

House of Commons
Committee of Public Accounts

**INPATIENT AND
OUTPATIENT WAITING
IN THE NHS**

Forty-fifth Report of Session 2001–02

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*Report, together with
Proceedings of the Committee,
Minutes of Evidence and an Appendix*

Ordered by The House of Commons to be printed 2 July 2002

HC 376
Published on 4 September 2002 by authority of the House of Commons
London : The Stationery Office Limited
£10.00

Committee of Public Accounts

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by ‘Q’ followed by the question number; references to the written evidence are indicated by the page number as in ‘Ev’.

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FORTY-FIFTH REPORT

The Committee of Public Accounts has agreed to the following Report:

INPATIENT AND OUTPATIENT WAITING IN THE NHS

INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. At 31 March 2002 some 195,000 people in England had been waiting over 13 weeks for an outpatient appointment and 1,035,000 were waiting for treatment. Waiting a long time can be a painful experience, and over a third of patients have stated that their condition worsened while waiting.¹

2. On the basis of a Report by the Comptroller and Auditor General,² we looked at progress in reducing waiting lists and waiting time, ways of improving performance and steps being taken to give patients better information and choice on where to be treated. We have also taken into account the Government's latest plans for the Health Service, set out in *Delivering the NHS Plan* published in April 2002.³

3. In the light of this examination, the Committee draws the following conclusions.

- Reductions in waiting lists and waiting times require concerted action on the main challenges facing the NHS. These include the number of staff, hospital capacity, the availability of effective patient administration systems, the working practices and referral arrangements of consultants and general practitioners and the need for more effective partnership between the NHS and social care sectors in planning patient discharge, particularly for older people.
- The increased expenditure announced in the 2002 budget and the wide-ranging changes described in *Delivering the NHS Plan*,⁴ seek to tackle all of these issues. In addition to more money, success requires changes in culture and working practice amongst all medical professionals, and increased partnership working and between health and social care. We plan to track progress.
- Key to the changes is the plan to provide patients with accurate information on the performance of NHS trusts and waiting times, and give them and their general practitioners a real choice over where to go for examination and treatment.

On progress in reducing waiting lists and waiting time

- On published figures, the Department of Health are making steady progress in reducing waiting lists and waiting times for outpatients and inpatients. But there remains some uncertainty about the accuracy of the figures, partly because not all hospitals validate their waiting lists often enough and because there have been at least ten cases where hospitals have made inappropriate adjustments to their waiting lists in order to keep reported numbers down. We are reporting separately on these ten cases.
- To the patient, the primary concern is the total time they wait from seeing their general practitioner to treatment. The NHS currently only measures this for cancer, although they plan to do so for other serious conditions where they implement National Service Frameworks and there are clear co-ordinated pathways of care.

¹ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 1–2; Q53

² C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02)

³ *Delivering the NHS Plan*, Cm 5503

⁴ *ibid*

This would clearly be desirable. There are substantial numbers of patients waiting for tests or further examinations who are currently not captured in the statistics and a risk that many of them might suffer undue delays in the process. The NHS should monitor the numbers and length of times involved, so that managers are fully aware of any hidden backlogs.

- The pressure to reduce waiting lists has led a significant number of consultants to treat some patients before others with higher clinical priority. The challenging targets for waiting times set in *Delivering the NHS Plan*⁵ can only increase this pressure. Although the Department has issued clear guidance that clinical priorities must be adhered to, they should supplement this guidance with annual surveys of consultants to assess whether it is being observed.

On ways of improving performance

- One key to reducing waiting times is increasing the capacity of the NHS. The plans announced in *Delivering the NHS Plan*,⁶ should go a long way to increasing skilled staff resources and providing more beds. The Department's review of the system for allocating resources is also important, in view of the significant variations in waiting lists and times in different parts of the country, and in different specialisms. The Department should complete this review quickly and publish the results with any action they plan to take.
- As the Committee of Public Accounts said in its Report, *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals*,⁷ the NHS needed to develop modern patient administration systems, appoint discharge co-ordinators, and achieve closer co-operation between hospitals, general practitioners and social services departments. All of these issues are now being taken forward. However, it is important to monitor the use of this money so that it is spent effectively on tackling delayed discharges and bed blocking, including the expansion of intermediate care, and does not merely feed through in higher costs, for example for places in care homes.
- The Department are making strides in introducing best practice, including experience from overseas. There are already examples of good practice, for example in developing protocols between general practitioners and trusts for referrals to hospitals. Success will require effective transfer of best practice across the NHS, through for example the NHS Modernisation Agency. It also requires the active involvement of clinicians and general practitioners, and the Department needs to bring to an early conclusion their negotiations on the new consultant contract, and their discussions with royal colleges on new working practices, including different groups of staff undertaking work traditionally done by doctors.
- In areas and specialties where waiting lists and times are high, there is a risk that the use of NHS facilities for private healthcare may mean NHS patients waiting too long or other patients being treated ahead of the clinical priority. On the other hand, private use of NHS facilities can generate extra income for NHS use and help retain top clinicians in the NHS. NHS Trusts should monitor this balance closely, and be ready to act where NHS waiting lists and times are long.

⁵ *Delivering the NHS Plan*, Cm 5503

⁶ *ibid*

⁷ 1st Report from the Committee of Public Accounts, *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals* (HC 135, Session 2000–01)

On steps being taken to give patients better information and choice on where to be treated

- Patients and their general practitioners are tied to their local NHS Trusts, when other hospitals, often only a few miles away, may have lower waiting times. The proposals in *Delivering the NHS Plan*⁸ to provide information on waiting times and performance and to introduce greater choice, starting with patients with the most serious conditions, is a positive step. We expect the new Strategic Health Authorities, with their larger catchment areas, to work with Primary Care Trusts to develop more flexible commissioning arrangements within their areas, to provide all patients with greater choice locally.

PROGRESS IN REDUCING WAITING LISTS AND WAITING TIME

4. Since the creation of the National Health Service in 1948, most people who need to see a consultant or who require surgery but are not emergency cases have had to wait. The total time a patient waits for treatment, from the date the general practitioner refers the patient to a consultant until the patient is admitted to hospital comprises three main elements:

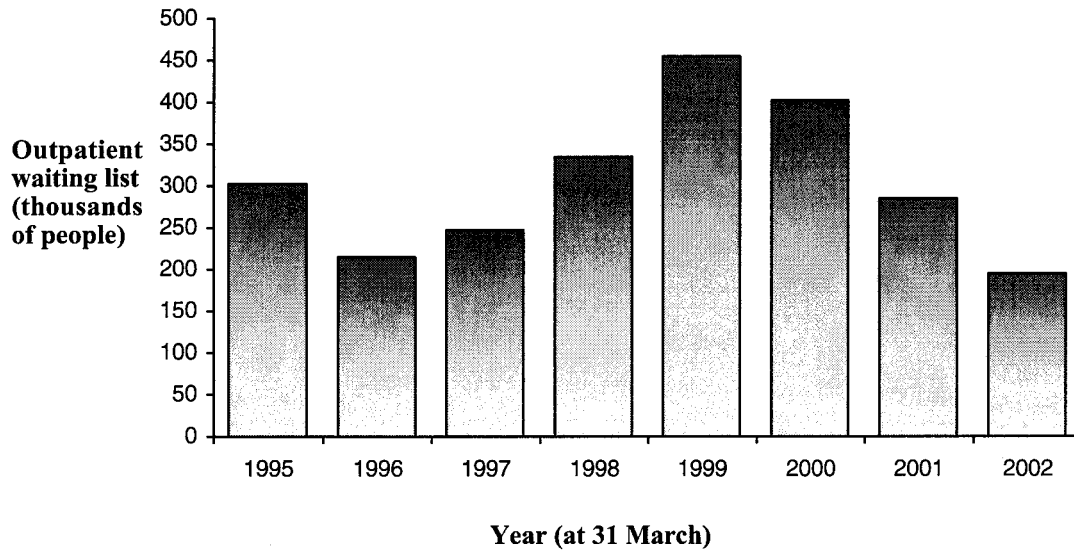
- Waiting to see the consultant (the outpatient waiting list) covers the time a patient waits from seeing the general practitioner until they are seen at an outpatient clinic by a consultant or other health professional. In April 1999 local NHS agreements aimed to reduce the number of people waiting over 13 weeks to 334,000 by March 2000. This was achieved by 31 March 2001 and by 31 March 2002, 195,000 outpatients had been waiting over 13 weeks. (Figure 1)
- To establish whether surgery is required, a consultant might require tests or diagnostic procedures to be carried out before determining what treatment, if any, is required. Such tests may be conducted on the day the patient attends the outpatient clinic, or may take substantially longer. This time is not measured or monitored, although the base information is held on Patient Administration Systems.⁹
- Waiting for treatment (the inpatient waiting list) is the time a patient waits from being placed on the inpatient waiting list for surgery until they are admitted to hospital. In 1997 the Government set a target to reduce the number of people on the inpatient waiting list by 100,000. This was achieved during 1999–2000. (Figure 2)¹⁰

⁸ *Delivering the NHS Plan*, Cm 5503

⁹ C&AG's Report, para 6

¹⁰ *ibid*, paras 1.1, 2.2–2.7 and Figures 5, 6; Qs 36–42

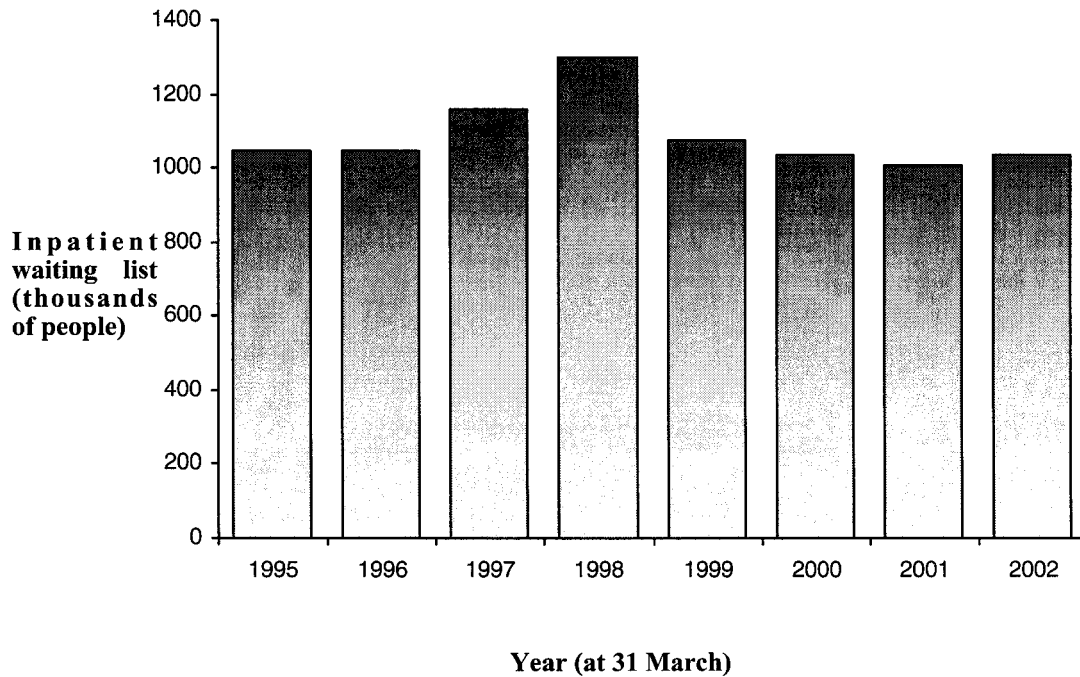
Figure 1: The number of outpatients waiting over 13 weeks



The diagram shows the number of outpatients waiting over 13 weeks for an initial clinic appointment with a consultant between 31 March 1995 and 31 March 2002

Source: *Department of Health*

Figure 2: The number of NHS inpatients waiting each financial year end



The diagram shows the number of NHS inpatients between the years ending 31 March 1995 and 31 March 2002

Source: *Department of Health*

5. The Department focus measurement on the outpatient and inpatient lists because these are two distinct elements in the process. The time taken to establish whether surgery is required can involve a range of tests and examinations, and admission to hospital may not be required. However, where there is a clear co-ordinated patient pathway through the system the NHS are measuring time from urgent referral to treatment. For example, the NHS brought in a target of one month between urgent referral and treatment for children's cancer, and one month from diagnosis to treatment for breast cancer from December 2001. They expect to adopt similar arrangements for areas where they have developed National Service Frameworks, for example coronary heart disease.¹¹

6. The NHS has shifted its focus from reducing the numbers on waiting lists to reducing waiting times, especially for the most seriously ill patients. In *Delivering the NHS Plan*,¹² published in April 2002, they set new targets for reducing waiting times for outpatients and inpatients, plus waits to see a general practitioner and in Accident & Emergency departments (Figure 3). However, they remain interested in waiting lists, since reducing them will also bring waiting times down.¹³

Figure 3: Current targets for reducing waiting times, set in <i>Delivering the NHS Plan</i> published in April 2002	
By 2004	A reduction in waiting to see a general practitioner, so that patients are seen within 48 hours or seen by another primary care professional within 24 hours.
By 2004	A reduction in maximum waiting times in Accident & Emergency Departments to 4 hours with average waits reduced to 75 minutes.
By 2005	A reduction in waiting times for an outpatient appointment to a maximum of 3 months.
By 2005 and 2008	A reduction in the maximum wait for treatment to 6 months by 2005, then falling to 3 months by 2008 (with an average wait of half this time).

7. Although the published statistics show that the Department of Health are making steady progress in reducing waiting lists and waiting times for outpatients and inpatients, there remains some uncertainty about the accuracy of the figures. This is partly because not all hospitals validate their waiting lists often enough.¹⁴ It is also because there have been at least ten cases where hospitals have made inappropriate adjustments to their waiting lists in order to keep reported numbers down.¹⁵ We are reporting separately on these ten cases.

8. Despite progress in reducing waiting lists, there remain wide variations across the country. The Comptroller and Auditor General found that the number of inpatients waiting per 1000 head of population varied between 23.7 in the North West Region and 15.8 in the West Midlands, while the North West Region had the highest number of outpatients (7.2) compared with 3.8 in the West Midlands. He also found significant variations across three specialties, Ear, Nose and Throat; Trauma and Orthopaedics; and Urology.¹⁶

¹¹ Qs 3–4, 91

¹² *Delivering the NHS Plan*, Cm 5503

¹³ *ibid*

¹⁴ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 8, 2.25–2.28

¹⁵ C&AG's Report, *Inappropriate adjustments to NHS Waiting Lists* (HC 452, Session 2001–02)

¹⁶ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 2.8–2.13 and Figures 8–10

9. The Department identified three main causes of regional variations;

- Capacity constraints in some parts of the country. For example, the facilities available for treating coronary heart disease are much greater in the south of England than in the north, and in specific areas, such as North Staffordshire there is serious under-capacity in acute facilities and at the Mayday Hospital in Croydon, significant capacity shortages around orthopaedics;
- Emergency pressures can reduce the beds available for elective surgery, as can delayed transfers of patients to other forms of care;
- Difference in the ways NHS Trusts manage their healthcare systems.

10. The NHS has to tackle each of these issues, for example through new resources and by identifying and disseminating best practice. There is also an extensive study being undertaken into the funding formula the Department use to allocate resources across the country, to see whether change is needed.¹⁷

11. The Comptroller and Auditor General surveyed 600 consultants in three specialities—Trauma and Orthopaedics, Urology and Ear, Nose and Throat. Fifty two per cent of the 558 consultants who responded considered that working to meet the waiting list targets meant they had to treat patients in a different order to their clinical priorities, and 20 per cent said this occurred frequently.¹⁸ A number of other organisations, including the British Medical Association and the Kings Fund have also drawn attention to this issue. The Department doubt whether the problem is as widespread as this survey suggested, partly because there are particular problems in these specialties. However, they have made it clear consistently that clinical standards or priorities should not be compromised. Moreover, the National Service Frameworks now provide a strong driver to give priority to the most serious conditions, such as cancer and coronary heart disease.¹⁹

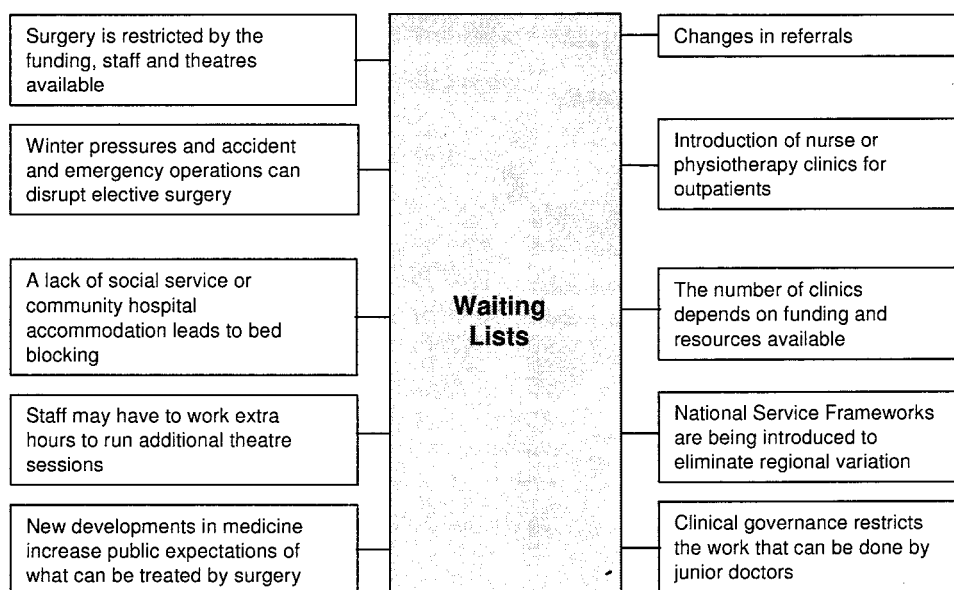
WAYS OF IMPROVING PERFORMANCE

12. Waiting lists are influenced by a wide range of factors (Figure 4), and reducing them requires concerted action across many of the key areas of the NHS. We looked specifically at: progress in identifying and spreading best practice; action to overcome capacity problems, including staffing and bed blocking; managing GP referrals; and changing consultants' working practices.

¹⁷ Qs 5–7, 88, 108–112, 150–154; Ev 24

¹⁸ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), para 2.22

¹⁹ Qs 9–10, 49–54, 68–71, 93–98, 186–189

Figure 4: Factors influencing waiting lists

Source: *Department of Health*

(a) Progress in identifying and spreading best practice

13. The Department have taken a range of steps to identify and spread good practice (Figure 5). This is the key role of the NHS Modernisation Agency, and within it the National Patients Access Team. Securing improvements in practice requires not only clear policies and procedures, but strong clinical involvement with them. The Modernisation Agency has service improvement managers working on a regional basis with local trusts, and teams tackling specific problems, for example in outpatients, operating theatres and pre-operative assessments. They have also run a learning centre for 11 trusts, which had most difficulty in terms of outpatients, and three of those have moved into the top quarter on performance.²⁰

14. In addition there is a considerable programme, which includes research and development work, to consider what is happening overseas and how it can be applied to the United Kingdom. The Modernisation Agency has strong links with other health care organisations in Europe, the United States, Australia and New Zealand. For example, there are interesting developments in Norway and Denmark on the information provided to general practitioners on waiting times for inpatient appointments.²¹

²⁰ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 1.14–1.16; Qs 8, 11, 135–136

²¹ Qs 8, 11, 15, 146

Figure 5: The Department of Health's initiatives to improve waiting lists and waiting times	
1998–99 to 2000–01	Provided an additional £737 million to NHS trusts to reducing waiting lists.
From 2000	Action to reduce variation, for example <i>Action on Cataracts</i> , <i>Action on ENT</i> , <i>Action on Orthopaedics</i> , and <i>the Cancer Services Collaborative</i> .
2000–2002	The Coronary Heart Disease Collaborative.
Ongoing	Guidance on best practice, including to trusts on how to manage waiting lists and how to treat patients within the new shorter maximum waiting times.
	Implementation of a National Booked Admissions Programme by 31 December 2005.
By 2004	20 new diagnostic and treatment centres.
By 31/12/05	All patients in any part of the country will be able to choose where their treatment takes place.

(b) Tackling capacity problems

15. The Department see the availability of staff, particularly ancillary staff and nurses, as one of the biggest factors in addressing waiting lists. The Department are now arranging for a substantial increase in staffing so that by 2008 there will be 15,000 more general practitioners and consultants, 30,000 more therapists and scientists, and 35,000 more nurses, midwives and health visitors.²²

16. The second major factor is the availability of beds. In its Report, *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals*,²³ the Committee of Public Accounts looked at how patient admission and bed management might be improved, including how to develop better collaboration between NHS agencies and social services departments in the discharge of patients from hospitals. The Committee's recommendations included the need for improved planning of inpatient admissions and bed management, and the development of modern patient administration systems. The Committee also called for the identification and dissemination of good practice, the appointment of discharge co-ordinators and closer co-operation between hospitals, general practitioners and social services departments.²⁴

17. Through the National Service Frameworks for major diseases, such as coronary heart disease and cancer, the Department are now identifying the levels of treatment needed in different areas, including capacity shortfalls. They have a programme of introducing new electronic patient records across the country by 2005, and are working with 12 trusts on a pilot basis as part of their waiting and booking information systems project.²⁵ In addition, more elective surgery will take place in new free standing surgical units or diagnostic and treatment centres: there will be 750 primary care one-stop centres around the country; and

²² Qs 79, 125–126, 202–210; *Delivering the NHS Plan*, para 6 and Chapter 3, (Cm 5503)

²³ 1st Report from the Committee of Public Accounts, *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals* (HC 135, Session 2000–01)

²⁴ *ibid*

²⁵ Qs 8, 134

hospital capacity (currently around 135,000 beds) is likely to grow by at least 10,000 more general and acute beds.²⁶

18. Since our hearing, the Government have announced a range of actions and plans to tackle delayed discharges and bed blocking, especially by older people. This includes plans to expand intermediate care by about 30 per cent by 2005–06.

19. In 2001, for the first time, the Department required local councils to produce a three year strategy for building capacity and partnerships in residential and home care in agreement with local health services and the private sector. The Department are analysing this. They are also spending an additional £300 million on social services—£100 million in 2001–02 and £200 million in 2002–03, on the understanding that they spend it alongside health and that they use flexibilities available under the Health Act 1999 – for example joint budgets and joint management – to do that.²⁷

(c) Managing GP referrals

20. A consultant relies on the judgement and experience of general practitioners to help decide how quickly to bring an outpatient into a clinic. But a general practitioner deals with a variety of symptoms and ailments each day and, unlike the consultant, does not specialise in one area of medicine. As a consequence, general practitioners' referral practices vary widely. The Royal College of General Practitioners has concluded that much of this is a result of geographical variation in patient need and affluence, characteristics of referring doctors and organisational factors of individual general practices.²⁸

21. The Comptroller and Auditor General's survey of consultants in the urology, orthopaedics and ear nose and throat specialties identified concerns about the number of inappropriate referrals from general practitioners. The mean proportion of "inappropriate" referrals between the three specialties was 25 to 29 per cent. However 40 consultants thought the percentage was over 80 per cent.²⁹

22. The involvement of general practitioners is crucial to progress, because from the patient's point of view it is the whole process, the whole patient journey, that they want to see improved.³⁰ There are, however, cultural issues to be resolved, for example by reducing referrals to specific consultants and pooling referrals to avoid lengthy waits to see particular consultants, unless there are sub-specialty reasons. This needs to be embedded into people's behaviour, and the Department are encouraging general practitioners and consultants to draw up referral protocols, and for them to work together with hospital managers and primary care trusts to plan the system in a way that works. This includes identifying cases where the referral should be to specialists other than consultants, for example referrals to physiotherapists in orthopaedic cases, and in some cases cash incentives to encourage general practitioners to introduce better referral practices.³¹

23. Trusts and health authorities have developed over 850 separate referral protocols. One trust alone has developed 126. Many trusts and health authorities have developed similar protocols on common topics such as breast cancer and screening. The National Patients Access Team commenced a project in April 2000 to collate existing referral protocols from trusts. Protocols have also been developed as part of the Cancer Services Collaborative, and work is ongoing to introduce referral advisors in every Primary Care Group. The Modernisation Agency is also developing referral guidelines as an integral part of its

²⁶ Q158; *Delivering the NHS Plan*, para 6 and Chapter 3 (Cm 5503)

²⁷ Qs 80–85, 148, 211–212

²⁸ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), para 3.5

²⁹ *ibid*, para 3.6

³⁰ *ibid*, paras 3.12–3.13

³¹ Qs 12–13, 43–48, 103–109, 155–156, 169–181

modernisation programme. In addition, by April 2001 every general practitioner, primary care group and trust has been required to put in place systems to monitor referral rates, and the Department will be able to review the position in 2002.³²

24. There are barriers which stop general practitioners referring patients to trusts outside their Health Authority area – through “out of area treatments”, even to trusts close by where waiting times are much shorter. These include the agreements between Health Authorities and NHS Trusts on planning and paying for care, which mean that Health Authorities committed to send their patients to specific trusts, which in turn enabled those trusts to plan their resources. The new primary care trusts can change their commissioning arrangements year on year, making decisions closer to patients, but the Department are looking at ways of introducing greater flexibility and choice within the system.³³

(d) Changing consultants’ working practices

25. One of the barriers to tackling waiting lists is the history and culture of the NHS. The Department believe that doctors are very good at moving forwards on clinical practice, but less good on some of the management practice issues. They have set up the NHS Leadership Centre, because really good leaders are essential if change is to happen. Getting best practice transferred across the NHS, requires strong involvement of clinicians and the Modernisation Agency is bringing consultants together to look at how they manage their lists.³⁴

26. There are over 20,000 consultants in the NHS, many of them part time. Full-time consultants are allowed to do private work up to 10 per cent of salary and this is monitored by NHS trusts. For those who are part-time, there is no limit to private work but the consultants have to meet their commitment to NHS trusts for agreed sessions. The Department pointed to studies that show that the vast majority of doctors, part-time or full time, work longer than their contracted hours. At the same time, in 1999–2000 almost 7,000 beds were taken up by private operations in the NHS. These patients may be treated outside their normal clinical priority, thereby adding to waiting lists. On the other hand, private use of beds and facilities produces additional revenue to hospitals, which can be spent on patient care.³⁵

27. There are a number of initiatives and actions looking at the way consultants work. For example, the Department are negotiating a new consultants’ contract, including issues such as productivity and workload. They are also engaged in discussions with the royal colleges about new standards that might increase the time clinicians spend with patients, on ways of working differently and on different groups of staff undertaking work traditionally done by doctors. In *Delivering the NHS Plan*,³⁶ the Government announced initiatives to develop the role of therapists and nurses, and new training opportunities for staff through a NHS University, which will start work in 2003.³⁷

STEPS BEING TAKEN TO GIVE PATIENTS BETTER INFORMATION AND CHOICE ON WHERE TO BE TREATED

28. The Department of Health recognise the importance of keeping patients informed about the time they can expect to spend on a waiting list, and the national booked admissions system is crucial to this. In its Report, *Inpatient Admissions, Bed Management and Patient Discharge in NHS Acute Hospitals*, the Committee of Public Accounts saw the

³² C&AG’s Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), para 3.9; Qs 169–170

³³ Qs 43–48, 127–131, 213–214

³⁴ Qs 11, 16–18

³⁵ Qs 22–35, 194–204

³⁶ *Delivering the NHS Plan*, Cm 5503

³⁷ Qs 18–21, 86–87, 115–119; *Delivering the NHS Plan*, para 15 and Chapter 9 (Cm 5503)

introduction of the system as a way of reducing unnecessary cancellations for medical reasons or because patients do not turn up. Since 1998–99, the Department has made £65 million available to support this programme, and allocated a further £50 million in 2001–02. By 31 March 2002, five million patients a year will be in booked admission systems and there will be fully integrated booking by 2005. One example of progress so far is Kings College Hospital NHS Trust in London, where 24 general practices are linked in electronically, three quarters of all their appointments are booked electronically, and what used to take weeks now happens in a matter of minutes.³⁸

29. There are initiatives in other countries to ensure that patients are kept well informed about waiting times. For example in Denmark, waiting times for each hospital for 25 common medical problems are available on the internet, including maximum waiting times for patients on both the outpatient and inpatient waiting list. In Norway, patients can review on the internet waiting times for elective surgery at each hospital before deciding where to be treated. From January 2001 patients have had free choice of hospital, and the Norwegian Patient Register is developing an internet information system which will show waiting times at individual hospitals for specific treatments.³⁹

30. The Department told us that the NHS Plan had been set up to design a service around the patient, shifting from a producer to a customer focus. Ministers wished to see how the NHS could improve choice within the service in a controlled way, and the Department believe that over time patients will be much more in control. They are introducing greater choice in cancer and maternity. The evidence from abroad showed that where people have the information, change had happened because of the new pressure and dynamic in the system.⁴⁰

31. In *Delivering the NHS Plan*, the Government announced arrangements to introduce greater patient choice, drawing on practice in Scandinavia, and starting with patients with the most serious clinical conditions. For example, from summer 2002 patients who have been waiting six months for a heart operation will be able to choose from a range of alternative providers, public or private, who have the capacity to deliver quicker treatment.⁴¹

32. The Department will also publish on the internet and elsewhere regularly-updated information on waiting for all major treatments at all providers. By 2005, the aim is that all patients and general practitioners will not only be able to book appointments at both a time and a place that is convenient to the patient, but compare waiting times in different hospitals and have access to independently validated information on the availability, quality and performance of local health services.⁴²

³⁸ 1st Report from the Committee of Public Accounts, *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals* (HC 135, Session 2000–01); C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02) paras 3.32–3.37; Qs 15, 77–78, 160–162, 190, 215–218

³⁹ C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 14–16, 3.28–3.31; Qs 15, 140–143

⁴⁰ Qs 46, 60–62, 72–73, 147, 163–165, 185

⁴¹ *Delivering the NHS Plan*, para 10 and Chapter 5 (Cm 5503)

⁴² *ibid*, para 10 and Chapter 5 (Cm 5503)

MINUTES OF PROCEEDINGS OF
THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2001-02

MONDAY 19 NOVEMBER 2001

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Brian Jenkins
Mr Ian Davidson	Mr George Osborne
Geraint Davies	Jon Trickett
Mr Barry Gardiner	Mr Gerry Steinberg
Mr Nick Gibb	Mr Alan Williams

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Glenn Hull, Second Treasury Officer of Accounts, was further examined.

The Comptroller and Auditor General's Report on Inpatient and outpatient waiting in the NHS (HC 221) was considered.

Mr Nigel Crisp, Permanent Secretary, Department of Health, and NHS Chief Executive, was further examined; and Mr David Fillingham, Director of the Modernisation Agency, NHS, was examined (HC 376-i).

* * * * *

[Adjourned until Wednesday 21 November at Four o'clock.

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MONDAY 1 JULY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Brian Jenkins
Mr Ian Davidson	Mr David Rendel
Geraint Davies	Mr Gerry Steinberg
Mr Frank Field	Jon Trickett
Mr Nick Gibb	Mr Alan Williams
Mr George Howarth	

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Brian Glicksman, Treasury Officer of Accounts, was further examined.

* * * * *

Draft Report (Inpatient and outpatient waiting in the NHS), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 and 2 read and agreed to.

Paragraph 3 postponed.

Paragraphs 4 to 32 read and agreed to.

Postponed paragraph 3 read and agreed to.

Resolved, That the Report be the Forty-fifth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

* * * * *

[Adjourned until Wednesday 3 July at Four o'clock.]

MINUTES OF EVIDENCE

TAKEN BEFORE THE PUBLIC ACCOUNTS COMMITTEE

MONDAY 19 NOVEMBER 2001

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Ian Davidson
Geraint Davies
Mr Barry Gardiner
Mr Nick Gibb

Mr Brian Jenkins
Mr George Osborne
Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

SIR JOHN BOURN KCB, Comptroller and Auditor General, further examined.

MR GLENN HULL, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

Inpatient and outpatient waiting in the NHS (HC 221)

Examination of Witnesses

MR NIGEL CRISP, Permanent Secretary, Department of Health and NHS Chief Executive, and MR DAVID FILLINGHAM, Director of the Modernisation Agency, NHS, examined.

Chairman

1. Good afternoon, welcome to the Committee of Public Accounts and welcome to Mr Crisp once again.

(*Mr Crisp*) Thank you, Mr Chairman.

2. This afternoon we are looking at the Comptroller and Auditor General's report on Inpatient and Outpatient Waiting in the NHS. Would you like to introduce your colleague, Mr Crisp?

(*Mr Crisp*) Could I introduce Mr Fillingham, who is the recently appointed director of the Modernisation Agency, which is that bit of the Department which is focused on driving forward change and spreading good practice. I have brought him along with me because this is a topic of considerable importance in the light of this report.

3. Thank you very much. We last reported on this subject in November 1995 and we recommended that the NHS measure the total time a patient waits for treatment. Why has this not happened?

(*Mr Crisp*) We have looked at this on a number of different occasions. What we have done is actually go for a two-part process effectively. The first one is to say that for most patients with most conditions going for an outpatient appointment does not necessarily result in an inpatient appointment, and indeed, putting it the other way round, for many people who are admitted they do not necessarily come through an outpatient route, therefore for performance management purposes it seemed sensible for us to measure those two elements. That is in general. However, on specific cases, where it is clear there is a co-ordinated patient pathway, if you like, through the system, we are specifically measuring time from urgent referral to treatment, and we are bringing in some new targets around cancer, coming in in

December this year, and we are bringing in a target of one month for time between urgent referral and treatment for children's cancer, bringing in the same thing for two months for breast cancer and so on. So for those conditions where we think it is appropriate to do that, that is precisely what we are doing, but in general we are going for the two separate indicators.

4. I am glad you mentioned cancer because that begs the question, if you are doing it for cancer why not do it for a wider range of conditions?

(*Mr Crisp*) I think over time we will do that in those areas where we have got National Service Frameworks, and for example in coronary heart disease we will be looking at the total wait and so on, but in the generality of cases that is not the case. People go to outpatients, it is not known they will be going on for inpatient operations, and, as I said before, a number of people coming in for inpatient operations will not necessarily come in through the outpatient route.

5. I now refer you to the variations in the average patient wait for treatment. If you look at Figure 7 on page 12, you will see there are very wide variations. Why is this the case and what are you going to do about it?

(*Mr Crisp*) There are three issues here in terms of variations. One is simply capacity, and the history of capacity, and if you look at some of those areas, and I take an example like, having mentioned it already, coronary heart disease, the facilities available for treating coronary heart disease are much greater in the south of the country than in the north. That is something we have to change and indeed we are in the process of changing. So the first issue is the capacity constraints in some parts of the country. The second issue is about effectively the management of the systems and the focus within the systems, and we know that some hospitals can do this far better

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[Continued

[Chairman Cont]

than others, they can move people through the system far better than others, and that is precisely why this report focuses on the fact we need to make sure we identify through active research the lessons why some people do it better and make sure we spread those good practices, which is the role of the Modernisation Agency.

6. But you accept it must be one of your objectives to overcome these disparities, otherwise you are going to get more publicity about postcode lottery, are you not?

(Mr Crisp) I think it is very important we do. As I say, the particular discrepancy I have just referred to between the north and the south is something which is particularly important.

7. But it is not just between north and south, there are discrepancies between areas which are very adjacent. For instance, let us take one example close to me, in the Lincolnshire Area Health Authority, 24.6 people per thousand of the population are on an inpatient waiting list compared to 19.1 in South Humber, just over the border. So it is not just between north and south, is it? Perhaps you could explain that variation?

(Mr Crisp) That is why I say it is multi-factorial, it depends on a number of different things. One is the capacity, and that may apply in those two hospitals which are being referred to, which I do not know in detail, historically one may have greater capacity than the other, and therefore that needs to be tackled. The second one is, one may have some better practices in terms of bringing in people in terms of running the whole system, and that too needs to be examined. It is the combination of the two things together.

8. You will be trying to disseminate best practice, for instance, in that particular example I have just referred to?

(Mr Crisp) I do not know the particular example but very clearly we have produced two things. Firstly, the National Service Frameworks for the major diseases, such as coronary heart disease and cancer, which are identifying the levels of treatment which are needed in different areas, if there is a capacity issue in your part of the country, in either cancer or coronary heart disease, it ought to be picked up through those frameworks and planned for. Secondly, we have a whole battery of ways, a number of which are illustrated in this document, in which we spread good practice, including at one level sending out documents and making work books available to people, but on the second basis perhaps more strongly sending in teams to help and support people make change where that is necessary.

9. Another important difficulty that the report shows up is dealt with on page 18, paragraph 2.22, and this lists a number of cases where people requiring urgent surgery have had to wait while patients with more routine surgery are treated in order to meet waiting list targets. Do you agree this is wrong and what are you going to do to prevent it?

(Mr Crisp) Yes, we do agree that is wrong, and the Department of Health has consistently said it is important we do not have this happening. Let me say two things. The first is, if the waiting list system is run effectively, this need not happen. Indeed the report

itself points out that you can run the systems in a way which allows you to make sure that you put patients in order of clinical priority and then in each category you take the patients who have been waiting longest, and the report itself points out there will be times for example on a theatre list where you have a bit of space at the end of the list where you can take two or three minor cases which may be less important cases to balance up the major cases. So there are ways of doing this. We are clear, again, about the importance of disseminating that good practice. The second point I would make is that this is a relatively brief survey of a number of consultants only in specific specialities, it is not either our policy nor is it as widespread as this might imply I think. Let me give you two examples. Firstly, we have driven up rates of coronary bypass surgery faster than we have driven up activity in other areas, so we are concentrating resources on some of the most important areas. Secondly, if you look at the lists and analyse them, you will see that we are continuing to admit the same proportion of people who have waited three months as those who have been waiting longer. The point being, we are giving the same priority to the different parts of the list now as we have been doing over the last few years.

10. But is it not going to become even more a problem for you because the Government has set very ambitious targets to try and reduce waiting times, I think 15 months by next March, six months by 2005, and could this not introduce even more potential distortions?

(Mr Crisp) Not if we actually manage the system appropriately. We have examples around the country, as this report again shows, of people who have been managing to do that. The sort of accusations you have talked about will not be coming in, for example, from Dorset, which features largely in this report, and those sort of areas, who have much smoother systems it seems to me of bringing patients into hospital. So the models show we can do it, the key is to make sure everyone involved, the clinicians as well as the managers, buy into this process and make it happen.

11. Let me then just spend a moment talking about good practice and how this can be spread around the country. On page 23, paragraphs 3.2 and 3.3, we can see there is good practical advice available to chief executives on how to manage waiting lists. Can you give us a flavour of what are the main obstacles to spreading good practice and what are you doing to improve matters?

(Mr Crisp) Let me give an outline answer to that and then it may be appropriate if I brought in Mr Fillingham to make it more precise, if that is okay. There are obstacles and the main obstacle is the one of history, if you like, on the basis that we have done it this way for years within this particular setting and therefore what are the incentives to change. We know among the incentives to change there is providing people with information, but that does not always work. The most effective incentive to change, it seems to me, for a surgeon working in a particular area, say eye surgery, is to see what surgeons are doing elsewhere within that speciality, and that is why we have programmes like the Action on Cataracts, which is precisely about bringing together the

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[Continued

[Chairman Cont]

clinicians working on cataracts around the country so they can learn from each other. Doctors will learn from doctors and managers from managers, and that is the most effective way it seems to me to spread it.

(*Mr Fillingham*) The report actually refers to the National Patients Access Team and from April of this year that is now part of the Modernisation Agency and we have added to the National Patients Access Team a number of other teams who are working with front line clinicians to help make change happen across the NHS. As Nigel Crisp has said, that is not easy in a very large and complex organisation but we are beginning to see some successes coming through. There are three strands to what we are doing. The first is a series of national programmes to make sure we do reduce variation, we do get consistently good practice right across the NHS, Action on Cataracts, Action on ENT, Action on Orthopaedics, for example, and we have a Cancer Services Collaborative which focuses on front line clinical staff working together to resolve the problems and difficulties. Set alongside that is intensive support for those organisations who are in the most difficulty, and we have a visiting support team which can visit trusts in Lincolnshire, in Southampton, in other areas right across the country, to bring to them examples of good practice elsewhere, and to bring to them skills they may not have had before. The third and final strand, which is very important, is that the new NHS Leadership Centre is part of the Modernisation Agency and if a lot of the change is to happen it is about really good leaders, and that is not just about managers and chief executives, it is about operational managers everywhere and crucially about clinical leaders. If there is one single big thing which helps get best practice transferred across the NHS, it is very strong clinical involvement from clinicians.

12. Let me take one example of good practice, it is mentioned on pages 25 to 26, which is the case of doctors making referrals to consultants. If they refer to a particular consultant who may be heavily overloaded that can cause difficulties, but if they just write a "Dear Doctor" letter that is much easier on the system. So that is one example. What are you doing to spread around that example of good practice?

(*Mr Crisp*) The point there is that doctors traditionally have not liked the "Dear Doctor" letter, there is a resistance to that.

13. Why?

(*Mr Crisp*) If I think of hospitals where I have worked, the issue has been about developing the relationship between the primary care doctor, the GP, and the hospital consultant, and therefore people see them as "their patients" coming into the system, and they are part of that referral relationship. We have had to move on from that for a number of conditions, for the reasons you have talked about, and that would be precisely one of the things which would be tackled within the sort of processes which David Fillingham has talked about, and there would be agreement about for what conditions it would be appropriate to do that, because it may not be appropriate for every condition if, for example, some people were more specialised than others.

14. Do you want to say a word about that, Mr Fillingham?

(*Mr Fillingham*) The involvement of GPs is absolutely crucial to the kind of programmes the Agency is running, so Cancer Collaborative, the Heart Disease Collaborative, have GPs very much as part of those teams, because from a patient's point of view it is the whole process, the whole patient journey they want to see improved from first going to the GP with a problem, right through to that problem being resolved and them hopefully being well again. That is the whole pathway we have to manage effectively. We have a number of programmes running with general practitioners looking at how we improve referral processes, how we improve the monitoring of that patient journey, and we are starting to see some quite considerable successes.

15. One last question from me before I turn to colleagues, what are you doing to provide better information and more information on likely admission dates?

(*Mr Crisp*) At the moment, there are two or three things. There is the College of Health to whom we provide information which they then are able to provide to patients when patients approach the body. Secondly, we provide a certain amount of information retrospectively around waiting times and so on, which is available on the internet across the whole of the country. Thirdly, we provide specific information to GPs, so GPs should have the information available to them of waiting times for an outpatient or inpatient appointment within their local hospitals. However, that is not good enough, and again there are some interesting examples in here from Norway and Sweden where that latter information being provided to GPs is actually provided much more widely to patients, and the GP and patient can look at it together. We are looking at the feasibility of doing that. Certainly, we know we can do that by 2005 when we have the fully integrated booking system, which is referred to in here, but the question is whether or not we can bring it forward, and that is what we are looking at at the moment.

Mr Steinberg

16. I am going to choose some of the points the Chairman has raised and a few other ones. Based on the number of constituency cases which I have had over the years, going back I suppose 15 years now, I came to the conclusion a long time ago that one of the biggest problems in the Health Service is the doctors and the consultants themselves. I think they cause most of the problems, frankly. Vast resources have been put into the system over the last two or three years, I think it says at the beginning £737 million, and this has shown some results but there are still problems. Why are the problems still there when considerable sums of money have been put in?

(*Mr Crisp*) Because it takes a long time. That in some ways is a trivial answer but maybe we can contextualise it a bit. In your local hospitals, you will have a number of clinicians who certainly are the leaders locally, who have been doing their work in a particular way over a number of years, and they have been brought up and educated and trained—

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[Continued

[Mr Steinberg Cont]

17. Exactly, so they will not change their practices. They have had practices for 20, 25 years, and they will not change the way they work.

(Mr Crisp) That may be true for some people, but I think the important thing is actually we have also, if you like, left those people working in those areas without actually coming and working alongside them and making sure we introduce them to some of the changes which have been going on in recent years. The sort of things we are doing through the Modernisation Agency, where we are bringing the consultants who work in cataract surgery together with the other consultants who work in that field, to look at how they manage their lists and so on, is I think very important. The other point I would make, before I go down on the record as implying doctors are stuck in the mud and do not change—

18. If you had said that originally, I would have given you more respect, because that is the situation, is it not?

(Mr Crisp)—is that it seems to me doctors are very good at moving on in clinical practice, what they are less good at is some of the management practice issues which they may not see as being as important as we do.

19. On page 8, paragraph 1.13 and I think it is mentioned in paragraph 1.21 as well, it tells us about how consultants have a contract with the NHS. Tell us a little more about the consultants' contracts which specifies their workload et cetera, because that impacts tremendously on the lists, does it not?

(Mr Crisp) It can do but a consultant contract is, and I suspect you know they are being renegotiated at the moment—

20. Which they object to, do they not?

(Mr Crisp) Well, the negotiations are going all right at the moment actually.

21. That is good. They threatened to strike about three months ago, did they not?

(Mr Crisp) I think you are thinking about the GPs, I am talking about the consultants at the moment. The consultant contract renegotiation is looking at issues such as productivity and workload and also issues such as—

22. Tell us about the private work they do.

(Mr Crisp)—private work and exclusivity to the NHS.

23. How much private work can they do in their contracts? How much are they allowed to do?

(Mr Crisp) It depends on whether or not you are a full-time consultant or a maximum part-time consultant. If you are a full-time consultant, you are allowed to do an amount which should not add up to more than 10 per cent of your salary, but you can also be a part-time consultant, at which point you are entitled to do more private work.

24. So every consultant who is on a full-time contract can do 10 per cent private work?

(Mr Crisp) That is my understanding.

25. How many consultants are there in the country?

(Mr Crisp) There are somewhere between 17,000 and 20,000.

26. Exactly. That just about answers the question, does it not? If they did full National Health Service work instead of private work, how many more operations could be done a year in the National Health Service?

(Mr Crisp) I have never attempted to do that calculation.

27. I bet you have not.

(Mr Crisp) I would just make the point that if people were not doing some operations in the private sector, those operations would have to be done in the NHS.

28. But they might have to wait their turn?

(Mr Crisp) That may be the case. This is not a simple adding and subtracting issue.

29. I accept that. How much private work is done in National Health Service hospitals?

(Mr Crisp) Again, I am sorry, I will have to give you a note on that, I do not know the answer.

30. How many National Health Service beds are used for private care?

(Mr Crisp) Again, I do not know that answer.¹

31. Shall I tell you? I knew this meeting was coming up so I asked a Parliamentary Question last week and I asked the number of admissions from non-National Health Service hospitals into National Health Service trusts, and last year alone, 1999-2000, there were almost 7,000 beds taken up by private operations in the Health Service. That does not seem to be right to me.

(Mr Crisp) If you looked at the same set of figures, you will also see the NHS had actually reduced in the last year the number of private patients it treated.

32. It did, by about 200 or 300?

(Mr Crisp) Yes.

33. It also increased from 1996-97 though.

(Mr Crisp) There is an element in which the NHS is providing service to private patients and there will be a number of private patients who would rather use the NHS for a whole series of reasons, including they are dealing with some of the most—

34. I am not against private medicine, if people want to pay, that is up to them, but what I do object to is them using the National Health Service hospitals and creating longer waiting lists.

(Mr Crisp) But the argument about allowing it within the NHS has three or four prongs to it, and one of the important things is it does actually produce some additional revenue into the hospital which then provides for more beds. So you will find that if there were 7,000 beds—and I have to say I do not recognise that figure—private patients are paying more than those 7,000 beds and contributing to the bigger pot.

35. I do not think that answers the question.

(Mr Crisp) That is one argument for it. There are other arguments for it as well, including it is important for many hospital managers to have their consultants doing their private practice actually within the hospital, because that actually supports the hospital as well. So there are some good arguments for having a mixed economy.

¹ Ev 24, Appendix 1.

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[Continued

[Mr Steinberg Cont]

36. I do not want to get bogged down in this so I will move on. Figure 5 on page 11 shows us the inpatient waiting list is falling, the number of operations is going up, and that sounds great and so it is, so why is it then that some people do have to still wait 18 months?

(*Mr Crisp*) We do not want it to happen. These figures here say that 70 per cent of people are admitted within three months.

37. That is not the question though.

(*Mr Crisp*) That is where we are building from. To get everybody else admitted within six months, which is where we are aiming to be by the end of—

38. But you are missing the question. I want to know why people have to wait 18 months. I cannot understand why they have to wait 18 months. If there are more operations and the lists are coming down, why is somebody having to wait 18 months?

(*Mr Crisp*) Year on year it is moving in the right direction, but it will take some time because this is a very, very big organisation, these are huge numbers of people. We have some estimates of the further increases in activity we need to get our waiting lists down, so we can bring everybody in.

39. It is still not answering the question though, why do they have to wait 18 months?

(*Mr Crisp*) I am sorry, I am being obtuse here as to what the answer is. Clearly, we need to put more resources into the system, we need to put more money, more capacity and more staff into the system, all those things are happening but they take time to build up.

40. Presumably the number of people waiting 18 months is not very many, is it?

(*Mr Crisp*) 200 or 300.

41. Exactly, so why are they waiting 18 months?

(*Mr Crisp*) Specifically on the 18 months, about two-thirds of them are tonsillectomies and adenoidectomies where we have had a particular problem in dealing with those patients in the course of this year. So there are about two-thirds who are there for a very, very specific reason. On top of that, there are a few people who have slipped through the system for whatever reason. We should not have any.

42. Why can you not say to someone who has had to wait 18 months, "Come in and we will do that operation now"?

(*Mr Crisp*) These really are anomalies. We actually have at the moment something of the order of 8,000 who are over 15 months, and the number who are over 18 months is a very small number and they are there for very specific reasons, but they should not be there.

43. Let's move on quickly and get on to the part I really want to get to. This is the topic I raised in this Committee a year ago probably, 18 months ago, I have written to ministers about it, I have written to the Chairman of the Health Select Committee and—I am going to take the credit—I think it is in this report because of me, to be quite honest. It is to do with GP referrals and trust lists.

(*Mr Crisp*) Can you show me where?

44. Paragraphs 3.12, 3.13 and 3.14. The Chairman touched on it. When I said that the consultants were to blame and the doctors were to blame I came to that conclusion because of constituency cases. I had a constituency case where a gentleman came to see me in my surgery, his eyes were streaming with tears and he was complaining that he had to wait 15, 16, 17 weeks to see a consultant. I said to him, "Did the doctor give you an opportunity to go somewhere else?", he said, "No, that was never given as an alternative." This was a Saturday and I said, "Go back to your doctor on Monday morning, tell your doctor you do not want to see the consultant she has told you, you want to see another consultant, I have the lists in my office, I will look up the lists and I will ring you up over the weekend." I found out that the North Durham Hospital was 15, 16, 17 weeks, but at Sunderland it was three or four weeks. He went back to the doctor on Monday and told the doctor and she said, "Who has told you this?" He explained and she said, "You have to go to North Durham", he said, "I don't want to, I have been told I can be seen quicker somewhere else". He insisted and he was sent to the hospital in Sunderland in three weeks, and two or days after he wrote me a letter saying "Thank you very much indeed." I then got a letter from the doctor telling me to mind my own business, that I had destroyed patient/doctor trust. I wrote back and said, "No, it wasn't me who betrayed the trust, you betrayed it because you did not give him the information in the first place." That was one case. There are other cases where doctors refer patients to a consultant in a specific hospital—and the Chairman has mentioned this. I have some examples here which I got this morning. In North Durham, for ENT the longest waiting list is 13 weeks, the shortest is six weeks. That is not a very bad example. In ophthalmology, 32 weeks for one consultant in the hospital, another consultant in the same hospital, nine weeks. So the list could be virtually halved if there was a system of pooling where the doctor referred to the hospital pool for ophthalmology rather than to a specific consultant, yet they will not do this. When I asked my doctor why he did not do this he said he did not have the time to do it. That is in the same trust. Take gynaecology, for example, in North Durham you have to wait 42, 33 and 33 weeks to see the consultants, in Sunderland, which is ten minutes down the road, five weeks, eight weeks, nine weeks, 11 weeks. So why are those consultants not used by different doctors? All they have to do is look at the list, see where the shortest list is and send their patients to those hospitals. Why are consultants and doctors stuck 100 years ago where they are not prepared to manoeuvre at all to help the patients?

(*Mr Crisp*) Let me deal with the two issues separately. Firstly, the one about the GP deciding whether or not to refer to the person in the local hospital who had the shortest waiting list. They have that information at the moment, what we are saying, and what I said to the Chairman earlier, is we want to make sure that information is also available to the patient because there may be some reason for going to the person with the longest waiting list. They may be a particular sub-specialist in that particular speciality.

45. Or the doctor plays golf with the consultant.

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[Continued

[Mr Steinberg Cont]*(Mr Crisp)* I think that is not relevant.

46. I think it is very relevant.

(Mr Crisp) It certainly would not be relevant when the patient has got that information as well. I do think it is right for us to be in that position and you will have heard our Secretary of State saying that. On the second one, where people are referred to North Durham Hospital rather than to Sunderland Hospital, the health authority which has responsibility for planning for the care and paying for the care of people within that area has chosen to do that. They may choose to do it differently in the following year and send patients to Sunderland rather than to North Durham, however that is a local choice, but again you will have heard the Secretary of State talking about how it would be important to try and introduce some choice within the system, because the point you make is a very strong one.

47. Do you accept that if the system was to change so that GPs referred not to specific consultants but to pools or to different trusts where the lists were much shorter, the people having to wait would considerably reduce without another penny being spent?

(Mr Crisp) The two issues are separate. The first one about the pool, in general we think that is the right way to go unless there is a sub-speciality reason—if the guy you are referring to is good on shoulders and not knees. That sort of issue.

48. I accept that.

(Mr Crisp) The second point is these are powerful arguments, we need to look at them and work out how to do it practically. You will be aware that was where the Health Service was a few years ago to a significant extent in terms of running the internal market. Now we are looking at how we ought to manage the introduction of some choice without going down the same route as before.

Mr Gibb

49. I want to go back to the Chairman's question regarding paragraph 2.22. You gave a measured answer talking about balancing positions and so on. If you read the paragraph it is really quite damning, it says that nearly 52 per cent of consultants said they are working to meet NHS waiting list targets which meant that they had to treat patients in a different order than their clinical priority indicated. That is a very damning thing to say, and you talk about balancing positions and priorities as a response to that. Have any consultants been disciplined by their professional body as a result of taking these kind of decisions?

(Mr Crisp) Let me explain the reply. This helpfully tells me there are 20,000 consultants working in the NHS, I said 17 to 20,000. You will notice that they interviewed 558, and you should be aware that half of those were in trauma or orthopaedics, so this is a very selected group of consultants you are talking about. That is just by way of background and there may be some particular issues in some specialities and not in others. That may be more likely to be the case there than it would have been in heart surgery, for example. Your second point, has anyone been disciplined to do this, I am not aware of anyone being

disciplined for doing this. Where issues have arisen or have come to the attention of the Department, clearly we have intervened and made sure they are not repeated.

50. Do you think it is ethical for a consultant to cave in to pressure from management to deprioritise somebody they believe in their professional judgment should take priority over another patient?

(Mr Crisp) If it were that black and white and if we were absolutely clear, but if you just look at this information here, this is asking consultants if that has ever happened and giving a few examples which—because we do not know what they are—we have not actually had a chance to look at properly. If a doctor believes that he or she is being ethically compromised by something they are meant to be doing, then they need to raise that with their managers, they need to decide how to handle that. We are very clear, we do not want clinical standards or priorities to be interrupted.

51. So do you think it is not happening?

(Mr Crisp) It may be happening in some individual cases.

52. Do you not know?

(Mr Crisp) One hears allegations from time to time and where those are investigated, if there is a problem, it is made sure it is stopped.

53. Do you agree with Martin Taylor, who said before another Select Committee, the Public Administration Select Committee last week, that the NHS targets such as waiting lists are essentially political targets? He said that he did not blame ministers, it was the natural consequence of excessive promises made in the past and a kind of national hysteria. He went on to say that if you have one key target and subordinate all else to that, things will go wrong, "it is a dangerous trap which we fall into". Are we falling into that trap?

(Mr Crisp) No, I do not believe we are. The first thing which has to be said, whether there are political issues here or not you will be better able to judge, but there are patient issues here. When we talk to patients, the single biggest issue which they raise every time is waiting, and it is not just waiting for admission to hospital, it is waiting for access to a GP, it is waiting within the Service. This is a very important patient issue. Secondly, it is not our only target. In fact, we normally get accused of having too many targets. We have very clear targets around cancer, coronary heart disease and so on, which are enormously important, and around emergency care. So this is not the only target we have, but it is one which for patients is important.

54. I am slightly alarmed by your complacency. We have the NAO Report saying there is something going on here, we have people like Martin Taylor saying there is something funny going on here, but you are saying as far as you are aware there is nothing funny going on?

(Mr Crisp) I am sorry if I am being complacent because this is serious, as I hope I said at the beginning, not least because we have issued so much guidance on it. The other thing, and this brings me back to what we are doing in the future, is you can tell people to do things or you can tell people not to

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do things, but how do you make sure it happens. One of the things we need to do is to help people manage their waiting lists better and that takes us back to the issues of good practice, and again we have issued some very clear guidance around how to handle that.

55. There have been some recent falls in the waiting lists but there have also been some increases in the waiting times at the wrong end, between 12 and 17 months. For example, in the last quarter I have figures for, inpatient waiting lists have gone up from 41,000 to 46,000. Are we seeing falls in inpatient and outpatient waiting lists at the expense of longer waiting times? Is it like squeezing jelly, you push it in one place and it comes out somewhere else?

(*Mr Crisp*) You are referring to the quarter on quarter change, are you not?

56. Yes.

(*Mr Crisp*) Whereas actually, if you take a year on year change, you will see the 12 month-plus waiters are coming down. At the moment they are 44,670. Is that the figure you have for 12 month-waiters at the end of September?

57. It is a similar figure to the one I have.

(*Mr Crisp*) Whereas a year ago it was 51,000. The year before that it was 50,000. We are trying to squeeze that down. At the end of this financial year I am expecting that figure to be about 25,000.

58. So it is not just coming out somewhere else? You do not see an extension of waiting times as a consequence of targeting waiting lists?

(*Mr Crisp*) Sorry, the point I should have made is that we have actually changed our policy in the last few months to make it clear we are concentrating on waiting times, not pure numbers on the list. But we do need to increase activity to get those waiting times down. Waiting times are the important issue.

59. On a general issue, how do you think that health policy should be changed to cope with ever-improving advances in medical science?

(*Mr Crisp*) I think I am here to talk about implementation rather than speculate about health policy.

Chairman: I should say we should not get too much into policy.

60. You mentioned earlier Norway and the fact that as from January of this year in Norway people have a free choice of hospital. The *Telegraph* reported the other day that you will be able to have a choice if you have been waiting more than 12 months. Is that right, that you will have a free choice of hospital if you have been waiting for more than 12 months?

(*Mr Crisp*) Happily I am not here to speak on behalf of the *Telegraph* or any other paper, but we are certainly, as Mr Milburn has made clear, looking at how we can introduce more choices in the system. There are some choices in the system at the moment and we want to emphasise them and make it clear that patients have more control in the ways I talked to Mr Steinberg about earlier. Whether that particular report is accurate or not, I do not know.

61. But you are the Chief Executive of the NHS.

(*Mr Crisp*) But not of the *Daily Telegraph*. My interest is in looking at firming up exactly how we introduce choice into the NHS.

62. Is it not possible we could have a free choice of hospital throughout Britain without waiting 12 months first of all?

(*Mr Crisp*) I think that would be highly desirable. Let us be clear though that we are coming from a position which is, as this report says—and this is what I am relying on, I am not remotely complacent about it—unsatisfactory. We need to make a lot of changes here and we need to increase activity, increase staffing, improve the way we are doing things. Over that period of time we will, I believe, get to a point where the patients will be much more in control and where we should be able to look at choices in the way you are talking about.

Chairman

63. Before I turn to the next member can I ask a question of the Comptroller? It arose from an answer given by Mr Crisp on paragraph 2.22, where Mr Crisp mentioned the very low numbers who responded to the survey, 558 out of 20,000, and Mr Crisp seemed to be suggesting that this threw into doubt the validity of the conclusions reached. Would the Comptroller or somebody from the National Audit Office like to comment on that?

(*Sir John Bourn*) The position on the figures, Chairman, is that we got the fullest information we could in the time available and we discussed it and the number of cases with the Department, but we are not claiming that the figures meet the highest criteria of the statistical profession. Nonetheless, we think they give to the Committee a good indication of the thrust and the nature of the issue.

64. But of course Mr Crisp has agreed this report, so presumably you both agreed that although it is a low sample it does have a real validity for our deliberations, otherwise you should not have agreed the report.

(*Mr Crisp*) I intended to make the point, and am happy to make it now, that this sample, 50 per cent of which is from one speciality, is an indication that we have a problem. My point was that it is not so it is a problem across all specialities and there may be some other areas where this is not an issue, so we need to treat it as a problem and identify it as a problem and deal with it but there are some other aspects to take into account as well. That is all I can say.

65. But if you had some further information that this was giving us a wrong view of it, because of the other specialities, you might share that with us in a note?

(*Mr Crisp*) Indeed, let me come back to you on that.

Geraint Davies

66. Turning to the point that has just been made, in Croydon, which is my patch, it says that 52 per cent of orthopaedic patients have to wait over six months, which sounds appalling. At the same time, when I quizzed the Trust they said to me between March 1997 and March 2001 there was a 13 per cent overall reduction in inpatients and a 44 per cent reduction in outpatients. How would you comment

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on that? Is that something that underlines your earlier comments, namely this is very tightly focussed on certain disciplines and we cannot infer it across the board or is Croydon trying to pull the wool over my eyes?

(*Mr Crisp*) I have a briefing here from Mayday. I think what they have illustrated to you is that they have focussed on a set number of issues, they have actually made a significant improvement in quite a lot of areas but I think they are also recommending they have further to go and the capacity issues around orthopaedics are significant, it is a very high number.

67. They have to try to make improvements but I am only commenting on the point that has been made by the Chairman of the C&AG that it appears in that case that we cannot infer from specifics, in general they seem to be doing very well and in specifics they seem to be doing very badly.

(*Mr Crisp*) I think that is right. I also think the point there is that we have to look at this in each trust to understand what is really going on.

68. There is trade-off, if one wanted to be a statistical manipulator, working in the trust between producing the overall numbers on the list and getting maybe a quarter of patients and making them wait an extra six months, you keep a certain section of people waiting an enormous amount of time and you push through a lot more people and therefore reduce your overall waiting list, is that a strategy you see adopted?

(*Mr Crisp*) I do not think it works like that. What you need to do, what the chief executive needs to look at is to understand the composition of people on their list and they need to understand the people in each speciality by the clinical severity. They need to make sure that people who are most clinically urgent are got through quickest and even within a category the people who have waited longest are dealt with first, sometimes it is just as basic as that.

69. There is trade-off in there because even if one went down the line that it has to be clinical importance first then you would never treat anyone with an ingrown toe nail, would you?

(*Mr Crisp*) On paragraph 2.21 of the Report there is an important balance to be struck. There needs to be some flexibility in the order in which patients are treated. We must not do it too far the other way, but the point that is made here is that on an operating list you know you are able to do two big cases and three little ones.

70. If there is a little bit of space over I can have my ingrown toe sorted out. The point I am making is that unless you say that it is not the case that the more serious ailments are dealt with then we are never going to deal with minor ailments, other than in the five minutes at the end of your session.

(*Mr Crisp*) You can do it in a planned way, if you look at the more serious ones and you conclude they need to be done in the next four weeks or five weeks you can plan to do that, but if you have the right strategy you can also plan to do the people who have been waiting up to 12 months. You can actually do it a planned way and manage to achieve getting clinical priority right and also getting admission for the more minor cases.

71. The NHS plan pushes forward a more ambitious target, you no longer have to wait more than six months by 2005. Coming back to my ingrown toe nail, does that mean there is enormous pressure suddenly to deal with large numbers of minor and relatively trivial cases?

(*Mr Crisp*) We may put more capacity on to it, perhaps I can give you another illustration, we do as a matter of practice make sure that we get patients of clinical, with some minor exceptions, importance, that does not mean to say we should not also plan for the people who are less clinically important. I note that the Royal Marsden, which specialises in cancer, seems to have an average waiting least of seven weeks whereas the average waiting time across the country as a whole is three months. You can see we are putting resources in places where people have greater clinical need, you have to do both.

72. You are not encouraging people where there are longer waiting lists to go to the Royal Marsden?

(*Mr Crisp*) There may be some scope for that but currently people will be referred to the Royal Marsden primarily based on geography and clinical need.

73. If you did allow Mr Steinberg's suggestion will find that the Royal Marsden waiting list is increasing again?

(*Mr Crisp*) I am sorry we have opened up the whole question and debate of whether or not we should have an internal market for this because you are assuming certain consequences of doing that. I think there is scope for us to introduce choice for patients in a controlled way and in looking at it we need to make sure there are not negative effects that come out of it.

74. We would all agree with that. 46 per cent of chief executives are said to have redefined the way they accounted information in the year 1999/2000, of which nearly 90 per cent said that meant a reduction in waiting lists. Are you finding that a preoccupation inconsistent with other trusts and is this going to be straightened out so that we do not have apples compared with oranges?

(*Mr Crisp*) Yes, we are. Firstly, the definitions have remained consistent through this period. It may be that people may be looking at how those definitions have been applied in their own hospitals.

75. It says in the Report, "redefined the way it counted its inpatients and nearly halved it in one year", the definitions have not remained the same.

(*Mr Crisp*) What you will find that that means, as I understand, is that some procedures which have previously been treated as inpatients have become outpatients, so that something like an endoscopy or a cataract operation will have transferred from an inpatient procedure to being an outpatient procedure. That is because medical practice is changing. That is why that is happening. We have kept the definition consistent through this period and that will continue to happen, more and more people will be treated as day patients who have previously been treated as inpatients.

76. In terms of definitions this Report does not include Accident & Emergency, pregnancy admissions or anything like that, does it? From the

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point of view of inpatients that does not include second or subsequent appointments, just the first appointment.

(*Mr Crisp*) It does not.

77. There are limitations to this Report, are there not? Tell me about the 1.5 million patients who are scheduled to have a first appointment and the 13.7 million who do not turn up, what are we doing about that?

(*Mr Crisp*) One very strong thing we are doing about that is moving to a booked admission system. What I mean by that is at the point at which it is decided that you need an operation or an outpatients appointment—Mr Fillingham can explain the system much more clearly - you will have the choice of a date and you are able to be slotted into a diary.

78. It is extraordinary that we are only just starting that. At one point I ran a travel business where people telephoned and said, can we go on holiday on this particular date in this particular place. You booked them, or not, they either go somewhere else earlier on or later, there will always be trade-off in booking appointments in the NHS. It is amazing to me that we have waited this long for people to know when they have their appointment rather than some time in six months. Is that not one of the reasons why we get so many people not turning up, because there is no clarity from the NHS when they are supposed to go and if they do not turn up there is no sanction against them?

(*Mr Crisp*) In general I agree with you, which is why we are introducing the booked admission system. Where we have introduced this the evidence has shown that we are reducing the number of people who do not attend. That is where we need to go. By March 31 five million patients will be in the booking system, so we are moving there.

79. Operating theatres are normally open between 8.30 and 5.30 normally, something like 40 per cent go over that. What I do not understand is why they are not open 24 hours a day?

(*Mr Crisp*) Let me just pull out two points here, in every acute hospital there will be some theatres that are because of emergencies, we will have that continuation. In terms of planned lists in general we are working a day that is between 8.30 and 5.30, as you say. The limiting factor there is other aspects of capacity, most notably staffing, including surgeons and secondly bed availability. Our theatres are not in general bottlenecks for getting more people through.

80. Tell me about bed availability and bed blocking, it is the case that some people in the nursing home industry say had there is almost a shortage of nursing homes, particularly in London and the southeast, and people are selling up and going into residential homes, normal people who do not need support, and in fact the cost of beds in nursing homes is appreciably less than the NHS. Do we have the numbers wrong, should we invest more in nursing homes and less in marginal beds in the NHS?

(*Mr Crisp*) This is taking us into another hugely big and important topic.

81. It does impact on waiting lists.

(*Mr Crisp*) But it is not quite exactly as you describe it. We have this year about the same number of people delayed in hospital by lack of a transfer to nursing homes as we have had in previous years.

82. Too many.

(*Mr Crisp*) Too many. We need to understand why and what we can do about it, because it is not just as simple as putting up the price of nursing homes or creating new ones. There is a whole series of interventions we need to put in place. You are quite right, when we have people in hospitals who do not need to be in hospital, we cannot put people in hospital who do need to be in hospital. So it is all part of a much bigger system.

83. What I am getting at in simple terms is that the cost of an extra bed in the NHS is the same as the cost of two beds in the nursing home sector, so clearly at the margin you start shifting resources.

(*Mr Crisp*) But if you have also worked in the airline industry, you will know the marginal cost of a seat in the airline industry is pretty small, and if we shift two people out of Mayday Hospital and put them in nursing homes, we will only release the marginal cost in Mayday and it is not as big as the cost of putting them all in nursing homes for the next three years, which is the average length of stay people have in nursing homes.

84. These people do end up in nursing homes, so it is a question of when they go in.

(*Mr Crisp*) But they go in through a properly planned and funded stream. It is not as simple as saying, "You can take the marginal cost out of hospital", which is by and large smaller than the cost of introducing a new residential bed.

85. Actually the marginal cost of acquiring an extra bed and not using it but buying it is more than the average cost, is it not?

(*Mr Crisp*) We can open this up for a longer discussion.

86. I will move on. A comment I made the last time you appeared before us was something along the lines that various royal colleges were saying that because of recent cases of negligence claims have been successful against doctors, and doctors are reluctant to rush through very large numbers of patients they are diagnosing in case they make a mistake, and because of that the Royal College of Surgeons, the Royal College of Physicians, the Royal College of Ophthalmology and indeed Urology and Orthopaedics as well, as I understand it, are recommending that they look at 15 minutes per patient, or 20 minutes for a new patient, 10 minutes for a follow-up. Given that is quite a lot more than currently they take to see these, does that not mean there will be an increase in waiting lists, other things being equal, although I realise more money is going in? Secondly, that the average cost would go up? In other words, because there is more pressure and more concern even though there is more money, we are going to see costs rising and the waiting list erosion is going to be less than we might have hoped.

(*Mr Crisp*) You are quite right that royal colleges and others are seeking to introduce new standards which would have that effect, but that is not the end of the story. We are also engaged in discussions with

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the royal colleges about whether we can do things differently, because that is assuming we run things exactly as we have run them to date, and maybe we can do things in different ways perhaps with different groups of staff doing different jobs and so on. So that is a pressure but one we have to make sure does not have the effect you are talking about.

87. If we are not to put more pressure on them and not increase the amount of time per patient, what will we do? Give them more legal protection?

(*Mr Crisp*) You can see a whole series of things which are happening in the NHS where we are doing things differently, so the anaesthetist may be seeing them at a particular time of day, we may be bringing them in in the morning rather than overnight. There are lots of other things we can do to increase throughput, if you like, in terms of the number of patients going through the system which are not purely dependent on that point. We can do things differently.

88. Finally, is your general view that things are getting better although there is room for improvement?

(*Mr Crisp*) Yes. There is a big underlying infrastructure renewal happening at the moment. There is a lot of learning, a lot of spreading of good practice, some very good things going on through the programmes of the Modernisation Agency, but it is taking time to come through.

Mr Osborne

89. Mr Crisp, you said earlier to members of this Committee that waiting times are the important issue, and I would agree with you. Do you think it was a mistake for the NHS to target waiting lists instead of waiting times for four years?

(*Mr Crisp*) I think again that was actually a policy decision which it does not seem to me I should be commenting on. There is an advantage, however, in the argument of targeting waiting lists as well, which is we need to bring them down overall because if we are going to get the waiting times down to an appropriate point we need to have reduced our waiting lists to do that.

Chairman

90. That is a policy issue.

(*Mr Crisp*) Yes.

Mr Osborne

91. Do you agree with the King's Fund which says that national waiting list targets divert attention away from the issue which matter most to patients, by focusing simply on the number of people waiting for treatment after seeing a hospital consultant, and that the list ignores the time people are waiting and the severity of their need?

(*Mr Crisp*) I did say earlier that the policy as it stands at the moment within the Department is that we are focusing very much on waiting times and specifically on reducing waiting times for the most seriously ill patients.

Mr Osborne: So you do not agree with the Chairman of the BMA Consultants Committee who said that the waiting list issue had distorted clinical priority and denied care to people in most acute medical need, that the NHS must end its obsession with numbers on lists and focus on patients in greatest need?

Chairman

92. You can answer that or not as you wish, Mr Crisp.

(*Mr Crisp*) Let me make the point that I have recently written to the chairman of the BMA setting out where money is being spent within the NHS and how we are targeting long waiters. I think I have already answered the point in that we have put within our overall policies, our deliberate attention on the most seriously ill people.

Mr Osborne

93. If I could turn to the NAO survey at paragraph 2.22, which we have already discussed, and I take your point about the sample, I was slightly surprised to hear you say that you did not think this was particularly widespread due to the sample and the kind of consultants who had been interviewed. Can you give me some indication of how widespread you think it was at the time the report was put together that some consultants were distorting clinical priorities?

(*Mr Crisp*) The first answer is not enough to distort the overall figures, because if I look over this period the number of patients who have been admitted within three months of waiting has stayed broadly level. That would indicate we are giving the same level of priority as we always have done to those people who have the most difficult clinical conditions. So not enough to show up in those figures, otherwise we would have seen a trend in the under three months coming down as a proportion, would we not?

94. A large number of organisations, the BMA, the King's Fund and so on have said the same thing. The chief executive of the Nuffield Orthopaedic Centre said that "the name of the game is to get numbers off the list" (*Electronic Telegraph*, 15/11/98) so it is going to be more beneficial to focus on the cheaper procedures and that by deploying such a process he successfully cut 400 patients off the list in four months. Surely all these signals must be coming into the Permanent Secretary's office that consultants around the country are distorting clinical priorities?

(*Mr Crisp*) This report entirely fairly says we have issued guidance and instructions on this many times, we have also invested money in the high profile and important procedures such as coronary heart disease, and if you start to look at the figures on a widespread basis you will actually see that does not appear to be happening. There may be quite a lot anecdotal cases, and I have no doubt there are specific instances where that will happen, and I have also no doubt that people can see incentives in making that happen, just as you have described the chief executive of the Nuffield Orthopaedic Centre did. That does not mean to say it is widespread. Where we come across

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that as an issue we need to do something about it and make sure it is not continuing to happen, but I am not complacent about it.

95. You conceded there are specific instances and specific incentives, do you think it is possible that anyone has died because they were not treated with the degree of clinical need they should have been because someone was trying to meet a target?

(*Mr Crisp*) I would have no way of knowing that. Nobody has brought that sort of case to my attention.

96. No one has brought it to your attention?

(*Mr Crisp*) No. My point is undoubtedly in a service which sees 5½ million elective patients on an annual basis there will be some instances where there will have been some distortion of clinical priorities, but not at a level which is enough to distort the overall figures and show there is a real pattern of this happening.

97. There was an interview in which Peter Wilde, a heart specialist at the Bristol Royal Infirmary, said of the 20 patients on his heart operating waiting list who had died in the past six months: "If those patients, who had been classified as urgent, had been operated on within a month we would have saved half of them." (*Daily Telegraph* 1/3/00)

(*Mr Crisp*) I cannot comment on that particular example, I am not sure if that is the same thing.

98. He was attacking the waiting list targets.

(*Mr Crisp*) He was not implying that instead he had been asked to operate on people of a lower priority. I do not know the particular quotation, I do not think I can frankly comment on it.

99. Can I turn to outpatient lists? Do you think it is possible that the pressure to reduce inpatient lists resulted in a surge on the outpatients list?

(*Mr Crisp*) I think there are some figures here which I am desperately trying to find.

100. Figure 6, page 12, maybe.

(*Mr Crisp*) The one before that. What you have seen is that may have been the case initially but if you look at 2000 and 2001 on pages 11 and page 12, where you have the inpatient waiting list on one and the outpatient waiting list on the other, then you can see that in the last two years both have been coming down for the first time ever.

101. I certainly agree with you on that. If you look at figure 6, the first bar graph, there is quite a steep rise when inpatient waiting lists have been targeted, there is quite a steep rise in the outpatient waiting list, do you think the two are linked?

(*Mr Crisp*) They may be, certainly. The other point to make about the outpatient waiting list, this is the long wait, this is not everyone on the outpatient list, this is people waiting over 13 weeks. There may or may not be a link between the two. However, having seen that steep line in the outpatient waiting list what we did in the Department was to refocus attention on the outpatient waiting list as well and make sure that we drove both of them.

102. I feel you are being a bit evasive, you must have seen these figures rising dramatically and I am quite willing to accept that you took action that was

successful in bringing those lists down, but you must have had some idea why suddenly outpatient waiting lists were going through the roof?

(*Mr Crisp*) If you look at 1998 on these two cases you will see that the inpatient and the outpatient waiting list rose in 1997 and 1998, both lots rose, there was only one year where what you are talking about happened, which is 1999, where the outpatients continued to go up and the inpatients came down. There may or may not be a direct connection between the two. The important thing is that the corner was turned on them.

103. Is pressure being applied to GPs to curb patient referrals in order to reduce outpatient lists?

(*Mr Crisp*) Not as such. Not that I am aware of. What I think is happening is that GPs, as with other clinicians, are looking at places where they can get treatment done in different ways, so they will be looking all of the time at that. If you look at the first outpatient attendances you can see year-on-year outpatient attendances are going up, which are linked to the number of GP referrals going up over that same period, I think it is broadly on the same curve. GPs will need to look and see if they are getting the right treatment for their patients so there is no pressure on the hospital.

104. According to *Doctor* magazine last year two schemes in the primary care groups in North Staffordshire—I know Mr Fillingham is going to be very interested in this two schemes—offered GPs up to £1,000 to meet outpatient referral targets in a North Staffordshire hospital, is that practice widespread?

(*Mr Crisp*) That is an incentivisation to do what?

105. To meet outpatient referral targets.

(*Mr Fillingham*) Mr Fillingham: I was familiar with North Staffordshire, what that was about was incentivising better referral practice, not simply about reducing outpatient waits. Just as there is variability across the country in hospitals there is considerable variability across general practice. Using the best clinical advice it is sometimes clear that some practices are very high referral, some practices are quite low in referrals, because they are not referring enough, and what those two primary care groups are doing is working with good clinical advice to try to incentivise better referral practice. The key to all this, which is what the agency is working hard on, is getting GPs and consultants together to agree what is appropriate clinical practice and then to incentivise that behaviour. As part of that quite often it does become clear patients did not need to be referred to hospital, they did not need to see hospital consultants, they could have been treated in other ways.

106. In this case you are saying they are offered £1,000 to hit specific outpatient referral targets?

(*Mr Fillingham*) If they were successful those payments were used for facilities within the general practice for the benefit of patients. Just as in previous times when we had prescribing incentive schemes, which are aimed to incentivise good practice, that money again has been able to be used for equipment, for a physiotherapist within the practice, and so on.

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107. I do not doubt it is an attractive sum of money, that is what I am saying, it might influence a doctor's decision to refer somebody to a consultant in order to get £1,000

(Mr Fillingham) The intention was to influence more appropriate referral practice and if this was done with good clinical advice that seems to me to be right and proper, just as we want less variation across hospitals and good practice we want the same within primary care.

(Mr Crisp) That is drawn out in this report, you have the same example of consultants making comments about GP referral practice and the wide variations within it.

108. It does not really work in North Staffordshire because they have the highest outpatient list in the country?

(Mr Fillingham) They do. It was starting to have an effect. For example, linked to that scheme was the development of the Back Pain Service, that was physio and OT led, it was quite clearly demonstrated that only about seven per cent of the patients that were going to see an orthopaedic consultant for back pain actually needed to see that consultant, the rest could be dealt with by physio and OT instead. North Staffordshire have a particular problem, they have a steep hill to climb and they are getting there. In every area we need to understand what is okay and what needs new investment and what we can achieve by doing things differently and by promoting good practice, and that is as true in North Staffordshire as anywhere else.

109. Are you going to use that to modernise the NHS?

(Mr Fillingham) I am certainly going to use my experience of understanding the very real pressures there are. You will also be aware that North Staffordshire does very, very well on the inpatient day case figures. The major problem is in outpatients and that is what we have started to tackle.

110. On the inpatient list it is sad to see that one of my own health authorities with many of my constituents, North Cheshire, is the worst performing health authority when it comes to inpatient lists. Can I finish, since my time is almost up, with a very general point, why is there such an enormous variation? Any Member looking at these will be astonished by the fact that in some health authorities, for example in North Cheshire, 49.9 of all ear, nose and throat patients wait almost six months for an operation, yet in Rotherham, so it is not a question necessarily of more affluent areas doing better, only 1 per cent of patients wait. North Cheshire 49 per cent and Rotherham 1 per cent and Dorset zero per cent. Why is there such an extraordinary variation between different health authorities?

(Mr Crisp) I think it is individual cases. The example we were just given of Croydon shows that in the particular instance of orthopaedics it was an outlier for Croydon compared to other specialities in Croydon. It is a mix of capacity, and historical capacity, and in some cases just how effectively the management system works. It is both and we have to tackle both.

Mr Osborne: Thank you.

Chairman

111. I do think that is something that we need to investigate further, you have been asked this question several times and you keep saying it is a question of capacity. It would be interesting to go into it deeper?

(Mr Crisp) Do you want a note on that?

112. Yes. It does not really bring the debate forward much more if you say, that is a very interesting statistic, it is a question of capacity. Do you understand?

(Mr Crisp) I take the point but we can illustrate it with North Staffordshire where there is a serious under-capacity in acute facilities, but we will produce a note, Mr Chairman.²

Chairman: Thank you very much.

Jon Trickett

113. I want to follow on from the point you have just been making, Chairman. When you look at my home health authority, which is Wakefield, and using the data which is in front of us, it turns out Wakefield Health Authority does worse than all the other adjacent authorities in terms of inpatients per thousand, in terms of inpatients waiting for more than six months in trauma, in urology and in ear, nose and throat. In some cases the differences are quite striking and in fact alarming really. I do not expect you to know the geography of the area, I will talk about that in a minute, but first of all can you comment and give any reason why Wakefield should do worse than all the adjacent authorities and the English average as well?

(Mr Crisp) I can obviously, and would be happy to, produce you a note on the specifics of Wakefield but I do not have that with me at the moment.³

114. There are these quite severe disparities. My first assumption was that Wakefield does very poorly in terms of health, given the industrial heritage of the coalmining industry, that was probably the explanation, but then I looked at comparisons with Doncaster and Barnsley, which are adjacent, and discovered extremely disturbing disparities. For example in ear, nose and throat we have over a quarter, 26 per cent, waiting more than six months in Wakefield but in Barnsley and Doncaster, which are adjacent, in Barnsley it is only 3 per cent, which is an eight-fold difference, and in Doncaster it is 4.5 per cent, which is a six-fold difference. Do you have any comments at all about those quite alarming differences, all of which are coalmining communities?

(Mr Crisp) I am sorry, I will have to give you a note on the specifics of your constituency. I am afraid I just do not have them with me.

115. The Chairman has asked for more work to be done on capacity and I wonder whether we have any information about output or productivity, or is it too vulgar to apply the notion of output to consultants?

² Ev 24, Appendix 1.

³ Ev 24, Appendix 1.

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[Continued

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(*Mr Crisp*) We do know the number of units of activity in a hospital and we do know the number of consultants within a hospital and within specialities.

116. Presumably there are variations, are there, between consultants?

(*Mr Crisp*) There are.

117. Do you find that groups of consultants within a trust also vary in terms of the number of outputs per personnel relative to other trusts? Are there differences in productivity between one trust and another per specialism?

(*Mr Crisp*) There will be and in cases like ENT there undoubtedly will be, not least because some units are very specialised and do the long, major pieces of surgery, and some do the shorter ones.

118. Barnsley, Doncaster and Wakefield Trusts are not specialists in ENT, so I have no knowledge of any specialism being done on a sub-regional basis, outside of Leeds probably, on ENT. I wonder why the C&AG did not look at that because clearly the productivity of consultants, whether as individuals or groups, must impact on the disparities between trusts. Is it not something you chose to look at?

(*Sir John Bourn*) It certainly is something well worth looking at. We did not look at it but that does not mean to say the point is not a good one.

119. I think the data will be very interesting. Whether or not we find Wakefield is more or less productive than the surrounding authorities I think will be very interesting. It would be interesting to try to do some kind of scatter graph to see whether you can get some statistical correlation between waiting lists, waiting times and the productivity of consultants. After all, if coalminers are judged by the amount of coal they produce, why should consultants not be judged by their productivity? I want to go on to two specific questions in the time left available to me. The first relates to this issue of capacity. We have touched on human productivity but capacity also relates to physical capital.

(*Mr Crisp*) Yes.

120. A striking fact which has already been referred to is that theatres are actually closed more than they are open during the week, but how many wards are actually closed each week or for parts of the week?

(*Mr Crisp*) That is certainly not a piece of information we collect. We do collect the information retrospectively on the number of beds open as opposed to wards.

121. Would it surprise you if I said that within the last three months I have visited a hospital and found wards padlocked with chains and padlocks on the doors which led both to beds and also to theatres being sealed? This was a very, very large general hospital.

(*Mr Crisp*) If that is what you found, I would be interested to know why that was the case.

122. Are you not aware that is happening?

(*Mr Crisp*) I do not know the context but let me say that we have very recently received the analysis of the number of beds open last year as opposed to the year before, based on a daily census, and that has gone up. We are having another census very shortly, on 30 November I think, when we will be looking around

the country to see what capacity we have in place for winter. If there are any doubts or questions about it, we will be picking up the issues as to why in Wakefield, or wherever it is, you have this.

123. It was in Leeds. My father was being treated late on a Friday afternoon in an emergency admission, and we discovered there were two wards and several theatres with padlocks and chains at 4.30 on a Friday afternoon. Apparently, the padlocks and chains were not removed, and never are, at the weekend in those theatres. The staff were available and actually came in and did the operation and he was put into another part of the hospital.

(*Mr Crisp*) In that case, it sounds to me as if it was a planned process for running five-day wards. There are a number of procedures, which are not normally conducted on a Friday afternoon, where the length of stay is one, two or three days, and we find it is an effective way to run our facilities with the staff we have to run them Monday to Friday on a five day week and close them down at the weekend. There will be a number of wards like that.

124. The staff were available and were brought in, in fact they were being paid to stay at home. I spoke to all the staff because I was admitted into the theatre and discovered they were being paid to stay at home and the wards and the theatres were locked. If this is a practice which you are aware of, it is a rather surprising one.

(*Mr Crisp*) Not as described by you. There are in any hospital emergency wards which are open all week round, all year round, and theatres running all week round and all day round, there are then day facilities which are only open 8 to 8, there are then outpatient facilities which are open something like 8 to 8, and then there will be five-day wards designed specifically for certain categories of surgery. Obviously, I do not know the case and I do not understand why staff should be waiting at home rather than being in the theatre or in the ward, but hospitals are not just one thing, there are all different streams of patients and some patients need different treatments.

125. There is no company which would have an amount of capital plant tied up and closed more often and for more hours in a week than actually being open and used. When we talk about optimising, on page 26, the capacity of clinics and the capacity of operating theatres, we are actually optimising all of the plant which is available in a hospital. By the way, I could take you to another hospital where there are three wards which are permanently closed and padlocked and have been since I was elected an MP in 1996, although other parts of the hospital are in use. I think there are a large number of wards which are simply padlocked either for parts of weeks or whole weeks.

(*Mr Crisp*) Can I make one comment on that. The bottleneck is staff by and large within the NHS rather than physical facilities. I do not know the state of those wards, they may need refurbishment. By and large if we could get staff we could open more beds. Beds are increasing, by beds we mean staffed beds.

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126. We have beds which are not being used. We do not need more beds, we need to optimise and possibly maximise bed space and theatres. There are empty beds and theatres throughout the country in significant numbers. I did not go looking for them.

(Mr Crisp) There is hard worked staff.

127. We have had the questions already about private medicine and the way in which there are operatives, it is made convenient for them to work weekends in private medicine when there are NHS facility closed. That is probably a policy issue which you and I ought not to trot into this afternoon. Can I move on to one other thing, which is the apparent conspiracy between GPs and consultants, again for the interests of the patient. I come back to these figures about Barnsley, Doncaster and Wakefield, what separates my constituency from Barnsley and Doncaster is a stream which I can bstride, I have quite long legs and it is not a very wide stream. In terms of my own constituency, it is actually nearer to Barnsley and Doncaster than it is to Wakefield hospitals, why do the GPs not take advantage of these really quite astounding differences in the waiting times to refer the patients to Barnsley or Doncaster? I do not ask you about specifics, but the general principle of extra contractual referrals across trusts boundaries?

(Mr Crisp) The responsibility for planning at a local level rests at the moment with health authorities and they reach agreements with hospitals to provide for their local population. They can change that on a year-on-year basis and they can determine that your part of their health authority should go to those hospitals rather than the other hospitals, I do not know why they do not. However, the point that Mr Steinberg has raised is that maybe patients should have more say in that and we should introduce an element of choice into that, that is certainly something that we are looking at to see whether or not we can actually do.

128. What would happen if my local GP, at the moment the GP is administered by Wakefield Health Authority or the health within his boundary, but for historic, cultural and I think administrative and bureaucratic reasons he refers patients to a longer waiting list in Wakefield or Pontefract than exists cross this stream in Barnsley or Doncaster. I think there must be some organisation or bureaucratic imperative to do that. I just remember vaguely being on a health authority at one stage in Leeds and I remember extra contractual referrals, which really means crossing boundaries, was frowned upon at the time.

(Mr Crisp) It is because we have basically a planned system and basically we are planning for the people within a particular health authority.

129. You are planning for people to wait in effect, are you not?

(Mr Crisp) This is the point Mr Steinberg made, we do have a release valve which is called extra contractual referral but by and large that should be used for specialist services that are not available within your normal pattern of availability. It is, undoubtedly, an issue and one we are looking at.

130. Is it not true that health authorities measure GPs by the number of ECRs and those GP practices which are looking after the patients that may be across a boundary are frowned on because they are not "loyal" to the bureaucratic imperative. Is that not the reason why my patients are waiting more than six months when they could be in Barnsley or Doncaster and be seen?

(Mr Crisp) GPs have contracts with the NHS and they have a number of duties to fulfil. In addition to that they are expected to take part in things which are about looking at their referral practices, comparing their referral practices to others, there are things to learn within all of that system. The point you make and Mr Steinberg has made is how do you explain that to patients? That is difficult.

131. I agree. You have to explain to yourself and go to bed with a clean conscience, but the fact is that you are accepting, I think, the scenario, which is wholly missing from this Report, that there is pressure on GPs not to engage in ECRs. It is this question of extra contractual referrals across trust boundaries which could make a massive impact into waiting lists in those areas where the waiting lists are particularly acute, especially where the boundary separates good practice and bad practice as it appears to do between Wakefield, Doncaster and Barnsley?

(Mr Crisp) We do have a planned Health Service, it is a Health Service that is planned through the health authorities and we do want GPs to be part of that, indeed we are making the changes in the system to give them more control within the system so that they will be making decisions that are appropriate. If they are part of the planned system they can have more say over things, precisely the ones that you are talking about. I also want to make one minor correction, they used to be called extra contractual referrals they are now called out of area treatments.

Jon Trickett: For the record, the plans you make involve people in my parts waiting longer than if they moved across the road in another area. If that is the planned Health Service you are constructing I do not find it very satisfactory.

Mr Bacon

132. Mr Crisp, could I take you back to paragraph 2.22 and this question of distortion of clinical priorities. I understand you to have said, I wrote down what you said, "it is not enough to distort the figures". I remember when this Report was published, it was on the front page of a number of newspapers, and the topic of the BBC *Today* programme two days running, when I read this paragraph I read the words, "we contacted a representative sample within three specialities, granted 50 per cent might have been in trauma, to give a broad indication across the whole spectrum". 558 consultants were interviewed, of which 52 per cent said they considered a distortion had occurred. You will know that a typical opinion poll is conducted on the basis of 1,000 people, that is to represent 30 million, in terms of voting intentions. I would have thought that 558 out of 20,000 is a pretty

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good sample, do I understand you to say that you basically disagree with this paragraph, that is what I think you said earlier?

(*Mr Crisp*) I think what I said, and let me try and repeat it, was that they need to be seen in context, this is not the whole of the story. This is a worrying and important point that is being made here which does need attention, that is why, as I said before, we have both put out some clear statements about where priorities need to be so that people understand that if they are doing that that is not what we are trying to get them to do and, secondly, why we are doing so much work through the Modernisation Agency to improve the way in which waiting lists are managed. There is a lot of work round that. It is not the whole picture, because in other areas we are clearly targeting the highest priority of clinical cases.

133. Do you think it is still going on?

(*Mr Crisp*) I do not know whether or not this is still going on. If it is it will be decreasing for the two reasons of, firstly, the instructions we have sent out and, secondly, the fact that the management of waiting lists is improving.

134. I wanted to come on to that. You also said that if the waiting list system is run effectively this need not happen. The Report provides quite a lot of evidence that the system is not being managed efficiently, may I start with paragraph 2.29, which talks about the patient administration system and how they vary, yet some of the software was not designed to provide key waiting list management data that trusts are now required to produce. Why would the trusts go off and buy computer systems that did not enable them to provide the basic information?

(*Mr Crisp*) My understanding on what that is referring to is that some of these patient administration systems are relatively old and at that point we were not requiring hospitals to manage outpatient systems in the way we are doing. They are patient administration systems, the route into the hospital, they are not designed to collect that sort of information. We have a big programme of introducing new electronic patient records across the country as a whole which will be, I think, in place by 2005.

(*Mr Fillingham*) Two things, as well as looking at the IT solution we are also looking at what information is of most help to help the NHS improve. There is the review of waiting and booking information systems project which is working with 12 trusts on a pilot basis which is due to report in February next year. That will help on the information side. I think your earlier point was also about, is there something about the design of hospital systems that could be improved? I think it is absolutely the case that there is and that is what the modernisation is all about.

135. If I may interrupt, my next point 2.33, when the NAO visited the 50 trusts, six trusts had no agreement on even draft waiting list policy at the time of our visit, and it was not that long ago? It was not that long ago, what is the position now?

(*Mr Fillingham*) That is clearly an unacceptable situation. Trusts should have not only clear policies and procedures but strong clinical involvement with them.

136. They range, in the next paragraph, 2.34, from two to 66 pages. Have you told trusts what you expect them to have in a clear, simple, understandable form?

(*Mr Fillingham*) We certainly have issued guidance but it is clearly in an organisation of a million people not simply about issuing guidance, it is about bringing about improvements in practice. The way we have structures now we have service improvement managers working on a regional basis with local trusts, we have a team tackling outpatients, other teams tackling theatres, tackling pre-operative assessments, and what we are starting to see are some considerable improvements. For example, if you just take outpatients, we ran a learning set for 11 trusts which had the most difficulty in terms of outpatients, and three of those have moved into the top quarter in terms of performance. So when you work with people on the ground, when you invest in learning and development, when you provide the support and information, you do get results.

137. Paragraph 2.25 talks about outpatient validation. "Nearly half of the trusts were not undertaking validation . . . When they were, most outpatients . . .", who had been validated, ". . . had been on the list for 13 weeks, but the criteria ranged from 9 to 26 weeks. As a result of this work, these trusts . . .", which had done validation, ". . . had been able to remove 5 to 15 per cent of patients who should not have still been on the outpatient waiting list." Yet half of the hospitals in the NHS are not doing this work at all.

(*Mr Fillingham*) It is a major challenge to make sure that is happening everywhere.

138. What is going on? You are the accounting officer, you spend £47,000 million—and I think I am right in saying that apart from Social Security you are the biggest—

(*Mr Crisp*) Yes.

139. What interests me is ensuring that that money reaches the people who need it, the people who phone us up and say, "I cannot get an appointment". The point Mr Steinberg made very powerfully is that actually the resources are in some cases there, £737 million is being flung at the system, yet for one reason or another, be it the doctor does not want to look on the list to see 200 miles away there is someone with a two week waiting list or whatever, hospitals are not actually checking or validating—half are, half are not—and I am not persuaded you are managing the resources you have effectively enough.

(*Mr Crisp*) This report identifies a number of weaknesses, clearly, and this is one. What we are doing on this one is, apart from issuing the instructions and the best practice here as well, introducing the booked admissions system which I talked about before.

140. You are coming to my next question.

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(*Mr Crisp*) Actually if we tell people the date when they can come in at the point at which agreement is reached, by and large they come in, and we know there are improvements which can be made in that way.

141. You have described this fully integrated booking system which you hope will be available by 2005, that is four years away—we fought the First World War in that time—why do you not just do what they do in Denmark, stick it on the internet so people can look? Although it might not be integrated in a nice management consultant way with bar charts, you are effectively letting the patients figure it out for themselves, if you give them the information.

(*Mr Crisp*) That is a different thing from the booking system. The booking system is about booking appointments and so on. I take the point about providing more information and you will be aware the information being provided in a national newspaper today has been supported by the Department of Health. We see it as very important that we do get as much information as possible to the public because the people who will provide some of the dynamic for change here are the public.

142. Absolutely. Are you going to put this information on the internet and, if so, how long will that take?

(*Mr Crisp*) I am afraid my answer is still, we are looking at it, but that may be an interim step to what we are talking about here.

143. Why do you not just do it?

(*Mr Crisp*) I will take your advice. We will no doubt be able to report to the Committee in due course.

144. Paragraph 2.36. Mr Davies made the point that a lot of chief executives have varied their definitions of what constitutes outpatient waiting lists and, surprise, surprise, in almost every case the number of outpatients fell, 88 per cent fell. I am right, am I not, that since 31 March 2000 outpatients have gone up by 80,000 and inpatients by 30,000?

(*Mr Crisp*) This year, the long-waiting outpatients have gone up, you are right.

145. Outpatients by 80,000 and inpatients by 30,000 between the end of March and end of June, yet this paragraph, 2.36, implies that people are managing their lists better and that the result is a reduction in the number of waiting lists.

(*Mr Crisp*) The figures you have quoted are the three months figures. They are three months figures which have gone the wrong way and have gone against the trend of the last two years and need to be tackled. You are quite right, it has not gone away.

146. Can I return to Scandinavia. The report mentions Norway where there is a choice of hospitals. Perhaps I can put the question more generally, and this again may be a question for Mr Fillingham, plainly there is a lot of good practice overseas, people generally have a perception that things are done better in many cases overseas than they are here. You often hear France, Germany, Scandinavia quoted. What are you doing in a systematic way to look at what is going on overseas and learn from it?

(*Mr Crisp*) Again, if I may, that is not the total story. People from abroad come and visit us and look at the things we are doing, and things like our National Service Frameworks and the fact we have national standards are rated very highly by a lot of different countries.

(*Mr Fillingham*) There is a considerable programme which includes research and development work to consider what is happening and looking at how that can be applied to the UK, but we also have strong links with other health care organisations not only in Europe but in the US, Australia and New Zealand as well. So there is a considerable amount of effort which goes into comparing notes and making sure we are adopting best practice, in just the kind of way you have suggested yourself.

147. I would like to return to choice. Mr Crisp said that you were looking at introducing an element of choice for patients. I think most patients would regard that as a little understated. They are the people who are providing this £47,000 million you are using, and you are saying, “We are introducing an element of choice.”

(*Mr Crisp*) Over and above what is already there because patients are involved in their own care. If you think about what patients are saying to us about choice, they want to be involved in the decision-making about their own care, that is very important, and a lot of the work Mr Fillingham’s agency is doing such as on cancer is actually about developing that patient-professional relationship, and there are choices in terms of care. There is generally more choice around in maternity care as well. We are talking about the relatively limited aspect of choice in acute hospitals when you have an elective case. I think there are arguments which Mr Milburn has spelt out as Secretary of State for why we now need to be looking at that and finding ways of improving the amount of choice which is in the system, but I do not have any announcement to make to this Committee, that is merely an up-date of where we are.

148. Can I draw your attention to paragraph 3.21 which talks about effective discharge plans to ensure that admissions and operations are not cancelled due to beds being occupied by patients who should have been discharged. It goes on in paragraph 3.23 to say, “NHS acute trusts could use their knowledge of patterns of emergency admissions to help plan more effectively the number and type of inpatient admissions.” My perception of my own constituency, and this is probably shared by colleagues, is that this is going in the other direction, that things are getting worse. Could you comment on the question of discharges and bed blocking and what steps you are trying to take to get round this?

(*Mr Crisp*) There are several things to say. The first thing is that for the first time this year we asked health and social care jointly to produce for us a capacity plan, and this is a capacity plan which will not only deal with beds in acute hospitals but with the issue of residential homes and care homes and also with the amount of capability of social services departments to provide packages of care for people at home. So it is a full capacity plan. We got those in at the end of September so we could begin to analyse

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them and understand what the picture is looking like and, secondly, so we could get in to do what we are trying to do all the time now which is share good practice and make sure that one area learns from another. The second significant thing we have done in recognising the problems which are around the care home market and the residential home market in particular is provide an additional £300 million—£100 this year and £200 next year—to social services departments to develop plans for improving the position on bed blocking jointly with the Health Service, which is the first most important point, so they are not just a way of disappearing into the social services budget if you like. That money is recurring. That is important because it is not just a bit of sticking plaster this year, it is about a longer-term strategy.

149. One more bite of the cherry, then I have to stop, you must have looked at the question of what it would cost to provide a guarantee, whether the threshold is three months, six months or nine months, you could say that either you would either provide the service yourself within that time to make a guarantee to the patient or if you could not you would find another way of having it done in the private sector or you would fly them off to Sweden or wherever it would be?

(*Mr Crisp*) There has been debate around this and there is debate continuing. The one guarantee we are bringing in next year is the one that if your operation is cancelled we will either admit you again within 28 days or you can go to a hospital of your choice. That is how the words are written, maybe we are starting down that route.

Mr Jenkins

150. Mr Crisp, I have been striking questions off as we have gone through some of the stuff and I will not go over it again. I see the list in front of us with regard to our own constituencies and our own local areas, it is rather illuminating insofar as I have one inpatient waiting six months or more for urology, and I have 23.6, and in the four areas I have 8.2, 6.1, 5.2 and 10.6. I have a better case than that, I can give you an instance of two people living opposite one another on the road where they both want the same operation, hip replacement, in their own hospital. They are in the same location, with the same surgeon and the same operation, one would have to wait for maybe up to three months and the other would have to wait 15 to 18 months due to the contract of the hospital health authority drawn up by this particular hospital, this is simply down to funding.

(*Mr Crisp*) If it can be done—

151. It is quite simple, it is what is called in terms of standard assessment, it is a weighted average, they put money together and they give authorities and areas different amounts of money to treat the population.

(*Mr Crisp*) Your road has two health authorities, one on each side.

152. That is right.

(*Mr Crisp*) They will receive money as health authorities on the basis of the formula

153. Yes.

(*Mr Crisp*) That formula will be weighted for the age of the population, and so on, and they will then locally make the decision about the priorities that they need for categories of patients and there may be a difference between the two, except where we have a national policy which says they have to be the same.

154. Yes. The formula is wrong quite simply because the formula was derived to produce the same level of service depending on the make-up of the population and it is simply not doing so. It produces extra waiting time and waiting lists in under funded areas.

(*Mr Crisp*) There is a very extensive academic study going on at the moment which is due to report sometime soonish to advise us on how to create a formula that may be better, but it is not a simple answer. At the moment the formula is weighted towards areas of greater need and to some extent towards areas of greater cost.

155. Here they are starting to show up with regard to extra waiting time, they have to suffer because of a lack of funding and they should be produced at the same hospital, producing roughly the same waiting times. If I can move on to one other thing, the doctor referrals, I have the impression it has been going up because doctors are making more referrals, would you say this is down to the public's expectation of being able to be treated for everything at any time and their right to go to a consultant or would you say that it is also being influenced by the medical insurance that doctors have to carry to cover that shift in risk?

(*Mr Crisp*) The figure here shows it is going up. There is another thing, which is probably the strongest driver of that going up in some areas, which is that we introduced national standards. When you introduce national standards we then introduce the doctor's expectations of their referral patterns to hospitals. The people who were already referring at that high level do not refer any less and the people who refer less will refer more. We will gradually see as we introduce and drive through in some areas an increase. In other areas, Mr Fillingham gave an example, we will see less because they will be referred to physiotherapists straightaway, whereas sometimes it is up to the consultant. There are two different dynamics going on here, the quality one is a big one, the national standards one is a big driver.

156. Not and insurance one?

(*Mr Crisp*) I am not convinced how big a driver that is, it may influence people to follow the national standards.

157. I notice one of things we have in our locality is A&E is going up by 9 per cent, apart from the ones turning up with cuts and bruises because they cannot see a doctor, because the system is not flexible enough. We have a situation with regard to doctors who open from 9 am to 4 pm, when most people are at work, and do not open in the evenings or at weekends, so people go down the hospital and once again they are involved in blocking the system up. What are you prepared to do about it?

(*Mr Crisp*) The one about the people with the more minor injuries?

158. Yes.

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(Mr Crisp) Again we have about three different programmes reflecting that, one is the introduction of minor injury units, which are nurse-led and designed specifically to deal with such issues. Having visited a number I am aware that they run to about 10 o'clock or 11 o'clock at night and at the weekends. The second one is, walk-in centres, again typically nurse-led and these are for people particularly in those areas where people are not registered with a doctor, where there is a high level of refugees, and so on. That is certainly happening. The third thing is that we have introduced NHS Direct so that people can ring up. Seven and half million people we think will use that this year, seven and a half million people will ring up to ask for advice from a nurse on their particular problem. It is the biggest call centre of its kind in the world, it is a very substantial increase. There are a lot of big things happening now and I think we will see more of that.

159. Why then have A&Es gone up by 9 per cent?

(Mr Crisp) I have seen two sets of figures. I have not seen the Staffordshire ones, overall A&E attendances have fallen slightly but admissions through A&E, ie the most serious patients, have gone up. It has only gone up by about 3 per cent. More serious cases seem to be coming in, which is a worry because we need to plan much more for them, it is much easier to deal with the less serious ones.

160. I would like to move on to appointments. I am glad we are getting away from the present system, I find it rather unusual that you could send out an appointment to a patient and it was an open loop system, where you get no feedback, so that letter could be gone to a house where the person has left, the person could have moved away or even died. I am told the amount people that do not turn up is quite high and it seems a bit late in the day to go into this booking system. I do urge the booking system to have people confirm whether they are going to attend so that they can get tied into a system.

(Mr Crisp) Yes, yes.

161. The system you are going to use, it seems to me we do not have a single consistent roll-out system for every hospital in the country?

(Mr Crisp) Well, we do on booked admissions, Mr Fillingham can fill us in on that. We now understand how to do this much better, the standard information system and things like that, we are literally rolling that out.

162. If we look at that, I can understand with administrators where they have money there is always a difficulty of where you are going to spend the money, are you going to spend it on patient care or on paperwork. There is a lot of pressure to spend it on patient care and the paperwork system gets pushed to the back of the queue when it comes to resourcing, this has been the case, why have we not ring-fenced the money that needs to go into the new systems?

(Mr Crisp) Specifically and partly for the reasons you have just talked about, we have ring-fenced it for this booked admissions system, so there is money following it into the system. We need to drive it in. You are quite right, what is happening in the NHS is we have actually low costs on the overheads of the

systems, as this report demonstrates, because we have tended to put money straight into the clinical issues.

163. This choice of hospital scenario, there is obviously good reason why we are not going to get a choice of hospital because if we are told exactly how hospitals are doing and what the survival rates are that does not fit well with the hospitals and clinicians particularly and they are going to fight like hell to stop that information going out, so we are looking at the producers rather than the customers.

(Mr Crisp) That is exactly what we are trying not to do. That is the change which is going through. The NHS Plan was set up specifically to design a service around the patient, and that means precisely what you are talking about, shifting from a producer focus to a customer focus. All the things we are doing at the moment to get patients more involved, the provision of more information, the question of where we can extend choice at the moment, which we need to do carefully because it must succeed, we cannot afford to fail, all of those things are about moving in the direction you are talking about.

164. One of the reports today was with regard to survival rates for heart bypass operations.

(Mr Crisp) This is Dr Foster.

165. Yes. I challenge you to go back over every report that has been issued and show me a hospital somewhere at the bottom of the league where the chairman of the trust does not say, "Well, it is not the full picture, you know, because underlying that there are difficulties because we are the most deprived area, we have the hardest cases", there is some reason why they do not really belong at the bottom of the league. Someone has to be at the bottom of the league but they never admit to why they are there. Why?

(Mr Crisp) That behaviour, because we have looked abroad at this, has been exactly what we have seen when the same thing happens in the States and so on. Two things happen, people immediately want to explain in the way you are talking about because that in a sense is human nature and some of it, of course, is right, some of it does justify the position. But, secondly, people then have looked at that information in a different way for the first time because somebody is holding a mirror out to them and you have seen change. The evidence from abroad is that change has happened when this has happened because you are putting a new pressure and a new dynamic into the system.

166. So if you have a hospital which has the lowest survival rate in the country, where clinicians have walked in and had a vote of no confidence in the management, and you have a hospital which really has been going wrong on a number of occasions, how much power do you have to sack the chief executive?

(Mr Crisp) I suspect you are talking about a specific case and we have made it clear that in a particular case if things are not improving within a timescale, which is a reasonable thing for us to say, then we will expect the management to be changed, and we have the ability to make that happen. The contract is with the employer but we can reasonably expect to see that change is brought through.

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[Continued

[Mr Jenkins Cont]

167. When you say you have the ability, do you have the will to do it, because I think in some of these instances you are going to have to drive forward? Can you sack a chief executive, chairman of a trust and suspend a trust? Do you have that power?

(*Mr Crisp*) There are some powers. The first point which needs to be made is that the chief executives actually work for individual trusts and their employment is with individual trusts, however, and I would have to check the exact powers, we have the right to intervene in cases where the Secretary of State deems this is the appropriate thing to do, and we can make changes in the management of the trust. I will have to give you the actual chapter and verse around that but, more importantly than that, at the point at which trust boards have maybe lost the confidence of the Department of Health—and if you look around the country you will see examples of where this has happened—then decisions are taken and we move on.⁴

168. So we are prepared to do it and grab this nettle and say, “Yes, we are going to drive forward these changes against all the vested interests”?

(*Mr Crisp*) Absolutely, where that is the right thing to do.

Mr Jenkins: I look forward to the day.

Mr Gardiner

169. Can I refer you to paragraph 3.5? “Under the NHS Plan every general practitioner practice and primary care group and trust must put in place, by April 2001, systems to monitor referral rates.” How has that gone? Are they all in place and what is the feedback we are getting from them?

(*Mr Crisp*) This is from April 2001. I have not asked the question as you have asked it and we will not get the details on that for some time yet. I am not aware there is a problem with it. That is not one of the things which is flagging up on our systems saying there is a problem, but we will not get the full picture because it is only April 2001.

170. So when will you get the full picture?

(*Mr Crisp*) We will get it at the end of the year, the end of March. We will know where we are. If there are particular problems, our systems pick them up earlier in the year, so I am not aware there are particular problems.

171. Perhaps you would be good enough to let us know what the outcome is.

(*Mr Crisp*) Right.

172. Under referral pools, Mr Osborne, my colleague, asked if pressure was being applied to GPs and there was the £1,000 example. I would rather look at it the other way and want to know if pressure is not being applied to GPs. Why, if we are not making GPs refer to pools, are we not putting in place a system where there are targets within the NHS Plan so that referrals should be to pools for the consultants then at a particular hospital to share them out, obviously as is appropriate with clinical

expertise—and you talked about expertise in shoulders and so on—but surely the consultants can then take that decision as a pool?

(*Mr Crisp*) We have actually got a lot of targets and, as you will be aware, from time to time we have been criticised for having too many specific targets. How we are approaching this is saying, we have to embed this in people’s behaviour, not just whether or not they hit targets, and therefore we are firstly making clear we think this is the right way for us to go but, secondly, encouraging GPs and consultants to draw up referral protocols. So what happens in your particular patch has been discussed with the GPs and consultants so we can provide best practice, and there is a Steps guide which David and colleagues have produced which helps do that. But actually we have to embed it in people’s behaviour rather than just instruct people, because we know that does not work.

173. Your colleague is nodding furiously and looks as if he would like to add something.

(*Mr Fillingham*) I think that is absolutely right. It is about making change sustainable. The way to do that is to engage staff in it and get them to want to make the changes because they can see it is in the best interests of patients. Sometimes that will mean a pool referral, that is quite an important way to go. Sometimes it will be alternative forms of provision without patients going to a hospital consultant at all. The exciting way forward is to get GPs, consultants, hospital managers, primary care groups, sitting down together to plan the system in a way which works.

174. I do not doubt that referral protocols are very good and important and the right way to go, what I am keen to see is that you are monitoring the increase of pool referrals and that you have of yourself, if not for public consumption, some clear standards, clear targets, which you want to see achieved. Because otherwise it seems to me that one can say, “Let’s agree it on a local basis” but we will not actually then go in the right direction.

(*Mr Fillingham*) Absolutely. The way we are doing that is by getting local organisations to have ownership of those plans and targets. So hospital trusts were asked to produce outpatient improvement plans, to agree them with the local primary care groups and issues like pooled resources were included.

175. Paragraph 3.6: I do not know whether you were, but I certainly was staggered to see that 20 per cent of the consultants considered that 80 per cent of the referrals were inappropriate.

(*Mr Crisp*) Yes.

176. Why? Are you not staggered by that?

(*Mr Crisp*) Yes. I then wanted to ask the question which speciality it was and whether it was orthopaedics where I am less staggered actually because in certain parts of the country people have been referring to consultants who then refer back to physiotherapists, as I just said, and the most appropriate result might be to a physiotherapist in the first place. It is a very good example of where the surgeons and the GPs need to get together and agree

⁴ Ev 24, Appendix 1.

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[Continued

[Mr Gardiner Cont]

what they are doing, GPs may be thinking they are referring to a consultant to get a physiotherapy appointment. Do you see what I mean?

177. What you seem to be saying is that within certain disciplines there is likely to be a large percentage of wholly inappropriate referrals. Is that correct?

(*Mr Crisp*) I think there may be if do we not have the local referrals protocol in place.

178. I accept you are working to change it. What you are saying is that within certain specialties up to 80 per cent of referrals may be inappropriate, we are wasting 80 per cent of initial consultant's time.

(*Mr Crisp*) Yes. I was surprised to see that, that is the reason why.

179. You are telling us that is the reason why, are you not?

(*Mr Crisp*) I am telling you I think that is the reason why. I was trying to give you an example of where I thought there was a reason for it. I am surprised to see that 80 per cent figure.

180. So that I am not going off in a tangent here, I want to be absolutely clear, have you chased down those figures and those cases and found that they do, in fact, refer to those particular specialties, so that you can now say to this Committee with confidence, "the reason for that is that they happen to be orthopaedic and trauma".

(*Mr Crisp*) We do know what the specialties are but we have not asked those individual consultants, neither has the National Audit Office asked those individual consultants, why they think that is, or what sort are inappropriate referrals. It would be interesting to see whether the GPs in those cases also thought they were inappropriate referrals. We have not done that with these 40 people.

181. That is something where I think it would be helpful if the Committee could have further information from you?

(*Mr Crisp*) If we know who these 40 people are, and I do not know whether we do or not.⁵

(*Sir John Bourn*) I will certainly make the information we have available.

182. Thank you. Could we also have a note about what Mr Trickett was asking about on extra contractual referrals, out of area treatments, as you now call it, and the pattern and the penalties that are applied for out of area treatments?

(*Mr Crisp*) The pattern for out of area treatment is the levels and specialties, and so on, and then the question of whether there are any penalties, you mean penalties on GPs?⁶

183. Yes, such as were discussed earlier. Under the 42nd hearing of the Committee in paragraph six, this is when we are talking about the referrals which could be allocated equally across all consultants it says, "existing guidance requires that patients are told in their appointment letters that shorter waiting times may be available with alternative consultants and/or providers", this is largely what my colleague Mr Steinberg had been approaching with you at the

beginning. Now what I would be grateful for from you, given that was being said in 1994 is, how is that guidance monitored and how is it enforced, because it certainly sounds from Mr Steinberg's experience that it is not?

(*Mr Crisp*) I think you are referring to the fact that in 1994 we were running a different system in the Health Service which tends to get called by the name of the internal market and that that was guidance that was appropriate to 1994. I suspect, although I would be happy to check, that that guidance does not still continue.

184. That guidance does not apply now?

(*Mr Crisp*) I would need to look at the details of it but the way you have described it sounds to me as though—⁷

185. I understand that things change, often for the better. What I would simply ask you is that given the experience that Mr Steinberg has outlined do you not think it would be appropriate to provide patients with that information, that they might be able to get a shorter waiting time if they went to a different consultant?

(*Mr Crisp*) There are two elements there, the first bit of it is, do we provide people with information on the internet or, indeed, elsewhere about waiting times throughout the country. That is something that I think we will certainly be looking at in advance of being able to do it in 2005. The second point is, do patients have a choice based on that information. The second point, as I have said our current Secretary of State says that he wishes to see how we can improve choice within the service, so let us look at it, but let us look at it in a way that does not have some of the counter-consequences and problems associated with it which may have been when it was last done.

186. I will take that as we will look at it. Thank you very much. It has been quite a political afternoon in many of the questions that we have had, particularly on paragraph 2.22, I only want to touch on the waiting list waiting time matter briefly, it is to ask you this, we have heard a great deal about the distortion of clinical priority because of political priorities effectively and that had we not concentrated on waiting lists, and you said well, of course, we are now concentrating on waiting times.

(*Mr Crisp*) Yes.

187. Why should it be any less likely that by concentrating on waiting times there should be in any given circumstances less likelihood of a distortion of clinical priority?

(*Mr Crisp*) I think the answer—

188. I do not want you to rehearse the answer that you gave earlier. I understand fully about there is no need to distort clinical priority, I understand that argument, and it can be achieved in other ways. What I am putting to you is this, in exactly the same way that the waiting list and the desire to cut waiting list could have distorted clinical priorities so, surely, any political priority such as cutting waiting times can do exactly the same?

⁵ Ev 25, Appendix 1.

⁶ Ev 25, Appendix 1.

⁷ Note by witness: EL(94)90—Waiting Time Policy—was cancelled on 30 November 1995.

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[Continued

[Mr Gardiner Cont]

(*Mr Crisp*) I think it is very important to make another distinction and to move away from politics here and to patients and professionalism, if we actually look at the area where we are being specific about waiting times, broadly at the moment within cancer they are broadly coming out of the cancer plan and also the coronary heart disease plan, which has been built up from the expertise around the country and not from political routes. The things that you will see in the NHS plan about the requirements to get from urgent referral to completion of treatment within two months of surgery is a clinical priority, a different priority, rather than a political one. I think there is a strong driver there to say that that is how we are building up those standards. I think that will help in the context you are talking about because we will be starting with the most serious conditions anyway, like cancer and coronary heart disease.

189. Would you accept—I have five more questions in the two minutes left to me—that any prioritisation of waiting times could also, in a situation where somebody is coming up against the maximum allowable under the rubric, bring about a situation where there was distortion of clinical—?

(*Mr Crisp*) I think when we are talking about the levels we are talking about it is clearly a hypothetical point, a hypothetical possibility that that will happen, but the most important thing is that people need to have planned what is going to happen to the patient at the point of entry to the system. If they have done that, it may go wrong during the course of it in which case you readjust, if they plan at the beginning that should not happen.

190. Three very easy ones, a fully integrated booking system by 2005, is that going to happen?

(*Mr Crisp*) I hear a nod to my left.

191. The second easy question, cancellations rebooked within 28 days or paid for privately by 2005, is that going to happen?

(*Mr Crisp*) That is next year.

192. Goodness me! The third easy question, the maximum in patient waiting of six months by 2005, is that going to happen?

(*Mr Crisp*) We certainly intend it to.

193. If they do not will you be resigning from your job?

(*Mr Crisp*) Thank you for that question, I think that is a policy question.

Chairman: You have been done very well, Mr Crisp. The last questioner is an easy one, Mr Alan Williams.

Mr Williams

194. Mr Crisp, I want to follow up where Gerry Steinberg started on the consultants. You gave him a figure of 17,000 to 20,000 consultants. How many of those are full-time?

(*Mr Crisp*) There are over 20,000, I got that wrong. I will give you a note on your point, I am afraid I do not know.⁸

195. Not even a ballpark figure, a rough estimate?

(*Mr Crisp*) I would be guessing. It very much varies by speciality.

196. The full-time are allowed to do private work up to 10 per cent of their salary?

(*Mr Crisp*) That is correct.

197. How much can part-timers do? Mr Steinberg asked that but you did not give an answer.

(*Mr Crisp*) Sorry, if I did not. There is no technical limit, however, they have to agree what sessions they are doing with the NHS provider, and they have to stick to those sessions. Therefore the practical limit is what else they can do outside those sessions.

198. So there is no limit at all on what the part-timers can do and, unfortunately, you do not know what proportion are part-time. My understanding is in many cases it is difficult to get consultants who are willing to be full-time; they want to be part-time.

(*Mr Crisp*) Well—

199. I do not need an answer to that because it was not really a question, it was a statement. How do you monitor the 10 per cent?

(*Mr Crisp*) It is monitored by trusts.

200. How?

(*Mr Crisp*) Specifically by the mechanism that is in place, which is that there should be a review with each consultant each year on the basis of what their job programme is, and as part of that they should be looking at what they are doing in the private sector, and they need to make a return on it.

201. But the 10 per cent is not a matter of the number of contracts, it is the amount of money. Who monitors the 10 per cent is 10 per cent of salary?

(*Mr Crisp*) Trust chief executives.

202. And you do not know on what basis?

(*Mr Crisp*) I was explaining on what basis, which is that there is an annual meeting.

203. If, for example, of the 20,000 all were full-time, we would be needing to employ an extra 2,000 consultants just to make up the 10 per cent they are doing outside the Health Service?

(*Mr Crisp*) If we want to talk about consultants' workload there are a number of other figures you want, such as how many hours consultants are working for the NHS.

204. It is almost impossible to get that from the chief executives. I have been trying with mine in Wales for some time to get the figures, and they refuse to give them.

(*Mr Crisp*) There are a lot of studies which show by and large the vast majority of consultants, part-time or full-time in this country, work longer than the hours for which they are contracted and do more work than the hours for which they are contracted, and their 10 per cent private work is Saturdays or Sundays or whatever.

205. When one of my colleagues asked about operating theatres and the 8.30 to 5.30 timescale, you said that operating theatres were not the bottleneck.

(*Mr Crisp*) Yes, generally.

206. So what is the bottleneck?

(*Mr Crisp*) Staff.

207. Consultants and other staff?

⁸ Ev 25, Appendix 1.

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[Continued

[Mr Williams Cont]*(Mr Crisp)* Nurses more than doctors.

208. So if the doctors who are working part-time elsewhere were not, we would be able to make more use of the theatres which are already there and are under-utilised?

(Mr Crisp) That is certainly potentially true, but the bottleneck is not actually consultants, the bottleneck generally is the ancillary staff and nurses who actually provide those services rather than doctors. You will no doubt also have come across doctors who say they would like to operate more but they cannot get the facilities, by which they normally mean staff.

209. Do you have any measure of the physical surplus capacity which is in there? Working 8.30 to 5.30 means there is a less than 50 per cent usage of the hardware facility.

(Mr Crisp) Of some of the hardware facility.

210. So one could use that much more intensively.

(Mr Crisp) But it is only a bit of the system, because by and large you need beds to put the patients into afterwards—not always, there are day surgery units which operate on longer hours, day surgery units which operate 6 in the morning until 10 at night to take advantage of that. We have more theatre space but we do not necessarily have the beds and the staff to go with it.

211. You were rather dismissive when one of my colleagues—Geraint I think—raised the issue of bed blocking. You said that a whole series of interventions are needed but you did not seem to regard it as a matter of some significance, whereas most of us in our own constituencies probably think it is a matter of some significance.

(Mr Crisp) My tone of voice obviously came over wrongly. I think the two biggest issues we are facing are bed blocking and staffing, the two issues we are talking about, and that is why, during the course of this year, we have invested an additional £300 million in bed blocking and that has not effectively happened for anything else. It is because chief executives from Croydon and elsewhere have pointed out to us this is the most significant problem they have, or one of the two.

212. Alan Langlands pointed this out some years ago at a hearing here. He made the point, which is a valid one, which is a point for politicians, not for you, that while you have the division between social services with responsibility for post-hospital care and the hospitals who are left saddled with the people who are not accommodated by social services, you are never going to be able to use the facilities efficiently. So how would the 300 million resolve it?

(Mr Crisp) That was the point of the fact that this money has come to social services on the understanding that they spend it alongside health and that they use the Health Act flexibilities to do that, which are about joint budgets, joint management and so on, which is a move towards systems integration if not actually merger of the organisations. It is precisely for that reason.

213. The other major problem in terms of surplus capacity which several of my colleagues have touched on, Mr Trickett in particular, is the health authorities' blindness across the borders and their

inability to look beyond their own borders to use what is clear surplus capacity perhaps a few miles from where they are working.

(Mr Crisp) Your colleagues have shown the problems at particular boundaries. Next year, we will have primary care trusts, which will be in general smaller than the current health authorities, making these decisions closer to their patients perhaps. They will therefore be able to make the sort of decisions we are talking about so in an area like Mr Trickett's health authority they could use the other hospitals rather than the one they usually refer to.

214. Is there any reason to think that a multitude of small authorities will be more efficient in their use of facilities than a relatively small number of large authorities, which should be able to find out where the surplus capacity is?

(Mr Crisp) The point which I think you and colleagues have been making is that health authorities may be a bit distant and bureaucratic and look at things on a planned basis. Primary care trusts are going to be very interesting, new organisations with a chair, a chief executive and lead doctor, and I expect on the basis of that they will be making decisions in a rather different way and more locally.

215. But if you are having a diffusion of decision-making, you also need a diffusion of information to people.

(Mr Crisp) I agree.

216. Our experience in this Committee has been rather sad as far as IT is concerned in the Health Service. We had the disaster with Wessex and then we had the NHS Hospital Information Service which lost £60-odd million. Have we made any worthwhile progress in the extension of the use of IT within the Health Service?

(Mr Crisp) This Committee is managing to range over most of the current issues in the Health Service. There is a lot of work which has gone on in putting in infrastructure over the last two years which is starting to bear fruit. For simply getting information to GPs about inpatient and outpatient waiting times, faxes will do and those arrangements are in place. They should have that information anyway.

217. You say, "faxes will do", I suppose it seems rather bureaucratic when you can just get information on the screen. With dozens of doctors in any one hospital area making arrangements in any one day it would obviously be far better if there were an IT solution rather than a fax solution?

(Mr Crisp) I misunderstood you, I thought you were asking the hospitals to give the GPs information, I am saying that they already have that, they can get that through whatever route is appropriate. If you are talking about an electronic booking system then there are clear plans to introduce that by 2005, and I think we just said we are on time to do that. That will allow people to book through their GPs.

218. Now we are back on sensitive ground, you have plans to do that, we have been through other plans, do your plans have a grandiose software or hardware project at the heart of them or is there something less sophisticated?

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[Continued

[Mr Williams Cont]

(*Mr Fillingham*) We certainly need to invest in information technology in order to deliver electronic systems. We do not envisage grandiose national schemes to do that. Some local organisations have their technology in place, King's Hospital in London have 24 general practices already linked-in electronically, three quarters of all their appointments are booked electronically. What used to take three weeks takes a matter of minutes. We need to get the rest of the NHS up to that kind of level and standard. We are learning some lessons from IT development, the intention is very clear, national specifications, clear project management to make sure benefits are delivered, systems that fit well with what we already have in existence and which deliver the end result overall.

219. With the PFI hospitals do you work on the planning possible throughout as far as the use of their theatres are concerned? Do you work on the same assumption in terms of utilisation of the physical resources of their operating theatres as you apply to existing hospitals?

(*Mr Crisp*) It varies. And as I said, for some theatres we do use them more extensively than 8.30 to 5.30 for day procedures and there are some that work on Saturdays. By and large, planning has been done on the basis of what we do now, plus an estimate of some improvement.

220. The specialist centres we have been hearing about, will they also be—

(*Mr Crisp*) Specialist centres, not necessarily. For example, one that is being looked at which is being developed in the Middlesex in London is looking at just what is the best way to do it and what is the best way to use facilities.

221. Looking at page 22, Sir John, you indicated that some trusts inappropriately adjusted their waiting list figures, I presume that means they cooked the books in some way or another, such as Redbridge, Guy's, St Thomas's, University College London Hospital, Plymouth, South Warwickshire and Stoke Mandeville, when do you hope to be able to produce your report on what has been happening there and what they are doing to put things right?

(*Sir John Bourn*) In December.

222. Public in December?

(*Sir John Bourn*) Yes.

Mr Williams: That is very good, I cannot wait.

Mr Bacon

223. A very quick question, Mr Crisp, you mentioned NHS Direct as one of new things you are taking forward which prompted a thought in my mind, I read a few months ago from memory expenditure of £87 million from NHS Direct resulted

in two per cent of GP appointments being avoided. I was wondering whether you can comment on the effect that is having? Secondly, I have been told that the call centre has people sitting there doing PHDs in NHS time because of low utilisation levels. I wonder if you can comment on that.

(*Mr Crisp*) The first one, I cannot remember the figure, what we are seeing on NHS Direct is, it is increasing demand to some extent because it was always bound to increase demand, you are making a service available and it is having some effect. That effect is both in sending more people to hospital who might not have gone as well as some reduction, it may be, it is too early to say, related to the fact that A&E attendance is down. There is a preliminary evaluation round that. The second point, I am not aware of these PHD students you are referring to, but I would happily follow it up if you want to give me the information on that. But NHS Direct has got further to go. We have got it in parts of this country linking into GP out of hours services, so there is one phone call you can make to get to your GP as well as to get information and advice from a nurse. We are looking at extending that so it becomes a much more ordinary way for us as members of the public to go to NHS Direct. We are also linking it with 999 calls, because you will be aware that a lot of the ambulance service calls are "inappropriate", in that we are using big vehicles for a small issue. So perhaps we can use NHS Direct to screen those out. So if there is spare capacity, I am delighted to know that because we will be able to do those extensions more cheaply and more effectively.

Geraint Davies

224. This Committee is about value for money and the efficient use of resources, what do you think about the idea of prioritising working people in the waiting list over non-working people, the logic being that this would actually generate an enormous amount of extra tax revenue which in theory at least could be hypothecated back into the system so everybody would have to wait less time.

(*Mr Crisp*) I am not sure what I think of it. I am not sure it is being looked at within the Department or not.

Geraint Davies: Perhaps you could have a think about it and, who knows?

Chairman: Thank you very much, Mr Crisp. You have done extremely well. You will remember you promised Mr Williams a list of part-time and full-time consultants. It has been a very useful session, it is obviously politically controversial but we have managed to shed some light on these matters. Thank you for your patience in being with us so long.

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[Continued

APPENDIX 1

Supplementary memorandum submitted by the Department of Health

INPATIENT AND OUTPATIENT WAITING IN THE NHS

Question 30: How many National Health Service beds are used for private care?

NHS elective beds are only available for use by NHS patients. Private patients in NHS hospitals can only use beds designated as private beds. Of course, if a patient admitted privately suddenly required unforeseen intensive care this would happen without hesitation.

Private beds are not covered by the Department's annual beds census. However, Hospital Episode Statistics (HES) identify 104,000 private patients admitted to NHS hospitals in 2000–01.

Question 112: Why is there such an extraordinary capacity variation in acute facilities between different health authorities?

There are a number of factors which can, at any one point, impact on the available capacity in an acute trust to deal with elective inpatient waiting list work. In most instances elective work requires a mix of theatre time, beds and staff, both clinical and ancillary. The non-availability of these elements can impact on the treatment of patients from the waiting list.

Emergency pressures, for example, can reduce the amount of available beds for elective patients. Similarly, delayed transfers of care can have the same effect. Chapter 4 in the NHS Plan acknowledged this issue, and outlined plans for 5,000 extra intermediate care beds. Equally as important as having beds available for post operative care is the availability of operative theatre capacity. The Modernisation Agency is currently leading a Theatre Project to optimise the use of these resources. Obviously without sufficient staff neither beds nor theatre time can be fully utilised. The NHS Plan Chapter 5 highlighted our plans to increase the overall numbers of both doctors and nurses.

At any one point the interaction of these factors will vary from locality to locality leading to different levels of available capacity.

Question 113: Why does Wakefield Health Authority do worse than adjacent health authorities in terms of inpatients and outpatients waiting longer than 6 months?

We recognise that there are currently wide variations in levels of performance across the country, and the below health authorities, as at December 2001 reflect this:

<i>Indicator</i>	<i>Wakefield</i>	<i>Barnsley</i>	<i>Doncaster</i>
Outpatient over 13 week waiters	1,804	2,175	2,087
Outpatient over 26 week waiters	258	504	548
Inpatient over 12 month waiters	175	18	12
Inpatient over 15 month waiters	5	1	0

However, both Wakefield HA and Pinderfields & Pontefract Hospitals NHS Trust have a good record of achieving local waiting list and waiting time targets in recent years. At the end of December 2001, Wakefield HA was very close to having achieved the 15 month maximum waiting time target and the 175 patients waiting over 12 months represent less than 3 per cent of the waiting list. This compares with 80 over 15 month waiters and 341 over 12 month waiters a year earlier. Wakefield HA, the Trust and the two local Primary Care Trusts are working together closely to ensure patients receive treatment even more quickly in the future. Current initiatives include putting on extra operating theatre sessions, and offering patients the choice to be treated at other hospitals such as Barnsley District General Hospital and by the independent sector.

I set out at the hearing some of the initiatives we are using to address such variations, including the programme of work to implement best practice being taken forward by the Modernisation Agency. We are aiming to reduce the maximum waiting in successive years so that by 2005 no one waits over three months for an outpatient appointment or six months for an inpatient admission. These targets recognise the importance that patients place on waiting time.

Question 167: What powers do you have to dismiss a chief executive or chairman of a trust?

Section 13 of the Health and Social Care Act 2001 enables the Secretary of State to make an intervention if he is satisfied that an NHS body "is not performing one or more of its functions adequately, or at all, or that there are significant failings in the way the trust is being run". Intervention orders are required to be placed before parliament and would give specific directions that were relevant to the use of the power in the particular case. The Secretary of State's powers include the removal of any board member from the board of the trust. The Chief Executive's employment is a matter for the employing trust.

19 November 2001]

[Continued

Question 181: Can you provide a breakdown, by specialty, of the consultants that considered 80 per cent of referrals were inappropriate?

The table below provides the specialty breakdown requested:

<i>Specialty</i>	<i>Number of consultants</i>
ENT	12
T&O	23
Urology	9
Not stated	2
Total	46

Question 182: What are the patterns for out of area treatment?

There are a number of means through which patients can be treated outside their normal locality.

The out of area treatment (OAT) arrangements were introduced on 1 April 1999 as part of a package of new commissioning arrangements that saw all patient care arranged under service agreements. OATs are used where pre-arranged service agreements are not practical, primarily emergency treatments required while away from home—for example treatment required while on holiday. Under the OAT arrangements each NHS trust has a main commissioner health authority. The main commissioner is funded for OATs through a non-recurrent adjustment to allocations. This is based on past referral levels. The adjustments are:

- an addition to the resource limit of the health authority which is the main commissioner for the NHS trust; and
- a deduction to the resource limit of the health authority responsible for the patient.

For elective care the local health authority should commission care from each NHS Trust that provides care for its responsible population. Local GPs should be consulted and where possible the agreements should reflect their referral preferences.

These arrangements try to strike a balance between coherent planning for service development, and responsiveness to individual needs.

Question 194: What percentage of consultants are full time?

The following table details the number of consultants in the NHS and the percentage of the total number of consultants who are full time.

CONSULTANTS IN THE NHS, 30 SEPTEMBER EACH YEAR

<i>Year</i>	<i>Total headcount</i>	<i>Full time</i>	<i>Maximum part time</i>	<i>Part time</i>	<i>Honorary</i>	<i>Whole time equivalent for part time staff</i>	<i>Percentage of consultants who are full time</i>
2001	25,690	14,464	5,628	3,878	1,720	1,992	56%
2000	24,306	13,877	5,750	3,005	1,674	1,690	57%
1999	23,225	13,383	5,640	2,692	1,510	1,534	58%
1998	22,224	12,645	5,381	2,545	1,653	1,442	57%
1997	21,373	11,880	5,451	2,357	1,685	1,352	56%

Source: Department of Health medical workforce census

Department of Health
April 2002

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ISBN 0-215-00551-1



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