Committee for Health, Social Services & Public Safety

Review of Waiting Times Report

Committee powers and membership

The Committee for Health, Social Services and Public Safety is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of the Belfast Agreement, section 29 of the Northern Ireland Act 1998 and under Standing Order 46. The Committee has power to:

- Consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- Consider relevant secondary legislation and take the Committee stage of primary legislation;
- Call for persons and papers;
- Initiate inquiries and make reports; and
- Consider and advise on any matters brought to the Committee by the Minister for Health, Social Services and Public Safety.

Membership

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The current membership of the Committee is as follows:

Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells MLA (Deputy Chairperson)
Mr Roy Beggs MLA
Mr Mickey Brady MLA
Ms Pam Cameron MLA
Mrs Joanne Dobson MLA
Mr Gordon Dunne MLA
Mr Kieran McCarthy MLA
Ms David McIlveen MLA
Mr Fearghal McKinney MLA

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Background to the Review

1. Long waiting times for elective care has been an issue of concern for the public, the Department of Health, Social Services and Public Safety, and Assembly committees for more than a decade. In October 2013, the Committee for Health, Social Services and Public Safety agreed that the subject of waiting times for elective care would be one of its strategic priorities for the 2013/2014 Assembly session.

2. The statistics show that the total number of people waiting for elective care has substantially increased since the mid 1990s. Improvements were made in the mid - 2000s, however, the majority of these gains were lost within a couple of years.

3. Since the start of the Assembly mandate in 2011, the Department has submitted bids at nearly every monitoring round for money to reduce the waiting times for elective care. Some of this money is to pay for more in-house provision, while some is used to pay private sector providers to treat health service patients. A significant number of the bids have been met since 2011, indicating that reducing waiting times is of major importance to both the Department, and the Executive.

4. Given this context, the Committee believed that it would be timely and relevant to carry out a review of the Department's approach to managing waiting times for elective care.

Terms of Reference

5. The Committee agreed the following terms of reference:

   "To assess the effectiveness of the Department's current approach to reducing waiting times for elective care, and to identify effective approaches to reducing waiting times which have been used in other countries/regions which could be applied in Northern Ireland".

Committee Consideration

6. The Committee held 5 evidence sessions with a range of expert witnesses who provided information on approaches to tackling waiting times in various countries and regions. The Committee heard from:

   - Professor Charles Normand on approaches taken in the Republic of Ireland;
   - Dr Rob Findlay on the approaches taken in England;
   - Professor Luigi Siciliani on approaches taken across a range of Organisation for Economic Co-operation and Development (OECD) countries;
   - Mr Mike Lyon on the approach taken by the Scottish Government; and
   - Mr Pedro Gomes on the approach taken by the Portuguese Government.

7. The minutes of evidence of these sessions are at Appendix 1, and the presentations and notes provided by the expert witnesses are at Appendix 2.

8. The Committee also held an evidence session with Departmental officials on Wednesday 4 June 2014 (see Appendix 1) and considered written correspondence from the Department (see Appendix 3).

9. The Committee considered two papers from Assembly Research and Information Service entitled ‘Waiting Times for Elective Care’ and ‘Waiting Times - Supplementary ‘Issues’ Briefing on the 18 Week RTT Policy in England and Scotland’. These can be found at Appendix 4.

List of Recommendations

10. **The Committee recommends that the Department introduces a system to measure Referral to Treatment (RTT) times for elective care and sets corresponding targets for RTT times.**

11. **The Committee recommends that the introduction of Referral to Treatment targets is accompanied by new arrangements for managing the performance of the Trusts against these targets. The new arrangements should be determined by the Department. They should be centred around strong Departmental leadership and should clearly identify where accountability for enforcing the Trusts' compliance against targets lies.**

12. **The Committee recommends that the introduction of Referral to Treatment targets is accompanied by a clearly defined policy on how compliance against targets will be enforced. This policy should be set by the Department. In setting the policy, the Department should consider utilising both sanctions and incentives, and directing any such sanctions and incentives at a level which will encourage more personal accountability for compliance against targets.**

13. **The Committee recommends that the Department produces an action plan detailing how it will decrease spend on private sector elective care over the next 3-5 year period by making better use of in-house health service based solutions. The action plan should include projected costs for spend on private sector elective care for the next 3-5 years; proposals to develop capacity within the health service sector to better match supply against demand on a long-term basis; proposals to ensure that any private sector contracts required demonstrate value for money; and a timetable setting out the key milestones in the process.**

14. **The Committee recommends that the Department develops policies which pro-actively mitigate against the potential conflicts of interests which exist for doctors who carry out private work as well as working in the health service. In order to understand these potential conflicts of interests more fully, the Department should ask the Patient Client Council to carry out research which examines the extent to which health service patients are advised about the option of paying for treatment in the private sector.**

Discussion of Key Issues

Referral to Treatment (RTT) targets

15. At present, the Department does not operate Referral to Treatment (RTT) targets, whereby the complete journey time from GP referral to start of treatment is measured and a target set for this journey time. Rather, the Department measures separate parts of the patient's journey, such as the waiting time for a first outpatient appointment, the waiting time for a diagnostic test, and the waiting time for inpatient admission. However, these parts of the journey are not linked up, and the waiting time for a review appointment is simply not measured at all. This means there is no way to measure the time it takes for patients to be referred by their GP to when they begin definitive treatment.

16. The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014 set out the standards and targets which the Department expects to be met through the Commissioning Plan for 2014/2015. There are a number of waiting time targets associated with elective care:
    - From April 2014, at least 80% of patients wait no longer than 9 weeks for their first outpatient appointment and no patient waits longer than 15 weeks.
    - From April 2014, no patient waits longer than 9 weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.
    - From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

17. Evidence taken during the course of the Committee's review identified a number of problems with these styles of stage of treatment targets currently being applied in Northern Ireland.

18. Dr Findlay argued that in relation to first outpatient appointment targets, setting a percentage of patients who must be seen within 9 weeks, can actually create

a perverse incentive for managers not to treat people who have already been waiting over the 9 week target. In relation to the new target for 2014, his point would be that what the target is actually saying is that out of 10 patients a consultant sees, at least 8 must be short-waiters and no more than 2 must be long-waiters. Therefore, consultants pick patients from the waiting list in a 8:2 ratio. This means that there is limited capacity available to treat the long-waiters, so it pushes their waiting time up.

19. Dr Findlay suggested that this was part of the reason why the Department was not meeting its target for the maximum waiting time a patient should wait for a first outpatient appointment, which is 15 weeks from April 2014, but was 18 weeks at the time Dr Findlay gave evidence to the Committee.

20. Another major problem with stage of treatment targets is that certain parts of the journey are not measured – such as the time spent waiting for a review appointment. This in turn can create perverse incentives for managers to delay patients at those very stages. Dr Findlay stated:
"The potential perverse incentive is this: imagine that you are a manager in a hospital again, and you have a very large waiting list for surgery. You cannot keep up with the demand for surgery. You want to try to slow the number of patients who are arriving on your inpatient waiting list. I am not saying that this is happening in Northern Ireland — I do not know, because I have not seen the data — but there is the potential to delay patients at this diagnostic and follow-up outpatient stage where they are not tracked by a stage-of-treatment target. That is a potential difficulty with the stage-of-treatment regime" (Appendix 1).

21. The general opinion from the experts who gave evidence to the Committee was that Referral to Treatment targets were a good idea. They reflect the patient's experience in terms of their journey, and give patients a clear sense of how long they should expect to be waiting to receive definitive treatment for their condition. Mr Gomes from the Portuguese government commented on the desirability of introducing RTT targets in Portugal:

"From the point of view of the patient, it would be better, without a doubt, because what matters to the patient is that he has a problem and the time begins to count when the problem surges. If possible, the ideal is to measure the time between going to the general practitioner and then from the general practitioner to the hospital and so on until the problem is solved" (Appendix 1).

22. Mr Lyon from the Scottish government explained that one of the reasons RTT targets had been introduced in Scotland was because medical personnel could see the advantage:
"It was clinically popular. Clinicians recognised the idea of a pathway of referral to treatment. It instinctively felt right in the sense that it was what the patient experienced" (Appendix 1).

23. However, the Committee learned that RTT targets are a relatively new approach to managing waiting times and are only operating in a small number of European countries at present – England, Scotland and Denmark. Professor Siciliani made this point:
"Some countries have moved in the direction of measuring the referral-to-treatment time (RTT), but it is still early days. England and Denmark use referral-to-treatment time, but we do not have too many countries from which to draw experience and judge whether it has worked well" (Appendix 1).

24. Portugal is not currently using RTT targets but is aiming to move in that direction. Mr Gomes from the Portuguese government advised:
"We have two different systems, and we are trying to integrate them. That is the future. . . What we are trying to do is to monitor the three time periods: between referral and first consultation at the hospital; between first consultation at the hospital and inscription in the list; and the last one is between inscription and treatment" (Appendix 1).

25. One of the reasons why only a limited number of countries are using the RTT system may be because of the resources needed –in terms of information systems, finance and staff to operate the system.

26. Dr Findlay advised the Committee that putting in place systems to measure RTT targets is a complex process. There is a requirement to be able to measure how long patients who have been treated waited, while at the same time being able to measure how long patients who are still on the list have been waiting. This type of system takes time to develop. He explained: *"However, it is correct to say that RTT is more difficult to measure . . . If you are trying to capture all of the patients who are still waiting, you have to measure their waiting time since referral, at every stage in their journey: when they are waiting for outpatients, when they are waiting for diagnostics, when they are waiting for follow-up outpatients and when they are waiting for surgery. That might be two, three, four or five different IT systems, and it might include some paper-based waiting list management systems in the hospital, and you need to capture the data for every one of those. That is a big challenge. So, if you propose to implement referral-to-treatment waiting time targets — which, I think, would be a good idea — you should be advised that it is likely to take some years before you can implement them with good coverage in practice, and that during the transition period, it would be a good idea to retain the stage-of-treatment waiting time monitoring and targeting while the new system phases in" (Appendix 1).*

27. Professor Siciliani made a similar point:
"From the English experience, I observe that some complications arise from using the referral-to-treatment measure. You need to report at least three different types of measurement. Normally, in England, you have the admitted pathway and the non-admitted pathway, and the number of patients on the waiting list and the number who have been treated. That leads us on to the measurement issue. There are two main ways to measure waiting times: take a snapshot of the number of patients on the list and check how long they have been waiting; or check the total number of patients treated in, say, a given month, and find out how long they waited. Those are really two different measures, and there are benefits and disadvantages to using each. Possibly, it would be a good idea to have both. When you put that idea in the context of measuring referral-to-treatment times, the snapshot measure does not tell you whether the patient will be admitted because patients on the list will be a mix

of the two distributions. However, with the number of patients treated, you know whether they received hospital treatment, or maybe some just saw a specialist and did not need surgery. So you can see that the idea of measuring referral-to-treatment time is interesting because it covers the patient journey. However, it brings in some extra complications, which mean that, in practice, you may need at least three different measures of waiting times" (Appendix 1).

28. The Committee discussed the possibility of introducing a RTT system in Northern Ireland with departmental officials at length during the evidence session on 4 June 2014.

29. The Department advised that its position is that a move to RTT targets is "highly desirable" because it better reflects the patient experience and clinical interests, and it also removes potential perverse incentives for delays at stages of the journey which are present with stage of treatment targets. Officials stated:
". . . the Department's view on a referral-to-treatment target is that we think that it is highly desirable for the range of reasons that have been given to the Committee in recent weeks by the other witnesses who have come before you, because it would remove those perverse incentives and take them out of the picture completely, it would better reflect patient experience and what the patient is really interested in, which is the entire journey, and we think that it would also reflect the clinical interests" (Appendix 1).

30. The Department recognised that a system of RTT targets is regarded as best practice, which aligned with the evidence presented to the Committee by the waiting times experts. Officials explained:
"Nevertheless, it is the direction of travel for those who are at the leading edge. If we want Northern Ireland to be at the leading edge, that is the direction in which we will have to go" (Appendix 1).

31. However, officials clarified that a shift to using RTT targets would ultimately be a decision for the Minister:

"That would be a policy decision for the Minister, but, in replying to the Committee, the Minister has endorsed the line that it is highly desirable" (Appendix 1).

32. In terms of how the Department was progressing any move towards RTT, officials advised that they wished to see the Committee's recommendations before putting any definitive advice to the Minister.

33. The Department outlined three main challenges associated with moving to RTT targets – policy, resource, and technical feasibility.

34. In terms of policy, a decision needs to be made on what model of RTT should be introduced. Officials referred to the fact that a decision needs to be taken on what is measured – completed patient journeys or a snapshot of people still on the list. The Committee acknowledges that measuring RTT targets is a complex task. However, given that these issues appear to have been overcome in England and Scotland, it would seem reasonable that the Department would be able to learn from the English and Scottish experiences, through engaging with their counterparts in the relevant government departments.

35. In terms of resource, the Department explained that RTT would take a number of years to put in place and would cost "millions" of pounds:
"It would take a number of years of hard work to get it in place, with perhaps investment running into millions of pounds to put it in place. Of course, there is an opportunity cost there" (Appendix 1).

36. However, the Department was not able to provide a rough estimate of how much RTT would cost to implement. Officials stated:
"I am not aware that there is a reliable estimate for Northern Ireland" (Appendix 1).

37. While the Committee is fully aware of the financial pressures which the Department is currently facing, it is of the view that investment in RTT targets

would ultimately lead to more efficient spend on elective care. It may also lead to less reliance on the private sector to deal with back-logs, which could lead to cost savings in the long-term. Given that officials stated that the need to reduce waiting times for elective care is a Ministerial priority, the Committee believes that the issue of resources should not be an obstacle to implementing RTT.

38. In terms of technical feasibility, the Department advised that information systems would need to be developed. The Committee accepts this point, but given that other information systems have been successfully introduced across the health and social care sector, such as the electronic care record, it is of the view that the technical issues could be worked through.

39. The Department advised the Committee that it is aware that RTT is being used in other European countries such as England and Denmark. However, officials stated that they want to assess the experiences from those countries before deciding whether investing in RTT for Northern Ireland is worthwhile. Officials explained:
"We know that one such approach is to look at measuring the entire patient journey through a referral-to-treatment time. This approach is being followed in a number of countries — England and Denmark, for example — but the key thing is that it is early days in their implementation of that approach. We are very keen to learn from that and look at the experience elsewhere in order to inform whether the significant investment needed to pursue this approach in Northern Ireland is worthwhile, particularly in the prevailing financial climate that we find ourselves in" (Appendix 1).

40. However, it was not entirely clear to what extend the Department is actively assessing the experience of RTT in other countries. When officials were asked if they were engaging with other countries and regions on the issue of RTT, the response was:
"We are at the start of that engagement. The review that the Committee has undertaken has been enormously helpful in identifying where we can usefully look" (Appendix 1).

41. The Committee is of the view that the Department should begin discussions with their counterparts in England and Scotland in order to learn more about the RTT system.

42. Given the evidence presented by the waiting times experts on the benefits of RTT targets, and the Department's position that a move to RTT targets would be desirable, the Committee came to the view that an RTT system should be introduced in Northern Ireland.

43. **Recommendation: The Committee recommends that the Department introduces a system to measure Referral to Treatment (RTT) times for elective care and sets corresponding targets for RTT times.**

Responsibility for managing waiting times

44. At present, there are a number of people/organisations responsible for monitoring and managing compliance with waiting time targets in Northern Ireland. The ultimate responsibility lies with the Minister. However, the Department advised that this is deferred to the HSC Board on a day-to-day basis, who manage the Trusts' performances against the services that they have been commissioned to provide. The Department receives a report from the HSC Board each month on the Trusts' performances against the targets. The Department then holds the Board to account for the work it does to monitor the targets.

45. The Committee learned that there are various options in terms of the structures which can be established to monitor and enforce waiting times. One approach is to create a dedicated unit focused on this task. For example, in England, when RTT was first introduced, the Prime Minister's delivery unit was responsible for managing performance against targets. In Scotland, a focused team was also established. Mr Lyon from the Scottish government explained: *"We established a performance management team, mainly of NHS employees, which I led, whose job was to assess a target, see whether it was*

deliverable, look at the risks to delivery, and then agree trajectories for that delivery with the NHS board of chief executives" (Appendix 1).

46. Similarly, in Portugal, Mr Gomes was appointed as the individual to head up the unit that monitored waiting times known as SIGIC.

47. The Committee explored the issues of leadership and responsibility with the HSC Board and the Department during the evidence session on 4 June 2014.

48. The Board's position was that it does not believe that any new structures or units are required to manage waiting times for elective care. Officials advised that a separate unit had been set up within the Department in 2002 -2003 to do this, but in their view it was not particularly effective. Rather, they believe that the individuals in the Board who are currently in charge of monitoring waiting times have the experience and expertise to be able to do so. Officials stated:
"*A service improvement unit was established in 2002-03, and there was quite a fanfare around it. However, it did not have a huge impact at the time . . . My personal view, and, I suggest, that of the board, is that I am not sure that having a single person in charge of this across Northern Ireland who acts in a different role to the structures that we have is necessarily the magic bullet that we are looking for . . . I am as acutely aware as anyone around the table of the current performance not being acceptable, just as I was back in the Department in 2004, when we, not prompted by any wider process, put in place something that transformed things. . . We will turn it around again . . When I look back, I see that we made huge strides between 2005 and 2008 in unscheduled care, elective care, ambulance waiting times, cancer waiting times and so on and so forth. I encourage you to look at those numbers to see how much change can be made by the present incumbents" (Appendix 1).*

49. The Board made the point very firmly to the Committee that it wishes to continue to lead on monitoring and ultimately improving waiting times for elective care, and that it believes that it has the personnel and the structures to do so. Similarly, the Department was not in favour of creating a unit which

would deal solely with waiting times for elective care. Departmental officials stated:

"I also think that is not just a simple case of putting in a team to sort out the elective care and waiting list problem. A whole-system approach is required. As was said, unscheduled care impacts on elective care, workforce planning impacts on elective care and the financial situation is currently impacting on the delivery of those standards and targets. In effect, that one team would have to tackle the entire work of the Department" (Appendix 1).

50. However, the Committee noted that during the evidence session, the Department gave no indication of its assessment of how effective the Board has been, in terms of performance managing the Trust's compliance with waiting time targets.

51. The Committee was not convinced by the logic of the Department's argument that it would not be possible to create a team to deal solely with the issue of waiting times for elective care, given that this has been done in other countries. In addition, the Committee did not see evidence that the Department or the Board had looked closely at the structures used in other countries. When the Committee asked the Department whether it had looked at mechanisms used in other places such as Scotland and Portugal, officials replied:

    "We have been monitoring the work the Committee has done . . ." (Appendix 1).

52. This did not suggest to the Committee that the Department had been actively considering other models for managing and overseeing the reduction of waiting times. The Committee also observed that the Department does not seem to have considered that setting up a new team might be useful in terms of injecting new impetus to the issue and providing renewed focus.

53. The Committee came to the conclusion that a move towards measuring RTT and establishing RTT targets would present a useful opportunity to introduce new arrangements for managing the Trusts' performances on elective care.

Given the evidence from other countries on the benefits of establishing a focused unit within high level government structures, the Committee believes that the new arrangements are likely to work best if they involve a strong degree of departmental leadership.

54. **Recommendation: The Committee recommends that the introduction of Referral to Treatment targets is accompanied by new arrangements for managing the performance of the Trusts against these targets. The new arrangements should be determined by the Department. They should be centred around strong Departmental leadership and should clearly identify where accountability for enforcing the Trusts' compliance against targets lies.**

Enforcement of targets

55. The question of how best to enforce targets set for elective care emerged as a key issue during the Committee's review. There are various approaches which governments can adopt, and these tools can be used to enforce any style of targets – whether they be RTT targets or stage of treatment targets.

56. The Committee learned that in England, a very strong approach was adopted, which was characterised as "targets and terror". Under this system, NHS providers faced financial penalties if waiting time limits were breached, and senior executives' jobs were under threat if their organisation performed poorly. Dr Findlay described this system to the Committee:
"In England, they did targets and terror. It achieved the result; there is no denying that. When the coalition Government came in, they experimented with not having centrally enforced targets, and they were promptly rewarded with the failure that I showed in my third chart. If they did the same, I am sure that they would be rewarded in the same way with another failure. The targets-and-terror approach worked" (Appendix 1).

57. However, even though the “targets and terror” approach appears to have been successful in the English case, Dr Findlay did introduce a word of caution:
“I am not a great fan of targets per se. There is a risk that the target can be literally something that you try to hit as accurately as possible, but it should be a backstop, a minimum standard, something that the NHS usually comfortably exceeds so that it is rare and unnecessary to enforce it” ((Appendix 1).

58. Professor Normand also suggested that there were drawbacks to using a very top-down, punitive style to enforce targets:
“The evidence suggests that, if you have someone running round with a big stick beating anyone who fails, you will be successful so long as that person runs around but unsuccessful as soon as they stop (Appendix 1).”

59. Similarly, Professor Siciliani stated:
“To have targets for maximum waiting times and then to attach heavy penalties, such as people losing jobs, seems extreme. That is at one end of the spectrum and is excessive” (Appendix 1).

60. The Committee was advised that withholding of revenues when targets are not met, rather than heavily “fining” providers, is another approach to enforcing targets. Professor Siciliani told the Committee:
“However, you do need enforcement. The current policy in England in which part of the revenues are retained if the target is missed seems to be a compromise. You need enforcement otherwise changes are not going to happen, but what I outlined is not as radical as the extreme fines that had been put in place. So, attaching some serious financial incentives to the maximum waiting times seems to be a reasonable compromise and balance” (Appendix 1).

61. Similarly, Mr Lyon advised that in Scotland one of the sanctions for not meeting targets was deciding not to confirm additional funding as recurrent funding. He explained:

"There was not a big stick with regard to money, but we had flexibility to regain the money" (Appendix 1).

62. Mr Gomes provided the Committee with an insight into some of the approaches that had been tried in Portugal. The Portuguese government has produced benchmarks on productivity to identify which hospital or which sector within a hospital is performing badly compared to other ones. They also measure levels of non-conformity against a set of rules which relate to maximum waiting times, treating patients in the correct order and proper record keeping. The government then publishes rates of productivity and non-conformity, which in itself promotes accountability. Financial penalties are imposed on the hospital as a whole for non-conformities.

63. In addition, the Portuguese government operate a system whereby patients automatically receive a voucher when they reach 75% of the maximum waiting time, which is 9 months in normal cases. The voucher can be used in a private hospital and the public hospital must foot the bill. Mr Gomes explained: *"Patient transfers are automatic when the risk exists of exceeding the maximum waiting times guaranteed for surgery. In this case, the original public hospital pays the bill" (Appendix 1).*

64. However, Mr Gomes also pointed out the limitations of relying on financial penalties to influence behaviour, if the penalties are simply absorbed by the hospital as a whole, rather than impacting on individual managers. He explained:
"As to how we apply the penalties, so far it has been just at a financial level for the hospital as a whole. That is not very effective because it is difficult to close a hospital. So, even if that hospital does not perform well enough financially, it will be sustained by the Government. It will be paid off. In contracting with the top managers now, the contract includes penalties, and you can eventually not continue as a top manager if you fail to meet the targets. We are now doing that. It is very recent and was put in place just last year and this year" (Appendix 1).

65. Therefore, it would appear that in Portugal they have come to the conclusion that financial penalties or the withholding of revenues from hospitals as a whole is not particularly effective in terms of enforcing targets. Therefore, they have moved to a system whereby failure to meet targets will impact on an individual's employment status.

66. However, along with these sanctions which appear to be applied to managers, Portugal also has introduced a system of incentives for doctors. Mr Gomes explained:
"This year, we are also introducing restraints to additional practice. Additional practice for doctors is seen as an incentive. It is not really an incentive because we are paying them for doing things, but they are seen as incentives. We are now trying to limit access to that practice if they do not achieve the minimal productive standards that we publish. So, you can earn the rest of the money for the rest of the production if you achieve the minimal standards that are published. The minimal standards are based on the top 25 for productivity in all countries. So, it is a big step to achieve that kind of additional payment" (Appendix 1).

67. The Committee discussed the issue of enforcing targets with the Department and the HSC Board during the evidence session on 4 June 2014.

68. The Committee was advised that the HSC Board has legislative responsibility for performance management of Trusts to ensure ministerial targets are met – this includes targets for elective care. Within the Board, this is led by the Director of Commissioning and the Director of Performance.

69. Officials from the HSC Board told the Committee that in 2013/2014 it had introduced "sanctions" whereby if a Trust underperforms against its agreed core activity then funding is withdrawn:
"With the agreement of the Department and the Minister, last year we introduced the sanctions to which you referred, whereby, if a trust materially underperforms against its agreed contract, then the funding is withdrawn at a marginal rate. That is what has happened, and that should not directly impact

in the short term on any patient; it is more to encourage the right sorts of behaviours in the system" (Appendix 1).

70. However, as the evidence session progressed the Board appeared to move away from the idea that the withdrawal of funding was a sanction or a punishment for poor performance. Officials said:
"I commission services . . . if routinely services were not delivered in the required volume or to the required standard, there would be some comeback to the relevant provider. That seems entirely reasonable and does not sound to me like a sanction or anything" (Appendix 1).

71. The Board then said that only 25% of the funding is withdrawn and that it largely related to "consumables" and that it would not have an impact on patients. It further advised that in the first three quarters in 2013-14, £1·5 million was withdrawn from the Trusts for under-delivery.

72. On reflecting on the evidence, the Committee is concerned that the Board does not seem to be clear about whether the withdrawal of the funding in this manner is supposed to operate as a sanction or not. Furthermore, the Board did not provide any evidence or view on whether these withdrawals had had any impact on improving the Trusts' performances.

73. The Board then advised the Committee that it was in the process of trying to change the nature of its relationship with the Trusts – away from a "transactional" arrangement to one where clinicians are more "empowered". The Board was quite firm in stating that it did not want to create a "blame culture". Officials said:
"I do not think that it is helpful for all of us to get into some sort of blame culture. It is about trying to create a system where, in particular, clinicians in primary care and secondary care are facilitated to do the right things for patients and in which, hopefully, we can avoid sanctions, threats, terror and any other unpleasantness" (Appendix 1).

74. The question was then put to the Board that if it did not favour a blame culture, did it favour using incentives. Officials replied that the Board was "actively looking at what incentives we might put in place". They elaborated:
"On the incentives culture, I touched on the board having progressed discussions with a small number of provider organisations within Northern Ireland in recent months around a small number of specialties. That has been a much more open-ended discussion, which is whether we can move away from a transaction-based approach whereby my relationship with you as a provider is to buy three of these, four of these and five of these, to an arrangement whereby my relationship with you is to ensure that you provide timely and effective care on a long-term, sustainable basis for the population via the LCG that you serve" (Appendix 1).

75. From the evidence presented, the Board appears to favour a partnership approach with the Trusts. The Committee acknowledges the value of this attitude in some circumstances, and noted that Mr Lyon also emphasised the importance or working with clinicians to drive forward change in Scotland. Mr Lyon said:
"Effective clinical engagement is fundamental to delivering Scottish waiting-time standards. For example, the delivery of the referral to treatment target for cardiac services was led by a clinical group. . . Fundamentally, the Scottish drive to improve waiting times has been based on a collaborative approach to service improvement and rigorous performance management" (Appendix 1).

76. However, the Committee was concerned that the Board's emphasis on partnership working with the Trusts was not matched with strong performance management arrangements. The Board seemed to suggest that waiting time problems could be resolved simply by clinicians wanting to do the *"right things for patients".* The Board clearly does not favour an enforcement approach based on sanctions or financial penalties which affect individual managers or clinicians in terms of their pay or employment contract. However, in terms of incentives, the Board did not describe any concrete incentives which are in place, either for clinicians or managers. They did however refer to ongoing

discussions with clinicians to look at how they could be given more control over their daily work environment.

77. Overall, the Committee was concerned that the Board did not seem to acknowledge that the current culture around enforcing targets has not produced compliance with the targets. There was also little reference made to approaches which have been used in other countries, apart from a brief mention of New Zealand by departmental officials.

78. In terms of the view of the Department, very little information was provided on whether the Department endorsed the Board's approach, whereby there should be no blame culture and no sanctions, and yet no specific incentives. Officials from the Board stated:
"I do not think that it is helpful for all of us to get into some sort of blame culture. It is about trying to create a system where, in particular, clinicians in primary care and secondary care are facilitated to do the right things for patients and in which, hopefully, we can avoid sanctions, threats, terror and any other unpleasantness . . . I am confident that that is the direction that the Minister and the Department are continuing to work towards. I can speak on behalf of the board, and it is certainly the direction that we are seeking to work towards." (Appendix 1).

79. Given that the Department did not disagree with this statement, it would appear that it is content with the Board's approach.

80. After considering all the evidence, the Committee came to the view that there is a lack of clarity in terms of the policy approach which the HSC Board is currently taking to enforce compliance against targets. Furthermore, it appears that the HSC Board itself is not clear whether one of the current elements of enforcement, whereby funding is withdrawn from a Trust, constitutes a sanction for poor performance or is simply a refund for services not delivered. The Committee also noted that the Board did not appear to have fully considered enforcement methods used in other countries and whether they could be effectively applied or adapted for use in Northern Ireland.

81. As stated previously, the Committee believes that a move towards measuring RTT and establishing RTT targets would present a useful opportunity to introduce new arrangements for managing the Trusts' performances. Alongside these new arrangements, a clearly defined policy on enforcement against targets should be established. The Committee believes that the Department should take the lead in setting this policy direction, and should determine how best to use both sanctions and incentives to maximise the Trusts' performances. This will be a matter for the Department, however, the Committee has observed that the experience from elsewhere suggests that sanctions and incentives are more effective when they impact on individuals, rather than on organisations.

82. Recommendation: The Committee recommends that the introduction of Referral to Treatment targets is accompanied by a clearly defined policy on how compliance against targets will be enforced. This policy should be set by the Department. In setting the policy, the Department should consider utilising both sanctions and incentives, and directing any such sanctions and incentives at a level which will encourage more personal accountability for compliance against targets.

Use of the private sector

83. There has been consistent use of the private sector to provide elective care in Northern Ireland over a number of years. The Department advised the Committee that since 2009, the spend has been between £55 million and £65 million per annum, with the figure reaching £66 million in 2013-2014. In overall terms, this represents around 5% of total spend on elective activity.

84. During the course of its review, the Committee learned that in countries which have had success in bringing down waiting times, the private sector is used in a limited way. For example, in England and Scotland the private sector is used to provide additional capacity at the margins which is not required all-year round. Mr Lyon from the Scottish government explained:

"The last time I looked, the spend in the independent sector was less than 0·2% over a year; however, I would have to check those figures again. It has been significant for limited periods . . . we use the independent sector, largely to avoid putting on additional capacity at the margins that we will not use all year" (Appendix 1).

85. Other countries have used the private sector in effect to provide competition for the public hospitals, and thereby create an incentive for public hospitals not to lose patients to the private sector because of a failure to meet waiting time targets. Professor Siciliani explained:
"Other countries . . . prefer to mix it with incentives that are more related to choice and competition so that patients who wait more than the maximum time are entitled to seek treatment in other public hospitals or, maybe, in a private hospital at the expense of the public system. That is a quite different way to use the maximum waiting times, and this approach has been experimented in Denmark, the Netherlands and Portugal" (Appendix 1).

86. Mr Gomes provided details of how this approach operates in Portugal:
"The central office automatically emits a voucher when the patient achieves 75% of the maximum time guaranteed. In Portugal, we have four categories of maximum time guaranteed. For normal situations, priority is nine months. When the time comes to six months and 22 days, a voucher is automatically emitted. The voucher covers all private hospitals that perform the type of surgery that the person needs. Each person can choose to stay in his hospital or to go to one of the private hospitals and have surgery performed" (Appendix 1).

87. However, despite the advantages of utilising the private sector, many of the experts pointed to the potential difficulties of having a mixed public/private model for elective care. For example, if the same doctor is involved in treating the patient in the public and private sectors, there is an incentive for that doctor to maintain long waiting lists – so that some patients choose the private sector because they want to avoid a long wait. Professor Normand gave this view:

“. . . essentially, people find themselves diverted into the private practice of the same individuals, where that is an incentive. There has been a lot of evidence of that. Not everyone does it, but some people will find a way that you reappear to their profit elsewhere if you have that conflict of interest potentially there. You have to be very careful. Public/private mix, through the same individuals or organisations, is typically associated with some people abusing the system to some extent” (Appendix 1).

88. Dr Findlay made a similar point:
“I do not have a view on the merits of public versus private, but I will make one observation about the potential conflict of interests that it puts before the consultant. If the same consultant is operating on a patient in the private sector as would have operated on a patient in the public sector, and the consultant is being paid for that, there is a potential conflict of interest for that consultant that could push them in the direction of maintaining long waiting times” (Appendix 1).

89. Professor Siciliani also flagged up the conflict of interests issue:
“ . . . people in health policy know that the dual role of doctors generates a conflict of interests. Especially on waiting lists, you know that, if the waiting list is longer, the patient will be more willing to go private if they can afford it. In that sense, there is a conflict of interests” (Appendix 1).

90. Experts suggested a range of safeguards that can be put in place to ensure that doctors are not given perverse incentives to underperform and maintain long waiting times. Dr Findlay suggested that if a patient is transferred part way through their journey from the public to the private sector, then the consultant they see in the private sector should not be the same person who initially assessed them in the public sector:
“How do you solve that, if you are using the private sector and it is the same consultants? One option is to try to make sure that it is not the same consultant. It can be difficult to persuade patients to change consultants if they have already met them in clinic. Most, but not all, patients typically say, "I

would like to see the nice doctor I saw in clinic, please". Therefore the ideal time to move them is before the first outpatient appointment. Many more patients will agree to move at that stage than after an outpatient's appointment" (Appendix 1).

91. Mr Lyon advised that in Scotland they have a range of measures to try to mitigate against potential conflicts of interests:
"I think that the neater the separation between private and NHS work, the better. In fact, if we commission a private organisation to do work for NHS patients, they are commissioned as such, and the patients stay on the waiting list. One NHS board will not use consultants from the local area. In other areas, use of consultants is very marginal. With the possible exception of cardiac surgery, we do not treat private patients in NHS hospitals, so there is a strong separation between private work and NHS work" (Appendix 1).

92. Dr Findlay also pointed out that if a country's health system needs to repeatedly and significantly make use of the private sector, then this suggests that baseline capacity is not aligned to demand. It may seem like a quick fix to use the private sector, but it does not work in the long term. Dr Findlay stated:
"Relying on short-term solutions, whether by bringing in locum and bank staff, exporting patients to the private sector, or by using some other short-term waiting list initiative, is part of the same approach of trying to fix a problem that we have this week or this month rather than realigning baseline capacity to fix the longer-term shortfall of capacity against demand, which, incidentally, is usually cheaper. It is usually cheaper for the NHS to adjust its baseline capacity than it is to pay, usually, premium rates for locum or other short-term work" (Appendix 1).

93. The point was also made that in the UK and Ireland, using the private sector is usually more expensive than doing the additional work in the public sector. For example, Professor Normand made the point that in the Republic of Ireland civil servants are not trained negotiators in terms of trying to achieve good deals with private providers:

". . . the National Treatment Purchase Fund people clearly did not drive hard bargains. . . You should never underestimate the difficulty of public or quasi-public officials dealing with very well organised commercial organisations, because it is often an unfair contest. In this case, none of the private providers was shown to be cheaper. Overall, they were clearly significantly more expensive" (Appendix 1).

94. Mr Lyon from the Scottish government advised that they had built up alternatives to the use of the private sector to deal with back-logs:
"We have built up alternatives. We have a national waiting-times centre, which is basically a hospital that provides activity just for waiting times. We have a treatment centre on the east coast. NHS boards often provide additional activity at the weekend using clinicians from elsewhere in the UK." (Appendix 1).

95. Professor Siciliani also made the point that there are different ways to provide extra capacity, and that the use of the private sector is just one policy option:
"There is always a choice of how to structure the involvement of the private sector: do you just try to involve the private sector and ask whether it can do this extra elective care, or could you use the same resources for the public hospitals and ask the doctors working there to do that extra volume of work? There are some different policy options here that, maybe, in the bigger picture, could be equivalent in the sense that, if you have some extra resources, you can give them to the private sector; the private sector might recruit doctors working in the public hospitals; or you could have public hospitals with public doctors and ask them to do extra sessions and tell them that you will put some extra resources on the table" (Appendix 1)

96. In terms of Northern Ireland's approach to the use of the private sector, the Board advised the Committee that they wish to decrease their reliance on the private sector moving forward:
"The board and Department have made clear on numerous occasions their desire not to be reliant on the independent sector to the extent that we are. I know that the figures sound high, but they account for only about 5% of total

elective activity, so they are small in absolute terms, but my view is that they are still too large and I do not wish that to be the position as we go forward" (Appendix 1).

97. The Board explained that it was aiming to be able to match supply against demand, with the exception of orthopaedics which has particular supply problems. In future, the Board hopes to be using the private sector only at the margins:
"However, it is my desire and hope that, following the initiatives that I referred to earlier, we will be able to move to being less reliant on the independent sector and other areas. It is useful in exactly the way that you described it: at the margins when there is a particular issue to respond to. However, it is not useful as a sustainable, ongoing way of doing business. It is not how we wish to be commissioning routinely" (Appendix 1).

98. The Board clarified that when demand exceeds supply, they try to plug the gap through additional in-house work:
"In response to a question on how we respond to gaps, I said that the first thing we do is to seek, from the in-house team, whether they can, as a non-recurrent, one-off initiative, do something more" (Appendix 1).

99. The Board also provided information on how they seek to ensure value for money when they do use private sector providers:
"We have a framework contract, and no company can be on that framework contract unless it is committed to delivering services for the English tariff. Civil servants across the water — as able as my colleagues who sit beside me — drawing on lots of procurement expertise, have agreed, over a long time and through a very robust process, a reasonable price to be paid for individual procedures. We do not try to invent that wheel locally; we simply use it. There is an orthopaedics tender out at the minute. Whilst providers are free to bid at whatever price they wish for that orthopaedics tender, from our perspective, we have a clear frame of reference for what would be a reasonable price to pay, consistent with the tariff. I believe that, providing that and for as long as we secure prices from the independent sector that are at or below tariff, we

are securing value for money from the use of the independent sector" (Appendix 1).

100. In relation to the potential conflict of interests which are associated with a mixed public/private system, the Department and the Board appeared not to be fully aware of this issue. When the Department was asked whether it was aware of consultants advising patients in the public sector of the fact that they have a private practice, the Department stated they were not aware of it, but "would look into it". The Board gave a fuller answer to the same question:
"The other point you made was about anecdotal evidence you have of the potential risk of patients being advised by consultants to see them in the private sector. I have no evidence of that, but I can see how, the longer the waiting times are, the greater that risk is, and greater, more generally, is the risk/need that patients will see that as a necessary evil for them. While they should reasonably expect to receive timely care in the HSC, they may feel that they have no choice but to go to the private sector. That takes us back full circle again; the prime objective for us is to fix that at source by not having long waiting times. If patients know that they are going to be seen in outpatients within nine weeks, there would be little or no incentive for them to pay privately to be seen" (Appendix 1).

101. The Committee observed that while both the Department and the Board stated that they had no evidence of consultants "advertising" their private practice to public sector patients, this does not mean that this is not occurring. The Committee believed that the Department/Board's approach appears to be passive, rather than pro-active, in terms of dealing with potential conflicts of interest.

102. When the Committee advised the Board that in Scotland, some health boards deliberately avoid contracts with companies who employ locally based consultants, in order to avoid conflicts of interests, the Board replied:
"As for getting more capacity into the system and avoiding a tension/conflict between the private sector and the public sector, we have sought, through our commissioning of independent sector capacity, to make as much use as

possible, within procurement rules, of capacity from outside Northern Ireland, be it from the Republic or GB. That is simply to try to draw in more capacity, reflecting the challenge that you are putting on the table, which is that we are just cycling the same work around the same group of staff. We are trying to bring genuine additionality to the system, and we have actively been pursuing that as a strategy" (Appendix 1).

103. However, this seemed to suggest that the Board's preference for using private providers based outside Northern Ireland was more about harnessing capacity, rather than mitigating against potential conflicts of interests.

104. The Committee welcomes the Department's stated policy intention to reduce its reliance on the private sector in the future, by better matching in-house supply against demand. It also welcomed the fact that the Board's first approach to dealing with backlogs is to find an in-house health service solution if possible. However, the Committee is of the view that these policy intentions would be usefully supported an action plan setting out how this will be achieved.

105. The Committee came to the conclusion that the Department and the Board do not seem to have fully considered the potential conflicts of interests for doctors who work in both the public and private sector. As such, the Department has not put in place any policies to mitigate against such conflicts. The Committee believes that the Department needs to investigate the issue and develop appropriate policies based on its findings and the experience of other countries/regions.

106. Recommendation: The Committee recommends that the Department produces an action plan detailing how it will decrease spend on private sector elective care over the next 3-5 year period by making better use of in-house health service based solutions. The action plan should include projected costs for spend on private sector elective care for the next 3-5 years; proposals to develop capacity within the health service sector to better match

supply against demand on a long-term basis; proposals to ensure that any private sector contracts required demonstrate value for money; and a timetable setting out the key milestones in the process.

107. Recommendation: The Committee recommends that the Department develops policies which pro-actively mitigate against the potential conflicts of interests which exist for doctors who carry out private work as well as working in the health service. In order to understand these potential conflicts of interests more fully, the Department should ask the Patient Client Council to carry out research which examines the extent to which health service patients are advised about the option of paying for treatment in the private sector.

Appendix 1

Minutes of Evidence

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Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: Professor Charles Normand, Trinity College Dublin

22 January 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Waiting Times: Professor Charles Normand, Trinity College Dublin

22 January 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Professor Charles Normand Trinity College Dublin

The Chairperson: You are very welcome, Professor Normand. The procedure is that we ask you to make a 10-minute presentation and then invite questions from Committee members. Members, Professor Normand is a professor of health policy and management at Trinity College Dublin.

Professor Charles Normand (Trinity College Dublin): Thanks for inviting me. It is nice to be back and nice not to be talking about death and dying, which seems to be what I have spoken to you about on previous occasions.

I am sorry if I divert slightly into some general principles as well as the experience in the Republic, but it is useful to understand some of the underlying problems as well as to look at the specific experience. As people will be aware, in the South, as is the case in most jurisdictions, there have been significant concerns over a very long period about long waiting times and long waiting lists, particularly for elective procedures. Around 50% of the population has private insurance that allows them, to some extent, to jump the queue and get ahead, but the other 50% that do not have it are seen to be particularly disadvantaged. The other complication is that the same doctors may well be doing public and private work, and there are some interesting problems with those incentives. Indeed, people can be paid or not paid depending on the nature of the patient, not on what they are doing or where they are doing it. The hospitals are paid mainly on the basis of block grants. They are given money for a year in a budget to run the hospital, and the service agreements that go with that are quite vague at the moment. Essentially, hospitals are told to be a hospital, not told to do particular things. There is a mixture of public, private and voluntary organisations in the system.

I am sorry about the top of the second page of my slides, but every time that I thought about what message I wanted to leave with you, I decided that it was the same message, so I repeated "It's complicated" a lot of times. People are constantly looking for the simple answer, and my main

message, if I have one, is do not, because it is a complicated problem with lots of parts, and if you think that you will solve it by finding the right answer, you will be disappointed. You will have to find lots of right answers and do things carefully. I was not sure whether it was different to say "It's not simple" instead of "It's complicated", but it is both of those things.

It is worth giving a bit of thought to what waiting lists are, because getting on to a waiting list and getting off it are the two things that happen, and you are left with those who got on it but did not get off. It is important to understand that, because people very often look at getting people off a waiting list without looking at how they get on to it. Indeed, I was on a waiting list once at that excellent hospital in Dundonald, and by the time that I had got to the top of the list, I could not remember which knee gave the problem. It was only around 23 months between being referred and getting the appointment, and I had lost the place. That is an interesting example of how a waiting list may not really be a waiting list, and it has to be thought about and understood quite carefully.

It is also important to understand about waiting to wait, because a lot of the waiting times that you see are the times after you have waited to wait. You have to be very clear about where we start the clock and where we stop it. There is also a difference between being told that you are on a waiting list and being told that you have an appointment but that it will not be for another six months or another nine months. People are much more resistant to the uncertainty that goes with being on a list. Moreover, there is a question of who owns the waiting list. Is it the people who are commissioning and paying for care, or is the people who are providing it? If you are a hospital and are told to provide 4,000 procedures, and you produce 4,000 procedures, in some sense, it is not your fault that you did not produce 4,500. If there were 500 people waiting on the list, that will be the difference. We need to be quite clear about who owns the problem. People often think about the hospital owning the problem, but the problem very often is also around the resources and the way in which people are given expectations.

The other thing to understand is that some people like waiting lists. We tend to forget that, but, if you are provider of care, nothing gives you a boost quite like knowing the resilience of people waiting to see you. I understand that. I hate it when I have such an easy diary that people can see me tomorrow or the day after. I want them to have to wait three weeks for a 20-minute slot. We have to understand that it is not always against people's interests for a waiting list to be there. It can be good.

That is a bit of background. We also have to understand with any of these initiatives that a lot of it is to do with the incentives and the consequences. Often we produce incentives that we never intend to, and the three initiatives that I will talk about are, in some ways, victims of the problem of people not understanding the incentives that they were creating. Waiting lists can also just be a way of rationing, as I described. In fact, my going to the Ulster Hospital when I did was a waste of time, because it was impossible for it to do anything useful. However, as I had waited for a year and a bit, I thought that I would find out what it was like, and sometimes a waiting list is used as a rationing device, albeit a bad rationing device, because it does not discriminate well. It is also a way of being dishonest, because you put someone on the waiting list knowing that there is no chance of the person getting to the top of it. It is just a way of getting rid of someone, like giving out a prescription. I am sure that you are all aware of that as a good way of finishing a consultation. A waiting list is a way of avoiding hard choices sometimes, because you can pass the problem on. As I said, it is a complex interaction between the referral process and the treatment process, and we tend to look only at the treatment end.

There were three initiatives in the Republic that were trying to do something about that: first, the waiting list initiative; secondly, the National Treatment Purchase Fund (NTPF); and, thirdly, the Special Delivery Unit (SDU). I will talk for a few minutes about each in turn. The waiting list initiative was a fund that was set up that paid hospitals that had long waiting times to allow them to do more treatment. It seemed, on the face of it, quite a logical thing to do. The monitoring, however, was relatively weak. It is hard to assess how much of an effect it had on reducing waiting times, but one of the things that was quite clear about it was that it produced very strong incentives to underperform, because, if you could make your waiting times longer, you got more money. One of the things that we have to recognise is that people who run healthcare organisations are not stupid. If you give them more money for doing something badly, some of them will do it badly. That is very much what we found in that case. Therefore, the waiting list initiative was later replaced — I will talk about that in a moment — because it was producing the wrong incentives. It rewarded those who underperformed and appeared to penalise those who did a good job. If you give extra money for the purpose of fixing a problem, you may well find that that is not in fact the way in which things work. Instead, you make the problem bigger in order that hospitals can fix it better.

The National Treatment Purchase Fund was a reaction to that. It was set up not to reward the bad performers but to give rights to patients. If patients had been waiting for more than nine months, or whatever the designated period was for some particular procedures, they were eligible to have almost immediate treatment under the NTPF. That would buy you a treatment, either initially in a public or private hospital or abroad. Latterly, it was made only in private hospitals or abroad, and that meant that, if you were a long waiter, you got immediate access to care.

The initial results were very similar to those of the waiting list initiative, but, once access to public hospitals on an accelerated basis was abolished, that problem seemed to go away. The real question that came out was about whether it was good value for money. It was effective at reducing waiting times, but at what cost? You can see in the report some estimates that came out of the Public Accounts Committee. I tried to find out what the spending was, but, of course, it was described as commercially confidential, and therefore I was not allowed to know. I reverse-engineered from the information that we had what the likely costs were. They varied from between being 20% to 30% higher than the cost of doing the treatment in the public system to being about double, so there was a big range. The thing that was quite clear was that it was much more expensive than the treatment would have been had it been done under the original normal public system.

The other criticism of the National Treatment Purchase Fund was that it made it permanently OK for the system to underperform, because, when it underperformed, you had a solution. Therefore, people did not complain, and there was no pressure on the public hospitals to do anything much about it, because a solution was offered that did not involve them any pain or discomfort.

The Special Delivery Unit was an idea that was to combine the NTPF with a fairly macho, aggressive approach to trying to improve the performance of the public hospitals at the same time. I am sure that you have heard people advocating traffic-light systems. When I see a traffic-light system, my heart sinks, because I know that it will be simple-minded monitoring that will tell you that you are green, but you can be green and not very good or green and very good. You can be amber and fairly good or amber and terrible. I have always thought that those things are kind of crude, but it brought in that kind of measurement to assess whether you were a good performer. At the other end, if there were people who waiting too long, they got swept into what was effectively the National Treatment Purchase Fund continued.

Furthermore, new rules were introduced so that the longest waiters were the people who got the first priority. If you were a short waiter, you would be kept waiting, however important your treatment was. If you were a long waiter, you got the treatment, however unimportant it was. The idea was that we would get rid of the very long waiters, but we managed to find that, at the end of that, the average waiting time went up, the maximum waiting time went down and the minimum waiting time went up. People turned out to be treated on the basis of when they joined the waiting list rather than on any basis of need. Although it solved the problem of the very long waiters, it created another problem of unreasonably long waits for people with very important needs that were not being met quickly. It was working on getting people off the waiting list, but it did nothing to stop people getting on the waiting list, and that was another problem.

I will try to get some overall learning from those experiences. First, in each case, the providers and the users of the service responded to the incentives that were there, both the intended and the unintended ones. The other thing that became clear was that there was a lot of gaming of the system. If you know that waiting lists are very long, people will be put on the list early so that, by the time that they really need the treatment, they will be ready for it. For example, if you have a cataract, and it is not yet ready for surgery but will be perhaps in two years' time, and the waiting list is two and a half years, the logical thing is to be referred on to the waiting list early. There is a lot of evidence that that was happening. People knew that there was a long wait, so they were anticipating that and working ahead.

Another problem is rather similar to one that I dealt with about 25 or 30 years ago, before some of you were born probably. I was working on a project at the Royal Victoria here in Belfast on trying to reduce the waiting time for knee surgery. We brought in people on Saturdays, and lots of extra work was done. It was a great scheme, but, after three months, the waiting list was longer. The explanation was very simple. Word got around GPs in Belfast that waiting times for knee surgery were going down, so there was a flood of new referrals. We looked at it, and there was a huge increase in the number of referrals. People had thought that it was not worth waiting two and a half years, but, if they had to wait only three months, that was good value. Therefore, you have to be very careful and look at what the effect of success is on the behaviour of people doing the referral, and we saw some evidence of that.

We have waiting lists for a number of reasons: the package is too big — that is to say that too many things are promised relative to the resources available; there is too little funding to cover what we are promising; the provision is inefficient; or the priorities for who gets the treatment are wrong. We have to understand that all those things are interacting in causing the problem.

What can we learn from the Irish experience? First, the initiatives were brought in without adequate understanding of what incentives they were going to produce, and they ended up producing some intended and some unintended incentives. It was not really understood why the waiting lists had got longer, and it was therefore not surprising that the effects were not always what had been hoped for.

The refusal to determine what the entitlements are, and the refusal to do explicit rationing, which is always an alternative to implicit rationing, meant that we had implicit rationing through the misuse of the waiting list system. The problems were both funding and provision, because, when there was inadequate funding to commission the amount of work that was needed, one of the effects was that the waiting lists got longer. However, the initiatives also failed to recognise that some people benefit from longer waiting lists. Indeed, if you are helped when you have a problem, you are encouraged to have a problem in order to be able to get the help.

Another thing that we learned, which may be a good lesson, given that the health system in Northern Ireland is relatively simple compared with that in the South, is that the more complicated the system, the more difficult it is to introduce incentives and initiatives that are likely to work. The reason for that is that they will have curious feedback loops that lead to the wrong thing happening. Where you have a large private system interacting with a large public system, you tend to get difficulties of the kind of the wrong incentives being generated. We learned very clearly that people respond to incentives. Never think that people are going to be sentimental just because they work in the health system. If you produce strong incentives, they will, to an extent, follow those incentives, and we saw clear evidence of that.

If I have a message, it is that this is very complicated. You will not solve the problems instantly. You have to look at how you get on the waiting list as well as how you get off it. You have to look at the efficiency and inefficiency, and you also have to look at the adequacy of the resources relative to what you are asking people to achieve. You have to be very clear that, if you generate incentives, people will follow them, even if, in principle, they are good people and are trying to do a good job. Nevertheless, if you reward inefficiency, you will get inefficiency, and if you reward perverse behaviour, you will get some perverse behaviour.

Thank you for your attention.

The Chairperson: Thank you, Professor. The Committee is taking a keen interest in the review of waiting times. It is interesting that your analysis tells us that there was no understanding of why lists were long in the first place. We are only in the middle of this process, but a message that we are getting concerns how the information is collated. There was a suggestion that we need to look at the total patient journey time. I do not know whether that has been a similar experience for you. Using the Assembly research structures, we have looked at what happens in other European countries. We have looked at Portugal, at different voucher systems and at patient and incentive systems, and we will take evidence on Scotland's experience. However, it also seems that enforcement is the key.

Professor Normand: I think that it is. Proper monitoring and proper evaluation of these things are important. Of course, one of the other lessons is that, to some extent, people did not want the initiatives to be evaluated too closely because that might show that they were not working as planned. Too much information can be difficult and embarrassing when you are trying to do this. The Special Delivery Unit was set up to be light on its feet, responsive and quick, but one of the things that went with that was the fact that there was no careful monitoring of what it did and what effect it had. That is a very important message. I think that people were hopeful that there was a quick and easy fix, as opposed to recognising that the fix involves probably seven or eight different things. A lot of it has to be bottom-up. There was a tendency to go in and say, "Here are some answers. Go and do it", rather than go in and say, "Here are some things that you have got to work on to improve".

The Chairperson: I am interested in one of your slides on the NTPF, which states:

> *"Initially treatment was in both public and private hospitals".*

I suppose that that is one of the models that we are looking at, particularly among European models: incentives that are effectively private treatment. Your analysis is that, later, treatment mostly took place in private hospitals or abroad, which is more costly.

Professor Normand: It was definitely more costly. I never quite understood, because I did nine years of training as an economist and then found that the private system in the health system did not seem to work as it was meant to. It was out of line with me, rather than me being out of line with it. There are complicated reasons why private treatment tends to be more expensive. Some of it is simply down to the fact that the markets do not work very well in that area. Part of it, however, is because the scale tends to be quite small. For some of the treatments, a larger scale can be much more efficient.

Here, the National Treatment Purchase Fund people clearly did not drive hard bargains. They felt very weak in their negotiations with private providers, partly because they had announced the results before they had done the negotiation and, as such, ended up being weak negotiators. You should never underestimate the difficulty of public or quasi-public officials dealing with very well organised commercial organisations, because it is often an unfair contest. In this case, none of the private providers was shown to be cheaper. Overall, they were clearly significantly more expensive.

Mr Dunne: You are very welcome, Professor Normand. You have brought us an informative document that contains some very interesting facts.

Is there a tendency for health authorities to manage the waiting lists rather than manage the patients?

Professor Normand: I think that there can be. It goes back to what the Chair said about the importance of the whole journey. At the moment, the clock starts ticking only at certain points, and sometimes the journey can be very long before you get there. I have been doing a lot of work on epilepsy recently, and one of the things that we traced was the journey that got people to the specialist service in the first place. A lot of those people have intellectual disabilities, so navigating is difficult. If you are partially disabled, it is always going to more difficult. We found that the problems were three, four or five years earlier, before we even saw them, because they had missed the boat on so many occasions on the journey. Indeed, all the recording happened only after people had appeared in the system. What should have been looked at was where people had gone through the wrong referrals early on, then waited to get appropriate referrals and gone around the loop. It was almost a matter of luck if people ended up getting into the right place.

You are absolutely right: it is not easy to get at what the whole patient experience is, but that is ultimately what we are interested in, rather than the patient's experience from when the clock starts.

Mr Dunne: We know that there is a concentration on meeting targets, but how that is done is an issue of concern. Is the patient being put first, or does the patient come second in a lot of cases?

Professor Normand: For my sins, I was chairman of the Central Middlesex Hospital when I worked in London, and, every year, we had to hit our financial target exactly, which we did. Some years we had more money than we started with and others we had less money than we started with, but we always met our target, because we had a very good director of finance. If the targets are very explicit, people will find ways in which to meet them, whether or not they do the things that are desirable on the way to meeting them. Therefore, we have to be very careful, because, if you set the targets crudely, you will get crude behaviour to some extent, and you will not achieve what you are trying to achieve.

Mr Dunne: Let me turn to the issue of consultants and specialists working privately. Most of them are direct employees of the trusts. Is there a risk of a conflict of interest?

Professor Normand: Absolutely. I have worked in many countries. You see it grotesquely in places such as Bangladesh, but you see it just about as much in Birmingham because, essentially, people find themselves diverted into the private practice of the same individuals, where that is an incentive. There has been a lot of evidence of that. Not everyone does it, but some people will find a way that you reappear to their profit elsewhere if you have that conflict of interest potentially there. You have to be very careful. Public/private mix, through the same individuals or organisations, is typically associated with some people abusing the system to some extent.

Mr Dunne: So the risk is there.

Professor Normand: Yes.

Mr Dunne: Is there a possibility that those people will not work as efficiently?

Professor Normand: There is always that possibility, particularly if there is some reward for not doing so.

Mr Dunne: Have you seen evidence of it?

Professor Normand: There is some evidence. We saw it at an organisational level. Organisations that were rewarded under the waiting list initiative, for example, were found to perform worse in order to keep the waiting list money coming. There was clear evidence that they did not try so hard because there was an advantage in not being successful.

Mr Dunne: Was that during their direct employment?

Professor Normand: No, this was the organisation. We could not observe individual clinicians, but they are a part of that organisation. There was evidence that organisations that were rewarded for failing failed more. I do not think that we should be surprised. It was not that they were grotesquely worse, but they were a little bit worse when they were paid more for having failed in the last year, so they got more waiting list money in the next year.

Mr Wells: The lessons in the Irish Republic are very useful. I remember when you were here three years ago, giving us a fascinating insight into budgets. That was very welcome. The situation in the Republic is very different, in that you have a dual model. Everybody in Northern Ireland gets healthcare at the point of demand; there is no issue. If you want to have private treatment — which is a tiny proportion of the service here — you can join BUPA and go to the Ulster Independent Clinic. However, the vast majority of people do not.

Can you replicate the lessons learnt in the Republic, given the fact that, for half of those people, it is the private sector that is effectively paying for a reduction in waiting lists?

Professor Normand: I think that you can, to some extent. I agree entirely. What the Republic offers is some serious warnings about how not to do things with respect to organisation, because it produces so many perverse incentives. I would be the first to say that it is not a useful model to replicate but that it may be a useful model to learn from, because there are constant suggestions of moving towards more mixed public and private systems. The Republic is a good example of where that is shown not to be a very good idea.

The figure of 50% of the Republic's population not covered by private insurance has now risen to about 55%. They are very much equivalent to the population in Northern Ireland in that they get the public system or nothing. Some of the lessons are that introducing a private system will cause distortion. However, those initiatives were aimed at the experience of those who were in the public system all along, and the problems that arose were problems that, I think, will be generic.

Mr Wells: That is useful. As you know, the situation in the Republic, until 2008, was that the economy was booming, money was being thrown that their health service and everyone was enjoying a boom. Were your examples taken from the period before 2008, or during the recession, when there was a lot less money. A billion euro have been taken out of the health service in the Republic since the recession. Was it possible to continue the initiatives during that period?

Professor Normand: The initiatives continued; however, like everything else, the amounts of money involved got smaller. Indeed, some of the costs got smaller as well. For example, there were pay cuts and other things that made delivery cheaper. The treatment purchase fund was started during the boom years and ended four or five years into the recession. It covered that area. The special delivery unit came in as the new model pretty much in the middle of the recession. In the boom times, many of us felt that a huge opportunity was being wasted because, during that period, it would have been possible to increase the volume of care had they not simply thrown money at it but had gone for more money being associated with a requirement for clear improvement in performance. That was very weak. It comes back partly to the fact that monitoring and information systems have been very crude, and it has been difficult to enforce any improvement of that kind.

Mr Wells: Another thing that you said, which I found intriguing, was that it is a bit like motorway construction: if you build motorways, cars seem suddenly to appear from nowhere to fill the lanes. Equally, I have noticed with new schools in south Down that, if you build a brand new school, children just appear out of the bushes. It is extraordinary. You do a projection of the number of children who are available to go to a school and suddenly an extra 50 have appeared from somewhere because they are attracted by the wonderful new facility. Are you saying that there are GPs in the Republic who have patients who would benefit from those surgeries, but they are not actually being put on the list because the doctor does not perceive that there is any likelihood of the operation's taking place? Surely, to do that is almost negligent?

Professor Normand: Of course, these things are always fine distinctions in that one person's "not appropriate" is another's "should be done urgently". Realistically, people have often made the assessment that there is no likelihood that the person will be treated during the period in which they are likely to benefit. After all, in many cases, those treatments are for chronic conditions, typically in older people. The judgement would be made that, by the time the person gets the treatment, it will not be worth their while to have it.

Take the example of knee surgery in Belfast: because it was widely available, there was a sensitivity to its being something worth trying to treat rather than accepting that it is a chronic problem that people live with reasonably well and that we will not really bother with referral.

Mr Wells: The logic of what you are saying is that, no matter how well we manage waiting lists, all that we will do is prompt people to join those lists because there is an opportunity.

Professor Normand: The logic of what I am saying is that unless you are clear about what is covered and what is not covered in the health system's priorities, the margin will always be interpreted as GPs observe whether it is possible to get treatment or not. We have always been reluctant to be explicit about what is and is not included. There has been a general statement that anything that is useful or important, you should get. Countries that have universal insurance systems tend to have more explicit listings of what is and is not included. Although it is never a perfect system, it attempts to say that those whose treatments are less important are less likely to get them unless resources increase. Therefore, you can include more things in it.

If you look at protocols for when people get tests or not, you see that they can often reduce significantly the numbers of tests that people have, because as long as a test is free and freely available, people will be referred for it, even if, when you stop to think about it, you see that a test may bring little value to the individual concerned. We should never think that there is a simple dividing line between useful and not useful. That will depend a little on how easy it is to get access. My warning is that if you increase the number of people who get the treatment by 1,000, you will not reduce your waiting list by 1,000. You may reduce it by quite a lot or by almost nothing. As I said, in the knee case we actually increased the waiting list in the short run because suddenly people thought that they could get something done about their knees when previously they thought that they could not.

Mr Brady: Thank you for your presentation. You have answered one of my questions about the private and public sectors having the same clinicians. However, some of those clinicians use health service facilities and tie them up when doing their private work. I have come across examples of that in my constituency where, for a day, they were doing private work and seeing huge numbers of people for relatively short times. It was not taking the waiting list down, but, from a financial point of view, it was enhancing their budget.

Nobody disagrees that it is a very complicated issue. As with anything complicated, there has to be a will there to do it. It takes leadership. There is the example in the South of a Health Minister who did a lot less with a bigger budget than had been done previously with a much smaller budget. The incentive has to be there. If huge waiting lists become the accepted norm, that will simply continue.

Professor Normand: That is right. Considerable leadership is required throughout the system. The evidence suggests that, if you have someone running round with a big stick beating anyone who fails, you will be successful so long as that person runs around but unsuccessful as soon as they stop. We have to be wary of people who know that they can borrow your watch and then sell you the time. It is the management consultant problem generally. It all looks very good for a time and then it stops.

You have to be clear that you need to have monitoring and high-visibility management of the process. However, you also have to be supportive of the clinicians and managers at the individual facilities; you

have to work with GPs on what is referred and how it is referred; and you must have protocols for what referrals you accept. It is about going through the process bit by bit and understanding, at each stage, that you have to be supportive of the provision of sensible practice and appropriate pathways.

You have to play a long game. You must recognise that it will take two, three, four or five years to get significant progress. You have to accept that, sometimes, you will be working with people who are perhaps not the best people in that position but that throwing them out and bringing someone else in would push the whole thing back by two years because they will have to learn their way up and so on.

Many complicated judgements have to be made to make it work. The critical thing is accepting that you are managing a complex problem and trying to manage it as a complex problem rather than trying to eliminate the complexity and then finding that your simple solutions only produce more problems that are similar to the ones that you are trying to get rid of.

Mr Brady: You made the point about waiting 23 months for a procedure. By the time you arrived, it was almost too late. People may see a consultant who tells them that they need elective surgery, but, by the time they are put on a waiting list and wait, it is too late. There does not seem to be a prioritisation of particular problems. People can be seen and told that they need something done, but it is not done when it should be done.

Professor Normand: The big problem with prioritising is that you have to say no to some people, and you know how popular that is. We have to get a bit more grown-up. I am 62 — I know that I do not look it — and I have four or five things that could be treated. I choose not to have them treated, partly because I am scared and partly because it is just not worth it. One of my knees really gives me quite serious problems about one day a year. We have to get a little bit more grown-up about it.

It would be nice if we had unlimited resources, but we do not, so we have to start saying no sometimes. I do not mean by that that you refuse to treat important problems, but we need to be more sensitive to where some of the margins could lie, particularly around investigations. I am vice-chairman of St James's Hospital in Dublin, and we have the biggest laboratory service in the country. We do a huge number of pointless tests. We know that they are largely pointless, but we cannot stop them coming. We need people to be a bit more sensible.

The Chairperson: OK, thank you very much. That was very informative. You have left us with a number of messages about the process being complicated and the fact that you cannot simply throw resources or funding at one aspect of it. Thank you for your time today. We will certainly reflect on what you said.

Professor Normand: All I can say is "Good luck".

The Chairperson: We are good at the long game.

Professor Normand: It is the only one you can play.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: Gooroo Ltd

5 February 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Waiting Times: Gooroo Ltd

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Dr Rob Findlay Gooroo

The Chairperson: I welcome Dr Rob Findlay. The normal procedure here is that you give a 10-minute presentation, and then we open it up to questions and answers. You are very welcome, and we appreciate you taking the time to come before us today.

Dr Rob Findlay (Gooroo): Thank you, Chairperson. It is a privilege to be here. My introduction probably will not take as long as 10 minutes, but I would like to talk a little bit about one of the issues that I have drawn attention to in my briefing note. I would like you to imagine for a moment that you are a manager in a hospital where you have a lot of long-waiting patients on your waiting list. You would like to do the right thing for those long-waiting patients by treating them. Now imagine that you have the capacity laid on and you are treating your long-waiting patients. What happens to the proportion of the patients that you treat who are long waiters? If you are treating your long waiters, the proportion of long waiters being treated will go up for a while, because you are treating lots of long waiters, and the number of long waiters left on your waiting list will go down.

So we have done the right thing by treating our long waiters, and the number of long waiters left on the waiting list has gone down. It is very simple stuff. What I want to explain now is how the English NHS got on the wrong side of that very simple concept and ended up in some difficulty with its waiting-time targets. I think that you have a copy of a piece of paper that looks something like this? Do you?

The Chairperson: Yes. It is in the tabled papers.

Dr Findlay: This is an extract from the 'Guardian' website. It says:

> *"Waiting lists grew 61% in the past year".*

At the bottom of the page, I have put the statistics that this story came from. You will see that the number of patients admitted during the month who had waited 26-plus weeks rose from 7,360 in June 2010 to 11,857 in June 2011. Those of you who are good at your 61 times table will know that that is a 61·1% increase.

What does that 61% mean? Does it mean that the waiting list got bigger by 61%? No, it does not. Does it even mean that the number of long waiters got bigger by 61%? No, it does not. It means that the number of long waiters being treated went up by 61%. If you treat more long waiters, you would expect there to be fewer long waiters left on the waiting list, and that is, indeed, what you find. If you look at the second row of numbers, you see that the number of patients still waiting who had waited over 26 weeks fell from 95,814 to 93,123, which is a decrease of 2·8%.

So, waiting lists grew 61% in the past year? Sounds terrible, but that is not what happened. They treated their long waiters, so the number of long of waiters remaining on the waiting list went down, and long waiters got their operations. So, it is a good thing that happened. Interestingly, if you challenge, as I did, newspapers that print reports like that, you find that their response is almost invariably the same: we are reporting the figures that the Government put out. So, my word of caution to you is that if you in Northern Ireland were to implement targets in the same way that the English did and then follow those figures, you might end up with headlines like that even when actually things have got better, not worse.

To go a little bit deeper into the story, you have a chart from University College London Hospitals (UCLH). There are two charts. At the outset, I should say that I do not in any way blame the hospital for what it did — for what I am going to explain to you that happened here — because this was during the era of targets and terror. If you were an English hospital that was failing against the targets, the consequences were very severe, both financially and in terms of your personal career.

What the top chart shows is the performance of this hospital trust against the headline target in England, which was that 90% of the patients being admitted — being treated as an inpatient and a day case — should have waited less than 18 weeks. On the left, in 2008, you can see the target being achieved for the first time as the line drops below 18 weeks. The hospital successfully achieved the target every single month thereafter. It kept its nose so clean that if you look at the first marker in 2011 — I have put a couple of markers on the timeline — you will see that UCLH did not appear in a list of 28 hospitals that were failing on the long-waits target. A few months later, the Prime Minister, David Cameron, honoured the hospital with his presence, so that he could give a speech in which he pledged not to lose control of waiting times.

If you look at the bottom chart, you will see what was happening underneath those figures on the waiting list itself. The dotted line shows how long 92% of the patients on the list were waiting, and you can see that, in 2011, it was not far off a year. The solid line that is plotted on the right-hand scale shows how many one-year waiters there were on the waiting list — who had waited more than a year since referral. You can see that that peaked at around 1,700 one-year waiters in just one hospital trust just before the Prime Minister came down to give his speech.

So, on the one hand, according to the headline target, we have a very rosy picture of short waits, but, on the other hand, if you look at the waiting list, you can see that there were patients waiting for a very, very long time indeed. If you want the true picture of what is happening on waiting times, always look at the waiting list. Do not simply rely on looking at the waiting times of those patients lucky enough to get treatment.

The final chart that I will draw your attention to shows England's overall figures for a similar period. Just after the latest figures were released in June 2011, the deputy chief executive of the NHS in England wrote a very fierce letter to all the chief executives of every NHS organisation in which he said:

> *"it is unacceptable for performance to fall below the expected standards as it did in February and March 2011."*

Look at the chart: in which months did the NHS fall below an acceptable standard in England? If you look at the dotted line, you can see what the position was like on the waiting list. You can see that 90% of the waiting list was waiting up to 19 and a bit weeks at the peak around January 2011. That was when there were a lot of long waiters on the waiting list. In February and March, which are the months that the deputy chief executive drew attention to, the NHS treated its long-waiting patients and

sorted the problem out. What he was criticising was actually the NHS fixing the problem, not the months when the NHS had the problem in England.

I have devoted my few minutes to this point because it is something that has got the NHS in England in some difficulty in the past. It is an apparently technical and arcane distinction, perhaps, between the waiting times of the patients being treated and the waiting times of the patients still on the list. You might think that the one would be a reflection of the other. What I have hoped to explain to you is that they are not necessarily a reflection of each other — and, worse than that, if you apply a target to the waiting times of those patients being treated, it distorts the behaviour of managers. All targets distort behaviour — that is their purpose — but this distorts their behaviour in particular ways that are unhelpful.

With that, I will conclude. I look forward to your questions.

The Chairperson: Thank you, Dr Findlay, for that very useful overview. First, this is something that the Committee takes very seriously, for very obvious reasons, in relation to the delivery of health. We are researching this issue, taking evidence and talking to the Department and other experts in the field, and one of the lessons is that it is the complete journey time that needs to be examined. Also, there is a sense, particularly coming from the professor from Trinity College, that to throw money or finances at one part of this particular issue may not, in his interpretation, resolve it, and can often be seen as rewarding bad practice in some ways. I would welcome your views on that. Specifically in relation to the referral-to-treatment (RTT) system that you talked about, we have a response in front of us from the Minister, and he states that it will be challenging both financially and logistically, and he is referring to the disparate reporting systems that exist across the trust. I am very interested in how credible you think that is for preventing us from looking at the whole patient journey. I am interested in your view on that.

Dr Findlay: Measuring the journey time from referral all the way through to treatment has obvious benefits over measuring each stage of treatment separately. The principal benefit is that a typical surgical patient may take the following route through the system. Imagine that you go to your general practitioner with a sore knee. Your GP may look at your knee and say, "I don't like the look of that. I'd like you to go and see a consultant, please". So, you are referred to the hospital. At that point, the clock starts. You might then have a wait, and then you will see the consultant for your first outpatient appointment. On a stage-of-treatment basis, your clock then stops. On an RTT basis, your clock carries on ticking, because what happens next is the crucial thing that RTT targets capture, but stage-of-treatment targets do not capture, which is that the consultant may say, "I don't like the look of your knee either, but I would like you to have a scan to check". So, you go off and have a diagnostic. You then need to see the consultant again after the scan has been done, so that the consultant can make a definitive decision about whether you need surgery, and you may need a further test and then to come back again after that. That cycle of diagnostic and follow-up outpatient appointment can take a lot of time, and there is a possible perverse incentive, which I will come back to in a moment. After the decision has been made to offer you surgery, you then have the wait for inpatient treatment, which, under a stage-of-treatment target regime, is captured as a waiting time in its own right, and then you get your operation.

The potential perverse incentive is this: imagine that you are a manager in a hospital again, and you have a very large waiting list for surgery. You cannot keep up with the demand for surgery. You want to try to slow the number of patients who are arriving on your inpatient waiting list. I am not saying that this is happening in Northern Ireland — I do not know, because I have not seen the data — but there is the potential to delay patients at this diagnostic and follow-up outpatient stage where they are not tracked by a stage-of-treatment target. That is a potential difficulty with the stage-of-treatment regime. With RTT, the clock carries on ticking all the way up to the point at which they get their definitive treatment. So, there is a clear advantage for RTT.

However, it is correct to say that RTT is more difficult to measure. There are two main kinds of RTT target. One measures how long the patient waited, but it only captures that measurement at the point where the patient gets treated. As I have just explained, that can get you in hot water, if that is what you monitor. The better thing to do is measure referral-to-treatment waiting times while the patient is on the waiting list. That is more difficult. If you are measuring RTT waiting times at the point where the patient is treated, all you have to do is say, "You have been treated, so let's look back. When was your referral date? It was back then, so you have waited this long". That is the figure that you report as the waiting time.. If you are trying to capture all of the patients who are still waiting, you have to measure their waiting time since referral, at every stage in their journey: when they are waiting for outpatients, when they are waiting for diagnostics, when they are waiting for follow-up outpatients and

when they are waiting for surgery. That might be two, three, four or five different IT systems, and it might include some paper-based waiting list management systems in the hospital, and you need to capture the data for every one of those. That is a big challenge. So, if you propose to implement referral-to-treatment waiting time targets — which, I think, would be a good idea — you should be advised that it is likely to take some years before you can implement them with good coverage in practice, and that during the transition period, it would be a good idea to retain the stage-of-treatment waiting time monitoring and targeting while the new system phases in. Both systems should be based on the patient still waiting, and not focused primarily on the waiting time of patients as they come in, as previously explained.

You raised one further point, Chairperson, about rewarding failure, throwing money at the places where there are problems, and not resolving the problem. There are ways around that. That question falls into several parts. The key to the issue about rewarding failure is to understand that waiting times are a function of two things. First, how long is the queue? Secondly, in what order are the patients treated? Think of your everyday experience. If you go to a supermarket, it matters that the queuing system is fair so that you have a free choice of which queue to join. You can estimate which queue you will get to the front of quicker. If you go into the post office where there is a single queue, everybody gets seen on a first-come-first-served basis, which is fair. If you have a lot of queue-jumpers pushing in ahead of you, you will wait longer. Queue-jumping pushes waiting times up and can be unfair.

In hospitals, you have patients with urgent clinical conditions such as cancer or aneurysms that need repair. You have a number of patients whose clinical need is greater than the clinical need of others. Those patients absolutely must be treated ahead of the others. They need to get treatment for their clinical condition quickly enough. Incidentally, while we are talking about waiting tines, the single most important thing that any hospital can do is to make sure that its urgent patients are always treated quickly. They are jumping the queue. That pushes up the waiting times for others, but that is OK because that is a good reason to jump the queue.

To the extent that the long waiting times are caused by inappropriate waiting-list management, which is mostly pulling patients out of order when there is no good reason to, you do not want to reward that kind of behaviour by throwing money at it. However, that is easy enough to detect. If, on the other hand, the problem is caused by the waiting list being too big, there is a fair argument that money is the appropriate solution. The hospital has a queue that is very big, and the way to get rid of a big queue is to treat the patients.

There would then be the argument, "If we throw money at a long queue, it will draw in demand and the queue will never go away." If you eliminated the queues at one hospital in isolation, I agree, it could draw in demand from the surrounding areas and you would apparently have achieved nothing at that hospital. However, if you did it across the whole of Northern Ireland, you would not necessarily see that. When the referral-to-treatment waiting-time targets were achieved in England, GP referrals stepped up significantly; I estimate it at about 22%. However, that is not a tsunami of demand. It is not losing control of demand. It is not opening the floodgates. It is 22%. Bringing down waiting times may increase demand — some of that demand may have arisen anyway — but it is a counsel of despair to say that there is no point in trying to shorten waiting times because we will only end up back where we started. I do not think that the evidence supports that.

The Chairperson: That advice about looking at the waiting list as opposed to the patient waiting time is extremely useful and important. You have probably answered my question around what you view as the reluctance in the health service to look at RTT. You have explained that it is a complex and difficult process. Are you aware of other regions that have moved to RTT? Can you give an indication of the cost? We are being told that one of the challenges is financial constraints.

Dr Findlay: I cannot answer the question about cost, I am afraid.

England is quite a long way down the road with this. From memory, I think that it was 2004 that they announced it, and the target was first met in 2008. Initially, it was measured only on the basis of the retrospective wait when a patient got treated. It now also captures all the patients who are still waiting. Even in England, where they have been doing it for some years, they are still not capturing the whole waiting list. If you look at the data by specialty and by hospital, you still see hospitals discovering waiting lists that they had not previously been reporting, and you get a step up in the number waiting; that still happens.

Scotland has been doing it for a few years less. If you want to seek evidence on this, Scotland would be a good place for you to seek a witness. I understand that you have somebody from Scotland coming here next week. They might be able to help you to find an information analyst who is very close to the issues and can assist you.

The Chairperson: Yes, we have looked at the Scottish model through the Assembly Research processes. That is very useful.

Mr Beggs: You said that it would be easy to detect hospitals that tend to produce better figures by moving onto other waiting lists, massaging the figures etc? How would that be easy to detect?

Dr Findlay: Our company has done quite a lot of research in this area to understand the dynamics of waiting-time management. We have looked at the arrival rate of patients on the waiting list and how you can book patients in so that urgent patients are always seen first. It is about following the three principles outlined in the first paragraph of my submission: "safe, fair and short." I would add one more to that: "efficient". The principles are that urgent patients must always be treated within their clinically safe limit. "Fair" means that routine patients should, broadly speaking, be treated on a first-come-first-served basis. I say "broadly speaking" because there will always be exceptions. "Short" means that no patient should wait an unreasonably long time. "Efficient" means that the hospital should be able to utilise its capacity fully in doing all of this.

We have established some very simple rules that hospitals can follow patient by patient to keep the waiting list continuously optimised. By studying that in simulation, we have established the link between the size of the waiting list and the times that patients wait. If you were to say to me, "Here are the figures for the number of patients who arrive on the waiting list at the given rate, this is the number of patients on the waiting list, this is the proportion who are urgent, this is the proportion who are removed without being treated", and the hospital is managing the list on either a fully or partially booked basis, I could tell you, for example, that, "In that case, you would expect 90% of the patients on the waiting list to be waiting less than x weeks if the list were managed according to those rules." In practice, hospitals tend not to manage it in that optimal way, so you would allow a little bit of a tolerance. However, beyond that there is scope for improving waiting times simply by managing patients in a better order.

We can do that visually as well. This will look slightly odd in the Hansard record, but a normal waiting list looks a bit like an elephant. You have the head dropping at the start where the urgent patients are coming in. The elephant has a flat back where no patients are coming in because they are waiting their turn, Then the elephant's rear drops off very steeply at the back where the patients are coming in, broadly on a first-come-first-served basis.

A real NHS waiting list tends to look like a dinosaur's tail. You have quite a lot of patients at the front; then the waiting list dribbles on and on and on and on up to 20, 30 or 40 weeks. It is not at all uncommon to see on a waiting list urgent patients who have waited much longer than they should have. It is not uncommon to find long-waiting patients who do not even have an appointment for surgery, while, at the same time, very short-waiting patients who arrived on the list only two or three weeks ago and who have already got dates for their operations in the next week or two. That is very common.

It is easy to detect when a waiting list is not being managed according to those well-accepted principles and to work out what it would look like if it were and, therefore, whether a backlog clearance is needed to bring waiting times down to a target level.

Mr Beggs: You said that some people can be on the list for a very long time. I have come across constituents who have waited perhaps six months for exploratory surgery with one consultant and then been advised, "Sorry, it is not this problem. It is actually a different problem." They are told that the six-month clock starts again in the wait to see the second consultant. Having to wait a year, or perhaps even longer, before you see the appropriate consultant seems excessive. What is the case in England and Scotland?

Dr Findlay: Without knowing the specifics of the case, that sounds a little bit like a stage-of-treatment issue as opposed to a referral-to-treatment issue. Your constituent has waited a certain amount of time to see one consultant. The moment they walked in the door to see the consultant, the clock stopped. If they are then referred to another consultant, a new clock starts for that second wait. In England — I think also in Scotland, although I am not 100% sure — if they were waiting to see the

second consultant for the same condition, the original clock would still be ticking. Therefore, with regard to the measurement against the 18-week target, the clock would still be ticking all the way through. That is a cause of anxiety for tertiary hospitals in England. If you have great big teaching hospitals with super specialists, they often have patients referred to them who already have 16 weeks on the clock, and it is very difficult for them to treat a patient within 18 weeks.

Mr Wells: This is a bit uncanny. As we speak, my daughter was wheeled into an operating theatre five minutes ago for knee surgery, for which she has waited more than a year. It was the result of a skiing accident, and although it was inconvenient and slightly painful, had the operation occurred in another year's time, there would probably be no difference in the outcome. Has any empirical work been done to establish whether delays led to worse outcomes or is it just inconvenience to the patient? Has any work been done to show that the longer you wait for routine procedures, the worse the outcome may be five years down the line?

Dr Findlay: That is a little bit outside my field of expertise, so I am not sure whether I can give you a definitive answer. However, you would probably find that it would matter in some cases but not in others. If some conditions deteriorate, the operation might save your life, particularly if it were an aggressive cancer, an aortic aneurysm or heart surgery. As I said, that is a bit outside my field of expertise.

Mr Wells: Am I right in thinking that the vast majority of these are things like hips and knees. I can think of dozens of constituents who have contacted me complaining about the 17-week wait. Indeed, they have been put on the list for a knee replacement, but, at the end of the day, although it is very painful it is not fatal. Is that the norm when we are talking about waiting lists, or are we dealing with a lot more complicated issues than that, if it is non-urgent?

Dr Findlay: Your question is more about rationing than waiting. If the patient and their doctor have agreed that the patient should have an operation and if the NHS has promised the operation, the NHS should deliver on its promise. If the NHS does not intend to operate on a patient because it considers the treatment to be of low clinical value, that should be clear to the patient at the outset. That has been done in England, particularly for things such as tonsillectomies and varicose veins — I think, from memory — where there are procedures of low clinical effectiveness and fewer patients are being offered surgery for it. You may be right in that some patients may not come to harm or very limited harm by waiting a very long time. However, my view is that the NHS has made a promise and it should deliver.

Mr Wells: Have any trusts in GB come close to eliminating or dramatically reducing, and can that be done without throwing vast amounts of money at the problem?

Dr Findlay: What — to eliminating the waiting lists?

Mr Wells: To get it down to a month or something ridiculously short. Is anybody coming close to that target?

Dr Findlay: Yes, there are some areas. The curious thing about waiting lists is that some areas have very large pressures while others have very little. This brings us into the area of planning. The NHS is relatively good at big set-piece plans: planning for the next financial year, doing a business case for a consultant or capital development — the big adjustments to capacity. If you were the captain of a ship, that would be charting your course. My impression is that what happens a bit less well is the constant adjustments on the tiller that keep you on that course and the continually adjusting capacity to keep up with demand. That is something that the NHS is not so good at — planning on a time horizon of six weeks to a few months into the future. What happens is that the capacity that the NHS is laying on drifts out of line with the demand for healthcare, so you end up with some areas with very big waiting lists and long waiting times and others where people can go home in the middle of the afternoon because there are not that many patients to treat.

This is an issue of planning, evening out the pressures and of the internal allocation of existing resource to the areas where it is most needed to relieve the pressure on the hardest-pressed areas by recycling resources from areas under less pressure. There are areas that are under less pressure, and there is scope to do that. It is not done as well as it could be, certainly in my experience in England and Scotland.

Mr Wells: You are saying that with proper planning you can greatly reduce the waiting list without throwing vast amounts of extra funding at them.

Dr Findlay: You can even out the pressures between different services. Ideally, planning should be done at the level of inflexibility in the system. Take orthopaedics, for instance. You have consultant orthopaedic surgeons, but they are mostly sub-specialised now: some do hips and knees or possibly only hips. In a very big hospital, you may have surgeons who do only hip revisions. Then you will have shoulder surgeons, spinal surgeons, hand surgeons, foot and ankle surgeons, to the extent that they do only one kind of procedure. That is the level of inflexibility.

In orthopaedics in England, the pressures often tend to be in spinal surgery. If you look at the orthopaedic waiting list in a big teaching hospital, the patients waiting out to a year are very often spinal patients. It is difficult for the hospital to find the capacity in the system to treat them all — some could be 14 hours on the operating table. So there is a particular sub-specialty where, over a long period, the planning has not made sure that capacity is aligned with demand. At the same time, hand surgery may have quite short waiting times in some hospitals.

Mr Wells: Are there good examples of trusts on the mainland that have cracked this? This is a big political issue in Northern Ireland; it is probably the big headline. It is the waiting time at A&Es and the waiting time for routine operations. To some extent, the efficiency of a health trust is measured by those two figures. In my opinion, to some extent at the expense of, perhaps, quality of care, we have to get those figures down. Are there examples in GB where proper planning rather than huge amounts of additional money have produced such results?

Dr Findlay: Not that I am aware. It is a problem almost everywhere. Waiting list initiatives are often done, so you do not have an early warning of pressure but actual pressure. You have actual long-waiters. Hospitals have difficulty booking in patients within a reasonable time, so they know that they are going to have trouble with their waiting times. Therefore they lay on a waiting list initiative, negotiate extra capacity, put non-recurring money into it and clear the problem for the month.

Guess what, a couple of months later they have the problem again because it is not an issue of a backlog that needs clearing. The issue is that supply is not keeping up with demand. It is their baseline that is wrong. They do not need extra now just to clear a bit of list. The problem is that their list is growing. They are not keeping up. Even now, you will find examples in English hospitals of the plans for next year not being based on demand but on hospitals' ability to supply.

Let me give you a more sophisticated example. A hospital is doing its plans for next year. It is an inclusive process, involving all the stakeholders, all the general managers and clinicians in the hospital. It is a devolved process and you say to the managers, "What is your plan for next year?" They may go through a sum that goes something like this, "Well, I have this many consultants, they have this many sessions a week, and they do this many patients per session. Multiple those three numbers, and you get the number of patients that we can treat every week. Multiple that by 42 weeks of the year or however many weeks the consultants work and that is the number of patients that we will treat in a year. That is our plan." Where is the demand for healthcare in that calculation? Nowhere. It is a plan based purely on the hospital's ability to deliver. I know that, in Northern Ireland, you have an exercise that is about planning capacity starting from demand, and that is the right thing to do. That happens in most places in England. However, it is by no means universal, and there are a significant number of hospitals in England that base their plans on their capacity to deliver and not on starting from the demand for healthcare.

Mr Wells: I was hoping that you were going to point us in the direction of south Essex or north Yorkshire so that we could go over and get the information and come back and solve our problem.

Dr Findlay: Most hospitals do long-range planning based on demand. Many hospitals tweak their capacity at short range — the next two, three, four or five weeks — to respond to specific problems, but the crucial range is six weeks to a few months. It is outside the annual leave notice period when you do not know the names of most of the patients and capacity is still reasonably flexible. There needs to be good week-by-week planning in that area. I do not know of any examples of hospitals that are really good at that.

Mr Wells: We had a brief chat about this over lunch, and it is a point that I made when Professor Normand was here recently. It never ceases to amaze me when they build a new primary school in south Down, children just appear from nowhere. It is extraordinary. When you add the sum total of all

the old schools that it replaced, suddenly, there are another 50 children, and we do not know where they came from.

Similarly, if you build a new road, the traffic will increase to populate it very quickly, and, suddenly, you have as much of a problem with tail backs as ever. Is there evidence that there is a latent demand that is not in the statistics, which will become evident if a trust is performing particularly well? In other words, people who elude their GPs, or even themselves, by thinking that there is no sense in putting their name down for a routine operation because they will have to wait for ages. Does it become a self-perpetuating problem in that more people come forward because the rumour has got out that you get quick treatment?

Dr Findlay: You would need to ask a health economist, but I will make two observations. First, as I understand it, it is well known that you stimulate demand if you appoint a new consultant, particularly if it is a consultant who has a special interest that is not currently served in the local population. In that case, you get people popping up who have that condition wanting treatment.

My other observation is the new motorway that quickly fills up with cars; however, at least people are getting to their destinations more quickly. Therefore it is not necessarily a bad thing.

Mr Wells: The demand on the service is still as intense if new people are coming forward to replace the more efficient model that you have. You never get to the bottom of the pile because people are coming into the area for treatment because the rumour has got out that there is a particularly efficient model.

Dr Findlay: Yes. I will go back to my earlier remarks about the experience in England. In 2007, hundreds of thousands of patients had been on a waiting list for more than a year. The 92nd percentile waiting times were out to nearly a year. Now, there are only a few hundred patients on the waiting list for more than a year in England, and 92% of the waiting list is well within 18 weeks. There has been an enormous reduction in waiting times in England across the whole country. There has been a step up in GB referrals in that period — 22%, as I said earlier — but it is not out of control. It rose and then it broadly stopped rising. It was a step. I think that a health economist would be a better person to ask, but I am not convinced that there is good evidence of the rationing impact of waiting times.

Mr Beggs: You talked about hospitals needing to react to demand in their plan. Are there good examples of hospitals adapting quickly to that demand? My perception is that generally what happens is that, in the end-of-year monitoring round, money comes and it is just fired off to the private sector for it to deal with rather than the hospitals and consultants putting in additional capacity and overtime for staff.

Dr Findlay: I recognise that scenario from England and Scotland, but particularly England, where the use of the private sector is more widespread. Most hospitals, certainly in England, could do a better job of planning their baseline capacity in line with demand over all timescales, particularly the six key weeks to a few months into the future timescale, which is when they need to be responding to seasonality and changes.

The use of the private sector is widespread in England, although it is not necessarily an easy option for hospitals. They are losing the income by paying for treatment in the private sector. It may cost more or less, depending on the deal that they have struck. I do not have a view on the merits of public versus private, but I will make one observation about the potential conflict of interests that it puts before the consultant. If the same consultant is operating on a patient in the private sector as would have operated on a patient in the public sector, and the consultant is being paid for that, there is a potential conflict of interest for that consultant that could push them in the direction of maintaining long waiting times.

How do you solve that, if you are using the private sector and it is the same consultants? One option is to try to make sure that it is not the same consultant. It can be difficult to persuade patients to change consultants if they have already met them in clinic. Most, but not all, patients typically say, "I would like to see the nice doctor I saw in clinic, please". Therefore the ideal time to move them is before the first outpatient appointment. Many more patients will agree to move at that stage than after an outpatient's appointment.

Mr McKinney: I had one point, but I now have two, because of the point that Roy made. Does the use of the private sector to get rid of the problem quickly encourage bad practice?

Dr Findlay: What sort of bad practice are you thinking about?

Mr McKinney: Does it encourage bad practice in meaningfully dealing with the problem. You are dealing with something that has erupted, or you are factoring in something to try to eradicate the problem, and you are not dealing with the problem as a whole.

Dr Findlay: Yes, I see what you mean. I suppose that it could, but I think that it is another manifestation of not dealing with the underlying problem. As I said earlier, a waiting time problem falls into two parts: the waiting list is too big, or patients are being managed in the wrong order — or both. In many hospitals, they do not know which of the two is the problem. The analysis exists now to tell the difference. Relying on short-term solutions, whether by bringing in locum and bank staff, exporting patients to the private sector, or by using some other short-term waiting list initiative, is part of the same approach of trying to fix a problem that we have this week or this month rather than realigning baseline capacity to fix the longer-term shortfall of capacity against demand, which, incidentally, is usually cheaper. It is usually cheaper for the NHS to adjust its baseline capacity than it is to pay, usually, premium rates for locum or other short-term work.

Mr McKinney: Thank you for that; that is very helpful. I was struck by your original slide, and I was thinking of lies, damned lies and statistics. In essence, that was an interpretation by the paper of what you point to as otherwise good work, because there was a 2·8% drop in the overall figure. Jim was not able to drag you to a particular place in respect of expertise or an example of good practice, but what are the drivers for political and management change, and what are the ingredients for change? Can you sum that up for me?

Dr Findlay: Yes. My favourite Aesop's fable is the one about the sun and the wind trying to get the fellow's overcoat off. The wind blows and blows, and the harder it blows, the tighter the guy holds his coat around himself. Then the sun comes out, and he says, "Ah, that's lovely", and he takes his coat off. If you want something done, people have to want to do it. How do you make them want to do it? In England, they did targets and terror. It achieved the result; there is no denying that. When the coalition Government came in, they experimented with not having centrally enforced targets, and they were promptly rewarded with the failure that I showed in my third chart. If they did the same, I am sure that they would be rewarded in the same way with another failure. The targets-and-terror approach worked.

I am not a great fan of targets per se. There is a risk that the target can be literally something that you try to hit as accurately as possible, but it should be a backstop, a minimum standard, something that the NHS usually comfortably exceeds so that it is rare and unnecessary to enforce it.

How do you reach that happy state of affairs? If you were to have a target as a minimum standard, you may wish to set it not as a stretch goal for the service to get to but as something that the service should comfortably be able to achieve. Then you should focus on getting well below that target by concentrating on the two underlying factors of waiting times — the size of the waiting list and the order in which patients are treated.

Put very bluntly, as I said in paragraph 12 of my submission, when focusing on waiting times it is easy to forget the waiting list. That happened widely in England; people forgot to watch the waiting list. If the waiting list is getting bigger, you have a problem; if the waiting list is going away, your problem is going away. If you want to reach the happy position where there is no involuntary waiting in the NHS, getting rid of the waiting list is the way to do it.

Mr McKinney: You talked about people having to want to do it and you said that targets and terror worked even though it was not necessarily nice. In our context, what is the driver? Is it ministerial or departmental will? At what point in the chain of command is the driver located?

Dr Findlay: I am afraid that I cannot answer that. That is not my field of expertise; I am not a manager or a politician. You had better ask someone else about that.

The Chairperson: Thank you for that. It has been very informative, Dr Findlay. Thank you for taking the time to talk to us. There is a lesson in this, because I am reflecting on the fact that we have called

this review a review of waiting times. One of the things that we have learned today is that we should not lose sight of the waiting list. There is a recognition from your evidence that this is complex but that processes such as referral to treatment are productive and can deliver if they are done alongside the stage-to-patient journey. That has been very useful, and the discussion about targets is specifically relevant to us. In your paper you say that even if there is a target it should not be a 100% target and that we should be realistic about people, obstacles and changes, the patient journey, cancellations and holidays. That has been useful.

We really appreciate your evidence. We are actively working our way through this process, and it would be very useful to share our recommendations with you and to hear your feedback.

Dr Findlay: I would be delighted to do that.

The Chairperson: Thank you very much for sharing that with us.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times:
Professor Luigi Siciliani, University of York

26 February 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Professor Luigi Siciliani University of York

The Chairperson: I welcome Professor Luigi Siciliani, who is professor of economics at the department of economics and related studies at the University of York. The procedure is that we will ask you to make a 10-minute presentation, and I will then invite questions from members.

Professor Luigi Siciliani (University of York): Thank you very much, Chairperson. It is a pleasure to be here. In my 10 minutes, I will try to give you an overview of maximum waiting time policies across the Organisation for Economic Co-operation and Development (OECD) countries. Then, time permitting, I will discuss some waiting time measurement issues. Most of this draws from a review of the policies that I co-edited for the OECD. I will give you the headlines and a brief summary of the 300-page report.

Across the OECD countries, the most common policy is to have a maximum waiting time. You see convergence across several countries in the way that their policies develop by their specifying a maximum. The way that the maximum is specified and used in different countries can be quite different, and that is where I want to identify three different groups. First, the maximum waiting time is used as a target. This was used in England and Finland, for example. Under that, if providers do not perform within the maximum time and have patients waiting beyond that target time, they receive penalties. That is one way to use the maximum waiting time.

Other countries do not like that approach and prefer to mix it with incentives that are more related to choice and competition so that patients who wait more than the maximum time are entitled to seek treatment in other public hospitals or, maybe, in a private hospital at the expense of the public system. That is a quite different way to use the maximum waiting times, and this approach has been experimented in Denmark, the Netherlands and Portugal.

The last way to use the maximum waiting time is quite different and is a tool of prioritisation. It is not so much about penalties and targets; maximum waiting time is used simply as an indication of the severity of a patient's condition. Countries such as New Zealand, Canada and, perhaps, Norway have gone down this route, so their key focus is prioritisation.

Generally, there is a trend to differentiate maximum waiting times, so you may have general maximum waiting times for all elective care but some shorter ones for more urgent care such as cancer and heart conditions. I have observed that across a range of countries.

My key policy message from the review is that we know that, generally, supply policies are not necessarily successful in reducing waiting times because you increase the supply and, possibly, the demand goes up by the same amount, so nothing happens with waiting times. I have seen that a key ingredient of success is to combine increasing supply with a maximum waiting time, which results in an increase in the supply but keeps the demand under control. Having a maximum waiting time means that referrals cannot go up so quickly. In a few countries, this has led to quite substantial reductions in waiting times.

For the rest of my few minutes, I will go through some examples. I will go through the English examples quite quickly because you are probably quite familiar with what has happened there. England started with quite high waiting times in 2000: more than 200 days for a few elective procedures. As targets were introduced and more resources were put into the system, waiting times went down quite rapidly from more than 200 days to 50 days for some elective procedures such as hip replacements. One key issue with maximum waiting times is the potential for misprioritisation. Quite often, doctors make the point that one potential problem with a maximum waiting time is that it really applies to low-severity patients. In a system using prioritisation, the patients with lower severity tend to be treated later. So, potentially, you could have the maximum waiting time being applied to low-severity patients at the cost of higher severity patients waiting relatively longer. Maybe there is some evidence that this behaviour is happening.

Finland had a similar experience, so it introduced maximum waiting time targets. In 2000, it had very long waiting times, similar to the English ones, and it also managed to reduce them. Again, this was achieved through a combination of extra resources and a healthcare guarantee that specified a maximum waiting time for patients.

I will move on now to the second type of policies, which involve more choice. That has been experimented for a few years in Demark, where it was said that, if a patient had waited for longer than a certain time, they could go to, for example, a private hospital. That seems to have contributed to some reductions in waiting times.

One policy that I really want to mention is that of the Netherlands. Between 2000 and 2010, there have been quite some dramatic reductions in waiting times. In 2000, it had, on average, 15-week waiting times for a few elective procedures. In 2010, this was only five weeks, so waiting times went down quite a lot. How did the Netherlands do that? On one hand, it introduced some maximum waiting times, although its preferred terminology was "socially acceptable waiting time", which specified, for example, a maximum of seven weeks for inpatient treatment, and that was combined with another rule that 80% should be treated within five weeks. This is another alternative way to specify the maximum. You set a maximum waiting time for everyone, but you say that a proportion of the patients have to be treated within a shorter timescale. In doing so, you tackle, to some extent, the issue of misprioritisation, and the focus on low-severity patients is lessened.

In the Netherlands, that was not the only reason for the reduction in waiting times. Introducing a maximum waiting time would not have been as successful if the Government had not at the same time relaxed the capacity constraints. In 2000, hospitals changed from a fixed budget to activity-based payments. Specialist remuneration also changed from lump-sum payments to a fee-for-service scheme. All of that contributed to increasing the volume of activity.

These days, policymakers are no longer concerned about waiting times. Their main concern is the sharp rise in health expenditure. Sometimes, there are big trade-offs to be made. You can solve some problems — for example, reducing waiting times — but that can come at the cost of significantly higher expenditure.

The third type of policy is the use of waiting times as a prioritisation tool. The New Zealand experience is quite interesting. There, patients are divided into three groups. Patients can be booked in straightaway; be certain that they will be treated within six months; or put into active care and

review, which means that they are sent back to their family doctor to be checked. The idea is that some patients on the low-severity spectrum should not be put on the waiting list but sent back to their family doctor for review. That is more like a demand management policy.

The New Zealand Government tried to facilitate this policy through the development of prioritisation tools. To be practical, I will give you an example of how these tools look in practice. For hip replacements, a form asks what the patient's level of pain is when in motion and when at rest. Each level has a score attached to it, which gives a severity index. There are some formalised guidelines and tools that could facilitate prioritisation, and they are linked to the formulation of the maximum waiting time.

The last policy that I want to mention is the one in Norway, which uses waiting times as a prioritisation tool in the sense that every patient is entitled to an individualised maximum waiting time. That is quite different from the maximum waiting time policy that we normally observe in England or Finland. In Norway, a specialist sees a patient and, based on severity, decides on their maximum waiting time. One patient could be told six months, the next patient three months, so it is an individualised maximum waiting time.

Those policies solve the potential problem of prioritisation that comes from unconditional maximum waiting times, but, on the other hand, perhaps they introduce too much discretion into the system. The early evidence from the evaluation of the Norwegian policy is that it did not change dramatically waiting times in any way.

I have given you an overview of the policies on maximum waiting times and tried to distinguish between the three main types: use maximum waiting times as a target; combine them with choice and, perhaps, some involvement of the private sector; or use them as a tool for prioritisation. I have some measurement issues to discuss, but I will pause in case there are questions.

The Chairperson: Thank you very much. While conducting this review, we have been continuously told that we need to look at the complete patient journey and not just a part of it. Is that your sense of the issue? Should we be looking at the entire patient journey from the time of referral for treatment?

Professor Siciliani: Based on the current evidence, that is a good idea in general. Several countries are moving towards the idea that you should follow the patient journey. One reason is so that you have a complete measure of waiting times, but also so that, generally, we can understand the patient-care path better if we do that. So it seems a good idea to me. Some countries have moved in the direction of measuring the referral-to-treatment time (RTT), but it is still early days. England and Denmark use referral-to-treatment time, but we do not have too many countries from which to draw experience and judge whether it has worked well.

From the English experience, I observe that some complications arise from using the referral-to-treatment measure. You need to report at least three different types of measurement. Normally, in England, you have the admitted pathway and the non-admitted pathway, and the number of patients on the waiting list and the number who have been treated. That leads us on to the measurement issue. There are two main ways to measure waiting times: take a snapshot of the number of patients on the list and check how long they have been waiting; or check the total number of patients treated in, say, a given month, and find out how long they waited. Those are really two different measures, and there are benefits and disadvantages to using each. Possibly, it would be a good idea to have both. When you put that idea in the context of measuring referral-to-treatment times, the snapshot measure does not tell you whether the patient will be admitted because patients on the list will be a mix of the two distributions. However, with the number of patients treated, you know whether they received hospital treatment, or maybe some just saw a specialist and did not need surgery. So you can see that the idea of measuring referral-to-treatment time is interesting because it covers the patient journey. However, it brings in some extra complications, which mean that, in practice, you may need at least three different measures of waiting times.

The Chairperson: Is it your view that there needs to be a separation of waiting lists and waiting times?

Professor Siciliani: There are different orders of measurement. The most basic distinction is between waiting time and waiting list. The waiting list is simply the number waiting. I think that, possibly, policymakers have moved away from just counting the number of patients on the list. Perhaps, what you are suggesting — maybe I have misunderstood — is that we measure the waiting

times of the patients on the list. There are benefits from and disadvantages to measuring that. If you measure the waiting times of the patients on the list, you have a reasonably accurate and responsive measure of what is going on in the system at that time: they are the patients on the list at that time, so you can check the distribution and the average. It could be useful for monitoring purposes. On the other hand, it measures an incomplete waiting time because, by definition, the patients on the list are still waiting, so you do not have the full measurement of how long the journey has taken. That is where the other measure is really useful: if you have the average waiting time of patients treated within a given month, you know that they have completed the journey. That is a more accurate reflection of the patient journey, but it can be made only with a delay. As the patients have now been treated, your measurement is actually of the numbers of patients treated in the past, so you do not have a very accurate measure of what is going on with patients at that point in time. In that sense, there is scope for measuring both because each captures a slightly different aspect.

The Chairperson: You have given us some detail of a decrease, or positive impact, on waiting lists and waiting times. Has there been any analysis of the impact of that decrease on health outcomes or even economic outcomes?

Professor Siciliani: Some research has tried to test whether patients who wait longer have worse health outcomes. In my assessment, that literature is not huge and is still a little preliminary. I am aware of some studies, mainly from Canada, that tried to test whether longer waiting times affected the health outcomes of patients waiting for a coronary bypass. The study seems to suggest that, while they were waiting, patients were more likely to die while waiting or maybe had a higher chance of having an emergency readmission. So, for coronary bypass, there seems to be evidence that goes in that direction.

There is other evidence that relates more closely to orthopaedics departments and, for example, hip replacements. That evidence seems slightly more optimistic, in the sense that longer waiting times do not affect how much pain the patient experiences. Whether the patient waits six months or three, the condition does not get worse with the passing of time. That is my reading of the evidence, and those are the two primary examples that I have been able to identify.

Mr McCarthy: Thank you very much for your presentation. Are we omitting accident and emergency?

Professor Siciliani: So far, I have omitted accident and emergency. The primary focus of my review was elective surgery, so it is really about the long waiting times for patients. From my reading of the literature, I think that the issues that you have with waiting times in accident and emergency are quite distinct from those for elective surgery. So all that I have said applies to patients waiting for elective surgery. You are right.

Mr McCarthy: We could keep you here all day talking about accident and emergency, but you have not gone down that road. What are the most important aspects of treatment times that we should seek to measure in order to get an accurate view of performance?

Professor Siciliani: The referral-to-treatment waiting time seems to me to be a good measure, in the sense that it captures the full journey. I suggest capturing the three distributions. Once you have those, I do not see why you should go somewhere else or try to seek collection of other data. One thing to keep in mind is how you want to collect the data: ideally, it would be nice to collect it from existing sources so that you do not have to start a new data collection. My understanding is that England had a separate new data collection for RTT.

Mr McCarthy: Is there a critical mass of countries measuring referral-to-treatment times?

Professor Siciliani: At the moment, the only two countries that use RTT are Denmark and England. Other countries are not measuring referral-to-treatment times. That is, I think, because it is still early days, and, although people like the idea of measuring the patient journey, the other two waiting time measures are traditional. Many countries have chosen either one or the other, so they all focus either on inpatient waiting times or the patients treated. So there is lots of heterogeneity and, hopefully, over time, we will converge on the measure of time from referral to treatment.

Mr Wells: The stats are very interesting, and the UK does not come out very well in your analysis. I suspect that, within the UK, Northern Ireland is probably even less impressive. You are citing data from countries such as Norway, the Netherlands and Denmark, which are all very wealthy countries

that allocate a huge proportion of their income to social welfare and health treatment. Your English is extraordinarily good, but have you ever heard this question: are we comparing apples with oranges? In Denmark, for example, where tax rates start at 40%, if you throw enough money at the problem, presumably you have enough money for a good programme to address waiting times.

Professor Siciliani: I see your point. However, you might think that in the Nordic countries, where public budgets are quite high, there should be no waiting times at all. So it is perhaps surprising that even countries such as Norway or Denmark have significant waiting times. Some of those countries have been successful, but even countries such as the Netherlands had a significant problem. It is true that they put in quite a lot of extra resources, but now even the policymakers are saying that health expenditure is rising too quickly, and it could be that they will scale it back. I think that many countries are struggling with the waiting time problem. It is not all about income and how rich the country is.

Mr Wells: I was intrigued by your comment that, in some countries, if you cannot get a hip replacement or whatever done within the appropriate target time, you have a right to go to a private provider, get the work done and bill the health service. That nugget of information was in the middle of your presentation. Will you give us a little bit more detail about it? That is quite revolutionary.

Professor Siciliani: That is the Danish experience, and perhaps I should qualify that policy a little bit better. A patient, after the maximum waiting time, is entitled either to treatment in another public hospital, maybe in a different region, or through the private sector. In practice, the number of patients who choose to do that is not massive, so, in a way, although the policy states that that is the case, in practice, there were some increases in private sector involvement, but they were not massive.

If you think also about the English experience, where the independent sector was brought in, that sector can do 5% of extra elective procedures like hip replacements. Private sector involvement is one ingredient in this policy, but I would not say that it has the critical mass to be the contributing factor that would reduce waiting times, even in Denmark or the Netherlands.

Mr Wells: The model here is different. The patient does not have the choice. If the health trust finds that the wait is too long, it can commission the private sector to carry out a number of procedures. Indeed, in Northern Ireland, we allocate procedures to hospitals in the Irish Republic, so people will go down to Dublin or Athlone and get treatment. What is so radically different about what you describe is that, once a certain date passes, the patient has a right to knock the door and say, "I demand that this be done." Does that then concentrate the minds of the health trusts or equivalent in the sense that, presumably, they do not want to pick up that bill and, as it is more expensive, they try to stay within their limits?

Professor Siciliani: Yes, that was the intention of the policy. The Government hoped that this would have a disciplining effect so that the initiating hospitals or local authorities would try to stay within the maximum waiting times in order that this would not happen so much. I think that Portugal followed a similar idea and route, although it is not listed in my presentation. You will have another presentation next month. Again, in practice, that works maybe as a threat, but there are still not a huge number of patients who exercise that choice.

There is a combination of factors. There is always a choice of how to structure the involvement of the private sector: do you just try to involve the private sector and ask whether it can do this extra elective care, or could you use the same resources for the public hospitals and ask the doctors working there to do that extra volume of work? There are some different policy options here that, maybe, in the bigger picture, could be equivalent in the sense that, if you have some extra resources, you can give them to the private sector; the private sector might recruit doctors working in the public hospitals; or you could have public hospitals with public doctors and ask them to do extra sessions and tell them that you will put some extra resources on the table.

Mr Wells: Is there evidence that having a high-quality service for procedures and short waiting times generates more work? In other words, if people perceive that there will be a short time to wait, as in, for instance, in the Netherlands, which is an extremely good performer, does that just cause more work because GPs and patients are more likely to demand that type of surgery rather than making do?

Professor Siciliani: That tension is always there with waiting times. When you expand the supply, your primary concern is that demand will go up and then you start to do marginal care. That is where the maximum waiting times policy comes in: you say that the maximum has to stay within the five weeks, three weeks or whatever period has been set by the regulator, and that keeps the focus on

keeping the referrals more limited. Otherwise, demand would go up, and you would not be able to have a short waiting time. In that sense, it is, I think, a combination of supply and maximum waiting times that help to keep the demand under control.

Mr Wells: An obvious question is why Italy does not feature in any of this research.

Professor Siciliani: Italy was covered in the review. However, it has 20 regions, and there is quite a lot of heterogeneity in it. That made Italy quite difficult to cover in my 10 minutes before the Committee. It is there, but we would need a long digression.

Mr D McIlveen: Thank you for your presentation. From the point of view of the work that we do on a day-to-day basis in our constituencies, to the person who is waiting for a hip replacement, knee replacement or whatever it should happen to be, this is hugely important. I think that this piece of work is really important. A lot of the media focus is on accident and emergency, but it would be wrong to ignore the suffering that people quietly endure on a day-to-day basis, as their name creeps slowly up the waiting list. You have given a very helpful overview of what different regions are doing. Can I encourage you to come off the fence a little? I say that with the greatest of respect. Can you give us an indication as to what, in your experience, works best?

Professor Siciliani: I risk repeating myself a little. The combination of extra supply with maximum waiting times works best to make sure that waiting times for hip and knee replacements are brought down to acceptable levels. Many governments try to create those extra resources, but how do we make sure that that does not just translate into extra referrals and waiting times do not change? We need that combination. Having read reviews and evidence from all these countries, I made that my main conclusion: we must combine the two. In the past, most countries would act either on one side or the other. They would increase supply and hope that waiting times would go down, but that would not happen; or they would decide that patients should not have to wait longer than 30 days without receiving an explanation, but that would not work either.

So, to me, the key is understanding that waiting times are a demand-and-supply phenomenon. You can create extra supply in different ways, either by increasing capacity in the public sector or by involving the private sector. Those are the alternatives. However, the key is demand. We must make sure that demand for referrals does not respond so quickly to reductions in waiting times. We hear stories that, when waiting times reduce, doctors tend to make more referrals. That is the balance that has to be struck. To me, that is the key.

Mr D McIlveen: Perhaps I will reword the question, and put it in a different way. If the Chairperson were to ask you where she should book a flight to in order to explore best practice, where would you suggest?

Professor Siciliani: I would suggest the Netherlands, because that is where I saw this happening. There, they did not like the phrase "maximum waiting times". They brought doctors round the same table and asked what was the reasonable maximum time that patients should wait on medical grounds. That seemed like a good starting point. Once that had been settled, they asked what resources were needed to bring supply to that level and to make sure that it stayed there. Therefore, I would say that the Netherlands was the best example.

Mr D McIlveen: In your research, did you find that there were any obvious societal differences between what is happening in the Netherlands and what happens in the UK? As my colleague said, we can pour money into things, but, if there is no change in society, culture or how the public thinks, it can result in throwing good money after bad. Is there a cultural difference between the attitude to healthcare in the Netherlands and that in the United Kingdom?

Professor Siciliani: In the Nordic countries, and perhaps in the Netherlands as well, you do things more by consensus and almost by unanimity. Everyone is brought round the table to make sure that everyone agrees on the plan. That is not necessarily always the case in other countries. It may be more top-down, and they say "These are the targets; get on with it". That is the major cultural difference.

Mr Beggs: Thank you for your presentation. You talked about the considerable improvement in New Zealand, and you can see quite a dramatic drop in its waiting times over a one-year period. Your explanation for that is that a mixture of issues has brought about best results in certain areas,

including an increase in service delivery and a part review of the waiting lists. Can you tell me a bit more about the review of waiting lists? It is easy to remove someone who has already been treated; that is non-controversial. However, you also indicate that many patients were informed that they would not be assessed. How do they get on the waiting lists if they do not need to be assessed? I am trying to understand how people would be removed without some sort of clinical assessment.

Professor Siciliani: It is a reasonably common phenomenon that I have observed in various countries that, when the waiting list problem suddenly becomes more of a real policy concern, the first thing that policymakers try to do is make sure that the data are of good quality, and that is when the reviewing of the data happens. I have an old paper that contains some very similar pictures for England and its early initiatives on waiting times, and, basically, the waiting list data were not very good in the sense that, on that list, there were patients who were on other lists in other hospitals, or perhaps some patients had already received treatment. Therefore, in a way, patients who were not supposed to be on those waiting lists were part of the review of waiting lists. That was inflating waiting lists for no reason because those patients were not supposed to be there. I have seen in a few countries that, when you try to make a jump in the quality of the data, in the first review of the data, the waiting lists will suddenly drop and will then stabilise, since, once you have taken out all the patients who were not supposed to be on the waiting lists, they are gone. Once the quality of the data becomes acceptable, those patients are not added to the waiting list. You have that one-off effect. The drop is only partly due to that. However, other things were going on at the same time, including a bit of an increase in supply and perhaps some patients having sent back a negative carer review. That was just one of the ingredients.

Mr Beggs: I am trying to see for what other reasons people would be brought off their waiting list and returned to the GP. I recently came across a constituent who had been referred from his GP to a consultant for a hip replacement. Part of the process in Northern Ireland is to go through an Integrated Clinical Assessment and Treatment Service (ICATS) centre. He waited for a few months to go there. Having passed that and it having been identified that he did need a hip, he was referred to a consultant for whom there was six-month waiting list. Once he sees the consultant, there will be another six-month waiting list for the operation. You said that, in New Zealand, people wait six months for treatment. Is the definition of "six months waiting for treatment" the same everywhere? Six months does not really mean anything to my constituent: he has been waiting more than a year.

Professor Siciliani: The New Zealand policy was six months to see a specialist and six months to get surgery. I do not know whether that answers your question. I mentioned initially the active carer and review group, which is the most interesting thing for the New Zealand experience. When the policy was initiated and introduced, the government decided on a clinical threshold over which patients can benefit from surgery and an economic threshold, and those were the terms used in the policy documents. Ideally, all those patients could benefit. However, there were perhaps 200 patients but money for only 100 to be treated; that is where the active carer and review group came in. It was the gap between what could be funded and afforded by the public system and the patients who could be treated. In a way, it is the rationalisation of demand. Rather than add patients to the waiting list and hope that, at some point, they will be treated, the idea was to make demand management more explicit so that some of the patients who would never be treated — even if they were on the waiting list — could be sent back to the family doctor for active care and review. That was the idea. I am fascinated by the New Zealand policy, because it looks quite different from any other policy that I have seen in any other country.

Mr Beggs: Have they significantly moved the point on the threshold at which you would get treated?

Professor Siciliani: I think that the idea has evolved over time. I do not think that the threshold has been operationalised in a very precise way. The answer to your question is that the threshold is still informal. It is there, but it is not precisely measured.

Mr Beggs: You say that it is informal. Does it just qualify whether the money is there to allow you to be operated on and then people are prioritised based on that and, therefore, if you are not a priority, you are not on the list? Is it as simple as that?

Professor Siciliani: The family doctor and the specialist have to work together. The idea is to prioritise patients early on so that you can rank the severity. You use that information to decide the patients who are entitled to public treatment and those who are not.

Mr Beggs: So it might not be a good area to look at.

Mr McKinney: I have two consequence questions. Are there financial implications in maximising supply to deal with waiting times? Does your proposal for the best model cost more or less or is there evidence to show that it is within budget?

Professor Siciliani: The policies that have been successful, in the sense that waiting times have gone down, were all accompanied by a significant increase in resources. They are not policies that come free; they probably implied significant extra expenditure. Most of the policies were in the early 2000s and onwards, before the recession. In those times, it was a little easier to provide extra resources. Now that we are in recession, it will perhaps be more difficult to implement similar policies, because the budget is more constrained for everyone. Replicating that idea, starting at a higher level of waiting times, will be more difficult. You can still try to experiment and introduce maximum waiting times with not so much of an expectation for an increase in supply. However, it will be harder to obtain a reduction in waiting times.

Mr McKinney: Over time, has that cost stayed up?

Professor Siciliani: The way to think about waiting times is as a dynamic phenomenon. In past policies, one way of reducing the waiting list was to introduce a one-off increase in supply, which would make it disappear. However, that does not work. You need a steady increase; otherwise you will reduce the backlog for a period, but it will tend to come back. The policies are long term with constant increases in expenditure. If you have an increase in supply, it should be a permanent and not a temporary increase.

Mr McKinney: Do the proposals have any positive or negative impact on other waiting lists associated with the health service?

Professor Siciliani: Normally, the more recent policies try to affect all elective care. In that sense, they should cover quite a lot of the healthcare setting. That seems to be a good way of doing it; otherwise you would be concerned that, if you focus on one subset, other areas may suffer. Here, the concern may be about elective versus accident and emergency in the sense that you focus on elective procedures at the possible cost to accident and emergency. I am not aware of evidence to support that, so I cannot comment specifically on it.

Mr McKinney: I wonder whether savings are to be had or whether additional costs would be imposed elsewhere as a result of doing this.

Professor Siciliani: I am not aware of any evidence as result of trying to look at how extra resources being provided to, or a focus being put on, maximum waiting times could have diverted incentives from other areas.

Mr Dunne: I think that most of the points have been covered. Is there any evidence that the use of the private sector goes a long way to improving the waiting times?

Professor Siciliani: No, that is just one complementary policy among others. Normally, the private sector is used in conjunction with other policies that reinforce it. So far, from what I have seen, there are no policies that introduce the private sector only, so it is difficult to disentangle what is due to the private sector compared with the other policies. My overall impression is that the private sector was an ingredient and was one of the determinants that helped the success of these policies, but it was not, perhaps, the number one. The focus on the maximum waiting time was more important. The increase in supply could be obtained through the private sector but could also be obtained in other ways. Perhaps increasing the sessions and changing the contract for specialists and doctors who work in the public sector could be another way, as could building new public hospitals. Those are alternative policies, and I do not necessarily see that the policy of using the private sector in itself is the one that dominates.

Mr Dunne: What about the internal processes in the existing services? Is that an issue that is worthwhile addressing?

Professor Siciliani: You are referring to the dual practice issue.

Mr Dunne: Yes.

Professor Siciliani: That is an important issue that needs to be addressed, because people in health policy know that the dual role of doctors generates a conflict of interests. Especially on waiting lists, you know that, if the waiting list is longer, the patient will be more willing to go private if they can afford it. In that sense, there is a conflict of interests.

Mr Dunne: That is a real risk.

Professor Siciliani: It is a risk. First, you should think about why you want dual practice to exist. Is it because doctors are more willing to work in the public sector? Perhaps it brings other benefits. Do you really need it? Perhaps you could change that element and say that doctors work for the public sector only. Those are all policy options. There is a conflict of interest there, and that has to be taken into account when deciding policy. I do not think that there are any easy fixes.

Mr Dunne: There are no easy answers.

Professor Siciliani: No.

Mr Brady: Thank you for the presentation. In your paper, you give an example from western Canada of prioritisation guidelines on hip and knee replacement. That seems to deal with the person as opposed to the system, because it asks whether the pain on motion is none/mild, moderate or severe, whether pain at rest is none, mild, moderate or severe and asks the patient to assess their ability to walk. Therefore it seems to be looking at how the person is affected as opposed to putting them into a system where they become just a statistic. Is that how they look at it in western Canada, because, if a person is in severe pain, they will be prioritised, presumably because their mobility and quality of life is affected? That seems to be patient-centred rather than looking at numbers and statistics.

Professor Siciliani: Let me say a bit more about the Canadian policies, which resemble those of New Zealand. We know that prioritisation goes on informally and that doctors are pretty good at it. The idea behind the policies was to develop a tool that would help doctors to do something that they already knew how to do a little. It is correct that that system puts the patient at the centre. It was quite costly to develop those guidelines, because, basically, you had to bring together doctors, patients and members of the public. The guidelines are interesting tools. They help the prioritisation but, at the same time, if you are thinking large scale, they are potentially quite costly to develop, in the sense that we have one for hip replacement and three or four others, but they still cover a small subset of care. So, these tools can help but there is a danger in the sense that they are costly, so I do not necessarily see them as the solution to the whole problem. Ideally, if this were to be costless, then —

Mr Brady: The point is that it is the solution for the patient. If you do not have a system that is patient-centred, it seems to me that you do not have a proper system in place. Ultimately, if you are the person suffering severe pain because you need a hip or knee replacement, you are not interested in somebody else's waiting list; you are worried about yourself and how you may be prioritised and dealt with. It may be costly, but at least it is dealing with that particular person's problem. That could probably be multiplied a thousand times over, so it seems sensible. I accept that it is a tool, but it is a sensible way of dealing with an increasing problem.

Professor Siciliani: I will complement what you said by referring to the Dutch experience and the idea about determining the maximum waiting times by simply looking at it from a regulatory perspective rather than having maximum waiting times that are acceptable to the patient and society, which seems a good way to go.

Mr Brady: When you talk to someone who is in severe and chronic pain and is waiting for a hip replacement, and then talk to them again afterwards, you know that it has really enhanced their quality of life. That is particularly true of older people who may not have many years left. To increase and enhance their quality of life seems to be a good thing.

The Chairperson: OK, professor, thank you very much for that. What I take from this is that you suggest that there is not one quick fix but it is a combination of a supply issue generally, which I expect also takes in issues such as GP contracts, workforce management and the maximum waiting times target. I suppose, for us, the issue is around enforcement of that as well. As we conclude, it

might be good to get your thoughts on the best models of enforcement. We can have all the extra supply or have maximum waiting times without proper models of enforcement.

Professor Siciliani: There have been key experiences around enforcement. To have targets for maximum waiting times and then to attach heavy penalties, such as people losing jobs, seems extreme. That is at one end of the spectrum and is excessive. However, you do need enforcement. The current policy in England in which part of the revenues are retained if the target is missed seems to be a compromise. You need enforcement otherwise changes are not going to happen, but what I outlined is not as radical as the extreme fines that had been put in place. So, attaching some serious financial incentives to the maximum waiting times seems to be a reasonable compromise and balance.

The Chairperson: Thank you for that, and thank you for taking the time today. Your evidence has been informative. Obviously, the Committee and wider community feel strongly about this ongoing work. I take this opportunity to suggest to you that, as we develop our draft report on waiting times, we feed it back to you for your thoughts.

Professor Siciliani: It would be a pleasure.

The Chairperson: That is great. We will take it that we can forward that to you and you can feed in your thoughts. So, thank you for your time and have a safe journey home.

Professor Siciliani: Thank you. It was a pleasure to be here.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: Mr Mike Lyon

12 March 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Mr Mike Lyon Scottish Government Health Delivery Directorate

The Chairperson: I welcome Mr Mike Lyon, senior adviser on waiting times for the Scottish Government, to the Committee. We appreciate your taking the time. Finding a solution to this problem has perplexed not merely the Committee but wider society. Our normal procedure is that I first refer members to the presentation that has been circulated at page 2 of their tabled papers. I will ask Mr Lyon to make a 10-minute presentation, and then we will invite questions from members.

Mr Mike Lyon (Scottish Government Health Delivery Directorate): Thank you very much for inviting me to give evidence on Scotland's challenges and successes in reducing waiting times. It is always a pleasure to be in Northern Ireland.

Much of what I say will be familiar to members and the NHS in Northern Ireland, for example, through your quality strategy. I would like to focus on three themes: underpinning principles; service improvement and performance management; and information systems, definitions and measurement. In addition, I will highlight 10 key aspects of Scotland's approach to improving waiting times that I think may be relevant to Northern Ireland. I have provided those in my handout.

In underpinning principles, the 2003 good practice guide and managing waiting times, which is pretty much when we started this, states that the patient's rights are paramount and that patients are to be offered care according to clinical priority and within agreed waiting times. Clinical priority is not to be compromised under any circumstances. The Patient Rights (Scotland) Act 2011 legislates that it is the right of every patient to receive care that is patient-focused; takes account of the patient's needs; provides optimum benefit; keeps the patient informed; encourages patients to participate as fully as possible; treats the patient with dignity and respect, privacy and confidentiality; is caring and compassionate; is based on recognised clinical guidance; and causes no avoidable harm or injury.

That is a long list of aspirations that I think everyone will agree to, and I think that it is in your quality strategy. The point is that it is in pursuance of those rights that all reasonable and practical steps must be taken to ensure that clients are treated within the legal treatment time guarantee. We have a legal time guarantee with the same principles that account for other guarantees. Waiting times are in pursuance of patients' overall rights, taking account of a patient's clinical needs and the clinical needs of other patients, including patients undergoing unscheduled care.

Waiting time standards are part of an overarching Scottish NHS strategy for quality. Waiting times are managed as one of the six dimensions of quality: effective, efficient, safe, patient-centred, equitable and timely. We have a 20:20 vision that sets out a strategic vision for achieving sustainable quality in the delivery of care and which is supported by a quality strategy. That quality strategy builds on significant achievements to date, such as improving waiting times, so it is all meant to tie together.

Scotland's quality ambitions are further supported by the Scottish Patient Safety Programme; the quality improvement hub; health improvement, efficiency, access to services and treatment (HEAT) targets covering health improvement, efficiency, waiting times and appropriate treatment; the 20:20 workforce vision; Healthcare Improvement Scotland, which, among its other responsibilities, develops evidence-based advice and guidance; and public annual reviews of each NHS board. In summary, it is Scotland's policy that waiting times be part of an overall quality strategy applying to all areas that places the patient at the centre. Waiting times should be an outcome of quality and efficient services.

Service improvement and the transformation of services have been central to Scotland's drive to improve waiting times. Improvement programmes have utilised change and improvement methodologies, for example, the improvement model, statistical process control, queuing theory, lean, demand, capacity activity queue and flow analysis. I will say something more on the three central concepts of queue pathway flow in my summary.

Improvement in Scottish waiting times has been supported by strong central performance management — I led that for five years, and it was very strong — through collaboration with NHS boards. For example, monthly improvement trajectories towards targets are agreed with each board's chief executive individually, and regular review meetings are held. Where progress is not satisfactory, binding recovery plans are agreed. Weekly performance management is introduced where required and board capacity plans can be assessed and amendments recommended or mandated. Tailored support and peer monitoring can be initiated. Additional funding is related to performance to achieve best value.

Effective clinical engagement is fundamental to delivering Scottish waiting-time standards. For example, the delivery of the referral to treatment target for cardiac services was led by a clinical group. Delivery of the 18 weeks' referral to treatment standard has been supported by a number of clinically led task-and-finish groups. There have been clinical champions for service improvement in each NHS board. A musculoskeletal and orthopaedic quality drive is in place, which extended out of our waiting-time improvements. Fundamentally, the Scottish drive to improve waiting times has been based on a collaborative approach to service improvement and rigorous performance management.

I now turn to information systems, definitions and measurement. The improvement in waiting times in Scotland has been supported by the implementation of a wide-ranging e-health strategy, covering, among other programmes, a unique patient identifier, the e-referral programme, digital imaging and extensive upgrades of IT systems.

Historically, information systems in the NHS, as I am sure you will know, have managed discrete episodes of patient care, and a great deal of NHS activity has not been recorded electronically. A suite of products known as a patient management system has been nationally procured, and boards are implementing IT systems that can support the management of patients across entire pathways of care. A suite of definitions is available to support the consistent measurement and management and reporting of waiting times.

The 18 weeks' referral to treatment standard was supported by an information strategy and delivery team. After more than five years, that information team is still very busy. Specific enhancements to the available information set were put in place, including a unique pathway number for each individual 18-week pathway; clinic outcome codes to identity when an 18-week pathway continues or when it has stopped, and an onward referral data set to transfer pathway information between NHS organisations.

Upgrading IT systems and establishing effective definitions and measurement have been central to delivering a referral to treatment standard. We could not have done it without that.

In summary, Scotland moved from a simple 18-month maximum waiting time for in-patients and day cases in 1991 to a portfolio of waiting-time standards in 2014, covering GP access, accident and emergency, stage of treatment, referral to treatment, diagnostic tests, cancer treatment, child and adolescent mental health, psychological therapies, drug and alcohol treatment, audiology and hip fracture. Most of the improvement was achieved over 10 years.

The delivery of an 18 weeks' referral to treatment standard was preceded by delivering successively shorter targets for outpatients and in-patients and by introducing targets for eight key diagnostic tests, which covered about 80% of all diagnostic tests, and initial referral to treatment standards for cancer, coronary heart disease and cataract surgery.

Initial referral to treatment standards were managed by using patient trackers, who managed the progress of a patient through a pathway in cancer, or by dividing the pathway into times for assessment, testing and treatment that added up to the whole journey and actively driving out administrative delays. Those initial methods were replaced by the actual referral to treatment measurement as information systems were upgraded. So we achieved our referral treatment standard incrementally over time.

I will say a few words on the concepts of queue, pathway and flow, which are central to our improvement agenda in Scotland. Stage of treatment targets are essentially queue targets, and to manage queues it is necessary to have information identifying the number, size and scheduling of queues and the variation in additions to, or removals from, queues. I think that a person who previously gave evidence, Rob Findlay, identified the same issues in regard to queues.

Queues are generally contained in pathways, and referral to treatment targets measure the time between the start and finish of a pathway. To manage referral to treatment targets, it is necessary to design and manage pathways effectively.

As regards flows, elective or scheduled care targets are part of overall hospital and healthcare provisions that include unscheduled — for example, accident and emergency — as well as scheduled care, and it is influenced by care outside the hospital. To manage our scheduled care targets, it is necessary to take account of the flows of scheduled and unscheduled patients through a hospital.

This is a brief point. It is our view that there should be a focus on the wider spectrum of healthcare. Demand in hospital care and challenges to elective care targets are influenced by the quality and extent of care outside the hospital and by the health status and behaviours of the population. The extent and quality of primary care and the support for social care — for example, support to carers — will have a direct impact on the resource requirements to deliver elective waiting time standards. Successful health improvement actions will ultimately impact positively on elective waiting times. The more effective the relationship between healthcare and social care, the more effective healthcare will be overall. We are moving towards the integration of health and social care, which I believe you have achieved.

In summary, I will go through the 10 key aspects of our approach to waiting times in Scotland that may be of some interest to you here. First, a forceful central performance management team working in partnership with NHS boards. Secondly, skilled central support for service improvement, integrated with NHS boards or your local organisations. Thirdly, a strong emphasis on the determinants of waiting times, which are primary, secondary and social care; demand/capacity management; queue; pathway; flow; the relationship between scheduled and unscheduled care; workforce; and, yes, financial resource. Fourthly, the placing of waiting time standards in a broader strategic and quality-improvement approach. Fifthly, effective clinical engagement. Sixthly, the development of waiting-time standards over time, building on success step by step, from stage of treatment to referral to treatment. Seventhly, the development of information systems, measurement and definitions. Eighthly, the use of the independent sector at the margins and for a limited duration to manage unexpected demand and unforeseen events. Ninthly, the allocation of funding in the short term to address need but the balancing out of recurrent funding in line with the national funding formula and the allocation of funding to support service improvement as well as to increase capacity. Tenthly, targets should be fit for purpose and provide real benefit to patients; they should be able to be measured and reported and delivered; and they should be affordable and promote effective care and resource efficiency. Thank you for listening to this brief summary.

The Chairperson: Thank you. That is very useful. You mentioned the wider emphasis that is required on the wider spectrum of healthcare. Can you expand on that? You say that that requirement or that emphasis would have an impact on waiting times.

Mr Lyon: The emphasis on, for instance, health in early years will affect individuals' health in later years and the requirement for care of the elderly. Of course, that takes time to work through. Support for carers, in the short term, can have an impact on patients admitted to hospital. Providing good care or assessment for patients before arrival at A&E will reduce the demand on A&E and the pressure on beds and can aid emergency and elective care.

The Chairperson: So, it is, in effect, an early intervention prevention model that you are looking at.

Mr Lyon: It is early intervention prevention and care in the appropriate setting. For example, we have significantly reduced referrals in measures to orthopaedic surgery by having appropriate allied health professional physio care in the community. Those people never needed to come into hospital.

The Chairperson: Specifically on referral to treatment, what were the drivers for ensuring that that was used or utilised as a particular approach.

Mr Lyon: It was clinically popular. Clinicians recognised the idea of a pathway of referral to treatment. It instinctively felt right in the sense that it was what the patient experienced. They experienced the time for their first outpatient appointment, the time for tests and then the time for their operation; they could wait well over a year with all those different parts. We did not always know how long a patient was waiting between a diagnostic test, seeing the consultant and being put on the waiting list. I think that it promoted resource efficiency, because if patients are spread out over a long pathway, that is a lot of administrative cost and personal involvement. If you are getting them through the beginning of the pathway relatively quickly, it can be not only clinically but resource beneficial. It also has an economic benefit in that it gets people back to work more quickly.

The Chairperson: So there might have been a particular political context.

Mr Lyon: It was part of Scotland's wider strategy for health and economic well-being.

The Chairperson: OK. I appreciate that. I also noted that the first of the 10 key aspects that you talked about mentions:

> *"a forceful central performance management team".*

Can you expand on how that was acted on?

Mr Lyon: The structure in Scotland is that the chief executives of the NHS are also the Civil Service heads of the Health Department. We have chief executives of the health boards who are accountable to them. Therefore you have an accountability framework. We established a performance management team, mainly of NHS employees, which I led, whose job was to assess a target, see whether it was deliverable, look at the risks to delivery, and then agree trajectories for that delivery with the NHS board of chief executives.

If somebody had no in-patient and day cases waiting over, say, 26 weeks and somebody had 1,000, you would agree, "We think that you can reduce that to 700, 800 or 500." You would look at demand, capacity and seasonality. We used the phrases risk-assessing and delivery-proofing. That team would meet regularly with each NHS organisation; you could ask for binding recovery plans, and we had step-in rights etc. It was partnership working; we did not do targets and terror.

The Chairperson: It is slightly different, but take the issue of waiting times in our emergency departments. There is increasingly a view that the focus on targets can be counterproductive. I know that it is different, but the principle is the same, namely how you get targets that are sustainable and realistic.

Mr Lyon: Targets are problematic and may even be counterproductive if you are not focusing on the determinants of the targets. Eighty per cent of your time should be spent on getting the service right, not just delivering the target. Getting there in the end, dipping under the wire and rising up again is not the way to deliver targets. The very simple principle is that if you are adding more people to a

waiting list — for orthopaedics, say — than are coming off it, it does not matter what target you have, you will not meet it or you will end up rationing by waiting. There is more complexity to that, which I can go into. It is about how you deliver the target as much as, if not more than, the fact that the target is delivered.

The Chairperson: Finally, one of the key aspects again was the allocation of funding. Some of the evidence that we are finding is — I will use the word counterproductive again — that you will not achieve your ultimate outcomes by throwing funding at short-term parts of the problem. Is that your experience?

Mr Lyon: That is absolutely the case. I suggest that there is a time to apply funding for a short period. If you have six months in which to treat patients and nine months' worth of patients on your waiting list but they are coming on and off in balance, you have to get rid of that extra three months of work because you have too many people on your list. That should be a one-off. There should be an agreement with the healthcare provider that that money is to reduce your list from 200 to 150. If you have more patients going onto your list than coming off it — say you have 1,000 a year going on and only 800 coming off — you have to give them funding for an extra 200 or change demand or change what you do. If money is simply given rather than tagged to the need for it, it can be problematic.

Mr Wells: I am fascinated by the way that you went about this. You told us earlier that you have 22 years' experience in this field.

Mr Lyon: Twenty, probably.

Mr Wells: Twenty. How many trusts do you have in Scotland?

Mr Lyon: We have 14 territorial health boards; we do not have trusts.

Mr Wells: I am interested in your role. Had you executive authority over those trusts, or were you an adviser?

Mr Lyon: I have been an adviser for two years. Before that, the chief executives of the NHS in Scotland had executive authority. My boss, who was then the director of delivery, had executive authority. I had authority to ask for recovery plans, look at how they were progressing, speak to whom I wanted etc.

Mr Wells: So you were basically looking over the shoulder of the trusts and giving them instructions as to what needed to be achieved to bring about a recovery in waiting times.

Mr Lyon: It is a bit like that. Scotland, like Northern Ireland, is a fairly small country. We know everybody. We know all the chief executives. It is more or less a case of, "You can deliver; can't you? Prove it to me."

Mr Wells: What sanctions had you if a trust was falling behind?

Mr Lyon: We could not confirm non-recurrent money as recurrent. There was not a big stick with regard to money, but we had flexibility to regain the money. We could put in an expert clinical support team and ultimately exercise other sanctions.

Mr Wells: And your entire role was to get on top of waiting times.

Mr Lyon: That was my entire role, yes.

Mr Wells: When you started, was there a great variation between performance in what we call trusts?

Mr Lyon: "Trusts" is fine.

Mr Wells: Was there a great variation?

Mr Lyon: Yes.

Mr Wells: Having been involved for such a long time, do you find that there is more uniformity now?

Mr Lyon: There is certainly more uniformity now. However, you always get areas of difficulty, and we have some just now.

Mr Wells: Were you satisfied that those areas of difficulty were inherent problems that were insurmountable, or was it down to lack of management and effective processes?

Mr Lyon: Management and processes are always variable; there are times when they can be improved. So, yes, there are process and management issues. The challenges that we have now are well recognised, but they are not insurmountable. One health board needs to grow more local capacity, and it is doing that by investing.

Mr Wells: As part of your research for coming over here, did you compare the performance of our trusts with that of your 22 authorities?

Mr Lyon: I did not look at the performance of your trusts directly. I read your published statistics and noted how your outpatient and in-patient day-case targets had got worse and then improved and how you are heading towards your target. I could not draw many conclusions with that level of data.

Mr Wells: Could you conclude whether our performance was considerably worse, much worse or just slightly less efficient than Scotland's?

Mr Lyon: My feeling is that you have a little bit further to go in managing your stage-of-treatment targets for outpatients and in-patients.

Mr Wells: Did you identify any area in which Northern Ireland is performing better than in Scotland?

Mr Lyon: You have an integrated health and social care system, which is very positive. I did not have the statistics to identify anything else.

Mr Wells: That leads to my next question. We have a different structure here, as you know. We have had an integrated health and social care system for 40 years. You have a health system and then a social care system that is the responsibility of the councils.

Mr Lyon: Largely, yes.

Mr Wells: Was that an impediment to improving waiting times? Is our system a better one in which to improve them?

Mr Lyon: Theoretically, I would have thought that your system is a better one, but I am not familiar with it. With regard to dealing with councils, we have issues around discharging patients from hospital. Nursing home facilities are within councils' remit, and patients staying longer in beds when they are medically fit to be discharged is an NHS problem.

Mr Wells: Under the present comprehensive spending review, how the health service in Northern Ireland has been funded is that the health element has been given a 1·9% real-terms increase — we are three and a half years into that — and the social services element, which is part of our health services, was split off for the purposes of funding and did not get a real-terms increase. Is one of the reasons why Scotland has performed better is that your devolved government have added money on top of that to reduce waiting lists, or have you stuck to the same budget allocated under Barnett that we have?

Mr Lyon: Under Barnett, we have flexibility on where we allocate money across service provision. Over the past 10 years, there has been additional investment into direct NHS care and, specifically, waiting times.

Mr Wells: So one of the reasons for the improvement over the decade may be that you have had more money to put into the system.

Mr Lyon: We have funded additional capacity for waiting times. If you add more patients to a waiting list than you can take off it, you have to treat those patients or you will get into a waiting-time problem. So, yes, we have added more funding.

Mr Wells: One of the ways in which we have reduced waiting times is the use of the private sector. We have sent folk to clinics in Northern Ireland and, indeed, in the Irish Republic and England. That has been one way of relieving the pressure. Have you been able to get any statistics on how much the Scots have used that process?

Mr Lyon: The last time I looked, the spend in the independent sector was less than 0·2% over a year; however, I would have to check those figures again. It has been significant for limited periods. We have built up alternatives. We have a national waiting-times centre, which is basically a hospital that provides activity just for waiting times. We have a treatment centre on the east coast. NHS boards often provide additional activity at the weekend using clinicians from elsewhere in the UK. All those are alternatives to the independent sector, but, yes, we use the independent sector, largely to avoid putting on additional capacity at the margins that we will not use all year.

Mr Wells: So, you sit in your control room somewhere in Edinburgh and watch, presumably on a screen, the performance of all the trusts, and they will fear you ringing up and saying, "Hey, you are slipping on orthopaedics. You are slipping on cancer screening. You are slipping on X-rays.".They regard you as our trusts regard the Regulation and Quality Improvement Authority (RQIA) here. They fear you.

Mr Lyon: I hope that they do not fear me.

Mr Wells: But they know that you are watching them.

Mr Lyon: They know that they are being held to account rigorously, yes.

Mr Wells: When they get a phone call and see your number come up on the screen, they know that there is something to be fearful of.

Mr Lyon: They know that there is something that they have to address.

Mr Wells: You have the power to say to the chief executive — Fred, Jean or whomever — to get it fixed by a certain time or else. You can do that.

Mr Lyon: We would expect the chief executive to want to get it fixed by that specific time, yes. The authorities know that they have to deliver their waiting-time standards.

Mr Wells: May I ask you a difficult question? I do not have to ask this, but we heard something two weeks ago from the RQIA, which deals with regulation and quality improvement here. It said that there was evidence that staff are manipulating and massaging figures to make them look better than they should. We have not got to the bottom of it yet, but it is a very serious allegation, because if we cannot depend on the figures provided by the trusts, we have no basis on which to start.

Mr Lyon: This is in Northern Ireland?

Mr Wells: Just Northern Ireland, yes.

Mr Lyon: The first thing I will say is that, if you are managing many hundreds of thousands of patients, each with a waiting-time standard, that requires accurate recording of information to be translated into electronic systems and reported. Things will go wrong. Perhaps with no wilful intent, people will make mistakes. The English audit team, when it looked at its 18-week referral-to-treatment (RTT) period, found a large number of records in which it could not account for the fact that the patient was seen within 18 weeks. That does not mean to say that authorities were cheating, but you will have millions of transactions for patients, so they are not always recorded as accurately.

In Scotland, we had one health board where the figures were being manipulated. The Cabinet Secretary called in PricewaterhouseCoopers internal auditors to audit the whole system, and there

were quite severe consequences. Audit Scotland then audited the whole of Scotland and found one other board in which there were some minor irregularities. Internal audits audited everything in every board, and the audit recommendations have been implemented. Audit Scotland recently pointed out that we could not account for the patient pathway on every record. I think we have now met all the Audit Scotland requirements. Therefore, yes, you have to be alert for quality assurance and external audit.

Mr Wells: But you are now happy that you are getting accurate data coming in from the health boards so that you can interpret their performance.

Mr Lyon: Yes, I am.

Mr Beggs: You indicated that trusts were organising additional capacity at weekends rather than pulling in the private sector. Have you found that to be a more efficient method of dealing with the extra capacity that you need?

Mr Lyon: I think that it is an efficient method. Some of the authorities do that through an independent sector company that simply coordinates clinicians coming in and working in the hospital. Some of them do it themselves, so it has proven to be an effective approach.

Mr McCarthy: Thanks very much for your presentation. Your briefing paper states:

> *"the Scottish Government introduced a new HEAT target to support the sustainable delivery of 4 hour A&E".*

Will you explain what that is? Furthermore, has any consideration been given in Scotland, in the context of accident and emergency provision, to allowing other health professionals such as nurses to act as decision-makers?

Mr Lyon: Yes to both. The supporting target to the four-hour A&E target is to reduce attendances at A&E as part of shifting the balance of care.

It is not my area of workforce development, but there is a strong workforce development programme for skill mix within emergency departments, whereby non-doctors can discharge patients.

Mr McCarthy: What does HEAT stand for?

Mr Lyon: Health, efficiency, access and treatment. From alcohol-reduction targets and breastfeeding to waiting times.

Mr McCarthy: Has there been any suggestion or trialling of greater use of out-of-hours GP services?

Mr Lyon: Yes, there has been, but I do not have the detail. I can provide it separately, if that will be helpful.

The Chairperson: I will just make the point that this is obviously not specifically about A&E. We are talking about waiting times, elective care and all of that.

Mr McKinney: I am also interested in the issue that the Chair raised at the start. There is dealing with the queue and dealing with the causes of the queue, and how you go about doing that structurally and strategically . As well as sending out health messages, which strikes me as something that would take time to bed in, what other things can be done to promote, underpin or extend community care or that type of thing to decrease queues overall?

Mr Lyon: Again, it is not my area of expertise, but, in the integration strategy, Scotland has a wide-ranging programme for care at home, hospital at home, support for carers, etc. We have targets for reducing readmission of patients over the age of 75, for reducing admission of patients over the age of 75, for reducing hospital stay, etc. There is a whole range of initiatives, which I can provide separately, to enable patients to be better treated out of hospital, to stay the minimum time in hospital and not to return to hospital.

Mr McKinney: I am conscious that there are themes coming in around A&E. I am not dealing with those specifically, but can doctors refer people to hospital in the Scottish system? What is the entry point?

Mr Lyon: A doctor can refer a patient to hospital. Absolutely, yes. Doctor can ask patients to go to A&E or they can send them to, say, a respiratory unit in one of the hospitals as an acute take.

Mr McKinney: Has that been helpful in reducing queues?

Mr Lyon: It probably has little effect on the elective queues.

Mr McKinney: Yes, I understand that.

Mr Lyon: There is much that can be done with queues on the elective side. One example is that, at one hospital, we had 87 separate queues for orthopaedics. It is very difficult to manage 87 queues. Imagine you were to go to the supermarket or the post office, and it had 87 queues. That number was reduced to 12 or 13. It is much easier to manage 20 or 30 than it is 87. That is a cost-free change.

Mr McKinney: You said that the more effective the relationship between healthcare and social care, the more effective healthcare will be overall. Can you elaborate on that?

Mr Lyon: Largely going over the points that I have made already, I will say that if you have integrated planning for health and social care, for example, if patients are able to discharged from hospital and are medically fit, they are not remaining in beds where there is no benefit to them. If you have anticipatory care, where people have chronic obstructive pulmonary disease or diabetes, it is managed before they hit hospital. All that will take pressure off hospitals. In particular, when you are facing A&E pressures, the point that I tried to pull out is that, on the flows of patients coming out through A&E and the flows of patients for acute care, you may find that orthopaedics admits all its patients on the day on which you have the biggest emergency flow or the doctors do the ward rounds only every second day, which results in patients sitting in beds unnecessarily. It is about getting all the different aspects to flow together.

Mr Beggs: Thanks for your presentation. It is always interesting to learn from someone who has similar problems and perhaps addresses them slightly differently. In one of your papers, you indicate that, for managing new attendance at emergency departments, you have a target for reducing attendance by around 2%. Are you on target for that, and, if so, how have you achieved that?

Mr Lyon: Without making excuses, I have to say that it is not my area, so I do not know whether we are on target or not. We have a programme of shifting the balance of care, which is to provide care for patients outside hospital. We have NHS 24, which is an advice and help line, and you go through that before you call an ambulance. Pharmacists are providing more advice to patients, and there is a programme around that. We are aiming to have GP surgeries open for longer hours. We have a 48-hour standard for access to the appropriate person in the practice, who is not necessarily the GP. Those measures are all ambitions to shift the balance of care away from hospitals.

Mr Beggs: How long have you had those new policies? I am not sure what standards there are in Northern Ireland.

Mr Lyon: The GP standard has been in for at least five years. The shifting the balance of care programme has been running for that period. I cannot recall off the top of my head how long the reduction in attendances at A&E policy has been running, but it is certainly several years.

Mr Beggs: OK. That is very interesting. On measuring the time on a waiting list — the RTT — how long did it take for you to switch over from the old way of recording to the new system? What level of investment has been required?

Mr Lyon: It probably took three or four years from the official launch of the document to its first going live. I think that it was four years, if I recollect correctly. There was marked investment behind it. We had investment in our e-health programme. Our patient administration systems were falling over, so we invested in patient management systems that could track patients from end to end. We invested in diagnostic information systems. A small area such as audiology had paper-based systems, so all of

those were put in place electronically. We put in a unique care pathway number, because a patient could have been in several pathways — diabetes, respiratory, knee replacement — at the same time. That was a significant information investment.

Mr Beggs: Did going over to that new system shake out the inefficiencies, such as queues and admin, of the old one? How did the patient experience change?

Mr Lyon: Our patient satisfaction surveys recorded around 80% to 88% satisfaction rate for waiting times. An amount of this is patient satisfaction, which indicates that there has been improvement in satisfaction with their overall waiting time. Administratively, I would argue that it has made life easier and saved money. We would have to gather full evidence of that, but managing a lot of queues and long queues was costly administratively.

Mr Beggs: Finally, if the private sector is used, do patients remain in your queue or do they disappear?

Mr Lyon: No, they remain in the queue until they are treated.

Mr Beggs: I am uncertain what happens here, but I came across a patient who had just hit six months on a waiting list before being transferred to the private sector. That patient has still to get a date and is just in another queue.

Mr Dunne: Thanks very much, Mike, for coming over to talk to us.

Mr Lyon: My pleasure.

Mr Dunne: You are very informative. To get down to specifics, was there a major issue with the handling of waiting list data? Perhaps a lot of the data was out of date, not handled properly or needed cleansed? Is that an issue?

Mr Lyon: Over the 10 to 12 year period, there has been a constant work programme to get the data right and fight for purpose. We started with waiting lists, which had to be made more accurate. We needed electronic recording of data. We had something called the New Ways project and a refresh project, all of which were designed to make our data more fit for purpose. We spent a lot of time on agreeing definitions, such as guidance for management on waiting times so that, as far as possible, hospitals were managing patients in the same manner. There is a degree of local flexibility, but the situation should be the same wherever you are.

Mr Dunne: Is the same system in place across all the various trusts?

Mr Lyon: Over half of Scotland is covered by a patient management system called TrakCare. The other management systems are of similar functionality.

Mr Dunne: Has that gone some way to making the lists more efficient?

Mr Lyon: Yes, it has. We also an e-referral system called SCI Gateway, where GPs can make electronic referrals, and that is increasing as well. We are introducing electronic systems in and around allied health professionals (AHPs), and I think that we are also upgrading the GP system.

Mr Dunne: What sort of funding is required for the installation of such systems?

Mr Lyon: I do not have that information to hand. I can provide it, but the figure is millions of pounds.

Mr Dunne: The other issue that we keep talking about is the risk of a conflict of interest between consultants both doing private work and working in the trusts or for health boards. Have you any evidence that that can be a risk?

Mr Lyon: No, I do not.

Mr Dunne: What is your opinion of it?

Mr Lyon: I think that the neater the separation between private and NHS work, the better. In fact, if we commission a private organisation to do work for NHS patients, they are commissioned as such, and the patients stay on the waiting list. One NHS board will not use consultants from the local area. In other areas, use of consultants is very marginal. With the possible exception of cardiac surgery, we do not treat private patients in NHS hospitals, so there is a strong separation between private work and NHS work.

Mr Dunne: You do not treat private patients in NHS hospitals.

Mr Lyon: As far I am aware, apart from for cardiac surgery possibly, because no private hospitals can set up a cardiac unit. It is too specialised. There are several private hospitals in Edinburgh, several in Glasgow, one in Dundee, one in Aberdeen and one in Ayr, so there are private facilities without the need to use hospitals.

Mr Dunne: They are working independently of one another.

Mr Lyon: They are working independently of the NHS. The doctor will have a contract that will allow a certain amount of work in the independent sector, and the doctor should not exceed that amount.

Mr Dunne: OK. Thank you very much.

The Chairperson: Thank you, Mr Lyon. Your evidence has been very informative. We will certainly be reflecting on the information that you have given us. It may be useful for us, if you are willing, to share our findings and recommendations with you. The important message from your presentation and evidence was on a central performance management system and, in your words, a "forceful central performance management team". I think that that brings up its own issues around governance and accountability that we have to look at for our situation.

Thank you for taking the time to come here. It has been very informative. If you are willing, we will share our recommendations with you. Feel free to feed back to us on those.

Mr Lyon: I am very happy for you to share the recommendations. On behalf of the Scottish Government, I can say that we are happy to provide any support and advice that you may find useful.

The Chairperson: I appreciate that.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: Mr Pedro Gomes, Ministry of Health, Portugal

9 April 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Waiting Times: Mr Pedro Gomes, Ministry of Health, Portugal

9 April 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Mr Pedro Gomes Ministry of Health, Portugal

The Chairperson: We have Mr Pedro Gomes with us. Good afternoon, you are very welcome. You are the national coordinator of the central unit of the integrated management system of the waiting list for surgery for the Portuguese Government. The procedure is for you to give a 10-minute presentation, and then we will open things up for questions and answers.

Mr Pedro Gomes (Ministry of Health, Portugal): I must read because my English is not fluent enough for me to improvise, so excuse me. Thank you for the invitation. I hope to transmit what we are doing in Portugal regarding access to surgery.

Portugal is a country in southern Europe with 10 million people and a GDP per capita of €15,000. Regarding health resources, we have 417 doctors and 622 nurses per 100,000 inhabitants. We have 235 hospital beds per 100,000 habitants in 109 hospitals and 1,400 primary care units. The national health service performs 3,800 consultations, 88 hospital admissions and 50 surgeries per 100,000 inhabitants per year. The total state expenditure on health, as a percentage of GDP, is 6·3. The infant mortality rate is 3·4 per 1,000 live births, and life expectancy is 80 years.

Since 1998, successive Governments have tried to find solutions to the problem of access to surgical services, experiencing various measures, yet have failed to reverse the problem. The problem of access, which manifested itself particularly through excessive delay for surgery, found its roots in a culture of poorly oriented services for patients. Professionals worked in a rigid organisational architecture to ensure survival of the institution in the logic of preserving corporate interests and pursuing concepts that did not encourage conduct that intended efficiency.

Other problems include equitable access, demographic change, technological change and a culture in a society where people become more demanding and aware of their rights, reinforcing the need for

intervention. We also recognised the absence of updated and credible information that supported decision-making for all stakeholders.

The waiting list for surgery integrated management system (SIGIC) was created in 2004 by the Minister of Health to fight against waiting lists for surgery. By then, the median waiting time was nearly nine months for more than 200,000 patients. Now, the waiting time is three months for 1,500 patients. SIGIC is coordinated nationally by a central unit and is supported by five regional units and by hospital units based in public and private care providers. The activity of surgical services is not limited to performing surgical procedures; it involves every phase of screening, investigating procedures, analysis, and complementary medical treatments, pre and post surgery. The activity of this service cannot be evaluated without taking into account that they are integrated in the network of care that includes primary care, hospital and community care.

As of 2013, SIGIC represented more than 500,000 surgeries, five million appointments and a business volume of €1·5 billion. SIGIC has a matrix management approach that integrates needs expressed by patients, pathology and the various elements of the varied change in surgical services. SIGIC observes the distribution of demands, process compliance and the public disclosure of results and promotes competition and negotiation, and improves efficiency and effectiveness of the entire system so that it is contributing to its sustainability.

The SIGIC business model is sustained by an information model named SIGLIC, which is a financial funding model, a correlating model and a business process model to manage the waiting list for surgery. SIGIC's main goal is to focus the services provided by hospitals to meet patients' needs by reducing the waiting time for surgery, guarantee equity in access to surgical treatments, promote efficiency and effectiveness in health services, ensure quality and transparency in management and information and to ensure the responsibility of players involved in the process. An additional goal is to guarantee that the system is sustainable according to the budget constraints that Portugal faces nowadays.

The patient waiting time for treatment cannot be measured by taking into account only the waiting time between inscription and surgery. Monitoring access is done in order to know the partial waiting times in all processes, which starts with the detection of health problems and finishes with the treatment provided, with measurement of the gain in health for the patient. The next step for SIGIC will be measuring the referral to treatment times.

SIGLIC addresses, in an innovative way, the information for clinical governance, focusing on the core business of health. The approach to a disease or a set of diseases is made with the establishment of a care plan that projects the necessary events to treat a patient. The events occur, as many as are needed, to complete the diagnosis and treatment of the patients. Those sets of events are aggregated in one tri-periodic episode.

SIGLIC has warnings for players involving the management of financial penalties. SIGIC stakeholders can access information through reports from SIGLIC according to their profile access. Access restrictions are applied to those profiles. All hospitals have to transfer normalised data automatically every day to a central data centre. Data is analysed, qualified and reported back to hospitals. Indicators are regularly produced and used to form management decisions. SIGLIC collects data to provide information for the Government to plan, regulate and make the best decisions in political and economic terms.

Since the beginning of the programme, we have observed a positive evolution in all indicators. The number of episodes in waiting lists has diminished regardless of the increase in admissions. At the same time, production has increased due to a new possibility for medical teams to operate on patients after work at a price per patient. The overall result is the dramatic fall in waiting times by 59%. The referral of patients to the private sector plays a little role — 5% to 7% — but is nevertheless important. Access to surgery, measured by the number of inscriptions per year, has successfully improved. Last year, we saw an increase of 42% over numbers from 2006 and an increase of 3% compared to the year before. The extent of the inscriptions list for surgery on 31 December 2013 shows a decrease of 20% compared to 2006. However, there is an increase of 5% compared to 2012.

The reduction in the waiting times is notable. That decreased 59% over 2006 and 6·7% compared with 2012. Nowadays, the average waiting time is 2·8 months. Surgical activity maintains a sustained growth of 57% since 2006. Between 2012 and 2013, that growth was 1·8%, which we consider satisfactory given the current crisis and given the 8% reduction in the budget for surgery. The percentage of patients who exceeded the maximum guaranteed responses, which has improved

greatly since 2006 through a reduction of 7%, still has a high value at 12%. Nevertheless, it has decreased by 15% compared to 2012.

Why does SIGIC work? It works because it established penalties for non-compliance with the guaranteed maximum response time. That reduces waiting times, and allowing doctors in public hospitals to do additional surgery promotes productivity. The analysis of express demand allows possible optimisations in reallocating resources. Through the analysis of supply for each provider, it is possible to increase productivity. The monitoring of compliance can correct errors. The collection of standardised data that allows us to compare providers and benchmark them increases efficiency. Identification of who is responsible for each event and the management of information in documents allows accountability. All stakeholders, physicians, patients and managers share the same information and so control each other. Patient transfers are automatic when the risk exists of exceeding the maximum waiting times guaranteed for surgery. In this case, the original public hospital pays the bill. The regular publication of the time results promotes accountability and allows all stakeholders to control the process. Publication of rates of productivity and non-conformity promotes quality and efficiency.

The Chairperson: Thank you very much for your detailed presentation. I think that you said there were penalties for non-compliance.

Mr Gomes: Yes.

The Chairperson: Can you explain what those are?

Mr Gomes: When it comes to the hospitals, we have a set of rules. Those rules are about complying with the maximum time for surgery, but there are also rules according to equity: if you pass one patient in front of another, that is a non-conformity. If you do not keep your registers well, that is a non-conformity. All of that has a penalty that is contractually established with the hospitals. So, the hospital will have less money if there are lots of non-conformities and penalties.

The Chairperson: Some of the information that we are gathering has been around the whole patient journey. You said that we need to look at the period from when a person is referred for treatment right through their entire journey. Is that your —

Mr Gomes: No. We have two different systems, and we are trying to integrate them. That is the future. Now, we are monitoring the time between inscription in the list, which is a central, national list, and treatment. We have another programme that monitors the period between referral and the first consultation, and we have a gap between the first consultation and the inscription in the list. That gap is not monitored. We have established that that gap can be from five days in urgent cases to one month in non-urgent cases, but it is not monitored. What we are trying to do is to monitor the three time periods: between referral and first consultation at the hospital; between first consultation at the hospital and inscription in the list; and the last one is between inscription and treatment.

The Chairperson: So, is it better to look at the entire patient journey when trying to deal with waiting times?

Mr Gomes: From the point of view of the patient, it would be better, without a doubt, because what matters to the patient is that he has a problem and the time begins to count when the problem surges. If possible, the ideal is to measure the time between going to the general practitioner and then from the general practitioner to the hospital and so on until the problem is solved. However, you have to see whether you have the means to address the problems that are disclosed through that. You can see that you would have to make more investment in the system to cover the whole process. That is why we are delaying the viewing of the process as a whole for a little bit, because if you have dark points, the system will adapt and will monitor the times at the darkest points.

The Chairperson: I noted as well that you talked about political will in relation to this. Is that a big factor in trying to tackle waiting times? What was your experience in Portugal? What was the biggest driver for trying to tackle issues around waiting times?

Mr Gomes: In Portugal, we have a problem and a blessing in that our constitution says that every person is entitled to every kind of treatment that will make them well, so it is difficult for the Government to establish a line to draw under what you should provide to people or what you cannot

provide. Prices are going up, and technology in medicine gets more sophisticated all the time, so the reality is that we cannot afford to pay for everything. However, we also cannot establish that line. That is the trade-off that would be necessary to solve politically. SIGIC is now doing the process more efficiently, so we can achieve more surgery. We had a productivity gap. We can make public hospitals more productive if we establish the right incentives.

The Chairperson: Finally, from me, one of the pieces of information that we found is that sometimes investment or money can be injected into part of the issue, but it does not address the overall issue. Sometimes, it can actually almost support bad practice.

Mr Gomes: Yes, I understand the question. In Portugal, we pay for medical acts. So, if a hospital does more medical acts, even if they are not needed, it will get paid more. That is why we are trying to change that to another form of funding that sees the whole tri-periodic episode. For example, when you have to replace a hip, you get a certain amount for the consultation, examination etc. That stops the increase in multiple appointments that are eventually not needed but are added to increase the budget. If we can, at the same time, put different systems, public and private, in competition with each other, we expect that we can maintain costs at the lowest price. The problem with that is that, at the same time that you measure access and production, you should also measure quality and health results, because you can have degrees of quality. We have seen that in several aspects — minor points, but it happens.

The Chairperson: Finally, definitely, have you seen better health outcomes as a result of tackling waiting times?

Mr Gomes: We had a big problem with access in Portugal. We have had a huge increase in access. Nowadays, people can go to the hospital. In the past, we had waiting lists of two or three years. Overall, that has reduced dramatically. Nowadays, most people have treatment within three months. However, in the worst cases, you see six or eight months. One thing that we have also — and we are not quite well, but we are much better — is a difference throughout the country. In the north, we have much better access than in the south. We are trying to make the different parts of the country more homogenous and alike.

The Chairperson: Is there evidence that that is improving health outcomes for the population?

Mr Gomes: General health outcomes have not decreased. We do not have precise measures of health outcomes. We have the gross health outcome measures, such as net mortality, life expectancy and so on. With these programmes, we need to have a programme for each kind of pathology, because we must know what is better with regard to plastic surgery, orthopaedics and so on, which do not have a great impact on survival. We have to make several studies. We need programmes for each of those pathologies. It is not case-sensitive enough to see the big picture. With the big picture, we are a little better than in the past but a little worse over the past year, not in surgery but in other areas on account of the crisis and with less access to others. That is also a problem. You must address health as a whole because, if you focus on only surgery, in other areas such as diabetes, you can have a big fall.

Last year, we were slightly worse but, generally, had better results in surgery. It is not specific for surgery and each pathology. That is something we have yet to do.

Mr Wells: What I find so extraordinary about what you are saying is that we see Portugal as undergoing an incredibly difficult economic time since 2008. Were you able to continue the progress through this economic downturn and a cut in the health budget?

Mr Gomes: Yes. I am also amazed with that. The public health service has a big role in health assistance in Portugal. Eighty per cent of all health assistance is public. The restrictions in budgets for hospitals are essentially in the salaries for doctors, nurses and so on. They are not responding yet. I do not know what will happen in the future, but they are staying there and not leaving, yet they are earning much less than three or four years ago. You can have a medical career doctor or consultant in a hospital earning 40% less than two or three years ago.

We have strong measures in public expenditure. Our taxes are much higher and salaries have decreased. We have the possibility of extra-time work. That used to be well paid but not now. All in all, we are working the same amount but earning much less.

Mr Wells: Did I pick you up right that you said that only 1,500 patients are waiting more than three months? Is that right?

Mr Gomes: It is important to understand that we have two possible ways to measure waiting times. We measure the time for the patients who are not yet operated on or treated and who are still on the list. We have 150,000 people on that list.

Mr Wells: Right, 150,000. But everyone else —

Mr Gomes: The median waiting time for those people is three months. The most recent figure is 2·8 months.

Mr Wells: Does that mean that every other patient has to wait less than three months?

Mr Gomes: No.

Mr Wells: It is the average.

Mr Gomes: That is the median. If you see the curve of the time taken to operate on people, you will see that most people are treated within one and a half to two months. You then have a queue in that line, and lots of people wait for six, nine or 10 months. Certain specialties have major difficulties in overcoming those waiting times. So, the median is three months; the average is three months.

Mr Wells: You managed to bring overall waiting times down by 59%.

Mr Gomes: Yes, because the median was eight months. In the past, the average was eight months.

Mr Wells: I was very interested in your idea that a patient could refer themselves to a private hospital, get the work done, and then the Portuguese health service would pay.

Mr Gomes: They do not refer themselves. The central office automatically emits a voucher when the patient achieves 75% of the maximum time guaranteed. In Portugal, we have four categories of maximum time guaranteed. For normal situations, priority is nine months. When the time comes to six months and 22 days, a voucher is automatically emitted. The voucher covers all private hospitals that perform the type of surgery that the person needs. Each person can choose to stay in his hospital or to go to one of the private hospitals and have surgery performed.

Mr Wells: And the state will pay for that, automatically.

Mr Gomes: Yes.

Mr Wells: How do you keep within your budget, because, presumably, at six months and 22 days, most people will say that they will go to the private hospital?

Mr Gomes: Most people do not achieve six months. The average is three months, so most people do not have the option to have the voucher. The problem is to do with how the queue forms. When you measure times, how do you get the higher time or the lower time? It has lots to do with how people are managed in the list time. If you have a regular, normal curve and everyone is treating everybody in more or less the same time, you should not have any person with vouchers, because no one will achieve the six months to have the voucher. The problem is that some specialities in some hospitals have longer queues. Those queues and those persons will achieve six months, 10 months. At six months, they receive the voucher. One thing that we have in mind when contracting with privates, as far as the budget is concerned, is that the private is contracted for less than the money expended in public health. So, if the person goes to a private hospital, it will cost the government less.

Mr Wells: That is fascinating, but I do not think that many private clinics here would agree to charge less than what the state pays for the operation; they just would not take on the work. So, you must have a good relationship with the private sector.

Mr Gomes: We have a problem with productivity in the public sector. The private sector is able to do things more productively. If you have a hospital that is set up to treat very complicated situations at

the same time that it is going to treat simple situations that are the most frequent, you have an investment that is not going to rise. You have all kinds of people working there, but they are not needed for most of the things that are being done there. We are not yet able to achieve the maximisation of productivity in public hospitals. Private hospitals can be much more productive than public hospitals. They can achieve 20% lower costs than the public hospital. Public costs are also incremented with some contaminations, because, even if we have a separate social department that is not in healthcare, the social department cannot give responses at the time. The public hospitals will then have patients that cannot go anywhere else.

Mr Wells: We have had evidence from Scotland, which has a central monitoring system where all the waiting lists are fed through to one desk. You have a similar system in Portugal.

Mr Gomes: Yes.

Mr Wells: Is it you who sees all the statistics?

Mr Gomes: Yes.

Mr Wells: So, you are able to identify hospitals that are performing poorly and those that are performing well. In the Portuguese system, is there an ability to move patients to hospitals that have capacity? You have 109 hospitals, I think. Do you, as a central control, move patients around?

Mr Gomes: You cannot move patients without their agreement; you must ask them whether they want to move. That is the first problem. The second problem is that it is worse to move patients from one hospital to the other, if the other has more capacity to respond in real time, because you will move the problem from one place to another. We are trying to do that; we are trying to incentivise; and we are trying to make organisational policies in public hospitals in the sense that they will want to get more patients. However, we cannot give incentives to the professionals at this time because, now that we are in crisis, the incentives have been cut off. It is forbidden to give incentives above salary, so it is not easy, at this time, to incentivise other hospitals, even if they are performing better, to receive patients from another place.

So, there are two things. First, you must get the consent of the patient to move them to another list or to another hospital, because the patient has already spoken with the doctor and has agreed with that particular doctor what kind of surgery they will have and what the consequences of that surgery may be and so on, and we do not think that it is ethical to just take that patient and put them in another place. It can be done, but only if he consents. We can say that if he goes there, he will be treated in less time, but mobility is also a problem. Many patients will not want to pay the extra that comes with mobility issues. If you take the patient from one place to another that is far from the original hospital, that would be a problem for moving.

Mr Beggs: Thank you for your presentation. I was interested in your emphasis that placing a penalty has forced hospitals to improve their productivity. How do you pitch the penalty at the right level to the right organisation? The set-up of each may limit their ability to respond. If you pitch it too high, you will just completely undermine the service, and they will not be able to reply to it. How do you pitch the level of the penalty, and how do you know whether there is capacity in a hospital to improve?

Mr Gomes: We have benchmarking on productivity, so we know which hospital and which sector in a hospital is performing badly in comparison with the other ones. That is one point. As to how we apply the penalties, so far it has been just at a financial level for the hospital as a whole. That is not very effective because it is difficult to close a hospital. So, even if that hospital does not perform well enough financially, it will be sustained by the Government. It will be paid off. In contracting with the top managers now, the contract includes penalties, and you can eventually not continue as a top manager if you fail to meet the targets. We are now doing that. It is very recent and was put in place just last year and this year. This year, we are also introducing restraints to additional practice. Additional practice for doctors is seen as an incentive. It is not really an incentive because we are paying them for doing things, but they are seen as incentives. We are now trying to limit access to that practice if they do not achieve the minimal productive standards that we publish. So, you can earn the rest of the money for the rest of the production if you achieve the minimal standards that are published. The minimal standards are based on the top 25 for productivity in all countries. So, it is a big step to achieve that kind of additional payment.

Mr Beggs: Do you have a uniform health accounting system to attribute costs? Depending where overheads are parked, that can have a major bearing.

Mr Gomes: Yes. All episodes are coded by ICD-9. Now with no country having ICD-9, we are migrating to ICD-10. All episodes are coded.

Mr Beggs: What percentage increase in productivity have you achieved through those pressures on the hospitals and the public service?

Mr Gomes: We achieved nearly 50% of the productivity of the hospital. That is not in accordance with the expenditure. That account is not yet made. The expenditure has also risen but the price per unit is falling, and we estimate that it is over 20% less than three or four years ago, based on measuring productivity on an expenditure and income basis.

Mr Beggs: I have a final question. You mentioned earlier that screening and various tests are all part of an integrated service. I am picking up that, with our service, depending on where it is parked, it can be a blockage. Who decides when the test occurs? Is it the GP, or do you have to see the consultant before you get that added delay to an operation or a process?

Mr Gomes: In theory, to go to a consultant, you must go to the GP first. In Portugal, we are still trying to change what happens in practice. Until now, just 30% of people who go to the first consultation with a consultant come from a public GP. The other ones are patients who go to the hospital and are cross-referred from other consultants and other hospitals. So, we are trying to improve, including through having a financial incentive for referrals that come from a GP. However, it is not forbidden to have a patient consultation if that patient did not come from a GP.

Mr Beggs: To what extent can GPs request appropriate tests, as opposed to consultants, so that there is not a bottleneck at consultant level?

Mr Gomes: That is also quite different around the country. When the funding for examinations was not provided to GPs, they could ask for whatever, because it would not affect their budget. Now, we have two kinds of system for GPs. We are changing, but that change is slow. We have 30% in the new form, which permits that GPs have incentives to their practice in functions to do with the quality of services and attendance numbers etc, but examinations are also included in that funding. Those GPs do not want to ask for very many examinations, and they refer earlier to the consultant in the hospital. If the examination is asked for by the consultant, it is the hospital that pays, not the funding for the GP. We have a mixed situation now.

Mr McKinney: I want to ask about the IT system, which is clearly key to the whole project. How difficult or easy was it to commission and implement that system?

Mr Gomes: We had a good start because 80% of the hospitals had the same information system. So, we could change one system and it would change 80% of the whole system. That system was a public government one. We asked the other hospitals to alter their systems to match the central one, so it was not very difficult. Now, we have experienced serious problems in matching different systems when trying to match the private care system with the hospital system. That has been a problem, but the first one was not.

If you have a strong determination and say, "Things must go there, and requests for functions are those", and you tell people that, if they do not comply with those requests in three months, you will not process them, things will change quickly enough.

Mr McKinney: Was there a big cost implication with the IT system?

Mr Gomes: We have an estimation for all the modifications and implementation of the IT system of €1·5 million a year for five years.

Mr McKinney: So, it is not an extraordinary cost.

Mr Gomes: That is to connect all hospitals and to have a central system to analyse data and make reports and all that.

Mr McKinney: Just to be clear then: the system has to be available in common to all hospitals.

Mr Gomes: Yes.

Mr McKinney: And all hospitals must have an electronic record of the patient.

Mr Gomes: Not a complete electronic record, but the consultations must be electronic. Medical text does not comply.

Mr McKinney: It is not necessary. It is simply a record of —

Mr Gomes: The system has two ways of working. One way is to interact with local systems, and data passes from the local system to the central system. Hospitals that do not have a local system that is good enough, with all that is required to connect, can connect directly to the central system and put their information in there. That is what is happening in most private hospitals that have less quantity and do not want to acquire another system. They use the central system as their own electronic process management system.

The Chairperson: OK. Thank you for that information and for taking the time to come here. This is something that the Committee takes very seriously, and your evidence today will feed into that. It is important in respect of the central unit, and we have heard that before, as some members have pointed out. Thank you for your information. We will reflect on it, and it will form part of our recommendations. Thank you very much. Safe journey home.

Mr Gomes: Thank you.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: DHSSPS and Health and Social Care Board

4 June 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Waiting Times: DHSSPS and Health and Social Care Board

4 June 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Dr Eugene Mooney	Department of Health, Social Services and Public Safety
Ms Heather Stevens	Department of Health, Social Services and Public Safety
Mr Chris Stewart	Department of Health, Social Services and Public Safety
Mr Dean Sullivan	Health and Social Care Board

The Chairperson: You are very welcome, folks. We have with us, in no particular order, Heather Stevens, director of service delivery at the Department; Mr Chris Stewart, director of healthcare transformation at the Department; Dr Eugene Mooney, director of information and analysis at the Department; and Mr Dean Sullivan, director of commissioning at the Health and Social Care Board (HSCB).

I advise the witnesses that, in the process of our inquiry, there are a number of key issues that the Committee wishes to discuss today. We want to work through each of these in turn and use the opportunity to gain an understanding of the position of the Department and the board on these issues before we make any recommendations in our report. We would welcome an open and constructive debate. You know the formalities, and I understand that you will make an opening comment.

Ms Heather Stevens (Department of Health, Social Services and Public Safety): Thank you very much, Chair. We are grateful for this opportunity to participate in the Committee's review of waiting times and build on the input that the Department provided to the Committee back in January and February. We appreciate that you have set out a number of areas that you want to explore with us, so I will be very brief in these opening remarks.

The need to improve access to health services and, in particular, to reduce waiting times is certainly a key priority for the Minister. It has been pursued through setting standards and targets in successive commissioning plan directions. However, we in the Department fully accept that, in many instances, performance is not where it should be, although some progress has been made compared to the

position of, say, eight to 10 years ago. We also know that this is one of the most complex and challenging issues that we have to get to grips with. That has, in fact, been a message that has come through consistently in these evidence sessions.

It is a universal problem, and no one seems to have identified the magic bullet to fix it. Instead, we can see that different countries are approaching it in different ways. We are very keen to consider practices and learning experiences from other countries or regions that have implemented different models to reduce elective waiting times. We very much welcome the Committee's thorough investigation of these issues. We look forward to receiving your recommendations in due course. We would welcome sight of any further evidence that is available on the efficiency and effectiveness of other approaches as we continue to seek to improve the patient care pathway and experience.

We know that one such approach is to look at measuring the entire patient journey through a referral-to-treatment time. This approach is being followed in a number of countries — England and Denmark, for example — but the key thing is that it is early days in their implementation of that approach. We are very keen to learn from that and look at the experience elsewhere in order to inform whether the significant investment needed to pursue this approach in Northern Ireland is worthwhile, particularly in the prevailing financial climate that we find ourselves in. However, while we assess the merits of other approaches, our immediate focus continues to be on improving the waiting times for the individual elements of the patient pathway, namely outpatient assessment, diagnostic tests and inpatient day case treatments.

We are in the process of developing, in parallel, other measures that are much more focused on the outcomes and experiences of the patient to help them make informed choices and help address the issue, which was identified by Professor Normand in his evidence, that a lengthy waiting time may not necessarily mean that a patient is suffering a detriment.

We also know that reducing waiting times is not fixed by simply focusing on elective care provision. There are important linkages between other parts of the secondary care system — for example, unscheduled care — as well as primary care. So, a whole system solution is required that looks at patient flow right across the piece.

We have robust information. The HSCB has carried out a demand capacity analysis across all the secondary care specialties so that the board knows when demand exceeds the capacity of the trust to deliver. However, we also know, and the evidence sessions have again borne this out, that what is needed is not simply a supply side solution with additional capacity being brought in to reduce ever-growing waiting lists. We need to find ways to manage demand in the context of a demography that can present only an unsustainable increase in demand. So, local commissioning groups (LCGs) are already working on developing pathways to reduce pressure on secondary care services. We are, indeed, starting to see some exciting new initiatives from GPs themselves in the form of federations or clusters of practices maximising their own particular interests and areas of expertise in order to reduce referral rates.

In summary, we know that we have a significant challenge to grapple with and that we have to tackle it in a number of ways. We have to manage demand but also continue to invest in capacity and make sure that we measure progress effectively, all while making sure that we keep the needs of the patient absolutely at the front and centre of this. Chair, that is all that I want to say by way of preamble. Colleagues and I are happy to go through the issues that you have raised and answer any questions.

The Chairperson: Thank you for that, Heather. I am initially seeking your view on the referral-to-treatment time. One of the pieces of information that we discovered as we have gone through the inquiry is that, if there are only the stage-of-treatment targets, there can be perverse incentives for managers to delay patients. Do you have a view on that or a sense of it?

Mr Chris Stewart (Department of Health, Social Services and Public Safety): Chair, if it meets with your approval, I will answer that and, in doing so, expand a wee bit on some of the things that Heather said. First, to answer your specific question, we recognise the potential in the system for those sorts of perverse incentives.

I am not aware — unless Dean is aware of anything different — of specific evidence of that happening in our system in Northern Ireland. Nevertheless, we recognise that the potential for it would be there. In overall terms, it is important to emphasise that the Department's view on a referral-to-treatment target is that we think that it is highly desirable for the range of reasons that have been given to the Committee in recent weeks by the other witnesses who have come before you, because it would

remove those perverse incentives and take them out of the picture completely, it would better reflect patient experience and what the patient is really interested in, which is the entire journey, and we think that it would also reflect the clinical interests. Doctors and other clinicians are interested in the patient's entire experience. Therefore, we would have a much better target all round as and when we were ready to move to that.

It would also ensure that we have a complete end-to-end focus on performance and we would be able to ensure that any hidden delays in the system were being identified and tackled. Therefore, for all those reasons, we think that a referral-to-treatment target would be a very good thing.

As you have heard from a number of witnesses in recent months, it is difficult to achieve, and there will be a number of challenges that we will have to overcome in moving to that form of target. They fall into three broad groups: policy, resource and technical feasibility. I should stress that those are not excuses for not doing it, and we think that all of those are capable of being overcome.

With regard to policy, there are a number of key decisions that we would have to take. First, how would we do it? As Heather said, this is still a relatively new approach. It is not particularly well established around the world and there is no single obvious best practice model that we could pick at the moment to follow. That does not mean that we cannot do it; it just means that we have a difficult choice to make up front.

We also need to look at some more technical aspects of policy. What type of measure would we adopt? Again, you have heard from witnesses in recent months that there are several approaches that you could take to this. You could have a snapshot of those who are waiting within the system at any given time, or you could base a measure on completed journeys, and there are advantages and disadvantages to both. You could measure completed journeys, where you know exactly what the experience has been for those patients and where the problems have been — if there have been any — but that measure is retrospective. It tells you what the system has done, not what the system is doing or is going to do. A snapshot of people waiting is more current but is not complete: because people are waiting and you have not entirely bottomed out what their experience has been. Therefore, there is a choice to be made. What type of measure or, perhaps, would both need to be included?

Another key issue in policy terms at the system level is that if we are going to use such a measure, not just to manage the performance of our own system day to day, week to week, month to month, but also to do a comparative analysis of how we are doing against other jurisdictions — I am not saying that we have to adopt the same measure as every jurisdiction — we have to have a rich understanding of what the differences are so that we can make some comparisons.

The second group of challenges relates to resources. Again, you have heard from witnesses that this is not something that is easy or quick to do. It would take a number of years of hard work to get it in place, with perhaps investment running into millions of pounds to put it in place. Of course, there is an opportunity cost there. Undoubtedly, it is a very good thing to do, but while we were doing it, we would have to divert some of our performance management resource to develop that new approach, so there is a danger that our eye might be off the ball with regard to managing the system while we develop the new target.

Related to that, we have heard from the Scottish and English experiences that those developments and the introduction of those targets need to be preceded by a focus on getting the performance and the measurement right in the individual stage targets that we have. So, there is a challenge for us in trying to do both of those things at once.

The third set of challenges is around technical feasibility. We need to be certain that the information systems that we currently have are compatible with that sort of approach, that they are comprehensive so that we are capturing all of the elements of a patient's journey, and some development of systems would be needed. We need to think carefully about how we do that. To put it candidly, do we rip out and replace the existing systems or do we try to overlay them with a new system that would sit on top and gradually replace the legacy systems underneath? There is a key decision to be made there.

Chair, I am afraid that you and the members will know of many examples in the public sector where the approach has been based on "rip out and replace", and we have not got it right. Information projects have gone over time and over budget. I think that there is a strong argument for trying to overlay a system on the existing systems and replace as they come to the end of their natural life. A very good example of that is the electronic care record. That was the approach that was taken: we did not rip out and replace. The existing systems will reach the end of their natural lives and be

replaced, and each time that happens they will be compatible with the overlying electronic care record system.

All those challenges have to be overcome, and there is one final point that is worth making. When is the right time to introduce a referral-to-treatment target? There is a strong argument for saying that the right time and the right context would be as part of a change to commissioning arrangements. We do not commission full patient journeys let alone outcomes. However, we commission episodes or stages of treatment. Success in that approach is much more likely if we can get those two things aligned. If we can move to new commissioning arrangements so that we are commissioning patient journeys, better still outcomes, and so that the currency that we use, both for commissioning and the measurement of performance is the same.

We do not offer those to you as a series of excuses for inaction but simply as a candid description of the things that we will need to do to put this sort of target in place.

The Chairperson: Thank you for that, Chris. I welcome the detailed response. Can I take it that when you say that referral-to-treatment, as a system and process, is highly desirable that the Department is committed to it in principle at least?

Mr Stewart: That would be a policy decision for the Minister, but, in replying to the Committee, the Minister has endorsed the line that it is highly desirable. He will expect us to treat that as a priority.

The Chairperson: That is ultimately a shift — a welcome shift, but a shift nonetheless — from the engagements that we had before on the issue.

Mr Stewart: It is a shift in the sense that it represents the leading edge of best practice. As we have said, it is not practice that is fully developed; we are watching developments in other places. Nevertheless, it is the direction of travel for those who at the leading edge. If we want Northern Ireland to be at the leading edge, that is the direction in which we will have to go. It is highly desirable, but, as I said, and this is not a cop-out, policy decisions are for the Minister rather than us. But, it is recognised that that is best practice.

The Chairperson: In the response that we had from the Department, there was talk about a move to referral-to-treatment (RTT) measurement being challenging both financially and logistically. You outlined that in your comments around policy, resourcing and technical feasibility and gave us some details on that. Are we about to move to a business case? Has there been consideration of feasibility and cost?

Mr Stewart: No, we are not at that point. I would be misleading the Committee if I gave you the impression that we were about to go to that point. A great deal of work would have to be done first.

The Chairperson: OK, but we are moving in the direction of considering —

Mr Stewart: As Heather said, we recognise that that is best practice, but we recognise that the Committee is doing an important and serious examination of the area. We would want to see your recommendations and conclusions before putting definitive advice to the Minister.

Ms Stevens: As we said earlier, because the other countries have gone down this route at an early stage, we want to monitor how they are progressing and learn from their mistakes and the good practice that they identify.

The Chairperson: So, are there engagements from the Department with other countries and regions?

Ms Stevens: We are at the start of that engagement. The review that the Committee has undertaken has been enormously helpful in identifying where we can usefully look.

The Chairperson: OK, glad to be of help.

Mr Dean Sullivan (Health and Social Care Board): It is not totally new to us in Northern Ireland: we have one pathway where we measure from referral through to treatment for cancer patients. So, for patients referred urgently by their GP, there is a 62-day target that the Minister has set, whereby 94%

of patients are required to commence their treatment within that 62-day period. So, that demonstrates for us all that it is feasible in principle, but I fully agree with my departmental colleagues about the technical and logistical challenges that there would be around a big-bang approach to introducing that more generally. The cancer pathway shows that there might be a possibility, subject to the view of the Minister and others, of incrementally moving towards that.

The more fundamental issue is around making sure that at least the individual stages of the pathway were broadly in the right sort of place before moving to that system, otherwise you would just be measuring differently something that was not what you wished it to be. Moving to total patient journey time measurement would not in itself fix underlying major difficulties at any individual point.

The Chairperson: I think that some of that will come out in the discussion around targets in general and their enforcement.

Mr Beggs: How long has the cancer treatment system been running and what has been your experience of it.

Mr Sullivan: Mr Beggs, as I recall, the 62-day cancer target was introduced in 2007.

Mr Beggs: I am interested in your monitoring systems.

Mr Sullivan: The facility was in place to monitor that target in the 2007-08 financial year, as I recall. I am sure that departmental colleagues can check that and confirm that to Committee members after the meeting. That was the target at the time in England and an equivalent target was introduced in Northern Ireland. I understand that England has now reduced that to 85% rather than 95%. Therefore, for cancer, that has been in place for several years.

Mr Beggs: Why could that software system not be extended to other departments?

Mr Sullivan: Chris can speak for himself. It is less the software technicalities around some of all this; it is the sheer scale of things. You are tracking for the patients who are urgently referred with cancer and who go on to require definitive treatment. It is a tiny subsection of the numbers that we are talking about here in terms of the breadth of specialties, trusts, systems and so on. All of that could be teased out. The more fundamental issue for me is around getting everything ready for the system to be introduced rather than necessarily huge systems — issues that Chris talked about —

Mr Beggs: Why can it not be rolled out? It does not have to be a big bang. Why can it not simply be adopted in another department, for instance, and widened?

Mr Sullivan: The scale of things within cancer, where you are talking about patients in relatively small numbers each month, allows a different and more targeted approach than something in relation to elective care more generally, where we know we would be talking about tens and hundreds of thousands of patients, as opposed to dozens and hundreds of patients. It is simply a scale thing.

However, you are right; the principles would not necessarily be any different. We are able to identify when an urgent referral has been made, and we are able to identify all the bits in the pathway, including the complexities in cancer patients perhaps being seen in the first instance in, say, Antrim, and then if they require specialist care like radiotherapy, the patient would then be referred into Belfast. We are able to track the patient around the system in that way, but it is because the numbers of patients are literally slightly more than handfuls but not in thousands that we are talking about. However, I am sure that you are right; the principles would be applicable.

Mr Stewart: Just to add to that, I think that it is an issue of scale. Once we reach the point where there is a software system in place, it can pull out all of the various pieces of information and stitch them together. Yes, you can roll that out anywhere. I do not know, but I suspect that there is an element of manual processing in the cancer target at the moment. Again, as you heard from the Scottish experience, that is one way of starting, which is that you can have a largely manually driven process and have people with the role of patient trackers joining up the various pieces of information at the minute. It is hugely labour intensive and it would be a distraction of resources from, as Dean said, managing the bits of the system that we know are not working well enough at the moment and where the real problems are. It could be done that way. However, it is not a terribly efficient way of

doing it and probably not a terribly effective way of doing it. At the sort of scale where you would be rolling out to the big numbers in, say, orthopaedics, it is probably not practical at the moment.

Mr Beggs: Can you tell us something more about the current patient administration system? How old is it and what is its life expectancy?

Mr Stewart: I have to look to my colleagues for that. It is not something that I have detailed knowledge of personally.

Dr Eugene Mooney (Department of Health, Social Services and Public Safety): I could not say in terms of years, but I know that it has been raised by the Committee in the past. When we looked at consultant cancelled outpatient appointments, we looked to see whether it could be revised. However, the patient administration system is common across the UK. It is not a question that it is not fit for purpose; it is fit for the purpose for which it was designed. With regard to introducing a referral-to-treatment target, there are a number of stages where we switch clocks on and off. My colleagues have talked about where some of those clocks start and stop. There are parts that we miss; we miss when the decision is made to send a patient for a diagnostic test. It will stop in terms of the time taken to report that back, come back to the consultant, the consultant to look at that and make a decision and then have a review appointment.

Mr Beggs: Why does the clock stop?

Dr Mooney: It is just because there are different systems in place to record. We have different systems for inpatients, for outpatients and for diagnostics. One of the things that we are seriously looking at is if we have captured a number of the elements of the stages, and as we are now looking at the clinical community gateway, we are looking to see if we can get most of the referrals that are coming from GPs through electronically. So, we will know that they are all coming to the trust, and we will be able to capture how many are coming through there, and then at the other end of the stage. So we may still be able to get that time difference, but maybe not in the way that our colleagues across the UK have it.

Mr Beggs: To go back to my question, how old is the current system?

Dr Mooney: I do not know the exact date.

Mr Beggs: Can you come back to us with that?

Dr Mooney: I certainly will.

Mr Beggs: I recall that when we were looking at missed appointments, there were difficulties in adopting new technology, such as automatic text messaging and that sort of thing. What is the cost of those missed appointments? Do you accept that a new system might bring about a number of other benefits, as well as capturing the referral time to treatment?

Mr Stewart: I think that there is no doubt that investment in improving the systems will bring all sorts of benefits such as those that you have described. I am afraid that we will have to come to you with the detail on the PAS system, as none of us are familiar with that. In respect of a strategy to achieve that, I will go back to what I said earlier: the first decision that we face is, do we rip out and replace, or do we adopt what instinctively what would be the better approach, which is to look at things such as PAS and look at its limitations and where it is falling down, what is its natural life cycle and how close is it to that? In replacing it, underneath some sort of a portal or overlying system that would sit on top of that to ensure that its replacement has those features that you have talked about, such as automatic text messaging, which simply would not have been thought of when PAS was introduced, I would imagine, because that sort of technology did not exist. It is the very opposite of a Big Bang approach. It is graduated and it is incremental, which means that you do not realise all the benefits for some years, but it is lower risk, and as we have shown with the ECR success story, ultimately, it is more likely to be successful.

Mr Beggs: From talking to your English colleagues who have the system, do you have a ballpark figure of what it would cost here?

Mr Stewart: I am not aware that there is a reliable estimate for Northern Ireland.

Mr Beggs: Have you seriously looked at it, if you do not have a figure? Do you even have a guesstimate?

Mr Stewart: No, is the straightforward answer to that. I do not think that there has been an estimate made.

Mr Sullivan: Chair, if it is helpful, Mr Beggs referred to the issue of patients not attending appointments on the day of the appointment or cancelling on the day of the appointment. Having sat with a different hat on in front of this Committee and other Committees in the Assembly, I know that if we had been here three or four years ago, the typical DNA rate was around 11% or 12% against an English average at the time of about 10·5%, as I recall. The position in Northern Ireland now is materially different to that. The position last year in Northern Ireland was that about 7·5% of patients did not turn up for their appointment on the day. That is lower than the equivalent position for England. So there are always further opportunities, ideally through technology, but through other measures as well. I do not think that would be the only reason why you would introduce this, and I know that you are not suggesting that. I think it is important for the Committee to be aware of the demonstrable progress that has been made in relation to that issue, which has been an important issue for this Committee and other Committees in the Assembly.

Mr Beggs: Another issue that I hope you will accept is that people who are partially sighted have been unable to get appropriate messages through a variety of means because of their disability, if you like, and the technology in our dated systems. Do you accept that a number of other benefits would follow?

Mr Sullivan: I think that would be a very important spin-off benefit, yes.

Mr McCarthy: Thanks very much for your presentation. I want to talk about enforcement of targets and the tools that you have to ensure that the targets are met. You have issued us with some correspondence, but there are a few other questions that I would like an answer to. Is the monitoring of targets for waiting times for elective care completely delegated from the Department to the board? Who leads on that area of work in the board? Do they have the expertise and resources, in terms of time and staff, to effectively keep on top of what the five trusts are doing? Does the approach of a financial punishment of trusts who do not meet their core activity work? Who is actually impacted by it? I notice from your correspondence that the board withdrew some £876,000 from three trusts in 2013-14 for not delivering against core activity. That was a punishment but, at the end of the day, who is at the end of that punishment? It must surely be the patient. Is it?

Ms Stevens: Dean, do you want to start with the board's role, and I will come in and say what the Department does?

Mr Sullivan: I am happy to proceed on that basis. Go back to the legislation: the 2009 Act makes it clear that the board is responsible for performance management and service improvement to ensure the delivery of ministerial standards and targets, of which elective care are clearly some. Who leads within the board at director level? We have a director of performance who is a colleague of mine, Michael Bloomfield. He and I work very closely together, obviously, with the commissioning and the performance bits being two sides of the same coin, and we also work very closely with our finance colleagues. Do we have the necessary skills to do that? Certainly, within the board, we have access to a range of different skills. Michael and I have been directly involved with this for about 10 years previously in the Department. We have, through the work that we did in the Department and more recently, secured, at points in time, substantial improvements in waiting times. What we are talking about today is how, in a very resource-constrained environment, with the demographic increases and pressures that Heather has referred to, secure sustainably short waiting times? That is where we are keen to focus.

To answer your other question — do we have the necessary tools? — I will remind Committee members of what we actually do. The most important tool, perhaps, is timely, robust information. We certainly have that; we had that in departmental days, and we now have it in the board for the past seven years or so, so we know on a weekly basis what the numbers look like by organisation and so on. With the agreement of the Department and the Minister, last year we introduced the sanctions to which you referred, whereby, if a trust materially underperforms against its agreed contract, then the

funding is withdrawn at a marginal rate. That is what has happened, and that should not directly impact in the short term on any patient; it is more to encourage the right sorts of behaviours in the system. Clearly, at scale and over time, there would be the risk, in Northern Ireland terms, of an outcome in that regard, but it is trying to avoid the sanction being applied at all, Mr McCarthy.

Beyond that, it comes back to what Heather talked about, which is the correct place for us to go. All the discussion to date has been about what we can do at scale in primary care to manage demand differently, and there have been very active discussions with very senior members of primary care, involving colleagues sitting beside me and myself. One initiative in that regard at scale is due to commence during the summer, in addition to a number of other smaller-scale initiatives in terms of better management of the demand at source in primary care. Equally, though, within trusts, we are trying to move away from what is quite an operational, transactional arrangement with trusts at the minute. As we speak, Michael is meeting with two of the trusts this afternoon as part of a series of fortnightly meetings that we have with trusts toward having a less hands-on, less transactional, less operational arrangement, whereby trusts and clinicians are empowered with — as Chris touched on — a greater focus on outcomes. One of the key elements of that, not just actual patient outcomes, is obviously timely access to care which, in some cases, is a key prerequisite to a satisfactory outcome. So we are looking at the fundamentals of that and how we might reform things going into the future.

Ms Stevens: Shall I add the Department's role in that? It is twofold, really. First, the board itself is an arm's-length body of the Department, and we meet monthly with Dean and Michael. A report is produced on performance right across the commissioning plan standards and targets, and we go through that in some detail looking at individual trusts, where the areas of good performance are, where best practice can be identified and shared, and where performance is falling short — and the reasons for that and what the board is doing about it to help trusts to improve. That is one approach.

Secondly, the trusts are also arm's-length bodies of the Department, and there is a very formal accountability and assurance process in place whereby, twice a year — mid-year and end year — the trusts are brought in, and a meeting is held with the chair, the chief executive and senior members of the trust's management team. It is chaired by our permanent secretary. We formally hold them to account on a range of issues, such as a raft of corporate governance issues flowing from their governance statement. We look at their performance on targets generally; we look at their performance on finance; and we look at their performance on quality and safety. The board is invited to those meetings to give its assessment of performance, and the trust is then given the opportunity to come back and give its report to the Department on the reasons behind any areas of underperformance.

That process is particularly significant this year, following a letter to all of the trusts from the permanent secretary back in November. That letter set out our commitment in the Department to do a strategic assessment of the trusts' position on quality, finance and performance. That will be completed when we do this round of end-year assurance and accountability meetings. In fact, that letter from the permanent secretary held out the possibility of further intervention on foot of that process, and escalation is a possibility, if required.

Mr McCarthy: To finish, Chair, that £876,000 that was taken off the trusts concerns me. In England, for instance, they use a "targets-and-terror" approach. Do you know what is coming? Chief executives lost their jobs. That is putting on them the blame or the responsibility for not delivering what was expected of them, rather than taking cash from the trust, which, obviously, will come down to the patients. That has not happened here; at least, I have not heard about it. Is it likely to happen in the near future? In Portugal, they offer incentives. Only doctors who have met their basic targets are permitted to do additional in-house work. Is there anything like that on your radar?

Mr Sullivan: I will go back to how it manifests itself. We withdraw funding for services not delivered at 25%. In reality, that 25% is largely related to consumables, and so on, associated with that activity and might have been incurred anyway. So, at the minute, I am fairly certain that there is not a material impact on other patients within that LCG or trust area. The total figure for the Committee to be aware of in the three quarters in 2013-14, which supersedes the information that you have, is £1·5 million being withdrawn for under-delivery. Departmental colleagues will have a view. I do not think that it is helpful for all of us to get into some sort of blame culture. It is about trying to create a system where, in particular, clinicians in primary care and secondary care are facilitated to do the right things for patients and in which, hopefully, we can avoid sanctions, threats, terror and any other unpleasantness.

This is all much more straightforward for all of us, particularly the patients, if they receive timely access to care. I am confident that that is the direction that the Minister and the Department are continuing to work towards. I can speak on behalf of the board, and it is certainly the direction that we are seeking to work towards. That does not mean that, from time to time, as is the case currently, we will not face particular challenges. I encourage members to look at the movement in these numbers over time and be assured that, between the Department and the board, we will turn this around. There are challenges with that, and we have talked about some of those, but I think that we have the building blocks to allow that to be turned around. However, because it is of such a scale, the difficulty is that it is not just a quick flick of a switch so to do.

Mr McCarthy: To finish, Chair, until we see real efforts to get on top of this, it is going to continue. If you come back here this time next year, will we be seeing the same problem?

Mr Sullivan: I can assure members that, from the board's perspective, real efforts are being made every day of every week in looking at this as a specific agenda issue. This is not something that we come round to once a month; it is something on which there is an acute focus within the board and trusts — probably, bluntly, too much of a focus on it, because there are bigger prizes around Transforming Your Care that we need to be focusing on, and almost making this part of routine business. Clearly, the two are not unconnected. The demand management initiatives within primary care, particularly, and the discussions with leaders in that regard, are entirely consistent with the Minister's vision as set out in TYC. But that is where we need to be focusing, and the other being just more routine business.

The Chairperson: It is important that there is a role for the Committee in understanding the Department and the board's view or policy on a specific way forward. Kieran's question was around those kind of financial almost punishments and their use. Did they achieve anything? What I am hearing from you is almost a sense that we do not want to move to that blame culture. If we are saying that, are we then saying that we will look at a process of incentives? And if we look at incentives, what will they be?

Mr Sullivan: I commission services. If any of us in our day lives are going to Tesco's, we are not spending money for things that we do not receive, so I reserve the right — and I think you would expect me, working on your behalf, to have a position that if routinely services were not delivered in the required volume or to the required standard, there would be some comeback to the relevant provider. That seems entirely reasonable and does not sound to me like a sanction or anything. That is just routine commissioning from a provider organisation.

I was trying to explain my desire and the board's desire not to get to a place where every problem becomes an opportunity for everyone to point fingers at everybody else in the system. I would rather that our collective efforts were spent on trying to fix the thing, so if I was unclear in responding to Mr McCarthy, I apologise. I was simply trying to say that we are at a place that we are at. We are trying to avoid any blame culture. I do not think where we are now is, and I saw the quote, in terms of the "threat and terror" from across the water. They have been in a slightly different position from us in that regard, but they are a different system and on a different scale from us.

The Chairperson: Specifically, Dean, because I know there are a number of people who want in on this particular issue: the incentives culture.

Mr Sullivan: On the incentives culture, I touched on the board having progressed discussions with a small number of provider organisations within Northern Ireland in recent months around a small number of specialties. That has been a much more open-ended discussion, which is whether we can move away from a transaction-based approach whereby my relationship with you as a provider is to buy three of these, four of these and five of these, to an arrangement whereby my relationship with you is to ensure that you provide timely and effective care on a long-term, sustainable basis for the population via the LCG that you serve.

As part of that, we are actively looking at what incentives we might put in place in the context of that being delivered. The flip side would be potentially not paying for services when they are not delivered, but the point is well made: it is often easier to design the sanctions bit of this than to incentivise. The biggest incentive, though, and what has been very well-received — and these are discussions actively with clinicians, orthopaedic surgeons, urologists and others — is to give them a little bit more control over their day life.

I meet routinely with clinicians who say that if only they were untethered from all the bureaucracy and so on, they could do so much more for patients. As an organisation, supported by the Department, we are putting that challenge out to the clinical groups and saying, "Show us what that looks like. It needs to be within broadly acceptable parameters from a commissioning perspective, but show us what that looks like."

The Chairperson: We would like to be kept informed of that particular piece of work as it is rolled out.

Mr Sullivan: I am happy to.

Mr Stewart: I would like to make a couple of points to amplify Dean's answer. The ultimate incentive is to empower clinicians to make better and more efficient and effective use of the resources that we have. Central to that are mechanisms like integrated care partnerships, which members will be familiar with. I will give you a more local example of where this can be extremely powerful. Some work on medicines management, which was pioneered in the Northern Trust by Professor Mike Scott, is now being rolled out across all the trusts. I will not detain members with the fine detail of that, but I would be happy to send that to you. Essentially, some very progressive software packages have made a step change in the way the medicines regime is applied to patients in hospitals. As a direct result of that, the average length of stay in hospitals has been reduced by two days. Of course, that frees up capacity in hospitals to admit more patients and to increase throughput. That has come about through the empowerment of Professor Scott and his fellow clinicians in the trusts to innovate, to develop good practice, to have that recognised by the board and the Department, and to have it rolled out and replicated relatively quickly across the HSC, although I think that we could still do better in that regard.

The Chairperson: Thank you for that.

Mr Dunne: Thanks, folks, for coming in this afternoon. I have just a couple of quick things. Does your data include A&E waiting times and trolley wait times?

Mr Sullivan: Yes.

Mr Dunne: It does? Right. Briefly, without getting bogged down, how is that managed differently from the rest?

Mr Sullivan: One of the key ways in which it is measured differently is that we tend to track the waiting time side of things for planned care, which is what elective care is, on a weekly, fortnightly and monthly basis. We get live feeds on A&E waiting times, so colleagues in the board know now what the position is like across all the A&E departments in Northern Ireland. I get an update every morning at 9.00 am and another one at 4.00 pm to tell me what the position is, as do other senior board colleagues.

The principles are broadly the same. The principles are that we seek to identify the demand from patients in an LCG area for services, commission services consistent with that demand, and then hold providers to account for the delivery of the services that have been commissioned. So, the principles are almost identical to those for elective care. The key difference is that there is not the opportunity for the independent sector to deal with excess pressure in the system. For the demand that presents itself in the trusts, we are wholly reliant on the ability of trusts to deliver timely and effective services to —

Mr Dunne: The figures are fairly predictable, though, are they not? When we visited the Royal, we learnt that the figures are predictable. We always felt that they were unpredictable, but they gave us the assurance that they are fairly predictable. Why are we not managing resources better, then?

Mr Sullivan: Well, I can speak from a commissioning perspective. I am satisfied that we have worked very closely with trusts over a prolonged period to be reassured on the sufficiency of resource that exists in trusts to deliver timely access to care. That is not to say that there have not been and are not always potential opportunities to invest, on an issue-by-issue basis, in order to improve patient flow in the system. However, the resources are there now to deliver reasonable performance against the Minister's extant waiting time targets. That is easy for me to say today; the very real challenge is around actually delivering that, given the complexities in the patient journey and the challenges that the trusts have had.

As you say, Mr Dunne, whilst the front door is reasonably predictable and is actually fairly steady for the time-of-day and day-of-week demand, one of the remaining and continuing challenges for trusts is to keep their discharge performance equally steady during the days of the week and the times of the day. The greater the extent to which discharges are pushed later in the day and into the evening time, and the greater the extent to which the flow of discharges does not happen over the weekend, the greater the pressure on the front-door system through ED. As you will all know, ED pressures are only a symptom of the system itself not flowing through. At the end of the day, by definition, all patients eventually get discharged and, over time, admissions equal discharges. Having blockages in the system that prevent the flow from working as it should is only a timing thing.

Mr Dunne: Going back to the point about enforcement, is there a risk that front line staff are under excessive pressure to meet targets? We have had it at first hand from staff that, within wards, staff are told by managers, "These patients are going to breach". Is that putting patients and their standard of care at risk, because managers are more worried about breaching the target than they are about the condition of the patient or the level of care? Do you feel that that is an area of risk?

Mr Sullivan: If that were to happen, it would be an area of risk. Certainly, right the way through the system — from the highest level, going from the Minister down — any suggestion that we should be chasing targets rather than prioritising patient care would just not be countenanced, as the permanent secretary, the board's chief executive and trust chief executives said. Having said that, I can see that how, in extremis, suboptimal decisions might be thought about. That is just human nature. I reassure members by reminding them of the ongoing reminder reinforcement from the highest level in organisations, particularly the provider organisations, that patient care, outcomes and needs are paramount and the targets are secondary. That is not to say that the targets are not important measures, but when it comes down to the individual patient, it is about making the right decision for that patient.

The Chairperson: We also need to be mindful that we are dealing with elective care. We are straying into a conversation, albeit that it is an important one, about A&Es.

Ms Stevens: Chair, it actually reinforces the point that the two systems are interconnected. That is because this is about patient flow. So, they are relevant, and a whole-system approach is necessary.

The Chairperson: I think that the principles are similar. Some of the symptoms coming from those systems are different, however.

Mr Dunne: Dean, you indicated that you felt that too much effort is focused on meeting targets, rather than on dealing with issues such as TYC.

Mr Sullivan: I do not think, Mr Dunne, that I said that too much effort was expended on meeting targets per se. I think —

Mr Dunne: On initiatives, perhaps?

Mr Sullivan: This is qualified as always, and we are working in very complex systems, dealing with millions of patient episodes every year, but it is important that we ensure that there is as much or more of a focus on the transformation of services looking ahead as there is on the here and now. That is a juggling act of managing competing priorities, but that is where we have to be going. If we do not get the transformation bit right, we will go into some sort of a tailspin. What is a difficult performance now will become even more difficult in the future because of the pressures that we talked about. Just humour me by allowing me to come back to this, Mr Dunne: your point about unscheduled care is correct. The initiative that I talked about with the trusts, whereby we are saying to clinicians in trusts "Tell us what you would do differently", is a discussion about elective care primarily, but it also picks up unscheduled care. So, if it was in urology, it is about not just the planned patients but the emergency patients, because, clearly, a urologist, for example, deals with both. If I were to hold the mirror up to my approach to commissioning, I would see that it is maybe being too siloed down, in that we do elective care and we do unscheduled care. So, we all need to learn as we go forward and try to recognise that, at the end of the day, trust teams work as single teams and, therefore, it might unlock some opportunities for us if they think of things in the entirety of both the planned and unplanned work.

The Chairperson: Thank you very much. David, is your question about enforcement? Is it on the same theme?

Mr D McIlveen: It is, Chair; thank you. I think that Gordon Dunne has taken this discussion to an interesting place, and this question follows on from that.

Heather, you mentioned capacity in your opening comments. Obviously, capacity is very important. Am I right in thinking that, in that context, any suggestions to reduce capacity in the system at the moment would be, I guess, nothing short of irresponsible?

I have in mind a specific case. For some time now, the axe has been hanging over the Causeway Hospital in the Northern Trust, and there are concerns about the closure of certain departments. Might it not be helpful, in the environment that we are now in, for that axe to be lifted from Causeway? Some may argue that it is not there at all, but I think that most of us here, and there locally, know that it is, and that has caused capacity issues when it comes to medical staff actually wanting to be employed in the hospital. Nobody wants to work in a hospital that is about to be closed or that is going to have departments closed. Do you feel that it would be helpful, at this stage, if a very clear message was sent out regarding those departments that are facing a threat, whether they are ED or elective, and that that threat should be lifted?

Ms Stevens: That is a difficult issue for me to comment on. I think that it is very clear that the system's capacity is under pressure across the board. The work that the HSCB has done on the demand-capacity analysis shows that. Some specialties are under more pressure than others. The question of where the capacity that exists is deployed is an issue for individual trusts. Decisions on a range of things, not least the quality and safety for patients in the places where particular services are carried out, have to be made. So, I think that the location of services is a separate consideration, particularly in a jurisdiction the size of Northern Ireland. However, that is a different point from the overall availability and capacity that exists, which is certainly under pressure. So, you are absolutely right.

Mr D McIlveen: So, are you —

Ms Stevens: I cannot comment on the Causeway.

Mr D McIlveen: OK. Let me take it away from the specific. In general, do you accept that it would seem bizarre to the public to be, on the one hand, saying that we are already at the limit of our capacity, while, on the other, effectively reducing it?

Ms Stevens: I think that the public want a service that is timely and top quality. So, we need to put that service in place. I think that the public are probably more concerned with that than they are about specific location. They want the right service, and they want it to be to the highest available standard that we can provide.

Mr McKinney: I apologise for not being here for the start of your comments, but I caught the tail end of what you were talking about. I see some of the direction of travel, and I am slightly concerned about the idea of merely monitoring elsewhere. That leads me to the core of what I am asking, which is this: who exactly is responsible for managing and reducing waiting times in Northern Ireland?

Ms Stevens: First of all, the primary responsibility is on each trust to deliver on what it has been commissioned to do.

Mr McKinney: Can I stop you there?

Ms Stevens: Yes.

Mr McKinney: Who has the ultimate responsibility for reducing waiting times in Northern Ireland? Who has the strategic responsibility?

Ms Stevens: Ultimately, the Minister.

Mr McKinney: He cannot do that as part of his day job, so who does he defer to?

Ms Stevens: Absolutely. On a day-to-day basis, he defers to the board to manage the trusts' performance, and then the Department manages and monitors the board's performance as one of its arm's-length bodies.

Mr McKinney: Outline for me the clear responsibilities of the Department, the board and the trusts.

Ms Stevens: The trusts' responsibility is to deliver the activity that is being commissioned by the board. So, the board sets out the levels of service that it is giving money for, and the trust is contracted to deliver that. Dean explained the board's process for monitoring the delivery of the trusts' progress, and he discussed the fact that, in this year and last year, an element of funding was withdrawn, because, in certain specialities, the level of commissioned service had not been provided. So, there is a process there, which the board looks at. It has the demand-capacity analysis, so it knows when trusts are delivering to the levels that it expects.

On a monthly basis, the Department receives a report from the board setting out the performance against the standards and targets that we set. That is because, ultimately, it is the Department and the Minister's responsibility to set out the levels that we expect. We then hold the board to account for the work that it does to monitor the trusts. As well as looking at the work that the board does to tackle poor performance, we look at good performance, because there are areas of good performance. We look to see what can be done to share that more widely.

Mr McKinney: I could rephrase the question: who owns the waiting time problem?

Ms Stevens: We all do; it is a shared responsibility. Ultimately, the Minister is responsible.

Mr McKinney: I know, but sometimes sharing responsibility is a good thing, and sometimes it takes somebody to take charge. Has the Department ever considered putting somebody in charge to get this problem sorted?

Ms Stevens: In effect, that is what happens. We have a performance management process in place.

Mr McKinney: That is process. I am asking whether you have ever considered putting a person or a team in charge of dealing with waiting times, given the scale of the problem.

Dr Mooney: A number of people in the Department share that responsibility. Part of my responsibility is to make sure that the information is there to inform progress against the target. Part of Heather's responsibility is to chase up the performance management and oversight of the boards in their role of trying to manage the trust to be able to deliver that. The Minister and Department will set out clearly in a commission plan exactly what they want.

Mr McKinney: I understand that, but we have a problem. You value, as you said, the Committee's work. The Committee is bringing in evidence from elsewhere. It is interesting evidence, and it has to be evaluated. As I said, I am concerned that you are waiting for all this to filter down. If you were to change the system, surely you would need somebody in charge as a team. It would set some direction and send a signal that a mechanism was going to be put in place so that a difference could be made. Is there such a mechanism? Is there such a core responsibility either for dealing with this issue in the current way and achieving better outcomes or for changing it?

Ms Stevens: The teams are in place. In my team, one of my branches is responsible for —

Mr McKinney: Are they actively considering some of the mechanisms that are in, for example, Scotland, Portugal and elsewhere?

Ms Stevens: We have been monitoring the work the Committee has done, because —

Mr McKinney: No, that is our work. What is your work?

Ms Stevens: Yes. That will feed in to what we do. At this precise moment in time, we are gearing up for the assurance and accountability meetings that will take place over the next month or two so that we can be very clear about how the trusts are performing. As I said, this year is particularly significant, because we have undertaken to do an exercise that looks right across the trusts' performances and at

how they fared in quality and safety and in their financial process so that we can come to a view of the overall position. That is the point at which we make recommendations to the Minister.

Mr Sullivan: I will interject and say that, if it has not done so, it might be helpful for the Committee to look at tracing the story in Northern Ireland back to about 1995. There are lessons to be learned from the past. There is also the risk of reinventing things that have not worked and thinking that we are reinventing something that has worked. Most of the approaches that you are describing have been tried in one way or another. A service improvement unit was established in 2002-03, and there was quite a fanfare around it. However, it did not have a huge impact at the time. I was in the Department from 2004 to 2010 and was directly involved in an initiative that had a big impact. My personal view, and, I suggest, that of the board, is that I am not sure that having a single person in charge of this across Northern Ireland who acts in a different role to the structures that we have is necessarily the magic bullet that we are looking for.

As I said, the closest that the system gets to having an access point is the board. The board has responsibility, which is set out in legislation, for ensuring the delivery of the Minister's targets while working with trusts and being held to account by the Department. I have, hopefully, given a flavour of that already. I am as acutely aware as anyone around the table of the current performance not being acceptable, just as I was back in the Department in 2004, when we, not prompted by any wider process, put in place something that transformed things. I worked with Michael Bloomfield at the time; he was part of the team that I worked with in the Department. We will turn it around again. It is more difficult now. We face a lot more competing challenges on resources. The demographic position is massively different now as well. I assure you that we are thinking about all the things that we should be thinking about. I look forward to the Committee's recommendations, because we can always learn as well.

Mr McKinney: Of course, but I heard you say that you did not favour targets of terror and a robust approach. Now you are saying that you do not necessarily favour the individual approach. How are you evaluating that?

Mr Sullivan: Again, there is subtle difference in the words. I said that I would not like to get to a place where we were reliant on some terror arrangements, but I was instrumental in the introduction in Northern Ireland of not just elective care targets but the whole target regime that we have, which can be fed back to arrangements that were put in place in 2005 under my direction in the Department. So, I know the importance of having absolutely clear targets, of having robust monitoring arrangements in place that are linked to those targets, of having incentives and sanctions when those targets are not delivered and of having escalation arrangements. That is our mantra, our performance wail, and that is still where I am. What I was trying to convey was this: if all that you can rely on is the big stick and the threat of something when it is not delivered, it does not feel like a sustainable position for me. We have to get to a place where most of the time most of the things are routinely delivered and where we are not just trying in a big push to get over the line in a 12-month window. When I look back, I see that we made huge strides between 2005 and 2008 in unscheduled care, elective care, ambulance waiting times, cancer waiting times and so on and so forth. I encourage you to look at those numbers to see how much change can be made by the present incumbents. It is the same people there now, but the context is different.

Mr McKinney: I accept what you say, but I am just asking whether evaluations are being done on that. Clearly, the work that has been done has not arrived at the position where we would prefer it to be. There are other models out there, and the Committee has been looking at them. Had you looked at them, we would not have had to look at them. So, who is taking responsibility?

Mr Sullivan: I assure the Committee that I am personally taking responsibility for improving the arrangements that are in place between the board and primary care to switch off demand at source through maximising the skills that exist in primary care, not with a formal evaluation perhaps —

Mr McKinney: Should there be a departmental focus or a team whose job it is to enforce that? I use that word in its broadest sense. In other words, that is the job. Should there be another tier or another function to look at this and to ultimately resolve it? With respect, I hear what you say, and I respect the work that you are doing, but it is taking time, and the results are still not there.

Ms Stevens: I also think that is not just a simple case of putting in a team to sort out the elective care and waiting list problem. A whole-system approach is required. As was said, unscheduled care impacts on elective care, workforce planning impacts on elective care and the financial situation is

currently impacting on the delivery of those standards and targets. In effect, that one team would have to tackle the entire work of the Department. It would be too big for any one team to take on, but a team is in place that works with the board to monitor performance.

Mr McKinney: That is, however, substantially different from what I am talking about. Monitoring is different from leading, in that sense.

The Chairperson: Teams have been created elsewhere on this specific issue that did not necessarily have to look at the entire system. What I am hearing, Dean, is that people do not want to move to targets of terror. A special unit was set up that seemed to have had some impact, but then you acknowledged that it did not have the impact that we desired or wanted collectively. What is it that you, collectively as a Department or as a board, need? What is the ask in this question?

Mr Stewart: Investment, Chair.

The Chairperson: It is resources.

Ms Stevens: It is resources to provide the additional capacity that we know we need to meet increasing demand. However, on the other hand, it is about being able to manage down the demand as far as possible. We need to do both.

The Chairperson: You acknowledged, Dean, that it did not have the desired impact in, I think, 2004 or 2005.

Mr Sullivan: I would be happy — I am sure that departmental colleagues would be happy — to share with you the history of all the different approaches. The Department established a service delivery unit in 2006 that is now part of the board. It morphed from being part of the Department into being part of the board under the review of public administration phase 2 in 2009. That is still there today and is part of Michael Bloomfield's team, which I talked about before. The vast majority of the same staff still work there, all the performance information arrangements and so on are still there, and the same approaches to interacting with trusts are taken. As colleagues said, they were just working within a very different context at the time.

The evidence from the previous initiative, which was set up in 2002, is that it did not result in any material change to the numbers. The numbers moved in the way that Mr McKinney referred to from 2005 onwards through very specific focused inputs. We now find ourselves in a place that is more difficult and more challenging, but it is still fixable. If it would be helpful, Chair, I could outline to you what I believe are the five or six particular issues affecting performance in elective care. I do not know whether it would be helpful to have that information now or whether you would like us to drop a note to the Committee afterwards.

The Chairperson: We can take that information from you and reflect on it. On the point about strategic leadership, a special unit was set up, which, in your words, morphed into becoming part of the Department —

Mr Sullivan: Part of the board.

The Chairperson: Does that need to change?

Mr Sullivan: I do not believe so. If you said that the Committee's view is that there is not the necessary effective engagement with primary care at a senior level to change fundamentally the approach to demand management, I would say that the Committee was misinformed. However, that has applied at a very senior level, including Tom Black, only in the past number of months. That will bear fruit, I assure the Committee, later this year.

The Chairperson: With respect, Dean, it is not about engagement at that level. It is about the leadership, management and strategic direction of dealing with elective care waiting times.

Mr Sullivan: Let us go through the component parts of that. Why is there an elective care problem? One reason is that demand has increased by 12% in the past two years. Within that overall increase of 12% are significant spikes in particular specialities and/or particular LCG areas. We have to find a

way of sustainably holding demand at a manageable level. That is why I am personally having the strategic discussions with Tom Black and senior colleagues in primary care land, with a view to putting in place arrangements that will deliver that for us. You have seen the work that the board has done on demand and capacity. This is about getting to a point at which I know that there will be 2,000 referrals, not only in 2013-14 in specialty X in LCG area A but in 2014-15 and 2015-16, because that would be the nature of the arrangement with primary care to deliver that.

Separately, once we have a hold on the demand position, and at scale, for all specialties throughout Northern Ireland, we will have a hold on the trust side of things, which is the one that I described earlier. It is at scale within a specialty covering off planned and unplanned work. So, rather than getting into widget counting and counting individual bits of activity, we have a more strategic relationship with the trusts to deliver reasonable waiting times consistent with extant standards over that similar period. That feels like a position that covers exactly the sort of concerns that you raise, which are, I think, the right concerns, and you express those as, "not more of the same". We know that more of the same will not fix the problem. There is not enough capacity in the trusts and independent sector to continue doing what we need to do. We need to ramp things up in trusts by bringing clinicians to the fore and, equally, giving GPs much more of an opportunity to manage differently at their side.

Mr McKinney: That is all ambition. That is what you are aiming for. I do not want to crack the whip, but I want you to come up with imaginative ways of doing it differently so that the power rests with the people charged with that responsibility. Will power at that level make a difference? Does it exist now?

Mr Sullivan: I do not feel any lack of power, authority or ability to make change.

Mr McKinney: Yes, but long waiting times persist.

Mr Sullivan: That comes back to where we started. There are a lot of factors to bring to the table. It is useful to rehearse where we started in 2013-14, when I know, by specialty and by trust, the capacity of each organisation. I know, by LCG and by specialty, what the demand is expected to be. Where demand is expected to be more than the capacity, my expectation is that we will secure that, first, by additionality from within the trust and, where that is not possible, through purchasing capacity from the independent sector. That is where the year 2013-14 started.

Let us track the history of this. In 2010-11, 2011-12, and 2012-13, there were successive and significant reductions in waiting times. The year 2013-14 has been a poor year because demand has spiked in particular specialties beyond that which we had planned for. There was no contingency in our planning; we simply do not have the resources to send 100 patients to the independent sector and then send another 20 just in case demand is higher. This year, demand has been higher than we forecast; there have been some difficulties in the delivery of core capacity by trusts; and, crucially, in buying independent sector capacity, there have been, for the first time, some difficulties — certainly, for the first time to this scale — in identifying independent sector providers that can deliver certain types of work at the volumes that we require and, crucially, at a price that we can pay. Those three factors conflated, and all three were pulling in the wrong direction: under-delivery of core capacity; greater demand than forecast; and under-delivery of independent sector planned activity. Together, they generate, very quickly, numbers in the hundreds and thousands.

The Chairperson: Roy wants in on this same issue, and then we will hear from Chris.

Mr Beggs: There have been significant increases in a range of waiting list times for inpatient admission and those awaiting procedures. You seem to put that down to lack of capacity to outsource. Have you looked adequately at how you can more efficiently deal with spikes in-house? If there is virtually a monopoly in the private sector, why are you not increasingly doing that?

You say that there have been significant difficulties, including a resource issue, this year. However, the health service got over £100 million in in-year monitoring, which is more than ever before. So why has that happened?

Mr Sullivan: I will deal with the first question, about the ability of the system to deal with spikes in demand. The more mature arrangements with trusts that I referred to, which are a long-term strategic deal within individual specialties, are precisely that. Unless demand moves massively beyond reasonable expectations, my expectation and that of my LCG colleagues is that the provider would

respond to it. That is not the routine arrangement now; we are in more of a transactional, operational arrangement whereby the trusts' prime focus — not their only focus, but their prime focus — is on delivering activity. The waiting times are more of an outcome or product of all that. If trusts deliver activity, and demand is greater than that activity, the waiting time is what it is.

There are a number of draws on resources within Health and Social Care. I am sure that Committee members have been briefed on the fact that cost pressure is running at circa 6% a year; and increases in income are running at about 2% or 2·25%. Health and Social Care — across trusts, crucially, but also in pharmacy and primary care — has delivered cash saving and productivity improvements of £450 million cumulatively in the past three years. The system is running hard to stand still in some areas. I gave you an example of independent sector spend. Back in 2005 through to 2009, I was in a similar role to the role that I have now within the board and was in direct drive mode. We built in a much greater tolerance in terms of sending patients out to the independent sector because we could afford to. We could afford to deal with spikes in demand by building in tolerance and contingency.

If you look at the numbers, you will see that they were massive: in January 2007, 55,000 outpatients waited for more than nine weeks. By the end of March, it was about 25, so numbers were delivered down to zero or as near to zero as makes no difference. In the current financial context, it is much more difficult to do that. That is not to say that there are not huge pressures across the public sector. We know that there are, but we are here to talk about HSC.

Mr Beggs: I have not heard you talk about the value for money in simply farming everything out to deal with the —

Mr Sullivan: Sorry, Mr Beggs, I missed the start of that question.

Mr Beggs: I did not hear you address how you identify value for money in farming everything out. Every year, generally from January to March, a lot of work goes to the private sector. I am asking about the value for money of doing that rather than trying to find a more efficient way of dealing with it in-house: do you have the numbers to justify that? I —

The Chairperson: Sorry, Roy. One issue that we wanted to address was the role of the private sector, and we are moving into that. I know that Mickey and Pam indicated that they wanted to put questions on that. As their questions are in a similar vein, they can be addressed collectively.

Mrs Cameron: Thank you for your presentation. Use of the private sector is of great interest to the Committee and a key issue. The Committee has learned that in countries that have had success in bringing down waiting times, the private sector is used in a limited way. In England and Scotland, for example, the private sector is used to provide additional capacity at the margins and is not required year round. Portugal has a voucher system whereby, if a patient reaches 75% of the maximum waiting time, he or she is issued with a voucher that can be used in a private hospital. However, many experts pointed to potential difficulties in having a mixed public/private model of elective care.

What contracts exist with the private sector for elective care, how much are they worth and for how many years they have been signed up to?

Mr Sullivan: I do not have a list of every single independent sector contract. We can certainly let the Committee have that. Broadly, the spend on the independent sector has been in the £55 million to high £60 million range since 2009-2010. It was £57·5 million in 2009-10 and £66 million in 2013-14. The board and Department have made clear on numerous occasions their desire not to be reliant on the independent sector to the extent that we are. I know that the figures sound high, but they account for only about 5% of total elective activity, so they are small in absolute terms, but my view is that they are still too large and I do not wish that to be the position as we go forward.

I encourage Committee members to distinguish between the use of the independent sector to reduce long backlogs and what a sustainable equilibrium position might be. There will always be, from time to time and for various reasons, the need to clear a backlog — that was the case going back to 2005, 2006 and 2007 — and a desire to get to a point at which the system washes its own face. That is exactly what I was trying to describe earlier: our desire is to get to a place where demand in primary care and delivery in secondary care are locked down because the output of one is the same as the expected input to the other. It is my expectation that, in principle, we should be able to get there, or close to there, in the majority of specialties, with the exception of orthopaedics. The problem in

orthopaedics is of a different scale altogether: there are simply not the orthopaedic surgeons or the theatre capacity to allow us, straightforwardly, to respond to that from within the public sector, and there are other key constraints in Northern Ireland. So, there will, for some time, continue to be a need to utilise the independent sector. However, it is my desire and hope that, following the initiatives that I referred to earlier, we will be able to move to being less reliant on the independent sector and other areas. It is useful in exactly the way that you described it: at the margins when there is a particular issue to respond to. However, it is not useful as a sustainable, ongoing way of doing business. It is not how we wish to be commissioning routinely.

Mrs Cameron: Thank you. You have probably, partially, answered my next question. What is the Department's long-term approach to the use of the private sector?

Ms Stevens: It is as Dean has said. It is a necessary part of the picture in order to meet short-term need, but, ultimately, we want to be in a position in which there is not wholesale reliance on the independent sector.

Mr Brady: Thank you for the presentation. I am sure that I will be accused of repeating myself, but, if you were taking a cynical view of Transforming Your Care, you might consider that it is not so much a shift to the left as a shift towards privatisation. That is one view. Has the Department put in place any policies to prevent the same consultant treating patients in the public and private sectors?

Ms Stevens: There are workforce policies in place, and that is certainly dealt with in the consultants' contracts. Very stringent arrangements are in place. Doctors may combine work in the public sector with private sector practice, but it is regulated, and they must declare it. If they conduct private work in trust premises, the trusts ensure that they take back the associated cost so that they are not out any money as a result. That area is very closely monitored by the trust that employs the consultants.

Mr Brady: There is anecdotal evidence of consultants using public facilities in their private capacity and then, presumably — this is anecdotal — incorporating that cost within the charge for their private work.

Ms Stevens: They may well pass on the charge to the patient, but, ultimately, the public purse is not penalised as a result because the trust captures that cost.

Mr Brady: Ultimately, the patient may well be penalised. We have been talking all day about the patient being the priority, so that needs to be addressed. There is also anecdotal evidence of consultants who treat patients in the public sector passing on the information that they also work in a private capacity. That needs to be addressed, but is there anything in place to do that?

Ms Stevens: I am not aware of that, but we can look into it.

Mr Brady: As I said, the evidence is anecdotal. On a constituency basis, we deal with a lot of health issues, and I have come across this and the issue of consultants using public facilities for private work.

Ms Stevens: I am happy to take that back to workforce colleagues.

Mr Stewart: Chair, I will add to that briefly. We recognise the importance of the issue. There is always a tension between the capability of someone to work in the public and private sectors. That tension exists not only in HSC in Northern Ireland but in the NHS in other parts of the UK. In doing whatever we might do on that, we need to be conscious that the employment market is UK-wide, if not broader. So, if we were to make a change and, perhaps, restrict that further than is currently the case here in Northern Ireland, it could have an effect on the employment market and on our ability to fill important posts.

Mr Brady: I accept that, but we are saying that the patient is the priority. There is anecdotal evidence that some consultants are more interested in doing private work than they are in doing contractual work in the National Health Service. That needs to be looked at and addressed. You have to strike a balance. Ultimately, if we have a service that is free at the point of delivery, it seems slightly contradictory if people doing that work are allowed to do other work, which impacts on waiting times etc. That is surely one of the issues that we are trying to curtail.

Mr Sullivan: As Heather said, there is a very clear set of rules around the only basis on which consultants can undertake work in the private sector. It is after demonstrable evidence that they have delivered the expectations of the public contract.

Mr Brady: With any set of rules or regulations, enforceability is paramount.

Mr Sullivan: That is a big role for trust management.

The other point you made was about anecdotal evidence you have of the potential risk of patients being advised by consultants to see them in the private sector. I have no evidence of that, but I can see how, the longer the waiting times are, the greater that risk is, and greater, more generally, is the risk/need that patients will see that as a necessary evil for them. While they should reasonably expect to receive timely care in the HSC, they may feel that they have no choice but to go to the private sector. That takes us back full circle again; the prime objective for us is to fix that at source by not having long waiting times. If patients know that they are going to be seen in outpatients within nine weeks, there would be little or no incentive for them to pay privately to be seen.

Mr Brady: But you can see why that can happen. You are reducing your resources and capability if someone is being given that offer. Ultimately, surely one of the issues is to protect the National Health Service. It is one of the few bastions left that needs to be and should be protected at all costs. It seems that the move towards privatisation is totally undermining what has been and continues to be a very good service. We look at the negatives, but, sometimes, we have to look at the positives.

Mr Sullivan: Certainly, in the context of the discussion we have had today, there is categorically no move towards privatising anything. It is quite the reverse. In all the initiatives that I have talked about in primary care, the desire in the public sector and secondary care is that they would offer a more holistic wrap-around service and deliver the outcomes that patients expect.

Mr Brady: What this space, then.

Mr Sullivan: Yes.

The Chairperson: The issue is not about the tension that you referred to between public and private. As you rightly pointed out, it is more than a tension; it could potentially be a conflict. You are saying that there is no appetite to move towards greater privatisation than already exists. In Scotland, for example, certain boards do not use consultants from their particular areas. What are you doing to ensure that that conflict does not exist? I hear workforce planning, but there has to be something more than that.

Mr Sullivan: There are a number of subtleties in the different ways of asking the same question. I will try to answer it from my perspective of what I think the issue is. If what we are saying is that all of us — you, as elected representatives, and colleagues and me in our respective day jobs — need to be assured that what I am commissioning from the public sector — from trusts, from within trusts and, ultimately, from individual consultants — is what we actually get, then, clearly, we do. That is why we have the transparency that we have all the way down to the number of diagnostic tests, outpatient appointments, review appointments and so on and so forth. That was built from the bottom up on the basis of the number of consultants, how many sessions they have and so on and so forth. Notwithstanding that transparency and clarity, I flagged it up that some of the limitations with that approach are that it is a bit operational, a bit transactional and, bluntly, does not necessarily motivate consultants to get out of bed in the morning. If we are not careful, all we collectively do is to turn their job into a series of individual patient episodes as opposed to a more holistic caring for a wider population and group of patients. That has been the approach on that side of things.

As for getting more capacity into the system and avoiding a tension/conflict between the private sector and the public sector, we have sought, through our commissioning of independent sector capacity, to make as much use as possible, within procurement rules, of capacity from outside Northern Ireland, be it from the Republic or GB. That is simply to try to draw in more capacity, reflecting the challenge that you are putting on the table, which is that we are just cycling the same work around the same group of staff. We are trying to bring genuine additionality to the system, and we have actively been pursuing that as a strategy.

The Chairperson: One of the things that we were becoming aware of was the cost of using the private sector. Here in the North, across the island and in England, it is much more expensive to use the private sector. Some of the experts indicated to us that civil servants, with respect, are not trained negotiators or practised at achieving good deals with private providers. How do you address that?

Mr Sullivan: I will try to address it. The starting point has to be that, in a position where it is a fact that demand exceeds capacity, we have a choice: either we can have longer waiting times than we do; or we can secure additional capacity from another provider. The only other provider that is readily and straightforwardly accessible for us is the independent sector. So, first in the order of things, we need to get past that. I am happy to have a separate discussion about why there is any capacity gap and what we might do about it.

The Chairperson: No. That is not the question that has been raised.

Mr Sullivan: I realise that. I was going to get —

The Chairperson: The question that has been raised is this: what can the Department and the board do in relation to dealing with that conflict?

Mr Sullivan: Right. Second in the order of things is about getting value for money from the independent sector. We have a framework contract, and no company can be on that framework contract unless it is committed to delivering services for the English tariff. Civil servants across the water — as able as my colleagues who sit beside me — drawing on lots of procurement expertise, have agreed, over a long time and through a very robust process, a reasonable price to be paid for individual procedures. We do not try to invent that wheel locally; we simply use it. There is an orthopaedics tender out at the minute. Whilst providers are free to bid at whatever price they wish for that orthopaedics tender, from our perspective, we have a clear frame of reference for what would be a reasonable price to pay, consistent with the tariff. I believe that, providing that and for as long as we secure prices from the independent sector that are at or below tariff, we are securing value for money from the use of the independent sector. Generally, we have been successful in doing so, but I mentioned, in response to a previous question, that we have had some challenges in some specialties in doing that of late.

A separate question is whether better value for money could be secured from delivering the services within the public sector. Perhaps, probably. However, that is a separate question, given where we started the discussion from.

Mr Beggs: Let me reinforce the point that, in order to get value for money, you should at least be testing what local clinicians, teams of nurses and allied professionals can provide the service for. I have heard criticism of some of the work subcontracted, because it does not have the same level of follow-up as is possible when locals carry it out. We are seeking confirmation that you are open to enabling teams to do that and to build and improve their existing teams for the long-term.

Mr Sullivan: Absolutely. In response to a question on how we respond to gaps, I said that the first thing we do is to seek, from the in-house team, whether they can, as a non-recurrent, one-off initiative, do something more. Holding a mirror up to the approach that we have, we ask whether there is more that we can do, even than that, to energise those teams. Unencumbered by such bureaucratic, limited thinking that we may directly or indirectly be imposing on them — untethered from all that — they are asked, "Show us what you can do. If you can demonstrate to me that, following all demonstration of good practice that we would expect to see at outpatients, one-stop shops and access to diagnostic tests and so on and so forth, there is a resource bill at the end of that but that, in return, we receive significantly greater throughput than is currently the case, we are all ears". So, yes, absolutely, Mr Beggs.

Mr McKinney: I want to delve into that a wee bit further. Given that the private sector exists and the public sector exists, what would be the motivation for somebody to squeeze more out of the public sector in productivity, if the private sector is there to pay some of those people to do it elsewhere?

Mr Sullivan: You could have separate discussions with some clinical teams and that would be helpful to reassure you how committed those teams are to trying to do the best thing within the public sector. There are always exceptions, but the vast majority of clinicians want to do the best for patients within

the public sector. They think that they can do that and do private sector work at the margins, rather than the two being in conflict, as the Chair referred to.

Mr McKinney: Do you, then, routinely measure the extent to which public service contracts or consultants work in the private sector? Are you aware of the scale of that? Do you get feedback that person x works x hours there, whenever they work in the private sector? Do you know that?

Mr Sullivan: I would not know that individually, but what I mentioned earlier —

Mr McKinney: Does the system know that?

Mr Sullivan: An individual trust would know that, because there is a set of rules about what a consultant must deliver before he or she is able to work in the private sector.

Mr McKinney: But do you then know the scale of the work they have done in the private sector?

Ms Stevens: We know that we are paying about 6% of elective spend in the independent sector.

Mr McKinney: No, that is the total. Surgeon x is working in the public sector and is contracted for x days a week and x number of operations. Do you know how many operations that individual is doing routinely in the private sector?

Mr Sullivan: I do not think that we would know that at an individual consultant level. The trust would know clearly what work that individual is undertaking within the public sector contract. The individual's employer in the private sector would know how much work they are doing in the private sector. The individual is accountable for ensuring that their working hours do not exceed the working time directive, which is the sum of both of those. To an extent, they are separate from each other.

Mr McKinney: Given that we are talking about waiting times, is that not valuable information?

Mr Sullivan: What would we do with that if we had it, Mr McKinney? Let us say that I am a consultant, and I do 11 PAs within the public sector and three PAs, half-day equivalents, within the private sector, I am not quite sure what I —

Mr McKinney: But we do not know.

Mr Sullivan: But I am not sure what I would do with it if I did know or even whether it would be within my gift to —

Mr McKinney: Given that we are spending millions in the private sector, it might encourage us to think differently about how we do our work and how we negotiate with consultants overall, but we do not know the information, so we cannot make a judgement.

Ms Stevens: The trusts know the information in relation to their —

Mr McKinney: Does the Department?

Ms Stevens: We can ask the trusts for information.

Mr McKinney: No. This brings me back to the responsibility thing.

Ms Stevens: No, we do not have that level of detail.

Mr McKinney: You do not have it, Dean; and you do not have it. Who is responsible?

Mr Stewart: Not all the work that consultants do in the private sector is paid for by the public sector. Some of it is fully private.

Mr McKinney: That is true, too, and given the conflict that we have talked about notionally here, would it not be valuable to have that information? I raise this because it underscores for me the issue

of the responsibility that we talked about in terms of at departmental level or banging up against the Minister.

Mr Sullivan: If I might challenge you, Mr McKinney — genuinely, I find a lot of the discussion today helpful, and there are ideas that we will take away — I am trying to work out what I would do with that. Let us use the example that we mentioned. One provider that we use a lot within Belfast is 3fivetwo Healthcare. If I know that consultant x, a surgeon, was doing his or her 11 sessions within the public sector in Belfast Trust, I know what that needs to look like because I have numbers that tell me how that adds up for him or her and the team. I know that I am getting that, or I know if I am not getting that, so I know that already. Equally, if I were commissioning from 3fivetwo, I know what I am meant to get from it as well, as an organisation that I am commissioning from. I am trying to work out what I would do with the information, if I knew it, for an individual consultant who happened to be working in both bits of the system and, as Chris said, maybe some of the work that he was doing in 3fivetwo, as a particular provider, could be pure private sector work and some of it could be funded. I will reflect on that. I am not sure what I would do with that if I had it.

The Chairperson: Would that information not also give you an insight into an individual having an appetite to work in that field, and, therefore, could that person not be given the additional hours in the public sector?

Mr McKinney: It goes back to your point about squeezing that extra bit out of the public sector and getting teams to imagine how they would work differently.

Mr Sullivan: I think that that is right. There are consultants who, for a whole combination of reasons, do not want to do anything beyond their 10 PAs. It certainly would give a flavour of those consultants for whom 13 or 14 PAs in total is the working arrangement that they would like to have. I come back to the approach that I talked about, which is the one unencumbered by all the bureaucracy and so on, where a team of surgeons, urologists or whatever tell us how they might deliver things differently for us and we see whether that motivates them in a different way, rather than the way in which we have been commissioning.

Mr McKinney: I think that even your last response indicates that you would see value in the information that I am talking about.

Mr Sullivan: I am not sure that I necessarily would, bearing in mind what that discussion looks like. Let us say that there is a team of five urologists at the top of the table, for example, and I am passing the challenge across to them and asking them to come forward with something radical for me. The risk for the process that I described earlier of doing what you are describing is that I am getting back into my bad old ways of wanting to second-guess everything. What the team of urologists should be saying to me is, "Dean, get off the pitch and let us get on with this. We will come forward with a radical solution." The more we micromanage and the more we operationalise things, the greater the risk of us getting what we have always got, because that has been the approach to date. We know everything that moves in unscheduled care and elective care by trust, by site, within trusts and all the rest of it. I am suggesting — hypothesising — that a different approach that is more hands-off might be helpful. There might be key information in there that might be helpful either for me or the trusts. I will reflect on that. However, we are primarily trying to empower clinicians rather than second-guess them.

Mr Stewart: One recent example of where we have seen that happening successfully was in Canterbury in New Zealand. It came about for a particular reason. There had to be a fundamental change in the way in which care was delivered, because the earthquake knocked down a lot of the buildings. There was a sudden disruptive need for change. The analysis of that, which has been done by the King's Fund and others, points to the very fact that Dean is emphasising, which is that changes were clinically led. It was not characterised by a targets and terror regime. There was, of course, robust monitoring of performance, and there still is. However, primarily, the change in the pattern of services and in the way in which the services were delivered was led by the clinicians, and it is seen as having been very successful because of that. There is now effective management of waiting lists and waiting times in Canterbury.

Mr McKinney: Let us hope that it does not take an earthquake.

Mr Brady: I just want to make a comment, and I do not expect you to comment on what I am saying. It seems to me that, around the whole issue of privatisation, there is a perception that — this is predicated on the perception abroad — the current British Government are intent on, if not already involved in, dismantling the welfare state as we know it. There is no doubt that that would have a knock-on effect. I would not necessarily be of that opinion at the moment, but there is a notion abroad that that process is happening. When you look at Transforming Your Care, you can see what it could become and, in some cases, that reinforces that notion. However, I do not expect you to comment on that necessarily.

Mr Stewart: I think that any civil servant should always be very hesitant before putting themselves in the place of the Minister, but, if the Minister were here, I think that he would say very clearly that he has no agenda for privatisation and that that is not what TYC is about.

Mr Brady: With respect, the point that I was making is that the Minister is not a member of the British Government, but it will have a knock-on effect possibly.

The Chairperson: OK. Thank you for your presentation. It has been a useful exchange. It probably leaves us with a number of questions. Obviously, the Committee is about to go into a process of making recommendations. The key message that I took from this was about the shift in the referral to treatment time. We have not been given a sense of what a realistic time frame for that might be, and we look forward to getting that clarification from you.

There is also the issue of the enforcement of targets. Whose responsibility is it to enforce those targets? What are the policies around incentives or the developing policies around incentives? Equally, the management of this piece of work is a huge issue. Where does it sit; does it need another team; is there a lead body; is that strong enough; and what lessons have been learned from the 2004-05 processes?

There is also the issue of private sector involvement in relation to the investment that is there and how that can be used to assist, support and enhance the workforce in the health service and, equally, how we can use that information to ensure that the conflict that exists on some occasions between the public and private sectors is eradicated.

We will continue to have those conversations. Thank you very much for your time today.

Appendix 2

Presentations and additional information provided by witnesses

22 January 2014	**Professor Charles Normand**	**Page 111**
5 February 2014	**Dr Rob Findlay**	**Page 115**
26 February 2014	**Professor Luigi Siciliani**	**Page 116**
12 March 2014	**Mr Mike Lyon**	**Page 130**
9 April 2014	**Mr Pedro Gomes**	**Page 149**

A Tale of 3 Initiatives: Reducing waiting times for elective care in Ireland

Charles Normand
Edward Kennedy Professor of Health Policy & Management

It's Complicated

- It's complicated
- It's complicated
- It's complicated
- It's complicated
- It's complicated
- It's not simple.

Background 1

- Long waiting time, particularly for public patients for some elective care
- Almost half the population with private medical insurance who (generally) can get quicker access
- Dual public and private practice in public hospitals – some patients attract additional insurance payments for the same treatment.

A (useful) digression on waiting lists and waiting times

- Getting on the list, getting off the list
- Waiting to wait
- Waiting lists versus long dated appointments
- Who owns the waiting list – funders or providers?
- Who likes waiting lists?

Background 2

- Hospitals mainly paid by block budgets
- Service agreements are a bit vague
- Provision is by mixture of public, voluntary and private hospitals
- Doctors are paid salary for public work but FFS for private.

Incentives and consequences

- To funders of care
- To providers of care
- To patients
- To referrers

Waiting lists as:

- A (bad) way of rationing
- A framework for being dishonest
- A way of avoiding hard choices
- A result of complex interaction of referral and treatment.

Waiting List Initiative 2

- Incentive to underperform to get paid twice to do the job
- Rewards those that do underperform
- Those that do well feel penalised.

The Three Initiatives

- Waiting list initiative
- National Treatment Purchase Fund
- Special Delivery Unit

NTPF 1

- After designated period patients were entitled to investigations or treatments paid by the fund
- Initially treatment was in both public and private hospitals, but later mainly in private hospitals or abroad.

Waiting List Initiative 1

- Additional funds to public hospitals (with long waits) to carry out extra procedures
- Relatively weak monitoring of how the extra funds were used
- Hard to assess how much effect.

NTPF 2

- When patients were treated in public hospitals, hospitals could receive double funding
- Even when in private hospitals it could be the same clinician
- Evidence suggests that NTPF did reduce waiting times

NTPF 3

- Value for money?
- Contract prices were not revealed
- Estimates suggest significantly higher cost than public hospital normal delivery
- Managed the problem but did not remove the problem.

Some general principles 1

- Providers and service users respond to incentives
- Long waits lead to gaming of referral – early referral makes sense if waits are long
- Effective measures can lead to longer lists as more are referred.

Special Delivery Unit 1

- Incorporated NTPF and its funding
- Worked with hospitals with long waits and monitored progress
- Traffic lights for performance
- Required patients to be taken in order of referral
- Continued to buy some services from private sector.

Some general principles 2

Waiting lists normally result from combination of:

- Benefit package too big
- Funding too little
- Provision too inefficient
- Priorities in who gets treatment are wrong

Special Delivery Unit 2

- Top down – as with other cases the effects are temporary
- Shortened long, long waits but increase in average waits (is this a good thing?)
- Worked on those on the list but not on how you get on the list.

What can we learn from RoI experience? 1

- Initiatives were introduced without clear understanding of why lists were long
- Initiatives were introduced without understanding the incentives they generate

What can we learn from RoI experience? 2

- Refusal to define entitlements tends to lead to excessive demands
- Problem is one of funding as well as provision
- Some people like and benefit from long waits

What can we learn from RoI experience? 3

- Initiatives are more difficult in context of complex system and complex incentives
- Efficiency and performance are best improved bottom up
- People do respond to incentives (both planned and unplanned).

Thanks

for your attention

29 Jan 2014

NI Assembly review of waiting times

*Submission by **Dr Rob Findlay** (rob.findlay@nhsgooroo.co.uk), Director of Gooroo Ltd*
Gooroo Ltd provide specialist software to the NHS for capacity planning and waiting times management

1. All targets have unintended consequences, and waiting times targets are no exception. So the aim is to set targets that achieve the desired result (waiting times for patients that are **safe, fair and short**) while minimising the unwanted side-effects. There are several choices to be made:

Stage of treatment, or referral to treatment (RTT)?

2. A common waiting list pathway is: referral by GP; wait for first outpatient appointment; wait for diagnostic; wait for follow-up outpatient appointment (perhaps more than one); and finally the inpatient wait.

3. Stage of treatment targets address the outpatient, diagnostic, and inpatient waits separately. They are easy to measure. But when hospitals are struggling with inpatient waiting times, they may be tempted to delay patients at the follow-up stage because stage of treatment targets do not capture that.

4. RTT targets avoid this problem by capturing the whole journey up to initial treatment. But RTT waiting times are much harder to measure, especially when applied to patients who are still on the waiting list. So it would be sensible to retain stage of treatment targets while an RTT target is being phased in.

Set the target at 100 percent, or 90-something percent?

5. There will always be some patients who want to delay or rearrange their treatment (for instance, if they are on holiday on the date offered by the hospital). So if the target is that 100 percent of patients must wait less than a specified time, then rules must be created that allow patients to exercise such choice. These rules get very complicated, and may be perceived as loopholes which hospitals exploit to meet the targets.

6. So it is better to set a 90-something percent target. Then patient choice is catered for by the tolerance, without having to specify rules to cover every scenario.

Measure waiting times as patients are treated, or while they are still on the waiting list?

7. Waiting times targets have perverse incentives when applied to patients as they are treated. For instance, say the target is that 90% of patients treated must have waited less than 18 weeks. This is easy for hospitals to achieve: they simply ensure that, for every long-waiter they treat, they also treat 9 short-waiters. So fewer long-waiters are treated, there is large-scale queue-jumping, and real waiting times go up.

8. But if 90% of patients *on the waiting list* must be within 18 weeks, this perverse incentive disappears. Now hospitals can only achieve the target by preventing backlogs of long-waiters from building up.

Other considerations

9. For safety, it must be understood throughout the system that clinically urgent patients always take precedence over routine patients, even if that means breaching a waiting times target.

10. Hospital waiting lists are notoriously error-prone. It is sensible to 'validate' all waiting list patients continuously as they pass a waiting time of (say) 12 weeks. This validation 'checkpoint' should not coincide with a target or it will be vulnerable to gaming.

11. Hospital capacity should constantly adapt to changing demand and to reduce waiting times. Generally the NHS does not do this because it requires complex modelling. Such planning should be encouraged, but it is counterproductive for the centre to recommend any particular method or model.

12. When focusing on waiting times, it is an easy mistake to neglect the number of patients waiting. If the waiting list is growing unexpectedly then there is a problem. If it is shrinking then waiting times will fall.

Max Waiting Time Policies

Professor Luigi Siciliani
Department of Economics and Related Studies
University of York

26 February 2014

Outline

- Max waiting-time policies around OECD countries (focus on success stories)
- Referral to treatment waiting times and other measurement issues

Reviews policy tools to tackle excessive waiting times in 13 countries

- *Australia*
- *Canada*
- *Denmark*
- *Finland*
- *Ireland*
- *Italy*
- *Netherlands*
- *New Zealand*
- *Norway*
- *Portugal*
- *Spain*
- *Sweden*
- *United Kingdom*

A very brief summary

- Most common policy:
  - some form of ***maximum*** waiting time guarantee
- Implementation can be quite different
  - ***Target*** (increasingly with sanctions): England, Finland
  - With ***choice***, competition (and private sector): Denmark, Netherlands, Portugal
  - ***Prioritisation***: New Zealand (and Canada) plus others
- Increasingly, **max waits** differentiated for urgent conditions such as **cancer**, **heart** conditions

A key message

- Supply policies are no guarantee of success
- They can work if demand is kept under control
- The latter may be implemented through max wait targets or guarantees (data are now good enough!)
- Pay not only for higher production but also for simultaneous reductions in waiting times (ie avoid the "waiting time" game)

ENGLAND

Mean waiting times (days) in 2000

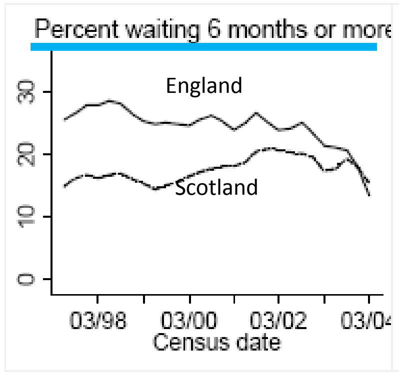
	Hip replacement	Knee replacement	Cataract surgery	V:
Australia	163	201	179	
Denmark	112	112	71	
Finland	206	274	233	
Norway	133	160	63	
Netherlands	96	85	111	
Spain (Insalud)	123	148	104	
Sweden			199	
United Kingdom (England)	244	281	206	

Hurst and Siciliani, 2004

Maximum waiting times guarantees

England 2000-2005

- Can you reduce waiting times by enforcing waiting-time **targets** and **penalties**?



Propper et al. (2008), BJEPA

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Potential of misprioritisation: probability of being treated as time passes

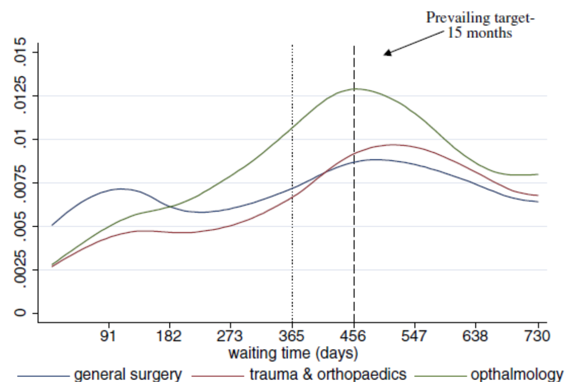

Fig. 3 Hazard curves for three specialties, 2001/2002 (*top*) and 2002/2003 (*bottom*)

Dimakou et al, 2009, Healthcare management science

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Patients' entitlements (England)

- **NHS Constitution** (2010): "You have [the patient has] the **right** to **access** services within maximum waiting times,…"
- Max wait from GP "referral to treatment RTT" of **18 weeks**
- **90% of patients** to be treated **within target**
- Breach of targets can result in **reduction of up to 5% of revenues** for the relevant speciality in the month in which the breach occurs

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FINLAND

Mean waiting times (days) in 2000

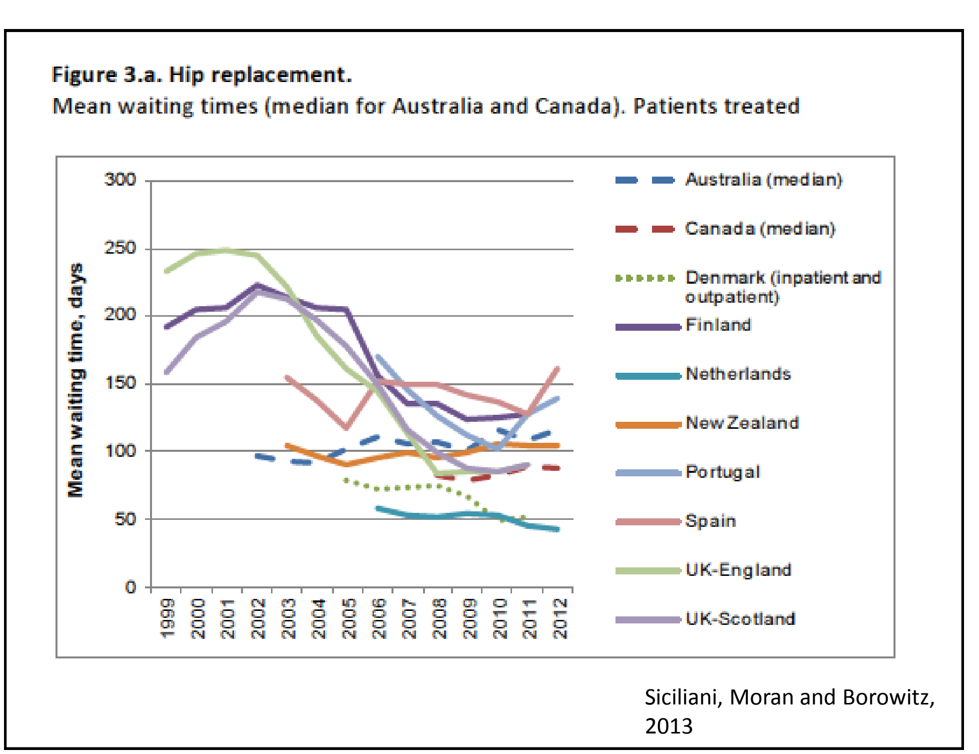
	Hip replacement	Knee replacement	Cataract surgery
Australia	163	201	179
Denmark	112	112	71
Finland	206	274	233
Norway	133	160	63
Netherlands	96	85	111
Spain (Insalud)	123	148	104
Sweden			199
United Kingdom (England)	244	281	206

Hurst and Siciliani, 2004

Health care guarantee 2005

- **Primary** care services: within 3 days
- **Specialist visit**: 3 weeks (including diagnostics)
- **Surgery**: 6 months from assessment
- Patients waiting over 6 months decreased from 126 to 66 per 10 000 population between 2002-2005

- Critical role played by **Supervisory Agency** (Valvira)
- Authority to **penalise** municipalities
- **30 orders for improvement**, including 8 with a **threat of fines**



Siciliani, Moran and Borowitz, 2013

DENMARK

Mean waiting times (days) in 2000

	Hip replacement	Knee replacement	Cataract surgery
Australia	163	201	179
Denmark	112	112	71
Finland	206	274	233
Norway	133	160	63
Netherlands	96	85	111
Spain (Insalud)	123	148	104
Sweden			199
United Kingdom (England)	244	281	206

Hurst and Siciliani, 2004

Choice, choice, choice…

- 2002: **2 months** from referral to treatment
- 2007: **4 weeks**

- If hospital cannot fulfil max wait, patients can **choose** another **public** or **private** hospital
- If **outside** of region's own hospitals, expenses covered by region (no patient travel expenses)
- % of patients in commercial **private** hospitals up from 2% to 4.2% in 2006-2008

NETHERLANDS

Table 10.4. **Mean waiting time of patients admitted by surgical procedure in Dutch hospitals, 2000 to 2011**[1]

Weeks

Surgical procedure[2]	2000	2006	2007	2008	2009	2010	2011
Cataract surgery	16	7	7	6	5	5	5
Varicose veins	15	7	6	5	5	5	4
Hip replacement	14	8	8	8	8	7	6
Knee replacement	12	10	8	8	8	8	6

Socially acceptable waiting time (2000)

- Therefore not a guarantee
- 7 weeks (80% within 5 weeks) **for inpatient treatment**
- 6 weeks (80% within 4 weeks) for **day treatment**
- 4 weeks (80% within 3 weeks) for hospital specialist **diagnosis** and medical assessment

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… though not only 'norms'

- 2001: hospital **fixed budget** scheme replaced with **activity-based payments** ("***cash on the nail***")
- Abolished **restrictions** on **specialist positions**
- 2008: **specialist remuneration** changed from **lump-sum** payments per hospital to **output-based payments**

- But health care expenditure has rapidly increased; waiting lists no longer a policy concern
- Policy makers primarily concerned with rapid growth in expenditure

New Zealand Booking system

- ***Three groups***
  - ***Booked***, treatment within 6 months
  - ***Certainty of treatment*** within 6 months (added to list)
  - ***Active care and review*** (not added) sent back to GP

- Patient's **entitlement** depends on **need and ability to benefit** assessed by the specialist **(within 6 months from referral)**

- **Prioritization tools (CPAC)** to help specialists to assess need consistently (similar to **Canada**)

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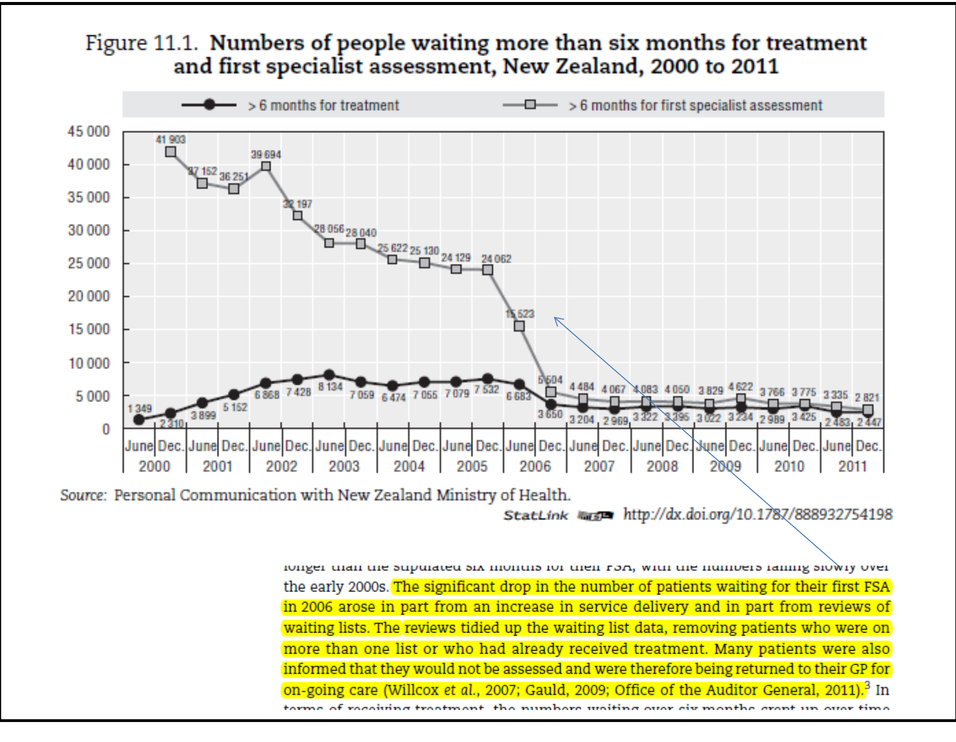

the early 2000s. The significant drop in the number of patients waiting for their first FSA in 2006 arose in part from an increase in service delivery and in part from reviews of waiting lists. The reviews tidied up the waiting list data, removing patients who were on more than one list or who had already received treatment. Many patients were also informed that they would not be assessed and were therefore being returned to their GP for on-going care (Willcox et al., 2007; Gauld, 2009; Office of the Auditor General, 2011).[3] In

Example of prioritisation guideline: hip and knee replacement; Western **Canada** Waiting List Project

1. **Pain on motion (e.g. walking, bending): ***
   - ❐ None/mild (0)
   - ❐ Moderate (6)
   - ❐ Severe (13)

2. **Pain at rest (e.g. while sitting, lying down, or causing sleep disturbance): ***
   - ❐ None (0)
   - ❐ Mild (3)
   - ❐ Moderate (8)
   - ❐ Severe (11)

** Take into account usual duration, intensity, and frequency of pain, including need vs. non-narcotic medication.*

3. **Ability to walk without significant pain :**
   - ❐ Over 5 blocks (0)
   - ❐ 1-5 blocks (0)
   - ❐ <1 block (4)
   - ❐ Household ambulator (7)

Norway: Individual max wt time

- ***Elective with individual maximum waiting time***
- ***Elective without maximum waiting time***

- Max wait determined based on *severity, efficacy of treatment, cost in relation to expected outcome*

- If not respected, patient can *be treated in a different hospital (public or private) billed to the originating hospital*

A key dilemma on guarantees

- **Unconditional** (same for everyone) max waiting time guarantees are:
  - *easy to operationalise*
  - *contradict prioritisation*

- **Conditional** (on severity, benefit or other) max waiting time guarantees are:
  - *difficult to operationalise*
  - *do not contradict prioritisation*

Measurement issues

- Waiting time vs. Waiting list

- Outpatient waiting time, inpatient waiting, RTT
- Waiting time of patients admitted vs waiting time of patients on the list
- Mean waiting time vs median waiting time
- Number of patients waiting more than 8/12 months

- Waiting time by speciality
- Waiting time by procedure

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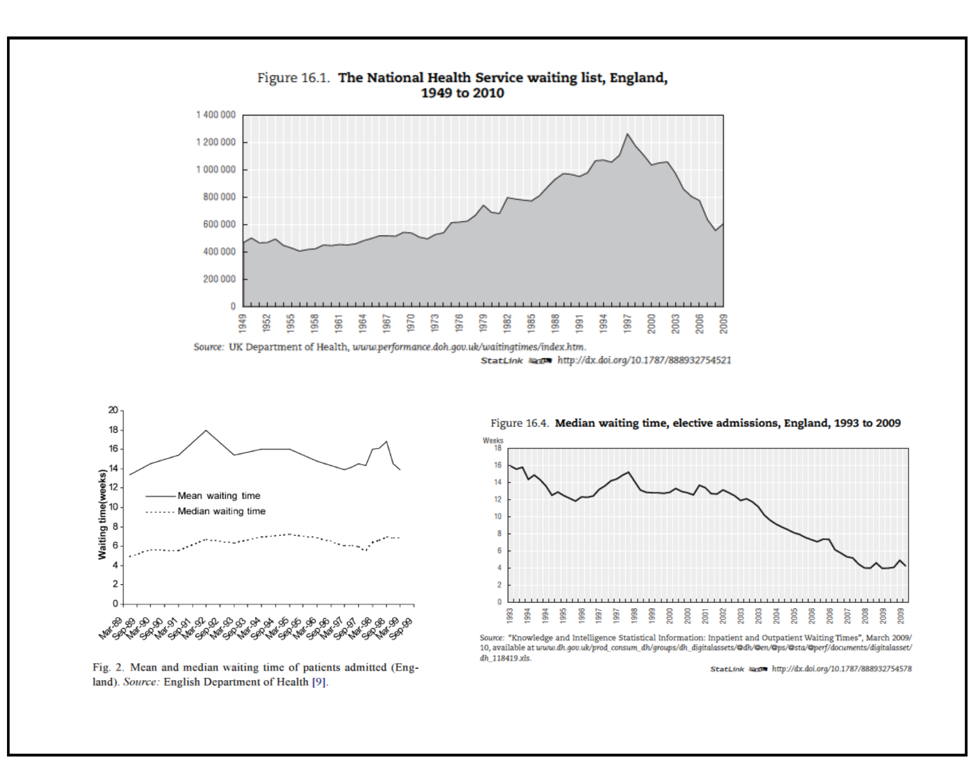
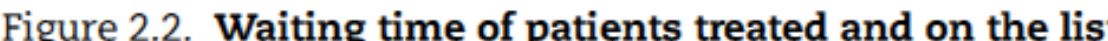
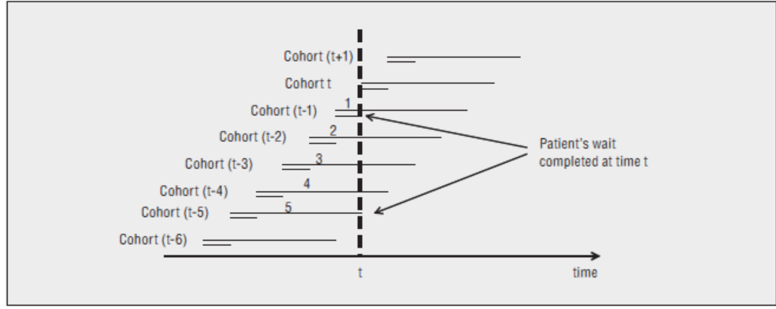


Fig. 2. Mean and median waiting time of patients admitted (England). *Source:* English Department of Health [9].





Source: Luigi Siciliani for the OECD.

Patients treated – inpatient wait (2011)
Days waited: median (mean)

	Hip replacement	Knee replacement	Cataract
Australia	108	173	90
Canada	89	107	49
Finland	113 (127)	136 (149)	111 (114)
Netherlands	(46)	(44)	(33)
New Zealand	90 (104)	96 (112)	84 (94)
Portugal	87 (128)	195 (206)	49 (66)
Spain	(127)		(89)
UK-England	82 (90)	87 (97)	59 (66)
UK-Scotland	75 (90)	80 (94)	62 (70)

Patients treated – Referral to treatment (t

Denmark	39 (51)	46 (59)	70 (99)

Patients on the list – inpatient wait

	Hip replacement	Knee replacement	Cataract
Ireland	103 (130)	119 (153)	118 (144)
New Zealand	60 (78)	65 (84)	51 (63)
Portugal	137 (191)	164 (201)	67 (100)
Spain	(93)		(71)
Sweden	43	45	40
Slovenia	340 (354)	495 (512)	58 (63)

Siciliani, Moran and Borowitz, 2013

Referral to treatment wait (RTT)

- Covers the whole patient's journey

- Three key measures
- Complete pathway
  - Admitted
  - Non-admitted
- Incomplete pathway

Scotland's Waiting Time Journey

Three Themes

- Underpinning Principles
- Service Improvement and Performance Management
- Information Systems, definitions and measurement

Mike Lyon
Senior Advisor

Underpinning Principles

“The patients’ rights are paramount” and patients are to be offered care according to clinical priority and within agreed waiting times.

It is in pursuance of these rights that all reasonably practicable steps must be taken to ensure compliance with the legal Treatment Time Guarantee, taking account of the patient’s clinical needs and the clinical needs of other patients.

In summary it is Scotland’s policy that waiting times are part of an overall quality strategy which places the patient at the centre. Waiting times should be an outcome of a high quality efficient service.

Service Improvement and Performance Management

- Service improvement and transformation of services have been central to Scotland's drive to improve waiting times.

- Improvement of Scottish waiting times has been supported by very strong central performance management through collaboration with NHS Boards.

- Effective clinical engagement is fundamental to delivering Scottish waiting time standards.

Information Systems, Definitions and Measurement

- The improvement of waiting times in Scotland has been supported by the implementation of a wide-ranging eHealth Strategy.
- Patient Management Systems have been implemented that support the management of patients across entire pathways of care.
- A suite of definitions is available to support consistent measurement and management of waiting times.
- The 18 weeks referral to treatment standard is supported by an Information Strategy and an Information Delivery Team – a unique pathway number; clinic outcome codes; an onward referral data set are in place

Queues

Stage of treatment targets are essentially queue targets and to manage queues it is necessary to have queue information identifying the number of queues, the size of the queues, scheduling of the queues and variation in ‘additions to’ and ‘removals from’ the queues.

Focus on the wider spectrum of healthcare

- Demand on hospital care is influenced by the quality and extent of care outside the hospital.
- Successful health improvement actions will ultimately impact positively on elective waiting times.
- The more effective the relationship between health care and social care the more effective health care will be overall.

10 Key aspects of Scotland's approach

1. A forceful central performance management team working in partnership with NHS Boards
2. Skilled central support for service improvement integrated with NHS Boards
3. A strong emphasis on the determinants of waiting times – primary, secondary and social care; demand/capacity management; queue; pathway; flow; the relationship between scheduled and unscheduled care; workforce; financial resource
4. The placing of waiting time standards within a broader strategic and quality improvement approach
5. Effective clinical engagement

The Scottish Government

10 Key aspects of Scotland's approach

6. The development of waiting time standard over time, building on success step-by-step, from stage of treatment to referral to treatment.
7. The development of information systems, measurement and definitions
8. The use of the independent sector at the margins and for limited duration to manage unexpected demand and unforeseen events.
9. The allocation of funding in the short-term to address need but the balancing out of recurrent funding in-line with the national funding formulae. Allocate funding to support service improvement as well as to increase capacity.
10. Targets should be 'Fit for Purpose' – will provide real benefit to patients, can be measured and reported, can be delivered, are affordable, promote effective care and resource efficiency.

1. Waiting Times National Targets & Standards

Waiting times are of public and 'management' interest for measuring among other things how well the health system is performing. It is also about prompting management action where pressures on the standard of service required by the public are apparent. Performance is monitored against a variety of Scottish Government (SG) targets and standards. Targets are the live performance benchmarks that NHS Boards are assessed on by the SG and generally last for a few years. After this point, if the target is being met, it can become a standard and part of NHS Board's 'business as usual' i.e. it is now just expected that they maintain this performance.

There are two main measures for assessing performance within waiting times:

Patients waiting - waiting times of patients who are still waiting for health care at a point in time(waiting list census)

Patients seen - the waiting time actually experienced by patients who have been treated (seen) i.e. completed waits.

Currently ISD Scotland report on the following standards and targets across NHS Scotland:

Child & Adolescent Mental Health

For the NHS in Scotland to deliver a maximum 26 week waiting time from a patient's referral to treatment for specialist CAMH services from March 2013, reducing to 18 weeks from December 2014. The target is based on patients seen; however the publication also includes statistics on both patients waiting at month end too. For more information see the CAMHS waiting times web pages.

Psychological Therapies

From December 2014, patients accessing mental health services can expect to wait no longer than 18 weeks from referral to treatment for Psychological Therapies. The target is based on patients seen during the quarter; however the publication includes

statistics on patients waiting at month end too. For more information see the Psychological Therapies waiting times web pages.

Stage of Treatment (Inpatients & Day cases)

From 1 October 2012, eligible patients who are due to receive planned treatment provided on an inpatient or day case basis can expect to start to receive the treatment within 12 weeks from the date they agree to the treatment, known as the Treatment Time Guarantee. The measurement is the time from the decision to treat to the date treatment commenced. This target is based on patients seen; however the publication also includes statistics on patients waiting too. For more information see the Stage of Treatment waiting times web pages.

Stage of Treatment(New Outpatient Appointments)

From the 31 March 2010; no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. This will include referrals from all sources. The measurement is the time from receipt of referral to date of 1st appointment. This target is based on patients waiting; however the publication includes statistics on patients seen too. For more information see the Stage of Treatment waiting times web pages.

Diagnostics (Key Diagnostic Tests)

From the 31 March 2009; patients will wait no more than six weeks for any of the 8 key diagnostic tests and investigations. The measurement is the time from receipt of the initial referral to the date the verified report is received or made available to the requester. This standard is based on patients waiting. For more information see the Diagnostics waiting times web pages.

Referral to Treatment (RTT)

From 31 December 2011, the national maximum waiting time for the whole journey from referral to treatment will be 18 weeks. The measurement is the time from

receipt of initial referral to start of treatment. This standard is based on patients seen. For more information see the Referral to Treatment waiting times web pages.

Audiology

The national maximum waiting time for the whole journey from general practitioner referral to treatment will be 18 weeks from 31 December 2011. NHS Boards deliver this service in different ways so ISD publish on 4 measures:

- Time from receipt of initial referral to assessment (first contact)
- Time from assessment to fitting of hearing aid
- Time from assessment to start of treatment (other than fitting of hearing aid)
- One stop clinic (assessment and treatment at the same appointment)

This standard is based on patients seen. For more information see the Audiology waiting times web pages.

Cancer

The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days. The maximum wait from decision to treat to first treatment for all patients diagnosed with cancer is 31 days. Performance against these targets was achieved by December 2011; the timescale agreed by the Scottish Government. These two targets were considered as National Standards from 1st April 2012. For more information see the Cancer waiting times web pages.

Accident & Emergency

From the 31 December 2007; 98% of new and unplanned return attendances at an A&E service should be admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care i.e. emergency departments, assessment units, minor injury units, community hospitals; anywhere that emergency care type activity takes place. This continues to be the measure by which the Scottish Government (SG) monitors NHS boards' performance within A&E Services.

In 2013, the Scottish Government introduced a new HEAT target to support the sustainable delivery of 4 hour A&E performance all year round. The first target milestone is for 95% of patients to wait no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by the year ending September 2014.

The above standard and target are based on patients seen. For further information see the Accident & Emergency Activity web pages.

In order to reduce the number of attendances at Emergency Departments (EDs) across Scotland and shift the balance of care, the Scottish Government introduced a HEAT target performance measure. NHS Boards are tasked with reducing the attendance rate at EDs between 2009/10 and 2013/14. The aim of the target is to reduce attendances through better provision and use of primary care services, better preventative and continuous care in the home and improved self care. This will result in more appropriate alternative services for patients. The target only applies to EDs and excludes MIUs.

The HEAT target is to reduce the rate of new attendances at Emergency Departments to 2,095 per 100,000 population by March 2014. For more information, see the Emergency Care web pages.

Drugs & Alcohol Treatment

By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to the start of appropriate drug or alcohol treatment that supports their recovery. For more information, see the Drugs & Alcohol waiting times web pages.

From: Mike.Lyon@scotland.gsi.gov.uk [mailto:Mike.Lyon@scotland.gsi.gov.uk]
Sent: 14 March 2014 10:48
To: Black, Lesley-Ann
Subject: FW: 11 Procedures UK analysis - detail stats tables

Lesley-Ann, you may find the attached summary of comparative waiting times from an OECD report interesting. It compares median and 90th percentile waiting times for 11 key procedures for Scotland, Northern Ireland, Wales and England. For example, the average waiting time for heart bypass surgery in Scotland is 37 days and in Northern Ireland it is 99 days; in Scotland 90% of patients receive an angiography (an essential test for cardio-vascular disease) within 57 days and for Northern Ireland it is 263 days.

Happy to provide source document

Best wishes, Mike

11 PROCEDURES UK ANALYSIS

DETAILED STATISTICS

Hip Replacement		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	6,310	6,201	7,210	14.3%	16.3%
	Median Wait (Days)	122	90	67	-55	-23
	90th Percentile Wait (Days)	222	143	133	-89	-10
England	Number	53,376	60,805	70,160	31.4%	15.4%
	Median Wait (Days)	148	75	77	-71	2
	90th Percentile Wait (Days)	220	144	156	-64	12
Wales	Number	3,299	3,928	3,868	17.2%	-1.5%
	Median Wait (Days)	219	119	170	-49	51
	90th Percentile Wait (Days)	367	208	290	-77	82
NI	Number	1,756	1,851	1,747	-0.5%	-5.6%
	Median Wait (Days)	168	123	222	54	99
	90th Percentile Wait (Days)	337	206	334	-3	128

Knee Replacement		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	6,203	6,197	7,238	16.7%	16.8%
	Median Wait (Days)	125	91	68	-57	-23
	90th Percentile Wait (Days)	246	155	134	-112	-21
England	Number	58,941	68,657	73,993	25.5%	7.8%
	Median Wait (Days)	155	77	82	-73	5
	90th Percentile Wait (Days)	236	151	169	-67	18
Wales	Number	4,072	4,997	4,239	4.1%	-15.2%
	Median Wait (Days)	241	120	177	-64	57
	90th Percentile Wait (Days)	389	241	296	-93	55
NI	Number	1,324	1,439	1,110	-16.2%	-22.9%
	Median Wait (Days)	196	130	238	42	108
	90th Percentile Wait (Days)	433	230	373	-60	143

Cataract Surgery		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	28,508	30,145	32,699	14.7%	8.5%
	Median Wait (Days)	69	45	56	-13	11
	90th Percentile Wait (Days)	146	102	122	-24	20
England	Number	254,868	305,725	324,428	27.3%	6.1%
	Median Wait (Days)	69	56	59	-10	3
	90th Percentile Wait (Days)	115	103	121	6	18
Wales	Number	18,660	19,626	15,620	-16.3%	-20.4%
	Median Wait (Days)	70	91	94	24	3
	90th Percentile Wait (Days)	125	134	253	128	119
NI	Number	7,785	9,346	8,881	14.1%	-5.0%
	Median Wait (Days)	101	104	127	26	23
	90th Percentile Wait (Days)	172	154	232	60	78

Angioplasty		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	2,484	2,035	2,395	-3.6%	17.7%
	Median Wait (Days)	37	25	37	0	12
	90th Percentile Wait (Days)	85	53	61	-24	8
England	Number	27,250	25,279	21,844	-19.8%	-13.6%
	Median Wait (Days)	50	32	36	-14	4
	90th Percentile Wait (Days)	87	69	81	-6	12
Wales	Number	835	861	887	6.2%	3.0%
	Median Wait (Days)	89	70	50	-39	-20
	90th Percentile Wait (Days)	182	146	155	-27	9
NI	Number	1,695	1,468	1,213	-28.4%	-17.4%
	Median Wait (Days)	14	25	58	44	33
	90th Percentile Wait (Days)	153	53	263	110	210

Angiography		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	9,515	7,634	7,032	-26.1%	-7.9%
	Median Wait (Days)	34	20	26	-8	6
	90th Percentile Wait (Days)	56	35	57	1	22
England	Number	104,417	104,408	98,226	-5.9%	-5.9%
	Median Wait (Days)	55	28	34	-21	6
	90th Percentile Wait (Days)	132	57	72	-60	15
Wales	Number	5,771	5,728	4,655	-19.3%	-18.7%
	Median Wait (Days)	67	43	49	-18	6
	90th Percentile Wait (Days)	125	103	160	35	57
NI	Number	3,581	3,658	3,993	11.5%	9.2%
	Median Wait (Days)	27	35	84	57	49
	90th Percentile Wait (Days)	176	126	263	87	137

Bypass Surgery		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	1,372	1,452	1,035	-24.6%	-28.7%
	Median Wait (Days)	55	53	37	-18	-16
	90th Percentile Wait (Days)	122	86	75	-47	-11
England	Number	14,313	15,009	10,968	-23.4%	-26.9%
	Median Wait (Days)	68	54	56	-12	2
	90th Percentile Wait (Days)	112	108	137	25	29
Wales	Number	678	691	374	-44.8%	-45.9%
	Median Wait (Days)	107	106	135	28	29
	90th Percentile Wait (Days)	202	176	288	86	112
NI	Number	454	509	386	-15.0%	-24.2%
	Median Wait (Days)	117	113	99	-18	-14
	90th Percentile Wait (Days)	191	170	196	5	26

Endoscope of Bladder		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	14,896	15,566	15,381	3.3%	-1.2%
	Median Wait (Days)	39	28	27	-12	-1
	90th Percentile Wait (Days)	140	76	70	-70	-6
England	Number	139,870	161,595	145,798	4.2%	-9.8%
	Median Wait (Days)	34	24	24	-10	0
	90th Percentile Wait (Days)	134	62	64	-70	2
Wales	Number	15,389	14,983	16,384	6.5%	9.4%
	Median Wait (Days)	50	41	42	-8	1
	90th Percentile Wait (Days)	237	181	232	-5	51
NI	Number	5,951	7,151	7,762	30.4%	8.5%
	Median Wait (Days)	66	42	41	-25	-1
	90th Percentile Wait (Days)	213	129	185	-28	56

Endoscope of Upper Gastro intestinal Tract		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	31,891	30,191	27,478	-13.8%	-9.0%
	Median Wait (Days)	34	23	20	-14	-3
	90th Percentile Wait (Days)	98	54	46	-52	-8
England	Number	260,708	343,033	434,641	66.7%	26.7%
	Median Wait (Days)	27	21	22	-5	1
	90th Percentile Wait (Days)	96	42	47	-49	5
Wales	Number	21,910	24,098	24,209	10.5%	0.5%
	Median Wait (Days)	30	33	36	6	3
	90th Percentile Wait (Days)	147	95	147	0	52
NI	Number	17,760	19,735	17,650	-0.6%	-10.6%
	Median Wait (Days)	39	54	34	-5	-20
	90th Percentile Wait (Days)	176	132	86	-90	-46

Hernia Repair		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	7,366	7,165	7,092	-3.7%	-1.0%
	Median Wait (Days)	79	67	54	-25	-13
	90th Percentile Wait (Days)	179	127	121	-58	-6
England	Number	75,643	75,466	72,011	-4.8%	-4.6%
	Median Wait (Days)	96	54	59	-37	5
	90th Percentile Wait (Days)	186	112	131	-55	19
Wales	Number	4,143	4,259	3,502	-15.5%	-17.8%
	Median Wait (Days)	116	85	99	-17	14
	90th Percentile Wait (Days)	315	161	251	-64	90
NI	Number	1,985	2,254	1,938	-2.4%	-14.0%
	Median Wait (Days)	102	75	122	20	47
	90th Percentile Wait (Days)	241	142	270	29	128

Tonsillectomy and Adenoidectomy		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	4,856	4,992	5,393	11.1%	8.0%
	Median Wait (Days)	93	59	52	-41	-7
	90th Percentile Wait (Days)	169	120	103	-66	-17
England	Number	57,445	54,980	53,394	-7.1%	-2.9%
	Median Wait (Days)	113	55	62	-51	7
	90th Percentile Wait (Days)	187	117	127	-60	10
Wales	Number	3,756	4,030	3,127	-16.7%	-22.4%
	Median Wait (Days)	189	110	87	-102	-23
	90th Percentile Wait (Days)	343	166	239	-104	73
NI	Number	4,051	3,616	3,525	-13.0%	-2.5%
	Median Wait (Days)	161	95	118	-43	23
	90th Percentile Wait (Days)	267	153	244	-23	91

Varicose Surgery		2006-07	2008-09	2012-13	Change from 2006/07	Change from 2008/09
Scotland	Number	4,222	4,125	3,017	-28.5%	-26.9%
	Median Wait (Days)	103	82	57	-46	-25
	90th Percentile Wait (Days)	219	156	149	-70	-7
England	Number	34,565	34,687	23,456	-32.1%	-32.4%
	Median Wait (Days)	126	63	65	-61	2
	90th Percentile Wait (Days)	216	133	147	-69	14
Wales	Number	2,112	2,236	1,186	-43.8%	-47.0%
	Median Wait (Days)	217	113	92	-125	-21
	90th Percentile Wait (Days)	371	193	294	-77	101
NI	Number	1,400	321	241	-82.8%	-24.9%
	Median Wait (Days)	150	107	232	82	125
	90th Percentile Wait (Days)	308	198	369	61	171

Management of Waiting List for Surgery

Northern Ireland Assembly's Health Committee

www.acss.min-saude.pt

Unidade Central de Gestão de Inscritos para Cirurgia

Belfast, 9 April 2014

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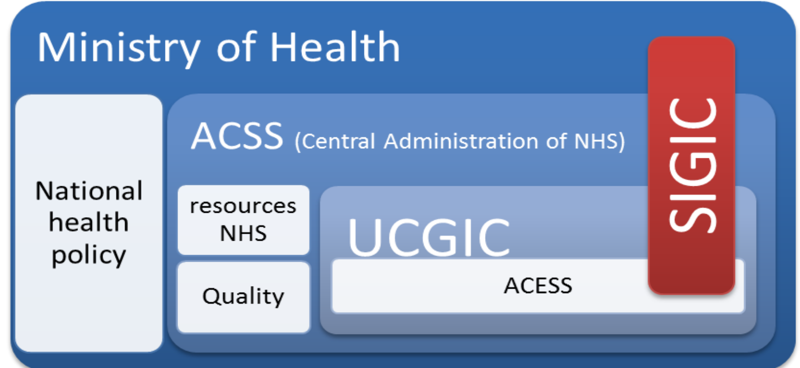
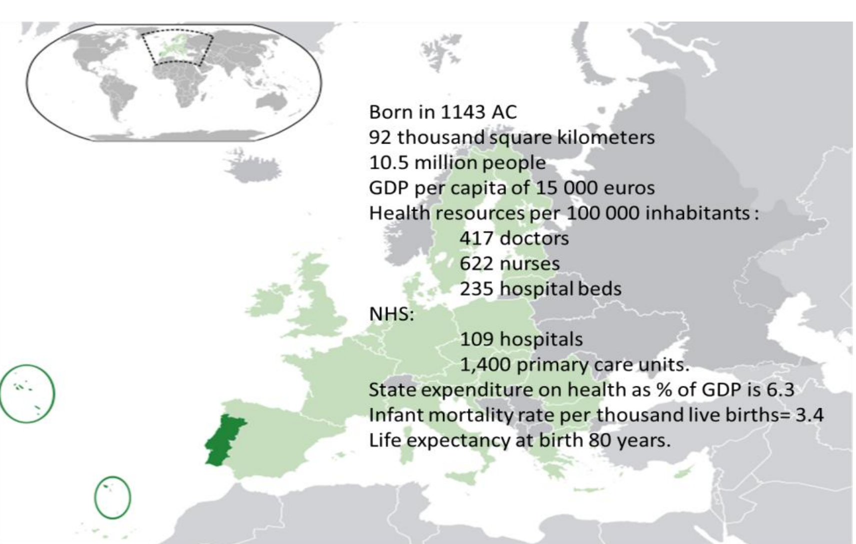
1. Introduction



Thank for the invitation.
I hope to transmit what we are doing in Portugal, regarding access to surgery.

2. Portugal

Portugal is a country in Southern Europe, with 92 thousand square kilometers, 10.5 million people, and a Gross Domestic Product (GDP) per capita of 15 000 euros.

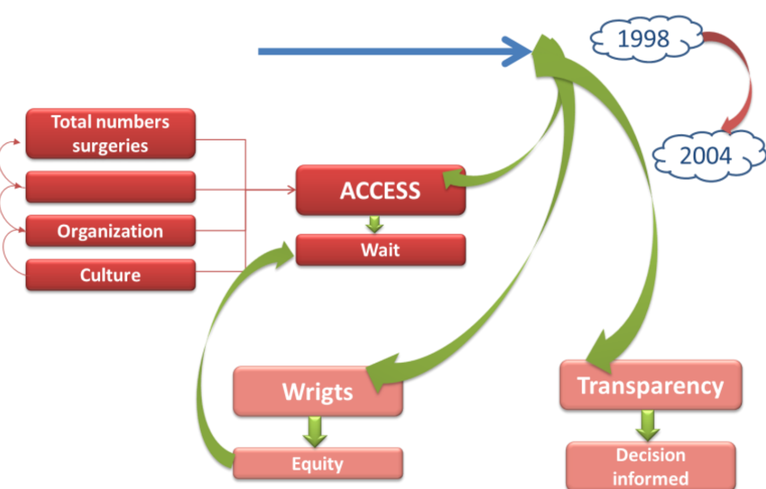


Regarding health resources we have 417 doctors and 622 nurses per hundred thousand inhabitants, 235 hospital beds per hundred thousand inhabitants in 109 hospitals, 1 400 primary care units.

National Health Service (NHS) performs per year and per thousand inhabitants: 3 800 consultations, 88 admissions, 50 surgeries, 0.8 episodes of urgency. The total state expenditure on health as % of GDP is 6.3.

Infant mortality rate is 3.4 per thousand live births and life expectancy at birth is 80 years.

3. The problem



Since 1998, successive governments have tried to find solutions to a problem of access to surgical services, experiencing various measures that have failed to reverse the problem.

The problem of access, which manifested itself particular through excessive delay for surgery, found its roots in a culture of poorly oriented services for patients. Professionals worked in a rigid organizational architecture to ensure the survival of the institutions in the logic of preserving cooperative interests and pursuing concepts that did not encourage conducts that intended efficiency.

Another problem is an equitable access. Also the demographic change, the technological change and acculturation of society that becomes more demanding and aware of their rights, reinforces the need for intervention.

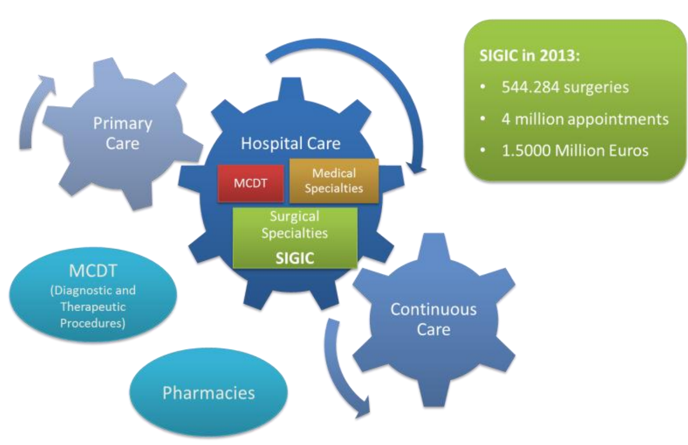
We also verified the absence of updated and credible information that supports decision-making for all stakeholders.

4. The SIGIC has born

SIGIC is program created in 2004 by the Ministry of Healthcare to fight against the waiting list for surgery. By then the median waiting time was nearly 9 months for more than to (2) hundred thousand patients, nowadays it is 3 months (minus 62%) for one and a haft hundred thousand patients.

SIGIC is coordinated in national terms by a Central Unit. It is supported by 5 regional units and by hospital units based in the care providers, public and private.

5. Surgery in all health care

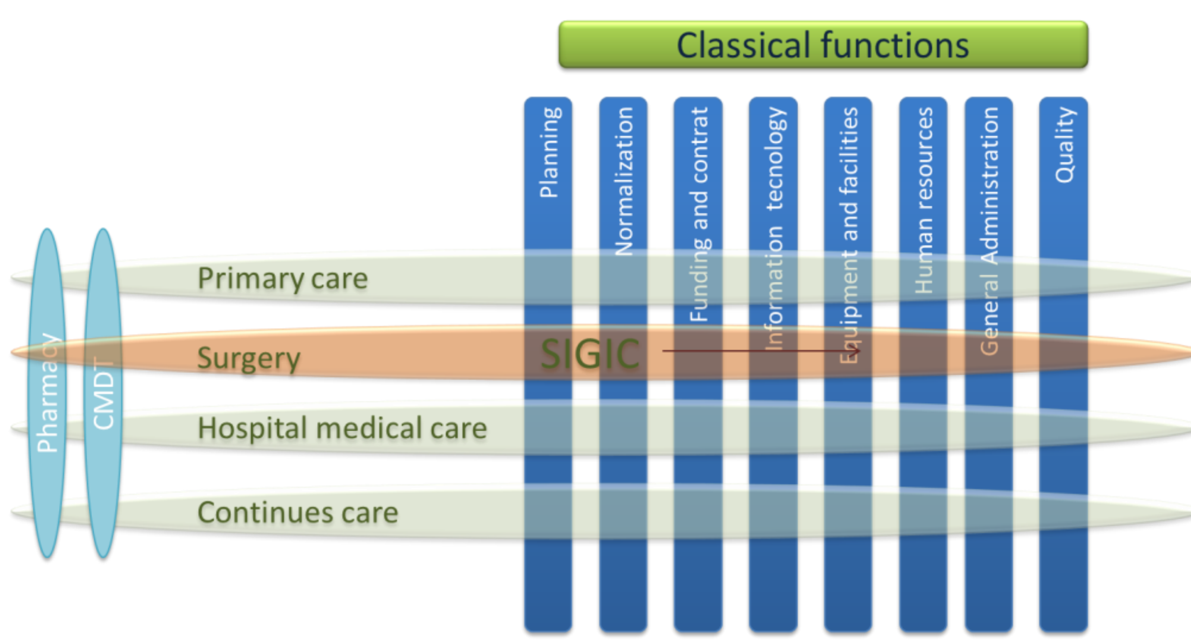


The activity of surgical services is not limited to performing surgical procedures, it involves every phase of screening, investigative procedures, analysis, complementary medical treatments and pre and post-surgery.

The activity of these services cannot be evaluated without taking into account that they are integrated in a network of care that includes primary care, hospital and continued care.

SIGIC represented in 2013 more than 5 hundred thousand surgeries, 4 million appointments and a business volume of 1.5 billion Euros.

6. Matricial management



SIGIC, has a matrix management approach, it integrate needs expressed by patients, pathology and the various elements of the value chain in surgical services. SIGIC observe the distribution of demand, the process compliance, public disclose results, promotes competition and negotiation, improve the efficiency and effectiveness of the entire system thus contributing to its sustainability.

7. Elements and objectives

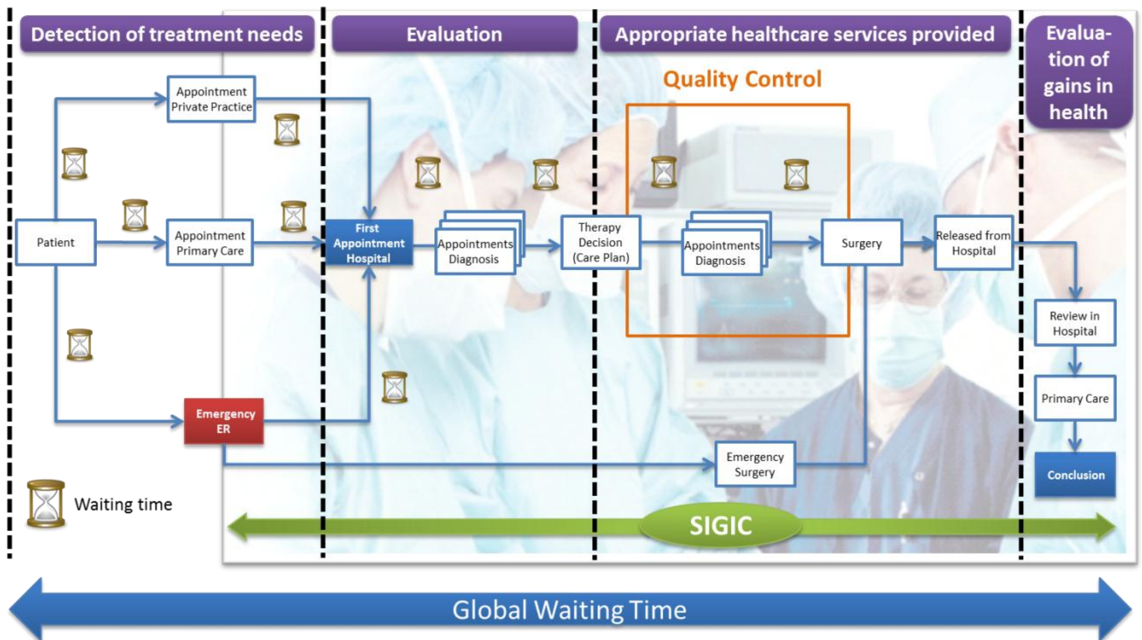
SIGIC business model is sustained by an information model named - SIGLIC, a financing/funding model, a regulation model (laws) and a business process model to manage the waiting lists for surgery.

The main goal of SIGIC is to focus the services provided by the hospitals to meet the patients' needs by:

1. Reducing the waiting time for surgery
2. Guarantee Equity in access to surgical treatments;
3. Promote efficient and effectiveness in health services;
4. Quality and Transparency in the management and information;
5. Responsibility of players involved in the process.

An additional goal is the guarantee that the system is sustainable according to the actual budget constraints that Portugal faces nowadays.

8. Waiting times

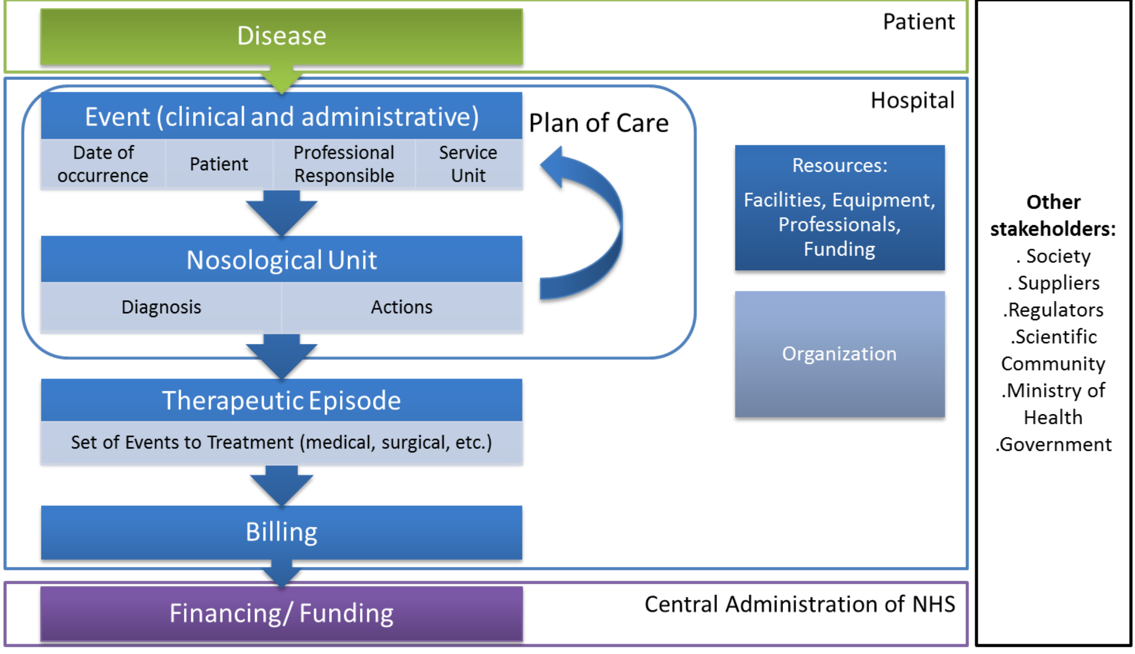


The patient waiting time for treatment, cannot be measured by taking only into account the waiting time between inscription and surgery.

Monitoring the access is to know the partial waiting times in all the process, which starts with the detection of health problems and finishes in the treatment provided whit measurement of gains in health for the patient.

Next step will be measuring referral to treatment times

9. Systems information



SIGLIC addresses in an innovative way the information for clinical governance, focusing on the core business of health.

The approach to a disease or a set of diseases is made with the establishment of a care plan that projects the necessary events to treat the patient.

The events occur as many as needed to complete the diagnosis and treatment of the patient. Those set of events are aggregated in a therapeutic episode.

SIGLIC has warnings to players involved and manage financial penalties.

SIGIC's stakeholders can access the information through reports from SIGLIC, according to their profile access. Access restrictions are applied to those profiles.

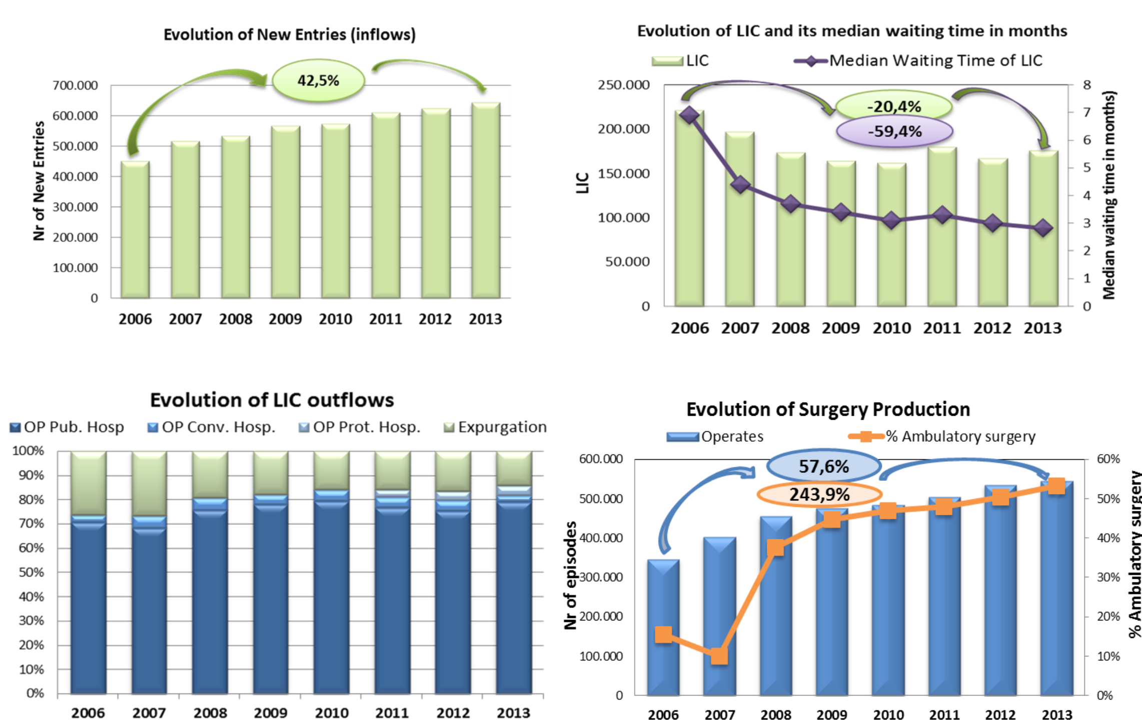
All hospital has to transfer normalized data automatically every day to a central data center.

Data is analyze, qualified and reported back to the hospitals.

Indicators are regularly produced and used for management decisions.

SIGLIC collects data to provide information to plan, to regulate and to make the best decisions in political and economic terms by government.

10. Results



Since the beginning of the program we observe a positive evolution in all indicators.

The number of episodes in waiting lists diminishes regardless of the increase in admissions; at the same time production increase due to the new possibility for medical teams in operate patients after work at a price per patient.

An overall result is the dramatic fall of the waiting time – less 59%. The reference of patients to private sector plays a little roll (5 to 7%), never the less important.

Access to surgery, measured by the number of inscriptions (entries in the list) per year, has been successively improved, we have seen last year an increase of 42.5% over numbers from 2006 and 3.2% compared to year before.

The extend of inscriptions list for surgery in December 31, 2013 shows a decrease of 20.4% compared to 2006, however there is an increase compared to 2012 by 5.6%. Notable is the reduction of waiting times which decreased 59.4% over 2006 and 6.7% when compared to 2012.

Nowadays the average waiting time is 2,8 months.

The surgical activity maintains a sustain growth of 57.6% since 2006. Between 2012 and 2013 this growth was 1.8%, which we consider very satisfactory given the current crisis and given the 8% reduction in the budget for surgery.

The percentage of patients who exceed the maximum guaranteed response times, which has improved greatly since 2006 (a reduction of 70.6%), still has high values in 2013 (12.8%), nevertheless it has decreased by 15.2% compared to 2012.

11. Why does SIGIC works

- Establishing penalties for non-compliance with guaranteed maximum response time reduces waiting times
- Allowing doctors, in hospitals, to do additional surgery, promotes productivity;
- The analyses of expressed demand turns possible optimizations relocating resources;
- Through the analyses of supply for each providers it's possible to increased productivity;
- The monitoring of compliance can corrected errors;
- The collection of standardized data that allows to compare providers (benchmarking) increases efficiency;
- The identifications of a responsible for each event and the management of information as documents, allows "accountability";
- All stakeholders (physicians, patients, managers) share the same information and thus control each other;
- Patients transfers are automated when exists risk of exceeding the maximum waiting time guaranteed for surgery, in this case the original public hospital pays the bill;
- The regular publication of detailed results promotes accountability and allows all stakeholders to control the process;
- Publication of rates of productivity and non-conformities – promotes quality and efficiency

Administração Central do Sistema de Saúde, IP

Unidade Central de Gestão de Inscritos para Cirurgia (UCGIC)

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Appendix 3

Departmental briefing papers and correspondence

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FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Ms Maeve McLaughlin MLA
Chair
Committee for Health Social Services and Public Safety
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Ballymiscaw
Stormont
BELFAST
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Our Ref: AGY/880/2013

Date: 28 January 2014

Dear Ms McLaughlin

WAITING TIMES REVIEW

Thank you for your letter of 16 December, setting out the Terms of Reference and timescale for the Committee's Review of Waiting Times and seeking information on my Department's current and planned approach to reducing elective care waiting times. I apologise for the delay in response.

Established under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Health and Social Care Board (HSCB) is responsible for "*Implementing a comprehensive framework for performance management and service improvement that will monitor HSC performance against relevant objectives, targets and standards and provide appropriate assurance to the Department and the Minister about their achievement. Poor performance will be addressed promptly and effectively through intervention and, where necessary, the application of sanctions. An integral part of these arrangements will be the identification and promulgation of best practice to promote consistent service improvement across the HSC*";

Through successive Commissioning Plan Directions (CPDs) since 2011 and prior to that, through agreed Ministerial Priorities for Actions, annual priorities and associated Standards and Targets for the HSC system, are set. I have been seeking to strike an appropriate balance in setting direction to the HSC between access targets (for both elective and unscheduled care) and outcome measures. I am well aware of the significant concerns about the relatively poor performance of the NI HSC on access times. However, I do believe that there is much to be gained by improving our understanding and targeting of measures that actually focus on improving the effectiveness of care as measured in terms of patient outcomes (such as reduced mortality, better recovery, sustained independence and reduced suffering).

Through the mechanism of the annual CPD, HSCB's approach to reducing waiting times for elective care is to ensure sufficient elective capacity to meet demand and it works closely with Trusts in doing so. During 2013/14, HSCB has carried out an extensive

exercise to establish an agreed position in relation to the level of capacity for every Trust in each elective specialty, taking into account agreed levels of productivity and efficiency, and the demand for each specialty based on referrals received. The outcome of this exercise has enabled HSCB to monitor the system to ensure that appropriate levels of activity are delivered and inform decisions on where available recurrent funding should be targeted in order to address identified capacity gaps. HSCB has been making targeted recurrent investments in specialities where there is an agreed capacity gap relative to demand with investment being made in additional Trust services and primary care.

Where service capacity is insufficient to meet demand in the timescales required, including any short-term backlog reduction to meet Ministerial target waiting times, HSCB has funded Trusts non-recurrently to undertake additional activity in-house and, if appropriate, to procure this from the independent sector. It is HSCB's expectation that Trusts undertake as much of any required additional activity in-house and utilise independent sector providers only where in-house capacity is insufficient to meet patient demand for assessment or treatment.

Whilst, regionally, I recognise that performance in relation to waiting times is not where I would wish it to be, this approach has delivered a significant improvement in waiting times over the last two years. Waiting times for a first outpatient appointment have reduced by 36% since November 2011 – at the end of November 2013, 34,766 outpatients were waiting longer than nine weeks for an appointment, compared with 54,642 in November 2011. There has also been a significant improvement in waiting times for inpatient or daycase treatment – at the end of November 2013, 14,256 patients were waiting longer than 13 weeks for surgery, compared with 23,102 at November 2011 – a reduction of 38%. Similarly, there has been a considerable reduction in the number of patients waiting longer than nine weeks for a diagnostic test – at the end of November 2013, 5,732 patients were waiting longer than nine weeks for a diagnostic test, compared with 8,044 at November 2011 – a reduction of 29%. While these are still short of the standard we aspire to provide, the improvements are welcome.

HSCB regularly meets with Trusts to monitor elective care performance and these meetings include discussion on ensuring delivery of agreed levels of core capacity across all elective specialties. HSCB has to be assured that Trusts deliver the levels of elective activity that have been commissioned and, given the impact that under delivery of core activity has on waiting times for elective care, arrangements have been put in place to withdraw an element of funding from Trusts on a quarterly basis in specialties where there is continued material under delivery of core activity.

Effective waiting list management within Trusts has also contributed to the improvement in waiting times over the last two years. The Integrated Elective Access Protocol (IEAP) (first produced in 2005/06, and revised in April 2008) contains extensive guidance to assist Trusts to manage patients waiting for access to elective care services effectively for example by:

- chronological management of waiting lists to ensure patients of the same clinical priority are seen in strict chronological order;
- pooling of lists between consultants in a specialty to equalise waiting times; and
- partial booking to allow patients to choose a suitable date and time for their appointment thereby reducing the likelihood of patients not attending or cancelling their appointment.

In addition to monitoring waiting time performance and delivery of agreed volumes of core activity at the regular performance management meetings with Trusts, HSCB monitors Trusts' progress against a wide range of performance indicators including compliance with the principles set out within the IEAP.

Where monitoring identifies concern about Trusts' performance or highlights a serious risk to achievement of maximum waiting times for elective access, a range of escalation measures are in place that may be applied including to require detailed recovery plans, more intense monitoring, and more frequent review meetings with Trust Chief Executives and their senior teams until performance improves.

As the HSCB is an Arms Length Body of the Department, officials monitor the Board's performance in delivering against is statutory responsibility in relation to performance management, including elective care waiting times, through normal accountability and assurance procedures.

Referral to Treatment (RTT) Waiting Times

A move to an RTT measurement in Northern Ireland would be challenging, both financially and logistically. This is principally due to the difficulties that would be faced in linking information on a patient's wait, through the care/treatment pathway, given the disparate reporting systems currently used by the HSC in Northern Ireland.

From the perspective of using the existing hospital waiting times, there can be a misconception that three component waits can be placed 'back to back' ie 'outpatient wait' to 'diagnostic wait' to 'inpatient wait', to provide an indication of the waiting time between 'Referral to Treatment'. This can be misleading as this type of methodology excludes some crucial parts of the patient pathway. For example, it does not include waiting times between first outpatient appointment and a subsequent review outpatient appointment or the time it takes to make a decision to send the patient for a diagnostic service; neither would it include the waiting time between the reporting of a patients' diagnostic test and a decision to admit to an inpatient setting.

I trust that you find this response helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

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Our Ref: AGY/94/2014

Date: 21 February 2014

Dear Ms McLaughlin

WAITING TIMES REVIEW

Thank you for your letter of 6 February seeking clarification on a number of issues arising from my previous letter to the Committee on 28 January 2014 (AGY/880/2013), in which I set out my Department's current and planned approach to reducing elective care waiting times. I apologise for the short delay in responding.

The Committee's letter of the 6th February posed a series of seven questions and I am responding to each in the order set out in that letter.

Question 1 - Has the Department/HSCB carried out any work to look at what drives demand for elective care, and why demand has increased over the years?

An increase in demand for elective care services is not unexpected in view of the increasing population, the increased age of the population, the complexity of co-morbidities and advances in medical technology.

The HSC Board, through its Local Commissioning Groups (LCGs), works with Trusts and primary care to develop and implement care pathways to reduce/avoid the need for patients to be seen in secondary care. For example, in the Southern locality, a patient pathway has been agreed that enables GPs to access directly audiology services without the need to go through the ENT consultant first, thus reducing the overall number of audiology referrals into secondary care and saving the patient an unnecessary appointment.

Question 2 - Has the Department/HSCB carried out any work with GPs on the issue of referrals for elective care?

GP practices have been asked to review their referrals data via the Quality and Productivity process for the past three years and to then meet collectively and propose improved pathways to commissioners. The HSC Board has analysed the referrals data at Integrated Care Partnerships and LCG level to identify if there are specific issues/patterns in particular areas. However this is not straightforward, as there are variations in the way

in which referrals are coded across Trusts which make comparisons difficult, for example, gastroenterology can be a separate specialty or a subset of general medicine. To help address this, the Clinical Communications Gateway (CCG) has been introduced in Northern Ireland and is available in all GP surgeries and Trusts to enable referrals to be completed and sent electronically. It is expected that the full roll-out of CCG will provide a robust mechanism to monitor referrals from primary care.

Question 3 - The Committee requested a summary of the piece of work carried out by the HSCB in 2013 to assess the core capacity in each Trust for each speciality. This should include detail of where the gaps in core provision exist across the Trusts and across the specialities.

The HSC Board's approach to reducing waiting times for elective care is to ensure that there is sufficient elective capacity to meet demand. To this end, the Board, working closely with Trusts, has carried out an exercise to establish an agreed position in relation to the level of capacity in each elective specialty (outpatients and inpatient/daycase), taking into account agreed levels of productivity and efficiency, and the demand for each specialty based on referrals received. The outcome of this exercise has informed decisions on where available recurrent funding should be targeted in order to address identified capacity gaps. The HSC Board has been making targeted recurrent investments in specialities where there is an agreed capacity gap relative to demand, with investment being made in additional Trust services and primary care.

Details of the specialities where a recurrent capacity gap exists are set out in the table below:

Specialty	Belfast Trust		Northern Trust		SET Trust		Southern Trust		Western Trust	
	Capacity Gap		Capacity Gap		Capacity Gap		Capacity Gap		Capacity Gap	
	OP	IPDC	OP	IPDC	OP	IPDC	OP	IPDC	OP	IPDC
General Surgery		✓	✓	✓	✓	✓	✓	✓	✓	✓
Breast Surgery		✓	✓	✓	✓	Included in General Surgery	✓	Included in General Surgery		Included in General Surgery
Vascular Surgery	✓	✓								
Gynae	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urology			✓	✓	✓	✓				
ENT		✓	✓	✓	✓		✓	✓		✓
Pain Mgt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Plastic Surgery	Included in SET	✓			✓	✓				
Ophthalmology	✓	✓			✓	✓	✓	✓	✓	✓
Oral / Max Fax	✓	✓			✓	✓	✓	✓	✓	✓
Orthopaedics	✓	✓						✓		✓
Neurosurgery		✓								
Paediatric Plastics		✓				✓				
Paediatric Surgery		✓								
Cardiac Surgery		✓								
Dermatology	✓		✓	✓	✓			✓		
General Medicine (including Gastro, Endocrinology and Thoracic Medicine)	✓ (endo-crinology)	✓	✓ (Gastro & endo-crinology)	✓			✓ (endo-crinology)			
Geriatric Medicine	✓		✓	✓	✓	✓				
Rheumatology	✓		✓		✓		✓		✓	
Neurology	✓						✓		✓	
Cardiology	✓		✓		✓		✓			
Thoracic Surgery	✓	✓	✓		✓		✓		✓	

Cardiology Procedures		✓
Cardiac MRI		✓
Cardiac Surgery Procedures		✓

NOTES

Position as at February 2014

Paediatrics - Further work to be completed following the Paediatrics Review

Urology - Position pending the HSCB Urology Review Stocktake

Question 4 - A breakdown of the amount of non-recurrent funding which has been allocated to the Trusts over the last 5 years to create additional in-house capacity, and to make use of the private sector.

Details of the non-recurrent funding allocated to Trusts over the last five years to undertake additional activity in-house or, where appropriate, in the independent sector are set out in the table below:

Year	IS Spend £m	IH Spend £m	Total Spend £m
2012/13	66.1	17.3	**83.4**
2011/12	52.7	24.1	**76.8**
2010/11	24.7	15.7	**40.4**
2009/10	57.5	25	**82.5**
2008/09	60	8.6	**68.6**

It should be noted that activity undertaken in the independent sector (IS) accounts for approximately 4% of all elective activity.

Question 5 - Information on whether the HSCB has withdrawn funding from any of the Trusts for not meeting their core capacity targets.

The HSC Board's expectation is that Trusts deliver fully on agreed levels of core capacity across all elective care specialties. In any specialties where there is a continued material underdelivery of core capacity, the HSC Board has put arrangements in place to withdraw an element of funding pending demonstration by the Trusts that specialties are delivering in full the required volumes of activity.

In the first half of 2013/14, the HSC Board withdrew funding totalling £876k from Trusts in a number of specialties based on performance in 2012/13 and where there had been a continued underdelivery of core capacity during quarters one and two of 2013/14 - £497k was withdrawn from Belfast Trust, £289k from Northern Trust and £90k from South Eastern Trust.

The Board is currently reviewing the delivery of core position for quarter three and will write to Trusts shortly to confirm the withdrawal of funding in any specialties previously highlighted where there has been a continued underdelivery against agreed levels of core activity.

There has also been an underdelivery of core capacity in specialties other than those where funding has been withdrawn. However, the Board has decided not to take action in relation to these specialties, either due to the level of under delivery or where there are particular mitigating circumstances.

Question 6 - Has the Department/HSCB costed a move to a Referral to Treatment measurement?

A move to a Referral to Treatment measurement has not been costed. A 25-week 'RRT' target had been planned for Northern Ireland in the 2008 *Programme For Government* but this was discontinued due to public sector funding pressures, which made it unlikely that the level of investment required to deliver the target would be available to the HSC in the immediate future. Instead, efforts were refocused on working to ensure the HSC met existing targets so that, regardless of the measurement adopted, waiting times were minimised for patients.

Question 7 - In relation to the disparate reporting systems used across the HSC, why are the new IT systems in place not able to link the reporting systems?

There are a number of points to be considered in response to this question.

From a technical perspective, measurement of the time taken to complete a referral to treatment pathway requires full coverage of data on all patients for each stage of the pathway included in the measurement and an ability to link that data in a consistent manner, to facilitate the measurement of the entire care pathway.

All data would need to be on a database system of some sort. For example, currently there is approximately 5% of consultant-led outpatient activity that is not recorded on the Patient Administrative System (PAS) for reasons such as limited access to PAS, choosing to use other systems separate from PAS etc. This translates to approximately 2% of outpatient waits which are not included in the current information system, which Trusts manually supplement to their information returns to the Department.

In addition, there are elements of a full care pathway that may not currently be recorded on any system, such as the time it takes to make a decision to send the patient for a diagnostic service or the waiting time between the reporting of a patient's diagnostic test and a decision to admit a patient to an inpatient setting.

I trust you find this response helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

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Appendix 4

Research papers

Research and Information Service Briefing Paper	**Waiting Times for Elective Care**	**22 November 2013**	**Page 171**
Research and Information Service Briefing Paper	**Waiting Times - Supplementary 'Issues' Briefing on the 18 Week RTT Policy in England and Scotland**	**23 January 2014**	**Page 201**

Research and Information Service
Research Paper

22nd November 2013

Dr Janice Thompson

Waiting Times for Elective Care

NIAR 611-13

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.

Research and Information Service briefings are compiled for the benefit of MLAs and their support staff. Authors are available to discuss the contents of these papers with Members and their staff but cannot advise members of the general public. We do, however, welcome written evidence that relates to our papers and this should be sent to the Research and Information Service, Northern Ireland Assembly, Room 139, Parliament Buildings, Belfast BT4 3XX or e-mailed to RLS@niassembly.gov.uk

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 is 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 waiting[2]:

- 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. It also presents evidence that there are policies in place across the UK and other countries[7] 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 RaISe 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

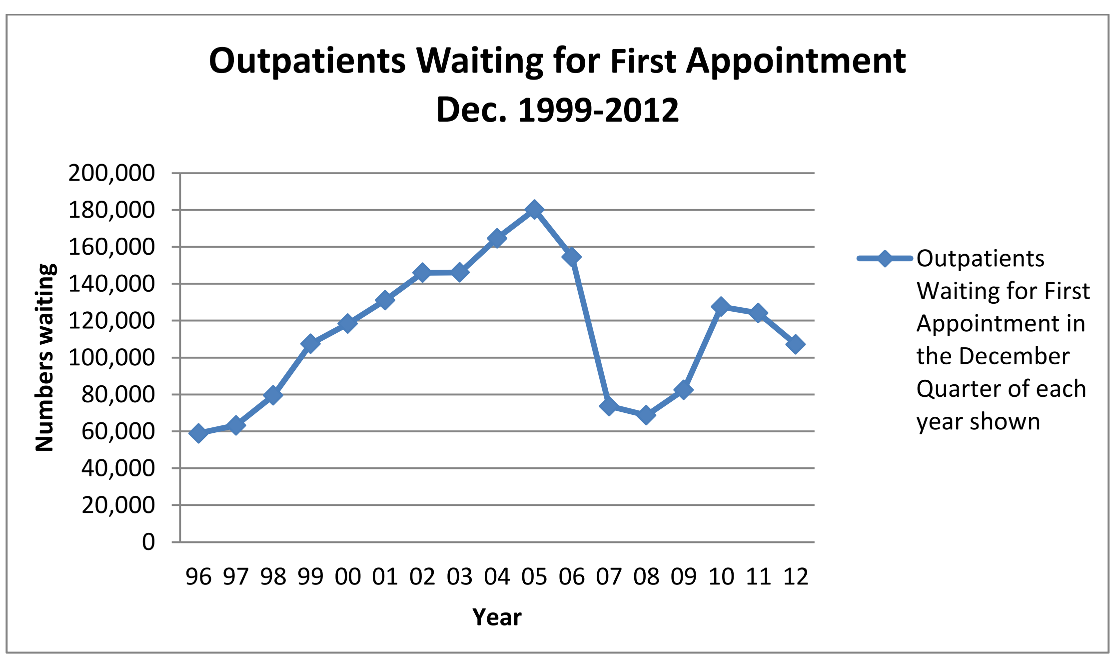
[12] DHSSPS, *Northern Ireland Waiting Lists: September 2010, Technical Notes*, published December 2010

[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 Febraury2012

bulletins as published on the DHSSPS website[15] 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 years[17])



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).

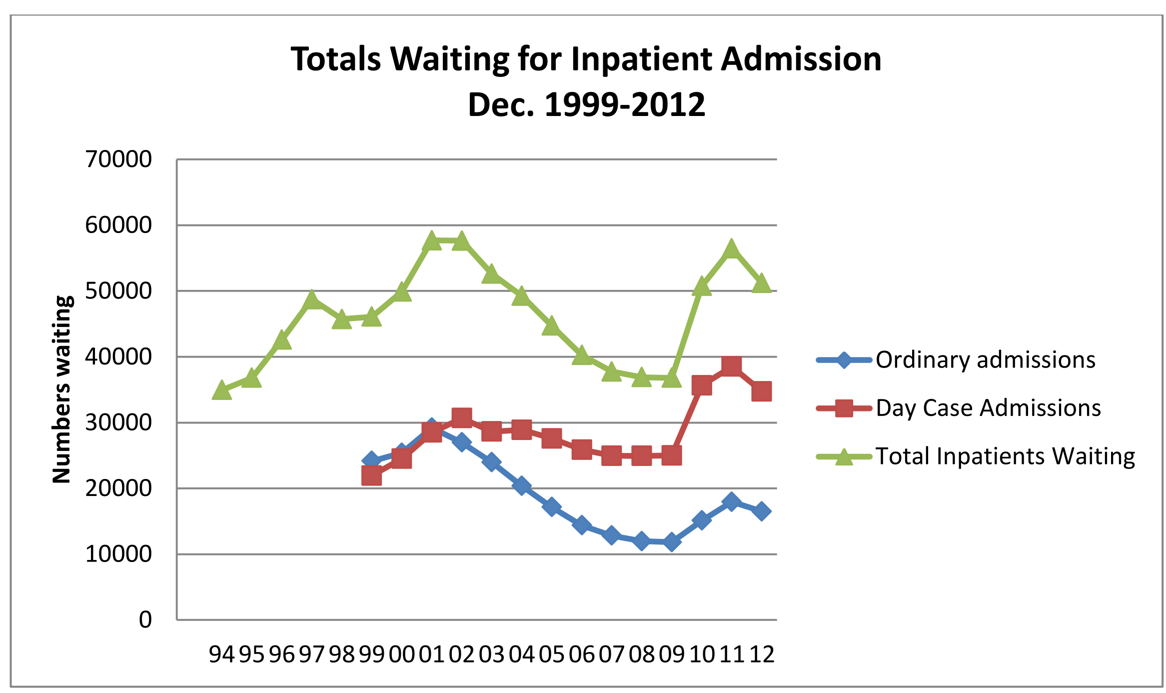
[15] http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/waiting_times_main/stats-waiting-times.htm

[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 follows[20]:

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 action[21].

The Framework set out how the Boards were to develop their action plans under four key areas as follows[22]:

(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 issues[23]:

- 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_hscc.htmRefe

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, including[26]:

- 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 2012[27] (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 31st 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 31st 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 31st 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 31st 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 31st 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 31st 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 that[32]:

  > *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 efficiency[33]:

[29] DHSSPS Priority for Action (2008) pages 9-10
[30] Black, Dr LA, RaISe Briefing Paper, NIAR 45-13, Cancelled Outpatient Appoinments, 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 be[34]:

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 England[35] 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 RaISe 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:

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[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 RaISe 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 HEAT[52] 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: **H**ealth Improvement for the people of Scotland - improving life expectancy and healthy life expectancy; **E**fficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS; **A**ccess to Services - recognising patients' need for quicker and easier use of NHS services; and **T**reatment 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 is[58]:

- 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 are[61]:

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 WTs[67] 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 are[68]:

- *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 are[69]:

- 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 countries[70].

4.3.1 Waiting Time Guarantees[71]

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 Guarantee[72];

[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 Provider[74]

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 Policies[75]

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 Policies[77]

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 SIGIC[78] – 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 includes[82]:

- 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 include[85]:

- 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 WTs[86]:

[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 RoI (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 tackled WTs in as sustained and 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; does not hold health care providers to account for not achieving WT targets with the same rigour as has been described for England and does not 'offer' a choice of provider if a target is about to be breached as is possible, for example, in England and Portugal.

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), RaISe, 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

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Dr Janice Thompson

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 England[2] 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 RaISe 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 RaISe paper published in July 2012[7] 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 RaISe questions, 19th July 2012
[7] Thompson J. (July 2012), Waiting Times Supplementary Briefing (July 2012), NIAR 369-12, NI Assembly, RaISe, http://www.niassembly.gov.uk/Documents/RaISe/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 met[12]:

- 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 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 achieved[15]:

(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 times[18]. 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 three0 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 Bate[25]) 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 times[27]:

- **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 Ltd[28], 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 example[30]:

- 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 Trust[31] 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 that[34]:

- 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 HEAT[36] 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 missed, and the 12 week outpatient target also 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**ealth Improvement for the people of Scotland - improving life expectancy and healthy life expectancy; **E**fficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS; **A**ccess to Services - recognising patients' need for quicker and easier use of NHS services; and **T**reatment 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 were[40]:

- 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 of[42]:

- 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 revealed[45]:

- 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 should[46]:

- 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 Ltd[50], 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]

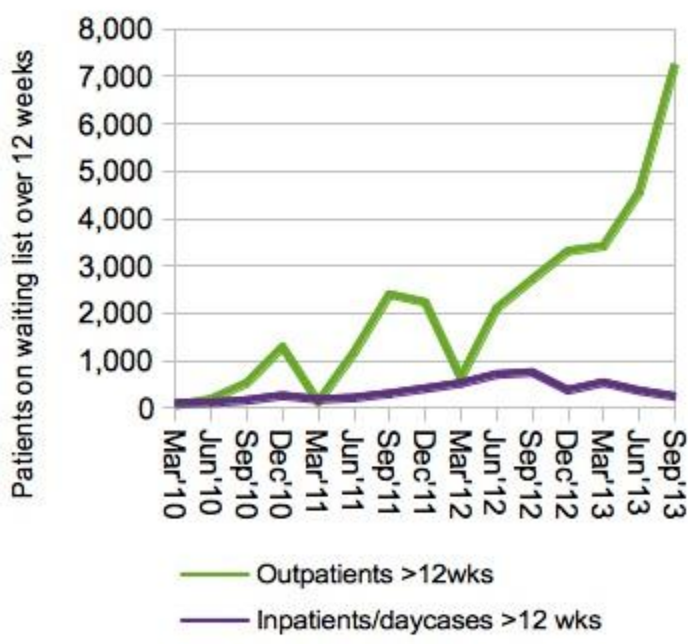
He highlights that both these things can be true because Scotland’s current 18-week target only applies to those patients “*lucky enough to be treated*” Unlike England, there is no ‘live’ target for those patients who are still on the waiting list (see section 2.1 for discussion of tackling ‘hidden waiters’).

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]



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 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 rules[62]:

(i) An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to[63]:

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

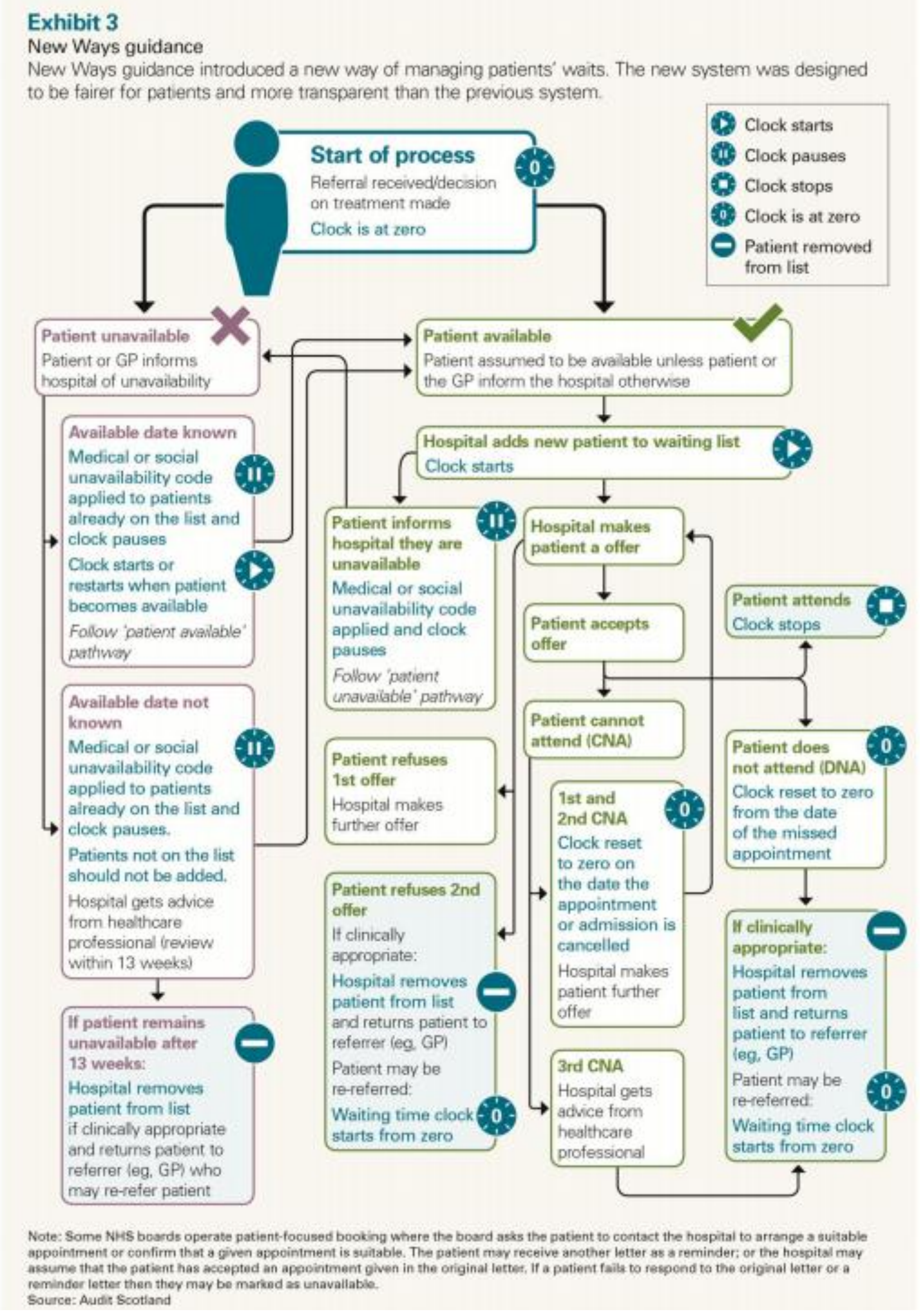
As for England, NHS Scotland also has an extensive website devoted to the publications related to meeting the 18 week target.[65]

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

Appendix 2 'New Ways' Guidance for Scotland[68]



[68] Directly extracted from - Management of patients on NHS waiting lists, Audit Scotland, February 2013, page 11