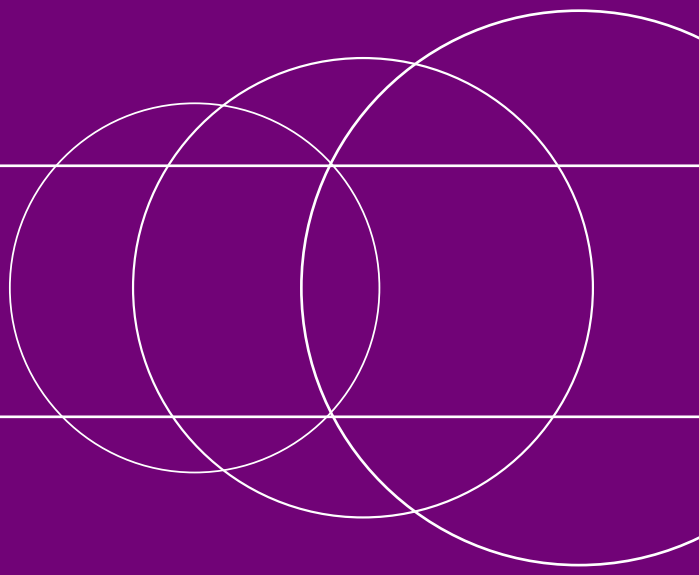
AUDITOR GENERAL

PERFORMANCE AUDIT

Review of the management of waiting lists in Scotland



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PREPARED BY AUDIT SCOTLAND

Review of the management of waiting lists in Scotland

A report to the Scottish Parliament by the Auditor General for Scotland

Auditor General for Scotland

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Acknowledgements

Judith Acton and Sara Twaddle managed the review, under the general direction of Barbara Hurst, Director of Performance Audit. Audit Scotland is grateful to ISD for provision of data and analysis. Audit Scotland gratefully acknowledges the input of the reviewers (listed in Appendix 3), Leslie Honeyman, trust staff, local health councils and staff in NHS boards.

AGS/2002/3

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Executive summary

In December 2001, the First Minister asked the Auditor General for Scotland to undertake a review of the management of NHS waiting lists across Scotland. Audit Scotland was instructed by the Auditor General to examine:

- the arrangements for placing patients on waiting lists
- the monitoring of lists and the way in which these are kept up to date
- the extent to which trusts are consistently applying central guidance from the Information and Statistics Division of the Common Services Agency, NHSScotland (ISD) in recording waiting list information
- whether trusts had taken any action in managing lists which resulted in inappropriate delays to treatment.

Introduction

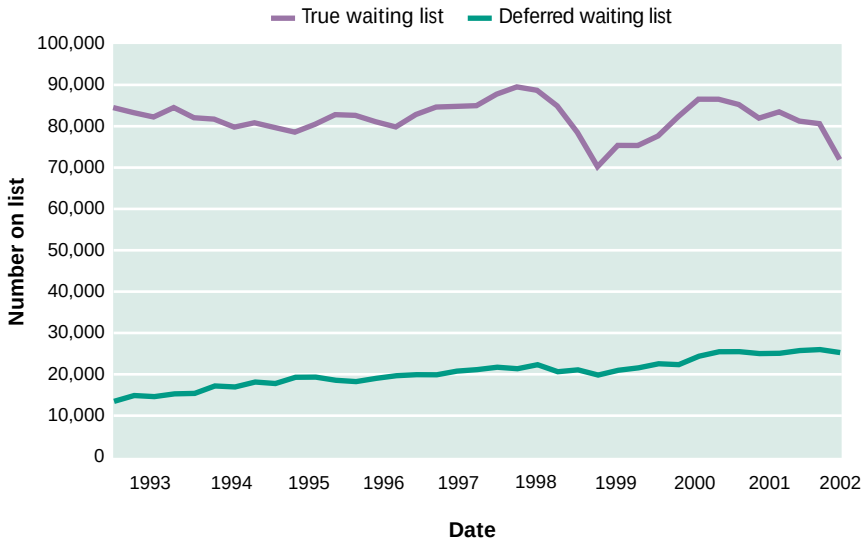
Waiting lists and waiting times are important measures of how the health service is responding to demand. They highlight where there are delays in particular parts of the health system and can be used as a measure by which trusts' performance can be compared. In Scotland there are two main waiting lists[1]:

1. **True waiting list**
   This is the main waiting list for inpatient or day case treatment and most patients are placed on this list.
2. **Deferred waiting list**
   A deferred waiting list is used if patients are unavailable for admission for a period of time for medical or social reasons, or if the patient did not attend on an offered admission date. Once patients are placed on the deferred list they can be selected for admission but they do not transfer back to the true waiting list.

Exhibit 1 overleaf shows trends in the true and deferred waiting lists from 1993 – 2002. Over this time the true waiting list has fluctuated with an overall reduction; the deferred waiting list has shown a steady rise.

[1] If patients require a series of treatments they may be placed on a planned repeat waiting list. This list is used largely as a scheduling mechanism.

Exhibit 1: Trends in the number of people on waiting lists, March 1993 – March 2002



Source: ISD

There is now a shift in emphasis from waiting lists to waiting times as a measure of NHS performance in Scotland. Unified health boards are held to account by the Scottish Executive Health Department through accountability reviews and a new Performance Assessment Framework (PAF). The current PAF contains one indicator relating to waiting lists and six relating to waiting times (Exhibit 2). Although Audit Scotland's review was focused on the management of waiting lists, the recommendations apply equally to issues arising out of managing waiting times.

Exhibit 2: Current PAF indicators relating to waiting lists and times

Area	Indicator
Fair access to healthcare services	
Waiting lists	Progress towards reduction of inpatient/ daycase list to 75,000 by March 2002
Patients' experience, including service delivery	
Waiting times	Patients seen within 9 weeks for new outpatient appointment
	Mean wait for inpatient/day case admissions from the waiting list
	Percentage of patients with a guarantee waiting more than 9 months for treatment[2]
	Percentage of patients waiting more than 12 weeks maximum for angiography after seeing a specialist
	Percentage of patients waiting more than 24 week maximum wait for surgery or angioplasty following angiography
	Percentage of patients with urgent referral for breast cancer waiting more than one month for treatment following diagnosis (where clinically appropriate)

Main findings

Audit Scotland found no evidence of systematic or deliberate irregularities in the management of waiting lists. However, we found some inconsistencies across Scotland in the administration of waiting lists and the application of central guidance on recording waiting list information which could affect the quality and comprehensiveness of waiting times information for the future. In some acute trusts practice needs to be improved to safeguard patients' interests and to provide assurance to the public that waiting lists and waiting times are being effectively managed. We also identified gaps in the provision of information to patients and the public.

Acute trusts

Audit Scotland identified three areas where a more consistent approach is needed across Scotland to ensure that all acute trusts are performing at the level of the best. These were in:

- administering the waiting list
- reclassifying patients' treatment from inpatient or day case to outpatient
- using the deferred list according to central guidance.

[2] A guarantee of treatment within a specified period applies to all patients on the true waiting list unless an exception code is applied.

Administering the waiting list

Audit Scotland found that trust-wide waiting list policies and procedures were in place in all acute trusts, but there were some instances where day to day practice varied from the stated procedures in:

- adding people to the waiting list
- updating the list
- ensuring that confidential information is protected.

A small number of patients waiting for elective treatment are not routinely placed on waiting lists. In the main these are patients waiting for urgent treatment or investigation who are 'fast tracked' through the system. However, there are a few anomalies where the reason for not adding patients to the waiting list is unclear. Audit Scotland also found some administrative errors in placing people on the waiting list. Instead of recording the date for placement on the list as the date when the decision was made we found a number of instances where the date was recorded as that when the administrative staff updated the list – the biggest delay we found was 20 days.

Waiting lists contain confidential patient-based information and so should be subject to high levels of security access. Only those people with a demonstrable need to access the waiting list should be able to do so. This is an area where practice needs to be tightened up. Audit Scotland found that not all computerised systems had password protection or an audit reporting facility.

Reclassifying patients' treatment

As medical practice changes, some procedures previously carried out on an inpatient or day case basis are now undertaken safely in an outpatient setting. This has a number of benefits for patients and for the health service. However, guidance on data recording has not kept pace with these changes. Waiting time targets are set for first outpatient appointments but there are no formal waiting times or waiting lists targets for outpatient procedures or treatments. Whilst patients waiting for inpatient or daycase procedures are placed on the waiting list, those who can be treated in an outpatient setting are not. In practice this means that patients who are waiting for procedures that are reclassified as outpatient procedures have been taken off the waiting list and may have lost their waiting time guarantees unless a trust chooses to retain them.

Acute trusts have dealt differently with patients whose procedures have been reclassified from inpatient or daycase to outpatient. Only two trusts – Grampian and Lothian – have continued to monitor both existing and new referrals for their reclassified outpatient procedures, and have maintained their waiting times guarantees as if they were day cases. In the absence of national guidance on this issue, this practice would appear to be fairest to patients. They are treated in the most appropriate setting but they retain waiting time guarantees.

Of the remaining trusts:

- two – Highland and Yorkhill – have not reclassified any day case procedures to outpatient procedures.
- two – North and South Glasgow – have not formally announced reclassification but are carrying out endoscopies as outpatient procedures. Patients are not placed on the waiting list or covered by waiting time guarantees.
- seven – Ayrshire and Arran, Argyll and Clyde, Borders, Dumfries and Galloway, Fife, Tayside, West Lothian – have reclassified some procedures and patients waiting for these, who could be treated as outpatients, have been taken off the waiting list. New referrals are not added to the waiting list if they are to be treated in an outpatient setting. Some existing patients retained their waiting time guarantees and others did not.
- two – Forth Valley and Lanarkshire – have reclassified some procedures but existing patients were left on the waiting list and treated as day cases. New referrals are no longer placed onto the waiting list and are treated as outpatient referrals.

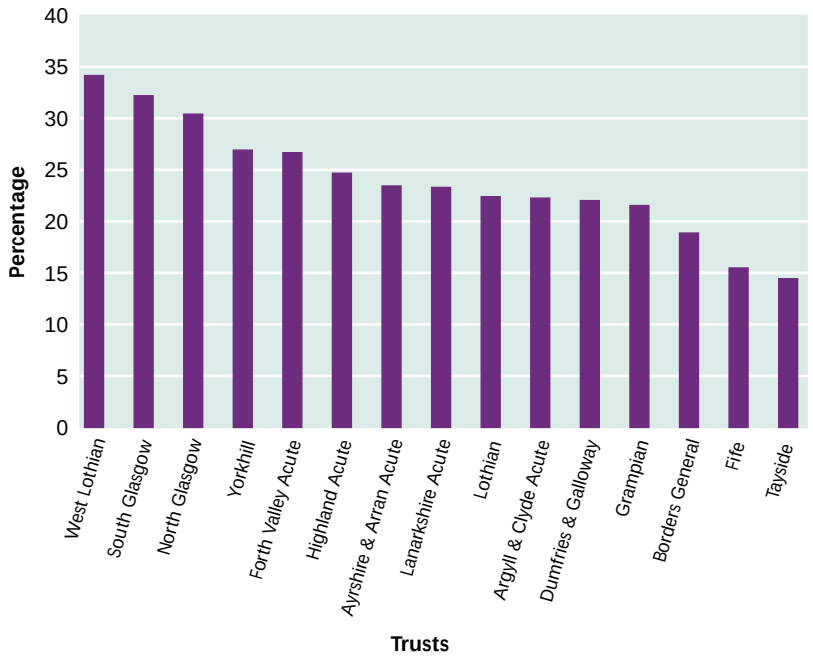
Audit Scotland found no evidence that reclassification had been used as a deliberate device to reduce waiting lists, but the lack of central guidance combined with variation in reclassification practice across Scotland has led to variations in practice. We recommend that this situation is addressed urgently to ensure that patients across Scotland are treated equally in relation to waiting time guarantees irrespective of treatment setting.

Deferred waiting list

The rationale for the existence of two waiting lists, the true list and the deferred list, is unclear. In addition, the prohibition on moving patients back to the true waiting list once they become available for treatment can cause problems. Emphasis upon monitoring waiting times rather than the size of the true waiting list provides an opportunity to reconsider the value of running two lists.

Audit Scotland's detailed data analysis showed that in all trusts patients are selected for admission from both the true and the deferred waiting lists. However, there has been a steady rise in the number of people on the deferred waiting list with a yearly rate of increase in excess of 8% from 1999 to 2001. In addition there is a wide variation in the proportion of patients on deferred waiting lists (Exhibit 3).

Exhibit 3: The deferred waiting list as a proportion of all patients waiting by trust



Source: ISD, December 2001

This variation is unlikely to be fully explained by underlying differences in the population's health. It is more likely to be related to a lack of consistency in placing patients on and removing them from the deferred list. For example, Audit Scotland found instances in a small number of trusts where certain categories of patients had been wrongly placed on the deferred list: these include patients who cannot attend for their appointment but who let the hospital know in advance; and those who require treatments of low clinical priority. National guidance states that both these categories of patients should remain on the true waiting list and be given a waiting times guarantee exception code.

Primary care trusts (PCTs)

Waiting list management in PCTs represents a different challenge from that faced by acute trusts, as the majority of care is carried out in community settings. Although waiting lists for elective inpatient

care are covered by the same routine data collection systems as acute trusts, information about waiting lists and waiting times for all other activity requires collation, validation and interpretation from a range of locations and sources.

Audit Scotland found different practices among PCTs in the recording of waiting lists. All PCTs use ISD definitions and standards manual for their inpatient services. But only four trusts – Ayrshire and Arran, Renfrewshire and Inverclyde, Lanarkshire and Lothian – have written waiting list protocols and procedures to cover all their services. Better data collection and monitoring, and validation of waiting list and waiting times information is needed by PCTs to ensure that patients are treated equally across Scotland in the time they wait for all treatments. This is likely to require investment in information systems in most PCTs.

General issues for all trusts

Audit Scotland also identified a number of general issues that apply to acute and primary care trusts and island boards. These include the need for trusts to:

- provide clearer information to all patients, and the public more generally, on waiting lists and times.
- ensure that all patients understand their waiting list status and the implications of the use of the deferred waiting list and Guarantee exception codes.
- have in place sufficiently rigorous monitoring systems that provide early warnings of patients who may be at risk of breaching waiting time guarantees. In orthopaedics, which is the specialty that Audit Scotland sampled in all acute trusts, nine patients were found who had been waiting just over 12 months for treatment. This will become more important as waiting time guarantees are reduced to nine months.
- identify services under pressure. Where there are significant staff shortages or other constraints, it is not acceptable to close lists or leave the list to grow ever larger; management action is required to ensure that patients do not suffer as a result. Audit Scotland found no formal written policies or procedures to deal with lists under extreme pressure, although most trusts had informal strategies. This is a gap that needs to be rectified as a matter of urgency.

In the main report Audit Scotland recommends a number of actions for trusts, unified health boards, the Health Department and ISD in order to improve practice in managing waiting lists and to standardise data recording.

Background

In December 2001, the First Minister asked the Auditor General for Scotland to undertake a review of the management of NHS waiting lists across Scotland. Audit Scotland was instructed by the Auditor General to carry out the review in all acute hospital trusts, primary care trusts and island health boards in Scotland, with the aim of reporting to the Scottish Parliament in June 2002.

In particular, Audit Scotland was asked to:

- examine arrangements for ensuring that NHS trusts place patients promptly onto the appropriate waiting list and for keeping lists up to date, for example by reviewing patients' continuing need for treatment.
- confirm that trusts are following ISD (Information and Statistics Division of the Common Services Agency, NHSScotland) definitions in recording patients as inpatients, day case patients or outpatients.
- confirm that trusts are following ISD guidance in placing patients on the deferred waiting list.
- examine arrangements within NHS trusts for recording and reviewing waiting list numbers.
- investigate whether trusts have taken any action in managing lists that has resulted in patients' treatment being delayed inappropriately or patients' records being amended inappropriately. This was particularly important for public confidence, as there have been reports of irregularities in the management of waiting lists by a small number of NHS trusts in England[1]. Also towards the end of 2001 a few 'closed' waiting lists in Scotland were identified[2].
- make recommendations on the improvement of management of waiting lists.

This report summarises Audit Scotland's findings from the reviews undertaken in all trusts in Scotland during April and May 2002.

[1] *'Inappropriate adjustments to NHS waiting lists',* National Audit Office, December 2001
[2] News Release SE 5076/2001. December 2001

Introduction

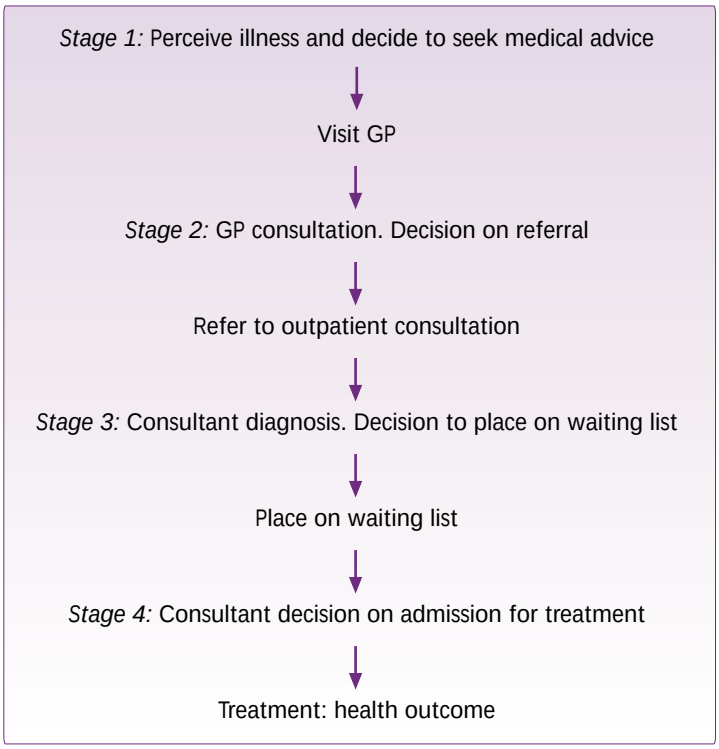
Why are waiting lists important?

Waiting lists provide a record of patients who are either waiting to see a consultant or other health practitioner or, having done so, are waiting for NHS treatment[3]. During the course of a patient journey of care (Exhibit 1), a patient may experience a wait at any one of four stages:

1. to see the GP
2. to see a consultant or other healthcare professional
3. for diagnostic tests or other procedures to decide whether treatment is necessary
4. for treatment on an inpatient (IP), day case (DC) or outpatient basis.

Audit Scotland's review covered stages **2** to **4**.

Exhibit 1: The pathway of care



Source: '*Access to elective care*', King's Fund, 2000

[3] Waiting lists apply to patients who are booked for treatment or investigation and do not apply to patients who are admitted as emergencies. Patients waiting for booked treatments or investigations are known as elective patients.

Waiting lists and waiting times are important measures of the way in which a health care system is responding to the demand for services. They highlight where there are major delays in particular parts of the system or in particular services and can provide a measure by which different parts of the system or geographical areas can be compared.

There are a number of accepted principles that underpin their use (Exhibit 2).

Exhibit 2: Key principles for the use of waiting lists and waiting times

- Waiting lists and times are quality indicators, and work to reduce delays in access to care should be part of the quality improvement system at institutional, regional and national levels.
- The management of lists and waiting times guarantees should be transparent so that patients understand how the system works.
- Patients must have equitable access to health care.
- Priority should be given to those with greatest need but waiting times should not be so long as to put any patient at risk of deteriorating health.
- Giving a patient a place on a waiting list means a commitment to give care to that patient

Source: Council of Europe, Committee of Ministers. Recommendation No R (99) 21 of the Committee of Ministers to member states on criteria for the management of waiting lists and waiting times in health care. Adopted on 30 September 1999.

What waiting list information is collected currently?

A number of waiting lists are collected by individual trusts. These relate to first outpatient appointment and true and deferred waiting lists for day case and inpatient treatment. In addition, a planned repeat list may be collected as a scheduling device. Detailed definitions are included in Appendix 1. ISD collate and publish the following waiting lists:

- **True inpatient (IP)/day case (DC) waiting list** – for inpatient or day case treatment. This list carries a waiting time guarantee except where a Guarantee exception code is applied (Appendix 1). Patients who cannot attend for an offered admission date are kept on this list but have an exception code applied.
- **Deferred waiting list** – for patients unavailable for treatment for a period of time due to a variety of reasons, including illness, extended holidays or work commitments. Treatment is postponed during the period that they are unavailable. This list carries no waiting time guarantees, and once placed on the deferred list a patient cannot be transferred back to the true waiting list.
- **Planned repeat waiting list** – initially a patient may be admitted from the true waiting list. If subsequently a series of treatments are required, such as regular cystocopies every three months, the patient may be placed on a planned repeat waiting list.

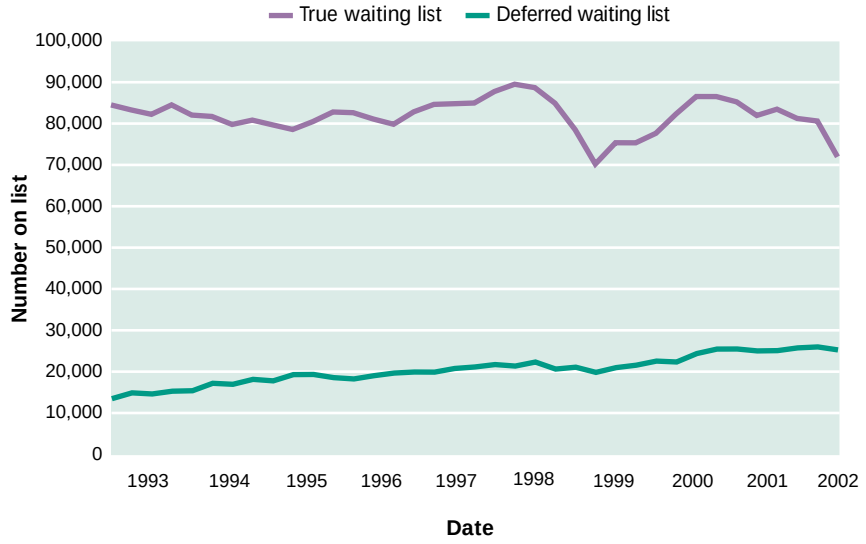
Currently there are no formal waiting lists for subsequent visits to outpatient clinics or for outpatient procedures and treatments. This issue is considered later in the report.

How many people are on the true and deferred waiting lists?

Exhibit 3 shows the true and deferred waiting list for Scotland between 31 March 1993 and 31 March 2002, measured by the quarterly SMR3[4] waiting list census. Over the period the true waiting list has fallen from 84,521 to 71,965 (-15%) and the deferred list has risen from 13,451 to 25,270 (+88%).

[4] SMR3 waiting list census provides a snapshot of patients for inpatient or day case treatment at the end of each quarter.

Exhibit 3: Trends in the number of people on waiting lists, March 1993 – March 2002



Source: ISD

Moving towards waiting times

The Waiting List Support Force was tasked with reducing the waiting lists in 1998/99 and invested £44.5 million on a recurrent basis to do so. As can be seen from Exhibit 3, this investment resulted in a significant reduction in the true waiting list, from 89,525 in March 1998 to 70,227 in March 1999. This Group subsequently became the Waiting Times Support Force, with a greater emphasis on the reduction of waiting times.

In 1999 the then Minister for Health set a target of a maximum of 75,000 people waiting at the end of March 2002. Trusts achieved this target in March and there are now just under 72,000 people on the true waiting list. However, in future the emphasis will move from reducing the overall number of people on a waiting list to reducing the total waiting time for patients, with the aim of achieving better, fairer access to services.

Waiting time guarantees have been set by the Scottish Executive Health Department for hospital inpatient or day case treatment (12 months maximum wait). This has resulted in this area having the best developed and most comprehensive waiting list information and management. Waiting time targets for first outpatient appointments have been in place since 1992[5].

[5] *'The Patient's Charter: a charter for health'*, The National Health Service in Scotland, 1991.

Further waiting times guarantees have been published in 'Our National Health – A Plan for Action, a Plan for Change' (Scottish Executive, 2000) and are due to take effect over the coming year. These include a maximum waiting time for inpatient and day case treatment of nine months in 2003 and explicit targets in certain key specialties for clinic appointments, investigations and treatment for certain conditions.

Although there has been this change in emphasis to waiting times as a measure of NHS performance in Scotland, there remains a need for accurate compilation, recording and management of waiting lists for each stage of the patient journey. All the key features of a well managed waiting list will still need to be in place to achieve reductions in waiting times (Exhibit 4).

Exhibit 4: Key features of a well managed list

- Clear managerial ownership and control.
- Senior clinical and managerial leadership.
- Clear lines of accountability for the management of the list, and clarity in the roles and responsibilities of everyone involved.
- Integrated IT systems so all waiting lists within a trust can be accessed, interpreted and audited consistently.
- Consistent application of definitions for national reporting and comparisons to ensure equity for all patients.
- Early warning system in place to identify unacceptably long waiting lists or times.
- Data protection of patients' information guaranteed.
- Information provided to patients on position on list and expected waiting time.
- Information for the public on waiting lists and waiting times.

Trusts will increasingly need to demonstrate, in an open and transparent way, that waiting times have been reduced and that these are being measured in a consistent way across Scotland.

Audit Scotland's approach

Audit Scotland's review was carried out in all trusts and island health boards in Scotland (Appendix 2).

A risk-based approach to reviewing waiting list management was adopted. This recognised the impossibility of reviewing every waiting list in every trust, but allowed Audit Scotland to review the quality of waiting list management in each trust within the time available.

Different approaches were used in acute trusts, primary care trusts and island boards, reflecting the degree to which routinely collected information represents activity within the different settings:

- in acute trusts Audit Scotland used information from the Scottish Morbidity Records scheme (SMR). Specifically we looked at waiting list information (SMR3) and activity data (SMR01[6]) to identify issues for discussion with the trusts during interviews, and the lists to be reviewed.
- in primary care trusts, where only a small proportion of activity and associated waiting lists is covered by the SMR scheme, interviews were conducted to obtain an overview of how waiting lists are managed in the absence of national data collection systems.
- in island boards, telephone interviews were used to identify any special factors which influence waiting list management in these areas.

The different approaches were reviewed by an external reference panel to confirm that the approach was rigorous, realistic and would address the necessary issues. The panel members were chosen or nominated for their expertise in the topic and are identified in Appendix 3.

A review team consisting of Audit Scotland staff and secondees from the health service undertook the reviews, and were trained in the methodology to ensure consistent application across all trusts. Secondees did not review any trust within their own health board area. Members of the review team are also identified in Appendix 3.

[6] SMR01 is a record of discharges from inpatient or day case treatment.

Methodology for acute hospital trusts

The reviews in acute trusts were undertaken in four stages:

1. Initial information review

Acute hospital trusts were asked to provide initial information including monthly monitoring information, trust board or management team reports and a summary of waiting list complaints. This information was reviewed prior to the interviews. Audit Scotland also contacted local health councils prior to the reviews being undertaken. The local health councils were asked to provide a summary of complaints received about waiting lists. This information was analysed by Audit Scotland and followed up by the reviewers. The results were used to identify additional questions to ask during the interviews.

2. Analysis of National Waiting List Data

For each trust, two specialties were identified for review:

- orthopaedics, because it contributes the greatest numbers of patients on the waiting list.
- one other specialty that had experienced the most significant and sudden change(s) to either the true or deferred waiting lists.

Audit Scotland commissioned ISD to undertake an analysis of national waiting list trends to identify the particular specialties in individual trusts for the review team to target. The second specialty differed among trusts (Exhibit 5).

Lists of patients from the waiting list census snapshot (SMR3) and elective inpatient/day case admissions (SMR01) were generated by ISD for both orthopaedics and the second specialty. In total, four lists were generated for each trust.

Exhibit 5: Second specialties identified by trust

NHS Trust	Second specialty
Argyll & Clyde Acute Hospitals	Plastic surgery
Ayrshire & Arran Acute Hospitals	General Medicine
Borders General Hospital	ENT
Dumfries & Galloway Acute and Maternity Hospitals	Gynaecology
Fife Acute Hospitals	Gastroenterology
Forth Valley Acute Hospitals	Gastroenterology
Grampian University Hospitals	Ophthalmology
Highland Acute Hospitals	ENT
Lanarkshire Acute Hospitals	Plastic surgery
Lothian University Hospitals	Gastroenterology
North Glasgow University Hospitals	General surgery
South Glasgow University Hospitals	Urology
Tayside University Hospitals	Plastic surgery
West Lothian Healthcare	Gastroenterology
The Yorkhill Trust	Surgical paediatrics

Audit Scotland sampled at random from these patient lists to produce cohorts for analysis[7]. The cohort sizes are included in Appendix 4.

3. Data analysis by individual trusts

Individual trusts were sent the four patient cohort samples and asked to complete pre-printed proformas that analysed what had happened to each patient:

- patients in an SMR3 cohort had been on the waiting list for that specialty at a particular point in time. Trusts were asked to track what had happened to each of these patients subsequently.
- patients identified in an SMR01 cohort had been recorded as an elective admission for either inpatient or day case treatment during the period in question. For these patients, trusts were asked to record the patient journey from GP referral to the patient being admitted and all decision points along the way.

[7] The samples were 10% of the cohort for the particular specialty for the trust, up to a maximum of 60 patients.

Exhibit 6 details the information requested for each patient in the two proformas.

Exhibit 6: Information requested on proformas

SMR3 proforma – information requested about patients on a waiting list

Date on waiting list
Waiting list type
Use of guarantee exception code
Care type (IP/DC)
Whether patient still on waiting list
Date of removal from list
Removal reason

SMR01 proforma – information requested about elective inpatient and day case patients' journeys

Date of admission
Whether admitted from waiting list
Date on waiting list
Date decision made to place on waiting list
Care type (IP/DC)
Waiting list type
Use of guarantee exception code
Date of outpatient attendance
Route onto waiting list
Date of referral from GP to hospital

Patient confidentiality was maintained at every stage. There was no patient identifiable information on the pre-printed or completed proformas. The completed proformas were returned to Audit Scotland and analysed. Major issues or queries were summarised and given to the relevant member of the Review Team for use during face to face interviews.

The reviewer also sampled at random from each of the returned proformas and, using the trust information systems, ensured that the data had been completed accurately.

4. Face to face interviews

Two interviews were held in each trust. The first was with the chief executive and director or general manager responsible for waiting lists. The second meeting was with people responsible for the day-to-day operational maintenance of waiting lists, such as medical records and/or information managers.

Issues covered in the interviews were:

- ownership and control
- systems and procedures
- definitions
- data integrity
- reporting
- management intervention.

These issues reflected the key elements of a well managed waiting list detailed in Exhibit 4.

Methodology for primary care trusts

The review process in primary care trusts took the form of a face to face interview with the trust chief executive and members of his/her team, to establish how primary care trusts manage their waiting lists for all services. Issues covered in the interview were:

- waiting list management
- systems
- monitoring
- reporting.

Information from the interviews was supplemented by a review of trust policy and procedures; a summary of waiting list complaints; and information from the local health council on complaints received regarding local waiting lists.

Methodology for island health boards

Telephone interviews were conducted with board general managers or their representatives. The interview used the same questions as those for acute and primary care trusts.

Island health boards have shorter waiting times than mainland trusts; the proportion of patients waiting less than three months for treatment was 94% in Orkney, 98% in Shetland and 82% in Western Isles, compared with 58% for Scotland as a whole[8]. These boards also reported that monitoring and validation is simplified because of the

[8] ISD data 30/09/01

small numbers of patients on waiting lists (Orkney 160, Shetland 164 and Western Isles 537)[9]. There are, however, specific problems which apply because of their geography. In particular, problems can arise as a result of adverse weather preventing consultant staff from visiting. This can lead to delays in patient treatment unconnected to waiting list management, which current ISD definitions do not cover. This report does not specifically address these issues relating to the island health boards. However, the recommendations do apply.

[9] ISD data 31/12/01

What we found

This chapter outlines Audit Scotland's findings under three main headings:

- the management of waiting lists by acute trusts
- the management of waiting lists by primary care trusts
- general issues in both acute and primary care trusts.

As already noted, waiting list data are more comprehensive, and thus capable of more detailed analysis, in acute trusts. This influenced Audit Scotland's methodology and findings in the acute trusts are significantly more detailed than in the primary care trusts. However, important data collection issues are highlighted for primary care trusts which will have implications for the future collection and monitoring of waiting times information. This chapter concludes with issues that are relevant for all trusts, including:

- the provision of information to patients and the public
- the role of unified health boards in measuring performance on waiting lists and waiting times
- the way in which managers are alerted to potential problems in waiting lists.

The management of waiting lists by acute trusts

Audit Scotland found no evidence of systematic or deliberate irregularities in the management of waiting lists. However, we found some inconsistencies across Scotland in the administration of waiting lists and the application of central guidance on recording waiting list information which could affect the quality and comprehensiveness of waiting times information for the future. We also identified gaps in the provision of information to patients and the public. In some acute trusts practice needs to be improved to safeguard patients' interests and to provide assurance to the public that waiting lists and waiting times are being effectively managed. These are in the areas of:

- regular monitoring and active validation of waiting list information
- reclassification of patients from inpatients or day case patients to outpatients and the way in which these are recorded
- transparency for patients about the use of deferred waiting lists and the inherent risks associated with running two lists.

Monitoring and validation of waiting list information

An effective system for managing waiting lists needs to demonstrate that:

- there are clear lines of accountability and individual responsibilities are understood
- all patients referred for diagnosis or admission are registered by the trust and the date of referral or decision is recorded promptly
- there is consistent guidance and training for all staff involved
- all waiting lists in the trust can be accessed, interpreted and audited consistently
- there is a regular review and validation of lists in order to ensure they remain accurate.

Do trusts have clear lines of accountability for managing waiting lists, and do staff know their individual responsibilities?

The management of waiting lists and times in accordance with national targets is a high priority in every acute trust and a great deal of time and effort has been put into this area. Where local targets have been set in conjunction with the NHS board, these are also given high priority.

Management responsibilities vary depending on the organisational structure of the trust but, in general, Audit Scotland found clear lines of accountability in all acute trusts. This accountability structure led from individual clinicians and their secretaries, through the management hierarchy to the trust board or management team, with the chief executive as the accountable officer.

Management responsibilities also vary in line with the organisational structure but managers and staff involved in waiting list management are aware of their responsibilities and the importance of maintaining accurate lists and achieving waiting list targets. Medical Records and Information Departments provide support to both managers and clinicians in terms of data collection, information and report production and waiting list training.

Audit Scotland found that trust-wide waiting list policies and procedures were in place in all trusts but there were some instances where day to day practice showed some variations from the stated procedures, as detailed below. These findings highlight the need for greater consistency in the application of policies and procedures within trusts and a greater degree of staff supervision across specialties.

Are all patients placed on a waiting list?

A key principle of waiting list management is that all elective patients presenting for treatment or diagnosis are placed on a waiting list. Audit Scotland found that some patients waiting for elective treatment are not routinely placed on waiting lists. In the main these are patients waiting for urgent treatment or investigation who are 'fast tracked' through the system. This should not affect the time a patient waits for treatment – indeed patients in these circumstances are likely to have relatively short waits. However, there are a few anomalies where the reason for not adding patients to the waiting list is unclear (Exhibit 7). To ensure consistent treatment of patients across Scotland these few instances need to be resolved.

Exhibit 7: Examples where patients are not placed on a waiting list

Trust	Reason for admission
Argyll & Clyde	Care of the elderly admissions at one hospital
Fife	Gastroenterology
Lanarkshire	Dermatology
South Glasgow	General Surgery minor procedure day case surgery

Case study: Good practice in ensuring that all elective patients are recorded

Yorkhill The computer system, HISS, will not allocate a theatre time for elective patients unless they are on the waiting list – thereby ensuring that all elective patients are placed on waiting list.

Are all patients placed on the waiting list in an accurate and timely manner?

Managing a waiting list is a complex task, made more difficult for trusts by the fact that there are many waiting lists and that these are not all necessarily managed on the same information system. Many of the waiting lists are managed using computerised systems, not all of which are compatible, and some individual clinicians still use manual systems with the data collated at a later stage. This creates a significant challenge for trusts in ensuring that their centralised information is accurate.

Trust wide policies and procedures for managing waiting lists are therefore essential. All acute trusts have policies in place, which incorporate ISD definitions and how they should be applied. The policies and procedures for all acute trusts also outline guidance on managing and updating the waiting lists.

Staff need to be trained in the implementation of the procedures. There also needs to be adequate cover so that there are not delays in entering a patient on the waiting list and the information recorded is accurate. In particular, trusts should provide adequate administrative cover for holidays or sickness absence. In practice, Audit Scotland found some inconsistencies in the way in which people are placed on waiting lists. There were a number of examples where the date recorded for placement on the waiting list was not when the decision was made to place the patient on a list, but instead when the waiting list was updated by administrative staff – the biggest delay we found was 20 days.

Case study: Examples of good practice in managing administrative cover

Grampian Medical Secretaries work in specialty teams, which ensures cover is always available.

Lothian Medical Secretaries work in teams with a centralised service within each specialty.

Tayside and West Lothian both stated that administrative cover was not always available. Tayside provided examples where significant fluctuations in waiting list data could be attributable to the availability of administrative cover.

As well as having guidance on managing and updating lists, trusts should also have clear levels of security access to waiting lists. This is particularly important to ensure that patient confidentiality is protected and also to provide assurance that unauthorised people cannot amend patient records, as has happened in some English trusts[10]. On the whole Audit Scotland found that medical secretaries were only able to access the waiting lists of their own consultant or specialty, with the exception of North Glasgow and West Lothian where secretaries can access all waiting lists. Not all the computerised systems reviewed by Audit Scotland, as part of the data validation exercise, have password protection and an audit reporting facility.

[10] '*Inappropriate adjustments to NHS waiting lists*', National Audit Office, December 2001.

Are waiting lists actively reviewed and validated?

Audit Scotland found that the degree to which trusts review and validate their waiting lists in order to ensure that they remain an accurate account of patients waiting for treatment varies across Scotland. This ranges from selective audit by specialty through to six monthly audits on both true and deferred waiting list, supplemented by monthly sample checks on patients (Exhibit 8).

Exhibit 8: Validating the waiting list

Trust	Action taken
Argyll & Clyde	Every patient at Royal Alexandra Hospital waiting for longer than 6 months is reminded in writing that they remain on a waiting list
Ayrshire & Arran	Full 6 monthly audit of true and deferred lists with ad hoc checking of patient details and waiting list categories on a monthly basis
Borders	Regular audits to check patient details and waiting list categories on true and deferred waiting lists
Dumfries & Galloway	Full quarterly audit to check patient details and waiting list categories on true and deferred lists
Fife	Periodically selects a specialty and audits all waiting list data
Forth Valley	Weekly waiting list review. A new system for communicating with patients to validate list has been drafted
Grampian	Patients waiting more than 6 months on the true waiting list are contacted and asked if treatment is still required and to contact hospital if circumstances change
Highland	Waiting list validation on a bi-monthly basis
Lanarkshire	Monthly review of true and deferred waiting lists
Lothian	True waiting list reviewed twice weekly by waiting list manager and medical secretaries. Waiting list manager and operations manager review deferred list at least every 6 months
North Glasgow	6 monthly review where inpatient and day case patients are contacted and advised to inform the trust of any change in circumstances
South Glasgow	Regular waiting list reviews, but patients are not contacted
Tayside	A major 'cleaning' exercise was undertaken across all specialties early in 2002.
West Lothian	Six monthly review. All patients are contacted and asked to confirm their details. GPs are contacted if patients do not respond
Yorkhill	Monthly validation of true and deferred lists. Patients are not contacted.

Not all trusts contact patients to check that their circumstances have not changed – an essential component of a thorough review and validation process.

As shown by the Waiting List Support Force in 1998/99, validation of waiting lists can have a significant effect on the total list size (see Exhibit 3). There has however, been no independent validation of waiting lists in NHSScotland. This could become part of external audit arrangements for NHS trusts.

The effect on patients of reclassifying their procedures

Medical treatments are developing at a rapid pace. A number of common procedures were once carried out on an inpatient basis, then shifted to day case treatment and are now being carried out in out-patient clinics. These are often carried out in locally-based outpatient facilities and can have distinct benefits to patients in terms of local treatment and reduced waiting times. It can also have benefits to the health service itself by freeing up inpatient and day case facilities.

Audit Scotland examined practice in this area to identify the extent of reclassification across Scotland and whether patients are adversely affected.

Reclassifying procedures does not affect health outcomes for patients. However, unlike day case procedures, outpatient procedures do not routinely have waiting list information recorded, are not covered by national waiting list guarantees and should not be recorded as elective admissions. It is this, in combination with the inconsistent classification of the same procedures across trusts in Scotland (Exhibits 9 and 10), that may have led to a suspicion that reclassification has been used as a means of artificially reducing the waiting list figures.

Exhibit 9: Reclassification of some day case procedures to outpatient procedures by acute trusts

- Some trusts have not reclassified any day case procedures to outpatient procedures.
- Some trusts have not formally reclassified but are following changing medical practice and providing certain procedures in an outpatient setting.
- Some trusts formally announced reclassification of a particular procedure(s). In doing so, two methods have been employed at the point of reclassification:
  1. existing patients waiting for that particular procedure who could be treated as an outpatient were taken off the waiting list and any new referrals are not added to the waiting list. All these patients are now treated as outpatient procedures; or
  2. existing patients were left on the waiting list and treated as day cases. New referrals are no longer placed onto the waiting list and are treated as outpatient procedures.

Two trusts (Highland and Yorkhill) have not reclassified any procedures and record patients for all the procedures in question as day cases. These patients are placed on the day case waiting list, covered by the appropriate waiting time guarantee and recorded as elective admissions.

Two trusts (North and South Glasgow) have not formally announced reclassification but provide endoscopies as outpatient procedures. Patients are not placed on the waiting list, covered by waiting time guarantees or recorded as elective admissions.

The remaining eleven acute trusts have formally reclassified certain procedures from day cases to outpatients. In nine of these trusts, the reclassification applied to both existing patients on the waiting list and new referrals; in two cases, this only applied to new referrals (Exhibit 10).

One trust (Forth Valley) has reclassified some procedures from day cases to outpatients but continues to record these patients as elective admissions. This should not happen. However, the trust stated that this was because of problems implementing a new outpatient management system which will formally record this activity. Until these problems are resolved they want to be able to record the activity.

Exhibit 10: Formal reclassification and effect on patient

Acute Trust	Formal Reclassification	Specialty/ procedures reclassified	Effect on existing patients already on the waiting list for IP or DC procedure	Effect on new patients referred after reclassification for outpatient procedure
Argyll & Clyde	√	Dermatology	Existing patients taken off the waiting list and not recorded as elective admissions. WTG do not apply	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
Ayrshire & Arran	√ (From December 2000)	Plastics – Minor Procedures, Urology – flexible cystoscopies, Gastroenterology – upper GI endoscopies	Existing patients taken off the waiting list and not recorded as elective admissions. Waiting Time Guarantees (WTG) continue to apply.	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
Borders	√ (During 2002)	Some ophthalmology, endoscopy and cystoscopy patients	Existing patients taken off the waiting list and not recorded as elective admissions. WTG continue to apply.	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
Dumfries & Galloway	√ (From 1 February 2002)	GI endoscopies, Flexible sigmoidoscopies, Cystoscopies, Vasectomies	Existing patients taken off the waiting list and not recorded as elective admissions. WTG continue to apply.	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
Fife	√	Some urology (check cystoscopies) and gastroenterology procedures	Existing patients taken off the waiting list and not recorded as elective admissions. WTG do not apply.	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
Forth Valley	√	Endoscopies Minor ops for skin lesions Ingrowing toenails	Reclassification only applied to new patients. Existing patients treated as day cases and covered by WTG	New patients not placed on waiting list but are recorded as elective admissions. WTG do not apply
Grampian	√	Cataract removal, Vasectomies, Ingrowing toenails, removal of cysts, lumps and bumps in general surgery, Ophthalmology & plastics	Existing patients removed from waiting list and not recorded as elective admissions. Patients continue to be monitored by outpatient module of patient administration system (PAS). WTG continue to apply.	New patients not added to waiting list or recorded as elective admissions. Patients monitored by outpatient module of PAS. WTG apply.
Highland	*X*			

Acute Trust	Formal Reclassification	Specialty/ procedures reclassified	Effect on existing patients already on the waiting list for IP or DC procedure	Effect on new patients referred after reclassification for outpatient procedure
Lanarkshire	√	General surgery, Plastic surgery	Reclassification only applied to new patients. Existing patients treated as day cases and covered by WTG	New patients not added to waiting list or recorded as elective admissions. WTG do not apply.
Lothian	√	Urology Gastroenterology	Existing patients removed from waiting list and not recorded as elective admissions. Patients continue to be monitored by outpatient module of PAS. WTG continue to apply.	New patients not added to waiting list or recorded as elective admissions. Patients are monitored by out-patient module of PAS. WTG apply.
North Glasgow	*X* However, some patients for endoscopies are classified as out-patient procedures, not placed on waiting list and not recorded as elective admissions.			
South Glasgow	*X* However, some patients for endo-scopies are classified as outpatient procedures, not placed on waiting list and not recorded as elective admissions.			
Tayside	√ (Early 2001)	Endoscopy Plastic surgery Urology Cystoscopy	Existing patients taken off waiting list and not recorded as elective admissions. WTG do not apply.	New patients not placed on waiting list or recorded as elective admissions. WTG do not apply.
West Lothian	√	Oral surgery Plastic surgery Gynaecology Gastroenterology	Existing patients taken off waiting list and not recorded as elective admissions. WTG do not apply.	New patients not added to waiting list and not recorded as elective admissions. WTG do not apply.
Yorkhill	*X*			

Note: Not all patients needing the above procedures are able to be treated as outpatients. This will depend on a clinical assessment.

As Exhibit 10 demonstrates, only two acute trusts (Grampian and Lothian) have continued to monitor both existing and new referrals for these reclassified outpatient procedures and have maintained their waiting times guarantees as if they were day cases. In the absence of national guidance on this issue, this practice would appear to be the fairest to patients. They are treated in the most appropriate setting but they retain waiting time guarantees.

Audit Scotland found no evidence that reclassification had been used as a deliberate device to reduce waiting lists, but the lack of central guidance combined with variation in reclassification practice across Scotland has led to variations in practice. We recommend that this situation is addressed urgently to ensure that patients across Scotland are treated equally in relation to waiting time guarantees irrespective of treatment setting.

The risk of perverse incentives in national targets

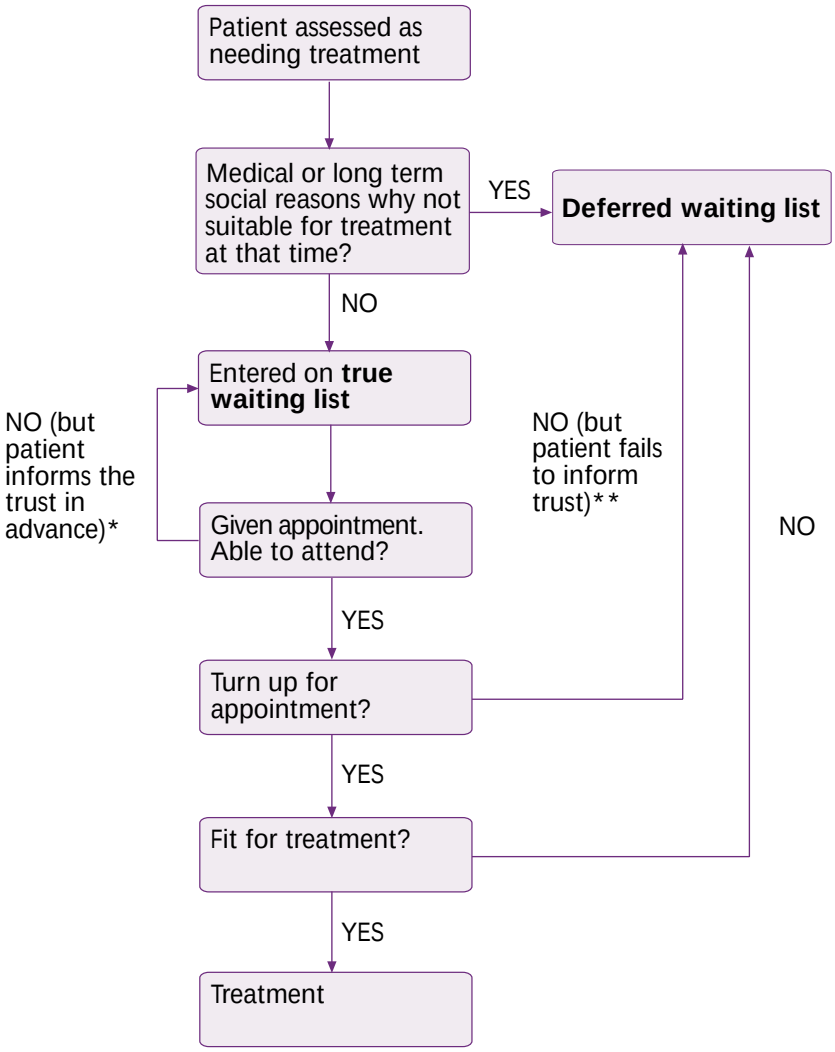
The fact that current definitions and targets have not kept pace with advances in medical practice has led not only to the above inconsistencies and difficulties in measuring comparable activity across trusts, but also to some confusion in measuring trust performance. In particular:

- The Performance Assessment Framework (PAF) includes a target for day cases for a number of specified procedures. The target expresses day cases as a percentage of all elective procedures. Reclassifying day case procedures to outpatient procedures may lead to a reduction in the proportion of activity undertaken on a day case basis and may lead to a perverse incentive for trusts to continue to treat patients as day cases even when they can safely be treated in an out-patient environment, with all the benefits associated with this.
- Reclassification of day case procedures to outpatients has, in some cases, involved patients being removed from the waiting list. In all cases new referrals to the reclassified procedures will not be added to the waiting list. The consistent recording of waiting times against targets for outpatient procedures would ensure transparency and reduce suspicion that changing a patient's status from a day case patient to an outpatient has been used to falsely reduce the true waiting list figures.

Deferred lists

In addition to the true waiting list there is also a deferred waiting list (see Appendix 1 for full definition). Patients are placed on the deferred waiting list if they are unavailable for admission for a period of time. This may be for medical or social reasons, or if the patient did not attend on an offered admission date. ISD guidance states that once a patient is placed on the deferred list they can be admitted but they do not transfer back to the true waiting list (Exhibit 11).

Exhibit 11: How patients are placed on the deferred waiting list



Note: * known as cannot attend (CNA); ** known as do not attend (DNA)

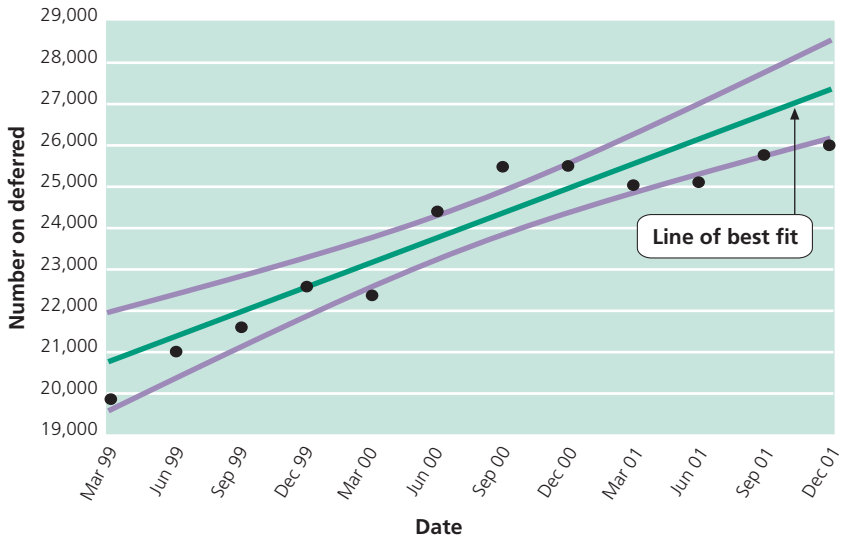
Audit Scotland is unclear about the reason for having two waiting lists, and the rationale for why patients cannot move back onto the true waiting list once they become available for admission. Computerised systems can easily identify different categories of patients reducing the need for separate lists.

Audit Scotland found clear evidence, from the analysis of proformas on a sample of patients, that patients in all trusts are selected for admission from both the true and the deferred lists. Trusts stated that the selection of patients from both the true and deferred lists is based on clinical priority. However, the risk remains that some patients awaiting treatments of low clinical priority who are on the deferred list may experience a long wait for treatment. Because waiting times guarantees exist for the true waiting list there is an incentive for trusts to more actively manage this. Moving patients back on to the true waiting list when appropriate may reduce the risk of long waiting times.

The shift in emphasis from the number of people on the waiting list to how long people wait for treatment suggests that further consideration should be given to how waiting times will be monitored for patients on the deferred list in the future.

Across Scotland, the number of people on the deferred list has increased year on year. Between March 1999 and December 2001 the deferred list grew from around 21,000 to 26,000. The yearly rate of increase has been in excess of 8% (Exhibit 12). This trend is particularly high in general surgery (17% per annum), ophthalmology (11% per annum) and orthopaedics (11% per annum).

Exhibit 12: Trend in the deferred waiting list, March 1999 – December 2001

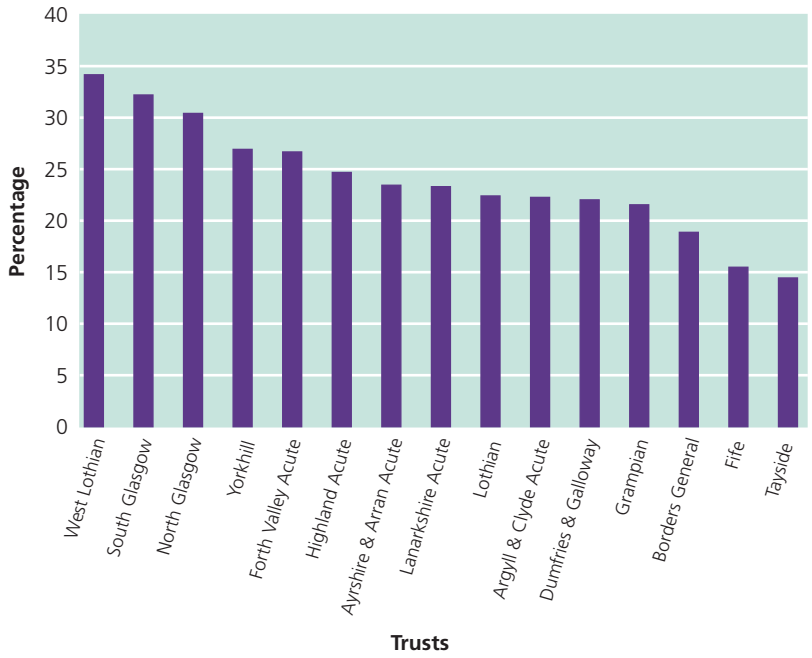


Note: Change + 8.6% p.a. R 0.91868 p<0.0001
R is measure of best fit, p is the significance level
Curved lines show 95% confidence limits

Source: Audit Scotland

There is wide variation in the proportion of patients on deferred waiting lists, ranging from more than 30% in West Lothian to less than 15% in Tayside (Exhibit 13).

Exhibit 13: The deferred waiting list as a proportion of all patients waiting by trust



Source: ISD, December 2001

This variation is unlikely to be fully explained by underlying differences in the population's health. It is likely to be more closely related to a lack of consistency in placing patients on and removing them from the deferred list.

Some trusts have not been consistently following ISD guidance about which patients should be placed on the deferred list and which patients should be kept on the true waiting list. The two specific examples are:

- patients with a low clinical priority. These patients should be placed on the true waiting list with a Guarantee exception code 3 applied. This should be fully discussed with the patients.
- patients who cannot attend for a given appointment but who have informed the trust in advance. These patients should be kept on the true waiting list with a Guarantee exception code 2 applied.

West Lothian Trust has incorrectly used the deferred list for patients waiting for treatments of low clinical priority in plastic surgery. This may in part explain the high proportion of patients on the deferred waiting list as shown in Exhibit 13. However this has recently been rectified, following a review by ISD in the period January to April 2002. These patients have been reinstated to the true waiting list with a review by a clinician of the use of a Guarantee exception code 3[11]. It is unclear whether the application of a code relating to low clinical priority has been discussed with all the patients concerned.

Referral protocols, such as the West of Scotland protocol for plastic surgery, can assist in managing demand in areas of low clinical priority. Clear, Scotland-wide, guidance for low clinical priority cases should be developed as a priority.

Trusts have interpreted ISD guidance on people who cannot attend on the day of their appointment and have informed the hospital in advance (CNA) differently. Some trusts record these people on the true waiting list with an Guarantee exception code 2, which is in line with ISD guidance; others place these patients on the deferred list (Highland, South Glasgow, North Glasgow, Yorkhill). It is not clear whether the implications of these actions are always explained to the patients, or whether they know that their waiting times guarantee status may have been affected.

[11] Guarantee exception code 3 indicates that after discussion with the patient the treatment is judged of low medical priority.

Patients are removed from the deferred list when they have been treated; when the list is validated and patients are found to no longer require treatment; or when they repeatedly do not attend their appointments without letting the hospital know in advance (DNA). There is inconsistent treatment of this last category of patients. Some trusts have no trust-wide policy on how these patients should be treated, the decision being taken by the individual clinicians (Argyll & Clyde, Fife, Lanarkshire, West Lothian). Other trusts (Tayside, Grampian) have a policy stating an upper limit of times that a patient does not attend after which they are taken off all waiting lists; and yet others have a mix of the two approaches (North Glasgow, South Glasgow). Yorkhill routinely discusses cases with the GP after two failures to attend.

The management of waiting lists by primary care trusts

Waiting list management in primary care trusts represents a different challenge from that faced by acute trusts, as the majority of care is carried out in community settings. Although waiting lists for elective inpatient care and consultant-led outpatient clinics are covered by the same routine data collection systems as acute trusts, information about waiting lists and waiting times for all other activity requires collation, validation and interpretation from a range of locations and sources. This is further complicated by a lack of national definitions, standardised data sets and national waiting times targets for non consultant-led services; for example, nurse-led clinics and those held by professions allied to medicine such as physiotherapists.

Audit Scotland's review found different practices among primary care trusts in the recording of waiting lists. To ensure patients are treated equally across Scotland in the time they wait for all treatments, data collection, data monitoring and validation of waiting list and waiting times information is needed. This is likely to require investment in information systems in most primary care trusts.

Among trusts, eighteen different computer systems were described, along with manual systems. Responsibilities for ensuring data consistency are clear in primary care trusts. However, with the exception of inpatient services, primary care trusts vary in terms of the comprehensiveness of their data collection.

Individual clinicians and primary care practitioners are responsible for managing their own waiting lists and ensuring that clinical priorities are maintained. From the review, because many of the lists

are held at individual clinician level and are not aggregated by the trust, it was not possible to establish whether all patients awaiting treatment in primary care settings are placed on a waiting list accurately and promptly.

All trusts use ISD definitions and standards manual for their inpatient services. But only four trusts – Ayrshire and Arran, Renfrewshire and Inverclyde, Lanarkshire and Lothian – have written waiting list protocols and procedures to cover all their services.

Case study: Good practice in developing waiting list procedures and monitoring waiting lists and times in primary care trusts

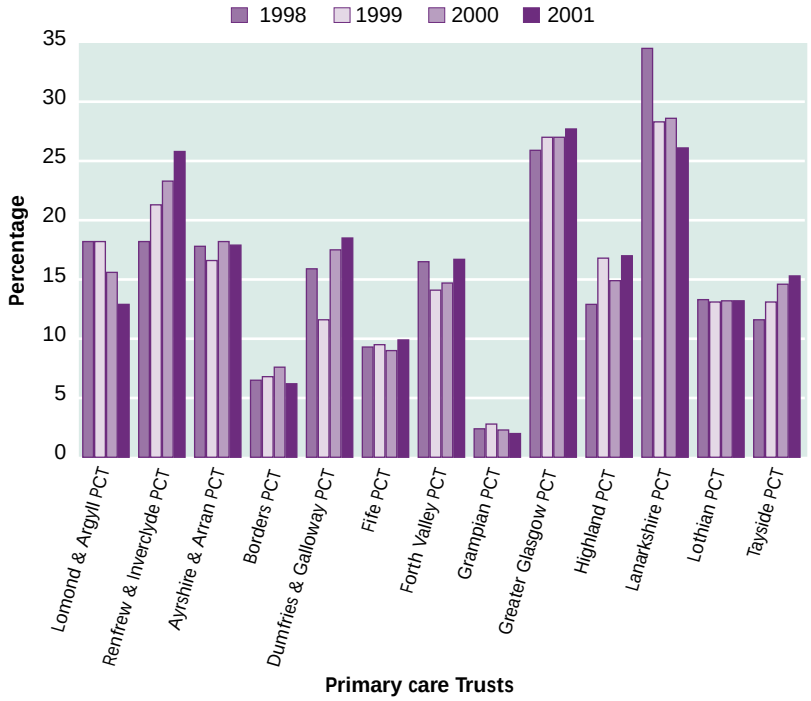
Renfrewshire & Inverclyde Primary Care Trust uses a procedures manual, which is given to all those involved in waiting list management.This is also available electronically.

Lanarkshire Primary Care Trust has implemented a comprehensive and effective monitoring system across all its services to manage the time that patients wait according to clinical need. A template has been developed to help clinical teams structure clinical information, helping it ensure consistency in data collection and simplifying reporting mechanisms.

Greater Glasgow Primary Care Trust has developed a comprehensive waiting times reporting mechanism with a standardised approach to all the services it provides.

Information for patients asking them to contact the trust if their details change or they no longer require treatment is provided by all trusts, either in appointment cards or information leaflets. Do not attend (DNA) rates are generally high for first appointments at consultant-led outpatient clinics in primary care trusts. This overall figure is distorted slightly by mental health specialties where non-attendance is significantly higher than other specialties. Nevertheless it is a significant enough factor to need active management. Exhibit 14 shows a significant variation in the DNA rates among primary care trusts.

Exhibit 14: Do not attend rates for first outpatient appointments in primary care trusts



Note: 2001 figures are provisional.

Source: ISD

Some trusts are more proactive in contacting patients before their appointments in an attempt to reduce the number of patients who do not attend. There may be opportunities for trusts to share good practice.

General issues in both acute and primary care trusts

In addition to the specific issues for acute and primary care trusts outlined above there are a number of more general issues. These include:

- the provision of information to patients, the public more generally and other health care professionals involved in a patient's care
- the developing role of unified health boards in measuring trust performance in managing waiting lists and waiting times
- intervention when waiting lists or times are becoming too long because of problems such as recruitment and retention of specialist staff.

Availability of information

In general, contrary to accepted good practice[12], there is little published information available for patients in particular, and the public more generally, on waiting list sizes in individual trusts and expected waiting times.

Patients should be actively involved in decisions about their own health care. This means that, when they are added to a waiting list for diagnosis or treatment, they should be told:

- which list they are being added to, true or deferred, whether a Guarantee exception code has been applied, and the implications that these have for waiting times guarantees.
- how long the waiting list is and what the expected waiting time is likely to be.
- what happens if they cannot attend for an offered admission date and they let the trust know in advance. In this case they should remain on the true waiting list with a Guarantee exception code 2 applied and are no longer covered by a waiting times guarantee.
- what happens if they do not attend an appointment without letting the hospital or clinic know in advance. In this case they should be added to the deferred list and will no longer be covered by a waiting times guarantee.
- what happens if they are admitted for treatment but are sent home because they are unfit for surgery. In this case they should be added to the deferred list and will no longer be covered by a waiting times guarantee.

Patients should also be kept updated about their progress on the waiting list, and how much more time they are likely to wait. Audit Scotland found that trusts, in general, do not have comprehensive protocols on waiting list information for patients. This means that, although healthcare professionals may keep patients informed on an individual basis, trusts and patients have no standard against which to measure performance in this area.

Patients, in discussion with their GPs, should be able to make informed choices about where they are referred for treatment taking a number of factors into account, including the size of waiting lists in trusts and the likely waiting times for treatment (accepting that waiting times will be largely determined by clinical priorities). At present, information on waiting lists and waiting times across Scotland is collated by ISD but is not made routinely available to the

[12] Council of Europe, Committee of Ministers. Recommendation No R (99) 21 of the Committee of Ministers to member states on criteria for the management of waiting lists and waiting times in health care. Adopted on 30 September, 1999.

public in a user-friendly format. Many trusts hold regular meetings with their local health councils where waiting lists and times are discussed but the information provided is rarely made available in published reports.

Role of unified health boards

Unified health boards (UHBs) should receive regular reports on waiting lists and waiting times. The UHBs need to satisfy themselves that trusts have the appropriate systems in place to manage waiting lists and waiting times, and that they hold trusts to account for performance in managing the lists.

Unified health boards are held to account by the Scottish Executive Health Department through accountability reviews and a new Performance Assessment Framework (PAF). The current PAF contains one indicator relating to waiting lists and six relating to waiting times (Exhibit 15).

Exhibit 15: Current PAF indicators relating to waiting lists and times

Area	Indicator
Fair access to healthcare services	
Waiting lists	Progress towards reduction of inpatient/daycase list to 75,000 by March 2002
Patients' experience, including service delivery	
Waiting times	Patients seen within 9 weeks for new outpatient appointment
	Mean wait for inpatient/day case admissions from the waiting list
	Percentage of patients with a guarantee waiting more than 9 months for treatment
	Percentage of patients waiting more than 12 weeks maximum for angiography after seeing a specialist
	Percentage of patients waiting more than 24 week maximum wait for surgery or angioplasty following angiography
	Percentage of patients with urgent referral for breast cancer waiting more than one month for treatment following diagnosis (where clinically appropriate)

The PAF does not cover all relevant waiting time issues. At present those patients on deferred waiting lists are not covered by waiting times guarantees and therefore are excluded from the indicators in the PAF. Also, patients waiting for outpatient care in non-consultant led services, such as those waiting for an appointment with a physiotherapist, are also excluded. This latter issue makes the application of the PAF to primary care trusts of limited value in terms of waiting lists and times. This is likely to remain the case until information collection in primary care is more comprehensive and subject to national definitions and data collation. Because of these factors, UHBs should monitor against their own health plans and local targets for waiting times so that these issues are addressed alongside national targets.

Audit Scotland recommends that the Health Department considers amending the PAF to take account of the mean waiting time on both true and deferred waiting lists, and waiting times for all outpatient appointments.

Management interventions

Once a patient is placed on a waiting list the trust has a duty of care to ensure that they will receive treatment[13]. Trusts need to have in place systems for identifying patients who are at risk of having their waiting time guarantee breached. All trusts have mechanisms in place to highlight patients in this category. However in orthopaedics, which is the specialty that Audit Scotland sampled in all trusts, nine patients were found who had been waiting just over 12 months for treatment. This suggests that the early warning systems are not preventing patients exceeding the waiting times guarantee. This will remain an issue as waiting time guarantees are reduced to nine months.

Over recent months there have been a few highly publicised reports of 'closed' waiting lists in some trusts. These cases have been largely attributable to a lack of specialist staff such as psychologists and dermatologists and have led to increasingly long waiting lists. The Health Department has recently issued a circular to all trusts instructing them not to close any waiting lists[14]. However, it is not acceptable to simply leave a list to grow ever larger; management action is required to ensure that patients do not suffer as a result.

[13] Council of Europe, Committee of Ministers. Recommendation No R (99) 21 of the Committee of Ministers to member states on criteria for the management of waiting lists and waiting times in health care. Adopted on 30 September, 1999.

[14] News Release SE 5076/2001. December 2001

Problems such as this need to be actively monitored, and all trusts need to ensure that they have early warning systems and contingency plans in place to identify and manage potential waiting list problems.

Audit Scotland found no formal written policies or procedures to deal with 'closed' lists or those under extreme pressure, although most trusts had informal strategies. This is a gap that needs to be rectified as a matter of urgency. The development of such policies would be helped by national definitions of what is an acceptable length of wait for each service. Although these policies would then need to be locally determined, depending on the service and the circumstances, as a minimum they should:

- provide for effective risk management by reviewing clinical priorities for patients on the list
- include ways of keeping patients and referring GPs informed
- clearly state at what point the UHBs should be involved so that each individual board has the opportunity to work with its local trusts in taking early corrective action
- if possible, identify alternative treatment options, including the use of different locations and clinicians.

UHBs should inform the Health Department where local action cannot resolve the issue. The new Waiting Times Unit has been set up to 'crack local waiting times problems and speed up treatments within NHSScotland'[15]. One of its stated tasks is to co-ordinate a regional or national response wherever there is a significant local delay in treatment times. The Unit is also tasked with developing Scotland's first national early warning system for where patients are waiting a long time for treatment.

[15] News release SE5129/2002. January 2002

Moving forward

Conclusions

Audit Scotland found no evidence of systematic or deliberate irregularities in the management of waiting lists. However, we found some inconsistencies across Scotland in the administration of waiting lists and some gaps in the provision of information.

Audit Scotland recommends a number of actions for trusts, unified health boards, ISD and the Health Department to improve practice in waiting list management and to address issues identified in the review. Although the review was focused on the management of waiting lists, the recommendations apply equally to the shift in focus to the management of waiting times.

This report has highlighted the value of reviewing, on a Scotland-wide basis, waiting list systems. Audit Scotland may revisit this issue in the future to ensure that recommendations for improving the management of waiting lists have been implemented. At the same time Audit Scotland would review unified health boards' arrangements for monitoring and strategic management of waiting times.

Recommendations

Acute trusts

Acute trusts should ensure:

- consistent application of waiting list policies and procedures across the whole trust
- all new staff are trained in applying polices and procedures and refresher training provided for existing staff
- ongoing monitoring of staff applying policies and procedures
- adequate administrative cover for sickness and annual leave to ensure no delays in recording patients
- clear levels of security access to waiting list systems in line with current guidance[16].

All patients waiting for services should be entered onto a waiting list to allow monitoring of the time waiting and early warning of pressures in service areas.

[16] '*Protecting patient confidentiality, final report*',The Confidentiality and Security Advisory Group for Scotland, 2002.

Waiting times on deferred lists should be monitored routinely.

Primary care trusts

All primary care trusts should have written protocols and procedures for waiting lists and times for all services.

There should be investment in systems to allow collation and monitoring of waiting lists and times for all primary care trust activity. Once these systems are in place, all recommendations relating to acute trusts will also apply to primary care trusts.

All trusts

Patients should be routinely informed about the implications for waiting time guarantees when they are placed on a deferred waiting list, or have a Guarantee exception code applied.

To reduce the DNA rate, patients should be contacted routinely to ensure that circumstances have not changed.

All trusts should develop formal early warning systems and contingency plans to identify and manage potential waiting list problems.

Trusts should develop and provide regular information for patients, GPs and the public about waiting lists and waiting times for all services.

Unified health boards

All unified health boards should review their arrangements for monitoring waiting lists and times in all trusts and should satisfy themselves that appropriate governance arragements are in place.

Health Department

The Health Department should consider amending the Performance Assessment Framework to include other waiting times issues, the mean time waiting on deferred lists, as well as times waiting for non-consultant outpatient clinics. Waiting time targets for non consultant-led outpatient services should also be considered across both acute and primary care trusts.

Guidance for the management of low clinical priority cases should be considered.

Information and Statistics Division

ISD is currently undertaking work to review definitions associated with waiting lists and times. Audit Scotland recommends that this review should include:

- developing definitions which reflect current medical practice, such as the move from day case to outpatients procedures, to ensure that perverse incentives do not remain
- strengthening definitions relating to 'cannot attend' and 'do not attend'
- producing definitions for primary care services.

In addition, ISD should:

- review the rationale of a deferred waiting list to ensure that patients are not disadvantaged by being placed on this list
- progress the consistent recording of outpatient procedures in conjunction with all trusts.

Appendix 1: Definitions

These are extracted from the full ISD definitions which can be accessed on www.show.scot.nhs.uk/isd

Inpatient

An inpatient is a patient who occupies a bed and who either:

- remains **overnight** (whatever the original intention, eg a day case who is unfit to go home at night); or
- at **admission**, is expected to remain overnight but is discharged earlier or dies; or
- is a mother who delivers in hospital and goes home the same day; or
- is admitted as an **emergency or urgent case**, regardless of length of stay; or
- is a patient allowed out of hospital "on pass" (patients can go 'home' on pass for up to 28 days in psychiatric specialties, and up to five days in other specialties and still be recorded as an inpatient).

Elective admission

An elective admission is a patient who does not present as an emergency and who is able to wait for treatment.

Day case

A day case is a patient who

- makes a planned attendance for clinical care (often a procedure), carried out by a doctor or dentist;
- requires the use of a bed (for recovery);
- is **not** expected to remain overnight (and would be reclassified as an inpatient if they did).

Many of these patients require some form of anaesthesia, eg

- general anaesthetic; or
- another type of anaesthetic that requires the presence of an anaesthetist; or
- the patient is sedated and requires a substantial recovery period.

Outpatient

An outpatient is a patient who:

- attends a **scheduled clinic** for which at least one consultant is responsible; or
- is seen by appointment **outwith** a scheduled clinic session.

Outpatients may be new (first appointment after referral) or return patients.

Clinic sessions may be held at a variety of locations (eg outpatient departments, wards, health centres and others)

True Waiting List

The True Waiting List is a list of patients who:

- have to wait for hospital resources to become available before they can be admitted (including patients who are given a date of admission in advance, usually while they are at the outpatient clinic); or
- were offered admission but **could not attend**; or
- are inpatients waiting for a routine transfer to another specialty (usually long stay for the elderly for example).

Waiting Time Guarantees that specify the maximum length a patient should wait for a particular operation or procedure, apply to patients on the true waiting list eg a maximum of 12 months wait for inpatient or day case treatment.

Deferred Waiting List

The Deferred Waiting List is a list of patients who:

- when the decision was made to place them on a waiting list, were under either social or medical constraints which means they could not accept an admission date if offered (eg a patient who has to lose weight before surgery can be carried out); or
- were admitted but sent were sent home soon after because they were unfit for treatment, eg if the doctor discovered high blood pressure, or the patient had a cold that prevented them having anaesthesia; or
- were called for admission but did not attend; or
- are “one-off” holiday or respite admissions. These are admissions usually arranged to give relatives some respite from their caring responsibilities, or to allow families to go on holiday.

Once patients are categorised as deferred, they do not transfer back again to the true waiting list. Patients are admitted from the deferred waiting list but Waiting Time Guarantees do not apply.

Guarantee Exception Codes

Guarantee Exception Codes may be applied to individual patients on the True Waiting List whose circumstances exclude them from receiving any normal Waiting times guarantee for that operation or procedure. They result in Waiting times guarantees no longer being applied for that patient. For example:

- where the patient has asked to defer admission for personal reasons or refused an offer of admission or an outpatient appointment has been rescheduled for his/her convenience (Code 2); or
- in individual cases where, after discussion with the patient, the treatment has been judged of low medical priority (Code 3); or
- with highly specialised treatments identified at the time of placing the patient on the waiting list (Code 4); or
- in circumstances of exceptional strain on the NHS such as a major disaster, major epidemic or outbreak of infection, or service disuruption by industrial action (Code 9).

Reclassification

Is the movement of a patient from one classification category to another for example from day case to outpatient or day case to inpatient or outpatient to day case. This happens when:

- an error is discovered in the original classification;
- the circumstances used to determine the classification have changed, eg the patient no longer requires a general anaesthetic and therefore may be more appropriately treated as a day case, or a patient who was originally classified a day case has to stay in hospital overnight and therefore is reclassified as an inpatient. Sometimes, medical practice changes which means that procedures that used to be carried out as a day case can be undertaken on an outpatient basis.

Appendix 2: NHS trusts and Island health boards included in the review

Primary care trusts

Ayrshire and Arran Primary Care Trust
Borders Primary Care Trust
Dumfries and Galloway Primary Care Trust
Fife Primary Care Trust
Forth Valley Primary Care Trust
Grampian Primary Care Trust
Greater Glasgow Primary Care Trust
Highland Primary Care Trust
Lanarkshire Primary Care Trust
Lomond and Argyll Primary Care Trust
Lothian Primary Care Trust
Renfrewshire and Inverclyde Primary Care Trust
Tayside Primary Care Trust

Acute trusts

Argyll and Clyde Acute Hospitals NHS Trust
Ayrshire and Arran Acute Hospitals NHS Trust
Borders General Hospital NHS Trust
Dumfries and Galloway Acute and Maternity NHS Trust
Fife Acute Hospitals NHS Trust
Forth Valley Acute Hospitals NHS Trust
Grampian University Hospitals NHS Trust
Highland Acute Hospitals NHS Trust
Lanarkshire Acute Hospitals NHS Trust
Lothian University Hospitals NHS Trust
North Glasgow University Hospitals NHS Trust
South Glasgow University Hospitals NHS Trust
Tayside University Hospitals NHS Trust
The Yorkhill NHS Trust

West Lothian Healthcare NHS Trust (a combined acute and primary care trust)

Island boards

Orkney Health Board
Shetland Health Board
Western Isles Health Board

Appendix 3: External reference panel and review team

External Reference Panel

Kate Harley	Head of Data Intelligence Group, ISD
Mike Lyon	Waiting Times Unit, Scottish Executive Health Department
Peter Gabbitas	Chief Executive, West Lothian Healthcare NHS Trust
Andrew Gardiner	Acting Director, Scottish Association of Health Councils
Iain Wallace	Medical Director, Greater Glasgow Primary Care Trust

Four nominations were also received from medical directors from acute trusts. Due to the timescales involved, these nominations were received after the approach had already been validated and therefore it was not possible to recruit a representative from the four.

Review team

Judith Acton	Audit Scotland
Tricia Meldrum	Audit Scotland
Rhona Jack	Audit Scotland
Thelma Milne	Consultant (ex NHS Information Manager)
Mary Jack	Secondee (current NHS Medical Records Manager, Glasgow)
Peter Stephen	Secondee (current NHS Service Manager, Lanarkshire)
Alison Forrest	Secondee (current NHS Service Manager, Grampian)
Lesley Smith	Secondee (currently employed by Scottish Health Advisory Service)

Appendix 4: Sample specialties and patient cohort sizes by trust

NHS Trust	SMR01 Orthopaedics and number of patients in cohort	SMR01 Specialty and number of patients in cohort	SMR3 Orthopaedics and number of patients in cohort	SMR3 Specialty and number of patients in cohort
Argyll & Clyde Acute Hospitals	34	Plastic Surgery 14	38	Plastic Surgery 14
Ayrshire & Arran Acute Hospitals	43	General Medicine 51	43	General Medicine 26
Borders General Hospital	42	ENT 16	23	ENT 6
Dumfries & Galloway Acute and Maternity Hospitals	14	Gynaecology 32	19	Gynaecology 12
Fife Acute Hospitals	60	Gastroenterology 60	46	Gastroenterology 12
Forth Valley Acute Hospitals	60	General Medicine 60	43	General Medicine 20
Grampian University Hospitals	60	Ophthalmology 60	60	Ophthalmology 60
Highland Acute Hospitals	58	ENT 60	30	ENT 6
Lanarkshire Acute Hospitals	38	Plastic Surgery 5	58	Plastic Surgery 9
Lothian University Hospitals	47	Gastroenterology 60	60	Gastroenterology 38
North Glasgow University Hospitals	60	General Surgery 27	60	General Surgery 22
South Glasgow University Hospitals	32	Urology 12	60	Urology 10
Tayside University Hospitals	60	Plastic Surgery 60	60	Plastic Surgery 60
West Lothian Healthcare	24	Gastroenterology 60	12	Gastroenterology 30
The Yorkhill Trust	19	Surgical Paediatrics 60	8	Surgical Paediatrics 45

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