

Tackling waiting times in the NHS in Scotland

Prepared for the Auditor General for Scotland

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Contents



Summary

Background

Key messages

Page 2

Our approach

How the report is structured

Page 3

Part 1. Factors that influence waiting times

Waiting times are part of a complex healthcare system

Page 4

Several organisations work to reduce waiting times

Page 5

Our study

Page 8

Part 2. Waiting time performance

Key messages

Assessing waiting time performance is complex

Page 9

Progress has been made towards inpatient and day case targets

Page 12

Outpatient waiting times are improving

Page 15

Comparing Scottish and English waiting times is complex

Page 16

Part 3. Current approaches to reducing waiting times

Key messages

Boards have lead responsibility for tackling waiting times

Page 18

The SEHD plays a strategic role in reducing waiting times

Page 24

The Golden Jubilee could make a bigger contribution to reducing waiting times

Page 30

Patients should be more involved in decisions about where they are treated

Page 35

Part 4. Recommendations

Scottish Executive Health Department

NHS boards

Page 36

Golden Jubilee

Information Services Division

Page 37

Appendix 1. Recent history of waiting time targets

Page 38

Appendix 2. Project Advisory Group members

Page 39

Summary



Background

1. In this report we:

- review the performance of the NHS in Scotland against current waiting time targets for elective healthcare^{1 2}
- evaluate whether current approaches to reduce waiting times provide value for money
- assess whether current strategies are likely to achieve sustained reductions in waiting times.³

2. Waiting times are important to patients. Long waits for diagnosis or treatment may prolong pain and discomfort, and increase the time people have to tolerate health problems that affect their daily lives. Waiting to be seen or treated can also cause anxiety to patients,

even though for some conditions long waits may not adversely affect clinical outcomes. For these reasons, waiting times are one of the top priorities of the Scottish Executive Health Department (SEHD).

3. Targets have been set for most major areas of NHS activity.⁴ In this study we examine waiting times for inpatients and day cases and new outpatients. No patient with a guarantee should wait longer than six months to be seen or treated by the end of 2005 and a new 18-week target has been set for the end of 2007. We also assess performance against waiting time guarantees for certain cardiac procedures.

Key messages

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

5. The total number of people waiting for inpatient and day case treatment has changed little in the last two years. The number of people without waiting time guarantees has increased, and most of these patients have been waiting over six months. Together with changes in the way waiting time guarantees will be applied from the end of 2007, these trends suggest that the NHS will face a major challenge in meeting more ambitious targets in the future.

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

1 In the remainder of the report 'targets' refers to waiting times targets unless it is specified otherwise.

2 Elective healthcare is planned healthcare given at a prearranged time rather than in response to an emergency. It includes routine surgery and outpatient care.

3 *Sustaining Reductions in Waiting Times: Identifying Successful Strategies*, Appleby J et al, King's Fund, 2005.

4 *Fair to All, Personal to Each*, Scottish Executive, 2004.

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

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

Our approach

9. In carrying out our study we analysed waiting times, waiting list and financial data for elective hospital care; interviewed staff in NHS and the SEHD; and commissioned a survey of patients' views.⁵ Further information on our approach is included in Part 1.

How the report is structured

10. In [Part 1](#) we set out current targets and describe some of the factors that influence waiting times. We also list the organisations responsible for tackling waiting times.

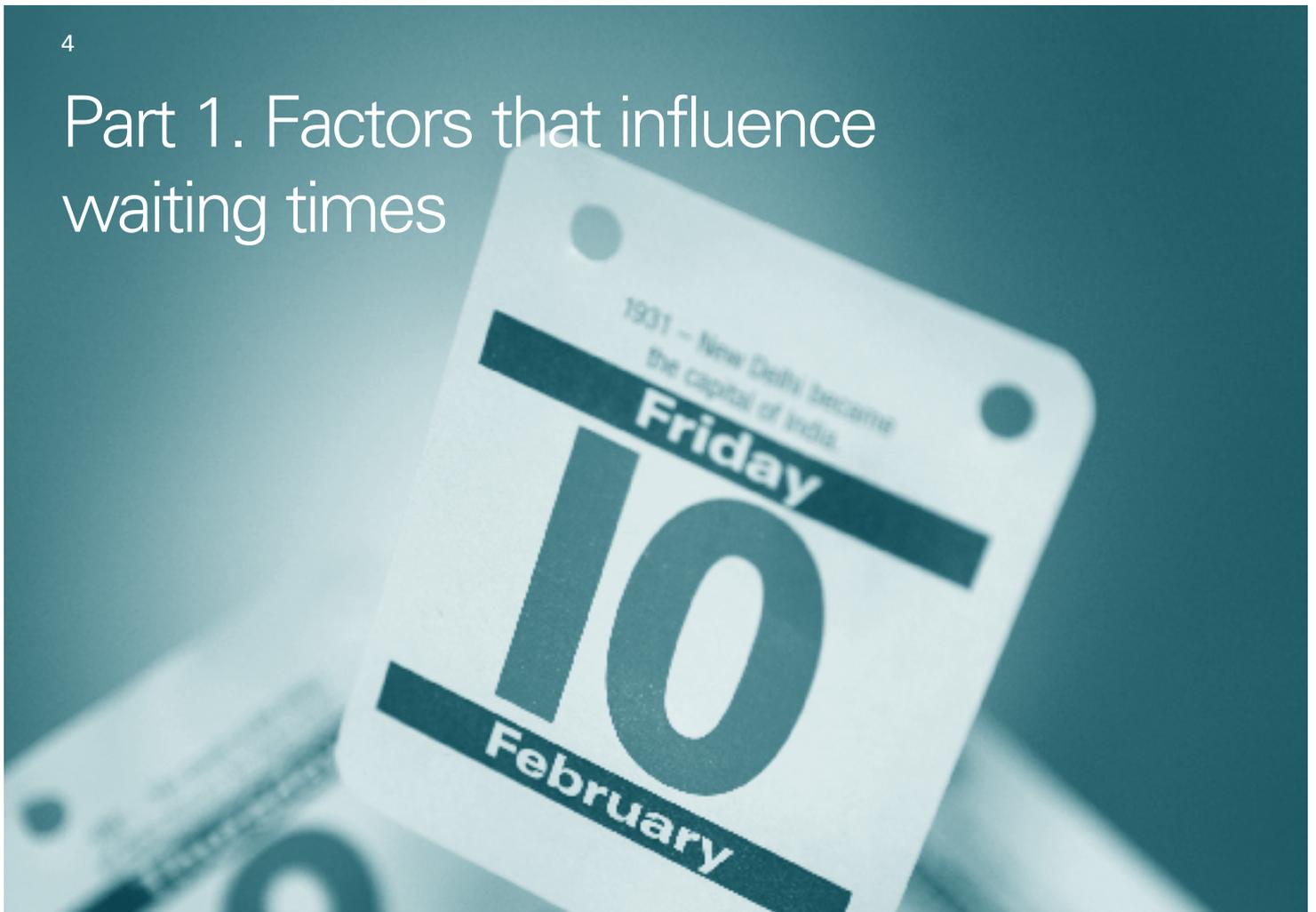
11. In [Part 2](#) we analyse trends over time in waiting lists and waiting times for elective inpatient and day case treatment and new outpatient appointments.

12. In [Part 3](#) we evaluate the value for money of approaches taken to reduce waiting times and assess whether they are likely to deliver sustainable reductions.

13. In [Part 4](#) we set out our recommendations.

⁵ Waiting list data refer to the list of all patients currently waiting to be seen or treated. Waiting time data refer to the length of time waited by patients already seen or treated.

Part 1. Factors that influence waiting times



Waiting times are part of a complex healthcare system

14. Health and community care is a complex system made up of smaller interrelated systems. These include hospital services such as elective care, emergency care and outpatients, and community-based health services such as those provided by GPs. Waiting lists and waiting times are affected by each part of the system and by the links between them. Whole system approaches are therefore needed to tackle waiting lists and waiting times effectively.

15. Exhibit 1 describes the stages that patients go through when they need elective healthcare. Patients wait at various points in the system:

- for a consultation with a GP or a dentist (**Wait 1**)
- for a first outpatient appointment (**Wait 2**)

- for a therapy, test or diagnostic procedure (**Wait 3**)

- for inpatient or day case treatment (**Wait 4**).

16. The length of time that patients wait at each point in the system is influenced by three factors (Exhibit 2, page 6):

- The demand for care. Demand depends on the number of people who see their GP or dentist and the number who are referred on to specialist services. The factors that influence demand are complex but include patient needs and expectations and the availability of alternatives to treatment in acute hospitals.
- The healthcare capacity available to deliver healthcare and the efficiency with which capacity is used. Capacity refers to resources such as staff, hospital beds, operating theatres and

community-based health centres. We discuss efficiency in Part 3.

- The way in which the waiting list is managed by managers and clinicians, for example, using referral guidelines.

Strategies for reducing waiting times should tackle the whole system

17. To achieve and maintain shorter waiting times, it is necessary to address the root causes of long waits (Exhibit 2, page 6).^{6,7} Evidence suggests that short-term increases in activity at particular points in the system do not lead to sustained reductions in waiting times.^{8,9}

18. Successful strategies to reduce waiting times involve:

- analysing patients' routes through the health system

6 *Inpatient and outpatient waiting in the NHS*, National Audit Office, 2001.

7 *Good Practice Guide to Managing Waiting Times*, National Waiting Times Unit, Scottish Executive, 2003.

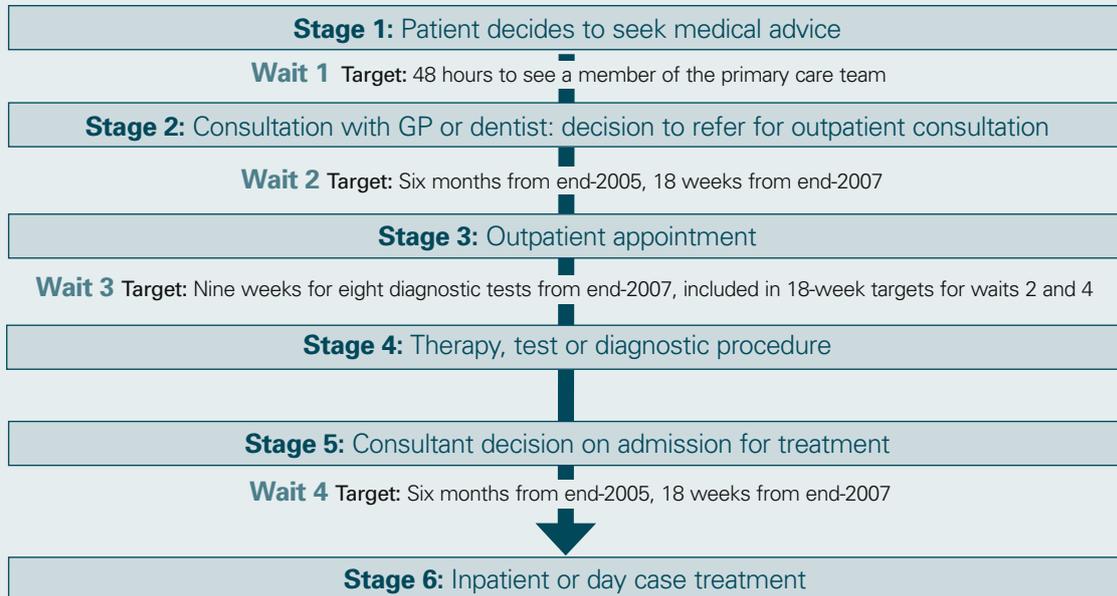
8 *Access to Elective Care*, Harrison A, King's Fund, 2000.

9 *NHS Waiting Times in Wales*, National Audit Office Wales, 2005.

Exhibit 1

Stages in the treatment of a patient

Targets are set for different stages of the referral and treatment process. Patients' total wait for treatment from the date they are referred by their GP is made up of waits 2, 3 and 4.



Source: Modified from *Access to elective care: what should really be done about waiting lists*, Harrison A, New B, King's Fund, London, 2000

- identifying the causes of bottlenecks that slow down patient flows, including pressures arising from the demand for emergency care or avoidable return outpatient appointments
 - increasing the efficiency with which staff and facilities are used, for example, by increasing the time operating theatres are in use, treating more patients per theatre session or treating more patients as day cases
 - redesigning services to simplify and shorten the referral and treatment process, for example, by developing community-based alternatives to consultant-led care
 - using information on variations in performance among individual doctors and other healthcare professionals to change working practices.¹⁰
- 19.** Temporary increases in activity can be useful as a short-term strategy to meet targets. They can be used to clear a backlog of patients who have been waiting a long time, where permanent increases in capacity are not required. But they should be used as part of a planned process for achieving and maintaining shorter waiting times.¹¹ Over-reliance on short-term measures, such as staff working in the evening or at weekends, can be expensive and does not address long-term needs.
- Several organisations work to reduce waiting times**
- 20.** NHS boards are responsible for meeting targets set by the SEHD. A full list of the current targets is set out in [Exhibit 3 \(page 7\)](#). A number of different NHS organisations help NHS boards to reduce waiting times:
- The National Waiting Times Unit (NWTU)** is based in the SEHD. It monitors performance against interim targets agreed with NHS boards.¹² It allocates funds to boards to reduce waiting times in specialties facing particular pressures and plays a lead role in arranging access to the GJNH.
 - The Centre for Change and Innovation (CCI)** is also part of the SEHD. It helps boards redesign services to improve their efficiency and effectiveness. As part of its remit, it has set up an Outpatient Programme to help boards reduce outpatient waiting times.^{13 14}
 - The Golden Jubilee National Hospital (GJNH)** was purchased by the Scottish Executive from the private sector in June 2002

10 *Sustaining Reductions in Waiting Times: Identifying Successful Strategies*, Appleby J et al, King's Fund, 2005.

11 *Building a Health Service Fit for the Future. Volume 2 A Guide for the NHS*, Scottish Executive, 2005.

12 Interim targets are agreed quarterly between the NWTU and NHS boards. The interim targets reflect the reductions in patients waiting in excess of target waiting times that need to be achieved each quarter to ensure that the targets for the end of 2005 are met.

13 *Improving Outpatient Waiting Times*, Scottish Executive, 2004.

14 *Modernising Scotland's Outpatient Services*, Scottish Executive, 2004.

Exhibit 2

Factors influencing waiting times across the whole system of care

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

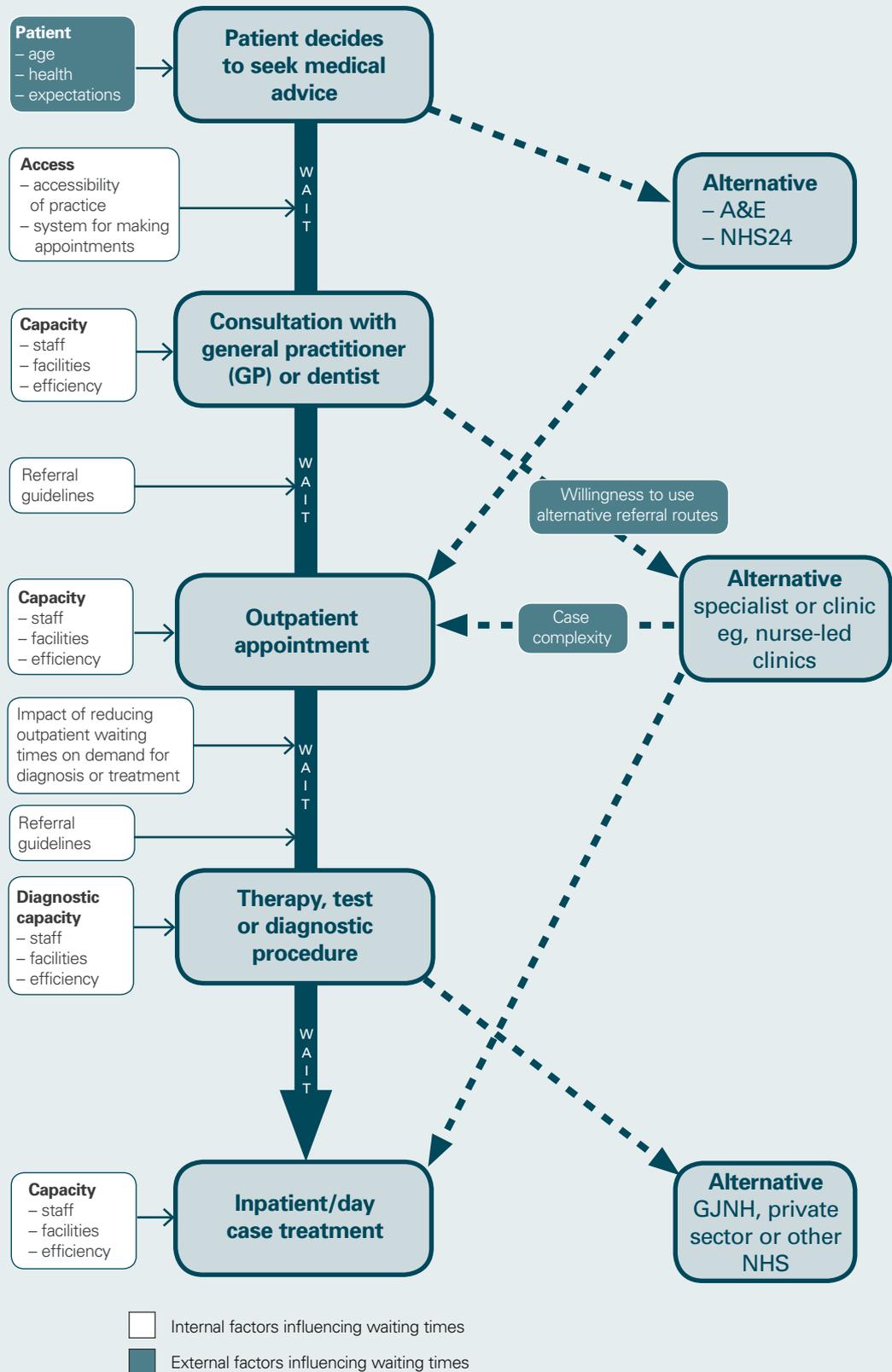


Exhibit 3

Waiting time targets

The Scottish Executive has set a number of waiting time targets for the NHS in Scotland to improve patients' access to healthcare.

Area	Target	Targets covered in this report
Inpatients and day cases	No patient (to whom the waiting time standard applies) will be required to wait more than six months by the end of 2005. ^{15 16} Reduced to 18 weeks by the end of 2007. ¹⁷	✓
New outpatients	No patient (to whom the waiting time standard applies) should wait longer than six months for a new outpatient appointment by the end of 2005. ¹⁸ Reduced to 18 weeks by the end of 2007. ¹⁷	✓
Cardiac services: angiography ¹⁹	The maximum wait between seeing a specialist and having an angiography should be eight weeks. ¹⁵	✓
Cardiac services: revascularisation ²⁰	The maximum wait between having an angiography and a revascularisation procedure (surgery or angioplasty) should be 18 weeks. ¹⁵ Combined wait for cardiac intervention, including angiography and revascularisation, to be reduced to 16 weeks by the end of 2007. ¹⁷	✓
Cancer – all	By the end of 2005 the maximum wait from urgent referral to treatment for all cancers will be two months. ^{21 22}	
Cancer – breast	No woman with an urgent referral for breast cancer will wait more than one month for treatment following diagnosis. ^{21 22}	
Cataract surgery	By the end of 2007, patients should not wait longer than 18 weeks from referral to treatment. ¹⁷	
Hip fracture	By the end of 2007, all patients admitted to a specialist orthopaedic unit will be operated on within 24 hours of admission. ¹⁷	
Accident and Emergency (A&E)	From the end of 2007, patients will wait no longer than four hours between arriving at an A&E unit and admission, discharge or transfer. ¹⁷	
Primary care	Anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours. ^{23 24}	

15 *New targets for waiting times*, Scottish Executive press release, 26/06/2002.

16 *Acute Activity, Waiting Times and Waiting Lists*, ISD, 09/12/2005.

17 *Fair to All, Personal to Each*, Scottish Executive, 2004.

18 *Partnership for Care: Scotland's Health White Paper*, Scottish Executive, 2003.

19 Angiography is a diagnostic procedure undertaken to establish the type and severity of coronary heart disease.

20 Revascularisation is a kind of heart surgery that involves bypassing arteries supplying blood to the heart that have been affected by coronary heart disease. Surgery improves the supply of blood to the heart muscle.

21 *Our National Health: A Plan for Action, A Plan for Change*, Scottish Executive, 2000.

22 *Cancer in Scotland: Action for Change*, Scottish Executive, 2001.

23 *A Partnership for a Better Scotland*, Scottish Executive, 2003.

24 *The Scottish Executive: Draft Budget 2006/07*, Scottish Executive, 2005.

and established as a national centre to help reduce the longest waiting times.

We discuss these organisations further in [Part 3](#) of this report.

Our study

21. In this study we carried out a high-level review of the value for money of the approaches taken by NHS boards and other organisations involved in reducing waiting times. We examined information on waiting lists and waiting times for first outpatient attendances and for inpatient and day case treatment ([Waits 2 and 4 in Exhibit 1, page 5](#)).²⁵ We also looked at waiting times for certain cardiac procedures where there are national waiting time guarantees. We used published and unpublished data from the Information Services Division (ISD) of NHS National Services Scotland.

22. We did not review waiting times for diagnostic tests ([Wait 3 in Exhibit 1, page 5](#)). Targets for these areas were set in summer 2005 and information to monitor performance is currently being developed. The new diagnostic targets are included within the 18-week targets for inpatients, day cases and outpatients for 2007.²⁶ We did not look at waiting times for cancer services but our recent report on bowel cancer services and our NHS overview report comment on performance against cancer waiting time targets.^{27 28}

23. We interviewed senior managers and clinical staff in a sample of NHS boards and the SEHD about the management of waiting lists and waiting times. We selected six NHS boards, including urban and rural areas, teaching hospitals and district general hospitals, and boards with different performance against targets. We also included boards that were frequent and infrequent users of the GJNH.²⁹

24. We commissioned a telephone survey of patients' views on their willingness to travel to reduce the time they had to wait for treatment.³⁰ Respondents were selected at random from the general public and a sample of 1,000 patients was interviewed. The sample was drawn from all over Scotland and designed to achieve a representative sample of inpatients and outpatients.

25 Inpatients and day cases are patients admitted to a hospital or other health facility for treatment. Inpatient treatments involve one or more nights in hospital. Day case patients are admitted, treated and discharged on the same day. A first outpatient attendance is a visit to a specialist, usually a hospital consultant, following referral by a General Practitioner (GP) or dentist.

26 *Delivering for Health*, Scottish Executive, 2005. This set maximum waiting times of nine weeks by the end of 2007 for eight diagnostic tests including CT, MRI and ultrasound scans and upper gastrointestinal endoscopy.

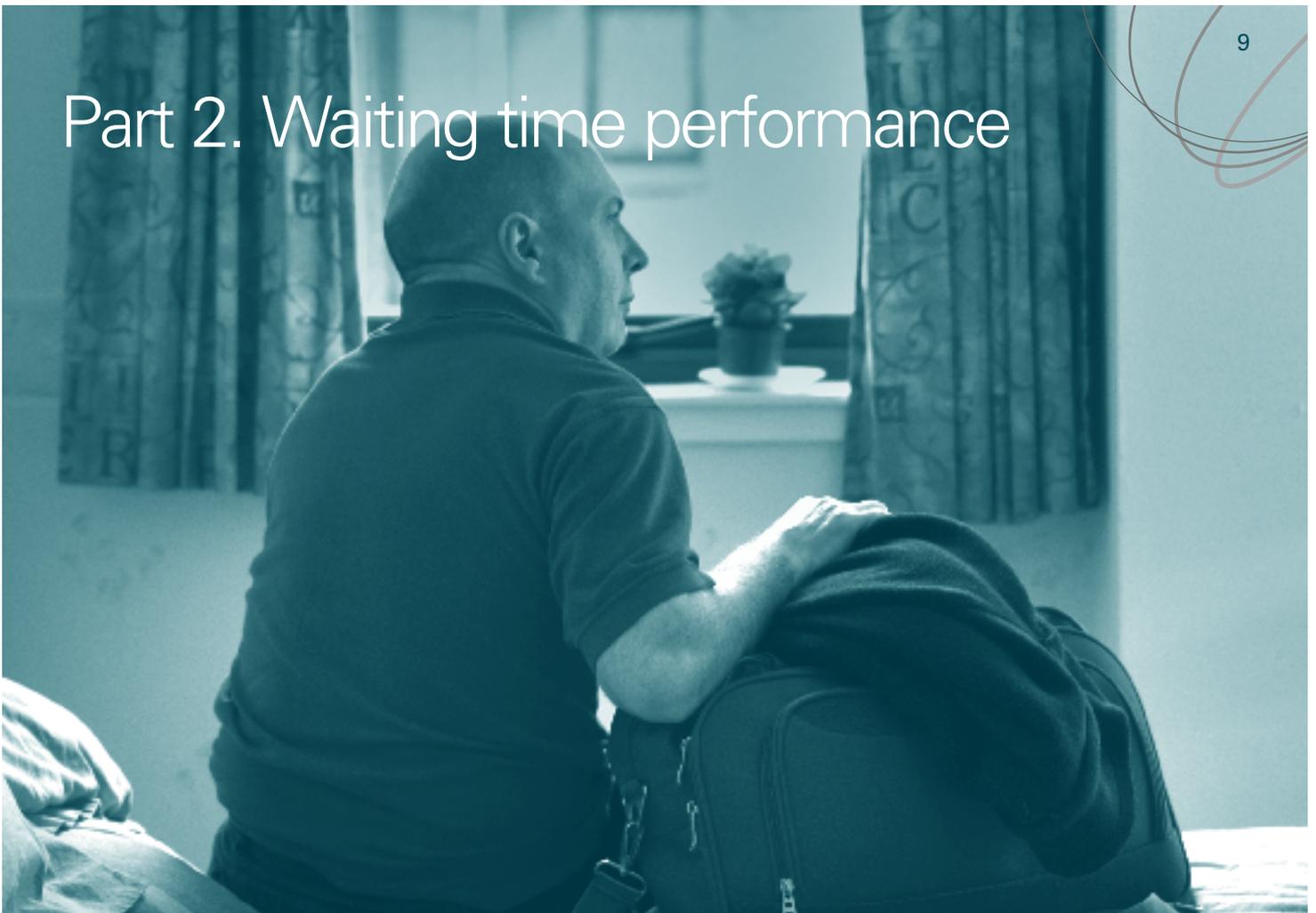
27 *A review of bowel cancer services*, Audit Scotland, 2005.

28 *An overview of the performance of the NHS in Scotland 2004/05*, Audit Scotland, 2005.

29 Greater Glasgow, Argyll & Clyde, Dumfries & Galloway, Fife, Forth Valley and Grampian.

30 The survey was undertaken by MORI Scotland.

Part 2. Waiting time performance



Key messages

- The NHS in Scotland has made significant progress towards meeting targets for inpatients and day case patients with waiting time guarantees. In addition, the number of outpatients waiting for a first appointment has decreased substantially since the end of September 2004.
- The total number of people waiting for inpatient and day case treatment has changed little in the last two years. The number of people without waiting time guarantees has increased and most of these patients have been waiting over six months.
- This, together with the changes in the way guarantees will be applied from the end of 2007, means that the NHS faces a major challenge in meeting more ambitious waiting time targets in the future.

25. In this chapter, we:

- explain the types of information that are available on waiting lists and waiting times
- analyse data on waiting times for inpatients, day cases and new outpatients, with and without waiting time guarantees
- discuss the difficulties in comparing waiting lists and waiting times in Scotland and England.

26. To assess trends in waiting lists and waiting times, we use published information from ISD from March 2001 to September 2005. We chose March 2001 as the starting point for our analyses because it preceded the change from targeting waiting lists to targeting waiting times.

27. The more detailed analysis of the number of patients waiting in each specialty (given in Part 3 of this report), and waiting times of patients without a guarantee is based on unpublished information supplied by ISD.

Assessing waiting time performance is complex

28. Two different types of information are available on waiting lists and waiting times:

- **Waiting list census information.** This provides a snapshot of the number of people waiting to be seen or treated, and how long they have been waiting at the census date. ISD publishes data quarterly from the censuses for inpatients and day cases, and new outpatients.
- **Waiting times information.** This information is collected retrospectively on all patients with and without waiting time guarantees. It shows the actual time patients waited from the point they were added to the waiting list to the date of their treatment or appointment. ISD publishes median waiting times and information on the percentages of patients treated

Exhibit 4

Availability Status Codes

Patients may be assigned an ASC for a variety of reasons.

- A Patients under medical constraints (condition other than that requiring treatment), which affected their ability to accept an admission date if offered.
- 2 Where the patient has asked to delay admission for personal reasons or has refused a reasonable offer of admission.
- 3 In individual cases where, after discussion with the patient, the treatment has been judged of low clinical priority.
- 4 For patients needing highly specialised treatments identified at the time of placing the patient on the waiting list.
- 8 Where the patient did not attend without giving prior warning.
- 9 In circumstances of exceptional strain on the NHS, such as a major disaster, major epidemic or outbreak of infection, or service disruption caused by industrial action.
- X Given to patients that had been on the deferred list but the reason for being there was not known. Code X was not used after September 2003.

Note: Only codes 2, 8 and 9 apply to outpatients.

Source: ISD

within different time periods.^{31 32} The median is used because it is not affected by a small number of very low or very high values. However, the median does not describe clearly what is happening to the longest or the shortest waiting times.

29. Information is available on patients who do not have a waiting time guarantee. Patients do not have a guarantee if they are unavailable or medically unsuitable for treatment. These patients are assigned an Availability Status Code (ASC). Exhibit 4 sets out the codes and their definitions. Because of the way waiting list and waiting time information is collected, patients without a guarantee can be identified in the waiting list information but cannot be separately identified in the waiting times information. This affects the usefulness of each type of information for measuring progress against waiting times targets.

30. At the end of 2007, ASCs will be abolished.³³ After 2007, patients who would currently be assigned an ASC because they are unavailable for treatment for medical or social reasons will have waiting time guarantees. But the times when patients are unavailable for treatment will be subtracted from their total waiting time, as already happens in England. Patients who could not attend (CNAs) will have their waiting time set to zero from the date at which the cancellation is made. Patients who did not attend (DNAs) without letting the service know will either be referred back to their GP and taken off the waiting list, if clinically appropriate to do so, or they will be kept on the waiting list and their waiting time set to zero. These patients will then have a guarantee to be seen or treated within 18 weeks. Codes 3 (low medical priority) and 4 (highly specialised treatments) will not be used after 2007.³⁴

31. At the time of our fieldwork (June to August 2005), boards were in the early stages of reviewing ASCs and developing plans for managing the new system from the end of 2007. Boards should ensure that they review their DNA and CNA rates and identify where systems could be improved to reduce them. In doing this, they should consider the potential impact of these changes on patients' access to care.

Different types of information on waiting can lead to different interpretations of waiting time performance

32. The waiting list information and the waiting times information measure waits in different ways. Each has advantages and disadvantages as a way of measuring waiting time performance.³⁵ These are outlined in Exhibit 5.

31 The median is a way of measuring the average. The median waiting time is the waiting time of the person in the middle of a line of people arranged in order of length of wait.

32 Outpatients: nine weeks, 13 weeks and 26 weeks. Inpatients and day cases: three months, six months, nine months and 12 months.

33 *Fair to All, Personal to Each*, Scottish Executive, 2004.

34 *Preparing for 'New Ways' – Interim Guidance*, Scottish Executive, 2005.

35 *Waiting for Elective Admission. Review of National Findings*, Audit Commission, 2003.

Exhibit 5

Advantages and disadvantages of using waiting list and waiting time information

Both waiting list and waiting times information should be used in analysing waiting time performance.

Waiting list information	Waiting times information
Advantages	Disadvantages
<p>Both inpatient and day case and outpatient data include patients with and without waiting time guarantees. This means:</p> <ul style="list-style-type: none"> numbers waiting and lengths of wait can be analysed separately for each group waiting times for people with ASCs, which are not fully under the control of the health service, can be analysed separately. 	<p>Inpatient and day case information combines patients with and without guarantees. This means:</p> <ul style="list-style-type: none"> waiting times cannot be analysed separately for each group periods when patients are unfit or unavailable for treatment are included, which overstates the waiting times that could be controlled by the health service. (Waiting time information on outpatients should exclude patients without guarantees, which reduces this problem.)
<p>Measures the number of patients who are still waiting and how long they have been waiting. This means:</p> <ul style="list-style-type: none"> it provides a basis for planning the activity required to meet waiting times targets. 	<p>Measures the waiting times of people treated in the previous quarter. This means:</p> <ul style="list-style-type: none"> there may be a time lag between clearing a backlog of patients waiting a long time and reported reductions in waiting times.
<p>Includes patients while they are waiting for treatment, even if they are never admitted.</p>	<p>Omits patients who waited for treatment but were never admitted.</p>
<p>Includes patients who have been waiting a long time.</p>	<p>Only includes people once they have been admitted for treatment, so it is not useful for monitoring the number of patients who continue to wait a long time.</p>
Disadvantages	Advantages
<p>Does not measure completed waits. This means:</p> <ul style="list-style-type: none"> patients with short waits that fall between census dates are never recorded some patients' waiting times may exceed targets without ever being recorded as such at the time of the census. <p>(These disadvantages could be addressed with more frequent censuses, which would reduce the number of patients affected and the potential difference between the actual time waited and the waiting time measured at the time of the census.)</p>	<p>Measures completed waits. This means:</p> <ul style="list-style-type: none"> patients with short waits that fall between census dates are included waiting times of all patients who wait longer than target to be seen or treated are recorded, although they cannot be separated for patients with and without guarantees.

Exhibit 6

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

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



Source: ISD inpatient and day case waiting list census

33. Most of the analyses in this report are based on waiting list information, because it provides an up-to-date picture of the progress made in tackling long waits. But the waiting times information is also useful because it identifies how long people actually waited and whether this is changing as the backlog of patients waiting a long time is reduced. Therefore, we also analyse the information on the waiting times of patients seen or treated in each quarter.

34. When we report waiting list census data for a particular month, the data refer to patients waiting at the end of that month. When we report waiting times data for a particular month, the data refer to patients seen or treated in the quarter up to the end of that month.

Recommendations

In consultation with SEHD and the NHS in Scotland, ISD should consider:

- Extending the measures of waiting times that it publishes. For example, as well as median waits, it could produce interquartile ranges or other measures which provide a more complete picture of the distribution of waiting times.
- Increasing the frequency of the inpatient and day case waiting list census from quarterly to monthly.

Progress has been made towards inpatient and day case targets

Fewer patients with a guarantee are waiting a long time

35. The latest waiting list census information shows that the number of inpatients and day cases on the waiting list increased from 106,996 in March 2001 to 114,052 in December 2004. The total number of patients waiting then fell to 109,992 in September 2005.³⁶

36. The number of patients with a guarantee, who had been waiting longer than six months for treatment, fell in all NHS boards and most major specialties between March 2001 and September 2005.³⁷ In March 2001, 11,573 patients (15% of patients with a guarantee) had been waiting over six months. By September 2005, this had fallen to 1,249 patients, less than 2% of patients with a guarantee, although this figure is slightly higher than in June 2005 (Exhibit 6).

37. The number of patients with a guarantee waiting over 18 weeks (the new target for the end of 2007) also fell, from 21,289 in March 2001 (27%) to 9,672 in September 2005 (13%), again slightly higher than in June 2005.

Waiting time targets for cardiac procedures are being met

38. In September 2005, no patients had been waiting longer than the 18-week target for revascularisation, the fifth consecutive quarter that NHS boards achieved this. In addition, no patients had been waiting longer than the eight-week angiography target.³⁸

³⁶ Inpatient and day case waiting list census, ISD, 24/11/05.

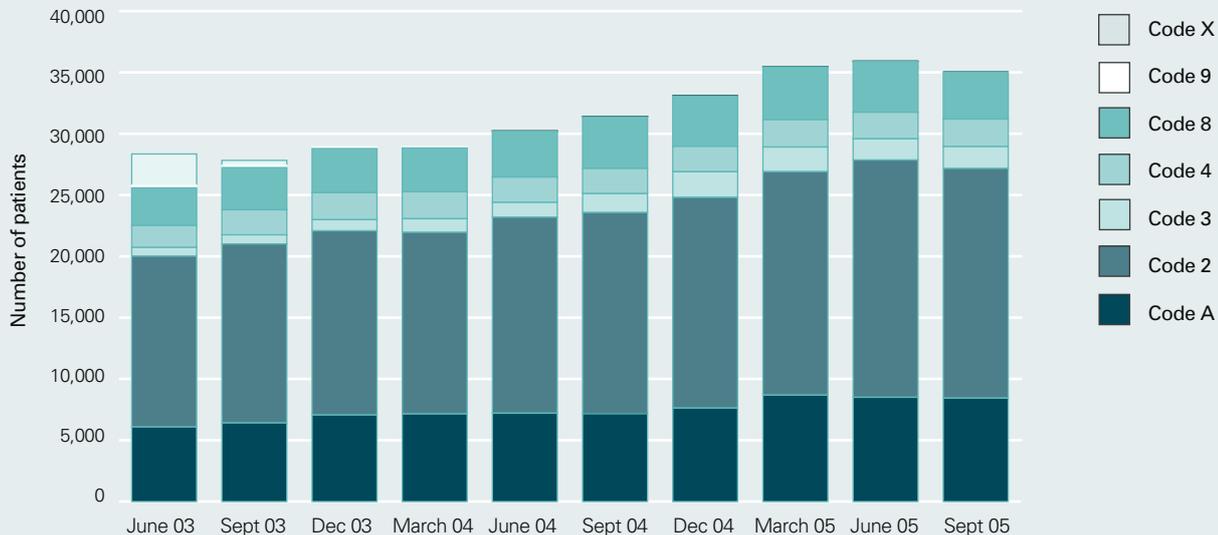
³⁷ Inpatient and day case waiting list census, ISD, 24/11/05.

³⁸ Waiting list census data on coronary heart disease procedures, ISD, 24/11/05.

Exhibit 7

Inpatients and day cases waiting by ASC type, June 2003 to September 2005

The number of patients without a waiting time guarantee has increased but the proportion of patients with each type of ASC has changed little over time.



Note: definitions of codes are given in Exhibit 4.

Source: ISD inpatient and day case waiting list census

The number of patients without a guarantee has increased

39. We analysed unpublished data, requested from ISD, on the time that patients without a waiting time guarantee have been waiting for treatment, and the reasons why these patients had been given an ASC.

40. Up until June 2003, people who were unfit or unavailable for treatment were either put on a deferred waiting list or given a guarantee exception code.³⁹ Audit Scotland's report on the management of waiting lists recommended a review of the rationale for the deferred list.⁴⁰ Following the review, the deferred list was abolished and ASCs were introduced in June 2003. Information on ASCs is therefore available from June 2003.

41. In June 2003, 28,349 patients did not have a waiting time guarantee and had been allocated an ASC, which represented 25% of all patients waiting. By September 2005, the number of patients waiting without a guarantee had increased to 35,048, or 32% of all patients waiting. This is a slight reduction from the peak of 35,910 in June 2005.⁴¹

42. Over half of these 35,048 patients did not have a guarantee because they had delayed or refused a reasonable offer of treatment (code 2); around a quarter of patients were medically unfit for treatment (code A); and around one in ten patients had failed to attend for their treatment without giving prior warning (code 8). Although the number of patients without a guarantee has increased between June 2003 and September 2005, the proportion of patients with each code has remained fairly constant (Exhibit 7). For example,

since December 2003, the proportion of patients assigned an ASC for medical reasons has remained at about one quarter and the proportion of patients who delayed admission for personal reasons or refused an offer of treatment remained at just over one half.

43. Patients without a waiting time guarantee typically wait longer. Exhibit 8 (overleaf) shows that between June 2003 and September 2005, the number of patients without a guarantee who had been waiting longer than six months increased by 16% to 23,568. This accounts for around two-thirds of patients without a guarantee.⁴² Since June 2003, the number of patients without a guarantee waiting less than six months has increased by 43%, and the number waiting between 18 weeks and six months has increased by 93%.⁴³

39 For fuller details of these changes and their effect on the analysis of waiting times trends, see: *Changes in the recording of waiting list information in Scotland and the impact on published statistics*, ISD, 2003.

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

41 Inpatient and day case waiting list census, ISD, 24/11/05.

42 Inpatient and day case waiting list census, ISD, unpublished information supplied by ISD, 24/11/05.

43 Inpatient and day case waiting list census, ISD, unpublished information supplied by ISD, 24/11/05.

Exhibit 8

Changes in inpatients and day cases waiting in relation to future targets

The number of patients without a guarantee waiting longer than the six-month target has increased, from 20,322 in June 2003 to 23,568 in September 2005.



Source: ISD inpatient and day case waiting list census

44. It is unclear what effect the abolition of ASCs will have as it is not known how many patients without a guarantee, in particular those who have been waiting a long time, still need to be treated. This information is not routinely collected.

45. The total number of patients on the waiting list has remained fairly constant in recent years while there has been a growth in the number of people without guarantees. This, together with more ambitious future targets and the abolition of ASCs, suggests that the NHS in Scotland faces a major challenge in meeting future inpatient and day case targets.

The length of time patients waited to be treated has varied over time

46. The latest waiting times information shows that the percentage of patients who waited more than six months for their treatment increased from 10% in March 2001 to 15% in December 2003 before decreasing to 9% in September 2005. During the same period, the median wait increased from 38 days to 43 days, although it peaked at 48 days in March 2005.⁴⁴

47. The rise in median waiting times may be partly explained by targeting patients who have been waiting the longest time.

Recommendations

In their planning for the abolition of ASCs, boards should:

- review the status of patients with an ASC to identify if they still require treatment or if their circumstances have changed

- develop strategies for seeing or treating patients with an ASC before these codes are abolished at the end of 2007
- put in place processes for administering and monitoring the new rules for defining and measuring periods of unavailability for treatment, to ensure that they are used appropriately and consistently
- review their DNA and CNA rates before the new rules are introduced and identify where systems could be improved to reduce them.

Outpatient waiting times are improving

48. Information on new outpatients currently waiting to be seen comes from the Outpatient Waiting List. Information is available from September 2004.⁴⁵ ISD is still developing the information and the figures used in this report are provisional.

49. Outpatients who have asked to delay a first outpatient appointment, refused a reasonable offer of an appointment or failed to attend an appointment without warning the clinic concerned are given an ASC and do not have a waiting time guarantee.

Good progress is being made towards meeting outpatient targets

50. The number of people waiting for a first outpatient appointment decreased by 21% from 265,228 in September 2004 to 210,586 in

September 2005.⁴⁶ The number of outpatients without a waiting time guarantee also decreased though at a slower rate than patients with a guarantee – from 18,254 to 17,001 in September 2005.

51. The number of outpatients with a waiting time guarantee waiting over six months decreased by 78% between September 2004 and September 2005 from 53,579 to 11,854 (Exhibit 9, overleaf). The number with a guarantee waiting over 18 weeks also fell, from 76,311 in September 2004 to 32,074 in June 2005, although it increased slightly again to 34,342 in September 2005.

52. The number of patients without a guarantee waiting over six months fell from 6,823 to 4,933 (29% of patients without a guarantee) between September 2004 and September 2005. The number waiting over 18 weeks also fell by 19%, from 9,606 to 7,790. Outpatients who do not have a guarantee tend to wait longer than those who do.

Outpatient waiting times have fluctuated over time

53. The percentage of outpatients who waited longer than six months for a first outpatient appointment fluctuated between 9% and 14% from March 2001 to September 2004. It peaked at 19% in March 2005, before falling back again to 10% in September 2005. Median waits show a similar pattern peaking at 62 days in March 2005 before falling back to 54 days in September 2005.⁴⁷

54. The peaks in March 2005 correspond to the period when the number of people on the waiting

44 Data on trends in acute activity, ISD, 24/11/05. Data for September 2005 are provisional. The 2001 figure is based on the revised method for calculating retrospective waiting times prior to April 2003. The revised method includes patients on the deferred waiting list. For further details, see: *National Statistics Internal Review of Methodology – Presentation of Historic Waiting Times Trend*, ISD, 2005.

45 The Executive's outpatient waiting time target is six months but waiting list data reports 26 weeks. For the purposes of this report, when referring to the target and presenting data we use 'six months'.

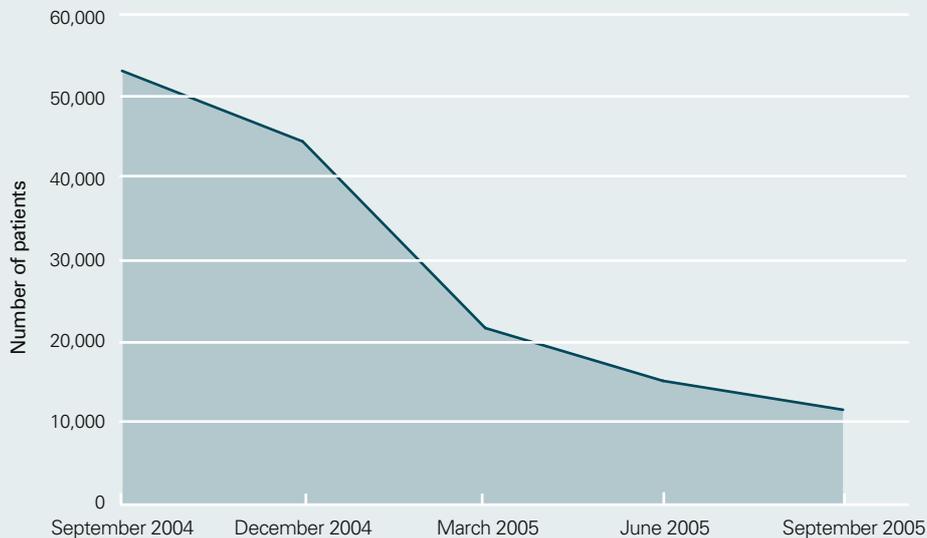
46 Outpatient waiting list census, ISD, 24/11/05.

47 Data on trends in acute activity, ISD, 24/11/05. Data for September 2005 are provisional.

Exhibit 9

New outpatients with a waiting time guarantee waiting over six months, September 2004 to September 2005

The number of new outpatients with a guarantee waiting over six months has decreased significantly since the end of September 2004.



Source: ISD outpatient waiting list census, provisional data

list who had been waiting over six months fell most rapidly. This suggests that the rise may have been due to treating large numbers of patients who had been waiting a long time.

Comparing Scottish and English waiting times is complex

55. Current guarantees and future targets differ between Scotland and England (see Exhibit 10). In Scotland, the target is that no patient should wait longer than six months for inpatient or day case treatment or for a first outpatient appointment by the end of 2005. In England, inpatient and day case targets are the same as in Scotland but the Department of Health (DoH) has set a target maximum wait for a first outpatient appointment of three months by the end of December 2005.

56. The future target in Scotland is that no one should wait longer than 18 weeks for a first outpatient appointment and 18 weeks for inpatient or day case treatment by the end of 2007, including the waiting time for a diagnostic test. In England, the DoH has set a longer-term target that by the end of 2008, no one should wait more than 18 weeks from GP referral to hospital treatment.⁴⁸

57. Exhibit 6 (page 12) shows that in Scotland, the number of inpatients and day cases with a waiting time guarantee waiting over six months has fallen to 1,249 (2% of all patients waiting with a guarantee) in September 2005. This is down from 11,573 (15%) in March 2001. Exhibit 9 (page 15) shows that in Scotland the number of new outpatients with a guarantee waiting over six months has fallen from 53,579 to 11,854 in the year to September 2005.

58. In England, the number of inpatients and day cases with a waiting time guarantee waiting over six months was 34,378 (4% of all patients waiting) in September 2005, down from 188,343 (19% of all patients waiting) in June 2003. The number of outpatients waiting over 21 weeks for an outpatient attendance following referral by their GP was 1,580 in September 2005.⁴⁹

59. This suggests that Scotland performs better than England on inpatient and day case waiting times, but Scotland has many more outpatients waiting over six months than England. However, the differences in the way information is collected in the two countries make direct comparisons difficult and potentially misleading (Exhibit 10).^{50 51}

48 *The NHS in England: the Operating Framework for 2006/7*, Department of Health, 2006.

49 *Hospital Waiting Times/Lists Statistics*, Department of Health, 24/11/05. In England, outpatient waiting times are reported in three bands (Exhibit 10).

50 *Discussion paper: Comparing median waiting times in Scotland with those in England*, ISD, 2005.

51 *Effect of diverging policy across the NHS*, Alvarez-Rosete A, Bevan G, Mays N, Dixon J, BMJ 2005.

Exhibit 10

Differences between Scotland and England in waiting times targets and measurement

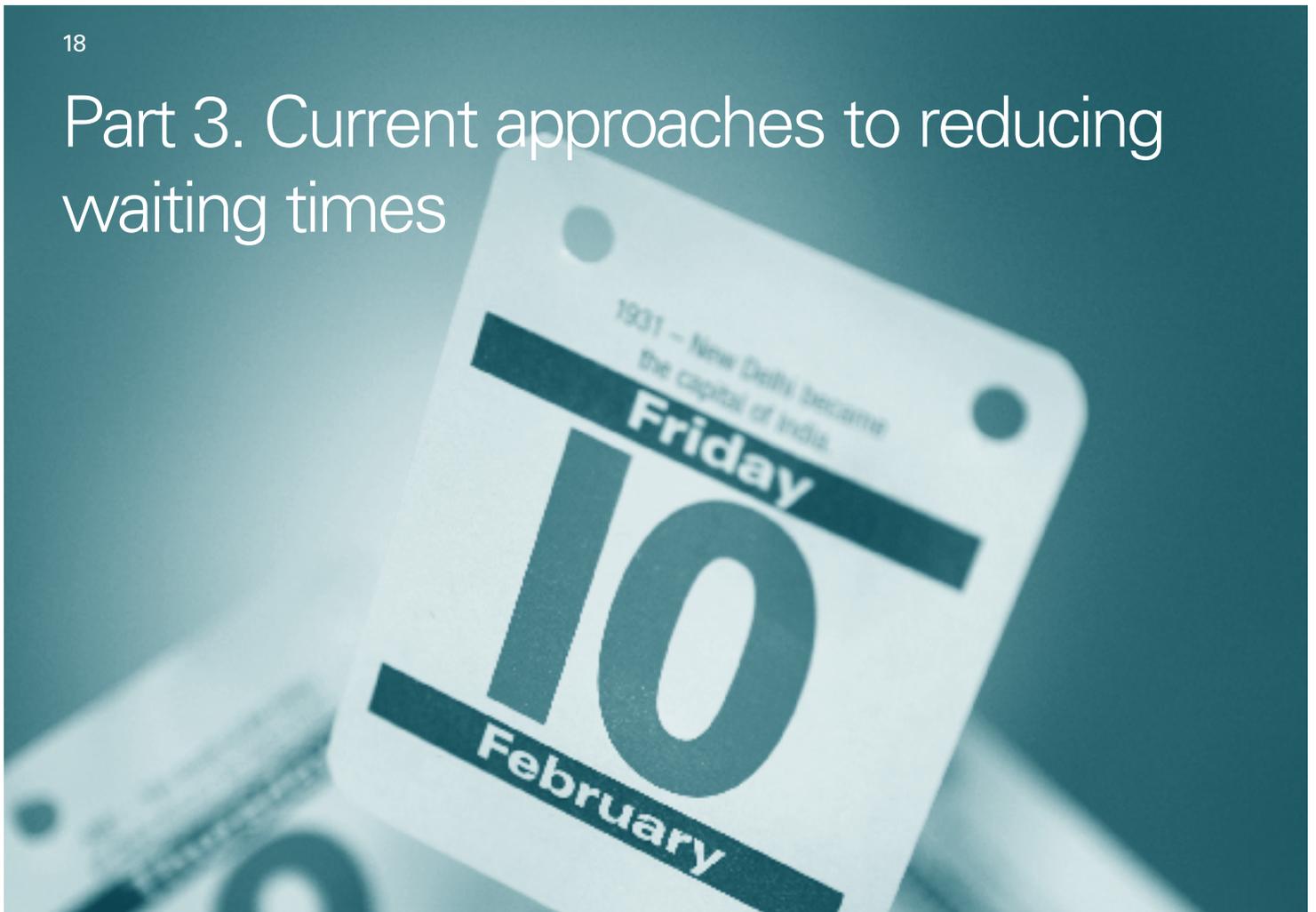
Differences in targets and data in Scotland and England make comparisons difficult and potentially misleading.

		Scotland	England
Current targets	Inpatient and day case	Six months by end 2005	Six months by end 2005
	New outpatient	Six months by end 2005	Three months by end 2005
Future targets	Inpatient and day case	18 weeks by end 2007	18 weeks from GP referral to hospital treatment by end 2008
	New outpatient	18 weeks by end 2007	
Data available	Inpatient and day case	Total number of patients waiting Number of patients with a guarantee waiting over 18 weeks, six months and nine months Proportion of patients seen within three, six, nine and 12 months	Total number of patients waiting Number of patients waiting by length of wait in months (from one month to over 12 months)
	New outpatient	Total number of patients waiting Number of patients with a guarantee waiting over 18 weeks and six months Proportion of patients seen within nine, 13 and 26 weeks	Number of patients waiting 13-17 weeks, 17-21 weeks and over 21 weeks Number of patients seen by length of wait in weeks (from less than four weeks to over 21 weeks)
Calculation of median waits (see note)		Based on retrospective waiting time data	Based on waiting list census data
Patients unavailable for treatment		Excluded from waiting list information on patients with guarantees. Current systems do not allow these patients to be added to the list when they become available.	Excluded from waiting list information. Patients are added back to the list once they become available for treatment
Periods of unavailability for treatment		Included in waiting times information	Subtracted from the time that patients have been waiting

Note: Differences in the way in which information is collected mean that the comparison of median waits between Scotland and England is not statistically valid.⁵²

Source: Acute Activity, Waiting List and Waiting Times, ISD, and Hospital Waiting Times/List Statistics, DoH

Part 3. Current approaches to reducing waiting times



Key messages

- The NHS in Scotland has made significant progress in reducing waiting times. Some of this has been achieved by using the GJNH, private providers and waiting times initiatives, all of which have been relatively high-cost. There is a place for these short-term approaches but they need to be part of a wider strategy which looks at the whole system for achieving a sustainable reduction in waiting times.
- The NHS in Scotland has increased its spending on reducing waiting times. In 2004/05 this was at least £116 million. To date, most of the NWTU and CCI's funding has been allocated on a non-recurring basis.
- The GJNH exceeded its overall activity targets in its first three years. But the hospital could

make a bigger contribution to tackling waiting times by improving the way activity is planned and increasing activity.

- Involving patients in decisions about where they are treated could help reduce waiting times, but is not currently common practice within the NHS in Scotland.

60. In this part of the report, we:

- review current approaches adopted by the NHS in Scotland to reduce waiting times
- examine the roles of the main organisations involved
- estimate the money spent on reducing waiting times
- assess whether these approaches provide value for money.

Boards have lead responsibility for tackling waiting times

61. Exhibit 2 (page 6), in Part 1 of this report, illustrated the wide variety of factors that influence waiting times. The relative importance of these factors differs among NHS boards and specialties and the solutions adopted to reduce waiting times also differ. But we have identified common difficulties faced by NHS boards in reducing waiting times, and some similarities in the solutions being adopted.

Managing demand for services is an essential part of reducing waiting times

62. Managing demand for elective care is not uniformly well developed in the NHS in Scotland. Long waiting times for hospital care have traditionally been seen as a sign of capacity shortages or poor management of capacity in the acute hospital sector, without considering the effect of GP referrals on the demand for hospital care.⁵³

Case Study 1

NHS Lothian's dermatology email advice service reduces referrals and speeds up treatment

NHS Lothian set up a new dermatology email advice service for GPs in January 2004. It aims to offer fast advice to GPs on non-urgent clinical problems that may not need to be referred to a specialist. GPs use the service to seek help with diagnosis, general advice on how to manage conditions and specific advice on how to treat particular patients.



NHS Lothian has carried out a clinical audit of this service. This found that most specialists replied within 24 hours of GPs' emails being received. The majority of GPs are satisfied with the new service reporting that it is easy to use, provides quick responses and has avoided referrals to specialists.

Source: NHS Lothian

63. The development of demand management has been limited because the NHS in Scotland does not have information on the effect of changes in one part of the health system on demand, activity and waiting times elsewhere in the system. To estimate the impact shorter waiting times have on demand and capacity requirements, boards need better information on:

- GPs' referral patterns and changes in the number and type of referrals in response to shorter waiting times
- the status of patients who do not currently have a guarantee
- the effect of reducing outpatient waiting times on demand for inpatient and day case services
- the effect of service redesign and additional capacity on the number of patients flowing through the system.

64. GPs also need better information on the full range of services available and they need to work with boards to further develop referral protocols so that patients are referred to the most appropriate service.

65. NHS boards recognise the importance of managing demand and are beginning to address this through the development of a number of schemes. These include Referral Information Services being piloted in NHS Glasgow and NHS Lothian and Referral Management Systems being piloted in specific specialties in six NHS boards. Referral Information Systems aim to improve the information available to GPs and hospital doctors on referrals from primary care. Referral Management Systems help to manage referrals more appropriately, for example, by referring outpatients to specialists in the community rather than in hospital, where appropriate.⁵⁴ Case studies 1, 2 and 3 provide examples of good practice in NHS Lothian, NHS Grampian and NHS Greater Glasgow.

NHS boards are starting to change the way in which services are organised but more work is needed

Emergency admissions can affect elective care

66. Increased emergency admissions can affect NHS boards' ability to plan elective care and capacity. The GJNH and private sector hospitals provide elective capacity which can help alleviate these problems.

67. Boards are developing local ways of ensuring that planned admissions are not affected by emergency admissions. Some NHS boards – for example, Greater Glasgow, Fife, and Forth Valley – are locating emergency and elective services in separate hospitals. Other boards are developing alternatives such as medical admissions units where emergency patients' needs are assessed and alternatives to admission are identified if appropriate.

Case Study 2

NHS Grampian is developing alternative ways of managing orthopaedic referrals

NHS Grampian has established new posts to reduce waiting times for orthopaedic services, including four extended role physiotherapists and seven specialist GPs. These posts are supported by consultant orthopaedic teams in Elgin and Aberdeen who also provide training. The approach was adopted following a review of the existing orthopaedic workload. The review team concluded that up to 40% of referrals could be dealt with differently if GPs had access to other referral options. When all the posts are filled it is estimated that they could deal with around 4,000 referrals per year.

The scheme will be fully evaluated, but information already available shows that at least 20% of referrals are being seen by specialist GPs or physiotherapists. Consultants involved in the scheme have seen significant reductions in the number of patients on their individual waiting lists. Specialist GPs will provide feedback to referring GPs to help them review the appropriateness of future referrals.

In the short term, the level of consultant input to outpatient clinics has been maintained to meet outpatient waiting time targets. In the future, the aim is that consultants will spend less time in outpatient clinics and more time in the operating theatre, which may help further reduce waiting times for inpatients. Success of this initiative has required:

- clinical team involvement
- effective clinical leadership
- effective project management and support
- a review of capacity across the entire care pathway to ensure that the more efficient management of outpatient referrals does not create bottlenecks later in the treatment process.

The cost of this initiative was met by NHS Grampian, CCI and NWTU.

Source: NHS Grampian

Boards need to use capacity more efficiently to help reduce waiting times

68. There are several measures of efficiency. For example, average length of stay (ALOS) and the number of patients whose discharge from hospital has been delayed can affect hospitals' ability to admit patients for elective care and meet waiting times targets. By treating more patients as day cases, hospitals can free up hospital beds and admit more patients. In addition, reducing the ratio of return to new outpatient appointments can increase the number of new outpatients who can be seen in outpatient clinics.

69. Efficiency is improving in some of these areas but there is substantial variation among boards. For example:

- The ALOS for all Scottish hospitals was 8.3 days in 2005, a reduction

of 1.5 days since 2001. There is variation across the country, ranging from 7.4 days in NHS Highland to 10.5 days in NHS Argyll & Clyde.⁵⁵ The change in the ALOS also varied among mainland boards. It increased by 5% in NHS Dumfries & Galloway and decreased by 22% in NHS Lanarkshire between 2001 and 2005.⁵⁶

- The number of patients whose discharge from hospital has been delayed fell by 50% from its peak of 3,138 in October 2001 to 1,576 in October 2005. The number of patients whose discharge was delayed by more than six weeks fell by 60% from 2,191 to 875 over the same period.^{57 58} Individual boards' performance varies.
- The percentage of elective patients treated as day cases was 66% in September 2005

for the whole of Scotland – unchanged over the last four years.⁵⁹ The percentage varies among boards, from 43% in NHS Grampian to 76% in NHS Fife in September 2005. The change in the percentage of patients seen as day cases also varies among boards. NHS Grampian had a 7% reduction while NHS Highland had a 9% increase. Some of this variation may be explained by an increase in the number of procedures performed on an outpatient basis. For example, NHS Grampian now undertakes most of its cataract operations in this way. However, Audit Scotland's latest report on day surgery confirmed that the rate of increase in day surgery for many procedures has slowed since the late 1990s and that there is substantial variation among NHS boards for particular surgical procedures.⁶⁰

55 Data on trends in acute activity supplied by ISD.

56 The number of cases treated in the island boards is much lower than the mainland boards so the figures are not directly comparable to the mainland boards.

57 Delayed discharge census, ISD, 9/12/05.

58 *Moving on? An overview of delayed discharges in Scotland*, Audit Scotland, 2005.

59 Data on trends in acute activity, ISD, 24/11/05.

60 *Day surgery in Scotland: reviewing progress*, Audit Scotland, 2004.

Case Study 3

NHS Greater Glasgow has redesigned orthopaedic services

NHS Greater Glasgow has extended the roles of healthcare professionals in two projects to reduce waiting times – the Orthopaedic Foot and Ankle Triage Service and the Community Outpatient Service Physiotherapy Knee Project.

The Orthopaedic Foot and Ankle Triage Service has been set up in south-west and north-east Glasgow. The Community Outpatient Service Physiotherapy Knee Project involves GPs in Clydebank and North Glasgow working in collaboration with Glasgow Royal Infirmary and the Western Infirmary.

Both projects are led by Extended Scope Practitioners (ESPs). These are physiotherapists who have received training to broaden their roles, allowing them to assess, treat and where necessary refer patients to a hospital consultant. GPs refer patients directly to ESPs instead of referring to a consultant. ESPs can place patients directly onto the waiting list for surgery.

At September 2005, 100 patients had been referred to the Orthopaedic Foot and Ankle Triage Service – around two-thirds have been treated by ESPs and one-third have been referred to the hospital orthopaedic department for surgery. The maximum waiting time for an appointment with an ESP is four weeks. NHS Greater Glasgow anticipates that once the service is working to full capacity around 3,000 patients could be referred through this service each year.

Factors critical to the success of these projects are:

- strong leadership and support from steering groups representing all the organisations involved
- active involvement of orthopaedic consultants from the early stages of the project
- enthusiastic and motivated clinical staff
- changes in GPs' referral patterns which require effective collaboration between the practices and hospitals
- adequate training and development of staff
- sufficient time to test the services and robust plans to measure the impact on patient care.

Both projects are funded with non-recurring funding from the CCI.

Exhibit 11

Extract from the new consultant contract in Scotland

Waiting Times Initiative Payments

In circumstances where, as a direct result of published national or local waiting time targets, the employer requires increased ad hoc activity not previously identified within the job plan, the employer and consultant may agree a separate contract for this purpose. Such work will be voluntary.

Such work will be paid at three times the hourly rate appropriate to point 20 of the seniority scale..., or alternatively and by agreement with the employer:

- paid at twice the hourly rate appropriate to point 20 of the seniority scale... and equivalent time off in lieu; or
- paid at the hourly rate appropriate to point 20 of the seniority scale... and twice the equivalent time off in lieu.

NHS patients may be treated within the private sector at the request of the consultant's main employer.

Source: *National Health Service Hospital Medical and Dental Staff and Doctors In Public Health and the Community Health Service (Scotland) Consultant Grade: Terms And Conditions of Service, SEHD, 2005*

- The ratio of return outpatient appointments to new outpatient appointments has fallen gradually from 2.4 in March 2001 to 2.2 in September 2005.⁶¹ But the ratio varies among boards, ranging from 1.7 in NHS Borders to 2.8 in NHS Ayrshire & Arran in September 2005.

70. In line with other studies, we found no simple relationship between boards' performance in these areas and their performance on waiting times.⁶² Improving the efficiency of existing services will help to reduce waiting times but other changes are also required. This includes changes in the way in which waiting lists are managed, using processes such as patient-focused booking, and establishing new

services such as one-stop clinics with faster access to diagnostic tests.⁶³

Capacity constraints influence waiting times

71. In some areas capacity constraints have made it more difficult to reduce waiting times. For example, there are a number of areas, such as orthopaedics, which have shortages in senior medical staff.⁶⁴ Doctors' working hours are also being affected by new pay agreements, changes in medical training and the EU Working Time Directive.

72. The new consultant contract seeks to limit consultants' working hours and this may mean that reducing waiting times will be more difficult, or more costly if patients have to be treated under

waiting times initiatives rather than during consultants' core hours. Exhibit 11 shows the terms and conditions relating to waiting times initiative payments for work carried out outside of consultants' core hours. Since 2002/03 spending on waiting times initiative payments to consultants has increased and an increasing proportion of payments has been made at three times the standard hourly rate.⁶⁵

73. However, the new consultant contract also has potential to reduce waiting times. For example, Case Study 4 provides an example of how NHS Dumfries & Galloway is using surgical capacity more efficiently, and reducing the effect of emergency activity on elective capacity, through the new consultant contract.

61 Data on trends in acute activity, ISD, 24/11/05.

62 *Waiting for elective admission. Review of national findings*, Audit Commission, 2003.

63 Patient-focused booking involves contacting the patient to tell them how long they are likely to wait for their outpatient appointment and then contacting them again six weeks before the due date to arrange a mutually convenient time for their appointment. It aims to reduce DNA rates and cancellations leading to better queue management and shorter waiting times. At one-stop clinics, patients receive a specialist consultation and diagnostic test, receive results and, where necessary, undergo treatment or receive an appointment all in a single visit. Previously, multiple visits would have taken place.

64 NHS Scotland Workforce Statistics, ISD.

65 Results of Audit Scotland fieldwork undertaken as part of a study looking at the implementation of the new consultant contract. Full results will be presented in the report of the study which is to be published in March 2006.

Case Study 4

NHS Dumfries & Galloway is using the new consultant contract to reduce waiting times

Two developments in NHS Dumfries & Galloway show the potential of the new consultant contract to change the way services are provided and reduce waiting times.

Anaesthetics

Anaesthetists carry out a maximum of six day time operating or on-call sessions each week. During consultant contract negotiations, it was agreed that any day time sessions not used during the week would be placed in a 'bank' and used at a later date, with the agreement of the consultant. The arrangement is reviewed weekly to ensure that elective operating sessions are covered.

Orthopaedics

Prior to the new consultant contract, five consultant orthopaedic surgeons were employed at Dumfries & Galloway Royal Infirmary. Each provided on-call cover one night per week and one weekend in five. A build up of emergency cases during consultants' on-call periods often led to elective cases being cancelled and affected waiting times.

During consultant contract negotiations, it was decided to appoint an additional consultant, supported by two associate specialists. All consultants now participate in a six-week on-call rota, which means that, for one week in every six, each consultant is on-call for the full week. During periods of leave, an associate specialist covers the elective operating sessions and outpatient clinics. Detailed guidelines on the management of the orthopaedic outpatient clinics have also been produced in consultation with the consultants.

The new way of working has improved the efficiency of the department. Inpatient, day case and outpatient waiting times have been reduced.

Source: NHS Dumfries & Galloway

74. Although staff and other capacity constraints can make it more difficult to reduce waiting times, increases in capacity will not necessarily achieve sustained reductions in waiting times. Changes in working practices and accurate measurement of how capacity is used are also required to ensure that changes elsewhere in the health system do not reduce the effect of the additional capacity.^{66 67}

75. In addition, local capacity shortages may be addressed by planning services on a regional basis. For example, shortages in specialist staff or equipment may be managed by centralising specialist services, and developing local services that can reduce avoidable referrals to specialist hospital facilities. The appropriate balance at a regional level between centralisation and local service development can enhance both the clinical quality of specialist services and

the accessibility of non-specialised services.⁶⁸ This underlines the need to address waiting times at the same time as managing the longer-term service planning issues discussed in the Kerr Report, and in the programme of action published by the SEHD in response.⁶⁹

Managers and clinicians need to work closely together to develop new ways of providing services

76. Reducing waiting times in a sustainable way requires effective working relationships and close co-operation between managers and clinicians, particularly in relation to waiting list management. Traditionally, patients were often referred to a named consultant who would manage his or her own list. Boards are now developing pooled lists, where patients are referred to a group of clinicians rather than a specific person. Boards are also moving towards managing lists centrally to reduce

variation in the number of patients seen or treated, and the efficiency with which capacity is used. This has the potential to further reduce waiting times.⁷⁰

77. In managing waiting lists and times, NHS boards need to consider the effect that prioritising waiting times may have on the order in which patients on the list are treated. For example, patients with a lower clinical priority who have waited a long time may be seen or treated before patients with a more urgent clinical need. Managers and clinical staff need to agree list management guidelines to ensure that waiting lists are managed in a way that is consistent with clinical need.

Total waiting times spending by NHS boards is difficult to identify

78. We identified three broad categories of spending to tackle waiting times:

66 *The outpatient waiting times problem (and the solutions)*, Donald J, Huby C, Maxwell D, 2005.

67 *Waiting for elective admission. Review of national findings*, Audit Commission, London, 2003.

68 *Building a health service fit for the future, The 'Kerr Report'*, Scottish Executive, 2005

69 *Delivering for Health*, Scottish Executive, 2005.

70 *The National Framework for Service Change in Scotland. Final Report of the Elective Care Action Team*, SEHD, 2005.

Exhibit 12

Planned spending by NHS boards on reducing waiting times, 2001/02 to 2004/05

Boards planned to spend more money each year to tackle waiting times.

NHS boards' budgeted spend	2001/02 (£m)	2002/03 (£m)	2003/04 (£m)	2004/05 (£m)
Recurring	9.4	14.5	24.0	28.9
Non-recurring	1.4	2.7	5.0	10.2
Total	10.8	17.2	29.0	39.1

Note: These figures exclude additional funds to tackle waiting times that boards have received directly from the SEHD or through the NWTU and the CCI.

Source: Information submitted by NHS boards. NHS Highland and NHS Western Isles did not supply the information requested

- Mainstream spending on patient care. All elective care makes a contribution to tackling waiting times and spending elsewhere in the health system can also affect waiting times indirectly. It is not possible to identify this spending separately. But it is important to recognise that funding earmarked for waiting times initiatives is not the only funding that NHS boards use to address waiting times. Waiting times funding is only a small proportion of the total health spend that affects waiting times in Scotland.
- Budgets set aside by NHS boards from within their financial allocations specifically to reduce waiting times (Exhibit 12).
- Funds allocated by the SEHD to specific initiatives or programmes of work. These include waiting times initiatives funded by the NWTU, the Outpatients Programme of the CCI, and the money provided to the GJNH (Exhibits 13, 15 and 16, pages 26-29).

NHS boards are spending more money each year on tackling waiting times

79. NHS boards budgeted to spend over £39 million on tackling waiting times in 2004/05 (Exhibit 12). Most of this money (£28.9 million) was recurring. Boards' spending on waiting times has increased significantly over the last four years from nearly £11 million in 2001/02.

Recommendations

Boards should:

- work with the SEHD to develop long-term capacity planning
- work towards reducing the need for short-term increases in activity to reduce waiting times by:
 - sharing examples of good practice in redesigning services
 - improving service efficiency through measures such as increasing the number

of patients treated as day cases; reviewing outpatient activity to increase the ratio of new to return outpatient appointments; and pooling referrals and management of theatre lists

- work with primary care practitioners to further develop referral guidelines and protocols
- develop ways of ensuring that emergency demand does not affect planned admissions.

The SEHD plays a strategic role in reducing waiting times

80. The SEHD sets national objectives for the NHS in Scotland, which include improving patients' access to health care. To support this objective the Scottish Executive has set waiting time targets (Exhibit 3, page 7). The Executive's waiting time targets have become more demanding over time (see Appendix 1, page 39) and the scope of targets has widened.

81. The SEHD measures performance against these targets and the Health Minister holds NHS boards to account through the Annual Review process, where progress against waiting time targets is specifically discussed. The SEHD can intervene at a local level if serious problems arise with performance on waiting times or other healthcare objectives.

82. Recent policy and guidance documents from the SEHD advocate whole systems approaches to understand and reduce waiting times.^{71 72} But this is not always matched by national and local actions and approaches to tackle waiting times.

83. Within the SEHD there are two units with specific responsibilities for waiting times: the NWTU and the CCI.

The NWTU focuses its support on meeting current targets

84. The NWTU monitors boards' performance against targets on a monthly basis and allocates funds to boards to invest in specialties where there is a risk that the targets will not be met. It also:

- agrees quarterly interim targets with each NHS board
- sets allocations of activity at the GJNH with each NHS board
- coordinates access to the private sector
- advises boards on capacity planning and on how to meet targets

- develops information to support capacity planning and waiting times management
- intervenes locally to rectify poor waiting time performance.

85. The NWTU calculates the amount of funding available for each NHS board using the Arbuthnott formula.⁷³ Boards submit bids to the NWTU for the available funds. The bids describe how the funds will be used to reduce waiting times but bids are not assessed on whether they address the underlying causes of long waiting times.

86. In 2004/05, the NWTU released funds to NHS boards once they had demonstrated that agreed interim targets for the end of December 2004 and the end of March 2005 had been met. Until 2004/05, all of the funding allocated by the NWTU was non-recurring. In practice, some boards have treated this funding as recurring and managed the financial risk involved locally. We understand that the NWTU is allocating some money on a recurring basis from 2005/06.

The NWTU has been successful in helping boards address long waits but it has targeted its spending on short-term solutions

87. Most of the money spent by the NWTU to date has funded short-term increases in activity to clear the large numbers of patients waiting longer than the target, and to treat patients whose waits are likely to breach targets. The number of patients with a guarantee who exceed the six-month waiting time target has reduced significantly,

which shows that this approach has been successful in meeting targets. But it does not necessarily address the underlying reasons for long waits, or enable the development of services on a permanent basis where this is required. Using non-recurring funding to pay for short-term increases in activity may also be expensive. For example, staff are paid at higher rates for NHS waiting times initiatives (Exhibit 11, page 22).

88. In addition, more activity is being purchased from private sector providers. Spending on private sector waiting times initiatives was £6.9 million in 2002/03, £7.7 million in 2003/04 (with an additional £2.6 million from the SEHD to fund a private sector orthopaedics initiative), and £7.6 million in 2004/05. Funding for the private sector has increased to £10 million in 2005/06.⁷⁴

89. Private sector providers typically charge higher prices than NHS providers. Scottish tariffs are not yet available, but NHS reference costs in England for 2004, for example, show that the national average unit cost for a single knee replacement was £5,300. If both knees were replaced at the same time, a procedure called bilateral primary knee replacement, the cost increased to £7,100. In private providers, national average costs were £7,200 for single and £8,300 for bilateral knee replacements.⁷⁵

90. In 2003, the NWTU and the SEHD spent £5.13 million on a private sector initiative to carry out 586 hip and knee replacement procedures. This represented an

71 *Good Practice Guide to Managing Waiting Times*, Scottish Executive, 2003.

72 *Delivering for Health*, Scottish Executive, 2005.

73 *Fair Shares For All: Report of the National Review of Resource Allocation for the NHS in Scotland*, Scottish Executive, 1999. The Arbuthnott formula is used to set the overall level of funding received by boards to provide health services. The formula takes into account differences between areas in demography, the health of the population, deprivation and the additional cost of providing services in rural areas.

74 *Targeted investment to reduce longest waits in the NHS*, Scottish Executive, 17/06/2005. Announced nearly £20 million of new funding to reduce waiting times with nearly half allocated for use in the private sector.

75 *Reference Costs 2004*, Department of Health, 2005. These provide costs for NHS and non-NHS providers.

Exhibit 13

National Waiting Times Unit inpatient and day case spending by specialty, 2002/03 to 2004/05

NWTU spent £45.7 million on tackling inpatient and day-case waiting times with nearly half spent in orthopaedics.

Inpatients and day cases	2002/03 (£m)	2003/04 (£m)	2004/05 (£m)	Total (£m)
Orthopaedics	6.25	8.76	6.13	21.15
General Surgery	1.95	1.88	2.52	6.35
Ophthalmology	0	1.60	1.38	2.98
Urology	0.37	0.72	1.15	2.24
Plastic Surgery	0.66	0.10	0.71	1.47
ENT	0.28	0.04	0.53	0.86
Other	0.86	4.53	5.29	10.68
Total	10.37	17.63	17.71	45.72

Note: Orthopaedics in 2003/04 includes £2.63 million funding from the SEHD, which met just over half the cost of an initiative to carry out hip and knee operations in the private sector.

Source: Audit Scotland analysis of information supplied by NWTU

average cost per case of £8,750. Average costs per procedure at the GJNH are not available. But the average cost per case for orthopaedics is £9,692 (Exhibit 18, page 30).

91. We understand that more recently the NWTU has been negotiating lower charges with private sector providers for joint replacement surgery, the highest volume procedures funded in the private sector by the NWTU. Currently no up-to-date published information is available that would allow us to compare Scottish NHS and non-NHS prices with healthcare providers elsewhere in the UK. But the publication of the Scottish NHS tariffs and English reference costs for 2005/06 will enable us to examine relative healthcare costs.

NWTU spending is targeted on specialties with long waits

92. The NWTU spent a total of £56.8 million in the three years to 31 March 2005 on tackling

waiting times.⁷⁶ Annual spending has increased from £12.7 million in 2002/03 to £23.9 million in 2004/05.

93. Exhibit 13 shows that the NWTU spent £45.7 million on tackling waiting times for inpatients and day cases between 2002/03 and 2004/05. Most of this money has been targeted on six specialties – orthopaedics, general surgery, ophthalmology, urology, plastic surgery and ENT. These specialties had the most patients with a waiting time guarantee waiting over six months in 2002/03.

94. Changes in the number of patients waiting with and without waiting time guarantees are presented in Exhibit 14. There have been substantial reductions in the number of patients with a guarantee waiting over six months in these specialties. But some of these specialties also experienced large increases in the numbers of inpatients and day cases without a guarantee waiting longer than six months.

95. The NWTU spent around £7.9 million on tackling outpatient waiting times between 2002/03 and 2004/05. Annual spending increased from £1.5 million (12% of NWTU expenditure) in 2002/03 to £5.1 million in 2004/05 (34% of NWTU expenditure). Spending was highest in the specialties with the most patients waiting over six months (Exhibit 15).

The CCI emphasises service redesign

96. In October 2003, the CCI established the Outpatient Programme to help boards reduce outpatient waiting times. The programme supports three types of project:

- **Demand management projects**, such as the Patient Pathways projects, that look at how referrals are managed and develop community-based alternatives to consultant-led outpatient services.

⁷⁶ This sum includes the running costs of the NWTU.

Exhibit 14

Changes in inpatients and day cases waiting over six months in the specialties receiving most funding from the National Waiting Times Unit

NWTU inpatient and day case spending has been effective in reducing waiting times for patients with guarantees, but many patients without guarantees continue to wait a long time.

Inpatients and day cases	Patients with guarantee waiting over six months				Patients without a guarantee waiting over six months			
	30 June 2003	31 March 2005	30 Sept 2005	Change	30 June 2003	31 March 2005	30 Sept 2005	Change
Orthopaedics	2,669	963	646	-76%	5,070	6,250	6,140	23%
General Surgery	2,970	169	127	-96%	5,518	6,023	5,926	7%
Ophthalmology	868	95	107	-88%	1,039	1,867	1,753	69%
Urology	1,061	9	65	-94%	1,379	2,253	2,322	68%
Plastic Surgery	434	17	55	-87%	3,184	2,557	2,377	-25%
ENT	740	0	164	-78%	1,457	1,175	1,326	-9%
Other	1,232	347	85	-93%	2,675	4,290	3,724	39%
Total	9,974	1,600	1,249	-84%	20,322	24,415	23,568	16%

Note: Data are presented from June 2003 because this is when ASCs were introduced.

Source: Inpatient and day case waiting list census, unpublished information supplied by ISD

Exhibit 15

National Waiting Times Unit spend on outpatient waiting times, 2002/03 to 2004/05

NWTU outpatient spending has been highest in specialties with the most patients waiting over six months.

Specialty	2002/03 (£m)	2003/04 (£m)	2004/05 (£m)	Total (£m)
Orthopaedics	0.28	0.15	0.93	1.36
Ophthalmology	0.20	0.08	0.60	0.89
General Surgery	0	0.03	0.78	0.81
ENT	0.10	0.12	0.46	0.69
Dermatology	0.15	0.04	0.39	0.58
Plastic Surgery	0	0.04	0.37	0.40
Other	0.75	0.75	1.62	3.12
Total	1.49	1.22	5.14	7.85

Source: Audit Scotland analysis of information supplied by NWTU

- **Capacity management projects** in specialties with persistently long waiting times for new outpatients as demonstrated by the numbers or proportions of patients waiting over six months.
- **'Queue' management projects** using patient-focused booking to change the way in which the waiting list is managed.^{77 78}

97. NHS boards bid for both revenue and capital funding from the CCI. Bids for revenue funds need to have clear plans for managing the changes proposed. The CCI measures progress against plans by using a range of quantitative indicators such as changes in the numbers of patients waiting over six months; reductions in the number of patients who do not attend their outpatient appointment; and numbers of patients seen by practitioners other than a consultant. Progress is also measured using qualitative indicators such as the changes in the way clinic appointments are booked. The CCI allocates revenue funding on a non-recurring basis for 18 or 24 months.

98. The funding is used to give staff, including clinical staff, time away from their normal duties to develop and manage service redesign projects. The projects have helped to get clinicians involved in change programmes. The funding also helps people leading redesign projects or managing outpatient services to develop the skills needed to manage projects and to understand and plan capacity and demand.

99. The CCI allocates capital funding on the same basis as revenue funding. This money is used to fund facilities or equipment where bids

have clearly demonstrated the need for additional capital investment to support the redesign process.

100. Exhibit 16 shows the specialties included in the Outpatient Programme and the related funding. The CCI has spent £17.7 million on this programme between 2003/04 and 2005/06. Annual spending on the programme has increased from £590,000 in 2003/04, to £7.4 million in 2004/05 and a planned £9.7 million in 2005/06. Figures for 2005/06 have been included because the programme has extended into the current financial year.

101. The CCI has spent nearly half of this – £8.2 million – on revenue funding, and just over half – £9.5 million – on capital spending, for example, on diagnostic equipment or creating additional outpatient clinic facilities. The CCI's budget was higher than this but just over 30% (£5.5 million) of the capital expenditure budget was not allocated, mainly because NHS boards were not in a position to meet the future running costs of new assets and because some projects did not require capital expenditure. The CCI also rejected a number of bids because they did not meet the criteria for capital funding or because they impacted on 2007 targets, which are outside the scope of the Outpatient Programme, which ends in March 2006.

102. The Outpatient Programme is not the only CCI programme that affects waiting times. For example, the Unscheduled Care Programme has the potential to reduce waiting times by managing emergency demand in a way that does not affect planned admissions.

103. The specialties receiving the most outpatient funding from the NWTU and CCI combined were orthopaedics, dermatology, ENT, neurology and plastic surgery. Changes in outpatient waiting times in these specialties are set out in Exhibit 17. In all of these specialties, the number of patients with a guarantee waiting over six months fell between September 2004 and September 2005, although the size of the reduction differed among specialties. The overall total for all specialties also fell.

Early signs are promising but it is too early to assess the full impact of the CCI's approach

104. It is too early to say whether the CCI approach will help to deliver sustainable reductions in waiting times. Many of the projects are not complete because they are medium to long term, so information is not yet available on the effect they have had. However, the CCI along with the NWTU are having some success as shown by reductions in the number of outpatients waiting over six months in targeted specialties.

105. The principles underlying the CCI approach – the emphasis on redesign and project management, the dissemination of experience gained from developing redesign projects, and the monitoring of the effect of projects – are the right ones. The specialties covered by the programme were chosen because they had persistently long outpatient waiting times. However, boards have long outpatient waiting times in specialties not covered by the programme. It is important that these principles are applied more widely and that the NHS in Scotland as a whole learns from experience of redesign projects. The SEHD should work with boards to ensure this happens.

77 *Improving Outpatient Waiting Times*, Scottish Executive, 2004.

78 *Modernising Scotland's Outpatient Services*, Scottish Executive, 2004.

Exhibit 16

Outpatient Programme spend by the CCI 2003/04 to 2005/06

The CCI has provided both revenue and capital funding to help reduce outpatient waits.

	2003/04 (£m)		2004/05 (£m)		2005/06 (£m) (planned)		Total (£m)	
	Revenue	Capital	Revenue	Capital	Revenue	Capital	Revenue	Capital
Dermatology	0	0	0.50	0.97	0.50	1.54	1.00	2.51
Plastic surgery	0	0	0.30	0	0.15	0.12	0.45	0.12
Neurology	0	0	0.11	0	0.23	1.64	0.34	1.64
Orthopaedics	0	0	0.75	1.28	0.95	0.86	1.71	2.14
ENT	0	0	0.48	1.23	0.42	0.96	0.90	2.20
Patient-Focused Booking	0.59	0	1.33	0	0.17	0	2.09	0
Referral Information Systems	0	0	0.13	0	0.25	0.04	0.37	0.04
Community Outpatient Services	0	0	0.25	0	0.95	0.85	1.20	0.85
Other	0	0	0.08	0	0.07	0	0.15	0
Totals	0.59	0	3.93	3.49	3.70	6.01	8.22	9.49

Note: Patient-focused booking is being applied to all specialties where waiting times for a first appointment exceed six weeks.

Source: Audit Scotland analysis of information from CCI

Exhibit 17

Changes in new outpatients waiting by specialty, September 2004 to September 2005

The impact of outpatient waiting time spending differs among specialties.

	Patients with waiting time guarantee waiting over six months		Patients with waiting time guarantee waiting over six months		Percentage change in number of patients with guarantee waiting over six months
	30 September 2004		30 September 2005		
	Number	Percentage of all patients waiting in specialty	Number	Percentage of all patients waiting in specialty	
Orthopaedics	13,906	29%	3,183	10%	-77%
Dermatology	3,462	15%	356	2%	-90%
ENT	7,449	27%	1,683	8%	-77%
Neurology	1,841	31%	986	18%	-46%
Plastic Surgery	4,363	35%	1,386	17%	-68%
Other	15,954	12%	4,260	4%	-73%
Outpatients Total	53,579	20%	11,854	6%	-75%

Note: The total for 30 September 2004 includes 6,604 patients where the information available did not specify which specialty was involved.

Source: Audit Scotland analysis of unpublished outpatient waiting list census information supplied by ISD

Recommendations

The SEHD should:

- review the balance of funding between the longer-term development of whole system approaches and system redesign and shorter-term approaches to meet current targets
- continue to develop measures of waiting time performance for the whole patient journey
- develop incentives for hospitals and primary care to adopt collaborative approaches to reduce waiting times
- extend the criteria used to assess waiting times funding to include an assessment of whether and how money will be used to achieve sustainable long-term reductions in waiting times
- provide support for boards in coordinating waiting time strategies with regional capacity planning and workforce planning
- review the information available, and the methods used, to plan capacity and demand.

The Golden Jubilee could make a bigger contribution to reducing waiting times

106. The GJNH provides healthcare to patients from all over Scotland as part of a national approach to reduce waiting times. Most of its work is inpatient and day case treatment and diagnostic work, although it also carries out minor surgical procedures

on an outpatient basis. The hospital receives no emergency admissions. This avoids the problems experienced by some boards where emergency admissions affect the planning of routine admissions.

107. Since the GJNH was established as a national waiting times centre in June 2002, its total operating cost has increased to £45.6 million in 2004/05. Most of its funding, nearly 70% in 2004/05, came from the SEHD. All funding for the treatment of NHS patients was covered by the SEHD in 2002/03. Since then NHS boards have paid the GJNH the marginal cost of treating patients.⁷⁹ Income from NHS boards generated £4.5 million in 2003/04 and £7.7 million in 2004/05.

Planning activity at the Golden Jubilee is complex

108. The capacity available at the GJNH is allocated to NHS boards following discussion among the NWTU, boards and the GJNH. Each year, the GJNH informs the NWTU of its available capacity. The NWTU then allocates this to boards, taking account of the number of patients whose waiting times are about to exceed interim targets. The GJNH confirms activity with each board on a quarterly basis.

109. The GJNH does not yet make full use of its potential capacity. One of the floors remains unused but this will be occupied by the new regional cardiothoracic centre.

110. When allocating activity, the NWTU takes into consideration the demand from boards and the available capacity at the GJNH that is staffed and ready to be used. In 2004/05, 98% of the GJNH's

available treatment capacity and 94% of its available imaging capacity were allocated to boards in the annual planning process. A lower figure of 72% of available capacity for cardiac surgery was allocated to boards, consistent with the recommendations of a national review of coronary heart disease services. The review estimated the number of cardiac surgery procedures to be carried out at the GJNH.⁸¹

Activity has increased but there is scope to improve value for money

The Golden Jubilee has met overall activity targets but its use by NHS boards and by specialty varies **111.** Since it opened, the GJNH has increased its activity and met its overall targets each year. In 2004/05, the hospital treated 18,509 cases, slightly more than its target of 18,362.⁸⁰ The target for 2005/06 is 26,000.

112. Not all boards make full use of their allocated activity. This means that the activity carried out by the GJNH is less than allocated activity and available capacity for some specialties (see Exhibit 18). For example:

- 10% more cardiac surgery procedures were carried out than had been allocated, but this represented 21% less than available capacity
- 16% fewer interventional cardiology procedures than allocated were carried out, 16% less than available capacity
- 9% fewer orthopaedic joint procedures than allocated were carried out, 13% less than available capacity.⁸² The appointment of two additional

⁷⁹ Marginal cost includes the direct cost of supplies but excludes clinical staff costs.

⁸⁰ *Golden Jubilee National Hospital Annual Review 2004-2005*, Scottish Executive, 2005.

⁸¹ *Capacity Review for Coronary Heart Disease Services – Angiography and Cardiac Revascularisation: Final Report*, April 2004.

⁸² *Golden Jubilee National Hospital Annual Review 2004-2005*, Scottish Executive, 2005 and letter from NWTU to Minister for Health and Community Care, May 2004.

Exhibit 18

Available capacity, allocated activity and actual activity at the Golden Jubilee National Hospital, 2004/05

Performance in relation to available capacity and allocated activity varies by specialty.

Specialty	Available capacity (cases)	Activity allocated by NWTU (cases)	Actual activity (cases)	Actual activity as a percentage of available capacity	Actual activity as a percentage of allocated activity
Cardiac surgery	500	360	397	79%	110%
Interventional cardiology	400	400	336	84%	84%
Orthopaedic joint procedures	1,200	1,152	1,045	87%	91%
Ophthalmology	1,152	1,152	1,386	120%	120%

Sources: Letter from NWTU to Minister for Health and Community Care, May 2004. National Waiting Times Centre Board Annual Review, June 2005

orthopaedic consultants has helped to achieve targets in 2005/06 to date.

113. The GJNH exceeded other activity targets. For example, it carried out 20% more ophthalmology procedures than expected, and over 600 minor surgical cases were treated on an outpatient basis. These figures demonstrate that the GJNH has been flexible in responding to changes in demand for its services but there are areas where the match between capacity and demand needs to be reviewed.

114. The average cost per case at the GJNH has fallen over time due to the increase in its activity and changes in the types of patients treated. Three areas that have increased as a proportion of total caseload – general surgery, minor outpatient procedures and imaging procedures – have a relatively low cost per case compared to other procedures carried out at the GJNH.

But the average cost per case remains high.⁸³

115. Exhibit 19 (overleaf) shows costs per case for each of the main inpatient and day case specialties at the GJNH. The table includes medical staff costs, operating theatre costs and overhead costs.

116. Costs need to be interpreted carefully. An important factor affecting costs is the complexity of cases treated. For example, in orthopaedics, the absence of emergency surgery means that workload at the GJNH comprises a high proportion of joint replacement surgery which is relatively expensive because of the high costs of the prostheses used to replace the joint. Length of stay is sometimes used as an indicator of case complexity and stays are typically shorter at the GJNH than in Scotland as a whole. However, length of stay information is not directly comparable because before and after treatment, patients are sometimes

accommodated in the Beardmore Hotel at the GJNH, which is not included in length of stay data.

117. Differences in costs are sometimes attributed to the way costs are allocated by boards and hospitals. However, the consistently high costs across specialties and types of cost suggests that this is not the cause of the relatively high costs at the GJNH. High medical costs may reflect the way doctors are paid at the GJNH (see paragraph 120). High theatre costs suggest that theatre capacity needs to be used more effectively. Available data suggest that theatre usage hours per theatre per week fell 7% at the GJNH in 2004/05 while they rose by 8% in Scotland as a whole.⁸⁴ Hours per theatre per week at GJNH (24 hours) are below the Scottish average of 27 hours and many hospitals achieve substantially higher levels of use. Average monthly theatre use at the GJNH varied between 71% and 88%.⁸⁵ High overhead costs

⁸³ Scottish Health Service Costs 2004-05, Scottish Executive, 2005.

⁸⁴ Scottish Health Service Costs 2004/05, Scottish Executive, 2005.

⁸⁵ GJNH opened an additional theatre in 2004/05 increasing the theatres it has from five to six.

Exhibit 19

Cost per case and length of stay at the Golden Jubilee National Hospital compared to Scotland as a whole, 2004/05

The GJNH has high cost per case compared to hospitals in the rest of Scotland.

Inpatients		Length of stay (days)	Cost per case (£)				Percentage difference between GJNH and Scotland
			Medical staff costs	Theatre costs	Overhead costs	Total gross cost	
Cardiac Surgery	GJNH	5.9	2,241	4,004	7,257	15,574	50%
	Scotland	8.3	1,163	2,921	2,253	10,364	
Cardiology	GJNH	1.0	926	N/A	1,756	4,976	78%
	Scotland	4.4	422	198	733	2,795	
ENT	GJNH	1.0	399	778	1,059	2,631	57%
	Scotland	2.1	334	360	455	1,675	
General Surgery	GJNH	1.2	416	806	1,199	2,888	30%
	Scotland	4.4	360	383	623	2,217	
Orthopaedics	GJNH	6.7	819	2,796	4,515	9,692	180%
	Scotland	6.5	437	912	946	3,467	
Plastic Surgery	GJNH	1.4	550	1,149	1,502	3,540	36%
	Scotland	3.2	241	776	732	2,611	
Day Cases							
Ophthalmology	GJNH	N/A	396	278	514	1,305	68%
	Scotland		152	247	195	779	
General Surgery	GJNH	N/A	188	201	526	1,055	72%
	Scotland		114	185	171	613	

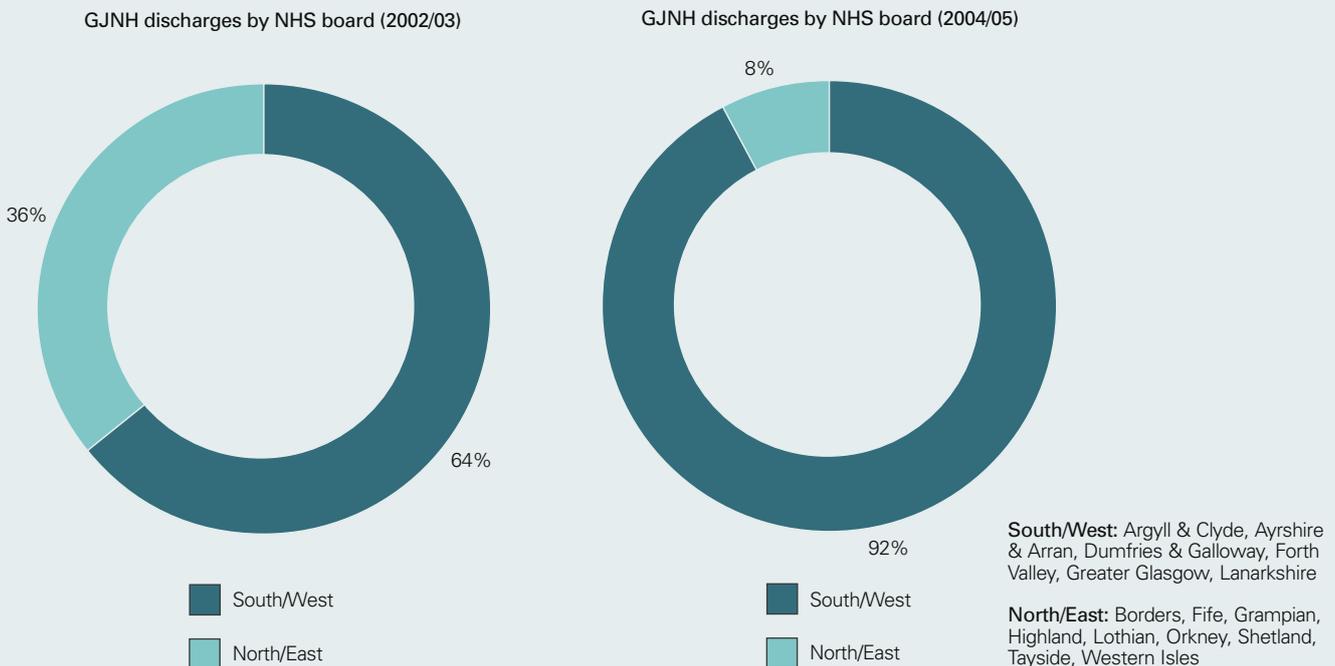
Note: In orthopaedics, the GJNH carries out a high percentage of expensive joint replacement operations relative to other hospitals.

Source: Scottish Health Service Costs 2004-05, Scottish Executive, 2005

Exhibit 20

Golden Jubilee National Hospital discharges

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



Source: ISD

can be partly explained by capital charges. Although the reasons for cost differences are complex, the differences show the need to make fuller use of capacity and review the mix of activity at the GJNH.

Boards and the Golden Jubilee need to work together to improve the management of referrals

118. The GJNH makes a valuable contribution to tackling waiting times in those boards that make substantial use of it. But several NHS boards have decreased the number of inpatients and day cases treated at the GJNH over the past three years, and boards in the south and west of Scotland make up a higher percentage of all patients treated at the GJNH (Exhibit 20).

119. Boards do not always take up their activity allocations at the GJNH. Some consultants are unwilling to refer patients to the GJNH, preferring to treat patients locally to meet waiting times targets. Boards also wish to maintain local services,

which might otherwise be at risk because of the need to retain a level of expertise – for example, cardiac surgery.⁸⁶ In addition, the processes for referring and assessing patients are time-consuming. Current referral arrangements mean that the GJNH receives patient information from other boards three weeks prior to the treatment being carried out. The GJNH has high numbers of late cancellations. The reasons for this include cancellations by patients, by referring hospitals and because patients are assessed as not being fit for surgery by GJNH staff. Boards that have effective referral procedures can take up unused allocations of activity (Case Study 5), but current referral arrangements mean that the GJNH faces difficulties in filling unused capacity at short notice. It needs to have staff in place in theatres and on wards to treat planned activity, so when boards are unable to refer their allocated activity to the GJNH, cost per case increases.

120. The GJNH continues to face difficulties in planning activity in 2005/06 due to a number of factors, including the availability of consultants, late cancellations and referral of patients who are assessed as unfit for surgery.⁸⁷

The Golden Jubilee's activity needs to be more evenly planned through the year

121. The GJNH has higher activity towards the end of the financial year. In 2004/05, nearly a third of treatments and 40% of imaging procedures were carried out in the final quarter of the year. In March 2005, 44% more treatments and 65% more imaging procedures were carried out than had been budgeted for at the start of the year.⁸⁸ Theatre use was also lower at the start of the year. This pattern of activity makes it difficult to plan effectively.

⁸⁶ *Golden Jubilee National Hospital Annual Review*, National Waiting Times Centre NHS Board, 2005.

⁸⁷ *Business Update Quarter 1 2005*, Paper presented to National Waiting Times Centre Board, July 2005.

⁸⁸ In February 2005, boards were encouraged by the SEHD to build additional diagnostic activity into their plans because new imaging equipment was put in place and the diagnostic waiting times targets were about to be announced. This may have increased activity at the year end.

Case Study 5

NHS Forth Valley has an effective process for sending patients approaching waiting times targets to the GJNH

To support the drive to reduce waiting times, NHS Forth Valley has established a waiting times unit. The unit advises consultants about which patients are approaching target waiting times. Consultants advise if they have capacity to treat the patients. If capacity is not available in Forth Valley, the Waiting Times Coordinator from the unit identifies capacity at the GJNH and discusses with the patient's consultant whether they are suitable for referral to the hospital. The Waiting List Team (WLT) gathers the patient's personal and medical details and contacts them by telephone to offer treatment at the GJNH or in the private sector. This is typically carried out a month in advance of the proposed treatment date. The patient is reminded of the implications of declining the offer for their waiting time guarantee, which is also explained in the initial correspondence informing the patient they have been put on the waiting list.

If the patient accepts, the WLT arranges a pre-operative assessment with a Clinical Support Nurse, who informs the WLT whether the patient is still suitable for surgery. The WLT then sends notes and X-rays to the GJNH, emails a completed patient list to the relevant specialty coordinator at the GJNH and checks the following day, after surgery, that patients have been treated so that they can be removed from the waiting list.

Patients often have pre-operative assessments well in advance of their date for surgery creating a group of patients who are ready to be treated. This enables Forth Valley to bring forward the treatment date at short notice, with patients' agreement, if they are allocated any extra theatre lists.

Factors critical to the success of the process are:

- good information
- early identification of each month's patients to assess the capacity required, identify where targets may be breached and make offers of treatment
- close working with consultants to manage their lists and agree which patients are suitable for referral to the GJNH
- staff trained in agreed processes with clear roles and responsibilities
- good communication throughout the patient journey between the patient and a named contact in the WLT
- good working relationships with specialty coordinators at the GJNH
- good working relationships among departments in Forth Valley to ensure a streamlined service for patients transferring to other hospitals.

The Golden Jubilee needs to change the way it employs medical staff

122. The GJNH currently employs three orthopaedic surgeons and six anaesthetists on standard NHS contracts. Most of the clinical input is by consultants who are employed by NHS boards and carry out additional sessions at the GJNH. Consultants are paid at different rates, more are now paid on the new consultant contract but most are still paid on a fee-per-procedure basis at discounted private sector rates.

123. The GJNH faces problems in recruiting consultants. This is partly due to shortages in some specialties, such as orthopaedics, across Scotland as a whole. But uncertainty over activity levels at the GJNH and the spread of work across many specialties may be unattractive to potential employees.

The role of the Golden Jubilee needs to be reviewed to increase value for money and the contribution it makes to reducing waiting times

124. Overall, value for money at the GJNH and its effectiveness in helping to reduce waiting times would improve if it made fuller use of its potential capacity and recruited more staff on permanent NHS contracts. This is dependent on increasing activity levels and ensuring that it is more evenly spread throughout the year.

125. The GJNH and SEHD are currently reviewing the role of the GJNH. Part of this review includes looking at the potential for the GJNH to concentrate on a limited number of specialties in which it could treat higher numbers of patients. The GJNH has already been involved in regional planning for cardiothoracic services for the west of Scotland, and a number of existing theatres and wards, which are not used at the

moment, are earmarked for transfer to the cardiothoracic service. This will help make fuller use of capacity.

Recommendations

The GJNH should:

- recruit more staff on permanent standard NHS contracts
- work with boards to improve day-to-day liaison and referral arrangements
- work with the SEHD in considering the potential to develop the work of the hospital as a specialist elective treatment centre working across a specified range of specialties
- explore with the SEHD alternative arrangements for agreeing activity with NHS boards.

Patients should be more involved in decisions about where they are treated

126. Involving patients in the decision about where they are treated could help improve waiting times and encourage greater use of the GJNH. [Exhibit 20 \(page 33\)](#) shows that NHS boards in the south and west of Scotland refer more patients to the GJNH than boards in the north and east. Some boards told us that patients are unwilling to travel to the GJNH and that it is difficult to persuade people to go. But not all boards are actively encouraging the use of the GJNH or offering it to patients as an alternative.

127. Our patient survey asked patients about their willingness to travel to alternative hospitals offering

quicker treatment. Very few patients (5%) were offered treatment in alternative hospitals but a majority said they would accept an offer of treatment elsewhere. Two-thirds of patients currently waiting for a new outpatient consultation or inpatient treatment would travel for treatment if it reduced the time they had to wait. Around half of patients seen or treated in the previous 12 months said they would have accepted such an offer.

128. Patients report a willingness to travel long distances to receive treatment. Around a third of inpatients and a quarter of outpatients said they would be willing to travel more than 100 miles for treatment if it meant being treated more quickly. Nearly a half of inpatients and outpatients would be willing to travel over 50 miles.

129. Patients indicated that length of wait is the most important factor for them when considering where and when they receive treatment, followed by the distance from their home to the place of treatment. The expertise of the surgeon and the reputation of the consultants were also important.

130. Nearly half of all patients surveyed felt that they were “not really involved at all” in the decision about their treatment. Less than a quarter felt they had been involved “a great deal”.

Recommendation

NHS boards should ensure that patients are involved in decisions about where they are treated.

Part 4. Recommendations



Scottish Executive Health Department

The SEHD should:

- review the balance of funding between the longer-term development of whole systems approaches and system redesign and shorter-term approaches to meet current targets
- continue to develop measures of waiting time performance for the whole patient journey
- develop incentives for hospitals and primary care to adopt collaborative approaches to reduce waiting times
- extend the criteria used to assess waiting times funding to include an assessment of whether and how money will be used to achieve sustainable long-term reductions in waiting times
- provide support for boards in co-ordinating waiting times strategy with other national issues such

as regional capacity planning and workforce planning

- review the information available, and the methods used, to plan capacity and demand.

NHS boards

In their planning for the abolition of ASCs, NHS boards should:

- review the status of patients with an ASC to identify if they still require treatment or if their circumstances have changed
- develop strategies for seeing or treating patients with an ASC before these codes are abolished at the end of 2007
- put in place processes for administering and monitoring the new rules for defining and measuring periods of unavailability for treatment to ensure that they are used appropriately and consistently

- review their DNA and CNA rates before the new rules are introduced and identify where systems could be improved to reduce them

- work with the SEHD to develop long-term capacity planning.

In addition, boards should:

- work with the SEHD to develop long-term capacity planning
- work towards reducing the need for short term increases in activity by:
 - sharing examples of good practice, showing effective ways of redesigning services
 - improving service efficiency through measures such as increasing the number of patients treated as day cases; reviewing outpatient activity to increase the ratio of new to return outpatient appointments; and pooling referrals and management of theatre lists

- work with primary care practitioners to further develop referral guidelines and protocols
- develop ways of ensuring that emergency demand does not affect planned admissions
- ensure that patients are involved in decisions about where they are treated.

Golden Jubilee

The GJNH should:

- recruit more staff on permanent standard NHS contracts
- work with boards to improve day-to-day liaison and referral arrangements
- work with the SEHD in considering the potential to develop the work of the GJNH as a specialist elective treatment centre working across a specified range of specialties
- explore with the SEHD alternative arrangements for agreeing activity with NHS boards.

Information Services Division

In consultation with SEHD and NHS boards, ISD should consider:

- extending the data and measures of waiting times that it publishes. For example, as well as median waits, it could produce interquartile ranges or other measures which provide a more complete picture of the distribution of waiting times
- increasing the frequency of the inpatient and day case waiting list census from quarterly to monthly.

Appendix 1. Recent history of waiting time targets

Year	Source	Target/Change
2000	<i>Our National Health: A plan for action, a plan for change</i>	<p>No patient should wait longer than:</p> <ul style="list-style-type: none"> • nine months for inpatient (IP) or day case (DC) treatment by the end of 2003 instead of the maximum then of 12 months • 12 weeks for angiography or 24 weeks for revascularisation by the end of 2002 • two months from urgent referral to treatment for all cancers by the end of 2005 • one month from urgent referral to treatment for breast cancer by the end of 2005. <p>Announced that waiting time targets would be reviewed in 2001 and set out explicitly.</p>
February 2002	SEHD press release: <i>Waiting times take over from waiting lists</i>	Announcement that March 2002 targets for waiting lists should be the last. Reaffirmed 2003 waiting time target for IPs and DCs.
June 2002	SEHD press release: <i>New targets for waiting times</i>	By 2005 no patient with guarantee will wait over six months for IP or DC treatment. No patient should wait longer than eight weeks for angiography or 18 weeks for revascularisation by the end of 2004.
November 2002	SEHD press release: <i>NHS urged to focus on longest waiting times</i>	Announced target for outpatients (OP) that, by the end of 2006, no patient should wait over six months for a new appointment.
2002	NHS HDL(2002)70 <i>The Management of Waiting Lists in NHSScotland</i>	Abolition of deferred list following publication of Audit Scotland report <i>Review of the management of waiting lists in Scotland</i> .
2003	<i>Partnership for Care</i>	OP target brought forward to 2005. Guaranteed GP or equivalent access within 48 hours.
2004	<i>Fair to All, Personal to Each</i>	<p>No patient should wait longer than:</p> <ul style="list-style-type: none"> • 18 weeks for IP or DC treatment or for a first OP attendance by the end of 2007 • 16 weeks combined target for cardiac surgery, including angiography and, if required, revascularisation • 18 weeks from referral to treatment for cataract surgery by the end of 2007 • 24 hours from admittance to a specialist orthopaedic unit for an operation for hip fracture by the end of 2007 • four hours between arriving at an A&E unit and admission, discharge or transfer from the end of 2007.
2005	SEHD press release: <i>New standards and investment to cut waiting times in NHS</i>	Existing 18-week IP, DC and OP targets to include diagnostic testing. Nine-week waiting time target for eight diagnostic procedures including MRI and CT scans.

Appendix 2. Project Advisory Group members

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