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Waiting Lists and Waiting Times for Elective Care in Northern Ireland: Taking Stock

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This paper takes its starting point from a series of previous Northern Ireland Assembly Research and Information Service briefings and provides an update on elective care waiting lists, waiting times and related policy and actions in Northern Ireland. For information and comparison, it also updates the same in neighbouring jurisdictions.

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Key Points

Elective Care is care planned in advance for those whose condition requires a procedure or treatment that can be managed by placement on a waiting list. It also includes diagnostic services - medical tests to aid in the diagnosis of disease and assist in the management of patient care.

In Northern Ireland, quarterly statistics are reported/published by the Department of Health NI for separate stages of the elective care patient pathway (outpatient waiters, diagnostic waiters and inpatient waiters [ordinary admission and daycase]).

The published statistics are based around waiting time targets set by the Health Minister. The outpatient and inpatient targets have rarely been met since 2009. As waiting times and waiting lists have grown over the years, the targets have been changed by the Department i.e. targets have become less stringent. This raises the question of the purpose of the targets?

The entire patient journey time in the elective care system from referral to treatment (RTT), which is reported against related targets in other jurisdictions of the UK, is not collated or reported in NI.

The number of people waiting for elective care has substantially increased in NI since the mid-1990s. Decreases in the numbers waiting were achieved in the mid-2000s but the majority of these gains were lost within a few years.

The reasons behind the increases in waiting times in Northern Ireland (over at least the past decade) in elective care are varied and include:

- Demand for elective care increasing with a year-on-year increase in referrals;
- Capacity to see and treat patients unable to keep pace with the demand due to limited resources available in-year to invest in additional in-house and independent sector waiting list activity, due to the wider financial position;
- Agreed volumes of funded activity not being fully delivered by the HSC Trusts across a range of specialties;
- Postponement of elective care procedures due to increased unscheduled admissions to hospitals;
- A growing and ageing population; and
- Significant gaps across the HSC workforce.

Most recent statistics for Northern Ireland for September 2019 were published at the end of December 2019 and show:

- 306,180 patients waiting for a first outpatient appointment;

- 105,450 of these patients were waiting more than 52 weeks for a first outpatient appointment;
- 87,353 patients waiting for inpatient admission in with 70% of these waiting over 13 weeks, compared to 36,808 waiting for admission in December 2009 when 16% were waiting over 13 weeks; and
- 140,237 waiting for a diagnostic service, with 57% of these waiting over 9 weeks. This represents an increase of 1508% waiting over 9 weeks since December 2008. The numbers waiting over 9 weeks for a diagnostic service, with 3,995 waiting in 2008, and 64,233 in 2018.

For longer term comparisons this paper uses December figures and in December 2009 there were only 82,570 patients waiting for a first outpatient appointment. Between December 2013 and December 2018 there was a 459% increase in the numbers waiting over 9 weeks for their first outpatient appointment.

In Northern Ireland, review appointments have no targets assigned to them and no waiting lists or times for these are published. The Public Accounts Committee for the National Assembly for Wales has recently focused on the importance of such review appointments, stating that 'follow-up' outpatient appointments are:

> *the largest and most common form of contact between patients and healthcare services in an acute setting.*

NI is exceptionally slow at providing elective care compared to the rest of the UK and although waiting times and lists have been rising in recent years across the UK, it is impossible to overstate the disparity between NI waiting times for elective care and the much shorter waits experienced by patients in England, Scotland and Wales.

For example, in England (total population around 55 million) at the end of November 2019 only 1,398 people were waiting more than 52 weeks on the RTT pathway to start treatment, whereas in NI (total population around 1.9 million), at the end of September 2019, 108,582 people were waiting more than 52 weeks for their **first** outpatient appointment.

Compared to Northern Ireland, Wales is the next worse performer in the UK with regard to elective care waiting times. Even so, a person here is at least 48 times as likely to wait more than a year for elective care compared to a person in Wales.

England, Scotland and Wales are all currently taking actions around elective care. For example, the future of elective care in England is linked to the new 'NHS Long Term Plan' (2019) and in connection with this, the NHS National Medical Director is reviewing the core set of NHS access standards.

There is presently no way to properly compare Northern Ireland's overall elective care waiting time performance to anywhere else in the UK because in Northern Ireland the

separate stages of the patient journey through the elective care pathway are unable to be added together to give a full patient RTT time.

To introduce the RTT measure and associated targets was a Northern Ireland Assembly Health Committee review recommendation five years ago to the Department of Health. At last, it seems to be gaining traction as stated in the *New Decade, New Approach* document recently published jointly by the British and Irish Governments:

> *The Executive will consider the scope for changing how waiting times are measured, to reflect the entire patient journey, from referral to treatment, with appropriate targets.*

The Chief Executive of NHS England recently noted that although the specific type of RTT targets used in England, Scotland and Wales all vary somewhat, he stated that:

> ***Northern Ireland does not have a way at all***.

It is difficult to envisage how elective care waiting times will be brought under sustained control here without having the baseline data to understand how long each patient is in the system from referral to treatment, as well as knowing how long a patient spends at each stage (outpatients, diagnostics, review and treatment).

For Northern Ireland, at present, based on the Department's published figures (using the time bands from the quarterly returns to the Department), we can only 'guesstimate' possible minimum and maximum full patient journey times through the elective care system.

Such estimates indicate possible times from referral to treatment of over four years in some cases. This correlates with figures released by HSC Trusts to the press showing that waits of up to four years for a first outpatient appointment are not uncommon.

In the preparation of this paper, the NI Assembly Research and Information Service (RaISe) asked the Department if it was possible in any way (either manually or electronically) to add up the elective care RTT pathway time for an individual patient, using data collected within the HSC system.

The Department's response indicated that it does not seem to be currently possible as there are elements of the pathway that may not be recorded anywhere. For example, the time it takes to make a decision to send the patient for a diagnostic service or the waiting time between the reporting of a patient's diagnostic test and a decision to admit a patient to an inpatient setting.

RaISe also asked the Department what would have to happen to allow the full patient pathway to be measured and would the new regional Encompass programme to introduce an integrated digital clinical record across the HSC help in this regard? The Department's response seems to indicate that this digital record should make it possible in the future.

In Northern Ireland the history of policies and actions to address issues within elective care and its waiting times and waiting lists go back around 20 years.

The most recent Departmental plan to tackle the issues here is the 2017 *Elective Care Plan – Transformation and Reform of Elective Care Services*, which stemmed from the overarching healthcare reform strategy *Health and Wellbeing 2026 – Delivering Together*.

The Plan was a welcome development as in a previous 2015 presentation to the then Health Committee, Departmental Officials stated that specific to reducing WTs there was a lack of a plan in place, unlike the other jurisdictions of the UK.

However, in an update to this, the *New Decade, New Approach* document states that the Northern Ireland Executive will now introduce a new action plan on waiting times.

The 2017 Plan highlights that pressures on the HSC's capacity to respond to increasing demand for elective care have been building for years and acknowledges that attempts to tackle this in the past have often had a short-term focus.

It has six commitments, with related actions, and makes it clear that sustainable improvement in elective care is dependent on the wider health care transformation. There is substantial emphasis on two key areas – the transfer of a growing range of procedures to Regional Assessment and Surgical Centres and carrying out more minor procedures in primary care settings.

However, as a recent Nuffield report notes, the health and social care system in Northern Ireland has seen seven substantial reviews in the past two decades, each delivering the similar messages that there is a need to reduce reliance on hospitals, centralise some services on a smaller number of sites and increase focus on prevention of ill health.

It appears that over the past two decades, the Department of Health here has not tackled waiting times in elective care in anywhere as near a determined or consistent a manner as neighbouring jurisdictions. The ICT to capture and report full patient RTT journeys here only now appears to be catching up, with the relatively imminent roll-out of the Encompass Programme.

The impact of the implementation of the transformation agenda, the related *Elective Care Plan* and the forthcoming Executive action plan on waiting lists referred to in *New Decade New Approach* remains to be seen in the years to come.

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1 Introduction

The operational performance of the Department of Health (DoH) and Health and Social Care Trusts (HSCTs) in Northern Ireland (NI) around Waiting Lists (WLs) and Waiting Times (WTs) for **elective care** has been of ongoing concern for almost two decades.

The overall number of people waiting for elective care has substantially increased in NI since the mid-1990s and although decreases in the number waiting were observed in the mid-2000s, the majority of these gains were lost within a few years.[1]

The *numbers* of patients on the lists and the *time* spent waiting to be seen, diagnosed and treated for elective care is of concern to the DoH and for the Health and Social Care Trusts (HSCTs). However, for patients the key concern is the time spent waiting. What is considered 'too long' a wait, can be subjective to an individual patient depending on the impact their condition is having to quality of life, ability to work, look after family etc. However, it also is a clinical matter and for some clinical services there is evidence linking longer WTs with poorer clinical outcomes and patient experience[2], [3]. However, the research is limited and it has been noted that the specific WT targets set by governments do not always have a clear clinical evidence base.[4]

This paper focuses mainly on WTs and WLs for elective care in NI over the past decade and provides updates to the policy and published statistics in this area. It draws on and updates information provided in a selection of previous research papers and briefing articles produced by RaISe in the past decade (see Appendix 1).

As the Referral to Treatment (RTT) policy, measures and targets for WTs used in England, Scotland and Wales were covered in some detail in a previous 2013 Raise paper,[5] this paper focuses on updates to policy and statistics in these jurisdictions and also in the Republic of Ireland (RoI).

[1] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[2] Tuominen U. et. Al. (2009), The effect of waiting time on health and quality of life outcomes and costs of medication in hip replacement patients: a randomized clinical trial, *Osteoarthritis and Cartilage*,**17** (9), 1144-1150

[3] Oudoff, J.P. et. al. (2007), Waiting for elective general surgery: impact on health related quality of life and psychosocial consequences*, BMC Public Health*, **7**, 164

[4] Gardner, T. (March 2015), Are people waiting longer for health care, Topic Overview, The Health Foundation, https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/a/r/e/are-people-waiting-longer-for-health-care.pdf

[5] Thompson Dr. J. (November 2013, NIAR 783-13, Paper 140/13), Research and Information Service, NI Assembly, *Waiting Times for Elective Care*, Section 3, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/14013.pdf

2 Defining Elective Care

Elective care (as opposed to emergency or unscheduled care) is defined as care, planned in advance, for those whose clinical condition requires a procedure or treatment that can be managed by placement on a WL. Elective surgeries aim to improve quality of life either physically (for example, cataract surgery, hip replacement) and/or psychologically (for example, reconstructive surgery). Some elective surgeries may extend the life of the patient (for example, non-emergency cardiovascular surgery).[6]

Elective care also includes diagnostic services - medical tests to aid in the diagnosis of disease and assist in the management of patient care. Aside from blood or urine tests that performed in primary care, tests in elective care usually require specialist equipment and trained professionals and are carried out in hospitals. This includes, for example, endoscopy, diagnostic imaging and cardiac diagnostics.[7]

In the first instance, it is important to understand the potential 'pathway' that a patient can take through the stages of the elective care system (all patients will not go through all stages) and also the definitions used by the DoH for reporting quarterly data at each stage[8].

The first stage is the referral of a patient by their GP (usually)[9] for an appointment at a consultant-led outpatient clinic. The WT for a first outpatient appointment begins on the date the HSCT receives the referral and ends on the date the patient attends a first outpatient appointment:

- **Outpatient waiters** are defined as the number of patients waiting for their first appointment at a consultant-led clinic in secondary care, including those who have cancelled or missed a previous appointment.[10]

The second potential stage is the patient then being referred for one or more diagnostic tests to assist in diagnosis and/or treatment of their condition:

- The **diagnostic waiting time** relates to patients waiting for a test with a diagnostic element. Such a test provides an examination, test, or procedure

[6] Elective Surgery, Encyclopaedia of Surgery, www.surgeryencyclopedia.com/Ce-Fi/Elective-Surgery.html

[7] Elective Care Plan, Health and Social Care, Department of Health, February 2017, page 8, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[8] NI Hospital Waiting Time Statistics, DoH, https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/hospital-waiting-times-statistics

[9] Examples of exceptions – in some cases dentists can refer directly to an oral surgeon and optometrists can refer to a hospital-based ophthalmologist.

[10] Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-december-2018

used to identify a person's disease or condition and which allows a medical diagnosis to be made.[11]

GPs can, on occasions, refer a patient directly for a diagnostic test, for example for a gastroscopy[12].

After a diagnostic test, a patient may or may not have a 'review appointment' at a consultant-led outpatient clinic, where a decision is made on the way forward in terms of treatment.

The third potential stage is the treatment stage, whereby the patient is referred for treatment:

- **Inpatient waiters** – are the number of patients waiting for either **ordinary admission** to hospital or for **day case treatment**. These are the numbers of patients waiting for inpatient surgery following a 'decision to admit' being taken by their consultant.[13]

In NI, quarterly statistics are reported/published by the DoH for each of the above separate stages of the elective care process. Published statistics are based around targets set by the Health Minister (Ministerial targets). This is with the exception of review appointments for which there are no targets. In addition, the published quarterly outpatient statistics include patients who have first been referred to an ICATS service[14] and been triaged or seen by ICATS teams before then being subsequently referred for a first consultant led outpatient appointment.[15]

The entire patient journey time from referral to treatment (RTT) (as reported with related targets in other jurisdictions of the UK), **is not reported in NI.**

[11] Northern Ireland Waiting Time Statistics: Diagnostic Waiting Times December 2018, Appendix Two Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-diagnostic-waiting-times-december-2018

[12] Gastroscopy - a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestine (duodenum)

[13] Northern Ireland Waiting Time Statistics: Inpatient and Day Case Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018

[14] The Integrated Clinical Assessment and Treatment Services (ICATS) provides a range of specialist assessment and treatment services for patients in a number of specialties, for example, orthopaedics. The aim of ICATS is to help reduce outpatient waiting times. The service is provided by multi-disciplinary teams including a doctor, specialist nurse and allied health professionals such as physiotherapists.

[15] Email Response (SCORR-0453-2019) (HC3-19-1653), from Department of Health to RaISe query, 25th June 2019.

3 Elective Care Policy and Scrutiny in NI

3.1 Introduction - Overarching System Reform in NI

A Nuffield report (2019) noted that the health and social care system in NI has seen **seven substantial reviews** in the past **two decades**, each delivering a similar message:

> *NI needs to reduce its reliance on hospitals, centralise some services on a smaller number of sites and increase focus on prevention of ill health.*[16]

The recommendations from the most recent review *Systems not structures* (Bengoa Report 2016)[17] led to the DoH's ten year planned programme for change *Health and Wellbeing 2026 – Delivering together*.[18]

This direction of travel has the potential to impact positively on WTs and WLs for elective care and as the Nuffield report states[19]:

> *There are some signs of increased commitment and interest being associated with greater and more widespread improvement in the direction Bengoa suggested over the last two or three years…..[it] is clearly not present everywhere and conflicts with other powerful drivers in the system….*

3.2 Specific Elective Care Policy, Plans and Scrutiny of Waiting Lists in NI

The most recent specific plan to tackle the elective care WLs and WTs issues in NI is the 2017 *Elective Care Plan – Transformation and Reform of Elective Care Services* (the Plan, see section 3.3), which stems from the overarching reform strategy *Health and Wellbeing 2026 – Delivering Together*.[20]

However, in an update to this, the recently published *New Decade, New Approach* document states that the NI Executive will now introduce a new action plan on waiting times[21].

[16] Dayan, M. and Heenan, D. (2019), *Change or collapse – Lessons from the drive to reform health and social care in Northern Ireland*, Nuffield Trust, July 2019, https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland

[17] Systems not Structures- Changing Health and Social Care, DoH NI, (2016), https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

[18] Health and Wellbeing 2026 – Delivering Together, DoH NI, (2017), https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

[19] Dayan, M. and Heenan, D. (2019), *Change or collapse – Lessons from the drive to reform health and social care in Northern Ireland*, Nuffield Trust, July 2019, https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland, pages 6-7

[20] Department of Health (NI), 16th May 2017, https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

[21] New Decade, New Approach, January 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

The 2017 Plan with its specific focus on Elective Care was a welcome development. In a previous Departmental 2015 presentation to the then Committee for Health, Social Services and Public Safety (CHSSPS), officials stated that specific to reducing WTs there was no overarching plan in place for NI, unlike the other jurisdictions of the UK[22]:

> *Around 2000, a 10-year policy was developed in England, and a clear focus of that policy was a reduction in waiting times. Likewise, Scotland and Wales introduced similar policies….Those policies set out how they planned to go about it on the ground.*

The Plan highlights that pressures on the HSC's capacity to respond to increasing demand for elective care have been building for years and acknowledges that attempts to tackle this in the past have often had a short-term focus.[23] It highlights that the capacity to see and treat the increasing number of new referrals is unable to keep pace for reasons such as:[24]

- Limited financial resource to reduce the current WLs with extra in-house or private sector clinics/treatments;
- Agreed volumes of funded activity not being delivered by the HSCTs across a range of specialties; and
- Postponement of elective care procedures due to increased unscheduled admissions.

A considerable number of the actions from previous Departmental work to tackle WLs and WTs over the past two decades are still relevant, so sections 3.4 to 3.6 take a brief look at other **selected** actions and scrutiny work over the years:

- *Review of Waiting Times Report*, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16;
- NI Assembly Public Accounts Committee commentary 2009; and
- *A Framework for Action on Waiting Lists (2000)*; Department of Health, Social Services and Public Safety.

3.3 The Elective Care Plan 2017– Transformation and Reform of Elective Care Services

In the 2017 Plan, the then Minister made clear that sustainable improvement in elective care is dependent on wider health care transformation in NI. The aim for elective care

[22] Committee for Health Social Services and Public Safety, Official Report (Hansard) Committee Report on Waiting Times for Elective Care, Department of HSSPS and HSCB, 15th April 2015, http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx?&cid=10

[23] Elective Care Plan, Health and Social Care, Department of Health, February 2017, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[24] Elective Care Plan, Health and Social Care, Department of Health, February 2017, page 11, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

is to develop a system, which can provide sustainable and sufficient activity 'in-house' rather than reliance on additional independent sector capacity.[25] Table 1 lists the six commitments and related actions in the Plan along with progress updates from three sources:

- February 2018 'Progress Report'[26] (the most recent progress report specific to the *Elective Care Plan*);
- *Health and Wellbeing 2026 – Delivering Together*[27] general progress report (May 2019); and
- Departmental response to specific RaISe queries in connection with the preparation of this paper.[28]

[25] Health and Social Care, Department of Health, Elective Care Plan, February 2017, page 17, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[26] Elective Care Progress Report (February 2018), Department of Health, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[27] Health and Wellbeing 2026 - Delivering Together, Progress Report May 2019, Department of Health, https://www.health-ni.gov.uk/progressreport2019

[28] Email Response (SCORR-0453-2019) (HC3-19-1653), from Department of Health to RaISe query, 25th June 2019.

Table 1 – Elective Care Plan - Commitments, Related Actions and Progress Updates

Commitment	Related Actions	Progress Updates
1. By March 2018, no-one should wait more than: 52 weeks for a first outpatient appointment and inpatient/day case treatment; and, 26 weeks for a diagnostics appointment. (Depended on funding).	Enhance HSC performance management/accountability for delivery of agreed outcomes and use of independent sector; Review of WLs - aim to provide alternatives to hospital referral; and add short-term additional theatre capacity (mobile theatres).	***Targets not met*** *- estimated £31.2m needed (only £13m made available in 17/18.[29])* *£30m in 18/19 from Confidence and Supply Transformation Fund – targeted to 64,700 extra patients in specialties with (i) greatest risk of patient safety (ii) with longest waits and (iii) for diagnostic and Allied Health Professions WTs.[30]*
2. Increase Patient Self-Management Services:[31] ***Patient self-management services will be increased for patients with long-term conditions** ***Public health support will be expanded and prioritised to promote health and wellbeing.**	Technology to support people to manage chronic conditions at home e.g. 'Patientview' allows renal patients to monitor their own blood results etc. Target local population and prevent ill health through education and an increased focus on addressing the social determinants of ill health.	*Examples of progress include: nurse specialist-led pain clinics; support groups for people with chronic conditions in disadvantaged areas;[32] educate GPs in MSK[33] pain management, funding for MSK self-management; redesign the patient pain pathway; and provide rehab. for spinal patients on the pain management WL.[34]*
3. Expand Capacity and Capability in Primary Care:[35] **so that patients can be appropriately managed locally, outside the secondary care setting.**	Increase GPs with Special Interest (GPSIs) to undertake high volume, low risk procedures e.g. in dermatology; The Local Enhanced Service (LES) enables GPs to review patients on Belfast HSCT WLs for a number of specialties. LES to be expanded and rolled out to other Trusts[36] (LES has shown that (in selected specialties) up to 50% of patients could be managed with primary care alternatives; Project ECHO – a telemonitoring approach for clinicians will be expanded across NI; and	*A range of examples[37]:* *-Use of high street optometrists for review of non-complex post-operative cataracts;* *'Mega' orthopaedic clinics delivered by GPSIs and extended scope physios, (support from consultants) – five had been held for over 800 patients at date of progress publication;* *Practice based pharmacists in 335 GP practices at date of progress;* *ICPs[38] developing plans to manage patients in primary care for a number of specialties e.g. General Surgery*

[29] Elective Care Progress Report (February 2018), Department of Health, page 3, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[30] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[31] Health and Social Care, Department of Health, Elective Care Plan, February 2017, pages 28-29, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[32] Elective Care Progress Report (February 2018), Department of Health, page 4, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[33] MSK - Musculoskeletal

[34] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[35] Health and Social Care, Department of Health, Elective Care Plan, February 2017, pages 30-32, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[36] LES has shown that (in the selected specialties) up to 50% of patients could be managed with primary care alternatives.

[37] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[38] ICPs – Integrated Care Partnerships

	Put in place a clinical pharmacist in each GP practice over four years (from date of plan).	*(expansion of minor procedures in primary care*
4. Improved direct access between primary and secondary care:[39] **The Interface/communication between primary/secondary care will be improved – more rapid access for to secondary care.**	Clinical Communications Gateway (CCG) to be expanded (allows GPs to make requests for advice directly to consultants; and Electronic triage by consultants will be expanded, allowing consultants to provide advice to GPs directly.	*Work ongoing with CCG and well-advanced in developing the NI Electronic Care Record. New pathways being developed to introduce direct access by GPs during 2018/19 for patients needing cardiology and radiology tests.*
5. Secondary Care Reform and Modernisation[40] **Secondary care services will be reformed/modernised to meet patient demand to ensure that patients are seen at the right time, in the right place and by the right person.**	Many actions ongoing e.g.: Outpatient services to be consolidated on a smaller number of sites and skill mix of the workforce will be extended; Focus on decreasing number of cancelled clinics and patients who 'do not attend'; Increase in 'one-stop' clinics for assessment/preparation for elective surgery and in pre-op assessment service to ensure fewer cancellations; and increase in theatre productivity and more patients treated as daycases; Imaging Services Reporting Network established.	*Progress reported for a number of the actions - one-stop visit service models, imaging, orthopaedics (seven orthopaedic consultants to be appointed), South Eastern HSC Trust Virtual Fracture Clinic; and the Reform of Patient Reviews.*
6. Establishment of Elective Care Centres:[41] **Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties.**	These are now termed **'Regional Assessment and Surgical Centres'** The aim is to increase capacity, productivity and use new technologies.[42]	*DoH (subject to funding) have committed to the model. By December 2020 to be delivering (in the centres) over 100,000 adult daycase procedures, 25,000 adult gastro. endoscopies; and 8,000 paediatric procedures. Prototypes active in varicose vein and cataract procedures by Dec.'18[43] - Varicose Vein (Lagan Valley, Omagh Urgent Care and Treatment Centre) and Cataract (Mid-Ulster Hospital, Down Hospital and South Tyrone Hospital). Public consultation in 2019.[44]*

In some cases, the progress reports have measurable objectives such as specific numbers of patients to be treated in a new service or pathway or have associated timescales. However, other actions do not appear to give any indication of the impact a

[39] Health and Social Care, Department of Health, Elective Care Plan, February 2017, page 33, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[40] As above, pages 34-40,

[41] As above, pages 41-42,

[42] General surgery, endoscopy, urology, gynaecology, orthopaedics, ENT, paeditarics, neurology - Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[43] Including General Surgery and Endoscopy, Gynaecology, Orthopaedics, ENT, Paediatrics and Neurology

[44] Radical plans to transform day surgery across NI are being accelerated by the Department of Health, Executive News Service, 21 March 2019, https://www.health-ni.gov.uk/news/radical-plans-transform-day-surgery-across-northern-ireland-are-being-accelerated-by-department

specific action is likely to have on the WLs or WTs over the short or longer term. It is clear that some actions are also dependent on specific finance being made available.

3.4 Review of Waiting Times for Elective Care - Committee for Health, Social Services and Public Safety

In October 2013, the then CHSSPS commenced a scrutiny review of WTs - *Review on Waiting Times for Elective Care*. The Committee published its report with recommendations[45] after considering evidence from the then Department of Health, Social Services and Public Safety (DHSSPS) and from experts in neighbouring jurisdictions and further afield. Its recommendations are now briefly considered, along with Departmental responses (at the time) and recent updates sought for the purposes of this paper.

The Committee report recommended that the then DHSSPS introduce:

1. **A system to measure the full Referral to Treatment (RTT) times for elective care and corresponding targets.[46]**

The Committee's evidence led it to believe that the Department's separate 'stage of treatment' measures/targets were not suitable and that a RTT measure (with related targets) best reflected the patient's journey through the system.

The then Minister gave a commitment that the Department would review the experience of other parts of the UK in introducing RTT targets. In a recent update sought in the preparation of this paper, the DoH advised that this was carried out solely by way of a literature review[47].

In a briefing paper and presentation to the CHSSPS in April 2015, the Department stated that it remained of the view that the RTT targets did represent a better approach and that should be the direction of travel for NI[48]:

> *because they provide a clear picture of the complete patient journey time and stop patients from being lost in the system, as they are tracked. They also reduce clinical risk….*

The Department went on to say that although it recognised the benefits of such targets[49]:

[45] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[46] As above, paragraphs 15-43

[47] Departmental email response to RaISe research request from the Department of Health (NI), 11th November 2019. (Department reference STOF-0151-2019)

[48] Committee for Health Social Services and Public Safety, Official Report (Hansard) Committee Report on Waiting Times for Elective Care, Department of HSSPS and HSCB, 15th April 2015, http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx?&cid=10

[49] As above

> *the question has always been, and remains, whether we will be able to introduce them in practice….considering the key aspects of….the policies that are in place…. whether there are sufficient funds to enable them to deliver such policies…..whether there is sufficient capacity to meet demand to deliver RTT targets…. and the ability to measure in practice the complete patient pathways — we have concluded that the existing financial pressures and lack of any assurance on future funding do not put the Department in a position in which we could realistically take similar action at this time…*

Section 12.4 of this paper discusses further the lack of progress to RTT measurement in NI but highlights the information technology developments in progress with the regional 'encompass' programme (Health and Social Care wide initiative that will introduce a digital integrated care record to NI) that may deliver progress in this regard in the future.

2. New arrangements for (i) managing the performance of the Trusts against new RTT targets and (ii) providing a clearly defined policy on how compliance against targets will be enforced - considering both sanctions and incentives[50]:

Enforcement of targets emerged as a key issue and the Committee heard a range of enforcement examples from other jurisdictions. These included, senior executives losing jobs if targets were not met; providers facing financial penalties; withholding revenues from providers; and automatic offers of private treatment to patients if certain WTs are breached.

The then Minister endorsed the recommendations on management of performance, personal accountability and compliance with targets.[51] The HSC Board advised that at that time, if a trust underperformed against core activity, then funding was withdrawn. However, the Committee were not convinced that this withdrawal of funding constituted a sanction as it could be interpreted solely as a refund for services not delivered.

In a recent update sought in the preparation of this paper the Department advised that it believed good progress has been made in strengthening accountability, roles and responsibilities and that a new Performance Management Framework and plan has been developed.

[50] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, paragraphs 55-105, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[51] Black, Dr. L-A, Why are we waiting? Outpatient appointments, section 7.3, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/12015.pdf

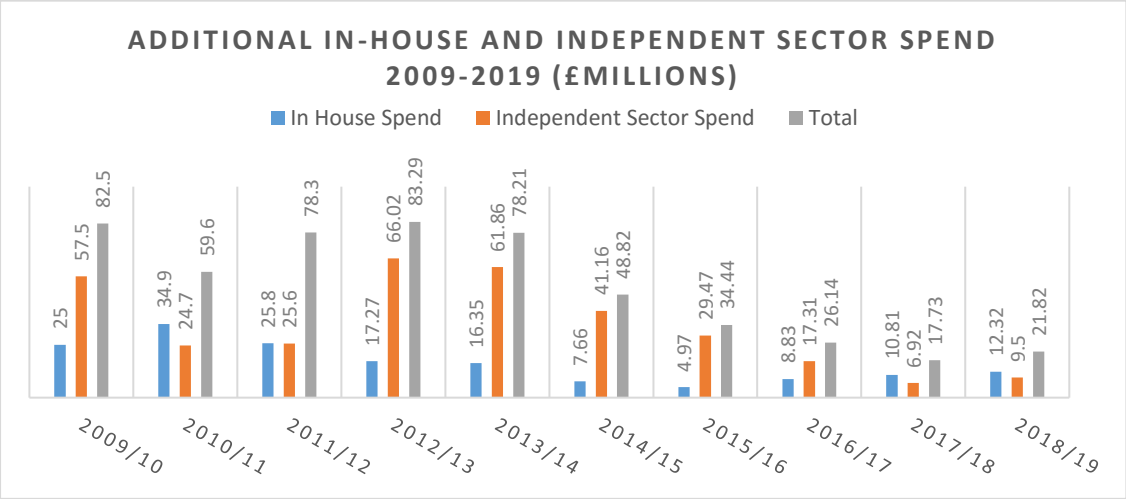
3. **An action plan detailing how the DHSSPS will decrease spend on private sector elective care over the next 3-5 year period by making better use of in-house health service based solutions[52]**:

At the time, the HSC Board advised the Committee that it wished to reduce reliance on the private sector and was aiming to match supply against demand using additional in-house work.[53]

Figure 1 shows that independent sector spend has decreased in recent years, however, this does not seem to have been matched with additional in-house spend. In an update sought for the purposes of this paper, the Department directed RaISe to the 2017 Elective Care Plan as its approach to reforming services to ensure there is sufficient health service capacity to meet the needs of the population of NI.

This would indicate that there was no separate Departmental action plan prepared, on decreasing private sector spend, in connection with this particular Committee recommendation.[54]

Figure 1: Additional In-house and Independent Sector Spend: 2009-2019



Source: Departmental Response to RaISe query, 19th July 2012 and 15th August 2019. Excludes 'Other' funding.

[52] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, paragraphs 96, 97, 106, , http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[53] Black, Dr. L-A, Why are we waiting? Outpatient appointments, section 7.3, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/12015.pdf

[54] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

4. **Policies which proactively mitigate against the potential conflicts of interests which exist for doctors who carry out private work and work in the health service:**[55]

At the time, the Committee were concerned that there *may be* perverse incentives at work for doctors to maintain long WLs, as the same doctors were providing private care outside of the hours they were contracted to an HSC Trust. However, it noted that there was no direct evidence of this. The then Minister stated that officials would be asked to discuss with the 'Patient and Client Council' the possibility of undertaking research in this area. In an update sought for the purposes of this paper, the Department stated that their records indicate that **this was never taken forward.**[56]

3.5 NI Assembly Public Accounts Committee (2009)

A decade ago, the NI Assembly Public Accounts Committee (PAC) scrutinised the elective care WLs and commended the Department on the reduction in outpatient WTs from around180,000 in 2005 to **just below 69,000 in 2008**.[57] The Comptroller and Auditor General noted, at the time, that the success was due, in part, to use of the independent sector for additional capacity.[58] The Department outlined the other measures it had put in place (at that time), including:[59]

- Tackling issues of staff recruitment and retention (*NB - the most recent Elective Care Plan highlights that medical and nursing workforce challenges remain an ongoing issue*[60]; and
- Changing ways of working, undertaking higher volumes of work and re-organising patient pathways, for example: (i) patients of the same clinical priority are seen in strict chronological order; (ii) Pooling of consultants' lists and undertaking evening/weekend sessions; (iii) Partial booking to offer patients a choice of date/time; (iv) reasonable time allocations given to new, non-urgent referrals; and (v) Introduction of Integrated Clinical Assessment and Treatment Services (ICATS).

In an update sought for the purposes of this paper, the DoH advised that Trusts still use[61]:

[55] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, paragraph 107, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[56] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[57] The Performance of the Health Service in Northern Ireland, Public Accounts Committee, Official Report (Hansard), 12 November 2009, www.niassembly.gov.uk/record/committees2009/PAC/091112_PerformanceofHealthService.htm

[58] General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland – 2010-2011, Paragraph 3.2.1, http://www.niauditoffice.gov.uk/index/publications/recent_reports/report_gen_report_hscc.htmRefe

[59] Thompson Dr J. and Egerton L. (April 2012), Research and Information Service, NIAR 820-11, NI Assembly, Northern Ireland Waiting Times, page 19, Northern Ireland Waiting Lists: Current and Historical Trends for Outpatients, Inpatients and Diagnostic Services

[60] Elective Care Plan, Transformation and Reform of Elective Care Services, Department of Health, February 2017, pages 14-17), https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[61] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

> *the Integrated Elective Access Protocol (first produced in 2005/06, and revised in April 2008) which contains extensive guidance on the processes for booking and scheduling patients and outlines good practice in the effective management of outpatient, Allied Health Professional, diagnostic and inpatient/day case waiting lists. In relation to partial booking, Trusts currently use this system to arrange the date and time of outpatient appointments across specialties.*

The DoH also noted the introduction of the Clinical Communication Gateway (CCG) and the NI Electronic Care Record (NIECR) since then along with changes in

> *clinical practice to modernise and streamline patient pathways[62]:*
>
> *the HSCB ….. is currently undertaking a review of the Integrated Elective Access Protocol to ensure it reflects these changes and to ensure that patients are being booked and scheduled in a consistent way….*

3.6 Framework for Action on Waiting Times (2000)

Although almost two decades old, the *Framework for Action on Waiting Lists (2000)*[63] is highlighted here as it contained actions which are **still pertinent today**, demonstrating **how intractable** the problems have been:[64]

(i) **Expansion of primary care role** - this has remained a **recurring theme** throughout subsequent service reform policies and plans, up to and including the most recent 'Delivering Together'[65];

(ii) **Management Action** – development of WL Action Plans and submission of quarterly returns to Department - quarterly returns **still form the basis** of the NI WL/WT statistics[66];

(iii) **Service Planning** included:

a. **setting targets** for overall reductions and for the numbers of long waiters - targets for elective care are still in place and are discussed further in Section 5; and

[62] As above

[63] Thompson Dr. J. (November 2013, NIAR 783-13, Paper 140/13), Research and Information Service, NI Assembly, Waiting Times for Elective Care, Section 2.3, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/14013.pdf

[64] McConaghy, R. and Thompson Dr J. (December 2002), Research and Library Services NI Assembly, Hospital Waiting Lists, Background Paper, December 2002, page 20 (unpublished)

[65] Department of Health (NI), 16th May 2017, https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

[66] https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/hospital-waiting-times-statistics

b. considering the use of dedicated elective units – it took around **17 years before an action to establish standalone elective care centres was at last a firm commitment** in the most recent Elective Care Plan[67].

(iv) **Efficiency Measures –** including validating WLs; pooling of consultant WLs; theatre efficiency; improve efficiency of outpatient appointment systems; and establishing a process for patient cancellations/those who do not attend - ***Most of these issues are still being tackled 20 years later*** *under commitment five (secondary care reform and modernisation) in the most recent 'Elective Care Plan[68]*.

4. Population Context

It is useful to place the increases in elective care WTs and WLs in the context of NI's population growth over the past decade or so. Particularly as the population increase (and especially the growth in over 65s) has been highlighted in the 'Elective Care Plan' as a key contributing factor to the increases.

Figure 2 and Table 2 show that the total population in NI increased by 5.2% between 2008 and 2017. The over 65 population has increased by 22.4% during the same period, according to the NISRA population estimates.

The NI Statistics & Research Agency (NISRA) recently stated that over the last decade (2008-18), the population aged 85 and over has increased by 30%. This population, referred to as the 'oldest old', has grown at a rate five times higher than the population of NI as a whole. By June 2018, the number of people aged 85 had risen to 37,700 people. Women account for two thirds (66%) of the 'oldest old'.[69]

Figure 3 shows that work to understand trends in the over 65 population in NI has been carried out in connection with an ongoing review of urgent and emergency care.

Although an ageing population is clearly a factor adding to the demand for elective care, it does not alone explain the dramatic WT and WL increases in recent years.

[67] Elective Care Plan, Transformation and Reform of Elective Care Services, Department of Health, February 2017, Commitment Six, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[68] As above, Commitment Five

[69] Number of People Aged 85 And Over Continues To Increase, NISRA News Release, 25th September 2019

Figure 2: Population Estimates, NI, 2008-2017

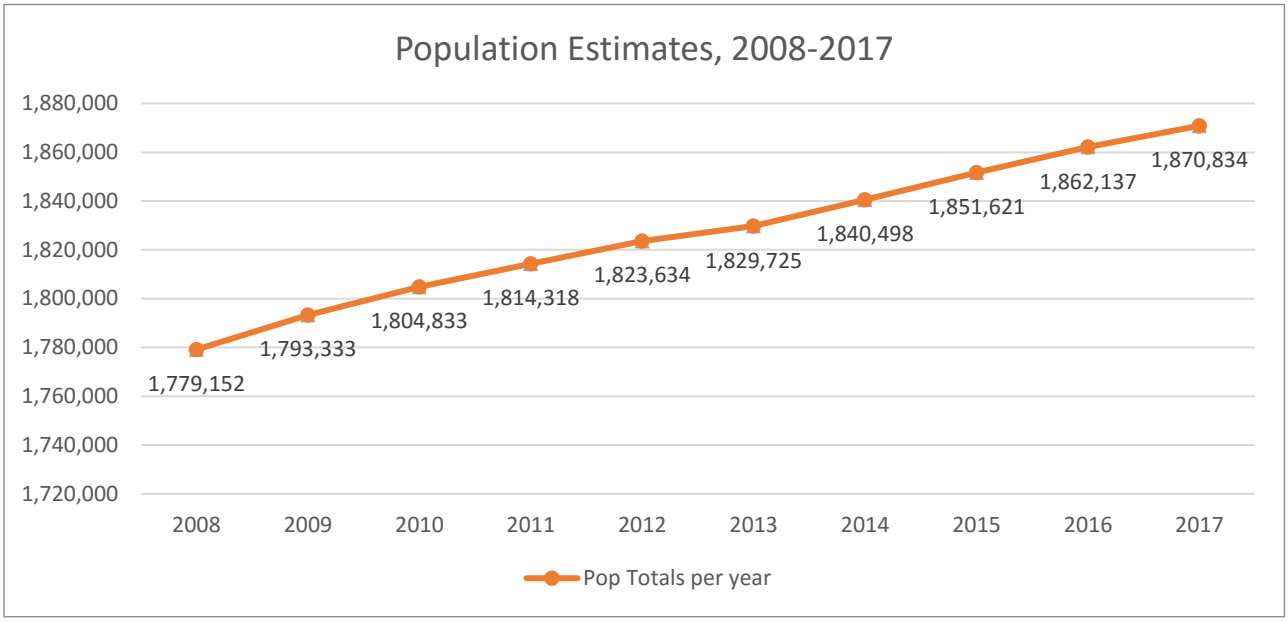
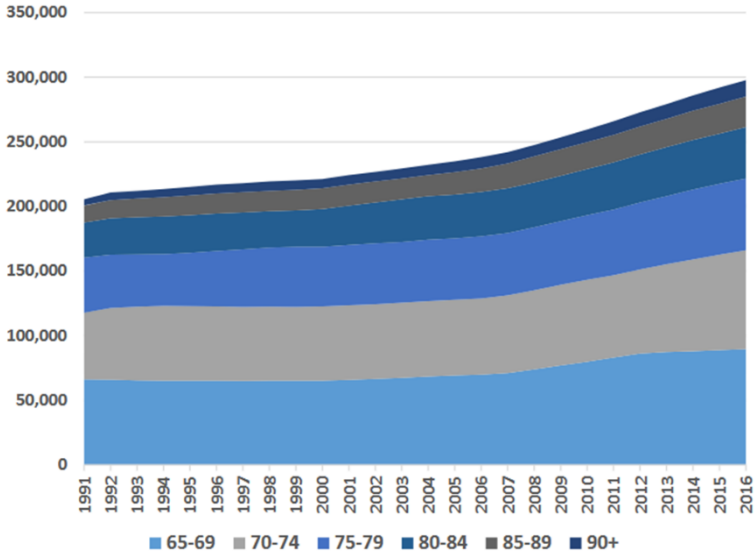


Table 2: Over 65 Population Estimates, NI, 2008-2017

% of Pop. over 65 Years	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
(All NI)	13.9	14.1	14.4	14.6	15	15.3	15.5	15.8	16	16.2

Source: NISRA Population Estimates: Broad Age Bands (HSCT) 2008-2017

Figure 3 Northern Ireland Population Age 65+, 1991 to 2016



Source: Northern Ireland Statistics and Research Agency

5. History of Waiting Time Targets for Outpatients and Inpatients in NI

The relevant 'goals' are set out in *The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-2020:*[70]

> *The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine and thirteen weeks that have previously been achieved. In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability.*
>
> *By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.*
> *By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.*
> *By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.*

Having been originally set as Ministerial targets, these targets or 'goals' have not changed since January 2017.

Tables 3 and 4 show the timeline, since 2009, of NI Ministerial WT targets for first outpatient appointment and for those waiting for inpatient admission and also if the targets were being met at certain dates.

[70] The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-20, page 17, https://www.health-ni.gov.uk/publications/ministerial-priorities

Table 3 Timeline of Waiting Time Targets for First Outpatient Appointment in NI

Ministerial Targets for First Outpatient Appointment	**Patient Numbers and % Waiting Beyond the Target** (Targets Not Met ✗, Met ✓, Almost Met ✓ (up to 10% over) or at dates shown), Percentages rounded to nearest whole number.
From April '09 no patient should wait longer than 9 weeks	54,472 (44%) waiting more than 9 weeks (31/12/10) ✗
By 31st March '11 no patient should wait longer than 9 weeks	31,909 (30%) waiting more than 9 weeks (31/03/11) ✗
From April '11 at least 50% of patients should wait no longer than 9 weeks and no patient longer than 21 weeks	59,378 (48%) waiting more than 9 weeks (31/12/11) ✓ 24,492 (17%) waiting more than 21 weeks (31/12/11) ✗
From April '12 at least 50% of patients should wait no longer than 9 weeks and no patient longer than 21 weeks – increasing to 60% by March '13 and none waiting more than 18 weeks	35,333 (33%) waiting more than 9 weeks (31/12/12) ✓ 7,405 (7%) waiting more than 21 weeks (31/12/12) ✗
From April '13 at least 70% of patients should wait no longer than 9 weeks and no patient longer than 18 weeks – increasing to 80% by March '14 and none waiting more than 15 weeks	38,261 (33%) waiting more than 9 weeks (31/12/13) ✗ 10,100 (9%) waiting more than 18 weeks (31/12/13) ✓
From April '14 at least 80% of patients should wait no longer than 9 weeks for a first outpatient appointment and none waiting longer than 15 weeks.	95,437 (56%) waiting more than 9 weeks (31/12/14) ✗ 61,311 (36%) waiting more than 15 weeks (31/12/14) ✗
From April '15 at least 60% of patients should wait no longer than 9 weeks for a first outpatient appointment and none waiting longer than 18 weeks.	164,638 (70%) waiting more than 9 weeks (31/12/15) ✗ 122,771 (52%) waiting more than 18 weeks (31/12/15) ✗
By March '17, 50% of patients should wait no longer than 9 weeks with none waiting longer than 52 weeks.	176,276 (70%) waiting more than 9 weeks (31/03/17) ✗ 53,113 (21%) waiting more than 52 weeks (31/03/17) ✗
By March '18, as above	198,296 (74%) waiting more than 9 weeks (31/03/18) ✗ 83,392 (31%) waiting more than 52 weeks (31/03/18) ✗
By March '19, as above (Target remains same by March'20)	213,708 (74%) waiting more than 9 weeks ✗(31/03/19) 97, 851 (34%) waiting more than 52 weeks ✗(31/03/19)

Table 4 Timeline of Waiting Time Targets for Inpatient Admission in NI

Ministerial Targets for Inpatient Admission	**Patient Numbers and % Waiting Beyond the Target** (Targets Not Met ✗, Met ✓, Almost Met ✓ (up to 10% over target) or at dates shown), Percentages rounded to nearest whole number.
From April '09 no patient should wait longer than 13 weeks	6,010 (16%) waiting more than 13 weeks (31/12/09) ✗
By 31st March '11 the majority of patients should wait no longer than 13 weeks and none longer than 36 weeks	17,630 (33%) waiting more than 13 weeks (31/03/11) ✗ 1,261 (2%) waiting more than 36 weeks (31/03/11) ✓
From April '11 at least 50% of patients should wait no longer than 13 weeks and no patient longer than 36 weeks	24,168 (43%) waiting more than 13 weeks (31/12/11) ✗ 5,013 (9%) waiting more than 36 weeks (31/12/11) ✓
From April '12 at least 50% of patients should wait no longer than 13 weeks and no patient longer than 36 weeks – increasing to 60% by March '13 and none waiting more than 30 weeks	18,354 (36%) waiting more than 13 weeks (31/12/12) ✗ 14,876 (31%) waiting more than 13 weeks (31/03/13) ✗ 2,243 (4%) waiting more than 36 weeks (31/12/12) ✓ 1,586 (3%) waiting more than 30 weeks (31/03/13) ✓
From April '13 at least 70% of patients should wait no longer than 13 weeks and no patient longer than 30 weeks – increasing to 80% by March '14 and none waiting more than 26 weeks	15,915 (33%) waiting more than 13 weeks (31/12/13) ✗ 3,275 (7%) waiting more than 30 weeks (31/12/13) ✓
From April '14, at least 80% of inpatients and daycases should be treated within 13 weeks, and no patient should wait longer than 26 weeks for treatment.	23,393 (43%) waiting more than 13 weeks (31/12/14) ✗ 9,766 (18%) waiting more than 26 weeks (31/12/14) ✗
From April '15, at least 65% of inpatient and daycases should be treated within 13 weeks, and no patient should wait longer than 26 weeks for treatment.	35,113 (52%) waiting more than 13 weeks (31/12/15) ✗ 21,413 (32%) waiting more than 26 weeks (31/12/15) ✗
By March '17, 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment, with no patient waiting longer than 52 weeks.	40,037 (56%) waiting more than 13 weeks (31/03/17) ✗ 9,615 (14%) waiting more than 52 weeks (31/03/17) ✗
By March '18, as above	50,228 (62%) waiting more than 13 weeks (31/03/18) ✗ 16,454 (20%) waiting more than 52 weeks (31/03/18) ✗
By March '19, as above (Target remains same by March '20)	56,871 (65%) waiting more than 13 weeks (31/12/19) ✗ 22,350 (26%) waiting more than 52 weeks (31/12/18) ✗

Note: The targets have **rarely been met since 2009** and therefore do not appear to assist the Department's management of the elective care system. As WTs and WLs have grown over the years, the targets appear to have been changed simply to make them easier for Trusts to achieve. This raises the question of the purpose of the targets? Also, the targets do not seem to have been enforced to any great degree as already highlighted in Section 3.4.

6. Waiting Lists and Waiting Times Statistics – Historic Trends

6.1 Outpatients - Numbers of Patients Waiting and Outpatient Activity

The most consistent Ministerial target has been based on monitoring the number of patients waiting over 9 weeks for a 'first outpatient appointment', ranging from 'no patient should wait longer than 9 weeks' (From April 2009) to '50% of patients should wait no longer than 9 weeks' (by March 2017). This latter target remains in place to date.

Other targets for waits beyond 9 weeks have varied over the years and the most recent 'long wait' target set was *by March '17, 50% of patients should wait no longer than 9 weeks with* ***none waiting longer than 52 weeks****.*

Information on WTs for a first consultant-led outpatient appointment is collated on the Departmental 'CH3 return'. **Prior to April 2015**, it was collated in weekly time-bands up to 26 weeks, and collectively for those waiting over 26 weeks. **From April 2015**, the CH3 return was amended to include patients waiting over 26 weeks in the following time bands; >26-39 weeks, >39-52 weeks, >52-65 weeks, >65-78 weeks, >78-91 weeks, >91-104 weeks and >104 weeks.

In order for historical comparison to be made, Figure 4A uses the consistent 9 week target and this alone shows the scale of the increases over the years. However, it is clear that 'waits' **far beyond 9 weeks** occur and this target or goal now seems to be more and more meaningless as each year goes by. The numbers waiting over 52 weeks at December of 2016-18 are listed below:

Waits over 52 weeks:

31st December 2016 – 47,072 (19% of total)

31st December 2017 – 80,651 (30% of total)

31st December 2018 – 94,953 (34% of total)

RaISe has attempted to delve deeper into these WLs in two areas. Firstly, to gain an understanding of how many people are waiting for multiple first outpatient appointments for different conditions or diagnostic tests, RaISe asked the DoH if it was possible to provide such data. It advised that it does not hold patient identifiable data for outpatient or for diagnostic waiting lists and is unable to provide a breakdown of

patients on these lists. However, this data is available for patients waiting for an inpatient or day case admission.[71]

Therefore, it follows that **currently** the outpatient WL total will contain an unknown number of patients that are counted **more than once**.

However, this is set to change. In response to further questions from RaISe, the Department revealed that the HSC Trusts do hold patient identifiable data to deliver patient care and this data is copied to the HSC Regional Data Warehouse. It stated that the DoH Information and Analysis Directorate (IAD) was undertaking a National Statistics Consultation on proposed changes to how and what data are collected for Outpatient Waiting Times and Outpatient Activity.[72] Regarding WTs, IAD is proposing a new method of extracting patient level data from the Data Warehouse relating to the number of patients waiting for a first consultant-led outpatient appointment. Using unique patient record identifiers this **will allow identification of patients on more than one list** and analysis at safe levels of geography (i.e. no risk of identification of individual patients).[73]

Secondly, to ascertain if there was any indication of links between deprivation and WTs, RaISe requested numbers waiting per council ward for those waiting past 9 weeks and past 52 weeks for their first outpatient appointment. The Department advised RaISe that data is not available on individuals per council wards as the Trusts provide an aggregated return for these waits.[74]

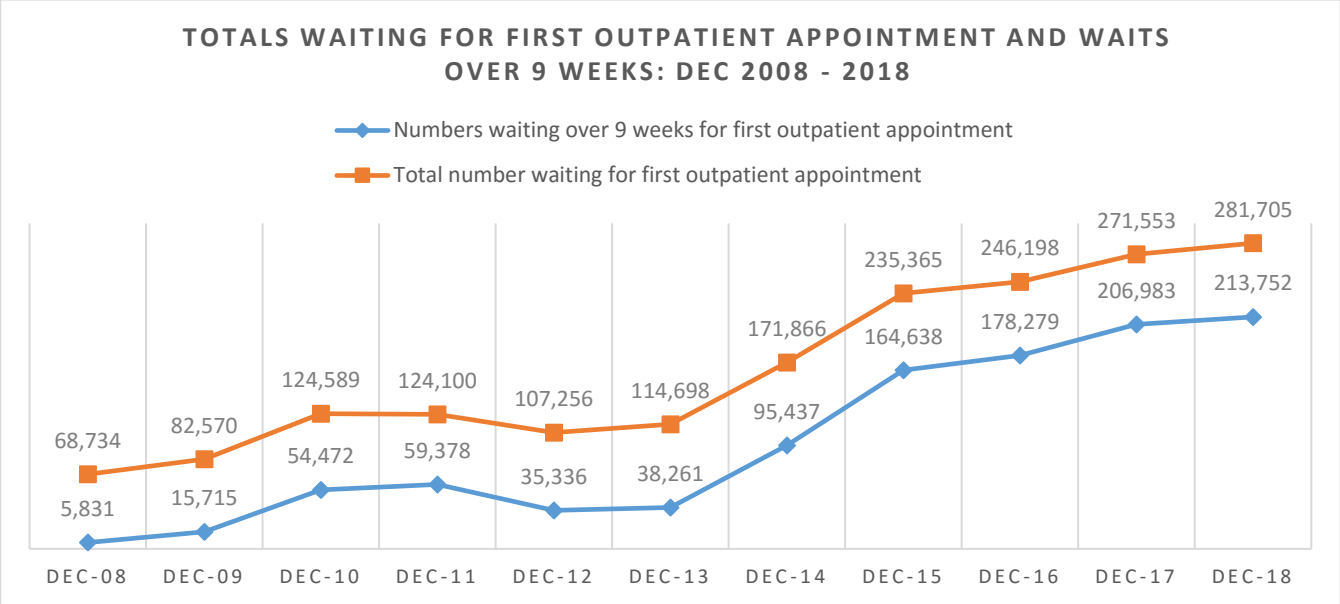
[71] Departmental email response to RaISe research request from the Department of Health (NI), 15th August 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[72] https://www.health-ni.gov.uk/consultations/national-statistics-consultation-changes-outpatient-waiting-times-and-activity-publications

[73] Departmental email response to RaISe research request from the Department of Health (NI), 11th November 2019. (Department reference – STOF-0151-2019)

[74] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

Figure 4A: Totals waiting for first outpatient appointment: Dec 2008 – 2018

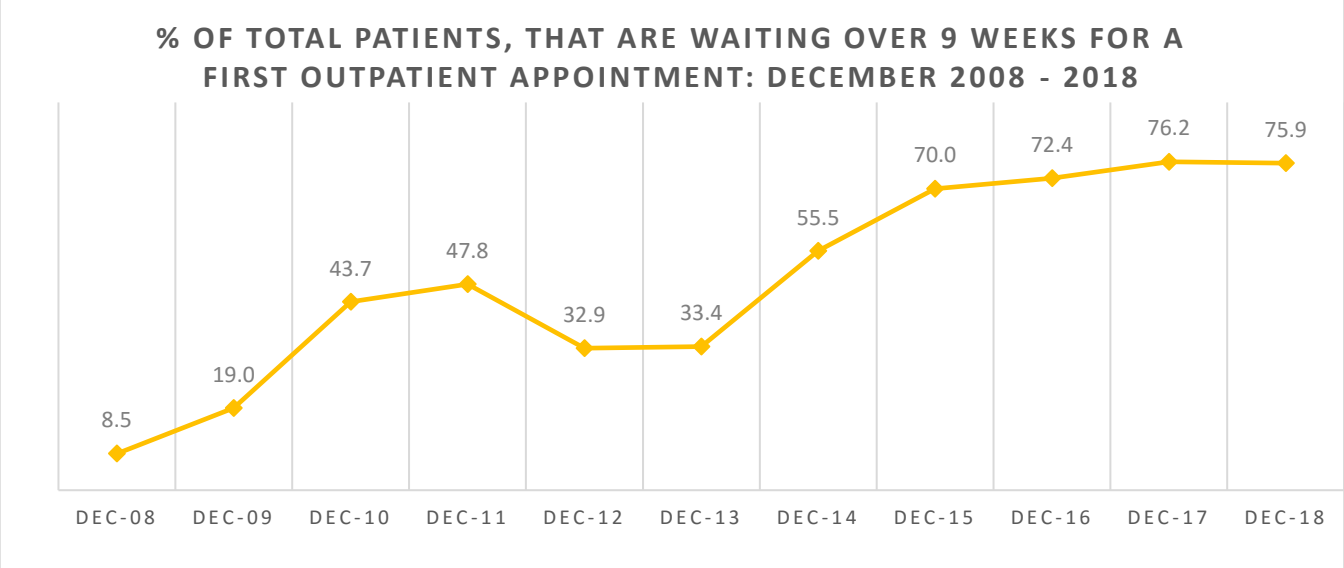


Data Source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018 - Day cases, Total Inpatients & Admissions for December Quarters

The trend indicates a steady increase in numbers waiting over 9 weeks from 2008 to 2011, with a slight decrease from 2011 to 2012. However, the numbers have not declined since this date, as between December 2013 and 2018 there has been an **increase of 175,491 (459% increase)** in the number of patients waiting over 9 weeks for a first outpatient appointment.

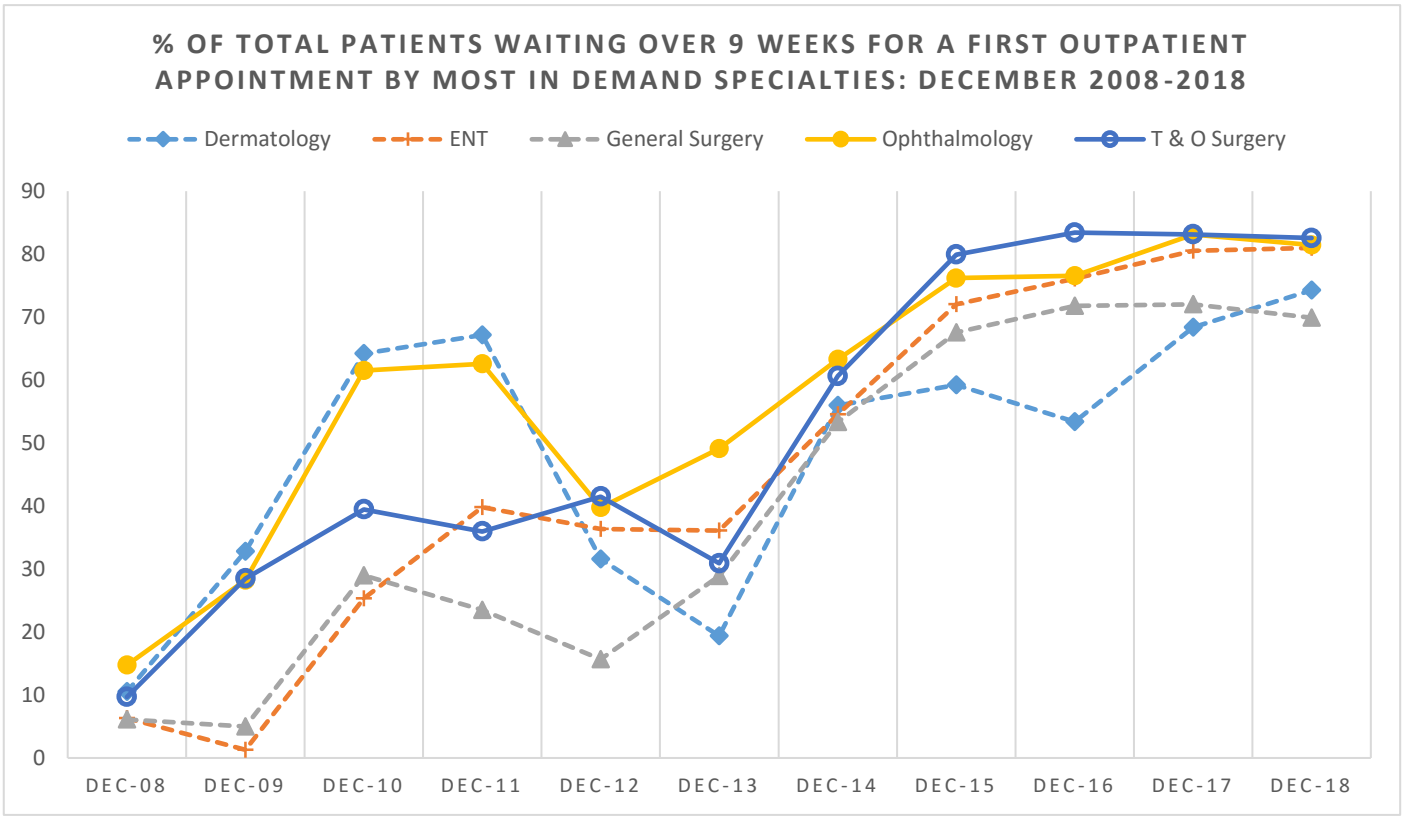
The latest published statistics (September 2019) show a **further worsening of the situation** with a total of 306,180 patients now waiting for a first outpatient appointment and 232,239 (76%) waiting over 9 weeks.

Figure 4B: % waiting for first outpatient appointment over 9 weeks: Dec 08 - 18



Data source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-december-2018

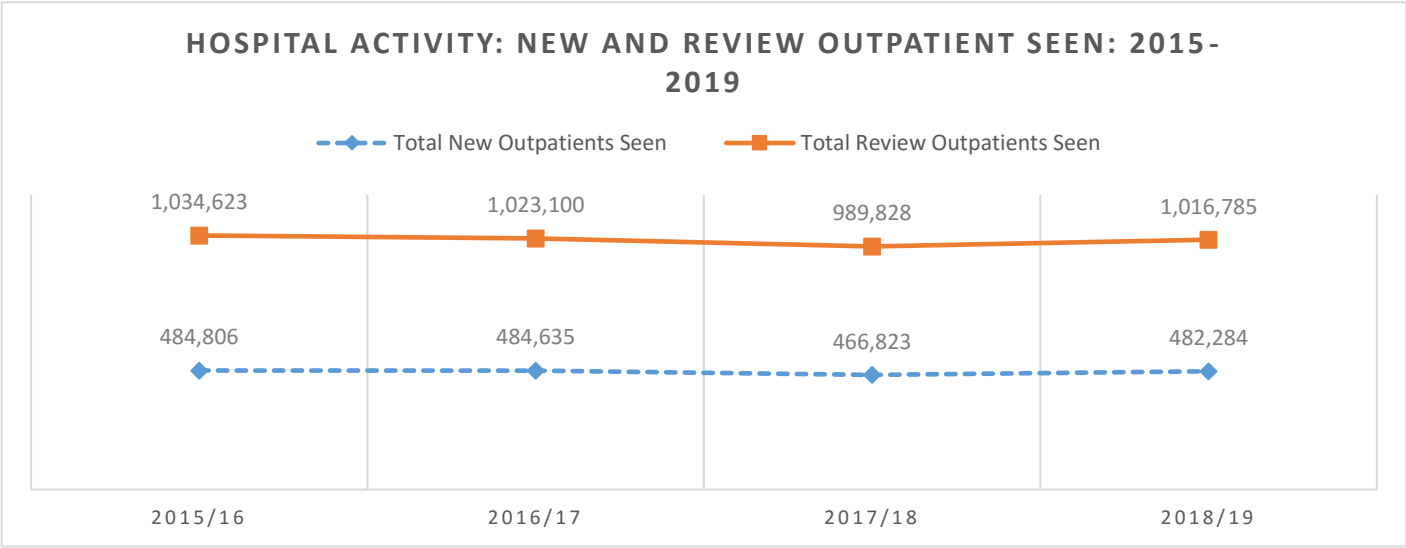
Figure 4C: % waiting for first outpatient appointment and waits over 9 weeks: Dec 2008 – 2018, by 5 most in demand specialties.



December Quarters Data source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-december-2018 December Quarters. And June 2019.

Five specialties were chosen for this graph based on size of WLs as of December 2018. Table 2 below shows the percentage of total patients waiting over 9 weeks per year. The rapid increase in recent years is similar for all five specialties, and there appears to be an indication of plateauing in the last 3-4 years.

Figure 4D : Hospital outpatient activity, new and review seen, 2015-19.



Data source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-outpatient-tables-18-19.ods

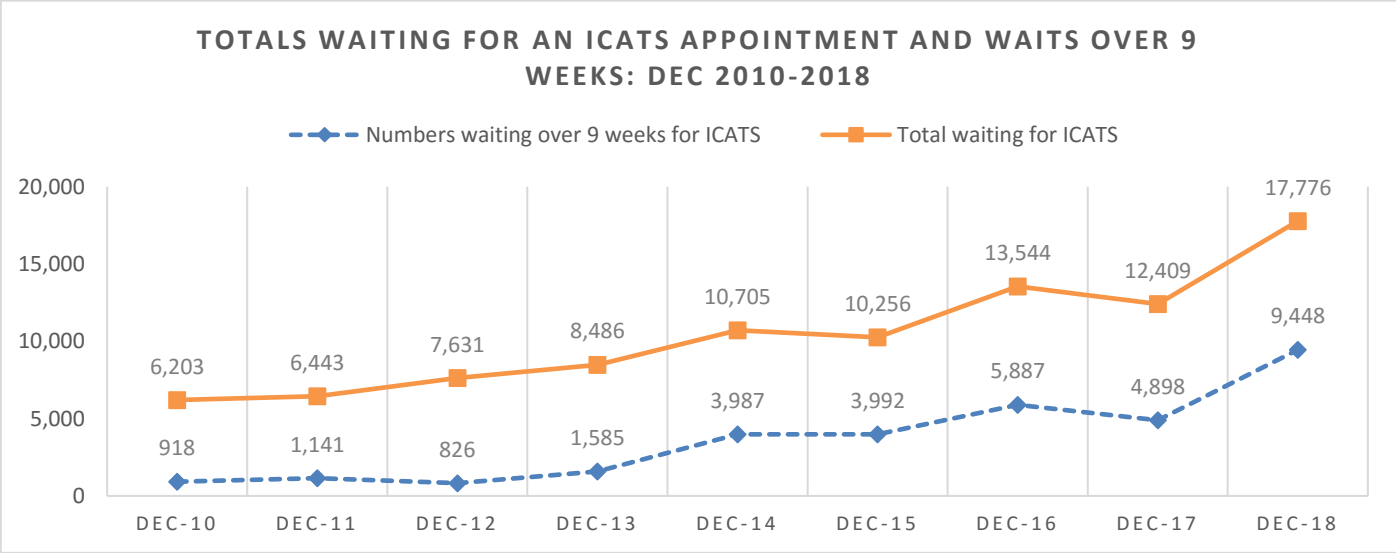
Outpatient activity is the number of patients seen in a given year. Activity Data before 2015 is not comparable due to changes made in the monitoring of the data. The activity graph indicates slight decreases in outpatient activity in the period available.

It would appear that numbers of new outpatients seen would need to be at least equal to the number of patients added to the outpatient WL in the year, if that particular WL is not to rise further each year.

6.2 ICATS - Numbers of Patients Waiting and Activity

The Integrated Clinical Assessment and Treatment Services (ICATS) provides a range of specialist assessment and treatment services for patients in a number of specialties, with the aim of helping to reduce outpatient WTs in those specialties, for example, orthopaedics. The service is provided by multi-disciplinary teams including a doctor, specialist nurse and allied health professionals. Patients who are assessed by their GP as not requiring urgent treatment in relevant specialties can be referred to a local ICATS team for assessment, treatment or diagnostic tests. If a patient's condition requires the attention of a consultant, the patient is then referred from ICATS for a first hospital outpatient appointment.[75]

Figure 5A: Totals waiting for an ICATS appointment, Dec 2010-2018



Data Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hs niwts-tables-icats-q3-18-19.csv

December Quarters.

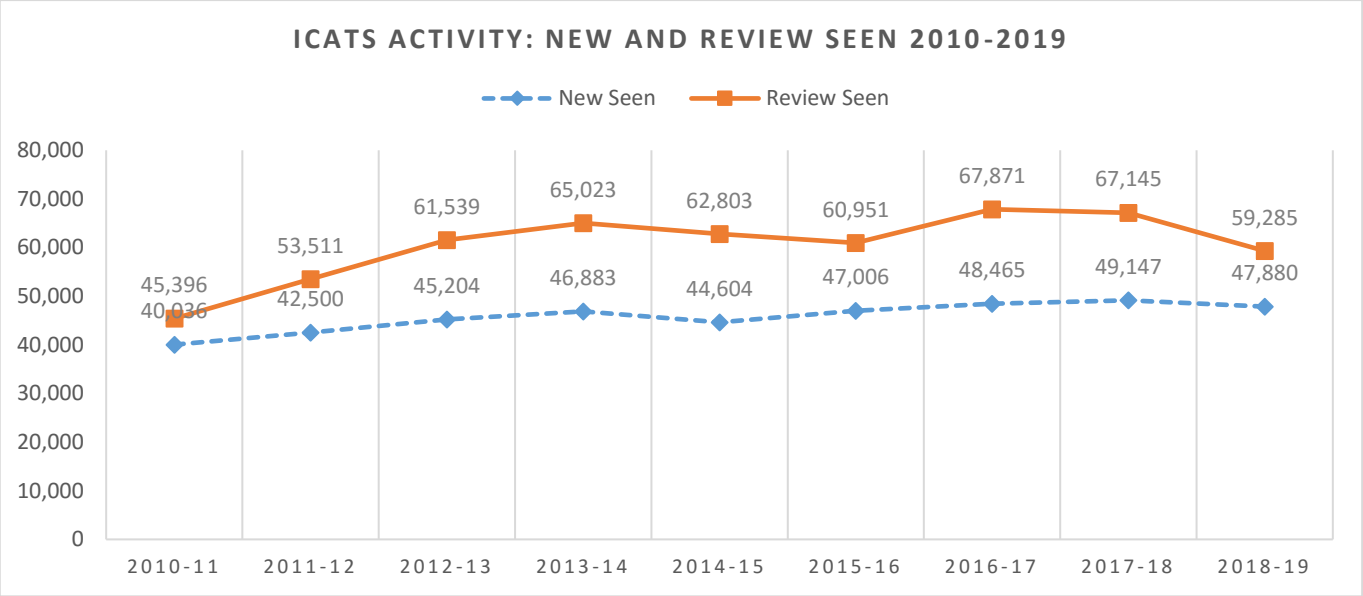
As of June 2019, there were 17,333 waiting for ICATS, while 8,304 were waiting over 9 weeks.

[75] Integrated Clinical Assessment and Treatment Services (ICATS), http://www.northerntrust.hscni.net/services/370.htm

Numbers for ICATS includes those waiting for; T&O surgery, Ophthalmology, Dermatology, ENT, Urology and Cardiology ICATS (not all trusts have the same services available and more services have become available over time).

NB – The Department's published quarterly outpatient WL totals include patients who have been seen by ICATS teams and then subsequently referred for a first consultant-led outpatient appointment. The referral from ICATS is managed as a GP referral would be and the waiting time for a first consultant-led outpatient appointment will depend on the patient's clinical priority.[76] These patients will therefore have had a first wait for an ICATS appointment (assessment and then perhaps treatment in ICATS), having been referred to ICATS by a GP, followed by a second wait for a first consultant-led outpatient appointment.

Figure 5B: ICATS activity, new and review seen, 2010-2019.



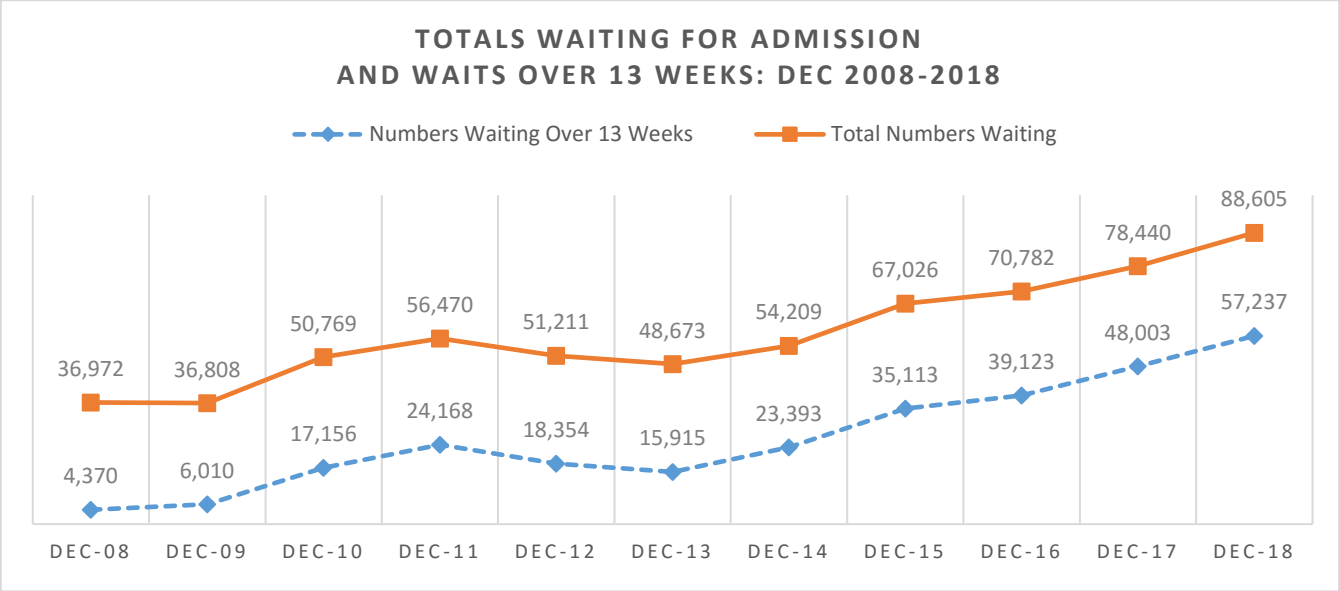
Data Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hs niwts-tables-icats-q3-18-19.csv

December Quarters.

[76] Departmental Email Response (SCORR-0453-2019) (HC3-19-1653), from Department of Health to RaISe query, 25th June 2019.

6.3 Inpatients - Numbers of Patients Waiting and Activity

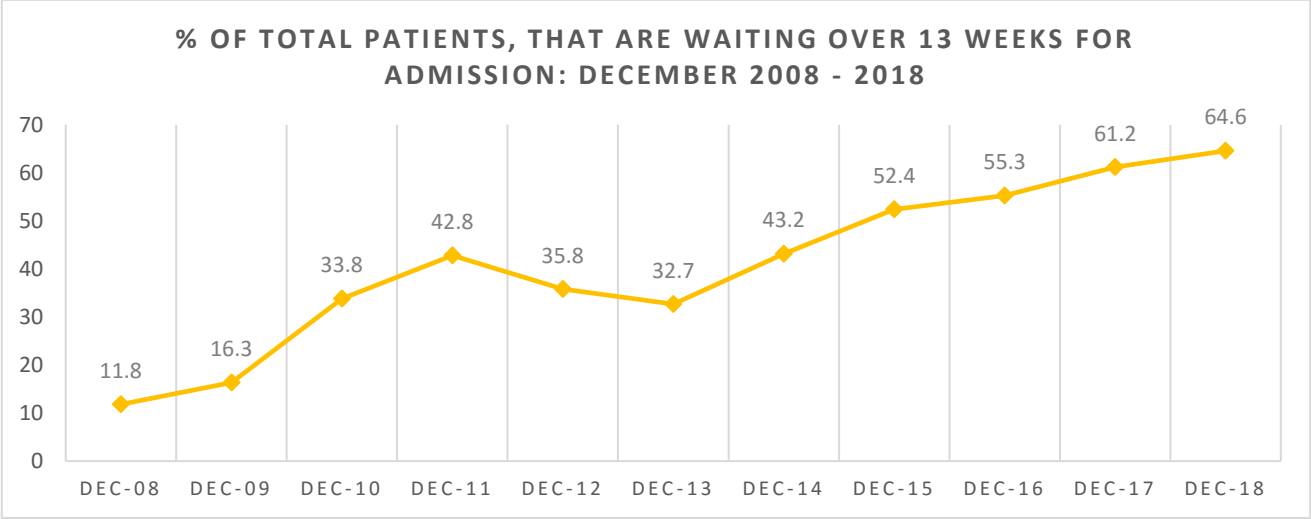
Figure 6A: Totals waiting for admission over 13 weeks, Dec 2008 - 2018.



Data Source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018 - Day cases, Total Inpatients & Admissions for December Quarters.

The Ministerial target for those waiting for admission has been consistently based around number of patients waiting over 13 weeks, for example, from April 2009 “no patient waiting longer than 13 weeks” to the current goal “55% of patients should not wait beyond 13 weeks”. Other targets based beyond 13 weeks have varied over the years.
Figures 6A and 6B use this 13 week target to enable historical comparison to be made. The totals waiting for admission includes those waiting for inpatient admission and day case admission.

Figure 6B: % of patients, waiting over 13 weeks for admission, Dec 2008 – 2018.



Data Source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018 - Day cases, Total Inpatients & Admissions for December Quarters

The graph indicates that there was a relatively consistent increase from 2008 to 2011, with totals waiting for admission increasing by 53% over that period. From the next low point in 2013 there has been a further increase of 82% in the total numbers waiting by 2018.

These patterns are mirrored in the percentages waiting over 13 weeks. The current target is 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment; however, as of December 2018 there were 65% waiting over 13 weeks.

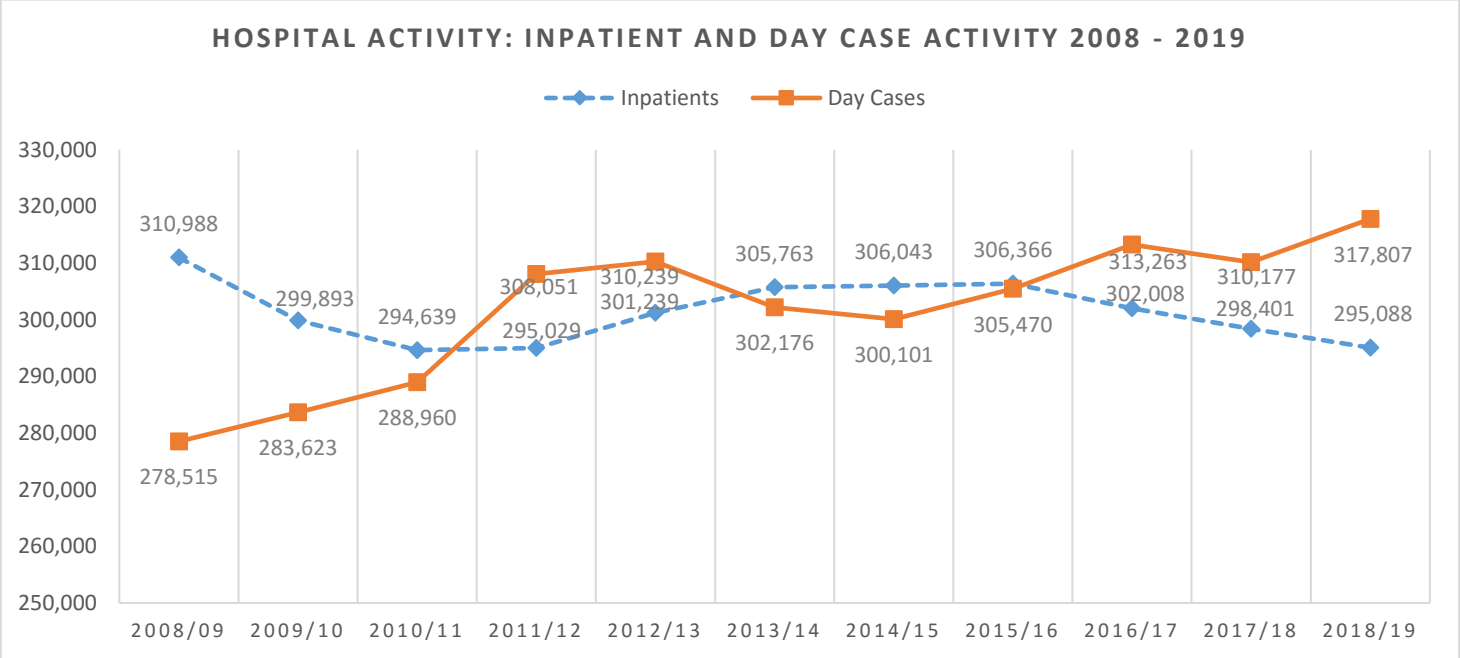
Published figures for September 2019 show that there are a total of 87,353 waiting for inpatient admission and of this number 60,809 (70%) are waiting over 13 weeks

The DoH holds patient identifiable data for patients waiting for an inpatient or day case admission, therefore it is possible to see how many patients are waiting for multiple admissions. At 31 March 2019, there were:[77]

- 87,450 'waits' for an inpatient or day case admission to hospitals in NI representing 82,667 unique individuals and excluding 259 cases of unidentified patients;
- 4,301 individuals waiting for multiple appointments for treatment:
    - 1,235 were waiting for more than one appointment within the same specialty. Trauma and Orthopaedic (T&O) surgery had the highest number (401 individuals) waiting for multiple admissions; and
    - 3,163 individuals waiting for appointments for treatment within multiple specialties, with the most common combination being waiting for general surgery and T&O surgery (245 individuals)

[77] Departmental email response to RaISe research request from the Department of Health (NI), 15th August 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

Figure 6C: Hospital activity, inpatient and day case activity 2008 - 2019



Data source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-inpatient-and-day-case-tables-17-18.xlsx

Day case admissions in 2008 were 278,515 and have now risen to 317,807, an increase of 14%. For total inpatients, the number decreased from its peak: 310,988 in 2008 to 295,088 in 2018/19, a decrease of 5%. This indicates the shift to more daycase procedures and a decrease in inpatient activity.

In a new development in March 2019, prototype 'Regional Assessment and Surgical Centres' (RASCs) became operational for the surgical treatment of cataracts and varicose veins. Patients waiting for either of these procedures can now be referred to a RASC for treatment rather than attend the hospital site they may have been referred to previously. RASCs have now been set up for:

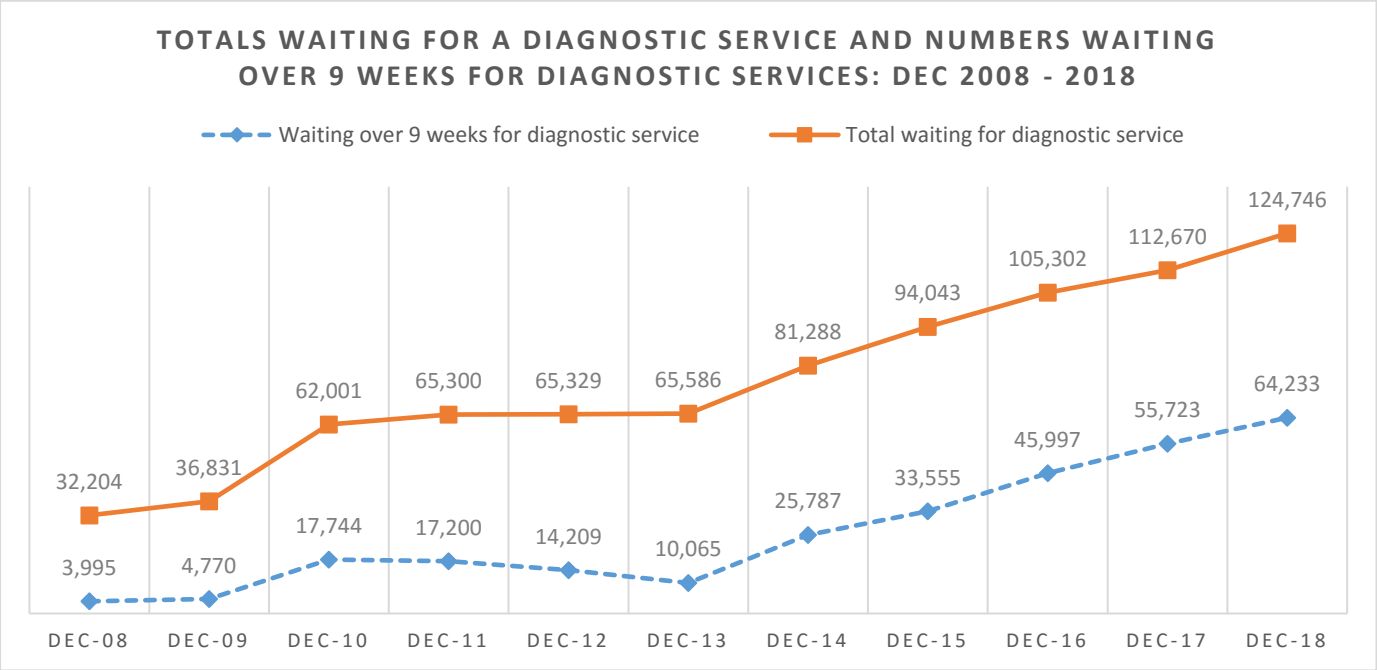
- Cataracts - Mid Ulster Hospital (Northern HSC Trust), Downe Hospital (South Eastern HSC Trust) and South Tyrone Hospital (Southern HSC Trust); and
- Varicose Veins - Lagan Valley Hospital (South Eastern HSC Trust), Omagh Hospital and Primary Care Complex (Western HSC Trust).

At 30th September 2019, 1,009 patients were waiting to be admitted to a Varicose Veins RASC and 2,305 patients waiting to be admitted to a Cataracts RASC.[78]

[78] Northern Ireland Waiting Time Statistics, Inpatient and Day Case Waiting Times, Quarter Ending June 2019, DoH NI, Information and Analysis Branch, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-june-2019

6.4 Numbers Waiting for Diagnostic Tests

Figure 7A: Totals waiting for a diagnostic service, Dec 2008 - 2018



Data source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-diagnostic-waiting-times-december-2018 December Quarters

Diagnostic WTs are based on 16 tests within three broad groups (imaging, endoscopy and physiological measurements). Activity data is presently only available for a number of particular test types within imaging and the test types changed in 2016/17 so data are not comparable over the period 2008 – 2018. Therefore, no graphs are presented here for activity for diagnostics.[79]

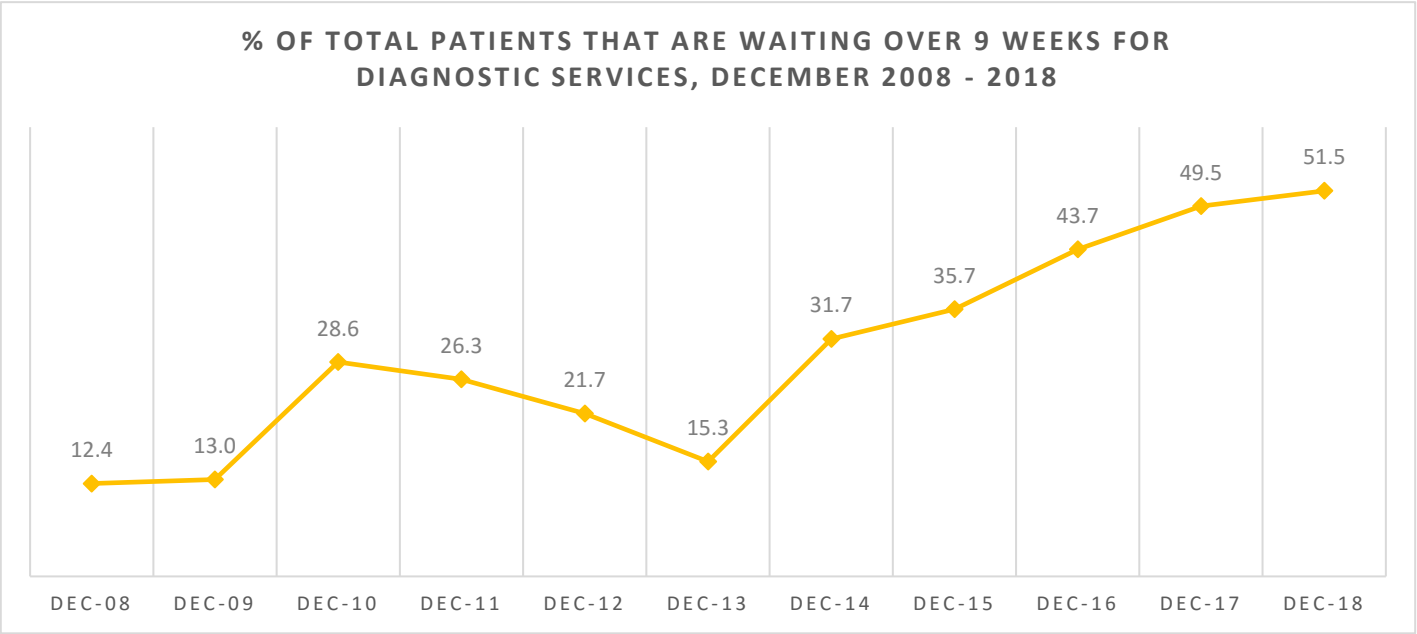
The Ministerial target is based around 9 weeks and the current draft 2019/20 Ministerial waiting time target is:

By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test, with no patient waiting longer than 26 weeks.

Totals waiting for diagnostic services has seen a significant increase in the past decade, from 32,204 at end of December 2008, to 124,746 by end of December 2018 (**a 287% increase**).

[79] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

Figure 7B: % waiting over 9 weeks for diagnostic services: Dec 2008 – 2018



Data source: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-diagnostic-waiting-times-december-2018 - December Quarters

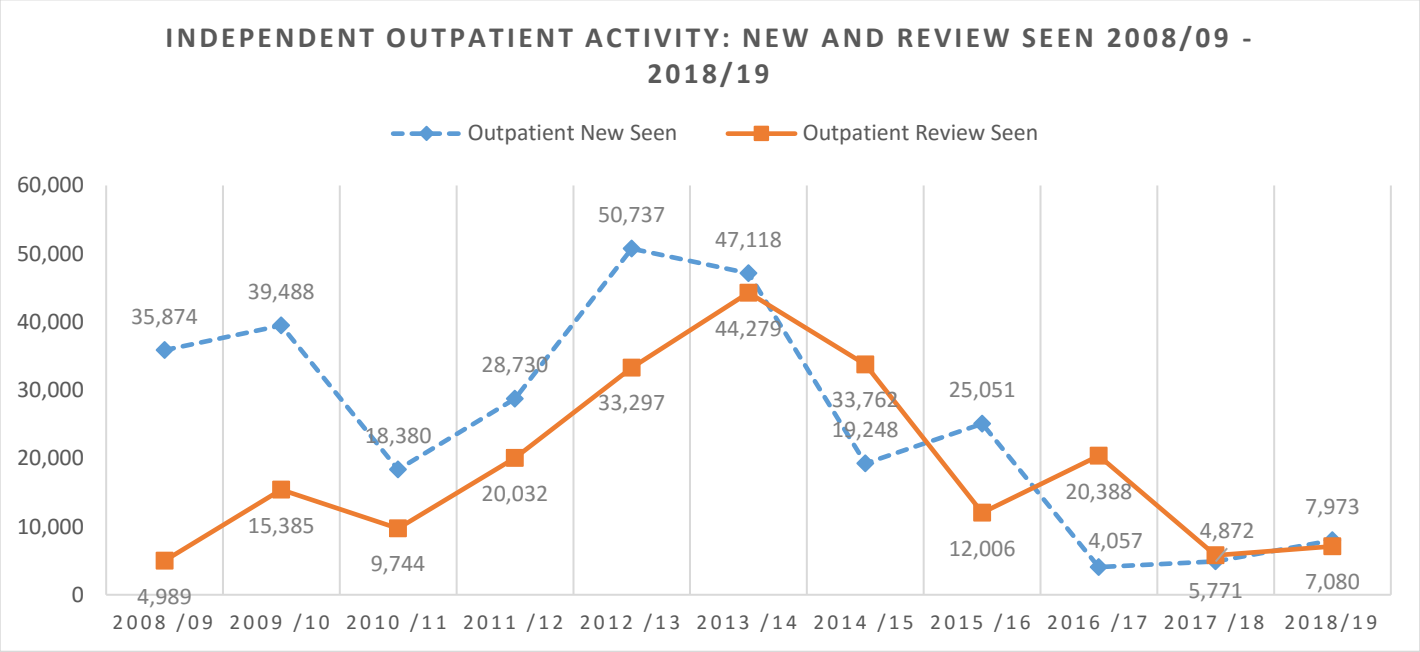
This pattern is mirrored in the numbers waiting over 9 weeks for a diagnostic service, with 3,995 waiting in 2008, and 64,233 in 2018 (**an increase of 1508%).**

Currently, as of 30th September 2019, there were 140,237 waiting for a diagnostic service, of these 79,842 (57%) were waiting over 9 weeks and 42,546 (30%) were waiting more than 26 weeks.

6.5 Activity in the Independent Sector

This section focuses on hospital activity carried out in the independent sector. Use of the independent sector has been a consistent method used in NI to reduce WLs and WTs.

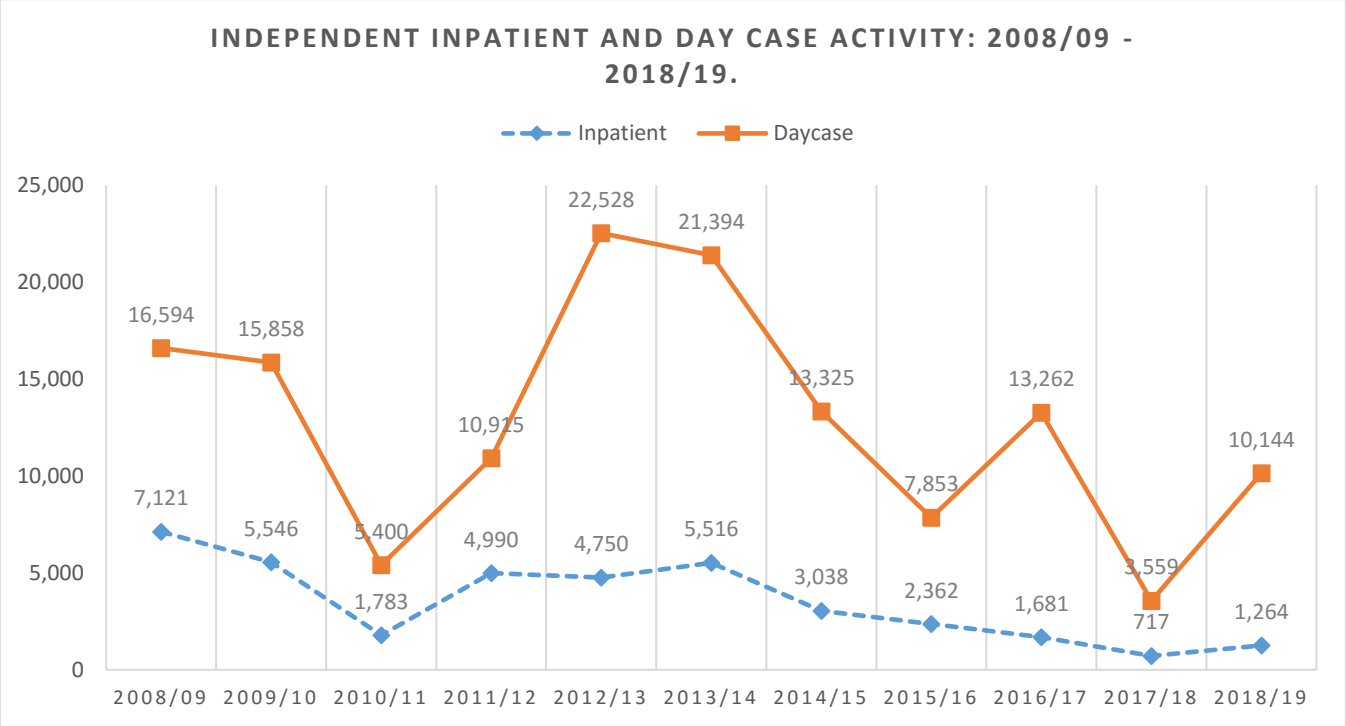
Figure 8A: Independent Outpatient Activity: New and Review Seen 2008/09 - 2018/19



Data source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-independent-tables-17-18.xlsx

Independent sector use for outpatient activity (new and review appointments) peaked around 2012 - 2014. From the peak of review outpatients seen (44,279 in 2013/14), there was a decrease of 84% by 2018/19. New outpatients seen in the independent sector has decreased from its peak in 2012/13 of 50,737 to 7,973 in 2018/19, also a decrease of 84%.

Figure 8B: Independent Inpatient and Day Case Activity: 2008/09 - 2018/19.



Please refer to metadata of the data source for more info. Data source: https://www.health-ni.gov.uk/publications/hospital-statistics inpatient-and-day-case-activity-201819

Independent sector use for inpatient and day case activity (i.e. patients treated) has been variable. Inpatient admission in 2008/09 to 2017/18 has seen a decrease of 82%. Day case admissions have dropped from a peak in 2012/13 with 22,528 day cases treated, to 2017/18 with 3,559 treated (a decrease of 84%). However in 2018/19 this jumped to 10,144 (an increase of 167% on the previous year).

The variable use of the independent sector is explained by inconsistent funding available for its use through WL initiatives and potentially a desire to decrease reliance on the sector.

7 Neighbouring Jurisdictions – Overview

With regard to measuring, monitoring and setting targets for elective care, the move to the RTT pathway measures and targets occurred over a decade ago for England[80], Scotland[81] and Wales.[82] Each jurisdiction has somewhat different targets and standards. There are no RTT measures or targets in NI.

Although the RTT time is retrospective, it does measure the total journey time of a patient from referral to treatment. Each jurisdiction has a published set of rules, including how the 'RTT clock' starts and stops for each episode of consultant-led elective care. In England, for example, this is called 'RTT Consultant-led Waiting Time Rules Suite'.[83]

Even with the RTT measure there are caveats. For example, in Scotland, the WT can only be fully measured for 90% of its patient journeys. Therefore, in Scotland the performance against the standard is based on only 90% of all identified patients.[84]

A previous RaISe paper (2013)[85] covered the history of the RTT measures and targets in England, Scotland and Wales and also policy in the Republic of Ireland (RoI) at that time. Elective care policies, measures and targets have continued to progress since then in each of those jurisdictions as Sections 7-10 below highlight. This clearly demonstrates that there is much experience for NI policy makers to draw upon.

For overview, Table 5 compares the current NI outpatient targets and WTs to the full RTT targets and latest published statistics in England, Scotland and Wales.

For NI, the current wait for a first outpatient appointment alone is substantially worse than the wait for the entire pathway in England, Scotland or Wales.

[80] Personal email communication from Paul Steele, GSI, Department of Health, 30/5/12
[81] 18 Weeks The Referral to Treatment Standard, NHS Scotland, February 2008
[82] NHS Wales, Information Standards Governance Process, Referral to Treatment Waiting Times, July 2009, http://www.wales.nhs.uk/sites3/documents/742/RTT%20-%20July.pdf
[83] RTT Consultant-led Waiting Time Rules Suite (2015), Department of Health, https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks
[84] ISD Scotland, NHS Scotland, NHS Waiting Times - 18 Weeks Referral to Treatment, https://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/index.asp
[85] Thompson, Dr. J. (2013), Waiting Times for Elective Care, NI Assembly Research and Information Service, NIAR 783-13, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/14013.pdf

Table 5 - Current NI outpatient targets and WTs compared with the full RTT targets and recent published statistics in England, Scotland and Wales

Northern Ireland	
Outpatient Target: 50% of patients should wait no longer than 9 weeks for first outpatient appointment; No patient waiting longer than 52 weeks.	**At end September 2019[86]:** 76% waiting more than 9 weeks (232,239 patients) **108,582** patients waiting **more than 52 weeks for just a first outpatient appointment.**
England	
RTT Targets: More than 92% of patients on *incomplete [RTT] pathways* should have been waiting no more than 18 weeks from referral to treatment. No patient should wait more than 52 weeks from referral to treatment	**At end November 2019[87]:** 84% of patients (4.4 million) waiting to start treatment were waiting up to 18 weeks (i.e. 16% had been waiting more than 18 weeks). **Only 1,398** patients were waiting more than 52 weeks on the RTT pathway to start treatment.
Scotland	
RTT Target: 90% of patients should wait no longer than 18 weeks from referral to treatment. **Outpatient Target (National Standard):** No patient should wait longer than 12 weeks from referral to a first outpatient appointment. **Treatment Time Guarantee:** All patients should be treated within 12 weeks of decision to treat.	**Quarter Ending 30th September 2019[88]:** 77% of patients were seen (completed waits) within the 18 Week RTT standard during month ending 30 September. 77% New Outpatients were seen within 12 weeks during the quarter ending 30 September 2019. 71% of Inpatients and Day cases were treated within the Treatment Time Guarantee in quarter ending 30 September 2019.
Wales	
RTT Targets: 95% of patients waiting less than 26 weeks from referral to treatment. No patients waiting more than 36 weeks for treatment.	**At end of October 2019[89]:** 85% of patients on open pathways waiting less than 26 weeks (i.e. 15% waiting more than 26 weeks) 4.5% of patients waiting more than 36 weeks.

[86] https://www.health-ni.gov.uk/articles/outpatient-waiting-times
[87] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
[88] https://www.isdscotland.org/Health-Topics/Waiting-Times/18-Weeks-RTT/
[89] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/percentage-patientpathwayswaiting-month-grouped-weeks

8 England

8.1 Targets, Performance and Current Statistics

In England, the NHS Constitution standard for RTT for elective care sets out what is termed the 'incomplete pathway standard' (i.e. the patient is still on the RTT pathway and treatment has not yet started)[90]:

> *more than 92% of patients on incomplete [RTT] pathways should have been waiting no more than 18 weeks from referral.*

The intention is to leave tolerance to allow for patients for whom starting treatment within 18 weeks would be inconvenient or clinically inappropriate e.g. weight loss is required before a surgery.

In a recent oral evidence session to the House of Commons Public Accounts Committee, the Chief Executive from NHS England stated that[91]:

> *the law requires the NHS to pursue the 92% target. Quite clearly, that does not translate exactly into an individual right, because it allows 8% not to meet the target. The NHS is required to pursue the target, but that is different from an individual right.*

To ensure long waiters are not forgotten, NHS England also introduced a **zero tolerance** of any RTT waits of more than 52 weeks in 2013/14.

Recent statistics are as follows[92]:

- At the end of November 2019, 84% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks, thus not meeting the 92% standard; and
- The number of RTT patients waiting to start treatment at the end of November 2019 was 4.4 million patients. Of those, 1,398 patients were waiting more than 52 weeks.

Comparable national data first became available in England in August 2007. In a period of major success, between August 2007 and January 2009, the WL (in terms of referral numbers) was reduced from 4.2 million to 2.7 million.

[90] Referral to treatment (RTT) waiting times statistics for consultant led elective care 2016/17 Annual Report Version number: 1 First published: 9th June 2017, paragraph 3.6, NHS England, Operational Information for Commissioning, https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/06/RTT-Annual-Report-2016-17-v0.9-final.pdf

[91] NHS Waiting Times for Elective and Cancer Care, Public Accounts Committee, House of Commons, Oral Evidence Session, 24 April 2019, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/nhs-waiting-times-for-elective-and-cancer-care/oral/100727.html

[92] Statistical Press Notice, NHS referral to treatment (RTT) waiting times data, August 2019, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2018-19/#Mar19

However, the total WL has now been growing again since 2012. The 18-week elective care standard (92%) was last met nationally in February 2016. Between March 2013 and November 2018, the number waiting more than 18 weeks grew from 153,000 to 528,000.[93] The NHS did achieve its ambition to halve the number of one-year waiters during 2018/19.[94]

To drive forward improvement, in 2016/17 NHS England and NHS Improvement introduced a £1.8 billion Sustainability and Transformation Fund (STF) to replace (in the case of most Trusts) the previous standard contractual penalties for the non-delivery of these targets. Money was released to Trusts if they hit their elective WT targets, accident and emergency targets and cancer targets.[95] However, from April 2017 STF money was only available to Trusts hitting their accident and emergency targets.[96]

The National Audit Office recently noted that while there has been no explicit policy to deprioritise elective care in England, incentives for achieving WT standards have been weakened or removed over the past few years. However, from 2019-20, the NHS plans to reintroduce financial penalties for both providers and commissioners in cases where patients wait longer than 52 weeks for treatment.[97]

8.2 Way Forward for Elective Care Targets in England

The future of elective care in England is now linked to the new 'NHS Long Term Plan' (2019)[98], which sets out a service model/roadmap for the coming decade to:

> *boost out of hospital treatment, dissolve the divide between GPs and community services, usher in a new era of more personalised care which is digital by default, and place a renewed focus on prevention.*[99]

In connection with this, the NHS National Medical Director is reviewing the core set of NHS access standards. Proposals for changes to access standards in **elective care,** mental health services, cancer care and urgent and emergency care are being 'field tested' at a selection of sites across England.[100] The table in Appendix 3 is taken from

[93] NHS Waiting Times for Elective and Cancer Treatment, National Audit Office, HC 1989, Session 2017-19, 22 March 2019, https://www.nao.org.uk/report/nhs-waiting-times-for-elective-and-cancer-care/

[94] Findlay, R. (2019), Success on one-year waits, but waiting list grows to record-breaking size, HSJ, Quality and Performance, 10 May 2019, https://www.hsj.co.uk/quality-and-performance/success-on-one-year-waits-but-waiting-list-grows-to-record-breaking-size/7025049.article

[95] Sustainability and Transformation in the NHS, House of Commons Committee of Public Accounts, 29th Report of Session 2017-19, https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/793/793.pdf

[96] Clover, B. (2017), Trusts 'will not be fined for failing waiting list and cancer targets', Health Service Journal (HSJ), Quality and Performance, https://www.hsj.co.uk/quality-and-performance/trusts-will-not-be-fined-for-failing-waiting-list-and-cancer-targets/7016645.article

[97] NHS Waiting Times for Elective and Cancer Treatment, National Audit Office, HC 1989, Session 2017-19, 22 March 2019, https://www.nao.org.uk/report/nhs-waiting-times-for-elective-and-cancer-care/

[98] NHS Long Term Plan (2019), https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[99] Clinical Review for NHS Access Standards, Introduction, https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/

[100] As above

an interim report and describes the access standards to be tested for elective care.[101] Two approaches are being tested for the RTT pathway:

- Defined number of maximum weeks wait for incomplete [RTT] pathways with a percentage threshold; and
- Average wait target for incomplete [RTT] pathways.

Full implementation of agreed new access standards is envisaged in spring 2020.[102]

Twelve hospital trusts are testing whether the use of an average (mean) wait between referral by a GP and starting treatment for routine conditions can better achieve the goal of reducing long waits for care than the current threshold standard[103]:

> *Initial modelling and analysis work with expert groups supported this hypothesis, and the initial feedback from trusts has assured us that it is possible to implement the measure effectively. Again, we are encouraged by public polling, conducted for Healthwatch England, which suggests that moving to an average measure would be more meaningful for patients when exercising choice over where to receive treatment*

However, there are differing views about the direction proposed. It has also been commented that consideration of an 'average wait target' is a "missed opportunity" as the 'average wait' mathematically correlates to around half the numbers meeting the current target, so all the proposed change would do is[104]:

> *roughly halve the reported numbers…in fact the correlation is so strong we can use it to translate between the current target and the new one.*

This means that a new 'average wait target' would need to be set at 8-weeks to ensure non-urgent patients would wait no longer than they do currently.

In terms of a "missed opportunity", it has been commented that the proposals could have been "so much better"[105]:

> *….Instead of tracking the percentage within 18 weeks, just track the number of weeks within which 92 per cent of the patients are waiting – this…..would not require any change to the target….the current referral-to-treatment target should be split into two stages: from referral up to the decision to be treated…..and from that decision up to treatment….If those*

[101] As above, pages 34-35, https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/
[102] Clinical Review for NHS Access Standards, page 36, https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/
[103] Clinically-led Review of NHS Access Standards: Summary, NHS England, 31st October 2019, https://www.england.nhs.uk/publication/clinically-led-review-of-nhs-access-standards/
[104] Findlay, R. (2019), Average RTT waiting times are pointless and a missed opportunity, HSJ, Quality and Improvement, https://www.hsj.co.uk/quality-and-performance/average-rtt-waiting-times-are-pointless-and-a-missed-opportunity/7024798.article
[105] As above

two stages add up to 18 weeks or less, then the public can have confidence that no sneaky relaxations of the target are going on.

9 Scotland

9.1 Targets and Current Statistics

Scottish HEAT[106] targets for elective care were recently replaced by Local Delivery Plan (LDP) Standards - priorities set between the Scottish Government and NHS Boards.[107] The LDP Standards dashboard is a web-based information tool and allows NHS Boards and the Scottish Government to monitor performance against national LDP Standards and progress is published on the 'Scotland Performs' website.[108]

The overarching RTT elective care target remains the same:

90% of patients should wait no longer than 18 weeks from referral to treatment and no patient should wait longer than 12 weeks from referral to a first outpatient appointment.

As in England, this allows for cases where it is not clinically appropriate for the patient to be seen and treated within 18 weeks and also to take account of any exceptional increase in demand for secondary care services.

For diagnostic WTs the standard is that patients waiting for one of the eight diagnostic tests/investigations will wait no longer than six weeks. Currently, NHS Boards are working towards local targets that no patient will be waiting more than four weeks.[109]

In addition, the NHS Scotland continues to deliver the *Patient Rights (Scotland) Act 2011* which contains a 12 weeks **'treatment time guarantee'** for inpatient and day case treatment.[110] The relevant LPD standard is[111]:

100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (Treatment Time Guarantee).

Recent published statistics are as follows[112]:

[106] H - Health Improvement, E – Efficiency, A - Access to treatment, T – Treatment, https://www.nhsggc.org.uk/our-performance/quality/meeting-our-targets/what-are-these-targets/
[107] https://www.isdscotland.org/Health-Topics/Quality-Indicators/HEAT/
[108] LPD Standards and Dashboard, https://www.isdscotlanzd.org/Health-Topics/Quality-Indicators/HEAT/
[109] Diagnostic Waiting Times, ISD Scotland, https://www.isdscotland.org/Health-Topics/Waiting-Times/Diagnostics/
[110] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes
[111] LPD Standard, NHS Scotland, https://www2.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance/TTG-LDP
[112] ISD Scotland Waiting Times, https://www.isdscotland.org/Health-Topics/Waiting-Times/

18 Weeks Referral to Treatment National Standard- *90% of patients being treated within 18 weeks of referral:*

- 77% of patients were seen (completed waits) within the 18 Week RTT standard during **month** ending 30 June 2019; and
- Recent media coverage notes that the 90% target has not been met since July 2014, with a steady decline in performance recorded since then.[113]

Outpatients National Standard - *95% of new outpatients waiting 12 weeks or less:*

- 73% (231,257) of New Outpatients were seen within 12 weeks **during the quarter** ending 30 September 2019.

Treatment Time Guarantee (TTG) - *All patients should be treated within 12 weeks of decision to treat:*

- 71% (69,779) of Inpatients and Day cases were treated within the TTG in quarter ending 30 June 2019.

9.2 Way Forward in Scotland – The Waiting Times Improvement Plan (2018)

The *Waiting Times Improvement Plan* (2018) is the latest plan for Scotland and the following information is extracted from the summary.[114] The Plan is supported by investment of £535 million (resource) plus £120 million (capital) over three years, in addition to an existing £200 million capital investment for delivering elective and diagnostic treatment centres. Through 2019/20, new models of care are planned through whole system design of local patient pathways, health and social care integration and regional service reconfiguration.

The aims are that by October 2019:

- 80% of outpatients will wait less than 12 weeks to be seen; and
- 75% of inpatients/daycases (eligible under the TTG) will wait less than 12 weeks.

By October 2020 :

- 85% of outpatients will wait less than 12 weeks to be seen; and
- 85% of inpatients/daycases will wait less than 12 weeks to be treated

By Spring 2021:

[113] Scottish NHS waiting times performance at record low, BBC News, November 2017, https://www.bbc.co.uk/news/uk-scotland-scotland-politics-42154358

[114] The Waiting Times Improvement Plan, Scottish Government, 23 October 2018, Summary, https://www.gov.scot/publications/waiting-times-improvement-plan/

- 95% of outpatients will wait less than 12 weeks to be seen; and
- 100% of inpatients/daycases will wait less than 12 weeks to be treated.

10 Wales

The main focus for Wales, as in England and Scotland, is RTT times. This is the total time waited from referral by a GP or other medical practitioner to hospital treatment in the NHS in Wales and includes time spent waiting for outpatient appointments, diagnostic tests, therapy services and inpatient or day-case admissions.[115]

The NHS Wales Delivery Framework and Reporting Guidance 2019-20 is the current policy used to measure delivery across the NHS in Wales. The WT measures come under a set of measures for 'Timely Care':

> *People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care[116]:*

Waiting times for RTT have the following targets[117]:

- 95 per cent of patients waiting less than 26 weeks from RTT (as opposed to an 18 week RTT in England and Scotland);
- No patients waiting more than 36 weeks for treatment; and
- No patients waiting more than 8 weeks for a specified diagnostic test.

These targets are assessed using figures for patients waiting to start treatment at the end of the month. At end of October 2019, 467,481 patients were on an open RTT pathway and neither the 26 week target nor the 36 week target were being met[118]:

- 84% of patients on an open RTT pathway[119] (i.e. treatment not started) were waiting up to 26 weeks;
- 11% of patients on an open RTT pathway were waiting between 26-36 weeks; and
- 4.5% of patients on an open RTT pathway were waiting over 36 weeks.

[115] NHS Waiting Times, NHS Wales, https://www.wales.nhs.uk/nhswalesaboutus/nhswaitingtimes

[116] NHS Wales Delivery Framework and Reporting Guidance, March 2019, page 25, https://gov.wales/sites/default/files/publications/2019-05/nhs-wales-delivery-framework-and-reporting-guidance-2019-2020-march-2019.pdf

[118] NHA Wales RTT Statistics, https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment

[119] A pathway is opened when a health board receives a referral for treatment.

The WT is calculated from the date the RTT was received until the point in the month where the data is requested for that month's statistics.[120]

Over 2016 and 2017 an extra £100million was provided to NHS Wales to reduce RTT, diagnostic and therapy waiting times. This resulted in the lowest number of people waiting over 36 weeks for RTT for over four years.

Health Boards were then able to access funding from the £30m performance fund to further reduce WLs by March 2019. Health Boards only receive the full amount of funding if they meet the agreed delivery targets to cut WLs.[121]

11 Republic of Ireland

11.1 Context

The health care system in the Republic of Ireland (RoI) is essentially a universal, public system, but many people do have to pay fees for each visit to a doctor or hospital. It is only fully free for around 37% of the population thus making it quite different from its neighbouring jurisdictions across the UK. There are two main categories of entitlement to public health services as footnoted.[122] Approximately 43% of the population have private health insurance, which is mainly used to access private hospital care, supplied in both public and private hospitals. There is a growing body of evidence that some people are experiencing difficulties in accessing health care due to cost and long waits for public hospital care, in particular for those without private insurance.[123]

11.2 Reform of Healthcare and Waiting Times - Sláintecare

In 2016, the cross-party Oireachtas Committee on the Future of Healthcare was established. Its report, 'Sláintecare'[124], was published in May 2017. One of its recommendations in connection to elective care was to[125]:

[120] NHS Wales Referral to Treatment Times: 2017–18, https://gweddill.gov.wales/statistics-and-research/referral-to-treatment-times/?lang=en

[121] Extra £30m to reduce NHS waiting times in Wales, Welsh Government Press Release, 20 June 2018, https://gov.wales/extra-ps30m-reduce-nhs-waiting-times-wales-0

[122] Those in Category I (medical card holders) are entitled to free public health services but pay a copayment for prescription items and those in Category II are entitled to subsidised public hospital services and prescription medicines, but pay the full cost of general practitioner (GP) and other primary care services. In 2005, the GP visit card was introduced and holders are entitled to free GP visits but otherwise have the same entitlements as in Category II. In 2015, this was extended to all children under the age of six, as well as to people aged 70 and over.

[123] Connolly, S. and Wren, M-A (2019), Universal Healthcare in Ireland – What are the Prospects for Reform, Health Systems and Reform, vol. 5(2), 94-99, https://www.tandfonline.com/doi/full/10.1080/23288604.2018.1551700

[124] Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, May 2017, https://webarchive.oireachtas.ie/parliament/media/committees/futureofhealthcare/oireachtas-committee-on-the-future-of-healthcare-slaintecare-report-300517.pdf

[125] As above, page 9

- Enact an Irish (Sláinte) Health Act to provide the legislative basis for a universal entitlement to a broad package of health and social care for everyone living in Ireland with maximum waiting times and a Cárta Sláinte, including:
    - No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and 10 days for a diagnostic test;
    - Individual waiting lists are to be published by facility, by specialty; and
    - Hospitals that breach guarantees to be held accountable through a range of measures including sanctions on senior staff, but not to the detriment of healthcare delivery.

The Government of Ireland subsequently published the *Sláintecare Implementation Strategy and Next Steps.* Several of the key actions by 2021 are to[126]:

- Select locations for new elective hospitals and commence planning;
- Invest in the National Purchase Treatment Fund (NTPF) to reduce WTs; and
- Implement integrated WL management system.

A range of more immediate actions are underway to be delivered in 2019 such as[127]:

- Develop multi-annual Outpatient Waiting List and Inpatient/Day Case Waiting List Action Plans; and
- Develop policy framework for evidence-based 'waiting list guarantee', incorporating consideration of legislation to support the guarantee.

It has been commented that the implementation plan:

> *fails to address one of the most significant proposals under Sláintecare - the removal of private practice from public hospitals. This aspect of the plan is being examined by a separate expert group….it does not include the promise of free GP care for all or free hospital care, which were commitments in the Oireachtas committee's report.*[128]

11.3 National Treatment Purchase Fund and Current Waiting Times

The NTPF was originally established in 2004 as an independent agency to address long WTs in **public** hospitals. Its role and function has evolved since then, however

[126] Sláintecare Implementation Strategy, Government of Ireland, page 12, https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/

[127] As above, Appendix 1: Table of Actions

[128] Bardon, S. (2018) *Sláintecare plan: What will it mean for the healthcare system?* The Irish Times, 8th August 2018, https://www.irishtimes.com/news/politics/sl%C3%A1intecare-plan-what-will-it-mean-for-the-healthcare-system-1.3590046

faster treatment of patients remains a key aim.[129] It was allocated €75m in 2019 and planned to arrange treatment for 25,000 patients on the active Inpatient /Daycase (IPDC) waiting list, 5,000 Gastrointestinal Endoscopies and 40,000 first-time outpatient consultant appointments.[130]

Since July 2012, the NTPF has also been responsible for the WT statistics and currently collects, collates and publishes information in separate stages of treatment/categories of 'Inpatient, Day Case, Planned Procedure' (IDPP), and 'Outpatient' Waiting Lists for *public hospitals*).[131] In 2017, it published an updated *National Inpatient, Day Case, Planned Procedure (IDPP) Waiting List Management Protocol* to replace the 2014 protocol.[132]

As of November 2019, the total number of people waiting for outpatient appointments had risen steadily over the year from just over 500,000 in November 2018 to just over 550,000 and the number of those waiting 52 weeks or more had risen 16% since November 2018 to around 175,000. There were 12,710 adults waiting 9 months or more for an elective procedure (a decrease of 14% on November 2018). For children, there was also a slight downward trend to 1,785 children waiting 6 months or more for elective procedures.[133]

12 Discussion

WT and WL management in elective care is a very complex area. By way of conclusion to this paper, this section brings together and discusses a range of key issues. This includes the overall situation in NI, comparisons with other parts of the UK, importance of review appointments, tracking patient journeys in the system, setting targets and accountability, risk of harm to patients and links to medical negligence, demand for elective care and resource issues. The DoH recently issued a press release summarising the issues for NI from its perspective[134]:

> *The causes of the continuing growth in waiting times are well documented. The solutions, however, are extremely challenging. They require sustained investment to address backlogs and build our workforce - as well as the radical reshaping of services. Demand for care has continued to increase, steadily outstripping the ability of the system to meet it.*

[129] NTPF Strategy and Action Plan 2017-2019, NTPF, page 5, https://www.ntpf.ie/home/pdf/strategy_action_plan.pdf
[130] NTPF Press Release, 10/01/19, https://www.ntpf.ie/home/pdf/pressreleases/December%20Press%20Release%2010.1.19.pdf
[131] NTPF, National Waiting List Data, https://www.ntpf.ie/home/nwld.htm
[132] National Inpatient, Day Case, Planned Procedure (IDPP) Waiting List Management Protocol https://www.ntpf.ie/home/pdf/National%20Waiting%20List%20Management%20Protocol.pdf
[133] Health in Ireland, Key Trends 2019, Department of Health, Government in Ireland, https://www.gov.ie/en/publication/f1bb64-health-in-ireland-key-trends-2019/
[134] Department of Health statement on latest waiting time statistics, DoH NI, Executive News Service, 28th November 2019,

The number of appointments and treatments being provided has increased over recent years. However, this increase hasn't been sufficient to keep pace with the growth in demand.

For a number of years, significant additional investment was made available to help bridge this gap between demand and capacity. This included funding for extra in-house clinics as well as paying for treatments for patients in private clinics. These extra monies have been in much shorter supply from 2014, due to financial pressures facing the Health and Social Care system and wider public sector. Waiting lists have climbed steadily since then.

The Department has publicly apologised to all those waiting too long for appointments and treatment. It reiterates that apology today.

Demand for consultant-led new outpatient assessments has risen by 9.3% between 2009/10 and 2018/19, from 483,220 to 527,972.

Consultant-led new outpatient assessments delivered has risen by 8.6% between 2009/10 and 2018/19, from 465,276 to 505,210.

Demand for inpatient/day case treatment has risen by 2.4% over the same time period, from 247,751 to 253,602

Inpatient/day case treatment delivered has risen by 1% over the same time period, from 244,463 to 246,821. However, this does not take account changes in casemix and complexity.

As discussed further in section 12.7, the DoH defines 'demand' as an annual demand figure, for example for new outpatient assessments. It defines patients who are on a WL at the start of any year as 'waiting list backlog' and this backlog is considered separately to annual demand.

12.1 The Situation in NI

In NI, WLs and WTs for elective care seem to be a 'never ending story' and could now be considered as verging on out of control. The graphs in this paper speak for themselves and clearly show the history and scale of the problem in outpatients, diagnostic services and inpatients.

For example, at the end of December 2008 there were in total only **68,734** patients waiting for **a first outpatient appointment**. By December 2018 this had risen to **281,705** and only nine months later at end of September 2019 to **306,180**. Of these, **105,450** were waiting more than a year for **a first outpatient appointment**.

In the *New Decade, New Approach* document recently published jointly by the British and Irish Governments, there is a new aim going forward that:[135]

> *No-one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021.*

This paper and previous RaISe papers have shown that the history of policies and actions to address the issues go back more than 20 years and many of the issues are **still being tackled**. For example, it took around **17 years** from the time 'Elective Care Units' were first proposed for NI for definite plans for specific 'Regional Assessment and Surgical Centres' to take shape in the most recent Elective Care Plan.

The DoH and HSCTs have made efforts over the years to reduce WTs and WLs, as outlined in Section 3. Some actions have clearly focused on 'fire-fighting' (extra in-house clinics and use of the independent sector to clear backlogs) and other clinical, service and management initiatives were implemented with varying degrees of success. However, there has often been a reliance on monitoring round monies to fund initiatives.

What was missing over the years seemed to be **sound analysis and understanding of demand and capacity** followed by **properly resourced and monitored policy and action plans**. This is where the new *Elective Care Plan* should come in to play and as was acknowledged by the then Health Minister, Michelle O'Neill, this Plan is intended to[136]:

> *transform the delivery of Elective Care Services through a process of modernisation and reform to ensure that sustained action is taken to address the root causes of excessive waiting times rather than pursuing temporary approaches.*

The Plan describes the main underlying reasons behind the increase in WTs as being[137]:

> *due to an increasing imbalance between demand and capacity. Demand has increased as illustrated by a year-on-year increase in referrals….. capacity has been unable to keep pace with this due to: the limited resources available in-year to invest in additional in-house and independent sector waiting list activity due to the wider financial position; an increased number of acutely ill patients presenting to acute and unscheduled*

[135] New Decade, New Approach, January 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

[136] Health and Social Care, Department of Health, February 2017, Introduction, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[137] Elective Care Plan, Health and Social Care, Department of Health, February 2017, page 10, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

> *services; and, agreed volumes of funded activity not being fully delivered across a range of specialties.*

The Department is putting substantial emphasis on two key areas. Firstly, the transfer of a growing range of procedures to the elective care centres and carrying out more elective care in primary care settings. The GP Federations[138] will be key in the latter as they support the overall health and social care delivery transformation agenda.

It has been commented that the shift in focus away from acute settings to providing more care at primary and community level would come at the expense of the WTs. However, the recent Nuffield report states that[139]:

> *It is not clear that any shift in services radical enough to explain the exceptionally poor performance has actually occurred yet. Poor performance relative to other UK countries, far predates the Bengoa review.*

12.2 Comparison across the UK – Performance and Measures

A Nuffield research report (2019) clearly states that in NI there is a:[140]

> ***low level of ambition around elective waiting times…***

and goes on to say that:

> *Northern Ireland's health service is **exceptionally slow** at providing patients with planned care, compared to health services elsewhere in the UK…a person in Northern Ireland is at **least 48 times** as likely as a person in Wales to wait more than a year for care. This despite Wales being the worst performer otherwise in the UK…*

The report states that this is 'likely to be an understatement' as the WT 'clock' starts are not comparable between NI and other jurisdictions of the UK. The comparator used for NI was the 'decision to admit' rather than the 'referral clock start' as used elsewhere in the UK.

This paper proposes that it is **definitely an understatement for NI**, given how much of a patient's 'wait' lies before the decision to admit. For example, at the end of June 2019 105,450 patients were waiting more than 52 weeks for **just their first outpatient appointment** and from that number 39,781 were waiting more than 104 weeks. Further waits for diagnostic tests and review appointments are then possible before the 'decision to admit' comparator as used in the Nuffield analysis.

[138] GP Federations in NI, http://www.hscboard.hscni.net/our-work/integrated-care/gps/gp-federations/

[139] Dayan, M. and Heenan, D. (2019), *Change or collapse – Lessons from the drive to reform health and social care in Northern Ireland*, Nuffield Trust, July 2019, page 10, https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland

[140] As above

Referring to comparisons between the WTs between England and NI, the Nuffield Report further states that it is:[141]

> ***Almost impossible to overstate the gulf in waiting times between the two countries**. In early 2019, the list of people waiting over one year in England was equivalent to one person per 48,524 inhabitants. In Northern Ireland, it was equivalent to **one person in 16**.*

In NI, review appointments have no targets assigned to them and no WLs or WTs for these are reported.[142]

Unfortunately, there is no way to properly compare NI's overall WT performance to anywhere else in the UK because the separate parts of the patient journey that NI measures are unable to be added together to give a full patient RTT journey time. Despite the fact that the previous Health Committee's Review recommended 'a system to measure the full RTT times for elective care and set corresponding targets',[143] there appears to have been very little work progressed in that area.

The DoH recently responded to RaISe that it had undertaken a review of the approaches taken by England, Scotland and Wales regarding RTT measurement but that any changes to measurements and targets needed Ministerial approval[144] (see section 12.4 for further discussion of RTT tracking).

The Chief Executive of NHS England recently acknowledged that the RTT target (more than 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral) for England is[145]:

> *only one way of tracking short waits: but it is not the only way, and it might not be the best way. The Scots have chosen a different way of doing it. The Welsh have chosen a different way. **Northern Ireland does not have a way at all.***

The Permanent Secretary of the Department of Health and Social Care in England has described the 18-week [RTT] target as a 'public service target' rather a ''clinical target' and stated that:[146]

> *targets, including this target, serve several purposes at once. It is very important to have targets for accountability purposes and for tracking*

[141] As above, page 11

[142] Committee for HSSPS, Official Report, Hansard, Cancelled Hospital Appointments: Health and Social Care Board/Health and Social Care Trusts Briefing, 1 May 2013

[143] Review of Waiting Times Report, NI Assembly Committee for Health, Social Services and Public Safety, Report Number 192/11-16, paragraphs 15-43, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2014-2015/review-of-waiting-times-final.pdf

[144] Departmental email response to RaISe research request from the Department of Health (NI), 25th June 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[145] NHS Waiting Times for Elective and Cancer Care, Public Accounts Committee, House of Commons, Oral Evidence Session, 24 April 2019, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/nhs-waiting-times-for-elective-and-cancer-care/oral/100727.html

[146] As above

> *purposes…..periodically you have to look at the composition of the target to say, "As well as giving you an accountability measure and a transparency effect, is it also putting the right signals into the system?"*

On a number of occasions in the past the DoH and the HSC Board have, confusingly, described the separate stage measurements in NI as both a 'planned approach' and as the result of 'disparate HSC reporting administrative systems' that could only be changed at significant cost'

> *At present there is no means of linking information on patient's waits ….given the disparate HSC reporting administrative systems …To make the necessary changes would involve significant cost (2013)*[147]

> *The English standard is 18 weeks from start to finish…..We are not at that point, so we have broken it down deliberately to be able to focus on the different elements and to ensure that nothing goes adrift in those particular elements. Ultimately, we want to….. bring it all together….(2014)*[148]

Sections 7 to 10 of this paper have provided significant detail on the active work ongoing in England, Scotland, Wales (and the Republic of Ireland) in relation to improving elective care.

Again, **it cannot be overstated** how much better the WTs in the other jurisdictions of the UK remain and how much more sophisticated are their tracking systems, targets and published information in this regard.

Despite the fact that England's elective care 'waits' remain in a league of their own compared to those in NI, there is no complacency in England as regards performance and slippage is being addressed on an ongoing basis with resources and implementation of the NHS Long Term Plan. The NAO noted that[149]:

> *… We estimate that it would cost an extra £700 million to reduce the waiting list to the size last seen in March 2018, based on current trends…. The NHS Long Term Plan commits to reducing face-to-face outpatient visits by one-third. Such a reduction would have a significant impact on elective care performance, as it is currently measure*d.

The NAO recently made a number of recommendations regarding addressing the declining performance in England. By October 2019, NHS England and NHS Improvement should:[150]

- clearly set out their objectives for waiting times;

[147] DHSSPS correspondence to RaISe, 21/03/13

[148] Committee for Health, Social Services and Public Safety, Official Report (Hansard), Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014: DHSSPS Briefing, 23 October, 2013, page 10

[149] NHS Waiting Times for Elective and Cancer Treatment, National Audit Office, HC 1989, Session 2017-19, 22 March 2019, https://www.nao.org.uk/report/nhs-waiting-times-for-elective-and-cancer-care/

[150] As above

- carry out research to better understand the impact of waiting times on patients' experience and outcomes and on urgent services; variations in performance against the waiting times standards; the impact of staff shortages on performance; the impact of bed occupancy on delays to treatment, and its links to other variables such as staff numbers and theatre usage.

12.3 Review Appointments

In NI there are no targets for review appointments. Yet, the Public Accounts Committee (PAC) for the National Assembly for Wales has recently focused on the importance of such appointments, stating that 'follow-up' outpatient appointments are[151]:

> *the **largest and most common form of contact** between patients and healthcare services in an acute setting….for patients who need a review after surgery, management or maintaining chronic conditions, or monitoring signs of deterioration, prior to intervention.*

The PAC in Wales also expressed concern about patients coming to harm while waiting for follow-up appointments and that the RTT targets [in Wales] appear to have[152]:

> *created an environment where the prime focus is on getting patients seen for their first appointment, rather than a follow up appointment, regardless of clinical need or risk.*

In connection with this the PAC (Wales) made a series of recommendations regarding 'follow-up' appointments, including that the Welsh Government[153]:

- provide the PAC with evidence that all Health Boards are making the required improvements against the new targets for outpatient follow up services by early 2020;
- clarifies whether each health board has appropriately robust mechanisms to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment; and
- bring forward proposals for recording (and collating) occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment or treatment more generally.

[151] Management of follow up outpatients across Wales, National Assembly for Wales Public Accounts Committee, July 2019, page 5, https://www.assembly.wales/laid%20documents/cr-ld12707/cr-ld12707-e.pdf
[152] As above
[153] As above

12.4 Tracking Patient Journeys in the Elective Care System

It is difficult to envisage how elective care WTs will be brought under sustained control in NI without being able to monitor how long patients are in the system from referral to treatment as well as how long is spent at each stage (outpatients, diagnostics, review and treatment [inpatient and daycase]. This measure, despite being one of the Health Committee's recommendations **five years ago**, at last, seems to be recognised in the *New Decade, New Approach* document recently published jointly by the British and Irish Governments[154]:

> *The Executive will consider the scope for changing how waiting times are measured, to reflect the entire patient journey, from referral to treatment, with appropriate targets.*

For NI, at present, based on the Department's **published figures**, we can only **'guesstimate'** possible minimum and maximum full patient journey times in the elective care system using the time bands from the quarterly returns:

	Possible Min. Journey Time	Possible Max. Journey Time
Outpatient Wait	0-6 Weeks	> 104 Weeks
Diagnostic Wait	0-6 Weeks	> 78 Weeks
Inpatient Wait	0-6 Weeks	> 52 Weeks
Approx. Total Journey Time Range	**0-6 Weeks to >234 Weeks**	

A possible journey time from referral to treatment of over four years sounds extreme, however, this does correlate with figures sourced for a recent press article[155]:

> *Figures released by the health trusts have revealed waits of up to four years for a first outpatient appointment are not uncommon…..Alarmingly, some patients are enduring waits of more than two years after being referred as an urgent case…..Neurology, general surgery and gastroenterology are particularly struggling to cope with demand, according to official statistics.*

RaISe asked the Department if it was physically possible in any way (either manually or electronically) to add up the full referral to treatment (RTT) elective care pathway for an individual patient (as has been done and reported across the rest of the UK for many years) using data collected within the HSC system. The response follows and indicates

[154] New Decade, New Approach, January 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

[155] Smyth, L. (2018), Devastating 4 year wait to be seen by Northern Ireland hospital, Belfast Telegraph, December 4th 2018, https://www.belfasttelegraph.co.uk/news/northern-ireland/devastating-4-year-wait-to-be-seen-by-northern-ireland-hospital-37590234.html

that it **does not seem to be currently possible as there are elements of the pathway not recorded**[156]:

> *From a technical perspective, measurement of the time taken to complete a RTT pathway requires full coverage of data on all patients for each stage of the pathway included in the measurement and an ability to link that data in a consistent manner….All data would need to be on a database of some sort…currently there is approximately 5% of consultant-led outpatient activity that is not recorded on PAS [patient administration system]….there are elements of a full care pathway that may not be recorded on any system, such as the time it takes to make a decision to send the patient for a diagnostic service or the waiting time between the reporting of a patient's diagnostic test and a decision to admit a patient to an inpatient setting.*

RaISe also asked the Department what would have to happen to allow the full patient pathway to be measured and would the new regional Encompass programme to introduce an integrated digital clinical record across the HSC in NI allow this to happen? The response indicates that Encompass should be able to do so[157]:

> *Encompass is a longitudinal integrated patient record and would capture the vast majority of the patient journey through the elective care system (referral to treatment times) either by direct recording within encompass or via interoperability with any systems that are not in the initial scope of encompass.*

There is no doubt that a complete picture of entire patient journeys from referral to treatment, in combination with the individual stages, would place HSC in a better position to manage the elective care system and assess the impact of the raft of measures in progress from the Elective Care Plan.

Encompass remains on track for approval and subsequent contract signing in early 2020[158] and would seem to be the way forward for tracking patient journeys for improved planning and service provision for elective care and right across the HSC system.

12.5 Target Setting and Accountability in NI

The longstanding HSC policy continues to be that all patients for elective care are seen and treated in clinical priority and thereafter in chronological order. The targets are described as being set to encourage and incentivise performance in the health and

[156] Departmental email response to RaISe research request from the Department of Health (NI), 11th November 2019. (Department reference STOF-0151-2019)
[157] As above
[158] Encompass Recruitment Update, HSCB, 28th November 2019, http://www.hscboard.hscni.net/encompass-recruitment-progresses/

social care system.[159] The Health Committee Review (2014) clearly noted that more needed to be done in that regard. The Department recently advised that it believed good progress has been made since then in strengthening accountability, roles and responsibilities and that a new Performance Management Framework and plan has been developed.

As the current WT targets are now a number of years old, it seems there is an urgent need to tackle these very long waits. The risk of long waiters slipping through the net has been recognised in other jurisdictions as a key issue. For example, with NHS England introducing a zero tolerance of any RTT waits of more than 52 weeks in 2013/14 and the RoI having the National Treatment Purchase Fund as an independent agency with its own budget to target long waiters.

12.6 Potential for Risk of Harm Through Long Waits

As referenced in the 'Introduction', for some clinical services there is evidence linking longer WTs with poorer clinical outcomes and patient experience. However, it has been noted in the literature that the specific WT targets set by governments do not always have a clear clinical evidence base.[160]

The National Audit Office (NAO) in England recently noted that there is a risk that longer waiting times may lead to patient harm and negligence claims against the NHS:

> *For many people, longer waits result in inconvenience and the discomfort associated with living with a medical condition. But for others their condition may deteriorate and a longer wait for treatment may cause them harm.*

Trusts in England are required to review whether harm has been caused to patients who have waited more than 52 weeks for elective care, but these data are not collected nationally. The NAO highlighted that as 40% of clinical negligence claims are brought because of delays in diagnosis or treatment, there is a risk that longer WTs may lead to an increasing number of future claims.[161]

Recent statistics published by the DoH on Clinical/Social Negligence Cases would indicate that NI may have a similar problem. In the 2017/18 statistics[162]:

- Of the 1,136 open cases which related to the 'Treatment' incident group, 73.9% (840) were associated with 'Fail to / Delay Treatment'; and

[159] Elective Care Plan, Health and Social Care, Department of Health, February 2017, page 8, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[160] Gardner, T. (March 2015), Are people waiting longer for health care, Topic Overview, The Health Foundation, https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/a/r/e/are-people-waiting-longer-for-health-care.pdf

[161] NHS Waiting Times for Elective and Cancer Treatment, National Audit Office, HC 1989, Session 2017-19, 22 March 2019, https://www.nao.org.uk/report/nhs-waiting-times-for-elective-and-cancer-care/

[162] Clinical/Social Care Negligence Cases in Northern Ireland (2017/18), Department of Health NI, Information Analysis Directorate, https://www.health-ni.gov.uk/publications/clinical-social-care-negligence-cases-northern-ireland-201718

- Of the 560 cases open in 2017/18 which were reported as 'Diagnosis & Tests', 79.8% were related to 'Failure to / Delay diagnosis'.

12.7 Demand for Elective Care

In NI, it is clear that there is a rising imbalance between demand for elective care and capacity to deliver that care. The Elective Care Plan included the following statements regarding 'demand'[163]:

- *Demand for consultant-led new outpatient assessments rose by 4% between 2011 and 2016, from 432,933 to 449,306;* and
- *Demand for hospital elective inpatient/daycase treatments has fluctuated throughout the last six years and figures for the last two years have shown a reduction on the previous four-year period. This may reflect slower conversion from outpatients because of growing outpatient waits.*

The method used to calculate demand was as follows[164]:

> *by taking the actual activity delivered each year and adjusting for any increase or decrease in the waiting list over the same 12 month period, for example, if the activity delivered in a given year was 1,000 new outpatients and the outpatient waiting list reduced by 100 over the same time period, the actual demand would be 900.*

RaISe sought an explanation for this definition of 'demand' as the calculation did not seem to include those already on the WL but only those new additions over the year. This could be interpreted as an underestimate, as those already on the list also represent 'demand' going forward. However, the DoH clarified that[165]:

> *Patients who are on the waiting list at the start of a year are identified as waiting list backlog and need to be considered separately to annual demand. The annual demand is calculated using the activity delivered that year plus/minus the change in the waiting list. Clearing the backlog of patients will not necessarily result in a reduction in the annual demand.*
>
> *To complement this method, an analysis of referrals received is also carried out as referrals are considered to be a primary indicator of demand…crude referrals are not taken as a demand estimate and a ROTT rate (removals other than treatment) is applied.*

[163] Elective Care Plan, Health and Social Care, Department of Health, February 2017, page 12, https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

[164] Departmental email response to RaISe research request from the Department of Health (NI), 15th August 2019. (Department references – SCORR-0453-2019 and HE3-19-1653

[165] Departmental email response to RaISe research request from the Department of Health (NI), 11th November 2019. (Department reference STOF-0151-2019)

The use of the private sector in NI, to see and treat elective care patients, remains in place to bolster capacity, although as Figure 1 shows this spend has varied considerably over the years and declined substantially in recent years, thus impacting on the success of this method to add capacity to the system.

The ageing population in NI has been cited as a factor increasing the demand for elective care. It would seem that this would be a key area for 'demand' planning in order to plan for the ageing population. However, in response to a RaISe query, the Department/HSCB stated that demand is calculated based on all age groups and a total population growth is applied to estimate future demand and there is not routine analysis demand "per year of life or per age category".[166] This response begs the question that without such specific age-related planning, how will the HSCB know, on average, how many more outpatient appointments or how many more day case or inpatient procedures are required as people age, either per year of life or per age category in order to meet demand?

The NAO in England found that a growing and ageing population only accounts for a quarter of the increase in referrals for elective care and admitted that the driver behind the increase in elective referrals is not well understood. In attempting to understand this further, there are indications that Trusts in England tend to perform more poorly on WTs for elective services when (all things being equal) they have a lower proportion of patients seen within six weeks for diagnostic services or when not meeting standards for emergency services.[167]

12.8 Resources

Lack of resources, both money and staff, have been consistently highlighted as being factors behind the rising WLs and WTs in NI. While funding has been constrained compared to need in recent years, analysis performed for the Nuffield report indicated that[168]:

> *It is not clear that Northern Ireland is radically more underfunded relative to other UK countries in particular Wales, which has lower funding per person and a similar legacy of deindustrialisation.*

Appointments and procedures cancelled by clinics and also patients who fail to turn up for appointments both play a part in terms of poor usage or wasting of limited resources and RaISe have previously looked at the issue of hospital cancelled clinics in 2013 in two linked papers.[169] A renewed focus on decreasing number of cancelled clinics and

[166] Departmental email response to RaISe research request from the Department of Health (NI), 15th August 2019. (Department references – SCORR-0453-2019 and HE3-19-1653)

[167] NHS Waiting Times for Elective and Cancer Treatment, National Audit Office, HC 1989, Session 2017-19, 22 March 2019, https://www.nao.org.uk/report/nhs-waiting-times-for-elective-and-cancer-care/

[168] Dayan, M. and Heenan, D. (2019), *Change or collapse – Lessons from the drive to reform health and social care in Northern Ireland*, Nuffield Trust, July 2019, page 10 https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland

[169] Black, Dr L-A (2013) Consultant-led Outpatient Appointments, NI Assembly RaISe Research Paper (NIAR 965-12) http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/2413.pdf; Black, Dr L-A (2013)

numbers of patients who 'do not attend' is a clear action in the Elective Care Plan going forward, however it would appear that the use of simple measures such as text/email reminders to patients have not yet been implemented fully.

Other less obvious resource issues put pressure on the elective care system. In 2016 pension rules were introduced that mean medical consultants and others earning more than £110,000 per year are at risk of large tax bills when their income increases, for example, by doing extra hours/clinics, making them less inclined to do so. Under new 'emergency' terms, clinical staff have been told that tax bills caused by overtime can be paid out of their pension, with the NHS committing to later topping this up, so the total value is not reduced.[170] The deal is for one year and a longer term solution will need to be found.

13. Conclusion

Overall, it appears that over the past two decades, the DoH and HSCB have not tackled or been able to tackle Elective Care WTs and WLs in as determined or consistent a manner as neighbouring jurisdictions.

The information technology to track full patient journeys through the elective care system and its stages only now seems to becoming available with the relatively imminent roll-out of the fully integrated digital clinical record across the HSC through the Encompass Programme.

The impact of the implementation of the transformation agenda and related *Elective Care Plan* remains to be seen over the next five to ten years but as the Permanent Secretary for Health stated recently the only way to eradicate the backlogs was[171]:

> *A very large injection of cash and we would estimate that to be somewhere between £700m and £1bn….what the transformation agenda will mean, if we eradicate those waiting lists, we will never again accumulate such a wait……even having a Minister in place would not make any difference to the waiting list figures. Even if the money was available, a minister still needs the tools at their disposal to be able to make a difference….It will still take many years to resolve that problem.*

However, the *New Decade, New Approach* document states that the Northern Ireland Executive will now introduce a new action plan on waiting times so it remains to be seen how this new action plan will link to the 2017 Plan.

Cancelled Outpatients Clinics: Follow-up NI Assembly RaISe Research Paper (NIAR 145-13), http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/5813.pdf

[170] Donnelly, L. (2019) NHS to pay doctors' tax bills in attempt to avert a winter crisis, The Telegraph, 18th November 2019, https://www.telegraph.co.uk/news/2019/11/18/nhs-pay-doctors-tax-bills-attempt-avert-winter-crisis/

[171] Connolly, M-L. (2019), £1bn needed to eradicate Northern Ireland waiting lists, 15 May 2019, https://www.bbc.co.uk/news/uk-northern-ireland-48281652

However, the HSC Trusts are reporting very detailed patient level data to the Regional Data Warehouse (RDW). Until the Encompass system is fully operational, it may be that better use can be made of current data in the RDW, via the work being done by the DoH Information and Analysis Directorate, to understand the patient journey through the elective care system.

In addition, it would seem prudent for the DoH to use to the fullest extent all contacts, experience and learning from our neighbouring jurisdictions as it strives to drive down WTs and WLs for elective care in NI.

Appendix 1 – List of previous RaISe research papers and briefing articles on waiting times/lists for elective care

From 2010 to 2015, a number of papers were prepared by RaISe concerning WLs and WT statistics, including historical trends and reviewing the policies, action and targets used elsewhere in the UK and in the Republic of Ireland:

Maginness, H. and Thompson Dr J. (Dec. 2010) Research and Library Services NI Assembly - *Northern Ireland Waiting Lists*[172];

Thompson Dr J. and Egerton L. (April 2012) Research and Information Service, NI Assembly, NIAR - *Northern Ireland Waiting Times*[173];

Thompson, Dr J. (July 2012) Research and Information Service, NI Assembly, *Waiting Times – Supplementary Briefing*[174]*;*

Black, Dr. L.- A. (January 2013, NIAR 965-12; Paper 24/13) - *Consultant-led Outpatient appointments*[175];

Thompson Dr. J. (November 2013, NIAR 783-13, Paper 140/13)[176], Research and Information Service, NI Assembly *Waiting Times for Elective Care* (**NB:** This paper provided a starting point for a programme of work that the Health Committee took forward culminating in a Committee report of its 2014 *Review of Waiting Times*);[177]

Black, Dr. L.- A. (October 2015, NIAR 590-15, Paper 120-15)[178], Research and Information Service, NI Assembly *Why are we waiting? Outpatient appointments;* (followed up with 'Research Matters' Blog Article 2016 *Outpatient Appointments: why are we waiting?)*.[179]

[172] Not published
[173] Northern Ireland Waiting Lists: Current and Historical Trends for Outpatients, Inpatients and Diagnostic Services, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2012/health/10412.pdf
[174] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2012/health/12012.pdf
[175] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/2413.pdf
[176] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2013/health/14013.pdf
[177] Health Committee, NI Assembly, Report of Review of Waiting Times, 22 September 2014, 192/11-16, http://www.niassembly.gov.uk/assembly-business/committees/2011-2016/health-social-services-and-public-safety/reports/
[178] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/12015.pdf
[179] https://www.assemblyresearchmatters.org/2016/05/25/outpatient-appointments-why-are-we-waiting/

Appendix 2 Waiting Times Definitions used in NI

- **Outpatient waiters** - defined as the number of patients waiting for their first appointment at a consultant-led clinic in secondary care, including those who have cancelled or missed a previous appointment;
    - An outpatient appointment is to enable a patient to see a consultant, a member of their team or locum for such a member, in respect of one referral.[180]
    - The **Waiting Time** for a **first outpatient appointment** in NI begins on the date the Health and Social Care (HSC) Trust receives a referral for a first appointment and ends on that date the patient attends a first outpatient appointment; and
    - Patients who cannot attend (CNA) have their waiting time adjusted to commence on the date they informed the HSC Trust they could not attend the appointment, while patients who do not attend (DNA) have their waiting time adjusted to commence on the date of the DNA.[181]

- **Inpatient waiters** – are the number of patients waiting for either **ordinary admission** to hospital or for **day case treatment**. These are the numbers of patients waiting for inpatient surgery following a 'decision to admit' being taken by their consultant;
    - **Ordinary admissions** include both (a) patients admitted electively with the expectation that they will remain in hospital for a least one night, and (b) non-elective admissions (e.g. emergency admissions). A patient who is admitted with either of the above intentions, but who leaves hospital for any reason without staying overnight, is still counted as an ordinary admission;[182]
    - **Day cases** are patients admitted electively during the course of a day with the intention of receiving care but who do not require the use of a hospital bed overnight and who return home as scheduled. In the event that the patient has to stay overnight, they are then counted as an ordinary admission;[183] and
    - Waiting time begins from the date the clinician decided to admit the patient. Patients who cannot attend (CNA) have their waiting time adjusted to commence on the date they informed the HSC Trust they could not attend,

[180] Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-december-2018

[181] Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-december-2018

[182] Northern Ireland Waiting Time Statistics: Inpatient and Day Case Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018

[183] Northern Ireland Waiting Time Statistics: Inpatient and Day Case Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018

while patients who do not attend (DNA) have their waiting time adjusted to commence on the date of the DNA.[184]

- The **diagnostic waiting time** relates to patients waiting for a test with a diagnostic element. Such a test provides an examination, test, or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made;
    - There are three categories of diagnostic test: Imaging test; Physiological Measurement test; and Day Case Endoscopy. This includes some tests that are part diagnostic and subsequently part therapeutic. Purely therapeutic procedures are excluded from the diagnostic waiting times target (patients currently admitted to a hospital bed and waiting for an emergency procedure, patients waiting for a planned procedure and patients waiting for procedures as part of screening programmes are also excluded from the waiting times target);[185]
    - The waiting time for a diagnostic service commences on the date on which the referral for the service is received by the Health Care provider and stops on the date on which the test is performed. Patients who cannot attend (CNA) have their waiting time adjusted to commence on the date they informed the HSC Trust that they could not attend, while patients who do not attend (DNA) have their waiting time adjusted to commence on the date of the DNA;
    - A number of diagnostic services may not be provided at all of the five HSC Trusts in Northern Ireland. In this situation, patients from one HSC Trust area will be waiting to be seen at a service provided at another HSC Trust.

[184] Northern Ireland Waiting Time Statistics: Inpatient and Day Case Waiting Times Quarter Ending December 2018, Appendix 2 Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-inpatient-and-day-case-waiting-times-december-2018

[185] Northern Ireland Waiting Time Statistics: Diagnostic Waiting Times December 2018, Appendix Two Explanatory Notes, https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-diagnostic-waiting-times-december-2018

Appendix 3 Proposed NHS access standards for England[186]

	MEASURE	CLINICAL RATIONALE	IMPLICATIONS FOR PATIENT CARE
Access Standards			
1	Diagnostic test - Max. wait of 6 weeks from referral to test*.	Ensure access to tests quickly so diagnosis can be reached and treatment begin in timely manner.	Need for consistent achievement in all places. Opportunity for faster overall pathway to diagnosis and earlier treatment
2	Defined number of maximum weeks wait for incomplete pathway** OR Average wait target for incomplete pathway.	Will test both approaches to see impact on prioritisation of care and reduction of long waits. Every week counts for all patients in achieving an average so maintains focus on patients at all stages of their pathway.	Measure from the point of referral until treatment. RTT clock starts and stops will reflect new arrangements in outpatients.
Supporting Measures			
3	26 week patient choice offer.	Ensures that patients can access faster treatment elsewhere in a managed way if they have not received treatment within recommended timeframe.	Faster care for many patients by re-directing to providers who can treat them more quickly.
4	52-week treatment guarantee	This is too long for any patient to wait and incentivising action to eliminate 52 week waits will focus on finding solutions for services unable to meet demand.	All patients must be treated within 52 weeks with fines imposed on commissioners and providers who are jointly accountable if not.

*Current standards have set the threshold for this at 99%. The Review does not propose any changes to this at this stage.

**Current standards have set the maximum wait at 18 weeks, and the threshold at 92% of patients who are on incomplete pathways. Field testing will consider whether these values are appropriate.

[186] Information in table extracted from *Clinical Review for NHS Access Standards*, page 34-35, https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/