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Northern Ireland Audit Office

Waiting for Treatment in Hospitals

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

NIA 132/03, 25 November 2004

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for Northern Ireland

Waiting for Treatment in Hospitals

NIA 132/03 BELFAST: The Stationery Office £21.00

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of that Order.

J M Dowdall CB
Comptroller and Auditor General

Northern Ireland Audit Office
25 November 2004

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List of Abbreviations

A&E	Accident and Emergency
BCHT	Belfast City Hospital HSS Trust
CABG	Coronary Artery By-pass Graft
CAHT	Craigavon Area Hospitals HSS Trust
CREST	Clinical Resource Efficiency Support Team
CNA	Could Not Attend
DHC	Department for Health and Children (ROI)
DHSS	Department of Health and Social Services
DHSSPS	Department of Health, Social Services and Public Safety
DNA	Did Not Attend
DoH	Department of Health (GB)
DQA	Data Quality Audit
ENT	Ear, Nose and Throat
GB	Great Britain
GP	General Medical Practitioner
HC	House of Commons
HOPE	Hospitals of the European Union
HPSS	Health and Personal Social Services
HSS	Health and Social Services
IT	Information Technology
MRI	Magnetic Resonance Imaging
NAO	National Audit Office
NHS	National Health Service
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NPAT	National Patient Access Team
NSF	National Service Framework
OGD	Oesophago Gastro Duodenoscopy
PAS	Patient Administration System
PFA	Priorities for Action
PTL	Primary Targeting List
RBHSC	Royal Belfast Hospital for Sick Children
RGHT	Royal Group of Hospitals HSS Trust
ROI	Republic of Ireland
T & O	Trauma and Orthopaedics
UCHT	Ulster Community and Hospitals HSS Trust
UK	United Kingdom

Table of Contents

Table of Contents

Table of Contents

Executive Summary

Waiting for Treatment in Hospitals

Background

1. Each year in Northern Ireland the local hospital service delivers some 1.9 million episodes of treatment. The great majority of patients do not have to wait long for treatment, and the treatment they receive is generally of a very high standard. 74.4 per cent of inpatients seen during the quarter ended 31 March 2004 had been on the waiting list for less than 3 months, and 94.4 per cent for less than 12 months. All cases presenting as emergencies are admitted within hours. Notwithstanding this, there has been considerable public concern at the length of time people have to wait for their non-urgent treatment. Comparisons with Great Britain show that proportionately more people in Northern Ireland have to wait longer for their treatment than elsewhere (paragraph 1.8, Figure 3). **This report deals with the waiting times for non-urgent inpatient and outpatient treatment. It does not cover waiting times for emergency hospital treatment** (paragraph 1.4).

2. The Northern Ireland Audit Office (NIAO) examined waiting list targets set by the Department of Health, Social Services and Public Safety (DHSSPS) and performance against them; the impact of additional waiting list funding provided by DHSSPS on the reduction of waiting lists; and the performance of Health and Social Services (HSS) Boards and Trusts against targets set under the Department's latest waiting list initiative, including establishing how effectively, additional waiting list funding was spent. We also assessed the accuracy of waiting list and waiting time performance data published by the Department (paragraph 1.15).

Executive Summary

Waiting for Treatment in Hospitals

Main Conclusions and Recommendations

On Waiting Lists and Waiting Times

3. As far as inpatients and day cases are concerned, over the last six years, the number of inpatients and day cases treated has risen by 8.0 per cent from 446,528 in 1998-99 to 482,449 in 2003-04. The number of inpatients who were admitted to hospital increased from 150,081 to 153,947, an increase of 2.6 per cent. However, the simultaneous rise in the level of demands on the system has been such that the percentage of patients treated who had been waiting 12 months or more has risen by 2.0 percentage points from 4.7 per cent in the quarter ended 31 March 1999 to 6.7 per cent in the quarter ended 31 March 2003, before falling to 5.6 per cent in the quarter ended 31 March 2004 representing an increase of 0.9 percentage points between March 1999 and March 2004. The percentage of patients treated, who had been waiting less than 12 months has fallen commensurately. Similarly the proportion of those treated within 3 months also fell from 75.5 per cent to 74.4 per cent over the same period. For these, and for patients in other time bands, particularly those requiring routine treatment, the total waiting time can be considerable (paragraph 1.5). Similarly, the total number of outpatient visits over the same period has increased from 1,427,894 to 1,482,038 - an increase of 3.8 per cent. The number of visits by those who attended their first appointment without having cancelled or missed a previous appointment increased from 318,585 to 345,298, an increase of 8.38 per cent. Of this total, the percentage seen within 3 months has fallen from 80.2 per cent in 1998-99 to 70.3 per cent in 2003-04; and the percentage of the total not seen within 12 months has risen from 0.7 per cent in 1998 -99 to 4.2 per cent in 2003-04 (paragraph 1.6).

Executive Summary

Waiting for Treatment in Hospitals

4. Against this background, the figures released by the Department of Health, Social Services and Public Safety in respect of the quarter ended December 2002, showed the first overall reduction in hospital waiting lists for over three years, to 57,649, and this fall continued in the following months to 49,975 in the quarter ended March 2004, although they have increased by 1,000 to 50,975 in the quarter ended June 2004 (see paragraph 1.10, Figure 4). This downward trend reflects an increase in the number of patients treated, in addition to action taken by the HPSS to validate waiting lists to ensure that all those included still require clinical intervention. It also reflects the review of good practice in waiting lists management implemented by the Department in 2002 (paragraph 1.7).

5. The latest statistics on waiting lists and waiting times, in relation to the Health and Personal Social Services(HPSS) and the National Health Service (NHS) indicate that those for Northern Ireland are the longest by far, per capita, in the United Kingdom (paragraph 1.8). However, the Department told us that these results need to be considered in the context of higher levels of morbidity in Northern Ireland and the differential demands on resources that result from this (paragraph 1.9). In England, both inpatient and outpatient waiting lists peaked in the late 1990s and then decreased. In Northern Ireland, inpatient waiting lists continued to increase, from approximately 36,000 waiting to be admitted to hospitals in March 1996 to nearly 60,200 in September 2002, though the numbers have dropped back to around 51,000 in June 2004. This represents a net increase of approximately 42 per cent in 8 years. For outpatients, waiting lists have increased by some 165 per cent, from approximately 59,000 at the end of March 1996 to approximately 156,357 at the end of June 2004 (paragraph 1.10).

6. More significantly, within the overall numbers waiting for treatment in Northern Ireland, there has been a very significant increase in hospital inpatient excess waiters. These have risen from 664 during the quarter ended March 1996 - just

prior to the implementation of a significant retraction in waiting list activity as a result of the financial settlement for 1996-97 - peaking at 9,158 at 30 September 2002 and dropping back to 3,235 during the quarter ended 30 June 2004. Of these 3,235 excess waiters, 5 patients were waiting 12 months or more for cardiac surgery (paragraph 1.12). While this recent decrease is welcome, the equivalent figures for England at the end of June 2004 were only 552 inpatients waiting 12 months or more, in all specialties, with no patients waiting 12 months or more for cardiothoracic surgery. In Scotland no inpatients were waiting 12 months or more for treatment, including cardiac surgery. The number of outpatient excess waiters in Northern Ireland (those having to wait more than 3 months for a first outpatient appointment) increased during the same period (March 1996 to June 2004) from approximately 16,100 to around 89,700 (457 per cent) (paragraph 1.13).

On Targets

7. In Northern Ireland, formal targets for reducing waiting lists in the HPSS were first set by the Department in 1998, when the Boards were set a maximum target of inpatient waiting lists of 39,000 by 31 March 1999. However, it has only been since 2000-01 that Trusts, along with Boards, have been formally required by the Department to set annual targets for the reduction in waiting list numbers. In September 2000, the Minister launched a new Waiting List Framework for Action to bring down numbers, which aimed, through a sustained effort over three years, to progressively bring waiting list numbers down to an acceptable level (paragraphs 3.6 - 3.8).

8. The Department has informed us that, as is practice elsewhere in Great Britain, it collects two different sets of waiting list data - data from the Trusts and data from the Boards. Quarterly data include private patients waiting for treatment in Health Service hospitals, and patients who reside outside of Northern Ireland.

Waiting for Treatment in Hospitals

This information, provided by the Trusts, is published on a quarterly basis and , as a National Statistic, is, therefore, subject to considerable validation prior to publication in the Department's quarterly Waiting List Bulletins. Monthly data is required to monitor performance against targets on a more frequent basis. This monthly data is provided by the Boards and exclude private patients and patients resident outside Northern Ireland. The Department has informed us that, as this information is required in a timely manner, it would not be practicable to subject it to the same lengthy validation processes as the Department carries out on the published quarterly data. To do so, it points out, would result in considerable delays in its availability and would minimise opportunities to take timely appropriate follow-up action. It has told us that this monthly data is validated by both HSS Boards and Trusts before being submitted to the Department, and it considers it to be an acceptable indicator of in-year performance against targets (paragraph 3.19). In view of the differences between the monthly waiting list data used to monitor performance against targets and the published quarterly waiting list data, the Department should consider standardising the methods of monitoring and reporting waiting list performance to obtain monthly data to the same standard of completeness as the quarterly figures. The Department has told us that it will be considering how best to monitor and report waiting list performance based on the outcome of the Statistics Commission's Review of Health Statistics which has concentrated on the collection of waiting list statistics throughout the UK, and has highlighted the importance of regional comparability (paragraph 3.28).

9. The Department's current objective is to reduce the maximum wait for any stage of treatment. It has announced a number of targets. It hopes to reduce the maximum waiting time to 3 months for outpatient appointments, and 3 months for elective procedures, by 2011. As an interim outcome, it presently hopes to reduce the maximum waiting time in each case to 26 weeks. It has also stipulated

Waiting for Treatment in Hospitals

that no patient should have to wait more than 12 months for cardiac surgery or more than 18 months for other inpatient treatment. Anyone having to wait longer than these times is regarded as an "excess waiter". Performance in meeting these targets is monitored. Targets are set from year to year in the Department's annual Priorities for Action programme. The Department's new Public Service Agreement for the period 2004 - 2006 has set targets to reduce the maximum waiting time for inpatient or day case treatment to 18 months by March 2005, and to 15 months by March 2006 (paragraphs 2.8, 2.9, and 3.18).

10. The different conditions that have prevailed in England have meant that the NHS there have significantly shorter waiting times and this has enabled the Department of Health to set targets in the NHS Plan to cut the maximum wait for inpatient treatment to six months, and for outpatient treatment to three months, by the end of 2005. In June 2004, the Government announced that a key objective of its new five-year NHS Improvement Plan is to reduce the maximum wait from referral by a GP to hospital treatment to 18 weeks by 2008 (paragraph 2.10). In Scotland, where waiting times are shortest, minimising delays and reducing waiting times are identified as a major priority for NHS Scotland in its NHS Plan. In June 2002, the Scottish Executive announced further commitments to reduce waiting times. Patients with a guarantee for treatment as an inpatient or day case will wait no longer than 6 months by the end of 2005. From the end of December 2005, no patient in Scotland should have to wait more than 6 months for a first outpatient appointment with a consultant following referral by a GP (paragraph 2.10).

11. DHSSPS's view is that there are several factors underlying higher waiting lists, including higher levels of morbidity in Northern Ireland and the differential demands on resources that result from this, and less access to the levels of private sector capacity available in Great Britain. It believes there is no lack of

commitment or of effort on the part of the HPSS, and it pointed to a survey carried out in 2000, which indicated that registered nurses in Northern Ireland deal with more patients than most other regions of the United Kingdom. It reported that productivity was high, and resources were being used at virtually full capacity. However, our recent report on the Use of Operating Theatres indicated that ninety-four per cent of the available planned capacity of Northern Ireland's hospital theatres was being used, but noted that there was a key issue concerning the fact that over one-third of the available weekday physical capacity of these theatres was not being used. The Department told us that it continues to work with the HPSS to secure improvements in the management of waiting lists and the throughput of patients through the Health and Social Care System. It also pointed out that the HPSS has been working under rising levels of demand, that emergency pressures have impacted on the ability to undertake elective surgery, and beds are being used at virtually full capacity, all of which has resulted in higher waiting lists for elective procedures (paragraph 2.11). However, waiting lists are influenced by a wide range of factors and reducing them requires concerted action across many of the key areas in the HPSS (paragraph 2.13).

On Progress against Targets and the Validation of Waiting Lists

12. The number of people waiting for inpatient treatment had been steadily increasing until July 2002, since when the position has substantially improved (paragraph 3.20). We note that the improvement in waiting list numbers over the past two years or so has been brought about by a comprehensive programme of action, involving additional investment, increased capacity, service improvement measures and an extensive exercise to validate waiting lists. However, it is

Waiting for Treatment in Hospitals

important that the Department separates the movement in the waiting list figures brought about by the validation work, from any substantive reduction caused by additional resource inputs and improvements in efficiency. This will enable it to properly adjudge the effectiveness of its policies on improving patients' access to care. We were told by the Department that the regular validation of waiting lists - to confirm both the accuracy of the data and the continued desire or requirement for an appointment or treatment - was an integral part of effective arrangements for managing waiting lists. The Department indicated that it would be almost impossible to separate the figures in the way described without significant work on patient level data which is not available to it. However, we have been told that Trusts are now establishing, as accurately as possible, the extent to which validation has contributed to reductions in waiting lists and reporting their findings to the Department as part of the monthly PTL monitoring (paragraph 3.29).

13. We note that the Department's Priorities for Action (PFA) waiting list targets for 2000-01 and 2001-02 were not achieved. The Department told us that the PFA targets for 2002-03 were revised in the light of changed circumstances, and a better understanding of what was achievable. We welcome the success attained in meeting the revised 2002-03 PFA targets. We also welcome the achievement of the 2003-04 PFA targets. However, the waiting lists on which these targets are based, are very high in Northern Ireland, particularly when viewed against those in the rest of the United Kingdom (Appendix 1), and the Department needs to accelerate its programme of reducing these to acceptable levels, and to reduce the length of time patients have to wait (paragraph 3.30).

14. The respective accountability of Boards and Trusts for waiting list performance needs to be re-emphasised by the Department. The development of more rigorous systems of accountability for waiting list and waiting time

performance, through the setting of realistic, but robust, annual targets for the reduction of waiting lists and times and the monitoring of their achievement, is important. We, therefore, support the Department's policy which holds Trusts (as well as Boards) to account, through their Chief Executives, for target achievement, and we note the Department's intention to reiterate this in its forthcoming Waiting List Handbook. This would be in keeping with current NHS practice in the rest of the United Kingdom (paragraph 3.41).

15. Accountability for the accuracy of the reporting of performance could usefully be backed up by the implementation of a code of practice for HPSS managers, similar to that issued for the NHS in England, in 2002 following the Kennedy Report on the Bristol Royal Infirmary Inquiry, and the reports by the Westminster Committee of Public Accounts on Inpatient and Outpatient Waiting in the NHS and Inappropriate Adjustments to NHS Waiting Lists (paragraph 3.42).

On Targets and Clinical Priorities

16. In our survey of consultants in 10 specialties in 13 acute hospital Trusts, some clinicians (36 out of 87) considered that working to meet waiting list targets meant that they had to treat patients in a different order than their clinical priority indicated. However, any negative impact on the condition of the patient was considered minor. The Department has told us that it has no evidence of any pressure being exerted on clinicians to do so. We are pleased to note that the Department issued clear guidance on this issue in December 2002. We welcome this action and we urge the Department to monitor its compliance. With the pressure to reduce waiting lists and waiting times in the HPSS, any failure to treat patients in accordance with their clinical priority could become a major problem unless waiting lists are managed effectively. We recommend that, in pursuing its

programme to reduce waiting lists and waiting times, the Department should ensure that Trust managers and consultants continue to develop constructive and co-operative working practices to reduce waiting times whilst maintaining clinical priorities (paragraphs 3.31 -3.39, and 3.44).

17. We recommend that in any Trust, where consultants delegate the selection of the number and type of patients for theatre lists, such selection should be in accordance with clear, written, defensible criteria, endorsed by the relevant consultant staff (paragraph 3.47).

18. The Department needs to monitor compliance with the guidance on waiting list management given by its Clinical Resource Efficiency Support Team (CREST), but in view of the time that has passed since the CREST recommendations were made (in 1989), we have recommended that the Department update this guidance. In response, the Department referred to the work being undertaken with Trusts on the formation of its Regional Waiting List Handbook. This is nearing completion and will provide comprehensive guidance on waiting lists, covering those areas of waiting list management contained in the CREST guidance (paragraph 3.48).

On the Impact of Funding on Board Performance

19. Additional expenditure totalling £13.74 million was allocated to the waiting list issue in 2000-01 and 2001-02. A significant part of the total expenditure in each of these financial years was spent on the treatment of excess waiters for cardiac, orthopaedic and plastic surgery in the private health sector. Much of this private sector treatment was provided by private hospitals in Great Britain. This was because the Boards were unable to purchase additional capacity from the HSS

Waiting for Treatment in Hospitals

Trusts providing these regional specialties. Despite this funding and these measures, the waiting list numbers and excess waiters continued to increase beyond the Department's waiting list targets for 2000-01 and 2001-02. The Department has told us that this was due to the continued rise in the demands and pressures on the HPSS and the inevitable time lag between making investment in additional capacity and other new measures and their contribution taking effect. In addition, it was necessary to use some of the funding earmarked for waiting list initiatives to meet higher priority pressures, notably the revenue deficits arising in some Trusts associated with the increased level of emergency pressures (paragraph 4.6).

20. Using private sector facilities, both within and outside Northern Ireland, has made a positive impact on waiting lists. However, expenditure on private healthcare outside Northern Ireland is more expensive (inclusive of travel and other costs) than local HPSS provision, and diverts much needed funding from HPSS providers. Funding such treatment should, therefore, only be a short- term expedient while local capacity in the HPSS is being built up. This is not considered by the Department to be a major problem, as it notes that, in Northern Ireland, private sector provision is sparse and only makes a marginal contribution to acute care provision, and that, in any case, the funding for this was only provided as a temporary expedient and there was no question of diverting a source of funding, used to build up capacity locally, to alternative use for overseas treatment. Appropriate management of waiting times and waiting lists in the HPSS will also help to prevent patients from having to go outside Northern Ireland to receive care (paragraph 4.14).

21. Ideally, waiting list funding allocated by the Department should be used exclusively for waiting list initiatives and not for any other purpose. However, the Department has pointed out that the diversion of a small proportion of

waiting list funds to address Trust revenue deficits in 2001-02 was necessary to deal with the costs of the emergency pressures which the Trusts had to meet (paragraph 4.15).

22. Proposed restructuring, and the investment in the HPSS of the increased recurrent resources made available to the Department through the Programme for Government, will increase the much needed capacity in acute and community services (including extra theatres, extra beds, and more specialist and nursing staff) to help improve and sustain waiting list performance. This must be backed up, however, by efficient and effective management of waiting lists through implementation of the many examples of good practice within the HPSS, in the NHS and elsewhere (paragraph 4.16).

On GP Referrals

23. Consultants need to work with local GPs to discuss appropriate referral practices and to encourage a re-think of existing practices in order to manage workloads better. Boards could make a significant contribution to this (paragraph 4.17).

On the Accuracy of Waiting List and Waiting Time Data

24. We found that, as a result of errors and omissions in the hospitals' Patient Administration Systems from which the data is extracted, there were some problems with the accuracy and completeness of the published waiting list performance data that gave rise to concerns about the reliability of the data. However, there was no evidence of inappropriate adjustments to waiting list performance data. The Department acknowledged that there were errors in some aspects of the data but considered that the data was sufficiently robust to present a reliable portrayal of the waiting list position (paragraph 5.5).

Waiting for Treatment in Hospitals

25. We noted a small number of instances, in the sites we tested, of inappropriate suspensions and removals of patients, and errors in the re-instatement of patients suspended. However, no evidence arose from our testing of any inappropriate adjustments to waiting list performance data, as had been uncovered by the NAO in England but there was evidence of inconsistent practices resulting from the absence of clear, standard, definitive guidance at Directorate level in Trusts (paragraph 5.34).

26. Information in the HPSS (both financial and patient-based), used for management purposes, must be accurate, relevant and timely to inform decision making. For most of the Trusts tested by the Audit Office, waiting list data did not yet meet the "accuracy" criterion (paragraph 5.38).

27. Much could be improved, with the production by Trusts, where they do not already exist, of Trust-wide waiting list protocols in the form of a single, coherent, corporate policy document which contains a clear statement about all aspects of waiting list management; the designation of overall responsibility for developing, implementing and monitoring waiting list policy to a senior officer within each Trust; the distribution of up-to-date copies of all relevant policies and procedures to all staff involved in waiting list management at Directorate level in each Trust; and further training of all staff on the use of the Patient Administration System (PAS), including the waiting list module (paragraph 5.41).

28. The Department has since informed us that all Trusts now have, or are developing, such protocols as are recommended above, and that the Waiting List Handbook will provide clear guidance on all aspects of waiting list management. We urge the Department to ensure that the recommendations contained within this report are covered by the Handbook (paragraph 5.42).

Waiting for Treatment in Hospitals

On Data Quality Assurance

29. Each Trust needs to create and maintain a Trust-wide commitment to data quality assurance to ensure that the waiting list performance data it produces and uses to inform its own, the Boards', and the Department's decision-making, is accurate, relevant and timely. In addition to work undertaken within its Data Quality Audit Strategy, the Department also recognises that it can improve data definitions, the training and awareness of staff, the utilisation of data provider league tables, and the development and roll-out of a local data accreditation process. We welcome this strategy and consider that the results of our validation testing on HPSS waiting list data should provide useful evidence to help in its implementation (paragraphs 5.43- 5.45).

On Measuring Total Waiting Time

30. There are substantial numbers of patients waiting for tests or for further examination, who are currently not captured in the HPSS waiting list statistics. There is a risk that many of these might suffer undue delays in the process (paragraph 5.46). HPSS bodies should measure and monitor the numbers and length of waiting times involved, so that managers and clinicians are fully aware of any hidden backlogs. The Department is working with the HPSS to develop systems which would allow waiting times for diagnostic tests to be measured. We welcome this new initiative (paragraph 5.47).

31. The Department accepts that the different stages in the patient's journey are not fully reflected in the HPSS waiting list statistics; that measuring these would provide a more complete picture but would involve a number of difficulties which would need to be overcome. It considers that there is a need to find an

appropriate way to measure the different aspects of the patient's journey which both fairly represents the waiting involved and avoids unnecessary additional bureaucracy (paragraph 5.47).

32. There should be a similar shift of emphasis in Northern Ireland to waiting times, as has occurred in the NHS. The Department's current objective is to reduce, by 2011, the maximum time waiting for outpatient appointments and treatment to three months, rather than to reduce a patient's total time waiting. It should set targets, measure, and publish statistics on the total time from referral to treatment for serious conditions where there are clear co-ordinated pathways of care. Some targets have been set. For example, a referral target has been set whereby all patients with suspected breast cancer should be seen by a specialist within two weeks of their GP requesting an appointment. The Department needs to follow this up for other conditions and it needs to have a mechanism for monitoring compliance. Finally, we recommend that it publishes guidance on such targets (paragraph 5.48).

General Comment

33. The Department has told us that it has established, in October 2003, its own separate unit to manage waiting lists and pressures arising from emergency admissions, and that a Regional Waiting List Initiative on waiting times, for both elective and emergency patient flows, is now being taken forward to ensure that best practice is identified, shared and implemented throughout Northern Ireland. We welcome this initiative.

Part 1

Setting the Scene

Introduction

1.1 The factors contributing to waiting lists in Northern Ireland are complex and diverse. The Department has told NIAO that at their heart is the interaction of demand and supply side factors, including strategic and operational priorities and pressures, all played out within an environment of rising demographic trends, advances in medical technologies and therapies and increasing public expectation. Other contributory factors include funding problems over the last decade and a half, increasing emergency pressures on elective surgery capacity, reduced bed availability with a high level of bed occupancy, and rising demands on community services. The case mix of patients has intensified with more highly dependent patients requiring more complex interventions and often longer post-operative recovery time in critical and intensive care wards. This impacts on the speed with which other patients can move through the system.

1.2 In addition, the Department told us that "differences in morbidity levels, funding, and in the ability of the private sector to absorb a proportion of the demand make straightforward comparisons with other health economies problematic" (see paragraphs 3.27 and 4.14).

1.3 It is against this background that this report examines the performance of the Northern Ireland Health and Personal Social Services (HPSS) in managing waiting lists.

Background

1.4 Each year in Northern Ireland the local hospital service delivers some 1.9 million episodes of treatment. The great majority of patients do not have to wait long for treatment, and the treatment they receive is generally of a very high standard. 74.4 per cent of inpatients seen during the quarter ended 31 March 2004 had been on the waiting list for less than 3 months, and 94.4 per cent for less than 12 months. All cases presenting as emergencies are admitted within hours. Notwithstanding this, there has been considerable public concern at the length of time people have to wait for their non-urgent treatment. Comparisons with Great Britain show that proportionately more people in Northern Ireland have to wait longer for their treatment than elsewhere (see paragraph 1.8, Figure 3). **This report deals with the waiting times for non-urgent inpatient and outpatient treatment. It does not cover waiting times for emergency hospital treatment.**

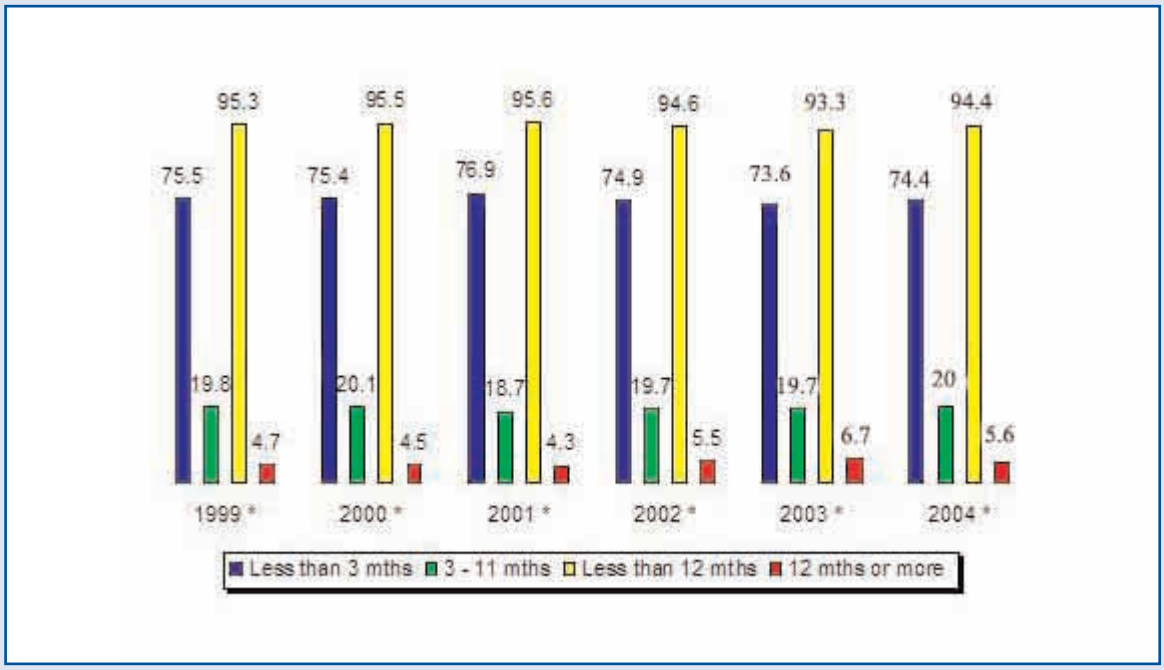
Waiting Lists and Waiting Times

Inpatients

1.5 Over the last six years, the number of inpatients and day cases treated has risen by 8 per cent from 446,528 in 1998-99 to 482,449 in 2003-04. The number of inpatients who were admitted to hospital increased from 150,081 to 153,947, an increase of 2.6 per cent. However, the simultaneous rise in the level of demands on the system has been such that, as Figure 1 demonstrates, the percentage of patients treated who have been waiting 12 months or more has risen by 2.0 percentage points from 4.7 per cent in the quarter ended 31 March 1999 to 6.7 per cent in the quarter ended 31 March 2003, before falling to 5.6 per cent in the quarter ended 31 March 2004 representing an increase of 0.9 percentage points between March 1999 and March 2004. The percentage of patients waiting less than 12 months has fallen commensurately. Similarly, the Figure also shows that the proportion of those treated within 3 months also fell from 75.5 per cent to 74.4

per cent over the same period. For these, and for patients in other time bands, particularly those requiring routine treatment, the total waiting time can be considerable.

Figure 1: Percentage of Inpatients Treated in Various Time Bands: 1999 - 2004



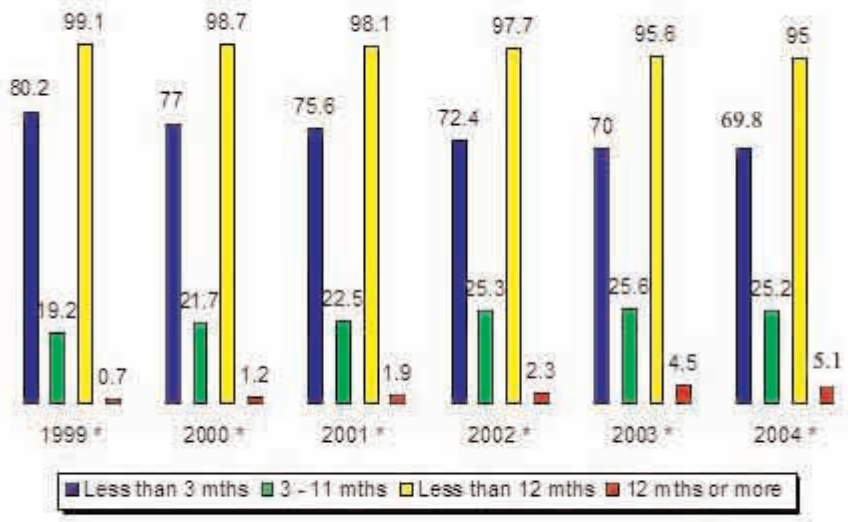
Source: **DHSSPS Quarterly Bulletins**

Notes: ***Figures relate to the quarter ended 31 March each year. Due to roundings, totals do not always add up to 100 per cent.**

Outpatients

1.6 Similarly, the total number of outpatient visits over the same period has increased from 1,427,894 to 1,482,038 - an increase of 3.8 per cent. The number of visits by those who attended their first appointment without having cancelled or missed a previous appointment increased from 318,585 to 345,298, an increase of 8.38 per cent. Figure 2 shows that, of this total, the percentage seen within 3 months has fallen from 80.2 per cent to 70.3 per cent; and the percentage of the total not seen within 12 months has risen from 0.7 per cent in 1998-99 to 4.2 per cent in 2003-04.

Figure 2: Percentage of Outpatients Seen in Various Time Bands: 1999 - 2004



Source: **DHSSPS Quarterly Bulletins**

Note: *** Figures relate to the quarter ended 31 March each year. Due to roundings, totals do not always add up to 100 per cent.**

1.7 Against this background, the figures released by the Department of Health, Social Services and Public Safety (DHSSPS) in respect of the quarter ended December 2002, showed the first overall reduction in hospital waiting lists for over three years, to 57,649, and this fall continued in the following months to 49,975 in the quarter ended March 2004 , although they have increased by 1,000 to 50,975 in the quarter ended June 2004 (see paragraph 1.10, Figure 4). This downward trend reflects an increase in the number of patients treated, in addition to action taken by the HPSS to validate waiting lists to ensure that all those included still require clinical intervention. It also reflects the review of good practice in waiting list management implemented by the Department in 2002 (see paragraph 3.2).

1.8 The latest statistics on waiting lists and waiting times, in relation to the Health and Personal Social Services (HPSS) and the National Health Service (NHS) indicate that those for Northern Ireland are the longest by far, per capita, in the United Kingdom (see Figure 3 and Appendix 1):

Figure 3: Comparative UK Inpatient Waiting Lists - June 2004

Waiting List Measure	Northern Ireland	Wales	England	Scotland
Number of inpatients waiting for treatment /1,000 population *	30.04	25.87	17.87	22.23
Number of inpatients waiting 12 months or more / 1,000 population *	4.04	3.06	0.01	0.00

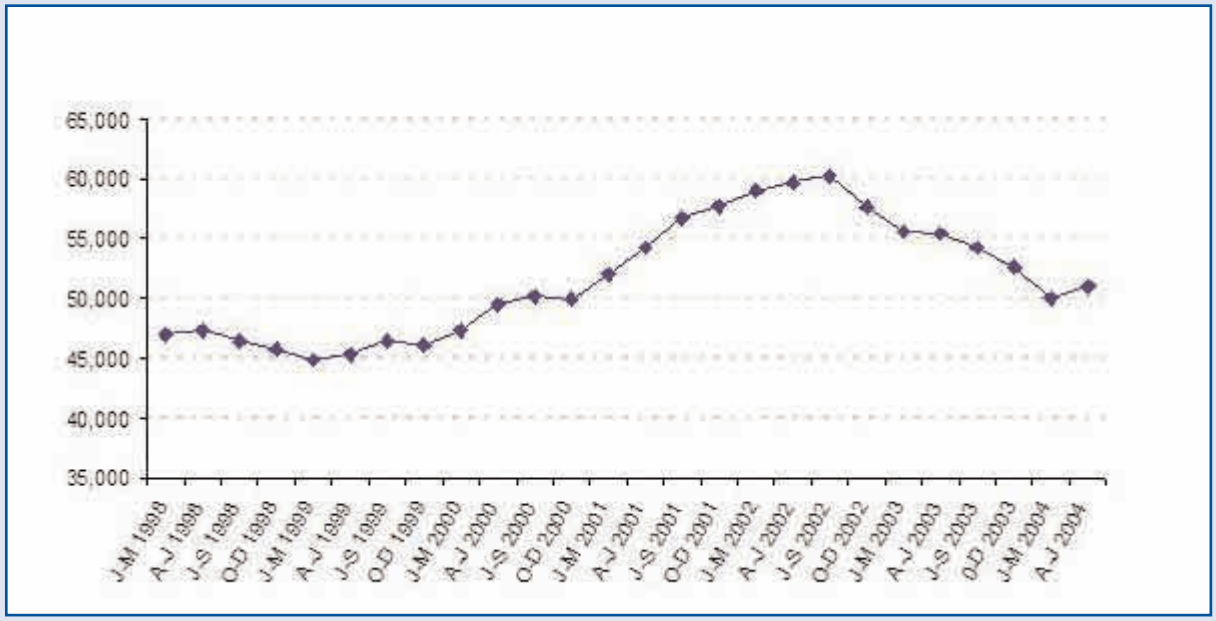
Source: NIAO
Note: * Based on 2001 Census

1.9 The Department has informed us that these results need to be considered in the context of higher levels of morbidity in the Northern Ireland population, and the differential demands on resources that result from this, compared to elsewhere and the higher necessary levels of intervention, resulting in proportionately more people waiting for treatment at any one time[1].

1.10 In England, both inpatient and outpatient waiting lists peaked in the late 1990s and then decreased. In Northern Ireland, inpatient waiting lists continued to increase, from approximately 36,000 waiting to be admitted to hospitals in March 1996 to nearly 60,200 in September 2002, though the numbers dropped back to around 51,000 in June 2004 (see Figure 4) - a net increase of approximately 42 per cent in 8 years. For outpatients, (including cancellations and deferrals) they have increased by some 165 per cent, from approximately 59,000 at the end of March 1996 to approximately 156,357 at the end of June 2004.

1. DHSSPS - Health & Social Care in Northern Ireland: A Statistical Profile

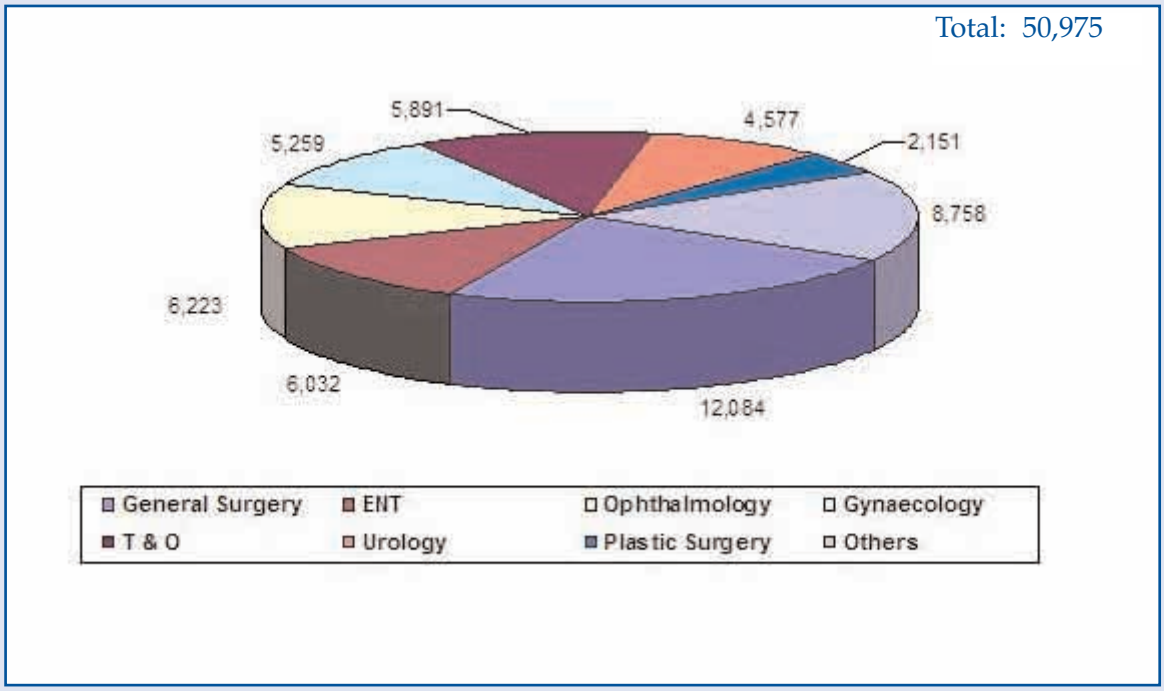
Figure 4: Inpatients - Quarterly Waiting Lists: 6 -Year Trends, 1998 - 2004



Source: **DHSSPS Quarterly Bulletins**

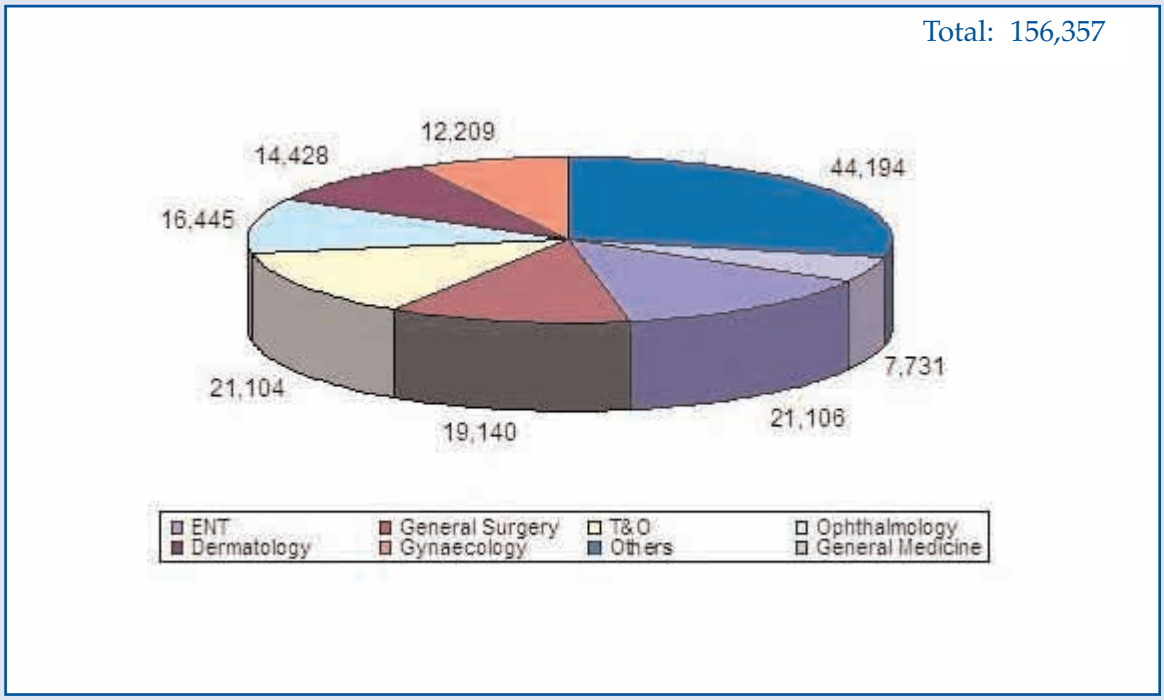
1.11 In the latest quarter ended 30 June 2004, the specialty with the highest number of inpatients waiting was General Surgery (see Figure 5) while the specialty with the highest number of outpatients waiting was Ear Nose and Throat (see Figure 6).

Figure 5: Inpatients -Total Waiters by Specialty -30 June 2004



Source: DHSSPS Quarterly Bulletins

Figure 6: Outpatients -Total Waiters by Specialty - 30 June 2004

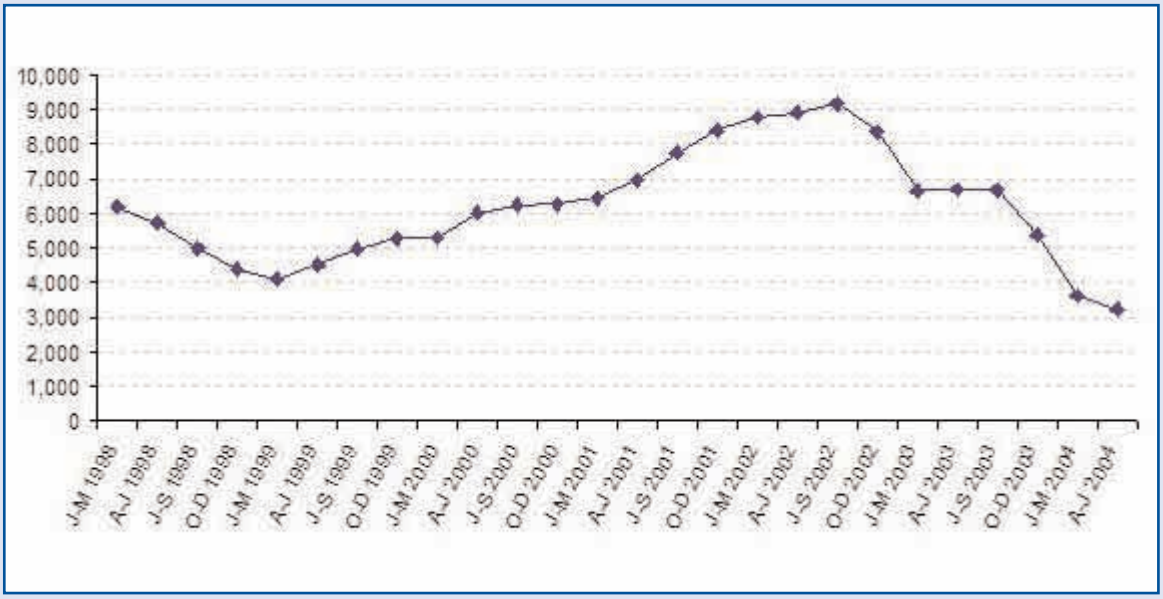


Source: DHSSPS Quarterly Bulletins

Excess Waiters

1.12 More significantly within the overall numbers waiting for treatment, there has been a very significant increase in hospital inpatient excess waiters[2]. These have risen from 664 during the quarter ended March 1996 (it should be noted that this was just prior to the implementation of a significant retraction in waiting list activity as a result of the financial settlement for 1996-97 - see paragraph 4.4), peaking at 9,158 at 30 September 2002 and dropping back to 3,235 during the quarter ended 30 June 2004 (see Figure 7). Of these 3,235 excess waiters, 5 patients were waiting 12 months or more for cardiac surgery.

Figure 7: Inpatients - Excess Waiters: 6-Year Trends, 1998 - 2004



Source: **DHSSPS Quarterly Bulletins**

1.13 While this recent decrease is welcome, the equivalent figures for England at the end of June 2004 were only 552 inpatients waiting 12 months or more, in all specialties, with no patients waiting 12 months or more for cardiothoracic surgery. In Scotland no inpatients were waiting 12 months or more for treatment, including cardiac surgery (see paragraph 3.26 and Appendix 1).The number of outpatient excess waiters[3] in Northern Ireland increased during the same period

2. Inpatient Excess Waiters - those patients having to wait 12 months or more for cardiac surgery and those waiting 18 months or more for other treatment - limits which were set out in the HPSS Patients' Charter
3. Outpatient Excess Waiters - those patients having to wait more than 3 months for a first outpatient appointment.

(March 1996 to June 2004) from approximately 16,100 to around 89,700 (457 per cent) (see paragraph 3.24 and Figure 9). This was despite an increase of 71,498 in the number of outpatients seen between June 1996 and June 2004.

NIAO's Reasons for Examining HPSS Waiting Lists

1.14 We examined waiting lists and waiting time for treatment in the HPSS because:

- waiting list and waiting time statistics are seen by the public as a key measure of the performance of the HPSS as a whole;
- they are a measure of the degree of access to timely and appropriate treatment and impact on the levels of public satisfaction with the HPSS ;
- the considerable public concern and local media attention as to waiting list performance, and the length of waiting for appointments and operations, has led to many questions by Assembly Members and scrutiny by the Assembly Health, Social Services and Public Safety Committee;
- there has been considerable national debate, about the adequacy of waiting lists and waiting times as key performance measures, the impact of initiatives to reduce waiting lists and waiting times, and on what the size of waiting lists actually indicates;
- attention has focused recently on the accuracy of waiting list and waiting time performance statistics in the NHS in England, Scotland and Wales with reports published by the National Audit Office (NAO), the Westminster Committee of Public Accounts, Audit Scotland and the Audit Commission[4].

4. - Inpatient and Outpatient Waiting in the NHS, NAO, [HC 221] July 2001.
- Inpatient and Outpatient Waiting in the NHS, Westminster Committee of Public Accounts, [HC 376] 45th Report, Session 2001-02, September 2002.
- Treasury Minute on the 45th Report from the Committee of Public Accounts, 2001-02 (cm5676), November 2002.
- Inappropriate Adjustments to NHS Waiting Lists, NAO, [HC 452] December 2001.
- Inappropriate Adjustments to NHS Waiting Lists, Westminster Committee of Public Accounts, [HC 517]Session 2001-02, September 2002.
- Review of the Management of Waiting Lists in Scotland, Audit Scotland, [AGS/2002/3] June 2002
- Waiting List Accuracy - Assessing the Accuracy of Waiting List Information in NHS Hospitals in England, Audit Commission, March 2003.
- Achieving the NHS Plan - Assessment of Current Performance, Likely Future Progress and Capacity to Improve, Audit Commission, June 2003.

We hope that our examination will prove to be a timely contribution to the current initiatives by DHSSPS to reduce patient waiting and to improve overall efficiency at local hospital level.

Scope of the NIAO Examination

1.15 Our examination involved:

- examining the nature of waiting times and waiting lists and the factors influencing them - **Part 2**;
- reviewing waiting list targets and performance against them; - **Part 3**;
- examining the impact of additional waiting list funding provided by DHSSPS on the reduction of waiting lists, and reviewing the performance of Boards and Trusts against targets set under the Department's latest waiting list initiative, including establishing how effectively, additional waiting list funding was spent - **Part 4**; and
- assessing the accuracy of waiting list and waiting time performance data - **Part 5**.

We are undertaking a supplementary review of outpatient clinic cancellations and missed outpatient appointments, which we will report on separately.

1.16 Many operational aspects of the HPSS impact on waiting lists and waiting times. These include the overall resource availability; the level of demand for both emergency and elective treatment; the use of operating theatres; the availability of hospital beds, including intensive care and high dependency beds; the numbers of consultants, other clinical staff and nursing staff; the length of

patient stay in hospital and discharge arrangements; consultants' contracts; and the order in which patients are admitted from the waiting list. Some of these further develop issues set out in previous NIAO reports, such as The Provision of Acute Hospital Services in Northern Ireland (November 1993); Hospital Outpatient Services (November 1995), Coronary Heart Disease (November 1996) and The Use of HPSS Operating Theatres (April 2003).

Methodology

1.17 We used a variety of methods to examine the issues identified for our examination, including validation work at a sample of acute Trusts. We also carried out separate questionnaire surveys of:

- Acute Trust Chief Executives;
- Area Health Board Chief Executives; and
- Acute hospital consultants.

Part 2

What are Waiting Times and Waiting Lists?

Waiting Times

2.1 The total time that a patient has to wait for resolution of a health problem is not simply the time that his or her name is on a waiting list for a consultation or for surgery. For those patients who need surgery or other intervention, the total time the patient has to wait is from the date on which the patient first seeks an appointment with a general practitioner (GP) until the date the patient is admitted to hospital for treatment. However, this total time is not applicable in all cases and embraces a number of discrete and often discontinuous stages. Aside from any wait for an appointment with a GP, the next stage begins at the point at which the GP determines that the patient requires further investigation - which can involve tests administered by the practice nurse or referral to a consultant. If the latter, that stage is generally on an outpatient basis and often involves diagnostic tests, scans and/or other investigations; it can also constitute an initial course of treatment. The next stage begins at the point at which the consultant determines that the patient requires surgery or other intervention or treatment and continues until the patient is admitted to hospital, on either a day case or inpatient basis, for that surgery or treatment. This, the Department has told us, points up the difficulty of determining a measurement which fairly reflects the extent of waiting involved in the case of each individual patient, and the need to consider how best to record the time that a patient has to wait.

2.2 The total waiting time from the date the GP refers the patient to a consultant up to the date the patient is admitted for any hospital treatment, is not routinely

measured in either the HPSS in Northern Ireland, or in the National Health Service (NHS) in Great Britain (see paragraphs 5.31, 5.32 and 5.48), though, in Wales, an attempt was made to measure total waiting times in the 1990s, and work is currently well advanced to collect diagnostic and therapy waiting times.

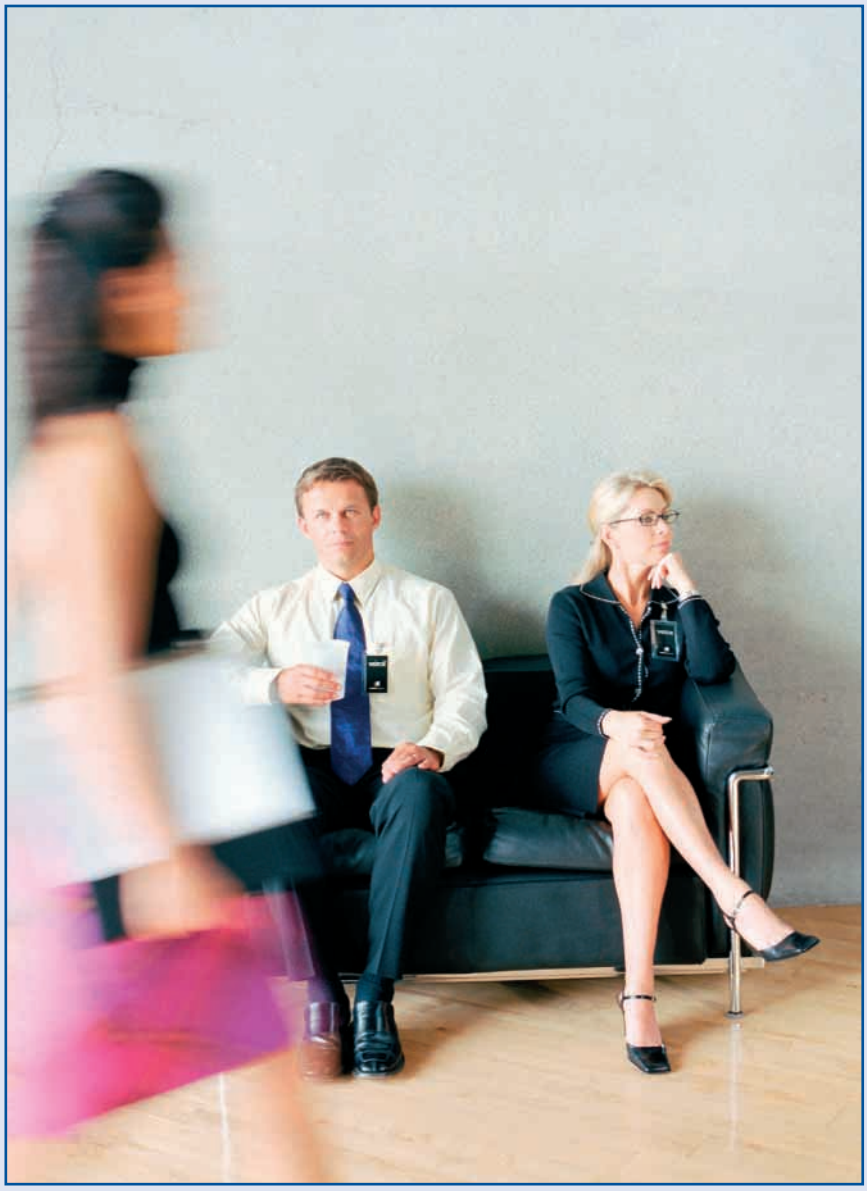
2.3 In its report on Inpatient and Outpatient Waiting[5] the National Audit Office identified three main elements to this wait:

- **waiting to see a consultant** (the outpatient waiting list), comprising the time a patient waits from seeing the GP until they are seen at an outpatient clinic by a consultant or other health professional;
- **establishing whether treatment is required**: in some cases a consultant might require tests or diagnostic procedures to be carried out before determining what treatment, if any, is required. Such tests may be conducted on the same day the patient attends the outpatient clinic, or may take substantially longer; and
- **waiting for treatment** (the inpatient waiting list), comprising the time a patient waits from being placed on the inpatient waiting list for treatment until they are admitted to hospital.

2.4 Not everyone referred to a consultant by a GP requires further inpatient treatment. Some require only a single outpatient appointment and others will have their condition addressed through a series of attendances at outpatient clinics. The Department has informed us that, because there is not always a clear time continuum from the initial GP referral through to patient admission, the time from GP referral to the time of admission would therefore be difficult to monitor meaningfully in terms of overall patients.

5. Inpatient and Outpatient Waiting in the NHS, NAO [HC 221], July 2001

2.5 The Department's view is that no single measurement adequately reflects the range of circumstances and extent of discontinuity involved in each individual case. It considers that the chief concerns for patients are how long they have to wait after referral for an appointment with a consultant and for admission for surgery or treatment, and this is why separate inpatient and outpatient waiting lists are maintained across the NHS and HPSS (see paragraphs 5.30 to 5.34, and 5.46 to 5.48), although we note that the Government appears to be moving away from this in respect of the targets now being set in England (see paragraph 2.10).



Waiting Lists

2.6 Formal waiting lists are a measure of the number of people waiting to be treated by the HPSS at a particular date. Patients can be listed on the **outpatient waiting list**, which indicates the number waiting for a first hospital outpatient appointment (the patient being added to the outpatient waiting list when the hospital receives the GP's referral letter, and remaining on it until first seen at an outpatient clinic). Subsequently, the patient can be listed on the **inpatient waiting lis**t, which shows the number waiting for surgery or other treatment (the patient being added to the list when the consultant decides to admit him or her to hospital for treatment, and remaining on it until treated, either as a day case or an inpatient).

2.7 In addition to some patients undergoing diagnostic tests, outpatient waiting lists, both in Northern Ireland and England, only include individuals waiting for their first appointment with a consultant. They do not include those, who as part of their treatment, are referred to another consultant's outpatient clinic, those sent for subsequent diagnostic testing, or those required to attend a further appointment. In Wales, the waiting list for a first outpatient appointment includes referrals from all sources, not just GPs. Scotland does not have an outpatient waiting list (see paragraph 2.10). In Northern Ireland, inpatient waiting lists only include patients awaiting admission for elective care from a consultant. Emergency admissions and maternity admissions are, understandably, excluded, and so, on the basis of Körner[6] guidance are:

- outpatients;
- patients undergoing a planned programme of treatment, e.g. a series of admissions for chemotherapy;
- patients already in hospitals but included in other waiting lists;
- patients who are temporarily suspended from waiting lists.

6. Körner indicators are based on data sets collected by individual hospitals based on guidance which is common throughout the United Kingdom.

2.8 For reasons set out in paragraphs 2.1 - 2.5, the Department believes it would be difficult to target total waiting times. Given the complexities of measuring waiting times across the primary care, outpatient and inpatient spectra the Department's current objective is to reduce the maximum wait for any stage of treatment. It has announced a number of targets. For example, in 'Developing Better Services', it said that, once the new pattern of hospital services (arising out of the publication of the Acute Hospitals Review and the Department's subsequent consultation exercise) is established, the Department hopes to reduce the maximum waiting time to 3 months for outpatient appointments, and 3 months for elective procedures, by 2011[7]. As an interim outcome, it presently hopes to reduce the maximum waiting time in each case to 26 weeks[8].

2.9 The Department has also stipulated that no patient should have to wait more than 12 months for cardiac surgery or more than 18 months for other inpatient treatment. This is in accordance with the current commitments set out in the Patients' Charter[9]. Anyone having to wait longer than these times, is regarded as an "excess waiter". Performance in meeting these targets is monitored. Targets are set from year to year in the Department's annual Priorities for Action programme (see paragraphs 3.7 to 3.17). The Department's new Public Service Agreement has set targets to reduce the maximum waiting time for inpatient or day case treatment to 18 months by March 2005, and to 15 months by March 2006 (see paragraph 3.18)[10].

2.10 The different conditions that have prevailed in England have meant that the NHS there have significantly shorter waiting times and this has enabled the Department of Health to set targets in the NHS Plan[11] to cut the maximum wait for inpatient treatment to six months, and for outpatient treatment to three months, by the end of 2005. In June 2004, the Government announced that a key

7. Developing Better Services: Modernising Hospitals and Reforming Structures, DHSSPS, June 2002.
8. Service Delivery Agreement/Corporate Plan 2003/04, DHSSPS, June 2003.
9. A Charter for Patients and Clients, Secretary of State for Northern Ireland, 1992, as revised.
10. Department of Finance and Personnel : Northern Ireland Priorities and Budget 2004 -06, 13 January 2004.
11. The NHS Plan, A Plan for Investment, a Plan for Reform, DoH, July 2000.

objective of its new five-year NHS Improvement Plan is to reduce the maximum wait from referral by a GP to hospital treatment to 18 weeks by 2008[12]. In Scotland, where waiting times are shortest (see Appendix 1), minimising delays and reducing waiting times are identified as a major priority for NHS Scotland in its NHS Plan[13]. In June 2002, the Scottish Executive announced further commitments to reduce waiting times. Patients with a guarantee for treatment as an inpatient or day case, will wait no longer than 9 months by the end of 2003, and no longer than 6 months by the end of 2005.The 9 month target has been met as at the end of December 2003. From 31 December 2005, no patient in Scotland should have to wait more than 6 months for a first outpatient appointment with a consultant following referral by a GP.

The persistence of waiting lists

2.11 The Department's view is that there are several factors underlying higher waiting lists, including higher levels of morbidity in Northern Ireland and the differential demands on resources that result from this, and less access to the levels of private sector capacity available in Great Britain (see paragraphs 1.2, 3.27 and 4.14). It believes there is no lack of commitment or of effort on the part of the HPSS and it pointed to a survey[14] carried out in 2000, which indicated that registered nurses in Northern Ireland deal with more patients than most other regions of the United Kingdom. It reported that productivity was high, and resources were being used at virtually full capacity. However, our recent report on the Use of Operating Theatres (NIA 111/02, HC 552, 10 April 2003) indicated that ninety-four per cent of the available planned capacity of Northern Ireland's hospital theatres was being used, but noted that there was a key issue concerning the fact that over one-third of the available weekday physical capacity of these theatres was not being used. The Department told us that it continues to work with the

12. The NHS Improvement Plan: Putting People at the Heart of Public Services, Department of Health, June 2004.
13. Our National Health - a plan for action , a plan for change, NHS Scotland, December 2000
14. Why are we Waiting? Snapshot Surveys of the Impact of Emergency Pressures on Patient Care, Royal College of Nursing & Association of Community Health Councils for England and Wales, February 2000.

HPSS to secure improvements in the management of waiting lists and the throughput of patients through the Health and Social Care System. It also pointed out that the HPSS has been working under rising levels of demand, that emergency pressures have impacted on the ability to undertake elective surgery and beds are being used at virtually full capacity, all of which has resulted in higher waiting lists for elective procedures.

2.12 Waiting lists persist - both in Northern Ireland and in Great Britain. National and international research[15] points to a dynamic relationship between the demand for treatment (emanating from patients and the GPs who advise them) and the supply of health resources (resources provided by Trusts, and the efficiency of their use). Waiting lists result, ultimately, from a mismatch between demand and resources, which helps to explain the persistence of waiting lists in public healthcare systems.

15. Research examples include:
- A Dynamic Model of National Health Service Waiting Lists, van Ackere & Smith, Systems Dynamic Group, March 1999.
- Waiting Lists and Waiting Times in Health Care - Managing Demand and Supply, Report of the Standing Committee of the Hospitals of the European Union (HOPE), 2000.
- Spend More, Wait Less?, Fraser Institute, August 2000.
- A Brief History of Waiting in the NHS, Harrison & New, King's Fund, November 2000 (see Appendix 1 of NAO Report on Inpatient and Outpatient Waiting in the NHS, July 2001).

Factors influencing waiting lists

2.13 Waiting lists are influenced by a wide range of factors and reducing them requires concerted action across many of the key areas in the HPSS. These factors include:

- the restriction in surgery as a result of the funding, staff and theatres available;
- winter pressures and accident and emergency operations which can disrupt elective surgery;
- a lack of community service provision leading to delayed discharge / bed blocking;
- the time taken to train specialist staff;
- staff may have to work extra hours to run additional theatre sessions;
- changes in GP referrals;
- new developments in medicine increasing public expectations of what can be treated by surgery;
- the introduction of nurse or physiotherapy clinics for outpatients;
- the number of clinics depends on funding and resources available;
- clinical governance restricts the work that can be done by junior doctors; and
- the efficient and effective management of the service.

Source: **Department of Health (GB), adapted by NIAO to take account of the situation in the Northern Ireland HPSS**

Part 3

Performance Against Targets

3.1 This part of the report examines the waiting list targets set for the HPSS, and shows performance against them. It examines, also, the effects of target setting on clinical priorities.

Importation of Good Practice from Great Britain

3.2 In 2002 a Regional Service Improvement Leader from the NHS Modernisation Agency was seconded to DHSSPS, to assist it in the implementation of good practice in waiting list management. This was an indication of the Department's commitment to tackle the waiting list problem. The recent downward movement in the waiting list figures, as shown above and discussed later in this Part, suggests that these efforts are having an effect.

Target-setting

3.3 Waiting list and waiting time targets are included in the package of performance measures used by the NHS to monitor the performance of Health Authorities/Boards and Trusts in England, Scotland and Wales.

3.4 In England, waiting list target-setting at Trust level has been an integral feature of the NHS's performance assessment framework for some time. Each year, Health Authorities agree targets with each Trust for:

- the number of outpatients waiting over 13 weeks; and

- the number of inpatients on waiting lists at the end of the financial year.

A new NHS performance assessment framework, including a star ranking system for individual Trust performance, was introduced under the Performance Improvement agenda, from April 2001. This introduced systems of incentives, both financial and non-financial, for improving performance. This policy was developed further with the passing of the Health and Social Care (Community Health and Standards) Bill in July 2003. Included in this legislation, is the provision for the establishment of NHS Foundation Trusts, which are intended to give high-ranked hospitals more independence from central control, by giving them flexibility to access a wide range of options for capital funding, freedom to retain surplus finances, to invest in new service delivery, and flexibility to manage and reward staff.

3.5 In Scotland, each year, the Scottish Executive agrees local targets for the coming financial year with each NHS Board. Local Trusts are represented in the meetings between the Executive and Boards, at which agreement is reached. In Wales, waiting time targets are set by the Welsh Assembly and agreed with each Trust as part of developing a Service and Financial Framework for each health community.

3.6 In Northern Ireland, formal targets for reducing waiting lists in the HPSS were first set by the Department in 1998 - in its HPSS Management Plan of 1999-2000 to 2001-02 - when the Boards were set a maximum target of inpatient waiting lists of **39,000 by 31 March 1999** - 7,000 below the 1997 level. Whilst total waiting lists reduced to 43,444 (see paragraph 1.10, Figure 4), this target was not achieved. (The 43,444 figure comes from the CHA Return - Monthly Waiting List Position, but paragraph 1.10 - Figure 4 relates to the Quarterly Waiting List information).

A Framework for Action on Waiting Lists

3.7 However, it has only been since 2000-01 that Trusts, along with Boards, have been formally required by the Department to set annual targets for the reduction in

waiting lists numbers. The Department told us that prior to 2000-01, its targets for waiting list reductions were set in the context of the internal market arrangements which applied at that time. As such, targets were directed primarily at Boards as purchasers of services.

3.8 In September 2000, the Minister launched a new Waiting List Framework[16] for action to bring down numbers, which aimed, through a sustained effort over three years, to progressively bring waiting list numbers down to an acceptable level. It required Boards and Trusts to provide Action Plans setting out targets for the overall reduction in waiting list numbers, including specific targets for reducing excess waiters, and the action to be taken under the following headings:

Clinical Initiatives:

- examination of scope for expansion of primary role care
- development of GP referral protocols for specific services
- reduction in inequalities in waiting times
- dissemination of good practice initiatives

Management Action:

- development of waiting list action plans
- submission of quarterly performance returns to the Department
- appointment of managers with responsibility for waiting lists
- establishment of systems for close monitoring of activity and trends
- improvement of information on service users.

Service Planning:

- setting targets for overall reductions
- setting specific targets for reducing the number of long waiters
- setting specific targets for cardiac surgery waiters
- targeting specific community care needs
- profiling non-urgent elective work to maximise yearly throughput
- consideration of expansion in 'slot' systems (a tool used for managing the demand from primary care for outpatient referrals, where a GP practice has access to an agreed number of appointment slots for their patients)
- consideration of use of dedicated elective units

Efficiency Measures:

- validation of hospital waiting lists
- improvement of efficiency of outpatient appointment systems
- establishment of managed process for patient cancellations or DNAs
- increasing partnership/ whole system working (where the waiting list process is jointly managed as a whole by all involved)
- exploring the pooling of consultant waiting lists in major specialities
- improvement of theatre efficiency

16. Framework for Action on Waiting Lists, 2000-01, DHSSPS, September 2000

3.9 Within the context of this Framework, the Minister indicated, initially, that she wanted all Boards to set a standard reduction for 2000-01, whereby hospital waiting lists at 31 March 2001 were to be no greater than the 31 March 2000 figure. Patient Charter standards covering waiting times were expected to be fully met, no later than the end of the year 2002-03, and Boards and the Royal Group of Hospitals Trust (which provides the region's cardiac surgery services), were to take necessary action to ensure that, by September 2001, no patient was waiting longer than 12 months for cardiac surgery.

3.10 These targets were not achieved, and overall waiting list numbers increased from 47,420 at the end of March 2000 to 50,693 at the end of March 2001 (see paragraph 1.10, Figure 4). The Department has put this down to the continued increase in the demands on the HPSS and the absence of substantial additional resources.

Priorities for Action 2001- 02

3.11 In the Department's Priorities for Action (PFA) for 2001-02[17], which outlined the planning guidelines, objectives and targets for the HPSS for that year in the context of the Programme for Government and Budget agreed by the Assembly, the following revised waiting list targets were set:

- waiting for treatment (inpatients): Boards and Trusts were to reduce waiting lists to 48,000 by March 2002, as a first step towards bringing the numbers waiting down to 39,000 by March 2004; and
- excess waiters (see the HPSS Patients' Charter limits in the footnotes to paragraphs 1.11 and 1.12): Boards and Trusts were to reduce the number of those waiting longer than 18 months by 50 per cent by March 2002, towards a total elimination of such long waiters by March 2003.

3.12 Waiting to see a consultant (outpatients): Whilst the Department aims to bring down waiting times for outpatient appointments, no specific targets were set for reducing the number of people on the outpatient waiting list. The Patients' Charter provides for a maximum wait of three months for a first outpatient appointment. In a March 2003 press statement the then Minister called on the service to focus effort over the coming months on improving waiting times for outpatients.

3.13 The report of the Acute Hospitals Review Group, published in June 2001, considered that these PFA waiting list targets did not go far enough. The Group recommended that new, more challenging targets be established with a view to ensuring that by 2010, no one should have to wait more than 3 months for treatment, and this was reinforced in the 'Developing Better Services' proposals, issued in June 2002, when the then Minister indicated her expectation that the new pattern of hospital services would substantially reduce waiting times, bringing them down to a maximum of 3 months for non-urgent cases (see paragraph 5.48).

17. Priorities for Action: 2001-02, DHSSPS, March 2001.

3.14 The Department's PFA waiting list targets for 2001-02 were not achieved. By 31 March 2002, the total number of patients waiting to be admitted for treatment rose to 57,308 from 50,693 at the end of March 2001, and, rather than being eliminated, excess waiters rose to 8,673.

Priorities for Action 2002- 03

3.15 Waiting list targets were subsequently amended in the light of actual HPSS performance during 2001-02, and the Department's PFA for 2002-03[18] revised the waiting list targets again, to the following:

- by March 2003, to have constrained hospital waiting lists to the March 2002 level of 57,308; and
- by March 2003, to provide for access to cardiac surgery for an additional 150 people, over and above the original planned levels of provision for 2001-02.

3.16 DHSSPS statistics show that, by 31 March 2003, the total number of inpatients on inpatient waiting lists had fallen to 54,541, thus achieving the PFA target for 2002-03. In relation to the cardiac surgery target, the Department told us that, against the planned level of procedures in 2002-03, of 800 at the Royal Group of Hospitals plus the additional 150 proposed in the PFA for that year, a total of 1,181 procedures were carried out. This included 786 at the Royal Victoria Hospital and a further 395 from providers outside Northern Ireland, including the former HCI Hospital Glasgow, Hammersmith Hospital in London, and the Blackrock Clinic and Mater Hospitals in Dublin. This target was, therefore, also achieved.

Priorities for Action 2003- 04

3.17 The Department's PFA , covering 2003-04[19], pointed to the action that had been taken to improve the management and validation of waiting lists and a number of other actions which would serve to increase activity levels, including the establishment of protected elective facilities and an expansion in capacity at key hospitals. Among its priority targets for the year, it now required:

- to ensure 95 per cent of people are treated within 12 months;
- by March 2004, Boards and Trusts to ensure that the number of people waiting longer than 18 months for hospital inpatient or day case treatment is reduced by 50 per cent from the June 2002 level of 9,063, by putting in place measures to improve the management of waiting lists; and
- by March 2004, Boards and Trusts to ensure that the number of people waiting for hospital inpatient or day case treatment is reduced by 5 per cent from the June 2002 level of 58,872.

These targets were achieved.

18. Priorities for Action: 2002-03, DHSSPS, March 2002.
19. Priorities for Action: 2003-04, DHSSPS, February 2003.

Public Service Agreement 2004- 06

3.18 The Department's new Public Service Agreement[20] has set targets to:

- ensure that by March 2005, 95 per cent of patients requiring hospital inpatient or day case treatment are admitted within 12 months of being placed on a waiting list; and
- reduce the maximum waiting time for inpatient or day case treatment to 18 months by March 2005, and to 15 months by March 2006.

The 18-month target is similar to the target set in 1992 under the Charter for Patients and Clients. However, unlike the Charter target, (which includes the target that no patient should have to wait more than 12 months for cardiac surgery), the 18 month target applies to all inpatients regardless of specialty (see paragraph 2.9).

The basis for measuring performance

3.19 The Department has informed us that , as is practice elsewhere in Great Britain, it collects two different sets of waiting list data - data from the Trusts and data from the Boards. The waiting list data, which the Department publishes quarterly, and which is quoted in other parts of this report, include all patients living outside Northern Ireland and all privately funded patients waiting for treatment in Health Service hospitals. This information is submitted to the Department by the Trusts and is published as a National Statistic. It is, therefore, subject to considerable validation prior to publication in the Department's quarterly Waiting List Bulletins. The Department has informed us, however, that the waiting list targets published in its HPSS Management Plan, Priorities for Action, and Public Service Agreement (see paragraphs 3.6-3.18, above), have baselines set using ***monthly*** waiting list data, submitted by the Boards to the Department which exclude these patient categories, and these are the figures

20. Department of Finance and Personnel : *Northern Ireland Priorities and Budget 2004-06*, 13 January 2004.

used in this part of the report (see paragraphs 3.20 to 3.23). The Department has informed us that, as this information is required in a timely manner, it would not be practicable to subject it to the same lengthy validation processes as the Department carries out on the published quarterly data. To do so, it points out, would result in considerable delays in its availability and would minimise opportunities to take timely appropriate follow-up action. It has told us that this monthly data is validated by both HSS Boards and Trusts before being submitted to the Department, and it considers it to be an acceptable indicator of in-year performance against targets (see paragraph 3.28).

Progress against targets

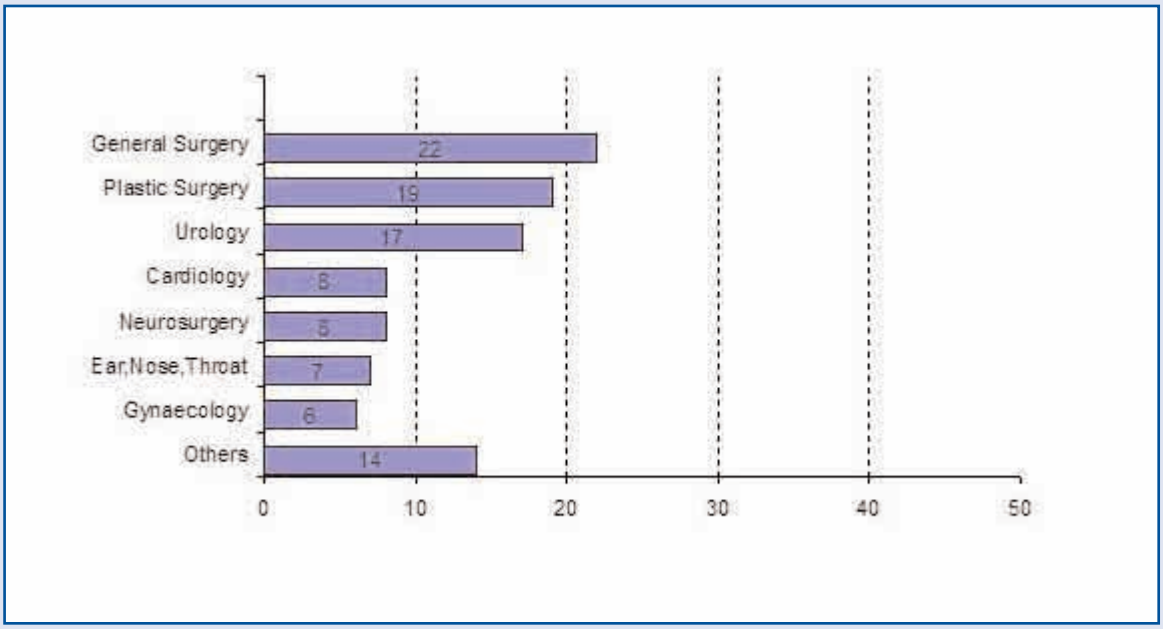
The number of people waiting for inpatient treatment had been steadily increasing until September 2002, since when the position has substantially improved

3.20 The numbers waiting for treatment were on a generally downward trend until March 1999 when the trend reversed and the numbers waiting, rose to peak in July 2002 at 59,969, before falling back to 50,004 in June 2004 - see paragraph 1.10, Figure 4.

3.21 Excess waiters have followed a similar trend, rising to a peak of 9,673 in August 2002, before falling back to 6,620 in April 2003 (some 12 per cent of the total numbers waiting for treatment in April 2003). Following a small increase to 6,886 by the end of August 2003 excess waiter numbers continued to fall to 3,197 by the end of June 2004 - see paragraph 1.12, Figure 7.

3.22 In the quarter ended 30 June 2004, the specialty with the highest number of patients waiting (see paragraph 1.11, Figure 5) and the highest proportion (in percentage terms) of excess waiters (see Figure 8) was General Surgery.

Figure 8: Inpatients - percentage (%) Excess Waiters by Specialty - June 2004



Source: **DHSSPS Regional Information Branch**

Note: **The specialties with the highest proportion of excess waiters within their own specialty are Neurosurgery and Plastic Surgery, the former, according to the Department, having a problem with the availability of specialist nurses, and the latter including many patients with a low clinical priority.**

3.23 An analysis of the excess waiters at Trust provider level, for those specialties with the major proportion of excess waiters is provided, for the four years up to 31 March 2004 at Appendix 2. This shows that trends in most specialties in most Trusts have improved significantly from 31 March 2003. In a number of specialties and in some Trusts, there has been a downward trend, whilst in a number of other specialties, levels continue to be high. Examples of each of these are :

(a) Position Improving:

- The specialties showing the most notable improvement across Trusts, from 31 March 2003, are General Surgery and Trauma and Orthopaedics. The Royal Group of Hospitals Trust has made good

progress in cardiac surgery and neurology over the four year period.

- The Mater Infirmorum Trust has shown good improvements in the gynaecology specialty over the four year period, with the percentage of patients waiting in excess of 18 months, and in excess of 24 months, having decreased from 36.2 per cent to 0.0 per cent, and from 30.5 per cent to 0.0 per cent, respectively, at the end of March 2004.

- The Ulster Community and Hospital Trust has improved in both categories, in the trauma and orthopaedics specialty, from 61.3 per cent waiting over 18 months at March 2001 to nil at March 2004, and from 55 per cent waiting over 24 months to nil. It has also improved, in both categories, for ear, nose and throat from 4.1 per cent at March 2002 to nil at March 2004 for those waiting over 18 months, and from 3.6 per cent at March 2001 to nil at March 2004 for those waiting over 24 months.

(b) Position Deteriorating:

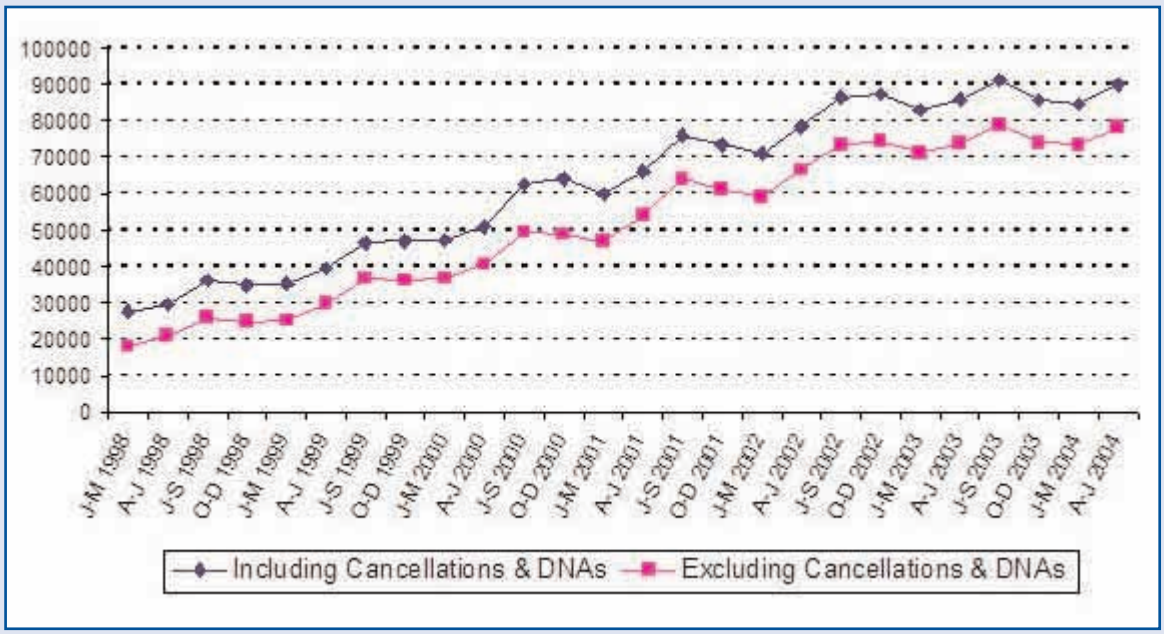
- The United Hospitals Trust figures are steadily increasing in gynaecology in both categories.

(c) Continuing High Levels at March 2004 - 18 month target

- Trauma & Orthopaedics - The Royal Group of Hospitals Trust - 13.5 per cent.
- Plastic Surgery - Royal Group of Hospitals Trust - 46.7 per cent, Ulster Community and Hospitals Trust - 24.9 per cent

3.24 Outpatient waiting lists have risen steadily over the past six years with the number of outpatients waiting for a first appointment (including cancellations and deferrals) standing at 156,357 at the end of June 2004. 57 per cent of these (89,712 patients) were excess waiters (i.e. waiting more than 3 months for a first appointment) - see Figure 9, below.

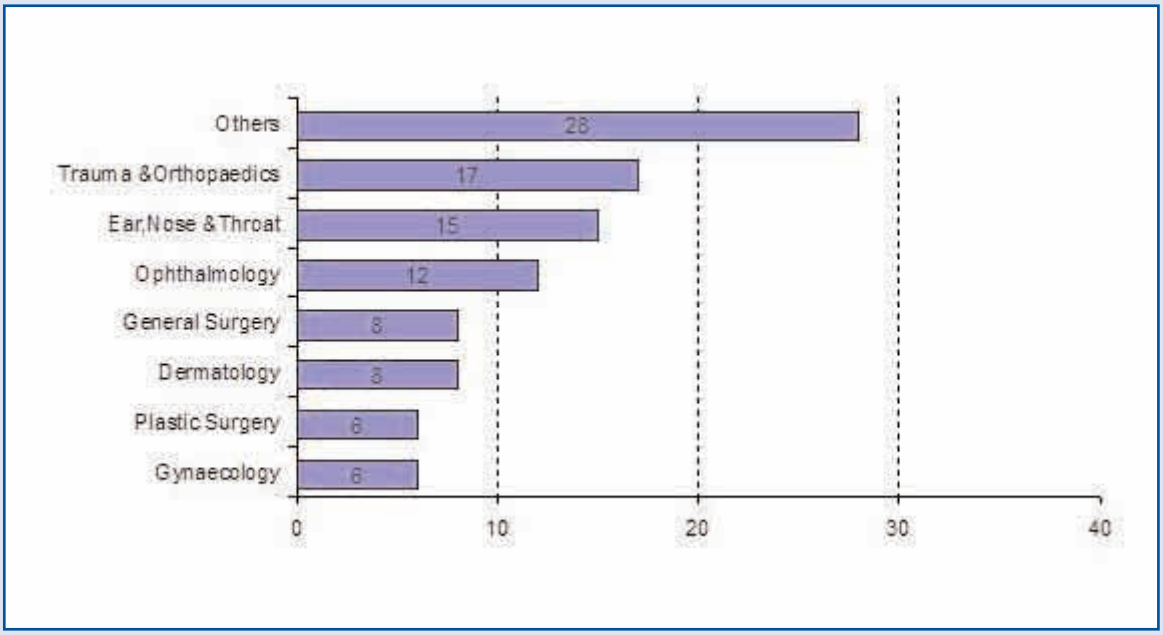
Figure 9: Outpatients Excess Waiters: 6-Year Trends, 1999 -2004



Source: **DHSSPS Quarterly Bulletins**

3.25 In the quarter ended 30 June 2004 the specialty with the highest number of patients waiting (see paragraph 1.11, Figure 6) was ear, nose and throat, and with the highest number of excess waiters, it was trauma and orthopaedics (see Figure 10).

Figure 10: Outpatients - percentage (%) Excess Waiters by Specialty - June 2004



Source: **DHSSPS Quarterly Bulletin**

Note: **The specialty with the highest proportion of excess waiters within its own specialty is Plastic Surgery, which, according to the Department, includes many patients with a low clinical priority.**

3.26 These figures for inpatients and outpatients have to be seen in the context of the equivalent figures for the NHS in England, Scotland and Wales. For example, for inpatients:

- In Wales, the total number of patients waiting 12 months or more for inpatient or day case treatment at 30 June 2004 was 8,940 (including patients waiting for tonsillectomies). No patients were waiting over 12 months for cardiac surgery[21];
- In Scotland, at 30 June 2004, no patients were waiting 12 months or more for inpatient treatment. 17 patients had waited over the 18-week maximum waiting time standard for cardiac surgery[22];

21. The National Assembly for Wales - Statistical Directorate: NHS Wales Waiting Times: at end June 2004, SDR 53/2004 of 28 July 2004.
22. ISD Scotland National Statistics release - NHS Scotland: Acute Activity, Waiting Times and Waiting Lists: Latest quarterly trends : to June 2004.

- In England, the 30 June 2004 records showed that 552 patients were waiting for inpatient and day case treatment 12 months or more, with no patients waiting 12 months or more for cardiothoracic surgery[23]; (see Appendix 1).

3.27 The Department informed us that these results need to be considered in the context of higher levels of morbidity in Northern Ireland, significant underfunding of the HPSS relative to England, and less access to the levels of private sector capacity available in Great Britain (see paragraph 4.14).

NIAO Conclusions and Recommendations - Progress against Targets and the Validation of Waiting Lists

3.28 In view of the differences between the monthly waiting list data used to monitor performance against targets and the published quarterly waiting list data, the Department should consider standardising the methods of monitoring and reporting waiting list performance to obtain monthly data to the same standard of completeness as the quarterly figures. The Department has told us that it will be considering how best to monitor and report waiting list performance based on the outcome of the Statistics Commission's Review of Health Statistics which has concentrated on the collection of waiting list statistics throughout the UK, and has highlighted the importance of regional comparability.

3.29 We note that the improvement in waiting list numbers over the past two years or so has been brought about by a comprehensive programme of action, involving additional investment, increased capacity, service improvement measures and an extensive exercise to validate waiting lists (see paragraphs 1.7, 3.17, 4.7, 4.19 to 4.20, and 5.17 to 5.21). It is important that the Department separates the movement in the waiting list figures brought about by the validation work, from any substantive reduction caused by additional resource inputs and improvements in efficiency. This will enable it to properly adjudge the effectiveness of its policies on improving patients' access to care. We were told by the Department that the regular validation of waiting lists - to confirm both the accuracy of the data and the continued desire or requirement for an appointment or treatment - was an integral part of effective arrangements for managing waiting lists. In addition the Department indicated that it would be almost impossible to separate the figures in the way described without significant work on patient level data which is not available in the Department. However, we have been told that Trusts are now establishing, as accurately as possible, the extent to which validation has contributed to reductions in waiting lists and reporting their findings to the Department as part of the monthly PTL monitoring (see paragraphs 4.18 - 4.20).

23. Department of Health - Provider Based Hospital Waiting List Statistics: English Summary - Ordinary and Day Case Admissions Combined: Quarter 1 2004-05.

3.30 We note that the PFA targets for 2000-01 and 2001-02 were not achieved. The Department told us that the PFA targets for 2002-03 were revised in the light of changed circumstances, and a better understanding of what was achievable. We welcome the success attained in meeting the revised 2002-03 PFA targets. We also welcome the achievement of the 2003-04 PFA targets. However, the waiting lists on which these targets are based, are very high in Northern Ireland, particularly when viewed against those in the rest of the United Kingdom, and the Department needs to accelerate its programme of reducing these to acceptable levels and to reduce the length of time patients have to wait.

Targets and clinical priorities

3.31 A fundamental principle of clinical practice is that the order in which patients are operated on by a consultant should be determined by their clinical priority so that those in greatest clinical need are treated first. However, pressure on consultants to meet waiting list targets can lead to them not treating patients in accordance with their clinical priority.

3.32 Guidance issued by the Royal College of Surgeons in 1991[24] states that patients should be selected for admission from the waiting list by the consultant or his nominee and that no patient should be removed from the waiting list without the permission of the consultant.

3.33 In a memorandum dated November 2001 to the Westminster Committee of Public Accounts[25], the Chairman of Ethical Audit commented that medical consultants should have total control of their waiting lists and that only they can make a fully informed assessment of each patient's condition and needs; that such decisions should never be taken by someone without medical qualifications; that if through pressure of work the consultant needs to delegate these decisions, this responsibility must be delegated to a medically qualified assistant who will know which cases need to be discussed with the consultant, who ultimately is always responsible.

24. Guidelines for the Management of Surgical Waiting Lists, Royal College of Surgeons, June 1991
25. Inappropriate Adjustments to NHS Waiting Lists, Westminster Committee of Public Accounts, 46th Report, Session 2001-02 - Appendix 3 to the Minutes of Evidence [HC 517].

3.34 The Chairman of Ethical Audit observed that in many instances consultants had lost control of their lists which have been manipulated by administrators without the consultants' approval; that the consultants had been obliged to treat or operate upon patients produced in the order laid down without their control so that it could be claimed that waiting lists had been reduced, not because patients had been treated but because their priority had been "adjusted" by management.

3.35 We sought to establish if target setting was causing a similar degree of distortion of clinical priorities in Northern Ireland as had been noted by the NAO in its report on Inpatient and Outpatient Waiting in the NHS[26]. We took account of the recommendations published by the Department's Clinical Resource Efficiency Support Team (CREST) in June 1989[27] which said that each consultant should be personally responsible for his / her waiting list and should monitor it regularly; each clinician should develop a short statement defining categories of clinical urgency; and all junior medical and non-medical staff involved in waiting list management should clearly understand the categories of urgency and the procedures to be followed.

3.36 From the 13 acute hospital Trusts that we surveyed, we invited consultants in 10 specialties - General Surgery; Trauma & Orthopaedics; Ophthalmology; ENT; Urology; Gynaecology; Plastic Surgery; Cardiology; Cardiac Surgery; Neurology - to comment on the influence of waiting list targets on the clinical priorities they afforded in the treatment of their patients. Their responses indicated that some consultants (36 out of 87) were of the view that waiting list targets were resulting in patients not being treated in strict clinical priority order. However, this outcome was not to the same extent as was reported by NAO for the NHS in England, and any negative impact on the condition of the patient was considered minor (see paragraph 3.39).

26. Inpatient and Outpatient Waiting in the NHS, NAO, July 2001 [HC 221].
27. A Short Guide to Waiting List Management, CREST, DHSS, June 1989.

3.37 The survey was carried out by asking the Chief Executives of Trusts to issue survey questionnaires to consultants in the ten specialties listed in paragraph 3.36. We were keen that the survey would be seen as unbiased by audit considerations, hence the decision to ask the Trusts to decide on the number and to whom the survey questionnaires should be issued.

3.38 The Department told us that caution was needed in interpreting the results of this survey. It considers the comments made were in the nature of unvalidated anecdotal comments, and that no wider conclusions could be drawn from them without establishing the circumstances or context within which they were made.

3.39 Thirty six consultants of the 87 who commented, considered that working to meet waiting list targets meant that they had to treat patients in a different order than their clinical priority indicated. Eight consultants told us that treatment of

patients in a different order had occurred frequently. Of the 36 consultants, 18 indicated that deferring treatment had a negative impact on the condition of the patient. It is important to note that all 18 regarded this negative impact as minor. No consultant reported a major negative impact.

NIAO Conclusions and Recommendations - Target-setting

3.40 We noted that, whilst the Minister's Waiting List Framework charges both Boards and Trusts jointly with responsibility for ensuring the reduction of waiting lists and waiting times, accountability for waiting list / time performance appeared to us, in the course of our review, to lie ultimately with the Boards. However, the Boards, as commissioners, are dependent on the performance - and capacity - of Trust providers in reducing waiting lists and times, and we saw evidence, in the waiting list Action Plans of Trusts, of targets agreed with Boards as their contribution to the Boards' own commitments to the Departments' annual PFA waiting list targets.

3.41 The respective accountability of Boards and Trusts for waiting list performance needs to be re-emphasised by the Department. In its Framework for Action on Waiting Lists (September 2000) the Department said that Chief Executives of Boards and Trusts should ensure that the Framework is fully and effectively acted upon by their organisations. We noted that the Department required Trusts, in submitting their Waiting List Action Plans for 2002-03, to identify a single person at board level with specific responsibility for waiting lists and waiting times, to report progress monthly to the Trust board. Trusts were also instructed to submit monthly targets, taking account of the PFA waiting list targets for 2002-03. The development of more rigorous systems of accountability for waiting list and waiting time performance, through the setting of realistic, but robust, annual targets for the reduction of waiting lists and times and the monitoring of their achievement, is important. We therefore support the Department's policy which holds Trusts (as well as Boards) to account, through their Chief Executives, for target achievement and we note the Department's intention to reiterate this in its forthcoming Waiting List Handbook. This would be in keeping with current NHS practice in the rest of the United Kingdom.

3.42 Accountability for the accuracy of the reporting of performance, as recommended in paragraph 3.41, could usefully be backed up by the implementation of a code of practice for HPSS managers, similar to that issued for the NHS in England, in 2002[28] following the Kennedy Report on the Bristol Royal Infirmary Inquiry[29] and the reports by the Westminster Committee of Public Accounts on Inpatient and Outpatient Waiting in the NHS[30] and Inappropriate Adjustments to NHS Waiting Lists[31].

28. Code of Conduct for NHS Managers, DoH, October 2002
29. Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Professor Sir Ian Kennedy, July 2001
30. Inpatient and Outpatient Waiting in the NHS, Westminster Committee of Public Accounts, 45th Report, Session 2001-02, September 2002 [HC 376]
31. Inappropriate Adjustments to NHS Waiting Lists, Westminster Committee of Public Accounts, 46th Report, Session 2001-02, August 2002 [HC 517]

3.43 Under such a code, managers are required to "support and assist the Accounting Officer ... in his or her responsibility to answer to Parliament, Ministers and the Department ... in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets." Individuals are held to account for their own performance, responsibilities and conduct, where employers form a reasonable and genuinely held judgement that allegations of breaches of the Code have foundation. This could include the manipulation of waiting lists. The new Department of Health (England) policy means that serious breaches of the Code, such as financial fraud, providing false information or negligence in providing for the safety of patients, could be regarded as gross misconduct and could lead to dismissal, with individuals being prevented from working again in the health service[32]. DHSSPS issued guidance in November 1994, which is still extant, on codes of conduct and accountability for Northern Ireland. Consultation on a Managers' Code of Conduct was recently completed and a code of conduct was issued to the HPSS in November 2003.

NIAO Conclusions and Recommendations - Targets and Clinical Priorities

3.44 Although some clinicians considered that working to meet waiting list targets meant that they had to treat patients in a different order than their clinical priority indicated, the Department has told us that it has no evidence of any pressure being exerted on clinicians to do so. We are pleased to note that the Department issued clear guidance on this issue in December 2002[33]. We welcome this action, and we urge the Department to monitor its compliance. With the pressure to reduce waiting lists and waiting times in the HPSS, any failure to treat patients in accordance with their clinical priority could become a major problem unless waiting lists are managed effectively. We recommend that, in pursuing its programme to reduce waiting lists and waiting times, the Department should ensure that Trust managers and consultants continue to develop constructive and co-operative working practices to reduce waiting times whilst maintaining clinical priorities.

32. Inappropriate Adjustments to NHS Waiting Lists, Treasury Minute, November 2002
33. A Cohort approach to Managing Waiting Times - Primary Targeting Lists

3.45 In the course of our validation testing of waiting list performance data at a selected number of hospital sites (see Part 5) we noted that some ENT consultants at Belfast City Hospital had delegated the selection of patients off the waiting list for operation, to their secretaries. Whilst these consultants had given guidance to their secretaries on such selection, we understand that it had been given on an informal, verbal basis. A written policy, which codifies acceptable criteria for the selection of patients off the waiting list for treatment, protects both staff (clinical and non-clinical) and patients from any suspicion of inappropriate distortion of clinical priorities in the selection process. This is in keeping with the Department's Clinical Resource Efficiency Support Team (CREST) 1989 guidance on waiting list management. Consequently, we welcome the fact that responsibility for the management of waiting lists for all surgical specialties at the Belfast City Hospital Trust has now been transferred to the Trust's central waiting list office, and that written guidelines have now been developed, based on NHS Primary Targeting Lists (see paragraphs 4.18 - 4.20).

3.46 We recommend that in any Trust, where consultants delegate the selection of the number and type of patients for theatre lists, such selection should be in accordance with clear, written, defensible criteria, endorsed by the relevant consultant staff.

3.47 The Department needs to monitor compliance with the guidance given by CREST, but in view of the time that has passed since the CREST recommendations were made (in 1989), we have recommended that the Department update this guidance. In response, the Department referred to the work being undertaken with Trusts on the formation of its Regional Waiting List Handbook. This is nearing completion and will provide comprehensive guidance on waiting lists, covering those areas of waiting list management contained in the CREST guidance.

Part 4

The Impact of Funding on Performance

4.1 This part of the report examines the impact of additional waiting list funding provided by the Department over the last six years on the reduction of waiting lists. We also review the performance of the Boards against their recent action plans and targets for reducing waiting lists, under the Minister's Framework for Action on Waiting Lists.

Waiting List Funding

4.2 The level of funding would be expected to impact on efforts to reduce waiting lists and waiting times. However, studies examining the link between the resources devoted to surgery and the associated waiting time have concluded that the relationship is far from straightforward (see paragraph 2.12). Such findings have been interpreted as evidence that increased funding would have little impact on waiting times and that more resources may simply induce greater demand[34]. However, the Department told us that it disagreed with this, and pointed to the positive impact that increased resources have had on waiting lists in England and to the significant progress which has been made in Northern Ireland in terms of both dealing with the increased volume of demand and the reduction which has been achieved in the numbers waiting.

4.3 A targeted, resourced waiting list initiative was first introduced in Northern Ireland in 1991 when £1.2 million non-recurrent funding was made available to Boards to assist with waiting list reductions. This seems to have successfully

34. A Dynamic Model of National Health Service Waiting Lists - Systems Dynamic Group of the London Business School, WP-0026, 24 March 1999

reduced inpatient waiting lists for a period in the early 1990s - from 27,086 in March 1991 to 24,778 in March 1993 (see Figure 11).

Figure 11: Annual Inpatient Waiting Lists: March 1988-March 1996

Quarter ending 31 March	Number
1988	26,969
1989	27,086
1990	26,553
1991	27,086
1992	26,567
1993	24,778
1994	34,520 *
1995	35,015
1996	36,377

Note: *Includes day cases for the first time

4.4 The Department told us that in 1996-97, the management of waiting lists suffered a major set back when the Public Expenditure Survey required a 3 per cent cash releasing 'efficiency' saving from the HPSS. 50 per cent of the targeted cost reduction was to be achieved through a retraction of waiting list activity - the financial equivalent of £20 million in today's terms. The cuts also had an impact on capacity, with reductions in both the number of beds and of nursing staff. As a result of this reduction (estimated by the Department at £140 million over the seven years since 1996-97), hospital waiting lists increased, and they continued on an upward trend until the second quarter of 2002-03, after which the figures started to fall. This did not allow much progress to be made on restoring capacity. While extra resources have been provided by the Department to reduce waiting lists since 1996-97 (a total of £35.3 million additional funding between 1 April 1997 and 31 March 2003), these were allocated, until 2001-02, on a 'one-off' non-

recurring basis. From 2001-02, a major proportion of the additional waiting list funding has been allocated on a recurring basis, including £5 million initially granted as non-recurring for 2000-01. However, the total additional recurrent funding made available has not been able to bridge the overall shortfall created by the reductions made in 1996-97.

4.5 The non-recurrent funding led to the expectation that waiting lists would follow a 'stop-go' cycle, levelling off as money was found and rising again once it was spent. As the impact of funding will not always be immediate and waiting lists will be sensitive to other influences, it is difficult to make the direct connection between an amount of waiting list funding and a specific numerical reduction in waiting lists. Although the substantial non-recurrent funding of £13 million in 1998-99 led to a reduction from 48,740 in the quarter ended December 1997 to 44,868 in March 1999, the lists began to rise again in subsequent years to an all time high of 60,190 in the quarter ended September 2002. The Department said that this underscored the point that non-recurrent funding can only provide temporary relief against increasing lists and that at the end of the funding period it is not surprising that lists began to increase.

Board Performance

4.6 We reviewed the performance of each of the Boards against their annual Action Plans and targets for reducing waiting lists, and the additional waiting list funding allocated by DHSSPS, for 2000-01 and 2001-02, under the Minister's Framework for Action on Waiting Lists. We found that:

- in spite of expenditure totalling £13.74 million in 2000-01 and 2001-02 (see Appendix 3), which included the spending of waiting list funding provided by the Boards themselves and the additional waiting list allocations from the Department, waiting list numbers and excess waiters continued to increase beyond the

Department's waiting list targets for 2000-01 and 2001-02 (see Figure 4, paragraph 1.10, and Figure 7, paragraph 1.12). The Department has told us that this was due to the continued rise in the demands and pressures on the HPSS and the inevitable time lag between making investment in additional capacity and other new measures, and their contribution taking effect. It pointed out that the additional funding did in fact achieve a substantial increase in the numbers treated but that this was overshadowed by the increased level of overall demand;

- a significant part of the total expenditure in each of these financial years (21 per cent in 2000-01 and 32 per cent in 2001-02) was spent on the treatment of excess waiters for cardiac, orthopaedic and plastic surgery in the private health sector. Much of this private sector treatment was provided by private hospitals in Great Britain. This was because the Boards were unable to purchase additional capacity from the HSS Trusts providing these regional specialties. Figures 12 and 13 provide details of treatment purchased by Boards from the private sector using waiting list funding[35];
- all Boards committed waiting list funds to outpatient Magnetic Resonance Imaging (MRI) initiatives;
- not all the funding earmarked for waiting list initiatives was actually spent on such initiatives. The Department informed us that it was necessary to use some of the funding earmarked for waiting list initiatives to meet higher priority pressures, notably the revenue deficits arising in some Trusts associated with the increased level of emergency pressures (see paragraph 4.15);
- the provision of recurrent funding from 2001-02 (see paragraph 4.4) has enabled more treatments and procedures to be provided and has helped to address both the ever-increasing demands and the existing waiting lists.

35. The Department estimates that some 36,000 procedures would be provided annually through the private sector in Northern Ireland if the use of that sector here was as high as in England.

4.7 The Department told us that if it had not invested in additional activity, waiting lists would be nearly 20,000 higher than they are now. It said that, as well as this additional investment[36], increased capacity, and the development of a range of service improvement measures, a significant contribution to the recent reduction of waiting lists, since September 2002, has undoubtedly been the validation of lists and the weeding out of names that should no longer be on lists. However, as pointed out in paragraph 3.29, it is not known the extent to which the validation exercise has contributed to the overall reduction.

Figure 12: Expenditure on Private Health Sector Treatment, 2000-01

Board	Amount £m.	Details of Treatment
Western	0.212	Treatment of cardiac and orthopaedic excess waiters at HCI, Glasgow and scanning by MRI Ireland
Southern	0.388	Cardiac, orthopaedic, general, and plastic surgery in private GB hospitals: and North West Independent and Ulster Independent Clinics in NI
Northern	0.452	Treatment of cardiac, orthopaedic, and plastic surgery excess waiters at HCI, Glasgow, and the North West Independent and Ulster Independent Clinics in NI
Eastern	0.414	Treatment of cardiac surgery excess waiters in GB
Total	**1.466**	

Source: Health and Social Services Boards

36. £12.6 million was spent in 2002-03 against total waiting list funding of £13.2 million, which includes waiting list funding provided by the Boards themselves, as well as DHSSPS's allocation for 2002-03 - see Appendix 3

Figure 13: Expenditure on Private Health Sector Treatment, 2001-02

Board	Amount £m.	Details of Treatment
Western	0.884	Treatment of cardiac, orthopaedic, and plastic surgery excess waiters at HCI, Glasgow, North West Independent Clinic in NI , and scanning by MRI Ireland
Southern	0.448	Cardiac and orthopaedic surgery in private sector hospitals in GB and ROI, and in the North West Independent Clinic in NI
Northern	0.687	Treatment of cardiac and orthopaedic surgery excess waiters at Ross Hall and HCI, Glasgow, and the North West Independent Clinic in NI
Eastern	0.189	Cardiac surgery outside NI
Total	**2.208**	

Source: Health and Social Services Boards

4.8 The detailed results of our review of waiting list performance, including an analysis of how each Board's waiting list funding for 2000- 01 and 2001- 02 was spent, has been passed to the Department, to inform it of our findings and to prompt it to pursue any problem areas for which it is within its power and responsibility to provide assistance, whether financial or through strategic policy adjustment.

Main problems encountered by Boards

4.9 In response to our survey, the Boards told us that they faced the following main problems, in trying to meet their waiting list targets:

- insufficient recurrent funding to meet elective demand;
- the non-recurrent nature of the waiting list funding allocated. Non-recurrent funding does not yield sustainable reductions in waiting lists and waiting times;

- non-recurrent funding allocated by the Department too late in the financial year, resulting in slippage in funding;
- the need to build and sustain additional capacity, skills and infrastructure;
- a lack of theatre availability in some specialties (especially in fractures);
- the limited availability of specialist staff, with difficulties in recruitment and retention, especially in the regional specialties where there is a significant number of excess waiters;
- the recruitment of staff on a temporary basis, at extra cost, to help to reduce waiting lists;
- the impact of emergency admissions and delayed discharges;
- inconsistent patterns of GP referral, with the need for more effective use of GP referral guidelines and further investment in primary care alternatives to acute assessment and treatment;
- Trust financial deficits and outstanding financial recovery plans;
- ownership by Trusts of waiting list and waiting time issues;
- improved management of waiting times needed at Directorate level in Trusts;
- a lack of local guidance in regard to waiting list management;
- pressure to meet waiting list targets, which can lead to consultants not treating patients in accordance with clinical priority (see paragraphs 3.31 to 3.39 and 3.44 to 3.48);
- consultants looking for premium rates (as in the private health sector) to do additional waiting list work;
- a lack of co-operation from some consultants in regard to permitting patient transfers; for example, a reluctance to send patient notes to private health providers;
- patients not wishing to travel to an alternative provider for treatment. In the majority of cases, the only option available to the Board is to provide any additional patients with treatment at the private hospitals;
- an increased number of patients being added to the waiting lists;
- unrealistic targets;
- the demise of GP Fundholders as commissioners to Trusts.

Main problems encountered by Trusts

4.10 In response to our survey, the Trusts cited the following main problems they faced with having to meet their waiting list targets:

- a lack of capacity - staff, beds and theatres;
- a shortage of key staff;
- emergency admissions;
- delayed discharges ;
- incoherent and inconsistent planning by the Department and the Boards, with different objectives set over the years;
- unrealistic targets;
- long outpatient waiting lists which, if tackled, will impact on inpatient and day case waiting lists.

4.11 To this list provided by Trusts, the Department has reported on the following additional problems encountered by Trusts:

- funding shortfalls in relation to demand for elective surgery;
- need to fund waiting list initiatives with non-recurrent resources;
- some patients are reluctant to travel to an alternative provider for treatment;
- increased GP referrals.

GP Referrals

4.12 Our survey of consultants in the General Surgery, Trauma & Orthopaedics, Ophthalmology, ENT, Urology, Gynaecology, Plastic Surgery, Cardiology, Cardiac Surgery and Neurology specialities identified variations in the rate of inappropriate referrals from GPs. Of the 83 consultants who responded to our

questionnaire, 21 (25 per cent) considered the rate of inappropriate GP referrals to be too high; 3 (4 per cent) considered it to be too low; and 59 (71 per cent) considered it to be about right. Of the 21 consultants who considered the rate of inappropriate referrals to be too high, 7 were General Surgeons, 6 were Gynaecologists, and 4 specialised in Trauma & Orthopaedics, with the balance spread among other specialties.

4.13 The Department acknowledges, in its Framework for Action on Waiting Lists, that there are often marked variations in GP referral rates within specialties. It has recommended that these should be identified and, where appropriate, referral protocols developed to assist GPs, with regular monitoring of subsequent referral being necessary.

NIAO Conclusions and Recommendations - Board Performance

4.14 Using private sector facilities, both within and outside Northern Ireland, has made a positive impact on waiting lists. However, expenditure on private healthcare outside Northern Ireland is more expensive (inclusive of travel and other costs) than local HPSS provision and diverts much needed funding from HPSS providers. Funding such treatment (see paragraph 4.6 and Figures 12 and 13) should, therefore, only be a short- term expedient while local capacity in the HPSS is being built up. This is not considered by the Department to be a major problem, as it notes that, in Northern Ireland, private sector provision is sparse and only makes a marginal contribution to acute care provision, and that, in any case, the funding for this was only provided as a temporary expedient and there was no question of diverting a source of funding used to build up capacity locally to alternative use for overseas treatment. Appropriate management of waiting lists and waiting times in the HPSS will also help to prevent patients from having to go outside Northern Ireland to receive care.

4.15 Ideally, waiting list funding allocated by the Department should be used exclusively for waiting list initiatives and not for any other purpose. However, the Department has pointed out that the diversion of a small proportion of waiting list funds to address Trust revenue deficits in 2001-02 was necessary to deal with the costs of the emergency pressures which the Trusts had to meet (see paragraph 4.6).

4.16 We note that the bulk of waiting list funding in 2001-02 and 2002-03 was allocated by the Department on a recurrent basis; and that, from 2002-03, Board and Trust action on waiting list initiatives does not have to await formal approval by the Department of waiting list action plans, thereby dispensing with potential 'slippage' in funding. The proposed restructuring, and the investment in the HPSS of the increased recurrent resources made available to the Department through the Programme for Government, will increase the much needed capacity in acute and community services (including extra theatres, extra beds, and more specialist and nursing staff) to help improve and sustain waiting list performance. This must be backed up, however, by efficient and effective management of waiting lists through implementation of the many examples of good practice within the HPSS, in the NHS and elsewhere[37].

4.17 Consultants need to work with local GPs to discuss appropriate referral practices and to encourage a re-think of existing practices in order to manage workloads better. Boards could make a significant contribution to this.

4.18 We recognise that there is no instant solution to resolving the waiting list problem in Northern Ireland. Any substantive improvement will take some time. However, we note the good progress made by the Department over the past 18 months and we also note that it has taken action to assist in the implementation of good practice in waiting list management. This has included development work on a Waiting List Handbook for the HPSS, including common waiting list management protocols. This handbook, which was issued for consultation in March 2004, includes details on Primary Targeting Lists (PTL)[38], a methodology developed by the NHS Modernisation Agency.

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37. Examples of good practice outside the HPSS include:
    - The NHS Modernisation Agency's Beacons Programme
    - Inpatient and Outpatient Waiting in the NHS, NAO, July 2001
    - Report of the Review Group on the Waiting List Initiative, Department of Health and Children, R0I, June 1998
    - Waiting Lists for Healthcare in Developed Countries - Initiatives for Long Term Management, Report to the Oireachtas, RoI, October 2000
    - Criteria for the Management of Waiting Lists and Waiting Times in Health Care, Recommendation No R (99) 21 of the Committee of Ministers of the Council of Europe to Member States, 1998
    - The findings of research by the Standing Committee of Hospitals in the European Union (see paragraph 2.12)
38. A Cohort Approach to Managing Waiting Times - Primary Targeting Lists, NHS Modernisation Agency, 2001

4.19 The Department considers that improved management and validation of lists is essential in its strategy to reduce waiting time and improve access to health and social services. In undertaking our review, we have noted that HPSS Chief Executives have attended a number of workshops in recent years, organised by the Department, to discuss the issues of the management and validation of waiting lists. Following these, Trusts were tasked with the development of action plans for taking forward these issues. To support Trusts in this task, the Department issued guidance documents in December 2002[39] on the management and validation of waiting lists that would eventually be incorporated into the Waiting List Handbook. These documents include details of the Primary Targeting Lists (PTL) methodology. Trusts were instructed to ensure that this guidance was followed in implementing their waiting list action plans.

4.20 Following the issue of these guidance documents the Department advised Trusts[40] that it intended to monitor the progress of Trusts' action plans. Under this monitoring system, the Department requires from Trusts, monthly progress reports on action relating to validation of waiting lists, and a monthly updated PTL return showing potential excess waiters.

39. DHSSPS Circular No: HSS (SC) 6/02 - Waiting Lists : Management and Validation, 3 December 2002
40. DHSSPS Circular No: HSS (SC) 8/02 : Waiting List Action Plan Monitoring - Acute Trusts, 5 December 2002

Part 5

Accuracy of Waiting List and Waiting Time Data

Scope of NIAO Validation Testing

5.1 This part of our report presents the results of our validation testing of waiting list and waiting time performance data at a selected number of Trusts. Similar exercises have been reported on in other parts of the United Kingdom by the National Audit Office, Audit Scotland and the Audit Commission (see paragraph 1.14).

5.2 Published HPSS waiting list and waiting time data are compiled from information provided by Trusts. Data are not externally validated. The Department told us that external validation would require a lengthy manual checking exercise, including access to patients' medical records. Not only would this be time consuming, it would also raise a number of concerns regarding data confidentiality. Consequently, accuracy and completeness are dependent on Trusts providing timely and robust data (see paragraphs 5.28 and 5.43 to 5.45). We have commented previously in this report (see paragraphs 3.19 and 3.28) on the different data sets produced for departmental monitoring purposes.

5.3 We visited six Trusts (the Royal Group of Hospitals, Belfast City Hospital , Green Park Healthcare, Craigavon Area Hospital Group, Altnagelvin Hospital, and United Hospitals) between November 2001 and May 2002, to assess the accuracy and reliability of waiting list and waiting time data reported by Trusts and published by DHSSPS. As a subsidiary issue, we also tested for any inappropriate adjustments to waiting list performance data. We also examined

the completeness of waiting list and waiting time data, which was reported by the Trusts and published by the Department. Our methodology was the same as that used by the National Audit Office in their examination of inpatient and outpatient waiting in the NHS[41].

5.4 We observed that United Hospitals Trust had taken the initiative of examining the issues raised in the NAO report on Inappropriate Adjustments to NHS Waiting Lists, considering in turn, each of the inappropriate practices described in the report. The Trust's conclusion, from its examination, was that none of the substantive practices highlighted in the NAO report was evident from examination of practice across the Trust. The report on the findings of its examination did, however, recommend that a review of the Trust's arrangement for re-instating suspended patients was required (see Appendix 4, paragraphs 33-36).

Summary of our Main Findings

5.5 We found that, as a result of errors and omissions in the hospitals' Patient Administration systems, there were some problems with the accuracy and completeness of the published waiting list performance data. This gave rise to concerns about the reliability of the data. However, there was no evidence of inappropriate adjustments to waiting list performance data on the part of the Trusts tested (see paragraph 5.34). The Department acknowledged that there were errors in some aspects of the data, but considered that the data were sufficiently robust to present a reliable portrayal of the waiting list position. The results of our testing are detailed at paragraphs 5.6 - 5.33. They are supported by the findings of a review by the Department of waiting list management as part of its current waiting list initiative. Some of these findings are summarised at Appendix 5.

41. Inpatient and Outpatient Waiting in the NHS, NAO, July 2001 [HC 221]

Details of our findings

Centralisation of the arrangements for the management of waiting lists could help improve the quality and accuracy of waiting list data maintained by Trusts

5.6 The management of waiting lists at most Trusts is decentralised. It is Directorate-led, with consultants' secretarial staff responsible for the day-to-day administration of the lists.

5.7 We noted that a Central Waiting List Office had recently been set up at Belfast City Hospital to manage the inpatient waiting list for the entire Trust - the first of its kind in the HPSS. The chief benefit of centralising the arrangements is greater consistency, and more rigorous management of waiting lists through dedicated staff, employed full-time on this key corporate function. We have recommended that other Trusts should consider adopting this practice and the Department has indicated that its new Waiting List Handbook will include guidance on centralising waiting list management.

Some Trust computer systems have not been developed to meet current demands for waiting list management data

5.8 One common Patient Administration System (PAS) application is used by all the acute sector Trusts in Northern Ireland, and has been implemented on nine different computer systems. These have resulted in minor differences in the way the systems are used. Furthermore, some Trusts have purchased additional software to facilitate the production of key waiting list management data. Further details relating to Trusts which we visited, are given in Appendix 4, paragraphs 1 to 7.

Patients temporarily suspended are not being routinely reviewed and as a consequence, some are being overlooked

5.9 Patients may ask to be suspended from the waiting list for a specific time, because they are unavailable for some reason, such as going on holiday, being pregnant, or having work or family commitments.

5.10 Other patients cannot be admitted to hospital at the present time and are suspended from the waiting list, by the consultant concerned, on medical

grounds. These patients may be obese and need to lose weight, or be heavy smokers and need to stop smoking, before any surgery is contemplated. They could also have a serious, but unrelated, medical condition, such as diabetes, which might affect surgery.

5.11 Patients, so suspended, do not appear in reported waiting list figures. Consequently, there need to be clear rules in place to ensure patients are not wrongly suspended, and to prevent patients being left as suspended for longer than necessary.

5.12 If a patient who is on one waiting list, is admitted to hospital for another, unconnected, condition, they are automatically suspended from the waiting list for the first procedure on the grounds that they are medically unfit. They are not counted as waiting again, until discharged, and the time spent in hospital, will be deducted from the total waiting time.

5.13 Our validation testing at each of the five sites included checks to ensure that the inpatient waiting list and associated average waiting times at these Trusts are not understated because individual patients have been incorrectly suspended from the waiting list. Our view is that there are problems arising from the suspension of patients from waiting lists. The Department considers that this is not a major problem and needs to be seen in the context of the small number of suspended patients relative to the total number of patients waiting; the impact on average waiting times would be minimal. However, we believe that these problems are not just associated with the accurate recording of suspended patients but to their being overlooked in the absence of procedures for routine review, and the resulting potential risk to their medical condition (see, in particular, the results of our review of cardiac surgery suspensions at the Royal Group of Hospitals Trust, Appendix 4, paragraphs 8 to 19). The results of our testing at each of the sites visited, are outlined in Appendix 4, paragraphs 8 to 36. The Department has pointed out that the Waiting List Handbook, issued for consultation in March 2004, provides comprehensive guidance on the review of suspended patients and should ensure that no suspended patients are overlooked.

There should be no delay in updating the PAS for patients where a decision has been made to remove them from the waiting list, and the patient and GP should always be informed of the decision

5.14 Patients may be taken off the waiting list permanently because treatment is no longer appropriate, because he or she has already been treated or no longer wants treatment; where the patient cannot be contacted or has moved; or where the patient has died.

5.15 Our validation testing at each of the five Trusts included checks to ensure that the inpatient waiting list and associated average waiting times at these Trusts were not understated, because individual patients had been incorrectly removed from the waiting list. Patients, and their GPs, need to be notified, in writing, of any decision to remove. This is an important control to prevent inappropriate adjustments to the waiting list. The patient details should be recorded as removed from the PAS on the date of the decision to remove and not any later, so as to avoid overstatement of waiting list numbers and times. We found some cases where notification did not take place, some cases where removal from the lists should not have happened, and others where delays were excessive. The results of our testing at each of the sites are outlined in Appendix 4, paragraphs 37 to 42.

Patients' records maintained by Trusts - both manual and computerised- should be complete, accurate and up-to-date, reflecting the full account of each patient's care pathway. There needs to be a standardisation of the information required to be retained on patients' records

5.16 From our examination of patients' records, we found instances where the records were incomplete (see Appendix 4, paragraphs 19 and 38 to 40).

Regular validation removes patients who no longer need to be seen

Outpatient Validation

5.17 The validation of outpatient waiting lists usually involves making contact with patients to confirm that they still need to see the consultant. At the time of our examination, we noted that some Trusts had made some progress in validating

outpatient lists, though the procedures were less developed than those for inpatients.

Inpatient Validation

5.18 The validation of inpatient waiting lists needs to be carried out regularly, to ensure that individuals on the lists still require treatment and that their details are correct. Any patient listed, who should not be there, should be suspended or removed. Regular validation results in more accurate records, but there are also benefits to be gained from greater contact with patients.

5.19 All 12 Trusts surveyed were conducting some inpatient validation - some on an ongoing basis, some on a periodic or ad hoc basis - though not all were fully documenting their procedures. Over half of the Trusts had, or were developing, a programme of ongoing validation of inpatients. The software of the PAS of some Trusts had been developed to routinely print waiting list validation letters for patients who had been waiting in excess of nine months.

5.20 Guidance on the validation of outpatient, inpatient and day case waiting lists[42] has been drawn up as part of the work led by the Regional Service Improvement Leader on loan from the NHS (see paragraphs 3.2 and 4.18) and is part of the new Waiting List Handbook. This guidance says that validation needs to be a continual process, but recognises that some lists have not previously been validated. For outpatients, every patient on a list, who has been waiting over 13 weeks, should be validated. For inpatients and day cases, every patient on a list, who has been waiting over 6 months, should be validated. Following this initial validation exercise, patients should be contacted once they have been waiting 13 weeks (outpatients) or 6 months (inpatients and day cases).

5.21 The validation procedures in place at a number of sites visited, are outlined at

42. Action on Waiting: Waiting List Validation Processes and Monitoring, DHSSPS, September 2002

Appendix 4, paragraphs 43 to 54. The Department has informed us that validation procedures have been drawn up by all Trusts.

Waiting for Planned Operations

5.22 A planned operation is part of an ongoing series of surgery, for example , the removal of cataracts from both eyes is usually done in two stages as bilateral operations. The second cataract cannot be removed until some time after the first operation. NHS guidance for England states that for bilateral operations the patient should be added to the waiting list for the first operation but not for the second planned operation[43].

5.23 In the course of our validation testing we found that Trusts were adding the second, planned, operation to the waiting list, as a new case, after the first operation had been completed.

5.24 We were advised by the Department that, in Northern Ireland, official guidance

43. Inpatient and Outpatient Waiting in the NHS, NAO, July 2001 [HC 221]

had not yet been issued with regard to waiting lists and the treatment of bilateral operations. The Department agreed that current NHS guidance on the matter is different, and it accepted that Northern Ireland practice was to include the second operation on the waiting list, with the practice being common across Trusts.

5.25 The Department will examine this issue and the Waiting List Handbook will contain appropriate guidance. We note that work carried out on validation since our testing, has resulted in the recommendation that "patients on planned lists should not be included in statutory returns".

Reconciling published statistics with Trust data

5.26 Data submitted by Trusts should be complete, accurate, reliable, timely, and based on consistently applied definitions and guidance. Otherwise, the value of published statistics is undermined. We found a number of errors in the Trust Charter returns we tested. See Appendix 4, paragraphs 55 to 57 for details. The Waiting List Handbook will address these issues.

DHSSPS needs to ensure that comprehensive advice and good practice on waiting list management, including clear, comprehensive waiting list data definition, data collection and preparation, and data quality assurance, are promulgated throughout the HPSS, in order to bring about improvement and a harmonisation of the disparate Trust waiting list policies that have existed in recent years

5.27 On-line electronic guidance from the Department has been available to the HPSS on the completion of the full range of waiting list Charter returns, through the HPSS intranet. In addition, meetings have been held 3 or 4 times a year with Regional Information Branch representatives at which all Trusts and Boards are represented.

5.28 However, this has not provided the Department with data quality assurance. It has recognised that there are significant variations in data quality between the acute and community sectors, with the acute sector being in a better position to

provide information than the community sector - this being attributable to the existence of the single software tool (the Patient Administration System) from which most acute information is generated. The Department is in a continuous process of data validation and is taking forward action to improve data quality, following implementation of its Data Quality Audit Strategy in May 2001(see paragraphs 5.43 - 5.45).

Each Trust needs to put in place a single, corporate waiting list policy document, based on Departmental guidelines, to provide clear, comprehensive and unequivocal guidance to all staff involved in the management of waiting lists

5.29 We found that some Trusts had produced guidance on their waiting lists policy, but others had little or no guidance. Appendix 4, paragraphs 58 to 63 give further details. We noted, however, that one of the Department's Priorities for Action for 2002-03 was the introduction of a common waiting list management system in all acute hospitals by 30 September 2002. Trusts within the Eastern Board area, for example, had made substantial progress in introducing this.

The way that waiting list data is collected means that it is not possible to state a patient's total waiting time

5.30 Current waiting lists statistics (both in the HPSS and the NHS) understate, in many cases, the patient's experience of waiting for treatment by treating the outpatient and inpatient elements of waiting as disconnected events. They do not account at all for the time spent on diagnostic testing and any delay which could be avoided during that stage (see paragraphs 2.1 - 2.7). This time is not measured or monitored, although the base information is available on PAS. As shown in paragraph 2.4, this distortion will not exist where patients only require outpatient treatment, but for many of those requiring inpatient treatment, the time spent on waiting lists will be a significant understatement of the total time a patient has to wait for treatment following his or her initial approach to a GP.

5.31 Although the NHS in England, Scotland, and Wales remains interested in waiting lists, we note that it has shifted its focus from reducing the numbers on waiting lists to reducing waiting times. In England, the NHS already measures total

waiting times for cancer patients, and they plan to do so for other serious conditions where they implement National Service Frameworks (NSFs) and there are clear co-ordinated pathways of care. For example, the NHS in England brought in, from December 2001, a target of one month between urgent referral and treatment for children's cancer, and one month from diagnosis to treatment for breast cancer. It expects to adopt similar arrangements for other areas covered by NSFs, for example, coronary heart disease.

5.32 In its strategy paper, Delivering the NHS Plan, published in April 2002, the Department of Health (England) set new targets, not only for reducing waiting times for outpatients and inpatients, but for waits to see a GP and in A&E Departments. Similarly, the Scottish Executive published its plan, Our National Health - 'A Plan for Action, a Plan for Change', 2000, which included waiting time targets, for the first time, in certain key specialties for clinical appointments, investigations and treatment for certain conditions. The NHS Plan for Wales (2001), 'Improving Health in Wales', set a framework for improving waiting times and targets that are announced each year. More recently, the Government announced, in June 2004, its key objective of reducing the maximum wait from referral by a GP to hospital treatment, to 18 weeks by 2008 (see paragraph 2.10).

5.33 In the sample of cases that we examined in the course of our validation testing at each of the Trusts visited, we calculated the total time waited from GP referral to being treated. We noted many instances where total time waited was over two years, and in some instances even longer. We recognise that delays in treatment often arise for reasons outside the Trusts' control. These reasons include:

- patients requiring a series of operations from a single referral;
- patients suspended from the waiting list because of work commitments, childcare arrangements, or other social reasons; or not being well enough for treatment;
- patients referred to consultants internally for specialist opinions; or

- patients who "did not attend" (DNAs) or "could not attend" (CNAs).

NIAO Conclusions and Recommendation - Accuracy of Waiting Lists

5.34 Suspending or removing patients from the waiting list for other than the regionally defined legitimate reasons shortens the numbers waiting on the list and the length of time waiting. We noted a small number of instances, in the sites we tested, of inappropriate suspensions and removals of patients, and errors in the re-instatement of patients suspended. However, no evidence arose from our testing of any inappropriate adjustments to waiting list performance data on the part of the Trusts, as had been uncovered by the NAO in England[44] , but there was evidence of inconsistent practices resulting from the absence of clear, standard, definitive guidance at Directorate level in Trusts.

5.35 The Department has informed us that its Waiting List Handbook will provide advice on these issues, and that work is ongoing "....on a patient level waiting list download..." which, when complete, will allow the number of suspensions to be monitored. It expects that the 'download' will provide more information than is currently collected under the current aggregate waiting list returns, will allow for more detailed analysis, and will improve the accuracy of waiting lists.

5.36 We understand the reason for removing a patient's name from the waiting list for one procedure while in hospital for another, unconnected procedure. Clearly the patient cannot always be treated simultaneously for unconnected conditions and will, therefore, be unavailable for one treatment, while receiving another. The Department told us that such discontinuity in the waiting time is often unavoidable and is in the best interests of the patient's care and treatment; that to retain the individual on the original waiting list would be inappropriate since they would clearly be unavailable for the original procedure while undergoing the second. However, we consider that on balance, it is wrong to exclude the time in hospital from the overall time waiting for a procedure, unless the first procedure was due to take place during the time that the patient was hospitalised

44. Inappropriate Adjustments to NHS Waiting Lists, NAO, December 2001 [HC 452]

or that procedure had some other impact on the patient's availability to undergo the other procedure. Subject to this caveat, this period should, therefore, be counted, in order to present an accurate picture.

5.37 Information in the HPSS (both financial and patient-based), used for management purposes, must be accurate, relevant and timely to inform decision making. For most of the Trusts tested by the Audit Office, waiting list data did not yet meet the "accuracy" criterion. This was particularly the case with the Royal Group of Hospitals Trust (RGHT), the largest Trust in the HPSS, where the fragmented nature of waiting list management in the Trust and the absence of a clear, definitive, common Trust -wide policy and guidance on waiting list management compromised the quality and accuracy of the waiting list data being produced by the Trust. Our examination of the RGHT's systems and procedures for recording waiting list performance data led us to conclude that the Trust's PAS could not be relied upon to produce accurate and complete waiting lists.

5.38 RGHT, in response to the results of our testing, acknowledged that the management of waiting lists had not been a main priority in the past, and that the lack of progress had been due to a shortage of resources within the Trust. It undertook to take forward our recommendations and, since our review, it has made significant progress. This has included:

- the use of a waiting list steering group consisting of Trust directors , clinical directors, and senior managers, which meets monthly to monitor the impact of divisional plans in meeting waiting list targets;
- the production of a comprehensive waiting list policy (which is nearing completion);
- the establishment of an information steering group;
- the procurement of Checklist - a waiting list management tool;
- the introduction of a suspended patient review process;

- the monthly audit of patients admitted and discharged; and
- a monthly audit to ensure that specialties are taking proper account of PTLs.

We welcome the action taken by the Trust to date.

5.39 We have reported the results of our validation testing to the other Trusts that we tested, along with our conclusions and recommendations.

5.40 Much could be improved, with:

- the production by Trusts, where they do not already exist, of Trust-wide waiting list protocols in the form of a single, coherent, corporate policy document which contains a clear statement about all aspects of waiting list management. This policy document should be underpinned by detailed supporting material which outlines procedures for implementing good practice in waiting list management. Supporting material should provide common guidance on the maintenance of waiting list data, waiting list management procedures and processes, and standard waiting list definitions. It should also incorporate the Users' Guide to the waiting list module of the PAS. In particular, it should include new guidance covering the transfer of patients for treatment elsewhere within the HPSS, and outside Northern Ireland. It should also provide clear guidance on arrangements for suspending, removing and re-instating patients from the waiting lists;
- the designation of overall responsibility for developing, implementing and monitoring waiting list policy to a senior officer within each Trust. This senior official should be responsible for developing the detailed procedures to implement this policy including, for example, standard referral protocols etc. These detailed procedures should be reviewed and updated on a regular basis;
- the distribution of up-to-date copies of all relevant policies and procedures, as appropriate, to all staff involved in waiting list management at Directorate level in each Trust; and
- further training of all staff (clinicians, nurses, secretaries, and administration staff) on the use of PAS, including the waiting list module. Departmental guidelines on the use of PAS, issued in 1992[45], advises that the waiting list module of PAS, properly used, should replace manual systems such as card indexes, diaries, and "operation books".

45. Guidelines for Clinicians on the Use of the Patient Administration System in Northern Ireland, Clinical Resource Efficiency Team (CREST), 1992

5.41 The Department has since informed us that all Trusts now have, or are developing, such protocols as are recommended above, and that the Waiting List Handbook will provide clear guidance on all aspects of waiting list management. We urge the Department to ensure that the recommendations contained within this report are covered by the Handbook.

Data Quality Assurance

5.42 Each Trust needs to create and maintain a Trust-wide commitment to data quality assurance to ensure that the waiting list performance data it produces and uses to inform its own, the Boards', and the Department's decision-making, is accurate, relevant and timely. The appointment of a Data Quality Officer at Altnagelvin and the establishment of a Data Quality Audit Group at Green Park are positive signs of a commitment at these Trusts.

5.43 In addition to work undertaken within its Data Quality Audit (DQA) Strategy (see paragraph 5.28), the Department also recognises that it can improve data definitions, the training and awareness of staff, the utilisation of data provider league tables, and the development and roll out of a local data accreditation process.

5.44 We welcome this DQA strategy and consider that the results of our validation testing on HPSS waiting list data should provide useful evidence to help in its implementation. The NAO observed, in its report on waiting lists in England[46], that there is a balance to be struck between the effort and expense required to improve accuracy, and the degree of reliability thereby achieved, particularly in the context of the use to which waiting list statistics are put. For example, the focus is shifting from an emphasis on the number of patients on outpatient and inpatient waiting lists to measuring how long each patient waits. This is particularly important for the most seriously ill patients. While we urge the Department to proceed with its endeavours to ensure that its published statistics are accurate, it needs to take into account this changing emphasis when it sets its priorities.

Measuring Total Waiting Time

5.45 To the patient, the primary concern is the total time they have to wait from seeing their GP to finally obtaining treatment. The Department said that the path to treatment is not necessarily linear nor continuous, but may consist of a number

46. Inpatient and Outpatient Waiting in the NHS, NAO, July 2001 [HC 221]

of discrete stages involving tests or further examinations, plus further consultations or decisions by either the GP or consultant. However, there are substantial numbers of patients waiting for tests or for further examination, who are currently not captured in the HPSS waiting list statistics. There is a risk that many of these might suffer undue delays in the process.

5.46 HPSS bodies should measure and monitor the numbers and length of waiting times involved, so that managers and clinicians are fully aware of any hidden backlogs. The Department is working with the HPSS to develop systems which would allow waiting times for diagnostic tests to be measured. We welcome this new initiative. The Department accepts that the different stages in the patient's journey are not fully reflected in the HPSS waiting list statistics; that measuring these would provide a more complete picture but would involve a number of difficulties which would need to be overcome. It considers that there is a need to find an appropriate way to measure the different aspects of the patient's journey which both fairly represents the waiting involved and avoids unnecessary additional bureaucracy.

5.47 There should be a similar shift of emphasis in Northern Ireland to waiting times, as has occurred in the NHS (see paragraphs 5.30 - 5.32). The Department's current objective is to reduce, by 2011, the maximum time waiting for outpatient appointments and treatment to three months[47], rather than to reduce a patient's total time waiting. It should set targets, measure, and publish statistics on the total time from referral to treatment for serious conditions where there are clear co-ordinated pathways of care. Some targets have been set. For example, a referral target has been set whereby all patients with suspected breast cancer should be seen by a specialist within two weeks of their GP requesting an appointment. The Department needs to follow this up for other conditions and it needs to have a mechanism for monitoring compliance. Finally, we recommend that it publishes guidance on such targets.

47. Developing Better Services: Modernising Hospitals and Reforming Structures, DHSSPS, June 2002

Appendices

Appendix 1

(paragraphs 1.8, 1.13 and 3.26)

Comparative UK Waiting Lists / Waiting Times

(a) Inpatient Waiting (Ordinary & Day Case) at 30 June 2004

Region	Inpatients Waiting for Treatment	Population* ('000)	Inpatients Waiting for Treatment per 1,000 Population
Northern Ireland	**50,975**	**1,697**	**30.04**
Wales	75,517	2,919	25.87
Scotland	112,375	5,055	22.23
England	885,503	49,559	17.87
United Kingdom	***1,124,370***	***59,229***	***18.98***

(b) Inpatients Waiting 12 Months or more for Treatment at 30 June 2004

Region	Inpatients Waiting for Treatment	Inpatients Waiting 12 months or more for Treatment	Population* ('000)	Inpatients Waiting 12 months or more per 1,000 Population
Northern Ireland	**50,975**	**6,858**[48]	**1,697**	**4.041**
Wales	75,517	**8,940[49]	2,919	3.063
England	885,503	552[50]	49,559	0.011
Scotland	112,375	0[51]	5,055	0.00
United Kingdom	***1,124,370***	***16,350***	***59,229***	***0.276***

***Source:** Government Actuary's Department -National Statistics: Population Trends, Spring 2004, No 115

** including patients waiting for tonsillectomies*

48. DHSSPS - Quarterly Bulletin : Northern Ireland Waiting Lists - June 2004
49. National Assembly for Wales, Statistical Directorate : SDR 53/2004, 28 July 2004
50. Department of Health: Provider Based Hospital Waiting List Statistics - England Summary - Ordinary and Day Case Admissions Combined: Quarter 1, 2004/2005
51. ISD Scotland National Statistics release - NHS Scotland: Acute Activity, Waiting Times and Waiting Lists: Latest quarterly trends : to June 2004

Appendix 2

(paragraph 3.23)

Patients Waiting in Excess of Charter Limits

Specialty	Provider	% waiting > 18 month				% waiting > 24 months			
		at 31/03/2001	at 31/03/2002	at 31/03/2003	at 31/03/2004	at 31/03/2001	at 31/03/2002	at 31/03/2003	at 31/03/2004
General Surgery									
	Royal	23.8	31.7	37.1	16.0	16.3	22.0	27.3	10.5
	Belfast City	34.8	46.2	24.1	19.5	23.7	33.4	16.3	12.7
	Ulster	15.2	11.6	13.8	3.6	9.4	8.5	9.3	2.4
	Down Lisburn	1.1	3.9	2.0	0.0	0.2	0.4	0.6	0.0
	Mater	6.2	1.1	0.0	2.7	3.1	0.7	0.0	1.9
	Causeway	10.2	16.1	27.1	2.5	4.2	10.0	18.6	1.3
	United	3.5	5.1	6.5	1.8	1.2	2.2	3.6	1.4
	Craigavon	21.3	28.7	28.3	10.7	12.2	17.0	20.1	8.4
	Newry & Mourne	5.9	12.4	10.2	0.5	2.1	5.8	6.3	0.5
	Altnagelvin	1.3	0.0	0.3	1.6	0.3	0.0	0.3	0.8
	Sperrin Lakeland	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Trauma & Orthopaedics	***Royal***	***8.3***	***10.9***	***25.7***	***13.5***	***8.3***	***3.1***	***15.7***	***5.4***
	Green Park	19.9	22.6	17.8	5.0	12.3	13.7	12.2	2.3
	Ulster	***61.3***	***63.8***	***34.6***	***0.0***	***55.0***	***58.6***	***33.3***	***0.0***
	Altnagelvin	0.6	0.7	3.0	0.6	0.0	0.0	0.9	0.2
Ear Nose & Throat									
	Royal	4.0	5.8	3.4	0.5	1.7	1.6	0.9	0.3
	Belfast City	9.3	14.5	12.1	6.8	4.0	7.9	6.1	3.5
	Ulster	***3.8***	***4.1***	***2.7***	***0.0***	***3.6***	***2.7***	***1.2***	***0.0***
	Mater	0.0	11.1	0.0	0.0	0.0	0.0	0.0	0.0
	United	9.5	10.3	10.4	2.0	2.3	4.0	4.5	0.7
	Craigavon	5.5	19.9	19.2	9.4	2.2	6.7	11.8	7.1
	Altnagelvin	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Sperrin Lakeland	0.9	0.9	0.0	0.0	0.0	0.0	0.0	0.0

Specialty	Provider	% waiting > 18 month				% waiting > 24 months			
		at 31/03/2001	at 31/03/2002	at 31/03/2003	at 31/03/2004	at 31/03/2001	at 31/03/2002	at 31/03/2003	at 31/03/2004
Ophthalmology									
	Royal	3.5	6.3	3.3	4.3	1.3	2.3	1.2	1.3
	Mater	0.2	2.6	0.1	0.0	0.0	1.1	0.0	0.0
	Craigavon	0.0	2.2	1.2	1.0	0.0	0.0	0.7	0.5
	Altnagelvin	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.0
Gynaecology									
	Royal	0.2	0.2	0.7	5.4	0.0	0.2	0.0	2.3
	Belfast City	4.3	6.8	6.7	3.4	1.4	2.3	4.1	2.1
	Ulster	2.6	3.4	0.6	0.5	0.7	0.2	0.0	0.0
	Down Lisburn	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Mater	***36.2***	***1.6***	***0.5***	***0.0***	***30.5***	***1.6***	***0.0***	***0.0***
	Causeway	0.0	0.4	0.5	0.0	0.0	0.2	0.3	0.0
	United	***4.3***	***9.3***	***10.3***	***11.0***	***0.5***	***3.2***	***4.5***	***6.8***
	Craigavon	1.9	3.3	5.2	2.9	0.5	1.2	1.1	1.1
	Newry & Mourne	0.0	0.5	1.6	3.4	0.0	0.0	0.0	0.0
	Altnagelvin	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0
	Sperrin Lakeland	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Plastic Surgery									
	Royal	***46.3***	***56.3***	***47.7***	***46.7***	***34.8***	***44.7***	***42.2***	***41.3***
	Ulster	***36.2***	***39.8***	***39.9***	***24.9***	***29.8***	***32.4***	***33.1***	***19.3***
Urology									
	Royal	44.6	70.6	97.2	*0.0	36.5	60.8	97.2	*0.0
	Belfast City	17.5	17.7	14.3	*20.4	12.0	11.8	8.6	*12.3
	Ulster	0.3	0.0	0.0	0.0	0.3	0.0	0.0	0.0
	Mater	1.3	0.0	0.0	0.0	0.7	0.0	0.0	0.0
	Down Lisburn	0.0	8.1	0.0	0.0	0.0	0.0	0.0	0.0
	Causeway	25.2	14.7	15.9	0.0	9.3	11.6	7.6	0.0
	Craigavon	20.7	35.2	23.2	17.6	12.6	25.7	18.3	13.8
	Altnagelvin	0.9	0.8	3.5	0.0	0.2	0.2	0.8	0.0
Neurology									
	Royal	***10.3***	***4.8***	***2.8***	***0.6***	***8.8***	***2.1***	***0.4***	***0.6***
Cardiac Surgery ▲									
	Royal	***27.6***	***20.8***	***15.0***	***4.7***	***12.7***	***11.0***	***6.9***	***0.0***

Source: **DHSSPS Regional Information Branch analysis of annual statistics.**
Notes: **Bold, italicised data are specifically referred to in paragraph 3.23 of main report.**

* **Urology was transferred from the Royal Group of Hospitals to the Belfast City Hospital.**

▲ Data for Cardiac Surgery excess waiters has been calculated as the percentage of patients waiting over 12 months and over 18 months for surgery.

Appendix 3

(paragraph 4.6)

Board Waiting List Funding and Expenditure: 2000-01, 2001-02 and 2002-03

HSS Boards	2000-01		2001-02		2002-03	
	Funding £m	Expenditure £m	Funding £m	Expenditure £m	Funding £m	Expenditure £m
EASTERN BOARD:						
DHSSPS allocation:	2.117		1.686		2.730	
Recurrent	*(-)*		*(1.258)*		*(1.680)*	
Non-recurrent	*(2.117)*		*(0.428)*		*(1.050)*	
Mobile MRI Scanner	0.275		-		-	
Board allocation	0.414		-		2.369	
Total:	**2.806**	**2.306***	**1.686**	**2.480**	**5.099**	**5.115**
NORTHERN BOARD:						
DHSSPS allocation:	1.178		0.829		1.536	
Recurrent	*(-)*		*(0.711)*		*(0.946)*	
Non-recurrent	*(1.178)*		*(0.118)*		*(0.590)*	
Board allocation	0.848		0.720		2.632	
Total:	**2.026**	**2.026**	**1.549**	**1.621**	**4.168**	**4.445**
WESTERN BOARD:						
DHSSPS allocation:	0.824		0.961		1.071	
Recurrent	*(-)*		*(0.501)*		*(0.662)*	
Non-recurrent	*(0.824)*		*(0.460)*		*(0.415)*	
Board allocation	0.493		0.696		0.670	
Total:	**1.317**	**1.317**	**1.657**	**1.596**	**1.741**	**2.106**
SOUTHERN BOARD:						
DHSSPS allocation:	0.881		1.046		1.157	
Recurrent	*(-)*		*(0.530)*		*(0.712)*	
Non-recurrent	*(0.881)*		*(0.516)*		*(0.445)*	
Board allocation	0.335		-		1.016	
Total:	**1.216**	**1.216**	**1.046**	**1.182**	**2.173**	**0.979**
Overall Total:	***7.365***	**6.865**	***5.938***	**6.879**	***13.181***	**12.645**

Source: DHSSPS
Note: * £0.500 million carried forward

Appendix 4

(paragraphs 5.4, 5.8, 5.13, 5.15, 5.16, 5.21, 5.26 & 5.29)

Details of NIAO Validation Testing of Waiting List Data at Selected Trusts

Some Trust computer systems have not been developed to meet current demands for waiting list management data

1. **United Hospitals Trust**, because of continuing software problems with its PAS, had been unable to produce quarterly Charter (CH4) 'completed outpatient waits' data since September 2001. The Trust has provided estimated totals to the Department, and estimates for each time band have been calculated by the Department for quarterly data since that date. When the missing CH4 data becomes available these estimates are to be recast.

2. Three of the Trusts visited **(BCH, Altnagelvin, and Green Park)** used a software enhancement on their PAS that could automatically reinstate patients whose period of suspension from the waiting list, had expired. In addition, at **Altnagelvin**, waiting list 'suspend' reports were generated automatically by its PAS one month before the suspension period expired, to allow for timely review and appropriate action. This automatic reinstatement function is an effective safety mechanism to ensure that patients who have been temporarily suspended from the waiting list, are not neglected after a period of suspension expires. **RGH**, **CAHG** and the other Trusts would benefit from such a software enhancement in managing waiting list suspensions. **CAHG** informed us, since our testing at their site, that it introduced an automatic reinstate function on its PAS, from 3 May 2002.

3. As part of its monthly data quality assurance on its waiting list data, used to compile the various Charter returns to the Department, **Altnagelvin** had been relying on a monthly, time-consuming manual count of GP referral letters to ensure the accuracy of its quarterly outpatient Charter returns. It is recognised by

the Trust, however, that even the manual count has not always been 100 per cent accurate. While the manual count is ongoing as a quality check mechanism, data is now extracted from PAS, with work ongoing from staff in the Appointments and Information Departments to ensure data quality. It is anticipated that this will be further improved through a Service Improvement Project.

4. We have been informed by **Altnagelvin** that software enhancements have helped to ensure the accuracy of outpatient source data on its PAS. Waiting list Charter returns to the Department can now be produced directly from PAS, and this dispenses with the previous reliance on an unreliable manual count of GP referral letters. All Charter waiting list returns are now available from PAS.

5. Important performance information on trends in the proportion of patients who fail to attend for treatment (DNAs) throughout a year are not available to Trust management at **Altnagelvin** since the Trust did not hold DNA data in an easily accessible form. Similarly, the rate of waiting list suspension over time cannot presently be monitored by the Trust, as its PAS is unable to isolate suspensions on a monthly basis.

6. Software enhancements to Altnagelvin's PAS should enable this important management information to be routinely produced, and the Trust anticipates that, in the near future, the Information Department at **Altnagelvin** will begin to provide information on the number of patients who DNA by Consultant and Specialty, each month.

7. **RGH** was not able to run off, from its PAS, a summary report of all patients removed from the waiting list, because this function had not been installed onto its PAS enquiry software. We had to rely on a list of RGH removals, produced for it by the Eastern Board, for extracting its samples for testing.

Patients temporarily suspended are not being routinely reviewed and as a consequence are being overlooked

Royal Group of Hospitals Trust

8. We examined a random sample of 16 patients out of a total of 393 patients recorded as "suspended" as at 30 September 2001. We found that, while four patients were correctly suspended at that date, of the remaining twelve:

- in one case the decision taken to extend suspension (because the Royal did not have the equipment to perform the operation) was inappropriate, resulting in an understatement of the waiting list and waiting time by the patient (the patient should have been reinstated on the waiting list until the necessary equipment was available to perform the treatment);
- the remaining eleven cases recorded as suspended at 30 September 2001 should have been removed permanently from the waiting lists: seven of these patients had already been treated (including two transferred to Scotland for treatment), three had died, and the one remaining case should have been removed per the Trust's DNA policy.
- in three of the cases that had already been treated, the patient's waiting time had been understated;
- there were errors in the re-instatement of suspended patients sampled. In these cases the secretaries either thought that re-instatement was automatic, or they did not use the correct function on PAS to re-instate the patient back on to the waiting list.

9. Lack of clear guidance at Directorate level in the Trust contributed to these errors.

10. The monitoring of waiting list suspensions by management varied within the Directorates examined. We observed that, while the Ophthalmology, ENT, Dental

and Paediatric Directorates ran off monthly suspension reports from PAS for review, Cardiology, General Surgery, and Neurology Directorates did not.

11. We noted, for example, that the Cardiology Directorate had 83 patients suspended from its Cardiac Surgery waiting list at 30 September 2001. Many of these patients have remained suspended for years - some have been suspended from as long ago as 1994 and 1995.

12. We observed that the only monitoring that was being carried out on these patients was by the secretarial staff (using manually held records), and that this was at their own discretion. No suspension reports were routinely produced from PAS and monitored by Cardiology management.

13. We referred a computer listing of details of the 83 patients suspended (obtained from PAS) to the Cardiology Directorate for review, and appropriate action. We have been informed by the Directorate that a regular monitoring system is now in place and that the secretaries now report quarterly on waiting lists to the Directorate Manager.

14. We observed that there were no formal written protocols in place to cover the recording, monitoring and review of suspensions from the waiting list in any of the Directorates that we examined.

15. We observed that waiting list suspensions were not being systematically reviewed to determine whether the patient should be re-instated back on to the waiting list or removed from it.

Transfer of Cardiac Surgery patients outside Northern Ireland

16. In two of the four cardiac surgery suspensions examined, we noted that the patients had already received their treatment in Scotland. The cardiac surgeon's secretary, in both cases, was not aware that surgery had taken place.

17. In one of the two transferred cases the patient was inappropriately suspended from the waiting list while awaiting surgery in Glasgow. The patient should have remained waiting list active until official confirmation was received from the Board confirming that the surgery had been performed.

18. In another case a patient was removed from the cardiac surgery waiting list ten days before the patient was actually treated in Glasgow resulting in the waiting time being understated for this short period. In this instance the patient should not have been removed from the waiting list until there was confirmation that the cardiac surgery had actually taken place in Glasgow.

19. There is a clear need, therefore, for clear, written protocols / procedures on how to deal with patients transferred for treatment outside (and elsewhere within) the HPSS, and to ensure that all interested parties are aware of when and where the transferred treatment is to take place and when it has actually been provided so that patients' files and charts, the PAS, and waiting list management reports, reflect the transfer activity.

Altnagelvin Hospitals Trust

20. We selected a random sample of 15 cases from patients suspended from the waiting lists as at 30 September 2001. 13 of these, were correctly recorded as suspended at that date.

21. One case should not have been recorded as suspended as the patient had moved to England at the end of April 2001. In the other case, the patient's file could not be located and made available for examination. The appropriate waiting list action has now been taken and update training is underway with relevant secretarial staff, with the emphasis placed on proper recording. However, arising from this case, we noted that neither the suspension nor subsequent removal actions on PAS were initialled with a user ID. User IDs should be attached to all suspension and removal records on PAS, thereby providing a clear audit trail on screen of who has made the entries.

22. We found that there are sound procedures for monitoring and reviewing suspensions at Altnagelvin. Patients suspended from the waiting list are automatically reinstated when the suspension period expires, and waiting list 'suspend' reports are generated automatically by PAS one month before suspension periods expire. These waiting list 'suspend' reports are issued to the Team Leader in each Directorate for review and appropriate action.

Green Park Healthcare Trust

23. Of the 15 cases randomly selected as suspended from the waiting list at 30 September 2001, we were unable to confirm that 6 were appropriately suspended. This was due to the fact that these patients' suspension periods had expired and no review had taken place to reinstate the patient or to extend the period of suspension. These findings highlighted the lack of review and monitoring of suspended patients by the Trust.

24. Further, from the report used to select the sample of 15 patients, it was noted that, of those patients listed as suspended at 30 September 2001, 23 patients' suspension periods had expired before 2001.

25. Green Park informed us that a Waiting List Monitoring Group was established in March 2002 to assess the impact, and audit the implementation, of the Trust's waiting list policies and procedures, with a view to ensuring accuracy of waiting list data. This has included production of suspension lists for validation. We expect that all cases suspended, including the six sampled by NIAO, would be reviewed by the Group and appropriate, timely action taken.

26. In addition, one patient's chart was not available for review as the patient was attending an outpatient clinic, and one patient's chart had been destroyed by the Royal Victoria Hospital.

27. In another case where the patient was suspended by the Trust because he was in

Australia for some considerable time, it appeared to us that the more appropriate action would have been to remove the patient from the waiting list and inform the GP of the removal. Green Park agreed that the patient should have been discharged and not suspended. The Trust informed us that action would be taken to remove this patient and inform the GP accordingly.

28. The testing pointed, also, to the need for closer liaison between staff in different hospitals. In one case tested the patient was suspended from the waiting list at Musgrave Park Hospital pending a review appointment at the Royal Belfast Hospital for Sick Children. This appointment took place in December 2001, but at the time of our testing, these details had not been provided by RBHSC, and staff at Musgrave Park had not made any attempt to follow the patient's progress with the Children's Hospital.

29. We concluded that it was possible that this patient should have been added back to the waiting list, with the waiting list totals therefore being understated at that time. Green Park has since informed us that this patient was reviewed at an outpatient clinic during 2002 and that he was to be admitted for surgery during that year.

30. We observed that patients were suspended from a waiting list with a start and end date entered on the system. This was to ensure that those patients who were suspended for a social reason were automatically reinstated on the waiting list. We understand that patients who are suspended for a medical reason are not automatically reinstated but require review and appropriate action by the consultants' secretaries. This can lead to patients being missed if no review of suspended patients takes place. We have been informed by the Department that the Trust appointed a Waiting List Manager on 1 April 2003, and one of the first pieces of work she undertook was a major audit of suspended patients. Reports on all patients who are medically suspended are now produced once a month and reviewed by individual secretaries. The results of these validation reports are a standing item on the agenda of the Waiting List Monitoring Group, which meets every month.

Craigavon Area Hospital Group Trust

31. In our sample of 12, selected from patients suspended as at 30 September 2001, we observed that:

- three of the suspensions were inappropriate and should have been removed from the waiting list completely as a result of a validation exercise undertaken in 2000. The Trust introduced an automatic reinstate function on its PAS with effect from 3 May 2002 which, it hopes, will help avoid this happening in future.
- two of the suspensions were reviewed and a decision was made to lift the suspensions. However, we noted that the period of the patient's suspension was incorrectly deleted from the waiting list episode resulting in the waiting list period reflecting a longer than actual waiting time. We understand that this error has been corrected and raised as a training issue for staff who use PAS.
- in another case which involved a suspended patient with a long standing condition which had been kept under review, we found that the patient had a new waiting list episode created in January 2002, without the original suspension being lifted until after they were treated for the condition. For an albeit brief period, the patient appears to have been double counted as suspended and waiting list active.

Belfast City Hospital Trust

32. In one of the cases examined we found that the suspended patient should have been subsequently removed from the waiting list. Although the patient was subsequently placed on the waiting list and treated, the suspension was not lifted from PAS. In addition, the patient had been suspended without an end date being placed for the suspension on the Trust's PAS which meant that it could not appear on any waiting list suspension report that could be run off from the

PAS for review (reports which are not generated routinely, or automatically from the Trust's PAS). We understand that it is now Trust policy for an end date to be placed on PAS against all suspended patients and that software enhancements now enable suspension reports to be produced automatically and routinely from the Trust's PAS. We have been informed that all patients suspended from lists now have a start and end date for the suspension period and that software enhancements at BCHT make this a mandatory requirement.

United Hospitals Trust

33. As part of its internal review of waiting list practices arising from NAO's report on Inappropriate Adjustments to NHS Waiting Lists, the Trust reviewed over 350 of its suspensions for appropriateness.

34. All were considered to be legitimate and in accordance with recognised guidance. It noted that the only instance where suspension occurred incorrectly was in relation to the suspension of patients for tonsillectomies that occurred when such operations were temporarily not held due to new regulations for sterilising equipment.

35. The Trust, however, has recommended a review of its arrangements for re-instating suspended patients, as it had concluded from its examination that there is potential that poor or inconsistent practice had caused undue delay in re-instating patients following suspension.

36. Automatic re-instatement of suspended patients is available on the Trust's PAS, but has not been used, it being perceived that the majority of suspended patients would not be re-instated to the waiting list. Manual procedures are therefore used to validate the suspended lists and arrange for re-instatement where appropriate. Arrangements for doing so vary across sites, being centralised at Antrim Hospital, and are carried out by the consultant and secretary, according to their procedures, across other sites. As a result, it is possible that where arrangements are not sufficiently robust, suspended patients could have their re-instatement delayed.

There should be no delay in updating the PAS for patients where a decision has been made to remove them from the waiting list, and the patient and GP should always be informed of the decision

Craigavon Area Hospital Group Trust

37. From our testing of removals, we noted several instances where there had been delays in updating the patient's status on the Trust's PAS - in one case a delay of 5 weeks and in another a delay of 3 months -before a decision was made to remove, after these patients had DNA'd. We acknowledge that delays can occur in reviewing the records of patients who DNA but would expect such delays to be minimised to avoid overstatement of waiting times and waiting list numbers.

38. In another removal, we found no documentary evidence that the patient's GP had been contacted. It is the Trust's Surgical Directorate's policy to contact the patient and the GP in the event of a patient being removed from the waiting list.

Belfast City Hospital Trust

39. In three of the ten removals examined for the quarter ending September 2001, we found no evidence that the patient's GP had been notified. We also found that some patients DNA'd four or five times before being removed, while others were removed after two DNAs.

40. We were informed by the Trust that, since the setting up of its Central Waiting List Office, it now has adopted a consistent policy relating to DNAs and referral to waiting lists. This includes a policy of removing patients who DNA two appointments. It has also assured us that they will retain written evidence of correspondence with the GP of all patients who are removed from the waiting list. All GPs receive a letter each time one of their patients is added to or deleted from a waiting list.

Royal Group of Hospitals Trust

41. Two of the ten cases of removals examined, were incorrectly removed. One of the cases is referred to at paragraph 18. In the second case, the patient should have been removed from the waiting list sooner than he was, resulting in overstatement of the waiting list.

Altnagelvin Hospitals Trust

42. All of the ten cases examined by NIAO were found to be correctly removed from the waiting list.

Regular validation removes patients who no longer need to be seen

Royal Group of Hospitals Trust

43. There is no central Trust-wide protocol for the validation of inpatient and outpatient waiting lists. As a result the various Directorates within the Trust adopt different patterns of validation of their waiting lists. There is ongoing validation of inpatient lists in most areas, with others undertaking ad hoc validation of lists in agreement with consultants, and when resources are available to do so.

44 During 2001-02 there had been ongoing validation of excess waiters in each specialty in line with waiting list targets and there has been a rolling validation programme in Ophthalmology and ENT. Ad hoc validation has been carried out in all other areas.

45. There had been little validation of outpatient waiting lists.

Altnagelvin Hospitals Trust

46. A rolling validation programme of inpatients and day case waiting lists was put in place by the Trust in April 1999, with its PAS being set up to routinely print

waiting list validation letters for each patient who reaches nine months on the waiting list, asking if they still require surgery. If the patient confirms they do, they remain on the waiting list. If the patient does not respond within 15 days, instead of being removed from the waiting list and the GP informed, telephone contact is now made with the patient as per the details on PAS. If this is not possible, contact is made with the GP to confirm these details. On confirmation of these, a second manual letter is sent out. If there is still no response to this, the patient's name is removed from the waiting list and the GP is informed. In the quarter ended 30 June 2003, 477 patients were validated in this way, resulting in 72 patients (16.1%) being removed from waiting lists.

47. Outpatient validation was carried out during the Summer of 2001. All patients waiting greater than 3 months were sent a letter to check if they still required an appointment. As a result, 268 people were removed from the waiting list and their GPs informed.

Belfast City Hospital Trust

48. The recent creation of the Trust's Central Waiting List Office has provided the opportunity of removing a considerable number of patients from the waiting lists through extensive validation exercises. Validation work by the Central Waiting List Office, between May and November 2002, resulted in the removal of 1,121 patients from the Trust's inpatient waiting lists. A major proportion (some 45 per cent) were removed because of repeated failure to attend for treatment (multiple DNAs).

49. The patients who were targeted initially were General Surgery and Urology inpatients waiting more than 12 months, and then subsequently extended to patients waiting less than 12 months. This validation work is continuous and by January 2003, a total of 1,235 patients had been removed.

Green Park Healthcare Trust

50. Green Park carried out a major validation exercise of inpatient waiting lists between September 2000 and January 2001. All patients waiting over 12 months for surgery were written to. Those who did not respond were written to a second time. GPs were then contacted to track patients. All Boards were written to with details of outstanding patients. The 219 who could not be traced were discharged, representing some 13 per cent of the 1,857 inpatients written to. Software was subsequently developed to ensure ongoing validation at 12 monthly intervals.

51. An outpatient validation was also undertaken.

Craigavon Area Hospital Group Trust

52. During 2000-01, all inpatients who were waiting over 12 months for treatment were written to by the Trust, and patients confirmed their requirements. This validation exercise was funded on a non-recurring basis for a four month period. Since then, the Trust has been developing a similar process for ongoing validation of inpatient waiting lists as part of the work of its Clinical Directorates.

53. During 2000-01, validation of outpatient waiting lists was carried out on an ad hoc basis as part of the completion of the Charter monitoring returns. Funding on a non-recurring basis for a six month period, was released during that year for a validation exercise commencing in late 2001 / early 2002. The Southern Board extended funding to 31 March 2003 with validation covering inpatients, day cases and outpatients.

Ulster Community and Hospital Trust

54. UCHT's Waiting List Handbook contains protocols for the validation and review of inpatients. Letters are routinely sent, by each specialty, to patients waiting over 9 months, 15 months and 18 months, to determine whether treatment is still necessary. At the time of our examination, ad hoc validation exercises were being carried out in respect of Orthopaedics and Ophthalmology outpatient waiters.

Reconciling published statistics with Trust data

Green Park Healthcare Trust

55. Our testing confirmed that the Charter returns provided to the Department for the quarter ended 30 September 2001 reconciled to the source waiting list information on the Trust's systems. We noted the monthly validation of outpatient data, by way of data quality assurance, and the Trust's intention to perform similar data reconciliation routines on inpatient data before submission to the Department. However, it was observed that private patients waiting data was incorrectly excluded from the Trust's Charter returns to the Department. Green Park has informed us that it was unaware that it was incorrectly excluding this data, and that it would follow this up with the Department to ensure that full waiting list data is supplied.

Altnagelvin Hospitals Trust

56. Altnagelvin undertakes monthly validation routines on the data used to compile the various Charter returns before submission to the Department. Our testing confirmed that the quarterly Charter returns provided to the Department for the quarter ending 30 September 2001 reconciled to the source data held on its PAS. However, there is no assurance that the Charter return on completed outpatient waits (CH3) for that quarter was accurate since the present CH3 validation routine could not be relied upon to ensure the accuracy of the return. Work on the quality of the CH3 is ongoing and will be addressed further in a proposed Outpatient Service Improvement Project.

Royal Group of Hospitals Trust

57. We noted that the Dental Directorate's CH3 Charter returns - completed outpatient waits, for the quarter ending 30 September 2001 were grossly overstated due to error on the part of administrative staff. The Directorate was aware of this overstatement at the time of our testing, informing us that the

subsequent CH3 returns for the quarters ending December 2001 and March 2002 were also likely to be overstated. We have since been informed that correct procedures have now been implemented by the Directorate. Clear policies and procedures must be issued by the Directorate to all relevant staff to ensure that waiting list data is accurate.

Each Trust needs to put in place a single, corporate waiting list policy document, based on Departmental guidelines, that provides clear, comprehensive, and unequivocal guidance to all staff involved in the management of waiting lists

58. Of the 12 Trusts surveyed, we observed that only four had a single, comprehensive, corporate waiting list policy document in place - **BCHT, UCHT, Green Park, and United.**

59. **CAHGT** and **Altnagelvin** were found to have various waiting list guidelines produced over the years that needed to be reviewed, updated, expanded, and amalgamated into a single, coherent corporate waiting list policy document.

60. In the largest Trust - the **Royal Group of Hospitals Trust**, each Directorate managed its own waiting lists with little by way of written operational guidance or direction on processes and procedures for the maintenance and review of waiting list data. We noted that the Trust had no single, definitive Trust-wide policy document / handbook / manual in place.

61. Prior to the establishment of its Central Waiting List Office **BCHT's** main Directorates each had their own policy and procedures manuals, which were essentially PAS user guidelines on how to record a patient's status on PAS. These documents did not provide guidance on the criteria or the Trust's policy for suspending or removing a patient from the waiting list, nor did they give a clear policy in respect of patients who DNA or CNA. Consequently there was no uniformity of practice throughout the Trust.

62. With the establishment of its Central Waiting List Office, BCHT has had in place (since January 2002) a consistent Trust-wide policy document for the management of inpatients and daycase waiting lists. This guidance contains a formal policy for DNA and CNA and how this will change the length of wait recorded. There is also guidance for staff to follow on the types of PAS monitoring reports that should be produced, and the frequency of these reports.

63. We found that **UCHT** has a Trust-wide Handbook for 'Good Practice for effective Waiting List Management,' produced in 1998. This comprehensive 24-page document contains guidance on adding patients to the waiting list and selecting a patient for admission, as well as rules for suspending, removing, and cancelling a patient from the waiting list. As well as providing a clear policy in respect of patients who DNA and CNA, the document also contains procedures for waiting list validation.

Appendix 5

(paragraphs 5.5)

Evidence Emerging during the course of DHSSPS's Review of Waiting List Management in 2002, as part of its latest Waiting List Initiative

- patient listed 1997 - 'does not want surgery'- still on list
- coronary artery by-pass patient listed in 1992, but suspended since 1995
- several patients on inpatient list for more than 2 years for removal of in-growing toenails
- patient refused operation 11 times
- DNA and CNA rates of 22 - 24 per cent *
- cancelled clinic rates of 26 per cent
- 35 - 40 per cent of appointments do not happen
- validation exercises not completed
- private patients seen in HPSS time
- 5 patients in one clinic already on a waiting list elsewhere

Source: DHSSPS

Note: * 'did not attend' (DNA) and 'could not attend' (CNA)

List of NIAO Reports

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The Sheep Annual Premium Scheme	NIA 75/02	6 February 2003
The PFI Contract for the Education and Library Board's New Computerised Accounting System	NIA99/02	20 March 2003
Areas of Special Scientific Interest	NIA103/02	27 March 2003
The Use of Operating Theatres in the Northern Health and Personal Social Services	NIA111/02	10 April 2003
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