



Northern Ireland
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Waiting Times – Supplementary Briefing

1. Context

This briefing paper has been prepared as a supplementary briefing to cover issues raised by the Committee for HSSPS in response to the RaISe paper (NIAR 820-11) entitled *Northern Ireland Waiting Lists: Current and Historical Trends for Outpatients, Inpatients and Diagnostic Services*, 26th April 2012. The areas covered by the briefing include:

- A review of the key messages from the April 2012 RaISe briefing paper with the addition of a brief update of the latest waiting times in Northern Ireland for June 2012;
- The various waiting time targets/standards across the UK – rationale and measurements used;
- The private practice work of consultants – a brief history of the private work of consultants; the consultant contract; guidelines on private work; and any potential impact on waiting times; and
- Other issues for Northern Ireland including financial penalties for Trusts not meeting waiting time targets; Outpatient ‘review’ appointments; and the measures in place in

Northern Ireland to address waiting lists and the success or otherwise of these initiatives.

2. Update of Key Messages from RaISe Briefing Paper (April 2012)

Outpatient waiting numbers have generally continued to rise over the past two years and at the end of December 2011 the total number of people waiting for a first outpatient appointment in Northern Ireland was 124,100. This is still below the 2006 peak of the last decade, when over 180,000 were waiting for a first outpatient appointment.¹

To update the situation, the total number waiting for a first outpatient appointment at the end of March 2012 showed improvement with 103,007 waiting. This represents a decrease of 17% since December 2011 and a 3% decrease from March 2011.²

The 2011/12 Ministerial waiting time target states that (i) at least 50% of patients should wait no longer than nine weeks, and (ii) no patients should wait longer than 21 weeks for an outpatient appointment.³

The most recent figures indicate a substantial improvement in the last quarter as at the end of March 2012, 28,277 (27.5%) were waiting more than nine weeks, which is a decrease from the 47.8% waiting more than nine weeks at end December 2011 and the 30.0% waiting more than nine weeks at the end of March 2011.⁴ The number of people waiting more than 21 weeks has also improved substantially in the last quarter as 5,903 patients were waiting more than 21 weeks compared to 24,270 at end December 2011.⁵

Inpatient waiting numbers have risen over the last two years and there were 56,470 people waiting for inpatient admission at the end of December 2011. This is just below the peak (of the last decade) in 2002 when almost 60,000 patients were waiting for inpatient admission. Much of the recent rise is related to increases in Day Case admissions.

The 2011/12 Ministerial waiting time target states that **“at least 50% of patients should wait no longer than 13 weeks, and no patient should wait longer than 36 weeks, for inpatient admission.”**

¹ Thompson J. and Egerton L. Northern Ireland Waiting Lists: Current and Historical Trends for Outpatients, Inpatients and Diagnostic Services, April 2012, NI Assembly Research and Information Service (RaISe), currently unpublished

² Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

³ DHSSPS, *Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending December 2011*, Statistics Release, published February 2012

⁴ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

⁵ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

The most recent figures for quarter ending March 2012 indicate improvement, with the total number waiting for inpatient treatment being 50,828 (10% less than the previous quarter and 3.9% less than the same quarter last year⁶). There were 18,109 (35.6%) patients waiting more than 13 weeks which was a decrease of 6,059 on the previous quarter, but up 479 on the numbers at the end on March 2011. The March 2012 figures indicate that 775 patients were waiting longer than 36 weeks, a decrease of 4,238 on the previous quarter and 486 down on the number waiting at that time last year.⁷

Waiting times for **diagnostic tests and procedures** have only been published since 2007 and at end December 2011 were at their highest point since publication began in December 2007. The total number of patients waiting at the end of March 2012 for a diagnostic service was 60,912, a decrease of 6.9% on the previous quarter and a decrease of 1.9% on the number waiting at end of March 2011.⁸

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*”.⁹ Figure 1a in the RalSe April 2012 briefing showed the reduction at that time from the peak of around 180,000 in 2005 to the lowest figure, of the last decade, of just under 69,000 in 2008. It also showed that during 2007 to 2009 the rate of reduction slowed then reversed. Figure 1b in the RalSe briefing showed that since then, outpatient waiting times had generally increased to the end of 2010; followed by a levelling out over the year to December 2011 (a brief decrease was seen in the March 2011 quarter). Improvements seen in the last quarter now take the outpatient waiting numbers to a level last seen in 2007.

The PAC identified that the success in tackling waiting times was in part due to the DHSSPS funding additional treatments in the independent sector and the PAC “*warned of, and the DHSSPS acknowledged, the dangers of ‘a quick-fix approach’ since it fails to deliver a sustainable solutions...*”¹⁰. 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 waiting times and these are described further in Section 6 of the April 2012 briefing.

Purchase of additional capacity from the independent healthcare sector has continued with over £57million being spent in 2009/10, the substantially lesser amount of over

⁶ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

⁷ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

⁸ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

⁹ 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

¹⁰ General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland – 2010-2011, Paragraph 3.2.1, http://www.niauditoffice.gov.uk/index/publications/recent_reports/report_gen_report_hssc.htm Refe

£24million being spent in 2010/11 and an increased spend again of over £52million in 2011/12 (see section 5 for further details).

Waiting times and related targets are currently measured differently in Northern Ireland from the rest of the UK. **In England, Scotland and Wales the complete patient journey time from GP Referral to Treatment (RTT pathway) is measured and the targets are based around that journey time. In Northern Ireland the total journey time of a patient is not measured** by the DHSSPS.

In both England and Scotland the target is that a patient should begin their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

The NHS Operating Framework for 2012/13 for England retains the RTT target that 90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral but in order to sustain delivery of these targets (and due to concern over long-waiters), now also 92% of patients who have not started treatment should have been waiting no more than 18 weeks.¹¹ This latter edition to the targets is “*welcome as it should prevent a backlog of long-waiters from building up in the first place*”.¹²

The Scottish Government has established HEAT¹³ standards for 2012/13, 90% of planned / elective patients to commence treatment within 18 weeks of referral and no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic.¹⁴

In Wales the target is that at least 98% of patients are to be referred for treatment within a maximum of 26 weeks, with no patient waiting longer than 36 weeks.

Although Northern Ireland retains separate hospital waiting time targets for outpatient, inpatient and, more recently for diagnostic services, the DHSSPS has acknowledged that from a patient’s point of view a single target covering the entire pathway from GP referral to starting treatment is a more relevant and understandable measure and is one to which it had hoped to move.¹⁵ In 2008, the NI Executive’s ‘Programme for Government’ and the Department’s ‘Priorities for Action’ included the aim to move to a total journey time of 25 weeks by March 2011.

¹¹Referral to Treatment Statistics, Referral to Treatment Waiting Times Clock Rules and FAQ, Department of Health, webpage last modified 2/02/12, http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

¹² Findlay, R, Disarray on waiting times targets, Health Service Journal, 24th December 2011, <http://www.hsj.co.uk/disarray-on-waiting-times-targets/5039698.blog>

¹³HEAT stands for **H**ealth **I**mprovement, **E**fficiency, **A**ccess to Services and **T**reatment. It is an internal NHS performance management system that includes targets that support National Outcomes. NHS Boards are accountable to the Scottish Government for achieving HEAT targets, <http://www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/recovery/HEAT/background>

¹⁴ Health Service Provision, Waiting Times, High Level Summary of Statistics Trend Last Update: Tuesday Feb 28th 2012, <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

¹⁵ Response from DHSSPS - Departmental Assembly Liaison Office to RaISe questions, 19th July 2012

However, it became evident to the DHSSPS that the level of funding required to implement a 25-week 'Referral to Treatment' target would not be available to the DHSSPS and "*efforts were refocused on working to ensure that the HSC meets the existing targets so that regardless of the measurement we adopt, waiting times are minimised for all patients at all stages of their care pathway*".¹⁶

3. The Measurement of Waiting Time Targets and Standards Across the UK

3.1 Are the Targets and Standards Currently being Met Across the UK?

In Northern Ireland - the 2011/12 target for **outpatients** states that (i) at least 50% of patients should wait no longer than nine weeks, and (ii) no patients should wait longer than 21 weeks for an outpatient appointment.¹⁷ The previous 2010/11 target was more ambitious and stated that, "*by March 2011, no patient should wait longer than 9 weeks for a first outpatient appointment*"¹⁸.

The figures for the 31st December 2011 show that at that time the first target (i) above was being met but the second was not as of the 124,100 outpatients waiting then, 47.8% (59,378) patients, were waiting for more than 9 weeks for their first outpatient appointment and 24,720 were waiting more than 21 weeks.¹⁹

The most recent figures for quarter ending March 2012 show a substantial improvement with the first part of the target (i) continuing to be met - 28,277 (27.5%) waiting more than nine weeks but the second part (ii) not being met, however the number of people waiting more than 21 weeks has improved substantially in the last quarter with 5,903 patients were waiting more than 21 weeks.²⁰

However, the present figures would not have met the previous target of "*by March 2011, no patient should wait longer than 9 weeks for a first outpatient appointment*"²¹.

The 2011/12 Ministerial waiting time target for **inpatient treatment** states that (i) at least 50% of patients should wait no longer than 13 weeks, and (ii) no patient should wait longer than 36 weeks, for inpatient admission. The same target was in place in

¹⁶ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

¹⁷ DHSSPS, *Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending December 2011*, Statistics Release, published February 2012

¹⁸ DHSSPS, *Northern Ireland Waiting Lists – September 2010*, Statistics Release, published December 2010

¹⁹ Thompson J. and Egerton L. *Northern Ireland Waiting Lists: Current and Historical Trends for Outpatients, Inpatients and Diagnostic Services*, April 2012, NI Assembly Research and Information Service (RalSe), currently unpublished

²⁰ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

²¹ DHSSPS, *Northern Ireland Waiting Lists – September 2010*, Statistics Release, published December 2010

2010/11²² and previously the 2009/10 target was more ambitious stating that “*from April 2009 no patient should wait longer than 13 weeks for inpatient or day case treatment*”²³.

The most recent figures for March 2012 indicate improvement with the total number waiting for inpatient treatment being 50,828, which is 10% less than the previous quarter and 3.9% less than the same quarter last year.²⁴ There were 18,109 (35.6%) patients waiting more than 13 weeks which was a decrease of 6,059 on the previous quarter but up 479 on the numbers at the end on March 2011. The March 2012 figures indicate that 775 patients were waiting longer than 36 weeks, a decrease of 4,238 on the previous quarter and 486 down on the number waiting at that time last year.²⁵

So at present, based on the March 2012 figures the first part (i) of the current target for inpatient treatment is being met, but the second part (ii) is not. However, the present figures would not have met the previous 2009/10 target of “*by April 2009, no patient should wait longer than 13 weeks for inpatient or daycase treatment*”.

The move to Referral to Treatment (RTT) targets elsewhere in the UK has been fairly recent, 2007 for England²⁶ and for Scotland; a National Plan was published in 2008 as to how the 18 week RTT would be met by December 2011.²⁷ Prior to the RTT targets/standards data was collected on the separate outpatient and inpatient waits as is still done in Northern Ireland.

The main driver behind the RTT Standard is the fact that it measures the total wait of a patient from referral to treatment, whereas inpatient and outpatient waits measure only part of the wait. It does, however, require the linking of patient records across various hospital systems.²⁸ It is not possible at present to measure the total patient journey time in Northern Ireland, “*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*”.²⁹

In England, the RTT target states that 90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral and now also

²² DHSSPS, *Northern Ireland Waiting Lists – September 2010*, Statistics Release, published December 2010

²³ DHSSPS, *Northern Ireland Waiting Lists – September 2009*, Statistics Release, published December 2009

²⁴ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

²⁵ Publication of the March 2012 Northern Ireland waiting list statistics releases, DHSSPS, EIS News Service (OFMDFM), 24 May 2012

²⁶ Personal email communication from Paul Steele, GSI, Department of Health, 30/5/12

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

²⁸ Personal email communication from Paul Steele, GSI, Department of Health, 30/5/12

²⁹ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

92% of patients who have not started treatment should have been waiting no more than 18 weeks.³⁰

The latest statistics for England show that at a national level, 91.2% of admitted patients (measured on an adjusted basis) and 97.5% of non-admitted patients completed their RTT pathway within a maximum of 18 weeks. For patients still waiting for treatment (incomplete pathways) at the end of March 2012, 93.4% were waiting within 18 weeks. Therefore, it appears that presently England is meeting its RTT targets.

The average (median) time waited for patients completing an RTT pathway in March 2012 in England was **8.1 weeks for admitted patients and 3.6 weeks for non-admitted patients**. For patients still waiting for treatment at the end of March 2012 the median waiting time was 5.2 weeks.

In Scotland, the HEAT standards for 2012/13 state that 90% of planned / elective patients to commence treatment within 18 weeks of referral and no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic.³¹

Quarterly statistics available from February 2012 (the fourth publication of 18 Weeks RTT statistics for Scotland) show that in December 2011 the target was met with, 92.0% of completed patient journeys for which an 18 Weeks Referral to Treatment (18 Weeks RTT) waiting time could be measured were reported as being within 18 weeks. The figure for January 2011 was 82.1% and therefore the target was not met in January.³²

As Scotland has more recently moved to this standard the picture is not yet complete and in December 2011 the waiting time could be measured for 87.5% of patient journeys and NHS Boards are in the process of fully implementing upgrades to their systems to improve the data collection.

It appears that the outpatient appointment target is not yet being met as the number of patients on the list who were waiting over 12 weeks for an outpatient consultation following referral from any source increased from 1,275 (0.7% of patients on list) to 6,141 (2.9% of patients on list) between 31 December 2009 and 31 December 2011.³³

³⁰Referral to Treatment Statistics, Referral to Treatment Waiting Times Clock Rules and FAQ, Department of Health, webpage last modified 2/02/12, http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

³¹ Health Service Provision, Waiting Times, High Level Summary of Statistics Trend Last Update: Tuesday Feb 28th 2012, <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

³² Health Service Provision, Waiting Times, High Level Summary of Statistics Trend Last Update: Tuesday Feb 28th 2012, <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

³³ Health Service Provision, Waiting Times, High Level Summary of Statistics Trend Last Update: Tuesday Feb 28th 2012, <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendWaitingTimes>

In Wales the targets are less ambitious, in terms of time, than those for England and Scotland - at least 98% of patients are to be referred for treatment within a maximum of 26 weeks, with no patient waiting longer than 36 weeks. The latest provisional statistics on referral to treatment times produced by the Welsh Government were released on 10 May 2012 - a total of 83,613 patients were treated during March. Of those patients, 82.2% were treated within 26 weeks and 94.7% were treated within 36 weeks of the date the referral letter was received in the hospital. From these figures, it appears that the targets are not being met; however the latter target of 36 weeks appears close to being met.³⁴

A broader picture is obtained by considering those still waiting and by the end of March 2012 a total of 390,228 patients were waiting for the start of their treatment. Of those patients waiting for their treatment, 94.0% have been waiting less than 26 weeks and 99.6% have been waiting less than 36 weeks from the date the referral letter was received in the hospital.³⁵

3.3 DHSSPS Guidance on Waiting Times Data Collection

The DHSSPS website contains links to a series of guidance documents which outline in detail how the waiting times datasets are collected and defined.³⁶ **For the first outpatient appointment**, the relevant guidance is – *Reporting of Quarterly Outpatient Waiting Time Information (Departmental; Return CH3) – Data Definitions and Guidance Document, Version 1.0 (June 2010)*.³⁷ The guidance covers the definitions of outpatient services, outpatient appointments, first outpatient appointments, DNA (Did Not Attend) and waiting times. It lists sources of referral and covers the collection of the dataset, the reporting and validation of the data.

The guidance outlines that it is the Departmental Return 'CH3' which provides the official monitoring of the Ministerial targets in relation to waiting times for a first outpatient appointment. The return collects information on the number of people and length of time waiting for a first outpatient appointment. The return shows the number of outpatients who are still waiting for their first outpatient appointment, by specialty, at the end of each quarter. The return extracts outpatient waiting time data from the 'CH3 universe' of the HSC Data Warehouse. These data report the number of patients waiting for a first outpatient appointment by weeks waiting.³⁸

³⁴ Referral to Treatment Times, March 2012, Wales,
<http://wales.gov.uk/topics/statistics/headlines/health2012/1205101/?lang=en>

³⁵ Referral to Treatment Times, March 2012, Wales,
<http://wales.gov.uk/topics/statistics/headlines/health2012/1205101/?lang=en>

³⁶ HIB Guidance Manuals, DHSSPS, http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/hib_guidance_manuals.htm

³⁷ http://www.dhsspsni.gov.uk/ch3_data_definitions_and_guidance_document_2010.pdf

³⁸ Reporting of Quarterly Outpatient Waiting Time Information (Departmental; Return CH3) – Data Definitions and Guidance Document, Version 1.0 (June 2010), DHSSPS, page 3
http://www.dhsspsni.gov.uk/ch3_data_definitions_and_guidance_document_2010.pdf

For waiting times for **inpatient admission**, the relevant guidance is *Reporting of Quarterly Inpatient Waiting Time Information (DGHSSPS Inpatient Waiting Time Dataset) Version 1.0 (June 2010)*.³⁹ The guidance covers the definitions of ordinary and daycase admission, planned admission, regular day attenders and night attenders, medical and non-medical suspensions from admission, and inpatient waiting times. It also covers the collection of the dataset, the reporting and validation of the data.

The DGHSSPS Inpatient Waiting Time Dataset provides official monitoring of the Ministerial targets in relation to waiting times for inpatient admission. The dataset contains patient level information and enables the Department to report the number of people waiting for inpatient admission (both ordinary admission and day case admission), and length of time they were waiting, at the end of each quarter, for each HSC Trust and specialty. Hospital Information Branch introduced this methodology (which allows greater analysis of waiting time data than its predecessor) for the collection of inpatient waiting time information at the beginning of 2007/08, replacing the former 'ISoft CH1' return that reported patients waiting in a series of three monthly time bands.⁴⁰

3.4 Further Details of the RTT Standard – England and Scotland

The Department of Health publishes extensive information on its website concerning the RTT standard for England and how it operates, including documents entitled the RTT Clock Rules and Referral to treatment *consultant-led waiting times – How to Measure*⁴¹. The Referral to Treatment (RTT) 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 rules⁴²:

- (i) An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to⁴³:
 - 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;

³⁹ http://www.dhsspsni.gov.uk/ip_waiting_times_data_definitions_and_guidance_document-2.pdf

⁴⁰ Reporting of Quarterly Inpatient Waiting Time Information (DGHSSPS Inpatient Waiting Time Dataset) Version 1.0 (June 2010), page 3, http://www.dhsspsni.gov.uk/ip_waiting_times_data_definitions_and_guidance_document-2.pdf

⁴¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

⁴² Referral to treatment consultant-led waiting times, How to Measure, Department of Health, First published 2006, pages 9-17, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_132485.pdf

⁴³ The RTT clock start date is defined as the date that the provider receives notice of the referral.

- 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;
- (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.

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 2011.⁴⁴ 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.

As for England, NHS Scotland also has an extensive website devoted to the publications related to meeting the 18 week target.⁴⁵

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.⁴⁶

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.⁴⁷

⁴⁴ 18 Weeks The Referral to Treatment Standard, NHS Scotland, and Scottish Government, February 2008, <http://www.18weeks.scot.nhs.uk/downloads/1274889329-18%2BWeeks%2B-%2BThe%2BReferral%2Bto%2BTreatment%2BStandard.pdf>

⁴⁵ <http://www.18weeks.scot.nhs.uk>

⁴⁶ Task and Finish Groups, NHS Scotland, www.19weeks.scot.nhs.uk/task-and-finish-groups/

⁴⁷ Task and Finish Groups, NHS Scotland, www.19weeks.scot.nhs.uk/task-and-finish-groups/

4. The Private Practice Work of Consultants – a brief history, current consultant contract and guidelines

The Committee expressed an interest in understanding further the place that private work plays in the overall work of consultants and any potential impact this may have on the waiting lists. This section summarises the history of the public-private mix in the UK healthcare system, how the current consultant contract aimed to deal with the issue; and the current Code of Conduct in place for consultants with regard to their private practice.

4.1 Brief History of the Private-Public Mix in UK Healthcare

The information in this section is directly extracted and summarised by Klein R., (2005) in Chapter 4 of the book entitled *The Public-Private Mix for Health*.⁴⁸

Overall it appears that “*no consistent strategy or philosophy guided the evolution of Britain’s mix of public-private provision and funding. It was, in fact, determined by the structure of interests created in 1948 and by institutionalised assumptions about what was economically desirable, administratively feasible and politically advisable*”.⁴⁹

A principle enshrined in the NHS, from its launch in 1948, was that all NHS salaried hospital consultants should have the right to engage in private practice. At the time there were concerns in Government about a two-standard system but it was thought that any other solution, given the difficulties in getting the medical profession to accept the NHS at that time, would have endangered the whole NHS project. There were, as now, conditions limiting the exercise of the right to private practice. In the new NHS, consultants could opt to be full-time NHS consultants or on part-time contracts leaving them free to carry on their private practice.

As part of the 1948 deal, hospitals set aside ‘pay beds’⁵⁰ where consultants could treat their private patients. In 1972 a Government report highlighted potential abuses in the ‘pay-bed’ system, although the actual scale of these abuses was not known, with the system apparently giving consultants an incentive to build up their waiting lists to divert patients to their private practices. This type of controversy remained over the decades with a 2000 House of Commons Health Committee Report concluding that there was, at that time, a lack of information making it impossible to ascertain “*the extent to which consultants are failing to meet their NHS obligations because of their private practice*”⁵¹.

In the early 1970’s a negotiated compromise with the medical profession meant the ‘pay-beds’ were to be phased out to the extent that there was to be alternative

⁴⁸ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books

⁴⁹ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 51

⁵⁰ a bed in a National Health Service hospital, reserved for private patients who pay a consultant acting privately for treatment

⁵¹ Health Committee (2000) *Consultant’s Contracts Third Report – Session 1999-2000*. London: The Stationary Office

provision in the independent sector with the construction of private hospitals. However, a change of Government saw this plan abandoned and the right to engage in private practice was extended to all consultants whether on full-time or part-time contracts. The consultants were not allowed to earn more than 10% of the value of their NHS income through private practice at that time.

The growth of privately financed and privately provided acute healthcare accelerated in the 1980s with a growth in private hospital provision and most of the activities are now financed by private insurance schemes.

With the Governments desire to bring down waiting lists and its preferred strategy to divert consultants from private to public practice, by the end of 2002 consultants in England voted against a new contract which would have given NHS managers greater control over consultant's working schedules. Subsequently in October 2003 consultants accepted a modified version of the contract.

In Northern Ireland a new contract was in place by April 2004 but those consultants in post prior to 15th January 2004 had the option of remaining on their previous terms and conditions.⁵²

Around 2000, the Labour Government realised that capacity in the NHS was a major constraint (as well as money) in the short term and subsequently embraced the private sector with a formal concordat.

Klein (2005) believes that that the "*NHS and the private sector have settled down to a successful, if unsanctified, partnership*" and that the "*NHS success in keeping specialist salaries to a relatively modest level by international standards...can be attributed, at least, in part to the ability of consultants to supplement their earnings by private practice*".⁵³

4.2 The Consultant Contract, Private Practice and Code of Conduct

In 2001, the Government expressed a desire for a new consultant contract (as it had been largely untouched since 1948) which would strengthen the hand of NHS employers. The intention was to have a stronger framework of contractual obligations, which would provide greater management control over when consultants work for the NHS.

Specifically with regard to private practice, in 2002, the Secretary of State for Health highlighted that misgivings still remained over the issue of consultants' private practice and its potential to create perverse incentives which negatively influence waiting lists.⁵⁴

⁵² Introduction of the 2004 consultant contract, DHSSPS, Circular HSS (TC8) 1/2004, <http://www.dhsspsni.gov.uk/scu-concontact-2004-consultantcontract.pdf>

⁵³ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 56

⁵⁴ Williams, S. and Buchan, J (2006) *Assessing the New NHS Consultant Contract, A something for something deal?*, The Kings Fund, 2006, page 2, <http://www.kingsfund.org.uk/document.rm?id=6365>

Evidence had also emerged from other sources that led the Government to claim that, while most consultants worked very hard for the NHS, a minority put their private practice before their NHS work.⁵⁵

The focus on private practice set the tone for the drawn-out negotiations on the new contract between the Department of Health and the British Medical Association (BMA) with one of the main underlying problems being that the old contract had never set clear boundaries around what was, and what was not, NHS time:

*“The issue related to accountability, clarity and transparency over consultants’ commitment to the NHS, but this was submerged by ideological clashes over the legitimacy of private practice”.*⁵⁶

The Kings Fund summarised the areas covered by the contract as follows:

*“An imposing array of benefits was ascribed to the new contract. For consultants, they included an increase in earnings and pensions, recognition of the various aspects of their NHS work (including on-call duties) and more flexible working patterns. For patients, there was the promise of better use of consultants’ time and the provision of services that are more responsive to their needs. For the health service, the contract was intended to formalise and support the provision of services over an extended day, allow for flexible timetabling that could help meet service needs at different times of the year, spread work more evenly throughout the day, promote better use of resources through new ways of working and provide greater clarity over private practice”.*⁵⁷

The details of the Consultant Contract (Northern Ireland) 2004 can be found in the DHSSPS publication Consultant Terms and Conditions of Service (NI) 2004⁵⁸ and these are summarised in the BMA publication A New Consultant Contract for Northern Ireland, A Summary by the BMA (NI) Northern Ireland Consultants and Specialists Committee.⁵⁹

The basic working week of the consultant now consists of 10 programmed activities (PAs), separated into:

- Direct clinical care;
- Supporting professional activities;
- Additional HPSS responsibilities: special responsibilities, e.g. Director of Public Health;

⁵⁵ Williams, S. and Buchan, J (2006) Assessing the New NHS Consultant Contract, A something for something deal?, The Kings Fund, 2006, page 3, <http://www.kingsfund.org.uk/document.rm?id=6365>

⁵⁶ Williams, S. and Buchan, J (2006) Assessing the New NHS Consultant Contract, A something for something deal?, The Kings Fund, 2006, page 3, <http://www.kingsfund.org.uk/document.rm?id=6365>

⁵⁷ Williams, S. and Buchan, J (2006) Assessing the New NHS Consultant Contract, A something for something deal?, The Kings Fund, 2006, page 4, <http://www.kingsfund.org.uk/document.rm?id=6365>

⁵⁸ <http://www.dhsspsni.gov.uk/consultants-terms-conditions-of-service-revised-may-2008.pdf>

⁵⁹ <http://www.bma.org.uk/ni/employmentandcontracts/employmentcontracts/consultantscontracts/NICSCsummary.jsp>

- External duties, e.g. trade union duties, work for the Royal Colleges or GMC etc.

With regard to private work specifically, under the contract there is no compulsion to undertake additional PAs and no restriction on private practice earnings. However, one of the HPSS pay progression criteria is that consultants should accept an extra paid programme of activity in the HPSS, if offered, before doing private work. The BMA highlighted the following points in connection with this⁶⁰:

- If consultants are already working 11 PAs (or equivalent) there is no requirement to undertake any more work;
- 11 PAs could equate to less than 44 hours if some work is in premium time;
- A consultant can refuse an extra PA and still work privately but with risk to HPSS pay progression for that year; and
- Any additional PAs must be offered equitably between all consultants in that specialty, if a colleague takes up the sessions there is no detriment to pay progression for the other consultants.

Alongside, but separate to the terms and conditions of the consultant contract, is A Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants, DHSSPS (November 2003). This is an agreement between the BMA (NI) Northern Ireland Consultants and Specialists Committee and the DHSSPS for consultants in Northern Ireland.⁶¹ The code stresses the importance of consultants and employers working together in partnership to prevent conflicts of interest between work in the two sectors.

Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards and the Code should be used at the annual job plan review as the basis for reviewing the relationship between HPSS duties and any private practice.⁶²

The Code is based in the following key principles⁶³:

- HPSS consultants and HPSS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and HPSS work;
- The provision of services for private patients should not prejudice the interest of HPSS patients or disrupt HPSS services;

⁶⁰ A New Consultant Contract for Northern Ireland, A Summary by the BMA (NI) Northern Ireland Consultants and Specialists Committee,

<http://www.bma.org.uk/ni/employmentandcontracts/employmentcontracts/consultantscontracts/NICSCsummary.jsp>

⁶¹ <http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

⁶² A Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants, DHSSPS (November 2003), BMA (NI) Northern Ireland Consultants and Specialists Committee and DHSSPS, paragraphs 1.2 – 1.3

<http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

⁶³ A Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants, DHSSPS (November 2003), BMA (NI) Northern Ireland Consultants and Specialists Committee and DHSSPS, paragraph 1.4

<http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

- With the exception of the need to provide emergency care (to private patients), agreed HPSS commitments should take precedence over private work; and
- HPSS facilities, staff and services may only be used for private practice with the prior agreement of the HPSS employer (the HPSS makes appropriate charges).

With particular relevance to waiting times, the Code specifies that subject to clinical considerations, consultants are expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for HPSS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time. Consultants are required to make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff.⁶⁴

5. Other Issues for Northern Ireland

The Committee for HSSPS were interested in several specific issues in order to further understand the picture for Northern Ireland and RalSe requested that the DHSSPS provide further information in certain areas. These areas are now discussed further below.

Regarding the issue of **financial penalties** – the DHSSPS has confirmed that “*under current arrangements HSC Trusts do not incur financial fines if they fail to meet these elective care targets. Elective care waiting time underachievement by Trusts is addressed through performance management arrangements established by the HSCB working with the PHA*”.⁶⁵

With regard to **Review Appointments**, the DHSSPS has advised that it does not collect data on waiting times for Review Appointments as a Review is generally scheduled for a ‘clinically appropriate’ time, which can range from weeks to years depending on the patient’s case. However, the DHSSPS is aware that that “*there have been instances of patients waiting longer than the appropriate time for their reviews and we have in the past indicated to the HSC the need to ensure review patients are seen in a timely fashion*”.⁶⁶ The DHSSPS advised RalSe that the HSCB Performance Management and Service Improvement Directorate performance manages review

⁶⁴ A Code of Conduct for Private Practice – Recommended Standards of Practice for HPSS Consultants, DHSSPS (November 2003), BMA (NI) Northern Ireland Consultants and Specialists Committee and DHSSPS, paragraph 2.14 -2.15, <http://www.dhsspsni.gov.uk/scu-concontact-niprivate-practicecode-03.pdf>

⁶⁵ Reply to HSSPS Committee from the Minister for HSSPS, COR/432/2012, 30th April 2012

⁶⁶ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

outpatient services to ensure patients are assessed as close as possible to the 'clinically appropriate' time.

HSC patients are transferred to the **independent sector** when demand exceeds HSC capacity to deliver treatment within the specified elective access target waiting times. Table 1 below, provided by the DHSSPS, outlines the number of inpatients and outpatients waiting at the end of March in 2010, 2011 and 2012, together with the respective number of patients treated within the Independent Sector in 2009/10, 2010/11 and 2011/12.⁶⁷

Table 1: Number of inpatients and outpatients waiting at the end of March in 2010, 2011 and 2012, together with the respective number of patients treated within the Independent Sector in 2009/10, 2010/11 and 2011/12.

	Outpatients		Inpatients	
	No. of patients waiting	No. of patients transferred to IS for a first outpatient appointment during the previous year	No. of patients waiting	No. of patients transferred to IS for inpatient admission in the previous year
QE March 2010	86,501	39,488	36,052	21,404
QE March 2011	106,206	18,380	52,880	7,183
QE March 2012	103,007	28,730	50,828	15,905

Source: DHSSPS

The DHSSPS highlight that these figures help to illustrate the impact that transfers to the Independent Sector (IS) have upon the total number of patients waiting. For example, the reduction of 21,108 (39,488 minus 18,380) in the number of patients that underwent a first outpatient appointment in the Independent Sector between 2009/10 and 2010/11 contributed to an increase of 19,705 in the total number waiting for a first outpatient appointment between QE March 2010 and QE March 2011. The reduction in IS transfers in 2010/11 correlates therefore with a steep rise in the total number of patients waiting. This rise was checked in 2011/12, due to a combination of improved waiting list management and additional in year investment.⁶⁸

⁶⁷ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

⁶⁸ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

Table 2 below shows the pattern of spend on waiting list initiatives in the period 2009/10 to 2011/12⁶⁹

	2009/10	2010/11	2011/12
	£m	£m	£m
In House Spend	25.0	34.9	25.8
Independent Sector Spend	57.5	24.7	52.6
Total	82.5	59.6	78.3

At a PAC meeting in 2009, the DHSSPS outlined to the PAC a number of **measures to reduce waiting times** as follows:

- Ensuring patients of the same clinical priority are seen in strict chronological order;
- Pooling of lists between consultants in a specialty to equalise waiting times;
- Partial booking to offer patients a choice of date and time for their appointment;
- Review of clinical templates to ensure that a reasonable allocation of time is given to new, non-urgent referrals;
- Additional evening and weekend sessions; and
- Introduction of Integrated Clinical Assessment and Treatment Services (ICATS) to ensure patients are seen quickly by the most appropriate healthcare professional.

The DHSSPS has advised that all of the above measures were implemented where possible; however *“it is difficult to quantify how successful the first 4 measures were individually. Each step is interlinked and co-dependent on the others”*.⁷⁰

Additional evening and weekend sessions were utilised to provide additional short term capacity and are not envisaged as a longer term solution. As a result of the consultant contract, additional evening and weekend sessions are more costly to provide as they incur a premium payment.

Integrated Clinical Assessment and Treatment Services (ICATS) have been developed and provided approximately 100,000 assessment and treatment slots across the region, in seven specialities in various HSC Trusts as detailed in Table 3 below:

⁶⁹ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

⁷⁰ Response from DHSSPS - Departmental Assembly Liaison Office to RalSe questions, 19th July 2012

Table 3: Integrated Clinical Assessment and Treatment Services (ICATS)

Speciality	Trust Area				
	Belfast	SET	Northern	Southern	Western
Orthopaedics	Belfast	SET	Northern	Southern	Western
ENT		SET	Northern	Southern	Western
Dermatology		SET	Northern	Southern	
Ophthalmology	Belfast	SET	Northern	Southern	Western
Cardiology				Southern	Western
Urology			Northern	Southern	Western

SET – South Eastern Trust

6. Discussion

In a recent development, in a presentation to the Committee for HSSPS concerning the June Monitoring Round, the DHSSPS confirmed that waiting lists have been increasing since mid-2010 and that currently, across all specialties, 120,000 people are waiting for assessments and 50,000 for treatment. To tackle this pressure, the DHSSPS bid for an additional £22million for elective care services. The specialties for which the DHSSPS are bidding are orthopaedics, ophthalmology, general surgery, dermatology and gynaecology. These are the areas in which there is the biggest demand and the highest increase in waiting lists. These are also the areas in which there is the greatest gap in capacity.⁷¹

The DHSSPS confirmed that services in these specialties would be provided by the HSC Trusts and, perhaps, by the independent sector, set in the context of value for money. The DHSSPS confirmed that the prime focus is on reducing waiting lists to deliver the Minister's targets.⁷²

The Chairperson of the Committee, Sue Ramsey, expressed concern that additional money might encourage specialists to see more patients outside normal clinic times, when these patients should have been able to be seen during usual sessions. The

⁷¹ June Monitoring Round and Forecast Out-turn for 2011-12: DHSSPS Briefing, Committee for HSSPS, Official Report (Hansard), 30th June 2012, <http://www.niassembly.gov.uk/Assembly-Business/Official-Report/Committee-Minutes-of-Evidence/May-2012/June-Monitoring-Round-and-Forecast-Out-turn-for-2011-12-DHSSPS-Briefing>

⁷² June Monitoring Round and Forecast Out-turn for 2011-12: DHSSPS Briefing, Committee for HSSPS, Official Report (Hansard), 30th June 2012, <http://www.niassembly.gov.uk/Assembly-Business/Official-Report/Committee-Minutes-of-Evidence/May-2012/June-Monitoring-Round-and-Forecast-Out-turn-for-2011-12-DHSSPS-Briefing>

DHSSPS highlighted that it is this area where the HSC Board's work on demand and capacity analysis is critical - the board is working with the HSC Trusts to determine what their capacity should be and where there is a gap between the level of demand and the capacity to deliver.⁷³

In England, over the past few years, Trusts have responded to waiting time pressures in different ways. Some reduced waiting times by treating 'long-waiters' (those waiting beyond the 18 week RTT target) with detrimental impact on the main 18 week target. Some have stuck to achieving the main target even if the backlog of 'long-waiters' has continued to grow. The new addition to the RTT target for England - 92% of patients who have not started treatment should have been waiting no more than 18 weeks - should tackle the long-waiters in England. However, it has been suggested that the target will be undermined by the financial penalties stipulated in the NHS Standard Contract 2012/13. This Contract lays out in detail the targets and penalties under which the NHS will operate in the forthcoming financial year and states in Section E, clause 43.4 that,

*If in any month the Provider underachieves the 18 Weeks Referral-to-Treatment Standard threshold set out in Section B Part 8.2 (Nationally Specified Events) for any specialty, then the Commissioners shall deduct for each such specialty, an amount calculated in accordance with Section B Part 8.4.....from any payments to be made to the Provider under this Agreement.*⁷⁴

It has been suggested that such a financial penalty should have been replaced with one that "punished Trusts for having too many long-waiters", in line with the new target.⁷⁵

As discussed in Section 4.2, there have been misgivings over the years regarding the impact that the consultants' private work may have on waiting lists and times. It has been commented that the private sector can be seen as "either one of the causes of the problem or as a possible solution".⁷⁶ It has been argued that if consultants devoted all their time exclusively to the NHS then waiting lists would decrease quickly, there would be no 'perverse incentives' for the maintenance of waiting lists and more NHS operations would be performed.⁷⁷

⁷³ June Monitoring Round and Forecast Out-turn for 2011-12: DHSSPS Briefing, Committee for HSSPS, Official Report (Hansard), 30th June 2012, <http://www.niassembly.gov.uk/Assembly-Business/Official-Report/Committee-Minutes-of-Evidence/May-2012/June-Monitoring-Round-and-Forecast-Out-turn-for-2011-12-DHSSPS-Briefing>

⁷⁴ Findlay, R, Disarray on waiting times targets, Health Service Journal, 24th December 2011, <http://www.hsj.co.uk/disarray-on-waiting-times-targets/5039698.blog>

⁷⁵ Findlay, R, Disarray on waiting times targets, Health Service Journal, 24th December 2011, <http://www.hsj.co.uk/disarray-on-waiting-times-targets/5039698.blog>

⁷⁶ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 54

⁷⁷ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 54

However, the problem with this argument is that consultant time is only one of the constraints on the output of elective treatment. For example other constraints are shortage of theatre time; limited bed capacity; other staff constraints.⁷⁸

These other constraints led to the reversal of policy by the Labour Government, several years after coming to power in 1997, when it was recognised that capacity as much as money was the main constraint on improving services at that time. So partnership with the private health sector was the new direction.⁷⁹

These constraints in Northern Ireland, particularly capacity, have recently been highlighted both by the money that has been spent purchasing additional capacity in the independent sector (as referred to in Table 2 above) and by the bid by the DHSSPS in the June Monitoring Round for £22million to provide additional elective care services.

⁷⁸ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 54

⁷⁹ Klein R., (2005) *The public-private mix in the UK*, Chapter 4 of *The Public-Private Mix for Health*, Edited by Alan Maynard, Radcliffe Oxford Books, page 54