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Archwilydd Cyffredinol Cymru
Auditor General for Wales

NHS Waiting Times for Elective Care in Wales



WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



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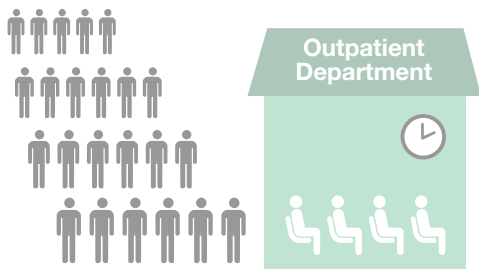
Summary

- 1 During our lifetimes, most of us will need some form of elective – or planned – NHS care. That could involve a diagnosis from a consultant or some form of planned surgery. The amount of time that patients wait to get a diagnosis or to get treatment matters a good deal to them. It is not the only thing that matters, but waiting times has been the key measure against which the Welsh Government and the public judges the performance of the elective care system. Since 2009, the NHS in Wales has been working to a target whereby at least 95 per cent of patients on a waiting list should be waiting less than 26 weeks and nobody should wait more than 36 weeks¹. The waiting list includes patients at all stages from their referral through to starting treatment. **Figure 1** provides a snapshot overview of the NHS waiting list in Wales in March 2014.
- 2 This report looks at how long patients are waiting for elective care. The report does not focus on emergency care nor care related to cancer – which is subject to separate targets – although it does consider the impact of prioritising these areas for elective care. In carrying out our work, we have sought to answer the overall question: ‘Is NHS Wales’ overall approach to managing elective waiting times effective?’ To answer this question we looked at current performance, the underlying causes of waiting times performance and NHS Wales’ plans to better manage waiting times. Our conclusions and our key findings are set out in this report. We are also publishing additional supporting information for readers interested in seeing more of the detailed analysis and data underpinning our findings:
 - a a technical report with more data on performance and the causes of long waiting times;
 - b a summary of the responses to patient surveys conducted as part of our review; and
 - c a compendium of good and promising practice.
- 3 Our overall conclusion is that while the vast majority of patients are treated within 26 weeks, the current approach does not deliver sustainably low waiting times. However, emerging plans do have the potential to improve the position if they are implemented effectively.

¹ Some specific services are excluded from the waiting times target, including fertility treatment, screening services and routine dialysis. Further detail can be found in the publication **Rules for Managing Referral to Treatment Waiting Times**.

Figure 1 – A snapshot of the waiting list at March 2014

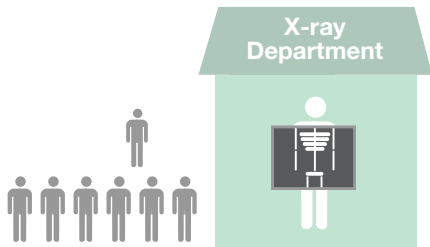
Outpatients



227,787 patients awaiting first outpatient appointment.

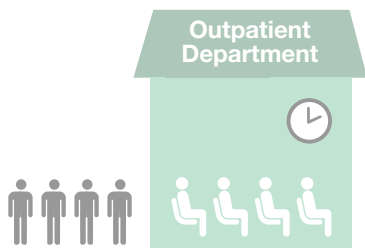
Median wait:
8.6
weeks

6%
waiting over
26 weeks



66,920 patients awaiting a diagnostic test.

No median wait due to data consistency issues.

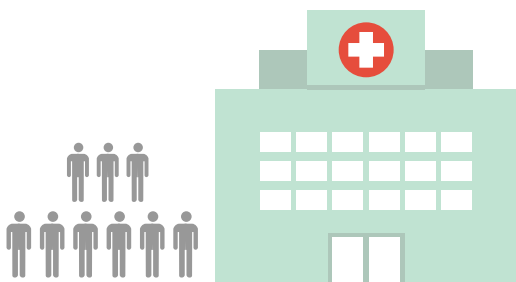


36,263 patients awaiting a decision following a diagnostic test.

Median wait:
12.9
weeks

12%
waiting over
26 weeks

Inpatients



87,472 patients waiting for admission as an inpatient or day case.

Median wait:
16.3
weeks

26%
waiting over
26 weeks

- 4 It is important to state that the vast majority of patients are seen and treated within 26 weeks and many are happy to wait for their treatment. Across 2013-14, the median waiting time of a patient on a waiting list in Wales was 9.9 weeks². **Figure 1** provides a snapshot of the median waits of patients at various stages of the patient pathway at the end of March 2014. However, performance against the Welsh Government waiting time targets has been declining significantly since 2009. In March 2014, 11 per cent of patients on the waiting list had been waiting more than 26 weeks and three per cent more than 36 weeks. There is evidence from independent reviews and our own survey that a minority of patients are coming to harm as a result of long waiting times. Moreover, despite some differences in the way they are measured, waiting times in Wales are longer than those in England and Scotland. The data which is available does not allow a similar comparison to be made to Northern Ireland.
- 5 The causes for the relatively long waits are complex but boil down to the inability of NHS Wales as a whole to sustainably match the supply of healthcare with demand for services. Some of the key factors that we see as having led to the current position are:
- a the Welsh Government not updating its approach since 2009 to reflect the challenges of meeting waiting time targets in an environment of increasing financial and resource constraints, though this is now being addressed through the integrated medium-term planning process;
 - b a lack of recurrent capacity for elective care and a consequent over-reliance on short-term funding for activity outside of normal working hours to deliver quick but unsustainable reductions in waiting times;
 - c over-optimistic health board plans that are based on meeting targets rather than what can realistically be achieved;
 - d greater financial, staffing and bed resource pressures compared to similar parts of the UK;
 - e pressures from rising demand for elective care;
 - f pressures from emergency admissions, urgent cancer care and follow-up appointments which reduces the resources available for routine patients; and
 - g inefficient use of existing resources and capacity, including an over-reliance on seeing and treating patients in hospital when they could be managed in a primary care or community setting.

² The 'median waiting time' is the length of time waited by the person in the 'middle of the queue'. For example, if there were 100 patients in the queue and they were all lined up in the order of time they had been waiting, the median waiting time would be the length of time the 50th person had waited.

- 6 One of the key messages we want to emphasise is that the relatively poor performance on waiting times is not due to a lack of will or effort on the behalf of staff working in the NHS. Our evidence shows that the system – the thinking, planning and detailed processes – of elective care is the problem, not the staff. Indeed, a major part of the problem is that the NHS has become over-dependent on short-term initiatives that generally involve staff working extra hours in order to try to reduce the numbers of patients facing very long waits.
- 7 A key question is whether the NHS can sustainably meet waiting times targets given the current financial and capacity constraints. Pressure on financial, staffing and bed resources are more pronounced than other parts of the UK with similar social and economic circumstances to Wales. In some areas, a lack of capacity is constraining NHS Wales' ability to match the performance of other UK countries. Based on performance to date, it is unlikely that NHS Wales could achieve and sustain low waiting times if it tries to do more of what it has done in the past.
- 8 However, NHS Wales' emerging thinking on the future direction for elective care could lead to lower waiting times. In part, the solution is about local efficiency improvements to make better use of existing capacity. But the greatest opportunity lies with challenging and changing some of the basic assumptions about what support and treatments patients need and want and who is best placed to provide them. In some cases, patients do not need or want the expensive hospital-based services that the NHS currently offers them. It is difficult to be certain given the relatively unsophisticated data that exists on demand and capacity, but we expect that by doing things differently, health boards could free up significant capacity to see more patients (see [Figure 2](#)). Making better use of existing capacity could lead to shorter and more clinically appropriate waiting times for patients. Putting the promising ideas that the NHS now has – particularly through prudent healthcare – into practice will require bravery to take managed risks and hard work to overcome the practical obstacles that have sometimes impeded radical reform in the NHS. Our Good Practice Compendium sets out examples of practices from Wales and further afield that can help in thinking about different ways of working.

Figure 2 – Potential efficiency/capacity gains identified through the report

	Report reference	Potential capacity gains in the medium term with substantial reform	Potential capacity gains in the long term with continued substantial reform
Re-designing the outpatient model to reduce reliance on hospital consultant to provide diagnosis and advice by using other staff and technological solutions	Paragraphs 3.8 to 3.9	If five per cent of outpatient attendees were seen by other clinical staff, consultants could potentially see an extra 67,000 patients.	A 10 per cent shift would free up capacity for consultants to see an additional 135,000 patients.
Reducing the number of patients that do not attend their outpatient appointments (DNA)	Paragraphs 3.10 to 3.13	A one percentage point reduction in DNA could free up capacity to see an additional 2,900 patients.	A four percentage point reduction in DNA could free up capacity to see an additional 11,600 patients.
Reducing procedures known to be of low clinical value for many patients	Paragraph 3.3	A 25 per cent reduction would free up capacity for 8,400 procedures, 11,000 bed days. The value of this capacity would be in the order of £13 million.	A 50 per cent reduction could release capacity for 16,800 procedures, 22,000 bed days. The value of this capacity would be in the order of £26 million.
Reducing variation in clinical decision making and intervention rates	Paragraphs 3.4 to 3.7	If health boards reduced intervention rates to the average in the 16 procedures in our sample, it would free up capacity equivalent to 11,300 procedures and 28,000 bed days. The value of this capacity would be £16 million.	Reducing variation across all procedures could free up capacity equivalent to 32,000 procedures and 47,000 bed days [1].
Reducing lengths of stay	Paragraph 3.25	Reducing length of stay across emergency and elective systems to the average of Welsh providers each month would free up 40,500 bed days which would equate to around 13,300 elective patients.	Reducing length of stay to the best would free up 201,500 bed days which would equate to 76,200 elective patients.

Note

These are broad estimates that indicate what capacity could potentially be created by doing things differently. They should not be seen as targets or forecasts. In some cases, freed up capacity may be better used to provide 'headroom' or breathing space rather than used to treat more patients.

[1] It was beyond the scope of this study to identify the cost of variation across all procedures carried out across Wales.

Recommendations

Recommendation

- R1 The Welsh Government has not formally reviewed its approach to managing waiting times in light of a sustained deterioration in performance and the challenges of real terms cuts to spending on health. However, with the introduction of a new planning framework, a Planned Care Programme and a range of prudent healthcare initiatives, there are positive signs of a clearer direction for elective care in an environment of austerity. While the Welsh Government is responsible for setting the overall direction, it is for health boards to plan and deliver sustainable and appropriate waiting times. The Welsh Government should therefore work with NHS bodies to:
- a review and set out the principles, priorities and intended outcomes for elective care, within the context of the wider healthcare system: to include a fundamental review of current waiting times targets and whether they are an effective method to prioritise resources towards those most in need;
 - b develop a shared understanding of demand and capacity across the NHS and develop a realistic timeframe for reducing elective waiting times and the backlog of patients in line with any changes to the targets resulting from R1(a) above; and
 - c assess the costs, benefits and barriers related to adopting seven-day working across the elective care system.
- R2 Our review found that aspects of the current design and operation of the outpatient system is not as efficient and patient focused as it could be. The Welsh Government and NHS bodies should work together to radically re-shape the outpatient system. In doing so, they should build on the prudent healthcare principles, to enable the emergence of a system that is based more on need, patients' own treatment preferences, use of technology and which reduces the risk of over-treatment and an over-reliance on hospital-based consultants to diagnose and advise on treatment.
- R3 We found that in some cases, patients could be facing substantially longer waits if they cancel their appointments because they can find themselves going to the back of the queue. The Welsh Government should review RTT rules and the way in which they are interpreted and applied locally to ensure patients are not being treated unfairly as a result of current approaches to resetting patients' waiting time clocks.
- R4 Our local fieldwork has identified pockets of good and interesting practice and innovation across the NHS in Wales. The Welsh Government, through the Planned Care Programme, should identify mechanisms to share interesting and good practice, in ways which enable frontline staff to share ideas and develop new approaches based on what works. This should include the use of statistical analysis to understand demand and plan capacity as set out in the 2005 NLIAH **A guide to good practice**.
- R5 A significant minority of patients in our survey were unaware of what would happen to them if they cancelled, did not attend or were unavailable for appointments. The Welsh Government and health boards should work together to better communicate with patients about their responsibilities, those of the different parts of the NHS and what they should expect when they are in the elective care system.

Recommendation

R6 The Welsh Government publishes some data on waiting times, but it could provide more useful information to help support scrutiny and management of waiting times, as well as providing local information that would be more helpful for patients on a waiting list. The Welsh Government should therefore publish more detailed national and local information:

- publish waiting times at different parts of the patient pathway (component waits);
- reporting separately waiting times for urgent and routine cases, for both the closed and open pathway measure;
- publishing the date for the closed pathway measure which separates out admitted and non-admitted patients; and
- publishing median and 95th percentile waiting times.

R7 Many people we spoke to on our local fieldwork identified current IT systems as a barrier to improving services and managing patients, although it is unclear to what extent any problems lie with the systems themselves or the way they are being used. The Welsh Government should carry out a fundamental review of the ICT for managing patients across the patient pathway and how it is being used locally and develop actions to address any problems or concerns that are identified.

R8 Capacity within secondary care is a major barrier to reducing waiting times. Welsh hospitals have higher occupancy rates than comparators elsewhere in the UK and clinicians raised concerns about the lack of flexibility in the system to manage peaks and troughs in demand from emergency care in particular. The Welsh Government and NHS bodies should review the approach taken to planning inpatient capacity across NHS Wales, to enable the NHS to better manage variation in emergency admissions at the same time as delivering sufficient elective activity to sustain and improve performance.

R9 Cancellations can result in inefficient use of NHS resources and cause frustration for patients. At present, the data on cancellations is incomplete and inconsistent, despite work by the Welsh Government to introduce an updated dataset. The only data that exists covers cancelled operations and health boards appear to be recording the reasons for cancellations differently. The Welsh Government and health boards should therefore work together to:

- ensure that there are comprehensive, agreed and understood definitions of cancellations, and the reasons for them across the entire waiting time pathway to include outpatients, diagnostics, pre-surgical assessment and treatment; and
- ensure that reliable and comparable data on cancellations (and the reasons for them) is collected and used locally and nationally to scrutinise performance and target improvement activities.

- 1.1 This part of the report examines the performance of the NHS in Wales against its targets for waiting times and looks at the experience of patients on waiting lists in Wales. It also compares performance in Wales to other parts of the UK where possible. A more detailed analysis of performance data can be found in our [NHS Waiting Times for Elective Care in Wales: Technical Report](#).

Box 1: Approaches to measuring waiting times

The patient clock: Waiting times are measured using the concept of the patient clock. In Wales, England and Scotland the clock starts when a health board/provider receives a referral (usually from a GP). The clock stops when the patient starts their definitive treatment or a decision is made that treatment is not necessary. Treatment is not necessarily a procedure: for many patients, treatment involves getting advice at an outpatient appointment.

Open measure: Is a measure of the length of time patients wait who are currently on the waiting list. It is the preferred measure of the Welsh Government and is also used in England. The advantage is that it is a live measure of how the system is currently performing. The key disadvantage is that it does not reflect how long patients actually wait to get their treatment.

Closed measure: Is a measure of the length of time waited by patients who have received their treatment. The closed measure is used as a key measure in Scotland and England. The advantage of the measure is that it reflects the end-to-end waiting times. The main disadvantage is that it is not a live measure so does not show how long people currently on the list are waiting.

Clock pauses, resets and adjustments: NHS bodies can legitimately make 'adjustments' to the measures to reflect, for example, patient choices (like choosing to wait longer to allow for a planned holiday) and behaviour (such as not turning up for appointments). The rules for adjustments differ across the UK and are discussed in [Part 3](#) of this report.

Data quality: There have been issues with the quality of published data on waiting times. In January 2014, the National Audit Office³ found errors in some trusts' recording of waiting times figures for England and concluded that they 'need to be viewed with a degree of caution'. An Audit Scotland report in February 2013⁴ found minor errors in waiting times data across Scotland. Our study has not included a review of the quality of Welsh referral to treatment data.

³ National Audit Office, [NHS Waiting Times for Elective Care in England](#), January 2014

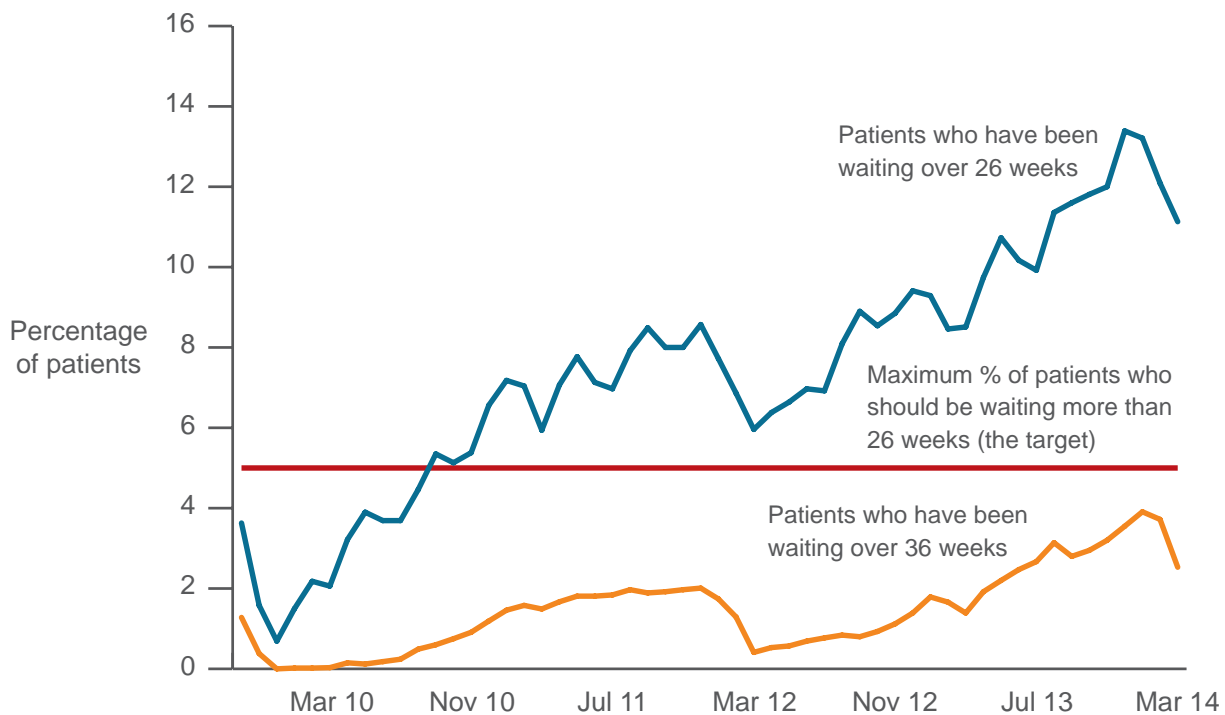
⁴ Audit Scotland, [Management of Patients on NHS Waiting Lists](#), February 2013

Although most patients are treated within 26 weeks and many patients are happy to wait, performance is getting worse and is some way from meeting the targets

Waiting times performance has got steadily worse since December 2009 and the targets have not been met since September 2010

1.2 The Welsh Government's 'open measure' target states that at least 95 per cent of patients on the waiting list should have waited less than 26 weeks from the date of their referral. Nobody should be waiting more than 36 weeks for treatment. As Figure 3⁵ shows, NHS Wales did meet the target at the end of 2009 but since then the proportion of patients waiting more than 26 weeks and 36 weeks has increased significantly. At the end of 2013-14, around 11 per cent of patients were waiting more than 26 weeks, and three per cent waiting more than 36 weeks.

Figure 3 – Patients on the list waiting more than 26 and 36 weeks



Source: Wales Audit Office analysis of Welsh Government data

5 Analysis is based on referral to treatment data for residents living in each health board area.

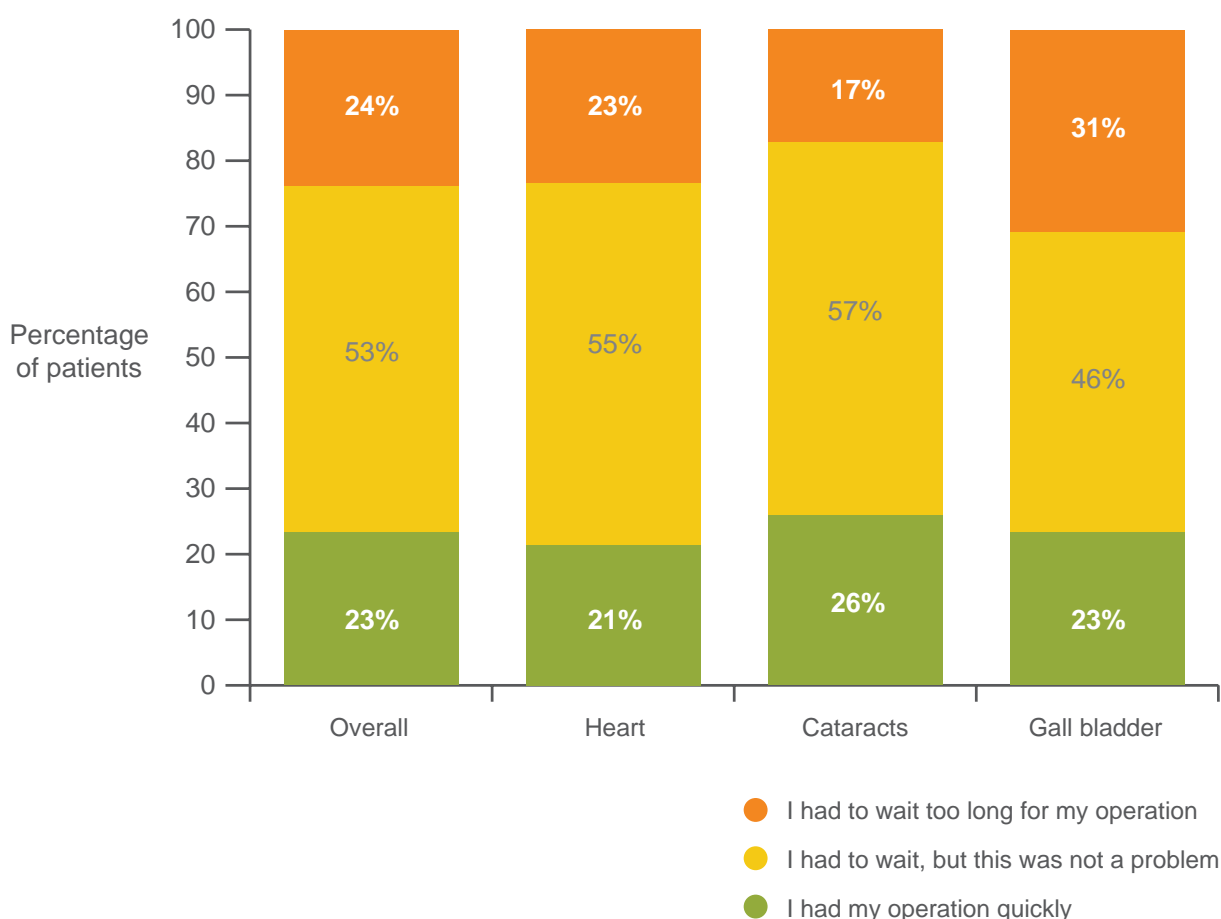
- 1.3 The overall figures mask some variation in terms of where people live and the type of condition they have. Residents living in the Powys Teaching Health Board area are least likely to be waiting more than 26 weeks, whereas residents in the areas covered by Cardiff and Vale University Health Board and Betsi Cadwaladr University Local Health Board face the longest waits. Shorter overall waits for Powys residents are likely due to these patients having much shorter waits for their initial outpatient appointment and diagnostic tests than in other parts of Wales.
- 1.4 **Figure 3**, above, does not include patients from Wales who are referred for treatment in England. The majority of these patients are referred from within the Betsi Cadwaladr University Health Board and Powys Teaching Health Board. Overall, Welsh patients face shorter waits for treatment in England than in Wales. However, in October 2012, Powys Teaching Health Board took a decision to extend waiting times targets for patients, including those referred to England⁶, from 26 weeks to between 32 and 36 weeks (although it has reversed that decision in 2014-15). Therefore, waiting times for patients referred to England from Powys have been longer than those referred from within the Betsi Cadwaladr University Health Board area.
- 1.5 There are significant differences between specialties, with trauma and orthopaedics, oral surgery, ophthalmology, general surgery, pain management, restorative dentistry and urology patients facing the longest waits. The specialties with the longest waits tend to be those with the highest volume of patients. Specialities with the lowest waits (fewer than one per cent waiting over 26 weeks) include dental medicine, paediatric neurology, audiological medicine and paediatrics.
- 1.6 There are particularly long waits at certain parts of the patient pathway, especially waits for a first outpatient appointment and diagnostic tests. In March 2009, nobody waiting for a first outpatient appointment had been waiting more than 10 weeks. By March 2014, 38 per cent of patients had been waiting more than 10 weeks for their first outpatient appointment with six per cent (14,000 patients) waiting for more than 26 weeks. The national target for a patient's maximum wait for access to diagnostic tests is eight weeks. But in recent years, performance has not met those standards: In June 2014, 22,717 patients (28.7 per cent of patients) were waiting over eight weeks for diagnostic services compared to just 10 per cent in October 2009.

⁶ We understand that Welsh providers did not act on the decision to change the waiting times target for Powys residents.

Most patients are treated within 26 weeks and are happy to wait for some procedures but a significant minority feel that they waited too long

1.7 It is important to recognise that while a significant minority of patients face long waiting times, most people⁷ are treated within 26 weeks. Moreover, most people who responded to our patient survey⁸ who had recently undergone specific types of heart, cataract and gall bladder treatments said that waiting for their operation was not a problem (Figure 4). Some people appreciated being kept informed of expected waiting times whilst others were aware of the number of people waiting for treatment. The majority of patients who said that they were happy to wait for treatment had waited for more than four months for their operation.

Figure 4 – Patient views on the length of time they waited (by procedure)



Source: Wales Audit Office patients survey

⁷ Figures from March 2014 show that 77 per cent of patients were treated within 26 weeks.

⁸ We conducted a postal survey of 900 patients who had undergone one of three procedures as an elective patient during October or November 2013. The procedures were cataract surgery, surgery to remove the gall bladder (both high-volume procedures with a high number of elective admissions), and catheterisation of the heart (a high-volume diagnostic procedure). We also conducted a shorter online survey targeted at patients who had undergone a planned operation in the last three years.

Comments from Wales Audit Office Citizen Survey

Naturally I would have liked to have had the treatment quickly but I understand that that was not possible due to pressures on the specialist and that there were patients who needed the treatment more quickly than me.

My optician told me that I would wait a maximum of eight months for my first appointment which was fairly accurate. Therefore I was forewarned about the length of delay and so I was prepared.



A significant minority of patients feel they wait too long and some patients are deteriorating and coming to harm while on a waiting list

- 1.8 The 26 and 36-week targets apply to all patients, but the NHS aims to see and treat those most in need more quickly. NHS bodies classify all patients on a waiting list according to whether they are 'routine' or 'urgent'⁹. In the first instance, the person referring the patient – usually a GP – will set out their classification. Each referral is then reviewed by a consultant who makes the final decision on whether the patient is routine or urgent. Health board systems are designed to ensure that urgent patients are treated more quickly than routine patients. The NHS data dictionary defines urgent as being patients who are at risk of material deterioration if he or she is not seen within four weeks. We were unable to get national data on the difference in waiting times for 'routine and 'urgent' patients. Figures provided by one health board show that while many urgent patients are waiting less than four weeks, there is a backlog of urgent patients in some specialities waiting significantly longer for a first outpatient appointment: in some cases, more than six months. We consider the complexities of clinical prioritisation in more detail in [paragraphs 3.14 to 3.17](#).
- 1.9 Information about the effect of long waits on patient outcomes is not readily available but we do have evidence of some areas where patients are coming to harm. Recent reviews of patients waiting for cardiac surgery concluded that waiting times in South Wales for many patients are 'longer than clinically appropriate leading to excessive morbidity¹⁰ and risk of mortality on the waiting list, poorer surgical outcomes, increased risk of emergency admission and reduced efficiency in resource utilisation'¹¹. The reviews showed that 99 patients have died whilst on the waiting list for cardiac surgery in the last five years although because of existing co-morbidities it is not clear how many of these deaths were directly attributable to long waits. NHS Wales is putting in place a range of measures to address the long waits for cardiac patients and there are signs that waiting times for cardiac services in some parts of Wales have reduced during the early parts 2014-15 ([NHS Waiting Times for Elective Care in Wales: Technical Report](#), paragraph 1.21). The Welsh Government and NHS bodies are taking action to improve the situation for cardiac patients ([paragraph 1.21](#)).

9 The 'urgent' category applies to patients with urgent suspected cancers as well as patients who are urgent for other reasons. Patients with urgent suspected cancer are managed to a separate target and are not included in the elective waiting times figures. To provide an indication of the urgency profile of the elective waiting list, one health board's data showed that in August 2013, 29 per cent of patients waiting for their first outpatient appointment and 28 per cent of patients on an inpatient/day-case waiting list were classified as 'urgent'.

10 'Excessive morbidity' in this context means that people are more unwell than they would be if they had not been waiting so long.

11 Welsh Health Specialised Services Committee: [Review of Cardiac Services](#) (March 2013), [Report of the Cardiac Surgery Working Group](#) (March 2013) and [Cardiac Summary Paper](#) (September 2013)

- 1.10 The Royal National Institute for the Blind (RNIB) has reported concerns that an estimated 48 patients a year are losing their sight while on a waiting list¹². In 2013, RNIB conducted a survey of ophthalmology staff in Wales, followed by interviews in April 2014 to understand some of the issues highlighted by the survey. All of the ophthalmologists who took part in the interviews reported that patients are experiencing irreversible sight loss as a result of long waiting times. Some of the problems relate to patients waiting for follow-up appointments as well as those on a referral to treatment pathway. Since March 2012, the number of ophthalmology patients waiting more than 36 weeks rose from 28 patients to around 2,000 in May 2014. The Welsh Government and NHS bodies are working together to try to improve waiting times for ophthalmology patients. The RNIB has identified similar issues with ophthalmology in England¹³.
- 1.11 The patient survey undertaken as part of this study found that almost a quarter of patients felt they had to wait too long for their operation. Many of the patients that felt that they waited too long reported concerns that their condition had deteriorated: with 29 per cent of patients reporting that their condition got worse while they were waiting. That figure rises to 40 per cent among patients who were waiting to have their gall bladder removed. Alongside the impacts on their physical health, patients also reported negative impacts on their economic wellbeing from missing work, social life, independence and emotional wellbeing. Below are some of the comments that patients made relating to the length of time they waited and their deterioration.

¹² Dr T Boyce, **Real patients coming to real harm – Ophthalmology services in Wales**, RNIB, November 2014. The Royal College of Ophthalmologists response to the report states that 'Whilst not based on a robust study the findings in the report highlight the pressing need for joint work to protect the eye health of the population and prevent avoidable sight loss'. The RNIB report **Saving Money, Losing Sight**, November 2013, found that 'patients are going blind due to sizeable capacity problems in ophthalmology units across England'.

¹³ The RNIB report **Saving Money, Losing Sight**, November 2013, found that 'patients are going blind due to sizeable capacity problems in ophthalmology units across England'.

Comments from Wales Audit Office Citizen Survey

I was in pain more days while waiting for my operation. I was eating very little due to the pain and needing to take prescription painkillers very often. My work and whole life was affected.

My condition gradually deteriorated. I gradually became more breathless and had greater chest discomfort/pain. My mobility decreased and hobbies such as gardening were no longer able to be enjoyed by me. I even had to pay someone to mow my lawn!

I couldn't see where I was going and had a few falls and was bumping into things. I became afraid to go out and everyday tasks became a nightmare.



Scotland and England are performing better against more stringent referral to treatment time targets

- 1.12 The four countries of the UK have adopted different approaches to managing and measuring waiting times. As the Nuffield Trust highlights, these differences make comparing performance very difficult¹⁴. Like Wales, Scotland and England have targets covering the full period from referral to treatment. But the targets are based on a waiting time of 18 weeks: shorter than the 26-week target in Wales. Therefore, direct comparison against the targets is not possible. Northern Ireland has separate targets for stages of the patient journey which prevents direct comparisons to other parts of the UK both in terms of the targets themselves and performance against them. However, in theory the total maximum wait permissible within targets in Northern Ireland is longer than in other parts of the UK. In addition to the different targets, there are other factors that make comparison difficult. For example, the countries have different rules as to when NHS bodies can 'adjust' the waiting times of a patient ([NHS Waiting Times for Elective Care in Wales: Technical Report](#), paragraph 1.15). In a further difference, the waiting times targets in Wales apply to a wider group of patients than other parts of the UK¹⁵. This does mean that the published RTT figures in Wales give a more complete picture of the number of patients waiting for treatment.
- 1.13 [Figure 5](#) sets out the targets for each country and performance as at March 2014. It shows that England and Scotland are performing better against their more stringent targets. Scotland met its 18-week target while England met its target for non-admitted patients but just fell short of its target for admitted patients.
- 1.14 Average (median) waiting times give an indication of the relative lengths of wait for patients in the different countries. Currently England is the only part of the UK that reports median waiting times for the full patient pathway based on the open measure. While there are some differences in how the data is measured – figures for Wales include adjustments while those for England do not – and which patients are included (see [paragraph 1.12](#)), it is possible to make a broad comparison between Wales and England. [Figure 6](#) shows the median waits of patients on a waiting list in England and Wales during 2013-14. In Wales, median waiting times ranged from nine to almost 11 weeks during the year compared to five and six weeks in England and North England¹⁶. England also reports figures for patients facing the longest waits: known as the 95th percentile¹⁷. These figures are not published in Wales, but the Welsh Government has data to show 95th percentile waiting times in Wales. [Figure 7](#) shows that 95th percentile waiting times in Wales were around 33 weeks in Wales in 2013-14 compared to about 19 weeks in England and North England.

¹⁴ Nuffield Trust, [The four health systems of the United Kingdom: how do they compare?](#) 2014

¹⁵ In Wales, direct GP access diagnostic and allied health professional services is included in published data but we have removed these figures as they are not included in England and Scotland. There are some other differences in data as some consultant-led services are excluded from the published figures in Scotland.

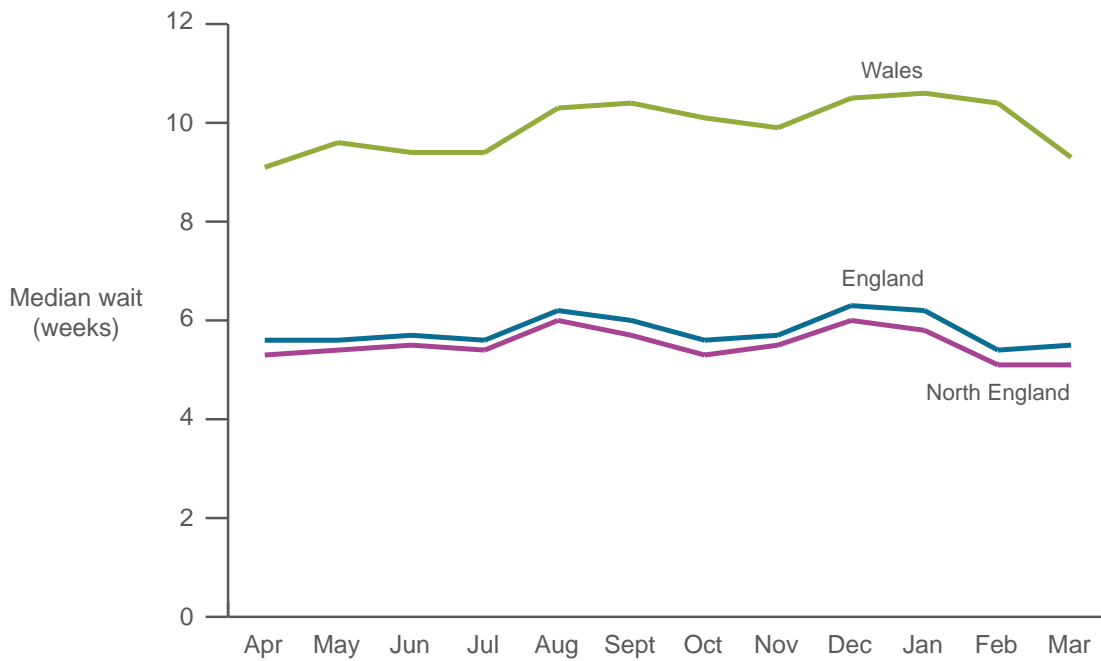
¹⁶ Differences in performance could reflect demographic issues, with Wales having an older population and specific issues around deprivation. We have therefore included figures for the north of England. Historically, the north east of England has been used as a comparator for Wales. However, changes to the structure of the NHS in England mean that the data for the north east is no longer published. The closest comparator is therefore the north of England, which includes the north east and north west of England.

¹⁷ The 95th percentile is an indicator of long waits. If there were 100 patients in the queue lined up in order of time they had been waiting, the 95th percentile would be the length of time the person in 95th place had been waiting.

Figure 5 – Comparison of targets and performance across the UK

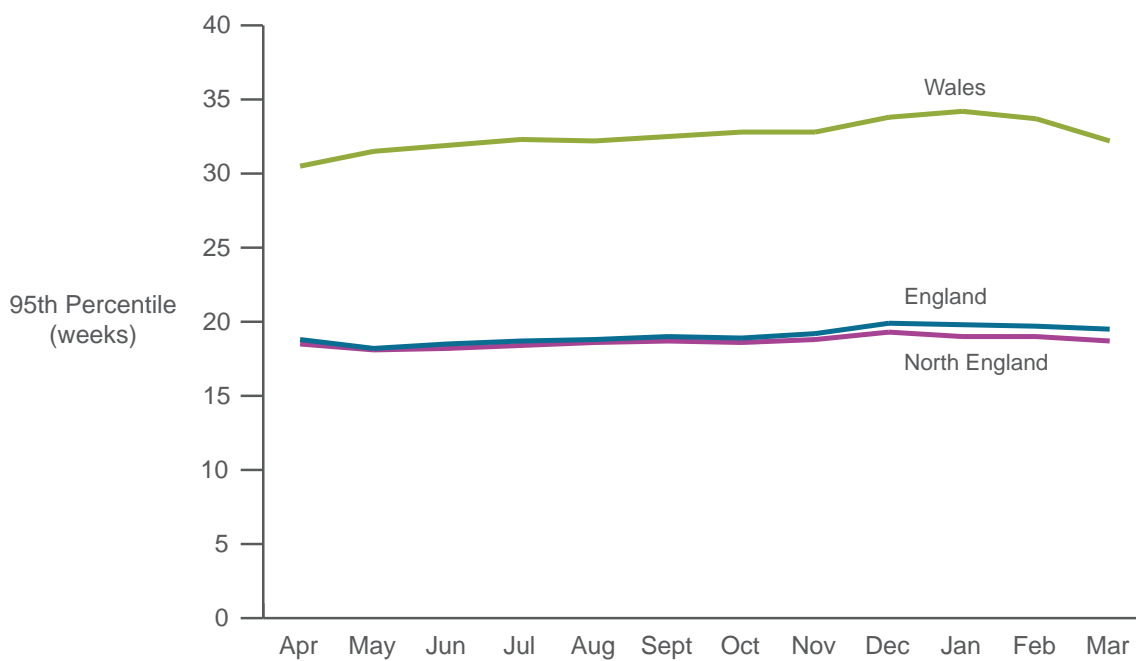
Target	Performance as at March 2014
<p>Wales</p> <p>95 per cent of patients on the waiting list should have waited less than 26 weeks from the date of their referral. Nobody should be waiting more than 36 weeks for treatment.</p>	<p>89 per cent of patients on the waiting list had waited less than 26 weeks and three per cent had been waiting more than 36 weeks.</p>
<p>England</p> <p>95 per cent of non-admitted patients to start treatment within 18 weeks.</p> <p>90 per cent of admitted patients to start treatment within 18 weeks.</p> <p>92 per cent of patients on the waiting list should be waiting less than 18 weeks.</p>	<p>In England, 89 per cent of patients who were admitted to hospital and 96 per cent of non-admitted patients started treatment within 18 weeks. Of those on the waiting list, 94 per cent had been waiting less than 18 weeks.</p> <p>In the north of England 91 per cent of patients who were admitted and 97 per cent of non-admitted patients started treatment within 18 weeks. Of those on the waiting list, 95 per cent had been waiting less than 18 weeks.</p>
<p>Scotland</p> <p>90 per cent of patients to start treatment within 18 weeks, within which:</p> <ul style="list-style-type: none"> • 95 per cent of patients waiting for a first outpatient appointment should be waiting less than 12 weeks; and • all patients to start treatment within 12 weeks of the decision to treat. 	<p>90 per cent of patients started treatment within 18 weeks.</p> <p>97.3 per cent of new outpatients had been waiting 12 weeks or less for an appointment.</p> <p>97.3 per cent of patients were treated within 12 weeks (covers the quarter to March 2014).</p>
<p>Northern Ireland</p> <p>From April 2013, at least 70 per cent should wait no longer than nine weeks for their first outpatient appointment and none should wait more than 18 weeks, increasing to 80 per cent by March 2014 and no one waiting longer than 15 weeks.</p> <p>From April 2013, no patient should wait longer than nine weeks for a diagnostic test.</p> <p>From April 2013, at least 70 per cent of inpatient and day cases should be treated within 13 weeks and none should wait more than 30 weeks. This increased to 80 per cent by March 2014 with no patient waiting longer than 26 weeks.</p>	<p>Of those patients on an outpatient waiting list, 31 per cent had been waiting more than nine weeks and 15 per cent had waited more than 15 weeks.</p> <p>Of those on a waiting list for a diagnostic test, 15 per cent had been waiting more than nine weeks.</p> <p>Of those waiting for inpatient treatment, 33 per cent were waiting more than 13 weeks and nine per cent more than 26 weeks.</p>

Figure 6 – Median waiting times for patients on an open pathway in England and Wales 2013-14



Source: Wales Audit Office analysis of Welsh Government and UK Government data

Figure 7 – 95th percentile waiting times for patients on an open pathway in England and Wales 2013-14



Source: Wales Audit Office analysis of Welsh Government and UK Government data

1.15 There is some comparable data for waiting times for the inpatient part of the patient journey. The Nuffield Trust has reported median wait for patients for seven common procedures¹⁸. The data shows an overall picture whereby between 2005-06 and 2009-10, median inpatient waits in Wales broadly matched Northern Ireland and were getting closer to those of England and Scotland. However, since 2009-10 median waits in Wales have increased significantly and in 2012-13 were much longer than Scotland and England¹⁹.

Some patients wait longer than the official recorded waiting times show and there is scope to use the existing data to better reflect patient experiences

1.16 The reported figures do not fully reflect the actual length of time some patients have been waiting. Welsh Government guidance sets out several scenarios in which the patient 'clock' can be reset back to zero, including where the patient cancels an appointment or does not attend. We consider the rules on clock stopping and how they compare with England and Scotland in [NHS Waiting Times for Elective Care in Wales: Technical Report](#), paragraph 1.15. The waits can also be adjusted if patients are unavailable for social or medical reasons. Clock resets in particular can result in significantly lower official waiting times than the actual waits patients have experienced. There is no national data on clock resets and health boards are not routinely capturing the information. There were around 38,000 cancellations of operations due to 'patient reasons' in 2013-14. According to the rules, in each case there should have been a clock stop or reset. There are cancellations at other stages – outpatients, diagnostics and pre-surgical assessment – which would also stop or reset the clock but these cancellations are not routinely measured by health boards. Data from one health board shows that clock stops or resets can result in significant differences between officially reported waits and actual waits:

- a one patient waited 68 weeks but the official wait was two weeks;
- b another waited 81 weeks with an official wait of five weeks; and
- c another 86 weeks with an official wait of seven weeks.

1.17 Unlike England, the data for Wales does not distinguish between admitted and non-admitted patients. The majority of patients on the waiting list will only require an outpatient appointment and will not go on to require an inpatient or day-case procedure. Because patients waiting for inpatient or day cases are in the minority, long waits for these patients can be masked by the overall figures which cover all patients and the whole period from referral to treatment. Our analysis of the open measure data showed that across 2013-14, around 30 per cent of patients waiting for an inpatient or day-case procedure had been waiting more than 26 weeks with around 11 per cent waiting more than 36 weeks.

¹⁸ Nuffield Trust, [The Four Health Systems of the United Kingdom: how do they compare? 2014](#)

¹⁹ Data for Northern Ireland for the period since 2009-10 is not available.

- 1.18 The published data does not show waits at different stages of the patient journey. We think that it would be helpful for patients to know how long they are likely to wait at the different points. The Welsh Government stopped measuring the 'component' parts of the patient journey in 2009-10 when it started measuring the full referral to treatment time. It started to again measure the components in September 2011 but does not publish this data.

Part 2

The main reason for long waiting times is the inability, despite a lot of effort, to sustainably match supply with patient demand



2.1 This part of the report considers the key causes behind the relatively poor performance of NHS Wales in relation to long waiting times and patient experiences. Fundamentally, the cause of long waiting times is that the NHS has not carried out sufficient activity to meet demand. Elective admissions have reduced since 2010-11 while demand has continued to grow steadily. With less activity to meet rising demand, a backlog has grown and waiting times have got longer. The analysis that follows looks in more detail at how this situation has arisen: the strategic direction that the Welsh Government has set and its management of the whole NHS to deliver waiting times targets. We then look at the underlying causes at a local level, including local planning and the use of resources.

The Welsh Government did not adequately consider how to sustain waiting time performance after 2009 and its approach to performance management has not been successful in securing achievement of waiting time targets

2.2 In common with several other political administrations around the world, the Welsh Government's strategy for securing timely access to healthcare treatment revolves around the delivery of waiting times targets. Based on an international review, the OECD has found that waiting times guarantees or targets are an effective part of a waiting times strategy²⁰. However, the OECD found that they need to be underpinned by a method for ensuring that performance is improved and sustained. The OECD points to two methods associated with success:

- a 'Targets and terror' – A euphemism for a form of hard performance management previously used in England and Finland whereby providers and senior managers faced tough sanctions for failure to meet the targets. The OECD reports that this approach, while effective in the short-term, is difficult to sustain over a long time.
- b 'Targets and choice' used now in England as well as Portugal, the Netherlands and Denmark, where patients can choose providers with lower waiting times.

2.3 The Welsh Government's approach to performance management in relation to NHS waiting times has varied over time. Previously, the Welsh Government had a detailed project plan, Access 2009²¹, to achieve the 26-week referral to treatment time target by December 2009. The plan involved an additional non-recurrent £80 million over four years. This funding aimed to deliver sustainable changes to the way health boards provided elective services as well as creating short-term capacity – through 'waiting list initiatives' (see **Box 2**) to address the backlog of long-waiting patients. The funding to NHS bodies was contingent on the Welsh Government agreeing annual local delivery plans which set out a detailed assessment of demand, capacity and planned improvements in efficiency such as reducing length of stay and increasing day surgery. Failure to deliver the targets was accompanied by financial sanctions, more detailed monitoring (in some cases daily) and intervention from the Delivery and Support Unit.

²⁰ OECD, *Waiting times policies – what works?* 2013

²¹ See 2009 Access Project Welsh Health Circular.

Box 2: Waiting list initiatives

Waiting list initiatives involve paying NHS staff to work outside their core hours – generally at weekends – to carry out elective activity. They can also involve commissioning elective activity from other private or NHS health providers. This activity has traditionally been classed as ‘additional’ rather than part of ‘core’ NHS elective activity. Waiting list initiatives have been used in the past to address long waiting times. They are often an essential part of a strategy to reduce a backlog of long-waiting patients. These types of initiatives mean the NHS does not create capacity/recruit staff that will not be needed once the backlog is cleared. However, waiting list initiatives are not a sustainable approach to balancing demand and capacity. They are a more costly way of delivering activity and they place pressure on medical staff who are being asked to work extra hours. Our local fieldwork suggests that staff are increasingly reluctant to take on this kind of work.

- 2.4 The Access 2009 project achieved its aim of meeting the 26-week referral to treatment time target in December 2009. However, no evaluation was undertaken by the Welsh Government to assess whether the project had been successful in supporting the re-shaping of local services to create a health system capable of sustaining waiting time target performance. Without this information, the Welsh Government was not in a position to know whether the achievement of the target was attributable to the strengthened performance management and additional funding that accompanied the Access 2009 project. Nor did it assess whether proper foundations had been laid to sustain waiting time performance beyond the life of the project. The Welsh Government did, as part of its routine performance management, recognise that the major challenge would be ‘ensuring that supply and demand are balanced in an efficient, effective and economic manner’ and set out a range of detailed remaining issues, including clearing some remaining backlog²².
- 2.5 The period following the achievement of the targets coincided with changes in leadership in the Welsh Government Department for Health and Social Care and a different approach by the Welsh Government to managing the NHS. The Welsh Government stopped requiring NHS bodies to produce and agree the detailed local delivery plans setting out demand and capacity. Also, it stopped imposing financial sanctions for organisations that failed to meet waiting times targets.
- 2.6 The Welsh Government has maintained a systematic approach to the monitoring and challenging the performance of health boards since 2011. However, this has not been effective in improving waiting times. Our review of performance management meetings and communication shows a pattern whereby the Welsh Government insists that health boards produce trajectories showing they will meet the waiting times targets by the end of the financial year. The health boards produce trajectories, but these are generally very optimistic and are quickly missed. The health boards then provide explanations and new trajectories which are again quickly missed.

22 NHS Wales, *Annual Operating Framework 2010/2011*

- 2.7 The introduction of a new planning framework with a requirement for NHS bodies to produce three-year integrated medium-term plans has provided a stimulus for greater rigour to be introduced into NHS planning and performance management. The new arrangements mean the Welsh Government now requires a higher level of detailed information on capacity and demand: reintroducing some of the rigour associated with local delivery plans. But the impact of the new arrangements on elective waiting times is yet to be seen: despite health boards submitting plans for 2014-15 showing they would meet the targets, performance across Wales has continued to deteriorate.
- 2.8 Tellingly, the deterioration of waiting times has also coincided with unprecedented financial pressures for the NHS. The period during which the NHS improved waiting times performance was characterised by additional specific funding alongside real terms increases in spending across the NHS. As our work on health finances has shown, since 2010-11, the Welsh Government has adopted a different approach to protecting health spending from other parts of the UK. It has reduced spending in real terms and in 2013-14 spending per head of population in Wales was 12 per cent lower than in the north east of England.
- 2.9 We have seen no evidence that the Welsh Government has systematically assessed the impact that funding pressures would have on elective waiting times. When it became clear that waiting times were deteriorating, the Welsh Government did not re-assess the realism of its expectations in terms of delivering the targets. Nor has it robustly tested whether the most clinically urgent patients have been appropriately prioritised and protected during the period of declining performance. The Welsh Government intends that the Planned Care Programme and prudent healthcare principles will enable it to better understand and respond to the financial pressures (see [Part 3](#)).
- 2.10 In response to the decline in performance, the Welsh Government has provided health boards with additional short-term funding to support waiting list activity. There have been some positive efforts to encourage sustainable reform of services for orthopaedics and cardiac patients, accompanied by funding for short-term waiting list initiatives within the NHS and in the private sector. In February 2014, the Welsh Government decided to allocate an additional, non-recurrent, £2 million to health boards to carry out extra activity to accelerate their plans to reduce the number of patients waiting over 36 weeks by the end of March 2014. Whilst extra funding is always likely to be welcomed by NHS bodies, the Welsh Government recognises that it is not a long-term solution. Managers reported that when the funding became available in February 2014, it was increasingly difficult to convince clinicians to take on waiting list initiative work and some struggled to do the work by the end of March.

2.11 The Welsh Government clearly cannot be involved in the day-to-day management of waiting times. Until recently, it has focused on setting the policy direction through the target and providing challenge to the planning and delivery through performance management. In support of its performance management, it has provided some direction to health boards on the need for better planning and to improve efficiency. This is supported by in-year support and intervention by the Delivery Unit. However, the scale of the deterioration in waiting times and its coincidence with the period of austerity point to a need for an approach that is wider than just performance management against a national target. The Welsh Government has recognised the need for a broader approach. **Part 3** of this report shows how the principles and ideas that are emerging as part of the 'prudent healthcare' and the Planned Care Programme alongside the three-year planning framework show how the Welsh Government is now moving towards clearer strategic leadership across the elective care system, although some significant issues remain to be worked through.

Health boards' planning of waiting times is generally unsophisticated and they have struggled to prioritise waiting times against competing pressures

Health boards' planning is hampered by a lack of sophisticated analysis of demand and capacity and plans are generally over-optimistic

- 2.12 Our review of health boards' self-assessments and local fieldwork found that, in general, health boards are struggling with planning for lower waiting times. Their plans are generally driven by the need to meet the targets. They produce plans showing what capacity is required in order to meet the targets by the year-end. In general, they identify likely demand using the previous year's activity and capacity in terms of the availability of consultants to provide outpatient and inpatient services. Health boards then set out the gap between the capacity they think they have and what they need in order to meet targets.
- 2.13 Before 2010-11, the capacity gap would have been filled to a large extent through funding for waiting list initiatives. However, financial pressures mean that is increasingly unavailable as an option. Over the period of Access 2009 and the subsequent decline in performance, health boards have not been able to plan and deliver new ways of working to sustainably match supply and demand without the need for waiting list initiatives. Generally they have continued to improve efficiency (see **paragraphs 2.35 to 2.44**) but have not radically re-shaped service provision, reduced activity that may have limited benefit for patients (see **paragraph 3.3**), or shifted activity away from hospitals in the ways they had originally intended. Nonetheless, there are some examples of good practice but these are not generally widespread (see our Good Practice Compendium).

- 2.14 Our review of health boards' plans showed that many do not have sophisticated information about demand which means that their analysis of the gaps can be unrealistic²³. Demand, as measured by GP referrals, is rising²⁴. But health boards have a fairly limited understanding of the drivers behind that increase, changes in the pattern of demand nor how much can be prevented by seeing and treating patients in different ways and in different care settings. Some have carried out demographic and population analysis, but generally this is focused on a small number of conditions such as diabetes and dementia and not incorporated into local elective care plans. Health boards do not have standardised information about the reasons that patients are referred for outpatient appointments: only what is in individual referral letters. As a result, health boards have very little population-level data about why patients are being referred for elective care, to inform their planning.
- 2.15 Our review found that health boards are not using factors such as age, complexity and co-morbidity²⁵ to match demand and capacity. As a result, plans do not take into account issues such as variation in the length of appointments patients will require, and the length of time in theatre different types of patients will need for their operations. Further, many health boards' plans do not consider bed availability and bed use. All health boards are conducting assessments of bed capacity to understand where possible surplus or shortfalls exist but it is difficult to see the link between these models and plans to match capacity to meet waiting list demand.
- 2.16 The availability of consultants is the primary capacity constraint that determines health boards' plans. Some health boards have sought to take account of constraints on staff capacity, such as annual leave and on-call duties, whereas others assume consultants will be available for the 42 weeks set out in their work contracts. Only one health board had incorporated expected levels of staff sickness on the availability of consultant capacity.
- 2.17 We have no doubt that health boards are committing much time and effort in trying to implement their plans. The senior managers and clinicians we met with feel under considerable pressure to improve performance and meet the targets. All of the health boards we visited had frequent meetings of senior managers that focused on delivering the planned trajectories. At these meetings, it was clear that the key barriers were being identified and action taken to address them. Nonetheless, despite the clear commitment and effort, for a variety of reasons – many of which are explored below – they were finding it increasingly difficult to bridge the gap between the capacity they have and what they need in order to achieve the reductions in waiting times they intended to achieve.

²³ We do not have information on demand and capacity modelling from Powys Teaching Health Board. The health board has commissioned an independent review of demand and capacity which reported in December 2014.

²⁴ Patients can be referred for treatment from other sources such as optometrists which are not included in these figures.

²⁵ The term 'co-morbidity' describes two or more disorders or illnesses occurring in the same person.

Health boards face real capacity constraints with lower levels of funding and staffing than comparable areas in the UK and pressure on bed capacity, especially from unscheduled care

- 2.18 The period of declining elective waiting time performance has coincided with an unprecedented squeeze on finances across the NHS. One senior clinician told us when we asked about the causes of performance 'if it weren't for the financial position we would not be having this conversation'. The process through which financial pressures translate into decisions about capacity is complex. Most health boards have reduced the use of 'waiting list initiatives'. And some health boards have curtailed 'backfill', where a consultant is paid to cover sessions when another consultant is unavailable due, for example, to illness or annual leave. Some health boards decide to reduce activity in this way during the financial year as a result of wider financial pressures. As a result, they find themselves less able to bridge the gap between existing capacity and what is required to meet waiting times targets. Many health boards have emphasised that they have reduced 'additional' rather than 'core' activity. By this, they mean that they classify treatment paid for through waiting list initiative funding and backfill as 'additional' and not 'core'. In our view, this is an unhelpful distinction. From a patient perspective, all such activity is core, regardless of how it is funded.
- 2.19 On top of reducing or stopping additional activity at premium rates, other savings such as curtailing the growth in staffing levels or not recruiting to vacancies and reducing the number of hospital beds can also impact on waiting times. Across the elective care system, staffing and beds are the two primary capacity constraints that stop NHS Wales being able to balance supply and demand.
- 2.20 Delivering a balance between demand and capacity without being over-reliant on extra activity means having sufficient permanent staff to deliver the activity. We have compared some of the staffing characteristics in Wales to those in the north east of England. Medical staffing levels per head of population are lower in Wales (186 per 100,000 people) than the north east of England (219 medical staff per 100,000 people). In particular, Wales has fewer senior clinicians per head of population (73 per 100,000 people in Wales compared to 88 in the north east of England). Several health boards told us they had difficulty recruiting to some specialities. There are further challenges with the growth of sub-specialisation, where many consultants now specialise in a much narrower set of treatments than in the past. This causes problems of a lack of resilience: in some cases, there may be only one sub-specialist in a health board or region. If the sub-specialists are ill or unavailable, patients often have to wait longer.

- 2.21 The question of whether health boards have sufficient bed capacity is a complex one. Bed numbers have reduced significantly over the past 20 years. In 2012-13, Wales had slightly more beds per head of population than the north east of England, but was on a faster downward trajectory. More important than the bed numbers is the bed occupancy rates. Bed occupancy rates in Wales are considerably higher than the north east of England and most international comparators. They are some way above the 82 per cent that is recommended as safe by the Royal College of Surgeons. High bed occupancy rates are associated with poorer outcomes for patients, and periodic bed crises. High rates of occupancy also make the system more inefficient: for example, it is more likely that patients will be located in beds not intended for their speciality, meaning extra work is required to keep track of them and ensure they receive appropriate care²⁶.
- 2.22 Many health boards told us that in theory they had sufficient bed capacity to meet demand for elective care. However, much of their analysis is based on having all elective beds available at all times, high occupancy rates and assumptions based on how long the average patient stays in hospital. In practice, the length of stay varies from patient to patient. There will be times when wards have several patients who can be discharged quickly (therefore surplus capacity) and at other times there will be several patients who need to stay longer (therefore a lack of capacity leading to cancellations). To manage this variation, there needs to be 'headroom' to manage those periods when capacity is stretched. The lack of headroom as a result of high occupancy levels was reported as a concern by clinicians and managers across the health boards we visited.
- 2.23 The assumption that elective beds will be available for elective patients is not always sound. Elective bed capacity comes under constant pressure from rising demand in other parts of the NHS. In particular, peaks in demand for emergency care mean that emergency patients are sometimes admitted to beds intended for elective patients. Health boards then cancel elective procedures at short notice, much to the patient's frustration. Because emergency patients typically have longer length of stay, our analysis shows that each emergency patient in an elective bed means three elective patients cannot be treated as planned.
- 2.24 There is a particular issue with 'routine patients' facing growing waits where available capacity is prioritised to urgent patients. There has been a rise in the number of, and proportion of, patients referred to a consultant with urgent suspected cancer. As a result, more outpatient capacity is allocated to these patients. When diagnosis is confirmed, cancer patients often have complex needs, requiring longer lengths of stay and longer time in theatre, and so displace multiple elective patients. Whilst national data in this area is not readily available, figures from one health board show that the number and proportion of patients waiting for inpatient or day-case treatment classed as 'urgent' has been growing (Figure 8). With more capacity dedicated to urgent and cancer patients, routine patients end up waiting longer and longer. This 'crowding out' of routine patients as result of prioritisation of scarce capacity explains why routine patients may end up waiting a very long time before reaching the top of the list for treatment.

26 Bagust A, Place M, Posnett JW, **Dynamics of bed use in accommodating emergency admissions: stochastic simulation model**, British Medical Journal 1999. Jones R, **Hospital bed occupancy demystified**, British Medical Journal 2011. Schilling P, Campbell D, Englesbe M, Davis M, **A comparison of in-hospital mortality risk conferred by high hospital occupancy, differences in nurse staffing levels, weekend admission and seasonal influenza**, Medical Care 2010

Figure 8 – Proportion of those on an inpatient waiting list at one health board classed as 'urgent'



Source: Wales Audit Office analysis of health board data

- 2.25 We considered the extent to which facilities such as diagnostic equipment, outpatient rooms and surgical theatres were a cause of long waiting times. We concluded that these are not currently a constraint on the system. For large parts of the evening and at weekends, many of these facilities are hardly used at all. The constraint is the availability of staff to use the facilities seven days a week. Several health boards recognised that staffing elective care seven days a week would improve patient experience and address capacity constraints but told us they were restricted by finances and recruitment problems, and current contractual arrangements.
- 2.26 Although health boards have found it difficult to balance waiting times targets with financial and capacity pressures, the relatively limited information about demand and capacity makes it difficult to reach a definitive conclusion on whether there are in fact insufficient resources to meet the current waiting time targets. More sophisticated planning is necessary in order to understand what demand could be avoided or met by adopting different models of care, in particular by helping treat people in primary and community based care settings. What is clear is that plans which are based upon doing 'more of the same' are going to be financially unsustainable. [Part 3](#) of the report looks at emerging plans and how more radical transformation of services could free up capacity to treat more patients and potentially reduce waiting times.

Despite incremental improvements, existing capacity is not being used to meet demand as effectively as it could be

Despite getting more efficient, the whole outpatient system through which patients get a diagnosis and a decision on treatment is too cumbersome

- 2.27 The purpose of the outpatient system is to provide expertise and advice on treatment, supported by some diagnostic tests where appropriate. It involves a relatively short amount of clinical time. As **Part 1** showed, waiting times for outpatient appointments and diagnostic tests has been growing significantly. Long waits for outpatients can be particularly distressing for patients: they may be desperate to know what is wrong with them, whether it is something serious and what options there are to make them better.
- 2.28 Fundamentally, the cause of long waits for outpatient appointments is a mismatch between demand and supply. The number of patients being referred for a first outpatient appointment has been steadily rising. However, after peaking in 2011-12, the total number of first outpatient appointments has since fallen. Therefore, the outpatient waiting list and waiting times have grown. Because of the limited information that health boards have about demand and capacity, it is not possible to conclude on the extent to which that mismatch is due to a lack of capacity or poor use of existing capacity. Looking at demand, the likelihood that GPs will refer patients to a specialist varies across Wales. This variation suggests that there is scope to reduce the number of people referred for an outpatient appointment although some variation may be due to differences in who is able to refer patients and demographics.
- 2.29 Our assessment and local fieldwork has shown that there is scope to make more efficient use of capacity. Some health boards allocate different lengths of time to each appointment. There is merit in health boards sharing learning to identify an optimal length that balances efficiency with the need for sufficient time for clinicians to talk to patients and provide advice and diagnosis. There is also scope to free up clinical and administrative capacity by addressing unnecessary complexity across the process for getting from the point of a referral from a GP (or other referrer) to setting up an appointment. There are multiple points at which the referral is passed from clinicians to clerks, and back to clinicians. Information about the referral is stored on paper and multiple ICT systems. Patients often end up having multiple contacts with the NHS in order to find out what is happening to them, what they need to do and, ultimately, to arrange for an appointment or a test. Some of the examples where activity could potentially be avoided and capacity redirected to more productive areas, are:
- a **Avoidable activity in 'booking centres'**. Several booking centre staff told us they were struggling to manage the high volume of calls, many of which (some estimated as much as 30 per cent) could have been avoided with better up-front communication with patients. Examples include patients wanting to know how much longer they would have to wait or wanting to know what letters they

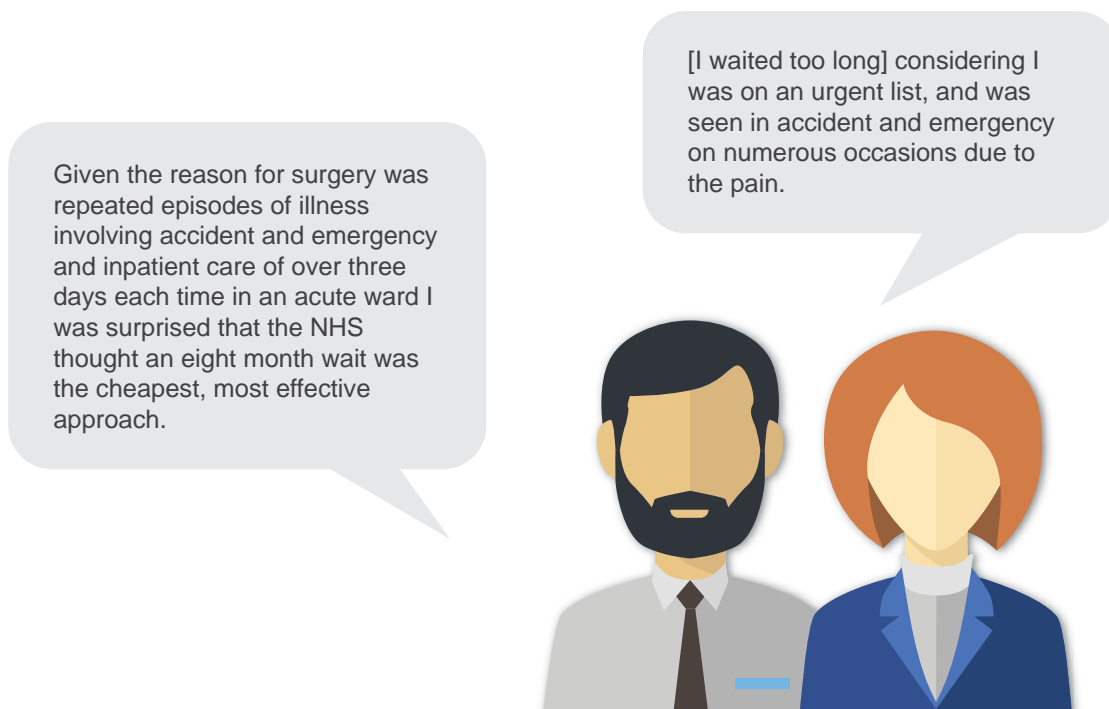
have received actually meant. Further, during periods of high call volumes, some staff were making paper notes rather than entering appointment dates directly on the IT system, thereby increasing the risk of human error.

- b **Duplication of activity entering data onto IT systems** because, for example, electronic referral systems, where they exist, and systems for recording diagnostic test results, do not 'speak to' the main patient database used for managing waiting times. Much of this activity would be avoidable if the ICT systems were compatible, and again, the reliance on duplicate entries increases the risk of human error.
- c **Activity to manage the reliance on paper records**, including having to enter data from electronic referrals and the extensive activity required to organise and physically transport patients' notes so that they are available for the outpatient appointment.
- d **Restriction of diagnostic tests available to GPs** in some health boards means that patients may arrive at their outpatient appointment without results needed to make a diagnosis. The patient therefore needs to wait longer and have an additional outpatient appointment. It also means that GPs have no choice but to refer patients for an outpatient appointment if they feel patients need a particular test.

2.30 Most of the staff we spoke with reported that the ICT systems – in particular the Myrddin patient administration system – were a significant barrier to efficiently managing patients. Specific concerns from booking centre staff included the system creating duplicate records and appointments, and not being set up to easily find the next available appointment when patients call in. Managers reported concerns that the system did not provide them with the detailed management information about demand, activity and capacity that they needed to plan and manage the services.

2.31 There is also a lot of activity, and cost, directly associated with the relatively long waiting times for outpatient appointments. It takes up GP time to monitor patients and contact hospitals to request a review of the patient's priority if they deteriorate. It takes up consultant time to re-assess the priority of the patient. Also, booking centre staff told us they regularly receive calls from patients asking to be prioritised because they have got worse: booking centre staff then have to record the information and advise the patients to visit their GP. Clinicians we spoke to referred to growing numbers of expedite letters being requested and sent. Figures from one health board show that the proportion of patients waiting for a first outpatient appointment classed as 'urgent' has been increasing steadily over the past three years. Also, several patients in our survey reported that they had attended accident and emergency to manage their condition while they were waiting.

Comments from Wales Audit Office Citizen Survey



- 2.32 One example of 'wasted' capacity occurs where patients do not attend their outpatient appointment. The proportion of patients that do not turn up for outpatient appointments had been falling over the decade to 2009-10. However, since then the picture has worsened: 7.6 per cent of patients did not attend their first outpatient appointment in 2010-11; this rose to 8.9 per cent in 2013-14. We look at some ideas to increase rates of attendance in [Part 3](#) and in our Good Practice Compendium.
- 2.33 The majority of outpatient appointments (around two-thirds) are for patients requiring 'follow-up'. In some cases, hospitals may be unnecessarily following up patients who could instead be seen by their GP or other health professional. Having a low ratio of new to follow-up appointments is therefore seen as an indicator of efficiency. The ratio of new to follow-up has been decreasing every year in the decade to 2011-12. However, the current position may not be so positive. There are no specific waiting times targets for follow-up appointments. With health boards focused increasingly on the 26 and 36-week targets, there has been less attention given to the management of follow-up appointments in recent years. Recent national scrutiny on this by the Welsh Government is resulting in health boards reviewing the current number of follow-up patients that are still in the system. Where necessary, health boards will need to manage clinical risks by re-directing capacity towards follow-up patients alongside work to validate and

check whether patients on the follow-up list need to be seen at all. In the short-term, the focus on follow-ups potentially reduces capacity to see and treat new patients. Over the long term, transformation of follow-up services could potentially free up capacity to see more new patients. The management of follow-up outpatient appointments by health boards is currently the subject of a separate review being undertaken by the Auditor General.

- 2.34 In **Part 3**, we consider how NHS Wales' emerging plans could help to re-think and re-shape the outpatient system to better respond to demand and free up consultant time.

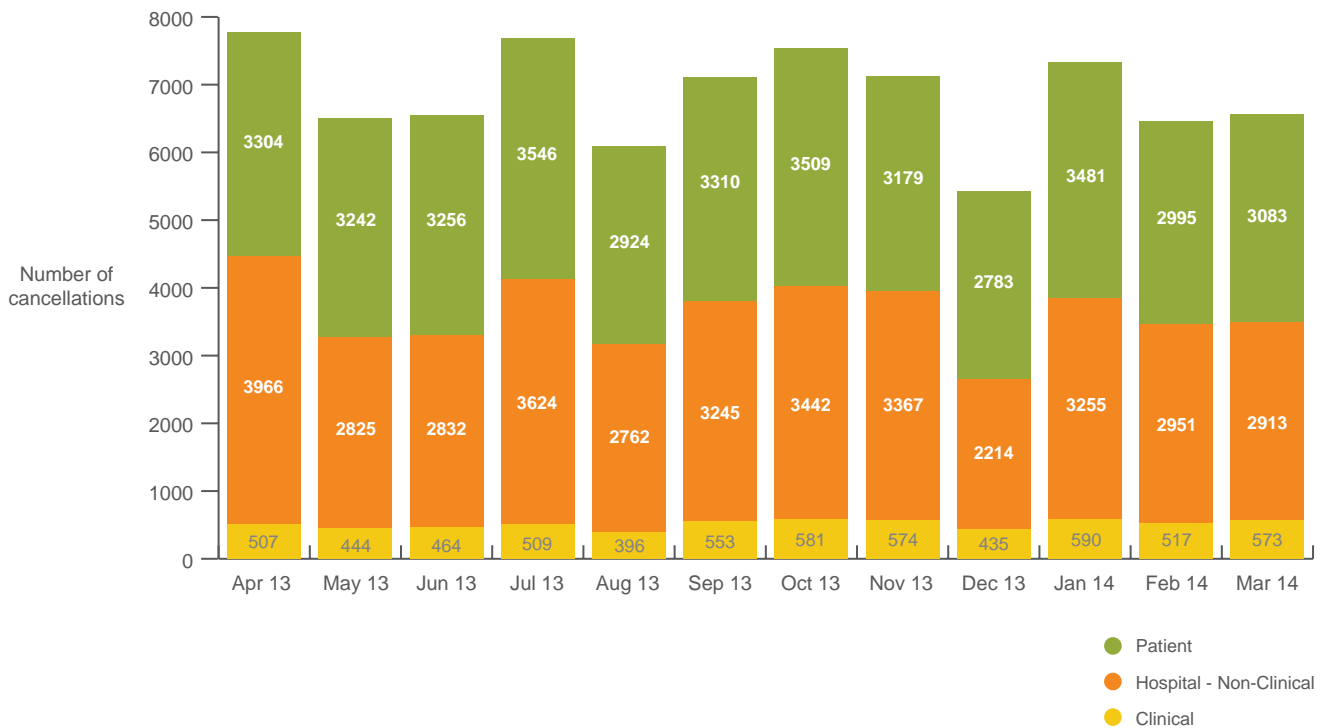
Inpatient services have been getting more efficient incrementally but there remains scope to step up the pace

- 2.35 This section considers the efficiency and effectiveness of the processes and systems to get patients treated as quickly as possible and to help get them back on their feet. In recent years, the NHS in Wales has focused on improving efficiency. During 2010 and 2011, a national Acute Productivity Board provided guidance on the top actions to improve efficiency across a range of areas. More broadly, a suite of efficiency and productivity data is available to help NHS bodies benchmark their performance, and target where specific action is needed. Some key markers of efficiency and productivity are considered in the following sections.

Cancellations

- 2.36 Short-notice cancellations of operations by hospitals are extremely frustrating for patients, while short-notice cancellations by patients can mean that scarce resources go unused. In 2013-14, there were 82,151 cancellations. Health boards reported that 38,612 were for patient reasons, 37,396 were cancelled by the hospital for non-clinical reasons and a further 6,143 were cancelled by the hospital for clinical reasons (**Figure 9**). Some patients do not turn up on the day and other reasons recorded for patients cancelling their operations are that the appointment was not convenient and patients no longer wanting the procedure. The main reasons for hospital cancelling procedures include a lack of available clinicians, a lack of ward and critical care beds and administrative error. The need to respond to peaks in unscheduled care will typically be one of the main reasons why health boards cancel elective care procedures.

Figure 9 – Reasons for cancellations



Note

We have some concerns that health boards' recording of the reasons for cancellations is not consistent, so these figures need to be treated with some caution.

Source: Wales Audit Office analysis of Welsh Government data

2.37 Health boards told us that they had experienced fewer cancellations during the winter of 2013-14 than the previous year (Figure 10). The proportion of procedures cancelled due to a lack of beds fell from 5.5 per cent in January 2013 to 2.9 per cent in January 2014. The Welsh Government and health boards invested a lot of time and effort developing plans to learn from and avoid some of the problems seen in emergency care during 2012-13. As part of these plans, several health boards made a planned reduction in activity over the period, with some stopping certain types of elective activity altogether. Health boards are making the decision to not schedule elective activity rather than cancel patients at short notice. While this is understandable and helps avoid high cancellations and frustrations for patients, it has left some health boards with a significant backlog of elective patients after the winter and has contributed to the difficulties in achieving waiting time targets.

Comments from Wales Audit Office Citizen Survey

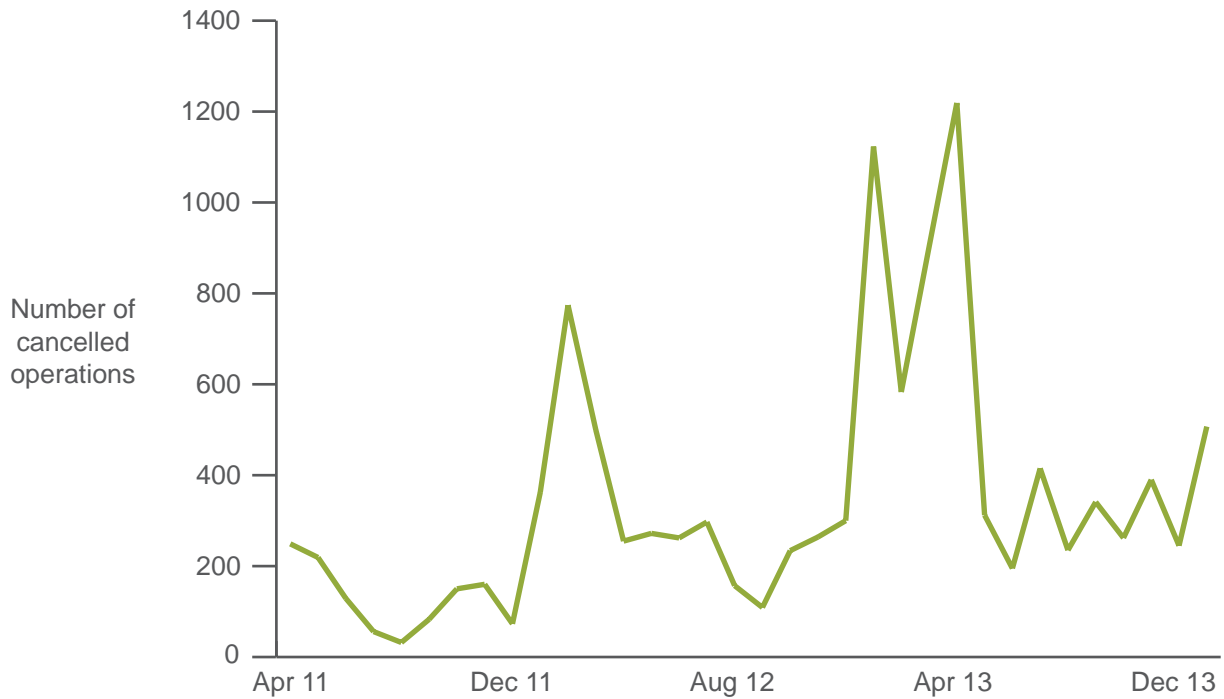
My operation was cancelled on seven occasions between February 2011 and November 2013, because of the lack of beds and the lack of communication between the departments (surgical and anaesthetics).

I was admitted, there was a bed, I was gowned up and ready to go to theatre and was told by the nurse on duty my operation was cancelled as there was an emergency and the consultant wouldn't have time. I was sent home with no future date and when I telephoned the waiting list clerk they couldn't offer me a new date.

It was difficult being deferred so often due to lack of beds, as arrangements at home had to be cancelled and rearranged each time.



Figure 10 – Cancelled operations at short notice due to lack of beds



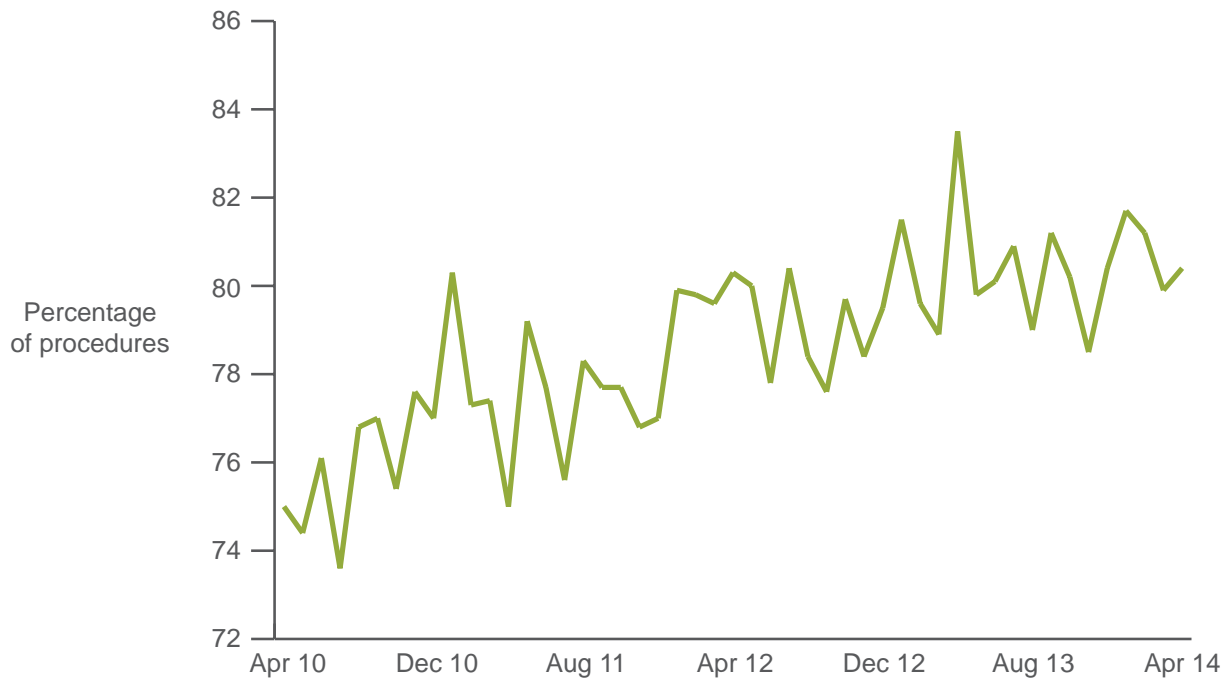
Source: Wales Audit Office analysis of Welsh Government data

Day surgery

2.38 Treating people as a day case is generally more efficient and is better for patients because they can get back on with their lives and are less exposed to the risks of hospital-acquired infections. Health boards have put a lot of effort into increasing the rates of day-case surgery for specific procedures where day surgery is known to be appropriate. The British Association of Day Surgery (BADS) has a list of 50 such procedures known as the BADS basket. Across Wales, the proportion of such procedures that are carried out on a day-case basis has increased steadily over the past three years (Figure 11)²⁷. This is a positive development and maintaining this direction of travel will assist in more efficient use of elective capacity.

²⁷ The rate of other elective procedures carried out as day surgery has also increased from April 2010.

Figure 11 – BADS 50 procedures carried out as day surgery



Source: Wales Audit Office analysis of Welsh Government data

Theatre efficiency

2.39 The Auditor General is currently reviewing the use of theatres in six health boards. Emerging findings from that work suggest significant scope to make better use of expensive operating theatre time. Specific themes emerging from the work include:

- a Problems freeing up beds for surgical patients causing procedures to be cancelled or delayed, with knock-on effects for other patients.
- b Weaknesses in the way that theatre lists are planned, in terms of the numbers and order of patients having their surgery on any particular day. These weaknesses can result in late starts, last-minute disruption to the order of operations, cancellations of patients' procedures and early finishes.
- c Many causes of inefficiency in theatres are not directly due to problems within theatres. For example, if patients are not assessed properly before their hospital admission, this can cause delays on the day of their surgery. And some patients have to wait in theatres after their surgery because there are difficulties freeing up a ward bed for them to return to.

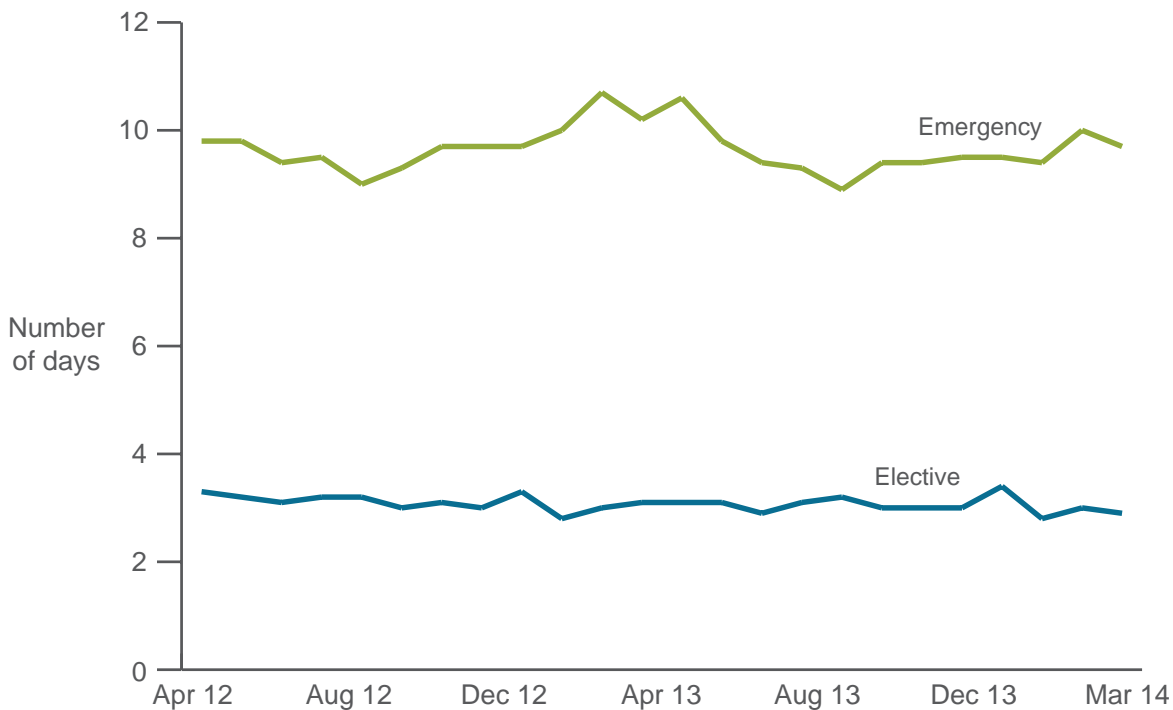
- d There are some real weaknesses in the data available to assess theatre performance. A lack of good performance indicators and problems with data systems mean that some theatres have very little robust information that staff can use to drive improvement.

2.40 The Auditor General's work on operating theatres will result in specific local recommendations to the health boards concerned.

Length of stay

2.41 To increase the availability of beds, NHS bodies can improve throughput, by getting patients in and out more quickly so that the bed can be used by somebody else. **Figure 12** shows that the average length of stay for elective patients has been reducing over recent years, from 3.2 days in April 2012 to 2.9 days in March 2014, (a reduction of 10 per cent). Health boards have managed to broadly sustain emergency length of stay during a period of increasing complexity and co-morbidity of emergency patients, particularly older patients. But they have struggled to secure a reduction in emergency length of stay.

Figure 12 – Average length of stay for patients



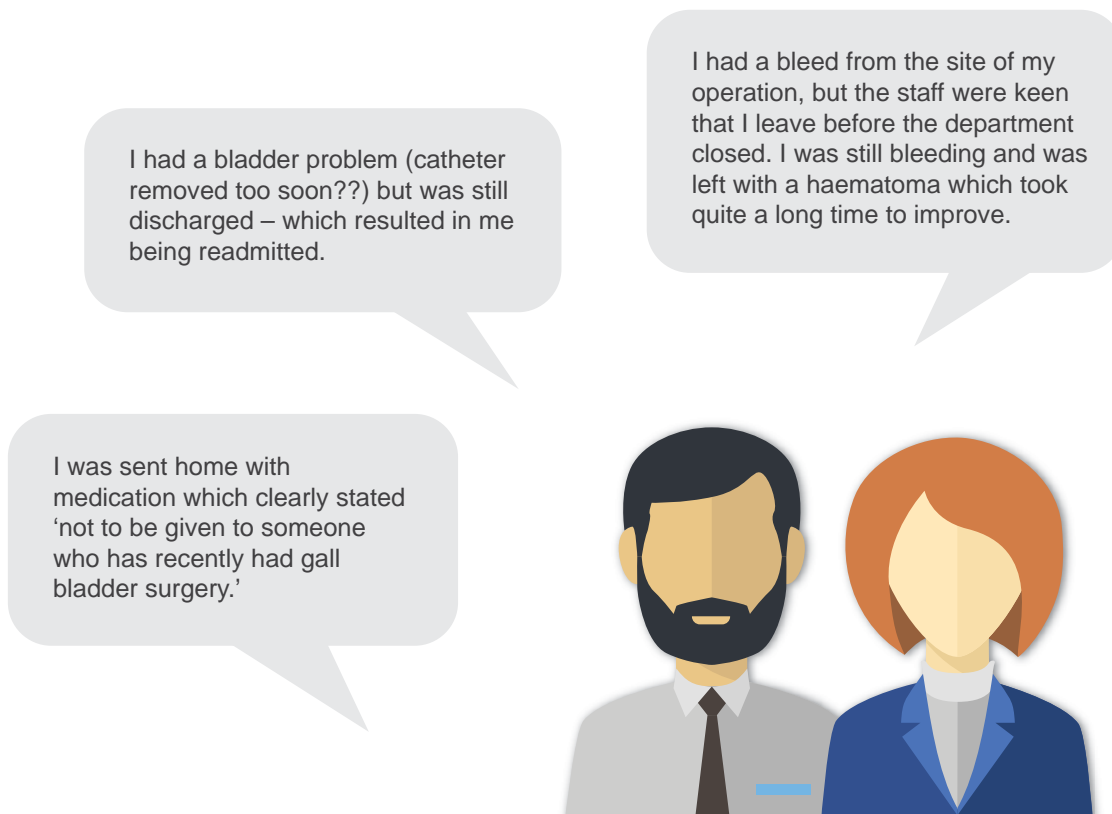
Note

The elective figures cover elective patients for whom there is a length of stay target. It does not include all specialities. Emergency data does not include patients who stayed less than one day.

Source: Wales Audit Office analysis of Welsh Government efficiency dataset

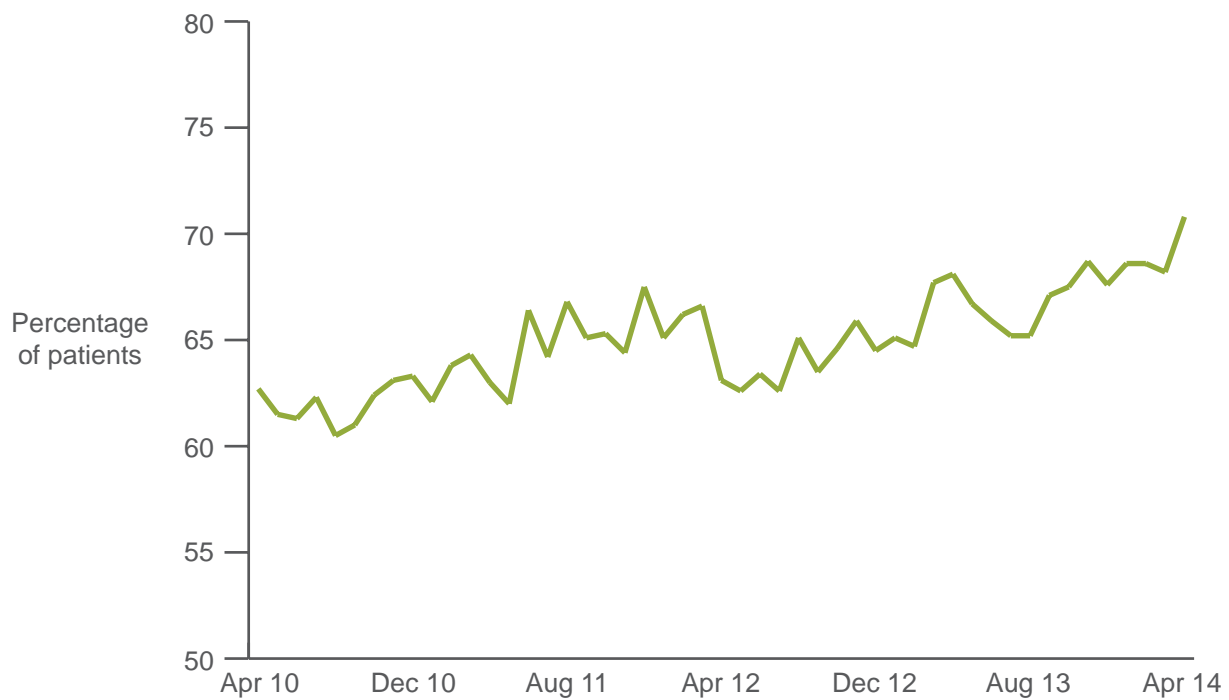
- 2.42 There is considerable variation between health boards in terms of length of stay of both elective and emergency patients, which indicates that some may be making more efficient use of beds than others. We consider some examples of how length of stay can be reduced in [Part 3](#).
- 2.43 There is a need for some caution around the impact on patients of reducing lengths of stay. Overall, one in twelve patients in our survey– and one in five gall bladder patients – felt they had been discharged from hospital too soon. Some reported that they had to be re-admitted to hospital, some were given the wrong medication or not given advice and other patients felt that they did not have enough time to recover in hospital before being sent home.

Comments from Wales Audit Office Citizen Survey



2.44 The proportion of patients who are admitted on the day that their surgery is planned provides an indicator of the efficient use of bed capacity. There has been a sustained improvement overall but the pattern prior to August 2013 seems to be one of increases followed by sharp reductions (Figure 13). The sharp drops seem to follow periods of high cancellations due to lack of beds. The sustained rise during 2013-14 corresponds to a period where cancelled procedures had reduced. Our hypothesis, based on the findings of the review of cardiac care in Morriston Hospital²⁸, is that during periods of high cancellations, clinicians lose confidence that the bed will be available if the patient is not already admitted the day before.

Figure 13 – Proportion of patients admitted on the day of surgery



28 Stephen Dorman, *Cardiac Surgery Waiting List Mortality*, 2013

- 3.1 This part of the report looks at the Welsh Government's plans for improving performance on waiting times. It looks in particular at the emerging ideas and plans for re-shaping the elective care system. It considers the broader work looking at re-thinking the purpose of the elective care system and how performance should be measured, with a particular focus on shifting towards measuring outcomes.

Through prudent healthcare in particular, the NHS is now challenging the current design of the elective care system

- 3.2 The Welsh Government is placing significant emphasis on the emerging 'prudent healthcare' agenda, initially developed by the Bevan Commission. The analysis that follows shows how the principles of prudent healthcare – as set out by the Welsh Government in 2014²⁹ – could be used to identify how the elective care system could be more 'prudent' and deliver shorter and/or more clinically appropriate waiting times for patients. The five principles are:
- a Do no harm.
 - b Carry out the minimum appropriate intervention.
 - c Organise the workforce around the 'only do what only you can do' principle.
 - d Promote equity. The principle that it is the individual's clinical need which matters when it comes to deciding NHS treatment.
 - e Remodel the relationship between user and provider on the basis of co-production.

There is potential to free up significant capacity by implementing the principle of 'do no harm' and reducing activity where the risk of harm outweighs the clinical benefits

- 3.3 The principle of 'do no harm' means that the NHS should not carry out procedures where the risks outweigh the potential benefits. Some clinical procedures are known to be of limited clinical effectiveness for many but not all patients³⁰. Despite longstanding guidance to reduce the volume of these procedures and all health boards having policies or plans to reduce the rates of these procedures they are still carried out in relatively high volumes across Wales. Our analysis shows that in 2012-13, the total cost of providing these procedures to admitted patients was around £51 million and in terms of capacity, these procedures took up around 44,358 bed days. We have not examined how many of these procedures were appropriate according to clinical guidelines³¹. The Welsh Government³² is developing revised national guidelines for such procedures supported by an enhanced compliance regime for local health boards and trusts. Given the

²⁹ Prudent healthcare

³⁰ Based on work by Public Health Wales Observatory for Betsi Cadwaladr University Health Board, **Demand and Variation in Elective Surgical Procedures**, Public Health Wales Observatory, 2010 and **Variation in elective surgical procedures across Wales**, Public Health Wales Observatory, 2010. **NHS Waiting Times for Elective Care in Wales: Technical Report** provides more information.

³¹ Further work would be required to determine precisely the number of procedures which had limited clinical effectiveness for patients across Wales.

³² Welsh Government, **Delivering Prudent Healthcare in Wales**, 2014

considerable costs involved, there are potential savings to be found in addressing the level of procedures with limited clinical effectiveness conducted at each health board to reduce unnecessary activity and reduce costs.

There is indicative evidence of scope to free up capacity by implementing the principle of carrying out the minimum appropriate intervention and reducing variation in rates of surgical intervention

- 3.4 There is significant variation across Wales in the rates of surgical intervention. For example, patients aged 75 or over living in Betsi Cadwaladr University Health Board area are considerably more likely than those living in Hywel Dda University Health Board to have a cataract operation. Research literature highlights that such variation is common to all healthcare systems driven by both individual and organisational preferences and practices. Research evidence shows that identifying the underlying causes of variation may present opportunities to reduce harm and to improve quality, cost and clinical effectiveness³³.
- 3.5 The scale of variation raises the question of whether many patients could get better treatment outcomes through a less interventionist approach. Our survey of patients who had knee surgery showed that 10 per cent said that their surgery had either made their symptoms worse or did not improve their symptoms. Nine per cent said their surgery had either made their pain worse or had not improved their pain. Although a small sample, only half of the 95 people who responded to our online survey said that their operation significantly improved their quality of life. Thirteen people told us that their quality of life did not improve and in some cases their health deteriorated.
- 3.6 In order to provide an indication of the scale of capacity that could be freed up by reducing clinical variation, we have carried out some indicative cost calculations for the most common procedures. We looked at 13 procedures that accounted for around 20 per cent of bed days in 2012-13³⁴ and identified variation in intervention rates between health boards across different age ranges³⁵. We calculated that if all health boards reduced their intervention rates to the average, there would be 11,300 (11 per cent) fewer procedures. Such a reduction would enable a capacity gain of 28,000 bed days, with a value of around £16 million. We have not carried out any work to verify that the average is the most clinically appropriate level and these figures can only be seen as indicative as it may be that some areas need to increase levels of intervention. But if a similar figure applied across the whole range of hospital activity, reducing variation in clinical practice could potentially free up significant capacity.

³³ **Variation in elective surgical procedures across Wales**, Public Health Wales Observatory, 2010. **NHS Waiting Times for Elective Care in Wales: Technical Report** provides more information.

³⁴ The total baseline of bed days in this calculation is bed days used by patients undergoing procedures where at least 33 per cent are admitted from a waiting list.

³⁵ Using age ranges helps to account for demographic differences between the populations. However, because the age ranges in the data are broad, we were unable to adjust sufficiently to conclude that our estimates are fully age standardised.

- 3.7 There are several approaches that can be adopted to reduce variation in clinical practice. One approach is to introduce tight clinical thresholds for each procedure and to police them through a compliance regime. Other approaches involve better forms of ‘feedback’ or communication to clinicians, including:
- a providing clinicians with data on their own rates of intervention and those of their peers;
 - b encouraging and enabling greater peer-to-peer learning to share up-to-date practices and provide supportive challenge;
 - c greater feedback from patients on what worked for them and whether interventions actually made a difference to their quality of life; and
 - d enabling patients to have a greater say and involvement in decisions about treatment in the first place (see [paragraphs 3.10 to 3.13](#)).

The outpatient system in particular could be radically redesigned and improved by widening the range of professionals able to provide diagnosis and advice to patients

- 3.8 One of the key barriers to patients getting timely expertise when they are in need of a diagnosis is the lack of capacity of consultants to provide sufficient outpatient appointments to match the number of referrals. The reliance on hospital-based consultants reveals underpinning and longstanding assumptions about who can provide expertise to patients and in what setting. Using the prudent healthcare principle that patients should only see a consultant if nobody else is capable of providing expertise, there is scope to re-think the consultant as the central focus of the outpatient system. Our Good Practice Compendium shows that some health boards are experimenting with alternative approaches to address the capacity gap and challenge these assumptions, such as:
- a having advice provided by other professionals, such as opticians and advanced nurse practitioners;
 - b providing direct support to GPs to enable them to provide advice and treatment without needing to refer – for example, providing telephone advice lines or email for GPs to directly contact consultants;
 - c using technology, for example in tele-medicine, so that patients do not need to attend an outpatient appointment in person; and
 - d developing referral criteria and guidelines, supported by direct communication, so that GPs can be clear about where they should provide advice and diagnosis themselves without referring.

- 3.9 There is also scope to further develop alternatives by better matching provision to known patterns of demand. Although the NHS carried out around 5,000 different types of procedure during 2012-13, just five elective procedures accounted for 21 per cent of all admissions and 31 procedures for 50 per cent of admissions.³⁶ A similar pattern emerges when you look at individual specialities³⁷. Given that a large part of what NHS Wales provides is predictable, there is scope to ensure that a wider range of clinical staff, not just sub-specialists, are able to diagnose these patients and decide on what treatment is required. Indeed, over the long term there may be scope to look at whether GPs and other healthcare practitioners with appropriate training could add patients to the waiting list for the most common procedures without their having to attend outpatients at all. The 2005 NLIAH *A guide to good practice* and the NHS Institute for Innovation and Improvement have advocated using this type of analysis to plan capacity.

There is potential to help reduce avoidable activity and improve patients' experiences through the principle of remodelling the relationship between user and provider on the basis of co-production

- 3.10 The co-production approach has developed in a number of countries. There are many different definitions, but in essence co-production is about public services doing things 'with' rather than 'to' the public. It changes the traditional 'deficit' model of healthcare where the professional instructs the patient based on their greater expertise to an 'asset-based' model where the patient is valued for their understanding of their health and is seen as an expert. Co-production also places greater responsibility on patients to manage their own health in order to reduce the likelihood of them needing healthcare.
- 3.11 Co-production could be a means to reduce variation in clinical decision making as well as improving patient experience. Research evidence³⁸ on 'patient preference misdiagnosis' shows that clinicians tend to assume that patients want the maximum healthcare they can get. In fact, where patients have a greater involvement in making decisions about referral and treatment, their preferences are generally to try alternative approaches to avoid escalating the level of clinical intervention. If there was a greater focus on understanding what the patient wants and helping patients to make decisions jointly with clinicians, a significant amount of elective activity could be avoided altogether. Importantly, this is not about rationing or not meeting need: costly clinical activity could be avoided while still meeting demand by providing patients with the service they want.
- 3.12 Co-production could also help to improve patients' experience of waiting. Our survey showed that patients who did not feel involved in decisions about their care were more likely to say that they had to wait too long for their operation and that their health got worse during this time.

³⁶ These five accounted for 25 per cent of procedures where at least 33 per cent of admitted patients were from the waiting list.

³⁷ NHS Institute for Innovation and Improvement

³⁸ Mulley, A., Trimble, T. ELwyn, G. *Patient's Preferences Matter – Stop the silent misdiagnosis*, London: The King's Fund, 2012

3.13 Although there are several examples of individual initiatives – including the Magic approach at Cardiff and Vale University Health Board and the Choose Wisely approach (see Good Practice Compendium) – there is still a long way for the NHS to go in terms of moving towards co-production practices. Several people who responded to our online survey told us that doctors did not take enough time to discuss the risks and benefits of treatment with them. Our survey shows that for a significant minority of patients, the NHS is not adequately informing them about what will happen to them, let alone involving them as equal partners. Our survey showed that around a third of patients said that no one explained what would happen to their waiting time if they cancelled or failed to attend appointments (having their clocks reset or being removed from the list). A higher proportion (40 per cent) of patients said that no one explained what would happen if they were not available for an appointment for more than a two-week period (potentially being removed from the list). Some 30 per cent of patients were not given information about how long they could expect to wait for a first appointment to see a specialist. Around a quarter were still unsure how long they could expect to wait for treatment after the decision to operate had been made.

Focusing on equity and clinical need could address clinicians' concerns about the targets but is complicated in practice and some existing practice may be inequitable

3.14 The prudent healthcare principles suggest a move away from prioritising patients and resources on the basis of how long they have waited towards prioritising on the basis of clinical need. During our local fieldwork, several clinicians reported concerns that the waiting times targets did not have a clear clinical basis and could sometimes distort clinical prioritisation of resources. Our patient survey showed that patients had different views on whether they waited too long, depending on the type of procedure they underwent. The elective care system already prioritises urgent patients but it does not do so in a way that is directly related to their condition. Once classified as 'urgent', a patient goes to the back of the 'urgent' list regardless of whether their condition may require them to be seen more quickly than a patient further up the 'urgent' list. Similarly, not all 'routine' patients have the same level of clinical need and some may be more likely to deteriorate or experience pain than others.

3.15 While the principle that patients should be treated according to clinical need seems sensible, there are potential negative practical consequences in doing so. At present, health boards use templates that ring-fence appointments for a mixture of urgent, urgent suspected cancer, routine and follow-up patients. Introducing more categories of clinical need potentially makes the management of waiting lists less efficient. This is due to the impact of 'carve-out': the more a hospital 'carves out' the waiting list into sub-waiting lists (separate lists for each category of clinical need), the less efficient they become. The other consequence is that increased clinical prioritisation exacerbates the 'crowding out' of 'routine' patients as described in [paragraph 2.24](#), with the result that those patients face even longer waits. One way

of avoiding the crowding out risk would be to adopt the type of clinical prioritisation system used in New Zealand. In New Zealand, patients are prioritised according to scores. Patients above a specific threshold are directly listed for surgery whereas patients below the threshold are referred back to their GP, potentially to wait until they deteriorate further and acquire additional points. The thresholds are determined by a combination of clinical criteria and capacity constraints. The New Zealand system avoids creating a long 'tail' of routine patients by preventing those patients below the threshold from being put on a waiting list in the first instance. Adopting a New Zealand-style approach would come with practical risks around the consistency of allocating points as well as the considerable political risks of adopting an approach that openly rations access to healthcare. The 2005 NLIAH **A guide to good practice**, which considered the New Zealand approach, concluded that 'points-based systems, or systems with many degrees of urgency, are not recommended'.

- 3.16 The 2005 NLIAH **A guide to good practice** recommends using the 'urgent' and 'routine' categories and prioritising entirely on the basis of urgency. That would mean not booking appointments for routine patients until all urgent patients had been given an appointment. If health boards adopted this approach, the current size of the backlog and capacity constraints mean that many specialities would only see and treat urgent and urgent suspected cancer patients for a significant period of time. Such an approach may be more 'equitable' in terms of matching capacity to clinical priority but would result in a significant deterioration in performance against waiting times targets and an even larger backlog of long-waiting routine patients. Over the long term, as NLIAH reported, 'the best method of safely and effectively prioritising patients is to ensure that no-one waits'.
- 3.17 Prioritisation is also determined to an extent by patients' own behaviour. Our local fieldwork has found that the application of some rules on patient cancellations in particular are having negative, inequitable impacts for patients. The rules state that when a patient cancels an agreed appointment, they should be given another appointment as soon as possible. However, the first time a patient cancels at any stage they have their clock reset to the date the patient notified the hospital of the cancellation. On second cancellation, they should be removed from the waiting list and referred back to their GP. Many patients will have genuine and legitimate reasons for cancelling appointments, such as ill health or unavoidable caring duties. There is a strong likelihood that patients who cancel end up waiting longer if they need further tests or treatment because of the way many health boards manage their waiting lists (see **Box 3**).

Box 3: Managing waiting lists – clinical referral date vs waiting list date

Health boards aim to treat patients in turn based on how long they have been waiting and depending on whether they are urgent or routine. Health boards have two different dates on which to base their calculation of how long patients have been waiting:

- The 'clinical referral date' which is the date the health board received the referral.
- The 'waiting list date' which is an adjusted date used for performance reporting and managing the targets. The waiting list date is reset when a patient cancels or does not attend an appointment.

The 2005 NLIAH **A guide to good practice** is clear that patient booking should be from the patient's perspective and patients should be treated in order of the clinical referral date. It says that using the waiting list date is 'unfair'. However, this element of the NLIAH guide is not reflected in the guidance issued to health boards. Because in many specialties patient booking is focused on avoiding breaches of the targets, health boards use the waiting list date as the basis for booking patients. As a result, patients who have had their clocks reset are potentially facing significantly longer waits to reach the top of the queue and get an appointment for treatment.

- 3.18 We compared the rules related to patient behaviour in Wales to those in place for England and Scotland (see [NHS Waiting Times for Elective Care in Wales: Technical Report](#)). The rules in England allow far fewer opportunities to stop patients' clocks and there is no provision for them to be reset. The rules in England are notably more focused on ensuring that the official waiting time reflects that actual amount of time that patients wait. The rules in all countries allow for patients to be taken off the waiting list and referred back to the GP if they do not attend appointments. There is, however, a notable difference in the perspective taken on patient cancellations: in Wales, the RTT Guidance treats cancellations as a negative patient behaviour, whereas the guidance for England treats any cancellation, right up to the last minute, as patients behaving positively to let the NHS know rather than simply not turning up. In Scotland, the patient clock can be reset if they cancel or do not attend but only where it is clinically appropriate and in the patient's best interests to do so.

The Welsh Government is moving towards clearer strategic leadership which will require bravery and determination across the NHS to enable whole-system change

The Welsh Government's emerging Planned Care Programme provides an opportunity to re-think the strategic direction and challenge assumptions about waiting list management

- 3.19 While the principles of prudent healthcare could underpin a more effective system, the NHS is yet to translate those principles into a clear strategy for elective care and waiting times. The Welsh Government is starting to work through the detailed issues and is developing a Planned Care Programme. The programme aims to provide strong clinical leadership for whole-system improvement in the quality, safety and performance of planned care services throughout NHS Wales. At the time of drafting this report, the programme was in its infancy with a lead clinician, a lead health board chief executive and an executive director recently appointed.
- 3.20 As the Welsh Government develops the Planned Care Programme, there is a need for a strategic articulation of the core priorities of the elective care system and the role of waiting times targets. The Welsh Government has signalled a desire to re-focus the whole NHS to move away from time-based targets towards measures of clinical need and outcomes³⁹. As paragraphs 3.14 to 3.18 showed, that may require some difficult decisions to be made about the balance between efficiency and equity. And it is not yet clear how emerging ideas around co-production, with its focus on more individualised services, fits with an approach that involves a single target that applies to all patients. At the same time as signalling a shift in focus to outcomes, the Welsh Government has made clear to health boards that their integrated three-year plans must show how they will meet the 26 and 36-week waiting times targets by the end of 2014-15. There is a real challenge for the Welsh Government to send out a clear message on the need for long-term systemic reform to focus on better outcomes as well as putting pressure on health boards to take action to meet existing targets in the short-term.
- 3.21 The Welsh Government recognises the need to develop its own understanding of capacity, demand, costs and benefits if it is to provide clear direction. There is a need for better information on current and future demand and capacity to support robust plans to improve elective care and reduce waiting times. There is also a need to understand the potential scope for service change plans to meet demand without bringing patients into hospital, thereby free up hospital capacity. As was the case with Access 2009, if lowering waiting times remains an explicit goal, a twin approach is required to reduce the backlog over time and then balance demand and capacity over the longer term. A detailed understanding of future demand and capacity is essential to identify the potential resource implications and enable the Welsh Government to set out an achievable timetable for reducing the backlog and balancing the system.

³⁹ Welsh Government, **Written Statement – Welsh Ambulance Services NHS Trust delivery of October 2013 eight-minute target and the introduction of the NHS Outcome Framework and development of future NHS measures**, 2013
Welsh Government, **New cancer waiting times piloted**, 2014
Welsh Government, **Together for Health: Eye Health Care Delivery Plan for Wales 2013-2018**, 2013

3.22 As it develops its new programme and looks to longer-term change, there is scope to revisit the assumption that some kind of waiting list and associated waiting times is necessary. Having a waiting list and associated waiting times comes with a cost: **Part 2** set out some of the administrative and clinical costs to managing patients while they wait. But a waiting list also has potential benefits in terms of ensuring a smooth flow of patients to fill up clinics and theatre lists. There is an economic and clinical balance to be struck as to whether and at what level waiting times are optimal. We have seen no evidence that the Welsh Government determines its waiting times targets on the basis of this balance.

The Planned Care Programme has potential to strengthen sharing and learning from good practice to improve the efficiency of the elective care system

3.23 **Part 2** of this report set out the areas where the elective care system is not currently efficient or prudent. In **paragraphs 3.2 to 3.18**, we considered the scope for different ways of working using the principles of prudent healthcare. There is also a set of more detailed efficiency improvements that can be made to release capacity to support lower waiting times. A good starting place is the 2005 Guide to Good Practice. It sets out a detailed analysis of how waiting list planning and management can be made more efficient and provides tools and analysis for use right across the patient pathway. Despite this information being promoted across Wales for nearly a decade, our review of health boards' self-assessments and our local fieldwork suggests that the examples of good practice have not been consistently learnt from and applied.

3.24 There are examples of promising practice around encouraging patients to attend their outpatient appointments included in our Good Practice Compendium. With around 290,000 patients not attending their appointments in 2010-11, there is scope to create significant additional capacity. Some examples of promising practice include the use of text messages to patients, with one trust in England using behavioural psychology to maximise the impact of the messages. Cardiff and Vale is also experimenting with its booking processes to remove patients who do not confirm the time of their outpatient appointments in advance (see our Good Practice Compendium). The approach is having promising early results in reducing non-attendance but the method appears to contradict Welsh Government guidance on booking appointments.

3.25 Another key area where there is scope to share good practice is detailed work to reduce the time a patient stays in hospital. Reducing length of stay is not simply a matter of getting patients out of the door more quickly. Reductions in length of stay need to be accompanied by improvements in detailed processes to ensure patients are still discharged safely, and, potentially, new ways of providing support to patients who still need a low level of care. Our Good Practice Compendium identifies two examples of process improvements from Cardiff and Vale University Health Board: discharge boards and the discharge lounge.

- 3.26 Health boards that are not already doing so could prioritise their effort to reduce length of stay in the areas where it is likely to have the biggest impact. As noted in [paragraph 3.6](#), just 13 procedures account for around a fifth of bed days used across Wales. Our analysis also showed that the 'pareto' principle⁴⁰ applies in elective care, with 80 per cent of elective bed days used by 18 per cent of patients during the period April 2010 to March 2014. Just five per cent of elective patients accounted for around 50 per cent of bed days. Health boards can use this kind of analysis to focus their efforts on finding ways to reduce lengths of stay for the most capacity-intensive procedures and tailor support to groups of patients with very long hospital stays.
- 3.27 If health boards made significant progress on reducing length of stay, we calculate that in an optimistic scenario where every health board at least matches the Welsh average of 2013-14 each month across emergency and elective care, there would be additional bed capacity for around 13,300 patients. In a highly optimistic scenario, where every health board matches the best in Wales for 2013-14 in both elective and emergency, the equivalent additional bed capacity would be sufficient for an additional 76,000 patients in a year. There are, however, some significant caveats to accompany any consideration of length of stay:
- a It would be unrealistic to expect all additional capacity to be converted into new elective patients, not least because of the need to free up capacity to create 'headroom' rather than use it for new patients.
 - b Freeing up bed days may help address issues where the beds are a constraint on the system, but will not address problems where the constraint is the availability of medical staffing.
 - c A growing number of older patients with more complex care needs may mean that despite efforts to improve systems and processes, lengths of stay do not reduce as much as they otherwise would.
 - d Discharging patients at an earlier stage of recovery means that the mix and condition of patients in hospital will change. There will be fewer patients with lower-level needs (as they will have been discharged) to be replaced by patients in an earlier stage of recovery with higher levels of need. This change has potential implications for staffing levels and associated costs.
- 3.28 One further area where there is clear scope to free up capacity is through reducing delayed transfers of care. While the position in Wales is improving: with a daily average of 17.8 delayed transfers per 100,000 population⁴¹ in 2010-11 compared to 14.7 in 2013-14, progress with securing further reductions has begun to tail off. Successfully addressing delayed transfers of care will require joint working between the NHS and local government to ensure that older patients have the support they need to be able to move from hospital into an intermediate or social

⁴⁰ The Pareto principle is also known as the 80/20 rule and 'the vital few'. It refers to the theory of Italian economist Vilfredo Pareto that in any situation or system 80 per cent of the outputs are a result of 20 per cent of the inputs. Pareto first observed that in 1900s Italy 80 per cent of the land was owned by 20 per cent of the population. This 80/20 split has been found to occur in many situations and systems.

⁴¹ This figure excludes mental health patients.

care setting and, wherever possible, to return to living more independent lives. This is a significant challenge given the funding pressures that are also being experienced in local government.

The NHS will need to be brave and work hard to overcome the hurdles that have hampered whole-system change in the past

- 3.29 The NHS in Wales has made many attempts to radically re-shape and redesign services in the past. Indeed, many of the principles of prudent healthcare and ideas about operational efficiency can be found in previous plans and strategies, such as the 2010 Five Year Framework⁴². Despite these various plans, there has been limited progress in fundamentally re-shaping the services that are offered to patients.
- 3.30 That is not to say that there has not been change and innovation. There are many eager staff with ideas and plans to improve their services. And the NHS has made a lot of progress in training staff in improvement methods. Our local work has identified a range of examples of local service innovation, many of which are set out in our Good Practice Compendium. However, many of the managers and clinicians who worked on those examples noted that it can take a considerable amount of time to introduce new ways of working.
- 3.31 That said, we also found that the squeeze coming from demand and financial pressures might be driving an increase in the pace of change. Some of the positive examples we found came about because the services were under severe pressure: waiting times were far from meeting the target, resources were being stretched and clinicians were concerned that they simply could not cope with the level of demand. As a result, they redesigned the processes and were prepared to take managed risks because the risks of doing nothing were even greater.
- 3.32 There is no shortcut to addressing the challenge of making change happen in the NHS. The enablers and barriers are multiple and complex. At a strategic level, considerable bravery will be required to re-think the waiting times targets in light of recent performance and current capacity, and re-prioritise services towards clinical need. Some of the principles and ideas in 'prudent healthcare' challenge assumptions and professional boundaries and may involve sharing and transfer of clinical risks, for example where people are diagnosed and treated by healthcare workers other than consultants. Many professionals will welcome those challenges while others may resist them. Some of the changes will involve taking financial risks on promising changes that could deliver better and more efficient care over the long term. Some managers and finance staff may understand and embrace such risks while others may resist change without a watertight cast-iron business case. All of these and more can combine to delay and hamper change. Encouraging and enabling more managed risk taking will require a significant degree of bravery and hard work, right across all parts of the NHS (See [Box 4](#)).

⁴² Welsh Government, [Delivering a Five Year Service, Workforce and Financial Strategic Framework for NHS Wales, 2010](#)

Box 4: Bravery and hard work

Why do we talk about being brave? Because taking managed risks is difficult. The easiest thing to do in any service is carry on with business as usual. However, the performance levels related to waiting times and future demand and financial pressures mean that more of the same is not an option. Taking the first step into uncertain waters – new service models for patients, changing clinical practices and actively enabling patients to choose for themselves what care they receive – needs people to be brave. And they need to be brave to be flexible and manage the inevitable barriers and problems that will come their way once new ways of working are put into practice and to accept the risk that things may not work out as planned.

And 'hard work'? Because making change happen is hard work. The danger is that producing plans, strategies and ideas can be seen as an end in itself. Of course, planning is important but it is the hard work on the ground to change practice and thinking that will make the biggest difference for patients. Those managers and clinicians we spoke to told us of the determination and work they needed to put in to get their ideas off the ground.

Appendices

Appendix 1 - Audit methods



Appendix 1- Audit methods

Data analysis

We have examined various statistics to analyse the performance of NHS Wales, identify current trends and compare performance across health boards in Wales, including:

- a data on admitted patients from the Patient Episode Database Wales (PEDW);
- b data on waiting times for a first outpatient appointment from NHS Wales Informatics Service (NWIS);
- c Welsh Government data on cancelled operations, day surgery rates, elective and emergency activity, length of stay, outpatient attendance and the average unit cost of treatment per procedure; and
- d Stats Wales data on elective waiting times, GP referral rates and NHS beds in Wales.

We were unable to get national data on the number of patients waiting for treatment classed as 'urgent' and on the number of patients who had their referral to treatment 'clock' adjusted. In these cases, we used data from one health board to illustrate the point.

We have also used data from other parts of the UK and internationally to compare demand, capacity and performance where possible. The data sources include:

- a NHS England Referral to Treatment and Hospital Episode Statistics;
- b Information Services Division Scotland Referral to Treatment Statistics; and
- c data from the Organisation for Economic Co-operation and Development (OECD) on elective waiting times, hospital beds and spending on health.

Our main report identifies a number of potential efficiency savings which have been calculated using the data described above and NWIS data on patient admissions from 1 April 2010 to 31 March 2014.

Document review

We have reviewed a range of documents published or provided by the Welsh Government including:

- a strategic documents on the NHS Delivery Framework and Annual Operating Frameworks;
- b documents setting out emerging plans for Prudent Healthcare and the Planned Care Programme;
- c Welsh Government correspondence to health boards on waiting times; and
- d notes of Quality and Delivery meetings where the Welsh Government discussed performance against waiting times targets with health boards.

The report also draws on research material from a number of sources including the Kings Fund, the Nuffield Trust, the OECD, Public Health Wales, the Royal National Institute for the Blind and the Welsh Institute for Health and Social Care.

Interviews

We interviewed senior Welsh Government officials to inform our view of the current strategic approach to managing waiting times. We also spoke to people from organisations representing NHS staff and patients including Aneurin Bevan Community Health Council, the Bevan Commission, the British Medical Association, the Royal College of Nurses, Royal National Institute for the Blind and the Royal College of Surgeons.

Local fieldwork

We asked all seven health boards to complete a self-assessment questionnaire during April 2014. The self-assessment focused on four key areas: the health boards' strategy to manage waiting times since 2009; their understanding of current performance; their understanding of the causes behind long waiting times; and plans to improve waiting times for the future. We also reviewed relevant health board documents including:

- a strategic documents and plans to address elective waiting times;
- b documents setting out the health board's approach to scheduling elective activity and matching capacity with demand;
- c board papers relating to waiting times;
- d internal reviews and audit reports relating to the accuracy of waiting times data;
- e information provided to patients about waiting times; and
- f documents relating to the impact of waiting times on patients.

We conducted more in-depth fieldwork at three health boards: Aneurin Bevan, Cardiff and Vale and Hywel Dda University Health Boards. Our work involved interviews with relevant staff, as well as observations of meetings and booking processes.

Patient experience survey

We conducted two surveys to understand patients' experience of waiting for NHS treatment comprising:

- a A postal survey sent in April 2014 to a random sample of patients who had undergone three procedures as an elective patient during October and November 2013. We chose three high-volume procedures: cataract surgery; surgery to remove the gall bladder; and catheterisation of the heart. We sent the survey to 900 people and had 400 responses which is a response rate of 44 per cent.
- b An online survey targeted at patients who had undergone a planned operation in the last three years. The survey was available on our website during May 2014 and achieved 95 responses.

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