Sustaining Reductions In Waiting Times
Identifying successful strategies

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and Louise Locock

This is an interim report detailing the research methods, findings and ideas for further research for the second half of a study funded by the Department of Health Policy Directorate. The work was undertaken between June and December 2002 and was carried out by a collaboration of researchers from the King's Fund, City University, Oxford University, Birmingham University and the London School of Economics.

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There is currently a great need to achieve significant reductions in waiting times. Some trusts have been consistently successful in achieving – and in some cases, exceeding – the current inpatient waiting-time target of under six months. This success provides an opportunity to identify the contextual, managerial and operational characteristics of these trusts that explain their success, and that might be transferable to other organisations. The aim of the paper is to identify the factors that can lead to sustainable reductions in waiting times.

About the research

The main research objective for this study was to identify strategies adopted by trusts that appeared to have been successful, not only in reducing inpatient/day case waiting times, but also in sustaining the reductions achieved.

Nine trusts were invited to participate in the research, with three trusts in each of three categories:

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

Through semi-structured interviews and the collection of trust/specialty and, where appropriate, consultant-level data, the study aimed to identify patterns within the trusts in the following areas, to isolate the factors that explain sustained waiting times performance, ranging from resources to management and clinical policies, attitudes and strategies.

Findings

The five main themes of the findings were:

- understanding whole systems
- the importance of sustained action over time
- catch up, keep up
- unexpected shocks
- clinical ownership and involvement.

Understanding whole systems

Trusts with a poor record in reducing waiting times had a limited understanding of the way in which an 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 historically to those trusts that had had a poor record on waiting times but had started to improve.

The situation in 'successful' trusts revealed the converse: they had not only a reasonably good sense of the whole system of care, but also an appreciation of the importance of such an understanding, which was reflected in the specific measures they took to achieve government targets.

The importance of sustained action over time

Successful trusts started to systematically address the task of reducing waiting times much earlier than unsuccessful trusts, and had persevered with the task.

Unsuccessful and temporarily successful trusts, on the other hand, had, by their own admission, only started to 'get going' with waiting-time reductions in the 18 months to two years leading up to January 2003.

Trusts that were unsuccessful, or only temporarily successful, had tended to rely on ad hoc initiatives, such as weekend working, or other measures that could not be sustained indefinitely, and which often depended on a time-limited injection of funds.

Catch up, keep up

Factors necessary to reduce waiting times are not always the same (or of the same importance or scale) as those involved in sustaining reductions: catching up is not necessarily the same as keeping up.

The need to 'ringfence' elective activity to protect it from emergency work or manage demand – for example, through referral protocols – is less relevant once waiting times are so low that all referrals can be quickly processed. It may be that the (feedback) effect of rising demand – as GPs, for example, reduce their referral thresholds in response to lower waiting times – is a transition problem. Once GPs feel confident that they can obtain treatment quickly for their patients whenever they need it, they may feel less urgency to refer.

Unexpected shocks

Even where there is an appreciation of the whole-systems nature of the waiting-time reduction issue, external shocks can upset the best-laid plans. The most obvious example is an unexpected increases in referrals or emergency admissions, but various events can knock a trust off its waiting-time reduction course, including:

- reorganisation (such as the introduction of PCTs), for example)
- mergers

- wholesale changes in senior management teams
- the need to meet financial targets.

Clinical ownership and involvement

Consultants are central to the job of reducing waiting times. They are traditionally responsible for managing the workload of a hospital, and hence for its waiting lists and times.

In a number of trusts that were unsuccessful or that were only temporarily successful overall, certain consultants nevertheless maintained short maximum waiting times. This suggests that good or bad performance depended to some degree on individuals rather than the effectiveness of the hospital management as a whole.

Four more detailed factors

The more detailed factors were grouped into four categories:

- analysis, forecasting and planning
- organisational focus and persistence
- capacity
- efficiency of the production process.

Analysis, forecasting and planning

There was an overwhelming consensus of the need for information that was reliable, detailed, comparative and continuous (daily or even hourly). This was apparent both in successful and in temporarily or partially successful trusts, and less so from poorly performing trusts.

In short, successful trusts would not find it hard to 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.

For successful trusts, planning meant being ahead of the game – in particular, looking further ahead than the next waiting-times milestone looming ahead – and engaging in detailed capacity-planning for the subsequent target (or, in one case, already looking beyond the six-month target).

Organisational focus and persistence

Commitment and everyday involvement from the very top of the organisation was seen as absolutely necessary in making progress on what all participants noted were very tough targets.

Organisational focus and persistence includes 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. Managerial tactics to persuade clinicians to own and internalise a commitment to reducing waiting times varied almost as much as the number of consultants. However, the use of comparative consultant-level waiting times and performance data (shared with consultants) was helpful, as were the arguments that reducing waiting times was not just a government target but was what patients wanted, and that it was good for their health.

Capacity

Having the resources to increase capacity (where it was identified as necessary) was seen as very important – with insufficient resources being seen almost as a guarantee of failure.

All trusts stated that previous ad hoc or one-off uses of such resources did not lead to sustainable reductions. Use of weekend working by trust staff, and ad hoc use of the private sector, were not seen by many trusts as long-term solutions to capacity constraints, even though they anticipated continuing to use those strategies for the foreseeable future.

There was a clear view that a temporary increase in capacity was essential as a short-term strategy to meet targets but that it was often wasteful and expensive, and prevented the same money being invested in permanent capacity.

Efficiency of the production process

Some trusts had made use of short-term initiatives but had come to accept that they could not be sustained in the long run, that they were expensive in terms of cost per case.

In contrast, successful trusts had begun to look in detail at the logistics of their hospitals' care processes. This might involve some degree of ringfencing, or scheduling of elective care over the course of the year in order to minimise the potential conflict between the needs of the elective and the emergency subsystems.

Within these broad strategies, successful trusts employed a host of smaller measures bearing on efficiency:

- tight bed management
- maximising day case activity
- ensuring full utilisation of theatres
- effective discharge planning, including possible investment in step-down facilities where the local private sector was inadequate.

Conclusions and recommendations

There appear to be four particularly important factors that account for variations in achieving and sustaining reductions in waiting times:

- a sustained focus on the task
- an understanding of the nature of waiting lists
- detailed information, analysis, forecasting, monitoring and planning
- development of appropriate capacity.

A sustained focus on the task

A clear and unambiguous message from successful trusts (and from those beginning to turn the corner on reducing waiting times) was that there are two absolute necessities:

- to focus the organisation on reducing waiting times
- to sustain management and clinical effort and priorities on the task.

The energy and detailed day-to-day management should not be underestimated, right down to the tracking of individual patients through the hospital system. Bringing about this sustained focus requires leadership and management that is skilled and strong, but sensitive, at all levels of the trust.

An understanding of the nature of waiting lists

Successful trusts seem to understand that waiting lists are not simply a backlog problem, but the manifestation of a more complicated, dynamic flow through interconnected parts of a whole system of care. This has enabled them to break down the problem, and to tackle those particular factors which, given their own circumstances, have given rise to long waiting times.

Detailed information, analysis, forecasting, monitoring and planning

Detailed, consistent and accurate time-series and cross-sectional information on waiting lists and times, as well as on key resources, provided successful trusts with a means to:

- analyse and understand their waiting lists
- see them in context with other trusts
- allow them to monitor progress and outcomes of changes in service delivery
- plan future changes in services to meet targets, and the resources required to provide them.

Development of appropriate capacity

Lack of capacity can ultimately undermine efforts to reduce waiting times. It was seen as essential to develop appropriate capacity – not just through increasing the totality of resources, but also through more efficient use of resources and managing the demand on those resources.

Introduction

Why this study?

The Labour Government came to office in 1997 pledging to reduce the numbers waiting for inpatient (including day-case) elective care by 100,000 (King's Fund, 2002). While committed to maintaining this reduction, with the publication of the NHS Plan (Department of Health 2000), the emphasis shifted from the numbers waiting to the length of time they waited. This was coupled with an increase in the scope of targets to cover specific priority groups, such as cancer patients, as well as outpatients and access to primary care (*see* Table 1, *below*).

Table 1: Waiting list targets (and milestones) announced since 1997

Target	Target date
Cut inpatient waiting lists by 100,000 from March 1997 level	end of 1997 Parliament
No one with suspected breast cancer to wait more than two weeks for outpatient appointment following urgent GP referral	April 2000
Number of outpatients waiting more than 13 weeks to be cut to 334,000	March 2000
No one to wait more than four weeks for treatment for testicular cancer, children's cancers and leukaemia following an urgent GP referral	December 2001
No one to wait more than four weeks for treatment for breast cancer following diagnosis	December 2001
No one with suspected cancer to wait more than two weeks for their first outpatient appointment for patients referred urgently	December 2000
Reduce number of over 12 month inpatient waiters	March 2002
No one to wait more than 15 months for inpatient treatment	March 2002
No one to wait more than 12 months for inpatient treatment	March 2003
No one to wait more than nine months for inpatient treatment	March 2004
No one to wait more than six months for inpatient treatment	March 2005
No one to wait more than three months for inpatient treatment (and an average wait of 1.5 months)	end 2008
No one to wait more than 26 weeks for an outpatient appointment	March 2002
Reduce the number of outpatients waiting more than 13 weeks	March 2002
No one to wait more than 13 weeks for an outpatient appointment	March 2005
Maintain the commitment to cut waiting lists by 100,000 from March 1997 level	Ongoing
All patients attending A&E to wait four hours or less from arrival to admission, transfer or discharge	March 2004
Patients to wait no more than 24 hrs for an appointment with a primary health care professional and no more than 48 hrs for a GP appointment	March 2004

King's Fund (2003)

To achieve these targets, the Government has taken a range of measures, including:

- significantly increasing NHS funding
- earmarking funds for waiting list or waiting times initiatives
- introducing patient choice in treatment location, facilitating faster treatment
- encouraging the use of private-sector capacity
- introducing a provider-reimbursement system, with incentives to increase activity in key high-wait health care resource groups
- disseminating best practice through organisations such as the Modernisation Agency.

While most of these initiatives and actions are designed to increase activity, the Government accepts that simply doing more of the same is only part of the solution to meeting the waiting times targets it has set. As the recent consultation document, *Reforming the NHS: Financial flows, introducing payment by results*, argues:

> *International and previous domestic experience suggests that increasing activity alone may not be enough to improve access and reduce waiting times. PCTs and trusts need to manage referral and admission thresholds and the priorities for admitting patients.*
>
> Department of Health (2002), p 4

As has been noted elsewhere (Harrison and New, 2000), the persistent existence of wide variations in numbers and time spent waiting (between trusts, between specialities, and within specialities) does not depend solely on variations in levels of activity and throughput.

Nevertheless, the existence of significant variations in waiting times across the NHS (variations that are too great be explained by differences in need) in itself suggests that the current pattern of waiting times can be changed. There are also some lessons from history on this point. In 1989, around 96,000 people waited longer than two years for admission to hospital (more than 10 per cent of the total list). However, through a combination of targeted funding and list validation, within two years this had been reduced to zero. Similarly, at the beginning of the 1980s, around one-third of all those waiting for admission had waited more than a year, but by the mid-1990s this too had been reduced substantially (to around 2–3 per cent of the total list).

There are, therefore, reasons to be optimistic about the prospects for further reductions in waiting times. However, such optimism needs to be tempered. While the very long waits of the 1970s and 1980s appear literally to be an historical feature of the NHS, current targets for reductions represent an increasingly difficult task. This is partly due to the number of patients currently waiting that are exceeding the target figures, compared with the number previously enduring very long waits.

For example, across England (and on a hospital basis), in June 2002, there were more than 250,000 patients waiting longer than six months, and more than 530,000 waiting longer than three months, compared with 96,000 waiting longer than two years at the end of the 1980s. Moreover, while these latter waits were reduced substantially, through relatively simple processes such as validation, the gains from such tactics have probably now been exhausted. So pushing waiting times ever-lower represents a task of increasing magnitude, and one that requires different strategies to those employed in the past.

Aims

There is currently a great need to achieve significant further reductions in waiting times. Some trusts have been consistently successful in achieving – and, in some cases, exceeding – these targets. This success provides an opportunity to identify the contextual, managerial and operational characteristics of these trusts that explain their success, and that might be transferable to other organisations. The aim of this study is to isolate the factors that can lead to sustainable reductions in waiting times.

Conceptual background

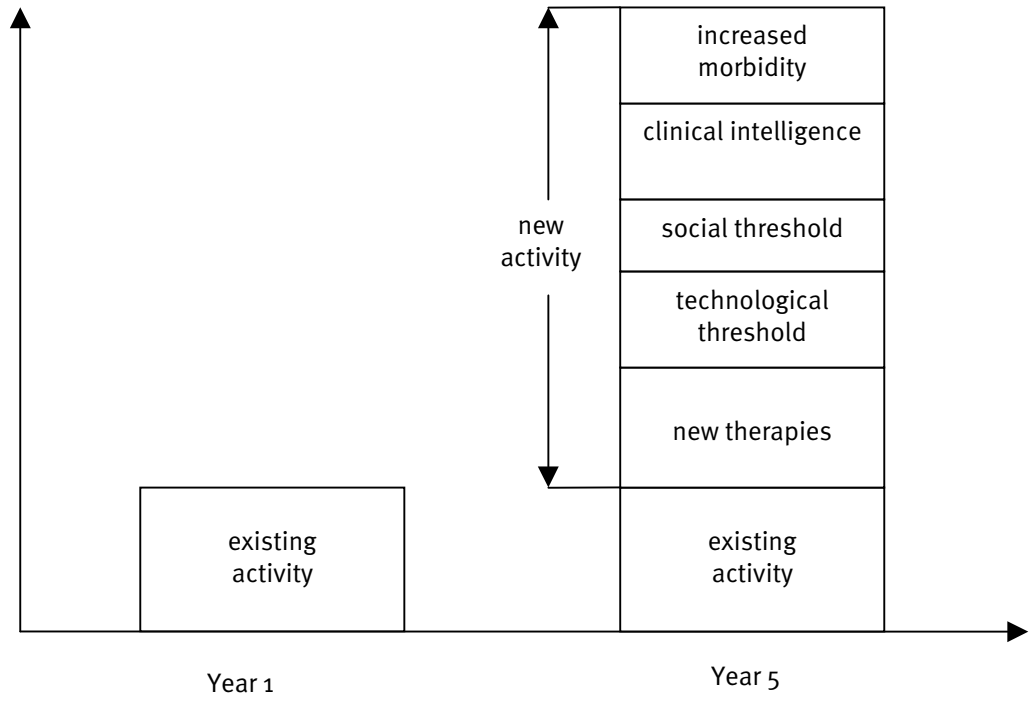
This section serves several purposes. First, it sets out the authors' view of how the elective care system works, highlighting the concept of whole systems and providing the conceptual model underpinning their analysis of the determinants of waiting lists and times. Second, it provides a critique of existing studies that have sought to explain variations in waiting times performance. The material in this section provides the rationale for the study design and specific hypotheses described in the following section.

How the elective care system works

Earlier King's Fund studies by Harrison and New (2000) and Hamblin, Harrison and Boyle (1998) described the various initiatives to tackle waiting lists and waiting times taken since the foundation of the NHS. The historical record showed that the number waiting had risen over time, and that any improvements had been short lived. There had been some success in reducing very long waiting times but, on average, waiting times had changed very little.

Harrison and New concluded that these initiatives had been based on an incorrect view of how waiting lists worked. They argued that these policies had been based on the view that waiting lists represented a backlog, which could be removed by *ad hoc* and temporary initiatives (such as those which characterised policymaking for much of the post-war period). Accordingly, they went on to set out an alternative view summarised in the Figure 1. A fuller discussion is provided in Harrison and New (2000).

Figure 1: Factors that may lead to new elective activity



Harrison, New (2003)

This view holds that sustainable reductions must rest on the indefinite continuation of policies designed to respond to the range of forces set out in Figure 1 – that is, to meet a level of demand that rises in response to:

- technical change
- demography
- rising user expectations
- changes in clinical behaviour.

Although it is impossible to put precise figures on the impact of these forces, at a minimum and in the absence of other measures, they require some sustained increase in activity.

In addition, if reductions in waiting times are achieved (for example, by short-term bursts of additional activity), this in itself may lead to responses that tend to obviate the initial success. That is to say, the demand for elective care will to some degree depend on waiting times themselves. So if waiting times are reduced, this reduction may lead to more people seeking treatment, and to changes in clinical behaviour that allow more people into the system for treatment. Such increases in demand may come from a range of sources:

- Improved access times in the NHS may encourage some of those using private facilities, particularly self-payers to remain in the public system.
- Those who might otherwise have treated themselves or sought help from other therapists may decide to go ahead with hospital treatment.
- GPs may be more ready to refer.
- Hospital consultants may modify their treatment thresholds.
- A successful hospital may attract referrals from less successful ones.

So achieving sustainable reductions requires strategies that deal with long-term trends while also responding to the initial impact of those strategies in terms of more people seeking, or being advised to seek, treatment.

The whole system

Before considering the range of strategies that might improve waiting times, it is necessary to consider the context within which the elective care system operates. In recent years, the term ‘whole system’ has come into common use, often without careful definition. In this report it is used in two ways:

- the whole-hospital system
- the hospital system.

The whole-hospital system refers to the local health economy in which the hospital is located, including private-sector and social-care facilities. This includes policies that might bear on the demand for care, as well as its provision.

The hospital system refers to a system within the hospital itself. Elective care is part of a wider system providing a number of other services of which the most important is emergency care. In most UK hospitals, staff, beds, operating theatres and diagnostic equipment are, to a greater or lesser degree, shared facilities. It follows that the capacity

of the hospital to provide elective care depends on the extent to which these shared resources are required for other uses.

The central characteristics of emergency care are:

- variability
- unpredictability
- immediacy.

Recent work from the King's Fund (Dixon and Damiani 2002) on the factors giving rise to variations in demand suggests that the pattern of demand over the winter period can be anticipated with some confidence. Moreover, hospitals working with the Meteorological Office (2001) have found that variations in demand that are linked to the weather can also be forecast for a short period ahead. However, some residual uncertainty remains arising from random variation in the day-to-day workload.

In the past, the elective care system, particularly its bed stock, has provided the main 'cushion', or reserve capacity, for emergency care. With shorter lengths of stay and increasing day-case treatment, this cushion has been reduced, with the result that cancellations of elective activity have become more common.

Accordingly, improvements in elective care capacity depend to some degree on the way in which the links between the elective and emergency sub-systems are managed. In addition, investment in facilities not forming part of the elective care system itself may be critical in allowing it to function more effectively and efficiently: for example, by increasing the number of beds available for dealing with emergency patients.

The wider health economy

The wider health economy is also critical to the performance of the elective care system. This is manifested in several ways:

- Some elements of the elective workload (for example, simple procedures or consultations in primary care) may be transferred to other parts of the wider health system.
- Through the referral process, the wider health economy is the main source of demand for the hospital elective system.
- The efficiency with which the wider health economy accepts patients back into the community is a key determinant of the efficiency of the whole-hospital system (as measured, for example, by average length of stay).
- Fundamental redesign of patient access requires contributions from all parts of the health economy.

So the elective care system itself is complex, and how it works is also determined by the wider system in which it operates. Any strategies to improve its performance must take into account three factors:

- the way the elective care system responds to changes in waiting times
- the way in which other demands on the hospital system are dealt with
- the whole system within which the hospital operates.

What counts as a reduction in waiting times?

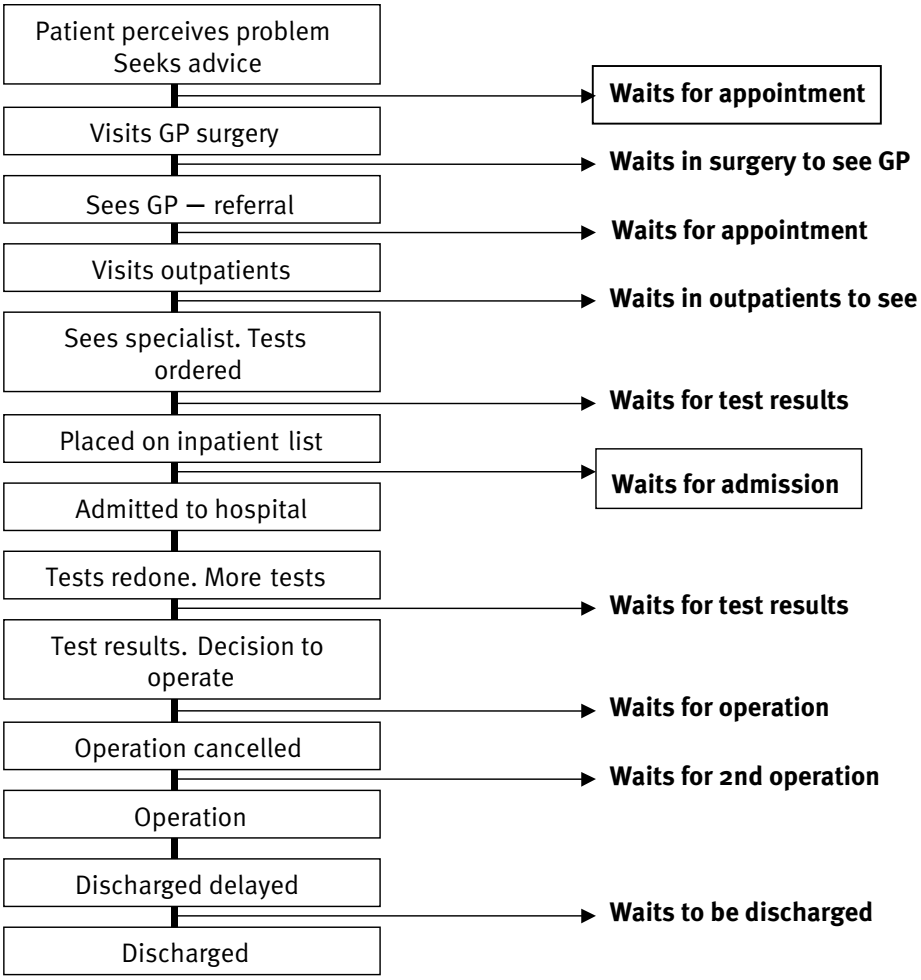
At present, the total time a patient spends waiting for treatment – in other words, waiting at any stage of the care pathway (*see* Figure 1) – is not captured within the reporting systems required by the Department of Health. Waiting times at some of the stages on the pathway are usually short, but there may, for example, be long unrecorded waits between the first outpatient wait and the decision to admit, particularly if the patient is referred from one consultant to another, and if initial diagnostic tests are inconclusive.

Department of Health targets for first outpatient appointments and patients treated from the waiting list only capture two of the stages at which patients may have to wait for treatment (*see* Figure 2). Accordingly, practical considerations dictate that only these partial measures could be included in this paper. But for this, and other reasons outlined in 'Sources of apparent improvements – confounding factors' (p 13), apparent improvements gleaned from the data held by trusts may disguise the situation on the ground. Examining the relationship between the apparent and real situation is outside the scope of this report.

Even within the available data, however, the measurement of a reduction is not straightforward. The trusts that are included in the study were selected using Department of Health performance indicators for numbers of patients waiting for admission. These focus on those who have experienced a long wait. However, eliminating such long waiting times does not necessarily mean that the average waiting time for all patients is reduced. In fact, even though waiting times of longer than 12 months have been almost eliminated in recent months, average waiting times have risen. In effect, recent policies (in a similar way to those adopted in the 1980s) have compressed the shape of the list.

For many trusts, there is scope for more of this kind of compression. However, reductions cannot be achieved by this route indefinitely unless they are accompanied by an increase in activity, which reduces waiting periods across the board. Accordingly, policies that may have been successful up to now may be less so in future years.

Figure 2: Waiting for care: an example of a patient's actual experience



NB: Officially recorded waiting times are shown in boxes.

King's Fund (2003)

Sources of apparent improvements – confounding factors

There are a number of other reasons why improvements that do not reflect a real improvement in the underlying situation may be recorded:

- **Hospitals may 'clean up' their waiting lists** by checking with all patients whether they still wish to be treated. If this task is neglected, and then suddenly attended to over a short period of time, the number waiting will fall and those still in the queue may be treated more quickly. But once the main gains from such procedures have been achieved, they cannot be repeated on the same scale. Here there is a genuine backlog effect.

- **Changes in priorities within the list** may lead to reductions in some categories of waits. Current policies targeting long waiting times may have the effect, where successful, of squeezing up the queue, but the gains to those who have been waiting a long time are at the expense of those nearer the top of the queue. As a result, the average wait may change very little.

- **Recording of waiting times** may not be complete. Current recording systems take into account only two periods of waiting:

  – the period of waiting for the first outpatient appointment
  – the period between the decision to treat until the time of treatment.

  It appears, however, that waiting outside these two periods may have been increasing (for example, for a subsequent outpatient appointment as a result of cross-referral). Furthermore, there is also evidence of unrecorded and lengthy queues for certain procedures.

- **There may be changes in recording** – at one extreme, such changes represent deliberate 'fiddling' with the data (*see* NAO 2002 and Auditor General for Scotland 2002). However, there are other, legitimate, reasons for recording changes that may impact on the recorded figures. The dividing line between elective activity relevant to waiting lists and other hospital activity is not absolutely clear. In particular:

  – where some elective activity takes place as a planned series of admissions at regular intervals and those waiting for planned care are not counted as waiting. Some procedures overlap these two categories
  – where the distinction between diagnosis and treatment is not absolute, and some procedures appear on both sides of the line
  – where some activity may be carried out and recorded as day surgery or as outpatient or clinic activity, or not recorded at all.

Because these boundaries are porous and because recording systems are incomplete, there is scope for improvement to appear without any change in the underlying situation.

Critique of previous studies

As far as we are aware, the present study is the first of its type. However, other studies have considered part of the ground covered here. While some (for example, Locock 2001) have provided some important indications of the multiple factors involved in achieving significant and sustained reductions in waiting times, it is hard to draw general conclusions from studies of single trusts.

First, investigating a single trust can provide only a partial analysis. It describes the characteristics of that trust that are associated with its waiting times performance. To identify which of the factors explain its performance, it is necessary to compare it with less successful trusts.

Second, relying on qualitative analysis identifies the factors that key actors in the system believe to explain waiting times performance. In practice, these views may misinterpret the importance of various factors, including the practices of those interviewed. They may be biased or indeed, wrong.

For example, certain managerial and operational practices may be a feature of successful trusts, but they will not necessarily be unique to them. Superior performance may be explained by differences in resources, and a reduction in waiting times might be explained to a greater degree by the proportion of resources allocated to elective surgery

and a greater use of non-NHS capacity. This would suggest both that it is important for qualitative analysis to be comparative between successful and unsuccessful trusts, and for qualitative analysis to be accompanied by quantitative analysis of key variables. This is, in large part, what has been attempted in this paper.

Other studies have attempted to identify significant differences between trusts with short and long waiting times in a range of characteristics, such as:

- measurable demand
- resource provision
- resource use.

For example, in a study of ENT waiting times, Harley, Jayes and Yates (1999) found that trusts with long waiting times tended:

- to make less use of day surgery
- to have a higher proportion of emergency admissions
- to have higher levels of new outpatient DNAs ('did not attends')
- to have much lower levels of productivity per senior surgeon than short-wait trusts.

A problem with this sort of pair-wise comparison (rather than a multi-factorial approach) is, as the authors note, that while statistically significant differences can be identified in a set of characteristics between short-and long-wait trusts, there is considerable overlap in the distributions for all such characteristics. For example, some long-wait trusts have a higher proportion of day case work than some short-wait trusts, yet still have longer waits.

A more recent study of access to ear, nose and throat (ENT) services (Audit Commission, 2002) also attempted to identify pair-wise correlations between whether a trust had short or long waiting times in the following three areas:

- measures of demand (for example, GP written referrals per 1,000 population)
- capacity (for example, whole-time equivalent consultants per 100,000 population)
- efficiency (for example, total outpatients seen per whole-time equivalent consultant).

No significant relationships were found. Nevertheless, as the Audit Commission noted, this does not mean that such factors are irrelevant. The problem here, again, is the limitation of the methodology in unravelling what is a complex interaction between variables such as demand and capacity, and waiting times.

Martin *et al* (2003) have attempted to identify which factors are associated with long waiting periods (longer than six months), taking the four main waiting list specialities of general surgery, ENT, ophthalmology, and trauma and orthopaedics.

They examined possible correlations between long waits and various explanatory variables covering the following factors:

- NHS capacity
- independent sector activity
- need for health care
- other characteristics of hospitals, such as teaching status and star rating.

In general, they found no significant correlation between long waiting times and any measure of capacity or private-sector activity. There appeared to be some positive correlation with the number of anaesthetists, and an inverse correlation with measures of population deprivation (more deprived areas had fewer patients waiting longer than six months). However, this study suffered from a number of limitations (noted by the authors), and it appears that the dependent variable was simply the number waiting for longer than six months (rather than, say, the proportion waiting longer than six months), which would give rise to size effects.

About the study

Research objective

The main research objective for the study was to identify strategies adopted by those trusts that appeared to have been successful, not only in reducing inpatient/day case waiting times, but in sustaining the reductions achieved.

Research design, methods and expectations

Given the limited success of previous studies (both quantitative and qualitative) to identify unambiguously factors associated with short waiting times, and hence provide clear policy recommendations to help reduce observed variations in waiting times, this study opted (in its first stage) for an in-depth qualitative analysis of short and long-wait trusts.

This is not to say that the approaches of the previous studies were without merit – it would seem extremely unlikely that observed differences in waiting times are completely unassociated with any other observed variations in a range of demand, capacity or performance measures. However, it may be that a more sophisticated, multivariate, statistical technique would be more fruitful, or, indeed, that whatever differences in key trust characteristics that are observed should be considered important whether or not such differences are statistically significant.

This paper builds and expands on existing research – particularly Locock's qualitative study of Dorset (Locock 2001) – together with collection and analysis of a range of data concerning the performance of trusts, and other information that was considered important.

Given the need for comparative analysis of factors linked to waiting times performance (as noted in What counts as a reduction in waiting times?, p 17) the project identified ten trusts to take part. One (successful) trust declined due to work pressures. The study then included nine trusts, with three trusts in each of three categories:

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

Further details of the way trusts were selected can be found in Appendix 3. Figure 3 shows historical trends in the proportion of patients waiting longer than six months for admission to hospital for each trust in the study, where:

- trusts A, B and C were in the 'successful' category
- trusts D, E and F were of 'variable performance'
- trusts G, H and I were in the 'unsuccessful' group.

Trust A eliminated long waiting periods by 1995 and has managed to more or less maintain that position since then. Trusts B and C have sustained progress, albeit with some setbacks. Trusts D, E and F have made progress but this has been reversed or stalled. In the remaining three trusts performance has worsened.

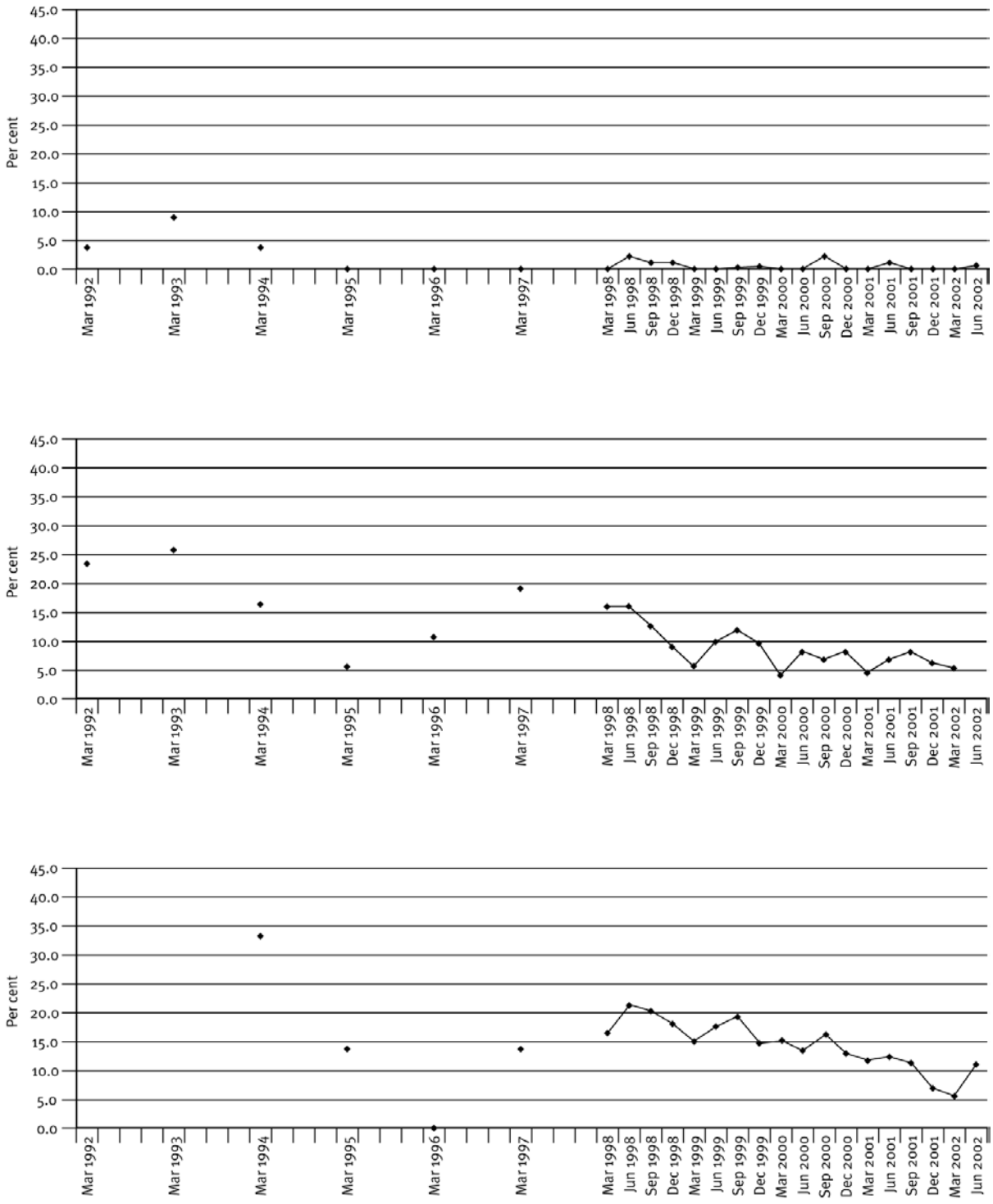
Figures 4 and 5 show distributions of waiting times using information from the Department of Health's Hospital Episode System (HES). These are not strictly comparable with Figure 3, which are based on Korner returns (official statistical returns made in the NHS). For example, according to Figure 4, all trusts had at least 10 per cent per cent of patients waiting longer than six months for treatment. Figure 4 shows the cumulative distributions of waiting times for the combined waiting lists of four key specialities (ENT, general surgery, ophthalmology, and trauma and orthopaedics) for the sample of trusts. Figure 5 provides profiles of the waiting lists for each trust in the sample for each of these specialities separately. For each specialty, the lines corresponding to each trust show the four quartiles of the distribution of waiting times (the shaded area is the middle 50 per cent range).

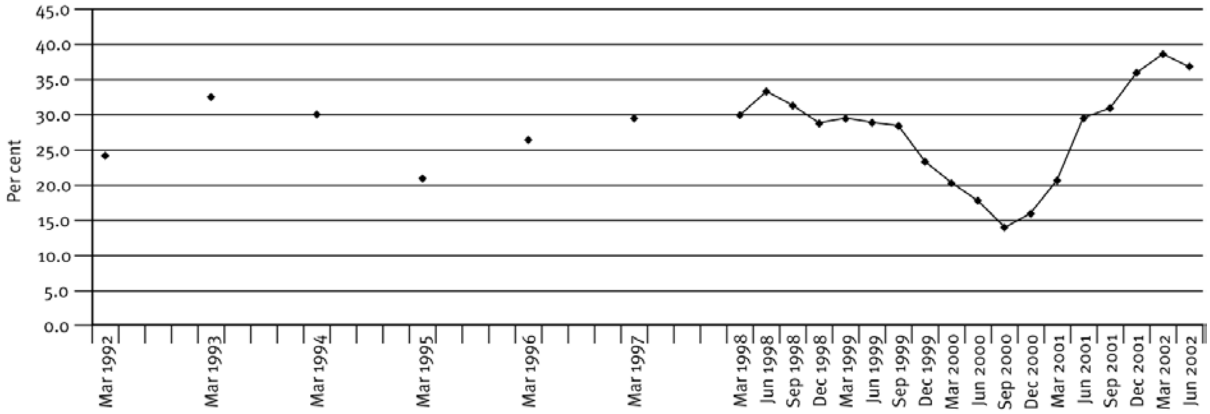
The general patterns in profiles and distributions reflect the groups we have chosen for our sample. Figure 4 shows that the 'successful' trusts tend to have more 'rectangular' cumulative waiting-time distributions – in other words, they have a greater proportion of patients waiting only a short period of time and the numbers waiting in the 'tail' are consequently lower. Similarly, Figure 5 shows that the 'successful' trusts have comparatively compact distributions for key waiting list specialities. Those in the 'unsuccessful' group tend to have the opposite distribution characteristics. Both figures reveal some overlap between those in the 'variable performance' group and the other groups, particularly when individual specialities are considered.

Through semi-structured interviews (*see* Appendix 5) and the collection of trust/specialty and (where appropriate) consultant-level data, the study aimed to identify patterns within the trusts in the following areas, to isolate the factors that explain sustained waiting time performance:

- activity
- resources
- management and clinical policies
- processes
- attitudes
- behaviours
- strategies
- contextual factors.

Figure 3: Proportion of patients (of total trust list) waiting longer than six months

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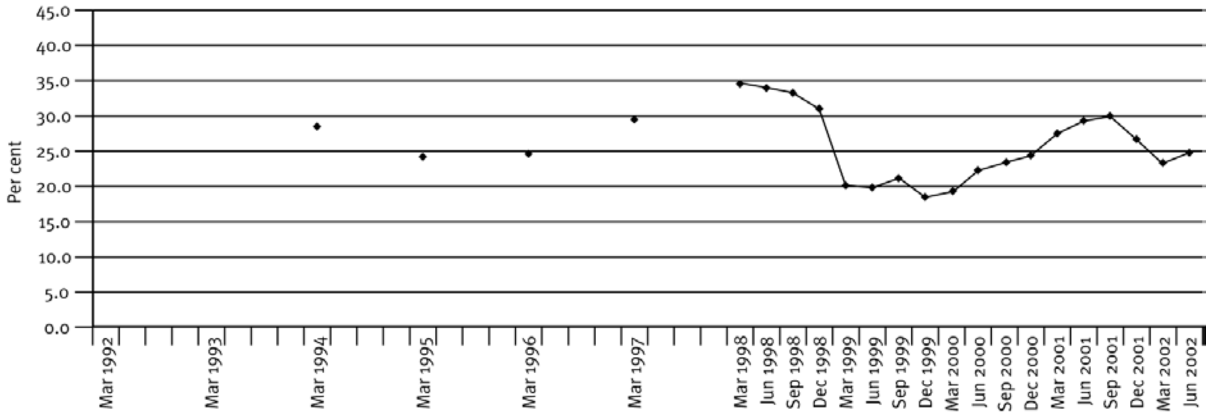
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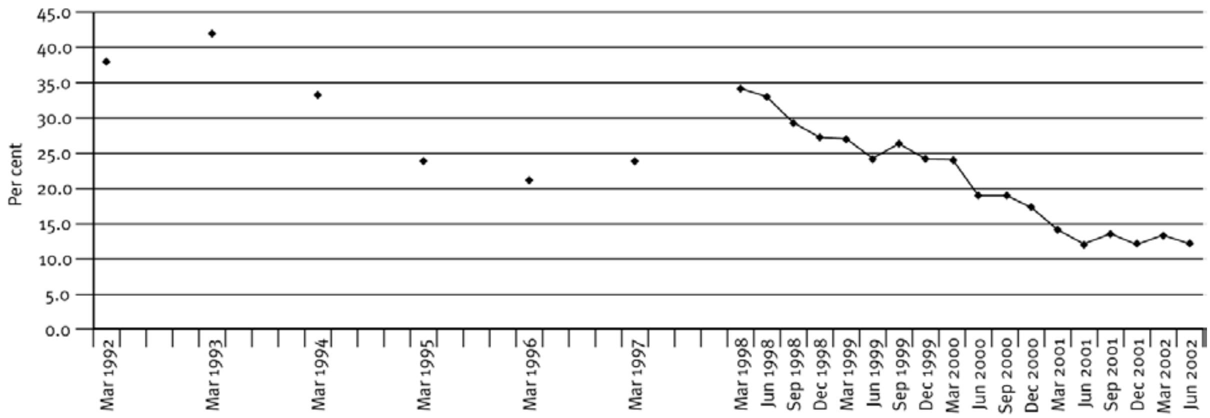
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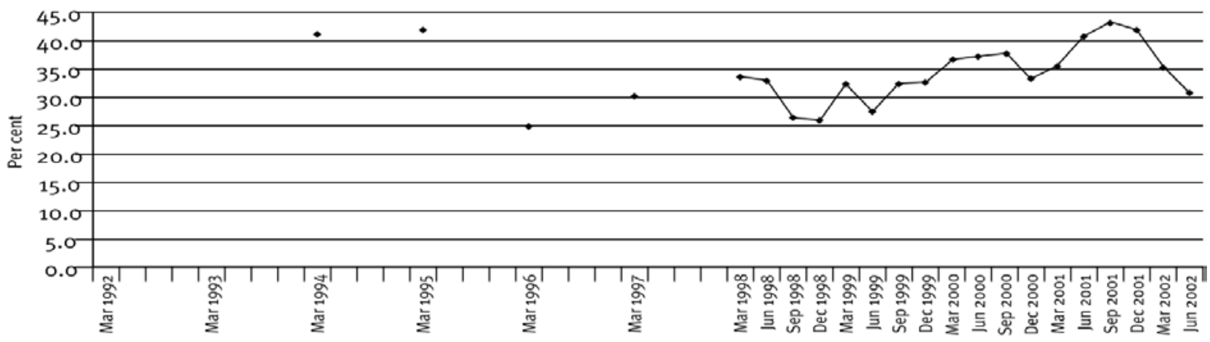
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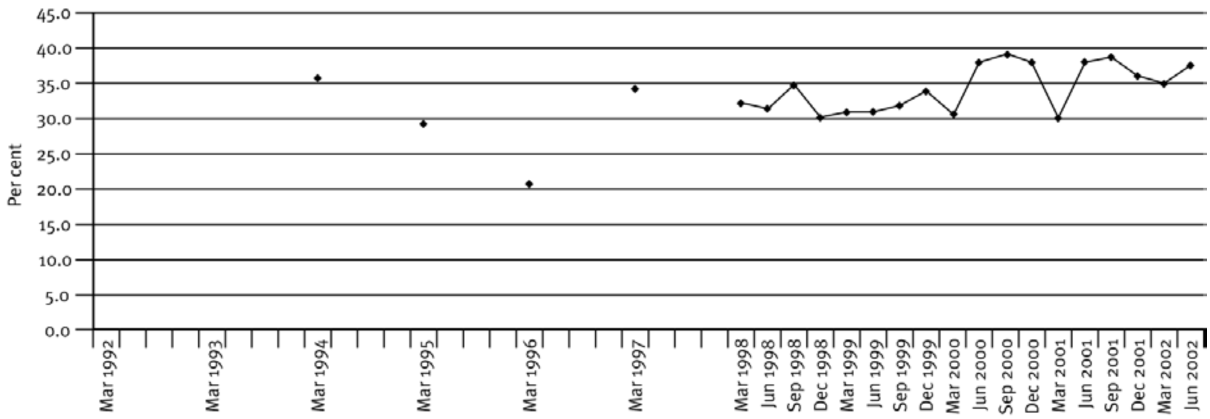
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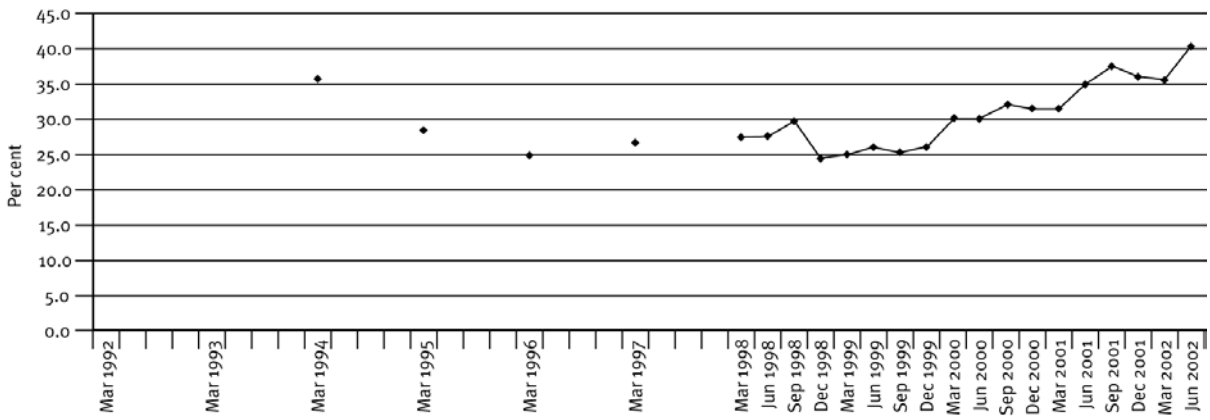
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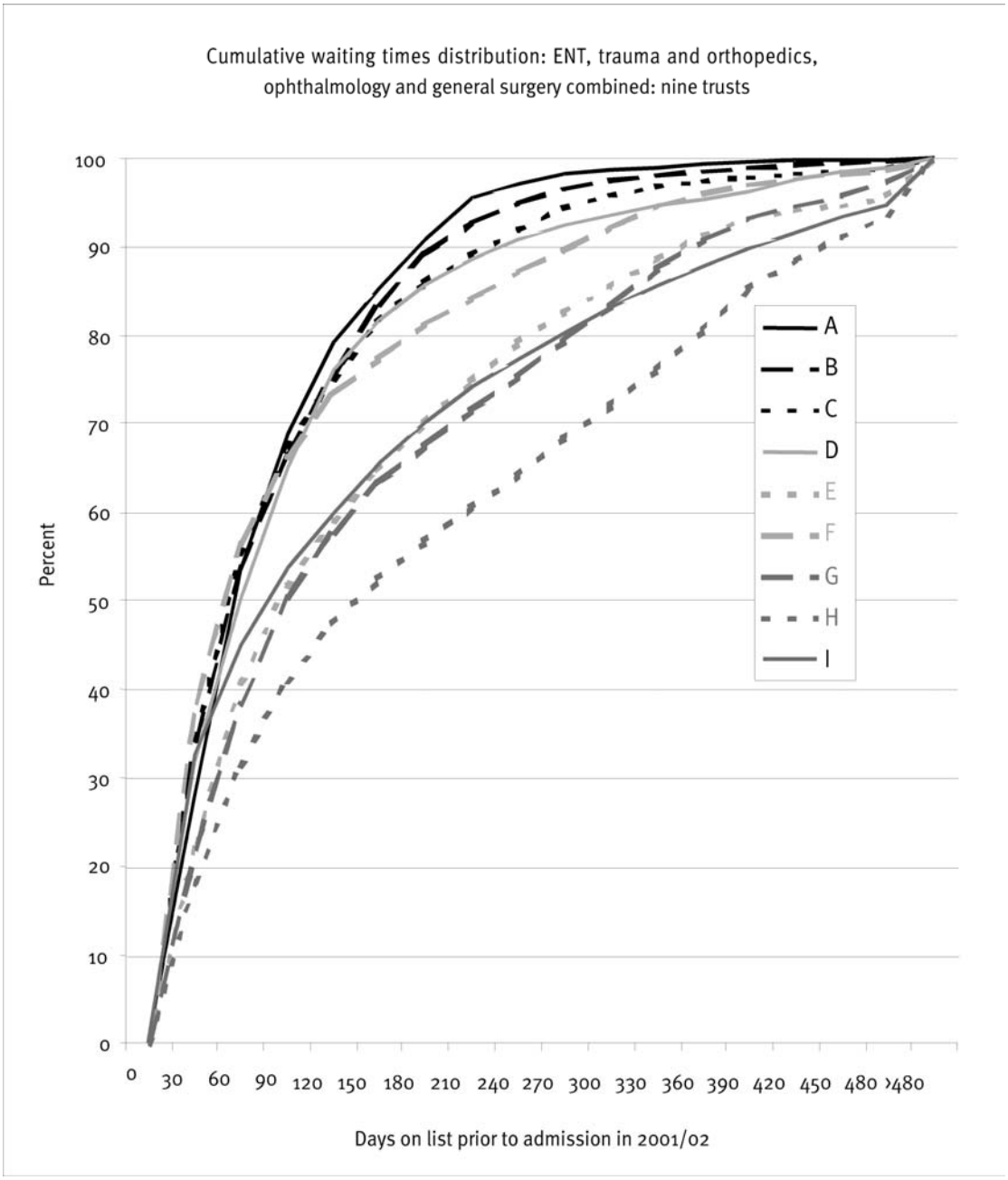
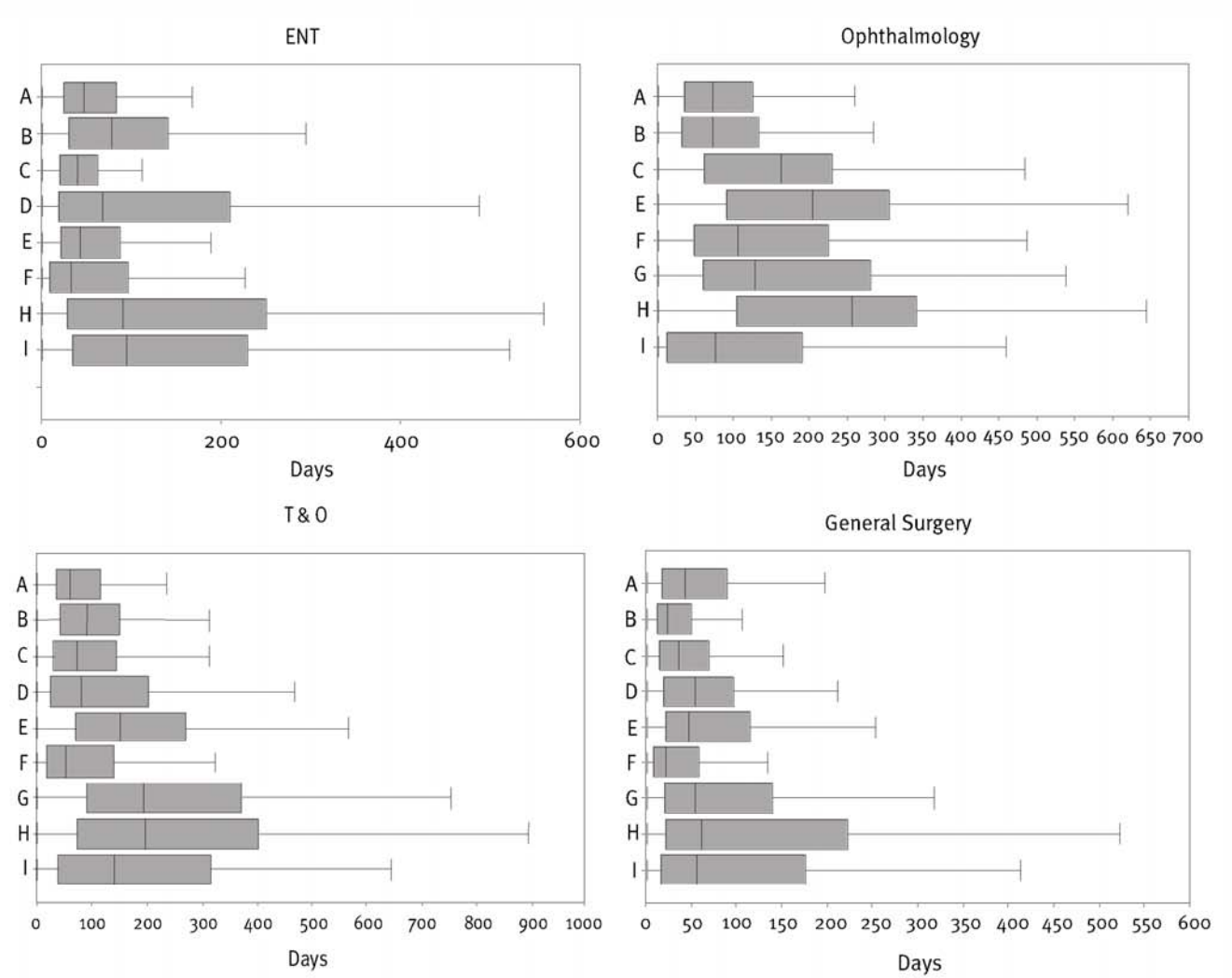
Figure 4: Cumulative distribution of waiting times for sample trusts



King's Fund (2003)

Figure 5: Waiting times profiles for patients admitted during 2000/01



These distributions show the shortest and longest waits for each trust (excluding outliers defined as 1.5 to 3 box lengths from the lower or upper edge of the box). The shaded box shows the middle 50% interquartile range and the line in the box shows the median waiting time.

Unsuccessful trusts tend to have greater ranges in distributions of their waiting lists (although median waits tend not to follow a particular pattern across the three groups of trusts).

NB: Trust G had no ENT and trust D no ophthalmology service.

King's Fund (2003)

Methods

The original research proposal set out a two-stage approach, involving:

Stage 1

- **collecting historic quantitative data** at hospital/consultant level, where appropriate, for each trust for the main waiting list specialities
- **interviewing key players** (consultants, managers and GPs) to explore attitudes to waiting lists in general, perceived reasons for success/failure, private work, and so on. The interviews were semi-structured: the interview protocol is in Appendix 5.
- **analysing quantitative and qualitative data** to draw out possible common explanations/indicators for success/failure.

Stage 2

The focus for the second stage of the work is dependent on the findings and hypotheses that emerge from the first stage. In addition, findings/hypotheses from Stage 1 will be disseminated to poorly performing trusts. Waiting times and other indicators of success in the trusts would then be monitored, and further selected interviews undertaken, to track any changes in attitudes, behaviours, and so on. (As agreed, activity for Stage 2 is to be discussed at the end of Stage 1. Suggestions, in the light of Stage 1 findings, are detailed at the end of this report.)

This interim report we focuses on the first stage and, in particular, the findings from interviews conducted in each trust.

Expectations

The data in Figures 3, 4 and 5 (pp 19, 22 and 23) show there are wide variations in performance between trusts. It is assumed that these differences are genuine, and not the result of recording differences. The previous discussion suggests that these differences may be attributed to a wide range of factors, and gives rise to a range of different explanatory expectations for each group of trusts.

Given the findings from previous studies (*see* Critique of previous studies, p 14), there was little expectation that from the small sample of trusts it would be possible to identify unambiguously a unique set of factors that wholly explained the variations in waiting times performance between the trusts. However, there was an expectation of being able, through the interviews with key managers and clinicians, and appropriate data analysis, of being able to identify broadly the right conditions for reducing waiting times and sustaining the reduction achieved. It was also anticipated that it would be possible to highlight particular examples of successful waiting-time reduction strategies.

Findings

In total, 45 senior managers and clinicians were interviewed in the study's sample of nine trusts, including, in some cases, managers from local PCTs. In all trusts, interviewees included the chief executive, medical director and director of operations and/or the senior manager with responsibility for targets in waiting lists or waiting times. In some trusts, additional interviews were carried out with other staff on the recommendation of other interviewees. Interviews in individual trusts/PCTs were carried out by the same primary interviewer for that site, with all interviews conducted using a common interview schedule (*see* Appendix 5). Interviews were carried out between August and December 2002.

Interviews were conducted using a mixture of face-to-face and telephone interviews. These were recorded, and summary transcriptions of the interview completed by the interviewers. At least one visit was undertaken for each site. These then formed the basis for a meeting of all researchers that drew together themes and explanations for the waiting times experience of each trust.

The initial summarising of reasons for and against successful reduction in, and sustaining of reduction in, waiting times produced around 50 separate factors. These ranged from the desirability of centralising (within a trust) the management of waiting lists to the need for organisational stability. In order to make sense of the many factors that emerged from the interviews, first drawn some overall issues/themes are drawn out and then more detailed factors are grouped under four headings.

Under each heading we look at the sorts of factors perceived by the interviewees as important reasons for their particular trust's success or lack of success in sustaining waiting-time reductions. Then the way these factors come into play in successful, less successful and unsuccessful trusts are set out. Finally, we examine some particular examples of actions or strategies that trusts have pursued in order to tackle their waiting list problems.

The reasons some trusts appear more successful than others at reducing waiting times are linked to a whole range of factors. What has bedevilled previous research (and this paper) is not so much the difficulty of identifying the many factors involved, but rather understanding the relative importance of individual factors, and their interaction with each other.

The main reason for this difficulty stems from the sheer variety of circumstances and history for individual trusts. In the literature bearing on the relative performance of similar institutions, there is now considerable consensus that the context in which these organisations operate is an important determinant of success or failure, and that each context comprises a unique constellation of factors and relationships (Pettigrew *et al* 1992, Pawson and Tilley 1997). This means that we cannot expect to uncover a clear prescription for success that can be universally applied.

So it may be very difficult to unambiguously identify for any individual trust the necessary conditions for being successful and the sufficient conditions as well. However, the research has also identified a number of common themes and factors, as well as an indication of a cluster of factors that appear to be associated with sustaining reductions in waiting times. These findings have arisen through

iterative discussion of the interview data by members of the research team, as well as through analysis of the quantitative data. These generalisable factors will be of varying importance in different sites over time, but it can be concluded that trusts should consider their relevance for their own current situation. Some NHS-wide recommendations can also be identified, and these are discussed in 'Discussion and policy implications' (p 37).

None of these factors on their own would be a sufficient condition for success. Sustained reduction in waiting times requires action across a number of fronts, and those trusts that are more successful are more likely to have several of these factors in place. In less successful trusts, some gaps can be identified that are undermining their efforts, or have done so in the recent past. Single initiatives are unlikely to prove to be a long-term solution, for the reasons outlined in 'How the elective care system works' (p 9).

The framework adopted here to present the findings seeks to move from a broad and overarching level (the need to understand hospitals as whole systems) through to more detailed factors (such as implementing a system for accurately reporting waiting times on a weekly basis to senior managers and clinicians). However, given the multi-factorial nature of the issue, there will inevitably be some overlap between sections. Where possible, the factors identified are illustrated with anonymous examples taken from the case study sites.

Understanding whole systems

One very broad generalisation that emerged from the interviews – and, in particular, from the research group's discussion of interview findings. This was that trusts with a poor record in reducing waiting times had a poor understanding of the way in which improvements 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 historically to those trusts that used to have a poor record on waiting times but had started to improve. Further, interviews with key personnel in the three successful trusts revealed the converse. Not only did they have a reasonably good sense of the whole system of care, but they also had an appreciation of the importance of such an understanding, and this was reflected in the specific measures they took to achieve government targets.

From an understanding of whole systems – not just in theory, but in practice – flows a whole range of managerial and clinical actions and behaviours which, when brought to bear on a particular objective (in this case, reducing and sustaining reductions in waiting times) tend to lead to sustained success, rather than failure or temporary success. For example, an appreciation of whole-systems working leads quite naturally to a focus on patient care pathways. Similarly, the need to take a view of activity across the whole-hospital system leads to prioritisation of investment in timely, system-wide information systems. Other actions and behaviours are noted below under individual factors and strategies.

Similarly, recognition of the whole system including the wider health economy may suggest measures bearing on the demand for hospital services, such as referral protocols, or measures such as investment in intermediate care which allow the hospital itself to operate more effectively.

The importance of sustained action over time

A second general observation is that 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.

Case study 1: The long-term approach

This site demonstrated the importance of a long-term approach, with more than a decade's history of concerted effort to reduce waiting times (with part of this time clearly spent learning what works and what does not). Interviewees in this site agreed that their success was the result of dogged persistence; reducing waiting times had been an unwavering and explicit priority.

However, success could not be solely ascribed to the length of time spent on this issue, and interviewees noted that a consistent emphasis on improving waiting times was backed up by an effective system of incentives to recognise good performance. At the same time, where problems were identified, managers and clinicians alike could expect very close monitoring and strong pressure to improve. Nonetheless, there was unanimity that other trusts could not be expected to produce similar results overnight.

On the other hand, unsuccessful and temporarily successful trusts have, by their own admission, only really started to 'get going' with waiting-time reductions in the past 18–24 months. It was not that they had previously ignored the issue, but it was only relatively recently that they had come to place it consistently in the top three of their organisational priorities (very possibly as a result of the emphasis on waiting times targets by ministers and the Department of Health), and thus devoted the necessary management energies to the task (which, in order to be successful, need to be considerable). In other words, until recently they had implicitly adopted the 'backlog' model of waiting-list behaviour, relying on ad hoc initiatives, such as weekend working and other measures that could not be sustained indefinitely, and which often depended on time-limited injection of funds.

Catch up, keep up

A third general finding was the observation that the factors needed to reduce waiting times are not always the same (or of the same importance or scale) as those involved in sustaining reductions. In other words, catching up is not necessarily the same as keeping up. As noted above, short-term measures are inadequate as they fail to deal with long-term demand trends alongside the impact of shorter waiting times on the demand for treatment. The authors also believe that where measures are sustained, the nature of the problem facing trusts changes.

There appears to be a clear demarcation between those trusts that have achieved consistently low waiting times and those still aiming to do so. Once waiting times have been kept low for some time, many of the problems faced by other trusts no longer apply. For example, the need to 'ringfence' elective activity or manage demand through, say, referral protocols is less relevant once waiting times are so low that all referrals can be quickly processed. It may be that the (feedback) effect of rising demand is a

transition problem (for example, as GPs reduce their referral thresholds in response to lower waiting times). Once GPs feel confident that they can obtain treatment quickly for their patients whenever they need it, they may feel less urgency to refer.

As Gravelle, Smith and Xavier (2002) have shown, demand and supply of elective care does appear to be responsive to the 'pseudo price signal' of waiting times. The demand response appears not to be directly related to the waiting times signal, but varies according to the length of time for which a trust manages to keep waiting times low. That is, when waiting lists or times are long, GPs may raise their referral threshold (or in some sense, under-refer), but as waiting lists or times start to reduce, GPs may then lower their referral threshold (or in some sense, over-refer). However, given sustained reductions in waiting lists and times, GPs may once again re-evaluate their referral threshold and settle on a rate somewhere between under- and over-referral.

The degree to which potential private patients switch back to the NHS may also be a transitional issue. Some interviewees argued that some patients would always choose to go private, thereby reducing the volume of switching. Nonetheless, there will be some patients who do choose to use the NHS instead of private, particularly if they are self-payers.

Trusts with very low waiting times may face their own, rather different, problems. One senior doctor noted that patients may become anxious that they are being treated so quickly and believe their condition to be much more serious than they are being told to warrant such speedy intervention. At an organisational level, trusts may find it more difficult to keep theatres working at full capacity. If there is a late cancellation, it can be difficult to find a patient willing to come in at short notice to fill the slot as their planned date is so close that there is little advantage for them in coming in earlier, with all the disruption that implies.

One trust manager reported working 'up to the last minute' to try to fill slots, and commented:

> *'We've now got people's heads around the fact that if you miss that slot you might as well stand there ripping up £5 notes.'*

As a result, it is arguable that as performance improves, the need for good information systems and active management measures becomes even greater, rather than diminishing.

Unexpected shocks

Furthermore, and perhaps unsurprisingly, even where there is an appreciation of the whole-systems nature of the waiting-time reduction issue, external shocks can upset even the best-laid plans. The most obvious example is where there are unexpected increases in referrals or in emergency admissions.

In some cases, disruption can be caused by policy changes imposed by the Government. For example, some trusts reported that the creation of primary care trusts had had an adverse effect because plans that had been agreed previously were now being subjected to renewed scrutiny by new PCTs that were understandably unwilling to commit resources to a development they had not helped to plan. This might include

plans to invest in new admission and observation facilities, to reduce inpatient admissions, or step-down facilities to improve the efficiency of discharge arrangements.

Straight trade-offs between objectives can have a similar effect. For example, some of the sample trusts for example, experienced significant difficulties in achieving financial balance. In some cases, these problems were sufficiently severe to potentially jeopardise their waiting-times reduction efforts – at least for a time – as management energy and financial resources were diverted elsewhere.

Case study: Changing pattern of activity

This is an example of a trust that had been making good progress in reducing waiting times but which then faced a dramatically worsening position. The trust ascribed this partly to an underlying shortfall in elective bed capacity compared to other similar trusts. However, it also identified a sudden change in emergency admissions that had knocked it off-course.

During 2001/02, average length of stay rose unexpectedly by one day, which severely disrupted planned elective activity. The reasons for the change in stay were not entirely clear, but were assumed to be partly related to an ageing population with more complex inpatient needs. Despite strong joint working with social services to improve the range of facilities available, delayed discharges remained a problem, and it was noted that the total stock of nursing home beds locally was declining as homeowners decided to close in the face of rising costs to meet legal standards.

This case illustrates how knock-on consequences affect the whole system. When length of stay went up and the hospital was struggling to find beds for incoming emergencies, care became more fragmented as medical patients had to be placed as outliers in surgical wards. This, in turn, meant that discharge was handled less efficiently, leading to further pressure on capacity. At the time of interview, the trust had responded by opening a new observation unit and a step-down unit, and was hopeful that waiting times would be brought under control again, despite an increase in emergency admissions of 14 per cent in the first few months of 2002/03.

Clinical ownership and involvement

A final broad observation is that those who are traditionally responsible for managing the workload of a hospital (and hence waiting lists and times) – the consultants – are also central to the job of reducing waiting times. This was borne out by the fact that in a number of unsuccessful and temporarily successful trusts, there were nevertheless certain consultants who maintained short maximum waiting times (of six months or under).

This suggests that good or bad performance depended to some degree on individuals rather than the effectiveness of the hospital management as a whole. However, in some cases, individual good performance may have been achieved at the expense of others. For example, keeping waiting times short by the simple expedient of not accepting any referrals that would increase maximum waits (given resources available to carry out the

work) almost certainly led to an impact on the waiting lists of consultant colleagues, or might result in waiting being exported back to general practice.

At this point, it is worth noting the potential conflict between the unit traditionally responsible for waiting times (the consultant) and the unit used to measure progress towards the nationally-set target on waiting times (the trust). Pressure from above on those nominally in charge of trusts, (in other words, managers) to meet waiting times targets can be dissipated at local level, especially where relations between management and consultants are poor, or where consultants' objectives with regard to their work are not fully aligned with the objectives of the organisation for which they work.

The question of consultants' motivation and behaviour was discussed during interviews, and the question of financial incentives cannot be ignored. Many interviewees – including medical directors – commented that repeated use of one-off initiatives had created a culture in which medical and some other staff expected to be paid extra for doing waiting list work, and had come to rely on the additional income. This was proving an obstacle in trying to change people's thinking to see waiting time reduction (and, in the longer term, consistently short waiting times, in line with central targets) as a mainstream activity that was part of everyone's normal daily work.

To expect consultants in addition to work towards a situation that would reduce patients' incentives to seek private care may be doubly difficult. This is not to criticise consultants, but simply to note that human reactions to change are inevitably conditioned by concerns about income and livelihood, and that this needs to be taken into account in planning a new solution.

Several interviewees commented on the potential to provide alternative incentives, such as investing in new facilities or equipment, or indeed, in additional consultants. In some cases, this might be seen as further undermining the potential to maintain levels of private income by increasing competition for patients, although there were several reports that consultants were very keen for new colleagues to be recruited, to reduce their own workloads and improve the experience and quality of care for patients.

This brings us to the broader motivation of the concern of consultants for their patients. One or two interviewees argued that waiting was a good thing (perhaps as a deterrent or perhaps to allow time to see if an operation was really necessary). However, most interviewees agreed that consultants did not like having to make patients wait, and that they fully appreciated that reducing waiting times was in their patients' interest. As one medical director commented, 'No doctor likes having to ring up a patient and cancel their operation – it feels terrible.'

There was considerable agreement that appealing to clinicians' motivation to do the best for their patients was more productive than top-down instruction. Interviewees suggested that peer discussion and comparison were ways of encouraging poor performers to do better. They also suggested that part of the problem was that consultants are rarely given sufficient information to judge for themselves what the problem is, and how they might tackle it.

Inevitably, there will be some doctors who are not fully engaged in the process. A medical director in one of the most successful sites commented that some doctors locally were still influenced by the vision of the doctor as:

> *a lone soldier, [with] everyone else… scuttling round supporting them… Some people are still making the journey, and we do have some dyed-in-the-wool dinosaurs…We have a number who are not entirely signed up.*

Others at this trust also commented that the organisation's culture was not especially innovative or radical but, even so, high levels of investment in new capacity and consistent focus on the issue had resulted in progress. Nonetheless, the medical director argued:

> *If you involve them in planning – and clinicians have been involved here – they're more likely to be brought in from the cold.*

Concerns were sometimes expressed about the possible distortion of other clinical priorities as a result of the attention and effort given to waiting-time reduction, even though the reasons for this prioritisation were understood and felt to be worthwhile. However, this is another example in which sites with consistently low waiting times showed clear differences. In these sites, there was no need to delay care for some individual patients in order to keep up with waiting time targets for less urgent cases, as everyone could be seen within a reasonable time. Any concerns about the priority given to waiting times in these sites were predominantly in terms of other service developments that might have been foregone as a result of expenditure on waiting times.

In some cases, performance would fall back once an initiative was exhausted, and this had led to the feeling that sustained progress was impossible. However some trusts noted the positive impetus to achieving waiting-time reductions through 'quick wins'. For example one trust successfully reduced very long waits in ophthalmology clinics through a combination of extra staff and managing to even out workloads across three clinics, and this demonstrated that the longstanding problem could be tackled, and helped foster a 'can-do' attitude.

Specific factors and strategies

To provide some structure to the many factors associated with good and poor performance on waiting times that emerged from the interviews, they have been grouped into four categories:

- analysis, forecasting and planning
- organisational focus and persistence
- capacity
- efficiency of production processes.

The first two categories are, in a sense, activities that support and inform various strategies identified within the last two categories. This simplified classification does not allow for overlaps between the issues and factors identified. Also, the sites that had been most successful usually ascribed their success to a wide array of activities. Each of these may be fairly small in itself, but taken together they have a much greater impact. It is not possible to list each tactic that has been used in all the sites, and in any case each site will need to find the range of actions that best suits its needs, given its own history, its pattern of relationships and its physical and organisational structure. The important point is that the availability of high-quality information to aid planning alongside strong

organisational focus and leadership provides fertile conditions for such tactics to be devised and implemented.

Analysis, forecasting and planning

There was an overwhelming consensus of the need for information that was reliable, detailed, comparative and continuous (daily, or even hourly). This was apparent both in successful and temporarily or partially successful trusts, and less so in poorly performing trusts. In short, successful trusts would not find it hard to produce waiting times information for a named patient, while unsuccessful trusts find it hard to know whether to trust their own total waiting list figures. During site visits, it was immediately apparent that senior managers in successful sites had a precise grasp of their current situation and could lay hands on the information necessary to answer questions about waiting times without any difficulty.

Two aspects relating to information are worth highlighting. First, successful trusts know (and others are beginning to realise) that tracking individual patients through the hospital system is vital. While some managers bemoaned the amount of detailed information they were receiving and the time it took to ensure that individual patients were chased up for appointments, they also intimated that for the individual in the trust with overall responsibility for waiting lists, this change in the nature of the job was probably permanent.

Secondly, the interviews threw up a number of examples where managers had collated comparative waiting times and other performance data at the level of individual consultants. Discussing the variations revealed by this data reveals had been the first step in persuading consultants to change their working practices (*see also* 'Clinical ownership and involvement', p 29).

The need for information has also been a strong driver for centralising waiting list management in successful trusts. In fact, all trusts recognise the need for far greater control over the flows and movements of patients into, around and out of their hospitals. 'Centralisation' does not mean a complete management takeover of the referral and operating list processes. In one case, for example, among other things, it meant having:

- one computerised, office for admissions clerks
- a standard 'Dear Doctor' referral letter to help even out outpatient clinic workloads
- 'earned autonomy' for consultants, with those managing their lists in a way that met targets being autonomous, and others agreeing to have their lists managed and 'profiled' – using software such as CheckList.

In another case, it meant having a co-ordinated waiting list 'team', headed by an executive director, which met weekly (or more often, if needed) to review waiting times and match capacity and anticipated demand. Again, in trusts where waiting times are consistently low and consultant workflows are already well-managed, the need for centralisation may be less relevant or take different forms.

For the successful trusts, planning meant being ahead of the game – in particular, looking further ahead than the next waiting-times milestone looming ahead – and engaging in detailed capacity-planning for the subsequent target (or, in one case, already looking beyond the six month target). To do this, successful trusts used capacity-planning models and ensured 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 their planned workload, but also how they undertook retrospective reviews of what had actually happened, and analysed reasons for any discrepancies.

Case study: Modelling elective activity

One trust used a computer-based model to work out what levels of activity it must achieve to reduce waiting times, and what resources it required to achieve the projected levels. The projection depended on a series of assumptions about:

- referrals
- the conversion rate (the proportion where the decision to admit is made)
- the rate of day-case activity and average length of stay for inpatients (both benchmarked against good practice).

It also involved estimating in broad terms the numbers of 'simple' and more complicated procedures, with the latter requiring more resources than the former. Actual activity levels could then be monitored against the project to check whether the trust was in line to achieve its target reductions.

It is hard to overstate the importance of accurate, frequent, reliable information. Even if trusts are conscious of the need to understand the whole system, including the wider health economy, they are unable to turn this into a reality if they do not have the information to underpin the good intentions.

Organisational focus and persistence

All the successful trusts in the study noted the importance of making waiting-time reduction an absolutely clear, unwavering priority. This in turn called for strong leadership – both managerial and clinical. Commitment and everyday involvement from the very top of the organisation was seen as absolutely necessary in making progress on what all noted were very tough targets. Good leadership also engenders commitment from other staff in the organisation, provides the channel to keep everyone continually focused on the task at hand and – almost by definition – implies good working relationships between managers and clinical staff, and good communication generally throughout the organisation. Not everyone may agree with the priority afforded to waiting-time reduction, even if they think it is understandable, but everyone understands that it is an organisational priority, and acts on it.

Organisational priorities may be upset by mergers, reorganisations and changes in senior personnel, which can deflect attention from focusing on waiting-time reduction. On the other hand, two of the three most successful case-study sites had faced a threat of merger and had found that this acted as a stimulus to radically improving their performance. This echoes the evidence on re-engineering, which suggests that such radical solutions are more likely to work when organisations face crisis.

Organisational focus and persistence incorporates 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.

A number of managers in successful and temporarily successful trusts emphasised the need to persuade clinicians to own and internalise a commitment to reducing waiting times. Managerial tactics in this area were almost as varied as the number of consultants. However, the use of comparative consultant-level waiting times and performance data (shared with consultants) was helpful, as were the argument that reducing waiting times was not just a government target but was what patients wanted, and that it was good for their health.

Capacity

Having the resources to increase capacity (where it was identified as necessary) was seen as very important, with insufficient resources being seen as almost a guarantee of failure. One of the successful trusts had, in the past, been very able at attracting funding for waiting time and waiting list initiatives, and this had undoubtedly helped it achieve substantial reductions in waiting times. Another had benefited from a new hospital build with extra capacity planned in, even if the capacity may not keep up with the future rising demand.

On the other hand, there was a realisation among all trusts that previous ad hoc or one-off uses of such resources did not lead to sustainable reductions. Use of weekend working by trust staff and ad hoc use of the private sector were not seen by many trusts as long-term solutions to capacity constraints, even though they anticipated continuing to use those strategies for the foreseeable future. There was a clear view that a temporary increase in capacity was essential as a short-term strategy to meet targets, but that it was often wasteful and expensive, and prevented the same money being invested in permanent capacity. The latter would probably yield greater efficiency in the long run, but the Government would need either to invest in both in parallel for an interim period, or to forego some short-term reductions in waiting times.

Case study: The whole-system perspective

This site was aware of the importance of taking a whole-system perspective. One example was its participation in the early development of intermediate care teams, which it described as a key factor in obtaining improvements in waiting times. The trust developed intermediate care in a joint venture with social services. Teams, led by one of the trust's consultants, delivered treatments to patients in their own homes. This required good co-ordination and took 12–18 months to get going effectively. The PCT had now taken on responsibility for this, with leadership continuing to come from the trust. Good intermediate care meant that the trust has fewer blocked beds and hence was getting more out of existing bed capacity.

However, even permanent increases in capacity may not solve the problem if demand patterns continued to shift. As noted in the case study 'Changing pattern of activity' (p 29), another site had invested in a new admission and observation unit and a new step-down unit, seeking to tackle both incoming demand and delayed discharge, but the latest waiting time figures suggested that this had not helped as much as the trust had hoped. In other words, additional capacity is not always sufficient.

Many trusts mentioned the difficulties they were experiencing in meet the requirements for financial balance, and the trade-offs they thought they would have to make with initiatives designed to reduce waiting times (for example, finding funding for a mobile day-case unit to help reduce waiting times when budgets were under pressure).

Efficiency of the production process

We have noted that some less successful trusts had made use of short-term initiatives and had come to accept that these could not be sustained in the long run and were, in any case, expensive in terms of cost-per-case. In contrast, the more successful trusts had begun to look in detail at the logistics of their hospitals' care processes. This involved:

- looking at the patient pathway
- attempting to simplify and shorten it
- identifying bottlenecks and pinch-points for the individual pathway
- using the whole-hospital system perspective, to work out, for example the best way of handling the interaction between elective and emergency flows.

This might involve some degree of ringfencing, and or scheduling of elective care over the course of the year so as to minimise the potential conflict between the needs of the elective and the emergency subsystems.

Within these broad strategies are a host of smaller measures, bearing on efficiency-tight bed management, maximising day-case activity and ensuring full utilisation of theatres and effective discharge planning, including possibly investment in step-down facilities where the local private sector was inadequate. As noted at the start of this section, overall success is likely to depend on many small actions rather than one or two magic bullets, but these are likely to be more effective if they are carried out within a whole-systems framework rather than in a piecemeal way.

Ultimately, efficiency is a matter of relating the resources available to the cost of deploying them and the resulting output. The researchers found virtually no evidence of the cost of making specific changes to the production process in order to help reduce waiting times, even in the successful trusts.

Summary

Table 2 shows how some of the characteristics that have emerged from this study can be used to profile 'successful' and 'unsuccessful' trusts. This is not intended to imply that all trusts in these categories have all of the characteristics associated with that category. However, the attributes associated with success are generally necessary if sustained success is to be achieved. The middle group of 'variable performance' trusts exhibited some of the characteristics of both other groups. However, their failure to sustain improvement appeared to be due to external shocks and their inability to react to them, rather than a fall-off in their own efforts.

Table 2: Sustaining improvement – a summary of trust characteristics

	Successful	**Unsuccessful**
Analysis, forecasting and planning	• close detailed monitoring of queues • good information at a detailed level • clear responsibility for planning and alerting operational managers of need for action • day-to-day connection between planning and operational sides • many people with a view of the whole system of elective care, trying to manage through the system	• poor information and only at very high level • no central function for managing queues • nobody seeing the whole elective-care system within the hospital • no connection between the planning process and day-to-day management of care system
Organisational focus and persistence	• strong leadership • use of incentives and motivation of staff • long-term view • organisational stability	• weak leadership • continual change in personnel • poor relations between managers and clinical staff • short-termism, which may be associated with 'getting the job done' and moving on
Capacity	• understanding what capacity is needed to deal with demand, now and in the future • ability to vary capacity when required, to meet contingencies of variations in demand, or other factors, such as surges in emergency care • getting extra resources by having a reputation for good management and use of resources • keeping demand for services within manageable limits	• insufficient resources to meet needs, resulting in always trying to catch up • inability to work in partnership with commissioners or other providers to bring in more resources • distortion of priorities, resulting from strength of one or more pressure groups in trust – for example, in teaching hospitals where the top research specialty gets more than fair share
Efficiency of production processes	• understanding the underlying production processes of the elective care system in detail • strong performance management • good discharge-planning procedures • strong booking systems • use of comparative information on internal performance • strong clinical leadership, resulting in better management of key workers in the elective-care system	• poor performance management • no use of comparative information to improve performance • an individual, clinical approach to care rather than a managed approach through strong clinical leadership

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Discussion and policy implications

This report focuses on the results from the qualitative analysis of interviews. The picture that emerges of factors that promote or inhibit the achievement of waiting time targets is therefore restricted to the views of those interviewed. The authors' ongoing quantitative analysis of key variables in each elective care system may confirm or qualify these findings.

Further, while the authors have identified sets of factors that appear to be more common among successful trusts, they cannot attribute any magnitude of effect to each. This is because the importance of that factor individually is not known, nor is it known whether it is likely to be effective on its own, or only in interaction with other factors in the set.

Conclusions and recommendations

A key finding from this research is that both at local (trust/PCT) and national (Department of Health) levels, success in sustained reductions in waiting times involves a combination of knowledge, attitudes and activities. The authors identify four particularly important factors:

- a sustained focus on the task
- an understanding of the nature of waiting lists
- detailed information, analysis, forecasting, monitoring and planning
- development of appropriate capacity.

These are addressed in detail below:

A sustained focus on the task

A clear and unambiguous message from successful trusts (and from those beginning to turn the corner on reducing waiting times) was the absolute necessity firstly to focus the organisation on reducing waiting times, and secondly to sustain management and clinical effort and priorities on the task. The energy and detailed day-to-day management (down to the tracking of individual patients through the hospital system) should not be underestimated. Bringing about this sustained focus requires skilled and strong – but sensitive – leadership and management at all levels of the trust.

An understanding of the nature of waiting lists

Understanding that waiting lists are not simply a backlog problem but the manifestation of a more complicated, dynamic flow through interconnected parts of a whole system of care has enabled successful trusts to break down the problem, and to tackle those particular factors which, given their own circumstances, have given rise to long waiting times.

Detailed information, analysis, forecasting, monitoring and planning

Detailed, consistent and accurate time-series and cross-sectional information on waiting lists and waiting times, as well as on key resources, provided successful trusts with a means to:

- analyse and understand their waiting lists
- see them in context with other trusts
- allow them to monitor progress and outcomes of changes in service delivery
- plan future changes in services to meet targets, and the resources required to provide them.

Development of appropriate capacity

Lack of capacity can ultimately undermine efforts to reduce waiting times, and interviewees considered it essential to develop appropriate capacity – not just through increasing the totality of resources, but also through more efficient use of resources and managing the demand on those resources.

It is interesting to note the similarity between many of the findings of this study and the conclusions reached by the Research into Practice Team in its work on sustainability and spread in the national booking system, and its analysis of sharing and learning from the cancer services collaborative (Modernisation Agency 2002a, 2002b). Clearly, and perhaps unsurprisingly, there are general management lessons to be learned from successful attempts to bring about permanent change in the way trusts organise and deliver services.

The points below bring together some of the elements that would help to bring about sustainable improvements in the management of waiting lists. These are mainly concerned with the need for a systematic and overarching analytic approach requiring intelligent gathering, and use, of information. But also essential to success are ensuring clear links and good working relationships between those responsible for the planning of the delivery of care and those delivering care, so that there is a confluence of aims, achievements and responsibility.

Key elements for managing the elective care system

Note: Where the following points refer to outputs or services, these are the various parts of the elective care process in the hospital; for example, consultations, tests and investigations of various kinds, and operative procedures.

- **Produce a 'menu of services'** for each specialty, with estimates of time taken per service (for example, type of operation), and the level of expertise required. Using this menu, produce a detailed profile of demand for services (operations and consultations), on a daily basis, showing levels of variability in numbers referred, the difficulty of cases, and the time taken per service.

- **Produce detailed output schedules** for the current configuration of services, indicating how many slots are available, with time allocations per slot, and the nature of the work that could be produced. So there might be three categories of

operation (simple, difficult and very difficult) and three time-slots for operations (less than 30 minutes, less than 1 hour, and over 1 hour). Similarly, there might be two categories of outpatient consultation (5 and 15 minutes). What is important is to encourage staff to think about how they allocate patients in queues into these categories, so that optimal use can be made of the time available. This requires prior knowledge, for example, of holiday rotas for all staff.

- **Produce an analysis of the potential constraints on output**, other than availability of direct-contact staff, such as operating theatre staff, and theatre slots. These would include:
  - all testing and investigation issues, both pre- and post-operation or consultation
  - care availability within the hospital setting – primarily staffed beds, which would require an understanding of the needs of individual patients in terms of the number of bed-days required (the profile of demand must take this element into account)
  - care availability outside of the hospital
  - availability of other professionals for rehabilitation, and so on (for example, physiotherapists, occupational therapists, dieticians). This is needed to ensure availability of other 'indirect' inputs required to produce planned outputs of elective activity.

- **Plan in flexible availability of additional physical capacity** (such as theatres out of hours) to deal with unpredicted surges in demand. Options such as the use of private facilities could also be considered in the same way.

- **Produce an analysis of patients who do not attend** for one reason or another, or are excluded from treatment at points in time (suspensions or cancellations), so that the impact on 'real' waits and on the efficient use of resources can be calculated. This should lead to changes in procedures to ensure that patients are not inadvertently missing their slots (using booking systems of various kinds, near-date reminders such as text messaging, letters, phone calls and emails). In all cases, the relative costs of any administrative procedures should be assessed and matched against efficiency gains in the use of health care delivery resources, and improvements to patient experience.

- **Produce a transparent costing** of all of the various options proposed for producing services, based on detailed a investigation into the variable inputs, plus an appropriate allocation of fixed costs. Ensure that all members of staff understand these costings and, if possible, that they agree that they are reasonably accurate.

- **If all of this is in place, produce a profile of demand and supply** at the start of each year for each individual service, detailing how this would be met throughout the year, together with the range of variability and how this would be dealt with. The profile would be based on best estimates of detailed activity in that year. There will be considerable variation in individual procedures, but this would be reduced by using the time-related and difficulty-related categorisations noted earlier.

- **Introduce a system of 'notional' booking for all patients in queues**, so that when a patient joins a queue there is a 'notional' slot allocated (but not necessarily given to that patient). This could be applied to all outpatient slots, inpatient and day-case treatments, tests and investigations. Where the patient does not require immediate treatment, it should be possible to predict when a treatment will become necessary, and a 'notional' slot allocated even in that case. This should prevent the 'chalking

the dartboard' phenomenon that is sometimes observed. Eventually the 'notional' system could become a live system for all queues. Some hospitals already have such systems in place for some of their activities. What is required is a roll-out from notional to live systems.

- **Trace patients' progress through the elective system** by using a unique patient identifier. This will make it possible to produce estimates of total average waiting times in different parts of the elective system within the hospital.

- **Give consultants responsibility for delivering timely services** to patients on their list. This requires a common agreement as each patient enters the queue as to the maximum time they should have to wait. Eventually, this process will become routine, and will be carried out by administrative assistants, but initially, the consultant body will need to think things through. Each consultant should produce a plan of how their own patients can be slotted in to the overall work of the hospital. This should result in situations where the inconsistency of current arrangements is seen ahead of time, and changes are introduced to deal with these.

- **Work out the best way to manage the interface between emergency and elective care**. This will involve forecasting the likely profile of emergency demand – drawing on Dixon and Damiani (2002), for example. It will also include assessing the scope for reducing bed and nursing requirements for elective care. This can be done by, for example, scheduling operations involving short hospital stays in times of likely peak demand, and working out the most effective and efficient balance between ring-fenced and general pool beds.

- **Improve the referral process**, with the aim of reducing unnecessary referrals and clinic visits through, for instance, the use of protocols and other forms of closer working between primary and secondary care.

- **Re-design the main care pathways** with a view to simplifying and speeding up access times for patients, and reducing the costs of providing each service.

- **Assess the scope for improving productivity** of staff and facilities, by referring to suitable comparators, for example, the number of operations per full-time consultant, or per theatre session, and so on.

Appendix 1: Follow-up work

(January to June 2003)

In the light of the findings from the interviews, the research group's discussions and the initial quantitative data gathering, there appear to be a number of possible areas of further work:

How do some consultants in unsuccessful trusts have short waiting times?

In a number of the unsuccessful and temporarily successful trusts, interviewees said that there were some consultants who managed to maintain relatively short waiting lists and times. In one instance, the reason given was that a particular consultant managed their own list, theatre time and other resources in a way that specifically kept waiting times low for their patients. This raises some questions: how, exactly was this achieved, and were there adverse knock-on effects, such as opportunity costs, elsewhere in the system?

Information requirements

At a practical level, the interviews revealed the importance of information relating not just to waiting lists and times, but also to resource capacity and use. But it is not yet clear which information is absolutely necessary, how can it be generated, what are the best ways to present it in order to aid waiting times analysis, monitoring and planning, and how can it be used (for example, through modelling), to forecast future levels of demand and required levels of activity. Although a number of initiatives have focused on particular elements, the authors did not find a comprehensive approach in operation within their study sites, nor an evaluation of different models in use in different parts of the country.

Minimising waiting times variations within trusts

During the research, a number of examples emerged in which a reduction in maximum waiting times was achieved, in whole or in part, through tackling variations in waiting times between clinics and between consultants. One obvious way to do this is through pooling lists (for common or routine procedures in a specialty). However, while a recent survey has suggested that pooling is overwhelmingly supported by patients and GPs, consultants are far less keen (Ramchandani *et al* 2002). More detailed analysis of, and investigation of the reasons for, the variations in waiting times between individual consultants (working for trusts in our study) in one specialty – ophthalmology, for example – and at the level of individual procedures, could highlight the scope for reducing maximum waiting times through reductions in variations in in-trust waiting times.

Managing demand

Determining the appropriate capacity requires consideration as to which demands on the whole system (including the wider health economy) should be met within the hospital system, and how much can be avoided entirely by changing working methods or taking preventive measures. The authors are aware, from this study and from the wider literature, of a number of different initiatives but they have not identified any attempt to estimate the scope for reducing or redirecting demand that takes account of the whole range of potential policies that might be introduced.

Appendix 2: Terms of reference

The abstract of research from the original research proposal stated:

The aim of this study is to identify factors linked to effective waiting times performance (maintaining low/no proportion of inpatients waiting more than six months) by comparing and contrasting three types of NHS trust which have been:

- successful
- unsuccessful or
- temporarily successful.

The first part of the study will establish a historical statistical profile of activity patterns (including use of private sector), resource use, referrals, workloads, productivity, and so on, for all trusts and waiting list specialities. Interviews with key stakeholders in each health economy will aim to establish:

- management actions on waiting times
- consultant management of referrals
- the use of financial and other incentives
- how those involved explained waiting times performance.

The outputs from Part One will be a *prima facie* list of relevant factors influencing good and bad performance and possible relationships between them. The second, prospective, stage of the study will draw on these findings and test hypotheses for good performance by instituting appropriate changes in some of the unsuccessful or temporarily successful trusts and tracking changes in waiting times and other factors for a further period of time.

Appendix 3: Selection criteria for inclusion of trusts

On the basis of their historic trends in the proportion of their total inpatient and day-case lists waiting longer than six months, three groups of trusts were identified for study.

For all trusts in England, the all-specialty inpatient (including day cases) quarterly waiting lists from June 1998 to March 2002 were obtained from the Department of Health's waiting times website. In addition, the number of patients who had been on the lists for longer than six months were obtained, and expressed as a percentage of the total lists.

The March 2002 figures were used as the basis for selecting the six trusts with very low or very high percentages waiting more than six months. In order to exclude trusts with little inpatient activity (for example, community trusts) all trusts with a total waiting list of less than 1,000 patients were eliminated from further consideration, as were specialist trusts (for example, those providing orthopaedics only).

The remaining trusts were sorted in ascending order of the percentage waiting longer than six months, since one of the key government targets for 2005 is that no one should wait more than six months for admission.

Successful trusts

We selected three trusts with very low percentages waiting longer than six months (Trusts A, B and C – *see* Figure 6, *opposite*). All three of the selected trusts had had relatively low percentages waiting longer than six months each quarter since June 1998.

Temporarily successful trusts

Three trusts were selected that showed significant change over time in percentages waiting longer than six months (Trusts G, H and I).

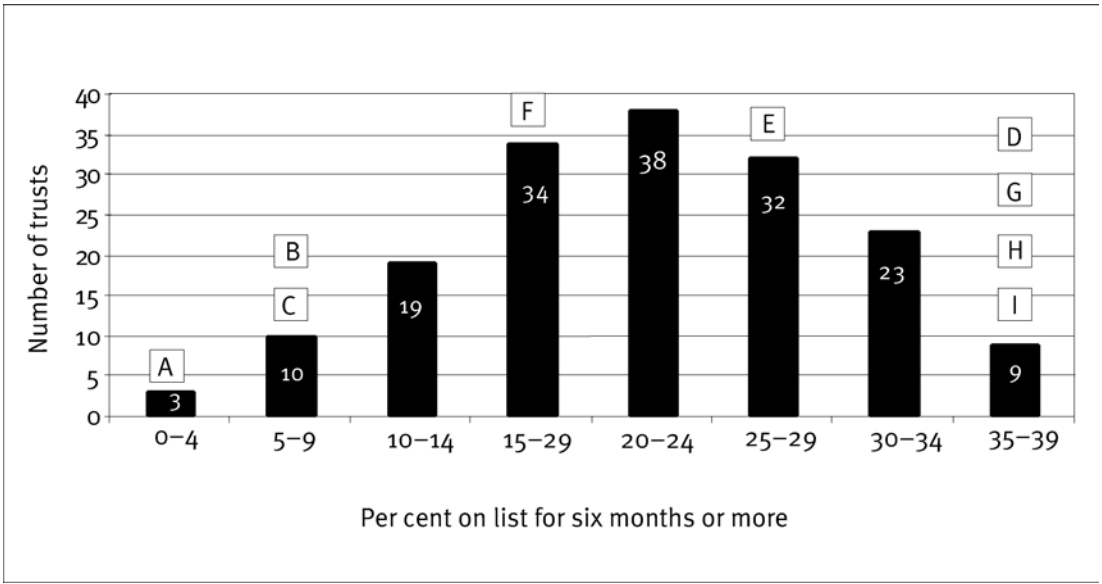
The first of these had shown a fairly steady and significant reduction in the percentage waiting longer than months from a high value in June 1998 to a relatively low value in June 2001, but had not improved further since then. The second had shown a reduction in the percentage waiting longer than 6 months from June 1998 to March 2000, but the percentage had then deteriorated again to its original value until September 2001, after which the position improved again. The third had shown a large reduction in the percentage waiting longer than 6 months from June 1998 to September 2000, but the situation had then deteriorated rapidly until it was worse than the starting position.

Unsuccessful trusts

Finally, we selected three trusts with very high percentages waiting longer than six months (Trusts D, E and F). Although there were other trusts with similar or worse performance, one was excluded because it involved a recent merger, another because it was already the subject of intensive scrutiny, and a third because it was to be included in the 'temporarily successful' group. All three of the selected trusts had had relatively high percentages waiting longer than six months each quarter since June 1998.

Figure 6, below, shows the trusts selected in relation to the total number of English trusts (following exclusions noted above). Figure 2 (p 13) shows waiting time trends for all nine trusts included.

Figure 6: Acute trusts: All-specialty waiting lists, March 2002



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Appendix 4: Quantifying trends in waiting and activity

This appendix provides some detailed analysis of trends in waiting in the nine trusts, based on data from the KH06 returns. There are distinct differences in the performances of trusts within and between the three categories used to group trusts in this study.

This section will be developed further for the final project report.

Appendix 5: Interview outline

This appendix contains the outline of the interviews that were carried out as research for this paper.

Introduction

Explain background and purpose.

The Department of Health commissioned the research:

- to understand the range of factors affecting waiting times in different trusts
- to try to explain different experiences in managing to keep waiting times low or otherwise
- to identify generalisable factors which could apply to other sites
- to identify how far a trust's waiting times performance was a product of unique local context.

We are looking specifically at inpatient and day-case waiting times, but are interested to know about possible inter-relationships with outpatient waiting times.

Is the interviewee happy to be taped? No individual names will be identified, and no sites will be named unless the trust chooses to be identified.

We will circulate our draft interim report (around end of December/early January) for information/comment.

Background/warm-up questions

How long have you worked in this trust (and other parts of the local health economy)? In what roles?
What has happened to waiting times in your trust?
Do the formal performance figures feel like a realistic picture, or is the reality better/worse?
Is this a recent situation, or has it always been like this?
Is your trust's performance similar to neighbouring trusts? In what ways is it different?

Factors affecting waiting times

(Show graph of the percentage of patients who have been waiting longer than six months.)

Can you briefly talk me through the trends and changes in trends on this graph, summarising some of the factors that you feel explain this picture?

In brief, have there been particular obstacles in achieving reductions in waiting times?

How have these been overcome (or otherwise)?

Hospital culture

Can you describe how you see the culture of this hospital, giving examples?

What is morale like locally?

What is recruitment and retention like?

Who are the key managerial and clinical leaders?

How long have they been in post?

What are relationships like (between managers, between clinicians, between managers and clinicians)?

Are there any very difficult relationships?

What impact has the hospital's culture had on the management of waiting times (give examples)?

Is the general attitude positive or negative in relation to waiting-time reduction?

Hospital organisation

Does the trust or each specialty have a waiting-list manager? Is this a full-time job?

Did the local health authority have a waiting-list manager?

Does the trust have a discharge co-ordinator?

Is elective and emergency work split across sites?

Is elective work/facilities 'ringfenced' to any degree – in other words, protected from emergency work?

Are there any particular problems with emergency work encroaching on elective work in any way?

Is there a dedicated day-case unit(s)?

Does the trust have an admissions ward?

Does the trust have a high dependency unit? (Note: all of our trusts have intensive care beds.)

Does the trust have access to intermediate care beds? (Where, and how many?)

What percentage of day cases is booked (all specialty totals)?

What percentage of inpatients is booked (all specialty totals)?

Does the trust make use of one-stop clinics?

Is pre-operative assessment combined with the outpatient appointment?

Is booking and allocation of outpatient appointments centralised?

Do consultants pool waiting lists?

Hospital management

Can you summarise the trust's financial position over recent years?

What is the financial situation this year?

If it is heading for a deficit, what are the reasons for this?

Have waiting times been a constant priority locally, or has it been intermittent, driven by specific initiatives?

How important have national waiting list initiatives been in the past?

Has the trust had access to reliable information to help manage waiting times? (What sort, who sees it, how often, and so on.)

How far has there been clinical ownership and support for waiting times initiatives?

Has the trust asked consultants to do extra sessions at weekends?

Has the trust asked consultants to do extra sessions in the evening?

Has the trust asked consultants to do extra sessions in private hospitals?

Are consultants paid for these extra sessions?

Are these extra sessions continuing?

Have other measures been taken to increase capacity (new posts, theatres, and so on)?

Have there been or are there any particular staffing problems?

Has the trust carried out any studies of its own or introduced new management measures to improve performance? Are there any reports available?

Does the trust use, or has it used in the past, any models to plan capacity or manage waiting lists (for example, checklists)? Have these been useful?

Has the trust, health authority or PCT used any direct financial or other incentives to reduce waiting times?

In your opinion, of all the initiatives and changes you have mentioned, which have contributed most to reducing waiting time?

Is there any hard evidence to support your opinion?

Effect on clinical practice

Has the drive to reduce waiting times affected the way clinicians practice?

How have clinicians reacted?

Has it distorted priorities?

Have there been any knock-on consequences on other services or on quality of care?

Local health economy

What are relationships like between local health organisations?

What are relationships like between primary and secondary care?

Do local trusts get on well together or compete? Did they get on with the health authority?

How important have the roles of the health authority and health authority chief executive been? How has that role been managed during reorganisations from hierarchy to quasi-market and now to 'partnership'?

Have your commissioners' decisions or actions made much difference to the management of waiting times?

What incentives or sanctions have they used?

Do referring GPs or PCTs have quotas (slots) for numbers of referrals?

Are formal protocols in place for managing the primary/secondary interface, and for which specialities?

Does the trust allow GPs to book day cases direct on to the list?

Are GPs given feedback on appropriateness of referrals?

Does the trust run outpatient clinics on primary care premises?

Are there any GP specialists providing initial consultations in the area?

What are the demographics of the local population? Has that made any difference to demand?

What are the referring patterns of local GPs?

Private sector

Has the trust used the private sector to reduce waiting times?

What has been the attitude of senior staff and local purchasers to using the private sector?

Has there been spare capacity locally?

Is the trust still using the private sector?

Has the health authority/PCT used the private sector?

Wrap-up

Reflecting on all the helpful and unhelpful factors we have been discussing, which do you think have been the most crucial?

What lessons would you identify from your experience that others could learn from (good and bad)?

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