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Waiting Times for Elective Care

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This paper provides a starting point for a new programme of work that the Committee has agreed it wishes to take forward concerning waiting times. The paper includes the history of policies, targets and numbers waiting in Northern Ireland and also some detail concerning neighbouring jurisdictions. It also highlights key evidence from a recent OECD study of 13 countries regarding examples of practices that have been implemented to drive down waiting times.

Key Points

Operational performance around waiting times and the numbers of patients on waiting lists has been of concern to the Committee for Health, Social Services and Public Safety for more than a decade. This paper provides a starting point for a new programme of work that the Committee has wishes to take forward on these issues.

With regard to patient numbers waiting for a first outpatient appointment and total inpatient admission, the historical trend of the past (almost two decades) has been a picture of substantial increase in the number of patients waiting, followed by a significant decrease. In recent years the numbers of patients waiting has increased again. At present there are indications of a downward trend, however, the numbers waiting for a first outpatient appointment and day case admission remain well above the lowest numbers achieved in the past.

The patient numbers waiting is, of course, not the whole picture. For patients the key concern is the time spent waiting to be seen and treated.

The paper highlights the Ministerial targets for a first outpatient appointment and inpatient admission and demonstrates how they have varied in stringency over the years since 2008.

The paper highlights evidence of practice, taken from a range of OECD countries including other jurisdictions of the UK, that has made a positive impact on driving down waiting times, including:

- Establishing 'waiting time guarantees' where no patient waits more than a pre-determined time for treatment;
- Enshrining the patient right to treatment within a certain time in the health system's constitution or in law;
- The linking of the 'waiting time guarantees' to targets enforced by sanctions on providers.
- Allowing patients to choose alternative providers (including the private sector) if the maximum wait is breached;
- Linking the measurements of separate parts of the patient journey to monitor the full patient journey time from GP referral to the start of treatment; and
- Establishing comprehensive IT systems to:
 - Link public and private providers and monitor the movement of patients between all providers; and
 - Allow patients to see where they are on a waiting list, in order that they can invoke their right to treatment.

It may be useful to further investigate the rationale behind the approaches used in Northern Ireland compared to those used elsewhere.

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1 Introduction

Elective Care is generally defined as care for those whose clinical condition requires a procedure or treatment that can be managed by placement on a waiting list. In an ideal scenario this will be scheduled at the convenience of both the patient and doctor or surgeon. 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 to improve heart function).¹

For a patient, there are four possible periods of waiting²:

- To see the GP;
- Between seeing the GP and waiting for GP recommended tests or examinations e.g. blood tests;
- From GP referral to seeing the Specialist; and
- From seeing the Specialist to start of treatment.

Operational performance around waiting times (WTs) and the numbers of patients on waiting lists (WLs) in Northern Ireland (NI) has been of concern to the public, politicians, the Department for Health, Social Services and Public Safety (DHSSPS) and the Committee for Health, Social Services and Public Safety (the Committee) for more than a decade.

The Research and Information Service (RaISe) of the Northern Ireland Assembly was first tasked with looking at this issue for the Committee in 2002, when a paper provided an assessment of WLs in NI at that time. Approaches to WL management across the UK and other parts of the world at that time were reviewed.³

From 2010 to 2012, a series of papers was prepared, by RaISe, for the Committee concerning NI WLs and WT statistics, including historical trends and reviewing the targets and standards used elsewhere in the UK and in the Republic of Ireland.^{4,5,6}

This paper provides a starting point for a new programme of work that the Committee has agreed it wishes to take forward concerning waiting times.

Section 2 sets the context around the current debate by reminding the Committee of the historical data from these past publications, updated with recent statistics and also

¹ Elective Surgery, Encyclopaedia of Surgery, www.surgeryencyclopedia.com/Ce-Fi/Elective-Surgery.html

² 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 2, page 36

³ McConaghy, R. and Thompson Dr J. (December 2002), *Research and Library Services NI Assembly, Hospital Waiting Lists, Background Paper*, December 2002

⁴ Maginness, H. and Thompson Dr J. (December 2010), *Research and Library Services NI Assembly, Northern Ireland Waiting Lists*

⁵ Thompson Dr J. and Egerton L. (April 2012), *Research and Information Service, NI Assembly, NIAR 820-11, Northern Ireland Waiting Times*

⁶ Thompson, Dr J. (July 2012) *Research and Information Service, NI Assembly, NIAR 369-12, Waiting Times – Supplementary Briefing*

looks at the history of the NI targets around WTs and WLs and how they have changed since their introduction. The paper also presents evidence that there are policies in place across the UK and other countries⁷ that have made and are making a substantial difference to WTs for patients.

The Referral to Treatment (RTT) measurement for WTs used across the UK (but not in NI) has been highlighted to the Committee in previous RaISe publications, it will be reviewed again here for comparative purposes.

This paper also looks at the conclusions from the *Organisation for Economic Co-operation and Development (OECD) Waiting Times Policy Study*⁸, which discusses the role of WTs in health systems and looks at variation and best practice in defining and measuring these across OECD countries. The OECD Study looks in more detail at the most common policies to address long WTs in case studies of 13 OECD countries.

In many OECD countries long WTs for health care services has been an important policy issue over the past decade as, “*more than half of OECD countries have long waiting times for elective treatments and these waiting times are often a contentious political issue*”.⁹ Although there is presently no common definition for measurement of WTs across OECD countries, emerging best practice is to measure the total patient journey, and the Referral to Treatment (RTT) measure used in England is cited as a good approach.¹⁰

The Committee recently highlighted the issue of hospital appointments that are cancelled by the HSC Trusts and has succeeded in working with the DHSSPS and HSC Trusts to improve data collection required for scrutiny of this particular area of operational performance. The work of the Committee highlighted that the data being collated was not fit for its scrutiny or for HSC management purposes in terms of understanding and acting on the operational impact of such cancelled appointments.

This paper may provide a starting point to stimulate similar debate around the current WT information captured by the HSC system.

2 History of the Waiting Time Issue in Northern Ireland

2.1 Definitions

Outpatient waiting numbers in NI are defined as the number of patients waiting for their first appointment with a consultant at the end of the quarter. An outpatient

⁷ Siciliani, L., Borowitz, M. and Moran, V. (Editors) (2013), OECD Health Policy Studies, Waiting Time Policies in the Health Sector, What Works?

⁸ As above

⁹ As above, Executive Summary

¹⁰ As above, Executive Summary, page 11-13

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.¹¹

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. 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.¹²

Inpatient waiting numbers in NI comprises 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.¹³

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.¹⁴

The waiting time (WT) begins from the date the clinician decided to admit the patient. If the patient is offered a date but is unable to attend they will have their WT calculated from the most recent date offered.

In NI, separate waiting time data is also published for a range of diagnostic services (collected since 2007 but not dealt with specifically in this paper) and for the Integrated Clinical Assessment and Treatment Services (ICATS – see Section 3.2).

2.2 Numbers of Patients Waiting

Previous RalSe papers have focused specifically on the WT statistics so this paper does not go into detail on the numbers of patients presently waiting across the individual specialties and HSC Trusts. However, to set the scene, Figures 1 and 2 show the historical trends for outpatient waiting and inpatient waiting using a snap shot number from each year. The numbers waiting are taken from the appropriate statistical

¹¹ Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending June 2013, http://www.dhsspsni.gov.uk/ni_outpatient_waiting_list_bulletin_june_2013.pdf

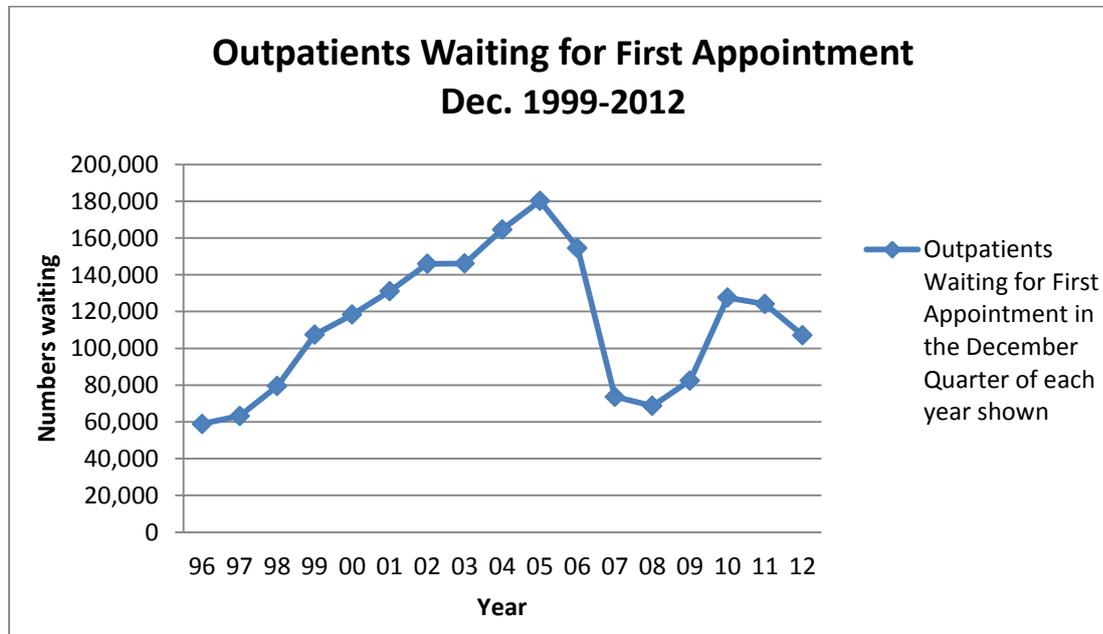
¹² DHSSPS, *Northern Ireland Waiting Lists: September 2010, Technical Notes*, published December 2010

¹³ DHSSPS, *Northern Ireland Waiting Time Statistics: Inpatient waiting times quarter ending December 2011, Explanatory Note 4*, published February 2012

¹⁴ DHSSPS, *Northern Ireland Waiting Time Statistics: Inpatient waiting times quarter ending December 2011, Explanatory Note 5*, published February 2012

bulletins as published on the DHSSPS website¹⁵ and from a previous RaISe publication.¹⁶

Figure 1 - Outpatients Waiting for a First Appointment in December Quarter from Dec. 1999 to Dec. 2012 (Figures for 96, 97 and 98 are the March Quarter figures of those years¹⁷)



Note: The most recent published figures are for the quarter ending June 2013, when 113,744 patients across NI were waiting for a first outpatient appointment.¹⁸

The trend indicates a consistent increase in the numbers waiting for a first outpatient appointment from the start of the graph in 1996 to the peak in 2005. This was followed by a substantial improvement in a two year period from 2005 to 2007, only for this improvement to be reversed over the years following 2007. This decline levelled off in 2010 and 2011 and there appears to be now signs of improvement (see quote from Minister for HSSPS at end of this section).

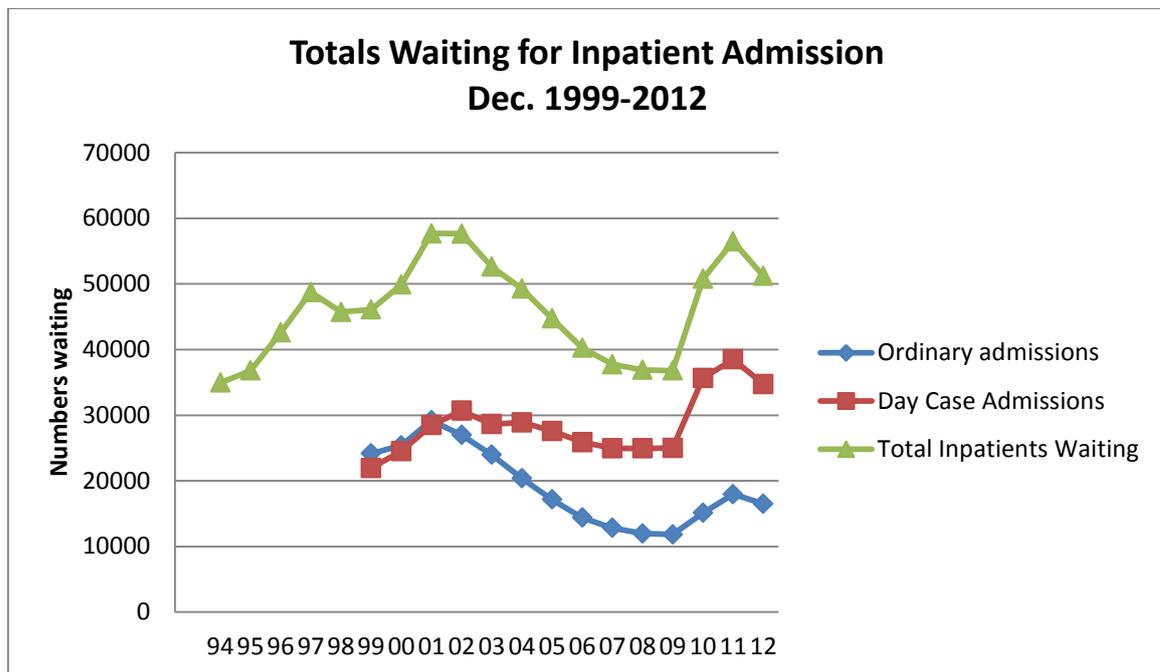
¹⁵ http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/waiting_times_main/stats-waiting-times.htm

¹⁶ McConaghy, R. and Thompson Dr J. (December 2002), Research and Library Services NI Assembly, Hospital Waiting Lists, Background Paper, December 2002

¹⁷ March data previously given to RaISe in preparation of a 2002 research paper

¹⁸ NI Waiting Time Statistics: Outpatient Waiting Times Quarter Ending June 2013, National Statistics, NISRA, DHSSPS, 29th August 2013, http://www.dhsspsni.gov.uk/ni_outpatient_waiting_list_bulletin_june_2013.pdf

Figure 2 Patients Waiting for both Ordinary and Day Case First Appointment in December Quarter from Dec. 1996 to Dec. 2012



Note: The most recent published figures are for the quarter ending June 2013, when 49,328 patients were waiting for inpatient admission to hospital across NI, including 17,039 for ordinary admission and 32,289 for day case admission.¹⁹

With regard to numbers waiting for inpatient admissions, the graph indicates that there was a relatively consistent increase from the start of the graph in 1994 to a peak around 2001/02. After which substantial gains were made over the next six to seven years, only for these gains to be lost over a period of two years (particularly in day case admissions). As with outpatient numbers waiting, there are now signs of improvement again.

In a recent Minister's Question Time, the Minister for HSSPS responding to a question from Ms P Bradley summarised the current situation as follows²⁰:

The number waiting for an outpatient appointment, for example, has been cut by 4,182 since June 2011, with excess waits reduced by 12,277. The number waiting for an inpatient admission is down by 7,361 compared with what it was in June 2011, with excess waits reduced by 5,936. However, I think it is very important that I state here today that we are not complacent. Things are going in the right direction, but there is considerably more work to be done. We have excellent people working in our health and social

¹⁹ NI Waiting Time Statistics: Outpatient Waiting Times Quarter Ending June 2013, National Statistics, NISRA, DHSSPS, 29th August 2013, http://www.dhsspsni.gov.uk/ni_inpatient_waiting_list_bulletin_june_2013.pdf

²⁰ Official Report (Hansard), Tuesday 12th November, 2013, Vol. 89 (4) Session 2013-2014

care trusts and our systems, turning things around very, very well. We need to keep the momentum going, build on the momentum and ensure that we can continue to reduce waiting times to a time in which people should reasonably expect to be seen, without having to have excessive waits.

Figures 1 and 2 show the recent positive direction that the Minister refers to, but also demonstrate that there is indeed more to be done to reduce WLs to at least reach the lowest numbers achieved in the past.

2.3 Historical Policies on Waiting Lists in Northern Ireland

In September 2000, the then Minister published *A Framework for Action on Waiting Lists* with an additional £5 million being allocated to the four HSS Boards to support its implementation to,

set in train a comprehensive 3-year programme of action to tackle waiting lists...a Framework for Action which set out for Boards and Trusts a challenging agenda of action on four fronts – improved planning; greater efficiency; better management; and some focused clinical action²¹.

The Framework set out how the Boards were to develop their action plans under four key areas as follows²²:

(i) Clinical Initiatives:

- Examine scope for expansion of primary care role;
- Develop referral protocols for GPs for specific services;
- Reduce inequalities in waiting times; and
- Disseminate good practice initiatives.

(ii) Management Action:

- Develop waiting list action plans;
- Submit quarterly returns to Department;
- Appoint manager with responsibility for waiting lists;
- Establish systems for close monitoring of activity and trends; and
- Improve information on service users.

(iii) Service Planning:

- Set targets for overall reductions;
- Set specific targets for reducing the numbers of long waiters;

²¹ <http://www.ni-executive.gov.uk/press/hss/001212c-hss.htm>

²² McConaghy, R. and Thompson Dr J. (December 2002), Research and Library Services NI Assembly, Hospital Waiting Lists, Background Paper, December 2002, page 20

- Set specific targets for cardiac surgery waiters;
- Target specific community care needs;
- Profile non-urgent elective work to maximise yearly throughput;
- Consider expansion in 'slot' systems; and
- Consider use of dedicated elective units.

(iv) Efficiency Measures:

- Validate waiting lists;
- Increase partnership/whole system working;
- Explore pooling of consultant waiting lists;
- Improve theatre efficiency;
- Improve efficiency of outpatient appointment systems; and
- Establish managed process for patient cancellations or DNAs.

In a presentation to the Committee (March 2002), the Department outlined the background to the problem of increasing WLs, which included the following issues²³:

- WLs for elective procedures had already been a problem in NI for a number of years prior to 2002 as cuts in resources in 1995/96 led to a 30% reduction in elective procedures that year. There was then a subsequent downward spiral, in spite of *substantial non-recurring* funds directed into elective surgery at that time;
- Over the 10 years leading up to 2002, bed capacity had decreased by 18%, while inpatient surgery has increased by 10%; and
- Delayed discharges and problems with staff recruitment and retention.

In the same presentation, the Department stated that the Framework for Action (2000) had failed to reduce the number of patients on the WL but had led to service improvements. Subsequently action on WLs remained a Departmental 'Priority for Action' in the years that followed, including finance for recurring initiatives.

By November 2009, the NI Assembly Public Accounts Committee (PAC) was commending the DHSSPS on the "*dramatic reduction in outpatient waiting times in 2006-2007 in comparison with those between 2000 and 2006*".²⁴ Figure 1 in this paper shows the reduction at that time from the peak of around 180,000 in 2005 to the lowest figure, of the last decade, of just below 69,000 in 2008.

The PAC identified that the success was in part due to the funding of additional treatments in the independent sector and "*warned of, and the DHSSPS acknowledged, the dangers of 'a quick-fix approach' since it fails to deliver a sustainable solution....*"²⁵.

²³ Minutes of Proceedings of the HSSPS Committee, Wednesday 13 March 2002

<http://www.ni-assembly.gov.uk/health/020313.htm>

²⁴ 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

²⁵ 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_hssc.htm Refe

In addition to this measure, the DHSSPS outlined to the PAC a range of measures it had put in place to change systems and ways of working to reduce WTs, including²⁶:

- Expenditure to use the independent sector to clear backlogs of patients [note: use of the private sector to tackle WLs is still ongoing];
- Tackling issues of staff recruitment and retention; and
- Clinicians and managers looking at how systems worked, changing ways of working, undertaking higher volumes of work and re-organising patient pathways, for example:
 - Ensuring patients of the same clinical priority are seen in strict chronological order;
 - Pooling of lists between consultants and additional evening/weekend sessions;
 - Partial booking to offer patients a choice of date and time;
 - Ensuring reasonable time allocations are given to new, non-urgent referrals; and
 - Introduction of Integrated Clinical Assessment and Treatment Services (ICATS).²⁷
 - *ICATS is the term used for a range of services for patients, which are provided by integrated multi-disciplinary teams of health service professionals, including GPs with special interest, specialist nurses and allied health professionals. They are provided in a variety of primary, community and secondary care settings and include assessment, treatment, diagnostic and advisory services.*²⁸

2.4 History of Waiting Time Targets in Northern Ireland

Tables 1 and 2 show the timeline of WT targets for a first outpatient appointment and for those waiting for inpatient admission (since 2008) and also if the targets were being met at certain specific dates.

²⁶ Thompson Dr J. and Egerton L. (April 2012), Research and Information Service, NIAR 820-11, NI Assembly, Northern Ireland Waiting Times, page 19

²⁷ ICATS provide annually around 100,000 assessment and treatment slots across the region. There were 8,031 patients waiting for a first ICATS Tier 2 appointment at the end of June 2013. This was 19.0% more than at the end of March 2013 and 5.1% more than at the end of June 2012²⁷ (WTs for ICATS are not considered further by this paper)

²⁸ NI Waiting Time Statistics: Outpatient Waiting Times Quarter Ending June 2013, National Statistics, NISRA, DHSSPS, 29th August 2013, page 13, http://www.dhsspsni.gov.uk/ni_inpatient_waiting_list_bulletin_june_2013.pdf

Table 1 Timeline of waiting time targets for first outpatient appointments in Northern Ireland

Ministerial Target for First Outpatient Appointment	Numbers Waiting More than target weeks	Numbers Waiting More than target weeks	Targets Key:	
			Met 	Not met 
By 31 st March 2008, no patient should be waiting more than 13 weeks	59 more than 13 weeks (31/03/08)		Target almost met at end March 08	
From April 2008, no patient should wait more than 13 weeks, reducing to 9 weeks by 31 st March 2009	5,831 more than 9 weeks (31/12/08)	239 more than 13 weeks (31/12/08)	9 week target not met at end Dec 08 13 week target almost met at end Dec 08	 
From April 2009, no patient should wait longer than 9 weeks for a first outpatient appointment	15,716 more than 9 weeks (31/12/09)	54,472 more than 9 weeks (31/12/10)	9 week target not met at end Dec 09 or at end Dec 10	
By 31 st March 2011, no patient should wait longer than 9 weeks	31,909 more than 9 weeks (31/03/11)		9 week target not met at end Dec 09	
From April 2011, at least 50% of patients should wait no longer than 9 weeks and no patient should wait longer than 21 weeks	59,378 (47.8%) more than 9 weeks (31/12/11)	24,492 (17.2%) more than 21 weeks (31/12/11)	9 week 50% target met ; 21 week target not met at end Dec 11	 
From April 2012, at least 50% of patients should wait no longer than 9 weeks and no patient should wait longer than 21 weeks, increasing to 60% by March 2013 and no patient waiting longer than 18 weeks	35,333 (33.3%) more than 9 weeks (31/12/12)	7,405 (6.9%) more than 21 weeks (31/12/12)	9 week 50% target met ; 21 week target not met at end Dec 12	 
From April 2013, at least 70% of patients should wait no longer than 9 weeks and no patient should wait longer than 18 weeks, increasing to 80% by March 2014 and no one waiting longer than 15 weeks	32,432 (19.8%) more than 9 weeks (30/06/13)	5,359 (4.7%) more than 18 weeks (30/06/13)	9 week 70% target met ; 18 week target not met at end June 13	 

Note: Up until the introduction of the less stringent 9 week target (“*from April 2011, at least 50% of patients should wait no longer than 9 weeks*”) the outpatient targets were not being met. Since the introduction of the 9 week ‘percentage-based’ target, the 9 week target has been met at the dates shown in the table and from April 2013 this has increased to 70%, which was also met. However, the follow-up 21 week target, introduced from April 2011 (now 18 weeks from April 2013) was not met at the dates shown in the table.

Table 2 Timeline of Waiting Time Targets for Inpatient Admission in Northern Ireland

Ministerial target for inpatient admission	Numbers Waiting More than target weeks	Numbers Waiting More than target weeks	Comment	
By 31 st March 2008, no patient should be waiting more than 21 weeks	56 more than 21 weeks (31/03/08)		21 week target almost met at end March 08	✗
From April 2008, no patient should wait more than 21 weeks, reducing to 13 weeks by 31 st March 2009	4,370 more than 13 weeks (31/12/08)		13 week target not met at end Dec 08	✗
From April 2009, no patient should wait longer than 13 weeks	6,010 more than 13 weeks (31/12/09)		13 week target not met at end Dec 09	✗
By 31 st March 2011, the majority of patients should wait no longer than 13 weeks, with no patient waiting longer than 36 weeks	17,630 more than 13 weeks (31/03/11)	1,261 more than 36 weeks (31/03/11)	13 week and 36 week targets not met at end March 11	✗
From April 2011, at least 50% of patients should wait no longer than 13 weeks and no patient should wait longer than 36 weeks	24,168 (42.8%) more than 13 weeks (31/12/11)	5,013 more than 36 weeks (31/12/11)	13 week 50% target met ; 36 week target not met at end Dec 11	✓ ✗
From April 2012, at least 50% of patients should wait no longer than 13 weeks and no patient should wait longer than 36 weeks, increasing to 60% by March 2013 and no patient waiting longer than 30 weeks	18,354 (35.8%) more than 13 weeks (31/12/12) 14,876 (31.2%) more than 13 weeks (31/03/13)	2,243 more than 36 weeks (31/12/12) 1,586 more than 30 weeks (31/03/13)	13 week 50% target met ; 36 week target not met at end Dec 12 13 week 60% target met ; 30 week target not met at end March 13	✓ ✗ ✓ ✗
From April 2013, at least 70% of patients should wait no longer than 13 weeks and no patient should wait longer than 30 weeks, increasing to 80% by March 2014 and no one waiting longer than 26 weeks	16,887 (34.2%) more than 13 weeks (30/06/13)	3,442 more than 30 weeks (30/06/13)	13 week 70% target not met ; 30 week target not met at end June 13	✗ ✗

Note: Up until the introduction of the less stringent 13 week target (“*from April 2011, at least 50% of patients should wait no longer than 13 weeks*”) the inpatient admission targets were not being met at the dates shown in the table. Since the introduction of the 13 week ‘percentage-based’ target, the 13 week target was being met at the dates shown in the table. From April 2013 this has increased to 70%, which was not met by end June 2013. However, the follow-up 36 week target (and from April 2012 – 30 weeks), to originally be met by March 2011 has not been met at the dates shown in the table.

2.5 Current Discussions

Both the 2008 Programme for Government and the DHSSPS Priorities for Action stated that “*Commissioners and providers should work towards a total patient journey time of*

25 weeks or less by March 2011".²⁹ The DHSSPS decided that this target should no longer be included "due to the impact of the global financial crisis on government funding".³⁰

In recent correspondence to RaISe, the DHSSPS suggested why the complete patient journey is not being measured:

*At present there is no means of linking information on patient's waits as they progress through their treatment pathway, given the disparate HSC reporting administrative systems ... To make the necessary changes would involve significant cost.*³¹

It could be argued that making an investment to record the total patient journey would provide the HSC management with the tools to make more informed and efficient decisions regarding tackling the WT issue and may well save money in the medium to long term and provide improved accountability.

That being said, recent statements made to the Committee indicate that the Department has given thought to the systems in place and to how patient waits are measured here:

- At a Committee evidence session on cancelled outpatient appointments, Mr Compton (HSC Board) indicated that looking at the systems has been a secondary concern to the demand and capacity work. He stated that³²:

We have focused all our energy and effort on understanding true demand and capacity and creating a new system for how we bring people forward to outpatients [Integrated Elective Access Protocol]. Following that, the point is that, when you do that and you get into a different place, you clearly have to look at the system that we have got, and there is a clear need to do that as a second order.

- Mr Beggs (MLA) of the HSSPS Committee responded, "Surely, to deliver the maximum output, you need to know the information so that you can manage the system".
- (It would appear that it is this latter approach that has driven reform of WT management in the other jurisdictions of the UK and further afield, for example, the SIGIC system in Portugal, where understanding the full patient journey has been viewed as key to solving the waiting time problem).
- At a second evidence session on cancelled hospital appointments, Mr Compton appeared to confirm that the total patient journey was important with regard to managing clinical efficiency³³:

²⁹ DHSSPS Priority for Action (2008) pages 9-10

³⁰ Black, Dr LA, RaISe Briefing Paper, NIAR 45-13, Cancelled Outpatient Appointments, Follow-up

³¹ DHSSPS correspondence to RaISe, 21/03/13

³² Committee for HSSPS, Official Report, Hansard, Appointments Cancelled by Hospitals: Health and Social Care Board/Health and Social Care Trusts Briefing, 6 February 2013, page 19

What we need to manage, with regard to clinical efficiency, starts with what the journey is for the patient, the individual – the journey time from when he or she first goes to the GP and is then seen at secondary-care level, if that is what is required, and if he or she has diagnostics. So, a journey time is needed. That is clinical efficiency, because it leads to better decision-making for the individual....The timeliness of the total journey is quite important as far as efficiency is concerned.

- At a recent Committee evidence session concerning the Commissioning Plan Direction for 2014, the Senior Finance Director of the DHSSPS indicated, in reply to Mr Roy Beggs, that the measurement of separate parts of the patient journey was a planned approach, although not where the Department wished to be³⁴:

The Acting Chairperson [Roy Beggs]: *Just generally. What is the patient experience of waiting times? Why do we cut waiting time up into separate blocks, rather than adopt the method that is used elsewhere?*

Ms Thompson [DHSSPS]: *The English standard is 18 weeks from start to finish, if I recall correctly. There is a shorter period for England in getting 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 do what you describe, which is to bring it all together. We are just not at that point yet, and, therefore, we focus on the individual elements of the journey effectively all the way through to ensure that no patient will get lost as they move through the process.*

3 Neighbouring Jurisdictions – Policies and Monitoring

3.1 England, Scotland and Wales

The move to Referral to Treatment (RTT) time targets elsewhere in the UK has been relatively recent, 2007 for England³⁵ and for Scotland; a National Plan was published in 2008 as to how the 18 week RTT would be met.³⁶ Prior to the RTT targets/standards data was collected on the separate outpatient and inpatient waits as is still done in NI.

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

³³ Committee for HSSPS, Official Report, Hansard, Appointments Cancelled by Hospitals: Health and Social Care Board/Health and Social Care Trusts Briefing, 6 February 2013, page 21

³⁴ 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

³⁵ Personal email communication from Paul Steele, GSI, Department of Health, 30/5/12

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

success story” and the policy history for England only is included below in some detail.³⁷

The main driver behind the RTT Standard is that, although it is a retrospective measure, it measures the **total journey time** of a patient from **referral to treatment**, whereas inpatient and outpatient waits measure separate parts of the wait. To measure RTT in NI would require the linking of patient records across hospital systems.³⁸ During the preparation of a previous paper for the Committee, the DHSSPS advised RalSe that it is not possible at present to measure the total patient journey time here, “*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*”.³⁹

3.1.1 England

Timeline of policies

In England, the drive for improvement in WTs started in 2000 when the NHS Plan was launched with the intention of injecting considerable funding into the NHS in exchange for an improvement in performance, particularly in relation to WTs.⁴⁰

There was concern that separate inpatient and outpatient targets had failed to address the real concern of patients of the *total time* taken to secure specialist treatment, especially as it ignored time taken for diagnostic tests and other activities between the first appointment and a decision to put the patient on a treatment waiting list. So, in 2004 the separate inpatient and outpatient targets were integrated into the single 18 week Referral to Treatment (RTT) target.⁴¹

By the time the final Public Service Agreement (PSA) targets were published in 2007, the pursuit of lower WTs had become embedded in the NHS culture and the 2007 ‘Comprehensive Spending Review’ reiterated the central performance of the 18 week RTT.

In March 2010, the NHS Constitution was updated to add new patient rights including:

³⁷ 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

³⁸ Personal email communication from a Departmental Official, GSI, Department of Health, 30/5/12

³⁹ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

⁴⁰ 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 304

⁴¹ As above, Chapter 16, page 304

- A new 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.⁴²

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 now can 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 (some waiting up to a year). These additional standards seek to overcome the problem of no incentive to treat patients once they are still waiting past 18 weeks.⁴³

Those 'long waiters' had arisen as NHS managers focused on meeting the 90% RTT target and those waiting past 18 weeks being forgotten once the target was met.⁴⁴ Hospitals in England now need 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.

A previous RaISe paper gave further details on how the RTT rules and RTT 'clock' 'starts' and 'stops' actually work in practice.⁴⁵

The use of targets 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 success.⁴⁶

⁴² Handbook to the NHS Constitution , Overview, page 10, <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

⁴³ 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

⁴⁴ Thompson Dr J. and Egerton L. (April 2012), Research and Information Service, NIAR 820-11, NI Assembly, Northern Ireland Waiting Times, page 6

⁴⁵ Thompson, Dr J. (July 2012) Research and Information Service, NI Assembly, NIAR 369-12, Waiting Times – Supplementary Briefing, section 3.4

⁴⁶ 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

NB: It has been proposed that the most striking innovation of the English experience was the introduction very strong managerial incentives, which some commentators characterised as ‘targets and terror’. The 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.⁴⁷

Responsibility for Implementation

Local Clinical Commissioning Groups (CCGs) in England are responsible for the implementation of this patient right - meaning that if the 18 weeks cannot be met by the provider to which the patient was referred, the CCG (or the NHS Commissioning Board) must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers.⁴⁸

The patient must contact either the provider they been referred to or the local CCG before alternatives can be investigated. The right to start treatment within 18 weeks from referral includes treatments where a consultant retains overall clinical responsibility for the service or team, or for the treatment.⁴⁹ The right, however, ceases to apply in certain defined circumstances, for example, if delaying the start of treatment is in the best clinical interests of the patient, for example where smoking cessation or weight management is likely to improve the outcome of the treatment.⁵⁰

Meeting the targets

Recent statistics show that the targets are being met in England - during August 2013. In relation to the retrospective RTT measurement - 92.2% of admitted patients (target 90%) and 97.2% (target 95%) of non-admitted patients started treatment within 18 weeks. The average (median) time waited for patients having completed an RTT pathway in August 2013 was 8.6 weeks for admitted patients and 5.2 weeks for non-admitted patients.

For patients waiting to start treatment (incomplete pathways) at the end of August 2013, 94.2% (target 92%) were waiting within 18 weeks. For these patients waiting to start treatment the median waiting time was 6.2 weeks.⁵¹

⁴⁷ 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

⁴⁸ Extracted from *Handbook to the NHS Constitution*, page 27, <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

⁴⁹ Extracted from *Handbook to the NHS Constitution*, page 27, <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

⁵⁰ Extracted from *Handbook to the NHS Constitution*, page 28, <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf>

⁵¹ <http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/10/Aug-13-RTT-Stats-PN.pdf>

3.1.2 Scotland

In Scotland, the current HEAT⁵² 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 June 2013, 91.6% of patient journeys for which an 18 Weeks RTT waiting time could be measured were reported as being seen within 18 weeks.⁵³ The percentage of outpatients waiting longer than 12 weeks on 30 June 2013 was 3.0% (7,232 out of 239,304 patients). This has increased from 2.5% on 31 March 2013, but has decreased from 3.1% on 30 June 2012.⁵⁴

It would seem that the 18 week target for RTT is being met, but the 12 week outpatient target is not quite met for those patient journeys that can be measured.

In addition, NHS Boards are 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 2012.⁵⁵ 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 per cent 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.⁵⁶

A previous RaISe paper gave further details on how the RTT rules and RTT 'clock' 'starts' and 'stops' actually work in practice for Scotland.⁵⁷

⁵² 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: **Health Improvement** for the people of Scotland - improving life expectancy and healthy life expectancy; **Efficiency and Governance Improvements** - continually improve the efficiency and effectiveness of the NHS; **Access to Services** - recognising patients' need for quicker and easier use of NHS services; and **Treatment Appropriate to Individuals** - ensure patients receive high quality services that meet their needs.

⁵³ The Scottish Government, HEAT Standards, 18 weeks referral to treatment, <http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/18weeksRTTStandard>

⁵⁴ The Scottish Government HEAT Standards, 12 weeks outpatients, <http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/12weeksStandard>

⁵⁵ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

⁵⁶ The Scottish Government, HEAT Standards, 18 weeks referral to treatment, <http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/18weeksRTTStandard>

⁵⁷ Thompson, Dr J. (July 2012) Research and Information Service, NI Assembly, NIAR 369-12, Waiting Times – Supplementary Briefing, section 3.4

3.1.3 Wales

In Wales, the targets are less ambitious than those for England and Scotland. In the NHS Wales Delivery Framework for 2013-14, the target relating to RTT is⁵⁸:

- 95 per cent of patients waiting less than 26 weeks from referral to treatment; and
- 100 per cent of patients (not treated within 26 weeks) treated within a maximum of 36 weeks.

These targets are assessed using figures for patients waiting to start treatment at the end of the month.

The latest provisional statistics on referral to treatment times produced by the Welsh Government relate to July 2013 - by the end of July, a total of 416,498 patients were waiting for the start of their treatment. Of those patients, 90.1% had been waiting less than 26 weeks and 97.3 per cent had been waiting less than 36 weeks from the date the referral letter was received in the hospital. The targets appear close to being met.

A total of 91,382 patients were treated during July. Of those patients, 83.0% were treated within 26 weeks and 94.4% were treated within 36 weeks of the date the referral letter was received in the hospital.⁵⁹

3.2 Republic of Ireland – Special Delivery Unit

From July 2005, the National Treatment Purchase Fund (NTPF) has been responsible for the collection, collation and publication of inpatient and day case waiting lists' through the Patient Treatment Register, for 42 public hospitals in the Republic of Ireland.⁶⁰ All public hospitals have the responsibility to ensure they meet the maximum WT guarantees for their patients. The current guarantees are⁶¹:

The maximum waiting time target for a first out-patient appointment is:

- < 12 months for a first time outpatient appointment by 30 November 2013.

For patients requiring admission to hospital these are:

- No adult patient should wait more than 8 months for inpatient or day case treatment before the end of 2013; and
- Maintaining a 20 week maximum wait time target for paediatrics.

⁵⁸ NHS Wales Referral to Treatment Times, July 2013, SDR 151/2013, <http://wales.gov.uk/docs/statistics/2013/130912-referral-treatment-times-july-2013-en.pdf>

⁵⁹ Referral to Treatment Times, July 2013, Wales, <http://wales.gov.uk/topics/statistics/headlines/health2013/referral-treatment-times-july-2013/?lang=en>

⁶⁰ NTPF, National Waiting List Data, www.ntpf.ie/home/nwld.htm

⁶¹ NTPF, About the NTPF, www.ntpf.ie/home/about.htm

Tables 3 and 4 are directly extracted from the NTPF website and show the number of new patients waiting for an outpatient appointment and the number of patients waiting for admission to hospital in August 2013.⁶²

Table 3 Total number of new patients waiting for outpatient attendance nationally August 2013 – Republic of Ireland

Period	0-3 months	3-6 months	6-12 months	12-24 months	24-36 months	36-48 months	48+ months	Total
30.08.13	138,922	78,809	72,206	55,422	20,501	6008	2236	374,109

Table 4 Number of patients waiting for admission nationally August 2013 – Republic of Ireland

Period	0-3 months	3-6 months	6-8 months	8-12 months	12+ months	Total
29.08.13	30,408	15,755	5820	5661	1005	58,649

In June 2011, the Minister for Health in the Republic of Ireland (RoI), Dr James Reilly TD, set up the Special Delivery Unit (SDU) in the Department of Health. The SDU was tasked with implementing performance improvement in hospitals involving emergency departments, inpatient and day case waiting lists and outpatient waiting lists. On 1st January 2013, the SDU transferred operationally to the Health Service Executive but retains its separate identity.⁶³

Prior to the establishment of the SDU, the history of policies to tackle WLs in the RoI includes the **Waiting List Initiative (WLI)** (1993-2003)⁶⁴ and the **National Treatment Purchase Fund (NTPF)**, introduced in 2001.⁶⁵

The **WLI** was intended as a short term initiative and additional funding was allocated between 1994 and 1998 for WL management; bed management; increased productivity using existing capacity (e.g. overtime), funding temporary consultant posts and purchasing external capacity in private sector. Despite these measures the WL continued an upward trend.

The **NTPF** was then introduced by the 2001 Health Strategy which set a series of graduated improvements for the commencement of treatment following referral from

⁶² Special Delivery Unit/NTPF, *Unscheduled Care/Scheduled Care Access, August Performance Report*, page 5
http://www.ntpf.ie/home/PDF/SDU_Access%20Performance%20Report.pdf

⁶³ Special Delivery Unit, Department of Health Ireland, www.dohc.ie/about_us/divisions/special_delivery_unit

⁶⁴ 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 8, page 153

⁶⁵ Chapter 8, page 158

outpatients and by the end of 2004 no public patient was to wait longer than three months.

The NTPF focused on long-waiters and purchased treatment for them primarily in the private sector in the ROI, NI, England, Scotland or Wales. Any NTPF work done in public hospitals had to be extra to core activity. Patients could be referred to the NTPF by their GP, hospital or consultant once they had waited for three months.

4 Waiting Time Policies – Evidence from the 2013 OECD Study

This section of the paper focuses on key evidence identified by the 2013 OECD Study entitled *Waiting Time Policies in the Health Sector, What Works?*⁶⁶

The OECD Study draws on 13 detailed country case studies to provide a framework for understanding the role and measuring of WTs in health systems (Sections 4.1 and 4.2 below) and to highlight the most common policies in use (Section 4.3 below). The Study highlights the “*policy success story*” of the English NHS in tackling WTs⁶⁷ and this has been covered earlier in this paper in Section 3.1. It also highlights Portugal’s success in recent years at tackling WTs (Section 4.4.1).

In addition, this paper further briefly covers selected examples of successful policies in Finland and Denmark, as highlighted by the OECD Study (Section 4.4). The health care systems of Finland and Denmark are both decentralised public systems with universal coverage and based on tax financing.

4.1 Understanding Waiting Times

Chapter 1 of the OECD Study provides a framework for understanding the role of WTs in health systems. The key insights are⁶⁸:

- *Hospital Efficiency* – there is a role for *some* degree of WT to ensure healthcare facilities are being used to full capacity;
- *Supply Issues* - WTs are not solely an issue of supply of surgical services (for example adequate numbers of beds, medical staff etc.). The demand for elective surgery is surgeon-managed and variations between doctors can be minimised by using agreed practice guidelines and prioritisation tools;
- *Use of WT Guarantee* – An increased focus on WTs usually leads to an overall reduction in the mean waiting time, including that for long waiters;
- *Expenditure* – high expenditure is not a guarantee of low WTs as several countries’ such as Norway and Denmark, spend above the OECD average on health care still report WTs as a significant policy issue;

⁶⁶ Siciliani, L., Borowitz, M. and Moran, V. (eds) (2013), *Waiting Time Policies in the Health Sector, What Works*, OECD Health Policy Study, OECD Publishing

⁶⁷ As above, Chapter 16, page 298

⁶⁸ As above, Chapter 1, pages 20 - 31

- *Inequality of WTs* –it is known that patients with higher socioeconomic status often experience lower WTs. They may engage more actively with the health care system and exert pressure when they experience long delays. They also have a lower probability of missing appointments.

4.2 Measuring Waiting Times Across OECD Countries

Chapter 2 of the OECD study gives an overview of different measures of waiting and some particular issues highlighted by the OECD Study are⁶⁹:

- The importance of measuring the actual WT of patients as the duration of the wait is important;
- A key issue for patients is the time waited and not necessarily the numbers waiting on the list;
- OECD countries presently measure WTs starting at various points in a patient's journey. However, countries are moving towards measuring Referral to Treatment (RTT) as that measurement captures WT across the entire patient journey; and
- The importance of other statistics, for example, the mean (average) WT and the median (middle) WT; the distribution including WTs at highest percentiles (e.g. 80th or 90th) or the proportion of patients with long waits above certain times.

4.3 Overview of Policy Tools

This section provides a brief overview of the most common policy tools used to tackle WTs across OECD countries⁷⁰.

4.3.1 Waiting Time Guarantees⁷¹

The most common policy tool used is to establish a 'WT Guarantee' i.e. no patient should wait more than a pre-determined time for treatment. The *enforcement* of the WT Guarantee is highlighted as 'critical' as without enforcement it may be difficult for patients to exercise their rights. The OECD Study has revealed that WT Guarantees are most successful when linked to targets with sanctions and when patients are allowed to choose alternative providers if the maximum wait is breached. For example:

- *England* - Targets with penalties were introduced in the period 2000-2005 with strong political oversight from the Prime Minister and in recent years there have been moves towards greater choice as a means of enforcing the WT Guarantee⁷²;

⁶⁹ 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

⁷⁰ As above, Chapter 3, pages 49-68

⁷¹ As above, Chapter 3, page 55

⁷² As above Chapter 3, page 55, 57

- *Finland* – A legal Health Care Guarantee in the Finnish Health Care Act 2010 – the National Supervisory Agency (Valvira) had the authority to financially penalise municipalities that failed to comply; and
- *Portugal* - when a patient on the WL reaches 75% of the maximum WT for surgery, guaranteed by law, a voucher is issued allowing the patient to demand treatment elsewhere, including in the private sector.⁷³

4.3.2 Choice of Provider⁷⁴

A free choice of hospitals is one of the characteristics of health systems with low WTs. In Denmark, for example, patients can choose a hospital in or outside Denmark provided that the Association of Danish Regions has an agreement in place with the hospital. England is also now moving towards a greater choice of provider as a way of enforcing the WT Guarantee.

4.3.3 Supply-Side Policies⁷⁵

Such policies are characterised by ‘bursts’ of targeted funding to bring down WTs. However, the funding tends to be insufficient to raise capacity significantly. For example, Portugal followed such policies for two decades before introducing a new approach to tackle its waiting lists (see Section 4.4.1).⁷⁶ Activity Based Funding (ABF) is another example of such a policy. An ABF system (as used in the Netherlands), pays hospitals a price for each additional patient treated and encourages increased productivity.

4.3.4 Demand-Side Policies⁷⁷

These include (i) shifting demand to private providers by encouraging private health insurance (as was encouraged in Australia but was not successful as those insured continued to use public hospitals because of, for example, high co-payments in private hospitals), and (ii) Use of clinical thresholds below which patients are not entitled to publicly-funded surgery - New Zealand has been at the forefront of such policies.

4.4 The Policies of Portugal, Finland and Denmark

4.4.1 Portugal

The OECD Study highlights Portugal’s success in reducing its elective WL due to the introduction in 2004 of a system called SIGIC⁷⁸ – an integrated management system

⁷³ As above, Chapter 13, pages 248

⁷⁴ As above, Chapter 3, page 57

⁷⁵ As above, Chapter 3, pages 59-64

⁷⁶ Acronym which translates as ‘Integrated System of Management of the Waiting List for Surgery’

⁷⁷ 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 3, pages 64-66

⁷⁸ Acronym which translates as ‘Integrated System of Management of the Waiting List for Surgery’

for the surgery waiting list. Over the last 18' years policy interventions aimed at WLs were implemented, including extra funding to increase activity levels and improving management and organisation associated with target WTs. However, it was not until the introduction of SIGIC that WTs substantially decreased.

Similar to the UK, Portugal has an NHS (established in 1979) funded mainly through taxation, with the private sector remaining a significant provider of certain health care services. All doctors in Portugal are government employees with fixed salaries and specialists often add to their income with private sector work.

*“The SIGIC now manages all [Portuguese] NHS patients requiring surgical treatment and involves all public healthcare providers with surgical services and 60 private healthcare providers with agreements for surgical treatment within the NHS”.*⁷⁹

In 2005, the median WT for elective surgery was 8.6 months and by 2011 it had reduced to 3.2 months. Due to its success the key points are included here with all information extracted from Chapter 13 of the OECD Study:⁸⁰

- At the heart of SIGIC is an IT system for managing WLs and WTs;
 - The information system integrates information from both public and private providers;
 - It registers the movement of patients between providers; and
 - It allows each patient on the list to know their current position on the list and the expected date for intervention; and
- Under SIGIC when a patient on the waiting list reaches 75% of the maximum waiting time for surgery guaranteed by law, a voucher is produced allowing the patient to demand treatment elsewhere, including in the private sector - hospitals do not wish to see patients transferred because they have already incurred costs with that patient and will lose a percentage of their financing;
- For elective surgery current WT targets are defined in law under three pathology groups (general, cancer and obesity) with four sub-groups depending on assessed urgency (normal, priority, high priority and urgent);⁸¹

The introduction of SIGIC has been associated with a 40% increase in surgical procedures in five years due to improved in-house efficiency; increased capacity outside regular hours (with surgical teams paid per extra procedure), and increased capacity by using private hospitals to absorb surgeries for which the public hospitals were unable to perform in time.

⁷⁹ 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 13, page 245

⁸⁰ As above Chapter 13, pages 237 - 261

⁸¹ As above Chapter 3, page 249

4.4.2 Finland and Denmark

The health system in Finland is one of the most decentralised in the OECD and is characterised by universal coverage and financed mainly through general taxation (both the state and the municipalities have the right to levy taxes).

The main WT policy is its 'WT Guarantee', incorporated into law in the 2011 Finnish Health Care Act. With regard to non-emergency hospital admission for elective care the guarantee includes⁸²:

- A patient will be assessed within three weeks of the referral from the GP;
- Treatment shall begin within six months from referral, based on the urgency; and
- By 2014 there is to be freedom for patients to choose (in collaboration with their doctor) any health care unit in the country that provides the required treatment.

The Health Care Guarantee WTs represent the minimum performance expected.

Non-compliance is dealt with by Valvira (National Supervisory Authority for Welfare and Health), which issues orders for improvement and can issue fines.⁸³

The Danish health care system is a decentralised public system based on tax financing and universal coverage. 'Danmark' a widespread private health insurance complements the Public Health Security Scheme with the main objective of reimbursing patients' co-payments (for example for pharmaceuticals, medical aids, physiotherapy etc.).⁸⁴

In Denmark, the current set of WT policies include⁸⁵:

- A WT Guarantee (but not legally binding and no penalties for providers) of four weeks from RTT (independent of disease type or severity); and
- To improve performance by hospitals in working towards the guarantee, an extended 'free choice' between public and private hospital was introduced in 2002. (The hospital chosen can be outside Denmark provided that an agreement exists between the Association of Danish Regions and the hospital/clinic);
- Activity-Based Finance (ABF) – ABF has gradually increased to around 50% of total budget – this is thought to balance incentives for increased activity in a way that is intended to control overall expenditure while increasing productivity and it facilitates patients' free choice of hospital;
- Increased activity in private sector hospitals as part of the 'extended free choice' (private hospitals still perform only a small part of total activity); and
- Two concepts are used in monitoring WTs⁸⁶:

⁸² 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 7, page 139

⁸³ As above, Chapter 7, page 141

⁸⁴ As above, Chapter 6, page 116

⁸⁵ As above, Chapter 6, page 115 - 129

⁸⁶ As above, Chapter 6, page 119

- ‘Expected’ WT – this is a measure of how long a new patient with uncomplicated problems can expect to wait from time of referral to being seen at hospital. Hospital wards routinely report ‘expected’ WTs to a central database and patients can view this database; and
- ‘Experienced’ WT – time elapsed from date of referral to actual start of treatment.

5 Concluding Comments

In NI the complete journey time from GP referral to start of treatment is not measured - once a referral has been made for a first out-patient appointment the WT ‘clock’ starts, then stops once they have been seen. A separate WT ‘clock’ starts if a patient requires inpatient treatment as an ordinary admission or a day case patient, or if they require a diagnostic test. Review appointments have no targets assigned to them and no waits for these are measured.⁸⁷ There is no way to 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 linked to give a full patient journey time.

The various measures taken over the years in NI to tackle WTs are in the categories of clinical initiatives, management action, service planning, efficiency measures and funding additional treatments, both in-house (for example weekend clinics) and in the private sector. It may be useful to ascertain the success or otherwise of the various methods employed and which, apart from the funding of additional treatments in the private sector, are still being used and what evaluations have been done.

In November 2009, the NI Assembly Public Accounts Committee (PAC) commended the DHSSPS on the “*dramatic reduction in outpatient waiting times in 2006-2007 in comparison with those between 2000 and 2006*”.⁸⁸ Both the PAC and the DHSSPS acknowledged that the success in tackling waiting times was in part due to the funding of additional treatments in the independent sector.

The use of the private sector remains a key part of the HSC Board’s plans. At a recent evidence session to the Committee, Mr Compton (HSC Board) acknowledged that in, for example, orthopaedics the demand and capacity problems could not be fixed “*in anything under 36 to 48 months*” and therefore the HSC Board wished to move to longer term contracts with chosen independent providers.⁸⁹

A recent OECD Study highlighted considerable variation across OECD countries with regard to the policies in place to tackle WTs and WLs but concluded that there are some clear common themes:

⁸⁷ Committee for HSSPS, Official Report, Hansard, Cancelled Hospital Appointments: Health and Social Care Board/Health and Social Care Trusts Briefing, 1 May 2013

⁸⁸ 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

⁸⁹ Committee for HSSPS, Official Report, Hansard, Cancelled Hospital Appointments: Health and Social Care Board/Health and Social Care Trusts Briefing, 1 May 2013, page 13

- The ‘WT Guarantees’⁹⁰ has become the most common policy tool across OECD countries to tackle long WTs but these are only truly effective if enforced by one of two means:
 - Setting targets and holding healthcare providers to account for achieving the targets, for example - the ‘targets and terror’ approach in England (Section 3.1.1); and
 - Offering choice of alternative health providers, including the private sector, to ensure the targets are met, for example, the voucher system in Portugal (see Section 4.4.1);
- The emerging best practice is to measure the entire patient journey from referral to treatment (RTT), for example, as discussed in Section 3.1 for the England.
- Extra ‘bursts’ of funding to decrease WTs, are not alone successful over the long term, for example, the WLI in the Rol (Section 3.2). Such policies can bring short-term improvements, potentially allowing other policies time to work.

In NI, HSC Trusts are expected to deliver the activity for which they are funded. If this activity is not delivered, the HSC Board reserves the right to withdraw funding to reflect the underperformance (not considered as fines). The management of WTs is done as part of a regular monitoring framework, involving senior HSC Board and Trust representatives.⁹¹ Mr Compton of the HSC Board confirmed in a recent evidence session to the Committee that this withdrawal of funding from a Trust has not yet been invoked, but “*we have required trusts to give us a detailed explanation of how they will reinstate the activity on which they have fallen behind*”.⁹²

Overall it does not appear that NI has perhaps tackled WTs in as determined a manner or had the same success as the other jurisdictions of the UK and other countries. At present NI does not use the RTT measurement and does not hold health care providers to account for not achieving WT targets with the same rigour as, for example, has been described for England.

It may be useful to further investigate the outcome of the various methods used in NI over the years to tackle WTs and WLs and also the rationale behind the statistical approach used compared to those used elsewhere. England, in particular, has been highlighted by the OECD study for the firm approach taken to the targets, including financial penalties (see Section 3.1.1).

As stated earlier in the paper, the Minister for HSSPS believes that the direction of travel for waiting times is good but that more remains to be done and that there is a need “*to keep the momentum going, build on the momentum and ensure that we can continue to reduce waiting times to a time in which people should reasonably expect to*

⁹⁰ ‘WT Guarantees’ mean that no patient in need of care should wait more than a pre-determined maximum time for that care

⁹¹ Black, Dr LA and Love, B (April 2013), RalSe, NIAR 281-13, Supplementary: Cancelled appointments (paper 3)

⁹² Committee for HSSPS, Official Report, Hansard, Cancelled Hospital Appointments: Health and Social Care Board/Health and Social Care Trusts Briefing, 1 May 2013, page 10

*be seen, without having to have excessive waits”.*⁹³ It could be argued that making an investment to be able to link the separate parts of the pathway and capture the total patient journey time, would substantially assist in sustaining the momentum and provide the HSC management with the tools to make more informed and efficient decisions regarding tackling the WT issue.

⁹³ Official Report (Hansard), Tuesday 12th November, 2013, Vol. 89 (4) Session 2013-2014