



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

NHS waiting times for elective care in England

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Department of Health

NHS waiting times for elective care in England

Report by the Comptroller and Auditor General

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Amyas Morse
Comptroller and Auditor General
National Audit Office

17 January 2014

This study examines the performance, recording and management of elective care waiting times in England.

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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.**

Part One

Performance against the waiting time standards

1.1 This part looks at reported performance against the 18-week waiting time standards. It covers:

- the waiting time standards and how they have evolved; and
- performance against the waiting time standards.

1.2 Waiting time standards have changed over time, but since 2008 the maximum time that all 'admitted' and 'non-admitted' patients should wait from referral to treatment has been 18-weeks. The standards are clear about the maximum times patients should wait for treatment from referral (usually by their GP) to receiving their first treatment. The standards are less than 100 per cent to allow for patients waiting longer than 18 weeks if they choose to, if it is clinically appropriate to do so, or if they fail to turn up for an appointment.

1.3 Over the last two years, a new standard has been introduced covering patients who have yet to be treated. In addition, NHS England has introduced zero tolerance of any patient waiting more than 52 weeks. These changes address the perverse incentive to focus unduly on patients recently added to waiting lists, at the cost of patients who may have been waiting longer.

1.4 The 2013-14 NHS standard contract between clinical commissioning groups and trusts incorporates the standards, and trusts currently face mandatory fines for failing to meet them. The standards are set out in **Figure 1**. Staff at the trusts we visited told us that the standards have given their management of waiting lists a clear focus.

1.5 NHS England collates and publishes monthly performance against the waiting time standards as reported by trusts. This was previously done by the Department.

1.6 Our previous work (paragraph 2.11 to 2.13) has identified concerns about the data systems relating to waiting lists, and when checking patient records at the seven trusts we visited we found inconsistencies and errors in their reporting. These findings mean that the figures set out opposite need to be viewed with a degree of caution.

Figure 1**The waiting time standards**

Introduced from April 2008 (to be achieved by December 2008). For patients who have started treatment:

- 90 per cent of patients who have been admitted to hospital should have started consultant-led treatment within 18 weeks of being referred for treatment (**the 'admitted' standard**).
- 95 per cent of the other patients (for example, those receiving outpatient treatment) should have started consultant-led treatment within 18 weeks of referral (**the 'non-admitted' standard**).

Introduced in April 2012 (announced in November 2011). For patients who are waiting to start treatment:

- 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks (**the 'incomplete pathway' standard**).

In addition:

- Since April 2013, there has been zero tolerance of any patient waiting more than 52 weeks for treatment.

Notes

- 1 The 2008 and 2012 standards were introduced by the Department of Health.
- 2 The 2013 zero tolerance was introduced by NHS England.

Source: Department of Health, *NHS Improvement Plan*, June 2004. NHS England, *Everyone counts*, January 2013

The reported overall performance trends for England

1.7 Introduction of the standards from April 2008 was followed by more patients being treated within 18 weeks. **Figure 2** overleaf shows that the standards were achieved in the year they were introduced. Performance improved over the following two years and has been relatively stable since.

1.8 Since 2008, the Department has continued to achieve the standards, reporting only two exceptions. In February 2011, performance against the 90 per cent standard for 'admitted' patients was 89.8 per cent, and in March that year performance was 89.6 per cent.

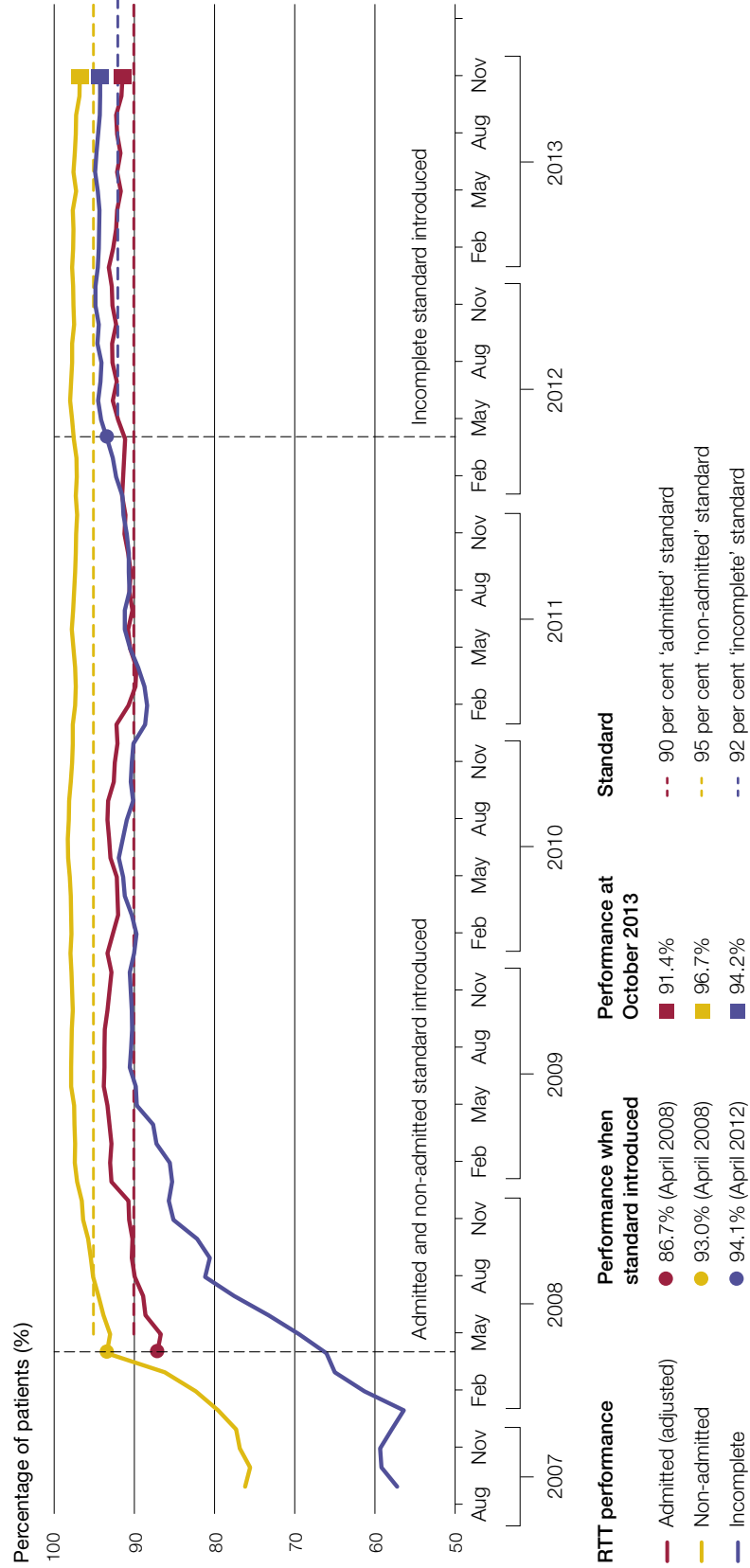
1.9 **Figure 2** also shows that performance against the standard for patients still waiting for treatment (those on the 'incomplete pathway'), had been achieved by January 2012 in anticipation of its introduction in April 2012. It has been maintained since then.

The improving picture for patients who have been waiting longest

1.10 **Figure 2** and **Figure 3** on pages 14 and 15 also show what appears to be the effect of trusts anticipating the introduction of standards. For example, the standard for people who have not yet started treatment (introduced April 2012) appears to have had a rapid and significant effect on reducing the numbers of people waiting a long time. The number of people waiting longer than 18 weeks without treatment each month fell to 138,000 by the end of October 2012 from 234,000 in October of the previous year. However, by the end of October 2013, the number of people waiting over 18 weeks for treatment had increased to 169,000.

Figure 2
Performance against 18-week standards

All standards are currently being achieved



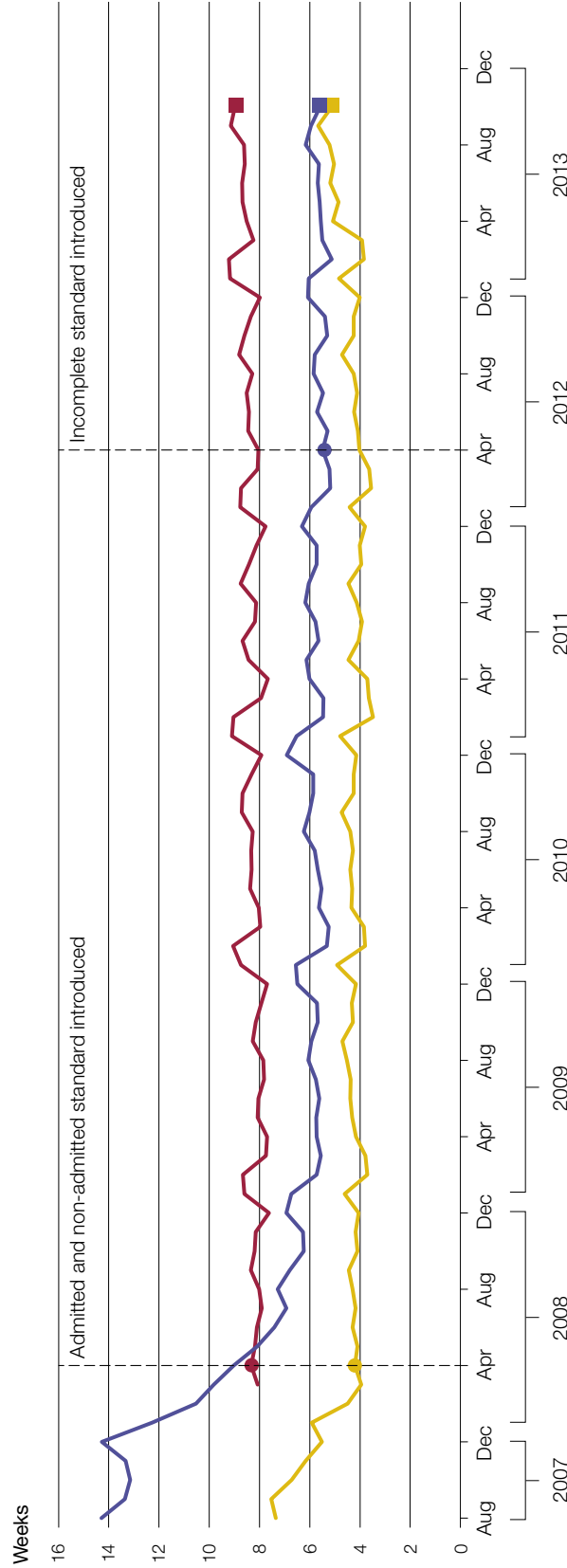
Notes

- Admitted (adjusted): figures are adjusted to take account of clock pauses.
- Standards for admitted and non-admitted patients to be met by December 2008, achieved in July and August 2008 respectively.
- Incomplete standard introduced in April 2012.

Source: NHS England, Consultant-led referral to treatment waiting times, October 2013

Figure 3
Median waiting times

Median waiting times fluctuate and peak between January and March each year



RTT performance Performance when standard introduced Performance at October 2013

- Admitted (adjusted) ● 8.3 (April 2008) ■ 9.0
- Non-admitted ● 4.2 (April 2008) ■ 5.1
- Incomplete ● 5.5 (April 2012) ■ 5.6

Notes

- 1 The median is the point at which the first 50 per cent of patients are treated.
- 2 Standards for admitted and non-admitted patients to be met by December 2008, achieved in July and August 2008 respectively.
- 3 Incomplete standard introduced in April 2012.
- 4 Seasonal peaks correspond with poor weather conditions in winter changing the balance between planned and emergency care.
- 5 Admitted (adjusted); figures are adjusted to take account of clock pauses.

Source: NHS England, Consultant-led referral to treatment waiting times, October 2013

1.11 This increase also coincides with the introduction of zero tolerance of any patient waiting more than 52 weeks in April 2013. The number of ‘admitted’ and ‘non-admitted’ patients who waited longer than 52 weeks to start treatment fell to 2,743 for April to October 2013, from 7,463 for the same period in 2012.

The position with median waiting times

1.12 The waiting time standards are distinct thresholds that are either achieved or not achieved. The median waiting time published by NHS England shows the waiting time for the first 50 per cent of patients to be treated and is set out in Figure 3 (NHS England does not publish the average (mean) time patients wait for treatment). However, in contrast to the overall performance improvements highlighted in Figure 2, Figure 3 shows that median waiting times from referral to treatment have increased since their introduction.

1.13 There could be many reasons for the recent increases in median waiting times (Figure 3), including the transfer, in April 2013, of relatively short sexual health treatment pathways to local authorities which are now excluded from reported performance against the 18-week standards.² But on the face of it they point to the interconnectedness of measures to improve waiting times for all patients – doing more for one group can mean doing less for another.

1.14 The median waiting times for ‘non-admitted’ patients, for example, were markedly higher in October 2013 (5.1 weeks) than in October 2012 (4.2 weeks). This increase broadly coincides with the recent reductions in the numbers of patients who have been waiting longest (see paragraph 1.10), which may mean that newer referrals are waiting longer as trusts deal with patients towards the end of the 18-week period, or who have already waited longer than 18 weeks.

The picture for individual trusts

1.15 While the overall national position is that the standards are being achieved, some of the 161 individual trusts fail to meet them.³ Over the last two years, there has been a reduction in the numbers failing, which appears to be consistent with the focus on treating patients close to breaching 18 weeks:

- For patients admitted to hospital, the number of trusts breaching the 18-week standard overall in at least one month in 2012-13 was 58 (81 in 2011-12). The number of months these trusts missed this standard ranged between 1 and 11, with a mean (average) of four months and median of three.⁴

² Sexual health services accounted for around 7 per cent of all referrals to treatment.

³ National statistics are the numerical average of all waiting times (including those who meet and breach the standards).

⁴ Mean is a mathematical average and the median the point at which 50 per cent of patients are treated.

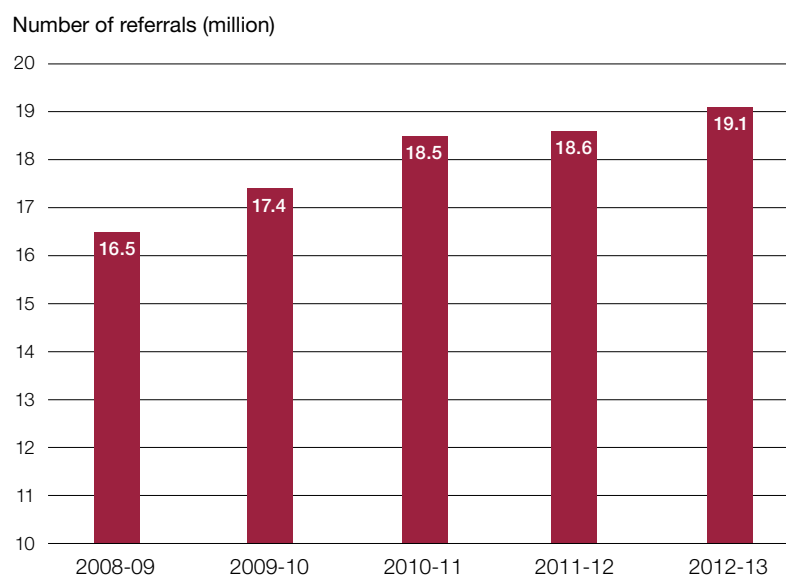
- For non-admitted patients starting consultant-led treatment, the number of trusts breaching the standard in 2012-13 was 11 (18 in 2011-12). The number of months these trusts missed this standard ranged between one and six, with a mean of three and median of two months.
- For patients still waiting for treatment, 36 trusts breached the standard in 2012-13 (no figure for the previous year as the standard had not been introduced). The number of months these trusts missed this standard ranged between 1 and 12, with a mean of three and median of two months.

The challenge to waiting time standards arising from increasing numbers of patients being referred for treatment

1.16 The pressure on waiting times is likely to continue. The NHS is seeking efficiency savings of up to £20 billion by March 2015 while trying to keep up with growing demand for its services. **Figure 4** shows that over the last five years, the number of patients referred for treatment has increased from 16.5 million to 19.1 million.

Figure 4
Number of referrals

The number of referrals is increasing



Source: NHS England, commissioner-based quarterly hospital activity data, November 2013

Part Two

Measuring and reporting performance

2.1 Reliable and comparable local data are required 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.

2.2 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. Accurate data are required to support the Department's assessment of whether the standards are being achieved nationally. The importance of high-quality information about what is being achieved is underlined by the fact that the financial pressures on the NHS and the demand for its services are increasing.

2.3 In this context, this part looks at:

- the approach to measuring waiting time;
- the recording of waiting time; and
- the assurance processes for waiting time data.

The approach to measuring waiting time

2.4 The national rules for applying the waiting times standards are set out in the rules suite (the rules), which is embedded in legislation.⁵ The explicit aim of the rules is to ensure that each patient's waiting time – clock start, pause and stop – is fairly and consistently recorded (see **Figure 5**).⁶ However, the discretion that NHS England gives trusts in the way they communicate with patients and respond to patient behaviours, a lack of clarity in the guidance and incorrect recording of waiting times by trusts can undermine these aims.

5 Mental Health, England and National Health Service England, *The National Health Service commissioning board and clinical commissioning groups (responsibilities and standing rules) regulations 2012*, December 2012, available at: www.legislation.gov.uk/ukxi/2012/2996/pdfs/ukxi_20122996_en.pdf

6 Department of Health, *Referral to treatment consultant-led waiting times: rules suite*, January 2012, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/198930/Referral_to_treatment_Rules_Suite.pdf

Figure 5

The referral to treatment consultant-led waiting times rules suite: clock starts, pauses and stops

What causes a clock start?

Any eligible professional that refers a patient:

- directly to a consultant-led service; or
- to an intermediary service offering clinical triage, assessment and, or treatment.

Patient rebooks after failing to attend a first appointment.

A self referral (where this has been locally agreed).

A decision to treat following a period of active monitoring.

A patient becomes fit and ready for the second of a bilateral procedure.

A decision to start a substantially different treatment.

When does the clock start?

For paper referrals:

- When the referral is received by the trust, if directly referred to a consultant-led service. If through an intermediary service – when received by that service.

For 'Choose and Book' referrals:

- When the patient's unique booking reference number is converted to a hospital appointment.

When a patient rebooks following a first appointment that they failed to attend and that nullified their clock:

- The date the new appointment is agreed.

After a period of active monitoring/for a substantially different treatment/when patient becomes fit for treatment:

- The date the decision to treat is made.

What causes a clock pause?

A clock can only be paused (and reported to NHS England) where a decision to admit has been made and the patient has declined at least two reasonable appointment offers.

For social reasons such as:

- holidays;
- care responsibilities; or
- work commitments.

When does the pause start/stop?

The pause starts with the earliest reasonable offer made by the trust.

The pause is stopped when the patient makes themselves available for treatment. For example, a patient who has declined two reasonable offers of 4 June and 7 June will have the clock paused from 4 June (the earliest reasonable offer date). The patient says they would be available after 15 July, but the first date the provider can offer is 18 July – in this case the clock should restart from 15 July – the date the patient is available from.

What causes a clock stop?

The first definitive treatment (intervention to manage a patient's condition and avoid further action).

When a patient declines treatment.

A period of active monitoring starts.

A clinical decision not to treat is made.

A patient does not attend their first outpatient appointment and the trust can demonstrate that the appointment was clearly communicated to the patient (which nullifies a clock).

A patient does not attend a subsequent appointment – subject to all conditions within the rules suite being met.

When does the clock stop?

The date the first definitive treatment starts; for example, admission to hospital; or, date that physiotherapist starts treatment if this is considered first definitive treatment.

The date:

- A patient informed a trust that they do not want treatment.
- A decision is made to start active monitoring.
- A decision is made not to treat a patient.

Note

- 1 'Choose and Book' allows patients with internet access, and 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.

2.5 The Department told us that the rules provide a framework within which local decisions can be made in consultation with clinicians, trusts, commissioners and patients. The Department produced measurement and reporting guidance for trusts on the application of the rules (the responsibility for this and future guidance now rests with NHS England). The guidance⁷ gives trusts some discretion in, for example, the way they apply waiting time clock pauses and how they handle patients who fail to attend appointments.

2.6 Further guidance by the NHS England Intensive Support Team⁸ says that good practice is for trusts to have publicly available access policies setting out the locally agreed application of the rules, developed in partnership with local stakeholders including GPs, commissioners, patients and clinicians. We found that only 25 per cent of 158⁹ acute trusts had published their access policies online. We requested copies of access policies from the remaining acute trusts in England. In total, we collected and reviewed 118 individual access policies. Of these, only 17 referred to all three 18-week waiting time standards and were within the review date set by the trust to make sure they kept up to date with national guidance and local referral practices.

Local differences in the management and measurement of waiting times

2.7 The local flexibility available to trusts results in differences in the way they measure waiting times, which mean that their reported waiting times are not directly comparable when patients and their GPs are deciding which hospitals they should attend. In addition to their effect on the waiting times recorded by trusts, these variations directly affect the length of time patients wait for treatment. For example, our review of access policies and responses to our census showed:

Patients making a first outpatient appointment:

- Forty-eight per cent of trusts refer patients back to their GP if the patient has not responded to a contact from the trust to make an appointment. This reduces the chances of the trust breaching the waiting time standard but puts the patient to the back of the queue. Other trusts contact the patient again without stopping the clock.

Cancellations and rearrangements by patients:

- The number of cancellations allowed by trusts before a patient is referred back to their GP and the clock restarted ranges from one to three. Those trusts allowing more cancellations are at greater risk of breaching the waiting time standards. Overall, 2 per cent of trusts set a limit of one cancellation, 88 per cent two and 10 per cent three before a patient is referred back to their GP.

⁷ Department of Health, *Referral to treatment consultant-led waiting times: how to measure*, January 2012, available at: www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

⁸ NHS Intensive Support Team, *Elective care guide, referral to treatment pathways: a guide for managing efficient elective care*, April 2013.

⁹ We removed the three cancer specialist acute trusts from our calculations as they were not included in our census.

Clock pause lengths allowed by trusts:

- The waiting time clock can be paused when patients choose to wait longer for personal or social reasons. Thirty-seven per cent of trusts do not set a time limit, and the remaining 63 per cent impose maximum pause lengths ranging from 2 to 26 weeks. Specifying maximum pause lengths means that trusts can remove patients from waiting lists and refer them back to their GP when this maximum is reached. NHS England's view is that there are no specific rules preventing the local application of a maximum pause but that a blanket application of a maximum pause does not sufficiently reflect the differing needs and preferences of individual patients.

2.8 Recording and reporting pauses seem to cause trusts particular difficulty. In response to our census, 32 per cent of trusts answered incorrectly when asked how they would record pauses for patients admitted for treatment. In addition, one-fifth of trusts told us that they would record pauses for 'non-admitted' patients; however, the rules and guidance are clear that pauses should only be applied and reported for patients on 'admitted' treatment pathways.

2.9 The rules say that a pause for an 'admitted' treatment pathway should end when the patient says they are available for treatment. However the guidance allows for two different approaches to measuring pauses.¹⁰ In line with the rules, five of our case study trusts ended pauses on the date when patients said they were available for treatment. However, there is guidance stating that trusts can pause the clock until the day of, or the day before, their admission for treatment if the following conditions are met:

- The trust makes every effort to apply a pause for the actual length of time a patient makes themselves unavailable for treatment in the first place.
- The trust clearly communicates to the patient that a pause will be applied and tells them how long it will last.
- The patient becomes available within a few days of their admission to hospital.
- If in any doubt about how the pause should be applied, trusts should not apply a pause and should keep the clock ticking.

2.10 Two of our trusts pause the clock until the day of, or the day before, their admission for treatment which potentially reduced the risk of them breaching the 18-week standards:

- sixteen of 17 pauses Oxford University Hospitals NHS Trust applied ended within a day of the admission date; and
- twenty of 26 pauses Dorset County Hospital NHS Foundation Trust applied ended within a day of the admission date.

¹⁰ Department of Health, *Referral to treatment (RTT) waiting times – patient initiated clock pauses*, October 2012, available at: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Patient-initiated-clock-pauses-guidance-Oct-2012.pdf

Recording waiting time

2.11 Previous work by us and the Committee of Public Accounts has highlighted the potential for inappropriate recording of data relating to patients waiting for treatment.

2.12 In 2001, we found inherent risks and a lack of complete reliability in acute hospital trusts' data systems and procedures, which undermined confidence in the accuracy of NHS waiting lists. Follow-up reports by us and the Committee of Public Accounts identified examples of patients being deliberately left off waiting lists, or delays in adding patients to them, and inappropriate use of waiting list suspensions.

2.13 In 2012, we reported on the Department's information systems.¹¹ The system for the 18-week waiting time standards achieved a rating of '1' on a scale of 0 to 4 (4 being the best), which meant that "the data system has some weaknesses which the Department must address".

Our test checking of waiting times

2.14 Against this background, across our seven case study trusts we audited 650 orthopaedic patient case files to see if the rules for recording waiting time had been correctly applied.¹² The sample was not designed to be representative of all acute hospital trusts or of the case study trusts' orthopaedic patients, and not therefore designed to allow us to assess the accuracy of national waiting time figures. Instead, we wanted to do enough work to assess whether there continue to be risks that need to be managed.

2.15 We found that the information on file to support waiting time clock start, pauses and stops was not always complete, but that where supporting documentation was available there were significant numbers of errors. Incomplete records are a cause for concern. We found 106 cases where there was no evidence of the date that the patient was referred to the trust. This means that the waiting time cannot be verified, and that the trust, the GP nor the patient can be sure that the clock started on time and that the patient's treatment is not being delayed.

¹¹ Comptroller and Auditor General, *Department of Health: Information assurance summary reports*, National Audit Office, November 2012, available at: www.nao.org.uk/wp-content/uploads/2012/11/Information_assurance_DoH.pdf

¹² We conducted our audit of case files in conjunction with trusts' staff responsible for managing and validating patient waiting time data.

2.16 Looking at the accuracy of the 650 individual patient cases we reviewed (**Figure 6**):

- For 202 cases (31 per cent), we were unable to find documented evidence of either clock start, or pause or stop dates.
- Only 281 cases (43 per cent) were fully documented and the clock start, pause and stop times correctly recorded. This rate varied from 13 to 57 per cent across the case study trusts.
- For 167 patient case files (26 per cent), there was documented evidence of at least one error.

Figure 6

Correctly and incorrectly applied clock starts, pauses and stops

Case study site	Number of cases reviewed	All correct	Incomplete records ¹	At least one error found
Dorset County Hospital NHS Foundation Trust	99	56	35	8
Frimley Park Hospital NHS Foundation Trust	100	56	34	10
Northampton General Hospital NHS Trust	94	53	27	14
Southport & Ormskirk Hospital NHS Trust	83	35	27	21
Bolton NHS Foundation Trust	83	33	26	24
Oxford University Hospitals NHS Trust	96	36	23	37
Leeds Teaching Hospitals NHS Trust	95	12	30	53
Total	650	281 (43 per cent)	202 (31 per cent)	167 (26 per cent)

Notes

- 1 'Incomplete records' refers to cases where we could not find documented evidence that they had been either correctly or incorrectly recorded.
- 2 Our case study trusts were chosen on the basis of performance against the standards, geographical region and number of referrals.

Source: National Audit Office audit of 650 patient case files, 2013

2.17 Figure 7 provides a breakdown of the 167 cases where there were errors. It shows that clock starts caused the most problems, with 72 per cent of cases having incorrect start dates. Pauses were wrongly recorded in 41 per cent of cases, and clock stops in 23 per cent of cases. The most case files with errors were at Leeds and Oxford.

Figure 7

Breakdown of errors by clock starts, or pauses, or stops

Case study site	Number of case files	Clock start Number of incidences	Clock pause Number of incidences	Clock stop Number of incidences
Dorset County Hospital NHS Foundation Trust	8	3	2	4
Frimley Park Hospital NHS Foundation Trust	10	3	4	3
Northampton General Hospital NHS Trust	14	6	2	6
Southport & Ormskirk Hospital NHS Trust	21	17	4	1
Bolton NHS Foundation Trust	24	9	3	13
Oxford University Hospitals NHS Trust	37	32	1	9
Leeds Teaching Hospitals NHS Trust	53	51	1	3
All cases with errors	167	121 (72 per cent)	17 (41 per cent)	39 (23 per cent)

Notes

- 1 Totals for clock starts, pauses and stops total more than 167, as some cases have more than one error. Clock start and stop percentages are based on the total number of cases with an error.
- 2 Pause percentages are based on the total number of cases where a pause is applied – 41 of these cases had a pause applied, 17 incorrectly.
- 3 Trusts were not always provided with the clock starts by referral management or interface services (see paragraph 3.24).

Source: National Audit Office audit of 650 patient case files, 2013

The impact of waiting time errors

2.18 We analysed the 167 patient case files with errors to see what impact they had on waiting times, and found that they led to both under- and over-recording of waiting time.

Under-recorded waiting time:

- There were 129 cases where errors led to waiting time being under-recorded. The mean (average) under-recording was 40 days and the median was 24 days¹³ – mostly because of late clock starts and incorrectly applied pauses. There were an additional 16 cases where waiting time was under-recorded but there was insufficient information to say by how much.

Over-recorded waiting time:

- In 22 cases the waiting time was over-recorded. The mean over-recording was 75 days and the median was 68 days – mostly because of delays in stopping the clock.

Overall under-recording of waiting time:

- The net effect of the errors was an under-recording of 21 days (the mean), with a median of 11 days.

2.19 We also analysed the errors to see what impact they had on performance against the 18-week waiting time standards. Again, the effect was under- and over-recording of waiting times under and over 18 weeks.

Under-recording of patients waiting longer than 18 weeks:

- There were 26 cases where the records showed that patients waited less than 18 weeks, when in fact they waited over 18 weeks.

Over-recording of patients waiting longer than 18 weeks:

- There were 11 cases where the records showed that patients waited longer than 18 weeks, but in fact they waited less than 18 weeks.

¹³ Mean is a mathematical average and the median the point at which 50 per cent of patients are treated.

Mis-recording at the North West London, Barnet and Chase Farm and Colchester trusts

2.20 Since we started work for our report, evidence has come to light of waiting time irregularities in some trusts' data:

- The North West London Hospitals NHS Trust failed to record the waiting times of 2,700 (60 per cent) of its elective inpatients, including 12 patients who had waited more than 52 weeks for treatment. The errors were identified during an internal validation of inpatient waiting lists and reported to the trust's board.¹⁴
- In May 2013, Barnet and Chase Farm Hospitals NHS Trust identified a failure to monitor more than 2,000 patients on the waiting list, of which 651 had waited between 18 and 51 weeks. The backlog developed as a result of a failure in an IT reporting system. At the time of the report to the board in May, there were no patients identified as waiting more than 52 weeks for treatment. However, further validation of the waiting list in July by trust staff identified 108 patients that had not been tracked and who had waited more than 52 weeks for treatment; these patients were subsequently reported to NHS England. In December 2013, Barnet and Chase Farm Hospitals NHS Trust had 181 patients who had waited more than 52 weeks for treatment.

2.21 In response to our census, North West London and Barnet and Chase Farm trusts said they had validated waiting times data, including for example: checks for missing services; changes in waiting list volumes; checks for missing clock starts; and reviewing a sample of patient files against recorded data.

2.22 In addition, the Care Quality Commission undertook an inspection of Colchester Hospital University NHS Foundation Trust in response to concerns by whistle-blowers regarding cancer waiting times. They found that "... in 22 cases the treatment dates recorded on the system had been changed" and that "... 22 people were placed at risk of receiving care that was unsafe or not effective due to delays in receiving appointments or treatment."¹⁵ The police are now conducting an investigation at Colchester.

The assurance processes for waiting time data

2.23 The Department has ultimate accountability for the waiting time standards and depends on effective data assurance processes at trusts, clinical commissioning groups and NHS England. Our work in 2012 (see paragraph 2.13) showed that the Department had comprehensive processing and internal consistency checks over the quality of data submitted to its central database.¹⁶ These checks did not, however, mitigate the risks arising from the lack of independent assurance about the data systems of individual trusts. Thus, errors introduced during data collection by trusts were unlikely to be detected by the checks. We concluded that "the Department lacks assurance that the reported data is reliable and comparable".

¹⁴ The North West London Hospitals NHS Trust, *Board Papers*, October 2013.

¹⁵ Care Quality Commission, *Colchester General Hospital Inspection Report*, November 2013.

¹⁶ Comptroller and Auditor General, *Department of Health: Information assurance summary reports*, National Audit Office, November 2012, available at: www.nao.org.uk/wp-content/uploads/2012/11/Information_assurance_DoH.pdf

2.24 In April 2013, NHS England took over responsibility from the Department for carrying out quality checks on data submitted by trusts before publishing it. NHS England improved the checks which should pick up some errors and inconsistencies as well as discrepancies between the current and past reported performance of trusts. However, without independent validation of trusts' data, the system will not detect errors or misreporting of the type identified in this report that remain within normal parameters or are consistently reported over a number of years. In essence, the position is the same as we and the Committee of Public Accounts found in 2001 and 2002.

2.25 There is limited assurance available to NHS England from trusts and clinical commissioning groups. Although responsibility for good quality information starts with the chief executive of each trust, our census results show that the chief executive or deputy of 119 of the 158 trusts signed off data. Of our seven case study trusts, five had their data signed off by at least a deputy to the chief executive (Leeds Teaching Hospitals NHS Trust and Northampton General Hospital NHS Trust being the exceptions).

2.26 Clinical commissioning groups can contract for services with multiple trusts. NHS England requires clinical commissioning groups to ensure data accurately represent waiting times prior to trusts submitting data to them. They told us that, in August 2013, 160 of the 211 clinical commissioning groups signed off waiting times data. They also told us that, for August 2013, four of our seven case study trusts had their data signed off by their main clinical commissioning group.

2.27 The fact remains that despite these assurance and sign-off arrangements, there are errors in the recorded waiting times of the seven trusts we examined.

2.28 The extent to which trusts' data quality is examined by external and internal auditors is variable. In 2012-13, 25 per cent of trusts had their data system(s) reviewed by external auditors and 43 per cent by internal auditors; 51 per cent did not have either. Auditors identified risks with the data systems at some trusts including misinterpretation of the rules, human errors in the data coding and a lack of training.

2.29 Since March 2010, the Audit Commission has not conducted any independent work on NHS trusts, data quality arrangements. Before this date, Audit Commission appointed auditors' work on NHS trusts' arrangements for managing waiting times data included:

- quality reviews, including aspects of waiting time data systems (2000–2005); and
- risk-based spot checks, focusing on the arrangements for ensuring accuracy of waiting time data (2002–2005).

2.30 The Commission published national summaries of auditors' work in 2002 and 2003. From 2005 to 2010, auditors considered NHS trusts' corporate arrangements for data quality more generally within local work programmes.

2.31 In response to our census, most trusts told us that they had controls over waiting time data, although 12 said that they had no controls around who is allowed to update patient records; 28 said that they did not have documented procedures on data editing; and eight said they did not have audit trails to enable data scrutiny. Our case study trusts told us that they had controls in place to monitor and update waiting time data. The fact remains, however, that there are errors in their recording and reporting of waiting times.

2.32 During our case study visits, we were struck by the apparent complexity of the local processes for recording waiting times. Staff referred to the systems they used as inflexible and unable to 'talk' to their other systems used to manage patient care – making it difficult for staff to record, track and validate waiting times. Information, ranging from referral letters to diagnostics and treatment decisions, was held on separate systems, with some trusts also using different systems for different specialties. Staff also identified patchiness in local training on interpreting the waiting time rules and inputting data.

Part Three

Managing the challenges

3.1 Many factors affect trusts' ability to meet the waiting time standards, including capacity and efficiency, and the numbers and types of patients being referred to them. As Part One shows, the NHS needs to keep pace with growing demand while making efficiency savings.

3.2 This part looks at:

- systemic challenges on waiting times;
- effective financial incentives to meet the standards; and
- understanding what good practice looks like.

Systemic challenges on waiting times

3.3 The factors affecting trusts' ability to manage waiting times are complex, interrelated and require sustained attention over time.

3.4 These factors include: financial challenges; structural and cultural 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. In 2012-13, trusts cancelled approximately one operation in every 100 admissions. Our recent reports on NHS financial sustainability¹⁷ and the management of consultants¹⁸ address some of these issues.

3.5 In response to our census, trusts that had breached the waiting times standards told us that the main reasons were:

- work to clear patient backlogs (80 per cent);
- higher than expected demand for elective care (48 per cent);
- high levels of emergency admissions (47 per cent); and
- staff levels (24 per cent).

¹⁷ Comptroller and Auditor General, *Department of Health: Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012, available at: www.nao.org.uk/wp-content/uploads/2012/07/1213191.pdf

¹⁸ Comptroller and Auditor General, *Department of Health: Managing NHS hospital consultants*, Session 2012-13, HC 885, National Audit Office, February 2013, available at: www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf

3.6 The number of patients waiting for treatment reached its highest point since 2008 in August 2013. The 2.94 million patients waiting for treatment in August 2013 was 11 per cent higher than in August 2012. The most up-to-date figures available are for October 2013, which show that 2.91 million patients were waiting for treatment compared to 2.64 million for the same month in 2012.

3.7 Unplanned emergency admissions will inevitably affect trusts' capacity to manage planned elective treatment. Emergency admissions increased by 8 per cent between 2008-09 and 2012-13, reaching 5.52 million (**Figure 8**). Although it is difficult to assess the impact this has on elective care, emergency admissions can reduce theatre and bed capacity for planned treatment at short notice, meaning consultants have less time to deal with elective patients.

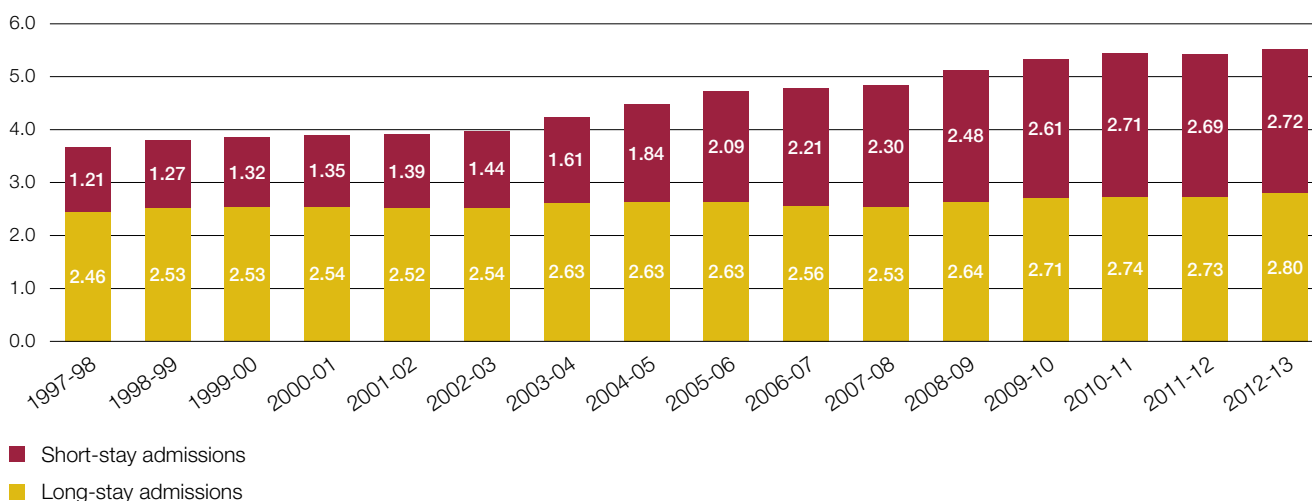
3.8 In our recent report on emergency admissions, however, we note that emergency activity is reasonably predictable, but that "...only 48 per cent of hospitals have matched their peaks in elective activity with their troughs in emergency activity, and vice versa, during Monday to Friday."¹⁹

Figure 8

Emergency admissions, 1997-98 to 2012-13

Emergency admissions increased by 8 per cent between 2008-09 and 2012-13, reaching 5.52 million

Emergency admissions (million)



Notes

- 1 Short-stay admissions are spells in hospital of less than two days; long-stay admissions are spells in hospital of two days or more.
- 2 Emergency admission numbers are based on the number of admissions that were discharged during the year.
- 3 Data for 2012-13 are provisional.

Source: Comptroller and Auditor General, *Department of Health: Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013.

¹⁹ Comptroller and Auditor General, *Department of Health: Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013, available at: www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf

Effective financial incentives to meet the standards

3.9 The increasing challenge of meeting the waiting time standards underlines the need for the financial incentives to be effective; they also need to be based on reliable information about what trusts achieve, and our findings in Part Two show that there are errors and misreporting in trusts' data.

3.10 Trusts face mandatory fines by clinical commissioning groups for failure to meet the waiting time standards. The fines are set out in the standard contract between clinical commissioning groups and trusts. They are capped at 5 per cent of the revenue of individual clinical specialties. In addition, trusts also face a mandatory fine of £5,000 for each patient waiting over 52 weeks.

3.11 Although clinical commissioning groups are required to impose fines for not meeting waiting time standards, our census showed that this is not done consistently. In 2012-13, there were no fines for 48 and 40 per cent of trusts that breached the respective standards in any given month for admitted and non-admitted patients in at least one specialty area. This is consistent with our 2012 report on NHS financial sustainability, which showed that 22 per cent of primary care trust clusters (now replaced by clinical commissioning groups) levied fines below the contracted rate or waived them altogether.²⁰

3.12 Eighty of the 158 trusts that responded to our census breached at least one of the standards (according to national data) and told us that they have not been fined. Twelve were directed by a clinical commissioning group to reinvest an amount equivalent to what the fine would have been in order to reduce waiting lists, while 46 had no conditions attached to not being fined. Fines were often seen as a last resort by the clinical commissioning groups we spoke to during our case study visits. They preferred to work with trusts to understand why they were not meeting the standards, and to request recovery plans through the contract monitoring processes.

3.13 NHS England's 2014-15 standard contract with trusts will, however, 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, however, the system of fines will need to be based on reliable performance information.

3.14 Fines mean that trusts alone bear the risk of financial penalties if waiting time standards are not met, even though their ability to meet the standards depends on the number of patients referred to them, which is not within their control. Their contracts with clinical commissioning groups should reflect historical referral trends, but trusts must accept all referrals which are clinically appropriate for the services they provide.

3.15 NHS England is implementing a new quality premium, which it expects will provide financial incentives that go beyond trusts. It will be paid to clinical commissioning groups in 2014-15 depending on their performance in achieving improved outcomes and the full range of NHS standards, including those for waiting times. The maximum amount payable for the quality premium in 2014-15 across all clinical commissioning groups is £270 million.

²⁰ Comptroller and Auditor General, *Department of Health: Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012, available at: www.nao.org.uk/wp-content/uploads/2012/07/1213191.pdf

Understanding what good practice looks like

3.16 The NHS is highly devolved, and the best ways of meeting local health needs are decided locally within national frameworks. It follows that developing local solutions to local problems means that there is scope to innovate and try different approaches. We saw limited evidence, however, of structured arrangements for identifying and sharing good practice in the way trusts manage waiting lists.

3.17 The following paragraphs set out a number of areas in which there appears to be scope for more consistent approaches to good practice.

Local efforts to reduce waiting lists and times

3.18 There are many different ways trusts manage waiting lists and reduce the backlog of patients waiting for treatment. Trusts' responses to our census showed that in 2012-13:

- Eighty-one per cent paid consultants for additional work.
- Seventy-three per cent employed locum staff.
- Seventy-one per cent outsourced work to the private sector.
- Twenty-six per cent received financial support totalling £34 million to help reduce waiting times. This was a reduction from the 40 per cent of trusts that received support in 2011-12, amounting to £45 million. This funding was mainly from primary care trusts; these have since been replaced by clinical commissioning groups, which can choose to provide additional funding to reduce waiting lists.

3.19 Trusts that find waiting time standards challenging, or wish to receive external assurance around demand and capacity planning, can request non-financial support from NHS England or clinical commissioning groups. The NHS England Intensive Support Team aims to help trusts in the lowest quartile of performance against the standards. In practice, the team helps those trusts that invite it to do so, if there are demonstrable challenges to waiting time performance.

3.20 Our census shows that 52 per cent of trusts received non-financial support in 2012-13 – mainly from the Intensive Support Team (58 per cent) and primary care trusts (32 per cent), to help manage waiting lists. Although our census does not provide detail on the type of help they received, our case study trusts told us that they received advice on:

- improving systems and processes to better plan patient flows;
- identifying key performance indicators to identify problems early on; and
- improving performance management arrangements.

3.21 We looked to see whether the trusts receiving support included those that were breaching the waiting time standards. From our census, of those trusts that said they had breached the standards overall or in any specialty area, 46 per cent received non-financial support and 29 per cent received financial support in 2012-13. Of the trusts not breaching the standards, 13 per cent received non-financial support and none received financial support. This suggests that, broadly, support is going to trusts that need it.

Referral management

3.22 Three-fifths of patient referrals that start an 18-week waiting time clock are made by GPs. The remainder are made by consultants, accident and emergency clinicians, and other healthcare professionals such as physiotherapists and dentists.

Referral management services

3.23 Some patients may be referred to an interface service, including referral management and clinical triage assessment and treatment centres. Interface services were set up to act as a collection point for referrals before they are forwarded to secondary (hospital) care. The effectiveness of these services was not within the scope of our work, but we used our census to ask trusts about the extent to which they receive referrals through such services, and their contribution to managing waiting times. Trusts' responses showed that 75 per cent of trusts receive some referrals in this way. Of these, 44 per cent told us that interface services have a negative impact on their ability to meet waiting time standards, 19 per cent said they had a positive impact and 30 per cent no impact.

3.24 In addition, we found confusion around interface services and how they were taken into account when calculating waiting times; this was compounded where information on clock start dates was not passed on by interface services to trusts. When interface services received referrals prior to patients being referred to the trust, our audit of case files showed that in many instances, they did not provide the date that they received the referral (the correct clock start date). Referral management service errors were responsible for at least 39 per cent of the incorrect starts recorded in our data validation work.

Electronic 'Choose and Book' system

3.25 Patient referrals can be paper-based (including faxes and emails) or made through the 'Choose and Book' system – an online electronic booking service which allows a patient or healthcare professional to select a hospital and book an appointment convenient to the patient or that has short waiting times. The booking is immediate, speeding up the time it takes for a patient to be treated; it improves the accuracy of recorded clock starts by automatically generating a date in trusts' computer systems; and it can lead to lower rates of failure to attend appointments. For example, by using the system, Doncaster and Bassetlaw Hospitals NHS Foundation Trust reduced failure to attend appointment rates by up to 60 per cent in some services.²¹ NHS England told us that this is because the patient has chosen the time, date and place of their appointment at their own convenience, rather than that of the NHS.

²¹ Doncaster and Bassetlaw Hospitals NHS Foundation Trust, *Choose and Book: reducing DNAs*, June 2007, available at: www.chooseandbook.nhs.uk/staff/communications/studies/donc-dnas.pdf

3.26 ‘Choose and Book’ also provides administrative savings. It was introduced in 2004 with total costs to March 2012 of £356 million,²² and is due to be updated as part of the move to a paperless NHS by 2018. ‘Choose and Book’ is already available to primary healthcare services (for example, GP practices), trusts and patients online, but is not fully utilised.

3.27 Although ‘Choose and Book’ is used to refer up to 40,000 patients every working day, NHS England estimates that this still only represents half of all possible GP-to-first-outpatient referrals. NHS England estimates that the online ‘Choose and Book’ system currently saves the NHS around £16 million annually. We calculate that the system could achieve additional savings of up to £51 million every year if it was used to book appointments for all GP and other healthcare service referrals (**Figure 9**).²³ The main savings would arise from reductions in process and staff costs, as patients book their own appointments and are less likely to fail to attend clinics. However, our case study evidence suggests that the full benefits of ‘Choose and Book’ will not be realised until all trusts’ services and appointment slots are made available on the system.

Figure 9

‘Choose and Book’ efficiency savings that could be made by trusts

The NHS could save up to £51 million a year if it fully utilised ‘Choose and Book’

	Total savings (£m)
Difference between current processing costs and cost of processing all referrals through ‘Choose and Book’ best practice	19.9
Savings from reducing the number of patients failing to attend appointments	27.8
Savings from ensuring all appointments are available to be booked online	2.5
Savings from patients rebooking their own appointments instead of trusts	0.3
Total	50.5

Note

1 Calculations use 2012-13 Reference Costs for NHS trusts.

Source: National Audit Office analysis

22 Department of Health, *NHS Informatics Final benefits statement for programmes previously managed under the National Programme for IT*, March 2013. For consistency with previous reports monetary values are reported at 2004-05 (£280.7 million) prices, discounted at a constant annual rate of 2.5 per cent. Total cost to March 2012: £356 million (2012 prices).

23 See Appendix Two for detailed data collection and calculations methods.

Communicating with patients

3.28 Patients' right to consultant-led treatment within 18 weeks are set out in *The NHS constitution*.²⁴ Patients also, however, have a responsibility to keep appointments, or cancel within reasonable time. Orthopaedic patients we spoke to seemed to be unaware of their rights and responsibilities. It is difficult for patients to understand how their actions affect the amount of time they will wait for treatment if they are not aware, for example, of the 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.

3.29 Reduced understanding can mean that hospitals struggle to meet the standards, and that resources are wasted. This underlines the importance of access policies being publicly available (paragraph 2.6) in a patient-friendly format. A concern raised by hospital staff during our visits was that patients were insufficiently aware of their rights and responsibilities. This suggests that clinical commissioning groups and trusts need to work with GP practices to see what can be done to promote greater patient awareness when being referred to hospitals.

3.30 Our census of trusts shows that the way they communicate with patients about appointments varies, although trusts share the common problem of patients not attending appointments. The census results show, for example, that:

- Seventy-four trusts send patients a letter with an appointment date and time; 42 contact patients by phone; and 33 send an invitation-to-book letter requiring patients to phone and make an appointment.
- The majority of trust appointment letters include a contact number and information on how to change and cancel appointments, while 55 trusts also use text messages to confirm appointments. Most trusts (136) send appointment reminders for outpatient appointments, but a significant minority do not.

3.31 There has been a slight overall downward trend in the overall proportion of patients who do not attend appointments (from 12 per cent in 2008-09, to 10 per cent in 2012-13), but it remains a problem for trusts. These are appointments that could have been given to other patients, and they waste money.

In 2012-13 alone:

- Overall, patients failed to turn up for a total of 5.5 million outpatient appointments. Of these, 1.6 million patients failed to turn up for first outpatient appointments – equal to 9 in every 100 made. We estimate that the cost to the NHS was up to £225 million.
- Patients failed to turn up for 109,000 admission appointments – equal to 2 in every 100 made.

²⁴ National Health Service, *The NHS constitution*, March 2013, available at: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Appendix One

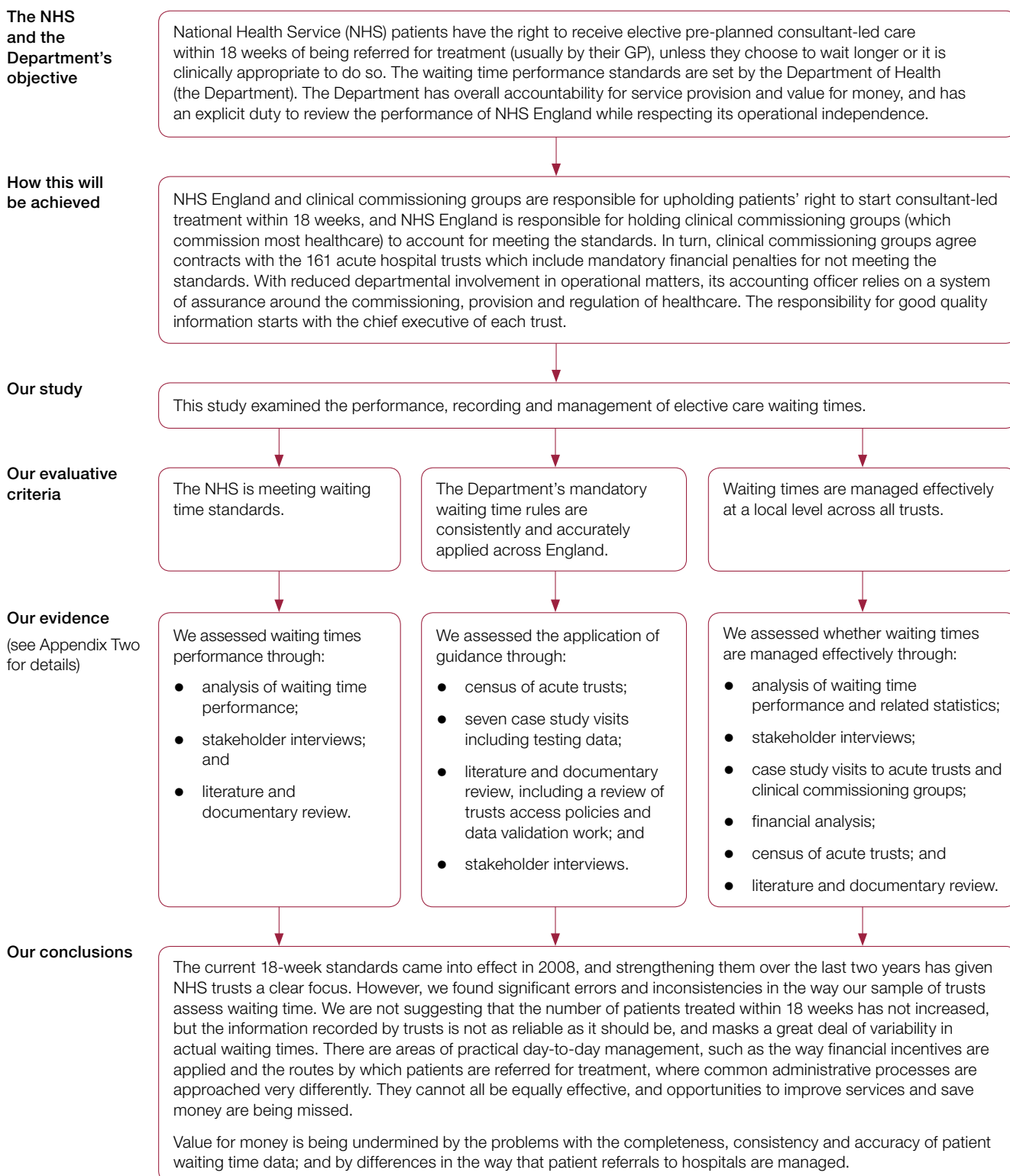
Our audit approach

1 This study examined the performance and management of elective care waiting times. The report examines:

- Performance nationally against the waiting time standards (Part One).
- How waiting times are measured and reported (Part Two).
- Management of the challenges (Part Three).

Figure 10

Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusion on the performance, recording and management of NHS elective care waiting times following our analysis of evidence collected between February and October 2013.

2 We analysed waiting time performance across England. We analysed data published by NHS England, including elective and diagnostics waiting times, NHS activity, cancelled operations, failure to attend appointments, booking and referral practices and tariffs (payments). We reviewed trends in performance against waiting time standards nationally and of the 161 NHS acute hospital trusts (trusts) in England.

3 We reviewed literature in relation to waiting times as well as drawing on previous National Audit Office work. For example, we drew on National Audit Office work on emergency admissions,²⁵ financial sustainability²⁶ and data validation.²⁷

4 We reviewed trust access policies. Access policies set out the locally agreed application of the waiting time rules, developed in partnership with local stakeholders including GPs, commissioners, patients and clinicians. Twenty-five per cent of access policies were publicly available online. We requested the remaining access policies from each trust and obtained 118 in total.

We assessed:

- whether local guidance on recording and managing patients' waiting time is compliant with national mandatory guidance; and
- the extent to which local guidance in the management of access to elective care varied.

²⁵ Comptroller and Auditor General, *Department of Health: Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013, available at: www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf

²⁶ Comptroller and Auditor General, *Department of Health: Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012, available at: www.nao.org.uk/wp-content/uploads/2012/07/1213191.pdf

²⁷ Comptroller and Auditor General, *Department of Health: Information assurance summary reports*, National Audit Office, November 2012, available at: www.nao.org.uk/wp-content/uploads/2012/11/Information_assurance_DoH.pdf

5 We conducted a web-based census of all English acute trusts achieving a 100 per cent response rate (158 trusts). This excluded three trusts that are specialist cancer hospitals. The census generated evidence on:

- how trusts book appointments, including the use of 'Choose and Book' and communication with patients;
- how trusts manage patients who fail to attend appointments;
- whether trusts receive support or incur penalties in meeting the 18-week referral-to-treatment standards;
- how trusts apply the clock start, pause and stop rules;
- how trusts record and validate waiting time data; and
- how trusts monitor and report performance against standards.

6 We conducted seven case study visits to NHS acute hospital trusts. Trusts were selected on the basis of volume of referrals, geographic spread and performance against the standards. During the visits:

- **We interviewed trust staff involved in the operational and strategic management of waiting lists.** The areas covered included: how data is validated and monitored; the challenges faced in delivering the standards; and, examples of best practice.
- **We interviewed staff from the patient advice and liaison services and complaints units.** The areas covered included: patients' satisfaction with the time they wait to see a consultant; patients' awareness of their rights and responsibilities regarding the 18-week standard; and, patient behaviour in choosing a trust and attending appointments.
- **We interviewed patients attending trauma and orthopaedic appointments at five of the seven trusts we visited (38 interviews in total).** The areas covered included: awareness of their rights and responsibilities in relation to the 18-week referral to treatment standards; experience of appointment booking; and, overall satisfaction with the care received.
- **We conducted a detailed audit of 650 trauma and orthopaedic patient case files against the waiting times data recorded on each trusts' patient administration system.** It was not a representative sample of all acute hospital trusts or of trauma and orthopaedic patients. Our aim was to establish whether there were data risks that need to be managed. We selected trauma and orthopaedics because it has the largest numbers of patients referred for treatment in 2012-13, with 1.3 million individual patient pathways. We conducted our audit in conjunction with trust staff responsible for managing and validating patient waiting time data and discussed each case and findings (including any recording errors) with them as they arose. The areas covered included: quality of data recorded in the information systems; and the correct application of clock start, stop and pause rules.

- **We interviewed staff from the main clinical commissioning group** involved in commissioning and managing contracts with our case study trusts and monitoring their waiting time performance. The areas covered included: the role clinical commissioning groups play in the management of elective care waiting lists; the role of GPs including their use of the 'Choose and Book' system and informing patients' of their rights and responsibilities; and, the use of referral management services.

7 We interviewed a range of stakeholders. For context, we interviewed officials from the Department of Health and NHS England, including staff from the performance insight team, the analytical service team and the interim management and support team. The interviews generated evidence on: the accountability structure for managing and monitoring waiting time performance; the quality of the reported figures; and, best practice in managing elective care waiting lists. We also consulted a range of other stakeholders including, for example, Monitor and the NHS Trust Development Authority²⁸ to obtain their views on:

- progress in achieving the waiting time standards across the NHS;
- the quality and robustness of the published statistics;
- the challenges facing the NHS in maintaining, and the levers available to improve, performance; and
- the impact of waiting times on access to treatment and patient choice.

8 We undertook a detailed modelling exercise to estimate the potential additional savings that the NHS could achieve if the 'Choose and Book' system was fully adopted by all referrers (for example GPs) and trusts. '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.

9 Our analysis was based upon a costing census of 158 NHS acute trusts. We achieved a response rate of 60 per cent and generated evidence on current savings from using 'Choose and Book' and the potential future savings if 'Choose and Book' was to be fully adopted.

²⁸ 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.

10 NHS England estimates that the online ‘Choose and Book’ system currently saves the NHS around £16 million annually. However, our modelling work shows that further savings of up to £51 million a year could be made if the system was used to book all hospital appointments (**Figure 11**).

Our model calculates four types of savings:

- **Best practice savings:** difference between trusts’ current processing costs and the cost of processing all referrals under ‘Choose and Book’ best practice, as identified by NHS England.
- **Failure to attend savings:** the savings from reducing failure to attend appointment rates under a trust’s current system to the rate normally seen when using ‘Choose and Book’. NHS England told us that ‘Choose and Book’ generates savings of up to £106 per missed first outpatient appointment.
- **Appointment slot savings:** current cost of processing patients who could not book an appointment because slots were unavailable on ‘Choose and Book’.
- **Rebooking savings:** current cost of rebooking appointments. Patients rebook their own appointment when using ‘Choose and Book’, so trusts do not incur any cost.

11 We estimated the cost to the NHS of patients failing to attend appointments.

We used reference cost data²⁹ agreed with the Department and NHS England to calculate the estimated maximum cost to the NHS of patients failing to attend first outpatient appointments in 2012-13. We multiplied the 1.6 million first outpatient appointments missed in 2012-13 by the associated reference cost of £141. This totals £225 million.

Figure 11

Potential future savings from increased use of ‘Choose and Book’

The NHS could make annual savings of up to £50.5 million

Saving type	Total potential savings
Best practice savings	19.9
Failure to attend savings	27.8
Appointment slot savings	2.5
Rebooking savings	0.3
Total	50.5

Note

1 Calculations use 2012-13 Reference Costs for NHS trusts.

Source: National Audit Office analysis of Outpatient Pathway Modelling Tool

29 Department of Health, *National Schedule of Reference Costs: the main schedule*, November 2013. The £141 has been calculated by averaging the lower quartile unit cost for first outpatient non-admitted face to face attendances.

12 We estimated the cost of elective, pre-planned care which is most closely aligned with the referral to treatment waiting time standards. The estimated £16 billion cost of elective care in 2012-13 financial year includes:

- **Outpatient costs of £7.3 billion** are based on 2012-13 reference cost data published by the Department. The total is for all outpatient procedures and consultant led appointments.
- **Patients admitted to hospital for treatment cost the NHS a further £8.8 billion.** Costs for elective admissions (day cases and longer admissions) are based upon 2012-13 reference cost data published by the Department.

13 Diagnostic imaging and high value drug costs have been excluded from the £16 billion given it is not possible to identify which of these costs relate to elective, consultant-led pathways.



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