Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Reducing waiting times in Wales

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Contents

Summary 4

Introduction 5

Why are patients waiting longer? 7

Policy Solutions 9

Conclusion 15

References 16

Summary

- In common with other parts of the UK, the NHS Wales referral to treatment (RTT) waiting list reached record levels. Performance against the Welsh Government's four and 12 hour targets for accident and emergency (A&E) waiting times has also worsened. The challenges have been exacerbated by the Covid-19 pandemic, but the underlying causes pre-date it.
- Increased RTT waiting times can be attributed to changing population health needs, workforce shortages, and increasing demand for NHS services.
- In the medium to long-term, sustained reduction in RTT waiting times will require system-wide change to address issues related to funding, service delivery, staffing, and patient care. This includes fundamental changes to work practices as well as governance and financing structures within the healthcare system.
- Proposed policies target five key areas to improve outcomes and reduce waiting times:
    - Workforce capacity;
    - Digital technology;
    - Reimagining primary care;
    - Systems collaboration; and
    - Follow-up care.
- Patient-centred policy approaches that address the systemic issues contributing to increased waiting times are more likely to be effective long-term and will have a wider impact on health system performance.
- NHS England waiting times were reduced in the early 2000s through the introduction of targets. However, it was found that targets resulted in the distortion of healthcare provider behaviour and performance against targets were not related to the quality of clinical care provided.
- While policies that set targets for waiting times can be enacted and implemented relatively quickly, in isolation, targets can distort behaviours and may result in unintended consequences, including increased health inequalities and reduced quality of care. Therefore, it is important to measure the right things.

Introduction

Referral to treatment (RTT) waiting times describe the total time waited from referral by a general practitioner (GP) or other medical practitioner to receipt of NHS-funded hospital treatment. RTT waitlists, reported by Local Health Boards to the Welsh Government, capture the number of people waiting for outpatient appointments, diagnostic tests, therapy services, and inpatient or day-case admissions, and they provide data on how long they have been waiting.

Waiting times are considered a key measure of how NHS Wales and the social care system are performing (King's Fund, 2020). Moreover, waiting for treatment, diagnostic, and emergency services often have a physical and psychological effect on patients as conditions may worsen, leading to increased stress on both patients and the health system. Therefore, reducing RTT waiting times is a priority for NHS Wales, Welsh Government, and the Welsh population utilising these services. In November 2021, the Senedd Health and Social Care Committee initiated an inquiry into and is seeking consultations on the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment (Senedd Business, 2021). The Committee considered the following:

- Services in place for people waiting for diagnostics and treatment;
- Access to psychological therapies and emotional support for those experiencing stress as a result of long waiting times;
- Potential contributions of the third sector in providing peer support and information to patients on waiting lists;
- The effectiveness of messaging and engagement with the public about demands on the system and the importance of seeking care promptly;
- The existence of inequalities in the elective backlog, particularly for deprived areas; and
- Plans to fully restore planned NHS care in Wales to pre-pandemic levels.

This report reviews the evidence about the underlying causes of increased RTT waiting times and discusses ways to reduce them. While the NHS has made efforts to meet waiting times targets, a focus solely on length of waiting times for planned runs the risk of distorting clinical decision making and prioritisation, taking focus away from other important measures including quality, safety, and patient outcomes (Audit Wales, 2020). Proposed policy solutions reflect the understanding that a patient-centred approach to addressing waiting times—while also maintaining high quality of care and preventing health inequalities—requires fundamental changes to the whole

system. This includes reforms in relation to workforce capacity and roles, delivery of services, and system governance.

Why are patients waiting longer?

The NHS Wales RTT waiting list reached record levels with over 750,000 patient pathways waiting to start treatment in August 2022—an increase of over 38 percent since before the pandemic (February 2020) (StatsWales, 2022).[1] The median waiting time to start treatment was over 22 weeks in August, compared to approximately 11 weeks in February 2020. (StatsWales, 2022).

RTT waiting times have been steadily increasing; even before the Covid-19 pandemic national standards were not being met. The sustained increase in RTT waiting times can be attributed to changing population health needs, workforce shortages, and underinvestment as the demand for NHS services increases (Kings Fund, 2020). The problem has been exacerbated by the Covid-19 pandemic during which non-urgent outpatient appointments were suspended and workforce activities shifted to prioritise urgent appointments and coronavirus cases.

Table 1: NHS Performance Against Welsh Government Waiting Times Targets

Welsh Government Targets	Performance Pre-Pandemic (February 2020)	Current Performance (August 2022)
Number of patient pathways waiting for the start of their treatment	Over 463,000 patient pathways	Over 750,000 patient pathways
No patients waiting more than 36 weeks for treatment from referral	Over 25,500 patient pathways had been waiting more than 36 weeks to start treatment (5.6%)	Over 271,000 patient pathways had been waiting more than 36 weeks to start treatment (36.1%)
95% of patients waiting less than 26 weeks from referral	84.3% patient pathways had been waiting less than 26 weeks to start treatment	54.8% of patient pathways had been waiting less than 26 weeks to start treatment

Source: Stats Wales (2022)

[1] Patient pathways represent the specific route a patient follows from their first referral through the start of treatment. Activity and performance is measured in this way as a single patient can have multiple referrals for multiple pathways.

Policy Solutions

Patient-centred policy solutions that effect system-wide change are more likely to improve outcomes and reduce waiting times

The Welsh Government has recognised the necessity for whole-system change and a shift from prioritisation of time-based targets towards measures of clinical need and outcomes (Thomas et al., 2015). Reducing RTT waiting times will require system-wide change to address issues that existed long before the Covid-19 pandemic—issues related to funding, service delivery, staffing, and patient care. This includes fundamental changes to work practices as well as governance and financing structures within the healthcare system (Notman et al., 2022). Of course radical change takes time, and "quick fixes" may result in only temporary improvements and unintended consequences. Moreover, the NHS does not currently have the capacity or the finances to rapidly address the supply and demand issues associated with waiting lists (Bevan Commission, 2021).

Through review of literature and discussion with healthcare providers, researchers, and government officials, several areas in which policy could be developed to improve outcomes and reduce waiting times have been identified. Five key areas have been targeted:

1. Workforce capacity;
2. Digital technology;
3. Reimagining primary care;
4. Systems collaboration; and
5. Follow-up care.

These areas target the underlying factors contributing to increased waiting times and can help to improve overall health system performance long-term. In addition, each of these areas is likely to have an impact on outcomes that matter to patients, resulting in a more patient-centred approach. Below is an overview of potential policy approaches.

Increasing workforce capacity

The NHS workforce does not currently have capacity to deliver the services demanded by the population. Wales saw only a small increase in doctors under 50 years old from 2012 to 2017. This is of particular concern as it is recognised that students who study in their own region are more likely to work in the same areas

(BMA Cymru Wales, 2021). The number of GPs in Wales decreased by 2.3 percent between 2011 and 2020 (BMA Cymru Wales, 2021) whilst demand for primary healthcare has increased steadily. The Covid-19 pandemic has had a significant impact on retention and recruitment of clinical and other NHS staff. The Royal College of Nursing Wales reported 1719 nursing vacancies in Wales alone, up from 1612 in 2020, with nurses in post giving the NHS an additional 34,284 hours in overtime every week (2021).

Increasing workforce capacity requires investment in staff and facilities, recruitment, training, and overall support for the wellbeing of staff. As well as seeking to increase overall staff numbers, attention should be given to diversifying and bolstering the workforce in key service areas where waiting times are far off from government targets (Health Foundation, 2019). It has also been recommended that the Welsh Government make secondary care workforce vacancy data available in the public domain; currently, vacancy data within secondary care can only be accessed by submitting Freedom of Information requests to health boards and trusts (BMA Cymru Wales, 2021). Timely access to vacancy data in Wales will allow for more strategic workforce planning to address shortages in key areas (Notman et al., 2022).

Continued use of digital technologies

Digital technologies and telehealth services can increase access to care. One significant change that emerged from the Covid-19 pandemic was the greater utilisation of virtual GP and outpatient consultations (Worthington, 2021). Investing in training and infrastructure to enable the continued use of digital technology can, if used correctly, increase the volume of activity and speed up diagnoses without affecting quality of care though it needs to be used in conjunction with face to face care to maximise good quality outcomes. Receiving medical support from home where appropriate through virtual consultations will also help to reduce hospital bed occupancy and overcrowding in A&Es (Department of Health and Social Care, 2021). In addition, increased use of virtual appointments may assist in boosting recruitment efforts, as it allows GPs to work from home. This is an important consideration as approximately 44 percent of British Medical Association (BMA) members stated that they plan to work more flexibly or from home (BMA, 2021).

It will be important to consider digital equality and access, moving beyond the technology itself to looking at the skills and confidence individuals need to gain access to digital spaces and how digital services should be structured and managed to be more accommodating and inclusive (Havers et al., 2021).

Reimagining primary care

Timely access to primary healthcare is associated with improved health outcomes, control of healthcare costs, and reduction in waiting times (Ansell et al., 2017). However, burdens on the workforce and increased demand create barriers to accessing primary care, thereby contributing to increased RTT and A&E waiting times. Open access scheduling leaves space in physicians' schedules (e.g., a half-day), eliminating the need to book weeks or months in advance and giving patients more flexibility (Ansell et al., 2017). In addition, using teams of primary care providers, such as nurse practitioners or physician's assistants increase the number of services provided for certain populations and increases practice efficiency (Ansell et al., 2017). This could reduce workload burdens on GPs.

The number of patients waiting longer than the target time for diagnostic tests has increased, and the number of patients waiting for diagnostics remains significantly higher than before the pandemic started (Welsh Government, 2021). Allowing primary care settings to provide diagnostic services—which will require investment in technology, equipment, staff and training—is likely to help decrease the backlog and reduce waiting times for future patients (Worthington, 2021). While access to diagnostic results through improved digital technology will help GPs diagnose and get patients the treatment they need early on, it is argued that providers need more than "improved sharing" (Haynes, 2021). This includes further diagnostic services across primary and secondary care. GPs are well-placed to provide diagnostic services, which often rely on the transportation of patients (NHS Improving Quality, 2014). Because GPs are more accessible to local populations, increasing capacity to perform diagnostic services at this level may improve the efficiency of these services.

Primary care delivery needs to be reimagined around patient need and sufficient capacity for community care. GPs, pharmacists, dentists and optometrists play a vital role in supporting patients to access care closer to home. New ways of triaging patient need, and using telephone and digital consultations where appropriate, were trialled during the pandemic and could be further developed. Better communication mechanisms between primary and secondary care, enabling access to specialist advice via email, may facilitate more effective referral management. Increasing provision of community pharmacy and optometry services may enable patients to access appropriate care and treatment without travel to a hospital.

Improving systems collaboration

According to the Welsh NHS Confederation, the development of and investment in health information systems and processes that facilitate more coordination and collaboration across hospitals, primary care, and diagnostic services can improve

record keeping, access to patient information, and communication across providers and health services teams (Worthington, 2021). This may help to reduce waiting times through:

1. More efficient and timely support for people with chronic conditions, who are more likely to require several pathways of care and more services and most likely to suffer from long waiting times.
2. More empowered and knowledgeable patients who have the ability to manage their own care through access to better information and health advice.

Given that the number of people living with multiple long-term conditions is increasing, improved systems collaboration allows for a more holistic approach to care delivery, which can alleviate pressures on the healthcare system and reduce waiting times (Notman et al., 2022). Many patients may not need to be seen at all, and patients with greater responsibility for and understanding of their health are better able to determine if and when they need help (Bevan Commission, 2021).

Improving follow-up care

Improving services that enable patients to leave the hospital safely and prevent readmissions can help reduce waiting times by making it less likely that patients will need future referrals, diagnostic services, and treatment for related conditions. This requires "an urgent solution to social care services, which are understaffed, unstable and unable to meet the needs of older and young adults" (Thorlby et al., 2019: 14). In addition to preventing the need for NHS services in the first place, strengthening social care and public health systems will help to ensure that patients receive adequate care once discharged. NHS Confederation Wales recently reported that there were between 1000 and 1500 people who were unable to be discharged from hospital because the right social care was not in place (NHS Confed 2022). In addition, the use of digital technology and virtual appointments for follow-up appointments has been shown to help reduce waiting times by limiting the number of unnecessary and time-consuming appointments and maintain continuity of care (Ansell et al., 2017; Bevan Commission, 2021).

Patient-centred policy solutions are more likely to prevent unintended consequences associated with waiting times targets

In the early 2000s, the Labour government introduced a "targets-and-terror" system of governance to generate incentives for improved NHS performance in England (Bevan and Hood, 2006). Managers of public healthcare organisations were at risk of being fired or shamed as a result of publication of poor performance against about 50

targets (Bevan and Hood, 2006). This system produced some improvements including a reduction in the numbers of patients waiting for first elective admission for more than nine and 12 months (Bevan and Hood, 2006). However, the “targets-and-terror” system also resulted in distorted behaviour on the part of healthcare workers. The National Audit Office reported evidence that nine NHS trusts had inappropriately adjusted their waiting lists (Bevan and Hood, 2006). In addition, Rowan *et al.* (2004) found no relationship between performance in star ratings and the clinical quality of adult critical care provided by hospitals. Therefore, “although there were indeed dramatic improvements in reported performance, we do not know the extent to which these were genuine or offset by gaming that resulted in reductions in performance that was not captured by targets” (Bevan and Hood, 2006: 533).

Policy approaches that address the systemic issues contributing to increased waiting times are more likely to be effective in the long-term and will have a wider impact on health system performance. As learned from the “targets-and-terror” system in England, policies that set targets for waiting times can be enacted and implemented relatively quickly, but in isolation, targets merely graze the surface of systems improvement and may result in unintended consequences, such as:

- Increased health inequalities; and
- Reduced quality of care (Kreindler, 2010).

The potential unintended consequences associated with policies that seek to reduce waiting times solely through targets mean that it is unlikely to help to achieve important priorities including:

Preventing health inequalities

Setting targets may reduce waiting times for some patients at the expense of others (Kreindler, 2010). Waiting lists are growing for specific conditions in Wales. The majority of patients pathways waiting over 36 weeks as of March 2022 are in a small number of specialties: orthopaedics (98,389); general surgery (85,400); and ophthalmology (83,168) (Welsh Parliament, 2022). In addition, waiting lists are expanding for ear, nose and throat and dermatology patients (Worthington, 2021). Of particular concern are the average waiting times to receive mental health treatment, which has become increasingly important as a result of the pandemic.

In addition, waiting lists vary across local health boards. The decision to postpone non-urgent treatment at the start of the Covid-19 pandemic in March 2020 applied across Wales. However, since December 2020, local health boards have been able to decide when and how much non-urgent work they could resume creating variation in backlogs and waiting times across Wales (Worthington, 2021). More data is

needed to determine the factors that led to local health board decisions and subsequent variation.

In England, there was variation in demand for services among clinical commissioning groups (CCGs) during the Covid-19 pandemic. Some CCGs—which have similar roles to local health boards in Wales—saw an increase of less than 10 percent while waiting lists nearly doubled in others. When grouped by relative deprivation, the most deprived areas saw the greatest rate of increase (Holmes and Jefferies, 2021). To better understand variations across Wales, there is an opportunity to use local or regional data to identify areas and populations within Wales where barriers to access are most pronounced.

Maintaining high quality of care

There is a concern that waiting times targets may lead to a reduction in quality of care. To meet targets, providers may spend less time with patients, discharge patients too soon, or prioritise patients who require less time and fewer resources to treat. Because some conditions can worsen over time, it is recommended that staff provide treatment based on clinical need, not the length of time the patient has waited (Bevan Commission, 2021). “Other considerations, such as whether the condition is negatively affecting an individual’s ability to work, or care for others, are also more relevant than simply waiting for treatment” (Bevan Commission, 2021: 11). According to the Thorlby et al. (2019), rigid waiting time targets also miss the mark as patients require continuity of care in addition to quick access to services.

In addition, waiting times targets may lead to poor measurement practices (Mannion and Braithwaite, 2012). For example, targets may encourage staff to simply tick boxes (measurement fixation), undervalue or ignore other important aspects of performance (tunnel vision), focus on immediate or short-term issues rather than equally important long-term considerations (myopia), miss opportunities for innovation (ossification), and overlook additional factors that impact performance, such as patient experiences (quantification privileging) (Mannion and Braithwaite, 2012).

Targets can also lead to misplaced incentives and sanctions, such as overcompensation for meeting targets where resources could be better utilised elsewhere and undercompensation for meeting targets resulting in limited buy-in from staff (Mannion and Braithwaite, 2012). Target incentives may also fail to capture the complexities of the health system, leading to inequalities within and among primary and secondary care organisations (Mannion and Braithwaite, 2012).

Even where waiting times targets have been met, there is sometimes significant variation in performance across local health boards (NHS Wales, 2010). Policies that

do set targets should include quality-related measures as well as wait-related measures. The concurrent focus may prevent the reduction in waiting times at the expense of quality (Kreindler, 2010).

Conclusion

Steady growth in RTT waiting times has been a long-standing problem, in Wales and the UK as a whole, and pre-dated the Covid-19 pandemic. Reducing waiting times therefore requires fundamental changes to healthcare delivery including approaches to workforce capacity, service delivery, systems collaboration, and patient care. These are necessary to effect long-term, system-wide improvements, which address the underlying factors contributing to the growing problems of waiting times. However, it is essential that policies addressing waiting times are inclusive and informed by local health data to prioritise services and communities and prevent inequalities. In addition, they should not solely focus on meeting waiting time targets—which pose the risk of inducing unintended consequences—but should also incorporate additional performance measures to maintain a high quality of care and 'upstream' determinants of health, which in turn drive future demands on the NHS.

References

Ansell et al. (2017). **Interventions to reduce wait times for primary care appointments: a systematic review**. *BMC Health Serv Res.* 17, 295.

Audit Wales. (2020). **10 opportunities for resetting and restarting the NHS planned care system**. Retrieved from: **https://www.audit.wales/sites/default/files/10_opportunities_planned_care_Eng_10.pdf**

Bevan Commission. (2021). **Doing things differently: tackling the backlog in the aftermath of Covid-19**. Retrieved from: **https://www.bevancommission.org/publications/doing-things-differently-tackling-the-backlog-in-the-aftermath-of-covid-19/**

Bevan, G. and Hood, C. (2006). **What's measured is what matters: targets and gaming in the English Public Health Care System.** *Public Administration.* 84(3), 517-538.

BMA. (2021). **Pressures in General Practice**. Retrieved from: **https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice**

BMA Cymru Wales. (2021). **Health and social care workforce: consultation by the Welsh Senedd Health and Social Care Committee**. Retrieved from: **bma-wales-response-to-an-healthier-wales-our-workforce-strategy-for-health-and-social-care-consultation-oct21.pdf**

Department of Health and Social Care. (2021). **Innovation and new technology to help reduce NHS waiting lists**. Retrieved from: **https://www.gov.uk/government/news/innovation-and-new-technology-to-help-reduce-nhs-waiting-lists**

Haynes, L. (2021). **NHS diagnostics overhaul wasted without adequate workforce plan, BMA warns**. GP Online. Retrieved from: **https://www.gponline.com/nhs-diagnostics-overhaul-wasted-without-adequate-workforce-plan-bma-warns/article/1732656**

Holmes, J. and Jefferies, D. (2021). **Health inequalities and the elective backlog—understanding the problem and how to resolve it**. *BMJ.* 375, n2574.

Kings Fund. (2020). **What is going on with A&E waiting times?** Retrieved from: **https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters**.

Kriendler, S. (2010). **Policy strategies to reduce waits for elective care: a synthesis of international evidence**. *British Medical Bulletin.* 95, 7-32.

Mannion, R. and Braithwaite, J. (2012). **Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service**. *Internal Medicine Journal*. 569-475.

NHS Confederation Wales (2022) **It's not just a crisis, it's a national emergency.** https://www.nhsconfed.org/publications/its-not-just-crisis-its-national-emergency-addressing-challenges-social-care

NHS Improving Quality. (2014). **Seven ways to no delays**. Retrieved from: **https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Seven-Ways-to-No-Delay.pdf**

NHS Wales. (2020). **Transforming the way we deliver outpatients in Wales**. Retrieved from: **https://gov.wales/sites/default/files/publications/2020-06/transforming-the-way-we-deliver-outpatients-in-wales--a-three-year-strategy-and-action-plan-2020-2023.pdf**

Notman, G., Lloyd, A. and Bristow, D. (2022). **Challenges and priorities for health and social care in Wales**. Wales Centre for Public Policy. Retrieved from: **https://www.wcpp.org.uk/wp-content/uploads/2021/12/Challenges-and-Priorities-for-Health-and-Social-Care-Wales-Briefing-Note-.pdf**

Rowan, K., Harrison, D., Brady, A., Black, N. (2004). **Hospitals' star ratings and clinical outcomes: ecological study.** *British Medical Journal.* 328, 924-925.

Royal College of Nursing Wales. (2021). **Nursing in numbers 2021: an overview of the nursing workforce in Wales**. Retrieved from: **https://www.rcn.org.uk/news-and-events/news/w-rcn-wales-publishes-nursing-in-numbers-2021-report-revealing-current-workforce-statistics-231121**

Senedd Business. (2021). **Impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment**. Consultation Display. Retrieved from: **https://business.senedd.wales/mgConsultationDisplay.aspx?ID=439**

StatsWales. (2022). **NHS Hospital Waiting Times: Referral to Treatment.** Retrieved from: **https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment**

Thomas, HV. (2015). **NHS waiting times for elective care in Wales**. Wales Audit Office. Retrieved from: **https://www.audit.wales/sites/default/files/nhs_waiting_times_main_report_english_accessible_7.pdf**

Thorlby, R., Gardner, T. and Turton, C. (2021). **NHS performance and waiting times**. Health Foundation. Retrieved from: **https://www.health.org.uk/publications/long-reads/nhs-performance-and-waiting-times**

Welsh Government. (2021). **NHS activity and performance summary: August and September 2021**. Retrieved from: **https://gov.wales/sites/default/files/pdf-versions/2021/11/2/1637074232/nhs-activity-and-performance-summary-august-and-september-2021.pdf**

Welsh Government. (2022). **NHS activity and performance summary: March and April 2022.** Retrieved from: **https://gov.wales/sites/default/files/pdf-versions/2022/6/1/1655707701/nhs-activity-and-performance-summary-march-and-april-2022.pdf**

Welsh Parliament. (2022). **Waiting well? The impact of the waiting times backlog on people in Wales.** Health and Social Care Committee. Retrieved from: **https://business.senedd.wales/documents/s124284/Waiting%20well%20The%20impact%20of%20the%20waiting%20times%20backlog%20on%20people%20in%20Wales%20-%207%20April%202022.pdf**

Worthington, P. (2021). **Hospital waiting times: a mountain to climb**. Senedd Research. Retrieved from: **https://research.senedd.wales/research-articles/hospital-waiting-times-a-mountain-to-climb/**

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