

# MANAGING WAITING TIMES

## A GOOD PRACTICE GUIDE



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National Waiting Times Unit  
NHSScotland

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# FOREWORD

Improving waiting times is a key priority for the NHS in Scotland. Patients expect to wait less for treatment and reasonable waiting times are indicative of a well-managed and efficient health service. This guidance supports the recommendations of the Audit Scotland report, **“Review of the Management of Waiting Lists in Scotland”** and builds on the commitments in the White Paper **“Partnership for Care”**. The approach outlined is about achieving sustainable reductions in waiting times and planning services through a “whole systems approach” from initial contact in primary care through to discharge from hospital.

**“Partnership for Care”** signalled a step change in the way in which we collect and record information for our outpatient services. Collecting information about outpatient referrals and recording and understanding how our outpatient waiting lists perform is vital to the delivery of services. With good information, communication with the patient, the GP and hospital practitioners can be improved. Good information also enables NHS Boards to act quickly where there are service deficiencies, and to plan and deliver services which meet national and local targets.

I believe that every patient has the right to expect treatment within a reasonable period of time. Delivering an improvement in waiting times and meeting our national standards is a key responsibility for all those involved in the care of patients. Improving waiting times is therefore about partnership between different parts of the health service, and particularly about partnership between primary and secondary care.

This Good Practice Guide provides a summary of accepted good practice in the management of waiting times. The approach is straightforward and emphasises the active management of waiting times in a structured and methodical way. This guidance is designed to support the outpatient action plan and the change and innovation programme in general.

I commend it to the service.



**Trevor Jones**

Chief Executive of the Health Service in Scotland

# MANAGING WAITING TIMES

## HEALTH IN SCOTLAND TODAY

### 1.1 WHY WAITING TIMES ARE IMPORTANT

Waiting times are important to patients because:

- The patient's condition may deteriorate while waiting and in some cases the effectiveness of the proposed treatment may be reduced.
- The very experience of waiting can be extremely distressing in itself.
- The patient's family life may be adversely affected by waiting.
- The patient's employment circumstances may be adversely affected by waiting.
- Excessive waiting times may be symptoms of inefficiencies in the healthcare system and should be addressed as part of good management.

A comparatively short period of waiting which is managed in the patient's best interests may support the appropriate scheduling of routine and emergency care and ensure the most urgent patients are seen first. Excessive waiting times, however, must be reduced. The Health White Paper, "Partnership for Care", holds NHS Boards accountable for a three-tier approach to improving waiting times by:

1. Ensuring that national targets will be met.
2. Ensuring that condition specific targets set by NHS Quality Improvement Scotland are delivered.
3. Requiring NHS Boards to set challenging local targets which reach and then exceed national targets.

The national waiting time standards which all NHS Boards must achieve as a minimum are outlined in Appendix A of this guide.

## 1.2 THE REASONS FOR UNACCEPTABLE WAITING TIMES

There are a number of reasons why waiting times may become unacceptable:

1. There may be insufficient provision of services to meet demand.
2. There may be poor management of additions to the waiting list. This may result in patients being added to the waiting list before they are ready for treatment or added for treatments that later prove to be inappropriate.
3. There may be poor management of admissions from the waiting list. This may result in patients waiting longer than necessary as patients are admitted in any order, without adequate consideration of each individual patient's waiting time or clinical urgency.
4. There may be poor administration of the waiting list and poor communication with patients. This may result in waiting list information being out of date and patients not being properly informed of admission dates.

The patient also has important responsibilities in supporting the efficient use of healthcare resources and shortening waiting times by:

- providing accurate information to healthcare professionals;
- updating general practice and hospital services of any changes in circumstances, and in particular changes in contact details;
- attending appointments as arranged and avoiding cancelling appointments at short notice.

## 1.3 IMPROVING WAITING TIMES

To be effective, plans to improve waiting times should take account of the entire waiting time journey, commencing with the initial outpatient referral and working through assessment and diagnostic tests to treatment and discharge from hospital.

**To effectively develop plans to improve waiting times, each health system should:**

- **Manage Demand** – ensuring each referral represents the most appropriate decision for the care of the individual patient.
- **Manage the Queue** – ensuring waiting lists are well managed and patients are called for treatment in appropriate order.
- **Manage Capacity** – providing efficient and effective services that meet the level of demand from appropriate referrals.
- **Provide Leadership** – ensuring that all parts of the local NHS work together to achieve waiting time improvements in the best interests of patients.

### Management of Demand

A patient's waiting time normally commences within primary care. There should be a close partnership between primary and secondary care in managing and delivering improved waiting times. This should include shared information on waiting times and agreement on local waiting time standards to be set.

Referral protocols should be utilised as appropriate to identify the most effective referral options for patients and the most effective use of both primary and secondary care resources.

The number of referrals received from primary care is the initial indication of demand for services within secondary care. The referral process should be actively managed and the number of referrals received should form a basis for calculating the level of services to be provided.

### Management of the Queue

- A waiting list is simply a queue of patients waiting for treatment. Every patient waiting in this queue has a valid expectation of treatment within a reasonable period of time. Waiting lists should be regularly reviewed to ensure they are accurate and it should be possible at any time to access up-to-date information on any individual patient on the list.
- Patients should be called from a waiting list in order of clinical priority and within agreed waiting time standards. Patients with similar clinical priority should be admitted predominately in the order of the longest waiting patients first.

### Management of Capacity

- Waiting time standards should be delivered on the basis of a clear capacity plan. Referrals indicate the level of demand and the waiting list shows clearly how many patients are waiting and how long they are waiting. It should therefore be possible at any time to assess the level of capacity required to maintain a waiting

time standard. Clinical activity plans should be set to take account of the assessed capacity required to maintain acceptable waiting times.

- Potential pressures on waiting time standards should be identified at an early stage, for instance an increase in the number of outpatient referrals, additions to the waiting list, emergency admissions or reduced capacity. Regular and effective performance review will identify requirements for management action which should be taken to ensure waiting time standards are maintained.
- The number of patients treated is related to the efficiency of services. The effective utilisation of resources, for instance beds or theatre time, should be ensured through regular management against agreed efficiency targets.

### Leadership

- There should be clear leadership and accountability within NHS Boards for the delivery of improved waiting times. It is recommended that a Board director leads a multi-disciplinary team drawn broadly from the local health care system, to provide leadership and direction in the reduction of waiting times.
- Each NHS Board should have a detailed and comprehensive plan setting out the manner by which waiting time standards will be achieved and maintained. This plan should address the requirements of all patient groups who wait for treatment and address services from primary care through assessment and investigation to discharge from the treatment process.

- Waiting Time improvement should not be seen as the responsibility of a narrow group of “experts” within a health care system. All of those involved in the care of patients who wait for treatment have a responsibility to ensure that patients are well informed, supported and wait as short a time as possible.
- It is important to build a positive culture around the improvement of waiting times. Local standards should be set following discussion with clinicians, patient representatives and the general public. The benefits of improving waiting times should be understood by all, including the benefits to patients and to the efficiency of the NHS. No interested groups should be excluded from the process of improving waiting times.

## 1.4 WAITING LIST INITIATIVES

### **Increasing clinical activity to improve waiting times**

Additional activity to improve waiting times may be provided for two purposes:

1. The short-term requirement to treat a “backlog” of patients on a waiting list and achieve an improved waiting time.
2. The long-term requirement to close any on-going gap between the number of patients joining a waiting list and the number of patients leaving a waiting list.

### **Treating a backlog of patients from the waiting list**

A “backlog” of patients to be seen from an outpatient or inpatient waiting list may take two forms:

1. The number of patients waiting longer than the waiting time standard which is to come into force.
2. The extent to which the current waiting list is too large to allow the maintenance of the waiting time standard. Whilst a waiting list size is not an objective in itself, a specific maximum waiting time will only be maintained if the waiting list is not over a manageable size.

It may be possible to admit a backlog of patients through improved efficiency and improved queue management. If this is not possible, then a one-off waiting list initiative may be required to see additional patients.

Waiting list initiatives may be used effectively to reduce the number of patients waiting and ensure a waiting time standard is achieved at a point in time. A waiting list initiative, however, will not necessarily ensure a waiting time standard is maintained.

The inappropriate use of waiting list initiatives will undermine the maintenance of waiting time standards. Waiting list initiatives should not be employed in isolation as a short-term means of attempting to solve long-standing problems

resulting from poor demand management, poor waiting list management or insufficient capacity to treat patients.

### **Closing the gap between demand and capacity**

Closing a recurrent gap between demand and capacity requires a different approach from treating a non-recurrent backlog of patients from the waiting list. It is necessary to project the expected recurrent difference between the number of patients joining the waiting list and the number of patients leaving the waiting list. Efficiency measures and additional resources should be agreed as appropriate to bring into balance the number of additions to, and removals from, the waiting list.

It should always be understood that the non-recurrent requirement to treat a backlog of patients on the waiting list is not the same as the recurrent requirement to close any gap between demand and capacity. The first approach may ensure that a waiting time standard is **achieved**, the second approach is designed to ensure that the standard is **maintained**.

## 1.5 THE 10 'GOLDEN RULES' FOR WAITING TIME MANAGEMENT

1. The patients' interests are paramount.
2. Referrals for health care services should be clinically appropriate and directed towards the most suitable service.
3. Adequate services should be available to meet appropriate referrals for assessment and treatment.
4. Patients should be offered care according to clinical priority and within agreed waiting time standards.
5. Patients should be advised of any waiting time standard that applies to their treatment and kept up-to-date on their expected waiting time.
6. Health care services should maintain accurate and complete information on patients waiting for treatment and provide patients with clear guidance to be followed when notifying any changes in contact details or availability for treatment.
7. Patients should be clearly advised of the action that will be taken if they fail to attend for an appointment and failures to attend should be minimised.
8. Improvements in waiting times should be delivered through an effective partnership between Primary and Secondary Care, with appropriate protocols and documentation in place for referral and discharge.
9. The factors which influence waiting times, such as changes in referral patterns, should be regularly monitored and management action taken in sufficient time to ensure waiting time standards are maintained.
10. Leadership and accountability for the improvement of waiting times should be explicit within each NHS Board area and staff should be adequately trained to ensure waiting times are managed and administered effectively.

## 1.6 DEVELOPING LOCAL PLANS TO DELIVER WAITING TIME STANDARDS

The Health White Paper, “Partnership for Care”, requires NHS Boards to have in place local plans to deliver a three-tier approach to improving waiting times by:

1. Ensuring national targets will be met.
2. Ensuring that condition specific targets set by NHS Quality Improvement Scotland are delivered.
3. Setting and delivering challenging local targets which reach and then exceed national targets.

The requirement for each NHS Board to develop and implement local programmes for waiting time reductions has been set out in the 2002/03 and 2003/04 guidance for the completion of Local Health Plans.

NHS Boards are required to:

- Set challenging local targets for their inpatient, day case, and outpatient services. They will demonstrate the progress which each Board is expected to make in reaching and then exceeding our national guarantees.
- NHS Boards should ensure that the whole patient journey is addressed, including waiting times for outpatients, inpatients/day cases and diagnostic tests.
- In setting local waiting times standards and laying the foundation to achieve the National Waiting Time standards, NHS Boards should consider the relevant risks/opportunities within their own local system (e.g. winter pressures, junior doctors, hours of work, service redesign projects and organisational development).
- Waiting time improvement plans should set out clearly any manpower or other resource implications necessary for the successful attainment of national and local standards.
- NHS Boards should consider how they consult with appropriate bodies to ensure that patients’ views are reflected in the selection of local standards.
- NHS Boards and Trusts are encouraged to consider how best to link across existing organisational boundaries both internally and within NHS and externally with other organisations.
- NHS Boards Local Health Plans will be supported by implementation plans for waiting times which are both specific and detailed.

## HOSPITAL SERVICES

### 2.1 MANAGING THE AVAILABILITY OF PATIENTS FOR TREATMENT

- Once a patient has been placed on a waiting list a commitment has been given to provide treatment within a reasonable period of time.
- It is not acceptable to allow patients to remain on a waiting list as an alternative to assessment or treatment.
- It is sometimes the case that a patient is correctly placed on a waiting list but will not be available for treatment for a period of time.

The NHS in Scotland has managed such patients by utilising a deferred waiting list where patients have, at some point in time, been unavailable for treatment, and availability status codes which describe the reasons for a patient's unavailability for treatment.

Availability Status Codes may also be used to describe particular circumstances relating to the patient's treatment, specifically if the procedure the patient is waiting for is judged to be of low clinical priority or to be of a highly specialised nature.

The process of managing patients who are unavailable for treatment is being modernised by NHSScotland. The deferred waiting list was abolished from 1st April 2003 and a revised process for managing periods of unavailability and applying status codes will be introduced from 1st April 2004.

When managing patients who are, or have at some time been unavailable for treatment, or have an Availability Status Code attached to their treatment, then a number of fundamental principles should be adhered to:

- The original date of placing the patient on the waiting list, whether this is an outpatient, operative or diagnostic list, should always be retained.
- NHS Boards should set a clear audit standard for the maximum length of time allowed for a period of unavailability or application of status code before patients circumstances and clinical status are reviewed.
- Hospitals and NHS Boards should ensure that the codes are being interpreted accurately and should monitor the application of all Availability Status Codes.

**The following recommendations are provided for the application of Availability Status Codes**

*Code 2 - where the patient has asked to delay admission for personal reasons or has refused a reasonable offer of admission.*

Once the period of unavailability ends and the patient is able to attend for treatment, then the patient should be admitted as soon as possible, taking account of their original date placed on the waiting list and according to clinical priority.

*Code 3 - in individual cases where, after discussion with the patient, the treatment has been judged of low clinical priority.*

The application of the code for low clinical priority should only be applied after full discussion with the patient. The patient should be advised of the likely timescale for their treatment and be advised of any changes to this timescale.

*Code 4 - with highly specialised treatments identified at the time of placing the patient on the waiting list.*

This code is intended for treatments which are clearly of a highly specialised nature and should therefore be identified and applied at the time the patient is added to the waiting list. The consequences of the application of this code should be fully discussed and explained to the patient and the patient should be advised of the likely timescale for treatment and updated of any changes to this timescale.

*Code 8 - where the patient did not attend or give any prior warning.*

This code should always be applied when a decision is taken to retain a patient on a waiting list following a failure to attend. Local protocols should be in place to determine if the patient is given another opportunity to attend or if the patient should be returned for care to general practice and removed from the waiting list.

*Code 9 - in circumstances of exceptional strain on NHS such as a major disaster, major epidemic or outbreak of infection, or service disruption caused by industrial action.*

This code must only be applied following agreement by the Scottish Executive Health Department and

the code may only apply to patients for an agreed and limited period of time.

*Code A - patients under medical constraints (conditions other than that requiring treatment) which affect their ability to accept an admission date if offered.*

These circumstances should be fully discussed with the patient at the time of placing on the waiting list and the likely consequences for their waiting time outlined. Once the patient is medically available they should be admitted as soon as possible, taking account of their original date placed on the waiting list and according to clinical priority.

*Code X - temporary code valid until September 2003 for patients transferred from the deferred waiting list where the original reason for placing on the deferred list is not known.*

By September 2003 all patients who have had this code applied must either be covered by a valid availability status code, be removed from the waiting list because they are no longer waiting, or have been admitted to hospital.

### **Identifying the start and end point of a waiting time period**

A waiting time exists for a patient from the point in time the patient requests, or has a request made on their behalf, for access to a particular healthcare service. Typical examples of a healthcare service are an appointment with your General Practitioner, attendance at a hospital outpatient clinic for diagnosis or advice or admission to hospital for investigation or an operation.

The waiting time period normally begins when:

- a. the patient requests to see a member of the primary care team;
- b. the general practitioner refers the patient for a hospital outpatient appointment. In most cases measurement is from the date the referral is received at the hospital;
- c. the hospital doctor agrees with the patient that an appropriate investigation or treatment should take place.

The waiting time period normally ends when the date is reached for:

- a. the appointment with general practice;
- b. the hospital out-patient appointment;
- c. admission to hospital for investigation or treatment.

The waiting time period does not end if the general practitioner or hospital cancels a patient's appointment or if following admission the patient is sent home before treatment commences.

Sometimes the time it takes for a patient's period of care to be completed includes one or more diagnostic investigations for which the patient is required to wait. These investigations may relate to serious conditions such as heart disease or cancer. NHSScotland has therefore set specific waiting times for investigation for coronary heart disease and a total waiting time standard from referral to commencement of treatment for cancer (Appendix A).

## 2.2 ADDING AND REMOVING PATIENTS FROM THE WAITING LIST

Audit Scotland has recommended that all patients waiting for services should be entered onto a waiting list to allow monitoring of waiting times and early warning of pressures in service areas. The level of information recorded for a patient placed on a waiting list should be proportional to the requirements for appropriate clinical management and the delivery of waiting time standards.

Patients should only be placed on a waiting list if:

1. There is a clear clinical indication that the proposed assessment or treatment is required and will be beneficial. A patient is not to be placed on a waiting list as a holding device until the patient's condition reaches an appropriate stage or the patient reaches a certain age.
2. Services are available within the hospital to provide the planned assessment or treatment.
3. There is a valid expectation that the assessment or treatment will be carried out within the agreed waiting time standard. If this is not the case then the hospital in partnership with the NHS Board and primary care should make arrangements for the provision of care at an alternative facility or through an alternative and appropriate method of treatment.

A patient should only be removed from a waiting list when:

1. The patient has been seen or admitted and the planned episode of care has commenced.
2. Within agreed protocols if the patient has failed to attend or repeatedly asked for appointments to be rearranged.
3. There is another valid reason for removal; for instance the patient no longer wishes treatment, has moved out of the area or has received treatment at another provider.

Patients should not be removed from the waiting list:

1. If, after being added to the waiting list at one hospital, it is agreed that their care will be provided at another hospital. In such an instance the patient's waiting time continues to be counted from the original date on the waiting list.
2. If the hospital cancels an appointment or admission or if the hospital sends a patient home after admission prior to the commencement of treatment.

### **Removing patients from the waiting list for reasons other than treatment**

Hospitals should set targets for the maximum number of removals from a waiting list for reasons other than attendance or admission.

These targets should, where appropriate, be subdivided by reason for removal, speciality of care, condition and proposed procedure. The hospital should calculate the removals for reasons other than admission as a rate against the total number of patients coming off the waiting list. Hospitals should benchmark the rates for removal for reasons other than admission against hospitals with similar services.

High levels of removal for reasons other than admission are indicative of problems in the policy and practice of adding patients to a waiting list, whether for outpatient or inpatient/day case care. Hospitals should ensure removals are at an acceptable level.

### **2.3 MANAGING INPATIENT/DAY CASE WAITING LISTS AND WAITING TIMES**

Patients should be ranked in order of clinical priority in a consistent, equitable and auditable manner. This should normally be the responsibility of a senior clinician.

Assignment of a patient's clinical priority should be in keeping with NHS Quality Improvement Scotland guidelines, including SIGN guidelines.

A hospital waiting list is an amalgamation of a number of separate waiting lists. The hospital waiting list can be broken down into waiting lists for individual specialities, individual procedures and for individual consultants. Waiting lists should be managed at an appropriate level of detail. It is recommended that a senior clinician with management responsibility should provide leadership to ensure that each sub-division of the hospital's total waiting list is managed to deliver the agreed waiting time standards. If appropriate this may involve the pooling of waiting lists for designated procedures or for routine referrals across a group of consultants.

In keeping with any national definitions, hospital services should agree with NHS Boards and primary care the criteria which constitute a reasonable offer of admission to a patient. It is recommended that a reasonable offer for attendance or admission should be notified to the patient no later than 3 weeks prior to the planned appointment or admission.

Failure to offer patients reasonable notice to attend may result in prioritising patients who are available at short notice. This may have the progressive effect of significantly admitting numbers of patients out-of-date order and therefore allowing some patients to wait excessively long times. Short notice booking also has a potential to disrupt good theatre planning.

The original date of placing the patient on a waiting list should always be retained. This date should be retained irrespective of the number of occasions the patient has asked for appointments to be rearranged, has become unavailable for treatment or has failed to attend. This date is required to ensure that patients do not remain on a waiting list when there is no prospect of admission, and to ensure that patients are not “lost” on a waiting list when their clinical condition may be deteriorating.

The majority of patients on a speciality waiting list are often waiting for the most common procedures. These patients may also have the longest waiting times. Hospitals should put in place plans to manage the waiting times for the most common elective procedures, making best use of resources available and promoting the greatest co-operation between consultant teams through the pooling of workload where appropriate.

Hospitals should monitor and review the cancellation of theatre sessions and operations. Targets should be set to reduce cancellations where these are at an unacceptable level. It is recommended that a theatre session should only be cancelled following consultation with a designated director, and specific protocols should be in place for action following the cancellation of a theatre session by a hospital.

The requirement to review the status of all patients after a stipulated period of waiting should ensure that patients on a waiting list are actively waiting for

treatment or their reason for unavailability is understood and managed. There should, however, be a formal written policy for the validation and review of both inpatient/day case and outpatient waiting lists.

Pre-assessment clinics should be considered, where appropriate as a means of reducing failures to attend and improving waiting times.

Performance benchmarking against comparable services should be employed as a means of assessing the efficiency of services in delivering waiting time standards. Typical performance benchmarks are; bed utilisation, theatre utilisation, length of stay in hospital and the number of operations carried out as day cases.

## 2.4 MANAGING OUTPATIENT WAITING LISTS AND WAITING TIMES

Hospitals should take action to identify referrals considered to be inappropriate and, for selected services, work with primary care and NHS Board's public health departments to produce joint referral protocols.

The prioritisation and management of outpatient referrals should be reviewed by consultant staff in partnership with primary care.

This process should be of mutual benefit to general practitioners and consultants in improving the entire referral process, and consideration should be given to the involvement of primary care referral advisers.

There should be the opportunity for general practitioners to refer directly the most urgent patients with the minimum of waiting time.

The management of follow-up outpatient appointments should be as systematic and thorough as the management of new outpatient appointments.

Hospitals should consider setting a standard for the number and type of referral from primary care which may receive a notification of receipt of referral. This may be particularly valuable where waiting times are particularly long and may have the benefit of reducing patient anxiety.

The recording of certain outpatient procedures is now mandatory. The information available should be utilised to set standards for the actual waiting times for these procedures.

The Information and Statistics Division (Scotland) have a data development programme in place to record an increased range of outpatient services that are not consultant-led. Hospitals should ensure that they are effectively managing the waiting times and services for all outpatient clinics regardless of the designation of the health care professional.

Hospitals should monitor and review the cancellations of outpatient clinics and set targets and reduce cancellations where these are at an unacceptable level. It is recommended that a clinic

should only be cancelled following consultation with a designated director, and specific protocols should be in place for action following the cancellation of a clinic by a hospital.

Outpatient services should be managed in accordance with the clinic template, also known as the clinic rules or clinic profile. It is recommended that the clinic template should contain as a minimum the following information for each clinic:

1. Clinic location and start and end time for the clinic.
2. Lead clinician for the service being provided.
3. Clinician holding the clinic.
4. Number and duration of urgent new outpatient slots.
5. Number and duration of routine new outpatient slots.
6. Number and duration of return slots.

Hospitals, in conjunction with primary care, should consider the introduction of booking systems which give patients early notification of their appointment time. This approach is convenient for the patient, promotes efficient use of services and assists in reducing failures to attend.

## 2.5 MANAGING FAILURES TO ATTEND FOR AN APPOINTMENT OR FOR ADMISSION TO HOSPITAL

There should be a written policy for the management of patients who fail to attend for appointment or admission. This policy should be agreed between the NHS Board, hospital services, and primary care. It is recommended that the policy on failure to attend should contain the following elements:

1. A senior member of staff should be identified as responsible for implementing and auditing the failure to attend policy. A senior doctor should be responsible for ensuring the clinical appropriateness and effectiveness of the failure to attend policy.
2. Specific action should be stipulated to follow a patient's failure to attend.
3. Action following a failure to attend should take account of the patient's provisional diagnosis and proposed procedure. Patient notes should be updated with details covering the failure to attend.
4. The general practitioner should be formally notified of the patient's failure to attend.
5. Hospitals should normally contact patients who have failed to attend and explain the actions which follow from this event. General practitioners should normally discuss with patients the consequences and options following their failure to attend.
6. Hospitals should promptly remove patient's from the waiting list where the decision has been taken to return the care of the patient to primary care.
7. The decision to retain a patient on a waiting list following a failure to attend should always be an explicit decision in keeping with local guidance.
8. Following a failure to attend, the patient's status against waiting time standards should be updated in keeping with national and local guidance.
9. The patient's original date of joining the waiting list should always be retained if the patient remains on the list following a failure(s) to attend. This is to ensure that patients are not retained on the waiting list for inappropriately long periods, and to identify the possibility of a deteriorating clinical condition.
10. The management of failures to attend should be supported by regular audit of the accuracy of patient contact details.
11. The local health system should develop and improve their means of contacting patients in an efficient and cost effective manner. For instance through the utilisation of mobile phones and e-mail in addition to conventional methods.

The policy on failures to attend should be developed to cover patients who repeatedly ask for appointments to be re-arranged.

Hospitals should set target rates for failures to attend as a percentage of total attempted appointments or admissions. This is known as the Did Not Attend (DNA) Rate. The hospital should benchmark their rate against similar services and aim to improve performance in this area. Targets for cancellation/failure to attend rates should be subdivided into Specialty or condition specific targets to take account of clinical circumstances.

A high failure to attend rate is generally an indicator of:

1. Long waiting times.
2. Poor communication with patients and management of patient contact details.
3. Inappropriate referral levels from primary care
4. A poorly managed hospital outpatient service.

Overbooking available outpatient appointment slots is not good practice and is a compensation approach to the management of outpatient services. Failure to attend rates should be managed and outpatient slots provided to meet the projected demand for services.

## 2.6 MEETING THE NEEDS AND EXPECTATIONS OF PATIENTS

Hospitals should work to ensure that patients are as fully involved as possible in their treatment process. Patients should normally have one clear contact point to go to for advice or to notify if their situation changes.

Hospitals should set targets for the quality of contact information held on patient records, for example targets covering:

1. Percentage of patient records holding a telephone number.
2. Percentage of patient records holding a mobile telephone number.
3. Percentage of patient records holding an e-mail address.

It may at times not be possible to offer all patients treatment at the first choice hospital or with the consultant who received the original referral. Where there is a particularly high level of demand for certain services consideration should be given to asking the patient at the time of being placed on the waiting list if they would be agreeable to receiving treatment by another appropriate consultant or at another suitable hospital.

Hospitals should aim to provide the patient with a simple list of rights and responsibilities when they are placed on either an outpatient or inpatient/day case waiting list. It is recommended that this information should include the following:

1. The service for which the patient is waiting
2. The doctor or other clinician responsible for the patient's care.
3. The expected time the patient will have to wait.
4. Any waiting time standard which applies to the patient.

5. Confirmation if the patient is available at short notice.
6. The amount of notice the patient will be given prior to their proposed attendance or admission date.
7. How the patient will be contacted by the hospital, for example by letter or by phone.
8. The actions required of the patient when notified of their appointment or admission date.
9. One contact point at the hospital in case of any queries.
10. The action the patient should take if they wish to re-arrange an appointment, notify a change in their circumstances or if they no longer wish to take up the offer of an appointment or admission.
11. The consequences for the patient if they fail to attend for an appointment or admission.
12. The action the hospital will take if it is necessary to cancel an agreed appointment or admission date.
13. Confirmation that the patient will be informed if they are not likely to be admitted within their expected waiting time.
14. Confirmation if the patient has agreed to treatment with an alternative consultant or at another hospital in order to provide quicker treatment within national or local standards.

## 2.7 SUPPORTING ACTIONS TO REDUCE WAITING TIMES

Actions to improve waiting times should be supported by actions to maintain service standards in other areas, such as emergency care and the discharge of patients following a stay in hospital.

Hospitals should aim to develop programmes for integrated care through a “whole systems approach” which take account of the entire patient pathway from referral by General Practitioner through consultation and investigation to treatment and discharge home. This approach will help avoid a fragmented care process where work may be duplicated and the focus on the patient may be lost.

Written protocols should be in place for the management of waiting times which are in keeping with required practice and guidance. The effectiveness of written protocols should be regularly audited. Specifically there should be a written policy and procedure for training staff in the management of waiting lists and waiting times. There should be the opportunity for refresher training for key staff.

A consistent approach should be applied to the management of waiting lists and waiting times across all hospital services, in keeping with the specific requirements of individual specialities.

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There should be adequate leave and sickness cover for key staff involved in the management of waiting lists and waiting times.

Access to details of individual patients on waiting lists should be entirely within current guidance on confidentiality.

## PRIMARY CARE

The Audit Scotland report, "Mind the Gap", covering management information for outpatient services stated, "clinicians need high quality timely information about patients referred in order to determine the appropriateness of the referral, the appropriate provision of services for each patient and the urgency with which they should be seen".

The Scottish Intercollegiate Guidelines Network (SIGN) report No. 31 "recommended referral document", identifies good practice regarding the content of referral documents. Primary Care should take account of the substance of this guideline when agreeing and managing the content of referral letters.

General Practitioners are central to the waiting time experience of their patients and should be provided with sufficient information to support their patients through their period of waiting, including the opportunity to influence the actual waiting time, the choice of clinic and arrangements for the clinic visit.

To support an effective partnership between Primary and Secondary Care on waiting time improvements, the following actions are recommended:

- It is often the case that general practice has more up-to-date and detailed information on a patient's circumstances than secondary care and hospitals should aim to link with general practice in the validation and updating of waiting lists.
- NHS Boards should take a lead in promoting the integration of waiting time information between general practice and secondary care. Where possible general practices should be provided with regular updates on outpatient and inpatient/day case waiting lists for their patients.

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Waiting List information may be complemented by the practice referral rates to the corresponding services. General practices will therefore be able to assess their referral rates in relation to waiting times, possibly in comparison with other practices.

General practices should consider having a written policy for patients who fail to attend for appointments, both at the practice and at secondary care. Such a policy should aim to support patients and minimise the level of failures to attend.

General practices may consider monitoring and if appropriate setting standards for the time between the decision to refer a patient to secondary care and the dispatch of the referral notification.

The planning process and local target setting to improve waiting times should have continuing and meaningful clinical involvement from both primary and secondary care. There should be clear clinical managerial leadership in ensuring that waiting time standards are delivered in a manner that does not distort clinical priorities and ensures that the patient's best interests are served.

## THE NHS BOARD

Low treatment rates or a high level of demand may be contributory factors to lengthy waiting times. In order to manage demand in relation to need and deliver care of an appropriate level and case-mix, Health Boards should consider the following actions:

- The appropriateness of referral rates for specific specialities should be assessed by NHS Boards in partnership with primary and secondary care and benchmarked against comparative populations. Intervention rates for selected procedures should also be benchmarked against comparative populations.
- Where appropriate, referral practice and intervention rates should be protocol driven, taking account of local health needs assessment and existing guidelines from NHS Quality Improvement Scotland, including SIGN guidelines.
- NHS Boards, in partnership with general practice, should review significant variations in referral levels between different general practices, or groups of general practices, with a view to benchmarking expected referral levels.
- Access to outpatient and consultative services for those from deprived communities, and those from the most vulnerable groups in society, should be reviewed and where access is perceived to be inadequate, targets should be set for improvement. Rates for patient failure to attend for appointment or admission should be audited in relation to deprivation.

- The public health contribution to improving waiting times should support the best balance between meeting need, managing demand and providing appropriate healthcare resources.

It is recommended that when agreeing activity levels to deliver waiting time standards, the following factors should be taken into consideration:

1. It should be determined if activity levels are appropriate to deliver the agreed waiting time standards. "Roll-over agreements" should not be employed in a manner that activity levels of the previous year are simply confirmed as activity levels for the following year.
2. Where appropriate, it should be determined at speciality or sub-speciality level if activity levels are appropriate to deliver a specific waiting time standard. The process of "bottom line agreements" should not be employed where increases in activity in one area are simply offset against decreases in activity in another area. An example of this would be off-setting an increase in emergency activity against a decrease in elective activity. Similarly, increases in activity in one speciality should not be off-set against decreases in activity in another speciality unless it is clear this is appropriate and waiting time standards will be maintained.
3. Where appropriate, annual activity targets should be phased to take account of seasonal variations in demand and capacity. Elective activity for most specialities should generally be lower in the winter period while emergency activity is generally higher in the winter period. Some specialities however, do not suffer from large seasonal fluctuations and this is particularly the case for day case services.
4. Outpatient appointments should not be utilised as a proxy for demand or for need. Outpatient referrals may be significantly higher than appointments leading to increasing waiting times. In addition, low appointment rates may mask unmet need which has not resulted in referral to hospital.

Planning to maintain waiting time standards should be part of an overall integrated and linked planning process. Action to deliver waiting time standards should complement and not detract from action to deliver other targets, for instance around the management of emergency care and chronic conditions.

The NHS Board should provide leadership in analysing and in managing the entire waiting time pathway from referral to completion of treatment. The aim should be to ensure that patient care does not become fragmented with the patient subjected to a series of consecutive waiting times which are poorly understood and reported.

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In completing service strategies and reviews, NHS Boards should take full account of the requirement to improve waiting times. Strategic plans should underpin the delivery of agreed national and local waiting time standards.

Each NHS Board should have an executive director with specific responsibility for waiting times and the Board should receive regular reports covering progress towards national and local standards.

## THE PATIENT

Patients should be consulted, informed and appropriately involved during their waiting time period and treatment.

It is usually the case that if the NHS takes the time and has a commitment to communicate with patients positively, patients will then respond positively.

Patients should be clearly informed of the actions that are expected of them, for instance in updating their contact details or informing their general practitioner and hospital of any change in their circumstances.

Following the guidance within the Hospital Services section of this document on “meeting the needs and expectations of patients”, will support patient involvement in their own care.

Patients themselves have a responsibility in:

- providing accurate information to healthcare professionals;
- updating general practice and hospital services of any changes in circumstances, and in particular changes in contact details;
- attending appointments as arranged and avoiding cancelling appointments at short notice.

## WAITING TIMES, GUARANTEES AND TARGETS

### Hospital Inpatient and Day Case Treatment

- No patient with a guarantee should wait longer than 12 months for inpatient or day case treatment. This will be reduced to 9 months from 31 December 2003 and to 6 months from 31 December 2005.

These targets are firm guarantees. If a patient's host NHS Board is unable to provide treatment within the target time, the patient will be offered treatment elsewhere in the NHS, in the private sector in Scotland, or England, or overseas.

### Coronary Heart Disease

- From 31 December 2002, the maximum wait from angiography to surgery or angioplasty will be 24 weeks. This will be reduced to 18 weeks by 31 December 2004.

These targets are firm guarantees. If a patient's host NHS Board is unable to provide treatment within the target time, the patient will be offered treatment elsewhere in the NHS, in the private sector in Scotland, or England, or overseas.

### Cancer

- By 31 October 2001, women who have breast cancer and need urgent treatment will get it within one month where appropriate.
- By 31 October 2001, the maximum wait from urgent referral to treatment for children's cancer and acute leukaemia will be one month.
- By 31 December 2005, no patient urgently referred for cancer treatment should wait more than 2 months.

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## **Coronary Heart Disease**

- From 31 December 2002, the maximum wait for angiography will be 12 weeks from seeing a specialist. This will be reduced to 8 weeks from 31 December 2004.

## **Outpatients**

- By 31 December 2005, no patient should wait more than 6 months for a first outpatient appointment with a Consultant, following referral by GMP/GDP.

## **Primary Care**

- From 31 March 2004, everyone should get access to an appropriate member of a primary care team within 48 hours.

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