Report

of the

Review Group

on the

Waiting List Initiative

June 1998

Executive Summary
Report of the Review Group on the Waiting List Initiative

Introduction

The Minister for Health and Children, Mr. Brian Cowen TD, established the Review Group on 9 April *1998* to examine the current *Waiting List Initiative (WLI) for public in-patients and to make* recommendations on how best to maximise its effectiveness. The Group was asked to report by the end of June. This is an Executive Summary only and should be read in conjunction with the body of the report.

Overall Conclusions

The Review Group believes that a series of immediate, medium term and long-term initiatives must be taken if waiting lists and waiting times are to be reduced substantially. There are no simple short-term solutions which, on their own, will have a significant impact. In addition, a satisfactory response must reach beyond the acute hospital services alone. The report makes a number of recommendations regarding organisational initiatives that could be implemented quickly, but these must be accompanied by an integrated set of medium to long term initiatives both within and outside the acute hospital sector.

Immediate-Term Recommendations: 1998

A number of recommendations, if accepted, could be implemented before the end of 1998. These relate to the assessment of hospital capacity, the improvement of information systems, steps to validate waiting lists and a number of short-term initiatives aimed at improving the operation of the system.

- Further study of hospital capacity is needed as a matter of urgency. Some hospitals have reached full capacity with existing resources in relation to elective work. Where staffing is an issue, these hospitals should be funded for the provision of appropriate temporary staff in target specialties, subject to certain conditions. Where physical capacity is an issue, favourable consideration should be given to developing, in the medium to long term, additional capacity in hospitals which demonstrate that their existing facilities are already appropriately utilised and fully committed.

- Agencies should be asked to review their information systems to ensure that they can maintain accurate and up-to-date WLI data and should be assisted if specific shortfalls are identified. The Department of Health and Children should develop and implement an improved IT system for recording and analysing national WLI data.

- Hospitals should carry out a bulk postal review of patients on their waiting lists where they have not done so in the previous twelve months. There should be an agreed protocol for periodic further reviews on a selective basis following this validation process.

- A set of short-term steps relating to the operation of hospital services should be taken. These include an improved flow of information between primary and hospital care regarding the status of patients on waiting lists; a continued move towards day case work; the appointment of bed managers and bed utilisation committees; agreement under each agency's service plan regarding the mix of public and private patients treated; and a written policy on planning the *discharge of older patients and on liaising with community-based services.*

Medium Term Recommendations: 1999

A number of steps should be taken during the course of 1999 These are summarised below.

- WLI funding should focus on a limited number of specialties and take the greatest possible account of health and social gain, the priority set according to clinical judgement and the length of time already waited by patients.

- The present system of allocating WLI funding may act as a disincentive to hospitals to improve their waiting list performance. The Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. A proportion of total WLI funding could be retained by the Department for distribution to the hospitals which showed the greatest reduction in waiting times in target specialties. The details of any such incentive system should be developed in conjunction with the relevant hospitals.

- Protocols should be developed in all major Waiting List specialties for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual hospitals.

- A number of measures should be pursued to reduce the pressure from A&E services on acute beds. These include developing rapid diagnostic systems for common emergency presentations; developing effective care guidelines for managing conditions which no longer require admission; further developing treatment/observation areas to allow frequent review of certain cases; and improving access by general practitioners to urgent specialist opinion.

Long Term Recommendations 1999 - 2001

The availability of beds for elective treatments is being restricted due to a number of factors. These include shortfalls in the provision of services for older people (and others who may need long-term care) such as day investigation facilities, rehabilitation facilities, community-based support services and long-term residential care places. The shortfalls in these services result in inappropriate use of acute hospital facilities and thus severely hamper the ability of hospitals to provide treatments to patients on public waiting lists.

- The development of Geriatric Day Hospitals on the site of acute hospitals should be prioritised in the medium to long term. The next priority should be the development of rehabilitation facilities on acute hospital sites where they do not already exist. Both of these developments would significantly increase the appropriate utilisation of scarce acute hospital services.

- Each health board should evaluate the long-term residential care needs of its region. There should then be a planned programme of investment in appropriate facilities for those in need of long-term care.

- For acute patients, the case for providing stand-alone day surgery units on the site of acute hospitals should be examined closely. Since many patients who are on public waiting lists could be treated on a day case basis, a dedicated day surgery unit could greatly protect them from delays that arise from other hospital pressures.

- The question of providing additional hostel or other short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed should be pursued as a means of reducing unnecessary hospital stays.

Chapter One
Introduction

Establishment and Terms of Reference

On 9 April 1998, the Minister for Health and Children Mr. Brian Cowen TD announced the establishment of a Review Group to examine the current Waiting List Initiative (WLI) for public in-patients and to make recommendations on how best to maximise its effectiveness. Its terms of reference were as follows:

> *'To examine the underlying factors giving rise to waiting lists and waiting times and to make recommendations on the most appropriate means of addressing the underlying causes of substantial waiting lists and waiting times.*
>
> *The review should have particular regard to:*
>
> *- The net effect of the current Waiting List Initiative on waiting lists and waiting times;*
> *- Any incentive effects of the WLI on participating hospitals in relation to their activity and treatment schedules;*
> *- The extent to which hospitals can consistently and accurately validate their waiting lists; and*
> *- The adequacy of existing information systems to permit routine evaluation of the WLI.'*

The Minister appointed the following persons to the Review Group:

Mr. Michael Lyons, (Chairperson) Principal Officer, Department of Health and Children.
Mr. Vincent Barton, Principal Officer, Department of Health and Children.
Dr. Eibhlin Connolly, Deputy Chief Medical Officer, Department of Health and Children.
Mr. Mark Doyle, A&E Consultant, Waterford Regional Hospital.
Mr. Liam Dunbar, former Chief Executive, St. James's Hospital.
Dr. Mary Hynes, Specialist in Public Health Medicine, Eastern Health Board.
Dr. Peter Kearney, Consultant Cardiologist, Cork University Hospital.
Mr. Austin Leahy, Consultant Surgeon, Beaumont Hospital.
Mr. Fergal Lynch, Assistant Principal Officer, Department of Health and Children.
Dr. Chris McNamara, G.P. Advisor, Department of Health and Children.
Dr. Eamon Mulkerrin, Consultant Geriatrician, University College Hospital, Galway.
Mr. Frank Thompson, Consultant Orthopaedic Surgeon, Tullamore General Hospital.

Ms. Celine Brosnan, Higher Executive Officer, Department of Health and Children, acted as Secretary to the Group.

The Minister indicated that he is committed to maintaining a separate stream of funding for addressing waiting lists and waiting times. He said that the purpose of the review was to identify the most appropriate means of building upon the present Waiting List Initiative so as

to meet the needs of public patients. The Minister asked the Review Group to report to him by the end of June 1998 so that its recommendations can be taken into account for the Estimates process in 1999 and subsequent years.

Method of Work

Given the short timescale available, the Group decided to focus on identifying a set of key issues that might be addressed in the short term, medium term and long term. To this end it held four full meetings (30 April, 12 May, 9 June and 29 June 1998). In addition it met with representatives of the Irish Hospital Consultants' Association and the Irish Medical Organisation to hear their views on issues relating to waiting lists.

The Group considered a number of discussion documents prepared by individual members. It also took account of a wide range of existing literature on the subject of waiting lists.

Acknowledgements

The Review Group would like to acknowledge the assistance it received from the Department of Health and Children during the course of its work. It also wishes to thank the Irish Hospital Consultants' Association and the Irish Medical Organisation for presenting their respective views.

Structure of Report

Chapter Two of this report sets the context of the current Waiting List Initiative (WLI), including the background to its establishment, details of the funding allocated to it and trends in waiting lists and waiting times.

Chapters Three, Four and Five deal with service issues in primary care, acute hospital care and continuing care. These chapters contain specific recommendations on the steps that should be taken to help reduce waiting lists and waiting times.

Chapter Six addresses what the Group believes to be the important service-wide issues in the operation of the WLI. It makes a series of recommendations which, taken together, would help to address waiting lists and waiting times in the medium to long term.

Chapter Seven summarises the main conclusions and recommendations of the Review Group.

Chapter Two
The Waiting List Initiative in Perspective

Introduction

This chapter reviews briefly the background to the introduction of the Waiting List Initiative (WLI) in 1993 and examines its performance in terms of waiting lists and waiting times since then. It then considers the challenges associated with any structured programme aimed at reducing waiting lists, setting the context for the Group's review and the recommendations that follow in subsequent chapters.

Introduction of a Waiting List Initiative

The current Waiting List Initiative was introduced in June 1993. It followed growing concern about the apparent length of time that public patients had to wait for certain elective procedures in Irish hospitals. It was clear that the problem was not confined to Ireland; health systems throughout the developed world were, and are, experiencing similar difficulties in catering for all of the demands that arise in some specialties.

The WLI introduced in 1993 is operated on the basis of dedicated funding from the Department of Health and Children for a specified number of elective procedures in participating health board and voluntary hospitals. The Department negotiates with each agency on the amount of special funding to be provided in exchange for an agreed level of waiting list activity. The work must relate to patients awaiting treatment and must be over and above the activity that would have been performed in the hospital from normal funding.

The criteria for allocating waiting list money to health boards and individual hospitals include:

- the extent of spare capacity in each hospital to carry out waiting list work;
- whether the hospitals with the longest lists have spare capacity;
- the price quoted by hospitals for targeted procedures and their relative efficiency in the targeted specialties; and
- the track record of individual hospitals from previous years in delivering the reductions agreed upon.

The aim of the WLI is to reduce waiting times for in-patient procedures in public hospitals to no longer than 12 months for adults and six months for children in target specialties. A total of £58 million was spent on the WLI between 1993 and 1997 and a further £12 million has been set aside for 1998. Table 1 below summarises the amounts allocated per year and the size of waiting lists at the end of each quarter since the initiative was launched.

Table 1

In-Patient Public Waiting Lists and WLI Funding 1993 - 1998

Year	Amount (£m)	March	June	September	December
1993	20.0	39,423	40,130	25,165	25,373
1994	10.0	27,576	24,778	27,633	23,772
1995	8.0	27,475	27,696	27,004	27,752
1996	12.0	28,865	30,447	31,519	25,959
1997	8.0	29,069	30,453	32,252	32,206
1998	12.0	33,847	-	-	-

Table 1 suggests that the WLI appears to have been successful in reducing the numbers awaiting treatment in the public system. The recorded figure fell from 40,000 in June 1993 to 26,000 by the end of 1996. However, the greatest progress was made in a concentrated effort between June and September 1993 when lists fell substantially. Part of this reduction arose from a validation exercise which removed those not actually awaiting treatment. Since 1994, the trend in waiting lists has been slowly upwards, with the notable exceptions of substantial reductions during the last quarters of 1994 and 1996.

It is difficult to point with absolute certainty to a direct link between WLI funding and a reduction in waiting lists. However, the available evidence suggests that there is a strong correlation between the amount of funding given and the reduction in numbers awaiting treatment by the end of each year. Total lists fell by the end of 1993, 1994 and 1996, years in which substantial WLI funding was provided. By contrast, total lists rose by the end of 1995 and 1997, years when WLI funding was reduced considerably from the previous year.

Waiting Times

To date the *number* of people on public waiting lists has received much greater public attention than the actual *time* for which they have to await treatment. This is perhaps inevitable, but it does not focus on the true nature of the problem. In practical terms what matters to the patient is the length of time that he/she has to wait for treatment rather than the absolute length of the list. In the major target specialties, the proportion of adults waiting for more than twelve months and the proportion of children waiting for more than six months, is detailed in Tables 2 and 3 below for December 1996, September 1997 and December 1997.

Table 2
Adults in target specialties waiting more than 12 months: 1996-1997

Specialty	December 1996		September 1997		December 1997	
Cardiac Surgery	1,030	74%	1,141	*77%*	969	76%
ENT	1,124	40%	2,067	*47%*	1,937	47%
Gynaecology	396	20%	512	*23%*	600	27%
Ophthalmology	647	30%	873	*36%*	803	29%
Orthopaedics	2,188	45%	2,972	*48%*	3,037	48%
Plastic Surgery	467	58%	769	*63%*	883	62%
Surgery (General)	666	27%	1,076	*39%*	1,110	40%
Urology	560	37%	812	*49%*	802	50%
Vascular	1,518	64%	1,652	*64%*	1,781	65%

It can be seen that a high proportion of adults have to await treatment for longer than the target maximum waiting period of twelve months. About three-quarters of adults awaiting cardiac surgery and two-thirds of those awaiting vascular surgery and plastic surgery appear on waiting lists for longer than twelve months. The proportion waiting for more than one year in other specialties is somewhat better (about 50 per cent of all ENT, orthopaedics and urology patients and about one-third for ophthalmology and gynaecology) but these figures have either remained static or have actually disimproved since the end of 1996.

Table 3 illustrates a similar picture in the case of target specialties for children. The proportion of patients waiting for longer than the target maximum period of six months remains high in many specialties, although the numbers involved are significantly fewer (other than in ENT). Some progress has been made since 1996 in waiting times for ENT, cardiac surgery, and plastic surgery. The numbers waiting in the other target child specialties are low, but the proportion who must await treatment for longer than six months remains considerable.

Table 3
Children in target specialties waiting more than 6 months: 1996-1997

Specialty	December 1996		September 1997		December 1997	
Cardiac Surgery	55	100%	74	*68%*	66	68%
ENT	1,524	62%	1,560	*54%*	1,714	57%
Ophthalmology	162	64%	102	*40%*	101	44%
Orthopaedics	53	83%	78	*81%*	89	88%
Plastic Surgery	157	80%	202	*69%*	218	72%
Surgery (General)	69	64%	58	*63%*	48	30%
Urology	20	77%	28	*78%*	6	40%

Revised Arrangements for Operation of WLI, 1998

In December 1997 the Department of Health and Children issued a revised set of arrangements for the operation of the Waiting List Initiative for 1998. These changes are of relevance to the Review Group's work and have been taken into account by the Group in its conclusions and recommendations. The main changes introduced were:

- *much earlier notification* to hospitals of the level of funding available to them. They received details of the funding in December, whereas in previous years the funding for waiting lists tended not to be allocated until around July. It is hoped that this earlier notice will enable hospitals to plan their activity accordingly;

- hospitals are required to specify *targets for waiting list activity* during the year. It is the responsibility of the Chief Executive Officer/Hospital Manager to ensure that the targets are achieved and to take corrective action as necessary;

- an increased focus on waiting *times* as well as on waiting *lists,* with the objective of ensuring that children do not have to wait longer than six months and adults no longer than twelve months in the specialties targeted for attention; and

- designation of an individual in each hospital to act as a *co-ordinator of waiting list work* and as a contact point with the funding agency.

The effect of these operational changes will become apparent as the year proceeds. The Department has indicated that they will be kept under review and assessed in the context of any recommendations made by the Review Group.

Waiting List Initiative in Context

The nature of the health care system is such that not all treatments can be made available to patients immediately. Services have to be provided in a way that use hospital facilities to best effect, and it is sometimes necessary to place patients for non-urgent treatments on a waiting list. Eliminating all waiting lists entirely would imply under-used resources in the health system, with facilities lying idle at times. The concern, therefore is to reduce waiting lists as much as possible and, most importantly, to bring waiting times to within reasonable limits.

A vital concern in the management of waiting lists is to ensure equity in the availability of treatment. It is very important to structure services in a way that ensures equity of access to services for which there is a public waiting list and to maximise health gain from available resources. Access to these services must be determined on the basis of clearly defined criteria for judging priorities.

The Review Group is conscious in particular that waiting lists are a phenomenon of public rather than private health services. Given the role which public hospitals play in providing services for both public and private patients and having regard to the sustained increase in the proportion of the population covered by private health insurance, there is a particular onus on managers to ensure that there is equity of access for all patients, both public and private. The Review Group believes that further consideration should be given to establishing the current

situation in hospitals in this regard and to enhancing systems which would ensure that the objective of equity, in all its aspects, is achieved.

The existence of waiting lists is an international phenomenon; it is not confined to Ireland. This is not to suggest that there should be any less attention to addressing the problems created by waiting lists, but it is useful to bear in mind the world-wide dimension to the issue. International experience indicates that it is very difficult to eliminate waiting lists or waiting times entirely. Among the reasons for this are:

- the ever-increasing demand for health care;
- when it becomes apparent that inroads are being made in a waiting list, new cases tend to be added to the list to replace those who have received a service;
- some hospitals or consultants may find it attractive to maintain a public waiting list because a proportion of those waiting may opt to be treated privately;
- even a sustained and successful effort to reduce existing lists may not address the underlying cause of waiting lists developing in the first instance. The lists could be the result of inadequate staffing or equipment, poor management of the hospital's facilities, lack of step-down facilities or a combination of such factors. *The Review Group strongly believes that waiting list money, while useful provided it is properly directed, serves only as a stop-gap unless the underlying causes of the emergence of a waiting list are addressed.* Nonetheless the Review Group believes that waiting lists can be addressed in a focused manner by targeting the limited funds available at a small number of selected specialties, setting specific objectives in relation to waiting times.

In the course of the review, the Group was conscious of the following issues which could have a potentially significant impact on waiting lists and waiting times.

- Hospitals must validate their waiting list data consistently and accurately. Failure to do so would make it very difficult to quantify the true extent of the problem.
- There must be no incentive under the Waiting list initiative for hospitals to maintain waiting lists. The Review Group considered whether the basis on which WLI funding is currently allocated might send inappropriate signals in this regard to hospitals, who might fear that an improvement in their waiting list performance would lead to a reduction in WLI funding.
- As indicated in the terms of reference, the Review Group was anxious to identify the underlying causes of waiting lists and waiting times building up in the first instance. It also wished to analyse how these causes might best be addressed.
- The Review Group was conscious of the need to ensure that the Department, health boards and individual hospitals are explicit about the criteria for compiling, validating and prioritising waiting lists and for allocating funding to individual agencies and specialties.

Approach to Review

It is clear that the review of the current Waiting List Initiative is timely. The challenges above underline the difficulty of dealing successfully with lengthy waiting lists and waiting times, but the Review group believes that progress can be made if these challenges are addressed in a focused manner, at both Departmental and agency level.

In carrying out its review, the Group had regard to the inter-relationships between three key elements that affect waiting lists and waiting times:

- **demand** for services: the number of referrals from primary care (general practitioners or other health professionals) to consultant specialists. It is important to distinguish here between those referred for assessment and those who are judged as in need of treatment and placed on a public in-patient waiting list;

- **supply** of services: the number and type of services available to those assessed as in need of a treatment for which there is a public waiting list. The configuration of these services and the manner in which the service is delivered at local level is vital; and

- **management of demand and supply**: the way in which waiting lists are managed by hospitals and individual consultants.

The Review group examined these issues from the normal first point of contact with the health services (primary care) through to hospital-based treatment services and ultimately to continuing care services. It also examined them from the wider perspective of the health service as a whole.

Conclusion

The Waiting List Initiative has been an important element of hospital activity since its inception in 1993. Inevitably, questions can be raised about validation (and hence the true extent) of waiting lists, the net effect of WLI on waiting lists and waiting times, and the management of waiting lists at hospital level. Nonetheless, it is clear that the WLI has funded a large number of elective procedures and has enabled thousands of patients to receive treatment more quickly than would have been possible under normal hospital services.

This chapter has reviewed the main elements of the WLI and the principal trends in its performance to date. The chapter also raised a range of issues for further consideration. These and other issues are addressed in the chapters that follow.

Chapter Three
Waiting List Initiative and Primary Care

Introduction

While the procedures for which patients are waiting are carried out in acute hospitals (whether as in-patients or day cases) the normal starting point for referral is primary care. The Review Group has noted earlier the important links between those awaiting in-patient and out-patient appointments, and that patients may have to wait a considerable time in some cases for a consultant appointment following referral by their general practitioner. While this issue is outside the Review Group's immediate terms of reference, it is one which has informed the Group's recommendations in relation to primary care.

A key concern under the Waiting List Initiative is how best to foster close liaison and co-operation between primary care, particularly general practitioners, and the hospitals providing WLI treatments. In this regard, the Review Group considered the following questions:

- How might general practitioners be given a stronger role in relation to the management of lists? The Review Group is conscious that they are often the first to identify the need for immediate or possible future treatment (eg orthopaedic procedures, ENT and general surgery). They have an important role in prioritising patients, particularly in distinguishing between those who need immediate treatment and those who may need it at some future stage.

- How best can greater dialogue be facilitated between general practitioners (and other providers of primary care) and hospitals? Liaison and co-ordination is clearly vital.

This chapter addresses these and related issues.

'Early Warning' System

The Review Group believes that it would be valuable to develop an 'early warning system' from primary care services to hospitals regarding the level of demand by specialty for particular treatments. This would alert hospitals of impending cases, particularly the most urgent ones which might require consultants to re-prioritise their waiting list.

It would be useful to develop a pilot study for this purpose in perhaps one health board area, using a hospital with a clearly defined catchment area of general practitioners. Health boards would be invited to submit proposals for a specific hospital (or group of hospitals) to participate. The hospitals would specify the specialty in which it proposes to conduct the study. A protocol would then be developed between the hospital(s) and the general practitioners, with the co-operation of the relevant specialists.

The general practices selected for participation in the pilot programme would develop disease registers[1] relating to the proposed specialty. Appropriate support and resources would have

to be available to the specialty and practices for record-keeping, technology and personnel to promote and monitor the pilot study.

The Review Group sees merit in this approach. If successful, the early warning system would enable hospitals to identify some of the future demands likely to be placed upon them and to plan their services accordingly. While it would not be expected to have an immediate effect in reducing waiting lists, it may have potential in the longer term for assisting hospitals in the planning of activity, thereby ultimately reducing pressure on waiting lists. It would be preferable if the hospitals and general practices selected for the pilot project had a history of good working relationships and professional interaction.

Accordingly, the Review Group recommends that a pilot project in primary care be established along the lines described above to ascertain whether an 'early warning system' aimed at alerting hospitals of likely future demands on waiting lists could be implemented. This approach could have potentially positive effects in the long term.

Communications between Primary and Hospital Care

The Review Group believes that a comprehensive flow of information between primary care and acute hospitals, including the relevant consultants, is vital. Liaison between the two can help ensure that cases are managed to best effect. In particular, liaison can ensure that patients are accorded the correct level of priority, that they are treated in the most appropriate setting, and that their current status is known to all dealing with the case.

In order to promote this flow of information, ***the Review Group recommends that all hospitals and general practitioners should establish a structured system of continuing information regarding the status of patients on their waiting lists. Hospitals should regularly inform general practitioners of their patients' current status, and the information should also be fed back from the general practitioners to hospitals, particularly in relation to changes in the patient's condition. In addition, hospitals should notify local general practitioners, on a routine basis, of the waiting lists and waiting times for the various specialties so that the general practitioners can prioritise their cases for referral to hospital. The Review Group notes that IT pilot projects in this area are already underway in a number of hospitals.***

Protocols

In addition to the flow of information advocated above, the Review Group is of the view that there should be agreed 'two-way protocols' between primary and secondary (acute hospital) care for patient referral, management of waiting lists, prioritisation of cases and return of patients to primary care. This is in keeping with the recommendation, made in Chapter Three, in favour of waiting list protocols to be developed either by the relevant professional bodies or by individual hospitals.
The two-way protocols would be developed as part of the protocols advocated in Chapter Three. In particular they would specify criteria for the referral and prioritisation of individual cases, for use by both general practitioners and the relevant specialists.

[1] This approach is already underway in other projects. For example, nine doctors in the North Eastern Health Board area are currently piloting a GP registration project aimed at collating epidemiological data into a profile of local health needs.

The Review Group recommends that, as part of the development of waiting list protocols, provision should be made for a special emphasis on agreed 'two-way protocols' to be operated jointly by general practitioners and the relevant consultant specialists. These protocols would set out the criteria for evaluating patients on a waiting list and for setting and adjusting priority cases for treatment.

This approach would also be in keeping with the proposal for a continuing validation and review process recommended in Chapter Three.

Maximising GP access to services

It is often argued that greater and speedier access by general practitioners to certain hospital and community-based facilities would reduce the need for patients to be placed on hospital waiting lists. Earlier access to paramedical services such as physiotherapy, occupational therapy and chiropody could, it is argued, alleviate the symptoms suffered by some patients and ultimately lessen their need for more treatments for which there is a public hospital waiting list.

A similar argument was made to the Review Group in relation to the services of Community Ophthalmologists. Greater availability of their services would, it is contended, deal with elderly patients' original condition and therefore reduce their need for hospital-based services.

It is also argued that speedier access of general practitioners to certain hospital diagnostic facilities would be of considerable value. It would enable general practitioners to complete their assessments of patients in a more efficient manner and would help them distinguish quickly between those needing hospital-based care (including a treatment for which there is a waiting list) and those who can be treated in the community[2].

The Review Group recommends a targeted programme of investment to ensure that general practitioners have speedy access to appropriate community-based and hospital-based facilities, with a view to reducing the need to place their patients on public waiting lists for in-patient services.

The Review Group recognises that access to many community-based facilities is hampered at present by staff shortages and difficulties in recruitment. This is part of a wider issue in manpower planning. Nonetheless, the Review Group believes that an increased availability of these services would bear significant dividends in terms of reduction in the need for some patients to await in-patient hospital treatments.

It has also been argued to the Review Group that lack of access to urgent consultant opinion means that general practitioners send out-patients to Accident and Emergency Departments for a second opinion. Ease of access to specialist opinion is discussed in Chapter Four below.

[2] The Review Group understands that a number of innovations are planned at the recently opened hospital in Tallaght, including GP involvement in a pilot precursor on improving A&E systems. There are also plans for enhancing primary care to avoid unnecessary admissions.

Cross Referral of Procedures by GPs

Under the present General Medical Services scheme, there is no direct incentive for general practitioners to refer their patients to a colleague for performance of a minor procedure. Such a procedure could be carried out by another general practitioner and avoid the need to refer patients for a hospital-based treatment . This could reduce the pressure on the hospital system and avoid the need for subsequent treatment for which there is a waiting list. ***The Review Group recommends that the cross-referral of patients between general practitioners for the performance of minor procedures should be facilitated within the General Medical Services scheme.***

Conclusion

The Review Group wishes to emphasise the central importance of primary care services to the management and reduction of waiting lists and waiting times. The Group believes that a number of steps can be taken to assist in the early identification of potential waiting list cases and that close liaison between primary care and hospital services can also be of value. The discussion again notes the inter-relationships between primary care, acute hospital services and a range of continuing care services.

Chapter Four
Waiting List Initiative and Acute Hospital Services

Introduction

The acute hospital system is placed under constant pressure from a range of demands for its services. It is often the focal point of public attention in the health services, although many very important services are provided elsewhere.

The acute hospital system is the location of all in-patient and day procedures carried out under the current Waiting List Initiative. Its important inter-relationships with other parts of the service have been noted earlier, but it is inevitably the source of much attention when the question of reducing waiting lists and waiting times arises.

The operation of the WLI in the acute hospital setting and the steps which the Review Group recommends to deal as effectively as possible with waiting lists, are considered below. These are considered under the headings of hospital capacity, organisational arrangements, targeting of funding and the interaction between accident and emergency cases and waiting lists.

Organisational Arrangements

The Review Group believes that a number of organisational approaches may help to utilise the existing capacity of acute hospitals to cater for the demands arising from waiting lists. These include:

- encouraging a progressive increase in the utilisation of day care instead of in-patient facilities;
- examining the scope for utilising beds that would otherwise be scheduled for seasonal closures;
- appointing bed managers and establishing bed utilisation committees or other mechanisms to assess and manage continuously the use of in-patient beds; and
- taking steps to facilitate the implementation of elective work throughout the year.

- Day Case Work

The value of day case over in-patient treatments, where possible, is well established. Day cases tend to be less expensive and are usually favoured by patients because they can avoid an overnight stay. In the case of treatments under the Waiting List Initiative, day case work is to be strongly encouraged for the same reasons. Since it tends to be cheaper than the in-patient alternative, it also frees up resources for other purposes, including treatment of additional patients who have been on a waiting list.

The Review Group recommends that every possible support be given to hospitals to encourage a continued move towards day case work under the Waiting List Initiative.

In the section dealing with further capital developments below, the Review Group makes a case for the provision of dedicated day surgery units in selected hospitals. This would obviously be a longer term measure, but would be particularly effective in encouraging a move towards day case activity.

- Seasonal Bed Closures

The Review Group heard strong arguments from a number of quarters that it was inconsistent to close beds for periods of the year, usually during the summer, while patients remained on waiting lists for elective treatments. It has been argued to the Group that if the beds are being closed to take advantage of lower demand, it would be the ideal time for elective work to be carried out under the Waiting List Initiative, subject to adequate emergency cover. It was accepted that the closures could be partly due to holiday arrangements of medical and nursing staff, for refurbishment of wards, or for budgetary purposes. In response it was argued that WLI funding could be used to employ locum or temporary medical and nursing staff, and that the net savings of summer bed closures was small.

The Review Group is conscious of the practical reasons for seasonal bed closures. However, it believes that every effort should be made to use slacker periods for elective WLI work. ***The Review Group recommends that hospital management should take full account of the scope for elective waiting list activity before making any decisions regarding seasonal bed closures.***

- Bed Managers and Bed Utilisation Committees

A regular feature of the acute hospital system is that in-patient beds are inappropriately occupied by patients who should be catered for elsewhere. They may be the result of an inappropriate admission, or due to an inability or failure to discharge patients who no longer need acute treatment in an in-patient bed. A range of reports have noted the reasons for this, including delays in processing test results, delays in reviewing cases, or the absence outside the hospital of facilities for recovery (The question of 'step-down' facilities is discussed further in Chapter Six).

It is clear that hospitals must adopt strict practices to ensure that patients do not occupy in-patient beds for longer than is necessary, and that proper arrangements are in place for their admission, discharge and follow-up care. In this regard, 'same-day' admissions for surgery should as far as practicable, be the norm, with preparation work being carried out the day before admission. Hospitals must also guard against practices aimed at 'reserving' beds for subsequent patients. In particular, the Review Group believes that hospitals should adopt measures to guard against the practice of retaining patients in a bed until the next patient in that specialty is ready for elective admission.

The Review Group believes that hospitals must develop adequate mechanisms for co-ordinating the management of acute beds. There is a clear need for a Bed Manager in each hospital with responsibility, in conjunction with the relevant consultant staff, for the day-to-day review of individual patients.

To assist the longer-term strategic review of bed management within the hospital, one approach which appears to be valuable is the use of a Bed Utilisation Committee. The function of the Committee, which is representative of medical, nursing and management staff, would be to develop policies in relation to admission, bed management and discharge and to monitor the operation of these policies. is to review cases periodically and to confirm that those occupying beds continue to need in-patient care. The Bed Utilisation Committee, in association with the Bed manager, can thus facilitate a structured review of cases and a planned approach to their subsequent care.

The Bed Manager should be responsible for implementing the policies formulated by the Bed Utilisation Committee. A critical function of a Bed Manager (on a daily basis) and a Bed Utilisation Committee (on a periodic basis) is to ensure that each acute hospital bed is appropriately occupied and conversely, to ensure that inappropriate admissions are minimised or eliminated. One means of identifying cases for review is to select those who have exceeded by a specified amount the average length of stay for the Diagnosis Related Group (DRG) in which they are categorised.

The inappropriate use of acute beds is a continuing problem and is compromising the throughput of patients in the hospital system. This issue has to be dealt with if waiting lists and waiting times are to be addressed effectively. Part of the solution is the better organisation and management of beds as discussed in this chapter; further issues in this regard are addressed in chapter six.

The Review Group recommends that every hospital which has not already done so should establish a Bed Utilisation Committee or a similar mechanism to develop admission, bed management and discharge policies for the hospital. However operated, the Committee or other mechanism should have sufficient status within the hospital to ensure that a plan is devised for the subsequent care of all in-patients identified as ready for discharge. The Review Group recommends that all hospitals should appoint a Bed Manager with responsibility for implementing the policies developed by the Bed Utilisation Committee.

- Hospital investigations

A particular issue connected with appropriate bed utilisation arises from access of patients to certain investigations. There is an understandable practice in most hospitals to prioritise in-patients for investigations. However, this results in some patients being admitted electively for investigations that could have been done as an out-patient. ***The Review Group believes that this could be addressed by the development of improved liaison and communication between hospital departments to co-ordinate the booking of a series of tests and procedures for individual patients.*** It could also be helped by the development of hostel or 'bed-and-breakfast' facilities for patients living a distance from the hospital, an issue that is referred to further at the end of this chapter.

- Facilitating Elective Work

The Review Group is conscious that it is often difficult for hospitals to plan and carry out elective work, including treatments for those on waiting lists, in a regular structured fashion. This is due in part to pressures from emergency work and increases in medical admissions at

certain times of the year. These pressures lead to the cancellation of elective work, with resulting inconvenience and frustration for patients.

The Review Group believes that an important function of the Bed Utilisation Committees (or similar mechanisms) proposed above would be to facilitate the implementation of elective work throughout the year. This is a challenging task which will require the full co-operation of all parts of the hospital. ***The Review Group recommends that the relevant health agencies should develop a mechanism aimed at ensuring the planned implementation of elective work, including waiting list treatments, over the full year.***

- Hospital Workload

Finally, the Review Group notes with approval that the Revised Contract for Consultant Medical Staff, applicable from 1 January 1998, provides for agreement regarding workload in a much more explicit manner than had previously been the case. The Review Group welcomes this development and anticipates that it will provide a vehicle for managers and clinicians to agree a planned approach to workload, including elective treatments such as those carried out under the Waiting List Initiative.

The Review Group regards equity of access, irrespective of means, as a critical principle in this connection. ***The Group recommends that the agreement regarding workloads, as provided for in the Revised Contract for Consultant Medical Staff, should be specified in each agency's Service Plan. The Service Plan should safeguard equity of access and maintain the agreed proportion of public and private patients treated. It should be a function of the Bed Utilisation Committee recommended earlier to monitor the public/private mix of patients by specialty.***

Targeting WLI Funding

The Review Group believes that it is vital to direct funds under the Waiting List Initiative specifically to the areas where they will operate to best effect. As noted earlier, there are nine target specialties at present, although agencies may decide to focus on a smaller number from that list if they wish. The Review Group considered the case for targeting all of the available WLI funding towards a much smaller number of specialties. For example, the specialties with the five highest waiting lists accounted for over 22,000 of the 32,000 awaiting treatment in December 1997, as illustrated in Table 4 below.

Table 4
Top Five Waiting List Specialties by Volume

Specialty	List at 31 December 1997
ENT	7,138
Orthopaedics	6,432
Ophthalmology	3,002
General Surgery	2,958
Vascular Surgery	2,726
Top 5 Total	**22,256**

In principle, it appears sensible to direct the available Waiting List Initiative funding towards the top five specialties (by volume). These account for almost 70 per cent of all cases on in-patient public waiting lists, and most of the remaining specialties have significantly fewer persons awaiting treatment[3]. However, the Review Group believes that it is not sufficient to consider numbers alone. It is important to take account also of such factors as:

- the health gain and social gain offered by different procedures;
- the complexity of procedures; and
- the priority attached to them on the basis of clinical judgement.

In some specialties it may prove easier to deal with the less complex cases quickly, thereby removing more people from the list, but only at the expense of more pressing complex procedures. For example, the Review Group noted that of the 1,700 children awaiting ENT procedures at the end of 1997, over 1,300 were for removal of tonsils/adenoids. The more complex procedures take longer to carry out but may offer considerably more benefit to patients.

However, it is not always easy to designate specific procedures for targeting. For example, of the 200 children awaiting the insertion of grommets, some would require urgent intervention to prevent hearing impairment and delay in educational development, while others might only be mildly disadvantaged from having to await the procedure.

In these circumstances, the Review Group recommends that, in keeping with the earlier recommendation regarding protocols and prioritisation of cases, the Department of Health and Children and health agencies should target the available WLI funding in a manner that :

- ***focuses on a limited number of specialties and***

- ***takes the greatest possible account of***
  - ***the health gain and social gain offered to patients,***
  - ***the priority attached to individual cases on the basis of clinical judgement, and***
  - ***the length of time already waited by patients.***

The Review Group believes that implementation of this approach, combined with the protocols and approach to prioritisation proposed in Chapter Three, would ensure that the

[3] Cardiac surgery and cardiology are to be the subject of substantial investment in the coming years under the Minister for Health and Children's forthcoming Cardiovascular Strategy, but they would clearly have to be targeted for priority under the WLI until a separate stream of funding is established for them.

available funding for treatments under the Waiting List Initiative is targeted to the best possible effect.

As part of the arrangements for the planning of Waiting List Initiative, the Review Group recommends that each hospital should establish an inter-disciplinary group to monitor the use of its waiting list funding. The Waiting List Co-ordinator would be a key member of this group.

In addition, the Review Group would emphasise the importance of ensuring that WLI funding should be directed specifically at work to reduce waiting lists and waiting times. Despite any budgetary pressures elsewhere, hospitals should ensure that funds are used for the purpose for which they were intended.

Interaction between A&E and Waiting Lists

Accident and emergency departments are identified as the source of emergency patients who need to be accommodated in beds which would otherwise have been available for elective surgical patients, thereby contributing to the lengthening of waiting times for surgery. There is little evidence that significant numbers of patients are admitted inappropriately from A&E departments. However, there is no doubt that acute admissions could be reduced if certain other systems were put in place.

Many acute admissions occur on the basis of uncertainty, i.e. to exclude conditions by investigation or time. In some areas, it has proved possible to reduce the time taken to rule out certain conditions (such as acute coronary syndrome where the symptoms include chest pain) by instituting rapid diagnostic systems incorporating dedicated areas, staff and priority access to laboratory investigation, exercise ECG and echocardiography. More rapid decisions can then be made, allowing discharge of many patients who would otherwise be in hospital for some days. The Review Group believes that the feasibility of extending this model to other clinical situations should be examined.

It is clear that, with developments in treatment, conditions which traditionally required hospitalisation can now be managed without admission. The Review Group believes that effective care guidelines for the management of these conditions should be developed, having regard to international best practice. This would help medical staff to discriminate between cases that required admission and those who did not.

Certain patients with emergency conditions may require short periods of observation and treatment in hospital. Examples include cases of minor head injury, asthma, overdose, epilepsy and diabetes. Specific appropriately staffed areas in, or close to, the Accident and Emergency Department, could accommodate these patients. Frequent review (every few hours) by senior medical staff would identify those who could be discharged and those requiring more prolonged admission to the specialty ward.

Chapter Four above referred briefly to the importance of easy access by general practitioners to specialist opinion. Because of delays in obtaining out-patient appointments, general practitioners are often obliged to send patients to A&E Departments for a second opinion. A number of these patients are admitted for investigations and treatment which could have been performed at out-patient level. The Review Group believes that ease of access to specialist

opinion, particularly for *urgent* as distinct from *emergency* referrals needs to receive further attention.

The Review Group recommends that in order to reduce the pressure on beds from Accident and Emergency Departments, the following measures should be pursued:

- ***development of rapid diagnostic systems targeted at a number of common emergency presentations;***
- ***development of effective care guidelines for the management of conditions which no longer require hospital admission, having regard to international best practice;***
- ***further development of short-stay treatment/observation areas to allow frequent review of selected cases by senior medical staff; and***
- ***improving access of general practitioners to urgent specialist opinion.***

The Review Group believes that the essential requirements for these measures to succeed would be increased senior medical input at emergency attendance level and greater interaction and co-operation between primary care, accident and emergency departments and admitting specialties. This is in keeping with the approach adopted by the Group in its discussion of interaction between sectors at the end of Chapter Six.

It has been argued to the Review Group that a shortage of fully trained and experienced doctors is hampering the ability of Accident & Emergency Departments to deal effectively with the cases presenting. The Review Group believes that the resolution of this and related personnel and training issues, which are currently being addressed by the Manpower Planning Forum, would have an important role in addressing the pressures being placed on A&E Departments.

Hospital Capacity

To date this chapter has suggested a number of organisational arrangements that might be used to improve the effectiveness and efficiency of the existing Waiting List Initiative. These measures are based on utilising the existing capacity of hospitals to best effect. They take account of the need to address problems of inappropriate admissions and difficulties in discharging patients from acute facilities at the appropriate time.

Based on the experience of its individual members, ***the Review Group believes that a number of hospitals are either at or near full physical capacity, particularly at certain times of the year when non-elective admissions tend to peak.*** In the time available to the Group, it was not possible to assess this in a formal way, but the preliminary evidence to this effect appears strong. For example, the latest available data indicate that bed occupancy rates in Irish hospitals are the highest of all countries in the European Union[4].
With an ageing and growing population, the Review Group believes that there is a need to provide extra capacity in the acute hospital system. In particular, the available information implies that WLI funding will have to be accompanied by measures to address shortfalls in

[4] **Source:** World Health Organisation Data Base. No data available for Greece.

such areas as theatre space, equipment and staffing. More study is needed to quantify the exact nature of any such lack of physical capacity to meet demand.

It has also been suggested that there is a shortage of in-patient beds for elective work, but the Review group would be slow to recommend any increase in bed numbers until hospitals have satisfied themselves that existing beds are being utilised appropriately. Without rigorously applied assessment procedures for bed utilisation, the Review Group would be concerned that increasing the number of beds would not ensure access for those most in need of care.

The Review Group is of the view that some hospitals have reached full or near-full capacity in relation to their elective work. The Group recommends that as a matter of urgency, further study of hospital capacity be carried out to ascertain each hospital's needs in this area. It further recommends that favourable consideration be given to supporting additional capacity in hospitals which demonstrate that their existing facilities are already appropriately utilised and fully committed.

The Review Group recommends that in certain specified circumstances, consideration should be given to supporting hospitals through the provision of locums or temporary staffing with particular reference to addressing the five specialties listed in Table 4 above. These specified circumstances would be where the following criteria are met:

> ***(i) the organisation and management of existing capacity is efficient;***
> ***(ii) physical capacity for additional WLI activity is available; and***
> ***(iii) there is a demonstrable shortage of specific personnel.***

In addition to the possible capital and other requirements above, the Review Group also considered the case for two forms of facility that would free up some capacity in the existing hospital system and help to reduce some of the pressure there at present. These are (i) dedicated surgical day centres as stand-alone units which would cater for a high proportion of waiting list cases and (ii) hostel facilities to accommodate patients who need to be close to hospital but do not necessarily require an acute in-patient bed.

- The Case for Dedicated Day Surgery Units

Much elective day activity is hampered by pressures that arise elsewhere in the hospital, particularly from medical admissions and Accident and Emergency cases. The experience of hospitals with separate day surgery units is that they can be more successfully protected from other hospital pressures provided that hospital management establishes a clear policy regarding their use. Where hospitals make it clear that day units must close at the end of a normal working day, and will not be available for other purposes, the elective treatments provided in them can be more easily protected.

An important requirement of dedicated day surgery units is that they are on the same site as the main hospital, with access to the full range of medical, nursing and laboratory facilities. Given the nature of much waiting list treatments, particularly in ENT, general surgery and vascular surgery, it is likely that a very high proportion of patients who are on a public waiting list could be treated in this setting.

Due to the capital cost and the amount of planning required, the provision of dedicated day surgery units on the sites of acute hospitals must inevitably be a longer-term objective.

However, ***the Review group recommends that the case for providing stand-alone day surgery units should be examined closely as a medium to long-term response to services under the Waiting List Initiative. Given that waiting lists are essentially peculiar to the public health system, the Review Group recommends that a very high proportion of activity in Day Service Units should be devoted to public patients.***

- Provision of Hostel Accommodation

The Review Group considered the argument that some in-patients receiving treatment in hospital have to be accommodated there overnight after their treatment has concluded due only to the distance from their home. This is particularly the case for those receiving renal dialysis and for those receiving chemotherapy or other treatments for cancer. Inevitably this reduces the availability of in-patient beds for other patients, including those on a public waiting list.

It has been suggested that the provision of suitable hostel or other short-term accommodation either on-site or close to the hospital would help to address this problem. ***The Review Group recommends that the case for providing hostel or other suitable short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed be pursued by the Department of Health and Children, the health boards and hospital management as appropriate.***

Conclusion

The organisation and management of acute hospital facilities can have a significant impact on waiting lists and waiting times. The Review Group believes that the organisational initiatives it has proposed offer scope for improvements in performance in the WLI. It also believes that an assessment of the capital requirements of hospitals, including the possibility of dedicated day surgery units and hostels, could be very beneficial in the medium to long term.

Chapter Five
Waiting List Initiative and Continuing Care

Introduction

The availability of adequate continuing care services is of considerable concern to the community as a whole and is an issue that deserves attention in its own right. For the purposes of this report, continuing care services are addressed specifically in the context of the Waiting List Initiative, but the Review Group also fully recognises their wider importance.

Continuing care services affect WLI policy in two notable respects: patients who have received treatment may need follow-up services (such as home support after a hip replacement) and non-acute patients must be catered for in appropriate 'step-down' or other supported facilities so that they do not occupy acute beds intended for WLI and other elective work.

This chapter examines the aspects of continuing care services that must be developed to help the achievement of a successful WLI policy. The older population forms a sizeable proportion of the client group concerned, but the Review Group recognises that there are other groups involved also, including the young chronic sick and persons of all ages who require long term care.

Use of Acute Facilities

A number of previous reports have pointed to the shortage of appropriate residential and other long-term care facilities for older people and other groups in need of non-acute care. The Review Group agrees fully with this view, and believes that the problem is leading to substantial blockages in the availability of acute hospital beds for elective in-patient activity, including treatments under the Waiting List Initiative.

In response to a recent Parliamentary Question, the Minister for Health and Children indicated that on 21 April 1998 approximately 418 beds (representing some 3.5 per cent of all acute hospital beds) were occupied by inappropriately placed patients. These included older and other patients who did not require, or who no longer required, acute care. Table 5 below gives details of the estimated numbers by health board area. It illustrates that over half of the inappropriate placements were in the Eastern Health Board area, with significant numbers in the Southern and Western Health Board areas also.

In their response to the Parliamentary Question, some health boards and voluntary hospitals also provided details of the average number of inappropriately placed patients per week since the beginning of 1998. The figures were similar to those given for 21 April in the table below. This reinforces the view that acute hospitals are continually faced with

accommodating a substantial number of patients whose needs would be catered for more effectively in other types of facilities.

Table 5
Estimated Inappropriate Placements in Acute Hospitals as on 21 April 1998

Health Board Area	Number of Inappropriate Placements
Eastern	220
Midland	19
Mid Western	5
North Eastern	26
North Western	0
South Eastern	32
Southern	67
Western	49
Total	**418**

Responding to Non Acute Care Needs

The Review Group spent some time examining how best to respond to the problem of inappropriate placements outlined above. It first looked at the older population as one of the key groups concerned. Many of the recommendations below will be equally applicable to the other non acute client groups involved, such as the young chronic sick, persons who have suffered strokes, victims of road traffic accidents and others who need rehabilitation and long-term care. The Review Group also deals separately with some of the specific needs of these groups.

- Demographic Projections

All of the recent projections of population anticipate a significant increase in the proportion of the population aged over 65 years in the next two decades. This has obvious implications for health services, including the need for long term care.

A report by the National Council for the Elderly published in 1995[5] estimates that the number of persons aged over 65 will increase in absolute terms by nearly 30 per cent, from 402,000 to 521,000 in the period 1991 to 2011. Even more importantly, the report projects a 75 per cent increase in the number of persons aged over 80 years, from 74,000 to 130,000, during the same period. Since dependency levels are much greater in this group, it is clear that they will place exceptionally high demands on the health services.

There will be some regional variations in these trends, according to the National Council for the Elderly's report. While the Eastern Health Board area is projected to continue to have the

[5] ***Health and Social Care Implications of Population Ageing in Ireland, 1991-2011*** (National Council for the Elderly, 1995).

lowest proportion of persons aged over 65 years, it will have the highest increase in absolute numbers in this category. Overall, the percentage of persons aged over 80 years is expected to increase by between 4 per cent and 6 per cent in most areas, but by between 7 per cent and 8 per cent in the Western and North Western Health Board areas.

- Factors leading to increased demand by the older people on acute services

The 1988 Working Party report[6] on services for the elderly, *The Years Ahead* highlighted factors which lead to increased demand for acute hospital services by older persons. The Review Group believes that while good progress has been made in implementing many of the Working Party's recommendations, many of these factors are still of considerable concern today. They continue to result in older people requiring significant levels of acute hospital services, including in-patient care. The factors of particular concern today include:

- a shortage of appropriate community services and day assessment services which contributes to inappropriate admissions of older patients to acute hospitals;
- insufficient provision of rehabilitation facilities which results in an increase in the average length of stay for patients, even when the initial referral was appropriate;
- insufficient liaison between acute and community services, which can lead to unsatisfactory discharge planning and an unnecessary prolongation of hospital stays;
- a shortage of long-term care facilities which can result (as argued above) in excessive utilisation of acute in-patient facilities by older patients; and
- a poorly developed service for older patients suffering from dementia associated with behavioural disturbance. This often results in inappropriate referral to acute hospital services, or an inability to discharge them after an appropriate admission to an acute hospital.

Developing Services for Older People

It is clear to the Review Group that the development of certain acute and long-term care services for older people must be pursued if the acute hospital system is to be used to best effect. The development of services for older persons is of obvious importance in its own right. However, the focus of this report must be on the extent to which the development of these services can assist in the successful operation of the Waiting List Initiative in acute hospitals.

With this in mind, the Review Group believes that a number of the recommendations of *The Years Ahead* deserve to receive further impetus. In particular, there is a need for further attention towards:

- improved discharge planning and liaison between sectors;
- the development of Geriatric Day Hospitals;

[6] *'The Years Ahead' ... Report of the Working Party on Health and Welfare Services for the Elderly* (Stationery Office, 1988).

- the improvement of rehabilitation facilities, to be integrated within acute hospitals;
- the provision of additional places in appropriate long-term care facilities;
- the provision of adequate support services in the community; and
- the pursuit of a health promotion strategy for older people.

- Discharge Planning and Liaison

The Review Group notes that some progress has been made in relation to improving arrangements for discharge planning and liaison between the acute and community sectors. However, few hospitals appear to have a clearly defined policy in this regard.

The Review Group recommends that health boards and voluntary hospitals should develop a clear written policy on planning the discharge of older patients and liaising with the relevant community based services.

In the case of patients with dementia, the Review Group believes that there is an immediate need to designate clear responsibility for their care and follow-up. At present responsibility appears to fall between the disciplines of Medicine for the Elderly, Psychiatry of Old Age and community services, with consequent uncertainty about how such patients should be treated and discharged or accommodated in an appropriate setting.

- Geriatric Day Hospitals

The Years Ahead advocated enhanced facilities for the multi-disciplinary assessment of older patients on the sites of acute hospital. One means of doing this would be to develop Geriatric Day Hospitals (GDH) with the necessary support staff and facilities for assessment and rehabilitation of older persons. The GDH would be close to radiological diagnostic facilities, thus minimising the need for admission of older patients for these purposes.

The GDH would also help enable older patients with increased disability to be followed up closely in a multi-disciplinary setting, thereby promoting early discharge. In order to maximise the interaction with other services it would be vital to locate the Geriatric Day Hospital on the site of acute hospitals. The evidence in favour of their development relates mainly to larger hospitals with a significant population nearby. The viability of GDHs on smaller hospital sites has yet to be clarified.

The Review Group recommends the prioritisation of the development of Geriatric Day Hospitals on the sites of acute hospitals in the medium to long term. This would represent the single most appropriate use of resources in developing acute services for older persons. The potential of GDHs to cater more fully for the needs of older persons and to reduce their dependence on acute hospital facilities is substantial.

- Rehabilitation Facilities

Some progress has been made in implementing the recommendation in *The Years Ahead* for the development of Departments of Geriatric Medicine. Most major acute hospitals now have acute assessment units for older patients. However, the Review Group believes that the

efficiency of these units is impaired by deficiencies in rehabilitation facilities. *The Years Ahead* recommended that these be properly resourced and integrated within acute hospital sites. Such facilities would help earlier transfer from acute hospital beds and therefore enable more elective activity, including WLI work, to proceed.

Both the GDH recommended above and improved rehabilitation services would facilitate early discharge and/or transfer of patients (such as orthopaedic, ophthalmology and other surgical cases) thus enhancing the efficiency of these services.

After the development of GDHs, the Review Group regards the development of rehabilitation facilities on acute hospital sites, where they do not already exist, as the next priority in acute services for older persons. It recommends that rehabilitation facilities be given the resources necessary to ensure that they can fulfil their functions effectively, including their role in reducing the need for older patients to use acute hospital facilities. Health Boards and voluntary hospitals should be requested to assess their needs in this regard.

- Young Chronic Sick

The Review Group notes that there is now a policy to create special units for the Young Chronic Sick in each health board area. The purpose of these units is to free up acute beds in hospitals and to provide long-term residential care for people with severe physical disabilities who are living in the community at present.

A database of service needs of people with physical and sensory disabilities is to be established in the immediate future, which will involve the identification of the precise needs of every person with a physical or sensory disability who needs a service. This will include the needs of persons, including the young chronic sick, requiring long-term residential care. The database will be of particular value in planning the development of services for people with disabilities and in making a case for the necessary funding to do so.

The Review Group understands that the basic objective in relation to services for people with physical and sensory disabilities is to provide the supports necessary to enable each individual with a disability to live in the community with the maximum possible degree of independence.

- Long Term Residential Care

For those assessed as requiring long-term residential care, ***the Review Group believes that there is an urgent need to provide additional publicly funded, appropriately designed continuing care places for older people.*** These will no doubt continue to be supplemented by places in private nursing homes. However, even when subvented by the health boards, private nursing homes cannot hope to cater for a large section of the older community who have minimal or moderate financial resources. Even an increase in the health board subventions is not necessarily a satisfactory response, since nursing homes can raise their accommodation rates proportionately. It is important to note, also, that delays by health boards in processing applications for subventions can in turn delay discharges from acute hospitals. This would be avoided if applications could be processed as quickly as possible.

It is probable that the responsibility will continue to fall on the state to provide directly the appropriate residential places for the lower income elderly groups. A similar situation obtains in the case of other groups likely to require long-term residential accommodation and care, including the young chronic sick, stroke cases and persons who have had serious road traffic accidents.

The Review Group recommends that health boards should carry out an immediate evaluation of the long-term residential care needs of older people and other relevant groups in their region. This should form the basis for a structured programme of capital investment by the Department of Health and Children to meet these identified needs.

- Support Services in the Community

The Years Ahead set out recommended norms for the provision of certain support services in acute hospitals, extended care and psychiatric services. These were seen as important to the provision of an adequate service for the older population. The Review Group believes that the under-development of community based services, such as home helps and day care places, respite services for carers and social work services, makes it more difficult to maintain dependent older people in the community following acute illness.

The Review Group recommends that an updated assessment of community-based services for older people and other groups in need of similar services be carried out at regional level by each health board. As in the case of long-term residential care places, this assessment should form the basis of a structured programme of investment by the Department of Health and Children.

The Review Group notes that the National Council on Ageing and Older People (formerly known as the National Council for the Elderly) recently identified a set of home and community care priorities for immediate development[7]. These include home help services, respite services for carers, sheltered housing, day care centres with transport when required, paramedical services at home and in the community, a social work service dedicated to older people, all services for older people with mental disorders and the community hospital sector.

The Review Group has recommended a programmed development of long-term residential services for older people and those needing long-term care, but it also appreciates the National Council's view that:

> '... home and community care must be the cornerstone of any health and social care strategy for older people'.
>
> National Council's report, page 31

The Review Group recognises that the development of services for older people and others in need of long-term care must span a continuum from early assessment, to a range of services in the community designed to minimise the need for admission to any form of acute or long-term care, through to well-designed residential facilities. The Group's recommendations are made in this context.

- Health Promotion for Older People

[7] ***The Years Ahead Report:* A Review of the Implementation of its Recommendations** (National Council on Ageing and Older People, 1997)

The health promotion strategy for older people[8] proposed by the National Council on Ageing and Older People (1998) reiterated the emphasis placed by the Health Strategy *Shaping a Healthier Future* (1994) on promoting healthy ageing in Ireland. The health promotion strategy refers to the need to develop appropriate policies, structures and support systems at community, regional and national level which help older people to make positive decisions in relation to their health.

The Review Group believes that an integrated approach to health promotion for older people is an important asset. A well developed health promotion policy has a valuable role to play in delivering the most appropriate services to older people and in enabling them to reduce their need for acute hospital care.

A specific initiative, within the context of wider health promotion policies for older people, is the scope for immunisation of the highest risk groups against such illnesses as influenza. The Review Group believes that appropriate vaccinations for high-risk patients should be encouraged and facilitated. This would help reduce the need for admission to acute care, particularly during the winter months.

Conclusion

The Review Group is strongly of the view that the implementation of an effective Waiting List Initiative, which meets the needs of public patients in the most flexible possible way, depends in part on structured, well organised access to elective facilities in acute hospitals. It is clear to the Group that a critical difficulty at present in ensuring access to elective treatment services in acute hospitals is the shortage or under-development of certain non-acute services.

Irrespective of their effect on waiting list work, a persuasive case can be made to develop residential and community-based services for older people and other client groups in need of long-term care. The Review Group's terms of reference are concerned with the Waiting List Initiative in acute public hospitals, but the Group also recognises the wider importance of its recommendations for developing these services.

In particular, the Review Group believes that a targeted development of additional residential places for those in need of long-term care, together with the case for Geriatric Day Hospitals, would be beneficial in freeing up acute beds for the purpose for which they were originally intended. Failure to invest in these facilities will make irresistible the pressure to increase the stock of more expensive acute hospital beds.

8 ***Adding Years to Life, Life to Years*** (National Council on Ageing and Older People, 1998)

can prioritise their cases for referral to hospital. The Review Group notes that IT pilot projects in this area are already underway in a number of hospitals.

The Review Group believes that it may be valuable to develop an 'early warning system' from primary care services to hospitals regarding the level of demand by specialty for particular treatments. ***The Review Group recommends that a pilot project in primary care be established to ascertain whether an 'early warning system' aimed at alerting hospitals of likely future demands on waiting lists could be implemented. This approach could have potentially positive effects in the long term.***

- **Day Case Work**

The Review Group recommends that every possible support be given to hospitals to encourage a continued move towards day case work under the Waiting List Initiative.

- **Seasonal Bed Closures**

The Review Group heard strong arguments from a number of quarters that it was inconsistent to close beds for periods of the year, usually during the summer, while patients remained on waiting lists for elective treatments. The Review Group is conscious of the practical reasons for seasonal bed closures. However, it believes that every effort should be made to use slacker periods for elective WLI work. ***The Review Group recommends that hospital management should take full account of the scope for elective waiting list activity before making any decisions regarding seasonal bed closures.***

- **Bed Managers and Bed Utilisation Committees**

A regular feature of the acute hospital system is that in-patient beds are inappropriately occupied by patients who should be catered for elsewhere. It is clear that hospitals must adopt strict practices to ensure that patients do not occupy in-patient beds for longer than is necessary, and that proper arrangements are in place for their discharge and follow-up care.

The Review Group recommends that every hospital which has not already done so should establish a Bed Utilisation Committee or a similar mechanism to develop admission, bed management and discharge policies for the hospital. However operated, the Committee or other mechanism should have sufficient status within the hospital to ensure that a plan is devised for the subsequent care of all in-patients identified as ready for discharge. The Review Group recommends that all hospitals should appoint a Bed Manager with responsibility for implementing the policies developed by the Bed Utilisation Committee.

The Review Group believes that the development of improved liaison and communication between hospital departments to co-ordinate the booking of a series of tests and procedures for individual patients would avoid the unnecessary admission of patients who are admitted solely for the purpose of gaining priority access to investigations.

- **Facilitating Elective Work**

Chapter Six
Waiting List Initiative: General Issues

Introduction

Earlier chapters dealt with areas of particular relevance to one part of the health service, such as primary care, acute hospitals and continuing care. This chapter deals with a set of issues that the Group considers vital to the success of the Waiting List Initiative as a whole. Not only are they individually important; the interaction between them has a strong influence over the outcome of the Initiative.

Definition and Coverage

It is important to define clearly what is meant by a *waiting list*. For the purposes of this review, a waiting list comprises all persons who, following referral to a hospital consultant, have been listed by the consultant for treatment as a public in-patient (or a day case) and who must wait until the necessary hospital facilities are available for such treatment. The waiting list should comprise only those who could, if the facilities were available, be treated immediately. The list must *exclude*

- patients who have received treatment for the condition in another hospital;
- patients who, on the basis of clinical judgement, no longer need treatment;
- patients who indicate that they no longer wish to be treated;
- patients who have been placed on a waiting list in anticipation of their needing treatment at some future stage; and
- patients who have died.

Data on waiting lists are collected in over 30 specialties. The Department of Health and Children's most recent circular relating to the Waiting List Initiative (3 December 1997) indicates that agencies should prioritise their waiting list work from within the range of nine specialties below during 1998. It also provides that agencies may decide to select a smaller number of specialties from within this list:

Cardiac Surgery, ENT, Gynaecology; Ophthalmology; Orthopaedics; Plastic Surgery; General Surgery, Urology and Vascular Surgery.

As currently defined, the waiting lists described above do not include those awaiting an out-patient consultant appointment. It is only after the consultant has seen the patient and has determined the need for a particular treatment that they appear on the type of waiting list discussed here. Patients may have to wait for a considerable time for a consultant appointment following referral by their general practitioner. The Review Group considers that this is a very important aspect in considering the full extent of waiting lists and waiting times for public patients.

However, the terms of reference of the current review relate to the present Waiting List Initiative, covering in-patient/day case waiting lists only. In view of the timescale available,

the Review Group decided to focus on waiting lists for those who have seen a consultant and have been listed for treatment. At the same time, it wishes to emphasise the close link between those awaiting in-patient and out-patient appointments. In the worst situation, there could be an incentive to keep in-patient waiting lists short by failing to refer patients as soon as possible from the out-patient setting.

Despite these arguments, it must also be borne in mind that not all patients awaiting an out-patient consultant appointment in a WLI-related specialty are ultimately referred for a procedure. In-patient waiting lists comprise (or should comprise) patients who will definitely need a WLI-related procedure; out-patient waiting lists will always include some patients who are subsequently treated in other ways. The Review Group recognises, however, that the situation in relation to waiting periods for out-patient appointments will require further examination.

Validation of Waiting Lists

Any analysis of the performance of a Waiting List Initiative is critically dependent upon the availability of accurate data. If the true extent of waiting times for public patients is to be known, all hospitals must constantly review their waiting list data rigorously. Failure to do so sends inaccurate signals to those monitoring progress at a national level. Under-stating the numbers involved results in missing out patients who need treatment; over-stating the numbers creates unnecessary concern among patients who fear that they will have to wait for longer than is actually the case.

The Department of Health and Children has frequently emphasised the importance of hospitals validating their recorded waiting lists carefully and on a regular basis. It has also drawn attention to a consistent definition of the types of cases that should be included or excluded from the lists. Despite this, there is evidence that some hospitals are not engaged in a regular and systematic validation process.

It is obvious that properly maintained and regularly updated waiting list data is a prerequisite to the successful operation of a Waiting List Initiative. This includes ensuring that patients are not included on the waiting list of more than one hospital for the same treatment. In order to ensure a system of fully validated lists, the Review Group makes a number of recommendations regarding Information Technology support and validation procedures in the paragraphs below.

- IT Support

It is vital that hospitals maintain accurate information relating to each patient on their waiting list. Failure to do so leads to inappropriate inclusions (such as those who have been treated elsewhere, no longer need treatment or who have died) and inappropriate exclusions (such as where changes of address are not recorded). There should also be information indicating the status of each case so as to facilitate prioritisation, an issue discussed later in this report. When treatment has been provided and the patient discharged, the IT systems of many hospitals do not appear to distinguish between those who have been funded from the WLI and those treated using normal funding. This makes evaluation of the effect of the WLI very difficult and even gives rise to questions about how much of the activity could have been carried out irrespective of WLI money.

Some hospitals do not provide the level of detail which the Department would ideally needs to enable an accurate assessment of waiting lists. This detail includes classifications within specialties. Part of this problem may relate to shortcomings in hospital IT systems. Some may be due to a shortage of time to input the information in the format required. In other cases, it appears that hospitals do not see the value of providing the level of detail sought by the Department of Health and Children.

The Review Group recommends that:

> ***(1) all health boards and hospitals should be asked to review their IT resource requirements to ensure that they can maintain accurate and up-to-date information on all patients on their public waiting list, and that they can provide the level of detail required to assess the waiting list situation accurately. Agencies with particular shortfalls in this area should be assisted as appropriate to enable them to meet the information needs of the Waiting List Initiative.***
>
> ***(2) Hospitals should be required to ensure that their IT systems distinguish clearly between patients treated under the Waiting List Initiative and those treated using normal hospital funding. Hospitals should be required to specify the reason for removing a patient from the waiting list (e.g. treatment was provided; treatment given elsewhere; opted to remove themselves from the list etc).***

The Department of Health maintains a national data base of all information on waiting lists since the inception of the WLI in June 1993. This contains information on the number of patients by hospital and by specialty who are awaiting treatment. The data is broken down by length of waiting time (3-12 months and over 12 months for adults; 3-6 months and over 6 months for children). The data relate to numbers and waiting times only; no patient names or addresses are included.

The Review Group believes that there is substantial scope for improvement in the Department's national data base. While the package used (*Business Objects)* can collate and summarise the data accurately, it is deficient as an analytical tool. It is not sympathetic to the production of non-standard reports and is now somewhat dated.

The Review Group recommends that the Department of Health and Children should develop and implement an improved IT system for recording and analysing national data relating to the Waiting List Initiative.

- Continuing Validation Arrangements

The importance of continuing and rigorous validation by hospitals of their waiting lists has been emphasised. The IT improvements recommended above by the Review Group would help to support this process. However, irrespective of the exact approach taken in these areas, it is clear that hospitals must be encouraged to adopt a continuing practice of systematic validation. The Dublin Hospital Initiative Group (*Kennedy*) set out a system for detailed review of existing waiting lists. It involved a combination of bulk postal reviews as an initial validation exercise to confirm that patients were still awaiting treatment, followed up by selected postal reviews after a specified period of time on the list and clinical reviews on a regular basis.

The Review Group supports the approach advocated by the Dublin Hospital Initiative Group regarding a formal validation process. The Review Group recommends that, under the terms of the Waiting List Initiative, hospitals should be required to engage in a specified series of reviews of their recorded waiting lists and waiting times. The Review Group recommends that:

> ***(1) Where they have not done so in the past twelve months, hospitals should carry out a bulk postal review of patients on their waiting list. This involves writing to all patients and their general practitioners to establish whether they are still awaiting treatment and to include any changes in patient details.***
>
> ***(2) Following such a comprehensive validation process, there should be an agreed protocol for selective further postal reviews. These should be combined with periodic clinical reviews, under which selected patients awaiting treatment for designated periods (eg six months, twelve months etc) would be called for an out-patient appointment to review their continued need for treatment and the priority that should be attached to their case.***

Development of Protocols

Part of the validation of waiting lists involves assessing the urgency of cases and setting (and adjusting) priorities accordingly. At the very least a hospital's information system should distinguish in some form between urgent, non-urgent and routine cases, although even this classification is not very specific. Neither is it very satisfactory if it is used on its own. A recognised, clearly defined system of specifying priorities by specialty is needed.

The Review Group believes that while it is not easy to devise a consistent and accurate means of ranking priorities, it is critical that patients awaiting treatment be classified in such a way that those most in need of treatment can be given it sooner. Equally, it is important that persons are not referred for treatment until such treatment is necessary.

One means of helping to identify priorities would be through the relevant professional bodies. The professional body for each specialty could be asked to devise protocols for both the validation and prioritisation of patients with specific conditions under the Waiting List Initiative. The Review Group believes that the value of this approach would be to ensure that patients were subject to the same assessment procedure in relation to their WLI status irrespective of hospital or place of residence. Such an agreed set of criteria would also facilitate the system of clinical reviews suggested earlier as part of the validation exercise. It would also act as a basis for primary care doctors in deciding whether or not, and at what stage of the person's condition, to refer him/her to the acute hospital system in the first instance.

An alternative method of approaching this issue would be for individual hospitals to devise their own agreed protocols for validating and prioritising waiting list work. This would have the advantage of taking account of local circumstances and perhaps of carrying greater weight because of this. It would also encourage experimentation with alternative methods in different hospitals, with scope for the more successful approaches to be transferred to other hospitals. A potential disadvantage of this approach is haphazard access to care for patients with similar conditions depending on where they live.

The Review Group recommends that clearly established protocols should be developed in all major Waiting List specialties for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual health boards or hospitals. Whether they are nationally or locally based the protocols should be devised with the needs of patients first. They should be fully supported by clinical, nursing and managerial staff and implemented accordingly.

Incentive Structures for WLI Funding

The Review Group is conscious of possible disadvantages in the incentive structure currently used in allocating funding under the Waiting List Initiative. At present, hospitals receive WLI funding to help them reduce waiting lists and waiting times in target specialties. The corollary is that hospitals with no waiting lists (or no lengthy waiting times) do not receive such funding.

This may act as a disincentive for hospitals to clear their waiting lists, or even to reduce them significantly. If the 'reward' for substantial reductions is the withdrawal or a significant lessening of waiting list money, hospitals may feel less inclined either to carry out the work or to reflect genuine reductions in their lists.

In allocating WLI funding, the Department takes account of the performance of each hospital in achieving the target reductions agreed upon at the beginning of the year. Hospitals which consistently fail to reach the agreed targets can be penalised accordingly. Hospitals are therefore aware that consistent under-performance will jeopardise their access to WLI funding in subsequent years.

Nonetheless, the system of funding remains heavily influenced by the extent of waiting lists and waiting times, and there are no directly proportionate financial rewards for achieving substantial reductions. The Review Group believes that there may be a case for adjusting the allocation system for WLI funds so that hospitals, or particular departments within them, are financially rewarded for good performance.

One approach worth consideration would be to use part of the funding available for waiting list work to reward hospitals which show the best performance in reducing the length of time their patients must wait for treatment in target specialties. The Department of Health and Children could, for example, hold back a proportion of the total WLI funding for distribution to the best-performing hospitals at the end of the year. Under this arrangement, the bulk of WLI funding would be allocated on the basis of agreed targets for reductions in waiting lists and waiting times, but the balance, perhaps 25 per cent, would be held back as an available pool of 'winnings' for distribution among hospitals which showed the largest reductions in waiting times. This would ensure that hospitals were offered a clear incentive to reduce waiting times in target specialties to the greatest possible extent. It would also underline the focus on waiting times rather than on waiting lists alone.

There are of course some disadvantages to any such reward system. Hospitals which perform poorly may do so through factors outside their control, such as a sudden increase in emergency cases, or the lengthy illness of a key consultant. However, while such problems may make it difficult to 'win' extra WLI funding from the pool of money held back, hospitals

would still set targets for waiting lists and waiting times at the beginning of the year in agreement with the Department. Many of the factors that influence waiting lists can be taken into account when setting targets in the first place, such as hospital capacity and availability of step-down facilities.

The Review Group believes that there is therefore, a strong case for introducing positive financial incentives for hospitals to take all possible steps to manage their caseload and to achieve realistically established targets. The details of any such system should be developed in consultation with the hospitals concerned.

The Review Group recommends that the Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. The bulk of WLI funding would be allocated on the basis of agreed targets for reductions in waiting lists and waiting times, but a proportion of WLI funding would be retained by the Department for distribution to the hospitals which showed the greatest reduction in waiting times in target specialties over the year. The details of the incentive system should be developed in conjunction with the relevant hospitals.

Interaction between Sectors

The chapters that follow deal with issues of concern to individual main service areas, such as primary care, secondary care (acute hospitals) and continuing care. Before dealing with these, however, the Review Group wishes to emphasise the importance of ensuring adequate interaction between the sectors.

The development of lengthy waiting lists and waiting times is a function of all three sectors. Actions taken to address unacceptable waiting lists and times must take this into account. This concern is particularly relevant in the context of addressing such areas as Accident and Emergency services and long-term care for the elderly. Both are of considerable importance in their own right, but it is of course their potential impact on waiting lists with which the Review Group is concerned.

The Review Group recommends that the Department of Health and Children, health boards and individual hospitals should have full regard to the inter-relationships between the Waiting List Initiative, Accident and Emergency services and long-term care services, particularly those for the elderly.

These issues are considered further in later chapters of this report.

Chapter Seven
Summary and Conclusions

The Waiting List Initiative

The Review Group believes that the Waiting List Initiative has been a valuable element of hospital activity since its inception in 1993. While waiting lists and waiting times remain unacceptably long in some specialties, it is clear that the WLI has funded a large number of elective procedures and has enabled thousands of patients to receive treatment more quickly than would have been possible under normal hospital services.

The Review Group has concluded that a number of steps could be taken to build upon the present Waiting List Initiative. However, it also believes that many of the underlying causes of the development of lengthy waiting lists and waiting times are well outside the immediate scope of the WLI itself. In particular, some shortfalls in hospital capacity and the deficiencies in non acute services (such as long-term care facilities for older people and other groups) are issues that must be addressed in a wider context. They clearly affect the ability of acute hospitals to carry out elective work, but they are also important in their own right.

The Review Group has divided its recommendations into three categories: those that could be implemented in the short term (July to December, 1998); those that might be put into practice in the medium term (during the course of 1999); and those which should be implemented over a longer period (1999 to 2001).

Immediate Term Recommendations: July - December 1998

The Review Group believes that a number of recommendations, if accepted, could be implemented before the end of 1998. These relate to the improvement of information systems, steps to validate waiting lists and a number of short-term initiatives aimed at improving the operation of the present system.

- Information Systems

The Review Group believes that a number of IT-related improvements need to be made to the system of collecting waiting list data at both hospital and Departmental level.

The Review Group recommends that:

> ***(1) all health boards and hospitals should be asked to review their IT resource requirements to ensure that they can maintain accurate and up-to-date information on all patients on their public waiting list. Agencies with particular shortfalls in this area should be assisted as appropriate to enable them to meet the information needs of the Waiting List Initiative.***

(2) Hospitals should be required to ensure that their IT systems distinguish clearly between patients treated under the Waiting List Initiative and those treated using normal hospital funding. Hospitals should be required to specify the reason for removing a patient from the waiting list (e.g. treatment was provided; treatment given elsewhere; opted to remove themselves from the list etc).

(3) The Department of Health and Children should develop and implement an improved IT system for recording and analysing national data relating to the Waiting List Initiative.

- Validation of Waiting Lists

The Review Group wishes to emphasise the importance of continuing and rigorous validation by hospitals of their waiting lists. The IT improvements recommended above by the Review Group would help to support this process. In addition:

The Review Group supports the approach advocated by the Dublin Hospital Initiative Group (Kennedy) regarding a formal validation process. The Review Group recommends that, under the terms of the Waiting List Initiative, hospitals should be required to engage in a specified series of reviews of their recorded waiting lists and waiting times. The Review Group recommends that:

(1) Where they have not done so in the past twelve months, hospitals should carry out a bulk postal review of patients on their waiting list. This involves writing to all patients and their general practitioners to establish whether they are still awaiting treatment and to include any changes in patient details.

(2) Following such a comprehensive validation process, there should be an agreed protocol for selective further postal reviews. These should be combined with periodic clinical reviews, under which selected patients awaiting treatment for designated periods (eg six months, twelve months etc) would be called for an out-patient appointment to review their continued need for treatment and the priority that should be attached to their case.

- Short Term Initiatives

The Review Group has recommended a set of initiatives which could be implemented in a relatively short period of time:

- **Communications between Primary and Hospital Care**

The Review Group believes that a comprehensive flow of information between primary care and acute hospitals, including the relevant consultants, is vital. In order to promote this flow of information, ***the Review Group recommends that all hospitals and general practitioners should establish a structured system of continuing information regarding the status of patients on their waiting lists. Hospitals should regularly inform general practitioners of their patients' current status, and the information should also be fed back from the general practitioners to hospitals, particularly in relation to changes in the patient's condition. In addition, hospitals should notify local general practitioners, on a routine basis, of the waiting lists and waiting times for the various specialties so that the general practitioners***

The Review Group believes that an important function of the Bed Utilisation Committees (or similar mechanisms) proposed above would be to facilitate the implementation of elective work throughout the year. This is a challenging task which will require the full co-operation of all parts of the hospital. ***The Review Group recommends that the relevant health agencies should develop a mechanism aimed at ensuring the planned implementation of elective work, including waiting list treatments, over the full year.***

- **Hospital Workload**

The Group recommends that the agreement regarding workloads, as provided for in the Revised Contract for Consultant Medical Staff, should be specified in each agency's Service Plan. The Service Plan should safeguard equity of access and maintain the agreed proportion of public and private patients treated. It should be a function of the Bed Utilisation Committee recommended earlier to monitor the public/private mix of patients by specialty.

- **Discharge Planning and Liaison**

The Review Group notes that some progress has been made in relation to improving arrangements for discharge planning and liaison between the acute and community sectors in relation to older patients and others likely to need long-term care. However, few hospitals appear to have a clearly defined policy in this regard.

The Review Group recommends that health boards and voluntary hospitals should develop a clear written policy on planning the discharge of older patients (and others in need of long term care) and on liaising with the relevant community based services.

- Capacity of Acute Hospital System

The Review Group is of the view that some hospitals have reached full or near-full capacity in relation to their elective work. This is not to suggest that the answer necessarily lies in additional in-patient beds; it would be important to confirm in the first instance that hospitals are using existing beds appropriately. However, the available information implies that WLI funding will have to be accompanied by measures to address shortfalls in such areas as theatre space, equipment and staffing.

The Group recommends that, as a matter of urgency, further study of hospital capacity be carried out to ascertain each hospital's needs in this area. It further recommends that favourable consideration be given to supporting additional capacity in hospitals which demonstrate that their existing facilities are already appropriately utilised and fully committed.

The Review Group also recommends that in certain specified circumstances, consideration should be given to supporting hospitals through the provision of locums or temporary staffing with particular reference to addressing the five specialties listed in Table 4 above. These specified circumstances would be where the following criteria are met:

(i) the organisation and management of existing capacity is efficient;

(ii) physical capacity for additional WLI activity is available; and

(iii) there is a demonstrable shortage of specific personnel.

Medium Term Recommendations: 1999

The Review Group has identified a series of steps that should be taken in the medium term, over the year 1999, to help improve the effectiveness of the current Waiting List Initiative. These relate to targeting of funding, altering the incentive structure brought about by the present payment system, developing protocols for the assessment and prioritisation of cases, and developing closer links with Accident and Emergency services.

- Targeting of Funding

An important issue of targeting relates to the specialties at which WLI funding should be directed. There are nine target specialties at present, although agencies may decide to focus on a smaller number from that list if they wish. The Review Group considered the case for targeting all of the available WLI funding towards a much smaller number of specialties. For example, the specialties with the five highest waiting lists accounted for over 22,000 of the 32,000 awaiting treatment in December 1997. However, the Review Group believes that it is not sufficient to consider numbers alone.

The Review Group recommends that the Department of Health and Children and health agencies should target the available WLI funding in a manner that :

- ***focuses on a limited number of specialties and***

    - ***takes the greatest possible account of***
    - ***the health gain and social gain offered to patients,***
    - ***the priority attached to individual cases on the basis of clinical judgement, and***
    - ***the length of time already waited by patients.***

As part of the arrangements for the planning of Waiting List Initiative, the Review Group recommends that each hospital should establish an inter-disciplinary group to monitor the use of its waiting list funding.

- Incentive Structures for WLI Funding

The Review Group is conscious of possible disadvantages in the incentive structure currently used in allocating funding under the Waiting List Initiative. While hospitals are aware that consistent under-performance will jeopardise their access to WLI funding in subsequent years,
there are no directly proportionate financial rewards for achieving substantial reductions in waiting lists or waiting times.

The Review Group recommends that the Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. The bulk of WLI funding would be allocated on the basis of agreed targets for reductions in waiting lists and waiting times, but a proportion of WLI funding would be retained by the Department for distribution to the hospitals which showed the greatest reduction in waiting times in target specialties over the year. The details of the incentive system should be developed in conjunction with the relevant hospitals.

- Protocols for Assessment and Prioritisation

The Review Group believes that while it is not easy to devise a consistent and accurate means of ranking priorities, it is critical that patients awaiting treatment be classified in such a way that those most in need of treatment can be given it sooner.

The Review Group recommends that clearly established protocols should be developed in all major Waiting List specialties for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual health boards or hospitals. Whether they are nationally or locally based the protocols should be devised with the needs of patients first. They should be fully supported by clinical, nursing and managerial staff and implemented accordingly.

At primary and secondary care level, the Review Group favours the development of 'two-way protocols' in keeping with the recommendation above. ***The Review Group recommends that, as part of the development of waiting list protocols, provision should be made for a special emphasis on agreed 'two-way protocols' to be operated jointly by general practitioners and the relevant consultant specialists. These protocols would set out the criteria for evaluating patients on a waiting list and for setting and adjusting priority cases for treatment.***

- Interaction between Sectors

The development of lengthy waiting lists and waiting times is a function of primary, secondary and continuing care sectors. So too must the actions taken to address unacceptable waiting lists and times. This concern is particularly relevant in the context of addressing such areas as Accident and Emergency services and long-term care for older people.
The Review Group recommends that the Department of Health and Children, health boards and individual hospitals should have full regard to the inter-relationships between the Waiting List Initiative, Accident and Emergency services and long-term care services, particularly those for older people.

- Accident and Emergency Services

There is little evidence that significant numbers of patients are admitted inappropriately from A&E departments. However, there is no doubt that acute admissions could be reduced, and waiting list work facilitated, if certain other systems were put in place.

The Review Group recommends that in order to reduce the pressure on beds from Accident and Emergency Departments, the following measures should be pursued:

- ***development of rapid diagnostic systems targeted at a number of common emergency presentations;***

- ***development of effective care guidelines for the management of conditions which no longer require hospital admission, having regard to international best practice;***

- ***introduction of short-stay treatment/observation areas to allow frequent review of selected cases by senior medical staff; and***

- ***improving access of general practitioners to urgent specialist opinion.***

- Maximising Access of General Practitioners to Services

It is often argued that greater and speedier access by general practitioners to certain hospital and community-based facilities would reduce the need for patients to be placed on hospital waiting lists. ***The Review Group recommends a targeted programme of investment to ensure that general practitioners have speedy access to appropriate community-based and hospital-based facilities, with a view to reducing the need to place their patients on public waiting lists for in-patient services.***

The Review Group also recommends that the cross-referral of patients between general practitioners for the performance of minor procedures should be facilitated within the General Medical Services scheme.

Long Term Recommendations: 1999 - 2001

Finally, the Review Group has identified a set of recommendations which it believes should be pursued in the longer term, over the period 1999 to 2001. Chief among these is the argument that certain services for older people, and others who may need long-term care, require further development so as to free up acute hospital facilities for elective work, including treatments for those on waiting lists.

The Review Group's long term recommendations involve:

- developing investigation and assessment facilities for older people through the provision of Geriatric Day Hospitals;
- providing rehabilitation facilities on the sites of acute hospitals where they do not already exist;
- evaluating long-term residential care needs by health board region and undertaking a process of capital investment.

In addition, the capacity of the acute hospital system must be examined and the scope for providing innovative alternatives to present forms of delivery, including the provision of dedicated day surgery units should be considered.

- Day Assessment, Rehabilitation and Long Term Facilities

- **Geriatric Day Hospitals**

The Review Group recommends the prioritisation of the development of Geriatric Day Hospitals on the sites of acute hospitals in the medium to long term. This would represent the single most appropriate use of resources in developing acute services for older persons.

The potential of GDHs to cater more fully for the needs of older persons and to reduce their dependence on acute hospital facilities is substantial.

GDHs would have the necessary support staff and facilities for assessment and rehabilitation of older persons and would be close to radiological diagnostic facilities, thus minimising the need for admission of older patients for these purposes.

- **Rehabilitation Facilities**

After the development of GDHs, the Review Group regards the development of rehabilitation facilities on acute hospital sites, where they do not already exist, as the next priority in acute services for older persons. The Group recommends that rehabilitation facilities be given the resources necessary to ensure that they can fulfil their functions effectively, including their role in reducing the need for older patients to use acute hospital facilities. Health Boards and voluntary hospitals should be requested to assess their needs in this regard.

- **Community Support Services**

The Review Group recommends that an updated assessment of community-based services for older people and other groups in need of similar services be carried out at regional level by each health board. As in the case of long-term residential care places, this assessment should form the basis of a structured programme of investment by the Department of Health and Children.

- **Long Term Residential Care**

For those assessed as requiring long-term residential care, the Review Group believes that there is an urgent need to provide additional publicly funded, appropriately designed continuing care places for older people.
The Review Group recommends that health boards should carry out an immediate evaluation of the long-term residential care needs of older people and other relevant groups in their region. This should form the basis for a structured programme of capital investment by the Department of Health and Children to meet these identified needs.

- Acute Hospital-Related Developments

- **Dedicated Day Surgery Units**

Given the nature of much waiting list treatments, particularly in ENT, general surgery and vascular surgery, it is likely that a very high proportion of patients who are on a public waiting list could be treated in dedicated day surgery units on the sites of acute hospitals. This would greatly protect elective waiting list treatments from other hospital pressures. Due to the capital cost and the amount of planning required, the provision of dedicated day surgery units must inevitably be a longer-term objective. However, ***the Review group recommends that the case for providing stand-alone day surgery units should be examined closely as a medium to long-term response to services under the Waiting List Initiative. Given that waiting lists are essentially peculiar to the public health system, the Review Group recommends that a very high proportion of activity in Day Service Units should be devoted to public patients.***

• Hostel Accommodation

It has been suggested that the provision of suitable hostel or other short-term accommodation either on-site or close to acute hospitals would help to address the needs of patients who have to be accommodated overnight due only to the distance from their home. ***The Review Group recommends that the case for providing hostel or other suitable short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed be pursued by the Department of Health and Children, the health boards and hospital management as appropriate.***

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