Tackling waiting times in the NHS in Scotland

Key messages / Prepared for the Auditor General for Scotland

February 2006

AUDIT SCOTLAND

Key messages

Background

In this report we:

- review the performance of the NHS in Scotland against current waiting time targets for elective health care[1]
- evaluate whether current approaches to reduce waiting times provide value for money
- assess whether current strategies are likely to achieve sustained reductions in waiting times.

Waiting times are important to patients. Long waits for diagnosis or treatment may prolong pain and discomfort, and increase the time people have to tolerate health problems that affect their daily lives. Waiting to be seen or treated can also cause anxiety to patients, even though for some conditions long waits may not adversely affect clinical outcomes. For these reasons, waiting times are one of the top priorities of the Scottish Executive Health Department (SEHD).

The Scottish Executive has set waiting times targets for most major areas of NHS activity. In this study we examine waiting times for inpatients and day cases, and new outpatients.[2] No patient with a guarantee should wait longer than six months to be seen or treated by the end of 2005. We also assess performance against waiting time guarantees for certain cardiac procedures.

Main findings

The NHS in Scotland has made significant progress towards meeting waiting time targets.

At the end of September 2005, 109,992 patients were waiting for inpatient or day case treatment, 3% higher than at 31 March 2001 but down slightly from its peak of 114,052 in December 2004. The number of patients with a waiting time guarantee who had been waiting over six months fell from 11,573 at 31 March 2001 to 1,249 at 30 September 2005 (Exhibit 1).

The latest waiting times information shows that the percentage of patients who waited more than six months for their treatment increased from 10% in March 2001 to 15% in December 2003, before decreasing to 9% in September 2005.

The total number of new outpatients waiting for an appointment fell by 20% from 265,228 at 30 September 2004 to 210,586 at 30 September 2005. Over the same period, the number of new outpatients with a waiting time guarantee waiting over six months fell from 53,579 to 11,854.

The percentage of outpatients who waited longer than six months for a first outpatient appointment fluctuated between 9% in March 2001 and a peak of 19% in March 2005, before falling back to 10% in September 2005.

The total number of people waiting for inpatient and day case treatment has changed little in the last two years. Also, the number of people without waiting time guarantees has increased, and most of these patients have been waiting over six months.

Together with changes in the way waiting time guarantees will be applied from the end of 2007, these trends suggest that the NHS will face a major challenge in meeting more ambitious targets in the future.

New targets have been set for inpatients and day cases and for new outpatients. By the end of 2007, no patient should wait more than 18 weeks to be seen or treated. At the same time, Availability Status Codes (ASCs) will be abolished.[3] The abolition of ASCs means that after 2007, periods of unavailability will be subtracted from patients' total waiting times. Low clinical priority and highly specialised treatments will no longer be reasons to exclude patients from waiting time guarantees.

At 30 September 2005, there were 35,048 patients without a guarantee waiting for inpatient or day case treatment – around 32% of all patients waiting. The number of patients without a guarantee has increased by 6,699 since 30 June 2003. Just over two-thirds (23,568) of these patients had been waiting over six months and four-fifths (28,142) over 18 weeks.

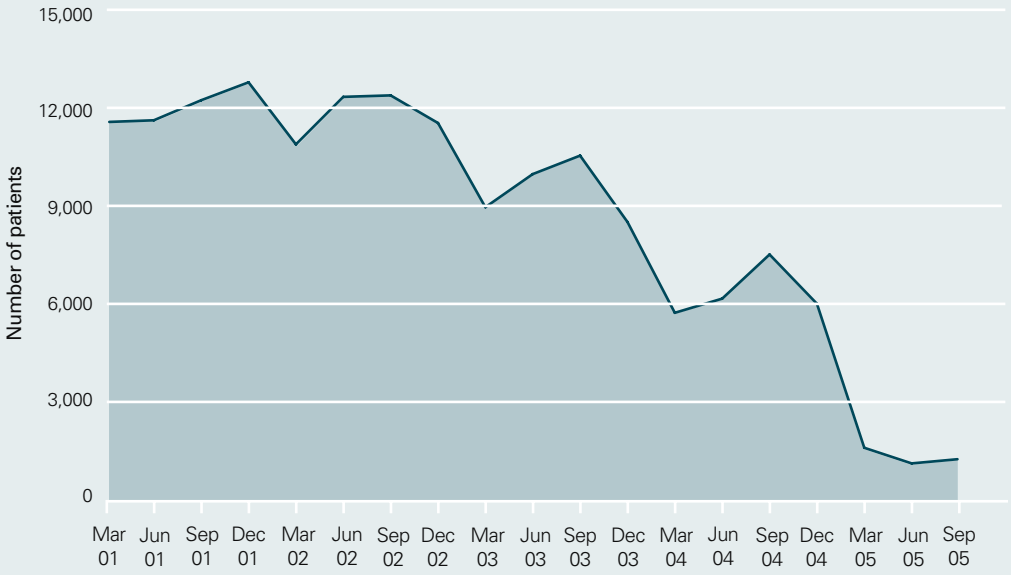
As the number of patients with a guarantee waiting over six months fell between June 2003 and September 2005, the number of patients without a guarantee waiting over six months and the number waiting between 18 weeks and six months increased. The total number of patients waiting less than 18 weeks also increased.

1 Elective healthcare is planned healthcare given at a prearranged time rather than in response to an emergency. It includes routine surgery and outpatient care.
2 New outpatients are patients waiting for their first appointment after referral to a specialist, typically by a GP.
3 The main reasons for giving patients ASCs are that they are unavailable, medically unfit or do not attend for treatment. Patients with ASCs do not have waiting time guarantees.

Exhibit 1

Inpatients and day cases with waiting time guarantees waiting over six months, March 2001 to September 2005

The number of patients with a guarantee waiting longer than the six-month target fell from 11,573 in March 2001 to 1,249 in September 2005.



Source: ISD inpatient and day case waiting list census

The growing number of people without a guarantee who are currently waiting over 18 weeks, together with the fact that the total number on the waiting list has changed little in recent years, suggests that the NHS will face major challenges in meeting the more ambitious targets in the future, especially when ASCs are abolished in 2007.

Activity has increased at the Golden Jubilee National Hospital (GJNH) and cost per case has fallen. But the NHS in Scotland could get better value for money from the resources invested in tackling waiting times, by making more efficient use of the GJNH and by reducing the need for high-cost increases in activity paid for with non-recurring funding.

The NHS in Scotland has invested substantially in reducing waiting times. In 2004/05, nearly £77 million was spent through the National Waiting Times Unit (NWTU), the Centre for Change and Innovation (CCI) and the GJNH. In addition, boards spent over £39 million from their own funding allocations to tackle waiting times locally. These sums are only a small proportion of all the money spent. Most patients on waiting lists are treated through the normal delivery of services so it is not possible to measure the total spending that is used to reduce waiting times.

The GJNH was established as the National Waiting Times Centre in June 2002 to help reduce waiting times. In 2004/05, 18,509 patients were seen or treated at the GJNH and it has exceeded its overall activity targets each year since it was established, but its use by boards and by specialty varies. Average cost per case has fallen due to increased activity and changes in the type of activity undertaken, but costs remain relatively high compared to other Scottish hospitals.

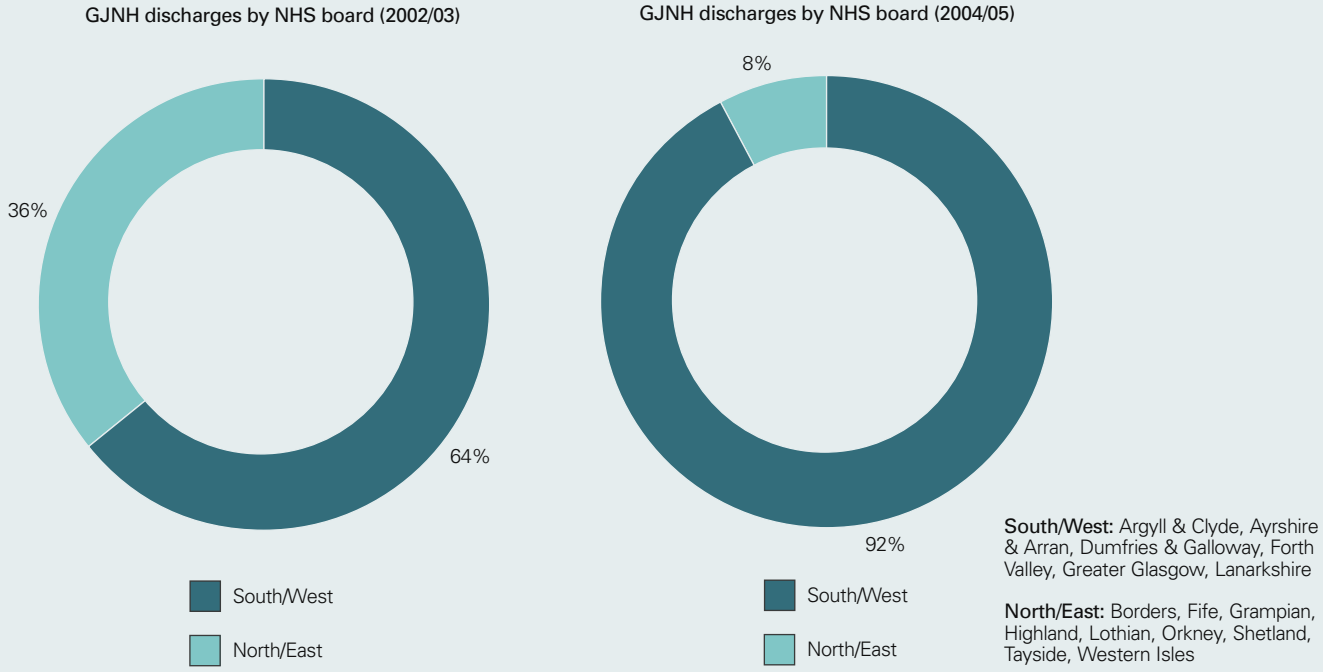
The high costs at the GJNH are due to several factors:

- Nearly all the currently available capacity at the GJNH is allocated to NHS boards by the NWTU, but not all of the allocations are taken up and some of the capacity at the hospital has not yet been brought into use.
- The number of patients treated has been less than available capacity and allocated activity in some specialties, for example, orthopaedic joint procedures. Also, in orthopaedics, the GJNH carries out a relatively high proportion of joint replacement procedures which are expensive due to the high cost of the prostheses used. In other specialties, such as ophthalmology, activity has been higher than planned.
- There are marked geographical variations in use of the GJNH. NHS boards in the south and west of Scotland make more use of the GJNH than boards in the north and east. This difference has increased over time (Exhibit 2).
- Most medical staff at the GJNH are employed by local boards and are paid at higher rates when they treat patients at the GJNH.

Exhibit 2

Golden Jubilee National Hospital discharges

An increasing percentage of patients treated at the GJNH is from the south and west of Scotland.



Source: ISD

In 2004/05, the GJNH had a high number of cancelled operations and a marked increase in activity in the final quarter of the year. NHS boards and the GJNH could make a further contribution to tackling waiting times by working more closely together to improve the way activity is planned. This would help the GJNH recruit more permanent staff and increase value for money. It requires a review of the processes for allocating activity and managing referrals to the hospital, and a review of the role of the GJNH. The opening of the new regional cardiothoracic centre represents a move in this direction.

Other measures to reduce waiting times rely heavily on non-recurring funding. They include referring patients to hospitals in the private sector and treating more patients in NHS hospitals in the evening or at weekends. The pay rates for medical staff carrying out this work are higher than the rates paid in core NHS contracts. We acknowledge that it may be appropriate to use non-recurring funding to treat the high numbers of patients waiting a long time but the current emphasis on this approach should be reviewed in light of the progress made in reducing the number of patients with the longest waits.

Involving patients in decisions about where they are treated has the potential to help reduce waiting times but is not common practice within the NHS in Scotland.

Patient involvement can improve patients' experiences of health care and help to reduce waiting times. Offering patients treatment at the GJNH also has the potential to increase use of the hospital.

Boards making less use of the GJNH suggested that many patients were not willing to travel to the GJNH for treatment. However, we found that not all boards actively encourage use of the GJNH and our survey of patients' views on travelling to alternative hospitals to reduce waiting times showed that less than 5% of the respondents were offered treatment in an alternative location.

Our survey found that two-thirds of people currently waiting for treatment and around half of people treated in the last year, would have been willing to travel to reduce the time they wait for treatment. Factors affecting patients' views in order of importance were their length of wait, the distance to travel, the expertise and reputation of the consultant, the severity of their condition and the reputation of the hospital.

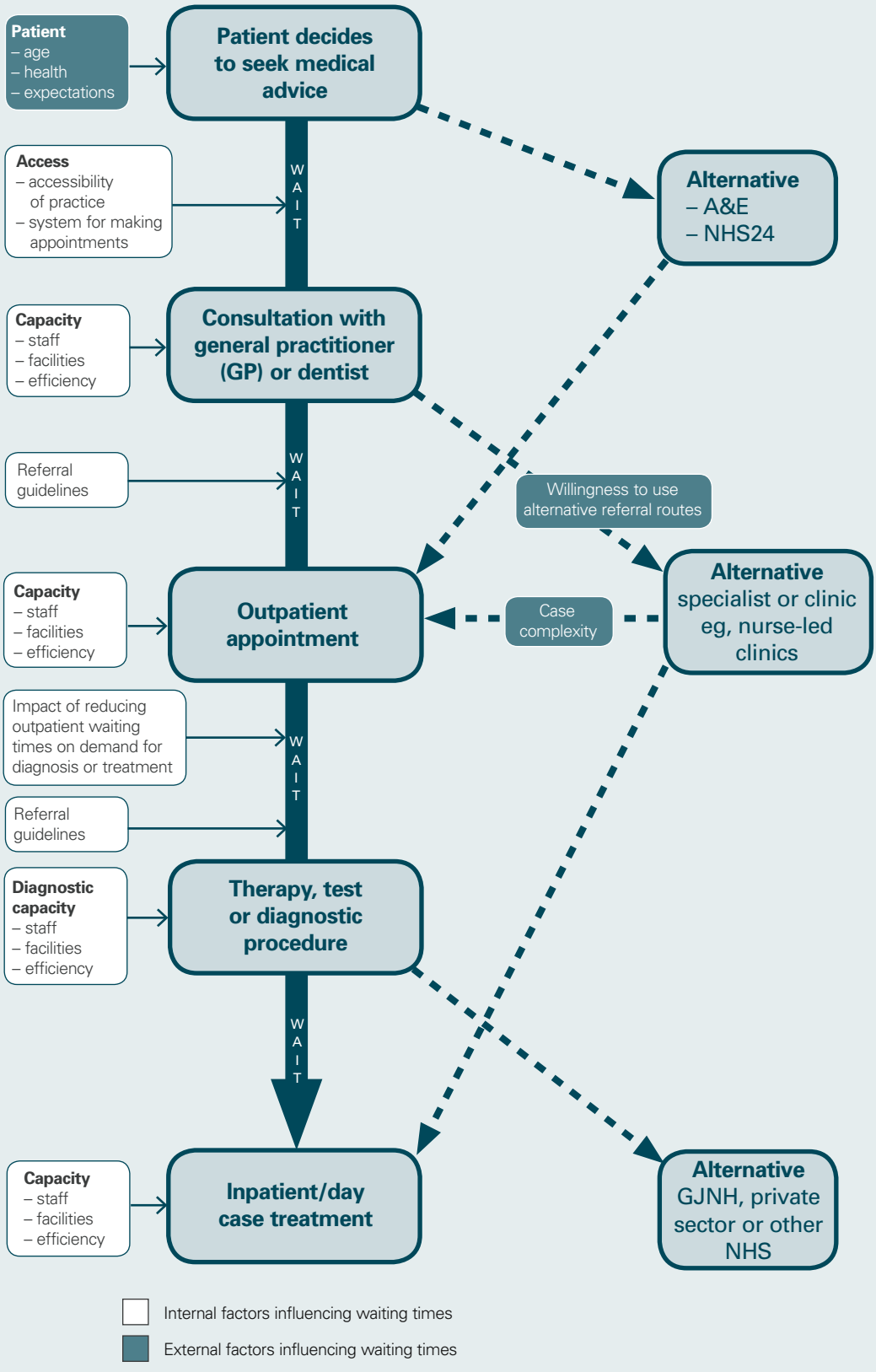
The NHS in Scotland needs to further develop whole system approaches to tackle waiting times.

Health and community care is a complex system made up of smaller interrelated systems. These include hospital services such as elective care, emergency care and outpatients, and community-based services such as those provided by GPs. Waiting lists and waiting times are affected by each part of the system and by the links between them (Exhibit 3). Whole system approaches are therefore needed to tackle waiting lists and waiting times, a message reinforced in recent policy statements by the SEHD.

Exhibit 3

Factors influencing waiting times across the whole system of care

A number of factors can influence the time that patients have to wait to be seen or treated.



Source: Audit Scotland

The length of time that patients wait at each point in the system is influenced by three sets of factors:

- the demand for care
- the health care capacity available and the efficiency with which it is used
- the way in which the waiting list is managed by managers and clinicians.

To achieve and maintain shorter waiting times it is necessary to address the root causes of long waits. Evidence suggests that short-term increases in activity at particular points in the system do not lead to sustained reductions in waiting times.

Successful strategies to reduce waiting times involve:

- analysing patients' routes through the health system
- identifying the causes of bottlenecks that slow down patient flows, including pressures arising from the demand for emergency care or avoidable return outpatient appointments
- increasing the efficiency of staff and facilities, for example, by increasing the time operating theatres are in use, treating more cases per theatre session or treating more patients as day cases
- redesigning services to simplify and shorten the referral and treatment process, for example, by developing community-based alternatives to consultant-led care
- using information on variations in performance among individual doctors and other health care professionals to change working practices.

Temporary increases in activity can be useful as a short-term strategy to meet targets. They can be used to clear a backlog of patients who have been waiting a long time, where permanent increases in capacity are not required. But they should be used as part of a planned process for achieving and maintaining shorter waiting times. Over-reliance on short-term measures, such as staff working in the evening or at weekends, can be expensive and does not address the long-term balance between demand and capacity.

There are examples across the NHS in Scotland of innovative projects taking a whole system approach to reduce waiting times. But, to meet more demanding targets in the future, the NHS in Scotland needs to place a stronger emphasis on whole system approaches to tackling waiting times.

Our study

In carrying out our study we:

- analysed trends in waiting lists and waiting times for non-emergency hospital care
- examined the funding targeted at improving waiting times
- interviewed clinical staff and senior managers in the NHS in Scotland and in the SEHD about the management of waiting lists and waiting times
- commissioned a survey of patients' views on what influences their willingness to travel to reduce the time they wait for treatment.

The main report makes a number of recommendations to the SEHD, NHS boards, the GJNH and Information Services Division (ISD).

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