



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

NHS waiting times for elective care in England

Key facts

19.1m

referrals in 2012-13, of which 61 per cent were made by GPs

2.94m

patients were waiting for treatment as of August 2013, 11 per cent higher than in August 2012

£16bn

cost of elective care in the financial year 2012-13

- 91.4 per cent** of patients who were admitted to hospital against a standard of 90 per cent started consultant-led treatment within 18 weeks of being referred in October 2013 (the latest month for which data was available). The standard was met every month in the previous 12
- 96.7 per cent** of other patients (for example, those receiving outpatient treatment) against a standard of 95 per cent started consultant-led treatment within 18 weeks of referral in October 2013. The standard was met every month in the previous 12
- 94.2 per cent** of patients who have not yet started treatment against a standard of 92 per cent have been waiting no more than 18 weeks in October 2013. The standard was met every month in the previous 12
- £225 million** is the estimated maximum cost to the NHS of patients failing to attend first outpatient appointments in 2012-13
- £51 million** the NHS could make annual savings up to this figure if the 'Choose and Book' system was used to make all referral-to-treatment appointments
- 48 per cent and 40 per cent** are the respective percentages of trusts breaching the admitted and non-admitted standards in at least one month (in any specialty) but not fined in 2012-13

Summary

1 National Health Service (NHS) patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment (usually by their GP), unless they choose to wait longer or it is clinically appropriate to do so. In 2012-13, there were 19.1 million referrals to hospitals in England, with hospital-related costs we estimate at around £16 billion.

2 The waiting time performance standards are set by the Department of Health (the Department). The Department has overall accountability for service provision and value for money, and has an explicit duty to review the performance of NHS England while respecting its operational independence.

3 NHS England and clinical commissioning groups are responsible for upholding patients' right to start consultant-led treatment within 18 weeks, and NHS England is responsible for holding clinical commissioning groups (which commission most healthcare) to account for meeting the standards. In turn, clinical commissioning groups agree contracts with the providers of services (161 acute hospital trusts) and there are financial penalties for not meeting the standards. Trusts have either foundation or non-foundation status. Foundation trusts have significant managerial and financial freedom compared with other NHS hospital trusts.

4 Accurate waiting time information is important if patients and GPs are to use it to make choices about how important waiting time for treatment is compared with other factors such as convenience and choice of consultant. It is also important for clinical commissioning groups and trusts that have to manage waiting time. Waiting time standards are one of the key measures that NHS England, the Department, the public and Parliament use for assurance about the NHS's performance at a time of financial pressure and growing demand.

5 The most recent survey evidence shows that patients' experience of their care might also be dependent in part on the amount of time they wait from referral to treatment. The Care Quality Commission's 2012 *Inpatients survey* reported that 76 per cent were admitted as soon as they thought was necessary, while 49 per cent of patients responding to the Care Quality Commission's 2011 *Outpatients survey* reported that they waited one month or less for a first appointment.

6 With reduced departmental involvement in operational matters, its accounting officer relies on a system of assurance around the commissioning, provision and regulation of healthcare. The responsibility for good quality information starts with the chief executive of each trust.

The scope of this report

7 Many factors affect the ability of trusts to meet the waiting time standards, including trusts' capacity and efficiency, and the numbers and types of patients being referred to them. The NHS received an additional £1 billion in 2006-07 and £1.9 billion in 2007-08 to help meet the growth in referrals, deliver existing waiting time initiatives, and to meet future waiting time standards. Since then, the standards have been met nationally, with few exceptions, within existing NHS funding limits.

8 Trusts' financial and clinical performance regarding waiting times was outside the scope of our work. In the light of our previous work that identified weakness in the Department's information systems, we focused particularly on checking trusts' recording of waiting times.

9 Against this background, the report examines:

- performance nationally against the waiting time standards (Part One);
- how waiting times are measured and reported (Part Two); and
- management of the challenges (Part Three).

10 Our methods are set out in Appendices One and Two. Key methods were our census of acute trusts that achieved a 100 per cent response; and seven visits to trusts and clinical commissioning groups, which included a detailed audit of 650 orthopaedic patient case files. Trauma and orthopaedics had the largest numbers of patients referred for treatment in 2012-13, with 1.3 million individual patient pathways.

Key findings

Performance against waiting time standards

11 The current 18-week waiting time standards came into effect in 2008 and have recently been strengthened. The standards introduced in 2008 stated that 90 per cent of patients admitted to hospital, and 95 per cent of other patients, should have started treatment within 18 weeks of being referred. Since April 2012, there has also been a standard covering the patients who are still waiting for treatment. This addresses the perverse incentive to focus unduly on patients recently added to waiting lists, at the cost of patients who may have been waiting longer. In addition, from April 2013, NHS England introduced zero tolerance of any patient waiting more than 52 weeks, for which trusts face a mandatory fine of £5,000 for each patient doing so (paragraphs 1.2 to 1.3, Figure 1 and 3.10).

12 The introduction of the standards was followed by more patients being treated within 18 weeks. The standards were introduced and achieved in 2008 and performance improved over the following two years and has been relatively stable since. In addition, the recent strengthening of the standards appeared to have a rapid and significant effect on reducing the numbers of people waiting a long time for treatment. Doing more for one group can mean doing less for another and the median waiting time (the time it takes for the first 50 per cent of patients to be treated) has increased (paragraphs 1.7, 1.10, 1.12 and 1.14).

13 With few exceptions, the waiting time standards have been met nationally, although the picture is varied for individual trusts. The overall national picture for England is that the standards have been achieved with the only exceptions being for patients admitted to hospital in February and March 2011. However, as noted above, the median time waited by patients who have received treatment is steadily increasing. Nationally, the figures for individual trusts show that some do breach the standard. In 2012-13, for example, 58 trusts breached the standard, overall, in at least one month for patients admitted to hospital (paragraphs 1.8, 1.13 and 1.15).

Measuring and reporting waiting time

14 The sample of case files we audited suggests that published waiting time figures do, however, need to be viewed with a degree of caution. Our previous work has also raised concerns about the data systems for waiting times. In following up, we have identified inconsistencies in the way trusts measure waiting time, and errors in the waiting time recorded, as follows:

- a Local variations in how the waiting time rules are applied mean that the performance of individual trusts is not directly comparable.** Under certain conditions, and taking account of individual clinical needs, NHS England guidance gives trusts some discretion in the way they communicate with patients and respond to patient behaviours. This affects how long patients wait and how waiting time is calculated. Local approaches should be set out in trusts' access policies, but most of these are not publicly available and are out of date (paragraphs 2.4 to 2.6).
- b There are errors in the trusts' recording of patients' waiting time.** We reviewed 650 orthopaedic patient waiting times across seven trusts. More than half of these were not supported by documented evidence or were incorrectly recorded. Although it was not a representative sample for the country as a whole, we established clear data risks that need to be managed. We found that:
 - in 281 cases, waiting times had been correctly recorded and were supported by documented evidence;
 - in 202 cases, waiting times were not supported by enough evidence to say whether they had been correctly recorded; and
 - in 167 cases, there was evidence of at least one error, leading to under- and over-recording of waiting time. There was an overall under-recording of three weeks (mean) per patient, with a median of 11 days (paragraphs 2.14 to 2.18).

- c Mis-recording of data was identified at The North West London, Barnet and Chase Farm and Colchester trusts.** The North West London Hospitals NHS Trust identified that it had failed to record properly the waiting times of 2,700 (60 per cent) of its elective (pre-arranged) inpatients, including 12 who had waited more than 52 weeks for treatment. Barnet and Chase Farm Hospitals NHS Trust identified that it had failed to monitor more than 2,000 patients on the waiting list, 651 of which had waited between 18 and 51 weeks for treatment (paragraphs 2.20 to 2.22).
- d** Responding to whistle-blowers, the Care Quality Commission reported that Colchester Hospital University NHS Foundation Trust had altered patient appointment and medical records on its cancer waiting times system. The Care Quality Commission found that in 22 cases the treatment dates recorded on the system had been changed. The police are now conducting an investigation at Colchester (paragraph 2.22).

15 The challenge of meeting the standards is increasing, but NHS England does not have sufficient assurance about the performance of trusts. The pressure on waiting times is likely to continue, with the NHS seeking efficiency savings of up to £20 billion by March 2015 while trying to keep up with growing demand. Over the last five years, the number of patients referred for treatment has increased from 16.5 million to 19.1 million. This underlines the need for reliable performance information. The system of checks that NHS England has taken over from the Department, and improved upon, should pick up some errors and inconsistencies as well as discrepancies between the current and past reported performance of trusts. Without independent validation of trusts' data, however, the system will not detect errors or misreporting of the type identified in this report. In essence, therefore, the position is essentially the same as we and the Committee of Public Accounts found in 2001 and 2002 (paragraphs 1.16 and 2.23 to 2.24).

Management of the challenges

16 Maintaining the waiting time standards poses systemic challenges that will need continued attention over time. The factors affecting trusts' ability to manage waiting times are complex and interrelated. There are: financial challenges; structural and management issues such as being able to match consultants, bed and theatre capacity against the volume of planned appointments and operations; effective consultant engagement and clinical leadership; staff levels; and cancellation of appointments by hospitals and patients. Our recent reports on NHS financial sustainability and the management of consultants address some of these issues (paragraph 3.4).

17 There are, however, day-to-day practical steps that could be taken to improve the management of waiting lists and more could be done to focus on what works best. The NHS is highly devolved, and developing local solutions to local problems means that there is scope to innovate and try different approaches. It is clear, however, that some essentially administrative processes are not working as well as intended, and that trusts' approaches vary. In particular:

- a** Around half (48 per cent) of the trusts that breached the standard for patients admitted to hospital in at least one month in 2012-13 (in any specialty) were not fined. Our findings were consistent with those in our 2012 report on financial sustainability, which showed that fines were below the contracted rate or waived altogether (paragraph 3.11).
- b** Trusts hold mixed views on the contribution referral management services (centres where patients can be assessed before being referred to hospital, or treated instead of having a hospital appointment) make to meeting waiting time standards (paragraph 3.23).
- c** NHS England estimates that the online 'Choose and Book' system currently saves the NHS around £16 million annually. However, further savings of up to £51 million a year could be made if the system was used to book all hospital appointments. 'Choose and Book' cost £356 million and allows patients with internet access, GPs and other healthcare professionals to select a hospital and book an appointment at a date and time convenient to the patient, instead of making a written referral (paragraphs 3.26 to 3.27).
- d** Orthopaedic patients we spoke to seemed to be unaware of their rights and responsibilities. It is difficult for patients to understand the impact of their actions on the amount of time they will wait for treatment if they are not aware of, for example, their right to be treated within 18 weeks of referral, or that they may be referred back to their GP and the clock restarted if they fail to attend an appointment. Patients failed to attend some 1.6 million first outpatient appointments in 2012-13. These were appointments that other patients could have used. We estimate that the cost to the NHS of patients failing to attend first outpatient appointments was up to £225 million (paragraphs 3.28 and 3.31).

Conclusion on value for money

18 The current 18-week standards came into effect in 2008, and strengthening them over the last two years, has given NHS trusts a clear focus. The number of patients being referred to trusts continues to increase at a time when the NHS is under financial pressure and needs to make efficiency savings of up to £20 billion by March 2015. The challenge of sustaining the 18-week standards is increasing, and with it the importance of having reliable performance information and spreading good practice.

19 However, we found significant errors and inconsistencies in the way our sample of trusts assess waiting time. We are not suggesting that the number of patients treated within 18 weeks has not increased, but the information recorded by trusts is not as reliable as it should be, and masks a great deal of variability in actual waiting times. This fails patients, GPs and other healthcare professionals, and hinders the identification and management of poor performance. The solution is not costly new processes, but making existing processes work properly and maintaining effective scrutiny of them.

20 Some of the challenges facing trusts when managing waiting lists are the perennial systemic issues of balancing financial and clinical capacity with the demand for services. But there are areas of practical day-to-day management, such as the way financial incentives are applied and the routes by which patients are referred for treatment, where common administrative processes are approached very differently. They cannot all be equally effective, and opportunities to improve services and save money are being missed.

21 Value for money is being undermined by the problems with the completeness, consistency and accuracy of patient waiting time data; and by differences in the way that patient referrals to hospitals are managed.

Recommendations

- a** **The Department should satisfy itself that NHS England has effective arrangements for making sure trusts' recording and reporting of waiting times is consistent and reliable.** The Department and NHS England plan to work with Monitor and the NHS Trust Development Authority to achieve this.¹ Our report presents clear evidence that there are risks relating to waiting time information that need to be managed firmly, and that the assurance arrangements on which NHS England relies (and ultimately the Department) are not working as well as they need to. In particular:
- **In view of the levels of errors and misreporting by trusts, NHS England should establish the underlying causes.**
 - **NHS England should consider whether greater consistency, accuracy and usefulness would be achieved if waiting times were recorded and reported in the same way by all trusts.** In addition, NHS England should work with trusts to ensure hospital staff understand and are properly trained in the measurement and recording of waiting times in line with national rules and local access policies.
 - **Primary responsibility for good quality data starts with the chief executive of each trust. However, NHS England should seek assurance that the controls over waiting time data are operating as intended at trusts, and should consider introducing direct testing of the controls.** In view of the level of errors identified, and until it is satisfied that trusts' records are reliable, NHS England should seek additional assurance, possibly through a regime of test checking.

¹ Monitor ensures NHS foundation trusts contribute to national priorities including waiting time standards. The NHS Trust Development Authority oversees the performance management and governance of NHS trusts.

- b NHS England should make sure that there are sufficient and reliable mechanisms in place to encourage trusts to meet waiting time standards, including effective financial incentives.** NHS England's 2014-15 standard contract will allow clinical commissioning groups some flexibility in how they apply sanctions if it is in the best interest of patients or promotes transparency. To be effective, the system of fines should be based on reliable performance information.
- c Clinical commissioning groups and trusts should work with referral management centres to ensure clock start dates are correctly recorded and passed on to trusts with supporting documentation.**
- d NHS England should work to maximise the benefits from the £356 million spent on the online 'Choose and Book' system.** Greater use of this system could save up to £51 million a year. NHS England should find out why 'Choose and Book' is not used more widely and make sure that the issues are addressed when implementing the planned update. In doing so, NHS England plans to work with Monitor and the NHS Trust Development Authority.
- e Clinical commissioning groups and trusts should work together to impress on patients their rights and responsibilities.** Almost all patients in the small sample we interviewed were unaware of the 18-week maximum waiting time and the implications if they failed to attend their appointment – although patients failing to turn up for appointments is a long-standing challenge which should not be underestimated.
- f Trusts and clinical commissioning groups should encourage patients to take ownership of their pathway to treatment by ensuring that each trust access policy is up to date, patient friendly and publicly available.**
- g NHS England should increase the work it does with clinical commissioning groups and trusts to identify and spread good practice in waiting list management.**