

Managing NHS waiting lists

A review of new arrangements



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Summary



The NHS has done well to implement the new arrangements but information for and about patients needs to improve.



Background

1. The time patients wait for treatment is important to them. On 30 September 2009, approximately 307,000 people in Scotland were waiting for a new outpatient appointment or for admission to hospital as a day case or inpatient.¹ The NHS in Scotland needs to manage patients' waits in line with national guidance and waiting times targets. In 2004, the Scottish Executive announced a new approach to managing patients' waiting times, known as New Ways, which came into effect on 1 January 2008.²

2. New Ways guidance set out how NHS boards should manage patients' waits and measure and report waiting times consistently. It was intended to:

- set out fair and appropriate procedures for patients who do not or cannot attend, cancel or refuse a reasonable offer of an appointment
- make explicit the shared responsibility of patients, GPs and hospital services
- replace a system whereby patients who were unavailable for medical or social reasons could lose their guarantee of a maximum waiting time.³

3. The new system introduces the concept of a waiting time clock to calculate the time that patients wait. This clock records the time between the hospital adding a referral for an outpatient appointment or treatment to the waiting list and a patient's appointment or admission. It excludes periods when the patient is unavailable for treatment for medical or social reasons, such as having another medical condition which needs to be treated first or being on

holiday. While patients can be added to the list and recorded as medically or socially unavailable, hospitals must review their status within 13 weeks to ensure that they do not stay on the waiting list indefinitely. This replaces the previous system where NHS boards could apply an availability status code (ASC) to some patients, including patients who were unavailable for medical or social reasons, which excluded them from waiting time guarantees.

4. The new guidance places responsibilities on patients, who are expected to accept a reasonable appointment offer. This is defined as offering the patient up to two dates with a minimum of seven days' notice. People can be taken off the waiting list and referred back to their GP if, having been given a reasonable offer, they do not attend their appointment without informing the hospital in advance. [Exhibit 1 \(overleaf\)](#) outlines the New Ways guidance and what this means for patients.

About the study

5. This study looks at whether NHS boards are complying with the new guidance for managing patients and recording information. It also looks at the impact on patients, particularly whether they are being disadvantaged by the new arrangements. The review did not focus on performance against waiting times targets, although we do make reference to this for context.

6. [Appendix 2](#) details the methodology. In summary, the study involved:

- analysing national data on waiting times and the number of people on waiting lists

- surveying all 14 NHS boards to identify what New Ways information they record and reviewing their policies and patient information

- reviewing a sample of patient information recorded by NHS boards for three specialties: orthopaedic outpatients, inpatients and day cases; dermatology outpatients; and oral surgery inpatients

- interviewing staff at a sample of four NHS boards, the Scottish Government, ISD Scotland and the Royal College of General Practitioners (RCGP)⁴

- conducting a survey and focus groups with people who had recent experience of waiting for healthcare.⁵

7. This report is in three main parts:

- [Waiting times \(Part 1\)](#).
- [Applying the new guidance \(Part 2\)](#).
- [What the new arrangements mean for patients and the NHS \(Part 3\)](#).

8. We have produced a separate document of issues for NHS board non-executive directors to consider. This is available from the Audit Scotland website www.audit-scotland.gov.uk

1 Waiting times statistics, ISD Scotland, <http://www.isdscotland.org/isd/3454.html>

2 *Fair to All, Personal to Each*, Scottish Executive Health Department, 2004.

3 *New Ways of defining and measuring waiting times – Applying the Scottish Executive Health Department guidance, version 3.0*, ISD Scotland, 2007.

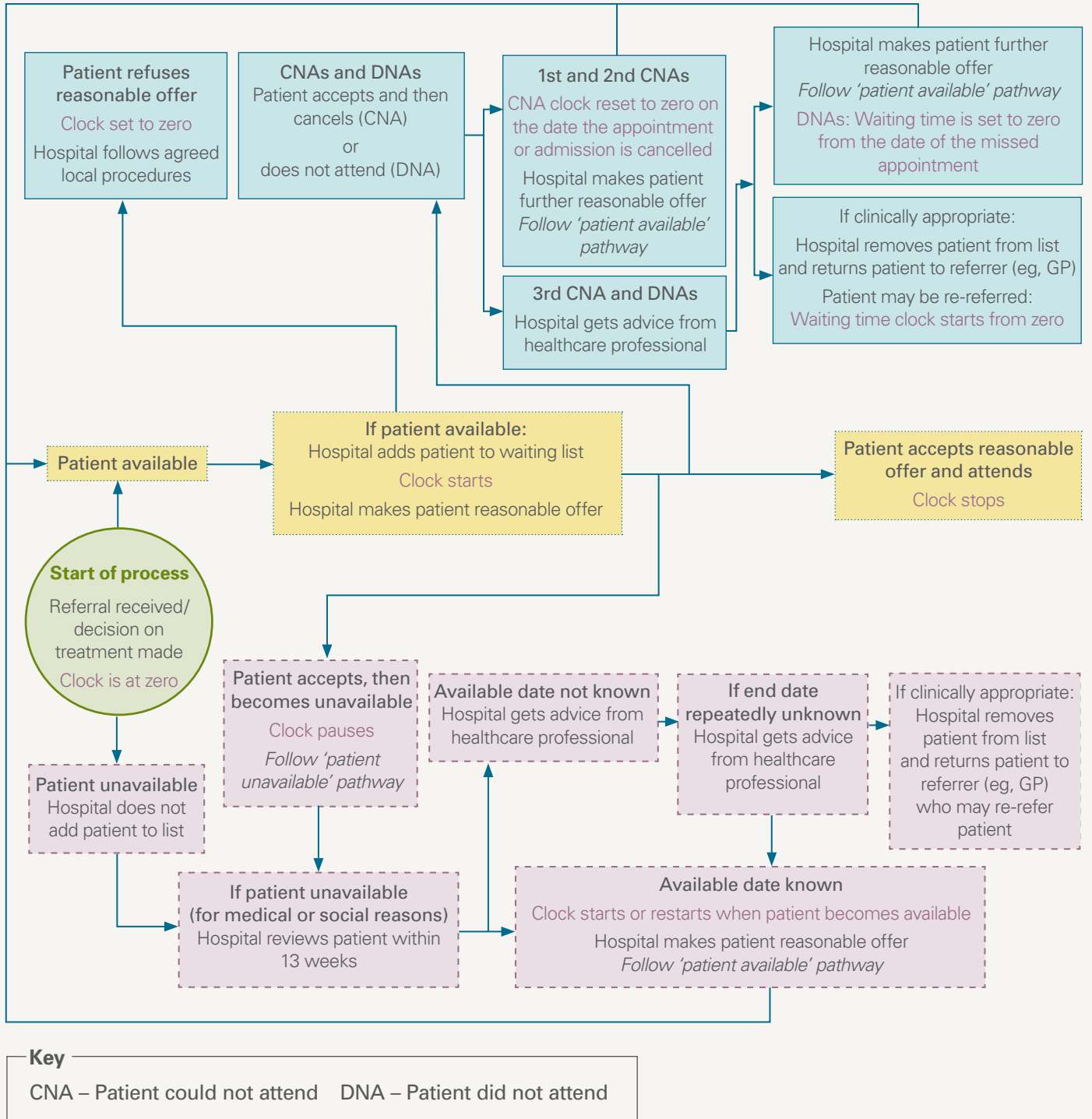
4 NHS Forth Valley, Highland, Lothian and Western Isles.

5 This work was carried out by George Street Research.

Exhibit 1

New Ways guidelines

New Ways introduced a new approach to managing patients' waits.



Key messages

- New Ways has stopped people remaining on waiting lists indefinitely. It introduced significant changes to the way patient waits are managed, and the NHS has done well to implement the new arrangements.
- New Ways is intended to ensure that all patients are managed consistently and fairly. NHS boards are able to apply elements of the guidance differently to reflect the clinical needs of patients and this has led to some differences in how patients are managed. NHS boards are recording most information required under the new guidance, but there are some gaps in recording data about reviews of patients who are unavailable and about transfers which make it difficult to demonstrate that they are managing these patients in the right way.
- Information for patients, and about patients, needs to improve to ensure that the new system operates effectively. Shorter waiting times mean that patients get less notice of appointments, and the NHS needs to communicate well to avoid any confusion or delays that may affect patients being able to attend.

Key recommendations

NHS boards should:

- record all New Ways data, including information on patient reviews and transfers, to ensure that all patients are being managed in line with the guidance and that this is demonstrated in a clear way
- improve systems for recording patients' additional needs and put appropriate support in place for those who need it
- ensure that communication with patients takes account of any need for additional support and tailor information to meet these needs
- continue to work with primary care to improve communication with patients, so that both primary care staff and patients are clear about their responsibilities under the new system, particularly the implications for patients of not attending their appointments
- use the Audit Scotland checklist detailed in [Appendix 4](#) to help improve how they manage waiting lists.

The Scottish Government and ISD Scotland should:

- consider issuing additional guidance about the treatment of patients who do not or cannot attend appointments to make sure that patients are managed fairly across Scotland, while still allowing for clinical judgement.

Part 1. Waiting times



The new arrangements have stopped people remaining on waiting lists indefinitely.



Key messages

- Waiting time targets have come down considerably in recent years and these targets now apply to patients who were previously excluded from the guarantees.
- New Ways has introduced clear arrangements for managing patients who are not available for an appointment or treatment, and it has stopped patients having to wait indefinitely.

Waiting times have reduced considerably in recent years

9. The maximum waiting time targets have reduced progressively in recent years (Exhibit 2).^{6,7} The current standard is 15 weeks (105 days) for a new outpatient appointment and up to a further 15 weeks for an inpatient or day case appointment.⁸ Both standards are reducing to 12-week targets by 31 March 2010. For the three months ending 30 September 2009, the average waiting time for an outpatient appointment was just under seven weeks (47 days) and 99.9 per cent of patients waited 15 weeks or less.⁹ The average waiting time for inpatients and day cases was just over four weeks (29 days) and 99.9 per cent of patients waited 15 weeks or less.¹⁰

10. From December 2011, a new target will be introduced. This will be a combined maximum wait of 18 weeks (126 days) between a patient being referred and the start of their treatment, including any tests and outpatient appointments.¹¹

Exhibit 2

Waiting times targets, 2005 to 2011

The maximum waiting time targets have reduced progressively in recent years and are planned to reduce further.

New outpatient appointment	Hospital inpatient or day case admission
–	9 months by 31 December 2003 ¹ (274 days)
26 weeks by 31 December 2005 ² (182 days)	26 weeks by 31 December 2005 ³ (182 days)
18 weeks by 31 December 2007 ⁴ (126 days)	18 weeks by 31 December 2007 ⁵ (126 days)
15 weeks by 31 March 2009 ⁶ (105 days)	15 weeks by 31 March 2009 ⁷ (105 days)
12 weeks by 31 March 2010 ⁸ (84 days)	12 weeks by 31 March 2010 ⁹ (84 days)
18 weeks from 31 December 2011 from referral to treatment (126 days) ¹⁰	

Notes:

1. *Partnership for Care: Scotland's Health White Paper*, Scottish Executive, 2003.
 2. *A partnership for a better Scotland*, Scottish Executive, 2003.
 3. *New targets for waiting times*, Scottish Executive, June 2002.
 4. *Fair to All, Personal to Each*, Scottish Executive Health Department, December 2004.
 5. *Ibid.*
 6. NHS Scotland Performance Targets – Access, Scottish Government, <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets/Access> (as at February 2010).
 - 7, 8, 9. *Ibid.*
 10. *Better Health, Better Care: Action Plan for NHS Scotland*, Scottish Government, December 2007.
- Source: Adapted from ISD Scotland, <http://www.isdscotland.org/isd/4657.html>

11. It is not possible to directly compare waiting times before and after New Ways was introduced because the previous arrangements excluded patients with an ASC code from the national statistics. However, looking at the average length of time that people wait and at how long most patients (90 per cent) wait indicates that there has been an improvement (Exhibit 3, overleaf). Longer waits can indicate services that are under pressure and at risk of not meeting waiting time standards. Across Scotland, 90 per cent of inpatients and day cases were seen within just over ten weeks (72 days)

for the quarter ended September 2009.^{12, 13} This was well within the waiting time standard of a maximum wait of 15 weeks.

12. In addition to reducing the average length of wait, the NHS has been successful in reducing the number of patients waiting for longer periods of time (Exhibit 3). Between March 2008 and September 2009, the percentage of patients waiting more than 12 weeks for inpatient or day case treatment fell from almost 17 per cent to almost one per cent, while the figure for outpatients reduced from 25 per cent to one per cent.

6 These targets do not cover all patients. There are separate targets for cardiology, cardiac surgery, cataract surgery, cancer treatment, hip fractures, diagnostic tests and waits at emergency departments.

7 The waiting times targets do not apply to mental health and obstetric patients. The outpatient target does not apply to patients waiting for a homeopathy appointment or those who have not been referred by a GP or General Dental Practitioner (GDP).

8 When the delivery date for a target has been reached that target becomes a standard.

9 In this report, we use the word average when we are referring to the median. The median is the number in the middle when the values are put in order from lowest to highest.

10 *Waiting Times: Statistical Publication Notice*, ISD Scotland, 24 November 2009, <http://www.isdscotland.org/isd/6059.html>

11 *18 weeks: The Referral to Treatment Standard*, Scottish Government, 2008.

12 This is known as the 90th percentile.

13 *NHS Scotland: Waiting times for inpatient or day case admission – completed waits for patients seen (30 September 2009)*, ISD Scotland, <http://www.isdscotland.org/isd/5619.html>

Exhibit 3

Length of time waited by patients before and after New Ways was introduced, NHS Scotland
Waiting times have reduced steadily in recent years.

	Before New Ways Year ended				After New Ways Quarter ended				
	March 05	March 06	March 07	Dec 07	March 08	Dec 08	March 09	June 09	Sept 09
Inpatients/day cases									
Average wait (days)	43	43	44	39	34	31	32	30	29
90th percentile wait (days)*	211	180	150	121	104	90	82	75	72
Per cent waited more than 12 weeks (84 days)	Not recorded	Not recorded	Not recorded	Not recorded	16.9	12	8.5	1.5	0.9
Per cent waited more than 15 weeks (105 days)	Not recorded	Not recorded	Not recorded	Not recorded	9.3	4.4	1.8	0.3	0.1
Per cent waited more than 18 weeks (126 days)	22.6	20.9	15.0	8.5	0.8	0.3	0.1	<0.1	<0.1
Outpatients									
Average wait (days)	56	53	48	49	43	48	43	42	47
90th percentile wait (days)	230	174	150	144	112	102	87	77	80
Per cent waited more than 12 weeks (84 days)	Not recorded	Not recorded	Not recorded	Not recorded	25.1	22.2	11.3	0.6	1.0
Per cent waited more than 15 weeks (105 days)	Not recorded	Not recorded	Not recorded	Not recorded	13.9	7.8	1.6	<0.1	0.1
Per cent waited more than 18 weeks (126 days)	24.4	21.5	15.8	14.3	0.6	0.2	0.1	<0.1	<0.1

Notes:

* The 90th percentile wait indicates that 90 per cent of patients waited up to the time shown and ten per cent waited longer.

1. The figures relate to completed waits, that is, patients who had been seen by that date.

2. The figures before New Ways exclude patients with an ASC. The figures after New Ways include patients with periods of unavailability whose clock was stopped when they were unavailable.

Source: ISD Scotland waiting times statistics as at December 2009

13. Long waits were also reducing before the new arrangements, but these figures exclude significant numbers of patients with an ASC. At March 2007, over 50,000 people waiting for an outpatient, inpatient or day case appointment had an ASC.¹⁴ This was 17 per cent of all patients waiting. Waiting times have come down in every NHS board since the new system was introduced and there is less variation among boards (Exhibit 4).

14. We looked at waiting times for different specialties and focused on three specialties with particular pressures for more detailed review (Appendix 3):

- Orthopaedic outpatients, inpatients and day cases – orthopaedics is one of the specialties under greatest pressure to meet waiting times targets, with 90 per cent of patients seen within 16 weeks (112 days) for an outpatient appointment and within 16½ weeks (116 days) for an inpatient or day case appointment in the year ended December 2008. This

compares with 90 per cent of inpatients seen within 96 days across all specialties. It is also one of the busiest specialties in terms of the numbers of patients seen – for the year ended December 2008, over 176,000 people were seen for an outpatient appointment and almost 50,000 were seen for an inpatient or day case appointment.

- Dermatology outpatients – a large number of patients are seen in dermatology clinics. Across Scotland, almost 113,000 dermatology outpatients were seen in 2008.

- Oral surgery inpatients – although oral surgery is a small specialty in terms of the number of patients, it has a higher percentage of patients waiting longer than 12 weeks. For the year ended December 2008, 90 per cent of oral surgery inpatients and day cases were seen within 16 weeks (112 days).

The new arrangements have stopped people waiting indefinitely

Patients previously excluded now have waiting time guarantees

15. In recent years, the NHS in Scotland has used different systems to manage patient waits. Before the introduction of the current system, deferred waiting lists and availability status codes (ASCs) excluded some patients from waiting times guarantees. Until 2003, hospitals used deferred waiting lists if patients were unavailable for admission for a period of time for medical or social reasons, or if they did not attend for an appointment. Waiting time guarantees did not apply to those who were on these lists and these patients were not counted in national statistics on NHS performance against waiting times targets.

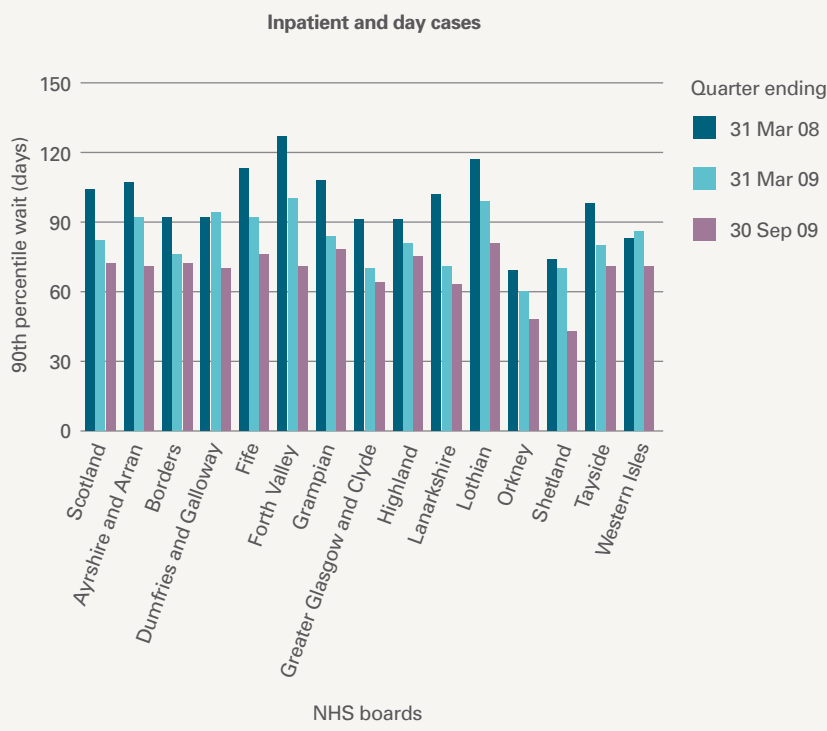
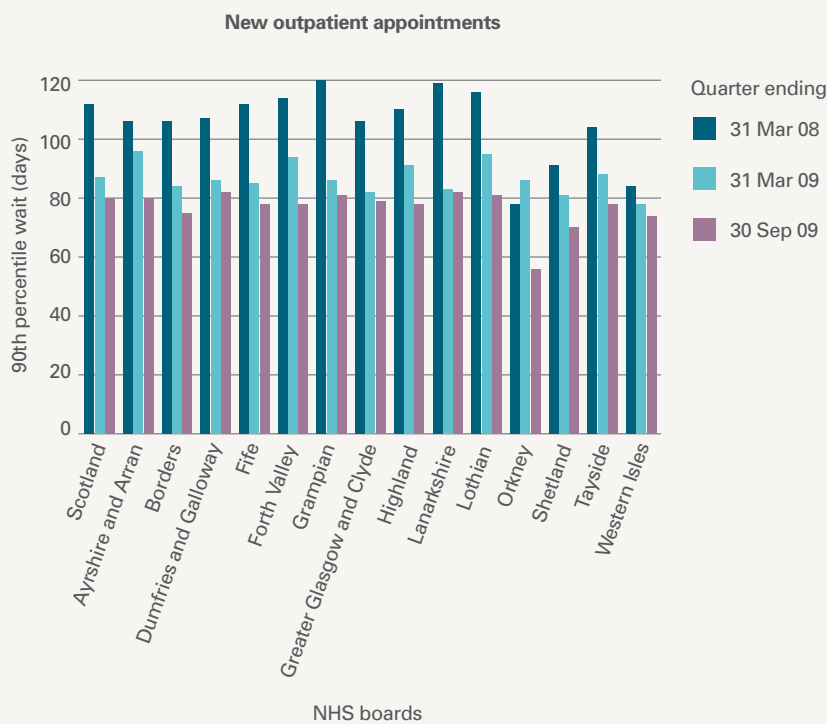
16. Deferred lists were abolished and replaced with ASCs in April 2003. This system also excluded some patients from waiting time guarantees. The NHS could apply an ASC to a patient if:

- the patient asked to delay their admission or appointment for personal reasons or refused a reasonable offer of admission or appointment
- it was clear from the referral letter that the patient asked to delay an appointment for personal reasons (for example, holidays) and this affected the hospital's scheduling of appointments
- the patient did not attend an appointment and did not notify the hospital in advance that they would not attend

Exhibit 4

Waiting times by board, 2008-09

Waiting times have reduced and there is less variation among boards.



Notes:
 1. The data are for completed waits, that is, patients who had already been seen.
 2. The 90th percentile wait indicates that 90 per cent of patients waited up to the time shown and ten per cent waited longer.
 Source: ISD Scotland, 2009

- the patient had another medical condition which affected their ability to accept an admission date
- after discussion with the patient, the treatment was judged of low clinical priority
- the patient required highly specialised treatment
- the NHS was under exceptional strain, for example if there was a major disaster, major epidemic or outbreak of infection, or service disruption caused by industrial action.¹⁵

17. Audit Scotland previously criticised deferred waiting lists and ASCs because they were perceived to operate as hidden waiting lists and did not provide an accurate picture of how many patients were waiting for treatment and for how long. Patients with an ASC code under the previous system did not have a waiting time guarantee and could be recorded as unavailable for an indefinite period of time before they were offered

an appointment. It also led to some inconsistencies in how NHS boards managed their waiting lists and in how they recorded information, contributing to concerns about the validity of national waiting times data.¹⁶

18. The new system has brought to an end the practice of excluding people from waiting times guarantees and it has stopped open-ended waiting periods. Patients who would previously have been given an ASC code because they needed specialised treatment or were assessed as low clinical priority are now entitled to the same waiting time guarantee as other patients on the waiting list. Those who are unavailable for treatment are coded as either medically or socially unavailable and must be reviewed within 13 weeks so that they do not remain on the waiting list indefinitely. The NHS board then has to make a decision on how to manage the patient, for example they may be offered an appointment or taken off the list and referred back to the GP (Exhibit 1).

People who would previously have had an ASC are now waiting for a shorter period of time

19. In December 2006, almost 60,000 outpatients, inpatients and day cases waiting for an appointment (18 per cent) had an ASC.¹⁷ This number reduced steadily as NHS boards prepared for the move to New Ways from 1 January 2008. In December 2007, just over 21,000 outpatients, inpatients and day cases waiting (nine per cent) had an ASC.

20. The percentage of inpatients and day cases with a period of unavailability after the new system was introduced in 2008 is similar to the percentage who had an ASC in 2007 (Exhibit 5). Most unavailability during 2008 was for social reasons – 80 per cent for outpatients and 77 per cent for inpatients and day cases.^{18, 19}

21. Patients with unavailability periods wait longer than other patients, but for less time than people who had an ASC under the previous arrangements (shown by the average and 90th percentile waits in Exhibit 5). This is

Exhibit 5

Patients with ASCs and unavailability, 2007 and 2008

Patients waited longer under the previous arrangements.

Year	Total patients seen during year	Percentage with ASC or unavailability over the year	Average wait (days) over the year ended 31 December		90th percentile wait (days) over the year ended 31 December	
			No ASC or unavailability	ASC or unavailability	No ASC or unavailability	ASC or unavailability
Outpatients						
2007	1,218,006	9.7	49	102	144	214
2008	1,245,149	3.9	36	59	104	116
Inpatients and day cases						
2007	436,669	10.2	39	133	121	314
2008	391,297	10.1	31	43	93	112

Notes:

1. The waiting time target during 2007 was 18 weeks (126 days).
2. ASCs could be applied during 2007. They were abolished from 1 January 2008.

Source: ISD Scotland, 2009

15 *Codes and values for availability status codes*, ISD Scotland's Health and Social Care Data Dictionary, <http://www.datadictionaryadmin.scot.nhs.uk/isddd/12585.html>

16 *Review of the management of waiting lists*, Audit Scotland, 2002.

17 *NHS Scotland: outpatient waiting list census by unified NHS board (31 December 2006)*, ISD Scotland, <http://www.isdscotland.org/isd/4053.html>

18 The rest of the inpatient and day case unavailability was for medical reasons.

19 Two and a half per cent of outpatient unavailability was medical. The remainder of outpatient unavailability was due to no response to a patient-focused booking letter. This is when a hospital sends a letter to the patient asking them to call the hospital to arrange a suitable appointment date. Patients who do not respond may be classed as unavailable.

partly because the 2008 waiting times figures exclude the days when the patient was unavailable, that is, when their waiting time clock was stopped. This accounts for a significant amount of the reduction – the length of unavailability for the specialties we reviewed was longest for orthopaedic patients, with an average of just over three weeks (22 days) for outpatients and almost eight weeks (55 days) for inpatients and day cases.²⁰ Even taking this factor into account, the waits of people with unavailability are shorter than for people who had an ASC ([Exhibit 5](#)).

20 Unpublished data – Number, type and length of unavailability for patients waiting for a new outpatient appointment, orthopaedics specialty, by NHS board, for patients seen during 2008, ISD Scotland, 2009.

Part 2. Applying the new guidance



Differences in the way the guidance is applied can have implications for patients.



Key messages

- New Ways introduced big changes which affected large numbers of patients, staff and services. The NHS has done well to ensure that systems are in place to implement and support the new arrangements.
- The percentage of patients who do not attend an outpatient appointment has not reduced. The new system allows NHS boards to apply elements of the guidance differently, particularly how they manage patients who do not attend or cannot attend for their appointment. These differences have implications for patients.
- Patients who live in remote and rural communities generally do not wait longer than patients in more urban areas.
- New Ways introduced a number of new data items and complex rules about the information that should be recorded by NHS boards. They are recording most information required under the new guidance, but there are some gaps in recording data about reviews of patients who are unavailable and about transfers which makes it difficult to demonstrate that they are managing these patients in the right way.

The NHS has done well to implement the new arrangements

22. The new system was intended to make sure that NHS boards manage waiting lists and times fairly. It is a complex system which needs support from hospital staff, GPs, ISD Scotland and patients to help it work effectively. It introduced major changes in working practices for NHS staff in Scotland, with:

- new rules on treating patients more consistently and openly, particularly patients who are not available for an appointment or treatment or who cannot or do not attend a reasonable offer
- new ways of collecting, recording and reporting data
- new responsibilities for patients.

23. The introduction of the new guidance involved significant changes to local IT systems to ensure that they were compatible with the new arrangements. ISD Scotland developed a national database, known as the data warehouse, to store and analyse data which are imported directly from NHS boards' own systems. Boards have adapted their information systems to make them compatible with the new arrangements and the national data warehouse. This is an ongoing process for all 14 NHS boards as the new arrangements become more established and the data collection systems are refined and improved.

24. Staff need to understand how the system works and how applying the guidance affects patients. NHS boards have put a lot of time and effort into training staff in the new procedures, particularly medical records and administrative and clerical staff, who work with complicated new rules for managing, coding and recording patient waits. It has taken time for training to be rolled out and for the system to be fully implemented but its aims are now largely being achieved, although there remain some problems with recording and with data quality.

25. Initial training about the new arrangements included:

- NHS boards providing information sessions for clinical staff in hospitals and primary care staff

- ISD Scotland producing national patient information leaflets and posters for NHS boards to distribute to staff and patients
- the Scottish Government sending letters and information leaflets to GPs
- ISD Scotland producing training materials and running national information sessions for NHS staff
- NHS boards providing internal training for medical records staff who use local databases and information systems which store data about patients.

26. Staff reported that ongoing training and on the job experience was the most useful, as they needed time to become familiar with the new system. An ISD Scotland survey of NHS board staff and managers found that 80 per cent of staff felt that the training provided was adequate or better and almost two-thirds said that the new arrangements had led to an increase in their work. The survey also found that staff had a good understanding of some aspects of the new guidance, particularly on reasonable offers, but less understanding of more complex issues such as how to manage and record patients with periods of unavailability.²¹

27. It is not possible to calculate the full cost of developing and implementing the New Ways system as this information has not been collected by NHS boards or the Scottish Government Health Directorates (SGHD). However, ISD Scotland has reported that it cost £481,000 for its new IT system between 2005 and 2009. It spent a further £130,000 to provide information, training and support to NHS boards and continues to incur the costs of providing training and ongoing support.²²

21 *New Ways of defining and measuring waiting times – Results from employee survey*, ISD Scotland, October 2008.
22 Personal communication, ISD Scotland, December 2009.

The number of patients who do not attend an appointment has not reduced

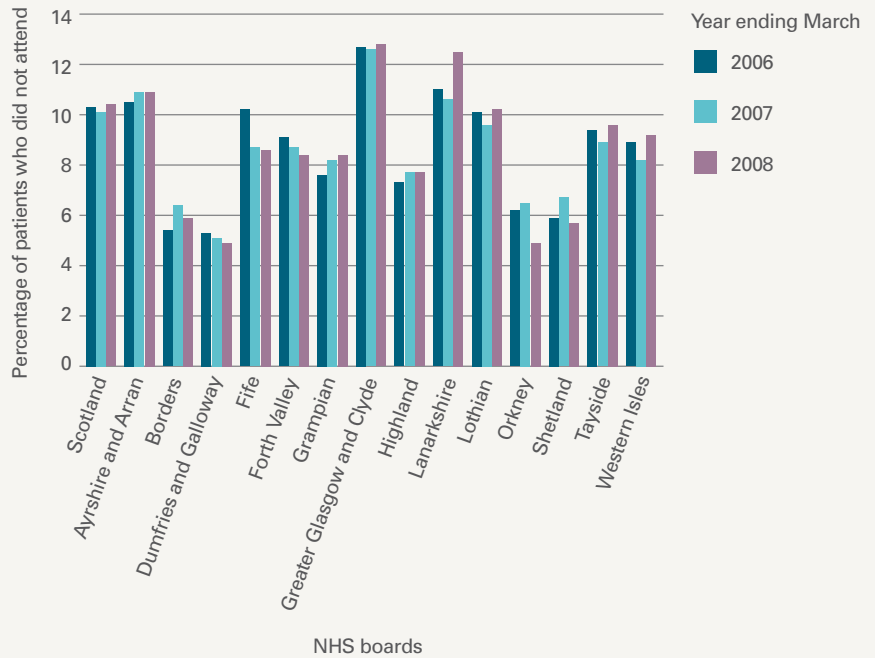
28. The national performance targets for the NHS in Scotland include an efficiency target to reduce the did not attend rate for patients attending their first outpatient appointment at a new clinic by ten per cent from the year ended March 2007 to the year ended March 2011.²³ Did not attend rates have been above ten per cent in recent years and have not reduced under the new arrangements (Exhibits 6 and 7). In the three months to September 2009, ten per cent of patients did not attend for a first outpatient appointment.²⁴ This is over 44,000 unused clinic appointments at an average cost of £112 for an outpatient appointment, costing the NHS in Scotland almost £5 million in wasted appointment slots in only three months.²⁵

29. Different boards and different specialties within boards vary in how they contact patients to make an appointment. Most boards contact patients by letter in the first instance. Two boards generally contact patients by phone to make an appointment.²⁶ The way patients are contacted after this varies. For example, the letter may ask the patient to contact the hospital to arrange a suitable appointment (known as patient-focused booking); the patient may receive another letter as a reminder; or the hospital may assume that the patient has accepted the appointment given in the original letter (known as implied acceptance). Communicating with patients by phone gives the hospital an opportunity to offer appointments that better suit the patient's needs. However, while there are some concerns about the quality of the data relating to did not attend rates, they do not suggest any link between these rates and whether boards offer appointments to patients by letter or by phone.

Exhibit 6

Percentage of patients who did not attend a new outpatient appointment, 2006 to 2008¹

Did not attend rates have not reduced across Scotland.



Note:
1. ISD Scotland has not published data for year ended March 2009.
Source: ISD Scotland, 2009

Exhibit 7

Percentage of patients who did not attend a new outpatient appointment since the introduction of New Ways

Did not attend rates have remained at a similar level since New Ways was introduced.

2008 Quarter ending				2009 Quarter ending		
31 Mar	30 Jun	30 Sep	30 Dec	31 Mar	30 Jun	30 Sep
10.3%	10.0%	10.5%	10.6%	10.3%	10.4%	10.0%

Note: ISD Scotland has noted some concerns about the did not attend data since New Ways was introduced and has advised that data up to June 2009 only give a general indication of did not attend rates. The figures for the quarter ending September 2009 are more accurate.
Source: ISD Scotland acute activity data up to 30 June 2009; ISD Scotland New Ways data for the quarter ended 30 September 2009

30. A high number of appointments are being cancelled by hospitals. During 2008, hospitals cancelled 21,802 patient appointments across the three specialties we reviewed. Orthopaedic outpatient

services have a relatively high level of service cancellations in many boards. In remote and rural boards, some services are provided on a visiting basis so high levels of cancellations can be due to bad

23 NHS Scotland Performance Targets – Efficiency Targets for 2010/11, The Scottish Government, <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets/Efficiency>
 24 NHS Scotland inpatient and outpatient activity by NHS board of treatment, ISD Scotland, <http://www.isdscotland.org/isd/5633.html> (as at December 2009).
 25 Costs book 2009 – Executive Summary, ISD Scotland, 2009.
 26 NHS Forth Valley and Greater Glasgow and Clyde generally make the first offer of an appointment over the phone. NHS Dumfries and Galloway, and Fife use a mixture of verbal and written offers. Inpatient and day case offers are mostly verbal in Orkney and a mixture in Highland.

weather, flights being cancelled and a dependence on single consultants who sometimes become ill or cannot hold their clinic for other unexpected reasons. The high level of cancellations may also relate to how boards record information on booked and cancelled appointments. For example, IT systems record all booked and cancelled clinics. Some of these clinics may be cancelled and re-scheduled before the patient has been contacted or the cancelled clinic may have been rescheduled to an earlier time, so the cancellation does not have a direct impact on the patient's experience.

Half of patients referred back to the end of the list wait longer than 15 weeks

31. New Ways introduced new arrangements for how boards should deal with patients who do not or cannot attend for an appointment or treatment. These patients can have their waiting time clock reset to zero which means they go back to the end of the waiting list or they can be taken off the waiting list and referred back to their GP ([Exhibit 1](#)). During the quarter ended 31 December 2008, 5,368 orthopaedic and dermatology outpatients and 689 orthopaedic and oral surgery inpatients and day cases attended after having their waiting time clock reset to zero because they did not attend or could not attend on a previous occasion. Some people may be disadvantaged by this system, particularly patients from more vulnerable groups who may find it more difficult to attend their appointment, such as single parents, people with disabilities or those whose first language is not English.

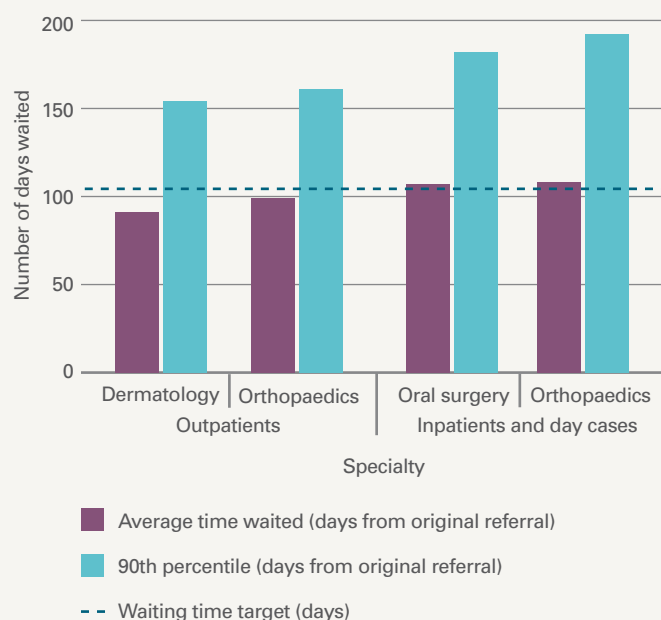
32. People who are put back to the end of the waiting list wait longer, but the average wait for each of the three specialties is around the 15-week (105 days) waiting time target ([Exhibit 8](#)).

33. In addition to those put back to the end of the list, some patients are removed from the waiting list and referred back to their GP ([Exhibit 9](#)).

Exhibit 8

Actual time waited by patients returned to the end of the list, quarter ended 31 December 2008

The average time waited by patients who did not attend or could not attend their appointment is around the waiting time target but many wait longer.



Note: The 90th percentile wait indicates that 90 per cent of patients waited up to the time shown and ten per cent waited longer.
Source: ISD Scotland, 2009

Exhibit 9

Number of patients removed from the waiting list and referred back to their GP because they did not or could not attend an appointment, year ended 31 December 2008

Almost 22,000 patients were referred back to their GP.

Specialty	Did not attend	Could not attend	Total
Inpatients and day cases			
Orthopaedics	267	67	334
Oral surgery	98	12	110
Outpatients			
Dermatology	8,669	749	9,418
Orthopaedics	10,936	1,112	12,048
Total	19,970	1,940	21,910

Source: ISD Scotland, 2009

Recorded waiting times for patients in remote and rural areas are generally no longer than for patients in more central locations

34. In remote and rural areas, some services are provided by a visiting clinician. This is a consultant who is based at a hospital but travels to more rural communities to hold clinics. These clinics are not held as often as the clinics at a main hospital

and are classed as infrequent. An infrequent clinic is defined as a clinic which is only held once every four weeks or less. For patients attending these clinics, New Ways defines a reasonable offer as only one date, with at least seven days' notice.

35. People living in remote and rural areas often have to travel to other areas for treatment if they want to receive it within the waiting time

standard. However, in general, patients who live in more remote locations are not waiting longer for an appointment or treatment (Exhibit 10). Overall, most people from remote and rural areas in our focus groups were very positive about their experiences of the NHS and waiting times and felt they are offered a good quality service.

Exhibit 10

Recorded number of days waiting (90th percentile) for patients living in remote and accessible postcode areas, year ended 31 December 2008

There is not much difference between how long people from remote and rural areas wait compared with people from more accessible locations.

NHS boards	Outpatients				Inpatients/day cases			
	Dermatology		Orthopaedics		Orthopaedics		Oral surgery	
	Accessible	Remote	Accessible	Remote	Accessible	Remote	Accessible	Remote
Scotland	113	104	112	111	116	114	111	116
Ayrshire and Arran	98	108	103	97	112	116	–	–
Borders	98	99	96	100	112	114	97	97
Dumfries and Galloway	42	43	102	104	123	120	128	123
Fife	95	–	117	108*	111	16*	106	58*
Forth Valley	77	87	110	112	125	120	117	106
Grampian	116	115	122	119	115	112	118	119
Greater Glasgow and Clyde	101	95	105	100	112	112	84	81
Highland	92	95	115	113	115	115	118	121
Lanarkshire	120	118	112	119	109	94	103	80*
Lothian	123	118	116	113	123	121	120	74*
Orkney	–	111	–	81	–	–	–	70
Shetland	–	111	–	110	–	93	–	91
Tayside	119	120	91	109	112	109	112	88
Western Isles	–	77	8*	68	85*	111	–	50

Notes:

* These figures relate to very small numbers of patients.

– No patients.

1. The figures are completed waits, that is, patients seen in the year to 31 December 2008.

2. Patients are recorded in the board they were treated. Patients who were transferred are recorded in the board they were transferred to.

Source: ISD Scotland, 2009

Boards can apply elements of the guidance differently and this affects how patients are managed

36. New Ways guidance allows NHS boards to apply elements of the guidance differently. This allows clinicians to review individual cases to make sure that patients are not being put at risk, for example because they are taken off the waiting list or referred back to the end of the list. Elements of the guidance which are applied differently include dealing with patients who do not attend or cannot attend. There is also variation in how NHS boards offer patients appointments and how they deal with patient choice. These can all have an impact on patients.

Boards deal differently with patients who did not or could not attend their appointment

37. If a patient fails to attend for an appointment without letting the hospital know in advance, the NHS board can remove them from the waiting list and refer them back to their GP or move them to the end of the waiting list ([Exhibit 1](#)). They can also remove a patient from the waiting list if the patient cannot attend after accepting a reasonable offer.²⁷ Although ISD Scotland reports concerns about the quality of data on did not attend rates before June 2009, the national data suggest that boards vary in the way they are applying the guidance in relation to people who did not or could not attend their appointment. Some boards may put a patient to the end of the waiting list after the first time they fail to attend an appointment. Others are more likely to keep patients on the waiting list unless they fail to attend more than once. There is also variation within boards and specialties, which may reflect clinical decisions about patients' needs because the guidance gives clinicians the flexibility to review individual cases.

38. During 2008, 55,276 outpatients (16 per cent) and 6,813 inpatients and day case patients from the three specialties we reviewed either did not attend or could not attend their appointment following a reasonable offer. This means that variation in how NHS boards manage patients who did not or could not attend potentially affects large numbers of people.

39. Participants in our focus groups generally accepted that people should not be able to continually turn down appointments and thought that it was reasonable for boards to return a patient to the GP if they refused two offers. However, most felt that local hospitals offered greater flexibility than the current system requires.

40. Shorter waiting times targets mean that NHS boards are giving patients less notice of appointments. Some boards are using a system of implied acceptance of offers to manage the number of patients they need to see within the waiting time target. This means that if a patient does not contact the hospital to cancel the appointment they have been given within seven days of receiving the letter then they are assumed to have accepted the offer. Patients who subsequently do not attend may be coded as failing to attend and may be moved to the end of the waiting list.

41. Some hospitals and specialties use a patient-focused booking system where patients are sent a letter asking them to contact the hospital to arrange an appointment. Under this system, patients who have not responded within seven days are recorded as unavailable, so their waiting time clock stops but they are not moved to the end of the waiting list. This system involves more work for hospitals because more people are classed as unavailable and the hospital must send out further letters or may need to review patients who are unavailable within 13 weeks of having their clock stopped ([Exhibit 1](#)).

42. The outcome for patients can be different, depending on which system their NHS board is using. The use of the implied acceptance system could disadvantage those who need the most support. For example, people with additional needs, such as needing information translated, may not be able to respond to the offer within the timeframe if support is not in place.

NHS boards treat patient choice differently

43. If a person lives in a remote and rural area, where clinics are infrequent, they may be given an offer of one appointment at the infrequent clinic, or up to two appointments at another clinic some distance away so that they can be seen within the waiting times standard. If the patient refuses these appointments, for example because they want to be treated locally, then the guidance states that their waiting time clock should be reset to zero from the date of refusal. Most participants in our focus groups preferred to access services locally wherever possible to fit in with working patterns, family lives and other commitments.

44. New Ways does not have a code for patient choice which could be applied if a patient refuses to travel and opts for a local but infrequent clinic. Some NHS boards choose to apply the social unavailability code instead. This means that the patient's clock stops but they are not moved to the end of the waiting list ([Exhibit 1](#)). Some boards record patients as socially unavailable when they choose to wait longer for an appointment at an infrequent clinic closer to home. If the board did not use the social unavailability code in this way, the patient would be recorded as repeatedly not being able to attend and could be put to the end of the waiting list, which would mean waiting longer for treatment.

45. During 2008, five per cent of patients in the three specialties across Scotland were classed as socially unavailable. There is wide variation in levels of social unavailability across boards (Exhibit 11). This implies that boards are applying the code differently, which has implications for patients. ISD Scotland also found wide variation across boards in the percentage of patients recorded as having a period of unavailability and concluded that at least some of the variation is due to different local practices.²⁸

Boards are mostly recording information in line with guidance but there are some gaps

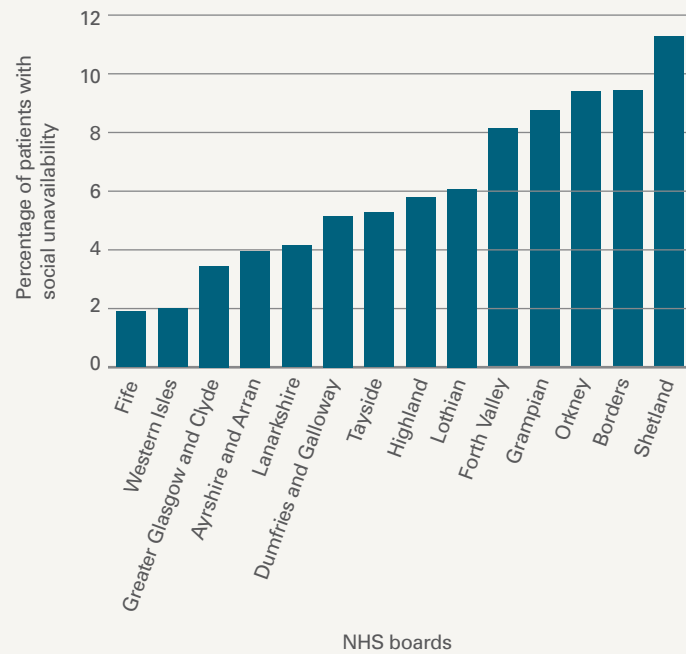
46. We commissioned ISD Scotland to review 2,675 patient records across three specialties in all 14 NHS boards to identify whether boards are recording the data required under the new arrangements. It reviewed information recorded in the national data warehouse, in patient case notes and in hospitals' patient administration systems (Appendix 2).

47. NHS boards are recording most information in line with the guidance. Data items such as the date that patients are added to the waiting list and the start and end dates of periods of unavailability are recorded in all the cases reviewed. However, there are gaps in some information that should be recorded, particularly reviews of patients who are classed as unavailable for their appointment or treatment and information recorded about transfers of patients within a board and between boards. These are patients who are transferred from one hospital or specialty to another within the same board, or who are transferred to a hospital in another board (Exhibits 12 and 13).²⁹

Exhibit 11

Social unavailability rates across NHS boards, 2008

Levels of social unavailability vary among boards.



Source: Audit Scotland analysis of ISD Scotland New Ways data warehouse, 2009

48. Across Scotland, in our sample specialties, a maximum of 25 per cent of inpatients and day cases with unavailability of more than 13 weeks had a planned review date recorded, and fewer than five per cent of patients had an actual review date recorded. NHS boards report that they are conducting reviews more frequently than at 13 weeks; however, this is not always being recorded. Five boards had problems with their IT systems in relation to transfers and a further two had problems with coding transfers during the period we reviewed and this may explain some of the information gaps.³⁰

49. The new arrangements aimed to make the system clearer, fairer and more transparent, but the gaps in recording some of the data make it difficult for NHS boards to fully demonstrate that patients are being managed in line with the guidance. From December 2011, the target for treating patients will change. Patients should expect an 18-week maximum wait from referral through to treatment, including any tests and outpatient visits. Recording data items clearly and accurately will become even more important when this overall target is in place. NHS boards will need to report on, and will be held to account on, their performance against this new target.

²⁸ *New Ways of defining and measuring waiting times – A report produced by the New Ways of Waiting Data Quality Assessment Project Board, ISD Scotland, December 2008.*

²⁹ Some boards did not have enough records in the three specialties we chose for review. Where this was the case, we asked ISD Scotland to choose additional records at random from other specialties.

³⁰ NHS Dumfries and Galloway, Fife, Orkney, Shetland and Western Isles reported problems with their IT systems and NHS Grampian and Lanarkshire reported problems with the way transfers were coded.

Exhibit 12

New Ways data recorded for inpatient and day case specialties reviewed – percentage of cases where information is recorded

NHS boards are not recording all data items.

Inpatients/day cases reviewed															
NHS boards	All patients			All patients with no transfer			Patients with periods of unavailability			Patients with medical unavailability for over three months (with no transfer)			Patients who were transferred to another board*		
	Number of cases	Waiting list date	Special needs flag**	Number of cases	Date of offer***	Offer outcome***	Number of cases	Start date of unavailability	End date of unavailability	Number of cases	Date of review	Outcome of review	Number of cases	Where transferred to	Reason for transfer
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Ayrshire and Arran	103	100	1	103	95	95	53	100	100	13	31	38	0	–	–
Borders	108	100	6	91	85	85	47	100	100	18	0	0	17	94	94
Dumfries and Galloway	109	100	20	109	95	95	59	100	100	20	0	0	0	–	–
Fife	123	100	7	115	77	77	55	100	100	15	100	0	20	75	75
Forth Valley	74	100	3	74	88	88	44	100	100	11	55	55	0	–	–
Grampian	85	100	9	85	80	80	41	100	100	20	10	0	0	–	–
Greater Glasgow and Clyde	93	100	5	93	95	95	46	100	100	7	29	29	0	–	–
Highland	113	100	13	113	97	97	65	100	100	28	7	7	0	–	–
Lanarkshire	91	100	0	91	92	92	42	100	100	15	27	27	0	–	–
Lothian	106	100	0	106	89	89	58	100	100	18	0	0	0	–	–
Orkney	77	100	4	77	100	100	27	100	100	7	0	0	0	–	–
Shetland	99	100	0	99	92	92	49	100	100	9	0	0	0	–	–
Tayside	86	100	1	86	88	88	37	100	100	17	0	0	0	–	–
Western Isles	86	100	6	86	97	97	39	100	100	2	0	0	0	–	–

Notes:

* We only reviewed transfers where more than one per cent of patients are transferred to another board.

** Special needs flag refers to any information recorded about what additional support the patient may need.

*** Where data are not recorded it is generally valid because a patient on the waiting list decided, before being made an offer, that they no longer wanted the treatment.

Source: Audit Scotland, 2009

Exhibit 13

New Ways data items recorded for outpatient specialties reviewed – percentage of cases where information is recorded

NHS boards are not recording all data items.

Outpatients reviewed												
NHS board	All patients			All patients with no transfer			Patients with periods of unavailability			Patients who were transferred within board*		
	Number of cases	Date of referral	Special needs flag**	Number of cases	Date of offer***	Offer outcome***	Number of cases	Start date of unavailability	End date of unavailability	Number of cases	Where transferred to	Reason for transfer
		%	%		%	%		%	%		%	%
Ayrshire and Arran	90	100	0	90	87	87	40	100	100	0	–	–
Borders	89	100	7	89	98	98	40	100	100	0	–	–
Dumfries and Galloway	90	100	11	90	90	90	40	100	100	0	–	–
Fife	85	100	2	85	95	95	35	100	100	0	–	–
Forth Valley	91	100	1	91	100	100	39	100	100	0	–	–
Grampian	91	100	2	91	93	93	40	100	100	0	–	–
Greater Glasgow and Clyde	106	100	4	90	71	71	40	100	100	16	69	25
Highland	107	100	7	87	95	95	38	100	100	20	15	0
Lanarkshire	102	100	0	88	85	85	39	100	100	14	93	93
Lothian	90	100	2	90	91	91	40	100	100	0	–	–
Orkney	91	100	5	91	93	93	43	100	100	0	–	–
Shetland	110	100	0	90	89	89	39	100	100	20	75	55
Tayside	89	100	0	89	96	96	40	100	100	0	–	–
Western Isles	91	100	8	91	98	98	41	100	100	0	–	–

Notes:

* We only reviewed transfers where more than one per cent of patients are transferred within the board.

** Special needs flag refers to any information recorded about what additional support the patient may need.

*** Where data are not recorded it is generally valid because a patient on the waiting list decided, before being made an offer, that they no longer wanted the treatment.

1. Outpatients did not include review of patients with medical unavailability of over three months (with no transfer).

Source: Audit Scotland, 2009

ISD Scotland is working with NHS boards to improve data quality

50. Introducing the new system to all NHS boards in Scotland was a big project. It introduced significant changes to the type of data recorded and it has taken time to resolve some initial problems. ISD Scotland and NHS boards reported concerns about the quality of some of the new data, although ISD Scotland noted that the boards have made a lot of progress with improving data quality and many of these concerns have now been resolved. Did not attend, cannot attend and cancellation rates were published in November 2009, based on data for the quarter ending 30 September 2009, although there are still concerns about the quality of these data for earlier periods. ISD Scotland is working with boards on an ongoing basis to further improve data quality, but some issues remain.

51. The New Ways Refresh Project was implemented in early 2009 to reduce the administrative effort for staff involved in collecting and monitoring data, while making sure that reporting was still clear and easy to understand. A steering group of NHS board operational managers, staff from ISD Scotland and the Scottish Government is overseeing the project. The change implemented through the project allows boards to identify which records are free of errors and which are not valid for waiting times calculation. ISD Scotland is planning to publish these data from February 2010.

Many patients are recorded as being removed from the waiting list because treatment is no longer required

52. The code for treatment no longer required is used for two main reasons: due to the patient's circumstances (for example, when a patient gets better, decides not to go ahead with the treatment, chooses to be treated privately or moves away); and when

the patient's needs are met through another treatment (for example, physiotherapy, or they are referred to another health professional).

53. During 2008, 26,666 patients (six per cent) in the three specialties we reviewed were coded as removed from the waiting lists because they no longer required treatment. For orthopaedic inpatients, 12 per cent of patients were recorded as removed from the waiting list for this reason. This ranges from 3.2 per cent in NHS Highland to 16.5 per cent in NHS Tayside. NHS boards and ISD Scotland have reported that some of these figures may be due to technical problems or local system and recording issues during the period reviewed. For example, if a patient was transferred to the Golden Jubilee National Hospital, some boards recorded this as 'treatment no longer required' in the national data warehouse. This coding issue has now been resolved.

54. There may also be other explanations. For example, NHS Greater Glasgow and Clyde carried out extensive waiting lists reviews to make sure that they were accurate and the patients listed still required treatment. A number of patients replied that they no longer required treatment and they were removed from the list. In NHS Shetland, orthopaedic and dermatology services are provided by visiting consultants every four to 12 weeks. If a patient cannot attend an appointment with the visiting service after a reasonable offer, they are referred back to their GP and coded as 'treatment no longer required' rather than as 'could not attend'.

55. The national statistics show that high numbers of patients are being removed from the list in this way. NHS boards should investigate any apparent anomalies and ensure that they are managing these patients appropriately.

Recommendations

NHS boards should:

- record all New Ways data, including information on patient reviews and transfers, to ensure that all patients are being managed in line with the guidance and that this is demonstrated in a clear way
- review the reasons why patients are coded as being removed from the waiting list as treatment is no longer required and ensure that patients are being managed appropriately and in line with the guidance
- monitor levels of clinic cancellations, ensure that clinics are cancelled for valid reasons and take steps to reduce cancellations where possible.


The Scottish Government and ISD Scotland should:

- consider issuing additional guidance about the treatment of patients who do not attend or cannot attend appointments to make sure that patients are managed fairly across Scotland, while still allowing for clinical judgement
- consider introducing a patient choice code which allows NHS boards to stop the waiting time clock for patients who choose to wait longer for an appointment or treatment.


ISD Scotland and NHS boards should:

- continue to improve the quality of the New Ways data to ensure they are reliable and fit for purpose.

Part 3. What the new arrangements mean for patients and the NHS



Information for and about patients needs to improve to ensure the new system operates effectively.



Key message

- Good communication between NHS boards and patients is essential, particularly since waiting times are continuing to come down. Patients are now getting less notice of appointments and failure to attend may mean they are referred back to the end of the waiting list or back to their GP. NHS boards need to make sure that they provide information which people can understand, and improve their recording of patients' additional needs.

Shorter waiting times mean that good communication with patients is even more important

56. Shorter waiting times mean that patients now get less notice of hospital appointments. From 1 January 2008 to 31 March 2009, patients were entitled to at least 21 days' notice of an appointment.³¹ Since 1 April 2009, NHS boards only need to give patients a minimum of one week's notice.³² Boards were already offering appointments less than three weeks in advance before April 2009, but patients did not have to accept these offers. In the specialties we reviewed, around half of patients were given less than three weeks' notice. Our patient survey found that almost one in five people had less than one week's notice of their appointment and almost 60 per cent had less than three weeks' notice.³³ However, 83 per cent of respondents felt the amount of notice was reasonable and only four per cent said it was too short. Over 90 per cent had a straightforward experience and both accepted and attended the first appointment they were offered.

57. NHS boards need to make sure that communication with patients is effective and that all patients get the information they need with as much notice as possible, so that they can make arrangements to attend. Patients also need to understand the implications of failing to attend an appointment since it can lead to them being referred back to the end of the waiting list or back to their GP. Good communication is especially important for patients who may need additional help, for example those who are older, homeless, have learning difficulties or whose first language is not English. These people may need to make additional arrangements to allow them to attend their appointment, and they need enough time to do this.

58. In general, respondents in our focus groups were happy with the notice period they were given. They felt that they were treated fairly, and some noted improvements in the appointment service. Most felt that there is good compromise between allowing time to organise schedules around an appointment, without having to wait for an appointment for a lengthy period of time. However, they recognised the difficulties for some people and highlighted the risk of disadvantaging those who need the most support. Participants felt that appointments should be offered two to four weeks in advance for non-urgent cases.

NHS boards need to make sure that patients get information they can easily understand

59. Information needs to be suitable for different patients' needs. This includes giving notice of their appointment in a language they understand or providing information in pictures for people with learning

difficulties. If appropriate information is not provided, it can take longer for the patient to understand the contents and this can further reduce the time they have to make suitable arrangements to attend their appointment.

60. GPs, hospitals and patients have a shared responsibility for communication. Patients are responsible for letting the hospital know about any changes in their availability and for communicating changes in personal details to their GP and hospital. GPs are responsible for encouraging patients to respond to letters and phone calls from the hospital, advising patients of the implications for them of not attending and letting the hospital know of any changes to the patient's details.³⁴

61. Two-thirds of patients in our survey did not recall receiving any information from their GP about what might happen if they could not attend an appointment. Few participants in the focus groups were given information about the new arrangements from their GP at the point of referral. More information from the GP at this point would be useful and patients consider this a good time to be told how the process works. An ISD Scotland survey found that over half of respondents had not been told what would happen if they cancelled or did not attend their appointment.³⁵ The amount and type of information included in letters to patients varies among boards and across specialties within boards. Hospitals in 12 boards send out the national information leaflet or their own tailored leaflet when a patient is invited for an appointment.³⁶

31 *New Ways of defining and measuring waiting times: Applying the Scottish Executive Health Department guidance, version 3.0*, ISD Scotland, 2007.

32 *Amendments to New Ways – Applying the SGHD guidance (version 3.0 – December 2007)*, ISD Scotland, February 2009.

33 Patients can indicate that they are willing to accept an appointment at short notice if the hospital has a cancellation. This may account for some of the patients who were given less than one week's notice.

34 Letter from the Cabinet Secretary for Health and Wellbeing to GPs, 19 September 2007.

35 *New Ways of defining and measuring waiting times – Patient survey*, ISD Scotland, October 2008. There were 999 respondents to the survey.

36 NHS Borders, Dumfries and Galloway, Grampian, Highland, Lanarkshire, Lothian, Orkney, Tayside and Western Isles send out the national leaflet. NHS Fife, Forth Valley and Shetland have developed their own leaflets. NHS Greater Glasgow and Clyde relies on GPs to provide the information. We did not receive a response from NHS Ayrshire and Arran.

62. Patients told us that the following language issues are important to them:

- People who do not speak English as their first language are concerned that many patients, in particular older people, are not able to understand information provided by hospitals. If a family member or carer is not available to help with the appointment process when an initial letter arrives, an important appointment could be missed.

“People like me who’ve been living here for a long time would not have a problem with this. But my parents speak hardly any English and they rely on me or my brother to act as interpreters for them. They won’t do anything with a letter like this until one of us next sees them and if that’s in two or three weeks’ time, they might have missed an appointment, through no fault of their own. I think this would be a particular issue with many elderly people like them.”

- Information should be offered in a variety of languages. Some people never think to ask for this and it is not always automatically offered.
- The letter offering an appointment should also include a telephone number for a language support helpline as some prefer this to accessing a translator service.

“Language is failing the system. Unless you have fully trained staff at the other end of the phone, you end up feeling let down.”

63. Ten boards provide some communication tailored to individual needs, such as access to translation services, letters in large print and materials for people with learning difficulties.³⁷ However, these are not always available when they initially contact the patient to arrange an appointment as hospitals are not always aware of individual patients’ additional needs at that point.

NHS boards do not always have a record of patients’ needs for additional support

64. Some people need additional support to help them both understand information from the hospital and attend for appointments, for example people with learning difficulties, physical disabilities and those who are homeless or have chaotic lifestyles. In Scotland:

- around 120,000 people have a learning disability³⁸
- 56,609 households made homeless applications to their local council in 2007/08³⁹
- 35,588 people were registered as blind or partially sighted in 2009, which is estimated to be less than a third of those with a visual impairment⁴⁰
- it is estimated that about 150 languages in addition to English are in use.⁴¹

65. Recording information about people’s additional needs would help patients to have a better experience and help hospitals to be more efficient in the way they communicate with patients about their appointments. However, NHS

boards are not consistently recording this information. We found that only four per cent of the patient records we reviewed had any information recorded about patients’ additional support needs (Exhibits 12 and 13, page 19 and 20). NHS boards reported that hospitals rarely receive this information from the GP, and different computer systems are not able to transfer it automatically. For example, outpatient administration systems cannot transfer the data to inpatient systems and GP systems cannot always transfer the information to the systems used by hospitals.

66. Almost all of the 337 people with a disability or long-standing condition who responded to our patient survey felt that the hospital handled their needs sensitively. However, just under half of those who said they would have liked additional support were offered it and just over a third actually received support.

67. ISD Scotland and NHS Ayrshire and Arran conducted a study in a GP surgery in 2008 to explore whether information about patients’ ethnicity and communication and disability needs could be collected and stored at a GP practice and transferred to hospitals using the electronic referral system. They also investigated whether hospitals would make use of this information.⁴² They found that:

- the additional personal information can be included in the electronic referral system, although the system would need to be redesigned a little
- the information can be electronically transferred to hospitals if this is supported by training for medical records staff

37 Some alternative formats are available in NHS Ayrshire and Arran, Borders, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Highland, Shetland, Tayside and Western Isles. We did not have sufficient evidence for NHS Dumfries and Galloway, Lanarkshire, Lothian, and Orkney.

38 *The same as you? A review of services for people with learning disabilities*, Scottish Executive, 2000.

39 *Key statistics on homelessness*, Shelter Scotland, 2009, http://scotland.shelter.org.uk/housing_issues/research_and_statistics/key_statistics/homelessness_facts_and_research

40 *Registered Blind and Partially Sighted Persons, Scotland 2009*, Scottish Government, October 2009.

41 *A strategy for Scotland’s languages: draft version for consultation*, Scottish Government, 2007.

42 *Patient Profiling Project*, ISD Scotland and NHS Ayrshire and Arran, 2008.

- all new patients registering with the practice were willing to provide the additional personal information (ethnic group, communication needs and disability/impairments information)
- there is a need to raise awareness of equality and diversity issues in hospitals.

68. The review concluded that there need to be incentives to support the NHS in collecting and transferring this information, such as national performance targets or Quality and Outcomes targets for primary care.⁴³ The work is still ongoing in NHS Ayrshire and Arran.

69. *Equally Well*, the ministerial report on health inequalities, recommended that the Scottish Government should:

- commission a review of health data needs that covers gender, ethnicity, age, disability, religion and belief, sexual orientation and transgender and develop an action plan with milestones to fill the information gaps identified
- set targets for the NHS to support work on monitoring patients and collecting equalities data.⁴⁴

70. ISD Scotland is working with NHS Health Scotland to take forward these recommendations. Overall, the work will be incorporated into the eHealth Programme, which aims to change the way information and related technology are used within the NHS in Scotland in order to improve the quality of patient care.⁴⁵

Recommendations

NHS boards should:

- improve systems for recording patients' additional needs and put appropriate support in place for all who need it
- ensure that communication with patients takes account of any need for additional support and tailor information to meet these needs
- continue to work with primary care to improve communication with patients so that both primary care staff and patients are clear about their responsibilities under the new system, particularly the implications of patients not attending their appointments.

⁴³ The NHS national performance system has a set of objectives and measures. These cover health improvement, efficiency, access and treatment (known as HEAT targets).

⁴⁴ *Equally Well: Report of the Ministerial Task Force on Health Inequalities*, Scottish Government, June 2008.

⁴⁵ <http://www.ehealth.scot.nhs.uk/>

Appendix 1.

Project advisory group members

Audit Scotland would like to thank the members of the project advisory group for their input and advice throughout the study.

Member	Organisation
Margaret Brown	Head of Service Planning, NHS Highland
Mairi Dick	Head of Information, Knowledge Services and Health Records, NHS Greater Glasgow and Clyde
Kate Harley	Head of Programme, ISD Scotland
Rosemary Hill	Development Manager, Scottish Health Council
Mike Lyon	Head of Access Support Team, Scottish Government

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 2.

Study methodology

Analysis of national data

We analysed ISD Scotland published data on waiting times and numbers of people on waiting lists for 2005 to 2008 to identify trends across Scotland and any variation across NHS boards and specialties. We updated the Scotland level analysis when new data were published in November 2009. This work was done by a consultant, Deborah den Herder. We commissioned ISD Scotland to carry out further analysis of New Ways data for 2008 recorded in their central data warehouse – see table opposite.

Review of data recorded by NHS boards

We worked with ISD Scotland to develop a short survey asking NHS boards what New Ways data items they record and whether they are recorded in the patient's case notes, in their Patient Administration System (PAS) or in ISD Scotland's national data warehouse. ISD Scotland used the results from the survey to help them tailor the review of data recorded by NHS boards.

We commissioned ISD Scotland to review the data recorded on 2,675 patients across Scotland, looking at around 200 patients at 16 hospitals across the 14 NHS boards.¹ It identified samples of patients from the data warehouse, mainly focusing on the three specialties chosen for more detailed review. Where there were not enough records in the chosen specialties then additional records were sampled from other specialties at random. ISD Scotland obtained approval for the work from the NHS boards' Caldicott

ISD Scotland analysis of New Ways data

Standard analysis of New Ways data items

- Number and type of offers
- Outcome of offers
- Unavailability: number of periods, type and length (average, 25th and 75th percentiles)
- Non-attendance rates (did not attend, cannot attend and cancellations)
- Reason for removal from list
- Number of patients transferred
- Number of transfers where there is a corresponding record at the transfer destination
- Percentage of patients whose clock is reset because they did not attend or could not attend

Further analysis

- Analysis of waits (average and 90th percentile) for patients attending/admitted from the waiting list having had their clock reset because they did not or could not attend, including time before and after the clock was reset but excluding any periods of unavailability
- Average number of days prior to appointment where a cancellation takes place for patients attending/admitted from the waiting list
- Average and 90th percentile 'complete wait' for patients attending/admitted from the waiting list 2003–08, including patients with ASCs (data sources: SMR00, SMR01 and Waiting Times Data Warehouse)
- Number of attendances and average and 90th percentile wait for patients attending/admitted from the waiting list, by urban/rural classification (accessible or remote postcodes)
- Analysis (average, 90th percentile and three-week breakdown) of days between the date the offer was made and the date of the offered appointment or admission
- Number of patients with a review date and planned review date of those expected to have one
- Number of patients removed from the waiting list because they did not attend and the number of those who did not attend more than once

Source: Audit Scotland, 2009

1 Three hospitals in NHS Greater Glasgow and Clyde and one hospital in all other NHS boards.

Guardians, and the reviews took place during July and August 2009. The samples included patients with periods of unavailability and patients who had been transferred to another hospital or specialty within the same board or to another board.

Patient views

We commissioned George Street Research to carry out a telephone survey and focus groups of people who had recent experience of waiting for care. Eight hundred semi-structured telephone interviews were conducted with people across all 14 NHS board areas in Scotland with a minimum of 35 interviews in each NHS board area – see table opposite. All focus groups and interviews were conducted between 9 and 20 September 2009. The full reports for these are available on our website at www.audit-scotland.gov.uk

We commissioned five focus groups, one paired in-depth interview and four single face-to-face in-depth interviews with people aged 16 or more who were either currently, or had been within the past six months, on an NHS waiting list for a new outpatient, inpatient or day case appointment.² A total of 36 people took part in these focus groups and interviews. All groups and interviews were conducted within three of the NHS boards where we were carrying out more detailed fieldwork as part of the study (NHS Lothian, Highland and Western Isles).

Number of patient interviews conducted within each NHS board

NHS board	Number of people interviewed
Ayrshire and Arran	50
Borders	50
Dumfries and Galloway	50
Fife	50
Forth Valley	50
Grampian	50
Greater Glasgow and Clyde	130
Highland	50
Lanarkshire	65
Lothian	100
Orkney	35
Shetland	35
Tayside	50
Western Isles	35
Total	800

Source: Audit Scotland, 2009

Overall, the groups and in-depth interviews included patients and carers who live in remote and rural areas; are older; have learning disabilities; have a visual impairment; are illiterate; are homeless or whose first language is not English. In some instances there was overlap between these groups, for example some people living in remote areas were also older people or had a visual impairment or learning difficulties.

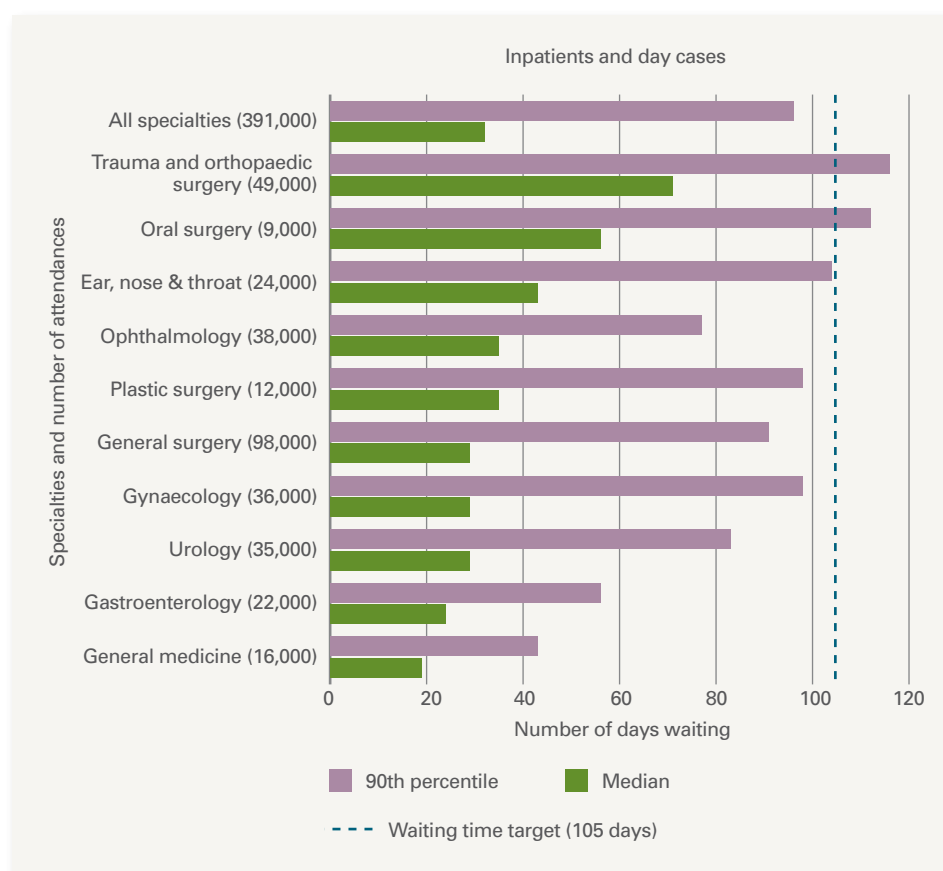
² A paired in-depth interview is when two people are interviewed at the same time.

Appendix 3.

Waiting times by specialty

This section gives more information about waiting times by a sample of specialties.

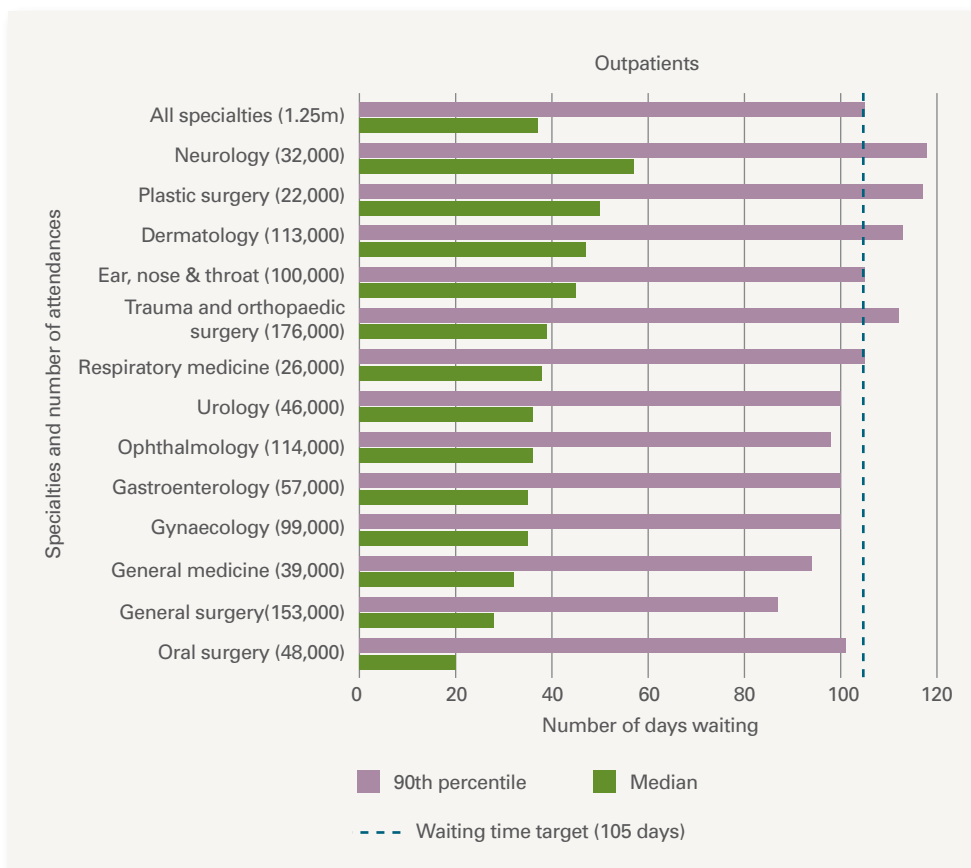
Inpatient and day case attendances and waiting times, year ended December 2008
Ninety per cent of patients in most specialties were seen within the waiting times target.



Note: The 90th percentile wait indicates that 90 per cent of patients waited up to the time shown and ten per cent waited longer.
Source: ISD Scotland, 2009

Outpatient attendances and waiting times, year ended December 2008

Waiting times vary across specialties, and some are under more pressure to meet the target.



Note: The 90th percentile wait indicates that 90 per cent of patients waited up to the time shown and ten per cent waited longer.

Source: ISD Scotland, 2009

Appendix 4.

Self-assessment checklist for NHS boards

The checklist overleaf sets out some high-level practical issues about New Ways based on issues raised in the report. NHS boards should assess themselves against each statement and consider which statement most accurately reflects their current situation. This approach will enable boards to identify what actions need to be taken forward.

Self-assessment for improving the management of waiting lists

The last column in the checklist can be used to record sources of evidence, supplementary comments to support your assessment or to highlight areas of interest.

Issue	Assessment of current position					Comment to support or explain your statement
	No action needed	No but action in hand	Yes in place but needs improving	Yes in place and working well	Not applicable	
Is the board recording all New Ways data, including information on patient reviews and transfers, to ensure that patients are being managed in line with the guidance? Is this demonstrated in a clear way?						
Is the board reviewing the reason why patients are being removed from the list because they are coded as no longer requiring treatment to ensure that they are being removed appropriately?						
Is the board monitoring levels of clinic cancellations? Is the board satisfied that clinics are cancelled for valid reasons and taking steps to reduce cancellations where possible?						
Is the board reviewing the quality of the New Ways data and working with ISD Scotland to improve local and national data?						
Is the board working with primary care to improve communication with patients about their responsibilities under New Ways and the implications of this for patients?						
Does the board have a system to record patients' additional needs?						
Is the board working with primary care to improve the way they collect and share information about patients' additional needs for support?						
Does the board provide additional support for all who need it to help patients understand the information given to them and to attend their appointment?						

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A review of new arrangements

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