Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: Mr Mike Lyon

12 March 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Mr Mike Lyon Scottish Government Health Delivery Directorate

The Chairperson: I welcome Mr Mike Lyon, senior adviser on waiting times for the Scottish Government, to the Committee. We appreciate your taking the time. Finding a solution to this problem has perplexed not merely the Committee but wider society. Our normal procedure is that I first refer members to the presentation that has been circulated at page 2 of their tabled papers. I will ask Mr Lyon to make a 10-minute presentation, and then we will invite questions from members.

Mr Mike Lyon (Scottish Government Health Delivery Directorate): Thank you very much for inviting me to give evidence on Scotland's challenges and successes in reducing waiting times. It is always a pleasure to be in Northern Ireland.

Much of what I say will be familiar to members and the NHS in Northern Ireland, for example, through your quality strategy. I would like to focus on three themes: underpinning principles; service improvement and performance management; and information systems, definitions and measurement. In addition, I will highlight 10 key aspects of Scotland's approach to improving waiting times that I think may be relevant to Northern Ireland. I have provided those in my handout.

In underpinning principles, the 2003 good practice guide and managing waiting times, which is pretty much when we started this, states that the patient's rights are paramount and that patients are to be offered care according to clinical priority and within agreed waiting times. Clinical priority is not to be compromised under any circumstances. The Patient Rights (Scotland) Act 2011 legislates that it is the right of every patient to receive care that is patient-focused; takes account of the patient's needs; provides optimum benefit; keeps the patient informed; encourages patients to participate as fully as possible; treats the patient with dignity and respect, privacy and confidentiality; is caring and compassionate; is based on recognised clinical guidance; and causes no avoidable harm or injury.

That is a long list of aspirations that I think everyone will agree to, and I think that it is in your quality strategy. The point is that it is in pursuance of those rights that all reasonable and practical steps must be taken to ensure that clients are treated within the legal treatment time guarantee. We have a legal time guarantee with the same principles that account for other guarantees. Waiting times are in pursuance of patients' overall rights, taking account of a patient's clinical needs and the clinical needs of other patients, including patients undergoing unscheduled care.

Waiting time standards are part of an overarching Scottish NHS strategy for quality. Waiting times are managed as one of the six dimensions of quality: effective, efficient, safe, patient-centred, equitable and timely. We have a 20:20 vision that sets out a strategic vision for achieving sustainable quality in the delivery of care and which is supported by a quality strategy. That quality strategy builds on significant achievements to date, such as improving waiting times, so it is all meant to tie together.

Scotland's quality ambitions are further supported by the Scottish Patient Safety Programme; the quality improvement hub; health improvement, efficiency, access to services and treatment (HEAT) targets covering health improvement, efficiency, waiting times and appropriate treatment; the 20:20 workforce vision; Healthcare Improvement Scotland, which, among its other responsibilities, develops evidence-based advice and guidance; and public annual reviews of each NHS board. In summary, it is Scotland's policy that waiting times be part of an overall quality strategy applying to all areas that places the patient at the centre. Waiting times should be an outcome of quality and efficient services.

Service improvement and the transformation of services have been central to Scotland's drive to improve waiting times. Improvement programmes have utilised change and improvement methodologies, for example, the improvement model, statistical process control, queuing theory, lean, demand, capacity activity queue and flow analysis. I will say something more on the three central concepts of queue pathway flow in my summary.

Improvement in Scottish waiting times has been supported by strong central performance management — I led that for five years, and it was very strong — through collaboration with NHS boards. For example, monthly improvement trajectories towards targets are agreed with each board's chief executive individually, and regular review meetings are held. Where progress is not satisfactory, binding recovery plans are agreed. Weekly performance management is introduced where required and board capacity plans can be assessed and amendments recommended or mandated. Tailored support and peer monitoring can be initiated. Additional funding is related to performance to achieve best value.

Effective clinical engagement is fundamental to delivering Scottish waiting-time standards. For example, the delivery of the referral to treatment target for cardiac services was led by a clinical group. Delivery of the 18 weeks' referral to treatment standard has been supported by a number of clinically led task-and-finish groups. There have been clinical champions for service improvement in each NHS board. A musculoskeletal and orthopaedic quality drive is in place, which extended out of our waiting-time improvements. Fundamentally, the Scottish drive to improve waiting times has been based on a collaborative approach to service improvement and rigorous performance management.

I now turn to information systems, definitions and measurement. The improvement in waiting times in Scotland has been supported by the implementation of a wide-ranging e-health strategy, covering, among other programmes, a unique patient identifier, the e-referral programme, digital imaging and extensive upgrades of IT systems.

Historically, information systems in the NHS, as I am sure you will know, have managed discrete episodes of patient care, and a great deal of NHS activity has not been recorded electronically. A suite of products known as a patient management system has been nationally procured, and boards are implementing IT systems that can support the management of patients across entire pathways of care. A suite of definitions is available to support the consistent measurement and management and reporting of waiting times.

The 18 weeks' referral to treatment standard was supported by an information strategy and delivery team. After more than five years, that information team is still very busy. Specific enhancements to the available information set were put in place, including a unique pathway number for each individual 18-week pathway; clinic outcome codes to identity when an 18-week pathway continues or when it has stopped, and an onward referral data set to transfer pathway information between NHS organisations.

Upgrading IT systems and establishing effective definitions and measurement have been central to delivering a referral to treatment standard. We could not have done it without that.

In summary, Scotland moved from a simple 18-month maximum waiting time for in-patients and day cases in 1991 to a portfolio of waiting-time standards in 2014, covering GP access, accident and emergency, stage of treatment, referral to treatment, diagnostic tests, cancer treatment, child and adolescent mental health, psychological therapies, drug and alcohol treatment, audiology and hip fracture. Most of the improvement was achieved over 10 years.

The delivery of an 18 weeks' referral to treatment standard was preceded by delivering successively shorter targets for outpatients and in-patients and by introducing targets for eight key diagnostic tests, which covered about 80% of all diagnostic tests, and initial referral to treatment standards for cancer, coronary heart disease and cataract surgery.

Initial referral to treatment standards were managed by using patient trackers, who managed the progress of a patient through a pathway in cancer, or by dividing the pathway into times for assessment, testing and treatment that added up to the whole journey and actively driving out administrative delays. Those initial methods were replaced by the actual referral to treatment measurement as information systems were upgraded. So we achieved our referral treatment standard incrementally over time.

I will say a few words on the concepts of queue, pathway and flow, which are central to our improvement agenda in Scotland. Stage of treatment targets are essentially queue targets, and to manage queues it is necessary to have information identifying the number, size and scheduling of queues and the variation in additions to, or removals from, queues. I think that a person who previously gave evidence, Rob Findlay, identified the same issues in regard to queues.

Queues are generally contained in pathways, and referral to treatment targets measure the time between the start and finish of a pathway. To manage referral to treatment targets, it is necessary to design and manage pathways effectively.

As regards flows, elective or scheduled care targets are part of overall hospital and healthcare provisions that include unscheduled — for example, accident and emergency — as well as scheduled care, and it is influenced by care outside the hospital. To manage our scheduled care targets, it is necessary to take account of the flows of scheduled and unscheduled patients through a hospital.

This is a brief point. It is our view that there should be a focus on the wider spectrum of healthcare. Demand in hospital care and challenges to elective care targets are influenced by the quality and extent of care outside the hospital and by the health status and behaviours of the population. The extent and quality of primary care and the support for social care — for example, support to carers — will have a direct impact on the resource requirements to deliver elective waiting time standards. Successful health improvement actions will ultimately impact positively on elective waiting times. The more effective the relationship between healthcare and social care, the more effective healthcare will be overall. We are moving towards the integration of health and social care, which I believe you have achieved.

In summary, I will go through the 10 key aspects of our approach to waiting times in Scotland that may be of some interest to you here. First, a forceful central performance management team working in partnership with NHS boards. Secondly, skilled central support for service improvement, integrated with NHS boards or your local organisations. Thirdly, a strong emphasis on the determinants of waiting times, which are primary, secondary and social care; demand/capacity management; queue; pathway; flow; the relationship between scheduled and unscheduled care; workforce; and, yes, financial resource. Fourthly, the placing of waiting time standards in a broader strategic and quality-improvement approach. Fifthly, effective clinical engagement. Sixthly, the development of waiting-time standards over time, building on success step by step, from stage of treatment to referral to treatment. Seventhly, the development of information systems, measurement and definitions. Eighthly, the use of the independent sector at the margins and for a limited duration to manage unexpected demand and unforeseen events. Ninthly, the allocation of funding in the short term to address need but the balancing out of recurrent funding in line with the national funding formula and the allocation of funding to support service improvement as well as to increase capacity. Tenthly, targets should be fit for purpose and provide real benefit to patients; they should be able to be measured and reported and delivered; and they should be affordable and promote effective care and resource efficiency. Thank you for listening to this brief summary.

The Chairperson: Thank you. That is very useful. You mentioned the wider emphasis that is required on the wider spectrum of healthcare. Can you expand on that? You say that that requirement or that emphasis would have an impact on waiting times.

Mr Lyon: The emphasis on, for instance, health in early years will affect individuals' health in later years and the requirement for care of the elderly. Of course, that takes time to work through. Support for carers, in the short term, can have an impact on patients admitted to hospital. Providing good care or assessment for patients before arrival at A&E will reduce the demand on A&E and the pressure on beds and can aid emergency and elective care.

The Chairperson: So, it is, in effect, an early intervention prevention model that you are looking at.

Mr Lyon: It is early intervention prevention and care in the appropriate setting. For example, we have significantly reduced referrals in measures to orthopaedic surgery by having appropriate allied health professional physio care in the community. Those people never needed to come into hospital.

The Chairperson: Specifically on referral to treatment, what were the drivers for ensuring that that was used or utilised as a particular approach.

Mr Lyon: It was clinically popular. Clinicians recognised the idea of a pathway of referral to treatment. It instinctively felt right in the sense that it was what the patient experienced. They experienced the time for their first outpatient appointment, the time for tests and then the time for their operation; they could wait well over a year with all those different parts. We did not always know how long a patient was waiting between a diagnostic test, seeing the consultant and being put on the waiting list. I think that it promoted resource efficiency, because if patients are spread out over a long pathway, that is a lot of administrative cost and personal involvement. If you are getting them through the beginning of the pathway relatively quickly, it can be not only clinically but resource beneficial. It also has an economic benefit in that it gets people back to work more quickly.

The Chairperson: So there might have been a particular political context.

Mr Lyon: It was part of Scotland's wider strategy for health and economic well-being.

The Chairperson: OK. I appreciate that. I also noted that the first of the 10 key aspects that you talked about mentions:

"a forceful central performance management team".

Can you expand on how that was acted on?

Mr Lyon: The structure in Scotland is that the chief executives of the NHS are also the Civil Service heads of the Health Department. We have chief executives of the health boards who are accountable to them. Therefore you have an accountability framework. We established a performance management team, mainly of NHS employees, which I led, whose job was to assess a target, see whether it was deliverable, look at the risks to delivery, and then agree trajectories for that delivery with the NHS board of chief executives.

If somebody had no in-patient and day cases waiting over, say, 26 weeks and somebody had 1,000, you would agree, "We think that you can reduce that to 700, 800 or 500." You would look at demand, capacity and seasonality. We used the phrases risk-assessing and delivery-proofing. That team would meet regularly with each NHS organisation; you could ask for binding recovery plans, and we had step-in rights etc. It was partnership working; we did not do targets and terror.

The Chairperson: It is slightly different, but take the issue of waiting times in our emergency departments. There is increasingly a view that the focus on targets can be counterproductive. I know that it is different, but the principle is the same, namely how you get targets that are sustainable and realistic.

Mr Lyon: Targets are problematic and may even be counterproductive if you are not focusing on the determinants of the targets. Eighty per cent of your time should be spent on getting the service right, not just delivering the target. Getting there in the end, dipping under the wire and rising up again is not the way to deliver targets. The very simple principle is that if you are adding more people to a

waiting list — for orthopaedics, say — than are coming off it, it does not matter what target you have, you will not meet it or you will end up rationing by waiting. There is more complexity to that, which I can go into. It is about how you deliver the target as much as, if not more than, the fact that the target is delivered.

The Chairperson: Finally, one of the key aspects again was the allocation of funding. Some of the evidence that we are finding is — I will use the word counterproductive again — that you will not achieve your ultimate outcomes by throwing funding at short-term parts of the problem. Is that your experience?

Mr Lyon: That is absolutely the case. I suggest that there is a time to apply funding for a short period. If you have six months in which to treat patients and nine months' worth of patients on your waiting list but they are coming on and off in balance, you have to get rid of that extra three months of work because you have too many people on your list. That should be a one-off. There should be an agreement with the healthcare provider that that money is to reduce your list from 200 to 150. If you have more patients going onto your list than coming off it — say you have 1,000 a year going on and only 800 coming off — you have to give them funding for an extra 200 or change demand or change what you do. If money is simply given rather than tagged to the need for it, it can be problematic.

Mr Wells: I am fascinated by the way that you went about this. You told us earlier that you have 22 years' experience in this field.

Mr Lyon: Twenty, probably.

Mr Wells: Twenty. How many trusts do you have in Scotland?

Mr Lyon: We have 14 territorial health boards; we do not have trusts.

Mr Wells: I am interested in your role. Had you executive authority over those trusts, or were you an adviser?

Mr Lyon: I have been an adviser for two years. Before that, the chief executives of the NHS in Scotland had executive authority. My boss, who was then the director of delivery, had executive authority. I had authority to ask for recovery plans, look at how they were progressing, speak to whom I wanted etc.

Mr Wells: So you were basically looking over the shoulder of the trusts and giving them instructions as to what needed to be achieved to bring about a recovery in waiting times.

Mr Lyon: It is a bit like that. Scotland, like Northern Ireland, is a fairly small country. We know everybody. We know all the chief executives. It is more or less a case of, "You can deliver; can't you? Prove it to me."

Mr Wells: What sanctions had you if a trust was falling behind?

Mr Lyon: We could not confirm non-recurrent money as recurrent. There was not a big stick with regard to money, but we had flexibility to regain the money. We could put in an expert clinical support team and ultimately exercise other sanctions.

Mr Wells: And your entire role was to get on top of waiting times.

Mr Lyon: That was my entire role, yes.

Mr Wells: When you started, was there a great variation between performance in what we call trusts?

Mr Lyon: "Trusts" is fine.

Mr Wells: Was there a great variation?

Mr Lyon: Yes.

Mr Wells: Having been involved for such a long time, do you find that there is more uniformity now?

Mr Lyon: There is certainly more uniformity now. However, you always get areas of difficulty, and we have some just now.

Mr Wells: Were you satisfied that those areas of difficulty were inherent problems that were insurmountable, or was it down to lack of management and effective processes?

Mr Lyon: Management and processes are always variable; there are times when they can be improved. So, yes, there are process and management issues. The challenges that we have now are well recognised, but they are not insurmountable. One health board needs to grow more local capacity, and it is doing that by investing.

Mr Wells: As part of your research for coming over here, did you compare the performance of our trusts with that of your 22 authorities?

Mr Lyon: I did not look at the performance of your trusts directly. I read your published statistics and noted how your outpatient and in-patient day-case targets had got worse and then improved and how you are heading towards your target. I could not draw many conclusions with that level of data.

Mr Wells: Could you conclude whether our performance was considerably worse, much worse or just slightly less efficient than Scotland's?

Mr Lyon: My feeling is that you have a little bit further to go in managing your stage-of-treatment targets for outpatients and in-patients.

Mr Wells: Did you identify any area in which Northern Ireland is performing better than in Scotland?

Mr Lyon: You have an integrated health and social care system, which is very positive. I did not have the statistics to identify anything else.

Mr Wells: That leads to my next question. We have a different structure here, as you know. We have had an integrated health and social care system for 40 years. You have a health system and then a social care system that is the responsibility of the councils.

Mr Lyon: Largely, yes.

Mr Wells: Was that an impediment to improving waiting times? Is our system a better one in which to improve them?

Mr Lyon: Theoretically, I would have thought that your system is a better one, but I am not familiar with it. With regard to dealing with councils, we have issues around discharging patients from hospital. Nursing home facilities are within councils' remit, and patients staying longer in beds when they are medically fit to be discharged is an NHS problem.

Mr Wells: Under the present comprehensive spending review, how the health service in Northern Ireland has been funded is that the health element has been given a 1·9% real-terms increase — we are three and a half years into that — and the social services element, which is part of our health services, was split off for the purposes of funding and did not get a real-terms increase. Is one of the reasons why Scotland has performed better is that your devolved government have added money on top of that to reduce waiting lists, or have you stuck to the same budget allocated under Barnett that we have?

Mr Lyon: Under Barnett, we have flexibility on where we allocate money across service provision. Over the past 10 years, there has been additional investment into direct NHS care and, specifically, waiting times.

Mr Wells: So one of the reasons for the improvement over the decade may be that you have had more money to put into the system.

Mr Lyon: We have funded additional capacity for waiting times. If you add more patients to a waiting list than you can take off it, you have to treat those patients or you will get into a waiting-time problem. So, yes, we have added more funding.

Mr Wells: One of the ways in which we have reduced waiting times is the use of the private sector. We have sent folk to clinics in Northern Ireland and, indeed, in the Irish Republic and England. That has been one way of relieving the pressure. Have you been able to get any statistics on how much the Scots have used that process?

Mr Lyon: The last time I looked, the spend in the independent sector was less than 0·2% over a year; however, I would have to check those figures again. It has been significant for limited periods. We have built up alternatives. We have a national waiting-times centre, which is basically a hospital that provides activity just for waiting times. We have a treatment centre on the east coast. NHS boards often provide additional activity at the weekend using clinicians from elsewhere in the UK. All those are alternatives to the independent sector, but, yes, we use the independent sector, largely to avoid putting on additional capacity at the margins that we will not use all year.

Mr Wells: So, you sit in your control room somewhere in Edinburgh and watch, presumably on a screen, the performance of all the trusts, and they will fear you ringing up and saying, "Hey, you are slipping on orthopaedics. You are slipping on cancer screening. You are slipping on X-rays.".They regard you as our trusts regard the Regulation and Quality Improvement Authority (RQIA) here. They fear you.

Mr Lyon: I hope that they do not fear me.

Mr Wells: But they know that you are watching them.

Mr Lyon: They know that they are being held to account rigorously, yes.

Mr Wells: When they get a phone call and see your number come up on the screen, they know that there is something to be fearful of.

Mr Lyon: They know that there is something that they have to address.

Mr Wells: You have the power to say to the chief executive — Fred, Jean or whomever — to get it fixed by a certain time or else. You can do that.

Mr Lyon: We would expect the chief executive to want to get it fixed by that specific time, yes. The authorities know that they have to deliver their waiting-time standards.

Mr Wells: May I ask you a difficult question? I do not have to ask this, but we heard something two weeks ago from the RQIA, which deals with regulation and quality improvement here. It said that there was evidence that staff are manipulating and massaging figures to make them look better than they should. We have not got to the bottom of it yet, but it is a very serious allegation, because if we cannot depend on the figures provided by the trusts, we have no basis on which to start.

Mr Lyon: This is in Northern Ireland?

Mr Wells: Just Northern Ireland, yes.

Mr Lyon: The first thing I will say is that, if you are managing many hundreds of thousands of patients, each with a waiting-time standard, that requires accurate recording of information to be translated into electronic systems and reported. Things will go wrong. Perhaps with no wilful intent, people will make mistakes. The English audit team, when it looked at its 18-week referral-to-treatment (RTT) period, found a large number of records in which it could not account for the fact that the patient was seen within 18 weeks. That does not mean to say that authorities were cheating, but you will have millions of transactions for patients, so they are not always recorded as accurately.

In Scotland, we had one health board where the figures were being manipulated. The Cabinet Secretary called in PricewaterhouseCoopers internal auditors to audit the whole system, and there

were quite severe consequences. Audit Scotland then audited the whole of Scotland and found one other board in which there were some minor irregularities. Internal audits audited everything in every board, and the audit recommendations have been implemented. Audit Scotland recently pointed out that we could not account for the patient pathway on every record. I think we have now met all the Audit Scotland requirements. Therefore, yes, you have to be alert for quality assurance and external audit.

Mr Wells: But you are now happy that you are getting accurate data coming in from the health boards so that you can interpret their performance.

Mr Lyon: Yes, I am.

Mr Beggs: You indicated that trusts were organising additional capacity at weekends rather than pulling in the private sector. Have you found that to be a more efficient method of dealing with the extra capacity that you need?

Mr Lyon: I think that it is an efficient method. Some of the authorities do that through an independent sector company that simply coordinates clinicians coming in and working in the hospital. Some of them do it themselves, so it has proven to be an effective approach.

Mr McCarthy: Thanks very much for your presentation. Your briefing paper states:

> *"the Scottish Government introduced a new HEAT target to support the sustainable delivery of 4 hour A&E".*

Will you explain what that is? Furthermore, has any consideration been given in Scotland, in the context of accident and emergency provision, to allowing other health professionals such as nurses to act as decision-makers?

Mr Lyon: Yes to both. The supporting target to the four-hour A&E target is to reduce attendances at A&E as part of shifting the balance of care.

It is not my area of workforce development, but there is a strong workforce development programme for skill mix within emergency departments, whereby non-doctors can discharge patients.

Mr McCarthy: What does HEAT stand for?

Mr Lyon: Health, efficiency, access and treatment. From alcohol-reduction targets and breastfeeding to waiting times.

Mr McCarthy: Has there been any suggestion or trialling of greater use of out-of-hours GP services?

Mr Lyon: Yes, there has been, but I do not have the detail. I can provide it separately, if that will be helpful.

The Chairperson: I will just make the point that this is obviously not specifically about A&E. We are talking about waiting times, elective care and all of that.

Mr McKinney: I am also interested in the issue that the Chair raised at the start. There is dealing with the queue and dealing with the causes of the queue, and how you go about doing that structurally and strategically . As well as sending out health messages, which strikes me as something that would take time to bed in, what other things can be done to promote, underpin or extend community care or that type of thing to decrease queues overall?

Mr Lyon: Again, it is not my area of expertise, but, in the integration strategy, Scotland has a wide-ranging programme for care at home, hospital at home, support for carers, etc. We have targets for reducing readmission of patients over the age of 75, for reducing admission of patients over the age of 75, for reducing hospital stay, etc. There is a whole range of initiatives, which I can provide separately, to enable patients to be better treated out of hospital, to stay the minimum time in hospital and not to return to hospital.

Mr McKinney: I am conscious that there are themes coming in around A&E. I am not dealing with those specifically, but can doctors refer people to hospital in the Scottish system? What is the entry point?

Mr Lyon: A doctor can refer a patient to hospital. Absolutely, yes. Doctor can ask patients to go to A&E or they can send them to, say, a respiratory unit in one of the hospitals as an acute take.

Mr McKinney: Has that been helpful in reducing queues?

Mr Lyon: It probably has little effect on the elective queues.

Mr McKinney: Yes, I understand that.

Mr Lyon: There is much that can be done with queues on the elective side. One example is that, at one hospital, we had 87 separate queues for orthopaedics. It is very difficult to manage 87 queues. Imagine you were to go to the supermarket or the post office, and it had 87 queues. That number was reduced to 12 or 13. It is much easier to manage 20 or 30 than it is 87. That is a cost-free change.

Mr McKinney: You said that the more effective the relationship between healthcare and social care, the more effective healthcare will be overall. Can you elaborate on that?

Mr Lyon: Largely going over the points that I have made already, I will say that if you have integrated planning for health and social care, for example, if patients are able to discharged from hospital and are medically fit, they are not remaining in beds where there is no benefit to them. If you have anticipatory care, where people have chronic obstructive pulmonary disease or diabetes, it is managed before they hit hospital. All that will take pressure off hospitals. In particular, when you are facing A&E pressures, the point that I tried to pull out is that, on the flows of patients coming out through A&E and the flows of patients for acute care, you may find that orthopaedics admits all its patients on the day on which you have the biggest emergency flow or the doctors do the ward rounds only every second day, which results in patients sitting in beds unnecessarily. It is about getting all the different aspects to flow together.

Mr Beggs: Thanks for your presentation. It is always interesting to learn from someone who has similar problems and perhaps addresses them slightly differently. In one of your papers, you indicate that, for managing new attendance at emergency departments, you have a target for reducing attendance by around 2%. Are you on target for that, and, if so, how have you achieved that?

Mr Lyon: Without making excuses, I have to say that it is not my area, so I do not know whether we are on target or not. We have a programme of shifting the balance of care, which is to provide care for patients outside hospital. We have NHS 24, which is an advice and help line, and you go through that before you call an ambulance. Pharmacists are providing more advice to patients, and there is a programme around that. We are aiming to have GP surgeries open for longer hours. We have a 48-hour standard for access to the appropriate person in the practice, who is not necessarily the GP. Those measures are all ambitions to shift the balance of care away from hospitals.

Mr Beggs: How long have you had those new policies? I am not sure what standards there are in Northern Ireland.

Mr Lyon: The GP standard has been in for at least five years. The shifting the balance of care programme has been running for that period. I cannot recall off the top of my head how long the reduction in attendances at A&E policy has been running, but it is certainly several years.

Mr Beggs: OK. That is very interesting. On measuring the time on a waiting list — the RTT — how long did it take for you to switch over from the old way of recording to the new system? What level of investment has been required?

Mr Lyon: It probably took three or four years from the official launch of the document to its first going live. I think that it was four years, if I recollect correctly. There was marked investment behind it. We had investment in our e-health programme. Our patient administration systems were falling over, so we invested in patient management systems that could track patients from end to end. We invested in diagnostic information systems. A small area such as audiology had paper-based systems, so all of

those were put in place electronically. We put in a unique care pathway number, because a patient could have been in several pathways — diabetes, respiratory, knee replacement — at the same time. That was a significant information investment.

Mr Beggs: Did going over to that new system shake out the inefficiencies, such as queues and admin, of the old one? How did the patient experience change?

Mr Lyon: Our patient satisfaction surveys recorded around 80% to 88% satisfaction rate for waiting times. An amount of this is patient satisfaction, which indicates that there has been improvement in satisfaction with their overall waiting time. Administratively, I would argue that it has made life easier and saved money. We would have to gather full evidence of that, but managing a lot of queues and long queues was costly administratively.

Mr Beggs: Finally, if the private sector is used, do patients remain in your queue or do they disappear?

Mr Lyon: No, they remain in the queue until they are treated.

Mr Beggs: I am uncertain what happens here, but I came across a patient who had just hit six months on a waiting list before being transferred to the private sector. That patient has still to get a date and is just in another queue.

Mr Dunne: Thanks very much, Mike, for coming over to talk to us.

Mr Lyon: My pleasure.

Mr Dunne: You are very informative. To get down to specifics, was there a major issue with the handling of waiting list data? Perhaps a lot of the data was out of date, not handled properly or needed cleansed? Is that an issue?

Mr Lyon: Over the 10 to 12 year period, there has been a constant work programme to get the data right and fight for purpose. We started with waiting lists, which had to be made more accurate. We needed electronic recording of data. We had something called the New Ways project and a refresh project, all of which were designed to make our data more fit for purpose. We spent a lot of time on agreeing definitions, such as guidance for management on waiting times so that, as far as possible, hospitals were managing patients in the same manner. There is a degree of local flexibility, but the situation should be the same wherever you are.

Mr Dunne: Is the same system in place across all the various trusts?

Mr Lyon: Over half of Scotland is covered by a patient management system called TrakCare. The other management systems are of similar functionality.

Mr Dunne: Has that gone some way to making the lists more efficient?

Mr Lyon: Yes, it has. We also an e-referral system called SCI Gateway, where GPs can make electronic referrals, and that is increasing as well. We are introducing electronic systems in and around allied health professionals (AHPs), and I think that we are also upgrading the GP system.

Mr Dunne: What sort of funding is required for the installation of such systems?

Mr Lyon: I do not have that information to hand. I can provide it, but the figure is millions of pounds.

Mr Dunne: The other issue that we keep talking about is the risk of a conflict of interest between consultants both doing private work and working in the trusts or for health boards. Have you any evidence that that can be a risk?

Mr Lyon: No, I do not.

Mr Dunne: What is your opinion of it?

Mr Lyon: I think that the neater the separation between private and NHS work, the better. In fact, if we commission a private organisation to do work for NHS patients, they are commissioned as such, and the patients stay on the waiting list. One NHS board will not use consultants from the local area. In other areas, use of consultants is very marginal. With the possible exception of cardiac surgery, we do not treat private patients in NHS hospitals, so there is a strong separation between private work and NHS work.

Mr Dunne: You do not treat private patients in NHS hospitals.

Mr Lyon: As far I am aware, apart from for cardiac surgery possibly, because no private hospitals can set up a cardiac unit. It is too specialised. There are several private hospitals in Edinburgh, several in Glasgow, one in Dundee, one in Aberdeen and one in Ayr, so there are private facilities without the need to use hospitals.

Mr Dunne: They are working independently of one another.

Mr Lyon: They are working independently of the NHS. The doctor will have a contract that will allow a certain amount of work in the independent sector, and the doctor should not exceed that amount.

Mr Dunne: OK. Thank you very much.

The Chairperson: Thank you, Mr Lyon. Your evidence has been very informative. We will certainly be reflecting on the information that you have given us. It may be useful for us, if you are willing, to share our findings and recommendations with you. The important message from your presentation and evidence was on a central performance management system and, in your words, a "forceful central performance management team". I think that that brings up its own issues around governance and accountability that we have to look at for our situation.

Thank you for taking the time to come here. It has been very informative. If you are willing, we will share our recommendations with you. Feel free to feed back to us on those.

Mr Lyon: I am very happy for you to share the recommendations. On behalf of the Scottish Government, I can say that we are happy to provide any support and advice that you may find useful.

The Chairperson: I appreciate that.