Managing waiting lists 2.1

Sometimes it seems that the NHS is primarily about waiting lists. Public perception focuses on waiting lists. Waiting lists provide media headlines. For those working within the NHS, it seems that too often the real work of providing a quality service for the people of Wales is lost in a concern for waiting times and targets.

What can be done to reduce waiting times? Chapter 2 deals with basic waiting list management: validation, prioritisation and the calculation and use of Primary Targeting Lists (PTL), rates and scores, patient focused booking, management of referrals, pooling and appointment booking.

PRINCIPLES
Some fundamental principles apply to the management of all waiting lists.

- The number of waiting lists should be kept to a minimum for each patient pathway or specialty through the use of pooling of referrals. This is dealt with in more detail in Chapter 2.6.

- Regular planning meetings should take place involving staff from across the whole patient pathway. The meetings should consider the demand on the service, the available and resourced capacity, the backlog and activity and variation in the service provided.

- The default position for the provision of outpatient services should be that follow-up is not provided unless clinically appropriate. There should be agreement with primary care about service provision and which conditions should be managed by primary care. Patients should be fully informed of service provision at the point of their referral to specialists.

- Alternatives to face to face follow-up should be available and included in reporting of activity e.g. virtual follow-up or letter to patient.

- Clinic cancellations should be avoided through the robust implementation of leave policies requiring six-week notification for clinical staff for all planned leave, including holiday and study leave. Short notice leave such as sickness, can have a significant impact on services and should be proactively managed.

- Sustainable service provision should be created across organisational boundaries that make best use of scarce specialist resource.

- The use of ‘see on symptom’ or ‘patient initiated’ appointments should be widely available, where clinically appropriate to enable patients to have control of their health and wellbeing and avoid the provision of appointments that do not meet patient needs.
Managing waiting lists 2.1

- Health boards should have organisationally agreed procedures about the application of the Rules for the management of referral to treatment waiting times 2017.

- Staff involved in the management of waiting lists should have access to an accurate waiting list on a daily basis.

- All patients on a waiting list should receive fair and equitable treatment, including those with adjustment to their pathway.

- A patient should only be placed on a waiting list if they are eligible to receive the service and the patient’s needs could be met tomorrow if no waiting list existed.

- Patients should be fully informed of what to expect from a service from the outset; this will help to manage expectations and meet the needs and goals of the patient.

UNDERSTANDING THE DEFINITIONS
The Welsh Government uses ‘Rules for Managing Referral to Treatment Waiting Times 2017’ to monitor waiting times across Wales.

VALIDATION
Validation of waiting lists, both administrative and clinical should be routine. 2.2 covers the principles of validation.

CLINICAL PRIORITISATION
Clinical prioritisation is a key factor in managing waiting lists. 2.3 looks at this in more detail.

PRIMARY TARGETING LISTS
PTL involve the ordered treatment of patients by referral date. Section 2.4 covers how PTL help to reduce waiting times.

PTL implementation is an important tool in the performance management process in Wales. There are waiting lists in the NHS because the management of lists could be improved. Additionally, demand for outpatient appointments outstrips capacity. Alternative ways of managing some patients needs to be further developed.
Over time, waiting lists become out of date. Patients may need an outpatient appointment when they are first added to the list, but circumstances may change. They may choose to have treatment at another location (either in the NHS or in private practice). They may move to another area. Their condition may improve so that treatment is not required. They may die. Systems must be in place to ensure that these patients are removed from the waiting list.

WHAT DOES VALIDATION ACHIEVE?
Validation ensures that the number of patients waiting for an appointment is an accurate figure. Health board performance may appear to be worse than it actually is if waiting lists contain high numbers of people who are not actually waiting for treatment. It may affect information given to patients, who will think that they may have a longer wait than is actually the case. It may also lead to wasted clinical time if patients not needing to be seen are given appointments for treatment.

PRINCIPLES
- Validation letters must be clear and unambiguous.
- Validation should start at the point of referral and be repeated at every patient contact whilst the patient remains on the waiting list.
- There is a need to balance the gains from validation against the time and cost of undertaking it.
- The longer the waiting time for each patient, the more frequently each patient should be validated.
- Patients who do not engage in the validation process should be removed from the waiting list; the patient and referrer should be informed.
- Telephone validation should be scripted.
- Validation is an opportunity to learn from the process to facilitate improvement to the system.
- At the point of first contact, the type of contact the patient prefers should be established. The validation can be by letter, phone, email or using other technology.

PATIENT FOCUSED BOOKING AND SELF-VALIDATION
In patient focused booking, there is an opportunity to engage patients in self validation by inviting them to contact the health board to update personal information while the patient is on the waiting list. This should be done in the initial letter to the patient notifying them that they have been added to the waiting list. This will ensure that records are kept up to date. Patients should be advised to discuss any change in their health with their referring GP.

While patient focused booking will validate patients before they are called for treatment, it does so when the patient reaches the top of the waiting list. Where waiting times are long, waiting lists will remain inflated if the lists are not validated at interim stages.

However, it is also important, where validation is done, to get the best value for the money spent.
Validation letters must be clear and unambiguous. The validation process involves removal of patients from the waiting list if they do not respond to the validation letter and this should be made clear to the patient. Patients and the referrer should be informed of removal.

Telephone validation should be scripted. Questions should be phrased such that the desired information is elicited; asking a patient whether they wish to remain on the waiting list will result in fewer removals than questions that ask if the patient is still having clinical problems; this should be asked in a way that the patient will understand. Clinical terminology should be avoided. It is also important to make clear to the patient that there are mechanisms for getting back on the list if their condition worsens within a specific time period.

Each contact or attempt to contact a patient should be recorded and available for subsequent audit.

**Patient responses to validation**
Validation can be an imposition on patients and too frequent validation may lead to patient complaints. If the only communication that a patient receives from a health board is a regular letter asking whether they wish to remain on the waiting list, they may have a negative impression of the health board. The more frequent the validation and the longer the list, the more patient perception of the process will become a problem.

**Timing of validation**
There are two ways in which validation can be timed – in bulk or continually. The health board may decide to do bulk validation at regular periods; for example all ENT validation in February and August. This approach has disadvantages. The validation workload is intensive and if done episodically, will lead to significant peaks in workload. Additionally, the purpose of validation is to link it to the patient process and if a speciality undertakes three monthly validation exercises, patients will be validated at less than three months on the list, or may wait up to 5 months before being validated. For this reason, where bulk validation is the only option, it needs to be done more frequently, although each patient should receive a limited number of validation letters.

Continual validation can be generated by the Patient Administrative System (PAS). Procedures in the PAS should automatically generate validation letters at the point where the wait hits specified time frames such as 6 weeks and 12 weeks. The advantage of this is that there are small numbers of letters generated every week, rather than very large numbers every few months and the validation process can be handled as part of the ongoing work of the department, rather than as an infrequent additional task.

Continual validation also ensures that small numbers of patients are removed each week, rather than large numbers at the end of a longer period. Infrequent ‘bulk’ validation will lead to artificial peaks and drops in patient waiting list numbers, where continual validation will not.

Frequent validation will have diminishing returns, with fewer removals each time the validation is performed. Most removals come from the first validation. There will be a high removal rate for this validation. There is no need to do validation close to the appointment time.
Placing the patient on the outpatient waiting list
When a new referral is received, the first step should be to avoid duplicate referrals for the same reason.

As part of the patient focused booking process, it is necessary to contact patients by mail and sometimes by phone. At the point of first contact, the type of contact the patient prefers should be established; this can include text where appropriate, email, phone or mail. It is vital that up to date information is stored on the PAS to allow that contact to happen. On receipt of a referral from a GP, the referral must be checked by clerical staff to ensure that all necessary information is included. Where it is not, the GP must be contacted and the full demographic information requested. Patients should not be added to waiting lists with incomplete demographics.

Where a referral is incomplete and not flagged by the GP as urgent, it should be recorded as received but returned to the GP practice requesting the remaining information. Where the referral is flagged as urgent, it should be processed as complete but the GP practice should be contacted by phone for the outstanding information.

Administrative validation
Administrative validation is undertaken by mail or by phone and is undertaken by management and clerical staff. It is primarily designed to determine whether the patient details are correct; whether the patient wishes to remain on the waiting list and review of the patient pathway in relation to Welsh Government Rules for Management of Referral to Waiting Times.

Every contact with the patient is an opportunity to discuss if any action is required to facilitate the patient pathway being reinstated as appropriate.

Particular care is required in the validation of a patient who is on more than one waiting list; validation of both lists should be completed in parallel.

Despite on-going validation of waiting lists, Betsi Cadwaladr University Health Board identified an issue with clerical errors that resulted in inflated waiting lists. Training was undertaken to resolve this issue resulting in a 35% reduction in their follow up waiting list. Read the case study

Clinical validation
Clinical validation is a more complex and more time consuming process. The purpose of clinical validation is to determine whether the patient’s clinical condition has changed in any way that may lead to their removal from the waiting list or re-prioritisation.

In the tertiary paediatric cardiology service in Aneurin Bevan University Health Board, there was a problem with 147 patients who had not received a follow up appointment within the timeframe that the Consultant had originally requested i.e a missed target date for their follow-up appointment. Clinical review of patient notes reset the order of who needed to be seen based on their clinical priority. Within 6 months there were just 8 patients on the ‘follow-up’ list without a date. Read the case study
Clinical validation can be undertaken by GPs or by health board staff. In the case of outpatient referral waiting lists, it is by default the GP who will need to undertake the validation. The health board may supply the practice with practice-based lists of patients waiting for an outpatient appointment and the medical records of those patients are reviewed to ensure that the patient still requires the appointment. Although the review process is undertaken in primary care, any contact with the patient advising them that their status has changed should be undertaken by the health board which has requested the validation.

In the case of validation of diagnostic or treatment lists, the clinical validation can be performed in the health board, or in primary care, or both.

Health board based validation can be either a review of the notes, or a clinical reassessment of the patient. Review of patient notes will have limited value, as it is unlikely that any information will be included in the record that will not have already been acted upon. Each organisation is best placed to decide on the need for clinical assessment. Likewise, GPs are best placed to consider the value of each patient remaining on a waiting list dependent upon the individual patient’s circumstances. Clinical validation should be undertaken during pathway re-design as patients may need to be moved within services.
Traditionally patients on waiting lists are prioritised according to a simple system: they are either 'Urgent Suspected Cancer' or 'Urgent' or 'Routine'. These terms are fundamental to the development of waiting lists.

THE ‘TRADITIONAL DEFINITIONS’

For outpatients, ‘urgent’ has traditionally meant that the patient needs to be seen within four weeks and ‘routine’ patients should be seen and start their treatment within 26 weeks and 36 weeks for complex cases. Newly diagnosed cancer patients that have been referred as ‘Urgent Suspected Cancer’ (USC) and confirmed as such by the specialist, should start definitive treatment within 62 days from receipt of referral at the health board. More information is available in the Cancer specific additional guidance 2017.

There is a fundamental flaw in all prioritisation methodology. As soon as prioritisation is used to ensure that one patient receives treatment ahead of another based on any criterion other than time waiting, some patients will wait longer. ‘Jumping the queue’ no matter that it is for the best of reasons, means that those at the back of the queue will have to wait longer. The higher the degree of prioritisation used, the longer those at the back of the queue will wait.

Overall, the best way to ensure that all patients wait the shortest average time is to have no clinical prioritisation at all, and to see each patient strictly in turn according to when they were added to the waiting list. However, unless there is a very short waiting time, there is always going to be clinical risk if some patients wait too long. In these situations, a level of prioritisation should be used.

PRINCIPLES

- The best form of prioritisation, if it must be used, is one with the fewest categories. The simple, ‘Urgent Suspected Cancer’, ‘Urgent’, ‘Routine’ is in fact a good degree of prioritisation to use in most situations where there are long waiting times.

- Prioritisation categories should be agreed with clinicians and applied consistently across a specialty or pathway within a health board. The waiting time for each category should be agreed with consideration of clinical risk and service provision.

- Patients within each category should be seen in referral date order.

- Peer review of prioritisation should be undertaken where there are concerns about length of wait for patients with high clinical risk.

- Systems should be in place to enable GPs to raise concerns about a patient waiting for an appointment without the need for re-referring patients for the same reason. Robust communication with GPs is vital in the provision of high quality services.

Finally, the important thing to remember about clinical prioritisation is that it is all about patients waiting. Prioritisation is a way of ensuring that no harm comes to those who have to wait. The best and most reliable way of achieving that goal is to have no waits.
CHAPTER TWO: WAITING LISTS AND BOOKING

Calculating and reporting primary targeting list scores 2.4

One of the key principles of good management of waiting lists is that patients of equal clinical priority should be treated in order of their referral date. In this section we look at how to order your waiting list and how to check if your waiting list is being managed to keep overall waiting times to a minimum.

Primary targeting rate (PTR) and Primary targeting list score (PTLS) are generally used to monitor effective management of routine patients. Where there is a large backlog of urgent patients, it may be useful to separately monitor PTR and PTLS for urgent patients but this should be for a limited period of time.

PRINCIPLES

- Wherever a waiting list exists, Primary Target Lists (PTL) should be used to allocate appointments to patients in order of clinical priority and referral date.

- Primary Targeting Rate (PTR) is the percentage of patients being seen in the appropriate chronological order.

- Primary Targeting List Scores (PTLS) is the percentage of the longest waits being seen in the appropriate chronological order.

- Health Boards should work towards a target PTLS of 80%; this flexibility allows for issues related to patient choice and clinical freedom without adversely affecting performance to the target.

Imagine you have a waiting list of 25 patients and 10 routine patients are seen (or treated) in a month.

In order to keep overall waiting times down, it is useful to know how many of those 10 routine patients have been seen in appropriate chronological order, i.e. in order of patients waiting longest.

If you organise your routine waiting list so that patients are in order of waiting time, how many of the 10 that were actually seen would be in your top ten on your list?

If 4 patients seen would be in your top ten, then only 40% were seen in appropriate chronological order.

This is your Primary Targeting Rate. A PTR of 100% would indicate that for a particular month, the patients were seen in the appropriate chronological order. This isn’t likely to happen in real life, due to patient choice and subspecialisation.

Rather than simply counting patients, it may be useful to factor in how long they’ve been waiting. This is particularly useful where there is a wide range of waiting times.

Taking the same waiting list and same 10 patients that were seen, look at how many days they have collectively waited and compare it to the patients in your top 10 and their collective length of wait.
In this example, the 10 patients seen waited a collective 355 days. However, the patients in the top 10 had waited a collective 628 days. If your patients were seen in an appropriate chronological order then this is how much time that would have been removed from the waiting list.

As a percentage of the collective time that could have been removed from the list, only 57% were removed from your waiting list.

This is your Primary Targeting List Score (PTLS). It is more difficult to calculate (perhaps your information teams could help) but this complements the PTR to indicate how well the waiting time is being kept to a minimum. Having used an example to introduce these measures, the calculation for both measures is outlined below.

**PRIMARY TARGETING RATE**

The Primary Target Rate (PTR) figure 2.1 is a simple measure that illustrates the ratio of the number of patients seen or treated compared to the number of patients who could have been removed from the waiting list if all were seen in the appropriate chronological order.

The PTR is calculated as follows:

1. Identify all **routine** patients treated during the month
2. Obtain an extract of the current **routine** waiting list
3. Add the **routine** patients treated during that month to that list
4. Sort the list by the ‘receipt of referral date’
5. Count how many routine patients were seen during the month (B)
6. Count this number places from the top (longest wait) of your waiting list and draw a line
7. Now count how many of the seen patients fit into this group (A)
8. Divide A by B and multiply by 100

![Figure 2.1]

Number of routine patients seen from the group at the top of the list (A) x100 = PTR %

Total number of routine patients removed from the waiting list (B)
Calculating and reporting primary targeting list scores 2.4

**PRIMARY TARGETING LIST SCORE**

The Primary Targeting List Score (PTLS) takes into account the time a routine patient has spent on the waiting list. The number of days on the list is used for the calculation. It therefore distinguishes between picking patients from the top of the list (with longest wait) and picking patients close to the end of the list (with shortest wait).

**The PTLS is calculated as follows:**

1. Identify all routine patients treated during the month, and calculate the total number of days those patients have waited: see figure 2.3 for an example.
   a. Days waited per patient = ‘appointment (or treatment) date’ minus ‘receipt of referral date’
   b. Total days waited = sum of days waited for treated routine patients; see figure 2.2

2. Obtain an extract of the current routine waiting list.

3. Add the routine patients treated during that month to the list. Sort the list by the ‘receipt of referral date’

---

<table>
<thead>
<tr>
<th>PATIENT TREATED</th>
<th>DAYS WAITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>210</td>
</tr>
<tr>
<td>B</td>
<td>142</td>
</tr>
<tr>
<td>C</td>
<td>130</td>
</tr>
<tr>
<td>D</td>
<td>123</td>
</tr>
<tr>
<td>E</td>
<td>213</td>
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<tr>
<td>F</td>
<td>132</td>
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<tr>
<td>G</td>
<td>141</td>
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<tr>
<td>H</td>
<td>220</td>
</tr>
<tr>
<td>I</td>
<td>137</td>
</tr>
<tr>
<td>J</td>
<td>154</td>
</tr>
</tbody>
</table>

---

**Total number of days removed from the waiting list**

\[
x \times 100 = \text{PTLS \%}
\]

**Total number of days which could have been removed from the waiting list**

---

**Example**

---

Figure 2.2

Figure 2.3
Calculating and reporting primary targeting list scores 2.4

4. Calculate how many days **could have** been removed from the routine waiting list. To do this, calculate how many routine patients were treated that month and count that many places down from the top (longest wait) of the list. For example, if 10 routine patients were treated in that month, count down 10 places from the top of the list. Now calculate days waited for each of these patients, based on a hypothetical assumption they were seen mid-month (e.g. 15th of the month) see **figure 2.4**

5. Calculate the PTLS as total number of days removed from the waiting list, divided by total number of days which **could have** been removed from the waiting list, multiplied by 100 (to get a percentage)
That is: (Step 1b ÷ Step 4) × 100 = PTLS%; see **figure 2.6**

<table>
<thead>
<tr>
<th>PATIENT FROM PTL</th>
<th>DAYS WAITED</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>231</td>
</tr>
<tr>
<td>2</td>
<td>230</td>
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<td>3</td>
<td>230</td>
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<td>9</td>
<td>209</td>
</tr>
<tr>
<td>10</td>
<td>208</td>
</tr>
</tbody>
</table>

Possible total no of days removed from waiting list: **2,178**

**Figure 2.5**

Create a ‘total days wait’ for these patients by adding them all together. see **figure 2.5**

**Figure 2.4**

<table>
<thead>
<tr>
<th>Calculate the PTLS as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,602</td>
</tr>
<tr>
<td>2,178</td>
</tr>
<tr>
<td>×100 = 74 %</td>
</tr>
</tbody>
</table>

**Figure 2.6**
Calculating and reporting primary targeting list scores 2.4

It is possible to get a relatively high score even though there were less than half of those patients treated within the top group of patients.

This is because no patients were taken from the shortest waiting part of the list; although the list was targeted imperfectly, in general patients were removed from the top of the list, not randomly throughout.

If more patients with a much shorter waiting time are removed the PTLS will be lower.
This section looks at a number of different aspects of outpatient booking. The total approach to booking is referred to as 'patient focused booking' and this phrase should be used whenever possible.

**WHY PATIENT FOCUSED BOOKING?**
The Prudent Healthcare principles recognise the importance of patient involvement in the booking of hospital appointments. 'Create a new relationship between the public and NHS Wales, based on openness and sharing information.' Active involvement of a patient in the booking process, enables them to take some responsibility for their own health and well-being. 1000 Lives Improvement recommends that all appointments between patients and health boards be made by agreement. This is also stipulated in the Rules for Managing Referral to Treatment Waiting Times 2017 and will help to avoid DNAs. In some cases, this means that appointments are made while the patient is present (for example, some follow-up outpatient appointments) while in other cases it means that appointments are made by telephone. In some cases, it will mean that an appointment with another health provider is made at a previous appointment. For example, a secondary care outpatient appointment may be made while the patient is at their GP surgery.

**Patient focused booking applies to full booking, automated booking, direct booking and partial booking.**

**Full booking**
The key principle of full booking is that the patient leaves an appointment knowing the exact date and time of their next appointment. Full booking requires a date to be negotiated with the patient no matter how far into the future an appointment will be.

**IMPORTANT** With a 6 week policy for leave, it is not possible to give the patient a reasonable assurance that the health board will be able to keep an appointment made several months into the future.

**Partial booking**
Under the partial booking process, an acknowledgment should be sent to the patient when the referral is accepted. This should explain the booking process that will be used for their appointment. A second letter, text or email should then be sent to the patient four weeks before it is anticipated they will be seen, asking them to phone and make an appointment within the next 10 days. In some cases the second (phone) correspondence, will include a proposed appointment date. The patient should be informed about their options and timeline to change this appointment.

Where partial booking is used which relies on the patient phoning to arrange their appointment, health boards should have efficient booking systems that enable patients to access the service in a timely way.
Abertawe Bro Morgannwg University Health Board identified problems with patients phoning to book appointments – they often had to wait ‘on the line’ for long periods of time only to be ‘cut off’ or ‘hang up’. A new telephone flow system improved the patient experience. The percentage of calls answered has risen from 86% to 96%. Read the full case study.

Patients should be informed of the importance of arranging their appointment in a timely manner and the consequence of not doing so.

Direct booking
If a patient is to be seen within six weeks a direct booking system should be used. Direct booking can take place in two ways. An appointment can be either booked in person with a patient or during a telephone conversation. The appointment being booked should be no more than six weeks into the future. Electronic booking, as an enabler of direct booking, may also be used.

Automated booking
Fully automated systems send the patient a letter, text or telephone call offering an appointment date. A process should be in place to allow the patient to play an active role in changing the appointment if it is not mutually agreeable. Cardiff and Vale University Health Board has seen a reduction in DNA from 13% to 5% and an increase in the re-utilisation of cancelled appointment slots since the introduction of fully automated booking. Read the case study.
Traditionally in the NHS, referrals have been made from a GP to a named Consultant. Patients seeing a specific Consultant have been placed on that Consultant’s waiting list. Patients seen in one location are usually followed up in the same location. Patients seen on one site will often have their diagnostic procedures performed on that site. Patients referred to secondary care, tend to be seen by a clinician with a specialist and possibly sub-specialist interest. All of these factors can increase waiting times and all can be addressed through generic referrals and pooling.

PRINCIPLES
Some basic principles are fundamental to the management of referrals:

- Referrals should not be graded by the referrer unless a red flag criteria applies; this ensures that clinical prioritisation is applied appropriately and consistently.

- Guidance should be agreed between GPs and specialists for clinical management of any condition. This will avoid referral to specialists of cases that could be managed by primary care.

- In each specialty there should be agreement about case mix for clinicians to avoid any imbalance within clinical teams.

- Pooling should be used for all waiting lists unless clinical exception exists and is agreed.

- Processing of referrals, from receipt of the referral to clinical prioritisation and adding the patient to the appropriate waiting list, should take place within an agreed timeframe. Electronic methods should be used in the management of referrals where possible.

- The most appropriate person should triage; multiple triage should be avoided unless clinically appropriate.

- Patients should be informed about their pathway from the outset. Information should include prioritisation, who they will see, where they will be seen and any options about choice of where they will be seen that are available to the patient.

- Patients should be involved in making decisions about all available treatment options, taking account of individual goals and be fully informed of the referral process.

- Patients should be seen as close to home as possible. The most convenient option for minimising travel should be discussed. Venues a distance from the patient’s home will be considered reasonable if this was explained to the patient when they were referred or in the receipt of referral acknowledgement.

WHAT ARE WAITING LISTS?
Waiting lists are simply queues and a lot can be learnt about managing waiting lists from how other organisations manage queues.
CHAPTER TWO: WAITING LISTS AND BOOKING

UNDERSTANDING QUEUES
Queuing theory is a well developed science in mathematics and fortunately one does not need to understand it in depth in order to make progress on managing waiting lists. The one thing it is important to know is that a single queue in front of multiple ‘windows’ will have shorter overall waiting times than a series of short queues in front of each window.

The basic unit of the queue is the PTL described in 2.4. Rather than each Consultant having a single outpatient waiting list, there should be a single list for the speciality. Eventually, outpatient lists should be managed as a single process on a single list. This is the same as having a single queue in a bank and the customer going to the next available window.

MANAGEMENT OF SUBSPECIALISATION
Unfortunately, waiting lists are not bank queues. There are multiple priorities within waiting lists and there are multiple subspecialties within a speciality. Multiple priorities within a list are easily managed through the use of PTLS, as illustrated in section 2.4. Management of subspecialisation is more of a problem, but it is one that must be resolved. There are three possible solutions.

1. Maintenance of a ‘pooled’ list
The simplest solution to the problem of pooling in subspecialties is to maintain a generic pooled list in addition to each Consultant’s own subspecialty list. All patients who need to be seen within a subspecialty are added to the individual Consultant list, while those able to be seen by any Consultant are added to the pooled list. The pooled list should be managed at the same level of priority as the individual lists.

2. ‘Hidden’ pooled lists
It may be preferable to ‘hide’ the descriptors that indicate which list patients are on. This solution is the best option where it can be implemented electronically, or where waiting lists are maintained centrally. It is harder to co-ordinate lists where each clinician or their secretary maintains the list.

Step 1: In this method, separate lists are maintained on the IT system; one for each subspecialty and one for the generic patients. Patients are added to the bottom of each list. See figure 2.7.

Figure 2.7
Step 1: Three different lists

<table>
<thead>
<tr>
<th>1</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>4</td>
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<tr>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

Consultant A  Consultant B  Generic Lists

Figure 2.7
**Step 2:** When the lists are displayed, the subspecialty lists are merged with the generic list in referral date order. Patients from the generic list (the blue cases in figure 2.7 – see page 35) are shown on each list. The patients have not been added to both lists — they still exist on a third actual list, so they are not duplicated although they appear to be. They are simply shown in the new ‘virtual’ lists as demonstrated in figure 2.8.

When the lists are displayed, it is important not to distinguish on screen between the generic patients and the subspecialty patients. Each Consultant will see a single waiting list of their own patients merged with the generic patients, with no visible distinction between the generic and the subspecialty patients. See figure 2.9. This avoids any preference for particular patients.

The reason that this method works best when implemented electronically or through a centralised waiting list management team is that otherwise there is the possibility for a patient to be picked from the list by more than one Consultant. In an electronic system using virtual lists, record locking protocols will prevent multiple picking, while in a centralised environment management procedures can be put in place to have the same effect.
3. The Matrix approach
What if it is not possible to implement a generic list either electronically or centrally? What about situations in large health boards where there may be multiple consultants in each subspecialty, making the implementation of the ‘hidden’ pooled list more complex? A number of health boards use an approach of adding each new referral to the shortest waiting list, using a matrix to determine which waiting lists are available.

**Step 1:** sit down with the clinical staff in the speciality, list all the conditions on the waiting list and all the staff available to see or treat those patients. A matrix is then constructed; see figure 2.10.

**Step 2:** Then, with the involvement of clinical staff, each cell of the matrix is filled in so that every condition has at least one Consultant marked.

Where there is not a Consultant, it must be determined who is available to see those patients, or what the health board policy is for managing those patients. There must be no blank rows on the matrix; see figure 2.11.
Step 3: Each row of the matrix can now be considered as a ‘clinical care or pathway group’, i.e. a group of patients who can be managed by a specific group of clinicians. Some Consultants may appear in several clinical care groups with different colleagues; see figure 2.12.

Figure 2.12
Step 3: Identify the clinical care group (CCG)

Each Consultant will have their own entirely unique waiting list. The patient is added to the shortest waiting list within the clinical care group.

What do we mean by shortest?
There are many definitions of ‘shortest’ when describing waiting lists. Each has potential problems.

Fewest patients on the waiting list
This definition does not take into account the rate at which patients are removed. A Consultant who manages a lot of complex cases will take patients off the waiting list at a slower rate. A Consultant who has many outpatient clinics will remove outpatient referrals at a faster rate than one who has few clinics.

Shortest wait
The Consultant with the shortest maximum waiting time may seem a sensible definition of shortest, but it is defining shortest future wait on the basis of shortest historical wait and will not take account of changes in circumstances.

A better definition, which is prospective rather than retrospective, is clearance time. This is calculated on the basis of the number of patients on the waiting list divided by the rate at which patients are being removed. The clearance time in weeks is the number of patients on the list, divided by the number expected to be removed each week. In effect, this is the time that it would take to clear the list if no new patients were to be added, or the time that a patient added today could be expected to wait.

Clearance time will only be accurate as long as circumstances do not change, but will be adjusted automatically if circumstances do change. It does take some account of casemix on the list, as casemix will affect removal rates. Counting on the basis of casemix would be even more accurate.
CHAPTER TWO: WAITING LISTS AND BOOKING

Who owns the pooled list?
There is one final question: who has clinical responsibility for a pooled or generic list? It is a requirement of the Welsh Government that every patient waiting on an outpatient list is allocated to a specific Consultant in terms of clinical responsibility. Where a matrix approach is used to allocate patients to lists, generic or pooled lists do not exist so this is not an issue. Where ‘hidden’ pooled lists are used, or even the simple pooled lists mentioned first, there needs to be a named Consultant for the pooled list.

In most cases in Wales, the Clinical Director of the service has taken on responsibility for the pooled list and is recorded as the named Consultant. The important thing to keep in mind is that the named Consultant for a pooled list has responsibility for the patient while they are waiting. Once the patient has been booked for surgery with a Consultant, they become that Consultant’s responsibility.

The impact of pooling
Pooling will have its biggest impact when there are significant differences between the length of waiting lists (either by Consultant or site). Where lists are relatively even, the effect of pooling on waiting times will be less. However, the use of pooling and generic referrals is good practice and should be encouraged even when the impact on waiting lists would be minimal.

WHY GENERIC REFERRALS?
Generic referrals are referrals sent to the health board, rather than a named Consultant. In most cases, the referral will be to a ‘Dear Doctor’. Generic referrals are good practice. They recognise that the health board delivers a service, not solely the Consultant and they allow the health board and primary care to determine how the service should best be provided (either pooled Consultant lists, or alternative practitioners). Generic referrals will promote equity of access as waiting times will be based on the date referred rather than the Consultant referred to.

Cost savings will be found when the use of generic referrals means that patients can be seen, where appropriate, by staff other than a Consultant. This will reduce the cost per case, allowing greater volume through the system.
This section deals in detail with the booking process: how and why partial booking works.

**PRINCIPLES**

Some fundamental principles apply to the booking process:

- The preference for the type of communication the patient prefers should be identified at the outset of the booking process, along with confirmation that the patient is on the waiting list and how long the expected wait is.
- Whichever type of booking process is used, the rules related to ‘reasonable offer’ should be followed.
- At least 80% of all patients should be booked for appointment in chronological order of the date of referral being accepted; the remaining 20% should include specified exceptions.
- Appointments should be mutually agreed with patients (new and follow up).
- If the patient is asked to phone to make an appointment, the consequence of not phoning promptly should be included i.e. other patients may take the available appointment slot.
- Patients with Urgent Suspected Cancer should be seen and treatment commenced within Welsh Government targets. More information is available in *Cancer specific additional guidance 2017* Booking systems must be set up to ensure that these patients will be seen within the required time.
- The health board leave policy requiring six weeks notification of any planned leave that will affect an outpatient clinic, should be proactively managed to avoid the cancellation of patient appointments.

**PATIENT FOCUSED BOOKING BASICS**

1000 Lives Improvement recommends the phrase **patient focused booking**, which incorporates the entire booking process. This document defines partial booking as part of the overall booking process.

Partial booking is not, in itself, a form of booking. It is a way of managing the waiting list to ensure that when booking takes place, it is done with the active involvement of the patient.

A reasonable offer to a patient is defined as any date mutually agreed between patient and organisation.

Abertawe Bro Morgannwg University Health Board introduced partial booking to enable patients to have more choice over their appointment – this has helped to reduce DNAs.
The booking process 2.7

The average variance between the two years (pre partial booking and after) shows a reduction in the DNA rate of 1.14%; 11% of patients who received letters were removed from the waiting list for either not responding or requesting removal – potential savings of £200,000 of wasted appointment time. Read the case study.

Partial booking is a set of processes and procedures to manage the waiting list (such as the integration of primary targeting lists into the patient letter generation process); a set of principles for patient booking (such that no appointment is made without the direct involvement of the patient either by phone or in person); a set of practices, such as the use of an appointment centre to provide a single and central point of contact for patients within the health board and to make efficient use of available appointment slots.

In summary, if the appointment is going to occur within the next six weeks, then full booking should be used. If it is going to be further than six weeks into the future, then partial booking should be used.

The acknowledgement letter
As a patient is registered and prioritised, a letter, text or email is generated telling the patient the approximate wait and to expect another communication closer to the time. A letter, email or text should be sent to the patient four weeks before they need to attend, asking them to phone and make an appointment. An explanatory leaflet (hard copy or electronic) on the process should be provided to the patient with the acknowledgement.

Management of ‘Do Not Attend’.
If the patient ‘does not attend’ (DNA) an agreed appointment without giving notice, the patient should be removed from the waiting list. The patient and referrer should be notified. If the Consultant responsible for the patient considers that the patient should not be removed for clinical reasons they remain on the waiting list but their ‘clock’ will be reset. Systems should be in place to enable clinicians to make effective and efficient decisions about the clinical need for another appointment, rather than all patients routinely offered another appointment. The DNA reset may be applied a maximum of two occasions in any given pathway. Notification of reset should be sent to patient and referrer.