NHS Waiting Times: follow-up report

28 June 2006

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Summary

1. The length of time people wait for planned NHS treatment is an important part of their experience of healthcare. In its report[1], published in May 2005, the Audit Committee of the National Assembly for Wales concluded that:
   - waiting times in Wales generally and especially in some areas had been and remained too long;
   - there was no single cause of long waiting times but rather a number of contributory factors acting on the whole health and social care system in Wales; and
   - to improve the position, a strategic, whole system framework was needed within which there would be scope for numerous specific actions.
2. Shortly before the Committee published its report, the Welsh Assembly Government announced an ambitious new waiting times target that by 2009 no patient should wait more than six months between referral and treatment, including diagnostics (the '2009 access target'). If achieved, this target would represent a very large reduction in the prevalence of long waiting times. It replaces the targets, when we last reported, of 18 months for a first outpatient appointment and 18 months for inpatient/day case treatment (a total combined maximum waiting time of 36 months plus time taken at other points in the patient pathway, such as diagnostics, which were not counted as part of the waiting times targets). The Committee concluded that these previous targets were 'not ambitious yet even they are not being met'. The new total waiting time target is consistent with developments in England, where by 2008 it is intended that waiting times should be no longer than 18 weeks from GP referral to treatment.
3. This report examines whether the NHS in Wales has made adequate progress in implementing all 13 of the Audit Committee's recommendations to achieve the Assembly Government's 2009 access target. Because we are considering including more detailed work on waiting times in the forward programme of work for 2007/2008, Wales Audit Office staff did not visit any local NHS bodies or conduct comparisons of performance between Wales and other parts of the United Kingdom in producing this follow-up report (Appendix C explains our methodology).
4. We found that the NHS in Wales has made considerable progress in reducing long waiting times and addressing their causes within a clear strategic context. And there are important known risks that need to be managed to deliver the ambitious 2009 target and sustain performance thereafter. The Assembly Government has made progress in discharging each recommendation. Appendix A provides a summary of progress against each of the Committee's 13 recommendations.

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[1] Audit Committee report, *NHS Waiting Times in Wales* (published in May 2005), summary page 3. This report was produced after three evidence sessions, based on the Auditor General's report *NHS Waiting Times in Wales* (published in January 2005).

Recommendations

5. Because the 2009 target is ambitious, its achievement will require determined focus. Experience shows that such focus on a target can bring the risk of inappropriate activity or manipulation of data. To mitigate that risk **the Assembly Government should commission a baseline verification of waiting lists, supported subsequently by a system of risk based spot-checks.**

6. Assembly Government officials have, understandably, focused on delivery of the 2009 target, paying little attention so far to how they will sustain a maximum 26 week total wait for patients in 2010 and beyond. Local Delivery Plans in the current financial year achieved low scores for innovation despite the need to redesign the steps patients take during their treatment. **The Assembly Government should include in its planning longer term objectives to sustain waiting times performance beyond December 2009, addressing:**

   a) **the transition from delivering the 2009 project and its 26 week maximum waiting time to maintaining performance by balancing demand and capacity in a sustainable manner;**

   b) **the financial implications of sustaining a 26 week maximum waiting time in 2010 and beyond; and**

   c) **ensuring that trusts and LHBs build significant innovation into future Local Delivery Plans to support long-term, sustainable reductions in waiting times.**

Part 1. The NHS in Wales has made considerable progress in tackling long waiting times

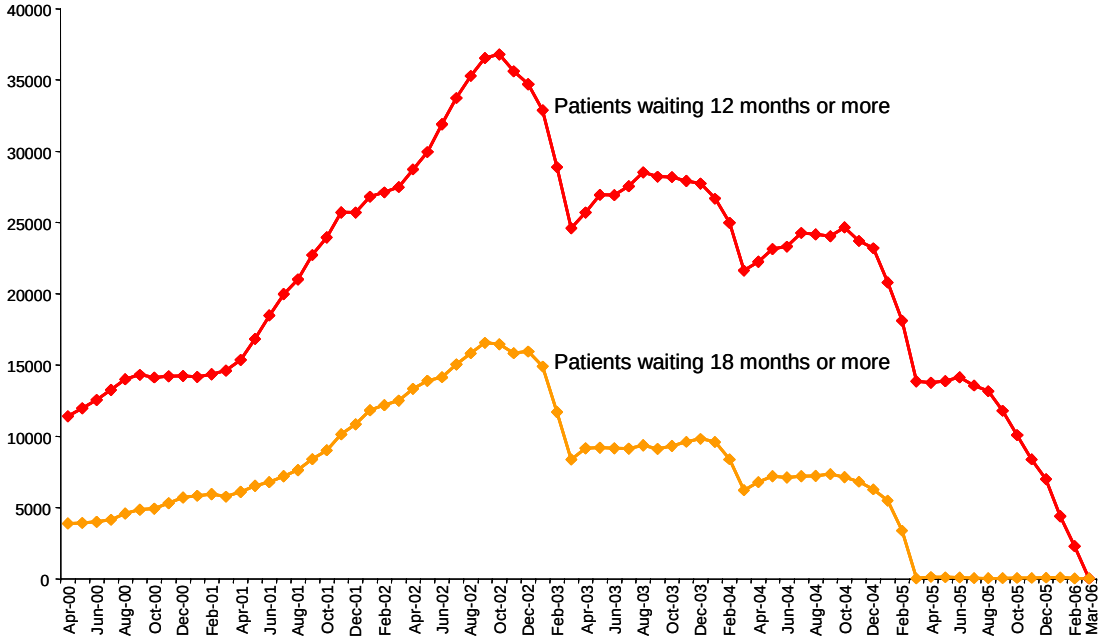
There have been substantial reductions in waiting times although regional variations remain

By March 2006, waiting times of a year or more had been virtually eradicated

1.1. There have been substantial reductions in NHS waiting times since the Audit Committee published its report in May 2005. Figure 1 shows that in March 2006, just 15 patients had been waiting more than 12 months for a first outpatient appointment and 10 patients for over 18 months. Figure 2 shows that by March 2006, waiting times of over 12 months for elective treatment as an inpatient or day case had been eradicated. The historical pattern of sharp improvements shortly before April, followed by rises at the beginning of the financial year reflects short-term waiting time initiatives to deliver targets at the end of the financial year.[2] However, Assembly Government officials told us that, as a result of more sustained investment, there had been no such pattern for inpatients/day cases, and a much less pronounced swing upwards for outpatients, in April 2006.

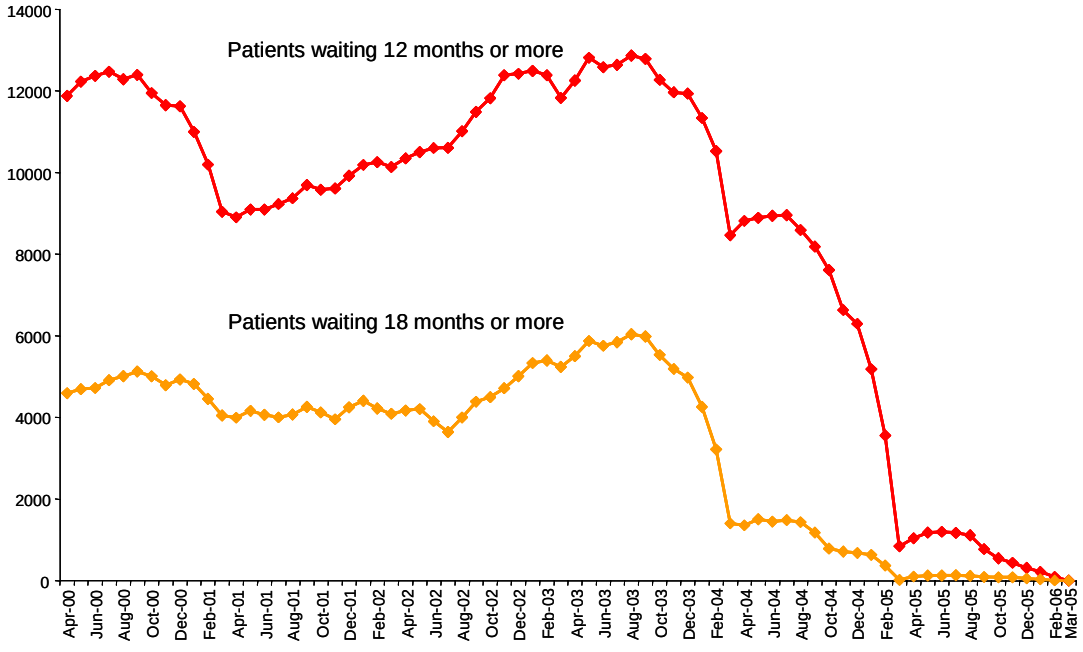
[2] AGW Report, *NHS Waiting Times in Wales*, volume 2 (January 2005) paragraph 4.42

Figure 1: By March 2006, the number of people waiting more than 12 or 18 months for a first outpatient appointment had reduced substantially



Source: www.statswales.wales.gov.uk

Figure 2: The number of people waiting 12 months or more for treatment as an inpatient or day case had reduced to zero by March 2006

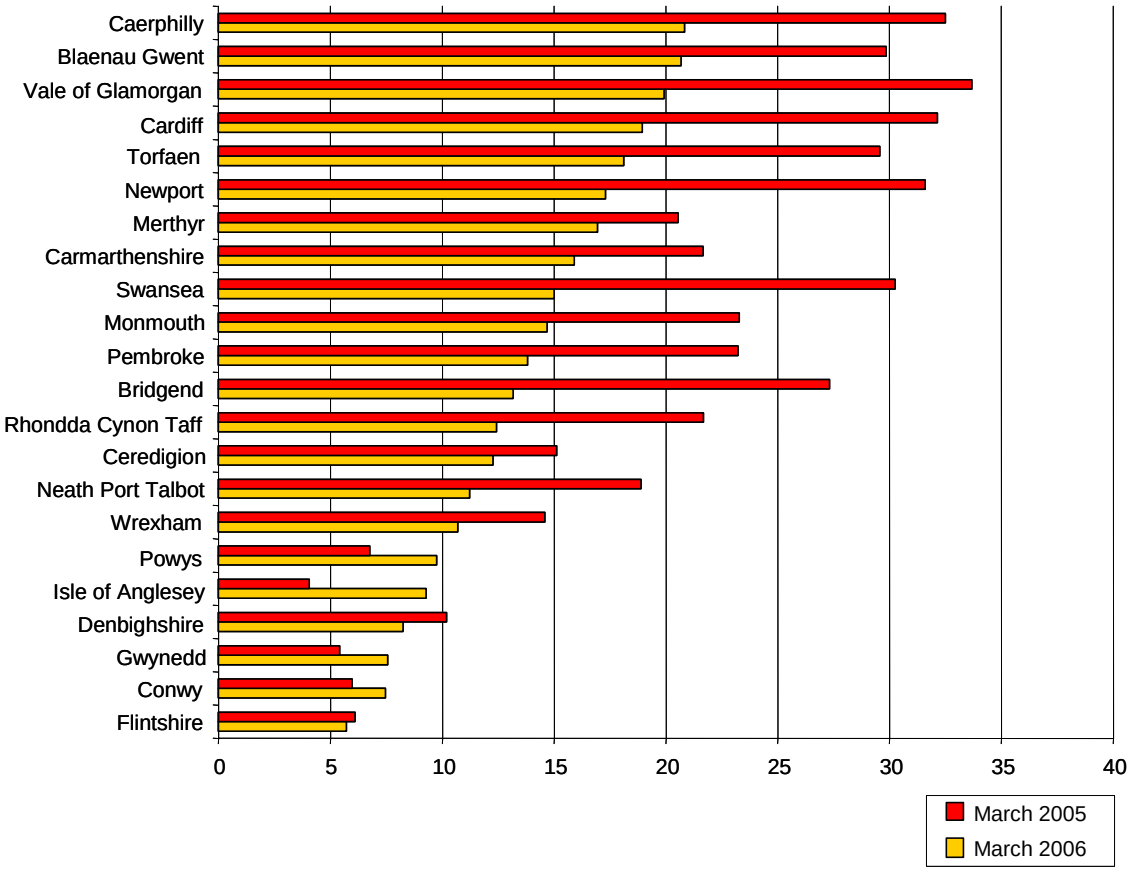


Source: www.statswales.wales.gov.uk

Delivery of the Access 2009 target should address remaining regional variations in waiting times

1.2. The Audit Committee's report showed that people in some Local Health Board (LHB) and Regional Office areas were more likely, per 1,000 head of population, to experience longer waiting times for treatment.[3] Regional variations have reduced substantially since the Committee last considered this issue. Figures 3 and 4 show that, while patients in some LHB areas are considerably more likely than others to wait over six months to be treated as an inpatient/day case or for a first outpatient appointment, there has been a reduction in the degree of regional variation between the 2004/2005 and 2005/2006 financial years. Delivering waiting times of no more than 26 weeks throughout Wales should mitigate the impact of variations in long waiting times.

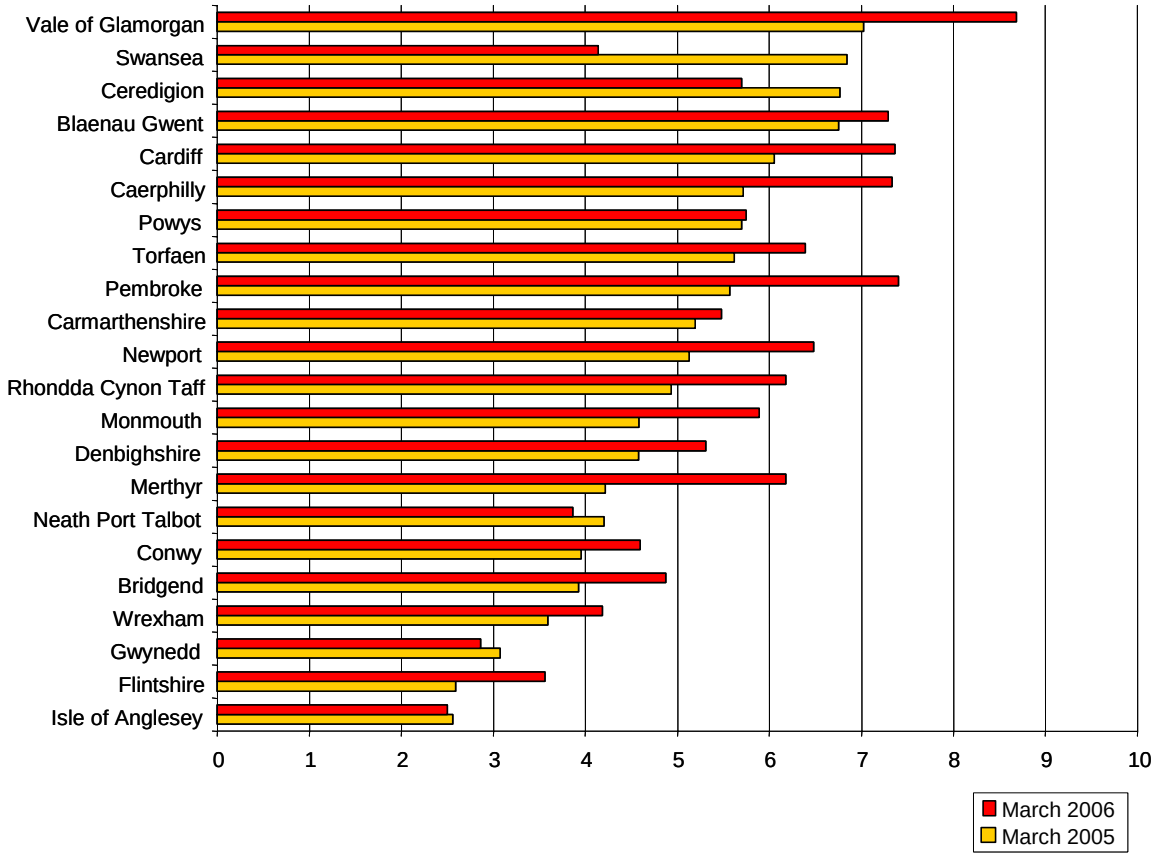
Figure 3: Number of people waiting more than six months for a first outpatient appointment per 1,000 head of population



Source: www.statswales.wales.gov.uk

[3] Audit Committee report, *NHS Waiting Times in Wales* (May 2005) paragraph 29

Figure 4: Number of people waiting more than six months for inpatient/day case treatment per 1,000 head of population



Source: www.statswales.wales.gov.uk

There has been some progress in addressing the causes of long waiting times identified in the Audit Committee report

1.3. The Audit Committee's report pointed out that long waiting times for treatment were a symptom of wider problems within the whole system of health and social care. Within that system, the Committee identified three main causes:

- high demand for NHS services;
- capacity problems; and
- delayed transfers of care - patients occupying hospital beds whilst waiting to transfer to another health or social care setting, such as a care home.[4]

Since publication of the Audit Committee's report, the Assembly Government has introduced a number of initiatives to address these causes of long waiting times.

[4] Audit Committee report, *NHS Waiting Times in Wales* (May 2005) page 4

The NHS is developing new ways to better manage demand for secondary care services

1.4. One of the main causes of long waiting times for a first outpatient appointment is the high level of demand. Better demand management – initiatives to reduce the pressure on the acute sector, for example by redirecting patients for treatment in the community, or by assessing the appropriateness of GPs' referrals - can help ensure that patients are not unnecessarily referred to consultants when they could often be seen more quickly and appropriately in an alternative healthcare setting.

1.5. Since the Audit Committee published its report, four health communities have piloted referral management centres, which assess and filter GP referrals. The Assembly Government is currently reviewing the results of the pilots, with a view to sharing learning across the NHS. The National Leadership and Innovation Agency for Health Care (NLIAH), an organisation that supports innovation and modernisation within NHS Wales, continues to promote its revised *Guide to Good Practice: Elective Services*, which advocates providing feedback to GPs on the quality and appropriateness of referrals and which the Assembly Government backed with a Welsh Health Circular.[5] In line with the Audit Committee's sixth recommendation, the Assembly Government now collects and publishes data on GP referrals which can be used to analyse GP referral patterns and to target demand management activities.

The Assembly Government is seeking to make better use of capacity

1.6. The Audit Committee's report showed that NHS Wales has sufficient overall capacity, but that better use of this capacity could improve waiting times. Since then, the Assembly Government has taken a number of steps to improve the use of existing capacity.

Work is underway to better protect elective capacity from emergency pressures

1.7. One of the major causes of long inpatient/day case waiting times has been emergency and medical pressures, which compromise the ability of trusts to treat patients from the elective waiting list, who have lower clinical priority than patients admitted as emergencies. Long 'tails' can develop at the end of waiting lists as routine patients who have already waited a long time are effectively overtaken by patients of higher clinical priority. The historical lack of protected elective capacity has exacerbated the impact of these pressures.

1.8. The Audit Committee's report showed that Wales had relatively higher rates of accident and emergency admissions than any other part of the United Kingdom.[6] The high rate of emergency admissions continues to place pressure on elective capacity in Wales. The ratio of emergency to

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[5] WHC (2005) 090

[6] Audit Committee report, *NHS Waiting Times in Wales* (May 2005), page 4

elective admissions has remained at around 58 per cent emergency to 42 per cent elective for the past four years. The number of patients admitted for one speciality but occupying a bed allocated to a different speciality - known as “outliers” - is another symptom of emergency pressures. In 10 of the 12 months between April 2005 and March 2006, the number of outliers was lower than in the same month the previous year. The figures show a pattern of sharp reductions across the financial year, with 493 outliers at the end of March 2006.

1.9. The Assembly Government is seeking to address the problem of emergency demand. It has funded two new units, at St Woolos and Llandough hospitals, which will provide ring-fenced elective capacity, and has also identified £65 million for further capital developments to help meet the Access 2009 target. Also, the Assembly Government is currently preparing policy guidance for emergency care services, which aims to reduce emergency admissions.

The Assembly Government has set targets to reduce cancelled operations

1.10. The Audit Committee found that the extent of cancelled operations was unacceptable and are a measure of the inefficient use of scarce NHS resources. Cancellations have a range of causes, including the impact of emergency pressures referred to in paragraphs 1.7 to 1.9, but also occur because of poor pre-operative assessment and patients themselves failing to attend.

1.11. Pre-operative assessment is important to check that patients are fit for surgery and understand what is going to happen to them. It also supports the safe expansion of day surgery provision. The revised NLIAH *Guide to Good Practice* emphasis the importance of pre-operative assessment, and advocates widespread use of partial booking (where patients and the providing trust agree a convenient appointment date in advance). Although we cannot prove a causal link between patient-focused booking and cancellation rates, it is positive that the number of cancelled operations reduced by 12 per cent between 2003/2004 and 2005/2006. In particular, the number of cancellations due to patients not attending has reduced by almost one third over the same period. However, progress appears to have stalled in 2005/2006, with the total number of cancelled operations in Wales rising from 3,550 in March 2005 to 3,600 in March 2006. The Wales picture masks significant local variation – in North East Wales NHS Trust cancellations reduced by 650 per cent during 2005/2006. In order to address the problem of cancellations, the Assembly Government has included an efficiency target to reduce cancellations within the 2006/2007 Service and Financial Framework (Figure 5).

The performance management framework includes efficiency targets to improve the use of existing capacity

1.12. The Service and Financial Framework (SaFF)[7] for 2006/2007 includes efficiency targets to improve the use of existing capacity and resources in eight areas, six of which are relevant to the Audit Committees recommendations (Figure 5).

Figure 5: SaFF efficiency targets

	Description
Average length of stay	Separate targets for each speciality to reduce the average time patients stay in hospital
Day case rates	Targets to increase the proportion of procedures in specific specialities that are carried out as day cases (patients admitted and discharged on the same calendar day)
Ratio of new to follow-up appointments	Separate targets to reduce the ratio of new to follow-up outpatient appointments for each speciality; increasing the proportion of new outpatient appointments enables trusts to see more patients on the waiting list for a first outpatient appointment
Did not attend rates	Targets to reduce the proportion of patients not attending outpatient appointments to 5 per cent for all specialities (excluding mental health where the target is 15 per cent)
Cancelled operations	Traffic light system based on proportion of scheduled operations cancelled on, or the day before, the operation
Waiting list management	Overall score of 80 per cent for primary targeting list which measures the extent to which a trust treats patients in turn, based on clinical priority, to avoid the development of waiting list 'tails' of routine patients who have waited a long time

Source: Wales Audit Office

The Assembly Government is addressing delays in discharging patients from hospital

The Assembly Government has issued guidance to accelerate the discharge of patients from hospital

1.13. The Committee's report found that patient throughput could be improved if trusts had more efficient and robust discharge processes which plan patients' discharge as soon as they are admitted. Consistent with the Committee's ninth recommendation, in May 2005 the Assembly issued a Welsh Health Circular providing updated guidance on discharge planning. This included many elements of good practice, including identifying a discharge date at the point of, or in the case of elective services before, admission. It advocates a multi-agency approach to discharge planning and requires that all arrangements, including transport and medication, should be planned in advance so that they are in place on the day of discharge. The guidance does not, however, explicitly refer to expanding

[7] A joint statement setting out the resource inputs and service outputs, including waiting times, which each health community – both commissioners and providers – will deliver.

the range of staff able to discharge patients, which formed part of the Audit Committee's recommendation, although it does refer to reviewing roles and responsibilities related to discharge planning across the multi agency team.

The Assembly Government is addressing delayed transfers of care, particularly those resulting from patient choice

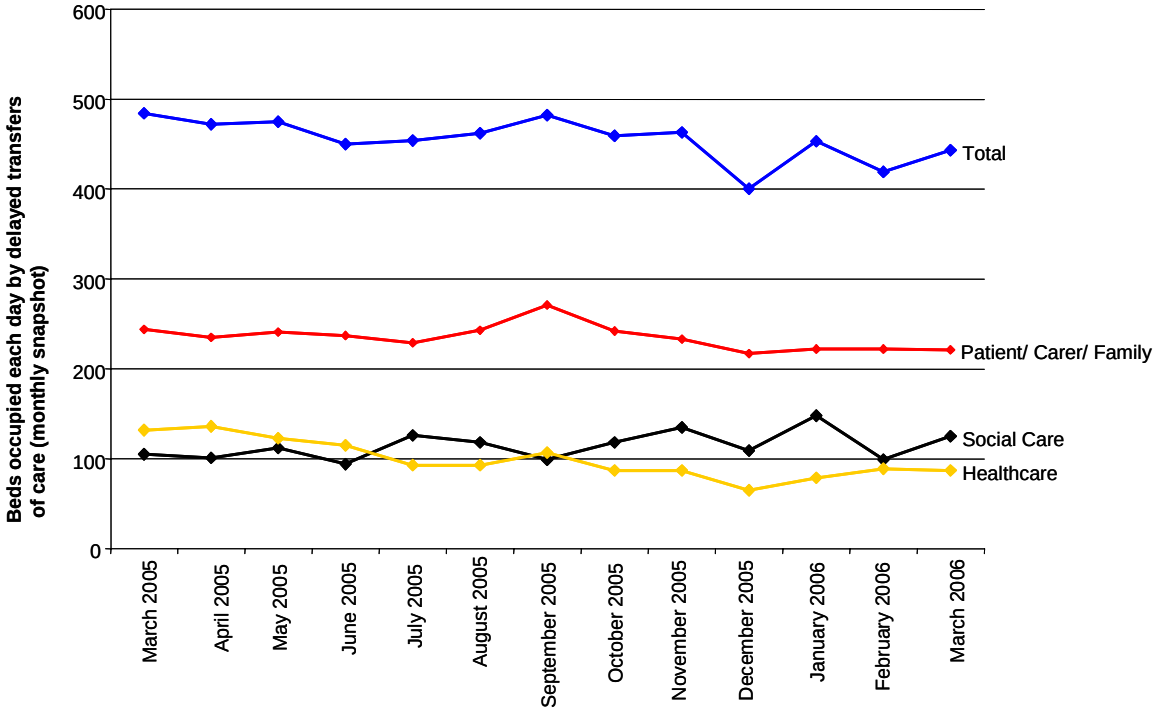
1.14. Delayed transfers of care - patients occupying hospital beds whilst waiting to transfer to another health or social care setting, such as a care home - is a serious drain on the secondary care sector. Whilst this can sometimes be due to delays in social care or medical assessments, the Committee's report highlighted the significant impact of delays due to the choices of patients, their families or carers. Ann Lloyd, Director of the Health and Social Care Department of the Assembly Government informed the Audit Committee that the Assembly Government had issued guidance on patient choice of care homes, highlighting the reasonable steps that should be taken to gain an individual's agreement to an interim care home, until a place in one of his or her chosen care homes becomes available.

1.15. Delayed transfers of care are measured through a snapshot census on one day each month. This data shows that the number of delayed transfers of care (excluding mental health[8]) has reduced, from a daily average of 723 beds between November 2003 and June 2004[9], to an average of 450 beds between March 2005 and March 2006, which could release around 100,000 bed days each year. Figure 6 shows that the choices of patients, their families or carers remain the main cause of delayed transfers of care, although delays for this reason reduced by around 9 per cent between March 2005 and March 2006. Delays due to healthcare reasons (delays in assessment or transfer to another NHS healthcare setting), fell by 35 per cent. However, there has been an increase in the number of delayed transfers of care due to social care reasons, which tend to be the most difficult to tackle. And whilst the overall national picture has improved, delayed transfers of care remain a significant problem in some LHB areas.

[8] Delays in mental health facilities are excluded because they have no direct impact on elective capacity

[9] AGW report, *NHS Waiting Times in Wales* (January 2005), Volume 2, paragraph 3.35

Figure 6: Main reasons for delayed transfers of care (excluding mental health) March 2005 to March 2006



Source: www.statswales.wales.gov.uk

There is now a clear strategic framework to reduce waiting times which is consistent with the Audit Committee's recommendations

There are now clear NHS strategies to deliver reductions in waiting times

1.16. The Audit Committee stated explicitly that the Assembly Government and local healthcare organisations needed to take a longer-term, more strategic approach to tackling waiting times than they had previously. In particular, the Committee was concerned at the absence of a clear overall strategy to reduce waiting times in Wales.

1.17. *Designed for Life*, the Assembly Government's ten-year strategy for the NHS in Wales published in May 2005, promises that: "unacceptable long waiting will have been consigned to history with a maximum 26 weeks for treatment from start to finish".[10] The project plan for Access 2009 includes provisional interim targets (Figure 7) for 2007/2008 and 2008/2009, although these may be modified following consultation with trusts and LHBs.

[10] Welsh Assembly Government, *Designed for Life* (published in May 2005), page 23

Figure 7: The Assembly has set more challenging targets for reducing NHS waiting times

	March 31 2004	March 31 2005	March 31 2006	March 31 2007	March 31 2008 (provisional)	March 31 2009 (provisional)	Dec 2009
Outpatient	18 months	18 months	12 months	8 months	6 months	4 months	
Inpatient/ day case	18 months	18[1] months	12 months	8 months	6 months	4 months	
Diagnostics				36[2] weeks	12 weeks	6 weeks	
Therapies				36 weeks	24 weeks	12 weeks	
Referral to treatment							**26 weeks**

[1] The 2004/2005 SaFF set an 18 month target for inpatient/ day case but the Assembly Government announced in June 2004 that no patient would wait more than 12 months for treatment as an inpatient/day case unless they were awaiting treatment under the Second Offer scheme, or had rejected Second Offer treatment

[2] ECG scans have a separate, lower target of 24 weeks

Source: Wales Audit Office analysis of NHS waiting time targets

1.18. *Designed for Life* reflects the view of the Audit Committee that, in order to deliver sustainable reductions in waiting times, the NHS in Wales must make better use of existing capacity; protect elective capacity from emergency pressures, redesign patient pathways, use staff and facilities more effectively; and build on innovation.

1.19. The Access 2009 project, led by the Delivery and Support Unit (DSU)[11] also reflects the Audit Committee's recommendations. The project links central strategy and implementation through Local Delivery Plans that outline how efficiency improvements will be delivered for the additional Access 2009 resources. The Local Delivery Plans must be agreed between trusts and LHBs, and are scored and approved by the Assembly Government, Regional Offices and the Delivery and Support Unit. By June 2006, all trusts had agreed their plans with one exception. Successful delivery of the 2009 target is heavily dependent on health communities implementing their Local Delivery Plans.

[11] The Delivery and Support Unit (DSU) was introduced in December 2005 as part of NHS Wales' Performance Improvement Framework. It has four main functions:

- to provide enhanced support to facilitate the improvement of performance within NHS Wales;
- the provision of advice on performance management policy development;
- to develop a framework for effective delivery planning; and
- to design and deliver the 2009 Access project.

Welsh Health Circular (2005) 097 provides more details on the role and functions of the DSU.

Designed for Life includes plans to reconfigure capacity

1.20. *Designed for Life* acknowledges that the current configuration of NHS services within Wales is 'inherently inefficient and expensive'.[12] The strategy intends to deliver different models of care which will require reconfiguration of services and capacity so that patients receive the most appropriate treatment in the most appropriate setting. Some services may become more centralised, in particular centres of excellence, while others may be delivered much closer to local communities. Regional Offices are currently producing proposals to reconfigure the secondary care sector in their localities. A key consideration in these proposals will be the need to re-balance emergency and elective care to make the most effective use of capacity.

Performance management arrangements have been strengthened

1.21. Assembly Government officials informed us that they are confident they have significantly strengthened the weaknesses in performance management arrangements highlighted in the Audit Committee's report. These weaknesses centred on the perception that performance management arrangements actually rewarded organisations that failed to meet Assembly Government targets. Assembly Government officials told us that there will be no rewards for organisations that fail to deliver the Access 2009 targets; if health communities fail to implement their Local Delivery Plan they will have to fund any additional activity needed to meet the waiting times target. Officials cited a number of further positive developments (Figure 8) which are being, or are due to be, rolled out across the service.

[12] Welsh Assembly Government, *Designed for Life* (May 2005), page 11

Figure 8: Steps taken by NHS Wales to improve performance management

NHS Balanced Scorecard	Key strategic elements of NHS organisations' performance are monitored through a balanced scorecard which looks at stakeholders, management processes, resource utilisation and learning and innovation
Incentives and Sanctions	The Assembly Government has commissioned, and is currently considering, research to develop an incentives and sanctions framework
Delivery and Support Unit (DSU)	The DSU provides support to enable NHS organisations to improve performance DSU automatically intervenes in organisations whose performance is deemed to be poor ('red' status) The DSU provides advice to the Assembly Government on performance management policy development Working with Assembly Government Regional Offices, the DSU scrutinises and approves the local delivery plans for the Access 2009 project
NLIAH Modernisation Assessment	This assessment aims to benchmark the implementation of best practice in trusts and LHBs against the English Modernisation Agency's ten high-impact changes Examines the efficiency with which organisations use capacity and their progress in modernisation Trusts are required to submit an action plan in response to their assessment

Source: Wales Audit Office

There are stronger controls over the provision of additional waiting times funding

1.22. The Audit Committee concluded that waiting times initiatives – the provision of additional non-recurrent funding to treat patients in the NHS at the weekends or in the evenings or in private hospitals – failed to deliver sustainable solutions to the waiting time problem, largely because they do not address the underlying causes of long waiting times.

1.23. Assembly Government officials told us that they have taken steps to ensure better value for money by linking waiting time initiative funding to improvements in waiting list management. In 2005/2006, the £24 million non-recurrent funding for waiting times initiatives was based on a detailed analysis of trusts' waiting lists, using the waiting list forecast tool (see Figure 9) and the allocation was linked to trusts' performance in managing their waiting lists. Funding was reduced where trusts did not meet targets. For example, because Swansea NHS Trust had low primary targeting list scores in 2005/2006, it suffered a £723,000 abatement of its waiting time initiative funding.

1.24. Assembly Government officials are confident that the additional recurrent and non-recurrent funding for Access 2009 – totalling around £80 million per year between 2006/2007 and 31 March 2009 - should provide better value than previous waiting times initiatives delivered. Access 2009 funding is tied to efficiency improvements set out in Local Delivery Plans.

Because the funding is recurrent for three years, trusts can invest in recurrent solutions by, for example, recruiting additional clinicians or redesigning the way a service operates, rather than spot purchasing extra activity.

1.25. The Audit Committee's report expressed concern about the control of Second Offer Scheme funding. The DSU is in the process of tendering for an 18 month contract for Second Offer Scheme activity, which it is confident will improve transparency and value for money relative to the previous system of individual negotiation with specific providers. The DSU informed us that the Second Offer Scheme will only be used by two trusts – Cardiff and Vale and Gwent Healthcare – in the current financial year and in time the DSU plans to make the scheme obsolete as part of the local delivery planning process integral to the 2009 Access project.

Work to develop commissioning is intended to support improvements in waiting times

1.26. The Audit Committee concluded that LHBs' commissioning strategies can improve waiting time performance. In support of *Designed for Life,* the Assembly Government will shortly publish *Designed to Deliver,* which will include a new framework for commissioning to be implemented from April 2007. Officials told us that the new framework will strengthen commissioning by ensuring it is based on clear rules and, as recommended by the Audit Committee, will focus on commissioning by patient pathway and outcomes, and help develop joint commissioning. Although we have not examined the quality of commissioning strategies at individual LHBs, the variation in long waiting times for LHB residents, shown in Figures 3 and 4, suggests that more effective commissioning could significantly drive down waiting times.

Improved forecasting and monitoring tools support more effective waiting time planning

1.27. The Audit Committee recommended that the Assembly Government develop systematic models of activity, demand and capacity to support the achievement of the 2009 access target. The Assembly Government has developed new tools which should enable the NHS in Wales to plan more effectively at a strategic and operational level (Figure 9).

Figure 9: New tools for better planning actions and strategies to reduce waiting times for patients

Tool	Description
Waiting list forecasting tool, produced by the Assembly Government Waiting Times Unit	• Based on an analysis of existing waiting lists • Forecasts the level of additional activity needed to address backlog in order to meet targets • Used by the Assembly Government, along with other tools, to forecast the costs of delivering the 2009 target
Demand and capacity toolkit, produced by the Assembly Government and DSU	• Identifies the gap between demand and capacity in health communities • Access 2009 money is used to fund action to address capacity gaps • Final capacity gap output has to be agreed by LHBs and trusts thus linking more closely with LHB commissioning strategies
Waiting times analysis conducted by RKW, commissioned by the Assembly Government	• Provides an analysis of waiting times based on detailed examination of large trusts' activity • Used by the Assembly Government, along with other tools, to forecast the costs of delivering the Access 2009 target
Activity model, developed by Cardiff University, commissioned by Assembly Government	• Allows detailed prediction of waiting lists based on weekly demand, capacity and activity data • Can be used for scenario planning, assessing in detail the impact of changes in demand and capacity

Source: Wales Audit Office

Part 2. Important known risks need to be managed to deliver the ambitious 2009 target and sustain it thereafter

2.1. Delivery of the ambitious 26 week waiting time target from GP referral to eventual treatment as an inpatient or day case, will involve significant redesign of the patient pathway. The DSU has produced a detailed delivery plan for the Access 2009 project, supported by six discrete work streams (Appendix B), to ensure the delivery of the target. The DSU is also funding three trusts as "early adopters" to test assumptions and spread learning across NHS Wales that supports delivery of the 2009 target. Two other trusts are also participating as early adopters but without DSU funding. The DSU is working closely with the Department of Health to learn from their experience in moving to the 18 week total waiting time target (paragraph 2 of the summary). This part of the report focuses on the known risks associated with delivering the Access 2009 target, all of which appear within the risks identified in the Access 2009 delivery plan. It also addresses the key challenges involved in sustaining 26 week maximum waiting times after December 2009.

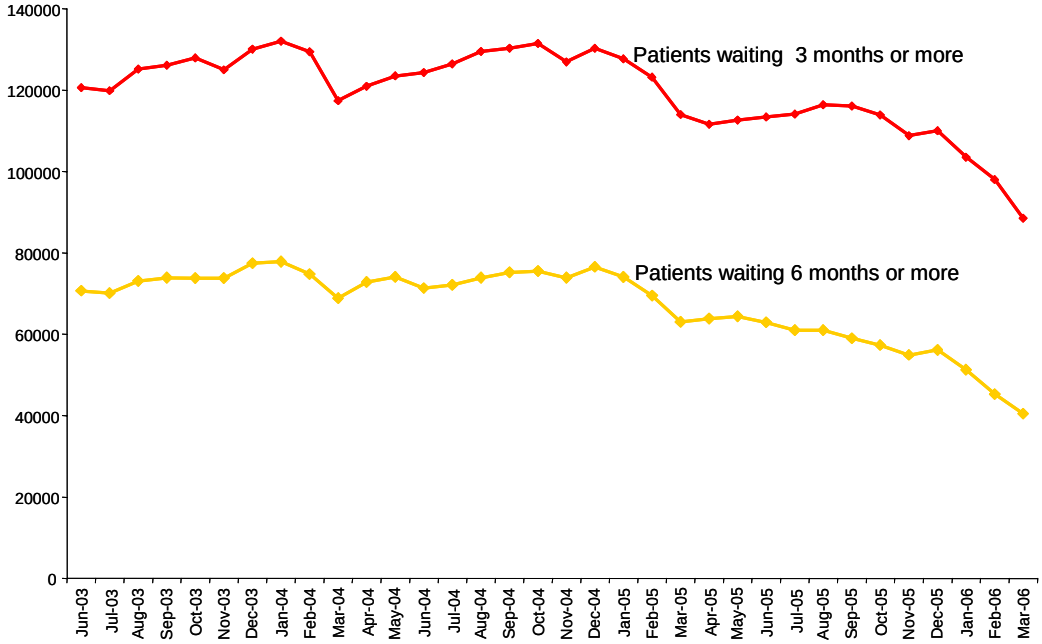
There are a number of known risks that might inhibit delivery of the 2009 target

Despite recent reductions in waiting times, further large reductions are required, particularly between March 2009 and December 2009

2.2. The Access 2009 delivery plan requires the eradication of waiting times of over six months for the current outpatient and inpatient/day case stages of the pathway by 31 March 2008 (Figure 7). The 26 week pathway target requires further significant reductions in maximum waiting times by December 2009.[13] Figures 10 and 11 show that although the number of people waiting three months or more has reduced between 2003 and 2006 there remains a significant backlog. In March 2006, 44 per cent of the total waiting for a first outpatient appointment had been waiting over three months, and 20 per cent had waited over six months. In addition, 47 per cent of the total waiting for treatment as an inpatient or day case had been waiting over three months, and 21 per cent had waited over six months.

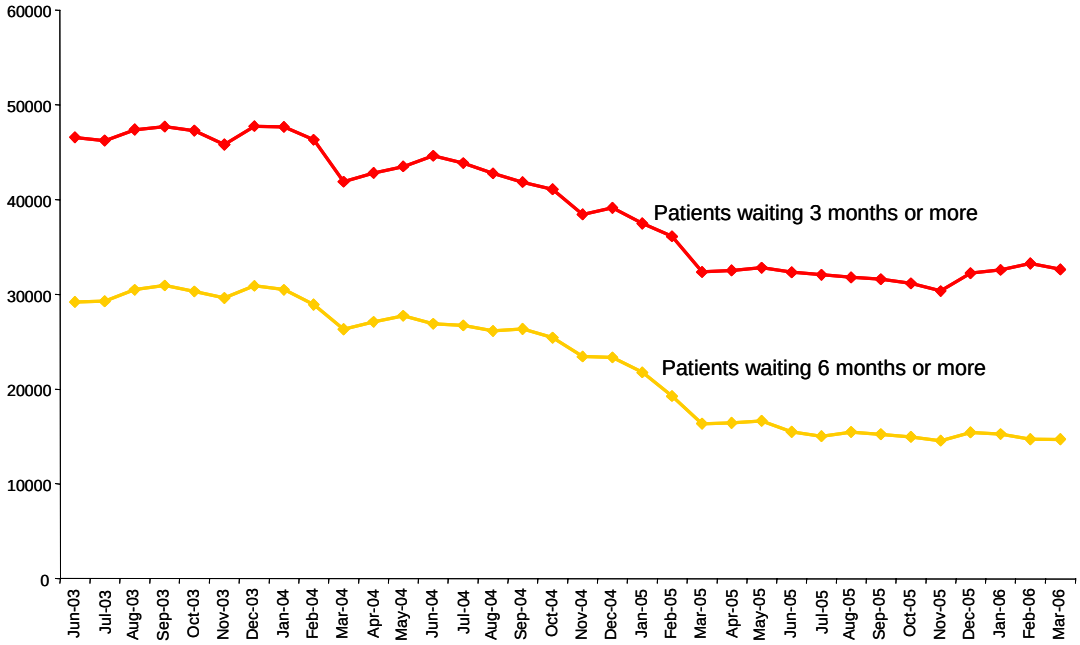
[13] Because the December 2009 target covers the whole patient pathway, the Access 2009 delivery plan contains no separate targets for outpatient or inpatient/ day case waiting times

Figure 10: Patients waiting more than three or six months for a first outpatient appointment



Source: www.statswales.wales.gov.uk

Figure 11: Patients waiting three or six months for treatment as an inpatient or day case



Source: www.statswales.wales.gov.uk

2.3. The provisional targets in the Access 2009 project plan (Figure 7) anticipate a sharp reduction in waiting times, from a 10 month total patient pathway in March 2009 to a 26 week pathway in December 2009. Although these provisional targets are subject to consultation, and will not be agreed until December 2006, there are clear risks involved in delivering a very sharp drop in waiting times over nine months. And if there is any slippage against the interim March 2009 targets, it will be extremely difficult to deliver the December 2009 access target. The redesign of the patient pathway (paragraph 2.4) will require significant innovation. The DSU informed us that the first year's Local Delivery Plans achieved low scores for innovation, and that the additional time to prepare Local Delivery Plans for future years should enable the plans to be sufficiently innovative.

Redesigning the patient pathway poses risks

2.4. The Assembly Government needs to define clearly the 26 week patient pathway. In particular, it will need to set out when the clock will start and stop in measuring patients' total waiting time, rather than individual parts of the total journey, and which referrals will be counted. The Assembly Government ran a consultation on definitions and data between December 2005 and January 2006. Clear definitions of which patients might legitimately be excluded are essential. Whilst it is entirely proper for patients to be excluded where treatment within the 26 week period would be clinically inappropriate, or where patients wish to stagger the episodes within their treatment, this process needs to be carefully monitored to ensure consistency of reporting and performance. Rather than the historical practice of suspending patients from the waiting list for social or medical reasons, the DSU informed us that the approach is likely to centre on a system of 'tolerances' whereby trusts are allowed a certain tolerance of patients whose journey lasts over 26 weeks. LHBs will be responsible for ensuring that all of these tolerances are appropriate.

2.5. The Assembly Government will need to ensure that waiting list data is sufficiently robust to monitor progress towards the target. The combination of new data definitions and the sustained pressure to meet waiting times targets increases the risk of inappropriate manipulation of data. In England, a robust process of waiting list data verification is performed annually by trusts' external auditors.

2.6. The current patient pathway includes significant unmeasured time, for instance waiting for diagnostic tests. The 26 week target may require patients to undergo their diagnostic tests between seeing their GP and the first outpatient appointment. The DSU told us that the early adopter sites had found that 60 per cent of the current patient journey centred on time waiting for tests or for the next stage of the pathway to commence. Redesigning the way patient services are provided on this scale is one of the most significant risks to delivering the 2009 Access target, and will require strong change management capability across NHS Wales.

Long waiting times for diagnostics and therapies are a major risk to the 2009 access target

2.7. Prior to 2006/2007, there have been no targets for diagnostic and therapy waiting times, and they have previously represented a bottleneck for patients. The Assembly Government has been developing systems to collect diagnostic and therapy waiting times and has recently published them for the first time for a selection of diagnostic tests and therapy services. This means that diagnostic and therapy waiting times are a known problem. In this respect, Wales is ahead of England, where the Department of Health began collecting data nationally in January 2006 and will publish waiting times for diagnostics and therapies in July 2006 at the earliest.

2.8. The published data[14] for diagnostic and therapy waiting times show some particularly long waiting times in Wales. In February 2006, 11,250 patients (12 per cent of the total waiting) had been waiting more than 36 weeks (the target waiting time for March 2007 - see Figure 7) for diagnostics or therapies. Of these, around 5,000 (5 per cent of the total waiting) had waited more than 60 weeks. Podiatry has particularly long waiting times; more than a quarter of patients (2,700) on the waiting list had been waiting over 60 weeks in February 2006.

Reconfiguration of the NHS through Designed for Life could impact on the timeliness of delivery

2.9. *Designed for Life* requires the Assembly Government's Regional Offices to produce reconfiguration plans for secondary care (paragraph 1.20). The delivery of these plans over the coming years represents a risk to the delivery of the 2009 target. Whilst the outcomes of reconfiguration are designed to support improved waiting times, the process of change and uncertainty might temporarily disrupt progress on delivering the target.

Increased demand could affect the ability of the NHS to deliver the 2009 target

2.10. The Audit Committee's report highlighted the relationship between waiting times and demand, manifested through GPs' referral practices. Long waiting times can act as a cap on demand, with GPs and patients choosing not to refer if they know they will experience long waits, or alternatively seeking treatment in the private sector. Shorter waiting times can release such suppressed demand, putting pressure on the planned reductions in waiting times. Increased demand is a particular risk in relation to first outpatient appointments, although this would have consequences for the inpatient/day case waiting list.

2.11. The Access 2009 project plan recognises that increased demand due to a major pandemic would jeopardise delivery of the target. Such a

[14] Waiting times data is published for art therapy, audiology, cardiology, dietetics, occupational therapy, physiotherapy, podiatry, radiology (Consultant and GP referrals) and speech/ language therapy

pandemic would substantially increase emergency pressures on the entire NHS in Wales, and would inevitably impact on the delivery of improved waiting times.

Short term financial pressures could inhibit long term strategic delivery

2.12. The NHS in Wales currently faces significant financial challenges. A number of NHS organisations have significant deficits, as highlighted in the Auditor General's recent report, *Is the NHS in Wales managing within its financial resources*? Such pressures risk NHS bodies focusing on short term financial measures, rather than long term strategic delivery. This could impact on the delivery of the 2009 Access target.

Engagement of clinicians will be crucial for delivery of the 2009 target

2.13. The Assembly Government now has a clear strategy for reducing waiting time in Wales, but individual clinicians are vital agents of its delivery. The Audit Committee's third recommendation emphasised the need for clinical engagement, to avoid the dangers associated with targets that are imposed on clinicians without their ownership and engagement. Consistent with the Committee's report, the Access 2009 project plan recognises that clinical engagement is a risk that needs to be managed. We did not examine the extent to which the Assembly Government or NHS organisations have engaged with clinicians as part of Access 2009, although part of the DSU's risk management strategy involves the appointment of clinical leads in primary and secondary care, and demonstrating success to clinicians through the early adopter sites.

Sustaining the target beyond 2009 will be challenging

2.14. Sustaining the target beyond December 2009 poses a number of further challenges. There is a difference in focus between delivering reductions in waiting times, which requires ongoing additional activity to treat the backlog of patients, and sustaining a waiting times target by balancing demand and capacity. Effective planning will be required to ensure a smooth transition between these phases.

2.15. Assembly Government officials acknowledge that their focus to date has been on the delivery of the Access 2009 target with less attention to sustaining it beyond 2009. The Assembly Government's strategy centres on balancing demand and capacity through achieving the 2009 access target across Wales. Nevertheless, it is essential that the Assembly Government builds into its delivery planning longer-term objectives to sustain the target beyond 2010, particularly because it may face pressure to deliver further reductions after December 2009 given the lower patient pathway target in England – 18 weeks – which is due for delivery by 2008.

2.16. Critically, the funding available to support the delivery of the Access 2009 target only runs until March 2009. The Assembly Government will need to

examine what, if any, funding NHS Wales will require in 2010 and beyond, if it is to sustain the target.

Appendix A - Progress against the Audit Committee's recommendations

No.	Recommendation	Progress
1	**Despite recent reductions, a significant minority of Welsh patients have still faced unacceptable waiting times of over 18 months. Waiting times in Wales compare badly with England and Scotland, although waiting times are longer in Northern Ireland.** Annex C provides the Welsh Assembly Government's announcement, two weeks after our final evidence session, of new waiting times targets intended to achieve a total waiting time of six months by 2009. The Welsh Assembly Government and trusts should develop systematic models of activity, demand and capacity to support the achievement of these targets.	Waiting times of 12 months or more have been virtually eradicated by March 2006, with no patients waiting 12 months or more for treatment as an inpatient/ day case and 15 patients waiting more than 12 months for a first outpatient appointment, all of whom were waiting for an appointment at an English Trust. The 2009 target is supported by different tools for assessing demand, capacity and activity (Figure 9): • a waiting list forecasting tool; • a supply and capacity toolkit; and • real time activity model - developed by Cardiff University and currently being rolled out as a pilot with "early adopter" organisations.
2	**There are substantial variations in waiting times within Wales.** The Welsh Assembly Government should use the redistribution of resources arising from implementation of the Townsend Review to better meet health needs and, as a consequence, reduce the current regional variations in waiting times displayed in Figure 1 of this report.	The degree of variation in waiting times between LHB areas has reduced between 2005 and 2006, and these variations should continue to reduce as the NHS moves towards the 2009 target. Nonetheless, there is still considerable variation, with patients in some LHB areas up to three times more likely to be waiting 6-12 months. Progress was been made implementing the Townsend review in 2003/2004 and 2004/2005 but this was limited in 2005/2006 because of financial pressures. It should be noted that the Townsend review covers a wide range of factors, other than patients' need for elective services.

No.	Recommendation	Progress
3	**The absence of a clear overall strategy to reduce waiting times in Wales has contributed to the current level of waiting time performance. There have also been weaknesses in performance management, which have led to a perception that the Welsh Assembly Government has rewarded failure to meet targets, while there has been little incentive for better performing organisations to improve their performance.** We recognise that different organisations have different starting points. The engagement of clinicians is critical in delivering better waiting times for patients, and there are particular dangers in targets which are imposed on clinicians without their ownership. Within a strategic framework, local organisations should then produce their own local targets, agreed and owned by clinical staff, for key measures of performance, including waiting times and their underlying causes. These local targets should reflect organisations' starting positions and should be subject to scrutiny, challenge and monitoring by Regional Offices. A strong framework of incentives and sanctions should support the delivery of these targets and reward good performance.	In *Designed for Life* and Access 2009, the NHS in Wales now has a clear strategy for delivering sustainable reductions in Waiting Times. These set clear targets for reducing waiting times: the overall target of a 26 week pathway from referral to treatment by December 2009 is supported by interim targets of 8 months for inpatient/ day case treatment and first outpatient appointments by 31 March 2007, with further provisional targets for March 2008 and March 2009. Assembly Government officials told us that performance management arrangements have been improved. The Assembly Government monitors performance through the NHS Balanced Scorecard. The Delivery and Support Unit now provides support for Regional Offices in managing performance, and will intervene directly where NHS organisations are underperforming. Through its Modernisation Assessment, NLIAH measures the performance of trusts and LHBs against the English Modernisation Agency's 10 high-impact changes. The Modernisation Assessments cover the key causes of long waiting times identified by the committee: demand, capacity and delayed transfers of care. Trusts and LHBs jointly develop their own Local Delivery Plans for Access 2009, which are required to demonstrate local efficiency improvements. The Delivery and Support Unit, Assembly Government and Regional Offices scrutinise the quality of the plans before they are agreed. These plans are performance managed by Regional Offices. Assembly Government officials told us that clinicians are consulted as part of the annual SaFF target setting process. The Assembly Government is also in the process of developing an incentives and sanctions framework, and has commissioned research into international best practice. Some progress has been made in tying the use of non-recurrent funding to performance (Recommendation 12 below).

No.	Recommendation	Progress
4	**NHS Wales has relatively little ring-fenced elective capacity compared to England and Scotland. New developments are in train but are overdue**. The Welsh Assembly Government and local health communities should further increase the amount of ring-fenced elective capacity available to improve the efficiency and speed with which NHS Wales treats patients from the waiting list. In particular, they should, like England, take a strategic approach to the development of capacity on a regional basis, either through capital developments or re-designation of existing facilities.	The Assembly Government has identified £65 million capital for a development programme to support the delivery of the 2009 waiting time target. This may be used to provide additional ring fenced elective capacity. New units have already been constructed at St.Woolos and Llandough; although the Llandough unit is not yet fully operational. The key driver for ring-fenced elective capacity is the pressure of emergency admissions. Despite the existence of a SaFF target to reduce emergency admissions, the ratio of elective to emergency admissions (42:58) has not changed for the past four years. *Designed for Life*, sets out the Assembly Government's strategic approach to developing regional capacity.
5	**LHBs' commissioning strategies can improve waiting time performance.** We recommend that commissioners use their commissioning strategies to change service models and minimise waiting times, particularly in commissioning by patient pathway and outcome, rather than traditional models of service delivery. Furthermore, LHBs should collaborate to reduce duplication, share skills and maximise the impact of their commissioning strategies, both within their region and across the whole of Wales.	The Assembly Government plans to issue *Designed to* Deliver, the first three year strategic framework in support of *Designed for Life.* It intends that this will set out details of a new commissioning framework for implementation from April 2007. The Assembly Government intends that *Designed to Deliver* will cover commissioning by patient pathway and outcome, and collaboration. We did not assess the extent to which LHBs' commissioning plans and actions were based on pathway and outcome, nor did we examine the extent of collaborative commissioning.

No.	Recommendation	Progress
6.	**It is essential that local health communities manage demand by providing services that are accessible to patients and reflect the way patients access and use services.** Consequently, we recommend that health communities seek to match services and patients' needs, for example by co-locating out of hours services with accident and emergency services; developing or expanding medical assessment units; and by developing new roles such that the most appropriate healthcare professionals treat patients in the most appropriate setting. They should also establish systems to capture data about referrals and establish mechanisms to enable consultants to feed back to GPs about the quality of referrals and alternatives to referral to a consultant.	LHBs and trusts are required to demonstrate how they will manage demand as part of their Local Delivery Plans for the Access 2009 project. The Assembly Government is currently considering an assessment of four pilot referral management centres, and is considering how best to expand their use. Demand management is also part of the NLIAH Modernisation Assessment. The Assembly Government issued guidance on changes to the out-of-hours GP service as a consequence of the new GMS contract. This guidance required LHBs to consider the new out-of-hours services in the context of wider emergency services. Assembly Government officials told us they are currently developing policy on emergency care services. They told us that the co-location of services and the development of common points of entry to the most appropriate services are likely to be key elements in the final document. Assembly Government officials told us that all trusts in Wales now have medical assessment units, although they felt that the effectiveness of such units was variable. In June 2006, the Assembly Government began publishing aggregate data on GP referrals across Wales on its website (www.statswales.wales.gov.uk). The NLIAH Guide to Good Practice advocates that GPs should receive feedback on the quality and appropriateness of referrals and the Modernisation Assessment examines whether such frameworks are in place.
7	**There is evidence that the National Leadership and Innovation Agency for Healthcare, and its predecessor bodies, have supported effective innovation and modernisation within parts of NHS Wales, but that there is considerable scope to spread best practice further, particularly through the more effective engagement of all clinicians.** We recommend that the National Leadership and Innovation Agency for Healthcare engages with clinicians who are resistant to new ways of working, as well as those willing to act as champions of change, to improve patient care, efficiency and waiting times by spreading recognised best practice throughout NHS Wales.	NLIAH's Modernisation Assessments have been carried out and all trusts were required to submit an action plan in response to their assessment by the end of May. A proposal for a Clinical Leaders Network is incorporated in the draft Service Level Agreement for 2006/2007 currently under consideration by the Assembly. Subject to confirmation, recruitment to the network will be timed to support the publication of *Designed to Deliver*.

No.	Recommendation	Progress
8	**The extent of cancellations is unacceptable and reflects, in part, weaknesses in pre-operative assessment processes.** We recommend that trusts should reduce cancelled operations, for example by strengthening the pre-operative assessment processes and by seeking to extend booking systems to inpatient/day case treatments. Should there be no reduction in the current number of cancellations, the Welsh Assembly Government should include in next year's Service and Financial Framework a target for health communities to reduce cancellations.	The NLIAH Guide to Good Practice, revised in 2005, advocates strengthening pre-operative assessment and patient focused booking, detailing processes for partial booking for outpatient and inpatient/day case treatments. The number of cancelled operations has reduced by 12 per cent between 2003/2004 and 2005/2006. In particular, the number of cancellations due to patients not attending has reduced by almost one third over the same period. However, progress appears to have stalled during 2005/2006, with the number of cancellations in Wales rising from 3,550 in March 2005 to 3,600 in March 2006, although this figure masks considerable variation in performance between trusts. The Assembly Government has included an efficiency target to reduce cancellations within the 2006/2007 Service and Financial Framework. A high level indicator of cancellations is also included in the NHS Balanced Scorecard.
9.	**Patient throughput could be improved if trusts had more efficient and robust discharge processes which plan patients' discharge as soon as they are admitted.** We recommend that all trusts develop discharge processes and protocols to ensure that discharge is as timely as possible. These should include setting target discharge dates for patients as soon as they are admitted, modernising pharmacy arrangements, expanding the range of healthcare professionals able to discharge patients and ensuring that ward rounds are timed to enable new patients to be admitted as soon as possible.	The Assembly Government issued updated hospital discharge planning guidance in May 2005. This includes setting discharge dates for patients at the point of, or in the case of elective patients before, admission. It also requires all necessary arrangements, such as transport and medicine, to be planned in advance so that they are ready on the day of the discharge. However, it does not make explicit reference to expanding the range of healthcare professionals able to discharge patients although it does refer to reviewing roles and responsibilities related to discharge planning across the multi agency team.

No.	Recommendation	Progress
10.	**The extent of delayed transfers of care, excluding mental health delays, is a serious drain on the secondary care sector, accounting for an average of 723 beds each day between November 2003 and June 2004.** Consequently, we recommend that health communities minimise the impact of delayed transfers of care arising from patient choice by developing and using staging posts in community settings, in which they can place patients while they wait for their chosen care home.	The Assembly Government published updated guidance on choice of accommodation in September 2004 as a joint Welsh Health Circular/National Assembly for Wales Circular. The guidance says that if returning home with a care package is not possible and an interim placement has been identified as being appropriate, reasonable steps should be taken to gain an individual's agreement to an interim care home. The person should then be assisted to move into this interim accommodation until a place in one of his or her chosen care homes becomes available. Delayed transfers of care form part of the NLIAH Modernisation Assessment. Also, there is a SaFF target for Health Communities to reduce delayed transfers of care. The total number of delayed transfers of care has reduced, accounting for an average of 450 beds each day between March 2005 and March 2006. However, the number of delayed transfers of care due to social care reasons has increased, from an average of 105 beds per day in March 2005 to 125 in March 2006. And whilst the overall national picture has improved, delayed transfers of care remain a significant problem in some LHB areas.
11.	**Waiting times could be improved if NHS Wales made better use of its existing capacity, particularly by improving bed and operating theatre utilisation, and maximising rates of day surgery**. We therefore recommend that the Welsh Assembly Government should only provide additional funding to those organisations which can clearly demonstrate that they are making good use of the capacity they already have. Otherwise, additional funding simply reinforces existing poor use of capacity.	The Assembly Government SaFF includes eight efficiency targets, including improving bed utilisation and increasing rates of day surgery. The Auditor General report will be publishing a report on day surgery in Wales. There is no specific target on operating theatre utililisation but there is a target to reduce late cancellations of operations, which impacts upon theatre efficiency. Funding for Access 2009 is linked to local delivery plans, which require LHBS and trusts to demonstrate improved efficiency in the way they use capacity.

No.	Recommendation	Progress
12.	**The Welsh Assembly Government has made extensive use of additional non-recurrent funding to run 'waiting time initiatives' in the private sector or in the evening or at weekends in NHS facilities. Although non-recurrent funding can be beneficial in some circumstances, initiatives have taken place for too many years without delivering sustainable solutions to the waiting time problem. This is largely because they do not address the underlying causes of long waiting times.** The Welsh Assembly Government should permit the use of non-recurrent funding, not only to treat additional patients, but also to achieve sustainable change by addressing the underlying causes of long waiting times in their health communities. The Welsh Assembly Government should ensure that any non-recurrent funding is subject to specific targets to reduce waiting times and their underlying causes, with claw back where health communities fail to achieve such targets.	In 2005/2006 waiting times funding was linked to Primary Targeting List (PTL) scores, which measure the extent to which patients are treated in turn according to clinical priority. Trusts with low scores suffered abatement of waiting time initiative funding. Trusts are able to use their Access 2009 funding, most of which is recurrent until 2009, to address the causes of long waiting times, as well as funding extra activity either in the NHS at weekends or evenings, or in the private sector. Trusts and LHBs are responsible for delivering the 2009 target locally, as agreed in their Local Delivery Plans, and will have to fund any additional activity needed to deliver the target should they not use the Access 2009 money effectively.
13.	**The Second Offer Scheme has contributed to recent reductions in inpatient/day case waiting times, but has some inherent risks which need careful management.** In particular, we recommend that the Welsh Assembly Government implements controls to make sure that NHS Wales does not pay twice for treating the same patient as a result of the Second Offer Scheme. The Welsh Assembly Government should consult LHBs about proposed developments under the Second Offer Scheme so that they are consistent with local commissioning strategies.	The Delivery and Support Unit now manage the Second Offer Scheme. The Director of the Delivery and Support Unit told us that only two trusts – Cardiff and Vale and Gwent Healthcare - were expecting to use the Second Offer Scheme in 2006/2007. The Delivery and Support Unit is in the process of tendering for an 18 month contract for Second Offer Scheme activity, which it is confident will improve transparency and value for money relative to the previous system of individual negotiation with specific providers. Assembly Government officials are confident that the Second Offer Scheme has only funded activity where demand had exceeded the capacity commissioned by LHBs and that there has been no double paying for the same patient. Local Delivery Plans for the Access 2009 project must be agreed between LHBs and trusts, including agreeing any capacity gaps which the Second Offer Scheme will cover. This clarifies links between local commissioning strategies and the Second Offer Scheme.

Appendix B - Access 2009 Workstreams

Workstream: **Communications**

Key objective: To implement the communications strategy and the communications plan. To implement the 'awareness of programme' section of the support programme.

Workstream: **Target and data definitions and measurement**

Key objective: To consult on target and data definitions and to arrive at final proposals. To ensure there are ways of measuring end to end pathways.

Workstream: **Capacity and demand planning**

Key objective: To deliver on the capacity planning process and scrutinise the local delivery plans. To allocate funding. To assure demand management strategies. To identify challenging specialty and geographical areas and ensure support is in place.

Workstream: **Performance management framework**

Key objective: To establish performance management framework for all strands of the project.

Workstream: **Information Management and Technology**

Key objective: To focus on the end to end measurement of the patient pathway.

Workstream: **Diagnostics and therapies**

Key objective: To ensure that the work on the modernisation of services is fed into this workstream and waiting times met.

There are also regular meetings on capital investment to ensure that capital planning is aligned with the requirements of the Access 2009 project.

Source: Access 2009 Delivery Plan

Appendix C - Study Methods

Key features of our study methods

Our approach to producing this report following up the Audit Committee's report on NHS Waiting Times involved a number of methodologies which we set out below.

1. We examined documents pertaining to NHS waiting times, their causes and the Access 2009 project from the Assembly Government and Delivery and Support Unit.
2. We collated and analysed relevant statistical material, including:
   - NHS waiting times data, published on www.statswales.wales.gov.uk – we did not conduct a validation exercise on this data, relying instead on the NHS' own data validation processes;
   - data provided by the Assembly Government on cancelled operations;
   - data published in the National Assembly for Wales' annual publication Health Statistics Wales;
   - information in Welsh Health Circular (2005) 094, which provides details of the funding for the Access 2009 project;
   - information provided by the Assembly Government from the Welsh Assembly Government's database of hospital activity; and
   - material gathered as part of the Wales Audit Office's wider work with the NHS in Wales.
3. We held meetings with relevant Assembly Government officials and with the Director of the Delivery and Support Unit.
4. We drew on information collated by the Assembly Compliance Office on progress in discharging the Audit Committee's recommendations.
5. We did not examine in detail the individual performance of NHS organisations, nor did we conduct fieldwork in local NHS organisations. We did not seek to make any comparisons between Wales and other parts of the UK because the scope of this project was to assess progress within Wales in implementing the recommendations of the Audit Committee.