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Waiting Times - Supplementary 'Issues' Briefing on the 18 Week RTT Policy in England and Scotland

1 Introduction

In a recent paper to the Committee, *Waiting Times for Elective Care*¹, RaISe highlighted examples of waiting time policies for elective care across a range of countries, including the Referral to Treatment (RTT) measurement, 18 week RTT target and supporting policies in use in England and Scotland. As the policies in England and Scotland have been in place for a number of years (particularly in England) this briefing paper takes a look at a range of the issues that have arisen in England and Scotland (and possible lessons to take) from the outworking of the policies in order to further inform the Committee review.

At present the targets for elective care in Northern Ireland (NI) are based around 'stage of treatment' by monitoring the separate waits for first outpatient consultation, waits for diagnostic tests and waits from decision to treat until inpatient or day case admission. We do not have a target based around the total journey time of a patient from referral to start of treatment (RTT).

¹ Thompson, Dr J. (November 2013), *Waiting Times for Elective Care*, NIAR 783-13, NI Assembly, RaISe, <http://www.niassembly.gov.uk/Documents/RaISe/Publications/2013/health/14013.pdf>

The move to RTT measurements and subsequent targets elsewhere in the UK has occurred within the last decade, 2004 for England² and for Scotland; a National Plan was published in 2008 as to how the 18 week RTT would be met.³ Prior to the RTT targets/standards, data was published on the separate outpatient and inpatient waits as is still done in NI.

With regard to tackling Waiting Times, England has recently been highlighted by the 2013 OECD Study entitled *Waiting Time Policies in the Health Sector, What Works?* as a “policy success story”.⁴

The recent RaSe paper covered the policy history for England and highlighted that the main advantage of the RTT measurement is that the waiting time target is based on the **total journey time** of a patient from **referral to treatment** – covering first outpatient consultation, diagnostic tests, any subsequent review appointments leading to first definitive treatment if required. The waiting time clock ‘stops’ at the start of the first definitive treatment or other allowed option (see Appendix 1).

To measure RTT in NI would require the linking of patient records across hospital systems.⁵ At present it is not possible to measure the total patient journey time here. According to the DHSSPS this is “*due not only to how the data are collected and analysed but, more importantly, how they are recorded on each Health and Social Care Trust administrative system...to make the necessary changes would involve significant cost*”.⁶

A RaSe paper published in July 2012⁷ provided further details on the RTT standards for England and Scotland and a summary of how they operate (for example when the waiting time clock ‘starts’ and ‘stops’). For background information and to demonstrate the detailed procedures behind the RTT targets, the information from that paper is included in Appendix 1.

2 England

2.1 Background to the RTT in England

In England, in 2004, the separate inpatient and outpatient targets were integrated into the single 18 week Referral to Treatment (RTT) target. Some years later, in March 2010, the NHS Constitution was updated to add new patient rights including:

² Personal email communication from Paul Steele, GSI, Department of Health, 30/5/12

³ 18 Weeks The Referral to Treatment Standard, NHS Scotland, February 2008

⁴ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), *Waiting Time Policies in the Health Sector, What Works*, OECD Health Policy Study, OECD Publishing, Chapter 16, page 298

⁵ Personal email communication from a Departmental Official, GSI, Department of Health, 30/5/12

⁶ Response from DHSSPS - Departmental Assembly Liaison Office to RaSe questions, 19th July 2012

⁷ Thompson J. (July 2012), *Waiting Times Supplementary Briefing* (July 2012), NIAR 369-12, NI Assembly, RaSe, <http://www.niassembly.gov.uk/Documents/RaSe/Publications/2012/health/12012.pdf>

- The right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible.⁸

The 2009/10 NHS Operating Framework stated that 90% of patients who were admitted to hospital and 95% who were not admitted should start their treatment within 18 weeks. A breach of the 90% or 95% limits can now lead to a financial penalty for those providers operating under a standard NHS contract.

The 2011 and 2012/13 NHS Operating Frameworks set out further operational standards to tackle the issue of the forgotten 'hidden waiters' waiting past 18 weeks for RTT (some waiting up to a year).⁹ Therefore, hospitals in England now also have a 'live' target to ensure that 92% of patients on an incomplete pathway (i.e. patients currently waiting to start treatment) should have been waiting no longer than 18 weeks.¹⁰

The use of targets in England has been augmented with other major reforms to address the supply-side of elective treatment - such as enhanced levels of patient choice, increased competition and diversity in the provider market, reformed provider payment mechanisms and increased attention to the strategic purchasing of health services. The contribution of these reforms is less easy to gauge but it is likely they have contributed to the reductions in waiting times.¹¹

The latest monthly National Statistics on NHS Consultant-led Referral to Treatment (RTT) waiting times were released on 16th January 2014 and show that targets are being met¹²:

- During November 2013, 91% of admitted patients and 96.5% of non-admitted patients started treatment within 18 weeks. For patients waiting to start treatment (incomplete pathways) at the end of November 2013, 94% were waiting within 18 weeks (218 patients were waiting more than 52 weeks).
- The average (median) time waited for patients completing an RTT pathway in November 2013 was 8.7 weeks for admitted patients (inpatients) and 5.1 weeks for non-admitted patients (day case). For patients still waiting to start treatment at the end of October 2013 the median waiting time was 5.7 weeks.

⁸ Handbook to the NHS Constitution , Overview, page 10,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170649/Handbook_to_the_NHS_Constitution.pdf

⁹ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), Waiting Time Policies in the Health Sector, What Works, OECD Health Policy Study, OECD Publishing, pages 38-40, Chapter 16, page 302

¹⁰ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), Waiting Time Policies in the Health Sector, What Works, OECD Health Policy Study, OECD Publishing, pages 38-40, Chapter 16, page 302

¹¹ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), Waiting Time Policies in the Health Sector, What Works, OECD Health Policy Study, OECD Publishing, pages 38-40, Chapter 16, page 307

¹² NHS Referral to Treatment waiting times statistics, November 2013, <http://www.england.nhs.uk/statistics/2014/01/16/referral-to-treatment-waiting-times-statistics-november-2013/>

2.2 'Issues' and Case Studies - RTT target implementation in England

2.2.1 Transformation in the way the NHS works

When the 18 weeks target was first announced in England in 2004, there was widespread scepticism that the NHS could ever deliver it. However, by the end of 2008, patients were getting treatment for both admitted (inpatient) and non-admitted (day case) pathways within this time, with a median wait of eight weeks for admitted, and four weeks for non-admitted pathways.¹³ As highlighted in section 2.1, recent statistics show that the targets continue to be met in England.

The RTT Implementation Director at the time, Philippa Robinson, made it clear from the start that the key issue was transformation - *"this was not just another waiting list initiative but would require a transformation in the way the NHS works, with all parts of the patient pathway examined and redesigned where necessary. Patients...are now often seen at a 'one stop shop' with diagnostic tests often completed at the same time"*.¹⁴

A 2008 HSJ (Health Service Journal) supplement on the 18 weeks RTT highlighted two case studies in orthopaedics (high volume specialty with historically long waiting lists) to demonstrate how such transformations were achieved¹⁵:

- (i) **Royal Bournemouth and Christchurch Hospitals foundation trust** – has a large orthopaedic department and substantial elective work and therefore had a *"challenge on its hands to reduce referral to treatment times to 18 weeks"*. The key points to its success were:
 - a. Radical redesign of how services deliver care;
 - b. Increased capacity for elective work through purchase of local private unit and turning it into a dedicated hip and knee trust;
 - c. Leadership from directors to allow staff to innovate; and
 - d. Improved utilisation of theatre time and increased capacity in scanning achieved through a range of actions including skill mix change.
- (ii) **Wrightington (Lancashire) – specialist orthopaedic hospital** - key points to success:
 - a. Patients referred by GPs are first assessed by an enhanced clinical assessment service which has reduced referrals to the hospital by 20% as more patients are offered appropriate alternative treatment such as physiotherapy;

¹³ Moore A. (2008), Success stories, HSJ Supplement/18 weeks, 8 December 2008, www.hsj.co.uk/resource.../hsj-supplement/-18-weeks/1943870.article

¹⁴ As above

¹⁵ As above

- b. The trust has expanded capacity with additional consultants and from four to eight theatres but without additional beds – a shorter stay length for patients means that the hospital can cope with more patients; and
- c. Redesign of patient pathway with more patients having diagnostic tests on same day as they see the consultant.

2.2.2 Central Performance Management – The Role of Rewards and Sanctions

The 18 weeks RTT was a key part of Labour's 2005 election manifesto. Generally, hospital managers and some clinicians disliked the targets as one of the most striking innovations was the introduction of very strong managerial incentives. It is believed that the targets worked "*because, crucially, under Labour they were rigorously performance-managed. Hence, chief executive's terror. Failure to honour the politician's pledges meant exposure, which concentrated minds*".¹⁶

The Labour Prime Minister's delivery unit was 'relentless' in reinforcing targets and the jobs of senior executives of poorly performing organisations came under severe threat. Rewards for good performance included some element of increased organisational autonomy with opportunities to apply for 'foundation' Trust status.¹⁷

The English NHS first instituted an "*aggressive target based policy*" in 2000 for various areas of NHS performance, including waiting times¹⁸. Such a policy was not implemented in other parts of the UK. This fact led a research group from Bristol University to exploit "*the 'natural experiment' of the common policy environment operating in England and ...Scotland – prior to devolution and the policy divergence post-2000 to test the impact of the 'targets and terror' regime on elective waiting times in England between 1997/98 and 2003/04*".¹⁹

From the data examined, the researchers concluded that the numbers waiting fell across the whole distribution of waiting time, with the greatest fall in the longest waits. They concluded that the policy in England met its aim. The methods the researchers used could not isolate the use of targets from the use of sanctions and a greater focus on the performance of the individual delivery unit, so they concluded that combination of the three "*resulted in changed behaviour on the part of English hospitals*".²⁰

¹⁶ Campbell, D. (2011) Longer NHS waits force Lansley to revive Labour's 'targets and terror', The Guardian, Health, 17th November 2011, www.theguardian.com/society/2011/nov/17/nhs-waiting-times-lansley-labour

¹⁷ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), Waiting Time Policies in the Health Sector, What Works, OECD Health Policy Study, OECD Publishing, Chapter 16, page 305

¹⁸ Waiting times from referral to inpatient admission, with a limited set of other key targets and a 'balanced score card' of a wider set of indicators, were used to calculate an annual star rating (which ranged from zero to three for each NHS hospital). These were published and used as a basis for direct sanctions and rewards.

¹⁹ Propper, C. et. al. (2007), Did 'targets and terror' Reduce Waiting Times in England for Hospital Care?, University of Bristol, The Centre for Market and Public Organisation, published in *The B.E. Journal of Economic Analysis & Policy* 8 (1) Article 5 (2008)

²⁰ Propper, C. et. al. (2007), Did 'targets and terror' Reduce Waiting Times in England for Hospital Care?, University of Bristol, The Centre for Market and Public Organisation, published in *The B.E. Journal of Economic Analysis & Policy* 8 (1) Article 5 (2008)

Despite the apparent success of the strong central management approach, the Secretary of State for Health (under the new coalition government), Andrew Lansley, was of the opinion that targets interfered with front-line staff's clinical opinion as to which patients needed treatment most urgently.²¹ He revised the 2010/11 NHS Operating Framework and removed central performance management, including the 18-week target for elective care. According to the Secretary of State, this was not a "signal that a deterioration of patients' experiences is acceptable" and "not a signal that unjustified waits are acceptable".²²

It was expected that that a combination of local GP-commissioners, greater publicity about waiting times and patient choice would continue to ensure waiting times did not rise. The King's Fund commented at the time that "shifting the balance of power to patients will take time, and may never deliver the same powerful incentives that central targets have done".²³

However, in what was seen by many as a U-turn by Andrew Lansley and a recognition that top-down targets were required due to increasing waiting times, in November 2011 a new target was set for hospitals in England to tackle the 'hidden waiters' waiting beyond 18 weeks. This was to ensure that 92% of patients on an incomplete pathway (i.e. patients currently waiting to start treatment) should be waiting no longer than 18 weeks.²⁴

2.2.3 Principles for Maintaining and Bettering Waiting Times

It has been commented by a former Director of the 18 week programme at the Department of Health (Matthew Kershaw) and a former Director (Paul Bate²⁵) of '2020 Delivery Ltd'²⁶ that "sustaining and bettering 18 weeks is one of the biggest success stories of the NHS in the last decade". In 2009, they published a list of six principles that they proposed would sustain and further improve waiting times²⁷:

- **Embed a cultural change so that short waiting times are second nature by ensuring four dimensions are in place:**
 - Frontline clinicians, managers and executives 'walk the talk';

²¹ Campbell, D. (2011) Longer NHS waits force Lansley to revive Labour's 'targets and terror', The Guardian, Health, 17th November 2011, www.theguardian.com/society/2011/nov/17/nhs-waiting-times-lansley-labour

²² Foot, C. (2010), The King's Fund, What will replace targets and terror?, www.kingsfund.org.uk/blog/2010/06/what-will-replace-targets-and-terror

²³ As above

²⁴ Lansley pledges to cut 'hidden' NHS waiting lists, The Guardian, 17th November 2011, <http://www.theguardian.com/society/2011/nov/17/nhs-waiting-lists-cut-government>

²⁵ Paul Bate is now Director of Strategy at the Care Quality Commission

²⁶ 2020 Delivery Ltd is a management consultancy focused on improving public services. It was started in January 2006 by David Seymour and Russell Cake, formerly consultants at McKinsey and Company who had worked on secondment with the Prime Minister's Delivery Unit. Its work in healthcare has been recognised with local and national awards, <http://www.2020delivery.com/about-us/who-we-are>

²⁷ Kershaw, M. and Bate, P. (2009), Waiting times, *HSJ*, 24th September 2009, www.hsj.co.uk/resource-centre/your-ideas-and-suggestions/waiting-times/5004947.article

- Supporting processes and systems are aligned with the new way of working – from management of performance to proactive patient tracking;
 - The benefits of change are clearly articulated, for example, sustaining waiting time reductions can generate income that helps to support clinical developments; and
 - Necessary capabilities are in place or training made available i.e. staff are confident they will be able to act the way leaders want them to.
- **Stage of treatment monitoring [as is done in NI] is no substitute for management based on RTT as:**
- Key elements of the RTT pathway (e.g. multiple outpatient appointments and diagnostic tests are not captured effectively;
 - Speeding up one element, for example outpatients, without understanding/planning for the knock on effect can create bottlenecks;
 - Patients can fall between stages of treatment; and
 - RTT works best when administrative and clinical pathways line up.
- **Ensure patients understand RTT and their part in maintaining low waits:**
- Providers need to be transparent with patients about policies and procedures linked to the 'RTT' rules and clock starts, pauses and stops; and
 - Sustainable systems also require RTT to align with patient needs and require patient initiated feedback.
- **GP engagement is required as GPs hold many of the key levers for achieving the RTT:**
- They are able to limit demand on the acute services;
 - They may provide some acute care;
 - Effective communication and transfer of patients from acute care back to GPs improves RTTs; and
 - They can help patients understand the system.
- **Once patient backlog is cleared, investment in additional treatment activity is more cost-effective than investing the same money in outpatient and diagnostics:**
- The effect of reducing outpatient and diagnostic waiting times is to list patients for inpatient or day case sooner but they will not be treated any more quickly unless additional inpatient or day case activity is also carried out;
 - If money is used to increase treatment activity, the RTT does decrease as the number of people waiting for treatment ahead of a newly referred patient will decrease.
- **A shared approach to modelling and monitoring between primary care and acute care, including developing a shared understanding of current and future capacity and demand:**

- Capacity needs to match demand day by day (and specialty by specialty), not just on average, otherwise lists will build up on those days where demand exceeds capacity but will not reduce on days where capacity exceeds demand.

2.2.4 Can the NHS Continue to Improve on the 18 week RTT?

Rob Findlay, a specialist in waiting time dynamics and Director of Gooroo Ltd²⁸, regularly publishes a HSJ blog analysing waiting times, particularly for England and Scotland.

In August 2013 he highlighted that England's elective care waiting times are "good. Really good. The problem is, they've been good for ages and the previous Labour government can take credit for that. The coalition government has toned and improved waiting lists and stopped austerity from pushing them up.... What then could an ambitious politician do that would get noticed?"²⁹

In other words, where can the English NHS go next to continue improvements on waiting times? Rob Findlay highlights that the conventional approach would be to push the targets further from 18 to 15 weeks or to raise the standard from 92% within target to 95%. But he advocates that these approaches would probably do more harm than good, for example³⁰:

- Being operated on is a 'big deal', which is one of the reasons why the target is for 92 per cent of the waiting list to be treated within 18 weeks, so that some patients can wait longer if they wish to; and
- Reducing targets below 18 weeks may have the potential to distort priorities including over relying on expensive "waiting list initiative" sessions or distorting clinical priorities, and in worst case scenario – fraudulent alterations of the figures.

He advocates that the NHS now needs to find a way of further improving waiting times without tighter targets and suggests that the Westminster government can make a difference to further improving the 18 week RTT by:

- Resisting the temptation to make the RTT more challenging but just keep on simplifying targets;
- Commending those hospitals that book patients according to clinical urgency and natural fairness, without being skewed by target chasing; and
- Set the expectation that the number of patients waiting should generally fall rather than rise, in a way that does not deter hospitals from counting their waiting lists properly.

²⁸ Gooroo Ltd, founded by Rob Findlay are specialists in NHS planning, waiting times and patient scheduling

²⁹ Findlay, R. (2013), How the NHS can chip away at 18 week waits, HSJ Blog, 12 August 2013, www.hsj.co.uk/comment/how-the-nhs-can-chip-away-at-18-week-waits/5062220.article

³⁰ As above

Overall he believes that if the English NHS keeps “*chipping away at the waiting list, the top-down enforcement of “18 weeks” will become rare and largely redundant*”.

2.2.5 Aspiring to Zero Waits for Outpatient Clinics

Section 2.2.1 has already described the ‘transformation’ in patient pathways that was required to meet the RTT targets. In 2006, a consultant vascular surgeon at Good Hope Hospital Trust³¹ proposed that the way to achieve zero waits for outpatient clinics was to “*design systems around patients rather than the organisation...designing a patient-centred outpatient system that is affordable and guaranteed to work is difficult – but not impossible*”.³²

Over two years the vascular surgery outpatient clinic at Good Hope Hospital Trust was redesigned to eliminate all steps that took time but did not add value. Firstly, the conventional multi-visit, new-review clinic model was changed to a one-stop shop where patients could get assessment, tests and treatment in one visit, typically eliminating 12 weeks of waiting at no extra cost. Secondly, delays caused by paper-based communication were eradicated by use of a shared electronic patient record for the most complex problem (chronic wounds). The result was a 40% increase in maximum capacity, which provided enough flexibility for changing demand to eliminate the need for a waiting list.³³

2.2.6 National Audit Office Findings for England

A National Audit Office Report published on 23rd January 2014, examines:

- The performance of the English NHS nationally against the waiting time standards;
- How waiting times are measured and reported; and
- Management of the challenges faced by the NHS.

The key findings included that³⁴:

- The introduction of the waiting time standards has meant more patients being treated within 18 weeks. With few exceptions, the waiting time standards have been met nationally, although the picture is varied for individual trusts. In addition, the recent strengthening of the standards appeared to have a significant effect on reducing the numbers of people waiting a long time for treatment;

³¹ Good Hope Hospital Trust serves North Birmingham, Sutton Coldfield and a large part of south east Staffordshire, including Burntwood, Lichfield and Tamworth, with a catchment population of about 450,000.

³² Dodds S. (2006), How to Aspire to Zero Waits, HSJ 22 June 2006, www.hsj.co.uk/resource-centre/how-to-aspire-to-zero-waits/3062.article

³³ As above

³⁴ NHS Waiting times for elective care in England, Department of Health, National Audit Office, HC 904, Session 2013-14, 23rd January, Summary, <http://www.nao.org.uk/>

- Doing more for one group (long waiters) can mean doing less for another and the median waiting time (the time it takes for the first 50% of patients to be treated) has increased;
- The sample of patient case files audited suggests that published waiting time figures do, however, need to be viewed with a degree of caution, “*we have identified inconsistencies in the way trusts measure waiting time, and errors in the waiting time recorded*” including:
 - Local variations in how the waiting time rules are applied mean that the performance of individual trusts is not directly comparable. (NHS England guidance does give trusts some discretion in the way they communicate with patients/respond to patient behaviours. This affects how long patients wait and how waiting time is calculated;
 - There are errors in the trusts’ recording of patients’ waiting time – “*we reviewed 650 orthopaedic patient waiting times across seven trusts. More than half of these were not supported by documented evidence or were incorrectly recorded. Although it was not a representative sample for the country as a whole, we established clear data risks that need to be managed*”.

The National Audit Office did not suggest that that the number of patients treated within 18 weeks has not increased, but that “*the information recorded by trusts is not as reliable as it should be, and masks a great deal of variability in actual waiting times... and hinders the identification and management of poor performance. The solution is not costly new processes, but making existing processes work properly and maintaining effective scrutiny of them*”.

3. Scotland

3.1 Background to the 18 week RTT target in Scotland

In 2008, NHS Scotland and the Scottish Government moved to achieve a whole journey waiting time target of 18 weeks, with the publication of a National Plan setting out the roadmap as to how this was to be achieved.³⁵ This Plan highlighted the key information elements that were necessary to facilitate RTT measurement including:

- Unique, patient-based care episode identifier;
- Record of outcome of outpatient attendance, including any treatment;
- RTT status of patient in order to track patients through the pathway;
- Protocols and minimum dataset for tertiary referrals.

³⁵ 18 Weeks The Referral to Treatment Standard, NHS Scotland, and Scottish Government, February 2008, <http://www.scotland.gov.uk/Resource/Doc/211202/0055802.pdf>

In Scotland, the current HEAT³⁶ standards state that 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. Recent statistics show that in September 2013, 91% of patient journeys for which an 18 weeks Referral to Treatment waiting time could be measured were reported as being seen within 18 weeks.³⁷

The percentage of outpatients waiting longer than 12 weeks on 30 September 2013 was 4.6% (11,544 out of 250,729 patients). This has increased from 3.0% on the previous quarter and has also increased from 2.7% on 30 September 2012 (the same quarter of the previous year).

It would seem that in September 2013, the 18 week target for RTT was just met, and the 12 week outpatient target missed for those patient journeys that can be measured.

In addition, NHS Boards are also working to deliver the Patient Rights (Scotland) Act 2011 which contains a 12 weeks Treatment Time Guarantee for inpatient and day case treatment that came into effect from 1 October 2012.³⁸ Once a patient has been diagnosed as requiring inpatient or day case treatment and has agreed to that treatment, the treatment must start within 12 weeks of the treatment having been agreed with the health board.

NHS Scotland acknowledges that to be able to calculate a patient's waiting time, it is necessary for NHS Boards to link all stages of the patient's journey from the initial referral to the start of treatment. In June 2013 the waiting time could be measured for 91.4% of patient journeys compared with 91.0% in June 2012. NHS Boards are in the process of fully implementing upgrades to their systems to improve data collection.³⁹

³⁶ HEAT targets and standards contribute towards delivery of the Scottish Government's Purpose and National Outcomes; and NHS Scotland's Quality Ambitions. The HEAT targets are grouped into 4 priorities: **H** Health Improvement for the people of Scotland - improving life expectancy and healthy life expectancy; **E** Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS; **A** Access to Services - recognising patients' need for quicker and easier use of NHS services; and **T** Treatment Appropriate to Individuals - ensure patients receive high quality services that meet their needs.

³⁷ To be able to calculate a patient's waiting time it is necessary for NHS Boards to link all stages of the patient's journey from the initial referral to the start of treatment. In September 2013, the waiting time could be measured for 92.3% of patient journeys compared with 91.5% in September 2012; NHS Scotland, ISD Scotland, 18 Weeks Referral To Treatment, Quarter ending 30 September 2013, <http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2013-11-26/2013-11-26-WT-18WksRTT-Summary.pdf?98997133971>

³⁸ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

³⁹ The Scottish Government, HEAT Standards, 18 weeks referral to treatment, <http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/18weeksRTTStandard>

3.2 'Issues' and Case Studies - RTT target implementation in Scotland

3.2.1 Defining and Measuring NHS Waiting Times

The introduction of *'New Ways of Defining and Measuring Waiting Lists'* ('New Ways') at the end of December 2007 led to significant changes in how the NHS Scotland collects and defines waiting times, and also how waiting lists are clinically and administratively managed. The Key 'New Ways' changes were⁴⁰:

- Changes to how waiting times were measured and reported;
- Introduced the concept of a 'reasonable offer' of appointment or admission;
- Records and reports patient non-attendance and unavailability; and
- Ended 'Availability Status Codes' and makes the management of waiting clear and transparent.

The 'New Ways' refresh project (November 2009) was subsequently developed to help reduce the administrative effort on staff involved in collecting and monitoring waiting times data.⁴¹ (As an illustration of the detail of the RTT measurements, Appendix 2 shows a flow chart summary of how the 'New Ways' guidance operates for waiting time clock starts, pauses and stops.)

Under 'New Ways' the time that patients are 'unavailable' for certain reasons is not included in their overall waiting time against the waiting time guarantee - a member of staff updates the patient's record and applies an 'unavailability code', including such things as medical or social reasons for the 'unavailability' (i.e. the waiting time clock is paused until the patient is 'available' again – the patient remains on the waiting list and so does not lose their guarantee to treatment and the target is deemed to be met – see Appendix 2 for flow-chart of waiting time clock starts, pauses and stops).

With any data gathering system, where staff must choose and apply appropriate codes to patient records, there is the potential for inaccurate (intentional or unintentional) use of such codes. In 2011, it was revealed that NHS Lothian had applied false periods of unavailability to patient records to appear to meet waiting time targets. An investigation revealed a management culture of⁴²:

- Putting pressure on staff to find ways around failing to meet targets, including "*finding "tactical" or paper adjustment solutions to waiting list issues*";
- Inaccurate internal performance reporting with encouragement to resolve such issues through the adjustment of waiting times results, rather than actually resolving delays in the patient journey; and

⁴⁰ 'New Ways', ISD Scotland, <http://www.isdscotland.org/Health-Topics/Waiting-Times/Hospital-Waiting-Times/>

⁴¹ Hospital Waiting Times, ISD Scotland, <http://www.isdscotland.org/Health-Topics/Waiting-Times/Hospital-Waiting-Times/Background/>

⁴² Review of aspects of Waiting Times Management at NHS Lothian, PricewaterhouseCoopers on behalf of the Scottish Government Health Directorate, March 2012, Overall Commentary, page 4,

- Misrepresenting the true scale of the challenges the board was facing in treating patients within waiting time targets.

Subsequently, internal auditors also reported the inappropriate use of unavailability codes at NHS Tayside, albeit on a smaller scale.

As both these events damaged public trust, Audit Scotland undertook an investigation into how waiting lists were being managed across NHS Scotland between April and December 2011, with specific focus on waiting list codes in patient records (such as unavailability or removal from list codes).⁴³ It did not find widespread intentional misuse of codes but did find a small number of instances where unavailability codes were used inappropriately. Due to the poor information, it was not possible to determine whether these were due to human error, inconsistent interpretation of guidance, or deliberate manipulation.⁴⁴

Audit Scotland made recommendations for improvement to the Scottish Government and NHS Boards based around the fact that the audit revealed⁴⁵:

- It was not possible to trace all amendments that had been made to the records of patients as the systems had inadequate controls and audit trails, and patient records were limited - most patients' records reviewed did not include enough information to verify that 'unavailability codes' had been properly applied;
- The proportion of patients coded as socially unavailable was higher in some specialties, such as orthopaedics and ophthalmology; and
- During 2011, there was not enough scrutiny of the increasing number of patients recorded as 'unavailable' - better use of this information could have helped identify concerns about the use of unavailability codes and could have identified pressures that were building up in the system around capacity.

Several of the main recommendations from the Audit Scotland report were that the Scottish Government and NHS boards should⁴⁶:

- Monitor and report the use of waiting list codes and ensure that they are being applied appropriately and consistently, and in line with updated national guidance issued in 2012;
- Use information about waiting list codes, alongside waiting time performance data, to identify where staff may be applying codes inconsistently or inappropriately and help plan and manage the capacity needed to meet waiting time targets; and

⁴³ Management of patients on NHS waiting lists, Audit Scotland, February 2013, Background, pages 3-4, <http://www.audit-scotland.gov.uk/media/article.php?id=228>

⁴⁴ Management and scrutiny of NHS waiting lists have to improve, Audit Scotland, Press Release, 21 February 2013,

⁴⁵ Management of patients on NHS waiting lists, Audit Scotland, February 2013, Key Messages, page 7, <http://www.audit-scotland.gov.uk/media/article.php?id=228>

⁴⁶ As above, Key Recommendations, page 8,

- Make sure that electronic systems have an audit trail to enable scrutiny of waiting list systems, and that good controls and safeguards are in place to provide assurance that waiting lists are being managed properly.

Subsequent to these investigations, one of the outcomes has been that the Scottish Government and ISD Scotland have put in place processes to get additional information from boards on how they are managing their waiting lists, but some gaps still remain, which the Scottish Government expect to be resolved early in 2014.⁴⁷

A recent Audit update highlighted that the Scottish Government and NHS have worked to implement the recommendations by Audit Scotland, the Parliament's Public Audit Committee and internal auditors. NHS boards are implementing better controls and audit trails, and have improved the information used for monitoring and reporting, including the use of unavailability codes.⁴⁸

3.2.2 Analysis of the Current Targets in Scotland

In November 2013, Health Secretary Alex Neil said,

*Patients in Scotland are being treated quicker than ever, and I am pleased that NHS Scotland is continuing to deliver on the 18 week target... The number of patients on the waiting list is now around 50,000, which has reduced dramatically from around 85,000 in March 2007.*⁴⁹

However, Rob Findlay, Director of Gooroo Ltd⁵⁰, in his Health Service Journal blog, highlighted recently that long waits in Scotland were “soaring” - “Long waits soaring? Patients being treated quicker than ever? Welcome to the confusing world of NHS waiting times, where both things can be true at once”.⁵¹

He highlights that both these things can be true because Scotland's current 18-week target only applies to those patients “lucky enough to be treated” Unlike England, there is no ‘live’ target for those patients who are still on the waiting list (see section 2.1 for discussion of tackling ‘hidden waiters’).

He also discusses Scotland's “Treatment Time Guarantee” (TTG) - once a patient has been diagnosed as requiring inpatient or day case treatment and has agreed to that treatment, the treatment must start within 12 weeks of it having been agreed with the health board.⁵² He highlights that the TTG covers those patients on the waiting list who have had their outpatient appointment and are now waiting for inpatient or day case

⁴⁷ Management of patients on NHS waiting lists, Audit Update, Audit Scotland, December 2013, http://www.audit-scotland.gov.uk/docs/health/2013/nr_131212_nhs_waiting_lists_km.pdf

⁴⁸ NHS has improved management and scrutiny of waiting lists, Audit Scotland, Press Release, 12 December 2013, http://www.audit-scotland.gov.uk/docs/health/2013/nr_131212_nhs_waiting_lists_pr.pdf

⁴⁹ Scottish Government, Waiting Times, November 26th 2013, <http://news.scotland.gov.uk/News/Waiting-times-6a0.aspx>

⁵⁰ Gooroo Ltd, founded by Rob Findlay are specialists in NHS planning, waiting times and patient scheduling

⁵¹ Long-waits soar in Scotland, The Waiting Time Guru, HSJ Blog, 26th November 2013,

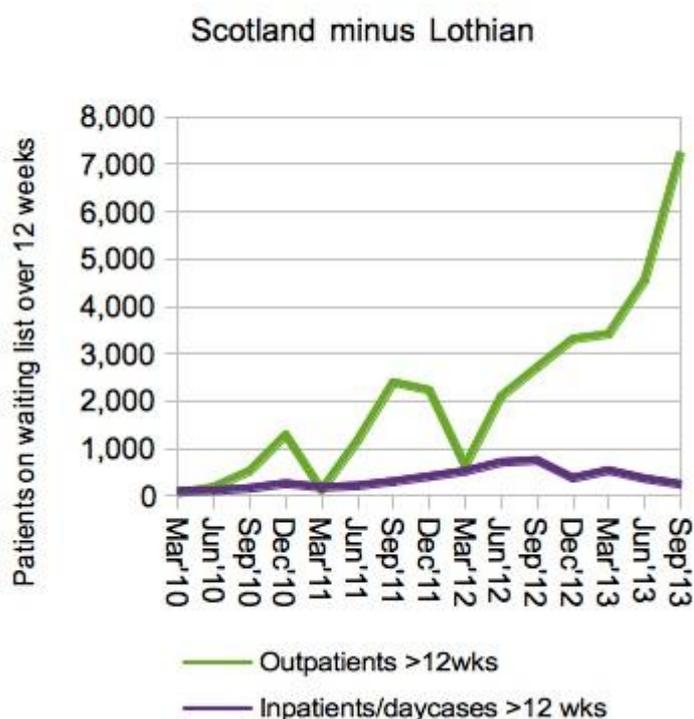
<http://www.hsj.co.uk/comment/blogs/long-waits-soar-in-scotland/5065791.blog>

⁵² <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

treatment, “the number of long-waiting patients on the inpatient and day case list is indeed coming down, which is a nice success for the guarantee and a good sign of control over the more expensive stage of the patient pathway.”

According to Rob Findlay, the problem in Scotland presently lies with the outpatient waiting list, where the target is that no patient should wait longer than 12 weeks from referral to first outpatient appointment - “where long-waits are rising at an accelerating rate” (waits over 12 weeks – see graph below directly extracted from the HSJ Blog).⁵³

Over-12-week waiters still on the list



He states that the ongoing outpatient waits are covered by a target, but one that has lower status than the Referral to Treatment and Treatment Time Guarantee targets, and it is possible to succeed on both RTT and TTG targets “even if real patient waiting times are going through the roof”.

He predicted in 2012 that this is the area where control could most easily be lost in the Scottish system and although the number of over 12 week waiters is still just a few percent of the waiting list, due to the speed of increase, his key message for the Scottish NHS is that it “needs to stop the build-up of outpatient long-waiters urgently. If it doesn’t, then the problem could grow so large that it overwhelms all their waiting times targets”.⁵⁴

⁵³ Long-waits soar in Scotland, The Waiting Time Guru, HSJ Blog, 26th November 2013, <http://www.hsj.co.uk/comment/blogs/long-waits-soar-in-scotland/5065791.blog>

⁵⁴ As above

4. Summary of Issues

This briefing paper has highlighted that great strides overall have been made in England and Scotland to tackle the waiting times issue through a combination of transformations in patient pathways; significant changes in the collection and definition of waiting times; changes to how waiting lists are clinically and administratively managed; and centrally monitored targets backed up with sanctions and rewards.

With such a complex issue, it naturally has not all been plain sailing and lessons continue to be learnt. The Governments and NHS in Scotland and England have come, and continue to come, under significant scrutiny of their management and performance of waiting times by relevant authorities and experts. This scrutiny has flagged up a variety of issues regarding the implementation of the waiting time policies and targets in each country and this briefing has aimed to cover a selection of them. Some of the key issues are summarised below:

4.1 England

Principles for Sustaining the 18 Weeks RTT

It has been commented of the English 18 weeks RTT that it “*is one of the biggest success stories of the NHS in the last decade*”. Section 2.2.3 detailed a list of six principles proposed to sustain and further improve waiting times in England. Three of these principles would seem to be particularly pertinent for NI:

- Embed a cultural change so that short waiting times are second nature;
- Stage of treatment monitoring [as is done in NI] is “*no substitute for management based on RTT*”; and
- GP engagement is required as GPs hold many of the key levers for achieving the RTT.

Transformation of Service Delivery

Transformation was the key message from the Implementation Director (at the time) of the English 18 week RTT programme. It was made clear that ‘18 weeks’ was not just another initiative but required a transformation in the way the NHS worked.

The Role of Central Performance Management

One of the main innovations of the English 18 week RTT policy was the introduction strong managerial incentives. The Labour Prime Minister’s delivery unit was ‘relentless’ in reinforcing targets, but with rewards for good performance including increased organisational autonomy for Trusts. The most recent top-down target was set in November 2011 to tackle the ‘hidden waiters’ waiting beyond 18 weeks.

A very recent Audit Office report has confirmed that, with few exceptions, the waiting time standards have been met nationally, although the picture is varied for individual

trusts and the recent strengthening of the standards appears to have a significant effect on reducing the numbers of people waiting a long time for treatment.

However, the report also highlighted the need for continued improvements in data collection and performance management as “*the information recorded by trusts is not as reliable as it should be, and masks a great deal of variability in actual waiting times... and hinders the identification and management of poor performance*”.⁵⁵

Effect of Other Reforms

The use of targets in England has been augmented with other major reforms to address the supply-side of elective treatment. It is likely that these reforms have also contributed to the reduction in waiting times there.⁵⁶

4.2 Scotland

Scotland is some years behind England in implementing its 18 week RTT and this may go some way to explaining the issues that have arisen there in recent years.

Defining and Measuring NHS Waiting Times in Scotland

One of the issues to emerge in Scotland stemmed from the finding, in 2011, that NHS Lothian had applied false periods of patient ‘unavailability’ to patient records to appear to meet waiting time targets. A subsequent investigation revealed various problems such as a culture of managers putting pressure on staff to find ways around the system to avoid failing to meet targets and inaccurate internal performance reporting, rather than actually resolving delays in the patient journey.⁵⁷

Subsequently, Audit Scotland undertook an investigation to see if such issues were widespread with the overall conclusion that during the period of the investigation in 2011, there was generally not enough scrutiny of the increasing number of patients being recorded as ‘unavailable’ as this could have identified wider pressures that were building up in the system around capacity.⁵⁸

Analysis of the Current Targets in Scotland

According to the Scottish Health Secretary, NHS Scotland is continuing to deliver on the 18 week target.⁵⁹ However, Rob Findlay, in his Health Service Journal blog

⁵⁵ NHS Waiting times for elective care in England, Department of Health, National Audit Office, HC 904, Session 2013-14, 23rd January, Summary, <http://www.nao.org.uk/wp-content/uploads/2014/01/NHS-waiting-times-for-elective-care-in-England-summary.pdf>

⁵⁶ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), Waiting Time Policies in the Health Sector, What Works, OECD Health Policy Study, OECD Publishing, pages 38-40, Chapter 16, page 307

⁵⁷ Review of aspects of Waiting Times Management at NHS Lothian, PricewaterhouseCoopers on behalf of the Scottish Government Health Directorate, March 2012, Overall Commentary, page 4, <http://www.scotland.gov.uk/Resource/0039/00390166.pdf>

⁵⁸ Management of patients on NHS waiting lists, Audit Scotland, February 2013, Background, pages 3-4, http://www.audit-scotland.gov.uk/docs/health/2013/nr_130221_nhs_waiting_lists.pdf

⁵⁹ Scottish Government, Waiting Times, November 26th 2013, <http://news.scotland.gov.uk/News/Waiting-times-6a0.aspx>

highlighted recently that long waits for outpatient consultations in Scotland were “*soaring*”.⁶⁰ According to Rob Findlay, the problem in Scotland presently lies with the outpatient waiting list, “*where long-waits are rising at an accelerating rate*”.⁶¹

His key message for the Scottish NHS is that it needs to stop the build-up of outpatient long-waiters urgently so that it doesn’t reach the stage where it could overwhelm all the other waiting time targets.

⁶⁰ Long-waits soar in Scotland, The Waiting Time Guru, HSJ Blog, 26th November 2013, <http://www.hsj.co.uk/comment/blogs/long-waits-soar-in-scotland/5065791.blog>

⁶¹ As above

Appendix 1 Measuring RTT in England and Scotland

England

The Department of Health (England) publishes extensive information on its website concerning the RTT standard.

The Referral to Treatment (RTT) clock rules document sets out the rules and definitions for RTT to ensure that each patient's RTT 'clock' starts and stops fairly and consistently. The rules document provides the framework in order that clinically sound decisions are made locally about applying the rules. The document also provides guidance on capturing and recording data on clock starts, clock stops, clock pauses and on calculating RTT times. There are six key rules defined in the RTT clock rules⁶²:

- (i) An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to⁶³:
 - a. A consultant-led service, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is referred back to the referring health professional or general practitioner;
 - b. An interface or referral management or assessment service, which may result in an onward referral to a consultant before responsibility is referred back to the referring health professional or general practitioner;
- (ii) An RTT clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional;
- (iii) Upon completion of an RTT period, a new RTT clock only starts:
 - a. When a patient is fit and ready for the second of a consultant-led bilateral procedure;
 - b. Upon the decision to start a substantively new or different treatment that does not form part of the patient's agreed care plan;
 - c. Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;
 - d. When a decision to treat is made following a period of active monitoring; and
 - e. When a patient rebooks their appointment following a first appointment DNA (did not attend) that stopped and nullified their earlier clock;

⁶² Referral to treatment consultant-led waiting times, How to Measure, Department of Health, First published 2006, pages 9-17,

⁶³ The RTT clock start date is defined as the date that the provider receives notice of the referral.

- (iv) A clock may be paused only where a decision to admit has been made and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission;
- (v) The RTT clock stops when;
 - a. First definitive treatment starts;
 - b. A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to the transplant list;
- (vi) An RTT clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that;
 - a. It is clinically appropriate to return the patient to primary care for treatment in primary care;
 - b. A clinical decision is made to start a period of active monitoring;
 - c. A patient declines treatment having been offered it;
 - d. A clinical decision is made not to treat;
 - e. A patient DNAs their appointment following the initial referral that started their RTT clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient; and
 - f. A patient DNAs any other appointment and is subsequently discharged back to the care of their GP.

Scotland

In 2008, NHS Scotland and the Scottish Government moved to achieve a whole journey waiting time target of 18 weeks, with the publication of a National Plan setting out the roadmap as to how this was to be achieved by the end of 2011.⁶⁴ This Plan highlighted the key information elements that were necessary to facilitate RTT measurement including:

- Unique, patient-based care episode identifier;
- Record of outcome of outpatient attendance, including any treatment;
- RTT status of patient in order to track patients through the pathway;
- Protocols and minimum dataset for tertiary referrals.

⁶⁴ 18 Weeks The Referral to Treatment Standard, NHS Scotland, and Scottish Government, February 2008, <http://www.scotland.gov.uk/Resource/Doc/211202/0055802.pdf>

As for England, NHS Scotland also has an extensive website devoted to the publications related to meeting the 18 week target.⁶⁵

NHS Scotland has established Task and Finish Groups in certain specialties. These have been formed to ensure the appropriate drivers are in place to minimise risk and overcome bottlenecks in the achievement of the 18 Weeks Referral to Treatment Standard. The Task and Finish Groups are as follows: Audiology; Demand and Capacity; Dental Specialties; Dermatology; Diagnostics; Neurological Service; Orthopaedics; and Plastic Surgery.⁶⁶

Task and Finish Groups all pursue a common methodology, based on the eight core work strands of Measurement and definitions; Demand/capacity/activity/queue; Demand side solutions; Performance management; Service redesign and transformation; Culture/change; Workforce; and Communication. The aim is for each group to identify the key issues and where there are 'sticking points' in the delivery of the standard. Where there are issues that cannot be resolved by the individual Group, these are taken to the overarching 18 Weeks Operational Delivery Team.⁶⁷

⁶⁵ <http://www.18weeks.scot.nhs.uk>

⁶⁶ Task and Finish Groups, NHS Scotland, www.19weeks.scot.nhs.uk/task-and-finish-groups/

⁶⁷ As above

