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CUTTING NHS WAITING TIMES

Identifying strategies for sustainable reductions

The full report on this research can be accessed from www.kingsfund.org.uk/pdf/dhwaitingtimes.pdf. An article based on this research appeared in the *Health Service Journal*.¹

THE WAR ON WAITING

The government and the NHS have launched many initiatives to reduce waiting lists and waiting times over the last 25 years, but success has been mixed. Since 2000, as part of a more focused attempt to reduce waiting times in England, the Department of Health has set maximum waiting times targets for NHS trusts. The NHS Plan set three main in-patient targets: no one to wait longer than 18 months by March 2000, 15 months by March 2002, and six months by the end of 2005. Additional targets were set for intermediate years. The ultimate goal for the end of 2008 is for patients to be admitted for treatment within a maximum of 18 weeks from the date of referral by their GP.

The enormous effort by the NHS in England over the last five years to reduce waiting lists has produced results. Waiting times are now at an all-time low. In 1989 more than 96,000 people waited over two years for admission to hospital; today, just a handful are waiting over eight months.

While the very long waits of the 1970s and 1980s no longer exist, current targets for reductions are challenging. As waiting times fall, different strategies from those tried in the past will be needed to sustain reductions.

This research summary outlines recent King's Fund work on waiting times, supported by the Department of Health. The research set out to learn from three groups of hospitals: those that have proved able to sustain reductions in waiting times; those with variable performance; and those with a poor record on reducing waiting times.

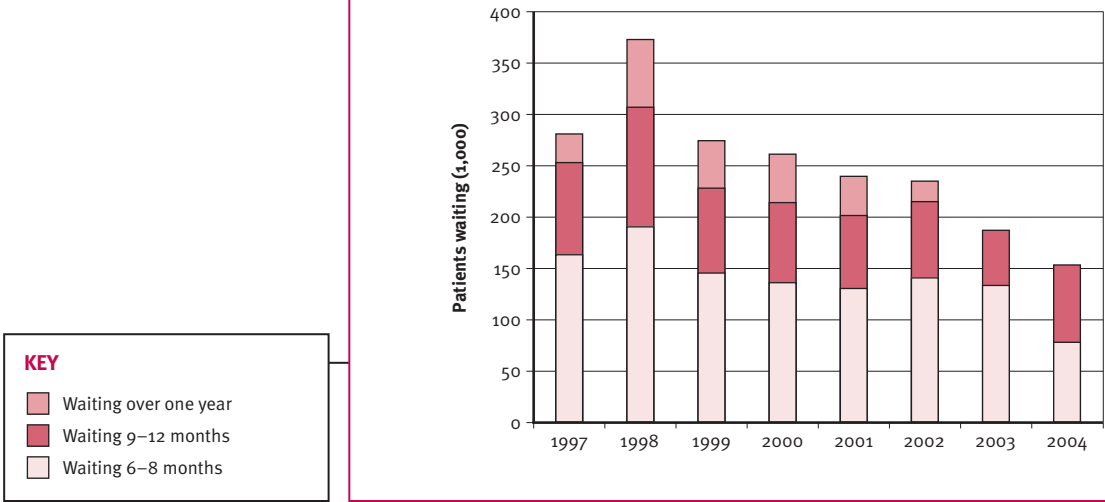
The research found that there are no easy answers. But some factors emerged as particularly important in achieving and sustaining reductions in waiting times at a local level:

- a sustained focus on the task, organisationally and through management and clinical effort
- an understanding of the nature of waiting lists and how they form part of a whole system of care
- the importance of detailed information, analysis, forecasting, monitoring and planning
- the development of appropriate capacity.

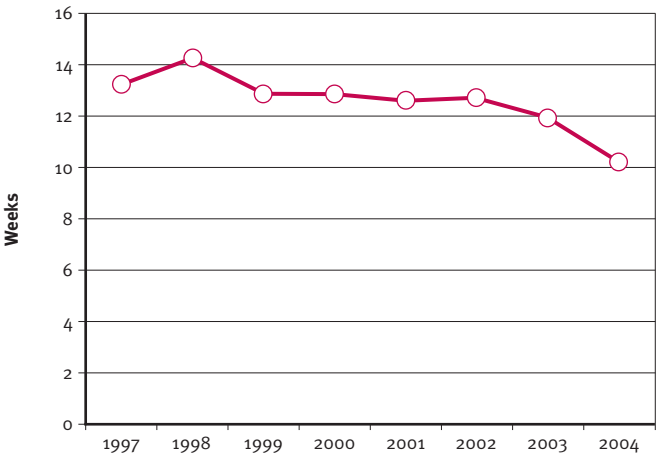
Since the NHS was founded there has been some success in reducing very long waiting times but average waiting times have changed very little.

Earlier King’s Fund studies^{2,3} describe various policies to tackle waiting lists and waiting times since the NHS was founded in 1948. The historical record shows that numbers waiting have risen over time, and that any improvements have not been sustained. There has been some success in reducing very long waiting times (see Figure 1) but average waiting times have changed very little (see Figure 2).

1 IN ENGLAND, VIRTUALLY NO PATIENT NOW WAITS OVER 12 MONTHS, AND THE NUMBER WAITING 6–8 MONTHS HAS MORE THAN HALVED SINCE 1997.



2 AVERAGE (MEDIAN) WAITING TIMES ONLY STARTED FALLING RECENTLY.



Sustainable reductions must rely on long-term policies designed to respond to a range of factors.

The studies argue that these policies were based on the incorrect view that waiting lists represented a backlog that could be removed by temporary initiatives, such as short-term increases in activity through one-off weekend working.

Sustainable reductions, as opposed to temporary or short-term reductions, must rely on long-term policies designed to respond to a range of factors. They must meet a level of demand that rises in response to technical change, demography, rising user expectations, and changes in clinical behaviour.

Our research aimed to answer the key question: what policies and strategies might prove successful in sustaining reductions in waiting times? Following analysis of extensive interviews with clinicians and managers in nine hospitals, we identified a range of factors that appeared important in separating successful from unsuccessful NHS trusts.

In general, successful trusts showed a greater understanding of the 'whole system' of health care and a better understanding of the nature of waiting lists than unsuccessful trusts. They also demonstrated the importance of sustained action over time, with a relentless focus on keeping waiting times down. Clinical ownership and involvement proved vital to any sustainable reduction strategy.

Successful trusts found that different strategies and tactics were needed to reduce waiting times compared with sustaining reductions. But even the best planning and most focused management can be upset by unexpected changes to the system, such as staff reorganisations and mergers.

Four other factors emerged as important:

- the need for accurate analysis, forecasting and planning
- focus and persistence on the waiting times problem throughout the organisation
- flexibility in capacity
- detailed examination (and understanding) of the whole hospital 'production process' to improve efficiency.

Successful trusts started to address the task of reducing waiting times in a systematic way much earlier than unsuccessful trusts, and have persevered with the task.

Research methods

Our main aim was to identify strategies adopted by those NHS trusts that appear to have been successful in reducing in-patient or day-case waiting times and sustaining these reductions.

Nine trusts took part in the research (selected on the basis of their record on waiting times), with three trusts in each of the three following categories:

- **successful** – consistently low proportions of patients waiting over six months
- **variable performance** – some success in reducing the proportion of people waiting over six months, but not sustained
- **unsuccessful** – consistently high proportions of patients waiting over six months.

The study conducted semi-structured interviews and collected trust, specialty and, where appropriate, consultant-level data, to identify patterns of activity, resources, management and clinical policies, processes, attitudes, behaviours and strategies, as well as contextual factors that characterised the three groups of trusts. This information was used to isolate factors that explain sustained waiting times performance.

Two additional issues arose from the research and were investigated further:

- possible ‘distortions’ to clinical priorities arising from strategies to meet waiting times targets
- information needed to manage the supply of elective care and to manage waiting times.

Details of research into these issues is contained in the full research report.⁴

Key findings

We identified five broad themes from the interview data, together with four more detailed factors that appeared important in separating successful from unsuccessful trusts.

Broad themes

WHOLE-SYSTEMS THINKING

Health services are complex systems comprising other complex systems: health economies, hospitals, departments, specialties. How a part of this whole system – such as in-patient waiting lists/times – operates is best understood not as a distinct issue but as a part of other systems – for example, a hospital's emergency system, GPs' referral behaviour, the out-patient department.

Whole-systems thinking aims to gain insights into the whole by understanding the links, interactions and processes between the elements that make up the system as a whole.

Understanding whole systems

Unsuccessful trusts had a poor understanding of the way that improvement in waiting time performance depended on measures taken in other parts of the hospital, and also on the wider health economy. This relative lack of understanding also applied in the past to those trusts that used to have a poor record on waiting times but had started to improve.

By contrast, successful trusts showed a reasonably good understanding of the whole system of care and realised the importance of this awareness, which was reflected in the specific measures they took to achieve government targets.

The importance of sustained action over time

Successful trusts started to address the task of reducing waiting times in a systematic way much earlier than unsuccessful trusts, and have persevered with the task.

Unsuccessful and temporarily successful trusts had, by their own admission, only started to 'get going' with waiting times reductions in the previous 18–24 months. These trusts also tended to rely on ad hoc initiatives, such as weekend working and other measures that could not be sustained indefinitely, and which often depended on a time-limited injection of funds.

Reducing versus sustaining

Strategies needed to reduce waiting times are not always the same (or of the same importance or scale) as those needed to sustain reductions. For example, the need to protect resources used for elective activity, or to manage demand – through, say, referral protocols – is less relevant once waiting times are so low that all referrals can be processed quickly.

Clinical ownership and involvement

Consultants, who are traditionally responsible for managing the workload of a hospital, are central to the task of reducing waiting times. Some individual consultants in a number of unsuccessful and temporarily successful trusts managed to maintain short (six months or under) maximum waiting times. This suggests that good or poor performance depended, to some degree, on individuals rather than the effectiveness of the hospital management as a whole.

Unsuccessful and temporarily successful trusts had only started to 'get going' with waiting times reductions in the previous 18–24 months.

Successful trusts knew that tracking individual patients through the hospital system was vital.

Pressure from above on managers to meet waiting times targets may not translate into positive action by consultants to reducing waiting times, especially where relations between management and consultants are poor, or where consultants' work objectives are not fully aligned with organisational objectives.

Repeated use of one-off initiatives meant that, in some trusts, medical and other staff expected to be paid extra for waiting-list work and relied on the additional income. This made it difficult to change staff attitudes so that they viewed waiting-time reduction (and, in the longer term, consistently short waits) as a mainstream activity that is part of everyone's daily work.

Peer discussion and comparison of performance were used to encourage poor performers to do better. However, consultants are rarely given sufficient information to judge for themselves what the problem is and how they might tackle it.

Unexpected changes

Unsurprisingly, even where there is an appreciation of the whole-systems nature of waiting times, external changes can upset even the best-laid plans.

Reorganisations (for example, the introduction of primary care trusts), mergers, wholesale changes in senior management teams, and the need to meet financial targets can all affect a trust's ability to meet its waiting times targets. Successful trusts recognised that their success could easily have been jeopardised by such issues.

Detailed factors

Analysis, forecasting, monitoring and planning

Successful and partially successful trusts (and, to a lesser extent, poorly performing trusts) agreed overwhelmingly that they needed information that was reliable, detailed, comparative and continuous (daily or even hourly). Successful trusts knew (and others were beginning to realise) that tracking individual patients through the hospital system was vital. Successful trusts could easily produce waiting times information for a named patient, while unsuccessful trusts found it hard to know whether to trust their own total waiting list figures.

In several cases, managers had collated comparative waiting times and other performance data from individual consultants. The first step in persuading consultants to change their working practices was to discuss the variations that such data revealed.

The need for information has been a strong driver for centralising waiting-list management in successful trusts. Centralisation did not mean a management takeover of the referral and operating list processes. In one case, it meant having a computerised office for admissions clerks, a standard

Planning in successful trusts meant being ahead of the game – in particular, looking further ahead than the next waiting times target, and engaging in detailed capacity planning for the subsequent target.

referral letter (to help even out workloads in out-patient clinics), and a version of 'earned autonomy' for consultants (with those who met their targets working autonomously, and others agreeing to have their lists managed and 'profiled' on their behalf, using, for example, software tools such as *CheckList*).

In trusts where waiting times were consistently low and consultant workflows already well managed, the need for centralisation was less relevant or took different forms.

Planning in successful trusts meant being ahead of the game – in particular, looking further ahead than the next waiting times target, and engaging in detailed capacity planning for the subsequent target. This meant ensuring that they had access to the right information to plan for changes in demand and consequent changes in capacity. Successful trusts also gave examples of how they not only tried to match capacity prospectively with planned workload, but also undertook retrospective reviews of what had happened, and analysed reasons for any discrepancies.

Capacity

Having the resources to increase capacity, when needed, was clearly important to trusts, while a lack of resources was seen as a virtual guarantee of failure in reducing waiting times.

Temporary increases in capacity were essential as a short-term strategy to meet targets, but were often wasteful and expensive in the long term, and prevented the same money being invested in permanent capacity. All trusts stated that ad hoc or one-off uses of additional resources had not led to sustainable reductions.

Organisational focus and persistence

Successful trusts stressed that commitment and everyday involvement from the highest level of the organisation were essential in making progress on meeting targets. All trusts emphasised the need to attract and retain experienced and skilled managerial staff – particularly directors of operations, or others with the main operational responsibility for meeting waiting times targets.

Managers used a wide variety of tactics to persuade clinicians to commit to reducing waiting times. Sharing comparative consultant-level waiting times and performance data with consultants was important, as was the argument that reducing waiting times was not just a government target but was also what patients wanted, and was best for their health.

Efficiency of the production process

Some trusts that had used short-term initiatives such as weekend working to reduce waiting lists had realised that they were unsustainable in the long run and expensive in terms of cost per case.

Successful trusts used a host of smaller measures to improve efficiency, including the careful management of beds, maximising day-case activity, ensuring the full use of theatres, and effective discharge planning.

In contrast, successful trusts had begun to scrutinise the logistics of their hospital's care processes. This involved looking at patients' routes through different interventions and attempting to simplify and shorten them; identifying bottlenecks and pinch-points for individual patients, and then using the whole-hospital system perspective to work out, for example, the best way of handling the interaction between elective and emergency flows.

Successful trusts also used a host of smaller measures to improve efficiency, including the careful management of beds, maximising day-case activity, ensuring the full use of theatres, and effective discharge planning, including investment in convalescent step-down facilities to free up beds for elective cases.

Ways forward

The King's Fund plans to publish further thinking about waiting times in 2005. The prevailing view is that, with the right set of policies finally in place and, in particular, the enormous increases in NHS funding, waiting as an issue will disappear. But our analysis on waiting times sets out a number of reasons why such confidence may be misplaced. Even if this is not the case, important issues concerning the goals of policies on waiting times, demand management and the development of more appropriate targets focusing on access to care still need to be addressed.



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