John Appleby, chief economist, King's Fund

WHAT'S HAPPENING TO WAITING TIMES?

The English National Health Service was once notorious for its excessive waiting times. But is it now winning the "war on waiting," asks **John Appleby**

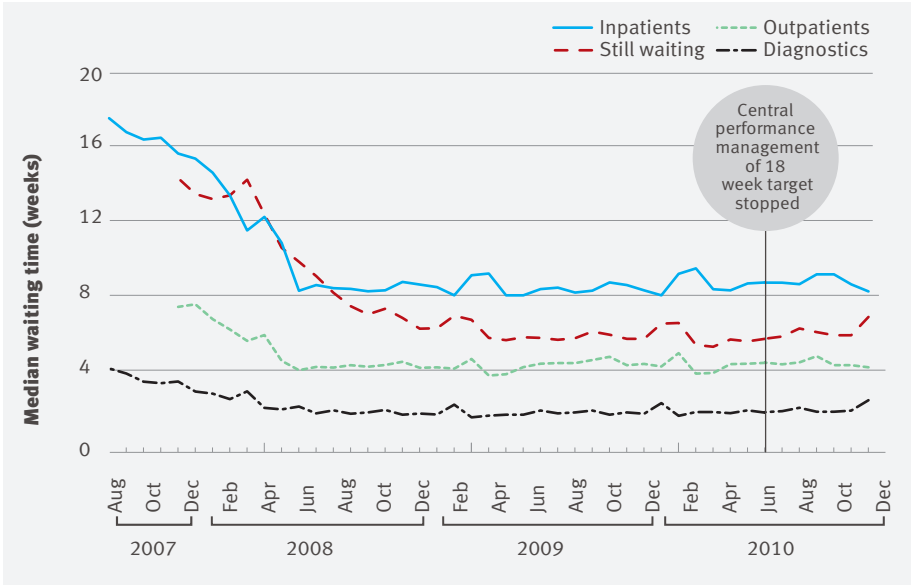

Fig 1 | **Median waiting times in the NHS. Adapted from Department of Health[7]**

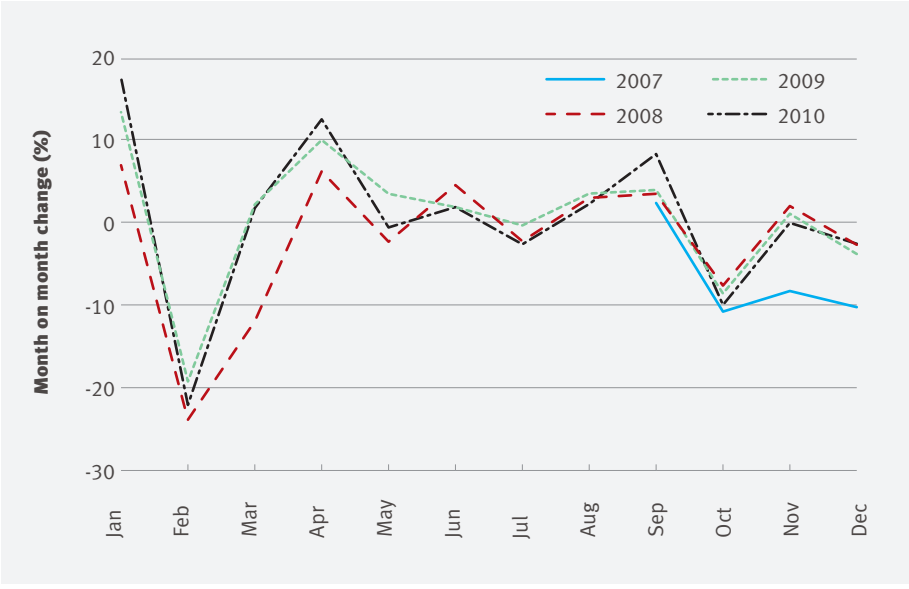

Fig 2 | **Seasonal trends? Month on month change in median waiting times for patients attenting outpatient clinics. Adapted from Department of Health[7]**

If there was one thing that characterised England's National Health Service for many people, it was the inordinate time patients waited to get treatment. At its inception in 1948 the NHS inherited a waiting list of nearly half a million. For decades after, it was all downhill—or rather uphill; numbers on lists rose and time spent queuing grew longer. It seemed that waiting was an inevitable rationing response of a system lacking the market's equilibrating price mechanism. Inevitable, that is, until the alignment of public opinion, money, and political determination at the turn of the century produced a plan of action to deal with excessive waiting.

The plan was more Baldrick than Blackadder in its cunning—more money, successively tougher targets (not known as "P45 targets" by managers for nothing), and practical help for the frontline in techniques to manage queues efficiently. The outcome is perhaps one of the most significant achievements for the NHS in recent years.

It can be hard to remember the scale of the waiting times problem and the almost daily media headlines. In December 1999, nearly 160 000 patients were still waiting over six months to have their first outpatient appointment and more than 50 000 were still waiting over a year to get a bed in hospital.[1] Despite the focus of the target regime, it is not just very long waits that have been virtually eliminated. The median waiting time—the time spent waiting by half of those on waiting lists—has also fallen, from around 18 weeks in 2007 to just one month now for inpatients admitted to hospital.[1]

Another consequence of the single minded focus on waiting was to establish better measures of waiting—measures closer to patients' actual experience of waiting, such as the time from referral by general practitioners to treatment in hospital. The scope of the "war on waiting" also widened to include primary care, specific diseases such as cancer, and other hospital services such as accident and emergency.

Regardless of the effect reductions in waiting times have had on patients' health (possibly rather negligible), waiting is certainly seen by patients as a negative attribute of healthcare; reductions in waiting are valued[2] and are likely to have contributed to rising satisfaction with the NHS over the past decade.[3]

- Data briefing: Does poor health justify NHS reform? (*BMJ* 2011;342:d566)
- Research: Equity, waiting times, and NHS reforms (*BMJ* 2009;339:b3264)
- Research: Waiting times for carotid endarterectomy in UK (*BMJ* 2009;338:b1847)

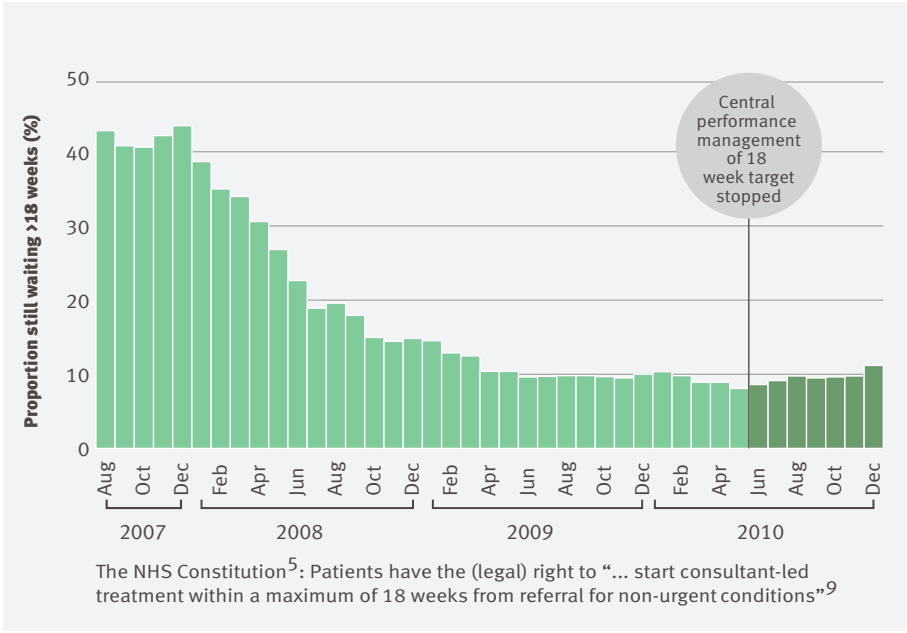

Fig 3 | **Proportion of patients not yet seen (as outpatients or admitted as inpatients) waiting >18 weeks. Adapted from Department of Health[7]**

All this makes the suspension of "central performance management" [4] of the iconic 18 week referral to treatment target (and a relaxation of the 4 hour maximum accident and emergency waiting target) an interesting experiment in the power of alternative policy levers to bear down on waiting times: notably, patient choice and the degree to which GP commissioning will reflect patients' values and their rights under the NHS Constitution. [5]

Tracking waiting times since June last year[6] gives a mixed picture, somewhat muddied by seasonal effects in changes in waiting times. Latest figures for December 2010 show median waits and the proportion who waited over 18 weeks down on the previous month for those admitted as inpatients.[7] But then, that would be expected for December. On the other hand, for patients still waiting (that is, not yet seen in outpatients or admitted as an inpatient) the proportion waiting over 18 weeks increased in December by more than the seasonal effect would predict. Meanwhile, median waits for diagnostic services are now back to the level seen in December 2007, although this largely reflects a seasonal trend.[8]

The coming months—and particularly the new financial year, when budgets get squeezed—will start to reveal some more consistent trends.

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BLOG **Monica Jackson**

At the epicentre of the New Zealand earthquake

I was at work on the third floor of the hospital, a building which was commonly believed not to be 'earthquake ready.' It started like all the thousands of aftershocks we have experienced; you have a split second warning as the ground rumbles and the building starts to creak. Almost instantly we knew it was big.

The noise was incredible as beds broke off their brakes and oxygen cylinders crashed over. Hand on heart, I thought it was going to collapse. I remember the feeling of resignation as I realised just how powerless I was to save myself. But in our case, the building stood.

As soon as the shaking subsided the priority was to ensure the patients were okay. Most staff on the ward stayed, regardless of concerns for themselves and their loved ones, and I can promise—you just want to run out and never come back. Although the fire alarm was instructing us to evacuate, we were to wait on the ward for further instructions. When the word came of the casualties lined up outside the emergency department, a few of us left to see if we could be of more use.

There were two waves of patients—initially horrible, horrible trauma. Status 1 patients arrived one after the other, every resus bay was filled with a full team attending to a critically ill patient. When you think of major incident planning you think of how the hospital will manage the casualties. But when the hospital itself is damaged it is something else. The lifts didn't work, the computed tomography scanner didn't work, the backup generator went, and for a while everything was done in semi-darkness.

There are plenty of extras helping out, but the workload has fallen right off, partly because anyone who could be discharged has been.

It is very early days at the moment. A lot of people are saying this will break Christchurch—I hope not. Seeing the number of people working 24 hours to keep the city functioning is astounding. It is all very well watching the surgeons/anaesthetists/ED docs bring people back from the brink, but there are a lot of very unglamorous heroes here, as cheesy as I know that sounds.

Monica Jackson is a house officer at Christchurch Public Hospital

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L to R: CRASH-2 trial collaborators, clinical trials unit, London School of Hygiene and Tropical Medicine, UK; Arjen Dondorp, Mahidol-Oxford Research Unit; Professor Wendy Atkin, Imperial College London

RESEARCH PAPER OF THE YEAR

Simple interventions that save lives

Trish Groves introduces the shortlisted 2011 award candidates

This year's judges have to choose between three randomised controlled trials, each of which finds that a relatively simple intervention could save many lives. The research topics ranged from screening for colorectal cancer and reducing bleeding in injured patients to treating malaria in children (see box).

Elizabeth Loder (clinical research editor) and I looked separately at all 150 or so nominated papers and then met to discuss our choices. We hadn't planned to shortlist only trials: there were plenty of great papers whose research questions were appropriately and robustly answered with observational study designs. But, in the end, we were clear that these three papers more than met the criteria for this award: originality; scientific robustness; international relevance; potential to help doctors make better decisions about clinical practice, public health, research methodology, or health policy; and potential to improve health outcomes for patients or populations.

Wendy Atkin and colleagues investigated whether a one-off flexible sigmoidoscopy could be a cost-effective and acceptable method of population screening for colorectal cancer. Their trial in 14 UK centres randomised more than 170 000 men and women aged 55-64 years to an offer of flexible sigmoidoscopy screening or to no invitation.[1] After 11 years the incidence of colorectal cancer was reduced by 33% and related mortality by more than 40% in those in the screening group. The numbers needed to be screened to prevent one colorectal cancer diagnosis or death by the end of the study period were 191 (95% confidence interval 145 to 277) and 489 (343 to 852).

Some of the participants were already in the national bowel cancer screening programme based on faecal occult blood testing that was being rolled out across England, but the authors' sensitivity analysis excluding cancers picked up by national screening made no difference to the trial's results. This study, along with economic analyses and a handful of ongoing trials from other countries, will soon enable policy makers to choose the best way to screen populations for what is the third commonest cancer worldwide.

Research questions of the shortlisted papers

Does one-off screening with flexible sigmoidoscopy for 55 to 64 year olds cut the incidence of colorectal cancer and related mortality over 11 years?

Does a short, low cost, course of tranexamic acid reduce adults' mortality from bleeding within a month of severe injury?

For African children in hospital with severe falciparum malaria, does parenteral artesunate save more lives than parenteral quinine?

Meanwhile, injuries from road crashes and other incidents are on course to be the third leading cause of death and disability worldwide by 2020, and a third of deaths in hospital from trauma are caused by haemorrhage. Might tranexamic acid, a low cost haemostatic drug already known to reduce the need for blood transfusion by a third in elective surgery, also cut mortality among trauma patients? Haleema Shakur and collaborators compared infused tranexamic acid against placebo among more than 20 000 recently injured patients in 40 countries who had major bleeding or were at risk of it. The drug significantly reduced both the overall mortality in hospital over the next month (14.5% in the tranexamic acid group compared with 16.0% with placebo; relative risk 0.91, 95% CI 0.85 to 0.97; P=0.0035) and deaths owing to bleeding (4.9% *v* 5.7%).[2] The authors called for tranexamic acid to be available to doctors treating trauma patients in all countries, and said it should be considered for the WHO *List of Essential Medicines*.

Quinine for treating malaria has gone in and out of favour over the past 400 years, with its use resurging each time resistance develops to newer treatments. It's a cheap and effective drug but it often causes hypoglycaemia and is locally toxic when injected intramuscularly, and the risk of severe hypotension demands very careful supervision when it is given intravenously. Parenteral artesunate, on the other hand, is safe and simple to administer and is known—at least from trials in southeast Asian adults—to reduce malaria mortality more effectively than quinine. Would the same hold true for African children? Arjen Dondorp and colleagues' trial found that, indeed, parenteral artesunate led to significantly lower mortality than parenteral quinine in children in hospitals in nine African countries.[3] The relative reduction in mortality was 22.5% (95% CI 8.1 to 36.9) and the overall number needed to treat to prevent one death was 41 (25 to 112).

The judges with the unenviable task of selecting just one Research Paper of the Year are Sally Davies, chief medical officer (interim), director general of research and development and chief scientific adviser for the Department of Health and NHS; Zulfiqar Bhutta, Husein Laljee Dewraj professor and chairman, department of paediatrics and child health, Aga Khan University Medical Center, Karachi, Pakistan; Fiona Godlee, *BMJ* editor in chief; and Melba Gomes, the winner of last year's award and scientist, Special Programme for Research and Training in Tropical Diseases, WHO Geneva.

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After Baby P: What next for GPs?

In the aftermath of high profile cases of maltreatment, general practitioners in the UK have been swamped with guidance on improving child protection. **Sue Learner** reports on the challenges

General practitioners are often the first professionals to come into contact with children at risk. So it was inevitable, following the high profile deaths of Victoria Climbié and Peter Connelly, also known as Baby P, that GPs were targeted in a series of guidelines designed to improve child protection.

However some of these guidelines have been controversial, with social workers complaining that some GPs are failing to follow them and GPs claiming that some of the guidance is just impractical and unworkable.

The abuse and murder of eight year old Victoria Climbié by her guardians in 2000 led to an independent inquiry and a radical rethink of the child protection system in England.

Eight years later, the death of Peter Connelly, 17 months old, triggered another independent review and more guidance.

At least five documents aimed at GPs have been issued in the past five years.

In 2006, the national interagency guidance *Working Together to Safeguard Children* was issued, closely followed in 2007, by the General Medical Council's (GMC) "0-18 years guidance for doctors on child protection."

The Royal College of General Practitioners (RCGP) in partnership with the National Society for the Prevention of Cruelty to Children (NSPCC) produced a toolkit for GPs in 2008, and a year later NICE produced guidance on *When to Suspect Child Maltreatment*.

It has been over a year since the BMA issued its 60-page document, *Child Protection—A Toolkit for Doctors*. As well as listing 40 signs and symptoms of maltreatment, the guidance called for GPs to attend child protection case conferences, to hold weekly meetings with health visitors, and to keep a list of vulnerable families.

Although the BMA says the guidance has been well received, there was criticism from GPs that it was too prescriptive in parts and that attending case conferences during surgery hours was difficult.

Iona Heath, RCGP president, believes this element of the guidance was never feasible in the first place. She says there is "a real endemic problem with case conferences being held at short notice and during surgery hours."

Hampshire Primary Care Trust carried out an internal audit last year in one area to find out how many GPs had actually attended case conferences. John Dracass, the region's named doctor for safeguarding children, says: "My colleague looked at 63 consecutive child protection case conferences and found GPs had not attended any of these conferences. Only five out of 63 GPs sent a report."

GPs need to be able to speak to senior social workers who have a lot of experience

Charles Wilkinson, a Wiltshire GP, agrees that the timing of case conferences is a major issue. "The last three case conferences I have been asked to attend have been at 10am on a Monday morning. How can I go when I have a surgery full of patients?"

Kambiz Boomla, a GP in Tower Hamlets, east London, agrees. He finds that "attending a case conference would often mean cancelling a surgery. Getting a locum for one session can cost £210 to £250 [€295; $405]. I agree it is desirable and often essential that GPs do attend."

Dr Heath believes social workers need to look at alternative ways of liaising with GPs. One way, she suggests, could be through health visitors, who could represent GPs at case conferences.

Over the past few years, however, many health visitors have moved out of GP surgeries into neighbourhood area teams in Sure Start children's centres, eroding strong links.

The BMA guidance says that it is "absolutely essential for GPs to meet regularly with health visitors." But in order to do this properly, says Dr Heath, "They need to be attached to GP practices. Health visitors should be integral to the practice. It is a structural thing that is essential as it is health visitors that have privileged access to the homes of these children."

The lack of a fixed fee for attending case conferences is another thing that deters GPs from attending Unfortunately, payment fluctuates according to the local authority.

"Technically GPs can still put in an invoice for the hours they have put in at a conference but the local authority is not legally obliged to pay that," explains Dr Dracass.

The Care Quality Commission review for safeguarding children in July 2009, held after the death of Peter Connelly, found 65% of GPs were not up to date with their level 2 safeguarding training.

Chris Cloke, head of protection at the NSPCC, calls it a "long standing problem, which is completely unacceptable and needs to be urgently addressed."He would like the government to set "minimum standards for child protection training for doctors and to set up ways for them to share information with social workers about children at risk."

Dr Heath is opposed to this. "Compulsory training was brought in for GPs after the Climbié report and it was awful," says Dr Heath. "It was delivered by a nurse and there was no distinction between GPs who already had significant experience and training in child protection and those who didn't. I don't like the knee jerk reaction that when something happens, patients must be given more information and GPs must be given training."

The referral mechanism to social services is another stumbling block, owing to distrust between many GPs and social workers.

Dr Heath says: "If I am worried about a patient on medical grounds I will speak to a senior doctor. But if I have a child protection worry, I will ring up social services and more often than not I get put onto a junior social worker. Too often, they either don't react at all or they over-react. GPs need to be able to speak to senior social workers who have a lot of experience."

This distrust needs to be tackled. The Care Quality Commission review concluded that better communication between health and social care was key to bringing down the number of child protection cases.

Whether they like it or not, GPs look set to play a bigger role under the coalition government's proposal to transfer safeguarding responsibilities from primary care trusts and strategic health authorities to GP consortiums.

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- News: Baby P doctor is allowed to remove herself from medical register (*BMJ* 2011; 342:d1015)
- News: Systemic failings in NHS contributed to death of Baby P (*BMJ* 2009; 338:b1967)