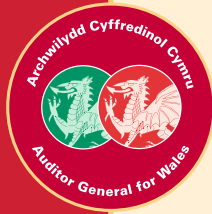




NHS WAITING TIMES IN WALES VOLUME 2 - TACKLING THE PROBLEM

Report by the National Audit Office Wales on behalf of the Auditor General for Wales



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14 January 2005

The Auditor General for Wales is totally independent of the National Assembly. He certifies the accounts of the Assembly and its associated sponsored public bodies; and he has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which the Assembly and its sponsored public bodies have used their resources in discharging their functions.

This report was prepared for the Auditor General for Wales by the National Audit Office Wales.

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NHS WAITING TIMES IN WALES VOLUME 2 - TACKLING THE PROBLEM

Report by Auditor General for Wales, presented to the National Assembly on 14 January 2005

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The scope of the examination by the National Audit Office Wales

1

- 1.1 This is the second of a two volume report on NHS Waiting Times in Wales. The first volume considers:
- the importance of waiting times (Part 2);
 - current waiting time targets and their achievement in Wales (Part 3); and
 - variations in waiting times within Wales, relative waiting times compared with other parts of the UK, alternative measures of patients' waiting times, and waiting list management (Part 4).
- 1.2 This second volume examines the complex factors which drive long waiting times and the methods that have been adopted to address them. It examines:
- the causes of, and solutions to, long waiting times for outpatients and diagnostic and therapy services (Part 2);
 - the different causes of, and strategies to tackle, long waiting times for patients who need admission to hospital and delays in discharging patients (Part 3); and
 - the effectiveness with which the Welsh Assembly Government has managed the waiting times issue (Part 4).
- 1.3 Our study methods are described in full detail in Appendix 1. In summary, we:
- examined waiting time and other key health statistics for Wales, compared them with other parts of the United Kingdom through statistical analysis and visits, and identified the particular variations in performance within Wales;
 - surveyed all trust and Local Health Board chief executives, all General Practitioners, consultants in the specialties of General Surgery, Trauma and Orthopaedics and Ophthalmology, chief officers of Community Health Councils and a limited survey of patients;
 - carried out visits to six NHS trusts and six Local Health Boards as well as interviewing a wide range of key stakeholders in health and social care; and
 - took advice throughout the course of the study from an Expert Panel; Appendix 2 lists panel membership and the role of the panel in our examination.
- 1.4 Our examination was based on the view that waiting times are a symptom of the problems affecting the whole system of health and social care. This reflects the key findings of the *Review of Health and Social Care*, commissioned by the Welsh Assembly Government, carried out in 2003 and advised by Derek Wanless (known as 'the Wanless Review'). These are summarised in Appendix 3. Consequently, our examination took a broad approach to the waiting times issue, and excludes from its scope:
- an audit of the accuracy of the waiting lists themselves, as the focus of the examination was waiting times; additionally, the Welsh Assembly Government has led a major programme to improve the management and accuracy of waiting lists; and
 - a detailed audit of differences in how individual waiting lists are compiled in different parts of the United Kingdom, relying instead on existing work.

2 Tackling outpatient, diagnostic and therapy waiting times



2.1 Volume 1 of this report showed that outpatient waiting times remain very long in Wales. The reasons for long waiting times vary at different points of the patient's pathway through the system of health and social care. There are very different causes of long waiting times depending on whether or not the patient requires a bed for an overnight stay. This part of the report examines the factors which impact on the length of time that patients wait where the patient does not usually stay in hospital overnight:

- outpatients; and
- diagnostic and therapy services.

Despite improvements in the efficiency with which outpatient services are provided, outpatient waiting times remain a serious problem

2.2 This section of the report examines the causes of long outpatient waiting times, and some of their national and local solutions, considering in turn:

- the main reasons for long outpatient waiting times;
- the Welsh Assembly Government's approach to tackling long outpatient waiting times; and
- local solutions which have led to reductions in long outpatient waiting times.

Increasing demand for outpatient services has been a major reason for long outpatient waiting times

2.3 **Figure 1** shows that new outpatient attendances have fluctuated between April 2000 and March 2004, but increased by 16 per cent overall. Our surveys asked Trust and Local Health Board chief executives, and Consultants in three specialties, to rank the significance of a series of barriers to achieving Welsh Assembly Government outpatient waiting time targets on a scale of 1 to 5. **Figure 2** summarises the results of responses to this question and reflects the view that increasing GP referrals were the most significant barrier to achieving Welsh Assembly Government outpatient waiting time targets. There was a 3.7 per cent increase in the number of GP referrals between April and December 2002, compared with the same period in 2001, the equivalent of an annualised increase of 5 per cent¹. The Welsh Assembly Government has not collected comprehensive referral data since December 2002, but is currently developing proposals to capture more robust central data on GP referrals.

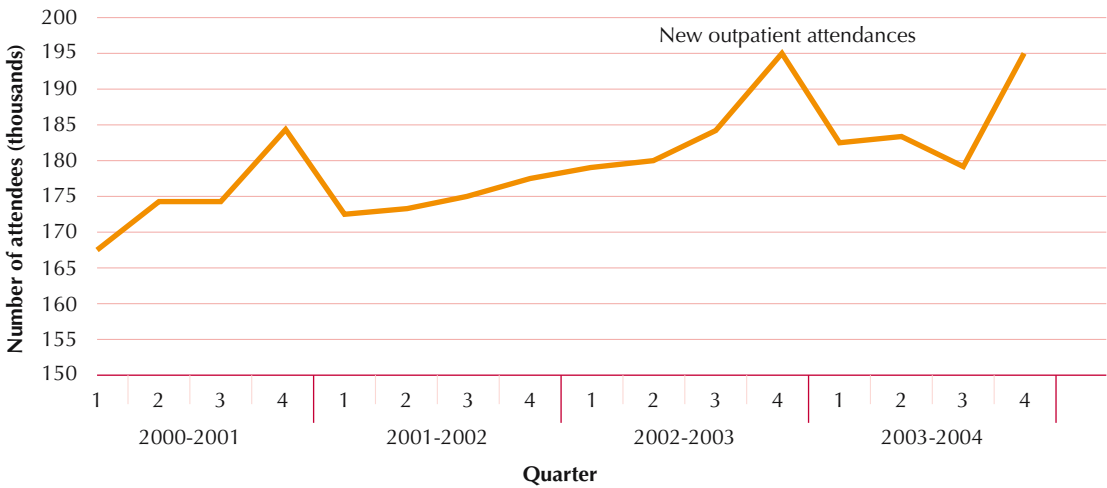
'The main problem is large numbers of non-surgical cases referred by GPs that delay 'true' surgical patients'.

'In the last two years or so the number of referrals I have received has dramatically increased. Younger GPs have very little experience in Orthopaedics and therefore are likely to refer far more cases than their older colleagues.....The volume of unnecessary referrals adds significantly to the outpatient waiting time problem'.

Source: National Audit Office Wales survey of Consultants

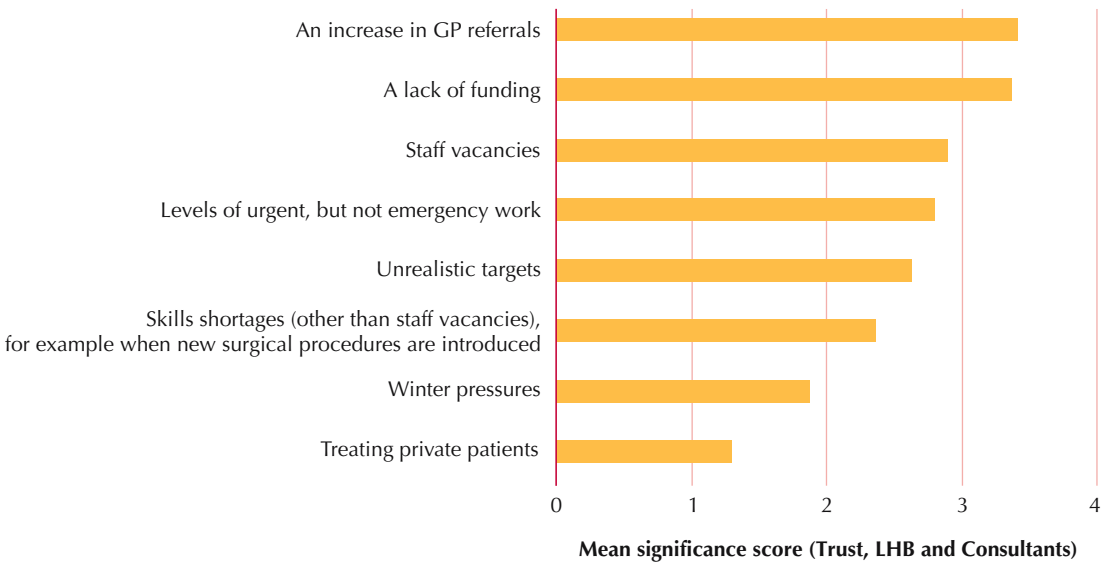
¹ Welsh Assembly Government, Report of the Task & Finish Group on Healthcare Activity Measurement, March 2003, page 13.

1 New outpatient attendances April 2000-March 2004



Source: QS1 data provided by the Welsh Assembly Government

2 Barriers to achieving outpatient waiting time targets²



Source: National Audit Office Wales surveys of consultants, and Trust and Local Health Board chief executives

² Our surveys asked respondents to rank the significance of a series of barriers to achieving Assembly inpatient/day case waiting time targets on a scale of 1 to 5. This graph summarises the results of responses to this question by trust and Local Health Board Chief Executives, and consultants.

Waiting times influence GPs' referral practices

2.4 There is considerable evidence that waiting times influence GP referral practices. When waiting times are short, the threshold at which GPs make referrals falls; whereas longer waiting times can encourage GPs to make fewer referrals (see the box below). Long waiting times may also result in some GPs making referrals when a patient is not ready for treatment but will be by the time their waiting time has elapsed (see Figure 3). This practice was especially prevalent in Trauma and Orthopaedics, where almost one third of GPs reported that they frequently made referrals before patients were ready, in order to circumvent long waiting times, and 49 per cent reported that they did this occasionally. Such referral practices fill the waiting list with patients who technically should not be on the list, increasing waiting times as a result.

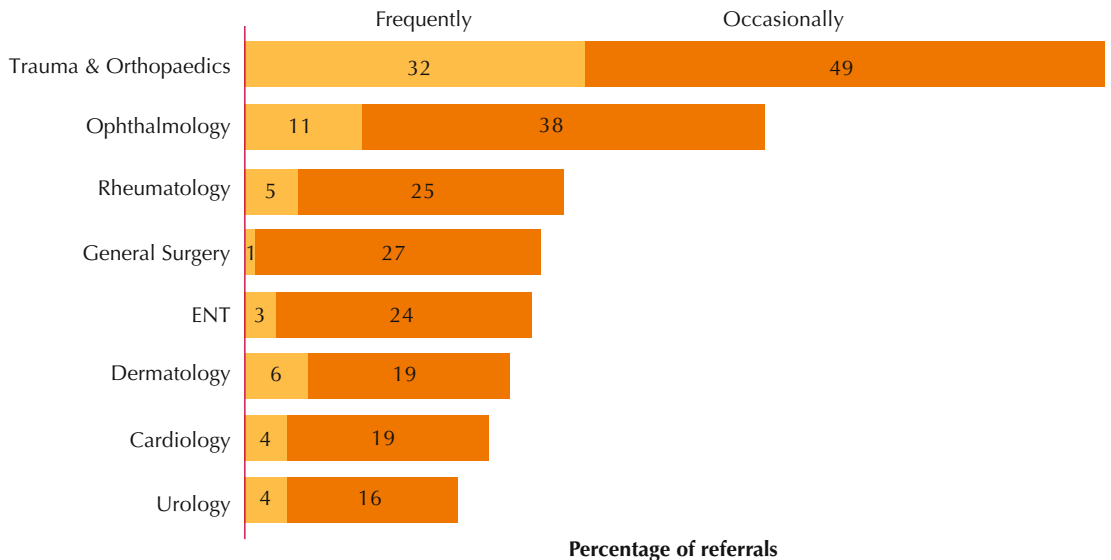
Waiting times influence referral thresholds

'There is a dynamic between waiting times and threshold for GP referral. Short waiting times mean low threshold for and increasingly trivial referrals which waste resources. Long waiting times increase the selectivity of referrals but risk missing early presentations'.

Source: Consultant responding to the National Audit Office Wales survey

2.5 Because of the length of time patients wait for outpatient services and the consequent deterioration in patients' condition, the majority of GPs contact consultants directly to ask for some patients' appointments to be expedited: 25 per cent of GPs responding to our survey indicated that they did this 'frequently', with 69 per cent doing so 'occasionally'. Consultants indicated to us that they tend to comply with such requests for expedition in the interests of patient care. The drawback is that those routine patients on the tail of the waiting list, who have already waited a long time, are displaced by new urgent referrals and other patients

3 Whether GPs make referrals when the patient is not ready, but will be by the end of the waiting time



NOTE

Base: All GPs (309).

Source: National Audit Office Wales survey of General Practitioners

whose GPs successfully expedite their appointment. The Treat in Turn initiative (see Volume 1 Figure 23), whereby routine patients are seen in strict date order according to the date that they were placed on the outpatient waiting list, has the potential to reduce the size of the tail of the waiting list, and to improve the equity of routine patients' waiting times.

Some GP referrals could be dealt with more appropriately in settings other than outpatients

2.6 Technically, a GP referral is appropriate whenever the presenting symptoms are beyond the practitioner's clinical competence. However, there will be some referrals where the patient did not really need to see a consultant, or could have been dealt with more appropriately in a different setting or by another health professional, thus reducing demand for acute services and allowing the consultants to see the patients who most need their expertise. The consultants we surveyed estimated that between 20 and 30 per cent of the GP referrals that they received in 2003 were 'inappropriate'. There was polarisation of consultants' opinion about the extent of inappropriate referrals - while 55 per cent believed they made a 'significant contribution' or 'made a contribution' to long waiting times for outpatient appointments, 45 per cent believed they made 'no contribution' or only 'a minor contribution'. 'Inappropriate' referrals may simply reflect the absence of alternative services, such as Multi-Disciplinary Teams, Extended Scope Practitioners or GPs with a special interest (see 2.22-2.27).

Patient behaviour affects the efficiency of outpatient departments

- 2.7 One of the major historical causes of inefficiency in outpatient departments has been patients' failure to attend appointments - such patients are known as 'Did Not Attend' (DNA). In 2003-04, there were over 341,000 outpatients - both first and follow-up appointments - who did not attend, 58 per cent more than the total number waiting for a first outpatient appointment at the start of that financial year (new outpatients represent only around 26 per cent of all outpatient activity - see Volume 1, 2.15). Between 2000 and 2004 the DNA rate remained between 10 and 12 per cent of all outpatient attendances (follow-up appointments as well as first appointments from the waiting list). In response to DNA rates, consultants have traditionally 'overbooked' their clinics to cover the anticipated DNA rate. Recent guidance on waiting list management requires trusts to take a more robust approach to patients who do not attend and remove them from the waiting list.
- 2.8 Based on the average cost of an outpatient appointment - £117³ - patients' failure to attend outpatient appointments in 2002-03 represents an annual opportunity cost of some £37 million. On this basis, each one per cent reduction in the DNA rate might generate an annual efficiency gain of approximately £3 million.



2.9 There is also anecdotal evidence that patients have become better informed about their health, through growing media coverage and access to much better information, particularly via the Internet and new, more accessible types of NHS services, such as NHS Direct. This leads to greater demand for second opinions, and pressure on GPs to refer patients for an outpatient appointment. There is also anecdotal evidence that patients' expectations of consultations have increased, with consultation times increasing.

Pressures leading to rising outpatient demand

'The GPs are scared of litigation and complaints and a very high proportion are referred to "make sure we do not miss anything".'

'The major cause of rising waiting times in my practice is the quite appropriate and justifiable demand from the public to have more information and discussion about their condition than was formerly the case. A single patient can now take up to forty-five minutes. When I was appointed consultant twenty years ago, a groin hernia appointment took five minutes, this can now take twenty minutes in a discussion about the pros and cons of surgery, the type of operation, the complications and recovery'.

Source: National Audit Office Wales survey of consultants

Managing demand for outpatient services is a crucial function of Local Health Boards

2.10 There is considerable variation in referral rates between individual GPs. **Figure 4** shows the extent of variation in annual referral rates per 1,000 practice population in two Local Health Boards in various specialties.

2.11 Local Health Boards have an important demand management function in monitoring and managing the extent and quality of referrals to secondary care, and developing alternative services and pathways to reduce the burden on outpatient clinics. Monitoring must be conducted sensitively, since any referral beyond a GP's clinical competence is appropriate, and must pay due regard to the complexities of clinical judgements. It can be difficult for Local Health Boards to influence referral rates - if each of the two thousand GPs in Wales makes a single additional referral each day, which to them would not feel like a major change in referral patterns, there would be a huge surge in demand across the whole system. This phenomenon means that multiple small changes at the local level can lead to a substantial change across the whole of NHS Wales.

4 Variations in referral rates per 1,000 GP practice population in Caerphilly and Denbighshire Local Health Boards

Range of referrals per 1,000 practice population 2002-03

Local Health Board	All specialties	General Surgery	Orthopaedics	Ophthalmology
Caerphilly	112-312	13-44	19-52	11-29
Denbighshire	136-257	16-38	14-39	13-29

Source: Information provided by Caerphilly and Denbighshire Local Health Boards

2.12 The following problems are particularly serious for Local Health Boards trying to monitor and influence referral patterns:

- information on GP referral rates generally exists only at the level of the practice, rather than the individual GP, which makes it difficult to identify patterns and training needs where there are particular variations in referral rates (too few referrals can be as serious an issue as too many); and
- there is generally no feedback mechanism to identify those referrals which are inappropriate, or which might have been dealt with by a more appropriate health professional or in a more appropriate alternative setting - this applies not only to elective work, but also to referrals to Accident and Emergency, which contribute to the emergency pressures which impact on elective capacity (see 3.3-3.5); 67 per cent of GPs responding to our survey reported that they never receive feedback from trusts about the quality of their referrals and, among those who did not receive frequent feedback, 81 per cent indicated that more feedback would be useful.

Outpatient activity for private patients within NHS facilities is not a major cause of long outpatient waiting times

2.13 NHS trusts carry out small amounts of activity for private-paying patients within their facilities. Such private sector facilities are usually ring-fenced from NHS capacity, and can help to attract consultants to the trust. Trusts also charge for this work, and should make a profit to reinvest in NHS services. **Figure 5** shows that, while there have been reductions in the volume of private inpatient and day case activity within NHS hospitals between 1997-98 and 2003-04, there has been an increase of over one quarter in outpatient activity for private patients in NHS hospitals over the same period.

2.14 Figure 2 shows that consultants, and chief executives of trusts and Local Health Boards saw treating private sector outpatients as the least significant barrier to meeting outpatient waiting time targets. This is backed up by official statistics, which show that outpatient attendances for private patients in NHS hospitals in 2002-03 represent less than one per cent of total outpatient activity within the NHS⁵.

2.15 Private sector outpatient appointments are much cheaper than inpatient or day case treatments, making them more affordable and a useful mechanism for patients, who choose to pay privately, to get an earlier diagnosis and avoid a long NHS waiting time for an outpatient appointment. If they require surgical treatment from the NHS, the private patient would be referred onto the inpatient/day case waiting list and should be admitted according to their clinical priority. Consequently, this can enable those who can afford to pay for a private outpatient appointment to go onto the waiting list for inpatient or day case surgery more quickly.

One of the approaches to tackling long outpatient waiting times has been to look at process improvement and modernisation

2.16 The Welsh Assembly Government has tackled the outpatient waiting time problem principally through modernisation and service innovation, supported by waiting time initiatives. The Assembly's approach to long outpatient waiting times has focused on modernisation and changing the modes of service delivery as well as using initiatives.

5 Use of NHS hospitals by private patients 1998-99 to 2002-03⁴

	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	Average	% change
Inpatient cases	1,621	1,601	1,691	2,004	1,863	1,558	1,579	1,702	-3%
Day case attendances	1,550	1,892	1,868	1,760	1,495	1,185	1,233	1,569	-20%
Outpatient attendances	6,283	6,969	7,364	8,192	7,567	8,451	7,986	7,545	27%

Source: Health Statistics Wales 2004, 16.3

⁴ There is no link between the outpatient and inpatient/day case attendances described in Figure 5. This table simply sets out the number of private patients using NHS hospitals.

⁵ The statistics for private outpatient appointments do not distinguish between first and follow-up appointments, making it impossible to make a direct link to the outpatient waiting list.

The outpatient improvement programme has achieved some success, particularly partial booking, although outpatient waiting times remain very long

2.17 Between April 2001 and March 2004, Innovations in Care - the department responsible for innovation and change in the NHS - ran the Outpatient Improvement Programme, at a cost of £2.5 million, of which trusts received 93 per cent. Partial booking (see the box below) is the major change initiated through the Outpatient Improvement Programme. Partial booking has been rolled out for most first outpatient appointments, although its extension to follow-up appointments has been much less widespread because of problems with trusts' computer systems. The greatest scope to reduce demand in outpatients is to reduce the volume of follow-up appointments, which represent the majority of outpatient activity (Volume 1, Figure 5), thus freeing up slots for the new outpatients on the waiting list. Only Carmarthenshire and Cardiff and the Vale NHS trusts have extended partial booking to most follow-up appointments. **Figure 6** shows that some trusts have made far more progress than others in introducing partial booking for first outpatient appointments. Given the benefits of partial booking, it is disappointing that progress has not been more widespread.

Partial booking

Under partial booking, trusts contact patients on the outpatient waiting list around six weeks before their likely appointment to arrange a mutually convenient date and time for the patient. The aim of partial booking is to reduce non-attendance at clinic and cancellations, as well as providing a better service to patients through enhanced communication and choice of appointment time. Partial booking initially covered first outpatient appointments, and is now being rolled out to follow-up appointments.

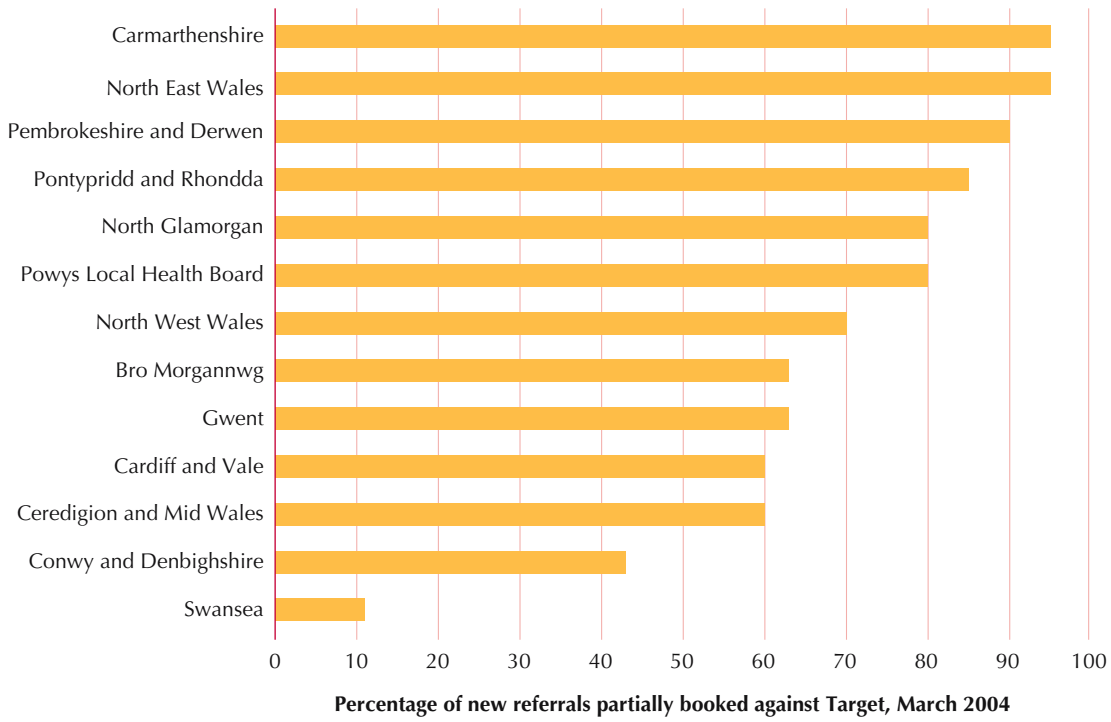
Partial booking is different from direct booking, which involves GPs booking the appointment electronically at the point of referral. The NHS in England is moving towards such a system under its Choose and Book initiative.

2.18 Although partial booking does not directly contribute to reducing outpatient waiting times, it does have advantages for patients, in terms of increasing their choice of appointment time and reducing cancellations. Partial booking has been an extremely positive development, and has delivered a number of benefits. It has reduced DNA rates which, for first appointments, fell to around 8 per cent by the end of March 2004, having historically been between 10 and 12 per cent (see 2.7). Although this is higher than the Assembly's 5 per cent target, such a reduction in the DNA rate is a very positive outcome. Partial booking contributes to list validation and the avoidance of unnecessary appointments. One trust reported that partial booking led to increased throughput of one thousand patients a month⁶.

2.19 Most stakeholders believed that partial booking had made a very positive impact since its introduction. **Figure 7** summarises the results of our surveys, and shows that all Trust chief executives saw the introduction of partial booking as an improvement on the previous system, with 83 per cent viewing it as being 'much better' than the previous system for first appointments. Feedback from patients was also positive: 67 per cent of Community Health Council chief officers, responding to our survey, indicated that patients in their health community saw partial booking as 'clearly an improvement on the previous system'; and trusts, which had carried out patient satisfaction surveys on partial booking, also reported positive feedback.

2.20 Although 33 per cent saw it as an improvement, **Figure 7** shows that consultants were generally less positive about partial booking. Their concern related to a belief that the system was inflexible and reduced their control of outpatient clinics. Over one quarter of consultant respondents perceived partial booking to have made little difference from the previous arrangements. Their key concern was the inflexibility of partial booking for follow-up appointments, particularly when patients need a follow-up appointment shortly after their surgery or initial appointment, if this is within six weeks. In such circumstances, the urgent patient may displace a patient who had earlier received an appointment through partial booking.

6 Trusts' progress in implementing partial booking for first outpatient appointments



Source: *Innovations in Care, Outpatient Improvement Programme Report, March 2004*

7 Partial booking has had a positive impact

The introduction of partial booking of first outpatient appointments has been

	Trust	Consultants
Much worse than the previous system	0%	21%
Slightly worse than the previous system	0%	18%
No different from the previous system	0%	27%
Slightly better than the previous system	17%	30%
Much better than the previous system	83%	3%

Source: *National Audit Office Wales surveys of trusts and consultants in General Surgery, Trauma and Orthopaedics and Ophthalmology*

There are a number of local solutions which have reduced outpatient waiting times

2.21 Local innovation has delivered a number of improvements in the way that outpatient services are delivered. This section looks at two key areas of local innovation:

- developing Integrated Care Pathways and extending the role of non-Consultant staff; and
- waiting list management.

Health communities have developed Integrated Care Pathways and extended the role of non-Consultant staff

2.22 Integrated Care Pathways seek to remove unnecessary steps in the patient's pathway, ensuring that patients see the most appropriate health professional, at the most appropriate time and in the most appropriate setting. This often involves working in a different way from traditional models of service delivery, particularly in outpatients, where there is more scope to change the way in which services are delivered. Achieving such change is especially important to meet increased demand for outpatient services (see 2.3).

2.23 Some Integrated Care Pathways remove the traditional outpatient appointment altogether. A common example is in Ophthalmology, where several trusts now operate direct referral for cataract surgery from Optometrists. Under such schemes, the Optometrist usually refers the patient directly to pre-operative assessment by a nurse, removing altogether the need for an outpatient consultation before surgery. In 2002-03, NHS Wales carried out over 18,000 cataract excisions⁷. On this basis, a significant number of first outpatient appointments could be saved if all trusts operated integrated care pathways which removed the initial consultant-led outpatient appointment for cataract patients. This would also reduce the workload of GPs in primary care.

2.24 Because of substantial rising demand for outpatient services (see 2.3), it is essential to identify other staff able to take on work, traditionally undertaken by consultants, to ensure reasonable waiting times.

Case Studies A and **B** show the significant role Extended Scope Physiotherapists and Nurse Practitioners can play in reducing demand for consultant-led outpatient services, either individually or working as part of Multi-Disciplinary Teams made up of a range of staff. Such teams enable patients to see the most appropriate professional at the right time, and take a more holistic approach to their care.

2.25 **Case Study B** describes a project which has involved training GPs to specialise in a particular field of medicine. This means that larger numbers of patients can be treated in Primary Care, consistent with the Wanless agenda to reduce the unsustainable burden currently facing the secondary care sector. Developing specialist GPs, and deploying them in Primary Care or outpatient departments, has considerable scope to reduce demand, increase capacity and provide viable alternatives to referral to acute hospitals. For example, training GPs with a special interest administering Orthopaedic joint injections in the Carmarthenshire health community has the potential to remove around 1,000 patients a year from the Trust's Trauma and Orthopaedics waiting list, which stood at 2,174 at the end of December 2003⁸. The development of GPs with a special interest must, of course, be subject to consideration of the pressures on GPs and their ability to meet demand for core primary care services - at the end of March 2003, there was a 3.1 per cent GP vacancy rate in Wales⁹.



⁷ *Health Statistics Wales 2004*, 8.6, page 154.

⁸ *Innovations in Care National Conference 2003, Conference Abstracts page 74.*

⁹ *Statistical bulletin SB58/2004, Workforce statistics for General Practitioners in Wales 1993-2003.*

A

Integrated Care Pathways

Gwent Healthcare NHS Trust developed a back pain pathway, whose first point of contact was an Extended Scope Nurse Practitioner. The Nurse Practitioners see and screen patients referred to the trust with back pain, giving advice and referring them to a physiotherapist as appropriate. The Clinical Director of Trauma and Orthopaedics estimated that the pathway has reduced the number of patients seen by the spinal Consultant by 95 per cent, thus freeing up their time to see other patients who have more significant back problems, particularly those requiring spinal surgery.

The Trust has achieved substantial reductions in outpatient waiting times in Trauma and Orthopaedics, reducing over eighteen month waiting times from 4,394 in January 2003 to 0 in March 2004. Innovations such as the back pain pathway have contributed to these improvements.

Source: National Audit Office Wales

B

Multi-Disciplinary Teams

North West Wales NHS Trust set up a Multi-Disciplinary Team, known as TEAMS, which is designed to improve services for back pain and musculo-skeletal problems, and to manage referrals through:

- central triage service for all Orthopaedic, Rheumatology, Chronic Pain and Physiotherapy referrals;
- a back pain pathway led by an Extended Scope Physiotherapist; and
- training GP specialists and Extended Scope Practitioners to provide services for patients with straightforward back problems in the community.

The Trust's musculoskeletal service has a waiting time of around six weeks. Since its inception in April 2002, the Trust reports the following outcomes:

- a 33 per cent increase in musculoskeletal referrals - long waiting times previously discouraged GPs from making referrals (see 2.4);
- a 22 per cent increase in outpatient musculoskeletal activity between 2001-02 and 2002-03; Trauma and Orthopaedic outpatient activity remained constant during the same period;
- a 150 per cent increase in the number of musculoskeletal patients seen in non-surgical clinics which, the Trust believes, means that traditional Orthopaedic outpatient clinics see a higher proportion of patients likely to require surgery;
- a 26 per cent reduction in the number of patients waiting over 4 months between August 2002 and August 2003;
- the use of Extended Scope spinal Physiotherapists has reduced the waiting times for patients with acute back pain to 4-6 weeks, improved the quality of referrals and significantly reduced the number of spinal x-rays and scans carried out;
- patients with non-inflammatory musculoskeletal conditions see GPs with a special interest - this frees up Consultants in Orthopaedics, Rheumatology and Pain Management to see more appropriate patients; and
- Orthopaedic outpatient waiting times have remained stable, there has been a dramatic reduction in outpatient waiting times in rheumatology from 9 months to 6 weeks, and waiting times in Pain Management have fallen from 14 to 3 months.

Source: North West Wales NHS Trust evaluation of the TEAMS project and National Audit Office Wales visit to North West Wales NHS Trust

2.26 Systems for recording activity often fail to keep up with service change and innovation. This means that much of the activity delivered through such new service models is neither measured nor recorded in the official activity statistics. In particular, the following types of activity, traditionally undertaken in outpatients but now provided in new ways and in different settings, is not recorded in the official outpatient activity statistics:

- activity carried out by Nurse Practitioners or Professionals Allied to Medicine;
- consultants' domiciliary clinics;
- tele-medicine;
- community-based work; and
- technicians' activity.

Pooled waiting lists and generic referrals

Traditionally each consultant has their own waiting list, which they manage with support from their clerk or medical secretary. If consultants within a specialty, or who all carry out a specific procedure, pool their waiting lists and allocate patients from the pooled list to the consultant with the next available appointment, differences in waiting times between consultants can be equalised. One of the problems with pooled waiting lists is that they can be somewhat inflexible and insensitive to important issues of sub-specialisation. This can be addressed by using 'generic referrals', whereby GPs make 'Dear Doctor' referrals, rather than referring to a specific consultant, with the consultants then allocating the referral to the most appropriate clinician, taking account of sub-specialisation issues and waiting times.

Pooled waiting lists and generic referrals help to develop a more team-based approach to managing services within a specialty, particularly with issues such as planning annual and study leave, which have traditionally led to widespread cancellation.

2.27 This lack of accurate recording of outpatient activity represents a barrier to effective management and planning. With such poor recording, it may appear that activity is falling when some activity delivered through new models of service delivery is simply not recorded. This creates a disincentive to innovation, as the failure to count activity affects performance management and service planning. This reflects the situation in Scotland, where a recent report by the Auditor General for Scotland found that much outpatient activity is not recorded, with doctors running only 52 per cent of all outpatient clinics in the week of Audit Scotland's census of activity¹⁰.

KEY POINTS

on outpatient waiting times

- A major reason for long outpatient waiting times is increasing demand, which manifests itself through rising GP referrals.
- Waiting times influence GP referral thresholds and practices, particularly the common practice of referring patients before it is really necessary, in order to circumvent the likely waiting time, and contacting consultants directly to expedite the patient's appointment.
- Consultants reported that between 20 and 30 per cent of referrals received in 2003 were 'inappropriate'. There is no feedback mechanism on the quality of referrals, while the availability of alternative services to those led by consultants is variable. Given the rising rate of referrals, this places great pressure on consultant-led outpatient waiting lists.
- Patients failing to attend appointments have historically accounted for between 10 and 12 per cent of all outpatient appointments. Every one per cent reduction in DNA could generate an annual efficiency gain of approximately £3 million.
- Demand management is a vital function of Local Health Boards, both in terms of monitoring and improving the quality of GP referrals, and in developing viable alternative pathways to replace referral to a consultant.
- Partial booking has increased the efficiency of outpatient clinics by reducing DNA rates and increasing patient choice; the roll-out of partial booking to follow-up appointments, the majority of outpatient activity, has so far been limited.
- Other local innovations include the development of Integrated Care Pathways, innovative forms of managing the outpatient waiting list, and new forms of service delivery. This latter is potentially key to reducing waiting times.

¹⁰ Auditor General for Scotland, *Outpatients Count*, August 2003.

Innovative approaches to waiting list management can reduce outpatient waiting times

2.28 Waiting list management influences waiting times for patients. The most significant innovation is the use of pooled waiting lists or generic referrals (see box on page opposite). Trust chief executives, consultants and GPs all reported positively on the impact of pooled waiting lists in reducing overall waiting times and equalising differential waiting times between individual consultants. At North East Wales NHS Trust the numbers waiting for a first outpatient appointment in Ear, Nose and Throat and General Surgery fell by 11 and 43 per cent respectively between April 2001 and April 2003 following the introduction of pooled waiting lists.

Diagnostic and therapy services are a hidden bottleneck in the patient pathway, but the Welsh Assembly Government has started to measure waiting times and focus on this important area, ahead of other parts of the United Kingdom

2.29 The waiting times recorded and published by NHS Wales, as in the rest of the United Kingdom, relate to discrete waits for outpatient appointments or for treatment as an inpatient or day case. From the patient's perspective, the 'real' waiting time begins when they present themselves to a GP or to A&E, and ends when they complete their treatment. Within this overall 'journey', Figure 2 in Volume 1 shows that there are various blocks of time that generally go unmeasured, of which the most significant is diagnostic and therapy waiting times.

2.30 Waiting times for diagnostic and therapy services have not traditionally been measured, meaning that NHS trusts may focus on the more heavily performance managed outpatient and inpatient/day case waiting times. This, allied to shortages of staff and equipment, may create a bottleneck in diagnostic and therapy services. NHS Wales has now begun to measure diagnostic and therapy waiting times, with a view to publishing this information when it considers it sufficiently robust. The Diagnostic Services Strategy, which the Welsh Assembly Government issued for consultation in January 2004, proposes a comprehensive reorganisation of diagnostic services across Wales to ensure greater co-ordination, consistency and rationalisation of resources. It also proposes a selection of studies that would examine the impact of timely and accurate diagnosis on the overall patient pathway.

'Waiting times for diagnostic tests for varicose veins are about two and a half years due to the lack of a vascular laboratory. A typical patient with recurrent varicose veins sees the GP today and is referred to me (January 2004). The waiting time to see a consultant is about 3 months. The patient is seen by the consultant in April 2004 and a duplex ultrasound of varicose veins ordered. The current wait for that is 2 and a half years. The test is performed in October 2006. It takes another 3 months to see the consultant to discuss the test results, with the patient seen again in January 2007 for the decision to operate on the varicose veins. The waiting time for elective, routine surgery is 16 months (January 2004). Varicose vein surgery eventually takes place in March 2008. The total wait from GP referral to completion of treatment is 4 years and 2 months. The above scenario is real and has been happening to some of my patients for the last four years and without change will continue to happen.'

Source: National Audit Office Wales survey of consultants



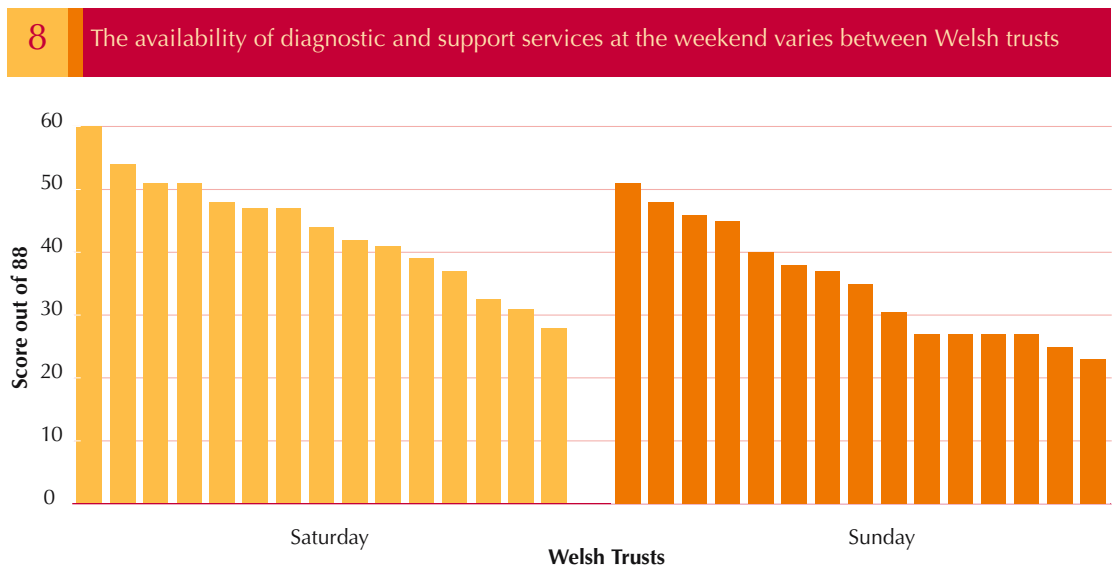
Waiting times for diagnostic and therapy services can increase patients' total wait and create inefficiencies and anxiety

2.31 Waiting times for diagnostics can be lengthy (see the box opposite). As with other stages of the patient pathway, long waits create anxiety on the part of patients about their condition and risk further deterioration in their health. Additionally, the absence of timely access to diagnostic procedures and informed interpretation of the results, may prevent patients from following the most appropriate care pathway. Consultants also informed us that long waiting times for outpatient or inpatient/day case appointments can result in repeat diagnostic tests, as their conditions may have changed while they waited.

Long waiting times for diagnostics and therapies often result from staff shortages and inefficiencies

2.32 Diagnostic services are a crucial component in the delivery of healthcare and account for just under 10 per cent of total acute healthcare expenditure in Wales¹¹. However, they have had a relatively low profile compared with many other service areas. Many diagnostic and therapeutic services operate limited services - this affects outpatient, inpatient/day case and emergency services, which compete for these scarce resources during daytime hours, with only on-call provision during the evening and night. **Figure 8** shows that there is considerable variation between Welsh trusts in the availability of their support and diagnostic services on Saturdays and Sundays.

2.33 A recent survey by the Welsh Assembly Government revealed inequitable access to diagnostic and therapy services across Wales, with referral and access criteria varying considerably between trusts and disciplines. In some cases, only referrals from consultants are accepted, in others referrals from GPs and/or from other relevant healthcare professionals are also accepted. Some restrictions apply specifically to certain tests or procedures¹².



Source: Audit Commission, Acute Hospital Portfolio

¹¹ Welsh Assembly Government, *Getting Results: A Strategy for Diagnostic Services in Wales. A Consultation Document*, January 2004, page 5.
¹² Report on Questionnaire Survey in Relation to Access and Referral to Diagnostic and Therapy Services, available on the Health of Wales Information Service website, at <http://www.wales.nhs.uk/documents/diag-therapy-refer-survey-e.pdf>.

The European Working Time Directive

This is a directive from the Council of the European Union to protect the health and safety of workers, by laying down minimum standards for working hours, rest periods, annual leave and working arrangements for night workers. From August 2004 the directive will apply to doctors in training, who were previously exempted from its provisions. The introduction will be phased from maximum working hours of 58 per week from 2004 to 48 hours in 2009.

The Welsh Assembly Government is now dedicating more attention to diagnostic and therapy services

2.34 In its Diagnostic Services Strategy, the Welsh Assembly Government acknowledges that current models of service delivery are unsustainable, as there are insufficient numbers of skilled and experienced staff available to provide a comprehensive range of services in each area. This leaves trusts to compete for scarce resources instead of collaborating to make the best use of the staff and skills available. Moreover, the implementation of the European Working Time Directive (see box above) will exacerbate this, along with the forecast increase in the numbers of staff reaching retirement age during the next 10 years. The strategy recognises that greater collaboration between organisations and integration of services will be essential to ensure that consistent, high quality diagnostic and therapy services are delivered in an equitable way across Wales.

2.35 The Welsh Assembly Government is also undertaking a pilot project, which is unique in the UK, to measure waiting times for specified Diagnostic and Therapy services. The 2003-04 Service and Financial Framework (the annual basis for performance management - see 4.6 and onwards) committed trusts to provide monthly data to Health Solutions Wales, with a view to publishing this data when it considers it sufficiently robust. This information will help to identify and address key issues in this area such as staff shortages, recruitment and retention, restricted opening hours and inconsistent referral guidance. Innovations in Care is also running a number of programmes to modernise diagnostics and therapy, such as a project aimed at universalising best practice in the staffing and organisation of endoscopy work.

2.36 The integration of diagnostic and therapy services into the patient's pathway addresses the impact that delays in access to these services can have on overall waiting times. An encouraging step in this regard is the introduction in Wales of a pathway-based approach to counting waiting times for urgent cancer referrals from September 2004, when the target will change from one based on the speed of access to outpatients to one where the target time will be the difference between the GP referral and the start of treatment. This will include diagnostic tests as well as the first outpatient consultation, addressing an issue that was consistently raised by respondents to our consultant survey: the importance of the speed of access to diagnostic services for suspected cancer patients. The NHS in England plans to move to a pathway based target for all patients over the next five years, with waiting time targets covering the period from GP referral to treatment (see Volume 1 Figure 7).



Making diagnostic and therapy services more accessible:

- allowing nursing or other staff to request radiology examinations and other diagnostic tests;
- increasing the availability to GPs of direct access to diagnostic and therapy services, which varies between sites and diagnostic services;
- making key diagnostic services more accessible to emergency and elective services, for example by 24 hour a day, seven day a week access to pathology, radiology and pharmacy services. This would maximise the use of expensive capital equipment;
- extending the role of clinical support services staff, for example, by developing protocols by which radiographers can provide interpretation of results for certain conditions; and
- increasing the use of new technologies, such as digital imaging with centralised reporting, resulting in faster delivery of results.

Source: A Question of Balance: a review of capacity in the Health Service in Wales 2002, p.86, and the Welsh Assembly Government's report on a questionnaire survey in relation to access and referral to diagnostic and therapy services



Local solutions to diagnostic and therapy bottlenecks have focused on the flexible deployment of staff and the development of Integrated Care Pathways

2.37 Case studies A and B on page 11 provide examples of the widespread development of Integrated Care Pathways to eliminate unnecessary steps in the patient journey. These have often involved linking diagnostic and therapy services more closely with both the outpatient and inpatient stages of the journey and making more flexible use of staff. Greater access to diagnostic facilities and services has also been achieved in some areas in a number of other ways (see the box below).

KEY POINTS

on diagnostic and therapy waiting times

- The Welsh Assembly Government is addressing the issue of waiting times for diagnostic and therapy services through its Diagnostic Services Strategy; traditionally, waiting times for such services have been unmeasured and represent a hidden wait. Identifying and measuring such waiting times is the first step to understanding them and reducing them.
- Waiting times for diagnostic and therapy services can be caused by staff shortages and process inefficiencies particularly through restrictions on access and the days of the week on which such services are available.
- The development of Integrated Care Pathways, which take account of diagnostic and therapy waiting times and make flexible use of staff, can reduce waiting times.

Tackling inpatient/day case waiting times, and accelerating discharge from hospital

3

3.1 The causes of lengthy inpatient/day case waiting times are different from those for outpatients and diagnostic and therapy services. Surgical procedures for inpatient and day case patients are more costly and complex because they require theatre time and staffed beds. This part of the report examines the causes of long inpatient/day case waiting times, and ways in which they may be shortened, considering:

- inpatient/day case waiting times; and
- delays in discharging patients from hospital.

Elective inpatient/day case capacity is insufficiently protected from medical and emergency pressures

3.2 The number of people waiting for inpatient/day case treatment has remained relatively stable (Volume 1, 4.26), and there have been recent reductions in the number of people waiting over eighteen months for inpatient/day case treatment. However, at the end of June 2004, 1,447 people had been waiting over eighteen months for treatment. Tackling waiting times for inpatient/day cases have been a greater priority in Wales than those for outpatients. This is shown by:

- the recently-introduced Second Offer Scheme, which guarantees an offer of inpatient/day case treatment by an alternative provider if the patient will breach an inpatient/day case waiting time target (see 4.4-4.5);
- Trusts devoted 92 per cent of waiting time initiative funding in 2002-03 and 2003-04 to inpatient/day case treatments (see 4.21), though the cost of inpatient/day case treatment is much higher than outpatient consultations; and

- the 'minimum standard' priority accorded to inpatient/day case waiting time targets in the 2003-04 Service and Financial Framework (the SaFF - see 4.6) compared with the 'continuous improvement' status accorded to outpatient waiting times (both have 'minimum standard' status in the 2004-05 SaFF).

The main cause of long inpatient/day case waiting times is emergency pressures, which encroach upon elective capacity

3.3 Figure 6 in Volume 1 showed that between 1997-98 and 2002-03 emergency inpatient admissions rose from 51 to 58 per cent of all admissions to hospitals in Wales, while admissions from the waiting list fell from 29 per cent to 27 per cent of all admissions. Increasing amounts of emergency work thus takes up a growing share of capacity which could otherwise have been used for elective work. In the calendar years between 2000 and 2003, emergency admissions to Welsh hospitals increased by 8 per cent, while the number of inpatient/day cases waiting over eighteen months increased by 8 per cent between April 2000 and December 2003.

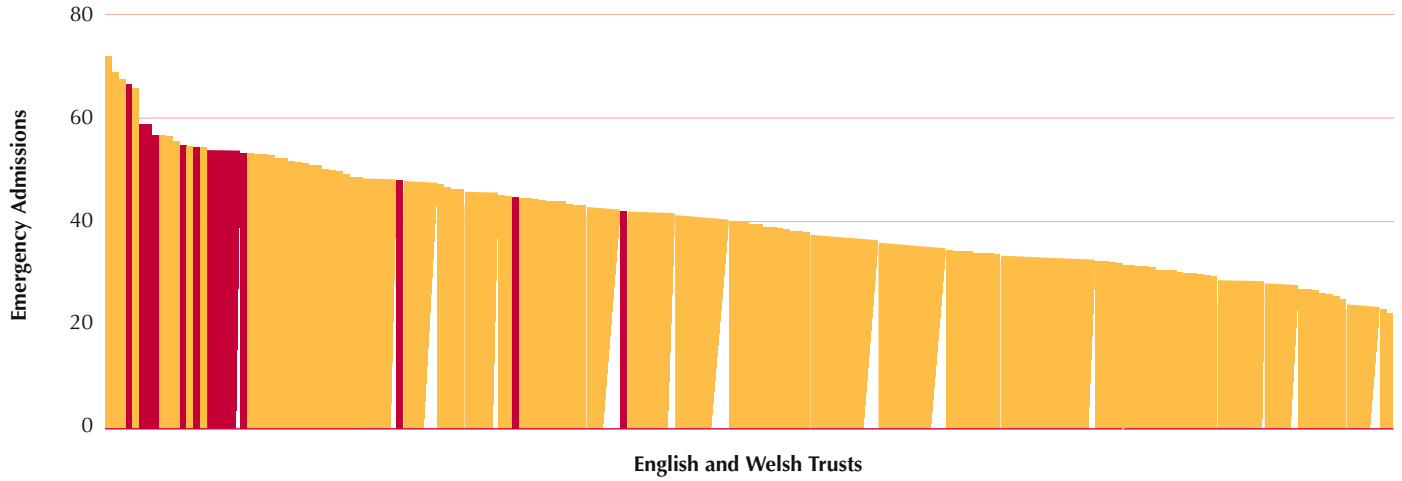
Figure 9 overleaf shows that emergency admissions per one thousand head of population are generally higher in Welsh trusts than in English trusts, reflecting the scale of the problem of emergency pressures in Wales.

3.4 **Figure 10 overleaf** shows that consultants and chief executives of trusts and Local Health Boards viewed higher than expected emergency admissions as the most significant barrier to achieving targets for inpatient/day case waiting times, followed closely by levels of urgent work and winter pressures. Acute hospitals in Wales face such a burden from medical, emergency and urgent surgical patients that this work effectively crowds out elective work for more routine patients.



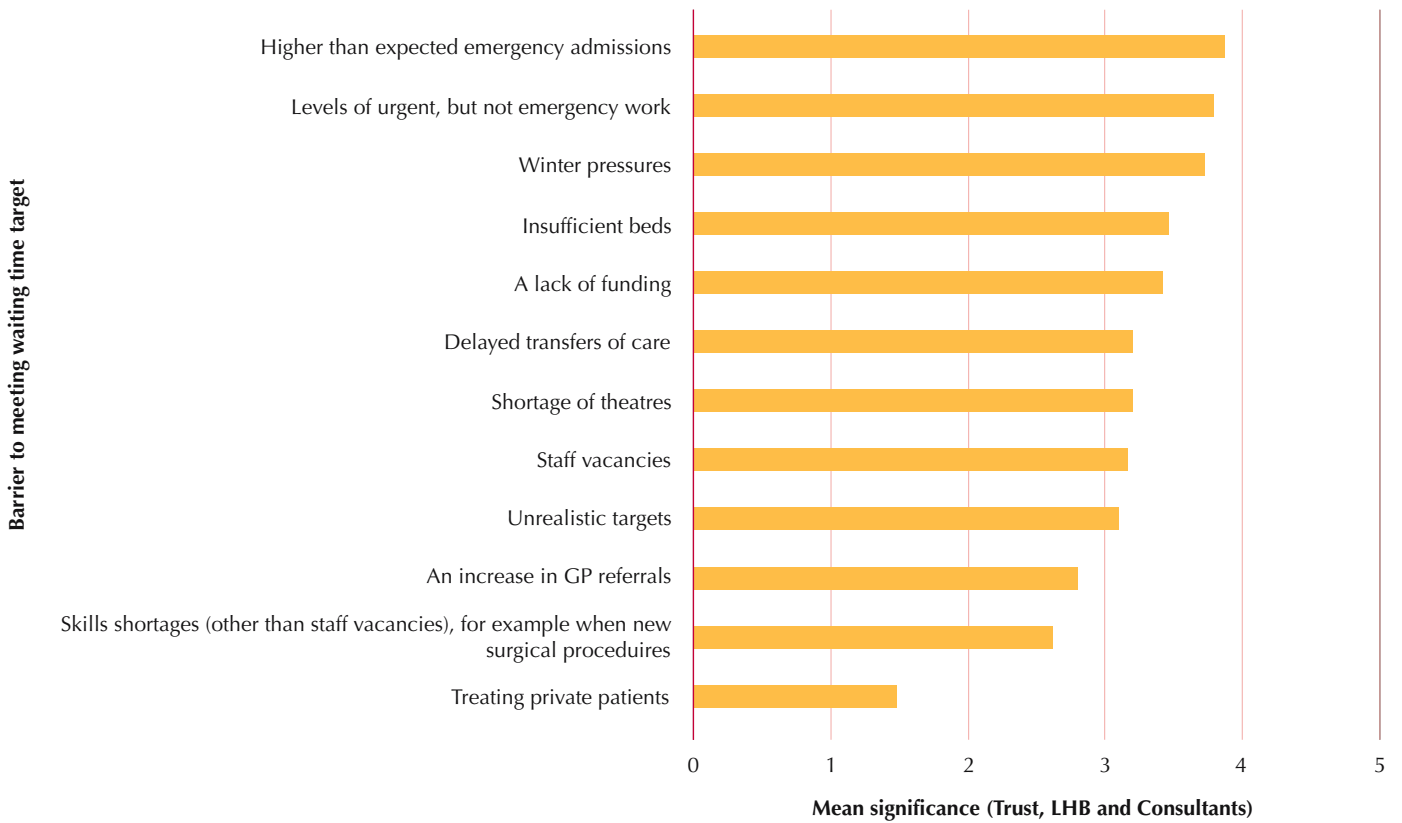
9 Emergency admissions are higher in Wales than England

Emergency admissions per annum per 1000 population.



Source: Audit Commission Acute Hospital Portfolio (Welsh trusts are highlighted)

10 Barriers to achieving inpatient/day case waiting time targets¹³



Source: National Audit Office Wales surveys of consultants, and Trust and Local Health Board chief executives

¹³ Our surveys asked respondents to rank the significance of a series of barriers to achieving Assembly inpatient/day case waiting time targets on a scale of 1 to 5. This graph summarises the results of responses to this question by trust and Local Health Board Chief Executives, and consultants.

- 3.5 One of the consequences of medical pressures is the number of 'outliers'- medical patients¹⁴ occupying a surgical bed. Across all NHS trusts in Wales, outliers account for between one and nine per cent of all surgical beds and are symptomatic of emergency and medical pressures. One consequence of this level of outliers is the widespread cancellation of surgery because of bed availability (3.9). In turn this makes it more difficult for physicians to carry out their ward rounds because some of their patients are often located remotely in surgical wards. There are also problems relating to the number of patients occupying beds in Welsh hospitals who have a chronic medical condition which could be managed appropriately outside the acute sector¹⁵.
- 3.6 The other key cause of long inpatient/day case waiting times is the shortage of key medical staff and skills. Although bed availability and the efficiency with which operating theatres are used contribute to waiting times, medical staffing issues are significant, as without such key staff and linked sub-specialist skills, no amount of beds or theatre capacity would enable more operations to take place. In total, although there were 14 per cent more consultants in 2003 compared to 1999, 8.8 per cent of consultant posts in Wales were vacant in March 2004. There are particularly high vacancy levels in Accident and Emergency (18 per cent), Cardiology (26 per cent) and Dermatology (27 per cent). As well as vacancies, shortages of specific skills also influence waiting times, particularly where a consultant is the only person qualified to deal with specific types of patient. The pressures on staffing resources will intensify as a result of the new consultant contract, the European Working Time Directive (see the box above paragraph 2.34), and the 'new deal' for junior doctors, all of which will reduce the hours medical staff work each week. Such changes are likely to have a particular impact on smaller hospitals and those in rural areas. Shortages in consultants, as well as driving up waiting lists, result in inefficient use of available beds and theatre capacity. There will therefore need to be additional investment to protect existing capacity.
- 3.7 As with outpatients (2.13), the impact on inpatient/day case waiting times of treating private patients in NHS hospitals is negligible. Figure 5 shows that 1,579 private inpatients and 1,233 day cases received treatment in NHS facilities in 2003-04. This represents less than 1 per cent of total elective activity in NHS hospitals, and an average of just 15 beds occupied each day by private patients across the NHS in Wales. This is marginal and makes no significant difference to overall waiting times. In our survey of consultants and the chief executives of trusts and Local Health Boards, treating private patients was ranked as the least significant barrier to achieving inpatient/day case waiting time targets (Figure 10). Such private patient occupancy also produces surplus revenue, which trusts can reinvest in service development and increased medical capacity.

There are other indicators of inefficiencies which affect waiting times

- 3.8 As well as the impact of emergency and medical pressures on waiting times, there are indicators of inefficiencies in the way NHS Wales uses its available capacity. More efficient use of existing capacity could reduce waiting times. This section provides a high-level overview of the following symptoms of inefficiency in the way NHS Wales utilises existing capacity:
- cancellation of elective operations;
 - bed usage;
 - day case rates;
 - theatre utilisation; and
 - recording and measuring activity.

¹⁴ Those patients who require hospital care because of illness, rather than requiring a surgical intervention.

¹⁵ Audit Commission in Wales, *Transforming Health and Social Care*, 2004, page 16.



Cancellation rates across Wales are very high, partly because of patient behaviour

3.9 NHS trusts in Wales cancel over one thousand operations each month¹⁶, which can be disruptive and distressing for patients, particularly those who have responsibilities as carers. From our analysis of cancellations, we found that between April 2003 and January 2004, eight per cent of all scheduled operations in Wales were cancelled on the day of surgery or the day before surgery. Such cancellations are the least likely to result in the reallocation of the theatre slot or bed.

3.10 **Figure 11** shows that 20 per cent of operations cancelled on the day of, or day before, surgery between April 2003 and January 2004 were because no ward beds were available. However, 27 per cent of such short-notice cancellations arose from patients failing to attend, inconvenient appointments or patients cancelling because they did not want their operation. This is very disruptive to the efficient functioning of hospitals, and makes it very difficult for trusts to utilise these appointments cancelled by patients at short notice, which account for over half of the total number of patients waiting over eighteen months in November 2003.

3.11 In England, patients whose operation is cancelled by the hospital for a non-clinical reason on the day of surgery or admission have a guarantee of an alternative appointment within twenty-eight days or the original provider will fund an appointment at a time and hospital of the patient's choice. No such guarantee applies in Wales, although the Health and Social Care Guide makes clear that the patient should have their operation, or a new date, within twenty-eight days. In its *Guide to Good Practice*, the Welsh Assembly Government indicated that only 70 per cent of Welsh patients whose operation is cancelled receive their operation within one month of cancellation¹⁷.

11 Main reasons for cancellations on the day or day before surgery, April 2003 - January 2004

Reason for cancellation	Percentage of total cancellations on the day of, or day before, surgery
Ward beds unavailable	20%
Patient did not attend	15%
Appointment inconvenient	9%
Unfit with illness (hospital cancel)	8%
Theatre list overrun	7%
Unfit for surgery (patient cancel)	7%
Operation not necessary (hospital cancel)	4%
Emergencies/trauma	4%
Operation not wanted (patient cancel)	3%

Source: National Audit Office Wales analysis of trust submissions to the Welsh Assembly Government on cancelled procedures

¹⁶ A Question of Balance (2002), page 28.

¹⁷ Welsh Assembly Government, A Guide to Good Practice (2003), page 99.

Beds could be used more efficiently

- 3.12 There is considerable scope for NHS Wales to use its bed stock more efficiently, particularly since medical pressures on beds are one of the main reasons for long inpatient/day case waiting times. Wales has 37 per cent more beds per head of population than England¹⁸. However, there is considerable pressure on this bed stock as a result of bed occupancy rates of around 98 per cent for general medical/acute elderly beds, compared with a recommended level of 85 per cent¹⁹.
- 3.13 The average length of stay for inpatients in acute beds in Wales is also relatively high and is rising - from 6 days in 1997-98 to 7.1 days in 2003-04²⁰. A recent report found that the average length of stay in Wales was 5 per cent longer, after adjusting for case complexity, than in England²¹. If the average length of stay in an acute bed reduced by one day (from its 2002-03 level of 7.1 days to 6.1 days), the resulting efficiency gain could release significant additional capacity to treat more elective patients each year. High turnover intervals - the time between each bed being occupied - of 1.5 days for acute beds in 2003-04²² exacerbate long average lengths of stay in Wales, and represent another indicator of the inefficient utilisation of available capacity. In the specialty of Trauma and Orthopaedics, where waiting times are particularly long (see Volume 1, paragraphs 4.3-4.4), the turnover interval varied between trusts in 2003-04 from 0.3 to 4.2 days²³. High turnover intervals are extremely expensive, given the daily cost of an acute bed - £329 (see 3.34).
- 3.14 Taken together, these indicators of the inefficient use of existing bed capacity and the relatively high number of beds within NHS Wales, reinforce the findings of previous reviews. Essentially, these concluded that providing additional acute beds would represent a solution to the symptom, rather than the cause, of the imbalances which characterise the current system of health and social care in Wales. The provision of additional acute beds risks reinforcing existing inefficiencies rather than alleviating their impacts²⁴.
- 3.15 In contrast to the high rates of bed occupancy in acute hospitals, bed utilisation is relatively low in community hospitals. A review found that bed utilisation in community hospitals was around 77 per cent and that the turnover interval - the time it takes for a bed to be reoccupied - for each bed was 7.5 days²⁵. Effectively, this means that Welsh community hospital beds are empty every second week. Community hospital beds are managed either by GPs or consultants, which can result in inflexibility and problems accessing the beds. Clearly, in a system with long waiting times and extremely high bed occupancy levels in acute hospitals, it is essential that community hospital beds are fully utilised in order to reduce the burden on the acute sector to enable it to deliver more operations and reduce waiting times. Improving the utilisation of community hospitals, and thus freeing up beds in acute hospitals, is fundamentally important in reconfiguring and rebalancing the system of health and social care in Wales and tackling inpatient waiting times.

18 *Review of Health and Social Care in Wales (June 2003)*, page 22.

19 *Review of Health and Social Care in Wales (June 2003)*, page 22, *A Question of Balance (2002)*, pages 11 and 101.

20 *Health Statistics Wales 2004*, 7.2, page 122, and *Statistical Bulletin SB66/2004* page 3.

21 *Welsh Assembly Government, Report of the Task & Finish Group on Healthcare Activity Measurement, March 2003*, page 1.

22 *Statistical Bulletin SB66/2004* page 3. The turnover interval was 1.1 days for medical acute beds, 1.6 days for surgical acute beds and 3 days for other acute beds.

23 *Statistical Bulletin SB66/2004* page 3.

24 *Review of Health and Social Care in Wales (June 2003)*, page 22, *Audit Commission in Wales, Transforming Health and Social Care (April 2004)*, page 11.

25 *A Question of Balance, October 2002*, page 11 and 102.

Day case rates are relatively low in Wales, which reduces efficiency and increases costs

3.16 Given the extent of problems with bed occupancy levels and cancellation because no beds are available, undertaking elective surgery as a day case or day surgery offers significant potential to increase activity and reduce waiting times. The Audit Commission has established a basket of twenty-five procedures which are generally accepted as being suitable for day surgery. Trusts in England and Wales measure their day case rates against this basket of procedures. Welsh trusts generally have lower day case rates than those in England²⁶, which means that more patients are admitted as inpatients, use beds, and stay in hospital for longer than is necessary. This is inefficient, adds to the cost of providing services and is bad for patients, who sometimes face an unnecessary stay in hospital. Overall, low day case rates lead to longer waiting times and less surgical activity because beds are unavailable for those patients who genuinely require admission as an inpatient. This is an issue which, if tackled, could significantly reduce inpatient waiting times in Wales. The Welsh Assembly Government, through Innovations in Care, is running a Day Surgery Programme, and recently published a good practice guide on Day Surgery.

3.17 The National Audit Office Wales and Audit Commission in Wales have recently commenced a joint examination of Ambulatory Care and Day Surgery in Wales, which they intend to publish later in 2005.

Operating theatre utilisation needs to improve

3.18 Surgery is highly complex and involves a wide range of staff, such as surgeons, theatre nurses, anaesthetists and porters. The logistics of arranging and delivering elective surgery are far more complex than arranging a consultant appointment in outpatients. Operating theatres are an expensive resource, both in terms of capital and ongoing running costs. Their inefficient use is very expensive and represents bad value for money. Maximising operating theatre utilisation is key to treating more patient/day case patients and thus reducing waiting times.

3.19 **Figure 12** shows that the overall utilisation of scheduled theatre hours is low in Welsh trusts compared with English trusts, with most Welsh trusts falling below the England and Wales average utilisation of 73 per cent of planned theatre session hours for scheduled operating sessions, mainly due to cancelled lists, list under-runs and gaps between patients²⁷. There is considerable scope to improve throughput in Welsh operating theatres but this would, of course, involve ensuring that other key resources, such as beds and staff, are available. Indeed, the balance between theatre capacity, beds and medical staffing lies at the heart of the efficient running of acute facilities and minimising inpatient/day case waiting times. Innovations in Care, the branch of the Welsh Assembly Government responsible for innovation and change in healthcare organisations, is currently running a programme to improve theatre management.

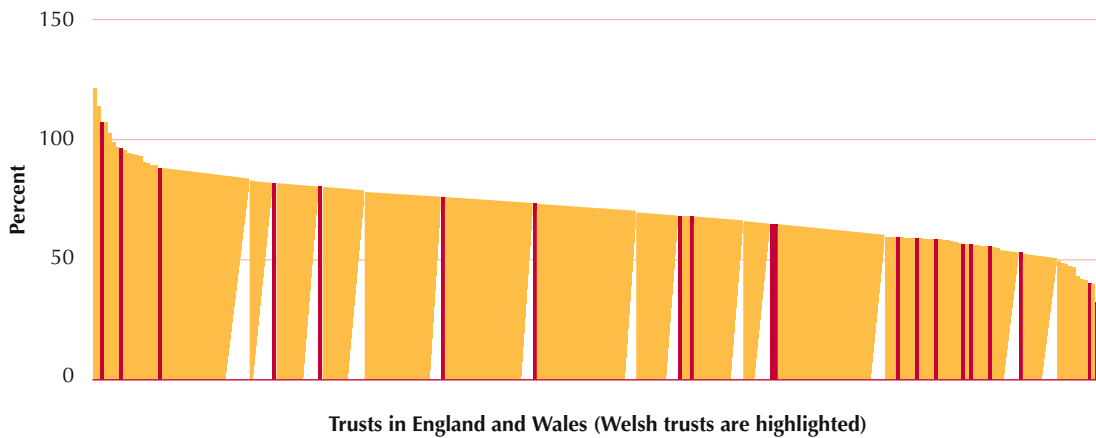
The way inpatient/day case activity is counted makes it difficult to assess the volume of work needed to clear the waiting list

3.20 An important issue for the management of inpatient/day case waiting times is the way in which NHS Wales counts elective activity on the waiting list. Inpatient/day case waiting lists simply count patient numbers, despite the fact that the amount of work, and cost, involved varies significantly by patient and procedure. Case mix and complexity are vital measures of inpatient/day case workload, and the level of activity required to clear a waiting list. The waiting list reflects neither the relative time needed in theatre, nor the length of stay required in hospital. Consequently neither the size of the waiting list, expressed simply as a number of patients waiting, nor the length of waiting times provide a full understanding of individual trusts' workloads. Activity statistics are similarly unhelpful since, by counting patient numbers, a fall in the number of patients treated could actually mask an increase in the volume of work carried out if the case mix had become more complex. This makes it difficult to plan activity and manage performance, and reflects once again the importance of modelling the key variables, such as day case rates, lengths of stay, case mix, theatre time, emergency pressures, and bed management, which affect the ability of trusts to clear the inpatient/day case waiting list and reduce waiting times. The Assembly has recently commissioned such a modelling exercise (see 4.3).

²⁶ *A Question of Balance (2002), page 28.*

²⁷ *Audit Commission Acute Hospital Portfolio, Operating theatres review of national findings, 2003, page 12.*

12 Overall utilisation of all scheduled operating hours in trusts in Wales



Source: Audit Commission Acute Hospital Portfolio

In contrast to England and Scotland, NHS Wales has little protected elective capacity, which could reduce cancellations and waiting times

- 3.21 England and Scotland have sought to address the impact of emergency and medical pressures on elective waiting times by developing discrete, ring-fenced capacity separate from emergency and medical work. By contrast, Wales has not adopted a similar policy on a comparable scale, although there have been some recent developments in respect of Ambulatory Care and plans to develop new dedicated Orthopaedic capacity.
- 3.22 England has adopted a different policy from Wales, developing a network of 'Treatment Centres' to provide pre-booked surgery and diagnostic tests for patients, particularly in specialties with the most significant waiting times - Orthopaedics and Ophthalmology. The Treatment Centre programme will provide 250,000 operations by the end of 2005 by which time there will be a total of 80 Treatment Centres, some run by the NHS, others by the private sector. Since Treatment Centres carry out solely elective procedures, there is little or no risk of cancellation as a result of encroachment by emergency and medical pressures, thereby safeguarding elective capacity.

3.23 Scotland has also developed protected elective capacity, albeit through a very different approach. In June 2002, the Scottish Executive purchased a former private hospital for NHS Scotland. The Golden Jubilee Hospital in Clydebank subsequently provided 16,000 NHS procedures between June 2002 and January 2004. The hospital also provides outpatient consultations and nursing assessments, and has a hotel in its grounds which provides accommodation for the carers of patients who live a long way from the hospital. Officials from the Scottish Executive informed us that the main benefits of the hospital were:

- high utilisation rates, and few cancellations, due to its separation from medical and emergency pressures;
- the scope to flex the hospital's capacity by opening up wards which are not currently open; and
- improved ability to plan and manage activity and waiting times.

3.24 The solutions developed in England and Scotland provide genuinely additional capacity to help increase activity and reduce waiting times for elective procedures. There is also scope to flex this capacity to meet increased demand or changing waiting time targets, either by extending opening hours or increasing the number of wards open at any time. Wales has not developed protected elective capacity to this extent, which reinforces the unsustainable pressures on the acute sector, manifested by long waiting times. Some modest dedicated elective capacity exists already in Wales as follows:

- Cardiff and the Vale NHS Trust has the largest Ambulatory Care Unit²⁸ in Europe, which provides approximately 14,000 simple procedures for 11,500 patients each year. The unit, which is used solely for routine elective procedures, is not yet fully utilised, but has helped the Trust deliver more elective activity; the Trust reports that activity will increase again during 2004/05 as commissioners begin to fund the unutilised capacity; and
- Bro Morgannwg NHS Trust has an Ophthalmic Treatment Centre and a Surgical Treatment Centre; the Ophthalmic Treatment Centre carries out cataract surgery on a day case basis, while the Surgical Treatment Centre provides common minor surgical procedures, such as hernias and varicose veins; both treatment centres accept referrals directly from the GP; both the Ophthalmic and Surgical Treatment Centres carried out an average of over 1,200 procedures in the financial years 2002-03 and 2003-04.

3.25 There are further plans to develop protected Orthopaedic capacity in Llandough Hospital, Cardiff and St Woolos Hospital Newport, under the *Orthopaedic Plan for Wales*. These will follow the model of NHS-run Treatment Centres in England, subject to final approval of their business cases. In November 2004, the Welsh Assembly Government also announced plans to spend £30 million on four day case centres (in Swansea, Ceredigion, North East Wales and Conwy and Denbighshire) and additional equipment to support diagnostic services and operating theatres.

Many trusts have pioneered examples of innovative practice

3.26 Innovation and modernisation of the way in which services are delivered can have a positive impact on inpatient/day case waiting times. This section considers local good practice by examining the impact of:

- pre-operative assessment;
- managing emergency pressures; and
- bed management.

Pre-operative assessment has had a positive effect, reducing cancellations and improving patient care

3.27 Pre-operative assessment involves an assessment of a patient's fitness for surgery, and desire to receive surgery, before they are admitted to hospital. Its use has improved efficiency and patient care in inpatient/day case services. Pre-operative assessment enables consultants to estimate the theatre time and length of stay required for each patient, thereby increasing bed and theatre utilisation. By pre-assessing patients, particularly before they receive a date for surgery, trusts can reduce rates of cancellation and keep the patient better informed about their treatment. The Audit Commission's Acute Hospital Portfolio shows that, while most Welsh trusts pre-assess all of their patients in Orthopaedics and Urology, the proportion of pre-assessment which takes place before patients receive the date of their surgery is much lower.

3.28 Given the benefits of partial booking for outpatient efficiency (2.17-2.20), and the much greater opportunity cost of cancelled inpatient/day case procedures, there is clear scope to extend partial booking to inpatient and day case work. **Case study C** provides an example of how pre-operative assessment and partial booking have the potential to work effectively together to improve the efficiency of inpatient/day case services.

²⁸ Ambulatory Care provides treatment on an outpatient basis to patients who do not require an overnight stay in hospital. Generally, this involves minor diagnostic and surgical procedures, provided to patients subject to particular criteria.

Initiatives to manage emergency and medical pressures help to reduce pressure on acute capacity

3.29 One of the most effective approaches to protecting elective capacity from emergency pressures has been to streamline the processes associated with emergency work, rather than addressing waiting times for elective services directly. **Case Study D** shows the success of Medical Assessment Units, which carry out rapid assessment of patients to determine whether they genuinely require acute hospital admission, or whether they could be treated in an alternative setting, avoiding unnecessary inpatient admissions through early intervention and close links with primary care.

Integrated bed management policies can support elective capacity to deliver waiting time targets

3.30 Various trusts have taken steps which have reduced significantly the number of medical outliers (see 3.5). Some trusts reserve the use of specific beds to particular specialties or patient groups - known as ring fenced beds - to maintain services and improve infection control. This is particularly common in Trauma and Orthopaedics, where there is a strong focus both on waiting time targets and infection control. Ring-fencing beds helps to reduce cancellation due to lack of beds in the specialties concerned, but risks shifting the pressure on beds to other parts of the overall bed management system. For example, in Cardiff and Vale NHS Trust, ring-fencing elective beds in Trauma and Orthopaedics has succeeded in eliminating outliers and driving down the number of cancellations, while meeting the Assembly's eighteen month target for Orthopaedic surgery. However, the ring-fenced beds have contributed to long trolley waits in Accident and Emergency and increased pressures on beds in other specialties as the Trust struggles to meet the overall level of emergency demand.

C

Pre-operative assessment

In North East Wales NHS Trust, there is an agreed procedure whereby patients have a pre-operative assessment at the same time as their outpatient appointment, enabling the Trust to refer them back to primary care if they are not fit for surgery. Previously, they would have had a pre-operative assessment two weeks before their set surgery date, giving the Trust less time to reallocate the bed and theatre slot if the patient was not fit. The Trust plans to extend the scope of pre-operative assessment to full booking of surgery at the preoperative stage. Patients will be given a choice of preoperative assessment date by ringing ten weeks before and a choice of surgery date six weeks before.

Source: National Audit Office Wales visit to North East Wales NHS Trust

D

Medical Assessment Units

The Medical Assessment Unit at the **Royal Gwent Hospital** has been highly effective in controlling emergency admissions. In July 2003 there were 560 referrals a month to the unit, rising to 850 by April 2004. Despite this increase in referral rates there has been no increase in emergency medical admissions, and over 30 per cent of patients are turned around on the day rather than being admitted. There are two acute physicians who carry out 'hot' clinics daily from Monday to Friday - GPs can refer to them on an outpatient basis that day or the next. The physicians have slots for diagnostic tests and can thus send the patients back to primary care with a letter outlining a medical management plan for the patient. There has also been a significant decrease in outliers since the opening of the Medical Assessment Unit.

Bro Morgannwg NHS Trust has had a **Fast Track Assessment Unit** since 2001 which deals with patients who could avoid hospital admission altogether and short-stay patients who become caught by delays in the system of managing medical patients. Through early consultant intervention, the unit aims to prevent patients being admitted unnecessarily if there is a more appropriate care setting. The Trust cites the following outcomes from the Medical Assessment Unit:

- despite increasing referrals, the Unit has prevented around 800 admissions a year, which we estimate has the potential to achieve a 3 per cent saving in terms of bed days;
- a reduction in the number of outliers; and
- reductions in elective cancellations because of emergency pressures.

Source: National Audit Office Wales visits to Gwent Healthcare and Bro Morgannwg NHS Trusts

3.31 Ring-fencing only works if there is sufficient overall bed capacity to accommodate the removal from overall bed stock levels of beds in particular specialties, booking systems are tight and all staff obey the rules and avoid inefficient practices to protect their bed stock (for example by bringing patients in sooner than is required to ensure that the bed is not lost before the day of surgery). An integrated, trust-wide bed management policy is more effective, managing proactively all of the trust's bed stock.

3.32 There are other examples of innovative practices which have reduced the pressure on elective beds and protected capacity, such as the development of the concept of a 'patient hotel' like the Short Stay Unit at the Princess of Wales Hospital in Bridgend (see Case Study E). This facility contributes to increasing the throughput of elective patients and therefore impacts on waiting times.

E Protecting elective capacity

The Short Stay Unit at the Princess of Wales Hospital in Bridgend is a 'patient hotel', which has thirty-eight single rooms for overnight accommodation for patients who do not require traditional ward-based care. The Unit was originally intended solely to provide ring-fenced beds for patients having minor elective procedures and investigations, who would go back to the Unit before going home. It was subsequently expanded to provide second stage recovery, where the additional recovery time ensured more patients met the criteria for non-ward based care. This frees a ward bed for a new elective or emergency inpatient. The Unit provides considerable flexibility in bed management, with some patients waiting there overnight while a bed is found for them, thus reducing cancellation rates.

In the 2002/03 financial year, 6,000 patients used the Short Stay Unit at a cost of £73 per patient in 2002-03, compared with a daily cost of a ward bed of £329 (see 3.34). The Short Stay Unit provides a model of cost-effective service delivery to patients suitable for placement in an environment where there is a low nursing input, and also contributes to more cost-effective use of more expensive ward beds. Patient feedback on the Unit has been very positive and consultants have also praised its impact. The Unit has also won the Wales Quality Award for Healthcare.

Source: National Audit Office Wales visit to Bro Morgannwg NHS Trust

KEY POINTS

on inpatient/day case waiting times

- One of the principal reasons for long inpatient/ day case waiting times is emergency and medical pressures, allied to and the level of urgent work, which crowd out capacity to carry out routine elective surgery.
- Staff shortages are another constraint, with 8.8 per cent of consultant posts in Wales vacant.
- There are considerable inefficiencies in the use of current capacity which, if improved, would free up additional capacity to carry out elective surgery;
 - despite having more beds per head than England or Scotland, Wales has unsustainably high levels of acute bed occupancy, relatively long average lengths of stay, high turnover intervals, and high numbers of outliers (medical patients occupying a surgical bed); given that the emergency work is all coming through into hospital beds, improving efficiency in the use of existing capacity in these areas could release significant additional capacity to treat more elective patients from the waiting list;
 - utilisation of operating theatres in Wales is relatively low compared to England;
 - the extent of elective surgery carried out as day cases in Wales is comparatively low. Increasing it would help to reduce the pressure on beds and increase elective activity; and
 - cancellation of elective surgery is a significant problem, with around 1,000 cancellations each month; some 27 per cent of short-notice cancellations arose from patients failing to attend, inconvenient appointments or patients cancelling because they did not want their operation. Emergency and bed pressures also lead to significant levels of cancellation.
- In contrast to England and Scotland, Wales has relatively little protected elective capacity separate from the emergency and medical pressures which impact on elective capacity.
- Local innovations have centred on managing the emergency pressures, which encroach on elective capacity, and streamlining the patient's pathway through the system of health and social care. Innovative initiatives include the development of Integrated Care Pathways, expansion of pre-operative assessment (particularly when linked to booking dates for surgery), managing medical pressures through Medical Assessment Units, proactive waiting list management and improvements in bed management.

Despite progress in tackling the issue, delays in discharging patients from hospitals still significantly affect elective capacity

3.33 One of the most serious obstacles to the efficient use of capacity in Welsh hospitals is the 'blocking' of beds, which could otherwise be used for inpatient or day case treatment, by patients who are medically fit to be transferred from their present care setting, but whose discharge or transfer has been held up by non-clinical factors. This part of the report examines the factors contributing to delays in discharge and the methods adopted to address the problem. There are two distinct main types of delay, which affect the timing of patients' discharge from hospital (see the box below).

- **Delayed discharges** occur when a patient's stay in hospital is unnecessarily prolonged by inefficiencies in internal processes, such as delays in getting test results or the timing of physicians' ward rounds. Such delays affect the speed with which hospitals can admit other patients to that bed.
- **Delayed transfers of care**, which can last much longer than delayed discharges, occur when a patient needs to move to a further care setting (this could be social service provision, another healthcare setting, the patient's home, or that of their family or carer), which is not yet available. Delayed transfers of care have complex causes resulting from processes, interactions within the whole system of health and social care, and decisions made by patients and their carers.

3.34 Research carried out in a sample of English hospitals demonstrated that nearly 29 per cent of all inpatients could be safely cared for in other settings²⁹. A census of acute and community hospital beds in Wales, carried out by the Audit Commission in November 2003, arrived at a similar figure for the combined percentage of beds occupied by both delayed discharges and delayed transfers of care³⁰. Such delays in discharging patients are extremely expensive, particularly given the duration of some the delays and the substantial opportunity cost of the bed days that they take up. Acute hospital beds are the most expensive part of the system, costing £120,000 a year, or £329 a day for each bed³¹.

Delayed transfers of care are expensive and impact on elective activity and waiting times

3.35 Delays reduce effective capacity, slow down throughput and contribute to longer waiting times, particularly for surgical procedures which require an inpatient stay. Between November 2003 and June 2004, the average number of delayed transfers of care across Wales was 723, or six per cent of all non-psychiatric beds³². This capacity represents over 250,000 bed days each year. Depending on the setting in which the delay took place, and the availability of other resources, such as staff and theatres, this could release significant capacity to enable thousands of additional elective patients to receive surgery.

29 *A Question of Balance (2002)*, page 118; *Audit Commission in Wales, Transforming Health and Social Care in Wales (2004)*, page 28.

30 *Audit Commission in Wales, Transforming Health and Social Care in Wales (2004)*, page 29.

31 *The Review of Health and Social Care in Wales: The Report of the Project Team advised by Derek Wanless, (June 2003)*, p.26.

32 *Health Statistics Wales (2004)*, page 121.

3.36 **Case Study F** shows that delayed transfers of care occur in both acute and community hospital beds. At the end of June 2004, only 19 delayed transfers of care occupied surgical specialty beds. However, delayed transfers can block capacity elsewhere in the system and impact indirectly on elective capacity. Delayed transfers of care typically involve older patients with chronic medical conditions, who no longer require hospital treatment, but who need continuing care, either in a nursing or residential home, in their own home, or that of their family or other carers. **Figure 13** shows the main reasons for the 633 delayed transfers of care (excluding mental health beds) in June 2004. Only 26 per cent of these delays related to healthcare arrangements. Of the remainder, 33 per cent took place at the point where responsibility for the patient's care was due to transfer from health to social services, and entailed waiting for patients' needs to be assessed or for social care packages to be arranged (a delay often caused by funding shortages in local government in relation to social services).

F Delayed transfers of care in community beds

Gwent Healthcare NHS Trust had 160 delayed transfers of care in June 2004 (excluding Mental Health). These delayed transfers occupied only 1 per cent of acute beds, but occupied a much higher proportion of the Trust's 600 community hospital beds. Some of the Trust's 13 community hospitals are effectively saturated by delayed transfers, with some community hospitals rehabilitation wards having an average length of stay of 40 to 60 days. This represents a substantial proportion of available capacity outside the acute sector, increases the pressure on acute beds, and impedes the Trust's ability to deliver work from the inpatient/day case waiting list.

Source: National Audit Office Wales visit to Gwent Healthcare NHS Trust

3.37 This exemplifies the urgent need for more effective joint working arrangements at the interface between health and social care. Such joint working is very difficult to achieve due to operational factors such as funding, budgeting, and political and managerial accountability. However, the results of our surveys and interviews highlighted two key issues between health and social care:

- capacity shortages in social services provision and the independent sector, which affect the ability of healthcare organisations to discharge patients; and
- intermediate care - care provided somewhere between hospital and home, by skilled nurses directly supervised by doctors, to provide a bridge between hospital and home care after initial surgery or treatment - has the potential to provide capacity to prevent, or reduce the extent of, delayed transfers of care by ensuring that patients receive appropriate treatment in an appropriate setting.

3.38 The largest proportion of delayed transfers of care - 41 per cent of the total - was due to the patient, their family or carer failing to accept an available care option, reflecting again the influence of patient behaviour. For example they may exercise their right to choose a nursing or residential home, which can cause delay when the preferred home has no vacancies. Delays because of patients, their family, or carers equate to 260 beds being blocked each day in Wales - some 94,900 bed days per year. The capacity represented by these blocked beds, even though some of this is outside the acute sector, could still enable significant additional activity to take place throughout the whole system. The problem is complicated by the fact that some patients or their carers prefer to prolong a hospital stay rather than expedite a transfer to a nursing or residential home, which will require a financial contribution or where the home in question is not their preferred home. In North West Wales, one patient was a delayed transfer of care in a community hospital bed for over six and a half years because of a longstanding disagreement, before their eventual discharge in February 2004. In September 2004, the Welsh Assembly Government issued updated guidance to health communities which clarified the approach to patient choice.

13 Causes of Delayed Transfers of Care in Wales (excluding mental health), June 2004

Main category	Sub-category	Welsh Assembly Government definition	No. of patients delayed	Percentage of total delays	No. of bed days per year
Social care reasons	Social care assessment	Awaiting completion of a Community Care Assessment (an assessment by Social Services of a person's needs and of which service can best assist them to continue living independently).	26	32.5%	9,490
	Social care arrangement	Following assessment, awaiting completion of Community Care Arrangements, for example: funding, home-based care package, re-housing or placement in a residential or nursing home.	180		65,700
Health care reasons	Health care assessment	Awaiting assessment by healthcare professional.	70	25.8%	25,550
	Health care arrangement	Awaiting arrangements to enable transfer, for example: start of rehabilitation programme, another NHS bed (hospice, rehabilitation) or non NHS hospital, equipment provision or home visit.	93		33,945
Patient/carer/ family related	Legal	Awaiting resolution of legal issues, such as informed consent, or financial assessment.	19	41%	6,935
	Disagreement	Disagreement between one or all parties concerned, such as internal family and/or carer disputes, or disagreement between patient, family or carer with health or social services.	26		9,490
	Choice/other	For example: family arranging care or choice of residential or nursing home; patient does not qualify for care or refuses to leave hospital.	215		78,475
Other		Principal reason not agreed.	4	0.6%	1,460
Total			633	100%	231,045

Source: National Audit Office analysis of data provided by the Welsh Assembly Government's Health and Social Care Department



3.39 While the total number of delays decreased steadily month by month over the first six months of 2004, the average duration of each patient's delay remained stable, suggesting that it is considerably more difficult to resolve a case once a delay has begun, than to prevent it from happening in the first place. This emphasises once more the importance of intermediate care provision, and innovations such as Rapid Response and Reablement Teams (see 3.52).

3.40 **Figure 14** shows that there is considerable variation in the scale and extent of the problem of delayed transfers between different Local Health Board areas, with the rate of delayed transfers of care per 10,000 population aged over 75 ranging from 4.9 to 69.2. As with waiting times, the incidence of delayed transfers of care was higher in south Wales, where waiting times are longer. Conversely, both delayed transfers and waiting times are lower in north Wales.

Process inefficiencies can delay discharge for patients in acute hospital beds

3.41 Paragraphs 3.8-3.15 showed that there are inefficiencies in the use of beds in Wales. The timing of discharge also affects the ability of trusts to use a particular bed in a timely and efficient manner. A 'simple' delay in discharging a patient, as opposed to a delayed transfer of care, can be due to any of a number of reasons (see the box below). Patients can stay in hospital longer than they need to because their discharge depends upon the timing of a consultant's ward round, or dispensing medicines for them to take home. Such apparently minor issues can determine whether or not a particular bed can be used again on a particular day in time to admit an extra patient for surgery.

3.42 There is considerable scope for trusts to make their processes more flexible, so that the type of obstacles listed in the box do not unduly restrict the throughput of patients. This requires health communities to look at the patient's journey, and to remove any unnecessary steps or delays. It is particularly important to link admission and discharge, and for all parties - nurses, doctors and carers - to plan the patient's discharge from the moment of their admission.

Process inefficiencies which can delay patients' discharge

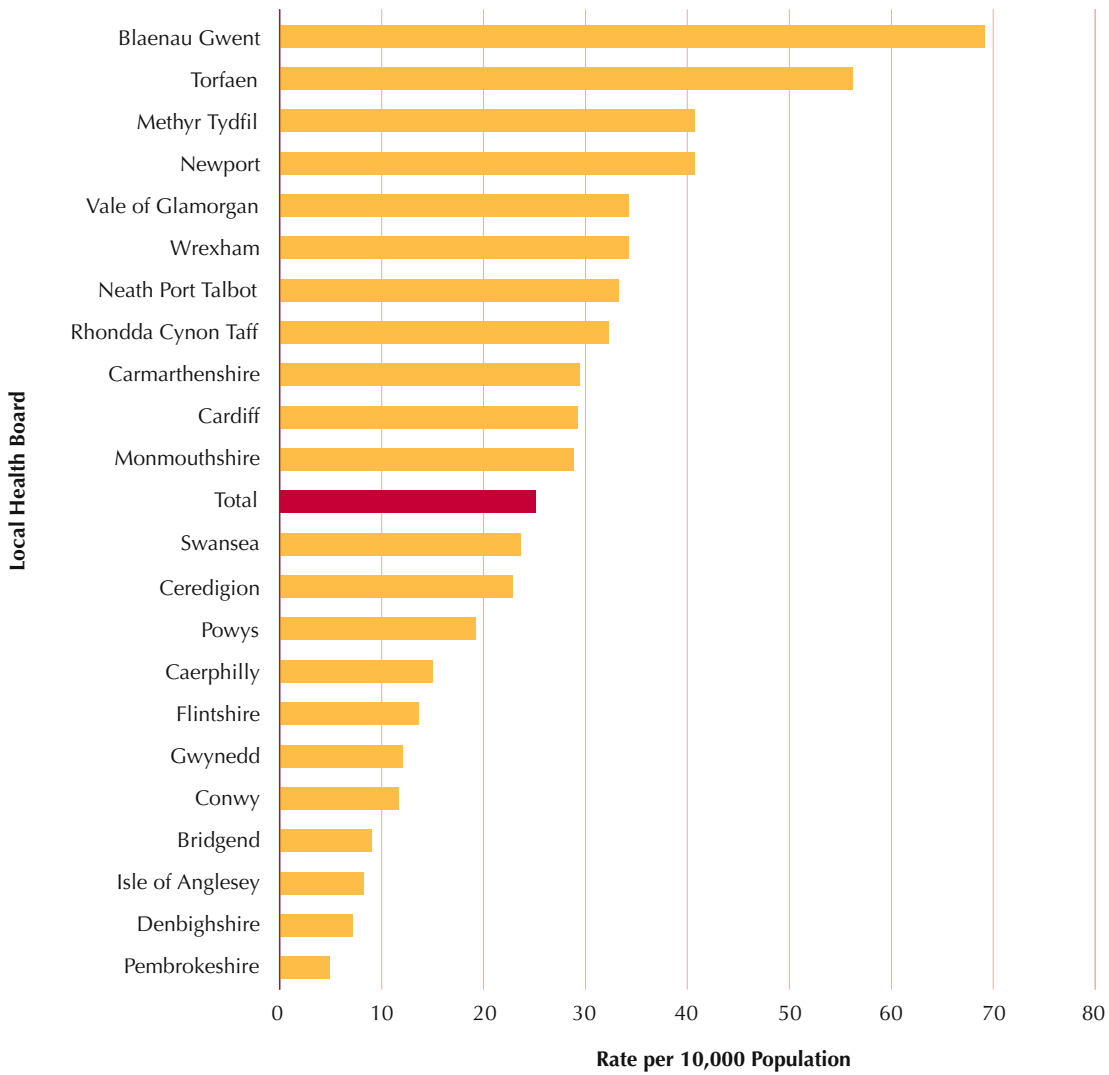
- patient waiting for ward rounds to be carried out;
- patient waiting for diagnostic procedures or tests, or for test results;
- patient waiting for take-home medication;
- transport unavailable;
- trust policy restricting the power to discharge patients to certain staff grades;
- restrictions on the ability to transfer to other areas on certain days of the week;
- inaccessibility of Social Services in the evening or at the weekend;
- delays in obtaining equipment necessary to support discharge; and
- training for carers required on aspects of caring for patient with physical and/or communication difficulties, for example manual handling.

Source: National Audit Office Wales

The Welsh Assembly Government's overall approach to the problem of delayed transfers of care has had some success although delayed transfers still impinge on elective capacity

3.43 The Welsh Assembly Government introduced a comprehensive all-Wales data collection system in April 2002 which established a standard definition of delayed transfers and a common set of categories against which data can be recorded. Assembly officials undertake a monthly census on the basis of data provided by hospitals, which social services validate. This framework for data collection, validation and collation helps the Welsh Assembly Government, the NHS and its partners understand the extent and character of the problem, and should better inform their policy response. This level of management information compares favourably with England and Scotland: in England, only delayed discharges from acute hospitals are counted, while in Scotland, delays are counted only after six weeks, making it more difficult to understand the impact of delays across the whole system.

14 The rate of delayed transfers of care per 10,000 population aged over 75 by Local Health Board, June 2004



Source: Welsh Assembly Government, Delayed transfers of care: June 2004, SDR 52/2004

- 3.44 The Welsh Assembly Government has provided various streams of non-recurrent funding to reduce the level of delayed transfers. In particular, it provided local health communities with £17 million over the two years, 2001-02 and 2002-03. The funding was conditional upon costed action plans and was initially tied to numerical targets for reductions in delayed transfers, which were affected by concerted pressure for fee increases from owners of independent nursing and residential homes. Ultimately, around 68 per cent of the additional funding was used to pay increased fees and thereby consolidate existing independent sector residential and nursing home capacity. While delayed transfers were not significantly reduced at this time, the fee increases did at least allow capacity to be stabilised and maintained, at a time when the independent care home sector was under great pressure.
- 3.45 In response to the 'Wanless Review', the Welsh Assembly Government released further funding of £4 million in July 2003 to local health boards to tackle delayed transfers across the whole system. In February 2004, the Health Minister announced that this would be recurrent for 2004/05, as part of a £30 million package distributed to health communities to enable them to implement the Wanless agenda through local action plans covering improvements in social care, primary health care and community services. In addition, the Welsh Assembly Government gave local authorities £19.5 million to boost capacity and thereby further reduce delayed transfers of care. While the Welsh Assembly Government has used funding to promote the modernisation necessary to address systemic inefficiencies, some trusts have criticised its approach to funding as insufficiently 'joined-up', impeded by separate funding streams for health and social care, which reinforce, rather than break down, the barriers between the two systems.
- 3.46 There has been a net reduction in delayed transfers of care of nearly 23 per cent in the total number of delayed transfers (excluding delays in Mental Health facilities) in Wales between November 2003 and June 2004. After a significant increase in January, following typical seasonal patterns, **Figure 15** shows that there has been a general trend of reducing delayed transfers of care throughout the first six months of 2004. Appendices 4 and 5 shows that there were net reductions in the number of delayed transfers in 10 of the 13 trusts, and in 15 of the 22 Local Health Boards. Few, however, managed to sustain an unbroken downward trend throughout this period.

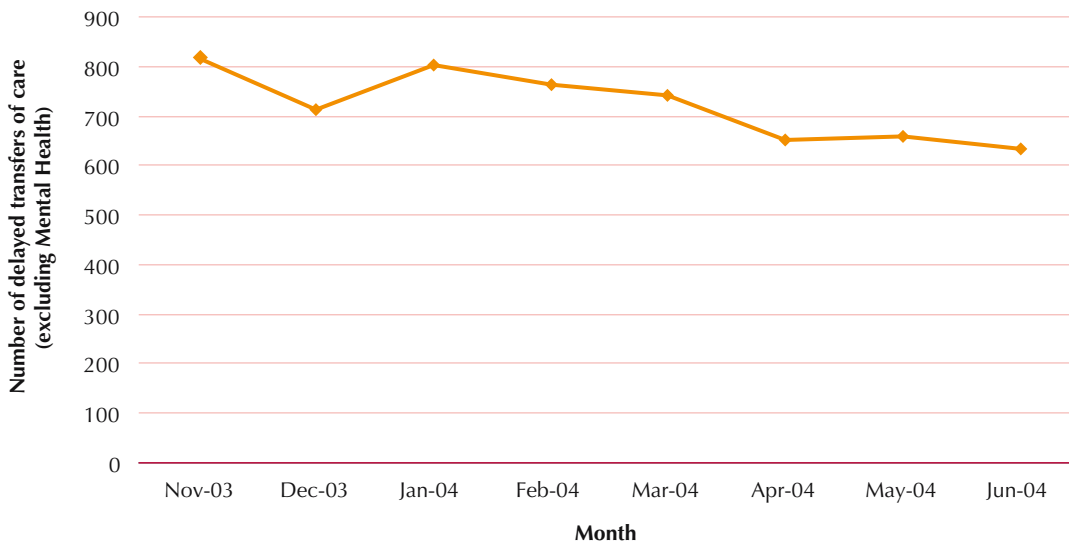
There are examples of local good practice, which have accelerated the discharge of patients from hospital and prevented delayed transfers of care

- 3.47 There are a number of examples of local good practice, which have contributed both to reductions in delayed transfers of care and to accelerating the discharge of patients from acute beds. This section highlights such examples of best practice for each.

Redesigning processes can help trusts accelerate patients' discharge

- 3.48 Many trusts have established discharge lounges, to which they can send patients from a ward on the day of discharge to await collection or transport, which frees up ward beds earlier in the day while providing a more relaxed setting for patients awaiting discharge from hospital. **Case Study G** highlights the impact of discharge lounges.
- 3.49 When patients leave hospital, they usually require medication to support their recovery in a different setting. Delays in preparing 'to take home' drugs in trusts' pharmacies can have a significant impact on the speed with which beds become available for other inpatients. Problems with medication, and patients' ability to administer medication, can lead to unnecessary readmission to hospital. Several trusts are examining their pharmacy processes in order to link them more closely to the overall patient pathway and to make sure that pharmacies prepare medication in a timely fashion to ensure the earliest possible discharge. **Case study H** describes one Trust's pharmacy process redesign project, which offers potential reductions of over three hours in discharge times, as well as reducing readmission rates because of medication.
- 3.50 There is also evidence that discharge planning is most effective when it is integrated into the overall management of patients' stay in hospital. Discharge planning should begin as soon as patients are admitted to hospital. Some trusts have developed protocols to allow registrars to discharge patients, rather than waiting for the consultant ward round. North East Wales NHS Trust proposes to introduce a project whereby it will place a target discharge date on the patient's bed on the day of admission, making clear the expected length of stay both to staff, the patient and their family and carers. In general, where the outpatient clinic schedule allows, morning ward rounds by physicians help to discharge medical patients earlier in the day, thereby freeing up beds for emergency or elective patients. Efficient discharge planning and processes can have a significant impact on the use of capacity by targeting patients for discharge at the most appropriate time of day.

15 Delayed transfers of care (excluding Mental Health), November 2003-June 2004



Source: Welsh Assembly Government Health and Social Care Division

G Discharge lounges

Cardiff and the Vale NHS Trust has set up discharge lounges in each of its two main acute sites - University of Wales Hospital and Llandough Hospital, accommodating twenty and fifteen patients respectively at any one time, and turning over around fifty patients each day. The discharge lounges are open from 9am to 5pm Monday to Friday, meaning that they offer the potential to free up around 250 beds a week, or 13,000 a year, earlier in the day. This offers the potential to admit patients earlier in the day and use capacity more efficiently.

The lounges are staffed by qualified nurses, who liaise closely with ward nurses and ambulance staff. There is still a culture which sometimes favours keeping stable patients on the ward, rather than sending them to the discharge lounge, although the Trust continues to work hard to overcome such cultural barriers to this important innovation.

Source: National Audit Office Wales visit to Cardiff and the Vale NHS Trust

H Pharmacy project in North East Wales NHS Trust

North East Wales NHS Trust has developed a detailed programme to redesign its medicines management by integrating and modernising the procurement, stocking, supply, prescription and administration of medicines. It will introduce an integrated ward-based pharmacy service, with one pharmacist and one pharmacy technician per ward. On the basis of pilot studies, the Trust expects that this will bring about an average reduction of 3½ hours in time to discharge. This would make it possible to free up beds half a day earlier, with a significant impact on bed capacity. The Trust also anticipates that the initiative, by training patients to administer and understand their medication, should reduce by 30 per cent readmission within twelve months, as well as reducing the average length of stay.

The project will make better use of medical, nursing and pharmacist time - a similar initiative in Belfast saved six nursing hours per ward, and 57 hours of junior doctor time, each week. In addition, the estimated avoidance of wastage of the patients' own drugs alone would mean a saving of £250,000 in expenditure on drugs by the Trust.

Source: National Audit Office Wales visit to North East Wales NHS Trust

Whole systems approaches can deliver reductions in delayed transfers of care

- 3.51 Reversing the pattern of widespread delayed transfers of care is a long-term process, which is heavily dependent on the development of effective joint working across the whole system of health and social care. This section highlights examples of good practice developed to date. For example, Caerphilly is the local authority area which has achieved the largest reduction - 78 per cent - in delayed transfers of care between November 2003 and June 2004. **Case Study I** below shows how it developed a system of securing short-term capacity for patients awaiting social services assessment.
- 3.52 One of the most effective innovations to date in reducing delayed transfers of care has been the development of Rapid Response and Reablement Teams, which are based in the community and aim to take timely action to prevent hospital admission and to safeguard and increase patients' independence. **Case Study J** shows examples of successful Rapid Response and Reablement Teams.
- 3.53 Joint working between health and social services is essential. The Welsh Assembly Government requires health communities to put in place by April 2005 unified assessment by health and social services to ensure a co-ordinated approach to each patient's care, and a single assessment in place of individual health and social services assessments. This is designed to streamline the system at the interface between health and social services, especially at the time of discharge.

I Overcoming delayed transfers through joint working between health and social services

In Caerphilly, there are nurse managers who are trained to carry out initial social care assessments themselves - rather than going through a social worker - and to access social services funding to provide two weeks' care for patients in their own homes, after which social services assess its appropriateness. This provides a fortnight's headroom, which helps to surmount delays in social services assessments, both preventing unnecessary delays in community hospitals and reducing social services expenditure at the same time. Liaison nurses have also been allowed to commission social care in Monmouthshire, in an initiative jointly funded by health and social care, with the liaison nurses reporting to social services on a day to day basis.

Source: National Audit Office Wales visit to Gwent Healthcare NHS Trust

J Rapid Response Teams and Reablement Teams

North West Wales NHS Trust has a **Rapid Response Team**, which is a multi-disciplinary team of nurses, therapists and social workers operating in the Bangor area. The Rapid Response Team handled 431 patients in 2002, reducing average lengths of stay in community hospitals. GP referral patterns also changed as a result of the Rapid Response Teams, with GPs referring directly to the team rather than referring patients to hospital. Patients going through the Rapid Response Team have shown considerable improvement in their ability to function independently and consequently have avoided going into care. In this way, the Rapid Response Team has contributed both to a reduction in admissions and an acceleration of discharge from community hospital beds.

Blaenau Gwent, despite having the highest rate of delayed transfers of care per 10,000 population over 75, has an award-winning **Reablement Team**, which consists of a nurse, physiotherapist, occupational therapist, speech and language therapist, staff grade doctor, reablement aides and a dietician. It operates daily between 8:00 and 22:00, preventing patients from being admitted into the acute hospital and becoming delayed transfers, as well as reducing length of stay through support provided at home. The opening hours of the service are crucial, since short delays in accessing services, for example over the weekend, can lead to admission, which increases both the dependency levels of elderly patients and incidence of delayed transfers of care.

Source: National Audit Office Wales visits to North West Wales NHS Trust and Gwent Healthcare NHS Trust

KEY POINTS

on delays in discharging patients from hospital

- Delayed transfers of care are a major problem, symptomatic of imbalances between health and social care. On average, excluding the many delays in Mental Health facilities, there were 723 delayed transfers of care between November 2003 and June 2004, which represents 6 per cent of non-psychiatric beds and accounts for over 231,000 bed days each year across the whole system.
- The majority of delayed transfers of care are not caused by healthcare delays - 33 per cent relate to social services, reflecting the importance of effective joint working between health and social care, while 41 per cent relate to patients, their family and carers. There is also considerable regional variation in the incidence of delayed transfers of care.
- Process inefficiencies, such as the timing of ward rounds and the timely dispensation of medicines to take home, can delay discharge - trusts must focus more aggressively on addressing such issues to ensure that timely discharge facilitates the admission of other patients.
- The Welsh Assembly Government has set up a broader framework to measure delayed transfers of care than England and Scotland, and provided £21 million in non-recurrent funding between 2001-02 and 2003-04 to tackle delayed transfers of care, of which the majority provided independent care home providers with fee increases to stabilise capacity.
- There was a 23 per cent reduction in delayed transfers of care (excluding Mental Health) between November 2003 and June 2004; however, the incidence of delayed transfers of care remains high.
- Whole systems approaches - such as developing Rapid Response and Reablement Teams, bolstering Intermediate Care provision and developing effective joint working between health communities and local authorities - can reduce delayed transfers of care.

4

Attempts to manage the waiting times problem have not yet delivered sustainable reductions in waiting times

4.1 The Welsh Assembly Government has adopted a range of strategies to tackle long waiting times in Wales. This part of the report considers the effectiveness of the following in reducing long waiting times:

- the Welsh Assembly Government's overall strategy for reducing waiting times;
- performance management;
- the contribution of waiting time initiatives to sustainable reductions in waiting times;
- the role of health care commissioners in reducing waiting times; and
- the contribution of Innovations in Care to spreading best practice.

There has been no clear overall strategy to reduce waiting times across Wales

4.2 Volume 1 described the fact that waiting times are an important part of the Welsh Assembly Government's overall health policy. Waiting time targets have been set out in a variety of documents, but have not always been clearly and consistently articulated or subject to clear and specific timescales (see Figure 16).

16 Inconsistently stated waiting time targets in Wales

	Current target and source	Other targets and source
Outpatients	No one to wait over 18 months (SaFF, waiting times strategy).	'No one to wait over twenty-six weeks, with no over eighteen month waits as a <i>first step</i> ' (Health and Social Care Guide for Wales). 'Achieve a sustained year on year reduction in the number of people facing outpatient waits of more than six months, aiming to reduce the number to nil by the end of 2002-03 <i>subject to resource availability</i> ' (NHS Plan 2001).
Inpatients/day cases	No one to wait over 18 months, other than specific targets for particular procedures (SaFF, waiting times strategy).	'Develop specific targets for clinically important services, viz cardiac and cancer services, mental health, cataract surgery and hip and knee surgery; and for ophthalmology, orthopaedics, general surgery and ear nose and throat treatments (NHS Plan 2001). The Health and Social Care Guide for Wales describes the aim of reducing waiting times below eighteen months <i>over time</i> .' All patients who are not expected to receive their treatment within waiting time targets to receive an offer of treatment by an alternative provider by March 2005 (Second Offer Scheme).
Orthopaedic surgery	Maximum waiting time of eighteen months (SaFF, waiting times strategy).	'Achieve a <i>sustained reduction year on year</i> in the number of people waiting over twelve months for orthopaedic treatment' (NHS Plan 2001). There are no detailed waiting time targets in the Orthopaedics Plan for Wales published in July 2004.
General targets	To <i>reduce waiting times year on year</i> until patients in Wales receive services as <i>speedily as elsewhere</i> (NHS Plan 2001).	Volume 1 of this report shows that Welsh waiting time targets are considerably longer than those in England and Scotland. This makes it almost impossible to achieve this relative target as waiting time targets become more stretching elsewhere within an overall strategy to reduce waiting times with specific milestones.

Source: National Audit Office Wales, based on *Waiting times strategy (2001)*, *Improving Health in Wales - a plan for the NHS and its partners (2001)*, *An Orthopaedic Plan for Wales (2004)*, *Health and Social Care Guide for Wales (2002)*, *Welsh Health Circular WHC (2003) 127*, and <http://www.statswales.wales.gov.uk>

- 4.3 The Welsh Assembly Government is currently undertaking a modelling exercise to understand the impact and achievability of setting particular waiting time targets. Among other impacts, the modelling exercise should help the Welsh Assembly Government in setting specific targets to reduce waiting times in Orthopaedics to support the *Orthopaedic Plan for Wales*, published by the Welsh Assembly Government in July 2004, which contained a commitment to reduce waiting times but omitted any separate targets to improve waiting times in this problematic specialty (see Volume 1, 4.3-4.4). The source document, which supports the overall strategy, indicates that there is a mismatch between supply and demand, acknowledges the ongoing national modelling exercise and indicates that waiting time targets 'will become more challenging in future'.³³ This is in contrast to the harder targets in force in England and Scotland which, as the box below shows, have formed part of more coherent, long-term strategies to reduce waiting times. For example, health communities in England already know that by 2008 they must achieve waiting times of no more than 18 weeks from GP referral to treatment. This allows them the time to begin modelling activity, demand and capacity to configure their services to meet these targets. No similarly clear medium term plan has existed in Wales to drive health communities to reduce waiting times over time.
- 4.4 There have been recent developments which have the potential to contribute to reductions in waiting times, principally the Second Offer Scheme (see box below) and *Orthopaedic Plan for Wales*. However, they do not constitute a clear and coherent overall strategy to tackle Wales' significant waiting times problem. The overall waiting time problem requires improvements in both outpatient and inpatient/day case waiting times. The Orthopaedic Plan contains no clear waiting time targets, and it is only feasible for the Second Offer Scheme to apply to inpatient/day case treatment.

A strategic approach to waiting times - England and Scotland

In **England**, the NHS Plan (July 2000) set out a medium-term approach to reducing waiting times, with specific milestones and targets. This required waiting times of 3 and 6 months for outpatients and inpatients/day cases by 2005, with staged reductions from 18 to 15, 12 and 9 months in between. The Plan also made clear that the eventual aim was to achieve by 2008 a maximum waiting time of three months for any stage of treatment. The Secretary of State for Health has superseded this target in the recently announced five year plan for health, which requires by 2008 a maximum waiting time of 18 weeks from GP referral to treatment (the combined outpatient and inpatient/day case waiting time).

In **Scotland**, waiting time guarantees have been used, whereby patients have a firm guarantee of treatment within a certain timescale. These guarantees applied from April 2003 for cardiac revascularisation and December 2003 for inpatient/day case treatment. A target of a first outpatient appointment within six months will apply from December 2005. The Welsh Second Offer Scheme is similar to the Scottish waiting time guarantees, albeit without the clear medium term targets for shorter waiting times.

Source: National Audit Office Wales

33 An Orthopaedic Plan for Wales, source document, page 53.

The Second Offer Scheme

The Second Offer Scheme, announced in November 2003, guarantees all patients on the inpatient/day case waiting list an offer of alternative treatment if they are likely to wait over eighteen months (reducing to twelve by the end of March 2005), or to breach specific targets for particular procedures. The alternative provider could be another Welsh NHS trust, an English NHS trust or a private sector provider. With the exception of specialist services commissioned by Health Commission Wales, treatments will be commissioned centrally by a 'Second Offer Commissioning Team' based in Rhondda Cynon Taff Local Health Board.

Between January and March 2004, the Welsh Assembly Government ran a separate preparatory project to offer treatment to patients who had already waited over eighteen months before the scheme itself began. This reduced the number waiting over eighteen months from 4,981 at the end of December 2003 to 1,401 at the end of March 2004, supported by funding of £5 million.

In the 2004-05 financial year, the Second Offer Scheme will be supported by £12 million funding to pay for treatments provided under the scheme. Thereafter, treatments provided under the Second Offer Scheme will be funded by the trust or Local Health Board responsible for the patient, depending on whether the breach of target is deemed to be the fault of the provider or commissioner. Disputes about responsibility for breaches will be subject to arbitration by Regional Offices.

The Assembly now publishes waiting time statistics which show how many patients are waiting overall, but also those waiting over eighteen (and subsequently twelve) months who have declined a second offer of treatment by an alternative provider.

Source: National Audit Office Wales

KEY POINTS

on the strategic approach to reducing waiting times

- The Welsh Assembly Government has not produced a clear strategy to reduce waiting times, and its statements of targets have not been consistent.
- The recently-announced Second Offer Scheme has the potential to reduce inpatient/day case waiting times, although the scheme contains some inherent risks, which will need to be managed carefully to ensure that it has a beneficial impact.

4.5 There are a number of key risks inherent in the Second Offer Scheme, which will require careful management:

- decisions about the responsibility for breaches of target may not be straightforward - if there are widespread **disputes**, this will remove capacity from organisations to tackle waiting times; there are clear rules in place to deal with such disputes, while Assembly officials believe that it is important for commissioners and providers to engage in robust debate about the causes of waiting time breaches;
- if a single Local Health Board or trust was forced to fund a significant volume of treatments under the Second Offer Scheme, this could have a major impact on their **financial viability** which might need to be addressed by reducing core acute services capacity, thus exacerbating the waiting times problem; however, the Second Offer Scheme seeks to provide incentives both to commissioners and to providers to avoid such financial liabilities;
- conversely, the financial risks for potential breaches of inpatient/day case targets means that the Second Offer Scheme may increase the incentive to avoid tackling outpatient waiting times - if outpatients are seen more quickly, throughput onto the inpatient/day case list will increase, thus making it more likely that trusts or Local Health Boards will face financial penalties for breaches of inpatient/day case targets under the Second Offer Scheme (see also 4.13);
- the preparatory project showed that a significant minority of patients were **reluctant to travel** - Figure 24 in Volume 1 shows that 22 per cent of patients contacted declined the offer of treatment by an alternative provider; this trend was particularly acute in certain areas, especially the Swansea area; in the first three months of the Second Offer Scheme, the proportion of those waiting over eighteen months who had declined a second offer was just over 20 per cent; it is essential for patients to receive treatment, rather than simply an offer of treatment - such local issues will need to inform local planning and commissioning decisions, to ensure that the Second Offer Scheme delivers and rewards genuine improvements in patients' waiting times;
- the scope of the treatment covered by the Second Offer Scheme is an important issue - consultants informed us that responsibility for **pre- and post-operative work** needs to be clearly defined and communicated to the patient; we heard of initiatives where there were complications with alternative providers, which then came back into the originating trust to be resolved, causing additional work in outpatients and sometimes in theatre (for example carrying out a revision of a problematic hip replacement); and
- **modelling demand, activity, capacity and waiting times** is essential for health communities so that both those commissioning and providing services can assess how they will avoid financial liabilities under the Second Offer Scheme from April 2005; the ability and capacity to carry out such modelling varies across Wales, and is a key issue for health communities to address to ensure that they manage the risks and plan their services appropriately to avoid the financial risks they face from the Second Offer Scheme affecting their services and financial viability.

Performance management arrangements have not been effective in delivering reductions in waiting times

4.6 Most health services in Wales are commissioned by the twenty-two Local Health Boards, which the Welsh Assembly Government created on 1 April 2003 to replace the five health authorities, which were previously responsible for commissioning. These bodies are coterminous with Welsh local authorities, and have responsibility for commissioning both primary and secondary care services. Health Commission Wales, another body created in the reorganisation of 2003, commissions highly specialised tertiary services - such as Neurosurgery, Plastic Surgery and cardiac services - on a national basis for all Welsh patients. This commissioning process informs the Service and Financial Framework (SaFF), which is a joint statement setting out the resource inputs and service outputs, including waiting times, which each health community - both commissioners and providers - will deliver for a particular financial input. The Welsh Assembly Government's three Regional Offices have overall responsibility for performance management, co-ordinating the SaFF process and quarterly reviews of each organisation's performance agreement, which sits underneath the SaFF. The quarterly reviews cover waiting time performance.

4.7 The Wanless review raised concerns about performance management and accountability: its implementation programme includes an Accountability sub-group, whose task is to look at the accountability of chairs and chief executives of NHS organisations. This section of the report considers the effectiveness of performance management arrangements in delivering reductions in waiting times, addressing:

- the incentives and sanctions in place to drive improvement in performance;
- regional variations in waiting time targets; and
- the impact of targets on clinical practice and prioritisation.

There are insufficient incentives and sanctions to achieve waiting time targets

4.8 Performance management processes have not been effective in delivering lower waiting times³⁴. In our survey, 42 per cent of trust chief executives indicated that the Welsh Assembly Government's performance management arrangements were 'not very effective', 42 per cent saw them as 'effective', while 17 per cent indicated that it was 'too soon to comment'. **Figure 17** shows that the majority of Trust and Local Health Board chief executives believed that there was scope to strengthen performance management arrangements through the use of stronger incentives and sanctions.

17 Incentives and sanctions for Trusts to achieve waiting time targets

	Performance management arrangements provide incentives for the trust to meet its waiting time targets...		Performance management arrangements provide sanctions if the trust fails to meet its waiting time targets...		Performance management arrangements would be more effective if they included stronger incentives and sanctions for achieving waiting time targets	
	Trust chief executive	LHB chief executive	Trust chief executive	LHB chief executive	Trust chief executive	LHB chief executive
To a large extent	0%	16%	8%	16%	55%	37%
To some extent	42%	42%	33%	21%	45%	37%
To a small extent	25%	16%	42%	37%	0%	26%
Not at all	33%	26%	17%	26%	0%	0%

NOTE

Cardiff and the Vale of Glamorgan Local Health Boards submitted a joint response. We treated this as two separate responses for the purposes of analysis.

Source: NAO Wales surveys of Trust and Local Health Board chief executives



4.9 In interviews, and their responses to our surveys, Trust and Local Health Board chief executives consistently described their perception that the current waiting time performance management regime effectively 'rewarded failure' to deliver waiting time targets. There is a strong correlation between expenditure on waiting time initiatives in each Trust, and the percentage of the waiting lists waiting over eighteen months (see 4.24). This makes it difficult for better performers to sustain continuous improvement, while providing a perverse incentive for other trusts to breach targets. The comments in the box below on performance management, incentives and sanctions, further reinforce the need for more robust incentives and sanctions to drive continuous improvement in waiting time performance.

Weaknesses caused by the lack of incentives and sanctions

'Current performance management arrangements effectively reward trusts who have failed to stop a major problem developing and penalise those who had managed it more effectively. Simply, this is rewarding those who fail to perform, and at the same time is a punitive system for those that deliver success. An effective performance management system would drive performance, ensuring that solutions to problems are separate from the problem itself.'

'At the moment it is perceived that we reward poor performance by giving waiting list monies to underperforming consultants and health trusts. We should be moving towards a position where good performance is rewarded. Adding financial rewards is a real incentive to high performing trusts, similar to the position in England.'

'There are no incentives to meet waiting list targets for outpatients. The targets are too soft and result in bad performance in other trusts being rewarded.'

'Although difficult to develop appropriately there should be a move away from providing funding for those providers who continually under perform and conversely some financial recognition should be made to good performers.'

Source: NAO Wales survey of Trust and Local Health Board chief executives

4.10 There are a number of ways in which the Welsh Assembly Government could develop incentives and sanctions for trusts and Local Health Boards to deliver on waiting time targets, such as:

- **financial incentives**, which might include:

- additional funding as a reward for achieving, rather than breaching, targets, subject to appropriate controls against manipulation of performance information;
- increased access to capital funding for organisations achieving their targets; and
- increased access to Innovations in Care funding, where organisations can demonstrate that innovation has led to demonstrable improvement in performance.

- **financial sanctions**, which might include:

- reduced budgetary flexibility and access to funding; and
- removal of funding at marginal or tariff cost where there was an under-performance against the Trust's Long-Term Agreement.

- **earned autonomy** - whereby the organisations which perform best have the possibility of increased flexibility and freedom, for example through reduced inspection and monitoring, or 'light-touch' performance management from the Regional Office; the sanctions would be the reverse;

- **external support** - organisations with waiting time problems could be supported by additional external input, to tackle waiting time and waiting list management issues, for example by Innovations in Care, another Trust or Local Health Board, or a multi-disciplinary Task Force; and

- **increased accountability** - chairs and chief executives could be invited to appear before the Audit or Health and Social Services Committee of the National Assembly for Wales to discuss their organisation's performance; a clear escalation procedure could set out the accountabilities and interventions to tackle poor performance against key targets.

4.11 The development of incentives and sanctions also needs to be considered locally. Most trusts have established internal incentives to encourage departments, directorates and clinicians to contribute to reducing waiting times, while a significant minority reported that they had established sanctions. However, most Local Health Boards have established neither incentives nor sanctions to encourage providers to meet waiting time targets for patients from their area. In devising incentives, it is essential that they focus on clinical staff, since it is they who ultimately influence the achievement of waiting time targets.

4.12 The Welsh Assembly Government is currently modifying performance management arrangements, principally through the new Performance Improvement Framework, which is based on a Balanced Scorecard, to inform a more holistic approach to performance management.

4.13 A key challenge for the Welsh Assembly Government will be to ensure that the Balanced Scorecard provides an integrated approach to waiting times, which recognises the relationship between outpatient and inpatient/day case waiting times, and the significance of waiting times for diagnostic and therapy services. Alignment of the targets is essential to avoid a situation where outpatient waiting times increase as inpatient/day case waiting times fall - in such circumstances, the overall time a patient waits from GP referral to treatment would not change significantly.

The lack of incentives and sanctions is exacerbated by concerns over regional variations in waiting time targets

4.14 The 2002-03 and 2003-04 SaFFs varied certain minimum waiting time targets in an attempt to recognise the individual circumstances, and starting points, of different health bodies. This meant that the SaFF for some health communities included a specific number of tolerated breaches of minimum targets. This practice led to organisations pursuing targets which were less stretching than the Welsh Assembly Government's published targets and much longer than those in most other parts of the United Kingdom (see Figure 7 in Volume 1).

The number of tolerated breaches of maximum waiting time targets was not publicised, meaning that people on these waiting lists would have expected treatment within the relevant waiting time target. Appendix 7 lists the number of tolerated breaches of minimum targets allowed to particular trusts in 2003-04.

4.15 The majority of Local Health Board chief executives believed that the practice of allowing waiting time targets to exceed minimum standards was inappropriate. Despite the last two SaFFs requiring a ten per cent improvement in waiting times by organisations, which have already achieved or improved on minimum waiting time standards, such continuous improvement targets are difficult to enforce in an environment where some organisations receive additional funding and less stringent targets after breaching minimum waiting time standards. In the 2004-05 SaFF, the Welsh Assembly Government ceased to include tolerated breaches of its minimum standards of performance.

4.16 Trusts also reported that there was some confusion about the relative priority of the various SaFF targets, with certain targets perceived to be more important than others, particularly financial and waiting time targets. The reduction in the number of targets within the SaFF, from 104 in 2003-04 to 40 in 2004-05, should help health communities to prioritise and allocate resources, and better enable the Welsh Assembly Government to support the achievement of its key objectives through the performance management process.

4.17 There has been a very different approach to the achievement of targets in England and Wales. Trust and Local Health Board officials, some of whom have worked in the NHS in England, informed us that there is a much more robust approach to meeting waiting time targets in England than there is in Wales. This approach has disadvantages - principally a rapid turnover of senior officials and the risk of inappropriate waiting list adjustments to ensure the achievement of targets³⁵ - but does have the benefits of stronger emphasis on the achievement of minimum performance standards, and greater clarity of objectives for individual organisations.



35 National Audit Office, *Inappropriate adjustments to NHS waiting lists, HC 452, Parliamentary Session 2001-02.*

Waiting time targets can affect clinical practice

4.18 Waiting time targets can influence decisions made about patient care. **Figure 18** shows that around a quarter of all consultants, who responded to our survey, reported that they had frequently treated patients in a different order from that suggested by their clinical priority in order to achieve Welsh Assembly Government waiting time targets.

4.19 **Figure 19** reflects the comments of consultants responding to our survey. Ophthalmology consultants who expressed concern about the four month cataract target and its effect on clinical prioritisation, a pattern which was reinforced in interviews. Other patients in this important specialty often face conditions which threaten their eyesight, unlike a degenerative condition such as a cataract. There were particular concerns about other types of work being displaced by cataract surgery in the final quarter of the financial year to accommodate the drive to achieve cataract targets by the year end. Despite real improvements in cataract waiting times since the introduction of the four month target, it is essential that waiting time targets do not supersede the clinical agenda - consultants must be free to make appropriate clinical prioritisations.

KEY POINTS

on performance management

- Performance management arrangements have not been effective in delivering lower waiting times, in particular:
 - there have been insufficient incentives and sanctions to achieve the Welsh Assembly Government's waiting time targets, although work is ongoing to address this weakness;
 - this is exacerbated by historical regional variations in waiting time targets, whereby some trusts were allowed a tolerated number of breaches of minimum standards, without patients being informed of these differential targets; this practice has ceased in the 2004-05 SaFF; and
 - waiting time targets can influence clinical prioritisation.

18 Some consultants treat patients in a different order from that suggested by their clinical priority to avoid exceeding waiting time targets

	Outpatients % responses	Inpatients % responses
Frequently	25%	27%
Occasionally	8%	15%
Rarely	13%	10%
Never	54%	48%
Total	100%	100%

Source: National Audit Office Wales survey of all Welsh Consultants in General Surgery, Trauma and Orthopaedics and Ophthalmology

19 The influence of waiting time targets on clinical prioritisation

'Cataracts are not clinically urgent, but are fast-tracked for political reasons.'

'Cataract waiting time is 'falsely' divided into time to be seen in clinic (over 14 months) and time to operation (four months). It is only time to operation that gains headlines. Therefore by regulating the numbers seen in clinic, management can reduce time to operation at the expense of time to clinic. The total time is eighteen months and should be quoted. Also unfortunately some patients referred as 'cataracts' have more serious undiagnosed ophthalmic pathology and the more important target should be to reduce the time to clinic. This also leads to patients going privately to jump time to clinic'.

'Management occasionally ask me to cancel outpatient clinics to transfer ophthalmic staff to a theatre list for cataracts'.

'Some patients with minimal cataract will not deteriorate significantly if waiting six months but I have been put under pressure to ensure no one waits over four months. This is inevitably delaying other patients with greater clinical priority'.

'Cataracts have been given priority to achieve targets over other problems'.

'In the last two months patients with varicose vein surgery have been listed because of length of waiting (over twelve months) rather than 'soon' that deserve higher clinical priority'.

'I had to do varicose vein procedures because targets have been breached'.

'The longest waiters take priority over urgent cases'.

'I refuse to - it is bad practice. Attempts have been made to persuade me to do 'cheap' cases, out of order, and achieve political targets. I work on clinical priority first and will continue to do so'.

Source: National Audit Office Wales survey of Consultants in Trauma and Orthopaedics, General Surgery and Ophthalmology

Waiting time initiatives have been widely used, but have not delivered sustainable reductions in waiting times

4.20 Our examination considered the value for money offered by waiting time initiatives - providing additional outpatient appointments or surgical procedures in the private sector or in marginal NHS capacity, funded by additional, non-recurrent monies (see the box below) - with a focus on the financial years 2002-03 and 2003-04. This section of the report considers the impact of waiting time initiatives, looking at:

- the extent to which initiatives have been used;
- the value for money offered by initiatives; and
- the overall effectiveness of waiting time initiatives in delivering sustainable reductions in waiting times.

Waiting time initiatives

Waiting time initiatives fall into two categories:

- those provided within marginal capacity in **existing NHS facilities** - generally these involve NHS staff being paid an additional sum for providing consultations or surgical procedures in the evenings or at weekends within existing NHS Wales hospital facilities; rates of payment for this additional work have generally been negotiated individually, although the new consultant contract provides a flat rate for waiting time initiatives; and
- those provided by the **private sector**, where the trust negotiates with private sector providers, to provide additional consultations or surgical procedures for a particular fee; if the private sector is used locally, the surgeons carrying out the work will often be the same as those providing work in existing NHS facilities; at other times, initiatives have been provided some distance from the originating provider, for example in England.

Source: National Audit Office Wales

92 per cent of expenditure on initiatives was on inpatients/day cases

4.21 **Figure 20** shows that in the financial years 2002-03 and 2003-04 trusts projected overall non-recurrent waiting time initiative expenditure - providing additional outpatient appointments and inpatient/day case treatments - of just under £34 million, with additional initiatives run by Health Commission Wales and Powys Local Health Board worth £2.15 million (£0.5 million by Powys Local Health Board and £1.5 million by Health Commission Wales), amounting to total expenditure of just over £36 million. This represents a small proportion of the discretionary funding provided to commissioners, which was £2.1 billion and £2.5 billion in 2003/04 and 2004/05 respectively. 92 per cent of expenditure on initiatives related to inpatient/day case initiatives, with only 8 per cent of expenditure being used for outpatient initiatives, where the costs are significantly less. In terms of patient numbers, we estimate that 29,000 outpatients received a first outpatient appointment through waiting time initiatives, and 11,000 inpatient/day cases received surgical treatment³⁶.



Waiting times initiative expenditure in the private sector doubled between 2002-03 and 2003-04, as marginal additional capacity in existing NHS facilities was exhausted

4.22 Total expenditure on waiting time initiatives grew by 49 per cent between 2002-03 and 2003-04. Figure 20 shows that 48 per cent of total expenditure on waiting time initiatives was in the private sector, and that the percentage of total expenditure through the private sector grew considerably - by 120 per cent compared with just 7 per cent in existing NHS facilities - between 2002-03 and 2003-04 because marginal NHS capacity had largely been exhausted.

³⁶ We estimate that Figure 20 understates the number of patients treated within marginal NHS capacity in 2002-03 because Gwent Healthcare was unable to provide figures.

20 Patient numbers and expenditure on waiting time initiatives 2002-03 and 2003-04

	2002-03			2003-04 (projected)			Total			Growth 2002-03 to 2003-04	
	Private	NHS	Total	Private	NHS	Total	Private	NHS	Overall	Private	NHS
Outpatients											
Patient numbers	701	12,635	13,336	2,979	12,931	15,910	3,680	25,566	29,246	325%	2%
Expenditure (£)	117,125	1,121,677	1,238,802	176,050	1,205,970	1,382,020	293,175	2,327,647	2,620,822	50%	8%
Inpatients/day cases											
Patient numbers	1,497	3,598 ^{1,2}	5,095	2,398	3,885	6,283	3,895	7,483	11,378	60%	8%
Expenditure (£)	4,949,996	7,426,624	12,376,620	10,961,990	7,971,020	18,933,010	15,911,986	15,397,644	31,309,630	121%	7%
Total											
Patient numbers	2,198	16,233	18,431	5,377	16,816	22,193	7,575	33,049	40,624	145%	4%
Expenditure (£)	5,067,121	8,548,301	13,615,422	11,138,040	9,176,990	20,315,030	16,205,161	17,725,291	33,930,452	120%	7%

NOTES

- 1 Gwent Healthcare NHS Trust was unable to provide patient numbers for inpatient/day case initiatives in existing NHS facilities for 2002-03.
- 2 In 2003-04 Powys Local Health Board spent an additional £0.5 million and Health Commission Wales £1.65 million. We do not have data on the number of patients treated under these initiatives, therefore they are excluded.

Source: National Audit Office Wales survey of trust chief executives

4.23 Decisions about whether to use the private sector, rather than marginal capacity within existing NHS facilities, tended to be pragmatic. **Figure 21** shows the main reasons for decisions to use the private sector or existing NHS facilities to run waiting time initiatives. Trusts reported that using existing NHS facilities was generally the first choice on the basis of cost and clinical effectiveness. However, trusts used the private sector when:

- there was no further marginal capacity;
- emergency pressures meant that bed availability would be a serious obstacle, which does not confront private sector providers; and
- the additional funding was released late in the financial year and the ability of the private sector to release its marginal capacity more quickly than the NHS was crucial.

The use of initiative funding was focused on particular trusts and regions

4.24 Waiting time initiatives were heavily focused on particular trusts and specialties. **Figure 22** shows that there was a strong positive correlation between the proportion of trusts' outpatient and inpatient/day case waiting lists waiting over eighteen months in April 2002, and their proportion of total expenditure on outpatient and inpatient/day case waiting time initiatives in 2002-03 and 2003-2004. Appendix 6 shows that 80 per cent of expenditure on inpatient/day case waiting time initiatives was shared between the three largest trusts, Cardiff and the Vale, Swansea and Gwent Healthcare NHS Trusts.

21 Reasons for using private sector or marginal capacity in existing NHS facilities to run waiting time initiatives

Reasons for using the private sector

All sessions fully utilised and no guarantee of bed availability so used private sector at extra cost

Emergency pressures and lack of capacity (beds, theatres, staff) cannot guarantee admission in marginal NHS capacity therefore trusts used the private sector

Time - non-recurrent funding had to be used within a small number of months, making it simpler to spot purchase from the private sector

Cost, quality and speed of response of private sector

Reasons for using existing NHS facilities

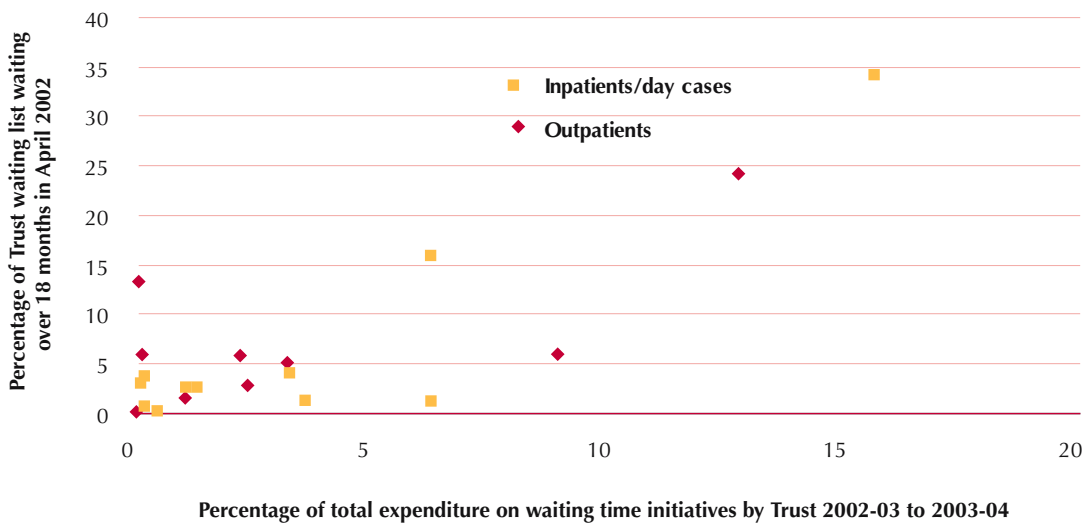
Continuity of care

Cost - existing NHS facilities tend to be cheaper than using the private sector

Local facilities are the most cost effective and clinically sound

Source: National Audit Office Wales survey of NHS trust chief executives

22 There is a correlation between waiting time initiative expenditure in 2002-03 and 2003-04 and the percentage of waiting lists waiting over 18 months in April 2002



Source: National Audit Office survey of NHS trust chief executives

4.25 The rationale for this pattern of funding is easy to understand. Appendix 6 shows that this was repeated on a regional basis, with 68 per cent of expenditure on waiting time initiatives in the south-east Wales region, with only 7 per cent of expenditure in north Wales, where waiting times are much lower (see Volume 1, 4.9). This reinforces the widespread perception that waiting time initiative funding is a reward for poor performance, with additional funding allocated to the trusts which breach targets. Waiting time initiatives also took place in England and Scotland, but both the Department of Health and Scottish Executive took steps to develop alternative NHS and independent capacity outside the originating providers to help reduce waiting times without funding the providers who had failed to meet waiting time targets.

4.26 Initiatives can provide a theoretical perverse incentive for organisations and individual clinicians, since the initiatives are usually performed by NHS consultants, either within additional NHS marginal capacity or the local private sector. The provision of large amounts of initiative funding to consultants could act as a disincentive for consultants to reduce their personal waiting times, as long waiting times lead to substantial additional expenditure on waiting time initiatives.

The use of waiting time initiatives was also heavily focused on particular specialties

4.27 Appendix 6 shows that the use of waiting time initiatives also varied considerably between specialties, particularly for inpatients/day cases, where 64 per cent of inpatient/day case expenditure was in the Trauma and Orthopaedics specialty. Ophthalmology was the next most significant specialty, accounting for 12 per cent of expenditure on inpatient/day case initiatives. Ear Nose and Throat accounted for 8 per cent of inpatient/day case expenditure, although the main issue here is that expenditure in the specialty rose significantly between 2002-03 and 2003-04, principally as initiatives were run for tonsillectomies and adenoidectomies when these procedures recommenced (see Volume 1, 3.14). Expenditure on outpatient initiatives was more evenly distributed, although Trauma and Orthopaedics was again the largest single specialty, accounting for 26 per cent of all expenditure on outpatient initiatives.

Waiting time initiatives provide questionable value for money

4.28 This section considers a series of indicators of the value for money provided by waiting time initiatives, specifically:

- a comparison of the cost of private sector initiatives and those provided in marginal NHS capacity;
- control of expenditure on waiting time initiatives; and
- the sustainability of reductions in waiting times achieved through waiting time initiatives.

Waiting time initiatives are generally more expensive in the private sector than in marginal NHS capacity

4.29 The most accurate comparisons of the cost of waiting time initiatives are for inpatient/day case initiatives. Because the vast majority of expenditure was on inpatient/day case initiatives, and the cost per case is considerably higher than that of an outpatient consultation, our analysis focused on the cost of inpatient/day cases in the private sector and marginal NHS capacity. **Figure 23** shows the average cost, as well as the range of costs, for a series of common procedures provided through waiting time initiatives. This shows that private sector costs were far more variable than those in existing NHS facilities, and that they were between 17 and 78 per cent more expensive than the same procedure provided at marginal cost within existing NHS facilities.

4.30 Where trusts used the private sector, they generally took various steps to reduce the cost of private sector provision as far as they were able, for example by:

- securing volume discounts from normal private sector rates, and for prompt payment;
- block contracts;
- establishing a long-term relationship with the private sector provider, a charity, which is cheaper than commercial private sector;
- negotiating rates on a cost per case contract;
- spot purchasing;
- piggy-backing on another trust's contract (3 trusts); and
- call off contract.

23 Cost of inpatient/day case procedures provided under waiting time initiatives in the private sector and marginal NHS capacity

Procedure	Average of average private sector costs (2002-03 and 2003-04)	Private sector range	Average of average NHS costs (2002-03 and 2003-04)	NHS range by trust	Difference between average private and NHS cost	Department of Health tariff cost	Number of patients treated under initiatives in 2002-03 and 2003-04	Additional cost of private sector compared with tariff rate
Hip replacement	£6,344	£5,600 - 8,708	£3,557	£2,500-5,900	78%	£5,568	395	£306,520
Hip revision	£15,198	£8,500 -16,755	£9,800	Only 1 trust - £9,800	55%	£7,240	21	£167,118
Knee replacement	£6,449	£5,400 - 8,865	£5,500	Only 1 trust - £5,500	17%	£6,182	389	£103,863
Cataract	£949	£727-1,250	£631	£250-1,137	50%	£786	1,630	£265,690
Tonsillectomy	£1,580	£1,500-1,818	£1,245	£947-1,467	27%	£944	425	£270,300
Total								£1,113,491

Source: National Audit Office Wales survey of NHS trust chief executives

4.31 In England, the Department of Health has recently established a tariff detailing costs for individual procedures, which will support the introduction of its policy of 'payment by results', whereby providers will be paid at tariff rates for the number of procedures they provide. We compared tariff rates, which in England are being phased in and did not exist at the time NHS trusts in Wales commissioned these services, with private sector costs for procedures provided through waiting time initiatives in 2002-03 and 2003-04. This showed that, compared with the Department of Health tariff, the additional cost of using the private sector for five procedures - hip replacement, hip revision, knee replacement, cataract and tonsillectomy - was £1,113,000 above the current tariff cost, which represents 15 per cent of overall expenditure in the private sector on these procedures.

4.32 Waiting time initiatives within marginal capacity in existing NHS facilities involve a number of different groups of staff - consultants, anaesthetists, nurses, theatre staff, porters and administrative staff. The rates paid to such staff by trusts varied widely. There were considerable variations in the amounts paid to individual consultants in 2002-03 and 2003-04. Individual trusts conducted their own negotiations with their staff for initiatives within marginal NHS capacity, and with the private sector. Trusts reported a number of different bases of payments for consultants, such as:

- a rate per theatre session;
- a rate per patient;

- setting the rate at the £500 per session identified in the (then) draft consultant contract;
- personal negotiation with individual consultants;
- full private sector rates or, more commonly, 75 per cent of the private sector rates;
- standard rates per specialty, with a cap preventing the rates from exceeding private sector rates; and
- benchmarking the agreed rates against those used in other trusts to ensure their consistency.

4.33 Such variation in payment rates between consultants in different trusts was exacerbated by the fact that initiative funding tended to be released late in the financial year, leading to a rush to spend the money, thus placing consultants in an extremely strong negotiating position with their trusts. This was inflationary in parts of Wales with a more developed private sector, where consultants could command high private sector rates outside their NHS commitments. Consultants in some specialties, where there was high demand for their services - such as Orthopaedics - received higher rates within the same trust than consultants in other specialties where demand for initiatives was lower. There was some tension between different groups of staff, particularly consultants and Anaesthetists, over the relative rates paid. Trusts also reported variation in the basis of payments to other staff, such as nurses, porters, theatre staff and administrators, who were not paid additional rates if they were in work anyway when the initiative took place.

Control of expenditure on waiting time initiatives has been poor

- 4.34 We found that some trusts lacked consistently reliable information about waiting time initiatives, and were unable to provide information about the number of patients treated and the sums paid to staff to deliver initiatives. Generally, we found that the quality of information was better for initiatives run in 2003-04 than it had been for initiatives run in 2002-03, suggesting that trusts had improved their recording of information about initiatives. The reason that information was so poor is that the funding for initiatives is often released towards the end of the financial year, meaning that the initiative is carried out under severe time pressure. Consequently, recording information about the initiative is a low priority. The lack of robust management information demonstrates poor control of expenditure and means that it is difficult to compare costs, and ensure value for money.
- 4.35 Central control and monitoring of the initiative funding was also weak: the Welsh Assembly Government had little information about the outcomes achieved through the £36 million it provided to run waiting time initiatives in 2002-03 and 2003-04, reflecting a short-term approach and the rush to release funding towards the end of the financial years. The Welsh Assembly Government knew neither how much money trusts had spent on initiatives, nor the relative costs of provision in the private sector compared with using marginal capacity in existing NHS facilities. Indeed, it did not have the basic cost information on initiatives run by NHS trusts, which the National Audit Office Wales collected directly from trusts.
- 4.36 The Welsh Assembly Government also failed to link the provision of waiting time initiative funding to specific reductions in waiting times. For example, there have been some initiatives where the trust began to under-perform against contract in a particular specialty soon after the initiative began, meaning that the initiative simply propped up activity levels in the specialty, rather than providing genuinely additional activity to reduce waiting times. There were no clawback arrangements if initiatives did not deliver reductions in long waiting times. This contrasts with Scotland, where waiting time initiatives are subject to clawback arrangements if they fail to deliver specific reductions in waiting times, agreed in advance. Additionally, Scotland has used a system of 'payment by results', whereby Boards are paid on a retrospective basis after they deliver waiting times milestones.
- 4.37 Waiting time initiatives should be closely linked to the commissioning process. If they are not, longer-term issues around capacity, activity, waiting times and health needs can be obscured by a short-term imperative to reduce waiting times. Funds were often provided directly to trusts by the Welsh Assembly Government under severe time pressure - we found that 45 per cent of Local Health Board chief executives indicated that they had not been consulted about the appropriateness of giving initiative funding to providers from whom they commissioned services.
- 4.38 The initiatives we analysed in the financial years 2002-03 and 2003-04 were characterised by duplication in procurement and negotiation, with twelve trusts generally negotiating separately with their own staff and the private sector. There is one example of a more joined-up approach, where Cardiff and the Vale and Pontypridd and Rhondda Trusts negotiated jointly with the private sector for a substantial contract for Orthopaedics. 80 per cent of Trust chief executives responding to our survey believed there was scope to secure lower costs from the private sector, principally through the potential to centralise negotiations with the private sector to secure volume discounts and a more strategic relationship with the private sector in Wales.
- 4.39 Welsh Assembly Government officials are aware of the value for money risks associated with waiting time initiatives and have now established a stronger framework to manage the cost of waiting time initiatives, particularly by resolving the variation in rates of payment to consultants and Anaesthetists through the new consultant contract, which provides for a set rate of £500 per additional initiative session. This will help to regularise the cost of initiatives in existing NHS facilities and reduce duplication in negotiations with staff.
- 4.40 Given the dramatic increase in expenditure on initiatives in the private sector between 2002-03 and 2003-04 (see 4.22), the Second Offer Scheme's central commissioning team now has the potential to deliver a more strategic approach to commissioning from the private sector and securing lower costs through its additional purchasing power as a single commissioner for Wales. Early evidence from the Second Offer Scheme suggests central commissioning can achieve lower costs from the private sector.

Although waiting time initiatives are good for the patients who receive treatment, they do not always contribute to sustainable solutions for future patients

4.41 Waiting time initiatives provided treatment for around 40,000 patients in 2002-03 and 2003-04. Clearly, this is beneficial to those patients, who represent 13 and 15 per cent of the total outpatients and inpatient/day cases waiting respectively at the end of April 2002. However, there are serious concerns about the sustainability of improvements in waiting times achieved through such initiatives, which appear to have functioned largely as a short-term expedient. **Figure 24** shows that most Trust and Local Health Board chief executives believed that initiatives enabled them to reduce the number of patients waiting over eighteen months significantly, but that such improvement was not sustainable without further funding. This is disappointing given the potential to release capacity through more efficient use of existing capacity, outlined in Parts 2 and 3. A significant minority of Trust chief executives believed that outpatient initiatives had enabled them to eliminate a temporary backlog of long waiters, and to catch up sufficiently to be confident that there was little prospect of waiting times exceeding eighteen months in the next twelve months.

4.42 The waiting time statistics, which Volume 1 of this report presents, back up the view that initiatives are a short-term expedient which can support the achievement of targets at the end of the financial year, but which do not deliver sustainable improvements. There is a general trend within the waiting time statistics which shows improvements in the second half of the financial year, when initiatives tend to take place, with waiting times increasing in the first half of the year.

4.43 Initiatives can be useful when there is a genuine backlog which needs to be eradicated or to support wider strategic developments. Initiatives for patients waiting for tonsillectomies have been successful in eradicating the backlog created by the decision to suspend tonsillectomy activity, helping to treat over 1,400 patients who required tonsillectomies in 2003-04 and reduce the number waiting over eighteen months for a tonsillectomy from 2,192 to 2 between the end of March 2003 and March 2004. Health Commission Wales also informed us of successful initiatives to treat three hundred cardiac surgery patients in Hammersmith Hospital between 2000-01 and 2002-03, to maintain service levels while Health Commission Wales developed additional recurrent capacity. In contrast to other initiatives run by Health Commission Wales, the funding for the cardiac initiatives was provided at the beginning of the financial year, enabling them to negotiate a better deal, set up a robust contractual framework and develop good communications between clinicians in the originating provider and Hammersmith Hospital. Without this more strategic approach to resolving underlying capacity issues, initiatives can simply distort case mixes and hide the underlying causes of long waiting times.

24 The sustainability of waiting time initiatives

We asked chief executives to tick the statement which *best* reflected the impact of initiative funding on waiting times in their area.

	Outpatient Waiting List		Inpatient/Day Case Waiting List	
	LHB	Trust	LHB	Trust
Despite the use of initiative funding, there has been no significant overall reduction in the number of patients waiting over 18 months.	14%	0%	0%	0%
There were initial reductions in those waiting over 18 months as a result of the provision of initiative funding, but the trust/providers have been unable to sustain them.	24%	11%	23%	11%
Initiative funding has changed the shape of the waiting list in the trust/LHB area, but has made no significant difference to the longer-term problem of patients waiting over 18 months.	14%	0%	9%	11%
The number of patients waiting over 18 months has reduced significantly, but the trust/providers will be unable to sustain this position without further funding.	38%	55%	59%	67%
Initiative funding has helped the trust/providers eliminate a temporary backlog of patients waiting over 18 months, allowing us/them to catch up to the extent that capacity and demand are sufficiently balanced for there to be little prospect of waiting times exceeding 18 months in the next twelve months.	10%	33%	9%	11%

Source: National Audit Office Wales surveys of Trust and Local Health Board chief executives

4.44 The main disadvantage of waiting time initiatives, notwithstanding the concerns about their value for money, is that they treat the effect not the cause of long waiting times. By simply treating patients who have waited for a long time, they fail to address the real causes of long waiting times across the whole system of health and social care. Parts 2 and 3 describe the main causes of long waiting times, particularly rising demand for outpatient appointments and the impact of medical pressures, delayed transfers of care and process inefficiencies on elective capacity. NHS Wales could release substantial capacity to perform elective surgery if there were fewer delayed transfers of care; and a reversal of the rising incidence of emergency medical admissions would release beds for elective patients, reducing the extent of cancelled surgery because no beds are available. Consequently, initiatives can reinforce the imbalances which characterise the current system, rather than changing it in a sustainable fashion, acting as a disincentive or barrier to innovation and modernisation. The use of initiatives reinforces the status quo, and current configuration of service provision, rather than driving innovation and change.

'Fiddling about with initiative clinics and theatres merely produces a sharp short-term fall in waiting times. The extra patients dealt with generate extra follow-up visits which in turn block the clinics, reducing the number of new patients seen immediately post-initiative. The numbers waiting then go up again.'

NHS Consultant

Source: National Audit Office Wales survey of Consultants

KEY POINTS

on waiting time initiatives

- Waiting time initiatives have been widely used - we estimate that £36 million was spent on initiatives in the financial years 2002-03 and 2003-04 - but have not generally delivered sustainable reductions in waiting times; key points relating to waiting time initiatives are:
 - In 2002-03 and 2003-04, 29,000 outpatients and 11,000 inpatient/day cases received treatment through waiting time initiatives;
 - 92 per cent of expenditure in 2002-03 and 2003-04 was targeted at inpatient/day case initiatives;
 - expenditure by trusts in the private sector represented 48 per cent of total expenditure, but doubled from 2002-03 to 2003-04, since marginal capacity in existing NHS facilities had been exhausted;
 - there is a strong link between trusts with a high incidence of patients waiting over eighteen months for a first outpatient appointment and those waiting over eighteen months for inpatient/day case treatment;
 - initiative expenditure was heavily focused on particular specialties, particularly Trauma and Orthopaedics, which accounted for 64 per cent of inpatient/day case initiative expenditure in 2002-03 and 2003-04, and 26 per cent of outpatient expenditure during this period;
 - initiatives represent questionable value for money, with the private sector considerably more expensive than initiatives provided within marginal NHS capacity;
 - initiatives carried out in the private sector were more expensive than the Department of Health's tariff costs - the cost of five common procedures carried out in the private sector in 2002-03 and 2003-04 was over £1 million higher than tariff cost; and
 - control of expenditure was weak as a result of the time pressures associated with funds being released late in the financial year, and the reductions achieved through initiatives are generally unsustainable.

There is scope to share the waiting times risk more evenly between providers and commissioners

4.45 Commissioning decisions influence waiting times. Figure 16 in Volume 1 showed the widespread, and unacceptable, variation in waiting times per head of population between the various Local Health Boards. The box below explains the structures which underpin commissioning of secondary care services. This section considers the role of commissioners in securing reasonable waiting times for their residents, focusing on:

- the influence of commissioning decisions on waiting times;
- the extent to which commissioners are accountable for waiting times;
- the extent to which the new commissioning structures have fully bedded in; and
- the specific issues relating to commissioning from English providers.

Commissioning arrangements

Each Local Health Board will produce, with the local authority, a **Health, Social Care and Well Being Strategy (HSCWBS)** covering the health needs of their community and how they will be met.

Underneath this, each Local Health Board produces an **Annual Service and Commissioning Plan (ASCP)**, which covers commissioning at all levels. To co-ordinate and clarify the commissioning of secondary care services - while there are twelve trusts providing general acute secondary care services in Wales, there are twenty-two Local Health Boards - there are fourteen **Secondary Care Commissioning Groups (SCCG)**, composed of trusts, one or two Local Health Boards, and local authorities. The SCCG meets at least quarterly and is responsible for co-ordinating the commissioning of secondary care services through a **Secondary Care Commissioning Plan**, which informs each Local Health Board's ASCP. Each SCCG has a lead Local Health Board.

Source: National Audit Office Wales

Poor waiting time performance can relate to commissioning activity as well as inefficiencies of provision

4.46 Long waiting times can result from inadequate commissioning as well as inefficiencies in provision. It is essential that commissioners do not simply fund services but use their commissioning strategies to influence both the

configuration and delivery of services, and waiting times for their residents. 50 per cent of Trust chief executives, responding to our survey, believed that waiting times were less important than historical patterns of service delivery and the availability of funding, while 50 per cent believed that waiting times form an integral part of negotiations with commissioners, and funding is heavily dependent on trusts' ability to meet waiting time targets.

4.47 We visited one Trust which delivered 43 per cent more Orthopaedic outpatient appointments than it was commissioned to carry out, and received twice as many referrals in the financial year as the volume of outpatient activity for which it was commissioned in this specialty. This represents a clear imbalance between capacity and demand, mitigated to some extent by the over-performance against contract, but which reveals that commissioning had not secured sufficient services for the trust to have a realistic prospect of achieving waiting time targets. Such commissioning shortfalls often relate to historical financial deficits and the tension between restoring financial balance and the need to deliver basic Welsh Assembly Government targets for service delivery. The arrangements for the Second Offer Scheme recognise this through sanctions applied either to providers or commissioners according to the cause of breaches of Welsh Assembly Government targets.

4.48 Local Health Boards monitor contracts by considering together elective and emergency activity against contracted volume within a specialty. This means that a trust may under-perform against its contract for elective activity in a particular specialty but make up the shortfall on emergency work within that specialty and be regarded as providing an acceptable level of activity despite very long waiting times for elective patients.

There is scope to increase the accountability of commissioners for long waiting times for their resident populations

4.49 While providers are responsible for the waiting times of patients referred onto their waiting lists, commissioners have a statutory responsibility to commission services on behalf of their resident populations. This responsibility includes securing Welsh Assembly Government waiting time targets. Although Local Health Boards are accountable in the same way as trusts through the performance management and SaFF processes, our survey results, and the outcomes of our interviews with senior officials in trusts, revealed a perception that waiting times were regarded as a greater responsibility for providers than for commissioners, and a lack of clarity about who owns the waiting list - commissioners or providers. Waiting times should be a shared risk.

4.50 43 per cent of Local Health Board chief executives reported that they had already considered setting waiting times for their residents, which were more stringent than Welsh Assembly Government targets, while 90 per cent indicated that they would do so in future. This ownership of improving local waiting times is welcome, although such variations in attitude could exacerbate the existing local variations (see Volume 1 Figure 16). Consequently, it is essential that the accountability arrangements for commissioners are sufficiently robust to tackle substantial variations in long waiting times between different parts of Wales.

The revised commissioning arrangements have not yet bedded in fully because of the challenging agenda facing the new organisations

4.51 The new commissioning bodies, created on 1 April 2003, have faced an extremely challenging agenda: setting up their new organisational arrangements; the new GP and Consultant contracts; producing local Wanless Action Plans; and tackling historical financial deficits. **Figure 25** identifies the range of risks and opportunities for reducing waiting times presented by the new commissioning structures within NHS Wales, drawing from our surveys of Trust and Local Health Board chief executives, and interviews with a sample of senior officials from trusts and Local Health Boards.

There are significant issues relating to cross-border commissioning from English providers

4.52 Many Welsh patients receive treatments from healthcare providers in England. For example, Health Commission Wales commissions around 13 per cent of all specialist services for Welsh residents from English providers. Local Health Boards along the border with England - particularly Flintshire and Powys - commission substantial volumes of activity from English providers. Volume 1 of this report identified differences in waiting time performance between England and Wales, and the fact that Welsh patients treated by English providers rarely face waiting times which are as long as those experienced by patients treated by Welsh providers.

4.53 Devolution necessarily produces different health policies, priorities and approaches. However, differences in health policy between England and Wales do present significant commissioning challenges. For example, Local Health Boards operating close to the border with England face increased pressure because of the shorter waiting times delivered by the NHS in England for English commissioners, and the strategic significance of differential waiting times experienced by some Welsh patients.

25 Commissioning risks and opportunities for minimising waiting times

Opportunities	Risks
<ol style="list-style-type: none"> 1 Local focus of Local Health Boards, and their coterminosity with local authorities. 2 Partnerships/whole systems working, especially developing integrated care pathways, engaging colleagues from social care and linking primary and secondary care. 3 Developing strategic regional approaches to service reconfiguration. 	<ol style="list-style-type: none"> 1 Fragmentation and confusion of responsibilities, resulting in duplication, lack of uniform commissioning models, and confusion about whether commissioners or providers own the waiting list. 2 Parochialism and an excessive focus on local issues, leading to insufficient focus on the regional and national overview. 3 Organisational immaturity and expertise, a dilution of expertise through the increase in number of commissioning bodies, and the relative size and power of Local Health Boards compared with much larger trusts. 4 Failing to progress the demand management agenda.

Source: National Audit Office Wales surveys of trust and Local Health Board chief executives and interviews with officials in trusts and Local Health Boards

4.54 The first challenge this presents is the cost of shorter waiting times in England. English providers may wish Welsh commissioners to contribute their share of the costs of the service developments required to deliver English waiting time targets. If Welsh commissioners do not provide such additional funding, because of the different waiting time policy and targets in Wales, the provider might work to differential targets for English and Welsh patients, with routine Welsh patients likely to face longer waiting times in accordance with Welsh Assembly Government waiting time policy. This is already the case at some English trusts. If Welsh patients are treated according to English waiting time targets, English providers' activity for Welsh commissioners may exceed contracted volumes, resulting in cost pressures for Welsh commissioners. The announcement by the Secretary of State for Health of shorter waiting time targets in England may exacerbate this situation if providers treat Welsh patients according to English targets (see Volume 1, 3.4). Lower waiting times at English providers may attract increased referrals from Welsh GPs and thus increase cost pressures.

4.55 There are specific additional financial risks for commissioners arising from widening policy differences between England and Wales. The new tariff - which is being introduced in England and will lead to hospitals being paid a set amount for each procedure carried out - will have a significant impact on Welsh commissioners purchasing services from England. The standard tariff for each procedure will in some cases be higher than commissioners have previously paid, leading to higher commissioning costs for the same service, which will force waiting times up if financial constraints restrict the volume of activity commissioners can fund.

Innovations in Care has made a positive contribution to spreading best practice, but their contribution to delivering shorter waiting times could be further enhanced

4.56 In 2000 the Welsh Assembly Government set up *Innovations in Care* to act as a catalyst to drive change and innovation throughout NHS Wales, embed best practice, modernise the delivery of care and ensure sufficient patient focus. Innovations in Care runs time-limited programmes to spread and embed best practice through pump-prime funding for trusts to run the programme locally, with a view to the Trust providing recurrent funding once the programme has finished and proved its cost-effectiveness. On 1 November 2004, Innovations in Care and the Centre for Health Leadership joined to form the National Leadership and Innovation Agency for Healthcare.

KEY POINTS

on commissioning

- There is scope to share the waiting time risk more evenly between commissioners and providers:
 - poor waiting time performance can relate to commissioning weaknesses as well as inefficiencies of provision;
 - there is scope to improve the accountability of commissioners for long waiting times;
 - the new commissioning arrangements have not fully bedded in because of the very challenging agenda facing the new organisations; the demand management agenda, and the development of robust, evidence-based commissioning based on need not historical patterns of expenditure is vital to the smooth implementation of the Wanless agenda; and
 - there are significant issues and risks relating to cross-border commissioning from English providers, particularly differential waiting time targets and the Department of Health's new tariff, and the potential impact of each of these on commissioners' choice of provider as well as their financial liabilities.

4.57 The running costs of Innovations in Care have been just under £4 million, and programme costs £25 million, between 2000-01 and 2004-05. The initial programmes run by Innovations in Care focused on waiting list management. Subsequent programmes focused on outpatient improvement, theatre management, the endoscopy project and emergency care. Innovations in Care is now running the Treat in Turn programme, which has significant scope to reduce waiting times through better waiting list management processes. This part of the report considers the overall impact of Innovations in Care, specifically:

- its contribution to spreading best practice
- local approaches to modernisation; and
- the ways in which Innovations in Care could develop its contribution further.

Innovations in Care has made a positive impact by spreading best practice

4.58 Trusts and Local Health Boards clearly value the work of Innovations in Care - the majority of chief executives believe their contribution to spreading best practice to have been good or excellent. Part 2 of this report described some of the positive impacts of Innovations in Care's programme, such as partial booking. However, Innovations in Care's contribution to producing sustainable reductions in waiting times has been less effective, with most chief executives regarding it as limited or poor. These results were reinforced by the interviews we carried out with staff in local healthcare organisations in Wales.

Local approaches to modernisation have varied

4.59 The majority of trusts have employed individuals as programme managers, who have specific expertise in the relevant area of healthcare delivery to run a particular programme, usually on secondment, before returning to their previous job. This leads to the skills of modernisation and change being lost to the organisation. However, **Case Study K** shows that one Trust - North East Wales - has adopted a more corporate approach, employing a generic change team to lead all programmes and train all staff in the Trust in the generic skills of change, innovation and service redesign. This focuses much more on softer issues of culture and values.

There is scope to improve the contribution of Innovations in Care further

4.60 Innovations in Care has already changed aspects of its working practices following a joint review by the Centre for Health Leadership and Audit Commission in Wales in March 2003³⁷. The key changes which resulted from the review were:

- the creation of local Innovations in Care Boards to strengthen local input to the modernisation agenda;
- replacing the bid process with a programme approach;
- programmes now seek explicit commitment of recurrent funding once pump-prime funding has been exhausted;
- building rigorous monitoring into programmes when they are designed, and
- applying a standard evaluation model.

4.61 There remain further challenges for Innovations in Care. Delivering change in the configuration and delivery of services, and reducing waiting times, depend on the ownership and engagement of clinicians. Our survey of Consultants in three specialties suggested that many are not aware of Innovations in Care, and that they are ambivalent about, or dissatisfied with, its contribution. Consultants, who are committed to modernisation and service change, sign-up readily to Innovations in Care programmes and local modernisation initiatives. However, there remains considerable resistance to, and suspicion of, such initiatives, with the associated risk that Innovations in Care tends to 'preach to the converted', who would have embraced change anyway, rather than working with the cadre of Consultants most resistant to change and wedded to traditional practices, who most need to be persuaded to change.

K

Modernisation in North East Wales NHS Trust

North East Wales NHS Trust is unique in Wales in having a central modernisation team, a board-level Head of Modernisation and a Modernisation Board chaired by the chief executive. A team of five Service Improvement Facilitators leads individual projects, and liaises with particular clinical directorates, thus taking forward both the national Innovations in Care agenda and local priorities for change. They are supported by information analysts, as producing evidence of the successful outcomes arising from change is critical to clinical ownership and commitment. The team also runs the modernisation training programme, whereby the Trust seeks to train staff in generic skills of change and innovation to embed a culture of change at all levels. The key lessons from this approach are:

- the benefit of senior sponsorship of modernisation;
- the synergies which may be possible from a corporate approach to allow the organisation to identify links and lessons across the organisation;
- the importance of information, and robust evidence, in influencing clinical behaviour and sign-up;
- the significance of organisational culture in spreading learning; and
- the importance of generic change management skills at all levels of the organisation.

Source: National Audit Office Wales visit to North East Wales NHS Trust

KEY POINTS

on spreading best practice

- Innovations in Care has made a positive contribution to spreading best practice but its contribution to delivering shorter waiting times could be further enhanced.

³⁷ Audit Commission in Wales and Centre for Health Leadership Innovations in Care Review, March 2003.

Appendix 1

Methodology

Our study methodology involved the following stages:

- 1 A background literature review - including external reviews, academic works, the work of the Organisation for Economic Co-operation and Development, the Audit Commission in Wales, the Commission for Health Audit and Inspection (now the Healthcare Commission) and Welsh Assembly Government strategy documents - and consultation with academics and clinicians. This, together with preliminary meetings with key Welsh Assembly Government officials and others, informed decisions about the scope of the study and the key questions which the examination sought to answer.
- 2 An extensive programme of interviews and meetings with leading health service administrators and clinicians, as well as representatives of other organisations and interested parties in the field of health and social care. This included:
 - key officials of the Welsh Assembly Government in the Performance, Quality and Regulation Division; Innovations in Care; the Health Information & Facilities Division; the NHS Finance Division; and the Social Care Policy Division;
 - Directors of Performance and Improvement in all three NHS Wales Regional Offices;
 - Health Solutions Wales;
 - the British Medical Association;
 - the Board of Community Health Councils in Wales; and
 - the Association of Directors of Social Services.
- 3 We maintained a particularly close working relationship with colleagues from the Audit Commission in Wales and drew on their existing work.
- 4 We collated and analysed relevant statistical data, from a number of sources, of which the following were especially important:
 - the Audit Commission's Acute Hospital Portfolio Phase 2, which provides data on outpatients, waits for admission, operating theatres and bed management;
 - data in the National Assembly for Wales' annual publication, Health Statistics Wales;
 - information provided by Health Solutions Wales, which maintains corporate national health databases, including Patient Episode Data Wales, covering all inpatient and day case activity;
 - the Assembly's published waiting times statistics and data published on Statswales (<http://www.statswales.wales.gov.uk>), the Assembly's statistical website;
 - the NHS Finance Division of the Welsh Assembly Government, which provided details of funding disbursed by the Welsh Assembly Government for waiting time initiatives;
 - the survey questionnaires completed by trust and Local Health Board chief executives, consultants, GPs, Community Health Council chief officers and patients (see paragraph 5); and
 - the Welsh Assembly Government's database of delayed transfers of care.

5 Surveys, by postal questionnaire, as follows:

Group surveyed	Issues covered	Response
All GPs in Wales	Patients' ability to access services/specialities; the impact of waiting on patients and GP workload; improvements in waiting times; the impact of 10 day cancer target; suspensions from the waiting list; validation of the waiting list; referral practices; pooled waiting lists; and means of improvement.	17 per cent
All consultants in Trauma & Orthopaedics, Ophthalmology and General Surgery	Consultants' own waiting times; waiting time information available to them; barriers to reducing waiting times; the impact of waiting on patients; referral and prioritisation; action taken to reduce long waits; and the impact of partial booking.	31 per cent
Chief executives of Welsh trusts	Waiting list management; partial booking; delayed transfers of care; commissioning arrangements; performance management; demand management and resource utilisation; and learning from best practice;	100 per cent
Chief executives of LOCAL HEALTH BOARDS	Commissioning secondary care services; and future commissioning arrangements;	100 per cent
Chief officers of Community Health Councils	Patients' experience of waiting times (expectations, complaints, cancellations); and tackling waiting times (partial booking, alternatives to hospital admission; pooled waiting lists).	45 per cent
Patients (questionnaires circulated via Consultants and Community Health Councils)	Length of time on waiting list; the impact of waiting on patients' condition and general well-being; information provided to patients; and cancellations.	113 surveys returned.

- 6 We visited six NHS trusts in Wales. Three initial visits were carried out to identify key issues, trends and best practice: Bro Morgannwg; Cardiff & the Vale; and North West Wales. Then, after surveys had been received and analysed, we undertook follow-up visits to Carmarthenshire; Gwent Healthcare and North East Wales. The duration of visits ranged from one to five days. In each case, we reviewed key documentation and carried out semi-structured interviews with appropriate managers and clinicians. We examined and documented examples of innovative approaches to the challenges presented by waiting times and identified case studies of good practice.
- 7 We visited six local health boards (Caerphilly; Cardiff; Denbighshire; Flintshire; Powys; Vale of Glamorgan) to interview key officials about waiting times and commissioning in Wales. Similarly, we visited Health Commission Wales to discuss their experience of commissioning tertiary services.
- 8 We visited health departments and audit bodies in Scotland and Northern Ireland to discuss their approaches to waiting times and facilitate comparisons with Wales. In addition, we obtained details of the Department of Health's approach to waiting times in England by correspondence, as well as close liaison with our colleagues in the National Audit Office in London.
- 9 We held a focus group of Community Health Council patient advocates, held during a two-day training event run by the Board of Community Health Councils in Wales. The focus group discussed waiting times and their impact on patients.
- 10 We also constituted an Expert Panel to advise us at key stages of the examination. Appendix 2 provides further detail about the role and membership of the Panel.

Appendix 2

Expert Panel function and membership

- 1 We constituted a panel of experts to advise us during the course of this examination. The panel members sat in an individual and advisory capacity, and had no executive role in the Auditor General for Wales' examination. We selected individuals to reflect an appropriate range of stakeholders in the issue of NHS waiting times.
- 2 The panel advised us at key stages of the examination. We held two meetings, which discussed:
 - the study scope and methodology; and
 - our emerging findings.
- 3 Panel members also provided advice remotely on the content of our various surveys, and all panel members received copies of our draft report for comment.
- 4 We are extremely grateful to the following members of our expert panel, who provided extremely helpful advice and gave freely of their time and expertise:
 - Dr Tony Calland, Chairman BMA Cymru;
 - Allan Cumming, Associate Director Innovations in Care;
 - Margaret Foster, chief executive Pontypridd and Rhondda NHS Trust;
 - Hugh Gardner, Vice Chair, Association of Directors of Social Services;
 - Peter Johns, Association of Welsh Community Health Councils;
 - Malcolm Latham, Audit Commission in Wales;
 - Dean Medcraft, Welsh Assembly Government, South-East Wales Regional Office;
 - Judith Paget, chief executive, Caerphilly Local Health Board;
 - Brian Rees, Royal College of Surgeons; and
 - Dr Rhiannon Tudor-Edwards, Centre for the Economics of Health, University of Wales, Bangor.

Appendix 3

Key findings of the Assembly's Review of Health and Social Care, advised by Derek Wanless (2003)

The key findings of the Wanless review, published in June 2003, were:

The present:

- Wales does not get as much from its health spending as it should;
- there is too much pressure on the acute sector, leading to unacceptably long waiting times and assessments without subsequent social service provision;
- the system contributes to the problems and needs to be rebalanced;
- there is inadequate workforce, estates and ICT capacity; and
- performance management arrangements are inadequate.

The future:

- there needs to be increased public awareness of health issues and more personal acceptance by people of their responsibility for their own health;
- immediate steps are needed to reduce delayed transfers of care;
- capacity needs to be developed in non-acute settings, with a strategic adjustment to focus on prevention, early intervention and alternatives to hospital admission;
- the barriers between health and social care need to be broken down;
- the Assembly should stop funding financial deficits; and
- demand could increase because of Wales' ageing population.

Appendix 4

Delayed transfers of care by Trust (excluding Mental Health), November 2003-June 2004

The figures below have been provided by the Assembly from its database of delayed transfers of care and relate to all delays, for all reasons, in non-psychiatric beds in acute and community hospitals in Wales. We have excluded Mental Health delays because these are unlikely to affect the waiting times of patients who are waiting for acute medical or surgical treatment.

Delays by Trust:

	Nov-03	Dec03*	Jan-04	Feb04*	Mar04*	Apr-04	May-04	Jun-04*	% change
Mid & West Wales									
Bro Morgannwg	24	24	31	27	35	29	42	35	46%
Carmarthenshire	91	62	104	121	100	100	99	59	-35%
Ceredigion & Mid Wales	20	13	13	11	18	14	20	12	-40%
Pembrokeshire & Derwen	29	16	15	12	15	7	5	5	-83%
Powys Healthcare	25	35	30	21	22	21	22	25	0%
Swansea	61	57	55	67	67	57	54	60	-2%
M&W Regional Total	250	207	248	259	257	228	242	196	-22%
North Wales									
Conwy & Denbighshire	50	23	28	34	39	22	21	24	-52%
North East Wales	55	58	66	58	50	46	58	49	-11%
North West Wales	29	29	19	20	18	13	17	24	-17%
NW Regional Total	134	110	113	112	107	81	96	97	-28%
South East Wales									
Cardiff & Vale	133	123	136	113	114	87	98	99	-26%
Gwent	207	199	200	184	187	190	159	160	-23%
North Glamorgan	56	35	49	44	35	26	25	37	-34%
Pontypridd & Rhondda	38	38	57	52	43	41	40	44	16%
SE Regional Total	434	395	442	393	379	344	322	340	-22%
ALL WALES TOTAL	818	712	803	764	743	653	660	633	-23%

*These figures represent the position at the time the breakdown was done and may vary from the "Census figure".

Source: Welsh Assembly Government Social Care Policy Division

Appendix 5

Delayed transfers of care by Local Health Board (excluding Mental Health), November 2003- June 2004

The figures below have been provided by the Assembly from its database of delayed transfers of care and relate to all delays, for all reasons, in non-psychiatric beds in acute and community hospitals in Wales. We have excluded Mental Health delays because these are unlikely to affect the waiting times of patients who are waiting for acute medical or surgical treatment. The figures are broken down according to the local health board or local authority area in which the patient in question resides.

Delays by Local Health Board:									
	Nov-03	Dec03*	Jan-04	Feb04*	Mar04*	Apr-04	May-04	Jun-04*	% change
Mid & West Wales									
Bridgend	7	7	15	9	12	7	15	9	29%
Carmarthenshire	82	59	82	107	91	83	78	49	-40%
Ceredigion	21	17	21	20	23	19	20	16	-24%
Neath Port Talbot	23	23	22	27	26	29	38	40	74%
Pembrokeshire	29	16	16	10	15	7	5	5	-83%
Powys	24	32	26	18	21	20	21	24	0%
Swansea	52	43	46	51	53	46	42	47	-10%
M&W Regional Total	238	197	228	242	241	211	219	190	-20%
North Wales									
Conwy	20	19	11	14	16	13	8	15	-25%
Denbighshire	30	10	15	17	17	15	13	7	-77%
Flintshire	20	21a	31	25	25	17	30	14	-30%
Gwynedd	19	11	9	15	16	7	11	13	-32%
Isle of Anglesey	7	10	7	5	3	2	2	5	-29%
Wrexham	29	33	31	31	26	20	27	34	17%
NW Regional Total	125	104	104	107	103	74	91	88	-30%
South East Wales									
Blaenau Gwent	30	36	40	39	41	51	44	39	30%
Caerphilly	83	63	63	57	48	39	27	18	-78%
Cardiff	80	64	66	53	49	50	57	64	-20%
Merthyr Tydfil	14	8	10	16	15	10	9	17	21%
Monmouthshire	8	11	12	11	16	16	15	21	163%
Newport	54	44	52	48	43	47	30	43	-20%
Rhondda Cynon Taff	71	61	79	67	62	55	55	58	-18%
Torfaen	50	60	59	42	46	42	41	40	-20%
Vale of Glamorgan	38	38	47	50	47	27	35	34	-11%
SE Regional Total	428	385	428	383	367	337	313	334	-22%
Local Authority Total	791	686	760	732	711	622	623	612	-23%
No fixed abode or postcode, and English residents	27	26	43	32	32	31	37	21	
TOTAL	818	712	803	764	743	653	660	633	-23%

*These figures represent the position at the time the breakdown was done and may vary from the "Census figure"

Source: Welsh Assembly Government Social Care Policy Division

Appendix 6

Expenditure on waiting time initiatives by specialty and region

Waiting time initiative expenditure by specialty, 2002-03 to 2003-04					
Outpatients	2002-03 £	2003-04 £	Increase %	Total £	Percentage of all expenditure
Trauma and Orthopaedics	95,464	562,960	490%	658,424	26%
Other	318,143	302,175	-5%	620,318	24%
Ear, Nose and Throat	242,413	140,300	-42%	382,713	15%
Dermatology	224,600	108,200	-52%	332,800	13%
Ophthalmology	128,563	111,320	-13%	239,883	9%
General Surgery	68,597	135,800	98%	204,397	8%
Rheumatology	89,022	9,800	-89%	98,822	4%
TOTAL	1,166,802	1,370,555	17%	2,537,357	
Inpatients/day cases	2002-03	2003-04	Increase	Total	Percentage of all expenditure
Trauma and Orthopaedics	8,339,155	11,456,600	37%	19,795,755	64%
Ophthalmology	1,585,377	2,017,500	27%	3,602,877	12%
Ear, Nose and Throat	22,000	2,450,700	11040%	2,472,700	8%
General Surgery	757,085	1,488,035	97%	2,245,120	7%
Cardiac surgery	1,068,000	250,000	-77%	1,318,000	4%
Other	394,000	733,700	86%	1,127,700	4%
Urology	237,000	307,720	30%	544,720	2%
TOTAL	12,402,617	18,704,255	51%	31,106,872	

Source: National Audit Office Wales survey of NHS trust chief executives

Waiting time initiative expenditure by region, 2002-03 to 2003-04

Waiting time initiative expenditure by specialty, 2002-03 to 2003-04				
Region	Total expenditure £	% total outpatient expenditure in Wales	% total inpatient/day case expenditure in Wales	% of total expenditure in Wales
South East Wales				
Cardiff and Vale	10,821,784	24%	33%	32%
North Glamorgan	523,693	6%	1%	2%
Pontypridd and Rhondda	1,200,597	1%	4%	4%
Gwent Healthcare	10,671,700	29%	32%	31%
Regional total	23,217,774	60%	69%	68%
Mid and West Wales				
Carmarthenshire	402,685	5%	1%	1%
Ceredigion and Mid Wales	748,500	0%	2%	2%
Pembrokeshire and Derwen	30,000	0%	0%	0%
Bro Morgannwg	2,392,500	13%	7%	7%
Swansea	4,867,246	6%	15%	14%
Regional total	8,440,931	24%	25%	25%
North Wales				
Conwy and Denbighshire	994,000	6%	3%	3%
North East Wales	1,044,000	3%	3%	3%
North West Wales	311,697	8%	0%	1%
Regional total	2,349,697	16%	6%	7%

Source: National Audit Office Wales survey of NHS trust chief executives

Appendix 7

Tolerated breaches of minimum Welsh Assembly Government waiting time targets in the original 2003-04 SaFF³⁸

Cardiff and the Vale NHS Trust

General Surgery inpatients/day cases - 450 breaches of the 18 month target

Neurosurgery inpatients/day cases - 150 breaches of the 18 month target

ENT inpatients/day cases (non-tonsillectomy and adenoidectomy) - 250 breaches of the 18 month target

Gwent Healthcare NHS Trust

General Surgery inpatients/day cases - 320 breaches of the 18 month target

ENT inpatients/day cases (non-tonsillectomy and adenoidectomy) - 340 breaches of the 18 month target

Urology inpatients/day cases - 110 breaches of the 18 month target

Swansea NHS Trust

General Surgery - no more than 600 inpatient/day cases to be waiting more than 24 months

ENT inpatients/day cases (non-tonsillectomy and adenoidectomy) - no more than 170 inpatient/day cases waiting over 22 months

Oral Surgery outpatients - no more than 25 patients waiting more than 20 months

General Surgery outpatients - no more than 390 waiting over 22 months

Orthopaedics outpatients - no more than 600 waiting over 24 months

Ophthalmology outpatients - no more than 350 waiting over 22 months

Rheumatology outpatients - no more than 225 waiting over 22 months

Pembrokeshire and Derwen NHS Trust

General Surgery inpatient/day cases - no more than 20 patients waiting over 18 months (subsequently reduced to 0 when waiting time initiative funding was provided)

Ceredigion and Mid Wales NHS Trust

General Surgery inpatient/day cases - no more than 30 patients to wait over 18 months

Source: NHS Wales Department Performance Management and Policy Development Team

³⁸ Some trusts' SaFF targets changed during the course of the financial year because they received additional non-recurrent waiting time initiative funding.

Appendix 8

Glossary

Activity: a medical or surgical intervention undertaken by health care professionals at any stage within the patient's pathway.

Acute hospital: a hospital that provides surgery, investigations, operations and other treatments for serious conditions.

Adenoidectomy: an operation to remove the adenoids.

Ambulatory care: clinical care provided on an outpatient basis, to patients who are not confined to a hospital but are 'ambulatory', i.e. able to walk.

Average length of stay: the average length of time, in days, that each inpatient physically occupies a bed.

Bed use factor: the average number of patients using each bed during a particular period.

Bottleneck: any part of the system where patient flow is obstructed.

Business Service Centre: the Business Service Centre is currently based at five sites and provides various support services to the twenty-two Local Health Boards where there are economies of scale. These include finance, human resources and information management and technology.

Capacity: the resources available to undertake work at a specific step in a patient's pathway.

Clinician: a person mainly involved in the area of clinical practice, that is, the diagnosis, care and treatment of patients.

Commissioner: an individual or organisation responsible for identifying local health and social care needs, making agreements with service providers to deliver services and monitoring outcomes.

Community Health Council: a statutory lay organisation - one of twenty in Wales - which seeks to represent the public interest in the NHS and has rights to information about, access to, and consultation with all NHS organisations.

Community hospital: a hospital which treats patients who need nursing care and medical input, but who do not require the 24 hour medical cover provided in an acute hospital, and who are not well enough to get their care at home or in a non-hospital setting.

Consultant: a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care.

Conversion rate: the proportion of those waiting for an outpatient appointment within a given period who are subsequently listed for an inpatient or day case procedure.

Day Case: a procedure not requiring overnight admission to hospital.

Delayed discharge: a clinically unnecessary prolongation of a patient's stay in hospital, usually as a result of inefficiencies in internal processes, such as delays in getting test results or the timing of physicians' ward rounds.

Delayed transfer of care: a delay that occurs when a patient needs to move to a further care setting (this could be social service provision, another healthcare setting, the patient's home, or that of their family or carer), which is not yet available. Delayed transfers of care have complex causes resulting from processes, interactions within the whole system of health and social care, and decisions made by patients and their carers.

Demand management: the set of strategies employed by NHS managers to deal as effectively as possible with the flow of patients seeking treatment.

Diagnostic and therapy services: the range of services that includes carrying out investigative tests and providing therapeutic treatment, such as radiology, physiotherapy and occupational therapy.

Diagnostic and treatment centre: a special facility which provides planned day case and short-stay surgery in order to reduce waiting times and the pressure on acute hospitals.

Did not attend (DNA): a patient who misses an outpatient appointment.

Discharge lounge: a dedicated area within a hospital where patients who have been discharged may wait to be collected, thus making their beds available more quickly.

Elective services: planned (non-emergency) outpatient, daycase or inpatient activity, usually emanating from referrals and/or waiting lists.

Emergency admission: an unplanned admission to hospital as a result of an emergency such as an accident or a sudden illness. This is usually through A&E department or through a GP organising an immediate admission.

Endoscopy: the direct visual examination of any part of the inside of the body, using an endoscope - a long, tube-like optical viewing instrument with a lens and light source.

Episode of Care: A phase of treatment during which the patient receives a particular type of care (for example, acute, rehabilitation, etc).

European Working Time Directive: a health and safety directive from the Council of the European Union, which lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. It was implemented for all NHS employees with the exception of junior doctors in training in 1998. It was applied to junior doctors from August 2004 and limits them to a maximum of 58 working hours per week, which represents a considerable challenge to the NHS in terms of the way in which services are delivered.

Extended scope practitioner: a clinical physiotherapy specialist whose work goes beyond the recognised scope of physiotherapy practice - for example, by requesting or undertaking investigation and using results to assist in the diagnosis and management of patients.

General surgery: the branch of surgery which covers a broad range of conditions.

Generic referral: a procedure whereby a GP makes a referral that is not addressed to a specific consultant, but which is allocated by consultants to the most appropriate clinician, taking account of sub-specialisation issues and waiting times.

Health Commission Wales: the agency responsible for planning and commissioning specialised health services in Wales.

Health community: all organisations with an interest in health in one area, which will include one or more NHS trusts, local health boards, community health councils, local authorities and voluntary organisations.

Inpatient: a patient who is formally admitted to a hospital or health service facility.

Innovations in Care: the branch of the Welsh Assembly Government which has been responsible for modernising patient access to hospital treatment and for driving change and innovation in NHS Wales. On 1 November 2004, Innovations in Care became part of the new National Leadership and Innovation Agency for Healthcare.

Integrated care pathway: a pre-defined plan of patient care relating to a specific diagnosis or operation, including standards and guidelines to help organise and manage care more effectively.

Intermediate care services: services that act as a bridge between care provided in hospital and in community settings.

Local Health Board (LHB): one of twenty-two bodies established in Wales in 2003 as the principal commissioners of health services. They are based on the Local Health Groups that existed prior to 2003, bringing together family doctors, community nurses and others involved in health care, but exercise the commissioning functions previously held by the five Health Authorities. They are co-terminous with the twenty-two Welsh local authorities.

Medical pressures: the impact on elective surgery of unpredictable demand for beds and other facilities to treat medical patients, especially those admitted as emergency cases.

Multi-disciplinary team (MDT): a group of people who are from different professional backgrounds concerned with the treatment and care of patients, who meet regularly to discuss patient treatment and care.

'New deal' for junior doctors: national standards to ensure that junior doctors are working for a reasonable number of hours, which their employers are now obliged to monitor each week.

Nurse practitioner: a nurse who is specially qualified to make professionally autonomous decisions, involving the diagnosis and treatment of patients.

Ophthalmology: the branch of medicine concerned with the diagnosis and treatment of eye disorders.

Optometrist: a person qualified to examine the eyes, and to prescribe and supply glasses and contact lenses.

Orthopaedics: a branch of surgery concerned with disorders and treatment of the joints and bones.

Outlier: a patient who is placed on a ward for patients of a different specialty when beds are not available within their intended ward (for example, a medical patient placed on a surgical ward).

Outpatient: a patient who receives a medical, surgical or other health service in a hospital facility, who is not formally admitted to the hospital at the time of receiving the service. Outpatient appointments can be divided into new or first appointments, where a patient is attending an outpatient clinic for the first time in relation to that particular ailment, and repeat or follow-up appointments, which are further attendances in relation to the same ailment, to monitor progress or receive further treatment.

Partial booking: a system of arranging outpatient appointments, which aims to reduce non-attendance at clinics and cancellations, by contacting patients around six weeks before their likely appointment to arrange a mutually convenient date and time.

Pooled waiting list: a team-based approach to managing services within a specialty, which aims to equalise differences in waiting times between consultants. It involves all consultants within a specialty, or who all carry out a specific procedure, combining their waiting lists, and allocating patients from the pooled list to the consultant with the next available appointment.

Pre-operative assessment: a system that assesses patients' health before they are admitted to hospital to make sure that their planned operations can go ahead.

Primary care: family and community health services and major components of social care which are delivered outside the hospital setting and which an individual can access on his/her own behalf.

Professionals allied to medicine: professionals working in health, social care, education, housing and other sectors who provide complementary services to patients and clients with developmental and acquired disability in hospital, community and educational settings. They comprise art therapists, music therapists and dramatherapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists.

Provider: an organisation that provides health and/or social services - for example, an NHS Trust.

Rapid response team: a multi-disciplinary team of nurses, therapists and social workers to which patients with chronic medical conditions can be referred for immediate treatment, as an alternative to hospital admission.

Reablement team: a multi-disciplinary team that provides active recovery and rehabilitation services and aims to prevent the unnecessary loss of independence, by preventing hospital admission and enabling patients who have been admitted to return home after a short period of rehabilitation.

Ring-fenced beds: hospital beds that are set aside for use by patients within a particular speciality, to guarantee their availability, regardless of demand pressures.

Second offer scheme: A Welsh Assembly Government initiative, in place from 1 April 2004, which offers anyone in Wales who has waited, or is likely to wait, longer than the maximum target inpatient or daycase waiting time the opportunity of having their treatment at another hospital, inside or outside Wales.

Secondary care: Care which is provided in a hospital setting.

Service and Financial Framework (SaFF): a performance management mechanism, which allows the partners within each health community to reach a collective decision about priorities for the forthcoming financial year, linking resources to activity and quality.

Speciality: The term used to describe the particular field of medicine in which a specialist doctor practises, e.g. orthopaedics, urology, gynaecology.

Surgery: the branch of medicine concerned with treatment of injuries or disorders of the body by incision, manipulation or alteration of organs with the hands or with instruments - generally performed in an operating theatre under some form of anaesthesia.

Suspension: the temporary removal of a patient from a published waiting list, either when treatment needs to be delayed for clinical reasons, or at a patient's request.

Telemedicine: the application of electronic information and communication technologies to provide health care for patients separated by distance, involving multimedia applications such as telephones, video conferencing and web cams.

Tertiary care: specialised care, for which a patient is referred by their local doctor or hospital to a dedicated unit, such as a children's unit, heart unit or specialist burns unit. Health Commission Wales commissions tertiary services for Welsh patients.

Tonsillectomy: an operation to remove the tonsils.

Treat in turn: an initiative, which is being implemented in all NHS trusts in Wales, to ensure that patients are treated in chronological order within clinical priority.

Triage: a brief assessment of patients, usually when they first arrive in A&E, to assess how serious their illness or injuries are and to determine the priority in which they should be seen by a doctor.

Trust: an autonomous NHS body, which is responsible for providing secondary health care services, principally to patients living within a particular area.

Turnover interval: the average length of time, in days, that a bed is empty between each patient.

Validation: the systematic checking of a waiting list to ensure its accuracy. This may include contacting those listed to ensure that they still require the appointment.

Waiting list: the number of people waiting for a planned procedure at an acute or community hospital.

Waiting list management: the ongoing process of decision-making by which a particular health community seeks to ensure that all those waiting for treatment are dealt with as efficiently as possible.

Waiting time: the period of time during which a patient waits for an outpatient, inpatient or day case appointment, from the date of their referral.

Waiting time initiative: a measure intended to bring about a rapid reduction in the number of people waiting for treatment, through the provision of non-recurrent funding, either to purchase treatment from the private sector, or to secure additional treatment by NHS staff outside normal working hours.