Management of patients on NHS waiting lists

AUDIT SCOTLAND

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Auditor General for Scotland

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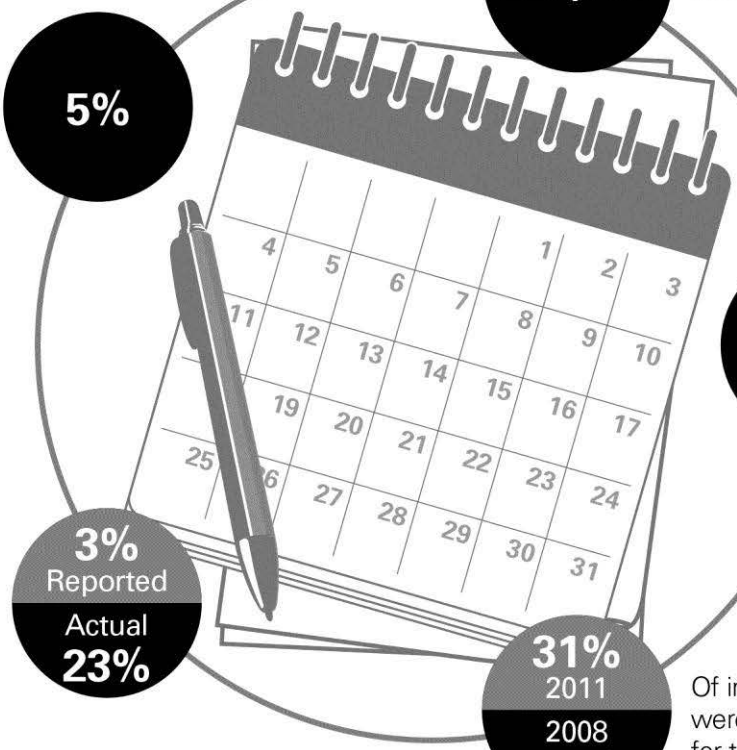
Key facts

Decrease in the number of patients on waiting lists for inpatient treatment between September 2009 and September 2012, with an increase in the number of patients still on waiting lists after 12 weeks, from 130 to 1,617

5%

228,700 Patients waiting for an outpatient appointment on 30 September 2012

55,100 Patients waiting for inpatient treatment on 30 September 2012



Of inpatients had a wait of over nine weeks in the quarter ending June 2011 (actual waits include any time patients are recorded as unavailable or have their waiting time clock reset)

3% Reported

Actual **23%**

31% 2011

2008 **11%**

Of inpatients in Scotland were socially unavailable for treatment on 30 June

Background

1. The time patients wait for treatment is very important to them. It has also been a major NHS performance target since 2003. Across Scotland, around 228,700 patients were waiting for an outpatient appointment and 55,100 patients were waiting for inpatient treatment on 30 September 2012.[1] The number of patients waiting for an outpatient appointment increased by over 20 per cent between December 2009 and September 2012, from around 187,700 to 228,700; and the number of patients waiting for an inpatient appointment decreased by five per cent from 57,776 to 55,096.[2,3]

2. Waiting time targets have reduced over recent years, from nine months for inpatient treatment in December 2003 to 18 weeks from referral to treatment in December 2011, and reported waiting times have also reduced.[4] In addition, from October 2012, the Patient Rights (Scotland) Act 2011 placed a legal requirement on NHS boards to treat inpatients within 12 weeks from the time the decision is made to go ahead with treatment.

3. In January 2008, the Scottish Government introduced a new way of defining and measuring NHS waiting times, known as New Ways, which was intended to be fairer for patients and more transparent.[5] This replaced a system where patients who were unavailable for an appointment or treatment due to medical or social reasons could lose their guarantee of a maximum waiting time. Medical reasons mean that a patient has another medical condition that prevents treatment from proceeding at that time. Examples of social reasons include not being able to get time off work, being on holiday or being away at university. Under New Ways, the time that patients are unavailable is not included in their overall waiting time against the guarantee, but they remain on the waiting list and so do not lose their waiting time guarantee. When a patient is unavailable, a member of staff updates the patient's record and applies an unavailability code to indicate that the patient is unavailable, for example for medical or social reasons.

4. The combination of shorter waiting time targets and more patients added to waiting lists means NHS boards are facing increasing challenges to treat patients within the required time. In 2011, NHS Lothian applied false periods of unavailability to patient records to appear to meet waiting time targets. This meant some patients were unknowingly waiting longer than they should have been. An investigation revealed a culture of:

    - managers putting too much pressure on staff to find ways around the system to avoid failing to meet targets

[1] Throughout the report when we refer to inpatient treatment this also includes day case treatment (when patients are admitted for less than 24 hours).

[2] We have compared September 2012 with December 2009 instead of September 2009, as prior to this optometrist referrals were not included. Comparing figures after December 2009 shows that optometrist referrals account for around 40,000 referrals per quarter.

[3] *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012.

[4] As well as GPs, optometrists and dentists can refer patients for hospital treatment.

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

- inaccurate internal performance reporting
- misrepresenting the true scale of the challenges the board was facing in treating patients within waiting time targets.[6]

5. More recently, internal auditors have reported the inappropriate use of unavailability codes at NHS Tayside, albeit on a smaller scale.[7] Both these events have put public trust in the management of waiting lists at risk. The public needs to have confidence that the NHS is reporting waiting times accurately and that patients are not being adversely affected.

6. In May 2012, the Cabinet Secretary for Health and Wellbeing asked each NHS board to carry out an internal audit of how it is complying with national guidance. The internal audit was also to provide assurance on how accurately each board reported its performance against waiting time guarantees between January and June 2012.[8] Audit Scotland is independent from the NHS and uniquely placed to look at how the NHS is managing waiting lists across Scotland. Our audit looked at how waiting lists were being managed between April and December 2011, the period when evidence came to light that waiting lists were manipulated in NHS Lothian.

About the audit

7. Our audit aimed to identify whether NHS Lothian's manipulation of waiting lists in 2011 was an isolated incident or whether it indicated more widespread problems across the NHS. Specifically we aimed to investigate whether patients were waiting longer than reported due to an inappropriate application of, or retrospective changes to, waiting list codes in patient records, such as unavailability or removal from list codes. Retrospective changes to waiting list codes are made after the code takes effect, for example adding a period of unavailability to a patient's record after the date that the unavailability starts. Removal from list codes include reasons such as treatment no longer being required or the patient being referred back to their GP as they did not attend their appointment.

8. We analysed national data on waiting times published by ISD Scotland.[9] The audit also involved a detailed review of NHS boards' electronic patient management systems, and an analysis of the application of waiting list codes in patients' records between April and December 2011. We commissioned consultants to extract extensive data from NHS boards' systems and provide a breakdown of the data (Exhibit 1, page 6).[10] Using these data, we analysed in detail the application of waiting list codes to identify unusual patterns and practices. We used this to select a sample of boards where we carried out more targeted

[6] Review of aspects of Waiting Times Management at NHS Lothian, PricewaterhouseCoopers on behalf of the Scottish Government Health Directorate, March 2012.

[7] NHS Tayside Waiting Times Arrangements, FTF Audit and Management Services, December 2012.

[8] The internal audit reports were published in December 2012 and can be found on each NHS board's website.

[9] Information Services Division (ISD) Scotland is part of NHS National Services Scotland.

[10] We extracted waiting list data from all 14 territorial NHS boards and the Golden Jubilee National Hospital.

sampling of individual patient records.[11] This analysis was complex and time-consuming due to the volume of data involved, the number of different systems in use across Scotland, and problems associated with incomplete information. For example, we had information on almost 273,000 transactions relating to periods of unavailability being applied or amended in patient records. A transaction is any amendment to a patient record. We have published an appendix on our website that provides a more detailed description of our methodology.

9. In addition to the detailed analysis of data, we examined whether NHS boards have improved their systems for recording patients' additional needs, such as a disability or requiring a translator, following up on a recommendation from our previous report on how the New Ways system was implemented.[12] We also reviewed how the Scottish Government monitors wider issues relating to the management of waiting lists alongside its monitoring of NHS boards' performance against waiting times targets.

10. This report has three main parts:

- Introduction (Part 1)
- Accuracy of waiting lists (Part 2)
- National monitoring of waiting lists (Part 3).

[11] We carried out more detailed work in NHS Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Highland and Lanarkshire.

[12] *Managing NHS waiting lists: A review of new arrangements*, Audit Scotland, March 2010.

Exhibit 1

Examples of data extracted from NHS boards' electronic systems for patients on waiting lists between April and December 2011

Audit questions	Type of data	Breakdown of the data provided for further analysis
Did NHS boards apply periods of unavailability appropriately, in line with national guidance? Did NHS boards retrospectively apply or amend periods of unavailability for appropriate reasons? Were high volumes of additions or changes made in short time periods? If so, were they appropriate?	All transactions that related to unavailability being applied or amended in patient records (total of 272,906 transactions creating or amending patient unavailability). The number of periods of unavailability that were added or amended in an hour by a single user (eg, up to 316 in an hour).	Breakdown by: • type of unavailability (medical, social or no response to patient-focused booking) • type of patient (inpatient, day case or outpatient) • hospital specialty • date and time of the entry being made in the system to apply a code or amend the patient record • recorded start date and end date of the period of unavailability affected by the transaction • the ID code for the user who made the entries • the total number of transactions by each user in an hour.
Did NHS boards remove patients from waiting lists appropriately? Did NHS boards apply the guidance on a reasonable offer appropriately?	All patients removed from the waiting list (total of 339,642 transactions to remove patients from the list, excluding patients removed from the list after receiving treatment). All patients who were offered an appointment with three days or less notice (total of 393,161 transactions for offers of an appointment date within three days).	Breakdown by: • type of patient • hospital specialty • the reason for the patient being removed from the list • date and time of the entry being made in the system to remove the patient from the waiting list • date of the patient being offered an appointment • date of the appointment.

Notes:
1. The number of transactions (any amendment to a patient record) is higher than the number of patients affected as several transactions can relate to one patient record.
2. Patient-focused booking is where the board asks the patient to contact the hospital to arrange a suitable appointment or confirm that a given appointment is suitable. The patient may receive another letter as a reminder; or the hospital may assume that the patient has accepted an appointment given in the original letter. If a patient fails to respond to the original letter or a reminder letter then they may be marked as unavailable.
3. We were not always able to get directly comparable data from all systems. The limitations in the analysis are summarised in the appendix on our website.

Source: Audit Scotland

Key messages

- **The systems used to manage waiting lists have inadequate controls and audit trails, and the information recorded in patient records is limited. This means that it is not possible to trace all the amendments that may have been made to the records of patients waiting for treatment, or to identify the reasons for them.**
- **Social unavailability codes are intended to give patients more flexibility, but most patients' records that we reviewed did not include enough information to verify that unavailability codes had been applied properly after discussion with the patient or their GP. The percentage of people waiting for inpatient treatment who were given a social unavailability code rose from 11 per cent in 2008 to just over 30 per cent at the end of June 2011. The proportion of patients coded as socially unavailable was higher in some specialties, such as orthopaedics and ophthalmology. The use of this code started to reduce in most NHS boards in late 2011, and the percentage of patients waiting longer than 12 weeks started to rise. The reasons for this are unclear, due to the limitations of waiting list management systems and the lack of evidence in patient records.**
- **Our sampling found a small number of instances in which unavailability codes were used inappropriately. The limitations of waiting list management systems and the lack of evidence in patient records mean that it is not possible to determine whether these instances were due to human error, inconsistent interpretation of the guidance, or deliberate manipulation of waiting times.**
- **During 2011, the focus within the Scottish Government and NHS boards was on meeting waiting time targets and developing capacity in areas where patients were waiting longer. There was not enough scrutiny of the increasing number of patients recorded as unavailable. Better use of the available information could have helped identify concerns about the use of unavailability codes. It could have also identified wider pressures that were building up in the system around the capacity within NHS boards to meet waiting time targets.**
- **Patients and staff have raised a number of concerns about the management of waiting lists. The Scottish Government has announced that it will pilot a national confidential phone line during 2013 to respond to these and other concerns. In order to safeguard patients' interests, it is important to have effective whistleblowing policies and an environment where people can raise concerns safely and know that they will be acted upon.**

Key recommendations

The Scottish Government and NHS boards should:

- **monitor and report the use of waiting list codes and ensure that they are being applied appropriately and consistently, and in line with updated national guidance issued in 2012**
- **use information about the use of waiting list codes, alongside waiting time performance data, to:**
    - **identify where staff may be applying codes inconsistently or inappropriately**
    - **help plan and manage the capacity needed to meet waiting time targets.**

NHS boards should:

- **make sure that electronic systems have an audit trail to enable scrutiny of waiting list systems, and that good controls and safeguards are in place to provide assurance that waiting lists are being managed properly**
- **ensure that information is recorded within patient records about the reasons for applying waiting list codes**
- **communicate clearly with patients about their rights and responsibilities under waiting time guidance and legislation**
- **ensure effective whistleblowing policies and procedures are in place and publicised.**

Non-executive directors of NHS boards should:

- **ensure they have the full range of information available to scrutinise how their board is applying waiting list codes and planning and managing capacity to meet waiting time targets.**

The Scottish Government and ISD Scotland should clarify:

- **the role of each organisation in monitoring the application of waiting list codes and performance against waiting time targets**
- **the process for raising concerns about issues within individual NHS boards.**

Part 1. Introduction

Waiting time targets have been steadily reducing

11. The time patients wait for treatment matters to them. It has also been a major NHS performance target since 2003. Waiting time targets have shortened considerably over recent years (Exhibit 2), and reported waiting times have also reduced. The Scottish Government set the NHS a challenging target from December 2011 to treat at least 90 per cent of all patients within 18 weeks of the patient being referred to hospital.[13] And from October 2012, NHS boards have had a legal requirement to treat inpatients within 12 weeks from the time the decision is made to go ahead with treatment. This guarantee operates alongside the overall 18-week referral to treatment time target.

Exhibit 2
Waiting time targets, 2003 to 2012
Waiting time targets have reduced significantly since 2003.

Date target came into effect	Targets for new outpatient appointment	Targets for hospital inpatient or day case treatment
31 December 2003	–	9 months (274 days)
31 December 2005	26 weeks (182 days)	26 weeks (182 days)
31 December 2007	18 weeks (126 days)	18 weeks (126 days)
1 January 2008 – *New Ways guidance for managing waiting lists* came into effect		
31 March 2009	15 weeks (105 days)	15 weeks (105 days)
31 March 2010	12 weeks (84 days)	12 weeks (84 days)
31 March 2011	12 weeks (84 days)	9 weeks (63 days)
31 December 2011	18 weeks from referral to treatment (126 days)	
August 2012 – *NHSScotland Waiting Time Guidance* replaced previous guidance and incorporates new Treatment Time Guarantee guidance		
1 October 2012		12-week treatment time guarantee applies alongside the overall 18-week referral to treatment target

Source: Audit Scotland

[13] From 31 March 2011, the NHS was working to interim waiting times targets of no longer than 12 weeks from referral from primary care to a new outpatient appointment and no longer than nine weeks for inpatient or day case treatment.

12. Not all of the treatment patients receive in hospital is covered by waiting time targets. Certain clinical specialties or treatments are excluded, such as psychiatry services, maternity services, assisted reproduction, organ transplants, and patients attending outpatient clinics for follow-up treatment. Our audit only looked at waiting list data on patients covered by waiting time targets.

13. New Ways introduced the concept of a waiting time clock. This calculates the time that patients wait between being added to a hospital waiting list and getting an outpatient appointment or inpatient treatment. The waiting time clock does not count periods when patients are unavailable for treatment for medical or social reasons. Examples of these include having another medical condition that needs to be treated first, or being on holiday. Patients are expected to accept a reasonable appointment offer, defined as up to two dates with a minimum of seven days' notice. People can be removed from 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 or they cancel two or more appointments. In some circumstances when the patient refuses a reasonable offer, their waiting time clock may be reset to zero and any time they waited before the clock reset is not included in the reported waiting time. New Ways was designed to be fairer to patients but has proved complex to operate (Exhibit 3).[14]

14. In August 2012, the Scottish Government published updated guidance covering aspects of New Ways that NHS boards had been interpreting and applying inconsistently. The guidance also incorporated the new treatment time guarantee.[15]

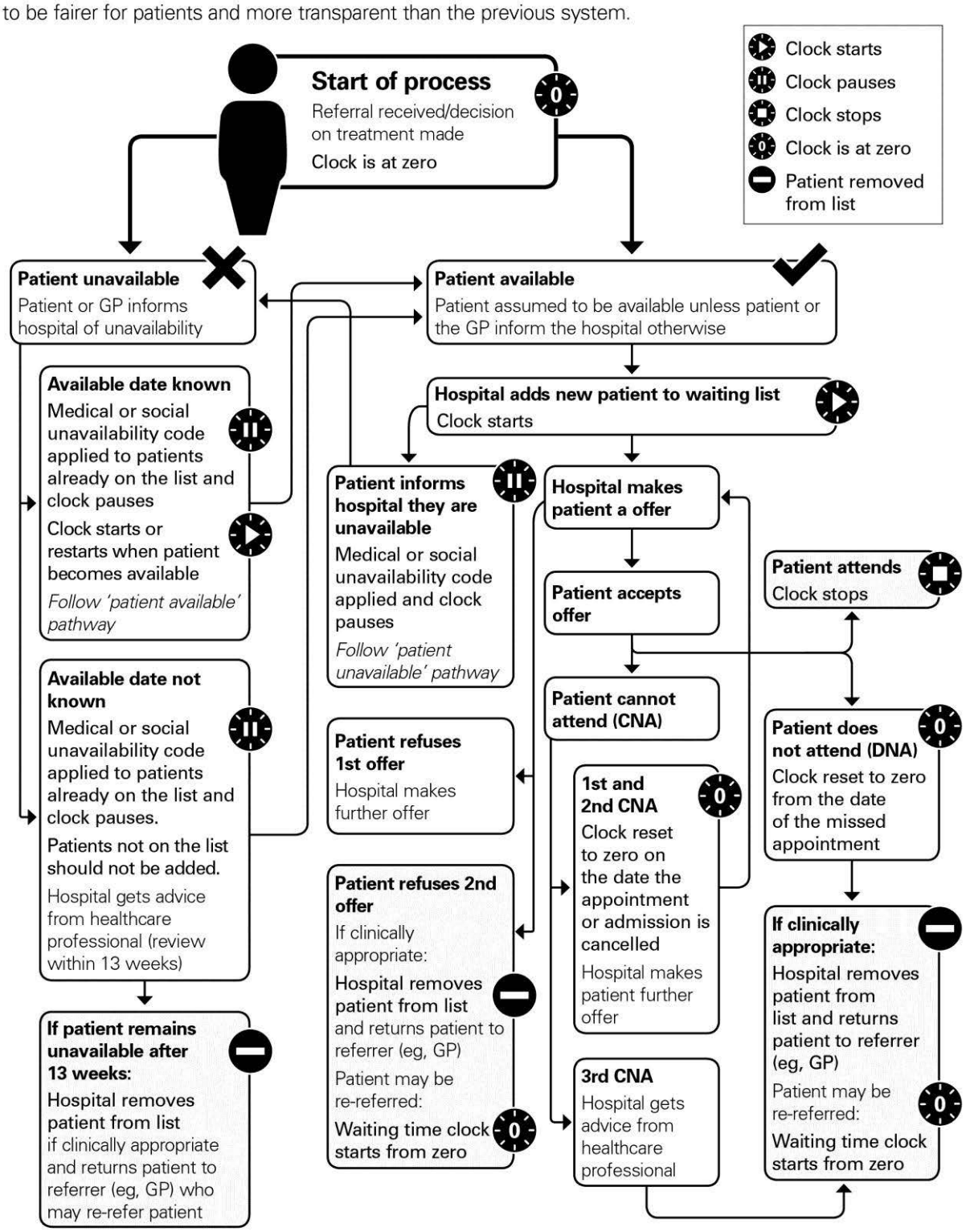
[14] *New Ways of defining and measuring waiting times: Applying the Scottish Executive Health Department guidance - version 3.0*, ISD Scotland, 2007.

[15] *NHSScotland Waiting Time Guidance: 18 weeks Referral to Treatment Standard, New Ways Stage of Treatment Standards and incorporating Treatment Time Guarantee Guidance*, Scottish Government, August 2012.

Exhibit 3

New Ways guidance

New Ways guidance introduced a new way of managing patients' waits. The new system was designed to be fairer for patients and more transparent than the previous system.



Note: Some NHS boards operate patient-focused booking where the board asks the patient to contact the hospital to arrange a suitable appointment or confirm that a given appointment is suitable. The patient may receive another letter as a reminder; or the hospital may assume that the patient has accepted an appointment given in the original letter. If a patient fails to respond to the original letter or a reminder letter then they may be marked as unavailable.

Source: Audit Scotland

Part 2. Accuracy of waiting lists

Key messages

- **The systems used to manage waiting lists have inadequate controls and audit trails, and the information recorded in patient records is limited. This means that it is not possible to trace all the amendments that may have been made to the records of patients waiting for treatment, or to identify the reasons for them.**
- **Social unavailability codes are intended to give patients more flexibility, but most patients' records that we reviewed did not include enough information to verify that unavailability codes had been applied properly after discussion with the patient or their GP. The percentage of people waiting for inpatient treatment who were given a social unavailability code rose from 11 per cent in 2008 to just over 30 per cent at the end of June 2011. The proportion of patients coded as socially unavailable was higher in some specialties, such as orthopaedics and ophthalmology. The use of this code started to reduce in most NHS boards in late 2011, and the percentage of patients waiting longer than 12 weeks started to rise. The reasons for this are unclear, due to the limitations of waiting list management systems and the lack of evidence in patient records.**
- **Our sampling found a small number of instances in which unavailability codes were used inappropriately. The limitations of waiting list management systems and the lack of evidence in patient records mean that it is not possible to determine whether these instances were due to human error, inconsistent interpretation of the guidance, or deliberate manipulation of waiting lists.**
- **NHS boards have been applying waiting time guidance differently, including how they apply unavailability codes, how they define a reasonable offer and when patients are removed from the waiting list.**
- **NHS boards are not systematically recording patients' additional support needs and it is not clear if they are being met. We found little evidence that many NHS boards are taking patients' individual circumstances into account before offering them treatment at a location outside the board area. Many NHS boards are not monitoring the number of offers made to patients for treatment outside the board and how many accepted.**
- **Patients and staff have raised a number of concerns about the management of waiting lists. The Scottish Government has announced that it will pilot a national confidential phone line during 2013 to respond to these and other concerns. In order to safeguard patients' interests, it is important to have effective whistleblowing policies and an environment where people can raise concerns safely and know that they will be acted upon.**

Systems for managing waiting list information have inadequate controls and audit trails

15. Each NHS board has at least one electronic patient management system which may contain several elements, including waiting lists, medical notes and test results. In 2011, six main systems were in use across NHS Scotland. They differ in the level of detail recorded about patients' waiting times and the level of assurance they provide about local practices in managing patient waits. The limitations of systems meant we were unable to do some of our analyses in all of the systems (see the appendix on our website).

The capabilities of electronic systems for managing waiting lists are limited

16. Some patient management systems have been in place in NHS boards for several years and were not designed for managing waiting lists. NHS boards have had to adapt their local systems as waiting time targets were introduced and subsequently reduced.

17. The information we were able to extract from the iSoft system used by NHS Highland was extremely limited. We were not able to carry out analysis on the iSoft or Meditech systems used by NHS Greater Glasgow and Clyde. Despite attempts to work with the suppliers of both systems, NHS Greater Glasgow and Clyde was unable to identify and extract the data we needed. The board was also in the process of transferring to the TrakCare system at the time of our audit. In addition, the audit trail provided in both these boards' iSoft systems is overwritten when changes are made to patient records and copies are not kept. More detailed information about the limitations of each system is contained in the appendix on our website.

18. TrakCare, used by NHS Lothian for several years, has a specific waiting list function built into the system. Since 2011, five other NHS boards have implemented TrakCare.[16] It has more advanced audit trails, providing better information about what is happening to patients. But TrakCare also has some limitations in the way information within patient records can be tracked. Some NHS boards said it cannot easily identify when waiting time clocks are reset, for example when patients do not attend appointments. Nor can it easily distinguish between staff applying a new period of unavailability and changing an existing period of unavailability. Boards would only identify this by reviewing individual patient records, which makes it more difficult for them to monitor amendments such as extending patients' unavailability. Some boards which use TrakCare, including NHS Lanarkshire and Lothian, are developing enhanced performance reporting to monitor patients on waiting lists. This good practice should be shared among other boards.

[16] NHS Ayrshire and Arran, Borders, Grampian and Lanarkshire implemented TrakCare during 2011. NHS Greater Glasgow and Clyde is phasing in TrakCare across the board during 2012 and 2013.

There are insufficient safeguards for access to waiting list systems

19. With the exception of systems in NHS Greater Glasgow and Clyde and NHS Highland, NHS boards had systems with audit trails in place that can identify unusual activity. Examples of this include a high number of waiting list codes being added or amended within patient records, who made the changes, and when changes were made. But we did not find any of the six NHS boards in our fieldwork routinely using this audit trail information to monitor how waiting lists were being managed within their board.

20. Many staff have access to NHS boards' patient management systems. Most internal audit reports (nine out of 15) highlight the need to monitor the number of users with access to the waiting list system and ensure levels of access are appropriate to job roles. Nine reports detailed the number of system users within the board.[17] The percentage of staff with access to electronic waiting list systems ranged from 14 per cent in NHS Greater Glasgow and Clyde (5,768 staff) to 64 per cent in NHS Lothian (14,700 staff).[18] Internal auditors highlighted other issues in two boards:

    - NHS Forth Valley - some accounts for access to electronic waiting lists belonged to individuals who were no longer employed by the board
    - NHS Tayside - the electronic waiting list system did not automatically lock after a period of inactivity and passwords did not automatically expire after a fixed period of time.

21. Systems for managing patient information require good controls and safeguards (Exhibit 4).

[17] The number of system users was provided for the following NHS boards: Ayrshire and Arran, Borders, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian and Tayside.

[18] Note that in some NHS boards access to electronic systems could be for functions other than managing waiting lists. Also, users in some NHS boards included those not directly employed by the board, including staff in GP surgeries and university researchers.

Exhibit 4

Necessary controls for safeguarding the integrity of waiting list systems

NHS boards need good controls and monitoring to be able to provide assurance on how they manage waiting lists and performance reporting.

Management of waiting list	Controls and monitoring that should be in place in each NHS board
Electronic waiting list system	• Access to the system limited to only those staff who need it, accompanied by strong and effective approval processes and security controls for access. • Minimise the number of staff who need to access the system, for example by centralising outpatient booking. • Ongoing training provided to all staff using the system to ensure everyone applies waiting list codes appropriately and consistently, and to minimise errors. • Links to electronic referral systems for all referral sources to ensure prompt referral into hospital systems and automatic addition of patients to the waiting list. • Links to electronic vetting systems to ensure prompt review of patient referrals and decisions on next steps by hospital clinicians. • Monitor key elements of waiting lists to ensure patients are being managed appropriately, for example patients added to list are vetted; patients are booked for an appointment or treatment; periods of unavailability are minimised, have an end date and are reviewed regularly. • Audit trail of all transactions within the system to allow boards to identify and analyse: – application of waiting list codes and changes to existing codes – retrospective changes to codes – the date and time codes were applied or changes made – the member of staff who applied the codes or made changes.
Electronic patient records	• Fields for all relevant waiting list codes and sub-codes to ensure boards can monitor and audit all aspects of the waiting list. • Specific field to flag patients' additional needs to help ensure services are aware of what support is required. • Adequate free-text field to add notes on reasons for codes being applied, conversations with patients and any other relevant information – each note should include the date and member of staff's initials. • Regular audits of a sample of patient records to ensure staff are applying codes appropriately and filling in fields correctly.

Source: Audit Scotland

There is a lack of evidence in patient records about the reasons for applying waiting list codes

22. Electronic patient records have a space where staff can add limited notes to record information, for example about why a code has been applied or details of a conversation with a patient or their GP about availability. These notes provide an important audit trail about why codes have been applied or amended. We found that in general staff were not recording the reasons for applying codes to a patient record, for example:
    - In NHS Greater Glasgow and Clyde, some patient records had notes about why social unavailability was applied, for example patients choosing to wait for a specific hospital or consultant, but this varied by specialty. In the electronic system used in the south of Glasgow, the full patient record was not accessible once a patient was removed from the waiting list and only limited information was kept. This made it difficult to review how individual patients had been managed and if waiting list codes had been used appropriately.
    - In NHS Grampian, records often had no information recorded about why social unavailability was applied. The board stated that this code is used extensively for patients choosing to be treated locally.

23. NHS Forth Valley was an exception in this aspect of the audit. We found good practice in the way information was recorded in its electronic waiting list system, with detailed notes in patient records, particularly for inpatients. These gave clear reasons for applying both social and medical unavailability codes and for removing patients from the list, and notes of discussions with the patient or their GP.

NHS boards have been applying waiting times guidance differently

24. NHS boards have been applying the guidance differently in a number of areas which directly affect the way in which patients are managed on the waiting list. These include differences in:
    - what constitutes a reasonable offer
    - how boards are applying unavailability codes
    - when the waiting time clock is reset
    - when patients are removed from the waiting list.

25. We also found variation in how guidance was being applied within NHS boards, which highlights a need for better and more consistent training. For example, guidance was being applied differently among specialties and between outpatient booking staff and medical secretaries. And we found a small number of errors in patient records (around 1-2 per cent of records sampled). Some of these errors have the potential to directly affect patients' waiting times. For example:
    - the wrong codes had been applied, for example social rather than medical unavailability
    - the wrong dates had been entered for periods of unavailability
    - patients had not been removed from the list after attending an appointment.

We found a lack of clarity and consistency in what constitutes a reasonable offer

26. New Ways guidance defines a reasonable offer as one where the patient is:

- offered up to two dates for an outpatient, inpatient or day case appointment, and
- given at least seven days' notice.

27. If a patient declines both offers then the waiting time clock should be reset to zero from the date the patient declines a second offer. Patients may also be offered short-notice appointments (less than seven days in advance) but if they decline these offers the waiting time clock should not be adjusted.

28. The biggest area of inconsistency among boards is whether an offer outside the board area constitutes a reasonable offer. As well as referring patients to other boards for regional or specialist treatment, NHS boards can use the Golden Jubilee National Hospital (GJNH) in Clydebank, Stracathro Referral and Treatment Centre (SRTC) in Angus, or private hospitals for additional capacity. At the time of our audit, many NHS boards did not make clear in their local guidance what constituted a reasonable offer. This is now required under updated national guidance issued in August 2012.

29. We found variation in whether NHS boards offer treatment at the GJNH, SRTC or private hospitals; and how far boards expect patients to travel for appointments or treatment. For example, staff in NHS Fife stated that most offers are for treatment within the board and they would offer some patients appointments at SRTC but not at the GJNH. However NHS Grampian stated it offered appointments at both the GJNH and SRTC. We found little evidence to suggest that NHS boards are taking account of patients' individual circumstances, such as access to transport, mobility or additional support needs, before offering them treatment at a location outside the board area.

30. We found that many NHS boards were not monitoring the number of offers made to patients for treatment outside the board area and how many of these had been accepted. This is essential information that should be available within NHS boards as part of monitoring local capacity to ensure they have enough skilled staff, equipment and facilities to treat people within waiting time targets. The information recorded about the location of offers in NHS Forth Valley's system was much more detailed than in other boards, but even in this board staff were not monitoring this information routinely.

It is not clear if patients' additional support needs are being met

31. Our previous report recommended that NHS boards should ensure patients with additional support needs, such as a disability or requiring a translator, are identified and provided with the support they require. The Scottish Government did not implement this recommendation within New Ways guidance. We found that most boards still do not have a systematic way of recording patients' additional support needs. Also, the guidance on what constitutes a reasonable offer did not take into account any additional support needs a patient may have had. The updated waiting time guidance requires NHS boards to do more to identify and

record patients' additional support needs, and to put appropriate support in place. This is so that vulnerable patients are not disadvantaged.

32. In NHS Lanarkshire, some patients who should have been covered by waiting time targets were not on the electronic waiting list and their waiting times were not being formally reported locally or to ISD Scotland during 2011 and early 2012. NHS Lanarkshire estimates that this could have affected around eight new patients referred each month over a period of 12 months. These patients were mainly patients with learning disabilities who needed dental treatment under general anaesthetic. As their waiting time was not being formally recorded or reported, they could well have been waiting longer than the guarantee.

33. The Scottish Government and ISD Scotland have looked at reported hospital activity against reported waiting time data at a specialty level. This was to assess whether all relevant specialties were included in waiting time reporting. The last time they did this comparison was in March 2011 and some differences in the two datasets were identified but not always explained. ISD Scotland has confirmed that it will be monitoring this more closely in the future.

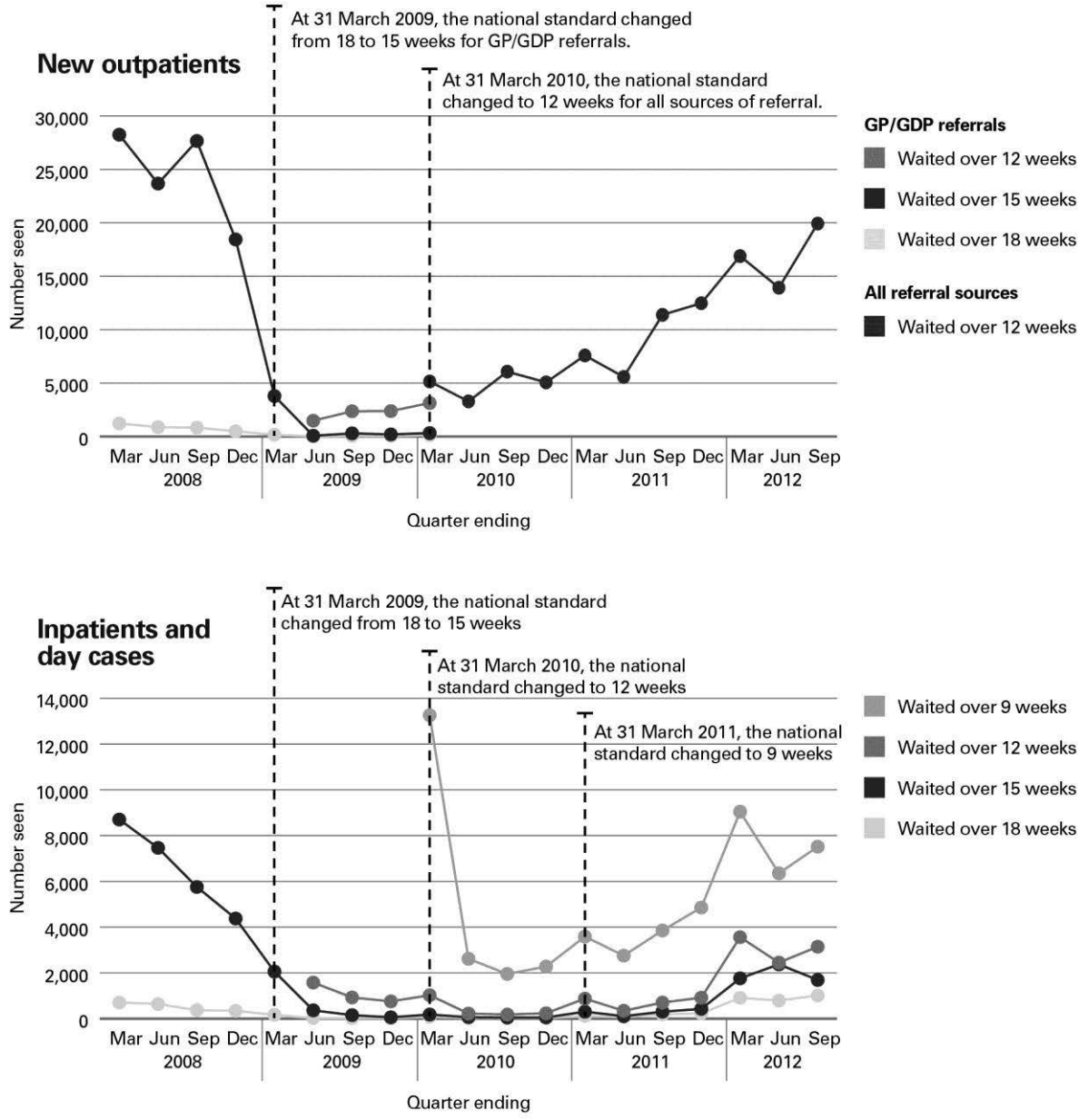
The percentage of patients recorded as unavailable increased as target times reduced

34. As waiting time targets have become shorter the reported length of time patients wait has reduced. The median actual wait for an inpatient and day case treatment reduced from 37 to 33 days between June 2008 and June 2012. However, the median actual wait for an outpatient appointment remained at 40 days between June 2010 and June 2012, and increased to 45 days in September 2012. In March 2008, around 28,000 patients waited over 15 weeks for an outpatient appointment and around 9,000 patients waited over 15 weeks for an inpatient admission. These both reduced to fewer than 200 patients who waited over the target of 15 weeks by the end of 2009. However, in 2011 the number of outpatients who waited over the target of 12 weeks and inpatients who waited over the target of nine weeks began to increase (Exhibit 5).

Exhibit 5

Completed waits for patients on a waiting list in NHS Scotland, 2008–12

Reported waiting times have reduced over recent years but started to increase during 2011.



Notes:
1. GP/GDP referrals are from general medical practices and general dental practices.
2. All referrals include: GP, GDP and optometrist referrals.
3. When the delivery date for a national target has been reached that target becomes a standard.

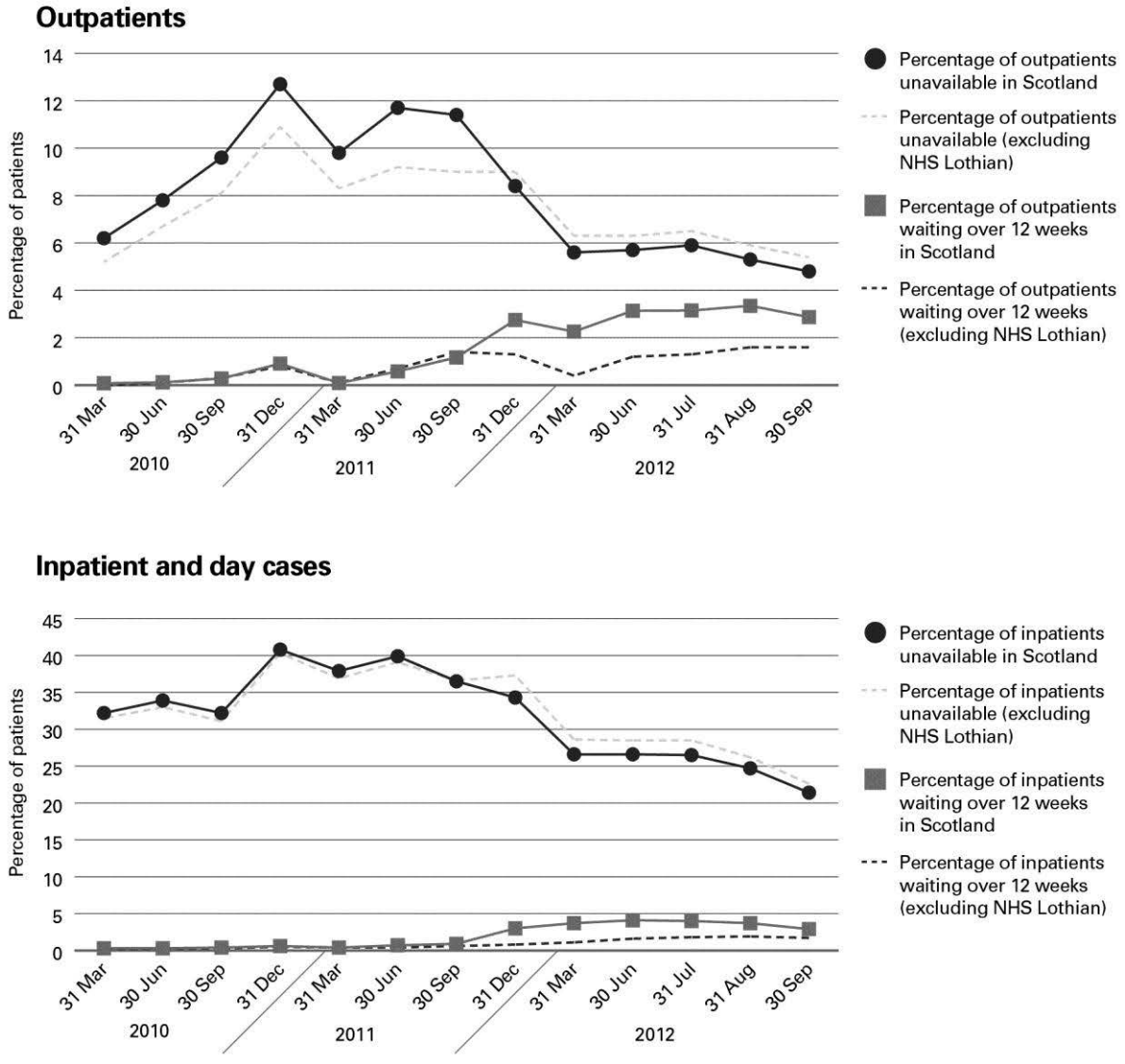
Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012

35. Most NHS boards' use of unavailability codes increased as the target waiting time reduced during 2010 and 2011. Towards the end of 2011, around the time concerns were raised about NHS Lothian, the use of unavailability codes began to reduce and the percentage of patients waiting longer than 12 weeks started to rise (Exhibit 6). The trends in NHS Lothian were similar to the rest of Scotland.

Exhibit 6

Trends in reported waiting times for patients on waiting lists and how NHS boards use unavailability codes in Scotland, 2010–12

As the percentage of outpatients and inpatients coded as unavailable decreased, the percentage of patients waiting over 12 weeks increased.



Note: The target for inpatients changed from 12 weeks to nine weeks in March 2011.
Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012

There is widespread use of social unavailability codes and it is not always clear why they have been applied

36. We examined boards' use of social unavailability codes as NHS Lothian used this code inappropriately to manipulate its waiting times performance (Case Study 1). More recently, an internal audit reported the inappropriate use of social unavailability codes in NHS Tayside. A subsequent internal investigation found no evidence of intentional manipulation of the waiting time figures (Case Study 2 overleaf).

Case Study 1

Misuse of social unavailability codes in NHS Lothian to manipulate performance against targets

High numbers of retrospective additions of, or changes to, periods of unavailability were being applied falsely in a number of surgical specialties at the end of each month. This was just before reporting to management was due on any patients not being seen or treated within waiting time targets. When staff were questioned about these patterns they indicated that periods of unavailability were often applied without contacting the patient. Staff felt under pressure to do this as the board did not have available capacity to treat patients within waiting time targets within the board, and a management culture of not wanting to report bad news.

As periods of unavailability are not included in patients' reported waiting times, this meant that many patients not being treated within waiting time targets were not reported and NHS Lothian falsely reported it was meeting the targets in nationally published reports. For example, nationally reported data showed 2,617 inpatients were marked as unavailable for the quarter ending December 2010. NHS Lothian subsequently changed this to 3,932, a difference of 1,315.

Source: *Review of aspects of Waiting Times Management at NHS Lothian*, PricewaterhouseCoopers on behalf of the Scottish Government Health Directorate, March 2012

37. Under New Ways guidance, NHS boards can record patients as socially or medically unavailable for treatment. This means that the period when a patient is unavailable for treatment or not able to attend an appointment is not included in the patient's overall waiting time. Patients who become unavailable while on a waiting list should be reviewed within 13 weeks to ensure they do not remain on the waiting list indefinitely (this has been amended to 12 weeks under the updated guidance).

38. There has been a considerable increase in the use of social unavailability codes in recent years. Our previous report highlighted that in 2008 the percentage of all patients reported as socially unavailable for outpatient and inpatient treatment ranged from around five to 22 per cent across NHS boards. In June 2011, the percentage of patients waiting for an outpatient appointment with social unavailability codes ranged from one to 21 per cent among NHS boards; and the percentage of patients waiting for inpatient treatment with social unavailability codes ranged from 12 to 40 per cent.[19]

[19] *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012.

Case Study 2

Inappropriate use of social unavailability codes in NHS Tayside

The internal audit reported that of 367 transactions reviewed, 94 transactions (which the internal auditor confirmed affected 92 patients) were not in line with New Ways guidance (around 25 per cent).

The report said: '…while some of these appeared to be based on misunderstanding, for 17 per cent of the 367 transactions tested, unavailability appeared to have been systematically applied to prevent patients being reported as not meeting their treatment guarantee date… It would not be accurate to extrapolate from our findings and conclude that there was a widespread problem, although it is apparent that areas of bad practice did exist.' Examples from the report include the following:

- 'Up to three weeks unavailability was routinely applied whilst the clinic was waiting for the patient to return a pain questionnaire, which should have been considered as a normal part of the care pathway. It is now recognised that this is not appropriate and the practice has ceased (21 examples).'
- 'Medical unavailability being added because the required equipment was not available in hospital (four examples).'
- 'Making patients unavailable on the grounds that the patient was informed by the consultant that the guarantee date was not achievable (this process was ongoing at the time of the audit) (17 examples).'
- 'Making patients unavailable because they were uncontactable to be offered a short-notice appointment (this process was ongoing at the time of the audit) (one example).'
- 'Making patients unavailable retrospectively without contact with the patient, from the day before guarantee date to the day before appointment, on the basis of waiting times information reports, albeit sometimes on the reasoning they would have been unlikely to agree to be treated outwith NHS Tayside had they been contacted (45 examples).'

The report notes: 'The final three issues, comprising 17 per cent of the sample (63 transactions) shared similar characteristics in that they all related to areas identified as capacity pressure points and in which, according to staff descriptions of processes then in place, staff reviewed weekly waiting times information reports, which identified patients at risk of not meeting their guarantee date and systematically applied unavailability to avoid a breach position. For the majority of these transactions, according to staff descriptions, there was no factual basis for the unavailability.'

It is not clear how many more patients may have been affected by the inappropriate application of unavailability codes or for how long some of the practices identified by the internal audit may have been going on.

NHS Tayside carried out a subsequent internal investigation under its Employee Conduct Policy. The investigation found that there was no evidence of any intentional manipulation of the waiting time figures.

Source: *NHS Tayside Waiting Times Arrangements*, FTF Audit and Management Services, December 2012. Copies of correspondence provided by NHS Tayside.

39. We examined how NHS boards were applying social unavailability codes during April to December 2011, including:

- an analysis of patterns of new and amended periods of unavailability, such as high numbers of periods of unavailability recorded in electronic systems over short periods of time
- if periods of unavailability were applied retrospectively
- if periods of unavailability were applied after a hospital cancelled an appointment.

40. Limitations in NHS waiting list management systems meant that we were unable to carry out all these analyses from the data from all NHS boards' systems. In particular, we were unable to use the data to investigate whether periods of unavailability were applied when a patient's waiting time was just about to exceed the target, or whether the application of unavailability prevented the patient from exceeding the target time (see the appendix on our website). This information is not readily available to NHS boards or the Scottish Government and limits their ability to monitor if boards are applying social unavailability codes appropriately.

41. Our analysis highlighted high levels of changes to patients' records in a sample of boards. Staff in NHS boards gave reasonable explanations for many of the instances of high numbers of changes to patients' records. For example, in NHS Forth Valley high numbers of transactions were generated overnight due to the system carrying out routine record updates for changes made during the day. NHS Lanarkshire made a large number of changes in a short period of time to move patients from different lists onto a single list. NHS Grampian and NHS Lanarkshire also described considerable problems they had with patient records after they transferred to TrakCare during 2011. This required correcting many records over several months.

42. We were often unable to verify the reasons for the application of social unavailability codes to patient records in NHS boards in our fieldwork sites. With the exception of NHS Forth Valley, individual patient records lacked evidence about the reasons why staff had applied social unavailability and we were therefore unable to assess whether this code had been applied appropriately. In our detailed fieldwork, we identified local practices that mean many patients may have waited considerably longer than the reported waiting time. These include:

- NHS Forth Valley used a local code, *Aware of breach - willing to wait,* for patients choosing to wait for treatment at a location within the board area. In October 2011, the board instigated a local investigation into how staff were using this code. The subsequent report estimated that use of this local code accounted for up to a quarter of patients who were unavailable. The board stopped using this code in May 2012.
- NHS Grampian had multiple, consecutive periods of unavailability, with no notes in patient records about why these had been applied. For example, 300 patients on the waiting list at 12 August 2012 had four or more periods of unavailability during their wait.
- NHS Greater Glasgow and Clyde had long periods of social unavailability, of up to six months, for ophthalmology and orthopaedic patients waiting to be seen at a particular hospital. In the absence of detailed data, we randomly sampled records where patients had been coded as unavailable. Of the 115 records sampled, 29 (25 per cent) had periods of social unavailability of over two months with notes indicating this was reportedly for reasons of patient choice.
- NHS Highland had patients with periods of social unavailability with no end date. This means patients could have remained unavailable indefinitely if they were not reviewed. In the absence of detailed data, we randomly sampled records where patients had been coded as unavailable. Six out of 23 records sampled (26 per cent) had periods of unavailability added without an end date, although sometimes end dates had been added

later. There were also two records with unavailability of over one year for ophthalmology patients who were not ready for surgery. These patients should have been referred back to the GP unless this was clinically inappropriate, and referred back to the hospital once they were in a position to have treatment.

- NHS Lanarkshire extensively used a local *patient requests suspension* code. Staff said they often used this for patients who wanted to be seen at a particular hospital. Out of the 40,518 transactions relating to unavailability over this period, 21,699 involved this code (54 per cent).

43. In NHS Grampian, we found a high number of orthopaedic patients who had been coded as medically unavailable over a relatively short period of time with the periods of unavailability ending on the same date: 171 patients in June 2011 over a period of two hours; and 180 patients in August 2011 over a period of one hour. The periods of medical unavailability were immediately followed by at least one period of social unavailability. NHS Grampian was aware of this issue and said it had exposed a training need in Dr Gray's Hospital in Elgin, where booking staff had mistakenly coded patients as medically unavailable rather than socially unavailable. While we consider that this is a reasonable explanation, when we reviewed a small sample of these patient records we found many other errors. These included duplicate records for the same patient, and return outpatient appointments added to the wrong records, but no explanatory notes. In addition, there was no documentary evidence that these patients had been reviewed or contacted to confirm that they were unavailable.

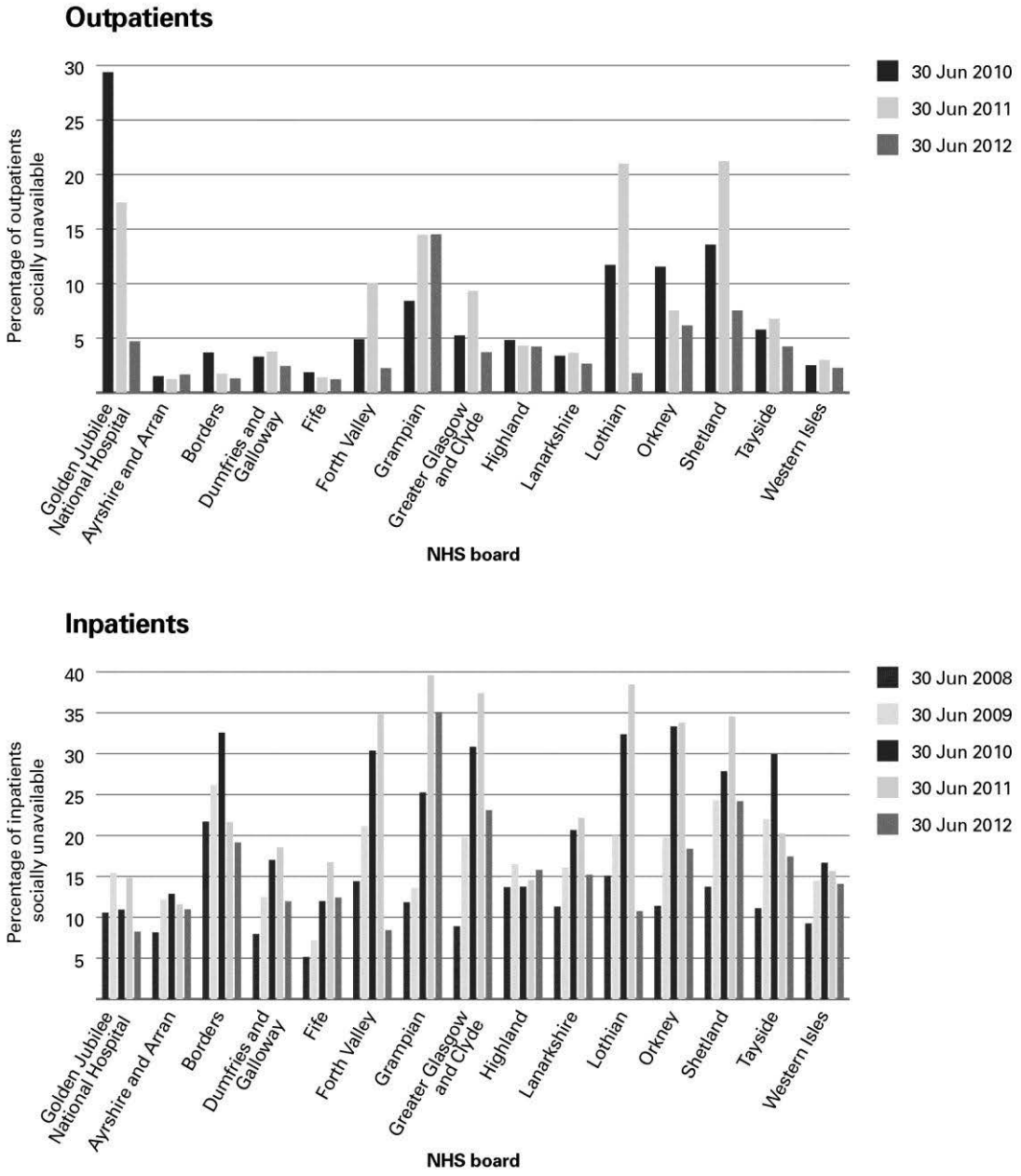
Social unavailability started to reduce in most NHS boards in late 2011

44. The percentage of patients with social unavailability codes reduced in most boards between June 2011 and June 2012 (Exhibit 7). Overall unavailability began to decrease in 2011, around the time concerns began to be raised about the way NHS Lothian was managing its waiting lists. Even with these reductions, social unavailability is still higher in most boards than it was in 2008.

Exhibit 7

Percentage of patients reported as socially unavailable, by board

The percentage of patients with a social unavailability code varies by board. In general, the percentage of inpatients with this code was growing from 2008 and then reduced in most boards between 2011 and 2012.



Notes:
1. Comparable figures for outpatients recorded as socially unavailable are only available from 2010.
2. The reason for higher rates of outpatient social unavailability at the GJNH is due to patients with long-term conditions attending the national service for Adult Congenital Heart Disease.
Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012

Use of social unavailability codes may have indicated wider capacity issues

45. NHS Lothian applied social unavailability codes falsely to patient records in order to appear to meet waiting time targets. Internal auditors in NHS Tayside reported that the board had inappropriately applied periods of unavailability in a number of specialties with capacity pressures.

46. New Ways guidance was designed to allow boards to be more responsive to patients' needs and many NHS boards reported that they used the social unavailability code to indicate when patients wanted to be treated locally (Case Study 3). However, there are indications that not all of these patients would have been able to be treated locally (either within the board area or at the local hospital) within the waiting time targets. Social unavailability tends to be higher in specialties with high patient numbers and more pressure on capacity, such as orthopaedics and ophthalmology (Exhibit 8, page 28). Staff told us they used these codes most extensively in higher volume specialties. Social unavailability can also vary between hospitals within a board area.

Case Study 3
Extensive use of unavailability codes in some NHS boards

In NHS Greater Glasgow and Clyde, staff told us that social unavailability was used extensively for patients who said they wanted to be seen at a specific hospital within the board area. This was particularly evident in some high volume specialties where it was more challenging to treat people within waiting time targets, although the percentage of patients recorded as unavailable did decrease at most hospitals during 2011. For example, in early 2011, around:

- 70 per cent of patients (900 patients) on the waiting list for orthopaedic inpatient treatment at the Western General Hospital were coded as unavailable
- 40 per cent of patients (145 patients) on the waiting list for an ophthalmology outpatient appointment at the Southern General Hospital were coded as unavailable.

In NHS Forth Valley, use of the local 'Aware of breach – willing to wait' code meant that the percentage of social unavailability within a number of specialties was particularly high compared to other boards. In June 2011:

- 47 per cent of patients (128 patients) on the waiting list for ear, nose and throat inpatient treatment had social unavailability codes (compared to a national average of 29 per cent)
- 39 per cent of inpatients (81 patients) on a waiting list for gynaecology treatment had social unavailability codes (compared to a national average of 22 per cent).

In NHS Grampian, extensive use of social unavailability codes for patients waiting to be seen within the board area meant that the percentage of social unavailability in some specialities was the highest of all mainland boards in Scotland. For example, in June 2011:

- 51 per cent of patients (1,076 patients) on the waiting list for orthopaedic inpatient treatment had social unavailability codes (compared to a national average of 38 per cent)
- 38 per cent of patients (488 patients) on the waiting list for general surgery (excluding vascular surgery) inpatient treatment had social unavailability codes (compared to an average of 28 per cent for the seven boards that define the specialty in this way).

Source: Audit Scotland fieldwork and ISD Scotland additional analysis by specialty based on waiting times data published in May 2012

47. Use of social unavailability codes reduced in a number of NHS boards from late 2011. For example, in NHS Greater Glasgow and Clyde during 2011, there was additional investment to increase capacity in some hospitals, fill consultant vacancies and redesign services to meet demand in some high volume specialties. The board also started to manage patients on a sector basis in 2012, for example, offering patients in North Glasgow an appointment in a North Glasgow hospital only, rather than at any hospital in NHS Greater Glasgow and Clyde, to try to reduce the number of patients coded as socially unavailable in some hospitals. In 2012, NHS Lothian invested considerably to treat the backlog of patients waiting longer than target times for treatment after the board amended social unavailability codes that had been applied inappropriately. NHS Lothian has estimated the total cost of delivering additional waiting times activity during 2012/13 at £26 million.[20]

48. Our previous report recommended that the Scottish Government and ISD Scotland should consider introducing a separate code for patient choice, such as patients choosing to be treated at a local hospital or by a specific consultant. This would have helped identify capacity issues when patients chose to be treated at their local hospital. This was not implemented and New Ways guidance does not specify the reasons for recording patients as socially unavailable. Therefore it was not possible to identify separately the number of patients recorded as being unavailable due to choice, as patient records lacked the evidence of why boards were applying social unavailability codes.

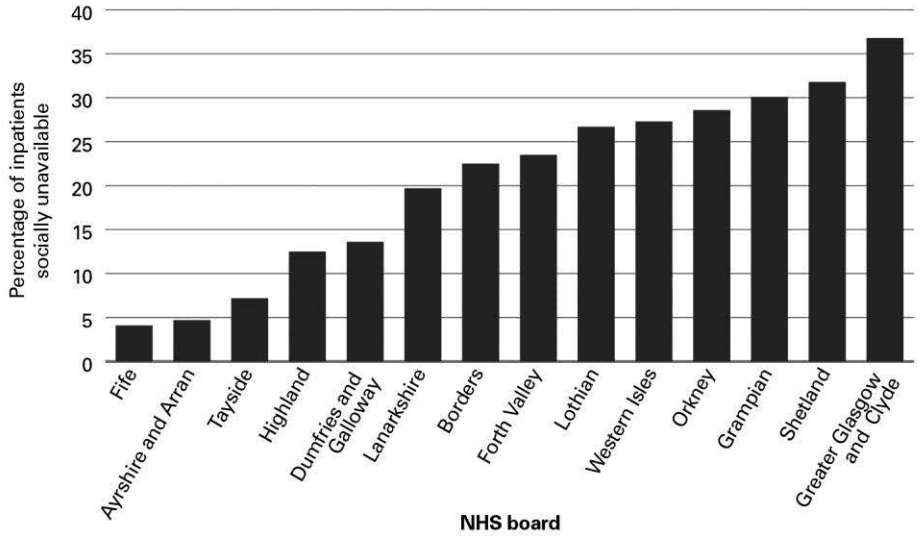
49. There are now specific codes under updated guidance published in August 2012 for 'patient advised unavailability (appointment location)' and 'patient advised unavailability (named consultant)'. The guidance states that using these codes would be unusual and would not be expected to affect large numbers of patients. Implementing this updated guidance will require a considerable change in practice by NHS boards as many have been using the social unavailability code extensively for patient choice (Case Study 3).

[20] NHS Lothian written communication, January 2013.

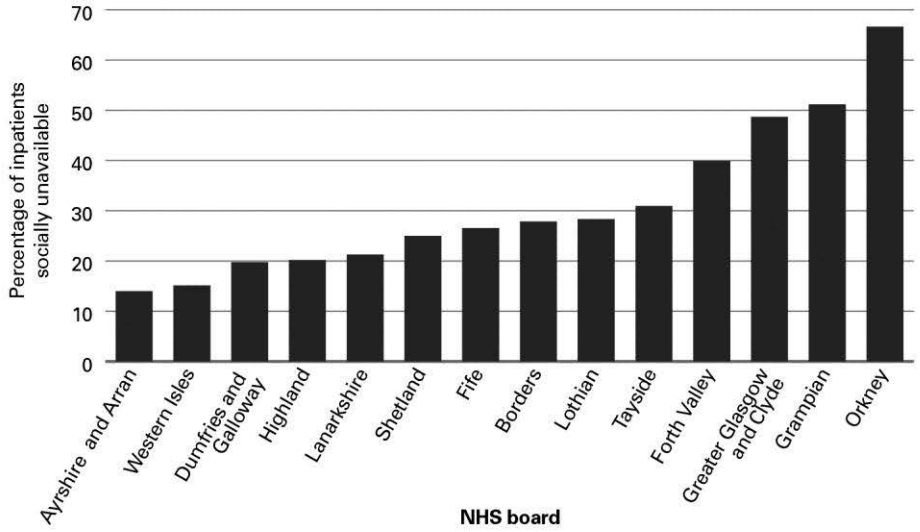
Exhibit 8

Social unavailability for ophthalmology and trauma and orthopaedic inpatients by NHS board, June 2011
Social unavailability is higher in some specialties and varies by NHS board.

Ophthalmology



Trauma and orthopaedic surgery



Source: ISD Scotland additional analysis by specialty based on waiting time data published in May 2012

The actual time patients waited is longer than the waiting time reported in national performance reports

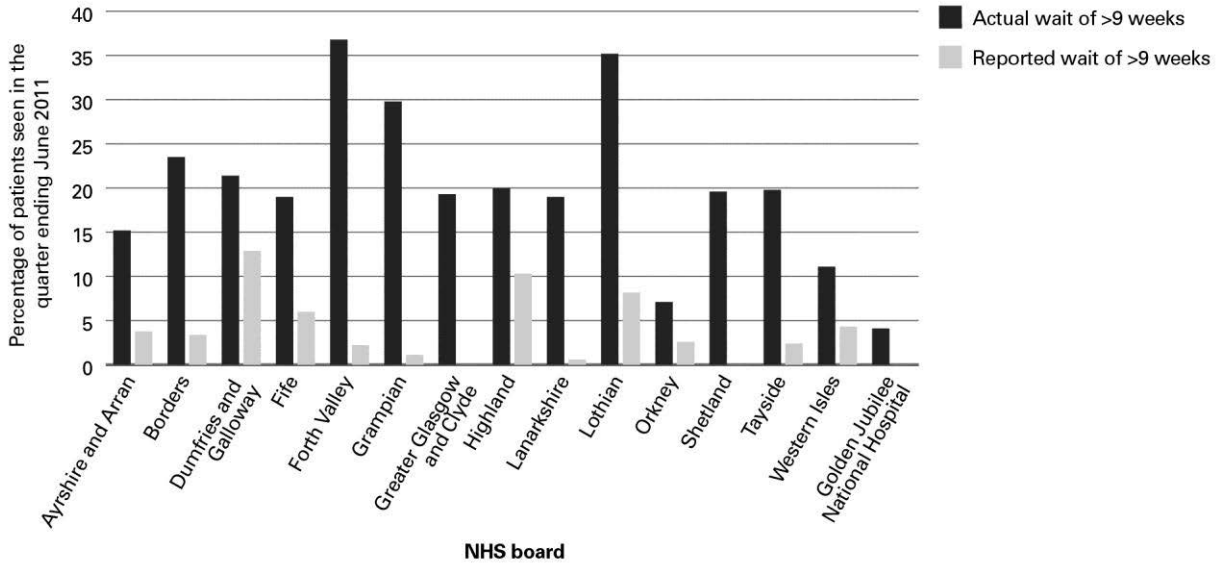
50. The consequence of boards using social unavailability codes extensively for patient choice is that patients' actual waits are longer than the waiting time reported against targets in national performance reports on the Scottish Government's website. When boards apply unavailability codes, the patient's clock stops and the time patients are unavailable is not included in the reported waiting time. Some of the excluded waiting time is when patients are physically unavailable for reasons such as holidays. A considerable amount is when patients choose to wait to be seen locally and, as a consequence, may have to wait longer than the waiting time target. For patients who were added to the waiting list before October 2012, it is not possible to separate the use of social unavailability codes for reasons such as holidays from patient choice.

51. In the quarter ending June 2011, 23 per cent of inpatients across Scotland had an actual wait (including periods of unavailability and clock resets) of over nine weeks, compared to three per cent with a reported wait of over nine weeks. This varied by board (Exhibit 9). The biggest percentage difference between reported and actual waits was in NHS Forth Valley (35 per cent); and the biggest difference in the number of patients was in NHS Greater Glasgow and Clyde (5,000 patients).

Exhibit 9

Actual length of time on waiting list versus reported waiting time against national target for inpatients and day cases by NHS board, June 2011

For inpatients seen in the quarter ending June 2011, the actual wait is considerably longer in some NHS boards than the reported wait against the national target.



Notes:
1. Reported wait: the time that is reported against national targets and does not include any periods of unavailability (medical, social or no response to patient focused booking).
2. Actual wait: the total time waited by patients including any periods of unavailability and clock resets.

Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012

52. In line with national guidance, public reporting of performance against national waiting time targets excludes the time that patients are recorded as unavailable. The extensive use of unavailability codes and how this affects patients' waits is not clear from the information published in national performance reports on the Scottish Government website.[21] More detailed information is provided on ISD Scotland's website.[22]

NHS boards apply other aspects of the guidance differently

53. The time patients wait for hospital treatment can be affected by differences in how NHS boards apply waiting time guidance. The main factor affecting patients' waits was the use of social unavailability codes. We also found a number of other ways in which patients' waits can be affected. These included:

- the use of medical unavailability codes
- the number of times patients are allowed to miss appointments before they are removed from the waiting list
- the circumstances in which waiting time clocks are reset
- delays between patients being referred to hospital for treatment and being added to the waiting list.

54. The percentage of patients waiting for inpatient treatment who are medically unavailable - that is, not fit enough to receive treatment - is considerably lower than the percentage of patients who are socially unavailable. It has remained fairly constant nationally at around six to eight per cent over recent years but varies considerably among NHS boards.[23] In our review of individual patient records we found a few examples of notes highlighting that patients' health conditions or other health treatment meant they were unable to go ahead with treatment. But in most of the records we reviewed with medical unavailability applied (around 60), there was limited, or no, information about why patients were considered medically unavailable.

55. New Ways guidance states that patients should be removed from the waiting list if they do not attend (DNA) once or cannot attend (CNA) twice, unless there is a clinical reason to keep them on the list. Most boards have this in their local guidance but many said they would not enforce this rigorously and tend to keep patients on the list longer rather than refer patients back to the GP. For example, NHS Greater Glasgow and Clyde's policy is that it does not remove patients from the waiting list until they cannot attend three times. In addition, NHS boards should review patients who are unavailable for 13 weeks and remove them from the list unless clinically inappropriate. In our fieldwork, we found examples of patients who had been on waiting lists for over three months with no recorded end date for their unavailability or

[21] Scottish Government website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/18weeksRTT

[22] ISD Scotland website: http://www.isdscotland.org/Health-Topics/Waiting-Times/

[23] For the quarter ending December 2011, around four per cent of inpatients on the waiting lists in NHS Forth Valley and NHS Lothian were coded as medically unavailable rising to around 12 per cent in NHS Borders and NHS Shetland. Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012.

who had remained on waiting lists for several years with no evidence in the patient records of their situation being reviewed.

56. Most NHS boards' waiting list systems automatically reset a patient's clock after a DNA or CNA. This means that a patient's waiting time is reset to zero and any time waited before the clock reset is not included in the reported waiting time. Generally NHS boards do not monitor how often clock resets happen and how much time this adds to a patient's wait, as this is not recorded separately within patient records. NHS Lothian has recently developed a tool called a forensic dashboard for monitoring key elements of waiting lists. This allows the board to monitor information for the main specialties, with any issues to be reported to the Medical Director, including: clock resets, numbers added and removed from waiting lists, types and lengths of periods of unavailability, retrospective changes to patients' records and waiting list trends.

57. Most referrals for hospital treatment are made electronically by GPs. In most NHS boards, electronic referrals are automatically added to the waiting list when they are received at the hospital, before clinical staff screen them to confirm the referral is appropriate. We found some exceptions where patients referred to hospital for treatment may be subject to some delay. In NHS Greater Glasgow and Clyde, we saw evidence of delays between GPs starting to complete an electronic referral form and submitting them to the hospital. We also found there could often be delays in paper referrals sent direct to a specialty or consultant. This could delay patients being added to the waiting list, particularly referrals made from community optometrists or dentists. The board is aware of these issues and is taking action to resolve them.

Patients need good information to understand the complexities of the waiting list system

58. Patients need clear information about their rights under the recent legislation introducing a treatment time guarantee for inpatients. They also need to understand how their own choices and actions could affect their waiting time guarantee. It is clear that, at the time of our audit, boards were managing waiting times inconsistently across the NHS. Decision-making about patients' waits has not been transparent to us and is unlikely to have been transparent to patients.

59. Because of the limited evidence in patient records it has been difficult, and in many cases impossible, to identify what discussions staff have had with patients about offers and the application of unavailability codes. It is not clear that patients were given adequate information about the risk of being removed from the waiting list if they do not attend an appointment without giving notice; or the timescales involved if they chose to wait to be treated locally. In addition, the lack of national and local guidance in 2011 about what constituted a reasonable offer may have led to patients being disadvantaged.

Public trust in waiting time statistics needs to be restored

60. Public trust in waiting time statistics has been put at risk by the events at NHS Lothian and NHS Tayside. Evidence that staff in NHS Lothian were put under pressure to falsify patients' waiting times has resulted in accusations of a more widespread bullying culture in the NHS. A long-established NHS whistleblowing policy did not operate effectively in helping to address concerns at NHS Lothian or NHS Tayside.

61. NHS boards must provide a safe environment for staff to raise any concerns about the management of patients' care, including the way in which waiting times are being achieved; and maintain their focus on patients and their needs at all times. The Scottish Government has recently announced that in 2013 it will pilot a confidential phone line for NHS staff to raise any concerns. An independent organisation will run the phone line, and issues raised by staff will be passed on to the relevant regulatory organisation for investigation.

62. This is an important first step in helping to restore public confidence, and providing independent support to NHS staff. Numerous cases of poor practice in health and social care across the UK have only come to light because of concerned staff and patients willing to provide evidence of sub-standard care. For example, the inappropriate use of social unavailability codes in NHS Tayside was not evident from an analysis of the data alone; it became apparent only after staff raised their concerns with the internal auditor. This highlights the importance of being able to raise concerns safely and knowing they will be acted upon.

Recommendations

The Scottish Government and NHS boards should:

- **monitor and report the use of waiting list codes and ensure that they are being applied appropriately and consistently, and in line with updated national guidance issued in 2012.**

NHS boards should:

- **ensure that information is recorded within patient records about the reasons for applying waiting list codes**
- **make sure that electronic systems have an audit trail to enable scrutiny of waiting list systems and that good controls and safeguards are in place, as described in Exhibit 4 on page 15, to provide assurance that waiting lists are being managed properly**
- **share good practice on enhanced performance reporting to monitor patients on waiting lists**
- **identify and take into account patients' individual circumstances, such as access to transport, mobility and additional support needs, before offering them treatment at a location outside the board area**
- **monitor offers made to patients for treatment outside the board area as part of wider monitoring of local capacity**

- **ensure patients with additional support needs, such as a disability or requiring a translator, are identified and provided with the support they require**
- **monitor use of social unavailability codes, including high numbers of changes, retrospective changes, and changes that affect waiting time performance, to ensure staff are applying the codes appropriately**
- **monitor the use of patient choice codes introduced under the updated guidance to ensure this is kept to minimum**
- **take action to reduce unavailability in specialties where use of these codes is particularly high and may indicate capacity problems**
- **ensure adequate systems are in place so there is no delay in the hospital receiving referrals or delays in the patient being added to the waiting list**
- **communicate clearly with patients about their rights and responsibilities under waiting time guidance and legislation**
- **ensure effective whistleblowing policies and procedures are in place and publicised.**

ISD Scotland should:

- **monitor reported hospital activity against reported waiting time data at a specialty level to assess whether all relevant specialties are included in waiting time reporting.**

Part 3. National monitoring of waiting lists

Key messages

- **During 2011, the focus within the Scottish Government and NHS boards was on meeting waiting time targets and developing capacity in areas where patients were waiting longer. There was not enough scrutiny of the increasing number of patients recorded as unavailable. Better use of the available information could have helped identify concerns about the use of unavailability codes. It could have also identified wider pressures that were building up in the system around the capacity within NHS boards to meet waiting time targets.**
- **The Scottish Government did not have ready access to the full information available that should have indicated the need to investigate how NHS Lothian was managing patients on its waiting list. ISD Scotland was not clear about what issues to escalate to the Scottish Government.**
- **The Scottish Government issued updated guidance on managing waiting lists in 2012 to help improve monitoring and reporting. This is an important first step, but NHS boards still need robust governance arrangements and audit trails to ensure that waiting lists are being managed appropriately. Non-executive directors need to provide effective scrutiny based on accurate information.**

The focus on waiting time targets led to insufficient scrutiny of how they were being achieved

63. Before the media and MSPs raised concerns about the management of waiting lists in NHS Lothian, the focus within the Scottish Government and NHS boards was on meeting shorter waiting time targets and developing capacity. The Scottish Government said that it worked closely with NHS Lothian, Forth Valley, Greater Glasgow and Clyde, Grampian and Lanarkshire on capacity issues within particular clinical areas when waiting times began to increase in June 2011.

64. There was not enough scrutiny of how NHS boards were applying waiting list codes. Available information should have highlighted potential concerns for the Scottish Government and NHS boards to investigate further. This information included evidence of increasing rates of social unavailability, reported use of social unavailability for patient choice, and retrospective changes to waiting list data. During 2012, there was more focus on making sure waiting list codes were being applied appropriately.

The Scottish Government and NHS boards could make better use of available information

65. ISD Scotland publishes quarterly census data on the number of patients waiting for an appointment or treatment in each NHS board, and how long they have been waiting. It also publishes data on the number of patients on the waiting list who are recorded as unavailable. The number of patients recorded as socially unavailable has increased considerably since our 2010 report on the implementation of New Ways (Exhibit 7, page 25). Boards have reported that a lot of social unavailability is due to patients choosing to be seen at a specific hospital. Demand has increased and waiting time targets have shortened, putting services under greater pressure. In addition to the increase in social unavailability, the number of patients waiting longer also increased. Available data show that across all NHS boards between December 2009 and December 2011:

- the number of people waiting for an outpatient appointment increased by over seven per cent from 187,721 to 201,716
- the number of people waiting over 12 weeks increased four-fold from 1,275 to 5,548
- the number of people waiting for inpatient appointments increased by two per cent from 57,776 to 59,199; but the number of people waiting over 12 weeks increased over eight-fold from 208 to 1,772
- the number of inpatients coded as socially unavailable increased from 14,955 (23 per cent of patients on the waiting list) to 17,360 (26 per cent of patients on the waiting list).[24]

66. These figures vary by NHS board and by specialty. Taken together, the available information suggests potential capacity issues in some boards and some specialties. It also raises questions about how boards were managing their waiting lists. While the Scottish Government and NHS boards recognised capacity pressures and risks to meeting waiting time targets, they did not give enough attention to ensuring that targets were being met appropriately (Case Study 4 overleaf). For example, the Scottish Government did not fully investigate the reasons for the high use of social unavailability codes across a number of boards, and the potential implications for capacity.

67. Non-executive directors of NHS boards have an important role in scrutinising the performance of their boards against national and local priorities and how this is being achieved. We have previously recommended that NHS boards should ensure that their boards' scrutiny includes organisational performance.[25] It is important that non-executive directors have access to the full range of information available to allow them to provide effective challenge.

[24] The figures in the first three bullets are for ongoing waits rather than completed waits, so the total wait may have been longer for some patients. Source: *Inpatient, Day case and Outpatient stage of treatment waiting times*, ISD Scotland, November 2012.

[25] *The role of boards*, Audit Scotland, 2010.

Case Study 4
Communication between the Scottish Government and NHS Lothian on meeting waiting time targets during 2011

Communication between the Scottish Government and NHS Lothian during 2011 shows that both raised concerns about the board's ability to meet waiting time targets in some specialties. They identified pressures on capacity, for example increased referrals, staff shortages and problems accessing additional support from the GJNH due to NHS Lothian requesting this later than other boards. The Scottish Government asked the board to identify the actions it was taking to deal with these issues and stressed the importance of achieving targets.

The extensive use of unavailability codes was not raised in the communication, although the reports available to the Scottish Government show larger increases in the numbers of patients recorded as unavailable in some specialties over this time. However, the Scottish Government was not aware of the full picture as NHS Lothian retrospectively changed unavailability codes, making the actual rates higher than those reported each month to the Scottish Government.

Source: Copies of correspondence provided by the Scottish Government

The roles and responsibilities of the Scottish Government and ISD Scotland in monitoring waiting lists need to be clear

68. ISD Scotland has a quality assurance role in monitoring the quality of the waiting time information that NHS boards submit to it. This includes raising with NHS boards any concerns about their data, such as differences from what would be expected based on previous quarters and compared to other NHS boards' data. ISD Scotland formally shares the data with the boards before publication of national waiting time statistics. It is responsible for providing performance management information to the Scottish Government but it does not have a role in challenging NHS boards on their performance.

69. ISD Scotland routinely has access to more information than the Scottish Government, for example retrospective changes to the number of patients coded as unavailable. Information on the level of retrospective changes was not part of the information that ISD Scotland made available to the Scottish Government in 2011 and ISD Scotland was not routinely monitoring retrospective changes at this time. The Scottish Government was not aware of additional information that may have helped identify possible concerns about how boards were meeting waiting time targets.

70. ISD Scotland's published data can change retrospectively each quarter due to legitimate updates such as delays in NHS boards' updating patient records. However, the level of retrospective changes in NHS Lothian was far higher than any other board. In NHS Lothian, retrospective changes meant that the number of patients with unavailability codes increased by:

- 1,315 for inpatients and 2,191 for outpatients in the quarter ending December 2010
- 1,280 for inpatients and 1,308 for outpatients in the quarter ending March 2011

- 1,417 for inpatients and 2,708 for outpatients in the quarter ending June 2011.[26]

71. Since 2012, the Scottish Government and ISD Scotland have increased their scrutiny of how NHS boards are applying waiting list codes and the information they submit. ISD Scotland is developing more detailed reports on performance against waiting time targets from 2013. This includes a tool that compares a range of data across all NHS boards to identify any potential areas of concern.

Updated waiting list guidance should help improve monitoring and reporting but does not address all the risks

72. The Scottish Government issued updated guidance on managing waiting lists in August 2012 (Exhibit 10 overleaf). This introduced new codes for unavailability, including specific codes for patient choice and a requirement for boards to take account of patients' additional needs. The new treatment time guarantee applies to inpatients, and the associated guidance requires NHS boards to write to patients being treated under the guarantee to confirm when a period of unavailability has been applied. This applies only to inpatients.

73. The updated guidance should help ensure better information to monitor how NHS boards are using patient choice codes. It should also help ensure better communication with inpatients and a more robust audit trail. There are still risks of NHS boards managing waiting lists inappropriately if there are not adequate audit trails within systems and processes within boards to monitor the use of waiting list codes. This remains a particular risk for outpatients as there is no requirement for boards to write to patients to confirm their unavailability.

74. The guidance still allows variation in how NHS boards define a reasonable offer and requires each board to make its definition clear to patients. The guidance on which board is responsible for managing a patient's waiting time when they are treated by a consultant from another board area is complex and boards are interpreting this differently. Generally, the board that employs the consultant who makes the decision about the patient's treatment is responsible for making sure the patient is seen within the inpatient target time.

75. There are still risks related to the challenge of delivering the new treatment time guarantee for treating inpatients within 12 weeks. As it runs alongside the overall 18 week referral to treatment target, it may put waiting times for outpatients at risk of lengthening if the priority shifts to meeting the inpatient target, which is subject to a legal guarantee.

[26] *Review of aspects of Waiting Times Management at NHS Lothian,* PricewaterhouseCoopers on behalf of the Scottish Government Health Directorate, March 2012.

Exhibit 10

Comparison of New Ways guidance and updated guidance issued in 2012
The updated guidance introduces specific codes for patient choice.

Aspect of waiting list management	New Ways guidance	Updated guidance
Patient unavailability due to patient choice of location or consultant	No specific code.	New codes introduced for social unavailability including: • 'patient advised (appointment location)' • 'patient advised (named consultant)'. NHS boards can only apply these codes at the patient's request and this must not be prompted by the board.
Reviews of periods of unavailability with no known end date	Review patients after 13 weeks. They may remain on the list or be referred back to the GP based on clinical advice.	Patients who become unavailable after they are added to the list should be reviewed after 12 weeks. If the patient is still unavailable after two reviews, they must be referred back to the GP. If the patient becomes available, their clock starts from zero again.
Patients who cannot or do not attend appointments	Refer back to the GP after two CNAs or one DNA unless clinically inappropriate. The patient's clock is reset after one CNA.	Patients should be referred back to the GP after three CNAs unless clinically inappropriate. The patient's clock may be reset after one CNA but this is not required. After one DNA the patient's clock may be reset, or they may be referred back to the GP, but neither of these options is required. New guidance included on how to manage patients who arrive for an appointment but cannot wait: patients can be coded as 'cancelled by service' or 'CNA' depending on the length of the delay.
Communication with patients about unavailability, refusal of a reasonable offer, DNAs, CNAs, removal from the list	Not mentioned.	Written communication with inpatients waiting for treatment is required under the treatment time guarantee when patients: • advise they are unavailable • refuse two or more appointments • do not attend an appointment • cannot attend three or more appointments • are removed from the waiting list.
Definition of a reasonable offer	Patients should be offered up to two appointments with a minimum of seven days' notice.	Patients should be offered two or more appointments with a minimum of seven days' notice. Boards are required to clearly state what locations are considered a reasonable offer.

Continued overleaf

Exhibit 10 (continued)

Aspect of waiting list management	New Ways guidance	Updated guidance
Meeting patients' additional needs	Not mentioned.	Boards have a duty to ensure that appropriate support is put in place as required and additional needs are taken account of, where these have been communicated by the patient, carer or doctor.
NHS board responsible for managing the patient's wait if the patient is treated outside the board in which they live.	The board that refers the patient (the patient's board of residence) is responsible for ensuring the patient is managed within the overall 18 weeks RTT target. Within that, the board treating the patient is responsible for meeting the target that applies to that stage of their treatment, that is the inpatient or outpatient target.	Under the treatment time guarantee for inpatients, the board that employs the consultant who makes the decision to treat the patient is responsible for meeting the inpatient waiting time target.

Source: *New Ways of defining and measuring waiting times: Applying the Scottish Executive Health Department guidance – version 3.0,* ISD Scotland, 2007; *NHSScotland Waiting Time Guidance: 18 weeks Referral to Treatment Standard, New Ways Stage of Treatment Standards and incorporating Treatment Time Guarantee Guidance,* Scottish Government, August 2012

Recommendations

The Scottish Government and NHS boards should:

- **use information about the use of waiting list codes, alongside waiting time performance data, to:**
    - **identify where staff may be applying codes inconsistently or inappropriately**
    - **help plan and manage the capacity needed to meet waiting time targets.**

Non-executive directors of NHS boards should:

- **ensure they have the full range of information available to scrutinise how their board is applying waiting list codes and planning and managing capacity to meet waiting time targets.**

The Scottish Government and ISD Scotland should clarify:

- **the role of each organisation in monitoring how boards are applying waiting list codes and performing against waiting time targets**
- **the process for raising concerns about issues within individual NHS boards.**

ISD Scotland should:

- **ensure that potentially significant concerns arising from data submitted by NHS boards are highlighted to the Scottish Government.**

Management of patients on NHS waiting lists

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