NATIONAL AUDIT OFFICE

Department of Health

Inpatient and outpatient waiting in the NHS

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 221 Session 2001-2002: 26 July 2001

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General

National Audit Office
18 July 2001

The Comptroller and Auditor General, Sir John Bourn, is the head of the National Audit Office, which employs some 750 staff. He, and the National Audit Office, are totally independent of Government. He certifies the accounts of all Government departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

For further information about the National Audit Office please contact:

National Audit Office
Press Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Email: enquiries@nao.gsi.gov.uk

Contents

summary and recommendations

1 Most patients seen each year in the NHS are treated promptly - 70 per cent of patients admitted to hospital waited less than three months. The time that people wait for treatment is, however, the public's top concern about the NHS and the number waiting is a key performance indicator.

2 The total time a patient waits for treatment potentially comprises three main elements:

- **outpatients list:** the time a patient waits from seeing the General Practitioner until they are seen at an outpatient clinic by a consultant or other health professional. At 31 March 2001, 284,000 patients had been waiting thirteen weeks or more for a first outpatient consultation;
- **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;
- **inpatients list:** the time a patient waits from being placed on the inpatient waiting list for treatment until they are admitted to hospital as daycases or ordinary admissions. At 31 March 2001, some 1,007,000 were waiting to be admitted to hospital for treatment.

Why we examined waiting lists

3 We examined waiting lists because:

- waiting list and times statistics are a key measure of performance;
- there has been considerable debate about the adequacy of waiting lists and times as a measure, the impact of initiatives to reduce waiting lists and what waiting list statistics actually indicate; and
- our examination provided an opportunity to identify good practice in waiting list management.

4 The NHS Plan, published in July 2000, set challenging new targets for waiting times; and in June 2001 the Department re-emphasised that, building on the reduction in waiting lists, the NHS will move to cut waiting times for treatment. The Department recognises that, as part of achieving lower waiting times, it remains important that underlying waiting lists are accurate and managed effectively and that the analyses and recommendations in the report continue to be relevant. The Department is currently considering a range of options, including how future waiting list data should be published.

Conclusions

What waiting lists include

5 There are some misconceptions about what is included in waiting list statistics:

- there is no full, published **outpatients** waiting list. The published data include those patients who have been referred by a General Practitioner and have been waiting more than 13 weeks to see a consultant for the first time. The list does not include second or subsequent outpatient appointments for the same condition. If, for example, a patient is referred on to another consultant, their wait is not counted. In 2000-01, second or subsequent attendances represented 72 per cent of all outpatient attendances.
- the **inpatient** waiting list reports the number of patients awaiting a first admission for an elective procedure under the care of a consultant. As such, the reported figures have always excluded accidents and emergencies and pregnancies. Also never included were second and subsequent operations that are part of a planned programme of treatment (such as the second of two hip replacement operations) and operations carried out by staff other than consultants or carried out in outpatient clinics. In addition, the inpatient waiting list has never included patients suspended temporarily from the list for personal reasons or on medical grounds. At 31 March 2001, this figure stood at 77,000.

6 In any event, to the patient, waiting time is more important than the numbers on the waiting list and the NHS Plan recognises this by placing a clear focus on how long people wait to see a consultant or to be admitted for treatment. The Department of Health has now set targets for the total waiting time from referral to treatment for cancer patients, and arrangements for monitoring total time are being put in place. The NHS does not calculate or monitor the total time that other patients wait from seeing their General Practitioner to being treated. In particular, diagnostic tests may be required following an outpatient appointment before a decision can be taken on whether a patient requires further treatment, but the time this takes is not currently covered in any of the published statistics. Although the base information is held on Patient Administration Systems, the systems do not presently calculate and report for individual patients or in aggregate how long the total wait is.

Accuracy of national waiting lists

7 The system used to compile waiting list data aggregates information from trusts' Patient Administration Systems but we found that trusts are not completely consistent in what they include on waiting lists. At many trusts there was an absence of, or variation in, effective validation procedures which meant that the data on the system could be out of date, and two trusts that we sampled used estimated data on their returns to the Department in one case because their Patient Administration System had crashed.

8 The inherent risks and lack of complete reliability in the systems and procedures mean that we cannot assure ourselves as to the complete accuracy of NHS waiting lists. But the main problems we identified, in particular deficiencies in validation procedures, lead us to the view that published numbers are likely to be overstated, specifically because validation tends to identify significant numbers of people who should no longer be included on waiting lists. These include people who have moved, died or no longer want treatment. The Department's main targets are now set in terms of waiting times rather than numbers on the list. It is, therefore, questionable how much resource should be devoted to making the waiting list more accurate.

Improving the management of NHS waiting lists

9 The Department regards waiting lists and waiting times as too long for many patients. At 31 March 2001, 246,000 people had been on the inpatient waiting list for longer than 6 months and, of these, 42,000 had been on the list for more than 12 months. In addition, there are large geographic inequalities. For example, in Dorset Health Authority 1.2 per cent of Trauma and Orthopaedics patients had been on the waiting list six months or longer at 31 March 2001, compared to 52 per cent in Croydon Health Authority.

10 The Department of Health has made, and is making, concerted efforts to reduce waiting lists and waiting times (**Figure 1**) and the Government is allocating significant resources to addressing the problem. Since March 1999 the inpatient list has reduced by 66,000 and the outpatients over 13 week waiters by 172,000.

1 Initiatives to reduce waiting lists and times

- additional funding for NHS trusts to reduce waiting lists, such as £737 million from 1998-99 to 2000-2001
- a revised Patients' Charter in December 1998 which recognised the importance of identifying and responding to patients' needs
- the publication of a range of guidance and best practice documents
- special teams such as the National Patients Access Team and the Waiting List Action Team, and now the Task Force that visit trusts to identify solutions to waiting list issues and spread best practice

11 Building on this the NHS Plan (July 2000) set challenging targets to be met by the end of 2005, in particular a maximum waiting time for inpatients of six months and outpatients a maximum wait of three months. Some of the difficulties include, overcoming years of under investment, introducing new ways of working so that various groups such as General Practitioners and consultants work better together and with agencies outside the NHS, being more aligned to the needs of patients and better management of unpredictable events, such as emergencies, to minimise any disruption to the elective treatments planned for the same day. Against this background, the NHS Plan recognised that it will take fundamental and comprehensive reform to tackle the problem of waiting for treatment.

12 Our report sets out some of the innovative ways in which trusts and others are working to tackle waiting lists and waiting times, including initiatives that help General Practitioners refer appropriate patients to consultants, ensure that outpatient clinics operate to optimal capacity, optimise the use of operating theatres, improve discharge arrangements and manage the process as a whole. Taken together with the additional funding allocated to the NHS, wider use of these initiatives could further improve the management of NHS waiting lists and times significantly.

13 One of the key difficulties in managing waiting lists is ensuring that, in accordance with NHS guidance, patients are treated in accordance with clinical need. Consultants decide the priority of each patient on the inpatient waiting list, and what mix of cases to include in each theatre session. For practical reasons there needs to be some flexibility in the order in which patients are treated but it is inappropriate to operate on routine patients in preference to those who require relatively more urgent treatment solely to meet waiting list targets. The Department of Health has reinforced this message on a number of occasions, including through guidance. 20 per cent of consultants in our sample of three specialties told us, however, that in 1999-2000 they frequently treated patients in a different order to their clinical priority in order to reduce their waiting list or to avoid patients waiting for more than the 18-month target.

Keeping patients informed

14 The Department of Health recognises the importance of keeping patients informed about the time they can expect to spend on a waiting list, and is committed to introducing a booking system for all inpatient and outpatient appointments - the National Booked Admissions Programme which is aiming for 100 per cent coverage by 2005. In the meantime there is more that the Department can do to ensure patients are kept informed about likely waiting times.

15 Other countries have introduced or are introducing initiatives to ensure that patients on waiting lists are kept well informed about waiting times. For example in Denmark, waiting times for each hospital for 25 common medical problems are available on the internet, including maximum waiting times for patients on both the outpatient and inpatient waiting list. In Norway, patients can review on the internet waiting times for selective surgery at each hospital before deciding where to be treated. From January 2001 patients have had free choice of hospital, and the Norwegian Patient Register is developing an internet information system which will show waiting times at individual hospitals for specific treatments. The Department intends that NHS hospitals should also produce and publish this type of information.

Recommendations

The Department of Health should:

i In addition to focusing more on the time inpatients and outpatients wait for treatment, consider whether trusts should monitor and manage the total time patients wait from seeing their General Practitioner to being admitted for treatment as is now happening for cancer services.

ii Ensure that all NHS trusts validate their inpatient and outpatient lists at least every six months and give trusts guidance and advice on how to resolve inconsistencies as to what treatments and categories of patients are included on waiting lists.

iii Conduct research into why different health authorities have different waiting times.

iv Take action through the National Patients Access Team and the Access Task Force to encourage trusts to implement the best practices identified in Part 3 so that waiting times and the likelihood of conflicts between clinical priorities and waiting time targets can be reduced.

v Review options for keeping patients better informed regarding the time that they can expect to wait, building on the improvements that will derive from the booked admissions programme.

Trust management should:

vi Fully involve consultants and other healthcare professionals in formulating policy, setting waiting list targets and managing the workload to ensure that in the vast majority of cases, patients are treated in accordance with their clinical need and within the waiting time targets set in the NHS Plan.

Part 1

Introduction

1.1 Since the creation of the National Health Service (NHS) in 1948, most people who need to see a consultant or who require treatment but are not emergency cases have had to wait. The total time a patient waits for treatment would be measured from the date the General Practitioner refers the patient to a consultant, until the date the patient is admitted to hospital. It comprises three main elements:

- **waiting to see the consultant (the outpatient waiting list).** The time a patient waits from seeing the General Practitioner 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;
- **waiting for treatment (the inpatient waiting list):** the time a patient waits from being placed on the inpatient waiting list for treatment until they are admitted to hospital.

1.2 At present a patient's total waiting time is not measured, although it is proposed that it will be in the near future for cancer treatment. Many patients, particularly those requiring urgent assessment or urgent treatment, are seen very quickly by the NHS. For others, particularly those requiring routine treatment, the total waiting time can be considerable.

1.3 Fifty years ago there were around 500,000 people in England waiting for an operation[1]. At 31 March 2001 there were over 1 million on the inpatient waiting list; over 5 million general and acute elective patients were treated in the last twelve months, and some 11 million patients had their first outpatient appointment in that year. In addition, whilst many people are able to see a consultant quickly, 284,000 had been waiting 13 weeks or more for an initial consultation. The typical steps a patient will encounter are summarised at **Figure 2**. Appendix 1 summarises the history of waiting lists in the NHS.

1.4 In all, some 2 per cent of the UK population are waiting for an operation (**Figure 3**). Having to wait is a common problem worldwide. Making realistic comparisons of spend on health is difficult due to the difference in health system structures. Some countries, such as France, have negligible waiting lists and funding is higher. Nearly 10 per cent of GDP is spent on health care in France compared to under 7 per cent in the United Kingdom. But many other countries in Europe and further afield are trying to cope with large and/or growing numbers of patients on waiting lists for surgery or for outpatient appointments.

1.5 With an ageing population, more people living longer, new treatments and advancing medical technology, the demand for NHS treatment is continuing to increase. Referrals of patients by General Practitioners to see a consultant have increased by 4 per cent in the last three years.

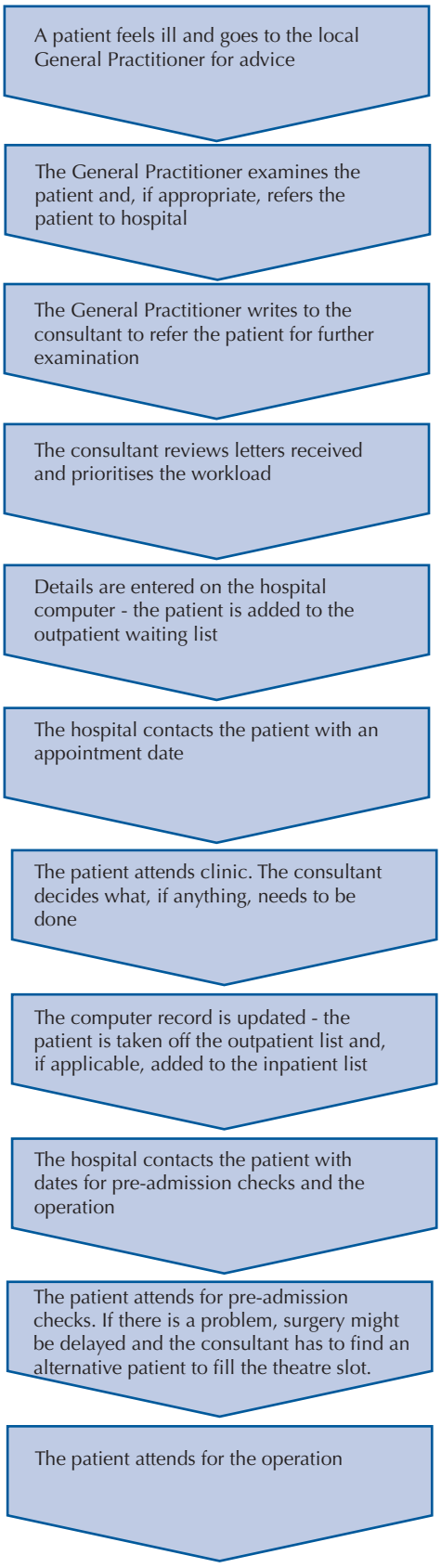
1.6 Many patients waiting for an operation receive their outpatient appointment quickly and wait only a short time for admission to hospital (Case 1) - some 721,000 patients (34 per cent of those seen in clinic) saw a consultant within 4 weeks. For those who have to wait longer it can be a painful, stressful and expensive experience, and long waiting lists can have serious consequences for them (Case 2). A Department of Health survey in 1998 found that over one third of people referred to a hospital by their doctor said their condition worsened while waiting to see a consultant. Over half of referred patients stated that waiting had caused pain and inconvenience, and the percentage increases the longer the wait[2]. A survey published in March 2000 by the College of Health showed that 45 per cent of people who contacted their Waiting List Helpline were in pain during the wait for an outpatient

1 The NHS did not count patients waiting for daycase treatment fifty years ago. At 31 March 2001, patients waiting for daycase treatment comprised more than half of the total waiting list

2 National Survey 1998

2 **Key stages for a typical patient**

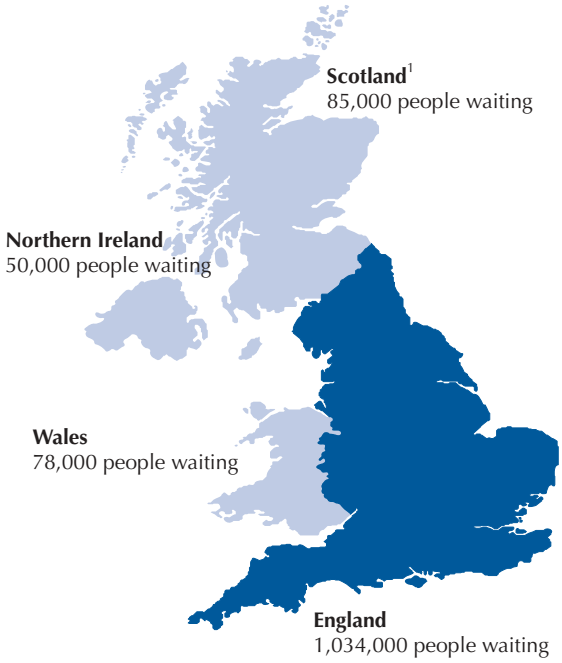
The key stages when a patient is referred to hospital for treatment



Source: National Audit Office

3 **The number of people waiting for treatment in the United Kingdom**

Some 2 per cent of the United Kingdom population were waiting for treatment at 31 December 2000



Note: 1. Excludes certain categories of patients and, therefore, is not fully comparable with other parts of the United Kingdom.

Sources: Department of Health, ISO Scotland, DHSSPS Northern Ireland and National Assembly for Wales

appointment or hospital admission. Of those patients that contacted the helpline, seven per cent were in minor pain, thirty four per cent of respondents were in a lot of pain, and four per cent found that the pain was unbearable. Fifty nine per cent felt their home life had been affected, and 24 per cent said their condition had affected their work.

1.7 The financial cost of waiting is difficult to estimate accurately, because of the range of ailments, levels of disability and pain, and variations in age, work and family commitments. Academic work in this area (Appendix 2) suggests that the personal value to patients of not having to wait is some £75 a month - equivalent to a monthly total cost of £80 million for those patients waiting for admission at 31 March 2000.

1.8 Waiting lists are seen as the most significant measure of how well the NHS is doing. But long waiting lists have also become symbolic, going beyond pure measurement, in the sense that they are seen to embody bureaucracy, slowness and inconvenience. Seven out of

ten patients who responded to the survey conducted by the NHS in preparation of the NHS Plan stated that they thought waiting lists and waiting times were too long.

What are NHS waiting lists

1.9 Waiting lists are a count, at any one point in time, of the number of people still to be treated by the NHS. There are two distinct waiting lists:

- **Outpatient waiting list (the number waiting for a first outpatient visit).** Approximately 80 per cent of the population in England visited their doctor in 1998[3]. In the majority of cases, they received reassurance or treatment. Over a third of the patients (35 per cent), however, were referred by letter to a hospital consultant specialising in the relevant area. From the date the hospital receives the letter, the individual is added to the outpatient waiting list, and remains on it until the patient is seen at an outpatient clinic.
- **Inpatient waiting list (the number waiting for surgery or other treatment).** Approximately one in ten of all outpatients seen require inpatient treatment, sometimes after one or more diagnostic tests. From the date the consultant concludes that an admission is necessary and the patient agrees, the patient is added to the inpatient waiting list and remains there until admitted into hospital for the proposed treatment, either as a daycase or involving a hospital stay.

1.10 Further diagnostic tests may be required following an outpatient appointment before a decision can be taken whether it is necessary to admit the patient and, therefore, add the patient to the inpatient waiting list. The time taken for such testing is not counted on either the outpatient or inpatient waiting lists, unless it is performed at the first outpatient appointment or as an inpatient episode. As a consequence, total patient waiting time is not necessarily recorded.

1.11 Certain categories of patient have never been included on reported waiting lists. The outpatient waiting list excludes individuals waiting for anything other than their first appointment with a consultant such as those referred to another consultant's outpatient clinic, sent for diagnostic tests or required to attend a further appointment. Also, the national **outpatient** waiting list statistics only count those patients who have been waiting thirteen weeks or more. The inpatient waiting list statistics report those patients awaiting elective admission for care from a consultant and, therefore, in addition to emergency admissions and maternity admissions, published statistics on the **inpatient** waiting list exclude the following patients:

Case 1

The NHS responds promptly when a patient might have cancer

An 83 year old lady saw her General Practitioner on 5 January 2000 with a breast lump. She was urgently referred to a Breast Care Unit and seen on 17 January, having a consultation, breast imaging and core biopsy on the same day. She returned on 20 January for the results. The biopsy was inconclusive and was repeated on 24 January. The results showed cancer.

On 27 January her results and a treatment plan were discussed with her. She left this consultation with a date for her surgery and was admitted on 7 February. The operation took place the following day. Surgery and recovery were uneventful.

She came back to the breast clinic on 17 February for post-operative results and was referred to an oncologist who she saw 6 days later.

Case 2

On occasion, patients are dissatisfied with the service they receive from the NHS

Mrs P saw a consultant at an NHS trust in the South East of England in January 1999 for a complaint with her foot, on which she had had an operation 2 years before. The consultant agreed it had not been set properly and placed her on the waiting list.

Mrs P was told by the trust on 1 June 2000 that she was to be admitted on 18 June. On 17 June she was telephoned at 5.30pm to say there was a bed shortage, and that she should telephone the next day. She telephoned at 11am and was asked to call again at 12pm and 1am. Shortly after, the trust told her the operation was cancelled.

Mrs P was told on 20 June to say that admission was re-booked for 22 June. Again, the day before, she was telephoned and asked to confirm bed availability on the day. This she did and was told the operation was again cancelled.

Mrs P rang the Waiting List Helpline that night, and the following morning was offered an appointment at a different trust where she was operated on successfully a week later.

- **Non consultant-led treatments.** Patients awaiting other forms of treatment, such as physiotherapy, speech therapy, or counselling are not included on the inpatient waiting list.
- **Patients who require subsequent operations.** Reported waiting list figures are based on the first operation and any subsequent treatment for the same condition, called planned admissions, is excluded. This is because the length of the wait is determined by medical rather than resource factors.
- **Minor operations and procedures carried out by staff other than consultants.** Patients awaiting treatment for minor procedures, such as the removal of a skin lesion or a bunion will not be added to the inpatient waiting list if the operation is to be done by a trained nurse or a chiropodist.
- **Operations carried out by a consultant in an outpatient clinic.** Patients that undergo a minor operation or diagnostic investigation by a consultant in the outpatient clinic are not added to the inpatient waiting list.
- **Patients temporarily suspended from waiting lists for personal reasons or because they are not medically ready for treatment.** Personal reasons might include holidays, pregnancy, work and family commitments. In such cases, patients are suspended from the waiting list at their own request for an appropriate period of time. A consultant might also suspend a patient for medical reasons, if the person is required to lose weight before surgery, needs to stop smoking, or has an unrelated medical condition.

1.12 The Department of Health's objective in the NHS Plan is to reduce the maximum wait for any stage of treatment rather than reducing a patient's total waiting time. The Department hopes to reduce the maximum wait for any stage of treatment to three months by the end of 2008, provided they can recruit the necessary extra staff and make the necessary reforms.

Responsibility for NHS waiting lists

1.13 There are a number of organisations and individuals within the NHS in England that work together on the reporting of waiting list data and the management of waiting lists and waiting times:

- **The Department of Health.** The Department collects and publishes waiting list data from health authorities and NHS trusts. Within the Department the eight regional offices are responsible for managing the provision of health care in their geographic area.
- **Access Task Force.** The NHS Plan set ambitious goals for providing patients with faster and more convenient access to services. The Access Task Force will oversee implementation of these elements of the NHS Plan and ensure optimum use is made of resources in the Department of Health, its regional offices and the Modernisation Agency in achieving these goals.
- **The National Patients Access Team (NPAT).** The team was established in 1998 to work with the NHS to help achieve the Government's waiting list targets. Their role has expanded, and the team now works closely with NHS staff to improve the way patients receive their care through investment in quality, service redesign and reducing unnecessary waiting times or delays.
- **Health authorities.** Each authority is responsible for representing the health interests of patients on the list of local General Practitioners plus unregistered patients within its geographical boundary.
- **Primary care groups and trusts** are accountable to health authorities, and provide both primary care services and commission hospital services for patients in their catchment area. As the NHS modernisation programme continues, such groups and trusts will increasingly be able to provide some minor procedures.
- **Trusts.** Trusts are responsible for the provision of health care. Each trust agrees performance targets and funding levels with its health authority. Trust managers record key data on waiting lists and report the results to health authorities and the Department of Health.
- **Consultants.** Each consultant has a contract with their trust specifying their NHS workload, including the number of weekly theatre sessions and outpatient clinics. Consultants prioritise patients for surgery and select patients for admission from their list.

Action to address NHS waiting lists and waiting times

1.14 The NHS has carried out a sustained programme of action to improve the management of waiting lists and to reduce waiting times and the number of people waiting. This includes additional funding for NHS trusts to reduce waiting lists, such as £737 million from 1998-99 to 2000-01, a revised Patients' Charter in December 1998, the publication of a range of guidance and best practice documents, and special teams such as the National Patients Access Team.

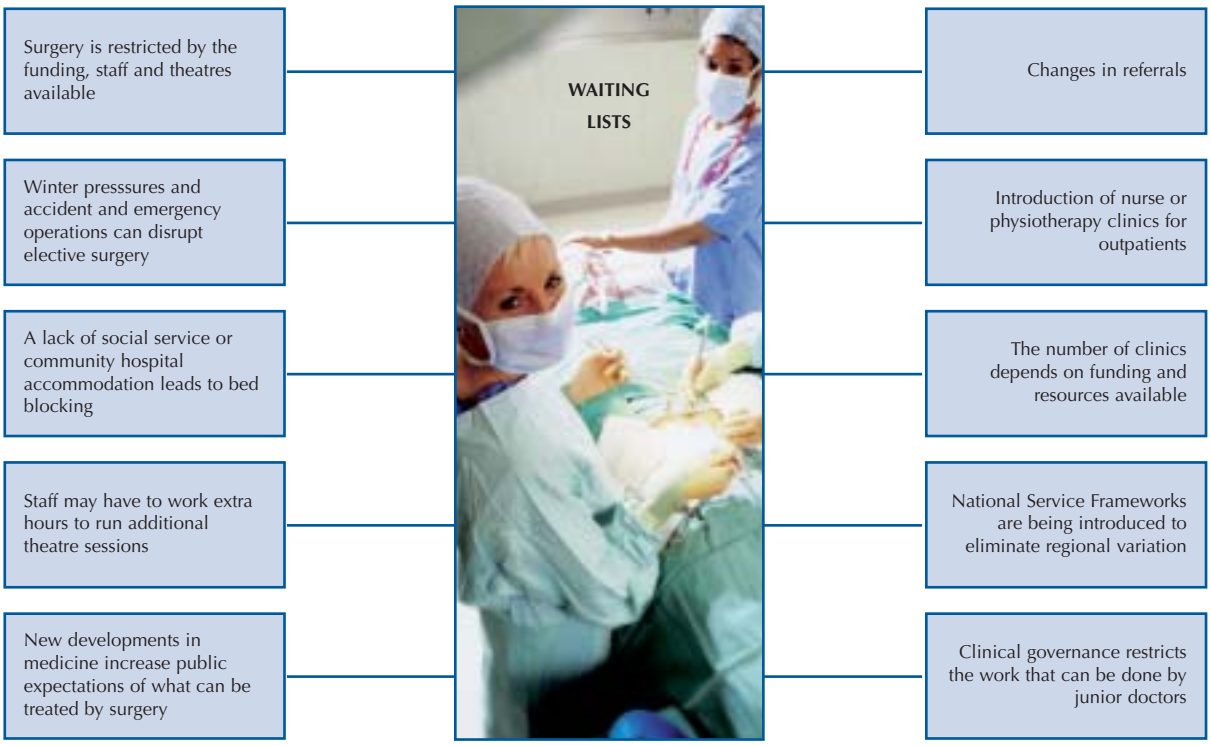
1.15 There are a number of factors that impact on NHS waiting lists (**Figure 4**).

1.16 The National Patients Access Team plays a key role in providing advice to trusts, disseminating good practices and the development and implementation of improvements in caring for patients. Trusts that they have advised have produced some significant improvements in waiting times through the introduction of improved management of care pathways and waiting lists. Specific initiatives include:

- **Action on projects.** The Department of Health has funded a range of initiatives proposed by clinicians to cut waiting times for Cataracts surgery, as well as treatments in Dermatology, Ear Nose and Throat, and Orthopaedic specialisms. The National Patients Access Team has taken a lead role in facilitating each project and disseminating results across the NHS.
- **Cancer Services Collaborative.** The initiative brings together clinical and management teams to redesign cancer services in order to provide a better service and shorter waiting times. It aims to ensure that different stages on the care pathway, for example, are done on the same day. The National Patients Access Team co-ordinates this programme and disseminates results.
- **Coronary Heart Disease Partnership.** As with the cancer initiative, the National Patients Access Team co-ordinates a similar programme to re-design services and cut waiting times for patients with heart disease.
- **A programme of trust visits to advise on best practice and to implement the National Booked Admissions Programme.**

1.17 In July 2000 the Government published 'The NHS Plan: A plan for investment; a plan for reform'. The Plan details the extra investment to be made in NHS facilities, including extra beds, new hospitals and one-stop primary care centres; and more consultants, General Practitioners, nurses and therapists. The Department of Health is committed to introducing a booking system for all inpatient and outpatient appointments. As a first step, the Plan announced that the maximum waiting times for a routine outpatient appointment will be reduced from

4 Waiting lists are influenced by many factors



Source: Department of Health

6 months to 3 months, and for inpatient treatment from 18 to 6 months, with both targets to be achieved by the end of 2005, and further reductions thereafter.

Why the NAO examined NHS waiting lists

1.18 We examined waiting lists in the NHS because:

- waiting list and time statistics are a key measure of the performance of the NHS;
- there has been considerable debate about the adequacy of waiting lists and times as a measure, the impact of initiatives to reduce waiting lists and on what waiting lists actually indicate; and
- our examination provided an opportunity to identify good practice in waiting list management.

Scope of our examination

1.19 We examined:

- waiting list and waiting time targets, and progress made - Part 2;
- using good practice to cut waiting lists and waiting times - Part 3.

1.20 Our examination focused on the waiting list data for outpatients and for elective admissions to NHS trusts in England. It does not cover patients admitted as emergencies. In addition, since Patient Administration System data from 1997 are no longer available, it was not possible to validate the 1997 'starting' figure for the NHS target to reduce the inpatient list by 100,000.

1.21 Virtually all operational aspects of the NHS impact on waiting lists and waiting times, including the availability of hospital beds, numbers of consultants and nursing staff, length of patient stay in hospital, consultant contracts and the order in which patients are admitted off the list. Some of these issues are referred to in this report; others are included in previous work by the National Audit Office, including reports on 'Hip replacements: Getting it right first time'[4], 'Inpatient admissions and bed management in NHS acute hospitals'[5] and 'NHS outpatient services.'[6] The Audit Commission report on 'The way to go home - rehabilitation and remedial services for older people' also touched on waiting list issues.

Methodology

1.22 During the study we were assisted by a panel of experts including Chief Executives and Medical & Nursing Directors from NHS trusts, General Practitioners, and representatives from the Association of Surgeons of Great Britain and Ireland, the King's Fund and the Audit Commission. We also discussed our findings at a seminar for management representatives from the 50 trusts we visited. We are grateful for the valuable help and assistance of all those who contributed to this report. Further details of our methodology, the individuals and organisations we contacted, and members of our panel of experts are at Appendix 3.

4 *HC 417, 1999-2000*
5 *HC 254, 1999-2000*
6 *HC 191, 1990-1991*

Part 2

Tackling waiting lists and waiting times

2.1 This part examines waiting list targets and performance against them. In particular:

- Progress against national targets
- Trust targets and their performance against them
- Strategies for further improvement

Progress against national targets

2.2 National targets on waiting lists cover:

- **Waiting for treatment (inpatients).** In 1997 the Government set a target to reduce the number of people on the inpatient waiting list by 100,000. The Patients' Charter provides for a maximum wait of 18 months for treatment.
- **Waiting to see a consultant (outpatients).** The current waiting list target is for a maximum wait for a routine outpatient appointment of 6 months. In April 1999 local NHS agreements aimed to reduce the number of individuals waiting over 13 weeks to 334,000 by March 2000.
- **Patients with suspected cancer** should see a specialist within two weeks of an urgent referral by their General Practitioner. From April 1999 this target applied to breast cancer and between April and December 2000 was rolled out to cover all cancers.

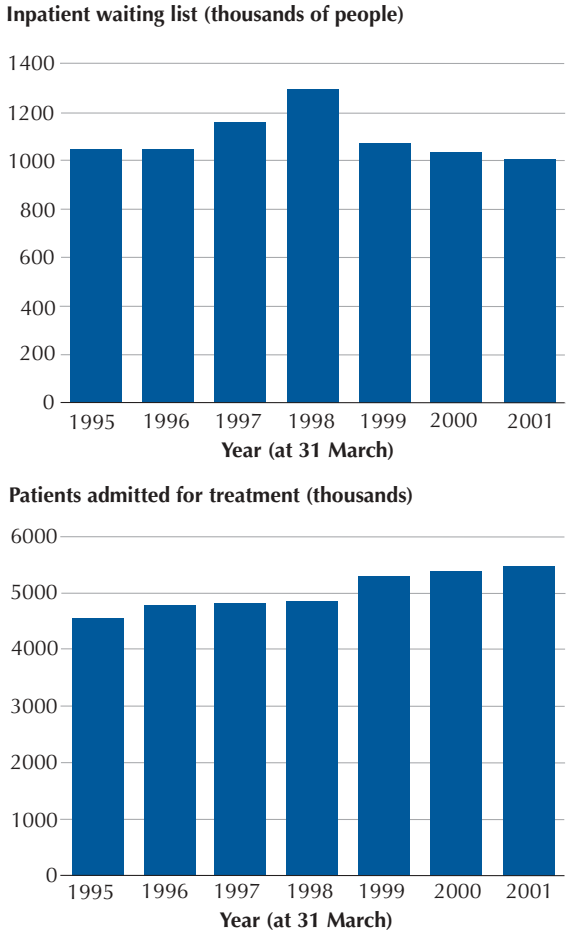
2.3 The Department of Health announced in May 2000 that they had achieved the target reduction in the number of inpatients waiting during 1999-2000. This reduction was maintained during the following year. The number of outpatients waiting over thirteen weeks was 284,000 at 31 March 2001.

The number of people waiting for treatment has fallen

2.4 The number of people waiting for treatment increased between 1995 and 1998 before falling in 1999, 2000 and 2001, see **Figure 5**. Over 50 per cent of patients on the list at 31 March 2001 had waited less than three

5 The number of NHS inpatients waiting and patients treated each financial year end

The diagram shows the number of NHS inpatients and the number admitted for treatment (defined as first elective finished consultant episodes) between the years ending 31 March 1995 and 31 March 2001



Source: Department of Health

months although around 4 per cent had waited over twelve months. The number of people waiting more than 12 months for hospital admission rose to around 42,000 at 31 March 2001 (up from 30,000 in March 1997), and 217 patients had waited longer than eighteen months.

2.5 The NHS recognises the importance of reducing waiting times further. The NHS Plan sets a new target to cut the maximum wait for inpatient treatment from 18 months to six months by 2005. As a result the average waiting time for inpatient treatment is expected to fall from three months to seven weeks.

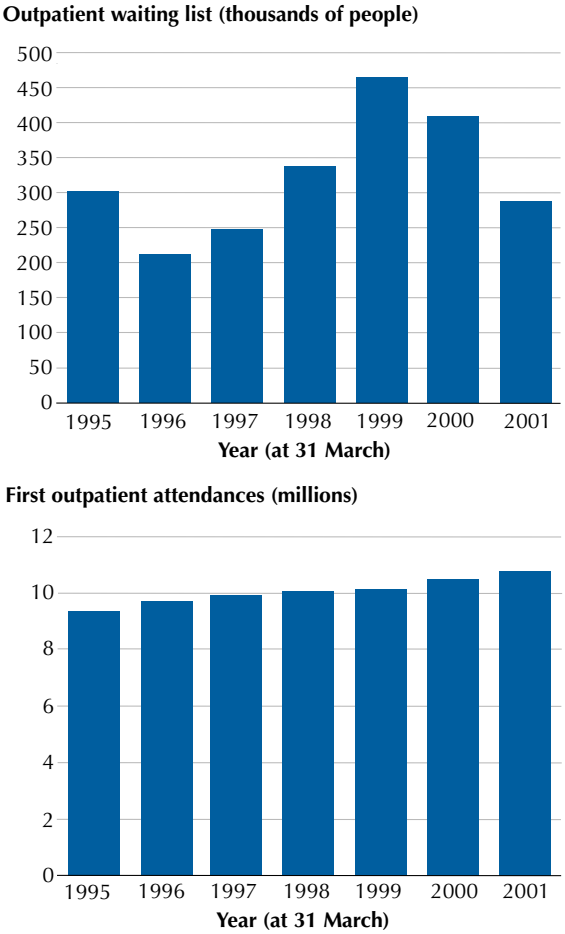
Outpatient lists have reduced substantially

2.6 The target set by the Department of Health to reduce patients on the outpatient waiting list waiting more than 13 weeks to see a consultant resulted in local agreements to reduce those numbers to 334,000 by 31 March 2000. **Figure 6** shows a rising trend from 1996 to 1999, followed by notable reductions in 2000 and 2001. At 31 March 2001 the number waiting more than 13 weeks was 284,000 of whom 82,000 patients were waiting more than the Patients' Charter target of six months. In the final quarter of 2000-2001 the NHS achieved a reduction of some 29 per cent in the number of outpatients waiting over 13 weeks.

2.7 Between March 1999 and March 2001, the number of patients waiting over 6 months decreased by 46 per cent (70,940 patients), and those waiting between 3 and 6 months decreased by 33 per cent (101,265 patients). As a consequence, average outpatient waiting times have decreased. The NHS Plan sets a new target to cut the maximum wait for a routine outpatient appointment from 6 months to 3 months by 2005. For cancers, the NHS performance indicators report, published in March 2001, showed that 96 per cent of cancer patients covered by the Government's 'guarantee' for breast cancer were seen within the two week target time. The NHS is currently working towards achieving a similar target for urgent referrals for all cancers.

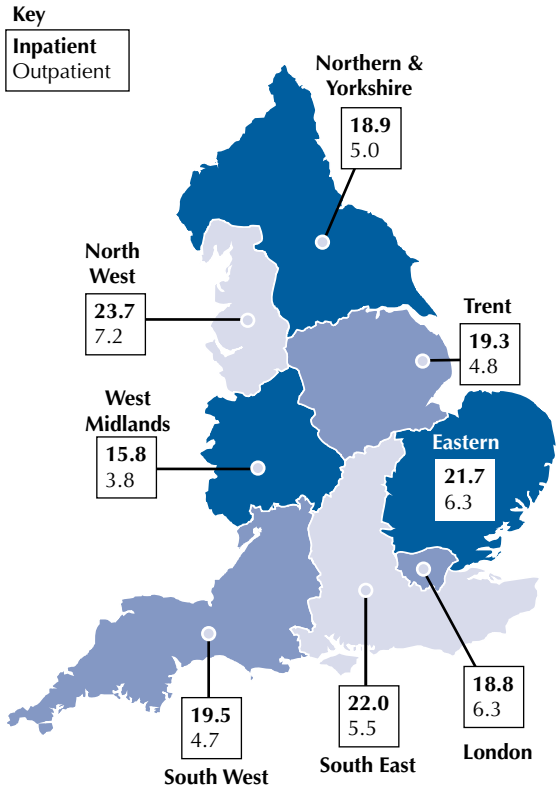
6 The number of people waiting over 13 weeks and the number seen for a first hospital clinic appointment

The diagram shows the number of outpatients waiting over 13 weeks for an initial clinic appointment with a consultant and the number of attendances between 31 March 1995 and 31 March 2001



Source: Department of Health

7 Average number of inpatients and outpatients waiting for treatment per 1,000 people



Note: Outpatients waiting more than thirteen weeks for an appointment

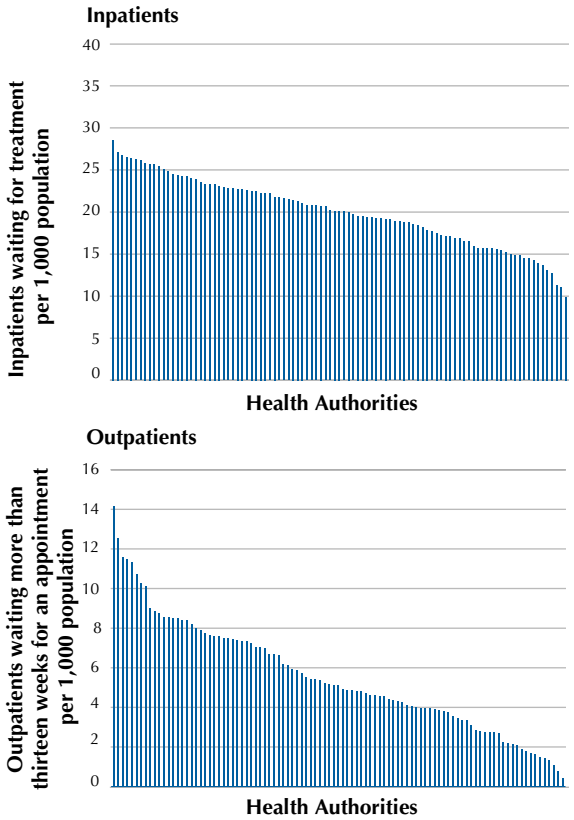
Sources: Department of Health statistics

There are significant variations across the country in the numbers on the inpatient and outpatient waiting lists

2.8 Across the eight NHS regions in England, the number of patients on the inpatient and outpatient waiting lists varies significantly (**Figure 7**). North West Region has both the highest number of inpatients waiting per 1,000 head of population (24.0) and the highest number of outpatients (7.2). West Midlands has the lowest number of both inpatients (15.8) and outpatients (3.8).

2.9 Across the country there are also significant variations amongst health authorities in the number of patients on the inpatient and outpatient waiting lists (**Figure 8**).

8 Variations in the number of patients per 1,000 population by health authority



Source: Department of Health

2.10 The health authorities with the highest and lowest number of inpatients and outpatients on their waiting lists are shown in **Figure 9**. North Cheshire Health Authority has the highest number of inpatients (29) per 1,000 head of population and North Staffordshire has the highest number of outpatients (14.2) per 1,000 head of population. Dorset Health Authority has one of the lowest number of both inpatients (13) and outpatients (0.8).

2.11 We also analysed waiting times across the country for the three specialties that we focussed on during our fieldwork at trusts - Ear, Nose and Throat; Trauma and Orthopaedics; and Urology. The percentage of patients waiting more than six months in these specialties varies considerably across England (**Figure 10**).

2.12 For all three specialties Dorset Health Authority had no or very few patients waiting more than six months. At Croydon Health Authority 51.8 per cent of Trauma and Orthopaedics patients waited more than six months for treatment, at North Cheshire Health Authority the wait was more than six months for 49.9 per cent of Ear, Nose and Throat patients, and at Bedfordshire Health Authority 37.4 per cent of Urology patients waited the same time (**Figure 11 on page 16**).

2.13 The NHS Plan includes a target to reduce the maximum inpatient wait to six months by 2005. The Department of Health consider that the target can be achieved through investment and by implementing best practice across the NHS. Our analysis of waiting lists at 31 March 2001 suggests that the target set by the Department of Health is a challenging one. Full details of our analysis are at Annex 1.

Trust targets and performance against them

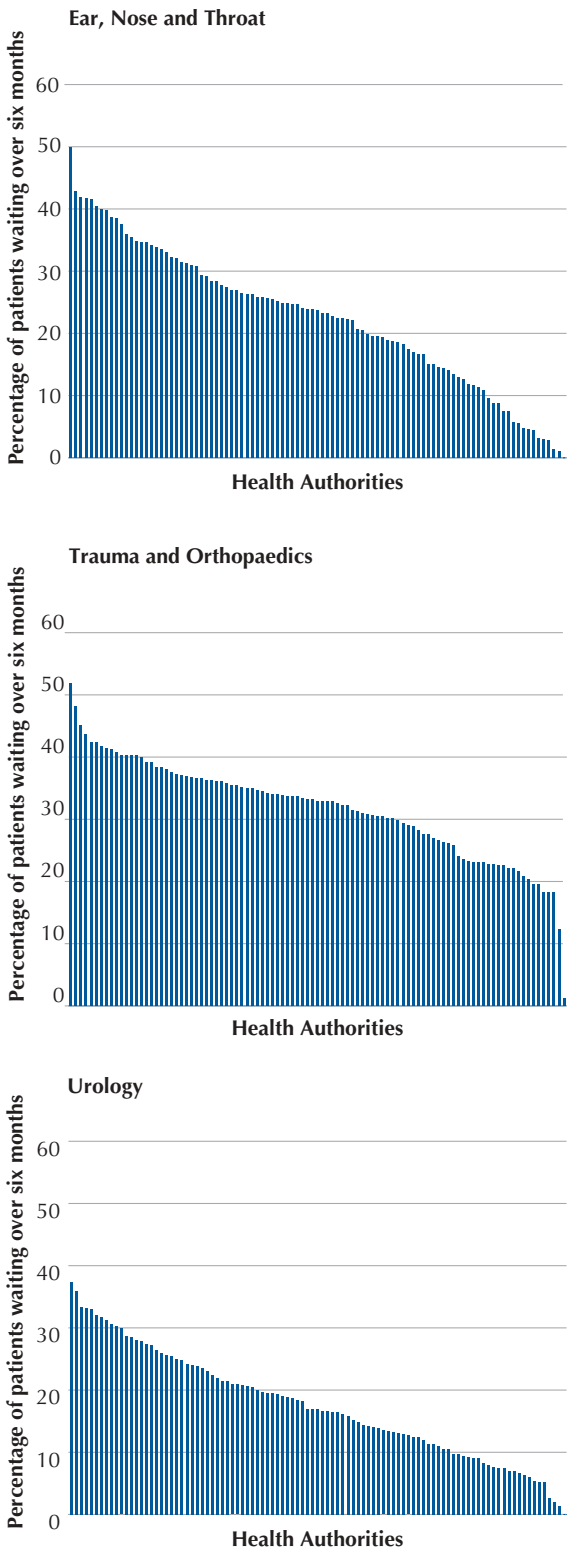
2.14 Trusts record key patient information on their Patient Administration System. They run monthly interrogation programmes to extract core data which is summarised and sent to the Department of Health to compile quarterly national statistics - see **Figure 12 on page 17**. The data provides a breakdown of the number of people waiting, including key data on both outpatients and inpatients. Validation checks, which ensure that trust returns are arithmetically correct and that, quarter on quarter, numbers do not vary by more than 20 per cent or 250, are undertaken at each trust, and figures can be amended if appropriate. Similar validation checks are

9 **Health authorities with the highest and lowest numbers of inpatients and outpatients over 13 weeks per 1,000 head of population**

Highest		Lowest	
Inpatients		**Inpatients**	
North Cheshire HA	29	Doncaster HA	13
East Kent HA	27	Dorset HA	13
Isle of Wight HA	27	North Staffordshire HA	11
South Lancashire HA	27	Kensington, Chelsea & Westminster HA	11
St Helens and Knowsley HA	26	Walsall HA	10
Outpatients		**Outpatients**	
North Staffordshire HA	14.2	Worcestershire HA	1.4
Wirral HA	12.6	Birmingham HA	1.3
Redbridge & Waltham Forest HA	11.6	Wiltshire HA	1.1
Liverpool HA	11.5	Dorset HA	0.8
Enfield and Harringey HA	11.4	Solihull HA	0.4

Source: Department of Health

10 **Variations in the percentage of inpatients waiting more than six months for treatment by health authority**



Source: Department of Health

quarter, numbers do not vary by more than 20 per cent or 250, are undertaken at each trust, and figures can be amended if appropriate. Similar validation checks are undertaken when the returns are received by the Department of Health, together with data quality checks to ensure consistency between quarters.

Most trusts met their waiting list and waiting time targets

2.15 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 and trusts. Each year, health authorities agree targets with each trust for the number of outpatients waiting over 13 weeks and inpatients on the waiting lists at the end of the financial year. These targets generally remain fixed throughout the year, though in exceptional circumstances may be revised following agreement with the health authority to allow for unforeseen events.

2.16 We asked the Chief Executives of 100 NHS trusts whether they achieved their inpatient and outpatient targets for 1999-2000. About half the trusts achieved their outpatient target, and over three quarters their inpatient target.

Trusts receive additional funding to help meet waiting list and waiting time targets

2.17 To help trusts to manage their lists, the Department of Health provided an additional £737 million between 1 April 1998 and 31 March 2001. Of the £417 million provided between 1 April 1998 and 31 March 2000, £20 million was allocated for capital expenditure improvements and the remaining £397 million to fund staffing and supplies costs for additional work. Trusts that we surveyed that had received such additional funding in 1999-2000 told us that it was used mainly to provide additional outpatient clinics (58 trusts), additional theatre sessions (50 trusts) and outpatient waiting list validation (41 trusts). Eighty-one per cent of Chief Executives said that they regarded the waiting list and waiting time funds spent by them in 1999-2000 as good value for money.

2.18 Performance improvement in the new NHS will be underpinned from April 2001 by a new system of incentives to support the delivery of better services for patients. The incentives will offer both financial recognition and non-financial reward to organisations and frontline staff for overall excellence and improved performance including performance against waiting list targets. Depending on their performance against a Performance Assessment Framework, all NHS organisations will be classified as 'green', 'yellow' or 'red'. Criteria will be set nationally but assessment will be by Regional Offices with independent verification by

11 Health authorities with the highest and lowest percentages of inpatients waiting over six months in three specialties

Trauma and Orthopaedics: The percentage of inpatients waiting over six months

Highest	%	Lowest	%
Croydon HA	51.8	Gloucestershire HA	18.3
Redbridge & Waltham Forest HA	48.2	Sandwell HA	18.3
Southampton & South West Hampshire HA	45.1	Walsall HA	18.3
East Surrey HA	43.6	Birmingham HA	12.3
North Staffordshire HA	42.4	Dorset HA	1.2

Ear, Nose and Throat: The percentage of inpatients waiting over six months

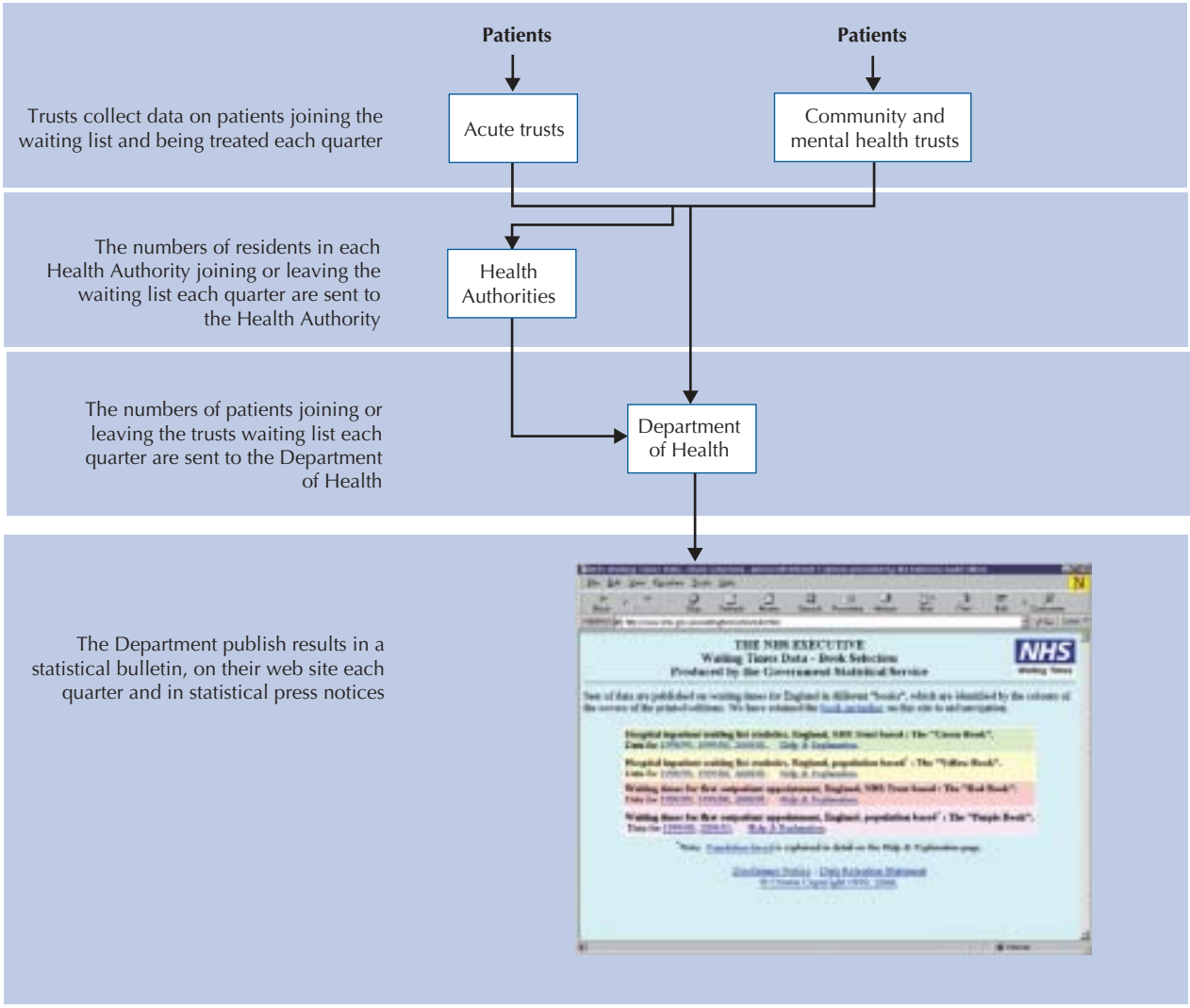
Highest	%	Lowest	%
North Cheshire HA	49.9	Barnsley HA	3.0
Lambeth, Southwark & Lewisham HA	42.9	Morecambe Bay HA	2.8
West Sussex HA	41.9	Wolverhampton HA	1.3
Ealing, Hammersmith & Harrow HA	41.7	Rotherham HA	1.1
Kingston & Richmond HA	41.6	Dorset HA	0

Urology: The percentage of inpatients waiting over six months

Highest	%	Lowest	%
Bedfordshire HA	37.4	Birmingham HA	5.2
Redbridge & Waltham Forest HA	35.9	Rotherham HA	2.6
Isle of Wight HA	33.3	Gloucestershire HA	2.0
West Surrey HA	33.2	Solihull HA	1.3
Sunderland HA	33.0	Dorset HA	0

Source: Department of Health

12 How waiting numbers and times are collected and reported



Source: National Audit Office

the Commission for Health Improvement. Red status will result from poor absolute standards of performance, triggering action to ensure a 'floor' level of acceptable performance is achieved throughout the NHS.

Pressure to meet NHS waiting list targets can lead to not treating patients in accordance with their clinical priority

2.19 Once a patient is on the inpatient waiting list, it is for consultants to decide what priority each case deserves, and what mix of cases to include in each theatre session. Most consultants assess the clinical priority of patients they add to the waiting list as 'routine', 'soon', or 'urgent', taking account not only of the clinical condition of the patient, but also other factors such as impact on home life and work. The clinical priority for an individual patient may change over time. It is a fundamental principle of the NHS that the order in which patients should be operated on by a particular consultant should be determined by their clinical priority so that those in greatest need are treated first. This principle has been stated numerous times by the Department and it is the Department's view that waiting time standards and targets, including the more demanding target for 2005 in the NHS Plan, can be achieved without any distortion of priorities given that extra funding and staff are being provided to increase the total volume of surgery carried out. Other countries manage this and the Department's view is that there is no reason in principle why the NHS should not. Only when deciding on which of two patients with the same clinical priority to operate first, should the length of time the patient has waited be taken into account.

2.20 It is, however, good practice in certain circumstances to operate on patients outside their normal clinical priority. For example, short periods of theatre time that might otherwise remain unused may allow simple, routine procedures to be carried out. The consultant might mix complex cases with routine operations for junior doctor training. And it may be good practice to devote some theatre sessions specifically to minor procedures in order to reduce the overall waiting list for a particular trust. Indeed, it may be argued, that if all patients were operated on strictly in accordance with their clinical priority, some routine patients would never get treated.

2.21 There is, therefore, an important balance to be struck. Whilst there does need to be some flexibility in the order in which patients are treated, it would be inappropriate to operate on routine patients in preference to, and to the detriment of, those who require urgent treatment solely to meet waiting list targets, or ensure no patient exceeds the 18 month maximum wait.

2.22 There are over 20,000 consultants working in the NHS. We contacted a representative sample within 3 specialties to give a broad indication across the whole spectrum. Nearly 300 consultants (52 per cent) out of the 558 who responded to our survey consider that working to meet NHS waiting list targets meant that they had to treat patients in a different order in 1999-2000 than their clinical priority indicated. This was, in the main, because the treatment of patients with higher clinical priority for surgery had to be deferred in preference to relatively less urgent patients coming up to an eighteen month wait. Twenty per cent of consultants (113) told us that the treatment of patients in a different order had occurred frequently. Of the 300 consultants who told us they had treated patients in a different order to their clinical priority, 80 per cent said that deferring treatment had a negative impact on the condition of the patient. Specific examples of distortion included:

- a series of routine elective hip and knee replacement patients close to the 18 month threshold, who were admitted in advance of clinically urgent revision joint replacement cases;
- a non-urgent sinus patient was passed to a consultant for treatment as an 18-month waiter. Urgent cases were displaced to make time for this patient on three occasions;.
- three patients with routine Ear, Nose and Throat conditions highlighted by a clinical business manager and given priority over clinically more urgent airway cases because they were about to breach the trust rule on maximum waiting time;
- routine reverse vasectomies performed at the expense of patients on the waiting list for bladder tumour surgery, because they came up to the 18 month limit.

2.23 There is a risk that with pressure to reduce waiting times further, the failure to treat patients in accordance with their clinical priority will continue to be a problem unless waiting lists are managed effectively. The Department of Health consider that many consultants could reduce the waiting times for their longest wait patients by improving the management of their lists without affecting clinical priorities. It will, therefore, be important that trust managers and consultants continue to develop constructive and co-operative working practices to reduce waiting times whilst maintaining clinical priorities. The Department believes that this situation should ease as the overall capacity of the NHS increases.

Accuracy of waiting list and waiting time data

2.24 Published national waiting list and waiting time data are compiled from information provided by NHS trusts. Data are not externally validated, and accuracy and completeness are dependent on trusts providing timely and robust data. We visited 50 trusts between March and May 2000 to assess the accuracy and reliability of waiting list and waiting time statistics. We also examined the completeness of waiting list and waiting time data reported by NHS trusts and published by the Department of Health. Further information on our methodology is at Appendix 3.

Regular validation removes patients who no longer need to be seen

2.25 Outpatient validation involves contacting patients to confirm that they still need to see the consultant. At the time of our examination, trusts had made some progress in validating outpatient lists though the procedures were less well developed than those for inpatients. Nearly half of the trusts were not undertaking validation at the time of our visit. Where they were, most validated outpatients who had been on the list for 13 weeks, but the criteria ranged from 9 to 26 weeks. As a result of this work, these trusts had been able to remove 5-15 per cent of patients who should not have still been on the outpatient waiting list.

2.26 To ensure inpatient waiting lists are not overstated, and to confirm individuals still require treatment, trusts should validate their waiting lists regularly and suspend and remove appropriate patients. Validation is a hospital-initiated routine check that patients are still expecting to have treatment and that their details are correct. Benefits include maintaining contact with patients, reducing the number of missed admissions, and providing a more accurate count of those waiting for treatment.

2.27 All 50 trusts we visited conducted some inpatient validation, though fewer than half (43 per cent) fully document their procedures. NHS guidance states that, as a minimum, hospitals should review patients waiting 12 months or more for admission, those who have been suspended for more than three months, or those who have postponed or deferred their admission more than once. Review letters to patients should be sent continuously throughout the year, or at least twice a year, and if a patient twice fails to respond, consideration should be given to removing them from the waiting list and referring them back to their General Practitioner. A small scale review by the Department of Health in 1998 found considerable variation in the validation processes followed by trusts, in the time intervals between reviews, and in the extent to which trusts had clear validation protocols.

2.28 We found that validation procedures continued to vary substantially between trusts. Typically, trusts validated patients waiting for six months, but the figure could be as little as three months and as much as 12. Some trusts validated continuously, others monthly, quarterly or six-monthly. Some trusts send only one validation letter to the patient before non-response leads to removal from the list; at others three letters may be sent before the removal process kicks in. As with outpatients, typically trusts have found that each validation exercise results in 5-15 per cent of patients either being removed from the inpatient waiting list or suspended. Validation exercises undertaken for the first time can result in up to 50 per cent of patients being removed or suspended.

Some Patient Administration Systems were not designed to meet current demands for waiting list data

2.29 Patient Administration Systems at trusts vary significantly. Each trust purchases its own software, of which there are numerous variants, each with different capabilities, though all should conform to national standards. Some of the software was not designed to provide the key waiting list management data that trusts are now required to produce. For example, at some trusts, the Patient Administration System allows patients to be suspended from the waiting list, but not to be re-instated once the period of suspension has ended.

2.30 In April 2000, the Department of Health Internal Audit reported that systems for recording outpatients were outdated, and that this, coupled with the lower priority afforded to outpatient departments, had contributed to historical problems in outpatient data and quality. The National Patients Access Team also concluded that outpatient management systems were archaic and needed updating.

2.31 From our examination of the data on the Patient Administration Systems at 50 trusts in a small number of cases we found:

- trusts estimated figures on their returns to the Department of Health. For example at one trust a catastrophic loss of computer data led to estimated figures being returned to the Department for that period. Other trusts had to rely on estimated figures for additions and removals to the waiting list because of inherent weaknesses in their Patient Administration Systems;
- information from the Patient Administration Systems used to complete waiting list returns to the Department of Health was not accurate. Examples include software errors in calculating the numbers removed from the list and difficulties in returning suspended patients to the list;
- instances were there were significant delays in formally adding patients to the waiting list, albeit the date retrospectively added was correct. In some cases the delay was two to three months after the decision to admit.

The NHS needs to continue to promulgate advice and good practice to harmonise disparate trust waiting list policies

2.32 The Department of Health have issued guidance including a data manual and data dictionary aimed at ensuring that NHS trusts record consistently all appropriate patients on waiting lists, and exclude any patients that should not be counted. Inevitably, as new clinical procedures are developed or become more common, there will be uncertainties as to whether certain categories of patients or certain treatments are to be included in the waiting list statistics, and the Department of Health encourage trusts to contact them, their Regional Office or the National Patients Access Team for advice and guidance in cases where the position is unclear.

2.33 Most of the 50 trusts that we visited had developed or were in the process of developing their own waiting list policies. Typically such policy documents contain definitions of the inpatient and outpatient waiting lists, procedures for waiting list validation, and the rules for removing or suspending patients. Six trusts had no agreed or draft waiting list policy document at the time of our visit.

2.34 Some of the waiting list policies that we reviewed had been prepared independently, while others had been produced in consultation with other trusts or the health authority. They ranged from 2 to 66 pages, and varied both in what they covered, and in policy.

2.35 Around one third of the policy documents did not define what should be included on the waiting list, fifteen per cent did not include procedures for validating waiting lists, and some 40 per cent did not set out the trust's policy for selecting patients from the waiting list for admission. Where trust policies covered patients who fail to attend their pre-assessment clinic prior to admission, one trust suspended the patient from the waiting list, one trust regarded the patient as having self-deferred and restarted the waiting time, four trusts removed the patient from the waiting list, and three trusts gave the patient a further appointment and only removed them if they failed to attend a second time.

What is counted on waiting lists varies between trusts

2.36 There are variations between trusts in what is included on or excluded from waiting lists. In part, this is because the way services are delivered in the NHS change all the time to meet patients' needs. For example, procedures once handled as daycases are now often dealt with in outpatient clinics. Forty-six per cent of the Chief Executives who responded to our questionnaire confirmed that during 1999-2000 they had redefined how they counted the number of inpatients, for example by re-classifying some patients who previously would have been included on the waiting list, as planned admissions. In 88 per cent of cases this had led to a reduction in the number of people on the waiting list.

2.37 One area that is difficult to define is the distinction between routine surgery and planned operations. Guidance issued by the Department of Health 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. Of the 50 trusts that we visited, ten had a written policy governing the waiting list treatment of bilateral operations. Six trusts counted the second operation as planned, and therefore not on the waiting list; four trusts added the second operation to the waiting list once the first operation had been completed.

2.38 Our discussions with trust waiting list managers indicated that there is also a fine line between what represents outpatient treatment and what is a daycase admission. Sixteen Chief Executives (22 per cent) responding to our survey told us that during 1999-2000 they had changed the definition of whether a treatment counted as an outpatient clinic treatment or a daycase admission. Such changes are usually due to changes in the way the treatment is administered, examples included patients seen as outpatients rather than being admitted for a procedure and the introduction of nurse led clinics. In all but one case this had resulted in a reduction in the number included on the inpatient waiting list, a consequent drop in inpatient activity in the trust and a rise in the number of outpatient over 13 week waiters. Examples where patients are no longer admitted but are treated as outpatients included:

- **Colposcopy daycases** - exploratory investigations for cervical cancer (one trust).
- **Endoscopy** - using a flexible optic cable for an internal examination (seven trusts).
- **Nephrology** - the study of kidneys (one trust).
- **Ophthalmology daycases -** two trusts identified certain procedures as diagnostic and therefore more appropriate as outpatient treatments.

2.39 The Department of Health recognises the difficulties faced by Chief Executives who might want to update existing definitions to take account of changes in procedures without wanting to appear to have manipulated reported figures. The Department commissioned a Review of Waiting and Booking Information in late Summer 2000. The terms of reference were to draw on existing expertise in the NHS to consider:

- What information the NHS needs to manage and monitor patient waiting times.
- Whether existing centrally collected data are suitable for measuring performance against the targets in the NHS Plan.
- What new information might be required on waiting times for therapists and diagnostic services.

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. The second cataract cannot be removed until some time after the first operation. In these circumstances, the patient will normally only be included on the waiting list for the first operation. Subsequent operations are treated as planned.

- What new information is required on the level of booked appointments and admissions.
- What the possible definitional issues are with any suggested future data items and how they might be resolved.
- What other information on waiting and booked admissions is collected elsewhere centrally in order to retain consistency between future data collections.

The Department aim to introduce any proposed changes during 2002.

Reconciling published statistics with trust data

2.40 The accuracy of published data is dependent on complete, accurate, reliable and timely data from trusts. We found few individual errors in those records we examined. We were also able to confirm that, for outpatients, aggregated data provided by trusts, was reflected in national published statistics. For inpatients, however, we were unable to reconcile aggregated changes in the waiting list for the quarter ending 31 March 2001, see **Figure 13**. There was a discrepancy, with the total waiting list figure being 24,000 greater than the sum of the flows on and off the list reported by the same trusts. The Department of Health explain the discrepancy by acknowledging that they do not measure every flow onto and off of the waiting list, but focus on the major ones such as hospital admissions and suspensions. The current Review of Waiting and Booking Information is due to consider whether data on **all** changes to the waiting list should be collected.

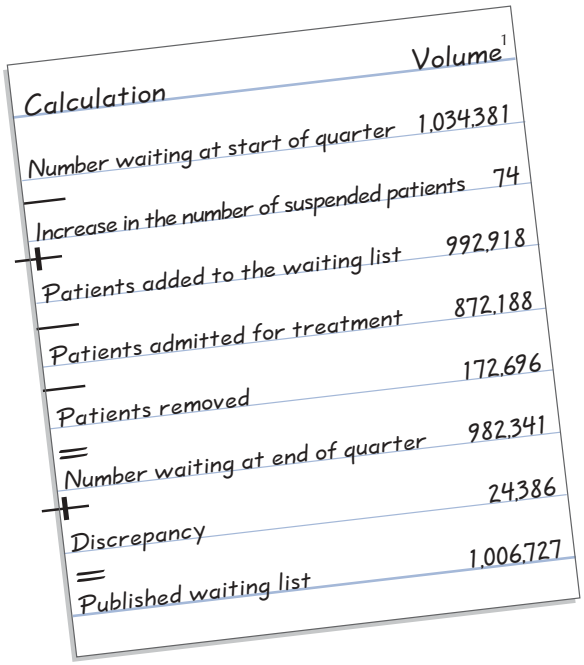
Patients temporarily suspended

2.41 Patients on the waiting list for surgery may be unavailable for hospital admission for specific periods of time. Reasons may include holidays, pregnancy and work and family commitments. In such cases, patients are suspended from the waiting list at their own request for an appropriate period of time.

2.42 In addition, there will be patients who, for medical reasons, cannot temporarily be admitted to hospital. Such patients include those who are obese and need to lose weight before surgery, heavy smokers, or those with a serious unrelated medical condition. These patients are suspended from the waiting list by the consultant concerned on medical grounds.

2.43 At any one time there may be around 75,000 patients suspended from the waiting list either through self-suspension or suspension on medical grounds. The number of patients suspended by each trust will vary according to its activity level, but even when this is taken into account the proportion of suspensions at each trust showed considerable variation - from zero at 48 trusts to over 30 per cent at five trusts. However it is recognised that as trusts reduce waiting lists the **rate** of suspension will automatically increase.

13 The inpatient list calculation



Note 1: Volume is for the quarter ending 31 March 2001

Source: Department of Health

Summary of our findings on the accuracy of waiting list data

2.44 Quarterly waiting list data is compiled by each trust and sent to the Department of Health to produce national published statistics. Our examination showed that published waiting list statistics accurately reflect information provided by trusts. In addition, our examination of trusts' systems and procedures found no evidence that patients on the waiting list get lost in the system. Inherent risks and lack of complete reliability in the systems and procedures mean that we cannot assure ourselves as to the complete accuracy of NHS waiting lists because:

- at many trusts there is an absence of, or variation in, effective validation procedures. For example nearly half of the trusts we visited were not undertaking validation of the outpatient waiting list;
- what is counted on waiting lists varies between trusts. For example trusts varied in terms of whether or not they added the second part of a bilateral operation to the waiting list;

- Patient Administration Systems cannot be relied upon to produce accurate and complete waiting lists. Examples include software errors in calculating the numbers removed from the list, and difficulties in returning suspended patients to the list;
- in a small number of cases, trusts estimated figures on their returns to the Department of Health and there were instances of significant delays in formally adding patients to the waiting list.

2.45 There are steps that the Department of Health can take to improve the accuracy of national published waiting list data - for example by greater use of validation, and by ensuring consistent definitions of what is included on the lists. There is, however, 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 the list to measuring how long each patient waits. It is therefore debatable how much effort should be devoted to ensuring that the number of people recorded as on the list is fully accurate. Considerable effort would be required to achieve complete accuracy, and it will be for the Department to set their priorities.

Some trusts have inappropriately adjusted their waiting list figures

2.46 At the majority of trusts that we visited there was no evidence that the trusts were deliberately or otherwise adjusting, inappropriately, their waiting list figures. However there have been a number of cases where trusts have adjusted inappropriately their waiting list figures. These include:

- Redbridge trust - July 1999.
- Guy's & St Thomas's trust- October 1999.
- University College London Hospital trust - November 1999.
- Plymouth Hospitals trust - Spring 2000.
- South Warwickshire General Hospitals trust - Autumn 2000.
- Stoke Mandeville NHS trust -Spring 2001.

We are undertaking further work on these cases.

Part 3

Using good practice to redesign services around the patient, to cut waiting lists and waiting times and better inform patients

3.1 This part examines:

- ways of promulgating advice and good practice;
- good practice that helps trusts meet five key principles of waiting list and waiting time management (see **Figure 14**); and
- keeping the patient informed.

3.2 There is considerable advice and guidance available within the NHS to help trust managers to improve the management of waiting lists. Guidance includes the NHS Beacon Programme (see **Figure 15**) and a range of key documents, including: the Waiting List Action Team Handbook (see **Figure 16**); the Five Step Guide; guidance for 'Action-On Cataracts', central guidance to Regional Offices on outpatient management, the Service and Financial Frameworks Checklist; and action plans agreed for specific trusts as part of the National Patients Access Team visit programme.

3.3 Chief Executives confirmed to us that practical advice offered by the National Patients Access Team and the Waiting List Action Team is well received. Only a minority of responses show any dissatisfaction with the advice available (**Figure 17**). Nonetheless, there is still considerable variation between trusts and, in general, a need for the better dissemination and adoption of good practice in waiting list management.

3.4 As the NHS Plan acknowledges, spreading good practice is a continual problem in the NHS. Better dissemination and implementation of good practice could be achieved by:

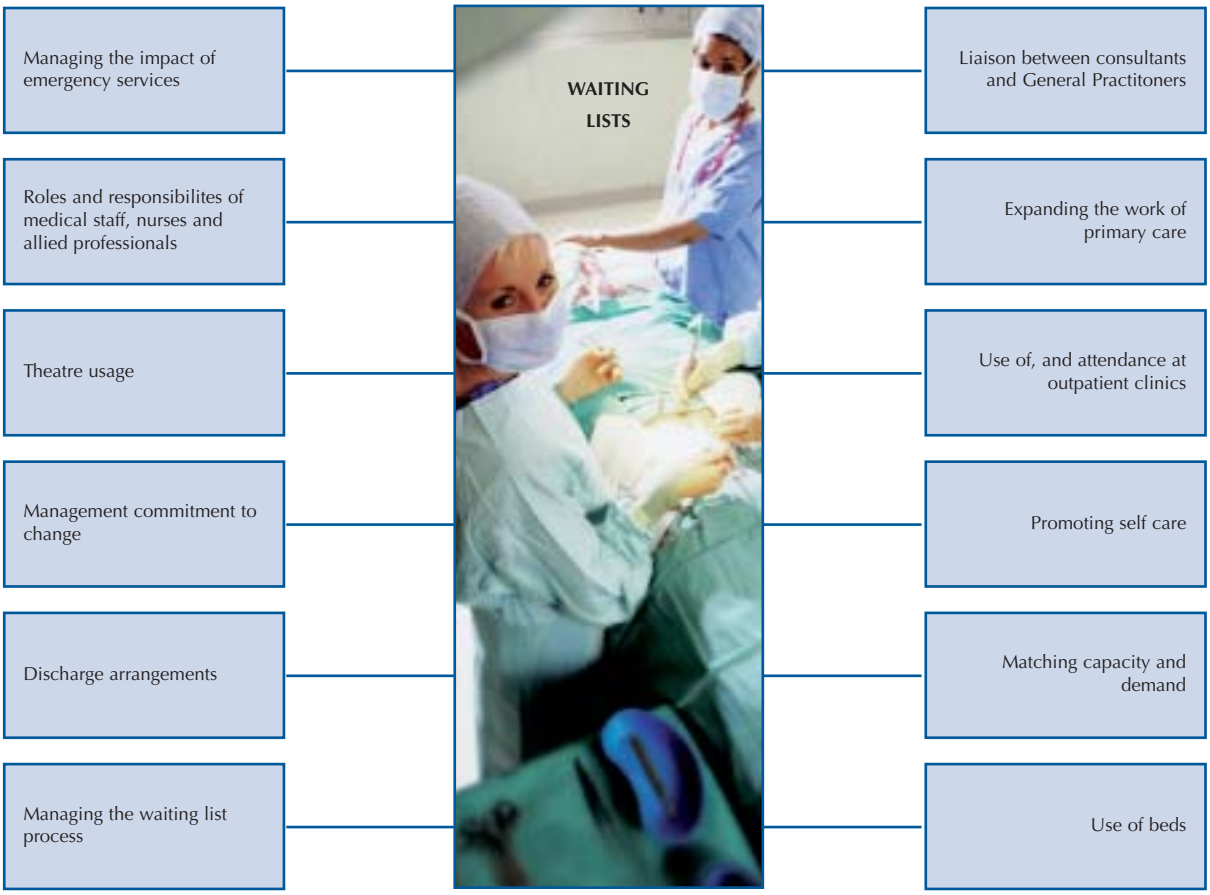
- **A multi-agency approach.** Responsibility for effective management of waiting lists does not rest with trusts alone. Primary care groups, General Practitioners, health authorities, local authorities, community hospitals, medical professions and the Department of Health all have a role to play.
- **Active encouragement.** Senior managers may regard initiatives as inappropriate to their organisation and remain reluctant to change. The National Patients Access Team has already demonstrated that visiting trusts and offering advice has ensured improved management of all aspects of waiting lists. They should be a key player in the implementation of the NHS Plan.
- **Identifying a champion.** One common theme that emerged was that whenever we identified good practice there was always one individual behind the initiative to drive it forward. The Modernisation Agency has taken on the role of developing leaders in the NHS. Chief Executives need to identify individuals with a commitment to change, and the drive and leadership skills to implement initiatives to improve waiting list management.

Five key ways of improving the management of waiting lists and waiting times

- General Practitioners should refer appropriate patients to consultants
- Outpatient clinics should operate at optimal capacity
- Optimise the use of operating theatres
- Have in place effective discharge arrangements
- Manage the process as a whole

14 Factors in managing waiting lists

There are a number of factors that impact on the length of waiting lists and the time that people wait. Fundamental resource and demand factors are shown in the Figure 4. This Figure shows a range of operational factors to which good practice can be applied to all waiting lists. Our examination focused on five key areas where we identified good practice during our visits to NHS trusts.

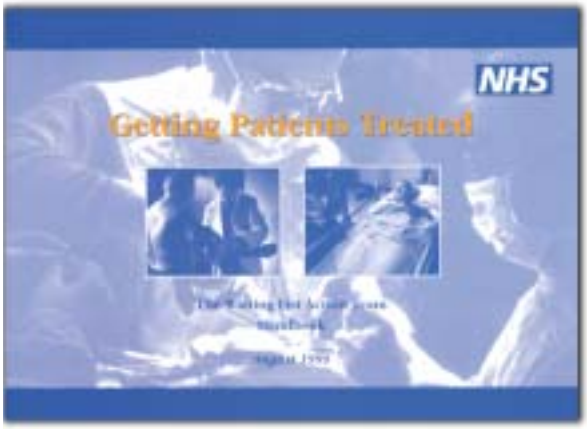


Source: Department of Health

15 The NHS Beacons handbook

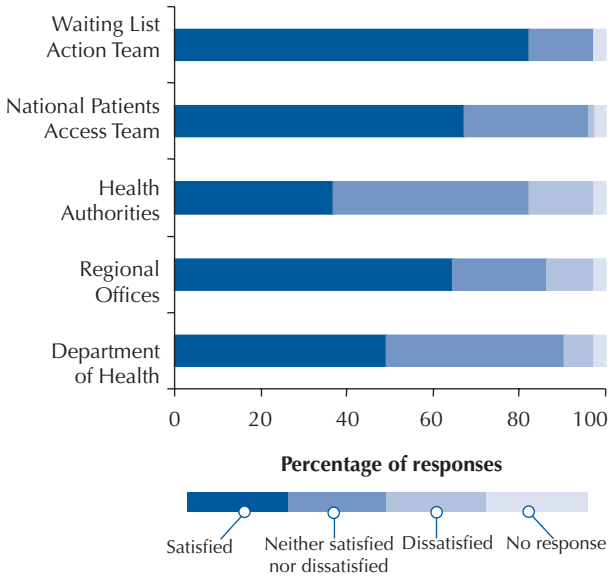
Source: Department of Health

16 NHS guidance on managing waiting lists



Source: Department of Health

17 Chief Executive's views on the helpfulness of advice



Source: National Audit Office survey, 2000

General Practitioners should refer appropriate patients to consultants

3.5 A consultant relies on the judgement and experience of General Practitioners to help decide how quickly to bring an outpatient in for a clinic appointment. But a General Practitioner deals with a variety of symptoms and ailments each day and, unlike the consultant, does not specialise in one area of medicine. As a consequence, General Practitioners' referral practices vary widely. The Royal College of General Practitioners concludes that much of this is a result of geographical variation in patient need and affluence, characteristics of referring doctors and organisational factors of individual General Practitioner practices. Patient demand is another variable since General Practitioners are required to refer patients who ask for a second opinion. Under the NHS Plan every General Practitioner practice and primary care group and trust must put in place, by April 2001, systems to monitor referral rates. The long term aim is that information about referrals will flow routinely between NHS trusts and other parts of the NHS.

3.6 Our survey of consultants in the Urology, Orthopaedics and Ear Nose and Throat specialties identified variations in the number of inappropriate referrals from General Practitioners. The mean proportion of such referrals between the three specialties was between 25 and 29 per cent. However, 207 consultants considered that less than 10 per cent of General Practitioner referrals were unnecessary, whilst 40 consultants thought the percentage was over 80 per cent.

3.7 Consultants should work with local General Practitioners to discuss appropriate referral practices and to encourage a re-think of existing practices in order to manage workloads better. To ensure patients see the appropriate health professional at the appropriate place and the appropriate time, good practice might include:

- Better co-operation between consultants and General Practitioners
- Development of referral protocols

3.8 Co-operation between General Practitioners and consultants helps ensure the right patients are referred. One trust, for example, identified locally a high incidence of skin cancers. Consequently two Dermatology consultants wrote an 'A-Z Gazetteer of Dermatology Treatments and Advice' to be used by local General Practitioners. This, together with a series of patient friendly leaflets, were sent to each practice, and a number of General Practitioners were invited to work in the trust as clinical assistants to build up further expertise.

3.9 Trusts and health authorities have developed over 850 separate referral protocols. One trust alone has developed 126. Whilst there are few in some areas, such as depression, many trusts and health authorities have developed similar protocols on common topics such as breast cancer and screening. Forty five consultants responding to our survey (8 per cent) stated that they had introduced referral protocols in 1999-2000.The National Patients Access Team commenced a project in April 2000 to collate existing referral protocols from trusts. Protocols have also been developed as part of the Cancer Services Collaborative, and work is ongoing to introduce referral advisors in every Primary Care Group. The Modernisation Agency is also developing referral guidelines as an integral part of its modernisation programme.

Outpatient clinics should operate at optimal capacity

3.10 Patients did not attend 1.5 million of the scheduled 13.7 million first appointments in 1999-2000. This may result in wasted clinic time, costing the NHS some £393 million a year at 2000 prices. The proportion of appointments missed remains about the same as when we looked at this issue in 1993-94.

3.11 We identified a number of good practices to improve outpatient clinic utilisation:

- Closer working between consultants
  - Pooling referrals
  - Updating referral practices
  - Provide data to General Practitioners on trust waiting lists
- The use of 'triage' clinics to help those patients who might require different forms of care than surgery

3.12 Consultants within a specialty at a trust can work independently or as a team in taking referrals from General Practitioners. Whilst the pooling of referrals might not be suitable when consultants specialise in a particular aspect of their work, the approach can be applied in most trusts. Pooling referrals ensures that consultants achieve an even balance between their respective waiting lists, and that any one consultant does not build up a significantly longer list of outpatients.

3.13 Whilst this might appear straightforward to implement, it requires General Practitioners and consultants to change their referral practices. For example, where a General Practitioner writes to a specific consultant, it would be inappropriate for anyone else to see the patient without that consultant's authority. And indeed there may be a good reason - for example very specific expertise - why a patient should wait to see a particular consultant. However there is scope for General Practitioners to write more 'Dear Consultant' referral letters, enabling consultants to pool referrals.

3.14 General Practitioners require detailed and timely information on how long patients might wait for a clinic appointment or surgery with each consultant in order to take decisions on which consultant to refer a patient to, in order to minimise waiting time. We found few instances during our visits that such information was provided to General Practitioners on a regular, timely and consistent basis. From April 2001, however, there is an explicit and formal requirement for all trusts to provide this information to General Practitioners on a regular basis.

3.15 Triage clinics enable a consultant to focus on serious cases and other trained staff to deal with those patients that need counselling or alternative forms of treatment. Examples include:

- **Physiotherapy 'triage'.** Many patients suffering pain or discomfort in their joints and limbs may require physiotherapy rather than surgery. Recruitment of a trained physiotherapist can reduce waiting times to see an orthopaedic consultant.
- **Nurse led clinics.** Some consultants use specialist nurses to deal with the less serious outpatients referred by General Practitioners.

Some 92 consultants that responded to our survey (16 per cent had introduced triage services in 1999-2000).

Optimise the use of operating theatres

3.16 Optimising operating theatre usage helps trusts to treat as many patients as possible. In general, the more operations performed, the lower the inpatient waiting list. We identified three good practices for trusts to optimise operating theatre usage:

- Use theatres at week-ends and evenings
- Minimise disruption from emergencies
- Re-allocate theatre slots to reflect changes in demand

3.17 Typical theatre working hours are 08.30-17.30, Monday to Friday. To make greater use of theatres, some trusts run additional week-end or evening theatre sessions. Forty-one per cent of the consultants who responded to our survey told us they had run additional theatre sessions in 1999-2000 to reduce the inpatient waiting list.

3.18 More NHS acute trusts could use their knowledge of patterns of emergency admissions to help plan more effectively the number and type of elective patient admissions. One approach is to timetable theatre sessions specifically to treat those patients from the waiting list that could be admitted and discharged the same day. Such sessions avoid the risk that emergencies might disrupt the session[8].

3.19 Demand for services and how surgical procedures are performed continue to change. Allocation of theatre time between specialties needs to reflect these changes. Some trusts have built additional theatres to handle increases in demand for some procedures and others have reallocated theatre slots previously used by doctors because clinical governance now requires a consultant to be present. Our discussions with trust managers and clinical directors emphasised the importance of regular management of theatre time slots to meet changing circumstances and to take account of the balance between emergency and elective work.

3.20 Cancelled operations can be a cause of great distress for patients and their families, particularly when this happens at the last minute. The NHS Plan states that from 2002, when a patient's operation is cancelled by the hospital on the day of surgery for non-clinical reasons, the hospital will have to offer another binding date within a maximum of the next 28 days or fund the patient's treatment at the time and hospital of the patient's choice. Work is in hand to reduce the number of cancellations and to ensure the NHS has systems in place to rebook operations when cancellations occur, using the private sector if the NHS itself cannot offer another date within 28 days. Additionally, the National Patient's Access Team started a project in April 2001 to investigate the link between poor theatre utilisation and cancelled operations. The aim is to investigate and redesign the theatre environment in order to prevent cancelled operations, identify best practice, optimise utilisation and establish capacity to meet demand. A project report and roll-out plan are due in September 2002.

Have in place effective discharge arrangements

3.21 Effective discharge planning ensures that admissions and operations are not cancelled due to beds being occupied by patients who should have been discharged. Our report on inpatient admissions and bed management (February 2000) found that hospitals with higher levels of average bed occupancy cancel significantly higher proportions of elective operations. We identified two good practices:

- Work with other organisations to ensure patients have somewhere to go after discharge
- Keep some wards specifically to deal with short stay elective surgery

3.22 In order to ensure the patient has somewhere to go after the operation, trusts need to liaise closely with community hospitals, social services and other organisations. Morecambe Bay Hospitals trust, for example, arranged for a local private hospital to accommodate patients after surgery in order to free up beds for further operations.

3.23 The principles behind minimising disruption to elective theatre sessions also apply to bed management. One trust, for example, keeps some wards specifically for short stay elective surgery patients in order to minimise theatre cancellations. And our report on 'Inpatient admissions and bed management in NHS acute hospitals' concluded that more NHS acute trusts could use their knowledge of patterns of emergency admissions to help plan more effectively the number and type of inpatient admissions.

Manage the process as a whole

3.24 Consultants are contracted by trusts to provide a specific number of outpatient clinic and theatre sessions a week. The balance is fixed, and any initiatives to improve outpatient performance are likely to impact on inpatient performance and vice versa.

3.25 As a consequence, the process needs to be managed as a whole and good practices include:

- Ensure the commitment of senior managers
- Create a forum to discuss and manage the whole process from referral to discharge
- Monitor performance regularly
- Have a contingency plan

3.26 A common thread through these good practices is the need for senior managers and consultants in the trust to be committed to managing waiting lists effectively. At one trust, for example, the Chief Executive stated that waiting times had been reduced by close, centralised management of lists. For each specialty a 'tail-gunning' approach was adopted with the details of urgent and the longest waiting patients released to medical staff for compilation of theatre lists. Each specialty is set monthly targets and clinical directors explain why any targets have not been met and what remedial action they propose.

3.27 Trusts need to monitor waiting list performance regularly to enable them to effectively manage their waiting lists. A number of trusts have developed monitoring systems, and the more effective ones have one individual responsible for compiling reports and circulating results, and the provision of timely and accurate data. In practice many trusts wait to see if a problem improves the following month before taking action. To speed up the response, one trust developed a contingency plan, so that if a waiting list deviated from the plan by more than a specified amount, it would trigger a series of agreed remedial actions.

Keeping the patient informed

3.28 The Department of Health recognises the importance of keeping patients informed on how their case has progressed. The NHS has started to monitor progress made in other countries to develop such initiatives. Denmark and Norway have developed sophisticated computer databases to track each patient through the system (see Appendix 4). And the Department of Health plans to give each patient a clear commitment from the outset of the dates of their future appointments.

Keeping the patient informed in Denmark and Norway

3.29 Health systems in Norway and Denmark are similar to those in the NHS. Health care is funded by the state, and patient care is based on the ethos of equal access to all. Both Norway and Denmark have introduced or are introducing initiatives to ensure that patients on waiting lists are well informed as regard the time they will have to wait (see Appendix 4).

3.30 In Denmark:

- Patients and family doctors can review waiting times on the internet for each hospital for 25 common medical problems. Information available includes maximum waiting time for patients on both the outpatient and inpatient waiting lists;
- The Danish National Patient Register publishes basic waiting times for all treatments.

3.31 In Norway:

- Patients can review waiting times for selective surgery at each hospital before deciding where to be treated. Data are published three times a year on the internet;
- From January 2001, patients have free choice of hospital. In connection with this initiative, the Norwegian Patient Register is developing an internet information system which will show waiting times at individual hospitals for specific treatments.

Whilst both countries have yet to evaluate the impact of these programmes, the initiatives offer improvements in how the NHS might keep patients informed.

National Booked Admissions Programme

3.32 The National Booked Admissions Programme aims to introduce an airline style booking system for hospital appointments by enabling patients to book hospital appointments or admission dates that are convenient for them. Such a system has clear benefits; it would alleviate any anxiety over the uncertainty of the next appointment and gives the patient sufficient time to organise other commitments, such as child care or work arrangements.

3.33 Since 1998-99, the Department of Health has made £65 million available to support the Programme. A further £50 million will be allocated in 2001-02. To date there have been three waves to the Programme. The first wave ran from September 1999 to March 2000 and involved twentyfour trusts. These concentrated mainly on booking daycase surgery while the patient was still in the outpatient clinic but ten sites also piloted booking outpatient appointments at the time patients were told by their General Practitioner that they needed to see a hospital consultant.

3.34 Second and third waves have concentrated on replicating first wave schemes at new sites and ensuring that by 31 March 2001 every hospital trust in the country was booking some patients in at least two specialties or high volume procedures. A fourth wave is set to be launched in September 2001. This will focus on mainstreaming booking into NHS activity and on making strong progress towards the NHS Plan target that by the end of 2005 all outpatient appointments and elective admissions to hospital will be pre-booked. A Service Improvement Guide which will provide practical advice to the NHS on the introduction of booking systems will be issued in Autumn 2001. In February 1999, the Department of Health commissioned the Health Services Management Centre at the University of Birmingham to conduct an evaluation of the first wave of the programme. An interim report, published in October 1999, identified key lessons which included:

- The introduction or extension of booking systems has stimulated managers and clinicians to consider fundamental changes in working practices.
- Advice and guidance from the National Patients Access Team had proved crucial to getting each of the projects up and running.
- A minority of patients did not wish to agree a date for their operation at the time of consultation.

3.35 Although the interim evaluation highlights several clear benefits, our discussions with hospital managers involved in the trial also identified some challenges in implementing the approach. Key lessons learned from the pilots include:

- Patients may be shocked to find out they need surgery and may need time to decide what to do. As a consequence, an individual may not want to make an appointment immediately, which means the system must be flexible enough to accept subsequent amendments.
- Implementation of a booked admission system will require consultants and General Practitioners working together to develop agreed guidelines on how to determine the seriousness of each patient's condition and what priority should be given when making an appointment. Such protocols take time to develop.
- The average waiting time needs to be relatively short. Patients may be unable to agree a date if the appointment is, for example, many months away.
- It may be more difficult to introduce booked admissions for specialties with unpredictable levels of emergency work. Work programmes are in place to address this.
- The further ahead appointments are booked the more likely the admission or operation will be subsequently cancelled.

A second evaluation report by the Health Services Management Centre in November 2000, however, demonstrated the potential benefits of the programme. Between the first quarter of 1999 and the first quarter of 2000, the proportion of patients in the pilot admitted for treatment increased by nearly 9 per cent and the percentage who did not attend fell from nearly six per cent to 3 per cent. Whilst many consultants already use a diary system to give their patients an approximate date for their operation, implementing a national system for outpatient appointments will take time. A third and final evaluation by the University of Birmingham is expected early Autumn 2001.

3.36 The National Patients Access Team developed a 'partial booking system' that can be used by trusts to introduce an outpatient appointment system. The aim is to ensure that patients of the same clinical priority are seen in chronological order. Agreeing a mutual date also minimises the risk that individuals will not turn up for their appointments. When a trust receives a letter from a General Practitioner referring a patient to a consultant, the trust writes to the patient to give an indication of how long the wait will be. Four weeks before the end of this period, the trust writes again to invite the patient to contact the hospital to agree a mutually convenient time and date.

3.37 An initial assessment of the pilots by the National Patients Access Team in November 1999 found:

- The percentage of patients failing to turn up at clinics fell from 10 per cent to three per cent.
- The proportion of patients contacting the trusts to cancel their appointment fell from 16 per cent to 10 per cent.
- Overall numbers of outpatients attending increased from 74 per cent to 88 per cent.

This improvement has resulted in additional patients attending clinics and greater predictability in numbers attending - important when planning capacity and resources. The report concluded that the impact of partial booking is of immense strategic importance to the NHS.

Appendix 1

A brief history of waiting in the NHS

1 When the NHS was established in 1948 the waiting list for hospital treatment was about 500,000[9]. Today the figure is over 1 million (including daycases), despite a series of initiatives designed to reduce the waiting list. In this note we briefly describe the main initiatives used to tackle waiting lists, and consider the reasons why waiting has persisted for so long.

Policy initiatives

2 Concern about waiting lists first appeared in 1949 when the first annual report of the Ministry of Health acknowledged that they were a problem that had to be addressed. The 1953 report expressed the hope that increased efficiency, in particular by 'reducing turnover intervals' in the use of beds, would lead to shorter lists. In fact lists did fall in the mid-1950s, but the respite was short-lived, and by 1957 the list was rising again.

3 The first formal guidance to the Service was issued in 1962, when the Ministry of Health issued a circular asking hospital authorities to review their waiting lists. But waiting lists continued to grow, and in 1963 the Ministry issued a further circular urging hospital authorities to 'make a concentrated attack' on the backlog. In 1964 the Ministry's annual report noted that the largest increases in those waiting occurred in specialties where there had been significant increases in the number of patients treated. Additional consultants were authorised in some specialties, but in these too waiting lists rose steadily. And it was clear that increasing the supply of care was proving insufficient to accommodate rising demand.

4 Some people were waiting a long time. A 1974 circular reported the results of a Departmental study which found that in six surgical specialties, 37 per cent of those on the list had been waiting for more than a year, nearly 20 per cent for more than 2 years, and some for 4 years or more. Once again the responsible Minister stressed the need to do something, and all authorities were required to review their lists. £5 million was set aside for minor capital works to finance schemes designed to reducing long waiting times. Numbers continued to rise, however, briefly disguised by the fact that the 'total' figure applies only to England, rather than England and Wales, from 1972.

5 In 1986 the Conservatives launched the Waiting List, later Waiting Time, Initiative. By now the list was approaching ¾ of a million, and many people were waiting over a year. A change in the way care was delivered also temporarily disguised the steady upward trend: daycase treatment was growing in popularity during the 1980s, but those waiting for daycase surgery were only included in official statistics from 1991.

6 When the Waiting List Initiative ended after eight years, the total waiting was higher than when the Initiative started; however by September 1992, virtually no patients were waiting over two years, and by June 1996 the number waiting over 18 months had been virtually eliminated. These changes reflected the 'rights' introduced in the Patient's Charter which were expressed in terms of access times rather than numbers waiting.

7 The total continued to rise, so that by the time the Labour Government came to power in 1997, the number waiting was well over one million. The Government had pledged prior to the Election that they would reduce the total by 100,000 over the lifetime of the Parliament. In 1998 the numbers peaked at 1,298,000, since when they have fallen back. The election pledge was finally met in March 2000 (and maintained in 2000-2001) when the number waiting fell to 1,037,000. However waiting for hospital treatment is only part of the total wait which patients experience.

8 In 1995 data began to be collected nationally on the time people waited for an outpatient appointment. The first results revealed some long waits, though around 80 per cent of people were seen within 3 months. Concentrated efforts to tackle outpatients waiting in 1999-2000 and 2000-2001 have resulted in a fall in both the outpatient and inpatient waiting list numbers.

9 The way that waiting list data is collected means that it is not possible to say what the patient's total waiting time is, particularly if, for example, patients are referred from one consultant to another. But for many the situation is better than in earlier years. Very long waits have been all but eliminated, at least in the recorded statistics, and the majority of patients are being seen within three months at outpatients and three months for inpatient treatment.

9 The NHS did not count patients waiting for daycase treatment fifty years ago. At 31 March 2001, patients waiting for daycase treatment comprised more than half of the total waiting list

Why waiting lists persist

10 While waiting lists have persisted in the NHS, the services provided have changed radically. The number of operations carried out has risen substantially, and if the waiting list in 1948 had been a simple backlog, it would have been eliminated by the 1950s. But by the 1960s it was clear that the list represented more than that. The 1964 annual report, noting increases in specialties where the numbers of patients treated had also risen, showed that the increase in resources was accompanied by more demand for treatment.

11 The number of operations has continued to increase and is now running at over 4.5 million a year. There have been some marked changes - some operations, such as removal of tonsils, are performed much less frequently; others, such as removal of cataracts, are much more common. And technical improvements and different operating techniques permit operations such as knee replacement that were impossible only a few years ago.

12 Thus attempts to cut waiting lists or waiting times have to contend with a dynamic situation. The extra resources that have become available to the NHS since its foundation have made it possible for more people to enjoy a wider range of operations. But that very success has led to more people coming forward for treatment. Waiting therefore persists.

13 The crude figures of the numbers waiting and the time they wait say nothing however of what it is like for patients while they are waiting. In the 1970s the Royal Commission on the NHS carried out a survey of waiting and found significant numbers reporting that their waits caused inconvenience or distress. Twenty years later, when the first national user survey was published, essentially the same findings emerged. These surveys however cannot reveal the full impact on individuals: how many had to give up work or were severely incapacitated or who died from the condition while they waited to be treated, is unknown.

Anthony Harrison/Bill New, November 2000

Appendix 2 The cost of waiting

1 The National Audit Office carried out a review of academic literature to identify the cost of waiting for an operation.

2 Patients waiting for an operation do not follow typical queuing theory rules. They are not necessarily seen on a first come first served basis, there are a considerable number of separate queues and an individual does not have to physically queue - which means that no actual time is lost due to waiting[10].

3 One view[11] is that in contrast to time spent in a queue, the time spent on a waiting list has no cost. But in a health care context, there are other costs to waiting that do result in a real cost to the patient. There are three main costs[12]:

- **The cost of poor health.** Individuals on the waiting list are not in full health and, as a consequence, may not be able to carry out usual daily activities;
- **Waiting for an operation creates anxiety.** The patient may be concerned about the thought of having the operation. There is a cost associated with this anxiety;
- **The stress and inconvenience of not knowing when they will be treated.** Most patients on the waiting list do not have a specific date for the operation. As a consequence, there is a cost associated with not knowing when the hospital might call the patient in.

4 One approach to estimating the cost of waiting is to use contingent valuation based on stated preferences. A random sample of individuals were given a standard scenario:

> The respondent was asked to imagine that he/she had a medical condition which required an operation. Prior to the operation, the respondent would be unable to perform all his/her normal activities, would have to take a specified amount of time away from work or from household duties, and would experience fairly constant pain. The medical condition would not deteriorate during the wait, but neither would it improve. Once the operation was performed, the respondent's health would return to normal.

5 Each respondent was represented with fourteen scenarios around these principles and invited to make choices from a list of options. Further testing was also undertaken to test the rationale and validity of decisions. The estimated cost of waiting (inflated to 1999 prices) was **£75** per month per patient.

6 This calculation is an estimate and, in reality, the costs will differ substantially between patients on the list. Some conditions, for example, do deteriorate the longer a patient waits. Around 38 per cent of patients awaiting a cataract operation will suffer further deterioration in visual acuity[13]. But many of these concerns can be resolved by better prioritisation of patients rather than by reducing average waiting times. An examination of mortality rates for patients waiting for cardiac surgery[14] found that reducing the length of lists for patients who waited a long time was less effective than providing better access to those patients in greatest need.

10 Barzel, Yoram: 'A theory of rationing by waiting', Journal of Law and Economics 17, 1974.
11 Lindsay, Cotton and Feigenbaum: 'Rationing by WaitingLists', American Economic Journal, 1984.
12 Propper: 'The disutility of time spent on the United Kingdom's National Health Service waiting lists', Journal of Human Resources Volume 30 1995.
13 Mordue, Parkin, Baxter, Fawcett, Stewart'. 'Thresholds for treatment in cataract surgery', Journal of Public Health Med 1994 Vol 16.
14 M Jackson, EH Blackstone, P Currie and BM Fabri, 1998 'Waiting for Cardiac Surgery: Is it fatal?'

Appendix 3 Methodology

We used a variety of methods to examine the issues identified for this study, including validation work at 50 NHS trusts, two self-completion questionnaires, a workshop for trust managers and a range of interviews, discussions and file examinations. The methods were chosen to:

- validate the accuracy of NHS waiting lists;
- provide a mix of qualitative and quantitative data to assess the performance of trusts;
- allow us to obtain examples of good practice;
- allow us to assess the extent of developments in the NHS in recent years.

Validation work at 50 trusts

We sought to examine the accuracy and appropriateness of the published performance data on NHS waiting lists. Validation of the performance measures involve assessment against five key criteria[15]:

- **Relevance.** The performance measure should be relevant to managers, the Department of Health, clinical and medical staff, patients and the public.
- **Consistent.** The terms used to describe and define the performance measure should remain the same over time. Published performance data should draw to the user's attention any changes required to update the performance measure.
- **Accuracy.** The performance measure should be sufficiently accurate to enable users to judge performance and any trends over time.
- **Timeliness.** Performance data should be produced promptly.
- **System value for money.** The performance measurement should provide value for money for the NHS.

We developed a two-stage sampling approach to select a representative selection of records to examine.

Stage 1: Select which trusts to visit

We identified 273 trusts that held waiting lists and, in discussion with statisticians from the Department of Health , agreed to select records from fifty of them. We categorised the trusts by size (in terms of the number of beds they had) and region in order to ensure a broad coverage.

Stage 2: Select a sample of patient records at each trust

We developed a series of audit programmes to test for each key risk we identified.

At each of the fifty trusts visited, we selected samples of ten records from the local files. For each record, the data on the Patient Administration System were checked to data in the medical file and from other sources in the trust.

Self-completion questionnaire survey of Chief Executives

We prepared a self-completion questionnaire for Chief Executives in 100 trusts with waiting lists. The purpose of the questionnaire was to seek their views on the implementation of strategies to improve waiting lists and waiting times, performance to date and the impact of any locally developed initiatives. Each Chief Executive was made aware that their responses would not be treated as confidential and might be quoted in our report.

75 out of the 100 Chief Executives we contacted replied to our questionnaire.

Self-completion questionnaire survey of consultants in Urology, Orthopaedics and Ear, Nose & Throat

We prepared a self-completion questionnaire for consultants. In view of the large number of consultants in the NHS, over 20,000, we chose to focus the questionnaire on consultants in three specialisms:

- Urology - care of the urinary tract and male genitalia.
- Orthopaedics - care of those parts of the body required for stability and movement, such as bones and joints, ligaments, muscles and nerves.
- Ear Nose and Throat.

We invited consultants in these disciplines at each of the 100 trusts selected for the survey of Chief Executives to respond. 558 out of 627 consultants replied.

15 *Performance Measurement, what to look for in vfm studies - National Audit Office*

The questionnaire sought key data, views and examples of good practice from consultants. We explained to consultants that their responses would not be treated as confidential - indeed the Chief Executives from the 100 trusts had an opportunity to see the responses from their consultants.

Workshop for trust managers

Towards the end of our data collection we hosted a four hour workshop for management representatives from each of the 50 trusts we had visited. The purpose of the workshop was to seek their comments on the emerging findings and to explore what could be done to improve performance further.

Interviews, discussions and file examinations

We sought further information and comments from our expert panel and a wide range of organisations, including:

- College of Health
- King's Fund
- Audit Commission
- Department of Health, Northern Ireland
- Department of Health, Scotland
- Patients Association
- Checklist UK Ltd

Representatives from our expert panel included:

- John Bailey. Public Services Research, Audit Commission
- Jill Copeland. Head of NHS Waiting and Booking, Department of Health
- Dame Pauline Fielding. Nursing Director for Preston Acute Hospitals and Chorley and South Ribble NHS trusts
- Mark Goldman. Medical Director, Birmingham Heartlands & Solihull NHS trust
- Anthony Harrison. Fellow in Health Systems, King's Fund.
- David Highton. Chief Executive, Oxford Radcliffe NHS trust.
- Sue Jennings. National Patients Access Team
- David Watkins. Vice President, Association of Surgeons of Great Britain and Ireland.
- Dr Paul Zollinger-Read. Chairman Witham, Braintree & Halstead primary care group.

Appendix 4

The management of patients waiting for treatment in France, Denmark and Norway

1 Different countries have different ways of providing health care. In some countries, such as France, the health care system is supported by private and national insurance funding rather than through taxation. The patient pays the General Practitioner or consultant and is reimbursed from the social security system and private health care insurance. Health systems elsewhere, such as in Norway and Denmark, are broadly similar to those in the NHS. Health care is funded by the state and patient care is based on the ethos of equal access to all. Denmark has some 80 hospitals serving a population of 5.3 million, and Norway has some 70 hospitals for a population of 4.4 million.

2 Average waiting times for treatment in each country are comparatively short. A patient in France can expect to be treated very shortly after being referred by their General Practitioner. In Denmark in 1998 92 per cent of patients waited less than three months for treatment. The French health care system demonstrates that waiting times can be eliminated. And Norway and Denmark have developed initiatives to improve the management of waiting lists and to give patients some say in their treatment. These initiatives are still in the process of development, however, and it remains too early to determine their final impact.

France

3 The French health care system is a mixed system, combining elements of private and public care, as well as publicly funded and private health insurance elements. Essentially a patient can choose between public and private healthcare providers. If the patient chooses a public provider the basic costs of the hospital is funded by the state and the remainder is payable by the patient. The patient can then claim back from state insurance schemes an agreed amount in respect of other costs but has to fund any excess from their own resources or from private insurance schemes. Similarly, if the patient chooses private healthcare the state will fund costs up to agreed amounts and the patient is responsible for funding the remainder, possibly through private insurance schemes. In total almost 80 per cent of health spending is publicly funded, about 10 per cent is paid by mutual and private insurers, and the remainder by patients.

4 The growth in insurance schemes means that, for most of the population, the cost of health care is refunded. As a consequence, health spending is largely demand led and the share of national health expenditure as a percentage of the country's Gross Domestic Product rose from 7.6 per cent in 1980 to 9.6 per cent in 1998, compared with nearly 7 per cent for the same period in the UK[16] Patient waiting times in France are negligible, and some two-thirds of the population are fairly satisfied with the existing system although French employers are complaining about the cost. Whilst recent initiatives have focused on curbing costs, budgetary constraints have proved difficult to implement, and progress in restructuring and re-organising hospitals has been slow.

Denmark

1. Key initiatives include:

- **Patients and family doctors can review waiting times for key procedures.** Since 1998 the Ministry of Health web site in Denmark (http//www.info.sum.dk) has included data on average waiting times for 25 procedures for all the hospitals in the country that carry out those procedures. The procedures include cataracts, knee replacement, hernia, varicose veins, tonsillectomy, hysterectomy, certain cancers and specific heart procedures. Information available for each treatment includes the maximum waiting time for an outpatient appointment, waiting time for treatment, and the number of weeks from the outpatient appointment until treatment is started. Over one third of a million Danish patients have accessed the web site since 1998. In 1999 the population of Denmark amounted to 5.3 million.
- **Danish National Patient Register.** A central register based on individuals, and including data since 1977. The Register was established with the aim of forming the basis for the National Board of Health's hospital statistics. Waiting time statistics were added to the Register in 1999, recording date of referral, diagnosis, and discharge date, and the Ministry of Health uses the Register to publish basic waiting times for all treatments.
- **Denmark has a waiting time guarantee for certain specific conditions.** Introduced in March 2000, and guaranteed by law, the guarantee states that patients with breast cancer, cancer of the uterus, lung cancer, intestinal cancer or serious heart conditions - in total, about 35 per cent of all patients - can expect to be treated within 30 days of referral from the family doctor. Performance against these targets is

16 *The Changing Health System in France. Imai, Jacobzone, Lenain. OECD November 2000*

monitored and published by the Ministry of Health. If a hospital is unable to meet the guarantee they must arrange for treatment to be provided elsewhere, either within the Danish public or private sectors, or overseas.

- **Denmark has a 'choose your own hospital' policy.** Introduced in 1993, patients have the right to choose freely amongst any of the public hospitals across the country.
- **Every hospital has a patient counsellor.** The role of the patient counsellor is to advise the patient on waiting times, the freedom to chose among various hospitals, and complaints etc.
- **The Danish Institute for Clinical Epidemiology carried out a survey to identify the consequences for patients of waiting time for admission to hospital.** The Institute undertook a nation-wide survey of 1,000 patients that had been admitted for slipped disc, inguinal hernia or hip or knee replacement six months earlier. Around half of the patients had waited more than three months to be admitted to hospital. Key findings included that:
  - *For knee and hip replacements* - More patients among those who waited the longest phoned the hospital during the waiting period, took more medicine, and were in greater need of help in their daily life than those admitted to hospital within three months. There was no difference in the effect of the operation in relation to the length of waiting time.
  - *For a slipped disc.* While waiting patients were in severe and constant pain, and their ability to function was significantly impaired. Twelve per cent of patients were admitted as emergency admissions while waiting. After surgery, those patients that had waited a shorter time experienced better recovery and improvement in condition than those patients that had waited longer.
  - *For inguinal hernia.* Most patients waiting for such surgery were able to carry out basic daily activities; only one in five patients were in constant pain. Half of hernia patients were admitted to hospital within three months, and 83 per cent reported an improvement in their condition following surgery.

2 The researchers concluded that while waiting for treatment, the daily life of patients is characterised by severe and constant pain, with many unable to carry out basic daily activities without help. There is increased medicine consumption while waiting, and increased contact with health services. For some procedures, such as slipped disc surgery, there is a signification correlation between the outcome of surgery and the length of waiting time. For other treatments, such as hernia repair, the length of waiting time does not influence the outcome.

3 The survey demonstrated that Danes can accept waiting time for diseases that are not potentially lethal. For patients with sudden severe and constant pain three months is too long to wait, whereas patients with symptoms which develop over a longer period of time can, to some extent, accept a waiting time of three months and, to a limited extent, four to six months.

Norway

4 Waiting lists have remained relatively constant since Summer 1997 at about 280,000 patients. Recent initiatives have focused on actions to reduce waiting times:

- **Patient guarantees** were introduced in Norway in 1991, with one of the purposes being to achieve a geographical balancing of waiting time by utilising available hospital capacity on a national basis. The scheme started with an initial six month guarantee for treatment. There were an increasing number of breaches under this guarantee, rising to 25,000 in 1997, and in that year a three month guarantee was introduced subject to the patient meeting restricted guarantee criteria. Under this revised guarantee the number of breaches was reduced to around 5,000. The guarantee was further revised and until a change in legislation in 2001 there were two patient rights:
- **Patients are evaluated by a consultant within 30 days of referral.** Patients have a guarantee that they would be seen by a consultant, their condition diagnosed and a treatment plan agreed within 30 days of referral by the family doctor. At the same time patients were given, if appropriate, a date for their treatment, or the length of anticipated waiting time. There was found to be a high degree of compliance with this guarantee, and around 98 per cent of patients were dealt with within this guaranteed time. Legislation in January 2001 extended this evaluation guarantee.
- **Treatment will start within 3 months of referral for patients given a guarantee for surgery and medical treatment.** Patients were given a guarantee of treatment according to their condition rather than for specific operations. Patients may have qualified for this guarantee if they were suffering from a serious condition and if it could be shown that the proposed treatment was efficient (based on documented evidence) and cost effective. A further criterion was that the treatment would provide improved quality of life or life expectancy and that delaying treatment would result in substantial shortened life expectancy, considerable pain or suffering for most of the day, or considerable

difficulty with vital functions. Patients meeting the criteria were offered a guarantee of treatment within 3 months of referral by the family doctor. Twenty per cent of patients were given such a guarantee in 1999. If an institution failed to offer treatment within three months the county municipality was required to obtain treatment for the patient elsewhere. In such circumstances the patient was also empowered to obtain treatment at an alternative institution.

5 From January 2001the Act on Patient Rights came into force. The Act replaces the patient waiting guarantees. Under the Act all patients have a right to be evaluated by a consultant within 30 working days of referral. The three month guarantee has been abandoned in favour of a mandatory right to treatment within the time limit demanded by good medical practice. The system for registration of waiting lists remains unchanged despite the legislative changes.

6 Other initiatives include:

- **Patients can review waiting times at each hospital before deciding where to be treated.** The Norwegian Patient Register, operated by the SINTEF Unimed Research Institute, is responsible for collating waiting list data. On the background of the data collected, the Patient Register has produced Infowait, a dynamic report generator used to monitor waiting lists. Data on the system includes the number and average waiting time of new patient referrals and those patients for whom treatment has started. The information also covers the number of cases where the patients' guarantee has been breached. Data is published each quarter on the internet (http.//www.npr.no/infovent).
- **Patients in Norway have free choice as to which hospital they are treated in.** A new law will come into effect in January 2001which will give patients free choice of hospital. It is a measure designed to ensure that available hospital capacity in Norway is fully utilised. The patient's county of residence in Norway is responsible for treatment and catering costs wherever the patient is treated. In connection with the introduction of free choice of hospital, the Norwegian Patient Register is currently developing an information system on the internet called Free Choice which will show waiting times at individual hospitals. Initially it will cover a number of specific conditions and treatments - knee replacement, hip replacement, cataracts, varicose veins and thoracic surgery. Further procedures are expected to be added in due course.

Annex 1

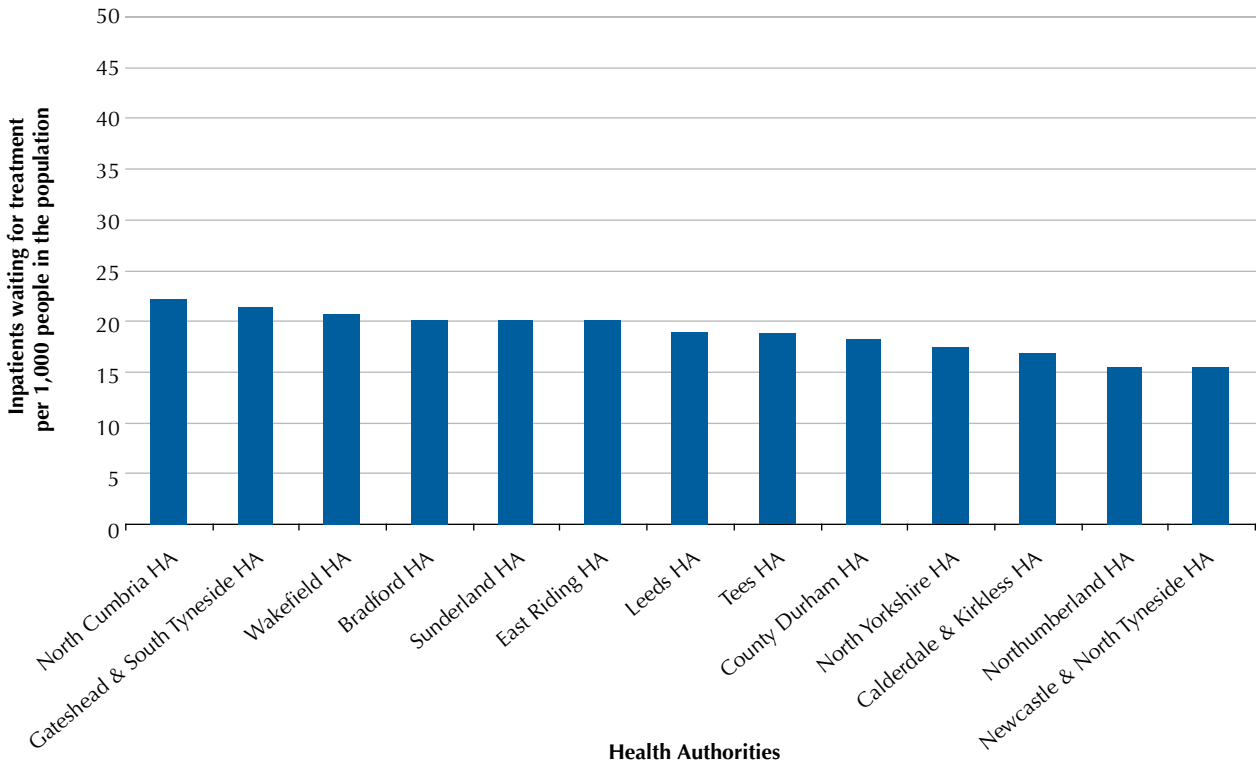
Northern and Yorkshire Region

	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001* (thousands)	Outpatients waiting for treatment per 1,000 people*
Bradford HA	483	9.7	20.2	1.7	3.6
Calderdale & Kirklees HA	584	9.9	16.9	1.6	2.7
County Durham HA	608	11.1	18.2	3.1	5.2
East Riding HA	575	11.6	20.1	4.1	7.1
Gateshead & South Tyneside HA	353	7.6	21.4	1.4	4.0
Leeds HA	727	13.7	18.9	7.8	10.7
Newcastle and North Tyneside HA	470	7.3	15.5	1.6	3.4
North Cumbria HA	319	7.1	22.2	0.5	1.6
North Yorkshire HA	742	13	17.5	2.5	3.4
Northumberland HA	310	4.8	15.6	0.9	2.9
Sunderland HA	292	5.9	20.1	3.0	10.1
Tees HA	556	10.5	18.8	3.0	5.4
Wakefield HA	319	6.6	20.8	1.6	4.9

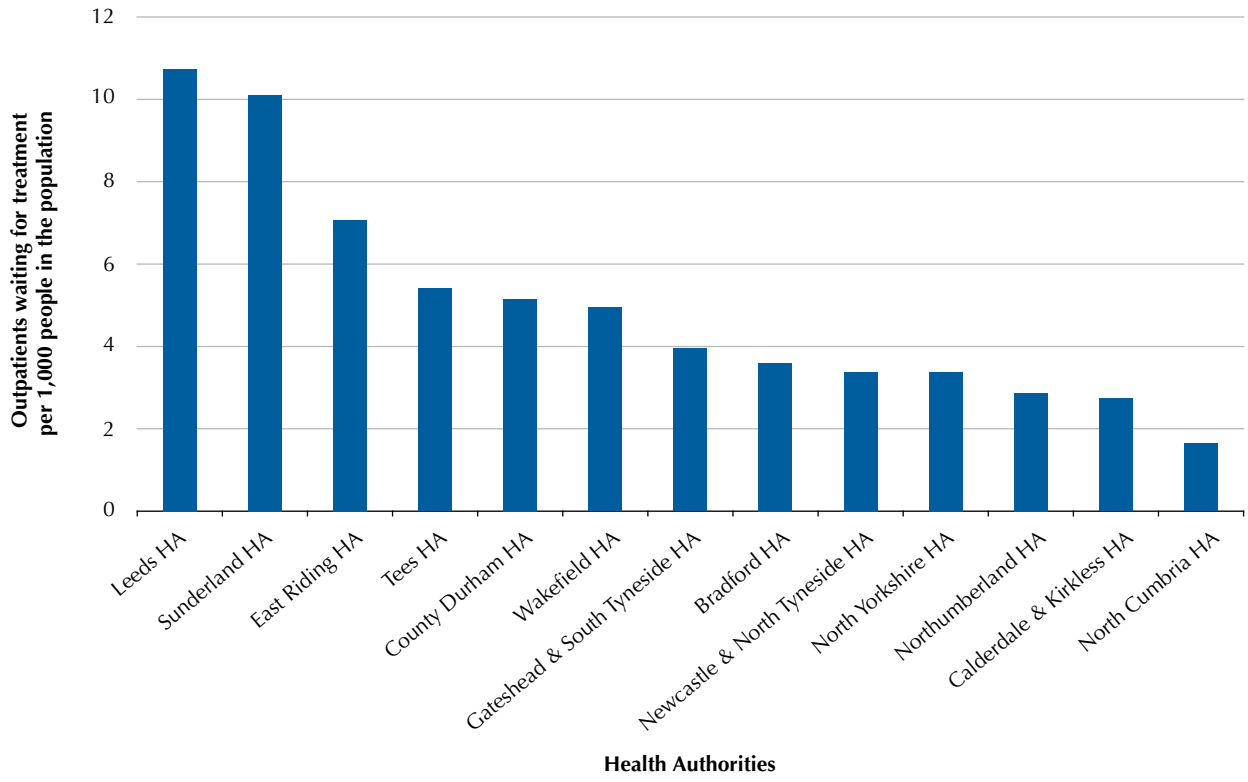
**All references to outpatients in this annex comprise those patients who have been waiting more than 13 weeks*

Northern and Yorkshire Region

Northern and Yorkshire Region - Inpatients waiting for treatment



Northern and Yorkshire Region - Outpatients waiting more than thirteen weeks for an appointment



Northern and Yorkshire Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Bradford HA	483	1.6	3.3	0.6	1.2	0.9	1.9
Calderdale & Kirklees HA	584	2.0	3.4	0.7	1.3	1.3	2.3
County Durham HA	608	2.5	4.1	1.2	1.9	0.9	1.4
East Riding HA	575	2.0	3.5	1.1	1.9	1.8	3.1
Gateshead & South Tyneside HA	353	1.7	4.8	0.7	2.0	0.5	1.3
Leeds HA	727	1.7	2.4	1.4	2.0	1.1	1.5
Newcastle and North Tyneside HA	470	1.4	2.9	0.4	0.8	0.9	1.9
North Cumbria HA	319	1.8	5.8	0.5	1.6	0.8	2.4
North Yorkshire HA	742	3.2	4.3	1.1	1.5	1.2	1.6
Northumberland HA	310	1.2	3.8	0.3	1.0	0.6	1.9
Sunderland HA	292	1.3	4.3	0.6	2.1	0.4	1.5
Tees HA	556	2.4	4.3	1.1	1.9	1.0	1.8
Wakefield HA	319	1.2	3.8	0.5	1.7	0.6	2.0

Northern and Yorkshire Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Bradford HA	483	0.7	1.5	0.0	0.0	0.1	0.1
Calderdale & Kirklees HA	584	0.3	0.5	0.0	0.0	0.2	0.3
County Durham HA	608	0.6	1.0	0.4	0.6	0.2	0.4
East Riding HA	575	1.8	3.2	0.2	0.3	0.3	0.5
Gateshead & South Tyneside HA	353	0.3	1.0	0.0	0.1	0.2	0.5
Leeds HA	727	2.0	2.8	0.4	0.6	1.3	1.8
Newcastle and North Tyneside HA	470	0.7	1.5	0.0	0.0	0.0	0.1
North Cumbria HA	319	0.1	0.2	0.0	0.1	0.0	0.0
North Yorkshire HA	742	0.8	1.0	0.1	0.1	0.1	0.1
Northumberland HA	310	0.5	1.6	0.0	0.0	0.0	0.2
Sunderland HA	292	1.0	3.5	0.3	1.0	0.2	0.8
Tees HA	556	0.5	0.8	0.3	0.5	0.1	0.2
Wakefield HA	319	0.1	0.5	0.0	0.0	0.1	0.3

Northern and Yorkshire Region

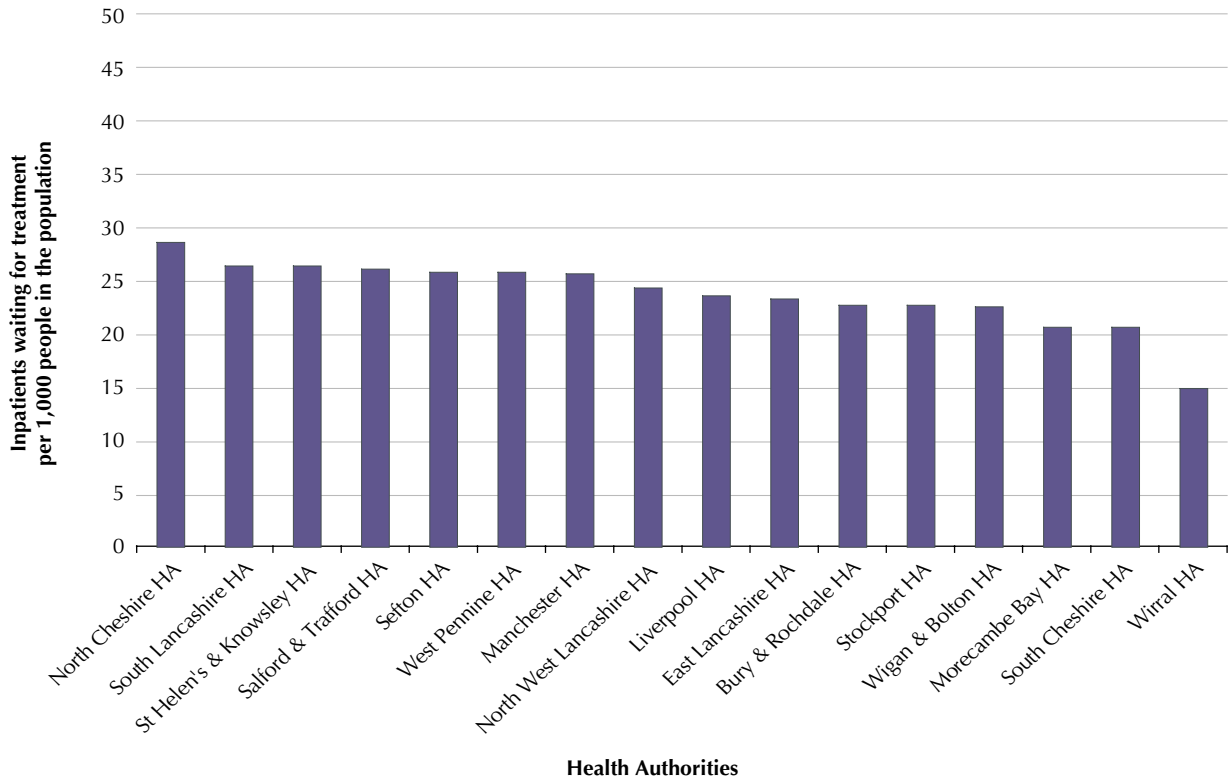
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 of months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Bradford HA	20.1	27.6	27.9	18.5
Calderdale & Kirklees HA	13.0	20.3	7.0	16.6
County Durham HA	16.7	23.1	24.1	5.7
East Riding HA	26.2	30.5	6.3	34.8
Gateshead & South Tyneside HA	19.8	23.0	20.6	15.1
Leeds HA	24.4	33.2	20.9	19.3
Newcastle and North Tyneside HA	18.7	35.0	9.1	20.5
North Cumbria HA	25.1	32.8	13.9	29.4
North Yorkshire HA	24.5	32.3	12.4	26.9
Northumberland HA	17.1	23.1	11.0	25.1
Sunderland HA	21.4	35.1	33.0	4.8
Tees HA	18.8	20.9	24.2	8.7
Wakefield HA	26.8	33.3	21.5	26.3

North West Region

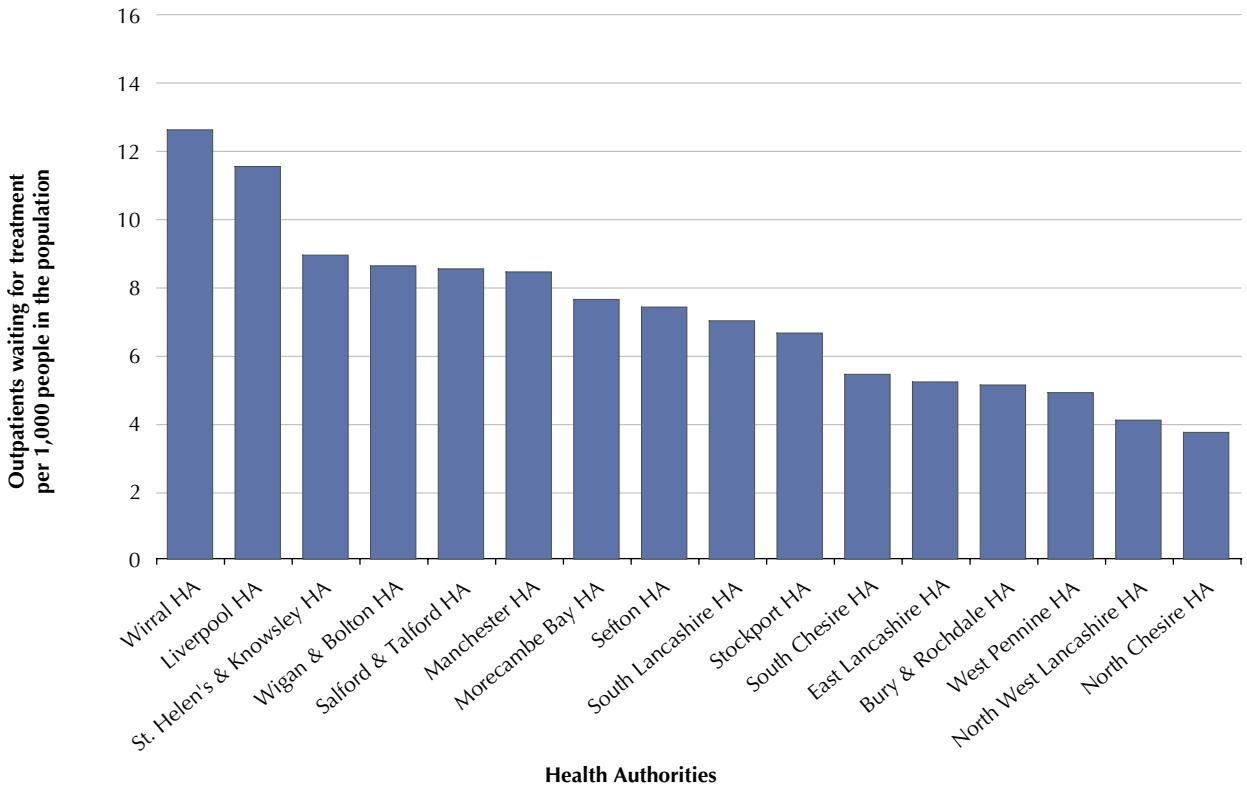
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Bury & Rochdale HA	391	8.9	22.8	2.0	5.1
East Lancashire HA	511	11.9	23.4	2.7	5.2
Liverpool HA	461	10.9	23.5	5.3	11.5
Manchester HA	430	11.0	25.6	3.6	8.4
Morecambe Bay HA	310	6.4	20.7	2.3	7.6
North Cheshire HA	312	8.9	28.6	1.2	3.7
North West Lancashire HA	466	11.4	24.4	1.9	4.1
Salford & Trafford HA	446	11.7	26.1	3.8	8.5
Sefton HA	288	7.4	25.8	2.1	7.4
South Cheshire HA	672	13.9	20.7	3.6	5.4
South Lancashire HA	313	8.3	26.5	2.2	7.0
St Helen's & Knowsley HA	333	8.8	26.4	3.0	8.9
Stockport HA	293	6.7	22.8	1.9	6.6
West Pennine HA	472	12.1	25.7	2.3	4.9
Wigan & Bolton HA	578	13.0	22.5	5.0	8.6
Wirral HA	327	4.9	14.9	4.1	12.6

North West Region

North West Region - Inpatients waiting for treatment



North West Region - Outpatients waiting more than thirteen weeks for an appointment



North West Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Bury & Rochdale HA	391	2.1	5.4	0.8	2.0	0.7	1.9
East Lancashire HA	511	3.0	5.8	0.9	1.7	1.0	2.0
Liverpool HA	461	2.1	4.6	0.6	1.3	1.2	2.7
Manchester HA	430	1.8	4.1	0.8	1.9	1.6	3.8
Morecambe Bay HA	310	1.2	3.9	0.7	2.1	0.5	1.8
North Cheshire HA	312	1.7	5.5	0.6	2.0	1.1	3.6
North West Lancashire HA	466	2.6	5.5	0.6	1.3	0.8	1.8
Salford & Trafford HA	446	2.5	5.7	1.0	2.3	1.1	2.5
Sefton HA	288	1.6	5.5	0.3	1.0	0.7	2.4
South Cheshire HA	672	3.8	5.6	1.1	1.6	1.5	2.2
South Lancashire HA	313	2.2	7.0	0.5	1.6	0.9	3.0
St Helen's & Knowsley HA	333	1.4	4.1	0.5	1.5	1.0	3.0
Stockport HA	293	1.7	5.7	0.4	1.4	0.6	2.2
West Pennine HA	472	1.8	3.9	0.9	1.9	1.6	3.5
Wigan & Bolton HA	578	2.9	4.9	0.7	1.2	1.5	2.6
Wirral HA	327	1.1	3.4	0.4	1.1	0.6	2.0

North West Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Bury & Rochdale HA	391	0.7	1.8	0.0	0.1	0.3	0.7
East Lancashire HA	511	0.9	1.9	0.0	0.1	0.0	0.0
Liverpool HA	461	1.2	2.6	0.6	1.3	0.7	1.5
Manchester HA	430	0.8	1.8	0.0	0.1	0.1	0.3
Morecambe Bay HA	310	0.6	1.9	0.0	0.1	0.2	0.5
North Cheshire HA	312	0.3	0.9	0.0	0.0	0.0	0.1
North West Lancashire HA	466	0.3	0.6	0.1	0.2	0.2	0.3
Salford & Trafford HA	446	0.9	2.0	0.2	0.4	0.2	0.5
Sefton HA	288	0.4	1.4	0.3	1.1	0.1	0.4
South Cheshire HA	672	0.5	0.8	0.1	0.2	0.4	0.5
South Lancashire HA	313	0.2	0.6	0.1	0.5	0.2	0.5
St Helen's & Knowsley HA	333	0.6	1.7	0.1	0.4	0.2	0.6
Stockport HA	293	0.4	1.5	0.1	0.3	0.1	0.2
West Pennine HA	472	0.6	1.2	0.0	0.1	0.3	0.6
Wigan & Bolton HA	578	0.9	1.5	0.2	0.3	0.3	0.6
Wirral HA	327	1.5	4.5	0.6	1.9	0.3	1.0

North West Region

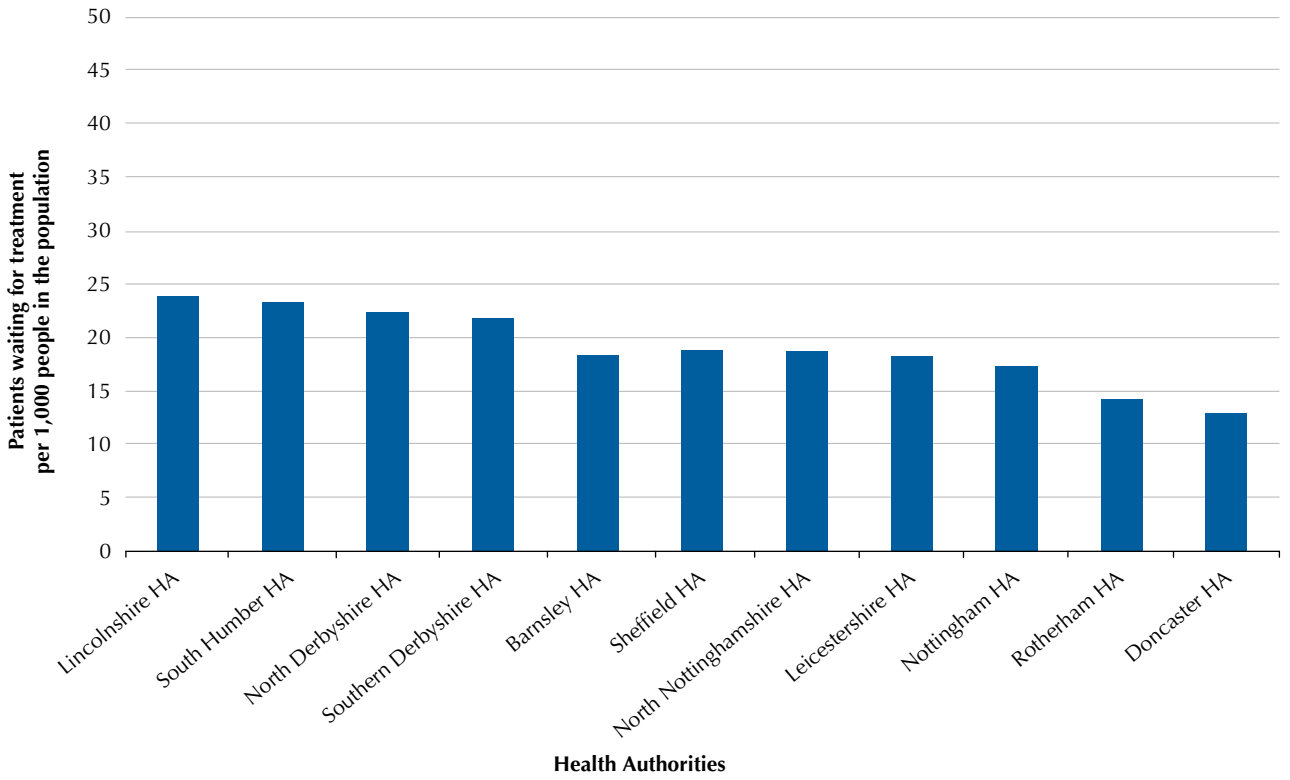
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Bury & Rochdale HA	19.4	34.9	13.4	14.1
East Lancashire HA	20.1	32.8	9.1	11.8
Liverpool HA	23.0	32.6	29.9	27.0
Manchester HA	26.0	36.1	16.9	35.5
Morecambe Bay HA	16.9	22.7	11.3	2.8
North Cheshire HA	34.5	40.3	24.8	49.9
North West Lancashire HA	16.6	26.3	9.3	12.9
Salford & Trafford HA	26.7	36.1	27.3	22.5
Sefton HA	24.4	30.8	7.5	27.8
South Cheshire HA	25.1	33.7	19.7	23.7
South Lancashire HA	23.0	31.5	7.6	26.5
St Helen's & Knowsley HA	20.2	26.6	12.5	23.3
Stockport HA	20.8	28.2	16.4	23.9
West Pennine HA	16.0	21.7	19.6	28.4
Wigan & Bolton HA	20.3	34.2	13.3	16.6
Wirral HA	16.4	23.3	11.9	13.5

Trent Region

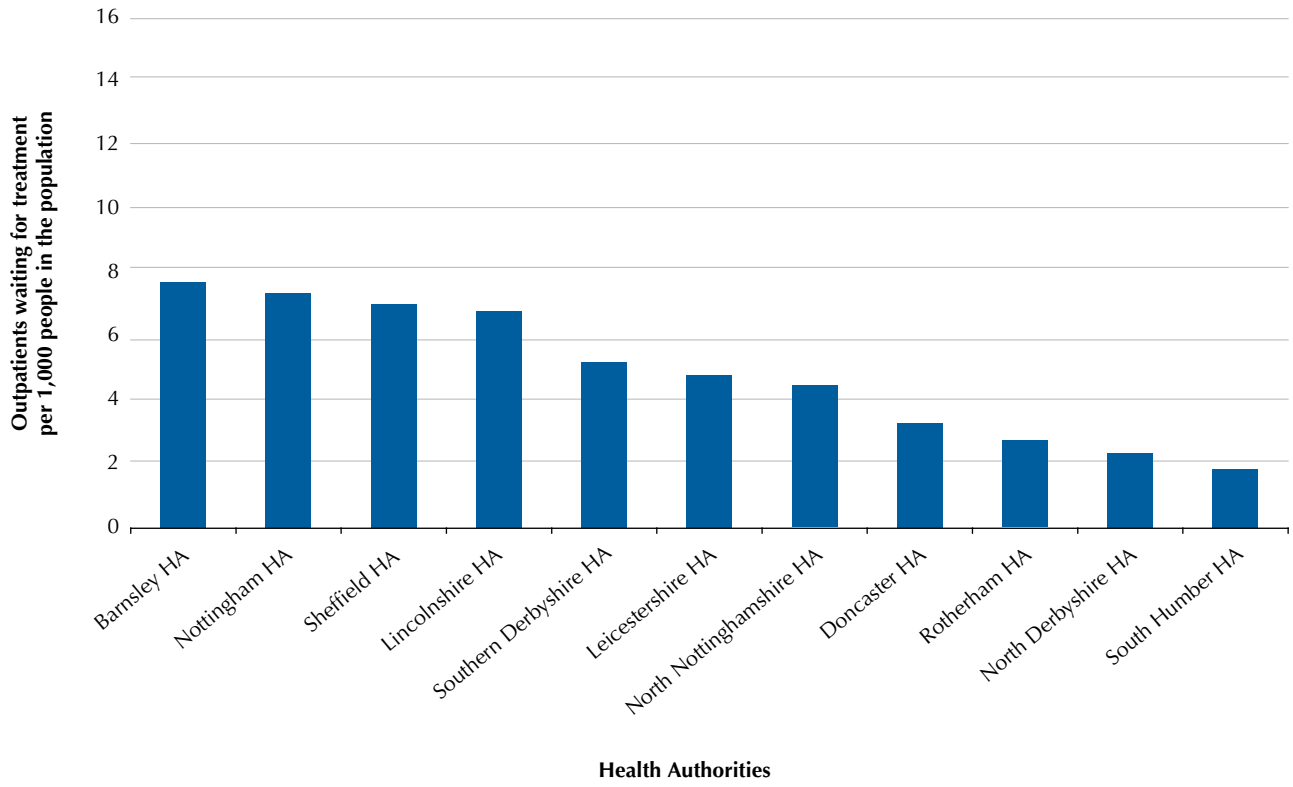
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Barnsley HA	228	4.4	19.3	1.7	7.7
Doncaster HA	290	3.8	13.1	1.0	3.6
Leicestershire HA	929	16.0	17.2	4.3	4.6
Lincolnshire HA	623	15.3	24.6	4.2	6.7
North Derbyshire HA	370	8.0	21.7	0.8	2.1
North Nottinghamshire HA	389	7.4	19.1	1.7	4.3
Nottingham HA	643	10.6	16.5	4.8	7.4
Rotherham HA	254	3.7	14.5	0.7	2.7
Sheffield HA	531	10.2	19.2	3.8	7.2
South Humber HA	309	7.4	24.0	0.6	1.8
Southern Derbyshire HA	567	12.2	21.5	2.9	5.1

Trent Region

Trent Region - Inpatients waiting for treatment



Trent Region - Outpatients waiting more than thirteen weeks for an appointment



Trent Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Barnsley HA	228	1.0	4.4	0.1	0.6	0.4	1.6
Doncaster HA	290	0.9	2.9	0.1	0.4	0.4	1.3
Leicestershire HA	929	2.5	2.7	0.8	0.9	1.8	1.9
Lincolnshire HA	623	4.3	6.9	1.5	2.4	1.3	2.1
North Derbyshire HA	370	2.4	6.6	0.3	0.9	0.8	2.3
North Nottinghamshire HA	389	2.4	6.1	0.3	0.7	0.8	2.1
Nottingham HA	643	3.1	4.9	0.6	0.9	0.6	0.9
Rotherham HA	254	1.1	4.3	0.3	1.2	0.3	1.4
Sheffield HA	531	2.8	5.3	0.7	1.4	0.7	1.3
South Humber HA	309	1.5	4.7	0.1	0.3	0.6	1.8
Southern Derbyshire HA	567	3.5	6.2	0.8	1.3	1.1	1.9

Trent Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Barnsley HA	228	0.4	1.7	0.0	0.1	0.0	0.1
Doncaster HA	290	0.3	1.0	0.0	0.0	0.1	0.2
Leicestershire HA	929	0.6	0.7	0.2	0.3	0.5	0.6
Lincolnshire HA	623	1.0	1.5	0.0	0.0	0.1	0.1
North Derbyshire HA	370	0.1	0.2	0.0	0.1	0.0	0.1
North Nottinghamshire HA	389	0.2	0.4	0.0	0.0	0.1	0.3
Nottingham HA	643	1.4	2.1	0.1	0.2	0.3	0.5
Rotherham HA	254	0.1	0.2	0.0	0.1	0.0	0.1
Sheffield HA	531	0.7	1.3	0.3	0.7	0.2	0.5
South Humber HA	309	0.2	0.5	0.0	0.0	0.0	0.1
Southern Derbyshire HA	567	0.7	1.3	0.2	0.4	0.2	0.3

Trent Region

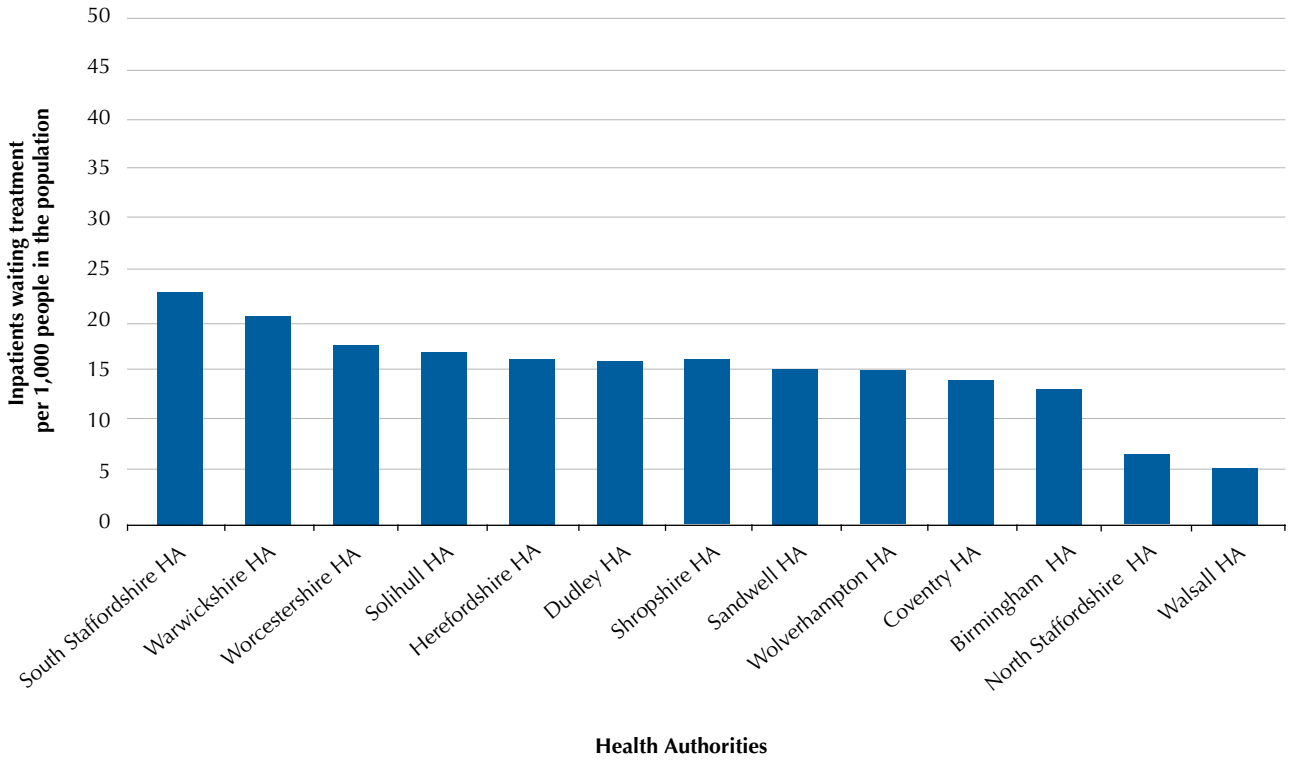
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Barnsley HA	13.7	19.5	7.0	3.0
Doncaster HA	11.4	26.9	9.4	4.6
Leicestershire HA	17.3	19.6	15.9	23.2
Lincolnshire HA	25.4	36.9	13.5	22.3
North Derbyshire HA	20.5	31.3	7.5	18.8
North Nottinghamshire HA	21.1	25.8	12.7	25.5
Nottingham HA	22.1	30.9	14.4	14.6
Rotherham HA	12.0	22.7	2.6	1.1
Sheffield HA	18.3	22.6	13.1	16.9
South Humber HA	21.2	26.2	12.9	19.8
Southern Derbyshire HA	20.7	29.9	10.6	19.6

West Midlands Region

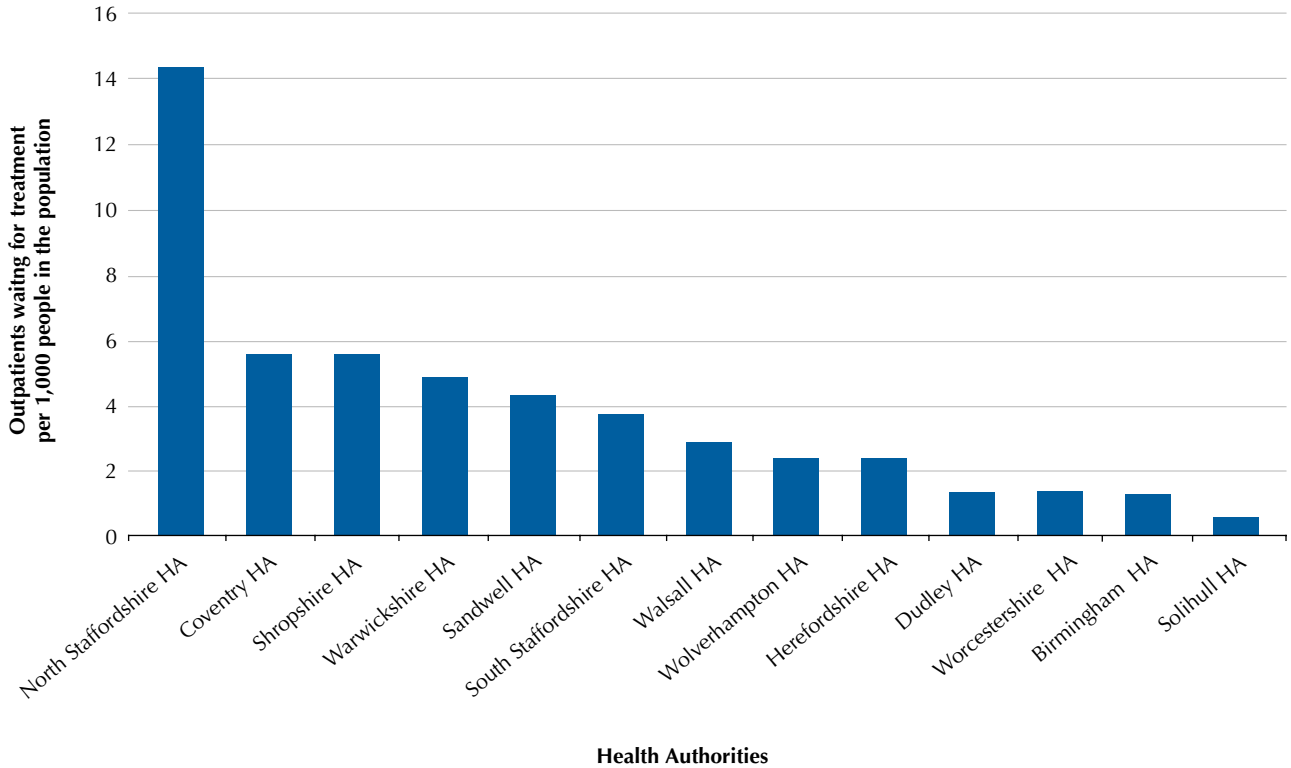
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Birmingham HA	1,013	13.9	13.7	1.3	1.3
Coventry HA	304	4.4	14.5	1.7	5.5
Dudley HA	311	4.9	15.7	0.5	1.5
Herefordshire HA	168	2.7	16.0	0.4	2.2
North Staffordshire HA	469	5.3	11.3	6.7	14.2
Sandwell HA	291	4.3	14.9	1.2	4.1
Shropshire HA	430	6.8	15.7	2.3	5.4
Solihull HA	206	3.4	16.5	0.1	0.4
South Staffordshire HA	592	12.6	21.3	2.3	3.9
Walsall HA	261	2.6	9.9	0.7	2.8
Warwickshire HA	507	10.2	20.0	2.3	4.6
Wolverhampton HA	242	3.6	14.9	0.5	2.2
Worcestershire HA	538	9.5	17.7	0.8	1.4

West Midlands Region

West Midlands Region - Inpatients waiting for treatment



West Midlands Region - Outpatients waiting for more than thirteen weeks for an appointment



West Midlands Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands) treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment per 1,000 people
Birmingham HA	1,013	3.4	3.3	0.8	0.8	1.9	1.9
Coventry HA	304	1.5	4.8	0.4	1.5	0.3	0.9
Dudley HA	311	1.6	5.0	0.1	0.4	0.4	1.4
Herefordshire HA	168	0.9	5.5	0.2	1.1	0.3	1.7
North Staffordshire HA	469	2.0	4.2	0.1	0.3	0.6	1.2
Sandwell HA	291	0.9	3.1	0.3	0.9	0.4	1.3
Shropshire HA	430	1.9	4.5	0.3	0.8	0.5	1.1
Solihull HA	206	1.1	5.5	0.2	0.7	0.4	1.9
South Staffordshire HA	592	3.0	5.1	0.7	1.2	1.3	2.2
Walsall HA	261	0.6	2.2	0.2	0.6	0.4	1.6
Warwickshire HA	507	2.5	4.8	0.6	1.2	0.8	1.5
Wolverhampton HA	242	1.2	4.9	0.2	1.0	0.2	0.9
Worcestershire HA	538	2.9	5.5	0.5	0.9	0.6	1.1

West Midlands Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Birmingham HA	1,013	0.1	0.1	0.0	0.0	0.1	0.1
Coventry HA	304	0.4	1.2	0.1	0.4	0.2	0.7
Dudley HA	311	0.2	0.5	0.0	0.0	0.0	0.1
Herefordshire HA	168	0.1	0.7	0.0	0.0	0.1	0.4
North Staffordshire HA	469	1.0	2.2	0.3	0.7	0.4	0.9
Sandwell HA	291	0.1	0.5	0.0	0.0	0.2	0.6
Shropshire HA	430	0.9	2.1	0.0	0.1	0.5	1.2
Solihull HA	206	0.0	0.0	0.0	0.0	0.0	0.0
South Staffordshire HA	592	0.5	0.8	0.1	0.2	0.1	0.2
Walsall HA	261	0.1	0.4	0.1	0.5	0.0	0.0
Warwickshire HA	507	0.6	1.2	0.1	0.2	0.3	0.6
Wolverhampton HA	242	0.1	0.6	0.0	0.1	0.0	0.1
Worcestershire HA	538	0.3	0.5	0.0	0.0	0.0	0.1

West Midlands Region

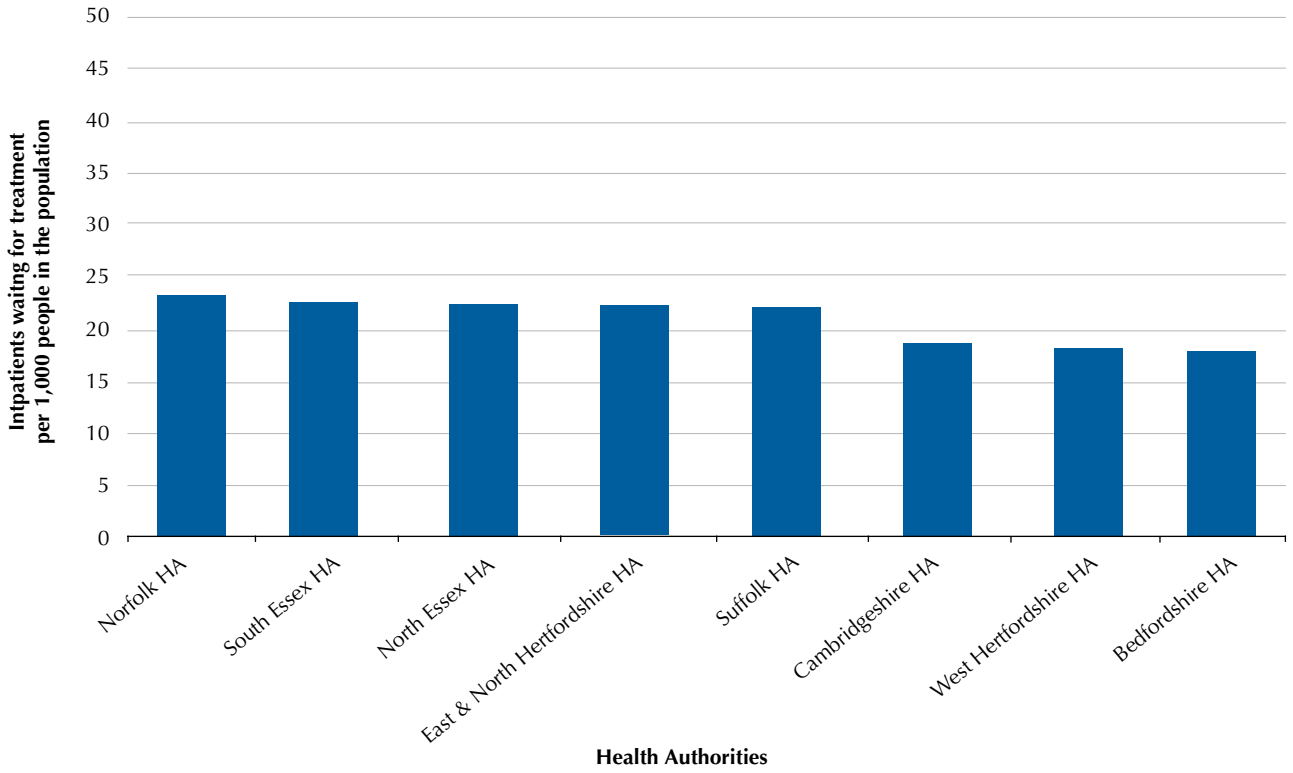
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number, waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Birmingham HA	13.9	12.3	5.2	11.6
Coventry HA	16.2	22.1	10.6	5.5
Dudley HA	15.6	22.6	5.2	15.1
Herefordshire HA	23.4	33.2	31.3	25.8
North Staffordshire HA	22.5	42.4	9.7	3.1
Sandwell HA	11.6	18.3	7.9	7.4
Shropshire HA	22.0	30.2	16.5	12.7
Solihull HA	13.9	23.5	1.3	8.8
South Staffordshire HA	29.3	33.7	23.6	17.5
Walsall HA	12.8	18.3	6.1	4.5
Warwickshire HA	18.9	29.3	8.2	18.9
Wolverhampton HA	16.5	22.1	11.4	1.3
Worcestershire HA	25.6	30.6	14.3	18.2

Eastern Region

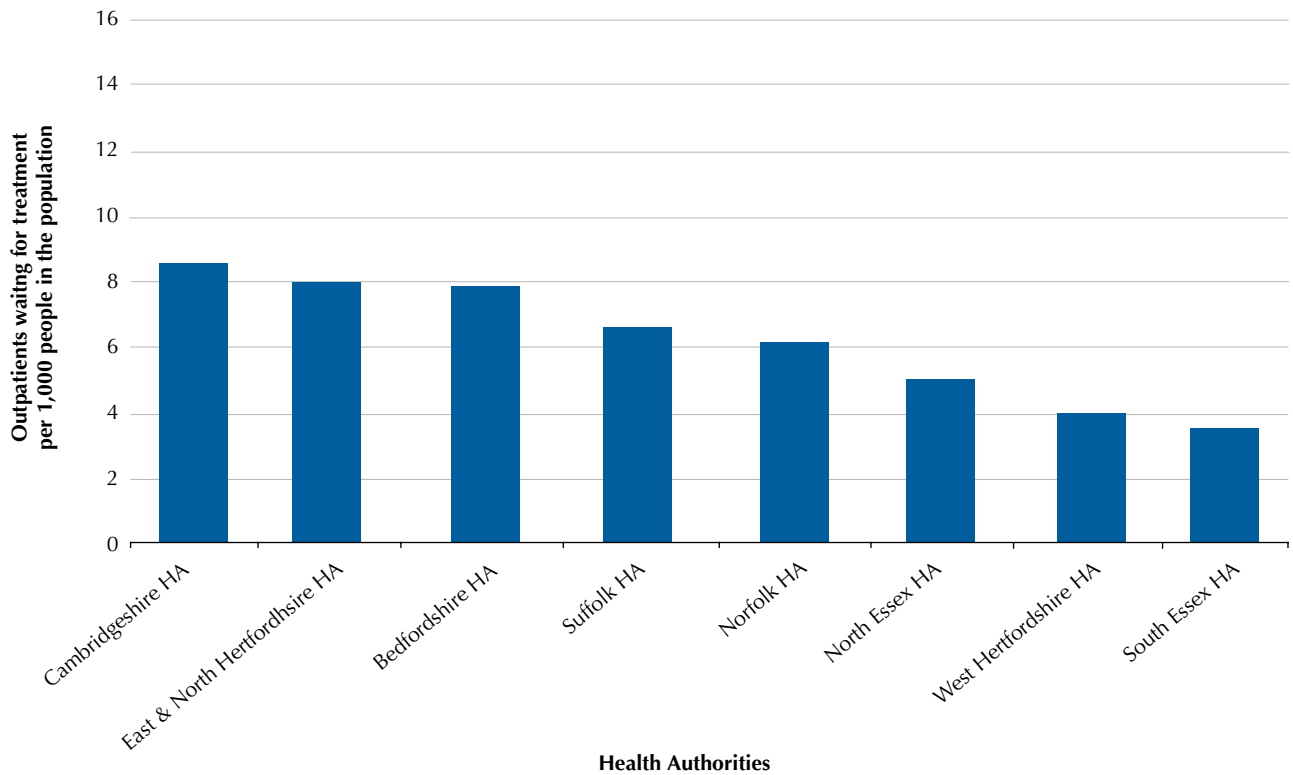
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Bedfordshire HA	557	10.3	18.5	4.4	7.9
Cambridgeshire HA	720	13.9	19.3	6.1	8.5
East & North Hertfordshire HA	500	11.4	22.9	4.0	8.0
Norfolk HA	790	18.9	23.9	4.8	6.1
North Essex HA	897	20.7	23.1	5.3	5.9
South Essex HA	709	16.5	23.3	2.5	3.5
Suffolk HA	671	15.1	22.6	4.5	6.7
West Hertfordshire HA	534	10.1	18.8	2.1	4.0

Eastern Region

Eastern Region - Inpatients waiting for treatment



Eastern Region - Outpatients waiting for more than thirteen weeks for an appointment



Eastern Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Bedfordshire HA	557	2.6	4.7	0.8	1.4	0.8	1.5
Cambridgeshire HA	720	3.0	4.2	1.4	1.9	1.4	1.9
East & North Hertfordshire HA	500	2.8	5.5	0.8	1.6	1.1	2.1
Norfolk HA	790	4.7	6.0	1.8	2.3	1.0	1.2
North Essex HA	897	4.0	4.5	1.5	1.7	1.8	2.0
South Essex HA	709	3.2	4.6	1.6	2.3	1.3	1.9
Suffolk HA	671	3.1	4.6	1.2	1.7	1.4	2.1
West Hertfordshire HA	534	3.2	5.9	0.8	1.4	1.0	1.8

Eastern Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Bedfordshire HA	557	1.4	2.5	0.4	0.7	0.4	0.7
Cambridgeshire HA	720	1.7	2.3	0.3	0.4	0.7	1.0
East & North Hertfordshire HA	500	1.0	2.0	0.3	0.6	0.2	0.4
Norfolk HA	790	1.5	1.9	0.4	0.5	0.6	0.8
North Essex HA	897	1.1	1.3	0.1	0.1	0.4	0.4
South Essex HA	709	0.9	1.3	0.1	0.1	0.1	0.1
Suffolk HA	671	0.8	1.2	0.2	0.3	0.3	0.4
West Hertfordshire HA	534	0.5	1.0	0.1	0.2	0.2	0.3

Eastern Region

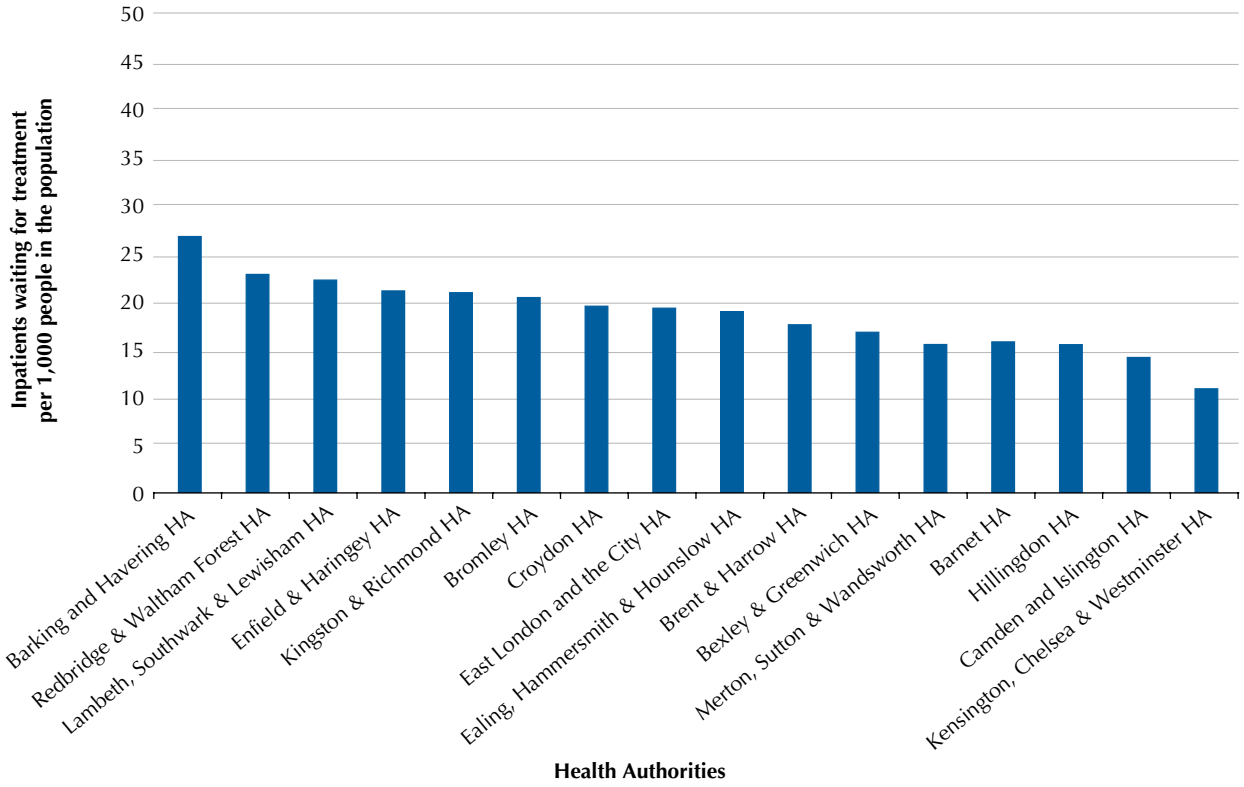
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number, waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Bedfordshire HA	30.1	41.4	37.4	22.8
Cambridgeshire HA	22.1	27.5	20.9	28.4
East & North Hertfordshire HA	27.3	39.1	27.4	22.1
Norfolk HA	21.6	40.2	16.2	14.4
North Essex HA	30.0	38.0	32.0	23.8
South Essex HA	25.0	28.8	23.1	20.7
Suffolk HA	25.4	30.1	20.0	24.7
West Hertfordshire HA	29.8	40.8	30.3	27.4

London Region

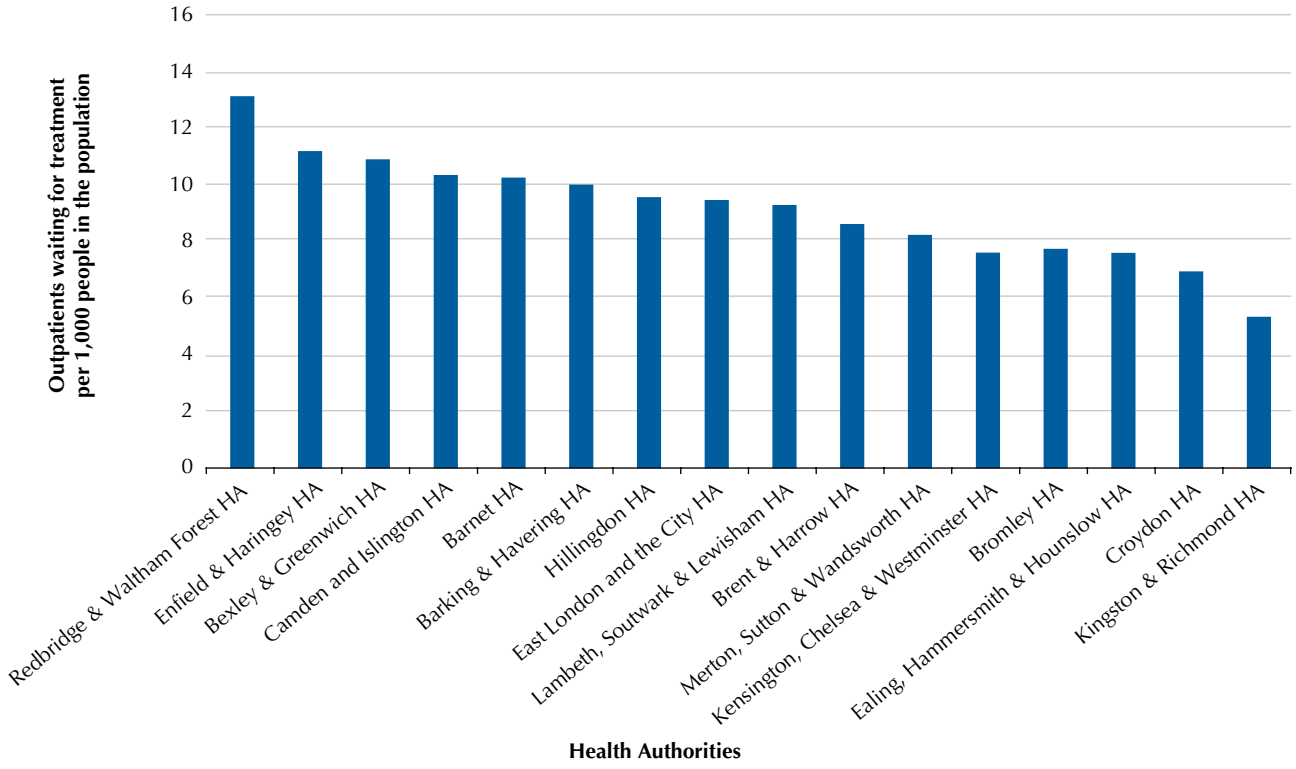
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Barking & Havering HA	384	10.1	26.2	2.9	7.5
Barnet HA	332	5.2	15.7	2.6	7.8
Bexley & Greenwich HA	433	7.4	17.2	3.6	8.4
Brent & Harrow HA	464	8.3	17.9	2.3	4.9
Bromley HA	297	6.0	20.2	1.2	3.9
Camden & Islington HA	368	5.3	14.3	3.0	8.2
Croydon HA	338	6.5	19.4	0.6	1.9
Ealing, Hammersmith & Hounslow HA	671	12.7	18.9	2.6	3.8
East London and the City HA	612	11.8	19.4	4.5	7.3
Enfield & Haringey HA	486	10.3	21.1	5.5	11.4
Hillingdon HA	251	3.8	15.3	1.9	7.5
Kensington, Chelsea & Westminster HA	391	4.3	11.0	1.5	4.0
Kingston & Richmond HA	334	6.9	20.8	0.6	1.7
Lambeth, Southwark & Lewisham HA	745	16.3	21.8	4.6	6.2
Merton, Sutton & Wandsworth HA	627	9.9	15.7	2.7	4.4
Redbridge & Waltham Forest HA	453	10.2	22.5	5.3	11.6

London Region

London Region - Inpatients waiting for treatment



London Region - Outpatients waiting for an appointment



London Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Barking & Havering HA	384	2.3	6.0	0.8	2.2	1.2	3.3
Barnet HA	332	1.3	4.0	0.6	1.7	0.6	1.8
Bexley & Greenwich HA	433	1.5	3.4	0.6	1.4	1.1	2.5
Brent & Harrow HA	464	2.1	4.5	0.5	1.0	0.9	2.0
Bromley HA	297	1.6	5.4	0.4	1.2	0.7	2.3
Camden & Islington HA	368	1.0	2.7	0.6	1.7	0.5	1.5
Croydon HA	338	1.8	5.4	0.4	1.1	0.4	1.2
Ealing, Hammersmith & Hounslow HA	671	2.3	3.5	1.1	1.6	1.9	2.8
East London and the City HA	612	1.9	3.1	1.1	1.8	1.7	2.8
Enfield & Haringey HA	486	2.2	4.4	0.7	1.5	1.3	2.6
Hillingdon HA	251	1.2	4.7	0.2	0.6	0.4	1.8
Kensington, Chelsea & Westminster HA	391	0.7	1.8	0.3	0.9	0.6	1.5
Kingston & Richmond HA	334	1.4	4.1	0.4	1.1	1.0	3.0
Lambeth, Southwark & Lewisham HA	745	3.0	4.0	1.1	1.4	2.2	3.0
Merton, Sutton & Wandsworth HA	627	2.2	3.5	0.4	0.7	1.1	1.8
Redbridge & Waltham Forest HA	453	2.1	4.7	1.2	2.6	0.9	1.9

London Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Barking & Havering HA	384	1.0	2.5	0.4	1.0	0.1	0.3
Barnet HA	332	0.4	1.1	0.1	0.4	0.3	0.9
Bexley & Greenwich HA	433	0.4	1.0	0.3	0.7	0.2	0.4
Brent & Harrow HA	464	0.5	1.0	0.0	0.1	0.2	0.4
Bromley HA	297	0.1	0.4	0.1	0.2	0.0	0.1
Camden & Islington HA	368	0.5	1.4	0.1	0.2	0.1	0.4
Croydon HA	338	0.1	0.2	0.0	0.0	0.0	0.1
Ealing, Hammersmith & Hounslow HA	671	0.4	0.6	0.2	0.2	0.3	0.4
East London and the City	612	0.8	1.2	0.2	0.4	0.6	0.9
Enfield & Haringey HA	486	0.6	1.3	0.5	1.0	0.5	1.1
Hillingdon HA	251	0.1	0.6	0.0	0.0	0.6	2.3
Kensington, Chelsea & Westminster HA	391	0.4	1.0	0.1	0.2	0.1	0.3
Kingston & Richmond HA	334	0.0	0.1	0.0	0.0	0.1	0.2
Lambeth, Southwark & Lewisham HA	745	1.0	1.3	0.2	0.3	1.2	1.6
Merton, Sutton & Wandsworth HA	627	0.4	0.7	0.1	0.1	0.1	0.2
Redbridge & Waltham Forest HA	453	0.8	1.8	0.2	0.4	0.8	1.7

London Region

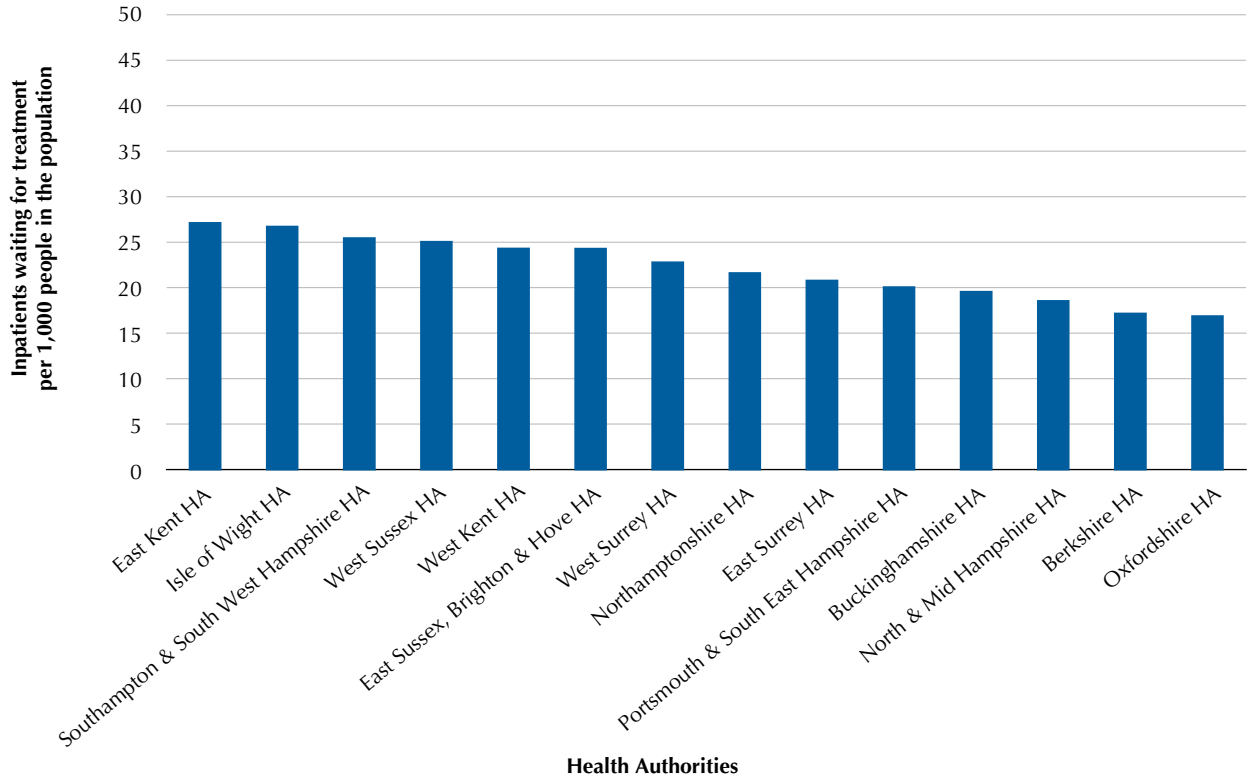
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number, waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Barking & Havering HA	28.5	36.8	19.1	33.5
Barnet HA	24.9	32.8	22.5	31.4
Bexley & Greenwich HA	27.8	37.5	18.8	40.5
Brent & Harrow HA	27.0	32.8	26.0	32.0
Bromley HA	30.5	39.1	16.7	22.5
Camden & Islington HA	21.8	30.4	16.7	24.8
Croydon HA	32.8	51.8	30.6	10.9
Ealing, Hammersmith & Hounslow HA	25.4	34.7	23.9	41.7
East London and the City HA	25.5	29.0	19.4	38.7
Enfield & Haringey HA	32.5	37.1	25.0	38.5
Hillingdon HA	25.7	34.0	18.4	29.2
Kensington, Chelsea & Westminster HA	19.5	24.0	16.9	26.3
Kingston & Richmond HA	23.9	35.5	15.2	41.6
Lambeth, Southwark & Lewisham HA	34.0	36.5	28.5	42.9
Merton, Sutton & Wandsworth HA	25.9	36.2	6.7	34.6
Redbridge & Waltham Forest HA	34.5	48.2	35.9	35.9

South East Region

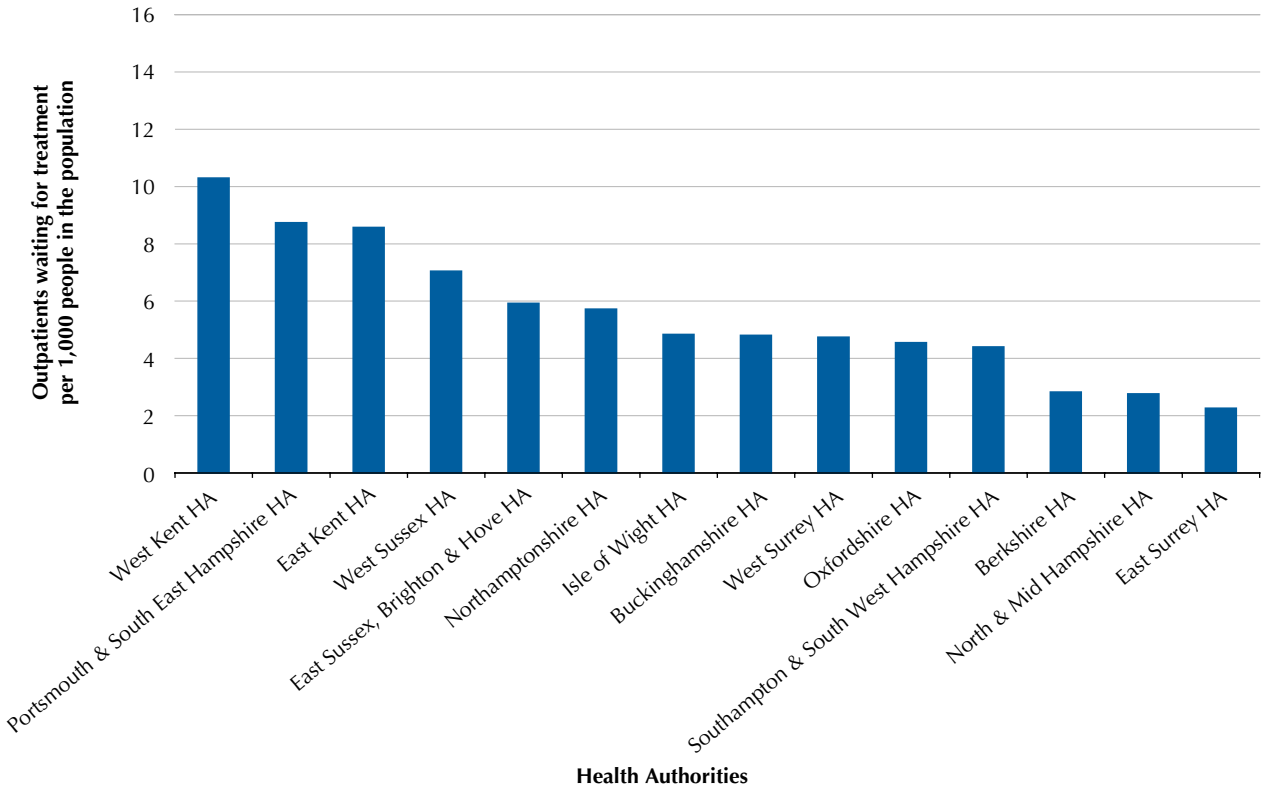
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Berkshire HA	800	13.7	17.2	2.3	2.8
Buckinghamshire HA	682	13.3	19.5	3.3	4.8
East Kent HA	601	16.3	27.1	5.2	8.6
East Surrey HA	420	8.7	20.8	0.9	2.3
East Sussex, Brighton & Hove HA	747	18.1	24.3	4.4	5.9
Isle of Wight HA	127	3.4	26.7	0.6	4.8
North & Mid Hampshire HA	557	10.3	18.5	1.5	2.8
Northamptonshire HA	616	13.3	21.6	3.5	5.7
Oxfordshire HA	617	10.4	16.9	2.8	4.5
Portsmouth & South East Hampshire HA	545	10.9	20.1	4.8	8.7
Southampton & South West Hampshire HA	542	13.8	25.4	2.4	4.4
West Kent HA	973	23.6	24.3	10.0	10.3
West Surrey HA	641	14.6	22.8	3.0	4.7
West Sussex HA	752	18.8	25.1	5.3	7.0

South East Region

South East Region - Inpatients waiting for treatment



South East Region - Outpatients waiting more than thirteen weeks for an appointment



South East Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Berkshire HA	800	3.5	4.4	1.0	1.2	1.0	1.3
Buckinghamshire HA	682	3.3	4.8	0.6	0.8	1.3	2.0
East Kent HA	601	3.4	5.7	1.4	2.3	2.1	3.5
East Surrey HA	420	2.8	6.6	0.5	1.3	1.1	2.7
East Sussex, Brighton & Hove HA	747	5.0	6.7	1.2	1.6	2.0	2.7
Isle of Wight HA	127	1.2	9.1	0.0	0.2	0.2	1.8
North & Mid Hampshire H	557	3.2	5.7	0.7	1.3	0.9	1.7
Northamptonshire HA	616	2.9	4.6	0.7	1.1	1.2	2.0
Oxfordshire HA	617	3.3	5.3	0.5	0.8	1.0	1.6
Portsmouth & South East Hampshire HA	545	3.1	5.6	0.7	1.4	0.9	1.6
Southampton & South West Hampshire HA	542	3.7	6.8	1.4	2.6	1.1	2.0
West Kent HA	973	5.6	5.8	1.8	1.9	2.9	3.0
West Surrey HA	641	3.2	5.0	1.0	1.6	1.8	2.8
West Sussex HA	752	5.7	7.6	1.0	1.3	2.2	2.9

South East Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Berkshire HA	800	0.6	0.7	0.1	0.1	0.3	0.4
Buckinghamshire HA	682	0.8	1.2	0.1	0.2	0.4	0.6
East Kent HA	601	1.0	1.6	0.1	0.2	0.4	0.7
East Surrey HA	420	0.2	0.4	0.0	0.0	0.0	0.0
East Sussex, Brighton & Hove HA	747	0.8	1.1	0.2	0.2	0.3	0.5
Isle of Wight HA	127	0.1	0.6	0.0	0.0	0.0	0.0
North & Mid Hampshire HA	557	0.4	0.7	0.0	0.1	0.1	0.1
Northamptonshire HA	616	1.6	2.6	0.2	0.3	0.0	0.0
Oxfordshire HA	617	0.6	1.0	0.2	0.3	0.2	0.4
Portsmouth & South East Hampshire HA	545	1.5	2.7	0.0	0.1	0.4	0.8
Southampton & South West Hampshire HA	542	2.0	3.7	0.1	0.1	0.1	0.1
West Kent HA	973	2.1	2.2	0.2	0.2	0.4	0.4
West Surrey HA	641	0.8	1.2	0.3	0.5	0.3	0.4
West Sussex HA	752	0.7	1.0	0.3	0.4	0.3	0.4

South East Region

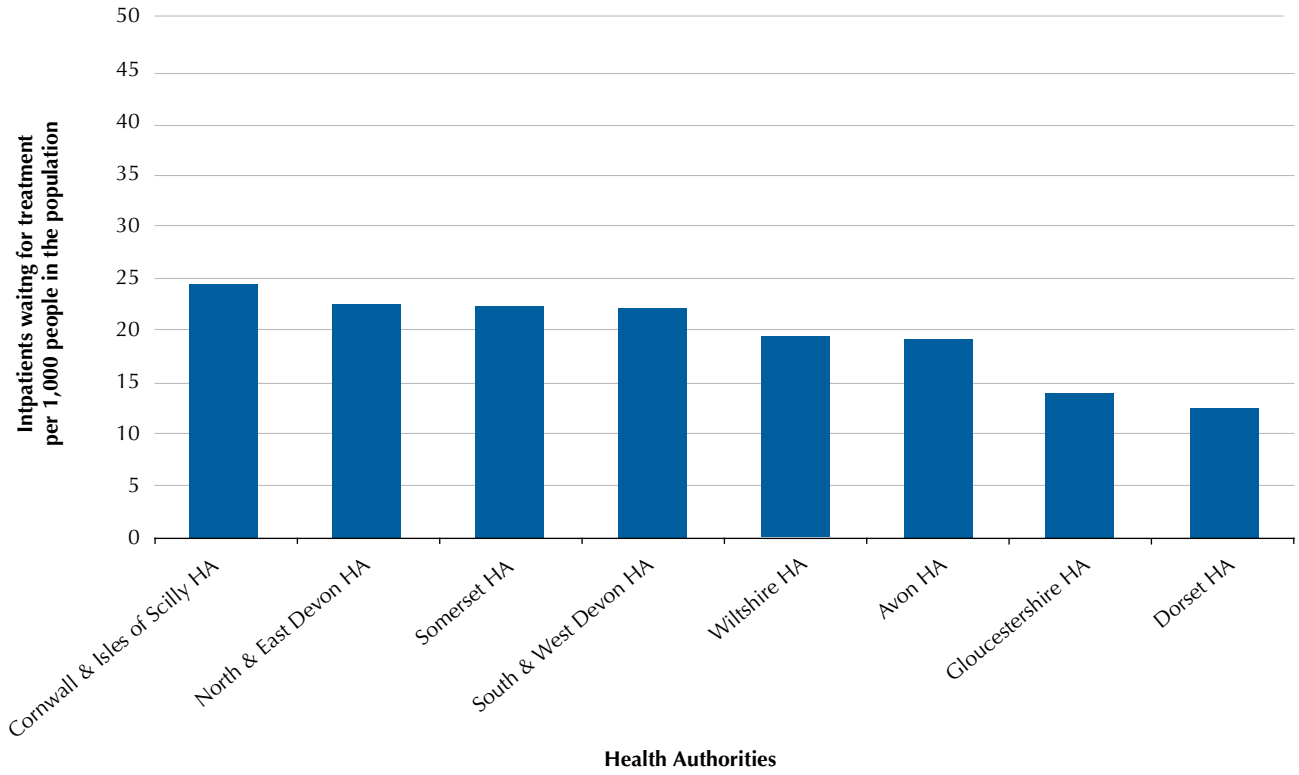
	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage of the total number, waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Berkshire HA	23.4	33.7	19.5	11.4
Buckinghamshire HA	25.6	34.5	18.9	30.9
East Kent HA	29.3	35.4	25.7	34.1
East Surrey HA	34.5	43.6	26.4	39.9
East Sussex, Brighton & Hove HA	27.6	36.5	20.8	32.2
Isle of Wight HA	27.6	40.3	33.3	24.9
North & Mid Hampshire HA	23.9	32.3	14.1	24.7
Northamptonshire HA	24.6	34.0	9.7	19.6
Oxfordshire HA	26.1	36.3	14.8	33.0
Portsmouth & South East Hampshire HA	27.5	40.2	17.0	9.6
Southampton & South West Hampshire HA	28.8	45.1	21.4	34.7
West Kent HA	32.2	42.4	31.8	37.6
West Surrey HA	35.5	35.8	33.2	39.8
West Sussex HA	37.0	41.7	25.5	41.9

South West Region

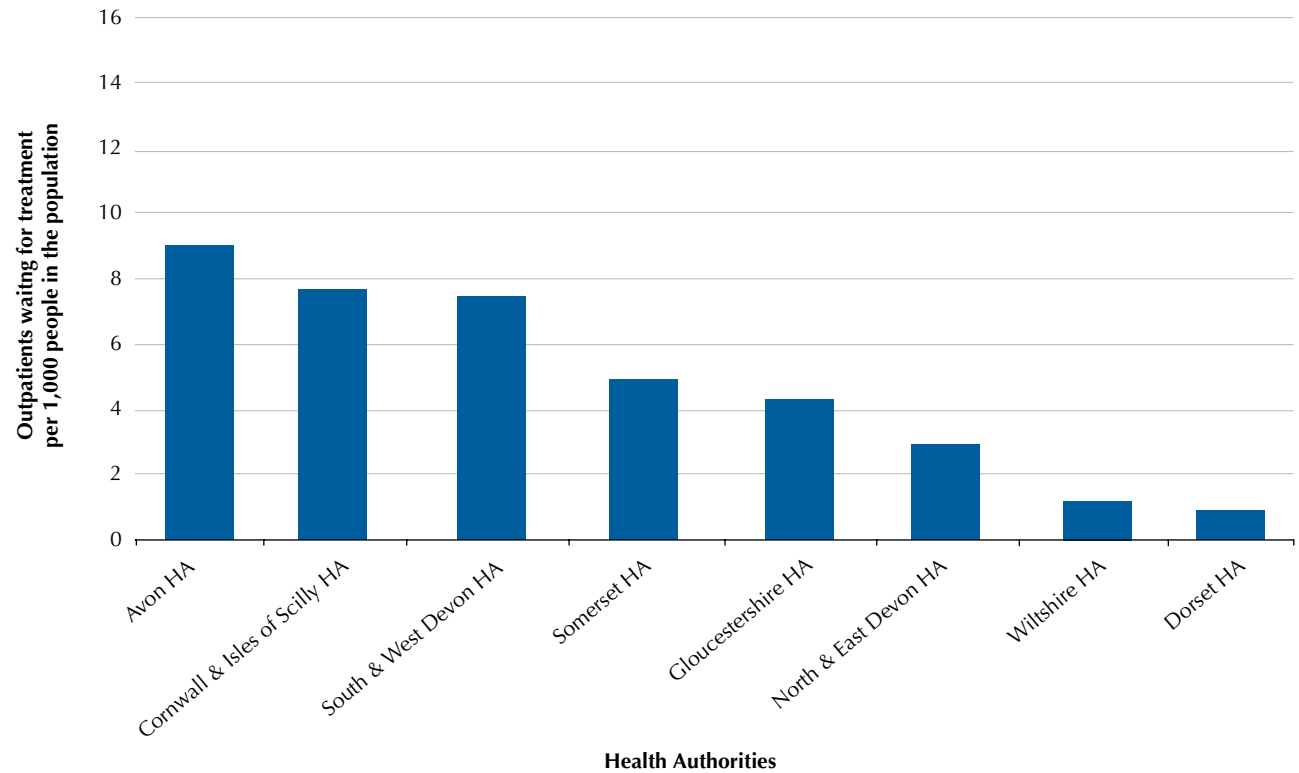
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Avon HA	999	19.5	19.5	9.0	9.0
Cornwall & Isles of Scilly HA	490	12.2	24.8	3.7	7.6
Dorset HA	691	8.8	12.8	0.5	0.8
Gloucestershire HA	557	7.8	13.9	2.4	4.3
North & East Devon HA	479	11.2	23.3	1.5	3.1
Somerset HA	489	11.2	22.8	2.3	4.6
South & West Devon HA	589	13.1	22.2	4.3	7.4
Wiltshire HA	605	11.9	19.7	0.6	1.1

South West Region

South West Region - Inpatients waiting for treatment



South West Region - Outpatients waiting more than thirteen weeks for an appointment



South West Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people	Inpatients waiting for treatment at 31 March 2001 (thousands)	Inpatients waiting for treatment per 1,000 people
Avon HA	999	4.7	4.7	1.3	1.3	2.2	2.2
Cornwall & Isles of Scilly HA	490	3.1	6.3	1.2	2.5	1.0	2.0
Dorset HA	691	2.4	3.5	0.8	1.2	0.7	1.0
Gloucestershire HA	557	2.2	3.9	0.4	0.6	0.7	1.3
North & East Devon HA	479	3.4	7.1	0.5	1.1	1.2	2.5
Somerset HA	489	3.2	6.5	0.8	1.7	1.3	2.6
South & West Devon HA	589	3.1	5.3	0.6	1.0	1.4	2.4
Wiltshire HA	605	3.6	6.0	0.9	1.5	1.1	1.8

South West Region

		Trauma and Orthopaedics		Urology		Ear, Nose and Throat	
	Population (thousands)	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people	Outpatients waiting for treatment at 31 March 2001 (thousands)	Outpatients waiting for treatment per 1,000 people
Avon HA	999	2.5	2.5	0.2	0.2	1.0	1.0
Cornwall & Isles of Scilly HA	490	1.2	2.3	0.1	0.2	0.4	0.7
Dorset HA	691	0.1	0.2	0.1	0.1	0.1	0.1
Gloucestershire HA	557	0.7	1.3	0.1	0.1	0.1	0.2
North & East Devon HA	479	0.1	0.3	0.0	0.0	0.2	0.3
Somerset HA	489	0.5	0.9	0.0	0.0	0.5	0.9
South & West Devon HA	589	1.5	2.6	0.1	0.2	0.3	0.5
Wiltshire HA	605	0.2	0.3	0.0	0.0	0.0	0.1

South West Region

	Inpatients waiting 6 months or more			
	Inpatients waiting 6 months or more as percentage of the total number of inpatients waiting	Inpatients waiting 6 months or more as percentage the total number waiting for each specialty		
	All specialties	Trauma & Orthopaedics	Urology	Ear, Nose and Throat
Avon HA	27.4	37.2	21.9	25.7
Cornwall & Isles of Scilly HA	29.9	40.0	28.7	24.0
Dorset HA	0.5	1.2	0.0	0.0
Gloucestershire HA	14.1	18.3	2.0	7.4
North & East Devon HA	27.6	38.4	20.5	33.8
Somerset HA	22.3	33.9	5.4	31.3
South & West Devon HA	28.6	41.2	18.2	25.8
Wiltshire HA	26.9	38.3	28.0	30.8