Healthcare Improvement Scotland

Improving Access to Integrated Care

A Guide to Measuring

July 2025

Improving Access to Integrated Care

Quality improvement methods are used to sustainably and affordably improve waiting times. Focusing on testing and implementing change ideas that will allow teams to reduce demand and increase activity, will ensure sustainable reductions of queues and increased access. NHS Education for Scotland's QI Zone has more information, tools and resources about measurement in quality improvement. More information on improving access can be found on the HIS website.

Measures are grouped into outcome, process and balancing measures. Data should be collected frequently enough to understand if the testing and implementing changes is leading to improvement. Data should be plotted weekly to give enough data points to demonstrate sustained change over time.

Collecting and sharing data

It is a requirement that each team shares **outcome data** at set intervals with Healthcare Improvement Scotland. Access to this data will allow monitoring of team progress and offer support where is it felt it may be required. It will also allow continued evaluation of the programme.

Teams are asked to:

- familiarise themselves with the measures outlined in this document
- share outcome data at set intervals, and
- view the data regularly as a team to ensure that changes being tested are having the desired impact.

Outcome measures

Concept	Measure	Operational Definition Guidance	How to interpret	Data Collection	Presentation
Demand for care Total number of requests by referring services to provide care.	Number of patients added to the waiting list.	A count of patients added to the waiting list over the time period. The count of additions to the list excludes any referrals that are redirected to other services (e.g. other acute specialties or primary care) before being added to the list. The count includes patients that are added to the list but subsequently removed. It is advisable to track these separately (see how to interpret).	This measure will show how many appointments the service is being asked to provide by referrers. The goal for services with long waiting lists is to provide more new appointments than are requested, thus reducing the waiting list size. As this is measured after any vetting/screening procedures, the measure can be balanced against the proportion of redirected referrals (see balancing measures). It is advisable to separately record the referrals that are removed from the waiting list without occupying a clinical slot. These include nonclinical removals (e.g. moved away) and cancellations where the slot was reused to offer a first appointment.	Referrals added to the waiting list should be available via routine clinical systems.	Weekly run chart. This measure will be displayed as a whole number.

Concept	Measure	Operational Definition Guidance	How to interpret	Data Collection	Presentation
New care activity The number of patients removed from the waiting list as a result of delivery of care.	Number of patients who attended first appointments	A count of the patients who attended their first appointment. Booked appointments where no clinical activity took place but a slot was used (for example, Did Not Attends or on-the-day cancellations by service or patient) are excluded from this measure. These could be tracked separately.	This measure will show the reduction in list size as a result of clinical attendances. The goal for the service is to at least match if not exceed demand with activity. Optimising the delivery of care means maximising the number of attended appointment slots. This measure plus the slots lost to nonattendance should equal the number of slots booked.	Attended first appointments should be available via routine clinical systems.	Weekly run chart. This measure will be displayed as a whole number.
The size of the waiting list	Number of patients waiting at end of index time.	A count of all patients on the waiting list at a specific time point. This count is a snapshot at the end of the time period of interest. For example, if analysing the data weekly, then it is calculated for the last day of the working week. If monthly, it is calculated for the last day of the month, and so on.	This measure will show the size of the waiting list at any one time point. This is a result of the rate at which patients are added to the list, the rate at which they are removed (through clinical activity or otherwise), and the pre-existing list size. The goal for the service is to reduce waiting list size to a sustainable level. A sustainable waiting list size takes into account the demand, the maximum allowable wait (the waiting time target) and the amount of notice given to patients. A sustainable list size allows for flexibility and patient choice whilst maintaining safe and timely care.	Routine clinical systems should be configured to produce a count of all patients who are on the waiting list at the index time.	Weekly run chart This measure will be displayed as a whole number.

Care Experience

It is important that teams engage with service users to understand service user experience. This will allow teams to identify change ideas that will allow the design of person-centred services as well as ensuring any improvements are meaningful.

Including care experience measures in your measurement plan will allow you to understand the extent to which people are receiving services that are built around what people really need and want - their preferences, needs and values. The things that matter most to them.

The Care Experience Improvement Model (CEIM) is a simple framework that supports health and social care teams to make improvements that are directly related to feedback in a person-centred way.

The model guides teams to:

- take a conversational approach to gathering qualitative care experience feedback from people for whom they provide care and support
- use a discovery approach to these conversations, so that care experience is central to the feedback
- hold at least six conversations monthly, focusing these across a specific care or support journey or pathway
- establish a routine multi-disciplinary (where possible) team reflective improvement meeting that supports a review of the care experience feedback and identification of improvement opportunities, so that acting on feedback becomes the responsibility of everyone rather than only one or two individuals in a team
- develop pragmatic Quality Improvement (QI) skills within the team, using a recognised quality improvement approach in order to effectively focus on and respond to the issues identified through feedback, and to
- identify and try out change ideas, then implement and embed those that make a positive difference

Teams are asked to show evidence of care experience data (qualitative or quantitative).

Process measures

Process measures are context specific and depend upon the change ideas being tested and implemented. Teams are asked to develop their own process measures based the change ideas they are testing locally.

NHS Education for Scotland's QI Zone has a helpful guide to defining measures and the Improving Access to Integrated Care team can provide tailored advice and guidance to support the creation of local process measures. If you would like support from the Improving Access to Integrated Care team, please contact us at his.accessqi@nhs.scot.

Below are some examples of process measures. Please note that these may not suit your pathway and are intended as examples only.

Change Concepts	Example process measures
Active clinical referral triage (ACRT)	• Percentage (%) of all new referrals that are redirected to other acute specialties • Percentage (%) of all new referrals that are redirected back to primary care
Patient initiated returns (PIR)	• Percentage (%) of patients who opt-in to patient-initiated review • Percentage (%) of patients on patient-initiated review pathway who request an appointment
Waiting list validation	• Percentage (%) of patients removed from the speciality waiting list following review • Percentage (%) of patients who avoided unnecessary procedures
Remote consultancy	• Percentage (%) of patients offered remote outpatients clinic appointment • Percentage (%) of outpatient clinic appointments delivered via video (NHS Near Me) • Percentage (%) of outpatient clinic appointments delivered via telephone
One-stop clinics	• Average number of days from referral to appointment • Percentage (%) patients referred onto one-stop clinic pathway
Clinic utilisation	• Percentage (%) of available inpatient clinic time booked • Percentage (%) of booked/available inpatient clinic time used • Percentage (%) of patients who do not attend a new appointment • Percentage (%) of patients who do not attend a return appointment

Balancing measures

Balancing measures check for possible consequences elsewhere in the system while improving the balance between capacity and demand. Performance measures include monitoring potential impact have on staff satisfaction as well as impact on key national performance measures.

Balancing measures will depend on the focus of your improvements and interpretation; the examples below may work better as outcome or process measures. As well as gathering data for the measures below, accelerator sites are asked to consider any additional balancing measures based the change ideas they are testing locally.

Concept	Example balancing measure
Staff experience	This could be as simple as stones in jars or using emoji's to check-out at end of shifts.
Redirected/removed referrals	Referrals not added to the waiting list expressed as a whole number or a percentage of the total referrals (NB this would instead be a process measure if undertaking for example ACRT)
Health Inequalities	Interventions to improve access can either widen or narrow existing inequalities within a local population. Services that have identified a particular demographic, geographic or socioeconomic inequality as a priority for improvement could measure any of the above outcome or process measures for that group separately or construct their own targeted measure. For example, comparing the redirected referral rate between local regions when introducing ACRT could highlight a gap in community services. When introducing patient-initiated review, comparing opt-in rates or re-referral rates from GPs between SIMD quintiles could check that factors associated with deprivation are not preventing patients from initiating their own necessary reviews.