliers);
- improving utilisation of operating theatres; and
- increasing rates of day surgery.

12 Trusts should offer patients an alternative appointment within 28 days of a cancellation according to the target set out in the Health and Social Care Guide and Emergency Pressures Planning Guidance. The Welsh Assembly Government should monitor compliance with this target.

Delays in discharge
13 The Welsh Assembly Government should continue to develop its shared approach and establish incentives for health and social services to work jointly to deliver specific reductions in the extent of delayed transfers of care at the interface between health and social care. Such arrangements should consider:
- joint budgets;
- stronger joint accountability for delayed transfers of care between health and social care;
- the availability of, and access to, intermediate care services, with a particular focus on service availability in the evenings, at weekends and at seasonal peak times, such as Christmas; and
- the National Service Framework for Older People.

14 The Welsh Assembly Government should also review the impact of its recent guidance on discharge from hospital and seek to ensure that the NHS and its partners identify mechanisms to reduce the widespread loss of capacity caused by delayed transfers of care relating to patient choice or disputes with patients and/or their carers.

15 All trusts should also consider the adequacy of the following processes which influence the timely discharge of their patients:
- setting target dates for discharge as soon as patients are admitted;
- pharmacy arrangements;
- the timing of physicians’ ward rounds;
- patient transport arrangements; and
- the adequacy of Discharge Lounge provision, to ensure the most timely discharge of patients.
Waiting time initiatives and the Second Offer Scheme

16 The Welsh Assembly Government and commissioners should seek only to provide additional funding to tackle waiting times to providers which are maximising the use of their existing capacity, and where such funding is aligned with local, regional and national commissioning strategies. The Welsh Assembly Government and commissioners should only provide such additional funding where the breach of waiting time targets is justifiable, for example where it relates to genuine imbalances in the system, rather than process inefficiencies.

17 The Welsh Assembly Government should set up a system to improve the monitoring and control of waiting time initiative funding.

Performance management and target-setting

18 The Welsh Assembly Government should establish and communicate a consistent overall strategy to reduce waiting times in Wales, which recognises overall waiting times and the inter-dependence of outpatient, diagnostic and therapy, and inpatient/day case waiting times. The strategy should be ambitious, set clear milestones, and take account of waiting times in other parts of the United Kingdom. There should be no more tolerated breaches of minimum waiting time targets unless such reduced targets are widely publicised in the appropriate localities.

19 The Welsh Assembly Government should develop within its performance management arrangements incentives and sanctions for waiting times and other key aspects of performance, while taking account of local variations in waiting times.

20 Trusts and Local Health Boards should develop internal incentives and sanctions for waiting time performance, particularly to engage the clinical staff, who have a vital role to play in improving waiting times.

21 The Welsh Assembly Government should adopt a more regional approach to tackling waiting times, looking at activity, capacity and waiting times at the regional and national levels to develop protected capacity for elective work and maximise the use of existing capacity.

Commissioning

22 Local Health Boards should focus closely on examining and resolving the causes of under-performance against contracts for elective work, irrespective of any associated over-performance against emergency contracts, taking steps to identify, and grip, the causes of rising emergency pressures ‘crowding out’ elective capacity.

23 The Welsh Assembly Government should develop a clear national strategy for service reconfiguration to support regional and local change and ensure that commissioning and service reconfiguration takes account of regional and national, as well as local, needs.

24 Local Health Boards should be creative in future commissioning structures, for example considering the development of joint commissioning teams or joint heads of commissioning to strengthen commissioners’ negotiating positions with a particular Trust - such an approach is increasingly common between individual Primary Care Trusts in England.

Spreading best practice

25 The Welsh Assembly Government should ensure that Innovations in Care programmes cover the new commissioning bodies as well as providers in order to support whole system change, rather than simply focusing on the capacity and configuration of providers.
Appendix 1

Schedule of recommendations requiring action by the Welsh Assembly Government, NHS trusts and commissioners

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