

## 3.6 Waiting and access

For public services free at the point of use, waiting has been one way of rationing or delaying access and hence aligning demand and supply. However, while waiting, in the absence of prices, may have a legitimate role in rationing scarce resources (given a fair waiting system), long waiting lists and times are not just a product of finite budgets. The existence of very long waiting times in Northern Ireland compared with England and Scotland, and variations in waiting times within Northern Ireland suggests considerable scope for improving Northern Irish patients' experience of waiting within current resource limits.

Although the numbers of patients waiting can be small in comparison to total activity in the health and personal social services, long waiting times can not only be damaging to patients' health but also increase costs of care. Conversely, the benefits of successfully reducing waiting times are not only reflected in better patient experience of their care (and better health) but also in more efficient health and social services.

In particular, we review data highlighting variations in waiting lists and times - between geographical areas, trusts and specialties. The existence of variations can be a sign of hope - long or excessive waiting may not be an inevitable consequence of the way the system is funded, for example. On the other hand, variations - for example, *within* a system - may suggest that resources are not being used optimally. Moreover, variations can also suggest that the problem is concentrated rather than dispersed across the whole system and hence suggest that particular policies will be more effective than others in tackling the problem.

### 3.6.1 Scale of the problem

Amongst the four parts of the UK, Northern Ireland has some of the longest waiting lists and times for inpatients and outpatients. Here we set out the scale of the problem, starting with waiting to see a specialist in an outpatient department through to waiting for admission to hospital and delays in discharges and waiting for other health and social care services.

#### Box 3.2: Measuring waiting times

How long patients wait can be measured in two different ways: a census (or snapshot) of the length of time patients still on the waiting list have waited; the actual length of time patients waited prior to seeing a specialist in outpatients or being admitted to hospital as an inpatient or day case.

Both ways of measuring waiting are valid, but provide different perspectives on waiting. However, from the patient's point of view, the main concern will be how long they waited having been seen at outpatients or having been admitted into hospital.

While patients who have been to outpatients or have been admitted may be seen relatively quickly, this may give a misleading impression of the way waiting lists are working or being managed.

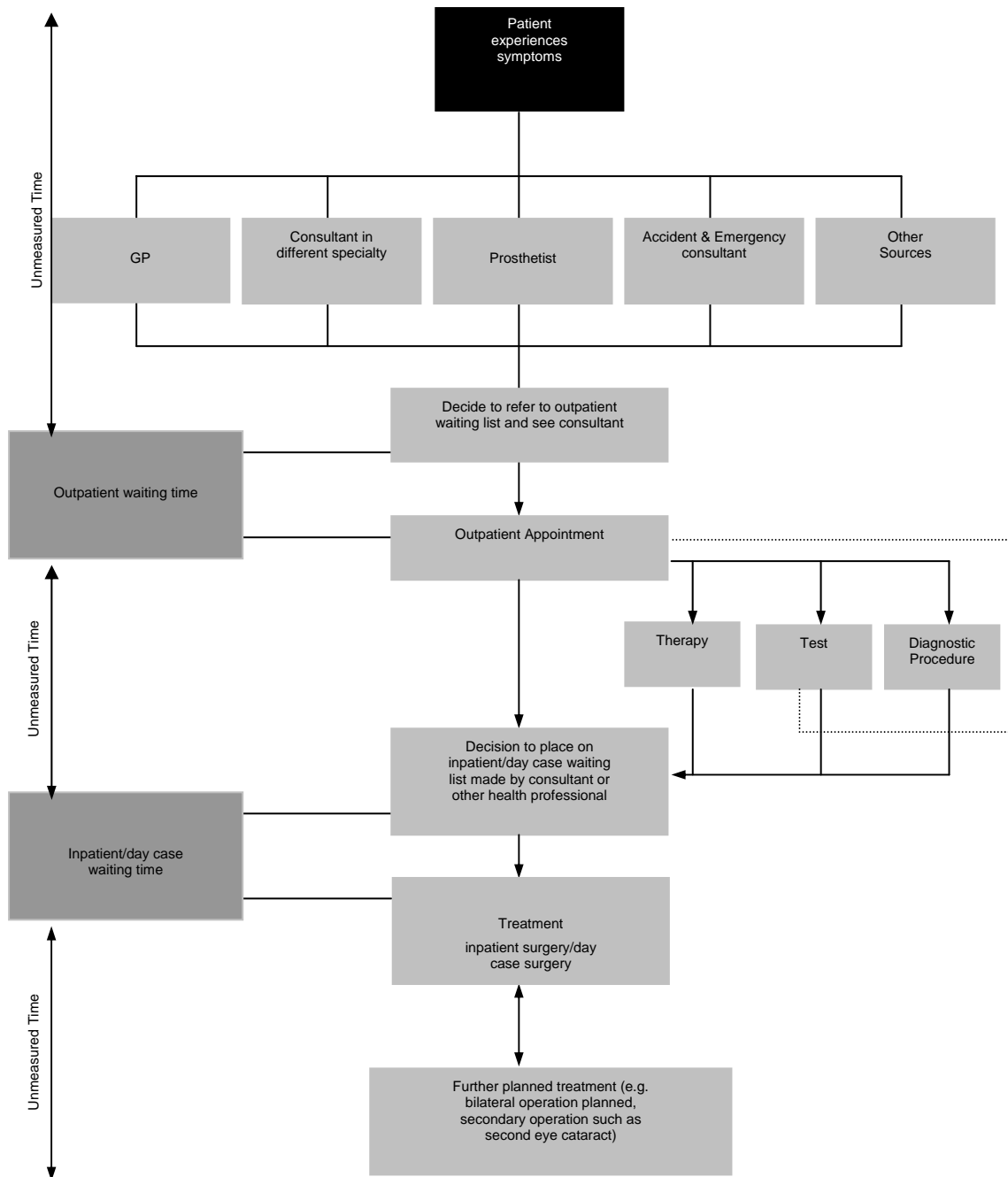
For example, as waiting lists do not operate as strict queues (on a first come, first served basis), but with patients moving around the list depending on changes in the urgency of their condition, the census view of waiting can reveal whether a group (of presumably less urgent cases) are continually bypassed by more urgent patients. The bypassed patients can end up as a 'mortlake' of patients who may never reach the head of the queue.

### Box 3.3: The actual waiting experience.

Official waiting time statistics in Northern Ireland (and indeed in other parts of the UK) do not capture the full waiting time experienced by patients from the time they experience symptoms to the conclusion of treatment. The patient's journey through the health care system, for example, is illustrated in the chart below which shows where the gaps exist in official recording of waiting.

As noted in Box 1, above, the way that waiting lists operate within outpatients and inpatients can also have a significant impact on some patients overall waiting times.

#### *The patient journey and reported waiting times*

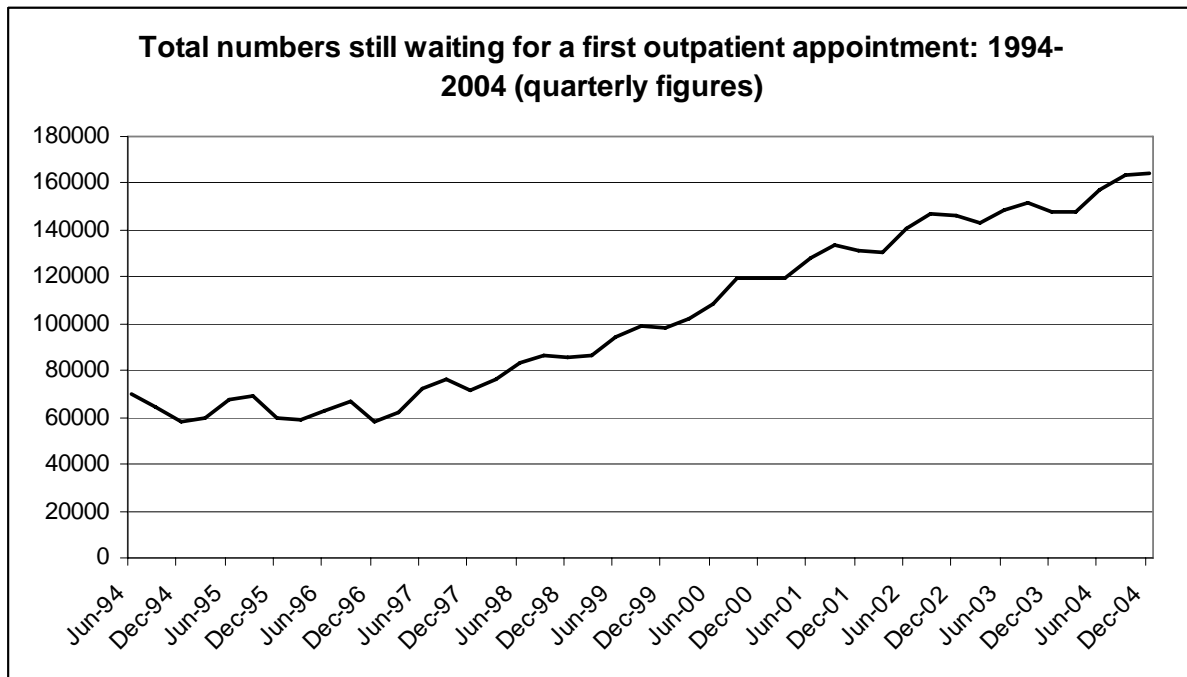


Source: NHS Waiting Times in Wales Volume 1 The Scale of the Problem, National Audit Office Wales

### 3.6.2 Outpatient waiting

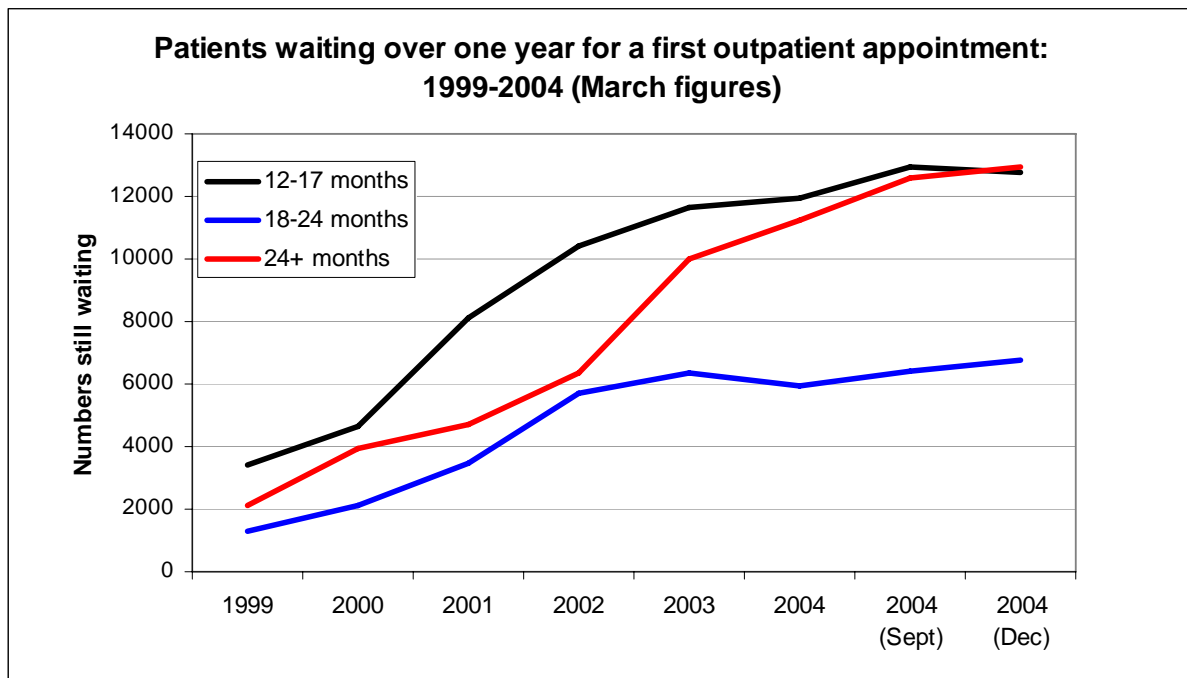
The total number of patients still waiting for an outpatient appointment in December 2004 stood at nearly 165,000. Trends over the last five years have been inexorably upward, and have risen by around 150% since 1994 (see figure 3.22). Nearly one in ten of the total Northern Ireland population is currently waiting to attend for a first outpatient appointment.

**Figure 3.22: Total numbers of patients still waiting for a first outpatient appointment have increased by over two and a half times since 1994.**



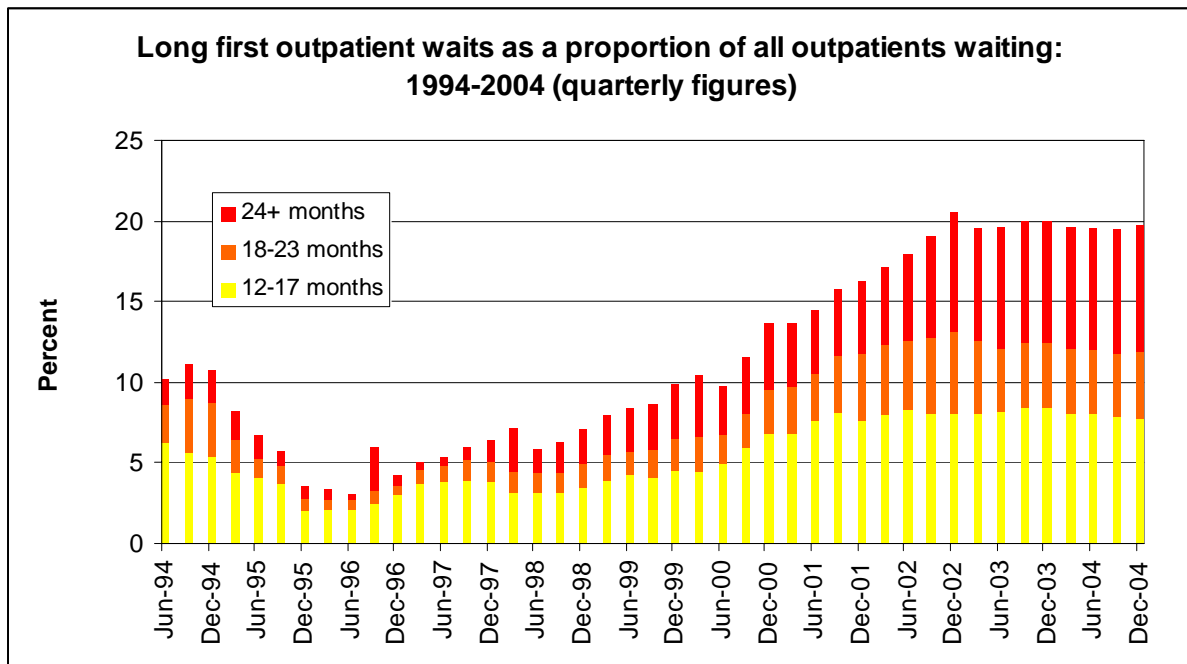
Of more concern to patients is how long they have to wait rather than the length of the queue in front of them. Over the last five years, 'excessive' waits (of more than a year) have risen. The number of people waiting 12-17 months has increased three-fold; those waiting 18 to 24 months four-fold, and those waiting over two years, six-fold (see figure 3.23).

**Figure 3.23: Numbers of patients waiting over one year for a first outpatient appointment have risen over four-fold between 1999 and 2004.**



While those waiting over a year have, since 2002, levelled off, there are no signs of any reductions in the numbers of excessive waits and 1 in 5 people are still waiting over a year for their first outpatient appointment (see figure 3.24).

**Figure 3.24: Although the increase in the proportion of patients waiting over a year for a first outpatient appointment has levelled off recently, nearly one in five are still waiting more than a year and nearly 1 in 12 are waiting over two years.**



The reasons *why* the number of long waits has increased over the last ten years are explored below. However, it seems unlikely that waits have increased either because of lack of funding - spending has increased considerably over the last ten years; or

due to increases in demand - between 1996 and 2002/3, total outpatient attendances rose by just 5% - around 0.5% per year on average.

### 3.6.3 Variations in outpatient waiting times

Apart from variations in waiting times over time, waiting times also vary among specialties, hospitals and in comparison to Wales, Scotland and England.

#### *Variations by hospital*

As figure 3.25 shows, there is considerable variation across hospitals in the share of the total outpatient waiting list across Northern Ireland. Of course, the main explanation for this is the variations in sizes of hospitals and workloads - bigger hospitals will have larger lists. However, as figure 3.26 shows, some hospitals - such as the Royal Group, Green Park and Ulster Community - appear to have a higher share of the total outpatient waiting list than might be expected given the number of GP referrals received.

Figure 3.25: Just three hospitals account for nearly half of the total number of patients still waiting for a first outpatient appointment

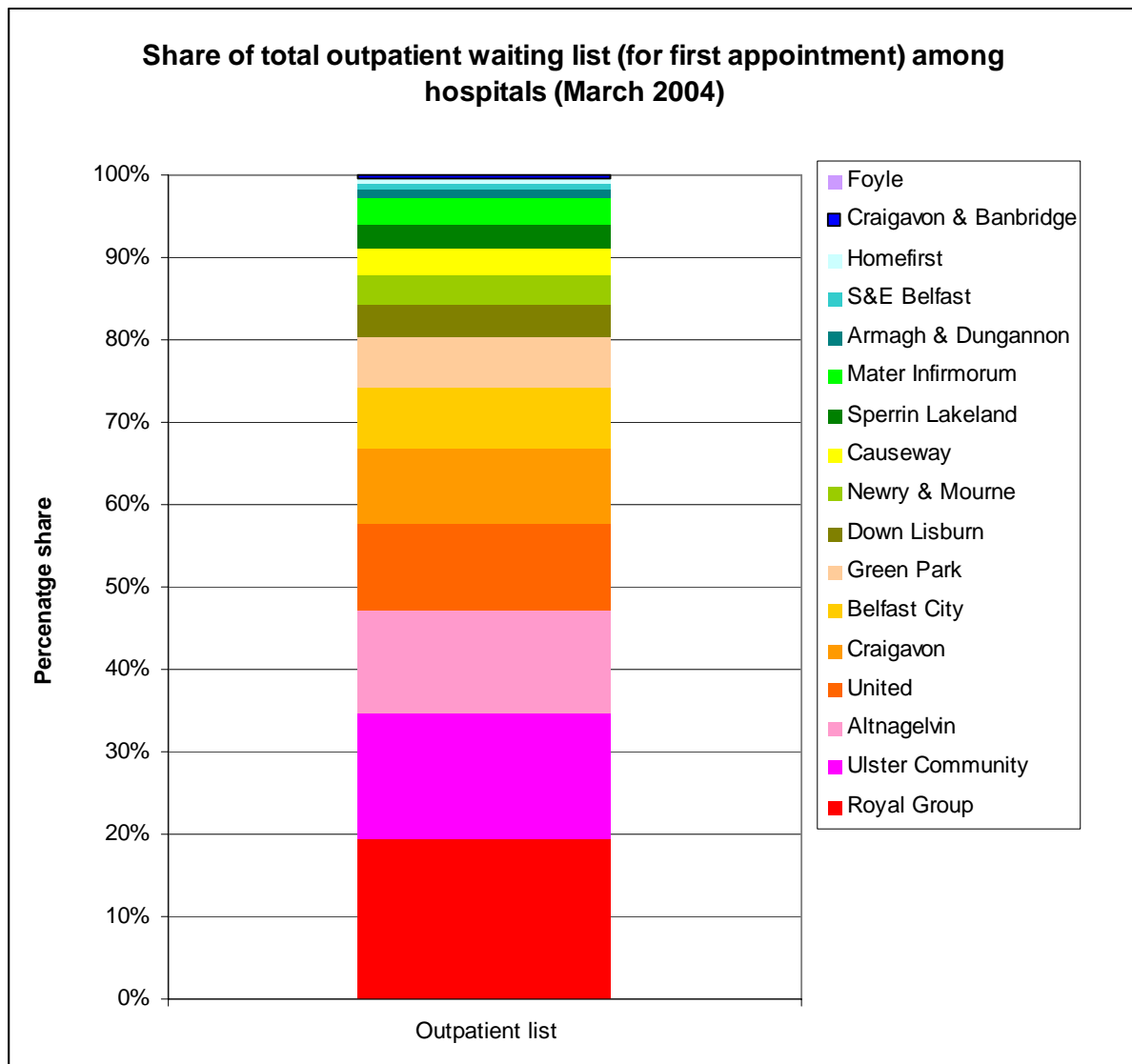
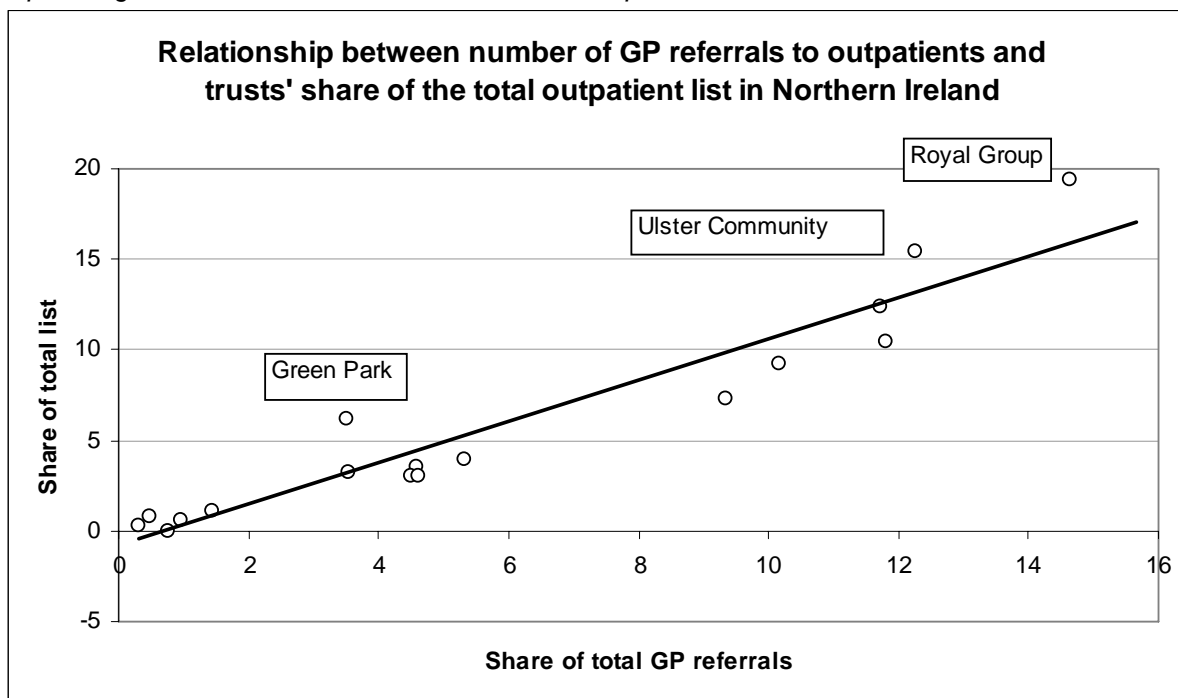


Figure 3.26: Some hospitals have a higher share of the total outpatient waiting list than might be expected given their share of total GP referrals to outpatients



As already stated, however, of greatest concern to patients is the time they have to wait rather than the total size of the list. And as figures 3.27 and 3.28 show, there are significant variations across hospitals in the proportion of those patients waiting over a year and over two years for admission.

Some variation is perhaps to be expected given differences in the sizes of hospitals, local pressures and circumstances. However, as figure 3.29 shows, there is a relationship between trusts' shares of total GP referrals to outpatient departments and their shares of the number of patients waiting over 12 months for a first appointment. However, some hospitals - such as Ulster Community, Green Park and the Royal Group - appear to have a greater share of long wait patients than might be expected given their share of referrals.

Figure 3.27: Over a quarter of patients in two hospitals are waiting more than a year for their first outpatient appointment

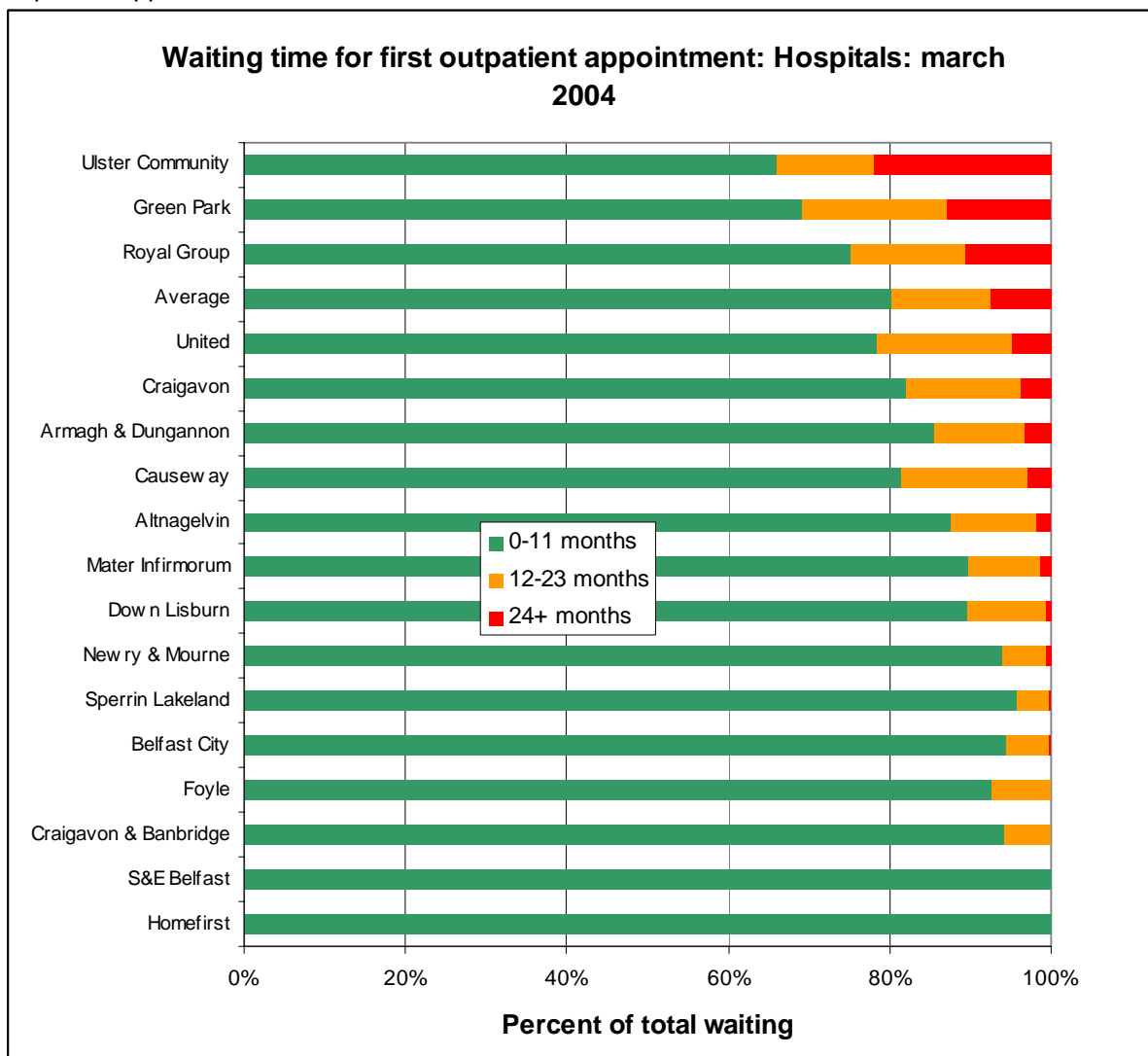


Figure 3.28: Just two hospitals account for 70% of patients waiting over 2 years; five hospitals account for 70% of patients waiting 12-23 months...

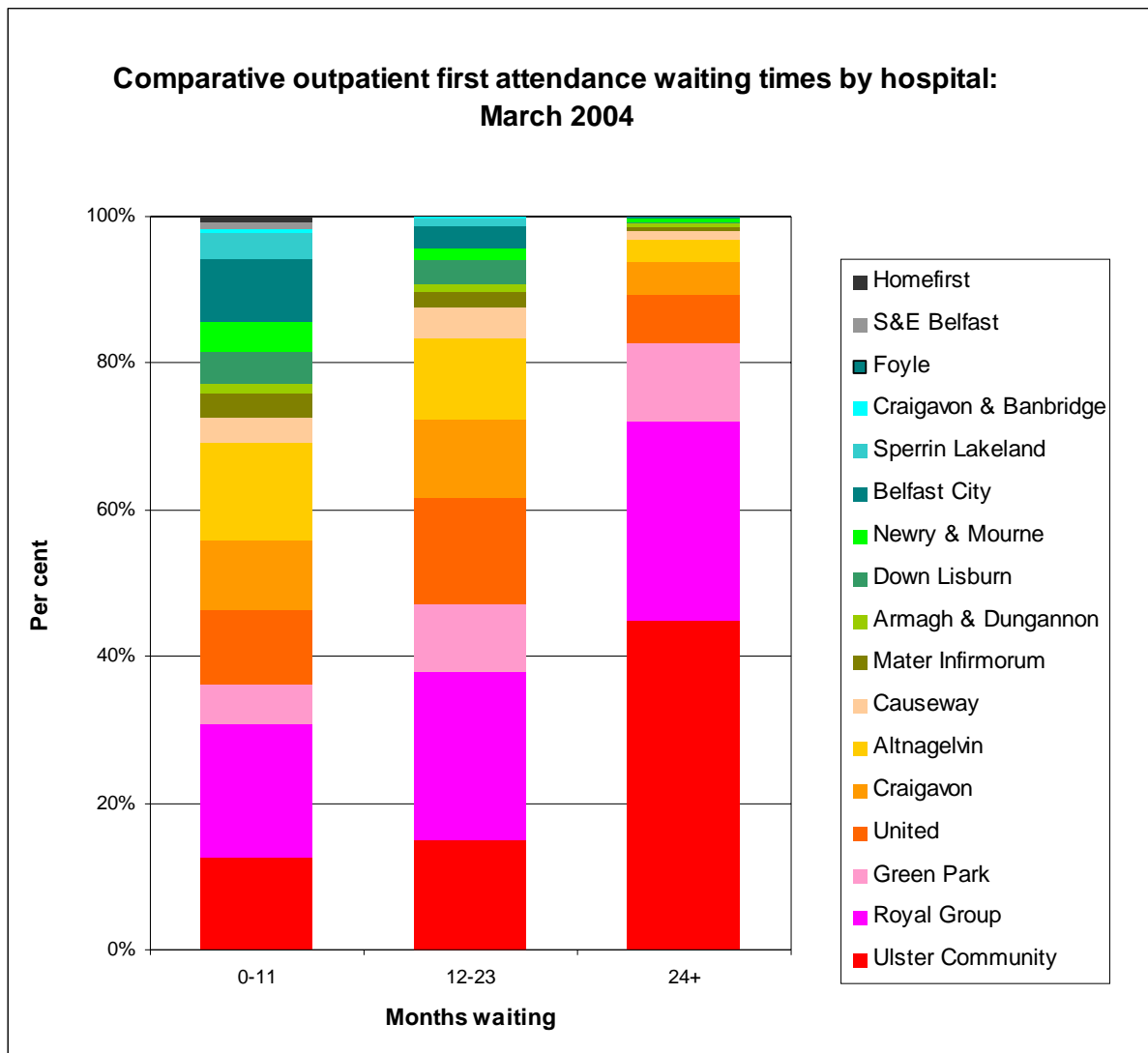
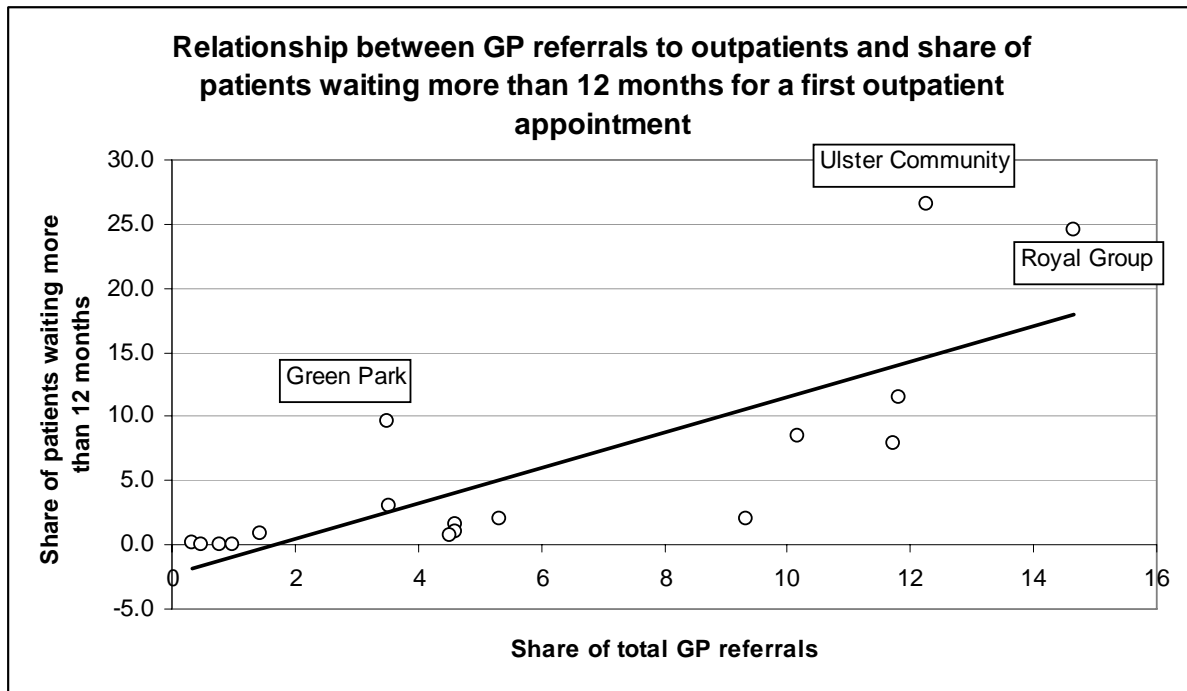
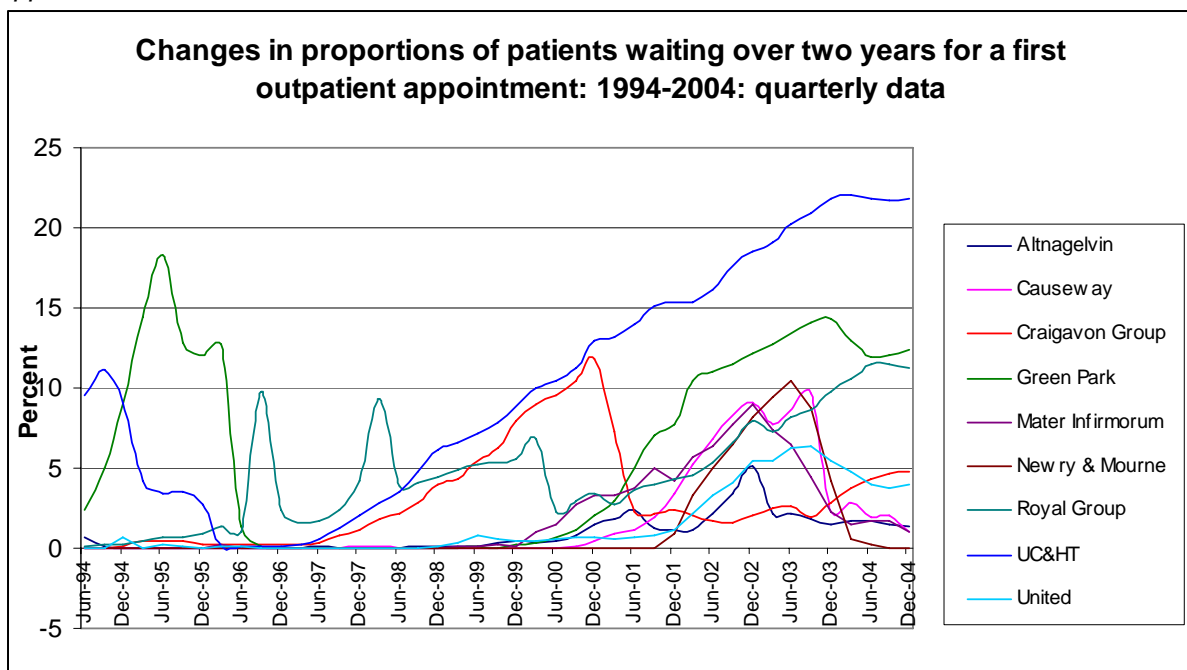


Figure 3.29: Some hospitals have a higher share of the total number of patients waiting more than one year for a first outpatient appointment than might be expected given their share of total GP referrals to outpatients



However, the fact that some hospitals have managed, for example, to virtually eradicate very long waits of over two years while others, with similar proportions waiting over two years in 2002, and although making big reductions over the last two years, have not, suggests that not all the variations in waiting times across hospitals are justified (see figure 3.30).

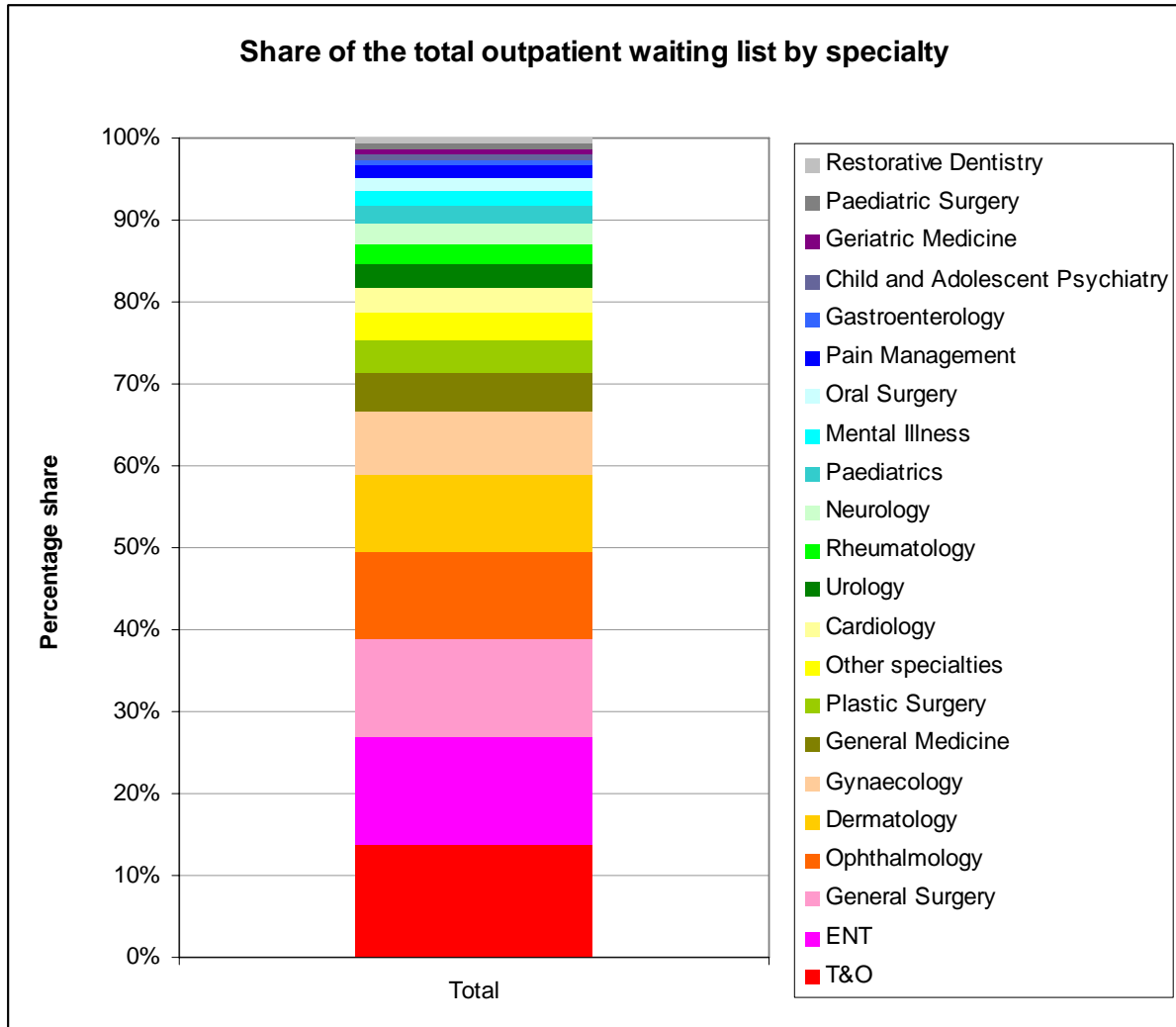
Figure 3.30: Some hospitals have reduced the proportion of very long waits for outpatient appointments; others have not.



### Variations by specialty

Again, as might be expected, there are variations in waiting lists and times across specialties (see figures 3.31, 3.32 and 3.33). And again, much of this variation will be expected given variations in, for example, workloads.

Figure 3.31: Just four specialties account for almost half of all those waiting for a first outpatient appointment in September 2004



However, it is very noticeable that just two specialties - plastic surgery and trauma and orthopaedics - account for over six out of ten patients waiting more than two years for a first appointment in outpatients (see figure 3.32). For plastic surgery in particular, over 60% of patients are still waiting for a first appointment after two years (see figure 3.33).

Figure 3.32: Just two specialties account for over 60% of patients waiting over 2 years for a first outpatient appointment; five specialties account for two thirds of all patients waiting 12-23 months

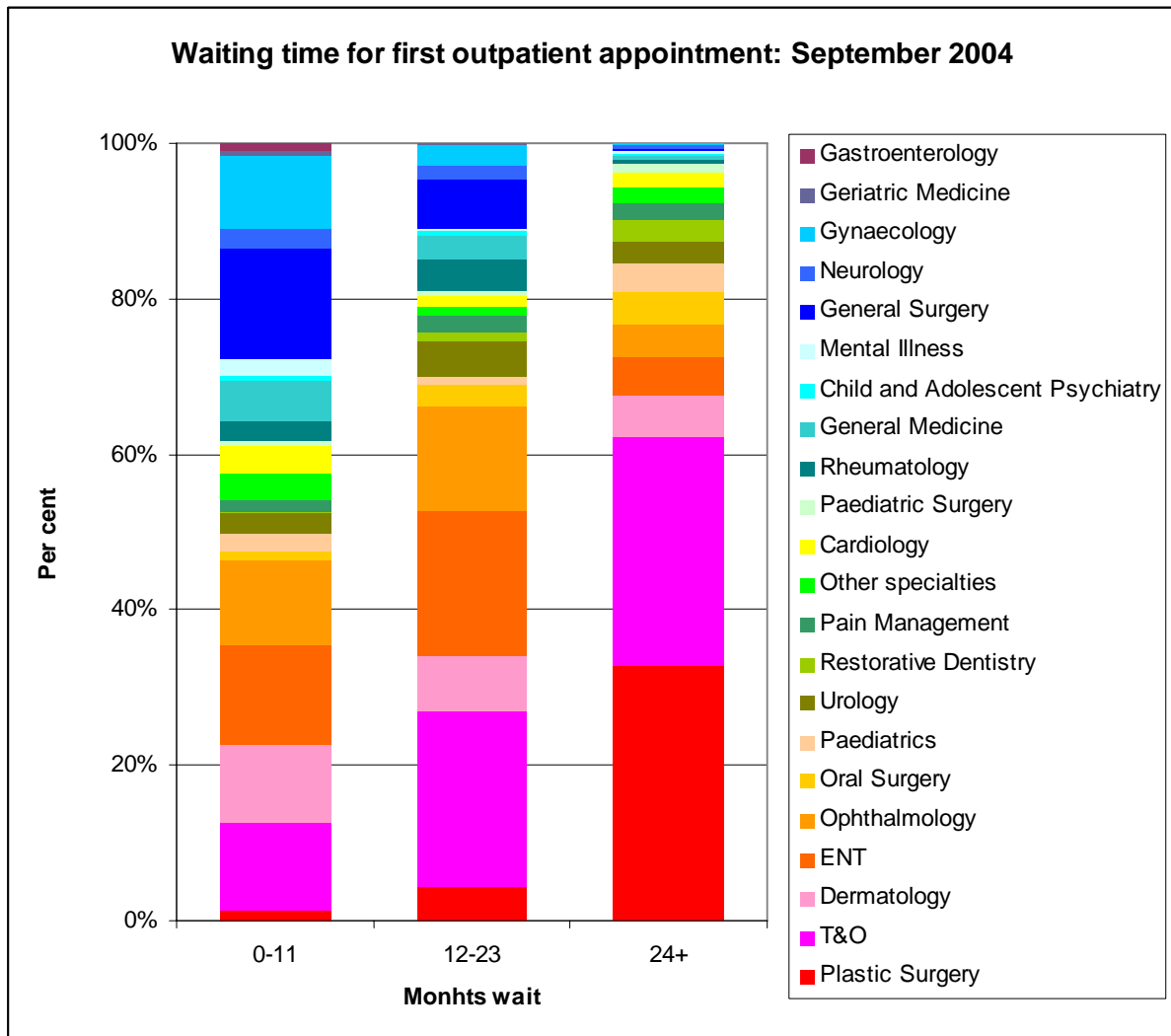
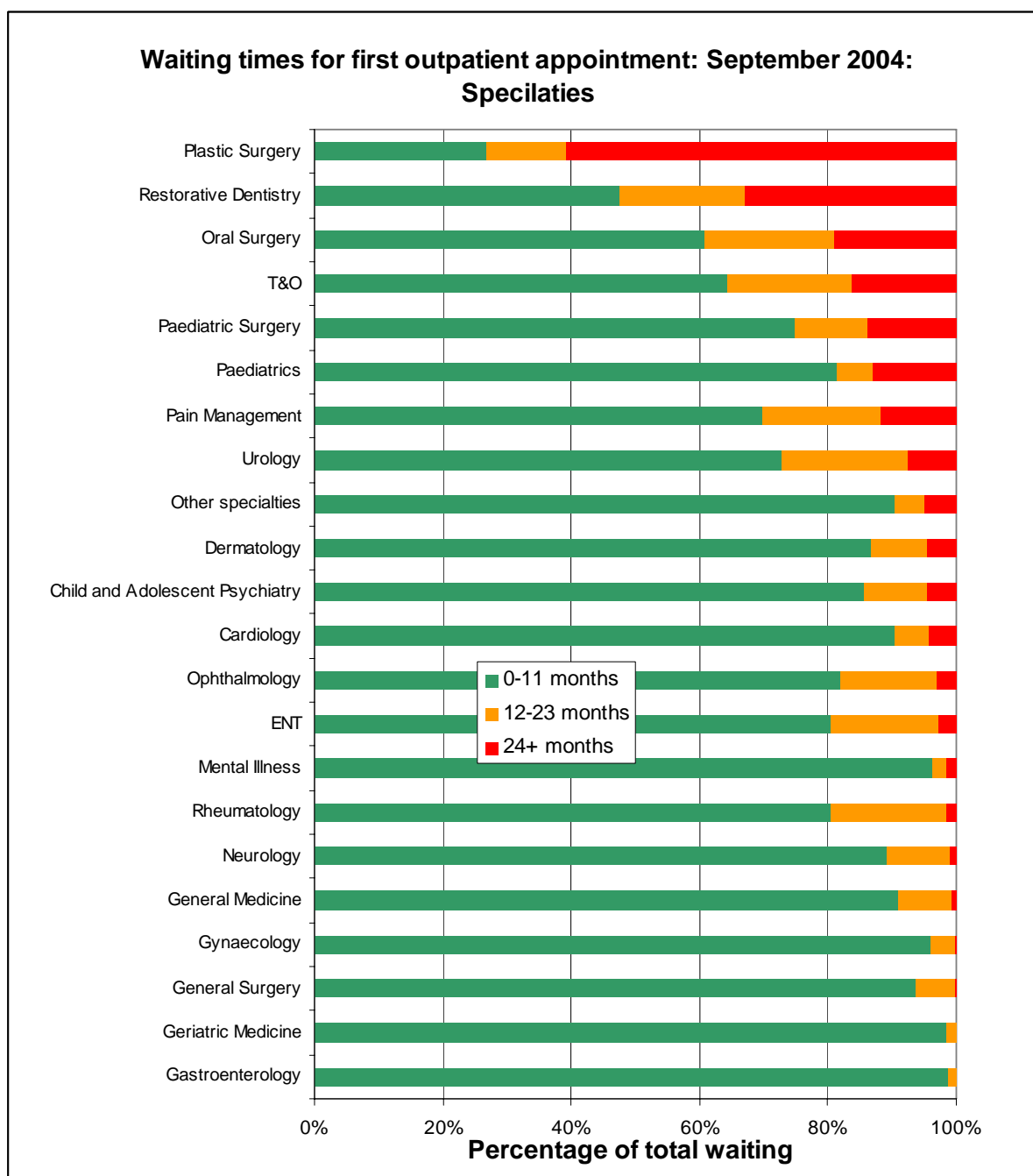
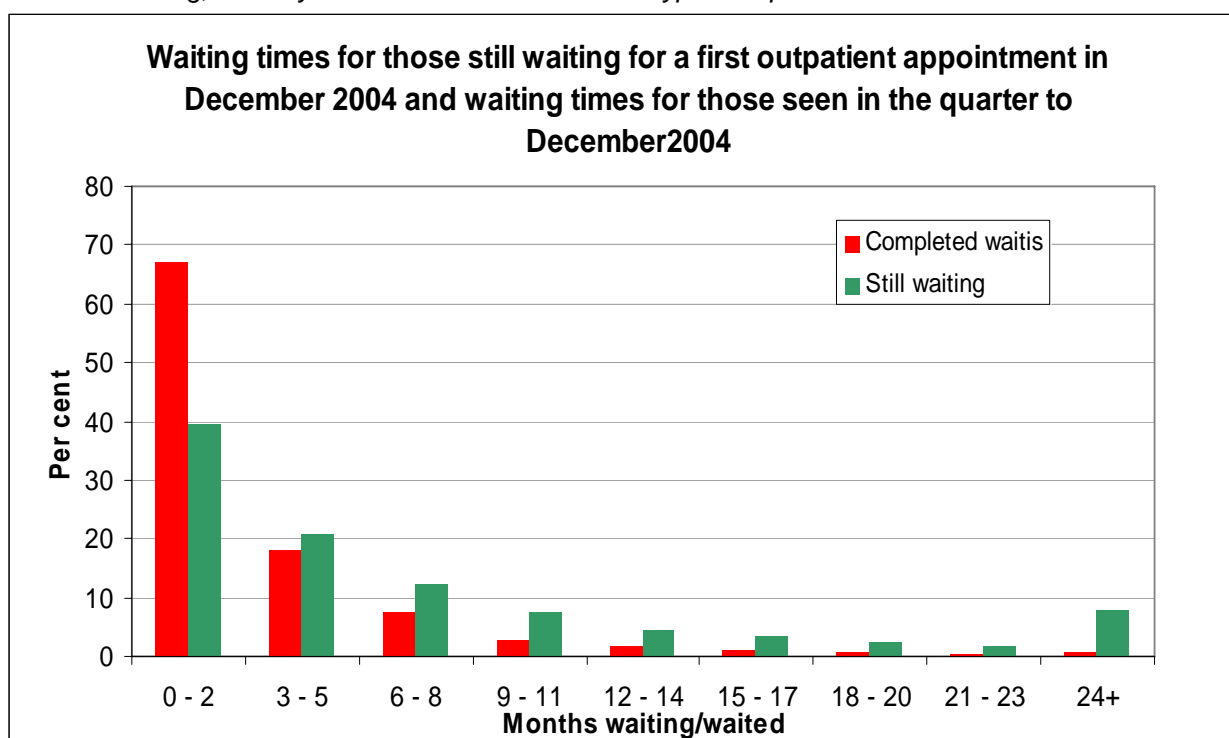


Figure 3.33: Six out of ten Plastic surgery patients are still waiting over two years for a first outpatient appointment; Outpatient waiting time variation among specialties



Another view of waiting is the length of time patients waited once they had had their first outpatient appointment. Figure 3.34 shows a marked difference in the waiting times distributions for those with 'completed' waits and those still on the waiting list. While just over 65% of those who did have an appointment only waited up to two months, the corresponding figure for those still waiting is 40%.

Figure 3.34: Patients who have had a first appointment tend to have waited less time than those still on the list. This is partly due to under 3 month waits being under-recorded by the quarterly census of those still waiting, but may also indicate a 'mortlake' of bypassed patients.



#### Variations across the UK

Comparisons of outpatient waiting lists and times across the UK are difficult to make due to lack of data. Scotland, for example, has no live outpatient list, rendering comparisons with Northern Ireland impossible. And no data is collected in England on the total numbers waiting.

However, figures 3.35 and 3.36 make what comparisons are possible - mainly with Wales. On all the comparisons that are possible, Northern Ireland has the poorest performance, with longer lists per head of population than Wales, proportionately more patients waiting longer than six months (38%) than either England (probably around 1%) or Wales (31%), and far more proportionately waiting over 18 months (12%) than Wales (3%).

Figure 3.35: Northern Ireland has more patients waiting for a first outpatient appointment per head of population compared with Wales and England

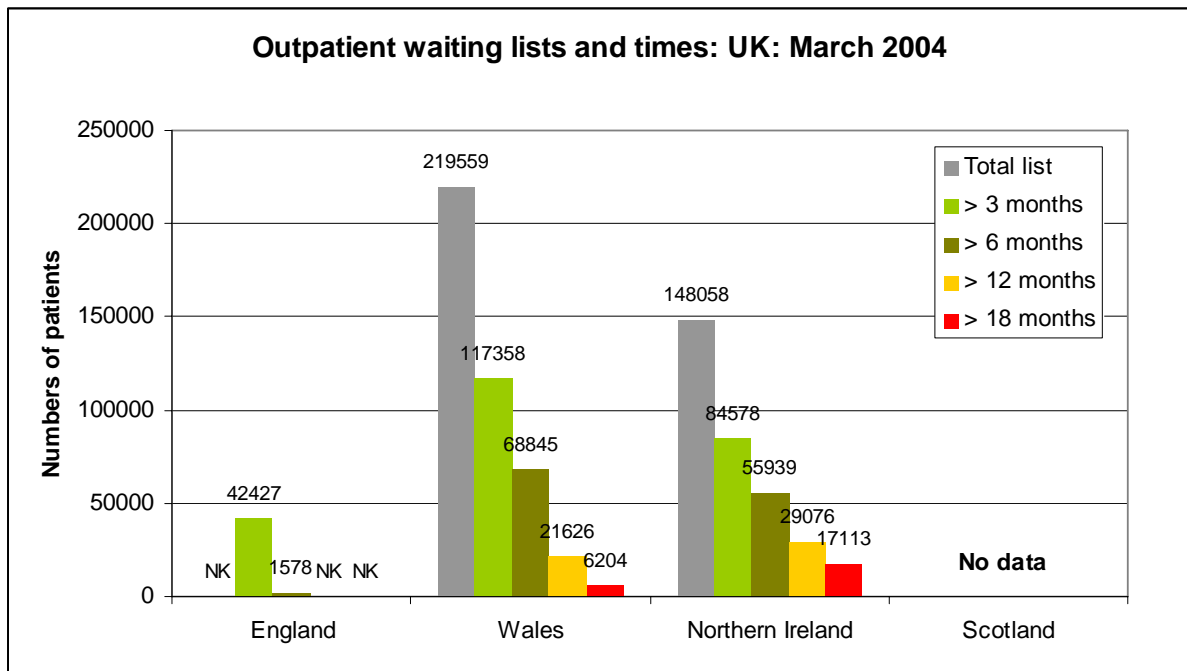
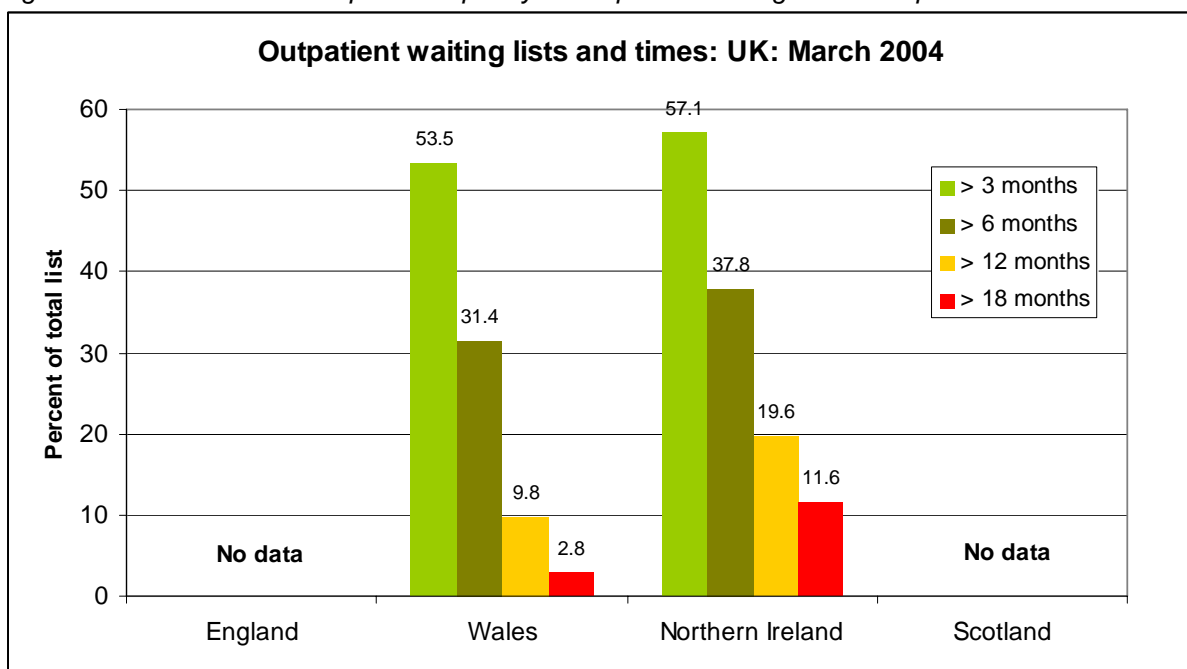


Figure 3.36: Northern Ireland performs poorly on outpatient waiting times compared with Wales

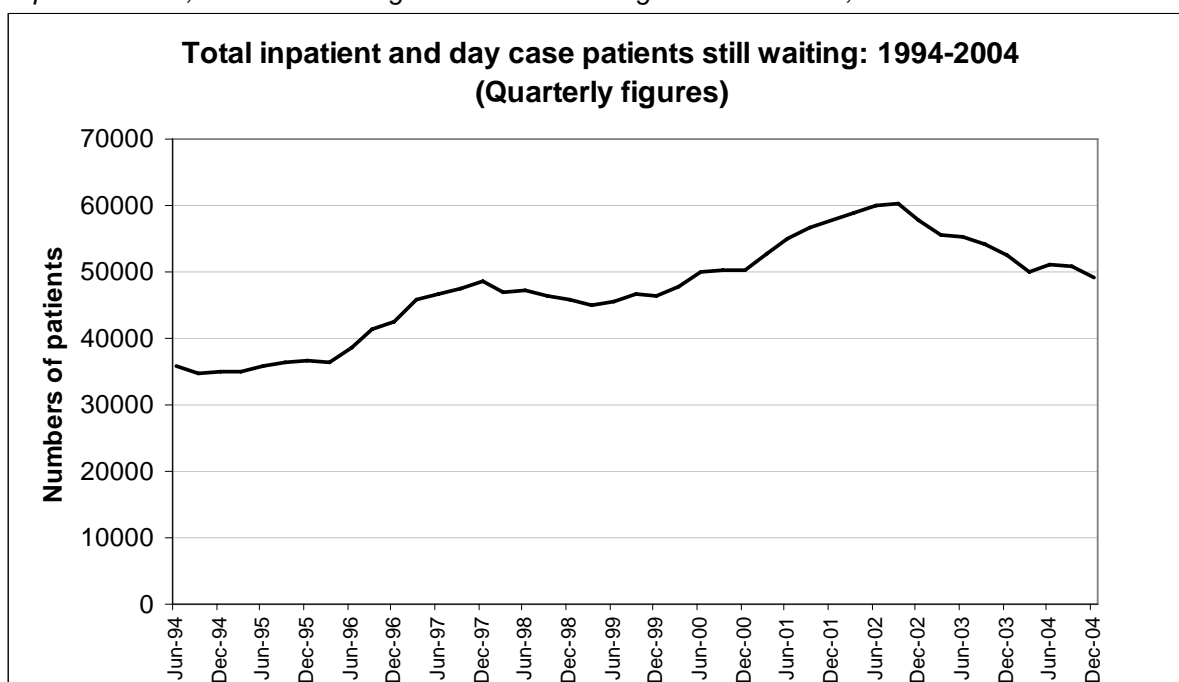


### 3.6.4 Inpatient and day case waiting

In December 2004, just under 50,000 people in Northern Ireland were waiting to be admitted to hospital for inpatient or day case care (see figure 3.37). The December 2004 reduction brings the total numbers of inpatient and day cases waiting to levels at the turn of the century

This represented 3% of the entire population - 15% more than Wales (2.6%), 36% more than Scotland (2.2%) and 67% more than England (1.8%).

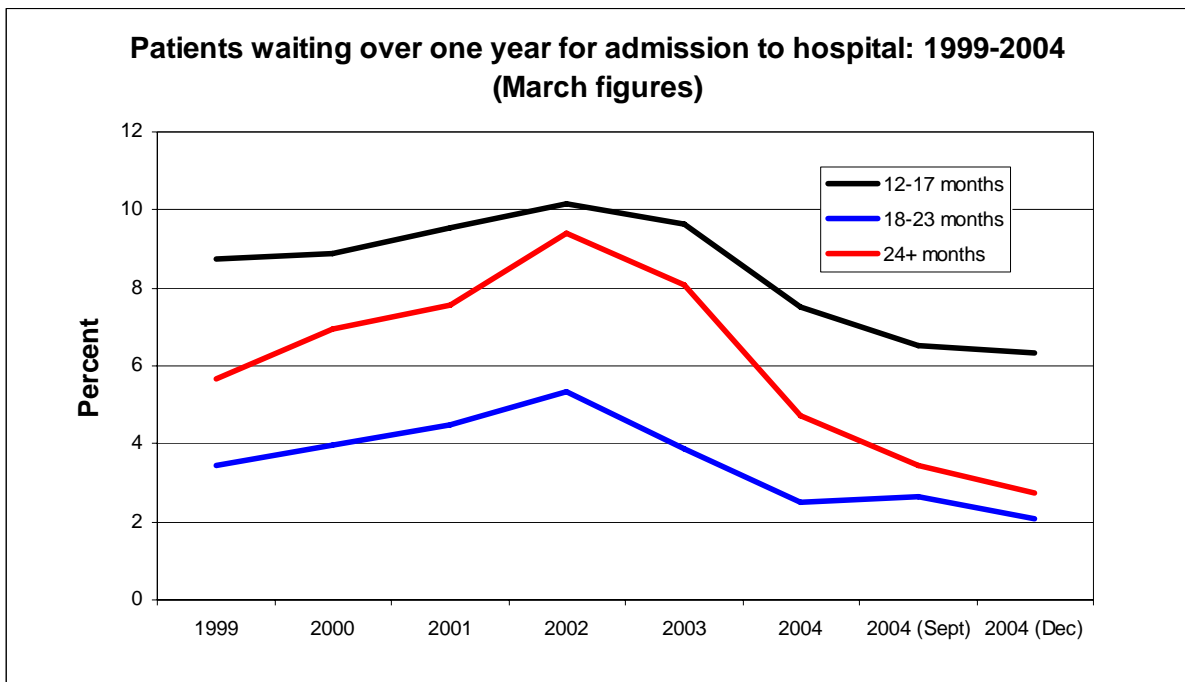
Figure 3.37: The total number of patients still waiting for admission to hospital has started to fall from its peak in 2002, but December figures show a levelling off at around 50,000



But while the total size of the waiting list for hospital admission can make headlines, of real concern to patients is how long they have to wait before admission.

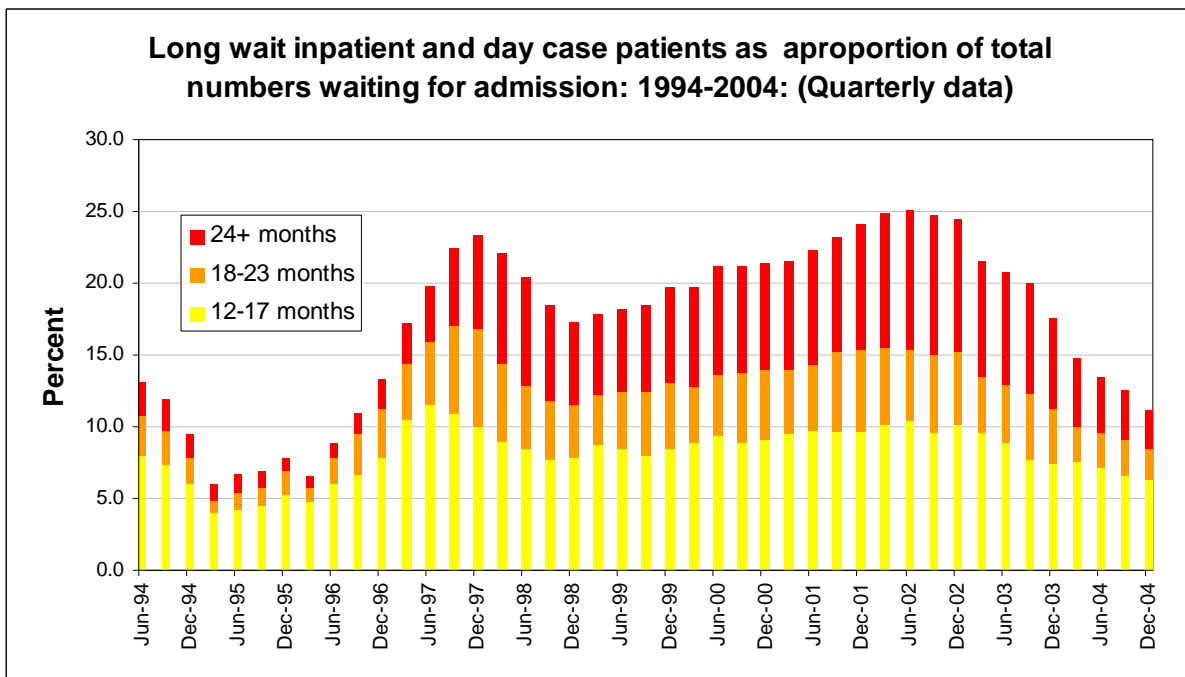
In terms of long waits - of which there is no definition, but over a year, might be a reasonable view of a long wait - there has been some progress over the last two years. Figure 3.38 shows that since March 2002, the numbers of patients waiting over a year have reduced considerably - although the rate of fall has slowed in recent quarters.

Figure 3.38: The numbers of patients still waiting over one year for admission to hospital have, since 2002, fallen to the level in 1999, and in December 2004 the number fell further, to 5,501.



These recent falls suggest that reducing long waits is not an intractable problem. However, looking back further over trends in long waits provides a mixed picture. As figure 3.39 shows, over the last ten years the proportion of the total inpatient list waiting over 12 months, has fluctuated between 6% and nearly 25%. There have been periods of significant reductions in long waits, but also subsequent periods where the proportion (and absolute numbers) have then built up again.

Figure 3.39: Since their peak in 2002, when a third of all inpatients and day cases were still waiting over 9 months for admission to hospital, the proportion of long waits reduced



Such trends raise the question of the sustainability of past attempts to reduce long waits and the effectiveness of actions and strategies to reduce waiting times. We return to these later on and in section 4 which looks at the performance management system.

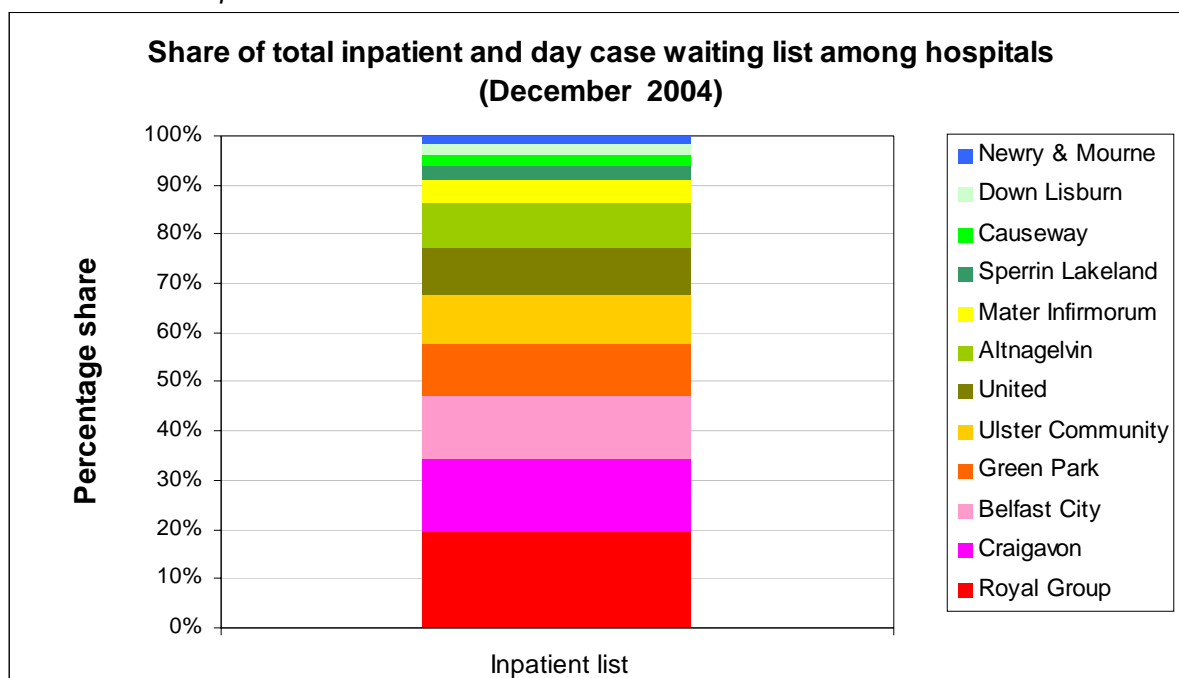
### 3.6.5 Variations in inpatient and day case waiting times

Apart from variations in waiting times over time, waiting times also vary among specialties, hospitals and in comparison to Wales, Scotland and England.

#### *Variations by hospital*

Figure 3.40, for example, shows that nearly 70% of all those on waiting lists are awaiting admission to five hospitals across Northern Ireland.

Figure 3.40: Just three hospitals account for nearly half of the total number of patients still waiting to be admitted to hospital



In part such variations in the share of the total list is explained by differences in the workloads of hospitals. Figure 3.43, for example, shows a relationship between trusts' shares of the total waiting list and their shares of total inpatient and day case activity (for 2003/4). Three hospitals, however, appear to have higher shares of the waiting list than might be expected given their workloads - the Royal Group, Craigavon Area and Green Park.

Figure 3.41: Over a quarter of patients in four hospitals are waiting more than a year for admission to hospital

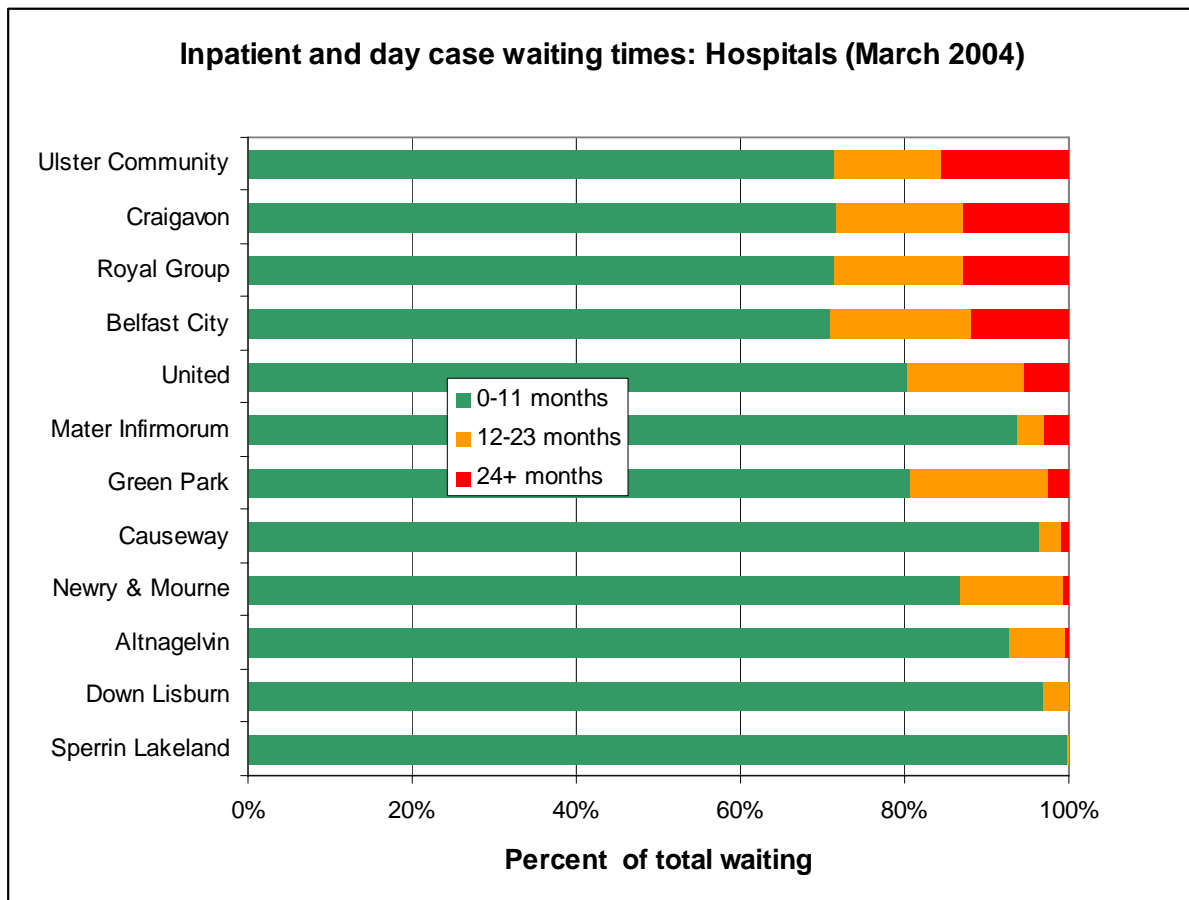
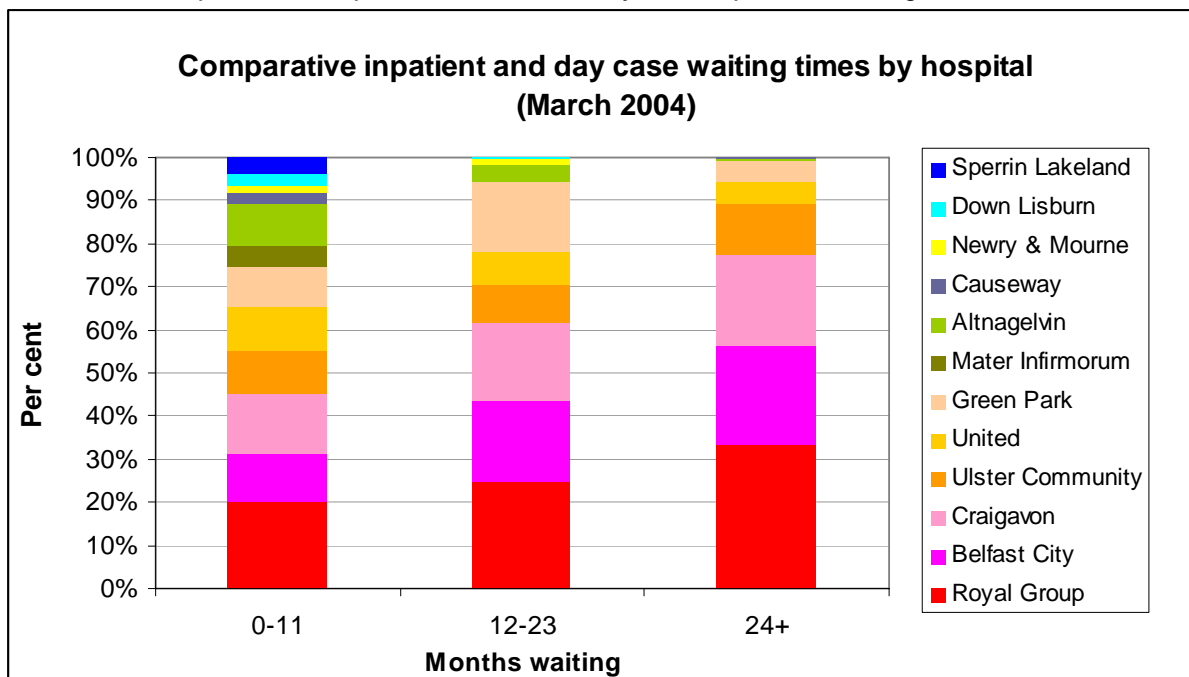


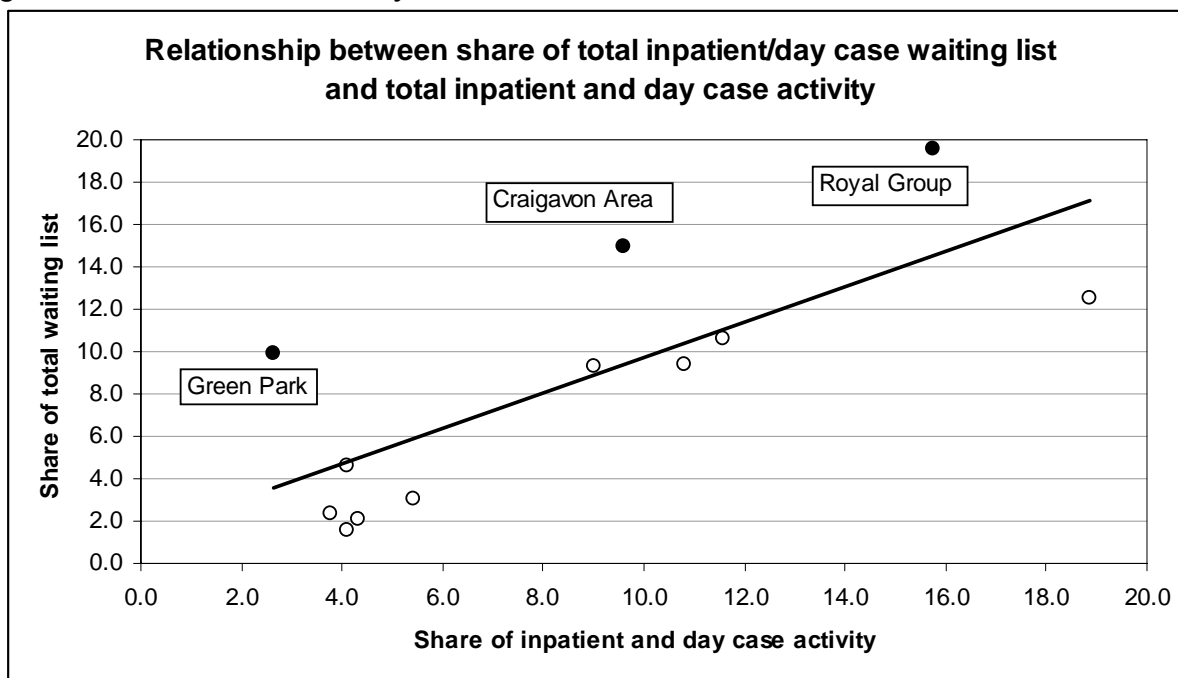
Figure 3.42: Just four hospitals account for nearly 90% of all patients waiting over 2 years for admission to hospital; five hospitals account for nearly 80% of patients waiting 12-23 months...



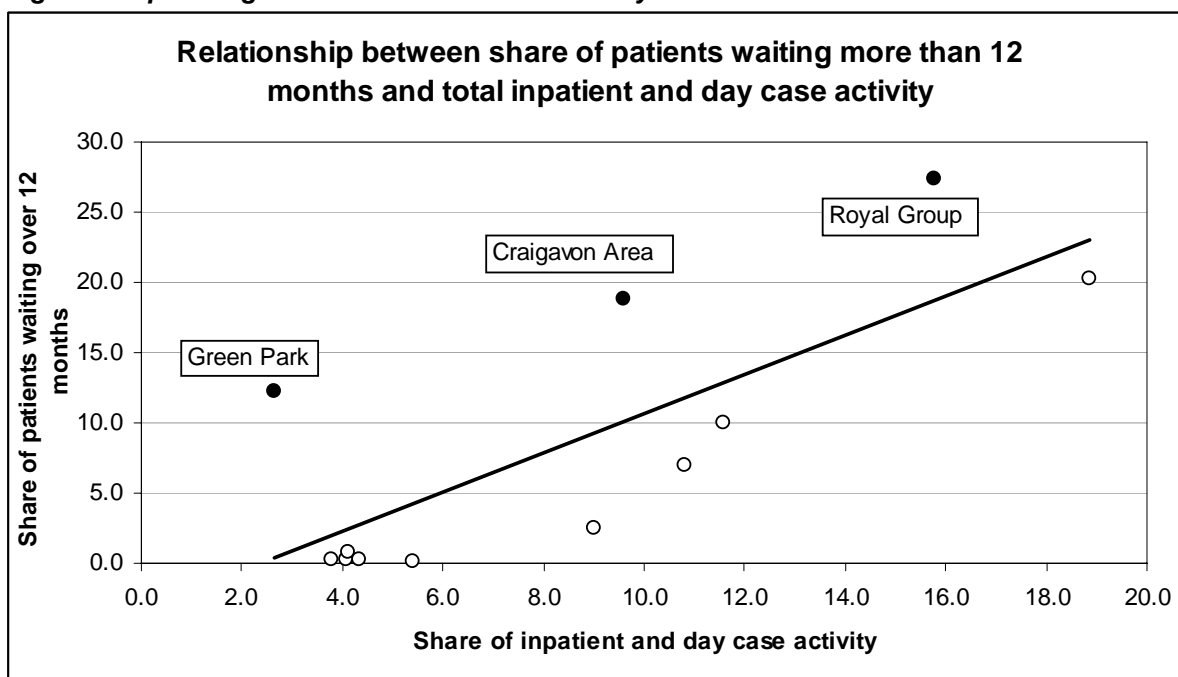
Variations in waiting times are also evident. And again, while these can in part be explained by differences in the workloads of hospitals, the relationship is not as clear

cut as with the size of lists, and further, the same three hospitals - the Royal Group, Craigavon Area and Green Park - are outliers, with a higher share of patients waiting over 12 months than might be expected given their activity levels.

**Figure 3.43: Some hospitals have a larger share of the total waiting list than might be expected given their share of total activity**



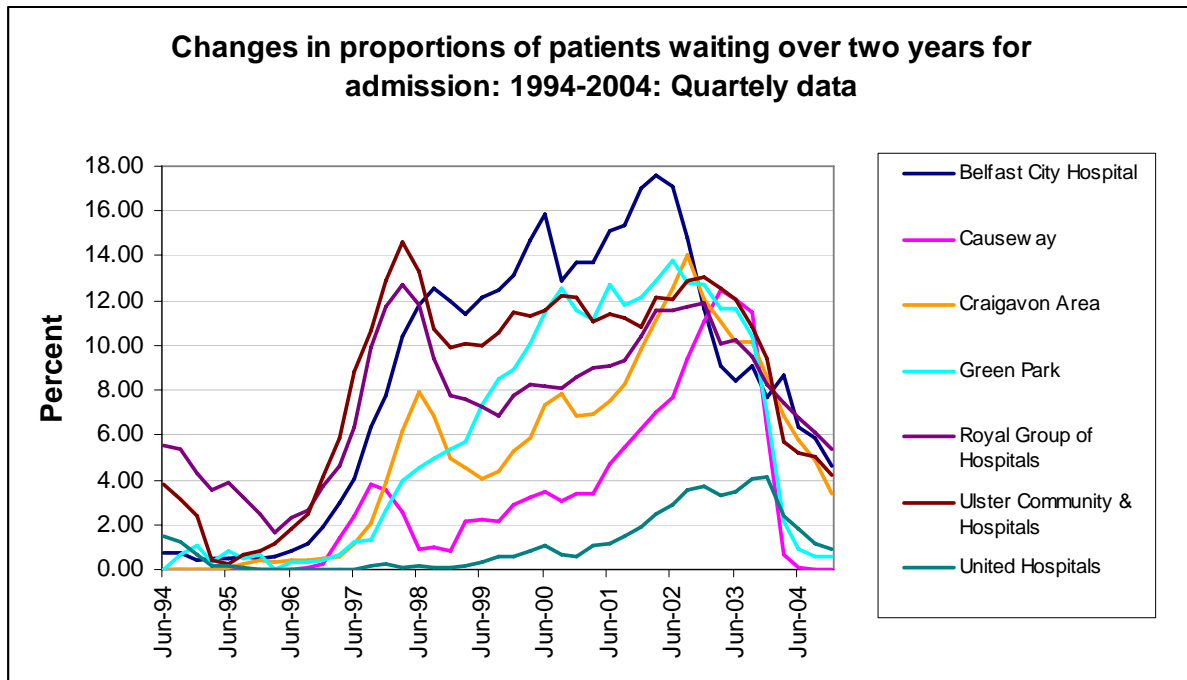
**Figure 3.44: Some hospitals have a higher proportion of patients waiting over a year than might be expected given their share of total activity**



However, the fact that some hospitals have managed, for example, to virtually eradicate very long waits of over two years while others, with similar proportions waiting over two years in 2002, and although making big reductions over the last two

years, have not, suggests that not all the variations in waiting times across hospitals are justified (see figure 3.45).

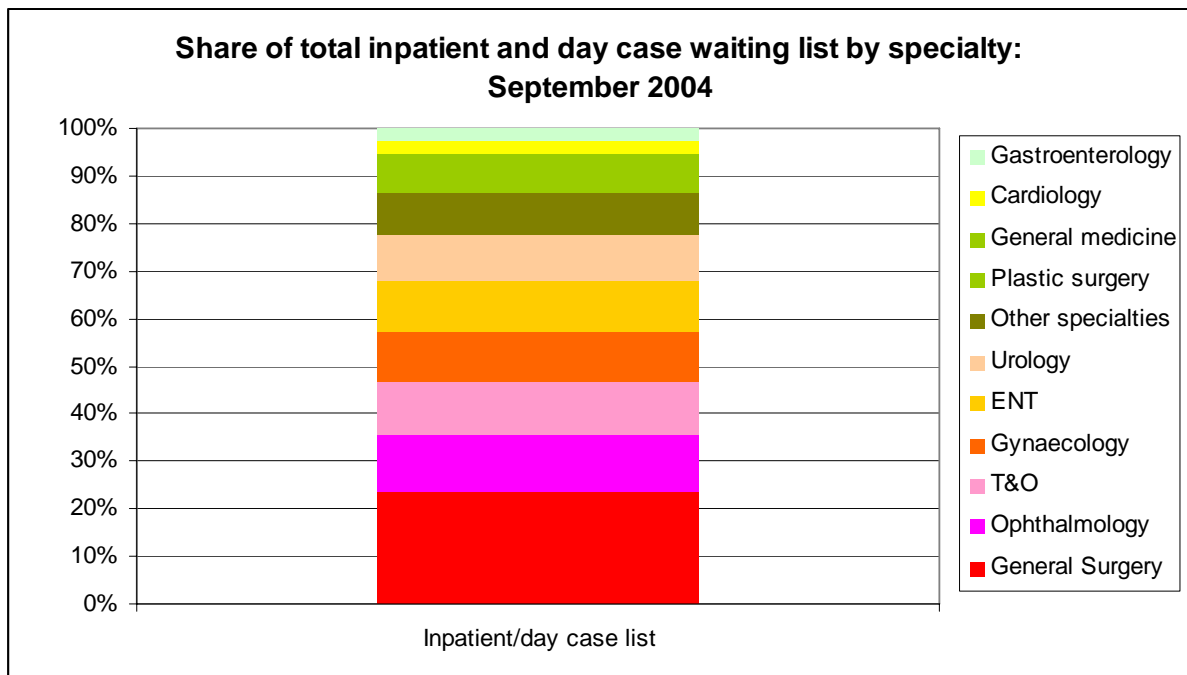
**Figure 3.45: Some hospitals have managed to almost eradicate very long waits**



*Variations by specialty*

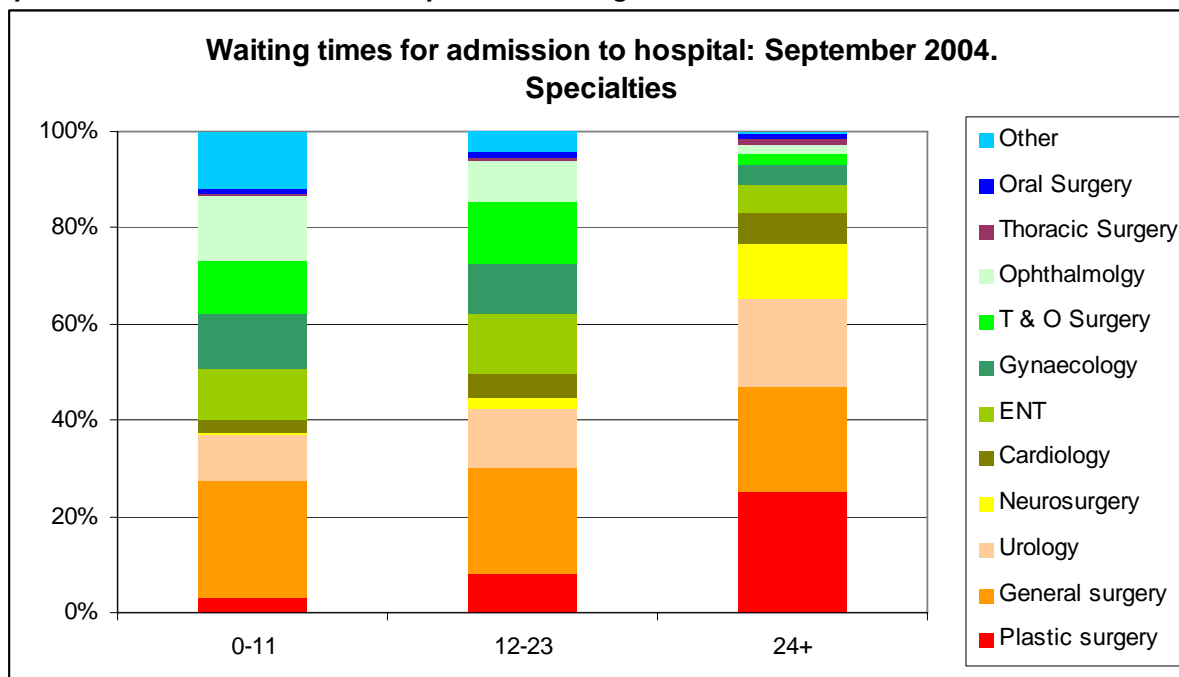
As with outpatient waiting lists and times, there are significant variations across specialties for inpatient and day case waiting lists (see figures 3.46 and 3.47).

**Figure 3.46: Just four specialties account for nearly 60% of all patients on inpatient/day case waiting lists.**



Again, as with outpatient waiting, the bulk of those waiting for admission to hospital are waiting in just a few specialties (general surgery, ophthalmology, trauma and orthopaedics...). And similarly, the majority of those waiting excessive times for admission are also concentrated in a handful of specialties - particularly, plastic surgery, general surgery and urology.

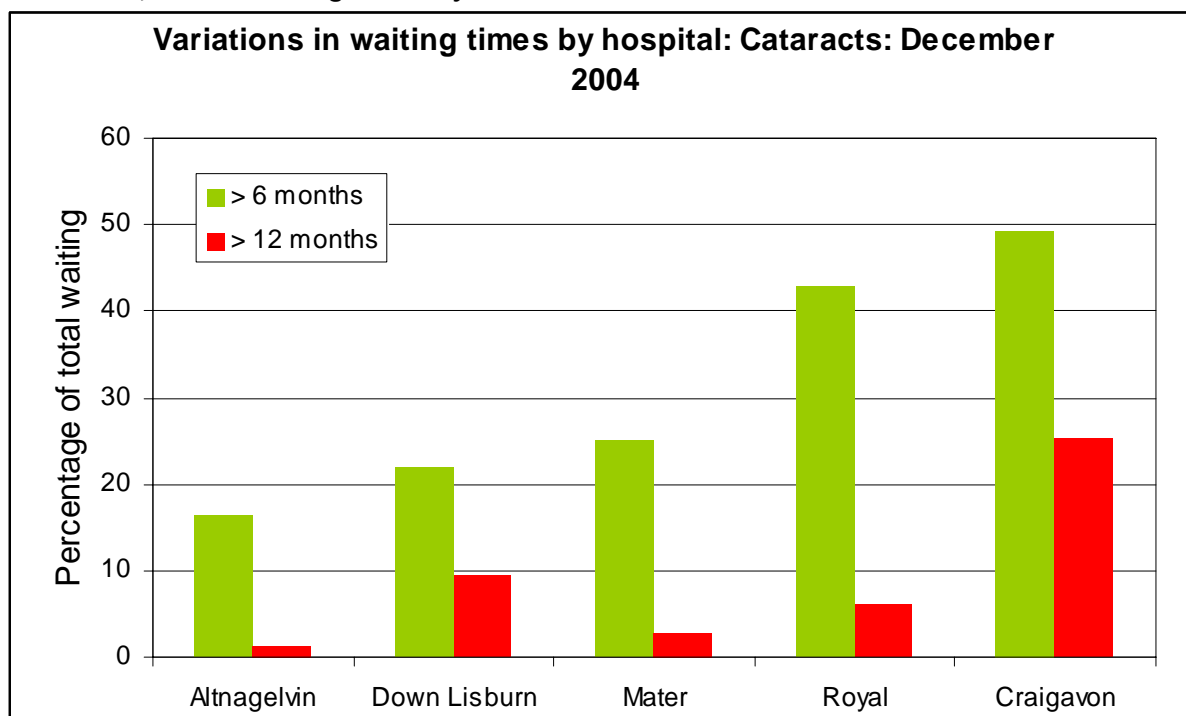
**Figure 3.47: Just three specialties account for over 65% of patients waiting over 2 years; six specialties account for 60% of all patients waiting 12-23 months**



Moreover, the majority of some specialty lists and waits are concentrated in just a handful of hospitals - sometimes, as in the case of trauma and orthopaedics, just one hospital - Down and Lisburn - accounts for over 82% of the total list. And in the case of ophthalmology, 62% of the total list is accounted for by the Royal.

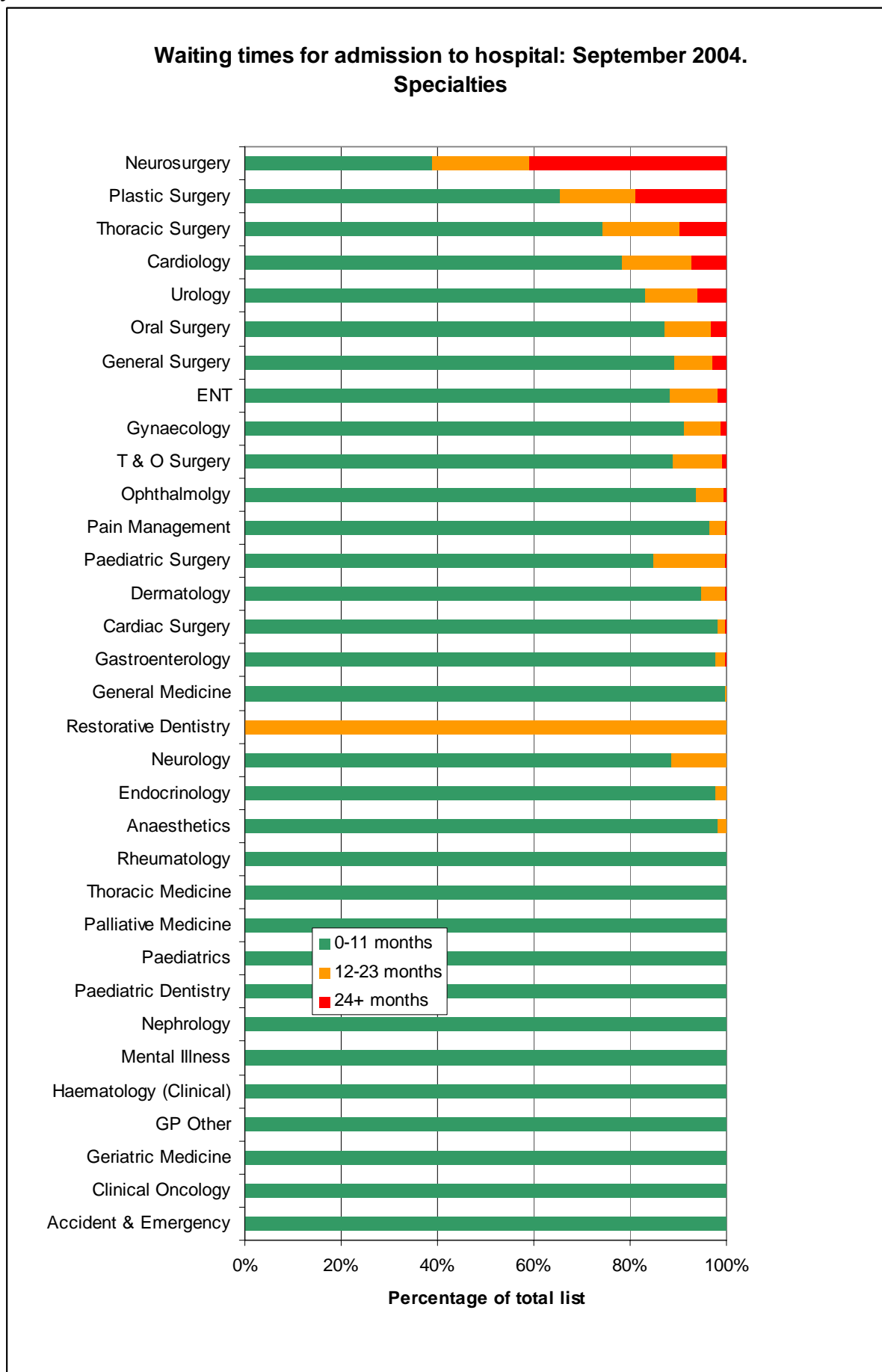
At the level of individual procedures there are also variations in waiting times, as figure 3.48 shows for cataract procedures.

**Figure 3.48: Nearly half of all patients waiting for a cataract operation at Craigavon wait over six months; while at Altnagelvin only 16% do so.**



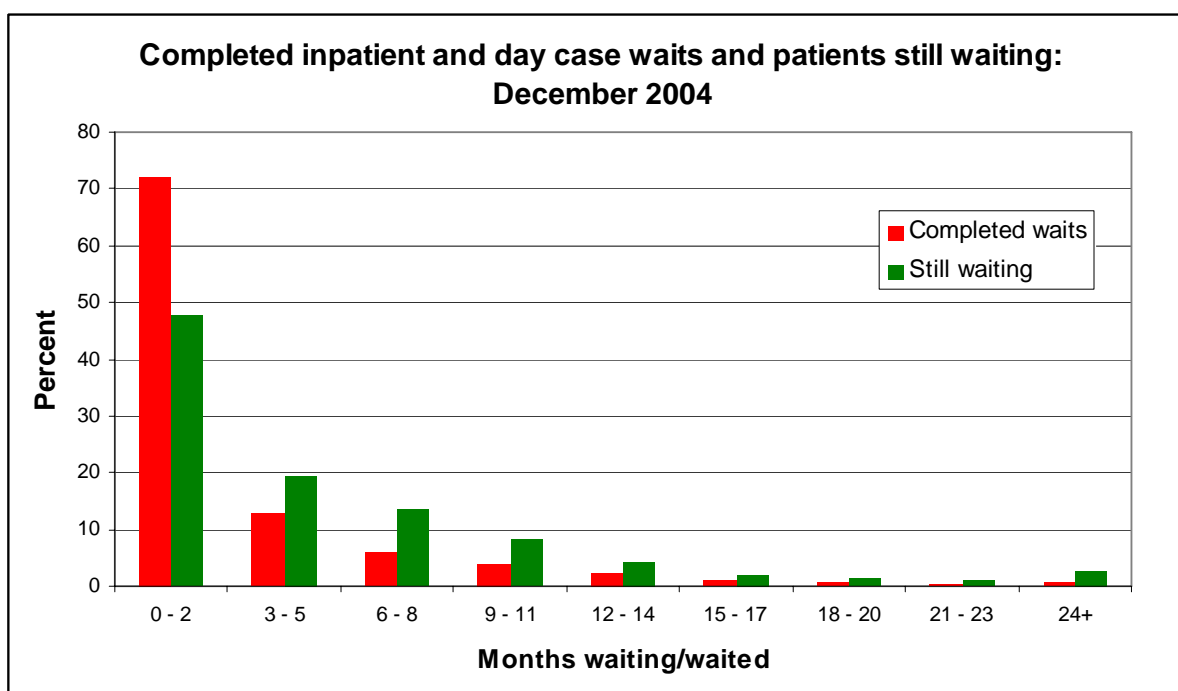
The reasons for very long waits in some specialties will depend on the nature of the specialty, the patients and the nature of the condition to be treated. For example, one reason for the very long waits in plastic surgery is undoubtedly the fact that much of the work carried out in this specialty is non-urgent and patients are rarely in pain.

**Figure 3.49: 40% of those waiting for admission to neurosurgery have been waiting over two years.**



As with the pattern of outpatient completed waits and those still waiting, patients who are admitted to hospital generally wait less time than those still on the list. In part this is a quirk of the data collection, but it can also be symptomatic of the dynamics of the way lists work in which a group of patients, considered by clinicians to be non-urgent, are bypassed by those deemed to be more urgent; some patients may find it very hard to move up and off the waiting list in this situation.

Figure 3.50: Patients who have been admitted to hospital tend to have waited less time than those still on the list. This is partly due to under 3 month waits being under-recorded by the quarterly census of those still waiting, but may also indicate a 'mortlake' of bypassed patients.



### Variations across the UK

There are significant variations in waiting lists and waiting times across the four UK countries. Figure 3.51 shows that Northern Ireland has longer waiting lists per 1000 population and poorer waiting times than Wales, Scotland and England. And figure 3.52 clearly shows the shorter waiting time experience for patients in England and Scotland compared to Northern Ireland and Wales.

Figure 3.51: Compared with the rest of the UK, Northern Ireland has the greatest number of patients per 1000 population still waiting for admission to hospital. It also has the greatest number still waiting over one year for admission per 1000 population

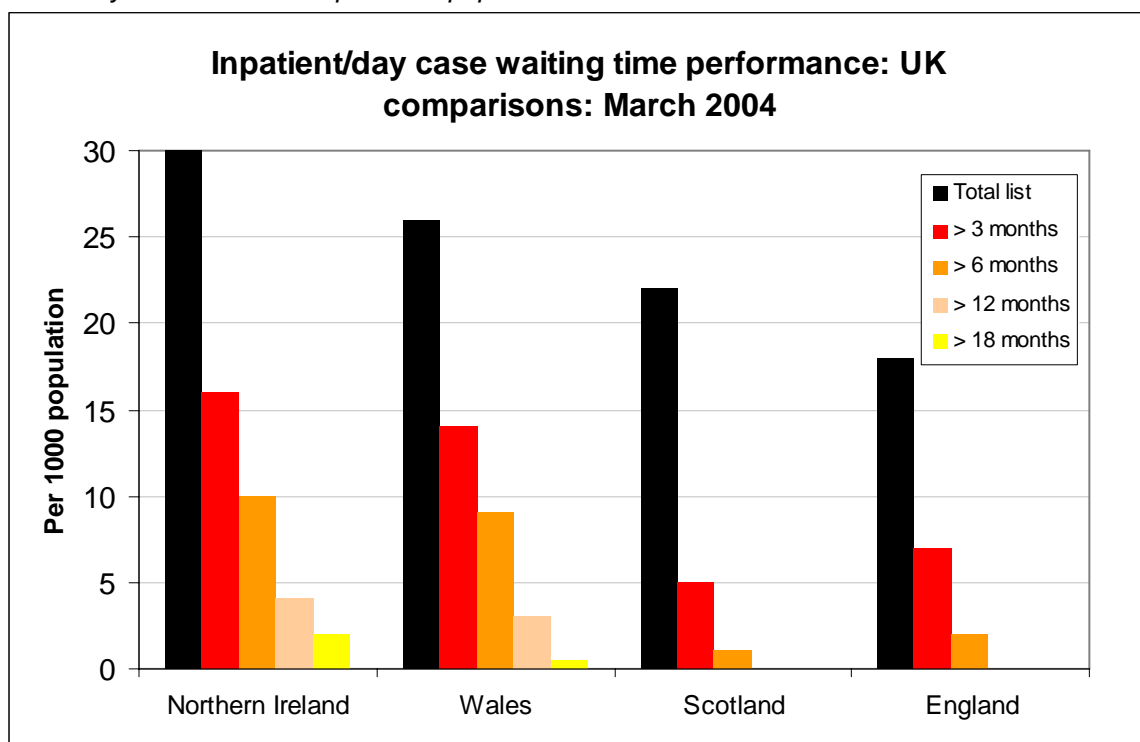
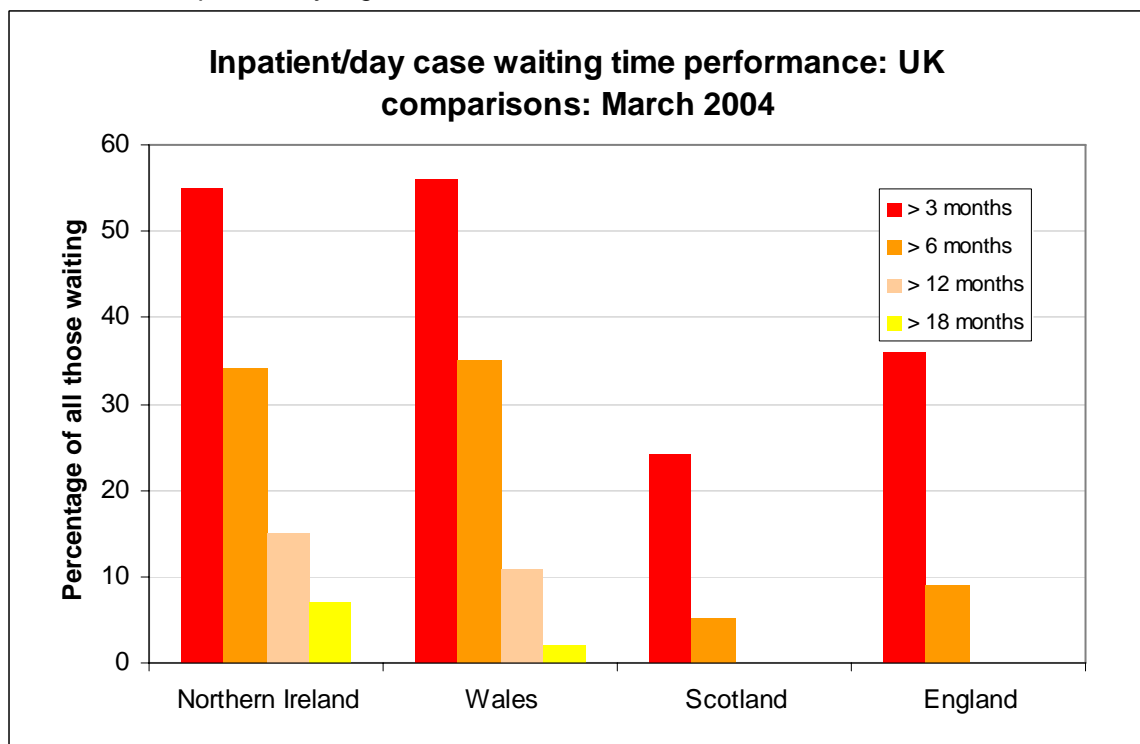
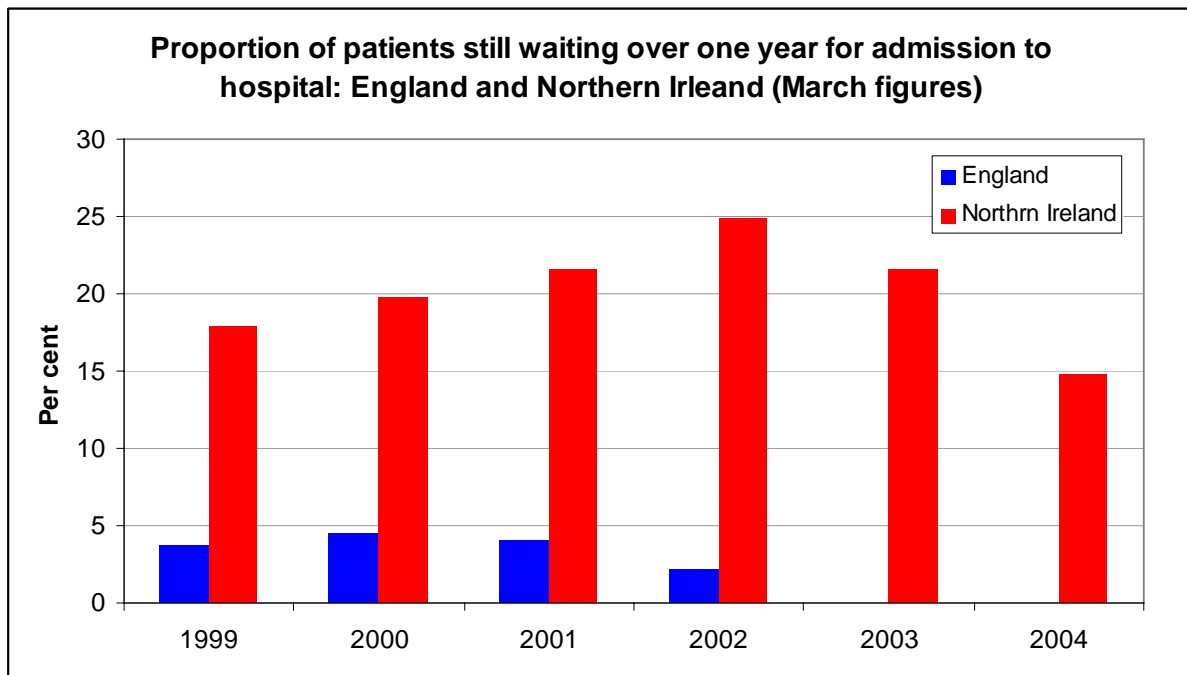


Figure 3.52: Northern Ireland currently has the worst waiting times situation for long waits for admission to hospital of any region of the UK.



The waiting times gap between, for example, Northern Ireland and England, is not a recent phenomenon; figure 3.53 shows that Northern Ireland is lagging someway behind England. Recent falls in the proportion of those waiting over a year are encouraging, but only take Northern Ireland to where England was in 1988 when a similar proportion of patients (15%) waited over a year.

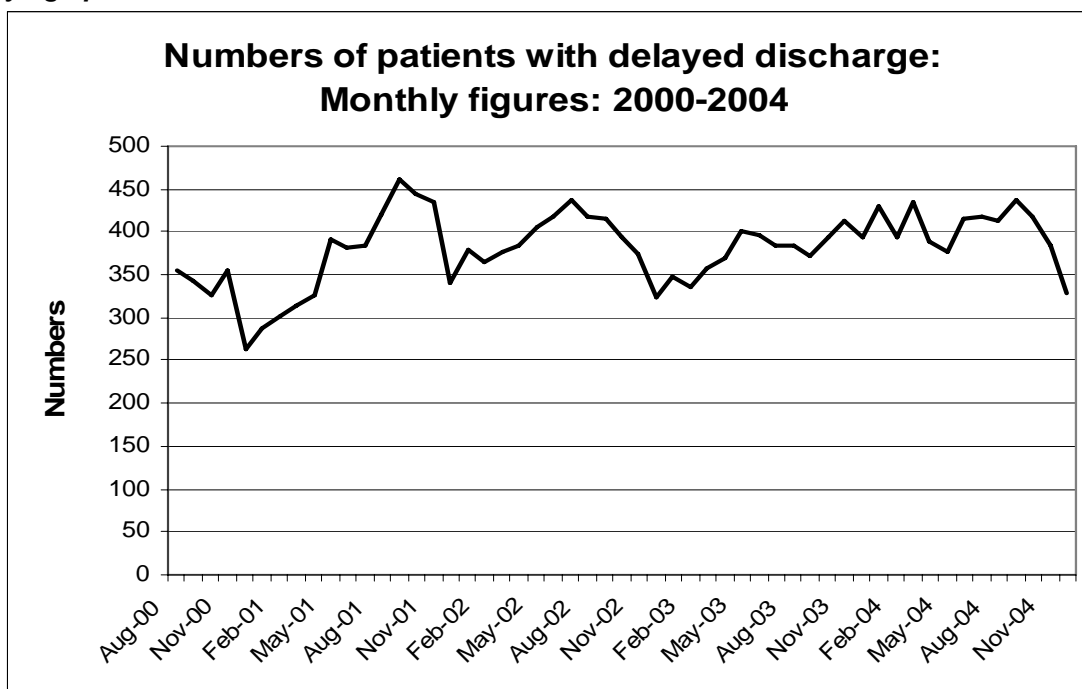
**Figure 3.53: Compared with England, over the last six years Northern Ireland have performed poorly in reducing the numbers of patients waiting over one year for admission to hospital.**



### 3.6.6 Waiting for discharge

As noted earlier, waiting occurs in many parts of a health care system. And potentially almost as distressing for patients as waiting to get into hospital, is waiting to get out - to be discharged - after treatment. Delays in discharges from hospital have remained at around 350 to 400 patients in any one month for the last four years (see figure 3.54); this is equivalent to a hospital the size of Altnagelvin Area Hospital occupied with patients (overwhelmingly over 75 years old) simply waiting to go home or on to other nursing or residential home accommodation.

**Figure 3.54: Since 2000, the number of delayed discharges has remained around 350 to 400 - tying up 4% of all beds.**

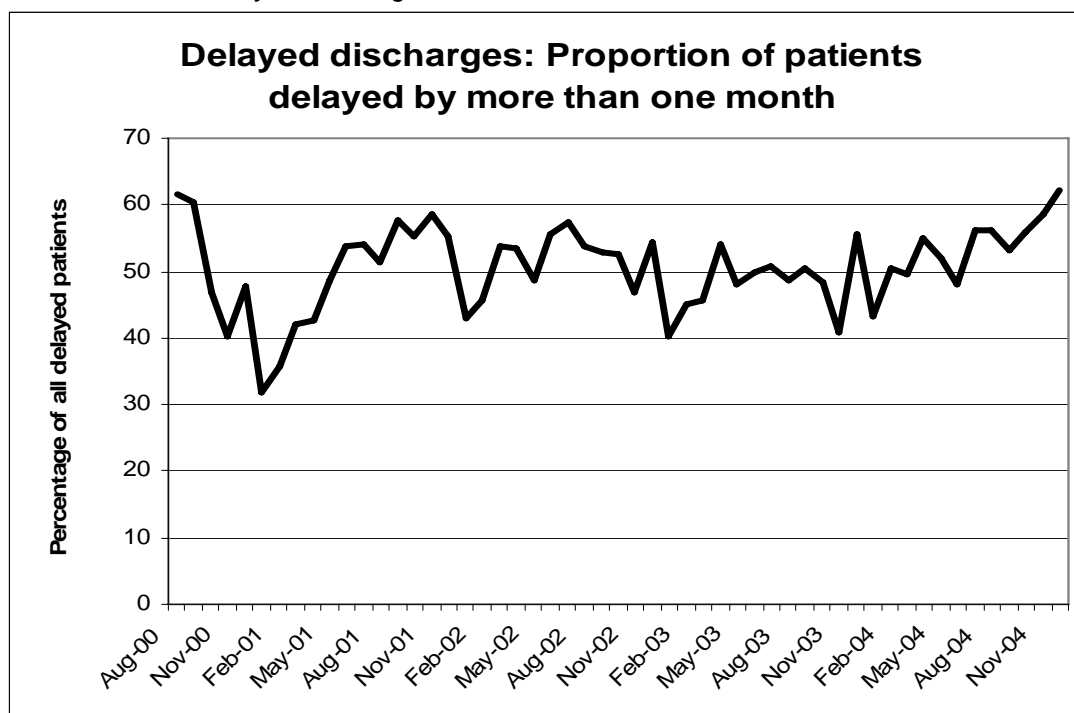


While the proportion of beds tied up with delayed discharges in Northern Ireland - 4% - is lower than in Scotland (6.2%) and Wales (5.1%), it is more than twice as high as in England, where significant reductions have been achieved over the last few years.

For those patients experiencing delays in discharge, waits can be considerable. Currently, as figure 3.55 shows, over 60% of all delayed discharge patients have been waiting over a month to leave hospital; and over a fifth are waiting more than three months, with over 6% waiting over six months.

The reported reasons for delayed discharges are most commonly 'lack of funding', waiting for an assessment of needs in hospital, and, the lack of an available and appropriate care package.

Figure 3.55: The proportion of patients delayed in hospital by more than one month has remained at around 50% of all delayed discharges since 2000



### 3.6.7 Targets to reduce waiting lists and times: a failed strategy?

It is clear that waiting times in most parts of the Northern Irish health system are, despite some improvements recently, very long - especially in comparison with England.

A significant minority of patients wait more than two years just to get a first outpatient appointment. A proportion of these patients who are then placed on the inpatient/day case waiting list will then go on to wait a further two or more years before being admitted to hospital. In total, some patients will have waited four or more years from the time they were referred by their GP until they get a bed in hospital - an intolerable length of time to have to wait for treatment. And, somewhat ironically, not only can it be difficult for some patients to enter hospital, it can also be difficult to exit; every year hundreds of patients find themselves unable to leave hospital for many weeks or even months due to discharge problems of one sort or another.

Dealing with the problem of (unnecessary and excessive) waiting in different parts of the health and social care system is not, as other countries have found, easy to do. One common approach has been to set targets for reductions in waiting lists and waiting times - a strategy which arguably has been the key factor in driving down waiting times in England over the last few years.

In Northern Ireland, targets, dealing with various aspects of waiting, have been in place (and promulgated by the Department's annual Priorities for Action documents) since the early 1990s (following the introduction of the Patient's Charter). However, as Box 3.4 details, since 1997, very few targets have been achieved. Moreover, as

can also be seen from Box 3.4, target setting has been somewhat erratic, with little apparent long term goals and intermediate milestones set, noticeable gaps (for example, no targets for reducing outpatient waiting times) and with many targets only appearing once over the last seven years despite not being achieved.

### Box 3.4: Waiting time targets: 1997/8 to 2005/6

Centrally set targets for any aspect of waiting in the Northern Irish health and social care system have been abstracted from the Department of Health's annual *Priorities for Action* documents.

#### 1. 2004/05

Target	Date to be achieved	Outcome?
No inpatient/day case to be waiting >6 months	2006/7 or 2007/8	This is a general indication of the timescale in which such a reduction should be reached. It is not, at present, considered by the DHSPSS to be a target as such.
95% of patients requiring hospital inpatient or day case treatment to be admitted within 12 months of being placed on a waiting list	March 2005	<b>Not on target?:</b> By December 2004, 11.1% still waiting >12 months. However, of those <i>admitted</i> in the quarter, 95% had waited 12 months or less.
Other than in exceptional circumstances, no patient to be waiting for inpatient or day case treatment >18 months	March 2005	<b>Target unlikely to be achieved:</b> By December 2004, 4.8% still waiting >18 months
No patient to be waiting for inpatient or day case treatment >15 months	March 2006	<b>On target?:</b> By December 2004, 6.9% still waiting >15 months
Number of delayed discharge days to be reduced by 10% compared to 2003/04 levels	March 2005	<b>Not on target:</b> Between March and December 2004 there were a total of 80,290 delayed discharge days, against a target reduction of 90,878 by March 2005.
Number patients waiting >2hours in A&E between a decision to admit and admission to a ward to be reduced by one third of 2003/4 levels	March 2005	<b>Not on target:</b> Between March and December 2004, 24,087 patients had waited more than two hours in A&E between a clinician's decision to admit and admission to a ward, against a target of 20,568 by March 2005.
Improve access to primary care services by ensuring that 90% of patients who request a clinical appointment (for other than emergencies) will be able to see a General Practitioner or an appropriate primary care	March 2005	<b>On Target</b> Boards anticipate meeting this target although the SHSSB has indicated some slippage will occur.

professional within the practice or provided by the practice within 2 working days		
85% of all people who are medically fit for discharge from hospital but who require access to community support to facilitate their discharge should wait no more than 8 weeks for such services to be provided	March 2005	<b>Unlikely to be Achieved</b> At December 2004, this standard was being met in the WHSSB area only. Elsewhere performance ranged from 66% to 73%.
To have made demonstrable progress towards achieving the strategic target of a 75% response rate within 8 minutes across all Board areas by 2007	March 2005	<b>On Target</b> Systems will not be place to enable the target to be measured until March 2006 but Boards record progress on track for delivery by 2007.

## 2. 2003/04

Target	Date to be achieved	Outcome?
Numbers of patients waiting longer than 18 months for hospital inpatient or day case treatment to be reduced by 50% from the level at June 2002	March 2004	<b>Target exceeded:</b> 61% reduction achieved
Number of patients waiting for hospital inpatient or day case treatment to be reduced by 5% from the level at June 2002	March 2004	<b>Target exceeded:</b> 16.7% reduction achieved.

## 3. 2002/03

Target	Date to be achieved	Outcome?
Constrain hospital waiting lists to the March 2002 level	March 2003	<b>Target exceeded:</b> total numbers fell by 2,767 (4.8%)

## 4. 2001/02

Target	Date to be achieved	Outcome?
Reduce waiting lists by a quarter, from 51,000 to 39,000, with a milestone reduction to 48,000 by March 2002	March 2004	<b>Not achieved:</b> waiting lists <i>increased</i> to 57,000 in March 2002, and were just under 50,000 by March 2004
No patient to be waiting >18 months, with a milestone reduction of 50% in those waiting >18 months by March 2002	March 2003	<b>Not achieved:</b> Numbers waiting >18 months and cardiac patients waiting >12months increased by 2,337 (+36%) over March 2001 levels; by March 2003 the number of 'excess waiters' was 6,659, an increase of 229 (+3.6%) over March 2001 levels.
No cardiac patient to be waiting >12 months, with a 50% reduction in those waiting >12 months by March 2002	March 2003	
No patient to wait >48 hours for surgery in fracture clinics	No date set	<b>Not Achieved.</b> Work was being addressed

		on a regional basis through the Fracture Crisis Working Group in which Boards participated. DHSPSS state that: "Winter pressures reduced the impact of the additional capacity introduced into the system."
Reduce the number of people waiting for occupational therapy assessments for housing adaptations at April 2001 by 20%	March 2002	<b>Not achieved.</b> Northern Board reduced the numbers waiting by 19% and Western Board by 17%.

## 5. 2000/01

No specific targets set in this year. General exhortation from DHSPSS to maintain downward pressure on waiting lists and ensure that gains made were not lost: By March 2001, waiting lists rose by 16.7%

## 6. 1999/00

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	2000	<b>Not achieved:</b> 77% seen within 3 months
No patient to be waiting longer than 18 months for admission to hospital	2000	<b>Not achieved:</b> 96% admitted within 18 months; 12% still waiting > 18 months by March 2000
No cardiac patient to be waiting longer than 12 months for admission to hospital	2000	<b>Not achieved:</b> 8% admitted within 12 months;
No patient to wait longer than one month for admission following a cancelled operation	2000	<b>Not achieved:</b> 1% not admitted within one month

## 7. 1998/99

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	1999	<b>Not achieved:</b> 80% seen within 3 months
No patient to be waiting longer than 18 months for admission to hospital	1999	<b>Not achieved:</b> 95% admitted within 18 months
No cardiac patient to be waiting longer than 12 months for admission to hospital	1999	<b>Not achieved:</b> 85% admitted within 12 months
No patient to wait longer than one month for admission following a cancelled operation	1999	<b>Not achieved:</b> 0.7% not admitted within one month

## 8. 1997/98

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	1998	<b>Not achieved:</b> 80% seen within 3 months
No patient to be waiting longer	1998	<b>Not achieved:</b>

than 18 months for admission to hospital		95% admitted within 18 months
No cardiac patient to be waiting longer than 12 months for admission to hospital	1998	<b>Not achieved:</b> 83% admitted within 12 months
No patient to wait longer than one month for admission following a cancelled operation	1998	<b>Not achieved:</b> 0.3% not admitted within one month

### End of Box 3.4

Despite the apparent lack of success in meeting waiting times targets - the reasons for which are discussed below, and in the next section on the performance management system - there are (recent) examples of successes in tackling the problem of waiting. Box 3.5, for example, summarises some of the approaches taken at local level - often using learning from the Modernisation Agency and experience of the National Patient Access Teams in England in reducing waiting times.

### Box 3.5: Examples of success in tackling waiting lists and times in Northern Ireland

The following examples of success in reducing waiting times are taken from *Tried, Tested, Shared 2: Summaries from the Service Improvement projects 2003-04* (DHSSPS, 2004).

The Service Improvement Unit was set up in 2003 and aimed to improve patient and client access ‘...by engaging multidisciplinary teams in redesign to reduce waits and delays..’. This bottom up, micro approach has helped many trusts improve their waiting times performance.

**Causeway Trust** managed to completely eradicate over 12 month waiters in just eleven months through a combination of protecting elective beds from emergency use, regular validation of lists, eradicating bottlenecks along the patient pathway, use of a points system to forecast necessary theatre capacity and development of a common general surgery waiting list.

**Foyle Trust** reduced the waiting time for a first outpatient appointment for its family planning services from 18 weeks to 4 weeks, reduced the average wait within clinics from 85 to 30 minutes and cut its DNA rate by introducing a computerised booking system, providing one contact telephone number for patients, sending out reminders for appointments, introducing nurse-led clinics and extending clinic opening hours.

**Craigavon and Banbridge Trust** reduced DNAs from 22% to 10% and cut the longest wait for a new assessment from four months to two weeks for its Continence Clinic by validating lists, introducing a partial booking system and generally redesigning clinic structures.

A common outcome of these and many other initiatives has not just been the reduction in waiting times and lists, but improved staff morale and motivation, higher patient satisfaction, improved information systems, a greater understanding of the ‘whole system’ and how services interlink and the need to monitor performance on an ongoing basis.

### 3.6.8 Solutions to reducing waiting times?

One, understandable, reason for the lack of success in achieving centrally-determined targets could be that the targets set have been too ambitious. However, as the National Audit Office for Wales noted in its recent report on waiting times in

Wales, in comparison with England, Northern Ireland (and Wales) have historically set rather unambitious targets<sup>70</sup>.

While it has been put to the Review that lack of funding was a key reason for lack of progress in reducing waiting times, this view was contradicted by some senior trust managers and by most of the general practitioners to whom we talked. From our survey of trust chief executives, *lack of funding* was, on average not the main barrier to meeting waiting time targets. In addition, as table 3.4 shows, other barriers were often rated as more important within trusts.

**Table 3.4<sup>(a)</sup>: Survey of trust chief executives: ‘What are the main barriers to achieving waiting time targets?’**

TRUST>	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Average score (d)
Staff vacancies	3	2	3	2	2	1	2	2	2	4	3	2	2	2	2.3
Levels of urgent, but non-emergency work	1	3	4	2	2	3	2	2	3	2	1	3	4	3	2.5
A lack of funding	(b)	3	2	1	3	3	2	(c)	3	4	1	3	3	2	2.5
Higher than expected emergency admissions	1	1	3	4	4	3	4	2	3	2	na	4	5	3	3.0
Insufficient beds	4	1	3	4	4	2	4	2	1	2	na	3	5	4	3.0
An increase in GP referrals	1	3	3	1	4	2	3	3	3	2	3	5	5	2	3.1
Winter pressures	2	2	3	4	3	3	4	2	2	2	5	4	5	3	3.1
Delayed transfers of care	2	1	4	4	4	4	3	3	1	2	na	3	5	5	3.2
Shortage of theatres	3	1	4	3	3	4	4	3	2	2	na	4	4	5	3.2
Unrealistic targets	4	2	2	2	4	3	5	2	4	4	na	3	3	5	3.3
Skills shortage	4	2	3	4	1	5	3	5	4	4	3	5	5	1	3.5
Treating private patients	4	5	5	5	5	5	5	5	5	5	na	5	5	4	4.9

a Rating 1=extremely significant, 2=very significant, 3=significant, 4=slightly significant, 5=not significant at all.

b No score given: ‘Varies by specialty’

c No score given: ‘Recurring funds a problem’

d Average= sum of scores divided by number of trusts

A more important reason for the apparent failure of the target setting regime in Northern Ireland, and a key theme in the next section on the performance management system, was and remains the lack, as far as this Review could discern, of a consistent commitment throughout the health and social care system to the objective of reducing waiting times, and in addition, the lack of any system of incentives - rewards and sanctions at organisational or individual levels - absolutely necessary in order to drive efforts to meet targets.

Overall, the conclusion of this Review with regard to the issue of waiting is that evidence exists - for example, variations in waiting times across hospitals in Northern Ireland, examples of significant reductions in waiting times in some hospitals and the example of historic reductions in waiting times in England - that excessive waiting is

<sup>70</sup> See for example Figure 7 in Report by the National Audit Office Wales, NHS Waiting Times in Wales Volume 1- The Scale of the Problem.

not inevitable, nor an intractable problem given the level of financial inputs to the system.

Broadly, solutions to the problem require a 'whole systems' perspective, acknowledging that answers to the problem will involve, for example, not just the elective care system, but all parts of a hospital as well as the wider health economy. In addition, solutions necessarily need to adopt the viewpoint of the patient, coupled with a consistent commitment to solving the problem - from managers, clinicians and others concerned with patients' welfare.

In practice, tackling excessive waiting will involve most if not all of the following:

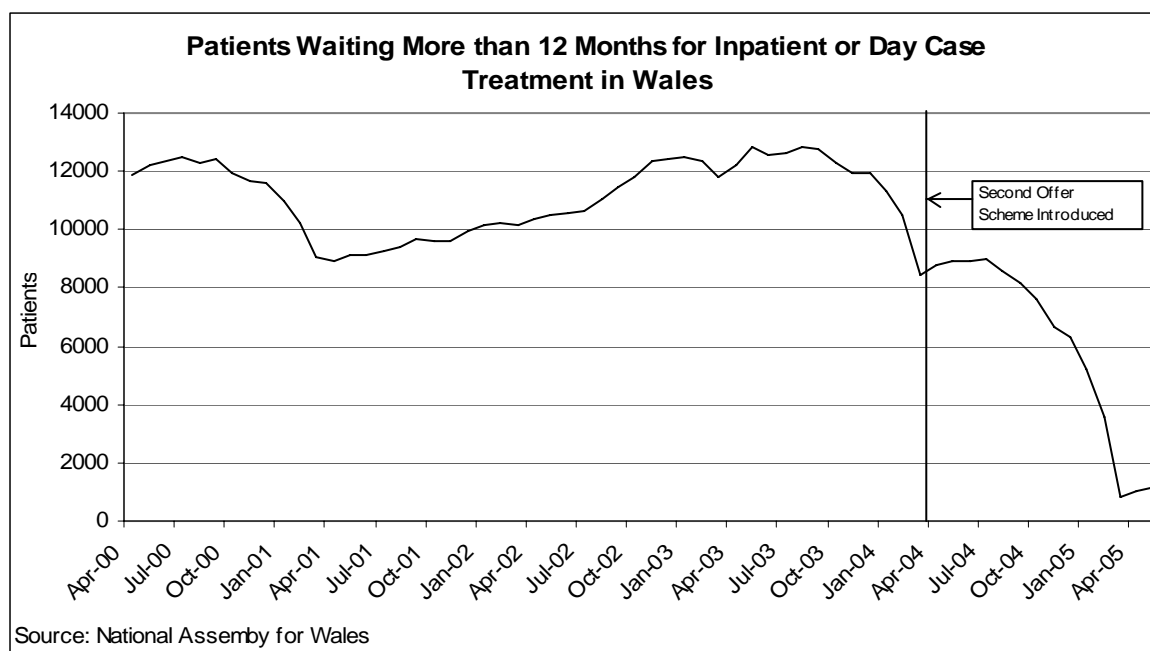
- Efficient use of key resources (theatres, beds, LOS, TOI etc)
- Weekly monitoring of lists by chief executives
- Continual validation of lists
- Treat-in-turn, together with consistent urgency prioritisation
- Clear bottlenecks (e.g. bed blocking, ringfence elective beds)
- Set targets coupled with incentives/sanctions (for individuals and organisations)
- Manage the entire patient pathway - from GP to outpatient to diagnostic services to waiting list to admission to discharge.
- Publish performance data (by hospital, specialty and clinical team).
- Reduce variations through patient choice
- Contain and if possible reduce, other demands on the hospital system - especially accident and emergency attendances and emergency admissions.

**Recommendation 12: Adopt multi-pronged long term strategy to reducing waiting times, including long term targets (with milestones) backed by strong incentives.**

A series of initiatives have recently been announced in relation to both inpatient and outpatient waiting lists following the work of Dr Martin Connor and colleagues at the Greater Manchester Strategic Health Authority. For those on inpatient waiting lists a 'Second Offer' system will be introduced similar to that introduced in Wales in 2004. Under this system, when a trust fails to treat patients within agreed time thresholds, they are offered treatment elsewhere and the original trust has to pay for the treatment in full. The corollary is that patient who refuse a reasonable second offer of treatment will be taken off the waiting list and referred back to their GP.

Figure 3.56 below shows that the Second Offer scheme does appear to have been successful in reducing the numbers on inpatient waiting lists in Wales. However, in their January 2005 report on waiting times, the National Audit Office of Wales raised a number of concerns with the scheme in terms of the impact on financial viability of trusts, disputes as to is responsible for delays in treatment as well as the reluctance of patients to travel.

**Figure 3.56: The number of persons in Wales waiting more than 12 months for inpatient or day case treatment has fallen by 87% since April 2004<sup>71</sup>.**



The major concern of the Welsh Audit Office, however, was that the scheme did not constitute a clear and coherent overall strategy because it did not address the issue of outpatient waiting and may make the problem worse. In Northern Ireland, this is being addressed by improvements in the management of primary care. Instead of being sent directly to a consultant, non-urgent referrals will be passed to a central assessment service which will determine the most appropriate next stage of treatment. Whilst this scheme has the clear potential to reduce the burden on hospital consultants, this depends on the extent to which consultants are willing to devolve some of their responsibilities to others. In addition, this raises questions as to why GPs have been unable to manage demand effectively to date.

Overall, this Review welcomes the adoption of a more robust approach towards tackling the waiting list problem in Northern Ireland hospitals. However, as has been highlighted by the work in Wales, the detail of how the schemes will be implemented is crucial. In particular, care should be taken that the cost of providing an alternative source of treatment is not excessive and that the addition of, in essence, a triage tier to the referral process does not simply create increased bureaucracy.

<sup>71</sup> This includes those who declined a second offer-719 in May 2005