Healthcare Improvement Scotland

Improving Access

A guide to measuring

May 2026

NHS SCOTLAND

Improving access to planned care programmes

Our programmes use quality improvement (QI) methods 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 to planned care can be found on the Healthcare Improvement Scotland website.

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

Collecting and sharing data

Teams working with Heathcare Improvement Scotland to improve access to care are required to share outcome data at agreed intervals with Healthcare Improvement Scotland. Access to this data will allow the national team to understand team progress and offer support where it is 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 data at set intervals as outlined in the Memorandum of Understanding (MoU) completed at the start of the process
- View and discuss the data regularly as a team to ensure that changes being tested are having the desired impact.

Care Experience

It is important that services engage with service users to understand user experience. This will allow teams to identify change ideas that will allow the design of person-centered 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-centered 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 QI skills within the team, using a recognised quality improvement approach to effectively focus on and respond to the issues identified through feedback.
- Identify and try out change ideas, then implement and embed those that make a positive difference.

Services working with the national team are not asked to share care experience data; however, teams are encouraged to consider this throughout the process.

Process measures

Process measures are context specific and depend upon the change ideas being tested and implemented. Healthcare Improvement Scotland will work with teams to develop appropriate process measures based on the change ideas they are testing locally.

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

ACRT

- % of all new referrals that are redirefcted to other acute specialities.
- % of all new referrals that are redirected back to primary care.

Patient Initiated Review

- % of patients who opt in to patient initiated reviewed.
- % of patients on PIR pathway who request an appointment.

Waiting list validation

- % of patients removed from the waiting list following review.
- % of patients avoiding unnecessary appointments.

One stop clinics

- Average number of of days from referral to appointment.
- % of patients referred onto one stop clinic pathway.

Patient information provision

- % theatre utilisation.
- No of late cancellations.

Balancing measures

Balancing measures check for possible unintended consequences elsewhere in the system while improving the balance between capacity and demand. Measures may 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. Teams working with Healthcare Improvement Scotland are required to consider balancing measures based on the change ideas they are testing locally. The HIS team will support services to develop balancing measures.

Examples may include;

Staff experience: This could be as simple as using a five-point scale at the end of shifts.

Redirected/removed referrals: Patients being re-added to the waiting list, resulting in increased waits.

Example measures

Concept	Measure	Operational definition guidance	How to interpret	Data collection	Presentation
Demand for care Total number of requested 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 non-clinical	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.

			removals (e.g. moved away) and cancellations where the slot was reused to offer first appointment.		
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 (e.g. did not attend 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 maximizing the number of appointment slots attended. This measure plus the slots lost to non-attendance 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	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	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.

		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.	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.		

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